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AROUND THE WORLD

The El-Tal El-Kebir Story: An example of social accountability from Egypt

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Abstract

Background: In 1985, the Faculty of Medicine at Suez Canal University responded to a request from the people of El-Tal El-Kebir, a district in Ismailia Governorate, Egypt, to assist them in addressing their poor health statistics. After an initial visit, the team realized that any long-term solution in dealing with and improving their community health problems needed a true inter-sectoral collaborative approach, with the involvement of other sectors such as agriculture, veterinary medicine, and education. The team also realized that establishing a true partnership with the community as well as the local governmental agencies was indispensible in order to maintain any long-term effects.

Aims: In this article, we will describe how the medical school mobilized other sectors to improve the community health.

Methods: The methodology adopted during this example of providing community outreach services was concordant with the principles of social accountability, which was later described by the World Health Organization.

Results: Our multi-sectoral team has established several projects for enhancing community participation in solving their own health problems.

Conclusion: Medical schools can lead a community development project in collaboration with the community.

Introduction

The Faculty of Medicine at Suez Canal University (FOM, SCU) was established in 1978 as the first community-based medical school in Egypt. A few years later, in 1985, the School received a letter from the people of El-Tal El-Kebir District, one of the rural communities surrounding the Faculty, asking for help in their healthcare. As a community, they felt that living in such a remote area, away from the any Governmental services was adversely affecting their access to healthcare and any consequent health improvement.

Aiming at making a difference in the people's health status in the surrounding community, the School responded positively to their request and opened a strong partnership, in the hope that a cooperative action would begin to address some of these health needs. Consequently, a story of social accountability of a medical school emerged well before this concept was later described in the healthcare literature (WHO 1995).

In this initial article, we will present this story, describe the difficulties, achievements, and lessons learned. A subsequent article will describe the short- and long-term effects this initiative has had on the El-Tal El-Kebir community.

Practice points

- It is possible for a medical school to respond to a request for assistance from its immediate community, in order to address the community's poor health and social care.
- Health and social care should be an important component of any community-based educational activity.
- It is possible for a medical school to lead an altruistic multi-professional academic team and establish a long-term collaboration with the local residents in order to achieve real health improvement.
- Inter-sectoral collaboration can involve multiple partners and develop several diverse programmes that cover both health and social care.

How the community relationship began?

After the inauguration of FOM/SCU as the first community-based medical school in Egypt, the School acquired a reputation in the surrounding region as being responsive to the community needs. The students as part of their curricular activities were conducting projects to survey, diagnose, and deal with priority health problems in the community around the school. As an added extra to the curricular activities, the results of these field projects were being further used to feed back into the on-going development of the curriculum and adding to the research plans of the academic departments.

El-Tal El-Kebir district is a rural under-developed and underserved area, which is located about 40 Km to the west of the Faculty. The residents there, having heard of the services provided by the School to other areas, thought that the School may be able to provide, as part of its outreach projects, humanitarian, scientific and innovative solutions to their health problems. They subsequently sent a written request to the

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Dean of the Faculty asking for help. After lengthy discussions in the School council, a delegate was sent to the district and discussed the problems with the residents.

What was not envisioned then was how the School was already addressing or about to address the issue of the Social Accountability of a Medical School before the topic had been fully and extensively described in the medical literature (WHO 1995; Boelen & Woollard 2009: Boelen & Woollard 2011; Gibbs 2011); the definition of social accountability being: "the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, or nation they have a mandate to serve" (WHO 1995). The national authorities of higher education were witnessing our progress in this new experience. Now, community outreach services are one of the national academic standards of accrediting medical schools in Egypt.

Working with the community?

Academics' entering a community is not a simple procedure and can in no way be taken for granted. Previously and so many times before, experience had suggested that academic researchers had directly intervened, often in unethical ways, to obtain community clinical data or even human tissue specimens for their researches without seeking any approval or allowing any advantage to be gained by the involved community. Even the results of the investigations were neither delivered to such people as promised, nor were there any follow-on activities from which the community could gain, either in health or social benefits. This attitude from academia had left a scar on the memory of the community population which, in this project, initially led to a strong skepticism of any outside interference. The School was advised to approach community informal leaders who usually volunteer to help others and take initiatives to solve community problems. We learned later that a link to a combination of formal and informal community leaders was to be more effective. Whereas the community population usually put their trust in their informal leaders, the key to opening doors to effective policy lay with the formal leaders who are top executives in the governmental local authorities.

