



The
Commonwealth
Dental Association

CDA BULLETIN

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

MESSAGE FROM THE CDA PRESIDENT

I could hardly imagine how three years could pass so quickly to signal the end of my term as *President of the CDA*, knowing very well that the next issue of the CDA Bulletin would carry a message from my successor. I recall being installed as President of the CDA at the 4th Triennial Meeting, the first triennial meeting to have been held in Africa - an exciting event in the CDA calendar.



Dr L K Gandhi (right) with Delegates Commonwealth Health Ministers Meeting

During my tenure there have been other major 'Firsts' for the CDA. In November 2005 the CDA held for the first time a *joint symposium* with three other health related Commonwealth Associations, at the Commonwealth People's Forum in Malta preceding the Commonwealth Heads of Government Meeting (CHOGM). The first *CDA Regional Pacific Meeting* was held in Fiji from 25 to 30 November 2005 in which I was honoured to participate. Again, for the first time, the CDA held a workshop in Geneva prior to the Commonwealth Health Ministers' Meeting; the theme of the workshop was *Commonwealth Priorities for Oral Tobacco Cessation*. This workshop was a follow-up to the CDA's oral cancer seminar held in Delhi during the FDI World Dental Congress 2004.

Other highlights of CDA's activities included: a workshop on *Awareness of HIV/AIDS and Infection Control in*

the Caribbean Region and, also, the transportation of donated dental books and journals to the Dental School at Muhimbili University in Tanzania - a scheme run in collaboration with Quayle Dental Manufacturing Company, UK. This triennium (2003-2006) has witnessed CDA working in partnership with other organisations more than ever and very successfully.

I thank all the CDA Executives, our partner organisations, CDA Friends and sponsors for their unstinted support to the CDA over the last three years, which will go a long way in helping CDA to always hold high its vision for all times to come.

My best wishes to you all.

Dr L K Gandhi
President, CDA

EDITORIAL

Prof Martin Hobdell
Editor, CDA Bulletin

CDA Elections

Details of the December Triennial Meeting of the CDA in Colombo, Sri Lanka are given at the beginning of this issue of the Bulletin. As a democratic body elections are central to our organisation. For meaningful elections candidates need to be nominated. Details of how to do this can also be found at the beginning of the Bulletin.

Health Advocacy

Influencing behaviour, public opinion or a government policy and encouraging actions that promote good health can be summarised under the term 'advocacy'. Advocacy



is a respected and recognised tool for non-governmental organisations like National Dental Associations and public health professionals that helps in their activism for better health (*FDI/WHO 2005*). This issue of the CDA Bulletin includes information about two meetings that were held recently concerning important topics where individual practitioners and their respective National Dental Associations could act as health advocates and make a substantial difference. The issues are: the training and retention of adequate numbers of health professionals; smokeless tobacco and smoking cessation.

Dr John Hunt reports on a meeting on mobilising the African diaspora in an effort to reverse the health care professional 'brain drain' from the region. The health workforce was also the subject of the Commonwealth Health Ministers' meeting held prior to the annual WHO World Health Assembly. As observers at the Commonwealth Health Ministers meeting members of the CDA Executive attended the meeting, which is reported on by Dr Sam Thorpe.

A report, by the Editor, of a CDA sponsored workshop, held immediately before the Commonwealth Health Ministers' meeting, on Smokeless Tobacco and tobacco use cessation is also included.

As usual this issue includes reports from the regions for which I would like to express my thanks to those Regional Vice-Presidents for their efforts - they are essential for the health of our organisation.

Dr Rosalie Warpeha

Finally, it is with sadness that we report the death of a gifted health advocate: Dr Rosalie Warpeha who spent a large part of her life working for better oral health in Jamaica. Some of her colleagues pay tribute to her life on page 14 of this issue.

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CDA 5th TRIENNIAL MEETING

Colombo, Sri Lanka 1-3 December 2006

in collaboration with the Sri Lanka Dental Association

Venue: Bandaranayake Memorial International Conference Hall

Hotel: The Cinnamon Grand (formerly the Crowne Plaza)

one of the premier hotels of Colombo

Programme

Lectures

- ◆ Current Dilemmas in Dental Education - How Global Influences are Impacting Dental Education.
- ◆ Infection Control.
- ◆ Aesthetic Dentistry
- ◆ Oral Surgery
- ◆ Orthodontics
- ◆ Continuing Education
- ◆ Dental Auxiliaries across the Commonwealth
- ◆ Women in Dentistry

Workshops

Plenary Debate

Election of CDA Officers

Installation of CDA President and CDA Officers for 2006-2009

Pre and Post-Conference Tours

Pre-arranged tours include:

- ◆ Amaya Lake, Dambulla
- ◆ Minneriya National Park
- ◆ Sigiriya Rock Fortress
- ◆ Kandy
- ◆ Spice Garden
- ◆ Elephant Orphanage
- ◆ Colombo City Tour
- ◆ Turtle Hatchery
- ◆ Kitulgala
- ◆ White River Rafting on the Kelani River
- ◆ Pine Hill Rubber Estate

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Current CDA Officers (2003-2006)

President	Dr L K Gandhi (India)
President-Elect	Prof Jacob Kaimenyi (Kenya)
Immediate Past-President	Dr Brian Mouatt (UK)
Executive Secretary	Dr Sam Thorpe (Sierra Leone)
Treasurer	Dr Anthony Kravitz (UK)
Regional Vice-Presidents:	
Canada/Caribbean	Dr Joyous Pickstock (Bahamas)
East Southern & Central Africa	Dr Pashane Mtolo (Zambia)
Europe	Dr John Hunt (UK)
Pacific	Dr Temalesi King (Fiji)
S E Asia	Dr Hilary Cooray (Sri Lanka)
West Africa	Dr Kofo Savaga (Nigeria)

Ex-Officio Members of the Executive

CDA Bulletin Editors	Prof Martin Hobdell (UK) & Prof DYD Samarawickrama (UK)
CDA Administrator	Julia Campion (UK)

NOMINATION FOR OFFICERS OF THE COMMONWEALTH DENTAL ASSOCIATION (CDA) FOR 2006-2009

Criteria for Officers

- **All Officers** - must be on email as this is the main form of communication. CDA Executive Meetings are conducted electronically, by email.
- **All Officers** - will participate in CDA Executive Electronic Meetings usually held at least 3 times a year. Each meeting takes place over a 7 to 10 day period.
- **CDA President** - will maintain regular contact with all CDA Officers and chair CDA Executive electronic meetings.
- **CDA Executive Secretary** - will maintain regular contact with the Commonwealth Foundation and the Commonwealth Secretariat and attend their meetings where possible. Also, will draft the Agenda for CDA Executive meetings and take an active part in the day-to-day running of the Association.
- **CDA Treasurer** - will produce a financial report for each CDA Executive meeting and prepare an annual budget. Also, will actively fundraise and seek sponsorship for the CDA.
- **CDA Regional Vice-Presidents** - must be resident in their Region. They will send by email to the CDA Administrator regular news of events in their Regions for the CDA Bulletin. They will actively fundraise for CDA meetings, workshops or conferences held in their Region. Also, they will keep in contact with the National Dental Associations in their Region and help the Treasurer to bring in the subscriptions from the NDAs in their Region.

