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ODONTOLOGUE

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Kenya Dental KDA Association



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Letter from The Editor



Dr. Akali Elikana Lesley
Editor-In Chief

Welcome to Mombasa.Welcome to Africa's Dental Congress.

There is something special about bringing Africa together. Different countries, different experiences, different perspectives, yet one profession and a shared ambition to advance oral healthcare across our continent.

As the Kenya Dental Association welcomes delegates, speakers, partners and friends to the FDI Regional Congress and 43rd KDA Annual Scientific Conference and Exhibition in Mombasa, we do so with immense pride and excitement. Against the beautiful backdrop of Kenya's coast, this gathering promises more than scientific exchange. It is an opportunity to challenge conventional thinking, forge new partnerships and imagine what African dentistry can become.

And what an extraordinary time to be having these conversations!

Dentistry is changing before our eyes. Artificial intelligence is entering our clinics, digital technologies are transforming treatment, and the possibilities for our profession continue to expand. Yet alongside this progress are questions we cannot ignore. How do we bring quality oral healthcare closer to underserved communities? How do we prepare the next generation for a rapidly evolving profession? And how do we ensure innovation improves lives beyond the walls of well-equipped clinics?

This edition of The Odontologue embraces these conversations while celebrating the people behind the profession. We explore the lessons that shape us, the unexpected directions our careers can take, the courage to embrace change and the generosity of those who serve communities where dental care remains out of reach. There is room for reflection, inspiration and a little humour too. After all, dentistry has never been short of remarkable stories!

Perhaps that is what makes this congress particularly meaningful. The future of African dentistry will not be shaped by technology or clinical excellence alone. It will be shaped by people willing to share knowledge, mentor others and collaborate across borders.

To our visitors from across Africa and beyond, karibuni Kenya, karibuni Mombasa! May you find inspiration in the discussions, warmth in our hospitality and friendships that last long after the congress ends.

As you turn these pages, we invite you to be curious, reflect and see our profession through a fresh lens.

Enjoy the congress, and enjoy this edition of The Odontologue!

Message from the President



Dr. Kahura Mundia
KDA President

Advancing Dentistry in Africa, Together

It is my great pleasure to welcome colleagues, delegates, partners and friends from across Africa and beyond to Mombasa for the FDI Regional Congress and the 43rd Kenya Dental Association Annual Scientific Conference and Exhibition.

This is a proud moment for the Kenya Dental Association and for our profession. Under the theme "Advancing Dentistry in Africa," we gather not simply to share scientific knowledge, but to strengthen the relationships, ideas and commitments that will shape oral healthcare across our continent. To everyone visiting Kenya, karibuni sana. We are delighted to host you.

Africa's dental profession stands at an important crossroads. Advances in digital dentistry, artificial intelligence, clinical techniques and research are opening remarkable possibilities. Yet the benefits of progress remain uneven. Too many families still face long journeys to find a dentist, while many communities continue to live with preventable oral disease. Our responsibility is to ensure that innovation and access move forward together.

That responsibility calls for leadership beyond the dental chair. It requires stronger advocacy, investment in our workforce, meaningful partnerships with governments and institutions, and a commitment to mentoring the next generation. As an Association, KDA remains dedicated to championing professional excellence, protecting patients and amplifying the voice of dentistry in national health conversations.

This congress gives us an invaluable opportunity to learn from one another. The challenges facing our countries may differ in scale and circumstance, but the solutions will be stronger when we develop them together. I encourage every delegate to engage fully, ask difficult questions, share practical experiences and build connections that continue well beyond these three days.

This edition of The Odontologue reflects that same spirit of curiosity and collaboration. It celebrates the people, discoveries, challenges and occasionally unexpected stories that make our profession so dynamic.

My sincere appreciation goes to our speakers, exhibitors, sponsors, organising teams and every colleague whose contribution has made this gathering possible.

May Mombasa offer you stimulating discussions, lasting friendships and a memorable taste of Kenyan hospitality. Let us leave not only inspired by what dentistry can become, but determined to help make it happen.

Welcome, and enjoy the congress.



Karibu Mombasa

On behalf of the Kenya Dental Association Coast Branch, I warmly welcome all delegates to beautiful Mombasa for the FDI Regional Congress and 43rd KDA Annual Scientific Conference & Exhibition.

We're delighted to host you in our coastal city, where science meets sunshine and every session brings opportunities to learn, connect and inspire. May your stay be enriching, memorable and filled with meaningful connections.

Karibu Mombasa, where dentistry meets paradise.

Dr. Rajeev Singh

Secretary - KDA Coast branch

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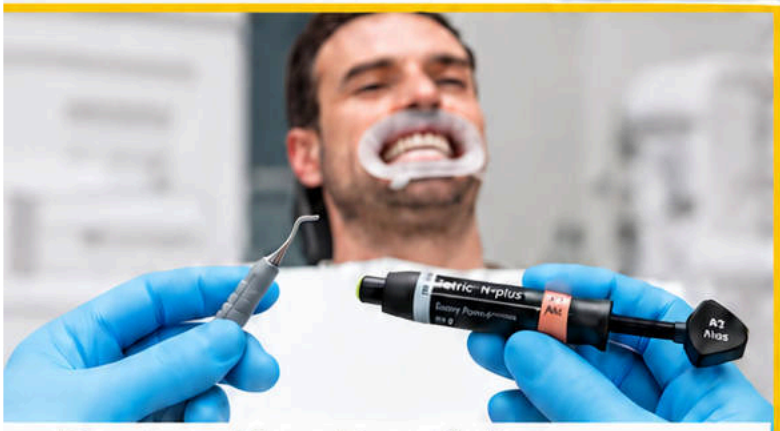
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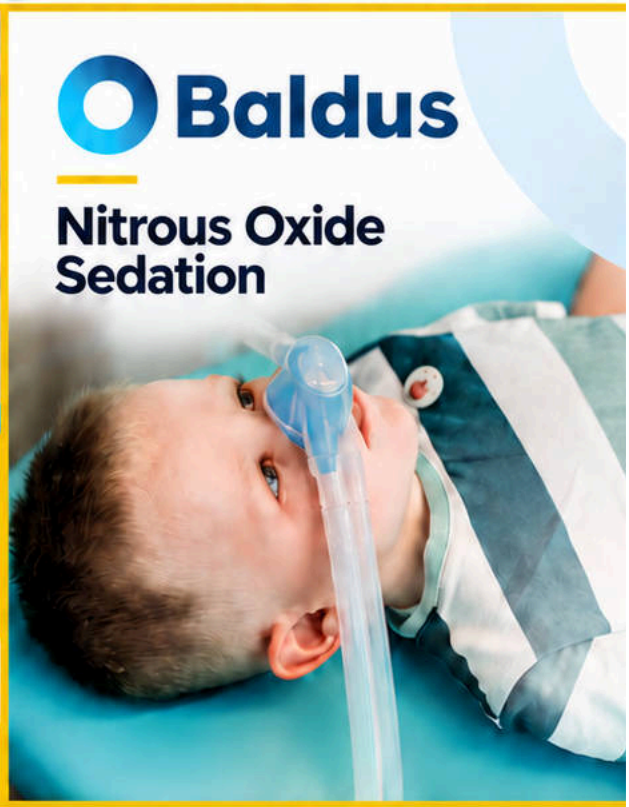
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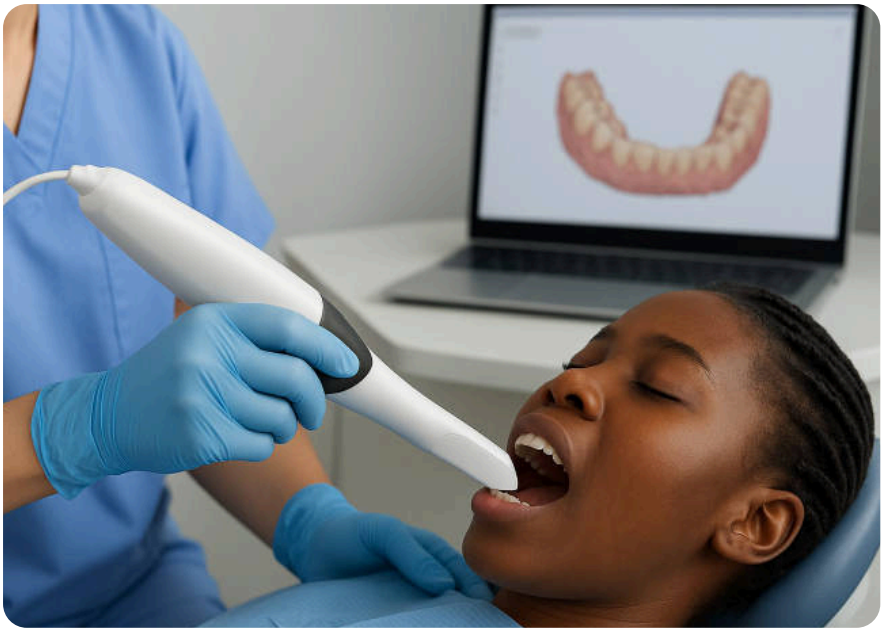
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Kenya's Digital Dental Transformation: The Rise of Intraoral Scanning and Global Lab Connectivity

By Marcus Claesen



In the last decade, dentistry has undergone a remarkable digital transformation. Advances that once seemed futuristic—3D imaging, artificial intelligence, and fully digital workflows—are now part of daily practice in many clinics. One of the most impactful developments within this evolution has been the widespread adoption of intraoral scanners.

Today, digital scanning is not just a modern alternative to conventional impressions; it is a technology that is fundamentally reshaping how dentists collaborate with laboratories, both locally and globally. With an intraoral scanner, a clinic is no longer restricted by geography. The digital file captured chairside can be transmitted instantly to any dental laboratory in the world, opening new opportunities for quality, efficiency, and patient satisfaction.

From Physical to Digital: A Shift in Clinical Workflow

Traditional impressions, while effective, have several limitations. They require physical materials, tray selection, patient tolerance, and careful packing for shipment. Every step introduces potential variables and a risk of distortion.

Digital scanning removes many of these challenges. Instead of polyvinyl siloxane or alginate, the scanner captures a high-resolution 3D model and produces an STL, PLY, or OBJ file that can be sent directly to a lab within minutes. The result is a cleaner, faster, and more predictable workflow.

For clinics, this translates to:

- Higher accuracy and fewer remakes
- Improved patient comfort
- Immediate visualization of preparations and margins
- Instant communication with the laboratory

Digital scans have become a universal language that both clinicians and technicians can interpret with clarity.

> ***"Africa is no longer catching up to the world; it is participating in shaping the next phase of digital innovation in dentistry."***

The World Has Become the Dental Laboratory Next Door

What makes digital scanning truly transformative is the freedom it gives clinicians. A dentist in Nairobi, Mombasa, Eldoret, or Kisumu can scan a patient today and collaborate with a laboratory located thousands of kilometres away—sometimes receiving the completed restorations faster than a traditional impression sent to a lab only a few blocks away.

This shift has been made possible through several global developments:

1. High-Speed File Transfer
Platforms like cloud-based portals, secure file-sharing systems, and scanner-integrated transfer software allow clinicians to send large datasets within seconds.

2. Advanced CAD/CAM Capabilities
Laboratories worldwide now operate with digital design software and high-precision milling and printing equipment. Once a scan is received, technicians can begin working immediately—often on the same day.

3. Modern Logistics
International courier services have become extremely efficient, enabling

clinics to receive restorations quickly and reliably. In practice, it feels as though the lab is "around the corner," even if it is located in another country.

4. Cross-Border Collaboration Norms
Digital dentistry has encouraged global mentorship, peer-to-peer consultations, and shared expertise. A dentist can consult with a specialist or technician overseas in real time, using digital models visible to everyone.

Benefits for Clinics and Patients

Access to Specialized Expertise
Clinics are no longer limited to their immediate geographical area. They can now choose laboratories that specialise in advanced cosmetic work, implant planning, clear aligners, or complex full-mouth rehabilitations—wherever they are in the world.
For the patient, this means:

- More predictable results
- Higher aesthetic standards
- Evidence-based digital planning
- Better long-term outcomes

Consistency and Quality Control
Digital workflows allow labs and clinicians to review preparations, occlusion, margin clarity, and reduction amounts in real time. If an adjustment is needed, the clinician can make it during the appointment, reducing delays and improving the quality of the final restoration.

Reduced Turnaround Times
A digital scan can reach a lab within minutes. Combined with fast international logistics, restoring a tooth from a distant laboratory can now be faster than the traditional process of impression-pickup, model pouring, and manual workflow at a local lab.

Enhanced Patient Experience

Patients increasingly expect modern technology in clinical settings. Digital impressions improve comfort, reduce chair time, and allow the dentist to visually explain treatment using 3D images. It enhances trust and strengthens the clinician-patient relationship.

The Future of Digital Workflows in Africa

As more clinics in Kenya and across East Africa adopt intraoral scanners, the region is becoming part of the global digital dentistry ecosystem. Young clinicians, in particular, are embracing the technology, using it for restorative work, aligners, prosthodontics, and implant cases.

The next steps are already emerging:

- Chairside 3D printing
- AI-supported treatment planning
- Remote digital consultations
- Fully virtual smile-design workflows
- Cross-border laboratory networks

Africa is no longer catching up to the world; it is participating in shaping the next phase of digital innovation in dentistry.

Conclusion

Digital scanning has removed the traditional borders that once defined how dentists and laboratories collaborated. With an intraoral scanner, a clinic gains access to the entire world's expertise. Files travel instantly, logistics are faster than ever, and communication is seamless.

In today's digital era, the distance between a clinic and a laboratory is measured not in kilometres, but in seconds. And with global digital workflows becoming the norm, it truly feels as though the dental lab—no matter where it is located—is just around the corner.



Protecting Dentistry in Kenya: Why Regulation Must Keep Pace with a Changing Profession

By Dr Tonnie K. Mulli



Dentistry in Kenya is at a defining moment. The profession has made important regulatory gains, but it is also facing new pressures from changing training models, unclear oral health cadres, quackery, insurance interference, digital dentistry and increasing public demand for care.Oral health is not a minor health issue. Dental caries, periodontal disease, oral infections, dental fluorosis, oral cancer and trauma affect how people eat, speak, smile, learn, work and live.

