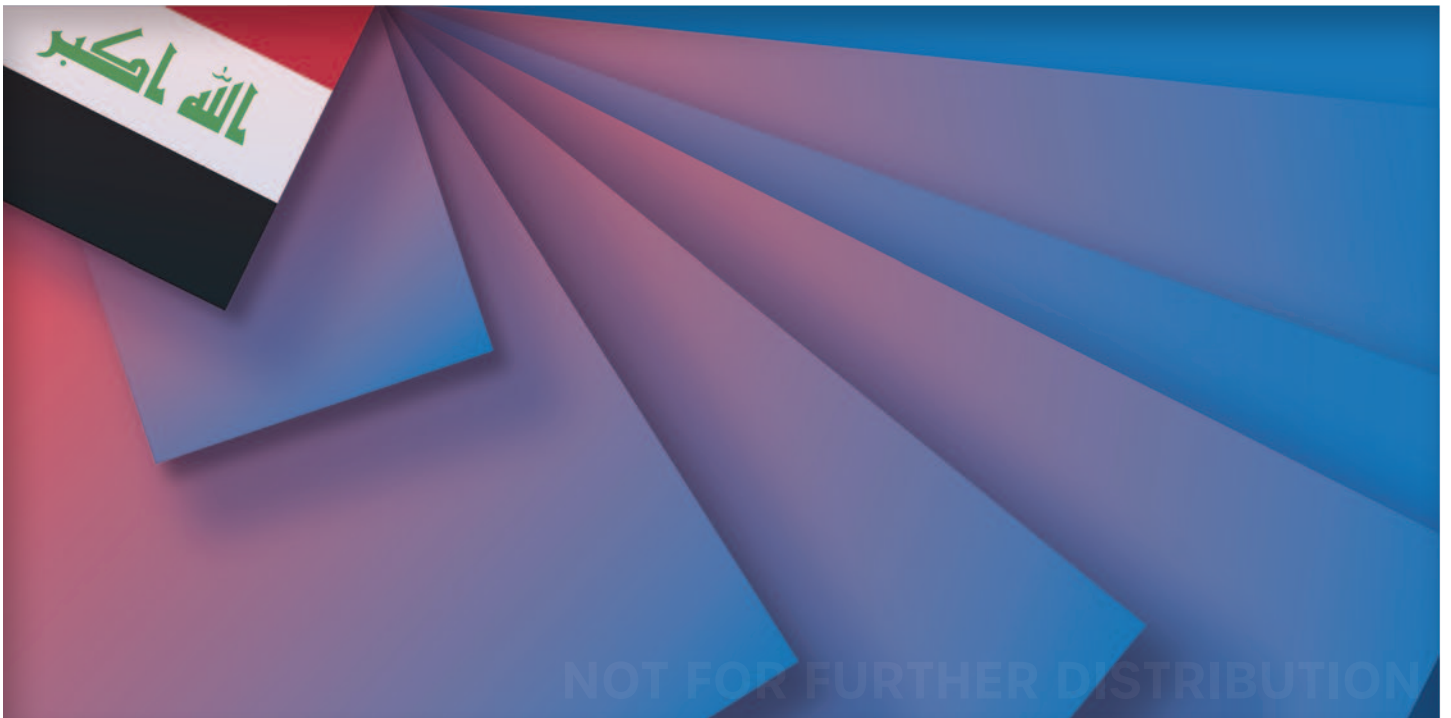


Iraq: a primary health care case study in the context of the COVID-19 pandemic

Goran Zangana



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Executive summary

This case study documents Iraq's primary health care (PHC) systems in the context of the country's response to COVID-19 between February 2020 and April 2022. It draws on the Astana PHC Framework (1) to examine the key PHC components: primary care and essential public health functions, community engagement and multisectoral collaboration.

Data were drawn from a literature review of 87 published journal and media articles; analysis of 25 policy documents; and stakeholder consultations with 22 high-ranking officials or former officials, plus experts in public health. The stakeholder consultations included both individual conversations as well as focus group discussions.

The COVID-19 pandemic reached Iraq while the country was experiencing considerable political, economic and social challenges and unrest. One of the largest popular demonstrations was in full swing, and a political deadlock led to the resignation of the government. Low oil prices and the conflict with the Islamic State (ISIS) shattered the economy. As the first confirmed cases of COVID-19 were reported, millions of Shiia pilgrims were preparing to undertake one of the largest religious gatherings globally.

