SAVING THE MOST LIVES & PREVENTING THE MOST SUFFERING- How the HEPFDC Has Been Used by: Ministries of Health, Hospitals, Clinics, Churches & FBOs, Schools, Communities and Medical & Dental STMs in the US and Globally.

BPGHM=Best Practices in Global Health Missions
CHE=Church/Community Health Education
CHE&S=Church/Community Health Education & Screening
CME=Continuing Medical (or other Healthcare Professional) Education
FBO=Church or other Faith Based Organization
HHS=US Health & Human Services & its divisions & collaborating partners (CDC etc.)
MoH=Ministry of Health (In US=HHS)
IS&Gs=WHO Evidence-based International Standards & Guidelines
STMs=Short-term Missions
WHO=World Health Organization & its divisions & collaborating partners (Includes HHS)

Part I: Integrating Community Health into Primary Care Practice

The 2008 World Health Report emphasizes the following as one of the most important problems in healthcare 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"***

A second major problem emphasized in the 2008 World Health Report 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"***

The HEPFDC enables the integration of Primary Care and Community Health and is

used at all three of the WHO "Health Pyramid" levels of care: Hospital, Clinic/Health Center, and Church/Community/School/Family:
--At the Hospital and Clinic/Health Center level it is used primarily by physicians and dentists for individual patient counseling, and by nurses for both individual and group counseling. (Teaching at the time of patient need is often the most effective method for behavior change).
--At the Church/Family/Community level it is used primarily by church/faith-based holistic health educators, school teachers, community health workers or other local Community Health Educator programs.
--This remains "***the key to community transformation and the success of healthcare systems in both developed and developing countries".***
The highly respected medical journal, The Lancet, 13 Sept 2008, reports: ***"The future of health care generally, and primary care specifically, depends on the integration of personal health care and public health at the level of the local community."***

This IS&G evidence-based holistic **Education Rx:**
1. not only provides the best **immediate lifesaving care** for the most common life threatening conditions (diarrhea for example), but also
2. enables the provision of life-saving care for *all future episodes* of the condition **(Long Term Impact).**
And as most patients have great respect for western medicine, your teaching
3. enhances patient acceptance of the program when later provided to surrounding communities by local church holistic health educators for a sustainable **(Long Term Culture Changing Impact).**

Part II: Why do Health Education Materials Need to be WHO International Standard & Guideline Evidence-Based?

1. Health education that is not evidence-based can cause as much harm as curative care that is not evidence-based.
2. WHO (through its constitution and 194 member countries) is invested with the following **authority:** "WHO…is responsible for providing leadership on global health matters, shaping the health research agenda, **setting norms and standards**, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends…"
3. The WHO requires that all its standards & guidelines be **evidence-based**. This is no easy task and requires teams of clinical experts, epidemiologists and statisticians to review and evaluate ***all*** the available scientific evidence throughout the world.
4. The WHO with its 194 member countries, thousands of clinical experts, epidemiologists and statisticians and over 700 collaborating partners (Includes the NIH, CDC and other HHS organizations) has more resources than any other organization or government in the world to accomplish this task (See BPGHM International Standards and Practice Guidelines and Health Missions).
5. As all countries are a part of the WHO, Ministries of Health look to the WHO for their country's guidelines.
6. Unfortunately, though tens of thousands of health education materials are available,

few are based on WHO evidence-based IS&Gs.
7. Ministries of Health are responsible for the quality of healthcare provided to their countries' patients. In order for the Church to reassume its responsibilities for the holistic health of its communities, collaboration with the Ministry of Health is essential.
8. Ministries of Health are usually overjoyed to find that the local church (or missionary if there is no church) will be assisting them in meeting their countries' WHO IS&G patient care requirements for the 70% of the disease burden that is preventable.

