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and oral

health care

development

WHO/AFRO Regional Strategy for Oral Health in Africa

By Dr Charlotte Ndiaye

It is with great pleasure and a real honour for me to address the international community through this important journal. This has given me the chance to share with you my vision of oral health in the African Region, my mission as Regional Health Advisor at the WHO Regional Office for Africa, our programme, our constraints, and our future prospects.

The problems of oral health that countries and their populations are faced with are constantly on the rise. These problems are reaching a serious nature due to the limited attention given to them by African governments, where poverty and the extent of communicable diseases (AIDS, tuberculosis, malaria, etc.) require a prioritisation of their interventions.

The profile of oral diseases appears to be changing more and more in our countries. In addition to dental caries and periodontal disease, which remain high, oral health workers are confronted with other pathologies such as NOMA, buccal lesions due to HIV/AIDS infection and oral cancers. This is giving dental

*... the African Region
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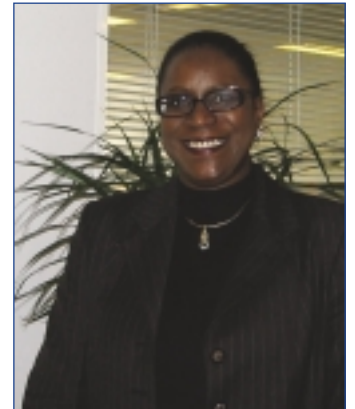
surgeons a new role, which consists not only in taking the medical status of these patients into account, but also in the detection and prevention of some of these diseases.

Consequently, it is obvious that the African Region faces a number of oral diseases as a matter of emergency, either because of their high morbidity rate, or due to the gravity of their prognosis or to their high mortality rate.

These facts led WHO/AFRO in 1999 to develop a regional strategy for oral health in the African Region for the next ten years.

The rationale for a regional oral health strategy

It is essential that existing strategies be reviewed, and that



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we take stock of our approach and facilitate the application of interventions that have proven their effectiveness.

As a matter of fact, after a follow-up period, we noticed that:

- Most African countries do not have oral health policies (only 14 out of 46 countries)
- There is a great difference as regards the supply of oral health services in underprivileged communities.

- The poverty prevailing in our region imposes an unequal distribution of budgetary resources allocated to health, which has important repercussions on resources granted to oral health.
- Efforts deployed up to now have mainly consisted in the management of oral health services depending on the circumstances, favouring a curative approach at the cost of prevention, without any planning at all.
- Training of oral health workers is often not adapted to the reality of the countries concerned and does not take their real needs into account.

Our vision for oral health in Africa

To assist countries in ensuring that the African population enjoys improved levels of oral health and function through a significant reduction of all oral diseases and conditions that are prevalent in the region, equitable access to cost-effective quality oral health care and adoption of healthy lifestyles.

To achieve this, several guiding principles have been elaborated emphasising a preventative participative approach targeting communities, especially women and children.

Our achievements

In view of this, the implementation of a regional strategy has allowed us to:

- Support countries in the drawing up of national oral health policies
- Develop and implement programmes against NOMA and oral manifestations of AIDS.
- Favour the integration of oral health in the PCIME programme (Integrated Care of Childhood Diseases) and school health programmes.
- To review training curricula of oral health workers in order to adapt them to the requirements of the countries concerned. A workgroup was set up in June 2002 bringing together the Deans of Dentistry Faculties and Directors of African Dentistry Schools.
- As far as research is concerned, the current emphasis is on effective collaboration with traditional medicine.

The programme to fight NOMA

With the shift of the NOMA programme from WHO Headquarters to WHO/AFRO there seems to be renewed interest in NOMA, which had appeared to be a forgotten disease. We were able to turn



A child with NOMA

the NOMA programme into a pioneering programme combining activities for a specific disease and a programme devoted to oral health prevention in general.

NOMA is a truly oral disease beginning in the mouth and leading to facial mutilations as it develops. In particular, it targets very young children. It is a disease affecting the poorest among the poor, rampant especially in Africa, and a predisposing factor for other childhood diseases such as measles or malnutrition.

The programme will start in four African countries thanks to a donation from the WINDS OF HOPE Foundation and its president, Bertrand Piccard. It will be devoted to the prevention and early detection of cases of NOMA, and to the training of instructors such as teachers, midwives, district nurses, and traditional practitioners.

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We are pleased to note that the FDI, through its World Dental Development Committee, has decided to make oral health in the countries of Africa a major challenge for the future.

The fight against AIDS

HIV/AIDS infection is increasingly becoming a chronic and frequent disease in Africa, and the care of buccal lesions is proving to be crucial. Oral lesions have a positive predictive value in the detection of HIV carriers and in the clinical follow-up of patients infected by HIV. The role of oral health workers in this context cannot be overemphasised and WHO promotes programmes taking this into account. We also insist on the teaching of technical information for the prevention of viral and bacterial infections in dental practice.

FDI as partner of WHO/AFRO

The FDI World Dental Federation is the privileged and official partner of the WHO, and we are pleased to see that the FDI has set up a

development committee oriented towards the support of deprived communities. The current focus on African countries is highly welcomed.

The complexity of the inter-relations between health, environmental, and socio-economic determinants has given rise to the concept of health-poverty-environment. In all the intervention programmes in the health sector, the recommended approach depends increasingly on the promotion of health beyond the prevention and the treatment of diseases.

Well aware that, for the coming years, all action taken must be consistent with this concept and the effective implementation of the programmes will, as a result, require the active and complementary participation of partners from public and private institutions and civil society.

This is why we are pleased to note that the FDI, through its

World Dental Development Committee, has decided to make oral health in the countries of Africa a major challenge for the future. To this effect, an immense effort to plea for and mobilise resources is going to be deployed during the organisation of the international Planning Conference for Oral Health in the African Region in Nairobi.

This conference, which will bring together top-level decision makers from African countries and dental health technicians, should facilitate a revitalisation of the sector and renew partnerships. The conference will be co-sponsored by WHO and WHO/AFRO plays an active role in the planning of the event. The rendezvous is set for December 2003 in Nairobi! As African Regional Advisor for Oral Health I would like to renew our congratulations to the FDI and assure all involved of our complete co-operation and commitment.

More information:

WHO/AFRO oral health website: <http://www.whoafr.org/oralhealth/index.html>

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African Oral Health Summit in Nairobi

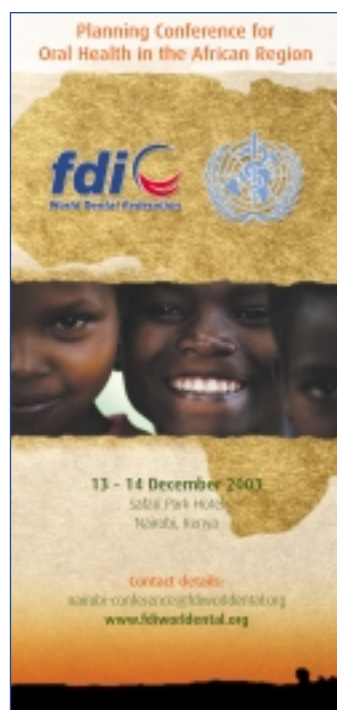
Nairobi will be hosting a major conference organised by the FDI:

The **Planning Conference for Oral Health in the African Region.**

The conference will be held on 13-14 December 2003 and will be co-sponsored by the World Health Organisation. The meeting aims at raising awareness for the impact of oral health and the link between oral and general health. Senior officers and scientists from various WHO offices, from the FDI and dental academia will highlight appropriate and effective policies and approaches to better oral health. The unique meeting will bring together all Ministers of Health of the 46 African WHO member countries, key health budget holders, chief dental officers and representatives from all African FDI member associations.

During the two days of the Conference presentations and workshops will sensitise senior African politicians about oral health matters and technical officers will get first hand information on how to develop and implement oral health policies. Numerous business meetings (i.e. of the African Regional Organisation ARO, the Commonwealth Dental Association CDA) will complete the picture.

Coinciding with these events a two day **Continuing Professional Education Programme** for dentists in



Kenya and the region will be organised jointly between the Kenya Dental Association, ARO and the FDI. In addition a small dental exhibition of local and international dental manufacturers is planned.

An optional social and excursion programme will offer participants possibilities of discovering the bustling city of Nairobi or Kenya's wildlife with several safaris organised by experienced tour operators.



If you wish to register for the Continuing Professional Education Programme and for more information about the political Conference please visit the FDI website

or contact the FDI head office at:

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The context of oral health in "Indigenous" people in Australia: a personal reflection.

By Dr Sandra Meihubers

Dr Meihubers is a public health dentist, and has spent many years working with the Indigenous communities of Australia at many levels: clinical care, health worker training, program planning and evaluation. More recently she has been involved in programs in Nepal and East Timor. (In Nepal as a volunteer dentist delivering clinical care and more recently as an educator of local dental workers) The work in East Timor has involved establishment of community-based dental services, as well as the design of the national oral health program. She is also working with the Australian Dental Association, to establish professional links with the newly formed East Timor Dental Association.

My story actually begins in East Timor. I was returning to Dili, the capital of East Timor, after working with an Australian dental colleague to set up a small dental program in a rural town. As our vehicle snaked along the winding coast road, I was discussing health issues in our respective countries with Sister Filomena, our East Timorese colleague. Sister Filomena politely enquired about Aboriginal people in Australia, and as I started to describe the state of people's health and living conditions, her eyes widened with surprise. I realised I was painting a picture of people almost in worse circumstances than in her own country; and my country is wealthy, with an abundance of resources and potential. I had to stop and gently move to another topic, as I knew that, given her limited English and my inability to speak one of her several languages, I would not be able to explain why this situation exists.

Who are Australia's "Indigenous" people?

Firstly, I must address the use of the word "Indigenous". Australia has two distinct "Indigenous" groups: the Aboriginal people, whose traditional lands and cultures occupy the mainland of Australia and Tasmania; and the Torres Strait Islander people, who inhabit the islands of the Torres Strait, that stretch between the tip of Queensland (in the country's far north) and Papua New Guinea.

At the time of white settlement in the 1700s, there were many distinct Aboriginal cultural and linguistic groups. There were an estimated 260 languages and 500 – 600 dialects spoken. Some of these languages are still spoken today. The culture of the Torres Strait Islander people, with their own distinct



Dental examinations

languages, is close to that of the peoples of Papua New Guinea and the countries of the South Pacific.

Australian Aboriginal and Torres Strait Islander people are often referred to collectively as "Indigenous" peoples. In my experience representatives from both groups feel uncomfortable with the word "Indigenous", as this fails to acknowledge the distinction

between them. Even though the use of "Indigenous" is becoming increasingly more accepted in many writings, I have chosen to respect the Aboriginal and Torres Strait Islander people by referring to them in this way rather than use the word "Indigenous" in this article.

Social and health conditions

The social and economic disadvantage suffered by Aboriginal and Torres Strait Islander people manifests in many ways. Following are just some examples of the negative impacts on their health and welfare.