Despite these challenges, the Government of Iraq (GoI) mounted a high-level response to the pandemic, led initially by the Minister of Health at the time and later by the Prime Minister. The response was centred, at least initially, around security measures such as curfews, border closures and restrictions on movement. From a health perspective, the response replicated the hospital-based, biomedically dominated and resource-intensive nature of the health system.

This hospital-centred approach was clear in the emergency response to the pandemic. Early on, the Ministry of Health (MoH) admitted people with a positive COVID-19 test to hospitals, regardless of their symptoms. The Ministry's procurement efforts also focused on hospital-based supplies and equipment such as personal protective equipment (PPE) and ventilators. Testing was conducted in central laboratories, usually linked to tertiary hospitals.

Additionally, expert committees were established to provide clinical guidance in the management of COVID-19, from which public health experts were often excluded. Even vaccination, which is a PHC function normally, began initially in hospitals. The marginalization of the PHC system reflects the historical approach to health care, which has attached superiority to hospitals and clinical specialities. It is also a direct outcome of decisions made under the movement restriction policies, which saw the closure of PHC centres and resulted in the complete cessation of primary care services.

Nevertheless, the COVID-19 pandemic offered several opportunities to enhance multisectoral action and promote community engagement. For example, new national, subnational and local structures were created to facilitate communication, coordination and planning. These can be institutionalized to promote health across all policy frameworks. There were also wide-ranging initiatives introduced by individuals, communities and civil society to meet the needs of the public during the pandemic.

Introduction and national context

Political commitment and leadership

The roots of the modern health system in Iraq date back to the start of the 20th century (2). The first case of COVID-19 was diagnosed on 24 February 2020 (3). At this time, the country was facing major political, security and economic difficulties. One of the biggest and most violent popular movements in recent history started a few months before the pandemic. Beginning in Basra, demonstrators in Baghdad and other major cities protested about poor public services (including health), corruption and the lack of jobs (3). The October revolution, as it came to be known, is seen by some as the start of a new “issue politics” vis-à-vis the dominant identity and religious politics of post-2003 Iraq.

A few days after the first case of COVID-19 was confirmed, a Crisis Cell was established, headed by the Minister of Health (4). This Cell issued several high-profile decisions to contain the spread of the virus, including movement restriction policies. However, it came under criticism, particularly after the leak of a video showing the ad-hoc nature of the Cell’s decision-making process (5).

The Crisis Cell was quickly replaced by the Higher Committee for Health and National Safety (6), which was headed by the Prime Minister. The Committee members included several other ministers, the National Security Advisor and the President of the Central Bank. The Committee’s work was recognized by international organizations such as the World Health Organization (WHO) as effective in containing the spread of the virus (7).

Governance and policy frameworks

The Minister of Health is at the pinnacle of the Ministry of Health (8) and the incumbents in this role were pivotal in shaping the country’s pandemic response. From the beginning of the pandemic in 2020 to April 2022, there were five different Ministers of Health. When the Minister of Health resigned in September 2019 citing political pressures and corruption (9), a caretaker Minister of Health took over in October 2019 and led the initial COVID-19 response efforts. The caretaker Minister of Health occupied the position for eight months (10); during this period, he had strong support from the Gol for the MoH’s efforts to control the pandemic (11).

Iraq implemented movement restriction policies early in the pandemic (12). Schools and universities were closed on 27 February 2020, followed by the closure of the border with the Islamic Republic of Iran in late February and the suspension of all domestic and international flights on 17 March 2020 (13).

The Higher Committee was headed by the Minister of Health, who visited key religious leaders to ask for a ban on religious gatherings (14). One such festival was Ashura, where in normal times 2–3 million people gather in the holy city of Karbala (15). Although the festival proceeded with about 15 000 people, participants observed reasonable adherence to preventative measures

supported by a *fatwa* by the Shia Grand Ayatollah Sistani. Similarly, Sunni religious leaders issued *fatwas* prohibiting mass prayers when curfews were in place (16). Some assessments show good adherence to preventative measures by the Iraqi population (17), and the Sunni leaders went a step further in March 2020 by closing all mosques as COVID-19 case numbers rose (18).

The caretaker nature of the government in the early phase of the pandemic response meant that any decisions by the caretaker Minister of Health needed to be approved by the Council of Ministers. However, some members of the public were concerned that the caretaker Minister of Health was using COVID-19 for political purposes (14). The decision to close the country's borders with the Islamic Republic of Iran contributed to the political pressures faced by the Minister (14).

