



Volunteer Manual

(put a smile on the world)

ADA

Volunteer Manual

A Manual for Dental Volunteers

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Introduction

This manual is produced by the ADA as a guide to those dedicated professionals that volunteer to assist the people in resource poor countries. Australians have a record to be proud of as providers of services, infrastructure and materials, and teaching in the Pacific basin and beyond. This manual is the work of an ADA Special Purpose Committee of Dental Volunteers. However, you will identify the writing as reflective of the style of Jamie Robertson, who brings a wealth of experience and considerable wisdom to this subject.

In choosing to be a volunteer, you are offering your knowledge and skills to people who otherwise might not receive any care at all. It is sensible then that your training should be used as effectively as possible. The following notes are designed to help you gain a fuller understanding about what it means to create or work on a sustainable project. They are not intended to be an encyclopaedia of everything that you could possibly want to know about managing a project.

We welcome feedback on how useful the manual has been to you. Every good wish for a rich and fulfilling period of service.

Dr JE Matthews

Federal President ADA

First Principles

There are many reasons why a person might volunteer their services to a dental project at home or overseas. They range from the religious and idealistic to the banality of a retired person getting out of the house or gaining a tax deductible holiday in an exotic location. No matter what the impulse is, the objective of better oral health for the community, however defined, must override individual agendas. Good projects have been terminated due to the proselytising efforts or the bad behaviour of individuals. Dentists should also recognise that 30 to 40 years of successful private practice in a developed country is not necessarily good training for promoting oral health in a developing one. Finally, the "have forceps will travel" tourist is generally too egocentric to adhere to any project objectives.

Perhaps in response to known adverse outcomes, yet recognising the enormous value of good volunteers, the FDI adopted a set of guidelines for dental volunteers at its meeting in Montreal in 2005. These are as follows:

- Preference should be given – wherever possible – to work in an established program or project, i.e., one that is integrated in the host community and recognised by national government officials, the National Dental Association or other health professional organizations.
- Under all circumstances the volunteer should be aware of the Code of Ethics for the Dental Profession and should strive to apply it in every situation and every setting. Dental volunteers have an important role as ambassadors of goodwill and are also representing the dental profession as a whole. They should therefore always act professionally and be personally responsible and ethical.
- Volunteers should conform to the legal requirements for the practice of dentistry in the selected jurisdiction and including the required qualifications diplomas and professional liability insurance.
- Emergency care and service provision are important aspects of volunteer activities. However, ensuring the long-term impact and sustainability of activities should be equally important, i.e., by training local personnel, introducing preventive measures or similar activities.
- A volunteer should be cautious about introducing new material and equipment without prior consultation of the project since it may not be useful in a particular context or proper maintenance may not be possible.
- General principles such as project planning, reporting and evaluation are essential to the success of a project and need to be respected. If a project is new or about to be established, support and guidance by experienced colleagues or experts should be obtained.
- Any volunteer should respect the culture of the host community and try to adapt as much as possible.

Several of these points will be covered again later in the manual. It needs to be remembered that volunteers are there to augment existing programs, to enthuse and perhaps establish local workers, to teach, to innovate and to offer themselves as role models. Volunteer projects cannot and should not be the sole delivery system of some human activity as ends in themselves.

Dental volunteers should critically ask themselves about their motivation and should choose an NGO that works on the basis of proven public health principles and track record, or they should seek guidance from experts when setting up their own project. (International Dental Journal 2006, Vol. 56, p. 48)

Project Types

These vary enormously from a one-man-band operation acting as an itinerant exodontist to a structured inter-institutional teaching program. The degree of sophistication will depend on the commitment of the establishing dentist and the level of development of the infrastructure. For example, a village in the Highlands of Papua New Guinea will only permit a low level of technology whereas a major Asian city will permit tertiary level teaching and surgical procedures. In practice this may mean that a project sees patients on a school or nursing station verandah using natural light or else there may be a fully equipped surgery permitting advanced care.

Projects have been started for a number of reasons and a common one is that someone stumbled across the need for dental care somewhere. Another prompt has been that a general nurse or teacher let it be known that there was a great need of care in their region. A project may therefore supply intermittent care where no other treatment exists or it may support and enhance a local dental operator who is chronically under resourced. In the latter case it is important that the local worker is not undermined because local people simply wait for the outsiders to return with their fancy equipment.

