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THE COVID-19 CRISIS AND HEALTH INEQUALITY

2023

A reciprocal magnification effect in the Arab region

Farah Al Shami

Senior Fellow – Arab Reform Initiative (ARI)
Former Program and Research Officer – ANND

This report is published as part of the Arab NGO Network for Development's Arab Watch Report on Economic and Social Rights (AWR) series. The AWR is a periodic publication by the Network and each edition focuses on a specific right and on the national, regional and international policies and factors that lead to its violation. The AWR is developed through a participatory process which brings together relevant stakeholders, including civil society, experts in the field, academics, and representatives from the government in each of the countries represented in the report, as a means of increasing ownership among them and ensuring its localization and relevance to the context.

This 6th edition of the AWR focuses on the Right to Health. The AWR 2023 on the Right to Health is a collaboration between the Arab NGO Network for Development and the Faculty of Health Sciences at the American University of Beirut. Through this report we aim to provide a comprehensive and critical analysis of the status of the Right to Health in the region and prospects in a post COVID-19 era. It is hoped that the information and analysis presented in this report will serve as a platform to advocate for the realization of the right to health for all.

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Farah Al Shami

Senior Fellow – Arab Reform Initiative (ARI)
Former Program and Research Officer – ANND

Farah Al Shami is a development economist. She is currently a Senior Fellow at the Arab Reform Initiative (ARI), leading ARI's social protection program. She has eight years of experience, working with CSOs, academic institutes, and UN entities on advancing policy reforms in the Arab region. Her areas of expertise include conducting and managing interdisciplinary research, coordinating national and international advocacy efforts, facilitating professional consortia/communities, and leading capacity-building programs. She holds an MA in Policy Economics from Williams College (MA-USA), an MA in Economics from the American University of Beirut, and a BS in Economics from the Lebanese American University.

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INTRODUCTION

Following the outbreak of the COVID-19 pandemic, the Arab region witnessed an exponential rise in health outcome disparities. The severity of the COVID-19 pandemic was magnified by existing inequalities in chronic diseases and inequities in the social determinants of health. The outbreak of the COVID-19 pandemic in 2019 caused drastic decays in employment, healthcare, education, economic activity, and welfare schemes in the Arab region, all while disproportionately affecting the poorest and the most vulnerable social groups (Kamurase & Willenborg 2021). Being in large part a sanitary crisis, the impact of the pandemic was primarily apparent on health systems and has especially deepened and accelerated health inequality. This translated into uneven infection and mortality rates, uneven access to medical facilities, hospital beds, testing centers and vaccination, as well as discrepancies in the quality of treatments, the competency of medical staff, and the cost burden borne by different social groups, with a direct impact on the right to health (Filip et al. 2022).

The link between income inequality and health inequality was further reinforced by the COVID-19 pandemic. Individuals with lower income often face barriers to accessing quality healthcare such as mobility difficulties and financial constraints, leading to disparities in health outcomes (Kawachi & Kennedy 1999). During the pandemic, these disparities were intensified as individuals with lower income, among others, were more at risk to be exposed to the virus due to correlated occupations or living conditions, and had limited access to healthcare and resources for both prevention and treatment. The pandemic, in turn, worsened income inequality by causing widespread job losses, business closures, and economic downturn, disproportionately affecting the poor. Indeed, the pandemic resulted in approximately 8.8 million people losing their jobs in the Arab region, which further exacerbated economic disparities. Moreover, the pandemic led to an unprecedented increase of 1.3% in the unemployment rate in non-GCC Arab States and left more than 39 million individuals in the region working in hard-hit sectors (Dewan et al. 2022; Abu-Ismail et al. 2021). Notably, the wealthiest 10% of the population now possess 81% of the region's total wealth, compared to 75% of wealth prior to the pandemic (ESCWA 2022a). In addition, in 2020, Bahrain, the United Arab Emirates (UAE), Yemen, the

Kingdom of Saudi Arabia (KSA), Oman, and Kuwait have joined the 20 most unequal countries in the world, which only included Lebanon and the KSA in the previous year (ESCWA 2022b).

Inflation also jumped to high levels in many countries like Sudan (269.3%), Lebanon (150.4%), Yemen (45.0%), and Libya (22.3%), largely due to the pandemic (Dabrowski & Domínguez-Jiménez 2021). Yet, the pandemic overlapped with many other protracted and compounding crises in the different Arab contexts, such as the economic and financial crisis and the August 4 Beirut Blast in Lebanon, the political "de-transition" following Kais Saeid's self-coup in July 2021 and the inception of a monetary predicament in Tunisia, the economic and currency crisis in Egypt, the water crisis and its subsequent economic volatility in Iraq, as well as the renewal of conflict in regional hotspots. These developments were coupled with economic fluctuations with severe socio-economic repercussions, especially since they were accompanied by an increased cost of living and a wave of subsidy lifting, affecting the price of fuel, food, and medicines due to exhausted public budgets and depleted foreign reserves, which further accentuated inflation and deteriorated people's purchasing power amid the loss of jobs and livelihood opportunities (Nehmeh/نعمة 2021). While this makes it hard to disentangle the impact of the pandemic on social justice and inequalities, it reinforces the notion of increased inequalities in the aftermath of COVID-19, and especially increased health inequality given its proxy relationship with wealth and income inequality.