While the cases of COVID-19 were rising, a new Minister of Health was sworn in in May 2020 (19). Yet his tenure lasted less than a year as he resigned in May 2021 following a fire in a COVID-19 hospital in Baghdad (20).

Funding and allocation of resources

At the beginning of the pandemic in 2020, Iraq was experiencing a financial crisis due to declining oil prices. The Minister of Health at the time announced publicly that the country lacked adequate resources to respond to the pandemic (14). Although per capita expenditure on health has increased over recent decades (21), overall under-resourcing and a high proportion of out-of-pocket (OOP) expenditure are major challenges. The Institute for Health Metrics and Evaluation (IHME) reports that health expenditure will increase from US\$ 169 per person in 2018 to US\$ 322 per person by 2050, with just over a third of the expected total representing OOP spending (22).

In 2019, the GoI allocated 4.5% of its total national budget to health care (23). At the onset of COVID-19, the MoH was reliant on donations from several countries including China, the United States of America and Kuwait. For example, the MoH received assistance from China in the form of a laboratory to conduct polymerase chain reaction (PCR) tests, masks, gloves and vaccines (24). Donor funds are an important source of health funding in Iraq (25). During the COVID-19 pandemic, most donor funds were channelled to the country through the World Health Organization (WHO) rather than being received directly by the Ministry of Health (14).

Engagement of communities and other stakeholders

The pandemic exacerbated existing political, social and economic challenges, which, in turn, had a negative impact on social cohesion (26). These consequences underscored the need for engagement with communities and other stakeholders as part of the pandemic response.

Methodology

The following methods were used to meet the objective of this study to examine PHC systems in Iraq in the context of the COVID-19 pandemic between March 2020 and April 2022.

- 1. Literature review:** we conducted a systematic search of the literature on Google Scholar and PubMed using different combinations of the terms “Iraq”, “PHC” and “COVID-19”. We identified 135 published articles in peer-reviewed journals and 34 that were directly relevant to the aims and questions of this study.
- 2. Document analysis:** we conducted a purposeful review of 31 documents provided by the government and nongovernmental organizations (NGOs) that were relevant to the aims of this case study. We analysed the documents thematically and triangulated this evidence with the data from the literature review and the stakeholder consultations.
- 3. Stakeholder consultations:** we conducted consultations with 22 key stakeholders. The stakeholders were selected because of their background and involvement in the COVID-19 response in Iraq. They included officials and former officials from government ministries (including the MoH), public health experts and representatives from civil society, the media and NGOs. Most stakeholder consultations were conducted via Zoom and Skype. All were recorded after obtaining consent from the stakeholders, then transcribed and analysed thematically.

How primary care and essential public health functions are responding to COVID-19

Scaling up and managing critical emergency services

Existing weaknesses in the quality and performance of the country’s PHC system affected capacity to rapidly scale up emergency services in response to COVID-19. Prior to the pandemic, only half of the population had access to essential health services (22).

Poor access to essential preventative care is arguably a crucial factor in the high prevalence and increased incidence of noncommunicable diseases (NCDs) and a related factor in the cause of mortality and disability.

One fundamental weakness in the PHC system is the low status of, and priority given to, PHC centres compared to hospitals, as noted in stakeholder consultations.

“[Primary health centres] were not given a big role, but the focus was more on hospitals. They evacuated a hospital and made it a COVID-19 hospital. There is a perceived low opinion of the PHC [centres] and low trust in [them]. People generally think that hospitals can manage better.”

Stakeholder 1

Initially, people who tested positive for COVID-19 were admitted to hospital regardless of their symptoms. Later, only symptomatic patients were admitted, and finally only those with severe symptoms (27). The first dose of a COVID-19 vaccine was administered in a hospital in March 2020 (28, 29).

Weaknesses in Iraq’s PHC system manifested in the acquisition, distribution and administration of COVID-19 vaccines. One stakeholder highlighted a lack of urgency on the part of the authorities to procure enough vaccine doses:

“There was not much eagerness to get the vaccine initially. Iraq was late in securing the vaccine compared to other countries.”

Stakeholder 10

In a cross-sectional study in 2021, more than 50% of the survey population indicated that they did not intend to receive the COVID-19 vaccine (30), while in an earlier study in December 2020, one third of health care providers were unsure about getting the vaccine (31). Such vaccine hesitancy relates mostly to misinformation (32). Mistrust in hospitals – as a source of infection – has also contributed to the low vaccination rate (33, 34). Only 25% of the population were vaccinated against COVID-19 as of March 2022 (35).

