CHAPTER 3
COVID-19 AND INEQUITIES
INTRODUCTION

The COVID-19 pandemic has exposed and amplified existing social and health inequities, and created new dimensions of inequity. Global evidence shows clear socioeconomic inequities in rates of infection and mortality from COVID-19, which reflect existing social, economic and geographic inequities. People in poor health, living in poverty or on low incomes, and those living and working in crowded conditions, unable to work from home or working in the health sector, care work and public-facing occupations are all at greater risk of contracting and dying from COVID-19 (1–5).

Policies to contain the spread of COVID-19 have increased poverty, unemployment and food insecurity, reduced access to essential services, and restricted movement and economic activity around the world. People in every country who were already poor, in ill health or in insecure employment have been the most negatively affected (6, 7). Without urgent mitigating action, the impacts of the pandemic will lead to long-term increases in poverty and ill health as well as social, economic and (potentially) political instability within countries. The impacts are also already increasing inequities between high- and low-income countries, which will be greatly exacerbated by inequitable roll-out of vaccines.

While the notified number of deaths from COVID-19 are low in the Eastern Mediterranean Region compared with other regions (up to February 2021), containment measures are having very significant effects on health inequities due to deteriorations in the social determinants of health. In a number of countries in the Region, levels of poverty, food insecurity and undernutrition substantially increased during 2020 (8, 9) as a result of COVID-19 containment measures and the associated decreases in income due to unemployment, reductions in working hours and insufficient social protection mechanisms. The pandemic is also projected to have significant effects on gender inequities: violence against women and girls has increased, girls have less access to online education than boys, and women have taken on more unpaid household and caring roles during containment (10). Vulnerable groups including refugees, internally displaced persons (IDPs) and those in fragile and conflict-affected settings are particularly susceptible to these adverse impacts (11).

Health emergencies and epidemics have profound economic effects, particularly on poor and vulnerable populations. Evidence shows that recent major epidemics (such as severe acute respiratory syndrome (SARS), Middle East respiratory syndrome, Ebola and Zika) increased income inequities, reduced the proportion of incomes for those in the lowest income deciles and reduced the proportion of people with basic education in work compared to those with advanced degrees (12). The United Nations, the International Monetary Fund (IMF) and the World Bank have warned that the pandemic could undo decades of progress in reducing poverty, health inequities and gender inequality (13, 14). Given the scale of the COVID-19 pandemic and extent of containment measures, the social and economic impacts have been hugely damaging in the Eastern Mediterranean Region, which will further worsen health and health equity, undermine development and stall progress towards the SDGs.

While these challenges are substantial and increasing, the pandemic is also an opportunity to reduce inequities, to put social justice at the heart of decision-making and foster a whole-of-society endeavour to improve health and reduce inequities. In short – to build back fairer (15).
INFECTION AND MORTALITY FROM COVID-19 IN THE REGION

At the start of the pandemic in early 2020, transmission of SARS-CoV-2 – the virus that causes COVID-19 – was fairly slow in the Region, except in the Islamic Republic of Iran where reported cases rose sharply. Strict measures to reduce transmission were introduced in countries across the Region during the early phase of the pandemic, including school closures, border closures, suspension of mass gatherings and mandatory confinement/lockdowns. Transmission increased after lockdown measures were relaxed during Ramadan (23 April–23 May 2020) and as public adherence to measures reduced in areas where they were still in place.

Analysis of testing data found testing frequency in the Region is similar to the rest of the world, but there are wide differences between countries in terms of testing capacity. Testing per million is highest in GCC countries and lowest in countries in conflict, especially in Somalia, the Syrian Arab Republic and Yemen (16). Studies also indicate lower mortality per million population and lower average incidence in countries of the Region, despite the high presence of risk factors for rapid transmission (17). The reasons why mortality and infection rates are low in the Region are unclear (17).

There is significant uncertainty about the actual number of infections, due to low levels of testing in many countries. However, at the start of 2021, over 5 million cases of COVID-19 had been reported in the Region with 125 000 reported deaths and a case fatality rate of 2.4%. This is higher than the case fatality rates in other regions and may relate to lower levels of testing in some countries. The Islamic Republic of Iran has the highest number of reported cases and deaths in the Region. Tunisia and Jordan have the second and third highest number of deaths per million, respectively. Fig. 3.1 shows the number of COVID-19 deaths (per million population) in countries and territories of the Eastern Mediterranean Region, as at 28 February 2021.

![Fig. 3.1. COVID-19 deaths (per million population) in countries and territories of the Region, 28 February 2021](source: Our World in Data (2021) (18).)

In the Region, the majority of health systems are unable to track excess mortality above that registered as COVID-19 mortality. Having reliable excess mortality data would help to monitor the health impacts caused by the pandemic, such as lack of capacity to treat other conditions, and also deaths caused by COVID-19 which have not been registered as COVID-19 deaths. Despite unreliable data, the number of deaths from COVID-19 does appear to be lower in the Region than in other regions, perhaps related to the relatively youthful population (19), although other reasons, such as the climate, have also been suggested (20, 21).

**INEQUITIES IN RISK OF INFECTION AND MORTALITY FROM COVID-19**

**UNDERLYING HEALTH CONDITIONS AND RISK OF COVID-19 MORTALITY**

Research shows that those living in poverty, working in certain occupations, living or working in crowded conditions, or with poor access to water and sanitation facilities are at higher risk of exposure to COVID-19. These groups are also at higher risk of severe COVID-19 and death, due to their high rates of general ill health which are a risk factor for COVID-19 (2–5). Underlying health conditions (particularly dementia, cardiovascular disease, diabetes and chronic respiratory disease) heighten the risk of severe illness and mortality from COVID-19 (22). A study of 648 COVID-19 patients in Saudi Arabia found worse outcomes were associated with previous cardiac disease, chronic respiratory disease and the presence of two or more comorbidities (23). The pandemic has also caused severe disruption to services for the prevention and treatment of NCDs, which is of concern not only in terms of the management of these conditions, but because people with NCDs are at higher risk of severe COVID-19-related illness or mortality (24). As this report demonstrates, poor health is closely associated with poverty and deprivation – the socioeconomic risk factors that worsen health inequities.

**INEQUITIES IN LIVING CONDITIONS AND RISK OF INFECTION**

The transmission of COVID-19 within households is a substantial driver of infection. Cramped living conditions and/or large households make social isolation impossible and lead to high rates of household transmission. This is particularly significant in the Region, due to large average household sizes (discussed in Chapter 10) and the high numbers of IDPs, refugees and migrants living in overcrowded conditions (25), including migrant workers in some GCC countries. A survey of 401 IDP camp residents in Somalia found that 71% lacked ease of access to washing facilities, 67% lacked access to soap and 47% said the camp living conditions needed to change to prevent the spread of COVID-19 (26). A spatial modelling analysis of the spread of COVID-19 in the Islamic Republic of Iran concluded urbanization rates were associated with a percentage increase in the number of COVID-19 cases, and suggested overcrowding and pollution should be further studied to understand their role in exacerbating risks (27). Households that lack access to safe water, good nutrition and cooking fuel are at higher risk of infection as they are more likely to have weakened immune systems (28).

The United Nations High Commissioner for Refugees (UNHCR) highlighted that without action, refugees, who mostly live in extremely poor conditions with limited ability for sanitation measures, could be some of the worst hit by COVID-19 (29); and their access to public health measures and health care is low (30). However, despite strong warnings about spread of COVID-19 in refugee and IDP camps from the United Nations and nongovernmental organizations, the infection rates in camps have remained relatively low. In the Region, as at 20 January 2021, there were 981 351 cases and 22 174 deaths from COVID-19 recorded in eight locations with Humanitarian Response Plans (in Afghanistan, Iraq, Libya, occupied Palestinian territory, Somalia, Sudan, Syrian Arab Republic and Yemen) (31), but no major outbreaks had occurred in refugee and IDP camps. Localized outbreaks continue, however, and in September 2020 new cases of COVID-19 were confirmed in a camp in Jordan where 40 000 Syrian refugees live in cramped conditions (32).

