

## Counselling Needs of Out-Patients in University College Hospital Ibadan (UCH), Nigeria

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**Abstract.** The inability of health personnel to meet certain needs of patients usually leads to patients' dissatisfaction. This is actually and in no doubt, calls for proactive actions. This study therefore, investigated the counselling needs of out-patients in UCH Ibadan Nigeria. The study also examined the influence of level of education and religion on respondents' views. Descriptive survey research design was adopted for the study. A total of 900 out-patients in UCH, Ibadan were selected using a three-stage sampling procedure which comprised simple random sampling, purposive and systematic random sampling techniques. The instrument used for data collection was a questionnaire entitled "Counselling Needs of Patients Questionnaire (CNPQ)". The validity of the questionnaire was established by three experts in the Departments of Counsellor Education. The reliability of the questionnaire was determined using split-half method and a correlation coefficient of 0.86 was obtained. Analysis of Variance (ANOVA) and t-test statistical tools were used to analyze the formulated hypotheses at 0.05 alpha level. The findings showed that out-patients in UCH Ibadan needed counselling to handle negative thoughts relating to illness, cope with the state of being ill and disease management. The findings also revealed that there were significant differences in the counselling needs of out-patients in UCH Ibadan based on level of education and religion. The study concluded that health personnel generally should take courses in counselling to further enrich their knowledge and skills on meeting the counselling needs of patients.

**Keywords:** Counselling Needs, Out-patients, UCH Ibadan

### 1. Introduction

Patients have significant psychological problems following an illness especially a critical one. To date, very few healthcare care units have specialized psychological/counselling services to help with the aftermath of the experience (Jones & Griffiths, 2007). In view of the importance of human feelings and emotions involved in health service delivery, counselling provides opportunity for handling psychological needs of patients.

According to Whitlock, Orleans, Pender, and Allan (2002), health personnel must develop a solid repertoire of basic counselling skills such as active listening, unconditional positive regards, confrontation, summarizing, warmth and effective communications. Health care providers play unique and important roles in encouraging and helping patients to make healthy behavioural decisions and changes (McInnis, Franklin & Rippe, 2003). Health counsellors assist in improving behaviours and providing self-management tools that are required for treatment and they encourage patients to manage health challenges (American College of Preventive Medicine, 2009). Some key elements of health care systems-oriented model in medicine can be achieved through health counsellors.

Clinicians have opportunities to intervene on matters related to health behaviours. According to Greenstone (2003), the challenge is no longer proving that changing health behaviours is effective, but rather in enhancing clinicians' and the health care system's commitment to learning how to incorporate counselling interventions in their practices and to give specific and compelling messages and strategies to patients and meeting their needs. The risks of not changing must be clearly expressed and a specific plan outlined (Greenstone, 2003).

### 1.1 Concept of Counselling

Counselling refers to a relationship that is characterized by mutual respect, effective communication, genuine and complete acceptance of the client by the counsellors. Counselling is the process of assisting people to overcome obstacles to their personal and interpersonal resources and goals in life. In daily practice, physicians attend normally to both functional and dysfunctional people, and patients' illness and psychosocial problems affect other areas of the patient's life (Kumar, 2009). Counselling has been used to denote a wide range of procedures including advice giving, support in times of trouble or needs, encouragement, information giving and test interpretation. The ordinary meaning attached to counselling is that of consultation, discussion, deliberation, exchange of ideas or process of decision-making (Amao-Kehinde, 2009).

Counselling is therefore required in health centers as doctors are expected to provide comprehensive care to their patients (UNESCO, 2012). Medication alone might not provide comprehensive care to patients. Counselling is needed to handle emotional and psychological aspects of the patients' life. A large proportion of patients' complaints probably have psychological components but, some doctors shy away from counselling patients and their families because they are usually busy and unable to spend much time with patients and most of them do not have adequate training or knowledge regarding counselling (Whitlock, Orleans, Pender & Allan, 2002). A bio-

psychosocial understanding of health issues and health problems has stopped being just a physician's job. Therefore, the role of well-trained counsellors in health care is gradually becoming more important (Karademas, 2009). Counselling is aimed at assisting individuals to make appropriate and satisfying personal, vocational, educational, marital and health choices (Kumar, 2009).