**The Officers will be elected at the CDA Triennial Meeting
in Sri Lanka, 1-3 December 2006**

**The Officers listed on page 2 are eligible for re-election except for
the President, President-Elect and Immediate Past President**

Please complete and send as soon as possible, by 30 October 2006 at the latest, to:

**Julia Campion, CDA Administrator
Email: JuliaCampion@cdauk.com Fax: +44 (0)20 7681 2758**

Nominated by:

PLEASE PRINT CLEARLY

National Dental Association	
Contact Name	
Email Address	
Fax Number	
Mailing Address	

PLEASE PRINT CLEARLY

Officer	Nomination	Email Address
President-Elect		
Executive Secretary		
Treasurer		

Regional Vice-Presidents

PLEASE PRINT CLEARLY

Officer	Nomination	Email Address
Europe		
South East Asia		
Pacific/Australasia		
Canada/Caribbean		
West Africa		
East Central Southern Africa		

Triennial Meetings

**CDA Triennial Meetings are held in partnership with National Dental Association meetings.
National Dental Associations wishing to host the CDA 6th Triennial Meeting in 2009 should
write to Julia Campion, CDA Administrator.**

THE NIGERIAN DENTAL ASSOCIATION / FDI / UNILEVER PROJECT

Dr Kofo Savage

CDA Regional Vice-President (West Africa) / Project Co-ordinator

The joint FDI World Dental Federation and Global Unilever project called 'Live, Learn and Laugh' is a three-year project. It involves 37 countries and there are four pilot countries of which Nigeria is one. The programme was launched in Montreal, Canada, during the FDI World Dental Congress in 2005. There was a National launch in Nigeria in August of the same year. The convener of the programme in each country is the National Association in conjunction with the National Unilever company.



Members of a local community during the oral health talk before dental examinations

The Nigerian Dental Association chose a topic to create oral health awareness nationwide. The broad objective is to educate Nigerians on the importance of maintaining good oral health. Specific objectives are:

- ◆ To improve the knowledge of targeted communities via oral health education.
- ◆ To increase the level of utilisation of oral health care facilities and NDA endorsed oral health care facilities and products in these communities.
- ◆ To screen for oral diseases thereby enabling early detection and prompt management/ immediate referral.

Measures of impact of the programme include:

- ◆ Questionnaires.
- ◆ Assessment sheet/examinations.
- ◆ Handouts with oral health tips.

Nigeria is divided into six geographical zones and, at the first instance, six states out of the 37 states including the Federal Capital Territory, Abuja, will be visited. These states are to be visited to evaluate the results of the assessments and to check if subjects responded to their referrals.

Lagos State from the South West zone has been visited. Fourteen Local Government Areas (LGA) in Lagos, and the Lagos State House of Assembly were visited between October 2005 and February 2006. The Local Government areas include Orile-Agege, Ibeju-Lekki, Badagry, Ikorodu, Yaba/Mainland, Surulere, Ajeromi, Epe, Alimosho, Somolu, Mushin and Isolo/Oshodi.

Over 7,000 subjects were seen. Oral health talks, oral health examinations and referrals to local dental clinics/centres were carried out. Common oral diseases such as dental caries, periodontal diseases, malocclusion, dental anomalies were assessed. Their knowledge attitude and practice of oral health were also assessed. Important and interesting findings were observed which shall definitely affect individuals and the communities, positively, when corrective steps are taken. The positive response of the people and the enthusiasm shown was very encouraging.

Many thanks to the FDI World Dental Federation, to Dr Habib

Benzian and Ms Jenny Lee, Deforges. Many thanks, too, to Global Unilever, Mrs Analia Mendez and to Unilever Nigeria, Mrs Dunke Afe, Mrs Foluso Babasola, Mrs Abiodun Adebese and Mr T M Rungo, the Marketing Director, for their immense support and provision of a mobile dental clinic and incentives for participants.

ORAL HEALTH WEEK, GHANA

Dr Eric Asamoah

President

Ghana Dental Association

The Ghana Dental Association (GDA) in collaboration with the Ghana Health Service, celebrated its annual Oral Health Week in October 2005 at Hohoe, in the Volta Region of Ghana. This celebration is a health promotion programme aimed at creating oral health awareness in the country.

During the week, selected deprived communities are provided with a package of oral health services. It usually starts with a launching, during which several stakeholders are invited to a durbar in a selected region of the country. Invitees include the Minister of Health, officials of the Ghana Health Service, regional and district political office holders, district health and education officials, administrators at the regional and district levels and school children.

Floats are organised through the streets of the selected city or town, with banners of oral health promotion messages.

Oral/dental screening of those present takes place. Teams of oral health personnel visit towns and villages offering dental screening and treatment on a limited basis. At the same time, oral health promotion programmes are run on national and local radio and television stations.

New Email Address?

Please keep CDA updated, if you have a new email address please let the CDA Administrator know:

JuliaCampion@cdauk.com

MOBILISING THE AFRICAN DIASPORA HEALTH CARE PROFESSIONALS AND RESOURCES FOR CAPACITY BUILDING IN AFRICA

Report on the CDA's activities at the two-day conference in London on 21st and 22nd March 2006

John M G Hunt

CDA Regional Vice-President (Europe)

We all know that Africa is faced with the enormous challenges of poverty and disease. This is exacerbated by the emigration of doctors, nurses and other healthcare professionals from the continent to greener pastures overseas. This was the background for the recent conference in London which attempted to come up with ideas and solutions to reduce this haemorrhage and to attract back the many talented Africans who are now working overseas.

A bewildering array of speakers - over forty of them - spoke with passion about their experiences and their ideas. Only a few minutes was available for each speaker and most focussed on the problems facing doctors and nurses. Space is too limited to cover all that was said but many of the presentations; all of the speakers' biographies and full details of the Conference are available on the web at: www.africarecruit.com/healthcare/index.htm If you are in any way interested in the problem and are willing to help find solutions then please do go to this website.

