



The COVID-19 Pandemic in the IGAD region: Impact on the Health and Economy Vol. I

Horn Economic and Social Policy Institute (HESPI): Pillar 2 An assessment of the health and economic impact on the HoA countries¹

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The Covid-19 Pandemic in the IGAD Region: Impact on Health and the Economy²

Abstract

The Covid crisis has cast its dark shadow in the IGAD region at the worst time as it came on top of the problems of weak or fragile states, lack of capacity, wide spread poverty and food insecurity, conflicts, and the desert locust invasion. Many of the member countries are also under major economic difficulties and have significant vulnerable populations, and large numbers of internally displaced persons (IDPs) and refugees. In addition to persistent fiscal and balance of payment deficits, debt burden, high inflation, foreign exchange shortage, and high unemployment (in the absence of social security), they are facing multiple shocks such as recurrent drought, floods, and conflict and common vulnerabilities such as environment degradation, land pressure, food insecurity malnutrition, limited access to health services and sanitation. Moreover, the region has an estimated 30 million pastoral population that move across borders, hence are less reachable with awareness and protection measures. Pre-covid-19 health service availability and distribution were grossly insufficient even for normal situations. Limited access to water and sanitation, poverty, poor nutrition and health, and weak health services exacerbated these risks. Social-distancing, 'staying at home' and 'working from home' were not feasible in the face of crowded settlements and high importance of daily jobs and informal income among the population. The countries were exposed to both the direct effects of the pandemic and the pandemic-induced recession in the developed countries, affecting both the demand and supply sides as they constitute key export destinations and import sources.

This study provides an overview of the pre-COVID socio-economic situation and state of health services, the IGAD health framework and health service cooperation and collaboration among member countries, and discusses the outbreak and spread of the virus, and its broad adverse health, economic and social impacts. It then discusses the rescue and social safety net measures being taken and financing, and highlights some key issues that recovery efforts in the region should take into account, stressing the importance of sustainability and inclusivity. It is based on review of the continental and IGAD frameworks for health services, analysis of data from key multilateral organisations including the World Bank, IMF and WHO, the country cases studies on the Impact of COVID-19 that HESPI conducted in Ethiopia, Kenya, Somalia and Sudan, as well as other studies on the IGAD sub region.

Despite the quick responses in setting health response mechanisms, awareness creation, and introducing rescue measures, lags in supply and affordability of face masks and sanitizing materials proved a challenge. Failure to observe regular use of masks and social distancing together with the difficulty to sustain lockdowns and restrictions exacerbated the situation. The

² The study benefited from comments and feedback from HESPI staff and an external reviewer. However, the views expressed in the study are those of the author and do not necessarily reflect the opinion of HESPI.

level and spread of infection, which had remained relatively low for several months, thus accelerated considerably, with rising community infections.

The large scale infection across the globe and its resurgence in many countries as well as occurrence of a second-wave means that the recession will be deep and prolonged, making recovery slow. With almost all major trading partners and bilateral funders of the IGAD countries as well as major destinations of migration from the region affected, the health, economic and social impacts are considerable; essential health services have been disrupted as human, financial and institutional resources are switched to deal with the pandemic emergency; schooling (from early childhood to tertiary and TVET) has been disrupted with implications on human capital; overall growth, revenue, exports, remittance, FDI and aid flows have suffered with consequences on economic activities, jobs and poverty. Governments, citizens and the private sector have taken a range of rescue measures to 'save lives, businesses and jobs'; the fiscal, monetary, foreign exchange, and social safety net measures were complemented by cash and in-kind contributions by citizens, business organisations and CSOs. In some cases, country-specific contexts allowed effective use of certain rescue measures, although they could not be sustained.

Initiating appropriate measures for fast and sustainable recovery is essential. With careful design the recovery measures may offer an opportunity rebuild in ways that are not only in line with the SDGs but also green and strengthen future resilience to shocks. While this may necessitate revisiting development strategies and policy incentives and re-prioritisation of budget expenditures, care should be exercised not to pre-empt recovery by attaching undue short term targets or funding conditionality.

Making design of recovery packages consultative and evidence-based is crucial in this respect. IGAD could take the lead in initiating and supporting research, analysis and policy advice and facilitating consultative processes to draw on the pool of knowledge and expertise in the region so as to design recovery packages (with possible regional components) well-grounded in the context.

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1 Introduction

The COVID-19 pandemic spread quickly across the globe affecting almost all countries. The cumulative number of confirmed cases and deaths reported globally, which was about 13.978million and 593,538 respectively as of 17th July 2020 accelerated to 17.59 million and 675, 341 by the end of the month. Despite the widespread (several times in a number of countries) lockdowns and other strict measures including bans/restrictions on travels, social and physical distancing, mandatory mask wearing, etc. it continued to rise, reaching 33.9 million and 1.01 million as of 30th September 2020. Africa has been getting its share of the brunt with Cumulative cases and deaths in the affected countries jumping from 668,019 and 14,407, respectively to 1.175 million and 25,825 at end of September 2020. The pandemic has led to crisis not only in the health sector but also in the social, economic, psychological, cultural, and possibly behavioural and political spheres as well.

The IGAD region, home to 5 of the 15 countries ranked as the world's "highest risk"³ in terms of exposure to pandemics and access to health care, by the CARE International Global Index, is more vulnerable than most regions. Three of the member states are classified as fragile; i.e., lacking the capacity to "carry out basic governance functions". In all 8 member countries, number of confirmed COVID-19 infections and deaths keep rising; as of 16th July 2020, they had 41,768 confirmed cases with 1,215 deaths⁵. In addition to hotspots like churches, weddings, funerals/mourning, parties, sports events, and crowded market places, socio-cultural practices in the region such as traditional greetings that involve hugging and kissing among family, relatives and friends, eating in large groups from the same plate (even feeding each other in rounds), chewing chat, etc. risk spreading infections fast. Added to these, are the limited access to water⁶, presence of crowded slum settlements and refugee camps, vulnerability of the population due to wide spread poverty, poor nutrition and health, and health services that are weak and of limited coverage. Affording protection equipment (face masks, sanitizer, etc.) for all family members is also an issue, especially if duration of the pandemic is prolonged. "Stay home" or "work from home" are not much of an option for those living on daily wages or informal income (and lacking savings to bridge the income gap) as well as for the rural population or pastoralists.

The crisis has cast a dark shadow on the region at the worst time; it came on top of the problem of weak or fragile states, lack of capacity (human, financial, institutional and technical) and wide spread poverty, conflicts, and the locust attack on most member countries. Many of the member countries are also under major economic difficulties and have significant vulnerable populations, and large numbers of internally displaced persons (IDPs) and refugees. They suffer from persistent fiscal and balance of payment deficits, debt burden, high inflation, foreign exchange shortage, high unemployment (in the absence of social security such as unemployment benefits), and wide spread poverty. They also face common shocks such as recurrent drought, floods, and conflict

³<https://www.care.org/newsroom/press/press-releases/care-analysis-vulnerable-countries-face-3-times-risk-covid-19-exposure>, accessed on 20 June 2020.

⁴ These are Somalia, South Sudan, Ethiopia, Sudan and Uganda.

⁵<https://covid19.who.int/region/afro/country/>, accessed on 16 July 2020.

⁶ Considering the four IGAD countries for which data is available (Djibouti, Ethiopia, Kenya, and Uganda), in 2015 deprivation of drinking water ranged from 7.1% in Djibouti to 42.7% in Ethiopia while deprivation to sanitation ranged between 30.3% in Ethiopia and 77.6% in Uganda.

(causing displacement and migration) and common vulnerabilities such as environment degradation, land pressure, poverty and food insecurity, malnutrition, limited access to health services and sanitation. They are exposed to both the direct effects of the pandemic and the recession in the developed countries induced by the pandemic affecting both the demand and supply sides. The highly affected countries include key export destinations and import sources of the IGAD countries. An IMF June 2020 projection shows that the world economy will shrink by 4.9%, which is bound to impact the IGAD countries.

The absence of a dense network of road and rail transport crisscrossing the region may lower the speed of spread of the virus between countries. But, the region has an estimated 30 million pastoral population who move across borders and whose movement is difficult to trace, let alone control. That population density is low in pastoral areas (perhaps except for urban centres) and the fact that households tend to split with the young adult men going away with the cattle/camels while others tend to stay around the homestead may also be a positive factor. But, mobility and inaccessibility (remoteness, harsh climate, vast area, etc.) make it difficult to reach them with the necessary awareness creation as well as protection measures. Lack of water and soap make hand washing as prevention method unrealistic while single-room houses/shelters render social distancing impractical. Besides, their mobility may mean that government could not reach them with the necessary services. In addition, several of the countries have porous borders with regular movement of informal traders and smugglers, hence potential for unchecked spread of the virus.

Governments and organisations are making decisions to simultaneously deal with the pandemic while minimizing the negative consequences (economic, social, etc.) of the measures,⁷ while also preparing to take recovery measures. Policymakers have been confronted with difficult choices never experienced or never been prepared for. The measures and choices they make are bound to have short, medium- and long-term impacts on individuals, households, communities, countries, regions and globally. Despite the early outbreak of the virus in most IGAD countries, the speed of its spread (compared to what happened in the developed countries and emerging economies) was slow for several months. This offered them with opportunity to learn the range of potential measures and discern what is feasible, what works and what does not as well as put the necessary protection and other mechanisms (produce/receive/purchase masks, sanitizers, and protective equipment; mobilise health personnel etc.). But, success depends on many factors including insufficient health services and financial, administrative, technical and infrastructure capacity to adequately and timely respond to the crisis. Many of these are wanting in the IGAD countries.

In view of the above, how are member countries individually and collectively responding to the pandemic? How actively has IGAD been involved and in what respects? This study provides an overview of the pre-COVID socio-economic situation and state of health services, and discusses the outbreak and spread of the virus, the broad adverse health, economic and social impacts of the pandemic, the rescue and safety net measures taken and funding. It also highlights some key issues that recovery efforts in the region should take into account. It is based on review of the continental

⁷ They include social distancing measures typically avoiding physical contact, school and workplace closures, canceling mass gatherings (meetings/conferences/workshops, church ceremonies, weddings, funerals and ..., etc.), travel restrictions, self-shielding, quarantine of potential cases, cordon sanitaire, protective sequestration and a host of other measures, including shutting down or limiting mass transit, closure of recreational facilities (hotels/restaurants/bars, cafes, bowling, cinema/theatre houses), and so on.

and IGAD frameworks for health services, data from key multilateral organisations including the World Bank, IMF and WHO, the quick cases studies on the Impact of COVID-19 that HESPI conducted in Ethiopia, Kenya, Somalia and Sudan, as well as other studies on the IGAD sub region.

2 Pre-COVID-19 socio-economic and health situation in IGAD region

The COVID-19 pandemic outbreak occurred at a time when many of the member countries are already under major economic difficulties. The countries have significant vulnerable populations, and large numbers of internally displaced persons (IDPs) and refugees. They suffer from persistent fiscal and balance of payment deficits, debt burden, inflation, foreign exchange shortage, high unemployment and wide spread poverty. They also face common shocks such as recurrent drought, floods, and conflict (causing displacement and migration) and common vulnerabilities such as environment degradation, land pressure, poverty and food insecurity, malnutrition, poor access to health and sanitation facilities.

