



Regional network for Equity in health in east and southern Africa (EQUINET), TARSC and Southern African Trade Union Co-ordination Council (SATUCC)¹



Information sheet 5 on COVID-19: Pandemic impacts on labour – experience and responses January 2021

New year greetings! This fifth information sheet comes as the COVID-19 pandemic enters its second year and at a time when many east and southern African (ESA) countries are facing rising numbers of COVID-19 infections and deaths, including from a new possibly more infectious variant. There is no doubt that the pandemic has affected working people. In [September 2020, ILO](#) reported that 94% of workers globally lived in countries where there had been workplace closures of some sort, that working hours and job losses in the prior 3 months were equivalent to 495 million jobs lost, and that workers' incomes had fallen by 11% globally during the first three quarters of 2020. This fifth information sheet summarises information on how COVID-19 has affected working people in the ESA region, and the response by workers, unions, states and others, with recommendations for how to better address the impacts. Previous briefs can be found on the [EQUINET website](#). The information is sourced from United Nations (UN), official, public health, labour, union, technical/ scientific and media sources, with sources hyperlinked for you to read further. *The brief complements and does not substitute information from public health authorities and labour organisations.*

In this information sheet we address five questions:

- a. [How is COVID-19 distributed in and affecting workers in ESA countries?](#)
- b. [What factors are causing workers to be at risk of or vulnerable to COVID-19?](#)
- c. [What impact has COVID-19 had on working people?](#)
- d. [What responses have there been to workers risk and vulnerability?](#)
- e. [What have workers organisations and others advocated for?](#)

Key messages

Nearly a million African workers are estimated to have had COVID-19 in 2020, probably more given the low level of testing. Health workers (HWs), those in crowded or poorly protected workplaces or in crowded accommodation, those in common contact with the public and those in caring roles may be more at risk. Informal, migrant, young, disabled and female workers may be more vulnerable to COVID-related disease.

Lockdowns and blocks in supply chains have disrupted key areas of employment, affecting working people's livelihoods, jobs and mental health, and leading to stigma and social insecurity and falling remittances from African migrants and revenues for social protection.

Possible responses include public health measures, including now equitable access and vaccines; workplace infection control; social protection to prevent impoverishment; protection of jobs and wage subsidies. Workers and unions have contributed to these responses, despite the pandemic undermining union operations.

The brief outlines recommendations to protect workers and their rights at work, noting that not implementing such measures makes the whole of society vulnerable.

¹ This brief was prepared from a draft of background information by Matsiame Mafa, Consultant, with further evidence sourced and written inputs by Dr Rene Loewenson, Training and Research Support Centre (TARSC) for EQUINET. Background documents and review input was provided by Paliani Chinguwo and Mavis Koogotsitse, Executive Secretary for SATUCC. With thanks to Open Society Policy Centre for financial support. Photographs used are under creative commons. [EQUINET](#) is a network of professionals, civil society, policy makers, state officials and others within ESA implementing research, analysis, dialogue and learning from action to promote health equity. [SATUCC](#) is a regional trade union organization representing all major trade union federations in the Southern African Development Community (SADC) region, and a member of EQUINET's steering committee. If not already subscribed, you can subscribe to EQUINET briefs and newsletters [online here](#).

