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Back At Last!

We needed a vaccine. Plain and simple. Until most local officials allowed convention venues to fully re-open. We are finally seeing signs of life, and some international shows are starting to slowly come back. We are delighted to meet our dental community again, in Dubai, a renaissance really worth celebrating!

We needed a vaccine. Plain and simple. Until most local officials allowed convention venues to fully re-open. We are finally seeing signs of life, and some international shows are starting to slowly come back. We are delighted to meet our dental community again, in Dubai, a renaissance really worth celebrating!

While things were on hold, many organizations tried virtual meetings, but attendee engagement was generally inferior compared to the old live events. Yet, reports are coming in that many companies' sales were unaffected by their absence from trade shows. The companies saved the money that previously had been spent on sponsorships, booths, collateral material, travel, and hotels. Does this experience mean that trade shows are to die off? Not at all. When competitors start pedaling again, companies that ignore trade shows will fall behind. Trade show participation drives sales in three ways: continued sales to existing customers, buyers attracted to a new offering, and sales to new buyers dissatisfied with their current providers. Over time, picking up new business is vital. Trade shows are a great way to show off new products, including new variants of old products. Potential buyers may not be aware that the new products exist, they may not understand them, or they may not have been motivated to learn how the new products would benefit them. Business-to-business sales can survive a year or two without trade show exposure, but the value of increased sales will eventually win out relative to costs savings.
What about the attendees? Those who are spending a good bit of money will want to attend to ensure they are getting the best products for their companies. Educational sessions may be less important now that people are used to webinars, and meetings that are primarily educational, rather than trade shows, will be more often virtual. But consumers who attend trade shows want to see multiple products and services offered and will likely not bother with those businesses that are absent. Networking advantages of in-person meetings are inevitably strong.

Yes, because, since the pandemic's outbreak, many have predicted the death of exhibitions as we know them, a bit like the doomsayers who foretell the end of cities. But why people move to big cities? to be with other people. The same happens with exhibitions: we mingle with like-minded peers who do something similar or related to what we do. They are colleagues, competitors, researchers, current or future clients. For three or four days a year we are all together, under the same roof. Wouldn't it be the same to send all these people our product catalogue by e-mail, and ask them if they are interested in buying something from us? Of course not. Zoom meetings or a webpage cannot quite reproduce or replace what happens when we meet face to face, see eye to eye, shake

hands to close a deal. Of course, I am not saying that digitization has no use or influence. New technologies, virtual or hybrid events, are here to stay for they are immensely helpful to reach more people and places. They are now an integrated part of an overall marketing strategy that will later be used as an effective tool to promote a presence at a trade show, and help build an audience and engagement prior to, during, and post event. But most virtual show platforms have not addressed the most important critical factor required for a successful event, virtual or otherwise, audience engagement. A site with a few simple links, or limitations to what you, the exhibitor, can do with creating your own virtual micro-site, does not adequately build, attract, or engage an audience.
Trade fairs are similar to conglomerates, like big cities or villages. Because energy, attitude, and personality cannot be 'remoted' through even the best fiber optic lines. That inspiring energy people have, springs forth solely when we get together, when we meet in places that enhance our creativity and make us feel that we are sharing something unique, something exceptional, with a lot of other people.
In closing, I simply wanted you to know that *Infodent International* will keep doing events that no one wants to miss, they will be better and more tech-savvy than ever!
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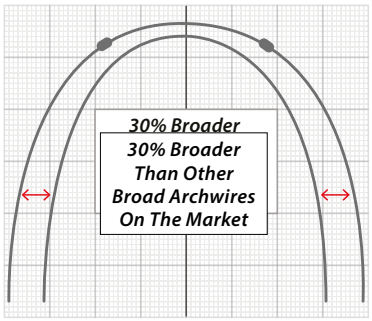

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Gingival recession treatment with Concentrated Growth Factors (CGF) in the esthetic zone

A CASE REPORT

Dott. Luca Mangani
Oral surgery specialist, Phd in "Materials for health, environment and energy"

Author: Luca Mangani

- In 2010 Dentistry Graduation at University of Rome "Tor Vergata".
- In 2013 Oral Surgery Specialization at University of Chieti Pescara "G. D'Annunzio".
- Teaching assistantship in "Periodontology" at University of Rome "Tor Vergata".
- From 2014 attendance at "Bichacho Clinic", Prof. N. Bichacho, Tel Aviv, Israel.
- From 2016 Opinion leader for "WAND STA (Single Tooth Anesthesia) SYSTEM".
- From 2017 "HTD Consulting" and "Silfradent" opinion leader.
- In 2020 PhD in "Materials for health, environment and energy" at University of Rome "Tor Vergata".
- Attendance in prostho-perio-implant courses. - International lectures.
- Author an co-author of scientific publications - Private practitioner in Rome.

Female patient, 30 years old, no smoking habits, no systemic disease. 5 years ago was placed an implant, zone 2.1, after a car accident. Unfortunately the implant developed a soft tissue loss during the following 3 months healing process and her esthetic defect was masked with the final prosthetic crown. Patient desires were to smile once again and not to suffer anymore. It was planned to perform a coronally advanced flap technique without taking connective tissue graft from the palatal side but using only CGF membranes, =8totally painless. Looking at the

Fig. 1 Patient smile profile

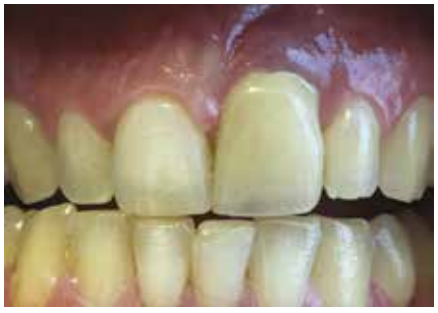

Fig. 2 Patient frontal smile

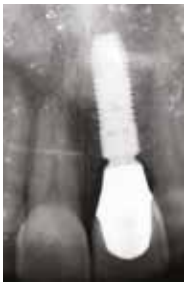

Fig. 3 Pre operative X-Ray

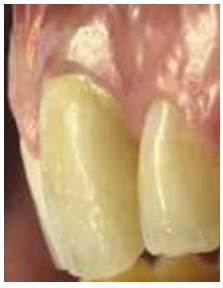

Fig. 4 Pre operative soft tissue defect analysis

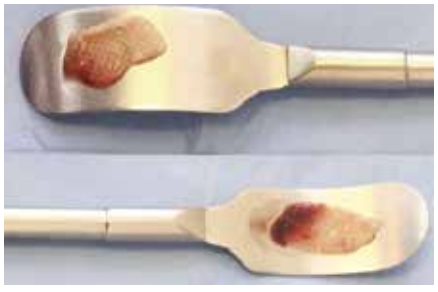

Fig. 5 CGF Membranes

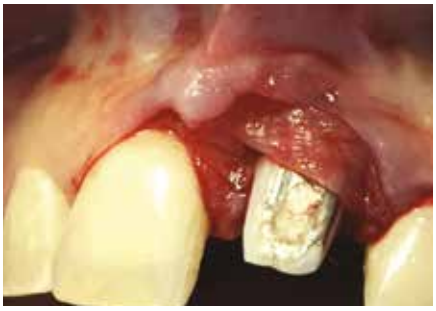

Fig. 6 Flap design and CGF membranes filling

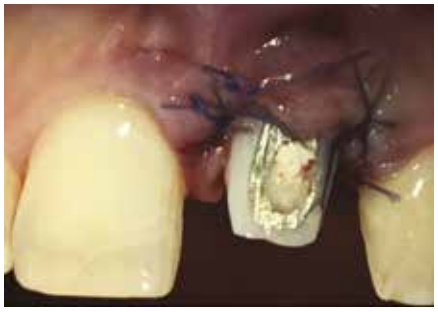

Fig. 7 Vicryl resorbable suture

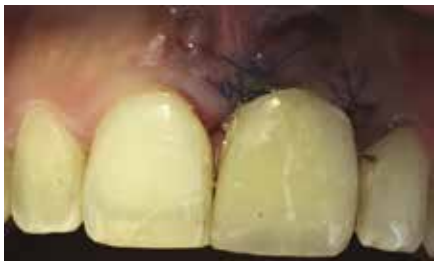

Fig. 8 Immediate provisional crown

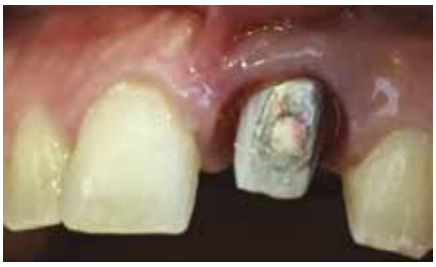

Fig. 9 3 Months post-operative soft tissue appearance

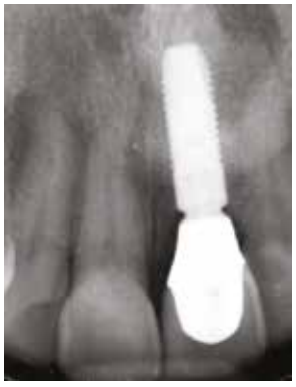

Fig. 10 3 months post-operative X-ray

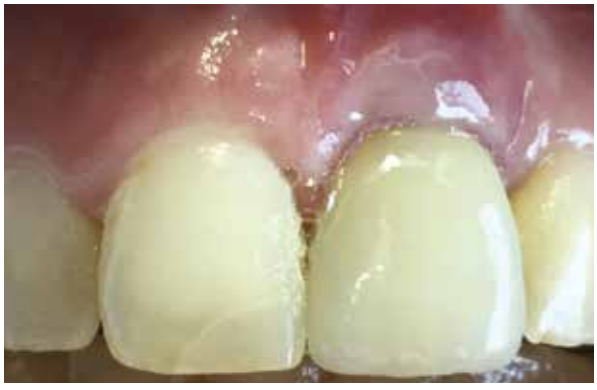

Fig. 11 FInal crown restoration

final very good result, despite Concentrated Growth Factors (CGF) did not improve clinical outcomes when compared with Connective Tissue Graft (CTG), surely this method had a more positive effect on postoperative pain.

It was planned to perform a coronally advanced flap technique without taking connective tissue graft from the palatal side but using only CGF membranes, totally painless.

XIMPLANT
Currents decontaminator in the treatment of infected peri-implant and periodontal sites

Doctor Paolo Calvani* and Doctor Cesare Paoleschi**
** Freelance in Florence, ** Dentist, freelance, founder of IRIS Dentistry Company*

This article presents a new decontaminating method through the application of currents for the decontamination of infected peri-implant and periodontal sites.
The method is called the XIMPLANT system.
The current treatment technique provides precise protocols, in terms of timing and intensity of automated currents, for each type of application, such as to carry out a non-invasive and non-traumatic treatment for healthy tissues. The concept of the treatment is based on the physical action of destruction of the bacterial biofilm. The "electrode" effect of the system is exploited, thus developing a current around its surface which decontaminates it. These treatments are performed "closed" without local anesthesia.
The XIMPLANT system involves contact with the active electrode on the implant, which is "crossed" by a high frequency electromagnetic wave that breaks the biofilm acting on the entire surface of the implant. In fact, it should be remembered that titanium has an ionic conductivity subjected to a potential difference of 3%, sufficient to induce the ionic movement on its surface, such as to induce the destruction of the bacterial biofilm.
Peri-implantitis represents a pathology that poses serious survival problems for a high percentage of prosthetic rehabilitations on implants.
The bacterial flora forms a biofilm that undermines osseointegration by inducing a resorption of the peri-implant bone which, in the long run, leads to the loss of implant anchorage, as in periodontitis occurs for a natural element.
The bacterial flora in question is the same responsible for periodontal problems.
The formation of the biofilm begins with the adhesion of microorganisms to a surface.
When a certain amount of bacteria accumulates on a surface and reaches a certain cell density, it begins to secrete a substance which is basically a polymer made up of polysaccharides, proteins and DNA. This substance mixes with the water present in the environment and gives rise to a matrix where bacterial cells are strongly rooted in the form of biofilms. Peri-implant mucositis occurs in about 80% of subjects and in 50% of implants. Peri-implantitis occurs in 28% and in a percentage greater than or equal to 56% of the subjects (Zitzmann, Berglund T. - J Clin Periodontol 2008 Sep, 35 (8 Suppl) 286-91). Currently, the therapeutic treatments of peri-implantitis involve mechanical maneuvers associated or not with topical and / or general pharmacological treatments, such as antibiotic therapy. Prevention actions are essentially based on home and professional hygienic maneuvers, in order to prevent irritative spines from which bacterial colonization can start, first of the gingival sulcus, creating a mucositis, then of the peri-implantation creating frank peri-implantitis. In the initial stage of mucositis, bone resorption is usually of little entity, but the bacterial biofilm already extends to affect the deep implant surface, that is, a contaminated area that is not evident in this phase with instrumental examinations.

Peri-implantitis represents a pathology that poses serious survival problems for a high percentage of prosthetic rehabilitations on implants.

It is precisely at this stage that it is interesting to have a device available that allows the "breaking" of the bacterial biolfilm along the entire surface of the implant, even the one where bacterial colonization has not yet caused pathology (not visible.)
In fact, even managing to remove the biofilm in the exposed parts of the implant, one does not act on those bacteria that colonize the perimplant in the areas where it is still anchored to the bone, but since the surface of the implant is an easily etched surface, it allows maturation and bacterial aggregation. Also, even in the face of "frank" peri-implantitis with bone resorption and suppurative state, an instrument that allows the deep decontamination of the implant and of the deep peri-implant areas

would be particularly effective from the point of view of survival of the implants themselves. Until now, this profound preventive-therapeutic action was not feasible.

