PD-AAS-562

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PROJECT EVALUATION:

POLAND/PROJECT HOPE OPG
(No. 1-0001)

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June, 1985

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PROJECT EVALUATION SUMMARY - PART II

I. EXECUTIVE SUMMARY.

A. Introduction: Purpose of the Evaluation

The Poland/Project Hope Operational Program Grant, as implemented by the People-to-People Health Foundation, Inc. (also known as "Project Hope", or HOPE) between Sept. 1982 and March 1985, was evaluated for the first and only time, as reported herewith. The equivocally formulated statement of objective was that "Project HOPE expects to meet about seventy per cent of the priority needs..." (defined in seven distinct categories) of the 19 recipient institutions, using resources from the OPG and other gifts-in kind.

In anticipation of a new Congressionally-mandated medical assistance OPG, to start in FY. 1985, the evaluation, consisting primarily of a site visit to six recipient institutions, interviews with all principal organizations involved, and a review of project records, intended to determine:

1. the effectiveness and efficiency of HOPE'S accomplishments in attaining objectives specified in their Grant Agreement with AID.

2. the validity of key project assumptions in the light of project experience, and future expectations.

Assuming favorable findings, the evaluation was also intended to provide "lessons learned" and recommendations to be considered in the design of any future OPG intended to provide medical relief assistance to Poland via similiar means.

B. Findings: (detailed in the body of the evaluation document esp. see sections II-XIV)

1. External Factors, and Validity of Key Project Assumptions
   The health and economic conditions in Poland, and the continued interest of the USG of the GOP, and of the Catholic Church in Poland suggest no fundamental changes. Key project assumptions relating to the goals, purpose, outputs and inputs both implicit and explicit to the OPG design, continue to be valid.

2. Inputs.
   The $5 million granted to HOPE for the supply of essential drugs, supplies, equipment, and related orientation/training to 19 maternal and child hospitals throughout Poland, were supplemented with $6.5 million worth of gifts-in-kind, also delivered to the

same institutions by HOPE. The actual expenditures of the GOP for international and in-country shippment, local currency travel and administrative costs are not known.

Given the absence of a strictly defined objective, and of the appropriate baseline data and information, it was not possible to quantify neither the the true effectiveness or extent to which this objective was met, nor the efficiency of its attainment. Thus, it is also not possible to determine with strict validity whether the input resources provided were adequate to realize the expressed objective and output. The above design weaknesses need to be addressed in any new OPG.

Overall, the evaluation findings suggest that HOPE has succeeded in providing a significant (though not always measurable) proportion of essential supplies and equipment to the select recipient hospitals in Poland during project life.

HOPE's management of the initial and continuing needs assessments, the procurement, packing and delivery (to the Dulles airport shipping facility), the assessments of utilization and orientation/training appear to have been conducted generally in a satisfactory manner. The orientation and training were particularly well-received by the Polish institutions and praised consistently by every hospital administrator interviewed.

Problems identified with these and other aspects of input management by HOPE are solvable, and are discussed in detail in sections ___ of the evaluation document. These, are also reflected in specific recommendations, with the explicit intent of being used during the design of a follow-on OPG.

3. Outputs.
Although available data and information was insufficient to determine to what extent OPG inputs contributed to the project objective (70% of essential commodities in seven selected categories), HOPE exceeded the planned number of recipient institutions by assisting a total of 24 hospitals.

The value of goods delivered to each recipient hospital ranges from $647,991 (at the Krakow Pediatric Institute) to $40,319 delivered to the Warsaw Mother and Child Hospital (see Appendix C attached). Unfortunately, HOPE was not able to provide a display of relief inputs by category of essential goods and related values.

4. Purpose
In general, the purpose of "providing emergency medical relief to

hospitals in Poland...in order to alleviate critical shortages of these items...and the resultant serious interruptions in the provision of medical treatment" has been fulfilled. As indicated above, and detailed elsewhere in this document, the design deficiencies of a loosely formulated objective and no baseline data make the strict assessment of effectiveness and efficiency in the the project's implementation very difficult if not impossible.

5. Goal.
The OPG's implicit goal of ameliorating the "mortality rates" among the "high risk groups (especially mothers and children) in Poland , continues to be valid given the credible contributions mediated through HOPE under the OPG. Information obtained through evaluation interviews suggests that neonatal mortality rates in at at least some of the recipient have been reduced as a result of respirators, and antibiotics provided by the project.

6. Unplanned Effects.
HOPE's superlative conduct of the commodity-oriented orientation/training seminars has has been recognized by enthusiastic participating hospital administrators as perhaps one of the most valuable long-term contributions to maternal and child survival made by the project. The instructional materials, prepared in Polish were distributed widely by the Poles themselves, providing precious references and knowledge concerning state-of-the art patient management to practicioners in many non-recipient hospitals as well. This effect should be viewed as highly advantageous, and should receive the emphasis it deserves in the forthcoming OPG.

7. Lessons Learned/Recommendations for a Follow-on OPG..

a. Project Design.
Standard principles of AID project design should be followed, to specifically include:

- a logical framework, quantified objectives, and End-of-Project Status;
- an annual implementation plan for AID's prior approval;
- an external evaluation plan;
- the plan to generate appropriate baseline information;
- an appropriately computerized management information and records system

b. Implementation

1. Hospital-specific percentage-of-need targets for commodities should be formulated, and explicit lists of procurement for well-defined "essential" commodities should be prepared for each recipient hospital to enable timely and appropriate use by the hospital in its annual

budget preparation.

2. Appropriate rapid feeedback systems to enable corrective action concerning problems with commodities received should be instituted and, if necessary, additional in-country and/or U.S.-based personnel should be employed to make this possible.

3. Consultant visits pertaining to commodity assessment and verification should be timed strategically, with intervals dictated by the annual procurement cycles. The visits should not be unduly frequent, and be carried out by the same individuals to the maximum extent possible.

4. Pharmaceuticals should be purchased in quantity and on a generic basis.

c. Evaluation.

An interim "process" evaluation should be completed at a strategic time following the first year of implementation; a final evaluation should assess effectiveness and efficiency in meeting project objectives. Semiannual AID site visits should take place to enable appropriate monitoring of project activities.

B. Special Issues

a. Coverage.

There is mutual agreement among the U.S. Embassy, the Polish health authorities interviewed, and the Polish Catholic Church representative, all of whom were consulted during the recent site visit to Poland, that:

1. continued medical relief to Poland is desirable; and

2. a future OPG should at least maintain the present number of recipient institutions, and not concentrate resources in southern Poland, as was proposed by HOPE previously.

b. Needs Assessment.

The definition of "essential commodities" should, in general, be based upon likelyhood of impact on reducing mortality and morbidity among mothers and children for least cost and maximum sustained duration. Formulation of procurement lists should be institution-specific and result in a clearly-defined and well-rationalized proportionate "mix" of consumable supplies, and essential equipment.

c. Infectious Diseases, Antibiotics, and Other Pharmaceuticals.

Expert consultants on infectious disease and nosokomial infections should assess the nature and prevalence of infectious diseases in recipient hospitals. Selection, procurement of appropriate antibiotics, and the implementation of appropriate orientation/training seminars should be planned accordingly with the aid of a consultant on clinical pharmacology. Selection and procurement of other pharmaceuticals should be rationalized by the criteria of maximum impact on reducing maternal and child mortality/morbidity for least cost.

C. Conclusion.

Given the very real limitations of the OPG design, the purpose and objective articulated in the Grant Agreement, and the limitations of the current evaluation methodology, HOPE appears to have performed well on most elements of implementation, and, according to hospital administrators, exceptionally well on the training and orientation seminars. It is clear that HOPE has established excellent relationships with the Polish health authorities, the administrators of the institutions visited, the Catholic Church in Poland, and our Embassy officials in Warsaw. HOPE project managers have shown themselves to be eager to consider improvements, and are more than willing to consider creative modifications of programing the delivery of relief assistance.

D. Recommendation.

It is recommended that HOPE's current proposal for implementing continued medical relief assistance to Poland be favorably considered, with modifications as needed, as arising from a thorough review and consideration of the recommendations and "lessons" presented in this document.

II. PROJECT BACKGROUND. PAGE BREAK

By mid-1981 the effects of the economic crisis in Poland were becomming noticeable in the deterioration of the health delivery system and in the status of public health of the country. Due to lacking foreign exchange, shortages in pharmaceuticals, hospital supplies, spare parts and equipment were increasing at alarming rates. These shortages made routine medical care extremely difficult, and restricted reliable health service delivery to emergencies only. Especially affected, were people in high risk groups --particularly mothers, children and infants, whose mortality had increased during the crisis, reversing the positive trends of the prior decades.

An American private voluntary organization called the People-to-People Health Foundation, Inc., otherwise known as Project HOPE, had been working in Poland with the American Children's Hospital since 1975. Together with AID's American Schools and Hospitals Abroad, Project HOPE had been involved in construction, equipment procurement, and medical education at the American Children's Hospital and its Pediatric Rehabilitation Center in Krakow, Poland.

In June , 1981 HOPE was requested by the Government of Poland (GOP)?? and the Polish Charity Commission?? of the Catholic Church to develop a program to

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FINAL REPORT

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I

GRANT NEB-0001-G-SS-2071-00

POLAND RELIEF PROGRAM

The People-to-People Health Foundation, Inc.
The Project HOPE Health Sciences Education Center
Millwood, Virginia 22646

May 1985

This is the final report, required under terms of Grant NEB-0001-G-SS-2071-00 dealing with emergency relief to hospitals in Poland and covers events from the start date of the grant (September 1, 1982) to the closing date (February 28, 1985).

Overview of Project Activities

In March 1982, before the start date of the grant, Project HOPE agreed on a plan with the Government of Poland (GOP) to deliver vitally needed emergency medical relief supplies and some equipment to a number of Polish hospitals to improve their ability to care for mothers and children. Based on its years of experience with the Polish health care system, HOPE and its Polish counterparts established a list of 19 hospitals throughout Poland. The list was agreed to by the GOP, and the Polish Catholic Church was accepted by HOPE and the GOP to monitor receipt and proper use of supplies by the hospitals.

In June and September, 1982, two survey teams of HOPE staff and medical consultants surveyed the hospitals on the original list and four others which had ben added.

