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The Pandemic: Challenges in the Arab Region



01

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Before COVID-19: The regional status quo ante

Health inequality was widespread in the Arab region before the onset of COVID-19 and closely mirrored disparities in income, which are highly pronounced in this region in light of its diversity of development profiles. Inequalities in life expectancy and health outcomes are clear and persistent, both between and within the countries of the region, not least given the fact that eight of the 36 most fragile and crisis countries in the world are in the region.¹

A closer look at the health sector in the Arab region reveals significant variations in the levels of health emergency preparedness (Table 1.1). Differences in this regard can be tracked by country groupings: 1) oil-exporting countries lead the region in terms of health infrastructure and human resources for health (HRH) – according to the latest available data, Kuwait has the highest ratio of medical doctors² in this group with 26.5 – and 74.2 nurses and midwifery personnel³ – per 10,000 population, while Bahrain has the lowest ratio of medical doctors with 9.3 and Algeria the lowest ratio of nurses with 15.5 per 10,000; 2) oil-importing, middle-income countries have lower levels of preparedness and infrastructure, with availability of medical doctors ranging between 2.2 (Djibouti) and 23.2 (Jordan) and nurses from 7.3 (Djibouti) to 28.2

(Jordan), and; 3) fragile and crisis-affected countries (FCCs), which have very weak health systems with availability of medical doctors ranging between 0.2 (Somalia) and 21 (Lebanon) and nurses from 1.1 (Somalia) to 65.3 (Libya).

The crisis has exposed fundamental shortcomings in preparedness for the pandemic, as Table 1.1 shows; health expenditure as percentage of GDP, hospital beds per 10,000 people and the availability of fixed broadband connections are low across the region as a whole.

Connectivity is a key determinant for the adaptive capacity of a country in responding to COVID-19. The technological landscape in the Arab region is characterized by wide, structural, digital disparities. The mobile-cellular subscription in half of FCCs does not exceed 75 percent compared to 208.5 in the UAE and 171.6 in Kuwait. Furthermore, while the percentage of individuals using the Internet reaches almost 100 percent in Qatar and Kuwait (both around 99.6 percent), in several FCCs it does not exceed 35 percent (Libya, Syria and Yemen).⁴

The decades before COVID-19 witnessed significant improvement in overall health indicators in the region; nevertheless, progress was not even within and among

1 The World Bank, *Life expectancy at birth, total (years) - Middle East & North Africa*, World Bank data (<https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=ZQ>).

2 World Health Organization (WHO), *Medical Doctors*, Global Health Observatory data repository (https://apps.who.int/gho/data/node.main.HWFGRP_0020?lang=en, latest available data).

3 WHO, *Nursing and midwifery personnel*, Global Health Observatory data repository (https://apps.who.int/gho/data/node.main.HWFGRP_0040?lang=en, latest available data).

4 International Telecommunication Union (ITU), *Country ICT Data (until 2018)*, (<https://www.itu.int/en/ITU-D/Statistics/Pages/stat/default.aspx>).

5 Adapted from UNDP, *Human Development Index*, 2020.

Table 1.1 Arab States preparedness for COVID-19⁵

	Human Development Index (HDI)	Inequality-adjusted HDI (IHDI)	Inequality in HDI	Hospital beds (per 10,000 population)	Current health expenditure (CHE) as percentage of gross domestic product (GDP) (%)	Medical doctors (per 10,000 population)	Nurses and midwives (per 10,000 population)	Mobile phone subscription (per 100 people)	Fixed broadband subscriptions (per 100 people)	
OECs	Bahrain	0.838		17.4	4.7%	9.3	24.9	133.3	11.8	
	Saudi Arabia	0.857		22.4	5.2%	26.1	54.8	122.6	20.2	
	Kuwait	0.808		20.4	5.3%	26.5	74.2	171.6	2.5	
	UAE	0.866		13.8	3.3%	25.3	57.3	208.5	31.4	
	Oman	0.834	0.732	12.2	14.7	3.8%	20.0	42.0	133.4	8.7
	Qatar	0.848			12.5	2.6%	24.9	72.6	141.9	9.6
	Algeria	0.759	0.604	20.4	19	6.4%	17.2	15.5	111.7	7.3
OIMICs	Egypt	0.700	0.492	29.7	14.3	5.3%	4.5	19.3	95.3	6.7
	Jordan	0.723	0.617	14.7	14.7	8.1%	23.2	28.2	87.6	4.0
	Tunisia	0.739	0.585	20.8	21.8	7.2%	13.0	25.1	127.7	8.8
	Morocco	0.676			10	5.2%	7.3	13.9	124.2	4.3
	Djibouti	0.495			14	3.3%	2.2	7.3	41.2	2.7
FCCs	Lebanon	0.730			27.3	8.2%	21.0	16.7	64.5	0.1
	Libya	0.708			32	6.1%	20.9	65.3	91.5	4.8
	Syrian Arab Republic	0.549			14	3.6%	12.9	15.4	101.1	7.8
	Yemen	0.463	0.316	31.8	7.1	4.2%	5.3	7.9	53.7	1.4
	Iraq	0.689	0.552	19.8	13.2	4.2%	7.1	20.5	95.0	11.7
	State of Palestine	0.690	0.597	13.5					90.0	7.5
	Sudan	0.507	0.332	34.6	7.4	6.3%	2.6	7.0	72.0	0.1
	Somalia				8.7		0.2	1.1	51.0	0.7
Arab region	0.703	0.531	24.5	16	5.2%	14.2	29.9	105.9	7.6	
World	0.731	0.596	18.6	28	6.3%	15.6	37.6	104.0	14.1	