A major underlying principle for running a successful volunteer project is the establishment of a partnership between the volunteer organization and an in-country grouping. This in-country partner could be a small local NGO or a branch of an

international NGO run by local staff or it could be an official arm of the country or region's Department or even Ministry of Health. The important point is to build on an existing infrastructure rather than set up in isolation from – or worse, in opposition to – that service. Reinventing the wheel is a pointless exercise. Such inter-organizational partnerships are important for many reasons including:

- The Ministry of Health or equivalent may require demonstration of such partnership before volunteer projects will gain approval.
- Local partners are needed to help guide the project in the most appropriate and effective application of the volunteers' knowledge and skills.
- Local partners facilitate an introduction to other local agencies, such as education authorities, who can assist in advancing the goals of the project.
- Only by having a local partner can a project ensure a better chance of support and sustainability.

Projects should begin with the objective of making themselves redundant in a particular area rather than creating a dependency. The training, enabling and status-raising of local workers and the reduction of the burden of disease should be the goal of any project.

Although organizations and individuals involved are often highly motivated and sacrifice significant amounts of time, money and resources with the best of intentions, the impact and sustainability of such volunteer engagement remains at best very limited. A profound strategic reorientation for the majority of dental NGOs and the volunteers serving for them is long overdue. Their programmes and projects need to be reoriented towards projects that are efficient, sustainable, integrated and accepted by host communities. (International Dental Journal 2006, Vol. 56 p. 45)

Prevention and Repair

The first rule for a health professional is to do no harm. Do not make a situation worse by your actions; assess the hazards and risks before treating.

It is generally true that the demand for primary care will far outstrip the possible supply. Projects should therefore aim to reduce the levels of dental disease and not simply deal with the terminal stages of it. When emptying a bath, it is better first to turn off the taps. However, prevention requires the cooperation of many other groups in the community. These include local authorities, partly out of courtesy and partly to enrol their support in the philosophy. Also included are schoolteachers and any other health care workers who will generally know the benefits of disease prevention. Access to primary schools to give oral health promotion, distribute resource kits for teachers and where possible to start or encourage regular school-based fluoride toothbrushing and/or rinsing, are well-tried and achievable steps. In addition, mother and infant welfare clinics make a receptive audience for the prevention of early childhood caries. A common risk factor approach linking diet and smoking to oral and respiratory diseases, diabetes, obesity and cancer will be understood by local health workers.

With regard to the type of treatment which volunteers can provide, it depends on the facilities available, the age and variety of the patients who present, and the disposition of the volunteers. If the project's population is, for example, a whole village or settlement, then relief of pain may be the primary goal. However, if the target population is a specific group, say, children, prisoners, a refugee camp or leper colony, then it is more likely that a systematised provision of primary care may be established.

WHO has devised a Basic Package of Oral Care (BPOC) for disadvantaged populations throughout the world. It was not formed to benefit charitable projects and volunteers but to assist dental services, policy makers and care providers in many of the non-established market economies of the world where remarkably good care is provided daily despite terrible odds. There are three ascending steps which should be implemented to the best that local conditions permit. These are:

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1. Oral Urgent Treatment (OUT), which is concerned with the relief of pain, the control of infection and the management of trauma.



2. Affordable Fluoride Toothpaste (AFT). This means more than simply the supply of toothpaste to a local market. It means the encouragement of the manufacturing of good quality, low cost paste and its introduction to as broad a population of families and schools as can be achieved. It is a key prevention strategy in lowering the level of disease.
3. Atraumatic Restorative Treatment (ART). This care using hand instruments and glass-ionomer cement may be done in dental and non-dental settings and is highly effective for single surface lesions and fissure sealants.

In addition to these and pervading all levels is the active use and encouragement of oral health promotion messages and other forms of prevention such as the use of fluoridated salt or rinses where toothpaste is unavailable.

