Project HOPE – CEO Rabih Torbay and Director Tom Cotton

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Marianne O'Hare: Welcome to Conversations on Health Care. This week, we welcome Project HOPE CEO Rabih Torbay, and his Emergency Preparedness Director Tom Cotter, who's on the ground in Romania, providing medical support for Ukrainian war victims and refugees.

Rabih Torbay: Even if the war ends today, our work will be there for a long, long time in terms of rebuilding the health care system.

Marianne O'Hare: Lori Robertson checks in from FactCheck.org. And we end with a bright idea, improving health and wellbeing in everyday lives. Now, here are your hosts Mark Masselli and Margaret Flinter.

Mark Masselli: As the war in Ukraine escalates before our eyes so does the scope of the unfolding humanitarian crisis. Millions of refugees are fleeing into neighboring countries, while aid agencies are flocking into the region. One such agency is Project HOPE, which has brought aid to disaster areas for more than 60 years. Today, we are joined by its President and CEO Rabih Torbay from their headquarters in Washington DC.

Margaret Flinter: And also by Tom Cotter, Project HOPE's Director of Emergency Response and Preparedness. Mr. Cotter is joining us from Bucharest, Romania, where he is overseeing the effort to provide desperately needed medical and humanitarian assistance on the ground. Gentlemen, we welcome you to Conversations on Health Care.

Mark Masselli: Rabih and Tom, you know this war is unfolding in real time for the whole world to see, and the images are devastating. Bombed children's hospitals and maternity wards, entire cities being levelled, and millions of desperate refugees flooding into neighboring countries. Rabih, let's start with you. Project HOPE has been delivering medical assistance and humanitarian aid in war zones and disaster areas for decades, but the magnitude of this crisis is being called unprecedented in the war zone, and in mass exodus of refugees. What are your gravest humanitarian concerns as this war escalates?

Rabih Torbay: Well Mark, as you mentioned, this is something that we haven't seen yet, not in the recent history. We are talking over 1.5 million that have crossed within two weeks, in addition to probably millions of internally displaced inside Ukraine. We are talking about women and children who are fleeing the conflict. Those are vulnerable people, leaving everything behind. The separation of the families is something that is of concern as well.

But also in addition to that, the health of people that are left behind with hardly any medicines or medical supplies, in addition to those that are fleeing, is something that is of great concern. And we are talking about both physical health, as well as mental health. This is

something that we are looking at. This is something of great concern. This is something that we will have to deal with for a long time.

Margaret Flinter: Well Tom, you are in Romania, and that's one of several countries that has responded to taking upwards of 3 million refugees so far. More people to come, and suffering from hunger, from illness and trauma. What kind of infrastructure do you have or are you trying to establish to meet this overwhelming need?

Tom Cotter: This is, as Rabih said, this is a crisis that's relatively unprecedented in near history, so a lot of the systems that are absorbing the refugees are being built as they are being run. This is -- you know, we like to say this is building the airplane while it's flying in the sky. And the systems will continue to improve. Right now, the host countries are doing a lot in terms of making sure that refugees have access to existing health care infrastructure that the normal populations of the host countries have, as well as making sure that incoming refugees are being screened for vaccines, including let's not forget we are still very much in the middle of the pandemic in various stages. And that's still a looming threat to make sure that countries like Romania, which have been doing quite well on their COVID-19 outbreaks, don't experience a surge.

Then on the mental health side, this is a particularly difficult challenge I think for host countries, especially with linguistic and cultural differences. Mental health is very much reliant on what I call the crucible of culture, and there is no getting around it. If you are trying to help someone through a crisis, you need to really be able to connect with them at a very human level, and those of us who have worked in the field really understand that. With language difficulty and folks not speaking language fluently, that can be a challenge. So, the ways around this are finding local resources and engaging refugees themselves who are able to be hired and can work within this infrastructure, to help and adjust and surge to meet the needs of people coming.

Mark Masselli: Project HOPE has a no regret approach to diving headlong into crisis. You say there is a critical window when lives are at stake and the impact could be the greatest. So you jump in the fire, you adapt as you go. Tell us about that approach and how it's been formed.

Rabih Torbay: You know, in medicine, and especially for emergency responders, there's something called the golden hour. When an accident happens you need to go in immediately. That's your golden hour to save the patient. And we are looking at it the same way. We need to go in when the needs are the highest. When we are going into a situation knowing what we know, but we know there are a lot of things that we do not know much about. Taking a risk, taking a chance, knowing that we are going to learn on the way, and it's proven to be very effective.