Sources: United Nations Development Programme (UNDP), Human Development Report Office; World Health Organization (WHO), Global Health Observatory data repository; International Telecommunication Union (ITU), Country ICT.

Note: latest data reported refer to different years.

■ Higher than world average

■ Lower than world average

countries.⁶ As with the disparities in economic growth in the region, there are significant variations between countries in terms of their current health expenditures, as shown in Table 1.1 (and Figure 1.1). Overall, the region exhibits low public spending on health, as reported in the table, and in the Regional Atlas of Health Financing, 2018.⁷ The report indicated that “The share of out-of-pocket (OOP) payment

in the region oscillated at around 40 percent of total current health expenditure between 2000 and 2015, compared to a global average of 32 percent in 2015”.⁸ In sum, countries would need to increase their investments in universal health coverage (UHC) before real progress could be made.

The 2019 Global Health Security Index⁹ provides a complementary perspective on relative national

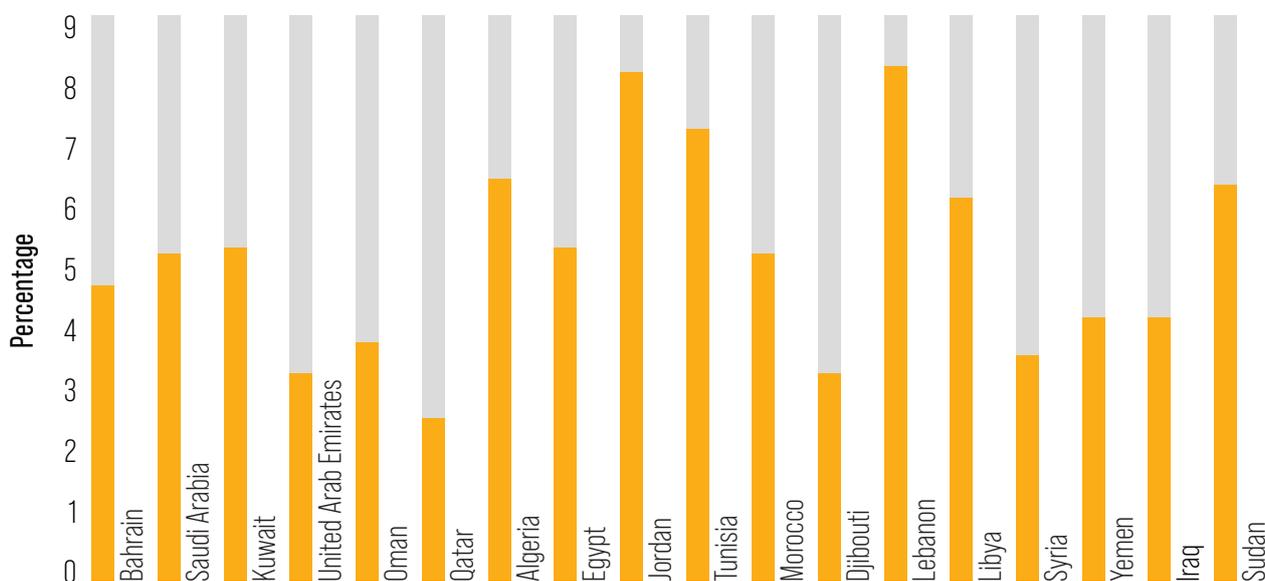
6 Horton, R., ‘Health in the Arab World: A renewed opportunity’, *The Lancet*, Volume 383, Issue 9914, pp. 283–4, 25 January 2014 ([https://doi.org/10.1016/S0140-6736\(13\)62703-8](https://doi.org/10.1016/S0140-6736(13)62703-8)).