BETWEEN THE NATURAL AND THE DELIBERATE: HEALTH EQUALITY IN LIMBO

A ONE-DIMENSIONAL RESPONSE, A SHORT-SIGHTED APPROACH

Arab States dealt with the pandemic as merely a health and sanitary crisis, instead of considering it as an economic crisis as well, thus inadvertently overlooking its socio-economic repercussions. Amidst the crisis, the region's average social spending accounted for only 4.6% of total GDP, in stark contrast to the global average of 12.9% of GDP (International Labour Organisation [ILO] 2021). Therefore, while a multitude of economic indicators, such as inflation, poverty rates according to multidimensional indices, unemployment, the deterioration of the business environment, and the striking business closures emerged as telltale signs of an economic crisis, many Arab States exhibited a continuity instead of a rupture in their economic policies and models at large (Ghannouchi 2021; Awad et al. 2021). Regrettably, this approach further magnified the detrimental impact of the pandemic on the right to health, intensifying health inequalities. One-dimensional measures that focused primarily on health overlooked the multifaceted nature of the crisis and the intricate interconnections between livelihoods, income security, welfare, and access to healthcare, treating the health crisis as if it was mutually exclusive from an economic crisis. This counter-intuitive approach was a manifestation of the State institutions' weak preparedness to crises and emergencies, and of the States' socio-economic paradigms that predated the crisis. It also constituted the main factor hindering the effective mitigation of the crisis' consequences.

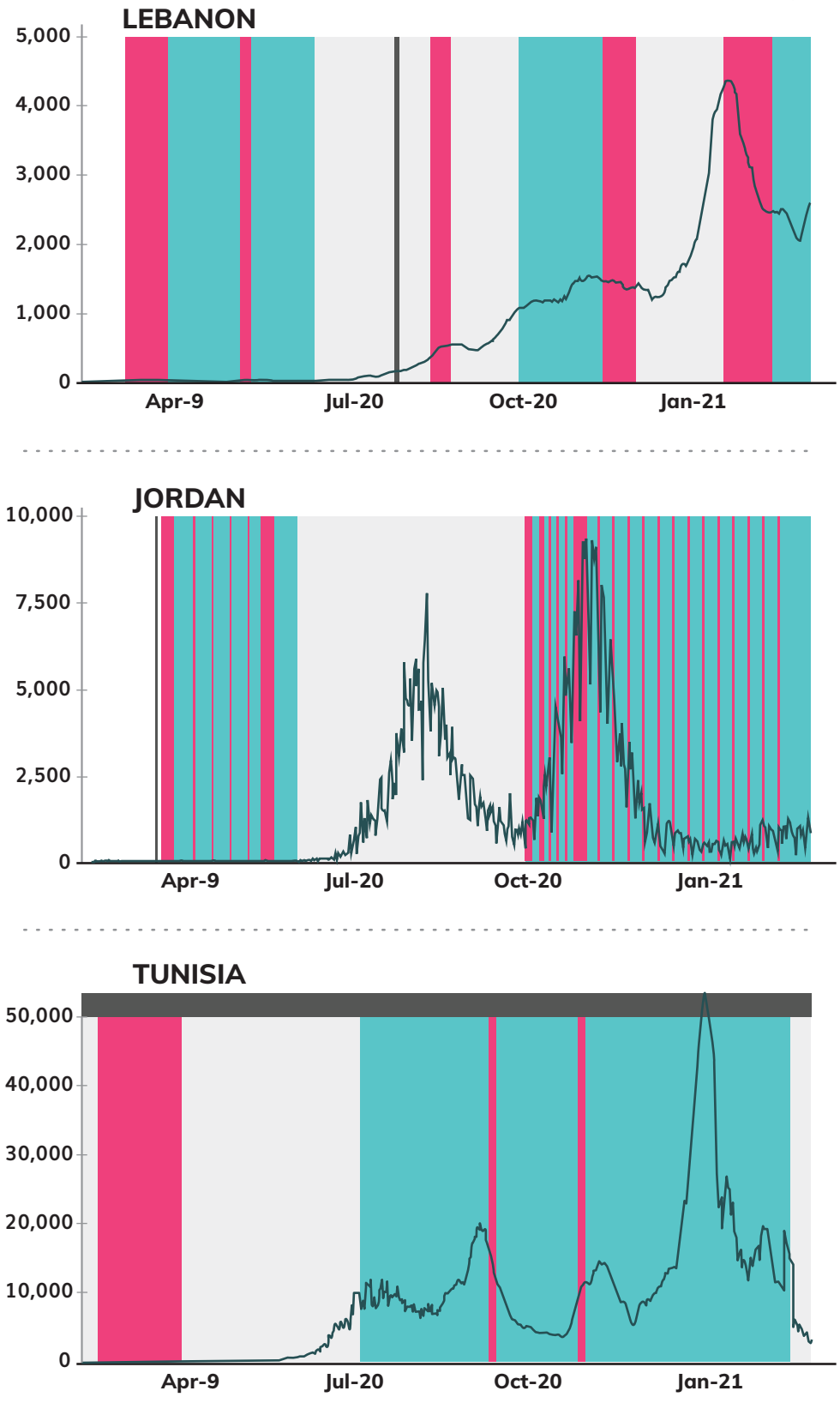
Remarkably, the average total expenditures on health in the Arab region during the pandemic accounted for a mere 3.2% of total GDP, which is significantly below the global average of 5.8%, despite considering COVID-19 to be a health crisis. This disproportionate allocation is further emphasized by the fact that the region spent 5.4% of its GDP on military expenditure, on the other hand (ILO 2021). Even more, subsidy lifting across the region and socially-insensitive attempts such as the one in Jordan, which consisted of making changes to the social security law and shifting to a "modern government" through

