PRIVATE HEALTH SECTOR DURING COVID-19 IN IRAQ

Exploring The Potential Role

ABSTRACT

The private health sector is playing a major role in health service provision worldwide. This is no exception during public health emergencies like COVID-19 pandemic. The private health sector role in Iraq during this global health emergency has been limited, this is not because of inherent weakness, but rather the lack of common language and discouraging environment for partnership.

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CONTENT

ABBREVIATIONS

COVID 19: Corona Virus Disease 2019

FAO: Food and Agriculture Organization of the United Nations

GP: General Practitioner

HWF: Health Work Force

ICU: Intensive Care Unit

IHR: International Health Regulations

JEE: Joint External Evaluation

MOH: Ministry Of Health

NCD: Non Communicable Disease

OOP: Out Of Pocket

OTC: Over The Counter

PCR: Polymerase Chain Reaction

PHC: Primary Health Care

PPE: Personal Protective Equipment

PPP: Public-Private Partnership

WHO: World Health Organization

1. INTRODUCTION

As a result of ongoing crisis, Iraq has been categorized as a country under health emergency by the world health organization[1]. The health system, suffering from financial difficulties, poor infrastructure, and insufficient health workforce size and capacities, had to handle a continuous pressure to sustain health services provision within the minimal accepted standards. Emergency response has dominated the health sector and has sapped most of the resources. Nevertheless, appreciably, there have been parallel efforts to improve routine health care, public health functions and health system development. Furthermore, the Ministry of Health is working on building skills and capacities for emergency preparedness and response and disaster risk reduction. The country has articulated the strategic directions in their National Health Policy 2014–2023. The strategic directions include provisions to strengthen core capacities required under the International Health Regulations (2005) for improving public health preparedness for response to acute emerging health threats and other natural, human-made and technological hazards[2].

Iraq has witnessed dramatic political transformations since 2003 changing from strict central authority system into more decentralized form.

The vast majority of health legislations were put in place before 2003 (majority are 30-40 years old) and the latter were consistent with the central form of governance with clear preference of the public over the private health sector contribution[3].

Several factors acting together in limiting the private sector role in public health emergencies including legal aspects, dual practice, poor funding mechanisms, and ineffective accountability measures[4]. The policy adopted by the MOH during COVID 19 is based on the acting laws[3], regulations and instructions that greatly limit the health service provision from outside the public sector during public health emergencies. Excluding the concept of active partnership in times when the health system is in bad need for all available resources, public and private, was not in the best interest of public health priorities. Therefore, the private sector contribution was greatly shaped by the currently acting factors which allow only donations to be the main available contribution related to the emergency response.

2. PRE COVID 19 HEALTH SECTOR PREPAREDNESS.

In order to shine the light on the health system (public and private) behavior and capacity during COVID 19 pandemic in Iraq, it worth taking a look at the country capacities and preparedness in the field of public health emergencies in the pre pandemic period.

The joint external evaluation of international health regulations conducted on March 2019 in Iraq has evaluated the preparedness of the Iraqi health system during public health emergencies.

The evaluation showed that the Iraqi health system has no capacity[2] in:

1. Funding timely response to public health emergencies and implementation of IHR capacities.

2. Strategic emergency risk assessment and emergency resource identification,
3. Activating and coordinating health personnel during public health emergencies, and Public communication for emergencies.

Limited capacities[2] were found in:

1. Assessment of national legislation and relevant sectors coordination involved in IHR implementation.

2. National diagnostic network effectiveness and laboratory quality system.

3. Surveillance system and use of electronic tools as well as reporting network and protocols in the country,

4. Efficiency of reporting to WHO, FAO and other international organizations.

5. Availability of effective human resources and updating multisectoral workforce strategy.

6. National multisectoral multi-hazard emergency preparedness measures including emergency response plans.

7. Risk communication systems for unusual/unexpected events and emergencies and Internal and partner coordination for emergency risk communication.

8. Communication engagement with affected communities.

9. Addressing perception, risky behaviors and misinformation.

The abovementioned weaknesses specially funding, health workforce and risk communication and assessment were endangering the health system response ability during the current crisis, but what has helped us in Iraq was the low disease transmission rate in the first few months (February, March and April) with relatively good containment measures offering time for the system to prepare for cases takeoff later in late of May.

So during this time window the public sector could improve testing capacity (although not in a satisfactory manner according to the private sector viewpoint), received national and international donations, and improve supply chain through establishing quick contracts with suppliers either directly by the government or through private sector agents, and increased the bed capacity and ICU capacity for COVID 19 patients.

On the other hand, the private health sector provides a very important proportion of the ambulatory care in Iraq, is operated by health professionals who are serving in the public sector at the same time as dual practitioners. This could explain a state of confusion in considering the role of the private sector practitioners by the governmental health authorities (as a separate entity) as they are already engaged in the public sector activities and plans during COVID19 outbreak[4, 5].

3. OVERVIEW OF THE PUBLIC SECTOR MEASURES DURING COVID 19.

The government was clearly determined to take full responsibility and control of the emergent pandemic from the first moment, in accordance with the legal framework that mandate the public sector to be in full charge of any public health emergency[3]. This chapter will illustrate the governmental measures adopted during the pandemic with the observed results on the disease progression and public health situation.