Globally, the World Health Organization and the LancetOral Health Series have described oral diseases as among the most common non-communicable diseases, affecting billions of people and remaining neglected in many health systems. In Kenya, the Kenya National Oral Health Policy 2022–2030 and the Kenya National Oral Health Strategic Plan 2022–2026 identify dental caries, periodontal disease, fluorosis, oral cancer, oral infections and trauma as priority public health concerns.

This is why dental regulation matters. It is not simply about protecting professional titles. It is about protecting patients, ensuring quality, guiding training, defining professional boundaries and safeguarding the future of oral healthcare.

> ***"Dental regulation is not simply about protecting professional titles, it is about protecting patients***

Regulatory wins worth celebrating

Kenya has made real progress. Dentistry is recognised under the Medical Practitioners and Dentists Act, Cap. 253, and regulated through the Kenya Medical Practitioners and Dentists Council. This gives the profession a legal foundation for registration, licensing, discipline and public protection.

Another major achievement is the development of a formal scope of practice for general, specialist and subspecialist dental practitioners. This is a landmark step. A clear scope of practice defines what dentists and specialists are trained and authorised to do. It also protects patients from unsafe treatment by persons who lack the required training, competence or registration.

The Kenya National Oral Health Policy 2022–2030 is also a major win. It places oral health within universal health coverage, primary healthcare and national health planning. This creates an opportunity for oral health to be integrated into school health, non-communicable disease prevention, cancer screening, elderly care and essential health benefit packages.

Mandatory continuing professional development is another important regulatory tool. CPD helps dentists remain current in clinical knowledge, technology, ethics, infection control, radiology, digital dentistry and patient care.

The Kenya Dental Association also remains central to professional advocacy. KDA provides a collective professional voice, supports continuing education, engages regulators and helps defend standards in the interest of both dentists and the public.

The education regulation gap

One of the greatest challenges facing the profession is the disconnect between academic programme approval

and professional recognition. Health professional education cannot be treated like ordinary academic training. A dental or oral health-related programme should not be developed, advertised or implemented without clear concurrence from the relevant professional regulator.

When this does not happen, students may graduate with qualifications that do not lead to lawful registration or a recognised scope of practice. Employers may misunderstand the competence of graduates. Patients may then be exposed to providers whose training and legal authority are unclear.

For dental and oral healthcare programmes, the correct sequence should be:



Clarifying oral health cadres

Kenya needs clarity on oral health cadres. Community Oral Health Officers have an important role in prevention, oral health promotion, screening, basic community-level interventions and referral. Their role is especially valuable in school oral health, fluorosis awareness, oral hygiene education and community prevention.

However, the broad term "oral health" can become problematic when used as a professional title without a clear legal identity. Oral health refers to the whole field. It does not automatically define a specific cadre, qualification, scope of practice or registration category.

Kenya needs a national oral health workforce framework that clearly defines dentists, dental specialists, community oral health officers, dental technologists, dental assistants and any other recognised oral health personnel. Each cadre must have a defined qualification, scope, supervision requirement, registration pathway and accountability mechanism.

This is not about exclusion. It is about patient safety, fairness to students, clarity for employers and protection of the public.

Quackery remains a serious threat

Dental procedures are invasive and technical. They involve diagnosis, radiography, local anaesthesia, extractions, periodontal care, orthodontic movement, prosthetic rehabilitation, infection control, prescribing and management of medically compromised patients.

When such procedures are performed by unqualified or unregistered persons, patients are exposed to serious harm. Quackery must therefore be treated as a patient safety threat.

Regulation must be visible. Illegal clinics should be identified and closed. Misleading advertisements should be acted upon. The public should be able to verify licensed practitioners and report unsafe practice easily. KMPDC, county governments, the Ministry of Health and professional associations must work together to strengthen enforcement.

Access must not mean lowering standards

Kenya has real oral health access challenges, especially in underserved counties. More preventive and essential oral healthcare services are needed. However, workforce shortages should not be used to justify unsafe substitution or unclear cadres.

The answer is not to lower standards. The answer is to train the right cadres, define their roles properly,

deploy them equitably, strengthen referral systems and invest in public oral health services.

Community oral health cadres should be empowered to provide prevention and basic care within defined limits. Dentists and specialists should be supported to provide diagnosis, definitive treatment, surgery, complex rehabilitation and specialist care.

Insurance and clinical autonomy

Dental insurance can improve af
fordability, but it should not undermine clinical judgement. Dentists increasingly face delayed approvals, unrealistic reimbursement limits, excessive documentation requests and denial of clinically indicated treatment.

The profession must advocate for fair and ethical relationships with insurers. Treatment decisions should be based on diagnosis, evidence, patient need and informed consent, not administrative convenience.

Digital dentistry: the next frontier

Digital dentistry is rapidly changing practice in Kenya. CBCT imaging, intraoral scanning, 3D printing, guided implant surgery, digital orthodontics, teledentistry, artificial intelligence and social media marketing are now part of modern dentistry.

These tools offer enormous benefits, but they also raise new regulatory questions. Kenya needs guidance on digital consent, data protection, radiographic justification, ownership of digital files, AI-assisted diagnosis, remote treatment planning, patient photography, testimonials and advertising claims.

Technology should improve care, not weaken accountability.

What the profession must now do
KDA and the wider dental profession must remain actively engaged in regulation. Key priorities include:

- Mandatory professional regulator concurrence before approval of dental and oral health-related programmes;
- A national oral health workforce framework defining all cadres and scopes of practice;
- Stronger enforcement against illegal dental practice;
- Clearer regulation of insurance-provider relationships;
- Inclusion of essential oral healthcare in universal health coverage;
- Updated guidance on digital dentistry, teledentistry, artificial intelligence and advertising;
- Public awareness on how to identify qualified dental practitioners.

Conclusion

Dentistry in Kenya has made important regulatory progress. We have statutory recognition, national oral health policy, CPD requirements, professional advocacy and a formal scope of practice. These achievements should be celebrated.

But the work is not complete. The profession must confront fragmented education approval, unclear cadres, quackery, weak enforcement, insurance pressure, workforce maldistribution and digital disruption.

At the centre of all these issues is one principle: public protection. Every patient in Kenya deserves care from a provider who is properly trained, lawfully registered, ethically accountable and practising within a clearly defined scope. Protecting that principle is the responsibility of every dentist, educator, regulator and member of KDA.

The future of dentistry in Kenya will depend on how firmly we protect standards today.

Key message

Dental regulation is not professional protectionism. It is patient protection.

Seven priorities for action

1. Align dental education approval with professional regulation.
2. Define all oral health cadres clearly.
3. Enforce scope of practice.
4. Act firmly against quackery.
5. Include essential oral healthcare in UHC.
6. Protect clinical autonomy from insurance interference.
7. Regulate digital dentistry and advertising.



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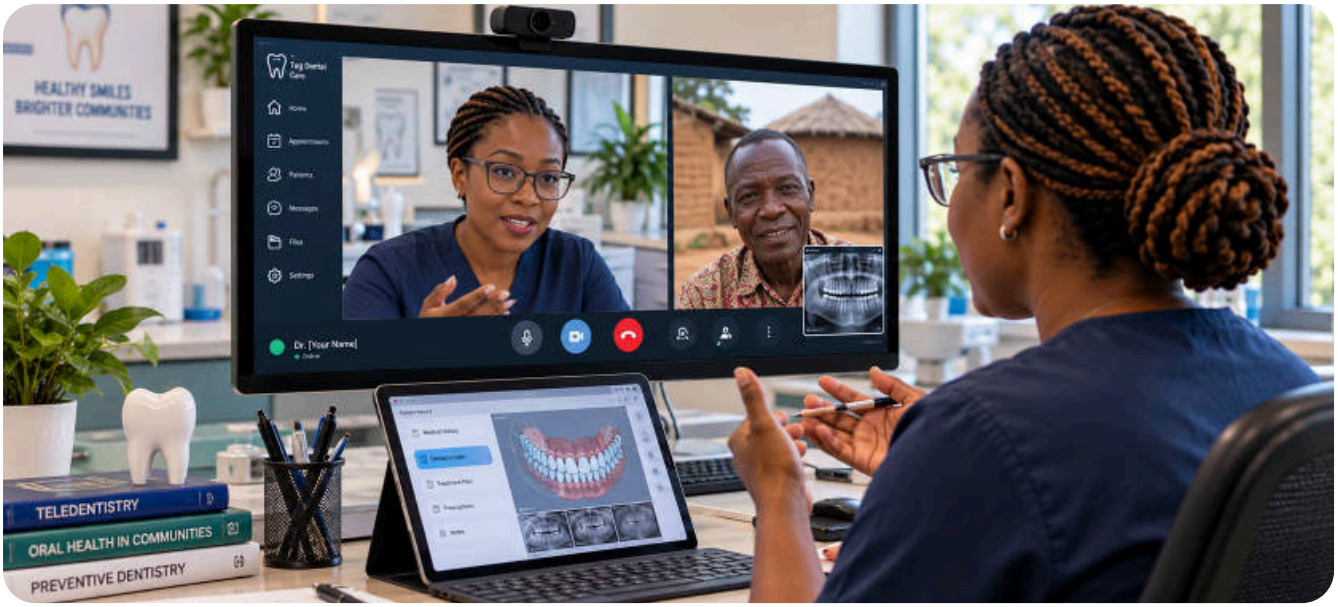
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Teledentistry in Kenya: An Untapped Opportunity to Bridge the Oral Health Gap

By Dr Lang'at Chepkurui



When many people hear the word teledentistry, the first reaction is often scepticism. How can dentistry happen online? It is a fair question. Dentistry is deeply hands-on. We restore teeth, manage pain, examine soft tissues, and perform procedures that require physical presence. A mobile phone cannot remove calculus, place a filling, or perform a root canal. But perhaps we are asking the wrong question. Teledentistry is not about replacing the dental chair. It is about improving access to it and in Kenya, that could contribute to preventive care enormously.

Oral disease remains one of the most widespread yet undertreated health conditions globally. In Kenya, the distribution of dental professionals is heavily skewed toward urban centres. Many counties have few or no registered dental practitioners within reach of the populations that need them most. For patients in rural and peri-urban areas, seeing a dentist often means travelling long distances, taking time off work, and bearing costs that extend well beyond the consultation itself hence people delay. They seek help only when pain becomes unbearable, and by then, what could have been a simple intervention has often become something far more complex, costly, and difficult to reverse. This is the gap teledentistry can begin to address; by creating earlier, more accessible entry points into it.

> ***The future of dentistry will still happen in the clinic. Increasingly, it may begin long before the patient ever arrives.***

At its core, teledentistry refers to the use of digital communication technologies to extend or support oral healthcare delivery. This includes virtual consultations, patient triaging, remote follow-ups, referrals, and oral health education. It does not require elaborate infrastructure. In many cases, a smartphone, a stable internet connection, and a willing practitioner are enough to begin.

In rural and underserved communities, a patient who notices unusual gum swelling but is uncertain whether it requires urgent attention is left, without a nearby clinic, to wait and worry. With a teledentistry pathway, even a basic asynchronous photo-based review, a dental professional could assess the situation remotely, advise on urgency, and direct the patient appropriately. Early triage prevents late presentations. In school settings, routine oral health screenings are often absent or inconsistently conducted. Teledentistry can support school-based oral health programmes by enabling dental professionals to review screening photographs captured by trained teachers or health aides, identify at-risk children, and prioritise referrals for in-person care. Given that dental caries remains highly prevalent among school-age children in Kenya, earlier identification means earlier intervention.

Perhaps, the most underappreciated channel is the community health worker. Kenya already has an established cadre of frontline health workers embedded in communities across the country. With basic training and simple digital tools, CHWs can be equipped to capture oral health data, photograph suspicious lesions, document symptoms, and transmit information to dental

professionals for remote review. This extends the reach of oral healthcare far beyond what clinic-based systems alone can achieve, embedding early oral health awareness into the community structures that already exist.

Kenya is not starting from zero. The country has seen significant growth in mobile phone penetration, digital health adoption, and telemedicine infrastructure in recent years. M-Pesa has demonstrated that complex transactions can be conducted reliably via mobile phones even in areas without formal financial infrastructure. Platforms like Africa's Talking support SMS and messaging-based communication at scale. Mobile internet access, while still uneven, continues to expand. The conversations that accelerated during the COVID-19 pandemic about remote healthcare delivery, digital health records, and decentralised care are still ongoing.

Oral health has, however, remained largely unseen from this digital health transformation. The infrastructure for teledentistry in Kenya already exists in nascent form. What is needed is the deliberate integration of oral health into this ecosystem platforms, protocols, and practitioners willing to work within a hybrid model of care that meets patients where they are, not only where clinics are located.

The most underappreciated potential of teledentistry lies not in reactive triage but in proactive prevention. The greatest challenge in oral healthcare is that most people only engage with the system when pain begins. At that point, disease is often advanced, treatment more invasive, and the costs, both financial and personal already significant. Digital engagement opens a different pathway. Oral health education on hygiene practices, dietary habits, early warning signs, and the importance of regular dental reviews can reach patients who would never otherwise encounter this information. Short videos, community messaging campaigns, and CHW-mediated conversations backed by professional guidance are tools that can begin to shift how communities relate to their oral health before disease takes hold.

While acknowledging that optimism alone is not a clinical strategy, teledentistry in Kenya would face real and legitimate challenges. Internet connectivity remains inconsistent across much of the country. Digital literacy varies widely among both patients and practitioners. Questions of patient privacy, informed consent, data protection, and professional accountability require careful regulatory attention, as per the clear frameworks governing what telehealth can and cannot replace.

