OPERATION TAGHOY
PROCEDURAL MANUAL

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UPLIFT INTERNATIONALE
mending faces...one child at a time

CHILDREN

Children are the most precious of all human treasures. Among them are those whose misfortune it is to have a deformed face, most often by being born with clefts of the lip and/or palate. In the Philippines, most come from families too impoverished to afford the needed care. Untreated and unable to mask their deformity, they live and die suffering in shame in the shadows of their community. They are the focus of our humanitarian activities

MISSION STATEMENT

Uplift Internationale (UI) aims to give a life-changing gift to children with facial deformities by ***mending faces...one child at a time***.

THE VISION

By recruiting volunteer healthcare professionals and support personnel
who are willing to share expertise and provide care
to children with facial deformities,
UI can change a life of shame and ridicule to one of hope and promise.

By appealing to like-minded individuals, organizations and corporations
for support and participation, the mission activities

- named **OPERATION TAGHOY** –
- can be provided without cost to the impoverished families
and minimal burden to the host hospital.

By developing and supporting year-round Cleft Clinics
in select rural communities, countless more children with facial deformities
can benefit from the reparative care
provided by Filipino volunteer healthcare expertise with the
participative stewardship of in-country philanthropists as well as
UI co-subsidy.

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HISTORY & PURPOSE

UPLIFT INTERNATIONALE (UI) is a Colorado-incorporated nonprofit humanitarian organization for volunteer health-care providers and support personnel seeking to donate their expertise and time to provide free reparative surgery and care to indigent children in rural Philippines.

ITS objectives are to:

- Recruit self-funded health-care providers to participate in patient care
- Share expertise with local colleagues willing to be caretakers of the poor
- Assist in improving health-care capability of a host hospital

A compelling reason for choosing the Philippines as the primary focus of our activity and concern is that, even today, it remains a country struggling to cope with unmet human needs. In public healthcare, the significant deficits, include:

- Municipal hospitals, institutions mandated to provide care to the impoverished, are typically ill-funded, poorly-equipped and understaffed so as to prioritize care to emergent before elective problems
- Less than one-half of the total hospital beds are located in rural communities where nearly 70% of the population resides, a mal-distribution which deprives the majority of its citizens - most of whom are indigent - adequate healthcare.
- It is estimated that even today nearly 1 of 10 Filipinos is born, lives and dies without receiving basic medical care and over one-half of its citizens are considered medically indigent.

In l989, a group of Colorado healthcare professionals volunteered to travel to Ormoc City, Philippines. Its founder, Philippine-born maxillofacial surgeon, Dr. Jaime A. Yrastorza, led this inaugural team. A mission of up to two weeks duration has since been organized annually, encouraged by the commendation of the host community as well as their healthcare professional societies and civic organizations. By l994, UI narrowed the focus of its humanitarian efforts. The annual mission activity has since been directed to render surgical and adjunctive care to children born with and/or have incurred facial deformities - primarily, however, clefts of the lip and palate.

The motives of the mission activity remain the concern that among Filipinos:

- 1 of every 350 live births is estimated to be at risk of having a facial deformity, more than twice the incidence noted in developed countries
- Over 100,000 of the 99+ million inhabitants - more than half of whom still have sub-standard existence - are estimated to have been born with a facial defect, which, unfortunately, could remain untreated and nearly 10,000 more may be added to the pool, annually.
- Children with the deformity do not always receive timely care and are at greater risk of frequent upper respiratory infections, hearing deficits, speech impediments as well as misaligned teeth and jaws - many are growing into adulthood with their faces visibly deformed, surgical care beyond their means or simply unavailable.
- Aware that the facial anomaly robs the child of the many functions of the mouth we take for granted, including the charm of a smile or even the pleasure of a whistle, the project is henceforth titled:

OPERATION TAGHOY*

(*a Philippine word for Whistle)

The goals of **Operation Taghoy** are to:

- Mend the children's facial deformities during an annual visit of UI-organized team of volunteers – FOR FREE...one child at a time
- Assist in the development and promotion of a community-wide program of information about the birth defect
- Affect a transfer of knowledge to local colleagues who can learn and provide the needed care at a year-round Cleft Clinic in select rural communities with participative stewardship of local philanthropists and UI co-subsidy

In l998, a consortium of Colorado Rotary Clubs, led by the **Rotary Club of Wheat Ridge** (RCWR) as well as the **Rotary Clubs of Ormoc City, Philippines** endorsed the humanitarian aims of Operation Taghoy. They have become among its key sponsors; and, as advocates they have successfully enjoined other Rotary Clubs to similarly participate.

In l999, the **Filipino-American Community of Colorado (FACC) -** an organization of Filipino immigrants, descendants and others having interest and ties with the Philippines as well as in its heritage and culture - adopted the project **OPERATION TAGHOY**. They, by their sponsorship, advocate like organizations to support similarly.

In 2005, the **Exempla Healthcare Corporation** extended its support by embarking on a program of subsidy for their employees who successfully participate in humanitarian missions. Their protocol, as an exemplary model for other healthcare corporations, portends an access to a pool of healthcare volunteers for UI Mission Teams.

In 2008, the **Smile Train,** an internationally renowned humanitarian organization that advocates and undertakes the care of children with cleft of the lip and palate in many developing countries of the world; and which supports nonprofit organizations with like goals willing to adopt patient care procedures equal to their own standards and those recommended by the World Health Organization, recognized Uplift Internationale for its comparable standards of care protocol and is designated a **Partner of Smile Train**.

In 2010, the **Chicago-based Global Coalition for Humanitarian Effort – Philippines** "umbrella organization" for mission groups of Filipino ex-patriate healthcare professionals from countries outside of the Philippines extended membership to UI. The membership is anticipated to provide linkages to sources of volunteers for Operation Taghoy and the potential of broadening venue selection.

Operation Taghoy, to date, is an undertaking of **UPLIFT INTERNATIONALE** with cooperation of and partnership with:

PHILIPPINE & AMERICAN ROTARY CLUBS
FILIPINO-AMERICAN COMMUNITIES
COMMUNITY HOSPITALS in rural PHILIPPINES
MEDICAL ORGANIZATIONS of the HOST COMMUNITY
HEALTHCARE CORPORATIONS
SMILE TRAIN

The venue and host institution of the project activities was originally at the **ORMOC DISTRICT HOSPITAL**. By 2010, the **AKLAN PROVINCIAL HOSPITAL** the **LEYTE PROVINCIAL HOSPITAL** the **ANTIQUE PROVINCIAL HOSPITAL,** the **CAPIZ MEMORIAL HOSPITAL,** the **ILOILO PROVINCIAL HOSPTIAL**, the **SOUTHERN NEGROS**

DOCTORS' HOSPITAL and the **WESTERN VISAYAS MEDICAL CENTER** have since become host institutions. They are visited on a rotational schedule.

UI recognizes the continuing need to appeal for support from individuals, organizations and corporations who share the humanitarian objectives of Operation Taghoy. Sponsoring organizations, therefore, will always be sought after and welcome. Sponsor Organizations are committed to the goals and aims of the project Operation Taghoy. They may:

- Provide funding assistance for acquisition of equipment and supplies needed for the Mission activities, annually.
- Assist in propagating the community awareness of the mission.
- Join the Mission Team.
- Delegate a member to serve as Liaison to the UI Board of Directors.

ROLES AND RESPONSIBILITIES

A. SPONSORS: CIVIC CLUBS & MEDICAL SOCIETIES

Sponsor Organizations cooperate with UI in facilitating a successful mission. The roles of Sponsor Organizations together with that of a Host Hospital and UI may include the following:

(1) ROTARY CLUBS, Philippines

Rotary Clubs of the Philippines enable the organization of, and provide assistance in the following concerns:

- PATIENT MONITOR: Assist UI in the development and implementation of plans to: recruit patient-candidates; tract post-operative patients; and disseminate educational programs designed to raise the level of community awareness about facial birth defects.
- TRANSLATORS: Recruit a corps of volunteers able to participate as translators for appropriate members of the UI Mission Team.
- TRANSPORTATION & GRUB:
    - Assist in customs clearance for the Mission Team at the port of entry.
    - Arrange ground transportation and portage for the Mission Team.
    - Provide lunches for the Mission Team at the hospital in order to maximize the efficient activity of the Mission Team.

(2) ROTARY CLUBS, American/International

Rotary Club of Wheat Ridge Colorado (RCWR) together with other Clubs of the District and of the US, as sponsors of the project, enable the purchase of specialized instruments and equipment for the repair of cleft lips and palate. They continue to donate funds raised from appeals on behalf of Operation Taghoy. Rotary Club(s) may recommend a Rotarian for appointment to act as the liaison to, and/or serve on the Board of Directors of UI.

UI continues to seek other Rotary Clubs to join in support of Operation Taghoy. The participatory role of a Rotary Club (RC) which may be undertaken on a continuing basis, include:

- FUND RAISING: At its own discretion, a RC may organize fund-raising support as well as participation in related activities of Operation Taghoy and facilitate UI appeals for support before other Rotary Clubs.
- MISSION TEAM: A Rotarian on a Mission Team may assist in any planned liaison activity with host Rotarians aimed at promoting the goals of Operation Taghoy.
- LIAISON: A Rotarian may serve on the Board of Directors of UI and provide liaison to participating Rotary Clubs.

(3) FILIPINO AMERICAN COMMUNITIES

Filipino-American Community of Colorado, an organization of Filipino compatriots and others interested in the preservation of Philippine culture and tradition, by adopting the project Operation Taghoy as its own undertaking, serves as a model for participation of similar organizations. Their participatory role may include:

- FUND RAISING: At its own discretion, they may organize support and provide participation in appropriate activities of Operation Taghoy. This effort may be undertaken

on a continuing basis.

- MISSION TEAM: A participating member, as part of the Mission Team, may assist in any planned liaison activity with local hosts aimed at promoting the goals of Operation Taghoy.
- LIAISON: One of its members may serve on the Board of Directors of UI and act as liaison to the Filipino-American organization and its members.

(4) MEDICAL & other Healthcare SOCIETIES & CORPORATIONS

UI seeks the invitation and support of the community MEDICAL SOCIETY as well as those of allied healthcare professions and CORPORATIONS, both in the United States and the Philippines. Its members may join in the mission activities and in so doing, partake in the professional interchange.

(5) Other Civic Organizations

UI seeks the support of organizations and corporations who share the humanitarian objectives of Operation Taghoy.

B. THE HOSPITAL

Operation Taghoy activities are conducted at a host public-funded hospital in rural Philippines. Today, UI seeks the venue at a provincial hospital, more often situated in the capital of the province and in a community with an established medical society and civic organizations.

Initially, the project activities were undertaken at the **Ormoc District Hospital (ODH)**, a 100-bed facility for a catchment population of approximately 200,000. Thereafter, the experiences gained from repeat mission visits have provided for UI a protocol of procedures with which the mission activities today continue to employ in order to gain a mutually rewarding, cooperative undertaking. They include support of:

- **The CHIEF:** In consultation and cooperation of the CHAIR of MISSION, the Chief is requested to:
  a) Approve the participation of properly credentialed Team Member volunteers, as recommended by UI.
  b) Extend overall supervision of the project activities, including the welfare of patients as well as the performance and well-being of UI volunteers.
  c) Provide such facilities and personnel, including operating room time and ward space, as may be deemed adequate for the proper function of the project activities and care of its patients.
  d) Appraise the CHAIR of MISSION of any prevailing limitations in supplies and medications in order to allow the Mission Team to acquire and provide adequate provisions for the activities of the project.
  e) Appoint a house officer as Project Coordinator.

- **PROJECT COORDINATOR (PC)** may:
  a) Create a census of all children with facial deformities born within the catchment area of the hospital. Sources for the census may be obtained from birth records of hospitals and Health Centers. The cooperation of Barangay Health Officers may be solicited to report the identity of afflicted children. Census data should include the

name, sex, date of birth and the manner in which repeat contacts can be facilitated.

b) Provide a list of tentative patient candidates for transmission to the CHAIR of MISSION, if possible, 2 months prior to a scheduled Mission Team visit.

c) Contribute to the efficient flow of patient activities, including any necessary continuity of patient care after the departure of the Mission Team.

Other Participating HOSPITALS

a) **AKLAN PROVINCIAL HOSPITAL:** Beginning the year 2000, the Aklan Provincial Hospital (APH) at Kalibo, Aklan agreed to become a participating facility. APH is a 100-bed facility with a catchment population of approximately 200,000. It is organized with a full complement of the major services; it has 4 operating rooms. The institutional role of APH is similar to that agreed on with ODH.

b) **Any hospital** with which UI hereafter arranges to extend the activities of the project Operation Taghoy shall, by mutual agreement, endeavor to follow the protocol outlined above. Please see p7 for list of host hospitals.