I was invited to be one of the speakers and in my brief presentation I was able to tell the large audience - around 300 delegates/speakers attended over the two days - about the importance of oral health and the need for oral health professionals and educators. I reported the outcome of the very successful FDI/WHO Nairobi Conference in April 2004 and delegates seemed to be impressed with the number of health ministers and chief dental officers who had participated in the meeting. More relevant, in terms of migration, was the work done during

the FDI's Annual World Congress in Montreal by its World Dental Development and Health Promotion Committee. I quoted freely from its policy statements on this subject (yet to be adopted by the FDI's Council and General Assembly) and showed pictures of a blacksmith in Uganda extracting teeth using part of a hoe; the tragic results of a village healer removing developing tooth buds using a sharpened bicycle spoke (from *Dentaid* - with thanks). These are methods developed by people to deal with common (oral) diseases in the worst areas of health worker shortage.



photograph from *Dentaid*

Also, some grizzly images of the results of Noma infection in Nigeria, (from *Facing Africa - Noma with thanks*).

These images dramatically demonstrate the need for oral health care and education and a number of delegates took the trouble to come up to me during the breaks and thank me for pointing out that we must be concerned with *all* healthcare professionals, not just doctors and nurses.

There is a certain momentum building up on the difficulties posed by migration of healthcare workers and it was good that the CDA was invited to play a part in this important conference.

COMMONWEALTH HEALTH MINISTERS MEETING

Dr Sam Thorpe OR
CDA Executive Secretary

Introduction

The annual meeting of Commonwealth Health Ministers took place at the Ramada Park Hotel, Geneva, Switzerland on Sunday 21 May 2006, the eve of the World Health Assembly (WHA).



Dr S Sule (Director, Health, Planning & Research, Federal Ministry of Health, Nigeria) and Dr Sam Thorpe (CDA Executive Secretary)

The meeting was organised by the Commonwealth Secretariat and had as its theme: '*Human Resources for Health*'. It was preceded by a meeting of the Commonwealth Advisory Committee on Health (CACH) which was held on Saturday 20 May 2006 at the same venue.

Participants included Health Ministers and delegates of 45 Commonwealth countries and territories, as well as representatives of other UN partners and regional and civil society organisations working in health.

The Commonwealth Dental Association (CDA) was represented by Dr L. K. Gandhi (*President*), Dr Sam Thorpe (*Executive Secretary*), Dr Anthony Kravitz (*Treasurer*) and Julia Campion (*Administrator*).

Opening

The Director of the Social Transformation Programme Division (STPD) at the Commonwealth Secretariat, Ms Ann Keeling, warmly welcomed the Ministers and other participants, and the Commonwealth Deputy Secretary General, Mr Winston Cox, delivered

the opening address. The meeting was chaired by Rosie Winterton (*Minister of State for Health, England*).

Method of Work

The method of work included presentations and discussions at Plenary Sessions and Roundtable Sessions for three groups on the theme: '*Crisis in Human Resources for Health - Commonwealth Responses*'. All groups discussed the same theme and the Commonwealth Secretariat ensured the widest possible geographical representation among Commonwealth country groups. Ms Joy Phumaphi (*WHO Assistant Director-General, Family and Community Health Cluster*) delivered an address on behalf of the WHO Director-General, Dr Lee Jong-wook, who was unable to attend through illness. The keynote address presented by Dr Timothy Evans (*WHO Assistant Director-General, Evidence and Information for Policy*) focused on the challenges to the achievement of the Millennium Development Goals (MDGs) posed by shortages in human resources for health. Professor James Buchan and Ms Peggy Vidot also gave a presentation on '*Migratory Trends and Enforcement of the Commonwealth Code of Practice for the International Recruitment of Health Workers*'.

Under Any Other Business (AOB), the following additional presentations were made:

- ◆ '*Avian Flu*' by Dr David Nabarro (*UN Systems Senior Coordinator for Avian and Human Influenza*);
- ◆ '*Human Resources for Health Research - Priorities for Action*' by Professor Stephen Matlin (*Executive Director, Global Forum for Health Research*);
- ◆ '*Polio Eradication in the Commonwealth*' by Dr David Heymann (*Representative of WHO Director-General for Polio Eradication Initiative*);
- ◆ '*New Anti-Malaria Treatment Policy*' by Dr Arata Kochi (*Director, WHO Global Malaria Programme*).

Main Outcomes

1. In the concluding statement of the meeting, the Ministers:

- ◆ noted the human resources constraints on health care delivery,

the high burden of avoidable and preventable diseases and the wider social determinants of health linked to poverty, environment, lifestyle and conflict;

- ◆ endorsed an all-inclusive approach to health workforce policy development, integrating a gender perspective and taking into consideration the roles of all health staff, including doctors, nurses, other care-givers, researchers and support staff;



Ms Anisha Rajapakse (Programme Officer, Commonwealth Foundation) and Dr Sam Thorpe

- ◆ emphasised the importance of managing health worker migration issues to protect the human resources of the most vulnerable countries. This should include implementing best practices in retention strategies and in attaining self-sufficiency, facilitating the re-integration of returning migrants into the health workforce, and encouraging bilateral agreements between countries as well as partnerships with civil society organisations;

- ◆ stressed the need to build regional capacity for training of health workers. They recognised the fact that the Commonwealth had an important role in taking forward the recommendations of the 2006 World Health Report, and in ensuring that 50% of international assistance funds are dedicated to health systems, and 50% of that is dedicated to strengthening the national health workforce, with a focus on expanding training capacity;

- ◆ recommended the promotion of best practice in ensuring that sufficient resources are allocated to health at the national level, and the exploration of innovative ways of accessing funds for healthcare workforce development;

- ◆ highlighted the fact that international assistance programmes should not impose constraints on health workforce expansion;
- ◆ agreed to continue to work together to ensure full implementation of the Commonwealth Code of Practice for the International Recruitment of Health Workers, including further assessment of the options on compensation set out in the Code of Practice, so as to benefit the poorest and most vulnerable Commonwealth citizens. They urged the Secretariat to develop an Action Plan to assist in this work.

2. It was proposed that '*How Should Health Systems Approach Preventable Lifestyle Diseases*' should be the theme for CHMM 2007.

3. The following statement was read out by Rosie Winterton, chairperson of the meeting: "*As we know, in most of the Commonwealth countries, tobacco is a major cause of untimely death. The Commonwealth Dental Association met on Friday 19th May 2006 here, in Geneva, and discussed the issue of Chewing and Smokeless Tobacco Cessation and prepared a statement. Although this is late in the process, I would like the delegates to take note of that issue, which you may get another opportunity to discuss during the coming months*".

Conclusion

The Ministers and delegates participated actively in the discussions, and the meeting was a success. The participation of CDA at the meeting provided an opportunity for its representatives to interact with many Ministers and senior health officials.

After the day's proceedings, the Commonwealth Health Ministers and other delegates attended a Reception jointly hosted by the Commonwealth Dental Association and Physicians for a Smoke-Free Canada.