The first shipment was made in July 1982 and consisted of US$1.1 million worth of supplies purchased with funds provided to HOPE by private sector donors. From September through December 1982, another US$2.4 million worth of supplies, donated to HOPE by private sector donors, were shipped before our grant funds were expended.

Principal activities carried out under the grant included the following:

1. Survey Visits of Each Proposed Recipient Hospital.

Each recipient hospital was visited by HOPE staff and consultants before any shipments were made to it.

The objective was to become directly acquainted with the unique needs of each institution. The visits were also used to educate the staff of the hospital as to the purposes of the relief, i.e. to supplement needed supplies and basic equipment which were currently in short supply or impossible to obtain. The restriction to maternal and pediatric services, and services supporting maternal and child health, was explained. A tentative list of most acute needs was completed on site.

2. Establishment of a Procurement and Delivery System for Materials

Utilizing the already existing HOPE International Headquarters and HOPE's Dulles Terminal Warehouse and shipment facilities, a computer-driven system of procurement, storage and shipping was developed especially for the project. This was a very complex and time-consuming part of the project activities.

The receiving operation in Poland was headquartered in The American Children's Hospital in Krakow where HOPE has had a continuous presence since 1976. The Director of that hospital, Professor Jan Grochowski,

was selected as Polish coordinator. Two full-time Polish employees assist him there and work with the site visit teams. Signed invoices for all goods, with the confirmation of the local church monitor, are sent there from each hospital after each shipment.

Two distribution points--one in Warsaw for hospitals in the North and the other in Krakow--were eventually established but with control remaining in Krakow. Transatlantic legs of all shipments were on Polish ships or airplanes, at Polish expense.

3. Quarterly Assessment Visits.

These were carried out by regions by four teams of HOPE staff and consultants. In general, the same team visited a given group of hospitals throughout the course of the grant which enabled them to become familiar with hospital staff and to monitor activities more easily and thoroughly.

The objects of these visits were to:

a. Double-check that supplies had, in fact, arrived intact and completely and were appropriate for the individual hospital.

b. See that supplies and equipment were being used appropriately. (The value of using health professionals familiar with the Polish health care system was great in this activity.)

c. Confer with hospital authorities about changing needs so that the material sent matched changing shortages.

d. Assist Polish staff where necessary in better use of the materials shipped.

e. Recommend to HOPE the types and amounts of material for subsequent shipments.

To carry this out, HOPE utilized three of its permanent senior staff and some 40 volunteer consultants familiar with Poland. The volunteer group included physicians, pharmacists, a biochemist, nurses and respiratory therapists. A list of the volunteers is included as ATTACHMENT A.

4. <u>Meetings Held Concerning the Project.</u>

a. Nine of the site-visit volunteers plus HOPE staff formed a committee which met at intervals at HOPE's Headquarters in Millwood, Virginia, to plan assessment visits and to make final selections of material to be sent in each shipment.

b. The Polish coordinator was able to attend a few of these meetings at the HOPE Headquarters. In addition, the HOPE Program Director (Mr. John Walsh) plus some HOPE staff and volunteers, met on an ad

hoc basis in Warsaw with Ministry Officials and in Krakow with hospital officials to monitor progress, to consider requests from other hospitals to be added to the recipient list, and to discuss dropping some original hospitals when their major needs had been met.

This kept the relief effort dynamic, and during the course of the grant, three additional hospitals (one in Tychy and two in Zabrze) were added, and one, in Lodz, was dropped.

c. Several permanent HOPE staff members formed a working group to assure efficient purchasing and shipment procedures. This included several members of our Development, Logistics, and Administrative Departments.

d. One very important meeting was held in the Vatican when the Program Director and three volunteers met with Pope John Paul II on April 27, 1983, to give him oral and written reports on the progress of the project and to thank him for the cooperation of The Polish Church authorities in checking the arrival of supplies.

e. As discussed in the next section, education of Polish doctors, nurses, and other health professionals in the optimal utilization of the equipment and supplies became an obvious necessary and one enthusiastically endorsed by the Poles.

Many organizational and development meetings were needed in the US to plan and execute this aspect of the project, some at HOPE Center, others at the universities and/or hospitals of the faculties who would present the seminars.

5. Educational Activities

An epidemiologic/demographic study done by a senior HOPE staff person during the course of the project indicated that a rising trend of infant mortality in Poland began in the winter of 1981-82 as a result of the deprivations brought about by martial law and Western economic sanctions.

This humanitarian relief project accented maternal and child health care for this precise reason. In addition to basic needed supplies (antibiotics and other drugs, disposables, dressings material, etc.) it was obvious that some monitoring equipment and treatment equipment would be necessary. The professional isolation of basically well-trained Polish health professionals over a 4-5 year period meant that for them to be brought up to date in the use of this equipment, symposia and workshops would be needed. Accordingly, a series of these was held throughout the course of the project.

They were received enthusiastically beyond our greatest hopes and lessons learned were immediately put into practice. They were held in Krakow, either at the American Children's Hospital or the Institute of

Obstetrics/Gynecology. One to two hundred registrants or more were present for each and came from all over Poland. Nurses and other health care personnel attended as well as physicians.

Very distinguished groups of American specialists made up the faculties as HOPE volunteers. Course material was prepared in Polish and equipment to be discussed was on hand and demonstrated. Questions from the floor were extremely numerous and relevant and indicated a hunger for improving current knowledge that was very rewarding to our faculties.

A list of the courses given is included as ATTACHMENT B. ATTACHMENT C is a summary of one course as an example of their organization and contents.

6. Summary of Commodities Shipped and Financial Status.

Material valued at at $856,389 was purchased with grant funds in the period from July 1, 1984, until the closing date of the project as detailed in ATTACHMENT D. Total value of material purchased with grant funds during the course of the project is $4,563,130.

In addition, gifts-in-kind shipped to Poland by February 28, 1985, reached a value of $6,597,737 for supplies, equipment and books.

7. Summary of the Financial Status of the Project.

Details of the expenditure of the grant funds over the life of the project are given in ATTACHMENT E.

Conclusion

The project was successful based on any criteria we have been able to use to measure it.

1. The amounts of equipment and supplies purchased and augmented by gift-in-kind have been large enough and carefully enough selected to have a significant impact on hospital cave of women and children in the recipient institutions.

2. The Polish institutions have been very careful users of the material:

   a. None has been diverted to illegal or inappropriate use.

   b. Their accounting for it has been meticulous.

3. The response of Polish health professionals to the educational components was positive far beyond our expectations and resulted in a rational and skillful use of new diagnostic and therapeutic modalities immediately upon their becoming available.

Our conclusion is that the relief program, with some difference in emphasis to broaden its impact even more, should be continued for another two to three years. During that time, we would:

1. Reassess the list of recipient hospitals to be certain that our impact will continue to be maximal for funds expended.

2. Continue the educational component covering some new areas and reemphasizing some of the ones previously discussed.

3. Extend our outreach into some primary care institutions in the southeast of Poland (where hardship is greatest) including with supplies and education some prospective analysis of the most effective ways for Polish primary care givers to minimize prevalent health problems so that our efforts will be maximally beneficial to Polish women and children.

MEDICAL PERSONNEL PARTICIPATING IN THE PROJECT HOPE RELIEF PROGRAM
September 1, 1982 - February 28, 1985

Marvin E. Ament, M.D.	University of California at Los Angeles
Philip Balderston, R.R.T.	Children's Hospital of Philadelphia, The Universtiy of Pennsylvania
Daniel Baranowski, R.R.T.	Children's Hospital of Philadelphia, The University of Pennsylvania
Shelly Baranowski, R.N.	Hahnemann University and Health Sciences Center
Charlotte Cady, R.N.	Children's Hospital of Philadelphia, The University of Pennsylvania
Lynn Cook, M.D.	University of Virginia Medical Center
Dennis a. Cotcamp, M.D.	The University of Florida School of Medicine
Robert K. Creasy, M.D.	University of Texas School of Medicine
Gary Cupit, Ph.D.	Pennsylvania College of Pharmacy and Science
Barbara J. Degnan, B.A.	McGaw Medical Center of Northwestern University
Susan DeHoog, R.D.	University of Washington Hospital
Floyd Denny, M.D.	University of North Carolina Medical Center
O. Richard Depp, III, M.D.	Northwestern University School of Medicine
Joann Desilets, R.N.	The Children's Hospital of Philadelphia, The University of Pennsylvania

Mary E. Donar, R.N.	The Children's Hospital of Philadelphia, The University of Pennsylvania
Henry R. Drott, Ph.D.	The Children's Hospital of Philadelphia, The University of Pennsylvania
Alexander Fakadej, M.D.	West Virginia Medical Center
Vickie Frey, R.R.T.	York Hospital
Pamela K. Fry, R.R.T.	The Children's Hospital of Philadelphia, The University of Pennsylvania
John Gallagher, M.D.	The University of Virginia Medical Center
Brett B. Gutsche, M.D.	Hospital of the University of Pennsylvania
Conley Heaberlin, Jr., R.R.T.	Presbyterian-University of Pennsylvania Medical Center
John J. Herbst, M.D.	University of Utah/Primary Children's Medical Center
C. Jeffry Hoydu, R.R.T.	The Chilren's Hospital of Philadelphia, The University of Pennsylvania
Dale Johnson, M.D.	University of Utah/Primary Children's Medical Center
John Kattwinkel, M.D.	The University of Virginia Medical Center
Kim L. Kaufman, R.N.	The Johns Hopkins University
Robert G. Kettrick, M.D.	The Children's Hospital of Philadelphia, The University of Pennsylvania
James D. Kitchin, III, M.D.	The University of Virginia Medical Center
Gerald B. Kolski, M.D.	The Children's Hospital, The University of Philadelphia

Richard A. Molteni, M.D.	The Johns Hopkins University School of Medicine
Susan T. Loud, R.N.	Uiversity of Virginia Medical Center
John D. Murphy, M.D.	The Children's Hospital of Philadelphia, The University of Pennsylvania
William I. Norwood, M.D.	The Children's Hospital of Philadelphia, The University of Pennsylvania
Richard H. Paul, M.D.	University of Southern California
Nancy Jo Reedy, MPH	Northwestern University Medical School
Rudy E. Sabbagha, M.D.	Northwestern University School of Medicine
Benjamin Silverman, M.D.	University of Pennsylvania/College of Medicine and Dentistry of New Jersey
Milton Skolaut, Ph.D.	Duke University Medical School
Alexander Spock, M.D.	Duke University Medical School
Stanislaw Szyfelbein, M.D.	Harvard Medical School/Massachusetts General Hospital
Lawrence Ten Eyck, R.R.T.	Bear Medical Systems, Inc.
M. Rita Thomas, R.D.	University of Utah
Kent Ueland, M.D.	Stanford University Medical Center
Sandra Wadlinger, R.R.T.	The Children's Hospital of Philadelphia, The University of Pennsylvania