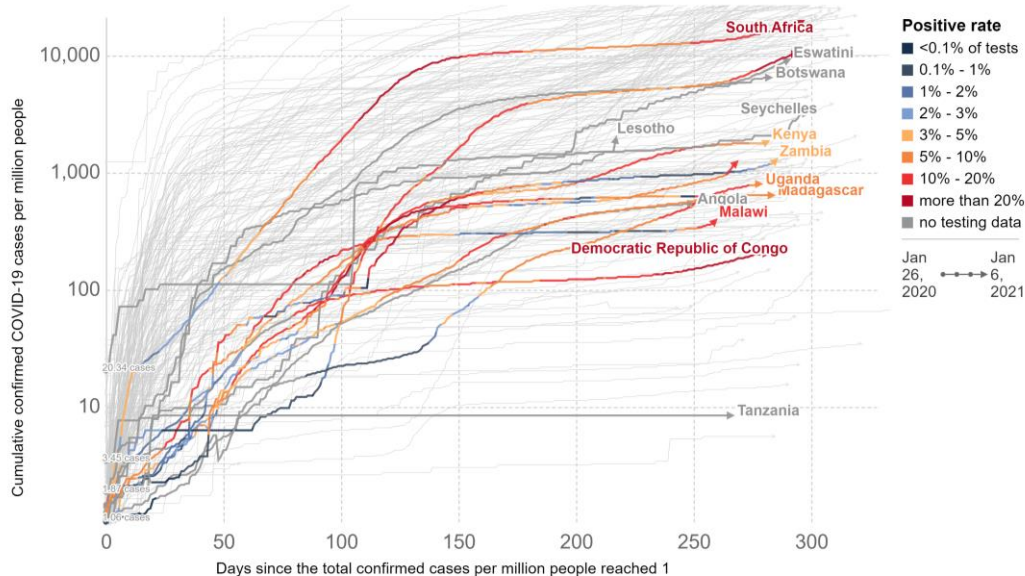
1. How is COVID-19 affecting workers in ESA?

Different ESA countries have had different trajectories of the pandemic, as shown in *Figure 1*. Some countries, such as South Africa, Eswatini, Botswana and Kenya report higher cases *per million people* than others, such as Malawi, Democratic Republic of Congo (DRC) and Uganda. However, as discussed in previous information briefs, this also depends on the level of testing and reporting in countries. *Figure 1* suggests, however, that after a lull in cases in many ESA countries in the second half of 2020, cases began to rise again in late 2020 in a second wave.

Figure 1:

Cumulative confirmed COVID-19 cases per million people

The number of confirmed cases is lower than the number of actual cases; the main reason for that is limited testing.



Source: Johns Hopkins University CSSE COVID-19 Data – Last updated 7 January, 06:07 (London time), Official data collated by Our World in Data

Source: [Our World in Data 2021](https://ourworldindata.org/covid-cases)

The available data does not disaggregate by economic activity or occupation. This makes it difficult to know the distribution of COVID-19 in different categories of workers. With an estimated [430 million workers in sub-Saharan Africa](#) (SSA) in 2020 and a cumulative rate of about [1700 cases per million people in Africa](#), it can be estimated that nearly a million workers had tested positive for COVID-19 by end of 2020. There are probably more than this number if the low level of testing is taken into account. We do know that some workers are more likely to be at risk of exposure to COVID-19. This includes health workers, those who work in crowded or poorly protected workplaces or live in crowded accommodation, those in common contact with the public and those in caring roles, amongst others.

Frontline health workers are likely to be more exposed to the COVID-19 virus at work, especially when they lack personal protective equipment (PPE) and work in conditions where infection control measures are inadequate. By July 2020, [WHO AFRO reported](#) that more than 10000 health workers (HWs) in 40 African countries had been infected by COVID-19. Preliminary data indicated that HWs make up 5-10% of all infections. A [systematic multi-country review of health worker \(HW\) morbidity and mortality from COVID-19](#) in May 2020 found that for

every 100 HWs infected, one died. For those countries in the world that disaggregated their data, 72% of all HWs testing positive for COVID-19 were women, reflecting the fact that more HWs are female. Nurses were in the largest group of infected HWs, but doctors were in the largest group of HWs who died. While older HWs had lower rates of infection, they had higher rates of mortality from COVID-19.

Mental stress in HWs responding to COVID-19



Source: [Anadolu Agency, 2020](#)

Globally infection and mortality were reported to be lower in HWs in Africa than in other regions, although the authors note that there may be lower registration and under-reporting of HW infections in Africa than in other regions. There is still limited data on HW infection and mortality from ESA countries, and it is an area that would benefit from better public reporting. One [EQUINET-ECSA HC brief in June 2020](#) that included evidence reported from selected ESA countries found higher COVID-19 infection rates in HWs than the general population, such as in Botswana, Malawi and Namibia.

