INTERNATIONAL & NATIONAL STANDARDS & PRACTICE GUIDELINES
WHO=World Health Organization & its divisions & collaborating partners.
HHS=Dept of Health & Human Services & its divisions & collaborating partners.

HOW THE PROGRAM HAS BEEN USED BY HOSPITAL/CLINIC MEDICAL TEAMS (Integrating Community Health into Primary Care Practice)

MEDICAL TEAM GOALS:
To enable medical teams to have a sustainable, long-term culture-changing influence by introducing high quality holistic health care services to the community
(Save the most lives and prevent the most suffering)
By
1. Enabling the provision of **safe, high quality, individual** medical care by **team doctors and local health care providers (Integrating community health into primary care practice.)**
2. Introducing desperately needed evidence-based (E-B) holistic health education services **for clinics, schools and churches to assist their communities and healthcare providers.**
(The information required for community health education is the very same information required for high quality individual health care)

Documentation of the critical importance of evidence-based health education in "Saving the most lives and preventing the most suffering" can be found at the following **link**

I. PHYSICIAN-PHYSICIAN & PHYSICIAN-PATIENT EDUCATION

BACKGROUND: Over the past several years, numerous international standards and practice guidelines have been established and published for the care of patients in developing countries. In nearly all cases, medical standards for host developing countries are based on World Health Organization (WHO) evidence-based standards and guidelines, which are posted on its website **www.who.int** and are now available free for downloading. (See also Best Practices in Global Health Missions website: **http://bpghm.org/**)

Compliance with current evidence-based standards and guidelines requires much that is different from our usual practice in the U.S. One of the most important differences is that our patients in developing countries are at much greater risk of harm from our medicines than patients back home. See Best Practices in Global Health Missions: **Why Patients are at Much Greater Risk of Harm From Drugs in the Short-Term Missions Setting**

The WHO also reports that at least 70% of the conditions we treat are preventable. WHO and U.S. evidence-based guidelines emphasize the need for providing preventive education for these conditions. For example, the medications we use for bacterial and parasitic diseases are among those that have been proven to be effective and they are often life-saving. However, without counseling emphasizing the importance of basic sanitation, our patients will very soon be ill again.

Curative primary care is essential for at least 30% of our patient's healthcare problems, and we must continue our efforts to provide and teach high quality curative services in accordance with WHO evidence-based guidelines for patients of developing countries. However, if we wish to provide high quality, evidence-based care for the remaining 70%, integration of community health with primary care is also essential.

The importance of integration community health into primary care practice cannot be overemphasized. (For example, see the 2008 WHO World Health Report which was devoted entirely to Primary Care). This integration is also strongly emphasized by the U.S. Department of Health and Human Services and the AMA for physicians in the US (For example see: *Roadmaps for Clinical Practice*. *A Primer on Population-Based Medicine*).

The Lancet (Volume 372, Issue 9642, 13 September 2008) reports that the very future of our health care systems is dependent on our ability to implement this approach.

The *Health Education Program for Developing Countries* has been used to integrate community health into primary care at all levels of the WHO health care pyramid (Hospital, Clinic/Health Center, and Family/Community[Includes Churches & Schools]) in both rural and urban areas, and in developed as well as developing countries all over the world. And it is used with or without the concurrent provision of curative care services (See **How the Program Has Been Used by Health Screening Medical Teams)**

QUALITY OF CARE REQUIREMENTS: To meet the above international and national standards and guidelines for adequate quality care in our use of drugs in the STM setting is no easy task. However, if we truly wish to assist local clinics, schools and churches in their efforts to help their communities, compliance is absolutely necessary.

It is therefore essential that team providers not only be competent in primary care, but also practice in accordance with the international and national standards and practice guidelines that apply to the unique diseases of the community we will be entering.

To enable compliance with those standards and guidelines, when curative care services are provided, a hospital or clinic setting, utilizing locally available drugs from the WHO Essential Medicines and/or Model Lists is nearly always required.

It is also important to recognize that, with access to the internet and WHO guidelines, local healthcare providers now often have a better understanding of applicable evidence-based international standards and practice guidelines than we do, and are using available resources far more effectively. Even more important, the local physician knows the culture. And more important still, the local physician knows the patient and/or can ensure appropriate follow-up. It is therefore absolutely essential that we always work alongside local physicians, in a true partnership, and recognize that the Physician-Physician education is mutual.

What nearly all communities lack most are the resources to integrate community health into primary care practice in accordance with the above guidelines. And here we can provide a critically important service.

