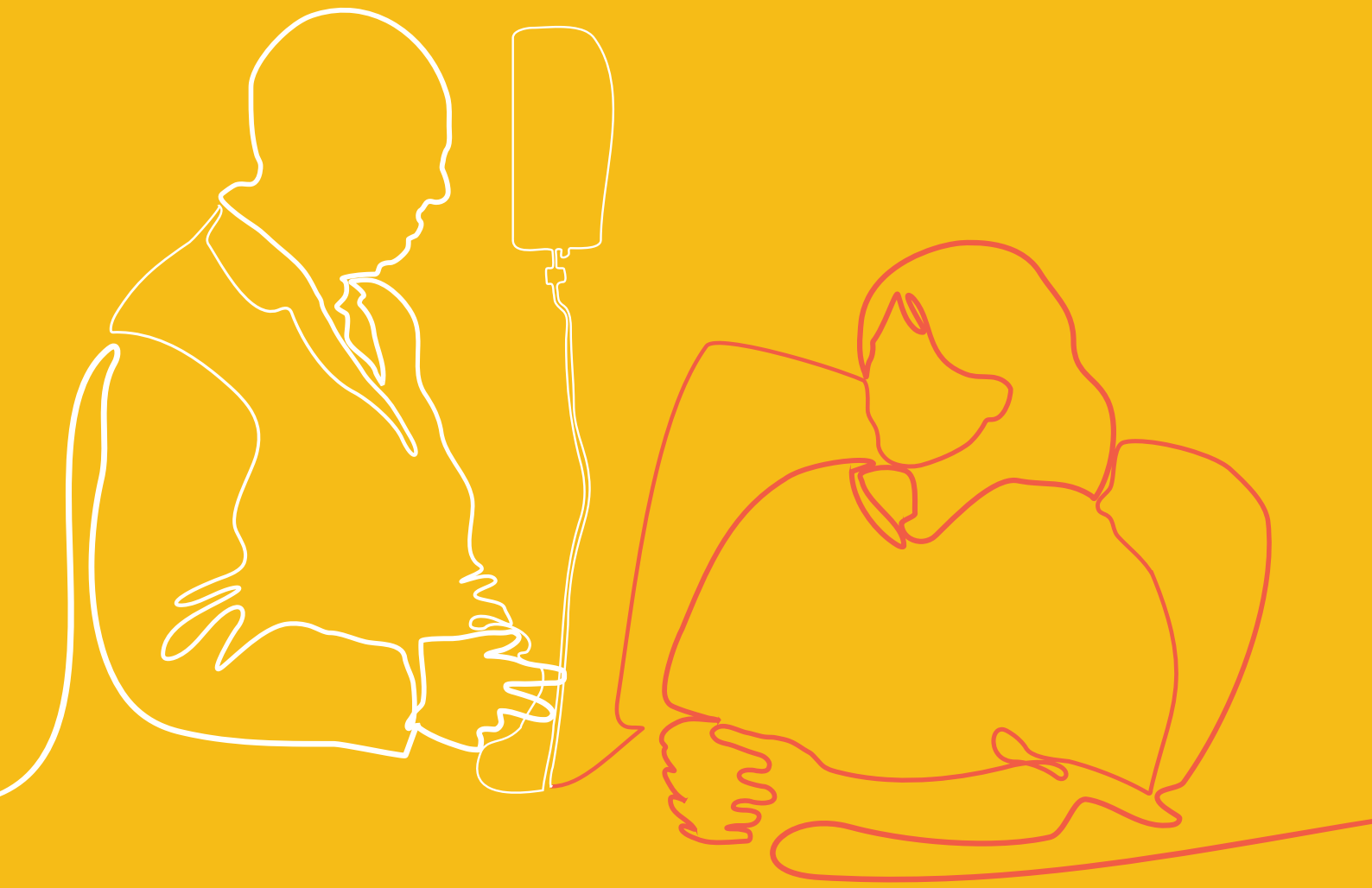
The role of the private health sector
in COVID-19 response



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Executive summary

COVID-19 presents extraordinary challenges to health systems around the globe, requiring the cooperation of all health actors at every level. In the Eastern Mediterranean Region of the World Health Organization (WHO), the private health sector is responsible for 53% of inpatient services and 66% of outpatient services and is, therefore, a major stakeholder in the COVID-19 response.

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In this context, the WHO Regional Office for the Eastern Mediterranean conducted an assessment of the role of the private health sector in the response to the pandemic in eight countries of the Region: Iran (Islamic Republic of), Iraq, Jordan, Lebanon, Libya, Pakistan, Tunisia, and the West Bank and Gaza Strip. The objectives were to explore the level of involvement of non-state actors in national response plans, map different engagement activities and present recommendations for addressing the challenges faced. This report compiles and summarizes the findings of these assessments.

Considering the size, influence and contribution of the private health sector to health systems and the scale of the health crisis that COVID-19 posed, collaboration with the sector in terms of response planning has generally been moderate to poor in the eight Member States within the scope of our study. Very few countries were found to have significant and coordinated involvement of the private health sector across the six domains of WHO's action plan on engaging with the sector as a part of the whole-of-society approach. In countries of the Region, in general, the involvement and role of the private health sector did not seem to be a part of a predetermined strategic direction or whole-of-system planning.

Countries usually engaged the private health sector at the implementation stage of the response rather than the planning stage. National response plans were set by the governments with occasional consultation or involvement of private providers. Only six out of eight countries have had private health sector representation in national response committees. Furthermore, none of these countries reported having clear and defined roles communicated to the sector.

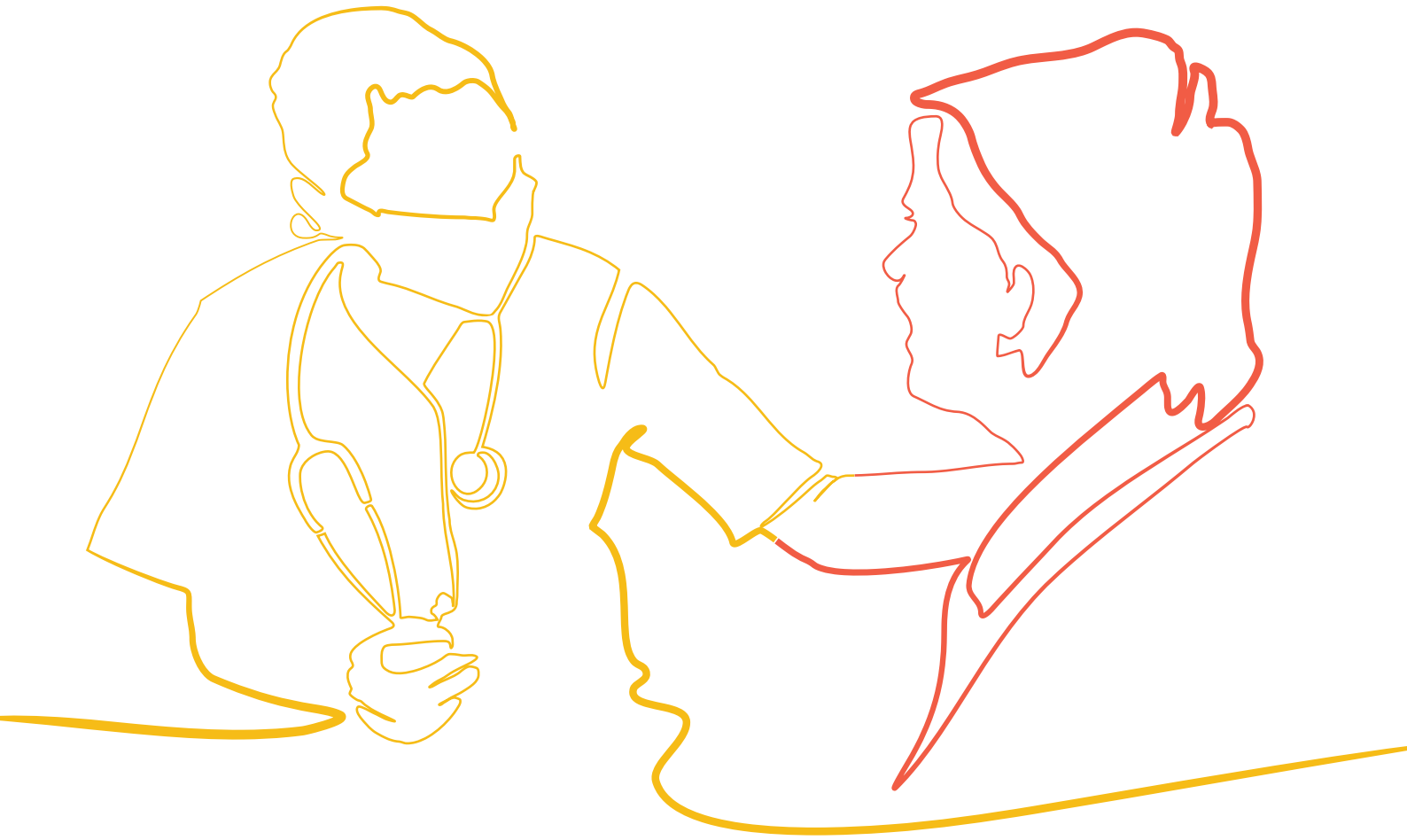
In terms of COVID-19 diagnosis and testing, five of the countries allowed private entities to contribute to testing. However, this typically took place after the first wave as more testing kits became available. Three countries chose to prohibit the private health sector from such a role despite the obvious lack of capacity in the public sector. As for case management, four of the eight countries have formally excluded private providers from this response pillar and thus no efforts have been made to update private providers on the latest COVID-19 treatment guidelines. This has further compounded the problem of unofficial involvement of private providers who were treating COVID-19 patients without following the recommended clinical guidelines. This unofficial involvement became inevitable in countries like Iraq where the cases surpassed the capacity of the public sector and the Government continues to struggle between an official ban on private sector involvement and the need for additional capacity.

In terms of deploying private ambulatory care in COVID-19 management, only the Islamic Republic of Iran and Tunisia formally stated a role in outpatient facilities. Clear and formal intersectoral referral processes were set up in the Islamic Republic of Iran, Jordan and Lebanon, but were not observed in other countries.

Mapping and reassignment of staff were undertaken by the Islamic Republic of Iran, Pakistan and the West Bank and Gaza Strip, where private health sector staff were either engaged in short-term contracts by the public sector or were seconded/deputized at public sector facilities.

The Islamic Republic of Iran and Lebanon had plans to cover the cost of COVID-19-related services that were provided at private health facilities. Libya and the West Bank and Gaza Strip offered coverage for specific non-COVID-19 services that were contracted out to the private sector. Iraq, Jordan, Pakistan, Tunisia and Yemen either did not allow the private sector to engage in COVID-19 treatment or the existing insurance systems did not cover the cost of COVID-19-related services.

Digital case-reporting platforms were used in the Islamic Republic of Iran, Lebanon, Pakistan and Tunisia. However, lack of compliance with the case reporting mandate was observed in Libya, Pakistan and the West Bank and Gaza Strip.



Islamic Republic of Iran, Iraq, Jordan and Pakistan reported expediting and facilitating the formal procurement process of COVID-19-related supplies

None of the countries had intersectoral logistics systems. Pakistan and Tunisia were the only countries that reported having a centralized COVID-19 procurement system in place accounting for the needs of the private health sector. For all the other countries, the sector was responsible for securing its own needs. This was particularly challenging in Lebanon given the economic strain facing the country and the restrictions on foreign currency hindering the importation process. Local manufacturing of personal protective equipment (PPE), ventilators and other requirements was leveraged in the Islamic Republic of Iran, Pakistan and Tunisia which enabled those countries to meet the local demand and, sometimes, to export. The private sector also got involved in the storage and distribution of needed supplies in the Islamic Republic of Iran and Jordan.

The Islamic Republic of Iran, Iraq, Jordan and Pakistan reported expediting and facilitating the formal procurement process of COVID-19-related supplies. Furthermore, the Islamic Republic of Iran supported the private health sector by postponing utilities and tax dues and expediting the release of reimbursement dues. Easing of customs and tax regulations was observed in the Islamic Republic of Iran, where the Government removed all customs clearance and import restrictions and taxes were waived for all equipment and medicines related to COVID-19 management. Jordan was the only country to pass an emergency law to allow for direct contracting of services to the private health sector during the pandemic.

The challenges faced by countries of the Region in engaging with the private health sector in the COVID-19 response were mostly consistent with the six policy challenges reported by low- and middle-income countries around the world. Countries in the Region seemed uncertain about how best to include the private health sector in planning and implementing national response measures. The absence of critical data on its resources and capacity hindered engagement efforts. The sector did not have the inputs needed for it to play a role as an effective partner in the pandemic response. Emergency legislation and existing regulations limited the role of the private health sector in many cases. Countries also seemed unsure of whether to, or how best to, reimburse the private providers for health services provided during the pandemic. Furthermore, governments have been unable to provide support to the sector, which has been incurring huge financial losses.

Based on this assessment, we recommend providing an enabling environment for the active participation of private providers and leveraging their assets and resources in addition to facilitating

access to capital and regulating their response to COVID-19 pandemic. Our recommendations stem from the belief that collaborating with the private health sector is essential for combating the pandemic and that this will not be possible without a legal and administrative framework that allows for such collaboration. In this context, the creation of an enabling environment in terms of policy, legal and governance framework and processes is critical for effective collaboration. Moreover, the immense financial and technical assets of the private sector present a huge opportunity to rapidly reduce the strain on the public sector and improve access to quality health care. This can be achieved through a systematic and strategic approach starting with an assessment of the capacity of the sector and its resources, to involving private players in planning and implementation, and building long-term relationships with the sector. Partnerships with private organizations towards achieving public health goals are possible in the presence of rigorous, transparent and fair regulatory measures.

Introduction

Background

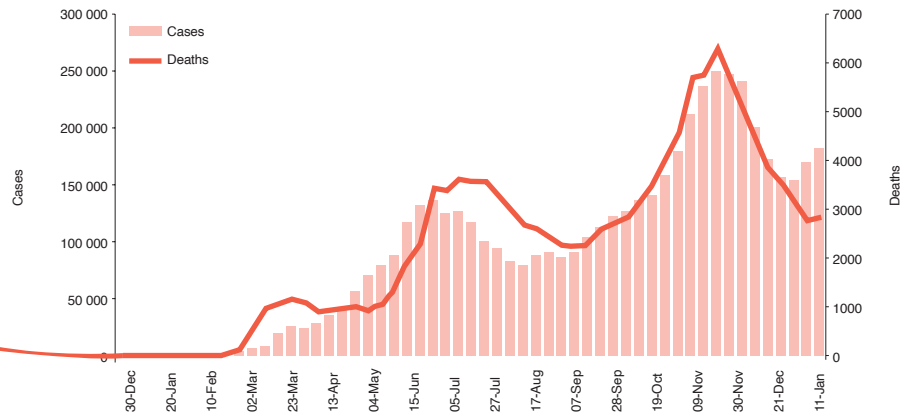
On 31 December 2019, the World Health Organization (WHO) detected reports of viral pneumonia through the media in China. WHO requested further information and set up the Incident Management Support Team across the three levels of the Organization, establishing the basis for dealing with a potential outbreak *(1)*.

Further investigation revealed that the cause of the disease was a novel coronavirus, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). The disease was later named after the virus and since then, it has been referred to as coronavirus disease 2019 (COVID-19). As cases continued to multiply and human-to-human transmission was confirmed, the WHO Director-General declared COVID-19 a Public Health Emergency of International Concern on 30 January 2020 and on 11 March 2020, COVID-19 was officially declared a pandemic *(1)*.

Epidemiological situation as of January 2021

As of January 2021, over 97 million COVID-19 cases and 2 million deaths have been reported worldwide *(2)*. Of these, the Eastern Mediterranean Region has reported over 5 million cases and more than 130 000 deaths. **Fig. 1** illustrates the progression of confirmed COVID-19 cases and deaths in the Region. The Islamic Republic of Iran and Iraq rank 16th and 26th in the world, respectively, for the cumulative number of cases. On the cumulative number of cases per million population, Bahrain ranks highest at 19th globally and Qatar ranks 28th. For cumulative deaths, the Islamic Republic of Iran ranks 9th with 57 294 confirmed COVID-19 deaths and Iraq ranks 27th with close to 13 000 deaths *(2)*. Further details on the epidemiological situation in the Region can be found in **Annex 1**.

Fig. 1: The progression of confirmed COVID-19 cases and deaths to 11 January 2021 in the Eastern Mediterranean Region *(3)*



The emergence of variants increases the likelihood of a prolonged COVID-19 pandemic

On 14 December 2020, health authorities in the United Kingdom of Great Britain and Northern Ireland reported a new variant of SARS-COV-2 to WHO. The variant of concern (VOC) was later designated VOC 202012/01 (B.1.1.7). Preliminary assessment showed increased transmissibility of this variant and no effect on disease severity. Another VOC (501Y.V2) was reported by the health authorities in South Africa on 18 December 2020. Initial studies suggest an association between these variants and increased viral load *(4)*. As of January 2021, almost 60 countries spanning all six WHO regions have reported either imported cases or community transmission of those variants. The emergence of such variants increases the likelihood of a prolonged COVID-19 pandemic, especially as studies show decreased efficacy of currently approved vaccines against the new strains *(5,6)*.

The impact of COVID-19

COVID-19 has had a dramatic impact on global public health and human life worldwide. It has led to unprecedented social and economic disruption and crippled health systems no matter how advanced they are. It has unmasked inequities and forced the world into a new way of life.

It has been estimated that almost 50% of the world's 3.3 billion total workforce are at risk of losing their livelihoods and tens of millions of people are at risk of falling into extreme poverty *(7)*. A survey conducted by WHO in 105 countries revealed that all 25 defined essential health services were disrupted as COVID-19 threatened decades of global health progress on many fronts *(8)*.

In order to support Member States in dealing with the challenges posed by COVID-19, WHO developed multiple guidance notes and guidelines for preparedness and response efforts, centred around nine pillars, as follows *(9)*.

Pillar 1	**Country-level coordination, planning and monitoring**
Pillar 2	**Risk communication and community engagement**
Pillar 3	**Surveillance, rapid response teams and case investigation**
Pillar 4	**Points of entry, international travel and transport**
Pillar 5	**National laboratories**
Pillar 6	**Infection prevention and control**
Pillar 7	**Case management**
Pillar 8	**Operational support and logistics**
Pillar 9	**Maintaining essential health services and systems**

One of the key aspects repeatedly highlighted in WHO guidance is the importance of adopting a "whole-of-government" and "whole-of-society" approach in COVID-19 response *(10)*.