7 WHO, *Strengthening health financing systems in the Eastern Mediterranean Region towards Universal health coverage: Health financing atlas 2018*, 2019 (https://applications.emro.who.int/docs/EMROPUB_2019_EN_22347.pdf).

8 Ibid.

9 Nuclear Threat Initiative (NTI) and Johns Hopkins Center for Health Security (JHU), *Global Health Security Index: Building Collective Action and Accountability*, October 2019 (<https://www.ghsindex.org/wp-content/uploads/2019/10/2019-Global-Health-Security-Index.pdf>).

Figure 1.1 Current health expenditure (CHE) (percentage of GDP)



Source: WHO, Global Health Observatory data repository.

health sector capabilities in a ranking that assesses 195 countries around the world. This includes three categories of countries in terms of their health security; none of the Arab countries ranks among the “most prepared” countries. Oil-exporting countries in the region, with the exception of Algeria, rank among the “more prepared” countries, while FCCs are ranked within the “more prepared” and “least prepared” categories.¹⁰ In terms of political commitment, UHC is agreed upon by all countries in the region as part of Sustainable Development Goal 3 (target 3.8). Moreover, the role of government in health care is supported by the constitutions¹¹ of

several countries in the region. In 2018, all the countries of the region signed the UHC 2030 Global Compact,¹² and endorsed the Salalah Declaration,¹³ demonstrating a high degree of political commitment to UHC. Yet the 2019 UHC Global Monitoring Report¹⁴ tells a different story; although the UHC Index of service coverage¹⁵ increased globally, to a global average of 66,¹⁶ the average remains around 57¹⁷ in the region.¹⁸ Furthermore, in 2018, 13.5 percent of the region’s population faced financial hardship and so-called “catastrophic health expenditure” – i.e. spending more than 10 percent of their income on health, which is used as an international benchmark.¹⁹

10 The GHS Index is the first comprehensive assessment and benchmarking of health security and related capabilities across the 195 countries that make up the States Parties to the International Health Regulations (IHR [2005]).

11 The right to health is recognized in the UN Convention on Economic, Social and Cultural Rights (<https://www.refworld.org/pdfid/4538838d0.pdf>); “International human rights law guarantees everyone the right to the highest attainable standard of health and obligates governments to take steps to prevent threats to public health and to provide medical care to those who need it.” (https://www.hrw.org/news/2020/03/19/human-rights-dimensions-covid-19-response#_Toc35446586).

12 UHC2030, *Global compact for progress towards universal health coverage*, International Health Partnership, n.d. (https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/About_UHC2030/mgt_arrangemts_docs/UHC2030_Official_documents/UHC2030_Global_Compact_WEB.pdf).

13 WHO, *Salalah Declaration signals countries’ firm commitment to universal health coverage*, Regional Office for the Mediterranean, 6 September 2018 (<http://www.emro.who.int/media/news/salalah-declaration-signals-countries-firm-commitment-to-universal-health-coverage.html>).

14 WHO, *UHC Global Monitoring Report 2019* (https://www.who.int/healthinfo/universal_health_coverage/report/uhc_report_2019.pdf?ua=1), accessed 31 May 2020.

15 UHC service coverage index combines 16 tracer indicators of service coverage into a single summary measure.

16 See: WHO, *Index of service coverage data by WHO region*, Global Health Observatory data repository (<https://apps.who.int/gho/data/view.main.INDEXOFESSENTIALSERVICECOVERAGEREGV?lang=en>).

17 Ibid.

18 WHO East Mediterranean Region includes Pakistan, Iran and Afghanistan and excludes Algeria.

The report also indicates significant variations between countries, as Algeria scores the highest on the Universal Health Coverage Index with 78,

followed by Bahrain (77), Jordan, Kuwait and the UAE (76), and with Somalia and Yemen scoring the lowest (25 and 42 respectively).²⁰