Part III: Why the Church is so Important

1. Until the last generation, the Church was always the main provider of healthcare services at all levels of care (even most hospitals were run by the Church).
2. Although most churches no longer have the resources to provide adequate quality curative care, no other organization has the resources or is better qualified to provide holistic health promotion and prevention services ("*the **70%*** "). See especially WHO's Building from Common Foundations (For example, under "Church-based assets, prayer is listed #1 in this WHO document).
3. Now that the disease burden is largely due to unhealthy lifestyle choices that are best treated with a holistic (Mind, Body. Spirit) approach, the Church is especially required. (The holistic, participatory approach was first developed and utilized by missionaries and has now also been adopted by secular Lifestyle Medicine, the fastest growing field in the history of medicine).
4. The HEPFDC is available free in numerous languages enabling US and most global churches regardless of resources, to reassume their healthcare responsibilities.
5. Church-based Community Health Education (CHE) and Community Health Education and Screening (CHE&S) have also received the ***WHO's highest evidence-based rating for effectiveness*** (See Interventions on Diet and Physical Activity: What Works)
6. See Parts IX & X for additional information.

Part IV: Why Ministry of Health (MoH) Approval is so Important

1. Collaboration with Ministry of Health: On STM Vison Trips, prior to utilizing the HEPFDC, 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).
2. We leave copies of the 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."
3. Why MoH Approval is so Important: Although the HEPFDC has been utilized in numerous countries for over 15 years, we have not yet had any words "crossed out." However we believe this process remains extremely important for a number of reasons:

--It demonstrates appropriate acknowledgement of the authority and responsibility of the MoH officials for the healthcare of the citizens of their country.
--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.)
--It establishes a participatory, collaborative, non-paternalistic, mutual learning relationship from the onset.
--It establishes a collaborative ongoing relationship with the local church (or missionary where there is no church).
--As noted above, Ministries of Health are usually overjoyed to find that the local church (or missionary if there is no church) will be assisting them in meeting their country's WHO IS&G patient care requirements for the 70%.
--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.)

Part V: Saving the Most Lives & Preventing the Most Suffering

Curative care continues to be needed for at least 30% of our patient's healthcare problems and we always collaborate with the Ministry of Health and a local hospital or health clinic (Usually a sliding scale clinic in the US) for those patients who may need to be referred for curative care follow-up.

However, if we wish to provide high quality, evidence-based care for the remaining 70%, **integration of community health into primary care** in accordance with evidence-based WHO International and National Standards and Guidelines is essential.

In accordance with current IS&Gs (See BPGHM Short-term health missions-Quality of care) most STMs no longer carry in drugs on short term missions (unless they supply them to the community long-term). However, as noted below there are **no professionals more important to the success of STMs and integrating community health into primary care practice than qualified physicians and pharmacists**.

The critical importance of evidence-based health education in meeting the goals of "Saving the Most Lives and Preventing the Most Suffering" is indicated by the following examples:

1. Prevention of Pandemics THE MOST IMPORTANT KNOWLEDGE as reported in Lessons 2 & 3 of the HEPFDC is undergoing revision to incorporate the following:
--COVID-19, SARS, Bird & Swine Flu, Ebola and other zoonoses (diseases transmitted from animals to humans) have now become our most important cause of unnecessary deaths and suffering.
--These are dramatically increasing due to wet markets, factory farms and our excessive use of animals for food.

--COVID-19 as bad as it is, is only a CDC category 2-3, and scientists fear our future pandemics may be even worse.
THE GOOD NEWS IS:
--UN, WHO, CDC and other evidence-based reports document the simple life-style change we can easily make to not only help survive current pandemics but also prevent future pandemics as well as WHO's three "Slow Motion Disasters" of 1. Non-Communicable Diseases, 2.Climate Change, and 3.Antibiotic Resistance.
--See IMPORTANT COVID-19 UPDATE / PREVENTION OF PANDEMICS (Five Scientific Evidence-Based Blessings of Plant-Based Eating) on the HEPFDC DOWNLOAD FREE page.