In some basic conditions, visiting volunteer dentists and therapists may only be able to undertake OOT while in other situations teams with field equipment may perform treatment far in advance of ART. Please try to remember that 30 years experience in a comfortable private practice is not necessarily good training for treatment choice and prioritisation when working for a short time in an alien environment. Older and retired dentists have a propensity to remove asymptomatic teeth regardless of the patient's wishes, and younger dentists can get carried away with inappropriate cosmetic dentistry.

Donations

There can be a temptation in rich developed countries to believe that "pre-loved" goods can have an extended useful life by being sold or donated to developing communities, either in their own country or abroad. Often the good intention of a donation is completely wasted because of its inappropriateness. Hence, Sydney buses turn up in East Timor and cannot be used because they are too wide and kidney dialysis units are sent to African hospitals without electricity. Therefore, one has to be wary about trying to replicate a typical Australian surgery in an alien environment.

Before volunteers go on a working visit they are often offered materials and equipment and it is sometimes necessary to learn how to say no thank you without offending the potential donor. In general, materials which have passed their "use by" date should not be taken for the following reasons:

- There may be regulations against the importation of expired pharmaceuticals.
- Local health workers may object to patients being offered "inferior" goods.
- Although expiry dates are set conservatively, local authorities know that there is a reason for the given date and may assume that goods become toxic after it.
- The handling properties and efficacy of the material may have deteriorated.

It is beneficial if some consumables can be sourced in the country of operation. This saves bulky transport, makes unit costs cheaper, and boosts the local economy.

Equipment will be covered in the next section. However, when considering a donated item, check to see that it works properly for someone other than its owner and that it looks presentable. Would you like to receive a scratched, scorched, torn or otherwise defective present? In addition, who is going to guide a shipped item through a Byzantine and often venal Customs system at a distant port and then find a means of transporting it to a remote work location?

Clinics and Equipment

Five hand instruments for ART are more useful than two containers of cast off equipment if the latter cannot be installed, maintained or function due to lack of power. Nevertheless, the gradual upgrading of robust and serviceable equipment to permit a fuller range of treatment is a wonderful benefit to local dental health workers who may have been sent to a distant village with no means of putting their training into practice.

Many volunteer projects receive offers of used equipment. However, there is often no thought given to the logistics of transport at each end, costs, Customs bribery, installation, availability of spare parts, voltage variation tolerance, susceptibility to humidity, or the human genius for using things the wrong way. It is therefore appropriate that early visits to a location should work under the KISS principle - "Keep It Simple - Stupid!" Generally, projects will set out their own requirements for what each volunteer should bring in terms of instruments and materials. These will clearly be related to the level of sophistication of service delivery.

Equipment needs to be reliable, robust and low technology. The utility of computerised, hi-tech, bells and whistles equipment is inversely proportional to its distance from a service centre or technician. Moreover, standardization of equipment is highly desirable because that requires a smaller range of spare parts and if several items are available then they can be cannibalised

to make a smaller number of fully functional items. It is important to know the mains voltage of the country of operation. You will then know whether or not a transformer is required. Voltage regulators or stabilisers are everyday necessities for most rural Asian and Pacific locations to prevent blown fuses from surges or brownouts.

An important point is to be comfortable while working. It does not make sense to hunch over an upright chair all day. Patients can generally lie on a bench top, desk or table with head support so that the dentist can sit and be comfortable. Sometimes in a clinic, an old donated chair is stuck in one position; if so then try to make it horizontal or use something else entirely.

If a project returns to one location many times then a clinic can be upgraded gradually. There will be an opportunity to review equipment operability and utility. Of prime concern is raising the standard of sterilisation and infection control but donated autoclaves have to work and the less automated the better. In many countries there is an increasing risk of viral infections, e.g., HBV, HCV and HIV and so there is an increasing obligation to minimise the risk that your project spreads infection through negligent infection control measures.

Infection Control

Most volunteer projects operate in areas where the rates of communicable diseases are much higher than in non-indigenous Australian communities. For this reason it is ethically reprehensible not to try to raise the standard of infection control in whatever situation the project operates; this includes large hospitals. Simply because you know that a Dental Practice Board team is not about to walk through the front door asking for autoclave logs and validation reports, is no reason to ignore infection control standards. Having said that, there can be situations in which it is difficult to practise infection control as well as one would want. Basically, a volunteer should ask if he or she would want to be treated with the same instruments after they have passed through the infection control measures employed by the volunteer on location.