Treatment methodology

Once the infection and the stage of mucositis and / or frank peri-implantitis (probing depth, plaque index, bleeding index) have been diagnosed, professional hygienic treatment is carried out. At the end of the peri-implant toilet, the active electrode is applied to the implant collar.
The ground electrode is held in the patient's hand. The XIMPLANT decontaminator is set on the peri-implantitis program and the currents are applied, according to pre-set times and methods. The treatment is painless. The patient is then invited to adopt an adequate home hygiene attitude. The bactericidal action of the current is reported by numerous studies in the literature. Particularly significant are the works of Del PozoJ, L, M.S. Rouse, (1) where there is an effective action of the electric current against the biofilm in culture, consisting of Pseudomonas aeruginosa, staphylococcus aureus and Staphylococcus epidermidis. Sy et all.
Other particularly significant works are those of Dreesa (2) on electrochemical inhibition of 2003, and of LEE, Sy et all (3) of 2012.
A recent work, currently being published, by Prof. Giammarco Raponi and Dr. Lisa Valentini, of the Department of Public Health and Infectious Diseases of the Sapienza University, highlighted the effectiveness of the XIMPLANT system: "In the experimental procedures, a strong bacterial biofilm produced by Enterococcus faecalis from ATCC collection has been layered on the implants that were successively treated in a treatment chamber by electric current produced by the X-IMPLANT machine. Evidences are provided that the electric treatment granted by the X-IMPLANT system completely removed the bacterial biofilm".
Particularly interesting in this method is the prevention of peri-implant infections.
The "prevention" protocol provides at the end of a normal scaling session the preventive application on the implant collar in the subgingival prosthesis-implant passage area of the active electrode. For "Toronto" rehabilitations, the application takes place directly through contact with the passing structure.

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Causal treatment management during mucogingival surgery procedures: application of ozone therapy at home and by professionals

TBM and DOHMA (Digital Oral Hygiene Motivation Approach)

Prof.ssa Gianna Maria Nardi*, Dott.ssa Roberta Grassi, Vanja Granberg***, Prof. Felice Roberto Grassi******
**Certified Researcher, Sapienza University of Rome*
***Orthodontist, Vita-Salute San Raffaele University*
**** Department of Dentistry and Dental Prosthestics, Aldo Moro University of Bari*
***** Professor SSD MED/28 (Odontostomatologic Diseases), Medical School, Aldo Moro University of Bari*

To effectively manage the patients' oral hygiene care is essential for the patients themselves and for professionals in complex clinical cases. Therapies may fail in case a patient undergoes intricated rehabilitative therapies without being previously informed and motivated towards committing to an oral hygiene regime and consistent medical follow-ups (Garmyn et al. 1998; Westfelt et al. 1985). For the therapy to be successful, it is necessary to implement an approach that involves tailored, personalised and shared protocols (Nardi et al. 2020) discussed and agreed upon by the patient. In the few instances where the mechanical control of the bacterial biofilm is insufficient, it is necessary to correctly manage the chemical control by the professionals and at home through the use of mouthwashes and gels that contain specific ingredients (Lang et al. 2008). Combining periodontal therapy with the application of ozone therapy at home and by professionals leads to the successful maintenance of healthy gingival tissues.

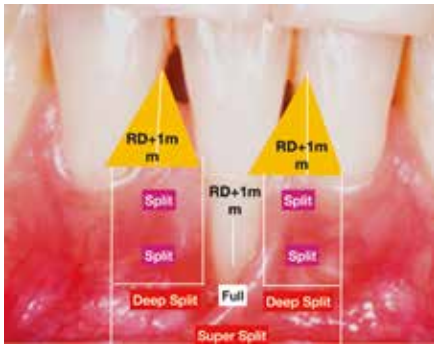
CASE REPORT

The patient selected for the study is a 25-year-old non-smoker healthy woman with a Zucchell's class III gingival recession of 12 mm (Zucchelli, 2011). The patient received orthodontic treatment (Verrusio et al. 2018) and was later subjected to a gum recession surgery. The condition has intensified after the patient was subjected to a frenectomy procedure using diode lasers (SICOI, 2011) which did not improve the aesthetic aspect and caused a scarring in the deeper tissues, thus worsening the clinical condition. A further issue consists of the thin tissue biotype (Cortellini et al. 2018) and a scarce gingival papilla in the teeth #41-#31 zone. fig. 1 (Zucchelli et al. 2006).

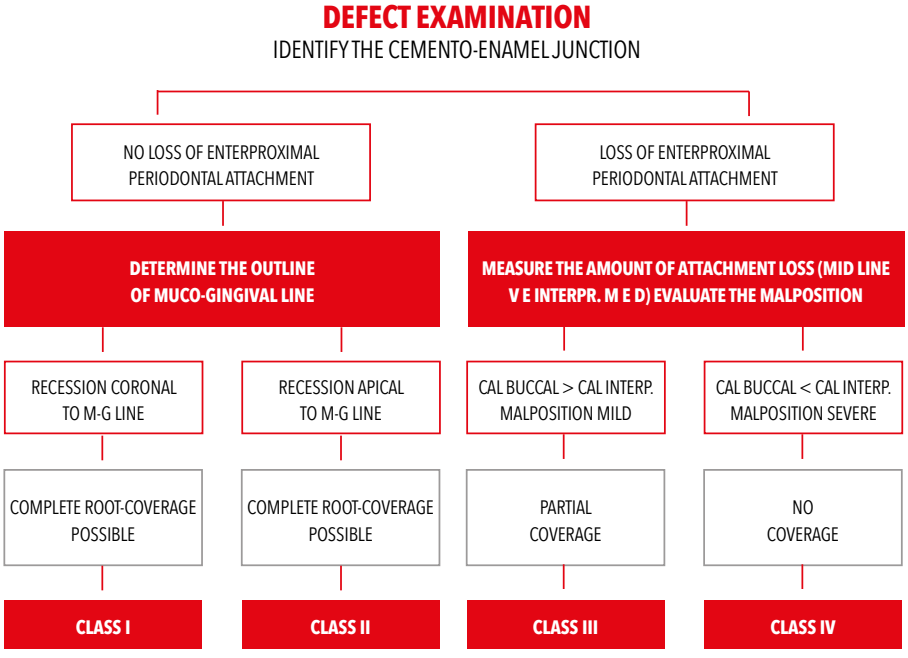
Baseline

MATERIALS AND METHOD

After a thorough assessment, the dental team designed a diagnostic- therapeutic approach that involves an integrated treatment strategy where the patient actively participates to the oral hygiene therapy at home. The general risk factors were evaluated (Van Dyke et al. 2005),

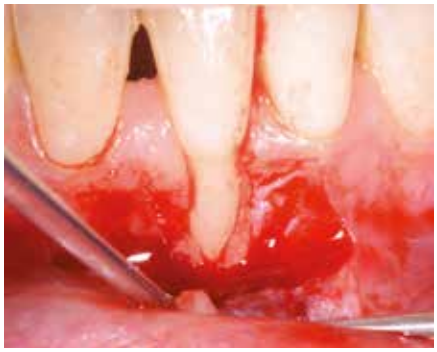


Mucogingival surgery steps

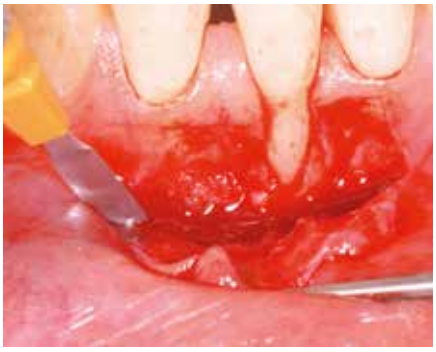


Zucchelli Classification

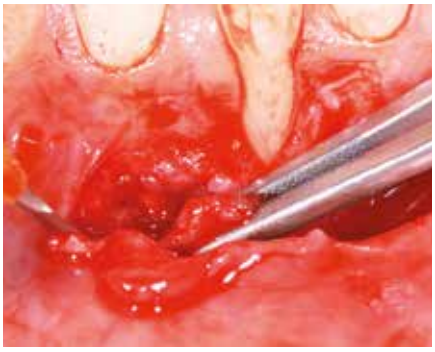
SURGERY PHASES



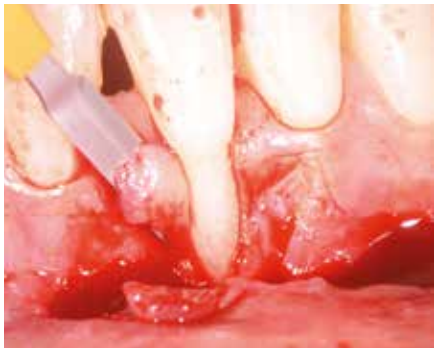
Sharp dissection to prepare a full-thickness tunnel



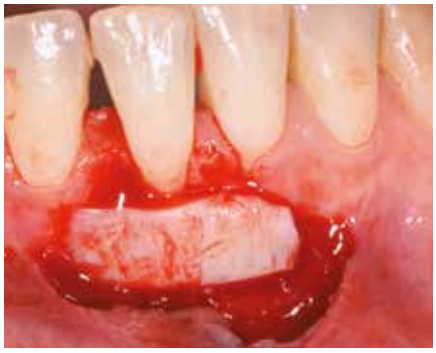
Deep incision to achieve a split-thickness envelope flap



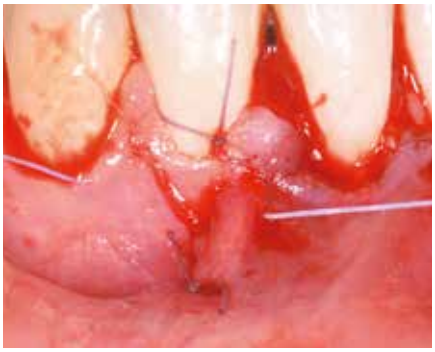
Superficial incision to achieve a split-thickness envelope flap



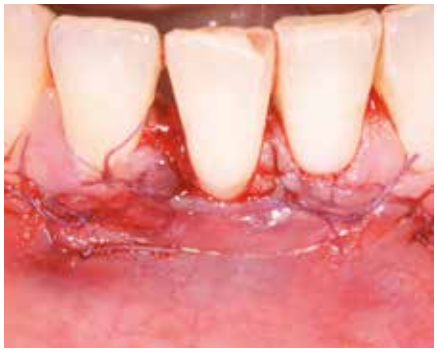
De-epithelialization of the papillae



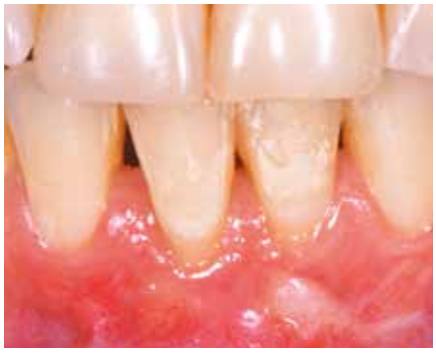
Connective tissue graft



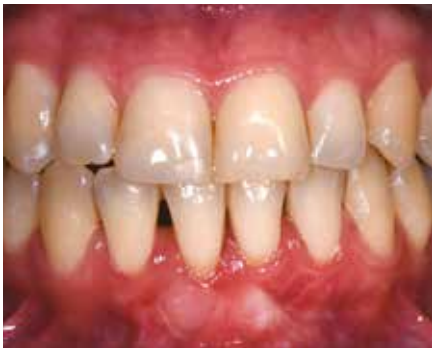
Sutures



Coronally advanced flap with the connective tissue graft to the CEJ



Surgey site after 6 months



1 year after surgery

the clinical situation was photographically documented and the pictures taken with the intraoral scanner were shown to the patient in order to include her in the evaluation of the local, aesthetic and biomechanical risk factors (Papapanou et al. 2017). The patient is affected by a class III gingival recession of 12 mm according to the Zucchelli classification in tooth #41.

NON-SURGICAL PERIODONTAL THERAPY

The motivational approach towards healthy lifestyles and the non-surgical periodontal therapy should be tailored to the patient before, during and after the surgical procedures.

BEFORE THE SURGERY

The anti-COVID-19 measures were put in place (Ministero Della Salute, 2020). The three-tone plaque disclosing gel containing Erythrosine was applied to the oral cavity surfaces in order to carry out the deplaquing and debridement through the D-BIOTECH Clinical Approach (Dental BIOfilm Detection Topographic Techniques): the assessment of the shape of the existing bacterial biofilm can be used to encourage the patient to improve their oral hygiene at home especially in the more retaining areas, to select the most suitable technologies and clinical approaches to identify the areas with the highest risk of inflammation. Managing the bacterial biofilm in the interproximal spaces was found to be inefficient.

The periodontal debridement is not going to be carried out manually to avoid inducing a recession of the interdental papillae and the nearby soft tissues (Zucchelli, 2011).

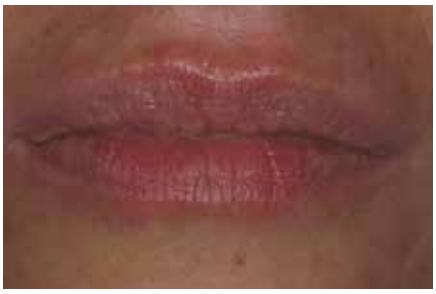
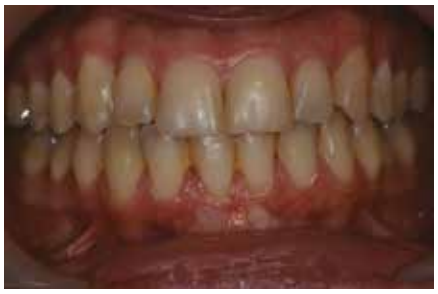
The non-surgical periodontal treatment was performed using the Comby touch (Mectron) device, consisting of a multifunctional piezoelectric scaler and a water jet, air and a sodium bicarbonate and glycine powder polisher. The debridement and deplaquing procedures were performed along the operations of double surgical aspiration and OzoActive virucide aspiration (ozonized water that through an aerosol function works as a biocide, fungicide, bactericide and virucide).
The polishing process during the deplaquing stage utilized air and glycine powder, which particles were <63µm. The implementation of a handpiece that can rotate to 90° or 120° allowed for an efficient clinical intervention which

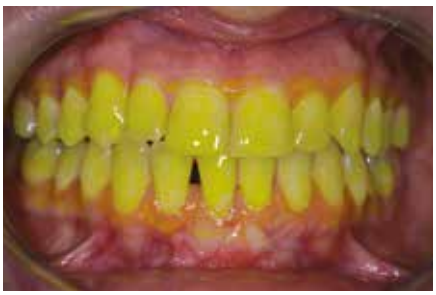
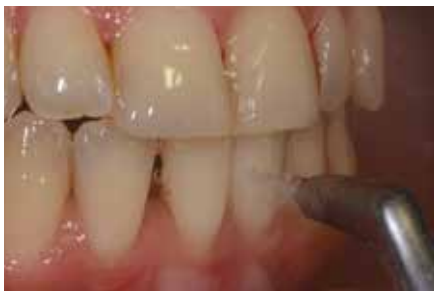
Combi Touch Mectron

did not damage the mucogingival tissues while also being as non-invasive as possible. The professional should evaluate and choose the most suitable powder depending on the clinical status of the oral cavity according to the tailored approach. Glycine powder, which particle size was around 25µm, was selected for the deplaquing. The soft setting was then selected in order to regulate the vibrations intensity.

