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A Localized Home-based Health Care Delivery Model for Refugees in Jordan

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Abstract

Inter-professional teams delivering home-based care hold promise as an effective model for vulnerable populations, but examples of good practice are limited. This case study presents the initial evaluation of a contextualized application of home-based medical care initiated from the faith community in Jordan toward Syrian and Iraqi refugees with constrained access to resources.

Reflexive responses to human need by local churches became the basis for home-based medical outreach. Heavily dependent on volunteers, these church-based teams were selected and trained to meet specific needs, inter-professional partnerships were created through networking, and electronic medical records were deployed to facilitate communication and follow-up.

The program's standards of operation are delineated, and a program description is included that clarifies matters regarding volunteer selection, training, faith inspiration, communication, continuity, inter-professional partnerships, and addresses obstacles to care. Based on subjective collective observations of team members, the advantages of the model in practice are reported along with lessons learned. These include dignity promotion, contextualization of health in the home, relationship development, inter-faith communication, inter-professional partnerships, and networking with local health professionals of other faiths and NGOs. Limitations of the model and potential applications in other contexts conclude the case study.

Keywords: refugees, home based, primary health care, Jordan, churches

Introduction

Following the outbreak of the Syrian war in 2011, hundreds of thousands of refugees began seeking safety in our country of Jordan. At times, more than 3,000 individuals were crossing the border every day. After getting screened and receiving background checks, many were allowed to seek refuge in cities and towns across the country as "urban refugees" living in basic and often substandard rented accommodations. As of the writing of this article, there are officially 740,150 refugees in Jordan, 657,628 Syrian and 66,262 Iraqi.[1] However, by including unregistered refugees, the government estimates a total of about 1.3 million.[2] Jordan is a small country of around 10 million, which means that it has the second largest refugee

population in the world compared to the overall population (20%). Eighty percent of refugees live below the poverty line, 51% are children, and 4% are elderly. Eighty percent of refugees live in urban areas rather than organized camps. Beside significant natural resource limitations and economic constraints, access to services, especially treatment for non-communicable diseases (NCDs), is complicated and under-resourced, despite heroic efforts by international aid organizations that tend to prioritize communicable diseases.[3] Significant mental health conditions were reported in refugee children in low and middle income receiving countries.[4] Malnutrition was a significant problem among refugees, and anemia was high non-pregnant women and children in the Za'atri refugee camp.[5] Half of Syrian refugee households in Jordan reported a family member with an NCD (hypertension, arthritis, diabetes, chronic respiratory disease), with a significant minority not receiving care, citing cost as a barrier.[6]

Despite high levels of care-seeking, cost of health services is a large barrier to access for health equity, and care for NCDs at the primary care, preventative, and self-care levels have been recommended.[7,8] The primary care system of receiving countries can serve as an integral portal to the larger society through Screen, Manage, Assist, Refer, Team (SMART) strategies and collaboration.[9]

Home-based primary care has been utilized for vulnerable refugee populations in the United States, and linguistic communication, cultural safety, and utilization of an inter-professional team has been associated with positive health outcomes.[10] The World Health Organization notes:

> Many people prefer home care to any other option. Home is a place of emotional and physical associations, memories and comfort... Home care promotes healing. Home care allows maximum freedom for the individual, in contrast to institutions, which are regulated environments. Home care is personalized — tailored to the specific needs of each individual.[11]

Inter-professional teams delivering home-based care to refugees show promise to bridge the health care gap, but more data are needed on effective models.[12] Urban refugees have faced many unique logistic challenges in seeking aid, which have revealed needs and opportunities for ministry by faith communities. This case study presents a home-based health care delivery model derived from a contextualized local response from the faith community in Jordan.