PROGRAM USE: The enclosed *Health Education Program for Developing Countries* Notebook is provided for your review prior to your upcoming medical trip. The illustrations you will use will depend on the particular needs of the patient population. Most physicians routinely use less than fifteen of the illustrations and either remove those most commonly used from the notebook, or identify them with the large colored paperclips, for easy retrieval. Because of limited physician time, some conditions will always require referral to the Team Health Educator for additional counseling, as described below.

To maximize the mutual learning experience, we usually alternate our team and local physician partners on a daily basis. In many cases, the local physician will also act as your interpreter.

After using the Notebook in our clinics, please turn it in to your team leader. The team leader will leave the program materials with the local physicians and educators to provide ongoing evidence-based holistic health education services after we leave.

The program will continue to be updated to incorporate evidence-based changes in international medical guidelines. Please send any questions or evidence-based recommendations for improvements to **edit@hepfdc.info** For further information and/or free downloading and copying of the program see **www.hepfdc.info**

Though WHO guidelines are lifesaving, some are relatively complex and take time to properly demonstrate. Referral to **Team Health Educators** enables team and clinic compliance with international and national standards of care. As noted in the following link, no position is more important in our efforts to Save the **Most** Lives and Prevent the **Most** Suffering

II. TEAM & LOCAL HEALTH EDUCATORS

A minimum of two team members are assigned as **Team Health Educators.** --At least one or two to provide health education to **groups of patients** waiting to be seen. The others to provide **individual** health education to patients referred by team/local physicians for conditions requiring time-consuming counseling. (Usually the Health Educators alternate positions.)

Whenever possible, the interpreters assigned to the Team Health Educators will be the local educators who will be responsible for carrying on the education program after we leave. They soon have much of the information memorized and use the Handbook and Illustrations to teach others, utilizing the cultural and participatory approach that is most effective for their particular community.

A copy of the Health Ed Program Notebook is sent to each Health Educator as part of their team packet. The **Notebook (written Handbook & Illustrations)** will often be in the local community's language (Spanish/ Mandarin/French/Khmer) so it can be left with the local educators. A copy of the written Handbook in English will usually be included for the Health Educator (If not included, a copy may be downloaded free at **www.hepfdc.info**).

Team Health Educators also use the large **poster-size illustrations or large screen projectors** to discuss the most critical community-specific health problems with groups of patients as they are waiting to be seen. (This is especially helpful when waiting times are long. Also, when all arrivals can not be evaluated, they may be referred for follow up health education services provided by the local clinic, school or church educators after we leave.)

A qualified physician will be appointed to serve as consultant for those questions the Health Educator is unable to answer. In practice, most potential questions are addressed in the Handbook, and additional consultation is seldom needed. (Please also refer any important questions that are not addressed in the program to **edit@hepfdc.info** for incorporation into future updates.)

Medical Directors assign sections of the *Health Education Program For Developing Countries* for **group presentation** based upon the community's most critical health care needs:
1. Topics most often requested for presentation to **groups of patients** include:

-Sections 1to11(Includes the common causes of death in the developing world. Also introduces holistic health care). Additional frequently requested topics include:

-Respiratory Infections (Sections 29, 30A&B)
-HIV/AIDS (Sections 4 & 5)
-Accident Prevention (Sections 44, 45, 46, 47 & 48)
-Safe Food Preparation (Section 17A&B)
-Recovering from Disasters & Other Traumatic Events (Section 49)

as well as those listed under the following:

2. Topics most often requested from physician referrals for additional **individual counseling** vary depending on the location, however, because of limited physician time, conditions such as the following will nearly always require referral to the Health Educator:
-CDC/WHO Lifesaving Guidelines for Treatment of Diarrhea (Sections 22-27)
-Problems with Breastfeeding (often a death sentence in developing counties) (Section 20)
-Heart disease, Stroke, Type 2 Diabetes (Sections 38 & 41)

See the HEPFDC **Participatory Approaches** page for additional information on **PARTICIPATORY HEALTH EDUCATION APPROACHES & MATERIALS (For Clinics, Schools, Churches, Health Screening Events, Health Fairs, Community Health Educators, Etc.)**.

Lesson Plan and **Picture Book versions** of the program specifically developed to assist Community Health Educators (CHEs) and others in the participatory approach can also be downloaded free at: **CHE Lesson Plans** and **Picture Books** (We are deeply indebted to Jody Collinge, MD, FAAP, and the Global CHE Network for these excellent resources.)

Disclosure/Conflict of Interest Validation: The author (editor), illustrator and HEPFDC receive no royalties or compensation of any kind related to the "Health Education Program for Developing Countries" or its website.

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