KONRAD ADENAUER STIFTUNG

How Resilient are the Healthcare Systems in the Mediterranean?

Cases of Algeria, Jordan, Lebanon, Morocco,Palestine and Tunisia

Rym Ayadi
Sara Ronco

In partnership with

EURO-MEDITERRANEAN ECONOMISTS ASSOCIATION

EMNES EURO-MEDITERRANEAN NETWORK FOR ECONOMIC STUDIES
الشبكة الأورو-متوسطية للدراسات الاقتصادية

Disclaimer: *The information and views set out in this publication are those of the author and do not necessarily reflect the views of the Konrad-Adenauer-Stiftung or its Regional Program Political Dialogue South Mediterranean.*

Foreword

On 11 March 2020, the World Health Organization (WHO) declared COVID-19 a global pandemic. This declaration marked the start of a crisis that was later spread across the world.
Moreover, the predictions of the implications of this pandemic, although its severity would vary from a country to another, were mainly narrowed down to the health and economic aspects. Drawing from previous conclusions in relation to pandemics, the change of the course of human history is inevitable.

With most of the countries currently witnessing the second wave of the pandemic, it became clear that most of the governments worldwide, in their response to the COVID-19 spread, showed willingness to take significant economic hit in order to save their citizens. Although the full impact of both the spread and the containment measures and restrictions taken to fight the pandemic is not clearly visible yet, many sectors had been already severely affected, if not failed to survive this phase.

The world was caught unprepared for this pandemic. With the healthcare sector being the epicenter of this unprecedented global pandemic, it becomes obvious that countries with already fragile healthcare service and infrastructure are the ones that have been affected the most. While the race to obtain the vaccine is intensifying, governments will have to re-allocate budgets to finance healthcare services. This could only be achieved through concrete steps towards recovery and inter-governmental/national support and collaboration.

This study was conducted in collaboration with the Euro-Mediterranean Economists Association (EMEA) to assess resilience of the healthcare systems in the Mediterranean with a focus on six countries: Algeria, Jordan, Lebanon, Morocco, Palestine, and Tunisia. This study sheds light on the healthcare systems in the targeted countries, their preparedness, crisis management, the role of the European Union and international community in supporting the targeted countries, and policy responses to contain the pandemic. The study also includes policy recommendations aiming at improving healthcare capacity in a medium-to-long term plan.

We extend our gratitude to the authors of this study, Rym Ayadi and Sara Ronco, for sharing their expertise on the subject matter.

This study is a part of the Regional Program Political Dialogue South Mediterranean of the Konrad-Adenauer-Stiftung (KAS PolDiMed), which aims to implement cross-national projects with reference to the South (Maghreb) and East Mediterranean (Mashrek). Its objective is to strengthen the political dialogue and societal and economic integration in the Mediterranean region and to sustainably promote cooperation and partnership with the European Union.

KAS PolDiMed is going to continue its work in the region to strengthen the dialogue between economic and political stakeholders for the wellbeing of the region.

Thomas Volk
Director
Regional Program Political Dialogue South Mediterranean

Table of Contents

List of Figures and Tables

Acknowledgements

Amidst the disrupting circumstances resulting from the global pandemic COVID-19, this new study aims at taking stock of the evolution of the pandemic in Algeria, Jordan, Lebanon, Morocco, Palestine and Tunisia, investigating the capacity and resilience of their healthcare systems to respond to the health crisis and their level of socio-economic preparedness and policy responses. It uses the updates from EMEA COVID-19 Monitor Platform: https://euromed-economists.org/activities/covid-19-policy-response/ and the main findings from the monitoring exercise implemented from the beginning of the pandemic till 30 November 2020. The study builds on EMEA policy research initiative: https://euromed-economists.org/activities/covid-19-policy-response/ on COVID-19 launched on March 18th, 2020. The initiative provides up-to-date research on COVID-19 related topics, publishes studies, data and policy papers and organizes webinars to discuss the outcomes. It is led and coordinated by Prof. Rym Ayadi, President of the Euro-Mediterranean Economists Association (EMEA) and Director of the Euro-Mediterranean Network for Economic Studies (EMNES). Since events surrounding COVID-19 are unfolding at the time of writing, EMEA research team and EMNES researchers and fellows continue updating the data, policy developments and the economic and social consequences of the pandemic throughout the Mediterranean and Africa. The updates are posted regularly on the EMEA platform. EMEA COVID-19 Tracker: https://research.euromed-economists.org/covid-19/ The Tracker collects automatically daily data from international institutions (e.g. WHO, OECD, IMF..) on the COVID-19 pandemic via a built-in algorithm. EMEA COVID-19 Monitor: https://research.euromed-economists.org/introduction/

The co-authors acknowledge the contributions from EMEA and EMNES researchers and experts in particular: Yeganeh Forouheshfar, Sandra Challita, Mais Shaban and Syrine Ayadi for collecting and updating the countries data and policies and the financial support from Konrad Adenauer Stiftung (KAS) and comments from Thomas Volk and Riadh Dziri.

Executive Summary

The COVID-19 pandemic took the world unprepared. With 118,000 cases and 4,291 deaths detected in 114 countries, on 11 March 2020, the World Health Organisation (WHO) declared COVID-19 to be a global pandemic. As of 30 November 2020, there are 18,041,338 active cases, the total cases detected in the world reaching 63,285,698, amongst which there are 1,469,226 deaths and 43,775,134 recoveries.

Governments across the globe adopted preventive and containment measures to stop the contagion. Most of the countries opted for policies of containment and mitigation such as lockdowns, which were different in timing and intensity. In the meantime, governments and international organisations implemented measures to cope with the socio-economic impacts of the pandemic and the healthcare systems' crisis. Overall, the level of preparedness and the capacity to face, to manage and to recover from the pandemic vary significantly across countries. The recent resurge of the contagion has raised further concern about the capacity of countries to face subsequent waves of the pandemic. For this reason, it is important to keep monitoring the spread of the virus and the responses to it, to learn from the recent past in order to avoid further draconian lockdowns and the collapse of healthcare systems, particularly in the most vulnerable countries.

This study aims at taking stock of the evolution of the COVID-19 pandemic in Algeria, Jordan, Lebanon, Morocco, Palestine and Tunisia, investigating the capacity and the resilience of their healthcare systems to respond to the health crisis and their level of socio-economic preparedness and policy responses, while surveying the socio-economic consequences and the responses of the international community.

The latest available data shows that, during the second wave of the pandemic, the severity of the disease increased in the countries examined in this study. These countries implemented containment, de-containment and re-containment measures differently, in terms of timing, duration and intensity, while their testing was generally below the numbers displayed in the North Mediterranean countries.

The healthcare sectors were unprepared to face COVID-19 pandemic. The overall Global Health Security (GHS) Index scores slightly above the world average (40.2) in Jordan, Lebanon and Morocco (respectively 42.1, 43.1 and 43.7), whilst Algeria and Tunisia score below the world average (respectively 23.6 and 33.7).

In addition to the preparedness of the healthcare sector, there are socio-economic considerations such as the fiscal space and the mobilisation of safety-nets that are of utmost importance. Using the Economic Preparedness Index, the countries under study show a low level of preparedness and economic policy response because of structural, long-lasting socio-economic vulnerabilities, with Lebanon, Palestine and Tunisia presenting the lowest scores.

Almost in all these countries, the first measures adopted were to support healthcare sector and to implement protective measures, mainly in terms of Personal Protective Equipment (PPE), coupled with awareness campaigns to inform citizens and to coordinate surveillance. All countries tried to respond to an unprecedented crisis with similar emergency policies, such as finding and/or building new facilities for COVID-19 patients, increasing medical staff where possible and enhancing the country stockpile of PPEs, through domestic production and/or import.

After the first wave of the pandemic in Summer 2020, it became clear that the health crisis has prolonged. In all countries, measures and plans for of intervention were of a short-term emergency approach. Only Tunisia and Morocco adopted medium-to-long-term strategies. Tunisia had a plan for managing COVID-19 with different designed strategies for different pandemic scenarios. Morocco was able to quickly activate a domestic production of essential PPEs and medical devices and to initiate a process towards the establishment of a Universal Health Coverage.

However, the region needs a healthcare sector that is better equipped, prepared, more inclusive to bridge the urban-rural divide and to extend health coverage to all. Nevertheless, the overall analysis reveals that all countries are far from building a resilient healthcare sector, which is strongly related to institutional and socio-economic vulnerabilities.
To enhance healthcare system resilience, we recommend:

To establish an early warning capability to strengthen the capacity of the healthcare sector to detect pandemics and to be ready to respond in case of large-scale infections. Capacity includes informational systems and reliable risk metrics that can be put in action when needed, a prepared healthcare sector in case of large-scale hazard, in terms of medical infrastructure, staff, protocols and emergency plans, a systematic collaboration between private and public healthcare and research facilities and a clear coordination plan with international organisations such as the WHO.

To reinforce the crisis management capability that allows a prompt activation of healthcare policies to combat the crisis. This system builds on a plan to procure the necessary medical equipment, garments, testing kits, medication and medical protocols, as well as any other essential material and equipment and potential extensions of the public healthcare infrastructure facilities (which could annex private healthcare facilities) that are required to manage the short-term impacts of the crisis, in close collaboration with international organisations such as the WHO. An activation of a crisis management fund, preferably funded jointly by the private and public sectors in order to manage the emergency financial situation, is essential and must be agreed as part of the policies before the occurrence of any healthcare shock. Special attention must be paid to vulnerable populations during the pandemic, especially those who are not covered by public health insurance.

To build a recovery capability: this includes an investment plan to further enhance the capacity of the healthcare sector (e.g. extending and modernising public healthcare facilities, developing digital platforms and e-health applications, training of medical staff to act in extreme cases situations ...etc. to manage future diseases, to fund research and development in order to

Prevent and find cures to existing and emerging health threats and to develop programmes for vulnerable populations that are worst hit by the pandemic and suffer from long-term health consequences.

Effectively increasing healthcare capacity, whereby countries in this region must adopt medium-to-long term plans aimed at enhancing their capabilities, as per the recommendations above with a particular attention to:

- Dedicate more public spending to healthcare and reducing out-of-pocket expenditure as part of the recovery plan;
- Reduce the public-private gap, investing more in the public sector and engaging the private healthcare system more to provide support in extreme shock situations;
- Reduce the rural-urban gap in healthcare service provisions through more decentralised and digital healthcare infrastructure and medical staff capacity building and rotation;
- Increase the social protection coverage, working for the implementation of universal healthcare coverage, starting with the inclusion in the social security system of the most vulnerably excluded (informal workers);
- Increase cooperation with neighbourhood countries, creating a platform for sharing good practices and increasing technologies, knowledge and worker sharing;
- Enhance coordination amongst international organisations to support healthcaresystems through increased transparency and auditing (particularly when external funds are provided) and to implement monitoring systems to maximize effectiveness and impacts.

Introduction

As of 30 November 2020, the world is still grappling with the global COVID-19 pandemic. Infection cases reached more than 60 million, over 1 million deaths and an uncertain recovery process for the rest.

To assess the policy responses, on 18 March 2020, EMEA launched a policy research initiative on COVID-19 aimed at identifying and assessing the policy responses and socio-economic challenges linked to the global pandemic, as well as future responses to enhance socio-economic resilience in Europe, the Mediterranean and Africa.

Building on the on-going EMEA research, this new study aims to explore healthcare system resilience in the Mediterranean region, in the following countries: Algeria, Morocco, Tunisia, Jordan, Lebanon and Palestine and to provide an-up-to-date assessment of the preparedness, policy responses and consequences of the COVID-19 pandemic.

The first section provides a regional assessment of the pandemic and the policies adopted to curb the contagion in the target countries. Section two explores healthcare system resilience by providing an overview of the preparedness and assessing the early warning capacity of the target countries, shedding light on government policy actions in terms of crisis management and recovery. Section three analyses socio-economic preparedness and policy responses, providing an overview of the target countries' preparedness and level of socio-economic response, discussing key considerations on both the socio-economic preparedness in the target countries, and government policy responses, with a particular focus on social security and labour policies. Section four delves into the main socio-economic consequences of the pandemic. Section five surveys the role of the international community during the pandemic.

1. Pandemic evolution and policy responses[1]

COVID-19 had already started spreading to the South and East Mediterranean by February 2020. Whilst in Algeria and Lebanon the first detection of the virus occurred respectively on February 25 and February 21, in the other countries the first cases were detected in early March (on March 2 in Jordan, Morocco and Tunisia, on March 5 in Palestine). The first period of the spreading of the virus caught the majority of countries unprepared - from governments to international organisations. All premier health organisations (i.e. the European Centre for Disease Prevention and Control, the World Health Organisation (WHO), the Centre for Disease Control and Prevention, amongst others) published risk assessments, guidance documents, training programmes and data platforms. Nevertheless, the fast-moving nature of the pandemic led to instances of conflicting guidance (GTTH, Health Report 2020). Meanwhile, China's epidemiological situation was broadly questioned, as to when the pandemic started in the country. On March 11, the WHO declared COVID-19 a global epidemic, whilst in Europe and the North-East Mediterranean, the virus was rapidly spreading. After the WHO pandemic declaration, the majority of countries implemented strict containment measures. Algeria and Lebanon implemented containment measures more than three weeks after the first COVID-19 case detection, respectively on March 23 and March 15. Morocco's containment measures were imposed by March 2, three weeks after the first COVID-19 case. Jordan, Palestine and Tunisia implemented emergency measures when the first COVID-19 infection was detected (in the first half of March). It is worth underlining that the countries that acted more promptly have managed to curb the contagion but also where the virus spread later on when they relaxed their emergency measures.

When the WHO officially recognised COVID-19 as a pandemic, in Europe the prevalence of the disease had already reached worrying levels. Fig. 1 shows the cumulative COVID-19 cases in the target countries. At the initial stage of the pandemic (March-April 2020), the South East Mediterranean countries presented low levels of infection, as compared to Europe. Containment measures were introduced quickly to avoid the likely collapse of precarious healthcare systems.