We have got on the ground in Ukraine, as well as Romania, Moldova, and Poland in no time, and we started providing medicines, medical supplies, sending the teams in to assess the needs and addressing it. And as Tom mentioned, one thing that is really critical as well is the culture, being culturally appropriate in terms of what we do. Learning what works and what doesn't work in every different culture and adapting, is something that we do very well, and it's critical.

Margaret Flinter: Tom, I know that an important element of what you are doing is coordinating with the other aid agencies that are on site. We are seeing Doctors Without Borders, UNICEF, the World Food Program. You have got a particular, in Project HOPE, focus on supporting the medical infrastructure. I am sure you have played this out in other areas of response before this coordination of your unique contributions. How is that going? Maybe tell us a little bit about that.

Tom Cotter: Well, it is a bit different in every disaster. And I think the scale and scope of this are really pushing the limits of how we approach the actual management of a response at this scale. This is four-five countries, and then if you look at refugees that are coming and then moving on towards other places in Western Europe, the scale is really hard to even define at this point this early on. So, coordinating is really important. It happens at a local level, it happens at a national level, and it happens at an international level. And making sure that we are tapped into existing infrastructure, I think that's really important.

We don't want to take a system and create a parallel siloed system to [inaudible 00:06:41] something that already exists. You know, part of what we are doing is helping host government surge to meet the needs. It's not creating new clinics, it's what can we do to support what already exists so that it can meet the needs. And we do that with the host government, we do that with local partners, and who best to address the needs of people but people who share their culture. So anyway that we can find local partner that then we can support and partner with and help them scale, that's the best way we think to do a lot of our work.

This is going to be a very long crisis, and so finding ways to get everyone at the table and making sure that there are no gaps, and there is no overlap as well. We don't want to waste resources. So, partnering a health NGO like Project HOPE that does health, we want to work with a food NGO, a child protection NGO, a water NGO, and making sure that we are providing comprehensive care and nobody is left behind.

Mark Masselli: You know, Rabih, I am interested in how you build the supply chain for a situation like this. And we have seen with pandemics, supply chains get disrupted, and I am wondering if you could just walk us

through the process from the United States over to Ukraine, and to the other points of how this gets set up. If it was easy anybody could do it, but it's not. It's a very complicated and demanding process that you have developed.

Rabih Torbay: Supply chain is one of the most critical aspects of any response, right? We can send doctors, we can send nurses, we can send experts, but if we don't have medicines and medical supplies that go with them there is really not much they could provide in terms of treating a patient. And we have developed a very robust supply chain. First of all, I mean donors in the US are some of the most generous people in the world. They reach out wanting to support, whether by donating resources or funds, or supplies, medicines, medical supplies and equipment.

And we have different partnerships with companies, with organizations, with corporations that always reach out to us and donate some of their supplies. But also, we do some procurement as well in the US and Europe. And as you said, in any emergency, the supply chain can become a bottleneck first of all, because a lot of supplies are going into the region, and airports and ports have limited capacity, but also the demand is high and sometimes the supply chain is not there to meet that demand. So, we tend to diversify in terms of where we get some of those medicines and medical supplies as long as they have the quality that we want, and they have the expiration – the long expiration date that we need. And we send them by air, by sea freight, whatever we can, to the ports.

We are relying heavily now on buying in Europe as well. Because of the proximity, we can get them in there sooner. But also, we have a lot of flights that are going in with medicines and medical supplies from the US. And it's something that we manage very closely. We have a team of expert logisticians and they are the ones that actually handle the cargo from the minute it's given to us, all the way to the delivery point to Tom and his colleagues as well.

Margaret Flinter: Well Tom, I would like to talk about the millions of refugees who we have seen leave Ukraine and go into other countries, and at the same time the whole world has been moved by the way people in these countries have opened their homes, their hearts to bring people into their homes, and probably not for a few days. And I wonder, and I don't know if this is outside the scope of what you do, but preparing people who are bringing individuals into their homes who have been traumatized, how are you working with people on the ground to prepare them to help the people whom they move into their homes?

Tom Cotter: It's an astonishing thing to watch. The outpouring of love and care from communities in literally throwing open their doors and receiving people, I have never seen anything like it in my career to this scale.

It's really encouraging and it really does matter. It's making a big difference in integrating people fleeing violence, into new communities. But as you said, there are some considerations that need to be forefront of mind, one of which is folks coming with specific needs. You mentioned mental health needs. It's a very delicate thing to receive someone and interact with somebody who's experienced such acute trauma at their own home. And there is a tool called psychological first aid that allows you, allows any layperson who is not a psychologist or psychiatrist, to essentially validate those feelings that a person might have fleeing violence, and allows you to help them return.

