Maintaining essential non-communicable disease services in the Eastern Mediterranean Region during the COVID-19 pandemic

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Abstract

Background: Health systems, particularly in low- and middle-income countries, struggled to maintain essential non-communicable disease services during the COVID-19 pandemic.

Aim: We assessed the extent of disruptions to non-communicable disease services in the Eastern Mediterranean Region during the COVID-19 pandemic, exploring the challenges and mitigation strategies.

Methods: From October to December 2021, we interviewed WHO country focal points for non-communicable disease from 16 Eastern Mediterranean Region countries and analysed the data.

Results: Emergency and primary care services were disrupted in most of the countries. One country experienced total disruption to primary care while 7 experienced at least 50% disruption. The proportion of fully disrupted essential non-communicable disease services was highest in the lower-middle income countries. Specialized services, including cancer screening and radiotherapy, were more severely affected, while dialysis was relatively well-maintained. The most frequently mentioned reasons for disruption were fear of contagion, staff redeployment to COVID-19 response, lack of access to services due to lockdowns, and cancellation of elective procedures. Two of the mitigation measures were use of telemedicine and community volunteers and home drug delivery.

Conclusion: COVID-19 caused disruptions to non-communicable disease services in the Eastern Mediterranean Region, however, some countries implemented measures to mitigate the disruptions. There is a need for long-term, sustainable, integrated and well-coordinated national and regional strategies that will ensure the continuity of non-communicable disease services during emergencies and pandemics.

Keywords: COVID-19, non-communicable disease, health system, health service, health emergency, pandemic, Eastern Mediterranean

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Introduction

Non-communicable diseases (NCDs) are the leading cause of death in the Eastern Mediterranean Region (EMR), with the 4 main NCDs (cardiovascular disease, diabetes, chronic respiratory disease and cancer) claiming around 2.8 million lives annually (*1*). The health systems in many EMR countries have not yet been fully developed to cope with the changing needs of populations, and low- and middle-income countries bear the highest age-standardised death rates attributable to NCDs.(*2*)

NCDs often progress silently. Therefore, they are usually not prioritised during emergencies. People living with NCDs were especially vulnerable to the COVID-19 pandemic on several levels. First, they were at higher risk of hospitalisation and death due to COVID-19 (*3–5*). Second, they depend on long-term care, to which access was restricted, as a planned infection control measure, due to reassignment of staff and facilities to the COVID-19-response, self-isolation of health workers, and full capacity at hospitals. Even where services remained open, various levels of disruption occurred. A rapid survey conducted by WHO revealed that in 58% of countries where outpatient and inpatient services remained open, one or more NCD-related services were disrupted (*6*). Third, disruption to supply chains affected medicine and equipment stocks. Fourth, the stay-at-home policies reduced access to fresh food and medicine, aggravating the challenge of unhealthy diets. There may also have been increased alcohol and tobacco use, lack of physical activity and stress (*3*).

Study objectives

This study explored the extent of disruption to essential NCD services in the EMR during the pandemic, and strategies adopted by countries to mitigate them. These are crucial in informing policies to build more resilient health systems that are better equipped to face future shocks, and to promote integration of NCD services into pandemic preparedness plans.

Methods

We developed a questionnaire containing 110 questions that were adapted from the previous WHO pulse survey and from "Maintaining essential health services: opera-

tional guidance for the COVID-19 context". It contained multiple-choice, "check all that apply" and open-ended questions, with an option for additional explanation at the end of each set. It assesses disruptions across various health care services, including emergency services, primary health care, specialised care, surveillance, research, reasons for disruption, and mitigation measures adopted. Since disruption may have occurred as a planned infection control strategy or a consequence of the impact of the pandemic on health services or access to them, we did not specify a starting point for the duration of disruption.

The web-based questionnaire was sent to WHO NCD country focal points in the 22 EMR countries/territories in October 2021, with 2 follow-up reminders at 2-week intervals. The focal points coordinated with the Ministry of Health (MoH) in their respective countries to complete it. We received responses from the occupied Palestinian Territory and 15 countries (Afghanistan, Bahrain, Djibouti, Iran, Jordan, Kuwait, Libya, Lebanon, Morocco, Oman, Pakistan, Saudi Arabia, Syria, Somalia, and Yemen). Aggregate results as number of countries that faced disruption were presented. Permission was sought from respondents where specific country examples were mentioned.

Results

Extent and duration of service disruption

Emergency services were partially disrupted in most countries and ambulance services were fully disrupted in 2 low-income countries (Figure 1). Most countries experienced 3–6 months of disruption, but these had been fully or partially restored in all countries at the time of the survey (Figure 2).

Disruption to primary care was reported in all 12 countries that provided response on this, with 50% disruption or more in 7 and full disruption in one. Disruption lasted 6 months or less and was fully restored in most countries (Figure 2).

Non-emergency cardiovascular disease services were disrupted at various levels in most countries. Cancer screening was fully disrupted in 5 of 11 countries. Disruption lasted 6 months or longer in half of them. Cancer diagnostics were substantially disrupted, but for a shorter duration (6 months or less in 7 of 9 countries) (Figure 1, Figure 2).

Cancer treatment was relatively well-maintained; with less than 6 months of partial disruption reported by most countries. Radiotherapy had the longest disruption among cancer treatment modalities (Figure 1, Figure 2).

Dialysis was relatively well-maintained in all countries. Only 4 countries reported disruption, and this was less than 50%. Among these, 3 had disruptions due to pre-existing political and economic instability, which caused supply shortages. Most countries had partial disruption to diabetes complications management (Figure 1).

