

Maintaining access to cancer care in Morocco during the COVID-19 pandemic through an early coordinated response, outreach services and universal access to cancer treatment

Country/Institution:
Morocco

Author:
WHO/EMRO - Universal Health Coverage/Noncommunicable Diseases and Mental Health - Noncommunicable Diseases Management Unit

Key learning points

Morocco's 2011 Constitution recognizes the right to health care. Recent reforms towards universal health care aim to cover the whole population, including the informal sector, by 2022, and to have social protection in place for all by 2025. Indeed, Morocco took measures to support vulnerable populations during the pandemic. This provides an example in the region that even in a lower- to middle-income country facing big resource gaps, it is still possible to maintain a strong health care system able to withstand adversity.

Background

Morocco is committed to improving care for cancer patients and has taken several steps towards achieving this goal in recent years. An overall cancer control plan was developed in 2010 and was recently updated to cover the period 2020-2029. A women's cancer screening programme (breast and cervix) was initiated gradually at primary care clinics to cover all the regions using clinical breast examination and visual inspection with acetic acid (VIA). Cancer treatment is provided free of charge, even for those patients lacking health insurance.

Civil society organizations and international collaborations have also advanced cancer care in Morocco. The Lalla Salma Foundation for treatment and prevention of cancer has played a leading role in advocating for cancer patients. Morocco is the first country from the African continent to join the board of the International Agency for Research on Cancer (IARC) and has been working closely with the International Atomic Energy Agency (IAEA) to organize training workshops for health care providers. One of the main focus areas for WHO cooperation is implementing a national strategy for the control of NCDs, including prevention, health promotion and palliative care.

Impact of COVID-19 on essential health services

The first imported case of COVID-19 in Morocco was reported on 2 March 2020. Shortly after that, the closure of schools, universities, mosques and national borders was announced. A curfew was declared on 20 March 2020 followed by four months of a strict stay-at-home order. Public transport was stopped, restricting movement between cities.

Initially, 45 out of 160 hospitals were dedicated to COVID-19, while the remainder continued to provide other health care services. When community spread increased, however, all the major hospitals were charged with managing COVID-19 patients, accepting only emergency non-COVID-19 cases. A significant proportion of health care providers were reallocated to the COVID-19 response, but those working in oncology were exempt from this. A field hospital with a capacity of over 700 beds was established within two weeks, and new intensive care units with a total capacity of 1500 beds were set up. Testing capacity was quickly ramped up and about 5 million masks were produced locally every day.

Early on in the pandemic, experts warned of the serious risk of COVID-19 for cancer patients, who would be particularly vulnerable both to the severe consequences of infection and the short- and long-term repercussions of disruption in their treatment. The Moroccan MoH and scientific community therefore worked with the United Nations Multi-Partner Trust Fund, which includes WHO, to draw up a plan to maintain care for cancer patients as a priority.

What was the intervention or activity?

Due to the interruption of transport between and within cities, along with the lack of cancer centres in some cities, two important initiatives were adopted: the MoH ensured the safe transport of patients from their homes to oncology centres and back; and with the support of the WHO country office, four mobile palliative care units were provided for bedridden patients in four provinces, Agadir, Tiznit, Beni Mellal and Errachidia. This programme is now planned to be rolled out to more regions. In total, at least 400 of the most vulnerable patients from rural and isolated areas have and will continue to receive palliative care through home visits under this programme.

In order to cope with the increased demand on health care and to provide safe palliative care services, the opening of two new hospital-based palliative care units at the Regional Oncology Centres of Agadir and Beni Mellal was accelerated, and they started operating in January 2021.

At cancer centres, clear procedures were developed to triage patients, first by calling them the day before their appointment, to screen for COVID-19 symptoms and history of contact with suspected or confirmed cases, and then again on arrival at the centre. Suspected cases were isolated in a separate area where they underwent a PCR test. Adjustments were made to the hospital waiting and treatment areas, including the establishment of unidirectional patient and staff flows, maintaining a 1.5m distance between patients, and presenting educational videos on screens in waiting areas.

The number of people attending the facility and the duration of their stay were limited through scheduled appointments, allowing only one person to accompany children or those with special needs, and using teleconsultation for routine follow-up of stable patients and cancer survivors. Dedicated telephone numbers were made available for phone consultations in all 11 cancer centres and were published on the centres' websites and social media accounts. Treatment protocols were adapted to reduce the number of visits, such as by prolonging the interval between chemotherapy sessions and switching to oral chemotherapy, where appropriate. Staff were organized into two separate teams that did not overlap, in case the need arose for one of them to self-isolate. Meetings were conducted by video conference. Cancer treatment was not stopped at any stage of the pandemic, but more urgent cases were prioritized and adjustments to treatment regimens were made through individual benefit-risk assessments.

Due to the closure of the "maisons de vie", guest houses near the hospitals which patients coming from distant locations used to rely on, treatment was adapted to be given over one day, or if not possible, patients were admitted to hospital for the duration of their treatment.

How did this intervention/activity contribute to the maintenance of EHS?

These measures collectively reduced the total admissions to oncology hospitals by over a third. For example, at the Oncology and Haematology Centre at Mohamed VI University Hospital in Marrakesh, a 40% decrease in the number of new outpatient cases and a 24% drop in admissions to ambulatory care units was observed, compared to the same period in 2019. However, it is unclear whether this reduction is due mostly to the planned adaptation of admission and treatment protocols, or whether barriers remain to access cancer care or diagnostic services.

What were the key challenges involved? How were these challenges overcome?

Although access to primary care continued in Morocco and focused on remaining COVID-free, its resources and personnel were partially reassigned to the COVID-19 response. This, along with movement restrictions, fear of contagion, and the suspension of population-based screening programmes may have led to a reduction in early diagnosis of newly occurring cancers. This raises concerns about increased pressure on health services once these cancers clinically manifest or progress, and poorer outcomes for patients presenting with more advanced tumours.

Despite the challenges faced, the Moroccan experience reflects how robust cancer care infrastructure, universal access to cancer treatment, and a rapid, coordinated response has enabled the continuation of care for patients with serious illness who require complex and time-sensitive management.

Links to relevant resources or references

World Health Organization. Country Cooperation Strategy - at glance. 2018.
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