

A Report on the Dental Equipment Donated to Back To God Evangelistic Association

The following report is from Dr. Rob Mundy, a dentist currently practicing in the UK. Rob spent around 20 years serving as a missionary and then as a government-employed dentist in northern Argentina forest regions, working among Amerindian people. Mostly he was in remote areas. His wife, Tricia, is a nurse who spent much of her childhood in Uganda. Rob had previously visited Uganda for a dental outreach in the northern region. Last year, as part of our team (from Chris Baille's church), they worked with Brian the Ugandan dentist a former employee of BTGEA) and another Ugandan dentist (who had been on placement with Rob during training in UK), and with Nurse Josephine and a doctor from UK. They operated a mobile field clinic with the help of other team members, visiting each of the four BTGEA schools. They saw over 1000 children and quite a number of adults, carrying out dental procedures on over 300.

Rob is very experienced at dentistry in developing country situations, although at present he directs a government dental access practice here in the UK. He is particularly interested in how dental programmes can be made effective in situations where resources are limited.

His report on the equipment donation:

Dental equipment donation to BTC Uganda. Comments on exchange of emails

I think there needs to be some realism here about the equipment and materials that have been given from the US. 'Dumped as trash in Uganda' is not exactly diplomatic language but the initial impression on entering the clinic is overwhelming. Having spent 15 years in a poor part of Latin America there was a sense of déjà vu in the many boxes of donations of materials and instruments stacked up and waiting to be sorted and put to use. Some of the equipment had been installed, some was waiting on other work to be completed to make it functional while installation of other equipment seemed to have been abandoned as an unresolved technical problem. As a dentist I could recognise the equipment and materials and assess their possible usefulness. As a Pastor and Director of a Social Programme I might be forgiven for using the word 'dumped' as little progress seemed to have been made however tirelessly Dr Miller and team may have worked. It is several months since I visited the clinic. I did not presume to look at the equipment with the view to writing a report so these thoughts are not complete and come from memory. However while I did go with the willingness to help Brian to sort the equipment, within a short time I realised that this was a huge job and not suited to a short visit. There were also policy decisions to be made on what to do with all the materials as clearly they were not going to be used within their expiry date within that setting. The following are thoughts on donations in general and these in particular which may give some clarity.

Donations in kind though well intentioned do need to be carefully screened. They can be divided into Useful, Inappropriate, and Superfluous and outside of usefulness.

Useful

There were two complete mobile units which I was impressed with. These were 'A Dec' a brand known for its particular usefulness in the remote areas as it is user serviceable. There were two folding dental chairs which I became familiar with as we were able to use on outreach. Among the boxes were many hand instruments which needed sorting. The forceps and other surgical instruments are particularly useful for outreach clinics. There were also other hand instruments which I did not look at closely. Providing equipment is useful if it has life in it; it does not need to be new. Some of the equipment clearly was not new but if it had been serviced prior to shipment and worn parts replaced then it could last for some time. The X ray machines seemed to be of an old model though, judging by the dated contours of the machines. This may still be the style in the US but I doubt it. X ray tubes do have a limited life. There were other items of equipment which I was not able to test such as curing lights and ultrasonic scalers. While these did not appear to be new they may well have been useful.

Inappropriate.

It is important that equipment destined for use in a remote area is going to be usable and useful. Some techniques used in private practice in the west may not be appropriate in a remote area with a huge need and few resources. Some of the equipment was not appropriate particularly the Orthopantomograph. This X ray machine takes tomographs of the jaws giving a useful pan oral picture of all the teeth at once. This is useful in orthodontics when it is important to assess the developing teeth and is useful, though not essential in oral surgery, when a wide picture may help in diagnosis. It does require large and specialised films which then require processing in large developing tanks. X ray solutions are not cheap and go off in two to three weeks whether or not they are used. I could not see that the work load either in numbers or kind would ever justify installation of such a tomograph. Some years ago these films were taken as 'screening'. There is no evidence base for this and certainly in UK there would need to be a much higher diagnostic justification than general screening for exposing a patient to radiation quite apart from any other consideration. A machine such as this could possibly be justified in a main centre such as Mulago or Mengo but even there extra-oral views taken with a normal dental machine will give as much (though less elegant) information. I understand that Siemens South Africa, the nearest Siemens agent suggested that the machine is now obsolete and no parts are available for it. It was certainly not a new machine and I am sorry that such an effort was made to transport it from the US and try and install it leaving it half dismantled in the middle of the surgery.