Other challenges recounted by stakeholders relating to scaling up and managing critical emergency services included limited health workforce education and training opportunities and political factors. Some stakeholder comments indicated low levels of trust in the government, including the Mo.

“60–70% of the staff had unacceptable training because teaching and education had deteriorated in Iraq, no recertification and no appraisal. Also, there is no research or postgraduate workshops or training. Finally, poor equipment and hospitals.”

Stakeholder 9

“The Iraqi government used COVID-19 and the associated measures as an excuse to demolish the demonstration and prevent further uprising.”

Stakeholder 10

Furthermore, due to financial and political factors, there was a lack of adequate supplies and 60% of staff received insufficient training in PPE usage (36, 37). There were challenges reported relating to the availability and geographical distribution of supplies such as COVID-19 testing kits, which arrived relatively late in the country. Initially, these were only available in Baghdad, with samples needing to be taken to the capital for testing. This created logistical difficulties and increased the risk of the virus spreading (38).

“During the pandemic, Iraq was going through a difficult financial crisis. There were not many available resources to take the required action. At the same time, the government did not understand or even don’t care.”

Stakeholder 10

In the face of these challenges and impediments, stakeholders reflected that the pandemic highlighted opportunities to strengthen emergency preparedness and response functions in the country. One stakeholder suggested several process improvements to support public health planning in the future, prompted by learnings from the COVID-19 experience. Another stakeholder recommended improvements in three key areas relating to the health workforce.

“There was no preparation for such a crisis. We could not find anyone who specialized in crisis management. There was no integrated system to follow and implement the decisions. [There is a] real need to coordinate the process of management with other relevant sectors.”

Stakeholder 1

“[The] first [priority] is improving human resources by training, attending workshops and providing guidelines. Second is a continuous evaluation to assess gaps in our system. The third aspect is supervision.”

Stakeholder 11

Several data sources indicated that there had been ineffective integration between national and subnational governance processes for PHC planning. For example, the subnational committee comprised solely of politicians who worked independently from national structures (12). Political and security factors, as well as poor attention to evidence-based decision-making, contributed to planning challenges (39). In addition, one stakeholder referred to a difficulty with planning due to ongoing contingencies and unexpected events such as terrorist attacks, which necessitated constant re-evaluation of priorities as the response unfolded.

“A public health emergency, epidemic or pandemic is something unplanned and you cannot expect the unexpected, so you do the action that is most important to prevent the crisis to be bigger.”

Stakeholder 11

These challenges meant that monitoring of the scale up of the emergency response was hampered. The pandemic also highlighted a failure to invest in data collection and analysis (40) – one stakeholder stressed the need to train health care workers in this regard:

“There are errors in data entry which made planning difficult. We need to concentrate on statistics both in terms of training staff and health information technology.”

Stakeholder 1

A key strength included that health care workers showed reasonable knowledge about COVID-19 (41), with the Internet found to be the main source of information for health personnel. As part of the response, the government used platforms such as Viber, Twitter and WhatsApp to provide information and an e-health monitoring system for surveillance and data collection (42). However, the media (both traditional and social) played a role in spreading information and misinformation (43), which affected the scale up and management of emergency services. For example, Reuters’ licence was suspended in Iraq for claiming that case numbers were higher than official numbers (44), while social media contributed to spreading panic and anxiety among the public (45).

Continuing essential services

Maternal and child health, mental health, and other essential services were negatively affected by movement restriction policies and similar public health measures introduced to contain the spread of COVID-19 (46).

The prevalence and severity of mental illnesses rose during the pandemic (47). The prevalence of anxiety increased to 47% in one part of the country, for example, and depression increased to 45% (47). In another study, 74% of older people reported that they were worried most or all of the time (48). Some international organizations working on mental health had to either stop their operations in Iraq or redirect their resources and interventions to COVID-19.

Services for patients with NCDs were affected by the closure and avoidance of PHC centres (49): for example, 65% of older people reported difficulties in accessing medicines (48). Similar patterns were seen in dental services (27). An increasing level of violence against health care providers was also observed – among a sample of 505 doctors, 87% reported that they had experienced violence against them during the pandemic (50).