Aboriginal and Torres Strait Islander people die 20 years earlier than other Australians. The life expectancy for Aboriginal and Torres Strait Islander men is close to that of many developing countries: 56 years. For women the average life expectancy is 63 years.¹ These statistics are a reality when I think of my dear friends and colleagues who are no longer here, particularly those who mentored me in my early years of working and living in Aboriginal communities, and who died before they had opportunity to fully share their wisdom and knowledge.

Within the present cultural and linguistic diversity of Australia, our Aboriginal and Torres Strait Islander population makes up approximately 2% of the total Australian population. However approximately 40% of the children in the juvenile justice system, and almost 19% of the adult prison population, are Aboriginal and Torres Strait Islander people. There are lower levels of schooling, high unemployment rates, and lower median weekly incomes.²

There has been an alarming increase in the incidence of

Type 2 Diabetes, often associated with obesity, poor nutrition, and low levels of physical activity. The rate for Aboriginal and Torres Strait Islander people aged 15 years and over, living in non-remote areas, is four times that of the general population. Aboriginal and Torres Strait Islander people aged 25-55 years experience Type 2 Diabetes at a rate 7-8 times higher than the general population¹. In some remote communities, 30% of women over the age of 30 years have Type 2 Diabetes.³ Investigations into possible predisposing genetic factors for diabetes are ongoing.

Some commentators have used the term "fourth world" to refer to the health and living conditions experienced by Aboriginal and Torres Strait Islander people. That is, "third world" conditions existing in our developed country.

Why, in a country whose health status ranks second highest in the world, should our Aboriginal and Torres Strait Islander people experience health that is on par with that of developing countries? I don't wish to delve into a historical and political analysis of issues affecting Australia's Aboriginal and Torres Strait Islander people. These issues are many and complex, and have much in common with other groups of people who have suffered colonisation and resultant disempowerment. Past government policies and racist ignorance have

contributed to this situation. The struggle to overcome their legacies is immense.

However, those of us working in the field of oral health need to be aware of the social, economic and cultural aspects of Australia's Aboriginal and Torres Strait Islander communities. We must consider these issues in our holistic approaches to program planning and delivery, if we are to make a difference.

Oral health

Deterioration of oral health conditions in some Aboriginal communities over the past two decades has reflected the decline in health and social conditions, as well as the difficulty in accessing health services. I now refer specifically to Aboriginal communities, as I do not have access to oral health data for Torres Strait Islander populations.

There has been very little coordinated collection of oral health data for Aboriginal populations, either regionally or nationally. We are working towards improving this, for more effective planning and implementation of appropriate programs.

To summarise some of the information that is known about Aboriginal oral health:

- Children generally have more than twice the caries experience, in deciduous

Some commentators have used the term "fourth world" to refer to the health and living conditions experienced by Aboriginal and Torres Strait Islander people. That is, "third world" conditions existing in our developed country.

Deterioration of oral health conditions in some Aboriginal communities over the past two decades has reflected the decline in health and social conditions, as well as the difficulty in accessing health services.

Another critical issue is whether the workforce of the future will have the appropriate skills: a large emphasis on "magazine-driven" cosmetic dentistry and high-end technology is depriving young dentists of a broader range of skills, that would equip them to work in a more diverse range of environments.

teeth, of non-Aboriginal children; the greater proportion of this is untreated caries;

- In 12-year old children, dental caries in the permanent teeth is almost twice that of non-Aboriginal children;
- Dental caries rates appear to be increasing in Aboriginal people living in remote areas;
- People living in remote areas are now experiencing edentulousness, most of it due to tooth loss from diabetes-related periodontal disease.⁴

Many of the above conditions, particularly in remote areas, reflect the transition from traditional foods, which are still accessed in remote regions, to store-bought foods. These foods, sometimes called "convenience foods" are often high in fats and carbohydrates.

We have no coordinated data on other conditions such as oral cancer. There are high levels of tobacco smoking in Aboriginal communities, and tobacco-chewing in some remote communities. The levels of alcohol consumption are lower than in the general Australian population, however those Aboriginal people who do drink, are more likely than non-Aboriginal people to drink at hazardous levels². I have seen two of my remote patients die from oral cancer. However, with the shortened life



Dental truck deliveries

expectancy rates, conditions other than oral cancer are more likely to cause mortality.

High levels of poverty and disadvantage often mean that family priorities will differ to those of non-Aboriginal families. Following the advice of dentists to buy toothpaste and toothbrushes is of low importance. These items also are often highly priced, especially in rural and remote stores. The practice of oral hygiene is variable, and, as many people only seek care for emergency reasons, there is little opportunity to gain information about good oral health practices.

Oral health services

Delivery of oral health care for Aboriginal and Torres Strait Islander people is fragmented across the country, with the responsibility for oral health becoming caught in an endless tangle between the

Commonwealth and State/Territories' governments. However all parties managed to come together last year in a national workshop on Aboriginal and Torres Strait Islander oral health. While tangible outcomes of the workshop are yet to be seen, it provided an opportunity to highlight the issues affecting the oral health, and the challenges to improving conditions.

Lack of available and appropriate dental workforce is of major concern. As in many countries, dentists are reluctant to leave the cities and private practice. Another critical issue is whether the workforce of the future will have the appropriate skills: a large emphasis on "magazine-driven" cosmetic dentistry and high-end technology is depriving young dentists of a broader range of skills, that would equip them to work in a more diverse range of environments.

There have been programs to educate Aboriginal health workers in oral skills, but dental legislation has made it difficult for non-dental personnel to practice any aspects of dentistry. While there are Aboriginal and Torres Strait Islander people in many professions, especially law and medicine, the Aboriginal dental workforce is very small, but growing slowly.

What can we do?

Where are we headed? There is some good news! It is too easy sometimes to dwell on the depressing issues, but there are many people, both in the Aboriginal and Torres Strait Islander populations and the general population, who work tirelessly to improve conditions. Aboriginal community-controlled health services across the country offer dental programs and training for Aboriginal and Torres Strait Islander people. Some regions are developing creative solutions to deliver care to rural and remote locations, which

ensures at least some minimal access to dental services.

There are curricula for dental training programs, both current and planned, that include modules on Aboriginal and Torres Strait Islander health issues

What about oral health promotion? I can hear the question. We still have a long way to go, particularly in determining best practice programs for Aboriginal and Torres Strait Islander communities. Water fluoridation has not been feasible for many small towns and remote communities, though there are some trials under way at present. Oral health is not perceived to be a priority in many areas, and we watch as funds and resources are passed on to other health and health promotion programs, no doubt worthy of such support. However one day we will have the mouth back in the body, and perhaps then we will be included in other associated programs, and receive support accordingly.

Now is the time for those working in oral health care for Aboriginal and Torres Strait Islander people to create better networks, and support each other in raising awareness about the oral health needs in these communities. Perhaps we can learn from models of programs in other countries, and work together with other health and community workers to improve conditions.

But, to return to East Timor and Sister Filomena. Her hope is that the people in her country will be free of hunger, disease and poverty. Interestingly, we hold similar hopes for many of the Aboriginal and Torres Strait Islander people in Australia. While some of my discussion has been quite depressing, I am constantly strengthened by the resilience, optimism and good humour of my Aboriginal friends and colleagues. They have taught me so many things, and above all, to keep pushing to find a way forward.

My thanks to Catherine Morgan for her invaluable advice and assistance.

Now is the time for those working in oral health care for Aboriginal and Torres Strait Islander people to create better networks, and support each other in raising awareness about the oral health needs in these communities.

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Is treating caries in children in developing countries by the restorative approach a rational objective?

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Introduction

Whatever happened to the sense of perspective of dental health planners and deans of dental schools? Did they ever sit down with a simple calculator and estimate how many dental personnel would be required, and what will it cost, to provide dental treatment to all who needed it using the current treatment

methods? One estimate, by David Barmes¹ when he was the Chief Dental Officer at the WHO was that for every increase of 1DMF per million children 200 dentists would be required to treat the increase in caries. Sheiham and Barmes¹ estimated that, "Even if the increase in caries were halted now (in 1986), restorative treatment needs already exist which would occupy a million

dental personnel compared to the present 200,000." Manji and Sheiham² estimated that to treat the periodontal conditions, found in Kenyan children, would require between 286 (low estimate) and 860 (high estimate) hygienist working years per million children aged 5 to 15 years. On the assumption that each child would require follow up care, then annually the follow-

- Millions of children in low-income countries die each year from diseases which are preventable through such measures as better nutrition, safe water and immunisation. An integrated strategy employing the common risk factor approach would be invaluable in stemming the tide of death and disease among children of low-income countries. To provide for an integrated strategy to deliver a minimum package of health care services would cost the governments of developing nations \$US7000 per 1000 children.
- Three-quarters of the low-income nations do not have sufficient resources to finance an essential package of health care services for the children of their countries, due primarily to enormous debt repayment and structural adjustment, vast expenditures on hospital and curative services.
- Although the level of dental caries in low-income nations is categorised as low (mean 12-year-old DMFT = 1.9), requiring mostly single surface restorations, approximately 90% of the caries remain untreated in both the primary and permanent dentition.

Conclusions:

- To treat caries with the traditional method of restorative dentistry is beyond the financial capabilities of the majority of low-income nations as three-quarters of these countries do not even have the sufficient resources to finance an essential package of health care services for their children.
- To treat dental caries by the traditional amalgam restorative dentistry in the permanent dentition of the child population would cost between £1024 (\$US1618) and £2224 (\$US3513) for 1000 children of mixed ages from 6 to 18 years. This requires financial resources beyond the capabilities of low-income nations. Even though caries is a low priority in relation to other childhood diseases, untreated caries in an age specific cohort will cost more to treat in the future.
- It is not rational to use the restorative approach to control caries. A concerted public health/health promotion approach to reduce the causes of caries is needed.

up would require a further 136 to 400 hygienist working years per million children. When we compare these unachievable figures for simple dental care with the overall health care needs to avert death and serious disabilities, it is clear that current dental approaches are both unrealistic and misguided. In this paper we set out some reasons for re-assessing the restorative dentistry approach. If the implicit goals of dental health planners is to eradicate pain and suffering and promote healthy living, then focussing on the determinants of dental ill health and on health promotion rather than on the repair and re-repair of teeth is the way forward. Improvements in health come about through a public health approach and health promotion, not from attempts to treat away disease.

For low-income nations, financial resources are limited and even basic health care and education are a burden. Often the poor are faced with the hard choice of putting food on the table for the family or having conventional treatment to restore carious teeth. The argument by proponents of the conventional restorative approach is that if there is a need, the poor deserve to have high quality dentistry. However, when assessing people's needs for dental care and prescribing dental care, the resources available for the procedures must be considered. If resources are scarce and unlikely to be available in the



This photo shows parents with children waiting to receive essential health care services at an MCH clinic in Nepal

near future, it is unethical to continue to prescribe treatments, which are not affordable. These problems raise dilemmas for planners of oral health services. For countries with low gross domestic product (GDP) and limited resources for health care, dental planners need to ask:

- What is the cost of restorative dentistry to treat current levels of caries?
- How can the needs for caries treatment of children in developing countries be met in the context of limited resources?
- How feasible is it for most low-income nations to treat existing levels of dental caries with current financial resources?