3.1 BACKGROUND

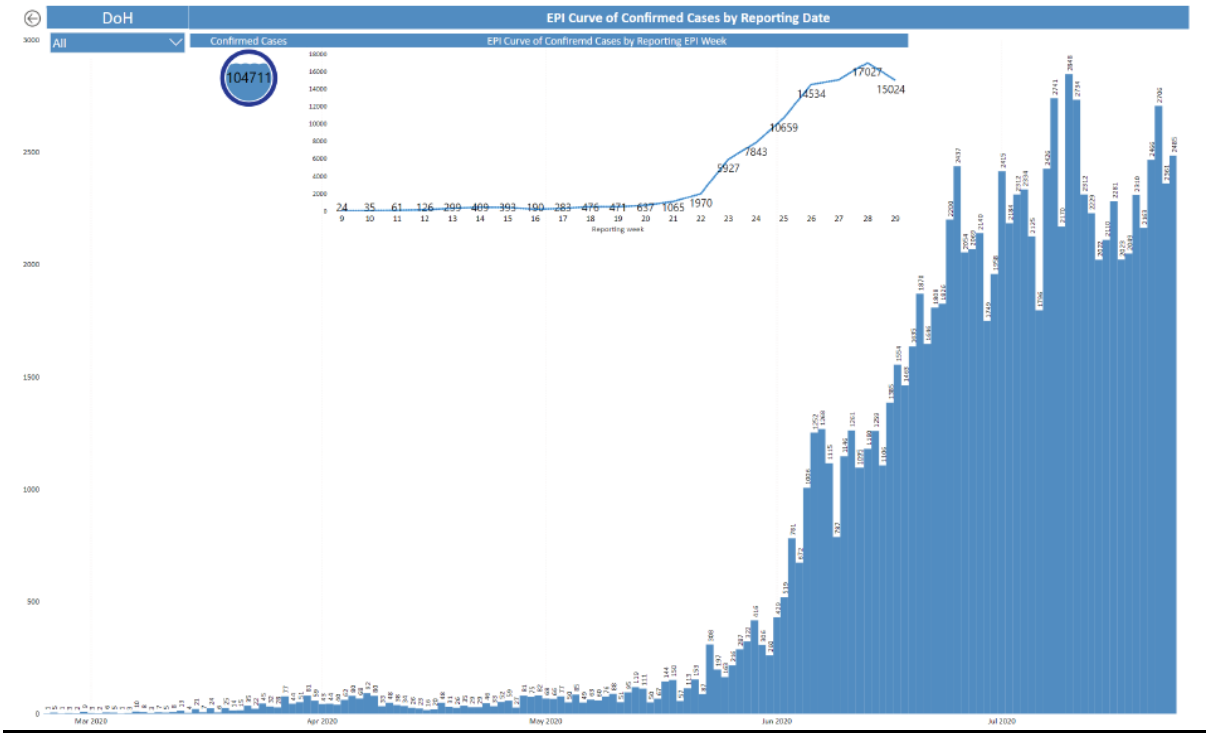
Two aspects need to be overviewed, the epidemiological situation of the disease transmission over time and the social response behavior.

Epidemiologically during the current pandemic, Iraq did not witnessed high number of new cases within the first 3 months (figure 1) with observed low transmission rate. Instead, during the time period from late February to the mid

of May, there were less than 100 case/day[6], while in comparison, some of the neighboring countries (such as Iran and Saudi Arabia) were suffering from high transmission rate and high number of new cases. The low transmission rate in the first few months was in favor of the health system preparedness measures.

Later on, and since the end of May, with the mitigation of containment measures including reopening of public places along with increasing testing capacity and the deteriorating general public compliance with social distancing measures, there was an observed increase in daily new cases that continued through June, July, august till present time as the country is suffering from high community transmission with around 4000 cases/day[6].

Figure 1: The epidemic curve in Iraq[7]



The second factor, the social behavior/social compliance with the government response measures was described by the ministry of health officials as being poor[8].

Several factors contributed to the poor community compliance as a mixture of economic pressure created by curfew imposition, travel and social gathering ban beside the low educational level for a proportion of the population who were denying the existence of the disease.

Another factor is the disease as a stigma. As a fairly large proportion of the population were considering the disease as a sin or stigma which eventually

pushed many patients to deny symptoms or to reject being tested or seeking care for it. As a result, these patients were not being identified and isolated and were spreading the virus in the community.

One more behavior was evading from testing that was either attributed to the previous mentioned factors or as a reaction to MOH testing policy in the first few months that forced suspected patient to stay in the hospital for 48 hours while waiting for test result which was not acceptable by many people especially women.

The combination of poor social compliance along with the pressure of the economic situation and the mitigation of containment measures have all contributed to escalating the disease spread and increased new cases starting from late of May adding further pressure on the public health sector which is already suffering from funding, infrastructure, and health workforce problems.

3.2 DECISION MAKING AUTHORITIES ESTABLISHMENT.

On the decision making level, there were several councils, committees established simultaneously or in sequence manner by the government to take over the management of the emergent COVID-19 pandemic during a relatively short time period[5], in general, the management process can be summarized in 2 phases.