The low levels of access to adequate water supply in some countries in the Region (described in Chapter 9) increase the risk of infection, as it is difficult to wash frequently and having to collect water makes it is impossible to isolate or avoid close contact with others. In Sudan, 5 million children have no sanitation services in their schools (33). More than half of schools in Libya (82%), the occupied Palestinian territory (76%), Lebanon (60%) and Tunisia (50%) have handwashing facilities with water but no soap (33). Less than a quarter of schools for refugees in Djibouti, Pakistan and Sudan have basic hygiene services (handwashing facilities with water and soap) (34). It is impossible for students to maintain required hygiene measures in such circumstances, although widespread school closures mitigated the effects. In Afghanistan, more than 60% of IDPs do not have access to basic hygiene items, particularly soap (35).

Many migrant workers live in crowded accommodation or poor-quality dormitories, some without access to running water or with very poor or no ventilation, where social distancing is impossible. In some countries
of the Region, migrant workers were quarantined in crowded dormitories, sometimes without support for access to food, sanitation and waste disposal, and with limited access to health care. Official figures from GCC countries early in the pandemic showed that the majority of infections were among migrants, although overall infection rates remain low in GCC countries (36–38). In Qatar in March 2020, 238 cases of COVID-19 occurred in a residential compound in the industrial zone, home to more than 360,000 migrant workers, which led to a strict lockdown of the area. In April 2020, Saudi Arabia stated that more than half (53%) of its cases were in foreigners (39) and by May, this figure rose to 75% of new infections (40). A survey of 6000 Filipino migrants working in GCC countries found 71% stated they risked exposure to COVID-19 in their job (41). Support to migrants at risk of or experiencing infection has been weak and many migrants have been solely dependent on ad hoc support from civil society organizations (42, 43). In Saudi Arabia, the Ministry of Health employed field units and tested for COVID-19 in migrant worker accommodation, and the Government offered free COVID-19 screening and health care services to all migrant workers during the pandemic (44).

INEQUITIES IN COVID-19 MORTALITY BY OCCUPATION

Evidence shows that public-facing occupations are associated with a higher risk of acquiring COVID-19, including health and social care workers, cleaners, security guards, public transport workers, taxi drivers, and hospitality workers (2, 45). Those unable to work from home are at higher risk of infection and death, as they are in contact with people at work and during their travel to work. Evidence from the United Kingdom of Great Britain and Northern Ireland shows that those working in occupations with higher academic qualifications were more likely to be able to work from home, while those in professional occupations had the lowest mortality rates (46).

In the Eastern Mediterranean Region, high rates of infection among health care workers at the beginning of the pandemic contributed to the spread of the virus, and between 7% and 10% of COVID-19 cases during the first three months were in health care workers (47). Inadequate infection prevention and control programmes and poor compliance have been cited as contributing factors to this, particularly given that 10 countries in the Region had no pre-existing national structures for infection prevention and control (47). By July 2020, 138 health care workers had died from COVID-19 in the Islamic Republic of Iran: 60% were physicians, 20% were nurses, and 20% were health workers in primary health care (48). In January 2021, the Syrian Arab Republic reported that 100 doctors had died from COVID-19 (49).

Many countries in the Region lack funding to provide their health care workers with the necessary personal protective equipment (PPE) and depend on international organizations such as WHO and UNICEF to provide PPE including gloves, gowns, face shields, and hand sanitizer (50). In December 2020, UNHCR reported having distributed over 530,000 masks, 841,000 gloves and 4000 gowns in Pakistan (51).

INEQUITABLE ACCESS TO HEALTH CARE AND COVID-19 MORTALITY

The COVID-19 pandemic has increased health care needs across the world, but underinvestment in health systems and infrastructure has resulted in inadequate access to health services in many countries. In some countries in the WHO European Region, the COVID-19 pandemic has overwhelmed health care capacity. This has also happened in the Eastern Mediterranean Region, where many countries are experiencing ongoing conflict or humanitarian emergencies that have already weakened their health systems.

In Lebanon in January 2021, it was reported that an increase in COVID-19 cases was overwhelming hospitals and that the occupancy rate of intensive care beds in Beirut and other parts of Lebanon was at 93–95% (52). In Tunisia, it was reported in October 2020 that intensive care unit beds were at around 80% capacity due to a surge in COVID-19 cases, with the situation being described by the health minister as “critical” (53). In Morocco, two temporary field hospitals were built to accommodate for rising numbers of COVID-19 patients, with a collective capacity of around 1200 beds (54). There is concern that hospitals may continue to be overwhelmed in the Region as the pandemic continues to spread and more infectious variants cross borders.

Disadvantaged geographical areas and social groups are generally served by under-resourced health services. In areas of conflict or in those receiving humanitarian and emergency support, COVID-19 threatens to overwhelm already weakened and fragile health systems. In the Syrian Arab Republic, close to half of health infrastructure is not functional and only half of the 113 public hospitals and public health centres are fully functional (55). Prior to the pandemic, three quarters of Libya’s primary health care clinics were not functioning due to shortages in medical staff, supplies, medicine and equipment (56). In Somalia, physicians stated there were no ventilators and only two intensive care units with a total of 31 beds across the country in April 2020 (26).

Access to health care services has declined in the Region during the COVID-19 pandemic. The 2 million residents of the Gaza Strip depend on Israel to issue permits to allow those seeking health services to leave Gaza; yet, during the COVID-19 pandemic, the number of permits issued decreased substantially. In September 2020, 260 permits were issued compared with a monthly average of 1777.
in one to three households stated they were unable to receive adequate medical care between March and October 2020 (9). In Somalia, a small survey of migrants found only one in five (20%) stated they were “strongly” or “moderately” confident they could receive medical services if infected with the COVID-19 virus (26). Research with stakeholders in Pakistan in April–May 2020 found access to all health care services decreased during the COVID-19 lockdown due to increased health care costs, reduced household incomes, and greater challenges in physically reaching health care facilities (58). In addition, community-based immunization and family planning programmes in Pakistan were suspended (58).

In humanitarian settings, accessing health care services is often further compromised due to existing shortages in the health workforce and shortages of medicines. The proportion of refugee families in Lebanon that reported being able to access primary health care fell from 90% in 2019 to 48% in May 2020, and access to secondary health care fell from 81% to 55% (59). Declining incomes also affect access to medicines, and 28% of refugee families in Lebanon were unable to purchase essential medicines in August 2020 (59). For the most vulnerable refugee populations, access was worse: more than two thirds (68%) of elderly refugees, those with disabilities and those with critical medical conditions could not afford health care-related costs (59).

Some migrant workers reported being unlikely to seek health care or testing for COVID-19 due to the risk of being quarantined and losing income (60), and when lockdown measures were lifted, some were still reluctant to visit health care facilities for fear of contracting COVID-19. A survey in Afghanistan in September–October 2020 found that 61% of respondents were still concerned about visiting a health care facility even after government restrictions had been lifted (61).

**INEQUITIES IN ACCESS TO HEALTH INFORMATION**

Poor or lack of access to public health information is a significant barrier to controlling the COVID-19 pandemic. Access to the internet is low in some countries and for some groups in the Eastern Mediterranean Region (discussed further in Chapter 11) (62). Women have limited access to the internet or mobile phones in some countries, making it difficult to communicate up-to-date information about COVID-19 and lockdown measures. In 2020, the Economic and Social Commission for Western Asia (ESCWA) reported close to half of the 84 million women in the Arab region do not have access to a mobile phone or are not connected to the internet (63). A survey of more than 8000 people in Afghanistan in May 2020 found 17% of men depended on the internet and social media as their main source of information about COVID-19, but only 7% of women used the internet and social media (64). Refugees and IDPs can face additional barriers to accessing COVID-19 health information due to lack of resources, limited access to the internet and language barriers, which may hinder their ability to comply with recommended public health guidance (65). In some countries, community health workers from the polio eradication programme have been engaged in raising awareness and support the COVID-19 response (Box 3.1).

