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BUILDING A BETTER WORLD: THE CRISIS AND OPPORTUNITY OF COVID-19

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Tackling Covid-19 and Building Back Better: The Case of Ethiopia*†

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Abstract The Covid-19 pandemic struck Ethiopia at an important juncture in its development and political path. Following impressive progress in poverty reduction and human development in recent decades, driven by a state-led model, it is transitioning towards a more democratic governance structure and a more liberal economic model. This article examines the country's response to the pandemic, focusing on social protection and health systems. Ethiopia's experience demonstrates the importance of building shock-responsive systems for social protection, including pre-identification of vulnerable groups and a financing strategy to trigger an immediate response. It also highlights how the health sector capacity can be further strengthened in anticipation of future health emergencies. For example, the government could identify and build the health sector industry capacity before future shocks occur in order to quickly scale up the response. Covid-19 had a disproportionate impact on women and girls due to the closure of schools; limited access to gender-based violence and health services; and the economic impact on informal sectors. The article concludes by sharing key lessons for developing countries on how prioritisation of vulnerable groups and ensuring strong political commitment can support a more effective pandemic response.

Keywords Covid-19, safety net, health system, education, women and girls, social protection, capacity, political leadership.

1 Introduction

In recent decades, Ethiopia has been held up as a development success story while still confronting immense challenges and ongoing fragility. It has experienced some of the highest growth rates globally, largely owing to the government's commitment to pursue a development approach focused on industrialisation and improving basic services. Poverty and human development indicators have mostly outpaced those of its neighbours and



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comparable countries. Ethiopia is one of the fastest-growing economies in sub-Saharan Africa, with an average gross domestic product (GDP) growth rate of 8.2 per cent between 2000 and 2011 – significantly higher than the sub-Saharan average (4.7 per cent) or the East African average (6.7 per cent) over the same period. Its reduction in maternal mortality is also a notable achievement, decreasing from 676 deaths per 100,000 in 2011 to 401 per 100,000 in 2017. Under-five mortality and infant mortality per 1,000 live births has also reduced from 123 and 77 in 2005 to 59 and 47 in 2019, respectively.

More recently, political turbulence has led to dramatic change and Ethiopia is in the midst of a bumpy transition from a restrictive developmental state towards more liberal and democratic governance. The political landscape is uncertain; internal ethnic conflict has escalated; institutional reforms are at nascent stage; and building state-citizen trust remains a challenge after years of authoritarianism. Maintaining its positive development trajectory during a transition while at the same time recovering from Covid-19 will test the limits of its progress.

Familiar challenges also endure. Ethiopia continues to face climate-related shocks due to the dependency on rain-fed agriculture and a high level of vulnerability in lowland areas. A recent World Bank poverty assessment (Bundervoet *et al.* 2020) asserted that, despite a decline in all measures of national poverty, inequality at the national level has increased over time – suggesting that deeper investment in social protection is warranted as the country liberalises further. The Gini coefficient at national level was 0.29 in 1996, rising to 0.3 in 2011 and to 0.33 in 2016 (Araya and Woldehana 2019), indicating that there are relatively fewer economic gains for lower-income households from recent growth (UNDP 2015). In addition, the growing service sector, where women are the majority, is predominantly informal and unprotected – characterised by low returns, low productivity, and with limited potential to transform the lives of those employed in the sector.

Ethiopia's health system came into particular focus as it responded to Covid-19. Luckily, significant gains had already been realised in the health sector over the past decade due to massive investment, placing it in a relatively strong position. The government's Health Extension Programme, which has focused specifically on women and children, has more than 38,000 health extension workers (the majority of whom are women) deployed throughout the country. One example of the significant health gains is a decrease in stunting rates from 58 per cent to 38 per cent between 2000 and 2016. Ethiopia also maintains a relatively low death rate compared to other sub-Saharan African peers, largely due to efforts in curbing the spread of communicable diseases (Ministry of Health 2019). The country has been successful in reducing deaths related to communicable, maternal, neonatal,

and nutritional deficiency diseases and injuries by 65 per cent, despite rates of maternal and neonatal mortality that remain unacceptably high (Misganaw *et al.* 2017).

Despite its impressive achievements, Ethiopia still has a lot to do in terms of creating health systems that can withstand shocks. The country registers a very high morbidity and mortality from the triple burden of diseases (common infection, undernutrition, and maternal mortality). The quality of health care in terms of improving patient safety, effectiveness, and patient-centredness is often inconsistent and unreliable. A health workforce shortage, low in-country capacity in pharmaceutical manufacturing, and limited regional collaboration on transboundary diseases and outbreaks are a few of the challenges that the country continues to face.