The private health sector includes the individuals and organizations that are neither owned nor directly controlled by governments and are involved in provision of health services

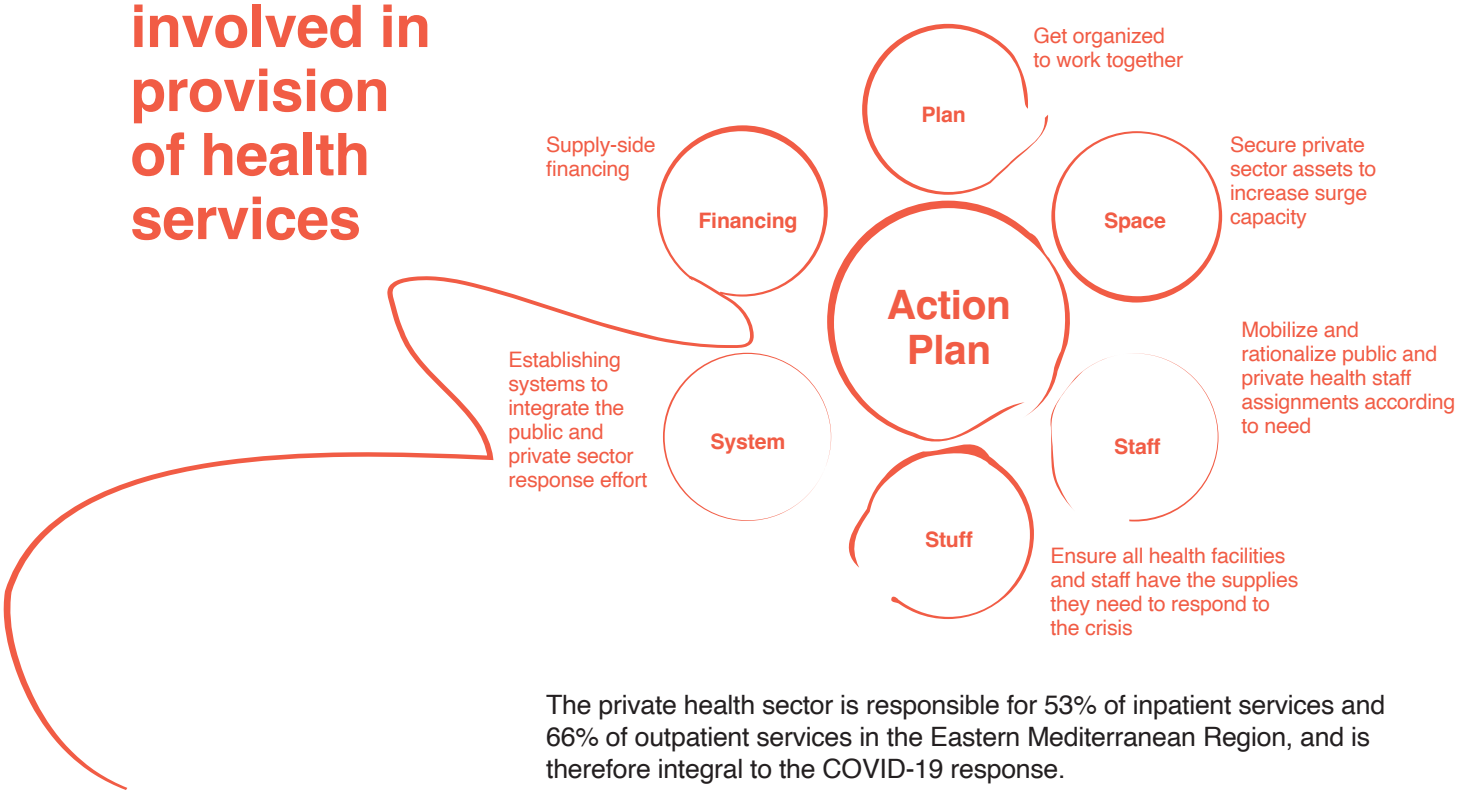
The role of the private health sector in the COVID-19 response

The private health sector is the individuals and organizations that are neither owned nor directly controlled by governments and are involved in provision of health services. It can be classified into subcategories as for profit and not for profit, formal and informal, domestic and international *(11)*.

In recent times, the private health sector has come to the fore as a vital player in the goal of achieving universal health coverage *(12)*. In the Eastern Mediterranean Region, the sector is very active, providing ambulatory, hospital and medical education services. It is also heavily involved in infrastructure development as well as the production and supply of health technologies.

As part of whole-of-government and whole-of-society approaches in responding to the pandemic, WHO developed *An action plan to engage the private health service delivery sector in the response to COVID-19 (10)*. The plan consists of six domains that have been developed in line with the global private sector engagement road map. **Fig. 3** illustrates the domains of this action plan.

Fig. 3: Action plan to engage the private health service delivery sector in the response to COVID-19



The private health sector is responsible for 53% of inpatient services and 66% of outpatient services in the Eastern Mediterranean Region, and is therefore integral to the COVID-19 response.

Development of this report

The WHO Regional Office for the Eastern Mediterranean commissioned an assessment of the role of the private health sector in eight countries of the Region, with the objective of exploring the level of involvement of non-state actors in national response plans, mapping the different engagement activities and presenting recommendations for addressing the challenges encountered. This report comprises findings from eight of those countries, providing a summary of the engagement with the private health sector in Iran (Islamic Republic of), Iraq, Jordan, Lebanon, Libya, Pakistan, Tunisia and the West Bank and Gaza Strip. The individual country assessments were based on desk review of peer-reviewed papers, technical documents and government reports. Insights from meetings, discussions and interviews with key stakeholders were also incorporated for further understanding of the existing situation.

The report is divided into four main sections.

Section 1	**Provides a review of the national-level response to COVID-19 in the Region and details the level of involvement of the private health sector.**
Section 2	**Analyses the way the engagement of the private health sector correlates with the WHO action plan.**
Section 3	**Outlines the current policy challenges that hinder the engagement of the sector in the COVID-19 response.**
Section 4	**Recommendations**

1

Review of national responses in the Region

Most of the governments in the Eastern Mediterranean Region initially responded to COVID-19 with a centralized approach, seeking to take sole responsibility for containing the spread and management of confirmed cases. As the pandemic progressed and the cases surpassed the capacity of the governments (i.e. the public health system) to manage demand for health services, the role of the private health sector became more prominent. The following sections summarize the response of the governments in the Region and the role of the private health sector as it has evolved across the different stages of the pandemic.

1.1

Representation of the private health sector in national committees varied from high-level representation to total absence

Planning, coordination and leadership

National-level committees were established either upon the detection of the first index cases or upon the declaration of COVID-19 as a Public Health Emergency of International Concern. The committees were commonly multisectoral and chaired by senior government officials. Several provincial and governorate-level committees typically branched from the main national committees with the objective of providing closer monitoring of the epidemiological situation and coordinating on-ground response. Representation of the private health sector in these committees varied from high-level representation to total absence. **Table 1** summarizes those committees and classifies the level of representation into three levels: high, moderate and low/non-existent.

Representation of the private health sector in national committees was observed in some countries such as the Islamic Republic of Iran, Lebanon and the West Bank and Gaza Strip. In the Islamic Republic of Iran, the head of the Iranian Medical Council, the representative of the Private Hospital Association and the head of the Iranian Medical Association were among the members of a "COVID-19 fighting headquarters". Members of medical associations have been specifically involved in the development of clinical and executive guidelines.

In Lebanon, the private health sector has been represented on all technical committees within the Ministry of Public Health, mainly through professional orders. The Lebanese Order of Physicians was engaged in providing recommendations through the National COVID-19 Taskforce and the Lebanese Society for Infectious Diseases and Clinical Microbiology. Moreover, the Order of Physicians published guidelines on its website, promoted multidisciplinary protocols and organized workshops in partnership with the Ministry of Public Health and other ministries. As part of the national COVID-19 taskforce, the Order of Nurses in Lebanon played a major role in the coordination and monitoring of the pandemic. The nurses were deployed as frontline workforce and underwent COVID-19 training. They contributed to the assessment of health centres all over the country, tried to engage communities and collaborated with municipalities to share guidelines on how to manage COVID-19 and reduce community transmission.

In the West Bank and Gaza Strip, the private health sector has been represented on the National Epidemics Committee which is responsible for providing the Ministry of Health with scientific guidance on COVID-19 and the recommended control measures. The committee included experts from three medical schools at national universities, two representatives of private hospitals and three representatives of major health-related nongovernmental organizations. Private health specialists have also been mandated by the Ministry to develop and update the COVID-19 case management protocol that serves as the main guideline for treatment of cases in the territories. The sector has also been included in the National Health Committee on COVID-19 along

A moderate level of private sector participation was observed in Jordan, Libya and Tunisia

with representatives from nongovernmental organizations, United Nations agencies, the Palestinian Military Medical Services, and medical, nursing and paramedical associations. This committee has the authority to make major policy decisions that are then passed to the National Emergency Committee chaired by the Prime Minister. Furthermore, the Prime Minister consulted with a longstanding health policy forum which has 25 Palestinian health experts representing the private health sector. Several nongovernmental organizations have also been involved in conducting research and developing policy papers on various issues, such as adolescent health and gender-based violence during the pandemic *(13).*

A moderate level of private sector participation was observed in Jordan, Libya and Tunisia. In Jordan, the private health sector was included in the working groups of the Health Development Partner Forum and the National Committee for Epidemics, which is part of the Eastern Mediterranean Public Health Network (EMPHNET) and is responsible for providing high-level coordination and recommendations to the Ministry of Health. In Libya, representatives of the private health sector and United Nations agencies participated in COVID-19 planning and policy development as members of national-level committees including the High Presidential COVID-19 Response Scientific Committee, which is currently being led by a private clinic manager and has four committee members from the private health sector. In Tunisia, a representative of private practising physicians was included in the scientific committee in August 2020 and different representatives of the private health sector were invited to multiple relevant committees starting from September 2020. However, the sector was not formally included in the response plan as a discrete sector or partner and was not represented formally on the COVID-19 National Coordination Committee.

The inclusion of the private health sector was minimal to non-existent in Iraq and Pakistan

The inclusion of the private health sector was minimal to non-existent in Iraq and Pakistan. In Iraq, the participation was limited to the involvement of the chairman of the Iraqi doctors' and Iraqi pharmacists' syndicates on the consultative committee for COVID-19, two months after the establishment of the committee by the Ministry of Health. In Pakistan, there has been no substantive engagement of the private health sector in this regard.

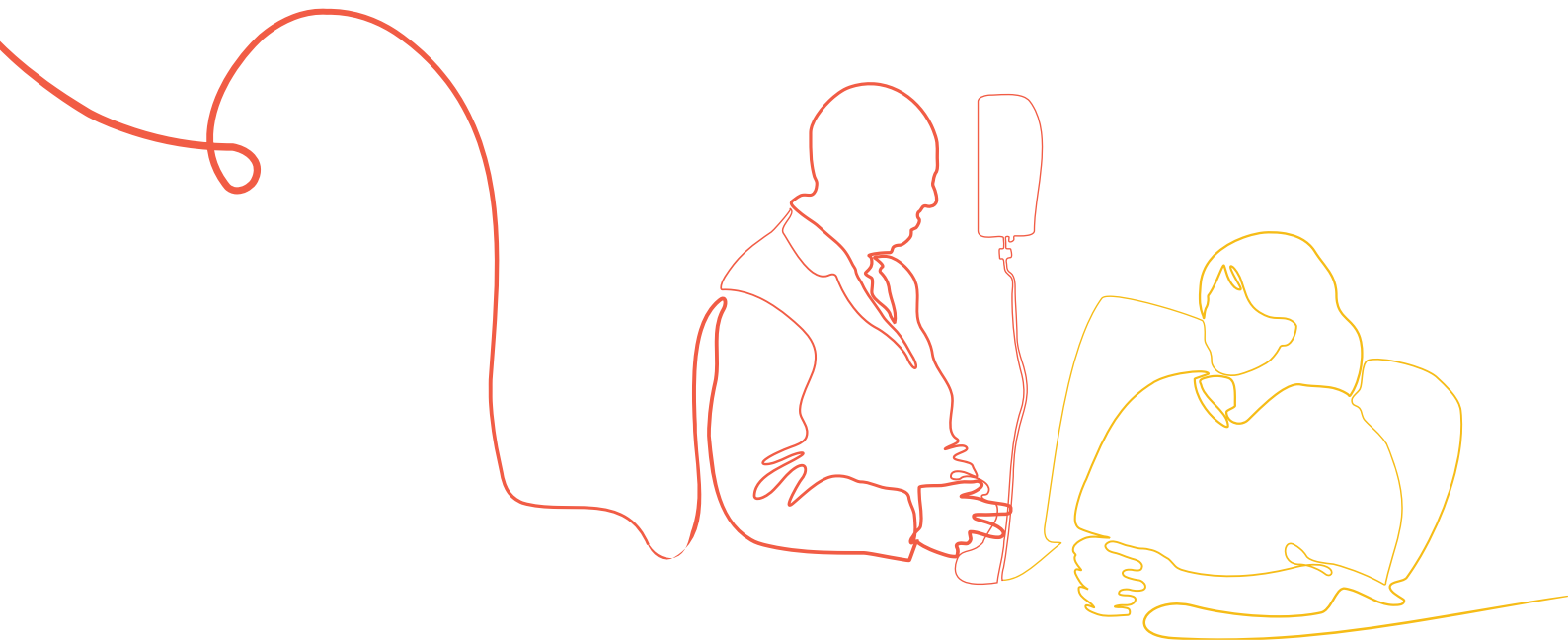


Table 1: Summary of private health sector representation on national COVID-19 response committees

	National response committees	Private health sector representation
High representation	**Islamic Republic of Iran**	
	A cabinet-level committee named the National Committee for Managing COVID-19 was established in February 2020. The committee was chaired by the President, with the Minister of Health and Medical Education as secretariat. Other ministers were also involved representing sectors such as industry, tourism, education, external affairs and agriculture. Similar committees have been formed at provincial level in addition to executive committees formed at national, academic/provincial and city levels.	The head of the Iranian Medical Council The representative of the Private Hospital Association The head of the Iranian Medical Association
	Lebanon	
	The National Committee for Communicable Diseases, established in 2001, took the lead in monitoring the spread of COVID-19. The committee is chaired by the Director General and serves as a scientific advisory board to the Minister of Public Health. It includes representatives from both the Ministry of Public Health and WHO as well as local experts in infectious diseases, virology, laboratory medicine and public health. In parallel, the Prime Minister established an inter-ministerial Emergency Corona Response Committee, headed by the Prime Minister and a National COVID-19 Response Task Force.	Members of different technical committees within the Ministry of Public Health
	West Bank and Gaza Strip	
	The National Emergency Committee was created, representing a cross-sectoral body for national decision-making chaired by the Prime Minister and involving different sectors such as health, security and economy. In late February 2020, the Ministry of Health created a National Epidemics Committee with a mandate to monitor the COVID-19 situation in the country and advise the Ministry on the most appropriate control measures. Shortly following the detection of the first COVID-19 cases in the West Bank and Gaza Strip, the Ministry of Health created ministerial planning and preparedness teams and established a National Health Committee on COVID-19 chaired by the Ministry, with representatives from WHO, the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), two networks of private/nongovernmental organization hospitals, four major health-related nongovernmental organizations, the Military Medical Services, and medical, nursing and paramedical associations.	Represented on the National Epidemics Committee and the National Health Committee on COVID-19

	National response committees	Private health sector representation
Moderate representation	**Jordan**	
	The Ministry of Health leads the health sector response in coordination with national authorities and international partners. However, the overall response to COVID-19 is managed by the National Center for Security and Crisis Management. High-level coordination and recommendations are provided to the Ministry of Health by the National Committee for Epidemics, part of EMPHNET.	Included in working groups of the National Committee for Epidemics
	Libya	
	The High Presidential COVID-19 Response Scientific Committee was established by the Presidential Council in March 2020. Municipality-level emergency committees were then established and chaired by respective mayors. These committees brought together representatives from the different sectors, responsible for coordinating the response with the High Presidential COVID-19 Response Scientific Committee, the Military Medical Council and the National Centre for Disease Control.	Representatives on various national committees including the High Presidential COVID-19 Response Scientific Committee
	Tunisia	
	In late January 2020, a COVID-19 National Coordination Committee was established and chaired by the Minister of Health. In February 2020, the Ministry of Health set up a National Multisectoral Commission for Prevention, Preparation and Response to COVID-19, chaired by the Head of Government.	The private health sector was not represented on the National Coordination Committee but a representative of private sector physicians was included in the scientific committee in August 2020. Representatives of the sector started to be invited to multiple relevant committees in September 2020
No representation	**Iraq**	
	Phase one: State Committee Number 55 was established at the end of February 2020. The committee was chaired by the Minister of Health and included high-ranked officials from different ministries. The committee was in charge of COVID-19 management and response planning until end of March 2020. Phase two: The State Committee handed the responsibility of managing COVID-19 to the Supreme Council for Health and National Safety which was established in March. The council is chaired by the Prime Minister and includes the Minister of Health and other high-ranked officials from different ministries.	
	Pakistan	
	The National Coordination Committee chaired by the Prime Minister provides guidance and action points which are then planned and implemented through the federal National Command and Operation Centre in coordination with the respective provincial taskforces. The provincial taskforces are chaired by the provincial chief ministers while the National Command and Operation Centre includes representatives from all ministries, provincial governments and operational entities including the army. These bodies, in collaboration with the Ministry of National Health Services, Regulations and Coordination, have played a pivotal role in streamlining a “One Government Response” across the country.	

The response to the first wave of infection featured travel bans, border closures, national-level lockdowns, curfews, complete shutdown of non-essential/non-health related businesses, cancellation of mass gatherings and public sector-led preparedness and response measures. However, the response to the second wave was typically scaled back to targeted or "smart" lockdowns. Between wave one and wave two, the reopening plan typically used a phased approach starting from the resumption of low-risk activities/businesses followed by moderate- and high-risk ones. Table 2 gives examples of the control measures imposed in selected countries of the Region.

The response to the second wave was typically scaled back to targeted or "smart" lockdowns

Table 2: Example of public health response measures in selected countries of the Region

	Travel bans	Cacelling mass gatherings*	Closure of schools and/or universities	Movement restrictions	Reduced working hours/ capacity	Curfew	Lockdown	Border closure
Iran (Islamic Republic of)	✓	✓	✓	✓	✓	✓	✓	✓
Iraq	✓	✓	✓	✓	✓	✓	✓	✓
Jordan	✓	✓	✓	–	✓	–	✓	✓
Lebanon	–	✓	✓	✓	✓	✓	✓	✓
Libya	–	✓	✓	–	–	–	✓	✓
Tunisia	✓	✓	✓	–	–	✓	✓	✓
West Bank and Gaza Strip	–	✓	–	✓	✓	–	✓	–

* Mass gatherings include prayers, weddings, concerts, cinemas and restaurants.