2. Prevention of NCDs. The WHO (Oct 05) reports that at least **80% of Premature Heart Disease** (#1 Cause of Death), **80% of Stroke** (#3 Cause of Death), **80% of Type 2 Diabetes** (#6 Cause of Death), and **40% of Cancer** (#2 Cause of Death) **could be prevented through just 3 things:**

1. **Healthy Diet**
2. **Not Using Tobacco**
3. **Adequate Exercise**

All achievable by nearly all patients, especially in developed countries. (See Lessons 3,38, &41)

3. Unhealthy Diet: Not enough fruits and vegetables and too much salt, sugar, processed foods, meat and other animal products (See also #1 re pandemics).
--The HHS (2015) reports **"About one-half of U.S. adults have diet-related chronic diseases, such as cardiovascular disease, high blood pressure, or type 2 diabetes"**
--Also 68% of US 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, and certain cancers.
--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.
--These numbers have continues to increase dramatically throughout the world and NCDs associated with over-nutrition have surpassed under-nutrition as the **leading cause of death in low-income communities** as well. (See Lessons 38&41B).

4. Smoking is the second greatest cause of avoidable morbidity and mortality
"…harms nearly every organ of the body."--Surgeon General's Report 2004. Numbers continue to rise globally, especially in developing countries.
--Evidence-based sources report that although only 15% of our of our medical treatments for all other conditions have been proven to be beneficial, **education for smoking cessation meets the very highest possible evidence-based ratings for effectiveness.**
--**Your teaching prevents the premature death and suffering of one of every two**

patients who decide to quit smoking (See Lesson 41A)

5. Safe and Effective Use of Medicines Although most STM Medical Teams no longer carry in their own drugs, there are **no professionals more important to the success of STMs than qualified physicians and pharmacists**.
a. As emphasized by the WHO: "Adverse drug reactions are among the leading causes of death in many countries." *WHO The Safety of Medicines-Oct 2008*
--This is true for patients in the US as well. 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.*
--The WHO 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*
b. Bringing STM drugs into other countries ***always*** *underemphasizes* the above harmful effects and *overemphasizes* the importance of drugs. "Why would these Christian doctors travel all this way just to give us medicines if they could harm us?" In spite of our best intentions this ***always*** promotes a drug-based culture and leads to *increase use of local pharmacy drugs* after we leave.
c. It is true that our western drugs may be of higher quality than those available locally. However this only leads to additional harm when patients go back to utilizing their locally available drugs, especially when trying to control conditions such as blood pressure or diabetes.
d. Promoting the use of drugs by bringing short-term supplies to indigenous areas where there are no healthcare providers is especially dangerous. Promotion of drugs also results in long term harm, especially when they can be obtained from in-country pharmacies without a prescription.
e. Ministries of Health are therefore now requiring that STMs no longer bring in additional drugs to further contribute to the above problems (See also Why Patients are at Much Greater Risk of Serious Harm from Drugs in the Short-term Missions Setting).
f. However, it is also true that **at least half of all patients world-wide (and even more in developing countries) *desperately need assistance in using their currently available medications appropriately***. (This is easily confirmed with simple home visits, asking to see all their medicines and how they use them.)
--Pharmacists can also provide critically needed services by working alongside local pharmacists, providers and health educators in offering participatory education to groups of patients re drug safety, appropriate use, etc. For example see Lesson 28 "Taking Medication."
--In addition, their expertise is also critically needed for local clinic/hospital pharmacist and provider CME in numerous areas such as pharmacy management and pharmacovigilance.
e. Leaving our drugs at home therefore also frees up the time and resources for critically needed, truly effective, high quality sustainable healthcare services and benefits for the curative care system, local church/missionary, as well as the individual patient.

6. 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 (See Lesson 36&37), but saves lives lost to the deadly combination of malnutrition and infectious disease (See Lesson 38A&B).
--Appropriate diet also helps prevent paradoxical over-nutrition and malnutrition (Lack of calcium and other essential nutrients) in older children and adults (See Lesson 38).
--It also offers the opportunity to provide holistic care by discussing better ways to demonstrate love for their children (See Lessons 2B&30B).