Phase 1, the establishment of the state committee number 55 at the end of February 2020 chaired by the minister of health and the membership of high ranked officials from different ministries. The committee was in full charge of COVID 19 management and response planning but, later on, formally handed over the responsibility at the end of March 2020 to anew council[5].

Phase 2, by the end of March 2020, the establishment of the supreme council for health and national safety chaired by the prime minister with the membership of the minister of health and other high ranked officials from different ministries which taken full control of the response measures and planning strategies till present[5].

Since the day of the first reported case on 24/2/2020 till now, there were several technical/advisory committees established in the ministry of health[9] and the parliament for the purpose of reporting consultative recommendations to the decision makers during phase 1 and 2 and help providing scientific opinions.

Meanwhile there were complains that their recommendations were not seriously considered.

The only private sector representatives included during this period was the addition of the chairman of the Iraqi doctors' and Iraqi pharmacists' syndicates to the consultative committee for COVID 19 established in the MOH on March 2020 (the addition was 2 months later on May 2020)[5].

On the other hand, there were COVID19 crisis cells established in every province and chaired by the governor with the membership of the provincial health directorate director general with local authorities to change the containment measures in the corresponding provinces according to the local epidemiological situation[10].

3.3 OUTBREAK MANAGEMENT/RESPONSE MEASURES AND PLANS.

The first phase was characterized by quick preventive steps represented by imposing travel ban to non-Iraqis coming from China early in February, followed by another decision that involved non-Iraqis arriving from Iran (as the first epicenter in EMRO region) in the second half of February[5, 10].

Other travel bans followed depending on the epidemiological situation for each country ended with a complete ban of all arrivals and closing all airports on mid of March. Closing land borders and stopping trade with Iran and Kuwait established with restriction of peoples' movement between provinces also decided and implemented in the beginning of March.

For the lockdown measures, the first phase witnessed rapid closure of all schools and universities in the affected areas by end of February followed by total closure for the whole country completed in the beginning of March, along with closure of public places, halving all governmental services and employee utilization routine including health personnel established as a protective measure for them not being infected[6].

Total curfew decided on mid of March in Baghdad and other affected big cities[11].

The first phase was also characterized by the following:

1. Low testing capacity (only one reference lab conducting PCR in Baghdad for all cases across Iraq excluding Kurdistan region) with capacity around 200 tests/day[6].

2. No role for home isolation as all diagnosed cases were required to be isolated in dedicated public isolation hospitals, leaving home quarantine for contacts.
3. Suspected cases were required to quarantine in the hospital for 48 hours waiting for the tests results.
4. Active case finding activities conducted to discover a symptomatic cases depending mainly on rapid antibody assay (although not licensed for diagnosis) and then followed by PCR testing for the positive cases.
5. Generally good level of compliance by the general public (could be attributed to total curfew measures).
6. Majority of private sector professionals voluntarily closed their private clinics in compliance with containment measures, waiting to acquire more knowledge about the new disease.
7. Some private sector professionals provided a variety of free phone consultations advertising mainly through social media and doctors' syndicate announcements.
8. No private sector hospitals' admission of cases were allowed as per country laws and regulations which a continuous practice till the moment.
9. All suspected cases seen in private sector were referred to public hospitals for diagnosis and treatment (as the private sector at this stage was not engaged in case management)

The second (administrative) phase commenced by the formation of the supreme council for health and national safety at the end of March[9] witnessed a brief continuation of the containment measures started in phase 1, but shortly after that, there was a change in strategy.

The first major decision was ending the curfew in Baghdad and other major cities by the second half of April[6]. The decision has been justified by the low number of cases and low transmission rate in the country at that time and dissatisfaction with lockdown measures by the general public due to the economic and financial pressure caused by these measures. The second mitigation measure was the opening of public places and markets and resuming of international flights by the second half of July.

The abovementioned decisions were criticized by large proportion of doctors from both public and private sectors[4,5] including the higher consultative committee for COVID19 in the MOH which contains members from the private sector, as they thought of being directly associated with increasing number of

new cases number and fatalities which left the health system under tremendous pressure and caused many fatalities among health care providers.

On the service provision level, and due to the rapidly increasing numbers of new cases since the end of May, and as the specialized isolation hospitals reached its' full capacity, the MOH was forced to establish COVID 19 isolation wards inside secondary and tertiary public hospitals. Gradually, the worsening situation mandated these hospitals (especially in Baghdad) to provide only emergency treatment (medical and surgical) as the only non-COVID 19 health service available besides case management of COVID 19 patients as the main service.

In this context, it needs to be mentioned that, as per MOH regulations, the private hospitals are still not allowed to provide any case management services to COVID 19 patients but only required to refer suspected cases to public hospitals but its role has been tremendous in managing non-COVID19 cases.

With time, (in the second half of august) and after securing the necessary emergency funds by internal loaning and national and international donations, the MOH could successfully established new isolation/treatment hospitals with extra bed capacities that eased the pressure on public hospitals (Doing so by solely depending on expanding public sector resources without using private sector facilities although the acting legislations do allow for such approach). The health workforce required to operate the new hospitals were secured by redistributing the already what is already available from other health facilities[5].