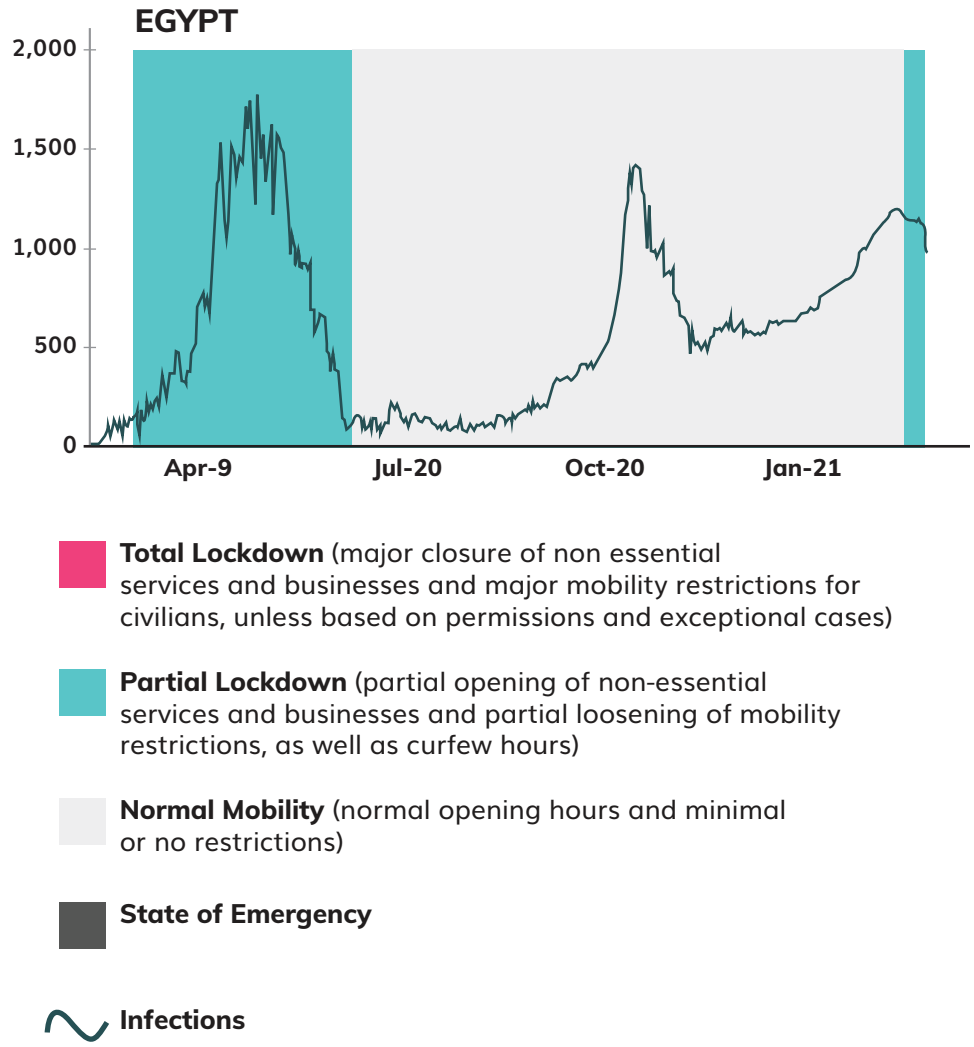
the abolishment of the Ministry of Labor during the pandemic, lend further proof to how flawed the responses of some States were. This reflects a misguided perception of the pandemic that overlooks the need for a comprehensive support and protection system by the States to their people. However, failure to adequately compensate individuals for the loss of jobs and livelihoods due to these restrictive measures immensely exacerbated these health disparities (Nehmeh/نحمة 2021).