Cancer registration was suspended in 4 of 8 countries. Of 4 countries that reported having other NCD registries, registration was partially suspended in 2. Disruption was attributed to restricted access of cancer registrars to hospitals, and the redeployment of staff to COVID-19 surveillance. Some disruptions predated the pandemic due to resource shortages.

Only 4 countries reported running clinical trials, all of which were at least partially suspended. Other health research was less disrupted (Figure 3).

The proportion of essential NCD services that were fully disrupted was highest in lower-middle income countries (7) (Djibouti, Islamic Republic of Iran, Pakistan, Palestine, Morocco) compared to the higher-middle income countries (Libya, Lebanon, Jordan), and higher in the latter group than in high-income countries (Bahrain, Kuwait, Saudi Arabia and Oman). In low-income countries (Yemen, Afghanistan, Syria, Somalia), no data were available on the status of more than half of the essential NCD services. Only in lower-middle- and low-income countries were any services disrupted for more than 12 months, and this impacted over 50% of services in both groups (Figure 4).

Reasons for service disruption

The most frequently mentioned reasons for disruption were fear of contagion, staff redeployment to COVID-19 response, and lack of access due to lockdowns and cancellation of elective procedures. Government interventions to control the pandemic, namely, closure of outpatient services and lockdowns or suspension of transport services were most frequently given as the main reasons for disruption in outpatient and inpatient care. Fear of contagion among patients and staff, and hospital bed shortages were also important contributors (Figure 5).

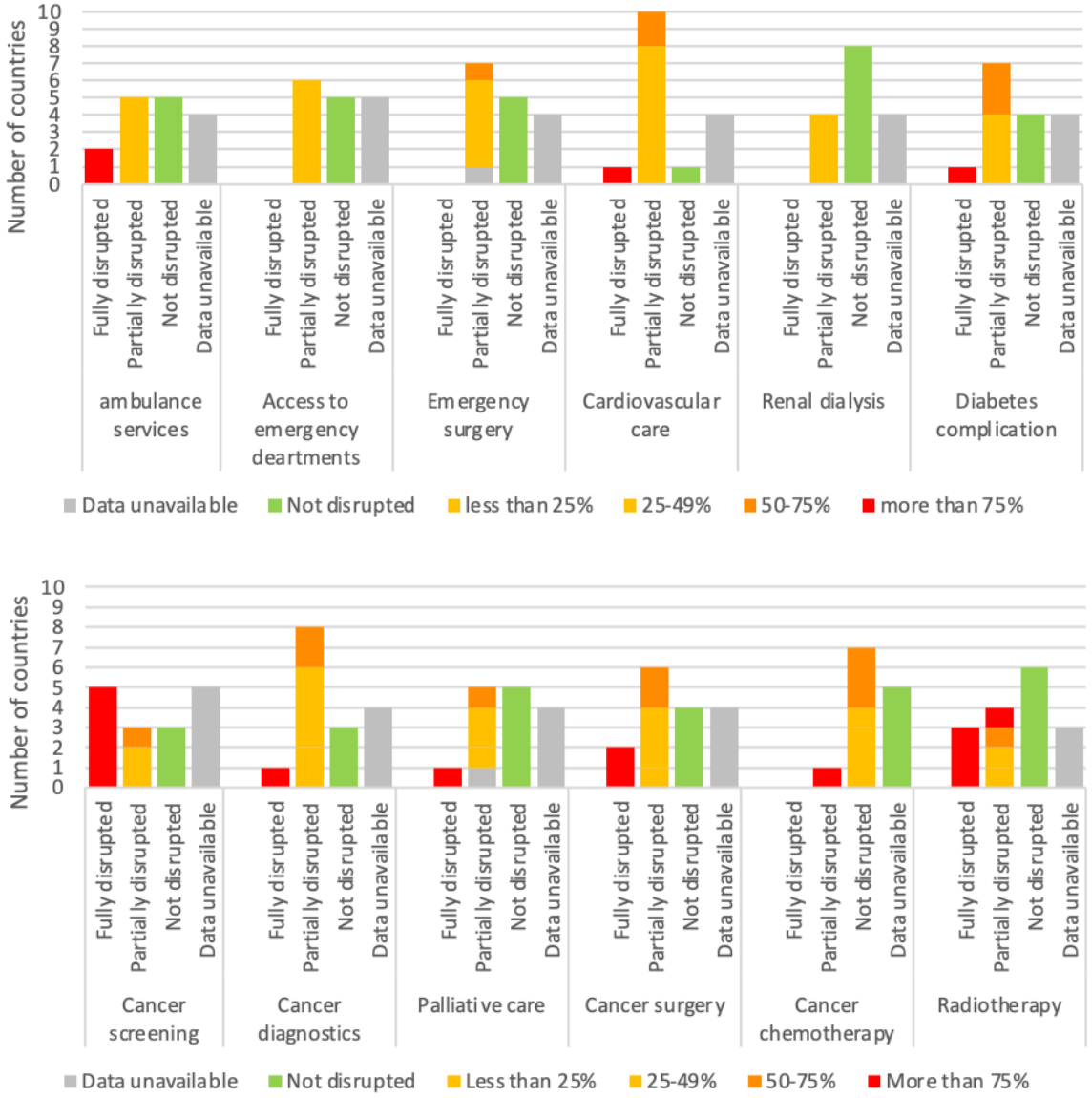
Mitigation measures

Although 9 countries had previous experience with outbreaks (e.g. SARS, MERS, H1N1 or cholera), only 6 had pre-existing pandemic preparedness plans (Table 1). Nine countries designated a focal point for essential health services in the COVID-19 incidence management team, but designated fewer than half of those established mechanisms for monitoring essential health services delivery.

In all 8 countries where essential health services were defined, NCD services were included. However, only 8 out of 14 countries included essential NCD services in their pandemic preparedness plans, and in 4 of them, these services were inadequately funded. Half of the countries had mechanisms to reallocate routine care towards essential health services, but only half of these had triggers or thresholds to activate the process.

