COMMUNITY HEALTH SCREENING & EDUCATION (CHS&E) GUIDELINES

Community Health Screening & Education (CHS&E) aims to assist communities, both urban and rural, in the U.S. and other developed, as well as developing countries, in their efforts to resolve their *most important* healthcare problems.

The goal is to enable communities to "save the most lives and prevent the most suffering" through an integrated, collaborative, sustainable approach to primary prevention, health promotion and transformational development.

It is based on international and national evidence-based (E-B) standards and practice guidelines. Although primarily focused on the 70% of the disease burden that is preventable, it facilitates high quality assistance in curative care areas as well (See Section IV).

All of the materials referenced are available free for downloading through www.hepfdc.info and nearly all are available in multiple languages. So although these preventable healthcare problems remain *the leading causes* of premature death and unnecessary suffering in nearly *every* community in *every* country; most communities *already have the resources* to implement these lifesaving guidelines.

As the world-wide epidemic of non-communicable diseases (NCDs) is currently of greatest concern, we will use NCDs as the example in this document. The World Health Organization (WHO) has emphasized that the root causes of this epidemic are not medical, but due to changes in lifestyle (beliefs & values).

The WHO has documented the effectiveness of local churches in addressing NCDs (Highest possible WHO evidence-based rating: See Interventions on Diet and Physical Activity: What Works). As this resource is seldom utilized, we will also address the importance of churches for meeting the above requirements. Although the WHO studies involved local churches, primarily in the U.S., we will use the term "church" to encompass all faith-based organizations (FBOs) worldwide.

The CHS&E approach can be implemented in a wide variety of ways, even by very small churches and other organizations with very few tangible assets. CHS&E can range from a very simple church-based local support group, to more complex approaches with local community health fairs, to CHS&E medical missions to other countries.

As there is currently an urgent need to address the NCD epidemic in nearly every community in every country, it is highly recommended that religious organizations first implement CHS&E in their own congregation before reaching out to their community and globally.

These guidelines include information on how CHS&E is used in various settings, including short-term missions (STM). Attempting to provide adequate quality care in the typical STM primary care setting is fraught with difficulty, and there is a great need for safe and effective alternatives to the commonly used STM drug-based approach.

We also address the extensive WHO and HHS documentation concerning the critical need for utilizing CHS&E, as well as provide access to the free evidence-based materials that have been developed for implementation and documentation of its effectiveness. Meeting all these goals required that these guidelines go on for 22 pages.

A contents page is therefore provided on the following page and at CHS&E Flow Chart However, the CHS&E process itself is really *quite simple* (especially for U.S. and other local churches working in their own communities) and can be implemented by simply utilizing a weight scale and tape measure as described in section III and can be summarized in 6 illustrations: CHS&E-6 Slide Summary

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INTRODUCTION

1. Evidence-based (E-B) National & International Standards and Guidelines.

a. When providing services in the U.S.: Our reference sources for the best available evidence-based *U.S. Standards and Practice Guidelines* are the US Department of Health & Human Services (HHS) and its numerous divisions and collaborating partners: HHS divisions include the National Institutes of Health (NIH), Centers for Disease Control & Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ), etc. Collaborating partners include numerous professional organizations such as the Institute of Medicine (IOM)..

b. When providing services in other countries: Our reference sources for evidence-based *International Standards and Practice Guidelines* are the World Health Organization (WHO) and its numerous divisions and over 700 collaborating partners (These also include a number of HHS organizations, such as the CDC.)

The importance of meeting in-country standards and guidelines, as well as legal requirements, can be found at *International Standards & Practice Guidelines and Health Missions*

The international health care standards and practice guidelines published by the WHO and posted on its website number in the hundreds, and finding the current applicable guidelines can be difficult. Links especially relevant to health missions are published on Health Topics page of the Best Practices in Global Health Missions website.

c. Identical Guidelines: As guidelines have become increasingly evidence based, HHS and WHO standards and guidelines have become essentially the same. The most important causes of preventable morbidity and mortality have also become increasingly similar in developing and developed countries (Premature deaths from NCDs such as Heart Disease, Diabetes, Cancer, Stroke, etc.).

The *Health Education Program For Developing Communities (HEPFDC)* is therefore being used in both rural and urban communities, in the U.S. and other developed, as well as developing countries, throughout the world. It was created to provide the most important evidence-based health care information to the people who need it most.

CHS&E uses only a portion of the HEPFDC content, but adds additional evidence-based guidelines and materials through its Health Screening and Participatory Approaches web pages. Additional information and free downloading of the program in 8 languages is available from the DOWNLOAD FREE page.

Note: We attempt to use and reinforce WHO and HHS evidence-based education materials that are already being used locally whenever possible. However in nearly all communities we have worked, these resources continue to be lacking.

2. Saving the Most Lives and Preventing the Most Suffering--Why is Evidence-based (E-B) Health Education so Critically Important?

Curative care is needed for approximately 30% of our patient's healthcare problems and we always collaborate closely with a local health clinic for those patients who may need to be referred for curative-care follow-up. However, if we wish to provide quality, evidence-based care for the remaining 70%, primary prevention and health promotion is essential.

For example, the World Health Report 2008 emphasizes the following as one of the most important problems in both developed and developing countries world-wide:
"Misdirected care. Resource allocation clusters around curative services at great cost, neglecting the potential of **primary prevention and health promotion to prevent up to 70%** of the disease burden"

See the above report and the following for further information and examples: Saving the Most Lives and Preventing the Most Suffering-Why is Evidence-Based Health Education so Critically Important?

CHS&E demonstrates to Department and Ministry of Health and other local healthcare providers how to **integrate community health into their primary care practice** in accordance with HHS and WHO standards; and how the church, school and other local community resources can collaborate in providing essential assistance in that process.

The critical importance of this integration cannot be overemphasized. For example, *The Lancet* (Volume 372, Issue 9642, 13 Sep 2008) reports that the very future of our health care systems is dependent on our ability to implement this approach. Yet nearly all communities, in the U.S. as well as developing countries, continue to need assistance in its implementation.

Lack of implementation of these guidelines has resulted in a world-wide "Slow-Motion Disaster." This global epidemic of non-communicable diseases (NCDs) primarily due to obesity and smoking recently resulted in the second ever UN General Assembly on Health in its 67 year history. The Director General of the WHO reported "In the absence of urgent action, the rising financial and economic costs of these diseases will reach levels that are *beyond the coping capacity of even the wealthiest countries in the world*." This is true for the U.S as well. For example, the CDC recently reported that between 1995 and 2010, the prevalence of diagnosed diabetes increased by 50 percent or more in 42 states, and by 100 percent or more in 18 states.

