A review of access of persons with disabilities to health care services in the Eastern Mediterranean Region

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Abstract

Background: The World Health Organization estimates that 14.7% of the Eastern Mediterranean Region population has significant disabilities, and this figure could increase due to aging, the burden of noncommunicable disease, war, and disaster.

Aim: To identify and document the facilitators and barriers to accessing health care services by persons with disabilities in the Eastern Mediterranean Region.

Methods: We searched Medline and Web of Science for peer-reviewed literature published in English or Arabic on health equity for persons with disabilities in the Eastern Mediterranean Region, from 2011 to July 2023.

Results: Thirty-six of the 23 284 publications identified met the inclusion criteria. Disability inclusion in health service provision varied across several countries in the region. Financial barriers, inaccessible or unaffordable transportation, and lack of training of health professionals were the most reported challenges to accessing health care for persons with disability. The most reported facilitators of access were application of spatial accessibility models for severe disabilities, improvements in communication with caregivers, and online training courses to improve the attitude of health care providers and reduce stigma.

Conclusion: Persons with disabilities in the Eastern Mediterranean Region still face health care barriers. To improve access to services, there is a need to improve health communication with and among them; train health care providers on inclusive care; provide financial, transportation and telehealth support; and formulate and implement inclusive evidence-based policies and programmes.

Keywords: disability, health care, health access, inclusive care, disability inclusion, Eastern Mediterranean

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Introduction

Approximately 16% of the global population and 14.7% in the Eastern Mediterranean Region (EMR) lives with significant disability (*1*), and this figure could increase due to aging, noncommunicable disease, and the impact of war, conflict and natural disasters. Disability is a result of the interplay between impairment or health conditions and personal or environmental factors, including personal attitude, physical access to infrastructure, discriminatory legislation, gender, and age (*1*).

Progress has been made in the EMR with the ratification of the Convention on the Rights of Persons with Disabilities (CRPD) by 21 of the 22 countries and territories, alongside increasing self-advocacy and government commitment (*2,3*). The United Nations Universal Health Coverage declaration and Sustainable Development Goal (SDG) 3.8 emphasise equitable health access without catastrophic costs, but evidence indicates that this goal is unmet for many (*1,3*). Persons with disabilities remain one of the most marginalised and underserved groups in the EMR, who face disproportionate barriers due to conflict, displacement, poverty, and fragmented health systems (*3*). Hence, disability inclusive health care service is a priority in the region.

This scoping review aims to contribute to available literature on the attainment of Universal Health Coverage (UHC) by persons with disabilities in the EMR (*3,4*). It examines access to health care services, an essential yet under-researched element of health equity for persons with disabilities. It explores the facilitators and barriers to health care access and highlights gaps and opportunities for advancing health equity for persons with disabilities in the region.

Methodology

We searched available published literature on access to health by persons with disabilities in the EMR. Access

is defined as the alignment of health services with the needs and expectations of health users across multiple components, including availability, accommodation, accessibility, acceptability, awareness, and affordability (5,6). This definition overlaps with the commonly used availability, accessibility, acceptability, quality (AAAQ) framework (7). We used the population concept and context framework as agreed in consultation with the WHO internal advisory panel set up specifically to provide oversight and guidance to the consultants on this review (8). Using this concepts, we followed Arksey & O'Malley's methodological framework (Table 1) (9).

Results

Of the 23 284 records identified from the 2 databases and 30 records from grey literature (Figure 1), 36 studies were included: Saudi Arabia (11), Islamic Republic of Iran (8), Jordan (5), Pakistan (4), Afghanistan (3), Kuwait (3), Sudan (1) and Egypt (1) (Table 3). Awareness was the most reported access element, with a total of 16 studies