Six countries allocated extra or flexible budgets to frontline service providers, but only one reported suspending user fees for essential NCD services. Routine NCD services were delayed or cancelled in 11 countries,

Figure 1 Extent of disruption to primary, emergency and specialized health services in Eastern Mediterranean Region



and only 2 of these had a clear roadmap for reintroducing services during the recovery phase.

In 9 of 13 countries, there was a need to prioritize essential NCD services. These needs, however, varied between countries; while some focused on urgent care (e.g. cancer treatment, acute cardiovascular care), others included diabetes and hypertension management, cancer early detection, cardiovascular disease risk assessment, and primary care NCD services (e.g. Morocco). In Jordan and Bahrain, there was also a focus on mental health.

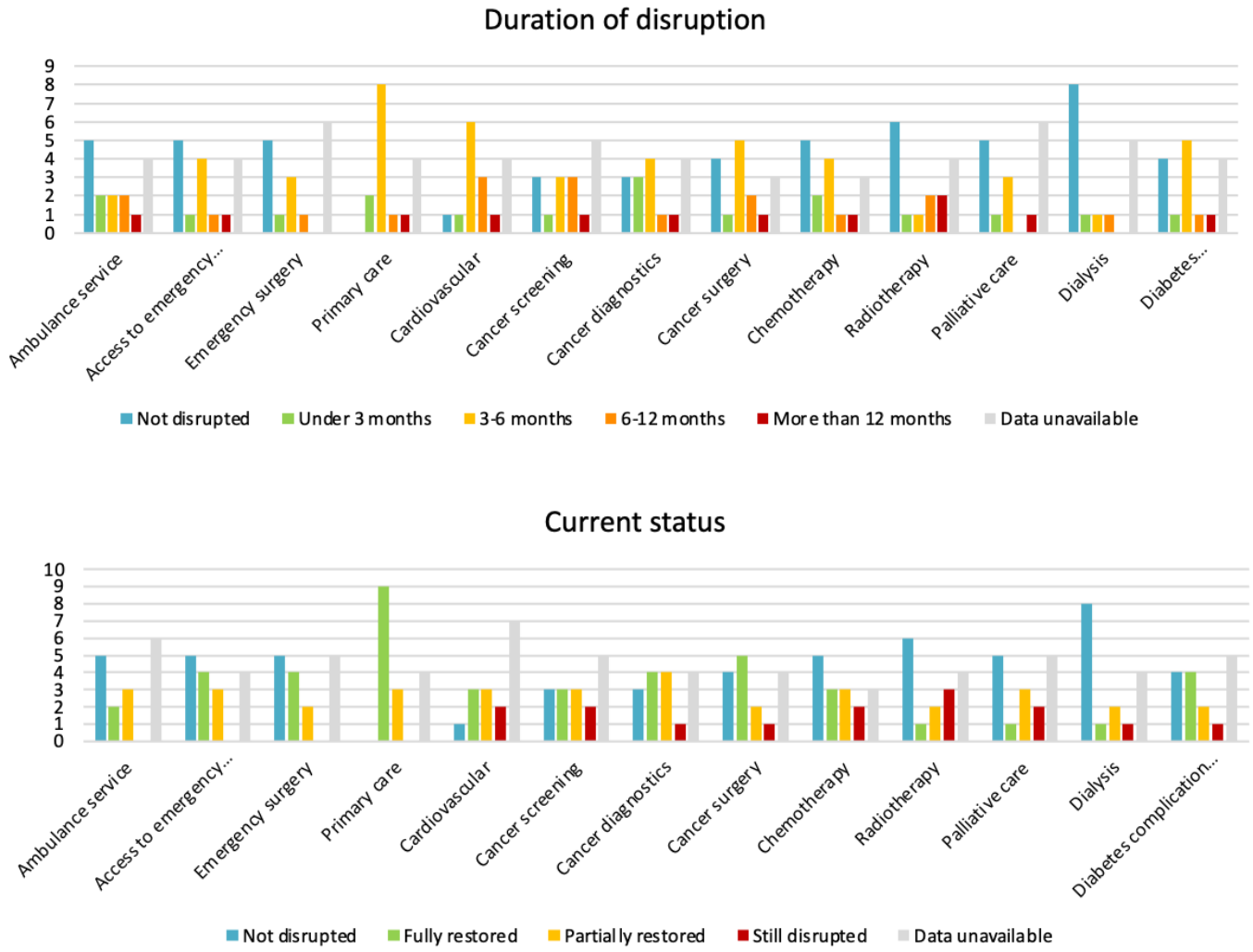
Eight countries implemented new supply chains or dispensing approaches (e.g. local production, home delivery and medication dispensing for a longer duration). Seven countries established outreach mechanisms to deliver NCD care, often as mobile clinics provided by non-government organizations and humanitarian agencies or MoH. However, in only about half of the countries have the public been informed of these changes to service delivery platforms. Ten countries provided contact numbers for safe care guidance but only 7 used digital platforms and telemedicine for service delivery. In Morocco, telemedicine was piloted to deliver care to NCD patients for the first time. In Bahrain, telemedicine was used for mental health but not NCDs.

Social media was the most widely used communication channel to inform the public about NCD services, alongside television, radio, telephone, press conferences, MoH website, community centres, home visit, and mobile clinic.

Only 5 countries reported that all patients were screened for COVID-19 on entry to health care facilities. In some countries, these measures were only implemented in hospitals or selected facilities.

