COVID-19 and MENA: Governance, Geopolitics, and Gender

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COVID-19 and MENA

Governance, Geopolitics, and Gender

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Abstract

The Middle East and North Africa (MENA) region has features that make it an instructive site for studying the gendered impacts of COVID-19. Health care systems are functional and some are of excellent quality, but challenges remain in many countries, such as extremely high out-of-pocket expenditures; gaps in quality between the private and public health systems; ill-served rural populations; and budgets that provide more funding to the military than to health care. Some countries also have large populations of refugees or migrant workers, have experienced conflict or harsh sanctions, or suffered economic difficulties even before the pandemic hit. Due to their relatively late demographic transition, most MENA countries still have large populations of young people and smaller populations of the elderly (unlike most Western countries). Finally, MENA countries have very high rates of youth unemployment, especially female unemployment, along with low levels of female labor-force participation and a multiplicity of gender-discriminatory laws, policies, and norms. As in other countries, the health care sector employs many women at different levels; women also care for children and the elderly in their own families. This article examines the various institutional, governance, and sociodemographic issues from a gender perspective, to show how different categories of women across countries are being affected by COVID-19, with suggestions for social investments and a new gender contract.

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Keywords

COVID-19; MENA; institutions; governance; women; gender contract

Introduction

This exploratory article highlights the gendered institutional and governance features in countries of the Middle East and North Africa region (MENA), features that have shaped the impact of the novel coronavirus, COVID-19, on citizens, residents, and economies. As such, different categories of women would be affected in different ways. The pandemic is global in nature, and has spread because of certain aspects of contemporary globalization, such as increased international travel, but also because of poverty, social exclusion, unequal health care, or underresourced health care systems. The severity of COVID-19's impact in any country could be mitigated by the early processing and diffusion of information, effective governance, and the quality, preparedness, and accessibility of the health care system. Richer countries would be expected to tackle a health care crisis more effectively, but we have seen the devastating effects of the pandemic in the United States, Italy, Spain, France, and England. By contrast, Vietnam, a poorer country, dealt with the pandemic far more quickly and effectively.[1]

Over the decades, MENA governments have vastly improved both health care systems and health outcomes, as measured by number of hospital beds and health care workers, infant and child mortality rates, maternal mortality, and life expectancy.[2] However, the "authoritarian bargain" that provided free health care and education, an array of subsidies, and guaranteed employment to graduates began to fray in the 1990s and by the new century had generated numerous protests. The first wave of protests erupted in the 2011 Arab Spring uprisings and a second wave in 2019–2020, with citizens in Algeria, Iran, Iraq, Lebanon, Morocco, and Tunisia protesting poor public services, high unemployment, and incompetent or corrupt governance. There also are differences in economic status and access to social benefits between citizens who work in the public sector and those in the private sector. The oil-rich Gulf sheikhdoms are in a different category, albeit one that includes very high military expenditures and huge populations of migrant workers without labor rights. It should be noted that MENA consists largely of Arab-majority countries. Iran, Israel, and Turkey are non-Arab, although roughly 21% of Israel's citizenry is Arab.

The region has features that make it an instructive site for the study of the pandemic:

- Because of their relatively late demographic transition, most MENA countries still have large populations of young people and smaller populations of the elderly (unlike most Western countries); they also have low levels of female labor-force participation. Youth unemployment rates are very high, and those of young women can be as high as 30–35%.[3]
- Certain countries have large populations of refugees (notably Syrians in Jordan, Lebanon, and Turkey) or migrant workers (the Gulf sheikhdoms em-

ploy millions of construction workers and nannies from South Asian countries; Jordanian, Lebanese, and Egyptian professionals also work in Gulf countries).[4]

- Health care systems are functional and some are of excellent quality, but (a) out-of-pocket expenditures are extremely high in most countries, (b) a quality gap exists between the private and public health systems in some countries, and (c) rural populations are often ill-served while others do not have health insurance.
- The MENA region is known for very high military spending, with several countries spending more on the military than on health care.
- Some countries were in conflict, or under harsh economic sanctions, or suffering economic difficulties even before the pandemic hit. Morocco and Tunisia, and especially Lebanon, had high levels of external debt.

In March 2020, all the MENA countries instituted the lockdown measures that countries elsewhere implemented, and as of July 2020, some had weathered the storm better than others. Unlike in the United States, wearing masks became mandatory in Morocco and Tunisia, and both countries accelerated the production of masks.[5] The country least prepared to tackle the pandemic was the poorest one, Yemen, which also was experiencing a civil conflict and frequent air assaults and sieges by Saudi Arabia and the United Arab Emirates (UAE). Nonetheless, by late July, the Arab countries with the largest numbers of cases and deaths were Saudi Arabia, Iraq, and Egypt.[6] Iran and Turkey also were badly hit, ranking 11 and 15 among countries affected worldwide.[7] By December, Turkey ranked sixth, although Iran, still at 15, had many more deaths per million: 623, compared to Turkey's 199. Other MENA countries with high death rates per million were Iraq (310), Jordan (335), and Oman (286).[8] By way of comparison, the United States topped the world in number of cases; the highest death rates per million (more than 1000 deaths) were in Italy, Spain, Peru, and Belgium. Countries that did remarkably well included Cuba, South Korea, and New Zealand. Vietnam's total population of 97.7 million saw only 1,405 cases of the virus and just 0.4 deaths per million. It is a country with an effective public health infrastructure—unlike the United States and many MENA countries.[9]

This article begins with background and contextual information on countries across the region, followed by an examination of state spending on the military compared with health care. Country vignettes show how COVID-19 has been experienced and tackled, and in some cases how it has exacerbated state–society tensions. Next, recognizing that the pandemic is not gender neutral, I examine the effects on women and girls, including the likelihood of joblessness and an increase in domestic violence. Finally, I ask whether the pandemic might compel governments to reconsider existing notions of national security in favor of the concept of "human security." This article is conceptually framed through a critical feminist perspective on development and security.[10] States, institutions, and policy outcomes are gendered; class, gender, ethnicity, and national origin comprise intersecting inequalities; and interstate rivalries in the

capitalist world system not only represent hypermasculinities but also drain resources away from people-oriented programs. This qualitative study draws on relevant secondary sources, including press accounts and policy briefs from within and outside the MENA region, and data from the UN's Economic and Social Commission for West Asia (ESCWA), the Worldometer coronavirus tracker, and surveys.