EDUCATIONAL CONNFERENCES-PROJECT HOPE RELIEF PROGRAM

Perinatal Continuing Education Program
November 15-17, 1982
Attendance: 125

Pediatric Pulmonary Pathology and Disease
June 6-9, 1983
Attendance: 175

Postgraduate Course in Management of High Risk Pregnancy
June 4-7, 1984
Attendance: 150

Postgraduate Course in Nutrition and Gastroenterology
October 16-18, 1984
Attendance: 200

Neonatal/Pediatric Respiratory Intensive Care Symposium:
Focus on "Mechanical Ventilatory Life Support"
November 26-28, 1984
Attendance: 125

ATTACHMENT C

NEONATAL/PEDIATRIC RESPIRATORY INTENSIVE
CARE SYMPOSIUM
FOCUS ON:

"MECHANICAL VENTILATORY LIFE SUPPORT"

TO BE HELD AT:

THE INSTITUTE OF PEDIATRICS
THE AMERICAN CHILDREN'S RESEARCH INSTITUTE AND HOSPITAL
KRAKOW, POLAND

NOVEMBER 26, 27 & 28, 1984

SPONSORED BY:

PROJECT HOPE

AND

INSTYUT PEDIATRII AKADEMII MEDYCZNEJ
MIKOLAJA KOPERNIKA
THE AMERICAN CHILDREN'S RESEARCH INSTITUTE AND HOSPITAL
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SYMPOSIUM GENERAL OBJECTIVES:

To review with the physician the concepts, practices and techniques of artificial mechanical ventilatory life support of the neonatal/pediatric patient. Additionally, the physician will be trained to operate the Bear II Volume Ventilator, the Bear Cub BP-2001 and the Bear BP-200 Infant Pressure Ventilators and assorted accessory ventilator and respiratory therapy equipment.

To review with the bedside nurse with basic concepts of artificial ventilation. To orient the nurse to the basic operation and safety features of volume and pressure ventilators. To train the nurse to deliver routine respiratory care to ventilator-dependent neonatal/pediatric patients.

To familiarize the bio-medical engineer in the basic functions of a mechanical ventilator and to train the engineer in the repair and routine maintenance of the Bear II Volume Ventilator, the Bear Cub BP-2001 and the Bear BP-200 Infant Pressure Ventilators.

WHO SHOULD ATTEND:

Physicians (anesthesiologists, neonatologists, obstetricians and pediatricians) responsible for the application of mechanical ventilatory life support on premature infants, neonates, infants, children and obstetrical cases should attend.

Nurses responsible for providing bedside respiratory care and respiratory therapy to intensive care patients; especially the ventilator dependent patient should attend.

Hospital bio-medical engineers responsible for the repair and maintenance of technological life support systems should attend.

Twelve (12) hospitals have been invited to participate in this symposium. The symposium attendance is limited to a total of 60 physicians, 24 nurses and 12 bio-medical engineers. Therefore, each hospital should send maximally 5 physicians, 2 nurses and 1 bio-medical engineer.

SYMPOSIUM FORMAT:

This respiratory intensive care symposium on mechanical ventilatory life support will be conducted according to two major formats.

Each morning (8:00 A.M. to 12:00 P.M.) a series of lectures will be conducted with the design to provide the participants with a conceptual framework in which to understand the applications, practices and techniques of artificial mechanical ventilatory life support.

Each afternoon (1:00 P.M. to 3:30 P.M.) a series of training workshops will be conducted in which the operation, function, repair and maintenance of 3 different types of mechanical ventilators will be taught. These ventilator training workshops are focused on Bear Medical Systems, Inc. ventilators which each institution participating in the symposium will receive. Additionally, a workshop on respiratory therapy equipment will also be conducted.

Moreover, a separate series of training workshops will be conducted for nurses on the bedside respiratory care of ventilator dependent patients. Finally, a separate training workshop will be conducted for bio-medical engineers in the repair and maintenance of 3 specific Bear Medical System, Inc. ventilators.

The workshops will be given on a rotating basis throughout the course of the 3 day symposium.

CLINICAL TEACHING IN THE FIELD:

Special teams (a physician, a respiratory therapist and a nurse) made up from the American Symposium faculty will travel to hospitals participating in this symposium immediately following the symposium. These clinical field teaching visits will take place beginning on November 29th and run through December 7 of 1984. It is expected that all 12 institutions participating in this symposium will receive a 1 or 2 day visit by a symposium team.

The major purpose of the clinical field visit is to reinforce the concepts and training provided at the symposium as well as to provide an opportunity for a review of this information directly at the clinical site. Hopefully, during these visits all mechanical ventilatory equipment and accessories can be checked for function and actually applied on patients where needed. A schedule of the proposed team visits will be provided through the director's office of the Institute of Pediatrics at the American Children's Hospital in Krakow.

SYMPOSIUM FACULTY:

Host Faculty

Jan Grochowski, M.D.
Professor of Surgery
The Mikolaja Kopernika Akademia Medyczna
Director, American Children's Research Insititute and Hospital,
Institute of Pediatrics
Krakow, Poland

Waldemar Macheta, M.D.
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Assistant Head Nurse, Neonatal Intensive Care Unit
The Johns Hopkins Hospital
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RESPIRATORY INTENSIVE CARE PROGRAM

MONDAY, NOVEMBER 26, 1984

8:00 - 8:30 A.M.
Registration

8:30 -9:00
"Introduction and Welcome"

Jan Grochowski, M.D.
Waldemar Macheta, M.D.
Robert G. Kettrick, M.D.
Daniel F. Baranowski, R.R.T.
Shelley L. Baranowska, R.N.

9:00 - 10:30 A.M.
"A Practical Review of the Anatomical and Physiological Aspects of the Cardiopulmonary System as They Relate to Artificial Mechanical Ventilatory Life Support"

Gerald B. Kolski, M.D., Ph.D.

Part A: Functional Anatomy of Bronchopulmonary System, Mechanics of Ventilation and Respiration, Control of Respiration

Part B: Pulmonary Blood Flow and Gas Transport in Blood, Tissue Oxygenation, Ventilation Perfusion Relationships

10:30 - 11:00 A.M.
Morning Break

11:00 - 12:15 Noon
"An Introduction to the Anatomy and Mechanics of Volume and Pressure Ventilators"

Daniel F. Baranowski, R.R.T.

12:15 - 1:15 P.M.
Lunch Break

1:15 P.M. - 3:45 P.M.
"Workshops":

A. Bear II Volume Ventilator
Lawrence G. Ten Eyck, R.R.T.

B. Bear Cub BP-2001 Infant Pressure Ventilator
Pamela K. Fry, R.R.T.

C. Bear BP-200 Infant Pressure Ventilator
Pamela K. Fry, R.R.T.

D. Respiratory Therapy Equipment
C. Jeffrey Hoydu, R.R.T.

E. Nursing Care
Shelley L. Baranowska, R.N.
Mary E. Donar, R.N.
Kim L. Kaufman, R.N.
Pamela K. Fry, R.R.T.
C. Jeffrey Hoydu, R.R.T.
Richard A. Molteni, M.D.

F. Intubation and Airways Management
Robert G. Kettrick, M.D.
Richard A. Molteni, M.D.

3:30 P.M.
Adjournment First Day

TUESDAY, NOVEMBER 27, 1984

8:00 - 8:30 A.M.
"Intubation: Techniques and Tubes and The Management of Artificial Airways"

Waldemar Macheta, M.D.

8:30 - 9:10 A.M.
"A Review of Indications for Mechanical Ventilation: Focus on Early Intervention

Robert G. Kettrick, M.D.

9:10 - 9:40 A.M.
Morning Break

9:40 -10:40 A.M.
"Mechanical Ventilatory Manuevers: Continuous Positive Airway Pressure (CPAP)/Positive End Expiratory Pressure (PEEP) and Mean Airway Pressure (MAP)"

Richard A. Molteni, M.D.

10:40 A.M. - 12:00 Noon
"Approaches to the Institution of Mechanical Ventilation"

Neonatal: Richard A. Molteni, M.D.
Pediatric: Dennis H. Cotcamp, M.D.

12:00 - 1:00 P.M.
Lunch Break

1:00 - 3:30 P.M.
"Workshops Repeated"

3:30 P.M.
Adjournment Second Day

WEDNESDAY, NOVEMBER 28, 1984

8:00 -8:40 A.M.
"Complications of Positive Pressure Breathing and Mechanical Ventilation"

Gerald B. Kolski, M.D., Ph.D.

8:40 -9:20 A.M.
"Monitoring the Patient on Mechanical Ventilation and Monitoring the Equipment"

Dennis H. Cotcamp, M.D.

9:20 - 9:50 A.M.
Morning Break

9:50 -10:45 A.M.
"Principles and Techniques of Bedside Care for the Ventilator Dependent Patient"

Shelley L. Baranowska, R.N.
Robert G. Kettrick, M.D.

10:45 - 12:00 Noon
"Clinical Indications for Weaning Mechanical Ventilatory Support and Weaning Techniques Including Extubation and Follow Up"

Neonatal: Richard A. Molteni, M.D.
Pediatric: Dennis H. Cotcamp, M.D.

12:00 - 1:00 P.M.
Lunch Break

1:00 -3:30 P.M
"Workshops Repeated"

3:30 P.M.
Adjournment Third Day

COURSE SYLLABUS AND WORKING LIBRARY:

Each participant to the symposium will receive a course syllabus which will extensively outline each lecture and workshop.

Additionally, each participating institution will receive a library of 10-12 selected textbooks which will serve as major references for all information presented in the symposium. Included in this library will be an anthology of the selected articles from numerous publications as they relate to mechanical ventilatory support.