Now, most people by and large are not going to need any additional support other than some sort of normalcy. We find this in most disasters. It's not that everyone needs to see a psychiatrist or psychologist, and these trainees can help. So, right now Project HOPE is actually working with, as I said, local partners in Romania to provide that training for psychological first aid for volunteers working at the border, and the people handing out the toys and the food and the water at the border, and also the people who are receiving refugees in their home.

The other thing that's really important for folks that are receiving refugees is helping them navigate their health care system. There was a case where someone who had cancer showed up in a Romanian person's home, throwing up at their doors. And they need to help them get appropriate care in the health care system in the neighborhoods they are in.

Mark Masselli: Rabih, I want to talk a little bit about the scenario planning that you are doing. We just witnessed an attack close to the Polish border. I am wondering how you are thinking about it, contemplating what happens if there is other scenarios happening and how you prepare for what we hope won't be an expanding war, but what's your thoughts there?

Rabih Torbay: I mean let's hope there is no expansion to this war, and let's hope that this war ends soon. Because even if the war ends today, our work will be there for a long, long time in terms of rebuilding the health care system. But you are right on point, Mark. I mean we do work with contingencies. The situation changes every minute. Any time there is an incident, or there is even a rumor of an incident, we start preparing in terms of okay if this happens what do we do, what do we do with our team. I mean the safety for our team is paramount as well. We want to make sure that Tom and all of our colleagues, their safety is our number one priority.

And this is where training of our local counterparts is critical, because at the end of the day our job is not to replace the Ukrainian health

workers that are working in Lviv or in Kyiv, or the Romanian health workers. Our job is to empower them and give them the tools that they need to do the work themselves. And that helps us also with the contingencies in terms of how much are we needed beyond sending supplies and supporting them and training them.

I mean we are looking at the team that's in Ukraine, and with the war raging and going further west, what do we do with our team? When do we evacuate? What happens if the supply roads also are cut off? So, we are pulling lot of those contingencies in place to make sure first of all that people continue to be able to provide medical services even as the war rages on. We need to make sure that our team are safe, but also at the same time the patients that we serve are also safe and getting the health care that they need.

I mean this is something that all the countries are working on, whether it's Poland or Romania or Moldova or Hungary. They are working on what happens if this escalates. And we are part of the coordination mechanism with other organizations, because one organization cannot do it alone. I mean over 1.5 million refugees in two weeks, who would have expected that? Yet, we pivoted. We provided support. We're sending additional teams. We're sending additional supplies to try to cope with it as much as possible.

Margaret Flinter: Well, we watch with just awe and admiration, the sheer bravery of clinicians who are choosing to stay in Ukraine amid the bombings and the rocket fire. We had the honor of speaking to a clinician from a polyclinic not long ago, and I think we will always remember her saying, "We run. We hide when we hear the alarms. We go back to work. We take care of our patients." The commitment is extraordinary. But we know that they are also running out of basic medicines and food and water and fuel. Are you able to actually get supplies into Ukraine?

Tom Cotter: Believe it or not, yes, and it's a pretty complex mechanism to get supplies into what is essentially a war zone. There is complexities by the availability of drivers for example. Men 18 to 60 can't leave the country. So we are having to work with the government directly, the Ukrainian government and the embassies, and the host country governments to move things across the border. One of the ways that we are preparing some of these contingencies, and one of the ways that we are making this as flexible as possible, is by having as many pathways into Ukraine as possible.

So, we don't just get one road or one particular city, we are going to cover as many as we can and find every option and use them because if any particular pathway gets closed the supply chain doesn't end. We still can boost up by others. So, one of our key partnerships is actually children's hospital in Lviv. And we are able to partner with a

hospital in Krakow in Poland and move supplies from that hospital into the other hospital in Lviv that needs them desperately. These hospitals in places that aren't feeling direct impact, are receiving patients from the other hospitals. And it's not just the war wounded, it's also people who need heart transplants, it's people with cancer as I said before.

So the supply chain is flowing, and it always needs to be more because essentially the normal pathways that Ukraine gets its medicines have been cut off. So, we are creating a system with as many branches as possible to get things in country.

Mark Masselli: You know Rabih, Tom was talking earlier about certain difficulty of providing direct culturally appropriate support to families. But one of the force multipliers that have come out of the sort of COVID pandemic if you will has been telehealth interventions. Talk to us a little bit about how telehealth has been leveraged by your organization, or how have you seen it scale up during this crisis.