Human Development and Economic Security: A Regional Survey

MENA countries differ in their resource base, wealth, and population size; the six members of the Gulf Cooperation Council (GCC) are oil economies and the richest in the region, but they also have the smallest populations and import most of their labor, largely from South Asian countries (India, Bangladesh, Pakistan, and Indonesia). The World Bank classifies countries by income and wealth (gross domestic product [GDP] or gross national income [GNI]); its 2015 classification of MENA countries by GNI per capita was as follows:

- Low income: Yemen.
- Lower middle income: Egypt, Morocco, West Bank and Gaza, Syria, Tunisia.
- Upper middle income: Algeria, Iran, Iraq, Jordan, Lebanon, Libya.
- High income: Bahrain, Israel, Kuwait, Qatar, Saudi Arabia, UAE.

To some extent this corresponds to the United Nations Development Programme (UNDP) human development rankings, measured by GDP, education, and life expectancy (see Table 1).

In the decades immediately following independence, during the era of Third World state-led development, and starting from a low base, MENA countries improved health outcomes by eradicating infectious diseases, improving immunizations, and lowering maternal, infant, and child mortality rates. MENA governments provided free schooling and health care, an array of subsidies on staples and utilities, and guaranteed employment for graduates.[11] Women's access to reproductive health improved, and fertility rates gradually declined as women's access to education, contraception, and jobs increased.

State-led social development began to change after the shift to privatization and liberalization in the 1990s, with "cost recovery" and introduction of "user fees." (In Iraq's case, the punitive sanctions regime of the 1990s largely destroyed the welfare state, and the 2003 invasion ruined much of the remaining physical and social infrastructure.) By the early part of the new century, out-of-pocket health care expenses were high (see the following discussion), especially in the large non-oil economies. In addition, certain shocks began to derail the steady progress in economic and social development: sanctions, invasions, wars, fiscal crises, environmental disasters. Between 2012 and 2018, some MENA countries moved down the human development ranking, and others up, as seen in Table 1. Syria moved down from medium human development in 2012 to low human development in 2018 (the result of the internationalized conflict), while Algeria and Jordan moved up to high human development. (By 2020,

Table 1. Change in MENA Human Development Designations, 2012, 2018, by Type of MENA Economy

	Very high human development	High human development	Medium human development	Low human development
2012				
Oil economies	Bahrain, Qatar, UAE	Kuwait, Oman, Saudi Arabia	Libya	—
Mixed oil economies	—	Iran, Tunisia	Algeria, Iraq Egypt, Syria	—
Non-oil economies	Israel	Lebanon, Turkey	Jordan, Morocco, Palestinian Territories	Yemen
2018				
Oil economies	UAE, Qatar, Saudi Arabia, Bahrain, Oman, Kuwait	—	—	—
Mixed oil economies	—	Iran, Algeria, Tunisia	Iraq, Egypt	—
Non-oil economies	Israel	Lebanon, Turkey, Jordan	Morocco, Palestinian Territories	Syria, Sudan, Yemen

Source: Author, from World Bank and UNDP.Note: It is very likely that given Lebanon's very high debt-to-GDP ratio and the terrible August 2020 explosion in Beirut harbor, Lebanon's GNI ranking will fall.

Syria was back on the medium human development list.)

Variations across the region—in terms of a country's wealth and income, state capacity, population dynamics, and stability and security—could help explain how COVID-19 has been experienced and tackled. For example, until recently, the GCC countries—Saudi Arabia, the UAE, Qatar, Kuwait, and Oman, with their oil wealth and absolutist monarchies—were largely immune to economic and political shocks. However, their economies rely on an army of migrant workers, largely from South Asian countries, who lack many labor rights (and cannot become citizens) and endure cramped housing conditions—with implications for the spread of COVID-19. Indeed, of all Arab countries tracked by ESCWA in the first few months of the pandemic, Saudi Arabia and Qatar had the largest numbers of COVID-19 cases, consisting predominantly of migrant workers.[12] Saudi Arabia had many more deaths than did Qatar, but by December 2020 the largest number of deaths within the GCC was in Oman.

Outside the GCC, Tunisia's very well functioning social welfare system began to fray in the early part of this century, and it has struggled to deliver quality services since the 2011 revolution. Since 2013 the government has sought loans from the International Monetary Fund (IMF) and World Bank, and in return has made cuts in public

spending. In 2016 Tunisia's public debt was €23,526 million (USD26,041 million), or 62.28% of GDP, a 6.85 percentage point rise from 2015, when it was 55.43% of GDP. It is estimated that in 2018 its debt consumed 87% of GDP.[13] Still, in Tunisia health care is considered a public good, not a privilege.[14] Thus, when a doctor lost his life in a malfunctioning elevator at a local hospital in early December 2020, the country's main trade union, the UGTT, called for a strike.

Morocco's 2011 constitution enshrines the right to health care, but less than half the population has health insurance and there are "problems of low service quality and delays in receiving care."[15] In 2019, medical professionals and students staged protests and strikes against privatization. Morocco's external debt of $35 billion consumes 65% of its GDP; at the end of 2019 its heavy external debt of nearly $35 billion represented a 0.15% increase from 2017. Morocco received numerous loans from several international institutions in 2019. In November 2019, the World Bank announced that it had approved a new $300 million loan to support the strengthening of "Morocco's municipalities" as part of Morocco's reforms to upgrade public administrations. The bank also loaned Morocco $500 million to promote the education sector. In December 2019, Morocco received several other loans, including $150 million from France, €100 million from the African Development Bank, and €401.5 million from the EU Investment Bank.[16] In May 2020, the Arab Monetary Fund (AMF) provided a loan worth $127 million to Morocco. In a press release, the AMF said that the fund was to provide financial resources to meet Morocco's needs amid the global pandemic. There has been much discussion in Morocco regarding the increasing external debt, including a warning from the governor of Morocco's central bank, Bank al-Maghrib.[17]

Lebanon has endured a political and fiscal crisis in recent years. The middle class has had difficulty making ends meet as salaries have been slashed and banks have imposed informal capital controls, all compounded by the coronavirus-induced lockdown measures.[18] Meanwhile, the United States proposed punitive measures in early June 2020 to target cash-strapped Lebanon, which was desperately seeking a loan from the IMF.[19] The government's ineptitude at providing prosperity and public services culminated in the numerous deaths, injuries, and infrastructural destruction from the August 2020 explosion, from which Lebanon has yet to recover.