3. The Holistic (Mind, Body, Spirit) Approach and WHO International Standards & Guidelines A second major problem emphasized by the World Health Report 2008 is
"Fragmented and fragmenting care. The excessive specialization of health-care providers and the narrow focus of many disease control programmes discourage a **holistic approach** to the individuals and the families they deal with and do not appreciate the need for continuity in care. Health services for poor and marginalized groups are often highly fragmented and severely under-resourced, while development aid often adds to the fragmentation"

In contrast, CHS&E approaches have been strongly endorsed by the very best E-B guidelines, both internationally through the WHO; and nationally through the HHS and other organizations promoting high quality, E-B care.

For example, the *Seventh report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC7)* reports the following:
"Healthy People 2010 has identified the community as a significant partner and *vital point of intervention* for attaining healthy goals and outcomes. Partnerships with community groups such as civic, philanthropic, religious, and senior citizen organizations provide locally focused orientation to the health needs of diverse populations.

The probability of success increases as interventional strategies more aptly address the

diversity of racial, ethnic, cultural, linguistic, religious, and social factors in the delivery of medical services. Community service organizations can promote the prevention of hypertension by providing culturally sensitive *educational messages and lifestyle support services* and by establishing cardiovascular *risk factor screening and referral programs*."

The importance of the holistic approach is even more strongly emphasized by the WHO, and numerous international guidelines address the requirements in this area. The WHO also specifically addresses the importance of spiritual needs. For example see: *WHO Quality Of Life Spirituality, Religiousness and Personal Beliefs (SRPB) Field-Test Instrument*

The WHO also documents its history of collaboration with faith-based organizations (FBOs) and the importance of the numerous tangible and intangible assets available through church-based interventions. For example see: *Building from common foundations: The World Health Organization and faith-based organizations in primary healthcare*

WHO evidence-based guidelines have also specifically documented the effectiveness of lifestyle interventions for non-communicable diseases when conducted in the religious setting. For example see: *Interventions on diet and physical activity: what works: summary report. WHO 2009* "Using the existing social structure of a religious community appears to facilitate adoption of changes towards a healthy lifestyle, especially in disadvantaged communities... Behaviour can be influenced especially in … religious institutions…

Effective interventions (include) Culturally appropriate and multi-component diet interventions that
- are planned and implemented in collaboration with religious leaders and congregational members using pastoral support and spiritual strategies and
- include group education sessions and self-help strategies"

In contrast to curative care approaches, church-based interventions such as the above have been documented by the WHO to meet the *very highest standards for evidence-based effectiveness*.

4. Community Participation & Collaboration For the above reasons, as well as the availability of the necessary facilities and resources, it is usually a local church that partners with the local health clinic to sponsor the CHS&E event. For children's screening and/or children's health fairs, partnerships with local schools are also necessary. Even very small churches with little financial wealth can offer invaluable community resources for enabling compliance with the above National and WHO International standards and guidelines, especially those related to lifestyle and group support. Unfortunately these critically needed resources are currently seldom utilized.

It is the establishment of ongoing collaboration of the local clinics, churches, schools and other service organizations that is essential. Our team's purpose is to assist the above in *their* collaborative, long-term, sustainable efforts *to enable their communities to resolve their own health problems.*

As a minimum the local church/religious organization and the local MOH clinic need to collaborate in their efforts. (The "C" in CHS&E often refers to "Church-based" as well as "Community" Health Screening & Education.)

This is not at all a new concept. In fact, it is only recently that religious organizations have not closely collaborated with the medical community in providing healthcare, even at the highest and most expensive levels of care. Until very recently most hospitals were even named after the

various religious communities providing those services (Presbyterian, St. Luke's, Lutheran General, etc.), and most religious communities had, in fact, been providing those services for hundreds of years.

The *Health Education Program For Developing Communities* and CHS&E are based on the following principles (From the WHO):

"a. Communities can and should determine their own priorities in dealing with the problems that they face.

b. The enormous depth and breadth of collective experience and knowledge in a community can be built on to bring about change and improvements.

c. When people understand a problem, they will more readily act to solve it.

d. People solve their own problems best in a participatory group process."

As in all areas of healthcare, health education materials that are not evidence-based (even those that are community initiated) can cause great harm, and a collaborative approach is therefore essential. Utilization of WHO guideline-based education materials at *all levels* of care (hospital, clinic and community) can prevent patient confusion and enable health educators at *all levels* to assist the Department or Ministry of Health (MoH)* in meeting WHO standards throughout the healthcare system. (*In this document we will refer to both "Department" and "Ministry" of Health as "Ministry of Health" or "MoH".)

See the *Health Education Program For Developing Communities* DOWNLOAD FREE page for Lesson Plan and Picture Book formats of the program to assist community health educators and others in implementing the participatory approach to learning.

I. VISION/PLANNING

I-1. VISION/PLANNING MEETINGS & TRIPS It is not possible to overemphasize the importance of these. If Vision/Planning trips are done well, and adequate local community resources are available, further STM trips may require very few team members or may not even be necessary.

Short-term efforts cannot hope to achieve the community health and development goals of long-term in-country efforts. And it is very important that we do not invest our resources in STM at the expense of long-term, ongoing work for true community transformation.

However, even for organizations with long-term in-country relationships that have existed for decades, these planning meetings are absolutely essential. As noted above, numerous WHO guidelines emphasize that any efforts to truly improve the health and well being of a community must be *community directed*. This has also been emphasized by the NIH and is true for healthcare services in the U.S. and other developed countries as well.

For example, WHO website's Effective Health Care-The Role of the Government, Markets and Civil Society reports:"...programmes, policies and projects carried out without the active participation of the people they are intended to benefit remain unsupported and unassimilated. It is only through participation of the beneficiaries that sustainable long-term changes are brought about."

Short-term mission partnering with a highly qualified long-term in-country host organization is necessary to meet these requirements. With the assistance of our in-country host, we attempt to establish relationships and partnerships with at least the following:

a. Ministry of Health (MOH) representatives: Prior to utilizing the program, we meet with the Ministry of Health (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). We leave copies of the *Health Education Program For Developing Communities (HEPFDC)* with the MoH officials and ask that they please review the program prior to our return trip. We emphasize the following to the MoH officials:

-"The information in the program 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, church 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 may disagree with the educators. Prior approval by the MoH prevents possible embarrassment of all concerned.)
5. Integration of community health into primary care practice is necessary at *all* levels of the health care pyramid. Although this integration is emphasized by the WHO and MOH leaders of most countries, it is important that providers at all levels understand this approach.
6. This process is also necessary to prevent the harm due to patient confusion from conflicting and inappropriate advice.
7. There are innumerable health education programs available, however most are not in compliance with WHO and other evidence-based international and national standards and guidelines, and may actually cause more harm than good.

It is therefore important that the education materials be approved at the highest possible level of the MOH; and that those used in the local community and throughout the health care pyramid be in compliance with the above standards and guidelines.