Counselling is a long-term process. It does not translate into desired effect immediately, but frequent sessions help in changing the behavior and the attitudes towards the problem leading to desirable results. Counselling addresses issues such as healthcare, physical financial, psychosocial and nutritional need. The objective of counselling is to meet the needs, ensure the right of the patient and support the patient where possible to overcome barriers to successful treatment (Sigh & Devir, 2015).

### 1.2 Counselling and Healthcare

The primary care setting is the obvious place to provide behavioural counselling as most patients have needs for counselling (Terre, Hunter & Poston, 2007; McInnis, Franklin & Rippe, 2003). In medical practice, health counselling services are provided in order to address the feelings, needs and emotions of patients. Some health problems result from chronic conditions that are related to an individual's behaviour, these behaviours can be changed through preventive measures such as primary (preventing disease) secondary (early diagnosis), and tertiary (slowing or preventing deterioration). This requires active participation of patients and guidance by physicians, nurses and counsellors. Studies have shown that patients' behaviours can be changed through counselling (Terre, Hunter & Poston, 2007).

About 72% of practitioners considered counselling as a responsibility that should be executed by health officers (Kushner, 1995). Many are also interested and able to give tailored advice. As stated by Smith, Bauman, Bull, Booth and Harris (2000), counselling is a strong incentive for health-promoting action.

Advice from a physician has consistently been shown to lead to improved lifestyle behaviours (Fontaine, Haaz & Bartlett, 2007). However, clinicians and other health personnel do not have the required expertise in counselling, this could be also be very cumbersome to clinicians. There is therefore the need for counselling centers in hospitals.

Prevention-oriented interactions between clinicians and patients have a counselling dimension; they focus on patient behavioural change such as scheduling a mammogram or beginning a regular exercise regimen. According to the Center for the Advancement of Health (2001), there is evidence that the clinician-patient interaction can affect the likelihood of follow-up services. Unfortunately, physicians often underestimate the power of their role as health behavioural change counsellors (Rippe, McInnis, & Melanson, 2007). Patients who attended counselling usually provide feedback on the benefits of speaking to someone who is independent and not directly involved with them or their treatment as this has allowed them to explore their feelings and discuss the essence of their treatment (American College of Preventive Medicine, 2009).

### 1.3 Counselling Needs of Patients

Patients look up to their Primary Care Providers (PCP) for counselling and preventive health information (Whitlock, Orlean, Pender & Allan, 2002). Most (90%) of adult patients of Health Maintenance Organizations (HMO) indicated that they need advice and help in major key behaviours, such as diet, exercise, getting enough rest, and drug use (American College of Preventive Medicine, 2009). An effective counselling provides clarification on misconceptions about health behaviours. For instance, most patients usually desire information about their diet and wellbeing; it has therefore been documented that these are areas where counsellors can be of assistance (Katz, 2005). American College of Preventive Medicine (2009) indicated that counselling based on health promotion and disease

prevention strategy is very relevant to health care.

Patients have various counselling needs including increased managing risk of drug reactions, the presence of additional health conditions, increased financial burdens of care, and caregiver stress and strain. Patients need counselling on a variety of musculoskeletal, neuromuscular, and cardio-pulmonary issues to achieve the highest possible level of functional independence. They need an individualized treatment plan that will help restore and maintain movement needed for everyday life. Patients also need help to reduce pain, increase endurance, and enhance safety awareness. They need a therapist that would work closely together with them to ensure that their personal goals are part of the treatment plan. When counselling needs are met, it also increases patients' satisfaction in healthcare.

Patients need counselling service to relieve sufferings while receiving other necessary treatments. They need counselling to address physical symptoms such as ache, shortness of breath, and nausea, including non-physical causes of suffering, such as sadness and depression and anxiety regarding treatment choices and end-of-life decisions. Patients need professional counselling in order to provide comprehensive symptom management, psychosocial and spiritual support, and care that are sensitive to their specific needs. Unfortunately, appropriate counselling services are not usually provided in hospitals and the counselling needs of patients are usually not met (Karademas, 2009).