2.1 Macroeconomic situation

GDP growth for the six countries (except Eritrea and Somalia) averaged 1.95% in 2018, which is below the average annual population growth of 2.21% (for the 5 countries excluding Sudan). The External balance (exports of goods and services less imports of goods and services) averaged -17.5% of GDP which is almost 6 times the SSA average. They also have large external debt accumulation; the external debt stock (which is the sum of public, publicly guaranteed and private external debt) as percent of gross national income averaged 101.2% (excluding South Sudan). Although complete inflation data is not available for all member countries, South Sudan and Sudan suffer from particularly high rates of inflation (187.9% and 51% per annum, respectively) followed by Ethiopia (15.8%).

In terms of FDI (net) inflow, the region fared better than the SSA average; in 2018 it averaged 3.54% of GDP compared to the SSA average of 1.8%. Poverty in the region is quite high; poverty headcount at national poverty line averages 46.2% for the eight countries. However, this average conceals the variation between countries; South Sudan, Somalia, Eritrea and the Sudan face particularly high poverty rates at 82.3%, 70%, 69% and 46.5% respectively. Unemployment is high, averaging 11.8% of the labour force (see Table 2). More than 72% of the urban population lives in slums; In fact, it goes as high as 96% and 92% in South Sudan and the Sudan, respectively. The rate of unemployment differs by gender, in that an average of 9.4% of the female labour force in the region is unemployed compared to 6.9% for the male labour force.

Of those employed, a large proportion (70.8%) are in vulnerable employment (compared to the SSA average of 73.7%), namely contributing family workers and own-account workers. Vulnerable employment is much higher among females than males; 78.6% of employed female population is in engaged in vulnerable employment compared to 65.4% for male. A large percentage of the labour force is engaged in informal employment/activities, hence cannot afford not to work for a day, as it is basically employed on a daily basis to sustain their livelihood. Social security arrangements, such as unemployment benefits are non-existent in the region.

It is almost two decades since the African Heads of States and Governments pledged, through the Abuja Declaration, to allocate 15% of the annual budget to the health sector (OAU 2001). Yet, so far the share of the health sector in the national budgets of the IGAD countries remains far below the target. For example, it is 7% in Kenya, 10.29% in Ethiopia, and 7-8% in the Sudan. The per capita

spending on health services is also far short of what the WHO recommends as minimum. It is \$29 in Kenya and \$34 in Ethiopia (compared to the \$34 that WHO recommends⁸).

Table 1: Recent developments in macroeconomic indicators in IGAD countries 2018

Indicators	Country								Aver	SSA
	Djibouti	Eritrea	Ethiopia	Kenya	Somalia	South Sudan	Sudan	Uganda		
GDP Grow (%)	5.46	n.a.	6.8	6.32	2.8	-10.7 (2015)	-2.3	6.15	1.95	2.39
Rev. (excl grants) % GDP	n.a.	n.a.	9.0	19.6	4.6	n.a.	9.5	15.0		
Imp (% GDP)	178.9	23.2	22.8	23	99.6	28.9	12.3	28.7		
External balance on G&S% GDP	(30.1)	(8.8) (2011)	(14.4)	(9.83)	(73.7)	7.75	(2.1)	(9.18)	(17.5)	(2.89)
External debt stock (% GNI)	157.6	40.8 (2011)	31.44	36.14	39.35	n.a.	56.9	46.3	101.2	n.a.
FDI (net)% GDP	5.75	1.5 (2011)	3.98	1.85	8.66	0.001	2.78	3.84	3.54	1.8
Gross (% GDP)	28	16	33	10	n.a.	10	15	18		
Gross Cap formation (% GDP)	48	10	34	18	16	6	19	25		
Infla CPI (%)	3.3	n.a	15.8	4.7	3.2	187.9	51.0	2.9		
Vulnerable empl (% of total empl)	44.74	86.38	85.97	51.5	87.2	84.85	50.4	75.39	70.8	73.7
F-in vuln. Emp%	54 (39)	93 (81)	89 (83)	60 (43)	94 (85)	91 (79)	65 (45)	83 (68)	78.6 (65.4)	
Poverty Headco (% Pop)	21.1	69.0	23.5	36.1	70.0	82.3	46.5	21.4	42.84	
Pop living in slums (% urban population)	66	70	74	56	74	96	92	54	72.75	

Source: World Development Indicators, World Bank Data Base (May, 2020)

2.2 Socio-economic and health situation and preparedness of the health system

Even without such an aggressive virus, nutritional deficiencies and communicable diseases are the most common causes of mortality in the region. The region has a large malnourished population both in absolute numbers and prevalence rate (ranging from 18.9% in Djibouti to 41% in Uganda). According to data from the World Bank, the five countries for which we have data⁹ alone have an estimated 62 million malnourished population.

Degree of urbanization in the region averages 37%: but with large variation across countries ranging from 20.2% in South Sudan to 78.1% in Djibouti. All the IGAD countries have a large proportion of their urban populations dwelling in slums; it ranges from as high as 96% and 92% in South Sudan and Sudan respectively to 56% in Kenya¹⁰. This effectively precludes social distancing and self-isolation as protection method, hence raises the risk of spread of the virus. Urban public transport

⁸ Average per capita health spending is \$10,000 in US, \$7,000 in Switzerland, \$4000 in OECD, \$2000 in China, \$1000 in India and Indonesia (<https://www.oecd-ilibrary.org/sites/876d99c3-en/index.html?itemId=/content/component/876d99c3-en>), accessed on 15 July 2020.

⁹ Djibouti, Ethiopia, Kenya, Sudan and Uganda.

¹⁰ 61% of Kenyans in cities live in slums (<https://qz.com/africa/955436/more-than-half-of-the-urban-population-in-east-africas-largest-economy-live-in-slums/accessed-on-29-May-2020>).

using public transport (buses, minibuses/matatus, trains, etc.) is highly crowded again precluding distancing. Both tend to increase the risk and speed of spread of the virus. Percentage of the population using at least basic drinking water is still low, at 55.1% (mostly through communal water points) while those using washing facilities including water and soap averaged 17.4% of the population, making hand-washing less feasible. The situation is far worse in rural areas where a large majority of the population resides.

A large proportion (72.7% or about 58 million) of the urban population lives in slum areas. Hence, a large number of people are highly susceptible to fast spread of infectious diseases due to high population density, lack of space to practice social distancing and self-isolation due to overcrowding, and poor access to health services. Malnutrition increases both the risk of contracting infectious diseases and the rate of severity of the disease¹¹. Recurrent drought, floods, conflict and other shocks in the IGAD region meant that prevalence rate of under-nutrition is high. For example, during 2014-16, it ranged from as high as 39% in Uganda to 12.8% in Djibouti¹². In absolute terms, four countries alone had an estimated 52.9 million malnourished people (28.8 million for Ethiopia, 15.2 million in Uganda, 8.8 million in Kenya and 0.1 million in Djibouti (HESPI, 2018¹³). Besides, access to basic needs such as food, water, shelter and sanitation tends to be poor. Together, they make the risk of contracting infectious diseases and their consequences, the speed of spread of infections in the community, etc. high.

Prevalence of underlying conditions such as TB, HIV/AIDS, and malaria is high. For example, TB incidence per 100,000 population averaged 189 while the incidence of malaria per 1000 population at risk averages 68.5. Mortality due to unsafe drinking water, unsafe sanitation and lack of hygiene is also high, 46.3%. The incidences vary considerably across countries. The incidence of TB, for example, varies from 77 per 100,000 people in Sudan to as high as 292 in Kenya and 272 in Djibouti. Similarly, mortality due to unsafe drinking water, unsafe sanitation or lack of hygiene varies, ranging from 17.3% in Sudan to 63.3% in South Sudan and 86.6% in Somalia (see Table 2 for more details).

¹¹ WHO (2011), Public health risk assessment and interventions: The Horn of Africa: Drought and famine crisis, July 2011.

¹² 19.1% and 28.8% for Kenya and Ethiopia, respectively.

¹³ HESPI (2018), Annual Report on IGAD Economies: Macroeconomic Developments, Climate Shocks and the State of Good Security in IGAD, 2018.

Table 2: Health and health services indicators (2017)

Indicators	Country								Average
	Djibouti	Eritrea	Ethiopia	Kenya	Somalia	South Sudan	Sudan	Uganda	
Malar. (incidence per 1000 pop at risk)	0.03	22.87	37.37	70.83	36.75	141.68	37.45	60.27	68.46
TB incidence per 100,000 population	272	99	164	292 (2018)	262 (2018)	146 (2018)	77	200.66	189.1
Mortality (unsafe drinking water, unsafe sanitary lack of hygiene)	31.3 (2016)	45.6	43.7 (2016)	51.2 (2016)	86.6 (2016)	63.3 (2016)	17.3 (2016)	201	46.3
Hospital beds (1000 people)	1.4 (2014)	0.7 (2011)	0.3 (2015)	N/A	0.9 (2014)	N/A	0.8 (2013)	31.6	0.82
No. of undernourished	200,000	N/A	21,600,000	14,600,000	N/A	N/A	8,200,000	N/A	62,200,000
Prevalence of undernourished %	18.9	N/A	20.6	29.4	N/A	N/A	20.1	17,600,800	26.0
Physician per 1000 People	0.22 (2014)	N/A	0.1	0.199 (2018)	0.023 (2014)	N/A	0.41 (2015)	41	0.174
Nurses & midwives (1000 people)	0.53 (2014)	N/A	0.84	1.54 (2014)	0.06 (2014)	N/A	0.83 (2015)	0.091 (2015)	0.738
% using at least basic drinking water	75.6	51.8	41.1	58.9	52.4	40.7	60.3	0.63 (2019)	55.13
People with basic hand washing facility (water. & soap)	N/A	N/A	7.96	24.6	9.83	N/A	23.44	21.22	17.41
Unempl (% labor force)	11.03 (2019)	6.55 (2019)	20.6 (2018)	14.9	13.96 (2019)	12.72 (2019)	12.99 (2019)	1.79 (2019)	11.82
F -Unemp (% of F labor force)	10.4 (10.2)	5 (5.3)	2.8 (1.5)	2.8 (2.5)	11.1 (11.4)	13.4 (11.1)	27.8 (11.6)	2.3 (1.4)	9.4 (6.88)

Source: World Bank database, accessed on 12 and 31May 2020

The statistics in Table 2 indicate the vulnerability of the region's population. Without quick protection related support, such as hygiene materials and masks, the infection is likely to be disproportionately higher among the vulnerable groups. Without appropriate economic and social safety measures, the economic impact of the pandemic may also fall disproportionately on these groups, further aggravating inequality.