At the beginning of the implementation of the restrictions, the total cases detected in the target countries were: 201 in Algeria, 93 in Lebanon, 13 in Jordan, 115 in Morocco, 41 in Palestine and 2 in Tunisia. At that time, the level of testing was very low and, therefore, it was difficult to assess the real prevalence of the pandemic. As shown by Fig.1, in the period of containment all the countries under investigation kept the epidemiological curve flat and well below 20,000 total cases. Fig. 2 shows that the weekly case variations declined in April, between two and three weeks after implementing containment measures. The trend started to worsen at the end of June 2020 when the epidemiological curve began rising again, similar to the weekly case variations, when containment measures were relaxed.

1 Data and information on containment and de-containment measures are produced by Euro-Mediterranean Economists Association (EMEA) and Euro-Mediterranean Network for Economic Studies (EMNES) research on COVID-19, between March and November 2020, comparing completed information with other two COVID-19 trackers: the COVID-19 Government Measures Worldwide, available on public tableau and made by Visualitics, retrieved from https://public.tableau.com/profile/visualitics#!/vizhome/Covid-19GovermentMeasuresWorldwide/CovidGovernmentMeasuresWorldwide and COVID-19; Government Measures Dataset, made by ACAPS, retrieved from https://www.acaps.org/covid-19-government-measures-dataset

As mentioned, testing has been increasing over time in countries where data is available. In principle, the higher the level of testing the greater the ability to identify infections at an early stage. Compared to the Mediterranean European Countries (e.g. Italy, Spain and France), the countries under study did not implement comprehensive quantity-based testing strategies. Fig. 3 shows that tests per million increased, particularly between August and September in Lebanon and Jordan, which present the highest level of tests per million amongst the target countries. In Palestine and Morocco, tests per million increased from September but remained consistently lower than in Jordan and Lebanon. Tunisia is where the lowest tests per million are reported. At the time of writing (November 30) Jordan implemented the highest number of tests per million (249,024), followed by Lebanon (237,927), Palestine (129,553), Morocco (106,208) and Tunisia (38,648). Currently, these countries are far from reaching the testing capacity of countries like France (313,959), Italy (363,181) and Spain (491,690), which are amongst the countries most affected by the pandemic but are also the ones testing more, as compared to worldwide averages[2] .
However, Jordan and Lebanon are showing a promising trend in testing, which will allow a better identification of the prevalence of pandemic in these countries.

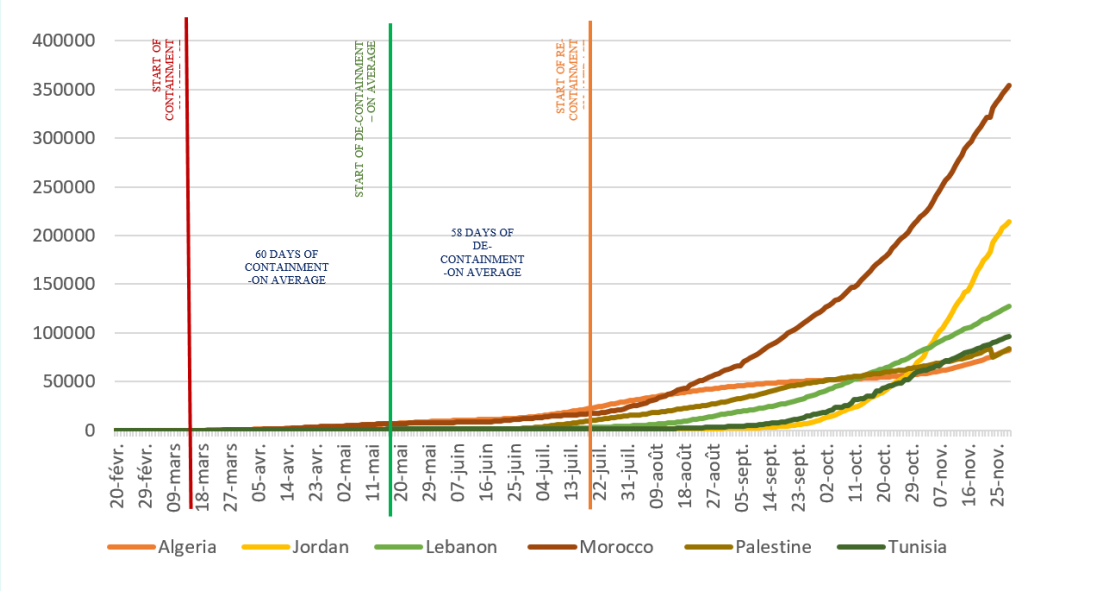

Figure 1: Cumulative COVID-19 cases in the target countries

Source: Our World in Data

2 https://www.statista.com/statistics/1104645/covid19-testing-rate-select-countries-worldwide/

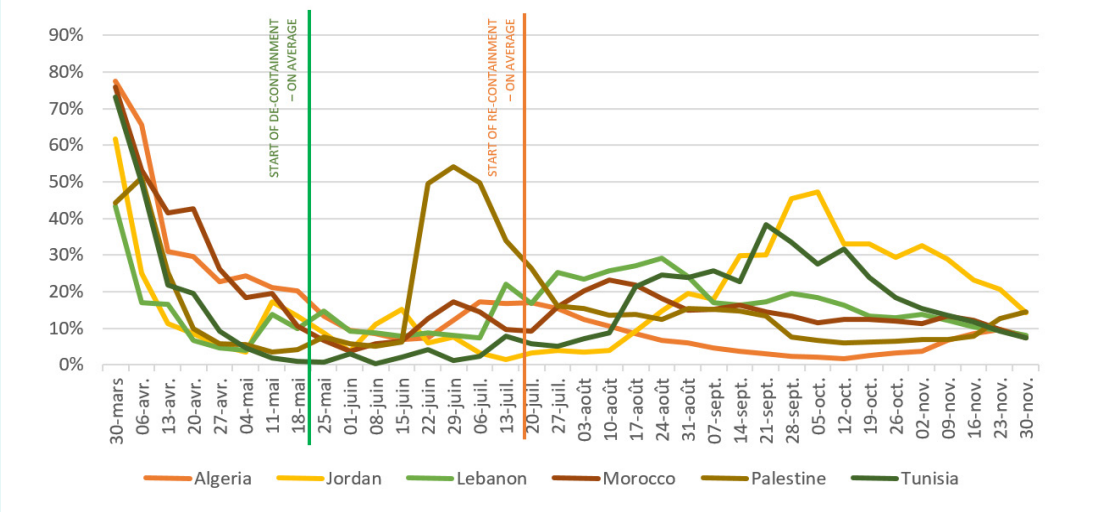

Figure 2: Weekly COVID-19 case variations in target countries.

Source: EMEA COVID-19 Research Platform 2020, Effectiveness Pillar

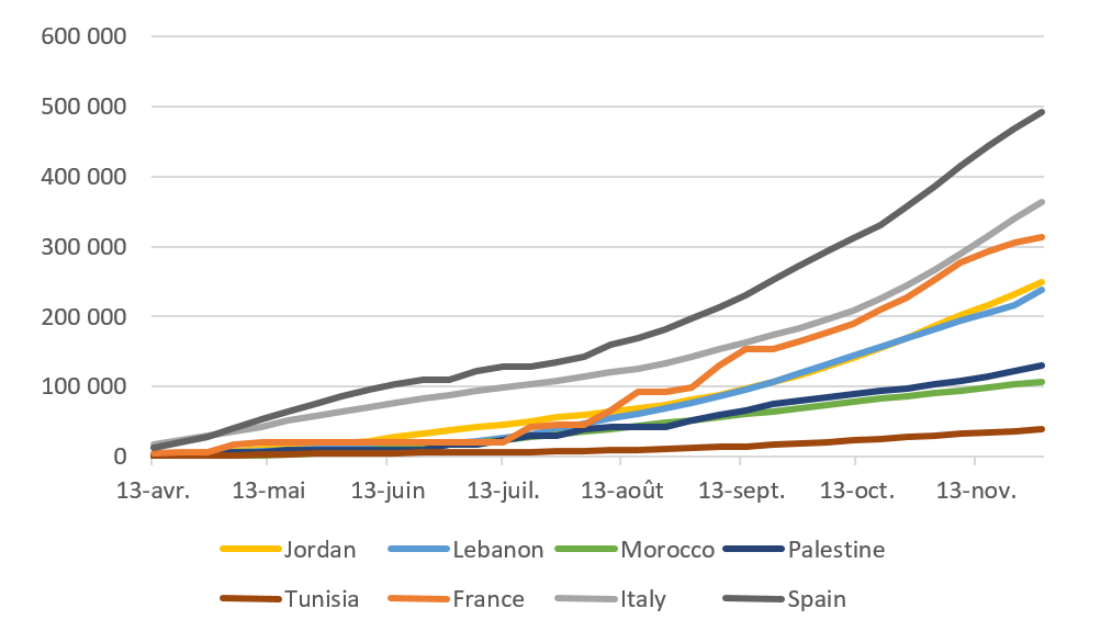

Figure 3: Cumulative tests per million in the target countries[3]

Source: Authors' elaboration with Worldometer.com data

3 Testing data not available for Algeria.

These countries implemented containment measures in March. The intensity of these measures varies. Lockdowns ranged from full (applied to all territories and businesses except for the essential activities) to partial (applied to specific high-risk businesses in infected areas and cities). Algeria and Morocco opted for partial lockdowns; for only certain cities in Algeria and throughout the national territory of Morocco. The other countries imposed full lockdowns of territories . Lookdowns were not imposed from the very beginning of the pandemic. In March, Algeria and Morocco suspended their air routes, whilst a rigid control of the Algerian airport was implemented from February.

In **Algeria**, on March 12, schools and universities, sporting and cultural events and party rooms, hammams, discos and shopping centres all closed. On March 23, further restrictions in the capital and in neighbouring cities were announced. After that, all types of transportation were suspended. All cafes, restaurants and shops closed, except for food stores (bakeries, dairies, grocery stores, fruit and vegetable stalls). These measures were enforced: violations led to license withdrawal and "blacklisting" without the possibility of having operating licenses reissued. Local governors were authorised to take additional measures. Central level public administration, local and regional authorities provided exceptional paid leave (at least 50%) for all employees where a physical presence in the workplace is not considered to be essential for guaranteeing the continuity of services. Personnel from the healthcare, national security, civil protection, customs, prison administration, national communications, quality control and fraud prevention sectors, the veterinary and phytosanitary authorities, hygiene and cleaning services and those assigned to surveillance and guarding missions, are exempted from the measures.

In **Morocco**, traffic by air and by sea with Spain, France and Algeria was suspended in early March and extended to 21 other countries including Greece, Turkey, Switzerland, Sweden, Denmark, Norway and Austria. In the second half of March, all educational activities, restaurants, cafes and cultural events were suspended and citizens were required to stay at home. Citizens were allowed to leave home with an authorisation from local state officials, with the exception of workers in food markets, medical clinics, pharmacies, banks and telecommunication companies.

Jordan closed the borders with China, Iran, South Korea and Italy in February and then extended the ban to all in and outbound flights by mid-March. Citizens were allowed to return from abroad, applying strict quarantines using government-run hotel services. From mid-March, schools and universities closed and work was suspended in all public institutions, authorities and private sector initiatives (except the healthcare sector and other essential services). Any domestic movement between governorates was prohibited and public transport was suspended. The lockdown in Jordan was very strict, but this has alternated between a strict, full lockdown and relaxation combined with night curfews.

4 Ayadi et al. 2020b classifies the different types of containment as follows: lockdown is the measure for which people are required to stay at home and activities to close; lockdown can be classified: local lockdown, when it is imposed on a few cities or regions; national lockdown when it is imposed to a national territory; partial lockdown when measures require certain activities to close; and full lockdown if all economic activities are required to close, with the exception of essential ones. curfews, can be local or national, whether it is imposed at local or national level;

Lebanon closed its schools and universities on March 1. In the middle of the month, the government declared the closure of all non-essential institutions and private companies, whilst all citizens had to stay at home. Public gatherings and religious ceremonies were banned and air traffic and the country's borders were closed.

In **Palestine**, the first measure implemented was to test incoming Palestinians and foreigners at border crossing points and to quarantine them in dedicated structures when it was not possible for them to self-isolate at home. These measures did not apply to visitors, citizens and Palestinian workers coming from Israel, exceptions which turned out to be the most critical source of virus transmission in Palestine. By mid-March, all schools and universities closed, events were cancelled, celebrations and demonstrations banned, tourist and religious facilities closed. At a very early stage of the pandemic, the movement of people was only prohibited to and from the Bethlehem Governorate. Later in March, bans were applied to the entire population on leaving their homes, except for healthcare and food purchases.

Tunisia started containment by banning travel to and from Europe early in March and then extended the ban to other countries. Schools and universities closed early in March. At the same time, conferences and events were cancelled and a curfew was imposed. Later in March, the fast evolution of the pandemic led to strengthening the containment measures by imposing confinement on citizens. All activities were suspended except for essential sectors.
All countries implemented equivalent measures to try to curb the pandemic. In a number of countries, strict measures lasted longer than in the others, but all countries maintained containment measures for an average of 60 days. Figure 4 shows the levels of intensity of containment, carefulness of de-containment and intensity of re-containment measures computed in indexes[5] available on EMEA COVID-19 Policy Research Platform 2020.