In addition to the MOH, we also meet with:

b. Local community leaders

c. Education leaders, local principals, teachers and school health professionals.

d. Church leaders, local pastors and church members in the healthcare, teaching and other service professions.

e. Physician and other healthcare provider and community services representatives

The purpose of establishing the above relationships is to seek in-country, local community direction and collaboration to the maximum extent possible. Local community organizations must be willing to sponsor (take ownership of) the event and work alongside other community organizations.

I-2. AN APPROACH TO SEEKING COMMUNITY DIRECTION, COLLABORATION & SPONSORSHIP Our meetings with local community leaders and potential sponsors in other countries usually include variations of the following (Our approach in the U.S. is similar except we reference HHS guidelines-- though as noted above, as guidelines have become increasingly evidence based, HHS and WHO standards and guidelines have become essentially the same)

--We attempt to determine the following:

a. Whether local community leaders, clinics, churches, schools and/or other service organizations are willing to *collaborate and invest* in efforts to improve the health of their community.

b. Whether they feel their communities have a need for health screening and education services.

c. Whether they feel the *Health Education Program For Developing Communities (HEPFDC)* materials could assist them in meeting those needs for their communities.

d. Whether they feel our team could assist them, working together, side by side, in meeting those needs through WHO-based health screening and education services.

(As noted above, *it is the establishment of the ongoing collaboration of the local clinics, churches, schools and other service organizations that is essential***.** Our team's purpose is to assist the above in *their* collaborative, long-term, sustainable efforts to enable their communities to resolve their own health problems.)

--We provide a brief description of the services we can assist their organizations in providing. If the following have not been previously distributed by our in-country host, or downloaded free from the website, we provide copies of:

a. These ***Community Health Screening & Education (CHS&E) Guidelines***

b. The ***Health Education Program For Developing Communities (HEPFDC)*** available in 8 languages.(For NCDs we focus on Sections 3.Saving the Most Lives and Preventing the Most Suffering/ 38.Nutrion/ 39.Physical Activity/ 41.Heart Disease, Stroke, Diabetes, Cancer, Dementia & other NCDs)

c. ***Saving the Most Lives and Preventing the Most Suffering***

f. ***Patient Health Screening & Education Record*** in English or Spanish.

g. ***Community Health Indicators Forms***

(All of the above are available free for downloading at www.hepfdc.info)

--Areas addressed usually include following:

a. Our goal is to assist (clinics, churches, schools, and other service organizations) such as yours in your efforts to resolve the most important health care problems ("save the most lives and prevent the most suffering") in your community.

b. The WHO reports that the *very best* way of accomplishing this is by assisting you with your primary prevention and health promotion efforts. The WHO reports that this can *prevent up to 70%* of the disease burden in your community.

c. It was for that purpose that the *Health Education Program For Developing Communities (HEPFDC)* was created: To provide the most important evidence-based health care information to the people who need it most. The program:

-is based on the most critical global health care needs as specified in the latest WHO World Health Reports.

-emphasizes the top 10 leading risk factors globally that cause the most deaths and suffering.

-describes WHO guidelines for prevention of these as well as other common diseases through "reducing risk and promoting healthy life."

d. As the WHO is made up of healthcare representatives of all countries, yours as well as ours, the information we use does *not* come from us, or belong to us. The program is available in

8 languages, is free for downloading, and is used by numerous organizations all over the world.

e. Most of the patients we see in both developed and developing countries are suffering from diseases that are preventable. Of all their medical needs, the greatest by far is for reliable health care information. Although life-saving information is available from the best WHO evidence-based sources, it seldom reaches our patients or even their health care providers.

f. This program enables the *integration of primary care and community health* at the hospital, clinic/health center, and family/community (Includes church & school) levels of care. The critical importance of this integration to the effectiveness and sustainability of all health care systems in both developed and developing countries has been repeatedly emphasized by the WHO (as well as the HHS and AMA in the U.S.).

g. We limit our health screening to those areas that we can provide safely and effectively in the short-term setting and are most important to the health and wellbeing of the local community.

In the past, we had always carried medicines and attempted to provide curative care services as well. However, we found we were actually causing communities more harm than good with that approach. We were, in fact, unintentionally reinforcing our patients' inappropriate use of drugs, even when they would cause harm. (For further information see Best Practices in Global Health Missions For example: Why Patients are at Much Greater Risk of Serious Harm from Drugs in the Short-term Missions Setting)

h. We continue to always collaborate very closely with local hospitals and health clinics, for the local doctors and nurses always know what is most needed, and we very much need their direction. In addition, we also need a local clinic/hospital for referral of our patients with the 30% of health problems that may need medicines or surgery or other curative care follow-up.

i. When requested, we also attempt to assist hospitals and clinics in their provision of high quality curative care services. However, this is only possible in those areas where we have the team expertise and resources to do so in accordance with international and national standards and practice guidelines. For example: We may have highly qualified, board certified specialists on the team who could provide training or consultation in certain areas requested by local hospital and clinic providers. (See Section IV. ADDITIONAL COLLABORATIVE ACTIVITIES for additional information.)

j. However, to truly assist communities, our primary focus must remain on the 70% of the disease burden that is preventable. Our health screening and health fair services utilize and reinforce WHO guidelines in those critical areas. Our purpose is to *support local physicians, providers, pharmacists, schools, churches and other service organizations in their collaborative efforts to enable their communities to prevent and resolve their most important healthcare problems*.

k. Never-the-less, this is your community, you are the experts here, and the *participatory approach* is therefore essential. For unless you appropriately direct us, our efforts are unlikely to result in any significant sustainable changes. We therefore very much need community representatives, especially from clinics, churches and schools to direct our mutual efforts.

l. As all communities are different, we also need to know the very best way we could assist you in your efforts. Are there families who have less healthcare problems in certain areas than the rest of the community? What can we learn from them? What areas of health services are working well in your community? Who is responsible for those services? Why do you think they are succeeding?

m. What areas do you wish you could change? How do you think they could best be changed? Do you think demonstration of our health screening and education services could assist you in those areas?

n. The Health Fair Setting. CHS&E may often best be accomplished in the health fair setting.

This adds a more festive atmosphere to the learning process, and can assist in establishing community collaborative efforts. Follow up health fairs are also often conducted based on CHS&E screening results. (See Paragraph III-6 below for additional information, as well as links to WHO/HHS based participatory learning materials often used in the Health Fair Setting.)

o. Sustainability & Multiplication. It is also important that our mutual efforts be sustainable. We will leave you with the Health Screening and Education materials. If you wish us to assist you in demonstrating their use, the process can easily be duplicated by you providing similar demonstrations in surrounding areas of your community, and so on. To facilitate multiplication, the entire program will remain available free for downloading at www.hepfdc.info

I-3. SERVICES & SITES SELECTED are determined by the community. The overall goal is to assist the community in its ongoing, collaborative, sustainable efforts to resolve its most important healthcare problems.