In the West Bank and Gaza Strip, the National Health Committee on COVID-19 created four taskforces, three of which are chaired by nongovernmental organizations

In the Islamic Republic of Iran, the Ministry of Health and Medical Education developed national plans for COVID-19 response and has been responsible for mobilizing resources, supplies and staff, in addition to coordination with multilateral agencies. The framework of the national response plan was developed in line with international guidance while adapting it to the country context. It involved strengthening the infrastructure of epidemiological forecasting and response to pandemics in addition to intersectoral collaboration between different organizations. The decisions of the National Committee for Managing COVID-19 are binding in each province. However, provincial committees have special powers and can decide to issue measures such as traffic restrictions, cancellation of ceremonies and mass gatherings as deemed necessary. Each province is responsible for implementing its actions.

In the West Bank and Gaza Strip, health preparedness and emergency response plans to combat COVID-19 were drafted by the Ministry of Health and finalized after discussion with all relevant stakeholders on the National Health Committee on COVID-19. The National COVID-19 Response Plan presented the response strategy and actions, identified critical needs and proposed an aid-coordinated approach. The main objectives of the response plan were to enhance preparedness of the health system, to ensure the provision of COVID-19 preventive and diagnostic services, and to ensure the continuity of essential services to all citizens. The plan has been developed with specific interventions in five different scenarios based on the number of confirmed cases. More recently, the National Health Committee on COVID-19 created four specific taskforces, focusing on the following areas: health policies and procedures, health education and promotion, management of volunteers, and training and capacity-building.

Three of these taskforces are chaired by nongovernmental organizations and one is chaired by the Ministry. Governorate-level emergency committees were also formed, chaired by governors, with the responsibility of monitoring and responding to the situation in their respective jurisdictions. These emergency committees report to the National Health Committee and include representatives from the public, private and nongovernmental health sectors. The governorate-level emergency committees proved to be instrumental in coordinating the response and involving the private health sector at that level.

In Jordan, Lebanon and Tunisia, national response plans were developed in accordance with the pillars of WHO's global COVID-19 strategic preparedness and response plan

In Iraq, several councils and committees were established simultaneously or sequentially by the Government to manage COVID-19. Currently, the planning and response to COVID-19 is led by the Supreme Council for Health and National Safety. Several technical/advisory committees have also been established at the Ministry of Health and Parliament level, with the purpose of providing scientific evidence and recommendations to decision-makers. Further, COVID-19 crisis cells have been established in every province and chaired by the respective governors with the membership of the Director General of each provincial health directorate as well as local authorities. Those crisis cells are responsible for changing the containment measures in the corresponding provinces according to the local epidemiological situation *(14).*

In Jordan, Lebanon and Tunisia, the national response plans were developed in accordance with the pillars of the WHO global 2019 COVID-19 strategic preparedness and response plan *(9).*

In Jordan, the Ministry of Health led efforts to develop the National COVID-19 Preparedness & Response Plan 2020 with the support of WHO. The overall objective of the plan was to define the overarching framework for the Ministry as well as the relevant national and international partners to accelerate their capacity to prepare and respond to the pandemic. The plan identified the interventions to be implemented to enhance pandemic preparedness and response. Four working groups were established under the umbrella of the Health Development Partner Forum. They are co-chaired by the Ministry, WHO and the United States Agency for International Development (USAID), and include United Nations agencies and nongovernmental organizations. Each working group was tasked with managing specific domains based on the WHO pillars of COVID-19 response: working group 1: Coordination and Planning, covering Pillar 1 and Pillar 9; working group 2: Risk Communication, Pillar 2; working group 3: Technical Support for COVID Management, covering Pillars 3, 4, 5, 6 and 7; and working group 4: Procurement, Pillar 8.

During the second wave in August 2020, Tunisia's National Action Plan was revised and presented to partners to urgently mobilize extra funds

In Lebanon, the Ministry of Public Health developed a health strategic preparedness and response plan for COVID-19 in March 2020 *(15)*. The plan aimed at scaling up the preparedness and response capacities with respect to prevention, early detection and rapid response. It included priority actions divided according to the WHO pillars. The plan featured (i) the establishment of the National COVID-19 Task Force to mobilize resources, monitor country-level activities and facilitate coordination with relevant ministries; (ii) inter- and intra-sectoral coordination of activities between stakeholders and partners; (iii) setting up and activation of emergency operation centres responsible for coordinating the response at both the national and subnational levels; (iv) mapping of human resource needs for the implementation of the national plan; and (v) establishment of a COVID-19 platform for national data collection. The National COVID-19 Response Task Force is responsible for following up on preventive measures and country preparedness activities. Another action plan was developed to combat COVID-19 in Lebanese prisons. The plan was developed by the Lebanese Society of Infectious Diseases and Clinical Microbiology, the Lebanese Order of Physicians, the Internal Security Forces, Ministry of Public Health, the Ministry of Interior and Municipalities, the International Committee of the Red Cross, WHO and several other United Nations agencies. It aimed at developing action points for prevention, preparedness, early identification and treatment of COVID-19 in the main prison *(16).*

The Ministry of Health in Tunisia set up a general plan for epidemic prevention, preparedness and response to COVID-19 in February 2020 with the main objectives of strengthening surveillance, case detection, implementation of prevention measures and case management. The Tunisian strategy was developed by the National Observatory for New and Emerging Diseases and adapted to COVID-19. As the pandemic spiked in March 2020, the Ministry of Health drew up a National Action Plan based on the nine pillars of the WHO Global Response Strategic Plan. This National Action Plan reflected the Government's strategic vision and aimed to mobilize available resources, including those of technical and financial partners. With the second wave in August 2020, the National Action Plan was revised and presented to partners to urgently mobilize extra funds. The general approach to response was to include the private health sector.

In Pakistan, the Ministry of National Health Services, Regulations and Coordination developed short-term, medium-term and long-term COVID-19 strategic action plans to guide and steer the response. Each of the strategic areas of the plans envisaged the role and engagement of the private sector in COVID-19 surveillance and response. However, private health representatives were not included in setting any of those plans. The short-term plan focused mainly on re-organization of human resources with built-in mechanisms for due care of the health workforce, regular data sharing, coordination strengthening and initiation of accountability and legislative measures. The medium- and long-term plans were based on the maturation of the processes and pillars of the short-term plan. The medium- and long-term actions were centred on the adoption of an enhanced and comprehensive approach by including standing committees for accountability, technical working groups and subcommittees for policy and programmatic reforms, developing a monitoring and evaluation framework, hazard mapping and the establishment of regulatory bodies. The National Coordination Committee provided oversight at the federal level, but the provinces exerted operational independence with respect to their individual response.

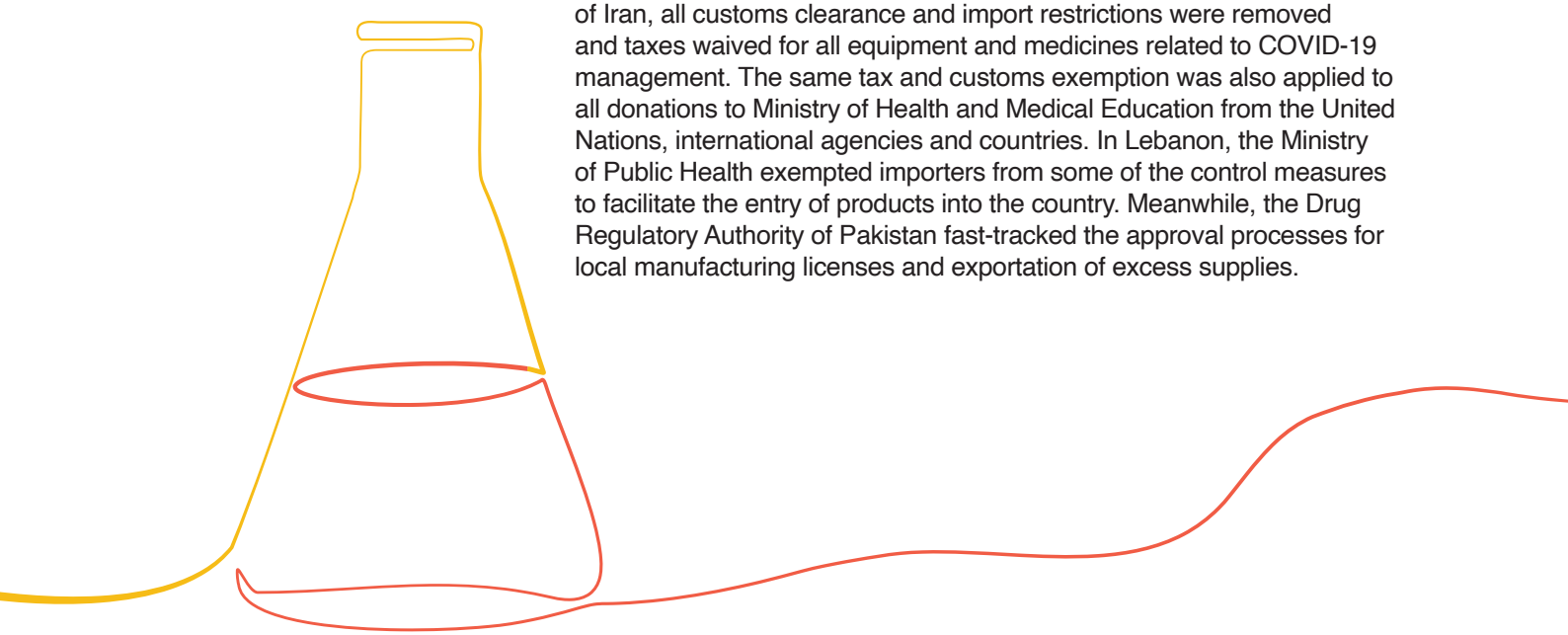
In Libya, the National Centre for Disease Control proactively started preparing the COVID-19 preparedness and response plan and launched this plan with the support of WHO in January 2020. The plan involved training core rapid response teams and providing testing kits to the National Public Health Laboratory.
In March 2020, the Government established the High Presidential COVID-19 Response Scientific Committee, a multisectoral emergency body. The Government allocated 500 million Libyan dinars for the COVID-19 response in April to be spent under the supervision of the High Presidential COVID-19 Response Scientific Committee and to be implemented by the Military Medical Council. Between May and June 2020, the Ministry of Local Governance in coordination with the Ministry of Health supported local governments in establishing municipality-level emergency committees responsible for monitoring and response. These committees report to the High Presidential COVID-19 Response Scientific Committee, the Military Medical Council and the National Centre for Disease Control. The Ministry of Health and its entities remain an integral part of the COVID-19 response in terms of coordinating the efforts and technical and scientific guidance. It is also responsible for arranging roles in coordination with the Military Medical Council municipal teams.

In Pakistan, COVID-19 strategic action plans envisaged the role and engagement of the private health sector in surveillance and response, however, private sector representatives were not included in setting the plans

1.2 Supplies and logistics

In most countries of the Region, no actual national quantification and supply plans were developed for COVID-19. There were some preliminary forecasting efforts that were led by the governments, with some contributions by international health partners and donors. In Jordan, such forecasting efforts were supported by WHO and USAID. In Lebanon, a needs assessment and planning were conducted in collaboration with private pharmaceutical companies. In Libya, there was no noticeable contribution of the private health sector to national supplies and logistics. In the West Bank and Gaza Strip, the role of the private health sector was limited to the procurement of needed supplies using donor funding on behalf of the Ministry of Health. It is worth noting that the private health sector in the West Bank and Gaza Strip has been using its own channels to cover its needs for COVID-19 supplies, given the lack of support of the Ministry in that regard.

To secure a prompt and sufficient supply of medical products, testing kits and infection control tools, some countries have dramatically eased the regulatory requirements for importation and cut or completely removed associated taxes and duties. This has been observed in the Islamic Republic of Iran, Lebanon and Pakistan. In the Islamic Republic of Iran, all customs clearance and import restrictions were removed and taxes waived for all equipment and medicines related to COVID-19 management. The same tax and customs exemption was also applied to all donations to Ministry of Health and Medical Education from the United Nations, international agencies and countries. In Lebanon, the Ministry of Public Health exempted importers from some of the control measures to facilitate the entry of products into the country. Meanwhile, the Drug Regulatory Authority of Pakistan fast-tracked the approval processes for local manufacturing licenses and exportation of excess supplies.

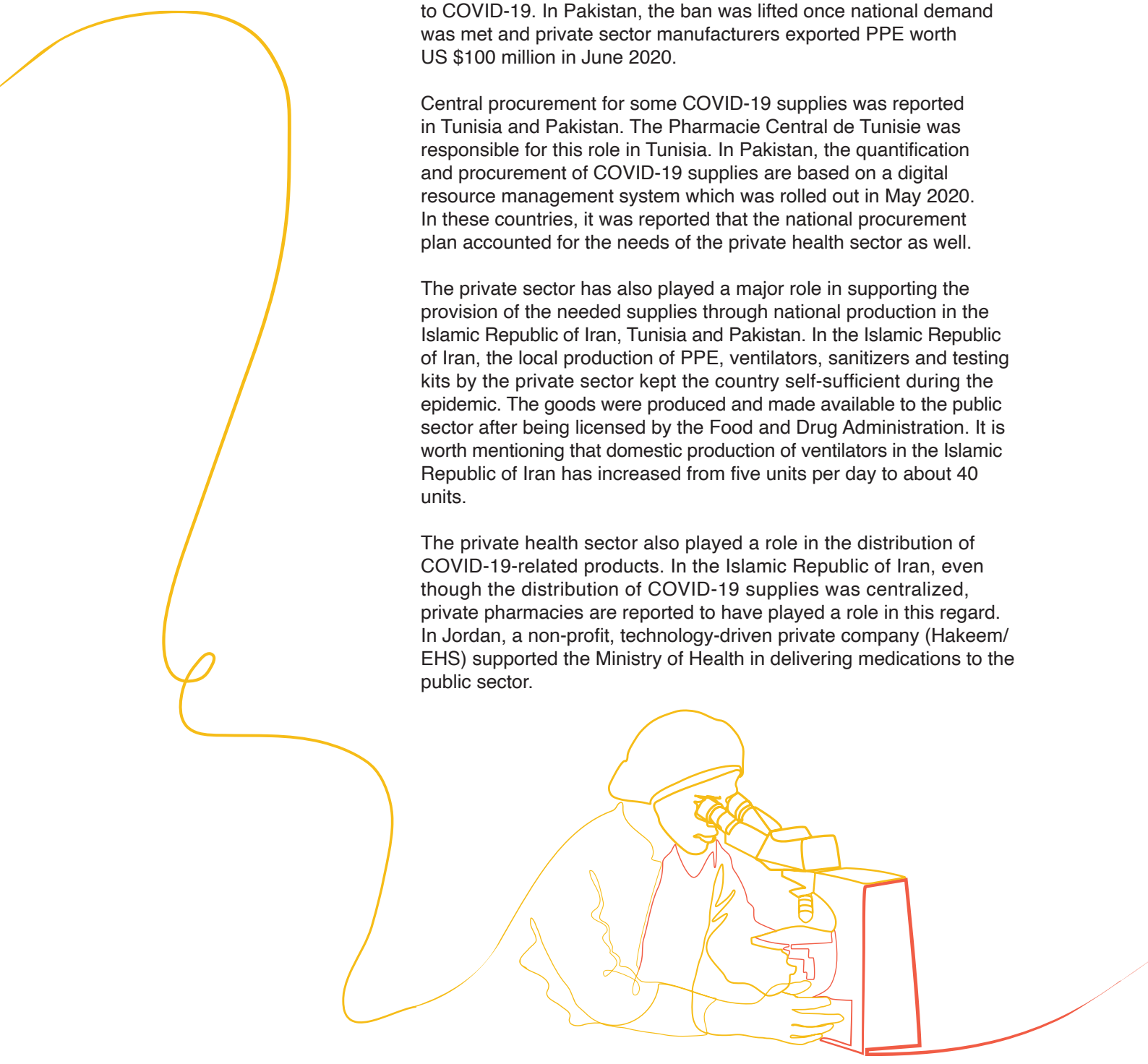


Moreover, in order to meet the national demand, a ban was placed on exporting any COVID-related supplies until the national demand was met in Jordan, Lebanon and Pakistan. In Jordan, the private health sector was required to maintain a six-month stock of all pharmaceuticals and medical supplies. The Jordan Food and Drug Administration also prohibited the export of medical supplies related to COVID-19. In Pakistan, the ban was lifted once national demand was met and private sector manufacturers exported PPE worth US $100 million in June 2020.

Central procurement for some COVID-19 supplies was reported in Tunisia and Pakistan. The Pharmacie Central de Tunisie was responsible for this role in Tunisia. In Pakistan, the quantification and procurement of COVID-19 supplies are based on a digital resource management system which was rolled out in May 2020. In these countries, it was reported that the national procurement plan accounted for the needs of the private health sector as well.

The private sector has also played a major role in supporting the provision of the needed supplies through national production in the Islamic Republic of Iran, Tunisia and Pakistan. In the Islamic Republic of Iran, the local production of PPE, ventilators, sanitizers and testing kits by the private sector kept the country self-sufficient during the epidemic. The goods were produced and made available to the public sector after being licensed by the Food and Drug Administration. It is worth mentioning that domestic production of ventilators in the Islamic Republic of Iran has increased from five units per day to about 40 units.

The private health sector also played a role in the distribution of COVID-19-related products. In the Islamic Republic of Iran, even though the distribution of COVID-19 supplies was centralized, private pharmacies are reported to have played a role in this regard. In Jordan, a non-profit, technology-driven private company (Hakeem/EHS) supported the Ministry of Health in delivering medications to the public sector.



In countries where the private health sector had a role, it was observed that the role was linked to governmental support in providing the enabling environment and space for the private sector to contribute to the response. For instance, the Ministry of Health and Medical Education in the Islamic Republic of Iran has been permitted to bypass the laws and regulations and issued temporary licenses for some private pharmaceutical companies to import medicines to address the shortage of some products that were deemed necessary in the response. Similarly, a waiver in standard purchasing procedures was observed in Iraq, where the lengthy importation processes were skipped to allow the pharmaceutical companies to provide the required medicines. In Jordan, the Jordan Food and Drug Administration facilitated and accelerated the registration process for any company that provided any potential drug for COVID-19. Despite the exceptions, regulatory measures were still in place in the country, and the Food and Drug Administration regulated the prices of pharmaceuticals and medical supplies and maintained and evaluated the quality of the goods, especially those related to PPE.