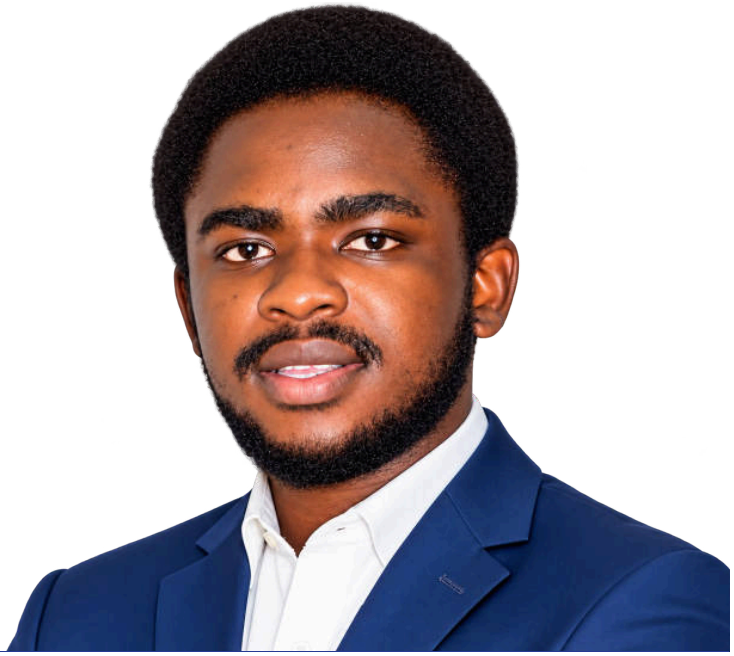
Clinical limitations are equally real. A photograph, however well-captured, cannot substitute for direct examination. Tactile assessment, intraoral examination under proper lighting, and the clinical judgement formed through physical presence remain irreplaceable for accurate diagnosis and treatment planning. No virtual platform can substitute for investment in dental workforce expansion, physical infrastructure, or the systemic reform needed to make oral healthcare genuinely affordable and accessible at scale. These are not reasons to dismiss teledentistry but are reasons to approach it honestly, as a complement to care rather than a replacement for it.

The case for teledentistry in Kenya is ultimately a case for a more connected system of care one where digital tools extend the reach of human expertise rather than attempt to replace it. In-person dental visits remain essential, and they always will be. The question is not whether teledentistry should replace the clinic, but whether it can help more people arrive at the clinic sooner, better informed, and at a point where care can still make a meaningful difference.

For the parent in a remote community uncertain about their child's oral health. For the school with no dental professional on staff. For the community health worker equipped with a smartphone and a willingness to help. For the patient who has been postponing care for months because access felt impossible. Teledentistry will not solve Kenya's oral health challenge. But it may help us begin solving it earlier.



Solving The Kenyan Dental Crisis With Artificial Intelligence



By Dr Arunga Elton

Kenya has less than 2000 actively practicing registered dentists with data from recent years indicate that approximately 75% hold active licenses. Against a population now surpassing 55 million, this translates to a dentist-to-population ratio of roughly 0.27 per 10,000 people, a fraction of the WHO-recommended standard of 1 per 7,000. This creates a genuine crisis of a rising burden of unattended oral health diseases.

Kenya's first National Oral Health Survey, conducted in 2015, revealed that 46.3% of sampled children aged five years and 34.3% of the adult population had dental caries, additionally 98.1% had gingival diseases. Access to care remains critically low, with only a small portion of the population seeking dental treatment especially due to pain or discomfort. More recent WHO data published in 2023 paints an even grimmer picture: the African region recorded an 87.2% increase in primary tooth caries among children aged one to nine years, the largest increase across all WHO regions, with Kenya ranking second highest on the continent at 44.9%.

The geography of this crisis is not uniform. Nairobi County, with full urbanization and a population density exceeding 4,000 people per square kilometer, holds 43% of the entire dental workforce, with a dentist-to-population ratio of 1:9,018. Meanwhile, counties such as Wajir have limited dental facilities. For the majority of Kenyans living outside major urban centers, a dental appointment is almost an impossibility.

"AI can dramatically extend what each clinician can do per patient contact, per day, and across geographic distances."

The Kenya Dental Association's 2026-2030 Strategic Plan confronts this reality with clarity and ambition. The plan commits KDA to a fundamental transformation, from a traditional learned society into a modern, professionally governed, financially self-sustaining national institution that is indispensable to every dentist and authoritative in every conversation about oral health in Kenya. Among the challenges it explicitly names are quackery, cadre overreach, insurer encroachment, and the urgent need to seize the opportunities presented by Universal Health Coverage and rising public demand for oral healthcare. Technology, and specifically artificial intelligence, is perhaps the most consequential of those opportunities.

What AI Offers Dentistry

Artificial intelligence is already demonstrating clinical value across multiple domains. AI as a diagnostic aid can help standardize dental caries and lesion detection, support periodontal screening, and triage radiographic findings, particularly in high-volume or resource-limited settings, improving efficiency and reducing inter-operator variability. A systematic review of AI applications in dentistry confirmed that most if not all dental disciplines have adopted AI, with the majority of applications focused on diagnosis from radiographic or optical images.

For Kenya, where the diagnostic burden on individual clinicians versus the population is enormous and specialist access is severely constrained, these capabilities are potential solutions to structural problems. The specialist workforce is particularly scarce, for example there are less than 50 paediatric dentists among the specialists registered by the Kenya Medical Practitioners and Dentists Council as of 2024.

AI-assisted diagnosis is undoubtedly the most important utilization. For instance, radiograph interpretation could enable a community oral health officer working in a rural dispensary to screen for periapical pathology, carious lesions, and early-stage bone loss with a level of accuracy previously requiring specialist review. With this capability, timely referrals and early case management benefit patients at a large scale.



Large language models can support clinical decision-making, help triage patients, generate patient education in local languages, and flag high-risk presentations for urgent referral. In a system where oral health services are available in only 9% of Level 2 and 19% of Level 3 facilities, extending the diagnostic reach of available clinicians is essential.

AI as a Force Multiplier for the Workforce

The most compelling argument for AI integration in Kenyan oral healthcare system is the force-multiplier effect. AI can dramatically extend what each clinician can do per patient contact, per day, and across geographic distances.

Teledentistry, augmented by AI triage, can connect patients in underserved counties to dental officers in urban centers for preliminary assessment and treatment planning. AI-powered smartphone tools, requiring only a camera and an internet connection, can support school-based oral health screening programmes at scale, identifying children at highest risk and channeling limited clinical resources toward those who need them most.

The WHO has recently endorsed an oral health training resource for community health workers in Kenya, recognizing that empowering community health workers to provide preventive care, catch problems early, and make timely referrals eases the burden on an already overstretched system. AI can be the backbone that makes such community-based platforms clinically credible and scalable.

In clinical practice, AI-assisted treatment planning can support more consistent, evidence-based decision-making among general practitioners managing complex cases without specialist back-up.

Alignment with National Policy

The integration of AI into oral health service delivery aligns directly with Kenya's existing policies. The Kenya National Oral Health Policy 2022-2030 and the accompanying Strategic Plan 2022-2026 both prioritize equitable access, Non Communicable Diseases integration, and evidence-based service delivery. The Strategic Plan calls for adequate and appropriate oral health information systems, technologies, and use of evidence in decision-making, as well as community engagement for oral health promotion and disease prevention. AI tools fit squarely within this framework.

Universal Health Coverage, Kenya's defining health policy goal, cannot be achieved while oral health remains structurally excluded from primary care. Kenya has substantial challenges regarding insufficient integration of oral health into primary health care and NCD services, inadequate financing, and maldistribution of the oral health workforce that create rural-urban disparities.

AI, deployed thoughtfully and trained on data that reflects African patient populations, oral health presentations, and local disease patterns, can help bridge these gaps without waiting for the decades it would take to train sufficient numbers of additional clinicians.

The Responsibility of the Profession

Harnessing AI is not a task for technologists alone, but also dentists who must lead this transition. Otherwise they risk having it shaped entirely by actors with no clinical grounding. The profession needs to define the ethical boundaries of AI in oral healthcare, establish what constitutes safe and effective AI-assisted practice, and ensure that patient safety and clinical judgement remain central.

KDA's commitment to positioning itself as the undisputed voice of dentistry in policy, regulation, and public awareness must extend to emerging technologies. This means advocating for AI to be incorporated into continuing professional development curricula; engaging KMPDC to develop regulatory guidance on AI-assisted diagnostics; partnering with dental schools to ensure that graduating dentists understand both the capabilities and the limitations of these tools; and it means insisting that AI systems used in Kenya are trained, validated, and audited using data that reflects the Kenyan population, not extrapolated from datasets drawn entirely from foreign countries.

The oral health crisis in Kenya is real, urgent, and deepening. The tools to begin addressing it at scale now exist. What is required is the professional will to embrace them intelligently, critically, and in service of every Kenyan who deserves a healthier smile.

The author is a dental surgeon with interests in digital health and AI applications in oral healthcare.

Fund Kenya's Public Oral Healthcare Through SHA

By Dr. Jonathan Kiprop (Surgeowriter)



Reproduction and nutrition are the two biggest drivers of evolution. You need to be there and have a means of energy to fuel your metabolic processes. Your mouth ensures proper nutrition and serves as the gateway to your body. Our mouths matter. The ability to feed without difficulty matters as much as the food itself. Good nutrition is our means to the future and optimised evolution.

However, your body system must be protected from the bugs in your mouth, which are accumulated from exogenous sources. Those microorganisms are deadly and work synergistically to break through your defences, turning your head and neck muscles into a malodorous, slurry black paste. In some cases, it just chokes you out of your breath when your neck is expanding dangerously in a condition called Ludwig's angina. You literally bask on the brink of death, experiencing intense anxiety and palpitations. You cannot swallow anything, even your own saliva, for days. You are dehydrated, sweating, hungry, cannot lie down and do not have the energy to stand. That is worse than misery. It will strip you of your dignity and comfort. It will rob you of your hope and end your life and dreams without warning.

> ***"Please fund the Kenyan public oral healthcare with taxpayers' money. Kenyans own both their teeth and the money."***

I have seen how demeaned and almost crazy patients with dental pulpitis can be. They come to hospital at 5 am when their tolerance is stretched taut, and their fuse of rationality is totally blown out. When they see anyone with a white coat, they want the tooth extracted. No amount of convincing about saving it works. Ask anyone who has had real dental pain about their experiences and they will run out of adjectives trying to describe the pain felt. Some women say it is worse than labour pains of childbirth. I don't think they were trying to be poetic; rather, they were trying to characterise the pain's demeaning nature.

As a maxillofacial surgeon, I struggle to block the gate to death for patients with such serious and advanced maxillofacial

infections. I often feel like the last ditch of hope. However, I feel like a porous goalkeeper because, in this strange football, too many balls are shot at my goal, to the point of being overwhelmed. To clarify the metaphor, each goal scored represents a life lost due to a preventable cause. The team players are working hard, but the controller (financier of public oral health) is absent without apology. He is our strongest player and our fortress, and his absence is as deflating as it is devastating.

Each goal scored represents a life lost due to a preventable cause.

I often leave the theatre with a smell of rottenness that lingers for almost two days despite a purging antiseptic shower. I don't mind because that is my battle, my calling and the hope for my patient. Half of such patients do not get out alive. Those who make it need immense resources, which may include ICU care. They need protracted daily wound management and sometimes many theatre episodes, first to control the disease and second to resurface the wounds and skin lost to it. Sometimes pus enters the chest cavity, and a chest tube is needed to remove it. Imagine a crushing force on your windpipe and a third load restricting your lungs to take in oxygen.

What is concerning is that the deaths from such severe infections are preventable. Almost all of those infections are odontogenic, coming from decayed teeth and periodontitis. By the time such cases get to me, we are almost more inclined to faith and superstition than science. When your doctor tells you about God openly, your bleak fate is almost assured. Such is the anticlimactic experience for the patient, relatives and the doctor. We don't need to overburden God with what we can do through our common sense. Kenyan dentists and oral health care workers have world-class training, which any human resource can dream of, but they lack the simple inclusion of oral health financing platforms, including inclusion in SHA packages.



> ***"Each goal scored represents a life lost due to a preventable cause."***

It is not a rationalization of resources. It is a definite trivialisation of collective human effort. Oral health cannot be shelved for years and years without solid justification. It is simple and lazy exclusion. Sadly, I have witnessed intense lobbying by healthcare across political offices to gain attention. The fragmentation of the body is appalling. Sadly, health cannot be politicized. It can only be understood and acted on. Even a small tax increase for people, with a genuine plan to protect them, is still better than leaving them to known danger.

Please fund the Kenyan public oral healthcare with taxpayers' money. Kenyans own both their teeth and the money. Fortunately, money can help solve their dental problems. Thank you.

About the author

The Surgeowriter is a maxillofacial surgeon writing on oral health and health financing in Kenya.

The views expressed in this article are those of the author.

How Arrow Dental Turned Oral Health Education into a People's Movement

By Dr. Rachael Gichuki Chege



There is a question we perhaps do not ask ourselves often enough as dental professionals:

How far can dentistry travel beyond the dental chair?

For many years, oral health promotion has followed a familiar pattern. We educate the patient sitting in front of us. We visit a school. We hold a dental camp. We distribute toothbrushes and toothpaste. We commemorate World Oral Health Day, share our message and return to our practices.

These interventions matter. But in 2026, as we began planning Arrow Dental Centre's World Oral Health Day campaign, we challenged ourselves to think differently.

What would happen if oral health education did not wait for people to enter dental clinics?

What if we took dentistry into the places where Kenyans already live their everyday lives—to their schools, churches, mosques, workplaces, sports fields, community barazas and social media feeds?

What if a grandmother in a manyatta could become an oral-health advocate? What if a boda boda rider could learn about preventing maxillofacial trauma? What if a person living with a disability received oral-health education designed specifically for them?

Those questions became the foundation of "Smiles Without Borders: Kenya's Largest Community-Driven Oral Health Movement."

What followed was a seven-month journey, from October 2025 to April 2026, spanning 23 counties and bringing together clinical dentistry, prevention, education, culture, music, digital communication, disability inclusion, occupational safety, mentorship, community leadership and advocacy.

Perhaps the greatest lesson from the journey was remarkably simple:

If we want oral health to matter to people, we must first make oral health part of their world.

Taking Dentistry to the People

Our starting point was to rethink the conventional idea of oral-health outreach.