Even when viewed as a health response, the measures taken during the pandemic were ill-suited to address "a health crisis" effectively, thus making access to quality healthcare limited and a privilege for the few, for several reasons. The absence of adequate, quality public healthcare and the prevalence of ineffective, non-inclusive social protection systems in several countries in the region, resulted in discrepancies in access to healthcare across income levels. While those with lower incomes were often unable to afford proper, high-quality medical care during the pandemic, the affluent could either protect themselves or overcome the limited capacity of public and even private medical centers by paying for required medical attention and care at home. The affluent were also often able to afford frequent PCR tests as well as blood and radiology tests prior, during, and after a COVID-19 infection episode, thus increasing their chances of survival compared to those who did not have the same financial means (Jamal & Robbins 2023). Studies showed that severe complications were not only determined by age, genetic predisposition, and biological risk but by pre-existing inequities along socioeconomic backgrounds, immigrant statuses, and racial/ethnic lines, bringing to the fore questions related to the link between the right to health and vulnerability in the face of an unexpected crisis (Mishra et al. 2021).

Furthermore, in many Arab contexts, the health response took on a militarized nature, particularly in countries such as Egypt, Jordan, Lebanon, and Tunisia, where total or partial lockdowns and several episodes of State emergency were implemented (Hoffman 2020; Oxford Analytica 2020). As per **Figure 1** below, such securitized measures were frequently imposed and did not coincide with upsurges in infection rates. Instead, lockdowns and curfews considerably coincided with protests and social upheavals, thus indicating their usage by States as tools to repress social movements and food riots (Houry 2020).

Figure 1. Lockdown versus infection timelines during COVID-19





Source: Figures retrieved from the Arab Region Hub for Social Protection's website (2022)

POWER AND PROFIT OVER PEOPLE: AN INEFFECTIVE RESPONSE

The level of preparedness across Arab health systems varied, rendering some systems more vulnerable to collapse or shocks like COVID-19 than others. The unequal level of susceptibility was attributed to factors encompassing the resilience of the health infrastructure, from hospitals to medical equipment and health technology, as well as numerous economic, financial, and social variables. For example, prior to the virus outbreak, the average number of hospital beds per 1000 inhabitants was only 1.5 (World Bank 2023). Consequently, the demand for inpatient care necessitated innovative alternatives, such as referring some supposedly in-patient cases to out-patient care modalities or even residential care, with individuals resorting to

personal oxygen generators and self-administering intravenous treatments, which are monopolized by a few private suppliers at overpriced rates. This was especially the case in countries that could not rapidly establish specialty field hospitals or turn public lands into dedicated field facilities, like Lebanon (Haldane et al. 2021). Furthermore, inequalities among medical staff were observed in several countries in the region, ranging from employment hierarchies to disparities between the private and public health sectors' personnel, and comprising variations in qualification, remuneration, access to protective gear, and reception of COVID-19 relief and benefits. Additionally, significant gaps in the coverage of cancer treatment, chronic, and cardiovascular diseases by public health institutions and existing social protection schemes persisted despite the heightened vulnerability to the virus by those with chronic illnesses (Isma'eel et al. 2020). Similar limitations were observed in addressing mental and psychological disorders, despite a drastic increase in such cases during the pandemic, thus further compromising patients' resilience against the virus (Mourani & Ghreichi 2021).

A key reason behind this bleak situation is that healthcare is significantly privatized in the Arab region, and so are health insurance systems (Aïta 2022). Nonetheless, the private sector was unable to accommodate the increased need for healthcare and to treat all citizens and residents equally, therefore highlighting the importance of solid and universal health systems both in disaster management and at baseline. The privatization of health services exacerbated inequality during the pandemic in several ways. First, privatized healthcare services are often more expensive than public healthcare, making them inaccessible to many low-income individuals and exacerbating existing health inequalities. For example, in countries like Egypt where private health centers were allowed to conduct PCR tests, major discrepancies were seen in the pricing across the country. For instance, the test costed between 1,000 and 2,000 Egyptian pounds (in the period spanning end of 2020-mid 2022) (EIPR 2021). Second, privatized health systems may prioritize profit over public health, especially with the lack of corporate social responsibility frameworks, like in the great majority of Arab countries, and in the midst of systematically poor regulatory quality. This leads to inadequate funding for public health measures such as vaccine distribution and testing programs. Third, privatized healthcare facilities may be less equipped to handle surges in demand during pandemics as they focus on profit rather than inclusive public health. This can lead to long waiting times,