In countries where the private health sector partners did not have a formal role in the supply of COVID-19 products, support was given through donating equipment such as ventilators, PPE and other medical supplies. This was observed in Jordan and Lebanon. In Jordan, the EMPHNET supported the Ministry of Health by donating PPE, PCR kits and swabs.

In countries where private health sector partners did not have a formal role in the supply of COVID-19 products, they provided support by donating ventilators, PPE and other medical supplies

1.3

Surveillance, contact tracing and diagnosis

National testing strategies were developed in multiple countries of the Region. In Lebanon, the Ministry of Public Health (supported by academic institutions and WHO) developed a clear COVID-19 testing strategy with an overall target of 15 000 tests per million population and a special focus on disease clusters and high-risk groups. The Syndicate of Biologists in Lebanon contributed to the refurbishing, structuring and preparedness of laboratories for COVID-19 testing through a committee established by ministerial decision. As part of the Reagent Committee, it assessed different reagents and checked international guidelines for advice on their usage. It also contributed to strengthening the surveillance and emergency response systems through reporting and inhibiting the use of inefficient tests, such as the antigen rapid test.

Islamic Republic of Iran, Lebanon, Pakistan, Jordan and Tunisia

allowed private providers to contribute to diagnosis and surveillance efforts

Iraq, Libya and West Bank and Gaza Strip

excluded them from such a role

The engagement of the private health sector in surveillance and diagnosis varied across the Region. While some countries allowed private providers to contribute to diagnosis and surveillance efforts, such as the Islamic Republic of Iran, Lebanon, Pakistan, Jordan and Tunisia, others excluded them from such a role as in the case of Iraq, Libya and West Bank and Gaza Strip. All countries within the scope of the study excluded the private sector from contact tracing efforts, except for Lebanon and the Islamic Republic of Iran.

Given the limited global supply of testing kits at the outset of the pandemic, countries in the Region initially sought to centralize the testing and diagnosis at public sector facilities. As the pandemic progressed, more kits became available and the need for testing exceeded the capacity of governments. In March and April 2020, some countries started accrediting private laboratories and hospitals to conduct reverse transcription polymerase chain reaction (RT-PCR, or PCR) tests for COVID-19. The testing numbers for countries of the Region as of January 2021 can be found in **Annex 2.**

Islamic Republic of Iran

Each medical university conducts about 8300 real-time PCR tests per day

In the Islamic Republic of Iran, at the initial stage of the pandemic, testing was available at public hospitals with limited availability in private laboratories and outpatient clinics. Later, testing became available daily for 16–24 hours at primary health care facilities. It has been estimated that each medical university conducts about 8300 real-time PCR tests per day. As of the time of writing, there are about 292 laboratories across the country that are licensed to perform PCR testing, of which 126 (43%) are private laboratories.

In Jordan, the Government initially accredited two private laboratories to test all travellers crossing the land borders at their own expense. In June 2020, the Ministry of Health issued official regulations that stipulated the provision of PCR testing kits to private laboratories and reimbursing them US$ 10 per test. By August 2020, private laboratories were still operating on a fee-for-service basis. To keep up with the increasing demand, the Ministry of Health approved 25 laboratories in the private sector to perform PCR testing. Of these laboratories, 10 were chosen by the Ministry to conduct the tests on behalf of the Central Public Health Laboratory in order to increase testing capacity within the public sector. However, since the beginning of October 2020, the Central Public Health Laboratory has increased its own capacity to perform around 20 000 tests per day, thereby reducing the need for testing by the private sector.

In Pakistan, private sector clinical laboratories were engaged in Khyber Pakhtunkhwa, Punjab and Sindh. In Balochistan, Azad Jammu and Kashmir, and Gilgit-Baltistan, however, the private health sector was not engaged due to adequate public testing capacities.

In Tunisia, some private laboratories were added to the testing facilities network after the first wave, particularly to facilitate testing for travellers who needed to meet the negative RT-PCR test prerequisite. A standard price was also established for a COVID-19 PCR test across those laboratories.

In Tunisia there are currently 61 private laboratories authorized to test for COVID-19. In Libya, COVID-19 molecular diagnostics and testing services are managed by the Ministry of Health through 20 laboratories nationwide. However, recently the Ministry in the eastern part of the country has authorized two private laboratories to conduct PCR testing to address the limited testing capacity in the region. In Lebanon, the laboratory at the Rafik Hariri University Hospital was the only one performing PCR testing for the diagnosis of COVID-19 until April 2020. The Ministry of Public Health then sought to engage university and private hospitals to provide case management and PCR testing *(17)*. There are currently around 50 private laboratories and nine drive-through testing centres nationwide that are contributing to both diagnosis and tracing *(18)*. It is estimated that 95% of COVID-19 testing in Lebanon is currently being done in the private sector. In Iraq, the Ministry of Health was able boost testing capacity through increasing the number of reference laboratories from one to 50 across the different regions. Accordingly, the capacity jumped from 200 tests per day at the beginning of the outbreak to more than 20 000 tests per day without allowing private laboratories to engage.

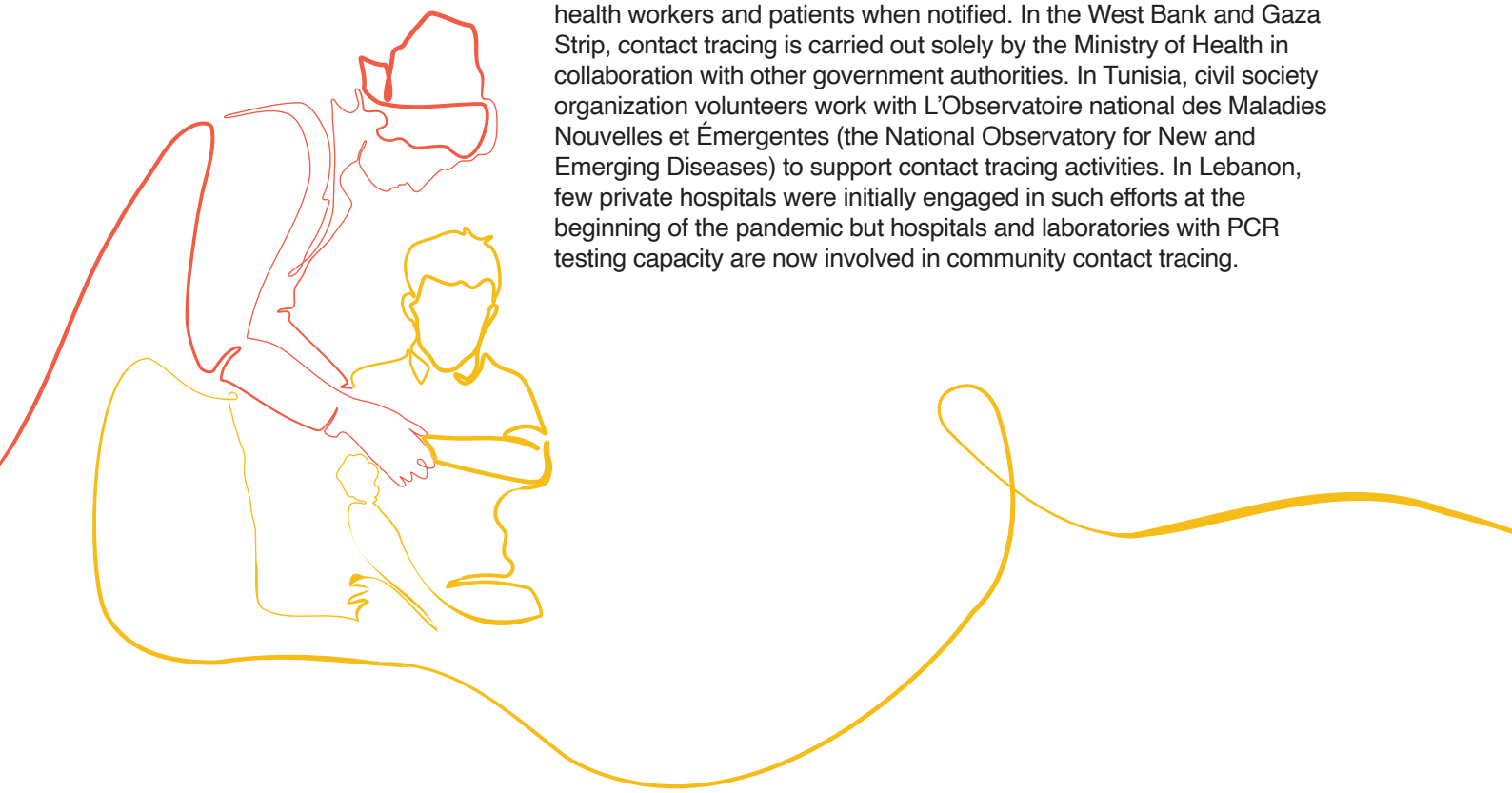
In Lebanon, 95% of COVID-19 testing is currently being done in the private sector

Systems are in place for reporting cases tested at private health facilities, mainly using web-based reporting platforms

In countries where the private sector is allowed to test suspected cases, systems have been put in place for reporting cases that are suspected or confirmed at private health facilities. In the Islamic Republic of Iran, Jordan and Pakistan, newly confirmed COVID-19 cases must be reported at the end of each workday to the respective authorities. The reporting platform as well as responsible authority are usually different for laboratories and hospitals, but both are typically overseen by a high-level committee or body. The data collected on the existing and projected number of cases from all the reporting mechanisms typically feed into the quantification and supply plan for COVID-19 to ensure the availability of supplies.

The platform for reporting varies from web-based as in the Islamic Republic of Iran, Lebanon, Pakistan and Tunisia to phone- or email-based as in Lebanon (in case of e-platform access issues).

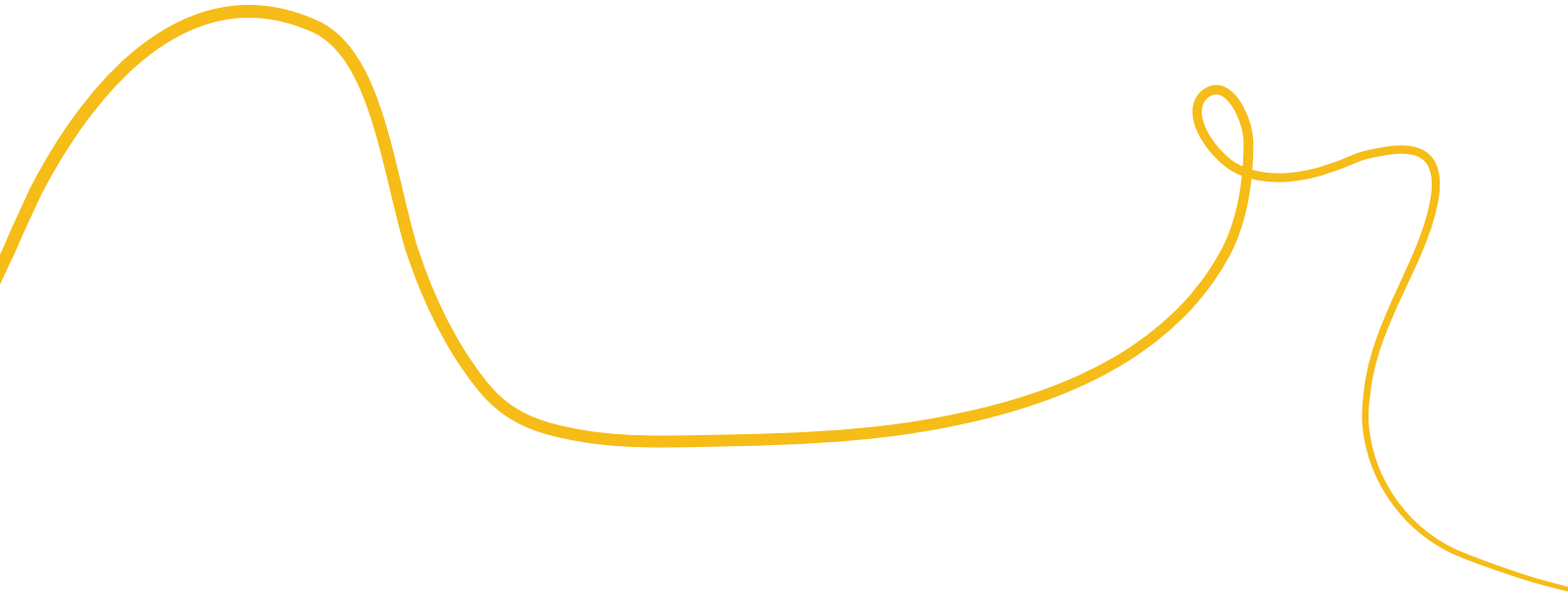
Regarding contact tracing, screening is being done to a variable extent. In the Islamic Republic of Iran, primary health facilities have been proactive in contact tracing of probable and positive cases through screening family members of suspected or positive cases. To 2 December 2020, more than 74 million people were traced and screened for COVID-19 by primary health facilities. Private providers are also required to test asymptomatic and suspicious contacts of each detected case. In Libya, the assigned surveillance and rapid response teams are responsible for investigating infections among private sector health workers and patients when notified. In the West Bank and Gaza Strip, contact tracing is carried out solely by the Ministry of Health in collaboration with other government authorities. In Tunisia, civil society organization volunteers work with L'Observatoire national des Maladies Nouvelles et Émergentes (the National Observatory for New and Emerging Diseases) to support contact tracing activities. In Lebanon, few private hospitals were initially engaged in such efforts at the beginning of the pandemic but hospitals and laboratories with PCR testing capacity are now involved in community contact tracing.



Private health sector participation in surveillance and diagnosis was not encouraged and even banned in some countries of the Region

In summary, private health sector participation in surveillance and diagnosis was largely not encouraged and even banned in some countries of the Region. In those countries, private laboratories and facilities were prohibited from conducting PCR tests and suspected cases were referred to designated public sector facilities and triage centres. However, in some of these countries, the private health sector still managed to find a way to get involved in the diagnosis of COVID-19 cases through non-specific and non-diagnostic tests such as rapid antigen tests and CT scans. This was particularly notable in Iraq, where private clinic practitioners were observed using those tests for confirming suspected cases.

Despite the mandatory reporting by private facilities, it was observed that some facilities refrained from sending such reports as in Libya, Pakistan and West Bank and Gaza Strip due to lack of enforcement, tax issues or fear of being labelled as infected facilities and risking suspension of operations or even closure. Another challenge reported in Iraq was the limited access to PCR testing for suspected cases due to the adoption of a testing strategy (by some directorates) that dictated testing with rapid antibody test at the primary care level before taking combined swabs, as well as the inability of the private sector to conduct PCR tests on suspected cases due to government-imposed bans.



1.4

Case management and referral

Initially, many governments attempted to isolate all positive cases in dedicated isolation wards

At the start of the outbreak, most countries in the Region tried to centralize the management of COVID-19 within public health facilities. As cases surged, the private health sector got involved in the majority of countries either officially as in the Islamic Republic of Iran, Jordan, Lebanon and Tunisia or unofficially as in Iraq. Table 3 provides an overview of the involvement of the sector in selected countries of the Eastern Mediterranean Region.

Governments initially attempted to isolate all positive cases in dedicated isolation wards but as the pandemic progressed, asymptomatic and mild cases have been required to self-isolate at home to free up space for moderate and severe cases.

One important challenge to testing and case management has been reported in Iraq and Pakistan where the governments' approach of isolating confirmed cases in designated facilities at the beginning of the outbreak led to stigma associated with virus. In Iraq, the Ministry of Health forced suspected cases to stay in public hospitals for 48 hours while awaiting their test results, which was unacceptable for many people, especially women. In Pakistan, testing positive for COVID-19 meant that government health teams along with law enforcement agencies would knock at the case's door and force them to be taken to a public health facility against their will. This approach led to fear among the population and drove suspected COVID-19 cases to avoid testing.

Table 3: Level of involvement of the private sector in case management in selected countries of the Region

Involvement of private health sector in case management	Country / territory	Notes
Involved	**Iran (Islamic Republic of)**	98 private hospitals designated to admit COVID-19 patients
	Lebanon	20% of private hospitals with ICU beds accept COVID-19 cases
	Jordan	Contribution to case management since November 2020
	Tunisia	Especially in second wave of the pandemic
Limited involvement	**Pakistan**	Only a few large private hospitals involved
Not involved	**Libya**	Discussions underway to involve private facilities
	Iraq	Private sector not officially involved in case management but has been playing a significant role on the ground
	West Bank and Gaza Strip	Only provide non-COVID-19 services to COVID-19 patients

In the Islamic Republic of Iran, private ambulances were allowed to transfer suspected COVID-19 patients to hospitals at the beginning of the outbreak. However, as a result of non-compliance with protocols, the transfer of patients by private ambulances is currently prohibited. Therefore, the private sector is no longer involved in this aspect. In terms of case management, only public hospitals affiliated to the Ministry of Health and Medical Education were defined as a care centres for COVID-19 at the beginning of the outbreak. From early March 2020, however, at least two hospitals in each province (one public and one private) were exclusively assigned to provide COVID-19 services. As the number of epicentres increased, more hospitals were allocated to treating COVID-19 patients. In some provinces, private hospitals were also contracted to provide services to the public on behalf of the Government. Currently, 98 private hospitals across the country are designated to admit COVID-19 patients. Mild cases detected at private outpatient clinics are referred to the assigned comprehensive health centre or hospital. The comprehensive health centre delivers the medicine to the patient according to a referral form filled by the private sector physician.

At the time of writing, only 20% of the private hospitals with ICU beds are offering their capacity to fight COVID-19

In Lebanon, the plan initially was to provide care only through public hospitals. Accordingly, university hospitals, which are all private except for Rafik Hariri Hospital, acted as referral centres to public hospitals during the early stages of the pandemic. Since referrals were mainly to Rafik Hariri Hospital, a transfer form was developed to allow adequate coordination between the hospital, the Lebanese Red Cross and the Ministry of Public Health. This referral system is still active, but the saturation of bed capacity is impeding its efficiency. Currently, referrals are controlled by the Ministry of Public Health. As the pandemic progressed, private hospitals were included in the response. Private hospitals follow the guidelines and the internal response and preparedness plans for COVID-19 established by the Government. As of the time of writing, only 20% of the private hospitals with ICU beds are offering their capacity to fight COVID-19. Nonetheless, the private sector offers support through university hospitals which participate on national committees and continue to contribute by giving advice on health measures and the creation of units for COVID-19 patients including negative pressure rooms. They are involved in training health professionals on the use of PPE and in taskforces and committees to respond to the pandemic. They are also actively conducting readiness assessments and operational plans. Some have also developed flu clinics or mobile units for testing, tracing and treating COVID-19 cases while others have entered into contractual agreements with smaller or peripheral hospitals to expand their capacities. The Order of Midwives collaborated with the United Nations Population Fund (UNFPA) in the monitoring of COVID-19 infections among pregnant women in Lebanon. In terms of follow-up, the Ministry of Public Health in collaboration with the Lebanese Red Cross launched a centralized hotline manned mostly by health professional volunteers to follow up on COVID-19 cases. Unfortunately, the hotline was difficult to sustain due to limited human resources. To November 2020, a total of 93 123 calls were answered *(20)*. University hospitals also offered support to public hospitals through training and coaching and to the Ministry of Public Health through case management and PCR testing.

