Lao PDR


The estimated 6 million inhabitants of Lao People’s Democratic Republic (Lao PDR) have a health status that is considered one of the worst in the region and social indicators that are similar to Sub-Saharan Africa. Approximately 80% live in rural communities. The Lao Ministry of Health (MOH) identified that trained primary care physicians were necessary to improve the health of the people. In 2004, the Faculty of Medical Sciences at the National University of Laos (FMS NUL), the MOH, and the Ministry of Education (MOE) partnered with the University of Calgary to develop a 2-year Family Medicine Specialists Program (FMSP).

The authors report on the use of a modified Delphi technique as the needs assessment for the FMSP first-year curriculum. Key aspects of this technique are anonymity, iteration with controlled feedback, statistical group response, and expert input. Expert input by leaders from the MOH, MOE, the Institute of Public Health, FMS NUL, training hospitals, and specialty departments generated recommended clinical knowledge and skill objectives. A consultant group of clinicians from surgery, pediatrics, internal medicine, obstetrics-gynecology, and emergency medicine and FMS teachers with rural or provincial experience then ranked these objectives with respect to priority for the health care needs of the Lao population and the level of competence to be achieved by a FMSP graduate. A weighted average system was used to generate a prioritized list of objectives. The final lists were reviewed by the clinical specialists and FMSP leadership to ensure consensus.

The response rate for the consultant group of clinicians was 86% (96/111). There were notable differences in prioritization between FMS teachers with rural or provincial experience and specialty clinicians and emergency physicians and surgeons. Respondents faced the dilemma of teaching what ought to be learned versus what can be practiced with restricted resources. In the pediatric examples provided, items such as diagnosis and treatment of dengue fever, malaria, diarrhea, hyperthermia, dehydration, shock, appropriate referral, and acute wound management were rated most high.

The authors think they achieved a robust assessment of needs to be met by the new FMSP resulting in a “made in Laos” program. The University of Calgary assisted with process, not content. The Delphi technique identified the priorities for the FMSP, functioned as a faculty development tool, developed relationships, provided important qualitative data, and generated lists for program evaluation.

Comment: This report describes one model for developing country-appropriate family medicine objectives and engaging leaders who are key for program success. Existing family medicine programs in the same region can also be a worthwhile resource for developing objectives, curriculum, and relationships. Tailoring family medicine education to meet the needs of the country is important and necessary. Details of the process used with the “expert leaders,” a response rate for this group, and a description of the prioritized objectives for each content area are not provided.

Sudan

How IMCI Can Be Integrated Into Medical School Curriculum and Impact Health (Abdelrahman SH, Alfadil SM. Introducing the IMCI community component into the curriculum of the faculty of medicine of the University of Gezira. East Mediterr Health J 2008;14(3):731-41.)

The World Health Organization (WHO)/United Nations Children’s Fund (UNICEF) Integrated Management of Childhood Illnesses (IMCI) is an algorithm-based process derived from expert opinion and research results for identification, management, and prevention of illness in children under 5 years at the community level in resource-poor settings using simple signs and empiric treatment. To facilitate successful implementation of IMCI in Sudan, six Sudanese universities introduced IMCI into their medical school curriculum in 2001. The authors aim to describe the integration of the IMCI community component into the curriculum of the Faculty of Medicine of the University of Gezira (FMUG).

An eight-step process was used to integrate IMCI into the community-oriented, problem-based FMUG curriculum. Following crafting of the rationale, guiding principles for planning and implementation of the curriculum were developed. These principles directed the determination of education objectives and content, teaching methodologies, and course modules for IMCI integration. Six curricular modules were identified for IMCI, and implementation occurred across the 10 semesters of the 5-year curriculum simultaneously. Finally, outcomes and impact of student activities were assessed. The National and Gezira State IMCI program and the Ministry of Health provided material and process support for IMCI student activities.
Assessment of short-term impact of student activities on family health practices was conducted in 2001–2002. Comparison between families visited by 240 medical students during their Primary Health Care Centre Practice and family medicine module with families not visited showed statistically significant improvements in children under 5 years and pregnant women sleeping under insecticide-treated bed nets ($P=0.002$), mothers practicing exclusive breast-feeding ($P=0.0129$), families following correct nutritional practices ($P<0.0001$), children completing immunizations ($P=0.0027$), and children receiving timely vitamin A supplementation ($P<0.0001$).

Organized theoretical and practical integration of IMCI into FMUG curriculum resulted in a positive short-term impact on some IMCI family health practices. The challenges encountered included lack of implementation of IMCI by some supervising doctors and medical assistants, turnover in and burden upon IMCI-trained health care staff, photocopying costs, cost for MOH staff, and the large number of students.

Comment: The authors describe a strategic, organized, and educationally sound approach to curriculum integration. The preexisting permeation of primary care, family medicine, and rural experience throughout the FMUG curriculum facilitated IMCI integration. While IMCI is not evidence based and does not use analytical decision making, it is an effective means to address childhood illness in resource-poor settings. Physicians working in such settings need to understand IMCI. Hopefully long-term assessments of this curricular innovation that include evaluation of student competency will be forthcoming.