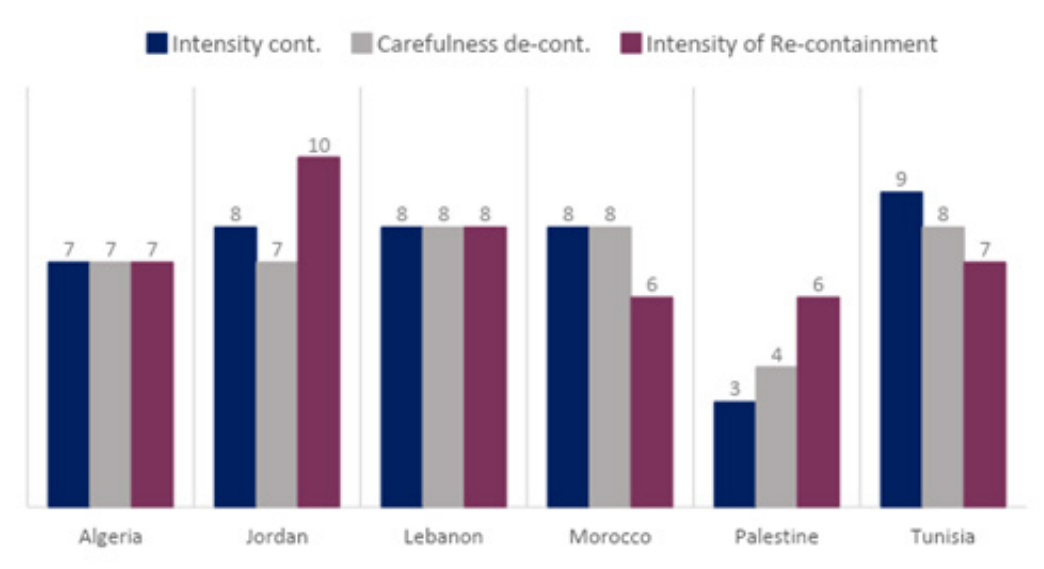

Figure 4: Containment, de-containment and re-containment

Source: EMEA COVID-19 Research Platform 2020, Pillar 2

*The three indexes score from 0 to 10, where 0 means respectively low level of intensity in containment and re-containment and low carefulness in de-containment, whilst 10 represents the highest level possible for all the indexes.For the methodology, see

https://research.euromed-economists.org/introduction/

5 The intensity of containment is assessed using a matrix including (type of containment measures, target population, number of extensions and enforcement). The carefulness of de-containment is assessed using a matrix including (number of positive tests, precautionary measures (e.g. face-masks, disinfection of public spaces, mandatory quarantines and contact tracing). The intensity of re-containment is assessed using a matrix including (timing, types and additional measures of re-containment).

Palestine scored low in the intensity of containment and in carefulness of de-containment, as compared to other countries. Tunisia has the highest level in intensity of containment and slightly less in carefulness, yet is comparable to its peers. Jordan scores higher in intensity of containment as in the carefulness of de-containment, whilst Algeria scores lower for both indices. Lebanon and Morocco present a high and equal level in intensity of containment and in carefulness of de-containment. Jordan presents the maximum level of intensity of re-containment (a maximum score of 10), being the only country to implement a new full lockdown after the first wave of de-containment. Palestine adopted more intense re-containment policies, as compared to the first wave of containment. Morocco and Tunisia show an opposite trend. Lebanon and Algeria re-containment measures were comparable to their peers. After the first wave of the pandemic in March and April, all the targeted countries started easing containment measures between May and June. Looking at the epidemiological evolution of the disease, as shown in Figures. 1 and 2, containment measures contributed to flattening the curve. In May, all countries displayed flat epidemiologic curves and shallow weekly case variations (lower than in March). As shown in the two figures 1 and 2, after lifting containment measures, cases increased again. Countries reintroduced targeted containment measures (curfews and lookdown).

Algeria, Lebanon and Palestine re-imposed restrictions of movement in or between cities from July, barely one month after the easing of the first wave of restrictions. They also re-established curfews and partial lockdown in some cities. Restriction measures were implemented a few times, with several extensions and only in some provinces/cities between July and October. On July 26, Algeria introduced a partial lockdown in 29 provinces, then lifted some of these from September. Lebanon implemented targeted local re-confinement and curfews when needed from July 2020. In Palestine, after a phasing-out measure between May and June, re-containment measures were reintroduced in July with a first short partial lockdown throughout the West Bank and several others since then.

Morocco and Tunisia reintroduced mixed containment measures (partial curfews and restriction of movements) but without imposing any new lockdowns. Morocco imposed a curfew early in September in the most affected cities related to the increase of cases, particularly in Casablanca. Tunisia implemented a gradual de-containment policy early in May, slowly relaxing containment measures in phases between May and June. By the end of August, the Tunisian Authorities announced a curfew in some provinces and started a re-containment phase characterized by the imposition of curfews in some of the most affected municipalities, in some cases during the week, in others only at weekends.

In this set of countries, Jordan was the only one to reintroduce a full lockdown after the de-containment phase started at the end of April. Immediately during the first wave containment period, Jordan imposed a very short full lockdown (usually the weekends) whilst other countries adopted lockdowns for one or more weeks at each implementation/extension. The same strategy applied in the re-containment phase, starting in mid-October 2020 with a total lockdown initially at weekends, which was strongly enforced with the deployment of the armed forces.

To complete the assessment of the pandemic evolution, Lo and Sy (2020) developed a Severity Index[6] as a synthetic index, combining several indicators and accounting for different dimensions. We transformed the Severity Index (computing 1-Severity Index) to explore the evolution of severity over time. Figure 5 shows the average severity trend in the target countries, as compared to other regions. Africa and Asia seem to follow the same trend, decreasing between April and July, then low and constant between August and November. The target countries seem to follow the same trend as in Europe. Severity sharply decreased between April and May, to then start increasing again between July and October.

Since October, severity started to decrease again, both in Europe and in the target countries, particularly sharply in the latter. Figure 6 reveals that severity trends in the target countries are decreasing in all target countries between April and July. Between July and August, Morocco and Algeria have maintained a low level of severity, below the target countries' average severity. During the same period, severity decreased in Lebanon, Jordan and Tunisia. Severity trends seem to reflect the different implementation phases of the containment policies. Not surprisingly, during the first wave of the pandemic (April-May) countries implemented similar containment measures. In the second wave of the pandemic (since July 2020), policy interventions to curb the pandemic were different. Whether there is a significant, causal relationship between containment measures and the severity trend has not yet been proven, but would be critical to investigate further.

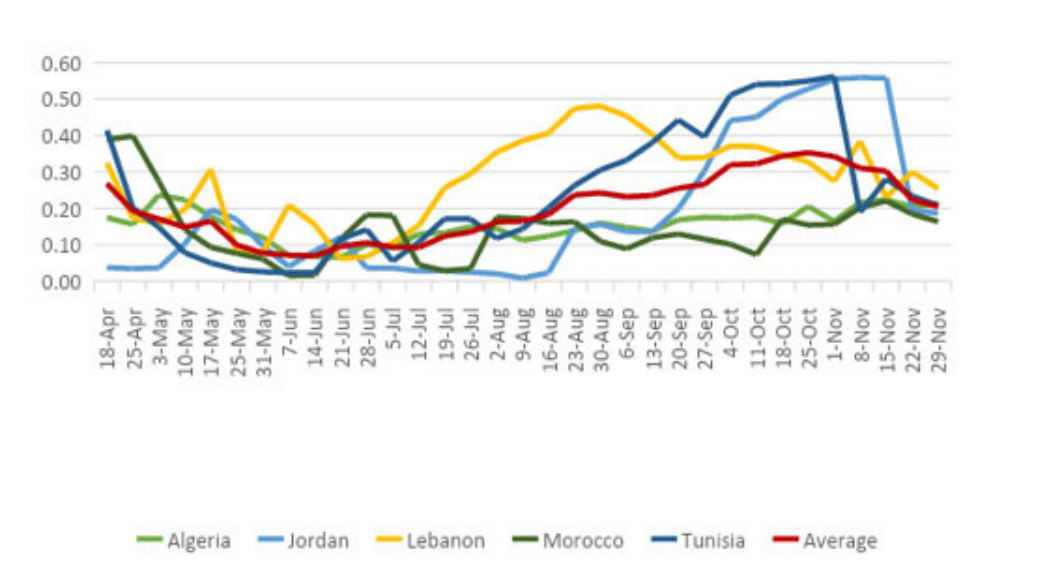

Figure 5: Average COVID-19 Severity in Asia, Africa, Europe

Source: Authors' elaboration based on Severity Index database (Lo, M. and Sy, A., 2020)

6 The index is composed of data on infection rate (the number of cumulative infections compared to the size of the population); the progression of new infections in the recent period; the cure rate (ratio of the number of cured to the number of infected during the previous period); the progression of cures over a period; the flow of new deaths over a period compared to the number of infected in the previous period); the case-fatality rate (ratio of the number of deaths to the number of infected). It can assume values of between 0 and 1, where 1 means a shallow level of severity. It can assume values of between 0 and 1, where 1 means a very low level of severity. As of 10 May 2020, the average score for the countries assessed (169 countries) is 0.74, suggesting a globally moderate severity. Europe scores on average 0.77, whilst countries in Africa present scores of between 0.99 and 0.30, with an average of 0.69. The index is calculated on a weekly frequency, making it possible to observe the evolution of severity over months and, therefore, to investigate the main drivers for the recovery. As of 14 April 2020, the correlation between the GHS Index and the Severity Index of COVID-19 is almost zero, suggesting that a sound healthcare system is only part of the equation for successfully coping with the virus.

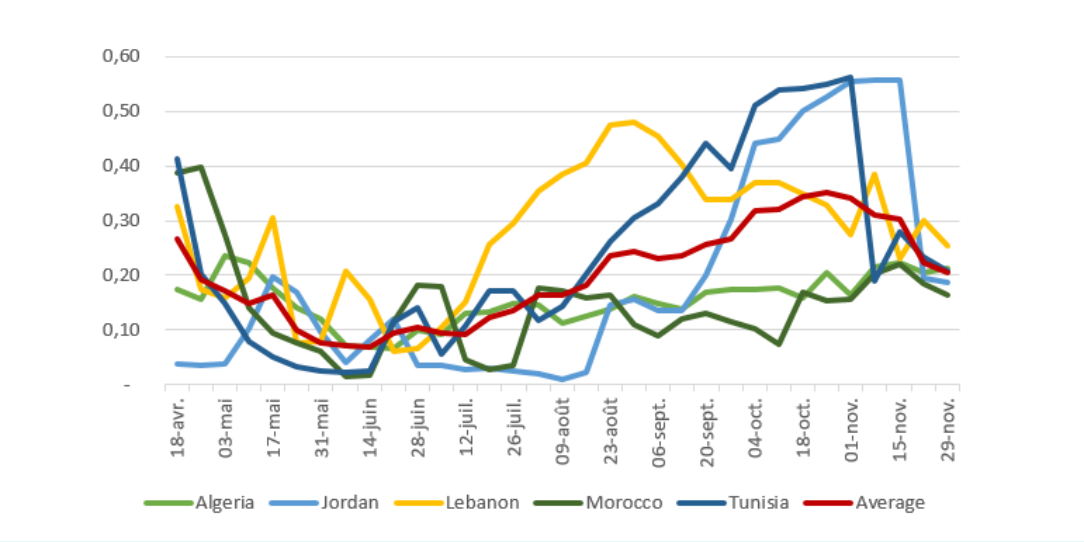

Figure 6: COVID-19 Severity in the Target Countries

Source: Authors' elaboration based on Severity Index database (Lo, M. and Sy, A., 2020

2. Assessment of healthcare systems resilience

In two policy papers by Ayadi (2020 a and b), a mutually interactive three-pillar system was introduced to contribute to enhancing systemic global resilience, in order to fight global pandemics that degenerate into a systemic crisis. The system proposed includes a Global Early Warning System (GEWS), a Global Crisis Management System (GCMS) and a Global Crisis Recovery System (GCRS) reinforced with a Global Crisis Recovery Fund or Financing Plan. This system can be applied by country and by sector.
This study applies this framework to the healthcare sector.

2.1. Preparedness and early warning

Back in 2005, the World Health Organisation (WHO) published the International Health Regulations (IHR), where one of the key recommendations is the need for member states to strengthen and to develop their public health capacity. Furthermore, the IHR provides countries with a mechanism to communicate risks promptly and to implement specific measures at entry points (i.e. airports, ports). Each State was expected to produce a Joint External Evaluation mission report (JEE) to strengthen the implementation of the IHR, assessing their capacity to prevent, detect and rapidly respond to public health risks. The Country Evaluation Tool contains four dimensions: Prevent, Detect, Respond and IHR Related Hazard and Point of Entry (WHO, 2018). Amongst the target countries, only Lebanon, Morocco and Tunisia have presented their JEEs.

In 2018, the WHO launched a new tool to monitor IHR implementation - the State Party Self-Assessment Annual Reporting (SPAR). The SPAR is based on 24 indicators for the 13 HIR capacities needed to detect, assess, notify, report and respond to public health risks («e-SPAR», WHO, 2020). The final score for each capacity is calculated as a percentage of performance. In 2020, the capacity average in the Eastern Mediterranean region is 66% (75% in the European area, the highest).

The average capacity for all WHO regions is 63%; therefore, the Eastern Mediterranean region is performing above the WHO average. All countries in the area had submitted the SPAR.

In 2019, a comprehensive assessment of health security across the 195 countries was prepared as part of IHR (2005): Global Health Security Index, developed by the Nuclear Threat Initiative (NTI) and the Johns Hopkins Centre for Health Security (JHU) with The Economist Intelligence Unit (EIU) (NTI et al., 2019). The overall score assesses a country's capacity to prevent and mitigate against pandemics or epidemics. The overall score goes from a minimum value of 0 to a maximum of 100. The average world score was of 40.2 in 2019, indicating global unpreparedness to an epidemic or a pandemic—the overall score results from the scores of all the six dimensions (EMEA, 2020). The sizes account for the prevention of the emergence or release of pathogens, the capacity to detect and reporting for a potential epidemic, the rapidity of the response and mitigation of the spread of an epidemic, a sufficient and robust healthcare sector, commitment to improving capacity, as well as overall risk environment. Data on Palestine is not available. The overall GHS Index scores above the world average in Jordan, Lebanon and Morocco (respectively 42.1, 43.1 and 43.7), whilst Algeria and Tunisia score below the world average (respectively 23.6 and 33.7).