As in Tunisia, Iranian citizens have enjoyed good health care and education mostly at state expense, but US sanctions have begun to make a serious dent on the government's ability to import needed health equipment. Moreover, according to the University of Oxford's Government Response Stringency Index time series, Iran had a less stringent and slower response, which is why the pandemic spread so widely in the early months.[20]

The country worst off in terms of health infrastructure is Yemen, which was the poorest to begin with and has seen its physical and social infrastructure decimated by civil conflict and especially air assaults by Saudi Arabia and the UAE since 2015. Vulnerable to water-borne diseases, Yemen's cholera outbreak in 2016 was worsened by the Saudi onslaught, with 2.5 million cases and nearly 4,000 deaths by December 31, 2020.[21] Syria, too, has suffered from an internationalized civil conflict, but it has a functioning government, which Yemen does not have, and thus citizens in areas under

Syrian government control can expect access to public health facilities.

Syria's once competent medical and pharmaceutical sectors have been devastated since the onset of war. In a 2018 interview, Elizabeth Hoff, who led the World Health Organization (WHO) office in Damascus, said that the principal obstacles to the recovery of Syria's medical infrastructure were the continued sanctions that prevent Syria from obtaining critical equipment and supplies to rebuild its health care capacity.[22] Despite the ongoing war, the Syrian government's armed forces had suspended conscription by March 20, 2020, and then announced the demobilization of thousands of reservists on March 29 in order to reduce the risk of infection.[23] With help from the UNDP, young Syrian graduates were putting entrepreneurial and engineering skills to use, in part to scale up preparedness and readiness to face COVID-19.[24]

However, just as the Syrian government, with some international cooperation, was beginning the long and arduous work of reconstruction, the Trump administration decided in June 2020 to enact even harsher sanctions, under the so-called "Caesar Act." In addition to targeting Syrian officials, it would enact sanctions on foreign persons or companies doing business with the government, specifically in the construction, engineering, energy, or aviation sectors. Targets included anyone providing support for the government's military operations or those of its main backers, Russia and Iran. Critics argued that the new sanctions, like the ones imposed on Iran, punish civilians more than the governments, and would adversely affect Lebanese business with Syria.[25]

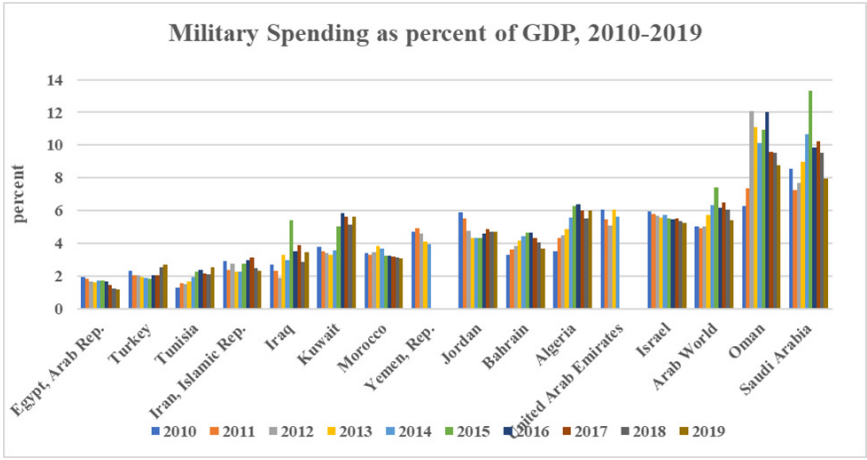
Given their wealth and small populations, the GCC countries perform well on health indicators. Medium-income and more populous countries such as Morocco and Egypt do less well, and their spending on health care has tended to be low. Health care spending as a percentage of GDP has been high in Algeria, Iran, Jordan, Lebanon, and Tunisia, but many MENA countries allocate an inordinate proportion of state resources to the military. There is thus a trade-off between "national security" and "human security," including the health and well-being of citizens. What is more, the MENA region is the least integrated in terms of economic cooperation, and development cooperation across MENA countries is almost negligible.[26]

Military Spending Compared with Health Care Spending

The MENA region is known for high levels of military expenditure. Differences in levels of military spending reflect varying government priorities, as well as international alliances. Military spending covers salaries, benefits, and infrastructure of the various armed forces, along with arms procurement. Over the past decade, the biggest spenders on military weapons have been Saudi Arabia and Oman, followed by the UAE (see Figure 1). Recent data are not available for the UAE, but in 2010, according to the World Bank, military spending consumed fully 6% of its GDP, two to three times more than the UAE spent on health or education. According to the UNDP's *Human Development Report 2011*, between 2006 and 2009, the UAE spent 2.8% of its GDP on health, and another 2.8% on education, compared with 6% on its military.[27]

Counterintuitively, the poorest country, Yemen, was a major military spender

Figure 1. Military Spending, MENA Countries, 2017



Source: World Bank, https://data.worldbank.org/indicator/MS.MIL.XPND.GD.ZS, accessed April 2020; courtesy Liangmou Zhang.

in the years before 2011, as it was a US ally in the "war on terror." According to the Stockholm International Peace Research Institute (SIPRI), Yemen's military spending consumed almost 7% of its GDP in 2002–2003, 5% in 2004, and 4% in 2014.[28] Libya's spending prior to 2011 was among the lowest—averaging 1.5% of its GDP between 2004 and 2008. After its "liberation" by NATO, Libya's military spending shot up to 7.6% in 2014 and a whopping 15.5% of the GDP in 2015.[29] Today, the states that spend the least on militarism are Egypt, Iran, Tunisia, and Turkey. The world average for military spending is 2.1% of GDP. For the Arab countries it is 5.6% of GDP. Not only is military spending high, but the region also is a conflict arena, including the longstanding Israeli–Palestinian conflict, the internationalized civil conflict in Syria, continued fighting in Libya, and the onslaught in Yemen by Saudi Arabia and the UAE. These continue despite Security Council Resolution 2532 of July 1, 2020, and the UN Secretary-General's appeal for a Global Ceasefire.[30]