Brian also showed me some molar endodontic Nickel Titanium rotary equipment. This had been demonstrated to him and certainly is state of the art and is especially useful for root filling molar teeth. However the cost of the new files is so expensive that we do not use them within the NHS in UK still using the old hand files for the molar endo we do. I

cannot conceive of a situation in Uganda where a molar tooth with pulpal involvement was not best removed rather than root filled. Molar endodontics is time consuming and technically challenging. While an effort may be made to root fill and save an anterior tooth for appearance, the investment of time (on the part of patients also) and resources in saving pulpally involved molars is not appropriate. In UK molar endodontics is the stuff of private practice for highly motivated patients and many people will choose an extraction rather than this. Anterior root filling can be done easily with hand files. I did many anterior root fillings in rural Latin America but never a molar root filling

There were large amounts of dental materials some of which were unlikely to be used within the vision of the dental work Brian was trying to establish. My experience has been that supply lines should be established for materials so that a service is sustainable. Setting up a service depending on materials that may or may not be donated in the future is inadvisable and a one-off gift of materials may be useful if they are the materials already in use. I did fear that some of the materials sent may pressurise Brian into using them because they were there rather than because they fulfilled the need of the service he was setting up. There were boxes of acyclovir tablets, an antiviral drug. I cannot think what these might have been used for except maybe in the treatment of viral infections of the immunocompromised. However Brian is a dental officer and would more appropriately refer HIV patients who he was worried about rather than trying to treat them himself. Sadly these very expensive drugs did not have a long expiry date and will be soon out of date as will many of the other dental materials.

Superfluous and unusable

There is only a certain quantity and quality that can reasonably be used and donors should be careful to supply what is usable. Having spent many hours sorting through well intentioned donations from far away I have to say what a discouraging task this is. One constantly tries to picture the enthusiasm of the donors and thank God for their care to avoid becoming disillusioned. The overwhelming impression was of too much and of some things I could not envisage ever being used. There is one box which stands out in my mind. It contains several hundred boxes of matrix bands for a toflemeier band holder. A matrix band is the metal strip in the clamp placed on a back tooth when packing amalgam into an interstitial cavity. While in UK these are often disposed of after single use they are not classified as single use and can be cleaned and reused. Each box of the several hundred contains 12 packets of bands. Each packet contains 12 bands. That is several hundred gross matrix bands. I may have used a gross in 15 years in Latin America.

The \$250,000 tag

What does this represent? Is this the value if bought on the open market? I am sure most of this stuff was donations. While dental materials are very expensive this is because it is a small market and there is not economy of scale. 'Superfluous to requirements' is not difficult to imagine in dental companies and donations from such stock do need to be kept in context. My assessment was that much of the equipment was second hand. Within the service I run in UK

when we refurbish a surgery I am pleased if someone will take away the equipment for nothing. In fact the better stuff we send to Dentaaid, a dental charity who reconditions dental equipment to send to Africa. In the recriminations about funds and money it is very important to clarify what is being said here. How much of this was actually bought for \$\$? How much did the donors forfeit by donating this? I have written thank you letters to donors having been asked to be explicit about the donation so that it could be set against tax. I do not doubt the enthusiasm commitment or love of the donors. 'It was \$250,000 in equipment, most of it new' is probably misleading. 'As of now the equipment is as if it was dumped as trash in Uganda.' while not being the most diplomatic language is not as far from the mark as it is made out to be.

In our efforts to help we make a lot of crass mistakes. We are all fallen people we carry a lot of cultural baggage which we mistake for godliness. As the brothers from the richer economies we must not assume that we get everything right and all the mistakes are with the other party. While I am aware of the problems that are being worked out between BTGEA and BTGUS over financial arrangements I do not understand all the intricacies. However I do understand something of Dental Care in the third world and I regret the economic use of the truth to try and gain the moral high ground here.