Table 1 Methodology based on Arksey & O'Malley's methodological framework

Step	Description
Identify the research question(s)	• What are the barriers and facilitators of access to healthcare services experienced by persons with disabilities worldwide? • What are interventions applied in EMR countries that have an effect on removing these barriers?
Identify relevant studies	**Search strategy** MEDLINE (Ovid) and Web of Science databases were searched given that they were also used in the scoping review of the WHO Global report on health equity for persons with disabilities. Databases were searched using medical subject headings (MeSH) terms, proximity, truncation, and Boolean operators. **Selection criteria** Studies published in English or Arabic from 2011 (when the first WHO-World Bank world report on disability was published) until 13 July 2023, excluding those focusing on mental illness due to construct differences (10,11). Papers were excluded if they lacked relevant data on health care access for persons with disabilities. Studies unrelated to the EMR, or not meeting inclusion criteria regarding language and publication dates were also excluded. The review adhered to the Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) guidelines for evidence synthesis (12). Grey literature and websites of key organisations of persons with disabilities and international organisations were searched (Table 2).
Select study	All studies derived from the 2 databases were deduplicated and then a reviewer screened all the 21 468 titles and abstracts. Eighty-four publications eligible for full-text review were independently assessed for eligibility by 2 authors (Figure 1). Disagreements were discussed and unresolved cases were reviewed by a third author for a final decision. Thirty records from grey literature were identified but they were rejected because they did not meet the eligibility criteria as they did not assess health equity.
Chart the data (including interpretation and synthesis)	Information about the author(s), year of publication and country in which the study was conducted was extracted for each included article.
Collate, summarise and report the results	Findings of the scoping review were narratively synthesised and structured according to the 6 access dimensions (5,6).

Table 2 Scoping review search strategy

Search step	Search block
1	exp Disabled Persons/
2	Disabilit* OR impair*
3	exp Health Services Accessibility/OR Universal Health Coverage OR Primary Care
4	exp Healthcare Disparities/
5	(Access* OR Inclus* OR barrier* OR facilitator* OR barrier* OR challeng* OR inaccess* OR obstacle* OR uptak* OR equal* OR equit* OR utili$* OR determinant* OR affordab* OR availab* OR accomm* OR accepta* OR awareness OR stigma* OR help*seeking OR attitud* OR training)
6	Iran OR Egypt OR "Saudi Arabia" OR Tunisia OR Pakistan OR Morocco OR Lebanon OR Jordan OR Kuwait OR United Arab Emirates OR Oman OR Qatar OR Iraq OR Sudan OR Syria OR Palestine OR Bahrain OR Libya OR Yemen OR Afghanistan OR Djibouti OR Somalia
7	1 or 2
8	3 or 4 or 5

Table 3 Summary of included studies by country, author and population

Country	Lead author and year	Study population
Jordan	Aburahma 2021	83 children with cerebral palsy and 84 healthy children were included as comparators
Pakistan	Ahmad 2013	245 rural men and women with physical disabilities
Saudi Arabia	Akeely 2022	166 emergency physicians working in different centres in Riyadh
Kuwait	Al-Daihani 2022	240 parents of people with disabilities attending a special educational school in Kuwait
Jordan	Al-Zboon 2016	54 dentists
Saudi Arabia	Aldharman 2023	613 people with neurological disorders
Kuwait	Alduhaim 2020	21 parents of children with hearing loss attending the Sheikh Salem Al-Ali Centre for Hearing and Speech in Kuwait
Kuwait	Alduhaim 2021	6 employees of the Sheikh Salem Al-Ali Centre for Hearing and Speech in Kuwait
Saudi Arabia and USA	Alkahtani 2014	131 dental students at King Abdulaziz University in Saudi Arabia and 76 at Tufts University School of Dental Medicine, USA
Saudi Arabia	Alkawai 2017	235 persons with physical disability at King Abdul Aziz Medical City, Riyadh
Jordan	Almhdawi 2022	198 undergraduate medical students
Saudi Arabia	Alodaibi 2022	12 physiotherapists
Saudi Arabia	Aloola 2023	303 pharmacists working in the Saudi Arabia community and outpatient pharmacies
Saudi Arabia	AlQahtani 2017	1000 dentists with various areas of specialisation who were proficient in English and eligible for practice in Saudi Arabia
Saudi Arabia	Alqassim 2022	289 persons with auditory and physical disabilities
Saudi Arabia	Alwadi 2022	10 children aged 9–15 years with intellectual disabilities and physical impairments attending special centres in Riyadh
Islamic Republic of Iran	Azadnia 2022	548 people with disabilities
Sudan, Namibia, Malawi and South Africa	Eide 2015	9307 individuals in Sudan, Namibia, Malawi, and South Africa
Saudi Arabia	Elkholi 2023	316 caregivers of children with disabilities from Riyadh
Jordan	Hassona 2021	26 parents of 26 individuals with intellectual disabilities (10 males and 6 females)
Austria, Egypt, Greece, India and Serbia	Isaksen 2022	Academics and health care professionals
Islamic Republic of Iran	Jafarabadi 2021	202 participants, including families of and children with ASD aged 2–16 years with an ASD diagnosis in the North-West of Islamic Republic of Iran
Pakistan	Khan 2017	People with disabilities
Iran	Kiani 2022	16 186 records of people living with disability
Pakistan	Mahmood 2022	6711 women aged 15–49 years with a live birth in the 5 years preceding the survey, with and without disabilities
Jordan	Masri 2023	Parents of children with ASD aged 2.5–17 years and who attended paediatric neurology clinics in 3 different university affiliated hospitals in 3 geographic areas in Jordan from February to December 2018
Islamic Republic of Iran	Matin 2019	403 adults with physical and/or intellectual disabilities
Islamic Republic of Iran	Mohebbi 2014	59 final year dental students
Afghanistan	Nasiri 2023	14 520 households across all 34 provinces. The adult tool of the survey was administered to a randomly selected household member aged ≥18 years.
Islamic Republic of Iran	Shirozhan 2022	18 persons including 12 nurses in clinical and managerial positions, an occupational therapist, a physical medicine specialist, a patient, and an informal caregiver
Islamic Republic of Iran	Soltani 2016	50 participants including people with disability, health care services providers and policymakers
Islamic Republic of Iran	Soltani 2019	56 individuals including people with disability, health care providers and policymakers
Afghanistan	Trani 2012	2696 people with disabilities or their caregivers
Afghanistan	Trani 2022	1861 newly recruited CBR participants with disabilities from 169 villages between July 2012 and December 2013, and 1132 controls screened with disabilities
Pakistan	Yawar 2022	Seven occupational therapists (5 females and 2 males)
Saudi Arabia	Zahran 2023	602 caregivers of children with autistic spectrum disorder (ASD), Down syndrome, cerebral palsy, and developmental delay

