Chapter 7
Social Justice Under COVID-19: A Comparative Study of Health and Socioeconomic Policy Responses in the Arab Mashreq and the Arab Gulf

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Abstract This chapter provides a critical overview on the patterns of health and socioeconomic policy responses in the Arab Mashreq and the GCC countries, from a social justice perspective. The social stratification and inheriting inequality in the Arab Mashreq affected the policy response, by favoring the economic support to big businesses, and depriving the poor from accessing quality health care, which shaped a class-based recovery. However, this disparity in the GCC policy responses in the health sector did not exist, since high-quality health care was provided to all. Moreover, the economic support was comprehensive and did not exclude small and medium-sized enterprises. However, the labor policy response undermined the social justice in the GCC pandemic response. Austerity measures were significantly directed toward the expatriate workers by reducing their numbers or cutting salaries and benefits. The chapter provides contextual analysis to draw a full picture of the structural factors that represent pressing determinants shaping different typologies of policy response in both regions.

Keywords Social justice · Policy response · COVID-19 · Health policies · Socioeconomic policies · Social Inclusion/Exclusion · Inequality · The Arab Mashreq · The Arab Gulf

7.1 Introduction: Social Justice in Policy Response to COVID-19

By the middle of the last decade, the Sustainable Development Goals (SDGs) emerged as a development agenda that countries would follow until 2030 and frame their national plans on accordingly. In the midst of the obsession with SDGs' data monitoring, reporting, and following up mechanisms, the COVID-19 pandemic hit the world in 2020 with great force, turning quickly into a global pandemic. The pandemic stole the show, leading policymakers, NGOs, and other stakeholders away

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from the "trendy" SDGs "policy design" and localization notions to the timely and significant "policy response" concepts. In fact, although the development agenda's moto was "no one left behind," yet crisis management and policy response concepts were actually left behind in the development agenda itself. The policy response to the pandemic in most countries prioritized the value of life and health over economic interests, while the measures taken disrupted and reshaped the functionality of many systems, such as labor and education.

The COVID-19 pandemic disrupted normal life across the world. It did not only ravage human health and caused untold suffering but has also threatened the integrity of social systems. The COVID-19 pandemic's impact and the subsequent response from authorities shed the light on disparities based on economic status, class, citizenship and immigration status, etc. The policy response to the pandemic in Arab countries reflected the long-standing inequalities in society. In fact, the pandemic brought to the fore imbalances in resource distribution modulated by the general socioeconomic inequalities at large. These disparities form the basis for this chapter's critical overview on the patterns of health and socioeconomic policy responses in the Arab Mashreq and the GCC countries, from a social justice perspective.

Response to the pandemic in different countries, not just the Arab countries, has reflected how the most vulnerable are left behind and becoming more marginalized (Fisher & Bubola, 2020). The socioeconomic disparities that preceded the pandemic became more pronounced as governments undertook policy positions like restricting movement and shutting down economic activities to contain the spread. These policy positions forced small businesses to shut down and caused many sectors to be paralyzed. These measures not only enforced the said disparities but also reinforced them, leaving the economically disadvantaged even more vulnerable, and exacerbated the hardship on the poor.

The COVID-19 pandemic raised important social justice issues related to preexisting social inequalities. Moreover, some policy responses to the pandemic were counterproductive and exacerbated the existing socioeconomic polarization. Such policy responses resulted in a skewed distribution of resources required for people to overcome the impact of the pandemic. Haase's (2020) description of COVID-19 as a stressor for justice issues was likely in response to the disparities exposed by the pandemic. This means that the brunt of the pandemic was not just born by the poor and the marginalized by the socioeconomic status. Their suffering was enhanced by policy responses that were insensitive to their low income, poor housing, and lack of access to quality health care.

Research suggests that social polarization spurred by ineffective policy responses will have long-term ramifications that will increase the socioeconomic disadvantages faced by the most vulnerable in society (Fisher & Bubola, 2020). The following discussions will explore the role of Arab Mashreq policy responses in reinforcing existing social crises rather than alleviating them. Moreover, the contrast will be made with policy responses in the GCC countries that have integrated intersectionality perspectives in handling the complexities of the pandemic in the health policy response, while nationality-based discrimination was clear in the labor policy response.

