

Restriction: The COVID-19 Policy Type of Choice for Fragile Middle Eastern States

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In response to the pandemic, strong states, such as Canada, typically aim to find their bearings during an initial period of restrictions, which are gradually lifted only if the governments are confident in their ability to accommodate future surges in cases (Public Health Agency of Canada 2020). However, weak states fall short in providing basic public services and meeting their citizens' expectations, such as limiting intrusion on freedoms (Kamrava 2016). Particularly in Middle Eastern countries with vast refugee populations, the provision of basic health supplies and services to the masses exacerbates long-standing economic downturn (Marcus 2020). Grappling with legitimacy and economic problems, the governments of some weak states hold long-standing political agendas that tend to devalue investment in public goods (Acemoglu 2005). This characteristic may be echoed in government responses to COVID-19 across weak Middle Eastern states.

The Middle East has historically been the home of numerous outbreaks, including Middle East respiratory syndrome and MERS-COV (Buliva *et alii* 2017). Compounded with economic and political instability, the increased prevalence of risk factors, such as diabetes and cardiovascular disease, renders the Middle East a region especially susceptible to COVID-19 with consequences of potentially catastrophic proportions (Sawaya *et alii* 2020). Countries with a large refugee population, lack of transparency, and weak infrastructure compromised by years of conflict are particularly vulnerable. Having different priorities, fragile Middle Eastern states are not necessarily aiming to mimic countries with the best outcomes: hailed as implementing one of the most successful strategies, Taiwan has opted for sanitation, temperature checks, and contact tracing over restrictions (Bremmer 2020). However, non-pharmaceutical interventions— i.e. restrictions rather than vaccine development— have been purported to more effectively minimize economic depression (Correia, Luck, Verner 2020). Despite not necessarily proving more effective from a public health perspective, this line of thinking has prompted some countries to prioritize general restrictions, which may also seem more convenient to instantiate. For example, consider the fragile state of Lebanon and the stronger state of Qatar. A