ORAL HYGIENE AT HOME

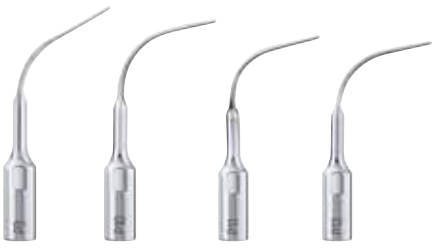
The patient was then encouraged towards carrying out the mechanical management of the bacterial biofilm at home with a "shared and personalized tailor-made" protocol (Nardi et al, 2016). This protocol involves an accurate evaluation of the behaviour tendencies and skill of each patient while performing oral hygiene care tasks. It is not necessary to instruct the patient on the different ways of brushing their teeth, however it is essential to discuss and agree on the most suitable tools to use in the various clinical and anatomical dental situations. The patient was not passive during the treatment process but through the interaction with the professional she agreed on the treatment options that appeared to be the most appropriate after a careful clinical evaluation. The pa-

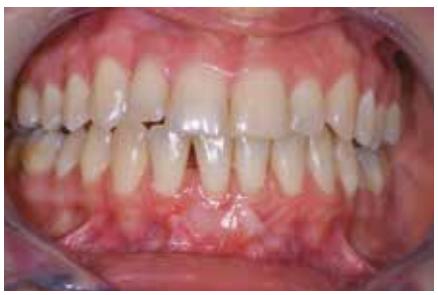




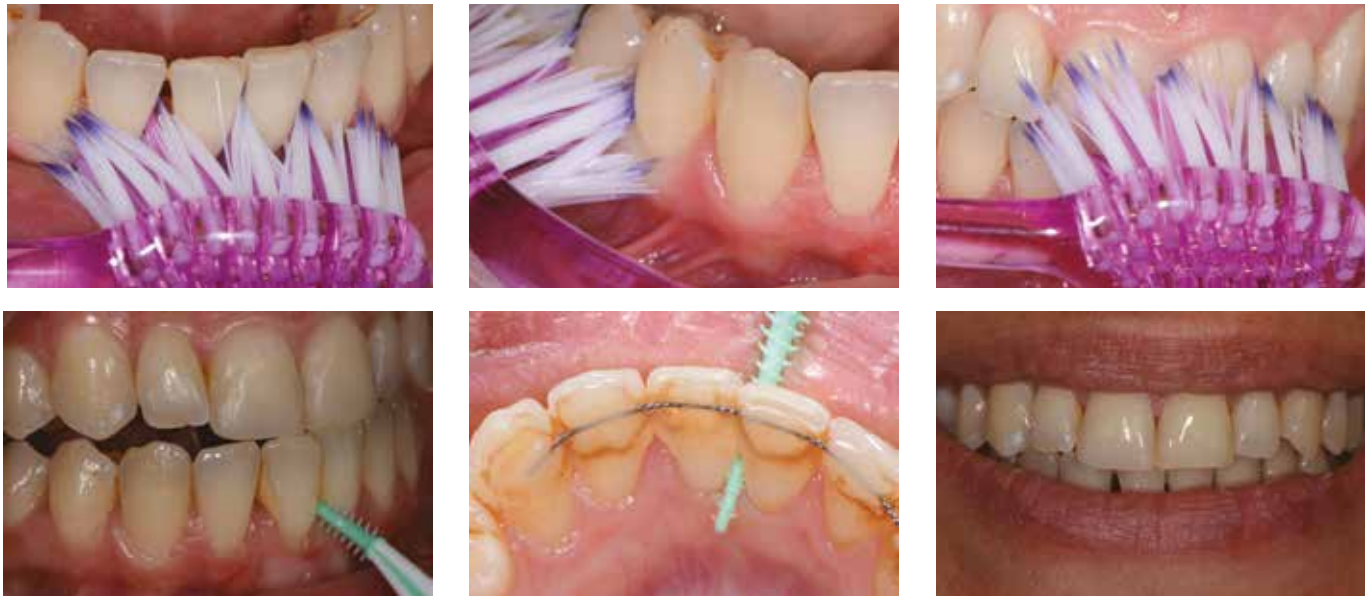
Mectron OzoActive





Periodontal ultrasonic inserts: P3, P10, P11, P12 (Mectron)





tient was invited to adopt a non-traumatic but efficient brushing technique in order to apply a more careful management of the areas that retain more dental plaque.

OZONE THERAPY AT HOME

The patient was instructed to use the ozonated olive oil mouthwash Ialozon Blu (GEMAVIP) twice a day, each time for 30 seconds. The ozonated olive oil has anaesthetic, anti-inflammatory and antioedema properties due to the reversible action of the neurofibrils which regulate the level of pain and oxygen transport to the inflammation site (7,10). Recently, numerous studies (11) determined the efficiency of the combined use of the ozonated olive oil contained in the mouthwash on the restoration of the gingival tissue conditions, on the reduction of the plaques clusters and on the treatment of the chronic gingival phlogosis (Nardi et al, 2020b). The patient was advised to apply the chemical instead of the mechanical at home management of the bacterial biofilm in the operation site to avoid potentially damaging the gingival tissue. The patient was informed not to brush the recession site and to apply the Ialozon gel (GEMAVIP) (Nardi et al. 2020a). A bilaminar trapezoidal flap surgery with a palate connective tissue graft was scheduled due to the extension of the recession, to the existing mesial and distal papillae and to the integrity of the cemento-enamel junction in tooth #41 (Zucchelli et al. 2003).

PROFESSIONAL OZONE THERAPY

Perioral 3 is applied on the stitches. In case of periodontal disease, a suitable antiseptic is going to be applied on the affected area with a 3 ml disposable syringe after the periodontal debridement session. The patient should not rinse or eat anything in the 30 minutes following the product application. Solid food can be consumed after 3 hours.

Among the oral cavity antiseptics, Perioral 3 is non-traumatic, antiseptic and anti-inflammatory medical solution that allows for the maximum patients' comfort. Perioral 3 stands out because of its chemical composition consisting of natural elements which makes for an innovative and efficient solution that is even suitable for those patients with nickel, lactose and gluten allergies or intolerances.

The active components comprise:

- Ozonated EVO olive oil which when activated combines the therapeutic effects of the olive oil to the active ozone molecules. Therefore, the product has antibacterial, fungicide and anti-inflammatory properties which specifically target the epithelial restoration.
- Cetilperidiunum which has bactericide and antiseptic effects.
- Chlorphenesin is an antimycotic and myorelaxant agent.
- Low-Molecular-Weight (LMW) Collagen is easily absorbed and targets the cellular regeneration.

It is not necessary to instruct the patient on the different ways of brushing their teeth, however it is essential to discuss and agree on the most suitable tools to use in the various clinical and anatomical dental situations.

• LMW and High-Molecular-Weight (HMW) Hyaluronic acid which promotes the cellular regeneration and does not affect the natural shade of the dental enamel.

Professionals endorse the use of specific mouthwashes containing ozonated olive oil and hyaluronic acid (Ialozon GEMAVIP) which have anaesthetic, anti-inflammatory, antioedema, antiseptic and healing properties and reactivate the microcirculation.

ADHERING TO AN AT HOME ORAL HYGIENE THERAPY WITH THE HELP OF ADVANCED TECHNOLOGIES: TBM AND DIGITAL ORAL HYGIENE MOTIVATION APPROACH (DOHMA)

Patients undergoing mucogingival surgical treatment need accurate and constant follow-ups. COVID-19 restrictions urged professionals to use telemedicine methods. The DOHMA clinical approach establishes a new follow-up tactic where teleconsultation appointments are scheduled allowing for the evaluation of the clinical situation through listening to the patient, and remotely sharing and discussing clinical pictures. The professional-patient interaction is essential to the monitoring of the clinical index, of the clinical evolution, of the presence of inflammation or gingival oedema, of the colour of the mucosa, and of the possible presence of discoloration. The patient can report on the symptoms: the presence of painful symptoms, potential bleeding during brushing, dentine hypersensibility, tongue dryness, the potential lack of taste perception or presence of unpleasant smells in the oral cavity, in which case the patient can carry out the sniff test in order to detect possible halitosis. The patient is further motivated towards the biofilm control and is presented with an individual maintenance procedure which is agreed upon by the patient and the professional through the DOHMA. This approach includes a revaluation stage during the teleconsultation, in order for the professional to support the clinical evolution of the patient in case it is not objectively possible for them to go to a dentist's office. Patients claim they are satisfied by the way in which issues are solved during the DOHMA teleconsultation. This ergonomic and efficient approach regarding the monitoring of the patients' health leads to a more thorough control of the oral hygiene at home and of the possible existence of painful symptoms. Therefore, a personalized and shared patient-professional relationship can be maintained. The continuous clinical discoveries contribute to the identification of the most suitable tools to solve any highlighted issue, accomplishing an absolute at home compliance.

CONCLUSIONS

Oral health maintenance requires an integrated approach consisting of:

• The constant critical evaluation of the scientific evidence

• The careful assessment of the biological, psychological and social aspects of the patient

• The professional's clinical experience

Regarding the causal therapy management during mucogingival surgeries, professional and at home ozone therapy has been found to be beneficial because of its biostimulant effects on tissues and its analgesic properties, and because of its antioedema, anti-inflammatory and analgesic effects during the post-surgery treatment. The patients' well-being is favoured by the selection of ergonomic and less invasive technologies.

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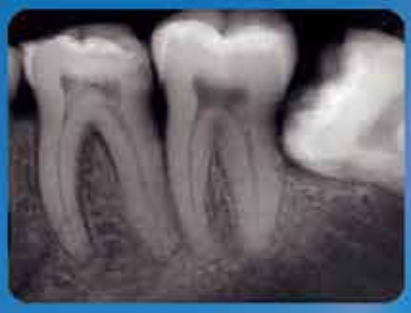


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The GCC Region

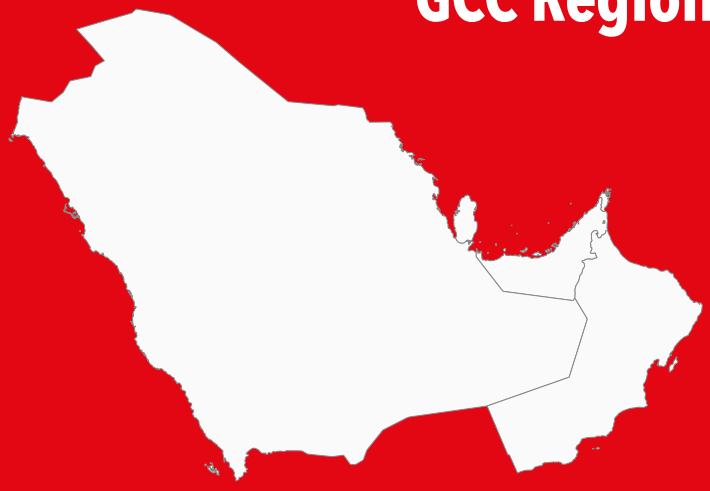
Facts and Figures

A changing demographic and epidemiologic structure, unprecedented reforms, and effective responses to curb the rising cases of Covid-19 infection, coupled with strong emphasis towards economic diversification and private sector participation are currently transforming the region's health systems at an unprecedented pace and scale, aiding economic growth in the long run.

General Outlook

The Gulf Cooperation Council (GCC) is an intergovernmental organization made up of six oil rich member nations, Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and the United Arab Emirates (UAE), lying at the North East of Africa (separated by the Red Sea) and South West of Iran (separated by the Arabian Gulf). Significant investments in healthcare infrastructure by GCC governments were observed in the past 25 years in the form of large medical cities and complexes. This increase in hospitals and clinics raised the quality of healthcare services in the region, reflecting a rise in health status. According to WHO World Health Statistics, the life expectancy in GCC countries has increased to 77.2 years in 2018, with Qatar topping the region, and infant mortality decreased to 6.9 deaths per 1,000 live births in 2018, from 8 in 2013. **Growing at a faster annual rate than the world average of 1.0%, the GCC population size is projected to increase to 61.6 million by 2022, also as direct consequence of the huge influx of expatriates (about 48.1% of**

GCC Region



GROWTH OPPORTUNITIES

- High investments in technology, digitization, telemedicine, and remote care. Acceleration in AI solutions innovation
- Regional governments strengthening the healthcare sector as one of the most critical avenues for the region's long-term economic diversification strategy
- Greater focus on public-private partnerships (PPP) and Mergers & Acquisitions (M&A)
- Implementation of mandatory health insurance presents significant opportunities for providers and insurers
- Ageing population, high prevalence of NCDs, and greater focus on preventive care and quality enhancing reforms are reshaping the GCC healthcare industry
- Increased investments in specialized health centers

	Population, 2020	% in Total Population Nationals Non-Nationals	Type of Government	GDP (current US$, billion), 2019	GDP per capita (current US$), 2019	GDP per capita, PPP (current International $), 2019
Kingdom of Saudi Arabia	34,813,871	62% 38%	Absolute monarchy	792.967	23,139.8	49,040.3
United Arab Emirates	9,890,402	11.5% 88.5%	Federal monarchy, Absolute monarchy	421.142	43,103.3	70,089.3
Sultanate of Oman	5,106,626	56.0% 44.0%	Absolute monarchy	76.332	15,343.1	28,507.5
State of Kuwait	4,270,571	30.8% 69.2%	Parliamentary system, Constitutional monarchy	134.629	32,000.4	52,059.7
State of Qatar	2,881,053	14.3% 85.7%	Absolute monarchy	175.838	62,088.1	94,028.6
Kingdom of Bahrain	1,701,575	48.0 % 52.0%	Constitutional monarchy	38.574	23,504	47,002.5

Source: worldmeter, elaboration of data by United Nations, Department of Economic and Social Affairs. / International Monetary Fund, 2019 and 2021 / The World Bank.

total population, mainly migrant workers), of which nearly 17% will be aged 50 years and above.