7.2 Health Context and Infrastructure Shaping Different Policy Responses

Quality health care for all is an essential element in achieving fundamental social justice goals. According to Van der Weide and Milanovic (2018), income disparities contribute to inequities in health systems between the poor and the rich. Like in most Mashreq countries, the health system has been stretched to its limit by the COVID-19 pandemic. Moreover, the pandemic has highlighted the health inequities in the system. Research suggests that marginalization and poverty are global risk factors that influence the spread, severity, or mortality of COVID-19. Countries in the Arab Mashreq with disproportionality higher poor populations have had higher COVID-19 cases and mortalities than GCC countries, whose populations are relatively less poor.

In the Arab Mashreq countries, the fragile health sectors and the coverage gap of medical insurance generated an association between appropriate recovery and the upper class. Accordingly, access to quality care was exclusively for the rich. On the other hand, the poor had to rely on public health, which is often underfunded, understaffed, and lacks sufficient resources (Aref, 2021a).

The COVID-19 pandemic shined a light on and exacerbated preexisting socioeconomic and political health inequalities in the Mashrerq. In some cases, policy responses to the pandemic widened the inequities and disproportionately exposed vulnerable communities to adverse health outcomes (Ku & Brantley, 2020; Marmot & Allen, 2020). Moreover, healthcare and local inequalities in poor communities promoted the spread of the virus as insufficient public health facilities derailed contact tracing efforts. Therefore, governments and authorities must understand the differential effects of COVID-19 to formulate effective policy responses within societies. Research suggests that health inequalities can be addressed through policy formulations that consider social determinants (Sokka et al., 2009; Tipirneni, 2021). This facilitates the formulation of COVID-19 policy responses based on an understanding of disease incidence and outcomes.

The lockdown measures in the Mashreq countries did not consider the disruptive effects on families' food security. In addition, refugees in countries like Jordan and internally displaced persons (IDPs) in war-torn countries like Syria and Iraq were left behind in the policy response. Instead of prioritizing their needs as vulnerable people, they faced restrictions on moving out from overcrowded camps due to the lockdown measures, which exacerbated their plight (Aref, 2021a, b).

Authorities in such areas should focus on channeling aid toward the creation of mobile healthcare facilities to assist vulnerable refugees and IDPs. The unsanitary condition in refugee and IDP camps coupled with crowded living conditions heighten the risk of exposure to the virus. COVID-19 policy responses that focus on handwashing have to integrate the provision of clean water in such areas. Health and sanitation of facilities are essential in such regions to curb disease outbreaks.

Unlike the Mashreq, the readiness and the well-invested health sector in the Gulf represented a strong foundation for recovery and inclusion. In an assessment of

coronavirus preparedness published by the World Health Organization (WHO) at the start of the pandemic, countries were rated on a scale from 1 (incapacity) to 5 (sustainable capacity), with all GCC countries scoring 4–5. During the pandemic, GCC countries boosted the health sector by further investment estimated at USD 90 billion (Al-Ani, 2022). With this massive investment, the Gulf governments have succeeded in controlling the outbreak of the disease with recovery rates above the global average. For instance, Qatar has become the only Arab country in the region to be among the top 15 countries in dealing with COVID-19, according to a classification published by Der Spiegel magazine in Germany (Al-Thani, 2021). Moreover, the UAE and Bahrain are among the world's leading countries in terms of examination, as they ranked first and third, respectively, in terms of the number of new tests per thousand people (OECD, 2020).

In general, all over the GCC countries, the rights for detection, quarantine, and recovery were fully supported for all citizens and residents, regardless of the different health insurance frameworks. The pandemic has shed the light on the suffering caused by the virus to migrant workers, especially unskilled workers, given the overcrowded living conditions that allowed the virus to spread in housing complexes. Hence, the authorities paid special attention to the health of the workers, provided periodic examinations, and built temporary hospitals for quarantine and recovery. Even in some countries with regions whose residents lack official documents, such as some western regions of Saudi Arabia, schools have been used to provide temporary accommodation and quarantine.

The case in Mashreq is different in terms of the resources allocation and distribution of wealth, which both affected the unjust shaping of the health policy response. For instance, the highly privatized healthcare system in Lebanon is already a major obstacle for the most in-need people in the country, who struggle to access affordable care. The annual inflation rate, which jumped above 133% in November 2020, hit the Lebanese and refugees alike, directly undermining their ability to access health care. (Elwatan, 2021). According to the estimates of the Egyptian Medical Syndicate, out of 220,000 registered doctors, 120,000 of them are outside Egypt, and hospitals lack about 55,000 nurses, in addition to low wages and a lack of medical supplies (Elshobky, 2020).