Rabih Torbay: Telehealth has become a critical component of what we do. Right? We learned it in the pandemic that if you can't treat people physically you can reach them in other ways. I mean the fact that we are having this conversation on Zoom is an example of what could be done. And we are exploring the same thing in Ukraine, because certain areas we might not be able to send trainers or additional doctors and nurses to work with them. But as long as they have connectivity we can do it; we can continue to provide either the training component or even consultation with experts in the region, or even here in the US as long as there is a common language.

This is something that's becoming more integrated into what we do rather than an afterthought, which is what telehealth used to be in the past. Now it's become integrated into what we do. When we look at options, we look at the telehealth option as one of the critical component through which we can provide patient care, also at the same time we can provide advice and training to doctors and nurses on the ground. And those are some of the solutions that we look at in a situation like Ukraine. I mean we don't know what roads are open today. We don't know what city or town is going to have connectivity today or not. And telehealth helps us reach the patients, reach the providers without taking great risk and at a very reduced cost. I mean it's much cheaper to do that than to do anything else.

So it's become a component of what we do. And we are looking – actually right now we are looking at different trainings that we can do based on demands from doctors and nurses in Ukraine. They said, "Can you help us with this?" And we are looking at those components to see how we can do that from the US, or from Poland, or Romania, and making sure that they still get the quality care that they need. I

mean Margaret, you mentioned the Ukrainian doctors and nurses that are staying behind. I mean we owe it to them. Those are heroes. They are staying behind. They are risking their lives to save others. We owe that to them. We owe it to them to find every single solution that we can to support them, and this is one of them definitely.

Margaret Flinter: Well, Rabih and Tom, that is a great example of how people around the world can help, but we want to make sure we give you an opportunity, because everybody watching this field is compelled to help in some way volunteer, amassing medical supplies. Tell the people viewing or listening to this what's the best way for people to help in this cause right now. What do you need that people in the United States and around the country can do to help?

Tom Cotter: You know, Project HOPE, we are not just here for the acute phase of this. You know as Rabih said, we get there, we get there soon and we get there quickly. But we also recognize if the war ends right now, there are going to be years of work, not only in the host countries but also to rebuild the health systems of Ukraine. So, every ounce of support is absolutely needed. It is all hands on deck for a crisis of this size. People can visit us at www.projecthope.org, follow us on our social media, see what we are up to. Anything anybody can do to support is greatly needed. Thank you.

Mark Masselli: And Rabih, the Project HOPE really has so many other humanitarian crises that it's also addressing. We are still in the pandemic. There is ongoing refugee crisis in Syria and other hotspots. Just let our listeners know a little more about the scope of Project HOPE. Obviously the tip of the spear right now is focused in on the battles that are happening in Europe, but you also have a much broader agenda that you are focused in on as well.

Rabih Torbay: The world didn't stop. The disease did not stop because of the war in Ukraine. You know, people are still struggling all over the world. For us at Project HOPE we are currently working in about 30 countries around the world in Africa, in the Americas, in Asia, and in Europe. And we are focusing on different things. You know, infectious disease. I mean we are still dealing with the pandemic, as you said, globally, and it's still raging in certain parts of the world. So this will continue to be one of our focus.

Focusing on maternal and child health. I mean the pandemic sent us back decades when it comes to maternal mortality and infant mortality. So, we are putting a lot of focus on that as well to make sure that women and children don't die unnecessarily because of lack of medicine or because of lack of vaccine or because of lack of training. Looking at noncommunicable diseases, I mean one of the main issues that's coming out of Ukraine is diabetes, cancer, is chronic diseases that are not being treated. In addition to all the hotspot that

we are dealing with around the world, whether that's what's going on in Venezuela in the region, or what's going on in certain parts of Africa, in Nigeria, or in Ethiopia, the war in Ethiopia as well, this is something that we continue to work in.

And we have our teams all over the world that are providing those services. And we urge everybody to go to www.projecthope.org, learn more about the organization, support us in whatever way you can. If you can donate, fantastic, if not, volunteer. And if we don't fall within what you are interested in, vet other organizations that you are interested in. The most important thing is for you to do something, because the worst thing that we can do to Ukraine, and to the world at large, is to sit back and do nothing. And this is what we urge people, just do something to help. If Project HOPE, if you like what we do, that's fantastic. If not, we are grateful for whatever support you give to other organizations as well.