At the outbreak of the COVID-19 virus, despite their wealth and advances in medicine and technology, the health systems of many of the richest nations on earth were ill-equipped for the Covid outbreak – they had not invested enough in emergency preparedness, not only financially but also in terms of institutions, approach as well as global cooperation. Even the EU member countries lacked such preparedness¹⁴, despite having a range of collaboration and institutional

¹⁴ It is argued that some countries, especially those that had invested in public health care systems, did better than others in responding to the pandemic. They point to the Scandinavian countries and Germany in Europe, China, South Korea and Singapore in Asia. However, systematic analysis and evidence establishing this is yet to be provided.

arrangements including the EU, European Commission, European Parliament, European council, European Central Bank, etc.

No developing country could thus have been prepared for the pandemic. We note that in the IGAD countries, pre-COVID-19 health service availability and their distribution were grossly insufficient even for normal situations. As Table 2 shows, even without an emergency of such proportion, the availability of health and sanitation facilities leaves a lot to be desired. For example, for the five member countries on which data is available (Table 2), hospital beds and physicians per 1000 people averaged 0.82 and 0.17, respectively while nurses and midwives per 1,000 people averaged 0.74. The number of doctors, nurses and midwives per 10,000 population is far below the WHO recommended threshold of 2.3.

The situation is worse when we consider availability and cost of drugs, quality of facilities as well as surveillance and laboratory capacity. At the early stage of the pandemic with lab capacity lacking, samples had to be sent abroad for testing. Access to health services differs both between countries in the region and within countries. For example, in some countries such as Somalia and South Sudan the health care system suffers from weak infrastructure, accountability, lack of technical capacity, and bias towards urban areas reflecting several decades of breakdown in governance, state fragility and associated flight of its skilled human resources. These left major gaps in the provision of nationwide health services, development and implementation of effective health policies and their regulation. Health service availability is much more constrained in areas that are difficult to reach (such as rural and pastoral areas), those affected by conflict/insecurity and among refugees and internally displaced persons (IDPs).

3 Health services cooperation and collaboration in the IGAD region

3.1 Continent wide health service framework

Africa had set continental level health goals before. However, at the level of a strategy, the Africa Health Strategy 2007-2015, introduced in mid-2000s was its first. Its successor, the current Africa Health Strategy (AHS) 2016-2030, was adopted with the vision of creating “an integrated and prosperous Africa free of its heavy burden of disease, disability and premature death”. It set the goal of ensuring “healthy lives and promoting the well-being for all in Africa in the context of “Agenda 2063: The Africa We Want” and the Sustainable Development Goals” (African Union 2016¹⁵: 7). Among other things, the strategy aims to improve “inter-country collaboration to achieve efficiencies”. It envisages Regional Economic Communities (REC) such as IGAD (together with AU organs, UN agencies and other partners) to facilitate, coordinate and support member countries, which are supposed to lead implementation of the strategy. The strategy is comprehensive in that it includes “strengthening health systems to sustain the gains in performance; ensuring strong leadership and good governance; forging multi-sectoral partnerships to address the socio-economic and environmental determinants of health; refocusing service delivery and empowering communities; expanding social protection to address equity; and prioritizing human resources for health; ensuring commodity security. It also encompasses building the regulatory and support environment for provision of quality medicines and

¹⁵ African Union (2016), Africa Health strategy 2016-2030, May 2016, Addis Ababa.

technologies, including to nurture African traditional medicine; establishing effective systems for disease surveillance and disaster management, and investing in youth and adolescents as well as improving inter-country collaboration to achieve efficiencies” (AU, 2016: 7). One of the key principles of the AHS 2016-30 is that “disease and disasters go beyond borders”. It thus takes “cross border cooperation in disaster management and disease control” as a requirement (AU, 2017: 16).

RECs, including IGAD, are expected to “provide technical support to Member States, advocate for increased resources for health systems strengthening, harmonize the implementation of national Action Plans, monitor and report progress, identify and share best practices.” (AU, 2016: 28). Member states on the other hand are expected to “adapt and incorporate the key strategic priorities of AHS 2016-2030 into their national health and multi-sectoral policy instruments” (ibid). They are supposed to demonstrate ownership of the strategy in deeds by putting in place “strong leadership efforts to ensure that the required advocacy, governance, legislative frameworks and actions including resource mobilization and allocations, governance, including legislative frameworks and actions are implemented”. They should also “undertake monitoring and reporting at country level to the RECs and AU Commission...ensure good governance, participatory and inclusive approaches required to meaningfully engage communities, CSOs and the private sector... ensure that a conducive environment is in place to implement [the strategy] including harmonizing and streamlining their own policies, strategies, standards and plans to ensure coherence” (AU, 2016: 28). While assessing as to whether and to what extent IGAD as a REC and member countries are delivering on their respective parts is beyond the scope of this study, below, we provide brief discussion of the IGAD framework and collaboration effort.

3.2 IGAD health framework and need for collaborative efforts:

The recognition that health interventions in the Horn countries are not likely to achieve the desired impacts without coordination amongst the countries and partners dates back to the early 1990s. For example, IGAD considers the region as “one epidemiological block” requiring coordinated health interventions between countries and among partners in order to achieve the desired results. Accordingly, “collaboration, coordination and innovative projects amongst the Horn countries” were initiated, starting with organising the Ministerial Conference on Public Health to strengthen cooperation in the region, focusing on vulnerable populations such as refugees, internally displaced peoples and pastoralists.

The Conference identified the main needs and constraints for inter-country cooperation and actions to be taken. Among the key constraints were the weak health information system at both national and regional levels; lack of cooperation and coordination in health programs of similar nature in border districts; inequity in distribution of health infrastructure and services; and “Haphazard delivery of health services in...emergency situations”.

The Ministerial Conference thus resolved for the Horn countries to:

- (i) develop health cooperation agreements and plan of action to address cross-border and other priority problems and regularly monitor implementation;
- (ii) establish health networks for free and timely exchange of health information;

- (iii) jointly elaborate inter-countries' strategies for control of major health problems at borders and increase implementation capacity; and
- (iv) develop the required capacity for "integrated epidemiological surveillance and response for priority communicable diseases and malnutrition.

Protocols of cooperation were signed between:

- (i) IGAD and the WHO in 1996 aiming to technically assist IGAD to establish a Health Desk, and
- (ii) member states in March 1998 to address cross-border health problems.

It is more than two decades since the resolutions were passed and Protocols signed. There has been some collaboration in the areas of malaria, TB and HIV/AIDS, focusing on cross-border areas. IGAD has also organized a series of meetings and workshops. It has also established a division responsible for health and social development. But, even as recently as 2017, no integrated TB, HIV and malaria strategic plan was in place. Besides, information on effectiveness of the collaboration or whether collaborations go beyond border areas is lacking.

What is clear, however, is that the region is now caught up by the outbreak of the COVID-19 pandemic, cross-border travellers between member countries being one of the main channels of transmission. For example, a good number of the confirmed cases disclosed by the Ministry of Health of Ethiopia are returning migrants, travellers or cross-border drivers from Djibouti, Somalia, and the Sudan. Returnees are reportedly avoiding the COVID-19 check points at borders, complicating the effort to prevent the spread. In addition to potentially exposing their family/relatives and community, this potentially widens the geographic spread of the virus, overstressing limited national capacities.

The scale of the problem of the pandemic is magnified by the presence of significant pastoral population which are mobile across borders as well as refugees and internally displaced persons (IDP). Border communities that are of the same ethnic group or with close social and cultural ties also regularly cross borders. Fighting the pandemic and dealing with its consequences thus calls for member countries, citizens, CSOs, and other stakeholders to bring out their best in working together. Strengthening health services at border districts or border crossings with adequate capacity is likely to be more effective and less costly as it allows identifying and containing communicable or infectious diseases before they spread to the hinterland. IGAD should thus seize this moment to lead in coordinating not only the member governments but also galvanize all capacities (human, institutional, technical and technological) in the region to bear on this.

Following the AU Protocol on Free Movement of Persons, Right of Residence and Right of Establishment, the IGAD Protocol of Free Movement of Persons in the IGAD region¹⁶ has been endorsed. Mobility of people and workers across borders in the region is thus expected to rise, increasing the potential for speedy spread of communicable diseases across countries once an outbreak occurs. This increases the urgency of putting in place a workable mechanism for cooperation in the area of health. Among the main channels of infection of COVID-19 virus in the

¹⁶ IGAD (2020) Communique of the Sectoral Ministerial Meeting on the Protocol on Free Movement of Persons in the IGAD Region, 26 February 2020, Khartoum, Republic of Sudan.

region is cross border spread involving travellers. Breaking this requires coordinated cross border responses, surveillances and information sharing. IGAD is better placed to handle this through its Health Division.

Besides, all IGAD member countries have significant Muslim population (with varying proportions) which they can take advantage of in the fight against the virus. Islamic teaching encourages cleanliness, including “a command that cleanliness is half the faith; washing hands before and after eating; and after using the toilet; washing hands, face, and feet before each of the five daily prayers; and bathing frequently”. These are crucial common foundations to build on by facilitating access to water & soap, and other hygiene materials.

4 The COVID-19 pandemic in IGAD: Outbreak, spread and containment measures

4.1 Health related responses:

Responses are expected at four levels: government, businesses, organizations (religious, civic, traditional, etc.) and individuals. Speedy measures to break spread of the virus at the early stage are critical for the IGAD countries for several reasons:

- They cannot count on interventions such as treatment for those infected, tracing their contacts, and extensive testing or disinfecting public places.
- Widespread poverty, high dependence on informal employment and absence of social welfare such as unemployment benefits make lockdowns and restrictions unsustainable; “Stay at home” or “work from home” are not much of an option for those living on daily wages or informal income with no ‘savings for the rainy days’, the rural population or pastoralists.
- In addition to hotspots, like churches and mosques, weddings, funerals/mourning, parties, sports events, and crowded market places, socio-cultural practices in the region tend to be conducive for community infection. Traditional greetings, eating from the same plate, chewing chat in groups, etc. pose high risk of rapid spread of the virus.
- Limited access to water¹⁷, presence of crowded slum settlements and refugee camps, inability to afford personal protection equipment (face masks, sanitizers, etc.) are likely to make protection difficult.
- Vulnerability of the population due to wide spread poverty, poor nutrition and health, as well as health services that are weak and of limited coverage are bound to make fatalities very high.

For the response to have the desired effectiveness, working with existing institutions, instead of creating new structures, is important. These include religious organisations and leaders, public figures, traditional institutions (such as Iddir and Mahber in Ethiopia), and civic society organisations (such as youth and women associations, trade unions, and coops).

¹⁷ Considering the four IGAD countries for which data is available (Djibouti, Ethiopia, Kenya, and Uganda), in 2015 deprivation of drinking water ranged from 7.1% in Djibouti to 42.7% in Ethiopia while deprivation to sanitation ranged between 30.3% in Ethiopia to 77.6% in Uganda.