In a study³ we conducted to analyse whether developing

countries have sufficient health dollars to treat existing diseases in general and dental caries in particular in their child population we found that:

- Even though the caries levels are low and most of the disease occurs on the occlusal and the buccal/lingual surfaces, more than 90% of the dental caries remains untreated in developing countries.
- To restore the permanent dentition of the child population of low-income nations using traditional amalgam restorative dentistry would cost between £1024 (\$US1618) and £2224 (\$US3513) per 1000 children of mixed ages from 6 to 18 years. This exceeds the available resources for the provision of an essential public health care package for the children of 15 to 29 low-income countries,

Improvements in health come about through a public health approach and health promotion, not from attempts to treat away disease.

If resources are scarce and unlikely to be available in the near future, it is unethical to continue to prescribe treatments, which are not affordable.

These costs are relatively high. To put them in perspective, let us compare the costs of restoring dental caries with the costs of the essential package of health care services for children of low income countries.

Cost of minimum package of preventative and health service interventions

Because children become ill from several conditions, the WHO integrated the health facilities and the tasks of health care workers to prevent and treat illness caused by five major conditions⁴ and the World Bank designed an essential national package of health services to enable developing countries to help resolve health problems^{5,6,7}. Packaging the interventions takes into account the common risk factor approach⁸ and makes the integrated management of the major childhood diseases more cost-effective, because clusters of diseases can often be treated together sharing the same treatment protocols, the same drugs and the same services. The cost of a minimum package of preventative and health service cost-effective interventions in low-income countries directed at ten disease conditions was calculated to be US\$12 per person and US\$7 (US\$ 7000 per 1000 children) for children per year for low-income nations⁵. The public

health component of the essential package (school health programmes, expanded immunisation, micronutrient supplementation, and essential public health interventions) would cost US\$4000 per 1000 children. Properly delivered, the essential package of health care would eliminate 21% to 38% of the burden of mortality and disability in children under 15 years in developing countries.

Total health expenditure including spending by both public and private sector spending and external assistance over a 5 year period, 1990-1995, for children age 0-14 years in low-income countries per 1000 children was lowest in Ethiopia, \$3449; Sierra Leone, \$4660; and Mozambique, \$4889. The highest levels were between \$30,000 and \$38,779 in countries like Honduras, Cameroon, Armenia, Zimbabwe and Nicaragua. Expenditure on public health in those countries was also pitifully low during the period 1990-1995. At the lower end of the scale were Tanzania and Uganda with \$795 and \$1256 per 1000 children while Sri Lanka and Nicaragua spent \$19,536 and \$22,095 per 1000 children respectively.

Based on the total health expenditure, all 48 low-income countries except for 6 African countries and one Asian country would be able to fully provide an essential package of health services (US\$7.00 per child or US\$7000 per 1000

children) for children age 0-14 years. All could afford the public health component of the essential package costing \$US4000 per 1000 children. Is the picture as rosy as it seems? Can governments of low-income countries truly provide for the essential health of its children?

Government expenditure on health

Based on government health expenditures (public expenditure) only, 30 countries would not be able to provide an essential health care package for its children without financial aid and without placing additional burdens on its people. However, the full extent of governmental health resources is not fully devoted to the priority of an essential health package for its children. Studies conducted by the World Bank in conjunction with six Pacific countries, showed that the percentage of government health expenditure devoted to hospital based curative services ranged from 48 to 67%, and curative health care as a percentage of public health expenditure, ranged from 80 to 89%⁹.

Even the small amount of external aid for assistance to finance health programmes is inappropriately allocated. If the governments of the 48 low-income nations only expended a conservative 40% of their budget on hospital and curative

services, 75% of the countries would still have difficulty in providing for the health needs of its children. Only 12 of 48 countries would be able to afford essential package of health services for its children¹⁰. It appears that 75% of 48 low-income countries are unable to provide US\$7 per child for a minimum package of public health interventions and 8 low-income nations spend US\$1 or less per child for such essential health care.

How much will restorative dentistry cost?

Against this background, what is the dental caries burden and what resources are required to treat caries, which ranks low on the list of health priorities?

All systems of dental care are based upon the imperative to restore all dental caries. Indeed equitable access to treat dental caries is a goal for most dental planners and most dental expenditure is on treatment. The treatment of dental caries is an expensive proposition for governments of both developed and developing countries and costs between 5% and 10% of total health expenditure in some industrialised countries^{11,12}. In most developing low-income countries the prevalence of caries is about 80%. Yet, over 90% of caries is untreated.

Based on data from the WHO Global Oral Data Bank¹³ the

mean 12-year-old DMFT for the 45 low-income nations was 1.9. For middle and high-income countries the DMFT was 3.3 and 2.1 respectively. For low-income African and Asian nations, the percentage of untreated caries approximates 95% in the caries in the primary dentition and 89% in the permanent dentition. The untreated caries far exceeds the treatment requirements of children living in high-income countries

Based on the 12-year-old DMFT, WHO provides a scale for categorising the severity of caries: a DMFT between 0.0 and 1.1 is considered to be very low, 2.8 to 4.4 is moderate, and a figure of 6.6 or more is considered to be high¹³. For most low-income nations the level of severity is low to very low. Although epidemiological data on caries of children in developing countries is scarce, knowledge of the life history and patterns of caries can be utilised to give a more detailed epidemiological picture and to divulge more specific information useful for planning cost effective public health interventions.

From the epidemiological information and appraisals, demographic information on the child population, and from some basic assumptions, the financial burden of treating existing and future caries in the permanent dentition can be estimated using a mathematical model (For details of methods used refer to Yee and Sheiham³). From a given level

of DMFT for 12-year-olds, the retrospective and prospective DMFT for the cohort and the distribution of caries by site for each age level can be estimated based on caries epidemiological principles.

The cost of traditional treatment for 1000 children of any age level of the 12-year-old cohort as well as the cost of treating 1000 children of mixed age group (total cost of treating 1000 children from each age group divided by 13 age groups), from 6 to 18 years, can be calculated. The calculations accounted for the fact that restorations fail and need to be replaced. Based on a conservative annualised failure rate for amalgam of 7%, the calculated cost of £1024 (\$US1618) to treat 1000 children of mixed ages, from 6 to 18 years, exceeds the estimated available public health expenditures for the children of 15 low-income countries. If the amalgam failure rate of 10% and 15% is applied, the cost per 1000 children is £1461 (\$US2309) and £2224 (\$US3513), which would then exceed the available public health expenditures of 23 and 29 low-income nations, respectively³.

The total financial burden of traditional restorative treatment for the children age 6 to 14 of 45 low-income nations was also estimated. Using population statistics from World Resources¹⁴, the child population for this age group is estimated at 1,018,223 million. Applying a failure rate

75% of 48 low-income countries are unable to provide US\$7 per child for a minimum package of public health interventions

When faced with the harsh realities of putting food on the table or enduring the suffering of a child's toothache or having conventional treatment to restore carious teeth, often the poor do not have a choice.

of 7%, the cost of traditional restorative treatment for this mixed age group was calculated to be £535 (\$US846) for 1000 children.

The United Kingdom National Health Service fee of £6.35 (\$US10.03) for a single surface amalgam and £9.40 (\$US14.85) for two or more surfaces was applied in our computations. The capital cost and maintenance of dental equipment was not included in the calculations. This is an underestimation rather than an overestimation of the cost of restorative treatment for the majority of people of low-income countries. Since many governments of low-income countries lack the financial resources to provide the essential package of preventive health care, private households have been burdened with the cost for general health and dental treatment^{4,15,16,17}.

Bratthall and Barmes¹⁸ reported that in a provincial hospital in a district of Zimbabwe, 48 kilometres from Harare, a simple filling would cost the equivalent of US\$2.50. For the same amount of money, 1 to 2 kilograms of meat could be obtained or two tubes of toothpaste. The patient would have to pay four to five times the amount at a private clinic. In Nepal the fee for a simple amalgam restoration is approximately US\$4. This does not include the many additional costs for rural families who may have to travel by bus or walk for a day or two to gain access to the nearest dental facility. Not including lost wages

incurred by the parent, the total expenses (dental fees, return bus fare, meals and lodging) for a child requiring a single surface restoration may amount to US\$12. This may not seem like very much, but for an average Nepali earning less than US\$0.75 a day, it is enough money for food for a month. When faced with the harsh realities of putting food on the table or enduring the suffering of a child's toothache or having conventional treatment to restore carious teeth, often the poor do not have a choice. A better approach is required to tackle the problem of untreated dental caries in developing countries.

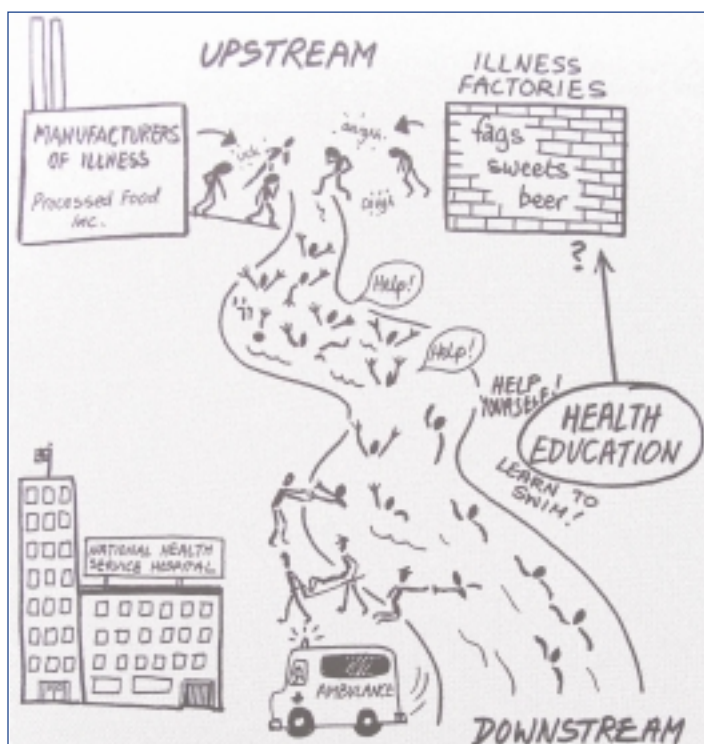
A better approach

It is not rational to use the curative approach to deal effectively with dental caries and other dental diseases. Traditional preventive techniques to address the untreated dental caries focus on lifestyle or behavioural change and the provision of knowledge. This approach is usually prescriptive with the health professional acting as the expert and the patients passively receiving the information. Even professionally applied fluorides and pit and fissure sealants can be classified as another form of operative care and suffer from the same limitations. Directing resources at the lifestyle and educational approach without concern for tackling the determinants of ill health or addressing the environment



which influences people's ability to adopt healthy lifestyles, results in 'victim blaming'¹⁹. A public health approach based on the five key areas of action of health promotion²⁰ is a more appropriate response:

- 1. Create supportive environments:** It recognises the impact of the environment on health and identifying opportunities to make changes conducive to health. The availability of affordable efficacious fluoridated toothpaste in the market place enables whole communities to adopt health enhancing oral hygiene skills.
- 2. Build healthy public policy:** It focuses attention on the impact on health of public policies from all sectors, and not just the health sector. For example, the prevention of dental caries is highly dependent on toothpaste manufacturers being accountable to a policy on fluoridated toothpaste and producing fluoridated toothpaste; and a government policy to remove the taxation on fluoridated toothpaste to make it more affordable for the population.