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**Box 3.1. Community health workers and COVID-19 in the Region**

Community health workers in polio programmes make substantial efforts to reach the most vulnerable communities. As such, they have an in-depth knowledge of communities that was of great value during the COVID-19 pandemic. Close to 9000 polio surveillance volunteers were trained to support Afghanistan’s response to the pandemic. The volunteers took various jobs, including raising awareness of COVID-19 and working on clinical diagnosis, case identification and contact tracing. As the polio campaigns returned, some of staff continued to work on COVID-19-related community engagement as well as continuing their work on polio eradication (66). In Somalia, community health workers in the polio programme used their knowledge and data to follow-up and investigate suspected cases of COVID-19 (67).
INEQUITIES AS A RESULT OF Containment Measures

INCREASING POVERTY AND INCOME INEQUITIES

All of the countries in the world have been affected to some extent by economic declines and increasing poverty as a result of the COVID-19 pandemic. In the Eastern Mediterranean Region, even wealthier countries have seen very concerning economic declines. Many countries in the Region are vulnerable to international oil price fluctuations and as long as oil prices remain well below pre-COVID-19 levels, the ability of countries to recover from the pandemic will be seriously hampered. GDP is estimated to decrease by more than 4% across the Region in 2020 and by 13% in conflict-affected countries \( (8, 68–70) \). It is estimated it could take 10 years to recover to pre-pandemic levels of economic growth \( (71) \). Table 3.1 shows significant projected increases in poverty in the Region due to the pandemic and the collapse in oil prices, and wide variation between the selected countries and territories.

Table 3.1. Projected poverty increases due to COVID-19 and oil price collapse, in selected countries and territories in the Region

<table>
<thead>
<tr>
<th>Country</th>
<th>GDP decrease (%)</th>
<th>Pre-COVID-19</th>
<th>COVID-19</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(% of population in poverty)</td>
<td>Poverty headcount at US$ 3.20</td>
<td>Poverty headcount at US$ 5.50</td>
</tr>
<tr>
<td>Djibouti</td>
<td>-8.5</td>
<td>31.8</td>
<td>62.3</td>
</tr>
<tr>
<td>Egypt</td>
<td>-2.3</td>
<td>24.1</td>
<td>68.9</td>
</tr>
<tr>
<td>Iran (Islamic Republic of)</td>
<td>-4.6</td>
<td>4.0</td>
<td>16.6</td>
</tr>
<tr>
<td>Iraq</td>
<td>-14.6</td>
<td>11.8</td>
<td>46.9</td>
</tr>
<tr>
<td>Jordan</td>
<td>-7.8</td>
<td>2.5</td>
<td>21.7</td>
</tr>
<tr>
<td>Lebanon</td>
<td>-19.5</td>
<td>0.1</td>
<td>1.3</td>
</tr>
<tr>
<td>Morocco</td>
<td>-9.8</td>
<td>4.9</td>
<td>23.4</td>
</tr>
<tr>
<td>Occupied Palestinian territory</td>
<td>-6.8</td>
<td>5.0</td>
<td>23.1</td>
</tr>
<tr>
<td>Tunisia</td>
<td>-11.4</td>
<td>2.4</td>
<td>15.0</td>
</tr>
</tbody>
</table>

Source: Arezki et al. (2020) \( (72) \).

Globally, the number of people living in poverty is expected to increase as a result of the effects of containment measures. The increase in poverty (those living on less than US$ 3.20 per day) is the first in 20 years, with estimates that globally there will be increases of between 88 and 93 million people living in poverty in 2020 and the number of "new poor" in 2020 is estimated to be between 119 and 124 million \( (73–75) \). The World Bank estimates there will be an increase of between 2.8 and 3.4 million people living in extreme poverty (that is, living on less than US$ 1.90 per day) in the Middle East and North Africa region by the end of 2020, whereas prior to the pandemic the expected forecast was a decrease in extreme poverty \( (79) \), as shown in Fig. 3.2.
In every country of the world, it is the poorest populations and those on the margins of poverty who have borne the brunt of the economic impact of COVID-19. The pandemic has pushed Morocco into recession for the first time since 1995, and the proportion of people vulnerable to poverty and/or poor could rise to 19.8% in 2020 from 17.1% in 2019 (77). Income loss in Morocco occurred more often in the poorest households: three quarters (74%) of workers in the most deprived households lost income, which is 30% more than those in the least deprived households (78). Close to a quarter (23%) of Lebanese workers stated they had a reduction in their salaries since March 2020 (59). Those most at risk of loss of income in Lebanon were women, young people aged 25–34 years old, and those in informal work (59). In Pakistan, more than half of those surveyed across all income levels reported a reduction in income during the lockdown period, but those with no education were more likely to report income loss compared to respondents with more than secondary education (79).

The baseline figures of poverty in the Syrian Arab Republic vary, mainly on account of different criteria used – for example, monetary indicators or the multidimensional indicator. However, a macroeconomic assessment by the United Nations Development Programme (UNDP) estimated that the poverty rate in the Syrian Arab Republic was 86% at the end of 2019 and had increased to nearly 90% by mid-August 2020; this translates to an increase of about 500 000 people in 12 months and, in addition, an increase of 1–2 million people living in extreme poverty (55). In Yemen, one in four households reported receiving lower income and wages due to COVID-19 (80).

The pandemic has had severe impacts on the income of refugees and IDPs, who are more likely to work in the informal sector. Poverty rates increased among Syrian refugees in Jordan, the Kurdistan region of Iraq, and Lebanon, as shown in Fig. 3.3. The highest increase was seen among Syrian refugees in Lebanon (56 percentage point increase in poverty) which is likely to also be fuelled by the political and economic situation in the country, with declining GDP and high rates of inflation (81, 82).
The COVID-19 crisis has had a number of adverse economic impacts on IDPs in Iraq (Fig. 3.4). A survey of IDPs in the country in 2020 found that 78% have lost their income and 66% have cut the number of meals for their household to save money (83).

Fig. 3.3. Estimated increase in poverty as a result of the COVID-19 crisis among Syrian refugees in Jordan, the Kurdistan region of Iraq, and Lebanon, 2020

Note: Shows the increase in poverty relative to the international poverty line of US$ 5.50 per day.

The COVID-19 crisis has had a number of adverse economic impacts on IDPs in Iraq (Fig. 3.4). A survey of IDPs in the country in 2020 found that 78% have lost their income and 66% have cut the number of meals for their household to save money (83).

Fig. 3.4. Proportion of IDPs in Iraq experiencing adverse impacts of the COVID-19 crisis, 2020

In Lebanon, refugee families have adopted various coping strategies to pay for basic necessities since the COVID-19 crisis began, including borrowing money and reducing food consumption. Fig. 3.5 shows results of a monitoring survey of 19,135 refugee households in Lebanon for 20 March–9 August 2020.

**Fig. 3.5. Refugee households’ response to the COVID-19 situation in Lebanon, comparison of weeks 1–20, 2020**

Note: Multiple choice answer.

In Afghanistan, the percentage of displaced households with an unpaid debt burden increased by 13% between 2019 and 2020 (61). Similar to Lebanon, in Afghanistan the population adopted severe techniques to manage catastrophic levels of debt, “selling critical assets which they will struggle to re-purchase even if the situation improves” (61). In Afghanistan, as incomes decreased and debt levels increased, food was the most common reason for people to borrow money (61).

The decline in GDP and economic growth has harmed health, reduced employment and income, raised prices, increased poverty, disrupted essential services such as health and education, and negatively affected national infrastructures; these negative impacts will continue. Urgent action, with a focus on improving equity, is needed to reduce long-term inequitable impacts and improve prospects for millions of people in the Region who have been particularly adversely affected.

**JOB LOSSES AND REDUCTIONS IN WORKING HOURS**

Unemployment has increased in all countries of the Region as a result of the pandemic, but low-income households have generally been hit much harder. A study of 230,540 respondents in 17 developing countries around the world found 71% of the lowest income households had one member lose their job and 61% of these households also reported that a household member had to close their business (84). In addition to job losses, working hours have also reduced due to containment measures. In the second quarter of 2020, working hours globally decreased by 17%, equivalent to 495 million full-time job losses, with informal workers disproportionately affected (85). In lower middle-income countries, the International Labour Organization (ILO) estimate the number of working hours decreased by 23%, equivalent to 240 million full-time equivalent jobs, constituting the majority of jobs lost globally during the pandemic (86).
World Bank phone surveys of over 12,000 people in Djibouti, Egypt, Libya, Morocco, occupied Palestinian territory, Tunisia and Yemen, between April and July 2020, found poorer households were less likely to be able to continue working than wealthier households (72). In Egypt, 32% of self-employed people continued to work as usual during containment measures, whereas close to double (61%) of public sector workers worked their usual hours and 20% of informal workers worked as normal (72), as shown in Fig. 3.6.

**Fig. 3.6. Effect of the COVID-19 pandemic on work in Egypt, 2020**

For countries in the Region where data are available, the impacts of containment measures on employment among lower income workers are clear, putting those already vulnerable to poor health, poverty and unemployment at further risk (Fig. 3.7).