The index is composed of several dimensions. Prevention of the emergence or release of pathogens is the first GHS index dimension. It includes different indicators, from antimicrobial resistance to vaccination rate. Early detection and reporting for epidemics of potential international concern is the second dimension. The latter accounts for surveillance and reporting and laboratory quality systems, amongst others. The third dimension investigates the rapidity of the response to and mitigation of the spread of an epidemic, accounting for the presence of a national public health emergency preparedness and response plan, risk communication, as well as private sector involvement in preparedness and response amongst other indicators. The fourth dimension is a sufficient and robust health sector to treat the sick and protect health workers. In this dimension, indicators taken into account include facility capacities, hospital beds and access to healthcare.
The fifth dimension assesses the commitment to improving capacity, financing plans to address gaps and adherence to global norms. Under this dimension, IHR reporting compliance and disaster risk reduction are considered, the participation in international agreements and financing indicators. The last dimension is on the overall risk environment and country vulnerability to biological threats, accounting for the risk of social unrest, terrorism and poverty (NTI et al., 2019). As is possible to see from Tab.1, all countries score very low in "prevention of the emergence or release of pathogens" whilst all present high scores for "overall risk environment and country vulnerability to biological threats".

COUNTRIES	PREV.	DET.	RESP.	HS	NORMS	RISK	OVERALL
Algeria	25.7	12	19.6	13.1	29.1	51.4	23.6
Jordan	31.8	42.9	47.8	27.8	48.6	55.8	42.1
Lebanon	27.3	62	47.9	23.8	49.3	45.5	43.1
MOROCCO	34.6	56.8	51.5	29.5	32.7	55.9	43.7
PALESTINE	-	-	-	-	-	-	-
TUNISIA	31.7	26.3	39.1	24	31	55.7	33.7

Table 1: GHS Index: overall scores in the target countries (2019)

Authors' elaboration of GHS Index data, retrieved from www.ghsindex.org

As per Ayadi et al., (2020a) assessment, the majority of countries in the South-East Mediterranean presented unprepared healthcare systems to face large scale pandemics.

In terms of the capacity of the healthcare sector, table 2 shows that health expenditure accounts for between 5.8% and 8% of GDP in the available years, which is less than half the 12% threshold that the World Health Organisation (WHO) recommends for countries to improve their healthcare systems. These countries seem to follow the general slowly declining trend in out-of-pocket spending, but they still present generally high out-of-pocket expenditure. In particular, Morocco spends 5.8% of gross domestic product (GDP) on the healthcare sector and relies on out-of-pocket expenditure for 48.6% of current healthcare expenditure. The economic capacity of the countries varies considerably, with countries, such as Algeria, which are upper-middle-income economies and could be better equipped to face the pandemic, as compared to countries such as Tunisia or Morocco which are lower-middle-income economies. The availability of hospital beds and healthcare staff is meagre in all the target countries. Before the pandemic erupted, Tunisia was endowed with around 500 ICU beds (400 in public premises, 100 in private ones) and Jordan had 226 beds in ICUs distributed throughout 32 public hospitals.Morocco's ICU capacity before the crisis was around 1,600 beds across the country, with around 2,300 in Lebanon. At the beginning of the pandemic, 86% of the ventilators available in Lebanon were in private premises. Jordan shows the highest number of medical staff, respectively at 3.4 nurses and 2.3 physicians per thousand people; the other countries are below these levels.

In the majority of countries observed, the healthcare system is mainly public, but with an increasing private sector prevalence. In Algeria, the entire healthcare system is public and managed by the government. In Morocco, the public sector is the primary healthcare provider, whilst in Lebanon, the public healthcare system is underdeveloped. In Lebanon, private hospitals are perceived as being more reliable and enjoy the highest market share (EMEA, 2020). In Jordan, the healthcare sector is a mix of public, semi-public and private sector, with the public sector offering the majority of hospital beds (9,235 out of a total of 13,731).

Concerning access to public health, in Jordan the public health system is free; 68% of Jordanians and 55% of the Kingdom's overall population, including children under six years old, are covered by various types of health insurance (2016 data). In Lebanon and Morocco, a large part of the population remains excluded from the healthcare system. In Lebanon, the social security only covers specific categories of the population; the excluded portion has to rely on private insurance, which is unaffordable for many people. In Morocco, around one-third of the population is not covered by any health insurance. The country offers a non-contributory health-insurance programme, along with Algeria and Jordan. Universal Health Coverage (UHC) (SDG target 3.8), means that "all people receive the health services they need, including public health services designed to promote better health (such as anti-tobacco information campaigns and taxes), prevent illness (such as vaccinations), and to provide treatment, rehabilitation and palliative care (such as end-of-life care) of sufficient quality to be effective, while at the same time ensuring that the use of these services does not expose the user to financial hardship" (WHO, 2019). The SDG UHC indicators monitoring the target reveal that our countries score medium-to-high in service coverage. The service coverage index is 77.8 in Algeria, 75.7 in Jordan, 73.1 in Lebanon, 70.3 in Morocco, 69.6 in Tunisia. Nevertheless, the incidence of catastrophic expenditure is quite high in all countries (Tunisia 18.4%, Lebanon 44.9% and Morocco 22%) except Jordan (1.7%) (Idem).

7 Coverage of essential health services is defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health; infectious diseases; non-communicable diseases; and service capacity and access; amongst the general and the most disadvantaged population. The indicator scores from a minimum of 0 to a maximum of 100. No data for Palestine. 2017 calculation with latest data available per country (WHO, 2019).
8 The proportion of the population with large household expenditures on health, as a share of total household expenditure or income. The percentage of people with catastrophic health spending stands for the percentage of the population with out-of-pocket health spending exceeding 10% of the household budget. No data for Algeria and Palestine. 2017 calculation with latest data available per country (WHO, 2019).

COUNTRY	CURRENT HEALTH EXPEND. (% OF GDP) (2016)	OUT-OF-POCKET EXPEND. (% OF CURRENT EXPENDITURE) (2016)	HOSPITAL BEDS (PER 1,000 PEOPLE) (2016)	Nurses and midwives (per 1,000 people) (2011-15)	PHYSICIANS (PER 1,000 PEOPLE) (2011-15)
Algeria	6.6	30.9	1.9	2.2	1.8
Jordan	8.9	27.9	1.4	2.8	2.3
Lebanon	8.00	32.2	2.9	2.6	0.1
Morocco	5.8	48.6	1.1	1.1	0.6
Palestine	-	-	1.2	-	0.8
Tunisia	7.00	39.9	2.3	2.6	1.3

Table 2: healthcare systems capacity in the target countries

https://data.worldbank.org/

2.2 Crisis management and recovery [9]

When the pandemic erupted, most countries worldwide were caught unprepared. Therefore, almost everywhere, the first measures that policymakers adopted were to support healthcare systems and to implement protective measures, mainly in terms of Personal Protective Equipment (PPE), united with awareness campaigns to inform citizens and to coordinate surveillance. All countries soon launched awareness campaigns through a specific website including information, online diagnostic tools for information, surveillance and a monitoring portal, with information on disease characteristics, epidemiological evolution and how to prevent infections. On March 21, 2020, the WHO published specific guidelines on testing strategy (WHO, 2020). In this document, different transmission scenarios and different testing capacities were considered.

The WHO suggested having a differentiated approach, to consider each situation at the local level. The importance of testing was emphasised but, at the same time, recognising that there was a possible shortage of agents to perform tests and a lack of laboratories, in particular during a surge. For these reasons, a strategic approach suggested by the WHO, is to adapt to each case and prioritise the most risky or vulnerable people (WHO, 2020). Despite all the initiatives implemented to reinforce testing in the target countries, the level of testing is low whilst slightly increasing (see EMEA COVID-19 Monitor, Pillar 1). Algeria has not reported data for months. As of November 30, Jordan had implemented the highest number of tests per million (249,024), followed by Lebanon (237,927), Palestine (129,553), Morocco (106,208) and Tunisia (38,648) [10].

9 Information and data contained in this sub-paragraph are produced by Euro-Mediterranean Economists Association (EMEA) and Euro-Mediterranean Network for Economic Studies (EMNES) research on COVID-19, between March and November 2020, comparing and complementing information with two other COVID-19 trackers: the COVID-19 Government Measures Worldwide, available on public tableau and made by Visualitics, retrieved from https://public.tableau.com/profile/visualitics#!/vizhome/Covid-19GovermentMeasuresWorldwide/CovidGovernmentMeasuresWorldwide and COVID-19 based on Government Measures Dataset, made by ACAPS available at https://www.acaps.org/covid-19-government-measures-dataset

10 https://www.statista.com/statistics/1104645/covid19-testing-rate-select-countries-worldwide/

Due to the high demand for PPE, particularly in hospitals and also for safeguarding strategic national reserves of medical products, Algeria banned the export of protective masks. Local governors were authorised to take any measures under the auspices of preventing and combatting the spread of COVID-19. Local authorities can require health personnel and any person or necessary activity, to dedicate their work or structure to COVID-19 prevention activities (any person concerning their function or professional competence, any hotel infrastructure or any other public or private infrastructure, any means of transport for the necessary people, public or private). Besides this, the Algerian government adopted various measures to equip places for sanitary confinement in hotels and tourist complexes and to rapidly identify hospitals able to transfer their beds to intensive care units if necessary. Specialised services for suspected and confirmed cases and materials essential for the care of patients have been set up. At time of writing (November 27, 2020) Algerian authorities are putting in place a new «Preparedness plan to deal with Covid-19» to contain the spread of Covid-19, after a rebound in the number of infections. The plan calls for «strict enforcement of coercive regulatory measures» and «to provide hospital facilities with all the means necessary to counter the pandemic». Algeria launched a vaccination campaign for seasonal flu early in November.

In **Jordan**, manufacturers began to produce or to increase their output of face masks and medical supplies, first to meet domestic demand and then for export. They produced surgical gowns, protective overalls, sanitisers and gloves. The country purchased new ventilators, whilst UNICEF donated forty ventilators to the Ministry of Health. The number of ventilators increased from 550 pre-COVID-19 to about 1000 (as of October 2020). At the first stage of the pandemic, only seven hospitals were able to treat COVID-19 patients, three of which were in Amman. Very swiftly, the government rented 35 hotels for quarantine purposes and several field hospitals were set up for quarantine. Doctors working in the public sector warned against reaching the stage of «health sector exhaustion», due to the sector's preoccupation with the crisis and the repercussions of the virus, as hospitals were unable to accommodate patients with diseases other than COVID-19. The government increased ICU beds in public hospitals by 700 new units. Private structures in the country dedicated 150 ICU beds for COVID-19 patients and, on November 8, the Ministry of Health signed an agreement with private hospitals to dedicate 1000 beds and 180 ICU units for public hospitals and rented a private hospital for COVID-19 patients. Furthermore, since Jordan is notably a host to a large number of refugees[11] it is worth noting that authorities, in cooperation with the UNHCR, prescribed necessary measures to avoid the spread of COVID-19 and to protect the health of refugees in the camps. The government has been firmly committed since the beginning of the pandemic to provide the necessary healthcare to all Jordanians, notwithstanding the type of medical insurance they have, if any. The government established a detailed coverage for COVID-19, extending health insurance coverage. Tests for COVID-19 are all imported.

11 In 2019, UNHCR registered 744,795 refugees in Jordan from a total of 52 nationalities. https://www.statista.com/statistics/1104645/covid19-testing-rate-select-countries-worldwide/

The country accounts for 15 private laboratories and eight hospital laboratories, in addition to the newly introduced drive-through testing service (there are over 100 fixed stations for free testing around the country). A particularly important part of the testing policy is having 400 epidemiological investigation teams going round the country providing free testing andtracking contacts for infected people. Tests are free for people tested by the epidemiological investigation team, for contacts in public hospitals and anyone coming into contact with a COVID-19 patient, for anyone for whom the contact tracing app AMAN indicates contact with a positive person and for people with symptoms.

In **Lebanon**, the government removed customs on imported health equipment and medicines necessary to fight the virus from the very beginning of the pandemic and was engaged in collecting foreign aid to support public and private hospitals during the crisis.
Foreign assistance turned out to be crucial for preserving the underdeveloped healthcare system in the country. Furthermore, a national strategy was swiftly put in place to ensure sufficient stock of property, plant and equipment - with focus on healthcare workers - and to support referral laboratories by the Ministry of Health and partners with the needed testing kits and PPEs. Lebanon introduced specific health insurance coverage for COVID-19. New doctors and nurses were employed and new facilities, dedicated to COVID-19 patients, were built. Furthermore, a policy was adopted aimed at increasing ICU capacity by 30% to receive patients in public hospitals. In October 2020, the Independent Lebanese Committee for the Elimination of COVID-19, a group of concerned citizens with various health-related expertise, denounced the failure of the government to carry out long-term measures necessary to control the pandemic and to help the vulnerable population. In particular, in the report, the group underlined the lack of transparency of available public data, and that there was no clarity and transparency surrounding the contact tracing policy and the validity of testing in different regions[12]. The contact tracing in Lebanon was done by traditional methods, calling up suspected contacts one by one, asking for their symptoms and urging them to self-isolate and to get tested. A mobile app for contact tracing was developed, but this has been widely criticised.

Morocco, has been very active since the beginning of the pandemic in providing clear information and guidelines to citizens and health professionals. Mainly targeting healthcare professionals, in March, the Ministry of Health launched an application «Santé Connect», providing real-time information about all the official statistics and information on the dressing and undressing of personal protective equipment. In June, a contact tracing app was developed that also provided information on the pandemic to citizens. At the first stage of the COVID-19 spread, the authorities regulated prices and controlled the distribution channels of facemasks and hydroalcoholic gels.