Reprinted from: Daly B, Watt R, Batchelor P, Treasure E. (2002). *Essential Dental Public Health*. Oxford: Oxford University Press.

3. Strengthen community

action: It recognises the importance of empowering individuals and communities in setting priorities, making decisions, planning and implementing strategies to improve health.

4. Develop personal skills:

It is moving beyond the transmission of information, towards the promotion of understanding and development of personal, social and political skills that enable individuals to take action to promote health.

5. Reorientation of health

services: Attention needs to be refocused away from the provision of curative and

clinical services towards the goal of health gain.

Some important strategic approaches to health promotion include:

- Focus on tackling the determinants of health. Dietary sugar is the main determinant of dental caries. Government policies and actions to reduce sugar consumption and increase the availability and affordability of healthy foods and affordable fluoridated toothpaste impacts on the incidence of dental caries.
- Integration of health including oral health into other sectors of society. Oral cleanliness is an integral

part of body cleanliness and oral health is related to general health. An integrated approach should be adopted and incorporated into other sectors. For example, the integration of an oral health curriculum into the education system will reach school children, parents and the community.

- Working in partnership with a range of organisations and different sectors of society. The stakeholders of oral health are not only oral health professionals but include broad groups such as lay people, government, industry (toothpaste manufacturers), non-government organisations and international non-government organisations.
- Adoption of a whole population approach²¹ along with a targeted-population approach²². This approach focuses on the whole population rather than on groups of the population who are at high risk to disease. Action is taken to reduce the whole population's exposure to disease producing agents and to ensure that the total environment is conducive to health. An example of a whole population approach to control dental caries is water fluoridation.
- Adoption of the common risk-factor approach⁸. It is more effective and efficient to focus attention on changing a small number of

factors that determine a large number of diseases, than utilise disease specific actions. Sugar is a common risk factor for dental caries, obesity, heart disease and diabetes. Reducing the per capita consumption of sugar will have a broad effect on a number of diseases, not only dental caries.

Summary

Ten conditions caused the deaths of more than 7.5 million children in 1995 in developing countries. Malnutrition and micronutrient deficiencies are also implicated as determinants of paediatric oral conditions of low-income nations. An integrated strategy to deliver a minimum package of preventive health services directed at these disease conditions would cost an estimated \$US7000 per 1000 children. However, because of the scarcity of resources, more than three-quarters of the 48 low-income countries are unable to provide for such a basic package of healthcare.

The most prevalent oral disease of public health concern in low-income countries is dental caries. Epidemiological information and analysis reveals that the severity of caries is low for the permanent dentition of children of Third World countries (mean 12-year-old DMFT = 1.9) and the normative treatment needs for caries is high for both permanent (% untreated caries > 87%) and primary dentition (% untreated caries > 94%).

The pattern and severity of disease is mostly limited to the occlusal and buccal/lingual surfaces of the permanent dentition. Even though caries is a low priority due to relatively low mortality and morbidity compared to other childhood diseases²³, the cost of traditional restorative treatment is disproportionately expensive in relation to its priority.

Current analysis indicates that treatment by traditional restorative dentistry for the permanent dentition would cost between £1024 (\$US1618) and £2224 (\$US3513) per 1000 children of mixed ages from 6 to 18 years. This exceeds the available resources for the provision of an essential public health care package for the children of 15 to 29 low-income countries.

The present dominant curative approach and its limitations is highlighted in the following allegory^{22,24,25}. A man was standing by the side of a river and heard a cry of a drowning person. He jumped in to rescue him, pulled him to the bank and applied artificial respiration. Just as the rescued man was recovering there were more cries from other drowning people. In jumped the rescuer brought some back and resuscitated them. The rescuer could not cope on his own so he got some helpers and machines. Still he could not cope. So they worked faster in teams - four-handed and six-handed - with more complex equipment. The numbers of drowning people

had become so numerous that some could not be rescued before permanent damage occurred. How could he stop them from drowning? A fence was constructed at midstream in an attempt to keep people from venturing into the river, but this had limited success. Swimming lessons were the solution. These rescuing and training activities kept him so busy that at no time did he stop to consider why people who could not swim were in the river. Who was pushing them in upstream?

The dentist's concentration on 'downstream' curative endeavours and 'victim-blaming' distracts attention from the 'upstream' activities of the confectionery, food and drink companies who are 'pushing people into the water'. Health workers usually intervene only after the damage has been done. Instead of concentrating so much effort on downstream and midstream 'preventive' activities, more efforts should be directed at changing the environment such as making the river shallower so that people do not have to learn to swim - 'making healthier choices the easier choices'²⁶ - and controlling the activities of those pushing people into the water - a direct attack on the determinants of health. In the light of the limitations of 'downstream' and 'midstream' activities, strategies for the improvement of oral health should be based on the recognition that 'health promotion is better than prevention and cure.'

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FDI Global Oral Health Planning Workshop



Robert Yee, Nepal



Seydou Ouattara, Burkina Faso
and Martin Hobdell, USA

The workshop as part of the long-term strategy of the World Dental Development Committee was held at the Holiday Inn Hotel, Thoiry, France, on 4-5 April 2003. 82 representatives from dental aid organisations, governments, WHO, FDI Regional Organisations and the dental industry were invited to discuss issues of global oral health development. The programme was structured with lectures, small group work and plenary sessions. In the opening presentation Prof Poul Erik-Petersen from WHO Headquarters, Geneva, outlined the importance of collaboration between different stakeholders groups and explained the procedure for collaboration with WHO. Other presentations gave important background information about the role of allied health care personnel in the provision of basic oral care, the role of NGOs in advocacy for affordable fluoride toothpaste, changing concepts in oral health promotion and many more. In three working groups participants further discussed these issues and presented their results to the plenary afterwards.

The meeting was concluded with the adoption of the "Ferney-Voltaire Declaration on Global Oral Health Development" approved by all participants. In the declaration the participants expressed "their concern over the growing disparities in oral health and access to affordable oral health care between the rich and poor throughout the world" and affirmed their commitment to improve oral health through increased access to affordable oral health care and development of appropriate policies (for full text see last page of this issue).

The complete working programme, the abstracts of presentations and information about the participants are available for download from the FDI website.

A comprehensive report will be issued by the end of the year. The report will cover in detail the results of the discussions and the different working groups.

The reactions to the workshop so far have been overwhelmingly positive. Besides the scientific discussions participants stressed that it was a good occasion to



facilitate networking, for renewal of old friendships and to make new important contacts with dedicated people. All commended the FDI for the initiative and noted with appreciation the FDI's dedication to issues of oral health development.

The FDI thanks the following organisations and companies for their financial contributions:

- ADA – American Dental Association, USA
- AOI – Aide Odontologique Internationale, France
- GlaxoSmithKline Inc, USA
- WHO Collaborating Center Nijmegen, Netherlands



82 participants
from 32 countries



Infant Oral Mutilation

By Dr Jenny Wordley, *Dentaid UK*



Child dying of septicemia

What is IOM ?

Over the past 40 years a cultural practice has emerged amongst certain tribal groups in parts of central Africa. IOM is the practice of removing unerupted deciduous teeth (usually the canines) from the gums of babies, sometimes only a few weeks old. The tiny white tooth follicles are tragically mistaken for “worms” or “nylon teeth” and thought to be responsible for causing fever and diarrhoea in the infant. No anaesthetic is used and unsterile bicycle spokes, knitting needles, knives, screwdrivers or even fingernails are used to remove the toothbuds often with resultant bleeding, infection and, not infrequently, septicaemia and death.

Indeed children may escape having endured the traumatic practice with only missing deciduous teeth and malformed permanent teeth. However it is quite possible that sequelae

such as tetanus, osteomyelitis and even the initiation of NOMA may result.

Who is researching it?

IOM has been documented since the 1960s and observed in Tanzania¹, South Sudan², Ethiopia³ and Kenya⁴. It appears, from the research, to be increasing both in geographic distribution and incidence. Whilst the practice of IOM may differ in the implement used, the age of the child treated and the type of ointments added to the wound after IOM the belief that these “worms” or “nylon teeth” in the gum cause diarrhoea and sickness is very similar between tribes. It has been suggested that the culturally held belief has been passed on between groups following the movement of displaced refugees fleeing from civil war in their own country.

Since 1999, Dentaid has been committed to eradicating this practice. In order to do this, it is essential to assess its prevalence and geographical extent.

Whilst working for 8 months with an aid agency in South Sudan, Dr Maggie Leonard, now a Senior Dental Officer with the Shropshire PDS, discovered that IOM was more common than originally believed. She has continued to research the subject on Dentaid’s behalf and has since visited Northern Uganda.

It was thought that this practice was largely limited to parts of Uganda and was performed by the local “village healer”. But it is now clear that it is much more widespread and has been observed throughout Uganda, South Sudan and in parts of Kenya, Tanzania and Somalia. Family members, midwives, school teachers and even the local priest have been known to administer IOM, all believing that they are helping the infant to avoid sickness.

How prevalent is the practice?



Child with removed tooth buds

Its frequency is disturbing. During her time in South Sudan, Dr Leonard examined over 200 children aged approximately 2 1/2 - 5 years old in villages of two different tribal groups. Of the children she examined, the average number of teeth missing was 5.6 per child. Whilst the occasional missing tooth may

IOM is the practice of removing unerupted deciduous teeth (usually the canines) from the gums of babies

National prevention programmes need to be implemented to eradicate this practice through widespread education. At the moment there are a limited number of small-scale local programmes that have been initiated by concerned healthcare workers.

be attributable to accidents or falls, it would appear to indicate that IOM is an endemic problem. Published research supports this view. Rasmussen et al² reported in 1992 that of nearly 400 children examined in Sudan, 22% had experienced IOM. In this instance, using a searing hot needle being pushed through the child's gum and into the tooth follicle. Hassanali et al⁴ reported that of the children they examined in rural Kenya aged between 6 months and 2 years, 87% had undergone the removal of one or more deciduous canine toothbuds. Reports from Ethiopia³ identified that mandibular toothbuds were removed 3.4 times more frequently than the maxillary toothbuds. This was thought to be due to the visibility of the canine prominence in the infant mandible.

Mortality

Research into mortality rates is difficult to establish. In 1983 H.J. Mosha¹ published a report examining 124 Tanzanian children who were receiving treatment at a hospital following local IOM treatment. 10 infants died as a direct result of the IOM. During her research, Dr Leonard spoke in depth to the Paediatric Consultant in Arua Hospital, North West Uganda. She attributed 6% of all infant deaths in her hospital directly to septicaemia following IOM. Tragically, the consultant reported that frequently a sick



The canine tooth buds have been removed

child, recovering from another illness, would be smuggled out of the ward during the night by the parents to have the toothbuds removed and, on returning, the child's condition would dramatically deteriorate.

What is being done about it?

Despite the published research IOM continues unabated. Indeed, it seems that the popularity of this practice is increasing. National prevention programmes need to be implemented to eradicate this practice through widespread education. At the moment there are a limited number of small-scale local programmes that have been initiated by concerned healthcare workers.