Several adaptations were made during the COVID-19 pandemic to strengthen future delivery of services. Doctors (both inside the country and among the diaspora) created online groups to provide advice to the public. Virtual clinics were set up, mostly voluntarily, with positive experiences reported by both service providers and patients (51). Some PHC centres introduced appointment systems and adapted waiting areas to ensure physical distancing. Awareness campaigns became more frequent too, and community outreach was conducted through religious events:

“Health care workers were invited to Friday’s ceremony to offer advice and guidance after the Mullah had completed their lectures. Others set up special public health tents along the route of pilgrims during Ashura.”

Stakeholder 1

Furthermore, the pandemic highlighted the need to develop the health information system (HIS). A WHO assessment in 2019 found that, at that time, the HIS fulfilled only 24% of the attributes needed for a functional system (52). The same assessment found a lack of national policy or strategy for e-health and information, communication and technology (ICT).

Some progress was being made in this area. As part of the pandemic response, dashboards were developed at the Council of Ministers level offering updates about COVID-19 case numbers. The demand for data resulted in pressure on health care facilities to adapt and supply prompt and accurate information. This, in turn, helped in gathering similar data about other notifiable diseases. For example, scabies was found to be the most commonly reported notifiable disease behind COVID-19 (39).

PHC and community-based workers faced the risk of transmission of COVID-19. Many were infected and multiple individuals died. In one survey, one quarter felt ill while infected with the virus and by 16 October 2020, 255 health workers had died from COVID-19 (36). Overwork, mental stress and delay in remuneration led to pressure on staff. Financial incentives were provided, and there were public

displays of support through clapping and by referring to providers as the “white army”. Some PHC workers argued that they should have been prioritized for COVID-19 testing, treatment and vaccination, and stakeholder highlighted the disproportionate focus on hospital workers and specialists in terms of support and training:

“Training should’ve focused on nurses and primary health care centres, not on hospital doctors.”

Stakeholder 1

Meanwhile, access to essential services was affected by social and demographic factors. During the periods when movement restrictions were in place, transmission rates were high among households and women who usually cared for their families (53). Furthermore, it has been found that women faced disproportionate difficulties in accessing care due to cultural factors, and that violence against them increased (54).

Managing referral systems to ensure appropriate distribution of service load

Several barriers existed to establishing fast, effective and safe patient flows during the pandemic. Inadequate testing capacity, mistrust and misinformation contributed to late presentation and high fatality rates from COVID-19 (55, 56).

This study did not identify any formal guidance on referral pathways in relation to COVID-19. However, stakeholder accounts indicated that Iraqi citizens could self-refer or contact the authorities through a dedicated phone number. One stakeholder described the flexible process of patient referral as facilitating fast patient flows:

“Referrals to our COVID-19 centre were made through an emergency department. Patients also self-referred by phone calls.”

Stakeholder 8

The Higher Committee for Health and National Safety guided the diagnosis and management of COVID-19 (12), and the perception among stakeholders was that those guidelines were transferred smoothly to the facility level:

“The guidelines to treat patients were provided to us by the Directorate of Health which was derived from guidance from the Federal Ministry of Health and WHO. We had good coordination with the Directorate of Health, Department of Public Health and the ambulance service.”

Stakeholder 8

However, movement restriction policies created a barrier to patient flows from primary health services. Stakeholders also described the tendency to refer patients to hospitals as opposed to PHC centres:

“We did not have any patients referred from PHC centres because they were closed during the lockdown [the period when movement restrictions were in place]. This continued after as well.”

Stakeholder 8

How multisectoral policy and action are responding to COVID-19

On 26 March 2020, the Council of Ministers issued Decree no. 64 ordering the establishment of the Higher Committee for Health and National Safety (57). The Committee was headed by the Prime Minister, with representatives from 21 ministries and other executive agencies. In addition to overseeing the pandemic response, the Committee was tasked with coordinating with all other executive branches.

Stakeholder accounts highlighted implementation strategies and mechanisms that promoted multisectoral collaboration during the pandemic. One stakeholder detailed the creation of new structures. Another stakeholder described how the pandemic had created an opportunity to engage in multisectoral action and policy.

“Operation rooms were established in all governorates. They consisted of police, security, emergency services, health directorate and mayors of the towns in our governorate. There were subcommittees in those towns and districts as well. There was a High Committee that was established in February 2020 headed by the Minister of the Interior. In addition to all relevant ministries, the governors of governorates were also members of the High Committee. Our local committee was meeting daily during the first wave of coronavirus and issuing necessary decisions. We were also receiving decisions from the High Committee.”