The CDA is grateful to Physicians for a Smoke-Free Canada and Dr Mike Knowles for their sponsorship.

SMOKELESS TOBACCO AND ORAL CANCER

*Professor Martin Hobdell
FDI World Dental Federation*

University College London; Queen Mary's School of Medicine & Dentistry, University of London

CDA Hosts a Pre-World Health Assembly Workshop for Commonwealth Ministers of Health and Senior Government Officials on Smokeless Tobacco and Oral Cancer

The well known dangers of tobacco and its association with ill-health, particularly lung disease, heart disease and stroke are usually associated in people's minds with smoking cigarettes. The less well known dangers and growing habit of the oral use of tobacco and snuff are rarely talked about - at least in Western Europe and other industrialised countries. But with growing immigration the problem is spreading worldwide. Because the oral tobacco use and snuff do not involve them being burnt they are usually referred to as 'smokeless tobacco' (ST). An added risk of ST is that it can serve as a gateway to smoking tobacco, in view of all this interventions to help ST cessation need to be undertaken. The Commonwealth Dental Association recently took an initiative with the Health Ministers of the Commonwealth, and senior members of their respective Ministries, to highlight the dangers of ST and the potential benefits of implementing health promoting activities to curb the habit, by organising a workshop on the subject prior to the meeting of Health Ministers and senior health officials in the run-up to the annual WHO World Health Assembly. Eighteen participants representing five Commonwealth countries attended the workshop. Presentations were made from Canada, India, Jamaica, Kenya and the UK.



Grace Allen Young (Permanent Secretary, Ministry of Health, Jamaica) and Cynthia Callard

This article summarises the key points made during the presentations and discussions. The References at the end will help readers find out more. The CDA Statement (page 13) agreed at the close of the workshop was tabled at

the Commonwealth Health Ministers Meeting on 21 May 2006.

Professor Saman Warnakulasuriya (*Department of Oral Medicine & Pathology, WHO Collaborating Centre for Oral Cancer and Precancer UK, Guy's, King's and St Thomas' Dental Institute*) explained the nature of the problem. He stated that there are two main types of smokeless tobacco (ST) - chewing tobacco and snuff. ST may be used alone or in combination with other substances.



(left to right) Raman Bedi (Director, Global Child Dental Health Taskforce and Co-Chairman of the Workshop), Saman Warnakulasuriya, Liana Zoitopoulos

Many forms of ST are carcinogenic to humans. Cancer development at the site in which it is placed, and other oral mucosal lesions caused by these products, has been described in several population groups¹. Leukoplakia - a precancerous lesion in the oral cavity, has also been strongly associated with ST use both among young adults and adolescents. As both composition and pattern of use of ST vary between communities and, over time, evaluation of each type of ST has to be undertaken with caution.

In 1985 the International Agency on Research on Cancer² confirmed the long held belief in the carcinogenicity of betel quid with tobacco used by many population groups in South Asia based on evidence from both human and animal experimental studies. The ST habit is also prevalent among Asian migrant communities in many parts of the Commonwealth who use commercially prepared sachets of freeze-dried tobacco known as Gutka^{3,4}.

Similarly the IARC has this year (2006) confirmed the carcinogenic potential of oral snuff after animal studies and several human case studies (*IARC, 2006 in press*). Twenty-eight known carcinogens have been identified in smokeless tobacco. Tobacco specific N-nitrosamines (TSNA) are the most abundant carcinogens identified in un-burnt tobacco and are formed during the aging, curing and fermentation of tobacco^{5,6}.

Sara Hiom (*Cancer Research UK and Department of Health Oral Cancer Cessation Campaign*) reported that cancer of the mouth is a growing problem in the UK with high relative mortality and increasing incidence.



Sara Hiom and Tony Jenner (Acting Deputy Chief Dental Officer, England)

The 2001 figures for 'oral cancer', defined as cancers of the lip, tongue, mouth and pharynx (excluding the nasopharynx), state UK incidence as 4,400 (with 3,447 cases in England). In 2003, UK mortality from the disease was 1,592 (with 1,231 deaths in England), higher than that for cervical cancer. The outcome is greatly enhanced by early detection, with prompt treatment improving survival rates from around 50 to 90 per cent.

Oral cancer is almost always preceded by visible changes inside the oral cavity or on the tongue or lips. Such accessibility allows for the detection and effective treatment of early intraepithelial stages of oral carcinogenesis. Despite this, most oral cancers are currently detected at

a late stage when treatment is complex, costly and has poor outcomes. Low public awareness of signs, symptoms and risk factors for oral cancer is a major barrier to improving outcomes as is a lack of prevention support and early detection by some health care providers. Most oral cancers are preventable, the major risk factors being tobacco use and excessive alcohol consumption. Incidence is strongly related to social and economic deprivation, with the highest rates occurring in the most disadvantaged sections of the population and in certain ethnic minorities. Raising awareness amongst these groups is a priority although by no means straightforward.

A new campaign by the UK Department of Health was launched this month (June 2006). It will run at national level to raise awareness of mouth cancer and methods for its effective prevention and early detection, especially among at-risk groups. It is a fully integrated health promotion campaign built around public communication, professional support, research and policy development. The campaign will target the groups at greater risk of mouth cancer (40+ year-olds who are heavy smokers and drinkers in lower socio-economic groups). In addition it will also target all the various health professionals who support them and operate at a community level in two focus areas by working with at-risk populations in Gateshead in North East England and the Bangladeshi population of Tower Hamlets in East London.

Professor Warnakulasuriya in his address had also indicated how the problem of ST had been tackled elsewhere by describing how, in the setting of Indian villages, it had been possible to influence behaviours associated with tobacco use and to quit ST use⁷. A substantial drop in the incidence of oral leukoplakia was reported after cessation of tobacco use in India⁸. He reported that already in a trial lasting 4 weeks among Bangladeshi residents in the UK 19.5% had stopped ST use⁹, some with the help of nicotine replacement therapy (NRT).

In this latter connection, he reported that six randomised control trials have already shown benefit with bupropion, and that NRT and oral examination and feedback had been shown to be

successful methods to assist quitting ST use¹⁰. Further research and eventual implementation of such important health promotion programmes will benefit populations addicted to ST use and will contribute to the control of oral cancer and improvements in both oral and general health.

Dr LK Gandhi (*CDA President, India*) reported that although the highest rates of oral cancer in the world are to be found in Southeast Asia there is some positive data. According to a paper by Elango et al (2006)¹¹ the number of head and neck cancers appears to have decreased in India over the past decade, in both rural and urban populations. The decrease is not uniform, for although pharyngeal cancer showed a reduction in urban females, it actually increased in rural females. Also, the rise in tongue cancer is of concern and may reflect changing nature of tobacco use. He attributed the overall positive improvement to the changing economic situation and urban migration of many Indians.