An example of one of these programmes is the Bartons' education programme in Kabale, Uganda. Following his visit to Uganda in 1999, Dr

Chris Barton, with his wife Polly, sold their practice in Truro and moved to Uganda to serve the rural population by providing a dental service there. Dentaid has been able to help by providing a complete dental surgery. In addition to his clinical work, Chris is assessing the dental needs in the surrounding areas, whilst Polly has set up and implemented a 5 day training programme for schoolteachers and health workers (including nurses, midwives and medical clinical assistants). The course is designed to enable them to teach oral health to their communities and to other health workers and includes oral and dental anatomy, dental caries and periodontology, oral hygiene and diet, oral diseases and communication skills. Most importantly, there is discussion on IOM, or "elbino" or "gidog" as it is known locally."

World Dental Development Fund Rwanda Project Visit Report

By Dr Habib Benzian

Rwanda, Land of the thousand hills

In May 2003 I had the opportunity to visit a project financed by the World Dental Development Fund in Rwanda. The country is often referred to as the "land of the thousand hills" due to its landscape of soft hills. But it is also known for being the home of the last mountain gorillas living in the volcanic mountains next to the border with Uganda.



However, Rwanda is also one of the poorest countries on the globe. Under all development and health indicators it is ranked as one of the least developed. Some examples:

- Life expectancy is 38.2 years
- 183 out of 1000 children do not reach the age of 5
- 40% of the population are undernourished
- 15-20% HIV+
- Health expenditure 40 USD per capita (United States: 4,499 USD)
- GDP per capita 196 USD (United States 35,277 USD)
- One of the most densely populated countries in Africa

(for full details see United Nations Development Report 2003; http://www.undp.org/hdr2003/indicator/cty_f_RWA.html)

Post-colonial history has been dominated by ethnical tensions and conflicts, that are

themselves seen as results of the colonial era in the Central African region of the Great Lakes. These conflicts culminated in a genocide in 1994, when during a very short period, almost 1,000,000 people were killed, mainly of Tutsi ethnic origin. War, massacres, famine and other social disruptions created a stream of 2 million refugees, both internally and externally displaced to and from the neighbouring countries.

After these events the new government under President Paul Kagame started the long and difficult process of National Reconciliation between different population groups.

Since then the reconstruction of the country in all aspects has priority: infrastructure, education, health care, economy and agriculture. Particularly the health care sector was hit by the genocide because the majority of health care workers belonged to the Tutsi. A new constitution was recently approved in a general vote and the first general elections after the genocide are scheduled for September 2003.

Oral Health in Rwanda

There is no recent data on oral health in Rwanda. The WHO



A woman is crying near the coffins containing the dead bodies of her family members. © Danilo Balducci/Still Pictures



Refugee camp in Nyaconga, Rwanda, home to 60,000 people.
© Adrian Arbib/Still Pictures

Global Oral Health databank lists a survey in 1993 and reports a DMFT of 0.3 in 6-year-olds and 1.8 in adults. It can be estimated that this has changed dramatically since then due to the disruptions following war, the massive influx of refugees and the enormous migrations towards the cities. Also, the DMFT does not reflect the real needs of the population that is left without access to even basic health and oral health care.

The country has 16 dentists, 14 of them working in public service and 12 of them in the capital Kigali. Facing a population of more than 8 million that is predominantly living in rural areas it is very obvious that these few dentists are not able to cope with the oral health problems of the country. The majority of the population has never seen a dentist or does not even know what a dentist is. People have to seek help from quack "doctors" or inexperienced traditional healers claiming to be able to treat teeth, but very often they do more harm than good. The dentists at the national reference hospital in Kigali very frequently see patients with severe complications resulting from such treatment, e.g. fractures, severe infection and abscesses or even septicaemia. The practice of Infant Oral Mutilation is very common as well (see paper in this issue of Developing Dentistry).



Dentists at Kigali Hospital

Outside the capital or the major cities there are no or only very poor facilities, no supplies or clean instruments or material available. And even the National Reference Hospital is short of almost everything and the facilities with worn out dental units date back to the 1960s.

On the political and educational side there is a complete absence of any co-ordinated approach to address oral health problems. There is no legal framework for the practice of dentistry and this lack of professional legislation heavily impacts on the quality of service. Despite this legal void, foreign dentists from neighbouring countries wishing to work in Rwanda face serious problems of recognition of their diplomas thus worsening the extreme manpower shortage. After the genocide dental nurse education was introduced to ease the workforce shortage but these courses will be stopped next year. No dentists are educated in the country.

It is very obvious that under these conditions the Rwanda Dental Association and their 16 members are struggling hard to give oral health a voice and that government offices and other administrations are not aware of their activities.

Background of the World Dental Development Fund Project

The project "Oral Health Assessment Rwanda" was one of the four initial projects approved by the former Developing Countries Committee in November 2000 in Paris.

The aim of the project is to conduct a survey on oral health on a national level in order to gather baseline data for proper service planning. The project was proposed and is conducted by the Rwanda Dental Association (Association des Chirurgiens Dentistes et Stomatologes du Rwanda).

From the beginning the project suffered from delays, administrative and communication problems mainly due to the difficult situation in the country. The first phase of the project consisting in defining the framework for the survey and in identifying the examination groups was completed in summer 2002. At the Vienna Congress in September 2002 the project leader and president of the Rwanda Dental Association, Dr Vincent Banyangiliki reported that the initially intended survey according to WHO standards was not feasible due to lack of experience, resources and support. It was therefore agreed to change the concept of the survey to a needs assessment that would be much easier to conduct. Additionally it was felt that such results would be more relevant for planning rather than purely epidemiological data. Following that decision a questionnaire to assess the oral health needs and a new project design were developed.

Next steps in the Oral Health Survey

During a brainstorming session with members of the Rwanda Dental Association all aspects of the survey were discussed in detail. It was decided to start the survey in September 2003



School children at Kigali

and to terminate the data collection in December due to the incoming rainy season, which would make travelling out of Kigali very difficult. The survey will cover 7 different districts of the country and schools in each of the districts have been chosen and contacted.

A total of about 1,000 pupils will be examined and interviewed. The survey itself will consist of a simple oral examination recording caries visually as well as oral hygiene. A questionnaire will explore oral health needs; however, given the very difficult communication within the country and internationally and the limited resources of the project team delays will be inevitable. The few dentists available will use parts of their annual leave for the data collection and will carry out the survey.

Tangible results of the visit

The Rwandan colleagues arranged for a number of official meetings with government officials and local authorities in order to give their association and the project of the oral health survey the necessary international backup.

Among the tangible results of the meetings four issues were of particular importance:

- All authorities and officers met committed themselves to fully support the oral health survey. The WHO Country Office offered support from one of their epidemiologists in the evaluations of data collected. Both government and WHO were keen to see the results of the survey and to use the data in their work.
- The WHO Country Representative agreed to include oral health in the next biannual action plan starting in 2004. This will include working with the government on oral health policies and advising on

effective dental public health interventions.

- The Ministry of Health welcomes the activities regarding oral health and will actively support and encourage the formulation of a comprehensive action plan, covering professional legislation, oral health policy and educational aspects.
- The Rwanda Dental Association is now recognised as partner in relation to dental and oral health issues and will be consulted and involved in all future activities on government level. The media coverage of the visit through the National Radio increased the public image of the association and awareness for oral health significantly.

I wish to thank all the colleagues of the Rwanda Dental Association for their personal commitment to oral health and all the work done to make the visit a success. Their positive thinking and spirit of optimism under very difficult conditions as well as their impressive energy and activity deserve our deepest admiration.



Dentists of the Rwanda Dental Association



World Dental Development Fund

During the last years the FDI World Dental Development Fund has supported two continuing education programmes for dentists organised by FOLA in Latin America. The following article reports about these activities, their background and achievements.

FOLA works, works, works.....

By Dr Enrique Cister, Argentina

The Latin American Dental Federation (FOLA), an FDI Regional Organisation, that has been professionally active for over 85 years, is composed of the 20 countries of the region, representing from the geopolitical point of view 350,000 dentists, almost 50% of the world human resources. In this context we carry out a variety of working programmes to project/put across our activities to the world.

The Latin American Dental Federation, was established voluntarily in 1917 by a group of dentists and organisations during the 1st Pan American Dental Congress being held in Santiago, Chile. From 1972 it has represented the Latin American region in the FDI as a Regional Organization. With almost half of the world's dentists as members. FOLA has many features that set it apart in the FDI.

Our practitioners share similar characteristics in terms of language, culture, socio-economic and historical profile, that added to a framework of union and integration and enabled them to develop stable policies that are increasingly worthy of praise and acclaim.

In this article we would like to highlight three of our working programmes, the Programme on Prevention and Oral Health Education "Smile Latin America", the Latin American Programme on STD-HIV-AIDS Prevention in Dentistry and the Latin American Programme on Oral Cancer the aim of which

is to raise the health team's awareness about this condition.

"Smile Latin America"

The aim of this project is to find a solution to the oral health needs of priority groups in Latin America, based on the strengthening of educational and preventive factors and the use of human resources from different sectors.

General Objectives

- 1) To secure a feasible programme for the countries in the region by emphasising/reinforcing the model/paradigm of education and personal care.
- 2) To insert professional organisations in the community.
- 3) To develop specific activities that facilitate the type of prevention that the Latin American countries really

need to achieve better oral health.

- 4) To boost resources by formulating/coordinating activities that seek the integration of facilitators and programmes.
- 5) To demonstrate – from the organisation and political point of view - that in Latin America we can develop and organise a technically and socially reliable and responsible programme.

At present, twelve countries in our region have voluntarily taken part in this project. The overall programme was unanimously approved by FOLA's Council of Delegates in January 2001, in Panama.

The composition of FOLA's Commission on Prevention has been agreed and although we are still in the process of reinforcing the working group, some specific activities are being carried out in Colombia, Dominican Republic, Cuba and Argentina.

FOLA/LARO Latin American Programme to Raise the Health Team's awareness of Oral Cancer

The aim of FOLA LARO's 1st Latin American Programme to Raise the Health Team's Awareness of Oral Cancer is to train professional human resources and their teams and to increase people's awareness about the preventive measures that are essential to improve the quality of life of the community as a whole.

Oro-pharyngeal cancers represent about 5% of all cancers and has important psychosocial and financial implications as most records show that it is already very advanced when medical treatment is sought. This in turn requires expensive treatment, delays the return of the patient to work and brings about problems of social adaptation as in many cases it involves disfiguring treatment. According to statistical data, only 15% of cases are diagnosed at an earlier stage, whilst 85% of cases are at an advanced stage which makes the prognosis worse.

The survival of a patient with oral cancer depends, among other factors, on the time the diagnosis is made, its location and the therapy chosen. There is a consensus that with tumors less than 2 cm and in absence of regional adenopathies, and

with the relevant treatment, 75% of patients survive after 5 years. If the lesion is larger than 2 cm and regional metastasis occurs, only 18% of patients are still alive after 5 years. If to the bucco-pharyngeal percentages (5%), we add those cancers related to facial skin (5%) and the oral and neck signs/manifestations of leukemia and lymphomas, we observe that 15% of cancer cases could be detected at an earlier stage by the dentist.