Health workforce capacity remained a particular area of weakness across the region, with most countries having inadequate plan for reassignment and funding for

Figure 2 Duration of disruption and status of noncommunicable services in in Eastern Mediterranean Region



additional workforce. However, volunteerism played an important role; at least half of the countries had trained volunteers to support essential NCD services.

Although pharmacies and suppliers of NCD medication and equipment were identified in 11 countries, resources to maintain these platforms for reporting stockouts and coordinating redistribution were available in only 5.

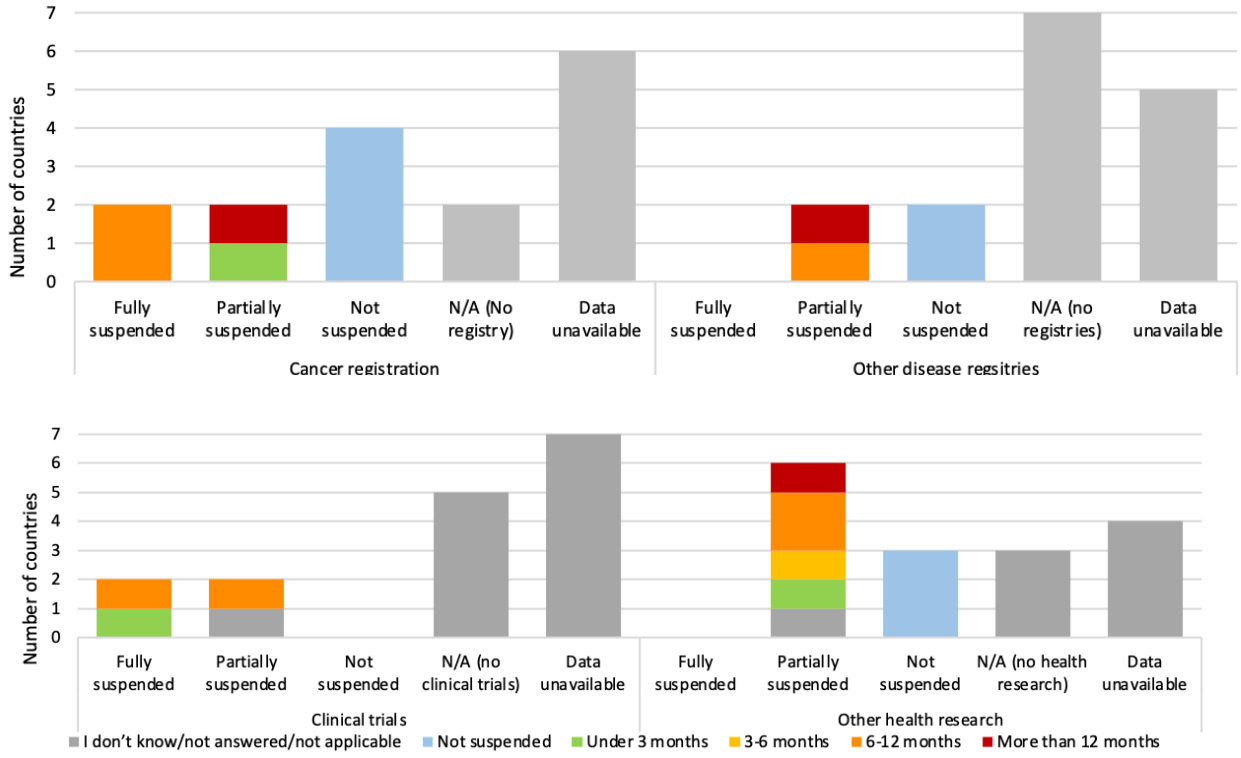
Besides the domains included in the survey, other measures were successfully implemented. For example, in Oman, there was a focus on enabling home-based NCD management by providing devices for diabetes and hypertension testing, telemedicine and medication delivery. In Jordan, a home medication delivery programme required extensive effort to compile patient lists and contact information, ultimately improving patient records. In Syria, public health centres were maintained with infection control measures, continuous capacity building for essential health services delivery and stockpiling of essential medicines and supplies. In Libya and Morocco, some health facilities were transformed into COVID-19 triage centres to allow other facilities to continue essential health services.

Discussion

There were various levels of disruptions to essential NCD services across the EMR during the COVID-19 pandemic. Most countries prioritised critical services such as emergency and cancer treatment, and suspended elective care, some kept their primary care centres operating to continue early diagnostic services and follow-up for NCDs, aiming to prevent disease progression and complications. Several countries prioritised NCD medications supply maintenance. This supported short-term treatment continuity but did not replace long-term follow-up.

There were substantial disruptions to cancer screening and diagnostics, probably due to limited access to primary and ambulatory care and elective procedures. Efforts to maintain cancer treatment through strict infection control measures, COVID-19 screening and other institutional measures showed success in Morocco and

Figure 3 Extent and duration of suspension of noncommunicable disease surveillance and research in Eastern Mediterranean Region



Saudi Arabia (*8,9*). Radiotherapy was the most impacted treatment modality, but this was rooted in longstanding healthcare infrastructure and political challenges. In the 3 countries that reported fully disrupted radiotherapy (Djibouti, Palestine, Afghanistan), the service was not available before the pandemic (*10,11*).

Dialysis was mostly maintained, likely due to its relatively independent operation. In contrast, diabetes complications management was partially disrupted in most countries due to the closure of outpatient clinics.

There was disruption to cancer registration, attributable to the inability to actively collect data, poor staffing and funding shortages (*12*). Timely cancer registration is crucial for monitoring the impact of the pandemic on cancer diagnosis, including delayed diagnosis, which impacts cancer survival. In the United Kingdom, this has been estimated to cause a substantial increase in cancer deaths (*13*).