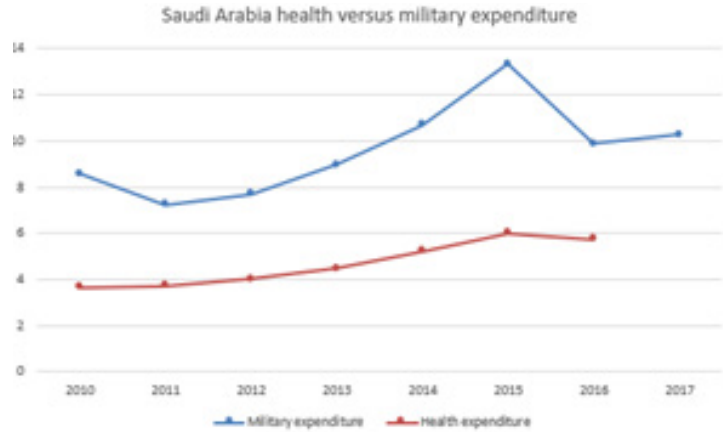
Health Care Systems and Spending

According to the World Bank, which relies on data from the World Health Organization (WHO), the 2018 world average for health care spending as a percentage of GDP was 9%.[31] For MENA, it was 5.7% (see Table 2). But for Arab countries alone health care spending was 4.9% compared to 5.6% of GDP on the military.[32] The gap between military spending and health care spending has been especially wide in Saudi Arabia, as seen in Figure 2.

The following are snapshots for other MENA countries:

- In 2014–2018, Morocco spent 5.8% of its GDP on health, 5.9% of its GDP on education (2014), and 3.1% of its GDP on the military. The health care spending share is below the WHO recommended average of 6.5%.[33]

Figure 2. Health Care vs. Military Spending in Saudi Arabia, 2010–2017



- Egypt's health care spending, at 4.6% of its GDP, is higher than its military spending but much lower than spending in Algeria, Iran, Lebanon, Tunisia, and especially Jordan.
- Jordan's health care spending in 2018 consumed fully 8.12% of its GDP, albeit a dip from 10% in 2001 and a high of 17% in 2012.
- The lowest MENA spenders on health care (apart from Egypt and Morocco) were Saudi Arabia, Qatar, Oman, Kuwait, Iraq, and Yemen. Note that this group includes countries with extremely high levels of military spending.
- Out-of-pocket health expenditures in non-GCC MENA countries are very high; in 2014 they ranged from 20% in Jordan to 55% in Egypt and 58% in Morocco and fully 76% in Yemen.[34] Citizens pay out-of-pocket for their own health care either because they do not have health care insurance, or their country has no public health care system, or the public system has been so defunded and is in such poor shape that citizens prefer private providers.

These snapshots are illustrated more systematically in Table 2, which provides data on military spending compared with spending on health and education, for MENA countries, 2010 and 2019. Note also the cross-regional comparisons.

As seen in Table 2 and in Figure 3, health care spending varies considerably across the region. It is high in Iran, Lebanon, and Jordan, and this is matched by some health care indicators. Here we examine neonatal and maternal mortality rates. The *neonatal mortality rate* (per 1000 live births) in 2018 was for Iran 8.9, Jordan 9.5, and Lebanon 4.3. At 5.5, Turkey's neonatal mortality rate was lower than Iran's or Jordan's, despite its lower (albeit still high) health care spending. In lower income Morocco the rate for neonatal mortality in 2018 was 13.8 and in Egypt 11.2.[35] According to UNICEF, "very low" *maternal mortality* is less than 100 deaths per 100,000 births; such low rates are found in Iran (16), Turkey (17), Egypt (37), Tunisia (43), Jordan (46), and Iraq (79).[36]

Table 2. Military and social expenditures, 2017–2018, MENA in World and Regional Perspective

	Military expenditure as % of GDP, 2018	Military expenditure as % of government expenditure, 2018	Health expenditure, as % of GDP, 2017	Education expenditure, as % of GDP, 2018
Algeria	5.9	13.8	6.4	—
Bahrain	4.0	10.9	4.7	2.3
Egypt	1.4	4.1	4.7	—
Iran	2.7	15.8	8.7	4.0
Iraq	2.7	8.4	4.2	—
Israel	4.3	11.1	7.4	5.8
Jordan	4.7	15.0	8.1	3.59
Kuwait	5.1	11.0	5.3	—
Lebanon	5.0	15.6	8.2	2.4 (2013)*
Morocco	3.1	10.5	5.2	—
Oman	8.2	19.0	3.8	4.97 (2013)*
Qatar	—	—	2.6	3.6
Saudi Arabia	8.8	24.6	5.2	2.9
Syria	—	—	—	—
Tunisia	2.1	6.9	7.2	6.6 (2015)*
Turkey	2.5	7.1	4.12	4.4
UAE	—	—	3.3	—
Yemen	—	—	4.2	—
World	**2.1**	**6.1**	**9.9**	**4.9**
East Asia and Pacific	1.7	5.4	6.6	4.2
Europe and Central Asia	1.7	4.0	9.3	5.1
LAC	1.3	4.1	8.0	5.3
North America	3.0	8.4	16.6	5.0
South Asia	2.5	9.8	3.5	2.1
Sub-Saharan Africa	1.1	4.6	5.2	4.6
MENA	**5.5**	**16.4**	**5.7**	**—**