Sedentary lifestyle and poor dietary habits have led to the rise in diabetes and obesity to epidemic levels with incidence rate of cardiovascular disease, diabetes, cancer, and respiratory ailments amongst the highest in the world. Moreover, lack of adequate focus on disease management, prevention and early-stage intervention is driving noncommunicable diseases (NCDs) as being major cause of the deaths and disability in the region. The confluence of these factors is challenging the capability of the already limited available healthcare resources and rising healthcare expenditure, while at the same time representing a key driver to the region's healthcare system. Both regional governments as well as private operators have consequently laid out plans to increase the number of hospitals, primary healthcare centers, clinics, and laboratories. An ageing population, high prevalence of NCDs, focus on preventive care and quality enhancing reforms are reshaping the GCC healthcare industry.

Recovery and Growth

The GCC nations were swift in their response to the COVID-19 crisis, however the pandemic has had a much more of a profound impact on the GCC than in many other countries, as the region is also dealing with an economic slowdown due to lowest oil prices in the past 17 years. GCC governments took several fiscal and economic measures to mitigate economic consequences stemming from the outbreak, and to help regenerate growth. Although these measures have helped in restoring confidence, according to the IMF, the GCC's 2020 shrink in GDP, at around 6.0%, is in line with contraction of the global economy and other major economies, while the region is expected to rebound over the next two years with the GDP likely to see a 2.3% and 3.5% growth in 2021 and 2022, respectively, as the COVID-19 situation normalizes. The GCC is then expected to revert to pre-pandemic levels by as early as 2022, marginally surpassing projections in peer countries like the US, UK, Singapore, Japan, and Germany.

With healthcare expenditure averaging 5% of GDP, much below other developed countries, the region offers immense scope for growth. Even though challenges like shortage of skilled healthcare professionals, limited specialized care centers and medical inflation exist, private players are making inroads to capitalize on the growing demand, technological advancements, and medical tourism. Saudi Arabia, representing around 56.3% of the region's healthcare market has started focusing on developing the sector through increased private sector participation and PPP (Private-Public Partnership) projects. In contrast, spending growth in the UAE, the second largest market in the GCC, recorded a negative CAGR of -0.1% between 2012 and 2017. The slowdown can be attributed to a fall in government as well as private spending. While expenditure in the UAE, Kuwait and Bahrain revived in 2017, an estimated lower private spending in Saudi Arabia and lower government spending in Qatar and Oman led to a downfall in the overall expenditure for these countries.

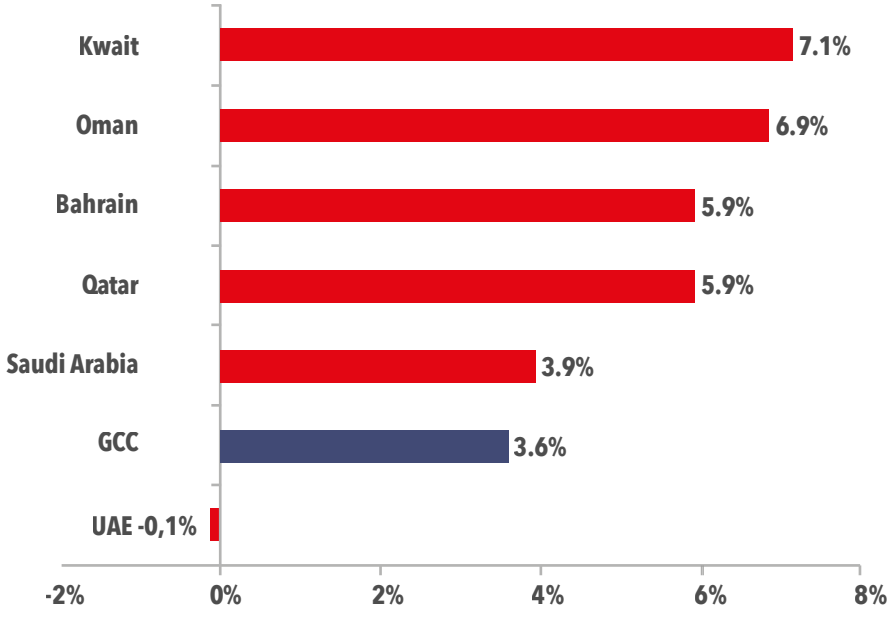
The Covid-19 outbreak has nevertheless eroded profits in the private sector as demand for primary and secondary care, dental services, mental healthcare, and allied health services have contracted significantly due to rise in COVID-19 medical procedures. This has led to around 8 million fewer patient contacts per week in the region, hampering profitability for many operators. The private healthcare sector is largely facing the heat as people opt for public providers as cheaper alternatives for treatment. As a result, hospitals are lowering their prices to stay competitive, which is likely to erode profit margins, strain revenues and derail any expansion strategy. On the other hand, health insurers in Saudi Arabia and the UAE face a profit squeeze as insurance premiums are failing to keep pace with the rising value of medical claims amid the COVID-19 pandemic. While treatment is free for the nationals of the two nations, foreign residents - who constitute approximately 38% and 88% of the Saudi and UAE populations respectively - rely on private insurance provided by their employer, consequently, insurers are likely

to tweak their product offerings with a potential increase in rates.

The Healthcare System

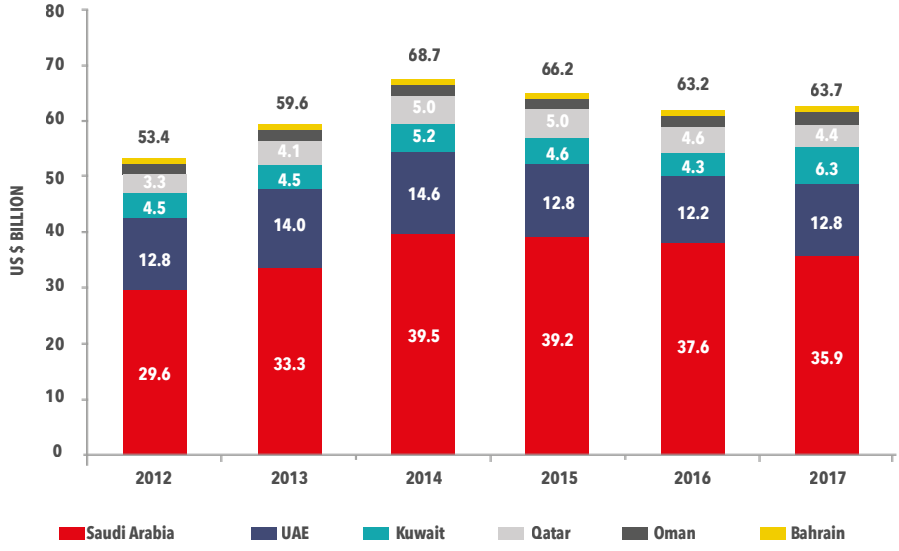
Health services in GCC are provided free of cost to all residents and, despite the current economic slowdown and budget constraints, regional governments continue to bear a sizeable part of the healthcare expenditure, which has put significant burden on state finances however, the gradual rollout of compulsory health covers across the region will increase the utilization of medical services at private healthcare facilities in a bid to transfer some of the cost to individual citizens, employers, and insurers. **Currently at different stages within the GCC countries, the implementation of mandatory health insurance is already widespread in the UAE and Saudi Arabia and is expected to be fully implemented by 2021-22 in the rest of the GCC countries.** Significantly increasing the utilization of medical services at private healthcare facilities, the health insurance market in the GCC is estimated to have reached US$ 13.4 billion in 2019 and is expected to reach US$ 25.5 billion by 2025. As part of their economic diversification plans, medical tourism has been receiving stimulus from the GCC governments. Dubai and Abu Dhabi are at the forefront amongst the GCC nations and ranked as the sixth and ninth most popular medical tourism destinations in the world during 2020-21. Dubai witnessed a 4% y-o-y rise in medical tourism arrivals in 2019 to reach 350,118, with Asian tourists as the highest share of 34%, followed by neighboring Arab countries at 28%, and 17% from Europe. The growth can be largely attributed to the Emirate's modern healthcare facilities and its commitment to enhance the experience of international patients and wellness tourists. **Within Dubai, dentistry, orthopedics, and dermatology were found to be the key treatments for inbound tourists. Dubai is also a prominent hub for cosmetic surgery and is home to the largest number of cosmetic surgeons per capita in the region, at about 50 specialists per million people.** To attract over half a million medical tourists by 2021, the Dubai Health Authority (DHA) issued 3,397 licenses to healthcare facilities in Dubai, while 45 new health facilities, a hospital, and 10 general and specialized medical clinics were inaugurated during the first half of 2020.

CURRENT HEALTHCARE EXPENDITURE GROWTH PER COUNTRY (CAGR: 2012-2017)



Source: WHO. Taken from Alpen Capital, GCC Health Industry Report 2020
Note: Current Health Expenditure (CHE) for Saudi Arabia in 2017 is an average of last 5 years CHE (2012-2016)

CURRENT HEALTHCARE EXPENDITURE BY COUNTRY



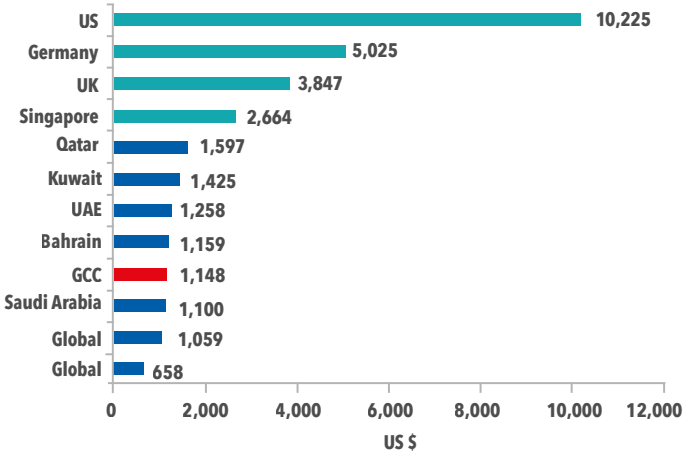
Source: WHO. Taken from Alpen Capital, GCC Health Industry Report 2020

Dependence on Highly Skilled Expatriate Talent

The lack of home-grown professionals can be partly attributed to the limited number of healthcare educational institutions in the region. On an average, the GCC had 5.7 nurses and 2.9 physicians and dentists per 1,000 population as of 2017. While the number of physicians (including dentists) density has grown in the years and was close to that in developed nations, nurse density in the region was significantly lower.

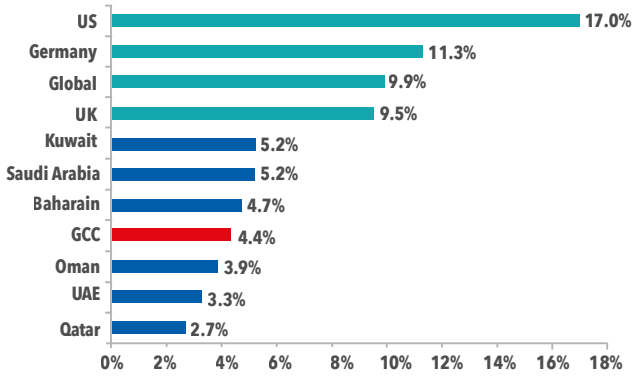
However, due policies adopted to increase the number of nationals entering the workforce, the growing nationalization of jobs within the region is likely to present a unique challenge for healthcare operators going forward. In Saudi Arabia, for example, authorities recently denied the renewal of employment contracts of many expatriate health employees who exceeded 10 years of service in the Kingdom, in line with their 'Saudization' plans. Similar localization initiatives are being implemented in the other GCC nations such as Oman. As of 2017, the GCC was home to 139 healthcare education institutes with Saudi Arabia (77 institutes) and the UAE (24 institutes) accounting for 73% of the total. While there are several nursing schools in the

CURRENT HEALTH EXPENDITURE PER CAPITA, 2017



Source: WHO, World Bank, IMF. Note: CHE for Saudi Arabia in 2017 is an average of last 5 years CHE (2012 2016). Taken from Alpen Capital, GCC Health Industry Report 2020

