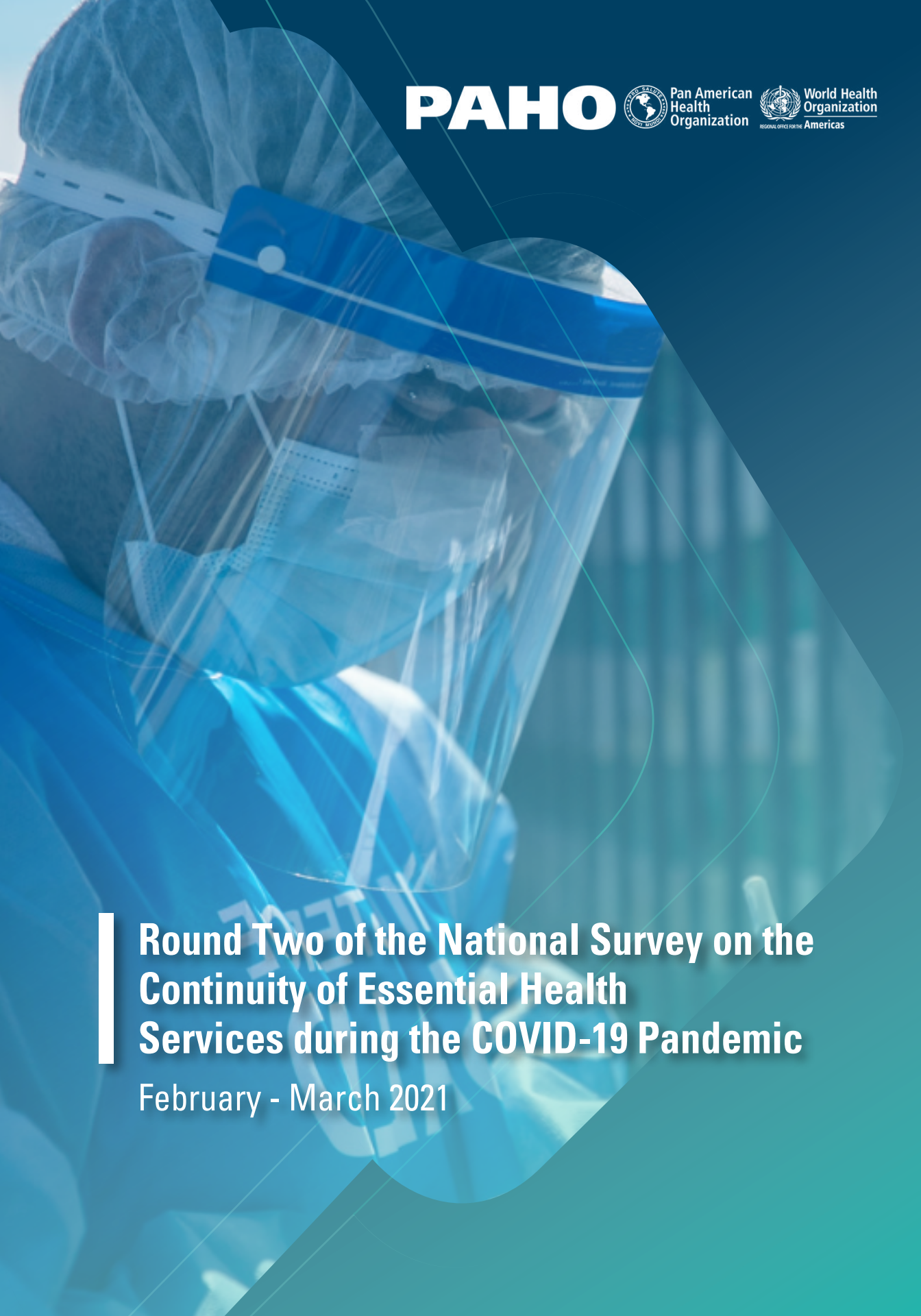

PAHO Pan American Health Organization

World Health Organization Regional Office for the Americas

Round Two of the National Survey on the Continuity of Essential Health Services during the COVID-19 Pandemic

February - March 2021

ROUND TWO OF THE NATIONAL SURVEY ON THE CONTINUITY OF ESSENTIAL HEALTH SERVICES DURING THE COVID-19 PANDEMIC

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SUMMARY

The Pan American Health Organization (PAHO) and the World Health Organization (WHO) are monitoring disruptions in the delivery of essential health services in the context of the coronavirus (COVID-19) pandemic. PAHO and WHO have implemented two rounds of pulse surveys, one in 2020 and one in 2021, with the aim of assessing the magnitude and extent of the disruptions.

Levels of disruption in essential health services

Overall, 97% of the 29 countries and territories that responded to the second round of the survey reported some level of disruption in the delivery of essential health services, slightly higher than in 2020 (92% of the 25 responding countries).

First-level, palliative, rehabilitative, and long-term care services have been the most affected: 55% of the 20 responding countries reported disruptions at the first level of care that affected the availability of and access to quality health services, especially for the most vulnerable populations.

The provision of life-saving emergency care, intensive care, and surgical services has been disrupted in 20% of the 18 reporting countries, which can have a substantial impact on health outcomes in the short term. In addition, 68% of the 22 responding countries reported disruptions in elective surgical interventions, which could lead to cumulative consequences given the length of the pandemic.

The disruption of services was widespread across all areas of priority health care: reproductive, maternal, newborn, child, and adolescent health; noncommunicable diseases; neglected tropical diseases; communicable diseases; immunization; and mental, neurological, and substance use disorders. On average, the latter groups of services experienced the highest disruptions (in 60% of the 27 responding countries).

In 2021, the magnitude and extent of interruptions increased slightly across countries: on average, 46% of the 35 tracer services were interrupted, compared to 44% in 2020. The largest increase in the magnitude and extent of interruptions was observed in communicable disease care services, immunization services, and reproductive, maternal, newborn, child, and adolescent health services.

Reasons for the disruptions

To some extent, the disruptions have been the result of intentional strategic changes to service delivery. Of 25 countries, 60% limited or suspended one or more service delivery platforms and 64% suspended or limited the provision of essential public health services.

The most frequently cited reason for disruptions is the insufficient availability of health personnel: 72% of the 25 countries that responded reported this reason. In addition, 32% of 25 countries reported supply chain disruptions during the three months prior to survey implementation. These supply chains are essential for the treatment of diseases that require management, such as hypertension and diabetes.

On the demand side, the most frequently mentioned reasons were community fear or mistrust when seeking care (reported by 60% of the 25 responding countries), travel restrictions that made it difficult to access health facilities (56% of 25 countries), and a drop in outpatient volume due to a higher volume of patient no-shows (54% of 24 countries).

Responses to minimize disruptions

Most countries have implemented policies and plans to provide continuity for essential health services: 92% of 23 countries reported that they had a national list of health services that should continue to be provided during the pandemic.

Strategies to mitigate service disruptions are being implemented in many countries. The most frequently observed strategies include: triage to identify care priorities (88% of 25 countries); provision of home-based care when appropriate (80% of 25 countries); community communication strategies (76% of 25 countries); and use of telemedicine technologies to replace in-person visits (76% of 25 countries).

In addition, 68% of 25 countries reported that they regularly monitor the continuity of essential health services during the COVID-19 pandemic and implement mitigation strategies to overcome disruptions. In addition, a team has been appointed in 53% of 25 countries to track and address health misinformation and infodemics.

Conclusions

The survey of key informants from 29 countries shows that, more than a year into the pandemic, health systems still face significant challenges. Almost all countries reported disruptions in the delivery of at least one service, as well as disruptions in all priority areas, highlighting the widespread magnitude of the pandemic's impact on health systems.

Moderate disruptions are likely to affect health outcomes: this is particularly worrisome in settings where progress toward universal access to health and universal health coverage was already limited, such as areas affected by violence and vulnerable environments. In this regard, ensuring that quality health services continue to be available and accessible is the most important priority, especially in the long term, when considering the pandemic's indirect and sustained consequences. As part of this effort, special emphasis needs to be placed on populations that were already vulnerable prior to the pandemic.

In 2021, the delivery of and access to essential health services continue to be disrupted, as was observed in 2020. In the countries that participated in both rounds, the average percentage of services disrupted increased slightly, from 44% in 2020 to 46% in 2021. This highlights the urgency of strengthening efforts to ensure that these services continue to be provided, and to do so with the same intensity as the actions being taken to control COVID-19 cases.

The magnitude and extent of disruptions in the delivery of essential health services have persisted since 2020, and have even increased in some areas. In others, the magnitude of the disruption has declined significantly. Additionally, almost all countries have intensified their efforts to respond to systems challenges, bottlenecks, and barriers to access that have been caused or exacerbated by the COVID-19 pandemic.

PAHO and WHO will continue to support countries in closing the remaining gaps in health service delivery and continue to respond to the constantly changing priorities and needs throughout the pandemic. They will also ensure that strategies to control COVID-19 are balanced with other health priorities in order to ensure continuous access to comprehensive health services.

INTRODUCTION

Countries in the Region of the Americas and around the world have been facing a number of challenges as they strive to ensure that health systems maintain the continuity of essential services while combating the coronavirus (COVID-19) pandemic. During this period, the delivery of essential health services for women and children, such as vaccination services for young children, care for pregnant women and new mothers, and the possibility of safe delivery attended by skilled health workers, has been disrupted in many of the Region's countries (*1*).

The same situation has been observed for the delivery of services for noncommunicable diseases, due to the cancellation of care services, closure of screening programs, and reassignment of specialized personnel, among other reasons (*2*). This is concerning, because people who have underlying health conditions, such as noncommunicable diseases, are more likely to become seriously ill if they get COVID-19 and to die from the disease. In addition, mental health disorders such as fear, depression, and stress have increased in the context of the pandemic, while the provision of essential services to address these conditions has been severely disrupted in the Region (*3, 4*).

To track and better understand the extent of the disruptions to essential health services caused by the COVID-19 pandemic in the Region of the Americas, the Pan American Health Organization (PAHO) has been supporting the implementation of national surveys on the continuity of essential health services during the COVID-19 pandemic. This instrument was developed by the World Health Organization (WHO) to monitor and manage the situation at the global level.

In 2021, the second round of the survey was launched to follow up on the first round, which was conducted in 2020 and consisted of several surveys: the national pulse survey on the continuity of essential health services during the COVID-19 pandemic (*5*); the rapid assessment of the impact of the COVID-19 pandemic on noncommunicable disease resources and services (*6*);

the rapid assessment of the impact of COVID-19 on mental, neurological, and substance use disorder services (*7*); and rounds 1 and 2 of the vaccination survey (*8, 9*).

This report presents the results of the second round of the survey in the Region of the Americas, which was conducted in 2021 and included the main questions from the surveys applied in 2020. In order to ensure coherence and harmonization, the second survey's structure and the explanation of the methodology used are taken from the WHO global report on the results of the second round of the survey (*4*).

The 2021 survey was sent to key informants in 52 countries and territories in the Americas with the goal of rapidly assessing the extent of the impact of the pandemic on essential health services and health systems. The findings provide immediate information on countries' current experiences, the extent of disruptions in a set of tracer services, the reason for the disruptions, and the mitigation strategies that have been implemented.

By providing a quick view of the situation, the survey results can support decisionmakers in taking stock of current challenges, and can be used as a basis for planning processes and resource allocation at the national, regional, and global levels. The findings can be used to support the planning and implementation of mitigation strategies formulated by WHO, namely, the strategies described in the document entitled *Maintaining Essential Health Services: Operational guidance for the COVID-19 context: interim guidance* (*10*), and those identified in the document *Community-Based Health Care, Including Outreach and Campaigns, in the Context of the COVID-19 Pandemic* (*11*).

The results are also used to support actions to mitigate the impact of the pandemic implemented by PAHO's Incident Management Support Team (IMST) (*12*), as well as the actions of the Access to COVID-19 Tools (ACT) Accelerator, specifically those in the Health Systems Connector pillar (*13*).

CHAPTER 1

METHODS APPLIED IN THE SURVEY

1.1 Instrument

The second round of the national survey on the continuity of essential health services during the COVID-19 pandemic consisted mainly of open-ended and multiple-choice questions about the existence of national policies, plans, and structures, disruption of health services, reasons for disruptions, mitigation strategies, monitoring information, and countries' priority needs.

The survey included sections targeting different key actors in each country, including a section on health system functions and cross-cutting services, and sections focused on the disruption of health services in specific areas. In some cases, countries were asked to upload or provide links to their national plans or documents that describe the national package or list of essential health services to be maintained during the pandemic, if available.

Table 1 shows the survey sections and the suggested key informants. The full questionnaire is contained in the document entitled *Second Round of the National Pulse Survey on Continuity of Essential Health Services during the COVID-19 Pandemic: January-March 2021* (4).

Table 1. Survey sections and key informants

Survey sections	Suggested key informants
Health system functions and cross-cutting health services for health promotion, disease prevention, diagnosis, treatment, rehabilitation, and palliative care	Focal points for health system, service delivery, or essential health services
Reproductive, maternal, newborn, child, and adolescent health and nutrition	Focal points for reproductive, maternal, newborn, child, and adolescent health and nutrition
Immunization	Focal points for immunization
Human immunodeficiency virus (HIV) and hepatitis	Focal points for HIV and hepatitis
Tuberculosis (TB)	Focal points for TB
Malaria	Focal points for malaria
Neglected tropical diseases (NTDs)	Focal points for NTDs
Noncommunicable diseases (NCDs)	Focal points for NCDs
Mental, neurological, and substance use disorders	Focal points for mental health and psychosocial support

Across all sections, the survey assessed the continuity of 63 tracer services. The first level of care, emergency care, intensive care, surgery, rehabilitation, palliative and long-term care, and auxiliary services were the service delivery channels included in the survey. Reproductive, maternal, newborn, child, and adolescent health and nutrition, immunization, communicable diseases, noncommunicable diseases, neglected tropical diseases, and mental, neurological, and substance use disorders were the health service areas included. The list of all services evaluated in the survey is provided in Annex 1.

In order to have more accurate data, the second round of the survey modified the questions related to the disruption of specific services. The first round had assessed the disruption of 44 essential health services using three response categories:

- More than 50% of users were not being served as usual.
- 5%-50% of users were not being served as usual.
- Less than 5% of users were not being served as usual.

In the second round, key informants responded to questions about the disruption of 63 essential health services using four response categories:

- More than 50% of users were not being served as usual.
- 26%-50% of users were not being served as usual.
- 5%-25% of users were not being served as usual.
- Less than 5% of users were not being served as usual.

In order to make the results of this report easier to read, the first three response categories were renamed as follows:

- Severe disruption: means that more than 50% of users were not being served as usual.
- Moderate disruption: means that 26%-50% of users were not being served as usual.
- Mild disruption: means that 5%-25% of users were not being served as usual.

In both rounds, respondents could answer "Do not know" if they did not have the information when responding to the survey, or "Not applicable" if the service was not routinely offered in the country.

It should be noted that, among the 44 services evaluated in the first round and the 63 services evaluated in the second round, there is a subset of 35 tracer services that are comparable.

1.2 Information collection process

Information was collected for the second round of the survey through collaboration between WHO and PAHO. The survey was distributed in a secure manner to PAHO officials in the Region's countries, through a web-based questionnaire published using LimeSurvey software, together with instructions on how to respond correctly. It should be noted that the questionnaire was translated into Arabic, Chinese, English, French, Portuguese, Russian, and Spanish to facilitate implementation.

In order to ensure completion of the survey, it was recommended that a country coordinator be designated, with the following functions:

- Identify the health authority coordinators or key informants who should complete each survey section.
- Send the survey link to the health authority coordinators or key informants.
- Follow up on the response to each survey section.

In addition, it was recommended that following survey submissions, the health authority coordinator should organize a meeting with key informants to examine the level of disruption present in the health system and its implications, identify the main challenges, and identify the most effective mitigation strategies for maintaining the continuity of essential health services while responding to the COVID-19 pandemic.

1.3 Data-sharing agreement

Before key informants responded to any survey section, they were asked to review the WHO data-sharing agreement and to communicate by email if they wanted to opt out. Consequently, the results for countries that chose to opt out of this agreement are reported only in the consolidated results at the global or regional level.

1.4 Response rate

The survey was sent to 52 countries and territories in the Region of the Americas, of which 29 (54%) responded. Of the 29, 16 (30%) responded to all survey sections that they considered relevant to their context. Table 2 presents regional response rates and Annex 2 lists the responding countries.

Table 2. Response rate for the Region of the Americas

Overall response rate	Complete survey	16 (31%)
	At least one survey section	29 (56%)
Response rate for each survey section	Section 1. Health systems and functions	25 (48%)
	Section 2. Reproductive, maternal, newborn, child, and adolescent health and nutrition	29 (56%)
	Section 3. Immunization	23 (44%)
	Section 4. Human immunodeficiency virus and hepatitis	22 (42%)
	Section 5. Tuberculosis	23 (44%)
	Section 6. Malaria	11 (65%)
	Section 7. Neglected tropical diseases	11 (52%)
	Section 8. Noncommunicable diseases	28 (54%)
	Section 9. Mental, neurological, and substance use disorders	27 (52%)

Note: The percentages are calculated by dividing the number of countries that responded to each section among the 52 countries and territories in the Region of the Americas that received the second round of the survey. In the sections on malaria and neglected tropical diseases (NTDs), the denominator is different because these problems are not relevant to all countries and territories. In the malaria section, the percentage is calculated out of 17 countries, and in the NTDs section, out of 21 countries.

The second round of the survey was sent to countries between January and March 2021. Responses were received between February and March, and only one country responded in April. Likewise, the information provided corresponds to the three months prior to the month in which the survey was answered. For example, for countries that responded to the survey in February 2021, the information reflects the situation in November-December 2020 and January 2021.

It should be noted that 25 countries and territories participated in both the first and second rounds of the survey. These are the countries that will be used to compare the level of disruption in essential services between one survey and another.

1.5 Limitations

The limitations of the survey must be considered when interpreting the results. In general, the responses provided by the key informants reflect their knowledge and opinions—views that may not be shared by other actors in the country.

It should also be recognized that different countries and territories had different types of respondents and different methods that they applied to respond to the survey. Informants included health policy advisers, directors of health services and systems, program managers, monitoring and evaluation coordinators, public health officials, and incident management teams. Coordination of responses between focal points was also done differently in different countries and territories. In some cases, key informants responded to the survey individually, while in others, all of the health authorities' focal points reviewed and validated the responses prior to submission.

It is also critical to note that national data may not reflect the variability that exists in each country at the subnational level. Also, countries were at different stages of the COVID-19 pandemic when they responded to the survey, so it is expected that variations will be found when making comparisons. In addition, the survey design led each country and territory to respond to different combinations of sections. Therefore, each survey section has a different denominator, which should be considered when interpreting the countries' consolidated results and the results for the survey sections.

The difference in the number and combination of countries that participated in each survey round introduces a potential bias in the overall comparison of the results from the first and second rounds. It is also likely that among the countries that were unable to participate in the second round there were some that experienced severe pandemic impacts. Therefore, the level of overall disruption may be underestimated.

Finally, the novelty of the concepts and terminology related to essential health services, service continuity, and mitigation strategies may have led respondents to interpret the terms in different ways, which could influence the results. The original survey was designed in English and subsequently translated into several languages, which may have introduced biases in the interpretation of terminology. For example, the English term *malnutrition* was translated as *desnutrición* in Spanish. Since both terms have different meanings, the responses corresponding to nutrition services were not included in the current report.

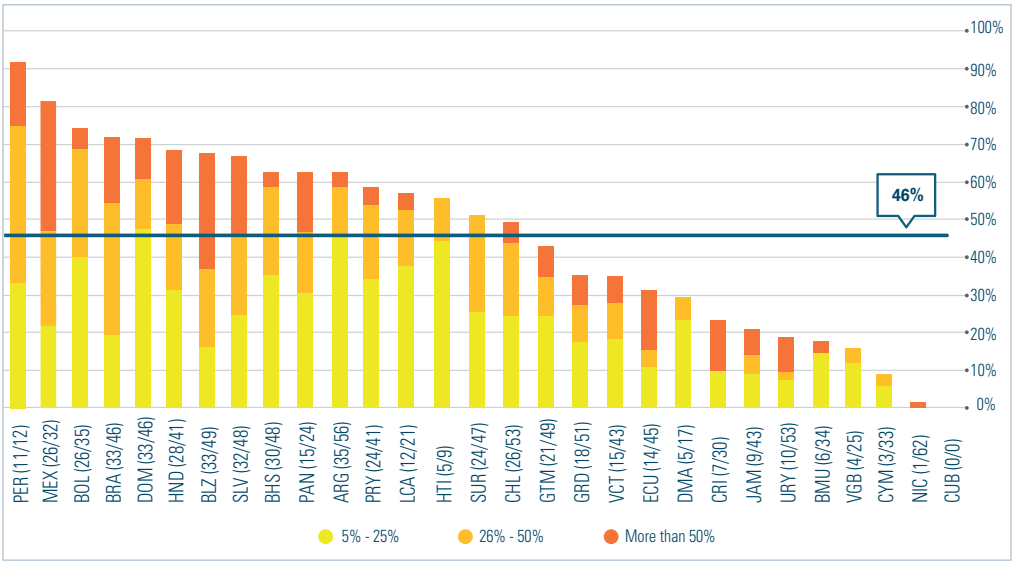
CHAPTER 2

RESULTS

2.1 Overall level of disruptions in the delivery of essential health services

Disruption in the delivery of essential health services remains widespread throughout the Region of the Americas. Figure 1 presents the results for the level of disruption for the 63 essential health services evaluated. The results are presented in three categories: severe disruption (more than 50% of users were not served as usual); moderate disruption (26%-50% of users were not served as usual); and mild disruption (5%-25% of users were not served as usual). On average, 46% of the 63 services evaluated had some level of disruption: 23% had mild disruption, 14% had moderate disruption, and 9% had severe disruption.

Figure 1. Percentage of services disrupted, by country (n = 63)



Note: n represents the number of interrupted services among the number of essential services evaluated in each country. It should be noted that services for which countries responded "do not know" or "not applicable" were not considered. For this reason, the number of services evaluated varies in each country. The "mild disruption" category means that 5%-25% of users were not served as usual; "moderate disruption" means that 26%-50% of users were not served as usual; and "severe disruption" means that more than 50% of users were not served as usual. For codes assigned to countries, see https://unstats.un.org/unsd/methodology/m49/.