It is therefore necessary to raise the practitioner and patient's awareness about prevention.

It is important to provide them with clear and precise information, so as to anchor in the practitioner the routine practice of checking all oral tissues on a regular basis, and in the patients the habit of paying regular visits to the dentist to have not only their teeth but also their gums checked.

In view of this situation, FOLA set out to try and improve the quality of life and consequently oral health, and to foster the scientific and ethical development of all of its member dentists. FOLA has the intention of collaborating with governments of the Region with the purpose of developing and implementing appropriate oral health policies throughout Latin America.

The programme's overall objective is to increase the awareness for prevention and early detection of oral cancer in

Latin American Dentistry by providing training courses for dental teams, multidisciplinary teams, community leaders and health agents during the various scientific events that take place in Latin America. The aim is also to minimize the consequences of this disease under the motto "To educate is to protect"

FOLA will select the human resources that will provide training from amongst university lecturers, health technicians, researchers and other health professionals, all of them with the necessary experience in the fields of Stomatology and Oral Cancer.

However, we should point out that the scientific events that are usually held in Latin America practically never include courses to train and increase the dental practitioners's ora cancer awareness. This assertion is even more conclusive if we state the FOLA's courses are free of charge.

The 8h training courses for dentists and their teams that are offered during our congresses and other activities in Latin America, consist of demonstration lectures with the additional help of the relevant technological resources. To make the most of the human and financial resources the two programmes on Oral Cancer and AIDS are presented together during eight consecutive daily hours. The programme will be carried out during this cycle in Argentina,

15% of cancer cases could be detected at an earlier stage by the dentist.



Poster used for the Oral Cancer Awareness Programme

Bolivia, Colombia, Paraguay and the Dominican Republic.

Latin American Programme on STD/HIV/AIDS in Dentistry

During the 2001-2002 cycle, the Latin American Programme on STD/HIV/AIDS Prevention in Dentistry included six 8h courses, free of charge to the dentists of the six applicant countries, all members of FOLA. All of these events were spectacular and even on Saturdays we had a record attendance of over 100 participants, with more than 250 in Montevideo and over 300 in Cuba.

We increased the number of lecturers to establish a Latin American reference team and to include more member countries as well as to unite the region in this regard and also to support the possible changes and our presence in every country, quite apart from the delivery of lectures.

We cannot conclude this report without acknowledging the

excellent and unselfish work carried out by the following colleagues: Dr. Decio Dos Santos Pintos-Dr. Cristina Cavalari-DR. Eduardo Ceccotti-Dr. Roman Carlos Bregni- DR. Fernando Jacobo Armach-DR. Ricardo Sforza-DR. José Zambrano Pico, Dr. Julio Santana Garay. They travelled around the entire region, providing their knowledge and experience to train and protect their colleagues and consequently the whole of the population. We should mention and be very grateful to all our FOLA colleagues, member associations and their officers that have contributed to the programme with their organisation, the facilities of their headquarters and their total and firm support to our endeavours for the benefit of the profession.

And of course we are very grateful to the FDI World Dental Development Fund for its continued support that made these programmes possible.

In 2003 cycle, the programme will be put into action in Argentina, Bolivia, Colombia, Paraguay and the Dominican Republic.



Poster used for the HIV awareness programme

The work and activities carried out until now makes us feel very pleased because they fulfil FOLA's original objectives and because they are having a real impact on the betterment of the quality of life of the Latin American people.

Latin American Dentistry feels very proud that through its support, the FDI World Dental Federation recognises and appreciates FOLA's educational projects on Oral Cancer and AIDS.

This clearly demonstrates that the positive interaction between our Regional Organisation - and FDI.

FOLA AND FDI WORKING TOGETHER !!!!!!!

Basic Package of Oral Care (BPOC) in Nepal

By Dr. Archana Pradhan and Dr. Robert Yee

Introduction

The WHO Collaborating Center for Oral Health Care Planning and Future Scenarios has recently produced a policy document on a Basic Package of Oral Care (BPOC)¹. The policy document outlines the three primary components: Affordable Fluoridated Toothpaste (AFT), Oral Urgent Treatment (OUT), and Atraumatic Restorative Treatment (ART). Oral health promotion is also considered an essential part of BPOC. It recommends the implementation of small-scale demonstration projects to assess the effectiveness and sustainability of BPOC under local conditions before introducing it on a wider scale. The report also suggests that its contents, extent of services and the specific tasks of various oral health care personnel involved should be based on the local situation.

Similar to most non-established market economies (non-EME) countries, Nepal faces problems with limited financial resources, limited or no access to oral care, and where services are available, they are not affordable by the majority of the population in most need.

The Oral Health Programme, United Mission Nepal (OHP UMN) aims to improve the oral health of the people of Nepal through oral health promotion and provision of basic oral care that is affordable by those in need. To achieve this, OHP



Affordable fluoridated toothpaste benefiting villagers in Nepal

UMN has formed partnerships and working relationships with the government, non-government organisations (NGOs), international non-government organizations (INGOs), private corporations and educational institutions. As recommended and stressed in the policy document, OHP UMN utilizes and promotes the utilization of appropriate technology and appropriate auxiliary personnel in the existing government health care structure, the Primary Health Care (PHC) System.

This paper outlines the components of BPOC and the delivery of BPOC in Nepal. It also describes the barriers currently faced in the provision of BPOC and recommendations for improvement.

Components of BPOC in Nepal

In response to the local needs of the Nepali population, additional services were

deemed necessary to be included in the BPOC in Nepal.

Therefore, **services in BPOC included in the Nepali context are:**

- Oral Health Promotion (OHP) which includes the promotion and use of fluoridated toothpastes (AFT).
- Arrest of Caries Technique (ACT), using silver fluoride or silver diamine fluoride and stannous fluoride to stop the progression of dental caries².
- Atraumatic Restorative Technique (ART) using glass ionomer cement and hand instruments for single surface restorations and for sealing pits and fissures³.
- Oral Urgent treatment (OUT), which includes extractions, dental emergencies and referral for advanced care.

This paper outlines the components of BPOC and the delivery of BPOC in Nepal. It also describes the barriers currently faced in the provision of BPOC and recommendations for improvement.

The Oral Health Programme, United Mission Nepal (OHP UMN) aims to improve the oral health of the people of Nepal through oral health promotion and provision of basic oral care that is affordable by those in need.

Appropriate Personnel for delivery of BPOC in Nepal

In the National Strategic Plan for Oral Health for Nepal, the National Oral Health Task Force identified the following Primary Health Care Workers in the government PHC System to carry out BPOC services in Nepal:

- Health Assistants (HAs)
- Community Medical Assistants (CMAs)
- Auxiliary Nurse Midwives (ANMs)
- Village Health Workers (VHWs)
- Maternal Child Health Worker (MCHWs)
- Female Community Health Volunteers (FCHVs)
- Traditional Birth Attendants (TBAs)

HAs, CMAs and ANMs undergo a 18 month training course which includes anatomy, physiology, pharmacy and pharmacology, first aid, basic medicine, basic surgery, environmental sanitation, health management and health-post administration, health-post laboratory technique (microbiology), mother and child health and family planning, nutrition, epidemiology, communicable disease, health culture and

community, and health education. Basic oral health is also included. ANMs have an additional 3 months training in antenatal and postnatal care. As they mostly work in MCH clinics, it is more appropriate for their training to be limited to OHP with particular reference to oral care in pregnant women, mothers and children and ACT. Similarly, VHWs, MCHWs, FCHVs and TBAs would be trained only to provide OHP and referral of oral health problems to the health care centers.

Other appropriate personnel not included in the PHC System who receive training in OHP are teachers and traditional healers. They are invited to attend a one-day seminar on oral health. Topics include causes and prevention of oral problems like dental caries, periodontal problems and oral cancer. Oral hygiene instructions are given, with emphasis on the promotion and use of fluoridated toothpastes, after meals. Incentives include daily allowance and certificate of attendance.

Hospital-based Training for OUT

To date, WHO has been sponsoring the training of CMAs and HAs in OUT. The trainers are dentists working in government hospitals. The hospital based training is for a period of 2 months (total training time ~144 hours). Incentives for participants

include travel allowance and daily allowance. Instruments are provided for use at the health posts. The training programme was based on the experiences of OHP UMN. Trainee to trainer ratio varies from hospital to hospital depending on the availability of dentists to act as trainers. It ranges from 4 trainees to 1 trainer, or 12 trainees to 1 trainer.

Community-based Training for BPOC

Back in the 1980's UMN OHP dentists were in the forefront of basic oral health care by conducting extraction trainings for HAs and CMAs in the District of Palpa and Lalitpur. Presently, UMN OHP partners with the local District Health Office to provide training and materials for PHC Workers in various Districts. More recently, with the realisation that 65% of 6 year olds in Nepal have more than 3 decayed teeth and almost 100% of them untreated⁴, OHP UMN initiated a new training programme for the delivery of BPOC. The trainers are dentists and dental therapists. One trainer supervises a maximum of 4 trainees at each practical session. Excepting for theory classes, the practical part of the training is conducted in the community and in schools. After conducting several trainings, a week's training (total training time ~ 40 hours)

for ANMs for OHP and ACT, and a three week training (total training time ~ 126 hours) for HAs and CMAs has been considered adequate. Based on the experiences from the training, a manual has been prepared for the training of primary health care workers to enable them to perform the duties included in the package within a specified period of time. If strictly adhered to, the training is expected meet the target of completing at least 25 ACT cases by ANMs, and at least 25 ACT cases, 25 ART cases and 70 extractions by CMAs and HAs.

Incentives for the training include travel allowance, meals during training period and daily allowance is substituted by a set of instruments and materials (starter kit). As PHC Workers are usually transferred from one health post to another every 2 years or so, they are advised to take the materials and instruments with them so they can continue to provide service and keep up their skills. However, it is a requirement that they inform UMN OHP of their new posting via the District Health Officer (DHO), so that their work can be evaluated at regular intervals.

Follow-up

The trained PHC workers are provided with forms to record treatment details and they are requested to send completed forms at regular intervals. Within a year of training, the trainers visit the health-posts to



Supervision of trainees performing ART and ACT

evaluate the performance of those trained or conduct follow up dental camps with the PHC Workers. Treated patients may be randomly selected from the record forms for cross-examination and to check the success or failure of the treatment carried out.

Barriers

Several problems have been noted which prevent the optimum delivery of the BPOC to rural communities in Nepal:

1. Low awareness of basic oral health care

Most villagers are still ignorant about basic oral health care. It is customary for Nepalese to brush their teeth first thing in the morning and not after meals. Very little importance is given to deciduous teeth as the general belief is that they will be replaced. Loss of permanent teeth is accepted as a part of ageing process. Patients therefore seek treatment only when they are in severe pain and when the only option is

extraction. Even then, most people believe that they can get relief simply by taking medicines. On the other hand, there are people who opt for extractions, even when the teeth can be restored.