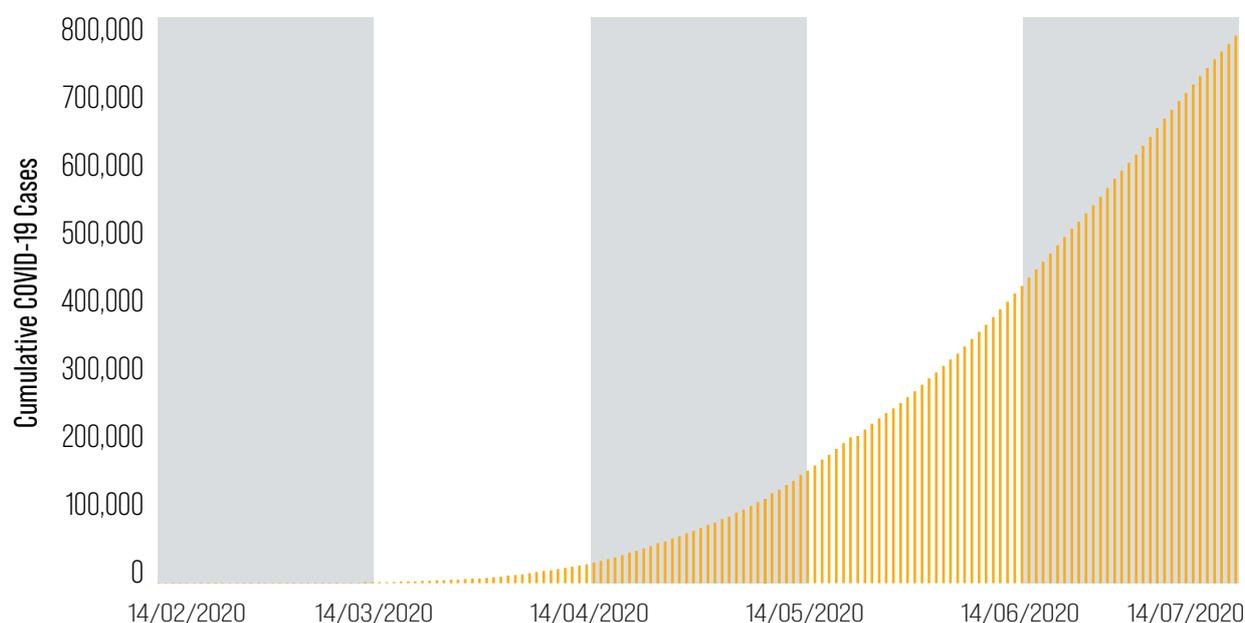
COVID-19: Status and policy responses in the region

Based on the COVID-19 situation reports published by the WHO, the first case of the virus in the Arab States was reported in the United Arab Emirates on 29 January 2020. Reports of the disease then spread from east to west, with Egypt becoming the first country on the African continent to report a positive case, on 15 February, followed by the remaining countries in the region, all of which reported cases over the next 15 days (with the exception of countries in conflict, which, due to their diminished institutional capacity, reported cases beginning only in mid-March, with Yemen being the last to report a positive case on

11 April). After experiencing an acceleration in the spread of the pandemic, since June the region has reported over 80,000 officially confirmed new cases on average each week.²¹

Unlike Europe and the United States, Arab countries have benefited from the relative youth of their populations, as COVID-19 symptoms among young people have generally been found to be less severe and their mortality rates remain low.²² Based on the latest population estimates, 7.4 percent of the population in the Arab States is above the age of 60. This could explain the comparably low

Figure 1.2 Cumulative trend in officially confirmed cases in the Arab region



Source: WHO data.

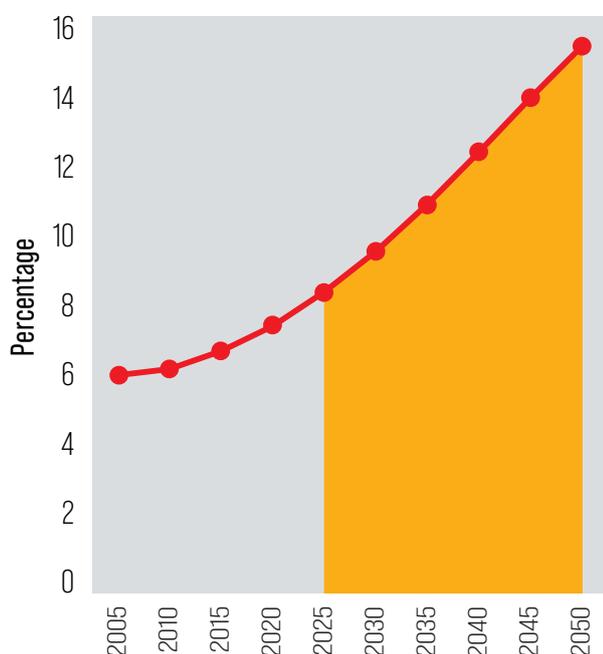
19 Li, Y., et al., "Factors affecting catastrophic health expenditure and impoverishment from medical expenses in China: policy implications of universal health insurance", *Bulletin of the World Health Organization*, 13 June 2012 (<https://www.who.int/bulletin/volumes/90/9/12-102178/en/#:~:text=Catastrophic%20health%20expenditure%20is%20defined,suffer%20the%20burden%20of%20disease>).