A Localized Aid Response

Jordan has a small but ancient Christian minority and many local churches have responded by reaching out to urban refugee families and distributing to them basic bedding, cooking, food, hygiene, medical, and school necessities. These have been funded by foreign and local donations, and the work was carried out by a large number of volunteers (local and foreign). Some faith communities have focused on centralized distributions, while a few churches have focused on home visits. Instead of having them go to the churches, the church went to them. Even though virtually all Syrian refugees are Muslims, the Christian volunteers have been welcomed and have, in many cases, built relationships that are now several years old. The inter-faith understanding of Jesus as a healing prophet and the cultural acceptability of praying in His name was an important way to connect with people.

Frequently on these visits, volunteers encountered medical needs that were not being addressed due to a variety of reasons. As medical professionals, and a part of the Christian church where we live, we were among those volunteers. We saw an obvious and great need for health care access and felt compelled to help with the medical needs in any way we could. Starting small, visiting as many families as we could, we offered free medical exams, consults, and treatments to the refugees in their homes. We were trying to reach those families who were not able to obtain basic, affordable, humane,

and effective medical attention. Throughout this crisis, governmental and non-governmental bodies such as Medair, Caritas, Operation Mercy, and Oun were offering medical care to refugees, but were unable to keep up with the demand, leaving a significant gap in the number who could receive adequate care. These NGOs only offered centralized care. Our focus has been on cases that were untreated or families not adequately served by other resources (Figure 1).

Figure 1. Care delivery in the context of the refugees' dwellings

Home-based Medical Outreach Standards

The idea of home-based medical outreach (HBMO) was born naturally as an extension to the home visits church members in several cities were already making, but it required formation through the following guiding principles:

Ethical standards

Even though the care seemed informal, volunteers were committed in writing to a high standard of Christian ethics and confidentiality, and medical information was shared only with the patient's consent. We respected the right of a patient to refuse care or seek a second opinion.

Informed consent

We never took photos without the express permission of the patient and, generally, only did so to take a friendly snapshot with the patient portrayed at their best for honorable purposes.

Impartiality

Although an openly Christian ministry, we offered our services to anyone regardless of race, religion, gender, nationality, refugee status, or political persuasion.

Cooperation

Coordination with churches and other groups working with urban refugees has been critical to reduce duplication of services and provide the most holistic care to patients.

Competency

Committed to providing a high level of quality and competent care, we did not hesitate to make referrals when a case was outside our scope of practice.

Qualitative outcomes

The total number of patients served through HBMO was often less than centralized models of medical outreach. We believed that focusing on numbers of patients served was often counter-productive to providing impactful medical, social, and spiritual care. Donors like to see numbers,

however, so we endeavored to define success in terms that demonstrated our commitment to quality holistic care and fruitful relationships.

Work balance

Being up close and personal with the living conditions of refugees could leave volunteers prone to discouragement and compassion fatigue, but we practiced healthy self-care in the community. We paid attention to having pastors and counselors on the team for the benefit of the volunteers as well as patients. Most of our visits took place for one or two hours in the evenings, and volunteers could give up one or two evenings a week without disrupting their lives or being a burden to their families. This healthy pacing was critical to long-term relationships as well as the sustainability of the model.

Education emphasis

Teaching on nutrition, health-promoting behaviors, affordable and available medications, health systems, and the importance of care adherence was a way to empower the refugee population served toward better health outcomes.

Sustainability

Short-term volunteers have provided a means of building a donor base but developing long-term volunteers from the community was necessary for success. Long-term volunteers who could drive and navigate the city in order to visit refugees or take patients to referral appointments were especially critical, and our team struggled the most to build this capacity. The times when our team had been reduced to only our doctors and short-term volunteers were frustrating, and our capacity was greatly reduced.

Trust

Our experience has been that the deepest spiritual impact has come after the medical case is closed but the social relationship and visits had continued. This was ideal work for non-medical volunteers who contributed towards trust-building with the refugees and medical staff.