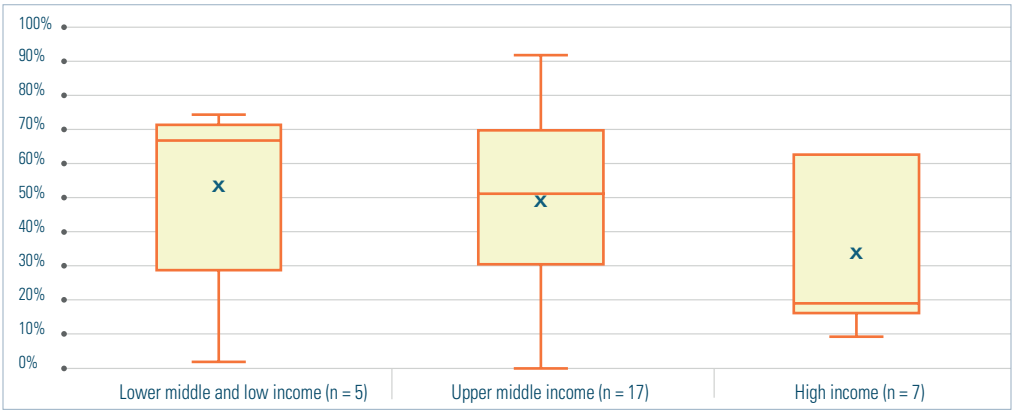
The level of disruption in the delivery of services affected by the COVID-19 pandemic was also different across the Region's countries and territories. Indeed, of the 29 countries and territories that responded to the survey:

- 28 (97%) reported that in the past three months, there had been disruptions in the provision of at least one of the essential health services evaluated;
- 2 (7%) reported that more than 75% of the health services evaluated in the second round had experienced some disruption;

- 13 (45%) reported that 50%-74% of their health services had been disrupted;
- 6 (21%) reported that 25%-49% of their health services had been disrupted; and
- 8 (28%) reported that less than 25% of their health services had been disrupted.

There were also some variations in the level of disruption of services according to countries' income level or degree of COVID-19 community transmission, although these results should be interpreted with caution given the variability in the number of countries included in each group. Overall, the percentage of services disrupted in countries in the high-income group was lower than in countries in other income groups (see Figure 2).

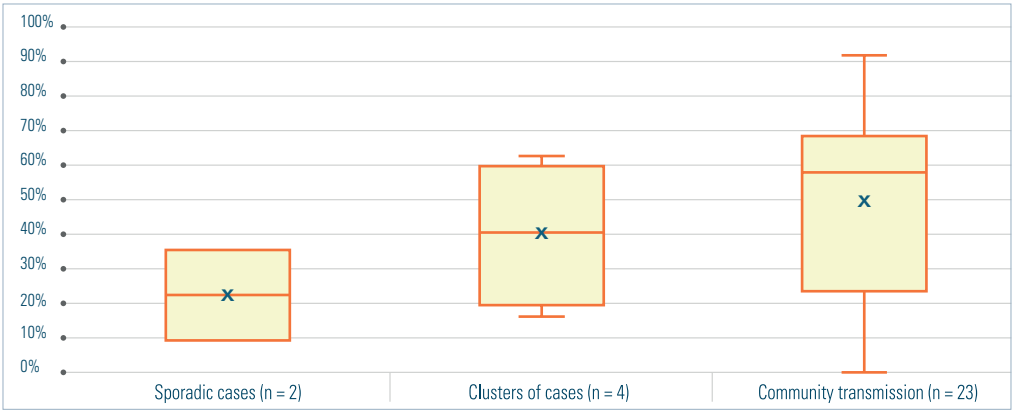
Figure 2. Percentage of services disrupted, by countries' income level (n = 29)



Note: The denominator (*n*) represents the number of countries or territories that responded to at least one survey section and reported on disruption levels for at least one service. X indicates the average percentage of services disrupted per country in each income group. The interior horizontal line (the line across the bar in the middle quartiles) indicates the median percentage of disrupted services reported per country in each income group. The vertical line indicates the upper and lower percentages.

Figure 3 provides a comparison of the variability in the average percentage of essential services disrupted by COVID-19 transmission level, defined according to the classification provided by WHO in the publication *Public Health Surveillance for COVID-19: Interim guidance* (*14*). Overall, the percentage of services disrupted was considerably higher in countries where there was community transmission. However, 79% of the responding countries (23 of 29) were classified as countries with community transmission, which limits the possibility of comparative analyses by transmission scenario.

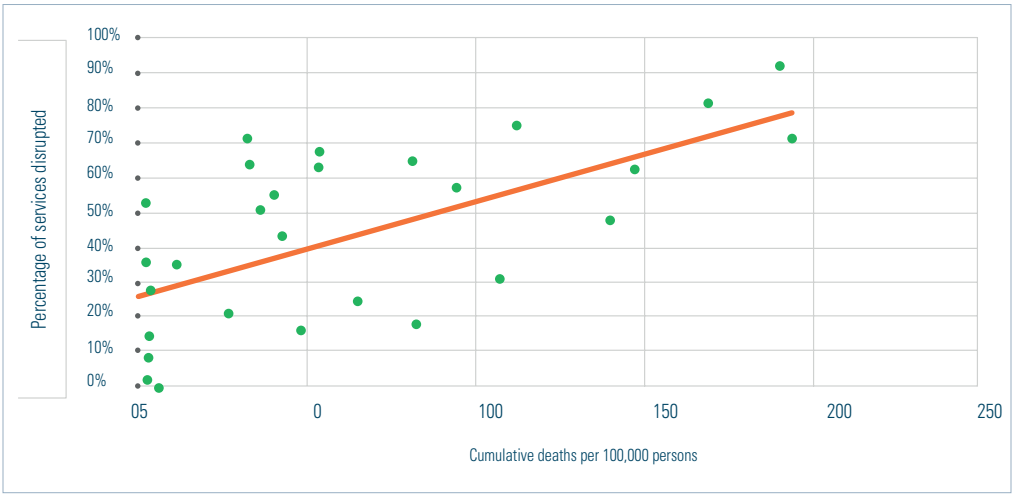
Figure 3. Percentage of services disrupted, by COVID-19 transmission level (n = 29)



Note: The denominator (*n*) represents the number of countries or territories that responded to at least one survey section and reported on disruption levels for at least one service. X indicates the average percentage of services disrupted per country in each group, according to the COVID-19 transmission situation. The interior horizontal line (the line across the bar in the middle quartiles) indicates the median percentage of disrupted services reported per country in each group according to the COVID-19 transmission situation. The vertical line indicates the upper and lower percentages.

Figure 4 presents an association between the percentage of services disrupted and the cumulative number of deaths due to COVID-19 per 100,000 persons in each country. However, it is necessary to analyze additional information to understand this potential relationship, given that there are other factors, such as the government's pandemic response, that could affect the analysis.

Figure 4. Relationship between cumulative COVID-19 deaths per 100,000 persons and percentage of services disrupted (n = 29)



Note: The denominator represents the number of countries or territories that responded to at least one survey section and reported on disruption levels for at least one service. The number of COVID-19 deaths was obtained from the figures reported on the WHO COVID-19 Dashboard (see https://covid19.who.int/).

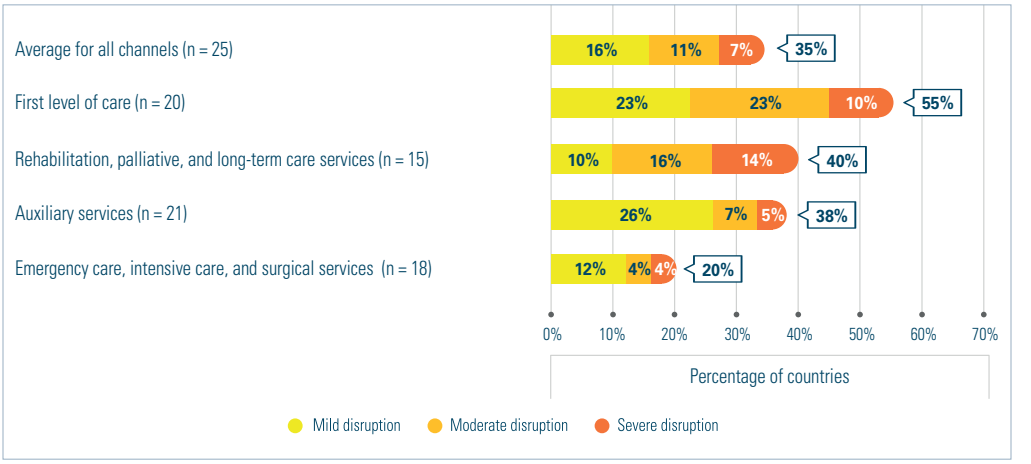
CHAPTER 3

DISRUPTION IN INTEGRATED HEALTH SERVICE DELIVERY CHANNELS

The first survey section—which addressed health system functions and cross-cutting health services aimed at health promotion, disease prevention, diagnosis, treatment, rehabilitation, and palliative and long-term care—assessed the level of disruption in the different service delivery channels. These include first level of care, emergency care, intensive care, surgery, rehabilitation and palliative care, and auxiliary services. Understanding disruptions in these services provides insight into which channels have been most affected by the pandemic and can help to guide and prioritize the response.

On average, 35% of 25 countries reported some level of disruption in the different health service delivery channels: 16% had a mild level of disruption, 11% had moderate disruption, and 7% had severe disruption (see Figure 5). First level of care services had the highest percentage of disruption (in 55% of 20 countries), followed by rehabilitation, palliative, and long-term care services (in 40% of 15 countries). This situation is alarming, given that first level of care services play a fundamental role in ensuring the good performance of health systems: they provide first-contact care that is accessible, continuous, comprehensive and coordinated, and focused on people and communities (*15*). Strengthening the response capacity of the first level of care is central to achieving universal access to health and universal health coverage. Disruptions in the provision of these services can have serious consequences throughout the system, as well as on people's overall health and well-being (*16*).

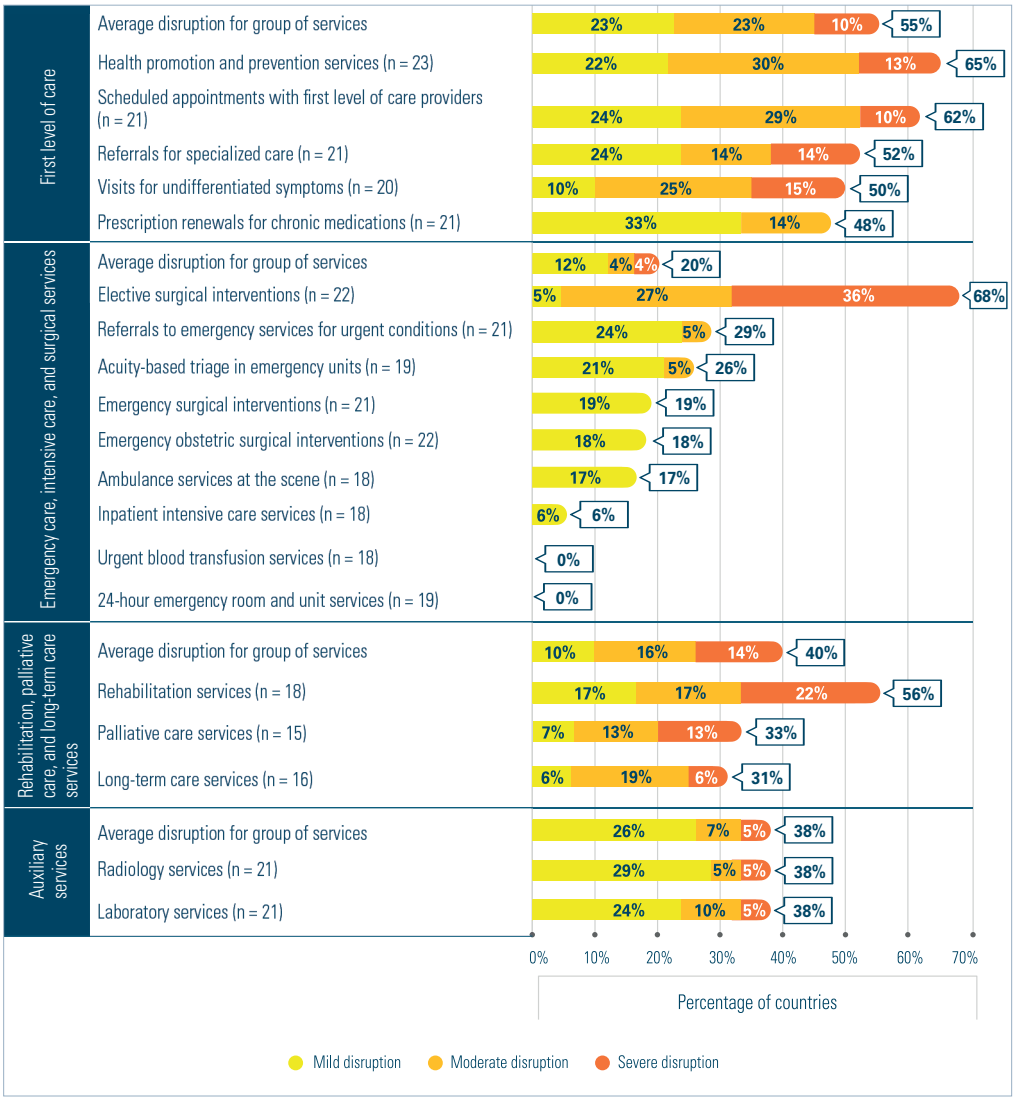
Figure 5. Average percentage of countries where the provision of integrated health services was disrupted to some degree, by channel (n = 25)



Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that answered the question for each type of service. The "mild disruption" category means that 5%-25% of users were not served as usual; "moderate disruption" means that 26%-50% of users were not served as usual; and "severe disruption" means that more than 50% of users were not served as usual. The total percentage may differ from the sum of the partial percentages due to rounding.

Under first level of care services, prevention and health promotion services and scheduled appointments with first level of care providers were disrupted in more than half of countries. Prevention and health promotion services were disrupted in 65% of 23 countries, and scheduled appointments in 62% of 21 countries. Other essential first level of care services were disrupted in half of the countries assessed. For example, referrals to specialized care were disrupted in 52% of 21 countries, and visits for undifferentiated symptoms in 50% of 20 countries (see Figure 6).

Figure 6. Disruptions in the provision of integrated health services, by channel (n = 25)



Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that answered the questions for each service. The "mild disruption" category means that 5%-25% of users were not served as usual; "moderate disruption" means that 26%-50% of users were not served as usual; and "severe disruption" means that more than 50% of users were not served as usual. The total percentage may differ from the sum of the partial percentages due to rounding.

Another major concern is disruptions in the delivery of life-saving services, such as emergency, intensive care, and surgical services, as any disruption to these services could have serious indirect consequences on short-term health outcomes. The largest disruptions were observed in elective surgical interventions: 68% of countries (15 of 22) reported some level of disruption, with more than half reporting severe disruptions. The following are other results obtained in this area:

- Of 21 countries responding about referrals to emergency services for urgent conditions, 6 (29%) reported disruptions.
- Of 19 countries responding about triage in emergency units, 5 (26%) reported disruptions.
- Of 21 countries responding about emergency surgeries, 4 (19%) reported disruptions.
- Of 22 countries responding about emergency obstetric surgeries, 4 (18%) reported disruptions.
- Of 18 countries responding about ambulance services at the scene, 3 (17%) reported disruptions.

Substantial disruptions in continuing care services were also reported. More than half of countries reported disruptions in rehabilitation services, and one-third of countries reported disruptions in palliative and long-term care services.

Auxiliary services, including laboratory and radiology services, were disrupted in 38% of countries (8 of 21).

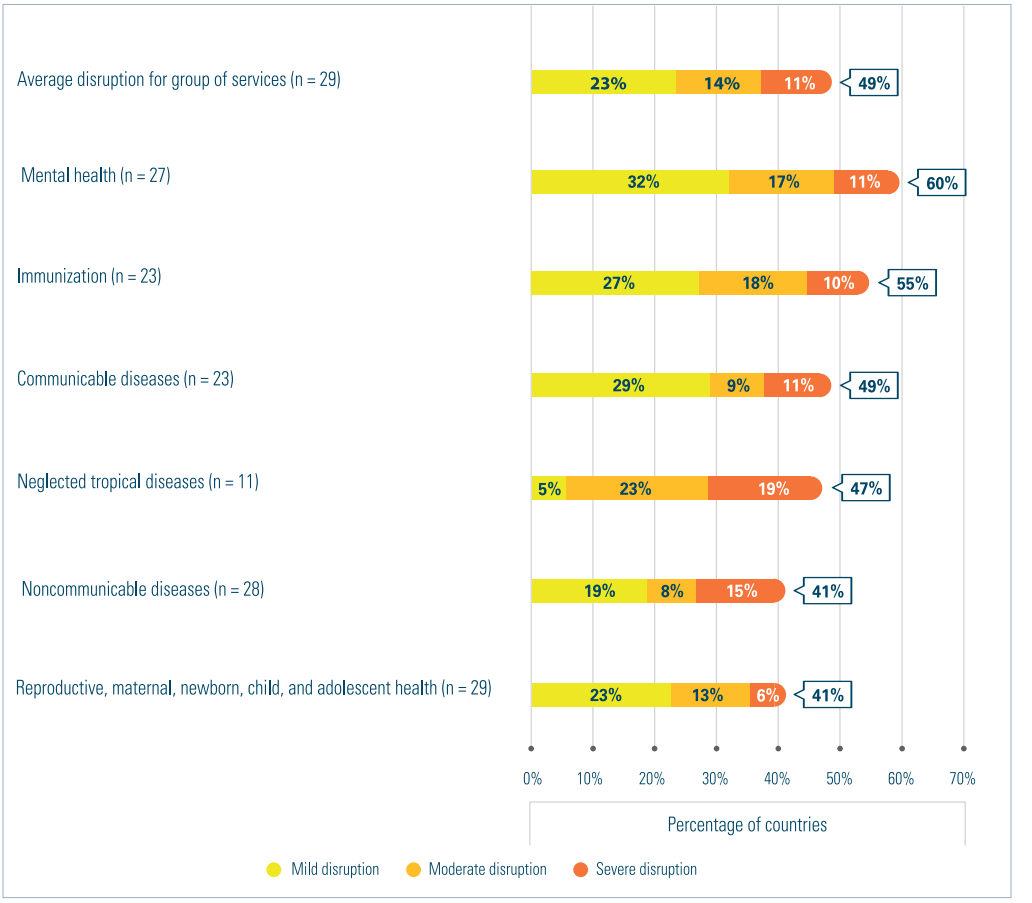
CHAPTER 4

DISRUPTION OF ESSENTIAL SERVICES FOR PRIORITY HEALTH AREAS

In order to further examine the extent of disruptions in essential health services, key informants provided information on the level of disruption in tracer services for reproductive, maternal, newborn, child, and adolescent health and nutrition, noncommunicable diseases, neglected tropical diseases, communicable diseases, immunization, and mental, neurological, and substance use disorders. On average, the latter services had the most disruptions (in 60% of 27 countries).

On average, of the 29 countries in the Americas that responded to the survey, 49% reported disruptions in the delivery of essential services in all priority health areas (see Figure 7).

Figure 7. Percentage of countries that reported disruptions in services for priority health areas (n = 29)



Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the smallest number of countries that answered a question regarding each type of service. The "mild disruption" category means that 5%-25% of users were not served as usual; "moderate disruption" means that 26%-50% of users were not served as usual; and "severe disruption" means that more than 50% of users were not served as usual. The total percentage may differ from the sum of the partial percentages due to rounding.

4.1 Reproductive, maternal, newborn, child, and adolescent health

The impact of COVID-19 is evident in the set of interventions linked to reproductive health, pregnant women, newborns, and children. On average, of the 29 countries in the Americas that responded to the survey, 41% reported disruptions in the delivery of reproductive, maternal, newborn, child, and adolescent health services (see Figure 8).

Figure 8. Percentage of countries that reported disruptions in reproductive, maternal, newborn, child, and adolescent health tracer services (n = 29)

Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that answered the questions for each service. The "mild disruption" category means that 5%-25% of users were not served as usual; "moderate disruption" means that 26%-50% of users were not served as usual; and "severe disruption" means that more than 50% of users were not served as usual. The total percentage may differ from the sum of the partial percentages due to rounding.

One of the most affected services was family planning and contraception, with 52% of countries (14 of 27) reporting some level of disruption. Disruption of reproductive health services can be associated with three factors:

1. Disruptions in the contraceptive supply chain and reduced out-of-pocket spending capacity in the poor population;
2. Political decisions that altered the functioning of health systems (suspension or reduction of services not directly linked to pandemic care, diversion of equipment and personnel to the pandemic response, reduction in supply due to lack of personal protective equipment);
3. Reductions in the demand for sexual and reproductive health services due to mobility restrictions and people's fear of going to health centers due to the risk of infection (*17*).

The second most affected services were those for the prevention of and response to sexual and intimate partner violence. Of the 18 countries that responded about this topic, 50% reported disruptions in these interventions, which paradoxically have been recognized as a priority in the context of the pandemic and during periods of confinement and social distancing. The latter is due to mobility restrictions increasing the risk of violence against women and girls, as it intensifies their isolation and creates additional barriers to accessing essential services (*18*).

In addition, prenatal and postnatal care were disrupted in 43% of 28 countries and 44% of 27 countries that responded to the survey, respectively. These services are essential for pregnant women and newborns to survive and remain healthy. The disruption mainly affected women in situations of greater vulnerability, whose access to teleconsultation options was minimal.

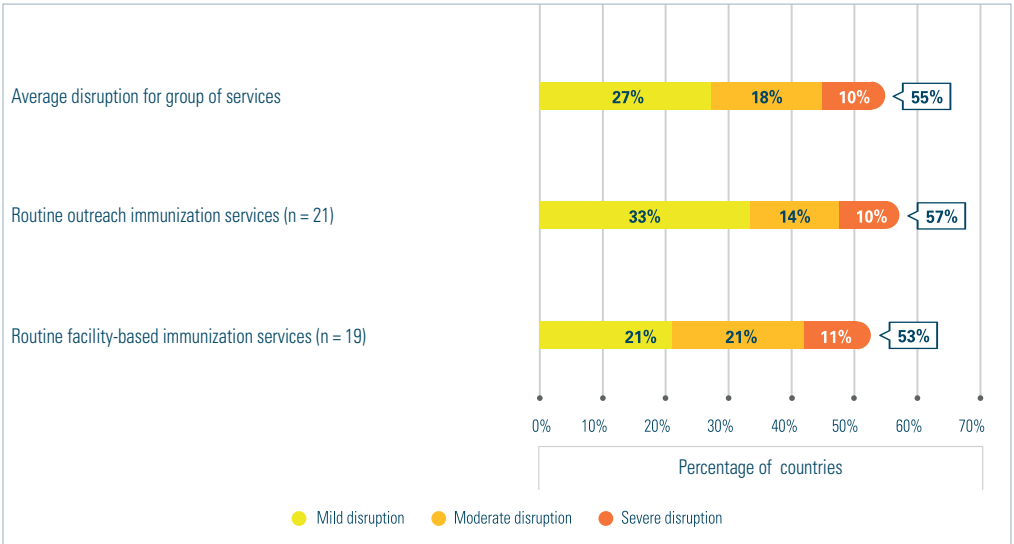
In addition, 23% of countries (6 of 26) reported disruptions in the provision of institutional delivery care services. In this case, disruption was greatest in countries where community childbirth care was initially higher. The disruption of prenatal and postnatal care, regardless of its magnitude, is expected to have repercussions not only in the short term, by increasing the risk of adverse maternal or perinatal mortality outcomes, but also in the medium and long term, due to the possible increase in the number of preterm births and their consequences, especially with regard to inadequate care for and follow-up of small and seriously ill newborns (*19*).

With regard to services for sick children, 44% of the countries that responded to this module (11 of 25) reported disruptions in the last three months. Most countries reported a mild level of disruption. Only four countries observed severe disruptions, meaning that more than 50% of users could not receive care.