The Need for Quality. Services selected must be restricted to those that the sending team can provide in a safe and effective manner, and should demonstrate the highest possible quality care in accordance with international and national standards and guidelines.

However, by concentrating on those services that evidence-based guidelines have determined to be most important in "saving the most lives and preventing the most suffering", our team training requirements are *greatly* simplified. By following these evidence-based guidelines, we can, in fact, demonstrate very high quality care for the community's most critical health care needs with comparatively little additional training. This is in sharp contrast to the often overwhelming efforts necessary to provide even limited, inadequate quality, drug-based primary care in the typical short-term missions setting.

For example, Body Mass Index (BMI), BP, Tobacco Use, Diet, Exercise, and Diabetes CHS&E can be safely and effectively provided by most primary care teams. As noted above, these services are of essential evidence-based importance in managing the most common causes of premature death and unnecessary suffering in developed and developing countries world-wide.

Evidence-based Relevance and Value. There are, in fact, very few services that can match the tremendous community and individual value provided with primary prevention and health promotion in the above areas alone. Evaluation and counseling concerning BMI has become of critical importance world-wide:

The HHS reports that 68% of U.S. adults, and over one third of our children, are now overweight or obese. Both national and international guidelines report that the higher the Body Mass Index (BMI), the higher the risk for heart disease, high blood pressure, type 2 diabetes, breathing problems, gallstones, osteoarthritis, certain cancers and numerous other conditions.

These BMI related diseases have now increased to *epidemic levels in developing as well as developed countries*. For example, the *Lancet* (June, 2011) reported that *nearly 10% of adults world-wide now have diabetes*, and the prevalence of the disease is rising rapidly.

Others report "It is estimated that by the year 2015 non-communicable diseases (NCDs) associated with over-nutrition will surpass under-nutrition as the *leading causes of death in low-income communities*." See WHO's Integrating Poverty and Gender into Health Programmes-Module on Nutrition and "The 3 Things" Guidelines for further information.

a. Provider Health Screening Exam-Adults. For the above reasons, in developing countries, as well as the U.S., CHS&E now nearly always includes:

--BMI measurement and review
--BP and pulse measurement and review
--Review of diet history (Including alcohol)
--Review of exercise history
--Review of tobacco use history
--Review of history of symptoms of diabetes

Usually this is all that time permits. Other areas may be substituted as determined by the local community and MOH, however this is unusual.

b. Provider Health Screening Exam-Children. In contrast to older children, adolescents, and adults; screening of younger children in developing countries may be significantly different from developed countries. This is due to differences in mortality causes and rates. Preventable deaths from respiratory infections and gastroenteritis lead the list in developing countries. *Integrated Management of Childhood Illness* and other evidence-based WHO child health guidelines for developing countries can be found at the following Best Practices in Global health Missions link Child Health and have been incorporated into the *Health Education Program For Developing Communities.*

Also in developing countries, under-nutrition remains a very important contributor to unnecessary mortality, especially in those less than 5 years of age. However, in older children and adolescents, paradoxical over-nutrition has become an increasingly important problem in developing countries as well. (In developed countries such as the U.S., over-nutrition is now responsible for *1 of 3* of our children and teenagers being overweight or obese; with associated dramatic increased rates of type-2 diabetes, high blood pressure and other diseases. In U.S. Senate testimony, the U.S. Surgeon General reported we may see "*the first generation that will be less healthy and have a shorter life expectancy than their parents"*)

The WHO Policy Brief: Preventing chronic diseases, designing and implementing effective policy therefore emphasizes the importance of the above approach for children as well as adults: "The growing epidemic of chronic disease is due to tobacco use, unhealthy diet, physical inactivity and other risk factors...Chronic disease risk accumulates throughout the life course, and risk factors are often established in childhood and adolescence. Consequently, chronic disease prevention must focus on promoting healthy diet, physical activity, and tobacco abstinence from an *early* age...

Skills-based chronic disease education should include participatory learning experiences that address nutrition, the benefits of physical activity, and the health consequences of tobacco use. Such programmes can be implemented with limited resources, and may be *highly beneficial* in *reducing chronic disease risk factors* among young people."

c. Provider-Patient Health Counseling/Education. Evidence-based WHO and HHS guidelines and illustrations are used to provide individual patient counseling based on the above screening and evaluation results. Copies are distributed to all in-country and U.S. team providers. In-country providers are given copies of the counseling materials in their preferred language (English, French, Hmong, Indonesian, Khmer, Mandarin, Russian and Spanish (with more

languages coming--See Paragraph II-5 below re: *Provider Guidelines & Patient Counseling Folder*)

d. "*The 3 Things*" approach based on WHO/HHS guidelines meets all of the above requirements. It addresses the most important causes of preventable morbidity and mortality in nearly all communities, urban or rural, developed or developing, world-wide, and is essential for children as well as adults. We will therefore use "*The 3 Things*" approach as the CHS&E example for the remainder of this document. (See "The 3 Things" Guidelines for further information and free downloading of materials.)

e. Site Selection is determined by the community. Most important is availability of patient privacy. Although CHS&E can be conducted in open areas such as parks, the provider/patient area for exam and patient counseling should always be set up with as much privacy as possible. It is best to use individual rooms providing both visual and auditory privacy whenever available. There should also be adequate space to accommodate relatively large numbers of people (Ideally, indoors if inclement weather is a possibility). In accordance with WHO and HHS guidelines, tobacco use should not be permitted. There should be adequate restroom facilities. Adequate seating for Patient Waiting/Participatory Learning Areas. Adequate space to set up additional participatory health education tables or booths. For Health Fairs, adequate open space for additional festive Health Fair functions as determined by the community.

As noted in paragraph 3 of the INTRODUCTION, WHO evidence-based guidelines have specifically documented the effectiveness of lifestyle interventions for non-communicable diseases when conducted in the religious setting.

For the above reasons, local churches are the sites usually chosen by community organizers and sponsors. In those communities where religious facilities are not available, local schools and clinics are often used.

II. TEAM PREPARATION & TRAINING

II-1. SHORT-TERM MISSIONS GUIDELINES Numerous sources of information exist related to short-term missions and medical team preparation (See especially Standards of Excellence in Short-term Mission and Best Practices in Global Health Missions). The importance of a thorough study of the local community's culture by *all* team members cannot be overemphasized.

Compliance with country-specific CDC Traveler's Health guidelines for the health and safety of all team members is also essential.

