COVID-19 And the Middle East

Q&A with Melani Cammett, Clarence Dillon Professor of International Affairs, Harvard University

You've written before on how and why political parties in the Middle East engage in service provision. How is the COVID-19 pandemic likely to impact this phenomenon?

In some countries in the Middle East, South Asia and other regions, political parties are integral to welfare regimes as providers or as brokers for access to services. Some of my own work focuses on the case of Lebanon, where sectarian political parties and politicians are the key actors in and beneficiaries of a power-sharing system characterized by corruption and poor governance. The "October Revolution" in Lebanon, spurred deteriorating socioeconomic conditions, pins the blame for decades of government mismanagement on these parties, whose patronage networks are dwindling as a result of a severe economic crisis.

Although the public sector is notoriously under-resourced, the system as a whole has thus far managed to control the spread of the virus relatively effectively. On the one hand, government hospitals and Ministry of Public Health officials have proactively addressed the pandemic. On the other hand, the sectarian parties, whose welfare provision and brokerage activities have long fueled their patronage and clientelist networks, have taken advantage of the pandemic. By rolling out their own efforts to control the spread of the disease and provide support to citizens, they have tried to showcase their "good governance" credentials. The shutdown of the country in response to the pandemic bought a temporary reprieve for the sectarian parties but protestors have returned to the streets to denounce corruption, the failure to provide adequate public services, and ongoing economic mismanagement.

Do you observe variation in how states in the Middle East deal with the pandemic? Are there any general patterns that you observe?

The spread of the Coronavirus has elicited normatively disturbing praise in some circles for the ability of authoritarian regimes to respond quickly and decisively to the pandemic. Renowned for its large concentration of authoritarian regimes, the Middle East and North Africa (MENA) region will enable us to explore this claim when we gather more information on country-level responses to the pandemic. Thus far, the efforts of MENA authoritarian governments to combat the disease confirm two widely cited trends: On the one hand, autocrats have taken advantage of their control over the media

to try to limit information on the spread of the disease or to manipulate coverage of their policy responses to their favor. (This is by no means unique to the region, as the cases of China, Russia and other countries attest.) For rulers who bank on "performance legitimacy," the crisis provides an opportunity to make the case for the superiority of strong man rule to face crises effectively. On the other hand, a defining feature of authoritarianism – coercion – arguably enables autocrats to enforce lockdown orders more effectively than regimes that place greater stock in safeguarding civic and political liberties.

Yet MENA regimes – including authoritarian regimes – vary in important ways, inviting us to unpack responses to the pandemic in more nuanced ways. Authoritarian regimes in the region deploy different levels and types of coercion, differ in the degree to which they aim to project a facade of political openness, and have divergent levels of fiscal and administrative capacity (in part shaped by different per capita resource endowments), among other factors. Their welfare regimes also feature different levels of regulatory capacity, social protection policies, and mixes of public, non-state and private actors involved in the financing and delivery of social services.

Since compliance with measures to prevent the spread of the Coronavirus involves both the supply of policies as well as citizen uptake of these policies, it is also important to examine variation in political and social trust. Mass willingness to comply with public health directives, such as stay-at-home orders or vaccination campaigns, requires trust in government. Furthermore, the scope and level of social trust shapes solidaristic sentiments, which in turn affect individual and communal willingness to make sacrifices for the greater good. In places with more politicized ethnoreligious divisions, for example, it may be harder to elicit broad compliance on a voluntary basis. Both forms of trust vary across MENA states, inviting empirical investigation of how they shape citizen behavior in the face of the pandemic.

In short, a systematic analysis comparing MENA responses to the Coronavirus must account for these state and societal sources of variation.

How does the COVID-19 pandemic affect vulnerable populations in the region, especially refugees/displaced persons or people residing in conflict zones and the states' policies dealing with these populations?

The Middle East is a conflict-affected region, with ongoing war and violence in Libya, Syria, Yemen, parts of Iraq, and Palestine. War and resultant refugee crises affect responses to the pandemic. Violent conflict undercuts the capacity of states and other actors to address public health threats by reducing resources and destroying infrastructure. In addition, war often gives rise to distinct zones of governance, hindering coordination across political authorities to limit the spread of the virus. At the same time, refugee populations often reside in dense areas, with limited access to sanitation and hygienic supplies, hindering their ability to comply with measures to control the pandemic. The fact that refugees often face social stigma and marginalization in host countries may also limit their access to services and resources needed to meet their basic needs. However, some of my recent research on displaced Syrians suggests that, paradoxically, negative stereotypes depicting refugees as "vectors of disease" may increase local efforts to control the spread of disease among this population.

The militarization of the pandemic is particularly relevant for the Middle East. As we move forward, what do you think are the big trends in this realm that scholars should be studying?

As I noted above, autocrats generally have more leeway than their democratic counterparts to marshal coercive capacity to enforce lockdown orders, among other measures – a capacity that some cite as a potential "advantage" of authoritarianism in responding to public health crises. In many countries in the region, the army and security forces have been deployed on streets to ensure citizen compliance with public health guidelines. If citizens perceive that such measures were successful in controlling the pandemic, then trust in the coercive forces may increase. Indeed, populations in Egypt and other Arab countries expressed decreased trust in democracy and more support for strong-man rule in the wake of the Arab uprisings, which some associated with instability and economic decline. Autocrats are aware of the political utility of threats to deflect public attention away from governance failures and shore up their support. In this vein, the pandemic can benefit autocrats, at least in the short-term before their shortcomings in the economic realm and suppression of civil and political liberties return to the forefront of popular consciousness.

Widespread corruption has long affected the efficacy of Middle Eastern health systems. Are there ways that public health authorities are now working to overcome these issues? What variation is there between states?

This question underscores why political scientists need to engage with public health and vice versa. As in other regions, MENA health sectors are sites of corruption, whether in terms of macro-level expenditures and contracts or in more micro-level bribery and clientelist exchanges enabling access to health services and related resources. In virtually all countries in the region, private, for-profit providers are the fastest growing element of national health systems. Even if corruption is less endemic in the private sector (and that itself is an open question), for-profit providers are financially out of reach for most citizens, who instead rely on public sector facilities to meet their health care needs. In some places, such as Lebanon, non-state actors linked to political parties and politicians, religious organizations and NGOs, are integral to health care provision. Although it may vary across provider types, corruption comes in the form of preferential access to services and financial support for health care needs for co-partisans, as well as credit claiming for brokering access to de jure citizen entitlements on a discretionary basis.

Regardless of health system type, dedicated technocrats in health ministries and other government agencies are working within the constraints of their respective welfare regimes to improve the quality of services and expand access to services for needy segments of the population. The degree to which they are succeeding is an empirical question for political scientists, who are well equipped to analyze how politics and social inequalities affect both the functioning of welfare systems and access to services. But the key point is that there is only so much that technocrats can do if larger political structures perpetuating corruption and inequalities remain in place. ●