IPCRG's role in delivering research and education with low- and middle-income countries

Everyone has something to teach and something to learn[1]

The International Primary Care Respiratory Group (IPCRG) is a clinically-led charitable organisation with the prime mission of carrying out and promoting research into the care, treatment and prevention of respiratory diseases in the community. In addition, through our network of over 125,000 primary care professionals, we make available the results of research for patient benefit.

We are an organisation of national primary care respiratory organisations and also a global community of practice. We aim to raise standards of care in individual countries and globally, through collaborative "real life" research, innovation, dissemination of best practice, education and advocacy. In line with the 2010 Lancet Commission on Education[2] we believe we have a role in extending academic learning into communities, developing global collaborative networks for mutual strengthening, and leading in the promotion of a culture of critical inquiry and public reasoning about the best ways to deliver effective respiratory care.

Research

Our Prioritised Research Needs statement[3] summarises the key respiratory research challenges. Twenty-three experts from 21 countries prioritised sixty-two questions. A recurring theme was for 'simple tools' (e.g. questionnaires) enabling diagnosis and assessment in community settings, often with limited access to investigations. Seven questions recorded 100% agreement: these involved pragmatic approaches to the diagnosis of chronic obstructive pulmonary disease (COPD) and rhinitis, assessment of asthma and respiratory infections, management of rhinitis, and implementing asthma self-management.

One of our research programmes is FRESH AIR. This is a research protocol developed in Viet Nam and being used (adapted for local conditions) in rural Uganda, Kyrgyzstan highlands and slums in India. It is a World Health Organization (WHO) Global Alliance against chronic Respiratory Diseases (GARD) demonstration project in Viet Nam and Uganda. It aims to measure in a defined geographical area and/or population exposure to environmental smoke (eg indoor/outdoor biomass and tobacco); lung health and quality of life. The subsequent stage is to develop locally-sensitive and sustainable interventions to address the problems found eg continued assessment and case-finding, public and professional education, stop smoking, improved ventilation in houses, physical activity programmes and access to medicines.

Another IPCRG research programme, UNLOCK, is using primary care datasets from 14 countries to compare and contrast the burden of disease and the outcomes of different interventions to identify best practice.

We are investing in three research schemes to build research capability in primary care: a Fellowship - the first candidate is from Viet Nam; our E-Faculty - currently working in Chile, and our first Respiratory Research School, in Singapore in 2015.

Education

Our Education Strategy[4] aligns with the World Health Organization recognition that improved access to, and application of, the principles and approaches of primary health care can contribute to the management of the global burden of respiratory disease. The high prevalence of asthma, COPD, tobacco dependence and respiratory infections means that primary care needs to be equipped to deal with respiratory diseases and yet there is substantial global variation, investment and development. We believe professional education and training of healthcare workers is a core component of this global response. We represent this primary care perspective on the Planning Executive of WHO-GARD and show by doing: Better Breathing Bangladesh, led by IPCRG-Bangladesh and pollen allergy camps in Pakistan are also WHO-GARD demonstration projects.

Our aim is to produce carefully designed, multifaceted educational programmes that engage health professionals in their learning, provide ongoing support, are sensitive to local circumstances and are delivered in combination with other quality-improvement strategies or incentives because the literature shows these are most effective. What makes us different is that we can offer programmes created and led by primary care peers.

Why is it important for primary care to teach primary care: what makes primary care practice different?

- Diagnosing, treating, managing (including referring) patients presenting with undifferentiated symptoms sometimes before advanced symptoms and signs described in the international and national respiratory guidelines have developed
- Practising in a low-tech environment, where the goal is to take a good history and 'rule out' conditions especially those requiring acute action or referral
- Inhaled medicines and medicines to support stop smoking may not be available
- The few pulmonary specialists tend to be concentrated in academic centres, the cost expended to seek and undergo specialist evaluation may be difficult to justify, and treatments recommended may not be readily or at all available
- Using generalist expertise to manage people with multi-morbidity as opposed to treating single diseases
- Seeing patients in the context of their families, homes and communities
- There may not be a clear distinction between primary and secondary care. In Asia Pacific specialist doctors may work in primary care practice in the evening on a pay per visit basis and in some countries primary care is still episodic and market driven.

As a global network, we believe **everyone has something to teach and everyone has something to learn**. We add value by:

1. Stimulating debate on the most effective educational methods and evaluation
2. Building capacity and capability by testing locally acceptable programmes
3. Sharing best practice in primary care and practical experience of respiratory programmes
4. Evaluating the results of our efforts using improvement science methods

We have **four target groups**: clinicians and health-care workers in primary care, academic workforce, experts in specific clinical areas and potential leaders.

We support learning and build capacity through teaching the teachers and teaching clinicians; stimulating discussion about effective educational methods and evaluation; promoting respiratory leadership, developing our E-Quality grant programme supporting the development of 'bottom up' educational projects; peer-reviewing education programmes and helping endorsed programmes receive accreditation; sharing best practice, narratives and case studies using the IPCRG web platform; disseminating information from our journal published by Nature Publishing Group *npj Primary Care Respiratory Medicine*; exploring technology as a way to capture the key messages and teaching methods to reach wide audiences with short illustrative films. We are also exploring the potential to develop a respiratory distance-learning module for primary health-care professionals.

In recognition of our local primary care-led approach IPCRG has been awarded one of the first Global Bridges awards in low and middle income countries. Work starts in November 2014 in Masindi, Uganda on a tobacco dependence education programme in the context of lung health.

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2. Frenk J *et al.* Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. *Lancet* 2010 Dec 4;**376**(9756):1923-58. doi: 10.1016/S0140-6736(10)61854-5.
3. Pinnock H *et al.* Prioritising the respiratory research needs of primary care: the International Primary Care Respiratory Group (IPCRG) e-Delphi exercise. *Prim Care Respir J* 2012;**21**(1):19-27.
4. McDonnell J *et al.* Building capacity to improve respiratory care: the education strategy of the International Primary Care Respiratory Group 2014–2020. *NPJ Prim Care Respir Med* 2014 Sep 25;**24**:14072. doi: 10.1038/npjpcrm.2014.72.