C. UPLIFT INTERNATIONALE (UI)

UI shall be responsible for the organization and conduct of the project Operation Taghoy, the President or his/her designate is to act as CHAIR of MISSION with assistance of the Taghoy Committee. Its role shall include the following areas of activity:

(1) VOLUNTEER RECRUITMENT:

- Self-funded healthcare expertise and support personnel may be recruited through advertisement, referrals and word-of mouth. Each Mission volunteer, unless previously arranged, is expected to participate for a duration of one or two weeks.
- For final approval of any volunteer candidate, the President may seek the advise, counsel and recommendation of the Taghoy Committee.
- Volunteer selection shall be based on:
    - Review of documented qualification and expertise in the particular healthcare discipline and/or support/outreach needs.
    - Demonstrated interest and willingness to adhere to common principles of conduct.
    - Ability to devote the time and effort required.
    - Capacity to defray the proportionate expense of a one or two week commitment.

(2) MISSION TEAM:

The Mission Team may be comprised of:

- Anesthesiologists
- Surgeons (ENT/ Oral-Maxillofacial/ Plastic-Reconstructive)
- Nurses/Assistants (RNs, OR techs, PAs, Dental Assistants, Hygienists)
- Pediatricians/ Family Practitioners/ Internists
- Dentists/ Orthodontists
- Speech Pathologists-Therapists/Audiologists
- Outreach Personnel - non-medical or any other person (ancillary or support) that may be deemed necessary in order to accomplish the goals of the project.

(3) TRAVEL ARRANGEMENTS: UI, unless previously exempted by agreement, shall arrange air and ground transportation as well as housing accommodations for each

volunteer, to include breakfast and lunches. At the discretion of UI, select individual volunteers may receive partial subsidy from monies derived through fund-raising appeals.

(4) SUPPLIES & EQUIPMENT: UI shall coordinate the inventory of equipment and supplies, after due recommendations by volunteer participants, consultation with the Chief of host hospitals and such reports as may be available of the estimated number of patients available for care by the Mission Team. UI may request volunteers to participate in the solicitation of charitable donation of appropriate supplies and materiel.

(5) ORIENTATION PROGRAM:

Mission Volunteers are recruited from various national and international resources. In order to ensure optimum coordination of the project activities as well as provide early opportunity to become acquainted with each other, UI shall formulate a program of guiding information and orientation. All Mission Team members are expected to be familiar with and adhere to the recommended guidelines. An Orientation Program at which ALL members of the Mission Team are requested to partake will be organized.

Each volunteer will receive an Orientation Packet, which will include the following:

- UI Mission Statement
- Copy of the **UI PROCEDURAL MANUAL** (when available, may be downloaded at: www.upliftinternationale.org)
- Advice on Cross-Cultural Sensitivity Awareness and Goodwill
- Ambassadorship opportunities

INDIVIDUAL VOLUNTEER RESPONSIBILITIES

All healthcare professionals selected to join a Mission Team are requested to provide documentary evidence of graduation from an accredited professional school, postgraduate training and/or specialty qualification, current licensure, two (2) passport-size head photos and curriculum vitae. Volunteers for the Outreach component need only submit two (2) passport-size head photos.

The composition of a Mission Team as well as the duties and obligations of the members may include the following:

1. HEAD of MISSION - shall:

a) Have the overall managerial responsibility of the Mission Team and mission activities
b) Liaison with the host community and hospital leadership on matters related to the welfare of the Mission Team and conduct of Operation Taghoy as well as with the assistance in the local arrangements of lodging/food/ diversions.
c) Supervise the overall function of the Mission activities and ensure the welfare of members of the Mission Team.
d) Appoint coordinators to oversee the conduct of OR and Perioperative Services as well as the activities of the Outreach projects.
e) Provide the Board of Directors a report on the Mission together with recommendations for future Operation Taghoy activities.

2. COORDINATOR of MISSION - shall:

a) Formulate the daily surgical schedule.
b) organize and supervise daily rounds and the discharge of Mission patients in coordination of all other Coordinators of the Mission Team
c) Ensure that discharged patients receive the appropriate and recommended instructions as well as postoperative medications and long-term follow-up.
d) Liaison with Outreach Coordinator
e) Provide the Head of Mission, an appropriate statistical and demographic post-Mission activity report, including recommendations on future supplies, equipment and formulary needs.

3. ANESTHESIOLOGIST

(Board-certified/qualified physician/Certified Nurse Anesthetist - pediatric anesthesia experience)

A Coordinator, when appointed, shall be responsible for the overall function of the anesthesia staff; assist in ensuring the proper function of the OR and its staff; provide the Head of Mission an appropriate activity report, including recommendations on future activities advantageous to anesthesia conduct and care; as well as:

a) Assist in the overall evaluation/management and care of patients in the pre- and post-operative, recovery room phase.
b) Determine suitability of the patient to undergo general anesthesia.
c) Assist in the informed consent of the surgical procedure, including its risk-to-benefit ratio.
d) Responsible for the general anesthetic conduct of the patient, including supervisory responsibility of Registered Nurse Anesthetist(s)
e) provide supervisor role and overall responsibility of any accompanying anesthesiologist and/or technicians as well as the procedures in the Recovery Room, as indicated
f) Coordinate the discharge and follow-up protocol with the Mission Coordinator.

4. DENTIST/ ORTHODONTIST/ HYGIENIST-ASSISTANT

(Experience in dental care of pediatric/facial deformities)

A Coordinator, when appointed, shall be responsible for the overall function of the staff and provide the Head of Mission an appropriate activity report, including recommendations on future activities advantageous to dental participation, conduct and care as well as:

a) Assist in the pre-operative evaluation of the patient.
b) Provide a dental/prosthodontic/orthodontic treatment plan and, render indicated care.
c) Promote a program of oral hygiene/nutrition/ oral disease-prevention.
d) Recommend and coordinate non-surgical treatment alternatives with the lead surgeon.
e) Participate in surgery at the concurrence of the lead surgeon.

5. NURSE/ OR TECHNOLOGIST/ PHYSICIAN ASSISTANT -- Perioperative

A Coordinator, when appointed, shall be responsible for the overall function the Recovery Room and post-operative patient care; supervise the staff activities as well as the inventory of supplies & equipment; provide the Head of Mission an appropriate activity report, including recommendations on future activities advantageous to nursing care; as well as:

a) Assist &/or provide the pre- and post-operative care of surgical patients in the ward and ICU.

b) Assist in the coordination of Outreach-volunteer function/activities in the hospital and the Outreach Program.
c) Assist in acquisition/packing/inventory of supplies and equipment.

6. NURSE/ OR TECHNOLOGIST/ PHYSICIAN ASSISTANT -- Surgical

A Coordinator, when appointed, shall be responsible for the coordinated function of the OR & the staff ; supervise the proper implementation of OR-related activities, including inventory of supplies & equipment; provide the Head of Mission an appropriate activity report, including recommendations on future activities advantageous to nursing care and conduct of the OR; as well as:

a) Assist at surgery and/or anesthesia on request under the supervision of attending surgeon and/or anesthesiologist.
b) Partake in the management of the surgical milieu.
c) Assist in the proper inventory-care of instruments/ supplies necessary for the daily OR conduct.
d) Assist in acquisition/packing/inventory of supplies and equipment.

7. PEDIATRICIAN/ FAMILY PRACTITIONER/ INTERNIST

(Board-certified/qualified with pediatric experience)

A Coordinator, when appointed, shall be responsible for the function of the Pediatric Staff; supervise the overall proper care of the patient; provide the Head of Mission an appropriate activity report, including recommendations on future activities advantageous to patient care and conduct.; as well as:

a) Assist in the screening/triage/scheduling of patient-candidates for surgery.
b) Conduct the general physical examination of the patient.
c) Provide consultation and care of the medically compromised patient.
d) Assist in the informed consent of the surgical procedure, including its risk-to-benefit ratio.
e) Assist in the overall evaluation/management and care of patients in the pre- and post-operative phase.
f) Coordinate the discharge and follow-up protocol with the Mission Coordinator.
g) Assist in acquisition/packing/inventory of supplies and equipment.

8. SPEECH THERAPIST/AUDIOLOGIST

a) Assist in the pre-operative evaluation of the patient.
b) Recommend a treatment plan and initiate therapy.
c) Participate in patient-parent educational program.
d) Promote professional interaction with local colleagues.

9. SURGEON, Lead

(Board-certified in ENT, oral-maxillofacial or plastic-reconstructive surgery with experience in the surgical care of facial deformities)

A Coordinator, when appointed, shall be responsible for the overall function of the Surgical Staff; provide the Head of Mission an appropriate activity report, including recommendations on future activities advantageous to surgical care and conduct; as well as:

a) Lead the organization, function & conduct of the surgical team
b) Recommend the priority classification of the patient
c) render the final decision about the surgical procedures and their indications for surgery
d) Obtain the informed consent of the surgical procedure, including its risk-to-benefit ratio
e) Be responsible for the surgical procedure on the patient
f) Provide supervisor role and overall responsibility of any other participating surgeon
g) Assist in the overall evaluation/management and care of the patient
h) Coordinate the discharge and follow-up protocol with the Mission Coordinator.
i) Participate in patient-parent educational program as well as liaison with the medical community.
j) Assist in acquisition/packing/inventory of supplies and equipment.

10. SURGEON, Associate

(Board-certified/qualified/trainee with experience in ENT, oral-maxillofacial or plastic-reconstructive surgery)

a) Assist in the screening/triage/scheduling of patient-candidates for surgery
b) Conduct the pre- & post-operative evaluation of the patient.
c) Assist in the informed consent of the surgical procedure, including its risk-to-benefit ratio.
d) Provide complementary & adjunctive surgical care, on concurrence of the lead surgeon.
e) Assist in the development and implementation of the pre-operative and post-operative management protocol of patients
f) Coordinate the discharge and follow-up protocol with Lead Surgeon and Mission Coordinator.
g) Participate in patient-parent educational program as well as provide liaison with the medical community.

11. OUTREACH (NON MEDICAL) PERSONNEL- may include:

a) Coordinator

i. Assist the HEAD of MISSION in providing overall supervision of the project activities and well-being of Team members.
ii. Coordinate participation and function of Outreach personnel, including assistance in the screening/documentation of patient-candidates for surgery.
iii. Organize the long-term follow-up search and visitation of prior patients in coordination with host support volunteers.
iv. Assist in the quartermaster management of supplies and equipment.
v. Arrange the necessary volunteer interpreter of the vernacular.
vi. Serve as liaison to local hosts, including the promotion of the project appointment, if needed, an Assistant Coordinator to aid in such matters as Mission Treasurer and inventory of supplies & equipment.
vii. Provide the Head of Mission an appropriate activity report, including recommendations on future activities advantageous to the goals of the project.

b) Computer Specialist

i. Responsible for the collation of all data - patient and Team members - as may be pertinent to the overall documentation of Mission activity.
ii. Assist in print-outs of certificates of recognition as may be recommended by the CHAIR of MISSION.
iii. Provide printed daily OR schedules as well as newsy information of interest to the Mission Team

c) Historian/Journalist/ Video-Photographer/Screener/Statistician

i. Participate in efforts at documentation/collation of demographic data/medical records and contact-maintenance of patients and their families who are under care of Operation Taghoy
ii. Responsible for the documentation and preservation of the pertinent activities of the project and preferably, able to provide a scripted slide/video/anecdotal presentation for UI use.
iii. Assist Surgical Coordinator in collection, collation and storage of data related to Mission patients and cooperate with Computer Specialist as needed.

d) Liaison Representative

i. Member of a Sponsor organization willing to participate in activities of the Mission and act as goodwill ambassador, as directed by the CHAIR of MISSION.

e) Youth Corps

i. Act as liaison to local youth to disseminate and share the goals of Operation Taghoy.
ii. Assist in any of the project activities, including acting as goodwill ambassadors, as directed by CHAIR of MISSION

GUIDELINES FOR THE SCREENING PROCESS OF PATIENT- CANDIDATES

1) All persons seeking correction of a facial deformity or pathology shall be evaluated.

2) All candidates for surgery shall have, prior to the operative schedule:
    a) Completed history and physical examination including, when possible, a dental and speech evaluation
    b) Pre-operative and follow-up photographs
    c) Any indicated consultations with appropriate specialists
    d) Anesthesia and surgery clearance, including estimate of surgery time
    e) A priority classification:
        - #1= REPAIR OF CLEFT LIP, all ages
        - #2= REPAIR OF CLEFT PALATE, ages 1-6
        - #3= REPAIR OF CLEFT PALATE, ages 6-adult
        - #4= REPAIR OF LIPS / PALATE, all ages
        - #5= other conditions (burn contractures, pathology, etc)

3) Surgery may not be recommended for the following reasons:
    a) Poor health
    b) High anesthetic &/or surgical risk
    c) Inappropriate indication due to age
    d) Complexity of the deformity &/or pathology beyond the equipment-capability &/or expertise of the Mission Team .

4) The surgical team should treat patients, when possible, according to their assigned surgical priority classification

SAFETY & QUALITY IMPROVEMENT PROTOCOL (as recommended by Smile Train)

Purpose: This Protocol outlines the basic elements needed to insure safe surgeries and to provide an ongoing review and improvement of the quality of care. Towards this goal, the UI President will create a Safety & Quality Committee (SQC) composed of members of the Taghoy Committee; and, its responsibilities to include, among others, the implementation of requirements outlined below. **Anesthesiologist:** Please see provided Smile Train Anesthesia Guidelines in Appendix A

Part 1: The Quality Review Process

Requirement 1.1:

UI-Operation Taghoy Mission Team will keep complete, organized and accurate records of patients in its care. The host healthcare facility will be provided the document so as to allow its incorporation into the institution's medical records.