Rather than asking communities to come to us, we went to them.

Schools became classrooms for prevention. Places of worship became platforms for oral-health conversations. Community barazas allowed us to engage elders and local leaders. Sports environments created opportunities to discuss dental trauma and mouthguards. Construction sites and motorcycle riders opened conversations around maxillofacial injury and safety.

Schools became one of the campaign's strongest pillars. Over the campaign period, 301 schools were visited. Children learnt about toothbrushing, diet, prevention and early treatment-seeking through education, FDI worksheets, Mouth Heroes activities, music and dance.

Importantly, children were not viewed merely as recipients of information. They became messengers capable of taking oral-health knowledge back to their families.

When Culture Becomes Part of Prevention

One of the most important lessons of the campaign came from listening.

As healthcare professionals, we are trained to communicate from evidence. But evidence alone does not automatically change behaviour. People understand health through the context of family, language, culture, history, faith and community.

We had conversations about practices that have existed for generations, including infant oral mutilation and the removal of lower anterior teeth in some communities. Rather than approaching these conversations with condemnation, we engaged elders, chiefs, traditional leaders and other trusted community voices.

In Maasai manyattas in Kajiado, engagement with families and elders created opportunities to discuss prevention, maternal oral health, oral-hygiene practices and harmful myths in culturally appropriate ways. Grandmothers and community elders became important voices in reinforcing the messages being shared.

That experience reminded us of something fundamental:

Sometimes the most influential oral-health educator in a community is not the dentist.

It may be the teacher, the chief, the grandmother, the religious leader or the community health promoter. Sometimes our role is to equip trusted voices within communities with accurate information and allow the message to travel through them.

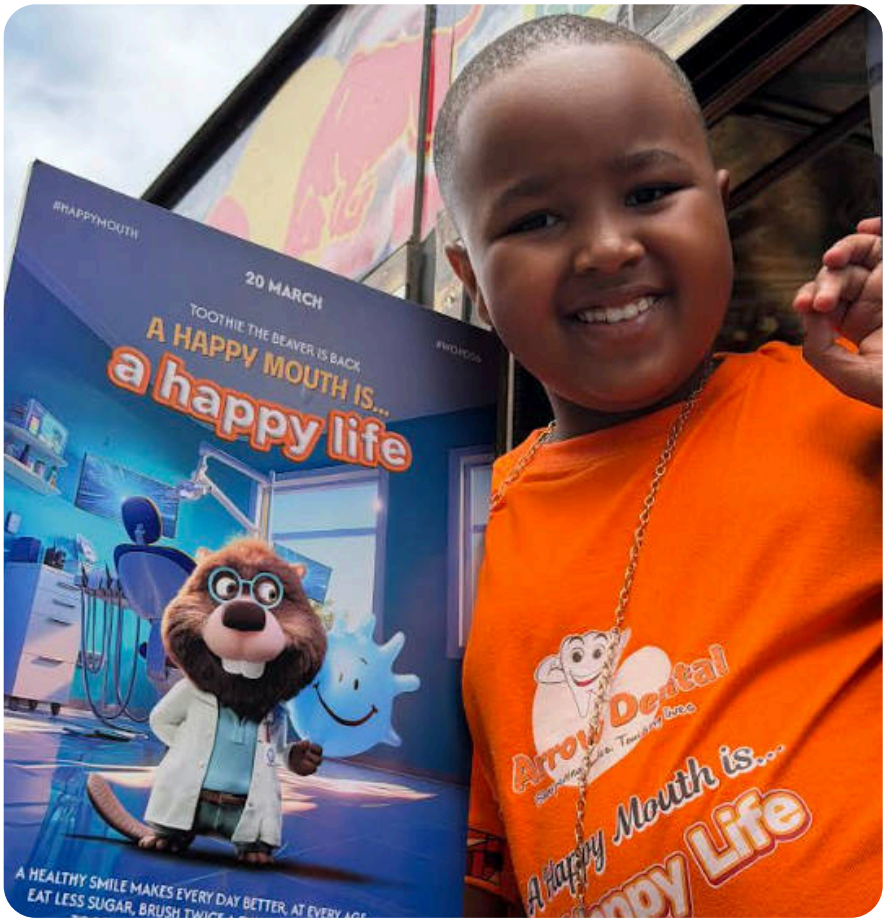
When Kibera Came Together for Oral Health

The scale of what we were attempting became most visible on World Oral Health Day itself.

On 20 March 2026, Kibera hosted the campaign's flagship Mega Dental Camp in collaboration with Kenya Dental Association. More than 550 healthcare personnel and volunteers were mobilised from across Kenya, bringing together the private and public sectors, academia, government institutions and civil society. The event attracted thousands of people.

There was screening and treatment, preventive care and oral-health education. Children learnt through games and storytelling. Older persons received age-responsive care. Persons





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with disabilities accessed adapted services, while students encountered dentistry through career mentorship.

For us, Kibera demonstrated what becomes possible when vision, leadership and partnership come together around a shared purpose.

Arrow Dental Centre led the campaign, but its scale was strengthened by the professionals, institutions, volunteers and communities who came together to support it.

It was partnership in action.

Inclusion Cannot Be an Afterthought

Another principle guided the campaign from the beginning: oral health for everyone must actually mean everyone.

At Thika School for the Blind, oral-health education was adapted using tactile and verbal methods. At Kambui School for the Deaf and Thika School for the Deaf, education was adapted for Deaf learners, including the use of Kenyan Sign Language. Learners with intellectual disabilities were also deliberately included.

Older persons were reached through an initiative titled "Stand By Me When I Am Old and Grey," while street-connected families and persons in correctional facilities were included in other outreach programmes.

These experiences forced us to ask: When we design an oral-health campaign for the "public", who might still be missing?

Equity requires us to ask that question repeatedly.

When Oral Health Found Its Rhythm

Perhaps the most unexpected part of the campaign was music.

We wanted oral-health education to be remembered—not simply heard. So we experimented with something very Kenyan: language, rhythm and dance.

A Kiswahili version of the World Oral Health Day anthem became one of the campaign's most powerful communication tools. The song recorded more than 2.1 million views across Kenya and beyond. A children's version generated more than one million views, while the campaign also produced adaptations in seven vernacular languages.

Children danced to oral-health messages. Families sang them. Communities encountered them online. The message was no longer confined to a dental presentation.

For healthcare professionals, there is an important lesson here. Public-health education does not have to sound clinical to remain scientifically responsible.

Sometimes simplifying a message does not weaken it.

It gives it wings.

The Other Side of Digital Dentistry

When dentists speak about digital dentistry, the conversation understandably turns to digital radiography, intraoral scanners, CAD/CAM, guided surgery and artificial intelligence.

> ***People do not have to come to dentistry before dentistry can come to them.***

But our campaign introduced us to another form of digital dentistry: digital public health.

Facebook, Instagram, YouTube, TikTok and X became extensions of our oral-health education programme, recording more than 31.8 million views across these platforms.

On 23 February 2026, when the Kiswahili anthem was launched, #HappyMouth and #WOHD26 trended nationally on X in Kenya. An AI-powered oral-health chatbot was also developed to respond to common oral-health questions beyond the physical campaign period.

Today, people are behind mobile-phone screens searching for answers about bleeding gums, toothache, children's teeth and oral-health myths. If qualified oral-health professionals are absent from these spaces, misinformation will not be.

Digital communication therefore deserves to be considered not merely a marketing tool, but a legitimate avenue for oral-health education.

Partnership Made the Movement Possible

Although Arrow Dental Centre conceptualised and led the campaign, its scale was strengthened by the many institutions and individuals who participated.

The campaign brought together the Kenya Dental Association, Kenya Defence Forces, Ministry of Health, Nairobi City County, Gem Smiles Foundation, Haleon, the Centre for Oral Health Research and Enterprise, universities and training institutions, schools, teachers, faith leaders, chiefs, community organisations and hundreds of volunteers.

When the objective is sufficiently important, government, private practice, academia, industry, professional associations and communities can occupy the same space and work towards a common outcome.

And oral health is certainly important enough.

From Kenya to the Global Stage

Months later, the journey took us from communities across Kenya to Prague.

The campaign that had begun in schools, manyattas, churches, streets and workplaces received international recognition from FDI World Dental Federation.

Arrow Dental Centre received the FDI World Dental Federation World Oral Health Day Award for Most Engaging Community Campaign, becoming the first private dental facility in Kenya to receive the award.



For our team, that moment represented far more than an institutional achievement.

We remembered the children, teachers, patients, volunteers, healthcare professionals, community leaders, musicians and partners who had carried the message in ways large and small.

What reached the global stage was therefore not simply the work of a dental facility - It was a Kenyan story.

And perhaps that is why the recognition meant so much.

So, Where Do We Go From Here?

The greater legacy of the campaign is what the experience taught us about the future of oral-health promotion in Kenya.

We need to communicate in languages people understand. We need to recognise culture while respectfully challenging harmful practices. We need to design intentionally for people who are too easily left behind. We need to embrace technology not only for better clinical dentistry, but also for better public education.

And above all, we need collaboration across our profession.

Perhaps the greatest lesson from our journey was this:

People do not have to come to dentistry before dentistry can come to them.

We found oral health in classrooms and churches, on football fields and construction sites, in manyattas and community barazas, on television screens and mobile phones.

What began as a World Oral Health Day campaign ultimately became something much bigger—a reminder that oral health belongs to everyone.

And as dental professionals, perhaps our opportunity is no longer simply to ask how many patients we can treat within the walls of our clinics.

We should also ask: How far can our knowledge travel beyond them?

Because when dentistry steps beyond the dental chair, we have the opportunity not only to treat smiles—but to change communities.



Expanding the Possibilities of a Career in Dentistry

Dr. Khadija Aliyan



When I graduated from dental school, my understanding of professional growth was fairly straightforward. I needed to practice, become clinically competent, improve my skills, continue learning and perhaps, eventually, specialize.

For young dentists entering the profession today, that question may be even more relevant. The transition from internship into employment in Kenya is no longer as predictable as it once was. Some young dentists find themselves taking locums or entering private practice while still building confidence and refining their clinical skills. Understandably, the immediate questions become: *Where can I practise? How do I become better clinically? What should I pursue next?*

But perhaps we should also be asking:

What else can my dental knowledge allow me to do? Like many young graduates, I entered practice determined to become very good at what I did. I cared deeply about getting things right, perhaps sometimes too deeply. I could spend far too much time thinking about the inflamed gingiva around a subgingival margin before a restoration, the impression that could have been better, the canal I had not managed to locate until a subsequent visit or the extraction that had taken longer than expected.

> ***"Sometimes frustration is simply frustration. But sometimes it is curiosity that has not yet found an outlet."***

With time, I realized that I loved dentistry, but I did not want to practice it in a way that left me so exhausted that I would eventually stop loving it. I wanted my patients to receive my best—good communication, good treatment and good follow-up.

Interestingly, when I began looking more closely at my working life, I realized that some of the things that bothered me most were not happening inside the patient's mouth.

I worried when a patient waited too long after treatment to be billed. I followed up when insurance pre-authorization delayed care. Laboratory delays bothered me because they prolonged someone's treatment. I wondered why patients who already used the hospital did not know there was a dental clinic within the same facility. I questioned why we could not purchase certain equipment, why departmental revenue and expenditure mattered so much, and why something that made perfect sense clinically could look completely different to hospital management.

Looking back, those frustrations were telling me something. I understood what was happening in my surgery, but I was becoming increasingly curious about everything happening around it.

What problems repeatedly catch our attention? Is it always the dentistry itself, or do we sometimes find ourselves thinking about the systems, behaviours and circumstances surrounding the patient?

When the problem begins before the dental chair

I would occasionally receive pregnant women referred from the maternity clinic for management of dental pain. Some would tell me that they seemed to lose a tooth with every pregnancy. I kept wondering why we had to meet only when there was already pain or disease. Could some of what I knew be useful earlier? What if nurses and other healthcare workers who interacted with women throughout pregnancy had enough oral-health knowledge to address common misconceptions, reinforce preventive care and recognize when dental referral was necessary?

I called one of my former lecturers and asked him at what point I could teach nurses about oral health. He told me that during his internship, he had volunteered to teach oral health to students at KMTC.

I wish I could say that I immediately went ahead and developed the programme I had imagined. I didn't. Between private practice from Monday to Saturday, motherhood and the demands of a young family, I did not have the capacity to actualize every idea I had. What I could do within my immediate environment was organize a hospital CME and use that opportunity to educate fellow healthcare workers on oral health.

Perhaps impact beyond the dental chair does not always begin with changing careers or launching a major programme. Sometimes it begins by asking: Who else could benefit from what I know?

The same thought returned through a completely different experience.

During holidays, I would occasionally receive children who had sustained dental trauma after falls at hotels or those that came through school sports accidents. Sometimes it was a fractured anterior tooth. Sometimes a permanent tooth had been completely avulsed.

I still remember receiving an avulsed tooth several hours after the injury, carefully wrapped in tissue paper.

Someone had tried to help. But those first few minutes mattered.

I found myself wondering what might have been different if the first person at the scene had known what to do. What if teachers, hotel staff, coaches and parents knew the basic immediate management of dental trauma, particularly an avulsed permanent tooth?

Today it is someone else's child. Tomorrow it could be mine, and I may not be the one standing nearby.

Perhaps our impact as dentists is not only in being available to manage the emergency well. It can also be in making useful knowledge available before the emergency ever happens.

> ***What else can you do with what dentistry has taught you?***

What have we been exposed to?

Looking back, I think one of the things that shapes our careers more than we realize is exposure. We naturally imagine possibilities from what we have seen, heard about or watched others do.

If professional growth is presented mainly as clinical practice, further clinical training, specialization and eventually practice ownership, it is understandable that these become the milestones by which we measure progress.

For years, I was frequently asked, *"Have you opened your own clinic?"*

There is nothing wrong with owning a dental practice. Building an excellent practice can create employment, improve access to care and allow a dentist to build something meaningful. But I began to wonder why it sometimes felt like the natural destination—the point at which one had finally "made it" as a dentist.

What if it is one possibility among many?