The first confirmed cases in the region were reported on 13th March 2020 in Ethiopia, Kenya and Sudan. To their credit many of the IGAD governments had taken swift responses long before confirmed cases were identified. For example, as precautionary measures, IGAD countries had ramped up their preparedness to detect and contain as well as mitigate the impact of the outbreak, partly drawing on WHO information. Kenya had already initiated, starting 2nd February 2020, “precautionary public health safety measures against its potential spread into the country including advising Kenyans to minimize contact with people with respiratory infections, against non-essential travel to affected countries, especially Wuhan in China, and adoption of a multi-agency approach to deal with the threat of COVID-19. On 28th February, 2020, the President issued *Executive Order No. 2 of 2020* establishing the overall framework to upscale and coordinate Kenya’s response to COVID-19” (Ayako, 2020), activated a national Public Health Emergency Operation Centre (PHEOC) covering WHO recommended areas (leadership, coordination and planning, supplies and logistics, risk communication and community engagement, surveillance and laboratory capacity, case management, infection prevention and control and point of entry screening) early on.

4.1.1 Coordination/management and enforcement of measures to fight the pandemic

Coordination: Alarmed by the rapid global reach of the virus in a short span of time, governments were quick to set up coordination and enforcement mechanisms at high levels of government. For example, Ethiopia, being highly exposed to the shock of the pandemic largely due to the extensive global flight of the Ethiopian Airlines and returning migrants and cross-border truck drivers (Djibouti, Sudan and Kenya in particular) responded quickly. A high-level national Task Force, chaired by the Deputy PM, was set up to lead and coordinate the national response to COVID-19. It set up a four level coordination:

- (a) National Disaster Risk Management (NDRM) Council led by the deputy prime minister’s office;
- (b) Public Health Emergency Management (PHEM) Task Force (multi-sectoral) led by the Minister of Health;
- (c) PHEM Technical Task Force led by the Director General of Ethiopian Public Health Institute (EPHI); and
- (d) PHEM Technical Working Group led by the national incident manager.

Task forces were established at regional states as well. Coordination included not only federal and regional government structures but also public agencies, the private sector, trade unions, and the public at large.

Similarly, the Sudan established a “high-level emergency committee to oversee the operations to deal with COVID-19” while in Somalia, the Prime Minister; in coordination with the WHO and UN agencies, launched a Country Preparedness and Response Plan to address the immediate humanitarian and socio-economic consequences. It also established Federal State level Task Forces and committees responsible to “prepare contingency plans to prevent, rapidly detect and

effectively respond to the pandemic outbreaks and to reduce morbidity and mortality rates in the country”¹⁸.

4.1.2 Containment measures

The Economic Commission for Africa (ECA) identifies 7 indicators of government COVID-19 responses related to containment. These include school closures, workplace closures, cancellation of public events, public transport closures, public information campaign, restrictions on domestic/internal movement, and restrictions on international travel (ECA, 2020: COVID-19: Lockdown exist strategies for Africa:6). The choice of interventions by a number of IGAD countries reflects their limited domestic financial and human resources as well as pragmatic expectation of minimal external support under the circumstances.

Public awareness and mobilisation: Massive public awareness creation and health education campaigns were conducted through health personnel and extension workers, government officials, religious leaders, known personalities and media channels¹⁹. In view of the resource intensity of case detection and management, the focus was on the “causes, transmission, prevention and consequences of the pandemic” aiming to bring behavioural change that prevents infection. Ethiopia is lucky in this respect as it has an elaborate prevention-based health infrastructure and health extension system in place, which it had built, together with its development partners over the past two decades. Its over 38,000 health extension workers and the trained “model families”²⁰, both of which have extensive grass roots presence in both urban and rural areas, were instrumental in the public awareness campaigns, community mobilisation and house-to-house screening that Ethiopia conducted.

Restrictions and prevention: All IGAD countries adopted containment measures of various types, some of which are common while others are differentiated in content, duration and/or comprehensiveness to reflect their local context. Among the common measures are closure of schools, colleges and universities; prohibition of mass gatherings including in churches and mosques, and meetings/conferences; closure of public places such as bars/restaurants, etc. and international passenger flights; restrictions on domestic travel, and social distancing. A range of preventive social and hygiene measures were also introduced to minimize community transmission of the virus. In Ethiopia, for example, these tend to be mandatory. They require people to wear face masks in public places, and organisations, businesses and other institutions to make hand washing and/or sanitizing facility available at entrances and making it mandatory to hand wash or sanitize prior to stepping inside. Domestic production of face masks and sanitizers was stepped up, putting restriction on export of the same (relaxed later), announcement of warning against increase in prices of protective equipment/materials. In Somalia, the government, together with its partners launched a joint effort to avert “large-scale community spread through risks awareness

¹⁸FGS (28 March, 2020), “Socio-Economic Impact and Required Response for Covid-19 in Somalia”.

¹⁹ Including dissemination of appropriate and timely COVID-19 related messages to the public and governmental stakeholders through daily press statement, dashboard update and monitoring.

²⁰ The ‘model family’ training is an important component of Ethiopia’s Health Extension Program, and is based on the idea of mass communication and diffusion of innovation (<https://www.capacityplus.org/model-families-model-country.html>).

communication, testing, contact tracing, and isolation of the infected ... and expanded distribution of personal protective equipment to health workers” (HESPI and NEC, 2020).

Several countries also introduced total or partial lockdown, mandatory 14-days quarantine on passengers (air and land) from abroad and regions, limits on number of passengers in public transport, curfews, and restriction on use of private vehicles. Kenya also encouraged teleworking. Ethiopia, however, refrained from imposing lockdown. Not only was it deemed not enforceable but also because of its implications on the hard won significant gains in terms of growth²¹, poverty reduction and health services, which had to be safeguarded. The need to protect jobs, enable firms to survive, and prevent households from sliding back to poverty necessitated, among other things, allowing economic activities to continue. In Sudan the government “imposed daily curfew varying from 12 to 18 hours in different states”; the quarantine period for passengers from abroad was one month (as opposed to the usual 2 weeks) but was not compulsory. Somalia enforced dusk-to-dawn curfew from mid-April 2020 with exception given to healthcare providers and those offering essential services, such as hospitals, pharmacies, security and ambulance services and supermarkets.

Enforcement: Enforcement and actual implementation, however, proved challenging in a number of countries for various reasons. The challenges included shortage of facilities, lack of Personal Protection Equipment (PPE), shortage of health personnel, funding, etc. Besides, some of the preventive measures such as ‘stay at home or work from home’, lockdown, social distancing, regular washing, etc. are impractical in the case of poor households that rely on daily income, work in the informal sector, and reside in crowded houses/settlements such as slums or lack access to water. Besides, certain public initiatives to support such families that occurred at early stage of the breakout were useful but could not be sustained. Others such as social distancing do not seem to be complied with because it is “viewed as going against cultural and religious behaviour of the society [e.g. in Somali Society,]” HESPI and NEC 2020).

Health service measures: Starting 13th March 2020, Ethiopia had established quarantine and isolation centres, and one hospital (EkoKotebe Hospital) was prepared, equipped with trained medical staff, open to receive and care for COVID-19 patients in the country²². It conducted massive house-to-house screening involving 11 million households (about 40 million people) in Addis Ababa, the regional capitals and other areas²³. A supplementary budget of 129 billion birr (more than 37% increase) was approved, additional medical professionals hired, and retired medical personnel and volunteers were called in. To cope with the shortage of space for the mandatory quarantine and isolation as well as space for medical treatment, it quickly converted a number of government universities into such facilities, adding 50,000 beds for quarantine and isolation centres with 15,000 beds as well as 5,000 beds for treatment. It trained national rapid response teams (epidemiology/surveillance, laboratory, case management, IPC, and risk communication, community engagement on corona virus surveillance, medical care for patients, public health communication and countering misinformation and rumours). In view of the high exposure that

²¹ It sustained an average GDP annual growth of 10.5% for a decade and half (2004.2018) while poverty had declined from 45% to 23.5%.

²²https://www.ephi.gov.et/images/pictures/pic_2011/pic_2012/First-English-Press-release-1.pdf

²³<https://www.weforum.org/agenda/2020/06/ethiopia-covid19-response/> accessed on 15 June 2020.

medical personnel face, it introduced life insurance for frontline health workers. It also arranged separate residence for medical personnel dealing with COVID-19 cases to minimize the risk to their families. The private sector and individual citizens also made private buildings and houses for use as quarantine centres (including conversion of the famous Millennium Hall into a medical treatment centre).

4.2 Spread of infection, fatalities and challenges

Fear and despair had gripped Africans as they watched the speed and scale of COVID-19 infections and deaths in the rest of the world²⁴. Africa reported its first confirmed case on 28th February 2020²⁵, more than two months after the outbreak was identified in China²⁶. Considering the aggressive nature of the virus as well as the weak health systems and underlying conditions of the population, fear and despair had gripped Africa. With 668,019 cases and 14,407 deaths²⁷ (compared to its population of 1.216 billion) as on 17th July 2020, some argue that the continent has been spared the worst. The IGAD region (with a population of 293.18 million) had even more lead time as it was on 13th March 2020 that the first confirmed case was reported in Ethiopia²⁸,²⁹ Kenya and Sudan. All other member countries reported confirmed cases between March 13 and 22, 2020, except South Sudan, which confirmed its first case on 4th April 2020³⁰.

In many of the member countries, number of confirmed cases remained relatively small for several months since the outbreak, offering valuable lead time to promote public awareness, supply PPE such as face masks and sanitizers and enhance their use, to adjust religious and socio-cultural functions that pose risk of infections, etc., hence break the spread. Quality issues aside, masks and sanitizers are easily available (on sale by street vendors). Judging from the recent acceleration in number of cases and deaths, the lead time does not appear to have been fully exploited; confirmed cases and deaths jumped from 42,848 and 1,223 as of 17th July to 139,076 and 2,875, respectively as of 22 September 2020. Lags in internalizing preventive practices (social and physical distancing in particular) and lack of adherence to disciplined use of masks may partly explain this. In absolute terms, Ethiopia now has the highest number of cases followed by Kenya and Sudan. However, in proportion to their population, Djibouti leads with 5,452 cases per 1 million population followed by

²⁴. As of 17th July 2020, Europe and North America, with a population of 741.4 million and 579 million respectively, had 2.639 million cases (and 198,406 deaths) while North America had 4.329 million cases (and 192,512 deaths). South America, with a population of 422.5 million, had 3.116 million cases (and 112,293 deaths). On the other hand, Asia, which has 4.463 billion inhabitants, had 3.219 million cases and 75,750 deaths https://www.worldometers.info/coronavirus/?utm_campaign=homeAdUOA?Si, accessed on 17 July 2020.

²⁵ <https://covid19.who.int/> accessed on 13 June 2020.

²⁶ The outbreak was first identified in Wuhan, China, in December 2019. The WHO declared the outbreak a Public Health Emergency of International Concern on 30 January, and a pandemic on 11 March.

²⁷ Of which three countries account for (a) 66.6% of the cases (South Africa 48.5%, Egypt 12.8% and Nigeria 5.2%) and (b) 66.3% of the deaths (South Africa 32.4%, Egypt 28.6% and Nigeria 5.3%).