**Fig. 3.7. Workers who stopped working (%) in selected countries in the Region, by income quintile, 2020**

Source: Arezki et al. (2020) (72).
Not only are members of poor households less likely to be able to work, they are more likely to be without any source of income when they are not working. In Tunisia, 78% of workers in the lowest income quintile received no payment when they were not working; in contrast, 67% of those in the highest income quintile continued to receive either full or partial payment (Fig. 3.8). The World Bank found similar patterns in Morocco, where only 10% of wealthy households reported earning no income during containment measures, while 44% of the poorest households reported no income. 

**Fig. 3.8. Percentage of workers receiving payment while not working in Tunisia, 2020**

![Surveyed workers affected (%)](Image)

Source: ILO (2020).

Despite relatively low infection rates compared with Europe and other areas of the world, northern Africa had the largest decline in working hours lost in both the second and third quarters of 2020 (Table 3.2), indicating just how severely the containment measures had affected low- and middle-income countries. Arab countries have also experienced loss of working hours, and in the third quarter of 2020 these losses were higher than in Europe and Central Asia, despite being slightly better than in the second quarter, suggesting recovery is slower in these countries.

**Table 3.2. Working hours lost and equivalent full-time job losses, by region, January–September 2020**

<table>
<thead>
<tr>
<th>Region</th>
<th>Working hours lost (%)</th>
<th>Equivalent number of full-time jobs (48 hours per week) lost (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Quarter 1</td>
<td>Quarter 2</td>
</tr>
<tr>
<td>Northern Africa</td>
<td>2.1</td>
<td>21.2</td>
</tr>
<tr>
<td>Arab States</td>
<td>2.3</td>
<td>16.9</td>
</tr>
<tr>
<td>Europe and Central Asia</td>
<td>4.1</td>
<td>17.5</td>
</tr>
<tr>
<td>World</td>
<td>5.6</td>
<td>17.3</td>
</tr>
</tbody>
</table>

Source: ILO (2020).
INEQUITIES AND INFORMAL WORK AND MIGRANT WORKERS

Informal workers are particularly vulnerable to loss of employment and income during the COVID-19 pandemic (86). A high proportion of employment in the Region is informal (more than 50% in many countries) and women and migrants work in large numbers in informal employment in low- and lower middle-income countries, so they are particularly affected by containment measures (13). The containment measures closed public spaces and markets where many informal workers earn a living, and many informal agricultural workers lost their jobs and even their accommodation. In Djibouti, informal workers were less likely to work than those from the formal sector: a nationally representative survey in September/October 2020 found 17% of informal workers were still not working, compared to 12% of those with formal work (88).

A systematic review of the effect of epidemics (including the COVID-19 pandemic) on migrant workers and their well-being found that major epidemics “negatively affect the physical, financial, psychological and social wellbeing of migrant workers” (89). Migrant workers have faced catastrophic loss of employment and income due to the COVID-19 pandemic, and some have been forced to return to their home countries without their final pay (90–93). A representative survey of 1000 workers in Bahrain (700 Bahrainis and 300 Bangladeshis living Bahrain) found that the migrant workers were more likely to lose their jobs and are highly vulnerable to adverse economic shocks from the pandemic (94).

In Jordan, 35% of Syrian refugees reported losing their jobs after the outbreak of COVID-19 compared to 17% of Jordanians (55). Refugees have also been significantly affected in Lebanon, where more than 60% report they have lost their livelihood/source of income (59). Job losses among refugees and IDPs mean they are more dependent on humanitarian aid or have to return to their home countries where there are often few, if any, jobs (95). In 2020, nearly 866,000 undocumented Afghan migrants returned to Afghanistan (96). Other migrants were stranded without support, unable to continue onward journeys or to return home. In Djibouti, traffickers abandoned migrants (97).

Because of reduced incomes as a result of the pandemic, many migrant workers were not able to send money to their families at home (98). In Afghanistan, many households depend on the income sent from family members working as migrant labour in the Islamic Republic of Iran and Pakistan; this income reduced by 50% between April and June 2020, due to economic problems caused by the pandemic in both countries (99). The World Bank estimated that US$ 61 billion would be sent to countries in the Middle East and North Africa from migrant workers by the end of 2020 (100). However, due to job losses and quarantine restrictions, in October 2020 it was estimated the remittances in the region would decline by 8% in 2020; Tunisia experienced a 15% decline in remittances, Jordan saw a 12% decline and Egypt 9% (101).

An example from Jordan of inclusive care for refugees during the COVID-19 pandemic is outlined in Box 3.2.

BOX 3.2. Inclusive care during the COVID-19 pandemic in Jordan

From the start of the pandemic, the Government of Jordan included refugees in their COVID-19 response. All refugees had the same access to COVID-19-related health care as Jordanian citizens, and refugees will be included in Jordan’s vaccination roll-out in 2021. Refugees with medical qualifications were included in the COVID-19 response: an important way of reducing the effects of containment measures, as refugees in Jordan reported they were less likely to be employed during the lockdown (102).
RISING LEVELS OF FOOD INSECURITY AND UNDERNUTRITION

Food insecurity affects the most disadvantaged groups in countries of the Region and, even prior to the COVID-19 pandemic, levels of food insecurity in the Middle East were among the highest in the world (85). This situation has further deteriorated due to the pandemic and will lead to worse health and higher mortality among disadvantaged people in the Region. Increases in food insecurity have occurred most often in low- and middle-income countries and those affected by conflict (84, 103, 104). Migrants and refugees have been particularly affected. Households in IDP and refugee camps generally do not have the capacity to store food and they depend on informal markets and street food vendors, meaning that when movement was restricted during containment measures, people’s ability to access food was greatly reduced (105). Meanwhile, as levels of income and work decreased, some poorer and more isolated communities found they were unable to afford food (104) (Fig. 3.9).

Fig. 3.9. Urgent support wanted by residents in Gilgit-Baltistan, Pakistan, May 2020

Reduced household incomes due to the pandemic have had immediate impacts on food security and nutrition. The countries in the Region that were already facing food crises have been the most severely affected. The pandemic has further exacerbated challenges in Afghanistan, Sudan, the Syrian Arab Republic and Yemen in the quantity, frequency and diversity of the food which children and families consume. These are among the top 10 countries in the world with the worst food crises in 2019 by number of people in “crisis or worse” (IPC Phase 3 or above), with nearly 40 million people affected. This is likely to create a new type of food crisis, or in most cases to worsen existing ones (106). In Sudan, 6 million people are estimated to be food insecure as at November 2020 – a 65% increase compared to the same period last year – and one in five are IDPs (9).

Box 3.3 shows the impacts of the COVID-19 pandemic on food insecurity in selected countries in the Region.
Box 3.3. Impacts of COVID-19 on food insecurity

In Afghanistan the number of people facing a food crisis or emergency increased from over 10.2 million in September 2019 to over 10.8 million in April 2020, including over 3.4 million people in emergency acute food insecurity (IPC Phase 4) (8).

In Jordan, in the first four weeks of containment, a survey of 3129 Jordanians found more than half of the respondents were food insecure and 23% were severely food insecure (107). The number of Syrian refugees reporting not having enough food to eat increased by 15% during the pandemic, compared to 2018, with one in five (21%) skipping meals (85).

In Lebanon the number of people requiring food assistance doubled between September 2019 and September 2020, reaching 2 million. Further increases were expected by the end of 2020 (8).

In Libya, an assessment conducted by the International Organization for Migration (IOM) across 21 regions found 65% of migrants surveyed had to resort to a stress, crisis or emergency livelihood coping strategy due to lack of food or means to buy food (42).

In Pakistan in April 2020, more than a quarter of households reported reducing the number of meals and size of meals (79).

In the Syrian Arab Republic in April 2020, the number of food insecure people was estimated to be 9.3 million, the highest number ever recorded, with refugees and IDPs most at risk (85, 108). More than half of surveyed households which reported losses of income for September 2020 also had poor or borderline food consumption, which represents a two thirds increase since April 2020 (80).

In Tunisia, 19% of households consumed less-preferred foods and 18% ate less food overall, but this national statistic hides inequities. Households in the poorest quintile are close to five times as likely to have reduced their food consumption compared to households in the top wealth quintile (Fig. 3.10) (72).