WORKSHOP SCHEDULE

1:00 P.M. - 3:30 P.M. Each Day

MONDAY	TUESDAY	WEDNESDAY
BEAR II VOLUME	BEAR II VOLUME	AIRWAY MANEUVERS
Krakow Peds Poznan Peds Poznan OB/GYN Kielce Peds	Gdansk Gen Lublin Peds Warsaw Trauma	Gdansk Gen Warsaw Trauma Bialystok OB/GYN Nowy Sacz Tychy Krakow OB/GYN Zabrze
BEAR BP-200	BEAR CUB 2001	BEAR BP-200
Bialystok OB/GYN Nowy Sacz Tychy Zabrze	Krakow Peds Krakow OB/GYN Poznan Peds Poznan OB/GYN	Kielce Peds Lublin Peds
RESP THER EQUIP'T	RESP THER EQUIP'T	RESP THER EQUIP'T
Gdansk Gen Warsaw Trauma Lublin Peds Krakow OB/GYN	Kielce Peds Nowy Sacz Tychy Bialystok OB/GYN Zabrze	Krakow Peds Poznan Peds Poznan OB/GYN

Nursing Workshops:

All nurses from all institutions:
1. Monitoring and recommendations
2. Artifical airway and cares
3. Chest physical therapy
4. Ventilators and humidification systems
5. Oxygen therapy
6. Nursing care plans

Each institution has been scheduled for workshops according to equipment (i.e. ventilator) received from Project Hope. All physicians and bio-medical engineers are expected to attend the workshops as outlined above.

All nursing personnel will attend a workshop each afternoon as well. This workshop will be designed to meet specific goals each day.

POLAND GRANT NEB-0001-G-SS-2071-00

Activity through February 28, 1985

Description	Funding Provided by Grant NEB-0001-G-SS-2071-00	Funding and Donations Provided by Project HOPE and Other Organizations and Individuals
Salaries	$ 148,509	$ 160,984
Fringe Benefits	28,268	7,257
Transportation	74,741	32,647
Allowances	4,260	4,029
Other direct Costs	144,888	318,289
Commodities	4,563,130	7,657,661
Total	$5,000,000	$8,180,860

PROPOSAL

OPERATIONAL PROGRAM GRANT

FOR

POLAND

The People-to-People Health Foundation, Inc.
The Project HOPE Health Sciences Education Center
Millwood, Virginia 22646

March 1, 1985

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ATTACHMENT B..... Renal Disease Prevention

A. PROJECT PURPOSE AND DESCRIPTION

Purpose and Target Group

Project HOPE under terms of AID Grant NE3-0001-G-SS-2071-00 carried out a project of humanitarian relief in Poland from September 1, 1982, through February 28, 1985. The purpose of the project was to provide relief in the form of drugs, pharmaceuticals and hospital supplies, spare parts and critically needed equipment to selected Polish hospitals to assure adequate basic care to mothers, infants and children, the target population group of the project.

This was in response to evidence that in the winter of 1981-82, economic and political conditions within Poland, plus economic sanctions from without, effectively cut off importation of much medical material from the West, causing a deterioration of health care of mothers and children and an upward trend in infant mortality. This was documented in a study done by HOPE in 1982/83. Infant mortality rate (IMR) was given by the National Research Institute for Mother and Child, Warsaw, as 20.5 per 1000 liveborns for 1980; 21.7 for 1981; and 22.3 for the first quarter of 1982. Forthe eight voivodships for which The American Chidren's Hospital, Krakow, is responsible, the IMR changed as follows:

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Province	IMR, 1981	IMR, First Quarter, 1982
Kielce	21.6	25.0
Krakow	19.5	18.3
Krosno	17.5	25.9
Nowy Sacz	26.6	26.8
Przemysl	19.5	23.1
Rzeszow	23.0	21.1
Tarnobrzeg	22.8	27.3
Tarnow	17.7	20.6

Figures for 1983 and 1984 are now being sought and will be reported when available to compare with the above.

Although martial law in Poland has now been rescinded, the government still has grave problems in importing both finished products and raw materials from which to manufacture drugs, other supplies or equipment. Because of this, a continued relief effort will be needed for the next three years if the health status of Polish mothers, infants and children is to be stabilized at least at present levels. The factors described above outline the rationale for the program's continuance. Especially important now will be the educational efforts which will enable equipment, drugs, and supplies delivered to be put into use immediately and most effectively. In our experience from the first grant period, we know that Polish health professionals are very eager to receive this training and do utilize it to the maximum extent possible. The final report of the first grant period outlines this.

The purposes of the project's continuance are similar to those of the first period (1982-85) but with some differences in emphasis to assure that priorities, which change with time, continue to be met properly.

Project HOPE has nine years of experience working at The American Children's Hospital in Krakow plus thirty months in the relief program just concluded. Using this background, we know that severe shortages of certain drugs, supplies and equipment still exist and are causing critical problems in the health care of the target population. Thus, direct supply of those items of critical need to particular hospitals will continue to be a primary objective.

The American Children's Hospital in Krakow will continue to be a prime recipient because of its major role in the care of children with the most complicated and severe disease problems in southeast Poland.

We found during the first project that in order to assure that the Polish health care providers gain the most benefit from our relief activities, educational conferences were needed demonstrating the use of diagnostic and therapeutic methods made possible by the material sent. We will continue and expand these courses. Delivery of medical books and journals will be included in the educational effort also. We have solved the major problems of certain hospitals included in the first relief effort so we will, during this grant period, assist some new institutions. In general, we have found that hospitals in the southeast are the most needy in Poland. We will, therefore, give some very basic relief to some smaller hospitals and clinics in the Southeast which represent the primary care units of the Polish health system.

To be maximally useful, we will carry out some special educational efforts on renal disease prevention, neonatology and high risk pregnancy in the

primary care system, rational use of antibiotics and other drugs, and other topics to help establish better care with less relief expenditures from the project.

General Description

It is anticipated that the project will provide drugs, pharmaceutical and hospital supplies, spare parts, selected hospital equipment, medical books and journals to the following hospitals:

Hospital	City
1. Klinika Poloznictwa i Perinatologii Slaskiej Adademii Medyczenj (AM)	Tychy
2. Instytut Pediatrii Slaskiej AM	Zabrze
3. Instytut Ginekologii i Poloznictwa AM	Krakow
4. Instytut Pediatrii AM	Krakow
5. Oddzial Intersywnij Terapii AM	Krakow
6. Instytut Ginekologii i Poloznictwa AM	Poznan
7. Instytut Pediatrii AM	Poznan
8. Wojewodzki Szpital Dzieciecy	Kielce
9. Oddzial Polozniczo-Ginelolgiczny Wojewodzkiego Zespolu Specjalistycznego Matrki i Dziecka	Kielce
10. Szpital Traumatologii Dzieciecej	Warszawa
11. Wojewodzki Szpital Zespolony	Tarnow
12. Wojewodski Szpital Zespolony	Nowy Sacz
13. Wojewadski Szpital Zespolony	Krosno
14. Wojewodski Szpital Zespolony	Przemysl
15. Wojewodski Szpital Zespolony	Wroclaw
16. Wojewodski Szpital Zespolony	Bialystok

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In addition, four primary care units in Tarnow Province and four in Nowy Sacz Province will receive very simple supplies and drugs (e.g. ampicillin, syringes, and clinistix to detect urinary tract abnormalities,etc.).

We are hopeful of meeting the most critical shortages of these institutions in a carefully carried out project based on the judgment of American health professionals with previous experience working with HOPE in Poland and by Polish authorities. We feel that in the next three years, we can supply items which, though less in dollar value per hospital or primary care institution, will relieve critical specific deficiencies and thus be maximally cost-effective, especially when combined with regular educational input in targeted areas.

These priority requirements are grouped under six categories:

1. Drugs

   Many drugs which were previously imported, or manufactured from raw materials, are still in short supply, or irregularly or never available in Poland. This imposes limitations on the management of many health problems of mothers with high-risk pregnancies and on newborns and children with severe diseases, (e.g. leukemia). As a result, infants and children are dying or are forced into lifetime disabilities who could otherwise be saved, and some mothers are also. It will be our policy to procure generic drugs to the extent possible.

2. Disposable and Consumable Supplies

This is a mundane but vital area. Syringes, needles, catheters, Harvard pumps, surgical gloves, etc. are in short supply chronically. These problems will not be relieved in the near future and we believe in supplying non-disposable items because of this. These shortages persist and must be relieved if care is to be maintained at basically sound levels.

3. Sutures

This is still a major problem and shortages here, which persist, limit surgery at times to emergency procedures. Elective and even some emergency surgery suffers as a result.

4. Laboratory and X-ray Service

Shortages of reagents, x-ray film and other lab and x-ray supplies continue as severe problems, especially in the smaller hospitals in the Southeast such as those listed above under the heading: "Wojewodski Szpital Zespolony" in Tarnow, Nowy Sacz, Krosno, Przemysl, Wroclow, Bialystok, which are secondary-level provincial institutions. Relieving shortages of diagnostic materials at this level, plus the educational procedures described below will enable much more efficient primary and secondary early diagnosis and prevention to occur, thus decreasing reliance on expensive tertiary diagnostic and treatment efforts.

5. Spare Parts and Small Equipment

Much equipment supporting hospitals and clinics is still not working because of a continuing problem of spare parts availability. Most equipment purchases directly from the West are impossible because of economic difficulties. Therefore, Polish hospitals and clinics continue to have severe problems in maintaining diagnostic and therapeutic equipment which they already possess. These problems exist not only at a sophisticated level, but at the level of repair and maintenance of ophthalmoscopes, blood pressure cuffs, and even equipment dependent on simple flashlight batteries.

6. Equipment

We have found in the past two and one-half years that Polish health care professionals were trained in the 1970s to take advantage of newly developed therapeutic and diagnostic equipment. Since then, they have become isolated professionally and many new developments responsible for reductions in maternal and infant morbidity and mortality have bypassed Polish health professionals. Their educational grounding enables them to understand and utilize new devices and so we have, in the past, delivered certain diagnostic and therapeutic devices to them to enable them better to care for severe problems of pregnancy, newborn and child health. We feel that limited amounts of this type of relief are still needed.