20 WHO, *Index of service coverage data by WHO region*, op. cit.

21 Time frame is 1 June to 29 September 2020. COVID-19 cases sourced from: <https://www.ecdc.europa.eu/en/publications-data/download-todays-data-geographic-distribution-covid-19-cases-worldwide>.

22 Scientific studies have shown that the mortality rate of Covid-19 is between 10% and 27% for people aged >84; between 3% and 11% for people aged 65–84; and less than 1% for those aged 20–54 years. See: Centers for Disease Control and Prevention (CDC), *Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19)*—United States, February 12–March 16, 2020 (https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm?s_cid=mm6912e2_w).

Figure 1.3 Population aged 60 years and above (percent of total population) current and forecast for Arab States region



Source: UNDESA, World Population Prospects 2019.

numbers of deaths and acute health complications due to COVID-19. The latest updates by the WHO revealed that the “crude clinical case fatality is currently over 3 percent, increasing with age and rising to approximately 15 percent or higher in patients over 80 years of age”.²³

While the Arab countries are not alone, globally, in struggling to grasp the scope of the pandemic domestically, it is to be noted that relative lack of testing capacity can be seen as a proxy for the overall preparedness and capacity of the public health sector. Differentials in testing capacities closely track regional economic disparities. Based on the

latest available data (up to 30 June 2020), among the high-income and oil-exporting countries, Bahrain has the highest reported testing rate (320,569 per million) followed by UAE, (317,098 per million), Qatar (125,600), Kuwait (89,656), Saudi Arabia (45,710) and Oman (37,496).²⁴ The testing rates for middle-income oil-importing countries show sizeable differences, ranging from 1,319 (Egypt) to 46,673 (Djibouti), a differentiation which may be partially explained by the particular challenges facing middle-income countries with relatively large populations. As for fragile countries, no testing data is available for Somalia and Syria, with the testing rates per million in Lebanon and Iraq being 18,998 and 13,233, respectively.

The relatively low levels of testing seen in many countries in the region pose tremendous analytical challenges, and limit considerably the scope for evidence-based policy making tailored to national and local circumstances. In this regard, therefore, the improvement of testing practices should be a fundamental priority across the region.

In non-health-related fields, lack of data is a serious impediment to understanding the severity of the crisis. Satellite data, social media and remote sensing data constitute excellent options for obtaining quantitative and reliable information in real-time – hence tech giants like Google and Apple have released daily data on mobility to actively contribute to combatting Covid-19.^{25, 26} The use of mobility data from the likes of Google and Apple could be considered as a benchmark to evaluate the effectiveness of the actions implemented by governments.

Each Arab country for which data is available has adopted a series of containment and control measures according to the pandemic development and transmission within their borders. Lebanon²⁷ and Qatar²⁸ enforced lockdown measures between 13 and 15 March, followed by Jordan²⁹ and Morocco³⁰ between

23 WHO, *COVID19 Strategy Update*, April 2020 (https://www.who.int/docs/default-source/coronaviruse/covid-strategy-update-14april2020.pdf?sfvrsn=29da3ba0_19&download=true).

24 Worldometer, *Reported Cases and Deaths by Country, Territory, or Conveyance*, Worldometer.com (<https://www.worldometers.info/coronavirus/#countries>).

25 Apple, *Mobility Trends: Change in routing requests since 13 January 2020* (<https://www.apple.com/covid19/mobility>).

26 Google, *See how your community is moving around differently due to COVID-19*, COVID-19 Community Mobility Reports (<https://www.google.com/covid19/mobility/>).

27 Houssari, N., “Lebanon extends virus lockdown by two weeks”, *Arab News*, 5 May 2020 (<https://www.arabnews.com/node/1670016/middle-east>).

28 Government Communications Office (Qatar), *Government Communications Office statement regarding measures taken by the State of Qatar to combat Coronavirus (COVID-19)*, 12 March 2020 (<https://www.gco.gov.qa/en/2020/03/12/government-communications-office-statement-regarding-measures-taken-by-the-state-of-qatar-to-combat-coronavirus-covid-19/>).

29 The Royal Hashemite Court (Jordan), *Royal Decree approves Cabinet decision to proclaim Defence Law*, 17 March 2020 (<https://rhc.jo/en/media/news/royal-decree-approves-cabinet-decision-proclaim-defence-law>).

30 Kingdom of Morocco, *Covid-19: “State of Health Emergency” Declared in Morocco As of Friday at 6:00 p.m. Until Further Notice*, Interior Ministry, Maroc.ma, 19 March 2020 (<http://www.maroc.ma/en/news/covid-19-state-health-emergency-declared-morocco-friday-600-pm-until-further-notice-interior>).