For me, the questions I had accumulated about patient waiting times, insurance processes, departmental resources and hospital decisions eventually contributed to my decision to study healthcare management. My motivation at the beginning was quite simple: I wanted to understand the language management was speaking.'

Why did something that seemed obvious from my side of the clinical door look completely different from the other side?

Further study did not take me away from dentistry. It gave me another lens through which to understand it.

Years later, after moving towns, KMTC advertised for lecturers and I applied. Teaching had never been part of a carefully mapped career plan, but the possibility that my dental knowledge could be useful in education had entered my thinking years earlier.

That is why exposure matters. We may encounter an idea today and do nothing with it. Life may be busy, the opportunity may not exist yet, or we may not be ready. But once something enters our realm of possibility, we are more likely to recognize it when the opportunity eventually appears.

What else can dental knowledge do?

Perhaps this is the conversation we need to have more often with young dentists.

Not, *"What other profession can you leave dentistry for?"*

But: **What else can you do with what dentistry has taught you?**

A clinical encounter may reveal a question worth researching. The ability to understand health science and communicate it clearly could find expression in medical or scientific writing. Repeated frustrations with care delivery may lead towards quality improvement, management, innovation or health technology. Seeing preventable disease repeatedly may prompt work

at community level. Others may create impact through education, policy, entrepreneurship or opportunities we have not yet imagined.

These possibilities do not have to replace clinical dentistry, and every interest does not need to become another career.

The point is awareness.

We cannot intentionally explore possibilities we do not know exist.

So, to the young dentist developing clinical competence: remain curious. What problem do you repeatedly wish someone would solve? What part of patient care continues to bother you after the patient leaves your chair? What are you naturally reading about, questioning or trying to improve?

Sometimes frustration is simply frustration. But sometimes it is curiosity that has not yet found an outlet.

Those of us further along in the profession have a role too. We can expose younger colleagues not only to accomplished clinicians, but also to dentists creating impact in less obvious spaces—not to draw them away from clinical practice, but to ensure that their environment does not determine the limits of what they believe is possible.

I am still discovering those possibilities myself.

But I now see professional growth differently from how I saw it when I graduated.

There will always be enormous impact to create inside the dental clinic. Our patients deserve clinical excellence. But our knowledge can also improve what happens before a patient reaches the chair, around the care they receive and long after they leave it.

Perhaps expanding the possibilities of a dental career begins by expanding the question we ask ourselves.

Not only:

"What can I do as a dentist?"

But also:

"What can I do because I am a dentist?"



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The Olmalaika Trust Journey of Smiles and Service

By Dr. Enock Rotich



Nestled at the edge of the Maasai Mara in Sekenani, Narok County, Olmalaika Trust is an organisation centred on care, opportunity, community and service. One of its key initiatives is Olmalaika Home, a home and community-based programme that provides a supportive environment for young people while creating opportunities for visitors and volunteers to engage with the local community.

Within Olmalaika Home is the Olmalaika Trust Dental Clinic, established to improve access to oral healthcare for the surrounding community. The clinic also provides a welcoming base for dentists and dental teams from Kenya and beyond who wish to volunteer. Dentists are invited to come with their families, with accommodation provided, allowing volunteering to become an experience that combines professional service, family time, cultural exchange and the opportunity to experience the remarkable Maasai Mara region.

The dental clinic is, however, only one part of the Trust's broader commitment to community service. Extending this spirit beyond Sekenani are the Olmalaika Giving Safaris—mobile dental outreach initiatives that take oral healthcare directly to communities in different parts of Kenya.

"Olmalaika Trust is demonstrating how dentistry can become not just a profession, but a journey of service."

The Giving Safaris aim to bring dental professionals together for three outreach programmes each year. Using portable dental equipment and supplies, volunteer teams establish temporary treatment stations within communities and provide a range of services according to local needs. These have included root canal treatment, fillings, extractions, dental examinations and other essential dental procedures, together with oral health education and preventive advice.

Giving Safaris have taken volunteers beyond the Mara to places including Narok, Samburu, Taita-Taveta and Mombasa. In each location, the objective is the same: to make quality dental care more accessible while creating meaningful connections between dental professionals and the communities they serve.

What makes the Olmalaika model unique is the relationship between these initiatives. Olmalaika Home provides the setting and community foundation; the Dental Clinic provides a more consistent avenue for oral healthcare in Sekenani; and the Giving Safaris extend the Trust's reach to communities beyond the Home. Together, they form a broader vision of service that goes beyond treating individual dental problems.

For visiting dentists, the experience offers a different perspective on dentistry. Working in a community setting—and, during Giving Safaris, with portable equipment—requires adaptability, teamwork and careful planning. It

also provides an opportunity to step away from the routine of conventional practice and reconnect with one of the fundamental reasons many enter healthcare: to serve.

For dentists and their families, Olmalaika offers an unusual opportunity to combine professional service with adventure and family experience. Volunteers can spend time at the Home, provide care at the dental clinic, participate in community outreach and experience the natural and cultural richness of Kenya.

At the heart of the Olmalaika Trust's work is a simple belief: oral health is an essential part of overall health and quality of life. Through the Dental Clinic and Giving Safaris, the Trust seeks not only to provide treatment, but also to promote prevention, oral health education and lasting partnerships with communities.

In a profession often defined by the dental chair, Olmalaika offers a different perspective: sometimes the chair can stay at home, and sometimes it can travel.

Whether a patient walks into the Dental Clinic in Sekenani or a portable dental unit is unpacked hundreds of kilometres away, the purpose remains the same—to reduce suffering, restore function, promote oral health and, most importantly, give people a reason to smile.

From Olmalaika Home to communities across Kenya, the Olmalaika Trust is demonstrating how dentistry can become not just a profession, but a journey of service.

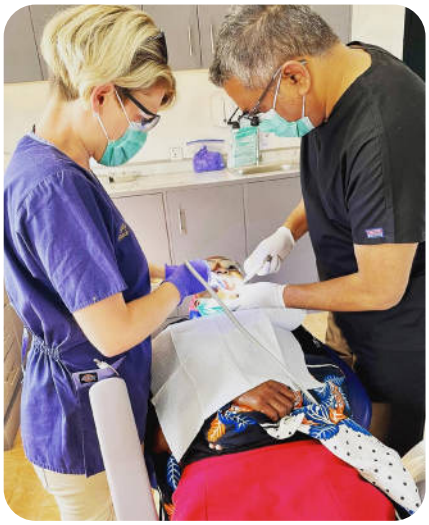
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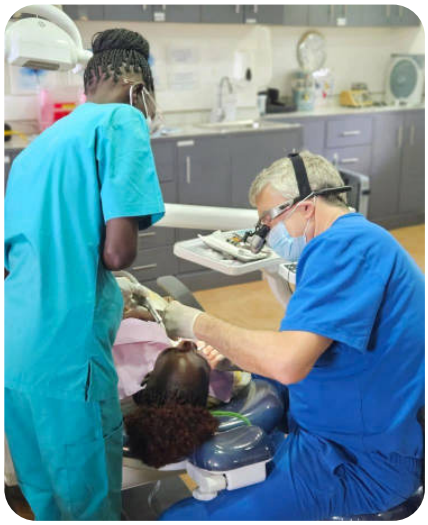
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If Only Robert Hanssen Had Become A Dentist

By Dr. Douglas Oramis



Permit me, the author of this piece to go down that rabbit hole of revisionist history. I love that rabbit hole. A lot of gremlins exist in there. On the 18th of February 2001 Robert Hanssen would have dropped by the Foxstone Park in Virginia for a relaxation session. The day's procedures at the clinic would have drained him. He would have wondered about that RPD took more time than he thought he would. He would have cursed his assistants for not telling him the alginate was unavailable way before he needed it. He would have sat on that park bench and assessed how long he wanted to continue cutting enamel as we call it. Instead he found himself hand-cuffed by the FBI for espionage related offences. He was in fact leaving classified material for his handler in that very park that very day.

Way before that fateful day, Hanssen was to be an up and coming dentist at the Northwestern University's Dental School. He had already gotten a degree in Chemistry from Knox College. He was on his way to satisfying those feisty examiners and getting his DDS. Imagine what a ball he would have had during Biomaterials with his chemistry background. Imagine how much fun he would have had during Metallurgy? Speaking of Metallurgy, when are we taking Dr. Kisumbi et al to the Hague? What was that! We need a gazette one-page apology in the Daily Nation or Standard. I digress. Imagine how he could have contributed to the adhesive dentistry movement together with Buonocore and Bowen. He was on his way to cutting lots and lots of enamel. Instead, he gave up. My theory is he got tired of looking for the elusive phrenic nerve in dissection. But the story has it that when he got into clinical dentistry, he realized it was not for him. Did he happen to have an OT in the clinic?

Unfortunately, for the rest of the world, that decision to quit dentistry came with very significant ramifications and time capsule material. After stints in Northwestern, this time getting an MBA in accounting and Information Systems he went through the Chicago Police Department and on to the steps of the Federal Bureau of Investigations as a Special Agent. He really missed out on looking for curing flasks in final year of dental school. Speaking of which?

Or maybe it is writing of which in this case. Those who stashed extra flasks in their lockers when it was a bear market for flasks should be placed in a special place in hell. I digress. Back to Hanssen. Instead of white-coloured clinics he began working on white-collar crime. Then when he was placed into Soviet counterintelligence work where he took the work a bit too nefariously. Instead of looking for perfect occlusion he got into looking for perfect collusion.

His initiation came in November 1979 when he approached the Soviet Military Intelligence (GRU). Just like that. The way pre-interns are out here approaching clinics for work. They will deny vehemently as they as the assistant to give them a block needle. Of course the soviets welcomed him with red open arms. He swiftly proceeded with the deft of a KAVO high speed to supply classified information concerning U.S intelligence sources and operations. This is around the time he would have been opening his first private clinic and employing his first staff. That day, he would have been thinking of where to put the compressor and wondering what time the clinic inspectors would be coming. Months later, Hanssen's eyes would have been on the tutor explaining hands-on concepts on the phantom head. He would have been fixated. He probably would have been on his way to be an accomplished specialist himself or a superdentist. Superdentists out here pretending they do not exist as they look at their schedule with a denture insertion, followed by a disimpaction, followed by bonding and finally an implant placement. He would have sat by the phantom lab bench trying his hands at the phantom head and loving dentistry. Instead he was busy sending information to the Russians about a secret tunnel the Americans were planning.

The Soviet Union was constructing its new embassy compound on Mount Alto, Wisconsin Avenue NW, Washington. The US intelligence saw a wonderful opportunity. Like an influencer who walks into your clinic and gets enthralled by your services. That kind of wonderful opportunity. The plan was to secretly excavate a tunnel toward or underneath the Soviet compound and use the resulting underground position for electronic surveillance. Millions went down digging, or billions if it was the Kenya Government doing it. Well, Hanssen did that thing.

Interestingly it could have all come tumbling earlier. In spring of 1981 he could have been complaining to his wife about how patient x is a very difficult one who does not pay their bills and is always arriving late. Instead, his wife caught him with suspicious material related to his new-found side-gig and confronted him about it. At first he panicked and was about to confess. Then he realized he could take this game to extra-time at least. He eventually finagled his way out of that jam. What could have been him relocating a difficult patient ended up with him relocating the wife from a suspicious place to a Hakuna Matata suburb. Maybe it was a case of stage fright. Maybe he figured continuous relocation of the wife would be difficult to maintain. Because he proceeded to take a hiatus of 4 years. Back to good ol Bob of the FBI.

How different life would have been had he been like the rest of us, complaining about late labwork drops at the clinic. Instead, he became the master of dead drops. The art of leaving classified material in a nondescript place for the intended recipients to find without meeting them face to face. Come to think of it. How about leaving dead drops inside an amalgamator. How many dentists are looking in there? How about those lab pigeonholes where lab works are placed? They look like textbook places, no?

He could have become a leader. President of an Association or two. Instead he kept getting promoted to even more higher places where he had even higher access to extraordinarily sensitive counterintelligence material. He ended up doing even more damage. From a separated instrument here and there to ill-fitting crowns with high contact spots to now supplying thousands of pages of highly classified documents. He gave up information about soviet officials co-operating with the US. Two of whom were executed by the Soviets. What was the worst he could have done in dentistry? Probably a hypochlorite accident. Patient would have been fine, unnerved by the experience, but still alive to tell the story. He did pocket decent chums. It is estimated to be more than

"So, next time you wonder whether you are in the right career or if someone should do dentistry. Just remember, it could be really really worse."



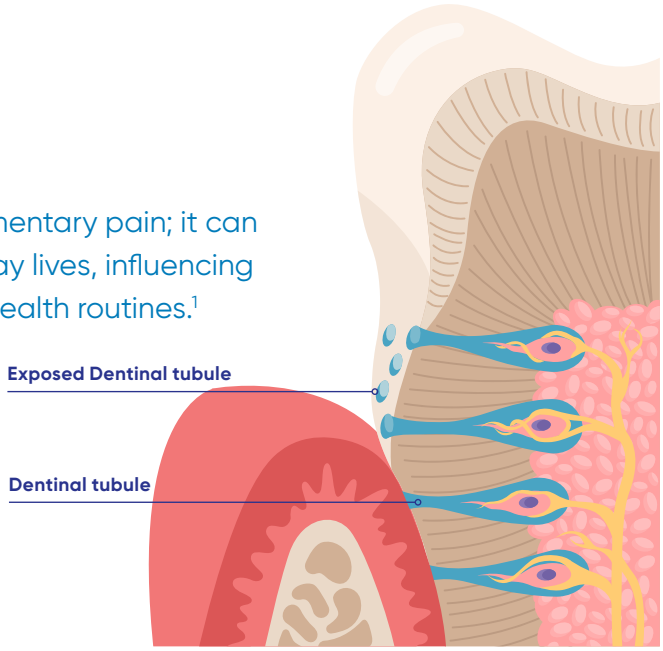
$1.4M in cash and diamonds (not to be confused with diamond coated burs).