Requirement 1.2:

The SQC will review the results of surgeries, by:

- Perusing patient records, discussing surgical results and sentinel events (see Requirement 1.3), if any
- Recommending opportunities for improvement in the quality of surgeries.
- Minutes of these meetings shall be presented to the BOD for disposition and the President shall transmit results of the meeting to the host Healthcare facility

Requirement 1.3:

The Head of Mission shall promptly inform the Chief of the host Healthcare facility of any and all sentinel events: unexpected morbidity &/or mortality occurrence or serious physical or psychological injury, including but not limited to patient death, cardiac arrest, respiratory arrest, stroke, aspiration, or aspiration pneumonia

- The SQC shall review the circumstances surrounding the sentinel event by analyzing the patient's chart (containing all pre- and post-operative records, including the anesthesia record, the recovery room record, all physician and nursing progress notes, lab reports, operative reports, and preoperative history/physical data) in order to understand causes and recommend system changes to educate involved personnel in order to improve patient care and safety as well as to prevent recurrence.
- The host Healthcare facility may, if it wishes, submit a separate narrative report of the event to the UI President.

Part 2: The Selection of Patients for Cleft Surgery

Requirement 2.1:

UI-Operation Taghoy shall implement a process of selecting patients who are healthy enough to undergo the surgery safely, by ensuring:

- That every patient receives a complete history and physical exam and health clearance from a primary care physician (pediatrics or family practice) familiar with the average health status and common health problems of the locality in which the healthcare facility is located
- That the history and physical exam include basic laboratory studies to rule out anemia and respiratory or urinary tract infection - severely underweight children should be examined for gastrointestinal parasites and treated preoperatively if possible - consideration should be given to preoperative malaria screening and prophylaxis in

endemic areas

- Those patient-candidates for surgery are excluded when determined at high risk of developing anesthesia-related problems, pre- or post-operatively - all candidates for surgery must qualify for American Society of Anesthesiology (ASA) physical status class 1 or class 2.

  [ASA class 1 patients have no organic, biochemical, or psychiatric disturbance and the pathologic process for which the operation to be performed is localized and does not entail a systemic disturbance. ASA class 2 patients are those with mild to moderate systemic disturbance caused either by the condition to be treated surgically or by other pathophysiologic processes, including the otherwise healthy child with cleft lip or palate.]

Part 3: The Surgery

Requirement 3.1:

The UI-Operation Taghoy Mission Team will be organized as to be capable of providing anesthesia safely to young children, by:

- Having an anesthesiologist with experience caring for small children, as documented by the cases done by that anesthesiologist/ anesthetist during the preceding 24 months.
- Using anesthesia machines and (or preferably, with) carbon dioxide monitors or having, at a minimum:
- Vaporizers for Halothane/inhalation gases
- A functioning oxygen supply.
- A sufficient drug formulary including antibiotics, I.V. hypnotics (e.g., thiopental), I.V. and oral analgesics, muscle relaxants (e.g. succinylcholine) and emergency drugs (e.g., atropine, lidocaine, dexamethasone).
- Using pulse oxymeters, appropriately sized for children, during surgery.
- Having appropriately sized blood pressure cuffs and precordial stethoscopes.
- Having and using other anesthesia equipment (including endotracheal tubing, IV catheters and tubing, oral airways, masks, laryngoscopes and laryngoscopic blades, stylette circuits, suction catheters disposable needles and syringes) sized appropriately for the age of the child.
- All equipment must be in good working order - if any of the specified equipment is not functioning properly, surgeries must be suspended.
- Recording the details (heart rate, blood pressure, ventilatory data, agents and drugs administered, etc.) of each anesthetic episode on a standard form and filing the form for later review.
- An up-to-date reference book on pediatric anesthesia.

Requirement 3.2:

The UI-Operation Taghoy Mission Team will be organized with surgeons qualified by training to perform and have experience in surgery for cleft lip and palate.

Requirement 3.3:

Host Healthcare facility is deemed appropriate when:

- Operating room personnel can cooperate with Mission Team peers and are familiar with sterile techniques and coagulation of bleeders
- The anesthesia capabilities, as described under Requirement 3.1 are either part of the in-house armamentaria or are part and parcel of the Mission Team material.

Part 4: Post-Surgical and Emergency Care

Requirement 4.1:

The UI-Operation Taghoy Mission Team shall provide safe post-anesthesia care, by:

- Ensuring that the anesthesiologist extubate patients when they are awake enough to have a return of normal upper airway reflexes.
- Ensuring that a surgeon be immediately available in the operating room suite until the patient is breathing spontaneously, is extubated, and has a clear airway.
- Having a clearly delineated medical chain of command, communication and responsibility for care of children in the first 24 hours after cleft surgery - this includes the ready availability of a physician capable of treating any complications that might occur.
- Having and using pulse oxymeters (appropriately sized for children) to monitor post-anesthesia.
- Staffing the post-anesthesia care unit with personnel trained in recovery care, to include knowledge in recognizing hypo/hypertension, airway obstruction, respiratory depression and hypoxemia as detected by a pulse oxymeter.
- Having sufficient numbers of skilled post-anesthesia staff – either members of the Mission team or their in-house peers - so that individualized observation is possible the first night after surgery
- specifically, having all patients in the recovery area monitored until they are fully awake, crying assessed at regular, frequent intervals for post-operative bleeding.

Requirement 4.2:

The host Healthcare Facility shall:

- Designate a unit for post-anesthesia care which is adjacent to or in the OR suite.
- Be able to provide intensive care if a patient requires it – a written protocol, as recommended by the SQC, for emergency care, triage, CPR, and blood transfusions, should be implemented.
- Have on-site immediately available suctioning machine, resuscitative medicines, an oxygen delivery system and oxygen supply, an ECG and blood pressure monitors, and resuscitation equipment – such supplies and equipment may be part and parcel of UI armamentaria.
- Have the ability to intubate children and support their breathing with mechanical ventilators and provide 24-hour monitoring by trained clinical staff; or by having a current, functioning transfer agreement with a healthcare facility that can provide this type of intensive care.

The "SHARING OWNERSHIP" Program

Background

Since the inception of the **Operation Taghoy** project, among its principal goals have always been to seek and promote the participation of local healthcare professional peers in patient care activities and encouraging opportunities for the exchange of knowledge and know-how. Although constrained by the limitation of time, a Cleft Clinic has been established in one of the mission venues, namely, Ormoc City, Leyte. The Clinic, chaired by surgeon Roland Tomaro and a team from the Ormoc Medical Society, provides surgical care to two children with facial deformities per month, year-round at no cost to their families. **UI** subsidizes the costs in supplies and equipment. More recently, Smile Train has extended partnership recognition and grant subsidy of patient-care expenses.

Encouraged by the experiences gained through the Operation Taghoy Cleft Clinic in Ormoc City, UI is eager to embark on a novel, challenging program of promising benefit to children with facial deformities, designated **Sharing Ownership.**

The Vision

Currently, it is estimated that annually upwards of 10,000 Filipinos are born with facial deformities, primarily clefts of the lip and palate. They are added to over a 100,000 of their fellow-citizens with similar, albeit untreated deformities. Most reside in rural regions of the country and belong to families of indigent means. The burdens and hardships they suffer are beyond measure; and, they are a tragic loss to the country as well. The Philippines' own healthcare programs to ameliorate the problem are, fortunately, aided by the contributions of many humanitarian organizations from outside the country. **UI** is one among them.

More children, however, can receive the mending care – *at no cost to their impoverished families* – by promoting the establishment of local, year-round Operation Taghoy Clinics, in the model of that in Ormoc City. Such a program can begin at every venue where UI's mission Team is invited. **The project, at its fruition, would function conducted by volunteer Filipino healthcare expertise and supported jointly by UI and Filipino benefactors and stewards of the program.**

The Process

UI can enable a potential pathway to a self-sustaining local, year-round Operation Taghoy Clinic. To promote its development, UI can:

- Intentionally compose its Mission Team with Filipino volunteers who, at an appropriate time, can be anticipated to form the nucleus of healthcare providers able and willing to staff a year-round local Operation Taghoy Cleft Clinic at a locale of their choice;
- Provide the necessary supplies and equipment;
- Help establish guidelines and protocol of patient care similar to its own standards; and,
- Seek and persuade philanthropic Filipino individuals &/or corporate/foundation to provide stewardship responsibilities of the Cleft Clinic and share with UI the subsidy of the program.

IMPORTANT ADVISORIES FOR MISSION TEAM MEMBERS

A. Funding & Travel Regulations

Uplift Internationale(UI), a 501(c)(3) n*on-profit organization, invite qualified volunteers to join the Team hailing from varied places besides Colorado, including those from communities within the Philippines and those from regions as Europe, Asia, Australia.* UI *is required by law to notify everyone that:*

1. To participate as a Mission Team member for the project Operation Taghoy, each volunteer may fundraise – from themselves, employers, friends or colleagues – an amount as determined by UI by mid-October preceding the mission normally scheduled for February of the following year for donation to UI. The contribution is due by November 1st of the year before the mission. However, Two-Hundred Fifty Dollars ($250.00) of the amount is to be remitted when accepting the invitation to join the Mission Team. It is a non-refundable amount, which will be applied to the donation requested.

2. Uplift Internationale may arrange and pay for all air, land and sea fares as well as lodging with breakfast, lunch at the hospital and two or three evening meals for all mission volunteers.

3. Volunteers who may request or are requested by UI, prior to November 1st of the year before the mission, to arrange their own international &/or domestic air travel to the UI-designated airport closest to the mission venue, would do so at their own expense. For those said volunteers, UI will arrange and pay all land and sea fares as well as lodging with breakfast, lunch at the hospital and two or three evening meals; and, they will be requested to fundraise and donate to UI an amount as determined by UI when accepting the invitation to join the Mission Team or by mid-October preceding the mission normally scheduled for February of the following year.

4. Should volunteers choose to claim the personal expenses of their air travel as charitable contribution, UI is not at risk.

5. All contributions must be made with the understanding that UI has complete control and administration over the use of donated funds. In other words, by law, *Uplift Internationale cannot refund any donations once accepted, and, all donations are tax-deductible to the extent allowed by law*.

B. Emergency Protocol/Evacuation Procedure

Each team volunteer is to read and understand the scope of the personal risk and responsibility attendant to mission travel, as outlined in the document **Acknowledgment of Risk & Release of Liability**.
Further:

1. Should a volunteer(s) cancel their commitment/duties at a time prior to the trip but after airline and accommodations have been arranged/confirmed or if during the mission trip a volunteer, because of illness or any unforeseeable circumstances, must discontinue participation, Uplift Internationale is enjoined by IRS 501(c)(3) ruling to regard all

donated monies as forfeited in favor of UI (please read **Funding & Travel Regulations).**

2. Should a volunteer become ill during the mission trip, Uplift Internationale will make every attempt to deliver proper medical care to that individual (patient), including transfer to an appropriate Philippine healthcare facility. Additionally, if evacuation to the patient's home country is deemed medically compelling, all of the health care and transfer costs will have to be incurred by the patient. Therefore, it is strongly suggested that each individual carry health insurance with international coverage and emergency evacuation benefits (please review your own policy and refer to your health insurance carrier for assistance).

3. Should an adverse event affecting the Republic of Philippines (e.g., political/ terrorist activity &/or natural disaster), either prior to or during the mission trip, which could potentially put the Mission Team volunteers in danger, Uplift Internationale will follow the prevailing United States Department of State advisories for travel and evacuation.

4. Should evacuation be necessary, as may be prescribed by the United States Department of State advisories, Mission Team volunteers will depart as a group under the direction of Uplift Internationale Head of Mission.

C. Mission Activities

Mission Team Composition
By prior agreement with our host medical society, the Taghoy Team will have Filipino-peer members in the disciplines of surgery, anesthesia, pediatrics, dentistry, speech therapy and nursing. The joint effort at patient care is an opportunity to develop programs of knowledge exchange and a projected self-sustaining, local, year-round community-based Taghoy Facial Cleft Clinic.

Arrival – Departure & Project Schedule
The Mission Team is planned to arrive at the host community on the Saturday before the workweek and depart the following Saturday, unless a volunteer has had the UI consent for itinerary deviations. Members, on:

- Sunday, are expected to have an orientation tour of the hospital facility and prepare the supplies and equipment for the mission activities
- Monday, will screen all patient-candidates, prepare to begin the surgical activities and all supportive projects in the afternoon and continue daily until Friday when the Team will prepare themselves, together with supplies and equipment to depart the following day

After Hours & Community Affairs
The Mission Team may anticipate invitations to social affairs organized by local UI supporters. Attendance is not compulsory. Nonetheless, they are opportunities to optimize hospitality interactions with our hosts.