The MOH could also increase the testing capacity several times (increasing number of reference labs from 1 to 50 across different country regions and the capacity jumped from 200 in the beginning of the outbreak to more than 20000 tests daily but without allowing private labs to engage) and the ICU capacity doubled from 2000 to 4000 ventilators and the drugs and supplies required for treatment and prevention were also offered by the MOH with dedicating around 10000 new beds for COVID 19 isolation and treatment purposes[5].

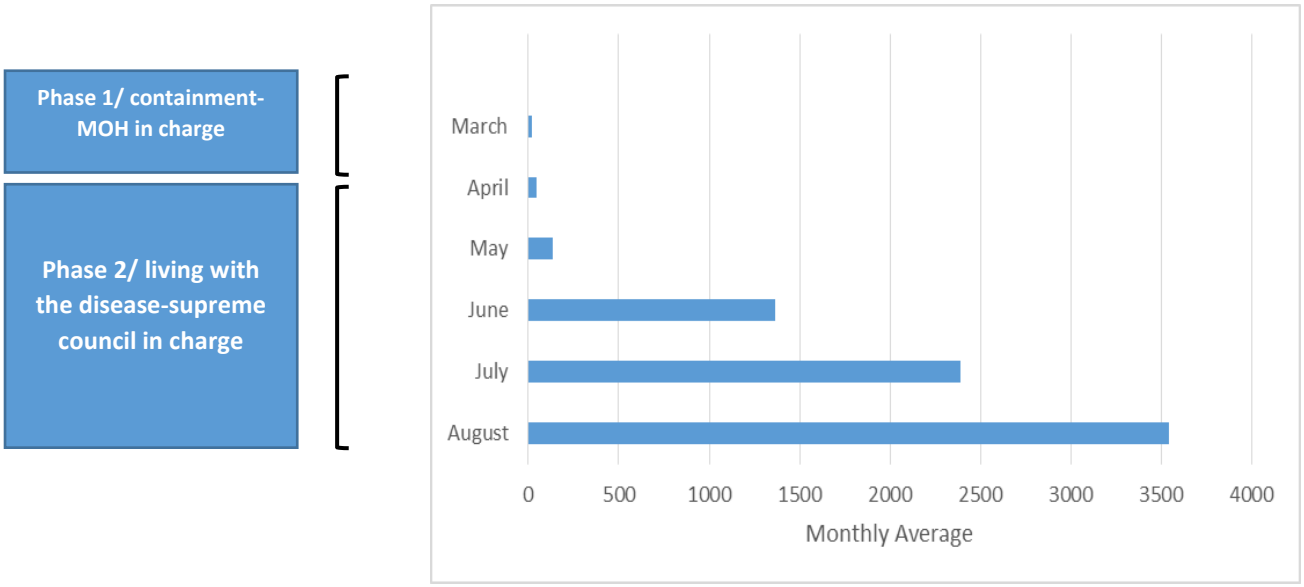
It has been noticed during this phase, and due to the public sector facing difficulties maintaining essential health services, and after building up of knowledge about the new disease, the private sector began to actively engage in COVID 19 case management in spite of the official health authorities' disagreement. So besides providing essential health services, the private sector clinics were treating COVID 19 cases[4].

In contrast to the first phase, case management became more practical by allowing home isolation and treatment for mild and some moderates cases[4,12].

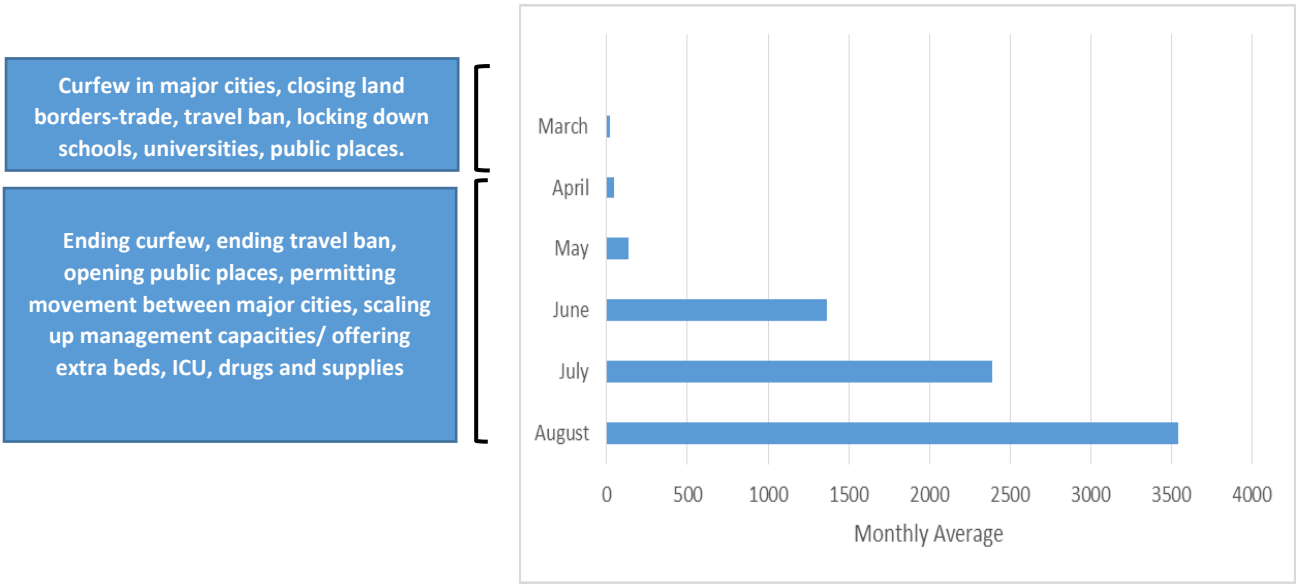
As a hint for the response strategies adopted by the government, the health authorities tried to contain the disease during the first 2-3 months (phase 1) which was accompanied by low transmission rate (sporadic to cluster of cases) but then there was a change in response strategy to mitigating containment measures accompanied with scaling up of case management capacities by the public sector and living with the disease with the resultant profound increase in number of new cases and fatalities and rapid community transmission. (Figure2 and 3).