CURRENT HEALTH EXPENDITURE AS % OF GDP, 2017



Source: WHO. Taken from Alpen Capital, GCC Health Industry Report 2020

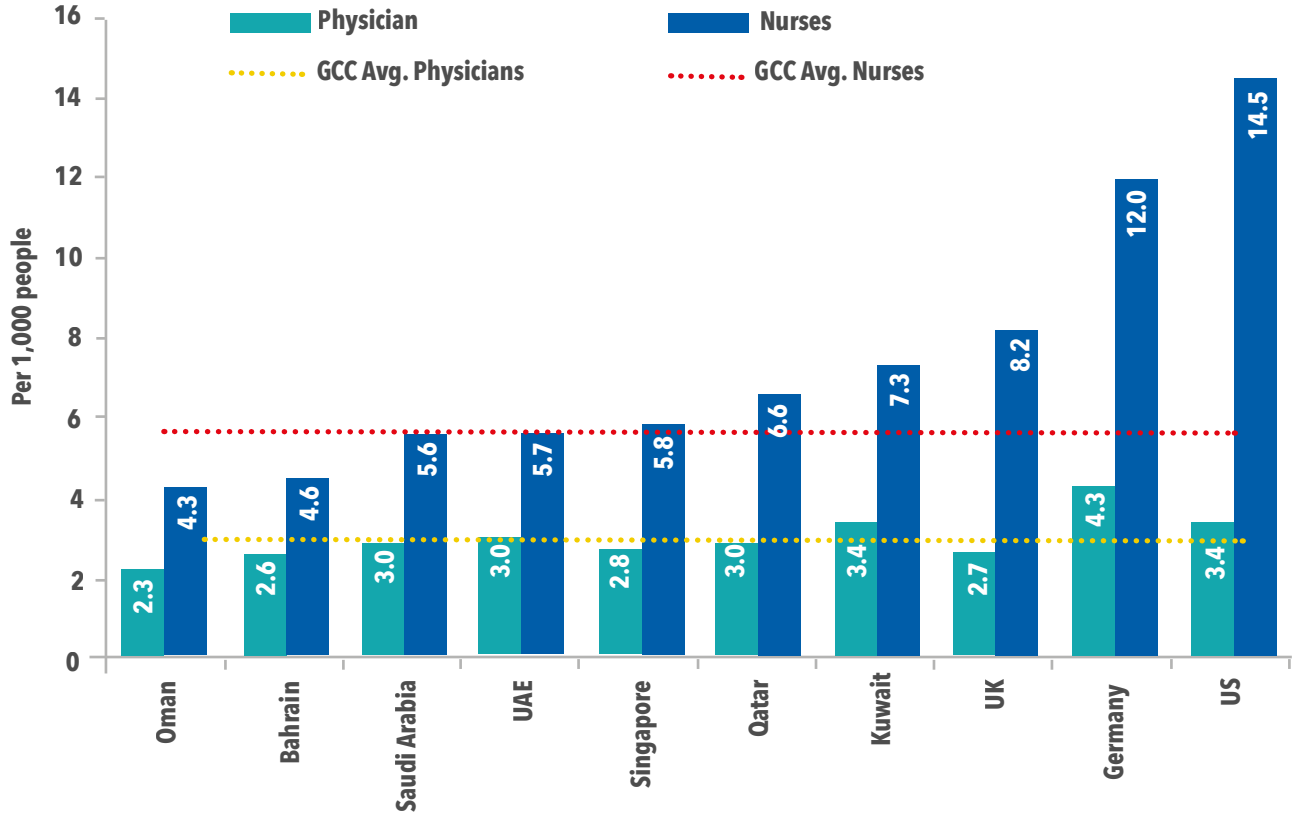
region, institutes for other health disciplines such as dental, medical, and pharmaceutical are inadequate. For instance, there is a need to establish a college of dentistry in Bahrain and Qatar so that the nations are less reliant on international dental graduates. Moreover, the region should focus on scaling up the training capacity of their existing schools and aim for international accreditation for the development of higher quality healthcare programs. This will reduce the shortfall in nationally trained medical professionals and the subsequent dependency on expatriate workforce.

Among Main Sources:

-Extracts (both text and graphs) from Alpen Capital, GCC Health Industry Report 2018 and 2020, for full and detailed report: http://www.alpencapital.com/industry-reports.html

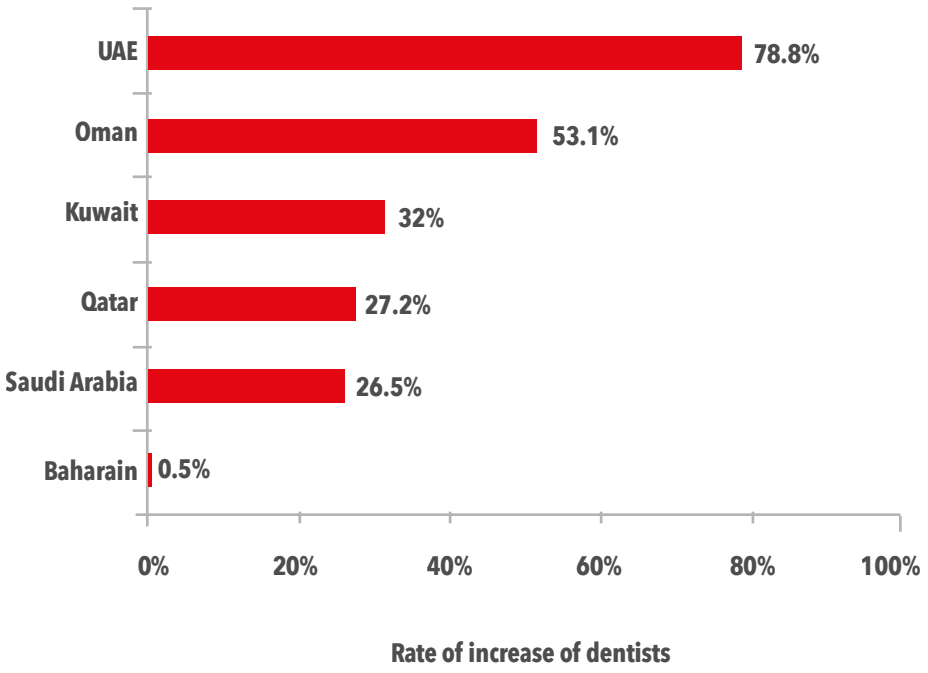
Alpen Capital offers a comprehensive range of financial advisory services to institutional and corporate clients across the GCC and South Asia. Alpen Capital combine the disciplines of strategy, organisation, leadership and finance into an integrated approach to help clients grow the long-term value of their companies. Alpen Capital works with some of the leading business groups in the GCC and South Asia providing them with unique investment banking advisory solutions based on their requirements. Alpen Capital's team comprises of experienced and innovative professionals who create value through extensive knowledge of local and international markets and access to key decision makers. It was established in 2005 in Dubai at the*

PHYSICIANS AND NURSES DENSITY (2017)



Source: Health Ministries of Bahrain, Oman, Qatar, and Saudi Arabia, FCSA, CSB, MDPS, IMF, OECD, WHO, Alpen Capital

GROWTH IN THE NUMBER OF DENTISTS IN THE GCC IN 2017, COMPARED TO 2013



Dubai International Financial Centre and expanded its operations to Qatar, Oman, Abu Dhabi and India.
*(*Alpen Capital refers to Alpen Capital (ME) Limited, Dubai, Alpen Capital (ME) Limited, Abu Dhabi branch, Alpen Capital Investment Bank (Qatar) LLC, Alpen Capital LLC, Oman and Alpen Capital India Private Limited collectively).*
-Embassy of the United Arab Emirates, https://www.uaeembassy.org/about-uae/health-care
- Health Care in Gulf Cooperation Council Countries: A Review of Challenges and Opportunities
Monitoring Editor: Alexander Muacevic and John R Adler, Tawfiq Khoja,1 Salman Rawaf,2 Waris Qidwai, 3 David Rawaf,2 Kashmira Nanji,3 and Aisha Hamad2
Cureus. 2017 Aug; 9(8): e1586. Published online 2017 Aug 21. doi: 10.7759/cureus.1586. For full article: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5650259/
-https://www.statista.com/statistics/1120429/gcc-increase-in-dentists-by-country/

Sultanate of Oman

Oral healthcare in Oman faces several challenges and has a long way to go; with high incidence of oral diseases, like dental decay, cavities, and gum disease, evident is the need to ensure that future demand for oral healthcare is met by the most appropriate health professionals.

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COUNTRY	DENTISTS per 10,000 population
USA	16.3
Germany	7.9
UA E	7
Qatar	5.8
UK	5.3
Saudi Arabia	5.2
Kuwait	3.5
GCC average	3.2
Oman	3.1
Global average	2.6
Bahrain	1.5

Source CIA World Health Organization. World health statistics. Geneva: WHO; 2013.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4490677/

Over the last 40 years, the Sultanate of Oman has invested heavily in the health sector, creating a relatively modern healthcare system, boosting a universal healthcare coverage for both citizens and non-nationals. High social welfare benefits, as well as access to medical facilities and doctors has greatly improved the lifespan of Omani citizens, as well as other health indicators, placing the country on a par with many advanced western nations. Free healthcare is provided to all Omani citizens, as well as expats from GCC countries, covering primary care, specialist appointments, and almost all medical treatments as needed. Employed in the private sector and visitors from outside the GCC are not covered by the public system and will need to have a health insurance, compulsory since 2018. **The Unified Health Insurance Policy (UHIP), introducing mandatory health insurance for all private sector workers and visitors (the Dhamani scheme), is one of the leading projects in the Sultanate and is expected to provide insurance cover for over 2.1m expatriate workers in the private sector.** Of this group, around 70-80% were uninsured in 2018. Overall, the health insurance industry grew by 30.5% from 2011 to 2018, making it one of the fastest-growing segments. A national insurance scheme would in fact allow for the outsourcing of specialised care to private facilities, which would enable more private clinics to be established, also stopping residents of Oman from needing to go abroad to receive specialised treatment that is not currently available in the sultanate. The scheme, now implemented amongst expatriates living in Oman, will be further expanded to Omanis, thus guaranteeing the sustainability of the health system, greater access to specialized treatments as well as quality healthcare and services.

The UHIP regime stipulates a set of essential benefits that must be covered, including in- and outpatient services, emergency care, doctors' fees, diagnostic services, medicines, and ambulance trips. The employer is responsible for the payment of the premium and in agreement with the employee he can include added benefits for pregnancy, childbirth, dental and eye care. Thus, you may have to pay a premium on your health insurance policy for dental care and most dental treatment is provided through private clinics.

Oral Healthcare and Future Needs

With an over 2% population growth rate, it is anticipated that Oman will exceed 7 million people by 2050. Although a young population, 20-24-year group making up almost 41.7% of the total, the proportion of older people is increasing significantly, together with a need for oral health. In recognizing the importance of oral health, the Sultanate is placing greater emphasis on education and training of dentists and, in line with the Omanization policy carried out by the Government on the whole workforce, including health professionals, Oman is developing an Omani-majority dental workforce. **Until recently in fact, Omanis who wished to study dentistry had to train abroad as no dental education was available in the Sultanate, thus relying on expatriate dentists, together with a minority of overseas-qualified Omanis. In 2010 only 24% of the dentist workforce was Omani, ranging from 53% in the Ministry of Health, 68% in non-Ministry of Health government sector which includes the military services, and with only 2% of Omanis in the private sector.** With the establishment of the Oman Dental College in 2006, the only dental school in Oman, over 300 dentists graduated so far thus improving the dentist-to-population ratio and helping the Sultanate to realize its most significant challenge of developing an Omani-majority dental workforce. Oman's dentist density remains lower than the GCC average and second worst in the region, substantially below high-income countries such as the UK and the U.S.A. **Well over half of the dental workforce works in the private sector with a total number of private dental facilities almost double the number of public dental clinics, while 74% of dentists working in the public segment are Omanis.** There is further need to strengthen the private sector as the demand for private sector facilities is growing and many patients prefer avoiding long queues in government facilities.

Oral Health Status

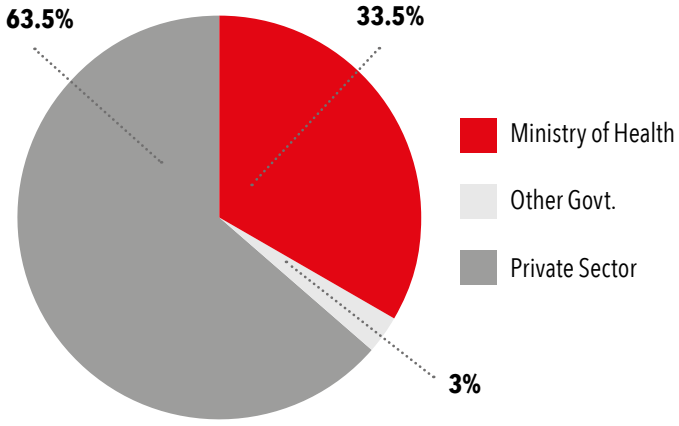
A recent local survey of adult health acts as a reminder that dental caries experience in adults remains high, and the majority of disease in children appears to be unmet. This suggests the need for a dentist workforce with a diverse range of skills, including good restorative and surgical skills, and highlights the importance of having a strong emphasis on oral health promotion as well as a dental team approach, very much lacking within the country. Almost all 6-year-olds (85%) have evidence of dental caries experience with an average of five teeth affected, high in relation to most countries. Although much has been done through important dental public

YEAR	2000	2010	2016
Number of Dentists	262	654	1,149
Dental Therapists	n/a	8	n/a
Dental lab technicians (over half working privately)	n/a	Between 85-128	n/a
Dental Hygienists/dental nurses	n/a	68	n/a
Private Dental Clinics	n/a	n/a	500

Source: Ministry of Health - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4490677/figure/Fig3/ / https://capp.mau.se/country-areas/oman/
Dr. S. Al Bulushi, Director of Dental & Oral Health Ministry of Health (2010)
www.wfpha.org/tl_files/doc/about/OHWG/Oral%20health%20and%20workforce%20issues%20OCo%20reflections%20from.pdf

High social welfare benefits, as well as access to medical facilities and doctors has greatly improved the lifespan of Omani citizens, as well as other health indicators, placing the country on a par with many advanced western nations.

DENTAL WORKFORCE DISTRIBUTION BY HEALTH SUB-SECTOR



health initiatives, especially in schools, contributing to promising oral health improvements amongst the 12-year-olds, however, the effects of dental caries in the permanent dentition are cumulative and lifelong.

Considering the high levels of dental caries experience in the Omani population, the rapidly increasing life expectancy and high-population growth, the existing dental workforce capacity, including the anticipated numbers of dental graduates from Oman Dental College, will be insufficient to meet the population needs in the foreseeable future. In addition, there is a need to develop a workforce of dental specialists with the introduction of postgraduate and specialty training programs. **Oman presently only supports specialty training in oral and maxillofacial surgery locally, thus, graduates seeking to train in other dental specialties must do so abroad, joining a general drift in healthcare workforce personnel with no, or limited, career development opportunities nationally towards countries which offer specialization and postgraduate education.** Health workforce migration is a challenge, and if Oman wishes to retain its workforce it must consider the necessary factors to monitor and manage migration, considering also that health education is state funded, while also recognizing the rights of healthcare workers. Furthermore, access to dental care should be equitable, and this will require a coordinated approach to ensure that intra-country planning and action ensures that dentists work across all areas of the country, rather than being concentrated in the capital city. There is an unquestionable need for primary prevention of oral and dental disease, supported by appropriately trained dental personnel. This approach involves team working and team training involving dental hygiene and/or dental therapists as well as dental nurses, in addition to community health workers promoting oral health. **There is a pressing need to establish a substantive and coordinated program of dental nurse training to ensure that there are enough suitably trained dental nurses to support the safe, effective practice of dentistry in the Sultanate, followed by wider team development.**

Domestic Medical Supplies

The Omani government currently spends an estimated OR120m ($311.7m) a year on

DMFT IN CHILDREN

AGE GROUP	% AFFECTED	DMFT*	YEAR
6 years		4.6 (DFT)	1994
6 years		4.25	2007
6 years	84.5%	5.1	2011
12 years		2.5	1991
12 years		1.5	1993
12 years	51%	1.3	2006
15 years		3.4	1996
15 years	60.5%	2.0	2006

**Note: DMFT = decayed, missing and filled teeth*
Source http://www.mah.se/CAPP/Country-Oral-Health-Profiles/EMRO/Oman/Oral-Diseases/Dental-Caries/

MEAN DMFT OF ADULTS IN OMAN*

AGE GROUP	Mean DMFT	CARIES FREE
23 – 50 years	6.3	7%

** Al Harthi L., Cullinan M., Leichter J., Thomson M. Oral health of an adult group in Oman – poster presentation at Oman International dental conference 2013*
Cross sectional study of 319 teachers who are randomly selected from Muscat Governorate public schools in Oman
Source: http://www.wfpha.org/tl_files/doc/about/OHWG/Oral%20health%20and%20workforce%20issues%20OCo%20reflections%20from.pdf

medicines, with more than 93% of medical supplies, including laboratory, surgical equipment, and pharmaceuticals, needing to be imported from abroad. There are at present only few pharmaceutical manufacturing plants ant there is an ongoing push to establish a domestic pharmaceuticals industry. Authorities in the country are also looking to local manufacturers to provide the healthcare system with 100% of its needs when it comes to more basic medical items, such as surgical gloves and gauze.