Our host communities and their surrounding areas will have dining and recreational attractions that volunteers may avail. Related information will be made available.

Attire

The country is tropical – dress casually, but considerate of Filipino mores.

Men: ties and jackets are very uncommon; long pants and long sleeve shirts are a consideration for invitational host dinners.

Women: casual shorts for after work wear are acceptable, otherwise slacks and dresses for dinner-social gatherings are suggested.

INFORMATION ON PHILIPPINE CULTURE, SOCIETY & the INDIVIDUAL

As Mission Team members, we will have opportunities to interact with our hosts as well as with our patients and their relations. There will be time to explore the communities where many aspects of the American lifestyle will seem visibly familiar. Is it? The issues that follow are offered as beginning guides, all in abbreviated form. They should help prepare to understand certain elusive differences. They will enable each of us to become credible and effective ambassadors of goodwill for UI and the project Operation Taghoy. *Added reading is recommended.*

A. HISTORICAL FACTORS

Aetas, aboriginal pygmies, are regarded as the first settlers of the Philippines about 20+ thousand years ago, possibly by southern land bridges from the Asian mainland. Malays, in subsequent millennia, arrived in such numbers as to displace Aetas into the interior mountains where their present descendants, in 60 ethnological groups, still largely reside. Malays settled into a livelihood of hunting and fishing, organized into family groups lead by a chieftain, called a DATU, whose authoritarian rule inculcated mores of unquestioning behavior and loyalty to the family. These group units, "BARANGAYs" were established in some of the 7000+ islands of the archipelago.

Separated from each other by sea and mountain ridges, these groups developed regionalism above nationalism. Rivalries between regions and families persist and dictate present-day social, economic and political attitudes. This separation of cultures also lead to multiplicity of dialects - today, despite decades of education, the constitutionally adopted Pilipino as the national language, is yet to be spoken universally.

By the 10th century AD, Indochinese, Chinese and Arabian commercial ties were well-established in the region, leaving many of their customs, cuisine and lifestyles for natives to absorb. Today, for instance, many Filipino dishes have Chinese origins. The reverence between family members, denoted by such words as "kuya"(big brother) and "ate"(big sister) also are of oriental derivative. Intermarriage would subsequently contribute to an elite group that provided leadership influence in commerce, agriculture, politics, etc.

By the 13th century, the global Islamic sphere of influence had spread to the islands, mostly established in the Sulu archipelago. Today, Muslims reside there and constitute 5% of the country's population. Their continuing separatist aims remain an intractable schism to peace and stability in the region. In the 16th century AD, Spain began 4 centuries of colonial rule; it named the archipelago Islas Filipinas after then reigning Prince Phillip.

The Spaniards used the Philippines mainly as a way station for their China-Acapulco trade route. Duri

- a noted scholar, physician and passive supporter of independence - was executed. In 1898, Filipino nationalists declared independence with a republican constitution patterned after that of the United States. Emilio Aguinaldo, a revered and charismatic leader, was its President. However, the nascent attempt at self-government was doomed, thwarted by the Americans who, as a result of their conflict with Spain that same year, became engaged in years of battles with Filipinos. American occupation forces subsequently established their form of cultural imperialism - “benevolent assimilation”. The Philippines was

quickly remodeled in America's own image, ruled as the Commonwealth of the Philippines. WWII brought the battle to Philippine soil. It resulted in a Japanese military occupation and establishment of a puppet government, which proclaimed "independence" in l943. American reconquest in l944 was devastatingly damaging to the country and its people. Although still in the throes of national rehabilitation from the ravages of war, the Philippines was granted independence by the United States in l946. The nation has the dubious distinction of having declared "independence" trice. Both colonialists encouraged the recognizable regionalism to their vested interests' advantage, further imprinting the tradition into the Filipino lifestyle.

B. CONTEMPORARY POLITICS

Much like previous governance, Ferdinand Marcos' government was riddled with corruption, cronyism and economic mismanagement. In 1972, he declared marshal law in a veiled attempt to retain perpetual power. Despite dictatorial control - with US consent and support - opposition to his rule reached unprecedented heights with massive rioting in l983, the people emboldened after the assassination of his main opponent, Benigno Aquino. As thousands of people took to the streets of Manila in a defiant display of discontent of the repressive regime and popular support for the widow Corazon Aquino - "People Power" - Marcos lost control. Within days, Marcos and his minions went into comfortable exile in Hawaii, and he died there in 1989. Attempts to recover the billions of dollars he allegedly defrauded his countrymen remain unsuccessful. Wife Imelda returned home to face graft charges, but - perhaps not surprisingly to the majority of Filipinos - a conviction eluded her, as it still does to this day.

Corazon Aquino's administration effected the abolition of U.S. military installations and with it, diminution of American influence on Philippine matters of State. The country, during her administration, unable to stem the tide of corruption already endemic by the post-Marcos era, suffered economic losses. President Fidel Ramos, her follower, revitalized the economy and quieted the communist guerilla war that had been raging in the countryside.
In l998, Ramos' successor Joseph Estrada turned out more personality than substance. Estrada was impeached, stood trial and was jailed for pocketing millions of dollars in bribes from gambling syndicates, using some of the money to build lavish houses for his several mistresses. Estrada's initial attempts to stymie the impeachment proceedings led to mass demonstrations in mid-January 2001 - 'people power II'. His replacement is President Gloria Arroyo. The country's relentless leadership problems, seesawing currency crises, as well as the kidnapping exploits of Muslim radical separatists based on the island of Mindanao, pose continuing challenges for the foreseeable future.

C. THE PEOPLE, CULTURE, CUISINE

Despite recurring political and economic difficulties, most of the Filipino culture is laid back, stable and relatively safe. The country likes to promote itself as the place where 'Asia wears a smile' and the people are, by and large, exceptionally friendly and helpful. As of July 2004, of the estimated 84+ million populace: 37% will be under 14 years old, 59% 15-64 years old and 4% 65 years or older. Eighty-three percent of Filipinos are Roman Catholics; 8% are Protestants; 5%; are Muslims, living chiefly on Mindanao; and, 4% are a collection of Buddhists, a mixture of Philippine Independence Church members and a small number of animists.

The family unit has been the traditional core of Filipino societal interactions. Ritual kinship in the form of "kumpare" and "utang sa loob" - a lasting form of fealty for favors gained - add to the group size, support and loyalty. However, increasing numbers of Filipinos now work in far-off places such as the Middle East, Europe, America, Japan and Hong Kong, and families are often

separated for extended periods. The fabric of this fabled trait of family fidelity is undergoing myriad changes.

Unadulterated Filipino culture is most apparent, as yet, among Muslims and among some of the isolated tribes. Elsewhere, native elements blend with foreign influences, predominantly Chinese, Spanish and American. “Kundimans” (love songs) and traditional theater in Pilipino mix with beauty contests and lurid soap operas, which, together with violent and sentimental Filipino movies, provide the fodder for mass entertainment.

Filipino cuisine has Chinese, Malay and Spanish influences although today, American fast-food establishments can be found in urban centers. Morning and afternoon snacks, called “merienda”, which are barbecued sticks of meat or chicken, are popular, as are the many tropical fruits. Standard dishes - always served with rice - include chicken, roasted pig (lechon), grilled grouper, meat stews, vegetables cooked with vinegar and garlic, and a variety of soups: rice, noodle, beef, chicken, liver, kneecap, and sour vegetable. Side dishes include strips of unripened papaya, fermented fish or shrimp paste and bite-sized pieces of crispy pig skin. “Halo- halo” is a dessert made from crushed ice mixed with sweets and fruits, smothered in evaporated milk. San Miguel is the local brand of beer and a drink distilled from coconuts is called “tubá”. Popular American soft drinks and bottled water are readily available.

D. SPOKEN & BODY LANGUAGE:

The concept of a national language was developed in 1898, during the Spanish-American War. In an attempt to unite its people who, even today, speak 87 different dialects - 90% speak 9 of the 70 known dialects - Pilipino was adopted the national language. It is based on Tagalog, but with linguistic elements of other dialects. English, however, remains the language of commerce and politics in the Philippines.

The Pilipino alphabet differs from the English by not having the consonants: c, f, j, q, v, x and z but with an additional ng; When speaking in English, the Filipino speech may manifest the peculiar difference by having difficulty pronouncing "f" or "v". Paradoxically, it causes a "p" and "f" or "b" and "v" inversion. Additionally, Pilipino does not use distinguishing personal pronouns; when speaking English, "she" and "he", "her" and “ him" may be misused.

There is a penchant for American slang - some past their fad: cameras are "kodaks", toothpaste is "colgate". Americans may sound nasal or mumbly to the Filipino ear; solution: speak slowly and enunciate purposely. Raising the eyebrow is a customary way of greeting. Pouting the lips or shifting the eyes towards a direction may be the answer to a question "where". To get someone's attention from afar: "psssst"; nearby, a gentle touch of the elbow.

E. HIERARCHY & TIME:

Filipinos refer to themselves and others using titles. To foreigners, the use may seem excessive. It's a carryover from the age-old mores: respect for authority and superiors, which, in turn, is expected by everyone, of everyone, all along the hierarchy of importance. So, its "junior engineer Santos", "assistant Principal Ramirez", "treasurer Tan".

When dining, table manners dictate the use of spoon and fork. Party givers and guests do not

expect punctuality. Tardiness of guests stretches in proportion to their perceived social stature and importance. This still prevailing and acceptable behavior can be attributed to interactions of early "barangays" where society members had clearly regarded and accepted tiers of importance.

Tardiness is commonplace. It finds its roots in the agrarian past when labors in agricultural cycles were measured by available sunlight, climactic changes, etc. Concepts of time, even among today's rural populace, are imprecise. Answers such as "for a while", "it is not too far", "be back soon" may be longer than the response might lead one to anticipate.

F. PERSONAL BEHAVIOR:

Filipinos are big on smiles: praise, criticism, awkwardness, embarrassment, avoiding controversy, etc. When coupled with a Philippine "yes", confusion may develop. "Yes" could mean just that or "maybe", "not sure" - it is always tempered by the desire to please, to consider the triad of influence. Input from a third person may be necessary to obtain the accurate interpretation.

Westerners may be called "Joe". Although staring is considered inappropriate, in rural areas where Westerners visit infrequently, they may be the object of consuming curiosity and obvious stares. Since the visitors may be regarded as people of importance - as Mission members are - one has opportunity to be gracious by extending a friendly smile, a salutation (especially in the vernacular).

G. US CONSULAR Advisory - 2010/2011

U.S. citizens are allowed to enter the Philippines without a visa upon presentation of their U.S. passport, which must be valid for at least six months after entry, and a return ticket to the U.S. or onward ticket to another country. Upon arrival, immigration authorities will annotate the U.S. passport with an entry visa valid for 21 days. The loss or theft of a U.S. passport should be reported ASAP to local police and the U.S. Embassy.

U.S. citizens are subject to Philippine laws and regulations, sometimes differing significantly from those of other countries. Penalties for breaking the law can be more severe than in the U.S. for similar offenses. Violators, even unknowingly, may be expelled, arrested or imprisoned. Convicted offenders can expect long jail sentences and fines. The Philippine Government has very strict laws regarding the possession of firearms by foreigners several of whom have been sentenced to life imprisonment for bringing firearms into the country. Americans who are arrested should immediately ask to speak to a U.S. Embassy representative.

U.S. citizens may feel secure in most areas of the country. However, in Mindanao, crime and insurgent activity may make travel hazardous to and within the provinces of Tawi-Tawi, Maguindanao, Lanao del Sur, Lanao del Norte, Sulu, Basilan, Zamboanga del Sur, Zamboanga del Norte, North and South Cotabato, and Sultan Kudarat.

The threat of terrorist action by extremists, both domestic and foreign, does exist in the Philippines. Although security is not a major concern and most of the country is hospitable to travelers, the State Department reminds all Americans of the need to remain vigilant with regard to personal security issues. Call the U.S. Embassy for an update on the current security situation.

Added Hints for Mission Team members: The sights, scents and sounds, the climate, the people with their disparate economic well-being, the ubiquitous signs of want, and, at the hospital, the compromises that patients are seemingly compelled to endure – these are the

conditions that await visitors to rural Philippines. Everyone is urged to exercise sensitivity to these conditions, and refrain from overt derogatory comments about the cultural differences, which can be distractions to activities related to our project goals.

Our hosts may invite us to gatherings with them, and these opportunities will be occasions to share their hospitality, cultivate their friendship and an chance to act as goodwill ambassadors for our project.

Bring attire suitable for a tropical climate. In social gatherings, 'beachwear" (short- shorts, tank tops) should give way to casual attire (neckties are rarely worn); in the hospital, OR "scrubs" are suitable. In-country electric current is 220v - using appliances may require a converter. Standard currency is the Piso, a 100 sintabos its equal. Exchange foreign currencies at local banks or money-changer establishments, rates being more favorable at the former.

When exploring our host communities, expect common courtesies to be returned in kind. In general, Filipinos will be charmed by attempts to converse in Pilipino, although English is understood by most. Filipino hospitality easily extends to foreigners, especially those of our Mission members and other like humanitarian groups. Filipinos have a large reservoir of goodwill for Americans.