²⁸ First confirmed case reported by the Ethiopian Public Health Institute after a Japanese who entered the country from Burkina Faso on 4th March 2020 tested positive (https://www.eph.gov.et/images/pictures/pic_2011/pic_2012/First-English-Press-release-1.pdf), accessed on 13 June 2020.

²⁹ The Ethiopian Airlines, having its main hub in Addis and a global flight network (reaching 110 destinations including major cities in China, Europe, and US that were hard hit by the virus) might have been a major source of exposure to the virus. But, both the Airline and the government were quick to react following the first confirmed case on 13th March 2020; in addition to suspending many flights, a 2-weeks mandatory quarantine was imposed on air passengers.

³⁰ A South Sudanese who returned from the Netherlands on 28th February 2020 (<https://www.afro.who.int/news/south-sudan-confirms-first-case-covid-19>), access on 13 June 2020.

Kenya (689 cases) and Ethiopia (603 cases). Similarly, Djibouti has highest deaths of 59 per 1 million population followed by Sudan (17) and Somalia (6).

Table 3: COVID-19 cases and deaths - absolute number and in proportion to population (22 September, 2020).

Country	Cumulative No of cases	Cumulative deaths	Cases per 1 m pop.	Deaths per 1m pop.
Djibouti	5,404	61	5,452	62
Eritrea	364	0	102	0
Ethiopia	69,709	1,108	603	10
Kenya	37,218	659	689	12
Somalia	3,465	98	217	6
South Sudan	2,649	49	236	4
Sudan	13,555	836	308	19
Uganda	6,712	64	146	1
Total	139,076	2,875	N/A	N/A

Source: https://www.worldometers.info/coronavirus/?utm_campaign=homeAdUOA?Si, accessed on 22/8/2020

4.3 Impact on other health services and implications on SDGs progress

Health services related to non-COVID conditions also suffered due to competing priorities. Scarce financial, medical personnel, medical supplies, diagnostic facilities and intensive care units had to be availed to the fight against the pandemic leading to disruption of essential health services. Basic health services including immunization, TB and HIV/AIDS, and response to common diseases such as malaria, diarrheal disease, dysentery, typhoid, and pneumonia and emergencies (e.g. cholera, malaria, measles, Yellow Fever, Chikungunya) have been affected. The situation was exacerbated by the infection by Covid-19 of a large number of health workers who got exposed due to insufficient supply of PPE. Members of the public are also reducing visits to health institutions partly for fear of getting infected (alerted by the news on infection of medical personnel) and partly by perceived decline in normal services. These risk reversal of the progress in the SDGs. For example, disruptions in essential services (such as antibiotics for pneumonia, DPT vaccinations, facility-based deliveries, and family planning services) are forecast to increase child mortality and maternal mortality in Ethiopia by 15% and 8% respectively next year (Sewasew, 2020). Ethiopia also reported a decrease in the uptake of immunization, maternal health services, and basic communicable and non-communicable services during March and April, 2020 as compared to that of July, 2019 to February, 2020. Protecting health workers and quickly putting the pandemic under control are critical without which the health care systems may be overstretched to the point where non-COVID health conditions may spiral out of control.

5 Socio-economic and health impact and measures in IGAD countries

5.1 Socio-economic Impact:

Macro and sectoral:

Growth: IMF's June 2020 projection shows the global economy and advanced economies to shrink by 4.9% and 8% respectively (and the Euro area by 10.2%³¹). Emerging market economies and developing countries GDP will contract by 3% (India by 4.5%); and Middle East and Central Asia by

³¹ According to World Bank projections, the contraction will be by negative 7.7%, 8.4% and 10.1% respectively (<https://www.worldbank.org/en/publication/global-economic-prospects>), accessed on June 29, 2020.

4.7% (Saudi Arabia by 6.8%) in 2020. The SSA economy is projected to decline by 3.2%, while its inflation (CPI) will average 11.3%,³² compared to 3% for the world (World Economic Outlook, June, 2020). World trade volume (goods and services) will shrink by 11.9% (-15.3% according to the World Bank). Similarly, trade volume of advanced economies will contract by 13.4% and that of emerging and developing economies by 9.4%). The pandemic may also cause damage to important determinants of growth; for example, a prolonged period of lockdown or restriction and measures to improve workplace safety³³ may affect productivity negatively.

Africa's growth in 2020, which was projected to be 3.2 to 3.9%, has now been compromised by the pandemic. With 56% of its 600 million urban residents living in poor settlements including slums, infection is expected to be high. According to some estimates 5 to 29 million people could be exposed to poverty due to the pandemic (which may be prolonged for up to 10 years). Ethiopia, which had enjoyed record average growth of more than 10% for a decade and half, is forecast to drop by 3.2% in 2020 (World Bank, 2020a) while another study puts the decline at 2.6%³⁴. Forecast growth in Uganda and Kenya is 3.3% and 1.5%, respectively. GDP in South Sudan, Sudan and Eritrea will contract by 4.3%, 4.0% and 0.7%, respectively in 2020 (World Bank, 2020a). In Somalia it will decline by 6% in 2020 (from annual average increase of 2.5% in the preceding 4 years) (IMF, 2020; World Bank, 2020).

The impacts differ by sector depending on exposure of the sectors, their importance and sensitivity of the products. For example, tourism, agriculture, and manufacturing sectors (which together account for 43% of GDP) are the hardest hit in Kenya. In Sudan, agriculture and services, which together account for 90% of the labour force and 78.6% of GDP, have been significantly impacted. The lockdown (including closure of airports and entry points by land and sea), comprehensive curfew and closure of cross-state borders affected agriculture through increased cost of transport; this has led to "reduced movement and increased wages of farm workers; freeze in extension services and support; sharp decline in agricultural exports demand; disruption of investment activities and farming finance; high inflation and exchange rate depreciation" (Ebaidalla, 2020). Growers of perishable products including tree crops and horticulture also suffered.

Dealing with the pandemic is estimated to cost the continent \$44 billion. With economies of all their important trade partners affected, IGAD countries are bound to be affected directly and indirectly. For example, according to the IMF, GDP growth in Ethiopia is expected to decline considerably in 2020 and 2021; a cumulative decline of 5.5% compared to the pre-crisis level³⁵ (IMF 2020).

Table 4: Some macroeconomic indicators

Country	% GDP growth (% decline)	Inflation (May 2020)	Budget share (%) of health sect
Ethiopia	3.2 (2.6)	19.8 (18.7 in Jan)	10.29
Kenya	1% to 2.5%	5.5	7
Somalia	(-6%)	n.a.	5
Uganda	-3.3%	3.9	n.a.

³²<https://www.imf.org/en/Publications/WEO/Issues/2020/06/24/WEOUpdateJune2020>, accessed on 29 June 2020.

³³ e.g. 'staggering work shifts, improved hygiene and cleaning between shifts, and improving proximity of personnel on production lines, all of which incur business costs (IMF June 2020).

³⁴<https://www.eeacon.org/sites/default/files/publications/Working%20Paper%2003%202020.pdf>, accessed on 20 July 2020.

³⁵<https://www.imf.org/en/Topics/imf-and-covid19/Policy-Responses-to-COVID-19>, accessed on 11 June 2020.

Source: IMF (June, 2020), World Bank (2020A), Ayoka (2020), Ebaidalla (2020).

Exports and exchange rate: GAD exports (dominated by primary commodities) suffered collapse in demand and prices following the deep recession in their major trading partners and disrupted supply chains, adding to the already dismal performance³⁶. Ethiopia's exports of cut flowers, textile and apparel, and services (tourism, international transport³⁷, hotels and related services), the country's important foreign exchange earners, suffered hugely. Production of exports was also impacted due to the restrictions and disruption of transport. In Somalia, livestock, which generates over 50% of its export earnings declined sharply due to the pandemic. Other exports are expected to face sharp decline as economic activities and incomes in the major trading partners, especially in the Gulf States, which experienced sharp decline in oil prices and cancellation of the 2020 Hajj in Saudi Arabia. Given its high dependence on oil exports, South Sudan is particularly impacted by the fall in oil prices. For oil importing IGAD countries, on the other hand, the decline in oil price allowed foreign exchange savings partly offsetting the prevailing shortage.

Collapse in remittances: Remittance inflow to SSA and IGAD (excluding Eritrea), which had reached \$48 billion and \$13.43 billion respectively in 2019, is expected to drop to \$37 billion (by 23.1%) and \$10.74 billion (20%) in 2020. Evidence shows that Diaspora remittances are important not only in supplementing family income/consumption back home but also in financing education, health, and/or cost of migration of family members. As such, they “reduce poverty, increase investment in children's schooling, boost health spending, finance small businesses and increase access to financial services”. Remittances are counter-cyclical in that migrants transfer remittances to families/relatives when the country of origin is hit by a shock to support and smooth their consumption. They are also important sources of foreign exchange, investment and balance of payment support.

Remittance inflow, in many developing countries, had become the single most important source of foreign exchange, surpassing FDI, portfolio investment, aid and exports and has been consistently rising. This, together with the rising propensity to migrate, especially among the young, in many countries including Ethiopia, suggested considerable room for remittance increase through appropriate measures. Many developing and least developed countries, including IGAD countries, were thus pursuing or initiating active remittance and migration policies in an effort to

- (a) encourage flow of existing remittances from informal to formal channels,
- (b) attract additional Diaspora remittances (especially for investment) including incentives to encourage the Diaspora to save and remit more, and
- (c) ensure that migration becomes more formal and of high quality, with higher chance of securing jobs and better wages.

The outbreak of the COVID-19 pandemic has affected remittances inflows both at the source and the transfer mechanism. The shock of the pandemic has simultaneously hit both the source and recipient countries. With reduced incomes due to layoffs, closure and downsizing of small and medium enterprises, etc. in host countries, such flows are likely to suffer. For example, recent

³⁶ Export growth in the region averaged less than 1% per annum during 2000-2018 (Trace Facilitation and Trade in the Horn of Africa region – forthcoming).

³⁷ The national carrier, Ethiopian, alone had to cancel flights to about 90 international destinations for several months.

studies on Ethiopia consider scenarios of decline in remittances of 25 to 70% (Lulit, Tadelles and Getachew, 2020; Seneshaw and Tewodros 2020).

A significant remittance reduction will render a blow to recipient countries and households for whom remittance inflow has been an important source of foreign exchange, business investment, household income as well as start-up capital for MSEs. Besides, some host countries such as Saudi Arabia and UAE are using the situation (on top of the decline in world oil price) to pressurize migrants to leave at the very time retaining them is critically needed. This adds to the already high unemployment in the IGAD region. The countries highly affected by the pandemic (US, Europe, and the Middle East) are major destinations for the Diaspora from the HoA region. With the on-going large scale layoffs, remittance inflows are bound to plummet with major implications on foreign exchange availability of countries and incomes and wellbeing of families of the Diaspora. Job loss in the US had risen to 50 million, at its peak, which is likely to include many from the IGAD countries. There are reports that migrants (for example in the US and Australia) are being excluded from the respective governments' support to small businesses. Besides, data from the US is already showing that a large proportion of those dying from the pandemic are African Americans.