intensify nepotistic and clientelist practices, and result in insufficient care for those who are unable to afford substantial out-of-pocket expenses. Finally, the privatization of healthcare can entail a lack of adequate coordination and communication between public and private healthcare providers, which can further exacerbate data centralization and management issues, worsen health inequalities, and widen gaps in the overall healthcare systems (Asfour & Jabbour 2020). As such, while neoliberal policies were shifting resources all along from public to private hospitals, private hospitals often refused to take infected cases at the beginning of the pandemic and the poorly financed public health sector bore the much heavier brunt of the crisis.

The privatization of healthcare in Arab countries manifests in various subtle and indirect ways such as geographic imbalances. Hospitals, both private and public but especially public, are rare and unevenly distributed across geographic areas in Arab countries, deepening the core-periphery and rural-urban dichotomies and mirroring the centralization of governance and development (Bajec 2020). Lebanon, Iraq and Egypt are illustrative of this picture. Despite this, even after the pandemic hit and in the middle of the crisis, deliberations to shift the health model in Egypt from free healthcare to a privatized model, following the Port-Said pilot model, were underway (Gad 2022). Such models and shifts can only increase the reliance on private health facilities and insurances, which only the wealthy can afford. Not only do insurance companies lack the corporate social responsibility frameworks that are necessary for the inclusion of cancer, cardiovascular, and mental and psychological illnesses, they likewise enjoy a striking degree of poor regulatory quality and have no social accountability to the extent that they could omit any COVID-19-related coverage amid the global health crisis. This forced all COVID-19 patients who could not access healthcare through overwhelmed public facilities to seek treatment through private ones, with the latter charging patients on a full out-of-pocket basis. Knowing that private health facilities were also overwhelmed during peak COVID-19 infection waves, this restricted the options for the majority of those who caught the virus and needed medical attention – especially before the vaccine roll-out phase (Abi Rached et al. 2020).

The scarcity of health services during the pandemic put to the fore the importance of a well-established, well-functional, efficient, inclusive, and universal public health system, with an enhanced capacity to accommodate increased demand during

health emergencies. However, it also exposed the deficiencies in the quality of medical care and competencies in existing public health systems in many Arab countries, just like it exposed their relatively limited capacity. In addition to issues of availability of medicines, equipment and hospital beds, the issue of medical staff migration from the public to the private sector (just like their migration abroad) was remarkable. Inequality in medical staff competence between private and public sectors – to the disadvantage of the latter – was evident in the difference in the protocols adopted between the two sectors. In countries like Lebanon and Iraq, these lingering problems and disparities contributed to significantly higher mortality rates due to COVID-19 which were significantly higher in public hospitals compared to private ones (Isma'eel 2020). Nevertheless, the pandemic did not trigger any serious attempts to invest in and improve public health systems, which goes back to a lack of political will to do so, not only because of exhausted public budgets, depleted foreign reserves, irrational government priorities, and misappropriations and embezzlements of public resources, but also because public health is one of the strongest tools in the hands of clientelist and sectarian governments (Tabaqchali 2020). Never-ending wait lists, having to pay bribes, and resorting to cronyism are characteristics of a system normalized by governments in the region, whereby the political class tends to use public health systems (or the provision of services through these systems) to indirectly force the disenfranchised and desperate who have no other recourse to join their constituency bases (Di Peri 2020).

These power dynamics were also witnessed on the level of access to the COVID-19 vaccines, which is a reflection of global inequality as well. Northern countries had access to patents and resorted to bilateral agreements with big pharmaceutical companies to get the COVID-19 vaccines, which undermined multilateral agreements that can provide or aim at providing a more inclusive coverage, thus violating the World Health Organization (WHO)'s Equitable Allocations Framework and the Access to COVID-19 Tools Accelerator (COVAX ACT). As for countries of the global South, most of them were refused patents to produce the vaccines or did not have the ability for such production. Some of them are part of the World Trade Organization (WTO) or the European Union-Deep and Comprehensive Free Trade Agreements (EU-DCFTAs), such as Tunisia and Morocco. These free trade agreements entail a binding "TRIPS" component on intellectual property rights, which has a degree of flexibility that the whole world should have benefited from to allow for the production of the vaccines

beyond the monopolizing big pharmaceutical firms and to open space for more affordable generic productions – like what was the case with the therapeutics of HIV, Hepatitis C, and Tuberculosis – to meet global needs at more affordable rates. Non-GCC Arab countries were victims of this model (Egyptian Initiative for Personal Rights [EIPR] 2020). This considerably slowed the vaccine roll-out in many countries, and prevented the vaccine from being free for everyone in some contexts, including Egypt (EIPR 2021).