7. 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)
--Follow-up scientific studies have proven, without question, that the evidence-based WHO/CDC guidelines as reported in Lessons 23-27 are lifesaving.
--This Education **Rx also enables the provision of evidence-based 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.
(Sustainable Long-Term Culture Changing Impact)

8. 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. (See Lessons 18-20)

9. Misconceptions about AIDS. The belief that having sex with a virgin will cure AIDS is a common cause of sexual abuse in children. Challenging just this one belief could save untold deaths and suffering. (See Lesson 4&5)

Part VI. Health Educators

1. Evidence-based health promotion & prevention is critically needed at all levels of the healthcare pyramid. Most Health Educators are nurses or teachers. However physicians and dentists play a very important role by introducing the information to the patient prior to referral for more comprehensive counselling.

2. Referral to Health Educators enables compliance with international and national standards of care.
--There is **no position more important** in meeting the requirements for our patients' health and wellbeing (Saving the *Most* lives & Preventing the *Most* Suffering).

--This is true at **all** levels of the healthcare pyramid: Hospital, Clinic/health-center, or Family/Community (Includes Church & School).

3. Health Educators are sometimes referred to as Community Health Educators or CHEs (Chays). However the information requirements are the same for both individual and community health education.

4. The information required for IS&G evidence-based health education is available free for downloading in numerous languages from the www.HEPFDC.org DOWNLOAD FREE page. Detailed guidelines for effective **participatory health education** (Drawing out the answers to establish individual and community ownership) can also be downloaded free from the same page: HEPFDC DETAILED PARTICIPATORY LESSON PLANS FOR GROUP LEARNING (We are deeply indebted to Jody Collinge MD and the Global CHE Network for creating these resources)

5. Although WHO and HHS guidelines are lifesaving, some are relatively complex and take time to properly demonstrate. And the participatory approach, although definitely most effective, is also time-consuming and providers rarely have adequate time. Health Educators are therefore required for both **group** health education as patients are waiting (This time should never be wasted), and for provider referrals for **individual** patient counseling.

6. For Medical and Dental Short Term Missions (STMs): STM & Local Health Educators work together as teams**.** If neither is fluent in the others language, a translator is also required.
a. Most **STM Health Educators** are nurses, teachers and medical or nursing students who have become familiar with the content of the HEPFDC and the HEPFDC DETAILED PARTICIPATORY LESSON PLANS FOR GROUP LEARNING.
b. As western 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, pastors and other educators in their attempts to implement WHO guidelines after the team leaves**.**
c. Local Health Educators are from local sponsoring churches, schools and clinics who will carry on the program after the team leaves (essential for ensuring subsequent sustainability and multiplication of the team's efforts).
--They have received copies of the HEPFDC (in English and the local language, when available) on the STM vision trip.
--Sending Team Members also leave their copies with Local Health Educators when the team leaves. Additional copies may be downloaded free for computers, smart phones as well as hardcopies. This is important for sustainability as well as multiplication of holistic health teaching to surrounding communities.
--Local educators soon have much of the information memorized and use the Handbook and Illustrations to teach others, utilizing the cultural and participatory approach that is most effective for their particular community.
d. The number of STM Health Educator Teams required will depend on the number of patients to be evaluated:
--At least two are needed to provide health education to **groups** of patients waiting to

be seen.
--Others are needed to provide **individual** health counseling to patients referred by team and local participating physicians for conditions requiring more time-consuming counseling.
--Others may be needed to man **Health Fair or other Health Education Booths** for additional participatory learning.
--Local Health Educators usually alternate positions to gain experience in all the above areas.

7. The HEPFDC is available free for downloading in numerous languages in two pdf file size:.
--**HANDBOOK & ILLUSTRATIONS (8.5 x 11 Inch-Letter Size) for Notebook size hardcopies.** The same pdf files are also used for **cell phone, computer, and large screen projection teaching**.
--**ILLUSTRATIONS (11x17 Inch-Tabloid Size) POSTERS** for small group teaching.
--See **PRODUCING YOUR OWN PROGRAMS** (It's EASY!).