12 https://www.arab-reform.net/publication/towards-a-zero-covid-lebanon-a-call-for-action/

The country started manufacturing its own ventilators and oxygen masks using locally supplied material and the government allocated 200 million dollars to buy medical equipment. In April, the Ministry of Health committed to increasing ICU capacity (from 1,640 to 3000 beds). Since then, all the hospitals in the country have doubled their ICU capacity and been equipped with new machines (as of November 2020). From March, the Ministry of Health started to provide chloroquine and its derivatives to health facilities, whilst testing capacity was meagre. Differently from other countries in the region, Morocco exported protective masks to Europe, sending out 560,601 masks by September 2020 (in 2018 the number of exported masks was 29,552). The country made wearing face masks mandatory from April and masks started to be sold at a subsidised price of US$0.08 per unit. The Ministry of Industry, Trade and Digital Economy brought together a group of 20 researchers and engineers that produced 100% Moroccan-made devices- an automatic ventilator and an infrared thermometer. The treatment for Covid-19 patients is free of charge in public premises (unlike in private facilities), but capacity remains limited. In October 2020, Morocco signed two partnership agreements aimed at promoting occupational health and safety standards. By signing these two new conventions, the aim is to achieve universal health coverage by 2022 and to promote acceptable standards and practices in occupational health and safety. The first agreement was signed between the Ministry of Health, the Interprofessional Development and Security Group (GIPSI) and the National Health Federation (FNS). It aims to ensure health protection at work, as well as the strengthening of interprofessional dialogue and public-private partnership in order to achieve universal health coverage. The second agreement was signed between the National Health Insurance Agency (ANAM) and the FNS, under the aegis of the Ministry of Health; it sets out to achieve universal health coverage by 2022. It also aims to enable the implementation of prevention programmes and the organisation of the healthcare offering. This is in favour of the optimal regulation of basic compulsory health insurance schemes.

In **Palestine**, from March 2020, the UN Relief and Works Agency (UNRWA) in the Gaza Strip placed patients with respiratory diseases into Gaza schools that the UNRWA converted into medical clinics. In April, Palestine appealed to the United Nations and concerned institutions to urgently provide the healthcare sector in Gaza with medical consumables, medicines, personal protective equipment (PPE), ventilators and examination kits to diagnose the Coronavirus. In March, in the city of Ramallah, the Palestinian Authority opened a new dedicated department at the Health Directorate of the Governorate to diagnose cases of COVID-19, in full collaboration with the Sanitary Directorate of the Governorate. The critical shortage of PPE, test kits and intensive care units was compensated by a prompt implementation of containment measures and the extensive recruitment of doctors, medical specialists and general practitioners; furthermore, quarantine facilities have been rapidly set up.

In **Tunisia**, there has been widespread use of telemedicine and 100 million TND was deployed quickly by the government for the acquisition of medical equipment. Late in March, Tunisia started to adapt hospitals to receive COVID-19 patients, initiated a large recruitment of health professionals and a substantial upgrading of laboratories, whilst private clinics strengthened the state effort to counter the spread of the virus. In April, the authorities started talking about a public health system reform project. In May, the first field hospital to treat people with COVID-19 was opened in Tunisia, with a new COVID-19 centre for pregnant women at the obstetric and infant medicine centre. In September, the government requested the support of the World Bank (WB) for the financing of the Emergency Response Project to COVID-19, to the sum of 20 Million dollars (nearly 60 million TND). A project management unit was set up to implement the project (UGPO) under the supervision of the Ministry of Health (MoH) with implementation focal points from other key agencies, such as the Central Pharmacy (PC).

A project management unit was set up to implement the project (UGPO) under the supervision of the Ministry of Health (MoH) with implementation focal points from other key agencies, such as the Central Pharmacy (PC). The project aims to provide Tunisia with sufficient resources for medical and paramedical staff, as well as laboratory agents to fill supply gaps reported in most health establishments that are needed in response to COVID-19, including tests and consumables. This will contribute to better detect and, consequently, to control the spread of the virus and for effective patient management. During the same period, a re-adjustment in the country's strategy adopted a change of paradigm - from an emergency approach towards a "cohabitation with the virus", with a careful prevention plan, a preparedness and response plan to the risk of introducing «SARS-CoV-2», as well as a manual of procedures, periodically updated.

All countries tried to respond to the unprecedented health crisis with similar emergency policies, such as trying to find or build new facilities for COVID-19 patients, increasing the numbers of medical staff where possible and expanding national supplies of PPE, whether through production or import. Nevertheless, after the first wave of the pandemic, during the summer of 2020, it became clear that the health crisis was not over and that COVID-19 would be lasting more than just a few months. All the measures and intervention plans seem to have a short-term emergency approach.Tunisia and Morocco are the two countries with medium-to-long-term strategies. Tunisia has presented a clear plan for managing COVID-19 with designed strategies for different pandemic scenarios.Morocco was able to quickly activate the domestic production of some essential PPE and medical devices, and to significantly engage a process towards Universal Health Coverage. More initiatives like these would be necessary throughout the region, to ensure healthcare sectors are better equipped, better prepared and more inclusive.

3.Socio-economic preparedness and policy responses

The capacity of the healthcare sector to respond to a pandemic is correlated to the socio-economic preparedness of countries and their economic policy responses. EMEA developed the socio-economic preparedness index and the economic policy response index (under Pillar 3 of the EMEA Monitor[13]) to assess socio-economic conditions pre-pandemic and the magnitude of the economic policy responses that were implemented. In the South and East Mediterranean region, both preparedness and economic policy response appear insufficient relative to the global average. The region presents heterogeneity in both preparedness and policy response across countries.

As displayed in Figures 7 and 8, Lebanon, Palestine and Tunisia show the lowest preparedness scores. Lebanon shows potentially more ample room for manoeuvre, thanks to its low tax rates, despite very high public debt. Furthermore, the quality of institutions and the rule of law are worryingly low and corruption scores high. Social vulnerability and the lack of comprehensive social safety nets are common features within these countries. In particular, high unemployment and poverty rates, combined with a lack of sufficient precautionary savings buffers, are reasons for concern. Lebanon scores dramatically low in all the banking-related component parts of the index calculation. Amongst those countries that are above-average prepared, Morocco out-performs the remaining countries of the region in almost all the indicators being considered. Algeria shows favourable social conditions and an inward-looking, profitable banking sector. Jordan stands out for the quality of its institutions, low corruption rates and the rule of law.

The economic policy responses in these countries were diverse. Monetary authority intervention has been timely overall with, at most, a week's delay from the first day of containment and movement restriction measures. Most of the central banks substantially cut their policy rates (except Palestine and Lebanon). Fiscal stimulus has been weak in all countries because of the lack of fiscal space. Algeria and Palestine respectively devoted only 0.35% and 0.7% of their GDP to support the economy. Other countries spent roughly 2-3% of GDP. Algeria paid a high price for its oil-rent dependency, which accounts for more than 12% of its GDP. Crude oil has been traded, even at hostile prices during the first wave of the pandemic. Algeria's insufficient fiscal response reflects the dramatic drop in revenues after the oil price collapse.

13 See https://research.euromed-economists.org/pillar-3/ and https://research.euromed-economists.org/pillar-3-policy-response/

Regarding the types of policies being implemented, the majority of countries promoted credit enhancing measures, in most cases via state guarantees on new loan issuance. All governments undertook measures to smooth the fall in income. The measures were shaped as tax deferrals, bills and rent payment postponements, transfers, grants and favourable conditions on new credit lines. Finally, whereas all countries directed resources to the healthcare sector, the support for other at-risk sectors has not been homogeneous. It is important to note that these countries paid specific attention to the informal sector, mostly via money transfers and food distribution.

Dealing with the banking/supervision pillar, we find moratoria on loans and mortgages in all countries. Only a few supervisors allowed the easing of regulatory constraints. Amongst those, the Algerian authorities consented to ease liquidity, capital, NPL and reserve ratios. Although not entirely - and not to the same magnitude - similar measures have also been undertaken in Morocco and Jordan. In Morocco, the authorities eased the provision of requirements for targeted loans and arranged a temporary suspension of dividend payments. Finally, there was the adoption of policies to ease electronic payments and a reduction of withdrawal fees. The intervention of the banking sector has been timely. Timing is defined as the days between the first day of lockdown and the day the first relevant economic reaction measure was approved; a negative value may be due either to a rapid economic policy response or to a delay in containment measures.

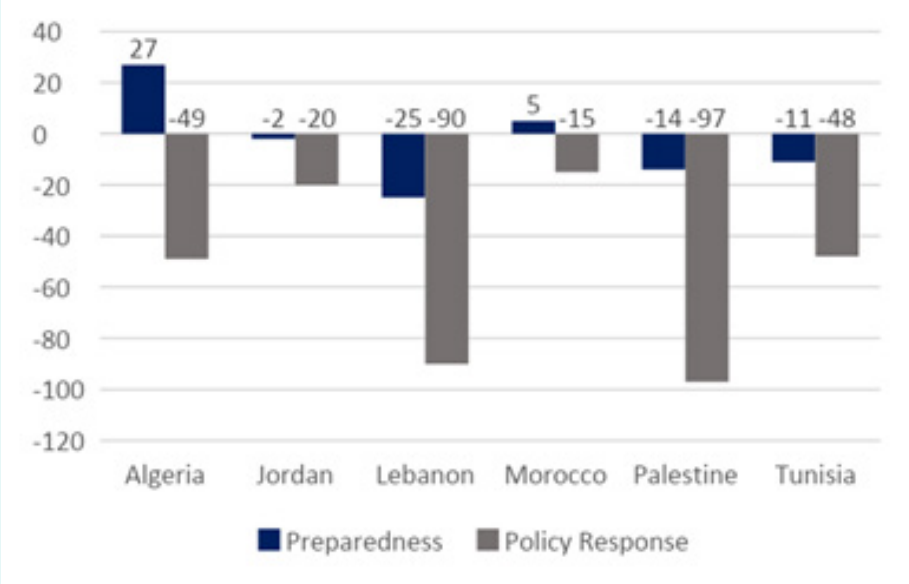

Figure 7: Preparedness and policy response index in the target countries

Source: EMEA COVID-19 Policy Monitor
***Methodology in Ayadi et al (2020b)**

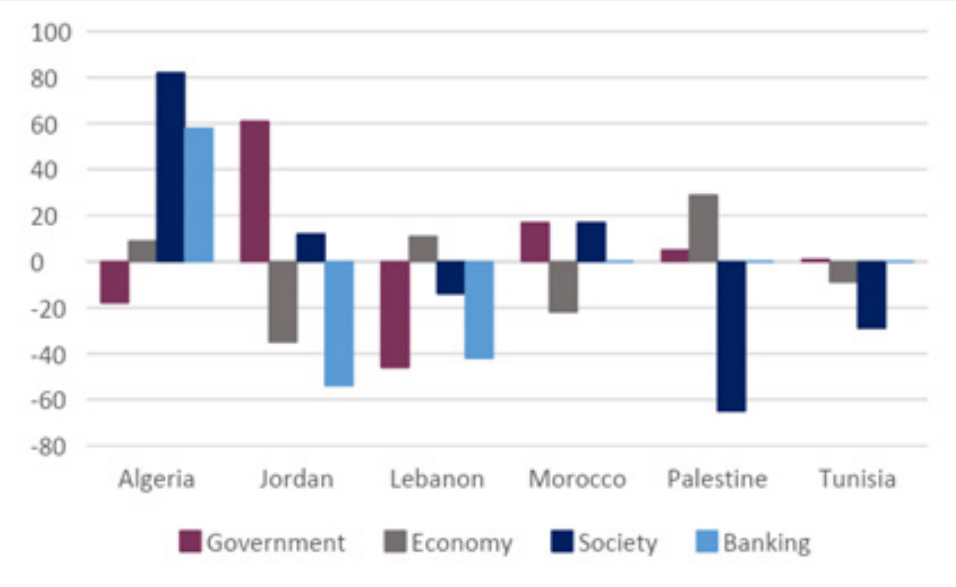

Figure 8: Preparedness index in the target country
Source: EMEA COVID-19 Policy Monitor
***Methodology in Ayadi et al (2020b)**

3.1 Socio-economic key considerations

There are some socio-economic aspects which are particularly important concerning the target countries and that can be of particular concern during and in the aftermath of the COVID-19 pandemic - first of all, inequality and poverty[14].

The lowest rate of poverty is registered in Algeria and Morocco. The Algeria Poverty Headcount Ratio (PHR) is 5.5%, in Morocco, 4.8%. The other countries show a high level of poverty and inequality. Tunisia and Jordan present a PHR around 15% (14.4% and 15.2% respectively), whilst the ratio is close to 30% in Lebanon and Palestine (respectively 27.4% and 29.2%). Inequality is high in all countries, with a GINI Index that extends from 27.6 in Algeria, the lowest value registered, to 39.5 in Morocco, the highest GINI index[15] amongst our countries of interest. Since the start of the pandemic, poverty is expected to increase worldwide and in the MENA region it could reach the levels registered in 1990, reversing the improvement achieved over recent decades (UN, 2020). Moreover, the MENA region was already the most unequal region before the crisis and inequality is expected to increase sharply in the aftermath of the pandemic.

14 EMEA data collection from World Bank database, last data available for each country. Poverty headcount ratio refers to the one based on US$ 1.9 poverty line in 2011 PPP.
15 The Gini index measures the extent to which the distribution of income (or, in some cases, consumption expenditure) amongst individuals or households within an economy deviates from a perfectly equal distribution.

The pandemic powerfully reveals the importance of social protection, which was shown to be essential for population resilience during and after the crisis. Around 55% of the world's population has no access to any form of social protection[16]. In all countries of the region, social protection measures are meagre. The elderly are amongst the most affected by the virus. Besides the health risks, this category also suffered from income insecurity which was exacerbated during the crisis. In Tunisia, 54%[17]of the population above retirement age receive a pension and this trend is increasing (from 33.8 in 2015 to 54% in 2017). For people of working-age, unemployment benefits are incredibly lacking. Generally, the percentage of population covered by some social safety net programme is low. The majority of countries in the region indicate less than 50% of the population is covered by a social safety net programme, except Jordan (66%)[18]. It is, therefore, worth considering that a large part of the workforce in the region is employed in informal sectors. For informal workers, the informal nature of their primary job primarily means the absence of social security coverage which would be gained through their employment relationship, with contributions paid by their employer on their behalf (ILO, 2018). Temporary workers are sometimes explicitly excluded from legal, social security coverage (Idem). Before the crisis, (according to data between 2010 and 2015) expenditure on social protection in the region remains relatively low, compared to other regions in the world.

