The International Collaborative Oral Health Development Project

W. R. Bedford and K. W. Davey
Ottawa, Ontario, Canada

In April 1982, at the request of Dr David Barmes, Chief, Oral Health, World Health Organization, representatives of several countries met in Geneva to discuss the feasibility of matching the potentially surplus dental resources of developed countries with the rising dental needs of many developing nations. It was out of this meeting that the International Collaborative Oral Health Development Project (ICOHDP) was conceived.

Coincidentally and shortly thereafter, Canada was approached by the Mozambique Government. Interest was expressed in the Canadian dental therapist programme. Dr Keith Davey, the Director of our National School of Dental Therapy was invited to visit Mozambique to assess their situation and to consider the possibility of setting up a similar concept in that country. He spent 4 weeks visiting various parts of Mozambique in order to gain an understanding of the dental delivery problems. Subsequently, he produced a report with recommendations for providing assistance. This was to take the form of training selected individuals to become trainers in a programme for dental paraprofessionals patterned upon Canadian dental therapy experience.

As a result of this, the Canadian International Development Agency (CIDA), a branch of our Federal Government charged with the responsibility for directing Canadian funds into worthwhile international projects, drew up a 4-year agreement to provide financial assistance to allow this programme to proceed.

In order to give a clear perspective on this project, it is important to have some understanding of how and why the Canadian Dental Therapy Programme was developed. Canada is a very large country with a relatively small population. The programme was originally developed to address the specific dental needs of the Indian and Inuit population residing in Northwest Territories. This area has a land mass of some 1·2 million square miles—about the same size as India, one-half the size of the United States or approximately 13 times the size of West Germany. The population numbers only 46 000 and, of these, 24 000 are Indian or Inuit living in 54 settlements. This creates a real servicing problem as none of these communities can support a private dental practitioner nor would any go to such remote locations.

In order to address this need, the Canadian Government developed a 2-year course in the basics of dentistry. It was designed to attract northern and native people who could return to communities to provide primary dental care and education. The programme proved to be so successful that it spilled over into the northern parts of the provinces where it was met with a great deal of enthusiasm from the 370 000 native Canadian people.

Undoubtedly, the reason for its success lies, in part, with the philosophy that it is important to provide care in isolated surroundings that is consistent in both quality and availability, as against the visiting dentist concept. A team approach is used wherein the dental therapists are employed as the service providers with visiting dentists to examine the patients and develop treatment plans for the therapists to follow. This has been important as it has assured standardization.

Patient care combined with modern preventive concepts was set as the first priority, followed by the organization of a dental health programme in each community. This approach meets the needs. However, it is recognized that it will not necessarily be the most suitable format in its entirety to address the specific needs of other countries that have problems in providing dental education and patient care. But it could serve as an excellent model and a starting point. It should be stressed that Canada is not in the business of developing programmes for Mozambique or for any other country, but it can provide an experience for stuidy.

There were some problems with language but there are similar language difficulties in some areas in Canada with our own native population. Therefore, this circumstance was not entirely a new one.

There was a mutual appeal for both the Mozambicans and Canadians in the development of specially trained dental auxiliaries to administer community dental health programmes and provide primary dental care. In order to meet the objectives for the Canadian programme and keep within strict constraints of time and funding, our training concept has had to focus on the themes of standardization, simplicity and portability and the tailoring of information selected on a "need to know basis". With appropriate modifications this approach was applied to the Mozambican project also.

The Mozambicans, while in Canada, work and study within the Canadian programme framework for most of the time. As their programme develops here, they are able to select and take away with them, those aspects of the Canadian model which they feel can be applied in their own country. It was considered helpful that, if possible, a consultant or someone familiar with conditions in Mozambique, should assist the Africans in formulating the Mozambican version of our plan. It was also necessary for the Canadian staff to adjust the Canadian programme in order to make the transition towards meeting the Mozambican requirements. During the first year of the project these understandings and adjustments were

made and refined. Making modifications to suit Mozambican requirements also resulted in improvements to the Canadian curriculum as well as further simplifying the portable dental equipment that had been successfully used in remote parts of Canada for some years. Considerable time has been spent in developing a durable, utilitarian and portable dental unit which is relatively inexpensive and can be easily repaired and maintained by the operator. Therefore, in the second year of the project, we were able to benefit from our experiences of the previous 12 months.