Healthcare providers also need to be aware of the in-country National and International Standards and Guidelines related to the care they wish to provide. Contact information for healthcare provider permission to practice for all countries may be found at International Association of Medical Regulatory Authorities (See also "When providing services in other countries" in INTRODUCTION paragraph 1)

Contact information for nurses may be found at International Council of Nurses

Note: Attempting to provide even limited adequate quality health services in the STM setting is very complex and expensive. It is therefore very important that we do not invest our resources in STM at the expense of long-term, ongoing work for true community transformation, an approach that may take 3-4 years or more of continuous in-country work for implementation.

Many U.S. churches and other organizations are instead choosing to support the medium or long-term assignment of critically needed members trained and qualified to meet those goals. Other churches are discovering that the need for their services is just as great, and often greater, in their very own community. In any case, CHS&E and these evidence-based materials were designed for use in *all* of the above settings.

II-2. PATIENT-CENTERED HOLISTIC CARE The importance of this approach has been stressed by numerous WHO and HHS guidelines. See also INTRODUCTION paragraphs1-4.

All team members, both U.S. and in-county, regardless of their duties, serve very important functions as members of the healthcare team. A thorough knowledge of the community's culture is therefore required by *all* team members.

Patients, even in the U.S., are often anxious when entering a health care setting. A caring, friendly, respectful, professional approach is essential. A smile, a gentle and quiet manner; and efforts to greet the patient in his/her own language (with an apology for not speaking more or better, if applicable) can do much to relieve the patient's anxiety and concern. How well staff members do this work will also affect the ability of the provider to do hers/his. For example, blood pressure readings can be very much affected by patient anxiety.

Our attitude and performance will also reflect on the clinic and church sponsoring organizations. And it may well determine whether our patients seek follow-up holistic health care services with those organizations. As emphasized by numerous national and international evidence-based guidelines, such follow-up is *absolutely essential* for nearly all of our patient's most important healthcare problems. It is, therefore, one of the *most important indicators* we evaluate concerning the *success/failure of our healthcare mission efforts* (See paragraph V-2)

The provider-patient consultation: One of the great joys of our profession is the privilege of getting to know our patients. Providers who have been on drug-based short-term missions will notice a remarkable change in their patient consultations.

As our drugs are so over-valued, and are often considered "magic" pills, especially by the poor; patients seen at drug-based clinics are very highly motivated to present in a manner that will result in the most pills being dispensed, especially when they are free or subsidized.

With the CHS&E approach, the patient is no longer preoccupied with this drug-seeking goal. Instead, physicians and pharmacists can focus on prevention of unnecessary deaths and the critical need for appropriate use of locally available medicines (See Section IV below).

So *with the substitution of drug-centered care with patient-centered care*, we actually have a bit of time to get to know our patients and to demonstrate true compassion. As noted above, the importance of this caring, patient-centered approach to the patient's healing response and wellbeing has been emphasized by both WHO and HHS reports.

II-3. PARTICIPATORY HEALTH EDUCATION (See also Introduction paragraph 4 and Section I-2 especially paragraphs k-m.) The importance of the participatory approach to teaching for all age groups has also been emphasized by numerous international and national guidelines (See Evidence-based Participatory Health Education Guidelines). For Health Screening events, this usually begins with distribution of the advertising flyers (See paragraph III-1) and continues onsite as patients are waiting in line to register.

For example, using "The 3 Things" approach, the Flyers lead people to ask "What are these 3 things that WE can do that would prevent 80% of heart disease, 80% of stroke, etc?" As patients are waiting in line to register, a local health educator can use the 11x17 posters to draw out the answers from the people, using the participatory and cultural approach most effective for their particular community. The lesson (with the WHO answers) is also included in the *Patient Health Screening and Education Record* (Page 4 is left blank so you can enter your own specific follow up information). The record is given to the patient for further reinforcement and multiplication of the lesson to the patient's family and friends. (This link shows an example of the information you can provide on the page 4 follow up page).

Additional evidence-based lessons in various formats can be downloaded free from the HEPFDC Participatory Approaches page. Lesson Plan and Picture Book versions of the *Health Education Program For Developing Communities* have been specifically developed to assist **Community Health Educators (CHEs)** and others in implementing the participatory approach for learning and behavior change. (We are deeply indebted to Jody Collinge, MD, FAAP, and the Global CHE Network for these excellent resources.)

II-4. PROVIDER GUIDELINES & PATIENT COUNSELING MATERIALS These are contained in the ***Provider Guidelines & Patient Counseling Folder*** and distributed to all In-country and U.S. Team providers. All folder contents can be downloaded free from the HEPFDC Health Screening page.

Folder Contents. For "The 3 Things" approach, the folder includes International and National standards & guidelines and health education/counseling materials on the following:

a. Body Mass Index (BMI). BMI standards, guidelines and charts from the CDC (For U.S.) and WHO (For other countries) are included. Although the BMI number is calculated the same way for children and adults, the criteria used to interpret the meaning of the BMI number for children and teens are different from those used for adults. For children and teens, BMI age- and sex-specific standards are included. For ages up to 2 years, the CDC has adopted WHO growth standards for children in the US. For ages 2-20, the CDC BMI standards are different for use in US children. See Body Mass Index Guidelines (Section VI-6C on the HEPFDC Health Screening page)

b. Blood Pressure Evaluation. Elevated blood pressure is one of the most common and important conditions we treat as health care providers. We believe it is important for the provider who is responsible for doing the counseling to take the measurement. This also reinforces its importance. As noted in paragraph II-3, a provider's caring touch can also be very important to the patient's healing response.

However, many blood pressure readings, even those in most physicians' offices and hospitals, are not taken in accordance with evidence-based guidelines**.** This can significantly affect the accuracy of the readings, and lead to unnecessary patient worry, as well as, unnecessary treatment. For this reason the following are also included:

The Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC7) (Section VI-6D on the HEPFDC Health Screening page) provides additional evidence based guidelines for evaluating patients. Sections on "Classification of Blood

Pressure" "Accurate Blood Pressure Measurement in the Office" and "Patient Evaluation" (Pages 12,17,18, and 20) are included in each Provider Folder.

c. Provider-Patient Health Counseling/Education. Evidence-based WHO/HSS patient education/counseling materials on prevention and treatment of NCDs can be downloaded free in 8 languages from the HEPFDC DOWNLOAD FREE page.

For Heart Disease, Stroke, Diabetes, Cancer, Dementia and other conditions related to diet, exercise and tobacco use--See Sections 3, 38, 39 & 41.The accompanying Illustrations are used by providers to assist with their counseling.

The materials are the same as those previously provided (by our in-country host or during the vision/planning trips) to the MOH, local clinics, schools, and churches. As U.S. healthcare providers are nearly always very highly respected by patients from developing countries, this process strongly supports and reinforces the MOH and local community physicians, nurses, teachers and other educators in their attempts to implement WHO guidelines after we leave.