At present, Iraq is the Arab country with the highest number of new, total cases and fatalities

(Figure 2) Authorities in charge during phase 1 and 2 in relation with average monthly cases



(Figure 3) Containment-Mitigation measures with average new monthly cases

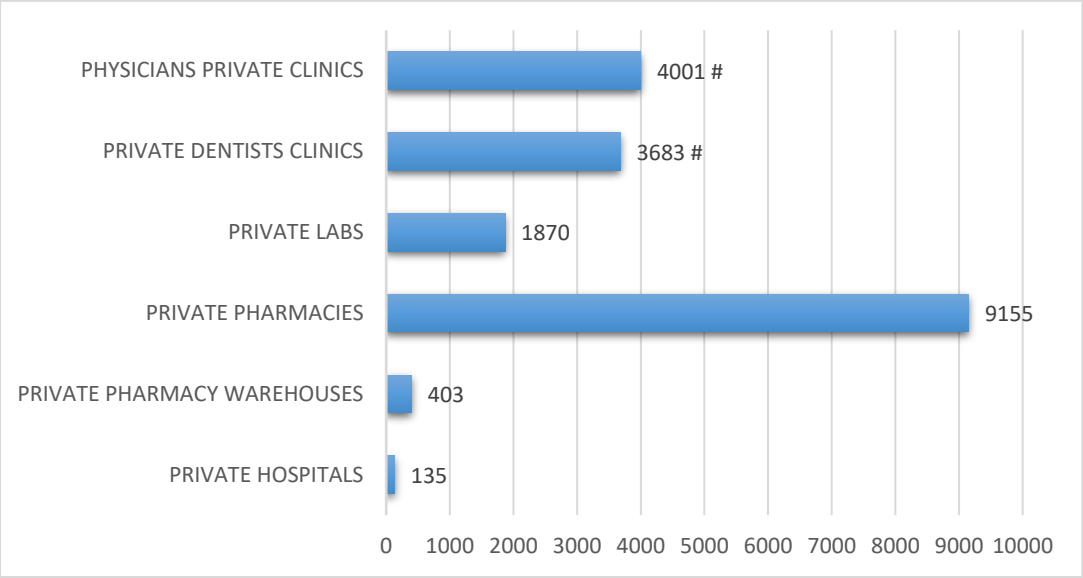


Health professionals both (public and private) have expressed their frustration from public health authorities' response strategy to COVID 19 pandemic as the public health professionals were demanding the continuation of containment measures to bring down the cases number first, while the private sector practitioners demanded granting them more freedom and support in case management process.

4. THE PRIVATE SECTOR AND THE PRIVATE SECTOR INVOLVEMENT IN RESPONSE TO COVID- 19.

The private sector in Iraq is composed of 19,247 entities (figure 4). The private sector in Iraq is almost completely for profit and is almost completely funded by out of pocket direct purchasing of services in the absence of nationally active health insurance system and PPP action framework.

Figure 4: The private sector in Iraq (2018)



Source: central syndicate of doctors, dentists, pharmacists, Kurdistan syndicate of doctors, and technical directorate of central ministry of health and environment.
refer to registered clinics.

As COVID-19 pandemic represents a common concern for all health authorities, public and private, everywhere on the globe. The Iraqi MOH tried so early to confine the response to its own facilities shaping specific roles for the private sector to play represented by donations, assisting in pharmaceutical procurements and other medical supplies provision, referral of suspected cases, disseminating health message and knowledge updating, and to the best possible limiting the active engagement in case management to the public sector

facilities. Weather the latter approach was successfully implemented would be illustrated in this section.

4.1 PRIVATE SECTOR DONATIONS, PHARMACEUTICAL PROCUREMENTS AND MEDICAL SUPPLIES.

The private sector expressed its good intentions in early days before the first index case in Iraq by donating PPE and medical supplies to China, the donation was highly valued by the Chinese government and reflected later on by counter donations to the MOH of Iraq, in the form of PPE, medical supplies, laboratory diagnostic equipment and advice based on their early experience[5].