Stakeholder 9

“[The COVID-19 pandemic] was an opportunity to test our ability to undertake collaborative work. For example, it tested the government’s ability to undertake drastic measures such as lockdowns [movement restrictions] and curfews and people’s acceptance of such measures. Coronavirus helped to make people adhere to hygiene measures.”

Stakeholder 9

Unlike the central GoI, the security apparatus took a leading role in the pandemic response in the only federal region of the country – the Kurdistan region. This was seen by some stakeholders as a step that helped enforce some of the prevention and control measures.

Despite the positive reflections from some stakeholders, certain interventions in some sectors lacked a clear evidence base. For example, the spraying of vehicles entering Iraq at border crossings introduced a false sense of protection against COVID-19, while the fees charged for this measure created a considerable burden on trade (46). The same issues are reported for the spraying of streets and shops in city centres (56), which was neither systematic nor had a solid scientific evidence base (58).

Moreover, there is evidence to suggest that the pandemic and associated interventions negatively impacted some of the broader determinants of health. The movement restriction policies resulted in increasing prices of food and other essential commodities (59), and they had a particular impact on small and medium enterprises (60). Some individuals abused the movement restriction policies to engage in profiteering from the supply of gloves, masks and disinfectants. Finally, the school closures and financial hardship increased the prevalence of depression and anxiety, particularly among women (61, 62). As one stakeholder elaborated:

“We faced major issues because of [the movement restriction policies], particularly with the closure of the government offices and schools. Our area is agricultural and was affected by the [restrictions] and a lot of people were visiting us seeking permission to continue to work. Although we were able to protect our people from coronavirus, as it became clear later, the [movement restrictions] were not an answer due to the social and economic characteristics of the region, therefore a decision was made to lift [the restrictions] in stages.”

Stakeholder 9

In addition, barriers were highlighted concerning the integration of public and private sectors into governance and communication processes. Some stakeholders suggested that patients considered public facilities to be a last resort when private hospitals ran out of resources or reached capacity:

“We had patients from private hospitals referred to us because they ran out of money and couldn’t afford to stay any longer.”

Stakeholder 8

The community response to these challenges is explored in the next section. But, arguably, the failure to engage the PHC system in addressing these multisectoral challenges represents a missed opportunity.

Conversely, the movement restriction policies resulted in the emergence of online shopping, which is new in Iraq (63). They also led to the introduction of online and distance education (64). More broadly, reduced human activity resulted in a significant improvement in air quality (65).

How communities are responding to COVID-19

The evidence from the stakeholder consultations and document analysis can be grouped into two main themes. First, examples of the community response and engagement were highlighted by many stakeholders. Second, stakeholders described barriers and challenges to effective community engagement (see Table 1 for detailed stakeholder quotes).

One achievement has been the establishment of mobile medical teams that voluntarily provided essential services to COVID-19 patients in their homes. In some instances, these mobile medical teams replaced PHC centres that closed and also difficult-to-access hospitals. Some of these teams offered their services virtually, either online or through telephone calls.

Civil society organizations (CSOs) also played a critical role in channelling the community response (66–71). For example, some CSOs suspended their regular activities to focus efforts on the public health response to COVID-19; others converted existing programmes into COVID-19-related campaigns, including monitoring the government’s policies. Some CSOs engaged in fundraising to provide food aid and other essential services. Stakeholders argued that CSO participation in service provision, policy-making and government structures should be institutionalized through legal provisions.

The role of the media (both traditional and social media) was also highlighted by stakeholders as a platform to offer knowledge, exchange information and maintain communication during the pandemic. For instance, communities were able to conduct many of their essential functions (e.g., education, funerals and

shopping, etc.) via social media. Such examples can be seen as evidence of the resilience of communities in responding to crises such as COVID-19.

At the same time, examples were identified of challenges and gaps in community engagement during the pandemic (the second theme in this section). This included a sense of mistrust in the government and its policies in relation to COVID-19 (26). Widespread corruption appears to have played a role in this mistrust, with Iraq currently ranking 157/180 in Transparency International's Corruption Perception Index (72). Stakeholders cited the lack of compliance with curfews and public health advice as evidence of the mistrust in the government. There was a perception that some members of the public felt that the pandemic was used to justify crackdowns on dissent and public demonstrations.