### 1.4 Moderating Variables

Researchers have observed and reported that several factors affect patients' needs. These factors include age, gender, religion and level of education. It has been reported that frequency of hospital visit increases with age; patients less than 15 years of age visit hospital less (average 2.4 visits per person annually), and those 15 years of age and older visit hospital more (average 1.6 to 6.3 visits per year). As age

increases, visits to hospitals increase which also increases the areas of patients' needs (U.S Bureau of the Census, 2002; American College of Preventive Medicine, 2009). Primary Care Providers (PCPs) manage many patients with chronic conditions; they attend to 75% of adults at least once a year; an average of 2-3 visits per year (Abraham, Stein, Schaufele, Frates & Rogern, 2000). Similarly, age of individuals could affect their needs. When providing needs of patients, provider must consider patients' age and developmental level (Nach, 2015). Some needs seem to vary in terms of importance as one ages (Molter, 2009).

Gender affects patients' expression of their needs. In a study conducted by Wieseman et al. (2004), women reported their needs differently from men. Also, in a study carried out by Al-Khashan, Almulla, Galil, Rabbulnabi and Mishriky (2012), men were found to express their need differently from women. Patient level of education depicts how well the patient could comprehend and express their needs (Borhani, 2001). Individuals and his or her characteristics, opinions and needs are situated within and affected by the family, community, level of exposure and educational status. Education is a key to filtering mechanism that place people within a particular ecology context. Education is linked to life experiences including health outcomes (Zimmerman, Wolf & Haley, 2015). With higher levels of education tend to have lower exposure to stress related and unhealthy behaviours (Pampel, Krueger & Denny, 2010).

Religion refers to one's faith and set of belief. Religion can protect and promote a healthy life style, social support (people can experience social contact with co-religionists and have a web of social relations that can help and protect whenever the case) (Rumun, 2014), physiological states (religious people can experience a better mental health, more positive physiological states, more optimism and faith, which in turn can lead to a better physical state due to less stress (Rumun, 2014). Beliefs of Christians are different from that of Muslims, Budhist, Judist and that of others (Miller & Therenson, 2003; Rumun, 2014). This informed

the researcher's choice of variables of level of education and religion.

## 2. Statement of the Problem

Lack of counselling services in hospitals might result in poor relationship between health personnel and patients, where patients would not be able to express their feelings and ailments appropriately. Whitlock, Orleans, Pender, and Allan (2002) noted that the most significant barriers to meeting patients' counselling needs at the system level are lack of time with patients, lack of training in counselling techniques and lack of reimbursement for these services. All these create dissatisfaction among patients; it could also have adverse effect on the recovery rate of patients invariably, proactive actions are necessary. In view of the need the relevance of counselling in addressing health challenges, this study investigated the counselling needs of out-patients in UCH Ibadan, Nigeria.

## 3. Research Questions

In line with the statement of the problem, the following research questions were raised:

- (i) What are the counselling needs of out-patients of teaching hospitals in Nigeria?
- (ii) Is there any difference in the counselling needs of out-patients of Teaching Hospitals in Nigeria based on level of education?
- (iii) Is there any difference in the counselling needs of out-patients of teaching hospitals in Nigeria based on religion?

## 4. Hypotheses

Based on the research questions, the following null hypotheses were formulated and tested at 0.05 alpha level:

- There is no significant difference in the counselling needs of out-patients of teaching hospitals in Nigeria based on level of education.

- There is no significant difference in the counselling needs of out-patients of teaching hospitals in Nigeria based on religion.

### 5. Methodology

Descriptive survey research procedure was adopted for this study. The population for this study comprised all patients of teaching hospitals in South West Nigeria, while the target population consisted of all out-patients in the ‘General Out-Patient Departments (GOPD) of the selected University Teaching Hospital in Nigeria. In order to ensure representativeness, a Three-stage sampling procedure was employed to select the participants for the study. At stage 1, the Simple Random Sampling procedure was used to select one Teaching Hospital in South West geopolitical zone of Nigeria. At stage two, purposive sampling technique was used to select the General Outpatient Departments (GOPD) in the hospital. The clinic was selected because patients at the clinics might not be too sickly to be approached for the needed interactions and they were most likely going to be more heterogeneous in terms of their illnesses than the homogenous specialist clinics such as Cardiology, Nephrology, Dermatology clinics, among others. Similarly, the GOPD patients were more likely than other patients to see different medical personnel during consecutive visits and thus would be best to give their experience on attitude of health workers.

