Health, Politics, and Stability in the Middle East: A COVID-19 Update

by Ali Mokdad **(/experts/ali-mokdad)** , Mohammed Hassan Khalil **(/experts/mohammed-hassan-khalil)** , Muhamed Almaliky **(/experts/muhamed-almaliky)**

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ABOUT THE AUTHORS

Ali Mokdad (/experts/ali-mokdad)

Dr. Ali Mokdad, a former senior official at the Centers for Disease Control and Prevention, currently the director of Middle Eastern initiatives and a professor of global health at the University of Washington's Institute for Health Metrics and Evaluation.

Mohammed Hassan Khalil (/experts/mohammed-hassan-khalil)

Dr. Mohammed Hassan Khalil, a retired cardiologist and founder/chairman of the Committee for the Defense of the People's Right to Health, based in Cairo.

Muhamed Almaliky (/experts/muhamed-almaliky)

Dr. Muhamed Almaliky, a practicing cardiologist, research fellow at Harvard University's Weatherhead Center for International Affairs, and director of the Iraqi American Institute.

Brief Analysis

Three regional health experts explain why countries that avoided the worst of the pandemic early on are now reeling from its spread.

On July 29, The Washington Institute held a virtual Policy Forum with Ali Mokdad, Mohammed Hassan Khalil, and Muhamed Almaliky. Mokdad, an epidemiologist, is the director of Middle Eastern initiatives and a professor of global health at the University of Washington's Institute for Health Metrics and Evaluation. Khalil is a retired cardiologist and founder/chairman of the Cairo-based Committee for the Defense of the People's Right to Health. Almaliky, a cardiologist, is a research fellow at Harvard University's Weatherhead Center for International Affairs and director of the Iraqi American Institute. The following is a rapporteur's summary of their remarks.

ALI MOKDAD

ne of the key challenges facing health officials worldwide is that many countries continue to underreport their

COVID-19 infection and mortality rates. This trend is mainly due to weak testing capacity, inadequate vital-health registration systems, and, in some cases, intentional government efforts to save face and hide the true numbers.

In the Middle East, some countries have done a commendable job of releasing their COVID-19 data, including Jordan, Lebanon, Tunisia, and others. Among the countries that have not released reliable data—whether intentionally or due to low testing capacity—are Egypt, Iraq, and Saudi Arabia.

The cost of testing remains expensive across the region, and governments have failed to appropriate the necessary funds to increase testing capacity to recommended levels. The sharp spike in cases can be attributed to the poor health infrastructure in many countries and the broader context of war and instability. Additionally, continued pilgrimages to highly frequented cultural sites led to skyrocketing infection rates in the early days of the pandemic, particularly in Iraq and Iran.

Although the region's initial response was generally positive and timely, many governments prematurely relaxed restrictions in order to open their economies, and cases soared as a result. The pandemic's economic repercussions are especially likely to exacerbate existing problems for marginalized groups such as foreign workers, who in many instances have been forcibly repatriated. Moreover, given that several protest movements were active before the spread of COVID-19, the current trend of economic downturn and rising infection rates may increase instability across the region.

The World Health Organization (WHO) has been effective in encouraging multilateral cooperation and information sharing. In most cases, however, Middle Eastern countries have not coordinated directly in combating the virus. Because each government is focused on its own fight to contain the pandemic at home, there has been little cross-border interaction to make this a truly regional effort.

The United States can best assist Middle Eastern governments by providing training for health workers through initiatives like the field nurse practitioners programs administered by the Centers for Disease Control and Prevention (CDC). It can also help by sharing health emergency guidelines with local hospitals in order to help them prepare for COVID-19 surges.

MOHAMMED HASSAN KHALIL

In Egypt, the first virus case was recorded in March, and the official numbers have since reached 93,000 infections and 4,700 deaths. Yet these figures are problematic because they only account for people who tested positive, omitting the many suspected cases and deaths among individuals who were never tested.

In terms of national strategy, Egypt has failed to implement an effective public screening campaign to locate outbreak hotspots, thus diminishing its ability to focus on areas most in need of containment measures. The government has managed to test only 0.13 percent of the population; in comparison, the average testing rate abroad is between 5 and 10 percent even among moderate-income countries. The lack of transparency and considerable underestimation of infections means that the pandemic's true extent in Egypt remains unknown.

The government's response at the beginning of the outbreak was adequate, but the problems facing Egypt's health system are structural. In the 1960s, the system was considered advanced in comparison to other developing countries, but since then, budget austerity measures have decreased funding for such services and led to a rapid decline in the quality of Egypt's healthcare. For example, between 2008 and 2019, the number of government hospital beds decreased by 25 percent, while private hospital beds increased very little. Egypt now has only 1.2 government beds per 1,000 people, well under the global average of 2.9. Despite the government's claim that hospital beds are available to all COVID-19 patients across the country, many Egyptians report being turned away from hospitals due to over-capacity.

The 2014 Egyptian constitution stipulated that total government expenditures on health should not be less than 3 percent of GDP. Between 2016 and 2019, however, the government continued to decrease healthcare funding even after signing a deal with the IMF. Going forward, Egyptian authorities must prioritize rebuilding the healthcare system, which can only be done by rolling back the austerity measures that have previously crippled it.

MUHAMED ALMALIKY

Since the beginning of the pandemic, Iraq has conducted around 1 million tests and registered over 112,000 cases, of whom 4,485 have died. These numbers place it third among Arab League member states in infection rates (trailing only Qatar and Saudi Arabia) and second in mortality.

After the first Iraqi case was reported on February 24, the initial government response was favorable, and infection rates trended in a promising direction early on. By mid-May, however, the number of cases skyrocketed as Iraqis celebrated Eid al-Fitr and stopped observing lockdowns. The steady rise in cases continued afterward, yet the government still decided to relax lockdown restrictions in June.

As in Egypt, Iraq's real infection rate exceeds the numbers reported by the government. The official estimate of 2,500 new daily infections reflects Iraq's testing capacity, not its actual infection rate. Troubling reports suggest that around 30 percent of Iraqi tests have yielded false negatives, meaning that total cases may be much higher than anticipated. As for the mortality rate, many people dying at home from COVID-like symptoms are not being tallied in the official statistics.

The pandemic compounds an already difficult situation in Iraq, which was already dealing with political tensions and economic turmoil caused most notably by dwindling oil prices. The virus is also straining a health system plagued by limited resources and insufficient medical staff.

Ultimately, Iraq's current infection levels can be traced to inadequate planning. Health facilities have been debilitated; health screening and tracking are poor; officials have been unable to prioritize severe cases over mild and nonlethal ones, thereby diverting resources to noncritical cases; high infection rates among medical staff show that healthcare workers are not being provided with sufficient protective equipment; and local hospitals continue to use outdated or debunked remedies for patients.

The United States can help the Iraqi people during this crisis by providing loans and grants to shore up the economy; this would also give them extra incentive to stay home and comply with lockdown measures. In addition, Washington can play a leadership role by sharing its standards of care through the CDC, WHO, and other outlets. Global information sharing between health institutions remains slow and disjointed—such cooperation needs to improve if Middle Eastern institutions are to benefit from the high standards of planning and care seen elsewhere.

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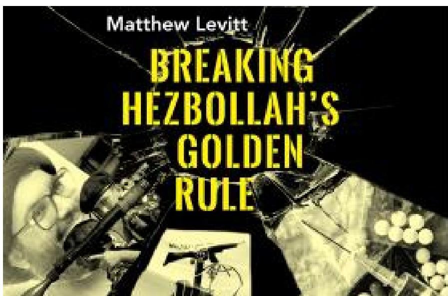

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