According to the ILO Social Protection Database, the North Africa region spent about 7.6% of GDP on social protection, Arab States[19] 2.5% (including both social assistance and social insurance, excluding health care) (ILO 2017). High unemployment rates also characterise the target countries (Algeria 11%, Jordan 14.71%, Lebanon 6.22%, Morocco 9.01%, Palestine 26.16%, Tunisia 15%) (Idem).

Another main concern of the Arab countries included in this investigation is food security. The Arab region spends around US$111 billion on imported food (around 4% of GDP) and more than 50% of daily calories consumed in the region come from imported food[20]. The high reliance on exports for domestic food security already represented a significant problem at the early stage of the COVID-19 pandemic in all our target countries.

Finally, migration, remittances inflows and refugees were significantly affected by the current crisis. Remittances are expected to decrease sharply due to the COVID-19 pandemic. This decline will particularly affect many of the target countries which are heavily reliant on remittances, particularly Jordan, accounting for 10.2% of GDP, Lebanon 12.7% of GDP and Palestine 16.3%[21]. Most refugees and asylum seekers, particularly in Jordan, are vulnerable, often living in overcrowded settlements and working in the informal sector.

16 https://www.ilo.org/secsoc/technical-cooperation-projects/building-social-protection-floors-for-all/lang--en/index.htm
17 Proportion of population covered by social protection floors/system (%) annual, ILOSTAT, last data available at time of consultation (November, 2020).
18 Egypt 45%, Jordan 66%, Lebanon 5%, Morocco 37%, Palestine 11%, Tunisia 14% Turkey 18%.
19 ILO Regional Office for Arab States (ILO ROAS) countries: Bahrain , Iraq , Jordan , Kuwait , Lebanon , the occupied Palestinian territory , Oman , Qatar , Saudi Arabia , the Syrian Arab Republic , the United Arab Emirates and Yemen .
20 https://www.unescwa.org/sites/www.unescwa.org/files/en_20-00119_covid-19_poverty.pdf
21 Remittances inflows as % of GDP data comes from EMEA data collection based on the World Bank database, the last data available for each country.

According to the ILO Social Protection Database, the North Africa region spent about 7.6% of GDP on social protection, Arab States[19] 2.5% (including both social assistance and social insurance, excluding health care) (ILO 2017). High unemployment rates also characterise the target countries (Algeria 11%, Jordan 14.71%, Lebanon 6.22%, Morocco 9.01%, Palestine 26.16%, Tunisia 15%) (Idem).

Another main concern of the Arab countries included in this investigation is food security. The Arab region spends around US$111 billion on imported food (around 4% of GDP) and more than 50% of daily calories consumed in the region come from imported food[20]. The high reliance on exports for domestic food security already represented a significant problem at the early stage of the COVID-19 pandemic in all our target countries.

Finally, migration, remittances inflows and refugees were significantly affected by the current crisis. Remittances are expected to decrease sharply due to the COVID-19 pandemic. This decline will particularly affect many of the target countries which are heavily reliant on remittances, particularly Jordan, accounting for 10.2% of GDP, Lebanon 12.7% of GDP and Palestine 16.3%[21]. Most refugees and asylum seekers, particularly in Jordan, are vulnerable, often living in overcrowded settlements and working in the informal sector.

3.2 Policy responses: social security and labour[22]

All the countries have swiftly implemented policies focussed on the healthcare sector and social protection (between April and May 2020). Policies related to social security and labour are particularly important for guaranteeing the health of the population and are often lacking in countries where informality prevails.

Since all countries implemented lockdown measures, unemployment insurance, wage subsidies and other measures are designed to support salary payments.

In **Algeria**, the national minimum wage was increased from DZD 18,000 to DZD 20,000 and the income tax on salaries below DZD 30,000 (May 2020) was reduced.

In **Jordan**, workers on unpaid leave can apply for disbursement of unemployment benefits (if employed in specific sectors, such as tourism, transportation and trade). On 17 April, the Prime Minister of Jordan announced three wage support programmes (Tadamon 1, Tadamon 2, and Musaned). The Tadamon programmes are for companies that had to reduce wages by 50%,

22 All the Information reported in this paragraph was retrieved from the "Social protection responses to the COVID-19 crisis in the MENA/Arab States region. Country responses and policy Considerations", Regional UN Issued-Based Coalition on Social Protection (IBC-SP), July 2020, United Nations, 2020 and from EMNES experts/researchers.

providing unemployment allowance and also supporting the uninsured, mainly businesses not registered with the social security. Musaned programmes are for companies who had to suspend activities without pay, providing them with unemployment insurance, the possibilities for employees to claw back a certain amount from their employment savings and spend their insurance funds in advance. The self-employed, irregular and daily workers are eligible for these, including Gazans and Children of Jordanian mothers (they aim to reach 400,000 vulnerable Jordanian families). Furthermore, the Central Bank of Jordan (CBJ) established a fund for soft/ low-interest loans for companies facing potential closure.

In **Lebanon**, the Central Bank enabled commercial banks to provide loans to companies to pay salaries and debts accumulated in recent months. Special conditions for the loans are zero interest and they can be issued both in dollars and in Lebanese pounds, for five years starting from 1 June. More than 30,000 farmers and 6,600 vocational workers will get a one-time payment of LBP4.5 million each (USD1,125 million/ around US$ 30 per capita).

In **Morocco**, a new unemployment benefit was designed, replacing the existing one, for employees of companies whose activities have ceased entirely, as well as to those of companies that needed to reduce their staff. One week after the announcement, 113,000 companies had registered for these benefits, covering more than 700,000 workers. Furthermore, companies with less than 500 employees, which had to stop their activities and whose revenues fell by more than 50 per cent, compared to the same period in 2019, will be considered companies «in difficulty». Those whose revenues decrease between 25% to 50%, or with more than 500 employees, will go to a special commission that will decide whether they should receive government assistance. These businesses will be able to pay up to 50 per cent of their employees' salaries without paying taxes or fees to social insurance. Employees affiliated to the National Social Security Fund (CNSS) will benefit from a monthly lump-sum allowance of MAD 2,000 net.

In **Palestine**, the Minister of Labour launched a Fund to provide support to workers affected by the pandemic. A two-month temporary employment programme was launched for unemployed workers, in partnership with the World Bank. The initiative aimed to employ 10,000 workers for 3 to 6 months and indicated that the Ministry would cover 30% of the wages for 20,000 workers. Unfortunately, this initiative did not achieve what it set out to do. From May 19th onwards, because of the exacerbation of the Palestine-Israeli conflict, monthly transfer of tax revenues were reduced, leading to a dramatic budget cut in the public sector. Fortunately, financial aid of USD100 for three months was distributed to female workers in Palestinian nurseries that had stopped working (and whose salaries have been cut off).

In **Tunisia**, the government allocated an amount of TND300 million (equivalent to circa EUR 100 Million) in aid for unemployed workers. The Tunisian government paid up to TND200 of the wages of workers that were in 'technical unemployment' (for those who could not continue their work) after registering through an online platform. Another platform for a similar assistance measure was instituted for self-employed workers (as of 22 April, there were 176,000 applications).
All countries modified social security contribution payments and adjusted social security benefits.

In **Algeria**, the National Social Insurance fund (CNAS) has extended the deadline for the payment of employers and independent contributions and penalties from previous late payments not made on time have also been suspended for six months (starting from April 2020).

In **Jordan**, the social security (SSC) has suspended old-age insurance for private-sector employees for three months that will be legally allowed to make such payments in the future. Half of the Maternity Insurance Contributions in 2020 will be used to support vulnerable groups, mainly the elderly and sick people, via cash transfers and in-kind benefits.

Lebanon introduced several initiatives facilitating the payment of social security contributions (e.g. a reduction of 100 per cent of social security contributions until 31 December 2020; the unpaid contributions will be exempted from additional interest rates; employers may request rescheduling of their unpaid contributions, amongst others).

Morocco's Economic Monitoring Committee decided to suspend the payment of social security contributions (CNSS).

In **Palestine**, the authority stopped collecting contributions from Palestinian workers, leaving compliance with sick pay rules to employers instead. The Palestinian National Authority (PNA) social protection system extended its provisions from 85,000 to 120,000 affected families.

In **Tunisia**, for businesses and companies operating in the formal sector, establi
shed a deferral of 3 months of the employer's contribution to the social security scheme for the 2nd trimester was established, on the condition of keeping the employees. One hundred and thirty thousand Tunisian pensioners who received a pension of less than, or equal to TND 180, benefitted from financial aid of TND 100.

Some countries introduced significant measures explicitly addressing the issue of the payment of salaries during the sickness/quarantine period and enforced business closure.

In **Algeria**, in early March, at least 50 per cent of the public administration workforce at the central level, as well as in local authorities, were placed on paid leave (excluding staff from certain sectors that require continuity). Algerian pregnant women and women raising children, as well as people with chronic illnesses and those with medical vulnerabilities, are considered a priority for exceptional leave, both in the public and private sector.

In **Jordan** during the quarantine period, an official licence was granted to public and private sector workers (except for some essential sectors). Employers cannot use this period as annual leave or sick leave and they cannot deduct it from their workers' vacation balance.

Lebanon introduced specific measures to ensure financial protection when accessing healthcare. The General Director of the National Social Security Fund issued a memorandum related to the laboratory diagnosis of COVID-19, setting the laboratory examination fee at LBP150,000 maximum (all laboratories are recommended to abide by this fee). The test is free at the Rafik Hariri Hospital (a public hospital).

Also, **Morocco** introduced a measure aimed at protecting access to healthcare, providing for workers in the formal sector (covered by the National Insurance Fund—CNSS), who were dismissed due to the crisis, will remain covered by health insurance. Many governments in the region took measures to include the portion of the population that was particularly badly hit by the pandemic. Amongst these categories, there are informal workers, which constitute a large share of the population in the region and who are not covered by social insurance or social assistance schemes. If specific measures targeted towards informal workers were lacking, probably also because of difficulties in keeping track of them, governments in these countries implemented some form of social assistance, via cash transfers and in-kind transfers, for the most vulnerable section of the population.

In April, **Algeria** announced a US$80 «solidarity transfer» for families that were in need, who were impacted by the measures taken against COVID-19.

In **Jordan** in early March, the Bread Subsidy Cash Compensation Programme was expanded to National Aid Fund (NAF) beneficiaries, allowing Jordanian women married to non-Jordanian men and Gazans registered with the passport department to apply. The Government of Jordan provided other cash transfers and in-kind aid through different funds and programmes for vulnerable families, both Jordanian citizens and refugees - a combination of old and new beneficiaries. Particular attention was given to daily wage workers, with programmes carried out by the NAF.

In **Lebanon**, the government developed a new social registry for a new emergency cash transfer for people in need. The Parliament ratified an LBP1.2 trillion (US$300 million) aid package for low-income families and vital sectors (agriculture and industry). Half will go to the Emergency National Social Solidarity Programme, providing monthly cash assistance of LBP400,000 (about US$100) to about 200,000 families for seven months, until December). People with disabilities, victims of landmines and explosions, parents of public-school children in need will be prioritised, as well as non-food voucher households in the National Poverty Targeting People (around 28,000 households). Also, the Lebanese Food Bank, thanks to private donations, distributed food boxes to vulnerable people.

In **Morocco**, households which were not benefitting from the RAMED health card (Régime d'Assistance Médicale, medical assistance scheme) have received cash support, whilst non-RAMED workers working in the informal sector have received financial aid (from 78 to 117 dollars according to their family size) during the country's lockdown. This was a significant initiative, since it is clearly targeted informal workers and households operating in the informal sector and with no income because of the mandatory lockdown.

In **Palestine**, the Ministry of Social Development and the Ministry of Labour developed various cash transfers and in-kind programmes. By April, 10,000 new families were already included in the Palestinian Cash Transfer Programme (CTP) and an urgent financial aid programme was established for families affected by COVID-19, covering everyone who lost their job, having no income or an income of less than ILS1,400. In May 2020, the Palestinian Ministry of Labour started the distribution of cash assistance to 40,000 workers affected by the crisis, establishing a technical committee to verify eligibility conditions. This initiative came to an end after stopping tax revenues coming from Israel, due to the PA decision on May 19th.

Tunisia allocated TND150 million (equivalent to EUR 50 million) for the vertical expansion of existing social assistance programmes, targeting beneficiaries in different specific categories; specific cash transfers were dedicated to households working in the informal sector and not covered by any social assistance programme.

Despite the efforts spent in trying to protect informal workers, the problem still remains of appropriately reaching them; data is lacking in all countries that should invest more in a long-term policy identifying and addressing informality.

The previously mentioned policy measures, adopted by governments in the region, are only part of the socio-economic efforts to help people and companies in need during the pandemic. Nevertheless, the majority of the measures implemented are emergency measures which helped face up to the immediate causes of the pandemic but which do not provide a long-term recovery. Furthermore, since the pandemic and the relative crisis seem to have lasted longer than initially expected, measures taken from an emergency perspective are not creating the conditions for the population to be resilient. Governments have relied on implementing temporary social safety nets, combined with immediate economic relief measures, such as lowering interest rates and rescheduling tax debts and loan payments. The poor comprehensive economic diversification and inclusive economic reforms for the middle and lower classes in policies adopted by the targeted countries risk widening socio-economic disparities amongst people in the long-term (ISPI, 2020).