Fig. 3.10. Changes in food consumption due to COVID-19 in Tunisia, by wealth quintile, 2020

Note: Results of a nationally representative phone survey. Source: Arezki et al. (72).
In Yemen in September 2020, 15% of households were in severe food deprivation, increasing from 11% in March 2020 (108). Analysis in October 2020, covering 133 districts, found over half a million children aged under 5 and more than a quarter of a million pregnant and nursing women were expected to suffer from acute malnutrition in 2020 (8). By December 2020, 37% of the most vulnerable displaced families said they were eating less as a result of the pandemic (109).

In countries and territories in conflict or with existing humanitarian crises, the nutritional status of children has worsened as a result of the COVID-19 pandemic (110, 111). Even as the need for urgent humanitarian assistance and nutrition support increases, levels of support and access to services have decreased. Children’s nutrition programmes in schools stopped when there were school closures. WFP estimated in April 2020 that globally 370 million children were missing out on school meals and essential health and nutrition services (112). Morocco and Tunisia have data and reported a 75–100% decrease in nutrition programmes in schools (80); however, most countries in the Region do not have data on coverage of nutrition programmes in schools. Between March and end of August 2020, nutrition support for pregnant and lactating women in Morocco and the occupied Palestinian territory decreased by 25–49%. Iraq, Jordan and the Syrian Arab Republic also experienced declines, as shown in Table 3.3. Coverage and screening of early and child wasting in the same period decreased in Iraq, Morocco, occupied Palestinian territory, Sudan, Syrian Arab Republic and Yemen, also shown in Table 3.3, with Iraq having the highest drop in coverage and screening (50–74% drop) (80).

Table 3.3. Percentage change in nutrition support, in selected countries and territories in the Region, March–August 2020

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage change in nutrition support for pregnant and lactating women</th>
<th>Percentage change in coverage and screening of early wasting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iraq</td>
<td>10–24% drop</td>
<td>50–74% drop</td>
</tr>
<tr>
<td>Jordan</td>
<td>10–24% drop</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Lebanon</td>
<td>Increased/new</td>
<td>&lt;10% drop</td>
</tr>
<tr>
<td>Morocco</td>
<td>25–49% drop</td>
<td>10–24% drop</td>
</tr>
<tr>
<td>Occupied Palestinian territory</td>
<td>25–49% drop</td>
<td>10–24% drop</td>
</tr>
<tr>
<td>Sudan</td>
<td>Not applicable</td>
<td>10–24% drop</td>
</tr>
<tr>
<td>Syrian Arab Republic</td>
<td>10–24% drop</td>
<td>10–24% drop</td>
</tr>
<tr>
<td>Tunisia</td>
<td>Do not know</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Yemen</td>
<td>Do not know</td>
<td>10–24% drop</td>
</tr>
</tbody>
</table>

Attendance at essential nutrition services in Morocco and the occupied Palestinian territory decreased by 10–24% and in Sudan by 10% (80). Restrictions in movement further increased the vulnerability of extremely poor populations, and there was low turnout for nutrition treatment in Afghanistan as a result of fears of catching COVID-19 in facilities which are often co-located in health centres (61).

In the first months of the pandemic, prices for staple food items increased, although prices stabilized by the end of 2020. In some countries of the Region, however, prices have remained higher than before the start of the pandemic. In Afghanistan, WFP reported the average wheat flour price increased by 11% between March and December 2020 and the cost also increased for pulses (21%), sugar (19%), cooking oil (36%) and rice (21%) over the same period (113).

Fig. 3.11 shows the change in the cost of the food basket for selected countries in the Region since the start of the pandemic (between January and September 2020).

**Fig. 3.11. Change in food basket cost in selected countries in the Region, January–September 2020**

![Fig. 3.11](image-url)

*Source: WFP (2020) (80).*

**SCHOOL CLOSURES**

To control the spread of COVID-19, educational facilities were closed in many countries around the world for long periods of time (or indefinitely) during 2020 (114). Although new technology-based learning methods have made it possible for pupils to continue the learning process, access to these technologies is inequitable between and within countries. In countries with low human development, the out-of-school rate of children in primary education is 86% compared to 20% in countries with very high human development (1).

Research on other epidemics/pandemics shows that school closures can harm a generation of children and young people, and that the effects continue over a lifetime (115, 116). Evidence from the Organisation for Economic Co-operation and Development (OECD) shows that school closures could reduce a learners’ lifetime income by about 3%, and lower a typical country’s GDP by an average of 1.5% over the remainder of the century (78, 114). This will also affect health and health equity in the longer term (117, 118). Evidence from the Ebola epidemic shows girls are more negatively affected by school closures than boys. In the 2014 Ebola outbreak, schools in Guinea, Liberia and Sierra Leone shut for 6–8 months, but girls’ enrolment did not return to the same levels in any of these countries and the teenage pregnancy rate doubled (119–121).
UNICEF and partners surveyed nearly 7000 families in seven countries in the Middle East and North Africa (including Egypt, Jordan, Morocco, Qatar, Syrian Arab Republic and Tunisia), and 95% of respondents stated their children were negatively affected by the consequences of the pandemic. Lack of access to computers or limited internet connections were the main factors preventing students from accessing distance learning (122).

The COVID-19 pandemic will exacerbate existing educational inequities, and those without easy access to the internet, a mobile phone, a personal computer, or a quiet space to study, will all struggle more than learners who have these advantages. Globally, less than 20% of low-income countries are responding to school closures with different forms of remote learning (such as online, TV and radio), compared to nearly 90% of countries in the high-income group. In high-income countries, the majority of schools turned to online learning whereas in low-income countries, TV and radio were more commonly used (123).

Students in the Eastern Mediterranean Region are using distance-learning solutions such as online learning, TV and radio broadcasts; however, this depends on having access to an internet connection and devices. In Pakistan, 43% of wealthy households reported using technology for distance learning, compared to 28% of households with no income. The wealthy households and those in higher skilled jobs were also more likely to be able to help children with studies at home (79).

Save the Children surveyed over 8000 children and 17 000 parents in 37 countries and found that less than 1% of children from poor households had access to the internet, and 40% needed help with their schoolwork but had no one to help them (124). Girls are less likely to have access to computers, from primary to university age, and girls and women are less likely to have their own computer (63).

**LIVING CONDITIONS**

Declining economies can lead to much poorer living conditions and area deprivation and, as a result, lead to worse health inequities. More deprived areas have worse housing, hygiene and access to basic services (detailed in Chapter 12). As outlined in the previous section, these factors are related to an increased risk of infection and mortality from COVID-19 and harm to health in general. As incomes decrease and unemployment rises as a result of the containment measures, living conditions will decline and deteriorate and health will worsen. In many countries of the Region (including Egypt, Lebanon, Libya, Somalia and Yemen), refugees and IDPs reported being unable to pay their rent and bills and being fearful of eviction; and many were evicted, due to their lack of income and inability to keep up with payments (125–127).
INCREASE IN GENDER INEQUALITIES

Early in the pandemic, the United Nations warned that COVID-19 threatened the limited gains made in gender equality and would exacerbate the number of women in poverty, increase vulnerability to violence and undermine women’s equal participation in the labour force (128). The United Nations Population Fund (UNFPA) also warned of increases in gender-based violence and in child marriage (129).

In the Eastern Mediterranean Region, data are emerging to show that containment measures have had inequitable impacts on women and men and girls and boys. In Afghanistan, reports estimate that violence against women increased during the pandemic, with a 91% rise in verbal abuse and a 55% increase in physical abuse (61). A survey of 687 women in Jordan between May and July 2020 found that 40% had experienced violence during the pandemic and 77% lived with the abuser. Only 10% had a previous history of violence (130).

In Tunisia and Lebanon, domestic violence cases doubled during the first few months of the lockdown (80). A survey of 562 women and girls in Lebanon found that 54% of respondents had observed an increase in harassment, violence or abuse against other women and girls in their household or community during the pandemic (131). The UN Women Regional Office for the Arab States conducted a rapid assessment of the impact of the COVID-19 pandemic on gender equality and violence against women and girls, which included inputs from over 220 civil society organizations from 15 countries and territories (including Bahrain, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, occupied Palestinian territory, Saudi Arabia, Sudan, Tunisia, United Arab Emirates and Yemen) (132). Data were collected on the impact of COVID-19 on violence against women. Fig. 3.13 shows that over 50% of responding civil society organizations had observed or heard about increases in violence against women during the pandemic, and over 40% reported increases in online violence against women (132).