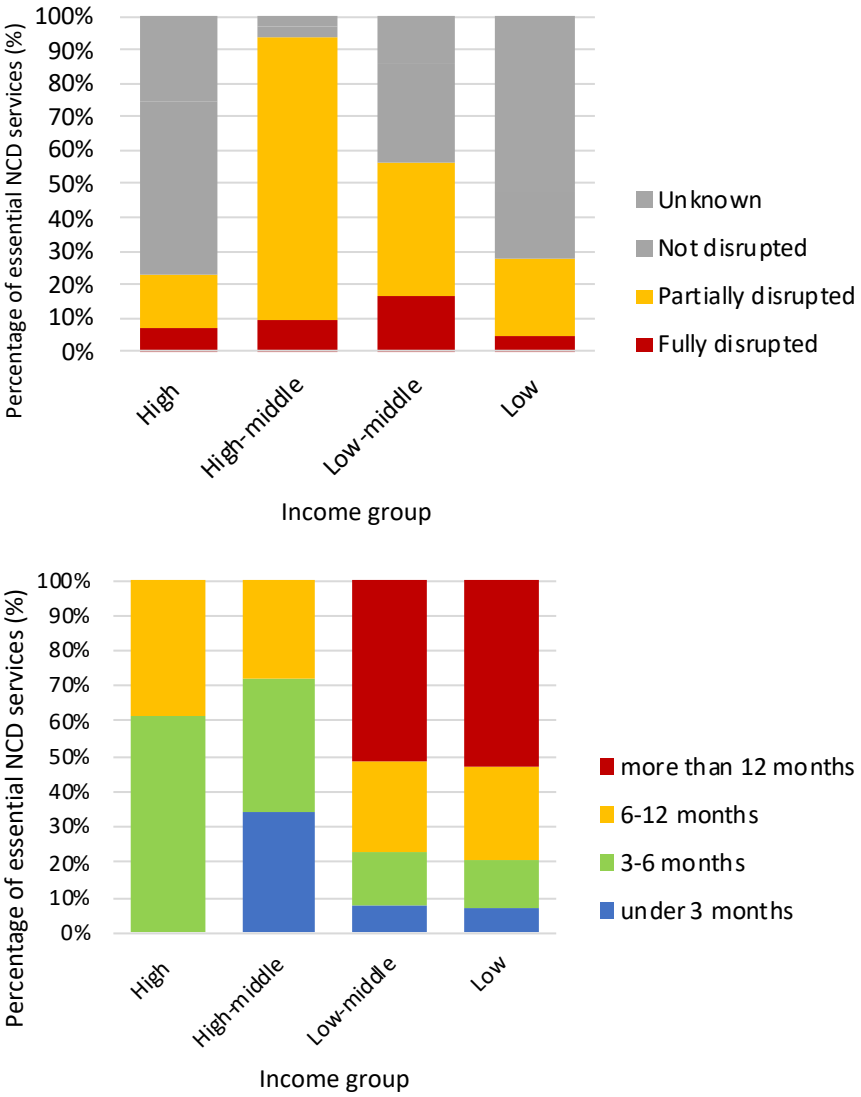
Clinical trials were disrupted in all countries that reported conducting them, while other health research was less disrupted. The clinical trials typically included electively admitted patients and elective admissions were limited in all the countries.

Some countries reported disruptions that coincided with the pandemic but were not primarily caused by it. For example, in Yemen, armed conflict and aid cuts limited the country's pandemic response capacity. Security challenges and fuel shortages impacted transportation. In the occupied Palestinian territory, referrals to East Jerusalem were halted for political reasons and medication shortages existed before the pandemic. Similarly, Afghanistan experienced widespread disruption to health services due to the fragile security situation. Countries with severely limited health care capacity returned to "normal" sooner. Yemen, already operating at only 50% capacity, could not afford to further restrict services. COVID-19 was perceived as an additional burden rather than the main concern in these communities.

NCD service suspension, lockdown or public transport suspension were the main reasons for disruption to outpatient care, followed by the fear of contagion. Similar findings were reported by International Rescue Committee for primary health care services in Jordan and Somalia, which observed a decrease in NCD visits although services remained accessible during the pandemic (*14*). Government policies should clearly designate priority groups for access to care during restrictions and communicate these to patients and all relevant authorities, including law enforcement.

There were bed and staff shortages for inpatient care because all hospital beds were used to full capacity and many health workers were isolating. Besides the public health measures to control infection, this challenge can only be mitigated by increasing bed capacity, training staff and equipping field hospitals, and it requires resources that many countries do not have. The United Nations and humanitarian agencies supported low-

Figure 4 Extent and duration of disruption to essential NCD services (by World Bank country income groups) (all services combined)



income countries with personal, protective equipment, ventilators and medicines (15).