2. Poverty

Where there is agreement on the choice of treatment on extraction or ACT or ART, extreme poverty becomes a barrier. Through the development of a National Strategic Plan for Oral Health, ACT and ART have now been included as part of the BPOC in health posts, primary health care centres and District hospitals. Provision of OUT is the first priority, followed by provision of ACT and ART in selected District hospitals, primary health care centres and health posts. Most villagers are too poor to pay the minimum fee of Rs 50.00 (US\$0.60) for ART per tooth. To cover at least the cost of materials, this service will have to be subsidized by the government or the community in order to sustain it.

A manual has been prepared for the training of primary health care workers to enable them to perform the duties included in the package within a specified period of time

Most villagers are too poor to pay the minimum fee of Rs 50.00 (US\$0.60) for ART per tooth. To cover at least the cost of materials, this service will have to be subsidized by the government or the community in order to sustain it.

3. Emphasis on curative care

Most health posts are curative centres and not health promotion oriented. ART and ACT are more suited to a community or school setting when combined with oral health promotion rather than the health post where most patients seek treatment only for dental pain. The HAs and CMAs at the health posts are allotted 2-4 hours a month to promote health in the community or schools, which does not allow them to keep up their ART and diagnostic skills.

4. Lack of a management system for BPOC

Appointment systems may not be feasible, due to lack of telephone service. Recall visits may not work as well, as patients may not necessarily return once out of pain. Therefore, simply training of PHC Workers in BPOC is inadequate. They need continued monitoring, follow-up supervision, technical, financial and logistic support (supply of materials) for effectiveness and sustainability of the programme.

Recommendations

Many of the problems highlighted will hopefully be addressed through the implementation of the National Strategic Plan for Oral Health where strategies have been recommended for oral health promotion, appropriate

curative care, human resource development and public-private sectoral cooperation in the improvement of oral health in Nepal. Some relevant strategies related to the delivery of BPOC include the following:

1. Oral health promotion

National Strategic Plan for Oral Health has an action plan to integrate oral health education into the school curriculum for both public and private schools. Clearly, there is an urgent need for oral health promotion and education in Nepal, especially in rural areas. Schools are ideal for oral health education,^{5,6} especially in Nepal, where teachers are highly respected and students listen to what their teachers say. Also, there is evidence from school projects that children are not only good learners and eager to learn new skills but also make good teachers to their peers and elders^{7,8}. It is expected that children carry on the good oral health habits taught in school through their student life and into adulthood. Assuming an average Nepali family has 5 members, if each student takes home the oral health message taught in school and passes it on to their family members, each of them will be contributing to the promotion of oral health in the community.

2. Re-orientation of health posts from curative care centres to community oriented health promotion centres

The vision for Primary Health Care should be 'health' rather than 'curative care'.

PHC workers trained in BPOC can serve as oral health promoters. Their job description and responsibilities should include visits to schools at regular intervals (once a week) for health promotion and general check up of children including oral health. Many dental problems in children can be detected early through oral screening. Children with problems could then be treated in schools or health posts or referred to dentists, if problems are beyond the treatment capacity of PHC Workers. Such programmes would help eliminate the problem of not being able to make appointments and recall visits.

3. Management and logistic system to support BPOC in rural areas

The National Strategic Plan for Oral Health contains draft duty statements for PHC Workers in oral health, guidelines for the management of common oral diseases and conditions for PHC Workers, establishment of managerial support by district dentists, training of district dentists to provide managerial support, and the establishment of logistic support for the expansion of BPOC within rural areas. These recommendations will be further discussed and developed in a series of workshops beginning this year. The workshops will also examine ways of improving and

accelerating the current government training programme for the delivery of BPOC.

4. Involvement of local community in BPOC

The Village Development Committee and District Development Committee of each district where BPOC will be instituted will be involved in assessing the needs of the community, raising awareness of oral health, promotion of BPOC within their communities and provision of funds allocated from central government for sustaining of BPOC. Patients would have to pay a nominal registration fee as for any other medical problem and a small fee for OUT, ART and ACT. This would hopefully make the BPOC services accessible and affordable.

Summary

The Nepal Government's Second Long Term Health Plan 1999-2017⁹ gives priority to health promotion and prevention activities, and development and implementation of "Essential Health Care Services" which are priority public health measures and essential curative services accessible and available to the total population. "Essential Health Care Services" are to be highly cost effective and address the most essential health needs of the population. BPOC in Nepal, with the essential components of oral health promotion, AFT, OUT, ART and ACT delivered through the Primary Health Care System through PHC Workers, has the potential to meet the basic needs of the

people of Nepal and also the need of the government to provide "Essential Health Care Services". Recommendations concerning oral health promotion, training, management and logistic support, community participation, sustainability and re-orientation of the curative services will hopefully be implemented in order to make basic oral health care universally available in Nepal.

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First ever international public health treaty approved

After almost four years of intensive negotiations, WHO's World Health Assembly unanimously adopted the Framework Convention on Tobacco Control amid thunderous applause on 21 May 2003. The sudden shift of the United State's delegation to support the treaty was result of international pressure from the majority of nations working for a strong convention.



WHO World No Tobacco Day 2000

"Today, we are acting to save billions of lives and protect people's health of generations to come," said WHO director-general Gro Harlem Brundtland, who made the anti-smoking convention a top priority of her five-year tenure.

"What a wonderful moment in global public health," said New Zealand Health Minister Annette King, adding that around 20 million people had died since the talks began.

The adoption of the FCTC marks a historic moment for global public health. By adopting the FCTC, the world's nations have stood up for public health and dealt a stinging defeat to Big Tobacco and the countries that continually attempted to weaken the treaty

throughout the negotiations. This legally binding treaty is groundbreaking and sets a precedent for the countries of the world to work in cooperation in the future to improve public health in all areas not just tobacco.

Many speakers hailed the outstanding contributions of civil society, namely the Framework Convention Alliance to the treaty. The FDI is active member of this alliance and has participated in the negotiating and lobbying process during the last four years. The FDI President, Dr Dato Ratnanesan, and the Development Manager, Dr Benzian, attended the World Health Assembly and were present during the adoption of the convention.

The Framework Convention on Tobacco Control (FCTC) – What is it all about?

The Framework Convention on Tobacco Control (FCTC) is the first treaty initiated by the World Health Assembly, the governing body of the World Health Organization (WHO). Negotiations began in October 1999 and concluded on March 1st 2003. It has been adopted by the World Health Assembly and is now open for signature and ratification of the member countries. As of July 2003 more than 40 countries already signed the treaty.

The objective of the FCTC is “to protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke.” The Preamble of the FCTC recognises the need for countries to give priority to their right to protect public health, the unique nature of tobacco products and the harm that companies that produce them cause.

The FCTC provides Parties with a considerable degree of flexibility in implementing measures beyond those described in the treaty. Significantly, Article 2.1 of the FCTC states that all Parties are encouraged to implement measures that are stronger than the minimum standards required by the treaty.

Significant treaty provisions include:

Advertising, Promotion and Sponsorship (Article 13)

A comprehensive ban is required: The FCTC requires all Parties to undertake a comprehensive ban on tobacco advertising, promotion and sponsorship within five years of ratifying the treaty. The ban must include cross-border advertising originating within a Party's territory. The definitions of advertising, promotion and sponsorship are broad and include indirect as well as direct forms. Countries with constitutional constraints are required to restrict advertising, promotion and sponsorship, including cross-border advertising, in a manner consistent with their constitutional principles. The Parties also agree to consider a protocol to elaborate on the cross-border provisions, for example the technical and legal

aspects of preventing or blocking advertising on the internet and satellite television.

Packaging and Labeling (Article 11)

Large health warning labels are required. Parties to the treaty agree that health warning labels ideally should cover 50% or more of the principle display areas of each packet, which for a standard cigarette package means both the front and back. Parties are required to implement health warning labels that cover, at a minimum, 30% of the principle display areas within three years of ratifying the treaty. Health warning labels must include rotating messages in the principle languages of the Party, and may include pictures or pictograms.



The World Health Assembly in Geneva during the adoption of the FCTC in May 2003



*Youth is beautiful - dont exchange it for cigarettes!
From a youth anti-tobacco campaign in Moldova*

Deceptive labels must be prohibited. Countries agree to prohibit misleading or deceptive terms on tobacco product packages within three years of becoming a Party. Research has proved that cigarettes that are labeled “light”, “low tar”, and “mild” (among other terms) are as dangerous as those denoted as regular and thus these terms mislead and deceive consumers about the risks involved in the use of these products. Although the treaty does not specify the terms that Parties should ban, the scientific evidence would certainly support banning the use of terms such as “light”, “mild”, “low tar”, etc.

Secondhand Smoke (Article 8)

Nonsmokers must be protected in workplaces, public transport and indoor public places. The

treaty recognizes that exposure to tobacco smoke has been scientifically proven to cause death, disease and disability. It requires all Parties to implement effective measures to protect nonsmokers from tobacco smoke in public places, including workplaces, public transport and indoor public places – evidence indicates that only a total smoking ban is effective in protecting non-smokers.

Smuggling (Article 15)

Action is required to eliminate tobacco smuggling. Measures required include marking all tobacco packages in a way that signifies the origin and final destination or the legal status of the product, and cooperating with one-another in anti-smuggling, law enforcement and litigation efforts.

Taxation & Duty Free Sales (Article 6)

Tobacco tax increases are encouraged. The treaty states that “each Party should take account of its national health objectives concerning tobacco control” in its tobacco tax and price policies. The treaty recognizes that raising prices through tax increases and other means “is an effective and important means of reducing tobacco consumption by various segments of the population, in particular young persons.”

Duty-free sales are discouraged. Parties may prohibit or restrict duty-free sales of tobacco products.

Product Regulation & Ingredient Disclosure (Articles 9 & 10)

Tobacco products are to be regulated. The Parties agree to establish guidelines that all nations may use in regulating the content of tobacco products.

Ingredients are to be disclosed. Parties shall require manufacturers to disclose to the government the contents of their tobacco products.

Liability (Articles 4.5 and 19)

Legal action is encouraged as a tobacco control strategy. The treaty recognizes that liability issues are an important part of a comprehensive tobacco control program and the Parties agree to consider legislative and litigation approaches to advance tobacco control objectives. Parties also agree to cooperate with one another in tobacco-related legal proceedings.

Treaty Oversight (Article 23)

A strong Conference of the Parties will oversee the treaty. The FCTC establishes a Conference of the Parties (COP) which will convene within one year of the treaty's entry into force. The COP is empowered to monitor the implementation of the treaty, adopt protocols, annexes and amendments to the FCTC, and to create appropriate subsidiary bodies to carry out specialized tasks.

Financing (Article 26)

Parties have committed themselves to promote funding for global tobacco control. The Parties agree to mobilize financial assistance from all available sources for tobacco control initiatives for developing country Parties and for Parties with economies in transition, including from regional and international intergovernmental organizations and other public and private sources.