reporting data, followed by 12 studies on affordability, 11 studies on accessibility, 9 studies on availability, 8 studies on accommodation and 5 studies on acceptability. The following is a thematic overview of the studies reviewed:

Availability

Nine studies reported data on the availability of health care services. In Sudan, more than 40% of persons with disabilities reported lack of services as a major barrier to accessing health care, while 30% noted insufficient drugs and equipment (*14*). More than half of 548 persons with disabilities in Islamic Republic of Iran reported unmet outpatient care needs, with gaps largest in rehabilitation (73%) and dentistry (70%) (*15*).

Disparities between urban and rural services emerged across multiple countries. In Pakistan, funding and infrastructure deficits were reported, especially in rural areas (*16,17*), and rehabilitation services remain underdeveloped (*16*).

The COVID-19 pandemic exacerbated accessibility issues; a regional report found only 4 of 18 assessed EMR countries had disability-inclusive response plans (*18*). In Saudi Arabia, caregivers of children with disabilities reported rehabilitation service reductions, negatively impacting development (*19*) and telemedicine emerged as a potential solution to address accessibility problems at the time (*1,19*).

Facilitators of availability

There were barriers to telehealth adoption especially in rural and low-resource areas, due to internet access issues. Asynchronous solutions like web applications offered alternatives (*20*). A government-run rehabilitation centre in Karachi, Pakistan, implemented a low-cost telehealth system to facilitate therapy-related communication between caregivers and therapists. One user reported that remote support reduced travel burdens and improved home care (*21*).

An initiative aimed to enhance accessibility through community-based rehabilitation (CBR) programmes in Afghanistan enhanced access to physical therapy; however, disparities in wealth continued to contribute to unmet health care needs (*22*).

Accommodation

A common theme from the 8 studies reporting on accommodation was dissatisfaction with the physical environment and unsuitability of hospitals waiting areas for persons with disabilities.

A survey of 235 persons with physical disabilities in Saudi Arabia found high dissatisfaction with hospital facilities: over 52% with parking, 50% with waiting areas, 51% with wheelchair services, and 45% with toilets (66% reported a lack of emergency buttons or phones in toilet facilities) (*23*). Consequently, over 88% required accompaniment for hospital visits. In this study, wheelchair users reported lower satisfaction with physical accessibility. In another study in Saudi Arabia, over half found health care facilities unaccommodating, with one participant noting that the limitations were exhausting, prompting them to seek service from traditional healers instead (*24*).