THE HARDEST HIT POPULATIONS: BEYOND EXPECTATIONS

COVID-19 infection rates were expectedly highest among the poorest, as they had disproportionately low access to masks, sanitizers, frequent tests, and in some cases the vaccines, medicines, and treatments. The most vulnerable social groups that are typically marginalized during crises and shocks were indeed the most affected, namely children, women, youth, the elderly, LGBTQ+ communities, rural populations, the urban poor, informal workers, refugees, and people with disabilities, among others (Nehmeh/نعمة 2021). Working women, apart from their initial gender-based vulnerabilities, had to shift to remote working and – at the same time – provide extra care for their families at home, thus having to juggle two careers and endure a wide spectrum of challenges. Many women and LGBTQ+ people could not afford reproductive healthcare or even access menstrual hygiene products and contraceptives. Increased gender-based violence during lockdowns aggravated this problem, to the extent of increasing unwanted pregnancies and sometimes abortion (McGrail et al. 2022). Migrant domestic workers also faced accentuated vulnerability as did precarious workers that are not necessarily informal, but semi-formal or even formal. For example, offline and especially online/platform gig workers who operate on a zero-hour contract, on-demand basis – the numbers of whom surged with digitalization during the pandemic – faced harsh work conditions and lack of social protection when they needed it the most (Alsahi 2020; Maktabi et al. 2022).

More importantly, the pandemic also intensified the vulnerability of people living in slums and informal settlements, under highly unsanitary environments, urban populations who are more exposed to air pollution and are therefore more susceptible to respiratory diseases such as COVID-19, people initially suffering from respiratory diseases, the elderly who are relatively more susceptible to the virus, etc. Notably, workers in

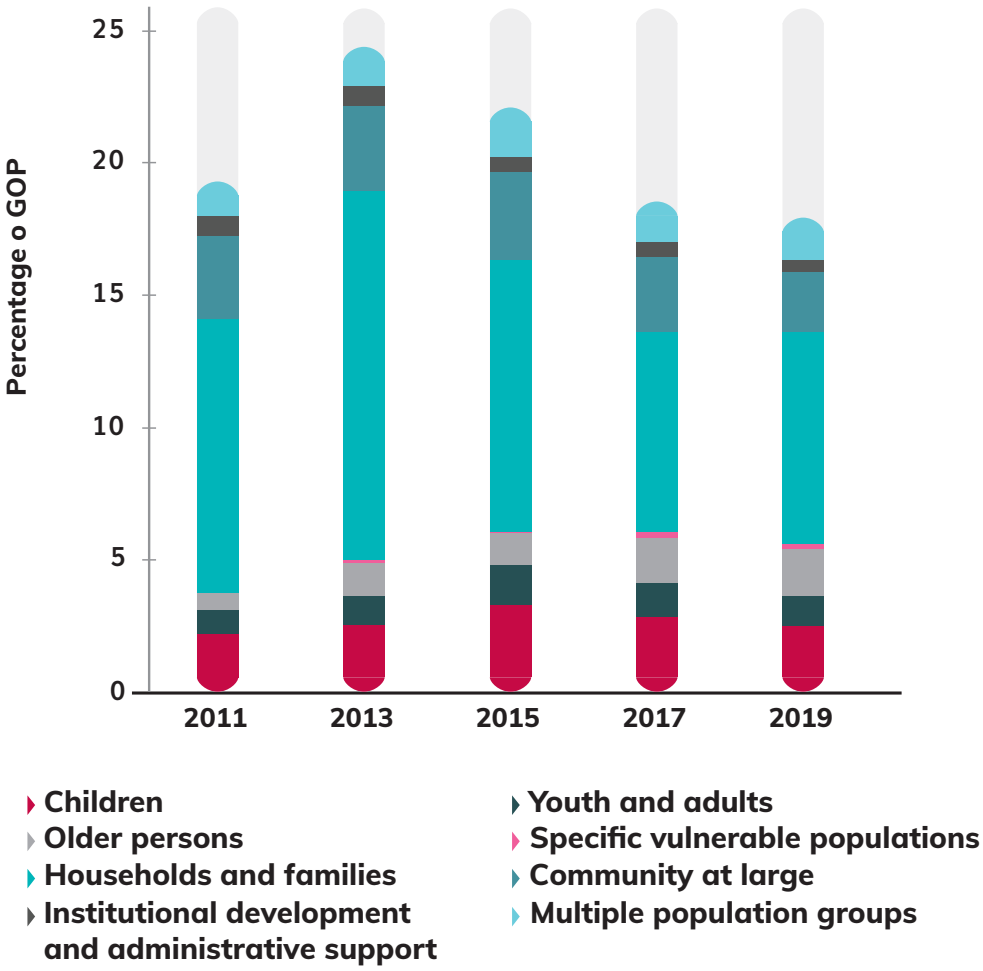
the informal sector were found to be better off in that they had the privilege to circumvent lockdowns, curfews, and business closures as they work independently from any registered employer. Moreover, in Egypt, for example, key government decisions aimed at supporting women through the pandemic were restricted to public sector employees and excluded the private sector. Thus, women working in the private sector, although usually perceived as being better off, were more affected by the crisis than those working in the public sector (Al-Shami 2022).