The Jordan Paramedic Society deployed their emergency medical teams to support Civil Defense teams during the lockdown

In Jordan, asymptomatic and mild positive cases are required to self-isolate at home. Moderate and severe cases are required to contact the Civil Defense Directorate, which transfers the patient to a private hospital at his/her expense, or a government hospital, or a referred hospital. It is worth mentioning that the Jordan Paramedic Society deployed their emergency medical teams to support Civil Defense teams in Jerash and Amman during the lockdown. A Paramedic Society emergency medical team also supported the Ministry of Health in the beginning of the pandemic through a telemedicine call centre line that was designed and activated by the Ministry. Moreover, it deployed 50 doctors as volunteers to support Ministry staff in responding to the calls. During the first wave, there was no role for the private hospitals in dealing with COVID-19 in Jordan. However, in November 2020, the Government passed Defense Order No. 23, allowing the Minister of Health to control any private hospital either totally or partially and assign its management and employees to operate and receive COVID-19 cases referred from public health facilities. The Ministry of Health then rented a private hospital with the capacity of 180 ward beds and 140 ICU beds and contracted a specialized company to build three field hospitals in Amman, Irbid and Maan with a capacity of 180 ICU beds. Additionally, the Ministry and the private health sector agreed on allocating 1000 ward beds and 180 ICU beds to receive COVID-19 patients transferred from public sector hospitals. In October, the Ministry through the Licensing Professions and Health Institute Directorate granted 12 private hospitals permission to receive COVID-19 patients and treat them at their own expense if they chose to go to a private hospital instead of a public one. As for cases detected at border screenings, all negative cases are requested to self-quarantine for 14 days at home, while positive cases are initially transferred to a public hospital. Recently, patients have been given the choice of going to a private hospital at their own expense.

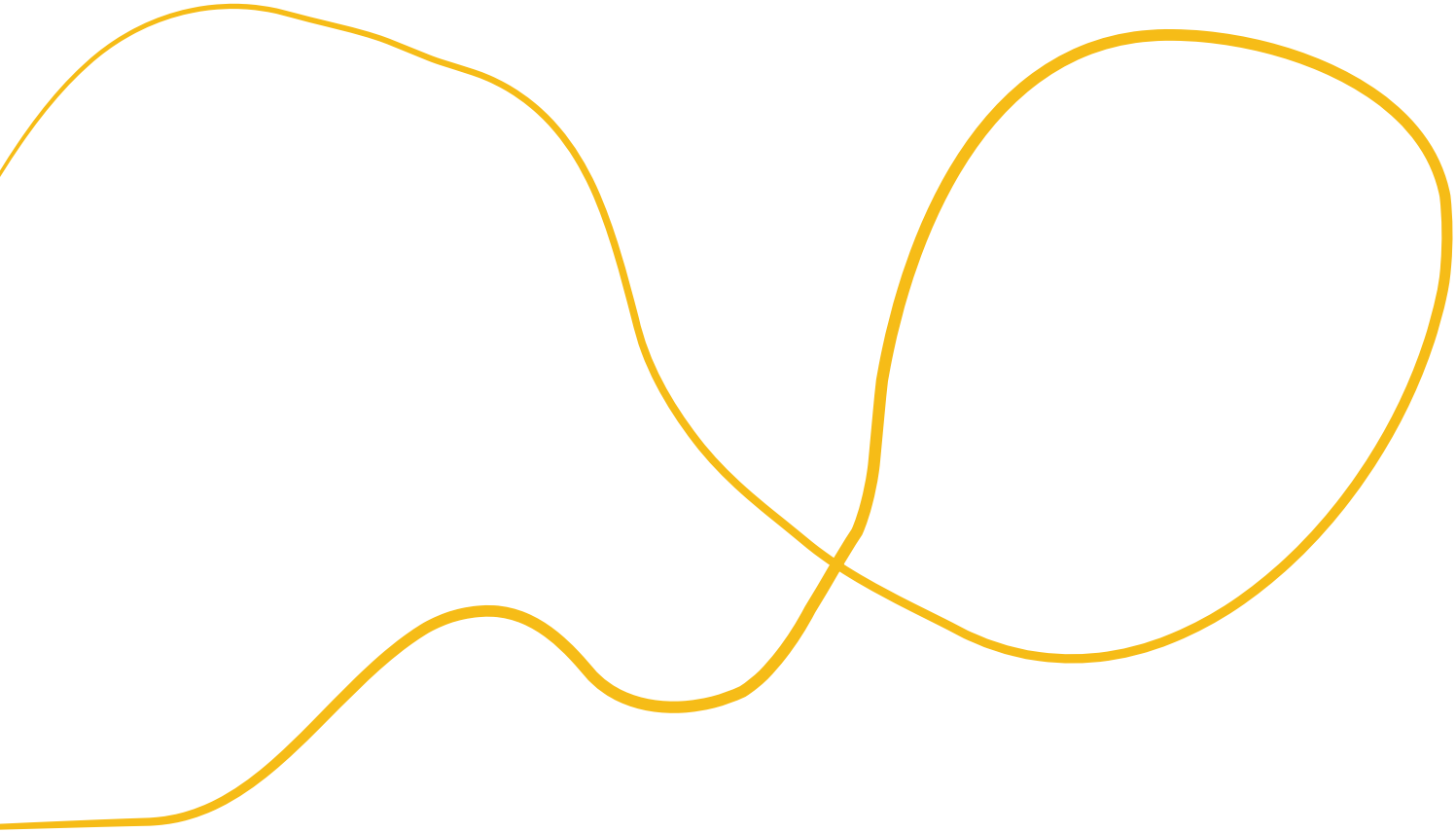
In Pakistan, rapid response mechanisms were contracted out to the private health sector

In Pakistan, private hospitals are minimally involved in COVID-19 management apart from several large hospitals that were requested to allocate in-patient beds for COVID-19 and dedicate a share of ICU beds and ventilators to enhance the capacity of the health system. The utilization of those hospitals is reportedly extremely limited. Nevertheless, rapid response mechanisms were contracted out to the private health sector including field teams along with public health call centres. A triage, tele-training and telemedicine public-private initiative called Yaaran-e-Watan was also launched by the Ministry of National Health Services, Regulations and Coordination, the Ministry of Overseas Pakistanis and the Ministry of Human Resource Development, with support from Pakistani diaspora health organizations. The initiative aims to address health gaps by tapping the expertise of Pakistani and foreign health professionals practising abroad.

In Libya, a huge communication and coordination gap between the different entities within the Ministry of Health manifested, with the private sector marginalized. The Military Medical Council has been working independently, while a vertical approach was employed for establishing rapid response teams and isolation centres by the Ministry due to resource shortages at primary and tertiary levels. This approach resulted in more fragmentation and high cost of services. The role of the private sector is still restricted to referring suspected moderate-to-severe COVID-19 cases to triage centres and advising mild cases to self-isolate. However, there are discussions underway to involve some private facilities in COVID-19 management to expand admission capacity.

Similarly, in the West Bank and Gaza Strip, all treatment and isolation facilities have been managed by the Ministry of Health despite the fact that many are provided by private sector entities and the local community. Accordingly, all suspected cases presenting to private or nongovernmental organization providers are referred to the nearest designated public facility. At the outset of the pandemic, all private hospitals introduced a triage system to identify and isolate suspected COVID-19 cases. Private hospitals admitting confirmed cases who require non-COVID medical procedures or surgeries provide isolated rooms or wards with separate pathways. Currently, COVID-19 patients receiving treatment at private hospitals are either patients admitted for specific medical conditions and then found to be COVID-positive or confirmed COVID-19 patients admitted to Ministry treatment facilities and found to be in need of further special care not available at these facilities.

In West Bank and Gaza Strip, private hospitals introduced a triage system to identify and isolate suspected COVID-19 cases



Private hospitals in Iraq are still not allowed to provide any case management services to COVID-19 patients

In Iraq, the management of COVID-19 is largely home-based except for severe cases which are admitted to specialized public isolation hospitals with a total capacity of 10 000 beds. As per Ministry of Health regulations, treatment of COVID-19 cases has been assigned to the public sector and private hospitals are still not allowed to provide any case management services to COVID-19 patients. They are required to refer suspected cases to public hospitals and maintain the provision of other essential health services. The follow-up of these (mild-moderate) cases is partially done in the public sector by family physicians, general practitioners and other health personnel serving in primary health care centres through home visits. It has been observed that despite the official ban of the private sector, it has been increasingly informally engaged in the role due to the limited capacity of the public sector.

In Tunisia, the early approach to the hospital sector was to try to prepare all regional and tertiary hospitals to admit COVID-19 patients. Forty private hospitals (out of 102) expressed their willingness to participate in these initial efforts. Inspection activities were targeted at these facilities, including visits by health ministry experts to assess readiness using the WHO Regional Office for the Eastern Mediterranean hospital readiness checklist *(21)*. During the visits and follow-up, patient pathways were examined alongside infection prevention and control protocols and staff pathways. Discussions were held to improve clinical and staffing systems for optimal COVID-19 care. An updated estimate regarding availability of beds for COVID-19 in private hospitals was then made in interested and qualified facilities. Furthermore, a platform for monitoring COVID-19 bed capacity in these facilities was created. During the second wave of the virus, more private hospitals became involved in providing clinical care due to increased number of cases. Pre-triage and triage were established in private hospitals providing services to COVID-19 patients. Some private clinics were also equipped with up to 275 dedicated COVID-19 beds, and the cases placed in isolation rooms. The case management protocol was developed by L'instance nationale d'évaluation et d'accréditation en santé and made available for all health care facilities. However, wide variations in protocol implementation have been observed. These have been attributed to frequent changes in COVID-19 management guidelines during both waves. Initially referrals were centralized through the national ambulance service, which received updates on the bed capacities at the different treatment facilities. As the pandemic progressed, regional committees became responsible for referrals from outpatient providers. However, it has been reported that referrals are mostly sought through informal and personal connections with the health authorities.

1.5

Maintaining essential health services

The lack of pandemic preparedness, rapid increase in demand for health services and the reallocation of resources to address the COVID-19 emergency have put unprecedented strain on maintaining non-COVID-19 services.

During the peak of COVID-19 cases across the Region, many health services were either scaled down or suspended, from elective surgeries to dental care and other services pertinent to noncommunicable diseases. It has been observed that the demand and referral to primary health services declined compared to the same time in previous years. A similar pattern was also observed at hospitals, where a decline in acute myocardial infarction, thrombotic problems and other acute conditions was reported. This can be explained by the public fear of contracting COVID-19 at health facilities as well as the decreased capacity to deal with other conditions.

During the peak of COVID-19 cases across the Region, many health services were either scaled down or suspended

The private sector again played a varied role at this time across the Region. In the Islamic Republic of Iran, Iraq and Tunisia, private outpatient clinics and specific services (such as dentistry) diminished in the first few months of the pandemic. This was either due to lack of operating guidelines at the time, limited supply of PPE or compliance with curfew orders, or even health staff not reporting to work. As time passed and more information on COVID-19 became available, many facilities resumed their work while applying the necessary infection control measures.

It is worth noting that in the West Bank and Gaza Strip, a different utilization pattern was observed of outpatient clinics: nongovernmental organizations' outpatient facilities witnessed a surge in patient visits after the scaling-down of such services in the public sector. This did not include more vulnerable groups, who avoided health facilities for fear of infection.

Unlike outpatient services, private hospitals were functioning at maximum capacity to maintain non-COVID-19 services at times when the public sector was heavily loaded. In Iraq, this was especially clear due to the deferment of many surgical procedures and the restriction of non-COVID-19 patient admissions by the public sector, leaving patients no choice but to seek those services from the private sector. In Jordan, private hospitals remained open to maintain emergency response and renal dialysis services, but elective surgeries were cancelled. A similar pattern was observed in the West Bank and Gaza Strip, where services at private hospitals were provided except for non-essential services, which were deferred for fear of COVID-19 infection. Recently, the Ministry of Health called upon all private and nongovernmental organization hospitals to accept patients with COVID-19 who were approaching them for other essential health services. Although the arrangement was not welcomed by a number of service providers, citing their lack of capacity and fears for the safety of their patients, an agreement was reached with five major private hospitals to receive COVID-19 patients who need specialized care, such as special surgeries and cardiac procedures, as well as for the delivery of babies by women with COVID-19. Patients in need of special procedures receive the required treatment at the private facility and are referred back to public COVID-19 facilities when their condition stabilizes. These arrangements are coordinated and maintained at the government-level through emergency committees. Accordingly, referral arrangements have been developed through practice and mutual dialogue and are based on need rather than established referral pathways. Consequently, there have been incidents of distrust and rejected referrals because of the lack of clear referral criteria. In Libya, the Government contracted some private health providers to provide specific services such as cancer care and management of war-wounded citizens, but with certain pre-approvals from the treatment directorate. Apart from the contracted services, patients in Libya have been observed seeking care in the private sector even for services that are fully covered in the public sector, either due to perceived superior quality or fear of infection in crowded public facilities.

Iraq

Some private sector health professionals provided free telephone consultations

Pakistan

Federal and provincial governments proactively launched COVID-19 telehealth facilities

Islamic Republic of Iran

Midwives were requested to follow up with all expecting mothers registered with antenatal care facilities

West Bank and Gaza Strip

Health-related nongovernmental organizations reached out to new or expecting mothers by deploying community health workers to conduct home visits

Telehealth and m-health services as well as home visits were reportedly activated by the private sector in Iraq and Pakistan to help fill the gaps in the provision of essential health services. The remote consultations were either paid or offered for free. In Iraq, some private sector professionals provided a variety of free telephone consultations, advertising mainly through social media and doctors' syndicate announcements. In Pakistan, the federal and provincial governments proactively launched the COVID-19 telehealth facilities in partnership with private sector nongovernmental organizations and academia whereby doctors either volunteered or were paid for their services.

Maintenance of reproductive, maternal, newborn, child and adolescent health services was among the key challenges faced by governments, given the vulnerability of this population. The private sector in the Islamic Republic of Iran has filled this gap through midwives who were requested to follow up with all expecting mothers registered with antenatal care facilities. Follow-ups were typically done remotely through a telephone-based midwifery service or midwife consultant. The service was put in place at the beginning of the outbreak, answering the questions and concerns of pregnant women and lactating mothers, with the aim of reducing unnecessary visits to health centres, increasing awareness, and reducing the level of stress and anxiety. Over 100 000 phone calls were answered by 600 faculty members and 300 experts during the first three months of epidemic. In the West Bank and Gaza Strip, this issue was addressed by health-related nongovernmental organizations that reached out to new or expecting mothers through community health workers who were deployed to conduct home visits.

Community pharmacies also played a role in the delivery of medications to emergency cases in Jordan.

1.6

Human resource management

Training and capacity-building activities on COVID-19 management have been facilitated by professional medical syndicates as well as local and international nongovernmental organizations and multilateral agencies across the Region. The role of the private sector ranged from providing staff to sharing knowledge and expertise with public sector peers. Below are several examples in which the private sector was involved in human resource management in the context of COVID-19.

Some university hospitals in Lebanon engaged in a "twinning project" between private and public hospitals

In Lebanon, some university hospitals engaged in a "twinning project" between private and public hospitals as a way of strengthening public hospitals and transferring knowledge between institutions. The agreement involved pairing each university hospital with one or two public hospitals for a six-month period. Further, the Order of Nurses and other professional organizations collaborated with the Ministry of Public Health on a series of training activities intended to strengthen respiratory disease surveillance system from indicator-based, community event-based and sentinel surveillance-based perspectives *(22)*. Health care professionals in hospitals and primary health care centres, as well as those working at land crossings or as frontline workers, were also involved in capacity-building events.

In Jordan, EMPHNET facilitated training for the Ministry of Health rapid response teams and supported a team in the north of the country by designing a database for COVID-19 cases in addition to providing data entry support and awareness sessions.

Mobilization of private health professionals was documented in the Islamic Republic of Iran, Pakistan, and the West Bank and Gaza Strip

Cases of mobilizing human resources have been documented in the Islamic Republic of Iran, Pakistan and the West Bank and Gaza Strip. In the Islamic Republic of Iran, staff from the private health sector were contracted through purchasing services and deployed on temporary assignments. During the earlier months of the pandemic, about 3195 private sector nurses were employed through short-term contracts. Similarly, in the West Bank and Gaza Strip, private and nongovernmental organization providers have seconded a number of their staff to take part in the operation of hubs under Ministry of Health command, while keeping them on their payroll. Furthermore, the Ministry indicated that it had recruited 300 additional medical professionals at the beginning of the pandemic in order to respond to the increasing need. The Ministry's health preparedness plan to combat COVID-19 also envisaged assigning ministry staff from primary health care facilities to work in its hospitals in place of infected or quarantined personnel. The plan also envisaged enlisting volunteers from the private and nongovernmental organization sector to support the operation of Ministry-run quarantine and isolation facilities. This arrangement has been confirmed by interviews with private health sector representatives. It is worth noting that the capacity-building/training taskforce in the West Bank and Gaza Strip is chaired by a national nongovernmental organization.

In Pakistan, initial sets of training on case identification, case management and infection control took place across the public and private sector during the short-term phase with a plan to expand cover to 10 000 care providers across the country. The Government of Khyber Pakhtunkhwa also introduced locum-based short-term engagement of health care professionals in order to fill gaps in public sector hospitals.

In Pakistan, training on case identification, case management and infection control took place across the public and private sectors during the short-term phase

In order to meet the increasing demand for health workers, Iranian universities were asked to expedite the graduation of medical students, while in Iraq, there was reallocation of human resources within the public sector.

1.7

Resource mobilization and financial arrangements

All countries relied on internal mobilization of resources, and donations from other countries as well as bilateral and multilateral international aid organizations, to raise the funds needed to respond to the pandemic. The private health sector helped governments in this regard as well. The Islamic Republic of Iran was the only country within the scope of the study in which the Government actively engaged with the private sector to raise funds. Although the budget required to fight COVID-19 has been provided by the Government, some measures have been taken to raise funds and resources from the semi-public sector. One of the most important of these measures was the cooperation of OTC Iran Company for collective financing, raising US$ 4 742 145 to help patients with COVID-19 during the pandemic.