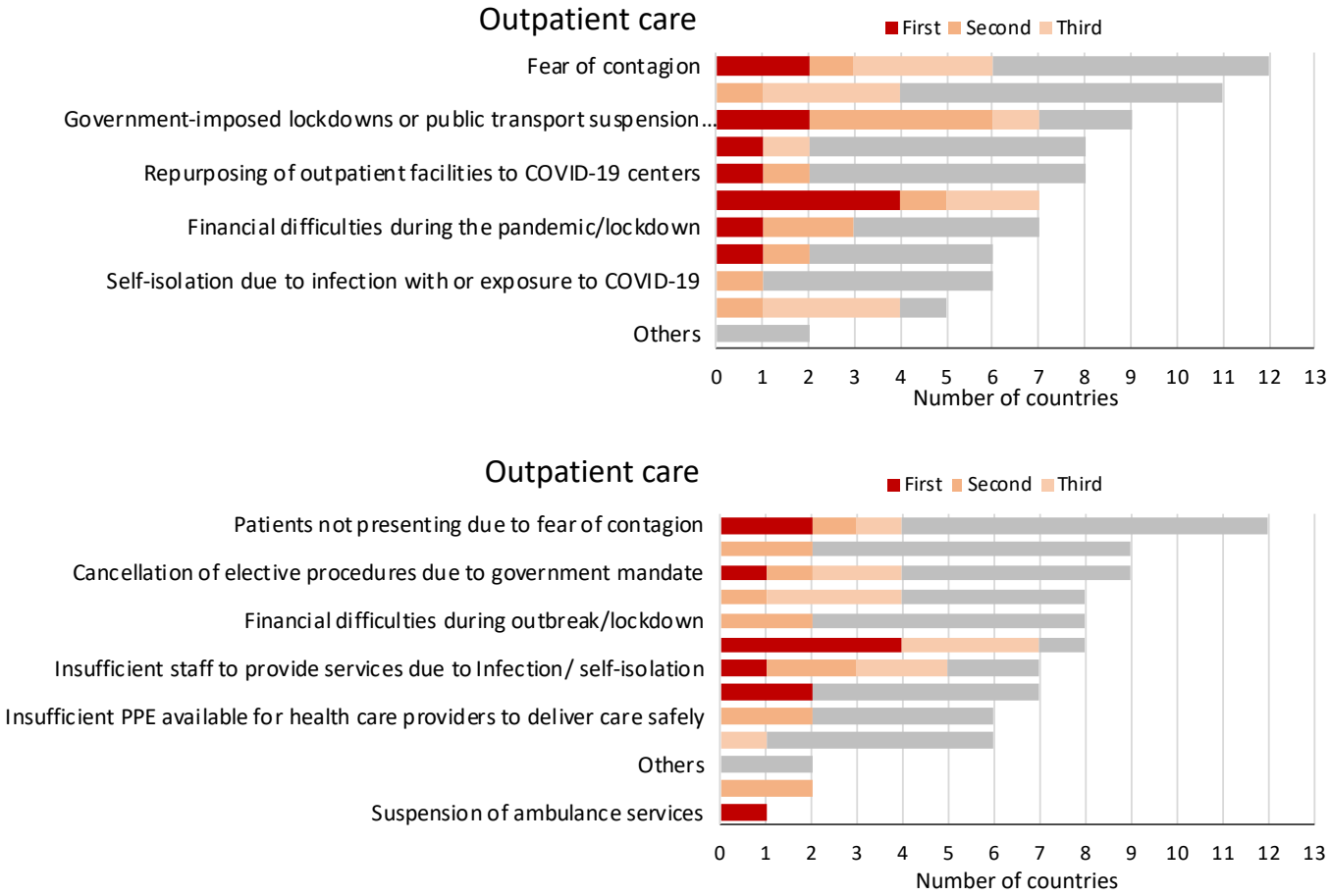
Triage according to priority, screening and isolating suspected COVID-19 cases are the most basic measures to take at health facilities. However, staffing and space shortages and, sometimes, resistance from patients, made these challenging. Implementing triage routinely with dedicated resources should continue post-pandemic to ensure appropriate prioritisation and reduce the risk of infection.

Telemedicine and digital prescribing were widely adopted, although their successes varied. Countries with stronger digital infrastructure like Saudi Arabia and Oman reached a wide proportion of their populations, while the occupied Palestine territory faced challenges in coverage and continuity because of the lack of pre-existing platforms, staff and funding. A WHO assessment of digital technologies use in 7 EMR countries reported challenges including the lack of data protection, unacceptability by patients, incomplete patient records and contact information, and time-bound funding (16). Successful telemedicine implementation requires an understanding of the smartphone, access, literacy, and user guidelines. Since family physicians were the first teleconsultation contacts at the ministry of health, this presented an additional opportunity to build trust in primary care and increase its utilisation (16).

Although WHO recommended task shifting as a mitigation strategy (17) it was essential to exercise caution to avoid exposing vulnerable patients to infection when alternating staff between COVID-19 and NCD care. For instance, in Morocco, oncology staff were exempted from COVID-19 duties.

The pandemic highlighted the urgency of achieving Universal Health Coverage, including financial risk protection, access to quality essential health care services and essential medicines for all (SDG 3.8). In the occupied Palestinian territory, the United Nations Relief and

Figure 5 Reasons for disruption to in- and outpatient essential NCD services (all that apply) and top 3 reasons for disruption to in- and outpatient essential NCD services



Works Agency expanded its services to include elderly non-refugees, offering free NCD care amid widespread income loss. Saudi Arabia provided free COVID-19 testing and treatment to undocumented migrants without legal repercussions. Outreach clinics were used in about half of the responding countries, helping to reduce health facility crowding and to bring care closer to patients.

Considering the workforce constraints and strong community ties, training volunteers for tasks such as screening and medication distribution could be highly effective across all income groups in EMR countries. Despite the minimal resources needed for training and coordination, only about half of the countries adopted this approach. Digital platforms or community networks, with supervision to ensure quality, can facilitate volunteer coordination.

Strategies used by countries have proved successful in enabling the continuity of NCD service delivery, including in humanitarian settings. Expanding the responsibility of community health workers and taking measures to protect NCD patients in health care settings (e.g. yellow cards during triage, separate waiting areas and designated clinical teams, measuring vital signs prior to appointment) have been very helpful (*14*). Although more difficult to measure, resilience and anti-fragility are also system attributes that have helped health authorities and stakeholders to address the pandemic especially when compounded with natural or human-made disasters. The rapid deployment, coordinated responses and resource mobilisation show the high adaptability of health systems to rapidly changing situations (*18*).