4.2 Immunization services

Vaccination coverage had already declined in the Region's countries in recent years. However, the disruption of services due to the COVID-19 pandemic led to an abrupt decrease in this coverage that was greater than the recent observed declines. On average, 55% of 23 countries in the Americas reported disruptions in vaccination services: 53% of 19 countries in intramural services, and 57% of 21 countries in extramural services (see Figure 9). This included measles and yellow fever vaccination campaigns. As of September 2020, and compared to the same period in 2019, the number of diphtheria, pertussis, and tetanus (DPT3) vaccines and measles, mumps, and rubella (MMR) vaccines administered in 33 countries and territories in the Region had decreased by 18.3% and 13.9%, respectively (*20*).

Figure 9. Percentage of countries that reported disruptions in immunization services (n = 23)



Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that answered the questions for each service. The "mild disruption" category means that 5%-25% of users were not served as usual; "moderate disruption" means that 26%-50% of users were not served as usual; and "severe disruption" means that more than 50% of users were not served as usual. The total percentage may differ from the sum of the partial percentages due to rounding.

Vaccination schedules affect immunization. If children are not vaccinated at the right age, they may lose the benefit of acquiring lifelong immunity. Entire cohorts of children may be left unprotected against diseases such as rotavirus diarrhea, pneumonia, or diphtheria. Given the importance of vaccination, WHO and PAHO have recommended and developed guidelines for this service to be maintained. However, declining demand has reduced vaccination coverage and increased existing gaps (*21*).

A clear example of this is measles. Given the circulation of the virus in some countries, the highly infectious nature of the virus, and the decrease in vaccination coverage, large and explosive outbreaks could occur that could significantly increase the burden of child deaths.

4.3 Communicable diseases

In addition to ensuring that quality services are provided to people who have COVID-19, it is important to ensure that prevention and treatment services for other communicable diseases continue to be provided to prevent these diseases from spreading. Disruptions in the provision of these services are of particular concern in the Region of the Americas.

On average, of the 23 countries that provided information about the provision of services for communicable diseases, 49% reported disruptions (see Figure 10). Tuberculosis (TB) diagnosis and treatment and human immunodeficiency virus (HIV) prevention services showed the highest degree of disruption: TB services were disrupted in 65% of the 20 responding countries providing information, and HIV services in 59% of the 17 responding countries.

Figure 10. Percentage of countries that reported disruptions in services for communicable diseases (n = 23)

Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that answered the questions for each service. The "mild disruption" category means that 5%-25% of users were not served as usual; "moderate disruption" means that 26%-50% of users were not served as usual; and "severe disruption" means that more than 50% of users were not served as usual. The total percentage may differ from the sum of the partial percentages due to rounding.

Among countries that experienced disruptions in the delivery of HIV prevention services (10 of 17 countries), two reported moderate and severe interruptions. These disruptions mainly affected HIV testing services. For HIV treatment, antiretroviral therapy services could be maintained in most countries. However, six countries reported some type of disruption in the initiation of new treatments, and five in the continuation of treatments that were already underway. For viral hepatitis, of the 18 responding countries, 56% reported some type of disruption in treatment and diagnostic services: 17% indicated that the disruption had been severe and had mainly affected the number of new diagnoses and new treatments.

Among the 20 countries providing information on TB diagnosis and prevention services, 13 (65% of the total) indicated that there were disruptions and, of these, 3 (15% of the total) indicated that these disruptions were severe. At the same time, among the 28 countries that reported TB cases in the Americas, there was an average decrease of 14.8% in the number of cases reported in 2020 compared to 2019: the number went from 225,029 to 191,777 from one year to the next. The percentage decline varied from country to country: in some cases, such as the Dominican Republic and the Bahamas, decreases of more than 35% were observed.[1]

The survey revealed that of the nine countries reporting on malaria diagnosis and treatment services, five (56%) had some level of disruption. These disruptions were also accompanied by a reduction in the number of malaria cases reported in the Region of the Americas. According to preliminary information obtained from the national epidemiological bulletins for 2020, there was a 32% decrease in malaria incidence at the regional level, compared to reports for 2019. In 2020 there was an increase in the number of cases in four countries, while in the remaining malaria-endemic countries, there was an overall decrease in disease incidence.

With regard to TB, the decrease in the number of reported cases could be due in part to a real decrease in transmission in certain countries given the adoption of measures aimed at preventing airborne diseases. With regard to malaria, the decrease in reported cases could be due to mobility restrictions imposed by the pandemic. At the same time, however, this reduction is also attributed to a decrease in the supply and demand for diagnosis and treatment, which is consistent with the impact on services that countries reported in the survey.

4.4 Neglected tropical diseases

Neglected tropical diseases encompass a diverse set of diseases and disease groups that are mostly communicable and found primarily in tropical and subtropical countries.[2]

On average, of the 21 countries providing information about the provision of services for neglected tropical diseases, 47% reported disruptions (see Figure 11). The services in which a higher degree of disruption was observed were large-scale preventive chemotherapy campaigns, followed by community awareness and education campaigns. Indeed, of the 16 countries providing information about chemotherapy campaigns, 56% reported disruptions, and of the 16 providing information about community awareness and education campaigns, 50% had disruptions.

1 See preliminary data extracted from the WHO global TB data collection system at the following link: https://extranet.who.int/tme/Default.asp.

2 Neglected tropical diseases include Buruli ulcer, Chagas disease, dengue and chikungunya, dracunculiasis (Guinea worm disease), echinococcosis, foodborne trematodiasis, human African trypanosomiasis (sleeping sickness), leishmaniasis, leprosy (Hansen's disease), lymphatic filariasis, mycetoma, chromoblastomycosis and other deep mycoses, onchocerciasis (river blindness), rabies, scabies and other ectoparasites, schistosomiasis, geohelminthiasis, snakebite, envenomation, taeniasis and cysticercosis, trachoma, and yaws and other endemic treponematoses.

Figure 11. Percentage of countries that reported disruptions in services for neglected tropical diseases (n = 21)

Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that answered the questions for each service. The "mild disruption" category means that 5%-25% of users were not served as usual; "moderate disruption" means that 26%-50% of users were not served as usual; and "severe disruption" means that more than 50% of users were not served as usual. The total percentage may differ from the sum of the partial percentages due to rounding.

It is important to note that, at the start of the pandemic, WHO and PAHO recommended that national neglected tropical disease control or elimination programs temporarily suspend community-based activities in order to avoid the risk of transmission and spread of COVID-19, both in the communities targeted by these interventions and among the programs' field workers. These activities included the mass administration of drugs for geohelminthiasis, lymphatic filariasis, trachoma, schistosomiasis, and onchocerciasis, as well as baseline surveys, impact assessment surveys, and active case finding surveys (*19, 22*).

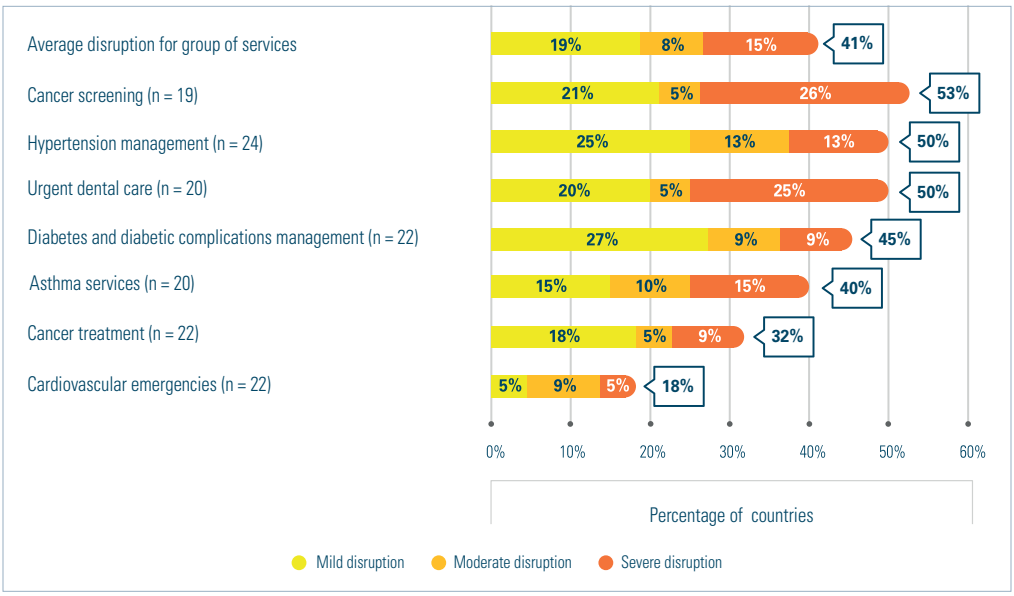
This recommendation was accepted by the Region's countries: most countries that had scheduled some of these activities suspended them and postponed them to 2021, as long as the pandemic conditions allowed for implementation. This will impact the detection of these diseases, and possibly lead to delays of at least 1-2 years in the elimination programs, and decreases in the number of cases reported for some of these diseases for 2020, compared to 2019.

4.5 Noncommunicable diseases

It is estimated that in the Americas, one in four people (250 million) live with at least one pre-existing condition, namely cardiovascular disease, diabetes, cancer, and chronic respiratory diseases, among others (*23*). Prior to the COVID-19 pandemic, responding to the needs of people with noncommunicable diseases already posed challenges, mainly in the provision of essential medicines and basic technologies (*24*).

The disruption of services due to the COVID-19 pandemic has a profound impact on the continuity of the management of noncommunicable diseases. It should be noted that people living with these types of disease have a greater risk of becoming seriously ill if they contract COVID-19, which demands the development of protection strategies that guarantee timely access to essential medicines and services. On average, of the 28 countries in the Americas providing information on services for noncommunicable diseases, 41% reported disruptions. However, there are services for which this percentage is much higher; for example, for cancer screening (53%, 10 of 19 countries) and hypertension management (50%, 12 of 24 countries) (see Figure 12).

Figure 12. Percentage of countries that reported disruptions in services for noncommunicable diseases (n = 23)



Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that answered the questions for each service. The "mild disruption" category means that 5%-25% of users were not served as usual; "moderate disruption" means that 26%-50% of users were not served as usual; and "severe disruption" means that more than 50% of users were not served as usual. The total percentage may differ from the sum of the partial percentages due to rounding.

In addition:

- Of the 20 countries providing information on urgent dental care services, 10 (50%) reported disruptions.
- Of the 22 countries providing information on services for diabetes and diabetic complications management, 10 (45%) reported disruptions.
- Of the 20 countries providing information on asthma care services, 8 (40%) reported disruptions.
- Of the 22 countries providing information on cancer treatment services, 7 (32%) reported disruptions.
- Of the 22 countries providing information on cardiovascular emergency services, 4 (18%) reported disruptions.

4.6 Mental, neurological, and substance use disorders

The global COVID-19 pandemic is impacting people in a variety of ways. Faced with the challenges of the new reality marked by physical distancing, teleworking, job insecurity, home-schooling of children, grief and loss, and lack of physical contact with loved ones and friends, many people suffer from fear, anxiety, or sadness at some point.

Events that cause a significant degree of stress, such as the COVID-19 pandemic, are a risk factor that can lead to a range of mental, neurological, and psychoactive substance use disorders, or trigger exacerbation or relapse, especially in the most vulnerable population groups. National-level studies conducted in the Region of the Americas describe an increase in restlessness, depression, anxiety, and insomnia, among others, as a result of the COVID-19 pandemic (*25–27*). In addition, COVID-19 cases can result in several neurological and mental complications (*7*).

This situation is made more complex by disruptions in the provision of services for mental, neurological, and substance use disorders. On average, of the 27 countries in the Americas providing information on services for mental health-related illnesses, 60% reported disruptions (see Figure 13). Some degree of disruption was observed in all of the services included in the survey. However, disruptions far exceeded the average for some services, such as neuroimaging and neurophysiology, for which 71% of the 14 responding countries reported disruptions, or school mental health programs, for which 69% of the 13 responding countries reported disruptions. The most affected services were psychotherapy, counseling, and psychosocial interventions, for which 71% of the 24 responding countries reported disruptions.

Figure 13. Percentage of countries that reported disruptions in services for mental, neurological, and substance use disorders (n = 27)

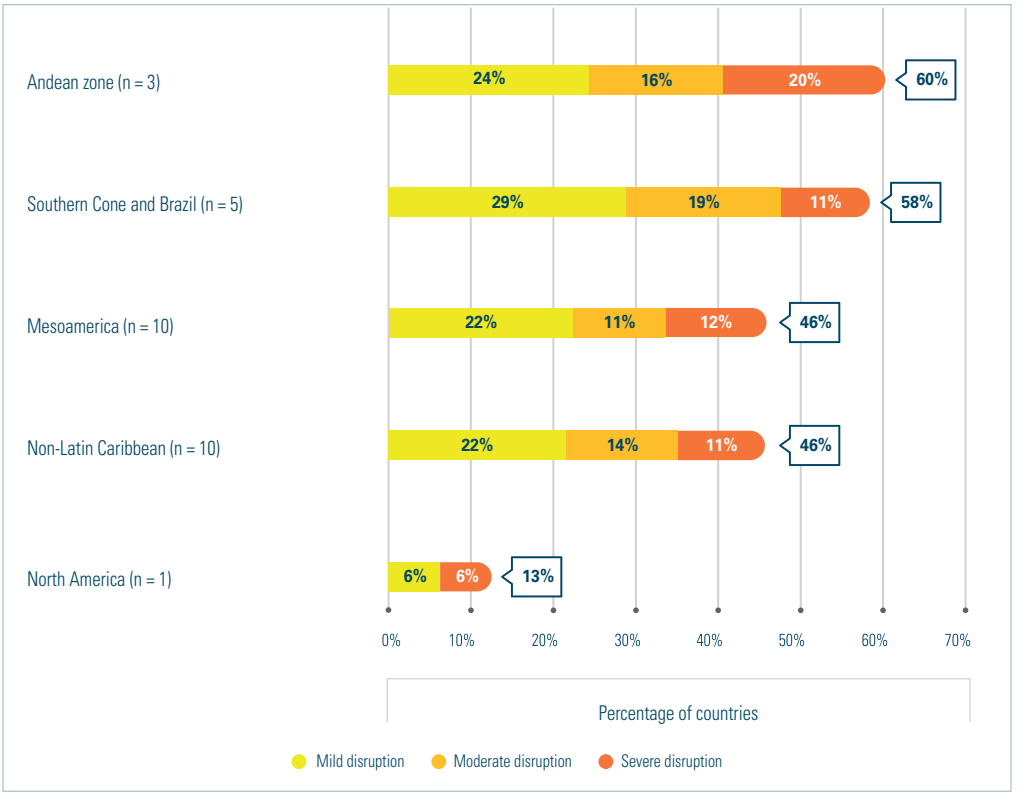
Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that answered the questions for each service. The "mild disruption" category means that 5%-25% of users were not served as usual; "moderate disruption" means that 26%-50% of users were not served as usual; and "severe disruption" means that more than 50% of users were not served as usual. The total percentage may differ from the sum of the partial percentages due to rounding.

In addition, some essential services were disrupted in about half of the countries. This includes services to treat emergency manifestations of disorders, which were disrupted in 52% of the 23 responding countries, or services to issue prescriptions for medicines for mental, neurological, or substance use disorders, which had disruptions in 48% of the 23 responding countries.

4.7 Disruption of services for priority health areas by subregion and income group

When examining the level of disruption of services for priority health areas by subregion of the Americas, it is observed that the Andean zone presents the highest percentage of countries with disruptions (60% of three countries), followed by the Southern Cone and Brazil (58% of five countries). It should be recognized that the interpretation of these results is limited, since response rates and the number of countries considered in each subregion are low (see Figures 14 and 15).

Figure 14. Percentage of countries that reported disruptions in services for priority health areas, by subregion of the Americas (n = 29)



Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that answered the questions for each service. The "mild disruption" category means that 5%-25% of users were not served as usual; "moderate disruption" means that 26%-50% of users were not served as usual; and "severe disruption" means that more than 50% of users were not served as usual. The Andean zone includes Bolivia (Plurinational State of), Ecuador, and Peru; Southern Cone and Brazil encompasses Argentina, Brazil, Chile, Paraguay, and Uruguay; Mesoamerica encompasses Costa Rica, Cuba, Dominican Republic, El Salvador, Guatemala, Haiti, Honduras, Mexico, Nicaragua, and Panama; and the non-Latin Caribbean includes Bahamas, Belize, British Virgin Islands, Cayman Islands, Dominica, Grenada, Jamaica, Saint Lucia, Saint Vincent and the Grenadines, and Suriname. The total percentage may differ from the sum of the partial percentages due to rounding.

Figure 15. Average percentage of countries that reported disruptions in tracer services, by subregion of the Americas (n = 29)

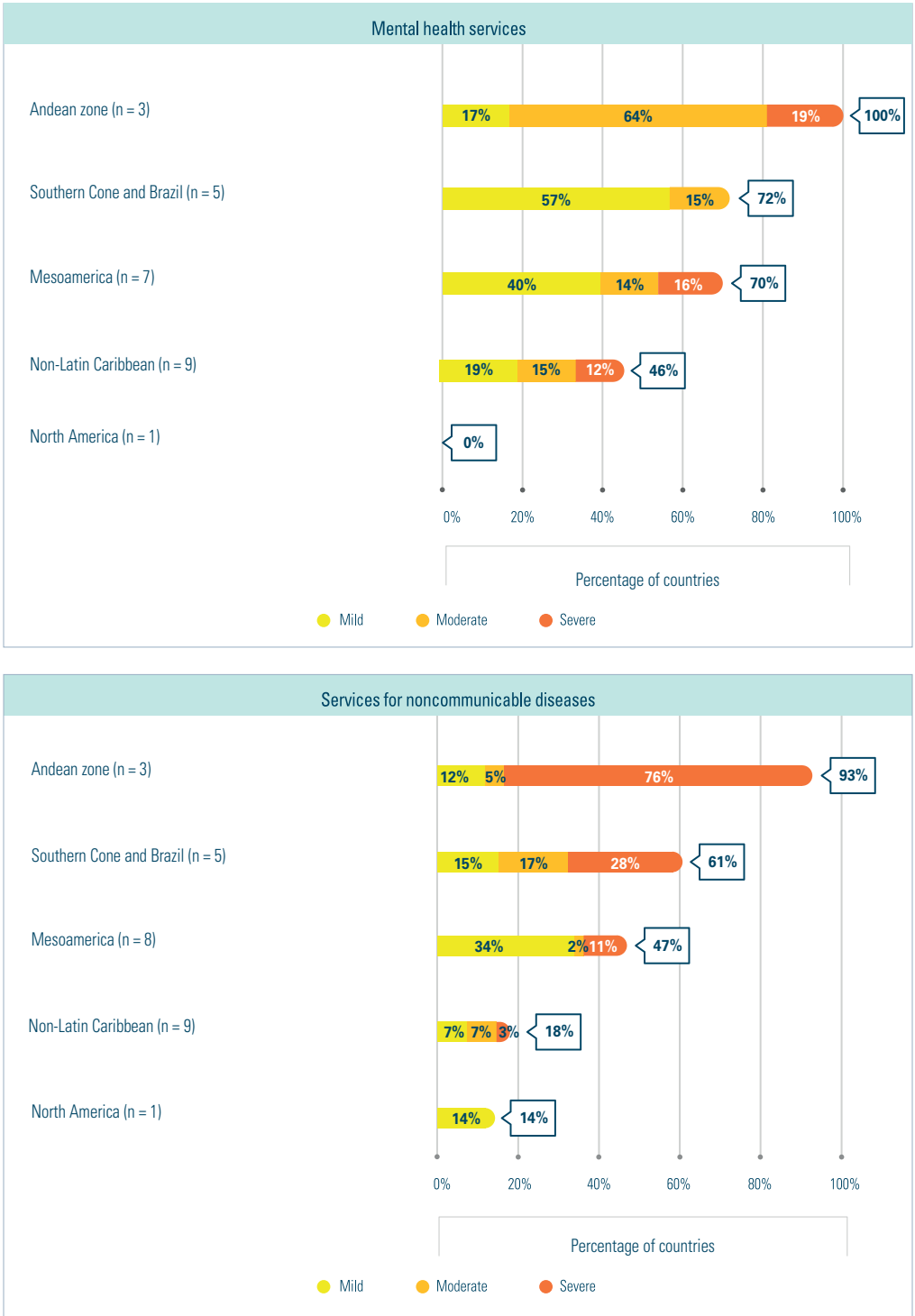
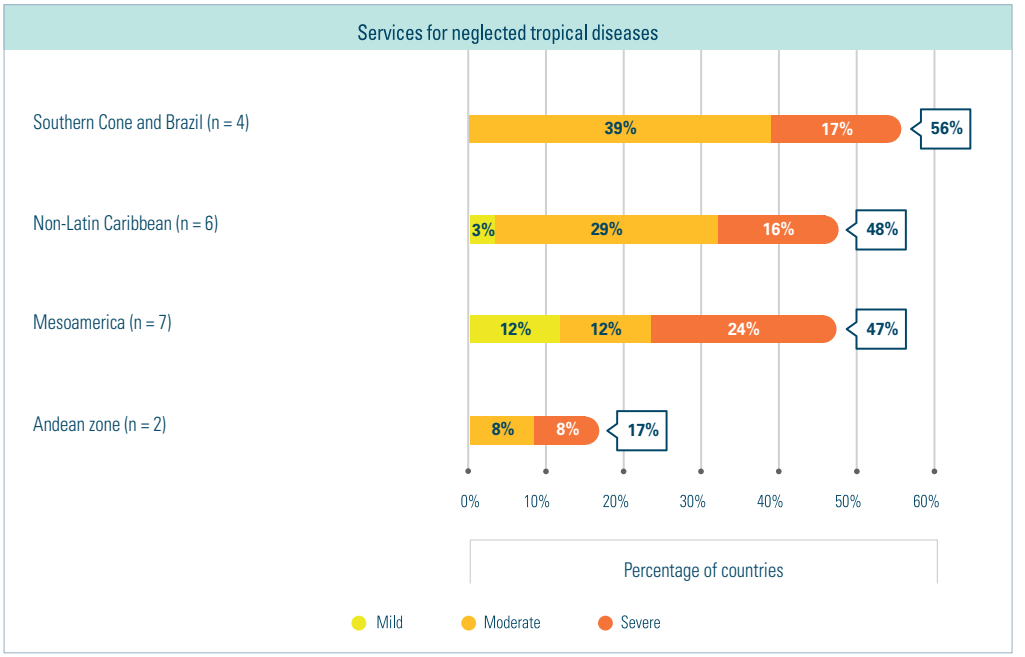