Dr Cynthia Callard (*Executive Director, Physicians for a Smoke-Free Canada*)



Ahmed Ogwell (Head, International Relations, Ministry of Health, Kenya) and Cynthia Callard

said that over the past 40 years, Canadian governments and health agencies have worked together to try to reduce the tragic human toll caused by the use of tobacco industry products. She said that tobacco use in Canada is now at one of the lower levels among developed countries (only 20% of Canadian men and women over the age of 15 are either daily or occasional smokers), 20 years ago Canadians had among the highest rates of per capita tobacco use¹². The first public surveys taken in 1965 showed that one half of Canadian men and women smoked. Oral tobacco is legally sold in Canada and widely available but it is not much used. Fewer than 1% report using

non-smoked forms of tobacco (i.e. chewing tobacco or snuff). National strategies to address oral tobacco use have not yet been developed nor is there a consensus over whether oral tobacco products should be promoted as a harm-reduction strategy. Progress over 40 years came in stages:

- ◆ 1960s - governments and health agencies relied on education campaigns.
- ◆ 1970s - governments proposed controlling tobacco industry promotions.
- ◆ 1980s - legislative measures were in place to ban promotion and to increase taxes on cigarettes.
- ◆ 1990s - smoking bans in public places became more widespread.
- ◆ 2006 - most Canadians live in jurisdictions where smoking is banned in all indoor public places and workplaces (including bars, casinos, prisons and hospitals).

She said that tobacco control must include comprehensive measures, relying on education and clinical support is not effective unless there are also measures in place which control the marketing (and price) of tobacco products and measures which create social norms that support living tobacco-free. The measures included in the *Framework Convention on Tobacco Control* have been found effective.

Dr Liana Zoitopoulos (*Community Consultant for patients with special needs, Honorary Senior Lecturer, Guy's, King's and St Thomas' Dental Institute, UK*) gave a European perspective on the role of public dental services on ST and tobacco use in general. She noted that smoking is a cause of fatal diseases and prevention of smoking is clearly to be preferred to cure of disease. It is important to emphasise that the risk of smoking leading to oral and dental disease is the same as for other serious diseases such as lung cancer, osteoporosis, coronary artery disease and other malignant diseases. Relatively inexpensive oral health promotion schemes could, therefore, provide much greater public health gain. The activities of the dental team should be built around the Common Risk Factor Approach, which addresses risk factors common to many chronic diseases¹³. Further, she pointed out that there is a professional and ethical duty to become actively engaged in efforts to combat tobacco use, however action should be evidence

based using professional guidelines^{14,15}. Dental practitioners and dental hygienists are ideally placed to examine their patients and to discuss habits such as smoking and alcohol. The results of the opportunistic giving of advice show a reduction of an additional 2% of those who quit smoking. But cessation of tobacco use needs to be supported by a professional and Nicotine Replacement Therapy (NRT), which is effective, so dentists should be allowed by national legislation to prescribe this treatment. In light of these findings training dentists in tobacco cessation is essential, but if they are unwilling to do this they must be able to refer patients to the right professional for help. Follow-up is needed each time a patient returns to the dental office. The role of the dental team can be summarised as: Ask, Advise, Assess, Assist, Arrange¹⁶.



Dula De Silva (Head, Health Department, Commonwealth Secretariat) and Anthony Kravitz (Co-Chairman of the Workshop)

Professor Martin H Hobdell (FDI World Dental Federation; University College London; Queen Mary's School of Medicine & Dentistry, University of London) tabled a short paper on Practical Research and Education Priorities in which he pointed out that the Framework Convention for Tobacco Control (FCTC) addresses treatment issues in Article 14 of the convention. The article is entitled 'Demand Reduction Measures concerning Tobacco Dependence and Cessation'. The article urges all parties to develop and implement appropriate and comprehensive programmes for treatment of tobacco dependence, referral and counselling. There is explicit mention of facilitating 'accessibility and affordability for treatment of tobacco dependence including pharmaceutical products'.

While rates of tobacco use over the last 3 decades have fallen overall in many high-income countries, rates still remain high amongst the poorer and more marginalised sections of

these countries. In parts of the developing world tobacco sales have increased significantly in recent years. In the coming decades the heavy death toll inflicted by tobacco use worldwide will increase dramatically, mainly in developing countries.

There are many evidence based treatment guidelines that exist which have been successfully implemented in many countries. The FDI World Dental Federation, as a member of the World Health Professions Alliance, together with the Commonwealth Dental Association wishes to facilitate the participation of National Dental Associations (NDAs) in tobacco dependence and cessation programmes.

Although the Conference of Parties (COP-FCTC) has not yet addressed the responsibilities of countries in respect of tobacco dependence treatment, the FDI and WHO feel very strongly about the involvement of professional organisations in tobacco dependence treatment¹⁷. However, many small dental associations in the economically disadvantaged parts of the Commonwealth either lack the ability to exercise their responsibilities in relation to tobacco dependence and cessation programmes or do not know if the existing evidence based treatment guidelines are appropriate to their environment and pattern of dental practice.

To assist in the development of appropriate programmes in economically disadvantaged parts of the Commonwealth education and practical research are necessary. A way forward is to look at cessation programmes that have been successful in similar communities elsewhere, not forgetting immigrant communities in economically developed countries. The priority in research is an action oriented implementation of evidence based programmes for their membership in tobacco dependence and cessation programmes for economically disadvantaged parts of the Commonwealth. The ultimate aim of education and research in this context should be to increase capacities of oral health professionals in tobacco dependence treatment and to help them use these skills in daily practice.

Acknowledgements

The CDA would like to thank the participants for having given their time at this workshop; Ms Anisha Rajapakse of the Commonwealth Foundation and Dr Dula De Silva of the Commonwealth Secretariat for attending the workshop and their support; the World Health Organization's Tobacco Free Initiative and the FDI World Dental Federation for their support and the documentation they provided for the workshop.