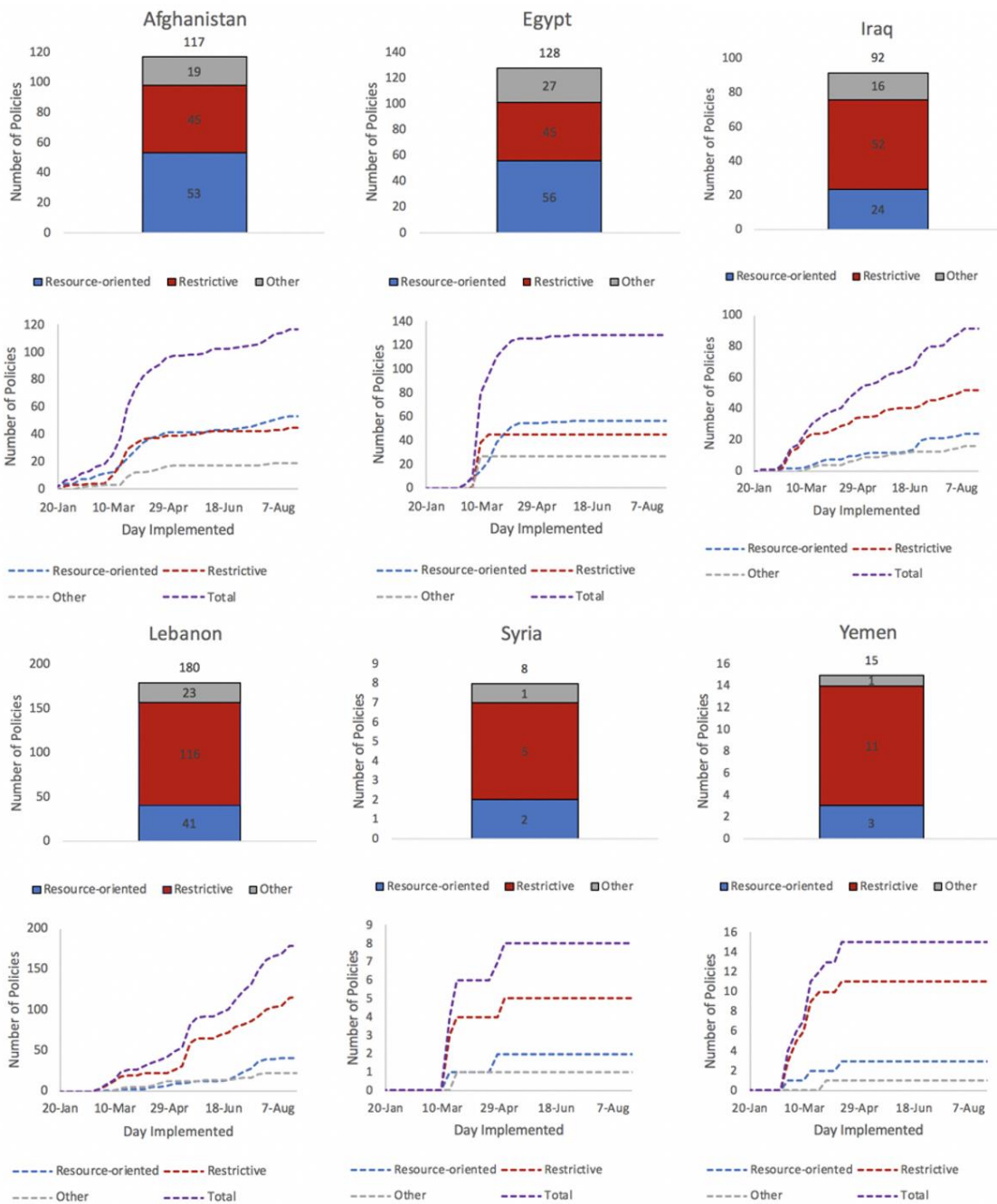
direct comparison of government effectiveness, which reflects the perceived quality of public services and policy implementation, yields a negative score for Lebanon and a positive score for Qatar (World Bank 2019). This distinction is apparent in their unique responses to COVID-19. In Lebanon, the army has been mobilized to cities for years and can readily shift gears to enforce border restrictions, lockdowns, and curfews with little additional investment. The restrictive approach seems more feasible in light of obstacles to importing and disseminating health resources: the devaluation of the Lebanese pound, \$1.3bil in debt to hospitals, and weak state capacity in preventing arbitrary bank restrictions on international money transfers (Human Rights Watch 2019). On the other hand, Qatar exhibits sufficient state capacity to home-deliver medication, spearhead drive-thru testing, and inspect 1,500 worksites during a four-phase shift to less stringent restrictions (Al-Thani 2020).

Table 1. Types of COVID-19 Policies

Resource-oriented	Restrictive
Health Monitoring	Closure and Regulation of Schools
Health Resources	Curfew/Lockdown
Health Testing	Internal/External Border Restrictions
Hygiene	Quarantine
New Task Force	Restriction and Regulation of Businesses/Government Services
Public Awareness Measures	Social Distancing/Restrictions of Mass Gatherings

Policies can be categorized into two groups (tbl. 1): those which impose restrictions and those which support health monitoring, hygiene, and the provision of resources. The timing and ratio of resource-oriented policies to restrictive policies in fragile Middle Eastern states (fig. 1), including Afghanistan, Egypt, Iraq, Lebanon, Syria, and Yemen, is compared to the timing and ratio in relatively stronger Middle Eastern states (fig. 2), including Kuwait, Oman, Qatar, and the United Arab Emirates (Messner *et alii* 2019). Combining the number and timing of COVID-19 policies in fragile and stronger Middle Eastern states respectively (fig. 3), this study identifies stagnation in transitioning away from restrictions in favor of resource-oriented policies. This intra-regional comparative case study draws from the Fragile States Index (Messner *et alii* 2019) to distinguish strong from fragile states and the CoronaNet Government Response Database (Cheng *et alii* 2020), which comprises thousands of COVID-19 policies in 190 countries.

Figure 1. Number and Timing of COVID-19 Policies in Fragile States of the Middle East.