Figure 15. *Continuation*



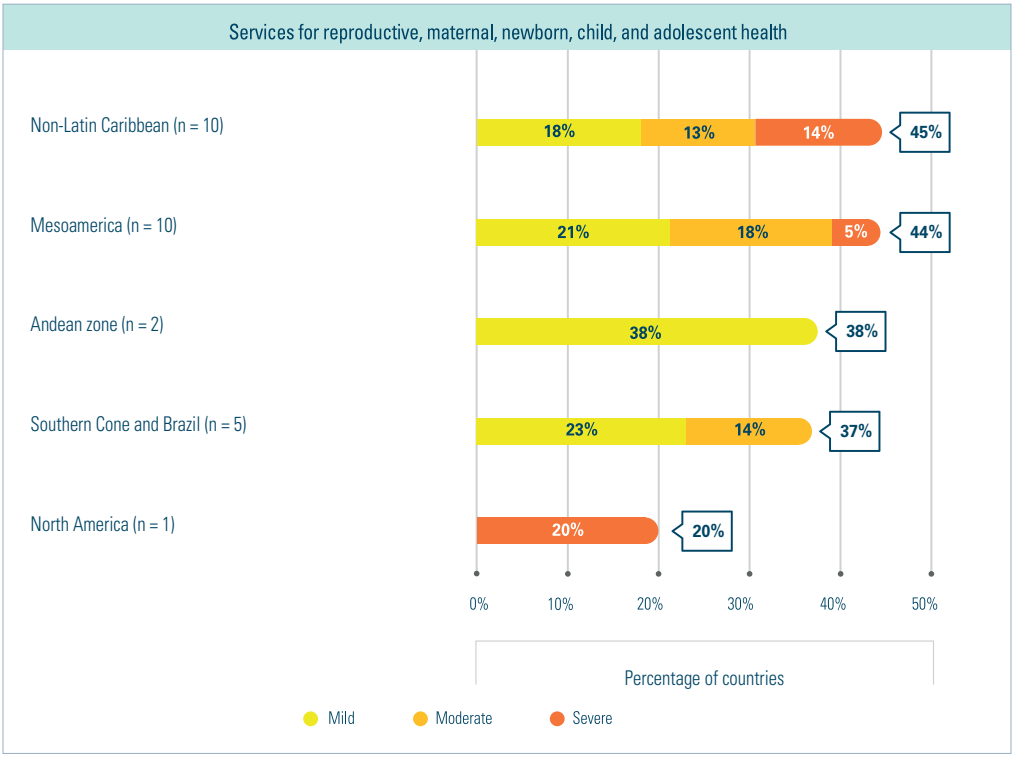
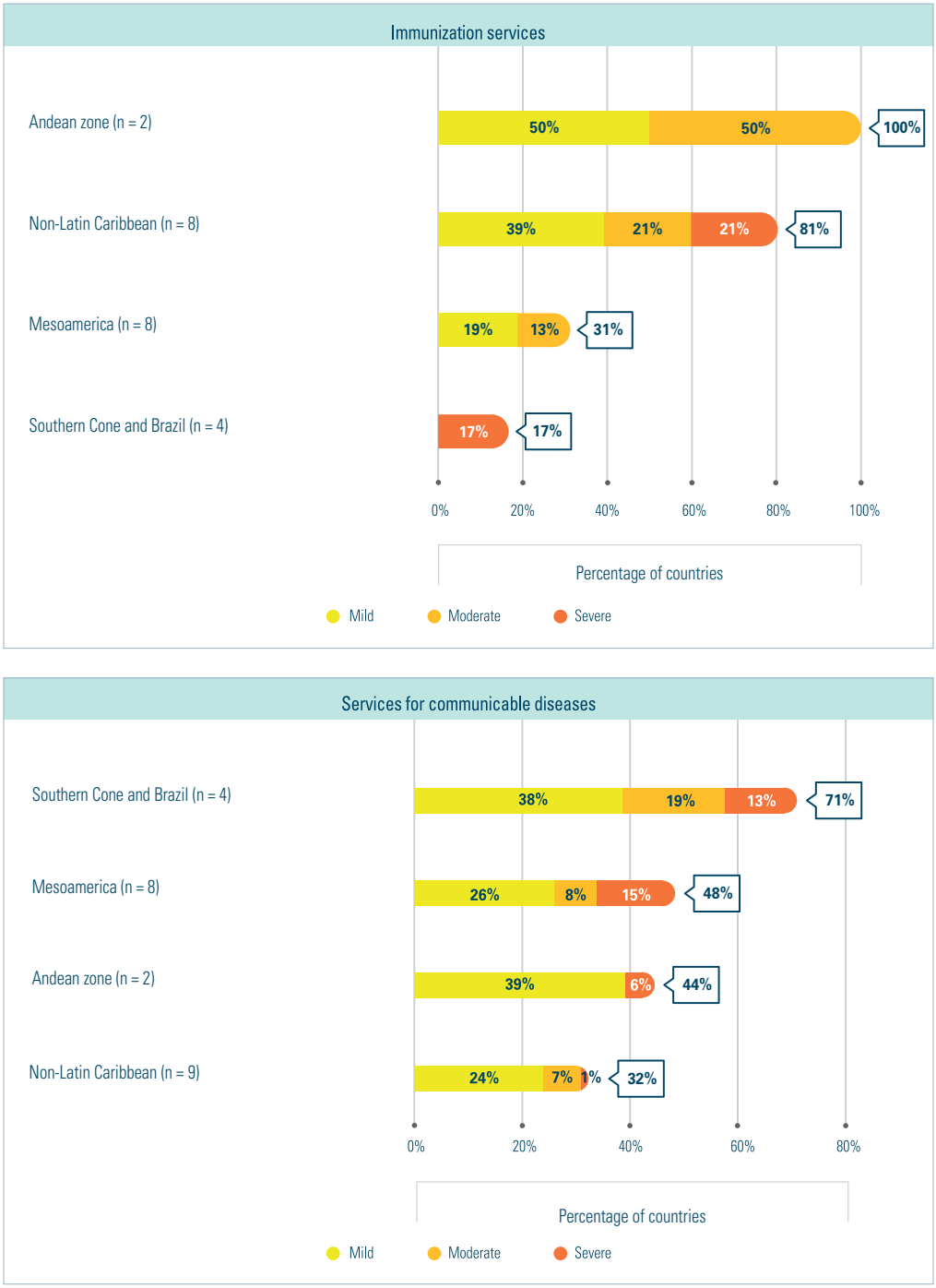


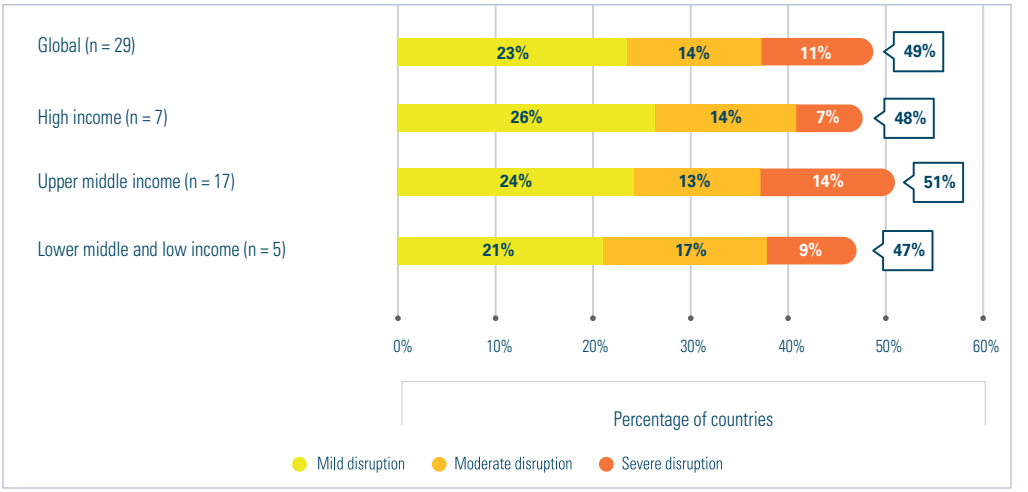
Figure 15. *Continuation*



Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that answered any question related to each type of service. The "mild disruption" category means that 5%-25% of users were not served as usual; "moderate disruption" means that 26%-50% of users were not served as usual; and "severe disruption" means that more than 50% of users were not served as usual. The total percentage may differ from the sum of the partial percentages due to rounding.

When examining the level of disruption in the provision of services for priority health areas by income group, no major differences were found (see Figures 16 and 17), except for services for noncommunicable diseases and services for reproductive, maternal, newborn, child, and adolescent health, where the percentage of countries with disruptions was lower in the higher income groups.

Figure 16. Percentage of countries that reported disruptions in services for priority health areas, by income level (n = 29)



Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that responded by each income level. The "mild disruption" category means that 5%-25% of users were not served as usual; "moderate disruption" means that 26%-50% of users were not served as usual; and "severe disruption" means that more than 50% of users were not served as usual. The total percentage may differ from the sum of the partial percentages due to rounding.

Figure 17. Average percentage of countries that reported disruptions in tracer services, by income level (n = 29)

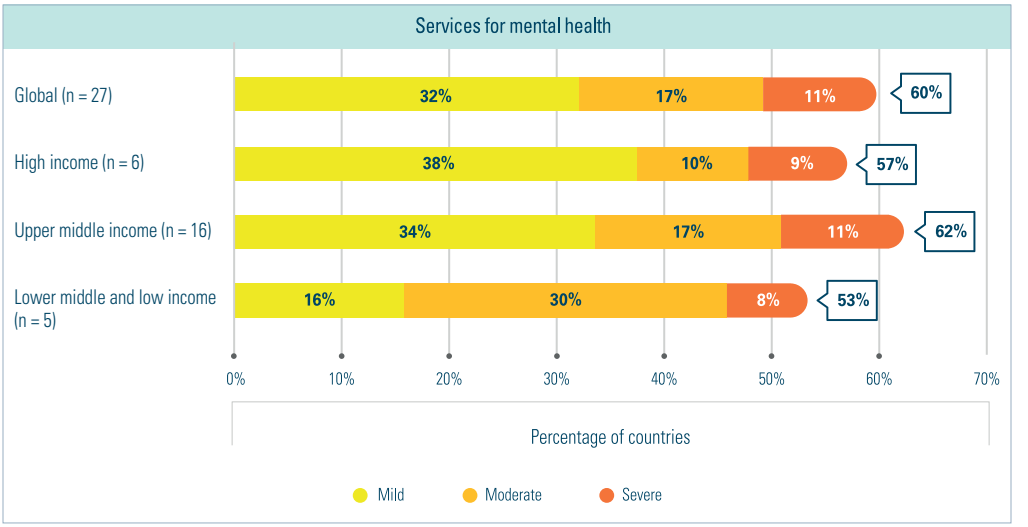
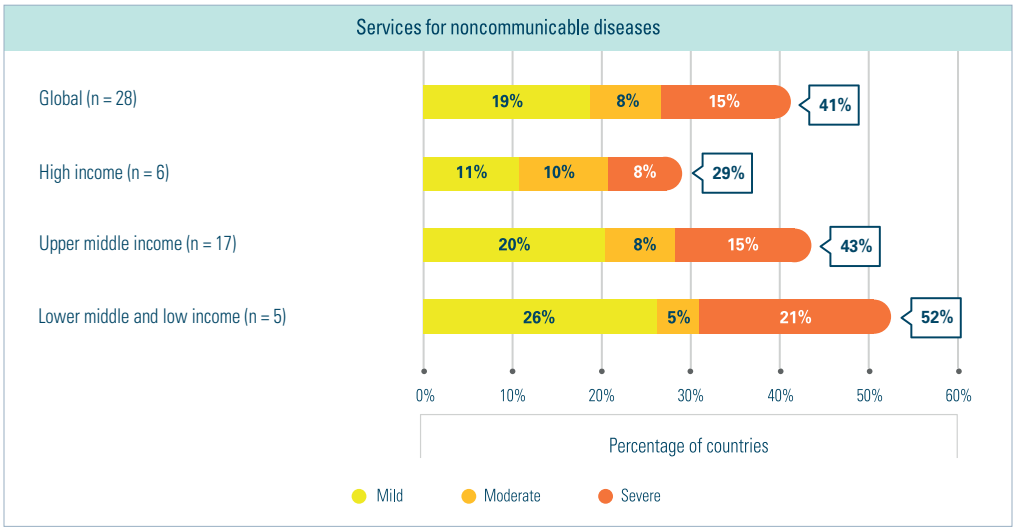
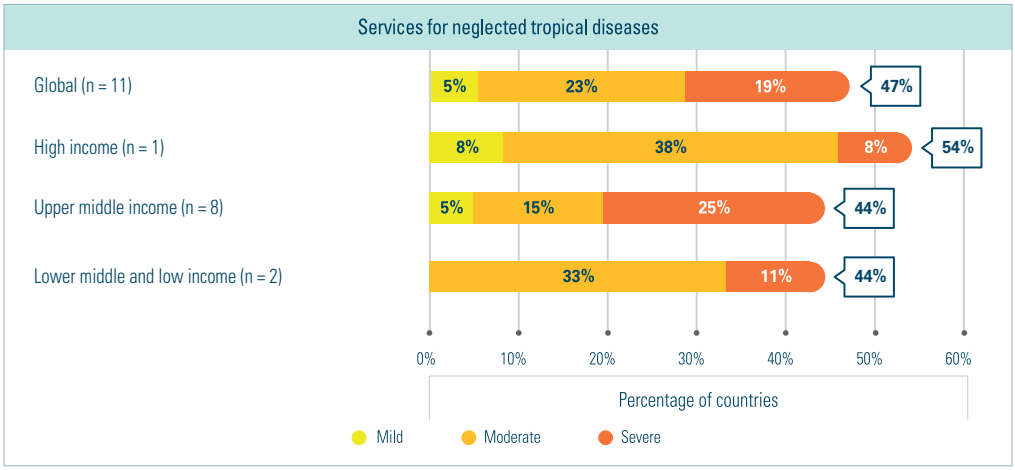


Figure 17. *Continuation*





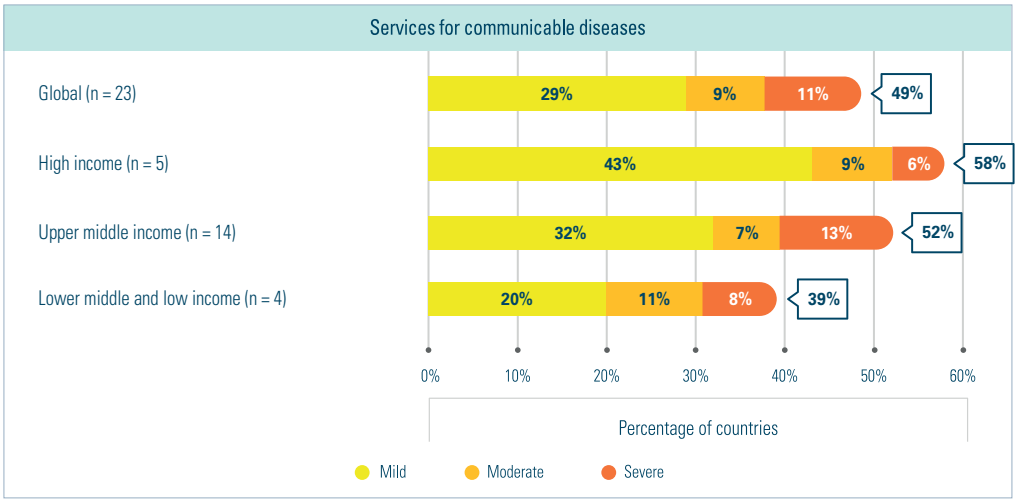
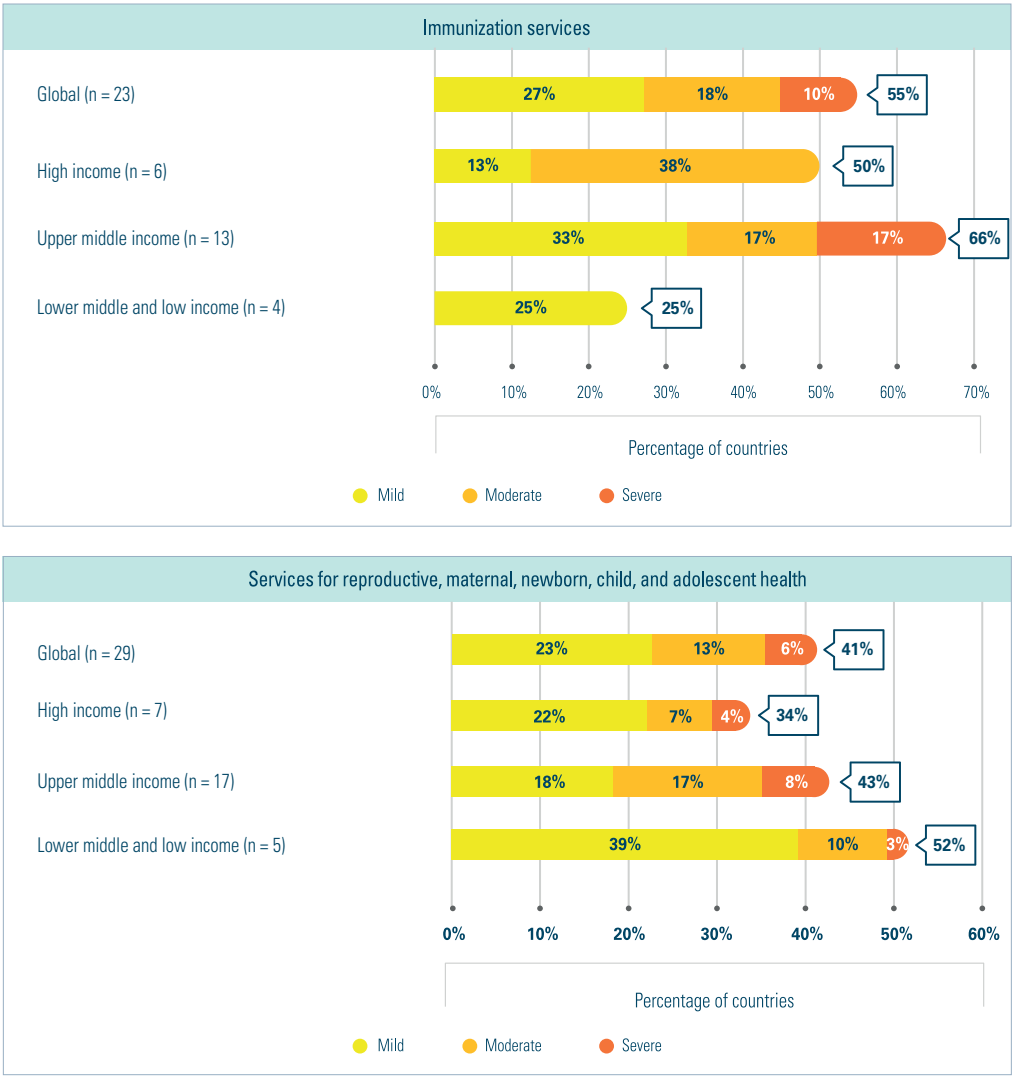


Figure 17. *Continuation*



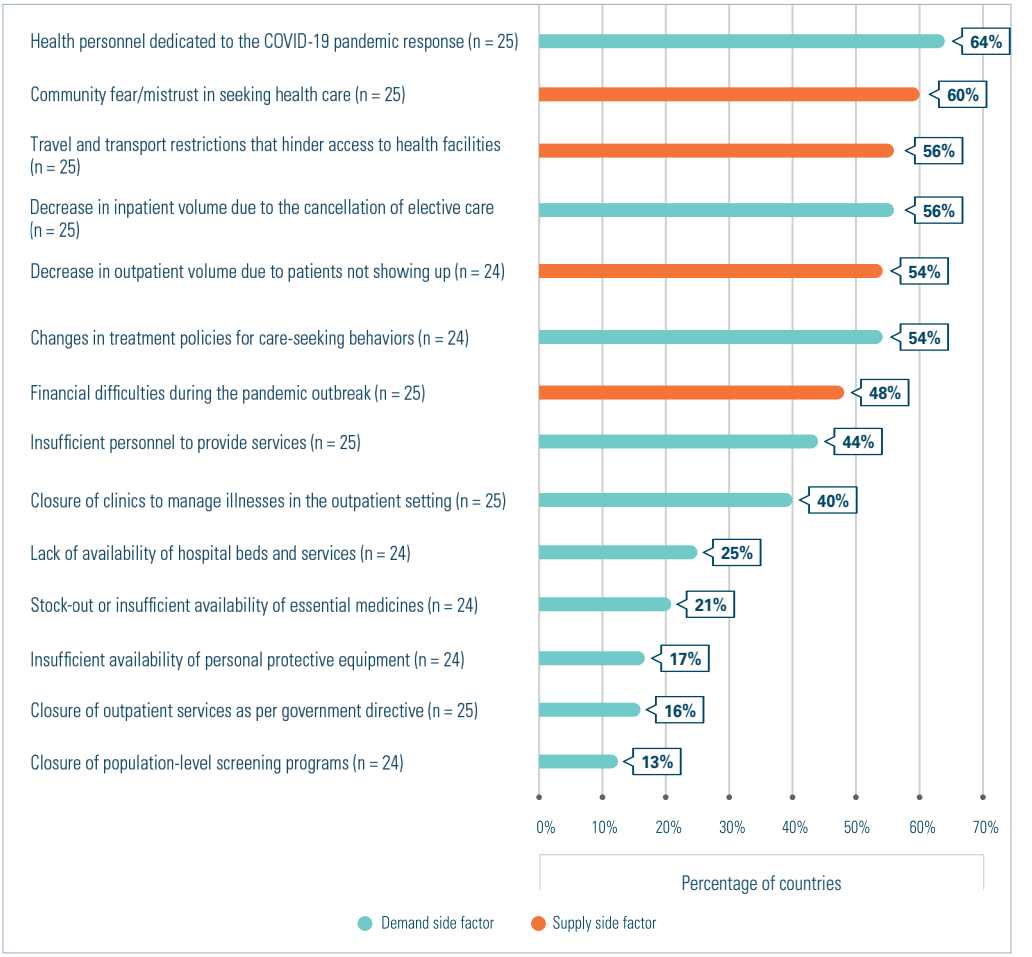
Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that responded by each income level. The "mild disruption" category means that 5%-25% of users were not served as usual; "moderate disruption" means that 26%-50% of users were not served as usual; and "severe disruption" means that more than 50% of users were not served as usual. The total percentage may differ from the sum of the partial percentages due to rounding.

CHAPTER 5

REASONS FOR DISRUPTIONS

Figure 18 shows the reasons for the disruptions in the delivery of essential health services from the supply and demand sides, as found in the second round of the survey on the continuity of health services.

Figure 18. Percentage of countries that reported each of the supply- and demand-related reasons for disruption (n = 25)



Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the smallest number of countries that mentioned each of the reasons for the disruption of essential services.