Project HOPE will continue to direct and even more closely control the procurement process. The benefit of receiving these materials will continue

to be felt by the needy women and children of Poland, especially in the primary care sector of the health system. These emergency relief supplies will be distributed at no cost to the patients. There is no way that Poland can solve the current deficits in needed supplies and equipment without outside assistance. The provision of the emergency relief materials described above will contribute to the stabilization of the health care system as it applies to women, infants, and children. Once the continuing problem is met, we believe that Polish authorities and health care professionals will be able to meet their own health needs. However, this will depend on an updated knowledge of health care technology which will be provided by us in the form of courses and other educational efforts designed to assist Polish health professionals in using current methodologies and technologies.

In the project to come, we will have courses in the following areas:

1. Intensive Care and Neonatology

   A post-graduate course in intensive care delivery will be given at the Institute of Pediatrics, Krakow, in the first year of the program for physicians and nurses working in intensive care units existing in the recipient hospitals.

   In addition, during the first program year baseline data on neonatology practice in the recipient hospitals will be gathered. Meanwhile, the latest edition of the self-instruction course book,

Perinatal Care: Continuing Education, written by Dr. John Kattwinkel at al. at the University of Virginia, will be translated into Polish. In September 1986, these course books will be distributed and explained during a post-graduate conference on neonatology to be given at the Institute of Pediatrics, Krakow, to those nurses and doctors, working in neonatology wards in recipient hospitals. Instruction will be given on exactly now to carry out the self-instruction course (which takes six months)by those attending the conference. Subsequently, two follow-follow-up visits will be made to each hospital to assure that the self-instruction course is understood and progressing. At six months and one year after termination of the course, visits will be made by specialists to reinforce the material and to evaluate the effects of the course on neonatal care in each hospital. Attached is a discussion of this course and funds required specifically for it.

2. Anesthesiology

During the course of the relief program and after survey visits by American anesthesiologists, certain anesthetic equipment and supplies will be made available to recipient hospitals which will increase the techniques capable of being carried out.

One post-graduate course will be held in the second project year which will assist anesthesiologists of the recipient hospitals to use the equipment, supplies and techniques. The techniques

emphasized will be those designed to provide safe, reliable anesthesia for pediatric surgery and for obstetrical cases. A follow-up site visit to involved hospitals will be made by one or more of the specialists from the original site visit and (or) the post-graduate course faculty.

3. Cardiology

In those eight voivodships mandated to be supported as a referral center by the Institute of Pediatrics, Krakow, a study and case registrations system supported by the Ministry of Health and Social Welfare has been going forward to determine the prevalence of congenital and other cardiac diseases in infants and children. In addition to its scientific value, its educational component has resulted in an increase in diagnostic knowledge among physicians in the area and a more orderly prioritization of the specialized diagnostic and therapeutic management of infant and child cardiac patients. A patient referral system has been created and physicians attending pediatric patients at the primary care level are able to diagnose and manage patients more rationally. For this to have a positive impact on pediatric (especially infant) patients with heart defects, there must exist a strong network which includes a high degree of awareness among primary care physicians that certain diagnostic signs and symptoms can mean heart disease, and an organized and functioning referral system for tentatively diagnosed patients with a tertiary care hospital which is especially interested in and capable of intervening diagnostically and therapeutically in referred cases. This is

currently the case at the Institute of Pediatrics, Krakow, and its eight related voivodships. It is proposed to expand these educational processes to such of those other recipient hospitals as are capable of open-heart surgery for infants (for example, the Institute of Pediatrics, AM, Poznan). The educational components will be opened to pediatricians and cardiologists working in other recipient hospitals. This will consist of courses given by US and Polish specialist colleagues on:

a. principles of basic diagnostics in congenital defects of the circulatory system in infants and children,

b. principles of echocardiography in the diagnosis of cardiac defects and diseases in infants and children,

c. indications for invasive diagnostic procedures and therapeutic management.

d. principles of management in emergency conditions in infants and children.

e. organization of pediatric cardiologic medical care as a referral system so that patients are diagnosed promptly, managed rationally, and followed-up adequately.

One course will be held in each of the program years to cover each of the five topics. These courses will be coordinated with the

delivery of simple diagnostic and therapeutic equipment and supplies for secondary and primary level institutions so that knowledge gained can be immediately applied.

A major outcome of these courses is to assure a rational use of the limited resources available in Poland even with the relief program. This will come about through improved outreach and earlier and more accurate evaluation of possible congenital cardiac lesions at the primary level.

4. High-Risk Pregnancy

High-risk pregnancy patients include those obstetrical patients with histories of habitual abortion, diabetes, serologic problems, hypertension, heart disease, certain previous pregnancy problems, etc., plus those with known or historically existing fetal disorders.

Every physician and nurse who deals with pregnant women should have the maximum understanding of the high-risk pregnant woman in order to recognize her and treat or refer her appropriately. In addition, those physicians and nurses working at referral hospitals (generally, Institutes of Obstetrics and Gynecology) must have the equipment and specialized knowledge required to care for these patients.

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The program in high-risk pregnancy will, therefore, include two courses, one designed for all health care personnel dealing with obstetrical patients. This course will update the attendees on recognition of risk, management options open at the general hospital level, and those requiring case referral. The other course will be designed for those hospitals possessing or capable of utilizing the specialized diagnostic tools (e.g. ultrasound, fetal monitoring devices) needed to manage the possible complications of high-risk pregnancy. The first course will take place in the first project year, the second in the second. Each course will take place in the Institute of Obstetrics and Gynecology, AM, Krakow.

5. Renal Disease Prevention

In October 1985, a post-graduate course on this topic will take place at the Institute of Pediatrics AM, Krakow.

This program will accent the early diagnosis and appropriate management of renal disease in children with the ultimate goal of lessening the need for dialysing the end-stage diseased kidney. It is designed to train primary-care physicians in early, simple diagnostic steps, to teach them how to recognize and manage certain benign kidney diseases so they will not have to be referred to larger centers for expensive diagnostic procedures, and how to prevent disease progression by aggressive early management, thus cutting down the prevalence of severe advanced renal disease. Cost

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savings and improved clinical outcomes should thus be combined to an unusually high degree.

We would like to document this part of the training activity, and will approach the Polish authorities to furnish personnel and other local support to do so. Dr. Warren Grupe of Harvard Medical School has agreed to advise such a documentation and a second teaching conference will be held later in the project by him and his colleagues (Polish and American) to illustrate the lessons learned in eight primary health care institutions in Nowy Sacz and Tarnow provinces which will receive relief supplies enabling them to carry out early renal desease scraening and management.

6. Other Mutually Agreed-Upon Subjects

Other courses will be carried out as specific needs become evident during the course of the project. Subjects will probably include nutrition, respiratory therapy, rational use of drugs (especially antibiotics) and childhood infectious disease problems. A total of up to 15 conferences is planned.

B. PROJECT BACKGROUND

Project HOPE has been working with the American Children's Hospital in Krakow since 1976. Together with the American Schools and Hospitals Abroad, a division of AID, our efforts have been directed to the areas of medical education, equipment procurement, and construction.

Through an exchange between American medical personnel and Krakow's Institute of Pediatrics (American Children's Hospital), HOPE has been involved in more than 20 teaching programs, including assisting with the establishment of the 312-bed hospital as one of the major centers for congenital heart disease surgery in Eastern Europe. The American Children's Hospital serves all eight southeastern Poland voivodships as a referral center. The primary care centers which we will reach in the proposed program refer complex cases, by law, to the ACH. However, children with congenital heart disease from all over Poland are referred for care at ACH.

HOPE educators have worked with Polish professionals in establishing training programs in the following disciplines at the American Children's Hospital, Krakow:

Anesthesiology	General Pediatrics	Obstetrics/ Gynecology
Biochemistry	General Surgery	Oncology
Cardiac Surgery	Hospital Administration	Perfusion Therapy
Cardiology	Immunology	Pharmacy
Community Health	Intensive Care Medicine and Nursing	Plastic Surgery
Dentistry	Medical Maintenance	Radiology
Endocrinology	Neonatology	Sanitation and Housekeeping
Gastroenerology	Nephrology	Respiratory Therapy
Gastrointestinal Surgery	Neurosurgery	

In 1985, hemodialysis was begun at The Institute. It is because of this extensive capability that we feel the need to involve in our relief program the primary care personnel who make initial contact with infants with potential renal disease. With education and a few simple supplies (e.g. clinistix and antibiotics), we can obviate the need for much dialysis. Dr. Warren Grupe, Associate Professor of Pediatrics (Nephrology) at Harvard Medical School and Chief of the Nephrology unit at Boston Children's Medical School, is our volunteer consultant in this area and will oversee this analysis and educational effort.

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Dr.John Kattwinkel, Professor of Pediatrics (Neonatology) at The University of Virginia, will supervise the neonatology project. Dr. James Kitchin, Professor of Obstetrics-Gynecology, University of Virginia, is the coordinator of the high-risk pregnancy courses.

Many other universities, teaching hospitals, and major clinics are also involved. The list includes:

Children's Hospital of Philadelphia

Children's Hospital Medical Center (Harvard University)

Primary Children's Medical Center (Salt Lake City, Utah)

Duke University

Vanderbilt University

Oschner Clinic (New Orleans)

University of North Dakota

University of Minnesota

Children's Hospital (Washington, DC)

University of Virginia

Henry Ford Hospital (Detroit)

St. Jude's Children's Hospital

Columbus Children's Hospital

University of West Virginia

Women and Infants Hospital of Rhode Island

Children's Hospital of San Francisco

Children's Hospital of Los Angeles

City of Houston Health Department

Children's Hospital Medical Center (Oakland)

C. PROJECT ANALYSIS

At the urging of the State Department, all of these programs are continuing despite the advent of U.S. and other Western nations sanctions against Poland. We have experienced no difficulty with the Polish Government and our programs are progressing successfully.

Economic Crisis

The economic crisis in Poland began to effect the health care system dramatically in mid-1981. Beginning in June, 1981, Project HOPE was asked to develop a program for all of Poland to meet the drug and medical supply shortages. This request and subsequent agreement were unique in that they represented a cooperative effort between the Solidarity Labor Union and the Ministry of Health. Project HOPE, working with the Polish American Congress and with the support of American Pharmaceutical and hospital supply industries, delivered three million dollars worth of drugs and supplies between June and December, 1981. The distribution of these supplies was under the jurisdiction of the Ministry of Health, and verification of their delivery and use was monitored by the Solidarity Labor Union. On December 13, 1981, when marital law was imposed and Solidarity outlawed , these shipments were suspended. In February, 1982, HOPE negotiated a similar agreement with The Ministry of Health with verification of delivery and use carried out by the Catholic Church. This system has worked faultlessly and will be continued.