The Government of the Islamic Republic of Iran actively engaged with the private health sector to raise funds

The only example for proactive resource mobilization by the private health sector was noted in the West Bank and Gaza Strip, where all private and nongovernmental organization health providers interviewed during the course of the study affirmed that they have been using their own channels to cover their needs for PPE and other supplies. A specific example was reported by east Jerusalem hospitals, which received adequate quantities of medical supplies and PPE through a grant by the European Union facilitated by WHO, besides direct support from a few donor countries. Makassed Hospital also reportedly received PCR testing equipment from the Israeli health authorities but is obtaining testing kits from the Palestinian Ministry of Health.

1.8 Treatment coverage in the private health sector

In terms of the arrangements in place to cover the cost of treatment of COVID-19 patients in the private health sector, once again there was diversity in working financial arrangements. While some countries had plans in place, elsewhere patients utilizing COVID-19 services incurred out-of-pocket payments. The Islamic Republic of Iran was the leading country in terms of a plan, providing coverage for all COVID-19 patients since March 2020 and taking measures to limit the profit margins of private providers while supporting them by postponing utility and tax dues and expediting the release of reimbursements. Lebanon, Libya and the West Bank and Gaza Strip relied on existing payment mechanisms with the sector without providing additional support. On the other hand, no coverage plans were made by Jordan, Pakistan or Tunisia despite the relative involvement of the private sector in COVID-19 management. In Iraq, no payment mechanism has been discussed for private health services since the sector has no official involvement in the management of cases. **Table 4** highlights the coverage status of COVID-19 services at private health facilities in the Eastern Mediterranean Region.

Table 4: COVID-19 service coverage at private health facilities in the Region

Country	Financial arrangement with the private health sector
Islamic Republic of Iran	All patients are covered by Iranian health insurance organizations for the diagnosis and treatment of COVID-19, including pharmaceuticals
	Tariffs are standardized at private facilities
	Private health insurance reimburses private facilities based on the set tariffs
Lebanon	Private hospital bills to be paid from the World Bank fund allocated to COVID-19
	Patients pay 15% of the bill in private hospitals and 10% of the bill in public hospistals (the cost of PPE is added to the final bill)
	Private health insurance does not cover COVID-19 costs
Libya	Private sector reimbursed for services contracted by Ministry of Health
West Bank and Gaza Strip	Costs ultimately covered through the usual referral arrangements with the Ministry of Health and private insurance companies, based on the same pre-pandemic tariffs and agreements
Iraq	Private sector is officially banned from managing COVID-19 cases
Jordan	Private insurance companies and third-party administrations are not covering or reimbursing any tests or treatments related to COVID-19
Pakistan	No arrangement for the reimbursement by Government to COVID-19 patients accessing care from the private sector, except in Sindh where a public-private partnership arranges for a subsidized testing fee at specific private facilities (50% less)
	No price regulation
	No coverage by private health insurance
Tunisia	No coverage at private facilities from the Caisse nationale d'assurance maladie (CNAM)* or any other state system

*Patients covered by CNAM receive care at public sector facilities under the regular overall annual ceiling for coverage as well as regular co-payments.

It is important to note that in countries where arrangements were made, the financial strain on both the government and the private sector has caused multiple challenges for both sides. Reimbursement delays have been reported in the Islamic Republic of Iran, Lebanon and the West Bank and Gaza Strip. In the Islamic Republic of Iran, the issue was resolved following a significant deposit by the national treasury to support insurance funds. However, in the West Bank and Gaza Strip, no budgetary allocations were made by the Government to cover COVID-19-related services outside Ministry of Health facilities and up to August 2020, no reimbursements had been made by the Ministry to private health facilities requested to provide specific services on a loan basis. The situation in Lebanon has been much more complex. The proposed tariffs/rates were arguably unrealistically low, which failed to incentivize the sector to participate in COVID-19 management. Given the overhang of pending payments from pre-COVID times and the struggle of providers to secure the needed supplies considering the foreign currency restrictions imposed by the central bank, the private sector was extremely reluctant to get involved. An agreement was eventually reached when funding from the World Bank was secured.

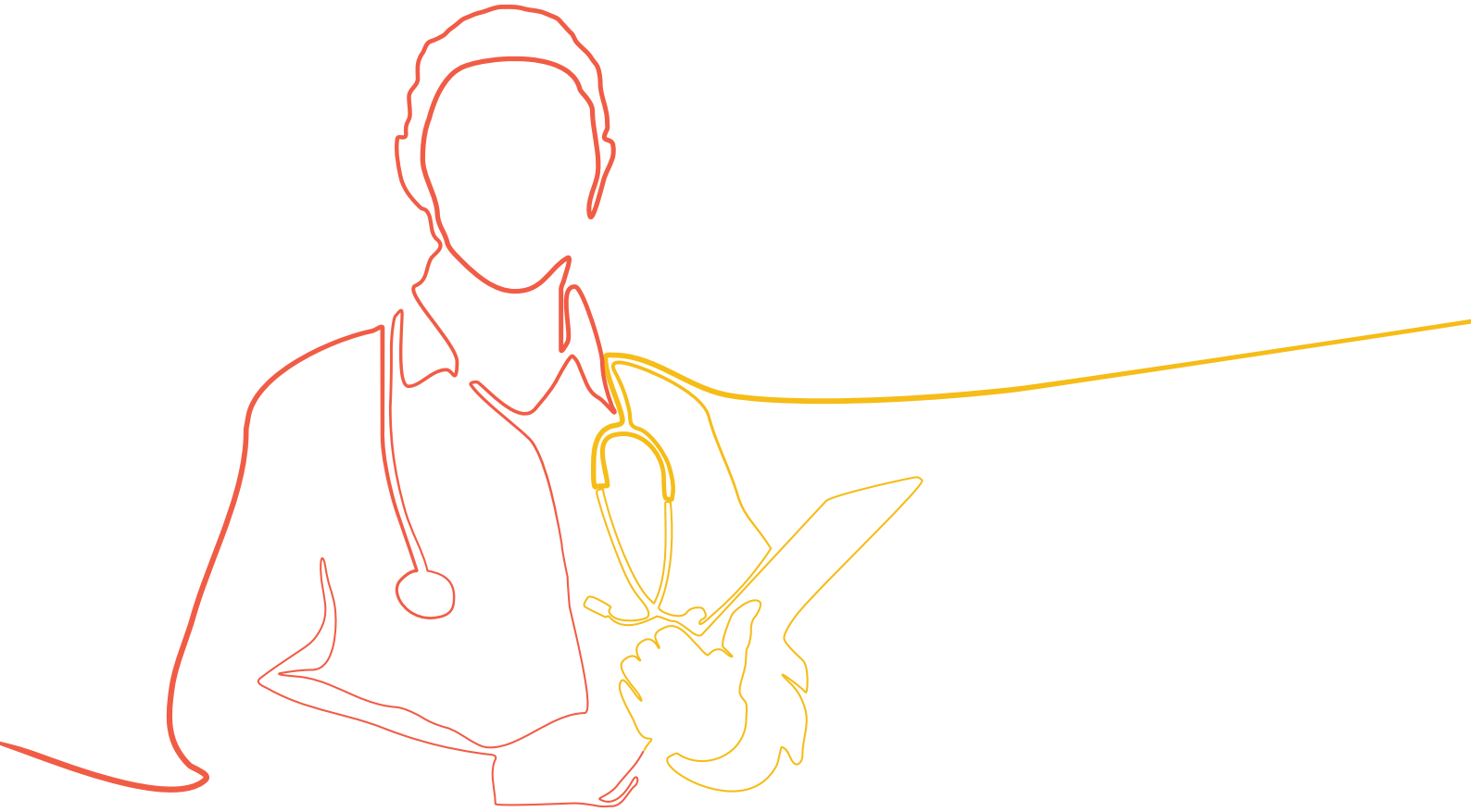
1.9

Risk communication and community engagement

There were no mechanisms in place to analyse findings or to establish a unified and consistent reaction to rumours, misinformation and various public concerns

In all countries within the purview of this study, risk communication has mostly been the responsibility of the public sector with voluntary participation and occasional collaboration with the private sector. The involvement of the private health sector typically included the physical dissemination of awareness materials, community outreach, developing risk communication and community engagement (RCCE) hotlines and mobile apps, in addition to raising awareness through different channels such as social media and TV. In general, there was no mechanism in place to analyse findings or to establish a unified and consistent reaction to rumours, misinformation and various public concerns. There has been a lack of social and behavioural insights data collection and analysis to inform and guide RCCE message and product development. Private health sector risk communication efforts were generally positively perceived except in Iraq, where private providers were accused of disseminating false information and misleading the public.

In the Islamic Republic of Iran, a hotline was created in February 2020 in collaboration with the private health sector to provide general information about COVID-19. Around 600 psychologists (mostly from the private health sector) also provided counselling services through the hotline. Later, another hotline was set up by the Iranian Health Insurance Organization to respond to health insurance issues and provide COVID-19 information. Besides the hotlines, some private banks and companies sponsored the printing and dissemination of the educational materials related to COVID-19. Another collaboration with the private sector involved the development of a digital app called Mask, designed to provide information relevant to COVID-19 incidence and mortality rates, risk maps and other information. Moreover, a telephone-based midwifery service was launched at the beginning of the outbreak in collaboration with the private health sector. The midwife consultants were active in answering the enquiries and concerns of pregnant and lactating mothers, with the aim of reducing unnecessary visits to the health centres, increasing people's awareness and knowledge and reducing the level of stress and anxiety. Over 100 000 phone calls were answered by 600 faculty members and 300 experts during the first three months of pandemic.



In Jordan, EMPHNET provided awareness sessions in schools and distributed handouts. Furthermore, the Network collaborated with Jordan Pharmaceutical Association in spreading awareness on social media. The Royal Health Awareness Society initiated a campaign in February 2020 through different communication channels. The campaign included publishing COVID-19-related articles, providing online sessions, interviewing paediatricians and epidemiologists, developing myth-busting videos and conducting training for to up to 500 people for 25 different organizations. To provide direct help to the Ministry of Health, the Royal Health Awareness Society participated in the development of the Ministry's COVID-19 website and supported the development of different digital apps in collaboration with the Paramedic Society.

In Lebanon, the RCCE taskforce included representatives from the scientific community, syndicates, local nongovernmental organizations, Lebanese Red Cross, United Nations agencies, the Ministry of Public Health and the Ministry of Interior. The taskforce was set up and led by the United Nations Children's Fund (UNICEF) and WHO to enhance community engagement, demystify the virus and promote safe preventive behaviours. The Ministry of Public Health in collaboration with civil society groups also engaged in mass text messages with videos by the Director General of the Ministry of Public Health explaining the latest COVID-19 trends, disseminating government directives around "stay home" orders and prevention measures and promoting a 24/7 hotline. Lebanese universities, hospitals, syndicates and nongovernmental organizations supported RCCE efforts by conducting awareness campaigns through different media outlets, disseminating awareness materials, and conducting webinars and awareness sessions. Some hospitals and universities also engaged their medical and health professional students in a 24/7 hotline to provide responses to the community. Laboratories were involved in educating rural communities about the importance of mask use and social distancing. Professional orders delivered short, simple messages to the public using the media as their main vehicle. The Order of Nurses started training nurses on self-protection and precautions against COVID-19 even before any official cases were declared in Lebanon. They also worked on increasing disease awareness among prisoners. The Order of Biologists used mobile text messages to educate the public on what to expect from a PCR test and the difference in testing procedures.

Jordan

The Royal Health Awareness Society participated in the development of the Ministry's COVID-19 website and supported the development of different digital apps

Lebanon

The Ministry of Public Health in collaboration with civil society groups also engaged in mass text messages explaining the latest COVID-19 trends, disseminating government directives around "stay home" orders and prevention measures and promoting a 24/7 hotline

Libya

The private sector helped in the development and dissemination of awareness materials

West Bank and Gaza Strip

A national nongovernmental organization currently chairs the health education and promotion taskforce

Pakistan

The Government contracted out public health call centres for COVID-19 information

Tunisia

Major communication campaign was launched in collaboration with the private health sector to raise awareness of COVID-19 risks and the importance of practising preventive measures

In Libya, the private sector supported RCCE activities through being involved in the development and dissemination of awareness materials. All private providers have also reported using the Government-developed RCCE materials and promoting them in their facilities and through the various social media platforms.

In the West Bank and Gaza Strip, a national nongovernmental organization currently chairs the health education and promotion taskforce, while another is leading the voluntary work taskforce. Health-related nongovernmental organizations have supported RCCE efforts by: reaching out to vulnerable families and communities with key messages promoted by the Ministry of Health and WHO; providing hygiene kits, offering home-based support for families in quarantine; mobilizing volunteers to sanitize public facilities; conducting psychosocial support activities; and operating hotlines to address people's concerns. On the other hand, private hospitals and experts used mass media and social media to deliver awareness messages. They offered individual patient counselling at primary health care centres and mobile clinics and helped in the distribution of awareness materials.

In Pakistan, the Government contracted out public health call centres for COVID-19 information and disseminated awareness messages through mobile networks. A voluntary RCCE taskforce, the COVID-19 Tiger Force, was also set up to work during the pandemic in coordination with the district administration. Furthermore, the Rural Support Program Network engaged in RCCE activities with 69 454 community-based institutions in 126 districts across the country.

In Tunisia, a major communication campaign was launched in July 2020 in collaboration with the private health sector to raise awareness of COVID-19 risks and the importance of practising preventive measures. The campaign was activated on social media platforms and has since generated thousands of engagements. On the ground, community engagement activities involve the Tunisian Scouts, Tunisian Red Crescent and the Tunisian Medical Student Association, among others.

1.10

Regulation and oversight of the private health sector during the pandemic

Countries of the Region sought to regulate the private health sector amid COVID-19 in different ways. While some relied on existing institutions and measures, others devised new methods and set up new structures to ensure the compliance of the sector with national response policies and standards.

In the Islamic Republic of Iran, supervision of private services prior to COVID-19 was the joint responsibility of the inspection unit of the Ministry of Health and Medical Education, the Deputy of Curative Services, medical universities and the Medical Council. Currently, the COVID-19 Fighting Headquarters at the Ministry has the authority to monitor the performance of private health facilities with respect to COVID-19 services. The COVID-19 Fighting Headquarters performs continuous monitoring of pre-hospital services, ambulatory care and hospital services. Meanwhile, the National Reference Laboratory oversees laboratories. It periodically assesses their performance and revokes licenses in case of deviation from the set standards.

In Tunisia, the private health sector is also generally considered to be strongly regulated. There has been close follow-up with hospitals to ensure adequate reporting of cases. The same cannot be said for regulation of laboratories. It is reported that government authorities have not systematically checked private laboratories (or even government laboratories) due to a shortage of supervisory personnel and consumables for test validation. However, the biological laboratory unit at the Ministry de-authorized several private laboratories from carrying out COVID-19 tests due to shortcomings in the technical specifications of the kits used.

The situation in Lebanon was quite different from that in the Islamic Republic of Iran and Tunisia, despite the huge role of the private health sector in the country. There has been no regulatory authority that monitors the response of the private sector to the pandemic; instead, the Government has shown limited ability to regulate care and coordinate the response *(22)*. This manifested in a lack of communication with the private health sector, vague directives and regulations, in addition to the absence of coordination with peripheral hospitals to facilitate the provision of equipment.

In the West Bank and Gaza Strip, the Ministry of Health's licensing department is the responsible body for licensing and regulating private facilities. The department carries out regular inspections and continues to do so during the crisis, but does not address COVID-19 management issues. The main platform for the Ministry of Health to coordinate with and regulate the engagement of the private and nongovernmental organization sector is through the National Health Committee on COVID-19 and governorate-level emergency committees. Similarly, in Libya and Pakistan, no additional structures were put in place to monitor the performance of the private sector with respect to the pandemic. In Pakistan, the quality of health services is regulated by statutory bodies (the Islamabad Health Regulatory Authority at federal level and healthcare commissions at provincial level) that regulate both public and private health facilities. In Libya, meanwhile, the only monitoring by Ministry of Health was related to infection prevention and control measures in terms of enforcing mask-wearing, ensuring availability of hand sanitizers and use of physical distancing signage.

In Iraq, doctors who were believed to be spreading false information were suspended from practising in state facilities but not from private practice

Iraq offers an interesting case-study in terms of regulating the private health sector during the pandemic. Given the formal exclusion of the sector from the diagnosis and management of COVID-19 patients, no additional measures were put in place to provide oversight in this regard. However, as the public sector became increasingly overwhelmed with the high case load, private practitioners gradually started to treat COVID-19 cases. The public health authorities did not agree with this involvement and as a result, the Supreme Health and Safety Committee closed private clinics for three weeks in July after holding them partially responsible for the rapid increase in new cases due to lack of social distancing and infection control measures inside clinics, the failure of private sector doctors to disseminate the correct health messages and the use of unapproved treatment protocols. During this time, the Supreme Council issued new instructions for infection prevention and control measures to be adopted inside the private clinics. However, no steps were taken to prevent private sector physicians from treating COVID-19 patients as the case numbers surpassed the capacity of the public sector. It is worth mentioning that doctors who were believed to be spreading false information were suspended from practising in state facilities but not from private practice.