Afghanistan

On January 25, the Afghan Ministry of Public Health instated measures, such as screening new arrivals from China, to “prevent the outbreak of a new lethal virus” (Ghubar 2020). Emergency committees and public awareness campaigns about the severity of COVID-19 were established on February 12. A mask production factory opened in the province of Herat. Despite implementing health resource-

oriented policies early on, the Afghan government increased restrictions as cases began to take their toll. On February 23, Afghanistan restricted its border with Iran, which “[lead] to confusion” (OCHA and WHO 2020). In March, schools and universities were closed, mass gatherings—entertainment, religious, etc.—were forbidden, and working hours were reduced. Additionally, larger cities implemented a curfew that was initially set to end in April but was later extended until the end of May. Lockdowns allowed public places to be disinfected to some degree with the help of the fire department. In April, a mandatory two-week quarantine was extended to travelers from China’s neighbors, such as Pakistan. Despite some difficulty at the height of the first wave, Afghanistan later began to implement resource-oriented policies at about the same pace as restrictive ones. On April 27, the Afghan government agreed to buy 500 ventilators and allocate \$4 million to health facilities. On June 4, the quarantine was extended further from passengers to elderly Afghan citizens, prohibiting them from leaving their homes for three months. Social distancing and wearing masks were also required for delegates of the Afghan grand assembly (Cheng *et alii* 2020).

Egypt

Egypt, the first African country to confirm a case of COVID-19 for a Chinese national (Egypt Today Staff 2020a), reported its first case to the World Health Organization (WHO) on February 15 and required everyone with whom the patient was in contact to isolate themselves for two weeks. A COVID-19 task force and public awareness campaign were created by the end of the month amid a social media scare warning against the spread of COVID-19 among students. Preventative measures were late to be instantiated (Sawaya *et alii* 2020). At the end of February, an epidemiological consultant for WHO reported that medical tests and quarantines were only being conducted on arrivals from countries known to harbor the virus (Egypt Today Staff 2020a). Egypt received 1,000 COVID-19 tests from China in early March. Egypt again denied claims on social media that schools would close for one month due to the spread of the virus but did close all educational institutions for two weeks in mid-March and deployed soldiers to disinfect them. Additionally, Egypt designated “fever hospitals” for suspected COVID-19 patients. This move was deemed controversial by some human rights activists since these centers were the only places for HIV patients, a highly susceptible subpopulation, to receive their medication: Human Rights Watch (2020) states that Egyptians suffering from HIV were “too fearful” to receive care. Along with the initial wave of restrictions, mass gatherings and court hearings were suspended for two weeks. On top of restricting travel abroad, the government delayed job training inside Egypt and mandated certain businesses to shift to remote work. On March 16, the Egyptian government denied an unpublished, disputed Canadian study that estimated the number of cases to be between 6,000 and 19,000: the Egyptian government maintained that their cases had not surpassed 150 (Egypt Today Staff 2020b). At the end of March, Egypt cancelled final exams and called for mosques to remain closed until June. Visas were extended for travelers who were unable to return to their home countries. In early April, Egypt shifted to resource-oriented policies. A percentage of ministers’ salaries were reallocated to COVID-19 related expenses, factories were forced to provide their workers with masks, more hospitals were designated for COVID-19 patients, and the International Monetary Fund approved an emergency fund for \$2.7 billion to prevent the spread of the virus (Cheng *et alii* 2020).

Iraq

Iraq prohibited the entry of passengers from China on February 2 and soon thereafter extended the restriction to Iranian nationals. In late February, the Ministry of Health provided health guidance to the public and restricted entry from South Korea, Kuwait, and other countries. Many governates, such as Kirkuk and Najaf, closed schools on February 25 ahead of a national closure that was initially set to last until March 7 but was kept in place until late May. Domestic travel was forbidden from March 15-25 while public places were disinfected. Additionally, non-essential businesses were closed for a week. On March 17, a suspension on all international flights was initially set to last for a week but was prolonged for over a month. The Iraqi government also allocated \$50 million dollars to the importation of medical supplies, lifted import regulations, and opened a new lab for COVID-19 testing. In April, a curfew was implemented, the number of passengers on public transit was limited, only one-fourth of the staff in government departments were allowed to work, over 20,000 detainees were released to minimize transmission, and quarantines were made mandatory for travelers from certain countries for which flight suspensions were lifted. During the Muslim holidays of Eid al-Fitr and Eid al-Adha, a lockdown and curfew were implemented to minimize mass gatherings. Moreover, restaurants were limited to delivery options. In July, Iraq reopened airports, promoted a robust public awareness campaign and pledged to build temporary hospitals with a loan from the German Development Bank (Cheng *et alii* 2020).