Reasonable adjustments, such as priority or extended appointments, may help mitigate access barriers for persons with disabilities (*1*).

In Afghanistan, individuals with moderate to severe disabilities rated waiting time poorly (*25*). Parents of children with disabilities in Jordan expressed frustration due to overcrowded hospitals, lack of elevators and unsuitable waiting rooms (*26*). Children with disabilities in Saudi Arabia described long waiting time as a barrier in dental care clinics (*27*). In Kuwait, short session time and restricted parental presence during service delivery for children with hearing loss hindered relationships with service providers and opportunities for home care guidance (*28*).

Accessibility

Eleven studies reported on accessibility of health care services. Barriers identified were cultural, financial and logistic with transportation emerging as a critical issue (*29-31*).

In Pakistan, persons with disabilities noted that inaccessible approach roads, entrances, waiting places and toilets were barriers to accessing health care (*32*). Poor health care access may reflect the broader systemic challenges. For example, a national household survey in Afghanistan reported low overall health service utilisation largely due to service inaccessibility (*33,34*).

Facilitators of accessibility

In Islamic Republic of Iran, a network analysis was conducted to model spatial accessibility of hospitals for persons with disabilities. Less than one-third of persons with disabilities had appropriate access to hospital services (*35*). The study reported that spatial accessibility can improve physical accessibility for persons with disabilities.

Acceptability

Five studies reported on acceptability. Public stigma towards persons with disabilities remains a global issue, affecting individuals at personal, family, public, and structural levels (*36*). A multicountry study reported negative attitudes in the EMR, often reinforcing self and family stigma (*37*).

In Jordan, dentists in general hospitals exhibited highly positive attitudes toward persons with intellectual disabilities, but social desirability bias and small sample size may have influenced the results (*38*). Conversely, a study in Islamic Republic of Iran showed that health care providers displayed negative attitudes and were sometimes reluctant to treat, leading to a cycle of fear and distrust towards the health system among persons with disabilities (*29*).

Women with disabilities face complex barriers, including restricted access to sexual and reproductive