Moreover, public health in Iraq is witnessing an old crisis, the results of which are unfolding today. Decades of conflict, along with international sanctions and a lack of interest in the health sector, have seriously damaged the healthcare system, creating an environment that has prompted many qualified doctors and others to emigrate. 5.4% of the total public budget is spent on health and the environment as a whole. According to the Public Health Organization, Iraq spends only $154 per person per year on health. Iraq's population has seen a significant increase, but the health system has not kept pace (Physicians for Human Rights, 2021).

In Lebanon, before the pandemic, the crisis stems from the government's failure to reimburse private and public hospitals, including funds owed by the National Social Security Fund and military health funds, making it difficult to pay staff and purchase medical supplies. In addition, a dollar shortage has restricted the import of vital goods and led banks to curtail credit lines (Human Rights Watch, 2019). The

situation was expressed by a formal political narrative from in Lebanon that "We have reached a stage, that only the rich can enter the hospital" (Lebanese Ministry of Media, 2021).

7.3 Case Studies of Social Inclusion/Exclusion in Health Policy Response

A closer look at the UAE experience for instance provides a case for inclusivity of the health policy response of the GCC states. The UAE's COVID-19 policy response was more sensitive to social justice concerns. Its response strategies focused on collaborative efforts through public–private partnerships to bolster supply chains for COVID vaccine and other essential items. This prevented serious disruption of the economy as people could access humanitarian, medical, and testing supplies. The government's policy response prioritized testing and treatment by setting up testing stations in all major heal facilities. This allowed for developing and planning for appropriate interventions as the pandemic progressed.

The UAE policies on vaccination integrated a collaborative approach, with government leaders at the forefront of pro-vaccination campaigns. The government's efforts to provide vaccines for all its citizens and migrant workers culminated in the UAE being ranked the 2nd in vaccine administration across the globe (Suliman et al., 2021). The UAE government availed COVID-19 vaccines to all its citizens at no charge, a policy that bridged socioeconomic disparities. Its locally manufactured Sinopharm and Pfizer-BioNTech were distributed in all the emirates for all people at no cost. The UAE government leveraged technology to bridge socioeconomic disparities through the digitization of healthcare data. Access to vaccines was made more convenient through mobile applications and telecommunication (Suliman et al., 2021). For instance, the government launched a contact tracing and vaccine registry mobile application, *Al Hosn*, to keep track of vaccination efforts. Digital technology was also deployed in data integration and COVID-19 community awareness initiatives.

The policy response is different when compared with another case study of Egypt for instance from the Mashreq. Historically, Egyptian health policies have been aimed at providing universal health care for all. The country had made commendable strides in these efforts with an impressive network of health facilities (World Health Organization, 2018). However, investment in the Egyptian health system did not match its high population growth rate, with government expenditure declining to 1.16% of the country's GDP in 2020, at the height of the pandemic (Diab & Hindy, 2021). Moreover, out-of-pocket payments remain the main form of health financing, with low-income earners spending more on health than high-income earners. The Egyptian policy response to COVID-19 has largely ignored these disparities. The quality of health in private hospitals remains significantly better vis-à-vis public health facilities. Differences in the quality of health also occur on a geographical basis, with urban facilities being significantly better than rural facilities.

The COVID-19 pandemic not only exposed but exacerbated the underlying health inequalities in Egypt. The policy responses to the pandemic did little in the way of attending to the needs of low-income populations. The inaccessibility of healthcare services in underserved locations placed poor communities at a higher risk of infection and death due to limited vaccination or testing (Shawky, 2018). The Egyptian government's policy response to the pandemic featured interventions to reduce the spread through lockdowns, social distancing, and masking policies. The government also aimed to equip health facilities with requisite medication, conduct effective diagnoses, and enhance the capacity of health personnel.