The Applications Process & Policies for Mission Team

SAMPLE

We are contacting you to provide information about an opportunity to volunteer for a medical mission in rural Philippines which provides surgical care to children and adults born with cleft lip and/or cleft palate conditions. We know that some of you are familiar with our humanitarian project and have, in fact, been vital members of past Mission Teams. Please peruse the accompanying documents, which should help clarify the aims and preparations for Mission 2011 as well as the roles and responsibilities of Team Members in contributing to the success of the Operation Taghoy project activities. To become better acquainted with Uplift Internationale, please visit our webpage at www.upliftinternationale.org.

We are recruiting for Mission Team 2011, scheduled for:

February 19-26, 2011 - Roxas Memorial Provincial Hospital, Roxas, Capiz

Should you be interested in applying for a position on the team, please complete the application forms and return as soon as possible. Due to licensing regulations in the Philippines, healthcare professionals are further required to include copies of the supportive documents as noted below. These documents are to include the following:

1. Copy of current license to practice
2. Copy of diploma (professional school)
3. Copy of specialty license or certificate if applicable
4. Two passport-sized photos
5. Curriculum Vitea (CV) or resume

All applications and requested documents are due NO LATER THAN July 15, 2010
In addition to the application form, **OUTREACH APPLICANTS** need only supply the following:

1. Two passport- sized photos
2. Curriculum Vitea (CV) or resume or personal statement of qualification

TIMELINE

1. Application with supporting credentials due by July 15, 2010
2. Applications reviewed by Taghoy Committee: Mission team members will be selected according to qualifications of the potential team members and needs of the team.
3. Applicants will be notified of their selection by August 1, 2010
4. For applicants selected for the mission, a non refundable deposit of $250 is due by August 10, 2010.

Thank you for your interest and cooperation. If you are unable to participate in the mission in 2010 but have contacts or colleagues who might be interested, please contact us so that we may send them an application.

We look forward to hearing from you.

Steve Krebs, MD
Taghoy Committee Chair

Kerri-Ann Appleton
Executive Director

Name_____

Street or PO Box _____

City/State/Zip/Country _____

Email _____ FAX _____

Primary Phone _____Alternate Phone_____

Citizenship _____ Passport #_ _____Valid till _____

Current Employer _____ Position _____

Foreign Language _____

Education (list academic degree/ specialty training)

Please check the box(es) below to match your level of interest and expertise with the proposed team composition.

1. I understand that volunteers are self-funded. Yes □ No □

2. I am willing to share my experience and knowledge with a local peer Yes □ No □

3. Team Composition (please mark category of interest):

   Healthcare Staff
   □ Anesthesiologist/ CRNA
   □ Dentist/ Orthodontist
   Nurse / PA / Tech
   - □ OR staff
   - □ Perioperative staff

   □ Pediatrician / Family Practitioner
   □ Speech Therapist
   Surgeon, Lead
   - □ ENT
   - □ Oral-Maxillofacial
   - □ Plastic-Reconstructive

   □ Surgeon, Associate

   Outreach
   □ Computer/Statistician
   □ Historian/Journalist
   □ Liaison Representative
   □ Visual Aid (Video/Photo)
   □ Youth Corps (min age 16)

4. I can help in the preparations by:
   - bringing my own 'special' surgical instruments Yes □ No □
   - obtaining sutures Yes □ No □
   - solicitation/ collection of supplies/equipment Yes □ No □
   - solicitation of air travel grants Yes □ No □

   Other _____

Application Form
OPERATION TAGHOY

Please discuss why you are interested in participating in this mission, including any prior volunteer experience or experience working with children with cleft lip and palate, and how the experience contributes to the goals of the Mission:

Please list 2 personal or professional references that can speak to your expertise in your field.

Name: _____

Phone: _____

Name: _____

Phone: _____

Upon return, may UPLIFT INTERNATIONALE elicit your continuing support by (please check all that apply):

- ☐ Recruiting volunteers by word-of-mouth among peers and your linkages
- ☐ Giving presentations on UPLIFT INTERNATIONALE and the mission before healthcare, civic &/or church groups
- ☐ Raising donations/contributions for UPLIFT INTERNATIONALE by writing to friends and colleagues on your experience
- ☐ Serving on a committee of the Board of Directors
- ☐ Participating in the planning and activities of UPLIFT INTERNATIONALE's Annual Fund Raising Event

SIGNATURE_____ DATE _____

Please return by mail to: Uplift Internationale PO Box P.O. Box 181658, Denver, CO 80218, U.S.A. OR fax at 208-379-0461 OR by email as pdf attachment to info@upliftinternationale.org

2011 VOLUNTEER ACCEPTANCE FORMS

UPLIFT INTERNATIONALE (UI) is an organization of volunteers such as myself. It has limited funds and no insurance to cover costs and/or risks associated with international travel. I hereby agree to indemnify, release, and forever discharge UI, its directors, officers, members and all other persons working on its behalf from any and all loss, liability, actions, claims and demands of any nature past, present or future that may result from or be in any way related to my personal activity conducted under the auspices of UI.

To the best of my knowledge, I have supplied correct and accurate information. If I am selected, I will uphold the goals and objectives of UI to the best of my ability.

_____ _____

Signature Date

I understand that my donation of $250 is non-refundable should I, for any reason, need to cancel my participation in the mission.

_____ _____

Signature Date

Policies on Travel & Personal Conduct

I, _____, as a Team Member of Operation Taghoy, accept and support the aims and goals of the project. Duly aware that my conduct directly contributes to the integrity and reputation of Uplift Internationale(UI), I agree to:

- conduct myself in a professional manner, with kindness and prudence to all patients entrusted to my care;
- avoid the possession or use of illegal substances;
- perform my designated role, recognizing the relevance and necessity of all documentation processes, including healthcare records as well as visual and technological aids which are thereafter retained in possession of UI;
- cooperate with the daily contingency plans for communication, transportation and project activities, recognizing that my flexibility and positive attitude will be of assistance;
- ask if I am unclear about any policies or procedures, or the daily contingency plans for communication, transportation and project activities;
- accept that for safety reasons, I need to remain with the team when traveling or inform ahead of time the Head of Mission of my plans and intended itinerary;
- respectfully comply with governmental, cultural, and moral standards of our hosts and country; and,
- willing cooperate and comply, if evacuation is necessary, to a standard team evacuation plan and its requirements.

_____ _____

Signature Date

Representation & Emergency Authorization

The personal and health history I have provided is correct. I understand and agree to abide within the restrictions which may be placed on my Operation Taghoy Mission activities.

I will willingly agree to engage in all prescribed activities, except as noted:

_____

_____

I hereby give permission to the healthcare personnel selected by Uplift Internationale or it's agents to order for me imaging studies, diagnostic tests as well as injection and/or anesthesia and/or surgery for emergency treatment.

I further agree to assume responsibility for all incurred costs including, but not limited to, charges for providing aid and arranging evacuation if Uplift Internationale or its agents determine that such evacuation is necessary or desirable.

_____ _____

Signature of Volunteer & Guardian Date
(co-sign if volunteer is under 18 years of age)

For Mission Team Members (Please read before signing)

Uplift Internationale (UI) has attempted to minimize risks to participants and to assure that their experiences are personally rewarding. Participants, however, need to be aware that missions, by nature, are not without risk.

I, _____, as an applicant to the Operation Taghoy Mission Team, acknowledge that there are certain risks and dangers which may occur on the mission. These include, but are not limited to: hazards of traveling by plane, boat, train, automobile, or other conveyance, accidents, encountering the country's inhabitants in close contact and crowded conditions, providing medical/surgical care in potentially compromised clinical settings, experiencing physical demands and fatigue/ jet lag, consuming local food and drinks, encountering cultural, language, and religious differences, and exposure to temperature extremes, environmental hazards, forces of nature, and criminal and terrorist elements, all of which can cause loss or damage to personal property, injury, illness, or in extreme cases, permanent physical or psychological damage and/or injury or even death.

I am healthy physically, mentally, and emotionally, and am capable of participating in this mission trip. I have listed any and all medical condition of which UI should be aware that may hinder my participation in the activities selected, understanding that it is solely my responsibility to determine whether there is any medical reason not to participate.

I also state that I am not under, and will not be under the influence of any chemical substance. I will not be under the influence of alcohol during the hours of performing my assigned role. I also understand that my participation in this mission is entirely VOLUNTARY. I enter into this mission taking full responsibility for my decision to participate or not to participate and agree to follow all safety instructions and policies as set forth by UI.

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Signature of Volunteer & Guardian (co-sign if volunteer is under 18 years of age)

Date

CUMULATIVE ROSTER OF VOLUNTEERS

ADAMS, Susan	nursing, OR	Colorado
ALFECHE, Shirlee	nursing, periop	Colorado
ALLEN, Barbara	anesthesiologist	Colorado
ALLEN, Rachel	outreach, youth	Colorado
ALLEN, Rose	outreach	Colorado
ALEXANDER, Richard	outreach	Colorado
ALEXANDER, Rosie	outreach	Colorado
ANGUS, Larry	outreach	Colorado
ANGUS, Scott	outreach	Colorado
APOSTOL-GAPAY, Angie	anesthesiology	Philippines
APPLETON, Kerri Ann	Exec Director	Colorado
BACALZO, Nora	nursing, periop	Colorado
BACKUS, Walter	anesthesiology	New York
BAJADALI, Jen	nursing, OR	Colorado
BALLIGAND, Pierre	surgery, maxillofacial	Belgium
BARKER, Liz	nursing, periop	United Kingdom
BART, Alex	anesthesiology	Illinois
BATEMAN, Michael	surgery	Colorado
BATTISTA, Lauren	nursing, OR	Colorado
BEARD, Patti	nursing, periop	Colorado
BIETY, Christopher	dentistry	Colorado
BIETY, Monnie	outreach	Colorado
BINKS, Stuart	medicine	United Kingdom
BLISS, Nancy	nursing, OR	Colorado
BODDEZ, Philippe	surgery, maxillofacial	Belgium
BOK, Tanya	nursing, OR	Canada
BOLLINGER, Shane	nursing, periop	Colorado
BIRSCH, Jordan	outreach, youth	Colorado
BROWN, Alphonse	medicine	Arizona
BROWN. Renee	outreach	Colorado
BROWN, Robert	anesthesiology	Colorado
BRUNGARDT, Tim	outreach, youth	Colorado
BRYAN, Edie	outreach	Colorado
BRYAN, Richard	pediatrics	Colorado
CALIMAG, Jhune	surg, plastic-reconstructive	Philippines
CAMARATA, Joseph	surg, plastic-reconstructive	Nebraska
CAMARATA, Colleen	nursing, periop	Kansas
CANON, Melba	nursing, periop	Colorado
CARANZA, Rob	anesthesiology	United Kingdom
CASSA, Joseph	outreach	Colorado
CASSA, Kay	outreach	Colorado
CATTANACH, Katherine	outreach	Colorado
CHANCHAREONSOOK, Nat	surgery, maxillofacial	Thailand
CHARLES David	surg, plastic-reconstructive	Colorado
CHRISTIANSON, Timothy	surgery, ENT	Wisconsin
CHU, Gina	nursing, OR	Philippines
CLAUSSEN, Eric	surgery, maxillofacial	Indiana
CLEMENS, Stephen	surgery, maxillofacial	Wisconsin

COATES, Jean	nursing, periop	United Kingdom
COCKS, Allison	nursing, OR	United Kingdom
CONOVER, Dan	nursing, anesthesiology	South Carolina
COULON, Jon-Pol	surgery, maxillofacial	Belgium
CUTHILL Gay	outreach	Colorado
DABATOS, Arthur	anesthesiologist	Philippines
DAHL, John	pediatrics	Colorado
DE LA CRUZ, Ferdinand	anesthesiology	Philippines
DE LA CRUZ, Revien	anesthesiologist	Philippines
DE VILLA, Glenda	surgery, maxillofacial	Philippines
del CASTILLO, Cynthia	surgery, maxillofacial	Philippines
DENKLER, Debbie	outreach	Arizona
DOWLING, Warren	outreach	Colorado
DUBOYS, Elliot	surg, plastic-reconstructive	New York
DY, Rob	medicine	Washington
ECKERT, Mary Anne	outreach	Colorado
FANOUS, Ramsey	surgery, maxillofacial	Oklahoma
FARFEL, Glenn	outreach	Colorado
FERRENDELLI, Ronald	dentistry	Colorado
FLOWERS, Melvin	outreach	Colorado
FRICK, William	surgery, maxillofacial	Texas
FUSHIMI, Sherry Lynn	nursing, OR	Colorado
GARCIA, JUDITH	pediatrician	Philippines
GABRIEL, Melissa	nursing, periop	Colorado
GILLES, Roland	surgery, maxillofacial	Belgium
GILLILAND, Thaine	physician assistant	Colorado
GUNDRAN-ALOOT, Consuelo	nursing, periop	California
GROSSHANS, Charles	pediatrics	Colorado
GROSSHANS, Mary	outreach	Colorado
HAMMERSCHMIDT, Mariah	outreach, youth	Colorado
HANSON, Sheri	outreach	Colorado
HARDWICK, Margaret	nursing, periop	United Kingdom
HARRIS, Stephanie	pediatrics	Colorado
HAYASAKA, Wallace	anesthesiology	Colorado
HAYS, Risa	outreach	Colorado
HEATON, Theresa	nursing, periop	Colorado
HERMAN, Lawrence	surgery, maxillofacial	Massachusetts
HERSHBERGER, Dominique	nursing, OR	Colorado
HERSEY, James	ophthalmology	Colorado
HEWITT, Sue	anesthesiology	United Kingdom
HILARIO, Oscar	surgery, ENT	Philippines
HILL, Julie	outreach	California
HILL, Libby	nursing, periop	Colorado
HOFHEINS, Donald	surgery, maxillofacial	Texas
HOLLENBECK, Michael	physician assistant	Oregon
HOLOHAN, Joan	nursing, OR	New York
HORAM, Valerie	nursing, periop	Colorado
HURLEY, Brenda	outreach	Colorado
JAMSAY, Hannah	outreach	Colorado
JANES, Patricia	nursing, OR	Colorado
JOHNSON, Debra	surg, plastic-reconstructive	California