The pandemic's heterogeneous impact on Arab societies stems from the specificities of the crisis itself as well as the various vulnerable social groups, on one hand, and the fact that vulnerability is a fluid term and a continuously changing phenomenon, which cannot always be captured by typical definitions and indicators, as dictated by international organizations that adopt colonial methodologies, on the other (Al-Shami 2022). However, it is worthwhile to note that, while some social groups benefited from the pandemic and others were harmed by its repercussions, the net social impact of this historical episode was negative, reflecting an overall pattern where the rich got richer or were less affected, and the poor became poorer or were more affected (Nehmeh/نعمة 2021).

COVID-19 responses have left many behind because of the status quo that predates the pandemic and the ineffective redistribution mechanisms of public resources, if they exist. UN-ESCWA's Social Expenditure Monitor for Arab States affirms that personal and corporate income taxes are low in most middle-income Arab countries compared to other kinds of tax that are less redistributive (such as the VAT). The Monitor, as per **Figure 2** below, also demonstrates that the largest share of social expenditure is targeted at households and families, although with a downward trend across the years. It shows as well that youth, children, older persons and other specific vulnerable groups benefit from a relatively smaller share of social expenditure despite being the most in need (Sarangi et al. 2022). The Monitor's results are further validated by ILO's data (2021), which indicates that, in Arab States, only 40% of the population are covered by at least one social protection benefit, 15.4% of children, 12.2% of mothers with newborns, 7.2% of persons with severe disabilities, 8.7% of the unemployed, 24% of older persons, and 63.5% of workers in case of work injury (ILO 2021). The latter number indicates that social protection systems in the Arab region are predominantly employment-based, which goes back to the absence of the needed social protection floors that provide universal health

coverage and minimum income security to all through a combination of contributory and non-contributory social assistance schemes. Arab governments have, among other practices, had cold feet to establish such floors since these floors fundamentally challenge the complex political-economy on which political regimes survive, which is characterized by clientelism (as described previously) and political redlines that exclude specific vulnerable groups like migrants and LGBTQ+ people. The disproportionate impact of these practices rendered only 32.2% of vulnerable persons covered by social assistance in the region (ILO 2021).

Figure 2. Distribution of social expenditures among different social groups



Source: Figure retrieved from UN-ESCWA's Social Expenditure Monitor for Arab States (2022)

During the pandemic, international organizations and humanitarian actors had to step in to offset the absence of the State (El-Jardali 2020). Amid one of the most severe

humanitarian crises in recent history, social protection therefore took the form of mere humanitarian relief that does not complement a baseline of universal social protection coverage. In the best-case scenario, it took the form of social safety nets such as Lebanon's Emergency Social Safety Net program (ESSN) and the national aid fund expansion programs in Egypt (expansion to Takaful and Karama) and Jordan (the Takmeely Support Program). These interventions are poverty-targeted and use proxy-means testing as a targeting method, which suffers a large margin of error by definition and excludes many who are in need of aid. The absence of universal social registries that provide the data necessary to respond to the targeting criteria, exaggerates the problem. More so, amid high levels of digital and financial illiteracy, especially in remote areas, and the disproportionate access to finance and telecommunication infrastructure, the adopted delivery mechanisms (e.g., e-wallet in Jordan) for these programs have left many beneficiaries unreachable. In addition, social safety nets are known to provide inadequate protection, and to be transient and non-viable. Humanitarian interventions are also largely disintegrated and ineffective. Their securitization, especially in light of the pandemic, and their politicization, especially in conflict-afflicted countries, have further hampered their ability to meet their purpose. Finally, the fact that non-State and trans-State actors tried to replace the States in providing this support and alleviating poverty in many contexts, has made it easier for States to evade their responsibility on this front while making these governments look good, thus stabilizing their failed systems and decelerating social upheavals.[1]

[1] This paragraph is in large part informed by research conducted by the author over the course of 2-3 years as well as outputs produced and exchanges undertaken in the framework of the Arab Reform Initiative (ARI)'s Arab Region Hub for Social Protection.