On 17th July 2002 he would have been complaining of increasing back pain and how he is not feeling this dentistry anymore. He would be looking at transitioning into a post dentistry life. He would have looked at his contributions to his patients and society and be glad. He would have sat at his porch like Thanos in that digs after vaporizing half the universe in Avengers: Infinity War. Instead, he was getting admitted at ADX Florence Supermax prison in Colorado as prisoner 48551-083 as one of the most dangerous spies in American History. Why am I writing this? So that next time you wonder whether you are in the right career or if someone should do dentistry. Just remember, it could be really really worse. So, choose dentistry. For history's sake.

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1. Grimaldi R, Smith G; The Impact of Dentine Hypersensitivity on Quality of Life: Pooled-Analysis Study; presented at IADR/AADOCR/CADR General Session & Exhibition 2026 (San Diego).
2. Wes*tet al*; Prevalence of dentine hypersensitivity, erosive tooth wear, gingival recession and periodontal health in seven European countries; Journal of Dentistry, 2024, Vol 150, 105364
3. British Society of Periodontology (2026) BSP S3 Dentine Hypersensitivity Clinical Practice Guideline.

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Failing and Learning

By Dr. Nduguyu Kerere



We have all received gifts or presents from our patients after successful treatment. The joy they feel when they are not in pain or after a smile transformation is indescribable. All we can do is grin sheepishly as a warm glow flows through us.

I once received a 'jogoo' from a patient's grandmother. She was elated because her granddaughter could eat 'githeri' and was not complaining of toothache. The only question running through my mind at the time was, 'how will I carry the jogoo home to slaughter it?'

However, do we reflect on our 'failures'? When you frankly have no diagnosis for a particular case and to use a bad cliché, you are fumbling in the dark. As Edwina Kidd said, 'A diagnosis is a mental resting place on the way to a treatment decision'. Without a diagnosis, you do not have a road map for your intended destination that is resolution of the particular dental disease. We try this and that hoping that eventually one of the attempts will be successful and save us the stress of 'guesswork'. Sometimes it works, other times it does not and we want to run away when we see the patient's name on the list for the day.

My own chastening experience includes molar incisor hypomineralisation (MIH) and a 5-year-old girl. I was fresh faced and with that confidence of the naïve. I examined the patient and noted the usual things a child with early childhood caries should have; decayed and missing teeth. Very quickly, I asked them to do radiographs, which her mum obliged immediately. I was well on my way to making a diagnosis and I felt good.

At the next appointment, I decided to extract a grossly carious lower primary molar. Easy work I thought to myself. " Both the child and mum will be happy now that the bad tooth will have been extracted", so I thought. I went through the motions, administereed local anaesthetic with a bit of resistance and then waited to do the extraction. I picked my instruments as I chatted with the patient trying to distract her. The requisite amount of time elapsed and I started the procedure.

Ladies and gentlemen, I want to tell you that the extraction went well, but I can't. All that could go wrong did. Despite adding local anaesthesia and trying all techniques to calm her down, she kept on screaming as I did the extraction. She was eventually physically restrained and the tooth came out. She was at that point inconsolable and angry at all of us in the room who had done that great injustice to her. Was I particularly happy after doing a 'successful extraction?' I had mixed feelings. 'Why was she still in pain after administering sufficient local anaesthesia?' I kept asking myself for the next couple of weeks.

Like a horrible itch that demands to be scratched, the question kept harassing me. Then one day I chanced upon molar incisor hypomineralisation (MIH) and hypomineralised second primary molars (HSPM) and it was a lightbulb moment. Everything made perfect sense. I looked at the clinical pictures I had taken and everything I needed to make the right diagnosis was staring at me.

From the characteristic discolouration of the incisors and permanent molars and the location of caries on atypical surfaces of the molars to the difficulty in achieving anaesthesia, it should have registered immediately that the diagnosis was MIH. Did I feel especially foolish? Very much so. Had I learnt something new? I did but at what cost to the child?

If I had known that achieving anaesthesia was difficult, I would not have persisted to do the extraction. I would have stopped and had a discussion with her mum on enhanced anaesthesia techniques to ensure the child's comfort. I only ended up traumatizing the child.

I have gotten better at diagnosing MIH but the 5-year-old girl's screams will always stay on mind.

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Things Every Young Dentist Should Know Before 30

By Dr. Elikana Akali



Before we begin, I should probably disclose a conflict of interest: conveniently, I am not yet 30. So this isn't one of those articles where someone in their 50s tells you, 'When I was your age…' before explaining how they bought a house for the price of a smocha. I'm still in the trenches, figuring things out and making mistakes while balancing patients, business, leadership, friendships, fitness, family and the occasional existential crisis that arrives mysteriously on a Tuesday afternoon.

I've been fortunate to learn a few things earlier than expected: some from mentors, some from experience, and some from decisions that, in hindsight, deserved a second opinion. From one young dentist to another, here are the lessons I think every dentist should know before 30.

1. Your degree is not a personality.

Congratulations, you are a dentist. You worked incredibly hard for it, but you don't have to make it your entire personality. Have hobbies, interests, opinions and a life that doesn't involve teeth. And when someone asks you for a check-up mid-conversation? Don't. You are off duty.

2. Being a good dentist is only the beginning.

Dental school teaches you to diagnose and treat disease, but not necessarily to manage people, negotiate rent, read a P&L, market yourself, handle difficult patients, resolve conflict, lead a team or fix the printer. Success takes clinical competence, people skills, business sense and emotional intelligence. Occasionally, it also takes knowing how to fix a printer and a dental chair.

3. You will never know everything.

At some point, a patient will ask you something and your brain will go blank. You'll smile and say, 'That's a very good question,' while thinking, 'I have absolutely no idea. Give me 30 seconds.' It's okay not to know; it's not okay to pretend. Say, 'I'm not sure, but I'll find out.' Confidence sometimes means being comfortable admitting what you don't know.

4. Learn to refer.

There is no award for doing every procedure yourself, especially one clearly outside your scope. Sometimes the most impressive clinical decision is, 'I'm referring this.' Your ego should never be the treatment plan. Referral is also treatment.

5. Your first job will teach you a lot — including what you don't want.

Your first employer may be amazing and become your mentor, or teach you exactly what kind of practice you never want to work in again. Either way, learn. Every workplace teaches you something, especially the terrible ones.

6. Don't confuse being busy with being successful.

You can work 12 hours a day, answer WhatsApp at midnight, see 25 patients and still not move forward. Busy is not the same as productive, and exhaustion is not a KPI. Ask yourself, 'Is this actually moving me towards where I want to go?' Otherwise, you may be running very efficiently in the wrong direction.

7. Learn about money before money becomes a problem.

You spent five years learning dentistry; now learn basic accounting. Know your revenue, expenses, debt and taxes. KES 1 million in revenue is not KES 1 million in profit. Your accountant has been trying to

tell you this. Listen.

8. Don't undercharge because you're young.

Being young doesn't mean your work is free. Equally, don't charge ridiculous fees just because you attended a course in Dubai. Your price should reflect your training, time, materials, expertise, overheads and patient experience. Communicate value and don't apologise for your fee.

9. Patients don't care how much you know until they know you care.

You can know every classification, material, technique and paper, but if your patient leaves thinking, 'That dentist didn't listen to me,' you've missed something important. People remember how you made them feel. Sometimes the most important part of the appointment is simply listening.

10. Learn to explain dentistry without sounding like a textbook.

Your patient doesn't need to hear, 'We have a mesio-occlusal carious lesion involving the dentine.' They need, 'You have a cavity that's getting quite deep, and if we leave it, it may reach the nerve.' Simple language doesn't make you less intelligent. It makes you a good communicator.

11. The Team you work with is part of your clinical experience.

Your team matters. Treat people well and train them properly. Remember that patient experience starts before the patient sits in your chair.

12. Your reputation is an asset.

Dentistry is smaller than you think. Colleagues, patients, labs and assistants talk, and somehow your business partner's cousin's neighbour hears about the case you thought nobody knew about. Be professional. Your reputation compounds, and so does bad behaviour.

13. Social media is a tool. Don't let it become your self-esteem.

One viral reel doesn't make you a great dentist; one poorly performing reel doesn't make you a terrible marketer. Don't spend 45 minutes refreshing Instagram insights. The reel won't suddenly gain 700,000 views because you checked again. Use social media; don't let it use you.

14. Find mentors.

Find people ahead of you whose careers, character and lives you respect, not necessarily celebrities or the dentist with the biggest Instagram following. Ask questions, observe and learn. Eventually, become that person for someone else. We all stand on somebody else's shoulders.

15. Your colleagues are not your competition.

Not every dentist in your city is trying to steal your patients. There are plenty of people who haven't seen a dentist in years. Build relationships, collaborate, refer appropriately and celebrate others' wins. Someone else's clinic opening doesn't make yours smaller.

16. Learn to say no.

Say no to the unpaid favour, the opportunity that doesn't align with your goals and the friend who calls only when they need a dentist. This is harder than it sounds, but no is a complete sentence.



17. Don't make major career decisions from a bad Tuesday.

One bad procedure, terrible day or disappointing month can have you Googling, 'Careers you can do with a dental degree.' Relax. Sleep, talk to someone, review the situation and then decide. A bad day is data; it isn't necessarily destiny.

18. Take care of your back. (For Real)

Your 22-year-old body may forgive terrible posture. Your 29-year-old body will send you an invoice, and your 35-year-old body may involve a physiotherapist. Learn ergonomics, strengthen your body, move, stretch and exercise. Your career needs your body to function for decades.

19. Go to the gym.

Run, swim, play football, hike or go to the gym. Do something. Dentistry can consume your identity if you let it; fitness gives you something different to think about. There is something strangely therapeutic about voluntarily suffering through a workout after a day at the clinic.

20. Travel.

Go somewhere, see something, experience another healthcare system, eat food you can't pronounce, get lost and talk to people. Your education doesn't happen only at conferences. Sometimes the best thing for your career is to leave your clinic for a while. Perspective is underrated.

21. Don't postpone your life until you "make it."

There is always another milestone: 'I'll enjoy life when I get a good job,' then 'when I specialise,' 'when I open my practice,' 'when it becomes profitable' and 'when I expand.' Suddenly you're wondering where your twenties went. Build the career, but live the life too.

22. Don't compare your life to Instagram.

Someone will graduate or specialise before you, open a bigger clinic, buy a nicer car, reach 100,000 followers, get married or travel to 14 countries. Someone will post, 'God's timing is perfect,' while you're eating Indomie noodles wondering whether you should have chosen pharmacy. Relax. Your timeline is yours.

23. Protect your friendships.

Dentistry can become all-consuming. One day you realise you've spent six months saying, 'Bro, let's link up soon,' without ever linking up. Don't let ambition make you lonely. Make time for your people. Patients will still be there tomorrow; your friends may eventually stop believing your 'soon.'

24. Learn leadership before you get the title.

Leadership isn't being at the front of the room. It's taking responsibility, making difficult decisions, listening, admitting when you're wrong and doing the right thing when nobody is watching. If you want to lead someday, start behaving like a leader now.

25. Don't be afraid to build something.

Build a clinic, research project, professional initiative, personal brand or something else. People will tell you why it won't work, and sometimes they'll be right. Build anyway. You learn more from attempting something real than endlessly planning something perfect.

26. Failure isn't always failure.

The job you didn't get, the relationship that ended, the business idea that failed, the course that didn't work out or the opportunity you missed may eventually teach you something valuable. Don't romanticise failure, but learn from it. Sometimes rejection is redirection; sometimes it's just rejection. Either way, keep moving.

27. Don't lose yourself trying to become "Dr."

You are a dentist, but also someone's child, friend, partner and perhaps parent one day. You are allowed to laugh, eat cake and have interests that have nothing to do with dentistry. The goal isn't to become the best dentist who ever lived. It's to become a good dentist and a whole human being.

28. Remember that we are still young.

Sometimes we act as though turning 30 means the government sends a certificate saying, 'Congratulations. You now understand life.' It doesn't. We'll still have questions, make mistakes and wonder, 'What exactly am I doing?' That's okay. I'm not 30 yet, and I don't have all the answers. We're supposed to keep learning, asking questions, taking risks and becoming better clinicians, leaders, friends and human beings. Hopefully, by 30 we've built not only impressive CVs, but lives we're proud to live. Here's to the difficult cases, first pay cheques, failed ideas, big opportunities, grateful patients, mentors and friends who kept us sane. We're not behind. We're just getting started. And if you're 29 wondering whether you should have life figured out by now, relax. I'm not 30 either. We have time.



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DESAMU GALA NIGHT

By Belyn Gesare



A night of elegance, sophistication, inspiration and endless possibilities is perhaps the best description of the inaugural DESAMU Gala Night. More than just a social gathering, it was a celebration of the community, achievement and a shared vision. This was a bold and ambitious idea brought to life: bringing together every affiliate of the Moi University School of Dentistry community under one roof for an evening dedicated to meaningful connections and networking.

As the 2025/2026 DESAMU Council assumed leadership mid last year, one of its aspirations was to establish a lasting tradition that would strengthen networks between current students and alumni. The objective was simple - to build a community that extends beyond graduation and creating a platform through which experienced professionals could inspire and mentor the next generation of dental practitioners.

Like many worthwhile endeavors, what began as a dream initially appeared daunting. The magnitude of planning such an event, coordinating stakeholders, securing partnerships and ensuring every detail was in place often felt overwhelming. The countless hours spent planning, often stretching late into the night and continuing into the early hours of the event day, seemed demanding at the time. Yet, we remained steadfast in our commitment. Guided by the theme, "Stronger Bonds, Inspiring the Future," the Gala Night became a testament to what can be achieved through determination and collective effort. The evening itself exceeded our expectations!!

> ***"... it is the relationships we build along the way that truly define our community."***

One of the most memorable moments was the Awards Ceremony, which celebrated excellence and recognized individuals whose dedication and contributions have positively shaped the Moi University dental community. Students, lecturers, alumni and partners who have consistently gone above and beyond were honored for their impact. Selecting the award recipients was no easy task. In our close-knit community, every individual brings something unique and valuable, making each nomination worthy of recognition. The trophies presented that evening symbolized gratitude, appreciation and a reminder that meaningful contributions never go unnoticed.