It is important to observe any existing procedures and find out what prescribed protocols have been published. It is then easier to build on that and introduce sustainable changes. In some areas where power is absent or unreliable there is a policy of enhanced cold "sterilisation" technique. This involves placing used instruments directly into one cold disinfectant, leaving them for the required period, scrubbing them under water to remove bio-burden then placing them into a second and different disinfectant for its required period. The temptation, as with all cold sterilisation techniques, is to take short cuts during busy clinic times. Unfortunately one of the disinfectants is often glutaraldehyde.

It is possible to introduce pressure cooker type autoclaves which can operate over any form of heat source, be it electricity, kerosene, butane or wood. These can often be bought locally and may need some chicken wire inserts to raise instruments above the water level. If you are going to donate an autoclave steriliser then there has to be a reliable power supply and its program should be largely manual and easy to follow. Fully automatic programs are great until a fault develops. The alternative of dry-heat sterilisers cannot be used for all items, have a long cycle, and have a disconcerting habit of having cycles interrupted by brownouts and blackouts.

Summary

1. Observe and assess existing procedures, if any. If these are satisfactory, say so, and if they are unsatisfactory discuss their good points as well as their failings.
2. Explain new procedures and invite dialogue on local perceptions, need for modifications, and attitudes to change. If necessary look beyond the dental workers for local support.
3. Only introduce technology which can be maintained and procedures which can be sustained. It may be that the local nurse or other general health worker will be delighted with a donated autoclave even if there is no resident dental worker.
4. Leave clear and simple written instructions for procedures in whatever language will be understood. Laminate them and have them prominently displayed.
5. Be prepared for back-sliding and a need for reassessment.

Culture

One of the most exciting things an overseas volunteer project can offer is to become immersed in another culture to a far greater extent than a holiday would permit. It is true that you will learn much about the country and its people but you will learn much more about yourself as you learn to cope in an alien environment. Another inescapable fact is that you will be an ambassador for the project, for Australia and for yourself. Although nothing may be said, people will judge both Australia and you by your actions and attitudes. This is particularly true of various body piercings and hair colours which may be frowned on in socially conservative Asia.

Your time as a volunteer may be one of the most enriching and memorable episodes of your life even if, at times, you find yourself in uncomfortable situations. The local people will treat you warmly and honourably and offer the best of whatever they have in food and accommodation. By all means take photos of your family, pets, and scenes of Australia but not of your Benz or in-ground pool as that is simply crass and breeds either envy or resentment. Sharing meals with local people allows you to learn more about them personally and about the country. It will benefit you to learn a little of their history and culture before leaving Australia - even if you have to revise it all once "on-station".

Among the cultural delights which may be encountered are drop toilets, lack of running water, no air-conditioning, no television and no sockets for hair dryers. You may well appreciate them more on your return home but you can indeed survive without them. In fact, experiencing some privation while working allows Australian health professionals an insight into some of the difficulties faced by local people all the time, not just for a period of two weeks.

Travel

The project may or may not have tax deductible status and so the organiser will be able to advise on how payments should be made and on what the various cost components are.

Volunteers generally have to pay for their own travel and living costs. It will probably be the case that the project uses a particular travel agent and that a routine has been established. Large and small teams should travel together because that is easier to organise and it helps with team bonding. Project coordinators get ulcers when various people ask to fly with a specific airline to boost frequent flyer points or when they ask to arrive at a different time or place. If a team is being met at the destination, it does not help if individuals want to arrive at a different time. The primary focus of your trip is to be of service to other people.

When the work period is over it may be possible to break up into smaller holiday groupings if you do not want to return immediately. Team meetings, Lonely Planet guides, and conversations with past volunteers may help to crystallise what volunteers want to do on completion of work.

The Department of Foreign Affairs and Trade (www.dfat.gov.au) gives travel advisory notices and traveller information. It is a good idea to familiarise yourself with these sites for up to the minute advice. You will also need health advice and preventive measures depending on which country you are visiting. Once more, the project coordinator and/or travellers' health clinics will have relevant information. Often volunteers carry with them assorted medicines either for routine use or in case of pain, infection or gastro-intestinal problems. It may also be prudent to carry non-dental syringes and needles in case you need medication while abroad. However, it is wise to check on what items may be considered as prohibited imports, e.g., codeine.