Several constraints affect trade and investment in Oman. The country has a relatively small population and there is no high-value consumer market beyond the capital area. This situation is exacerbated by intense competition from nearby global trading hub Dubai and well-established industries in Saudi Arabia. In addition, other countries in the GCC typically offer higher industrial subsidies and lower quotas for hiring nationals. **In fact, of particular concern for many international firms is the "Omanization" process, wherein the government sets quotas for Omani employment on a sectoral basis.** Many companies, both Omani and international, have noted that some of the quotas are difficult to satisfy. Further, obtaining labor clearances for new foreign workers can be a challenge. Despite considerable government efforts to replace expatriate workers with Omanis, Oman still heavily depends on South Asian and other foreign labor.

The divide between the government and the private sector is not well-defined in Oman, leading to potential conflicts of interest. Of note are the oligarchic, closely held businesses with familial ties to government officials. Government decision-making is often opaque. Firms that have been successful in Oman usually have previous experience in the Middle East or a full-time in-country representative or office.

Among main sources:
-Extracts from "Sultanate of Oman: Building a Dental Workforce". For full report: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4490677/
-Extracts from "Oman's health care system increasingly ready to meet the population's need". For full report, Oxford Business Group: https://www.oxfordbusinessgroup.com/overview/rise-growing-population-finds-health-care-system-ready-meet-its-needs
-U.S. Department of Commerce: https://www.export.gov/article?id=Oman-Healthcare
-http://www.wfpha.org/tl_files/doc/about/OHWG/Oral%20health%20and%20workforce%20issues%20OCo%20reflections%20from.pdf
-http://timesofoman.com/article/74784/Oman/Health/Inspections-start-as-soon-as-an-application-is-made-to-open-a-clinic-and-continue-throughout-the-lif
-https://www.cia.gov/library/publications/the-world-factbook/geos/mu.html
-The Economist Intelligence Unit: http://country.eiu.com/Oman
-International Monetary Fund: http://www.imf.org/en/Countries/OMN
-https://www.omanobserver.om/article/34709/Main/details-of-mandatory-health-insurance-in-oman-revealed
-Health Vision 2050, by Oman Ministry of Health
-https://www.omanobserver.om/article/6136/Main/health-insurance-mandatory-for-the-employees-of-the-private-sector-and-visitors

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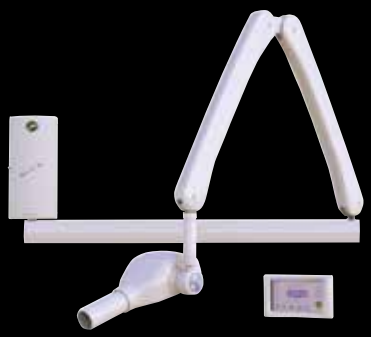

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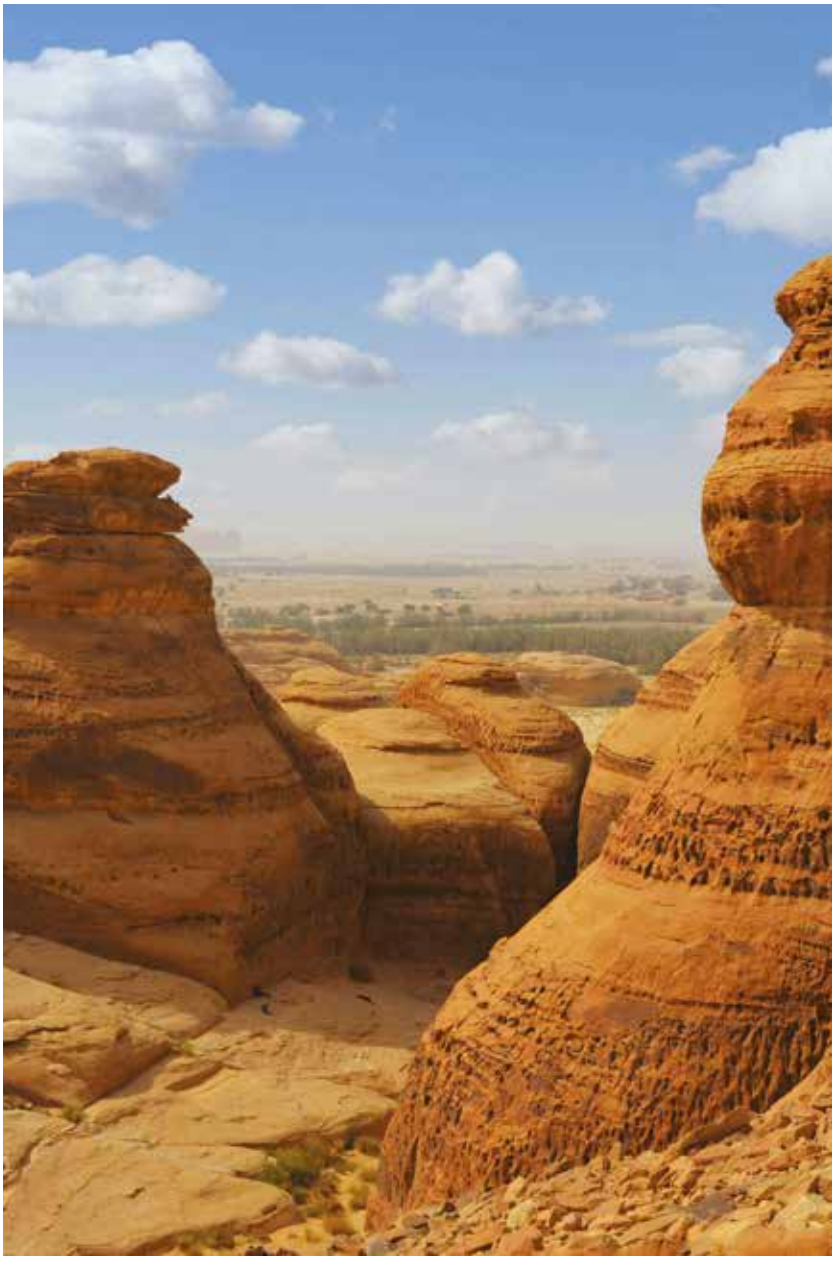
The Kingdom of Saudi Arabia

In spite of an increasing focus on oral hygiene and a growing demand for better oral healthcare, challenges remain within public primary healthcare centers, which play a central role in Saudi Arabia; while most dental care is provided by non-Saudi dentists, with rising unemployment among Saudi dentists, the governmental bodies have come up with a policy to gradually, but carefully, replace the non-Saudi dentists in both the public and private sectors.



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Public and Private Oral Healthcare

According to the Saudi constitution, healthcare services, including dental, are provided by the government and all citizens and residents have the right for complete and free accessibility to the health services. The healthcare system consists of a mix between the public (governmental) and private health sector. The same health services are provided by the private sector but under governmental supervision.

Although dental care services are supplied by the government at no cost, yet a large part of the Saudi population chooses to be treated in the private sector. Governmental primary dental care provides basic level of treatment; procedures such as implants, dentures, cosmetic dentistry, and other complicated procedures are not available in primary dental care and patients are referred to higher governmental dental centers with long waiting lists. On the other hand, in private practice patients receive the needed treatment and desired procedures in one place and in less time. Furthermore, most patients believe that, with paid care they can get enough time with doctors, better care and expect an enhancement in the way they look rather than just treating a dental problem.

As healthcare services budget remains one of the challenges faced by the Ministry of Health in the kingdom, a health insurance has been introduced to compensate a rapidly growing population and to maintain the desired level of health services at no cost. **The health insurance, planned to be extended to cover all Saudis in the future, is now compulsory for non-Saudis working in the private sector. Also, the government allows insurance companies to extend their services to cover the Saudis working in private companies who prefer to be treated in the private health sectors.** Healthcare insurance usually covers consultations, laboratory tests, diagnostic radiographs, medications, and follow-up. Unfortunately, many companies do not provide health insurance covering dental

DISTRIBUTION OF DENTISTS ACROSS PRIVATE AND PUBLIC SECTORS

SPECIALTY	Sector Private N (%)	Sector Public N (%)	Total
General Dentist	8,773 (74.85%)	3,151 (60.98%)	**11,924 (70.61%)**
Prosthodontics	721 (6.15%)	694 (13.43%)	**1,415 (8.38%)**
Pedodontics	242 (2.06%)	202 (3.91%)	**444 (2.63%)**
Periodontics	207 (1.76%)	180 (3.48%)	**387 (2.29%)**
Oral Maxillofacial Surgery	482 (4.11%)	432 (8.36%)	**914 (5.42%)**
Oral Maxillofacial Radiology	9 (0.08%)	8 (0.15%)	**17 (0.10%)**
Oral Maxillofacial Pathology	48 (0.41%)	57 (1.10%)	**105 (0.62%)**
Orthodontics	1,077 (9.19%)	296 (5.73%)	**1,373 (8.13%)**
Endodontics	201 (1.72%)	209 (4.04%)	**410 (2.43%)**
Dental Biomaterials	3 (0.03%)	9 (0.17%)	**12 (0.07%)**
Dental Public Health	49 (0.42%)	78 (1.51%)	**127 (0.75%)**

Note: data are expressed as frequency and percentage.
Source: http://www.sciencedirect.com/science/article/pii/S1319016417301603

CHARACTERISTICS OF SAUDI AND NON-SAUDI LICENSED DENTISTS

	Nationality Saudi No. (%)	Nationality Non-Saudi No. (%)	Total No. (%)
Age (average)	37.7	40.76	40.09
Gender: **Male** **Female**	 2,292 (61.45%) 1,438 (38.55%)	 8,019 (60.95%) 5,138 (39.05%)	 10,311 (61.06%) 6,576 (38.94%)
Sector: **Private** **Public**	 1,255 (33.65%) 2,475 (66.35%)	 10,465 (79.54%) 2,692 (20.46%)	 11,720 (69.40%) 5,167 (30.60%)
Specialist Dentists in Public Sector	924 (24.77%)	1,092 (8.30%)	2,016 (11.94%)
Specialist Dentists in Private Sector	428 (11.47%)	2,519 (19.15%)	2,947 (17.45%)

Note: data are expressed as mean ± standard deviation for age and frequency and percentage for the other variables.
Source: http://www.sciencedirect.com/science/article/pii/S1319016417301603

ORAL HYGIENE HABITS

Teeth brushed, at least once a day	71.5%
Never brushed teeth	16.3%
Use of dental floss, at least once a day	6.3%
Use of Miswak, at least once a day	30.3%

Dentists-to population (per 10,000 people) ratio	5.2
Dentist-to population ratio	1:1,880
Number of public dental clinics	2,408

care for its workers, as well as other medical conditions such as pregnancy and delivery, as it is usually expensive, or they create obstacles to minimize the use of insurance in dental care. These issues play a role in demoting the level of dental health especially between foreigners living in the kingdom, especially in the low educated category of workers.

Also, most licensed Saudi dentists are practicing in the public health sector (66.35%), because of high salaries and higher level of job security compared to the private sector.

Dental Workforce

The Saudi population faces difficulties to meet proper dental care, resulting in incompatibility between dental care provided in the public system and the increasing population with lifestyle changes, creating deficiencies in the quantity and quality of public dental care. **Over the last 20 years however, the Kingdom of Saudi Arabia has shown steady growth in the dental workforce. According to the Saudi Commission for Health Specialties (SCFHS), there were 16,887 licensed dentists as of December 2016, compared to 786 and 12,785 dentists in the year of 1987 and 2014, respectively, with the majority professionally registered as general dentists (70.6%).** Most dental care is still provided by non-Saudi dentists (77.91% of total number), with Saudi representing only 22.09% of the licensed dental workforce. Almost 70% of the licensed dentists are working in the three main regions of the kingdom (Riyadh, Makkah, and the Eastern province). Finally, around 80% of the non-Saudi dentists are working in the private sector compared to only 33.65% of the Saudi dentists and the percentage of non-Saudi dental specialists in the private health sector is also significantly higher than their Saudi counterparts. The fact that most of the Saudi dentists are registered as general dentists may be due to lack of accredited SCFHS residency programs in dental specialties within the kingdom.