The folder illustrations assist the provider in meeting international standards and guidelines for quality care. However, provider time may not be sufficient for completion of the required healthcare teaching. And after an introduction to the teaching materials, referral to Team and Local Health Educators and/or local follow-up is usually necessary.

d. Patient Health Screening & Education Record ("The 3 Things" Version) was also specifically developed to assist providers in meeting International and National Standards and Guidelines in the above areas (See Section III on the HEPFDC Health Screening page). Many providers use the illustrations on this form to facilitate counseling. (Others use the corresponding illustrations from their copy of the HEPFDC as described in paragraph c.)

e. Additional Evaluation and exam may be performed depending on the patient's needs and requests, available time, available privacy, and provider's license, credentials, and approval of in-country regulating authorities.

f. Community Health Screening Indicators Forms (See Paragraph V-2 Community Health Indicators Form Results)

III. HEALTH SCREENING & EDUCATION EVENT

III-1. ADVERTISING & ENGAGING THE COMMUITY A "flyer" can be used that includes time and location of health screening and education event. As noted in section II-3, the flyer can also be used to begin to engage the community in the participatory learning process.

III-2. REGISTRATION FOR THE EVENT Registration station functions include the following:

a. Participatory Learning. A local health educator facilitates this as patients are waiting in line to register. Patients "discover" the answer to the "The 3 Things" question posed by the flyer.

b. The *Patient Health Screening & Education Record* is given to the patient at the time of registration. This provides the answers to, and enables reinforcement and multiplication of "The 3 Things" lesson, and serves several very important additional functions (See *Patient Health*

Screening & Education Record-How it Can be Used)

c. Registration Numbers are provided for each patient and recorded on the *Patient Health Screening & Education Record* and the *Community Health Indicators & Follow-up Form* (See d. below) to facilitate follow-up. "Health related door prizes" based on registration number drawings are often included as another way of calling attention to important community health needs and solutions --Examples could include a soccer ball for exercise for children, locally available lockable medicine box for adults, etc.

d. Community Health Indicators and Follow-up Forms. Completion of these forms begins at registration. Content can include whatever information the local community determines is most important for evaluating and improving community health status. Registration numbers are used to facilitate evaluation of *health screening indicators* as well as *patient follow-up*. (See paragraph V-2)

e. Patient Instructions. In accordance with *JNC7* guidelines, if patients wish to have their BP measured, they are requested to avoid caffeine, exercise and smoking for at least half an hour prior to the measurement (Smoking is not permitted by communities in most health screening settings).

III-3. HEIGHT & WEIGHT STATION for BODY MASS INDEX (BMI)

a. Equipment. To provide highest possible quality services, it is important that our measurements be accurate. *Consumer Reports Health* and others report the results of testing and ratings of weight scales and should be checked for current recommendations. (For example, in 2011, the Taylor 7506 scale was top rated for accuracy and consistency and was available for about $25 on line.) High quality portable stadiometers for height measurement are also available on-line and can be packed in a large suitcase. (We have used the portable Seca 213 available for about $170 on-line. These are very accurate and make excellent gifts for local clinics and churches to provide ongoing monitoring and to carry on their own future CHS&E events. However it should be noted that height measurements can also be accomplished adequately with a simple $4 tape measure).

b. Safety and Respect. For safety reasons, it is often necessary to touch the patients while assisting them on and off the scales. It is very important that all touching, in all countries, be done with proper respect. It must also be done in accordance with local custom-- In some countries it is essential that women patients be assisted by women, and men patients by men team members.

c. Privacy. This is always essential. A separate room should be provided whenever possible. The area should be kept clear of non-essential personnel. The "head of the line" should be maintained far enough away to ensure as much patient privacy as possible.

d. Infection Control. The height measuring devise and scale should be wiped down with a disinfectant wipe before each patient (Those parts in contact with the patient). The staff member's hands should also be cleansed before each patient.

e. Quality of Care. With the high quality digital scales and stadiometers, these measurements can be accurately recorded by non-healthcare personnel. All measurements should be taken without shoes (A chair and floor mat should be provided). Coats and heavy

outer clothing should be removed when possible. Height measurement instructions can include: "Look straight ahead, keep your heels flat on the floor, and stand with your back against the stand, as straight as you can, like a soldier." and/or demonstration of same. Calculation and recording of the BMI can also be performed here. Patients should be advised that a team healthcare provider will review the results with them.

III-4. PATIENT WAITING & PARTICIPATORY LEARNING STATION There should be seating available so patients can relax for a time before seeing a provider for the blood pressure determination and additional evaluation. Participatory learning is provided while patients are waiting.

III-5. PROVIDER-PATIENT EVALUATION AND COUNSELING STATION See **Illustration**. Team providers work alongside local providers in providing these services. The importance of the holistic (body, mind, spirit) approach to healing is emphasized. WHO (and HHS) guidelines also emphasize the importance of the quality of the provider-patient relationship and a "caring" patient-centered approach for patient healing. (See also Section II)

a. Equipment: Blood Pressure Measurement--Consumer Reports Health and others report the results of testing and ratings of self-inflating blood pressure monitors. As these ratings are continually changing we recommend you consult those sites prior to purchase. (Although we have used high quality aneroid BP cuffs to confirm high readings in the past, we have found the self-inflating cuffs to be accurate.--ADC aneroid BP cuffs are also guaranteed to be accurate when new.)

A stethoscope, a small table, a couple chairs, hand sanitizer/disinfectant wipes and the *Provider Guidelines & Patient Counseling Folder* are the only other essential equipment requirements. Additional diagnostic equipment may be used as described in paragraph II-4-e.

b. Privacy: As with all physician-patient encounters, there should be as much privacy as possible. (See also Paragraph I-3-e)

c. Infection Control: The blood pressure cuff, stethoscope and any other diagnostic equipment used should be wiped down with a disinfectant wipe before each patient. The provider's hands should be cleansed before each patient.

d. Quality of Care is the focus of the CHS&E approach and is enabled through numerous evidence-based mechanisms described throughout this document. (See especially INTRODUCTION and Section II). Additional specific guidelines are contained in the *Provider Guidelines & Patient Counseling Folder* --Each In-country and U.S. Team provider is given a copy which is also reviewed during team training sessions. (See paragraph II-4)

e. Note Concerning Blood Glucose Screening: The CDC has reported infection control and quality of care problems related to blood testing in the health-screening/health-fair as well as clinic setting. Team financial and other resources may be better invested in assisting local clinics in training, equipment and supplies for high quality, safe and effective local glucose monitoring F/U in accordance with CDC/NIH guidelines(See Health Screening & Blood Glucose Monitoring). We therefore use the CDC Pre-Diabetes Screening test (Section IIIB on Health Screening page) and refer to a local clinic if follow-up is required.