References

1. **Warnakulasuriya S (2004)** Smokeless tobacco and oral cancer. *Oral Diseases* 10: 1-4.
2. **IARC (1985)** IARC Monographs on the Evaluation of the Carcinogenic Risk of Chemicals to Humans: Tobacco Habits Other than Smoking, Betel-Quid and Areca-Nut Chewing; and Some Related Nitrosamines. Lyon; IARC, 1985.
3. **Bedi R, Jones P (1995)** Betel-quid and tobacco chewing among Bangladeshi community in the United Kingdom Centre for Transcultural Oral Health. London, 1995
4. **Warnakulasuriya S (2002)** Smokeless tobacco use following migration and its consequences. 2nd International Conference on Smokeless/ Spit tobacco. NCI, US Department of Health and Human Services, p.13-15.
5. **Cogliano V, Stari FK, Baan R et al (2004)** Smokeless tobacco and related nitrosamines. *The Lancet Oncology* 2004; 5: 708.
6. **McNeill A, Bedi R, Islam S, Alkhatib MN, West R (2006)** Levels of toxins in oral tobacco products in the UK Tobacco Control 15: 64-67.
7. **Pindborg JJ, Daftary DK, Gupta PC, Aghi MB, Bhonsle RB, Murti PR, Mehta FS, Warnakulasuriya KAAS (1991)** Public health aspects of oral cancer: implications for cancer prevention in the community. In: *Oral Cancer Ed, Johnson NW. Cambridge; Cambridge Univ Press. Pp. 380-388.*
8. **Gupta PC, Murti PR, Bhonsle RB, Mehta FS, Pindborg JJ (1995)** Effect of cessation of tobacco use on the incidence of oral mucosal lesions in a 10-yr follow-up study of 12212 users. *Oral Diseases* 1; 54-58.
9. **Croucher R, Islam S et al (2003)** Oral tobacco cessation with UK resident Bangladeshi women: a community pilot investigation. *Health Ed Research* 2003; 18: 216-223.
10. **Ebbert JO, Rowland LC, Montori VM, Vickers KS, Erwin PJ, Dale LC (2003)** Treatments for spit tobacco use; a quantitative systematic review. *Addiction* 98; 569-583
11. **Elango JK, Gangadharan P, Sumithra S, Kuriakose M. (2006)** Trends in head and neck cancers in urban and rural India. *Asian Pac. J.Cancer Prev.* 1: 108-12.
12. **Collishaw N, Mulligan L (1984)** Recent Trends in Tobacco Consumption in Canada, *Chronic Diseases in Canada* 1984.
13. **Sheiham A, Watt RG (2000)** The common risk factor: a rational means of promoting oral health *Comm. Dent and Oral Epidemiol.* 28: 399-406.
14. **Fiore MC, Bailey WC, Cohen SJ et al (2000)** Treating tobacco use and dependence *Clinical Practice Guideline.* Rockville: USDHHS.
15. **West R, McNeill A, Raw M (2000)** Smoking cessation guidelines for health professionals. An update. *Thorax* 55: 987-999.
16. **Petersen P, Kwan S (2004)** Evaluation of community-based oral health promotion and oral disease prevention -WHO recommendations for improved evidence in public health practice *J. Comm. Dental Health.* No 4: 21 December 2004.
17. **FDI/WHO (2005)** Tobacco or oral health: an advocacy guide for oral health professional Edited by Beaglehole RH and Benizian HM FDI World Dental Federation, Ferney Voltaire, France / World Dental Press, Lowestoft, UK.

TOBACCO AND ORAL CANCER PROGRAMMES

A Senior Health Official's Perspective

Dr E Grace Allen-Young

Permanent Secretary, Ministry of Health, Jamaica and President, Commonwealth Pharmaceutical Association

Factors Influencing the Health Care Agenda

Local (National) Determinants

- Disease prevalence
- National health budgets
- Health care advocacy
- The social and political environment

International Determinants

- Performance targets -
e.g Millennium Development Goals (MDGs)
- Treaties and conventions -
e.g Tobacco Framework Convention; Crete Convention

Role of the Senior Health Official

- Interpret the agenda presented
- Critically review analyses prepared by technical teams
- Ensure congruence with organisation's strategic plan
- Approve the policy framework including the priorities
- Direct alignment of resources with priorities
- Identify extra-budgetary areas of support if required
- Approve performance targets
- Monitor target achievement
- Provide analytical feedback and direction

Priority Settings

- Strategic fit
- Alignment with external directives
- Clinical impact
- Community needs
- Resource implications

(Ref: Gibson J L, Martin D K, Singer P A 2004)

Resource Allocation Methodologies

Programme budgeting and marginal analysis (PBMA)

Economic Principles

- Opportunity cost - weighing one priority vs the other
- The margin - would a change in resource mix increase total benefit

(Ref: Mitton C, Donaldson C 2004)

PBMA Process

- Aim and scope of priority setting
- Budget preparation
- Advisory Panel formed
- Decision making criteria in response to local need identified through stakeholder input
- Options identification by panel
- Recommendations for funding, trade offs (measure and score health gain and access)
- Validity checks with stakeholders

(Ref: Mitton C, Donaldson C 2004)

PEARL Framework

- **P** propriety - suitability of intervention
- **E** economics - is it sensible in economic terms?
- **A** acceptability - community acceptance
- **R** resources - availability of funding
- **L** legality - in legislative framework in place?

(HP 2010 Toolkit 2004)

Ethical Considerations

- **Welfare / benefit maximisation**
Shift in focus from the individual to a group / community / national population
- **Equity and distributive justice**
Equal treatment for equals
Fairness and recognition that some have greater need as a result of the severity of the disease
- **Patient choice**
Patient's right of choice
Balance between fair distribution of limited resources between the individual and the entire population

(UK Ethics Network - Johnston C & Slowther A 2004)

Decision Making

Our Own Experience - Jamaica

- **Primary health care priorities**
School dental health programme
Maternal Dental Health
Salt Fluoridation (Dental Caries reduction)
- **Sustainable programmes contributing greatest disease burden**
- **Attention to others related to ability to access other sources of funds**

Estimated DALYS / 100,000 Population

Mouth and Oropharynx Cancers - Selected Commonwealth Countries

Country	Malignant Neoplasms	Mouth & Oropharynx
Kenya	609	1
Jamaica	1221	36
Malaysia	955	72
New Zealand	1734	26
Nigeria	748	20
South Africa	1026	36
Trinidad & Tobago	1148	47
United Kingdom	1977	34

(Source: WHO 2004)

Fact

Resource constraints aside, the evidence supports the need for countries to implement programmes to prevent mouth and oropharyngeal cancers.

Tobacco and Oral Cancer Programmes

Jamaica and Demand Reduction for Tobacco

- Convention ratified 7 July 2005
- Price and tax measures to reduce demand (*Article 6*)
- Special taxation to fund national health fund fortreatment of 15 chronic diseases: higher insurance premiums (*Article 6*)
- Designation of Government offices as smoke free and private firms' work place policies (*Article 8*)
- Packaging and labelling warnings (*Article 11*)
- Education communication training and public awareness (*Article 12*)
- No advertising of tobacco products (*Article 13*)

Supply Reduction

- Customs act to be revised to address smuggling of tobacco products (*Article 15*)
- Price and tax measures to reduce demand (*Article 16*)

Scientific and Technical Cooperation

- Jamaica to draft label standards for CARICOM (*Article 20*)
- Surveillance - cancer register (*Article 20*)

Prevention or Treatment?