8. ***Most patients will require follow-up counselling by local Church, Clinic or Community Health Educators.*** This is especially true for complex conditions such as diarrhea, NCDs and other conditions related to lifestyle. Church/FBO educators utilizing a holistic, participatory approach are especially important for meeting WHOs highest rating of effectiveness--See WHO's Building from Common Foundations and Interventions on Diet and Physical Activity: What Works

9. A qualified physician is usually appointed to serve as consultant for those questions the Health Educator may be 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 HEPFDC@gmail.com for incorporation into future updates.)

Part VII. Medical Teams

As noted above, although most STM Medical Teams no longer carry in their own drugs, there are **no professionals more important to the success of Healthcare STMs than qualified physicians and pharmacists**. This also frees up the time and resources to provide critically needed, high quality, safe and truly effective Medical STMs:
1. Vision/ Planning Trips by at least one team leader are essential to meet the following requirements:

1. Establish ***ongoing collaboration*** **between 3 main groups**:
   a. Churches and/or other local Faith-Based Organizations (FBOs)
   b. Ministry of Health (MoH) and
   c. Local Community (Includes community leaders, school systems, etc.).
2. Determine the **"Greatest Needs and Assets"** *from* the above 3 groups.
3. **Obtain MoH approval** of HEPFDC content.

2. "Greatest Needs and Assets" nearly always include:

a. Primary Care Physician to Physician collaborative demonstration of the integration of community health into primary care practice: "the key to community transformation and the success of healthcare systems in both developed and developing countries".
b. Primary Care Physician to Patient introduction to the HEPFDC and referral to team Health Educators
c. Specialty Services (such as cardiac clinics) are often critically needed not only for direct patient care, but local provider CME on how best to manage these patients (Long-Term Benefit). Enables specialists to provide critically needed care in their area of expertise to patients scheduled for STM specialty clinics by local providers
d. Pharmacy provider and patient education re safe and effective use of locally available medicines and management of pharmacy services.
Note: The above approaches are similar to CMDA's Medical Education International and often lead to follow-up return visits and long-term provider relationships (Long-term Culture-Changing Benefit).

3. After a brief introduction, the physician refers the patient to the STM/Local Health Educator Team. The Educator Teams provide:
--individual often life-saving counselling (health education is often most effective when provided at the time of need).
--participatory group counselling of the communities most important problems while patients are waiting to be seen.
--participatory health education booths at Church-Based Health Fairs and other CHE and CHE&S events. See: Parts IX & X below.
See also the HEPFDC Participatory Approaches tab.

4. Your STM use introduces the program to the community. It is difficult to overemphasize the importance of this for patients in developing communities:
--Most patients have tremendous respect for western physicians so *even a few words in support of the above HHS/WHO guidelines can often be lifesaving.*
--It also enhances patient acceptance of the program when later used by local church and other holistic health educators to reach out to their community. (Long term *Culture-Changing* benefit.)

For additional information see CHE&S Guidelines on the Health Screening tab.

Part VIII. Dental Teams

All of the above guidelines apply to high quality dental services. In addition:
1. HEPFDC Lessons **"36 Oral Health for Adults"** and **"37 Oral Health for Children"** are specifically provided to assist **Dental/Oral Surgeons** in the provision of high quality preventative health care services.

2. The following are also especially applicable to high quality dental care:
a. 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.

b. 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 causes, 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 HEPFDC Sections 2B & 30B).

c. Smoking Cessation.

--Smoking adversely effects dental post-op care "Adverse effects of smoking on **wound healing** have been well established"--Institute of Medicine Report 2001**.**

--Smoking is not only the "major cause of **oral cancer**…**periodontitis**…**Smoking is the single (Now second--next to unhealthy diet) greatest cause of avoidable morbidity and mortality**…harms nearly every organ of the body." Surgeon Generals Report 2004.