2

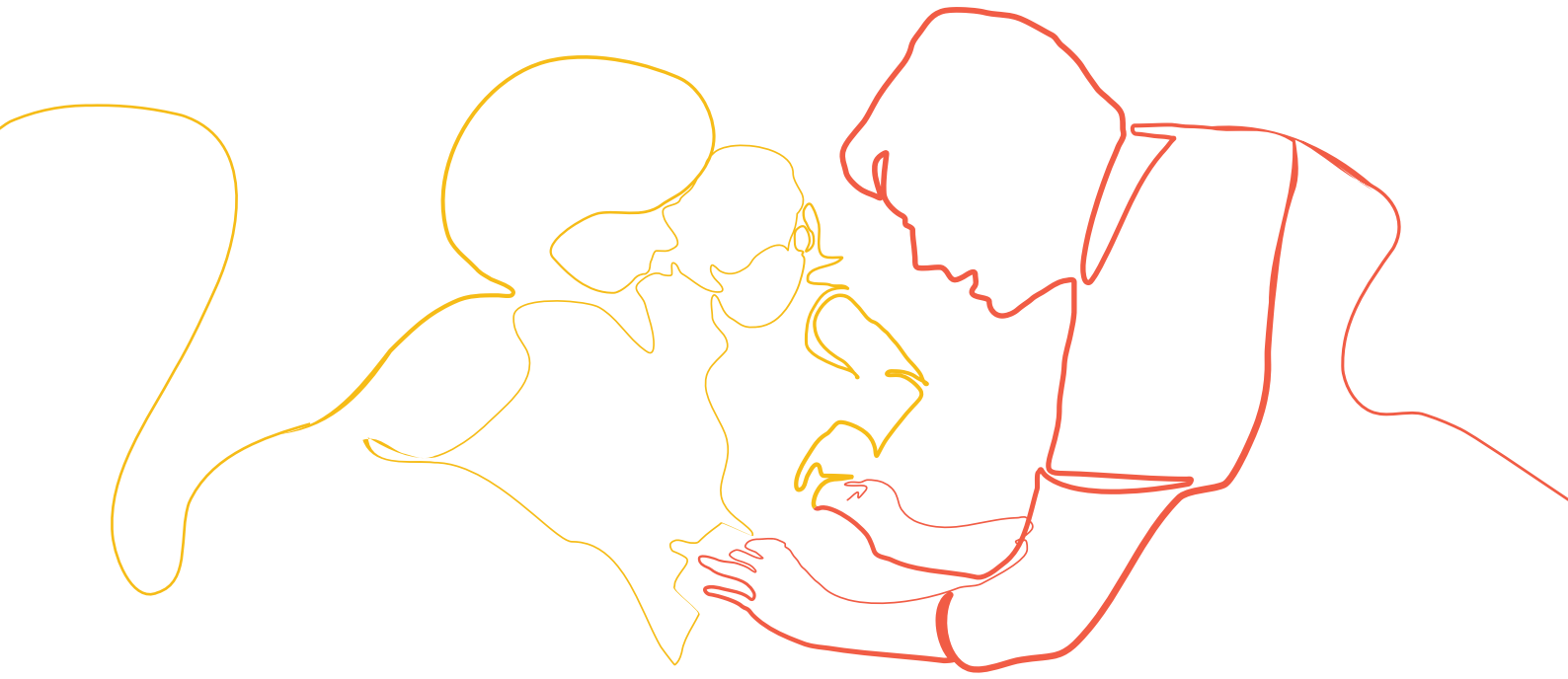
How the response correlates with the WHO action plan

Based on our assessment, collaboration with the private health sector in the context of COVID-19 has generally been moderate to poor and does not account for the size, influence and contribution of the sector to health systems of the Region or the scale of the current global health crisis.

Across the countries in the scope of our study, there was little significant and coordinated involvement of the sector across the six domains of WHO's action plan to engage the private health service delivery sector in the response to COVID-19 as a part of the whole-of-society approach. In this section we will be presenting the regional correlation of the response with WHO's action plan. A visual representation of the correlation is shown in **Table 5.**

The domains of the WHO action plan

1. Plan	Get organized to work together
2. Space	Secure private health sector assets to increase surge capacity
3. Staff	Mobilize and rationalize public and private health staff assignments according to need
4. Stuff	Ensure all health facilities and staff have the supplies they need to respond to the crisis
5. System	Establish systems to integrate the public and private sector response effort
6. Financing	Supply-side financing

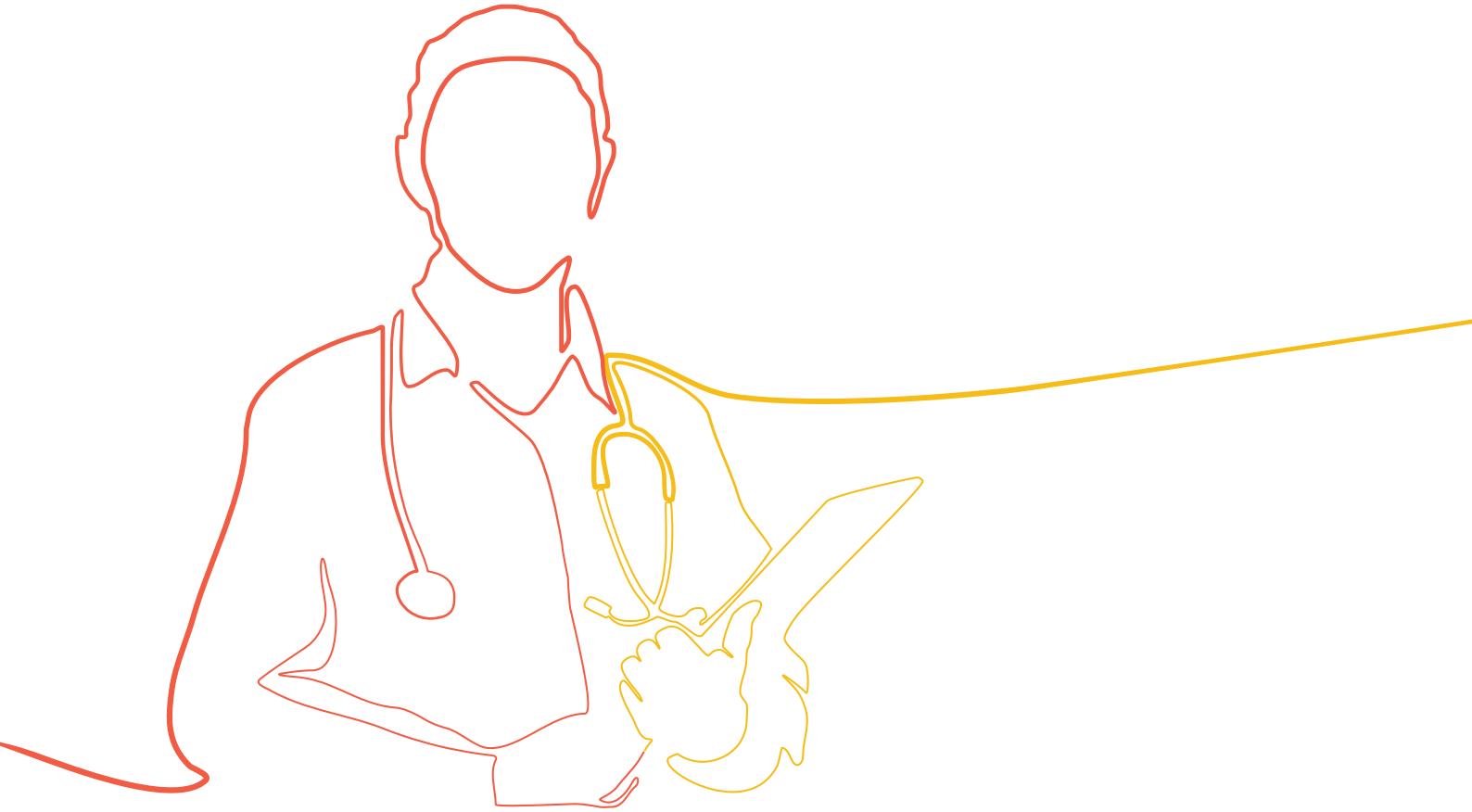


1. Plan

Get organized to work together

In this action point, WHO advises governments to initiate an inclusive policy process with the private health sector with the objective of assessing its willingness to support the response, identifying relevant resources, defining roles and responsibilities, creating communication mechanisms and ensuring its representation in the national emergency response team.

Viewing such recommendations in the Eastern Mediterranean context shows an immense gap. Countries usually engaged the private sector in the implementation phase of national plans (if any). Across the eight studied countries, national response plans were mostly set by governments with occasional consultation with the private health sector, as in the West Bank and Gaza Strip where the plan was drafted by the Ministry of Health and presented to other stakeholders before being finalized. When it came to representation in national response committees, only six of the countries had private sector representation. Meetings with the private health sector to identify relevant resources were only held in Iraq, which later banned the sector from any role in the response. None of the countries reported having clear and defined roles being communicated to the private health sector.



2. Space

Secure private health sector assets to increase surge capacity

Regarding space, WHO recommends having a cross-sectoral team that monitors the inventory of relevant resources such as ICU beds, laboratories and emergency rooms, organizes testing and case management at different levels of the health system, identifies partnership schemes with private providers that could reduce the financial burden on patients, establishes case management targets for each sector based on epidemiological forecasts, involves private health sector in testing, seeks support from non-health stakeholders such as schools, hotels and stadiums to establish quarantine units, and eases regulatory laws to allow the private health sector to extend its support while maintaining quality and risk-benefit balance.

When it came to the implementation, the countries of the Region again fell short in many of these dimensions. The involvement of the private sector did not seem to be a part of a predetermined strategic direction or whole-of-system planning. The Islamic Republic of Iran, Pakistan and Tunisia reported conducting an assessment of resources at private health facilities but only the Islamic Republic of Iran and Tunisia translated such assessments into formal involvement of the sector. None of the countries had a planned split of case management across the sectors. Moreover, four out of the eight studied countries did not have any partnership or scheme in place that would cover the cost of COVID-19 or other essential services at private facilities. Five countries allowed the sector to contribute to testing, while three chose to prohibit the sector from this role despite the obvious lack of capacity in the public sector. Easing of customs and tax regulations was only observed in the Islamic Republic of Iran, Lebanon and Pakistan, where import restrictions were relaxed and approvals for all equipment and medicines related to COVID-19 management expedited.

3. Staff

Mobilize and rationalize public and private health staff assignments according to need

This action plan pillar is concerned with: disseminating clinical protocols to private facilities; ensuring the availability of PPE and other infection control supplies in the private sector; mapping human resources and reassigning staff across sectors as needed; placing private outpatient facilities at the frontline for screening, management of mild cases and referral of severe and emergency cases; delivering COVID-19 training-of-trainers programmes at private health facilities; relaxing certification requirements for health care providers, and updating workforces in both sectors on disease progress and control strategies.

Reflecting this pillar against the experience of countries also shows multiple limitations. Four out of the eight countries have formally excluded the private health sector from case management and thus no efforts were made to update private providers on the latest COVID-19 treatment guidelines. Mapping and reassignment of staff were observed in the Islamic Republic of Iran, Pakistan and West Bank and Gaza Strip where private health sector staff were either engaged in short-term contracts by the public sector or were seconded to public sector facilities. The Islamic Republic of Iran was the only country that reported a relaxation of certification requirements for health care workers. In terms of deploying private ambulatory care in COVID-19 management, the Islamic Republic of Iran and Tunisia were the only countries that stated a formal role for those facilities.

4. Stuff

Ensure all health facilities and staff have the supplies they need to respond to the crisis

This pillar overlaps with the previous one and aims to ensure the availability of the needed supplies in the private health sector to respond to the pandemic. In this domain, WHO recommends developing an essential COVID-19 list of supplies to be used by providers in both sectors and rationalizing the procurement from a whole-of-health-system perspective, employing pooled procurement mechanisms, capitalizing on the local manufacturing capacity to secure COVID-19 supplies, and leveraging private sector supply and storage capacities.

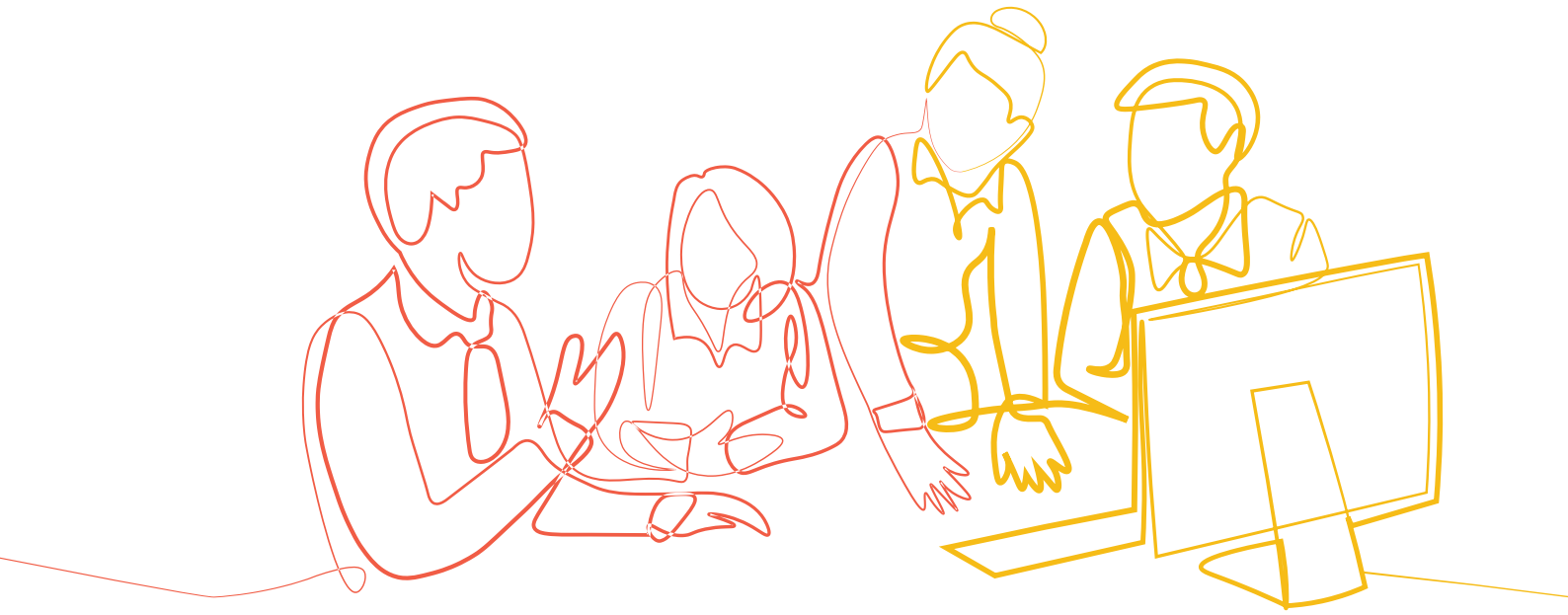
The availability of COVID-19 supplies was the responsibility of each private health facility without any government intervention, except in Pakistan and Tunisia which had central procurement for both sectors. The lack of support was particularly challenging in Lebanon given the economic situation and the restrictions on foreign currency that hinder the importation process. Local manufacturing of PPE, ventilators and other requirements was leveraged in the Islamic Republic of Iran, Pakistan and Tunisia, which enabled these countries to meet the local demand and sometimes to export. The private health sector also got involved in the storage and distribution of needed supplies in the Islamic Republic of Iran and Jordan.

5. System

Establish systems to integrate the public and private sector response effort

WHO's system-related recommendations include: establishing easy case reporting mechanisms; creating a single communication channel with private providers for sharing critical information; establishing a transparent referral system, and setting up an intersectoral logistics system to ensure timely provision of COVID-19 supplies.

In the systems context, digital case reporting platforms were used in the Islamic Republic of Iran, Lebanon, Pakistan and Tunisia. However, lack of compliance with the case reporting mandate was observed in Libya, Pakistan and the West Bank and Gaza Strip. A clear and formal intersectoral referral process was set up in the Islamic Republic of Iran, Jordan and Lebanon, but was not observed in other countries. None of the countries in the study had an intersectoral logistics system or a single channel with private health providers for rapid relaying of important information.



6. Financing

Supply-side financing

“Supply-side financing” refers to the establishment of partnership models that cover treatment in the private sector, relaxation of procurement and accreditation requirements, support for the sector as well as enabling of direct contracting of health services to the private sector in the current health emergency. Another recommendation was ensuring the coverage of COVID-19 treatment through all existing insurance mechanisms.

Only the Islamic Republic of Iran and Lebanon had plans to cover COVID-related services that were provided privately. Libya and the West Bank and Gaza Strip offered coverage for specific non-COVID-19 services that were contracted to the private sector. Meanwhile Iraq, Jordan, Pakistan and Tunisia either did not allow the private sector to engage in COVID-19 response or did not enable the insurance systems to cover the cost of related services.

The Islamic Republic of Iran, Iraq and Jordan reported expediting and facilitating the procurement process of COVID-related supplies. As noted, the Islamic Republic of Iran supported the private health sector through postponing utility and tax dues and expediting the release reimbursed payments. Jordan was the only country to pass an emergency law to allow for direct contracting of private health services during the pandemic.