Lebanon

The Lebanese government restricted flights to COVID-19 hotspots in late February and closed schools until March 22. In early March, all passengers were screened and those with symptoms were quarantined in a hospital for two weeks. Moreover, religious centers, gyms, movie theaters, restaurants, and sports teams were restricted. On March 16, administrative work was suspended unless given special authorization. In addition, a lockdown was extended three times, and the Syrian border was closed. On March 27, a curfew was imposed from 7:00pm to 5:00 am. On April 6, a unique restriction on circulation was implemented until mid-June: citizens were allowed to drive on alternating days of the week based on the last digit of their license plate (GardaWorld 2020). A four-day full lockdown was imposed on May 14. On May 18, the use of public transit was permitted at limited capacity, and passengers were required to wear masks. Certain towns conducted widespread PCR testing, and travelers were required to pay an additional \$50 to be tested upon arrival. The upcoming school year was pushed back, and COVID-19 awareness fliers were distributed at government administrations based on WHO guidelines (Cheng *et alii* 2020). In early August, WHO commended Lebanon's response to COVID-19, which has killed only around 100 people (BBC News 2020). However, the United Nations raises new concerns about the overcrowding of treatment centers following the unexplained explosion in the capital city of Beirut that damaged 6 hospitals, killed over 170 people, and left 300,000 homeless (BBC News 2020).

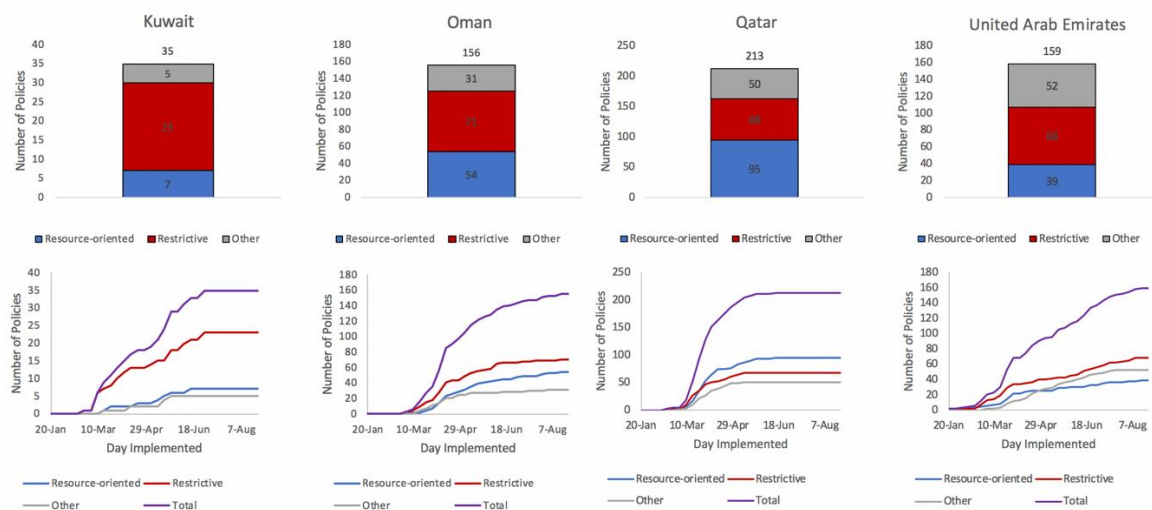
Syria

After denying allegations for weeks about the disease’s spread, the first official case of COVID-19 in Syria was confirmed on March 22 (Al-Khalidi 2020). The United Nations feared an impending catastrophe following a Syrian outbreak due to a weak health system coupled with militias backed by various countries and impoverished citizens in the war-torn country (Al-Khalidi 2020). Driver’s licenses and confirmation of military service completion were not issued from March until April 22. The Health Ministry added information on its website on the distribution of COVID-19, testing labs, and quarantine centers. Additionally, foreigners were barred from entry, schools were closed, a two-week curfew was imposed, and travel within Syria was restricted until May (Cheng *et alii* 2020).