A surprisingly high unemployment rate among fresh Saudi dental graduates can be attributable to significant growth in the educational sector, with the number of dentistry colleges that has increased to over 20, from a handful back in the year 2000. Also, most licensed Saudi dentists are practicing in the public health sector (66.35%),

DISTRIBUTION OF SAUDI AND NON-SAUDI DENTISTS IN DIFFERENT SPECIALTIES

SPECIALTY	Nationality Saudi No. (%)	Nationality Non-Saudi No. (%)	Total No. (%)
General Dentist	2,378 (63.75%)	9,546 (72.55%)	**11,924 (70.61%)**
Prosthodontics	532 (14.26%)	883 (6.71%)	**1,415 (8.38%)**
Pedodontics	174 (4.66%)	270 (2.05%)	**444 (2.63%)**
Periodontics	122 (3.27%)	265 (2.01%)	**387 (2.29%)**
Oral Maxillofacial Surgery	162 (4.34%)	752 (5.72%)	**914 (5.42%)**
Oral Maxillofacial Radiology	3 (0.08%)	14 (0.11%)	**17 (0.10%)**
Oral Maxillofacial Pathology	33 (0.88%)	72 (0.55%)	**105 (0.62%)**
Orthodontics	238 (6.38%)	1,135 (8.63%)	**1,373 (8.13%)**
Endodontics	156 (4.18%)	254 (1.93%)	**410 (2.43%)**
Dental Biomaterials	3 (0.08%)	9 (0.07%)	**12 (0.07%)**
Dental Public Health	45 (1.21%)	82 (0.62%)	**127 (0.75%)**

Note: data are expressed as frequency and percentage.
Source: http://www.sciencedirect.com/science/article/pii/S1319016417301603

because of high salaries and higher level of job security compared to the private sector. Furthermore, the ability of Saudi dentists to compete in the private market is limited due to employers' preference to employ non-Saudi who usually work more hours for less pay. All this has resulted in a decision (May 2017) by Saudi Arabia's Labour and Social Development Ministry, to stop recruiting foreign dentists in a bid to provide better employment opportunities for Saudis. **The "Saudisation" policy to replace, in almost all professions, foreigners with Saudis, is being inexorably implemented in the vast kingdom where foreigners make up one third of the total population.**

Oral Health Status

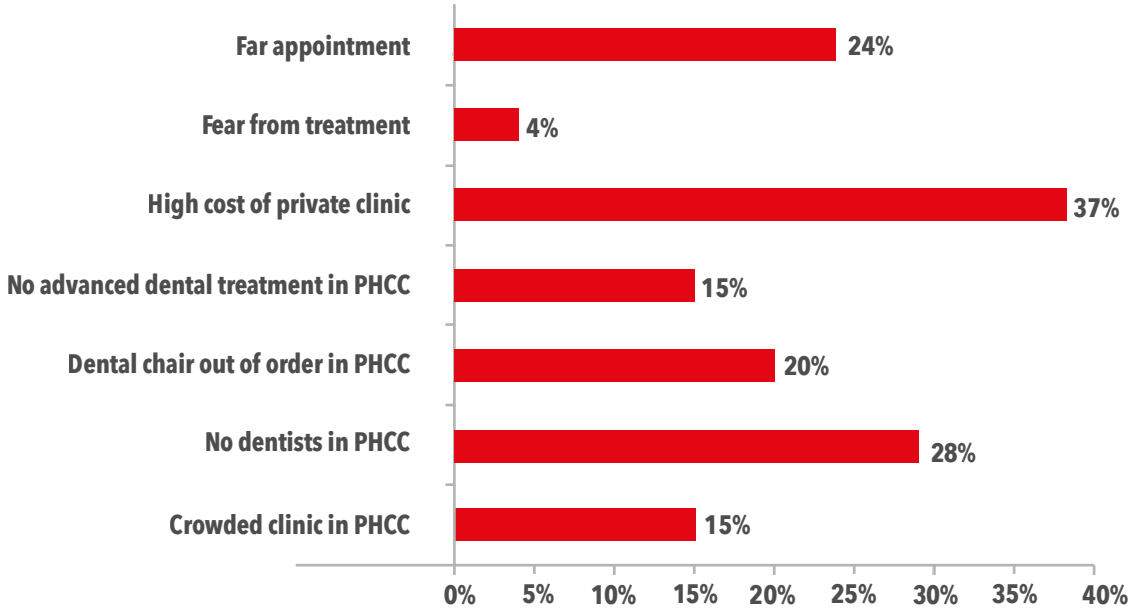
According to surveys, prevention and oral hygiene practices are limited. Only an estimated 11.5%-15% of Saudi Arabian people aged 15 and older visited a dental clinic for a routine check-up during the last year, whilst 48.6%-51% visited a dental clinic because of a complaint, 19% for dentures and 11% for braces.

The unavailability of a dentist in primary healthcare centers perhaps explains why most of the sampled patients indicated visiting private dental clinic more frequently (77 %) than public primary healthcare centers (45 %).

An interesting finding is the high prevalence of use of Miswak, a traditional chewing stick made from the plant *Salvadora persica* used as natural toothbrush. Among those who never brushed their teeth (16.3%), 93.2% also never flossed, but only 47.9% never used Miswak. **Lack of appropriate geographic distribution of primary healthcare centers often cause overcrowding in some centers and underutilization in others, causing a mismatch between primary healthcare services and population needs, a possible reason why caries prevalence in primary and permanent teeth and deepened periodontal pockets remain high among the population.** The ratio of one dentist to 1,880 people is in fact variable across regions, with the highest in Riyadh region (1:1536) and the lowest in Jizan region (1:4101). Nonetheless, the current dentists-to-population ratio of 5.2 per 10,000 people, remains higher than most developing countries and the Asia-Pacific region.

MAJOR DIFFICULTIES IN SEEKING DENTAL CARE

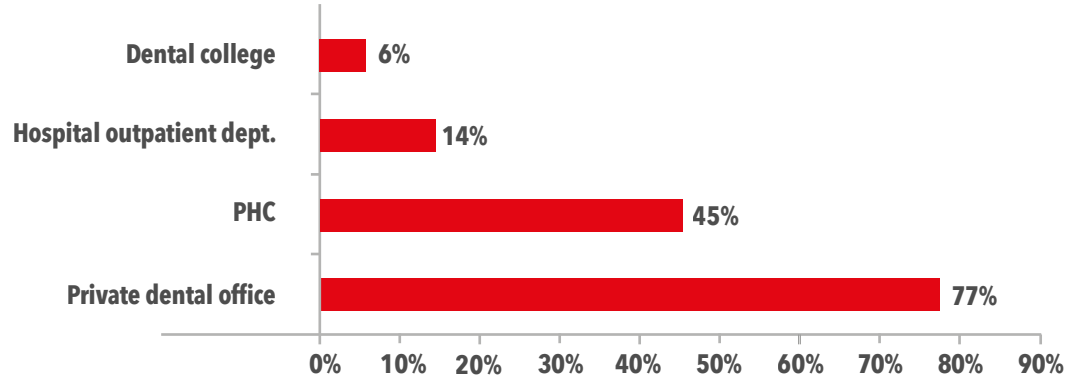
% patients considering major challenge



Note: PHCC = Primary Healthcare Center

Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5096290/

WHERE PATIENTS TYPICALLY RECEIVE DENTAL TREATMENT



Note: PHC = Primary Healthcare
Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5096290/

In general, dental clinics in Saudi Arabia provide standardized preventive and curative oral health care services. About 2,408 public dental clinics provide oral healthcare. These providers are classified as clinics in primary healthcare centers, dental clinics located within hospitals and dental clinics in specialized centers. There are also portable dental clinics that provide similar services. The unavailability of a dentist in primary healthcare centers perhaps explains why most of the sampled patients indicated visiting private dental clinic more frequently (77 %) than public primary healthcare centers (45 %). Patients reported lack of advanced dental treatments in primary healthcare centers given that these centers are known for primary dental treatment.

Among main sources:
-Extracts from "The characteristics and distribution of dentist workforce in Saudi Arabia: A descriptive cross-sectional study". For full survey: http://www.sciencedirect.com/science/article/pii/S1319016417301603

-Extracts from "Primary health care centers, extent of challenges and demand for oral health care in Riyadh, Saudi Arabia". For full survey: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5096290/-Extracts from "Use of dental clinics and oral hygiene practices in the Kingdom of Saudi Arabia, 2013". For full survey: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4834803/
-http://gulfnews.com/news/gulf/saudi-arabia/ban-on-recruiting-foreign-dentists-means-more-jobs-for-saudis-1.2025564
-Journal of International Oral Health 2016 "Health-care System and Accessibility of Dental Services in Kingdom of Saudi Arabia: An Update

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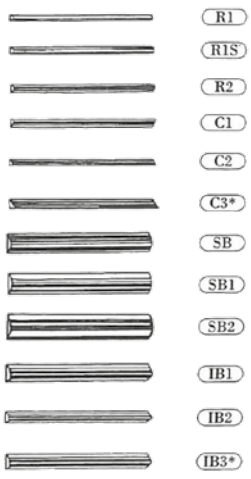

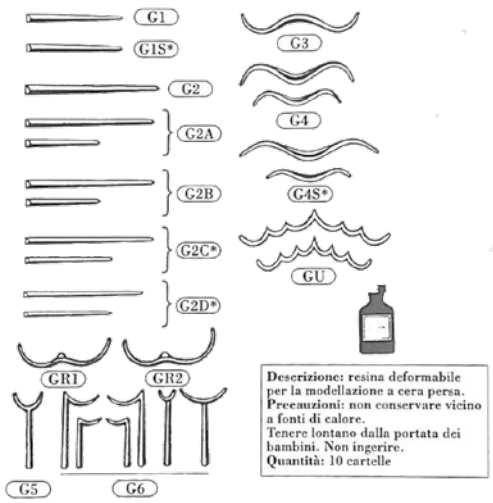

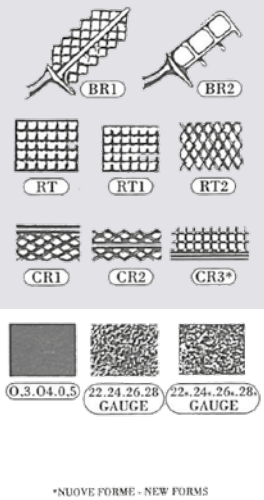

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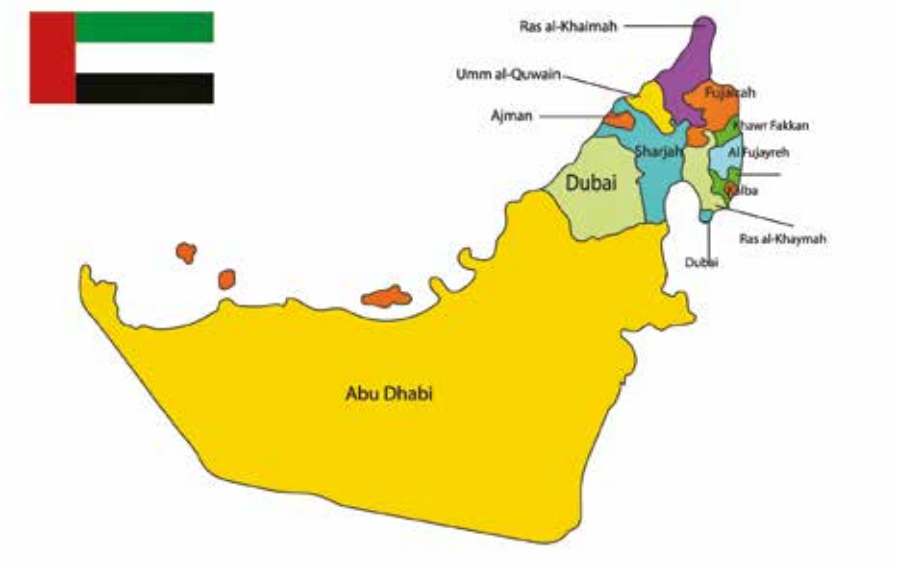
The United Arab Emirates (UAE) is a federation of seven emirates with a population of 9.8 million made up of various demographic groups from different ethnic, cultural, and socioeconomic backgrounds. Demographic factors such as an aging population, high birth rate, and expatriate majority have resulted in an increase in healthcare expenditures. **Health insurance coverage is universal for nationals, and laws have been instituted to ensure health insurance to be mandatory for nonnationals in the emirates. There is nonetheless a tendency, from insurance companies, to increasingly exclude dental care within their insurance coverage, mainly due to high costs of treatment.**



NO. OF DENTISTS IN THE UAE

Total no. of Dentists	6,273
Dentists per 10 000 population	7
Male	2,987
Female	3,286
Working in the public sector	845
Working in the private sector	5,428

Source: UAE Ministry of Health & Prevention, Report 2018

The UAE dental market focuses on high quality products and advanced technology. Most clinics and dental offices are equipped with modern and innovative devices and dentists focus on high-level treatments for their patients. According to statistics from the UAE Ministry of Health and Prevention, there are over 6,000 dentists in the UAE, of which around 90% are non-nationals. In recent years, there has been a strong influx of foreign professionals, a trend also characterizing the whole health sector, not only because of growth in the resident population and in investments in service facilities, but also due to higher salaries for professionals as well as health tourism growth. The growing medical-dental tourism is generating further demand for modern facilities and advanced equipment.