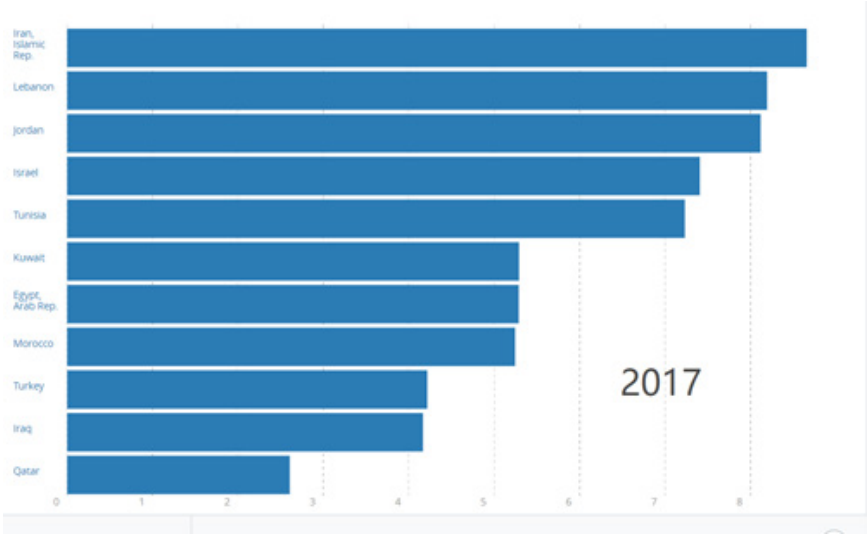
Note: Data not available for Libya.
*UNESCO Institute of Statistics, http://data.uis.unesco.org.
Source: World Bank, *World Development Indicators*: military, http://wdi.worldbank.org/table/5.7; health systems, http://wdi.worldbank.org/table/2.12; education, http://wdi.worldbank.org/table/2.7; accessed June 7, 2020.

Jordan does not do as well as other MENA countries on maternal mortality despite its high health care spending—although it is still in the "very low" category as defined by UNICEF. (By way of comparison, Brazil's maternal mortality rate is 60, Argentina's is 39, and Chile's 13.)

(Low) Satisfaction with Health Care

Among MENA citizens who have participated in the World Value Survey (WVS) and the Arab Barometer, Moroccans and Lebanese are least satisfied with their health care system, access, and quality. In the fifth wave of the WVS, and for the question on "Frequency you/your family have gone without needed medication or treatment that you needed" (V190), about half of Moroccans reported "sometimes" or "often" and half "rarely" or "never." The Arab Barometer found in 2016 that 71% of Moroccans surveyed expressed dissatisfaction or extreme dissatisfaction with their health care system and 68% believed that their government was doing a poor job of improving basic health services. There was also low satisfaction in Lebanon (26% satisfied) and Algeria (32% satisfied).[37] On the question of whether health care is improving, Moroccans scored the lowest (just 30% agreement), and were least optimistic about health care improving, with just three in 10 saying the government was doing a very good job or good job on health care. Moroccans appeared to be the most pessimistic about fair access to health care. Moroccan responses scored the third highest when asked about corruption in the health care industry, at 64%; two-thirds of citizens in Morocco said it was highly necessary to pay *rashwa* (tips, bribes) to receive better health care services. As for confidence in government performance in health care, in no country (other than

Figure 3. Health Care Spending as % of GDP, 2017



Source: World Development Indicators, http://wdi.worldbank.org/table/5.7. Courtesy Maggie King and Zhuolun Li.

Jordan) did confidence exceed 50%. Egyptians, Lebanese, and Moroccans were least optimistic, with just about three in 10 saying government was doing a very good or good job on health care.[38]

In contrast, Jordanian citizens are quite satisfied; 70% reported never going without required medicine or treatment. On the same V190 question, a large majority of Jordanians consider themselves to be in good or very good health. The influx of some 750,000 Syrian refugees, however, had likely placed pressure on Jordan's health care infrastructure, especially when the pandemic broke out.[39] Jordan was commended for being the first country in the region to impose a strict lockdown to confront and contain the coronavirus pandemic and with much success—just over 800 cases and nine deaths by June 2020, compared to tens of thousands of cases in Israel, Iraq, and Saudi Arabia. However, the number of cases and deaths increased, and by December 2020 there were nearly 268,000 cases and 3466 deaths.[40]

The pandemic inflicted a massive economic blow, and Jordan's government was criticized for failing to adopt measures to help ailing sectors. The government enacted the so-called Defense Law to absolve it from responsibility toward both employers and employees, even as a May 31, 2020, decision by Jordan's prime minister allowed employers to reduce employee wages. As of June 12, the government had not heeded private-sector calls for a lower sales tax on goods and services to stimulate public consumption.[41]

Migrant Labor and the Pandemic

The GCC countries may have cradle-to-grave social provisioning and other benefits, but these are available only to their citizens, and citizenship is highly exclusive and restrictive. As noted, GCC countries have long relied on migrant labor for an array of services outside the civil service and military: Construction, retail, hospitality, and even medical services are supplied largely by migrant workers and expatriate professionals. The share of migrant workers in GCC populations in 2019 is staggering: 80% in Qatar and nearly 90% in the UAE (8.6 million migrant workers), 70% in Kuwait, 50% in Kuwait, 45% in Oman and Bahrain, and 40% in Saudi Arabia (13 million migrant workers).[42] Migrants in the Arab States remitted over $124 billion in 2017, with the UAE and Saudi Arabia ranking second and third globally after the United States in terms of foreign workers sending money to their home countries.[43]

Largely from South Asian countries, migrant workers lack labor rights and often live in crowded conditions that make the spread of disease harder to control.[44] Contract migration schemes make citizenship acquisition nearly impossible, even for those who have lived and worked for years in a GCC country, and recent economic and health crises make any imminent changes further unlikely. As one report noted in early June 2020:

Hit by the twin crisis of the coronavirus pandemic and falling oil prices, more than 3.5 million migrant workers are expected to lose their employment and leave the Gulf as stimulus packages designed to shield local economies from the pandemic-induced recession largely exclude them. Saudi Arabia said it will pay 60% of the private sector wages for its citizens only.[45]

GCC governments were able to carry out free testing for the migrant workers, but they also furloughed or dismissed many migrant workers. This created difficulties not only for the dismissed workers but also for their families, which rely on the remittances sent home.