On the supply side, the main reason for disruptions was the insufficient availability of health personnel, either due to their inability to provide services or their reassignment to respond to the pandemic. These were the reasons indicated by 72% of the 25 responding countries, a reason that persists and has been observed in different priority health areas, such as vaccination personnel (*28*) and personnel specialized in noncommunicable diseases (*2*). The following are other supply-side reasons:

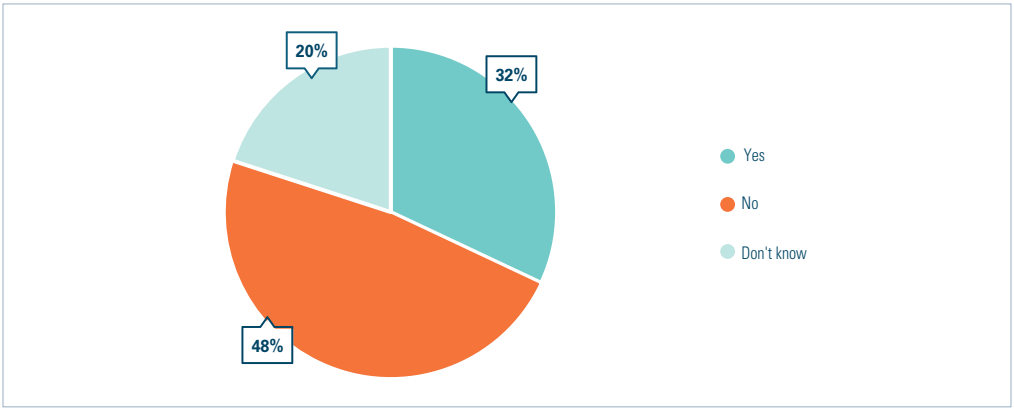
- Of the 25 countries responding on the topic, 14 (56%) indicated decreased inpatient volume due to the cancellation of elective surgical interventions as a reason.
- Of the 24 countries responding on the topic, 13 (54%) indicated the modification of treatment policies for medical care-seeking (e.g. stay-at-home policies) as a reason.
- Of the 25 countries responding on the topic, 10 (40%) highlighted the closure of outpatient services as the reason.

On the demand side, the main reasons for disruptions were as follows:

- Of the 25 countries responding on the topic, 15 (60%) indicated the community's fear of infection and mistrust when seeking medical care as a reason.
- Of the 25 countries responding on the topic, 14 (56%) highlighted travel restrictions that hindered access to health facilities as a reason.
- Of the 24 countries responding on the topic, 13 (54%) mentioned decreased outpatient volume due to patients not presenting as a reason.
- Of the 25 countries responding on the topic, 12 (48%) reported financial difficulties arising during the pandemic and lockdowns as a reason.

Countries' supply chain systems are critical to ensuring that the necessary health products are available in the adequate quantities in order to deliver essential health services. Consequently, disruptions in these systems may limit the continuity of services. In addition to the reasons mentioned in Figure 18, 32% of the 25 countries responding on this issue reported disruptions in supply chains during the three months prior to survey implementation (see Figure 19).

Figure 19. Percentage of countries that reported disruptions in the supply chain (n = 25)



Note: The calculations do not consider the answers "not applicable."

In the specific case of immunization services, difficulties were reported in the delivery of supplies and vaccines for programs due to the closure of international borders, difficulties with international transport, and other reasons.

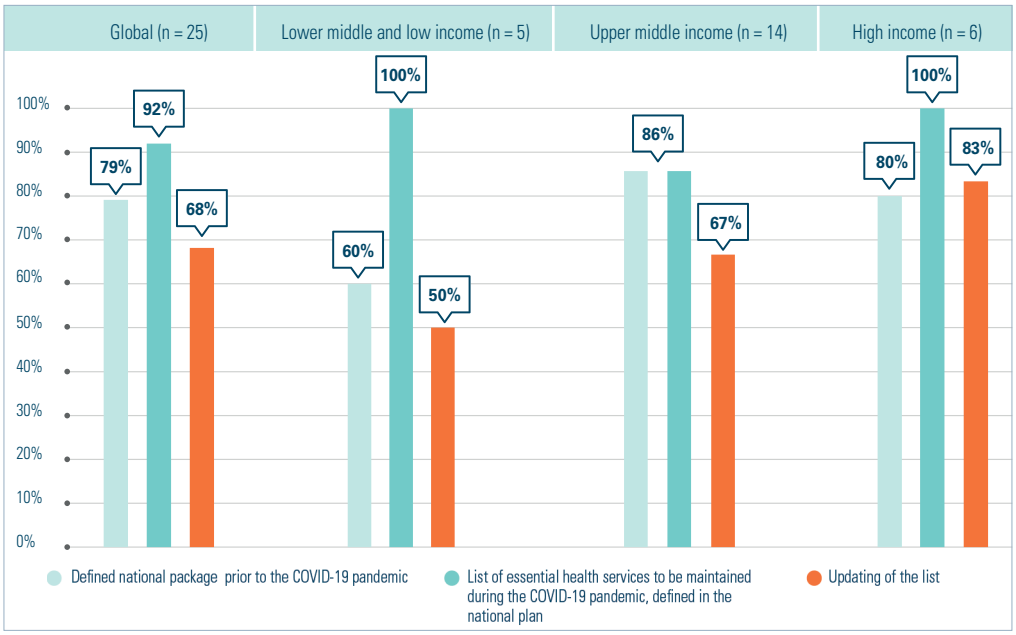
CHAPTER 6

RESPONSE CAPACITY TO MITIGATE SERVICE DISRUPTIONS

6.1 Policies, plans, and mechanisms to support the continuity of essential health services

In most countries of the Region of the Americas, policies, plans, and mechanisms have been established to support the continuity of essential health services during the COVID-19 pandemic. In this regard, 92% of countries (23 of 25) indicated that they had a defined list of health services that would be maintained during the pandemic, and 68% (17 of 25) indicated that they had updated or revised that list since the start of the pandemic (see Figure 20). It should be noted that among high-income countries, this percentage was higher than the percentage observed in countries of other income levels. Indeed, of the six countries in the high-income group, 83% had updated the national list of essential health services that should be maintained during the pandemic.

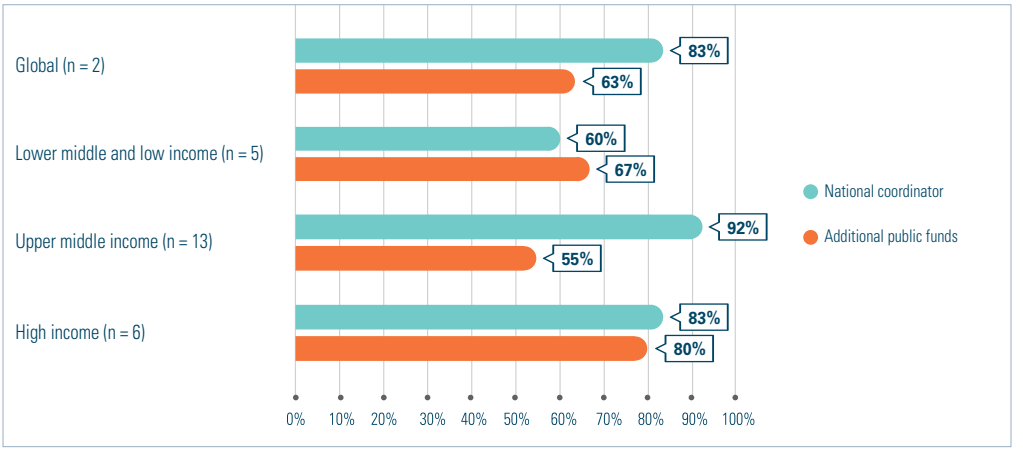
Figure 20. Percentage of countries that have a defined national package of essential services to be maintained during the COVID-19 pandemic, by income level



Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that responded in each income level.

In addition, 20 countries (83%) had designated a national coordinator to maintain essential health services during the COVID-19 pandemic, and 15 (63%) had allocated additional public funds to support service continuity (see Figure 21). Upper middle- and high-income countries reported more frequently that they had national focal points and additional funds to maintain services during the pandemic.

Figure 21. Percentage of countries with a national coordinator and additional public funds to maintain the continuity of essential services, by income level

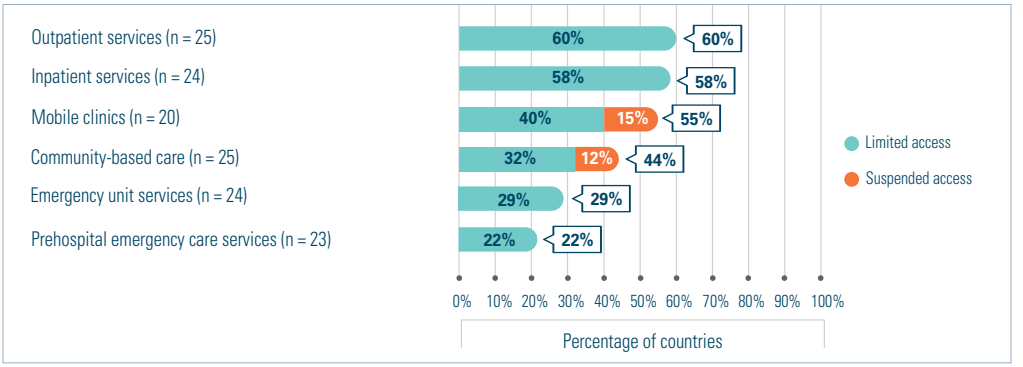


Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that responded by each income level.

6.2 Strategic changes in the provision of essential individual and public health services

To some extent, disruptions can be attributed to intentional strategic changes in the service delivery platforms and public health services in the context of the pandemic. Indeed, in more than half of the countries, outpatient services (60% of 25 countries), hospital services (58% of 24 countries), and mobile clinics (55% of 20 countries) were limited or suspended. The provision of emergency unit and pre-hospital services also declined by 29% and 22% in responding countries, respectively (see Figure 22).

Figure 22. Percentage of countries where service delivery was limited or suspended, by platform

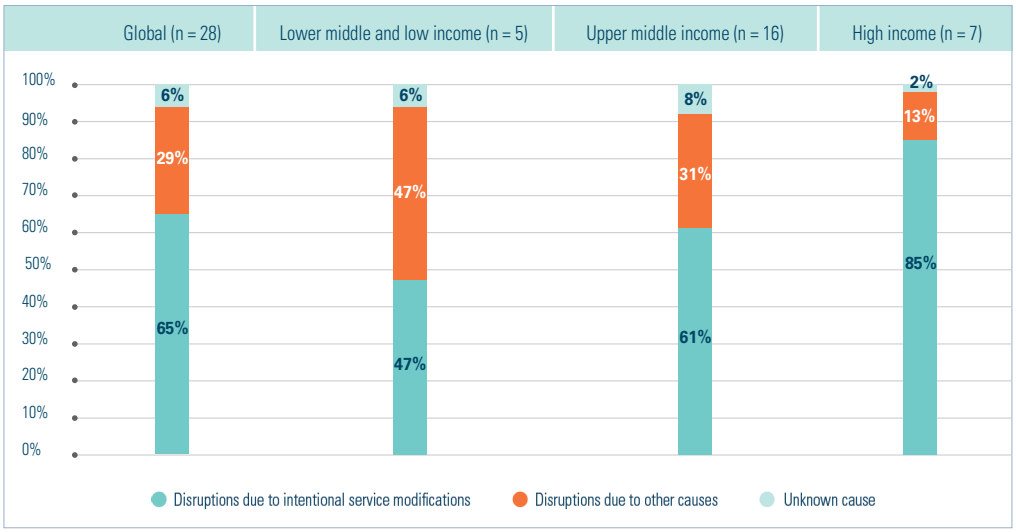


Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that responded about the level of disruption in each platform.

Countries in the Region of the Americas have responded in different ways to COVID-19 surges. One strategy has been to implement changes in the provision of specific services to ensure the safety of health workers and users. This strategy seeks to mitigate the collapse of health systems.

The survey makes it possible to determine whether the disruptions in service delivery, such as those due to strategic changes in the provision of services, were unintentional or intentional. On average, 65% of the countries assessed (18 of 28) reported that the disruptions resulted from intentional government-driven changes to the delivery of essential health services. In this regard, intentional disruptions appear to be more frequent in higher-income countries (see Figure 23).

Figure 23. Percentage of countries where the provision of tracer services was intentionally limited or suspended, by income level

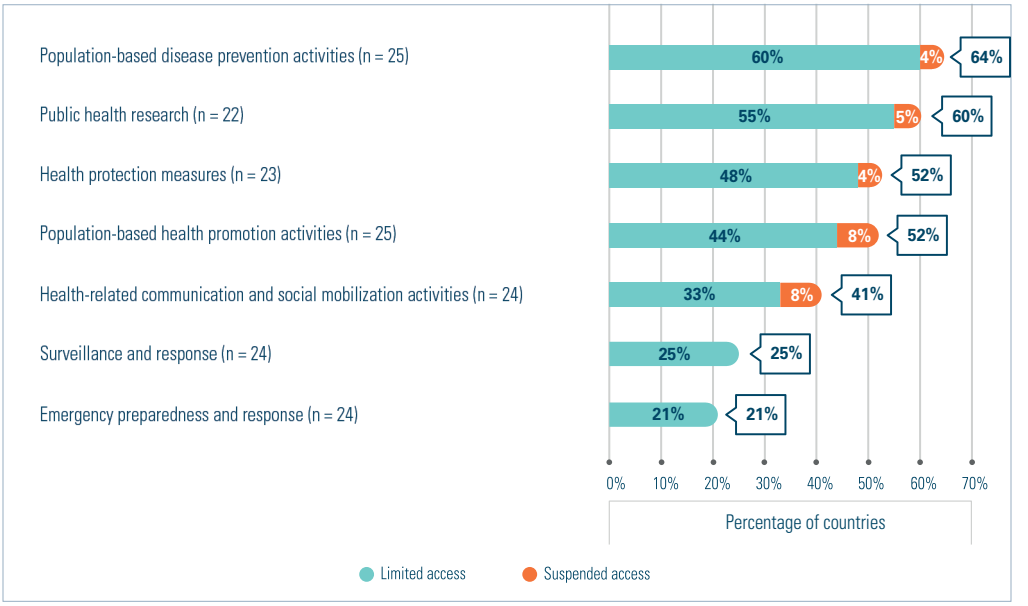


Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that responded in each income group.

The provision of essential population-based public health services was also greatly affected by the pandemic (see Figure 24). The major disruptions observed were as follows:

- Of the 25 responding countries, 16 (64%) indicated that they had limited or suspended population-based disease prevention activities.
- Of the 22 responding countries, 13 (60%) reported that they had limited or suspended public health research.
- Of the 25 responding countries, 13 (52%) reported that they had limited or suspended population-based health promotion activities.
- Of the 23 responding countries, 12 (52%) reported that they had limited or suspended population-based health protection measures.
- Of the 24 responding countries, 10 (41%) indicated that they had limited or suspended health-related communication and social mobilization activities.

Figure 24. Percentage of countries where the provision of public health services was limited or suspended



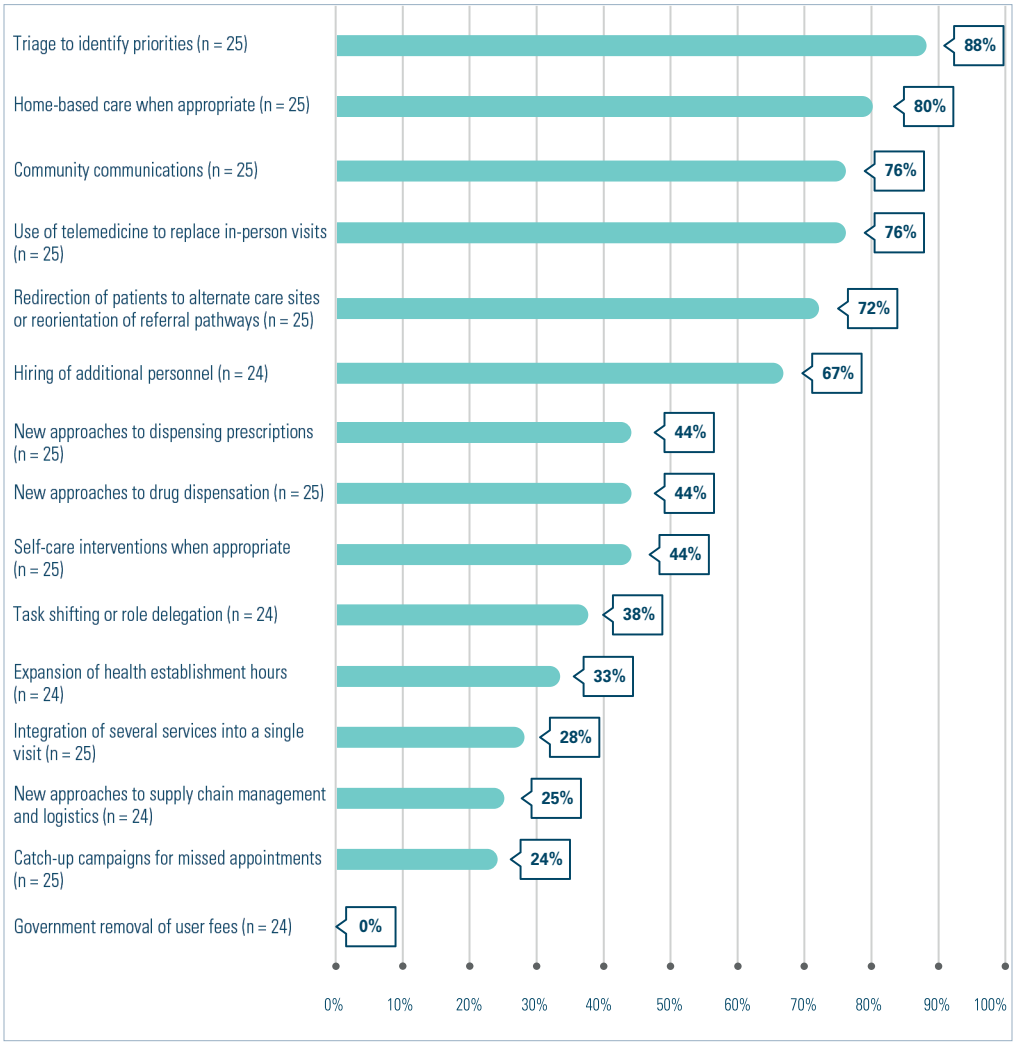
Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that responded about the level of disruption in each channel.

6.3 Mitigation strategies and approaches

Most countries are implementing strategies to mitigate disruptions in service delivery (see Figure 25). The most frequently reported approaches include the following:

- Of the 25 responding countries, 88% cited triage as a strategy to identify care priorities.
- Of the 25 responding countries, 80% indicated the provision of home-based care when appropriate as a strategy.
- Of the 25 responding countries, 76% indicated community communications as a strategy.
- Of the 25 responding countries, 76% indicated the implementation of telemedicine to replace in-person visits as a strategy.
- Of the 25 responding countries, 72% indicated the redirection of patients to alternate care sites as a strategy.
- Of the 24 responding countries, 67% indicated the recruitment of additional personnel as a strategy.

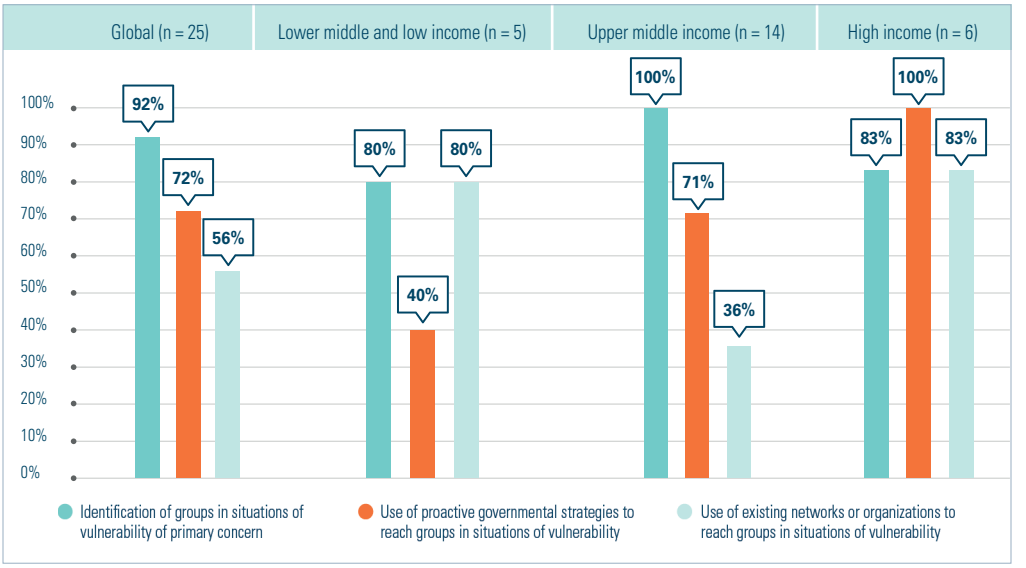
Figure 25. Percentage of countries that reported implementation of the various mitigation strategies



Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that responded about each mitigation strategy.

Many countries in the Region of the Americas have also implemented strategies to ensure that groups in situations of greater vulnerability have access to health services. In this regard, 92% of countries (23 of 25) have identified groups in situations of vulnerability of primary concern (see Figure 26). Likewise, 72% of countries (18 of 25) have public strategies to reach groups in situations of vulnerability, and 56% (14 of 25) used existing networks and organizations to ensure care for these groups. In general, there is no difference between countries from different income groups in the implementation of these strategies. The sole exception is the implementation of proactive public strategies to reach groups in situations of vulnerability, which were used more in high-income countries.

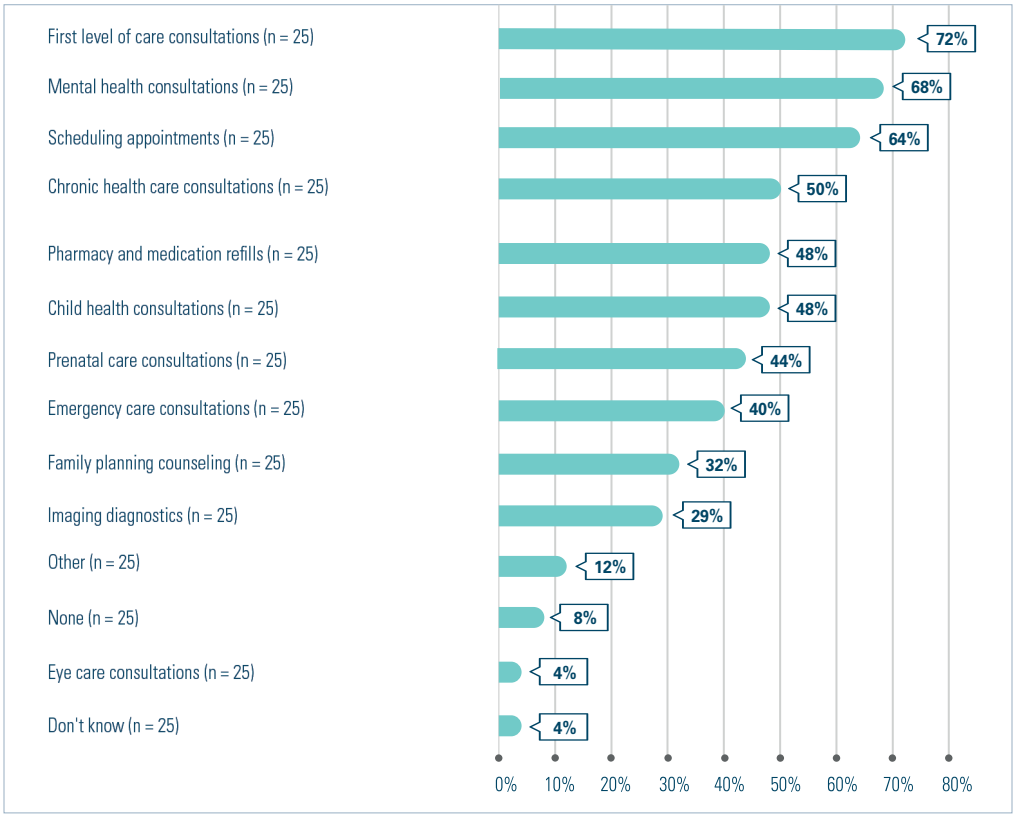
Figure 26. Percentage of countries that implemented strategies to ensure that groups in situations of vulnerability had access to care, by income level



Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the smallest number of countries that responded in each income group.