Hence the School initially contacted the informal leaders, meeting them either in community premises or one of their houses and then, with them accompanying the faculty, the wider community was contacted, by knocking on individual doors, on a house to house basis. The people felt more at ease when they received strangers in their houses accompanied by their respected leaders – a cultural trait which we subsequently found was important to follow. To break the ice, faculty followed simple traditions, like memorizing names, enquiring about the family members, and attending social events. The purpose of these simple measures was to gain the community's confidence and earn their trust; a mutual trust that was desperately needed to start any effective cooperation leading towards activities in improving healthcare. Faculty did not consider this period to be a waste of time, since it was considered as the social part of the "community diagnosis" stage in health improvement.

The next step, few weeks later, was to organize much larger and more purposeful meetings with the community representatives to address the community health needs and priority health problems. As an exercise, the School realized that this was ultimately going to be a one way communication exercise – allowing the community to express their feelings, concerns, demands, needs, and values; even at times of their anger. As an academic health team, surprise resulted from the richness of the information gained by this form of communication. Most of these complaints were multi-sectoral, involving many aspects of the community and seemingly out of any ability to be dealt with alone. As a Faculty, we were pleased to find that even those from the most simplistic and basic of backgrounds were able to communicate their problems very fluently, even to the stage of prioritizing them and highlighting the needs and providing solutions in addressing them. A summary of the community health needs and concerns are to be found in Table 1 (initially described by Talaat et al. 1995).

It was soon obvious that the residents of El-Tal El-Kebir were not being exposed to any of the four values which should characterize the type of health care, ideally provided to all people: quality, equity, relevance, and effectiveness. (Boelen & Heck 1995).

Seeking the help of a medical school implies an assumption that medical schools should have a role in health care delivery. This assumption conforms to the systemic principles of social accountability suggested later by Boelen and Woollard (2009), which state that medical schools should understand the complexity of the health system and formulate an effective role through creating partnerships with other stakeholders in the complex matrix of health care.

We had relied on the community and other stakeholders such as local authorities to identify the priority health needs and actions. This was in accordance with the statement issued by the WHO which mandated that the priority health concerns are to be identified jointly by governments, healthcare organizations, health professionals, and the public. (WHO 1995, 1997).

Facing the challenges

The first and biggest challenge was how the Medical School could achieve an effective inter-sectoral collaboration rather than working through a multi-sectoral, poorly communicated, parallel approach. It was quite evident from the very first discussions that the Medical School alone would not be able to solve the multi-sectoral problems that included, besides health, educational, economical, agricultural, and even veterinary medicine issues. Subsequently, Faculty returned to the same district with an extended team from the Suez Canal University that included physicians, veterinarians, agriculture experts, educationalists, and economists and to begin the journey of partnership with that simple rural community.

As the initiative moved forward in dealing with the different and complex issues affecting the community's health, other challenges arose, the major one being how to make each individual activity integrated and complementary. Several design projects tried to address this matter, most of which

are described further in this article. Decisions about which programs to implement were based on the prioritization of health problems and were taken collaboratively by representatives of the community, university, and local authorities. At the beginning, when partners agree on a certain program, they nominate a responsible person from the community. Later, when we established the NGO, a general director was appointed and a group of people from different sectors were assigned to help him.

Several years later, WHO emphasized the concept of intersectoral action for health (IAH) as "a recognized relationship between part or parts of the health sector with parts of another sector which has been formed to take action on an issue to achieve health outcomes (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone" (WHO 1997), describing almost exactly what the Faculty had set out to achieve.

The next challenge was how to convert the goodwill of the parties into a sustainable partnership that can make long-term achievements. The whole story could have been limited to achievement of one or more short-term outcomes. That would partially satisfy both parties, but would not have a long-term impact on people's health, which was the School and University's real aim.

The School made its relationship with the community legal and sustainable by obtaining the authorities' permission to establish a non-governmental organization (NGO) that brings together community representatives, university representatives (from different specialties), and a few governmental officials who are residents in this district; giving the community representatives the lead not just to run the meetings but also to be pro-active in shaping policy, and in planning and control activities, all of which has given sustainability to the relationship.