Though well-meaning, the Egyptian government's policy response did little to address the existing inequalities. The informal and unskilled nature of the work done by people in low-income communities did not provide opportunities to work from home either. According to Egypt's of Manpower (2020), it attempted to remedy the situation through an EGP500 monthly stipend to informal workers. However, only a fraction of the workers in the informal sector (about 1.6 million) were beneficiaries of the policy. Affluent Egyptians were better placed to cope with the lockdowns while working from home. Access to COVID-19 tests and quality medical treatment was to a large extent the preserve of the rich. The poor did not have the same access to quality care due to the dichotomy between Egyptian private and public hospitals. Unlike private facilities, Public Facilities in Egypt were overstretched and ill-equipped to provide quality care.

Despite the pandemic and the catastrophic situation that the health sector is going through in Egypt, which necessitates an increase in spending on the health sector, the government reduced health expenditure and drug subsidies by 40% (about 1.5 to 2.1 billion pounds, from a target of 3.6 billion pounds) (Aljazeera, 2020).

7.4 Case Studies of Socioeconomic Disparities in Policy Response

The COVID-19 pandemic found Iraq already in a dire state of socioeconomic and political instability. The nation was already reeling from a lack of economic opportunities and basic services, prompting nationwide demonstrations in the last quarter of 2019 (Hassan & Rubin, 2019). The spread of the COVID-19 only worsened the situation beyond the tensions with the USA and the collapse of oil prices. It exacerbated social, economic, and political challenges that Iranians had to grapple with. The Iranian authorities' COVID-19 policy response had little substance in terms of strengthening social cohesion, inclusion, and protections for all Iranians (United Nations, 2019). Their response strategies stressed scientific recommendations like handwashing and mask-wearing. However, challenges arose since vast sections of the Iraqi population were already socioeconomically underprivileged, with most of them internally displaced.

The Iraqi authorities' response to the COVID-19 pandemic did not (or could not) take into account the plight of internally displaced persons (IDPs). The living conditions of IDPs were characterized by a lack of clean water, poor sanitation, and insecure housing in densely populated communities. The pandemic found them already suffering from infectious and non-communicable diseases, malnutrition, and poor sanitation. Policies that limited movement, though well-intentioned, increased gender-based violence among vulnerable women and children in refugee and IDP camps (IASC, 2015). This trend was consistent with research in other jurisdictions that correlated spikes in domestic violence cases to prolonged lockdowns (Usher et al., 2020). Therefore, lockdown policies may have reduced the spread but with the unintended consequence of precipitating the humanitarian crisis.

The COVID-19 pandemic response policies in Iraq did little in the way of protecting vulnerable populations, already in dire need of humanitarian assistance. Research places the percentage of Iraqi workers who are dependent on casual labor at 45% while 28% have no income (CLCI, 2020). The authorities' response strategies to the pandemic were not tailored to prevent further discrimination or marginalization. For instance, restrictions on movement did not take into account implications on humanitarian aid supply chains (OCHA, 2020). Lockdown requirements disrupted livelihoods and further reduced access to food, shelter, and other basic needs. Marginalized populations like refugees and IDPs were disproportionately more disadvantaged by lockdown policies. Socially, economically, and physically disadvantaged groups like the elderly and persons with disabilities were exposed to greater health and psychosocial risks.

Iraqi authorities did not ensure their response to COVID-19 was rights-based or prioritized gender parity and the needs of the socioeconomically disadvantaged. Consequently, the strategies deepened health inequalities. Moreover, the disparities in access to information channels and internet coverage along socioeconomic lines predisposed vulnerable and marginalized Iraqi communities to COVID-19 misinformation.

In the Kingdom of Saudi Arabia (KSA), the COVID-19 pandemic triggered a precipitous drop in global oil prices and devastated its oil-dependent economy. Incomes in the country also suffered as a result since half of its GDP comes from oil exports. The KSA deployed COVID-19 prevention strategies from the onset of the pandemic before it hit its borders (Hassounah et al., 2020). Its intervention policies integrated strict measures including shutting down international travel, closing down mosques in Mecca, and restricting public transport. The KSA also imposed partial lockdowns modulated by the severity of outbreaks and enforced WHO guidelines on mass gatherings.

Beyond instituting movement restrictions, the KSA COVID-19 response strategies were such as mass testing and provision of dedicated ICU facilities ensured socioeconomic disparities did not overshadow its fight against the pandemic. Its early interventions were effective in slowing down the spread and paved the way for the creation of public awareness on prevention measures for all Saudi residents. It also prevented the KSA health facilities, laboratories, and medical equipment from being overwhelmed by the outbreak (Hassounah et al., 2020). The government channeled a

substantial portion of its GDP (about 7%) to shield all Saudi citizens and its economy from the lockdown impacts. This went a long way in preventing socioeconomic disruptions in the country and protecting the most vulnerable in society.