Margaret Flinter: We have been speaking with Rabih Torbay, CEO of Project HOPE, and Tom Cotter, Project HOPE's Director of Emergency Response and Preparedness. Learn more about their efforts in the war in Ukraine and the refugee crisis by going to www.projecthope.org. Rabih, Tom, thank you so much for your humanitarian efforts, for your leadership in this work, and for joining us today on Conversations on Health Care.

Tom Cotter: Thanks for having us.

Rabih Torbay: Thank you for having us.

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Mark Masselli: At Conversations on Health Care, we want our audience to be truly in the know when it comes to the facts about health care reform and policy. Lori Robertson is an award-winning journalist and Managing Editor of FactCheck.org, a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in U.S. Politics. Lori, what have you got for us this week?

Lori Robertson: The Centers for Disease Control and Prevention and Pfizer tweeted in February about the dangers of blood clots in veins, which are relatively common, and affect as many as 900,000 Americans each year. A story shared on social media however, misleadingly linked those public health reminders to the COVID-19 vaccines. Blood clotting in the deep veins, or deep vein thrombosis, is a serious and relatively common medical condition. Clots that form in the legs or pelvis can also travel to the lungs and block blood flow. That's known as pulmonary embolism which is often lethal.

Up to 900,000 in the US each year are affected by these conditions, and as many as 100,000 die according to the CDC. Half of blood clots occur after hospitalization or surgery. It also highlights the risk of

being immobile for long periods of time. Some of these factors also can apply to athletes who get injured, or who travel a lot. The CDC highlighted the risks in a Super Bowl themed tweet, reminding the public that DVT can happen to anyone. Online posts however, have misleadingly used the public health message to suggest that the COVID-19 vaccines including the two mRNA vaccines are a major cause of clotting.

One COVID-19 vaccine authorized in the United States, the Johnson & Johnson vaccine can cause a very particular blood clotting problem, blood clotting combined with low levels of blood platelets, but it is extremely rare. The condition has not been linked to either of the mRNA vaccines which account for the vast majority of doses administered in the US. No COVID-19 vaccine appears to cause blood clots generally. And mRNA vaccines have not been associated with any kind of clotting problem. And in fact, evidence suggests COVID-19 vaccination prevents blood clots by protecting against COVID-19 which raises the risk of clotting.

And that's my fact check for this week. I'm Lori Robertson, Managing Editor of FactCheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players, and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you would like checked, email us at www.chcradio.com. We'll have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

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Margaret Flinter: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Sub-Saharan Africa leads the world in maternal and infant deaths each year. An estimated 397,000 babies died at birth in that region in 2013, and some 550 mothers died per day as well. Most of the causes have to do with lack of access to medical care in these low resource regions, and often the local midwives lack formal medical training to prepare them to conduct interventions in the event of a life-threatening event like a hemorrhage or an infection.

Anna Frellsen: We know that 90% of all the deaths that we see today could be prevented if the mother had access to this really basic skilled care during the childbirth.

Margaret Flinter: Anna Frellsen is CEO of the Maternity Foundation. Their organization has created an intervention for midwives living in low resource areas if they just have access to a smartphone. It's called the Safe Delivery App, and it provides comprehensive training for midwives that teach

them and guide them on what to do in the event of a birthing crisis.

Anna Frellsen: This is really a matter of building the skills of the health workers who are already out there, and empower them to be able to better handle the emergencies that may occur during a childbirth such as the woman starts bleeding, or the newborn is not breathing and so forth. So, first and foremost it's a matter of finding a way that we can reach the health workers and build their skills.

Margaret Flinter: Frellsen says the real promise of the Safe Delivery application lies in its ability to provide ongoing obstetric and neonatal training so that local midwives can gain important clinical knowledge overtime. The Safe Delivery App has been designed to be culturally relevant and easily understood and it's received the United Nations' approval for wider deployment. A low cost, culturally sensitive mobile app that offers immediate guidance and assistance to midwives and health workers, the backbone of the health care system in low resource areas, empowering them with ongoing support and knowledge that can improve birth outcomes, now that's a bright idea.

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Mark Masselli: You've been listening to Conversations on Health Care. I'm Mark Masselli.

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Peace and health.

Marianne O'Hare: Conversations on Health Care is recorded at WESU at Wesleyan University, streaming live at www.chcradio.com, iTunes, or wherever you listen to podcasts. If you have comments, please e-mail us at chcradio@chc1.com, or find us on Facebook or Twitter. We love hearing from you. This show is brought to you by the Community Health Center.