JOHNSON, Julie	nursing, periop	United Kingdom
JOHNSON, Molly	nursing, periop	Colorado
KENNEDY, Amy	physician assistant	Colorado
KERNS, Bonnie	outreach	Colorado
KERNS, James	orthodontist	Colorado
KERVEILLANT, Joy	outreach	Colorado
KERVEILLANT, Olivia	nursing, periop	Colorado
KIERNAN, Derek	outreach, youth	Colorado
KIERNAN, Jasmin	nursing, periop	Colorado
KIERNAN, Zak	outreach, youth	Colorado
KING, Melody	nursing, periop	Colorado
KIRCHER, Mike	nursing, periop	New Mexico
KNIZE, David	surg, plastic-reconstructive	Colorado
KREBS, Steven	pediatrics/head of mission	Colorado
LABABIDI, Carrie	outreach	Colorado
LABABIDI, Sam	anesthesiologist	Colorado
LAMBERMONT, J-Yves	anesthesiology	Belgium
LARSON, Malia	outreach	Colorado
LARSON, Susan	pediatrics	Colorado
LAWRENCE, Dana	anesthesiologist	Oregon
LAVIGNE, Donna	outreach	Colorado
LAVIGNE, Jay	outreach	Colorado
LAVIGNE, Mahal	youth, outreach	Colorado
LEAMONS, Kirk	nursing, periop	Colorado
LEE, Lisa	outreach- youth corp	Missouri
LIGSAY, Ron	nursing, OR	California
LIPMAN, Arlene	outreach	Colorado
LIPMAN, David	outreach	Colorado
LIU, George	anesthesiologist	California
LODGE, Sarah	nursing, OR	Australia
LORD, Peter	physician assistant	United Kingdom
LUNN, Melrose	outreach	Philippines
LUTRELL, Gina	outreach	Colorado
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MAURO, Cynthia	nursing, periop	Colorado
MAY, Helen	technician, OR	Colorado
McCOMAS, Jane	nursing, OR	Colorado
MEDDICK-LORD, Jackie	nursing, periop	United Kingdom
MEE, Erin	nursing, OR	Colorado
MENOR, Tessie	anesthesiology	Philippines
MERIN, Ike	surgery, pediatric	Philippines
METZGER, Amy	nursing, OR	Colorado
MEYERS, Art	outreach	Colorado
MEYERS-ROMERO, Joy	outreach	Colorado
MILLER, Charles	dentistry	Colorado
MILLER, Jeanne	outreach	Colorado
MILLER, John	surgery, maxillofacial	Wisconsin

MILLER, Bobbie	surgical technologist	Wisconsin
MINK, Chelsea	outreach, youth	Colorado
MOJICA, Belen	outreach	Florida
MOYER, Barbara	dentistry/head of mission	Colorado
MOYER, John	outreach, youth	Colorado
MOYER, Molly	outreach, youth	Colorado
MOYER, BRYAN	outreach	Pennsylvania
MURARESCU, Bogdan	anesthesiologist	Colorado
MURPHY, David	anesthesiology	Colorado
MYERS, Anne	outreach	Colorado
MYERS, Chet	outreach	Colorado
MYERS, Lisa	nursing, periop	Colorado
NAJERA, Robert	surgery, associate	New York
NARIDO, Alma	anesthesiology	Philippines
NAYLOR, Kelly	nursing, OR	Colorado
NEWMANN, Rachel	nursing, periop	Washington
NEWMANN, William	medicine	Washington
NIBLO, Leonora	outreach	Colorado
NICHOLOFF, Theodore	maxillofacial surgery	Philippines
NIQUETTE, Betty	nursing, periop	Colorado
NIQUETTE, James	outreach, treasurer	Colorado
O'BELMITO, Betty	nursing, periop	Colorado
O'DAY, Flossie	nursing, periop	Colorado
O'DAY, Richard	surgery, maxillofacial	Colorado
O'DAY-GREENFIELD, Patsy	outreach	Colorado
OMEGA, Roslie	anesthesiology	Philippines
PALAD, Anne	nursing, OR	Philippines
PANGGAT, Jo-earl	nursing, OR	Philippines
PAOLINO, Rebecca	nurse anesthetist	Massachusetts
PAPADOPOULOS, Harry	surgery	Indiana
PARDO, Nellie	medicine	Arizona
PASCAL, Paulus	surg, plastic-reconstructive	Belgium
PASION, Edith	nursing, periop	Colorado
PASTON, Francine	pediatrics	Colorado
PAULUS, Pascal	surgery, maxillofacial	Belgium
PICCONE, Anne	nursing, OR	Colorado
PICCONE, Anthony	anesthesiology	Colorado
PICCONE, Jessica	outreach, youth	Colorado
PIETTE, Etienne	surgery, maxillofacial	Belgium
	outreach	Belgium
PINNEY, Anne	outreach	Colorado
PISON, Resy	speech therapy	Philippines
POTESTIO, Lucy	outreach, youth	Colorado
PRATT, Frederick	surg, plastic-reconstructive	California
PRO, Julio	anesthesiology	California
RAFFERTY, Diane	technician, OR	Colorado
RANDALL, Anita	nursing, OR	Colorado
REICH, Andrew	outreach, youth	Colorado
RICKARD, Sophia	outreach	Colorado
REICH, Marshall	surgery, general	Colorado
RISMA, Sid	medicine	Illinois

ROBBINS, Candy	nursing, periop	United Kingdom
ROBERTSON, Elizabeth	nursing, periop	Colorado
ROLLERT, Linda	speech therapist	Colorado
ROSE, Cecile	nursing, periop	Arizona
ROWLEY, Charlotte	nursing, periop	Colorado
RUDOLPH, Charles	outreach, liaison	Colorado
RUNNELS, Sara	surgery, maxillofacial	Massachusetts
RYAN, Doren	surgery, maxillofacial	Wisconsin
RYAN, Helen	nursing, OR	Wisconsin
RYAN, John	anesthesiologist	Colorado
RYAN, Timothy	outreach, youth	Wisconsin
SAMMAN, Nabil	surgery, maxillofacial	Hong Kong
SANDS, Teresa	nursing, periop	Colorado
SANICO, Gerry	surgery, maxillofacial	Philippines
SAUER, Leni	nursing, OR	Colorado
SAVELLE, Jonathan	outreach	Colorado
SCHACHTLIE, Amy Beth	nursing, periop	Colorado
SCHOYER, Nancy	outreach	Colorado
SEBESTA, Karen	outreach	Colorado
SEIBEL, Sandra	nursing, periop	Colorado
SEKIYA, Floyd	dentistry	Colorado
SHEEHAN, Patrick	anesthesiologist	Colorado
SIMMONS, Andrea	nursing, OR	Colorado
SMITH, Karen	outreach	Colorado
SNELLING, Theresa	speech therp/head of mission	Colorado
SOMES, Anne	nursing, periop	Colorado
STEPUTIS, Doris	outreach	Colorado
STEPUTIS, Fred	outreach	Colorado
STORMO, Alan	surg, plastic-reconstructive	Colorado
SWAIL, Jeff	surg, plastic-reconstructive	Colorado
SWEETRA, Susan	nursing, OR	Colorado
TARMAN, Kristin	nursing, periop	Colorado
TENAGLIA, Alyssa	outreach, youth	New Hampshire
TENAGLIA, Claire	nursing, OR	New Hampshire
THOMAS, Juanita	nursing, periop	Colorado
TOMARO, Roland	surgery, general	Philippines
VALDEZ, Regina	nursing, periop	Colorado
VELMONTE, Xenia	surgery, maxillofacial	Philippines
VEIT, Lynn	nursing, OR	Colorado
VERSOSA, Lee	ophthalmology	Philippines
WASLO, Denise	nursing, OR	New York
WAUGH, Lucy	outreach, youth	Colorado
WAYMENT, Kristi	physician assistant	Idaho
WHITMARSH, Stewart	dentistry	Florida
WETSTONE, Susan	anesthesiologist	California
WHITAKER, Kevin	anesthesiology	Colorado
WILLIAMS, Geoff	surg, plastic-reconstructive	Idaho
WILLMANN, Amanda	nursing, periop	Colorado
WINDTAKER, Talon	outreach	Colorado
WOLLENZIEN, Donald	outreach	Colorado
WONG, George Raymond	outreach- youth	Missouri

WONG, Mimi	anesthesiology	Colorado
WRIGHT, Jacqueline	outreach	Canada
YANG, Lucie	nursing, periop	Colorado
YOTOKO, Sandy Mae	nursing, periop	Colorado
YOUNGQUIST, Jo	nursing, OR	Colorado
YOUTZ, Teresa	anesthesiologist	Colorado
YRASTORZA, Jaime	surgery, maxillofacial	Colorado
YRASTORZA, Patricia	outreach	Colorado
ZAPANTA, Pamela	dentistry	Arizona
ZAPANTA, Victor	pediatrics	Arizona

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Appendix A

Smile Train: Anesthesia Guidelines

Anesthesia Guidelines

These guidelines are designed to promote the safety of children undergoing general anesthesia for cleft lip and palate procedures. They may be modified based on the patient's underlying medical condition and the anesthetic equipment, drugs, and facilities available.

The anesthesiologist or anesthetist participating in these cases should be familiar with the care and monitoring of small infants and young children. He or she should be adept in pediatric airway management, venous access, and resuscitation. He or she should be administering pediatric anesthesia on a weekly and preferably daily basis. A specialized team of personnel consisting of trained surgical nurses, technicians, surgeons, and anesthesiologists dedicated to these cases is highly desirable.

Preoperative evaluation

- History and physical exam completed by a pediatrician detailing family history of adverse reactions to anesthesia, medical and birth history including congenital abnormalities, other medical conditions, previous operations, current upper respiratory tract infection, allergies, current medications, height and weight.
- Laboratory work including CBC, platelets, PT/PTT (for cleft palate repair)
- CXR is not necessary if the history and heart/lung exam is negative
- ECG is not necessary if the history and heart exam is negative
- Consider having bank blood available for large cleft palate repairs
- The patient should be afebrile and in optimal cardiorespiratory condition, i.e., URIs resolved as much as possible
- Informed consent for the surgical procedure obtained by surgeon and discussion of general anesthesia, including potential risks and complications, by the anesthesiologist with patient's parents
- Schedule youngest and smallest patients early in the day. Schedule cleft palates, revisions, and other difficult cases early rather than later

NPO status for elective cases

- 2 hours clear liquids (water, apple juice) for all ages
- 4 hours for solids and milk/formula up to 6 mo old
- 6 hours for solids, non-clear liquids for all children 6 mo or older

Premedication

- Oral midazolam 0.25-0.5 mg/kg 1/2 hour prior to induction if >8 kg; otherwise, no premedication. Recognize that premedication may cause the patient to be drowsy postoperatively if the procedure is of short duration.

