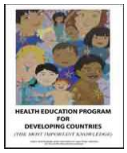

HEALTH EDUCATION PROGRAM FOR DEVELOPING COMMUNITIES (HEPFDC)

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

I. MEDICAL TEAM GOALS:

To enable medical teams to have a long term culture changing influence by collaborating with the Ministry of Health, churches and local community to provide high quality holistic health care services (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 hospitals, clinics, schools and churches to assist their communities in resolving the more than 70% of health problems that are preventable.**

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

II. THE HEPFDC & INTERNATIONAL STANDARDS

Care provided by medical missions must meet the legal requirements and medical standards and practice guidelines of the host country. In nearly all cases, developing country medical standards are based on those of the World Health Organization (WHO) with its 194 member countries. (See also Best Practices in Global Health Missions)

Although there are tens of thousands of health education materials available through the internet and elsewhere, very few meet the above requirements. **What makes the HEPFDC important is that its content does not come from us, but from WHO international evidence-based standards and guidelines.**

III. VISION/PLANNING TRIPS & MINISTRY OF HEALTH APPROVAL

Vision/ Planning Trips by at least one team leader are essential and are addressed in Section I of the Community Health Screening & Education (CHS&E) Guidelines. Goals include:

1. Establish ***ongoing collaboration*** between 3 main groups: a. Community b. Local Faith-Based Organization (FBO) c. Ministry of Health (MoH)

2. Determine greatest needs and assets of the above 3 groups.

3. Obtain MoH approval of HEPFDC Health Promotion & Prevention materials.

a. Several months prior to the missions trip, we meet with MoH officials locally and as high up the chain of command as possible (At times we have been able to meet with the director of the MoH for the entire country).

b. We leave copies of the HEPFDC with the MoH officials in whatever languages are used locally and ask that they please review the manual prior to our return trip.

c. We emphasize the following to the MoH officials:

-"The information in the HEPFDC does not come from us. It consists of evidence-based international guidelines from the WHO.

-As all countries are a part of the WHO, the information comes from health experts from all over the world, including your country.

-Never-the-less, if there is any wording you disagree with, please cross it out and we will not teach it."

Why MoH Approval is Important: Although the HEPFDC has been utilized in numerous countries for over 10 years, we have not yet had any words "crossed out." However we believe this process remains extremely important for a number of reasons:

1. It demonstrates appropriate acknowledgement of the authority and responsibility of the MoH officials for the healthcare of the citizens of their country.
2. It establishes local ownership and sustainability of the program. (The information comes from the WHO, including their country. The program is simply a tool to assist them in meeting their country's WHO goals.)
3. It establishes a participatory, collaborative, non-paternalistic, mutual learning relationship from the onset.
4. It protects the reputation of local school, FBO and community health educators after the team leaves. (Local physicians and/or other providers may not be aware of current WHO evidence-based guidelines and disagree with the educators. Prior approval by the MoH prevents possible embarrassment of all concerned.)

IV. PHYSICIAN-PHYSICIAN & PHYSICIAN-PATIENT EDUCATION

Compliance with current international evidence-based standards and guidelines requires much that is different from our usual practice in the U.S.

1. Curative care is needed for about 30% of our patient's healthcare problems, and we must continue our efforts to teach high quality curative services in accordance with WHO evidence-based guidelines for patients of developing countries. 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*. It is therefore essential that we coordinate any efforts at providing curative care with the MoH, and except for special needs of the local MoH, it is best to leave our U.S. medicines at home. Almost without exception, it is collaborative teaching of evidence-based curative care services that is most critically needed.
2. The WHO also reports that **over 70% of the conditions we treat are preventable**. WHO and U.S. evidence-based guidelines emphasize the critical need for providing health promotion and preventive education. For example, the medications we use for bacterial and parasitic diseases are among those that have been proven to be safe and effective and they are sometimes life-saving. However, without counseling emphasizing the importance of implementing basic sanitation, our patients will very soon be ill again.
3. The **integration of personal health care and community health** is the foundation of the **Primary Care** approach developed by the Christian Medical Commission and adopted by the WHO. 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 HEPFDC has been used to integrate personal care and community health at all levels of the WHO health care pyramid (Hospital, Clinic/Health Center, and Family/Church/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 HEPFDC manual 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 identify them with the 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 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 manual 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.)

Please send any questions or evidence-based recommendations for improvements to edit@hepfdc.info For further information and/or free downloading see www.hepfdc.info

V. TEAM HEALTH EDUCATOR

At least 2-3 team members are assigned as **Team Health Educators.** --One to provide health education to **groups of patients** waiting to be seen. The others 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 HEPFDC manual is sent to each Health Educator as part of their team packet. The manual will often be in the local community's language so it can be left with the local educators. If needed, a copy of the written Handbook in English 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 manual to teach others, utilizing the cultural and participatory approach that is most effective for their particular community.

Team leaders assign sections of the manual 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 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:

-WHO/CDC Lifesaving Guidelines for Treatment of Diarrhea [Sections 22-27]

-Breastfeeding Problems-often a death sentence in developing counties [Section 20]

-Heart disease and Stroke [Section 41] and Type 2 Diabetes [Sections 38 & 41]

VI. WHY THE TEAM HEALTH EDUCATOR IS SO CRITICALLY IMPORTANT

The critical importance of the Team Health Educator to meeting Medical Team goals of "saving the most lives and preventing the most suffering" is indicated by the following evidence-based 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 Diabetes (#6 Cause of Death), and **40%** of Cancer (#2 Cause of Death) **could be prevented through the "Just 3 Things" guidelines demonstrated by illustration 3B 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 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 curative 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 numerous 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)

-Though WHO/CDC guidelines are lifesaving, they are relatively complex and take time to properly demonstrate. The Team Health Educator enables medical teams to meet the WHO/CDC standards for care.

-This Education **Rx also enables the provision of E-B high-quality life-saving care for all future episodes of diarrhea. (Long Term Impact).**

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).**

For the reasons documented above, churches and other organizations are increasingly sending Community Health Screening & Education (CHS&E) and/or **Health Education Teams** that provide the above critically needed evidence-based services without the harms of the short-term mission drug-based approach.

Disclosure/Conflict of Interest Validation: The editor, illustrator and Standards of Excellence in Healthcare Missions receive no royalties or compensation of any kind related to the "Health Education Program for Developing Communities (HEPFDC)" or its website. Rev 12/15