Finally, it is worth mentioning the importance of civil society and third sector solidarity. In Jordan, Prime Minister Omar Razzaz established a coronavirus relief fund named «Himmat Watan», to which local and foreign donations will be deposited to eradicate COVID-19. Again in Jordan, many employees have deducted sums from their monthly wages and donated them to low-income families. In Morocco, INSAF NGO distributed food packages to single mothers and Trade Unions, including the Education International members, Syndicat National de l'Éducation - Confédération Démocratique du Travail (SNE-CDT), decided to encourage workers and educators to donate three days' worth of wages over three months to the newly established COVID-19 solidarity fund. In Palestine, the Federation of Unions of Palestinian University Professors and Employees (FUPUPE) decided to encourage its members to donate wages for one working day to the unemployed and vulnerable families. Previously mentioned initiatives are just a sample with respect to the overall the number of actions taken by associations, civil society, non-governmental organisations and private sectors. Non-governmental civil solidarity has been, and is still fundamental, to helping the most vulnerable during the pandemic worldwide, complementing and supporting governmental limitations in reaching more people in need.

4. Socio-economic consequences

The ultimate impact of COVID-19 on economic systems is tough to predict, due to the multifaceted nature of the shock and the continuing acceleration of the pandemic. Economies across the world are going through a massive contraction in activity, with multiple social implications. As a result of the Initiative on Global Markets (IGM) Economic Expert Panel[23], economic activity contraction arises due to five main reasons (Carracciolo, G. et al.,2020):

- Direct loss in labour supply due to deaths and infections with associated medical costs;
- Further loss in labour supply due to Government non-pharmaceutical interventions, such as lockdown and social distancing;
- A decline in household consumption propensity and firms' propensity to invest due to increased uncertainty and lockdown;
- Global interactions, in terms of disruption of trade and global value chains;
- Possible hysteresis effects, preventing a return to the pre-crisis economic equilibrium.

The COVID-19 pandemic has led to a deep global recession; the fourth deepest since 1879 and the most severe since the end of World War II (WB, 2020). Output in advanced economies is set to contract sharply in 2020, following a major disruption in domestic demand and supply, trade and finance. In 2020, the Euro Area is expected to contract by 9.1%, MENA countries by 5.8% and Sub-Sahara Africa by 5.3% (Idem). The ILO estimates that global working hours declined by 4.5% in the first quarter of 2020, equivalent to approximately 130 million full-time jobs[24]. In particular, the estimated decline in aggregate working hours in Arab States is 1.6% in the first quarter of 2020, and 10.3% in the second quarter. Furthermore, it is estimated that earnings of informal workers fell by 60% globally just in the first month of the crisis[25]. In 2020, world merchandise trade is expected to fall by between 13% and 32%. Estimates of the expected recovery in 2021 are uncertain due to the high uncertainty around the duration of the outbreak (WTO)[26]. UNCTAD estimations do not expect a slow recovery in investment flow before 2022, forecasting a decrease in FDI by up to 40% in 2020[27]. For the same year, global remittances are expected to fall by 19.9% and flows to Africa by 23.1% (WB). Developing countries and vulnerable people are the most dependent on remittances. An unprecedented fall in remittances, as expected, is likely to severely contribute to pushing a large number of people into poverty (Kalantaryan, S. and McMahon, S., 2020). The WB estimates that COVID-19 could push up to 100 million people into extreme poverty in 2020, representing the first increase in extreme poverty since 1998[28].

23 http://www.igmchicago.org/surveys/policy-for-the-covid-19-crisis/
24 https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/documents/briefingnote/wcms_743146.pdf
25 Idem.
26 https://www.wto.org/english/news_e/pres20_e/pr855_e.htm
27 https://unctad.org/en/pages/newsdetails.aspx?OriginalVersionID=2396
28 http://pubdocs.worldbank.org/en/461601591649316722/Projected-poverty-impacts-of-COVID-19.pdf

COVID-19 has worsened and magnified inequality, both within countries and between countries. Inequalities in terms of access to income, assets, internet, public services, education, formal employment, equal opportunities and social protection have been exacerbated by COVID-19[29]. Middle East and North African (MENA) countries and Sub-Saharan African (SSA) countries are showing severe structural and systemic vulnerabilities, aggravating the socio-economic effects of the pandemic. Most MENA countries have fragile economies, conflicts are endemic, as is also political uncertainty; furthermore, the recent sharp decline in oil prices placed more pressure on entire societies. Most countries have made unprecedented efforts to deploy resources fast, through fiscal and monetary policy. By the end of May, over 90 countries had already announced or introduced measures totalling US$10 trillion. Fiscal measures in advanced economies average 5% of GDP in each country; the figure is 2.3% of GDP in emerging and developing countries. In many low-income countries, fiscal space is too limited for governments to act[30]. International community efforts were also unprecedented and put in place early on, during the first stage of the pandemic[31]. Nevertheless, all the efforts deployed were simply not sufficient to restore some economies, considering the magnitude of the shock and pre-existing deep vulnerabilities.

The ILO estimates that developing countries would need US$1.2 trillion in 2020 to fully finance the total cost of a set of universal benefits for building a social protection floor[32]. The relative burden is exceptionally high in Central and Western Asia and North Africa. COVID-19 increased the level of incremental financial needs in 2020 and 2021, reflecting the increased level of spending in social protection to cover the emergency and the lower GDP growth rates in those years. The magnitude of domestic efforts required to finance the social protection floor financing gap may be particularly challenging for our countries and more external financial assistance will be required. The massive deterioration in fiscal deficit is expected to raise public debt to almost 95% of GDP in the MENA region[33]. The economic downturn and the lack of social security/safety nets are particularly critical, if combined with a high prevalence of informal work, which is mainly the case for our region. In Northern Africa, informal employment represents 68.6% of total employment and in the Arab States, 67.3% of total employment is informal (ILO, 2018). Cash transfers and in-kind transfers designed by the government helped most vulnerable people facing the pandemic, in some cases with specific programmes targeting informal workers (see paragraph 4.2).

Nevertheless, the longer the pandemic lasts, the more difficult it will be from the governmental side to fund social programmes. The ILO estimates that, in the second quarter of 2020, the Arab States will lose 10.3% of working hours, equivalent to 6 million full-time-workers (UN 2020). The resulting losses of income are likely to push 14.3 million people across the MENA region into poverty (ISPI, 2020). Inequality is likely to critically increase in the region that was already the most unequal in the world before the pandemic started.

29 http://www.fao.org/3/ca8843en/CA8843EN.pdf
30 https://www.ilo.org/wcmsp5/groups/public/@dgreports/@dcomm/documents/briefingnote/wcms_749399.pdf
31 See Ayadi, R. et al. 2020. Covid-19 in the Mediterranean and Africa. Diagnosis, Policy Responses, Preliminary Assessment and Wat Forward. EMEA-EMNES Studies – April 2020. Box 2- International/Regional Organisation Responses, p.108.
32 https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---soc_sec/documents/publication/wcms_755475.pdf
33 https://www.imf.org/en/Publications/REO/MECA/Issues/2020/04/15/regional-economic-outlook-middle-east-central-asia-report

Currently, around 50 million people are undernourished in the Arab region[34]. The general economic downturn caused by the COVID-19, the erosion of an agri-food global value chain and trade in general, as well as the increase in poverty, could push 1.9 million people into malnourishment. For the Global Food Security Index, the best performer amongst our countries is Morocco, ranking 59 out of 113 countries, followed by Jordan (64), Tunisia (69) and Algeria (70)[35]. Oil-exporting countries like Algeria will suffer from reduced global demand and oil prices, whilst oil-importers, like Jordan, Lebanon, Morocco and Tunisia, will suffer from a decline in remittances, investment and capital-flows from oil-exporting countries. The decline of oil income and trade disruption related to the COVID-19 crisis could critically affect the ability of MENA countries to pay for necessary food imports, considering that net food trade in Middle East is about -57,475 (1,000 of metric tons, 2019-20) and in North Africa -29,942 (1,000 of metric tons, 2019,20) (ISPI, 2020).

Finally, the socio-economic impact of the pandemic in the countries under investigation could be detrimental for inequality and poverty, putting further stress on the vulnerable socio-political situation in the majority of these countries. More long-term policies are needed, for economic diversification and the formalisation of the informal labour market, to build inclusive and sustainable jobs for inclusive and sustainable growth in the aftermath of the pandemic.

34 https://www.imf.org/en/Publications/REO/MECA/Issues/2020/04/15/regional-economic-outlook-middle-east-central-asia-report
35 https://foodsecurityindex.eiu.com/

5. Role of the international community

The European Union took prompt action towards its neighbourhood countries. Early in April, the European Commission, together with the European External Action Service, EU Member States and financial institutions, launched the Team Europe Package. It is a EUR 20 billion package to support European partner countries - in the most vulnerable countries of Africa and in the EU's neighbourhood, the Western Balkans, the Eastern Partner countries, the Middle East and North Africa, parts of Asia and the Pacific, Latin America and the Caribbean - to strengthen health, water and sanitation systems and to mitigate the social-economic consequences of the COVID-19 pandemic. The package is based on resources combined from the EU, Member States, the European Bank for Reconstruction and Development, along with existing programmes. The overall Team Europe package reached almost EUR 36 billion (EEAS, 2020). Team Europe was launched as an approach to provide a single framework of action for all European external response, in support of partners to address the health crisis. In addition, the European Fund for Sustainable Development (EFSD) supported steps by International financial institutions and European development finance institutions to provide local banks with the guarantees and liquidity provisions they need. In the Southern Neighbourhood, triage and isolation spaces have been set up in hospitals with EU support, the staff of Social Development Centres have been trained and local communication campaigns are underway. Three thousand five hundred surgical and respiratory masks have been procured. The Commission signed the new EU Initiative for Health Security with the European Centre for Disease Control (ECDC) amounting to EUR 9 million. It has already started, covering all 23 neighbourhood and enlargement countries and focusing on preparedness and medical capacity to address the outbreak and the numerous repercussions.

On top of the Team Europe strategy, the Commission also adopted a proposal for a EUR 3 billion macro-financial assistance (MFA) package to ten enlargement and neighbourhood partners to help them limit the economic fallout of the coronavirus pandemic[36]. Under the MFA fund, Jordan was expected to receive EUR 700 million, with two MFA operations covering public finance management, utilities, social and labour market policy, as well as governance[37]. Tunisia was also set to be included in the MFA programme. During the international donor conference, hosted by France on 9 August, a few days after the explosion in Beirut, the European Commission mobilised more than €64 million for Lebanon. The funding was dedicated to emergency needs, medical support and equipment, as well as the protection of critical infrastructure in Lebanon. It also helped address the most pressing humanitarian needs of the most vulnerable inhabitants of Beirut impacted by the devastating explosions.

36https://ec.europa.eu/commission/presscorner/detail/en/ip_20_716
37https://ec.europa.eu/neighbourhood-enlargement/news_corner/news/coronavirus-eight-macro-financial-assistance-programmes-agreed-support-enlargement_en

Early in May, the European Union set up the «European Union Humanitarian Air Bridge"[38]. It is an integrated set of services enabling the delivery of humanitarian aid to countries affected by the coronavirus pandemic. The European Union fully funded the flights, in coordination with Member States, humanitarian organisations and the receiving countries. It is a temporary initiative, complementing the logistics services of the United Nations Global Humanitarian Response Plan. The air bridge carries medical equipment and humanitarian cargo and staff, providing humanitarian assistance to the most vulnerable populations where the pandemic imposes constraints on transport and logistics. Furthermore, the EU offered diplomatic support to facilitate humanitarian access. The Air Bridge has been used several times to deliver essential aid to Beirut after the explosion in August. In the immediate aftermath of the blasts, 20 European countries offered to provide specialised search and rescue assistance, chemical assessment and medical teams, as well as medical equipment and other assistance through the EU Civil Protection Mechanism. On 13 August, a first EU Humanitarian Air bridge flight delivered over 17 tons of humanitarian supplies, medicines and medical equipment. On 31 August, the second European Union (EU) Humanitarian Air bridge flight landed in Beirut, Lebanon, delivering 12 tons of essential humanitarian supplies and medical equipment, including a mobile hospital and face masks. The transportation cost was fully covered by the EU, whilst the cargo was provided by the Spanish authorities, the Philips Foundation and the University of Antwerp[39]. In August, the EU announced the disbursement of EUR 22.7 million in humanitarian aid to the most vulnerable people in Palestine, mainly to support health care, education and safe water provision[40]. With these additional funds, the EU will provide financial assistance to vulnerable families, offering safe education for children and trauma care to the injured who cannot leave Gaza for specialised care.

As part of the EU's global response to the coronavirus outbreak, the Emergency Trust Fund for Africa (EUTF) has adopted a new assistance package to protect migrants, stabilise local communities and respond to COVID-19 in North Africa. The package includes EUR 80 million in new funds and EUR 30 million reallocated from non-contracted actions under the EUTF. In line with the Joint Communication on the global EU response to COVID-19, the purposes of the new funding were:

- Extending the immediate response capacity.
- Reinforcing healthcare systems and services in the North African partner countries.
- Mitigating the socio-economic impact of the crisis.
- Continuing the implementation of actions to protect refugees and migrants and stabilise local communities.

38https://ec.europa.eu/echo/what/humanitarian-aid/humanitarian-air-bridge_en#:~:text=The%20European%20Union%20Humanitarian%20Air%20Bridge%20is%20an%20integrated%20set,affected%20by%20the%20coronavirus%20pandemic.&text=The%20EU%20Humanitarian%20Air%20Bridge,EU's%20global%20coronavirus%20response%20actions.
39https://ec.europa.eu/neighbourhood-enlargement/news_corner/news/lebanon-eu-delivers-additional-emergency-assistance-following-explosion-beirut_en
40https://ec.europa.eu/neighbourhood-enlargement/news_corner/news/eu-allocates-over-%E2%82%AC22-million-help-palestinians-need_en

For the COVID-19 fast track, an emergency response programme in North Africa has been allocated EUR 10 million[41]. The EU financed two new programmes in Tunisia under the EUTF to strengthen support to migrants and the most vulnerable groups, who may be particularly hard hit by the COVID-19 crisis. The governance and protection programme is worth EUR 9.3 million and aims to provide protection services to vulnerable migrants. It will improve access to health services, as well as continue to provide support for migration governance and Tunisian-led services for the reintegration of returnees, hosted by the Office des Tunisiens à l'étranger (OTE). The skills mobility programme is built on two bilateral mobility agreements that are in place between France and Tunisia, for young professionals and seasonal workers to gain needed skills in the country of origin (EUR 5 million).