Health Promotion Strategy

- Healthy Lifestyles
Diet
Exercise
Behaviour change
- Target young
- Cross cutting health education messages

Way Forward

- Strengthen demand and supply reduction strategies
- Improve health information
- Specific surveillance of the disease
- Some of the revenue from taxation should be directly related to oral cancer prevention programme

References

- Gibson J L, Martin D K, Singer P A (2004) Setting priorities in health care organisations: criteria, processes and parameters of success, *BMC Health Services Research* 2004, 4:25
- Milton C, Donaldson C (2004) Health care priority setting: principles, practice and challenges, *Cost Effectiveness and Resource Allocation* 2004, 2:3
- Setting Health Priorities and Establishing Objectives (*Healthy People 2010 Toolkit*) <http://www.healthypeople.gov/state/toolkit/priorities.htm>
- WHO Department of Measurement and Health Information 2004 www.who.int/healthinfo/statistics/bodgbddeathdalyestimates.xls
- WHO European Health Report 2002, The burden of ill health www.euro.who.int/document/ehr/e76907h.pdf
- WHO - The Crete Declaration on Oral Cancer Prevention 2005 http://www.who.int/oral_health/events/crete_declaration_05/en/index.htm
- WHO Framework Convention on Tobacco Control (WHO FCTC) <http://www.who.int/tobacco/framework/en/>

ORAL CANCER and TOBACCO CONTROL PROGRAMMES IN KENYA

A Senior Health Official's Perspective

Dr A E Ogwel *BDS MPH MPhil*

Head, Office for International Health Relations, Ministry of Health, Kenya

The country

Kenya has an area of 580,000 sq km of which only 20% is arable land. It is famous for its Great Rift Valley, Lake Victoria, Mt Kenya and wildlife among other attractions. The economy is based on agriculture but industry and tourism are major contributors. It has a population of 32.2 million of which 41.3% are under 15 years of age.



Health Priorities are

- Promotion of Safe Motherhood and Child Health
- Eradication of Malaria
- Prevention of HIV and AIDS
- Prevention of TB
- Development of human resource for health
- Reduction in tobacco use
- Prevention of non-communicable diseases

Oral Cancer

- The epidemiology of oral cancer in the Kenyan population is uncertain
- Most studies are hospital based
- Oral cancers account for 1.5–3.6% of all malignancies
- A common thread in communities is tobacco use
- There is no vertical oral cancer programme
- There is scarcity of data due to:
 - Poor collection of samples
 - Lack of Pathologists / Cytologists
 - Poor recording
 - Poor collation of existing Information
- There is a lack of adequate funding
- However, opportunities exist:
 - National Oral Health Policy
 - Nairobi Cancer Registry is operational – trend: breast, cervical
 - Two more regions will be operational by the end of 2006
 - An increased budget to Ministry of Health (4, 7, 9.8 to 10.6%)
 - Prioritisation of Non-Communicable Diseases
 - National Cancer Prevention Programme

Tobacco Control

- The legal notice issued in 2006:
 - Bans smoking in all public places
 - Compels labelling → 50% of pack with message "Smoking Kills"
 - Is awaiting publishing in Kenyan Gazette
 - Will take effect after a grace period to ensure compliance
 - Formulated in the interest of public health



The Commonwealth Chewing and Smokeless Tobacco Cessation Statement

Tobacco use is a recognised health hazard and cigarettes are by far the dominant form of tobacco used worldwide. However, in many Commonwealth countries, especially those in South Asia, chewing tobacco represents over a third of all tobacco consumed. Smokeless tobacco delivers nicotine and is dependence forming. It causes considerable health risks; in particular it is a major cause of oral cancer. Recent evidence has demonstrated substantial amounts of tobacco specific nitrosamines (TSNAs) in smokeless tobacco products. TSNAs are the most common carcinogens in unburnt tobacco which are formed during the ageing, curing and fermentation of tobacco.

Smokeless tobacco products vary considerably and, in an unregulated environment, it is difficult for professionals and members of the public to know the contents of the different forms of chewing tobacco.

Health Professionals have a fundamental role to play in tobacco control and members of the dental team can play a special role in that process. Dental professionals have the opportunity to help people change their behaviour and then they can give advice, guidance and answers to questions related to the consequences of tobacco use in general and oral tobacco use in particular.

Members of the dental team should, therefore, be encouraged and trained to play a significant role in preventive measures, especially when considering the youth. They have the opportunity to promote social norm change, and forewarn children and adolescents of the dangers of oral tobacco use and assist in tobacco cessation.

Dental health professionals should themselves be the examples that a healthy society reflects upon. Many associations and establishments have started - and should continue - to designate their own workplaces as smoke- and tobacco-free. Adding tobacco control as a component of the training and education programmes of all dental health professionals is an important first step. Dental students should be trained in tobacco control during their educational years and so become more efficient at identifying and treating patients in tobacco-related issues, and be able to support their patients' cessation efforts.

Commonwealth Health Ministers are urged to:

- ◆ Recognise the dangers of tobacco use in any form
- ◆ Recognise the dangers and relative risks of smokeless tobacco within the general tobacco control programme and the role that members of the dental team can play in prevention and tobacco cessation.
- ◆ Request the collaboration, support of governments and international bodies (eg WHO, FDI, CDA, PAHO) to:
 - (1) Work towards the establishment of appropriate leadership centres and an international network in reducing chewing and other smokeless tobacco use
 - (2) Develop suitable continuing education programmes for members of the dental team to facilitate tobacco cessation
 - (3) Encourage the relevant national dental bodies to have policies on tobacco free work places and educational programmes on tobacco cessation
 - (4) Provide support for the development and evaluation of national programmes on preventing oral cancer
 - (5) Develop partnerships between civil society organisations and dental and other health professionals and the private sector, on tobacco cessation initiatives
- ◆ Direct the Commonwealth Secretariat to identify appropriate centres to monitor and evaluate the progress of the above.

Commonwealth Dental Association
London UK
19th May 2006

David Kalete

Civil Society Liaison Manager, Commonwealth Secretariat



David Kalete who joined the Commonwealth Secretariat as the new Civil Society Liaison Manager, on 3 April 2006, has an excellent track record of many years' experience working with civil society and governments at the national, regional and international levels. His last post was Director of Programmes for CIVICUS: World Alliance for Citizen Participation, a global alliance of civil society organisations based in Johannesburg, South Africa. Prior to this, he was the Kampala-based Regional Coordinator for Africa of the International Council for Social Welfare, one of the oldest global networks for social development. A Ugandan national, David has a wealth of experience, at senior level, in civil society capacity and alliance building, programme planning, implementation and monitoring, and relations between civil society and governments. He was previously the Programme Coordinator at DENIVA, the national umbrella body for Ugandan NGOs and prior to that held a senior post in the Ugandan government, responsible for the coordination of international development assistance. David holds a Masters Degree in Policy Analysis from the University of Zimbabwe.