The significance of the Gala Night was further elevated by the presence of Hon. Dr. Fredrick Ouma Oluga, Principal Secretary, State Department for Medical Services, Ministry of Health. As he addressed us, he highlighted the critical role young health professionals will play in advancing public health outcomes in the years ahead. Demonstrating his commitment in investing in future healthcare leaders, Dr. Ouma Oluga mobilized more resources towards the Student Assistance Fund (SAF), an existing programme dedicated to supporting dental students facing financial challenges. This remarkable gesture set the tone for the evening, inspiring alumni to contribute generously toward the course.

Even as we reflect on the memories and the seeds planted for the future, we look forward with optimism and anticipation. We hope that years from now, we will reminisce this inaugural Gala Night as the beginning of an even stronger and more connected dental community. The mentorship fostered, the opportunities created for those who will carry the profession forward and the support mobilized will continue to shape the lives of DESAMU members and the wider Moi University dental fraternity.

Beyond the speeches, awards and fundraising, we will fondly remember the laughter shared, the dances that brought out our competitive spirit, the elegant fashion that illuminated the hallways, and the opportunity to interact with our lecturers and mentors in a more relaxed, informal setting.While we are united by our profession, it is the relationships we build along the way that truly define our community.

We remain profoundly grateful to the Kenya Dental Association (KDA), our alumni, sponsors, partners, lecturers and every individual who contributed to the success of the evening. Your support transformed an ambitious vision into a memorable reality.









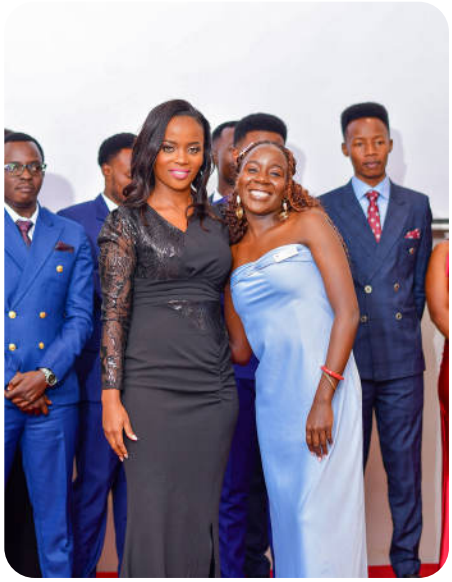












From White Coats to the World: Honouring the Journey, Embracing the Future

By Justus Junior Ouma, DESAMU Chairperson



On 15th August 2026, the Moi University School of Dentistry community gathered at Eka Hotel, Eldoret, for the DESAMU Finalists' Dinner 2026, a memorable evening dedicated to celebrating the 23 finalists of the BDS Class of 2026. Held under the theme "Embracing the Future, Honouring the Journey," the dinner was a celebration of achievement, reflection and transition. It provided an opportunity to look back on the years of training, challenges, friendships and experiences that shaped the finalists, while looking forward to their future as dental professionals. The occasion brought together distinguished guests, dental practitioners, faculty members and continuing dental students, creating a meaningful interaction between different generations within the dental profession.

The keynote address was delivered by Prof. Kuremu Tenge, Principal of the College of Health Sciences, who elaborated on the evening's theme and challenged the finalists to appreciate the journey that had brought them this far while remaining prepared to embrace the opportunities and responsibilities ahead.

The event also featured inspiring messages from Dr. Edwin Rono, KMPDU North Rift Branch Leader, and Dr. Wangwe Ongeti. The presence of respected members of the dental fraternity, including Dr. Serah Wanza, Dr. Scarlet Muhadia, Dr. Felix Chesney, Dr. Claire Chesney, Dr. Felix Ayunda together with faculty members and alumni further enriched the occasion. One of the most memorable moments of the evening was the crowning of the 23 finalists by the attending dentists. Beyond being a symbolic celebration, the moment represented their transition from dental students towards joining the professional community. Being crowned by practising dentists made the occasion particularly meaningful, as those present were not merely celebrating their academic achievement but welcoming them into the wider fraternity of dental professionals. The DESAMU Council also presented the finalists with awards, recognising their individual contributions and achievements. The awards formed an important part of the evening, giving the finalists an opportunity to be celebrated not only as a class, but also as individuals who had each contributed to the life of the dental school in their own unique ways.

The formal proceedings were complemented by dinner, entertainment and photography sessions, allowing everyone to relax and celebrate together. These moments created memories that will remain with the finalists long after their time at Moi University comes to an end.

The success of the dinner would not have been possible without the generous support of our partners and sponsors. DESAMU sincerely appreciates our Platinum Sponsor, Haleon, as well as KMA SACCO, KDA, KMPDC and SAI Pharmaceuticals. We are equally grateful to Arrow Dental, Versatile Dental Solutions, Smile Suites, Aquadent and all other private sponsors and individuals who contributed towards making the evening possible.

We also extend our appreciation to all the guests, faculty members, dentists and continuing dental students who attended and shared in this important milestone.

Special recognition goes to the DESAMU Council 2026/2027, whose dedication, teamwork and commitment made the vision for the evening a reality.
For the BDS Class of 2026, the evening was more than a dinner. It was a moment to pause and
appreciate the journey, celebrate how far they had come and confidently look towards what lies ahead.

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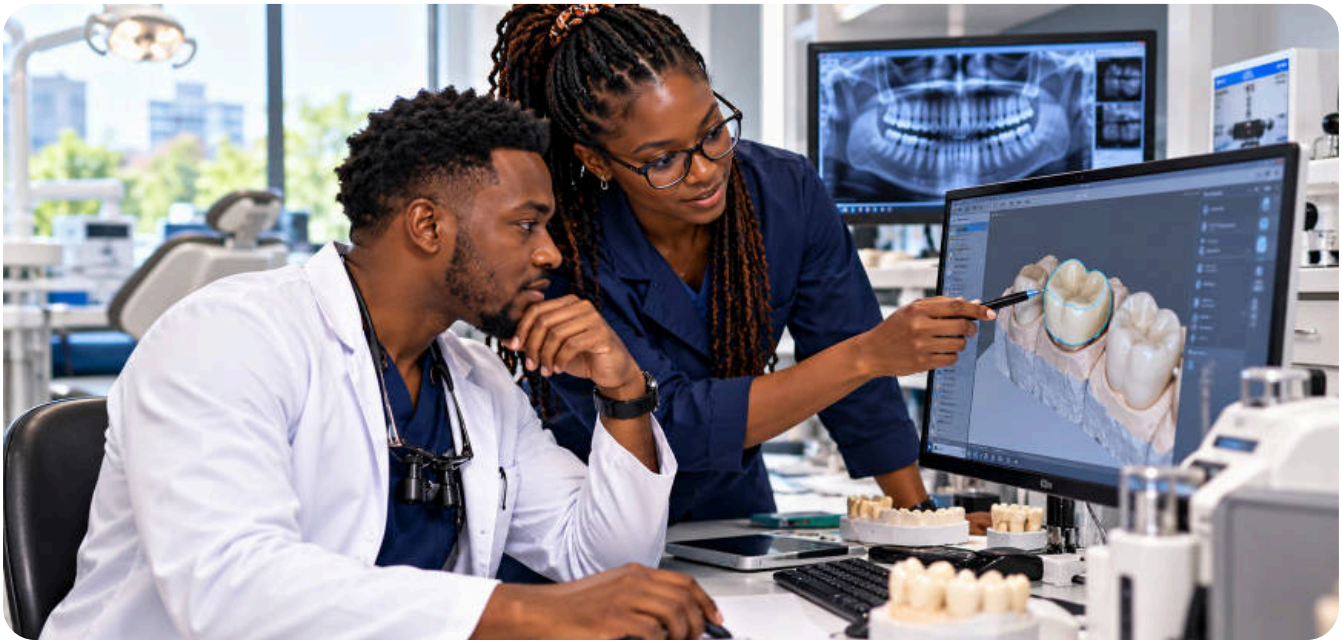
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Bridging the Gap: Communication Efficiency in Kenya's Growing Dental Ecosystem

By Mustaqim Quadir



Kenya's dental sector has grown steadily in recent years, with more clinics, laboratories, radiology and imaging centres, and suppliers entering the market across both urban and peri-urban areas. Yet as the ecosystem expands, a quieter challenge has emerged alongside it: the way these different players communicate with one another.

A Fragmented Workflow

Ask any practising dentist how a routine case moves through the system, and a familiar pattern emerges. A treatment plan requiring a laboratory-fabricated restoration is typically communicated by phone call or courier note. A radiographic referral is often handwritten, hand-delivered, or sent as a photo over a messaging app. Supply orders are placed verbally or through informal group chats. Each of these steps works, in the sense that the case eventually gets done — but each also introduces friction: delays in turnaround, misplaced instructions, duplicated communication, and a lack of any retrievable record when something needs to be clarified later.

This fragmentation is not unique to Kenya, but it carries particular weight here given the pace at which the dental sector is professionalising. As patient expectations rise and treatment planning becomes more collaborative — spanning general dentists, specialists, laboratories, and diagnostic centres — the tools used to coordinate that collaboration have, in many practices, not kept pace.

What research suggests

Recent dissertation research conducted among dental clinics and their external service providers in Nairobi examined precisely this question: how efficiently do dental clinics communicate with the laboratories, radiology centres, and suppliers they depend on for day-to-day patient care? The findings point to a sector still leaning heavily on informal, verbal, and non-standardised channels for case referrals, image sharing, and order placement.

Several recurring issues surfaced. Turnaround expectations were frequently unclear, since there was no shared system for tracking where a case stood at any given time. Information sometimes had to be repeated across multiple calls or messages before it reached the right person. And when a dispute arose — over a missed instruction, a delayed delivery, or an unclear referral — there was often no record to refer back to, leaving both sides relying on memory.

None of this reflects a lack of competence among practitioners or their partners. Rather, it reflects the absence of dedicated infrastructure built specifically for how Kenyan dental teams actually work together across organisational lines. General-purpose messaging tools were never designed to manage case histories, track multi-party workflows, or preserve an audit trail — they are simply the tools that were available, and dental professionals have adapted them out of necessity.

Why this matters for patient care

Communication inefficiency between dental clinics and their external partners is not merely an administrative inconvenience — it has direct implications for patient care. A delayed laboratory case can mean a patient returning for an additional, avoidable appointment.

An unclear radiographic referral can slow a diagnosis. A supply order lost in translation can leave a clinic without a material it needs mid-treatment. Each of these frictions, taken individually, may seem minor. Collectively, across a growing sector handling an increasing patient load, they represent a meaningful drag on efficiency and, at times, on the quality of care patients receive.

There is also a professional dimension. As dentistry in Kenya moves toward more collaborative, multidisciplinary models of care, the ability to communicate clearly and traceably with laboratories, radiologists, and specialists becomes part of the standard of practice itself, not simply a convenience.

Toward better coordination

Addressing this gap does not necessarily require complex or costly interventions. Even simple standardisation — consistent referral formats, clearer turnaround expectations, and a shared point of reference for case status — can meaningfully reduce the friction described above. What the research does suggest, however, is that the sector would benefit from tools purpose-built for this kind of multi-party coordination, rather than relying solely on channels designed for casual conversation.

This is a conversation worth having more broadly within the profession. As dental practices, laboratories, radiology centres, and suppliers continue to grow more interdependent, investing in how they communicate with one another may prove just as important as investing in the clinical skills and equipment each brings to the table individually.

A call for dialogue

The intention of this piece is not to prescribe a single solution, but to name a problem that many practitioners will recognise from their own daily experience, and to invite further discussion within the profession. Kenya's dental sector has shown itself capable of rapid growth and adaptation. The next stage of that growth may well depend on how deliberately the sector chooses to modernise the connective tissue — the everyday communication — that holds its various players together.



Who Deserves The Doctor Title More, The Dental, Pharmacy Or Medicine Graduate?

Article by NUDSA



I'm sure if you sat and asked most people who are in their first year of dental school, as in the first few days, whether MBCHB or BDS is easier, majority will state BDS. But this is truly a vitu kwa ground ni different moment. I'm not sure who plants this rumor in us that dental surgery is a breeze and we only learn about the head and neck in anatomy. Because that's what I knew, and shock on me when I found myself in the same anatomy classes as my peers in MBChB.

I was so taken a back, you could honestly not tell me what that leg had to do with my patients mouth but at the end of the day we just had to learn it. It also soon became apparent to me that apart from that, there were some extra hours that a certain unit known as oral biology was going to need. So MBCHB was in fact not harder and neither was bds because while I had barely an 100-pg. pdf to cover in behavioral science, MBCHB had a staggering 13 MODULES! And if you're wondering, what about pharmacy? they were off fighting fires to manage their chest full of units. So, as you can tell no one was just sitting back and easily slipping through first year.

The moral of the story is, why are we as members of the medical community always competing to see who has it harder or who is the best and so forth? I heard from various sources that when you come into this course people will not take you as seriously and initially, I laughed and said those are the things of the past. Shock on me, not only are people from other courses constantly trying to force you to admit that your only in the course because you missed out on a slot for medicine or engineering, they are also trying to gaslight you that what you do in oral biology is child's play after all who doesn't know about teeth!

> ***"The medical community should not be a competition over who suffers more or who is the best; every profession has a vital role to play in patient care"***

And its not just dentistry catching blows, I can never forget the time I had to sit in a career day and watch as a very well laned ophthalmologist fought tooth and nail to discredit a pharmacist of her doctor's title.Surely. And even us as dentists are not completely innocent, in retaliation many would take to laughing at the medical students for having to endure crazy long shifts as well as longer schooling time.

But at the end of the day, why do we put ourselves through an endless cycle of fighting over who deserves to be called a doctor more? Why is there so much pride in competition when really deep down we all know we can't do what the other can. I mean personally, the sheer amount of chemistry in pharmacy would finish me and the heaviness of the medicine profession would have my emotions in shambles and thus I respect them. I don't see the point in me trying to prove to them why I deserve to be a doctor more because at the end of the day I know we all need each other. I think its high time we squashed this imaginary beef and contest we have with each other and just work as a united front to offer quality healthcare to those we serve. That's my vison a well-oiled machine of medical excellence and I'm sure we can all agree on that.