Further, stakeholders associated low levels of trust in the government with public anxiety about the credibility of information provided by the authorities and, in turn, the emergence of other sources of information that the community felt were more credible. Indeed, prior to and during the pandemic, myths and misinformation spread (36). For example, a prominent Shiite religious leader announced that COVID-19 does not affect true believers, therefore people should continue their worship as normal (73). Such proclamations encouraged thousands of people to conduct a pilgrimage to holy Shiite sites, in defiance of government curfews and official *fatwas* (74, 75). Similarly, some politicians promoted conspiracy theories about the origins of the SARS-CoV-2 virus (76). This prompted some stakeholders to suggest the censoring of misinformation and to recommend that departments be established within the MoH that specialize in health information and awareness.

There is evidence to suggest that existing structural characteristics of Iraqi society shaped the community response to COVID-19. For example, poor community preparedness appeared to correlate with sociodemographic characteristics such as being male, unemployed and having a lower education (77, 78). However, other surveys have found no correlation between knowledge of the virus and socioeconomic attributes (79). Among those admitted to hospital, low educational attainment has been found to be a factor in virus transmission as well as in the severity of symptoms experienced by patients (80).

Table 1. Stakeholder quotes about community engagement

| Tools/approaches used to facilitate community engagement in the pandemic response | Examples of challenges/gaps in community engagement |
|---|--|
| <p>“Volunteer mobile medical teams were established to visit families and patients affected by COVID-19 to provide consultations and treatment including oxygen cylinders.”</p> <p>Stakeholder 2</p> | <p>“It is essential to make sure that information that is spread among the community about the outbreak is monitored and even censored when such information is harmful.”</p> <p>Stakeholder 4</p> |
| <p>“The ability to conduct meetings and other activities online was one of the positive outcomes of COVID-19.”</p> <p>Stakeholder 5</p> | <p>“It is necessary to have a department within the Ministry of Health that specialises in the management of public health emergencies. Also, a high committee at the ministry of health is necessary to make sure that credible information is provided.”</p> <p>Stakeholder 4</p> |
| <p>“We saw that the community itself was keen on informing about outbreaks or individuals who had COVID-19 in neighbourhoods. Some saw this as a form of spying.”</p> <p>Stakeholder 4</p> | <p>“Introducing legal tools such as laws to support community engagement is one possible mechanism. One measure can be the legal provision that secures the participation of civil society organizations in the high committees.”</p> <p>Stakeholder 2</p> |
| <p>“Artists and journalists played a role in the community’s response such as writing poems about the pandemic, making short films and even taking photos of lovers kissing with masks on.”</p> <p>Stakeholder 3</p> | <p>“These initiatives were done by some elites and were happening mainly in the city centres.”</p> <p>Stakeholder 2</p> |
| <p>“The role of the media in this area is very important particularly to sustain community engagement in the health system. Also, it is possible to introduce legal measures to sustain efforts. The groups and organizations that contributed should continue their efforts through organizing in networks.”</p> <p>Stakeholder 3</p> | <p>“First, religious leaders who opposed the closure of mosques contributed to the spread of misinformation such as that the virus will not enter mosques, or such bad virus will not infect pure believers and Muslims. Some people gathered close to mosques as a means of protection against COVID-19. Mistrust in the government led to poor preparedness as well because people were actively opposing measures as a tool of dissent against the authorities. Some doctors and health care professionals also contributed to the lack of preparedness by suggesting that the virus will not be as bad as expected.”</p> <p>Stakeholder 2</p> |

Table continues next page...