Home-based Medical Outreach Methods

Volunteer selection and training

Home-based medical outreach was heavily dependent on volunteers. Our administrative structure consisted of two doctors, one being a medical director and field operator, as well as counselors with pastoral training who monitored accountability, finances, and fundraising. Volunteers were assigned tasks according to their skills and availability. The tasks involved interaction with refugee families through regular visits and medical follow up. Volunteers did not need to have a medical background but could be trained to perform a simple medical assessment. Nurses and nurse practitioners were involved, and female volunteers participated when caring for female patients. Ideally, each volunteer was assigned a few families with whom they could build a relationship through regular visits. Volunteers needed to have Christ-like bedside manners, maintain confidentiality, have humility, and be able to follow through with medical follow-up whenever indicated. They were expected to be able to offer spiritual care and assist the medical personnel with tasks such as medication delivery, checking blood pressure, and transport to specialists or diagnostic labs.

Faith inspiration

The biblical pattern of caring for the foreigner and the poor is a strong motivator for volunteer action (Ex 23:9; Lev 19:34; Num 35; Heb 13:2-3). Jesus' model of care was pursued in each outreach. This consisted of entering their chaos, asking questions, listening intently to their story, holding their story, affirming their humanity, identifying and utilizing existing resources, meeting felt needs, pointing out other needs, networking in community, and holding out hope for a better future. Jesus' words in Luke 10: 5 & 9 are inspiring and instructive: "When you enter a house, first say, 'Peace to this house.'... Heal the sick who are there and tell them, 'The kingdom of God has come near to you.'"

Record-keeping, consent, and communication

When families or individual subjects are identified, their medical and personal information was logged into a password-protected online database built specifically for field work. This allowed for review and update of patient information during visits and medical follow ups and inter-provider communication. Consent followed the social norms, since the social visit component of the encounter dominated. The fact that the refugees accepted team members into their homes was considered implied consent. Integrated care at the community level using home-based care models with information technology support has been shown to be effective for care delivery.[13] Documentation is extremely important in any medical work or ministry, both for effective care coordination and effective reporting to donors. Confidential patient information was only accessible to healthcare providers involved in the medical outreach.

Continuity of care

While we often responded to acute cases, many of our patients suffered from chronic conditions (NCDs). Caring for chronic cases allowed frequent visits to build relationships and foster a continuity of care. Most new patients came via referrals from churches or existing patients. Initial assessment and triage was performed through a phone call or a quick home visit. The urgency of care needs was determined based on this assessment. We were not always able to respond to acute medical issues in the home; so in such cases, the patient was instructed to visit the nearest acute care facility. The team stepped in to help cover the cost. Often times, we transported or met the patient at the appropriate facility and stayed with them when feasible until treatment was administered, following Jesus' instructions in the parable of the good Samaritan in Luke 10:30-37. Medical and holistic care continued as long as necessary. Even when, at times, spiritual care was not welcomed, medical care was offered as long as the patient had no reliable sources to continue to obtain it. Medical cases were closed, and follow-up was discontinued when appropriate. The social relationship could remain active at the discretion of the volunteers and the willingness of the refugees (Prov 25:17).

Inter-professional partnerships

HBMO has thrived on fruitful partnerships with other healthcare providers and laboratories, many of whom offered their services free of charge or at a reduced fee. These valuable partnerships were created through personal connections and networking. This aspect of HBMO has been surprisingly positive. The decision to focus on building capacity for home visits rather than a fully capable clinic forced us to seek out local specialists and diagnostic labs. Working with these providers gave us continual opportunity to explain who we were, how and why our church was aiding refugees. Our need of the services of local providers and allied health professionals has given them opportunities to serve and give. By bringing patients to them, they could participate in our work without the time commitment or the burden of leaving their practices or offices. We were often making these types of referrals to dentists, ophthalmologists, cardiologists, surgeons, and imaging centers. We established a relationship with a local laboratory that allowed us to collect blood and urine samples during home visits and deliver to the lab for testing. We were sensitive not to overload any one community provider and diverted patients to others in order to not wear out our welcome. When we made referrals to another provider, our volunteers often accompanied the patient to help with transportation and made sure they received any medicines or medical devices that had been prescribed to them. Connections with the work of other NGOs partially helped fill gaps for the non-medical needs of those refugees.