Other Important Commitments

Each Party shall establish or reinforce and finance a national coordinating mechanism or focal point for tobacco control. (Article 5)

Parties shall endeavour to include tobacco cessation services in their national health programmes. (Article 14)

Parties shall prohibit or promote the prohibition of the distribution of free tobacco products. (Article 16)

Parties shall promote the participation of NGOs in the development of national tobacco control programmes. (Article 12)

Parties shall prohibit the sale of tobacco products to persons under the age set by national law, or eighteen. (Article 16)

No reservations to the FCTC are allowed. (Article 30)

The FCTC will enter into force 90 days after ratification by the 40th country. (Article 36)

The full text of the FCTC can be found at:
<http://www.who.int/gb/fctc/PDF/inb6/einb65.pdf>

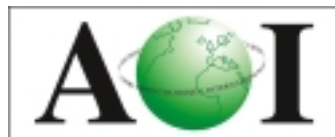
More information about the Framework Convention Alliance may be found at:
<http://www.fctc.org>

ADOPTED from: HIGHLIGHTS OF THE FRAMEWORK CONVENTION ON TOBACCO CONTROL (FCTC) - Framework Convention Alliance – FCA

<http://www.fctc.org/highlightsEN.shtml>



The new and the old WHO
Director General



Aide Odontologique Internationale (AOI) Symposium

What quality activities can be implemented in the area of oral health for rural populations in developing countries?

In these countries, the social, economic and health worries are great: lack of state and individual funds, other priorities such as AIDS or Malaria... the allocation of a realistic budget for oral health care faces such problems. It calls for the definition of "Minimum Packages of Activity" (MPA) which best correspond with the needs and demands of the population and the available resources.

The research undertaken on MPA's is oriented on: pain relief, ART and affordable fluoride toothpaste. What are the advantages and limitations? What is its relevance in response to the problems of developing countries?

To follow this idea, the AOI will organise, within the annual congress of the French Dental Association, a symposium on the theme:

**Pain relief, ART and
affordable fluoride
toothpaste: Realistic for
developing countries?**

It will be chaired by Prof. F. Mikx, WHO Collaborating centre in Nijmegen (The Netherlands). It will reunite the universities, NGO's, programme managers from developing countries and FDI World Dental Federation representatives.

Additionally, the situation in Mali and Burkina-Faso will be the focal point of a subsequent round table discussion. Simultaneous interpretation in English and French will be available.

Date: Saturday 29th November 2003 – 9:30 am to 12:30 pm, Paris –French Dental Association (ADF) Congress, Centre de Congrès Porte Maillot

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Dr Jong-Wook Lee

New WHO Director General confirms commitment to oral health

At the recent Council meeting the FDI was honoured by the presence of Dr JW Lee, the new Director General of the World Health Organisation. During his speech at a dinner function Dr Lee sent a very clear message to the FDI and the world that he is committed to the promotion of oral health as part of general health. Dr Lee also said that the FDI has an important role to play in health and oral health development and promotion globally. He went on to mention the importance of the FDI working closely and in partnership with the WHO to achieve mutual objectives and stressed the need to develop oral health as a strong and unique entity within the WHO.

Urgent call to improve survival of millions of children

27 June 2003 – GENEVA – The WHO has welcomed a call from a group of top scientists and policy makers for a renewed commitment to improve the survival prospects for over ten million children who face death from largely preventable illnesses.

The Bellagio Child Survival Study Group, which is made up of experts who took part in a team residency on « Knowledge into action : improving equity in child health » identified four urgent reasons to revive the stalled child survival revolution of the 1980s. Writing in the medical journal the Lancet, they say that advances in child health epidemiology have strengthened the basis for sound programmes, that 63% of all child deaths could be prevented and that 98% of under fives who die are in developing countries. They also reveal huge failures in delivery of services to mothers and children who are poor.

To address these issues, WHO has developed a broad strategy to support countries in achieving the Millennium Development Goal to reduce child mortality by two thirds by 2015. A key element of the strategy, endorsed by the World Health Assembly in May, is the adoption of a life course approach to child and adolescent health.



© PAHO

This recognizes that the quality of life at early ages is important not only for immediate wellbeing, but also for health and development later in life.

“In the 1980s the child survival revolution greatly reduced child mortality but that movement has to be revitalised. There is an urgent need to regain that momentum. More than 10 million children under five will die from easily preventable causes this year,” says Dr Tomris Türmen, Executive Director of Family and Community Health at WHO. “Child survival must be put back on the agenda if there is to be any hope of achieving the Millennium Development Goal of reducing child mortality by two thirds by 2015. These reports show that it can be done.”

There have been some notable successes in the past in reducing child mortality. For example, better nutrition can break the vicious spiral of poor nutrition leading to ill-health and ill-health causing further deterioration of nutritional status often leading to death. Preventable communicable diseases in children can be drastically reduced through three activities: the Expanded

Programme on Immunization, Integrated Management of Childhood Illness, and preventing mother-to-child transmission of HIV and reducing HIV among young people. All of these interventions have been shown to work but need to be dramatically scaled up. Further attention needs to be given to improving the health of new born children and their mothers. The health and survival of the child, especially in early infancy, is intricately linked with the health of the mother, her nutritional status, and the reproductive health care she receives.

An earlier goal set at the Child Summit in 1990 to reduce child mortality by a third is still far from being achieved. Instead of a 33% reduction under five deaths worldwide were reduced by only 10% by the year 2000. There are also enormous differences between regions and countries. In 2000, rates of child survival in sub-Saharan Africa had not yet reached the level attained in the Americas in 1950. In Angola and Niger, 25 babies in every 100 babies born will die before the age of five years. In Europe the comparable rate is fewer than one in every hundred.



Vaccination Campaign in Peru
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Vaccination Campaign in Colombia © PAHO



Drawing on the report of the WHO-convened Macroeconomic Commission on Health, the yearly cost of scaling up child health interventions would be around US\$7.5 billion - US\$1.0 billion for vaccinations, US\$4.0 billion for treatment of childhood illnesses and US\$2.5 billion for malaria prevention and treatment. The authors say this investment would be very cost effective.

Despite the urgent need to reduce the number of children dying the amount of development assistance for child health has decreased dramatically. In addition, there have been no clear mechanisms to track investments in child survival over the last decade. This has made it very difficult to link investments with better child

health and a reduction in the number of children dying.

“We urgently need to target financial and human resources for child survival more intelligently. We must put poor children and their mothers at the centre our efforts. We need to recreate a strong leadership and kick-start a global movement. Then we will be in a position to use our knowledge to bring down the terrible toll of childhood deaths,” says Dr Hans Troedsson, Director of Child and Adolescent Health at WHO.

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Annual World Dental Congress, Sydney 18-21 September 2003

As in previous years, the programme of the FDI congress features many sessions that are of interest and relevance to global oral health development. Some examples:

- Symposium on minimally invasive caries treatment (organised by Dr. Jo Frencken and Dr. Christopher Holmgren with emphasis on ART) - part of the Scientific Programme
- World Dental Development Forum (focus on the outcomes of the Planning Workshop held in April this year and on oral health in the Pacific region) - part of the Business Meetings open to all
- Meeting of Aid Organisations (open discussion forum) - part of the Business Meetings open to all
- Meetings of the FDI Section Public Health (topics include oral health promotion, Basic Package of Oral Care, Affordable Fluoride toothpaste, the new Global Goals for Oral Health etc) - part of the Business Meetings open to all

All details of these and all other events are available from the FDI website - please have a look at www.fdiworldental.org!

For more information see the series of papers in The Lancet at: http://www.thelancet.com/journal/vol361/iss9376/child_survival



Water – Source of life

World Water Forum ends in a flood of commitments

The eight day meeting held in the three neighbouring cities of Kyoto, Shiga and Osaka, Japan, ended on 23 March by issuing a statement of commitment. This commitment was made towards “facing the global water challenges” and “achieving the Millennium Development Goal (MDG) of halving, by 2015, the proportion of poor people without secure access to water and sanitation”. To do so, groups participating in the Forum made over 100 commitments, but what these add up to, and the extent to which they are and compatible remains to be seen. “The third World Water Forum has become a truly action-oriented conference,” said Kenzo Hiroki, its Vice Secretary-General. Over 24 000 participants from 182 countries attended — well over three times as many people as expected. Their main concerns were with meeting the increasing human need for adequate water supplies and balancing these with the demands of health, sanitation,

food production, transportation, energy and environmental protection. Most countries also stressed the need for effective government, improved capacity, and adequate financing to manage these issues.

Global water consumption has increased tenfold in the last century, according to ‘SustainAbility’, a development consulting firm. Over a billion people in the world have no access to safe drinking-water and 2.4 billion people lack adequate sanitation. A result is that 3 million people die from preventable waterborne diseases every year. The World Trade Organization and industry groups see the market as the only way to organise the distribution of this increasingly scarce resource, by setting a price on it. Others, such as Maud Barlow and Tony Cark, authors of *Blue gold*, see this approach as “the corporate theft of the world’s water”.

Lyla Mehta, of the Institute of Development Studies in the UK, told the Guardian that “because many people think of water as a basic human right, they react angrily to the idea of private companies making profits out of water provision”. She cites protests and revolts in Bolivia, Ghana, Peru, Trinidad and Tobago, and other developing countries, over the privatisation of water supply systems. The participants of the Water Forum had till 30 April to finalize the content and wording of their commitments.

These included setting up a global flood warning system, organising a consortium of institutions to support governments in managing their water supply systems, financing communities to solve or mitigate their water and sanitation problems and strengthening the capacity of indigenous people to protect their water rights.

The final statement said that increasing the efficiency of water use may not be sufficient to meet the growing demand for water in many developing countries, particularly in cities. “All options to augment the available water supply, including increased storage through the use of groundwater recharge and dams, need to be considered, ensuring that all those who will be affected will also benefit.” It concluded: “A wider adoption of good practice is required in order to avoid the environmental and social costs and risks of the past.” More concretely, Sir Richard Jolly, head of the Water Supply and Sanitation Collaborative Council, points out that although about US\$ 10 billion a year is currently spent on water and sanitation, meeting the MDG for water and sanitation will require “at least a doubling of this level of investment”.

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More information:
http://www.who.int/water_sanitation_health/en/



GLOBAL ORAL HEALTH PLANNING WORKSHOP

FERNEY-VOLTAIRE DECLARATION ON GLOBAL ORAL HEALTH DEVELOPMENT

Noting that

“Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures” (Article V Declaration of Alma Ata, 1978), and

Recognising that

Oral health is an integral part of general health and subject to the same determinants. All participants of the FDI Global Oral Health Planning Workshop expressed concern over the growing disparities in oral health and access to affordable oral health care between rich and poor throughout the world and consequently,

Support

The FDI Statement “Improving Access To Oral Health Care”,

Acknowledge

The central role of the FDI World Dental Federation and WHO in providing information, support and facilitation in the building of partnerships between national dental associations, NGOs and civil society, national governments and industry,

Affirm

Their commitment to health as a basic human right for all peoples, and

Urge

All concerned with health to work together in a network of formal and informal partnerships to reduce inequalities in health and to increase access to affordable oral health care by developing policies that focus on:

- Improving living and working conditions
- Enabling people to adopt healthier lifestyles
- Encouraging communities to participate in every stage of the policy planning process
- Enabling all people to access an appropriate locally determined programme of basic oral health care that includes: relief of pain, promotion of oral health and the management of oral diseases and conditions.

The participants of the workshop commend the FDI for this initiative. The participants call upon the FDI to build on the achievements of the workshop and commit themselves to supporting this effort.

Signed by the participants at Ferney-Voltaire, France, on the 5th of April 2003