In addition, two visits annually to all involved institutions will be made by senior HOPE staff and volunteer health professionals familiar with the

Polish health care system to monitor material delivery and utilization, to assist the hospitals in appropriate use of the materials and to modify the materials sent depending on evolving current needs.

Our long-term presence in health care programs in Poland provides the expertise and manpower within the Foundation to manage a relief operation of this kind and magnitude. The Ministry of Health is very involved in the project and has put all its resources behind the project and will continue to do so. By working with the Ministry, the project enjoys all the necessary logistical and technical support required for success. This includes the professional personnel for selection of priority needs, the transportation facilities for transfer of materials to the individual hospitals and the professional personnel to handle the distribution directly to patients. Each of the medical schools in Poland functions as an independent academy of medicine and maintains separate faculties of medicine, dentistry and pharmacy. These institutions have been available to HOPE as needed, especially the ones in Krakow. The Medical Director of the American Children's Hospital in Krakow, Professor Jan Grochowski, will continue to serve as Polish Coordinator of the project.

The beneficiaries of this emergency relief will continue to be mothers, infants and children who must seek care in those State run hospitals and other institutions which have demonstrated shortages or absences of critically needed supplies and equipment.

This sub-group of the population is the most vulnerable to such problems, and will be the group in our project to receive the full impact and benefit of our relief effort.

As noted elsewhere, selection of the most acutely needed materials will be based on field evaluations by HOPE staff and volunteers with experience in Poland and Polish health professionals

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D. PROJECT DESIGN AND IMPLEMENTATION

Implementation Plan

Project HOPE will be responsible for the conduct of the project. No sub-grants or contracts are envisioned.

The activities of the project can be divided into four major components:

1. Definition of Need for Materials.
2. Procurement of Commodities.
3. Shipment and Delivery of Commodities.
4. Supervision, Verification and Control.
5. Courses and Studies to Maximize Usefulness of Material Sent.

1. Definition of Need

A team of HOPE professionals will visit the selected Polish hospitals periodically to define the initiall needs and to establish a continuing process for the identification of need. With our have determined that the most urgent needs fall into the following six categories as described in the General Description of the project:

a. Drugs

b. Disposable and Consumable Supplies.

c. Sutures.

d. Laboratory and X-Ray supplies/equipment.

e. Spare parts and small equipment.

f. Equipment

A general inventory of needs will be defined for one year and a very specific inventory will be developed for the first six months. Twice yearly the HOPE team will revisit each of the hospitals to confirm, in cooperationwith the hospital staff, the needs for the following six months. In this manner real needs can be defined and we can be assured that all of the commodities will be most effectively utilized to meet the most urgent needs of the target population.

The HOPE teams will consist of pediatricians, obstetrician-gynecologists, nurses, allied health specialists, engineers and administrative personnel. Team members will be both HOPE staff and volunteer consultants.

2. Procurement of Commodities

The normal procurement process employed routinely by the Foundation will be used for this project. Equal attention will be given to cost and quality. The most important factor, however, will be the appropriateness of the commodity to meet the specific need in the recipient Polish hospitals and specifications will be developed with this in mind.

Because of the nature of this relief mission certain waivers from standard AID procedures have been obtained and should be continued. These waivers are listed and defined at the end of this implementation plan.

3. Shipment and delivery of Commodities

The individual suppliers will ship the commodities to the Foundation's Dulles terminal facility in Herndon, Virginia. At this HOPE materials handling facility, all commodities will be received and repacked for each recipient Polish institution. In this way the shipment will not need to be broken down from the time it leaves our facility until it is received at each recipient hospital.

The Ministry of Health will be responsible for receiving each shipment in Poland and transporting the subshipments to each recipient institution as addressed. The following protocol will be followed for the delivery of commodities in Poland:

a. Five packing lists will be attached to the inside of the lid of each box, or the first group of boxes. The recipients of these packing lists will be:

   1) Customs

   2) Ministry of Health

   3) Hospital receiving the shipment.

   4) The top church official of the region, or appointed

   5) Project HOPE office at the American Children's Hospital Institute of Pediatrics, Krakow.

b. The copy to be returned to the Project HOPE office in Krakow will be signed by:

   1) The Director of the receiving institution.

   2) The Director of Pharmacy or Medical Stores of the receiving institution, whichever is appropriate.

   3) The church's representative.

c. These signed packing slips will be forwarded by the Project HOPE office in the American Children's Hospital to Project HOPE

Headquarters in the U.S.A. monthly through the American Consulate in Krakow.

d. If the Project HOPE copies, signed as directed above, are not received by the Project HOPE office at the American Children's Hospital in Krakow within a reasonable amount of time (2-3 weeks), future shipments to that hospital may be suspended.

Once the commodities are received by the specific hospital, they will be utilized in accordance with that institution's established procedures.

4. Supervision, Verification and Control

Each activity (definition of need, procurement of commodities, and shipment and delivery of commodities) has the built in supervision and control of Project HOPE's established systems. The prime concern then is to be assuredthat the goods are delivered to the designated hospital and used as intended once they leave the HOPE Dulles Terminal facility.

The protocol for the delivery of commodities in Poland will assure this verification. The Catholic Church, the most reliable and independent non-governmental agency in Poland today, through the offices of the Primate of Poland, has formally agreed to confirm the actual receipt of delivered materials to the designated hospitals. This confirmation process worked faultlessly throughout the last thirty months and will be continued. Project HOPE has a permanent office in Krakow. Project HOPE representatives, in addition to the church, will also verify with the hospitals the receipt and proper utilization of the commodities. This will involve medical, nursing and pharmacy personnel of Project HOPE. A good deal of this supervision and verification will occur at the time the HOPE teams are visiting Poland to define and verify program needs.

The fact that we have a permanent materials handling facility in Herndon, Virginia enables us to support the hospitals in a controlled pattern. No hospital will receive too many commodities at any one time and thereby receipt and utilization can be more effectively monitored.

Evaluation and Project Accomplishments

Our implementation plan indicates in some detail how we will ensure the proper functioning of this emergency relief effort. Control exists at several points; 1) definition of need by joint teams of HOPE and Polish professionals, 2) proper purchasing through HOPE's established procurement process, and 3) shipment and delivery utilizing the HOPE materials handling facility the Ministry of Health, the Catholic Church of Poland and the individual hospitals. Verification of the proper use of the commodities will be conducted by the hospitals utilizing their established systems as well as by visits by HOPE professionals.

A key component of the control of the proper utilization of the commodities will be our ongoing educational programs, described elsewhere to be conducted at the American Children's Hospital in Krakow and the Institute of Obstetrics/Gynecology in Krakow. Using those facilities as a base, we will continue to provide orientation programs for Polish physicians, nurses, pharmacists, engineers, etc., as required for the best utilization of the relief materials.

Request for Waivers

The Waivers of A.I.D. rules and regulation considered necessary for the good conduct of the project are described below:

1. Standard Provisions 9 and 10-B. (c) (2) (iii) concerning transportation on ocean vessels should be waived with regard to all gross tonnage which shall be transported to the Cooperating Country on ocean vessels provided by the Cooperating Country at no cost to the Grantee or the U.S. Government.

2. Standard Provisions 10-A. (c) and 10-B. (a) (b) and (d) should be waived with regard to any commodities which, due to rules and regulations applicable to air and sea transportation of commodities, cannot be shipped from the United States; and with regard to equipment and supplies which must be purchased outside the United States in order to provide interchangeability with existing systems and practices.

3. Standard Provision 10-B. (c) (2) (ii), concerning prior approval for air charter, should be waived with regard to any full charter flight which is used solely to transport medical supplies and equipment to Poland in connection with this program.

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4. Blanket prior written authorization for the purchase of Schedule 2, 3, 3N, 4, 5 and pharmaceuticals should be granted in accordance with the requirements of Standard Provision 10-A.(b). Project HOPE is licensed by the Federal Drug Administration to export Schedule 2, 3, 3N, 4 and 5 drugs under DEA Registration Number PP0178776.

5. A Waiver allowing single source acquisition (AID Handbook 13, paragraph IU) and Small Business notification (Standard Provision 10A. (f)) should be granted because of the short time requirements existing in this emergency procurement situation.

6. Standard Provision 8(a). concerning prior written concurrence for travel outside the United States should be waived. This waiver is required to allow HOPE to utilize volunteer U.S. Technicians in various aspects of the proposed project. The lack of travel flexibility could seriously hamper HOPE's effort to conform the travel schedules to the needs of the necessary medical volunteers and thus endanger the evaluation and verification aspects of the program.

FINANCIAL PLAN

Poland Relief-US$4,000,000

1.	Commodities*	$2,900,000.00
2.	Education	800,000.00
3.	Transportation, handling, shipment	107,500.00
4.	Technical assistance	64,000.00
5.	Administrative expense	
	Salaries and wages	109,400.00
	Fringe benefits	16,500.00
	Allowance	2,600.00
	TOTAL BUDGET	$4,000,000.00

* Commodities include equipment and supplies in the following categories: drugs, disposable and consumable supplies, sutures, laboratory and x-ray equipment, intravenous solutions and sterilization/sanitation supplies. It is impossible to assign values to each category in the budget since it is necessary to change amounts in each category from time to time to meet changing needs.

NOTE: This budget has been prepared with the expectation that the $2,900,000 in commodity costs included above will be supplemented with commodities valued up to $2,000,000 which will be furnished through HOPE's Gift-in-Kind Program. In the event any of the personnel costs or other costs are not required, we anticipate using those funds for Commodities. In the event a lesser amount of Third-Country Commodities are required, we anticipate using those funds for U.S. Procured Commodities.

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F. CONDITIONS

In addition to the funds provided by AID through their OPG and the infrastructure provided by Project HOPE, we believe that we can obtain through private sources, the equivalent value of any contribution made to this project by the Government of the United States. We already have the support and participation of the Polish American Congress as well as many large American hospital supply and drug companies.