The instrument for the study was a self-developed questionnaire titled “Counselling Needs of Patients Questionnaire” (CNPQ). The questionnaire consists of two sections; viz A and B. Section A contained items on the personal data of respondent. Sections B contained 20 items seeking information on the health care expectations of patients. The validity of the questionnaire was established by three experts in the Departments of Counsellor Education University of Ilorin, Nigeria. The reliability of the questionnaire was determined using split-

half method and a correlation coefficient of 0.86 was obtained.

The questionnaire for the study was administered to the respondents by the researcher and six trained research assistants to ensure ease of administration and retrieval of the instrument. A total number of 900 copies of the questionnaire were administered to the respondents. Prior to the administration of the instruments, the researcher got approval from the Ethical Review Committee (ERC), University College Hospital, Ibadan. The Analysis of Variance (ANOVA) and t-test statistical tools were used to analyze the formulated hypotheses at 0.05 alpha level.

### 6. Results

#### Demographic Characteristics of Respondents

**Table 1:** Distribution of Respondents by Level of Education and Religion

Variables	Variables	Frequency	Percentage (%)
<b>Level of Education</b>	Non-Literate	410	45.6
	Literate	490	54.4
	<b>Total</b>	<b>900</b>	<b>100.0</b>
<b>Religion</b>	African Traditional Religion	63	7.0
	Christianity	394	43.8
	Islam	443	49.2
	<b>Total</b>	<b>900</b>	<b>100.0</b>

Table 1 shows the distribution of out-patients. The table indicates that 50.9% (458) of the respondents were females while 49.1% (442) of the respondents were males. The table shows that 8.0% (72) of the respondents were between ages 18-27 years, 30.8% (277) of the respondents were between ages 28-37 years, 34.7% (313) of the respondents were between ages 38-47 years while, 26.5% (238) of the respondents were between ages 48 years and above. The table shows that 45.6% (410) of the respondents were not literate while 54.4% (490) of the respondents were literate. The table also showed that 7.0% (63) of the respondents were practicing African Traditional Religion, 43.8%

(394) of the respondents were Christians while, 49.2% (443) of the respondents were Muslims.

**Research Question 1:** What are the counselling needs of out-patients in UCH Ibadan?

**Table 2:** Mean and Rank Order on the Counselling Needs of Out-Patients in UCH Ibadan

Item No.	I need counselling in the following areas in order to handle health challenges:	Mean	Rank
1	disease management	3.73	1 <sup>st</sup>
3	seeking information about my ailment	3.71	2 <sup>nd</sup>
2	adherence to medication	3.70	3 <sup>rd</sup>
5	management of stress	3.66	4 <sup>th</sup>
17	reducing anxiety	3.66	4 <sup>th</sup>
6	coping with the state of being ill	3.66	4 <sup>th</sup>
4	acceptance of my condition	3.65	7 <sup>th</sup>
10	pain management	3.64	8 <sup>th</sup>
11	psychological support	3.64	8 <sup>th</sup>
19	adhering to healthy meals	3.64	8 <sup>th</sup>
7	exploring my feelings	3.63	11 <sup>th</sup>
12	social support	3.63	11 <sup>th</sup>
18	prompt referral	3.63	11 <sup>th</sup>
13	coping with unmet health care expectations	3.61	14 <sup>th</sup>
16	handling negative thoughts	3.61	14 <sup>th</sup>
20	engaging in regular exercise	3.61	14 <sup>th</sup>
9	getting through the shock of being sick	3.60	17 <sup>th</sup>
14	handling financial challenges	3.60	17 <sup>th</sup>
15	fear of death	3.56	19 <sup>th</sup>
8	spiritual support	3.52	20 <sup>th</sup>

Table 2 showed the mean and rank order of the counselling needs of out-patients in UCH Ibadan. Out-patients in UCH Ibadan, Nigeria need counselling on disease management (3.73), seeking information about my ailment (3.71), adherence to medication (3.70), management of stress (3.66) and reducing anxiety (3.66) among others.

**Hypotheses Testing**

Two null hypotheses were formulated for this study. The hypotheses were tested using t-test and ANOVA statistical tools at 0.05 alpha level.