Operational challenges related to sending and receiving remittances (e.g. closure of agents and offices, limited access to cash, foreign exchange, and security) may also contribute, and possibly increase, the cost of remittances to Africa which is already high. With restrictions on movements due to the pandemic, recipients may face rising costs of collecting their remittances, especially poor and rural households with little or no access to and use of financial technology. As a result, remittance inflows, which is an important source of foreign exchange for the country and source of income for families of the Diaspora is bound to be affected at a time it is needed most. The World Bank³⁸ estimates remittance flows to SSA to decline by 23.1% in 2020 (from \$48 billion to \$37 billion) and then recover by 4% in 2021. Remittance in Somalia, estimated at \$1.5 to 2.0 billion per annum (about 23% of GDP), is an important source of funding for private consumption and investment in the country, suffered hugely due to economic slowdown and the rising unemployment in the Western nations and the Middle East countries which are major remittance sources. With both direct and indirect inflow (through financing of imports) affected, remittance is expected to decline by half in 2020. In Sudan where remittances finance up to 40% of its imports, a collapse in remittance is expected to cause severe blow on the economy and society, on top of the effects of sanctions.

Exchange rate: Foreign exchange shortages, mainly driven by the decline in export earnings, remittances and FDI, significantly constrained countries' ability to import depleting their reserves. The uncertainty created by the pandemic further increased the demand for foreign currency. As a result, the local currencies came under heavy pressure leading to depreciation and large rises in parallel market premiums. For example, in the Sudan the pound lost about half of its value against the dollar between January and April 2020, contributing to the sharp rise in inflation from 64.1% in January to 114.2% in May 2020 (see Ebaidalla, 2020 for details). In Ethiopia, the average exchange rate in banks depreciated by 21.6% between January and late July 2020. The parallel market exchange rate as of 18th July 2020 reached birr 47 (a premium of 33.6%).

³⁸ World Bank, PRESS RELEASE NO: 2020/175/SPJ.

Reversal of progress in poverty reduction: Even as it is, poverty in the region remains high; it is estimated to be 82% in South Sudan, 70% in Somalia, 69% in Eritrea, 65% in Sudan, and 46% in Kenya. Coming on top of the locust infestation that affected most IGAD countries³⁹, lockdown/restriction related layoffs, closure of SMEs or loss of business, decline in remittances, disruption of supply chains (delivery of agricultural inputs), and consequent rise in cost of transport and food prices are bound to push many to fall below the poverty line and to further destitution.

Travel restrictions and lockdown also preclude migration as means of securing livelihood. The disruption of ‘School Feeding Programs’ following the closure of schools exacerbates the problem of malnutrition and vulnerability to diseases. For example, poverty in the Sudan is projected to rise to 70% in 2020 (or from 27.8 million people to 30 million people”). With global recovery forecasted to be slow (IMF June, 2020), poverty may deepen. For example, the IMF projected unemployment in the Sudan to reach 25% in 2020 (IMF, 2020). The COVID-19 pandemic thus poses a real challenge to achieve the UN Sustainable Development Goal (SDG) of ending poverty by 2030.⁴⁰

Loss of revenue (both tax and non-tax): Shortage of global demand due to the recession, weakened domestic demand, both consumption and investment demands by private and public sectors, due to lockdowns/restrictions and business closures associated layoffs, disruption of supply chains, tax exemptions in connection with pandemic, and challenges of revenue collection under a pandemic situation are likely to translate into reduced government revenue. The IGAD economies have not been spared; they are squeezed on both the revenue and expenditure side. In the Sudan, foreign grants and taxes which account for 27% and 28% of total revenue are expected to decline considerably due to the pandemic. In addition to the negative revenue effects of the decline in business activities due to the lockdown, the sharp fall in global oil prices will also affect revenue collected as transit fees in transporting South Sudan’s oil. The substantial decline in revenue in the Sudan is expected to constrain its ability to engage in counter-cyclical fiscal measures. In countries such as Somalia, domestic revenue is extremely low, averaging 3.3% of GDP during 2016-2018, and the tax base is very narrow (international trade tax accounting for 80% of domestic revenue), reflecting poor tax administration capacity as well as culture of tax avoidance and evasion. Such level and structure of revenue hardly provides room for increased health expenditures or switching expenditures through re-prioritization to deal with the pandemic without compromising on basic services.

Economic impact is expected to differ depending on duration of the pandemic as well as between rural versus urban and across sectors. For example, the GDP impact forecasted for Ethiopia by the World Bank is 3.2%. Another forecast by Goshu et al (2020), assuming mild scenario 3-months duration of the pandemic indicates a 2.2% loss; assuming 6-months duration, the forecast loss will amount to 6.7% of GDP. Sector wise forecasted impact ranges between 3.8% for services, to 1.6% for manufacturing and 0.49% in agriculture. The relatively small impact on agriculture, according to the authors could be attributed to the fact the 3-months forecast period falls prior to the main

³⁹ Eritrea, Ethiopia, Somalia, South Sudan and Uganda (World Bank 2020a: 28).

⁴⁰ The estimation of poverty headcount is based on Sumner et al (2020) assumptions: international poverty lines of US\$1.90; medium scenario of 10% decrease in per capita income as well as the Sub-Saharan African context (see Table A2).

rainy season where Ethiopia's agricultural production is concentrated. They also anticipate lower impact in rural than urban areas.

Suspension of projects and congestion of transport: Governments are forced to prioritise expenditures and access to foreign exchange in addition to shifts in policymakers' attention to the fight against the pandemic. Projects thus faced suspension or delays in project cycles. Transport capacity being limited, public transport in these countries is usually congested. This together with the difficulty of making mass transport services (e.g. cross-country and city train and bus transports) virus-safe, raises the risk of spread of infection. This may encourage citizens to resort to use of smaller vehicle, leading to increase traffic congestion and GHG emission, especially in cities.'

Impact on refugees and internally displaced persons (IDPs):

The region hosts a large number of refugees and IDPs both from within and outside. For example, Sudan has more than one million refugees and asylum seekers from a number of countries including Ethiopia, Eritrea, South Sudan, Central African Republic (CAR), Chad, the Democratic Republic of Congo (DRC), Somalia, Yemen and Syria. Uganda, Ethiopia and Kenya have large refugee populations, estimated at 1.4 million, 900,000⁴¹(in addition to a million IDPs) and 500,000, respectively. The overcrowded settlements and limited access to hygiene facilities and health care services in refugee camps and poor nutrition and other underlying conditions make refugees and IDPs vulnerable to infections and fatalities. The lockdowns and travel restrictions have also disrupted the smooth running of humanitarian operations, exacerbating vulnerability. Refugees also suffered from unemployment and underemployment, and income loss due to shutdown restrictions, exposing their families to hunger and extreme poverty. People in camps suffer from limited access to services and work, limited freedom of movement, discrimination, poverty in the host communities, and high levels of vulnerability to shocks (see Ebaidalla 2020 for more discussion).

5.2 Measures

Dealing with the COVID-19 pandemic and its socio-economic consequences requires a range of health, social and economic measures. In addition to quick emergency measures to save lives and businesses, activating the economy to recovery is essential. In this respect, Hepburn et al (2020) distinguishes between rescue measures and recovery measures. The former refer to measures that aim to "keep people and businesses alive". The common priority is to try to "protect balance sheets, reduce bankruptcies and address immediate welfare concerns" (p.: 6).The later refer to measures that aim to "[reinvigorate] the economy once mobility restrictions can be relaxed" (p. 6). Therefore, while the "emergency rescue packages ... being implemented represent life and death decisions made by government officials about people alive today... the imminent recovery packages, soon to be designed and implemented, will reshape the economy for the longer-term, representing life and death decisions about future generations, including through their impact on

⁴¹<https://www.unrefugees.org/news/ethiopia-refugee-crisis-explained/#:-:text=With%20more%20than%20900%2C000%20refugees,South%20Sudan%2C%20Somalia%20and%20Eritrea.>

the climate” (Hepburn et al 2020: 7). IGAD countries have been taking active responses (Eritrea being an exception) through a range of fiscal, monetary, sectoral and social safety net measures.

5.2.1 Rescue Measures

Economic rescue responses: These relate to emergency measures that are countercyclical aimed at protecting balance sheets, reducing bankruptcies and addressing immediate human welfare concerns. They include support to businesses (such as worker and business compensations or tax breaks or forgiveness) to stay afloat and protect jobs and livelihoods. The common priority packages tend to “increase cash flows to individuals in financial distress and to support those who need to spend on food, shelter, health, electricity, and other basic goods” (Hepburn et al, 2020: 6).

Given the sudden nature of the outbreak and its wide simultaneous impact, speed is important for rescue measures. Designing appropriate policies thus challenges the already limited administrative capacities of the IGAD countries, expedite government payment to contractors, suppliers, etc. which is due. Below we discuss the socio-economic measures countries took in response to the pandemic.

5.2.1.1 Fiscal Rescue Measures

In addition to increased health and emergency spending to protect the public from the pandemic, spending in economic support of households and firms affected by the pandemic is essential. While the range and type of fiscal instruments used may differ, partly to reflect country context and capacity, all IGAD countries have taken a series of quick fiscal measures ranging from support to firms and employment including tax and related measures to cushion businesses and the public from the impact of the pandemic. They all gave emphasis to ‘saving lives and businesses’. The key specific measures are summarized in Table 5 for four countries (Ethiopia, Kenya, Somalia and Sudan).

The case of Ethiopia provides a good example of the extent to which certain contexts offer policy options that may not be available in other contexts. For example, the power, telephone and water utility companies in Ethiopia are under full government ownership. These permitted the government to suspend payments of utility bills for several months that directly benefited households and businesses (detailed below). Ethiopia also has a large stock of government owned houses (including the so-called Condominium Houses) rented for residence and business premises. This allowed the government to provide relief on rents to the occupying tenants (both residents and businesses). It also introduced an economic-support package based on cost sharing principles; the government, labour unions and Federation of Employers signed a tripartite agreement aimed to prevent layoffs with government covering part of the cost. Similarly, the government provided “tax relief on rental income”, partly intended to encourage landlords to pass on the benefits to their tenants. However, in this case, whether or not and the extent to which the benefits will reach the intended beneficiaries depends on persuasion of the landlords.