When the pandemic first struck, the GCC countries acted early to contain it, and by mid-March 2020 most had begun to impose restrictions on movement and travel. Still, as *The Economist* noted in late April, "Qatar has more cases than Ukraine, which is 16 times more populous."[46] The virus was spreading fastest among laborers in Qatar, mostly of them concentrated in a single residential compound in the Industrial Area, home to more than 360,000 people. Babar wrote that in May 2020, migrants in Saudi Arabia made up 76% of positive cases, "a very high proportion, given that migrants comprise 36% of the Saudi population as a whole."[47] ESCWA data show very large numbers of cases in Saudi Arabia: as of June 13, 2020, nearly 120,000 cases, with 81,000 recoveries and 893 deaths.[48] As noted, in July 2020, Saudi Arabia ranked 13 out of the 215 countries (including small islands) tracked by the Worldometer for COVID-19 incidence, recoveries, and deaths.

The effect of the pandemic on GCC countries with large migrant populations, as well as the low price of oil, may lead to changes in government employment policies. In Kuwait, the prime minister, a member of the Kuwaiti royal family, suggested in early June that the country should reduce its proportion of foreign residents from 70% to 30%.[49] In May 2020, Kuwait's municipality announced plans to dismiss all its foreign workers and replace them with Kuwaiti nationals, as well as through the increased use of automation and technology. By June 13, 2020, according to ESCWA data, Kuwait had recorded some 34,952 cases of the coronavirus, including 285 deaths. A significant portion of those infections was among expatriate workers from India, Egypt, and Bangladesh. Citing the coronavirus pandemic, the Kuwaiti government issued a 3-month extension for all residency permits and visas but declared its intention to vastly reduce the number of visas thereafter. Similarly, Oman announced in late May 2020 that contracts would not be renewed for at least 70% of foreign experts and consultants working for the government.[50]

The Pandemic, Poverty, and Human Development

Across the globe, the COVID-19 death toll as of July 2021 was over four million, with about 1.6 million deaths just in the US, India, and Brazil, and another million deaths shared by France, Russia, the UK, Colombia, Italy, Mexico, and Peru. It is an odd mix of countries that includes the most economically advanced as well as less developed countries. In those countries and the others, certain social groups have been more vulnerable to the pandemic: migrants, refugees, and low-income citizens, most of whom live in crowded conditions or have limited access to quality health care. As has been seen, labor migrants in the oil-rich Gulf countries were adversely affected early on. In the United States, seniors in for-profit nursing homes and lower income African-Americans have been the most susceptible to the coronavirus. A 2020 Oxfam report, *Dignity not Destitution*, cited a study by economists at UNU/WIDER predicting that the pandemic could push as many as half a billion people into poverty, or 8% of

the world's population.[51] According to the UNDP, global human development—measured by education, health, and living standards—was likely to decline in 2020 for the first time since 1990.[52] With school closures, UNDP estimates of the "effective out-of-school rate"—the percentage of primary school-age children, adjusted to reflect those without Internet access—indicated that 60% of children were not getting an education, leading to global levels not seen since the 1980s.[53]

In 2020, international organizations were predicting declining human development and poverty for MENA, especially within working-class and rural communities, and for those in the informal sector and small businesses.[54] Youth unemployment rates would increase. Labor-exporting MENA countries—among them Egypt, Jordan, and Lebanon—would experience rising unemployment and related effects of return migration and cessation of remittances.[55] Tourist-destination countries would suffer, along with the workers and enterprises involved in the tourism sector. With COVID-19's lockdowns, restrictions on travel, and closure of businesses, unemployment and poverty likely have increased in those MENA countries where tourism and remittances play a large role. A UN report expected that fully a quarter of the total Arab population would fall into poverty.[56] What is more, the presence of unequal gender relations and the persistence of male bias and patriarchal norms likely would result in a greater toll on women: job and income losses, a heavier care burden in the family, social isolation, and the possibility of spikes in domestic violence.

Some of the predictions have materialized. GDP has declined almost everywhere, many firms fell into financial distress, and household incomes have contracted.[57] Job losses predominated in the private sector, where many small and medium-sized businesses closed.

Gender Relations, Women, and the Pandemic

Feminist scholars have long highlighted gender dynamics of economic, political, and cultural institutions, policies, and outcomes, including research on the gendered effects of structural adjustment and on the political economy of violence against women.[58] The United Nations Fund for Population Activities (UNFPA) pointed out that disease outbreaks affect women and men differently, and pandemics make existing inequalities for women and girls worse. The effects of COVID-19 on women have been discussed in terms of job losses, intensified care responsibilities, susceptibility to the virus due to concentration in certain occupations, and the potential for domestic violence. In short:

- Women comprise most health and social care workers and are on the front lines of the fight against COVID-19.
- In GCC countries, nannies, elder care workers, and women in many private services are foreign contract workers.
- Mass school closures affect women because they bear much of the responsibility for child care.
- Shelter-in-place requirements and dense households increase the likelihood

of domestic violence. In MENA, the pandemic also could prevent implementation of the strict violence against women (VAW) laws recently adopted.

As in other regions, female nurses, midwives, and support staff dominate the health care and social services fields in many MENA countries (and in the GCC states, these are mostly migrant workers or expatriate professionals), which increases their risk of infection. In Iran, many health workers lost their lives. Some 80% of Lebanon's Order of Nurses is female, tackling not only a public health crisis but also a severe economic crisis.[59]

What is different in MENA is that women are not concentrated in the retail and hospitality sectors as they are some other regions—sectors that have seen closures, bankruptcies, and job losses. Nonetheless, an ESCWA policy brief stated that out of some 1.7 million jobs that would be lost in the Arab region, fully 700,000 of them would be women's jobs.[60] Who might such newly unemployed women be? In many MENA countries, most women work in micro and small enterprises, formal and informal alike, which are less resilient in times of crisis and more likely to shut down. In some cases, women with small children might leave their jobs because child care centers have closed or nannies have returned home.[61] Some lower level women workers in schools might experience job loss. Domestics and nannies (native or foreign) might be sent packing. The loss of jobs by women migrant workers also would adversely affect their families and communities back home. Lockdowns and reduced mobility in the wake of the pandemic would mean that women's care for the home, children, and elderly relatives would likely be intensified, at a time when their access to reproductive health services would be limited.