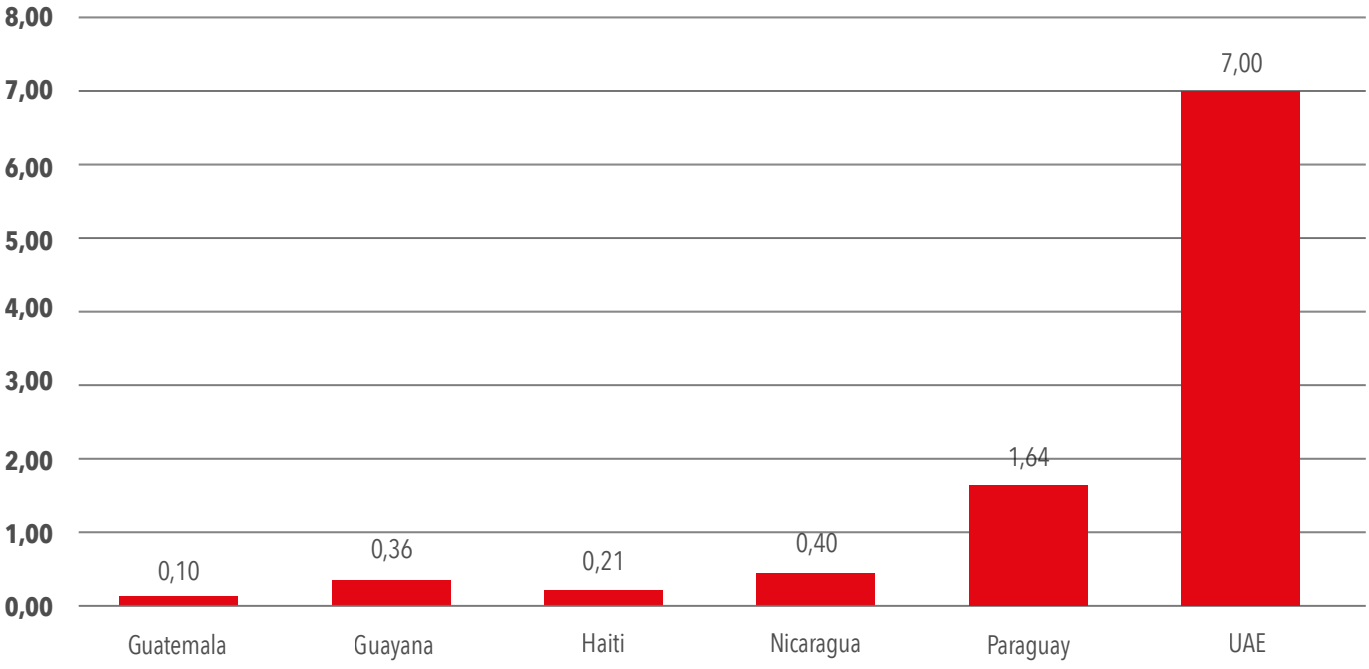
NO. OF DENTISTS BY EMIRATE

	No. of Dentists	Dentists per 10 000 population
Abu Dhabi	2,149	8
Dubai	2,322	5
Sharjah	1,025	9
Ajman	307	9
Umm Al Quwain	58	6
Ras Al Khaimah	232	5
Fujairah	180	7

Source: UAE Ministry of Health & Prevention, Report 2018

DENTISTS PER 10 000 POPULATION

As per below mentioned countries, Highest dentist density per 10 000 population is in UAE with 7.
Second highest dentist worker density per 10 000 population is in Paraguay with 1.64.



The strong growth in the number of dentists has created oversupply and competition. Most dental professionals (over 45% of the total) are concentrated in the Emirate of Dubai, followed by Abu Dhabi (31.8%). As in many countries, most dentists (85%) are working in the private sector. Public services are mainly used by Emirati citizens and offer almost exclusively basic dental care. More generally, the UAE has a relatively advanced healthcare system in terms of facilities, even if it suffers from a shortage of qualified and specialized staff. Both public, but mainly private investments are resulting in many health facilities, including dental clinics, being under construction or refurbished.

Emirate of Dubai

According to the Dubai Health Authority's (DHA) annual statistical book, Dubai has about 3.4 physicians per 1,000 people. **The proportion of dentists and nurses per 1,000 people has reached 0.8 and 7.2, respectively. These data indicate a gap in the number of health care professionals per population ratio especially for dental health services.** On this regard, the results of an oral screening conducted on schoolchildren (2013) in Dubai showed that children from different age groups have high levels of oral health problems, with a caries prevalence of 65% among children under the age of 7 and a DMFT of 3.8. In addition, in 2016, out of 164,036 patients treated in dental clinics of the Dubai Health Authority (DHA), 20% of these treatments were related to periodontitis. Dental health services in the Emirate of Dubai are provided by the governmental sector managed by Dubai Health Authority (DHA), and by the private sector. Community Dental Services (government sector) are linked to the Primary Oral Health Care Centers. There are 14 health care centers spread all over Dubai providing multidisciplinary approach (oral surgery, orthodontics, periodontics, conservative, restorative, and community dentistry) where comprehensive treatment is available to the public, free of charge.

In recent years, there has been a strong influx of foreign professionals, a trend also characterizing the whole health sector, not only because of growth in the resident population and in investments in service facilities, but also due to higher salaries for professionals as well as health tourism growth.

UAE Dental Market in Figures

Dental products and devices are supplied to the market essentially through imports, since local production covers only a small part of the demand and mainly low value-added products.

Among main Sources:
- Abu-Gharbieh, Eman & Saddik, Basema & Faramawi, Mohammed & Hamidi, Samer & Basheti, Mohammad. (2019). Oral Health Knowledge and Behavior among Adults in the United Arab Emirates. BioMed Research International. 2019. 1-7. 10.1155/2019/7568679. https://www.researchgate.net/publication/330917698_Oral_Health_Knowledge_and_Behavior_among_Adults_in_the_United_Arab_Emirates

-Italian Trade Commission ITA, Italian Dental Industry Association -UNIDI
-WITS-World Integrated Trade Solution - https://wits.worldbank.org/trade/country-byhs6product.aspx?lang=en
-United Arab Emirates Ministry of Health & Prevention https://www.mohap.gov.ae/en/OpenData/Pages/default.aspx
- https://capp.mau.se/bank-of-ideas/united-arab-emirates-dental-public-health-programs-implemented-by-dental-services-department-dubai/

EXPORTS (MILL. EUROS) OF DENTAL PRODUCTS TO THE UAE

	2013	2015	2017	2017 (Jan-Oct.)	2018 (Jan-Oct.)	Market Share (%) 2017	Market Share (%) 2018 (Jan-Oct.)
TOTAL	**349**	**493**	**525**	**422**	**425**	**100**	**100**
United States	59	95	107	93	88	20.4	20.7
Germany	54	86	77	60	64	14.7	15.1
China	29	45	41	29	35	7.8	8.2
UK	35	39	42	31	32	8.0	7.5
Netherlands	17	32	33	28	29	6.3	6.8
Belgium	11	23	36	27	28	6.9	6.6
Italy	13	25	22	16	17	4.2	4.0
Switzerland	13	22	24	20	16	4.6	3.8
South Korea	10	14	26	21	14	5.0	3.3
Saudi Arabia	11	18	18	15	11	3.4	2.6

Source: Data processed by the ITA-Italian Trade Agency from Trade Data Monitor source

EXPORTS TO UAE OF DENTAL INSTRUMENTS AND APPLIANCES, MARKET SHARE (%)

	(Products: 901849)	
	2017	**2018 (Jan.-Oct.)**
Germany	37.8	30.5
Japan	8.1	10.9
China	7.8	8.6
Switzerland	8.9	8.6
United States	6.4	8.2
France	3.9	5.2
Netherlands	0.3	5.1
Italy	4.7	4.3
Poland	4.0	3.5
South Korea	4.3	2.9

Source: Data processed by the ITA-Italian Trade Agency from Trade Data Monitor source

EXPORTS TO UAE OF DENTAL X-RAYS, MARKET SHARE (%)

	(Products: 902213)	
	2017	**2018 (Jan.-Oct.)**
Finland	29.4	40.1
Germany	31.5	16.0
Japan	8.7	15.6
Italy	14.0	12.5
South Korea	4.9	6.4
France	3.3	4.5
Slovakia	4.7	2.2
United States	0.7	0.8
India	0.8	0.8
China	1.1	0.6

Source: Data processed by the ITA-Italian Trade Agency from Trade Data Monitor source

EXPORTS TO UAE OF DENTAL DRILLS, AND OTHER DENTAL EQUIPMENT, MARKET SHARE (%)

	(Products: 901841)	
	2017	**2018 (Jan.-Oct.)**
Italy	58.0	46.4
China	8.0	17.6
South Korea	5.9	11.4
Germany	9.5	8.1
Switzerland	2.9	7.2
Slovakia	0.8	2.3
United States	3.3	2.2
UK	0.3	1.7
Netherlands	0.2	1.1
South Africa	0.0	0.9

Source: Data processed by the ITA-Italian Trade Agency from Trade Data Monitor source

EXPORTS TO UAE OF DENTAL PROSTHESIS (NOT ARTIFICIAL TEETH), MARKET SHARE (%)

	(Products: 902129)	
	2017	**2018 (Jan.-Oct.)**
Switzerland	24.1	28.0
United States	13.5	27.6
South Korea	43.5	26.8
Germany	5.4	5.3
Netherlands	5.6	5.2
Italy	2.8	2.3
UK	0.1	1.4
France	0.8	1.3
South Africa	0.0	0.8
Jordan	1.4	0.7

Source: Data processed by the ITA-Italian Trade Agency from Trade Data Monitor source

EXPORTS TO UAE OF ARTIFICIAL TEETH, MARKET SHARE (%)

	(Products: 902121)	
	2017	**2018 (Jan.-Oct.)**
United States	38.4	66.8
India	1.0	12.1
UK	4.8	6.9
Japan	0.5	3.4
Italy	1.1	2.5
Germany	2.4	2.4
Switzerland	49.9	2.1
Hungary	0.7	1.4
South Korea	0.3	0.9
Netherlands	0.0	0.6

Source: Data processed by the ITA-Italian Trade Agency from Trade Data Monitor source

EXPORTS TO UAE OF MEDICAL-SURGICAL-LABORATORY STERILIZERS, INCLUDING AUTOCLAVES, MARKET SHARE (%)

	(Products: 841920)	
	2017	**2018 (Jan.-Oct.)**
Italy	19.9	44.5
Belgium	3.2	15.4
Sweden	9.3	11.6
China	16.6	6.0
Germany	9.7	3.5
UK	2.7	3.1
India	3.6	2.9
Turkey	4.3	2.0
Slovenia	3.6	1.9
South Korea	2.3	1.9

Source: Data processed by the ITA-Italian Trade Agency from Trade Data Monitor source

EXPORTS TO UAE OF ORAL HYGIENE PRODUCTS, MARKET SHARE (%)

	(Products: 330610)	
	2017	**2018 (Jan.-Oct.)**
UK	25.8	22.6
Thailand	9.6	13.3
Saudi Arabia	15.6	11.8
China	6.0	10.5
Egypt	6.5	5.0
Belgium	7.7	4.6
India	3.4	3.9
Italy	3.6	3.3
Indonesia	2.5	2.4
Poland	2.8	1.6

Source: Data processed by the ITA-Italian Trade Agency from Trade Data Monitor source

EXPORTS TO UAE OF GYPSUM, MARKET SHARE (%)

	(Products: 252020)	
	2017	**2018 (Jan.-Oct.)**
Iran	30.9	37.8
Thailand	15.6	15.7
UK	17.7	15.1
Turkey	4.4	8.3
Saudi Arabia	9.8	7.9
Germany	1.8	5.0
United States	2.1	3.5
France	11.9	3.4
Italy	0.8	1.0
Spain	0.9	0.8

Source: Data processed by the ITA-Italian Trade Agency from Trade Data Monitor source

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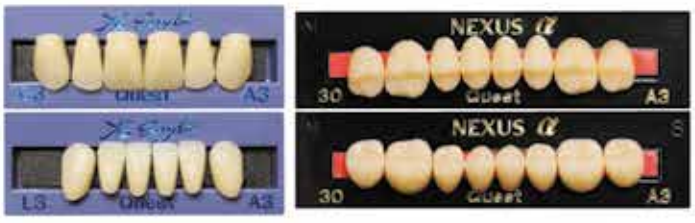

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NON PROFIT Give Back a Smile

Every year, more than five million people are affected by domestic violence in the United States and Canada. While great efforts have been made to raise awareness of this issue, little has been publicized concerning the dental problems victims may face. Victims may experience trauma to the jaw, including broken, chipped and knocked-out teeth. There is a significant need for programs like Give Back a Smile, whose member dentists are giving back by restoring the smiles of domestic abuse survivors. Give Back a Smile is dedicated to helping victims of domestic violence reclaim their smiles, their self-esteem and their lives. The Give Back a Smile program is a charitable foundation of the American Academy of Cosmetic Dentistry, a prominent national dental association committed to the art and science of cosmetic dentistry. Through the American Academy of Cosmetic Dentistry Charitable Foundation (AACDCF), the Give Back a Smile program is dedicated to providing cosmetic dental care at no cost to survivors of domestic violence by:

- Raising awareness
- Providing volunteer members of the AACD
- Giving survivors hope for a better tomorrow

Since its inception in 1999, over 900 dental treatment cases have been completed, resulting in over $9 million dollars' worth of donated dental work. Today, over 350 patients are being treated through the program. The American Academy of Cosmetic Dentistry's efforts to give back to the community has earned it worldwide recognition, including the 2001 Award of Excellence from the prestigious Associations Advance America Summit Awards, which recognizes excellence in charitable organizations.

The Whitening Fundraiser

You don't have to be a cosmetic dentist to participate in Give Back a Smile. The recent establishment of the Give Back a Smile Whitening Program allows everyone to give back and help heal the effects of domestic violence while whitening their smiles. Discus Dental, Inc., the makers of the Zoom!® teeth whitening system, have agreed to donate whitening kits to volunteer dentists. Profits from the purchase of these dental products will be donated to the AACD Charitable Foundation. For a list of participating providers, contact the American Academy of Cosmetic Dentistry.

Eligibility

Both men and women who have received injuries from a former partner or spouse are eligible for the Give Back a Smile program. Give Back a Smile is only responsible for correcting injuries to teeth in the smile-zone as a result of domestic violence. A volunteer dentist will perform an exam to finalize entry into the program and rule out other causes, such as previous neglect.

To meet the Give Back a Smile program's requirements, individuals must have been out of an abusive relationship for at least a year. Survivors are required to provide proof of domestic abuse, such as a signature from a counselor, social worker or case manager. Potential patients must fill out an application and undergo an interview process prior to being matched with a participating dentist who will make the final decision on the applicant's acceptance into the program.

Contact Information

If you or someone you know is a domestic abuse survivor in need of dental care, you can contact Give Back a Smile for help. You may apply online at www.givebackasmile.com or call their hotline at (800) 773 4227 or send an e-mail to **givebackasmile@aacd.com**.

Donations can be made to the AACD Charitable Foundation at the address listed below. There is a waiting list of applicants in some areas and volunteers are needed to help. The AACDCF needs dentists, laboratory technicians and other dental professionals to donate time and services to survivors of domestic abuse. If you're interested in giving back to your community, consider participating in the Give Back a Smile program.

For further information on the Give Back a Smile program, please contact the American Academy of Cosmetic Dentistry.

The Give Back a Smile program is a charitable foundation of the American Academy of Cosmetic Dentistry, a prominent national dental association committed to the art and science of cosmetic dentistry.

American Academy of Cosmetic Dentistry
402 West Wilson St.
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Article taken from:
www.1800dentist.com/dental-charities/give-back-a-smile

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