Other challenges arose throughout the initiative such as maintaining the enthusiasm of the people despite incidental set-backs, obtaining necessary funds to support activities, and defining clear roles for each partner. The best energizer for the community partners' batteries was the achievements that positively changed a lot of things in the community daily life and made them eagerly look for more opportunities through their active participation, effectively shaping their own future health.

A major challenge that the School consistently faced was related to the retention of medical graduates in areas where they are most needed, practicing much needed healthcare to the immediate community. Through a partnership with the Eastern Mediterranean Regional Office of the World Health Organization, the Faculty was able to investigate the skills of its graduates compared to other medical graduates from around the region. Graduates from the Suez Canal Medical School were found to excel in their communication skills, with the community, their families, and individual patients. The graduates also excelled in understanding community health needs, and in prioritizing and managing health problems. Their ability for critical appraisal was also considered rather unique among graduates from other institutions. On the other hand, their basic sciences core of knowledge when isolated from its clinical context was relatively deficient (Maklady & Talaat 1998).

Achievements

Increasing community awareness

As an intrinsic quality and rather than reinvent new models, the School used validated, tried, and tested models derived from WHO and other international organizations in order to raise community awareness:

- Training of community health workers (CHW) under financial constrains (Li et al. 1983).
- Involving children during their summer vacations in "Child-to-Child Programs". Child-to-Child is a rights-based approach to children's participation in health promotion and development. Through participating in Child-to-Child activities, the personal, physical, social, emotional, moral, and intellectual development of children is enhanced. The Child-to-Child approach is an educational process that links children's learning with taking action to promote the health, well-being and development of themselves, their families and their communities. Child-to-Child ultimately contributes a new, effective, revolutionary idea to educate the people and the community to lead a better, healthier life through children. (Webb 1988)
- Involving women in small industries to increase the income of their families to be able to spend more on their health promotion.

In addition, Suez Canal University also built an outreach centre, to facilitate and support the Community Health Workers (CHWs), under the supervision of the Family Medicine Department at the University.

Community empowerment

Community empowerment refers to the process of enabling communities to increase control over their lives (Reid 2000). Community empowerment, therefore, is more than the involvement, participation, or engagement of communities. It implies community ownership and action that explicitly aims at social and political change (WHO 2010).

To help develop and maintain community empowerment in El-Tal El-Kebir, the following was carried out:

- Functional literacy programs:

With the help of the Faculty of Education, Suez Canal University, functional literacy programmes were developed in collaboration with the Faculty of Medicine, to practice health education using simple literal and understandable terminology.

- As faculty believed that "information is power and power is information", an "Information Center" was established, through donated money and a piece of land given over by the community, where all information, gathered by the CHWs, was filed, stored and later accessible for analysis.

- Enhancing the communication skills of the informal leaders and the CHWs through specific programmes came up with surprising effects. The community gained a large water pump from Malaysia after contacting the American University in Cairo in a self-reliance initiative to solve their problem of the lack of safe drinking water. Previously, every family was installing private small water pumps to bring often contaminated water to their homes. The public pump was installed in a central place as a symbol of a tangible outcome of the collaboration of community participation, and a socially accountable university.
- In cooperation with the University School of Veterinary Medicine, a programme was developed to eradicate endemic parasitic skin diseases. These dermatological problems had been a major physical and psychological problem for the residents for decades and no attempt had previously been made to help in their eradication. Some 20 years later, endemic parasitic diseases were not identified as a priority health need by El-Tal El-Kebir community (Table 1).

Community partnership

A "living example" of this was the establishment of the "El-Tal El-Kebir Society for Health Promotion and Comprehensive Development".

Through this society the local people of El-Tal El-Kebir, with help from the University and using their own ability in fund raising, established three very large, inter-related projects:

(1) House-to-house refuse collection and mass-dumping in a distant area (land donated by a local resident).
(2) Recycling of the refuse and extraction of organic material.
(3) Using the organic material of recycling to manufacture and sell fertilizer of high quality to local farmers.

Students' involvement

Medical education – based predominantly in hospital environments with increasing specialization and a rapid turnover of patients – is being re-examined in the light of contemporary realities. A significant reorientation is needed in medical education to allow students to understand people in their social contexts in a more holistic way, rather than seeing them merely as parts of a biological machine (McKimm & McLean 2011; Wartman & Steinberg 2011). Health professionals must be responsive to the needs of the populations they serve, and improve healthcare systems through education (Mennin & Mennin 2006).