Preparation of Anesthetic Equipment

- Full vaporizer
- Functioning suction machine and catheters
- Full oxygen tanks
- ECG and pulse oximetry
- Capnography (end-tidal co2) if available
- Temperature-monitoring capability
- Appropriate circuit to give positive pressure ventilation (circle or Jackson-Rees)
- Appropriate sizes of blood pressure cuffs, ETT's, largynoscope blades, masks, oral and nasal airways
- Calculation of endotracheal tube size based on age (age/4 + 4) or one can look at patient's 5th finger as approximation. Rae tube preferred if available, but not required

- Lactated Ringers or normal saline IV solutions for early morning cases, dextrose 5% - containing solutions for pm cases (small or malnourished children may be unable to mobilize glucose stores if fasted for prolonged periods) #22 and #20 g iv catheters and appropriate 60 drop/cc iv tubing or buretrol drip chamber
- Warm blankets
- Anesthetic record with continuous recording of vital signs (every 5 minutes or less) and medications administered

Intraoperative Medications

- Inhalational agent – sevoflurane, halothane, or isoflurane
- Muscle relaxants – succinyl choline, short acting non-depolarizing agent (vecuronium, atracurium, or rocuronium)
- IV induction agent – propofol, thiopental, ketamine
- Anti-sialogogue, vagolytic – atropine, glycopyrolate
- Antibiotic
- Reversal agents – edrophonium or neostigmine, naloxone
- Rectal acetaminophen
- Steroids – to reduce swelling postoperatively (1 or 2 doses only)
- Narcotic – fentanyl or morphine
- Resuscitation medications – epinephrine, atropine, calcium, bicarbonate, glucose
- Bronchodilators – aminophylline, terbutaline, or albuterol inhaler
- Consider blood banking for repair of large palate defect, reoperation, or patient with borderline anemic preop

Induction of General Anesthesia

- Application of full monitoring including continuous ECG, BP, and pulse oximetry
- In healthy patients, inhalational mask induction with spontaneous ventilation and IV, start right after loss of consciousness. IV induction if IV access is easy or child is older. Alternatively, IM induction in the OR (with all monitors applied) with ketamine 3-5 mg/kg, atropine 0.02 mg/kg and succinylcholine 4 mg/kg if intubation appears straightforward In patients with suspected difficult airway, inhalation induction with IV in place.
- O2/N2O/inahlational agent
- Assure ability to ventilate by mask without muscle relaxants
- Intubation with patient on 100% O2, reasonably deep, to avoid bronchospasm and laryngospasm, with or without muscle relaxants--ETT size should allow airleak at 15- 30 cm H2O pressure
- Observe and auscultate equal bilateral chest movement and presence of end-tidal CO2 if available
- Rectal acetaminophen 30-45 mg/kg, if available

Intraoperative Maintenance

- Antibiotics and steroids given per preference of surgeon (e.g., cefazolin 25 mg/kg every 8 hrs if not allergic for wound prophylaxis, dexamethasone 0.25-0.5 mg/kg IV up to 10 mg for airway edema)
- Beware of ETT movement as patient's head is being positioned during surgery and as retractors are being placed. Beware of tube occlusion if mouth retractor is opened completely.
- Beware of throat pack placement and assure removal before extubation – recommend intraoperative suture tag placement on side of patient's cheek and sign in prominent place in OR to remind personnel of throat pack placement/removal
- Prefer maintainence of spontaneous ventilation during the procedure --guide to depth of anesthesia without risk of muscle-relaxant or narcotic overdose
- Prefer inhalational agent and O2/N2O or O2/air for maintenance--minimize narcotic administration as surgeon will infiltrate with local anesthetic/epinephrine solution which provides post operative pain relief and aids in hemostasis
- Record vital signs (BP, HR, RR, O2 sat, Temp, and ET CO2 if available) every 5 minutes on written record
- Carefully monitor intraoperative blood loss and fluid administration

Pediatric Intravenous Fluid Administration Guidelines

- Maintenance Fluids
  - 4 cc/kg/hr for 0-10kg
  - plus 2cc/kg/hr for next 10 kg
  - plus 1cc/kg/hr for additional kgs
- May use a dextrose-containing solution for maintenance fluids. Use balanced salt solution (eg., LR, plasmalyte) for deficit, third space and blood loss replacement
- Deficit: calculate from above then x hours NPO, replace 1/2 first hour, 1/4th second hour, 1/4th third hour
- Third Space Losses
  - 2-4 cc/kg/hr minor procedure (lip scar revision)
  - 4-6 cc/kg/hr moderate procedure (bilateral lip repair)
  - 8-10cc/kg/hr major procedure (large cleft palate repair)
- Blood Loss
  - Replace 3x blood loss with balanced salt solution
  - 10cc/kg/hr PRBCs raises HCT 5%
  - Estimated Blood Volume
  - Infant 80 ml/kg
  - 1-3 years 75 ml/kg
  - 3-6 years 70 ml/kg
  - >6 years 65 ml/kg
- In most cases, where climate is hot and IV has a chance of falling out, be generous with fluid administration--a well-hydrated patient will have less post operative nausea and vomiting

Emergence from General Anesthesia/Extubation in OR

- Ensure throat pack is removed
- Placement of tongue suture by surgeon post-palate/pharyngoplasty procedures.
- Allows forward retraction on tongue to relieve potential post op airway obstruction
- Strong suction available
- Patient should be breathing 100% O2 spontaneously, with no residual narcotization and oxygen saturation >97% or better
- Surgeon is present and immediately available in OR and instrument table remains set up
- Tracheostomy instrument tray available, not open
- Gently suction nares, oropharynx and stomach if possible—but beware suture lines and wounds
- Patient should be awake, eyes opening, with spontaneous purposeful movement, and able to open mouth and/or cough
- Retain ability to give 100% O2 by positive pressure mask
- Consider extubating with patient head-up or in lateral position

Transport to PACU

- Transport patient who is awake and breathing spontaneously with portable oxygen tank and mask if available
- Routinely administer supplemental oxygen to maintain O2 sat>96%
- PACU should be located immediately adjacent to or inside the OR suite and staffed with a 1:1 patient:nurse ratio. PACU nurses should be specially trained in airway management and recognizing/treating signs of airway obstruction
- Suction, continuous BP, pulse oximetry and temperature monitoring should be available
- Continuous ECG if available
- Ability to warm or cool patient
- Full oxygen tanks and ability to give positive pressure mask ventilation with 100%O2
- Availability of resuscitation drugs and equipment as described for the OR setting above
- Awake patient should be monitored for at least one-two hours in PACU setting for bleeding and nausea/vomiting

- Most young patients will be comfortable with acetaminophen, 15 mg/kg orally every 4 h, if local anesthesia/infraorbital nerve blocks have been administered in the operating room. Morphine should be used cautiously and the patient monitored carefully in the postoperative period.

Post op Observation

- Patient should be transferred to ward bed if the vital signs are stable and there is no evidence of bleeding. Vital signs and wound checked for bleeding at least every hour or more frequently for the first twelve hours.
- Clear liquids PO should be offered initially, then oral intake advanced as tolerated. Intravenous fluids should be continued until the patient is taking liquids well orally.
- Recommend high visibility bed with at least 3:1 patient:nurse ratio or better
- Emergency protocol established and in place to monitor and treat problems as they arise--chain of communication and command clearly delineated, ability to access anesthesiologist and surgeon for airway management post operatively if needed
- Surgeon immediately available to answer and address questions regarding postoperative wound care and drainage
- Family of patient to be fully informed of all events occurring during and after operative procedure, including success or failure of procedure performed.

- *These Guidelines have been approved by the Smile Train Medical Advisory Board*

Updated March 14, 2005

Appendix B:
World Health Organization - Surgical Safety Checklist

Surgical Safety Checklist

World Health Organization | Patient Safety
A World Alliance for Safer Health Care

Before induction of anaesthesia

(with at least nurse and anaesthetist)

Has the patient confirmed his/her identity, site, procedure, and consent?
- ☐ Yes

Is the site marked?
- ☐ Yes
- ☐ Not applicable

Is the anaesthesia machine and medication check complete?
- ☐ Yes

Is the pulse oximeter on the patient and functioning?
- ☐ Yes

Does the patient have a:

Known allergy?
- ☐ No
- ☐ Yes

Difficult airway or aspiration risk?
- ☐ No
- ☐ Yes, and equipment/assistance available

Risk of >500ml blood loss (7ml/kg in children)?
- ☐ No
- ☐ Yes, and two IVs/central access and fluids planned

Before skin incision

(with nurse, anaesthetist and surgeon)

- ☐ **Confirm all team members have introduced themselves by name and role.**
- ☐ **Confirm the patient's name, procedure, and where the incision will be made.**

Has antibiotic prophylaxis been given within the last 60 minutes?
- ☐ Yes
- ☐ Not applicable

Anticipated Critical Events

To Surgeon:
- ☐ What are the critical or non-routine steps?
- ☐ How long will the case take?
- ☐ What is the anticipated blood loss?

To Anaesthetist:
- ☐ Are there any patient-specific concerns?

To Nursing Team:
- ☐ Has sterility (including indicator results) been confirmed?
- ☐ Are there equipment issues or any concerns?

Is essential imaging displayed?
- ☐ Yes
- ☐ Not applicable

Before patient leaves operating room

(with nurse, anaesthetist and surgeon)

Nurse Verbally Confirms:
- ☐ The name of the procedure
- ☐ Completion of instrument, sponge and needle counts
- ☐ Specimen labelling (read specimen labels aloud, including patient name)
- ☐ Whether there are any equipment problems to be addressed

To Surgeon, Anaesthetist and Nurse:
- ☐ What are the key concerns for recovery and management of this patient?

This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged.

Revised 1 / 2009

Appendix C:
Pediatric Basic Life Support

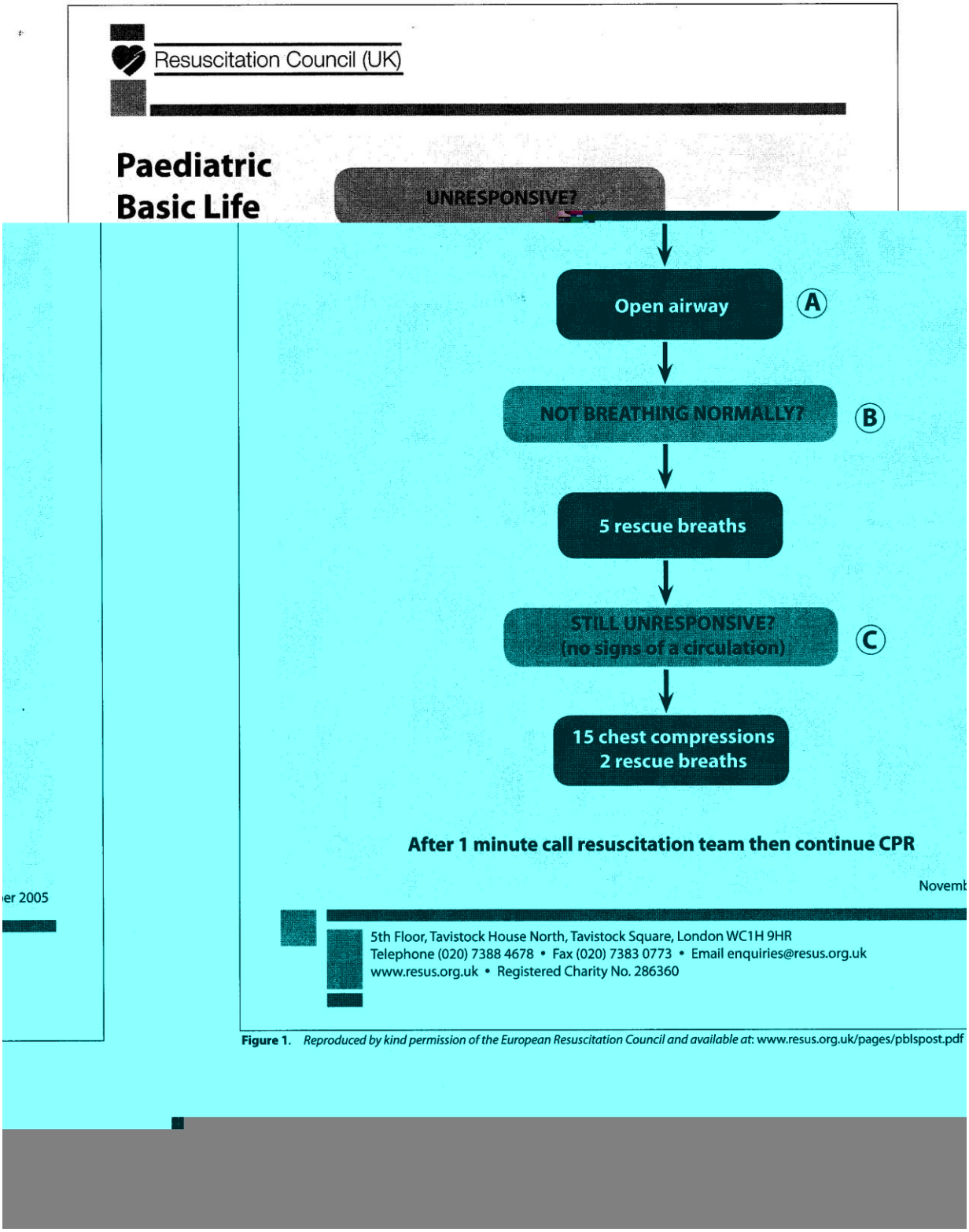

Figure 1. *Reproduced by kind permission of the European Resuscitation Council and available at*: www.resus.org.uk/pages/pblspost.pdf

Update in Anaesthesia

Paediatric life support

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Summary

Children usually suffer cardiac arrest secondary to hypoxia or ischaemia due to respiratory or circulatory failure.

Cardiac arrest is commonly reversed by simple interventions.

Early recognition of a child at risk of deterioration is essential.

Avoid interruptions in chest compressions.