Despite the increases in violence against women and girls as a result of containment measures, only two countries in the Region (Morocco and Pakistan) have included services to respond to/prevent violence against women and girls as essential services and/or integral parts of national and local COVID-19 response plans (133). Early in the pandemic, the United Nations reported increases in female genital mutilation in Somalia and Sudan; and 31% of community members surveyed in Somalia stated there had been an increase in incidents of female genital mutilation compared to the pre-COVID-19 period (134).

As noted earlier, girls have less access to the internet and therefore to online education, and there are fears that once girls are out of school, many will never return. More women have lost jobs and working hours than men in all countries in the Region, partly...
because of the large number of women working in the informal sector and in domestic work (86, 135). In the Syrian Arab Republic, 61% of women reported they had lost their jobs since the outbreak of COVID-19 compared with 48% of men (55). Despite more women losing jobs in the Region, out of the 252 fiscal and economic, social protection and labour market COVID-related measures registered for 23 countries and territories in Northern Africa and Western Asia, in 11 countries and territories only 12% of measures addressed women's economic security and social protection, this included: seven in Egypt, one in Lebanon, three each in Morocco and occupied Palestinian territory, two in Tunisia, one in United Arab Emirates, and zero in Bahrain, Iraq, Jordan, Kuwait, Saudi Arabia and Syrian Arab Republic (133).

Women's access to health care in the Region has also been curtailed during the pandemic. In Iraq, the United Nations reported families have denied women access to quarantine or health facilities because social and gender norms do not permit women to sleep outside of the home without their husband or father. A third of respondents to a survey in the city of Habbaniya in Iraq stated that they would not allow a female family member to go to the hospital (83). In Tunisia, it is estimated approximately 50% of sexual and reproductive health services have been either reduced or suspended since the onset of the pandemic (136).

Women are almost absent from COVID-19 decision-making committees and task forces in countries of the Region. Analysis of membership of decision-making task forces concerning COVID-19 in seven countries found six women on the committees, compared to 80 men; women accounted for 7% of the task force membership (Table 3.4) (137).

Some countries in the Region have made efforts to integrate the needs of women and girls in their COVID-19 response. In Egypt, the National Council for Women is monitoring all policy measures that have been undertaken by the Government during the pandemic (78). Without women’s voices at this organizational level, the COVID-19 response in countries is unlikely to recognize the needs of women and inadvertently widen gender inequity.

Table 3.4. Members of COVID-19 decision-making task forces in selected countries in the Region, June 2020

<table>
<thead>
<tr>
<th></th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bahrain</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Djibouti</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Libya</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Oman</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Qatar</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>Iraq</td>
<td>0</td>
<td>24</td>
</tr>
<tr>
<td>Saudi Arabia</td>
<td>0</td>
<td>17</td>
</tr>
</tbody>
</table>

Source: van Daalen et al. (2020) (137).

**SOCIAL EXCLUSION AND STIGMA**

In some countries of the Region, those working in frontline jobs and professions have been treated with suspicion and violence during the COVID-19 pandemic. In Egypt, analysis of COVID-19-related stigma among 509 physicians found that most had experienced some level of stigmatization and 31.2% reported experiencing severe stigma (138). In May 2020, Sudan created a police force to protect health facilities after doctors threatened to strike following attacks from local residents (139). Additionally, mistrust and apprehension about contact tracing systems and personnel have been cited as a predominant barrier for people engaging with contact tracing (140).

In Libya, due to the stigma around contracting COVID-19, many people were reluctant to be tested or treated (141). In some countries, migrant workers were blamed for spreading the virus (142). In parts of Iraq, containment measures have halted social cohesion activities between IDPs and host communities, and segregation and tensions between the communities have reportedly grown (83).
DISRUPTIONS TO HEALTH CARE SERVICES

Around the world, as health systems adapted to the COVID-19 crisis there were delays or interruptions to diagnostic, treatment, rehabilitation and palliative services for people with NCDs or other chronic conditions. Health care facilities, staff capacity, equipment and resources have been overextended by the need to treat large numbers of patients suffering from COVID-19. Although the Eastern Mediterranean Region has had fewer COVID-19-related cases and deaths compared to other regions, the pandemic has had severe impacts on broader health services and immunization programmes (143).

During May–June 2020, WHO conducted a rapid assessment of the impact of the pandemic on essential health services in the Region, using a brief questionnaire to which 13 countries responded. The most frequently disrupted services reported by countries included family planning and contraception (92%), dental services (92%), rehabilitation services (92%), palliative services (92%), antenatal care (85%), NCD diagnosis and treatment (85%) and mental health services (85%). The median level of reported disruption was found to be higher in the Eastern Mediterranean Region than in other WHO regions, with the exception of the Region of the Americas (144). A further assessment was carried out by WHO to assess the impact of the pandemic on NCD services in the Region, with responses received from 19 countries. The most common reasons reported for discontinuing or reducing services were the closure of outpatient clinics and a decrease in inpatient volume due to cancellation of elective care. Over half of countries reported either insufficient staff to provide services or deployment of NCD clinical staff to COVID-19 activities. Over half of the countries had partially or completely suspended services for hypertension treatment and urgent dental care, 48% for palliative care, 47% for asthma care and rehabilitation, 42% for diabetes treatment and cancer management, and 26% for cardiovascular emergencies (144).

It is estimated that a total of 166,830 elective surgeries were cancelled in the Middle East and North Africa region in the 12-week period of peak disruption, which translates to 70.4% of all operations (78% of surgeries for benign disease, 56% of cancer surgery and 30% of all obstetric surgery). The global estimate for cancelled surgeries during the same period was over 39 million, or 72% of all surgeries (145).

In Afghanistan 15% of households stated they were unable to access adequate medical care between April and October 2020, and antenatal care reduced by 21% in 2020 compared to 2019 (9, 61). In Yemen, the number of households reporting difficulty accessing medical care due to COVID-19 increased from 32% to 45% between April and September 2020 (80). In the Syrian Arab Republic, close to half (46%) of surveyed households reported not being able to purchase the necessary medicines in September 2020, and this rate was higher in female-headed households (52%) compared to male-headed households (45%) (80).

Temporary stoppages in immunization programmes across the Region have increased the risk of infectious diseases such as measles and poliomyelitis (146, 147). The estimated decline in child vaccinations due to the COVID-19 crisis in Afghanistan, Iraq and Karachi in Pakistan are outlined Table 3.5. In Karachi, the mean number of daily immunization visits fell by 53% in the early months of the lockdown, and by 27% from 10 May to 6 June 2020 when lockdown had lifted (compared to pre-lockdown). The areas most likely to have the lowest immunization levels during the lockdown were the slums and squatter settlements of Orangi, Baldia and Gadap, and other poor suburbs in Karachi. In these areas, the average number of daily immunization visits decreased by 69%, and in some places the decrease was as high as 90% (148).

Table 3.5. Estimated decline in child vaccinations due to COVID-19 crisis in Afghanistan, Iraq and Pakistan

<table>
<thead>
<tr>
<th>Country/area</th>
<th>Estimated decline in vaccinations due to COVID-19 crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan and Pakistan</td>
<td>50 million children missed polio vaccinations between February and July 2020</td>
</tr>
<tr>
<td>Iraq</td>
<td>300,000 missed vaccinations for children</td>
</tr>
<tr>
<td>Karachi (Pakistan)</td>
<td>53% decrease in mean daily immunization visits (early lockdown months) and 27% decrease (10 May–6 June 2020)</td>
</tr>
</tbody>
</table>

MEASURES TO MITIGATE THE INEQUITABLE IMPACTS OF COVID-19

SOCIAL PROTECTION PROGRAMMES

Most countries in the world have implemented mitigation measures to support their citizens during the COVID-19 pandemic, including cash transfers (conditional and unconditional), suspension of utility and financial obligations (for example, moratoriums or reductions on electricity costs), and ensuring access to essential services (151–153). In the Eastern Mediterranean Region, a range of measures were implemented in countries, territories and areas to protect people most at risk from the impact of containment measures. The assistance offered varied across the Region, and examples are given in Box 3.4.