Telehealth technologies allow people to receive care and support while minimizing their exposure, making them a useful tool in the pandemic context. In this regard, 88% of the countries evaluated (22 of 25) reported that they used telehealth in at least one of the identified services. Countries use these technologies most frequently for first level of care visits, followed by mental health-related visits, and scheduling of medical appointments (72%, 68%, and 64% of 25 reporting countries, respectively) (see Figure 27).

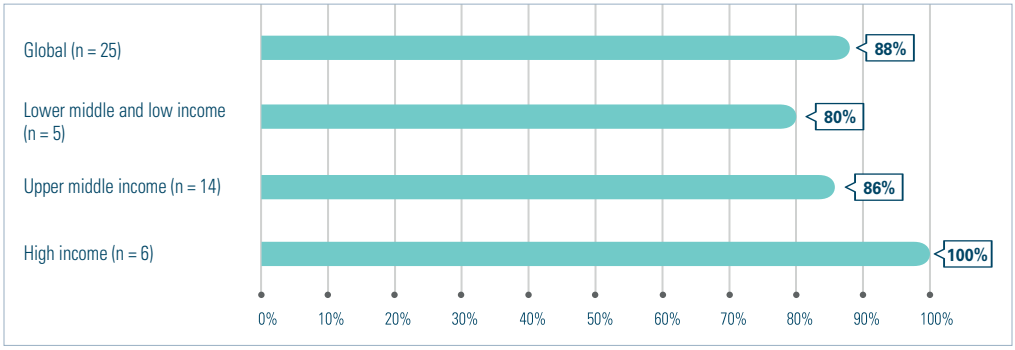
Figure 27. Percentage of reporting countries that used telehealth technologies to support service delivery, by type of service (n = 25)



Note: The calculations do not consider the answers "not applicable." The *n* value represents the smallest number of countries that responded about the use of telehealth technologies.

While the degree of use of telehealth technologies is high in countries from all income groups, countries in the high-income group reported using them more frequently (see Figure 28).

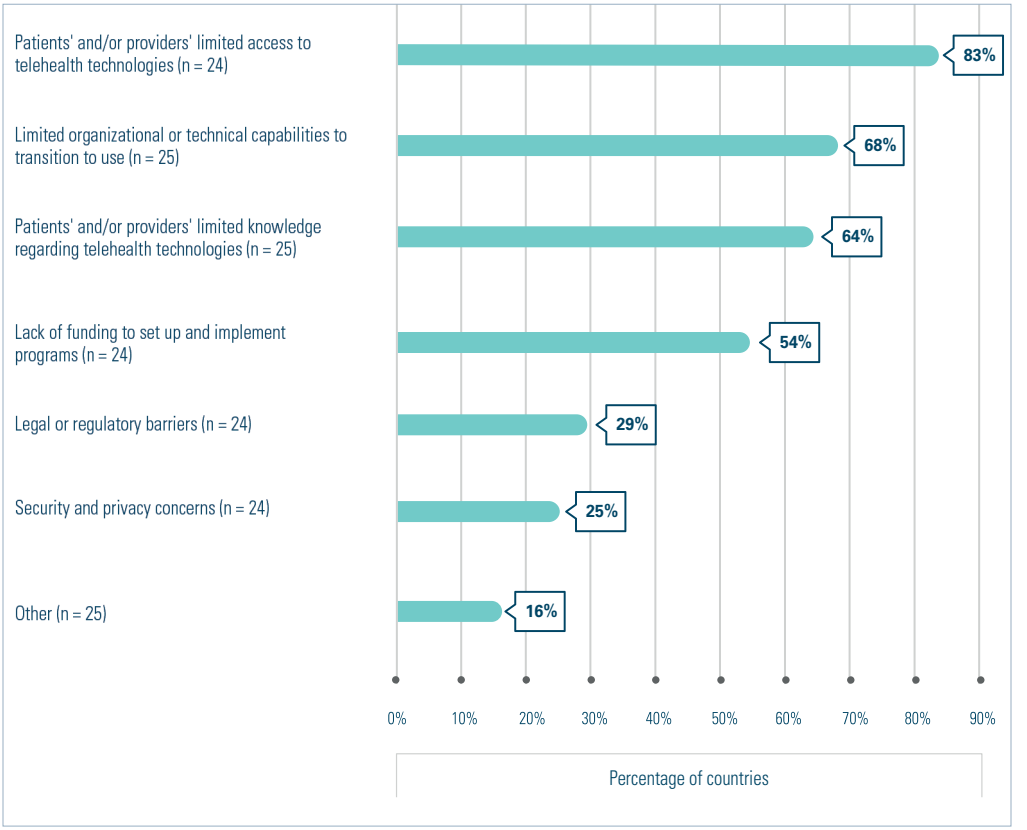
Figure 28. Percentage of reporting countries that used telehealth technologies to support service delivery, by income level (n = 25)



Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that responded in each income group.

It should be noted that a significant number of countries reported that they faced barriers in the use of telehealth technologies. The most frequently mentioned barrier was limited access to telehealth by patients and providers: of 24 countries, 83% reported this barrier (see Figure 29). It was followed by limited organizational or technical capabilities to transition to the use of these technologies (68% of 25 countries), and patients' or providers' limited knowledge about the technologies (64% of 25 countries).

Figure 29. Percentage of reporting countries that faced barriers in the use of telehealth technologies



Note: The calculations do not consider the answers "not applicable." The *n* value represents the smallest number of countries that responded about the barriers that they faced to the use of telehealth technologies.

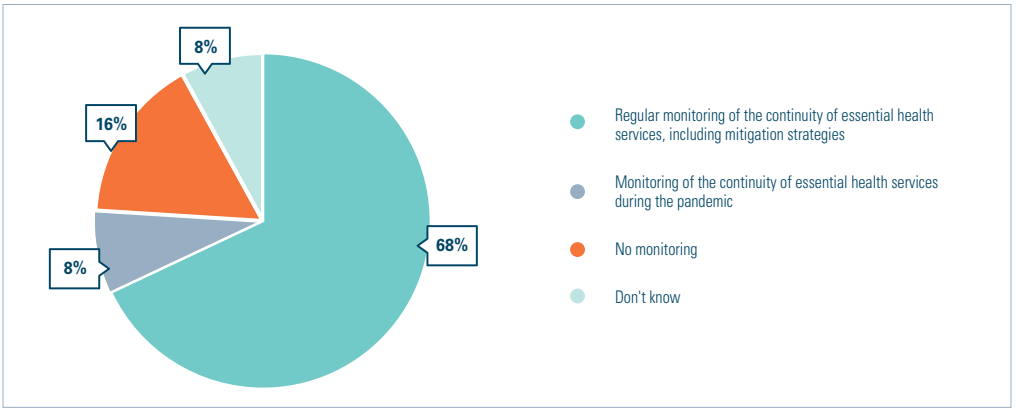
CHAPTER 7

INFORMATION TRACKING

Tracking information related to the continuity of essential health services during the COVID-19 pandemic is critical to proposing immediate planning and investment responses.

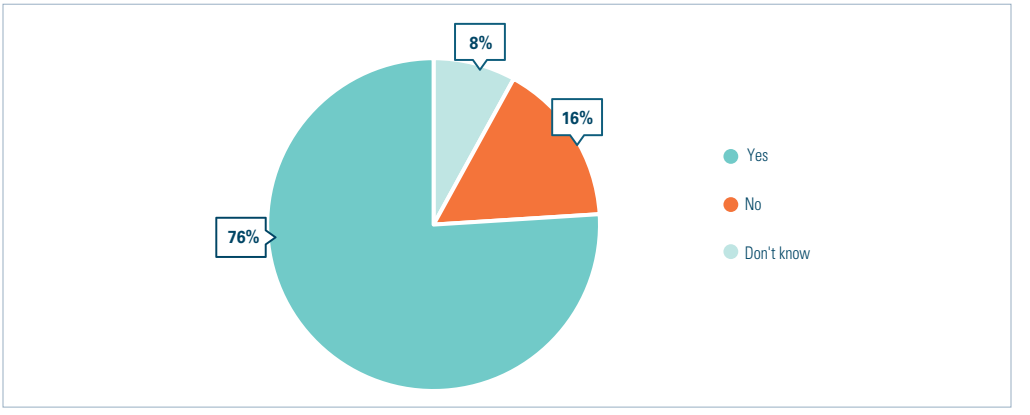
Survey results show that 68% of countries (17 of 25) regularly tracked the continuity of the delivery of essential health services and mitigation strategies aimed at overcoming disruptions during the COVID-19 pandemic (see Figure 30). To better understand the changing needs of the population, data on the comorbidities of COVID-19 patients are also being collected and compared in 76% of countries (19 of 25) (see Figure 31).

Figure 30. Percentage of countries that regularly monitor the continuity of essential health services during the COVID-19 pandemic (n = 25)



Note: The calculations do not consider the answers "not applicable."

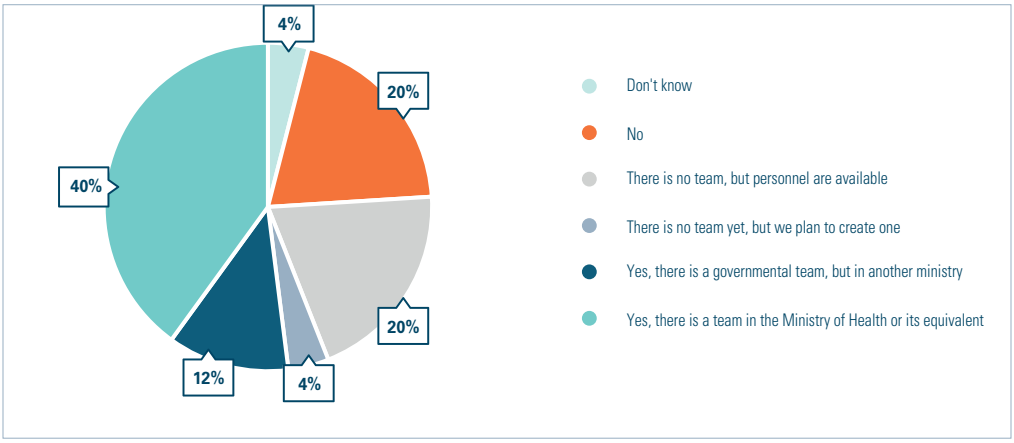
Figure 31. Percentage of countries that collect information on the comorbidities of COVID-19 patients (n = 25)



Note: The calculations do not consider the answers "not applicable."

Countries have also taken steps to better understand and respond to infodemics and pandemic-related misinformation. In this regard, 52% of countries (13 of 25) indicated that they had a team dedicated to tracking and addressing health misinformation and infodemics, either within the Ministry of Health or another ministry (see Figure 32). These teams perform essential functions, including analyzing and monitoring misinformation and how it affects the acceptance of public health measures and healthcare-seeking. In addition, they propose evidence-based interventions aimed at countering misinformation at the national, subnational, community, and individual levels.

Figure 32. Percentage of countries with a team dedicated to tracking and addressing health infodemics and misinformation (n = 25)



Note: The calculations do not consider the answers "not applicable."

CHAPTER 8

MONITORING THE REGIONAL SITUATION: COMPARISON OF THE RESULTS FROM SURVEY ROUNDS 1 AND 2

This section presents comparisons between the first and second rounds of the survey on the continuity of essential health services during the COVID-19 pandemic. Information from the first round comes from three surveys: the national survey on the continuity of essential health services during the COVID-19 pandemic (*5*), the rapid assessment of the impact of the COVID-19 pandemic on noncommunicable disease resources and services (*6*), and the rapid assessment of the impact of COVID-19 on mental, neurological, and substance use services (*7*).

It should be noted that the comparison only considers the subset of 25 countries that participated and responded during both survey rounds. In addition, comparative analysis of disruptions is only possible for the following 35 essential health services that were included in both surveys:

- Emergency, intensive care, and surgical services: 24-hour emergency room and unit services (e.g., myocardial infarction, stroke, shock, asthma, pneumonia, sepsis, and serious injuries), urgent blood transfusion services, inpatient intensive care services, and emergency surgical interventions.
- Reproductive, maternal, newborn, child, and adolescent health services: family planning and contraception, prenatal care, institutional deliveries, and services for sick children.
- Immunization services: routine facility-based and outreach immunization services.
- Services for communicable diseases: outbreak detection and control (of diseases other than COVID-19), continuation of established antiretroviral treatment, malaria diagnosis and treatment, malaria prevention campaigns, insecticide-treated nets, indoor residual spraying, and seasonal malaria chemoprevention.
- Services for noncommunicable diseases: cancer screening and treatment, hypertension management, diabetes management, and asthma-related services.
- Mental, neurological, and substance use disorders: management of emergency manifestations of these disorders; psychotherapy, counseling, and related psychosocial interventions; issuing of prescriptions for mental, neurological, and substance use disorder medicines; services for children and adolescents with mental health disorders or disabilities; services for older adults with mental health disorders or disabilities; school mental health programs; suicide prevention programs; overdose prevention and treatment programs; and critical harm reduction services.
- Rehabilitation and palliative care services.

8.1 General monitoring of disruptions in service delivery

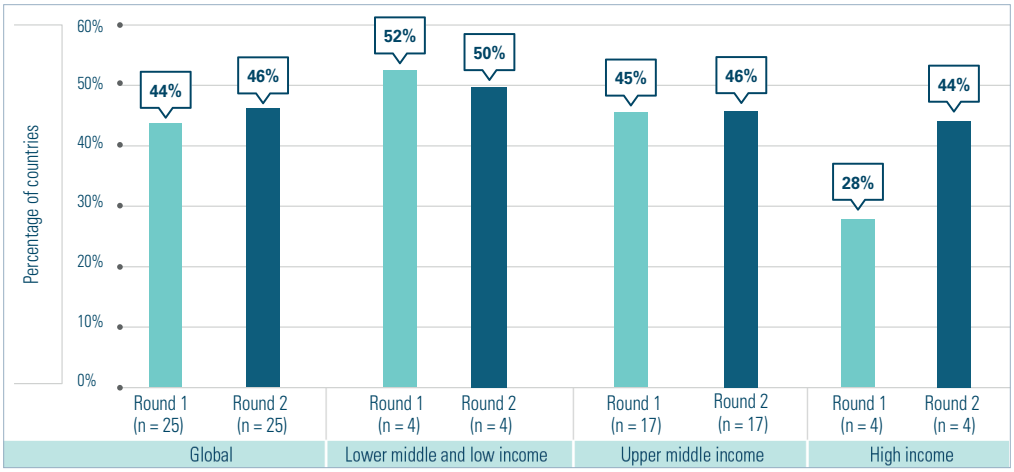
Overall, the percentage of countries reporting disruptions in the continuity of essential health service delivery due to the COVID-19 pandemic has not changed substantially since 2020. In 2020, of the 25 countries responding to the survey, 92% reported disruptions in the delivery of at least one health service, a slightly lower percentage than the 96% observed in 2021. Figure 33 shows that the average percentage of services disrupted increased slightly, from 44% in 2020 to 46% in 2021. Disaggregation by country shows that, in 2021, 52% of countries reported disruptions in more than half of the 35 essential health services, slightly higher than the 48% observed in 2020.

Figure 33. Percentage of the 35 tracer health services that experienced disruptions in each survey round, by country

Note: The calculations do not consider the answers "do not know" or "not applicable." The countries that participated in both survey rounds are considered. Round 1 was held in the second and third quarters of 2020, and round 2 in the first and second quarters of 2021. For the codes assigned to countries, see https://unstats.un.org/unsd/methodology/m49/.

The average percentage of services disrupted in the countries that participated in both survey rounds was also analyzed by income level. Overall, this percentage did not change greatly between 2020 and 2021 in any of the country groups. The exception is the high-income group, where the percentage of services disrupted increased by 16 percentage points from one year to the next (see Figure 34).

Figure 34. Percentage of countries that reported disruptions in tracer services in round 1 and round 2 of the survey, by income level

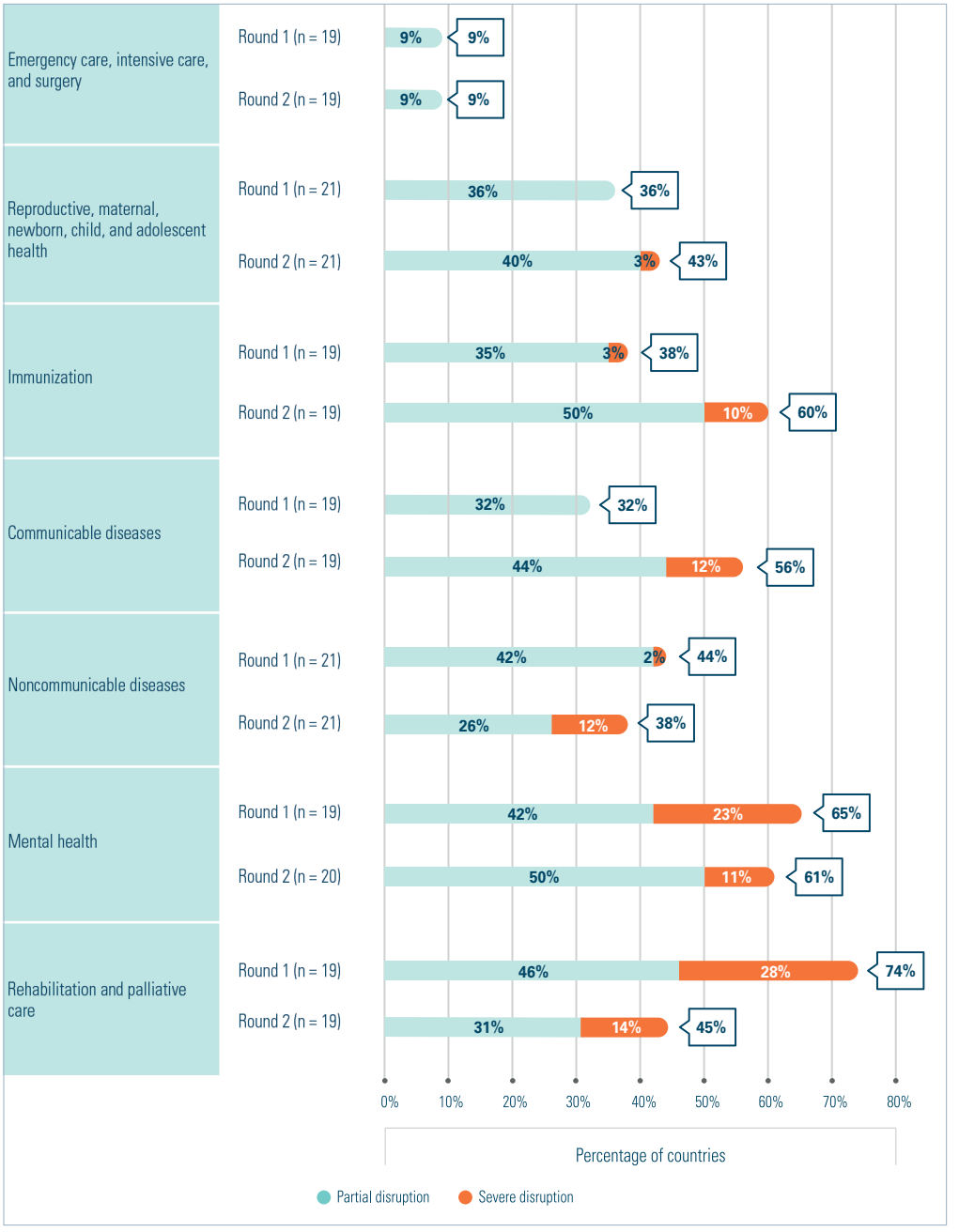


Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries in each income group that answered the questions in both survey rounds. Only countries that participated in both rounds are considered.

8.2 Monitoring of disruptions in services for priority health areas

The trend in the percentage of countries reporting disruptions in the delivery of essential health services varied by priority area. The largest reductions in this percentage were observed for rehabilitation and palliative care services, followed by services for mental, neurological, and substance use disorders. On the other hand, the percentage increased for reproductive, maternal, newborn, child, and adolescent health services, as well as for immunization services (see Figure 35).

Figure 35. Percentage of countries that reported disruptions in tracer services in round 1 and round 2 of the survey, by service

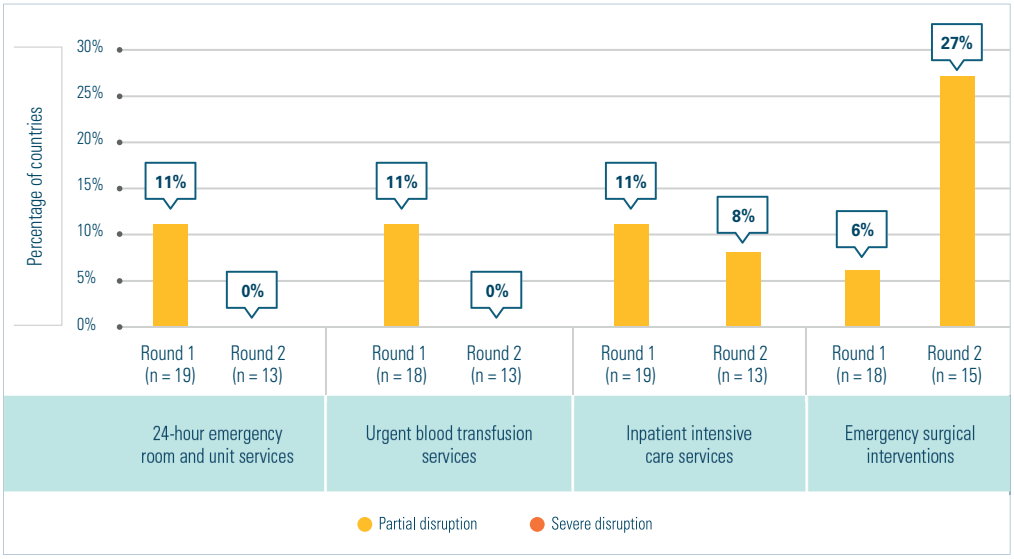


Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that answered the questions for each service in both rounds. The "partial disruption" category means that 5%-50% of users were not served as usual; "severe disruption" means that more than 50% of users were not served as usual. Only countries that participated in both rounds are considered.

8.2.1 Follow-up of disruptions in emergency, intensive care, and surgery services

Overall, the percentage of countries that reported disruptions in the delivery of emergency care, intensive care, and surgical services was lower in 2021 than in 2020, with the exception of emergency surgical interventions (see Figure 36).

Figure 36. Percentage of countries that reported disruptions in emergency care, intensive care, and surgery services in round 1 and round 2 of the survey



Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that answered the questions for each service in both rounds. The "partial disruption" category means that 5%-50% of users were not served as usual; "severe disruption" means that more than 50% of users were not served as usual.