The impact of Covid-19 on education also threatens Ethiopia's human development gains. Over 26 million primary- and secondary-level students have been out of the classroom due to school closures since March 2020. Although some children have been able to access online and distance learning, many – especially those in rural areas – have not, due to the wide infrastructure/digital divide. Prolonged school closures risk further worsening the country's already weak learning outcomes. The longer poor and marginalised children stay out of school, the more likely they are to drop out. Children from the poorest households are already almost five times more likely to be out of primary school than those from the richest (Khodr 2020). In Ethiopia, the closure of schools has deprived about 1 million children from the poorest families of school meals, which are a valuable source of nutrition. It has also deprived vulnerable children of a safe and secure environment free from dangers they may face in their homes or communities. By staying home for a prolonged period, children are more at risk of violence and abuse, and economic pressures have reportedly led to an increase in forced child marriage (*ibid.*).

Covid-19 has amplified existing inequalities, in particular for women and girls. Their incomes and economic opportunities have been disproportionately impacted as they are employed more in the informal sector. This includes Ethiopians working abroad as domestic workers, who have had to return after losing their precarious jobs. The findings from an assessment on *The Market-Reach of Pandemics: Evidence from Female Workers in Ethiopia's Ready-Made Garment Industry* (Meyer *et al.* 2021) documented the significant changes in female employment in the sector. The garment industry, once a source of majority-female formal employment, was hit by a sharp drop in labour demand, meaning that women are no longer working and have migrated away from urban centres of employment to rural areas which are known for high levels of food insecurity (*ibid.*). Covid-19 mitigation measures have also inadvertently put women and girls at increased risk

of intimate gender-based violence and forced marriage, and paused campaigns for sexual reproductive health rights and access to health services that many women rely on, including access to contraceptives (UN Women Ethiopia 2020).

2 General Covid-19 response

After Ethiopia reported its first Covid-19 case in March 2020, the government took a number of preventive and mitigating steps to contain the impact of the pandemic. It declared a five-month state of emergency,² officially postponed parliamentary and presidential elections indefinitely, adopted significant economic response measures to support its citizens,³ and granted a pardon for more than 20,000 prisoners. The prime minister, Abiy Ahmed, also prominently advocated for debt relief for African nations in advance of the anticipated economic impact of the crisis.

At the beginning of the pandemic, there was limited gender analysis carried out and the possible impact on women and girls and potential supports was not set out. However, subsequently, the government and civic groups did take a number of positive measures. Even though the Federal Court was partially closed to contain the pandemic, it decided to accept charges of domestic violence as urgent cases in response to reports of an increase in domestic violence during the state of emergency. Setaweet, a feminist organisation, provided free telephone services for women experiencing violence. Ethiopia's popular artists also started a campaign to raise awareness on violence against women and girls called #Zim Alilim ('I will not keep quiet').

Despite limited government capacity, a strong political and cross-party commitment helped to curb the pandemic by ensuring no legislative barriers to implementation. In addition, significant extra resources were mobilised including emergency financing from multilateral development banks; capacity was built quickly within the health sector; and an effective coordination mechanism amongst key stakeholders was put in place. Timing was also on Ethiopia's side compared to other countries, as the two months' delay in having the first cases and relatively slow onset gave the government and the public health system valuable time to absorb best practice and strengthen national systems for public health emergency preparedness.

While these efforts worked to stem the spread of the virus, Ethiopians have still suffered greatly. As of 5 October 2020, there have been 78,819 confirmed cases of Covid-19 and 1,222 deaths (EPHI 2020), making it the fourth highest African country in terms of total numbers.

2.1 Social protection and building back better

In order to respond to the persistent poverty and recurring shocks that have historically affected the country in recent decades, Ethiopia has designed and implemented two major social

protection programmes (rural and urban safety nets) that cover close to 9 million extremely poor and vulnerable people. While this is the largest social protection programme in sub-Saharan Africa, due to resources constraints, the majority of people living below the poverty line are still excluded (World Bank 2020). The development of institutions that can manage these massive programmes effectively has taken time and is continuously improving (Ministry of Agriculture 2014).

As it became clear that the pandemic would impact not just health but the wider economy and livelihoods, the government directed both the urban and rural safety net implementing agencies to adjust programme activities in response to the impact of Covid-19 (Teshome 2020). Implementers were instructed to provide lump sum payments in order to limit gatherings of beneficiaries when they receive their monthly cash/food transfers. Public works activities tied to programmes were temporarily halted. All activities that went ahead followed strict social distancing and preventive measures. The urban programme was able to provide sanitation resources to clients and scale up transfers to vulnerable households in response to the impact of the pandemic on the urban poor and vulnerable.

While these directives were quickly sent out to the authorities managing implementation, one weakness was that the government was not able to mobilise resources quickly enough to scale up the rural safety net, despite this being part of the national Covid-19 emergency response plan. This shortcoming emphasises the importance of expediting ongoing work to invest in and develop a truly shock-responsive social protection system. Such a system is needed to scale up rapidly in response to shocks, including pandemics such as the one we are currently confronting. It should cover existing clients, but also pre-identified additional vulnerable populations. A financing plan also needs to be in place before shocks hit, to ensure that there is no delay while resources are sourced.