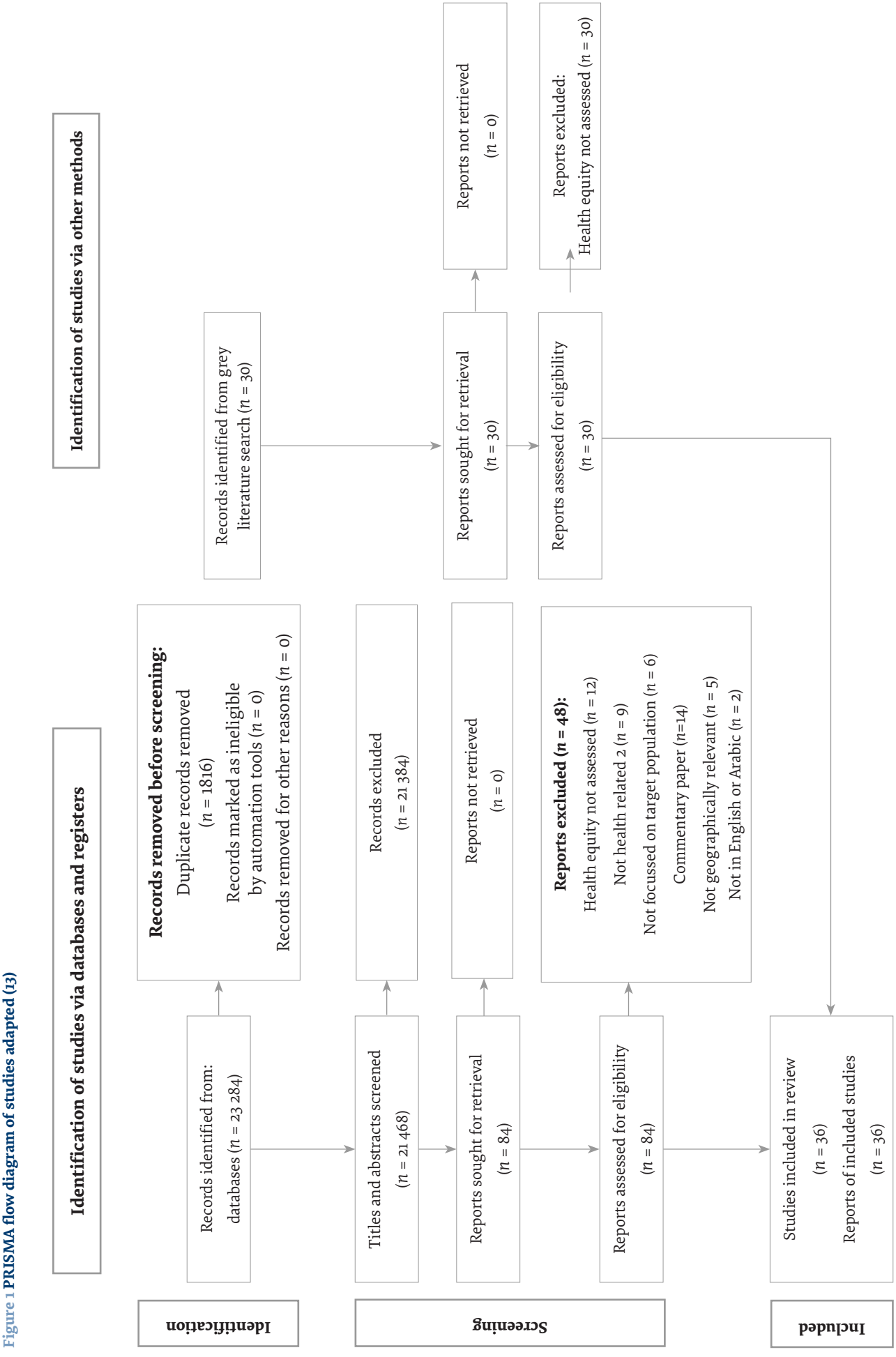

Figure 1 PRISMA flow diagram of studies adapted (13)

health information, limited or no family planning choices, forced sterilisation, and higher rates of intimate partner violence (*39,40*). In Islamic Republic of Iran, it was reported that women with disabilities may feel ashamed to talk about their issues with health care providers (*29*). Similar findings were reported in Pakistan, hindering reproductive health care access for women with disabilities (*32*). However, a more recent secondary analysis of a Pakistan health survey reported no statistically significant differences in the use of reproductive health services between women with and without disabilities, after adjusting for covariates (*41*).

Awareness

Sixteen studies reported on awareness. Health care providers in Islamic Republic of Iran showed a lack of awareness about disability and related health needs (*29*). A study in Saudi Arabia reported that a high proportion of emergency physicians lacked the skills to communicate effectively with deaf patients. Research recommended structured education, clear policies and access to specialised interpreters to improve response by physicians to deaf patients (*42*). Pharmacists in Saudi Arabia also expressed the need for training (*43*). More than half of 289 participants with hearing impairments and physical disabilities struggled to find specialised doctors or dentists in Saudi Arabia (*24*).

Persons with disabilities experience poorer oral health than the general population (*44,45*). In Saudi Arabia, 602 children with disabilities identified fear of the dentist (61%) and child uncooperativeness (38%) as the most common barriers to accessing dental care. Twenty-nine percent of parents reported that dentists were unwilling to treat their children, because they were not trained or had inadequate facilities (*46*). Similar challenges were reported in Jordan, where parents expressed concerns that primary dental care providers were not adequately equipped to manage children with disabilities (*26*).

Globally, disability-related training in health care remains inadequate (*47*). In Saudi Arabia, only 12% of dental students agreed that their training has equipped them to communicate effectively with individuals with developmental disabilities (*48*). In another Saudi Arabia study, only 14% of dentists reported high confidence in treating adults with disabilities, with paediatric dentists demonstrating significantly higher self-efficacy than non-paediatric specialists (*49*). This training gap extends beyond dentistry; physiotherapists in Saudi Arabia reported limited preparation to promote health care among persons with disabilities (*50*).

In addition to effective communication, effective information strategies are key components of awareness. In Kuwait, parents were less likely to seek health care information due to limited Arabic language resources, insufficient social agencies websites as well as printed and electronic resources. (*51*). In Saudi Arabia, online health information-seeking behaviours varied by region, suggesting targeted educational campaigns to improve access to services (*52*).

Facilitators of awareness

Some training initiatives have improved service provider responsiveness. In Kuwait, a training package enhanced confidence and communication during early intervention for children with hearing loss (*53*). Another study in Kuwait found that most parents of children with hearing disabilities preferred a variety of communication methods to maximise understanding and comprehension of their child's diagnosis and treatment (*28*).