Students involvement. After going through the experience of Community-based Medical Education (CBME) as part of their undergraduate attachments, FOM-SCU medical students were given a golden opportunity of "learning by doing" (learning by serving the local community). Benefits included:

- Active involvement of learners in community diagnosis and assessment of real health needs of the community.
- Direct and continuous contact with the people whom they are going to serve after graduation.
- Inter-professional collaboration, team work, education, and training.
- Working with limited resources.
- Development of a sense of belonging.

Lessons learned

Reflecting back over the 25 years from when this close relationship with that community began, the Faculty of Medicine now realises how rich that relationship has been. Social accountability as a concept was not encapsulated and developed as it is now. The School went through many trials and frequent tribulations and mistakes in order to build a community partnership approach, which over time has developed and further strengthened to become a model for those who wish to go through the same experience.

Faculty had many ups and downs at the beginning of this relationship but over time, confidence grew as did the community as it grew to maturity.

As a Faculty, we learn from our strengths and weakness.

Among the points of strengths in the initiative were:

- The collaboration was initiated by the community itself rather than by the academics after being initially encouraged by the community-based activities. Whenever the community initiates and desires a relationship with academia, it becomes, we believe, much more successful than forcing the community to respond to an academic or research need. El Tal El Kebir community had reported many previous traumatic and even unethical experiences of dealing with academia. However with a cautious and sharing approach, this initial traumatic experience was overcome
- The Faculty had actively shared in the promotion of health of an under-served community. To accomplish that, it created a sustainable partnership with the community and local health authorities. To become official and sustainable, it established an NGO which included all stakeholders.
- Inter-sectoral collaboration was found to offer more sustainable and cost effective solutions to community health problems.

On the other hand, the points of weakness were:

- The experience in using inter-sectoral collaboration, as a basis for our community services failed in the School adopting and promoting interprofessional education and training in our undergraduate curriculum. Hopefully, this will be rectified in the very near future.
- In order to stimulate other Medical Schools in our region to engage in similar community activities, the School should have arranged for an independent evaluation of the outcome of the whole process. Consequently, the outcome could have been published and disseminated, in order to exemplify the social responsibility of medical schools.
- At present, we have little evidence that this process has helped in the recruitment and retention of community-based health practitioners. A present study, to be presented

in a later associated paper, we hope will demonstrate some clearer long-term effects.

Further work is presently being carried out to elucidate the true effects upon the community, the changes in the health and social parameters, and the effects upon the healthcare professionals

Summary

Between 1985 and 2011, many events full of action, enthusiasm, frustrations, failures, and success have happened to the rural community of El-Tal El-Kebir; many as a result of their long-lasting partnership with the faculty and students of Suez Canal Medical School in Egypt, all of who believed in social accountability. We hope that short-term effects such as the eradication of certain parasitic diseases and poliomyelitis are the result of community intervention, at least in part if not through whole. Other health concerns have now surfaced on top of the community's health list, such as heart disease, malignancy, and road traffic accidents; those that usually reflect a priority concern of an urban community.

Although health is a multi-factorial issue, and any long-term effects are in the process of being measured, in demonstrating a socially accountable approach to healthcare, beneficial effects can be obtained.

Conclusions

"From little acorns large oak trees grow; from small initiatives, communities grow"

The Faculty of Medicine at the Suez Canal University firmly believes in the need for all medical schools to address the issue of Social Accountability; through this paradigm to become a socially responsive organization, dealing and hopefully improving the healthcare of its immediate community and subsequent country and nation. Although the project described has been active for 25 years, the Faculty is still growing into the concept. Its true value will be measured over time when we can see the effect on the community, the changes in the health and social status, and the development and retention of the doctors and healthcare practitioners who work in that community.

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Appendix: Methodology of prioritization of health problems by the community of El-Tal El-Kebir

By the early 1990s, the SCU-FOM decided to adopt a new method for prioritizing health problems in four governorates served by the school (Ismailia, Port-Said, Suez, and Sinai), and for incorporating these health problems into the medical curriculum. The method describes the various "home-made" ideas which made the approach more feasible and affordable. The methodology highlights:

- The role of what's called the "Problem Formulation Research Lab" in gathering health- related data and in formulating strategies for prioritizing and incorporating the health problems analysis into curriculum reform;
- The contributions made by faculty members, students, the Ministry of Health and the community representatives through nine months of identifying and prioritizing health problems;
- The application of specially designed computer software to analysing priority health data and its incorporation into the curriculum.