Confronting financing constraints and a social protection coverage gap, the prime minister also initiated an approach called 'Sharing Table', which mobilised resources from civil servants, investors, and diaspora to provide basic food and cash assistance to the most vulnerable populations (*ibid.*). This was supplemented by a strong community response across Ethiopia – with youth and women volunteers mobilising resources to support the most vulnerable in urban areas. As with many developing countries, such informal community-led responses are critical and this approach was quickly mobilised in response to Covid-19. Building on this to extend informal support beyond the immediate response could play an important part in the recovery.

2.2 Health and building back better

During the initial phase of the Covid-19 pandemic, Ethiopia had no testing centre; thus it had to send all test samples to South Africa. The Ethiopian Public Health Institute established 51 laboratories for Covid-19 testing across the country, with a total capacity to test 25,000 samples per day, although that has fluctuated due to a restricted supply at times of the chemicals needed for testing. Local garment factories also converted to producing personal protective equipment (PPE) as export opportunities dwindled. More recently, the government has initiated the production of Covid-19 test kits in the country, demonstrating further an important move towards self-reliance and with the ambition of exporting to other African countries (ENA 2020).

The initial readiness assessment of the World Health Organization (WHO) documented several gaps and weaknesses in intensive care capacity for Covid-19. With support from development partners, the government significantly increased the availability of mechanical ventilators in treatment centres. It stepped up readiness for the outbreak by converting schools, public gathering halls, and hotels into temporary Covid-19 isolation or treatment centres. Since then, the government has established contact-tracing capacity and isolation centres for return migrants as Ethiopians abroad found themselves out of work. Thousands of health-care providers received training on case management, the government introduced life insurance coverage for Covid-19 health-care workers, and it developed several implementation guidelines and protocols.

The health system in Ethiopia significantly shifted priorities towards the Covid-19 pandemic response over the past seven months. However, the country also quickly recognised that the same health systems must continue to provide essential health services to avert preventable morbidity and mortality from commonly known conditions such as maternal and child health issues, and communicable and non-communicable diseases (Mohammed *et al.* 2020). To this end, the Ministry of Health has given due emphasis for ensuring that facilities continue to provide essential health services while responding to the pandemic. Accordingly, the Ministry of Health published and distributed a directive to all regions and city administrations on prioritisation and continuity of essential health services while the country is responding to the pandemic (Ministry of Health 2020). This has minimised the impact of Covid-19 on the service uptake of other essential health services, and placed the country well to build services back once normality returns.

Another important lesson was how the domestic industrial sector adapted to support the health response – first through producing PPE and then Covid-19 testing kits. Such capacity of industries could be identified before future shocks occur, ready to quickly

scale up in response. It will also support the recovery as factories continue to feed domestic and international demand for Covid-19 equipment.

3 Conclusion

Covid-19 has demonstrated the importance of building the systems for a shock-responsive safety net, including the pre-identification of vulnerable groups and a financing strategy for triggering an immediate response. The lesson from the health sector is that the pandemic has provided an opportunity to build the capacity of health sector institutions and industry (i.e. the establishment of laboratories and testing kit production factories). This can be extended beyond the current crisis and used for future health emergencies.

Ethiopia is facing the Covid-19 pandemic while the country's political landscape is fragile and undergoing major economic, social, and political reforms. In addition, its health system faces challenges, and its social protection system is at a nascent stage with limited coverage for the extreme poor. The prolonged school closures risk further worsening the country's already weak learning outcomes, particularly for poor households. Due to the constrained fiscal space and coverage of social protection, poor households, particularly women affected by Covid-19, could not access temporary income support. Despite these issues and with room for systemic improvements and better gender analysis from the outset, progress made over the past two decades is evident in its effective response to the pandemic.

The government's approach has prioritised those most vulnerable, created a coordinated system, made efforts to respond to violence against women and girls, and ensured that the health sector continues to provide essential services. Looking towards recovery, the government will need to focus on building a shock-responsive safety net that can quickly scale up when crises hit. Informal networks and institutions should also be leveraged, including women's rights groups, to advocate for a gender-sensitive response and recovery mechanisms. The health system is also already better prepared in many ways, with domestic production of equipment and a more robust institutional capacity, although further development of this sector will support increased self-reliance.

Notes

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- 2 Which limited public gatherings, ordered schools closures, directed high-risk civil servants to work from home, closed borders, suspended flights to 120 countries, and restricted mass public transport.
- 3 Deferral of corporate tax and interest; waiver of 30 per cent rental tax for education institutions, and micro and small enterprises; waiver of four months' employment tax of workers.

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