This program also has a great deal of support from the Government of Poland. The Polish Government is pledged to provide duty free entry of all commodities, transportation on LOT Polish airlines and Polish ships for commodities, and transportation within Poland to the prescribed hospitals, housing and per diem for HOPE personnel responsible for administering and supervising the program.

This proposed project has been approved by the Polish Government.

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Department of Pediatrics
Children's Medical Center
OF THE UNIVERSITY OF VIRGINIA
Charlottesville, Virginia 22908
Telephone 804-924-5428

February 20, 1985

Harold Royalty, M.D.
Project HOPE
Millwood, VA 22646

Dear Hal:

It was a delight to see you again in Millwood on Tuesday. I'm excited about the prospect of development of a quality outreach perinatal education program in Poland and am particularly enthusiastic about the prospects of incorporating a system for collecting some evaluation data.

I am enclosing a copy of three of the key papers from the U.S. version of this Program in case they may be of value in developing the narrative for AID. The following bits of information might also be useful:

1. The Program has been used in 30 States and over 500 community hospitals, reaching nearly 20,000 perinatal health care workers in the U.S.

2. A key factor is that it is community based and is aimed at all perinatal health care workers as the target population (i.e. it is not a nursing or physician program, but addresses all members of the perinatal health care team).

3. The Program utilizes local personnel (the "perinatal education coordinator") and thus should be self-propagating, not dwindling as the American organizers leave.

4. The self-instructional books are updated every 6 months and hence do not become obsolete. By having the translation on word processor disc and using the American updates as a model, the Polish translation is also easily updated.

I particularly like the concept of collecting data and saving one voidvodship as a control. Baseline data could be accumulated throughout the first year of translation. It would be extremely important, obviously, that appropriate reliable data are collected during this period and I would suggest that one of the first activities should be to assure that appropriate data collection mechanisms are in place. As I mentioned, George Nowacek, one of the health educators on the U.S. PCEP was the primary architect for all of the detailed evaluation methodology described in the enclosed reprints. I think George would be interested in traveling to Krakow to establish these mechanisms through Kanska and also perhaps could suggest some additional methodology (e.g. pre-post testing or chart review). I am enclosing George's CV. Probably two trips for him over the 2-3 years would need to be included in the budget.

As you and John noted, we also need to expand the project beyond the September 1986 introductory conference. John suggested an additional $50,000 to the $150,000 of my estimated budget. I suspect this would be quite adequate for everything we talked about plus some as yet undefined additional evaluation strategy.

Please let me know wherever I can help with the proposal.

Sincerely yours,

John Kattwinkel, M.D.
Professor of Pediatrics
Director, Newborn Services

JK/ams

Encls.

cc: John Walsh

Perinatal Continuing Education Program
department of pediatrics
charlottesville, virginia 22908
university of virginia medical center
telephone (804) 924-5428

Polish Perinatal Education Program

Target population:

50 hospitals (10 per each of 5 regional centers)
25 perinatal personnel per hospital = 1250

Timetable:

June - July, 1985
Hire nurse coordinator (Lynn Cook)
Identify Polish coordinator
Contract with translating service
Begin Polish adaptation of English version.

August 1985 - May 1986
Poles and LC adapt English PCEP to Polish style
Prepare professional translation and rough draft on word processor.
Edit rough draft in Poland
Incorporate revisions on word processor
Second editing in Poland
Final copy of text in U.S.

June - August 1986
Paste-up of figures and text for printing
Print and ship books
Communicate with regional centers to identify hospitals.
Prepare for Dissemination Conference

September 1986
Conduct 1-week dissemination conference in Krakow.

6 month course
3 trips -

BUDGET

A. Using U.S. translating service:

Salaries:	
U.S. Nurse coordinator (60% effort x 15 mos.)	$ 22,500
Contractural services:	
Translation Service (e.g. Boston Language Institute)	40,000
Preparation of word processor copy	10,000
Printing ($36.50 x 1250 book sets)	45,625
Copyright fee ($5.00 x 1250 book sets)	6,250
Travel:	
4 nurse coordinator Poland trips (2-4 weeks each)	8,000
1 6-person Poland conference (1 week)	12,000
U.S. travel	2,000
Educational supplies	4,000
	$150,375

B. Using Polish translator(s):

Salaries:	
U.S. Nurse coordinator (75% effort x 15 mos.)	$ 28,125
Polish M.D. salary (100% effort x 12 mos.)	10,000
Contractural services:	
Word processor services	30,000
Printing ($36.50 x 1250 book sets)	45,625
Copyright fee ($5.00 x 1250 book sets)	6,250
Equipment:	
Recording instruments	500
Travel:	
8 nurse coordiantor Poland trips (2-4 weeks each)	16,000
1 6-person Poland conference (1 week)	12,000
U.S. travel	2,000
Educational supplies	4,000
	$154,500

ATTACHMENT B

The Children's Hospital • Boston

300 Longwood Avenue, Boston, Massachusetts 02115, Telephone (617) 735-6129
Division of Nephrology

February 11, 1985

Harold H. Royaltey,M. D.
Director, Community Health
Project HOPE Health Science Education Center
Millwood, VA 26646

Dear Hal:

Enclosed is a Proposal to get HOPE'S project in Poland at the primary care level. It is by no means complete, and is really designed to be a focus for our discussions on the 19th. My personal ulterior motive in its design, is to explore the possibilities of some closer community network arrangement with the Institute that can be subsequently exploited when a source of cadaver organs is required for transplantation.

The Proposal has at least 3 parts, the first of which could stand alone if there is limited interest in data collection and analysis. The first focus in the Proposal is the establishment of an ongoing,mutually productive relationship between the Institute and one or more primary care sites. The purpose would be to promote a local attitude towards the early detection of asymptomatic but treatable disease. The outcome would be a modification of primary care referral behavior. There are three phases to this part: Phase I - The Enhancement of Awareness; Phase II - The Fostering of Discovery; Phase III - The Development of Critical Assessment of Patient Data.

The second part of the Proposal is to document the extent to which medical behavior and referral practices can be modified, if at all, by educational intervention using a similar but separate medical population for comparison.

The third part is an evaluation of cost effectiveness of Level III - Preventive Measures in Poland. Of interest in this regard, we did a study here recently to determine who amongst adolescent girls should get a urine culture as part of a routine visit. Of a whole series of screening measures evaluated, we found that the best predictor of covert bacteriuria, was simply to ask the girl if she had ever had a urinary tract infection before.

I am sure there is a good deal of other information that would come out of this study if it were properly devised, we were allowed to carry it out, and we got full cooperation in Poland. That's not asking too much, is it?

I have written the Proposal with a definite nephrological slant, that's merely to create a skeleton to shoot at. If the basic concept of the Proposal is accepted, then we can hang the other speciality areas on the same skeleton.

I have not reviewed literature nor have I looked into any similar community health attempts. I don't know what types of programs applicable to Poland are already underway in other areas under the aegis of Project HOPE. For all I know, all of this has been adequately tested before and failed. I also have no public health background so I cannot even judge whether any of this is feasible, nor do I have any feeling for what A.I.D. wants. I do seek your thoughts and direction so I'm looking forward to the 19th.

Sincerely yours,

Warren E. Grupe, M. D.
Director, Pediatric Nephrology
Associate Professor of Pediatrics
Harvard Medical School
The Children's Hospital

WEG/rc

DRAFT PROPOSAL

PURPOSE

To establish a Level III Prevention Network in South Poland to detect selected asymptomatic diseases at the primary care level; to modify physician behavior through intensive educational interactions; to monitor outcome through changes in disease detection, referral patterns and intervention techniques; to define the cost-benefit of early detection.

BACKGROUND

It is virtually axiomatic in pediatric circles that early detection of disease through the organization of preventive services has a positive effect on health, morbidity and mortality. The premise of many primary care practices in fact is founded in prevention and early detection. However, any medical care delivery system depends to a large degree on the quality of motivation and enthusiasm of all of its care providers. This is particularly important when the medical system is structured so that the preventive and detection services are provided at locations and by personnel quite separate from those ultimately responsible for the treatment of such patients. The potential problem becomes even more evident when the system fosters secondary and tertiary services in hospital-based, urban-centered sites, while the Level III detection is mandated to the villages or small communities. Often, there develops a large cultural gap between the urban specialist and the rural generalist. The emphasis in the tertiary center becomes mainly curative approaches that mandate the development of relatively sophisticated services that are hospital based. The personnel charged with the detection and referral, on the other hand, are perceived to have the less glamorous task performed in more austere surroundings. The illnesses which command the effort of tertiary care providers may not

be foremost in the minds of the primary system, may be ones about which they know little, or may be perceived to be too infrequent to merit much effort. Further, the primary site may not be aware of the capabilities available at the referral center, or what constitutes a proper referral. This gap in perceived purpose and disease awareness often inhibits cooperative efforts towards early detection and efficient management.

Although the attitudes about Level III prevention are staunchly defended, it is not firmly established that broadly based early detection is, in and of itself, of significant benefit to either the patient or the health care system. It is perfectly reasonable, for example, that a detected illness may have no specific treatment or cure; the course and prognosis is inevitable whether detected in the asymptomatic stage or not. In other circumstances the accepted treatment for the disease may be unavailable to the patient. In each of these circumstances, physicians being what they are, tests are prescribed to monitor the inevitable while the benefit to the patient is zero. At other times, the illness detected is benign or self-limiting and no treatment is necessary. Just such an example is the detection by screening urinalyses of asymptomatic hematuria or proteinuria. This often leads to massive investigation to establish a benign entity followed by years of careful monitoring to assure it remains benign nevertheless. In this situation, early detection likewise elevates cost and morbidity with little benefit to the patient.

The Cardiff study of asymptomatic bacteriuria in school aged girls provides interesting insights to the problem. In that study, 12,000 girls aged 4-11 years, were screened for bacteriuria. An intravenous pyelogram and voiding cystourethrogram were performed on all of those with positive

cultures. Results showed that bacteriuria occurred in 1.7%, renal scars in 0.002%, and vesicoureteral reflux in 0.003%. Half of the patients were treated with antibiotics while half were not. All patients were monitored with urine cultures, blood studies and regular radiographic examinations according to "accepted" medical practices. The published results disclosed that no new scars developed in either group, there was no difference in renal function and no difference in infecting organisms. Those already with renal scars had no progression. Thus these lesions detected after age 4 years appear benign (at least over the short term) and do not appear to require specific treatment. What was not developed in any of the published reports was the cost of providing such "accepted" but unnecessary medical care. Using very modest costs to estimate only the expense of studies, exclusive of any personnel or physician costs, the total cost approximates $214,456/12,000 children. The cost per abnormal child was enormous; $6,917 per kidney scar, and $5,361 per refluxing ureter. Yet neither detection nor treatment could be demonstrated to have any beneficial effect on these girls whose asymptomatic disease was detected after the age of 4 years.