Communication partner training in Egypt aimed to improve interactions between persons with aphasia and health care professionals (*54*). Communication partner training is an umbrella term for interventions that aim to optimise communication between people with aphasia and a range of communication partners, including health care professionals, volunteers and family members, through components that include education, strategy identification, feedback and practice delivered to individuals, dyads and groups with/without the person with aphasia present, across a range of health and social care settings (*54*). In Islamic Republic of Iran, a 4-session disability management programme significantly improved the knowledge and attitudes of dental students (*55*). One study proposed integrating rehabilitation principles, teamwork skills and proper workplace design into nursing education to enhance disability care (*56*). A study from Jordan found that an 8-week elective improved the understanding and attitudes of medical students about disabilities, with no difference in effectiveness between online and in-person formats (*57*).

Affordability

Affordability emerged as a crosscutting issue. Disability imposes financial burdens, including transportation, assistive devices and long-term rehabilitation costs, which are often excluded from national health systems or insurance (*58*). UHC aims to ensure health care access without financial hardship, yet global reviews highlight income as a major determinant of access (*59,60*).

Persons with disabilities struggle with navigating health insurance and funding systems (*1*). In Islamic Republic of Iran, 42% of study participants who received rehabilitation services reported borrowing money for health care, with higher-income individuals having better access. Rehabilitation services, such as occupational therapy and assistive devices, were not covered by insurance (*31*).

Lower socioeconomic status among children with autism correlated with reduced health care access in Islamic Republic of Iran (*61*). In Jordan, children with cerebral palsy may have faced dental care barriers due to cost, fear and parental knowledge and attitude regarding the importance of oral care (*62*), while in Saudi Arabia, financial constraints were ranked third among barriers to accessing dental care for children with disabilities (*46*). Cost was reported as the primary barrier to autism

services in Jordan, with therapy expenses consuming up to a third of household income (*63*).

In Islamic Republic of Iran, persons with disabilities reported better access to health care services when they had supplemental insurance, highlighting the importance of expanding insurance coverage to improve service utilisation. However, gaps in insurance coverage persist, particularly for essential services such as rehabilitation and dental care, resulting in limited access to care or exposure to catastrophic health expenditures (*15*).

Four financial barriers to health care were identified in Islamic Republic of Iran: lack of insurance coverage for key services, low income among persons with disabilities, inadequate pensions, and high transportation costs (*30*). In Saudi Arabia, monthly income correlated with increased willingness to seek online health information (*52*).

Public transport remains largely inaccessible to persons with physical disabilities, forcing them to rely on expensive taxis (*30,32*). Among 274 parents of children with autism spectrum disorders in Jordan, nearly 40% cited transportation difficulty as a barrier to health care access (*63*). Similarly, health care costs prevented persons with moderate and severe disabilities in Afghanistan from seeking care (*24*). However, a national household survey in Afghanistan found no wealth-based disparity in health care utilisation due to widespread poverty (*34*). However, persons with disabilities reported higher medical expenses than persons without disabilities. Persons with disabilities in Sudan reported significant barriers to health care, with affordability cited as the top concern (*14*).

Discussion

This scoping review presents a regional overview of barriers faced by persons with disabilities in accessing health care and highlights interventions that have been valuable in improving access.

Stigma and discrimination

Acceptability is a core factor affecting access to health care. Surveys show lower acceptability scores among those with physical disabilities in the EMR, different from countries in other regions where persons with intellectual disabilities are more likely to report acceptability issues (*23*). This is probably because persons with intellectual disabilities have difficulties articulating their experiences during traditional surveys, emphasising the need for accessible, co-developed instruments for inclusive health policy research (*31,64*) in the EMR.

It is encouraging to note that some studies focused on certain groups of persons with disabilities at a higher risk of discrimination. Women with disabilities face complex exclusion (*65*). Our findings suggest that women experience shame, have difficulty with disclosure and experience persistent provider misconceptions which contribute to discrimination (*29,32*). Some studies show no significant differences in reproductive health service use between women with and without disabilities (*41*).

Enhancing awareness and training

In comparison to dental students in the USA, dental students in Saudi Arabia felt less equipped to communicate effectively with and treat individuals with developmental disabilities, often citing lack of training (*48*). Short-term training has been shown to improve the knowledge and attitude of dental and medical students towards persons with disabilities, even online (*55,57*). Enhancing the awareness of health care providers is vital in countering self-stigma, public stigma and reluctance to treat persons with disabilities, which contributes to mistrust and reduced health care engagement (*26,29,38*).