III-6. HEALTH FAIR and/or OTHER PARTICIPATORY LEARNING ACTIVITIES

Health Fairs provide a wonderful opportunity for additional participatory learning in a festive setting. Booths can reinforce and expand upon "The 3 Things" and other important lessons. Fairs also facilitate relationships and collaboration among the various community sponsors/organizers. Learning in such settings can be truly enjoyable, and memorable as well. Care must be taken to ensure the lessons demonstrate evidence-based guidelines. They should also address the most important health related conditions in the community.

For example, the **"Just One Soda" lesson** is based on a number of national and international reports and guidelines (See also paragraph I-3 re over-nutrition and BMI related morbidity and mortality). The CDC reports: "There is too much sugar in our diet. Six out of 10 adults drink at least 1 sugary drink per day...Sugar-sweetened beverages (SSBs) are the *largest source* of added sugars in the diet of U.S. youths...Among adolescents specifically, SSB consumption can contribute to weight gain, type 2 diabetes, and metabolic syndrome."

The WHO reports: "The high and increasing consumption of sugars-sweetened drinks by children in many countries is of serious concern. It has been estimated that each additional can or glass of sugars-sweetened drink that they consume every day increases the risk of becoming obese by *60%."*

Additional information and "Just One Soda" posters and others most commonly used in the health fair setting are available free from the HEPFDC Participatory Approaches page.

III-7. PATIENT FOLLOW-UP WITH LOCAL SPONSORS (ONSITE AND/OR REFERRAL)

Appropriate follow-up care of identified problems is of utmost importance and is one of the main indicators of success of a CHS&E event.

a. Page 4 of the *Patient Health Screening & Education Record* is dedicated to this most important follow-up function. It enables healthcare providers to easily encourage follow-up for additional education and other needed services. The page lists local sponsoring organizations of the event (Clinic, Church, School, and other Community Service Organizations) and includes the contact information and holistic health services provided.

Page 4 is left blank on the Template version. Each organization sponsoring the CHS&E event is asked what specific information they wish to include. For example:

i. Sponsoring Local Church Follow-up Information concerning Holistic (Mind, Body, Spirit) services could include: Contact Info; Groups for Weight Control & Physical Fitness; Heart Disease/Stroke/Diabetes Prevention Groups; Stress Reduction Groups; Alcohol & Drug Dependency Groups; Men's Groups; Women's Groups; Married Life Groups; Teenage Groups; Healing Prayer Groups; and/or additional culturally appropriate groups or services for other conditions that cause the most unnecessary deaths and suffering locally.

ii. Sponsoring Local Medical Clinic Follow-up Information: Health conditions are sometimes identified which require urgent medical follow-up. This is especially true in poor communities and patients who lack health insurance. This is also important for patients who will need more routine follow-up of high blood pressure and other conditions. If the screening setting is in the U.S., contact information for a local sliding fee-scale clinic is usually included. The contact info for the local Ministry of Health clinic is included in most other countries.

See Section II of HEPFDC Health Screening page for additional information and Examples and Templates of the *Patient Health Screening & Education Record.*

b. Additional On-site Sponsor Follow-up Information may also be provided at CHS&E

booths/tables or as part of a Health Fair setting.

c. Community Health Indicators and Follow-up Forms. These forms provide the information necessary for patient follow-up. They also enable documentation of patient requests for church and other community health follow-up services related to lifestyle changes such as Diet and Exercise Groups, noted above.

IV. ADDITIONAL EVIDENCE-BASED COLLABORATIVE ACTIVITIES

As noted previously, curative care remains essential for about 30% of our patients' healthcare problems and we always work side by side with physicians and other providers and staff from the local health clinics and/or hospitals. Although the short-term mission (STM) drug-based approach cannot be condoned (See Why Patients are at Much Greater Risk of Serious Harm from Drugs in the Short-term Missions Setting and Harm From Drugs in Short-term Missions--Review of the Medical Literature), there is *much* that qualified doctors and pharmacists can do to truly assist communities.

For it is not the drugs, but the individual team members that are the STM's greatest asset, and there is much that qualified doctors and pharmacists can do in collaboration with the MOH, Church and its communities in critically needed curative care areas. Simply leaving our drugs at home enables medical missions to focus resources on those services that are evidence-based, sustainable, and truly needed by patients as well as local healthcare providers.

IV-1. CRITICAL NEED FOR QUALIFIED PHYSICIANS AND PHARMCISTS (See also INTRODUCTION paragraphs 1-3).

Although we carry no drugs, there are no professionals more important to the success of our curative care efforts than qualified physicians and pharmacists. For the same references that condemn our use of drugs in the STM setting emphasize the tremendous need for patient assistance in using their *current* medications appropriately. (This is easily confirmed with simple STM follow-up home visits, asking to see their medicines and how they use them.)

For example, the WHO reports that "Adverse drug reactions are among the leading causes of death in many countries." *WHO The Safety of Medicines-Oct 2008*

This is also true for patients in the US. The FDA website reports that drug adverse events are: "the *4th* leading cause of death; ahead of pulmonary disease, diabetes, AIDS, pneumonia, accidents and automobile deaths." *U.S. Food and Drug Administration. Center for Drug Evaluation and Research. "ADRs: Prevalence and Incidence." Cited 15 April 2009.* And most of the Harm From Drugs in Short-term Missions--Review of the Medical Literature applies to care in the U.S. as well.

The WHO also reports: "Irrational use of medicines is a *major* problem worldwide. It is estimated that *half* of all medicines are inappropriately prescribed, dispensed or sold, and that *half* of all patients fail to take their medicine properly." *WHO Medicines Strategy-Oct,2004*

Pharmacists can also provide critically needed services by working alongside local pharmacists and providers in offering participatory education to groups of patients re drug safety, appropriate use, etc. For example see section 28 of the HEPFDC "Taking Medication" available in 8 languages.

IV-2. INTEGRATION OF COMMUNITY HEALTH INTO PRIMARY CARE PRACTICE As noted in paragraph 2 of the INTRODUCTION, the critical importance of this integration cannot be overemphasized. CHS&E demonstrates to local providers how this can be accomplished for a focused area (such as the most important NCDs in "The 3 Things" approach).

However, this integration is needed in *all* areas of primary care, communicable as well as non-communicable diseases, and the entire WHO-based *Health Education Program for Developing Communities* is utilized for this purpose.

The WHO requires that all guidelines be evidence-based, and the program 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**.**

As with CHS&E, partnership with local and sending team physicians working side by side is essential. However, this approach definitely requires *much* more provider training and expertise than the more focused CHS&E approach.

In nearly all cases, STMs can provide much higher quality care and community benefit by simply demonstrating the CHS&E approach in a *focused* area, and showing local providers where to access other evidence-based health education materials in their local language.