The FOM-SCU had created its own procedures. The team started to identify the health problems in their community "*de novo*" depending on the results of surveys done by the faculty staff and students, documents provided by the Ministry of Health, and interviews held with general practitioners, community representatives and health officials. Then, a questionnaire was designed that included all identified health-related problems in the surrounding community. The respondents were asked to evaluated the randomly displayed problems according to the following 10 indicators:

(1) Prevalence
(2) Preventability
(3) Treatability
(4) Social/economic impact
(5) Impending future outbreak
(6) National control program
(7) Morbidity/Mortality
(8) Disability
(9) Prototype value
(10) Interdisciplinary input

The questionnaire was planned and administered in 9 months duration with a target population formed of four main categories: community representatives, local health authority representatives, faculty, and students. Each category was asked to answer questions related to the relevant indicators. For incidence, the "Social/economic impact" was the main indicator tackled by the community representatives, the "Prevalence" was exclusively tackled by the local health authority representatives through their statistics. Such information was not available to any of the other categories including faculty and students. The "Prototype value & Interdisciplinary input" were the job of the faculty for being educational indicators. Although the students and junior faculty were participating mainly by interviewing the community and other categories' representatives to explain how to fill in the questionnaires and collect the filled out ones, yet they were participating themselves in answering parts of the questionnaires that are relevant to their community work. Five hundred questionnaires were distributed for this purpose according to the sample size. Data was then processed and transformed into information that was then used, in its final form in the prioritization in health problems and integration in our PBL school curriculum, and on the other hand it was used for the selection and prioritization of community health projects that are primarily done by the community in collaboration with the university and local government

Five hundred and fifty-five health problems were identified and ranked. The top 18 health problems, together with their total scores, were listed in Table 1 for comparison with another

Table 1. Prioritized community health needs and concerns in El Tal El-Kebir District in 1992 and in 2011.

Health problem/need or concern in 1992	Total score (Out of 200 points)	Health problem/ need or concern in 2011	Total score (200)
1. Schistosomiasis	195.60	1. Viral hepatitis, cirrhosis and hepatic failure	179.00
2. Malnutrition	189.40	2. Heart diseases	178.80
3. Family planning problems	184.20	3. Family planning problems	178.70
4. Water sanitation and sewage disposal problems	183.00	4. Breast masses	178.00
5. Hypertension	182.50	5. Diabetes mellitus	175.50
6. Diabetes mellitus	182.50	6. Water sanitation and sewage disposal problems	173.00
7. Addiction.	179.00	7. Hypertension	169.00
8. Viral hepatitis, cirrhosis & hepatic failure	178.80	8. Environmental pollution	176.40
9. Diarrhea and dehydration	178.70	9. Schistosomiasis	167.00
10. Breast masses	178.00	10. Addiction	167.00
11. Poliomyelitis	175.50	11. Diarrhea and dehydration	165.70
12. Tuberculosis	173.00	12. Tuberculosis	163.50
13. Food pollution	169.00	13. Urinary bladder cancer	163.50
14. Urinary bladder cancer	176.40	14. Food pollution	162.50
15. Environmental pollution	167.00	15. Bronchial asthma	160.00
16. Child abuse	167.00	16. Ante-post natal problems	160.00
17. Emergency problems	165.70	17. Anemia	154.00
18. Endemic communicable parasitic diseases	163.50	18. Road accidents	149.00

Notes: Scoring system: each health problem/need or concern was measured in terms of the 10 above-mentioned indicators and on a 5-point scale. Fifty participants from each of the 4 main groups: community representatives, students, faculty, and Ministry of Health doctors had participated (total sample size was 200 participants). Each of the 200 participants represented a score out of one point in the final list.

list that contains the top 18 health problems when re-prioritized some 20 years later. It is obvious that, over those years, chronic liver and heart diseases have replaced Schistosomiasis and malnutrition as the top listed health problems. Also, there is a general decrease in the total score of most of the problems. This can be attributed, at least partially, to improved community participation in improving their own health. The last prioritization exercise was done within a WHO research project in the Faculty of Medicine, Suez Canal University to investigate the potential of FOM, SCU, to produce competent physicians capable of dealing with the real health needs of their community and verifying the mission of this school as a community-based and socially accountable school (Maklady & Talaat 1998).