Educational programmes to improve attitudes towards persons with disabilities should be embedded in the medical training curricula, and online and in-person training formats have shown similar effectiveness (*57,66*). Global evidence confirms that social contact alongside education significantly reduces stigma (*67*), with similar results observed in the EMR (*48*).

Accommodating service users

Regional research highlights the importance of using mixed communication methods by providers (*28*) and the need for health care information to be provided in the first language of the health seeker and other accessible formats (*51,63*), in line with the global evidence review (*1*). Telehealth services increase availability of and access to some services (*1*), and international standards are available for increasing accessibility of telehealth services in promoting equitable access (*22*). Researchers should investigate the effectiveness of such initiatives in increasing acceptability in the EMR.

Cost of health care services

Financial barriers emerged as a major crosscutting theme. Limited coverage of services and insufficient supply of medicines and medical equipment drive high expenditures for persons with disabilities in the EMR. Inadequate subsidies further exclude them from formal health care (*32*). Poor health subsidies or lack of insurance limit access (*68*) and further exclude persons with disabilities from formal health care (*1,10,31*). Closely linked to this barrier in the EMR was transportation, consistent with reports in literature globally that non-existent or unaffordable transportation barriers hinders accessibility up to 15 times among persons with disabilities more than the general population (*1*). Regional advocacy calls for improved affordability and access to essential health services for persons with intellectual disabilities (*69*).

Regional gaps and challenges

Research in the EMR have consistently highlighted the need for further research on disability-related issues (*70*). Stigma remains prevalent and it renders persons with disabilities hidden from society. Recommendations from our studies highlight the need for research on the

impact of programmes on the responsiveness of health care professionals and financial barriers, considering alternative payment mechanisms and subsidies, and for elaboration on universal access to information on puberty, family planning, pregnancy, and menopause (*4*).

Another challenge is the dearth of inclusive and accessible methodology to capture the perceptions of persons with disabilities (*71*). Engaging persons with disabilities in research is a key action for disability inclusion (*1*). Some researchers who have reported using inclusive methodology to work with children with disabilities have noted that the children want to be listened to, respected, valued, and given truthful information (*27*). This approach can be adapted and adopted across the EMR. Health care professionals should be trained in different types of communication methods, tailored to different types of disabilities. Collecting feedback through participatory approaches can be effective in identifying barriers and context-specific adaptations (*1*).

Although many countries in the EMR are in conflict and emergency settings, only a few published studies have captured the access of persons with disabilities to health care services, despite evidence that persons with disabilities are at higher risk during conflicts, which reduce the availability of assistive devices and access to basic services while increasing abuse and stigma (*1,72*).

Strengths and limitations of this review

This review is among the first to examine peer-reviewed literature on health care access for persons with disabilities across the EMR, including all access components, diverse health care contexts and perspectives from key stakeholders. Although the authors carefully selected 2 of most relevant scientific databases, it would be desirable to run the search in more databases. Only articles published in English and Arabic were included, perhaps limiting representation from certain countries like the francophone EMR countries.

Conclusion

This review presents an overview of published literature on access to health services by persons with disabilities in the Eastern Mediterranean Region. Despite efforts by governments across the EMR to increase access to health care for all, persistent barriers remain. These include gaps in training of health care providers and the resulting inability to communicate well with persons with disabilities. Financial and transportation barriers limit access, while telehealth and targeted training interventions show promise and need to be evaluated. The limited availability of data on disability impedes the formulation and refinement of inclusive, evidence-based policies and programmes to improve health care for persons with disabilities across the region. Greater representation of the voices of persons with disabilities in research on access to health care services in conflict-affected and emergency settings are essential in achieving Universal Health Coverage.

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Examen de l'accès des personnes en situation de handicap aux services de soins de santé dans la Région de la Méditerranée orientale

Résumé

Contexte : L'Organisation mondiale de la Santé estime que 14,7 % de la population de la Région de la Méditerranée orientale souffre d'importants handicaps, et ce chiffre pourrait augmenter en raison du vieillissement, de la charge des maladies non transmissibles, des guerres et des catastrophes.

