Khaddit Beirut

Breaking the Cycle(s) of Dependence?

A Proposal for A Community-Led Healthcare Model

Issue 7

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There are at least three intertwined cycles of dependence in healthcare in Lebanon. First, the individual and community depend on the knowledge and availability of healthcare professionals. Second, service depends on class, national, political, and sectarian affiliation, which reinforce poverty, clientelism, and sectarianism. In fact, clientelism is reflected in the increased access to services based on the level of involvement with the political party or sect. Third, poor accountability and lack of long-term strategy affect provision of needed healthcare service. These three intertwined cycles were noticeably clear in the wake of the Beirut explosion, where the number and quality of healthcare professionals were inadequate, political financing was widespread, and access to accountable services was lacking.

We ask whether this three-fold cycle of dependence can be broken and replaced with a community-led or community-centric healthcare model? In our proposed model, our aim is to demonstrate how to offer services for all equitably, for people to take ownership over their own wellbeing and the wellbeing of those around them and for the healthcare system to be accountable.

This proposal is based on our experience in the Community Health team, where we are working hand-in-hand with local communities to co-create a new model of community healthcare in Lebanon guided by the WHO principle of "ensuring the highest attainable standard of health as a fundamental right of every human being." Our suggested community-led health care system, specifically primary health care, is based on the principles of universality (regardless of sectarian, political, or national affiliation), affordability, comprehensiveness, and accountability.

Here is how we have started, how we are proceeding and how we are using the process to collect lessons for our model.

Building the Karantina community healthcare model

The impact of the explosion on several communities within a radius of 10 km from the blast was horrendous; however, some communities got more attention than others. Karantina, despite being so close to the blast, was among the less targeted communities, in terms of assistance (cash and food) and healthcare services specifically. The few non-governmental organizations offering free health care services in this community were almost ready to leave by the end of September, leaving a community distraught by the explosion and suffering from severe economic deprivation. These two factors led us to consider a model for sustainable healthcare support to this severely underprivileged population.

We first conducted a comprehensive needs assessment of the community. We interviewed stakeholders and members of the community about the health status of the residents. We heard some horrific stories about elderly women and men living on the bare minimum with no access to essential basic needs such as bathing and services such as medications. We found that many adults with chronic diseases had not visited healthcare providers for years, as far as 10 years. Children, who were in the area during the blast, were suffering from severe anxiety, some would startle at the slam of a door.

Thus, we identified the following priority areas: healthcare affordability and accessibility, quality of chronic disease management and child's mental health. Our first focus was to find an accessible and affordable primary health care center. Our search led us to the Karantina Primary Healthcare Centre (PHC). In coordination with the Karantina Hospital administration, which houses the PHC, we are co-designing a model for community-led healthcare services to ensure that everyone can receive the healthcare and support they need, and when they need it. At the core of this model is providing comprehensive, evidence-based, and affordable services. To support the current services at Karantina Primary Health Care Centre, an official agreement between the Hariri School of Nursing (HSON) and Karantina Hospital was established. Currently, nursing students are engaged in service learning in Karantina PHC. As an example of the service-learning initiatives, we engaged the community in health promotion activities to create health awareness. Community engagement will be advanced to include participation of people in assessment, evaluation, and decision-making.

Engaging funders and diaspora

In addition to getting the Primary Healthcare Department of the Ministry of Public Health on board early on because we believe that state institutions are needed for policy and scaling up any community initiative, we also advocated with international donors to put healthcare in Karantina as a priority for any recovery and relief efforts. Further, we engaged the diaspora which has a large number of health professionals, activists, and experts who wanted to help in the aftermath of the explosion. We held several meetings to push for a community-model rather than piecemeal efforts. Sending medicine without understanding local needs can lead to waste for example. We pushed for the need's assessment and for community's voice in identifying priorities. We also fundraised on a small scale through our campaign of « صُحْتن بالدّني » or "sohoton bel dineh" (their health is a priority); beyond the money collected, this allowed us to spread the word and enter people's homes with a message about Karantina and the need for a systemic community-led approach.

Decentralizing the response to the COVID 19 explosion

Our collective movement further responded to the recent outbreak of the pandemic by developing the Municipalities COVID-19 Response Program (MCRP) as a community-led support system to alleviate the pressure on COVID-19 patients, their families, and the regional hospitals. Khaddit Beirut designed this program in partnership with Lebanon Needs and with the support of local NGOs to complement our work with the needed medical equipment and the program implementation. The initiative leveraged the medical expertise of the Family Medicine Department, the Continuing Medical Education Office, Infectious Diseases doctors at AUBMC, and the School of Nursing at AUB, as well as the International Lebanese Medical Association (ILMA), to develop a COVID-19 triage guidebook. The guidebook translated to educational sessions targeting municipality medical task force teams to extend their capabilities to respond to COVID-19 patients' medical needs and direct them to hospitals as needed. As news of our initiative spread, we are being contacted by more municipalities expressing readiness to implement a community-led response to COVID 19. Even now as the numbers begin to go down, this community approach to raising awareness and building capacity will remain needed in the long-term. The program is being adopted in multiple municipalities and has been developed systematically to scale nationally while assuring service quality monitoring through a scoring system and promoting municipality independence.

Using information and technology for monitoring and evaluation

Documentation is an important part of the process of reporting feedback and ensuring accountability. In line of this, the Data Analytics team in Khaddit Beirut works to provide the best digital solutions to support the implementation of all our initiatives. For the health initiative, the Data Analytics team has been managing the registration and follow up process for the various projects, such as « صُحْتن بالدّني ». It also manages our overall donations strategy through the website that it developed and keeps up to date. Most recently, the Data Analytics team with a group of computer science students have been implementing and managing a solution for the MCRP. The team prepared a patient tracking system that keeps track of patients from the time they get triaged, through the follow up phases, and to the time they either recover or get transferred to hospital. The solution also provides a dashboard at different levels to help the municipalities, the health team, and all partners stay up to date with respect to patients that were helped, equipment usage and needs, and team's performance. The solution also provides a dashboard at different levels to help the municipalities, the health team, and all partners stay up to date with respect to patients that were helped, equipment usage and needs, and team's performance.

A New Cycle?

Our vision is to break the cycle of dependence by improving the agency of the community, by improving access to services, and improving accountability by setting up a systematic approach to healthcare service delivery. Is it possible to break the intertwined cycles of dependence? How best to partner with government while ensuring community autonomy and the voice of the marginalized? We are still learning, but we know that we cannot go back to the old model. We are trying to set the building blocks for the new model. We believe this is just the beginning of breaking this cycle of poor quality of community health services in Lebanon. Our positions include a community that is engaged, people that take agency of their own health and decide on the types of services they need. What we are trying to do is to make essential healthcare universal to people regardless of nationality, socio-economic status, religion or sect, and political affiliation. Through the systematic approach adopted in the pilot model, we are aiming to provide services for chronic disease patients that can be scalable nation-wide. We are setting the standards for small scale interventions. Ultimately, we will build on the successes and address the challenges to scale those initiatives nationwide. We are determined that all our endeavors are guided by the principles of universality (apolitical),

affordability, comprehensiveness, and quality. We acknowledge that we will be facing many challenges along the way, but we are persevering until we break the 3 cycles.