Addressing obstacles to care

HBMO also addressed other limitations urban refugees faced. Going to the patients relieved them of the burden of paying for transportation. Even small amounts of money needed to travel within our

cities were too much for many families. Most of the aid available to refugees was in the capital city demanding even more costly travel. Another significant obstacle was childcare; the prospect of waiting for hours to be seen at a clinic while caring for small children could easily deter families from having minor conditions treated. Many refugee families were proud people from middle-class backgrounds, so they often seemed ashamed to publicly seek free healthcare. These obstacles to care meant that preventative or early treatment was foregone, raising the likelihood of subsequent major issues.

Observed Advantages of Home-based Medical Outreach

Through a system of face-to-face feedback and follow-up phone calls from local pastors, the team observed that this approach had many advantages.

- Personal medical history and case assessment were obtained in a relaxed environment within the context of a social visit.
- Direct assessment of the social and economic situation of the family.
- Contextualized observation of the interaction and behavior of children with their care-givers.
- Time for clinical instruction for adherence by patients with treatment plans.
- Face-to-face communication and trust-building, so that families felt safe to share their stories and struggles with us.
- An excellent environment to share the love of Christ and provide spiritual and emotional care following biblical patterns.
- Improved access to other relatives and neighbors with health issues.
- Socially and legally acceptable model for outreach, especially for those refugees whose access to healthcare was significantly challenged.

Lessons Learned

We found that HBMO was a medically effective and culturally appropriate health care delivery model. In the Middle Eastern culture, home visits are regarded as a highly-esteemed way to build relationships and connections. Visiting your neighbors is much more common than in the West. It conveys warmth, acceptance, respect, and friendship. Around the world, Arab culture is renowned for hospitality, and we have found it important to give refugee families opportunities to practice hospitality on us. Even the poorest of families can manage a cup of tea or coffee and some crackers. Our volunteers were often invited to share a meal in the patient's home. Even though refugees were under tremendous stress because of their displacement and conflict-related trauma, opportunities to practice hospitality offered them honor and a sense of normalcy. In this setting, the exchange of medical care from us and hospitality from them contributed towards equalizing the power dynamic (Figure 2). This was important for maintaining and restoring dignity and also for opening the doors for effective spiritual care.

Figure 2. Objective medical assessments over tea.

Coordination with churches and other groups working with urban refugees was critical to reduce duplication of services and provide the most holistic care to patients. Focusing on the number of patients

served was often counterproductive to providing impactful medical, social, and spiritual care. We defined success to donors in terms that demonstrated our commitment to quality holistic care. Healthy pacing of volunteer hours and pastoral care to workers was critical to long-term relationships as well as the sustainability of the model. Short-term, volunteer, church-based clinics were helpful motivators for connection with refugee populations, but long-term volunteers who could navigate the cities were more difficult to retain.

Limitations

Observations from this study were subjective, but consistent. Outcomes measured were based on subjective feedback to the team members and was not quantified through survey forms or structured interviews of recipients or partners. This could be an approach for further research into the outcomes of this model applied. The program itself had some limitations in the numbers of families reached, long-term volunteer retention, and primary care focus (unable to offer specialized care). We could not offer chronic care for longer than several months, often due to the constant movement of refugees which undermined follow-up. There was an inability to address every need.

Conclusions

Preliminary observations of home-based medical outreaches designed to fill a significant gap in health services to displaced urban populations in Jordan showed some advantages of this model, but several challenges. Further studies designed to measure its health-related outcomes are warranted. These would help to further develop program design, to scale for implementation in other cities, and to apply to refugee contexts in other host countries.

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