At the other extreme, at the time of the first documented urinary tract infection in infant males, 25% already have a renal scar indicating previously undetected or asymptomatic disease in this more restricted target group. However, the peak age at which urinary tract infections are detected in the U.S.A. is 3-4 years, clearly too late to make a difference. As another example, in Poland, 60% of children developing end-stage renal failure have congenital and structural abnormalities of the kidney. This compares to only 40% in Western Europe and U.S.A. At least some of the Polish children might be reversed by early detection and prompt surgical correction. Clearly then,

in these targeted groups, there is a rationale that encourages detection at the asymptomatic stages.

HYPOTHESIS

Early detection and early intervention of targeted diseases reduces morbidity and, thus, lessens the overall cost of providing care. [Note: this postulate does not involve the prevention of disease occurrences, since the etiology of the specific diseases under consideration is not known. It is directed rather towards the initiation of early care with the alteration of progression of the disease process]. Early detection in turn can be stimulated by increasing the awareness of the medical care community through education and marketing strategies.

SPECIFIC AIMS

1. Does early detection alter the disease process.
2. Does early detection prevent or reduce progression to more costly modes of therapy.
3. Does early detection increase the rate of referral to tertiary centers or increase the physician's ability to manage locally.
4. Do detection programs modify physician behavior in areas separate from the specific illnesses sought.
5. Does early detection alter the perception of need for capital expenditures, personnel expenditures, or the availability of sophisticated procedures.
6. Does early detection reduce or increase overall cost for a given disease category.
7. Does the possibility of early intervention reduce mortality or morbidity.

8. Does a reduction in mortality increase costs.

METHOD

Two regions in South Poland where patients would be regularly referred to the Institute for complex diagnosis and care, will be selected on the basis of: 1) Similar distance from Krakow; 2) Considerable distance from or a demonstrated lack of interaction with each other; 3) Established and similarly staffed primary care delivery sites; 4) Comparable populations.

Phase I (6 months): Region I will be the recipient of regular and relatively intense educational intervention in the form of conferences, seminars and medical rounds, utilizing pediatric specialists from the Institute and medical consultants from the U.S.A. including but not limited to those who are regularly involved in the current HOPE Polish program. The consultants need not be limited to physicians. In addition, videotape and audiotape presentations will be made available on a "sign out" basis to the region. The scope of the subjects presented will be broad and include all aspects of pediatric medicine and surgery. The curriculum will be developed in consultation with the medical care providers in the Region and the staff of the Institute, to assure a content that draws on the strengths of the Institute's programs and on the perceived needs by the medical personnel in the Region. An aspect of the presentations and communications will include relatively intense marketing of the specialty services at the Institute as to the scope of services available, new and relatively sophisticated techniques, and favorable outcomes. It will be implied, where appropriate, that early detection provides a better chance for correction. The influence of these strategies on Regional physician behavior will be monitored through changes in the number and type of patient

referrals from the Region to the Institute.

Phase II (12 months): After the initial 6 months, a series of screening programs will be established in stages in the Region. Patients with abnormal screening tests will be identified, a data base record established and the patient's progress through the health care system monitored with each intervention documented, each referral recorded, and ultimate disposition determined. Concurrently, the number and type of all pediatric referrals from the Region to the Institute will continue to be followed, the attendance at conferences will be recorded, and the use of audio-visual material documented.

Phase III (12 months): In both Phase I and II there is no attempt to modify specific behavior, either in the Region or at the Institute. In Phase III, the physician and consultant following illness identification will be specifically reviewed. Circumstances where additional intervention is required will be identified on a case-to-case basis with each care provider. Circumstances where intervention was excessive will, likewise, be reviewed with the provider. Circumstances where base-line information could and should be obtained before referral is made will be identified. Encouragement and support will be provided to the local facility to manage an increasing responsibility over the management of cases.

Phase IV (6 months): Collection and analysis of data.

Region II will be the comparison group against which changes in number and type of patient referral or intervention in Region I will be compared for pediatric diseases in general, and for specific illnesses identified through specific detection programs. Region II will be appraised of all services available at the Institute at the beginning of Phase I, of the areas of "specific interest" at the Institute at the

beginning of Phase II and again at the beginning of Phase III.

ASSUMPTIONS:

1. The pattern of medical response will change in the Region receiving educational intervention but will not change in the region where no intervention is given.
2. The prevalence of the model diseases is equal in each region.
3. The criteria used by the consultants at the Institute for medical intervention, investigation and treatment will not vary between regions.
4. Region II will not adopt screening practices used in Region I.

CASE IDENTIFICATION

All patients with targeted illnesses identified at the local clinic level through established local medical practice (either screen in Region I or standard clinic visit in Region II) will be identified and a central coded record established. The patient will be followed through the system. All investigative and treatment interactions will be tallied and the treatment site noted. The frequency of physician or clinic contacts will be recorded. The source of each physician or clinic contact will be noted. The length of hospital stay will be determined. The cumulative costs of investigation, treatment, monitoring, etc. will be computed on a unit scale. Costs per abnormal finding will be computed and outcomes judged as definitely beneficial, possibly beneficial, or of no benefit to the patient. The prevalence of complications, morbidity or mortality will be determined.

In each specialty category, two groups of targeted illnesses will be

identified:

1) Lesions for which early detection should be beneficial for the patient.

2) Lesions where early detection does not alter the outcome for the patient.

SCREENING PROCEDURES:

I. Renal: Intense, standardized history, including specific symptoms, family history, by checklist; urinalysis, urine culture.

A) Targeted Illnesses:

1) Lesions where benefit clear: UTI, obstructive uropathy, minimal lesion nephrotic syndrome, urolithiasis.

2) Lesions where no benefit obvious: Chronic glomerulonephnitis, orthostatic proteinuria, benign hematuria.

Figure 1: Voivodships Served by Institute of Pediatrics, Krakow, Poland, After 1977.
Ref.: Maly Rocznik Statystyczny, Warsaw, 1987.

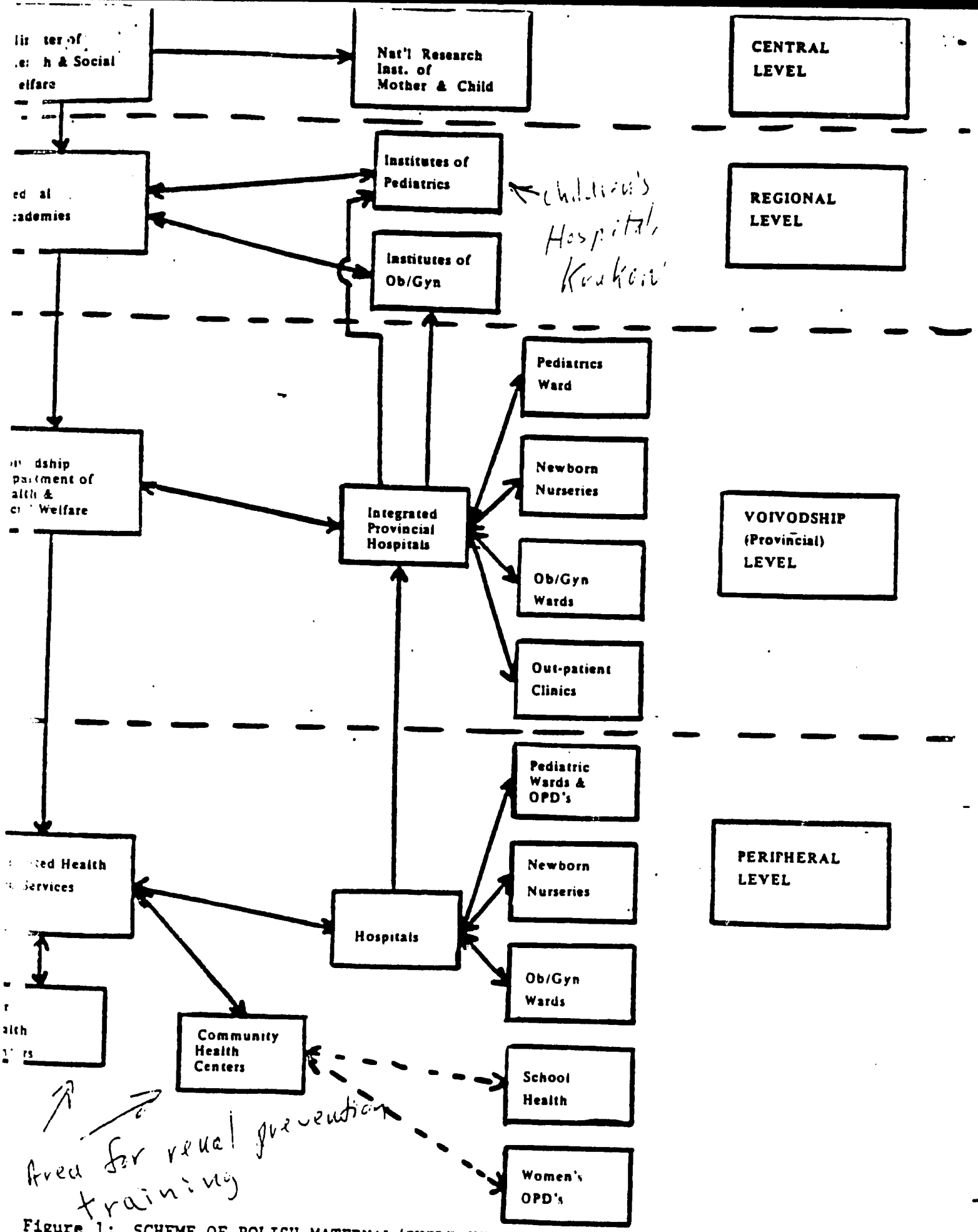

Figure 1: SCHEME OF POLISH MATERNAL/CHILD HEALTH CARE SYSTEM. (Modified from Child Health in Poland, 1980)