--Evidence-based sources report that although only 15% of our of our medical treatments for all other conditions have been shown to be beneficial, doctor/patient education for smoking cessation meets the very highest possible evidence-based ratings for effectiveness.

--*Your counseling saves the life of one of every two patients who decide to quit smoking.*

3. As with other STMs, after a brief introduction, the Dental/Oral Surgeon refers the patient to STM/Local Dental Team Health Educators. The Educator Teams provide:

--individual often life-saving counselling (health education is often most effective when provided at the time of need).

--participatory group counselling while patients are waiting to be seen.

--participatory oral health education booths at Church-Based Health Fairs and other CHE and CHE&S events. See: Part IX &X below.

See also the Oral Health Education section of the HEPFDC Participatory Approaches tab.

4. Your STM use introduces the program to the community. It is difficult to overemphasize the importance of this for patients in developing communities:

--Most patients have tremendous respect for doctors of western dentistry, so *even a few words in support of the above HHS/WHO guidelines can often be lifesaving.*

--It also enhances patient acceptance of the program when later used by local church and other holistic health educators to reach out to their community. (Long term *Culture-Changing* benefit)

Part VIII. Church/Community Health Education (CHE) Teams

The HEPFDC is most often utilized by both secular and faith-based organizations (FBOs) for standalone CHE (in collaboration with local Ministry of Health or local hospital/clinic in the US). **CHE:**

1. addresses the 70% of diseases that are preventable

2. is used in both long-term and short-term settings in the US and throughout the world.

3. enables the Church, both US and globally, to reassume its responsibilities for the holistic health of its community.

4. HEPFDC's IS&G evidence-based materials enable use at all levels of the Healthcare Pyramid (From Hospital/Clinic to Church/Community).
5. The same evidence-based information and participatory methods are required for both individual and community "Saving the most lives and preventing the most suffering."
6. "The future of health care generally, and primary care specifically, depends on the integration of personal health care and public health at the level of the local community" *The Lancet 13 Sept 2008*
7. is also an especially safe, effective and sustainable alternative to the drug-based approach to short-term missions.
8. Is most often used by Nurse short-term missions (either individual or small group) to enable Church/FBO and Ministry of Health collaboration in resolving the 70% of the disease burden that is preventable. They demonstrate use of the HEPFDC to:
--Local congregations (or FBOs and missionaries where there is no church)
--Nursing and other provider training schools and courses
--Seminaries and Bible Schools
--School teachers, Community Health Workers and other education systems
9. Church-based CHE and CHE&S (See Part X) have been given **WHO's highest evidence-based rating for effectiveness** (See WHO's Interventions on Diet and Physical Activity: What Works and Building from Common Foundations)

Part X. Church/Community Health Education & Screening (CHE&S) Teams

CHE&S adds simple evidence-based health screening to the CHE approach. **CHE&S:**
1. is especially important when assisting Churches and Ministries of Health in their collaborative efforts to resolve the "Slow Motion Disasters" of 1. Non-Communicable Diseases (NCDs), 2 Climate Change and 3 Antibiotic Resistance, as well as enable survival in current, and prevention of future pandemics
2. enables Physicians, Pharmacists and other Healthcare Providers the opportunity to provide critically needed, high quality, safe and effective care even in primitive settings. It also offers critically needed collaborative curative care CME activities with their in-country colleagues.
3. is often combined with Church/Community Health Fairs addressing the community's most important health problems.
4. is used in both long-term and short-term settings in the US and globally.
5. Church-based CHE (See Part IX) and CHE&S have been given **WHO's highest evidence-based rating for effectiveness** (See again WHO's Interventions on Diet and Physical Activity: What Works and Building from Common Foundations)
6. See HEPFDC Health Screening tab for specific comprehensive guidelines

Evidence-based recommendations for improvement to this program are very much appreciated and may be sent to HEPFDC@gmail.com

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