Table 5: Fiscal measures introduced in response to the COVID-19 Pandemic

Ethiopia	Kenya	Sudan	Somalia
Tax breaks /relief (including forgiveness of interest and penalty on tax debt, and personal income tax)	Personal income tax relief on low wage earners Reduction of corporate tax and VAT Raising non-resident tax on dividends	Removal of fuel subsidies to make room for increased health expenditures and health insurance ⁴²	Introduced 3-month tax holiday on basic commodities and reduced consumption tax on basic goods (include. Flour by 5%) to cushion cost of living Lifted restrictions on imports of rice.
Extension of period for tax payment		Subsidies for badly affected businesses	Transfers to federal member states and the Banadir region to help them respond to the impact of the pandemic.
Reduction of tax on rental income (intended to encourage landlords to pass on the benefits to their tenants)			
Suspension of payment of bills (water, electricity, telephone, etc.) by households – possible due to government ownership of power, telephone and water companies		Support to informal sector & families affected by lockdown	
Financial contributions by businesses to the fight against the pandemic recognized as tax deductible			
Worker or business compensation schemes that defend livelihoods - covering workers' wages (fully or partially) to prevent layoffs		Increased salaries of public sector employees	
Carry forward of loss by businesses			
Duty exemption on imports related to the fight against the pandemic	Duty exemption		
Fast tracking of rebates on turn over tax	Raising the threshold for turnover tax (reduction for small businesses)		
Suspension of deduction for pension monthly contributions;	Reduction of PAYE rates		
Relief of rents for those renting government owned houses/business premises		Supply of essential commodities through coops	
Resource allocation for emergency food distribution for those not covered by PSNP		package of support for most affected population groups such as, informal sector workers and public servants	Re-allocation of budget to health and social services

⁴² Wheat and energy subsidies in the Sudan absorb a huge fraction of the budget – for example, this amounted to 49% and 36% in 2019 and 2020 respectively.

We can see from Table 5 that economic stimulates of the type used in developed countries through injection of funds is not used.

Of the above measures, some are more likely to be effective than others. Similarly, some are more likely to have wider effect than others. For example, reduction of VAT (as done in Kenya) can be expected to have wide effect by reducing the shelf price on commodities while tax relief on personal wage income may not because wage earners account for a relatively small fraction of employment, and benefits may not materialize as workers may be laid-off and be sent on unpaid leave. In Ethiopia, suspension of payment of electricity, water and telephone bills and relief on rent of houses/business premises certainly leave more cash in the hands of both households and businesses. Hence, these reliefs are quite effective both in terms of amount involved and reaching the intended target, although they are likely to be for a very short time. However, such policy instruments are not available in countries where such utilities are privately owned. On the other hand, ensuring that the benefits of reduced tax on rental income from residential houses and business premises (as done in Ethiopia) reaches the tenants may be difficult as landlords may not pass them on. Moreover, the relief/reduction on personal income tax and wage subsidies, while useful to those covered, may not be expected to have wide impact because, in most IGAD countries, informal workers and firms, who cannot be reached through such measures, account for a large proportion.

Besides, the tax measures involve huge revenue loss to respective governments. For example, the Ethiopian government estimated the forgone tax income at 60 billion birr. In Kenya, revenue losses from the tax waver is estimated at 172 billion Kenyan Shillings. In the Sudan, revenue shortage has forced the government to reduce energy subsidy with implications on cost of transport. This comes on top of the expected decline in tax revenue due to the decline in business activities. Thus, failures of the benefits to effectively reach the target population and while government losses significant revenue, represents a dual loss. As the World Bank argues, innovative measures to deliver income support to informal workers and credit to informal businesses are needed. Policy should also aim maximum reach of informal participants during the crisis mainly through measures that are temporary and reversible in order to minimize the fiscal burden afterwards (WB, Global Economic Prospects June 2020: 40).

5.2.1.2 Monetary and Foreign Exchange Rescue Measures

Monetary measures:

With decline in business activities affecting incomes, both deposit mobilization and collection of loans by banks get affected with implications on their liquidity. Business impacted by the pandemic also required working capital. Thus, in addition to fiscal measures, governments resorted to monetary policy measures, depending on the country context including the space for monetary expansion in dealing with the pandemic. Some of the common measures include provision of liquidity to banks (Ethiopia, Kenya, Sudan, Uganda and Somalia), relaxing regulation on loan classification and provisioning, encouraging banks to provide flexible terms to borrowers (e.g. re-scheduling or temporary freeze of repayment of loans and interest, relaxed lending criteria, etc.), provision of working capital loans to businesses (Ethiopia, Kenya, Somalia, Uganda), measures that dis-incentivise the use of cash and reduce frequent visit to banks (.e.g. raising limits on mobile

money transfer, on daily withdrawals from ATM, etc.), introducing a mechanism that eases interbank money transfer, removing/reducing charges/commissions on bank transactions (transfers, withdrawals, renewal of loans, etc.).

Based on their context, some countries also introduced certain specific measures. For example, Ethiopia, removed the price floor on flower exports⁴³ that was in place as part of the effort to deal with transfer pricing. Kenya reduced its policy rate (by 100 bps to 7.25 percent and then further to 7.0 percent), the cash reserve ratio (by 100 bps to 4.25 percent) and increased the maximum tenor of repurchase agreements from 28 to 91 days; suspended the listing of negative credit information for borrowers whose loans became non-performing after April 1 for six months; and set a new minimum threshold for negative credit information submitted to credit reference bureaus⁴⁴. Somalia⁴⁵ is coordinating with its international partners to ease inflows of remittance and other transfers which the country needs badly.

Foreign exchange and related measures:

None of the IGAD countries except Uganda took exchange rate and balance of payment measures in connection with the COVID-19 pandemic. The Bank of Uganda announced its readiness to intervene in the foreign exchange market to smooth exchange rate volatility that may arise. Ethiopia has a managed float exchange rate policy and capital account controls in place. Exporters can retain 30% of foreign exchange earned from exporters for own use and expected to surrender the remaining 70% if not used within 28 days. The regulator has also a priority list for foreign exchange allocation that banks are supposed to follow in availing foreign exchange. As part of the emergency measures in response to the pandemic, the government gave priority access to foreign exchange to both importers and local producers of COVID-19-related goods.

With important commodity exports heavily hit by the pandemic, governments also had to revisit their export policies and regulations. For example, Ethiopia removed the minimum prices on flower exports introduced to deal with the problem of transfer pricing and under-valuation that is believed to be rampant. It also allowed those normally supposed to produce for exports (hence receive export incentives) to sale in the domestic market.

5.2.1.3 Social Safety Net Measures

A range of social safety net measures were taken by governments, private sector and citizens to mitigate the negative impact on households and enterprises in general, and especially the poor and vulnerable groups including slum dwellers, the elderly, disabled and orphan children. These included boosting social safety net by increasing direct cash transfers, in-kind distribution of food staffs, providing unemployment benefits and delivering basic food baskets to poor families at discounted prices, salary increases to and unemployment benefits for families previously working (e.g. Ethiopia, Kenya, and Sudan). Governments also introduced various public works programs to create jobs and healthier environment in slum areas; e.g. a hygiene program in Kenya to hire

⁴³ Office of the Prime Minister Ginbot62, 2012 E.C.

⁴⁴ <https://www.imf.org/en/Topics/imf-and-covid19/Policy-Responses-to-COVID-19>, accessed on 19 May 2020.

⁴⁵ The Central Bank of Somalia is constrained by the lack of policy tools to deploy in support of the deteriorating economy.

100,000 youth, improvement/maintenance of infrastructure (pedestrian walkways, roadside green areas, etc.) in Ethiopia.

Individual citizens, business organisations and CSOs have also been making critical contributions both towards the containment of the spread of the pandemic and mitigating its immediate impact on the low income groups. These included contributions to the government pool fund, in-kind provision of masks, sanitizers and sanitation materials (soaps, water, etc.), food items, availing their buildings/houses for use as quarantine, discount or relief of rents on houses/business premises to tenants.

5.2.2 Recovery measures/stimulus

At the global level, expectations regarding speed of recovery vary from a quick *V-shaped* one to a *U-shaped* recovery, a *hockey stick-shaped* one (implying 2-3 years stagnation before the economy picks up) to a *long-term stagnation*. In the IGAD region, four months since the first confirmed cases of COVID-19, infections and deaths continue to rise steadily rather than spiking fast and levelling-off. Duration of the pandemic is thus likely to be elongated with implications on the impact and speed of recovery. Efforts have been ongoing to control the pandemic and rescue people and businesses. But, economic recovery deserves attention. Recovery packages that aim to “stabilise expectations, restore confidence, and to channel surplus desired saving into productive investment” are needed (Hepburn et al, 2020). The usual factors in designing such package are “the long-run economic multiplier, contributions to the productive asset base and national wealth, speed of implementation, affordability, simplicity, impact on inequality, and various political considerations”.

Debate is ongoing regarding the type of recovery; some see this as opportunity that must be seized to ‘build back in a green and low carbon way’. There is a need to avoid a “return to ‘business as usual’ and environmentally destructive investment patterns and activities” (OECD 2020). Recovery packages should aim beyond “getting economies and livelihoods quickly back on their feet” to include investments and behavioural changes that decrease the likelihood of future shocks (focusing on wellbeing and inclusiveness) and enhance resilience and alignment with long-term emission reductions (OECD 2020).

Hepburn et al (2020) make distinction between recovery packages that focus more on consumption (which benefits the current generation) and those which focus on productive investment that promise returns for the future generation. They suggest an alternative way to restore confidence in a manner consistent with global climate goals; one that “steers investment towards a productive and balanced portfolio of sustainable physical capital, human capital, social capital, intangible capital, and natural capital assets” They also argued that “any recovery package, including climate-friendly recovery, is unlikely to be implemented unless it also addresses existing societal and political concerns – such as poverty alleviation, inequality, and social inclusion – which vary from country to country” (Hepburn et al, 2020: 7). Also important is ensuring that resources are directed “towards investments in high productivity assets, with higher economic multipliers, to deliver a capital stock and a labour force suited to the challenges of the future”. Similarly, the OECD emphasizes the importance of “not only getting economies and livelihoods back on their feet quickly” but also safeguarding prosperity for the longer-term”. Recovery policies that ‘trigger

investment and behavioural changes that will reduce the likelihood of future shocks and increase society's resilience to them when they occur' with focus on well-being, inclusiveness and reduction of inequality are needed (OECD 2020:2).

Tuning the recovery measures to address poverty, inequality, social inclusion and productivity is more critical in the context of IGAD countries. The feasible measures are, however, constrained by their resource capacity; the already high debt burden together with decline in revenue and inflation limit the scope for fiscal and monetary stimulus while FDI and aid flow is expected to decline. Where to inject their limited resources is thus crucial. Besides, some proponents of the "building back better" approach are arguing for, among other things, subsidies, loan guarantees and other government supports to be conditional on 'environmental improvements and better overall resilience and phasing out of fossil-fuel subsidies' (Energy Transitions Commission, 2020; OECD, 2020). While the attention to environment is appropriate, in the context of IGAD and other developing countries, this approach raises a concern of whether it might herald the return of (a new form) of donor conditionality on external aid and loans that may pose further constraint on access to external finance. Besides, such conditionality may slow down the flow of urgently needed recovery support as coming up with 'green projects' and policies that meet the conditions may challenge the capacities of countries. The large number of small businesses that provide jobs to millions of people which need support to survive or restart operation could be at a disadvantage in accessing support. Recovery measures in the region should include effective need-based support and channels of reaching them as key component.

At any rate, IGAD governments need to act quickly as timeliness and flexibility of recovery policy is important. Also important, as Hepburn et al noted, is making its design consultative and evidence-based (Hepburn et al, 2020: 14). IGAD may play a role in supporting such process as well as coordinating their recovery efforts (including possible regional recovery packages) and sharing experiences for greater impact. For example, travel/tourism and related services constitute an important sector in most member countries. IGAD may consider initiating and supporting the development of a joint recovery program that offers tourism packages covering several countries.

