



HEALTH EDUCATION PROGRAM FOR DEVELOPING COUNTRIES

HOW THE PROGRAM HAS BEEN USED BY MEDICAL TEAMS

MEDICAL TEAM GOALS:

To enable medical teams to have a 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.**
2. Introducing desperately needed evidence-based (E-B) holistic health education services **for clinics, schools and churches to assist their communities.**

(The information required for community health education is the very same information required for high quality individual health care)

PHYSICIAN-PHYSICIAN AND 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 Christian Short-term Healthcare Missions Best Practices website: <http://csthmbestpractices.org/ConsensusDocuments.html>)

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 Christian Short term Healthcare Missions Best Practices: <http://csthmbestpractices.org/resources/Harm+from+Drugs+in+the+STM+Setting+Jan09.pdf> The WHO also reports that over 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 integration of primary care and community health was one of the main themes of the 2008 WHO World Health Report which was devoted entirely to Primary Care. This integration is also being promoted by the U.S. Department of Health and Human Services and the AMA for physicians in our country: *Roadmaps for Clinical Practice. A Primer on Population-Based Medicine.*

The "Health Education Program for Developing Countries" has been used to integrate primary care and community health evangelism at all levels of the WHO health care pyramid (Hospital, Clinic/Health Center, and Family/Community), 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.

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 your 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 for counseling, some conditions will always require referral to the Team Health Educator, as described below.

If you do not speak the host country language, we will attempt to assign a physician as your interpreter. It is important to recognize that the Physician-Physician education is mutual, and 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.

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. Team members who wish additional copies for personal use and prefer not put together their own may purchase them at cost via the link below.

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

TEAM HEALTH EDUCATOR

Usually at least two team members are assigned as **Team Health Educators**. --One to provide health education to **groups of patients** waiting to be seen. Another to provide **individual** health education to patients referred by team physicians for conditions requiring time consuming counseling. (Usually the Health Educators alternate positions.)

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) 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 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 refer any important questions that are not addressed in the program to edit@hepfdc.info for incorporation into future updates.)

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.

Team leaders assign sections of the Handbook for presentation based upon the community’s most critical health care needs:

1. Topics most often requested for presentation to **groups of patients** include: Sections 1-11(Includes the most common causes of death in the developing world. Also introduces holistic health care, and assists with crowd control). Additional frequently requested topics

include Sections 30A&B (Respiratory Infections), as well as those listed under the following:

2. Topics most often requested from physician referrals for **individual counseling** vary depending on the location, however, because of lack of 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 and Stroke [Section 41], and
- Type 2 Diabetes [Sections 38 & 41]

The critical importance of the Team Health Educator to meeting Short Term Medical Team goals of “saving the most lives and preventing the most suffering” is indicated by the following examples:

1. The WHO (Oct 05) reports that at least **80% of Premature Heart Disease** (#1 Cause of Death), **80% of Stroke** (#3 Cause of Death), **80% of Type 2 Diabetes** (#6 Cause of Death), and **40% of Cancer** (#2 Cause of Death) **could be prevented through the educational guidelines demonstrated by the two illustrations for Section 41 alone**
2. **WHO recommendations for breast feeding** until at least 2 years of age. Not only reduces dental carries from bottle feeding, but reduces deaths due to bacterial contamination with bottles, as well as saving numerous additional lives due to breast milk antibodies. WHO reports this would save **over 1 million lives** per year.
3. **Under-nutrition** contributes to **53% of the deaths of children under age 5**. Yet poor families often spend their food money on sweets for their children as that is one of the few things they can afford to give them as treats. Educating parents to the harm this does not only prevents dental carries, but saves lives lost to the deadly combination of under-nutrition and infectious disease. It also offers the opportunity to provide holistic care by discussing better ways to show love for their children (See also “Health Education Program for Developing Countries” Sections 2B and 30B).
4. **“Smoking is the single greatest cause of avoidable morbidity and mortality...harms nearly every organ of the body.”**--Surgeon Generals Report 2004. Evidence-based sources report that although only 15% of our of our medical treatments for all other conditions have been proven to be beneficial, **education for smoking cessation meets the very highest possible evidence-based ratings for effectiveness. Your teaching saves the life of one of every two patients who decide to quit smoking**
5. **Misconceptions about AIDS**. The belief that having sex with a virgin will cure AIDS is a common cause of sexual abuse in children. Challenging just this one belief could save untold deaths and suffering.
6. **Diarrhea is responsible for 17% of the deaths** of children under age 5. The CDC reports that diarrhea medications increase morbidity and mortality. (It is not the vomiting or diarrhea that kills these children, but the dehydration)
 - a. Though CDC/WHO guidelines are lifesaving, they are relatively complex and take time to properly demonstrate. The Team Health Educator enables STHMs to meet the CDC/WHO standards for care.
 - b. This Education **Rx also enables the provision of E-B high-quality life-saving care for all future episodes of diarrhea. (Long Term Impact)**
 - c. As most patients have great respect for western medicine, your teaching enhances patient acceptance of the program when later provided by local educators. **(Long Term Culture Changing Impact)**

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.