18 and 19 March. Between 22 and 24 March, Egypt³¹, Syria³², the United Arab Emirates³³ and Libya³⁴ adopted curfew measures while Tunisia³⁵ chose to enforce a total lockdown. Regardless of the type of measure imposed, the effects on people's movement were remarkable; relying on mobility data released by Google and Apple, it is possible to detect a net and substantial decrease in daily commuting after the announcement of restrictions on social movements compared to the baseline period³⁶ (see table 1.2). As of early June, in the countries where data is available, decreasing trends in movement were recorded across all categories (retail & recreation; grocery and pharmacy; parks; transit stations; and workplaces) without distinction. Categories for which movement was classed as 'necessary' – such as grocery & pharmacy, and workplaces – dropped drastically (-12.6 to -41.4 percent and -25.9 to -59.3 percent respectively) as did non-essential movements like park visits (-20.2 to -68.8 percent). As a consequence, movement through transit nodes also decreased dramatically (-41.7 to -86.9 percent).³⁷

According to the Oxford COVID-19 Government Response Tracker (OxCGRT) Government Response Stringency Index (as of 30 May 2020),³⁸ the country groupings can be listed according to their scoring as follows:

Oil-exporting countries: similar measures were taken by these countries with very small variations in scoring – Kuwait was the strictest with 100 and UAE was the least strict with a score of 72.2.

Middle-income oil-importing countries: Morocco scored highest on the Index with 93.5, which demonstrates the fact that policy measures are not necessarily linked to economic capabilities – although, again, population size should be borne in mind. The second strictest country was Egypt, which scored 84.3, which was followed by Tunisia with 79.6. Djibouti was the lowest-scoring country with 50.9, driven by the lack of measures to close public transportation, restrictions on internal movement and stay-at-home orders.

Table 1.2 Mobility trends

	Country	Restrictive Measure	Retail & Recreation	Grocery & Pharmacy	Parks	Transit Station	Workplaces
OIMICs	Egypt	Curfew	-56.0	-12.6	-42.8	-51.1	-32.8
	Jordan	Lockdown	-63.3	-41.4	-53.9	-86.9	-59.3
OECs	Qatar	Lockdown	-52.7	-25.1	-41.5	-52.7	-32.3
	United Arab Emirates	Lockdown	-58.6	-28.2	-68.8	-71.0	-46.0
FCCs	Lebanon	Lockdown	-57.5	-28.4	-34.2	-71.7	-49.0
	Libya	Curfew	-37.8	-14.1	-20.2	-41.7	-25.9

Source: Elaboration from Google and Apple data.

31 State Information Service (Egypt), *Egypt declares partial curfew for 15 days starting Wednesday, 24 March 2020* (<https://www.sis.gov.eg/Story/144199/Egypt-declares-partial-curfew-for-15-days-starting-Wednesday?lang=en-us>).

32 UNFPA, *Syria Country Office COVID-19 Humanitarian Response Flash Update No. 2 | 9th - 22nd April 2020, 22 April 2020*, accessed via reliefweb.int (<https://reliefweb.int/paper/syrian-arab-republic/syria-country-office-covid-19-humanitarian-response-flash-update-no-2>).

33 Emirates News Agency (WAM), (UAE), *Local Press: UAE takes tough measures to beat coronavirus, 24 March 2020* (<http://wam.ae/en/details/1395302832583>).

34 Al Arabiya, *Libya's GNA imposes curfew to combat coronavirus*, AlArabiya.com 22 March 2020, <https://english.alarabiya.net/en/News/north-africa/2020/03/22/Libya-s-GNA-imposes-curfew-to-combat-coronavirus->

35 Guetat, M., *Tunisia and Coronavirus: The Reality of a Poor Governance*, Italian Institute for International Political Affairs, 9 April 2020 (<https://www.ispionline.it/en/publicazione/tunisia-and-coronavirus-reality-poor-governance-25671>)

36 Google baseline: mean value for the period 3 January and 6 February 2020; Apple baseline: 13 January 2020.

37 Apple data have been standardized in order to be comparable with Google trend data; this is due to the fact that Apple mobility trend data cumulates all the categories of movements, including residential displacements into two different groups, namely driving and walking movements. These have experienced a marked decrease of 82% and 85% respectively. The fluctuation of negative peaks refers to weekdays and holidays or to other extreme events (i.e. 12 March in Egypt all the main activities were closed due to inclement weather; see: Al Arabiya, *Five killed as heavy rain, strong winds batter Egypt, 13 March 2020*, <https://english.alarabiya.net/en/News/middle-east/2020/03/13/Five-killed-as-heavy-rain-strong-winds-batter-Egypt>).