Study limitations

Certain unexplored factors may have affected the continuity of NCD care. For example, the stay-at-home orders may have led to a loss of informal care, which many people in the region depend on. Our study focused on the public sector, but other government sectors that provide health care services (e.g. military) and the private sector may have different capabilities which may have influenced their pandemic response. Despite efforts to obtain complete response from all 22 countries, the pandemic restrictions affected participation. Respondents did not always fully answer some of the questions, which may be a reflection of the limited mechanisms to monitor service disruption and mitigation strategies.

Table 1 Number of participating countries that had mitigation measures to maintain essential NCD services

	Yes	No	No data	Not applicable
Policies and plans (pandemic preparedness)				
Did the country have a pre-existing pandemic preparedness plan?	6	7	3	0
Does the country have previous experience with outbreak management (e.g. MERS, SARS, H1N1)?	9	5	2	0
Is there a focal point for essential health services as a member of the COVID-19 incident management team (IMT) or equivalent?	9	2	5	0
Is there a mechanism for monitoring and assessment of essential health services delivery and incorporating data into the IMT?	4	6	6	0
Governance, finance and coordination mechanisms				
Is there a mechanism for reallocation of routine care towards essential services during the pandemic if the need arises?	8	5	3	0
Have triggers/thresholds been established that activate a process of prioritization and reallocation of routine care towards essential health services?	4	8	4	0
Is there a coordination mechanism between finance and health authorities to finance essential health services (including NCDs)?	2	7	7	0
Have extra/flexible budgets been allocated to frontline service providers?	6	6	4	0
Have co-payments/user fees been suspended for essential health services (including NCDs), regardless of insurance or citizenship status?	1	9	3	3
Are essential health services clearly defined?	8	4	4	0
Are NCD services included in the list of essential health services?	8	0	3	5
Have routine NCD services been delayed/ cancelled?	11	3	2	0
Is there a road map for re-introduction of services (including NCDs) during the recovery phase according to needs?	2	3	8	3
Prioritising essential health services				
Are essential NCD services included in the pandemic preparedness plan?	8	6	2	0
Are the included essential NCD services adequately funded?	1	5	4	6
Did the need arise to prioritize essential NCD services?	9	4	3	0
Service delivery settings and platforms				
Have healthcare facilities including those in public, private, and military systems been mapped?	11	3	2	0
Have supply chains for chronic disease medication been maintained?	10	5	1	0
Have novel supply chain and/or dispensing approaches for medicines through other channels been used?	8	5	3	0
Have outreach mechanisms been established to ensure delivery of essential NCD services?	7	8	1	0
Have the public been made aware of changes in NCD service delivery platforms, including 24-hour acute care services, those in repurposed facilities, or outreach services?	8	7	1	0
Are contact numbers available to guide safe and speedy care?	10	5	1	0
Have digital platforms/telemedicine been used to support essential NCD service delivery?	7	8	1	0
Mechanism for rescheduling cancelled appointments				
Preventive care (screening)	4	5	6	1
Primary care (diabetes, hypertension, chronic respiratory disease)	7	4	3	2
Ambulatory specialised care (cardiovascular disease, cancer care, renal dialysis)	6	2	6	2
Elective surgery	10	3	3	0
Patient flow				
Are all patients screened for COVID-19 on arrival to healthcare facilities?	5	10	1	0
Are there mechanisms for isolation of those fitting COVID-19 case definitions at all sites?	12	3	1	0
Are there effective acuity-based triage systems at all sites providing acute care?	9	5	2	0
Are there clear criteria and protocols for referral pathways (including NCDs)?	9	6	1	0
Is there clear communication on safe use of healthcare facilities?	11	4	1	0
Redistribution of health workforce and task sharing				
Have health workforce requirements for various COVID-19 transmission scenarios been mapped?	6	5	5	0
Is there a plan for health workforce redistribution/task shifting for NCD services?	4	8	4	0
Have funds been allocated for timely payment of salaries, overtime, sick leave, incentives, or hazard pay for healthcare workers delivering NCD services?	1	9	6	0
Are training mechanisms in place for additional/ volunteer workforce to ensure the continued safe delivery of essential NCD services? (e.g. triage, diagnosis, infection control)	8	5	2	1
Maintaining the availability of essential medications, equipment and supplies				
Have resources required to maintain essential NCD services been identified?	6	5	5	0
Have pharmacies and suppliers of essential NCD medications and equipment been identified?	11	4	1	0
Is there a platform for reporting inventory and stockouts of NCD medications, equipment, and for the coordinated redistribution of NCD supplies?	5	8	3	0

Adapted from "Maintaining essential health services: operational guidance for the COVID-19 context"

Conclusion

At the time of this survey, new infections were decreasing in most countries, and most services had been partially or fully restored. However, countries should aim to plan for the long-term impact of pandemics on people living with NCDs, reflecting on lessons learned to build stronger and more resilient health systems.

The pandemic highlighted the interconnectedness of communicable and non-communicable diseases, which are often treated separately in research, funding and policies. Several instruments existed at the onset of the pandemic, including the International Health Regulations 2005 (*19*), the Sendai Framework for Disaster Reduction (2015–2030) (*20*), and the Global Health Security Agenda (GHSA) (2014) (*21*), however, none of these integrates NCDs in the preparedness or mitigation of public health emergencies. New multilateral and multistakeholder governance systems are needed to address this challenge (*22*). Effective NCD control is a reflection of a strong health system that is well-equipped for pandemics or health emergencies.

Mitigation measures found to be effective and safe such as triage, screening for respiratory symptoms and hygiene measures can continue to provide benefits beyond the pandemic. Telemedicine for medication refills and home delivery may improve access for those with limited mobility. To sustain these measures, they must be recognised as essential services. Low-income countries need financial support to implement basic mitigation measures.