Most of the concerns were realized. By late April 2020, fully 57% of small and medium-sized businesses in Morocco had suspended their activities.[62] Egypt's unemployment rate rose to a near two-year high, with women's unemployment rate at 16.2%, nearly double that of men's.[63] Arab Barometer data found more job loss by women than men in the five countries surveyed. Another study found that by November 2020, total unemployment rates in Morocco were 30%, in Tunisia 22%, and in Egypt 9%. However, they were much worse for women: 52% in Morocco; 41% in Tunisia, and 16% in Egypt.[64] Such high rates are disproportionate to the (low) FLFP rates and represent a reversal of women's gains in economic participation and empowerment.

There is much evidence that intimate partner violence or domestic violence (IPV/DV) has increased in many parts of the world; families locked down in small spaces or suffering loss of jobs or access to basic needs experience stress and frustration, and this increases the likelihood of domestic violence—at a time when women's access to shelters or anti-DV services is reduced. In one expression of solidarity in Israel, Jewish and Arab women stood side by side, wearing masks, and demanded that the government enact emergency measures to help women at risk, removing them from their homes and placing them in shelters for battered wives.[65]

Since 2015, several MENA countries have abrogated penal code loopholes that absolve a man who has sex with an underage girl if he marries her, and they have passed tough laws to prosecute perpetrators of violence against women. The pandem-

ic has likely delayed implementation of such laws. The risks to the physical security and dignity of women and girls are exacerbated in conflict zones and humanitarian settings—as in Libya, Syria, Yemen, and the West Bank and Gaza—or in the refugee camps of neighboring countries.

In Tunisia, feminist leaders expressed the concern that VAW might increase. According to Asma Laabidi, Tunisia's Minister of Women, Children and the Elderly, IPV/DV had increased fivefold between March and mid-April 2020, despite the fact that the ministry had created a toll-free number operated by 11 pro bono psychologists to help victims. The feminist organization Association Tunisienne des Femmes Démocrates has long had hotlines and shelters, but its president, Yosra Frawes, feared that women's access to them would be limited during the pandemic.[66] Other reports showed increases of VAW in Palestine, Israel, and Morocco in May 2020.[67] Yet surveys carried out by the Arab Barometer between July 2020 and March 2021 found that despite the lockdowns, intensification of care work at home, and increased family stress, women respondents did not report increases in domestic violence. Indeed, a majority of Algerian women asserted that "family unity" had increased; this was less the case in Tunisia and Morocco.[68]

Women Doctors on the Front Lines

MENA women's labor-force participation is generally low, especially among married women with children and those with secondary schooling or less. Across the professions, however, female shares have risen steadily in many countries since the 1990s, with "feminization" occurring in fields such as education, social services, pharmacology, and the law.[69] In Tunisia, feminization of the health sector began in the early 2000s, in part due to the departure of many of Tunisia's doctors and health workers to Europe or the Gulf sheikhdoms, but also due to rising university enrollments of young women in medicine, nursing, and medical research. According to a study by the Tunisian women's policy agency CREDIF, women in 2015 comprised 42% of Tunisia's medical personnel.[70] Today, Tunisian women are professors of medicine, heads of hospital departments, and directors of research, as well as students at the medical faculties. There and in other MENA countries (notably Iran), women health workers have played a critical role at the time of the novel coronavirus, despite personal and financial sacrifices.

For example, although the Tunisian authorities "took huge steps to confront the pandemic," sociologist Lilia Labidi writes that this included a government decision to deduct one day's pay from the salaries of workers in the public and private sectors, to help pay for containment efforts through purchase of tests, masks, and personal protective equipment (PPE). Tunisian citizens, in principle, have access to public health care, but such access is uneven, and specialized care is concentrated in more prosperous coastal regions. There is a greater density of specialized doctors in Greater Tunis and the Center East (roughly 4.4 per 10,000 inhabitants), although general practitioners seem most evenly distributed across the country's various regions, with the highest concentration in the northwest and the southwest.[71] Nonetheless, Tunisia's women health workers became even more visible to the wider public, the media, and

the government after the outbreak of the pandemic. "In homage to the care-givers who are at the front lines of the fight against the coronavirus, in March 2020, Marouane El Abassi, head of the Tunisian Central Bank, presented a new 10-dinar banknote featuring the portrait of Tawhida Ben Cheikh—the first Tunisian woman doctor."[72]

Earlier in 2020, it appeared that Tunisia's health care system and the country's investments in women medical workers had paid off; as of June 13, 2020, according to ESCWA's pandemic tracker, Tunisia had 1,093 cases, 995 recoveries, and 49 deaths. The prime minister declared that the country had won the battle against COVID-19 and would reopen by the end of June. Some days later, however, health care workers went on strike to protest cutbacks and reduced salaries and to demand better working conditions.[73] Moreover, by December, total cases had shot up to nearly 120,000 with some 4000 deaths, still far less than Sweden, Portugal, and Belgium, with similar population size, but far more than Cuba (similar population size) as well as Algeria (population 44 million).[74] By July 2021, total cases and deaths had increased four-fold, and Tunisia was now ranked 45 on the global listing of COVID cases (see Table 3).

Will the Pandemic Compel a Shift Toward Human Security?

The economic effects of the pandemic, along with the legacy of the 2008 financial crisis and subsequent Great Recession, have hit economies and societies across the globe, with only a handful—notably Vietnam, New Zealand, Australia, Taiwan—weathering the storm in a relatively stable manner. COVID-19 has been "a great leveler,"[75] but MENA countries were not as badly hit by the pandemic as were the United States, England, Spain, Italy, France, and Peru. In June 2020, four MENA countries—Iran, Turkey, Saudi Arabia, and Qatar—were among the 20 countries most adversely affected by COVID-19, and as Table 3 shows, only Iran and Turkey remained in the top 20 in July 2021.