Box 3.4. Examples of support in the Region

**Bahrain** enhanced social benefits payments for low-income families (78).

In **Egypt**, pensions were increased by 14%, social assistance programmes were extended to an additional 60,000 households, and targeted cash transfers were provided to nearly 1.6 million informal workers. For three months, the Government disbursed a monthly cash transfer to informal workers who were facing income loss as a result of the containment measures (78). The Government expanded coverage under its social assistance programmes, Takaful and Karama (described further in Chapter 5), which enabled more than 1.5 million vulnerable families to benefit from direct cash transfers during the pandemic (78). These programmes mainly target women heads-of-households (133). More than 1 million households received a one-off cash payment of 450–500 Egyptian pounds for three months (133).

The **Islamic Republic of Iran** postponed health insurance, tax and utility payments for a period of three months to ease the economic strain on households; and provided cash payments to the 3 million poorest citizens; and subsidized low-interest loans for 4 million households (78).

**Jordan** implemented a number of tax and social contribution relief measures and expanded the existing Takaful social protection programme to include more households, including informal workers not previously covered. Old-age insurance coverage was expanded, in-kind and material assistance was provided to the elderly and sick, and a temporary cash transfer programme was set up for the unemployed and self-employed (72, 78).

The **occupied Palestinian territory** offered one-off payments to approximately 40,000 labourers in hard hit sectors (construction, tourism, services, transport), and 125,000 vulnerable households received financial assistance (78).

**Oman** introduced measures to provide cash and in-kind support to the most vulnerable households, providing low-income households affected by store closures with a weekly grocery kit of essential commodities (78).

The Corona Relief Tiger Force programme was set up in **Pakistan** to supply food items to those most in need who were affected by COVID-19. Increased relief packages were allotted to labourers, low-income groups, and to the Benazir Income Support Program. The monthly stipend provided by the Benazir Income Support Program was also increased from 2000 to 3000 Pakistani rupees. The Ehsaas and Kafalat programmes provided support and cash assistance to millions of poor families (154).

**Qatar** ensured that all quarantined employees, including expatriates and migrant workers, received their full salaries (78).
UNHCR supported vulnerable refugee households in **Sudan** with a monthly cash grant via ATM cards to support vulnerable families, and refugee households in some areas received food and hygiene packages (155).

Early in the pandemic, **Tunisia** offered free supplies of electricity and running water for two months for low-income and vulnerable households, including disabled and homeless people, retirees receiving a pension below a certain threshold, and the unemployed (78).

Despite the wide range of social protection initiatives, the World Bank warns that many of the cash transfer programmes implemented in the Region fail to reach the poorest households. Fig. 3.14 shows only 3% of the poorest households receive cash transfers in Djibouti. Egypt has slightly higher rates, yet only 17% in the poorest quintile receive cash transfers (72).

**Fig. 3.14 Share of population receiving cash transfer in Djibouti, Egypt and Tunisia, by income quintile, 2020**

![Graph showing share of population receiving cash transfer]

**Notes:** Data are from phone survey reports in countries in the Middle East and North Africa region, collected by the World Bank during the first half of 2020. The quintile breakdown is by household assets in Egypt, by income in Djibouti (the top quintile is not covered by the survey), and by consumption in Tunisia.

*Source: Arezki et al. (2020) (72).*

In addition, more targeted support is needed to ensure women can retain their jobs or re-enter the labour market. Globally, only one in five labour market, fiscal and economic social protection measures strengthen women’s economic security or support unpaid care, despite women being more likely to lose jobs and working hours compared to men (72, 156).

Investment in social protection programmes also contributes to economic recovery. ILO estimate the larger the fiscal stimulus package (as a percentage of GDP) the lower the working-hour losses: “an increase in fiscal stimulus by 1 per cent of annual GDP would have reduced working-hour losses by 0.8 percentage points in the second quarter of 2020 … [t]his also suggests that the comparatively smaller stimulus programmes in low and middle-income countries … may account for at least part of the large working-hour losses estimated for those countries” (88).
CHAPTER 3 | COVID-19 AND INEQUITIES

THE UNITED NATIONS AND NONGOVERNMENTAL ORGANIZATIONS

In addition to funding social protection programmes, United Nations agencies and nongovernmental organizations provided a range of policies and assistance to help populations during the pandemic. In the Eastern Mediterranean Region, expenditure on social protection is low (as described in Chapter 5).

In the Region humanitarian agencies are faced with multiple and increasing humanitarian crises, rising poverty levels and higher demands on humanitarian assistance. In Afghanistan in 2020, the number of people requiring humanitarian assistance increased to 18.4 million, which was close to a 100% increase in a single year (157). At the same time as the number of people needing humanitarian assistance is increasing, the amount of international funding is declining. In 2019, global international humanitarian assistance fell from US$ 31.2 billion to US$ 29.6 billion (158).

In 2019, UNICEF’s Middle East and North Africa region received US$ 830 million and this fell to US$ 560.2 million in 2020 (159). UNICEF had quadrupled its estimated funding requirement of Humanitarian Action for Children in the Middle East and North Africa for 2020, as funding shortfalls were expected to be among the highest of all regions. UNICEF’s Humanitarian Action for Children funding for the North Africa and Middle East region aims to “support access to continuous education, social protection, child protection, and gender-based violence services” (72). In particular, going into 2021, UNICEF is prioritizing the needs of children in Afghanistan, Somalia, Sudan, the Syrian Arab Republic and Yemen, as well as Syrian refugee children in host countries. UNICEF has highlighted that Yemen represents the largest humanitarian crisis in the world but received only 18% of the requested US$ 535 million funding.

Across the Region, UNHCR provided essential support during the COVID-19 pandemic, including cash transfers and hygiene packages to the most vulnerable populations (160). In Somalia, UNHCR installed 48 handwashing stations in front of hospitals, health centres and reception centres (161). In Sudan, UNHCR delivered over 3.8 million bars of soap to refugees, IDPs and vulnerable Sudanese citizens in 2020 (162).

Box 3.5 gives examples from the Region of additional support provided by faith-based organizations during the COVID-19 pandemic.

BOX 3.5. Initiatives by faith-based organizations during the pandemic

Faith-based organizations continued to provide aid in the Region during the COVID-19 pandemic. Muslim Aid emphasizes water projects in Pakistan, including providing handwashing facilities, and distributed PPE for health workers, food packages and personal hygiene kits. Muslim Aid Somalia used social media to improve public awareness of social distancing and hygiene measures. In the Gaza Strip, Muslim Aid continued funding existing water, sanitation and hygiene programmes and raised awareness via social media, similar to efforts in Somalia (163). In the Syrian Arab Republic, Islamic Relief provided medical items and training to 70 health facilities in the northwest of the country (164).

COVAX FACILITY AND VACCINATIONS IN THE REGION

By the end of 2020, a number of COVID-19 vaccines had been approved for use in countries of the Region, although their availability is uncertain even in high-income countries. To ensure equitable access, vaccines need to be affordable to low- and middle-income countries and those experiencing humanitarian crises and conflict. In all countries, it is essential that vaccines are available to the most vulnerable populations including refugees and IDPs, who should be fully incorporated into national planning processes (165). GCC countries began vaccinating their populations in December 2020, and Egypt announced major deals to secure vaccines (166).

Many countries in the Region (excepting GCC countries) will depend on the COVAX Facility for allocations of the COVID-19 vaccine. The COVAX Facility will procure COVID-19 vaccines to ensure fair and equitable access to vaccines for all participating
countries. The status of COVAX participation in the Middle East and North Africa, as at 4 January 2021, is shown in Table 3.6. Eleven countries in the Eastern Mediterranean Region have made commitments to the COVAX Facility, and the United Arab Emirates has indicated their intention to participate (166, 167). Afghanistan, Egypt, Morocco, the occupied Palestinian territory, Pakistan, Somalia, the Syrian Arab Republic and Yemen are among the 92 low- and middle-income countries who are eligible to have their participation in the COVAX Facility supported by the Gavi COVAX Advance Market Commitment (167).