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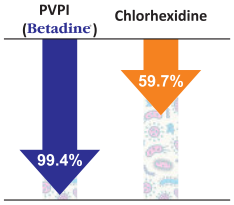
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1. Shiraishi T. et al, Dermatology 2002;204 (suppl 1):37-41.
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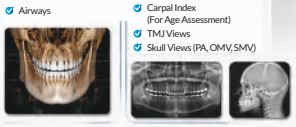
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Are Kenya's Future Dentists Ready to Go Digital?

Article by NUDSA



A University of Nairobi study finds dental students eager to embrace teledentistry in restorative and prosthodontic care but held back by connectivity gaps and the limits of a screen. Picture a dental student in Nairobi reviewing a patient's denture fit or a filling not across the clinic, but across a screen; a digital scan pinged from a rural outreach post, a photo of a crown margin sent for a second opinion. It sounds futuristic, but for restorative and prosthodontic care, teledentistry is already being used to bridge exactly this kind of distance in health systems around the world. The open question for Kenya has been simple: are the country's next generation of dentists ready for it? A study from the University of Nairobi's School of Dental Sciences set out to find out. Researcher Mwangi Antonio Maxwell, working under the supervision of Prof. Regina Mutave, surveyed 40 fourth- and fifth-year dental students, using the well established Technology Acceptance Model to probe not just whether students liked the idea of teledentistry, but whether they understood it, had been exposed to it, and felt ready to use it in the specific, hands on world of fillings, crowns, bridges, and dentures.

"Today's dental students are integrating the fundamentals of digital dentistry informally, even without a formal classroom on the subject."

A Generation That Knows More Than It's Seen

The results paint a certain picture: awareness of specific teledentistry services was surprisingly low with only about a quarter of students having encountered real examples of remote monitoring or knew of clinics offering virtual consultations. Yet when tested on the underlying concepts; digital impressions, CAD/CAM workflows, store-and-forward consultation, six in ten students scored "good" knowledge. In other words, today's dental students are integrating the fundamentals of digital dentistry informally, even without a formal classroom on the subject.

Enthusiasm Outpaces Confidence

Attitudes were resoundingly positive: students rated teledentistry favourably overall and saw clear value in it for improving access to care and supporting follow-up visits. But their confidence in actually using the tools lagged behind their enthusiasm for the idea, suggesting it's not persuasion these students need, but practice ; hands-on time with scanners, platforms, and digital case-sharing.

The geography of this crisis is not uniform. Nairobi County, with full urbanization and a population density exceeding 4,000 people per square kilometer, holds 43% of the entire dental workforce, with a dentist-to-population ratio of 1:9,018. Meanwhile, counties such as Wajir have limited dental facilities. For the majority of Kenyans living outside major urban centers, a dental appointment is almost an impossibility.

The Kenya Dental Association's 2026-2030 Strategic Plan confronts this reality with clarity and ambition. The plan commits KDA to a fundamental transformation, from a traditional learned society into a modern, professionally governed, financially self-sustaining national institution that is indispensable to every dentist and authoritative in every conversation about oral health in Kenya. Among the challenges it explicitly names are quackery, cadre overreach, insurer encroachment, and the urgent need to seize the opportunities presented by Universal Health Coverage and rising public demand for oral healthcare. Technology, and specifically artificial intelligence, is perhaps the most consequential of those opportunities.

What AI Offers Dentistry

Artificial intelligence is already demonstrating clinical value across multiple domains. AI as a diagnostic aid can help standardize dental caries and lesion detection, support periodontal screening, and triage radiographic findings, particularly in high-volume or resource-limited settings, improving efficiency and reducing inter-operator variability. A systematic review of AI applications in dentistry confirmed that most if not all dental disciplines have adopted AI, with the majority of applications focused on diagnosis from radiographic or optical images.

For Kenya, where the diagnostic burden on individual clinicians versus the population is enormous and specialist access is severely constrained, these capabilities are potential solutions to structural problems. The specialist workforce is particularly scarce, for example there are less than 50 paediatric dentists among the specialists registered by the Kenya Medical Practitioners and Dentists Council as of 2024.

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The Empty Chair

By Lee Makori - University of Nairobi.



"Ooowwwww!"

Kilavi's scream cut across the classroom before the teacher could even lower her chalk. He was nine, second row from the window, both hands clamped over his jaw as if he could hold the pain in by force. "Kilavi, what is it?" she asked, already moving toward him. He could not answer. He could only point at the side of his face, eyes streaming, while the rest of the class sat very still the way children do when something is genuinely wrong. The teacher sent him home with a note folded twice and pressed into his shirt pocket, the kind of note that says more by its shortness than it could ever say by length. His grandmother was the one who met him at the gate, and she knew before she read it, the way people who have raised many children learn to know. "Nini Kibaya!" she said in a vexed manner, pulling his hand from his cheek to look. The swelling had started two days earlier, low and small on the jawline, the kind you tell yourself will go down on its own if you are patient and it is the kind of thing patience sometimes fixes. Behind her, the baobab at the edge of the compound threw its short evening shadow across the swept yard, and somewhere past it the hills above Ikutha, in the drier reaches of Kitui County, were already losing their colour to dusk.At the dispensary the next morning, the nurse, a woman named Faith who had trained in Nairobi and been posted to Ikutha two years before, looked into Kilavi's mouth with a torch and did not like what she saw. "It's the back molar," she told his grandmother. "It's infected. I can give him something for the pain and something to fight the infection, but this tooth needs a dentist, and we don't have one here."

"When does the dentist come?" the grandmother asked.

Faith hesitated before answering, which was itself an answer. "He doesn't. Not to this dispensary. If it doesn't settle in two days, you'll need to take him to town."

For two days the amoxicillin bought them nothing but a little quiet. Kilavi stopped chewing on the right side of his mouth entirely, answering questions a beat too slowly, the way a child does when concentrating on pain is using

up whatever attention was left over for anything else. By the third morning the swelling had a shine to it, tight and shifting colour at the edges, and then, without warning, it simply stopped hurting. “Mama, haiumizi tena,” he told her, almost cheerful. It doesn't hurt anymore.

She carried him back to Faith anyway, relief loosening her shoulders for the first time in three days. Faith did not share it. A child who complains of pain for three days and then suddenly stops has not been healed; more often the nerve inside the tooth has died, and somewhere under a jaw that no longer aches, the infection is still moving. “We need to go now,” Faith said. “Today. Not tomorrow.”They left within the hour, on a road turned to red soup by the previous night's rain. The matatu that was supposed to run hourly took forty minutes to fill, and an old man in the back seat, seeing the boy's face, quietly pressed two hundred shillings into the grandmother's palm without being asked. “For his fare home,” was all he said. At the county hospital, a clinical officer met them at the dental unit's door, and the door was padlocked. “The dentist left in March,” he said, not unkindly. “Nobody has replaced him yet. I can give him something for the pain, but you'll need the referral hospital for this.” “How far,” the grandmother asked, though she already knew the answer would not be one she liked. “Far enough that you should leave now,” he said.

By the time a visiting dentist at the referral hospital finally opened Kilavi's mouth under general anaesthesia, the infection had tracked down along his jaw into the soft tissue of his neck, the kind of spread that turns a toothache into an airway emergency within two days. “We caught it,” the dentist told his grandmother afterward, wiping his hands, “but not by much.” Kilavi survived it. He was one of the fortunate ones, if fortunate is the word for a nine-year-old who spent nine days on a drip, missed the rest of term, and came home with a scar under his jaw that his grandmother would go on touching for years without quite meaning to.

Nothing about this is a single unlucky year. It is the ordinary shape of dental access across rural Kenya, and Kenya is not short of dentists to fix it; the University of Nairobi alone graduates dozens every year, most of them free after internship to work wherever they are needed most. Almost none choose rural stations by choice, so I asked 103 dental students, interns, and newly qualified dentists what would actually change their minds, using a study designed to force a real trade-off rather than a polite answer.

The numbers were blunt. Being posted rural cuts a job's appeal by more than half before anything else is even offered. Better equipment and housing help close that gap, and salary helps most of all, but participants still needed roughly KES 81,226 a month above baseline just to accept a rural post at all, whatever else came with it. Even the incentive Kenya already leans on, faster promotion, did not help; dentists in the data actually preferred the slower, ordinary career track, and would need a further KES 55,908 a month before a fast-tracked one stopped counting against a job rather than for it.

> ***“In rural Kenya, a treatable toothache can become a life-threatening emergency, not because dentists are absent, but because access to timely care remains out of reach.”***

This study is only one piece of a much larger puzzle, and it would be dishonest to pretend otherwise. Kenya's oral health gap will not close on the strength of one choice experiment, one thesis, or one dentist's decision to accept one posting. But oral disease deserves far more urgency than it usually gets. The World Health Organization's 2022 Global Oral Health Status Report found that oral diseases affect close to 3.5 billion people worldwide, roughly half of humanity, and that this single burden now outweighs the combined burden of the five diseases the world currently treats as its main non-communicable threats: cardiovascular disease, cancer, diabetes, chronic respiratory disease, and mental disorders. Untreated tooth decay alone accounts for an estimated 2.5 billion of those cases, making it, by that measure, the single most common health condition on Earth. It rarely makes the news the way diabetes or heart disease does, and that is a large part of the problem: a disease this widespread should not still be treated as a footnote. Kenya's own figures sharpen the picture rather than soften it. The country has roughly 1,300 registered dentists for a population of about 55 million, a ratio of only 0.27 dentists for every 10,000 people, and just 13% of health facilities nationally offer any oral health service at all. More than four in ten Kenyans live over twenty kilometres from the nearest dental clinic, and some counties, Wajir among them, have no dental facility of any kind, not one, anywhere within their borders, Kilavi happened to be in Kitui. He could just as easily have been counted in any of those figures.



If I could turn back, the hands of time

By Douglas Oramis



How did I ever let you separate away?
Never knowing that I'd be cursing moving forward today,
And now I'm troughing, troughing to get you,
Ever since you closed the canal.

If I could turn, turn back the hands of time,
Then my darling, you'd still be full,
If I could turn, turn back the hands of time,
Then my darling, you'd, you'd still be full.

Funny, funny how time flies by,
And am still agitating counter clockwise,
Why, oh, why, oh, why, oh, should one go on with ultrasonics,
When every second I pray please come up to me.

If I could turn, turn back the hands of time,
Then my darling, you'd still be full,
If I could turn, turn back the hands of time,
Then my darling, you'd, you'd still be full.

And you'd had enough stress for the both of us,
But,I,I,I did you wrong, I admit I did,
But now I'm facing, the rest of the session gone
Whoa.

If I could turn, turn back the hands of time,
Then my darling, you'd still be full,
If I could turn, turn back the hands of time,
Then my darling, you'd, you'd still be full.

Oh I'd never insert you (if I could turn back)
Never rotate you (if I could turn back)
And never use you again (if I could turn back)
If I could just turn back the hands

There'd be nothing for you to do (If I could turn back)
Forever honest and true to you (If I could turn back)
If you accept back to pulp chamber, I love you (If I could turn back the hands)
(If I could turn back)
Oh oh, that would be my will
(If I could turn back)
Darling I'm begging you to become loose
(If I could turn back the hands)
I'm troughing down, yes I am
(If I could turn back)
Down on my bended knee, yeah
(If I could turn back)
And I'm gonna be right there until you return to me
(If I could turn back the hands) Oh oh oh
(If I could turn back)
If I could just turn back that little clock on the wall
(If I could turn back)
Then I'd come to medicate and place a TF
Hate you, hate you, hate you, hate you
(If I could turn back the hands, If I could turn back the hands)
(oh oh oh oh!)

Inspired by the song
'If I could turn back the hands of time' by Robert Kelly

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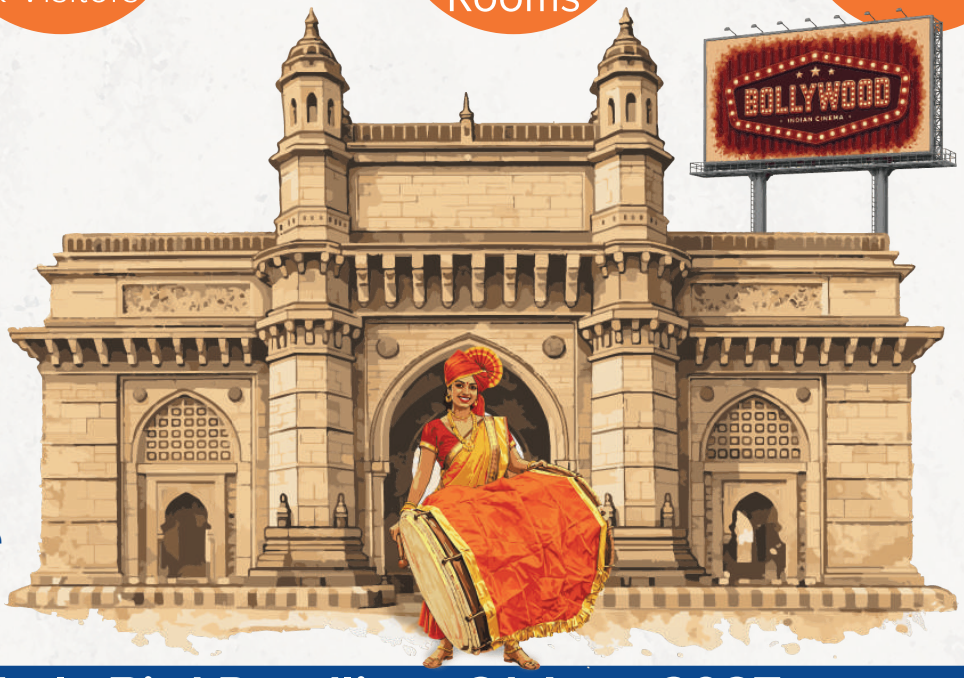
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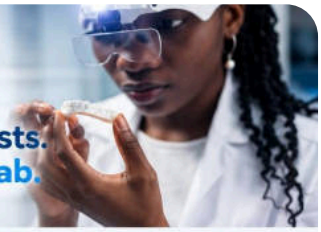
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