The KSA COVID-19 policy response also focused on supporting its health system to sustain continuous delivery of essential health services throughout the pandemic. This ensured that its vulnerable populations had access to timely and comprehensive COVID-19 treatment irrespective of their socioeconomic status (United Nations, 2020). The KSA government constructed additional health facilities to plug potential shortfalls and supported them with significant financial investment. It ensured all medical personnel and the general public had adequate personal protection equipment to contain the spread. Moreover, the government ran media campaigns providing useful information to all residents on the virus.

7.5 Economic Response Between Including All Businesses or Excluding Small Ones

The economic response in the Arab Mashreq was directed to support large-scale companies and gig business owners with no resources being pumped into small and medium industries, while they were the biggest losers from the pandemic. Also, the social protection policy development remained almost absent, although the poor and vulnerable groups' needs should have been prioritized in such a crisis. The case was different in the GCC, as the same support was extended to the small business owners.

The KSA COVID-19 policy response for instance prioritized jobs protection focusing on small and medium-sized businesses. It integrated economic recovery strategies for workers in the informal sector, thus securing a significant portion of the labor market. This strategy was critical in lessening the social implications of the pandemic by stimulating economic recovery post the pandemic. Key initiatives such as financial support not just for large private corporations but for SMEs as well ensured were critical ensuring vulnerable communities were protected from the economic disruptions of the pandemic. The government also introduced labor market regulations that supported immigrant workers and offered unemployment insurance to private-sector workers.

The Kingdom's policy strategies also leveraged macroeconomic policies that reinforced multilateral regional responses and secured the interests of the most vulnerable. The government achieved this through diverse fiscal measures aimed at propping up the economy. These involved lowering the repo rate and fiscal support of about $61 billion to cushion all Saudi citizens from the impact of the pandemic. The governments' policy response also involved bolstering resilience in vulnerable communities through the promotion of cohesion and deployment of rapid response systems. Key government ministries leverage social media to create public awareness and explain the reasons behind the closure of commercial activities in the kingdom. They also provided sanitary facilities to vulnerable populations in various locations.

Despite its best efforts, poor vulnerable communities in the KSA were still disproportionately more adversely affected by some of the interventions. For instance, non-Saudi residents working in the private and informal sectors were affected by salary cuts and the increase in VAT. To remedy the situation, the KSA COVID-19 policy response supported workers in the public and private sectors and businesses. The government rolled out public funds aimed at alleviating the suffering of the most vulnerable in society (United Nations, 2020). Moreover, the government engaged in a strategic partnership with the UN-network to distribute food aid to vulnerable communities through the Saudi Food Bank.

It is worth noticing that the support to small-scale businesses and the vulnerable population was not only initiated by the Gulf governments. The outbreak has redefined the responsibilities of citizens and the business community and highlighted economic and religious solidarity. The business community has become a buffer between the government and the population. Blurring the lines between the government and the business community is an attempt to make the economic challenge a shared responsibility. For instance, Kuwaiti businessman Fawaz Khalid al-Marzouq launched an initiative to mobilize support for the Kuwaiti government by donating $10 million for a fund to be located under the government's umbrella. Other businesses rallied to contribute by providing financial and medical aid, logistical support, and by placing hotels, hospitals, and other venues under government control. Kuwaitis hailed these initiatives as a reaffirmation of the business community's support and commitment to the government in times of need (Alhussein, 2020).

7.6 Unjust Policy Response in the Labor Sector

The labor market context in the Arab Mashreq related to the high rates of informality and the preexisting inequalities was distressing the pandemic response. Most of Arab Mashreq already had to struggle with preexisting labor market challenges, whether in relation to the influx of refugees, high youth unemployment, low female participation rates, or high informality (Kebede et al., 2020).

Even before the pandemic, workers in the informal sector in the Arab Mashreq countries were unable to benefit from social protection programs (Jull et al., 2018). The pandemic exacerbated these informality challenges. Lockdown policies in most Arab Mashreq countries exposed the informal workers to income loss. Pre-existing social inequalities among refugees affected by forced displacement have been compounded during the COVID-19 pandemic, with related disruptions to services and social networks (Jones et al., 2022).