Accommodation

Projects tend not to be at Club Med locations. The reason for the visit is to help under-privileged people in resource poor situations. Experiencing some of the conditions helps give an insight to these situations. This is true whether or not the project is in the Northern Territory, Papua New Guinea or Tamil Nadu. Volunteers should expect little of their on-location accommodation and any creature comforts will come as a bonus. Retreating to air-conditioned oases every night actually cuts the team off from part of the experiential learning. This is not to say that enjoying good hotels from time to time is wrong.

It is common that while working at a rural location, the hosts will provide free accommodation and meals or perhaps charge a nominal sum. Accept this with grace and modesty. Rooms are generally shared with gender segregation and there is a need to be considerate of others. While working, team members tend to live in each others' pockets with little chance for escape. Interpersonal problems should therefore be aired early and calmly rather than be bottled up until they prove explosive. Frequent team debriefings on life and work – say, before the evening meal – provide a good opportunity for the expression of feelings and for mutual support.

In many parts of Asia it is not acceptable for women to dress immodestly or for them to walk alone at night. Keep to well-lit areas and preferably go walkabout with a companion. For both male and female volunteers there is a need to guard personal belongings such as passports, air tickets and credit cards. If these are carried, they should be done so discreetly and not in a bulky and easily cut off bum-bag.

A Checklist of Ideas

1. Is there a national/regional/local dental health policy? It is pointless, in fact counterproductive, to try to reinvent the wheel when setting up a project. Initial discussions with relevant authorities will reveal the existence of any policy which will usually be based on WHO guidelines. By offering to work within policy parameters, voluntary projects can help to further policy goals. Health bureaucrats and politicians like this.
2. What is appropriate and who decides? This may not be obvious at the outset but objectives need to have a large amount of local input. There is a temptation to swamp the target group with new or surplus equipment. Furthermore, local dignitaries like to gain kudos from introducing these new-found resources. However, the long term benefit of these grand gestures of good will is often questionable.
3. The same young people who can learn to use mobile phones and DVD players in an instant can find it impossible to look after donated dental equipment. Knowledge of equipment maintenance is as important as any other and it can be demoralising for a local practitioner to be left with equipment and materials which do not function in their hands.
4. Volunteers should not do what local people should and could do for themselves. To do so encourages a loss of dignity and self-esteem on both sides. There may be some communities where help will be required for a long time. However, it is more rewarding to work with local people towards self-sufficiency and to give them the tools to facilitate this. Volunteers can complement a service or even set one up and provide demonstrations but in the long run local people must own it. If a community comes to rely on volunteer agencies to be the main or sole provider of a dental health service it has adopted a dependency posture, possibly to the detriment of its own health workers. This has been called the "development of underdevelopment".
5. New volunteers can be quick to criticise and suggest alternative actions and they may have valid points to make. However, there may be reasons why things work as they do, so bear in mind the following:
 - Do not rush in with all the answers.
 - On a first visit, be all eyes and ears and very little mouth.
 - Objectives need one or even two discovery visits to conceptualise.
 - Why should local people pay attention to outsiders who have little understanding and can leave at any time?
 - Small is beautiful.
 - Try to be aware of local hierarchies which may affect infection control and equipment maintenance.
 - Local ownership is essential for sustainability.
6. If after four or five visits to one location nothing has changed except for a clinic full of equipment and materials then either the project has become the de facto dental service, which the local people do not mind, or else the local authorities simply do not care. At this point new understandings and objectives have to be negotiated.
7. Outsiders who wish to change procedures should not think that their experience and training will be automatically accepted. Established routines tend to be stubbornly maintained. To change habits may require the intervention of remote senior authorities and repetition to the nth degree. It is better to find something right in the old ways and then build on that rather than try to sweep it all away.

Useful Links

Australian Dental Association website: www.ada.org.au

Guide for Safety and Infection Control for Oral Healthcare Missions: www.osap.org/displaycommon.cfm?an=1&subarticlenbr=15



AUSTRALIAN DENTAL
ASSOCIATION INC.

www.ada.org.au