When the pandemic spread across the globe in March 2020, Iran was singled out by media and politicians for weeks for its high number of cases and deaths. But the numbers paled when compared to the United States and England. Moreover, Iran was suffering harsh unilateral US sanctions, unable to import vital products or export much of its oil. Meanwhile, the United States threatened Iran when the latter sent barrels of oil in late May 2020 to struggling Venezuela (also under US sanctions). Just as the pandemic and aggressive talk of more sanctions were raging, a new crisis emerged—that of the killing of yet another African-American man, George Floyd, in police custody in the city of Minneapolis. Throughout the month of June 2020, protests spread in the United States and across the globe. The killing of Mr. Floyd (and countless others like him), along with the devastating effects of the pandemic in the United States, raises the question of whether *security* needs to be redefined away from national borders and the prerogatives of the police and the military toward the *human condition.* That is, rather than a focus on military spending and national security, should governments not prioritize improvements in the quality of life and the socioeconomic security of citizens and residents? At a time when violence against women not only persists but is likely to increase, should there not be greater attention to the physical security of

Table 3. MENA Countries in Worldometer COVID-19 Ranking of Cases and Deaths

World ranking	Country	Total cases	Total deaths	Deaths per 1 million population	Total population (m=million)
6	Turkey	5.46m	50,096	588	85.26m
13	Iran	3.34m	39,304	1,005	85.08m
25	Iraq	1.4m	34,396	425	41.13m
32	Israel	845,123	6,434	690	9.23m
36	Jordan	755,480	9,812	952	10.30m
41	UAE	647,182	1,853	185	10.0m
42	Lebanon	546,766	7,869	1,158	6.8m
43	Morocco	538,589	9,346	250	37.35m
44	Saudi Arabia	498,906	7,947	225	35.36m
45	Tunisia	473,229	15,861	1,328	11.94m
63	Palestine	314,869	3,577	685	5.22m
66	Egypt	282,737	16,351	115	104.3m
68	Oman	281,688	3,371	644	5.23m
74	Bahrain	266,919	1,371	158	1.76m
78	Qatar	223,031	598	213	2.8m
88	Algeria	143,652	3,798	85	44.65m
128	Syria	25,753	1,895	106	17.93m
165	Yemen	6,936	1,365	45	30.5m

Source: https://www.worldometers.info/coronavirus/ accessed July 9, 2021.

women? In recent deglobalization moves, countries have been looking inward and erecting trade and other barriers against each other, but should there not be more international cooperation to improve global social policy and people's wellbeing? Indeed, it may be time to revisit the concept of *human security.*

The end of the Cold War brought about an expansion of the concept of *human rights* to encompass economic, social, and cultural rights as well as civil and political rights. The UNDP's *Human Development Report* of 1994 called for a broadening of the concept of *security* from traditional associations with state sovereignty, military preparedness, and balance of power to entail economic, health, environmental, personal, community, and political securities. For some years, there were fruitful scholarly and policy discussions and debates around human security. In 2009, *The Arab Human Development Report: Challenges to Human Security in the Arab Countries* listed seven threats, including insecure environments, insecure states, and insecure citizens, high unemployment and persistent poverty, food insecurity, health security challenges, and occupation and military intervention. But by that time, global discussions had largely petered out. In the aftermath of the 2008 financial crisis, the socioeconomic rights of citizenship took a back seat to shareholder profits and austerity measures de-

manded by international financial institutions.[76] Funding for public services declined and human security became a dead letter. Meanwhile, in MENA countries, military spending continued to dominate, with arms purchases largely from the United States, the United Kingdom, and France.

Now might be the time to revive the human security agenda, as at least two transnational feminist networks—the Women's Learning Partnership for Rights, Development, and Peace, and the Women's International League for Peace and Freedom—recommend.[77] Human security could go a long way in addressing feminist critiques of militarism and profit-oriented economic growth, and is compatible with feminist values of care, cooperation, and peace. Bringing *people* and the *human condition* to the center of security would involve such novel ideas as universal and high-quality health care, women's physical security, water and food security, economic security, environmental protection and security, and political participation. The human security of people in one country would not be enacted at the expense of people's human security elsewhere. Foreign policy would not be about arms flows, sanctions, and destabilization of states but about ensuring global health, decent work, reductions of carbon emissions, peacebuilding, and the equitable distribution of wealth and resources. This would be accomplished through support and enhanced mandates for multilateral organizations such as the World Health Organization, the International Labour Organization, UNICEF, UNFPA, UN Women, and the Food and Agriculture Organization, funded through member-state dues but also through a global tax on financial speculation. For the Arab region, ESCWA has proposed a solidarity tax to improve the distribution of wealth as well as health outcomes. In early June 2020, ESCWA noted that the Arab region's top 31 billionaires owned almost as much wealth as the entire bottom half of the region's adult population, and it issued a policy brief calling for a 1.2% solidarity tax to lift millions out of poverty in middle-income countries. Similarly, a regional solidarity fund was recommended by the UN body monitoring progress toward the Sustainable Development Goals.[78] Debt relief or cancellation by the World Bank, IMF, and private banks also should be considered for countries like Morocco and Tunisia. Sanctions should be lifted.

It is difficult to predict how MENA countries will adjust policies and institutions to better prepare themselves for any future pandemics, or the extent to which women's roles in health care, education, and the care economy will be rewarded. A new, more egalitarian gender contract is long overdue in the region, although some countries have made progress in that direction.[79] Given the gendered effects of COVID-19, I offer several suggestions:

- MENA governments need to invest more in public health and the health infrastructure so as to reduce citizens' out-of-pocket expenses and improve the quality of health care.
- Training more women for jobs in public health to target neglected rural areas, schools, and workplaces should become a priority.
- Nationwide networks of affordable and quality preschool and child care facilities, with well-trained staff, would create more employment opportuni-

ties for women, free others for jobs elsewhere, and provide small children with safe and healthy environments.

- Internet penetration is high in most countries, and digital work could expand women-owned businesses or home-based occupations.
- Family care workers—predominantly women—deserve either a basic income or a guaranteed pension.

For now, the triple crises of conflict, economic crisis, and COVID-19 make these proposals appear unrealistic, but countries should consider them if MENA countries are to recover, grow, and prosper. For the Middle East and for the world, COVID-19 should be the wake-up call that changes government priorities, reduces military spending, ends economic sanctions, and increases international cooperation toward the common good and human security for all.

Biography

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