The labor market context in the GCC countries is different. The challenges are related to the demographic imbalance between a national minority and a majority of expatriates shaping the labor force. This challenge is placed within a complex political system of rentier monarchies that provide cradle-to-grave socioeconomic benefits to the nationals exclusively. This context affects the labor policy response in

the crisis as national entitlements cannot be touched (Aref, 2021b). Hence, despite the comprehensiveness of economic policy response in the GCC countries, the austerity measures directed to the expats' labor undermined the philosophy of social justice in the policy response. These measures were largely directed to expatriate workers in terms of reducing numbers or cutting salaries and benefits.

For instance, Kuwait has approved austerity measures that began with "zeroing" paid vacations for all expatriate workers, passing through reducing the salaries ranging from 30 to 65%, and ending their contracts. Oman has called to protect Omani nationals in the private sector. Bahrain launched a circular to reduce expenditure budgets by 30%, resulting in firing expatriate workers and cutting their salaries. In the UAE, although the Ministry of Human Resources has called on companies not to terminate the employees or reduce their salaries without their consent, and to resort to consensual measures such as unpaid leave, this did not prevent hundreds of companies from laying off expatriate workers and reducing their salaries by rates that sometimes exceeded the 75% threshold (Afzaz, 2020).

Saudi Arabia, whose economy is resource-driven, also had to reduce the workforce primarily from the oil and gas sector in response to the coronavirus crisis. The Saudi state oil company Aramco started laying off its employees in early June. Though the actual number of employees who lost their jobs is not clear, according to some business analytics, around ten percent of the total workforce has been laid off. The same case in Qatar, the world's largest gas producer had to reduce its workforce in various sectors in response to the financial impact of the ongoing pandemic. Qatar Petroleum, the world's largest producer of liquefied gas, has had to terminate around 800 jobs. The market downturn due to the ongoing pandemic has caused the company to restructure its model, which has led to the elimination of certain jobs and to cut spending by around thirty percent. (Center for International and Regional Studies, 2020).

7.7 Conclusion

This chapter has provided a critical overview on the patterns of social justice in the health and socioeconomic policy responses to COVID-19 in the Arab Mashreq and the GCC countries. The context of both regions was examined to underline the structural factors contributing to shaping the policy responses. The low-funded and fragile public health sector, along with the inherited inequality in the Arab Mashreq made it hard to have an inclusive policy response. The quality recovery was associated with the rich, while the poor and the most vulnerable were left behind. The same exclusion model was adopted by Mashreq governments in the economic policy response. The formal subsidies were directed to support big businesses, with no support dedicated to the small to medium-sized enterprises.

The Arab Gulf context is different in terms of the hydrocarbon economy, sufficient resources, and a well-invested-in health sector. This context helped the Gulf governments to pump the health sector with extra funds, achieve recovery rates

above the world average, and to provide inclusive health care for all. In addition, unlike the Mashreq countries, the economic response to the pandemic in the Gulf did not prioritize the big businesses. The small businesses were provided the same support to survive the crisis. However, the austerity measures that were taken by the Gulf governments toward labor policies undermined the inclusivity adopted in the health and economic sectors. These measures were shaped to reduce the number of expatriate workers by terminating their contracts and/or keeping them with cuts in salaries and benefits. The labor policy response was not constructed in a vacuum. The pressing political and socioeconomic context in the Gulf was explored to understand the exclusion typology in the policy response.

The review of COVID-19 policy responses in both Arab Mashreq and GCC countries reveals an imperative social justice dilemma that should be considered in all crisis responses. Rethinking the inherited context that shapes the policy responses is an area for future research and policy debate.