CONCLUSION AND POLICY RECOMMENDATIONS

The COVID-19 pandemic has exacerbated both income and health inequalities among populations in countries across the Arab region, thus reinforcing the vicious cycle between both types of inequality, which mainly emanates from the interconnectedness between health and socio-economic status. The pandemic exposed structural discrepancies in different aspects of human and economic development, coupled with structural flaws and deficiencies in both health and social protection systems prior to COVID-19, all of which led to a further devolution in health equality, and widened polarization in access to quality healthcare. In addition to poor disaster management, incompetence, and limited or misappropriated resources on the part of Arab States, health equality was victim to nefarious politico-economic factors overlaid by clientelism, political redlines, and a lack of political will to provide universal health coverage and social protection. In other words, in addition to natural channels, deliberate political channels drove up health inequality, among other forms of inequality, during the pandemic.

The pandemic response in many Arab countries was a one-dimensional, reactive, and short-sighted response whereby States dealt with the crisis as merely a health and sanitary crisis, instead of considering it to be an economic crisis as well, thus inadvertently overlooking its socio-economic repercussions. Economic and social policy were unchanged. Even though viewed as a health response, the measures taken during the pandemic were ill-suited to address "a health crisis" effectively. The response was largely securitized and often politicized. Arab governments used overstretched COVID-19 policies (e.g., lockdowns and curfews) as a pretense to repress social upheavals in reaction to economic hardships instead of to suppress the spread of the virus. In some countries, like Tunisia, COVID-19 was seized as a political moment to advance political agendas or even shifts (Daoudi 2023). Instead, pre-existing State policies should have been replaced with transformative, interventionist policies to contain the losses caused by the crisis and hedge its effects in order to avoid the consequential disruptions in economies and societies.

The pandemic response also prioritized power and profit over people's well-being and welfare. With the restricted capacity of health facilities, resorting to private healthcare was at many times the only option. However, private care was not affordable

or accessible to everyone. Amid the absence of universal social protection systems and the exclusion of COVID-19 from private insurance policies, people who could not access public healthcare had to pay significant sums out-of-pocket, despite the rise in the cost of living and the loss of livelihood opportunities. As the pandemic overlapped with other national and/or global political and economic shocks and crises, unexpected adverse measures were seen in many contexts, including subsidy lifting on food, fuel, and medicines, as well as discussions regarding shifts in health systems and government models.

As a result, people's purchasing power and access to health were impaired, and health outcome indicators saw an outstanding deterioration. More importantly, this situation disproportionately affected the poorest and the most vulnerable due to direct channels and indirect ones such as the disparity in infrastructure, personnel, and service quality between public and private health systems. The hardest hit populations were indeed those whose share of public social expenditures as a percentage of total GDP is the lowest. Additionally, new and invisible forms of vulnerability have been engendered, inviting us to rethink our definition, understanding, and measurement of vulnerability, especially during times of crisis. Discrepancies did not only manifest within countries, but also between Arab countries, and between the global North and the global South – as access to vaccines illustrated.

In conclusion, with the differences in health systems in mind, countries in the Arab region need to shift to a rights-based and multi-sectoral approach to health and well-being, including through consolidating public health systems and services into sustainable structures, strengthening the layers of a solid and resilient public health infrastructure, building the capacity of the public health workforce, and addressing the economic dimension of health coverage. To achieve such reforms, Arab States need to:

- Raise awareness and invest in both health promotion and health prevention equally, and refrain from overlooking the latter approach moving forward.
- Develop national strategic visions built around a clear diagnostic of the wider political, institutional, and legislative considerations that ought to be taken into account to ensure the feasibility of desired reforms.
- Develop a disaster management plan drawing on the success stories and lessons learned from the pandemic, taking into consideration the multidimensional nature of crises and emergencies.

- Conceive a continual participatory and consultative process where civil society can weigh in on public health policy design and emergency responses. This process should include the knowledge producing civil society as well as the grassroots civil society who speak to the communities and for the communities.
- Invest in the governance reforms needed to neutralize humanitarian responses from the effects of any political agendas and to finance universal social protection and health coverage, particularly by rationalizing public spending, advancing fiscal reforms, and prioritizing social spending.
- Build the foundations for universal health and social protection systems based on a human-rights perspective.
- Invest in health information systems, indicator enhancement, data collection, and data disaggregation considering the various forms of vulnerability and their intersections.
- Invest in e-government and open government systems, which are key for effective data management and usage. Disclose the data collected during the COVID-19 pandemic and use it as one of the building blocks to establish nation-wide registries.

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P.O.Box 11-0236 / Faculty of Health Sciences
Riad El-Solh / Beirut 1107 2020
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