During a meeting with David Kalete, Sam Thorpe and Julia Champion talked about CDA's projects and how the Association is run. The CDA congratulates David Kalete on his appointment and looks forward to working with him.

A Tribute to My Friend - Sister Rosalie

Dr G Erica Gordon-Veitch Paediatric Dentist

God wanted a more beautiful garden, so He came down and called our Rosalie. No doubt, she is already in Heaven organising some project. Rosalie, my friend for over 20 years has always been a tower of strength, pushing me beyond my limits and believing more in me than I did in myself. I am grateful that I benefited from her vast storehouse of knowledge and faith. So many memories, so many projects.

A very active member of the Jamaica Dental Association, Rosalie headed the Standards Committee. She guided Dr Hiram Foster and me during the Colgate endorsement in 1984. She was a member of the Dental Health committee, a major outreach program of the Association, and was instrumental in organising the Health Fair Concept. She was an Executive of the JDA until her passing.

As Principal Dental Surgeon she was an active member of the Dental Council. She guided me at the Dental Auxiliary School and was instrumental in my appointment as its first Jamaican Director in 1989 and was proud of my professional achievements. With links to the ADA's Health Volunteers Organization, she brought in Dr Cory Kruckenberg and Claudia Wieland, hygienist, to the School. Dr Cory wrote: *"Perhaps God needed her in heaven to help it become better organised!! I have never known anyone with more energy and vision than her"*.



Rosalie Warpeha with Dental Nurses trained at the Jamaican Dental School

Claudia wrote: *"Sister seemed to be that rock thrown into the pond that sets ripples out in all directions while remaining connected in the ever-expanding circle. We, her friends, are those ripples striving to accomplish more as we hold true to the rock that took that leap of faith and commitment to humankind and jumped into the pond that is life and all of us. She help set us in motion and we are grateful to her"*.

Forever striving for excellence, she worked tirelessly for Dental Auxiliaries in Jamaica. She upgraded the DAS curriculum with the consultant, Dr Sonia Niles. Mrs Mary Fagan-Cole, her friend and former Coordinator of Dental Auxiliary Services wrote: *"I will remember Dr Warpeha for the opportunity she gave me to grow, professionally, and Sister Rosalie for the interest she took in members of staff and their families. The home visits, and her presence at every funeral the blue VW Polo would*

take her. She had a heart big enough to share for everyone she touched and loved". Rosalie worked tirelessly for us, without fanfare. Until her final illness, she was placing the finishing touches on her fluoridation studies - to be concluded to her stringent standards.

Dr Victor Eastmond, Past President of the Caribbean Regional Dental Association (CARDA) and the Commonwealth Dental Association (CDA). wrote: *"Because of Dr Rosalie, and her introduction of Salt Fluoridation, Jamaica can now boast of an astronomical reduction in DMFT (decay), in spite of its low dentist: population ratio. She was, in our language a 'Bred-Caribbean' person who later accepted the Caribbean cultures and strived to improve the lot of those most in need of dental services (the poor), through salt fluoridation, which is not only preventative but most cost effective"*.

The CDA Regional Vice-President, Dr Joyous Pickstock, called her *"The Mother of Community Dentistry in the Caribbean"*. Condolences and accolades also came from Professor Martin Hobdell (CDA) and her class-mate, Dr Tom Beckman, who was happy to have spent time with her during our February 2006 Convention.

Rosalie, we will miss you but promise to continue your legacy of excellence.

Goodbye friend.



Working in partnership with oral healthcare professionals. Providing products and resources which have an oral health benefit

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Working Together with the Dental Team

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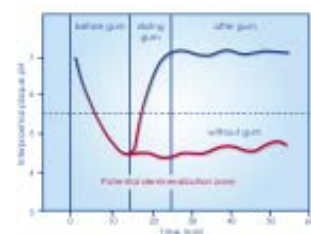
- supporting dental associations - e.g sponsoring conferences and continuous educational programs, encouraging dental professionals to communicate key messages to patients about better oral health care through informational brochures and leaflets
- helping patients to understand how to look after their health smile through leaflets, posters and online resources
- supporting independent clinical research into preventive dentistry, working locally with schools and kids by providing educational leaflets and brochures for teachers, parents and kids

- a dental schools program; supporting both lecturers and students with research studies and educational brochures on the oral care benefits of saliva
- a website offering a comprehensive overview of dental oral health for professionals, patients and journalists - www.BetterOralHealth.info

Wrigley works in partnership with the profession to encourage patients to adopt a healthy oral care routine, which includes communicating that chewing sugarfree gum is proven to help reduce tooth decay by up to 40% through an increase in salivary flow by up to a factor of 10.¹ (*published in the Journal of Dental Research in 2001*)²

This means, that as a dental professional you can confidently recommend sugarfree chewing gum, such as ORBIT, to your patients as part of their regular oral care routine.

For more information for you and your patients visit www.BetterOralHealth.info



Reference

1. Edgar WM, Bibby BG, Mundroff S, Rowley J (1975)
Acid production in plaques after eating snacks: modifying factors in foods.
J Amer Dent Assoc 90:418-25.
2. Szöke J, Bánóczy J, Proskin HM (2001)
Effect of after-meal sucrose-free gum-chewing on clinical caries.
Journal of Dental Research 80(8): 1725-29.

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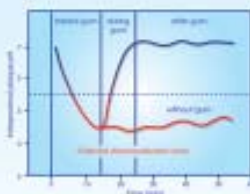


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Wrigley works closely with and supports dental professionals, dental associations and dental schools



to help promote better oral healthcare by providing information and practical resources. Wrigley works in partnership with the profession to encourage

patients to adopt a healthy oral care routine, which includes communicating that chewing sugarfree gum is proven to help prevent tooth decay by up to 40%, (published in the *Journal of Dental Research* in 2001¹) through an increase in salivary flow by up to a factor of 10².

So, as a dental professional you can confidently recommend sugarfree chewing gum, such as ORBIT, to your patients as part of their regular oral care routine.

For more information for you and your patients visit www.BetterOralHealth.info

References:
 1. Tsaike J, Bråncke J, Probst H (2001) Effect of alternative sucrose-free gum-chewing on clinical scores. *Journal of Dental Research* **80**: 1739-43.
 2. Edgar WM, Södy PG, Munkaflott S, Rowley J (1972) Acid production in plaques after eating sweets: modifying factors in food. *J Amer Dent Assoc* **85**:419-25.