38 All countries in the region, with the exception of Oman and Iraq, showed either a decrease or no change in the Stringency Index between 30 May and 1 July. For the same period, Tunisia, Jordan, Somalia and Morocco displayed a decrease of more than 30 percent in the index.

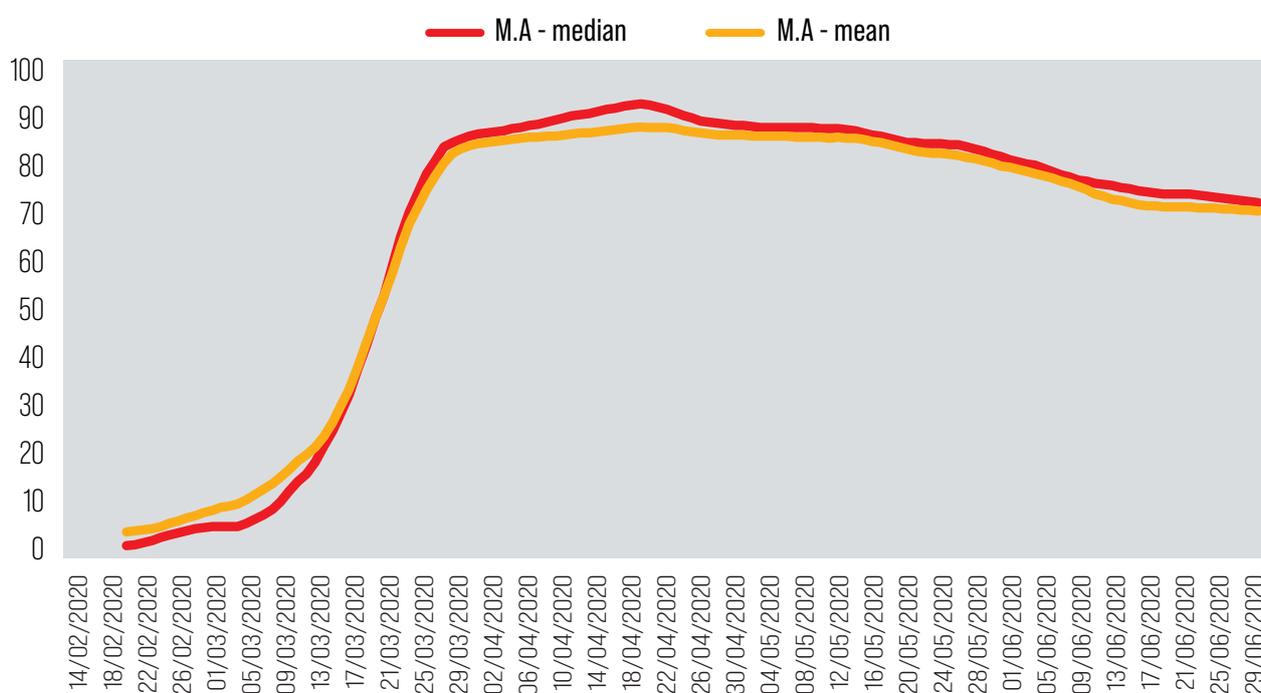
Fragile and crisis-affected countries: the strictest country was Libya with 93.5, followed by Iraq with 92.6. Somalia was the least strict with only 48.1 followed by Yemen (58.3).^{39,40}

A regionally aggregated trend in the index is reported in Figure 1.4 and shows how the acceleration of lockdown and social distancing measures swiftly accelerated in March and have been slowly relaxed over the second quarter of the year. A more detailed view of restrictive measures over time and by country grouping is available in Annex I of this report.

Moreover, we can visualize other important indicators, such as recent trends (in the last 6 months) in the median

Internet (mobile and fixed) speed in the countries in the region, which can be a useful in gauging the ability of governments and economies to cope with the social distancing measures that have been put in place, and of their ability to continue providing services. One can observe that Algeria, together with all FCCs and some middle-income countries have lower speeds than the world average. In addition, some countries have recorded a generalized reduction in speed in March, during the tightening of lockdown measures (see Annex II).

Figure 1.4 Regionally aggregated OxCGRT Government Response Stringency Index



Source: authors' calculations using OxCGRT data based on weekly moving averages.

39 Oxford COVID-19 Government Response Tracker, *Stringency Map* (<https://covidtracker.bsg.ox.ac.uk/stringency-map>).

40 Oxford COVID-19 Government Response Tracker (<https://www.bsg.ox.ac.uk/research/research-projects/coronavirus-government-response-tracker>).