For once the integrative process has been demonstrated, local providers easily adapt the process to other primary care areas when additional E-B materials are made available. The entire *Health Education Program for Developing Communities* is available in 8 languages with more coming and is downloaded free. For further information see How the Program has been used by Community Health/Primary Care Medical Teams

There is great benefit to the community when local churches and schools are able to utilize the same WHO evidence-based materials to support the local MOH in these efforts. With MOH approved materials, even the least wealthy church can be a tremendous resource for improving the health of a community (See INTRODUCTION paragraph 3). Unfortunately these Church-based resources are now rarely utilized either in the U.S. or globally. For further information see the Participatory Health Education Approaches and Materials webpage.

IV-3. OTHER CLINIC AND HOSPITAL COLLABORATIVE CONTINUING MEDICAL EDUCATION (CME) Includes Pharmacy, Medical, Dental, Surgical, Nursing, etc**.** It is team members practicing in their area of expertise, (not the drugs) that is by far the most important and valuable to the community as well as the individual patient.

Local clinic and hospital providers throughout the world are in great need of high quality, relevant, evidence-based CME in curative as well as preventive care. STM physicians, pharmacists, dentists and other providers can do much to meet these critical needs. Nearly all providers have an area of expertise that can be of great value. Vision/Planning Meetings are used to match up the individual team providers' area of expertise with the most important local community-determined CME needs.

Sub-specialty clinics in areas such as cardiology, for example, are nearly always requested. As opposed to the usual STM drug-based approach to primary care where we find adult cardiologists attempting to provide care for infants with diarrhea (with frequent poor quality care and poor teaching example for future care by local providers), we enable that cardiologist to practice high quality care within his/her area of expertise.

This simple change not only provides great value to the current patient, but of even greater importance, significantly improves the quality of care by local providers for future patients (Long-term, sustainable, community-wide benefit).

IV-4. OTHER PHARMACY/ MEDICAL/ DENTAL/ SURGICAL/ NURSING/ ETC. COLLABORATION There are *numerous* other areas where STM providers can greatly improve the quality of local curative care services. For example, the local hospital in a CHS&E area requested assistance in managing its laboratory facilities, and a laboratory manager was

available to the STM team with the credentials to provide such services. Again, Vision/Planning meetings are of utmost importance to appropriately match up qualified STM resources with local high priority needs. Arrangements can also be made for *email and future visit follow-up to enable long-term collaboration and sustainability of high quality services in virtually any area*.

V. EXIT EVALUATION/ SUSTAINABILITY/MULTIPLICATION

At least two Exit Evaluations usually take place.-One with all team members, another attended by leaders from all sponsoring organizations. The evaluation usually includes review of the following:

V-1. PROCESS EVALUATION usually includes the following 21 areas: What went especially well? What were the problems? What did we learn? How can we do better next time?

I. VISION/PLANNING

I-1. Vision/ Planning Meetings & Trips
I-2. Community Direction and Sponsorship
I-3. Services & Site Selection

II TEAM PREPARATION & TRAINING

II-1. Short-Term Missions Guidelines
II-2. Patient-Centered Holistic Care
II-3. Participatory Health Education
II-4. Provider Guidelines & Patient Counseling Materials

III SCREENING & EDUCATION EVENT

III-1. Advertising & Engaging the Community
III-2. Registration for Event.
III-3. Height & Weight Station for BMI determination.
III-4. Patient Waiting & Participatory Learning Station.
III-5. Provider-Patient Evaluation and Counseling Stations.
III-6. Health Fair and/or Other Participatory Learning Activities.
III-7. Patient Follow-up with Local Sponsors (Onsite and/or Referral)

IV. ADDITIONAL COLLABORATIVE ACTIVITIES

IV-1. Critical Need for Qualified Physicians & Pharmacists
IV-2. Integration of Community Health into Primary Care Practice
IV-3. Other Clinic and Hospital Collaborative Continuing Medical Education (CME)
IV-4. Other (Pharmacy/ Medical/ Dental/ Surgical/ Nursing/ Etc.) Collaborative Activities

V. EXIT EVALUATION/SUSTAINABILITY/MULTIPLICATION&PLANNING

V-1. Process Evaluation
V-2. Community Health Indicators Form Results
V-3. Sustainability/Multiplication & Planning

V-2. COMMUNITY HEALTH INDICATORS & FOLLOW-UP FORM RESULTS

Completion of these check-off forms begins as part of the registration process (Templates may be downloaded from Section II D of HEPFDC Health Screening page.)

a. The information obtained from the form is determined by the local community in collaboration with the Ministry of Health.

b. Form 5A includes the patient contact info needed for follow-up. The registration number is also recorded on the *Patient Health Screening & Education Record* which remains with and is

taken home by the patient. (The registration number is also often used for subsequent distribution of "Health Related Door Prize" drawings)

c. Form 5B includes "Indicators" for adults, usually the results of BMI, BP, Tobacco use, Exercise, Diabetes (History of symptoms associated with diabetes) screening.

d. This is valuable information for community and MOH planning purposes, and only takes a few seconds to check off with the *Community Health Indicators Form.* It also helps determine the need for further health education and other preventative services.

e. The *Community Health Indicators Form* is available in two formats. Use of Form 5A and Form 5B allows separation of indicators from follow-up contact info for confidentiality purposes. Form 5C includes the contents of both Form 5A and 5B and can be used in place of Form 5A at the Registration desk (The confidential contents of Form 5B can be added after the event to enable follow-up by healthcare providers). To summarize:

--Form 5A (or the patient ID portion of 5C) is completed at the Registration desk.

--Form 5B is completed either by the healthcare provider or by an assistant from the *Patient Health Screening & Education Record* immediately after the patient has been evaluated.

--To maintain confidentiality, information from the two forms is collated after the event to enable follow-up by healthcare providers.

f. When used in subsequent years, the forms can also provide documentation of the community's response to health screening and education efforts. For Example:
Total Patients____ # With Decreased BMI ____ #With Increased BMI____
With Tobacco Use____ # With less than 30 Min Exercise/Day___ #With positive Pre-Diabetes Screen____ # Requesting referral for F/U Evaluation/Counseling/Treatment/Support___

g. Exit evaluation of the indicator results could include:

--Did the screening document important risk factors for premature death and suffering?

--Was the WHO-based counseling potentially life-saving?

--Did the knowledge empower patients to assist in resolving their own health problems?

--Did the patient response indicate that the services you provided were important?

--(Often most important) What were the "# Requesting referral for Follow-up Evaluation/ Counseling/Support"?

V-3. SUSTAINABILITY/MULTIPICATION PLANNING Based on the above evaluation, was this a worthwhile project? Would you be interested in doing this again? Would you be interested in helping other churches, schools and clinics in your community provide similar CHS&E events? What would prevent you from doing this? When do you think you could schedule your next event?