Yemen

Yemen is split between the internationally recognized South and Iran-backed revolutionaries in the North. Citing the revolution that crippled its health system and left 80% of its people reliant on humanitarian aid, WHO raised major concerns about the low levels of immunity and the government’s inability to test citizens (Barrington 2020). Nevertheless, Yemen managed to begin screening and imposing quarantines on symptomatic travelers starting February 29. Entry for non-Yemeni citizens from China was barred. In mid-March, sporting events, schools, and court hearings were suspended. All transport services, including the UN Humanitarian Air Service, were required to disclose recent whereabouts upon arrival. Yemen reported its first case of COVID-19 on April 10, but the United Nations claims that many others had gone undetected for weeks based on the surge in cases soon thereafter (Barrington 2020). Land borders were closed, and a hospital isolation center was established along with several other quarantine facilities (Cheng *et alii* 2020).

Figure 2. Number and Timing of COVID-19 Policies in Strong States of the Middle East.



Kuwait

On February 24, Kuwait suspended flights from high-risk countries, such as Italy. The government instated a public holiday from March 12 to May 28: public transit, schools, prayer services, administrative offices, and commercial businesses were suspended. School closure was later extended by two weeks, and the new school year was set to begin in December. A national curfew was implemented for two months starting March 22. Additionally, private medical practices and laboratories were restricted for one month. On March 26, the Kuwait Psychological Association coordinated with the government to establish a hotline for remote mental health consultations. Drive-thru testing was established on May 16. Kuwait also required its citizens to wear masks, punishable by a \$15,000 fine and three months in jail. On May 21, Kuwait developed its own PCR testing kit to reduce dependence on importation. In addition, the government established an emergency field unit and called upon businesses to lease housing to quarantine infected workers. After a three-month suspension, mosques were allowed to reopen only in sparsely populated areas, the Kuwait National Assembly began to convene regularly, and employees in the public sector went back to work below 30% capacity (Cheng *et alii* 2020).

Oman

The first two cases in Oman were reported in late February, and over 2,000 people were instructed to quarantine— though not all of them stayed at home as per the government's instruction (*The National* 2020). Consequently, violation reports were filed and over 1,000 tickets were issued. On March 2, Oman suspended flights from high-risk countries. Retail stores were mandated to install hand sanitizer stations. Additionally, a Supreme Committee for COVID-19 was established. Schools as well as public places were closed, the government workforce was reduced to 30%, and all international flights were suspended by the end of March. Moreover, nine people were arrested for spreading false information. At the start of April, over 3,000 tests had been administered, and a plan for a mobile health station was announced. About 600 prisoners were also pardoned to avoid overcrowding prisons. For nearly all of April, checkpoints were enforced to restrict travel to different provinces. On April 10, industrial and commercial activities were suspended. The next day, over 1,000 businesses were inspected to ensure that they abided by the national mandate— eight were forced to close, and 10 violations were reported. Vehicle registration was also moved online. On April 14, eight test centers were established. Two weeks later, violations of social distancing resulted in arrests. At the end of April, a new molecular pathology lab was opened. In May, the school year ended early, health resources were shipped to Iran, and court hearings were held online. In June, malls reopened with conditions, and lockdowns were imposed on certain provinces. The next month, driver's license renewal moved online, private hospitals were prohibited from refusing COVID-19 patients, and surprise workplace inspections continued to be enforced. Public places were disinfected, and curfews were lifted in August due to a fall in the COVID-19 incidence rate (Cheng *et alii* 2020).