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Policy Recommendations

Short term (considerations for relaxation of restrictions)

Governments worldwide have to balance their policy response to COVID-19 taking into consideration health, social, and economic impacts. The experiences of those countries around the world that have begun to remove restrictions indicate a corresponding rise in COVID-19 cases, leading to increased need for advanced medical treatment and a rise in infections among health care workers. The WHO recommends that countries should take into consideration a mixture of indicators before – and during – the easing of restrictions. These indicators include the following considerations:⁴¹

Is the epidemic under control?

This is manifested by a continuous decline in the number of new confirmed cases (decline in the effective reproduction/'R' number) in addition to a reduction in deaths due to COVID-19 and in the need for hospitalization and ICU.

Health system:

it is important for countries to understand that strong health systems are essential for health security and in coping with resurgences of cases while resuming other essential health services (each country should design its country-specific list of essential services based on the indicators and disease

burden in consultation with the WHO and United Nations Country Teams).

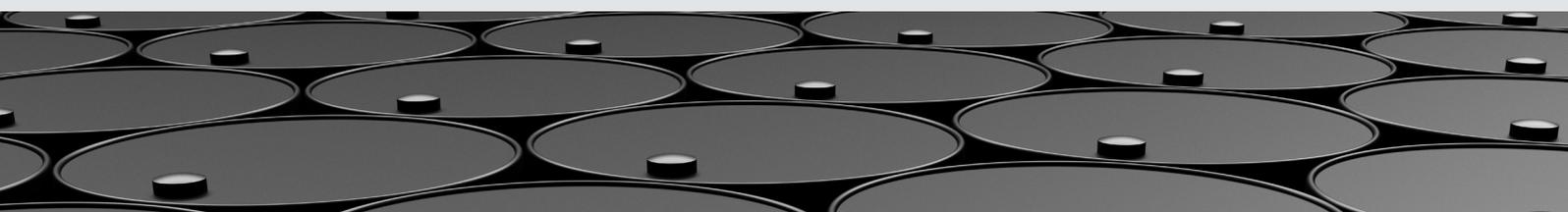
Digitalization:

digitized health system components, especially those related to the health supply chain management and the health information management system, can provide added efficiency in facing a resurgence of cases.

Surveillance:

are surveillance systems able to detect resurgences of cases and provide contact tracing? Countries are advised to strengthen their surveillance systems and integrate digital, real time data surveillance systems.

⁴¹ WHO, *Public health criteria to adjust public health and social measures in the context of COVID-19; Annex to Considerations in adjusting public health and social measures in the context of COVID-19*, 12 May 2020 (<https://www.who.int/publications-detail/public-health-criteria-to-adjust-public-health-and-social-measures-in-the-context-of-covid-19>).



Ongoing and long-term

Non-discrimination:

efforts to contain COVID-19 have been challenged in many countries by the high level of stigma inappropriately associated with the infection. The lessons learnt from decades fighting HIV and AIDS clearly indicates that stigma and discrimination reduce the effectiveness of efforts to contain an epidemic and mitigate its impacts. It is important, therefore, for countries to ensure strong anti-discrimination legislation.

Gender elements:

UNFPA figures⁴² suggest that, as with Ebola and other pandemics, there has already been an adverse effect on access to sexual and reproductive health facilities in the poorest countries of the region, where there are already very high rates of maternal mortality. Additionally, there is a gendered dynamic to the

provision of basic health care in the region – with the vast majority of nurses being women in public health services in Egypt, for example – and an overwhelming gender bias in looking after the sick at a household level. Health care workers on the frontlines have, understandably, been more exposed to COVID-19 infections than the rest of the population.

Inclusive social protection to 'leave no one behind':

many population categories were already deprived of health care services before the emergence of COVID-19. These include people living with HIV and AIDS, people with disabilities, sexual minorities, migrant workers, asylum seekers and others. It is important to consider policy options that ensure inclusion of these vulnerable groups in health, socioeconomic and other packages of support.

Looking to the longer term, as the Arab population ages – the percentage of elderly people is expected to increase to 9.49 percent in 2030 and reach 15.18 percent by 2050 (Figure 1.3) – the region will become more vulnerable to new emerging diseases and individuals will be at a higher risk of being exposed to serious complications. Therefore, efforts to protect older people should not be overlooked by governments while developing their response strategies.

42 UNFPA, *Impact of Public Health Emergencies on Sexual and Reproductive Health and Reproductive Rights in the Arab Region: The Covid - 19 Case*, Arab States Office, n.d. (<https://drive.google.com/file/d/1H68RVeMjbU1kEnN0YH3u6PvhdDEJoyG6/view>).