References

Afzaz, M. (2020). *Reducing salaries, terminating contracts and other measures: Monitoring the conditions of workers in the Gulf under Corona.* Aljazeera. https://www.aljazeera.net/ebusiness/2020/5/14/

Al-Ani, T. (2022). *Two years after it was classified as a pandemic, this is how the Gulf countries dealt with Corona.* Alkhaleej Online. http://khaleej.online/Q5xv3o

Alhussein, E. (2020). *The coronavirus redefines responsibility in the Gulf*. The Arab Gulf States Institute in Washington. https://agsiw.org/the-coronavirus-redefines-responsibility-in-the-gulf/

Al-Thani, M. (2021). Qatar weathered pandemic best among Arab countries. *The Peninsula.* https://thepeninsulaqatar.com/article/11/07/2021/Qatar-weathered-pandemic-best-among-Arab-countries

Aljazeera. (2020). *Despite the worsening of the Corona pandemic, Egypt cuts $6.4 billion in support allocations.* https://mubasher.aljazeera.net/news/economy/2020/12/27/

Aref, A. (2021a). *Austerity for the poor and prosperity for the rich: With fragile social protection systems in the Arab world, people have constructed their own resilience mechanisms for survival.* Fair Observer.

Aref, A. (2021b). Social inclusion and exclusion in GCC labour policy transformations: Evidence from Qatar and Saudi Arabia. *Journal of Politics and Law, 14*, 124.

Center for International and Regional Studies. (2020). *Asymmetric impact of COVID-19 on employment in the GCC*. Georgetown University Qatar.

CLCI. (2020). *Cash consortium for Iraq—Brief: Covid-19 impacts on prices and markets.* Cash and Livelihoods Consortium for Iraq (CLCI). https://www.calpnetwork.org/wp-content/uploads/ninja-forms/2/CCI-COVID-19-Impacts-on-Prices-and-Markets-in-Iraq-FINAL.pdf

Diab, O., & Hindy, S. I. (2021). *Background paper: Social protection and gender in the IMF Egypt program. Alternative policy solutions.* https://aps.aucegypt.edu/en/articles/672/background-paper-social-protection-and-gender-in-the-imf-egypt-programme

Elshobky, A. (2020). *Number of doctors.* https://www.almasryalyoum.com/news/details/2049512

Elwatan. (2021). *A dangerous reality revealed by "Doctors Without Borders" about Lebanon.* What is happening is painful! https://elwatan.news/english/a-dangerous-reality-that-doctors-without-borders-reveals-about-lebanon-what-is-happening-is-painful.html

Fisher, M., & Bubola, E. (2020, March 15). As coronavirus deepens inequality, inequality worsens its spread. *The New York Times*. https://www.nytimes.com/2020/03/15/world/europe/coronavirus-inequality.html

Haase, A. (2020). Covid-19 as a social crisis and justice challenge for cities. *Frontiers in Sociology, 5*. https://doi.org/10.3389/fsoc.2020.583638

Hassan, F., & Rubin, A. J. (2019, October 2). "Just give us a country": Thousands in Iraq protest corruption. *The New York Times*. https://www.nytimes.com/2019/10/02/world/middleeast/iraq-corruption-protests.html

Hassounah, M., Raheel, H., & Alhefzi, M. (2020). Digital response during the COVID-19 pandemic in Saudi Arabia. *Journal of Medical Internet Research, 22*(9), e19338.

Human Rights Watch. (2019). *Lebanon: Hospital crisis endangering health*. https://www.hrw.org/node/336503/printable/print

IASC. (2015). *Guidelines for integrating gender-based violence interventions in humanitarian action: Food security and agriculture*. Inter-Agency Standing Committee. https://gbvguidelines.org/wp/wp-content/uploads/2015/09/2015-IASC-Gender-based-Violence-Guidelines_lo-res.pdf

Jones, N., Baird, S., Abu Hamad, B., Bhutta, Z. A., Oakley, E., Shah, M., Sajdi, J., & Yount, K. M. (2022). Compounding inequalities: Adolescent psychosocial wellbeing and resilience among refugee and host communities in Jordan during the COVID-19 pandemic. *PloS One, 17*(2), e0261773.

Jull, J., Petticrew, M., Kristjansson, E., Yoganathan, M., Petkovic, J., Tugwell, P., & Welch, V. (2018). Engaging knowledge users in development of the consort-equity 2017 reporting guideline: A qualitative study using in-depth interviews. *Research Involvement and Engagement, 4*(1). https://doi.org/10.1186/s40900-018-0118-y

Kebede, T. A., Stave, S. E., & Kattaa, M. (2020). Facing double crises: Rapid assessment of the impact of COVID-19 on vulnerable workers in Jordan. *International Labour Organization (ILO)*.