5.3 Sources of Funding of the measures:

The IGAD countries finances are being squeezed on both the revenue and expenditure sides. They face considerably higher expenditures due to implementing the measures to deal with the health, social and economic challenges of the pandemic, while at the same time suffering significant revenue losses. This is exacerbated by the decline in remittances, and FDI (and possibly outflow of capital). The feasible policy options and potential interventions countries have at their disposal to deal with the situation critically depend on their affordability, more so in developing countries. Even without a shock of such scope and intensity, the IGAD countries have been finance and foreign exchange constrained. The pandemic came on top of the drought, flood and locust warm invasion. So, the scope to domestically cover the pandemic related additional expenditure, which is huge, is constrained. Emergency funding is needed for medical diagnostic services, surveillance and response, capacity building, quarantine, isolation and treatment centres, medical waste disposal, risk communications and community engagement as well as for strengthening the countries' capacity to provide safe blood services. According to some estimates Africa pandemic related financing requirements range from US\$44 billion to US\$ 100 billion.

Additional resources are thus badly needed to offset the revenue losses, increases in priority expenditures and outflows of capital. The scope for use of expansionary fiscal and monetary policies by IGAD governments is constrained by the already high budget deficits, exacerbated by the loss of revenue (due to decline in economic activities, tax forgiveness, and weakened tax collection in connection with the pandemic), high debt burden (both external and domestic), and inflation. So, liquidity assistance of various forms (e.g. debt relief, financing through global financial safety net, facilitating easy flow of remittances at low cost, etc.) is urgently needed.

5.3.1 Internal sources

Efforts to locally mobilise financial and non-financial resources include: re-purposing of existing government and donor resources, additional fiscal financing, new grants and loans, voluntary contributions from internal and external sources (including civic society – Diaspora, professional health associations, etc.) and distribute the same at federal, sub-regional and regional levels. Countries had also to do re-prioritise existing budgets, including suspending projects, and switch resources for emergency uses. Several countries also encouraged domestic businesses to take advantage of the high demand for PPE by producing such items domestically. This proved crucial in supplying PPE quickly and at low cost, replacing the disrupted global supply chain which also saved scarce foreign exchange. A software developed in Kenya increased efficiency of laboratory testing for COVID-19 (using existing HIV testing infrastructure) in the upwards of 37,000 samples in 12 hours, resulting in significant cost savings. Despite the innovative efforts, the financing gap has remained huge. External finance thus needs to be sought despite its uncertainty in terms of magnitude, timing and conditions.

5.3.2 External sources

The aggregate emergency funding requirements of member countries was so huge that even major multilateral organisations such as the World Bank and the IMF had to enhance their fast track funding capacities. Cash and in-kind support from multilateral and bilateral organisations including World Bank, IMF, EU, UN agencies, China, Islamic Development Bank, were crucial to IGAD countries. Many NGOs also provided support to the health system through awareness, providing medicines and logistics.

The 216 states and territories affected by the pandemic include almost all the traditional bilateral funder and recipient countries. All are facing high expenditures related to fighting the pandemic and providing economic stimulus while revenues have collapsed due to recession. The developed and emerging economies, which otherwise are the major sources of bilateral funding, have now been left with huge funding requirements, crowding out funding for other countries. For example, the difficulty that the EU is facing to come up with emergency and recovery funding of a size, form and conditions acceptable to its highly affected members seeking support illustrates the funding constraints. Still countries could help by facilitating easy flow of remittances which is important to IGAD countries and households.

Savings from debt relief measures constitute another potentially important source of external funding for the IGAD countries as they face heavy burden of external debt and debt servicing. IGAD countries have received debt relief/rescheduling and emergency funding from the WB, IMF, China

and other donors. For example, Ethiopia secured COVID related support of \$411 million from IMF, \$82 million from World Bank, and €42 million from EU; Kenya received \$739 million from IMF, \$50 million from World Bank, and €15 million from EU; Uganda received \$491.5 million from IMF and \$300 million from World Bank, while Djibouti received \$43.4 million from IMF, \$5 million from World Bank, and €500,000 from EU. Somalia recently reached a decision point for a significant debt relief under HIPIC.⁴⁶ In addition, it reportedly secured new commitments of US\$350 million from the IMF, \$159 million financial support for Covid-19 relief funding from the World Bank and €48 million support from EU. IGAD countries are also among the 50 African states that received in-kind support of much needed supplies of testing kits, ventilators, masks, and other medical supplies as well as expert teams, in addition to debt cancellation. The region may benefit from a regional approach to resource mobilization. IGAD has already paved the way through the establishment of the Emergency Fund for Covid-19 which should be strengthened. Similar joint initiatives may be considered for recovery efforts (discussed below).

6 Summary and recommendations

Home to 5 of the 15 countries ranked as the world's "highest risk"^{47,48} in terms of exposure to pandemics and access to health care, the IGAD region was among the least prepared. Some member states even lack the capacity to "carry out basic governance functions". In addition to hotspots, factors including traditional greetings that involve close physical contacts, eating in large groups from the same plate, chewing chat, and presence of cross border mobile populations increase the risk of community transmission. Limited access to water and sanitation, poverty, poor nutrition and health, and weak health services exacerbated these risks. Social-distancing, 'staying at home' and 'working from home' were not feasible in the face of crowded settlements and high importance of daily jobs and informal income among the population. Moreover, the pandemic came on top of the locust attack on most member countries as well as persistent fiscal and balance of payment deficits, debt burden, high inflation, foreign exchange shortage, and high unemployment. The countries are exposed to both the direct effects of the pandemic and the recession in the developed countries, affecting both the demand and supply sides.

Although governments were quick in setting health response mechanisms, awareness creation, and introducing rescue measures, lags in supply and affordability of face masks and sanitizing materials proved a challenge. Failure to observe regular use of masks and social distancing together with the difficulty to sustain lockdowns and restrictions exacerbated the situation. Thus, the level and spread of infection, which remained relatively low for several months, accelerated considerably, especially in June and July, reaching 61,861 cases and 1561 deaths by end of July 2020.

The large scale of infection across the globe, and its resurgence in many countries, means that the recession is not only deep but shall also be prolonged, and would make recovery slow. With almost all major trading partners and bilateral funders of the IGAD countries as well as major destinations of migration from the region affected, the health, economic and social impacts are considerable; essential health services have been disrupted as human, financial and institutional resources are switched to deal with the pandemic emergency; closure of schools has affected millions of children; overall growth, revenue, exports, remittance, FDI and aid flows have suffered with

⁴⁶ The arrangement is expected to reduce Somalia's debt stock of \$5.2 billion to \$557 million.

⁴⁷ <https://www.care.org/newsroom/press/press-releases/care-analysis-vulnerable-countries-face-3-times-risk-covid-19-exposure>, accessed on 20 June 2020.

⁴⁸ These are Somalia, South Sudan, Ethiopia, Sudan and Uganda.

consequences on economic activities, jobs and poverty. The pandemic seriously tested the capacities of governments, households and communities as well as their development partners. Governments, citizens and the private sector have taken a range of rescue measures; the fiscal, monetary, foreign exchange, and social safety net measures were complemented by cash and in-kind contributions by citizens, business organisations and CSOs. In some cases, country-specific contexts allowed effective use of certain rescue measures. For example, in Ethiopia, while limited financial capacity did not allow any meaningful direct financial support, state ownership of power, telephone and water utilities and a large stock of houses and buildings permitted it to use suspension of payment of bills and relief on rent of houses/business premises, leaving more cash in the hands of users and occupying tenants (both households and businesses). But, these couldn't go beyond a couple of months or so while the pandemic continues to spread.

As governments continue to struggle against the pandemic and rescue lives and businesses, they also need to introduce appropriate measures for fast and sustainable recovery. Governments will be served well by taking measures and processes that ensure the design of recovery measures that are not only in line with the SDGs but also deliberately aim to exploit opportunities to rebuild in ways that are green and strengthen future resilience to shocks. Funding constraints are likely to necessitate revisiting development strategies and policy incentives and re-prioritisation of budget expenditures, which should be based on sound analysis and evidence. However, care should be exercised not to pre-empt recovery by attaching undue short term targets or conditionality.

Making design of recovery packages consultative and evidence-based is crucial in this respect. IGAD could play an important leading role in initiating and supporting research, analysis and policy advice that inform the design of recovery packages (with possible regional components) and consultative formulation processes. It could also facilitate the formulation of recovery packages that are well grounded in the context by drawing on the pool of knowledge and expertise in the region using various modalities. For example, it can collaborate with think tanks in the region and development partners to organize conversations (e.g. via virtual conferences/webinars, or a hybrid of online and in-person as appropriate) and experience sharing among policymakers, researchers, and development partners; promote responsive collaborative research, knowledge sharing and networking in the region; etc. The discussion and ideas may also inform development partners working in the region to re-visit their development programs in light of the added dimension of the impact of the pandemic and the resource demands of a recovery that addresses poverty, inequality and inclusion as well as the environment.

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Annex 1: COVID-19 cases and deaths - absolute number and in proportion to population (Mid-June, 18 July, 31 July and 22 September 2020).

Country	Cumulative No of cases	Cumulative deaths	Cases per 1 m pop.	Deaths per 1m pop.
Djibouti:				
. 14 Jun	4,441	38		
.18 July	5,003	56	5061	57
. 31 July	5,084	58	5140	59
.22 Septemb	5404	61	5452	62
Eritrea:				
. 14 Jun	65	0		
. 18 July	251	0	71	0
. 31 July	279	0	79	0
.22 Septemb	364	0	102	0
Ethiopia:				
. 14 Jun	3,166	55		
.18 July	8803	148	77	1
. 31 July	17,530	274	152	2
.22 Septemb	69,709	1,108	603	10
Kenya:				
. 14Jun	3,457	100		
.18 July	12,750	217	237	4
. 31 July	20,636	341	383	6
.22 Septemb	37,218	659	689	12
Somalia:				
.14 Jun	2,513	85		
.18 July	3,106	93	195	6
. 31 July	3,212	93	202	6
.22 Septemb	3,465	98	217	6
South Sudan:				
.14 Jun	1,684	25		
.18 July	2,191	41	196	4
. 31 July	2,322	46	207	4
.22 Septemb	2,649	49	236	4
Sudan:				
.14 Jun	6,879	433		
.18 July	10,682	668	243	15
. 31 July	11,644	746	265	17
.22 Septemb	13,555	836	308	19
Uganda:				
.14 Jun	823	0		
.18 July	1,062	0	23	0
. 31 July	1,154	3	25	0.07
.22 Septemb	6,712	64	146	1
Total:				
.14 Jun	22,590	736		
.18 July	43,848	789	N/A	N/A
. 31 July	61,861	1,561	N/A	N/A
.22 Septemb	139,076	2,875	N/A	N/A

Source: https://www.worldometers.info/coronavirus/?utm_campaign=homeAdUOA?Si, accessed on 18/7/2020, 31/7/2020 and 22/9/2020.