

## Coronavirus Pandemic

# The forgotten sub-regional COVID-19 response layer. The case of the WHO Eastern Mediterranean Region

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### Abstract

The response to the COVID-19 pandemic have been driven by epidemiology, health system characteristics and control measures in form of social/physical distancing. Guidance, information and best practices have been characterized by territorial thinking with concentration on national health system and social contexts. Information was to a large extent provided from global entities such as the World Health Organization (WHO), Centers for Disease Control and Prevention (CDC) and others. This bipolar response mechanism came to the detriment of regional and sub-regional levels. The development of the global pandemic was evaluated in terms of the performance of single countries without trying to reflect on possible regional or sub-regional results of similar characteristics in health system and social contexts. To have a clearer view of the issue of sub-regional similarities, we examined the WHO, Eastern Mediterranean Region. When examining the development of confirmed cases for countries in the region, we identified four different sub-groups similar in the development of the pandemic and the social distancing measure implemented. Despite the complicated situation, these groups gave space for thinking outside the box of traditional outbreaks or pandemic response. We think that this sub-regional approach could be very effective in addressing more characteristics and not geographically based analysis. Furthermore, this can be an area of additional conceptual approaches, modelling and concrete platforms for information and lessons learned exchange.

**Key words:** Emergency response; epidemics; sub-regional.

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The response to the COVID-19 pandemic has been driven by epidemiology, health system characteristics and control measures in form of social/physical distancing. Guidance, information and best practices even in the shadow of the gap of information regarding the virus itself, have been characterized by territorial thinking with concentration on national health system and social contexts.

Information was to a large extent provided from global entities such as the World Health Organization (WHO), Centers for Disease Control and Prevention (CDC) and others. This bipolar response mechanism came to the detriment of regional and sub-regional levels. In the fight to find a place within this bipolar system most of the regional entities lost valuable time in dealing with regions, with little authority due to the territorial system, instead of trying to have a deeper

look into possible sub-regional similarities. Until now, the development of the global pandemic is evaluated in terms of the performance of single countries without trying to reflect on possible regional or sub-regional results of similar characteristics in health system and social contexts.

To have a clearer view of the issue of sub-regional similarities, we examined the WHO, Eastern Mediterranean Region (EMR) [1]. The region is known for its diversity in many public health aspects and unfortunately for hosting many protracted emergencies. Therefore, it is preemptive to have diverse approaches towards combating this epidemic.

When examining the development of confirmed cases for countries in the region over the first three months of the epidemic (until the first week of June 2020), it is obvious that there are four different sub-

groups, which are similar in the development of the pandemic and the social distancing measure implemented. Here we are using the Government Stringency Response Index (GSRI) [2]. This index simply records the number and strictness of government policies as an indication for the timing and the government power to implement these measures.

The first group (Jordan, Lebanon, Morocco and Tunisia), despite the difference in geographical locations, could to some extent flat the curve and started to have sound relaxation of measures with no or few daily reported cases. All these countries started social distancing measures almost on the same date on the first of March and reached GSRI of around 90% by the second week of March. What is notable in this group is that the level of strength in implementing the measures was dropped gradually after the daily reported case started to decline and it did not drop much below 80 % until now.

The second group (Afghanistan, Egypt and Pakistan) started the social distancing measures as early as the first group; however, they didn't reach the an GSRI more than 50% until the 23rd of March. None of the countries reached a GSRI of 100 % until the end of May 2020. This status of “*let's wait and see*” coupled with inconsistency in implementation of social measures led to a very sharp increase in daily reported cases so far and it is extremely difficult to predict the behavior of the epidemiological curve.

The third group, which includes the Gulf Cooperation Council (GCC) countries, is sharing the same geographical location and the same social and health system characteristics. Susceptible to heavy global movement which led to early detection of cases, considerable expatriates' population, very strong surveillance system which might have contributed to the notable increase in total confirmed cases so far. The daily reported cases look more or less identical as well as the GSRI. This is a strong reason to try to explore similar approach to these countries as a whole to save some critical time and efforts that might have been duplicated.

The fourth group, which is the most complicated one (Libya, Somalia, Sudan, Syria and Yemen), is presenting many questions regarding the validity of all actions taken globally. This is due to a very fragile health system, which brings the controversy of the reported numbers on the table. The social distancing concepts results of difficult interpretation in countries with frequent curfews and movement restrictions, which are common in emergency settings. The information provided by this group both on the GSRI and epidemiological curve looks very inconsistent with

any of the previous examples. Despite the complicated situation, this group gives space for thinking outside the box of traditional outbreaks or pandemic response. The main thinking should be fundamentally based on what can be achieved on the ground and not to be dragged into the global debate regarding the effect of traditional interventions. Lessons learned from the protracted emergency health service delivery in such contexts should be put in the frontline as well.

Outside of these four groups, one country could have been easily accommodated in the previous classification, which is Iran. However, due to the recent development with an almost ongoing second wave of the pandemic, can be an example of the not optimal GSRI since the first wave and reached only 60% during the peak. Later, the GSRI was dropped while cases continued to be reported. The development in Iran might stands as an unfortunate example of premature relaxation of social distancing measures and not optimal implementation of these measures.

The problem with the bipolar system of national and global response that took place until now, is that it minimizes the amount of exchange of information; furthermore, the novelty of the virus fueled the race to find own national model for response. In the attempt to bridge this gap, the regional level of response was still reporting and dealing with the region as a geographical territory and a liaison between the two poles. We think that the regional layer would have been very effective if it gave more further analysis to more characteristics and not geographically based analysis which can avoid any duplication of efforts and bridge many gaps. This can be in areas like more conceptual approaches, modelling and concrete platforms for information and lessons learned exchange.

### Authors' contributions

All authors equally contributed to conceive the idea and draft the manuscript.

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