There are some differences between resuscitation techniques for children and adults but there are also many similarities. There is no doubt that a child in cardiorespiratory arrest will be harmed more by doing nothing than by using adult resuscitation guidelines.

Children usually suffer from secondary cardiac arrest – the heart stops secondary to hypoxia or ischaemia caused by respiratory or circulatory failure. The main implication of this is that there is potential to recognise the primary cause early on and prevent its progression to full blown arrest. Respiratory or circulatory failure is initially compensated by the body's physiological mechanisms and the signs are fairly subtle.

Signs of compensated respiratory failure

- Tachypnoea or bradypnoea (e.g. in narcotic overdose)
- Increased work of breathing:
  - Anxious appearance
  - Use of accessory muscles of respiration
  - Noises – stridor, grunting or wheeze
  - Nasal flaring.

Signs of compensated circulatory failure

- Tachycardia
- Slow capillary refill
- Cool peripheries
- Thirst
- Lethargy.

In the compensated phase there are good opportunities to prevent deterioration by the administration of general treatment such as oxygen and fluid (in circulatory failure) and specific treatments such as salbutamol in asthma and antibiotics in pneumonia or sepsis. This compensated phase may progress to decompensation, however and, if immediate action is not then taken, to cardiorespiratory arrest.

Signs of decompensation

Diminishing level of consciousness is an important sign of decompensation and imminent arrest

In addition, for decompensating respiratory failure

- Sudden fall in respiratory rate
- Exhaustion
- Very quiet or silent chest.

Decompensating circulatory failure

- Hypotension
- Sudden fall in heart rate.

Fortunately, the actions required to reverse this process are usually simple and follow the familiar ABC format.

COMMENTARY - BASIC LIFE SUPPORT (Figure 1)

A – Airway

Opening a child's airway is similar to opening that of an adult – a head tilt and chin lift. The most important difference is to avoid pressing on the soft tissues underneath the jaw as this pushes the tongue backwards into the oropharynx and can worsen airway obstruction. Infants have a prominent occiput and simply require the head to be placed in a neutral position – overextension is not helpful. If this simple manoeuvre is ineffective a jaw thrust (performed in the same way to that in adults) usually works.

Sometimes an airway adjunct is required and the most useful is an oropharyngeal airway. The size is selected so that tip of the airway is level with the angle of the jaw when the flange is lined up with the lips. It can be inserted in the same way as for an adult airway (i.e. introduced upside down and then rotated 180 degrees into its final position) but care should be taken not to damage the hard palate.

Successful opening of the airway should be assessed by ***looking*** (for chest movement), ***listening*** (for air flow at the nose and mouth) and ***feeling*** (for expired air on your cheek held close to the child's nose and mouth).

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- If there is chest movement and you can hear and feel expired air then the airway is clear and oxygen (if available) should be given.
- If there is chest movement but no expired air then the airway is still obstructed and it should be repositioned.
- If there is no chest movement, positive pressure ventilation is required.

B – Breathing

Positive pressure ventilation (IPPV) may be given with expired air (mouth to mouth) or bag mask ventilation (BMV) with a self-inflating bag/mask system.

Mouth to mouth ventilation requires no equipment but is inefficient as it only delivers expired oxygen concentrations (about 17%). Nevertheless it can be lifesaving.

The most important points are to open the airway effectively (as above) and to achieve a good seal with your lips over the child's mouth (or nose and mouth in a small infant). You should deliver enough breath to make the child's chest rise as if they had taken a normal breath.

The same principles apply to BMV – the airway should be open and there should be a good seal, this time between the mask rim and the child's face. If this is difficult it may help to have 2 people – one to do a jaw thrust and to achieve a seal with the mask using both hands and the other to squeeze the reservoir bag. Again, the aim is to make the chest rise as if the child has taken a normal breath. Five rescue breaths should be delivered in this fashion and then an assessment of the circulation should be made.

C – Circulation

In diminished level of consciousness due to decompensated respiratory or circulatory failure, failure to respond to positive pressure ventilation by moving, coughing or resuming breathing is a sure sign of absence of an effective circulation and external chest compression (ECC) should be immediately commenced. Prolonged searching for a pulse (>10 seconds) is unnecessary may result in error or delay.

ECC is performed by compression of the chest to a depth of 1/3 to 1/2 of the A-P diameter, at a point just (1 finger's breadth) above the xiphisternum. Don't be afraid of pushing too hard. Compressions should be at a rate of 100 per minute and 2 breaths should be given after every 15 compressions. Compressions should be interrupted as little as possible so, if the trachea is intubated, they should be continuous with about 10 breaths delivered every minute. Generally, people ventilate too vigorously during resuscitation and this has been shown to impede venous return and reduce blood flow.

If a monitor or defibrillator is available it should be applied to check whether there is a shockable cardiac rhythm (ventricular fibrillation or ventricular tachycardia) or not. Adrenaline (10mcg.kg^{-1}) should be given every 3-5 minutes during ECC as it increases cerebral and myocardial perfusion.

COMMENTARY - ADVANCED LIFE SUPPORT (Figure 2)

1. Shockable rhythms - ventricular fibrillation (VF) or pulseless ventricular tachycardia (pVT)

If a shockable rhythm is present defibrillation with 4J.kg^{-1} should be performed immediately. Chest compression should be restarted immediately even if a rhythm change is seen on the monitor. This is important, as the heart will not be able to support the circulation for a minute or so, even if sinus rhythm resumes. If defibrillation is unsuccessful, CPR should be continued for a further 2 minutes and the defibrillation cycle repeated. If a third shock is necessary, epinephrine (adrenaline) should be given immediately before and an anti-arrhythmic should be used before a fourth shock. Amiodarone (5mg.kg^{-1}), where available, is preferred but lidocaine (1mg.kg^{-1}) is an acceptable alternative.

2. Non-shockable rhythm - asystole or pulseless electrical activity (PEA)

If the rhythm is not shockable, the emphasis is on good quality CPR with minimum interruption in ECC together with adrenaline administration every 3-5 minutes.

3. Reversible causes

In both shockable and non-shockable rhythms treatable causes should be sought and dealt with. Children rarely suffer from primary heart disease, so there is often a precipitating cause and resuscitation will not be successful if this is not removed. Treatable causes can be remembered by the 4Hs and the 4Ts mnemonic.

4**Hs**	4**Ts**
Hypoxia	**T**ension pneumothorax
Hypovolaemia	Cardiac **T**amponade
Hypo/hyperkalaemia	**T**oxicity
Hypothermia	**T**hromboembolism

4. Other points

Drugs

By far the most important treatment in resuscitation is good quality basic life support with continuous chest compression and effective, but not excessive, lung inflation. The next important action is to remove any reversible precipitating causes. Although drugs are commonly administered, there is little evidence to support routine administration of many of them. As the tracheal route of administration is largely ineffective, circulatory access had to be achieved rapidly; this is most effectively performed by intraosseous cannulation unless a peripheral vein can be accessed immediately.

Oxygen

This is the most important drug in paediatric resuscitation as many arrests in children are due to hypoxia. Although high concentrations are often used, effective airway opening and lung inflation are by far the most important steps in achieving adequate oxygenation.

Epinephrine (adrenaline)

Epinephrine been shown to increase the chances of restoring spontaneous circulation and should be administered in a dose of 10mcg.kg^{-1} every 3-5 minutes during resuscitation. Larger doses have not been shown to be effective and should not be used.

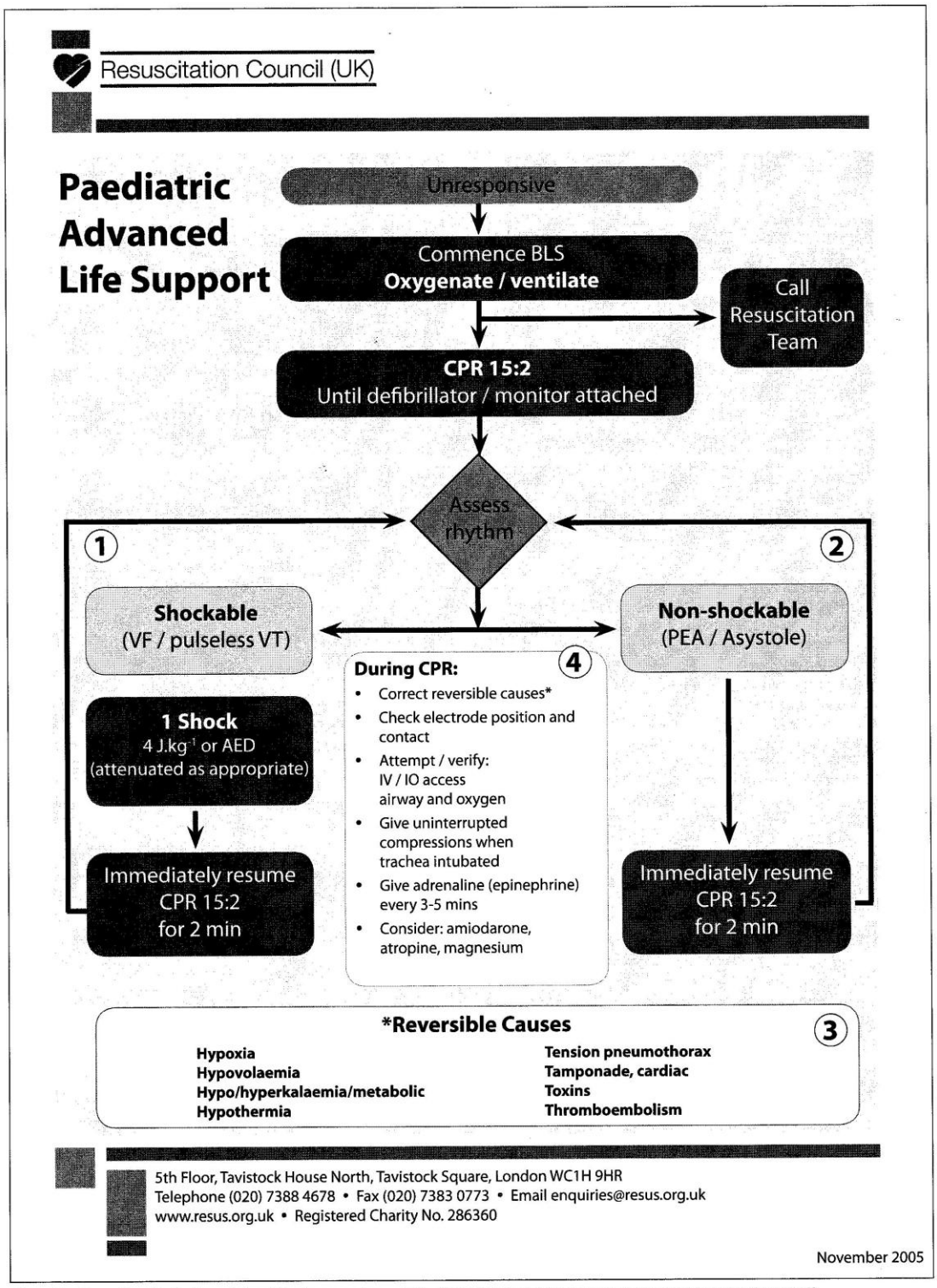

Figure 2. *Reproduced by kind permission of the European Resuscitation Council and available at*: www.resus.org.uk/pages/palspost.pdf

Sodium bicarbonate ($NaHCO_3$)

Bicarbonate neutralises acidosis by releasing carbon dioxide. During resuscitation, this cannot be cleared as there is insufficient pulmonary gas exchange, consequently, it has not been shown to be effective and should not be used routinely. $NaHCO_3$ may be indicated in specific circumstances such as hyperkalaemia or in drug toxicity (e.g. tricyclic antidepressants).

Calcium has not been shown to be effective in resuscitation and it may even be harmful, consequently it should not be used routinely. It may however, be effective in hyperkalaemia, hypocalcaemia and calcium receptor blocker overdose.

Amiodarone ($5mg.kg^{-1}$) has been shown to be the most effective anti-arrhythmic in resistant VF or pVT but lidocaine is an acceptable alternative. Amiodarone is incompatible with saline and should be diluted in 5% glucose.

OUTCOMES

Although it is often thought that children have extremely poor outcome after cardiac arrest, this is not entirely true. Large North American databases have shown that children that have a full cardiac arrest in a hospital have a 27% chance of survival to discharge and that 75% of these will have a good neurological outcome. Out of hospital resuscitation has poorer survival rates but these figures are significantly biased by infants with sudden infant death syndrome (SIDS). Older children and adolescents have survival rates of about 9%.

Children with respiratory arrest only who haven't progressed to full cardiac arrest have an excellent chance of survival with about 70% alive after 1 year.

SUMMARY

The most important intervention in paediatric resuscitation is early recognition of the child at risk of deterioration and the instigation of treatment intended to prevent progression to cardio-respiratory arrest.

Once cardio-respiratory arrest has occurred, early and good quality CPR is the most important step for a favourable outcome. Interruptions in chest compression should be avoided and compressions can be continuous once the trachea is intubated. Reversible causes should be actively sought and treated as many paediatric arrests are secondary to another event.