Along with the changes that were introduced into the Canadian programme, it was possible at the same time to blend the Canadians and the Mozambicans together for many aspects of training. Instead of the Mozambican students being taught separately as in the first year, frequently the Canadians and the Mozambicans worked together. This had benefits not only in orientation and English comprehension but also ensured that the Mozambican programme progressed in an orderly fashion and with greater exposure to all teaching staff. Evaluations were also standardized. By drastically reducing and simplying the biological science component in the Canadian programme, for example, and presenting this to the Mozambicans, dental concepts were more readily understood than before.

Although the African students are in Canada for 12 months, 2 months is devoted exclusively to English language training. However, the remaining 10 months is hardly adequate to meet all the requirements. In the future, the Canadian experience should be extended by 3 or 4 months, particularly if students do not speak English when they arrive.

Another concern was to determine how much preparation, or follow-up, there should be in the home country before the Canadian experience. A balance has been worked out concerning what is best taught or experienced in Canada and what training should be carried out in the home country. In this way, the students receive the best from both situations.

The Canadian curriculum covers 9 basic subject areas over a 2-year period (20 months). The Mozambican project focused on 4 major areas:

1. Preventive programme (40 per cent)
2. Patient care (curative programme—35 per cent).
3. Patient evaluation (15 per cent).
4. Programme support (10 per cent).

The 40 per cent of the curriculum time that is scheduled for preventive programmes was subdivided, with 15 per cent of the time for public health and preventive dentistry, as taught within the Canadian framework, and 25 per cent of the time devoted entirely to community dental health applicable to Mozambican requirements. This community dental health aspect of the curriculum is conducted by a consultant and another colleague familiar with the Mozambican environment. It might be that in the future a Mozambican could undertake this aspect of the course work, or it might be undertaken in Mozambique.

In addition to the time spent at the National School of Dental Therapy, the Mozambican students participate with the Canadians in a 6-week practical field experience in an isolated part of Canada. During the time with these communities they put into practice their training in patient care, and also their education and management skills in dental public health.

Over the last 15 years we have learned how to refine and change the Canadian programme to make it most effective for Canada. We have used the last year and a half to make appropriate modifications in order to give the Mozambicans as much assistance as possible in putting together a programme for themselves. Most changes have now been made but others may still be expected. If the Mozambicans are eventually to fulfil their role as supervisors and educators and providers of care within the structure of a dental auxiliary programme for Mozambique, they need a competent base as dental therapists which is similar to a senior level of dental auxiliary in their country. This is what we have tried to provide for them during their 10-month stay in Canada.

SUMMARY

The Canadian Dental Therapy programme was developed to meet the dental needs of remote communities in the North West Territories. In collaboration with the Mozambique Government trainees from that country are now being admitted to a modification of the programme designed to meet the needs of Mozambique. The aim is to help the Mozambicans to establish a core of supervisors, educators and providers of dental care within their dental auxiliary programme. (Editor's summary.)

DAS MUNDGESUNDHEITLICHE ENTWICKLUNGSPOROGRAMM MIT INTERNATIONALER ZUSAMMENARBEIT

ZUSAMMENFASSUNG

Das Kanadische Programm für zahnärztlich-therapeutische Maßnahmen wurde entwickelt, um den Bedarf an zahnärztlicher Behandlung in entlegenen Gebieten in den nordwestlichen Territorien zu decken. In Zusammenarbeit mit der Regierung von Mozambique werden ausgebildete Personen aus diesem Land nun für ein modifiziertes Programm zur Bedarfsdeikung in Mozambique zugelassen. Es ist das Ziel, der Bevölkerung von Mozambique dabei zu helfen, das sie einen Kern von leitenden, lehrenden und betreuenden Personen im Rahmen ihres zahnärztlichen Hilfsprogramms heranbildet. (Zusammenfassung des Schriftleiters)

PROGRAMME EN COLLABORATION INTERNATIONALE POUR LE DÉVELOPPEMENT DE LA SANTÉ BUCCALE