| Tools/approaches used to facilitate community engagement in the pandemic response | Examples of challenges/gaps in community engagement |
|---|--|
| <p>“Some civil society organizations have used their existing projects and resources that they couldn’t operate because of COVID-19 for awareness and service provision related to the pandemic.”</p> <p>Stakeholder 4</p> | <p>“Religious leaders played a negative role in this matter by indicating that those who pray (and clean themselves five times a day) will not get the virus.”</p> <p>Stakeholder 4</p> |
| <p>“Our organization was able to collect funds to purchase food baskets to distribute it to the needy people.”</p> <p>Stakeholder 5</p> | <p>“The lack of awareness by the society in health issues in general and this virus contributed to the poor preparedness. The military and security aspects of the response were needed to overcome the lack of preparedness.”</p> <p>Stakeholder 3</p> |
| <p>“During the [movement restrictions], some people found jobs online which was a good way of using the [restrictions] for financial benefits. The lockdown contributed to the development of mobile teams to provide various services.”</p> <p>Stakeholder 5</p> | <p>“Although the government announced curfews on several occasions, there was no real enforcement of the curfews. People continued to go to markets with no real social distancing, not wearing masks.”</p> <p>Stakeholder 4</p> |
| <p>“Online education was one of the mechanisms that were useful in responding to the need for continued education.”</p> <p>Stakeholder 2</p> | <p>“It is necessary to reform the memberships of the high committee for fighting coronavirus. These committees did not include representatives from the communities or even public health specialists.”</p> <p>Stakeholder 2</p> |
| <p>“The community used social media and phone to communicate during [movement restrictions] for example to offer condolences rather than attending funerals.”</p> <p>Stakeholder 2</p> | <p>“We have poor acceptance of monitoring by the community on health care services. We have weak oversight. That has resulted in a high number of medical errors including the death of patients. Even when investigations and oversight happen, those who committed errors are excused and the error is justified by false excuses or social reconciliations are done where the health care provider is forgiven in exchange for a fine.”</p> <p>Stakeholder 5</p> |
| <p>“Our NGO suspended all of its activities. We established a High Emergency Committee. Our projects with funders all were changed to emergency services to provide medical supplies. We established a specialized unit called the Committee of Volunteers. Their only function was to monitor the activities of the government, community, health system.”</p> <p>Stakeholder 6</p> | <p>“The Ministry of Religious Endowment or the fatwa committee can issue a fatwa saying that building a hospital or a clinic or a school has the same reward compared to building a mosque.”</p> <p>Stakeholder 5</p> |

Conclusion and lessons learned

The COVID-19 pandemic reached Iraq at a time when the country was experiencing considerable political, economic and social challenges and unrest. One of the largest popular demonstrations in the country was underway and a political deadlock had led to the resignation of the government. Low oil prices and the emergence of the ISIS conflict had shattered the Iraqi economy. As the first confirmed cases of COVID-19 were reported in February 2020, millions of Shiia pilgrims were preparing to join one of the largest religious gatherings in the world.

Such challenges will continue to exist in future public health emergencies. Therefore, any planning and preparedness for future crises must take into consideration the wider political, economic and social context.

Despite the challenging context, the GoI mounted a high-level response to the pandemic in 2020. Initially led by the then Minister of Health and later by the Prime Minister, the response was centred, at least at the onset, around security measures such as curfews, movement restrictions and border closures. As described in this case study, the response at the health level replicated the hospital-based, biomedical-focused and resource-intensive nature of the health system.

The hospital-centred approach to the pandemic was clear in the emergency response. Early on, the MoH decided to admit people with a positive COVID-19 test to hospitals, regardless of the severity of their symptoms. Procurement efforts also focused on hospital-based supplies and equipment such as PPE and ventilators; PCR testing was done in central laboratories usually linked to tertiary hospitals. Expert committees were established to provide clinical guidance in the management of the disease, but public health experts were often excluded. Even the vaccination programme, which is normally a PHC function, began in hospitals.

The marginalization of PHC reflects a historical path, whereby greater attention has been attached to hospitals and to clinical specialities. A direct outcome of this marginalization was the closure of PHC centres during the periods in which movement restriction policies were in force, which, in turn, resulted in the complete cessation of primary care services.

Nevertheless, the COVID-19 pandemic offered several opportunities to enhance multisectoral action and to promote community engagement. For instance, new national, subnational and local structures were created to facilitate communication, coordination and planning – and these can be institutionalized to promote health across all policy frameworks.

To enhance community engagement and meet the needs of the public during the pandemic, wide-ranging initiatives were introduced by individuals, communities and civil society. These initiatives – such as information gathering, basic service provision and awareness-raising campaigns – could be formalized within the function of PHC centres. For example, community hubs could be established that link to PHC centres and that operate as a form of PHC response to public health emergencies, rather than focusing only on the formal health system. Moreover, legislation should be considered to support community engagement at the national government level.

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Iraq: a primary health care case study in the context of the COVID-19 pandemic

This case study was developed by the Alliance for Health Policy and Systems Research, an international partnership hosted by the World Health Organization, in collaboration with the WHO Regional Office for the Eastern Mediterranean (EMRO) and WHO country offices. In 2015, the Alliance commissioned the Primary Health Care Systems (PRIMASYS) case studies in twenty low- and middle-income countries (LMICs) across WHO regions. This case study builds on and expands these previous studies in the context of the COVID-19 pandemic, applying the Astana PHC framework considering integrated health services, multisectoral policy and action and people and communities. This case study aims to advance the science and lay a groundwork for improved policy efforts to advance primary health care in LMICs.

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