**Hypothesis One:** *There is no significant difference in the counselling needs of out-patients in UCH Ibadan based on level of education.*

**Table 3:** Mean, Standard Deviation and t-value on the Counselling Needs of Out-patients in UCH Ibadan based on Level of education

Level of Education	N	Mean	SD	df	Cal. t-value	Crit. t-value
Non-Literate	410	56.14	8.23	898	11.11*	1.96
Literate	490	66.47	9.27			

\*Significant, p<0.05

Table 3 showed the mean, standard deviation and t-value on the counselling needs of out-patients in UCH Ibadan based on level of education. The analysis shows that the calculated t-value is 11.11 and the critical t-value is 1.96. The critical t-value is greater than the calculated t-value. Therefore, the null hypothesis which stated that there is no significant difference in the counselling needs of out-patients in UCH Ibadan based on level of education is rejected.

**Hypothesis Two:** *There is no significant difference in the counselling needs of out-patients in UCH based on religion*

**Table 4:** Analysis of Variance (ANOVA) Showing the Difference in the Counselling Needs of Out-patients in UCH Ibadan Nigeria based on Religion

Source	df	SS	Mean Squares	Cal. F-value	Crit. F-value
Between Group	2	624.412	312.206	4.43*	3.00
Within Group	897	63138.689	70.388		
Total	899	63763.101			

\*Significant, p<0.05

Table 4 shows the Analysis of Variance (ANOVA) showing the difference in the counselling needs of out-patients in UCH Ibadan based on religion. The analysis shows that the calculated F-ratio is 4.43 and the critical F-ratio is 3.00. The critical F-ratio is less than the calculated F-ratio. Therefore, the hypothesis which stated that there is no significant difference in the counselling needs of out-patients in UCH Ibadan based on religion is rejected.

To determine the mean value(s) that caused the significant difference observed in the ANOVA

results of Table 4, Duncan Multiple Range Test (DMRT) was used as a post-hoc test. The results of the DMRT procedure are displayed in Table 5.

**Table 5:** Duncan Multiple Range Test (DMRT) Showing the Difference in the Counselling Needs of Out-patients in UCH Ibadan based on Religion

Duncan Groupings	N	Mean	Group
A	63	71.18	1
B	394	73.00	2
B	443	73.25	3

Table 5 shows the Duncan Multiple Range Test indicating the significant difference noted in the ANOVA on Table 4. Group 3 with a mean score of 73.25 slightly differed from Group 2 with a mean score of 73.00, but significantly differed from Group 1 with a mean score of 71.18. All the groups differed from one another, but the significant difference noted was as a result of the mean of Group 1, hence the significant difference noted in the ANOVA on Table 4. The difference was brought about by out-patients who practice African Traditional Religion. Therefore, the hypothesis was rejected.

### 7. Discussion of Findings

The respondents indicated counselling needs in areas of disease management and coping with the negative impact of being ill. They expressed that they needed counselling to handle negative thoughts, cope with the state of being ill, social support and spiritual support getting through the shock of being sick, to cope with unmet health care expectations, and fear of death. This in line with the finding of Schnur and Montgomery (2012) that showed that counselling is needed by both health care providers and patients. The findings are also in support of the submission of Terre, Hunter, and Poston, (2007); and McInnis, Franklin and Rippe (2003) that the Primary Care Setting is the obvious place to provide behavioural treatment as most patients have needs for counselling. The reason for this finding could be that ill-health could be psychological and financially draining therefore,

respondents' expression of counselling needs is understandable.

Hypothesis one which stated that there is no significant difference in the counselling needs of out-patients in UCH Ibadan based on level of education is rejected. This means that level of education affects the expression of out-patients based on counselling needs. This finding is against the findings of Reeve (2004) who found that counselling plays a significant role in helping people who have one ailment, or the other, come to terms with their conditions irrespective level of education. The finding is also against the findings of Ntuli, Julieth and Sia (2011) who concluded that many patients are not satisfied with the consultation of health personnel; hence, they needed counselling. The result could be because of more exposure that the literate out-patients have, which could lead to higher better expression of their counselling needs. It is also possible that out-patients who are literate are better informed and it is possible they express their needs more.