Objectif : Identifier et documenter les facilitateurs et les obstacles à l'accès des personnes en situation de handicap aux services de soins de santé dans la Région de la Méditerranée orientale.

Méthodes : Nous avons effectué une recherche dans MEDLINE et Web of Science pour recenser la littérature évaluée par des pairs, rédigée en anglais ou en arabe, portant sur l'équité en santé des personnes en situation de handicap dans la Région de la Méditerranée orientale, couvrant la période de 2011 à juillet 2023.

Résultats : Trente-six des 23 284 publications répertoriées répondaient aux critères d'inclusion. La prise en compte du handicap dans la prestation de services de santé varie d'un pays à l'autre dans la Région. Les obstacles financiers, les difficultés liées à des transports inaccessibles ou inabordables, ainsi que le manque de formation des professionnels de santé figuraient parmi les principaux freins à l'accès aux soins pour les personnes en situation de handicap. Les principaux facilitateurs de l'accès aux soins les plus fréquemment signalés concernaient la mise en œuvre de modèles d'accessibilité spatiale pour les handicaps sévères, l'amélioration de la communication avec les aidants, ainsi que la mise en place de formations en ligne visant à améliorer les attitudes des professionnels de santé et à réduire la stigmatisation.

Conclusion : Les personnes en situation de handicap dans la Région de la Méditerranée orientale continuent de se heurter à des obstacles en matière de soins de santé. Afin d'améliorer l'accès aux services, il est nécessaire de renforcer la communication en santé avec les personnes en situation de handicap et entre elles, de former les professionnels de santé aux soins inclusifs, de fournir un soutien financier, en matière de transport et de télésanté, ainsi que d'élaborer et de mettre en œuvre des politiques et des programmes inclusifs fondés sur des données probantes.

استعراض لإمكانية حصول الأشخاص ذوي الإعاقة على خدمات الرعاية الصحية في إقليم شرق المتوسط

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الخلاصة

الخلفية: تشير تقديرات منظمة الصحة العالمية إلى أن 14.7% من سكان إقليم شرق المتوسط لديهم إعاقات كبيرة، وقد يزيد هذا الرقم بسبب الشيخوخة، وعبء الأمراض غير السارية، والحرب، والكوارث.

الأهداف: تحديد وتوثيق العوامل التي تُيسِّر حصول الأشخاص ذوي الإعاقة على خدمات الرعاية الصحية في إقليم شرق المتوسط، والعوائق التي تحول دون حصولهم عليها.

طرق البحث: بحثنا في موقعَي Medline و Web of Science عن المؤلفات المُحكَّمة المنشورة باللغة الإنجليزية أو العربية بشأن الإنصاف الصحي للأشخاص ذوي الإعاقة في إقليم شرق المتوسط في المدة من 2011 إلى يوليو/ تموز 2023.

النتائج: استوفى 36 منشورًا من أصل 23284 منشورًا مُحدَّدًا معايير الشمول في الدراسة. وتباينت مراعاة ذوي الإعاقة عند تقديم الخدمات الصحية في عدة بلدان بالإقليم. وكانت العقبات المالية، ووسائل النقل التي يتعذر الوصول إليها أو التي لا يمكن تحمُّل تكلفتها، ونقص تدريب المهنيين الصحيين أكثر التحديات المُذكورة التي تحول دون حصول الأشخاص ذوي الإعاقة على الرعاية الصحية. وكانت أكثر العوامل المُيسِّرة المذكورة هي تطبيق نماذج تيسير وصول ذوي الإعاقات الشديدة إلى أماكن تقديم الخدمات، وإدخال تحسينات على التواصل مع مقدمي الرعاية، وعقد دورات تدريبية عبر الإنترنت لتحسين موقف مقدمي الرعاية الصحية والحد من الوصم.

الاستنتاجات: لا يزال الأشخاص ذوو الإعاقة في إقليم شرق المتوسط يواجهون عقبات في تلقِّي الرعاية الصحية. ولتحسين حصولهم على الخدمات، لا بد من تحسين التواصل الصحي معهم وفيما بينهم، وتدريب مقدمي الرعاية الصحية على الرعاية الشاملة للجميع، وتوفير الدعم المالي والدعم الخاص بالنقل وبالخدمات الصحية المُقدمة عن بُعد، وصياغة سياسات وبرامج شاملة للجميع ومُسندة بالبيِّنات وتنفيذ تلك السياسات والبرامج.

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