In June, following the launch of the Coronavirus Response Investment Initiative packages, the European Commission adjusted the rules for cross-border cooperation programmes between the EU Member States and EU's neighbouring countries, funded by the European Regional Development Fund and the European Neighbourhood Instrument (ENI). This allows the regions on both sides of the EU's external borders to benefit from the simplified financial and legal measures put into place to fight the coronavirus crisis under these packages. This initiative should allow ENI CBC programmes and projects to benefit from 100% EU financing, to receive more flexibility for project implementation and to reduce the administrative burden for faster project selection, in response to the coronavirus pandemic. It should also represent a step towards a better harmonisation of rules between Interreg and cooperation programmes at the EU's external borders with Neighborhood partner countries and Russia[42].

As part of the EU's global response to the coronavirus outbreak, the EU Regional Trust Fund in response to the Syrian crisis, mobilised an additional EUR 55 million in June. The additional sum is dedicated to refugees from Syria and vulnerable people in Jordan and Lebanon to fight the pandemic, since the two countries host the highest number of refugees per capita in the world. The additional support packages (EUR 20.1 million to Jordan, EUR 34.6 million to Lebanon) is focussed on helping Jordan and Lebanon implement their national response plan and supporting essential water, health, sanitation and hygiene services[43].

The multilateral system played a crucial role in managing the health and economic shock in the region at a very early stage of the COVID-19 pandemic. Some main initiatives are reported in what follows.

41https://ec.europa.eu/commission/presscorner/detail/en/IP_20_1244
42https://ec.europa.eu/neighbourhood-enlargement/news_corner/news/coronavirus-commission-supports-eu-neighbouring-countries-making-rules-cross-border_en
43https://ec.europa.eu/neighbourhood-enlargement/news_corner/news/eu-adopts-%E2%82%AC55-million-support-

The IMF proposed placing itself at the centre of the global financial safety net, with a lending capacity of around US$1 trillion at the service of its membership. The IMF is providing financial assistance and debt service relief to member countries facing the economic impact of the COVID-19 pandemic[44]. Since late March 2020, under its various lending facilities and debt service relief financed by the Catastrophe Containment and Relief Trust (CCRT), the IMF is currently making about $250 billion - a quarter of its $1 trillion lending capacity - available to member countries[45]. At the time of writing (7 November), amongst our target countries, only Jordan and Tunisia have applied for funding from the IMF. From April 2020, Tunisia received US$745million under the Rapid Financing Instrument (RFI), loans to support pro-active policy responses to COVID-19. In March, Jordan obtained the Extended Fund Facility (EFF) of US$ 1,300.00 million and, in May, accessed the Rapid Financing Instrument (RFI) for an amount of US$ 396 million. Morocco didn't apply to any emerging financing, but purchased US$ 3 billion from the IMF Precautionary and Liquidity Line (PLL) to cope with COVID-19 emergency. The PLL provides financing to meet the actual or potential balance of payments needs of countries with sound policies and that may have some remaining vulnerabilities. It is intended to serve as a backstop or to help resolve crises under wide-ranging situations. The countries using the PLL are committed to specific policies, aimed at reducing their remaining vulnerabilities identified in the qualification process with some focussed conditionality.

The World Bank issued an emergency operation addressing COVID-19 in the region. Notably, in Palestine, the WB issued US$5 million as an emergency operation for COVID-19 and US$800,000 to support the Ministry of Health, under the Health System Resiliency Strengthening Project (Ayadi et al. 2020a). In Lebanon, the WB approved the reallocation of US$40 million from an existing project, to increase the capacity of Lebanon's healthcare system to test and treat COVID-19 (Idem).

United Nations Agencies have also been strongly engaged in the region. In Jordan, the already operational UNICEF's Cash Transfer programme, tailored to Syrian refugees and vulnerable Jordanian families («Hajati» programme), was expanded to cover 18,000 additional vulnerable children, whilst a UNICEF database was used to identify households not covered by the programme and in urgent need of financial support due to the COVID-19 crisis (UN, 2020). In Palestine, the World Food Programme was particularly active, launching a Multi-Purpose Cash Assistance (MPCA) pilot programme, providing direct cash to cover essential needs to 1,114 households, who required help in the Gaza Strip. The programme was supported by the European DG ECHO and covered food, shelter, health care and education needs (UN, 2020).

44 https://www.imf.org/en/Topics/imf-and-covid19/COVID-Lending-Tracker
45 https://www.imf.org/en/Topics/imf-and-covid19/COVID-Lending-Tracker

The International Organisation for Migration (IOM) launched a regional Strategic and Preparedness Response Plan for the Middle East and North Africa (in alignment and coordination with the UN Global Humanitarian Response Plan (GHRP); the World Health Organisation (WHO) Strategic Preparedness and Response Plan added its revisions; the UN framework for the immediate socio-economic response to COVID-19; country-level Preparedness and Response Plans (PRP))[46]. Total funding for the MENA regions is around US$72.9 million, focussed on migrant camps and displaced populations in the region, empowering and promoting regional coordination and partnership amongst countries. The IOM is engaged in this plan to support governments, in coordination with the WHO, to facilitate access to emergency health care for migrant workers in an irregular situation, including identifying legal solutions for access to healthcare, including the provision of technical assistance and the development of relevant SOPs[47].

The initiatives, as mentioned above, are not an exhaustive overview of all the sup
port that the countries received. Despite everything, we must say that this pandemic has demonstrated important international engagement in responding to this crisis collectively.

46 https://crisisresponse.iom.int/sites/default/files/appeal/documents/IOM_ResponsePlan_ROCairo_COVID19%20May2020.pdf
47 Ibid.

Conclusions

During the first wave of the pandemic, all the governments across the target countries have adopted swiftly preventive and containment measures in order to stop the contagion. Most of the countries opted for a lockdown, even if policies of containment and mitigation were different in timing and types across countries. In the South and East Mediterranean and Africa, the contagion followed later and more gradually than in Europe, giving countries in these regions the chance to test appropriate measures to contain the spread. Nevertheless, the recent resurgence in the contagion raises concern about the capacity of countries to manage future waves of the pandemic. Data shows that, during the second wave of the pandemic, the severity of the disease increased and the majority of target countries implemented containment measures in different ways, with different durations and intensities. All the countries have implemented measures to increase and to expand healthcare capacity, in terms of both human resources and facilities. Despite this, in some countries resources are still insufficient but, of particular interest, is access to public health. The majority of countries examined present low healthcare security and safety nets coverage. Therefore, almost all the measures and intervention plans seem to have a short-term emergency approach.

Tunisia and Morocco are the only two countries presenting strategies that have a medium-to-long-term perspective. Tunisia demonstrates a clear plan for managing COVID-19, with designed strategies for different pandemic scenarios. Morocco was able to quickly activate domestic production of some essential PPE and medical devices and to significantly engage a process towards Universal Health Coverage. More initiatives like these would be necessary for the region, for a better resourced healthcare sector, better prepared and more inclusive. Nevertheless, the overall analysis reveals that all countries must step up their efforts for resilient healthcare, which take into consideration institutional and socio-economic vulnerabilities.

References

Ayadi, R. et al. (2020a). Covid-19 in the Mediterranean and Africa. Diagnosis, Policy Responses, Preliminary Assessment and Way Forward. EMEA Study, April 2020.

Ayadi, R. et al. (2020b). Covid-19 Policy Assessment Monitor in the Mediterranean and Africa. March-September 2020. EMEA Study, September 2020.

Ayadi, R. (2020 a). Time for a decisive coordinated response to a costly global COVID-19 systemic crisis: toward a resilient global system. EMEA Policy Paper, April 2020.

Ayadi, R. (2020 b). Proposal of a global resilience three-pillar framework to face external shocks: the case of COVID-19 pandemic. EMEA Policy Paper, December 2020.

Ayadi, R. and Challita, S. (2020). Lebanon: a case of compounded crisis. A TRIS path for the phoenix to re-emerge from ashes. EMEA Policy Paper, June 2020.

ILO (2017). World Social Protection Report 2017–19: Universal social protection to achieve the Sustainable Development Goals. International Labour Office – Geneva.

ILO (2018). Women and men in the informal economy: a statistical picture. Third edition. International Labour Office – Geneva.

ILO (2019). Extending social security to workers in the informal economy: lessons from international experience. Living document, November 2019.

ILO (2020). Social Protection Spotlight. Financing gaps in social protection: Global estimates and strategies for developing countries in light of the COVID-19 crisis and beyond. 17 September, 2020.

ISPI (2020). Navigating the Pandemic. The challenge of Stability and Prosperity in the Mediterranean. Report published on the occasion of the sixth edition of Rome

MED – Mediterranean Dialogues, 25 November – 4 December 2020, promoted by the Italian Ministry of Foreign Affairs and International Cooperation and ISPI.
Lo, M. and Sy, A., (2020). A COVID-19 Severity Index. EMNES Working Paper N°32 / June 2020.

UN (2020). Social protection responses to the COVID-19 crisis in the MENA/Arab States Region. Country responses and policy considerations. Regional UN Issued-Based Coalition on Social Protection (IBC-SP), July 2020.

Saran, S., Shull, A. et al. (2020). Working Group #1 Report. Addressing the Public Health Crisis. Global Think Tank Town Hall, July 2020.

WHO (2019). Primary Health Care on the Road to Universal Health Coverage. 2019 Monitoring Report. Conference Edition.

Other references:

[1] http://pubdocs.worldbank.org/en/461601591649316722/Projected-poverty-impacts-of-COVID-19.pdf
[2] http://www.fao.org/3/ca8843en/CA8843EN.pdf
[3] http://www.igmchicago.org/surveys/policy-for-the-covid-19-crisis/
[4] https://covid19.apple.com/mobility
[5] https://crisisresponse.iom.int/sites/default/files/appeal/documents/IOM_ResponsePlan_ROCairo_COVID19%20May2020.pdf
[6] https://doctorswithafrica.org/en/whats-new/health-and-development/
[7] https://ec.europa.eu/commission/presscorner/detail/en/IP_20_1244
[8] https://ec.europa.eu/commission/presscorner/detail/en/ip_20_716
[9] https://ec.europa.eu/echo/what/humanitarian-aid/humanitarian-air-bridge_en#:~:text=The%20European%20Union%20Humanitarian%20Air%20Bridge%20is%20an%20integrated%20set,affected%20by%20the%20coronavirus%20pandemic.&text=The%20EU%20Humanitarian%20Air%20Bridge,EU's%20global%20coronavirus%20response%20actions.
[10] https://ec.europa.eu/neighbourhood-enlargement/news_corner/news/coronavirus-eight-macro-financial-assistance-programmes-agreed-support-enlargement_en
[11] https://ec.europa.eu/neighbourhood-enlargement/news_corner/news/eu-allocates-over-%E2%82%AC22-million-help-palestinians-need_en
[12] https://ec.europa.eu/neighbourhood-enlargement/news_corner/news/eu-adopts-%E2%82%AC55-million-support-package-syrian-refugees-and-local-communities-jordan_en
[13] https://ec.europa.eu/neighbourhood-enlargement/news_corner/news/lebanon-eu-delivers-additional-emergency-assistance-following-explosion-beirut_en
[14] https://foodsecurityindex.eiu.com/
[15] https://public.tableau.com/profile/visualitics#!/vizhome/Covid-19GovermentMeasuresWorldwide/CovidGovernmentMeasuresWorldwide and COVID-19
[16] https://www.acaps.org/covid-19-government-measures-dataset
[17] https://public.tableau.com/views/COVIDFundingvisualisation/COVID-19funding?:embed=y&:toolbar=no&:display_count=no&:showVizHome=no
[18] https://research.euromed-economists.org/pillar-3/
[19] https://unctad.org/en/pages/newsdetails.aspx?OriginalVersionID=2396
[20] https://worldhealthorg.shinyapps.io/covid/
[21] https://www.arab-reform.net/publication/towards-a-zero-covid-lebanon-a-call-for-action/
[22] https://www.cambridge.org/core/blog/2020/05/07/jordans-response-to-the-coronavirus-pandemic/
[23] https://www.google.com/covid19/mobility/
[24] https://www.ilo.org/secsoc/technical-cooperation-projects/building-social-protection-floors-for-all/lang--en/index.htm
[25] https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/documents/briefingnote/wcms_743146.pdf
[26] https://www.ilo.org/wcmsp5/groups/public/@dgreports/@dcomm/documents/briefingnote/wcms_749399.pdf
[27] https://www.imf.org/en/Publications/REO/MECA/Issues/2020/04/15/regional-economic-outlook-middle-east-central-asia-report
[28] https://www.imf.org/en/Topics/imf-and-covid19/COVID-Lending-Tracker
[29] https://www.unescwa.org/sites/www.unescwa.org/files/en_20-00119_covid-19_poverty.pdf
[30] https://www.who.int/groups/covid-19-ihr-emergency-committee
[31] https://www.who.int/news-room/detail/01-08-2020-covid-19-emergency-committee-highlights-need-for-response-efforts-over-long-term
[32] https://www.who.int/news-room/detail/01-08-2020-statement-on-the-fourth-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-coronavirus-disease-(covid-19)

Konrad-Adenauer-Stiftung
Regional Program Political Dialogue South Mediterranean
European and International Cooperation
www.kas.de/poldimed
info.poldimed@kas.de
Le Prestige Business Center,
No. F.0.1, Rue du lac Windermere,
Les Berges du Lac - 1053 Tunis
Tunisia
Tel: +216 70 029 460/464
Fax: +216 71 962 381