Hypothesis two which stated that there is no significant difference in the counselling needs of out-patients in UCH Ibadan based on religion is rejected. The difference was brought about by out-patients who practice African Traditional Religion; therefore, the hypothesis is rejected. This implies that religion affects the expression of the counselling needs of out-patients of teaching hospitals in Nigeria. This finding is against of the findings of Karademas (2009) who stated that appropriate counselling services should be provided in hospitals to meet counselling needs of patients of all ages, religions, and races as patients. The finding is also against the findings of Aweto, Oligbo, Fapojuwo and Olawale (2013) who found out counselling should be integrated in medicine for the benefit of all patients. This could also be linked to different perception that could be attached with different exposure. The three religions are giving different exposure to those practicing them. Also, life experiences differ based on the religious beliefs and ideology; thus, expression of counselling needs may not be an exception.

## 8. Conclusion and Recommendations

It was concluded that out-patients in UCH Ibadan need counselling to handle negative thoughts, cope with the state of being ill, for disease management, getting through the shock of being sick, to cope with unmet health care expectations, and fear of death to mention a few. There were significant differences in the counselling needs of out-patients in UCH Ibadan on the bases of level of education and religion. Based on the findings of this study, the following recommendations are made:

Government should mandate the employment of counsellors in all health institutions. These counsellors should form part of the team that treat patients. This will enable the counselling needs of all patients to be met.

Health personnel generally should take courses in counselling to equip them with counselling skills to help handle patients' emotions.

Health institutions should create conducive environment to allow counsellors to function at their best in the hospital. Physicians and nurses should be informed that counsellors are professionals and should be given opportunity to perform their duties.

Counsellors should publicize their profession as many people are not aware of the divergent roles they play in the society. This can be done through radio and television programmes.

The Counselling Association of Nigeria (CASSON) should take actions to help counsellors improve on their skills to be ready at all times to meet the needs of patients in disease management, and provision of psychological and social supports in and out of the hospital.

## References

Abraham, S., Stein, J., Schaufele, M. Frates, E. & Rogan, S. (2000). Personal exercise habits and counselling practices of primary care physicians: A national

survey. *Clinical Journal Sport Medicine*, 10, 40- 48.

American College of Preventive Medicine (2009). Coaching and counselling patients. Retrieved on 14 February, 2015 from [https://www.acpm.org/resource/res\\_mgr/timetools-files/coachingclinicalreference.pdf](https://www.acpm.org/resource/res_mgr/timetools-files/coachingclinicalreference.pdf).

Amao-Kehinde, A. O. (2009). *Fundamentals of Guidance and Counselling*. Lagos: BASHYPRINTS Publishers.

Fontaine, K. R., Haaz, S., & Bartlett, S. J. (2007). Are overweight and obese adults with arthritis being advised to lose weight? *Journal of Clinical Rheumatol*, 13(1), 12-5.

Greenstone L. (2003). Rationale for intervention to reduce risk of coronary heart disease: A General Internist's Perspective. *American Journal of Lifestyle Medicine*, 1, 20-23.

Karademas, E.C. (2009). *Counselling Psychology in Medical Settings: The Promising Role of Counselling Health Psychology*. Retrieved 13<sup>th</sup> December, 2014 from [www.ejcop.psychopen.eu/article/download](http://www.ejcop.psychopen.eu/article/download)

Katz, D.L. (2005). Competing dietary claims for weight loss: Finding the forest

Kushner, R. F. (1995). Barriers to providing nutritional counselling by physicians: A Survey of Primary Care Practitioners. *American Journal of Preventive Medicine*, 24, 546-550.

Rippe, J., McInnis, K., & Melanson, K. (2007). Physician involvement in the management of obesity as a primary medical condition. *Obesity Resources*, 9,302S-311S.

- Smith, B.J., Bauman, A.E., Bull, F.C., Booth, M.L., & Harris, M.F. (2000). Promoting Physical Activity in General Practice: A Controlled Trial of Written Advice and Information Materials. *Britain Journal of Sports Medicine*, 34, 262-267.
- Terre, L., Hunter C. & Poston, W. (2007). Treatment of Obesity in the Primary Care Setting: Are we there yet? *Eat Disorder*, 15, 135-143.
- U.S Beureau of the Census (2002). Statistical Abstract of United States: 2002. Retrieved 2<sup>nd</sup> October 2016 from <http://www.census.gov/library/publications/2002/compendia/statab/122ed.html>.
- Whitlock, E.P., Orleans, C.T., Pender, N.J., & Allan, J. (2002). Evaluating Primary Care Behavioural Counselling Interventions: An Evidence-Based Approach. *American Journal of Preventive Medicine*, 22(4), 267-284.