Qatar

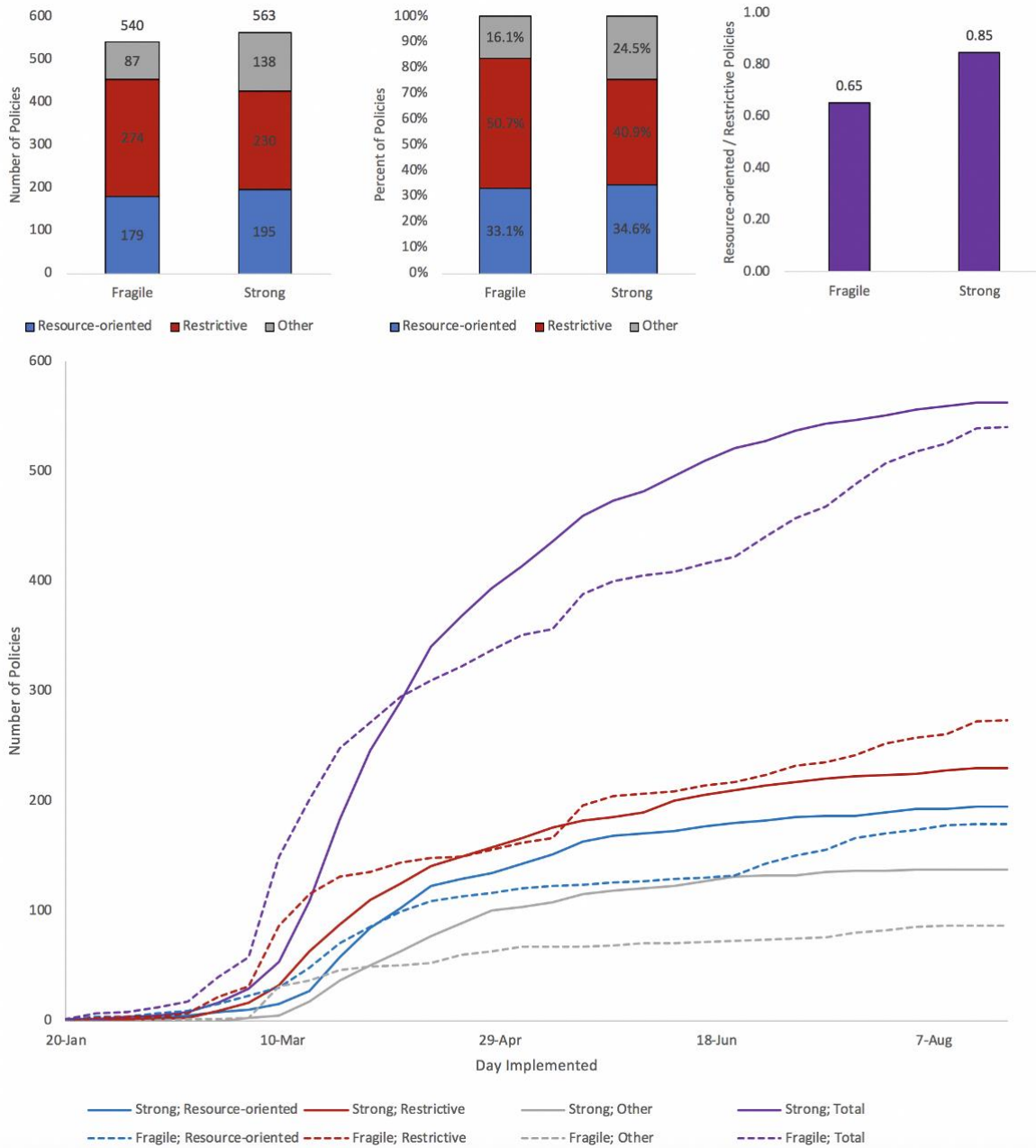
By February 23, all WHO recommendations, including health monitoring for 14 days after travel, were implemented in Qatar. The Ministry of Public Health created a webpage to provide accurate data about the virus in six languages. In mid-March, recommendations turned into requirements: entry from high-risk countries was barred, schools and commercial businesses were closed, mass gatherings were prohibited, applications requiring in-person government transactions were moved online, and telehealth was mandated for outpatient appointments. A cap on the price of antiseptics and certain food products was instated to stem price gouging. Psychological support programs for cancer patients, the Qatar International Court, and 80% of the government workforce started providing services online. The government also pledged \$150 million in conjunction with UN humanitarian aid to assist Palestinians in combating the virus. At the end of March, students began remote learning, and volunteers were requested to manage the logistics of medical facilities. The government established several temporary treatment centers, including three mobile testing units. Additionally, a home-delivery system for prescriptions was established, and the preparedness of quarantine facilities was inspected by the Ministry of Public Health. Qatar extended its free medical services not only to its own citizens but also to those of the neighboring island of Bahrain. In April, the government spearheaded a public awareness campaign called “Your safety is my safety” involving drones with loudspeakers and an alternative medical facility for elderly patients requiring check-ups or outpatient procedures. In addition, Qatar limited the capacity of busses and required employers to ensure that their workers download the “Ehteraz” mobile application to monitor chains of disease transmission. On May 17, Qatar mandated wearing masks, punishable by a \$50,000 fine and/or three days in jail. Over the course of the pandemic, three drive-thru testing stations were created, and the number of new hospital beds reached 3,500 (Cheng *et alii* 2020).