Ku, L., & Brantley, E. (2020). Widening social and health inequalities during the COVID-19 pandemic. *JAMA Health Forum, 1*(6). https://doi.org/10.1001/jamahealthforum.2020.0721

Lebanese Ministry of Media. (2021). *Haron: Hospitals are unable to absorb another wave of "Corona" nor to open the departments that were closed*. https://corona.ministryinfo.gov.lb/news/show/12137/

Marmot, M., & Allen, J. (2020). COVID-19: Exposing and amplifying inequalities. *Journal of Epidemiology and Community Health, 74*, 681–682. https://doi.org/10.1136/jech-2020-214720

OCHA. (2020, April 9). *IRAQ: COVID-19 situation report no.10*. United Nations Office for the Coordination of Humanitarian Affairs. https://reliefweb.int/sites/reliefweb.int/files/resources/09042020_COVID19_SitRep_No10.pdf

OECD. (2020). *OECD policy responses to coronavirus (COVID-19). COVID-19 crisis response in MENA countries*. https://www.oecd.org/coronavirus/policy-responses/Covid-19-crisis-response-in-mena-countries-4b366396/

Physicians for Human Rights. (2021). *Challenges faced by the Iraqi health sector in responding to COVID-19*. https://reliefweb.int/report/iraq/challenges-faced-iraqi-health-sector-responding-Covid-19-enar

Shawky, S. (2018). Measuring geographic and wealth inequalities in health distribution as tools for identifying priority health inequalities and the underprivileged populations. *Global Advances in Health and Medicine*, *7*. https://doi.org/10.1177/2164956118791955

Sokka, T., Kautiainen, H., Pincus, T., Toloza, S., da Rocha Castelar Pinheiro, G., Lazovskis, J., Hetland, M. L., Peets, T., Immonen, K., Maillefert, J. F., Drosos, A. A., Alten, R., Pohl, C., Rojkovich, B., Bresnihan, B., Minnock, P., Cazzato, M., Bombardieri, S., Rexhepi, S., & Rexhepi, M. (2009). Disparities in rheumatoid arthritis disease activity according to gross domestic product in 25 countries in the QUEST-RA database. *Annals of the Rheumatic Diseases, 68*(11), 1666–1672. https://doi.org/10.1136/ard.2009.109983

Suliman, D. M., Nawaz, F. A., Mohanan, P., Modber, M. A. K. A., Musa, M. K., Musa, M. B., El Chbib, D., Elhadi, Y. A. M., Essar, M. Y., Isa, M. A., Lucero-Prisno, D. E., & Moonesar, I.

A. (2021). UAE efforts in promoting COVID-19 vaccination and building vaccine confidence. *Vaccine, 39*(43), 6341–6345. https://doi.org/10.1016/j.vaccine.2021.09.015

Tipirneni, R. (2021). A data-informed approach to targeting social determinants of health as the root causes of COVID-19 disparities. *American Journal of Public Health, 111*, 620–622. https://doi.org/10.2105/ajph.2020.306085

United Nations. (2019). *A gender response to COVID-19 in Iraq: A guidance note on actors' engagement*. UN. https://reliefweb.int/sites/reliefweb.int/files/resources/un_women_gender_response_to_Covid-19_in_iraq._a_guidance_note_on_actors_engagement_final.pdf

United Nations. (2020, November). *Socio-economic impact of COVID-19 in the kingdom of Saudi Arabia and how to build back better*. UN. https://saudiarabia.un.org/sites/default/files/2020-12/Socio-Economic%20impact%20of%20COVID-19%20in%20the%20Kingdom%20of%20Saudi%20Arabia%20and%20how%20to%20Build%20Back%20Better%2C%20Diagnostics%20paper%2C%20UN%20in%20KSA%2C%20November%202020.pdf

Usher, K., Bhullar, N., Durkin, J., Gyamfi, N., & Jackson, D. (2020). Family violence and COVID-19: Increased vulnerability and reduced options for support. *International Journal of Mental Health Nursing, 29*(4). https://doi.org/10.1111/inm.12735

van der Weide, R., & Milanovic, B. (2018). Inequality is bad for growth of the poor (but not for that of the rich). *The World Bank Economic Review, 32*(3), 507–530. https://doi.org/10.1093/wber/lhy023

World Health Organization. (2018). *Egypt: Country operation strategy at a glance.* WHO. https://apps.who.int/iris/rest/bitstreams/610430/retrieve

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