After the appearance of the first few cases, the private sector continued to donate PPEs and relevant drugs approved at that time (600000 hydroxychloroquine tablets by the pharmacists' syndicate) to the MOH and also offered to donate 2 new (unused) hospitals to be ready for cases isolation and treatment (but have not been used by the MOH). The Holy Shrines Organization (one of the Iraqi religious entities) has contributed with funds and infrastructure to build rapidly deployable isolation hospitals during the last 3 months[5].

The private sector donations were very important in the outbreak management course, owing to the poor public sector preparedness to such events and limited availability of emergency funds and insufficient HWF and infrastructure with sudden surge in needs for relevant medical supplies.

On the other hand, the regular process of purchasing medical supplies in normal circumstances is time consuming passing through a bit of complicated procedures, and is usually met by either direct governmental contracting with foreign suppliers or internal contracting with private sector agents. Such procedures were skipped during COVID19 outbreak, consequently easing to a

great extent the private sector purchasing and provision of supplies to the MOH and to the private sector market[5].

On the market level, it wasn't odd to face PPEs doubling of prices several times during the first 3 months before the prices went down again back to their usual level since the end of July.

4.2 ROLE IN CONTAINMENT MEASURES

As previously hinted, the first 2 months witnessed markedly diminished private sector activity especially private clinics availability of ambulatory care either in compliance with the curfew orders or due to fear and lack of adequate knowledge about the new disease. So the main services of the private clinics were maintained through free phones' consultations offered by a variety of private sector specialists and practitioners. The same condition did not apply for private hospitals as the latter were functioning almost normally during the same period, the explanation for this difference in reaction was related first to the fact that there were all registered in the MOH, located in a well-known locations with easy to inspect property by the MOH inspection teams. Also the nature of services provided in private hospitals which were mostly surgical, non-COVID 19 consultations and procedures, and the better oriented staff with improved infrastructure, infection prevention and control measures allowing for better in-facility distancing. Finally the low transmission rate in the first period with almost normally functioning public hospitals that did not add any extra load to private and public hospitals.

After the mitigation steps started mid of April, (with the exception of private dentists' clinics) private doctors clinics resumed usual service provision and gradually started to provide COVID 19 case management services especially after the marked increase in new cases. It was inevitable that the private sector

practitioners engage actively in case management process as the new cases count was outscaling the governmental capacities. The public health authorities although were dissatisfied with the situation, could not afford to prevent private sector from conducting COVID 19 consultations through the same usual channels of monitoring private sector facilities. Instead the supreme council for health and national safety sent a message of dissatisfaction to the private sector through its decision of closing private clinics early in July accusing these clinics of being responsible in part for the rapid increase in number of new cases due to lack of social distancing measures inside the clinics and failure of private sector doctors to disseminate the correct health message and failure to use the proper infection control measures. Unfortunately, the decision was associated with reducing lockdown measures for public places such as malls and markets and re-allowing public gatherings and travel between cities.

At the same time, the supreme council issued new instructions for infection prevention and control measures to be adopted inside the private clinics and stressed on social distancing behavior for clinics' visitors. The ban on private clinics continued for 3 weeks and although disagreed by private sector doctors, it was associated with fairly high level of compliance after reflecting on their disappointment through doctors syndicate announcement describing the ban decision of being irrelevant.

Another issue raised after the engagement of private clinics in cases management was the dissemination of wrong messages to the public by the practicing private doctors and, as some of them, were (and still) insisting on the uselessness of wearing masks unfortunately broadcasting their ideas even on TV channels, some were advertising for their own treatment protocols and criticizing the MOH protocols accusing it of being useless. Such behaviors are endangering the public awareness and weakening social distancing measures

that is mainly relying on the public comprehension and cooperation. At the same time, it is shaking the confidence in the health system as a whole that is already experiencing frequent problems of repeated assaults on health care providers especially doctors during their public sector practicing time, while interestingly, these same assaults were very much less frequently observed in private sector practice setting.

The MOH has suspended these doctors from practicing in governmental facilities (as the majority of private sector practitioners are also serving in public facilities) but unfortunately not from private practice which indicate some weakness in accountability measures.

4.3 ROLE IN CASE MANAGEMENT

At present time, Iraq is facing the highest transmission rate in EMRO region reflected by more than 4000 daily new cases. Although the diagnosis, isolation and treatment capacities had been markedly upgraded in the public sector, the main percentage of cases are being treated and isolated at home. The follow up of these (mild-moderate) cases is partially being done in public sector by family physicians, GPs and other health personnel serving in PHC centers through home visits. This does not reflect the whole of the picture of the disease prevalence, as still, a large proportion of patients are seeking care from private sector clinics, as trusted, and specialized care supposed to be available. On the other hand, while the government could markedly increase the testing capacity relying on governmental and donations funds and collecting no fees from patients, they prohibited the private sector from conducting specific PCR testing in private labs and the private practitioners were forced either to refer to public health facilities for testing or rely on alternative less specific tests such as CT scanning. Consequently and as a result of the interacting factors mentioned, an unknown

proportion of patients are being empirically diagnosed and treated in the private sector facilities without being referred, counted or recognized by the public sector authorities[4,12].

4.3.1 PRIVATE CLINICS PRACTICE FOR COVID 19.

Revision of hundreds of private clinics prescriptions and interviews with patients and contacts and observation of private sector market revealed the following practices[4, 12].