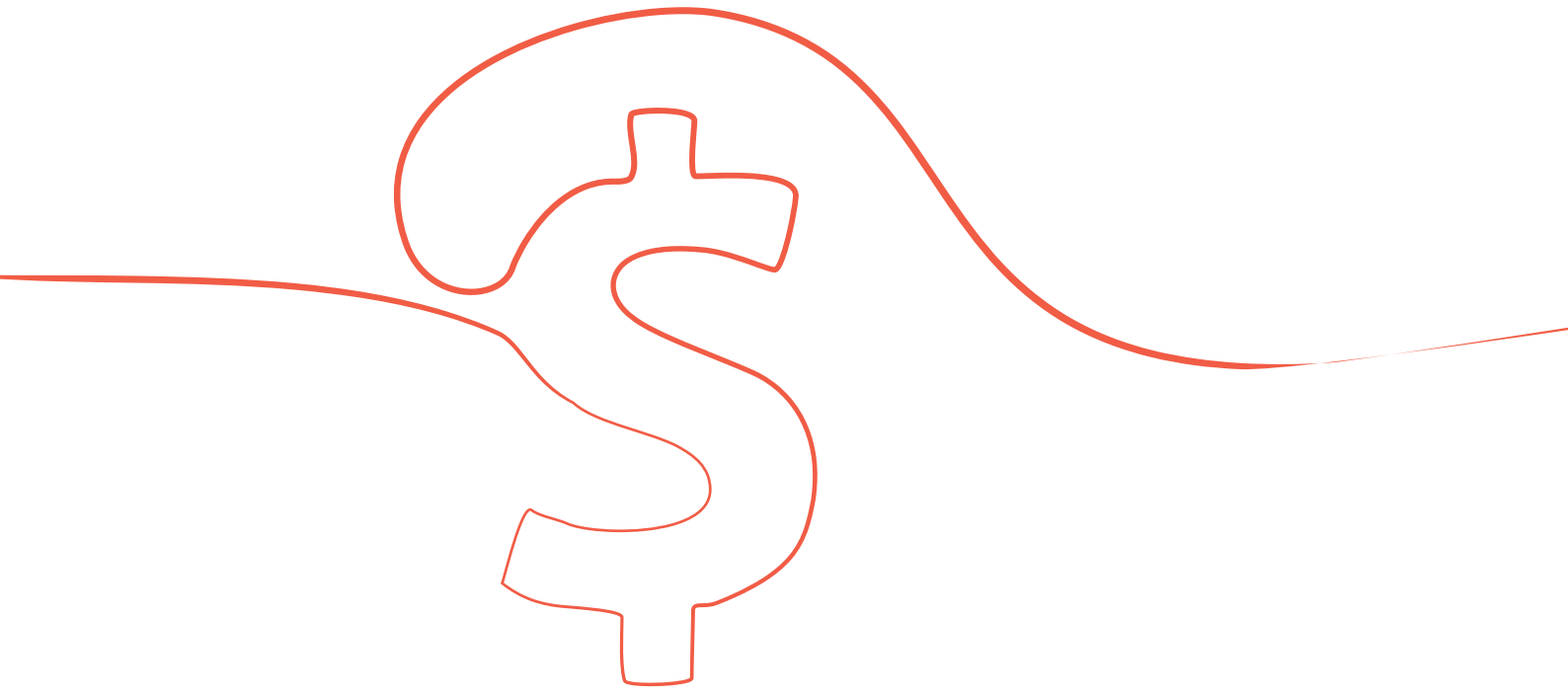


Table 5: Private health sector engagement in selected countries of the Region, with respect to the pillars of the WHO action plan

WHO action plan	Action point	Iran (Islamic Republic of)	Iraq	Jordan	Lebanon	Libya	Pakistan	Tunisia	West Bank and Gaza Strip
1. Plan **Get organized to work together**	Meet to identify relevant private health sector resources	✗	✓	✗	✗	✗	✗	✗	✗
	Define roles and create communication mechanisms	✗	✗	✗	✗	✗	✗	✗	✗
	Representation in national response committees	✓	✗	✓	✓	✓	✗	✗	✓
2. Space **Secure private health sector assets to increase surge capacity**	Monitor inventory and capacity in both sectors	✗	✗	✗	✗	✗	✗	✓	✗
	Organize case management and co-decide on targets	✗	✗	✗	✗	✗	✗	✗	✗
	Reduce financial burden through partnership schemes	✓	✗	✗	✓	✓	✗	✗	✓
	Involve sector in testing	✓	✗	✓	✓	✗	✓	✓	✗
	Ease space regulations	✓	✗	✗	✓	✗	✓	✗	✗
3. Staff **Mobilize and rationalize public and private health staff assignments according to need**	Disseminate updated COVID-19 clinical protocols to private facilities	✓	✗	✓	✓	✗	✗	✓	✗
	Monitor supplies at the private sector	✗	✗	✗	✗	✗	✗	✓	✗
	Mapping and reassignment of staff	✓	✗	✗	✗	✗	✓	✗	✓
	Use private ambulatory care in COVID-19 management	✓	✗	✗	✗	✗	✗	✓	✗
	Relax certification requirements for medical students	✓	✗	✗	✗	✗	✗	✗	✗

WHO action plan	Action point	Iran (Islamic Republic of)	Iraq	Jordan	Lebanon	Libya	Pakistan	Tunisia	West Bank and Gaza Strip
4. Stuff **Ensure all health facilities and staff have the supplies they need to respond to the crisis**	Create an essential list of COVID-19 supplies	✓	✓	✗	✗	✗	✗	✗	✗
	Centralize procurement for both sectors	✗	✗	✗	✗	✗	✓	✓	✗
	Local manufacturing of COVID-19 supplies	✓	✗	✗	✗	✗	✓	✓	✗
	Use private sector in storage and distribution	✓	✗	✓	✗	✗	✗	✓	✗
5. System **Establish systems to integrate the public and private sector response effort**	Establish **easy** case reporting mechanisms	✓	✗	✗	✓	—	—	✓	—
	Create a single communication channel with private providers for sharing critical information	✗	✗	✗	✗	✗	✗	✗	✗
	Set up a transparent intersectoral referral system	✓	NA	✓	✓	NA	✗	✗	NA
	Set up an intersectoral logistics system	✗	✗	✗	✗	✗	✗	✗	✗
6. Financing **Supply-side financing**	Cover the treatment at private facilities	✓	✗	✗	✓	✓	✗	✗	✓
	Relax procurement and accreditation requirements	✓	✓	✓	✗	✗	✗	✗	✗
	Support the private health sector	✓	✗	✗	✗	✗	✗	✗	✗
	Enable emergency direct contracting of private health services	✗	✗	✓	✗	✗	✗	✗	✗
	Coverage of COVID-19 treatment through all the existing insurance mechanisms	✓	✗	✗	✓	✓	✗	✗	✓

(–) denotes “partial involvement”

3 Policy challenges

The challenges faced by countries of the Region in engaging with the private health sector on the COVID-19 response were mostly consistent with the six current policy challenges reported by other low- and middle-income countries in the WHO review *Enabling the private health sector in the national response to COVID-19 (23)*. The following section summarizes how those policy challenges are presented in the context of the Eastern Mediterranean Region.

First challenge

Countries are unsure of how best to include the private sector in planning for the national response effort

This challenge has been particularly noted in Iraq, Jordan and Lebanon. In Iraq, the dual practice of health professionals caused confusion to government authorities who were unsure how to approach private ambulatory care services as a separate entity or how to include private health sector representatives in discussions related to national response plans. This confusion was explained by the dual role of health practitioners and their active involvement in service provision in both sectors. In Jordan and Lebanon, the lack of coordination between government and the private sector coupled with the lack of coordination among private sector players themselves, led to the duplication of unnecessary services while leaving important gaps in service provision unaddressed. Furthermore, it sent conflicting messages and weakened public trust in the measures proposed and undertaken by the government.

Another relevant challenge is the lack of trust between state and non-state actors. For example, even though the response to pandemics in Iraq is a public sector responsibility by law, there is no explicit regulation that prohibits partnership with the private sector during public health emergencies. Therefore, the exclusion of the sector was a policy choice by the Government. This decision has been a source of disappointment to private providers who showed willingness to support the response in a preliminary dialogue with federal and regional health ministries, agreeing to suspend non-urgent services and outpatient care, as well offering the provision of space and personnel for the emergency response and free telephone consultations.

Second challenge

Resource-based planning cannot take place as critical data on private sector resources and capacity are not held by the government

Lack of data on the private sector has been regarded as reason behind the slow cooperation between the private sector and the Government in Jordan.

In Tunisia, even though efforts have been made to map private health sector resources and keep track of bed occupancy at private hospitals, very little systematic information on COVID-19 is collected from private practitioners. Furthermore, data on non-doctor private practitioners in Tunisia does not exist at the central level (even before COVID-19) and their role in pandemic response has not been seriously considered.

Third challenge

The private health sector lacks certain inputs needed for it to play a role as an effective partner for government in the response

In Jordan, Pakistan and the West Bank and Gaza Strip, private health facilities had insufficient resources and capacity for active participation in the national response. This manifested in Pakistan as the limited involvement of private hospitals in COVID-19 management due to uncertainty about the availability and allocation of needed supplies and equipment. Similar concerns were expressed in the West Bank and Gaza Strip, where private sector representatives claimed that the Ministry of Health had neither considered their needs nor supported them with supplies and equipment, despite offering their facilities and seconding their staff to support the Ministry's response.

In Tunisia, the training efforts of the Government have been largely focused on public sector health workers. Furthermore, private providers lacked access to PPE, which were only available in limited amounts and at expensive rates. This led them to close their facilities during the first wave for varying periods of time.

Fourth challenge

Emergency legislation, compounded by weak systems and regulation, can limit the private sector's role

Legal restrictions blocked the involvement of the private health sector response to COVID-19 in Iraq, Jordan and Libya. There was no policy in place for such involvement nor any legal framework to support it, given that pandemics are considered to be emergency situations for which the respective government is the sole responsible entity. The sector was also excluded from discussions around the emergency defence orders that were passed, which resulted in additional economic strain on private health providers in Jordan.

Ineffective regulatory measures in general and specifically during the pandemic have failed to hold the private health sector accountable and ultimately resulted in efforts to ban or limit the sector's engagement. This was observed in Iraq's suspension of private health sector services. In the West Bank and Gaza Strip, the lack of oversight of private sector RCCE social media activities had unintended negative effects. The sharing of conflicting messages, rumours and misconceptions about the pandemic increased panic among the public and induced stigma around infected people. In Libya, Pakistan and West Bank and Gaza Strip, the failure of the private health sector to comply with the reporting mandate for suspected or confirmed cases was another example of insufficient enforcement of regulatory measures.

Fifth challenge

Countries are unsure of whether, or how best, to contract and reimburse the private sector for health services provided during the outbreak

Poor funding mechanisms between the private and public sectors have been reported in Iraq, Jordan, Lebanon, Pakistan and Tunisia. In Jordan, the lack of an engagement framework presented a challenge in processing payments for the private health sector, which had to be paid through official letters instead of proper contracting methods. Eventually, this challenge forced the private hospitals and laboratories to charge patients directly – and the patients were not reimbursed later by the Government, despite the official coverage of such services by law. In Lebanon, setting insurance payments for in-patient treatments of COVID-19 remained a challenge for quite some time due to the debate on pricing and the absence of a reference for COVID-19 treatment fees. In Pakistan, the lack of reimbursement measures or coverage for private health services has limited the use of private hospitals due to the high cost of services of these providers. No system was in place in Tunisia to reimburse the private providers.

Sixth challenge

Private health care businesses are exposed to significant financial losses at this time, but governments lack clear criteria for providing support

In many countries of the Region, the private health sector has been reluctant to engage in the response due to financial losses attributed to scaling down of non-essential services, standardization of the cost of treatment for COVID-19 patients, movement restrictions and the steep decline in medical tourism.

In the Islamic Republic of Iran, the Government tried to support the private sector with measures including introducing a three-month tax exemption for private hospitals, extending the deadline of the employee contributions to insurance payments until the end of September 2020, postponing the deadline for hospital financial statements until the end of September 2020, and granting a three-month grace period for water and electricity payments. However, the high cost of COVID-19 treatment and the strict enforcement of standardized fees by the Government sapped the interest of the sector, with the admission of COVID-19 patients not considered to be cost-effective. Furthermore, the deferral or cancellation of non-urgent procedures at the beginning of the outbreak led to huge financial losses, resulting in the termination of some employee contracts. However, the National Committee for Managing COVID-19 intervened to prevent layoffs.

Iraq

All private providers in Kurdistan were requested to reduce the cost of their service fees by 25%

Lebanon

Private providers were struggling to purchase needed supplies due to the devaluation of the Lebanese pound

West Bank and Gaza Strip

Financial burdens on private providers deprived them of the ability to pay staff salaries for several month

Tunisia

Private providers were faced with the added challenge of losing medical tourism, an important business for many of them

In Iraq, the regional ministry of health in Kurdistan requested that all private providers reduce the cost of their services fees by 25%, which was applied in the northern governorate until the end of May 2020.

The health sector in Lebanon, of which the private sector constitutes 83%, was already facing challenges prior to COVID-19 due to the influx of refugees, severe economic crisis, increased poverty levels and unemployment rates. Furthermore, the health system was having immense difficulties in the retention of health workers and securing the supply of medical equipment and medicines due to the imposed restrictions on the United States dollar and unpaid government dues. Accordingly, despite the attempt of the Government to seek support from the private sector, the engagement remained timid. This has been attributed to the high cost of developing COVID-19 units and the lack of contractual arrangements with private insurance companies. Moreover, private providers were struggling to purchase the needed supplies due to the devaluation of the Lebanese pound and the strain resulting from the financial backlog of several years of unpaid government dues (estimated at around 2500 billion Lebanese lira or about US$ 1.65 billion). Finally, the rise in COVID-19 cases among health care personnel heaped considerable pressure on service provision capacity *(24)*.

Similarly, the Palestinian government was confronted with a backlog of debts to the private sector when their support was sought. However, unlike Lebanon, private providers here could not reject any cases referred to them by the Ministry, given that such referrals constituted a significant share of their admissions. Nevertheless, the added financial burden on private providers deprived them of the ability to pay the salaries of their staff for several months. Furthermore, it has been reported that some hospitals experienced a 60% cut in their income in the first few months of the pandemic due to the reluctance of patients to seek medical care and the lockdowns imposed by the Government to control the spread of the virus.

Private providers in Tunisia were faced with an added challenge of losing medical tourism, an important business for many of them. As a result of worldwide travel restrictions, the revenue stream for those providers diminished to a great extent even as running costs remained the same.

4
Recommendations

FIRST:

PROVIDE AN ENABLING ENVIRONMENT

Collaboration with the private health sector is made possible by a legal and administrative framework that allows for such a relationship to exist and flourish. In this context, we believe that the provision of an enabling environment in terms of governance and process is integral to successful collaboration. Below are our recommended actions.

Governance

Approve regulations that permit access to the best of private health sector capacities in health emergencies instead of acting as a referral station.

Institutionalize the engagement of private health actors in response to public health emergencies.

Engage in policy dialogue with the private health sector to identify the gaps and build on the lessons learned during the pandemic.

Create (and institutionalize) an empowered governance authority to take quick decisions supported by a legal framework.

Develop coordination mechanisms with the private health sector for continuous dialogue, information exchange, partnership options and other types of cooperation.

Process

Relax unnecessary bureaucratic measures and strict emergency orders that hinder partnerships.

Facilitate the laws, regulations and instructions to make it easier for the private health sector to perform during pandemics.

Include data on the private health sector and its involvement in national reports and integrate in the monitoring and evaluation frameworks of government institutions.

Create formal channels for collaboration including two-way referral networks between the public and private sectors, sharing knowledge and capacity-building.

Consider accounting for the needs of the private health sector in the purchase of supplies to maximize operational efficiency and leverage economies of scale.

SECOND: LEVERAGE PRIVATE HEALTH SECTOR ASSETS AND ACCESS ITS CAPITAL

The immense financial and technical assets of the private health sector present a huge opportunity to rapidly reduce the strain on the public sector and improve the access to quality health care. In our view, this can be achieved through the assessment of the capacity of the sector and involving it in public health planning and implementation, in addition to investing in building long-term relationships with the sector.

Assessment

Conduct regular assessments of the role, resources and capacity of the private health sector.

Explore how the private health sector can address current COVID-19 response challenges.

Planning

Explore the willingness of the private health sector to be part of the COVID-19 response and map its potential contribution.

Plan for a coordinated response that involves:

- engaging private health sector specialists in planning COVID-19 response strategies;
- expanding the membership of private health sector and all relevant stakeholders in COVID-19 response committees/ bodies;
- establishing a public-private health sector coordination platform with a clear data flow system between both sectors;
- supporting, safeguarding and building the capacity of human resources in the public and private health sectors;
- setting plans for mobilizing human resources across the whole health sector with clear roles, responsibilities, referral mechanisms and terms for collaboration (e.g. via purchasing/contracting models);
- enabling better coordination among private health actors as part of the mitigation strategy;
- employing private health sector marketing and communication skills as well as media access and resources in RCCE efforts; and
- setting fair and standardized pricing policies.

Relationships	Reinforce the existing collaborative arrangements through knowledge transfer, data sharing and capitalizing on innovations during emergencies. Create an open communication channel with key private health actors.	Provide incentives to maintain and strengthen the relationship with the private health sector. Explore building partnerships with the private health sector to cover gaps in the medium- and long-term including services, infrastructure and medical supplies.

THIRD: REGULATE THE PRIVATE HEALTH SECTOR

Partnership with the private health sector will only achieve public health goals in the presence of rigorous, transparent and fair regulatory measures. We thus recommend the following actions.

Inspect	Arrange for frequent audits on private health facilities. Formulate a monitoring framework for the private health sector during the COVID-19 response. Expand the scope of the audit to include assessment of the quality of care beyond infection prevention and control (IPC) measures alone.	Build regulatory capacity and deploy resources for regulatory oversight of the private health sector.
Penalize	Take legal steps against all malpractice and proven contributions to the “infodemic”.	Develop a legal framework and enforcement mechanisms for repeated violations.

5
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Annexes

Annex 1. Epidemiological situation of COVID-19 in the Eastern Mediterranean Region, as of 24 January 2021

Country/territory	Cases cumulative total	Cases cumulative total per 1 million population	Deaths cumulative total	Deaths cumulative total per 1 million population
Iran (Islamic Republic of)	**1 367 032**	16 276	57 294	682.13
Iraq	**612 870**	15 237	12 988	322.9
Pakistan	**530 818**	2403	11 247	50.92
Morocco	**465 769**	12 619	8128	220.21
Saudi Arabia	**366 185**	10 518	6350	182.4
Jordan	**319 519**	31 316	4217	413.3
Lebanon	**276 587**	40 523	2280	334.04
United Arab Emirates	**274 376**	27 742	783	79.17
Tunisia	**195 314**	16 526	6154	520.7
West Bank and Gaza Strip	**174 413**	34 189	1951	382.44
Egypt	**161 143**	1575	8902	86.99
Kuwait	**160 901**	37 677	952	222.92
Qatar	**148 772**	51 638	248	86.08
Oman	**132 486**	25 944	1517	297.07
Libya	**112 540**	16 378	1737	252.79
Bahrain	**99 456**	58 449	367	215.68
Afghanistan	**54 595**	1402	2378	61.09
Sudan	**28 233**	644	1707	38.93
Syrian Arab Republic	**13 557**	775	879	50.23
Djibouti	**5918**	5990	61	61.74
Somalia	**4754**	299	130	8.18
Yemen	**2122**	71	616	20.65

Source: Worldometer: COVID-19 coronavirus pandemic [real-time statistics dashboard]. (https://www.worldometers.info/coronavirus/, accessed 27 January 2021).

Annex 2. Testing in the Eastern Mediterranean Region, as of 27 January 2021

Country/territory	Total tests	Tests per 1 million population	Total population
United Arab Emirates	24 872 781	**2 497 631**	9 958 551
Bahrain	2 647 934	**1 526 376**	1 734 785
Qatar	1 362 781	**485 355**	2 807 805
Lebanon	2 526 177	**371 069**	6 807 842
Jordan	3 759 470	**366 385**	10 260 978
Saudi Arabia	12 082 062	**343 999**	35 122 367
Kuwait	1 479 530	**343 555**	4 306 526
West Bank and Gaza Strip	997 480	**192 991**	5 168 542
Oman	883 340	**170 528**	5 180 031
Morocco	5 307 954	**142 840**	37 160 096
Iraq	5 484 106	**134 633**	40 733 692
Iran (Islamic Republic of)	9 070 167	**107 205**	84 605 769
Djibouti	106 483	**106 891**	996 181
Libya	634 401	**91 617**	6 924 526
Tunisia	829 093	**69 735**	11 889 218
Pakistan	7 764 114	**34 766**	223 326 576
Egypt	1 000 000	**9668**	103 430 228
Afghanistan	244 426	**6200**	39 424 858
Yemen	17 404	**576**	30 198 114
Syrian Arab Republic	NA	**NA**	17 741 132
Sudan	NA	**NA**	44 428 751
Somalia	NA	**NA**	16 143 406

Source: Worldometer: COVID-19 coronavirus pandemic [real-time statistics dashboard]. (https://www.worldometers.info/coronavirus/, accessed 27 January 2021).

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