Table 3.6. COVAX Facility participation status in the Middle East and North Africa, by country, as at 4 January 2021

<table>
<thead>
<tr>
<th>Eligible for Advance Market Commitment</th>
<th>Commitment agreement</th>
<th>Intention to participate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>Bahrain</td>
<td>United Arab Emirates</td>
</tr>
<tr>
<td>Djibouti</td>
<td>Iran (Islamic Republic of)</td>
<td></td>
</tr>
<tr>
<td>Egypt</td>
<td>Iraq</td>
<td></td>
</tr>
<tr>
<td>Morocco</td>
<td>Jordan</td>
<td></td>
</tr>
<tr>
<td>Occupied Palestinian territory</td>
<td>Kuwait</td>
<td></td>
</tr>
<tr>
<td>Pakistan</td>
<td>Lebanon</td>
<td></td>
</tr>
<tr>
<td>Somalia</td>
<td>Libya</td>
<td></td>
</tr>
<tr>
<td>Sudan</td>
<td>Oman</td>
<td></td>
</tr>
<tr>
<td>Syrian Arab Republic</td>
<td>Qatar</td>
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<td>Tunisia</td>
<td>Saudi Arabia</td>
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<td>Yemen</td>
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The allocations are expected to cover 20% of the population by the end of 2021, with no country being able to receive doses for more than 20% of the population until all of the countries in the financing group have been offered the same (168). By the end of February 2020, over 37 000 vaccine doses reached the occupied Palestinian territory and close to 94 000 doses reached Tunisia (169). There is also the intention to provide additional supply for higher coverage in 2022 (166). Recurring outbreaks are likely in countries with low levels of vaccination. Many countries in the Region are also looking to procure additional vaccines through bilateral agreements with the manufacturers to cover the remaining percentage of their population (for example, Pakistan).

It is essential that international assistance for the supply of vaccines and for logistics around distribution are provided to low-income countries. For instance, some of the COVID-19 vaccines require ultra-cold chain storage temperatures of below -80°C and many low-income countries, including those in the Region, lack the required infrastructure to facilitate this (170).

Meanwhile, it is essential to prepare for national vaccination programmes. There is an essential requirement and an opportunity for governments to address and reduce vaccination hesitancy, particularly among the most vulnerable populations. The experience of the United Kingdom has shown that during the first few weeks of the COVID-19 vaccination programme, minority ethnic communities were less likely to attend vaccine clinics (171). At the end of 2020, a poll of 15 countries in Africa, including Sudan and Tunisia, by the Africa Centres for Disease Control and Prevention, found the majority (79%) of respondents would take a COVID-19 vaccine “if it were deemed safe and effective” (172, 173).
BUILDING BACK FAIRER IN RESPONSE TO COVID-19

Although the numbers of deaths and infections from COVID-19 have been relatively low in the Eastern Mediterranean Region compared to other regions, the economic impacts have been extremely damaging and will widen income inequities and increase health inequities. Urgent action is needed in all countries to support disadvantaged groups who are faced with increasing poverty, destitution, hunger and ill health. The actions taken to support the most disadvantaged and vulnerable people through the pandemic need to be retained and scaled up. While many actions have been supportive, they are intended to be short term; however, many of the programmes should be retained even when the immediate COVID-19 health crisis abates, such as increased pensions for those on low incomes, targeting women heads-of-households, cash transfers to those on the lowest incomes and social protection for informal workers. This Commission makes relevant recommendations which will allow more equitable social and economic development and reduce unfair and inequitable health. These provide an agenda for building back fairer.

The pandemic has bought inequities to the forefront of public and political consciousness, which should directly translate into action to reduce these inequities. The whole-of-government and whole-of-society approaches that have been necessary to contain the pandemic can continue into plans for recovery and building back fairer. The pandemic has also demonstrated that protecting health is the highest priority for the public and should be the highest priority for governments. As we set out in this report, economic growth has been the driving concern of many governments, but economic growth should be considered as an ambition in order to achieve greater health for the whole population. Social and economic policies which are inimical to that should be reworked, so that greater health equity is at their centre. The agenda for action set out in this report will allow significant progress towards that goal and towards greater health equity in the Region. In Morocco, for example, the Government is developing a recovery plan that accelerates inclusive growth, including providing health coverage for all Moroccans within a five-year timeframe, expanding social welfare and reforming state-owned enterprises (174). Morocco has identified integrating the informal sector into the economy as a strategic pillar of its post-crisis recovery strategy (78).

Going forward, multisectoral and whole-of-government responses to the pandemic are important for longer term efforts to reduce health inequities. Newly established collaborations, multisectoral policies and governance arrangements can bring positive learning for action on the social determinants of health. Box 3.6 gives an example of policy efforts in Tunisia to balance post-COVID-19 economic growth with social equity.

Box 3.6. Reducing inequities to protect health in Tunisia

Tunisia passed a draft “social and solidarity economy” law in June 2020. The new law aims to balance economic growth and social equity by promoting equitable co-existence of public, private and social economy institutions (175). It also seeks to promote economic and social inclusion of disadvantaged and marginalized populations, including those living in isolated rural areas and unemployed youth, by encouraging them to associate in cooperatives, mutual organizations or self-help groups that can help to improve livelihoods and create jobs (176). The law aims to reduce COVID-19 transmission and mortality through reducing socioeconomic inequities (176, 177).
The pandemic is an opportunity to envision a more inclusive and sustainable economy. A green recovery has higher economic multipliers than the business-as-usual model of “brown” growth. Options include “investing in natural capital for terrestrial, marine, and coastal ecosystem resilience; restoration of carbon-rich habitats; resource efficiency; integrated land management systems; sustainable agriculture; and clean energy production are the prime policies for green growth” (178). Low oil prices will increasingly affect the capacity of many countries in the Region to respond to the COVID-19 pandemic. Oil demand is not expected to recover to pre-pandemic levels in 2021 (72). As the United Nations have stated, for countries dependent on oil revenues, low oil prices “underscore the urgent need to expedite diversification efforts to expand their sources of revenue beyond oil and embark on low-carbon development” (74).

COVID-19 infection and mortality are profoundly inequitable. Our first recommendation is to reduce these inequities through immediate reductions in inequities in exposure to COVID-19. One way to do this is through appropriate communication in areas and communities that do not have good access to information – including communication through pharmacies and community workers in rural and urban areas. We also propose introducing immediate measures to reduce transmission at scale, such as improving access to water and sanitation for hygiene in places that currently lack such facilities, including all schools and refugee and IDP settlements.

Secondly, this chapter shows that implementing the agenda and recommendations in all the areas covered in this report will not only help to reduce inequities in infection and mortality from COVID-19 – it will also reduce inequities in other health conditions. Taking these actions is essential for an equitable pandemic response and for building back fairer in the Eastern Mediterranean Region. In addition, we propose that specific and immediate attention is given to nutrition and mental health – populations have suffered immensely in both these areas during the pandemic.

Equitable acquisition and delivery of vaccines is a priority for countries in 2021–2022 and consideration must be given to prioritizing those most exposed and at risk of infection and mortality, including frontline health workers, those working and living in crowded conditions with low access to adequate washing facilities, and those most at risk due to pre-existing health conditions. Richer countries must help to fund and secure vaccinations for less wealthy countries in the Region.

SUMMARY AND RECOMMENDATIONS

While the pandemic has caused a health and health equity crisis and is amplifying existing social, economic and health inequities in countries, it has also made existing inequities more visible and provided opportunities to do things differently and build back fairer. Infection and mortality from COVID-19 relate to occupation, income, living conditions and prior health as well as to gender and age, and in consequence
### Recommendations

1. **Reduce inequities in infection and mortality by addressing the underlying causes of inequities and taking steps to minimize inequities in exposure.**
   - Intensify communication about COVID-19 risks in informal settlements, IDP and refugee camps, rural areas and among migrant workers. Work with communities to develop communication plans and use pharmacies and community workers to disseminate information.
   - Urgently ensure sanitation, hygiene, access to clean running water and soap in all IDP and refugee settlements and schools.
   - Improve migrant workers’ accommodation, reduce crowding, improve ventilation and ensure access to clean running water. Provide free testing and transportation to testing sites for migrant workers.

2. **Mitigate the unequal impacts of containment measures on unemployment, income, hunger and gender equity.**
   - Develop and implement plans to build back fairer based on this report.
   - Ensure emergency social protection and nutrition support to include everyone with low incomes in every country (not just those on the very lowest incomes) and provide financial support to quarantined workers.
   - Take steps to reduce the increased incidence of mental illness and expand access to mental health services.

3. **Implement equitable vaccination programmes.**
   - Develop equity-driven national vaccine roll-out plans with consideration of risk of exposure.
   - Wealthier countries should help secure and fund vaccinations for lower-income countries in the Region and promote cooperation, particularly through mechanisms such as the COVAX Facility.
   - Prioritize actions to reduce vaccination hesitancy.

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<tr>
<th>Recommendations</th>
<th>Relevant SDG targets</th>
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<tr>
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<td>hunger and gender equity.</td>
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