United Arab Emirates

The UAE implemented early preventative measures (Sawaya *et alii* 2020). Starting January 23, the Emirati government screened all travelers from China and halted Chinese flights soon afterwards. The government also launched a public awareness campaign, closed its borders to other high-risk countries, and required all suspected COVID-19 patients to be examined free of charge. In March, mosques, schools, and non-essential businesses were closed, quarantine facilities were established, public places were sanitized, a curfew was implemented, drive-thru testing was made available, and 312 repatriation flights helped over 35,000 people return to their home countries. Additionally, 70% of the government employees worked remotely, elderly citizens received free disinfection services at their residences, and an online price monitor allowed citizens to voice concerns about price gouging. In April, the UAE established the largest testing lab outside of China, launched the “Stay Home” mobile app to ensure mandatory quarantines were respected, sent medical supplies to several countries, opened a field hospital with 3,000 beds, imposed a fine for spreading false information, and allowed businesses to reopen with conditions. The next month, the UAE restricted mass gatherings during the Muslim holiday of Eid and helped develop Diffractive Phase Interferometry (DPI) as a

COVID-19 detection method. In June, the government imposed an age limit in public areas to avoid infecting the elderly, lifted the travel ban, and started the first phase III clinical trial in the world for a COVID-19 vaccine. A new testing center was established in July and used improved test kits in August so that results were available in a matter of minutes (Cheng *et alii* 2020).

Figure 3. Aggregate Number and Timing of COVID-19 Policies in Fragile and Strong States of the Middle East.



Conclusion

Restrictions on businesses, government services, mass gatherings, and movement were disproportionately implemented in the weak states of the Middle East, which lack the robust infrastructure and health resources to feasibly address potential spikes in infections upon lifting restrictions. Although more restrictions were implemented across the board, fragile states in the Middle East exhibited a lower ratio of resource-oriented policies to restrictive policies than their stronger counterparts. Additionally, the gap between the two policy types in fragile states increased while that in strong states remained relatively stable (fig. 3). Fragile states more quickly implemented restrictions, but the total number of COVID-19 policies in strong states overtook the number of policies in fragile states. Moreover, the graph for total cases in strong states approached an asymptote in late August while the graph for total cases in fragile states seemed to remain in its upward phase and had not yet reached its asymptote. This longer wave of policy enactment in fragile states may suggest a less effective response to COVID-19, but this implication must be considered on a case-by-case basis. For example, the unforeseen demands from the explosion and subsequent demonstrations in Lebanon will undoubtedly necessitate new policies to address mass gatherings and COVID-19 treatment centers—a longer period of COVID-19 policy implementation may not reflect an ineffective response in this case, especially considering earlier commendation for its COVID-19 response by WHO (*BBC News* 2020).

Border restrictions and business closures quickly mitigated the spread of COVID-19. However, medication delivery became more difficult, HIV patients failed to make their routine appointments (Human Rights Watch 2020), and employees across the globe lost their otherwise reliable income in the blink of an eye. Although relevant to working families in all countries, unpaid leave for residents in fragile states yielded especially dire consequences to families living day-to-day: in both Iraq and Lebanon, confinement orders were met with protests (*Sawaya et alii* 2020). A long-lasting emphasis on restrictive policies may have perpetuated frequently overlooked repercussions from which struggling families may never recover.

Although the Middle East lacked a coordinated response, it might not be too late for stronger states to work together in assisting their neighbors in need (*Sawaya et alii* 2020). Moreover, individualized responses would benefit from individualized aid. For example, the controversies and consequent anti-disinformation measures in Egypt suggest that bolstering public awareness may allow the government to mount a more robust defense directly against the problem at hand. In other cases, inadequate sanitation and health monitoring plainly calls upon humanitarian aid for antiseptics and COVID-19 test kits. Indeed, humanitarian efforts would prove more efficient and effective with knowledge from this study and others (*Cheng et alii* 2020), which identify the specific sectors that are falling behind in each country.

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