Viewing the pandemic as just history could risk missing important lessons for future emergencies. Countries should seek innovative ways to prepare for surges in demand, such as training volunteers for simple roles, expanding digital infrastructure and educating the public.

Beyond building capacity in healthcare, building healthy societies should be a priority to enhance resilience against infectious diseases in the long-term, and to control the increasing demand for services. Given their toll on society, NCDs should be addressed with the same urgency given to new infectious diseases through the whole-of-society approach. For example, there is a need to design cities to promote active transportation, increase physical activity and reduce air pollution; remove barriers to healthy diets; tightening tobacco control; and address the social and economic determinants of health.

Maintenir les services essentiels de lutte contre les maladies non transmissibles dans la Région de la Méditerranée orientale durant la pandémie de COVID-19

Résumé

Contexte : Les systèmes de santé, en particulier dans les pays à revenu faible ou intermédiaire, ont rencontré des difficultés pour maintenir les services essentiels de lutte contre les maladies non transmissibles durant la pandémie de COVID-19.

Objectif : Évaluer l'ampleur des perturbations des services liés aux maladies non transmissibles dans la Région de la Méditerranée orientale durant la pandémie de COVID-19, en examinant les défis et les stratégies d'atténuation.

Méthodes : Entre octobre et décembre 2021, nous avons interrogé les points focaux de l'OMS pour les maladies non transmissibles de 16 pays de la Région de la Méditerranée orientale et analysé les données recueillies.

Résultats : Les services d'urgence et de soins primaires ont été perturbés dans la plupart des pays. La perturbation des soins primaires a été totale dans un pays et a impacté au moins 50 % des services dans sept autres. La proportion de services essentiels de lutte contre les maladies non transmissibles dont la continuité a été totalement interrompue était la plus élevée dans les pays à revenu intermédiaire de la tranche inférieure. Les services spécialisés, notamment le dépistage du cancer et la radiothérapie, ont été plus gravement touchés, tandis que la dialyse a été relativement bien maintenue. Les motifs de perturbation les plus fréquemment mentionnés étaient la peur de la contagion, la réaffectation du personnel pour renforcer la riposte à la COVID-19, le manque d'accès aux services en raison des confinements et l'annulation des procédures non urgentes. Les mesures d'atténuation mises en place comprenaient notamment la télémédecine et la mobilisation de bénévoles communautaires, ainsi que la distribution de médicaments à domicile.

Conclusion : La COVID-19 a perturbé les services de lutte contre les maladies non transmissibles dans la Région de la Méditerranée orientale, mais certains pays ont mis en place des mesures pour en atténuer les effets. Il est nécessaire d'établir des stratégies nationales et régionales à long terme, durables, intégrées et bien coordonnées, qui garantissent la continuité des services de prévention et de prise en charge de ces maladies durant les situations d'urgence et les pandémies.

الحفاظ على الخدمات الأساسية لمكافحة الأمراض غير السارية في إقليم شرق المتوسط خلال جائحة كوفيد-19

إيمان الخلاوي ، هشام البري، بوي بوي فيو، إيمان حاج ، ماتيلدا بيستروم، أزموس همريش

الخلاصة

الخلفية: واجهت النُّظُمُ الصحية، لا سيما في البلدان ذات الدخل المنخفض والمتوسط، صعوبةً بالغة في الحفاظ على الخدمات الأساسية لمكافحة الأمراض غير السارية خلال جائحة كوفيد-19.

الأهداف: هدفت هذه الدراسة الى تقييم مدى تعطُّل خدمات مكافحة الأمراض غير السارية في إقليم شرق المتوسط خلال جائحة كوفيد-19، واستكشاف التحديات واستراتيجيات التخفيف من حدة تلك الاضطرابات.

طرق البحث: في الفترة من أكتوبر/ تشرين الأول إلى ديسمبر/ كانون الأول 2021، أجرينا مقابلات مع مسؤولي التنسيق القُطريين التابعين لمنظمة الصحة العالمية، المعنيين بالأمراض غير السارية، في 16 بلدًا من بلدان إقليم شرق المتوسط، وحللنا تلك البيانات.

النتائج: تعطلت خدمات الرعاية الطارئة والأولية في معظم البلدان. وتعرَّضت خدمات الرعاية الأولية لتعطُّل تام في أحد البلدان، بينما شهدت 7 بلدان تعطلاً بنسبة ٪50 على الأقل. وكانت نسبة الخدمات الأساسية لمكافحة الأمراض غير السارية التي تعطلت تعطلاً كاملاً أعلى ما تكون في بلدان الشريحة الدنيا من الدخل المتوسط. وكانت الخدمات المتخصصة، ومنها فحص السرطان والعلاج الإشعاعي، أشد تضررًا، بينما ظلت خدمات غسيل الكلى تسير جيدًا نسبيًّا. وكانت أكثر أسباب التعطُّل ذكرًا هي الخوف من العدوى، ونقل الموظفين للتصدي لجائحة كوفيد-19، وعدم الحصول على الخدمات بسبب الإغلاق، وإلغاء الإجراءات الاختيارية. وتمثلت بعض تدابير التخفيف في استخدام التطبيب عن بُعد، والاستعانة بمتطوعين من المجتمع المحلي، وتوصيل الأدوية إلى المنازل.

الاستنتاجات: تسببت جائحة كوفيد-19 في تعطُّل خدمات مكافحة الأمراض غير السارية في إقليم شرق المتوسط، ولكن بعض البلدان اتخذت تدابير للتخفيف من حدة التعطُّل. ويوجد احتياج إلى استراتيجيات وطنية وإقليمية طويلة الأجل ومستدامة ومتكاملة ومُنسَّقة جيدًا، تكفل استمرار خدمات مكافحة الأمراض غير السارية في أثناء حالات الطوارئ والجوائح.

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