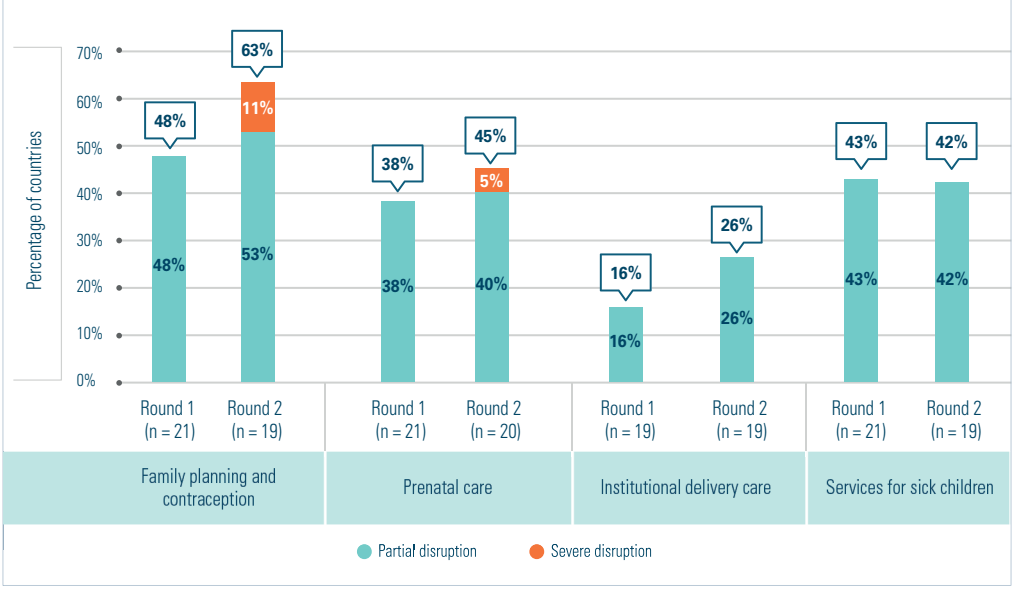
Figure 36 allows the following conclusions to be drawn:

- The percentage of countries that reported disruptions in emergency surgical interventions increased from 6% (of 18 countries) in 2020 to 27% (of 15 countries) in 2021.
- The percentage of countries that reported disruptions in intensive inpatient care services decreased from 11% (of 19 countries) in 2020 to 8% (of 13 countries) in 2021.
- The percentage of countries that reported disruptions in urgent blood transfusion services decreased from 11% (of 18 countries) in 2020 to 0% (of 13 countries) in 2021.
- The percentage of countries that reported disruptions in 24-hour emergency room services decreased from 11% (of 19 countries) in 2020 to 0% (of 13 countries) in 2021.

8.2.2 Monitoring of disruptions in reproductive, maternal, newborn, child, and adolescent health services

Comparison of the two survey rounds shows that the percentage of countries with some level of disruption increased in three of the four services evaluated, namely, reproductive, maternal, newborn, child, and adolescent health, family planning and contraception, prenatal care, and institutional deliveries. The largest increase was observed in the percentage of countries that reported disruptions in the provision of family planning and contraception services (see Figure 37).

Figure 37. Percentage of countries that reported disruptions in reproductive, maternal, newborn, child, and adolescent health services in round 1 and round 2 of the survey



Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that answered the questions for each service in both rounds. The "partial disruption" category means that 5%-50% of users were not served as usual; "severe disruption" means that more than 50% of users were not served as usual. The total percentage may differ from the sum of the partial percentages due to rounding.

Figure 37, which compares the percentage of countries that reported disruptions in both survey rounds, shows the following:

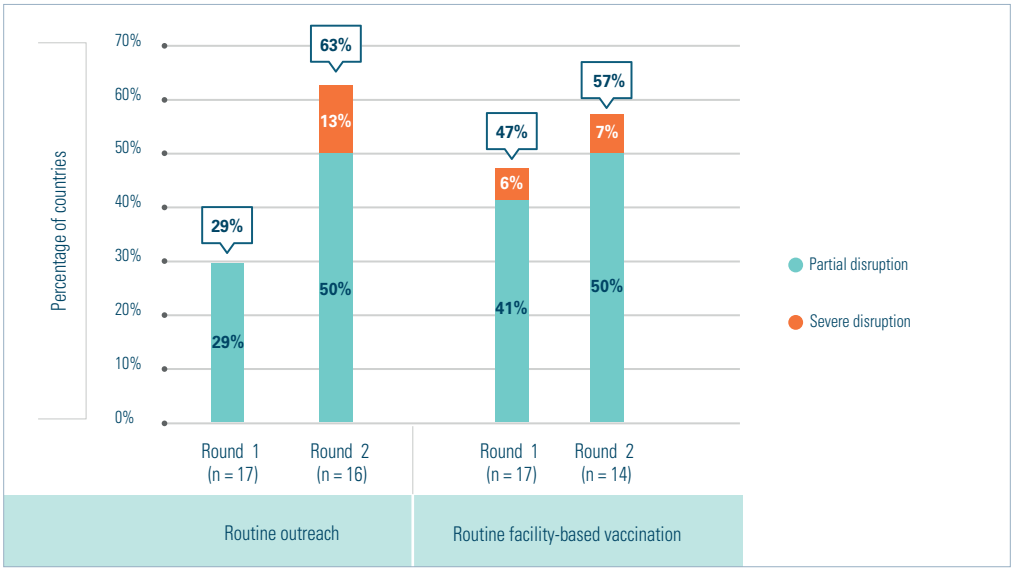
- The percentage of countries that reported disruptions in family planning and contraception services increased from 48% (of 21 countries) in 2020 to 63% (of 19 countries) in 2021.
- The percentage of countries that reported disruptions in prenatal care increased from 38% (of 21 countries) in 2020 to 45% (of 20 countries) in 2021.
- The percentage of countries that reported disruptions in institutional deliveries increased from 16% (of 19 countries) in 2020 to 26% (of 19 countries) in 2021.
- The percentage of countries that reported disruptions in services for sick children remained substantially unchanged, at 43% (of 21 countries) in 2020 and 42% (of 19 countries) in 2021.

8.2.3 Monitoring disruptions in immunization services

Figure 38 shows that the percentage of countries that reported disruptions in vaccination services increased between the first and second survey rounds:

- The percentage of countries that reported disruptions in routine outreach vaccination increased from 29% (of 17 countries) in 2020 to 63% (of 16 countries) in 2021.
- The percentage of countries that reported disruptions in routine facility-based vaccination increased from 47% (of 17 countries) in 2020 to 57% (of 14 countries) in 2021.

Figure 38. Percentage of countries that reported disruptions in immunization services in round 1 and round 2 of the survey



Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that answered the questions for each service in both rounds. The "partial disruption" category means that 5%-50% of users were not served as usual; "severe disruption" means that more than 50% of users were not served as usual. Only countries that participated in both rounds are considered.

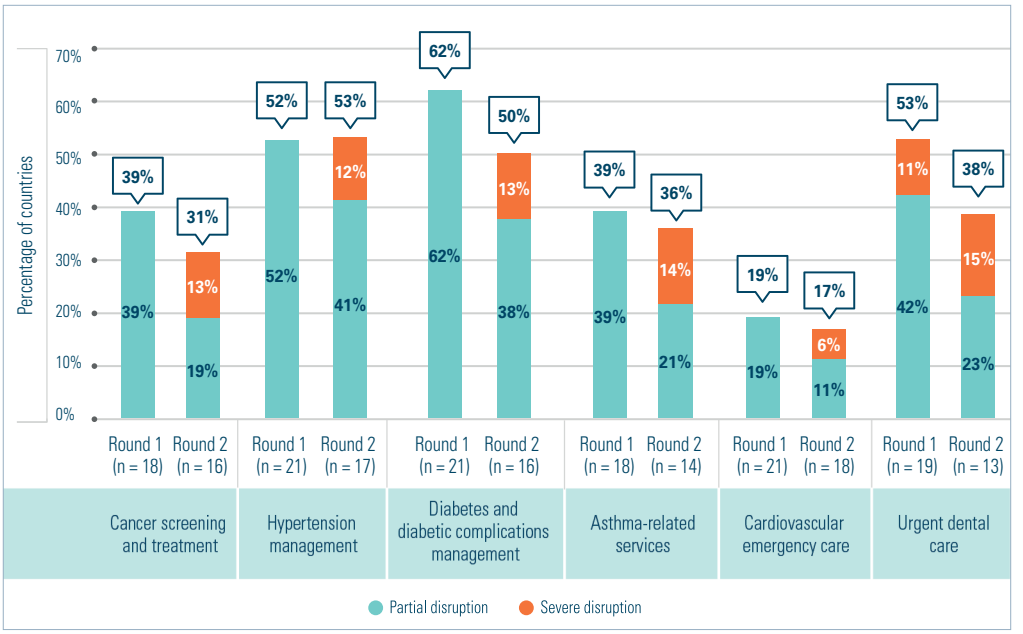
8.2.4 Monitoring of disruptions in services for noncommunicable diseases

At the start of the pandemic, in May and June 2020, a rapid assessment was carried out to assess the level of disruption in services for noncommunicable diseases (*29*). The results of this assessment were similar to those obtained in the first survey round: partial disruption was reported in all services. In fact, 52% of countries reported disruptions in services for diabetes and diabetic complications management, 45% reported disruptions in hypertension management services, 41% reported disruptions in urgent dental care services, and 28% reported disruptions in cancer treatment and asthma treatment services. The only service for which complete disruption was reported was for urgent dental care, in 7% of countries.

Among the countries that responded to both survey rounds, there is an apparent decrease in the percentage that reported disruptions in most of the tracer services for noncommunicable disease care. Figure 39 shows the following for the six tracer services:

- The percentage of countries that reported disruptions in cancer screening and treatment decreased from 39% (of 18 countries) in 2020 to 31% (of 16 countries) in 2021.
- The percentage of countries that reported disruptions in hypertension management showed no significant change, at 52% (of 21 countries) in 2020 and 53% (of 17 countries) in 2021.
- The percentage of countries that reported disruptions in diabetes and diabetic complications management decreased from 62% (of 21 countries) in 2020 to 50% (of 16 countries) in 2021.
- The percentage of countries that reported disruptions in asthma-related services decreased slightly, from 39% (of 18 countries) in 2020 to 36% (of 14 countries) in 2021.
- The percentage of countries that reported disruptions in cardiovascular emergency care decreased slightly, from 19% (of 21 countries) in 2020 to 17% (of 18 countries) in 2021.
- The percentage of countries that reported disruptions in urgent dental care decreased from 53% (of 19 countries) in 2020 to 38% (of 13 countries) in 2021.

Figure 39. Percentage of countries that reported disruptions in services for noncommunicable diseases in round 1 and round 2 of the survey



Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that answered the questions for each service in both rounds. The "partial disruption" category means that 5%-50% of users were not served as usual; "severe disruption" means that more than 50% of users were not served as usual. The total percentage may differ from the sum of the partial percentages due to rounding.

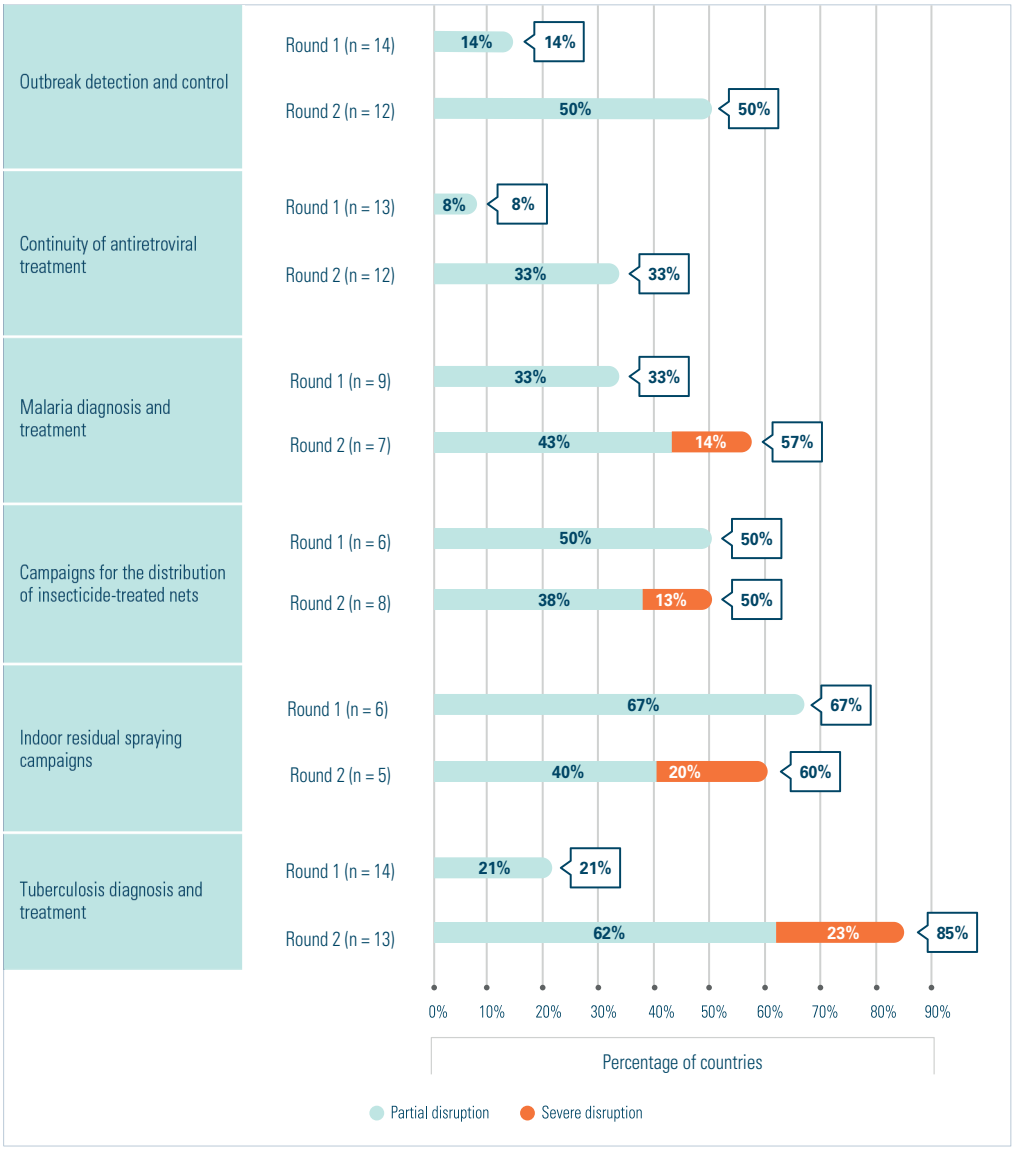
8.2.5 Monitoring of disruptions to services for communicable diseases

The number of countries that reported disruptions in the delivery of tracer services for communicable diseases increased overall, with the exception of the distribution of insecticide-treated nets and indoor residual spraying campaigns.

Figure 40 shows the change in the percentage of countries that reported disruptions in both survey rounds:

- The percentage of countries that reported disruptions in outbreak detection and control increased from 14% (of 14 countries) in 2020 to 50% (of 12 countries) in 2021.
- The percentage of countries that reported disruptions in the continuity of antiretroviral treatment increased from 8% (of 13 countries) in 2020 to 33% (of 12 countries) in 2021.
- The percentage of countries that reported disruptions in malaria diagnosis and treatment increased from 33% (of 9 countries) in 2020 to 57% (of 7 countries) in 2021.
- The percentage of countries that reported disruptions in tuberculosis diagnosis and treatment increased from 21% (of 14 countries) in 2020 to 85% (of 13 countries) in 2021.
- The percentage of countries that reported disruptions in the distribution of insecticide-treated nets remained at 50% (of 6 countries) in 2020 and 50% (of 8 countries) in 2021.
- The percentage of countries that reported disruptions in indoor residual spraying campaigns decreased from 67% (of 6 countries) in 2020 to 60% (of 5 countries) in 2021.

Figure 40. Percentage of countries that reported disruptions in services for communicable diseases in round 1 and round 2 of the survey



Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that answered the questions for each service in both rounds. The "partial disruption" category means that 5%-50% of users were not served as usual; "severe disruption" means that more than 50% of users were not served as usual. The total percentage may differ from the sum of the partial percentages due to rounding.

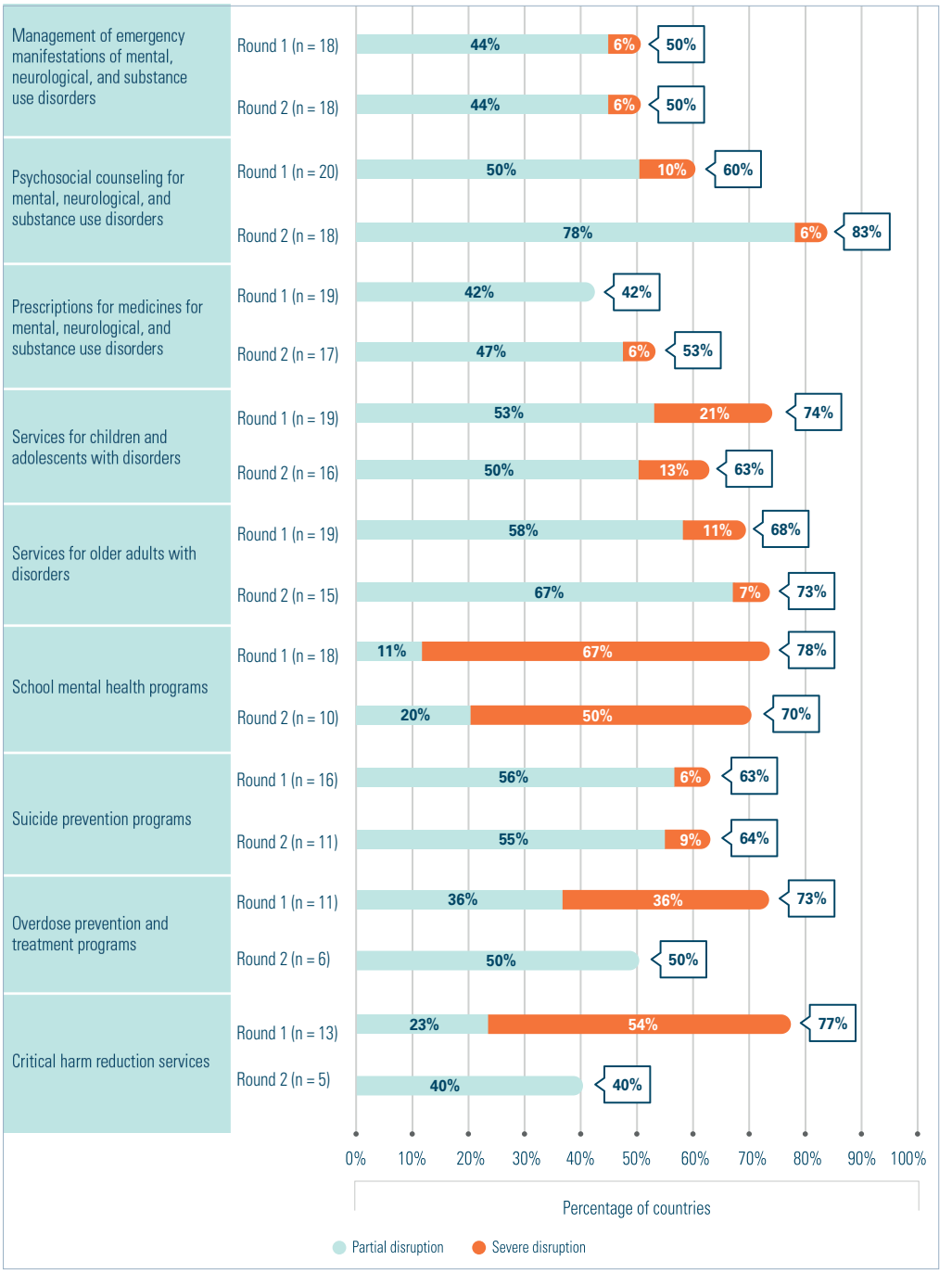
8.2.6 Monitoring disruptions in services for mental, neurological, and substance use disorders

Although the percentage of countries that reported disruptions in the provision of most tracer services for mental, neurological, and substance use disorder care decreased or remained the same from 2020 to 2021, delivery of these services continues to experience the highest degree of disruption.

In particular, when analyzing the percentage of countries that reported disruptions in both survey rounds, it is observed that the percentage decreased or stayed almost the same in the following cases (see Figure 41):

- The percentage of countries that reported disruptions in school-based mental health programs decreased from 78% (of 18 countries) in 2020 to 70% (of 10 countries) in 2021.
- The percentage of countries that reported disruptions in services for children and adolescents with mental, neurological, and substance use disorders decreased from 74% (of 19 countries) in 2020 to 63% (of 16 countries) in 2021.
- The percentage of countries that reported disruptions in overdose prevention and treatment programs decreased from 73% (of 11 countries) in 2020 to 50% (of 6 countries) in 2021.
- The percentage of countries that reported disruptions in critical harm reduction services decreased from 77% (of 13 countries) in 2020 to 40% (of 5 countries) in 2021.
- The percentage of countries that reported disruptions in the management of emergency manifestations of mental, neurological, and substance use disorders remained at 50% (of 18 countries).
- The percentage of countries that reported disruptions in suicide prevention programs did not show a major change, from 63% (of 16 countries) in 2020 to 64% (of 11 countries) in 2021.

Figure 41. Percentage of countries that reported disruptions in services for mental, neurological, and substance use disorders in round 1 and round 2 of the survey



Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that answered the questions for each service in both rounds. The "partial disruption" category means that 5%-50% of users were not served as usual; "severe disruption" means that more than 50% of users were not served as usual. The total percentage may differ from the sum of the partial percentages due to rounding.

On the other hand, the percentage of countries that reported disruptions in services for mental, neurological, and substance use disorders increased in the following cases:

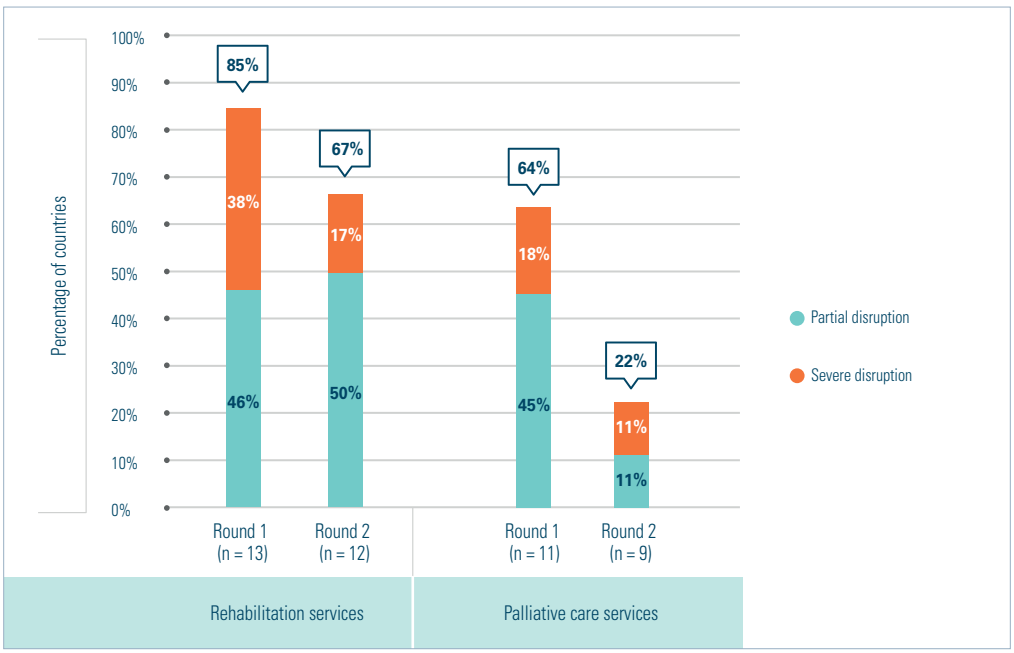
- Psychosocial counseling for these disorders: the percentage increased from 60% (of 20 countries) in 2020 to 83% (of 18 countries) in 2021.
- Prescriptions for medicines for these disorders: the percentage increased from 42% (of 19 countries) in 2020 to 53% (of 17 countries) in 2021.
- Services for older adults with these disorders: the percentage increased from 68% (of 19 countries) in 2020 to 73% (of 15 countries) in 2021.