1. As per country regulations that prohibit PCR testing by private labs, private clinics practitioners were observed to use a variety of tests for clinically suspected cases, although these tests were intended for follow up purposes, the private doctors were using it to confirm suspected cases, these include: (CT scans, Rapid Antibody test, CRP, WBC, S.Ferritin, D-Dimer and LDH). CT scanning heavily used to confirm the diagnosis in the private sector, and as it has been widely used, the price of which has been more than doubled specially in the first 2 months when the public sector PCR testing capacity was still poor. CT scanning in the private sector is completely purchased by OOP. Rapid antibody testing is now available in the market and is being used as a diagnostic test although it is not recommended or approved for diagnosis of COVID 19.
2. Hydroxychloroquine (available in the market/ OOP purchased) alone or in combination with azithromycin is still in use as a take-home medication although it has been removed from the majority of treatment protocols around the world including the Iraqi MOH protocol.

3. Ivermectin (available in the market/ OOP purchased) seen in so many private clinics prescriptions, effective only in vitro, not yet licensed for COVID 19 (not included in national protocols).
4. Steroids (available in the market/ OOP purchased) are being prescribed for majority of cases as a take-home medication while it is only approved for select inpatient by the MOH protocol. It is either failure to refer or failure to correctly treat practice by the private sector.
5. Favipiravir (available in the market/ OOP purchased) approved by MOH protocol for all patients, is widely used as take-home medication.
6. Anticoagulants especially enoxaparin sodium (available in the market/ OOP purchased) sometimes prescribed as a take-home medication by the private sector, approved by MOH protocol for select high risk moderate cases (prophylactic) and severe inpatient cases (therapeutic).
7. Oxygen therapy (available in the market/ OOP purchased) available in bottles, provided by private factories, sometimes used at home in times when the public hospitals beds were full or if the patient prefer not to be admitted to the hospital.
8. Vitamin D, vitamin C and Zinc (available in the market/ OOP purchased) almost prescribed for all patients, and also being widely used as OTC medication by contacts and general public.
9. Pulse oximeters (available in the market/ OOP purchased) available in multiple brands and qualities, although not approved for home care, advised for use at home by private sector practitioners as an alarming tool to guide for hospital admission.
10. Plasma therapy is not being used in the private sector as it is only available in hospital setting which is exclusively practiced in public hospitals.

All the mentioned treatment items and supplies are available in the market (with the exception of convalescent plasma) and could only be purchased by OOP as there is no governmental program currently applied specifically to aid persons diagnosed with COVID 19 with the absence of active national health insurance system and active PPP action framework. As noted, some of the items are not approved by national and WHO protocols and refer to private sector mal-practicing behavior. While almost all of the abovementioned treatments (if approved in the national protocols) and supplies are available for free in the public hospitals, it is why the minister of health has lately urged all patients seen by private doctors to visit the public hospitals to receive their treatment as some of them are really expensive in the market (e.g. favipiravir costs 200$ for 5 days course which is expensive for large proportion of the Iraqi patients)

4.3.2 PRIVATE HOSPITALS PRACTICE DURING COVID 19

Unlike private clinics, the private hospitals services were not banned at any stage during the pandemic[4], the reasons behind this exemption could be explained by:

First, the type of the services provided by the private hospitals are mostly surgical and as the majority of cold surgical cases were postponed by the heavily engaged public hospitals in COVID 19 management, the only available choice for these patients was to have their interventions in private hospitals. Moreover, the majority of obstetric surgical interventions were being done in private hospitals as preferred by the patients themselves.

The second factor was the need for non-COVID 19 inpatient care that was also stopped for a while in the public hospitals leaving the private hospitals to be the only available alternative.

So the private hospitals played an important role in maintaining essential health services during this crucial period.

4.4 ROLE OF NGOs AND INTERNATIONAL DONATIONS

The international donations from different countries has contributed in upgrading capacities and supplies provision. Donations coming from China, Kuwait, Egypt, Hungary, and others provided the MOH with testing materials, PPEs, CT machines, and drugs[5,6].

While the international organization also played an important role in supplies provision, training and capacity building and technical support such as the WHO, The World Bank, JICA, UNICEF. Others have been actively engaged in service provision both for COVID 19 and other diseases such as MSF (doctors without borders)[5].

With internal loaning and international donations' and private sector donations' funds and supplies, the government could scale up the MOH capacities.

