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COVID-19 and health care response in Lebanon: a lot left to be desired

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The spread of coronavirus in Lebanon started with the first case reported on Feb. 21, 2020. Initially, as expected there was a significant increase in the number of cases reported since at that phase each patient was potentially infecting 4-5 persons. The government responded with a series of steps that are referred to as nonpharmaceutical interventions (NPI) that are layered on top of each other aiming to reduce the spread. The first of these NPI was closure of schools, universities and day care and reached up to the closure of borders and the airport with public mobilization on March 15, 2020. These NPI slowed the spread and reduced the number of cases, although there is skepticism around the actual numbers, granting the health care sector time to prepare for the different phases of the spread up to the worst case scenarios. This planning should have taken into consideration the following resources: health care workers (HCW), hospital supplies and processes, non-COVID 19 infected patients, and community response.

HEALTHCARE WORKERS

Data from all over the world has shown that HCW are the vital human elements in combatting this pandemic. The alarming numbers coming from Spain showing that up to 12.5 percent of those who were infected were HCW, over and above death announcements of HCW from Italy and the USA, raised deep concern among HCW in Lebanon. Although the responses of the Syndicate of Nurses and Lebanese Order of Physicians were relatively swift to minimize exposure, the outcome was not good. Data from Lebanon clearly show that the rate of infected HCW is relatively high for a country that is not in a wide outbreak condition. HCW from several hospitals in North Lebanon, North Metn, Keserwan, Jbeil, and Beirut were either exposed or infected and required management. This indicates that the processes in place at these hospitals were suboptimal. Some of these hospitals have upgraded their response standards, however, effectiveness, uniformity and transparency in these standards are questionable. The status of health coverage for the HCW remains not entirely clear, and more worrisome are reports of hospitals forcing their HCW to purchase out of their pocket money their own personal protection equipment (PPE). These PPE include face masks, gloves, head covers, eye goggles and COVID-19 suitable gowns. Furthermore, reports of HCW intimidated to remain responsive to "business as usual" under threat of layoff is far from being legal or humane in these dire economic conditions in Lebanon. Such actions model what is being portrayed in the media coming from the USA where HCW are threatening to go on strike or ended up wearing garbage plastic homemade protection equipment. In a very recent article published by one of the most prominent cardiologists in the USA, Dr. Eric Topol states that the USA has betrayed its HCW. Such a strong and intense statement is resonating among many HCW in the world and in Lebanon in particular, and will certainly surface should similar images start appearing from here.

HOSPITAL SUPPLIES

It is no secret to anybody that even before the COVID-19 pandemic, availability of hospital supplies was a problematic issue being raised by many because of the illegal de facto capital control in Lebanon. Despite many reassuring statements by Bank Du Liban and the government, obviously this problem was not resolved. Now as COVID-19 pandemic ensued, the issue of hospital supplies became a global problem. Countries that used to export these supplies stopped in order to stock pile for their own needs to combat COVID-19. Subsequently, these needed supplies became not available and their prices soared. As such, competition between hospitals to scramble and buy what is available and hoard it is only going to lead to a disaster later on. A more media emphasized supply that got coverage was mechanical ventilators. However, simple things such as personal protection equipment are the truly missing supplies at this stage. Unfortunately, international "trust-worthy" organizations chose to lower the standards of personal protection equipment needed to meet the rising demand. These organizations disregarded data from the influenza experience clearly showing that wearing masks even by the public helps reduce the spread, let alone inside hospitals! In doing so trust in these organizations has decayed and paralleled the questionable timing of declaring COVID-19 a pandemic by the WHO.
As an example of strategic errors in medical supply management, COVID-19 testing kits fell short of demand. And the price set, plus the location of testing centers, raised barriers in front of people wanting to test. This was in complete contradiction with the suppression strategy followed by the government where there is significant need to test as many as possible to identify and case contain. The Lebanese sat on TV watching the drive-through testing units in S. Korea and the nearby Gulf countries, many of them not knowing that this is what should happen here. And more importantly that not testing leads to misleading numbers and misinforming the government and the public of the current condition. The latter represents the major cause of skepticism in the reported numbers from the disease surveillance governmental body. This skepticism is now further justified with emerging reports that anywhere between 30-50 percent of COVID-19 patients do not have visible clinical complaints i.e. asymptomatic. Thus, we can easily have pockets of asymptomatic patients that will spread the virus and lead to failure of the suppression strategy in Lebanon. Current reports from some officials suggest that testing kits are on their way. Experience teaches us to not believe what we hear, and believe half of what we see for the devil is in the details. And the details lies in the procedures that will be followed to ensure massive testing- not selective, discriminatory testing.

WHAT ABOUT THE OTHER PATIENTS?

As the world has come to a stop because of COVID-19, unfortunately the other illnesses did not. Our patients suffering from cancer or other noncommunicable diseases such as lung, heart or endocrinology diseases are now paying an additional toll. They do not/cannot come to hospitals that can compromise their safety. Some of these patients are labeled at high-risk of death should they contract the infection. And on the other hand, cancer patients cannot but be present for their cycles of chemotherapy. Furthermore, because of being afraid to go to hospitals and the economic pressure, patients complaining of time-sensitive illnesses, such as chest pain, are coming in a more deleterious condition because of delayed presentation. On a slightly longer term, the economic toll from the lockdown is clearly disastrously leading to increasing poverty. Poverty is directly associated with increased noncommunicable diseases and poor health outcomes. Who is taking the above into consideration when planning our strategy and tactics to combat COVID-19 during these difficult times remains a question suspended in vacuum?

COMMUNITY RESPONSE IN LEBANON

Without doubt COVID-19 pandemic will categorize countries into those with good rapid response systems to health care crises and those with not. This will be the measuring stick used to reflect greatness of a nation in the future. In Lebanon, there is much left to be desired and that can be accomplished now despite of everything. However, the view of how each political party is moving to fill the gaps the government has left unattended to would have been much more reassuring had that happened as part of a plan led by the public Health Ministry. After all the ministry is the legal custodian of such efforts in the eyes of everybody who believes in a state. The efforts led by these parties are part of the desired community response, but not in the way it was shown. What we saw and are seeing is going against the successful world trend. Singapore and S. Korea succeeded in their fight against COVID-19 because of a strong and centralized response. This response was guided by an information generating system to make them well-informed. Moreover, their response was characterized by being technology harnessing, transparency based, Parliament/regulatory body supported, and in coordination with community responses. The USA on the other hand is paying the price of a less organized response from a hesitant leadership. In Lebanon, the current view says we are very sadly heading for "cantonish" responses, where within each canton the wealthy/socio-economically supported and adherent to stay-home recommendations will be better off. And despite that, in the absence of a clearly developed plan with timelines for coordination among hospitals that is laid out by the Health Ministry is the reason the residents of Lebanon have a lot to worry about.

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