8.2.7 Monitoring of disruptions in rehabilitation and palliative care services

The largest disruptions in the provision of rehabilitation and palliative care services were observed in 2020. Indeed, Figure 42 shows that the percentage of countries that reported disruptions in the provision of these services decreased between the first and second survey rounds:

- The percentage of countries that reported disruptions in rehabilitation services decreased from 85% (of 13 countries) in 2020 to 67% (of 12 countries) in 2021.
- The percentage of countries that reported disruptions in palliative care services decreased from 64% (of 11 countries) in 2020 to 22% (of 9 countries) in 2021.

Figure 42. Percentage of countries that reported disruptions in rehabilitation and palliative care services in round 1 and round 2 of the survey



Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that answered the questions for each service in both rounds. The "partial disruption" category means that 5%-50% of users were not served as usual; "severe disruption" means that more than 50% of users were not served as usual. The total percentage may differ from the sum of the partial percentages due to rounding.

8.3 Monitoring the reasons for service disruptions

A comparison of the main reasons for disruptions in health services reported in the first and second survey rounds shows that lack of health personnel, failure of users to show up for outpatient visits, and cancellation of scheduled visits continue to be the reasons most frequently reported by countries (see Figure 43).

Figure 43. Percentage of countries that identified each of the main reasons for disruptions in round 1 and round 2 of the survey

Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that answered the questions in both rounds.

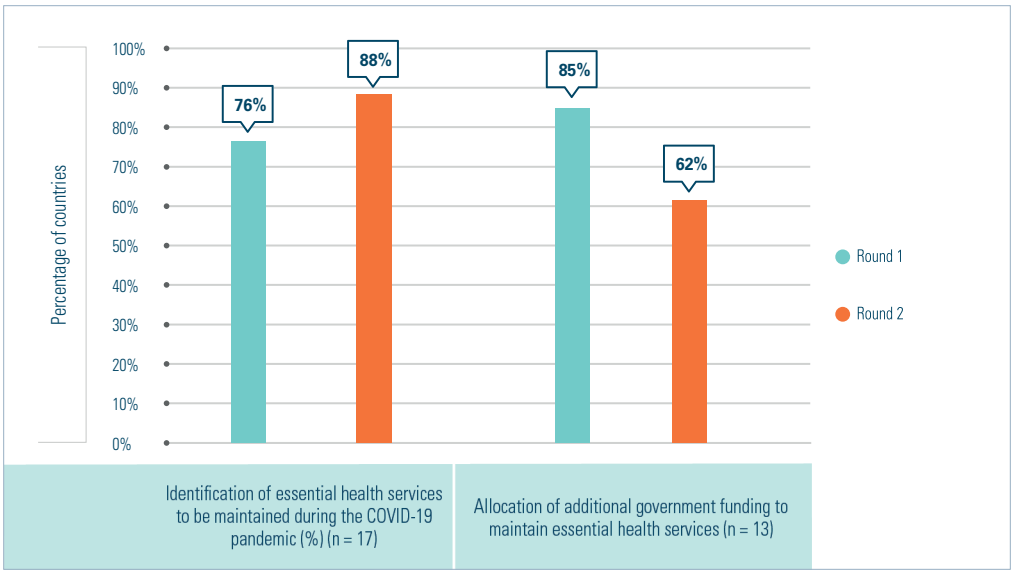
It should be noted that, compared to the first survey round conducted in 2020, in 2021 there is a decrease in the percentage of countries that reported disruptions due to users not showing up for outpatient visits, cancellation of scheduled visits, or modification of treatment policies.

Significant reductions were also observed in the percentage of countries that reported disruptions due to lack of personal protective equipment or beds and the closure of population-based programs. On the other hand, between the first and second rounds, the percentage of countries reporting financial difficulties caused by the pandemic and lockdowns as the reason for disruptions increased from 41% to 53% (7 and 9 of 17 countries, respectively).

8.4 Monitoring of national policies, plans, and mechanisms to support the continuity of health services

Figure 44 shows changes in policies, plans, and mechanisms to support the continuity of essential health services during the COVID-19 pandemic in the countries that participated in both survey rounds. The results show that the number of countries that have defined a list of essential health services that should be maintained during the pandemic increased: the percentage of countries that had created that list increased from 76% (13 of 17 countries) in 2020 to 88% (15 of 17 countries) in 2021.

Figure 44. Percentage of countries that reported that they had national policies and additional funds to ensure the continuity of essential health services in round 1 and round 2 of the survey



Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that answered the questions in both rounds.

On the other hand, the percentage of countries that have allocated additional funds to maintain essential health services during the COVID-19 pandemic decreased from 85% (11 of 13 countries) in 2020 to 62% (8 of 13 countries) in 2021. This apparent contradiction between developing a list of services to be maintained and the difficulties in allocating additional funds can be explained in part by the delicate situation that the Region's countries are facing in terms of public revenues. According to the Economic Commission for Latin America and the Caribbean (ECLAC), the subregion's gross domestic product (GDP) fell by 7.7%, which contributed to total public revenues decreasing by 0.5 percentage points of GDP in 2020 (*30*).

8.5 Monitoring of strategic changes in service delivery

The percentage of countries that reported intentional limitations or suspensions in the provision of essential services across the modalities assessed changed from one survey round to the next: in half of the cases, the percentage increased in 2021 (see Figure 45).

Figure 45. Percentage of countries that reported intentional limitations or suspensions in the delivery of essential services in round 1 and round 2 of the survey, by platform

Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that answered the questions in both rounds. The total percentage may differ from the sum of the partial percentages due to rounding.

In particular, when analyzing the results of both survey rounds, the following is observed:

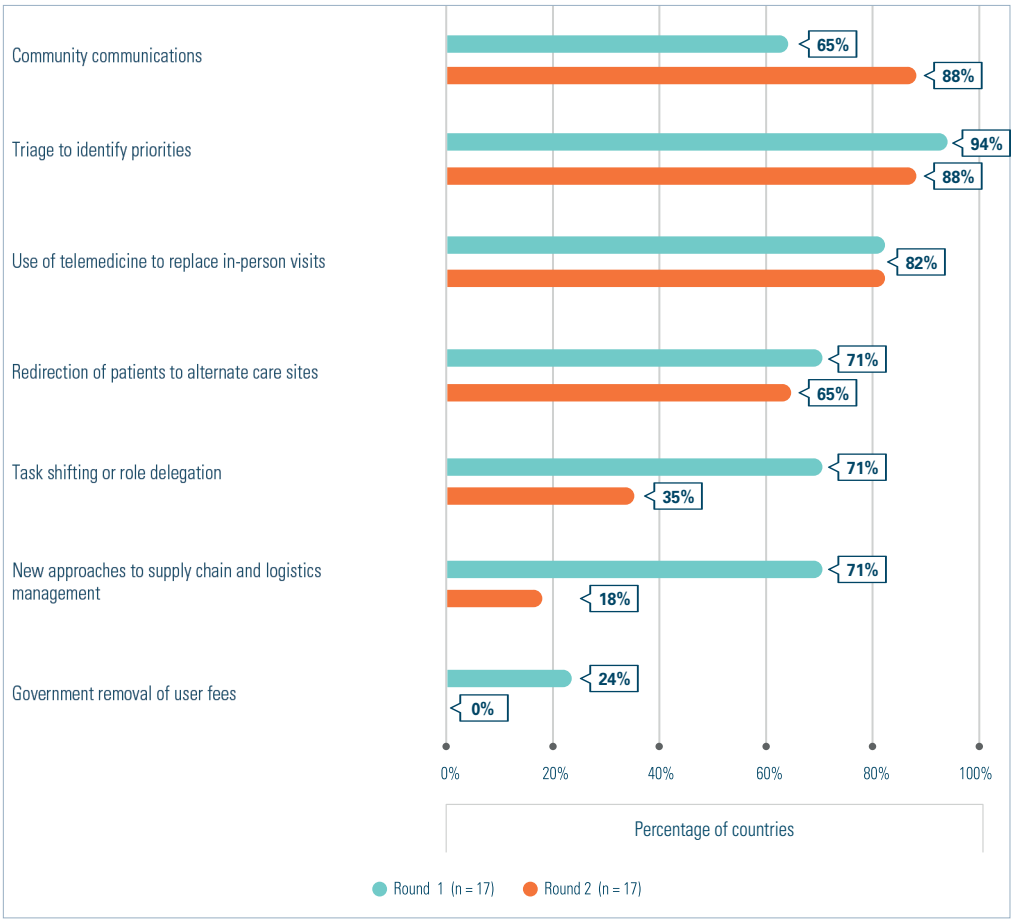
- The percentage of countries that reported having limited or suspended the provision of inpatient services increased from 43% (9 of 21 countries) in 2020 to 62% (13 of 21 countries) in 2021.
- The percentage of countries that reported having limited or suspended the provision of emergency unit services increased from 10% (2 of 21 countries) in 2020 to 29% (6 of 21 countries) in 2021.
- The percentage of countries that reported having limited or suspended the provision of pre-hospital emergency care services increased from 19% (1 of 21 countries) in 2020 to 24% (3 of 21 countries) in 2021.

In other cases, the percentage of countries that reported intentional limitations or suspensions in the provision of essential services decreased, namely:

- The percentage of countries that reported limiting or suspending the provision of outpatient services decreased from 62% (13 of 21 countries) in 2020 to 59% (13 of 22 countries) in 2021.
- The percentage of countries that reported limiting or suspending the provision of community-based services decreased from 62% (13 of 21 countries) in 2020 to 45% (10 of 22 countries) in 2021.
- The percentage of countries that reported limiting or suspending the provision of mobile clinic services decreased from 65% (11 of 17 countries) in 2020 to 59% (10 of 17 countries) in 2021.

With regard to monitoring the implementation of mitigation strategies by the countries surveyed, a comparison of the results of the first and second survey rounds shows an significant increase in the use of community communication strategies: in 2020, 65% of countries (11 of 17) said they had implemented this strategy; while in 2021, that percentage increased to 88% (15 of 17 countries) (see Figure 46). These activities are important for informing the community about changes in service delivery or care-seeking, addressing infodemics, and responding to community fear and mistrust.

Figure 46. Percentage of countries that reported implementation of mitigation strategies in round 1 and round 2 of the survey, by strategy



Note: The calculations do not consider the answers "do not know" or "not applicable." The *n* value represents the number of countries that answered the questions in both rounds.

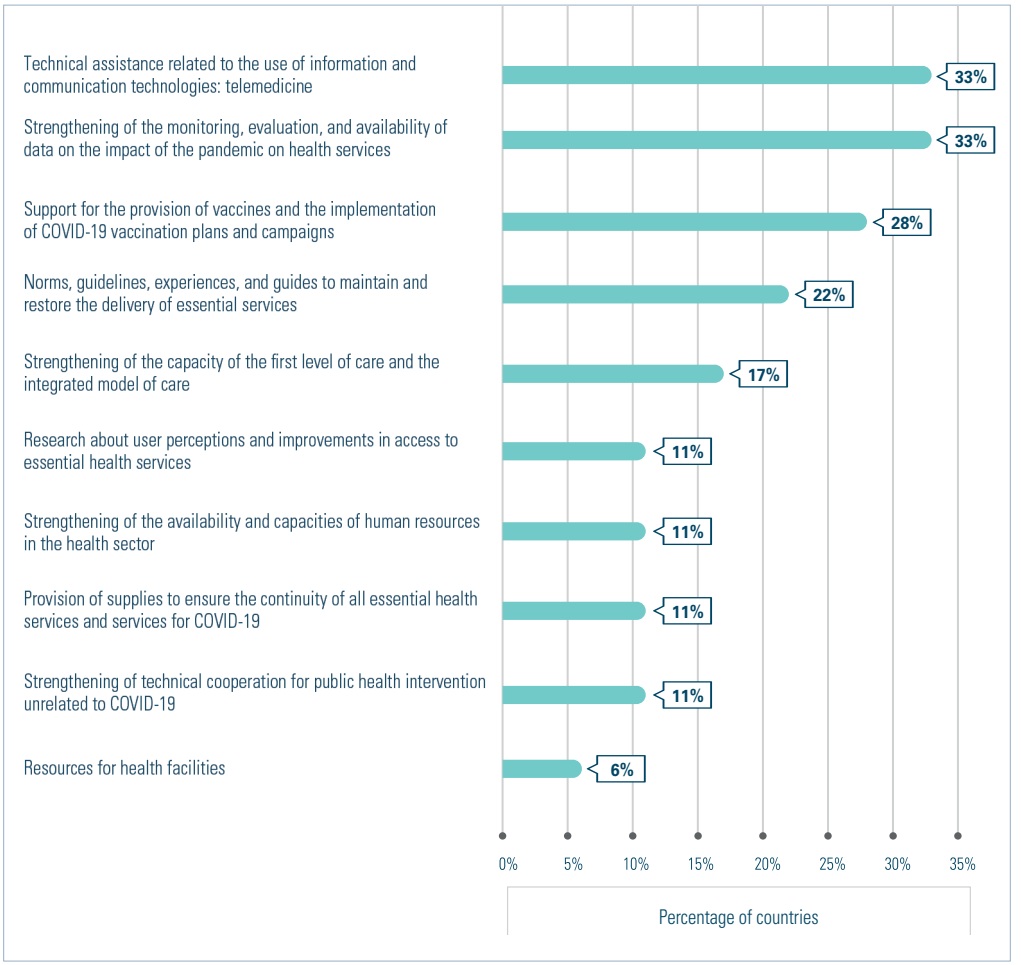
On the other hand, the percentage of countries that reported implementation of new approaches to supply chain management and logistics decreased from 71% (12 of 17 countries) in 2020 to 18% (3 of 17 countries) in 2021. The percentage of countries that implemented task-shifting or role delegation and eliminated direct user payments also decreased in 2021.

CHAPTER 9

COUNTRIES' PRIORITIES AND TECHNICAL ASSISTANCE NEEDS

The survey collected information on countries' priorities and technical assistance needs, and found that 18 had these needs (see Figure 47). The most frequent needs related to support to strengthen the monitoring and evaluation of the impact of the pandemic on essential health services, technical assistance to use information technologies and telemedicine, and support for the provision of vaccines and the implementation of COVID-19 vaccination plans and campaigns.

Figure 47. Percentage of countries that reported technical assistance needs, by need



Note: The calculations do not consider the answers "do not know" or "not applicable."

CONCLUSIONS

The second round of the national survey on the continuity of essential health services during the COVID-19 pandemic provides valuable information obtained from key informants about the extent of disruptions in the delivery of these services, the reasons for the disruptions, and mitigation strategies aimed at restoring services and keeping them in operation.

The results show that after more than one year into the pandemic, the health systems of the Region of the Americas continue to face significant challenges. Almost all of the countries that responded to the survey (97% of 29 countries) reported that the delivery of at least one of the essential health services assessed had been disrupted. Disruptions in the provision of these services were reported in all priority health areas and delivery platforms: the services that presented the highest percentage of disruption were those at the first level of care, which exhibited disruptions in 55% of the 20 countries that responded on this issue. This demonstrates the impact that the pandemic has had on health systems in the Americas and has potential implications for the entire population in terms of availability and access to essential services, especially for groups in situations of greater vulnerability. Given the persistence of the pandemic, it is very likely that disruptions will continue and have negative consequences on conditions related to long-term access.

It is important to note that the results of the 2021 survey suggest that the magnitude and extent of disruptions in the delivery of essential health services have persisted since 2020 in most cases, and that in some areas they have even increased. These areas include reproductive, maternal, newborn, child, and adolescent health services, immunization services, and services for mental, neurological, and substance use disorders.

In some areas, the magnitude of disruptions in service delivery decreased substantially, which could be due to intensified national efforts to respond to the challenges facing health systems in the context of the pandemic. These efforts include the different mitigation strategies that countries have been working on in order to restore the continuity of essential health services.

Unlike other regions, the Region of the Americas still has high COVID-19 infection and mortality rates, which perpetuates the bottlenecks and access barriers that emerged in the context of the pandemic.[3] Despite the limitations of this key informant survey for quantifying the scope and magnitude of disruptions in health services, it is reasonable to expect that even moderate disruptions can lead to worsened health conditions for a large part of the population.

The survey results also highlight the importance of effective national plans and policies. It is essential for countries' health strategies to focus on current needs and priorities—which are constantly changing—to ensure continuity in the provision of essential health services. In addition, the results highlight the need to balance COVID-19 control strategies with other health priorities. This includes having adequate availability of health personnel, establishing infection prevention and control measures to protect health care workers, and adopting measures that ensure the safety of users and patients who have COVID-19 and other diseases across the continuum of care.

With regard to financing and resource allocation mechanisms to provide health services, some key elements are highlighted for the near future. For example, during the forthcoming 2022 budgeting cycles, countries should, to the greatest extent possible, allocate additional resources to the health system to sustain and expand the delivery of essential services where these services are

3 According to data in the WHO COVID-19 Dashboard (see https://covid19.who.int/table), 48% of the cumulative COVID-19 deaths worldwide as of 4 June 2021 were in the Region of the Americas.

particularly overburdened. While reprogramming of resources within the health sector itself was initially a reasonable response in an unexpected context, it does not currently seem sustainable to continue to provide and expand essential services without additional resources. In this sense, during resource allocation, it is essential to prioritize the first level of care. Additionally, the resources allocated should be genuine, in the sense that they should not be associated solely with care for the pandemic (e.g., spending on testing, tracing, and isolation strategies).

Beyond the need for resources, countries should pay special attention to other challenges related to the circulation of funds within the health system. With regard to the pandemic response, both for vaccination and for the diagnosis and treatment of cases, new budgetary programs have been established in many countries to overcome rigidities present in the management of budgeted funds. In this sense, each country should compare the benefits of creating new financing mechanisms with the potential negative consequences that the creation of these parallel programs may have on the provision of essential health services that are not directly related to pandemic care. In some cases, there is a risk that health systems' regular financing mechanisms will be weakened by the emergence of what could be considered another vertical public health program.

In order to better measure the impact of short-, medium-, and long-term disruptions, it is necessary to analyze additional information that complements the findings presented here. Such information could be obtained from health facilities, the community, and subnational governments, helping to better understand local realities, the impact of the pandemic on health facility capacity, changes in the demand for health services and care seeking, and the emergence and hardening of barriers to access. It is also necessary to understand in greater depth the effectiveness and relevance of the mitigation strategies that have been implemented in countries, in order to identify which strategies work best and in which environments, and to identify the benefits and risks involved in applying these strategies during the pandemic.

In the context of the COVID-19 pandemic, the mission of WHO and PAHO is to continue supporting the countries of the Region of the Americas in their efforts to address the difficulties faced by health systems, to continue providing access to services, and to close the gaps in service delivery in order to ensure that systems respond to the needs of the population.

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ANNEXES

ANNEX 1. LIST OF ESSENTIAL HEALTH SERVICES ASSESSED IN THE SECOND ROUND OF THE NATIONAL PULSE SURVEY ON THE CONTINUITY OF ESSENTIAL HEALTH SERVICES DURING THE COVID-19 PANDEMIC

Groups	Services
First level of care	1. Prescription renewals for chronic medications 2. Visits for undifferentiated symptoms 3. Referrals for specialized care 4. Scheduled appointments with first level of care providers 5. Health promotion and prevention services
Emergency care, intensive care, and surgery services	6. 24-hour emergency room and unit services (e.g., myocardial infarction, stroke, shock, asthma, pneumonia, sepsis, and serious injuries) 7. Urgent blood transfusion services 8. Inpatient intensive care services 9. Ambulance services at the scene 10. Emergency obstetric surgical interventions 11. Emergency surgical interventions. 12. Acuity-based triage in emergency units 13. Referrals to emergency services for urgent conditions 14. Elective surgical interventions
Rehabilitation, palliative care, and long-term care services	15. Long-term care services 16. Palliative care services 17. Rehabilitation services
Auxiliary services	18. Laboratory services 19. Radiology services
Reproductive, maternal, newborn, child, and adolescent health, and nutrition	20. Institutional deliveries 21. Safe abortion and postabortion care 22. Management of moderate and severe malnutrition 23. Prenatal care 24. Postnatal care for women and newborns 25. Services for sick children 26. Sexual violence prevention and response 27. Family planning and contraception
Immunization	28. Routine facility-based immunization 29. Routine outreach immunization

Groups	Services
Communicable diseases	30. Outbreak detection and control 31. HIV prevention services 32. HIV testing services 33. Continuation of antiretroviral treatment 34. Initiation of new antiretroviral treatment 35. Hepatitis B and C diagnosis and treatment 36. Tuberculosis diagnosis and treatment 37. Malaria diagnosis and treatment 38. Insecticide-treated nets 39. Indoor residual spraying 40. Seasonal malaria chemoprevention
Neglected tropical diseases	41. Diagnosis, treatment, and care for neglected tropical diseases 42. Large scale preventive chemotherapy campaigns for neglected tropical diseases 43. Community awareness and health education campaigns 44. Support for self-care, rehabilitation, and psychosocial services for patients with neglected tropical diseases 45. Prescriptions for medicines for neglected tropical diseases 46. Surgical procedures for neglected tropical diseases
Noncommunicable diseases	47. Hypertension management 48. Cardiovascular emergencies 49. Cancer screening 50. Cancer treatment 51. Diabetes and diabetic complications management 52. Asthma care 53. Urgent dental care
Mental, neurological, and substance use disorders	54. Management of emergency manifestations of mental, neurological, and substance use disorders 55. Psychotherapy, counseling, and psychosocial interventions for mental, neurological, and substance use disorders 56. Prescriptions for medicines for mental, neurological, and substance use disorders 57. Services for children and adolescents with mental health disorders 58. Services for older adults with mental health disorders 59. Neuroimaging and neurophysiology 60. School mental health programs 61. Suicide prevention programs 62. Overdose prevention and management programs 63. Critical harm reduction services

ANNEX 2: LIST OF COUNTRIES AND TERRITORIES THAT PARTICIPATED IN THE SECOND ROUND OF THE PULSE SURVEY ON THE CONTINUITY OF ESSENTIAL HEALTH SERVICES DURING THE COVID-19 PANDEMIC

The Pan American Health Organization (PAHO) and the World Health Organization (WHO) would like to express their gratitude to all national health authorities and PAHO representatives who supported the participation of the following countries and territories in the second round of this survey:

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