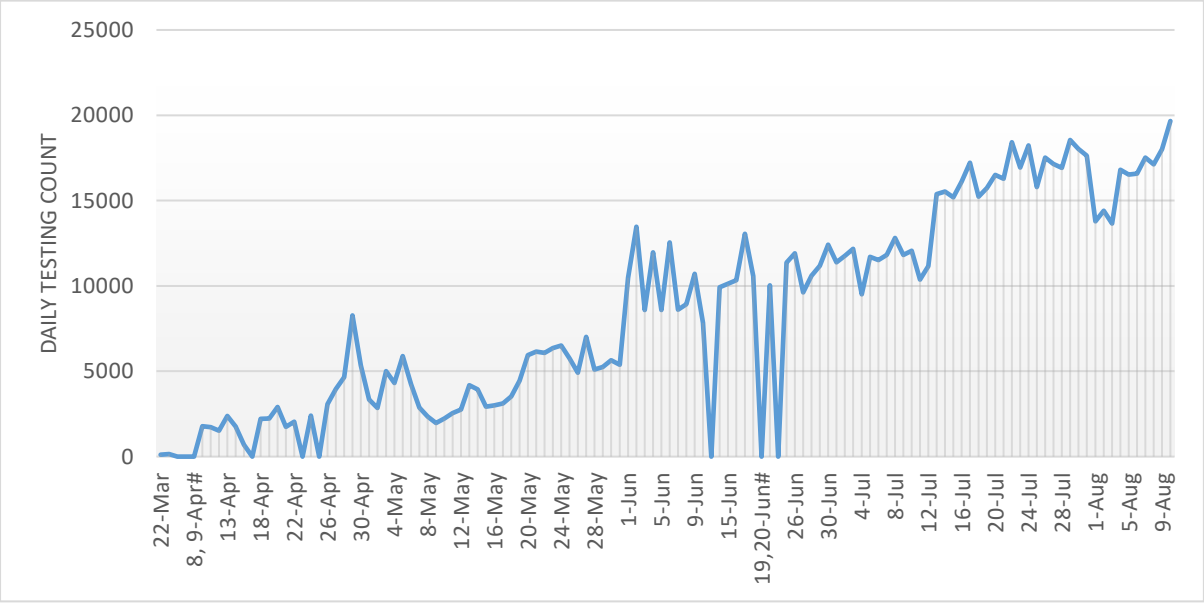
5 THE CURRENT SITUATION

Iraq is currently leading the EMRO region in regard to number of new cases with 3500-4500 new cases daily, the diagnosis is being done in governmental labs scattered throughout the country, patients visiting primary care centers or secondary public hospitals who are testing positive will either self-isolate or admitted to the hospital according to disease severity. Discovered mild cases that are home isolated will be followed up by primary health care providers in charge of their residential areas, while more severe cases admitted to specialized isolation/treatment hospitals that are available now with 10000 beds capacity dedicated to the purpose. No more admission of COVID 19 patients to general hospitals is currently allowed and these hospitals have

resumed providing the patients with ambulatory and other essential health services since the end of August.

Although the current testing capacity is more than 20000 tests/ day (figure 5), not all patients are having access to PCR testing due to 2 main causes, the first is the adoption for a long time by some public health directorates of a testing strategy that imposed testing with rapid antibody test for suspected patient seen at the primary care level before taking combined swabs, the result of the rapid test will decide whether to go (if positive) for swab or not (if negative antibody result).

Figure 5: Daily PCR testing by MOH[6]



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The second cause is the inability of the private sector to PCR test for suspected cases visiting private sector facilities due to governmental ban.

As a result, so many patients are empirically treated at home by using private doctors' prescriptions and only visit public hospitals if their clinical condition deteriorate.

Home isolated patients definitely diagnosed in public facilities are required to provide a written pledge mandating not leaving home unless for hospital admission. This specific protocol is considered useless in the context of lifting all lockdown and movement restriction measures currently applied, as well as the health and security authorities will never be able to discover their compliance level due to the absence of tools that can capture their movement.

6. EXPLORING THE POTENTIALS AND THE WAY FORWARD.

It is agreed that, establishing a common language is the key for any public private partnership project. This, in turn, need a mutual trust relied on legal, financial and administrative backgrounds.

The shaking of trust attributed to behaviors from both sides can be lessened by reflecting on the willingness to cooperate, setting priorities, recognizing the obstacles, and establishing a dialogue.

Legally, there is no explicit legal script prohibiting the partnership with the private sector during public health emergencies but rather a ministry policy to confine the services. Moreover, the executive powers authorities to issue regulations and instructions is wide according to the constitution. This can be used in any possible partnership without the need for new legislations[13].

Financially, the private sector is more than capable of establishing health projects and services when required (testing capacity as an example), which should represent an opportunity for the partnership[4].

Based on the lessons learned from combating COVID 19 during the last 6 months, it is beyond dispute that the best approach in responding to public health emergencies should not exclude any health providing entity including the private sector. Based on this conclusion, the MOH is invited to endorse and activate the emergency public private partnership policy in collaboration with

private sector representative that would definitely be based on and approve the following principles during public health emergencies.

1. Unifying the efforts of all health entities (public and private) based on evidence based best practice in controlling and managing emergent health events.
2. Approving regulations that permit gaining the best of the private sector capacities in diagnosis, admission, treatment, supply provision, health education and staff training instead of acting as a referral station.
3. Engaging private sector specialists in planning response strategies.
4. Activating legal steps against all malpractices and wrong health messages disseminated intentionally and contributing to diseases spread and impeding control measures.

Another suggestion of relevance is the adoption and activation of health in all policies approach, in order to best activate the multi-sectoral and inter-sectoral cooperation during health emergencies as the role of local communities, religious leaders, and media were evident and relevant during the last few months.

Throughout our contact in this work with the public and private sectors main representatives, there was a feeling of trust and credibility in the WHO as a professional and neutral side, so the organization is invited to play a role in establishing a dialogue with both parties that could help boosting PPP future plans and projects[4, 5].

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