With limited disaggregated evidence, we tend to assume that infection rates in **informal workers and all workers in particular occupations** such as mining, manufacturing, retail hospitality and commerce would be similar to the rates in the general population. However, infection may be higher, for those in education, vending, retail and commerce due to the social interactions required in their work. Rates may also be higher in workers in mining and manufacture where work is indoors or in poorly ventilated settings. With over 70% of non-agricultural employment in Sub Saharan Africa (SSA) [estimated by the ILO in 2018](#) be informal, and with this sector contributing to 30-65% gross domestic product (GDP), it is important to have better information on how COVID-19 is affecting different groups of informal workers.

Mineworkers in South Africa



Source: [Reuters, 2020](#)

Migrant labour is common in the ESA region, particularly in in health care, mining, hospitality, agriculture, and agro-food processing, in the informal sector and as domestic labour. People have migrated across ESA countries for work, education, trade, socio-cultural and other reasons for centuries. For example, [IOM estimate](#) that South Africa has an estimated 4.2 million migrants, primarily from neighbouring countries, with about 24 000 Mozambicans working in the mining sector. In 2004, 80 000 Mozambicans were estimated to be working in farms in South Africa's Mpumalanga province alone. African migrants living in trade hubs such as Kenya and South Africa often work in goods and services, including in the informal economy. Africans migrating for work outside the region may live in poor accommodation in other African countries on their way to final destinations, relying on casual labour for food and rent. There is no disaggregated data on infection and mortality rates in these migrant labour groups. Their poorer living and working conditions suggest that they may be as or more exposed and as vulnerable as the general population in ESA countries. Some African migrants are high skill workers working in the health and care sectors in higher income countries, where they are at [higher risk from their work of infection and mortality](#).

The socio-economic features and gender inequalities of these different worker potentially elevate their risks of and vulnerabilities to COVID-19. Further, [there is evidence](#) that people with disabilities face particular risk and vulnerability, including as workers. For example, as a result of the pandemic, 68% of people with disabilities in Kenya were not able to work and a further 65% perceived their jobs to be insecure due to their disability.

The absence of systematically organised data for the different groups of workers makes it difficult to assess, and thus respond to workers' risk. It is, however, evident that for various reasons, explored further in the next section, the nature of their employment is leading some groups of workers to face higher risk, including but not limited to HWs. For example, [evidence released by the Minerals Council of South Africa](#) in June 2020 showed that mineworkers had double the rates of COVID infection than the rates in the general population. Their union, NUMSA noted "The workers are aware that these are extremely dangerous spaces, but decide to risk it simply because they don't have the means to stay in isolation, feed their children, or care for themselves without due pay." It would seem essential that sero-prevalence surveys provide more effective data on the risk in various occupational groups in the region to better control this risk.

2. What factors increase risk or vulnerability in ESA workers?

The [risk factors for COVID-19 noted for the general population](#) also affect workers. These include overcrowded, poorly ventilated housing occupied by multiple generations; lack of safe water; overcrowded transport systems, food and other markets; lack of accessible information; inadequate spacing and ventilation in schools and other services; and social and environmental factors leading to poor hygiene, physical proximity and contact and social mixing after symptoms. Equally the general factors affecting vulnerability to severe disease from COVID-19 also apply to workers, including being in an older age group; having an underlying condition; obesity; and lack of access to appropriate health and social care. In 2021, access to immunisation will also affect severity of disease and mortality from COVID-19. (At the date of production of this brief, it is not yet proven that the vaccine prevents transmission of the virus).

There are, however some factors that make particular groups of workers more at risk of COVID-19, or more vulnerable to adverse outcomes. For HWs, [WHO AFRO reported in 2020](#) that many still have inadequate access to PPE due to global demand leading to supply shortages, and that many HWs work in settings with weak infection prevention and control measures, although this had improved in some countries. This 2020 WHO Afro assessment of infection control measures in clinics and hospitals across Africa found that only 16% of the nearly 30 000 facilities surveyed had assessment scores above 75%; many health centres lacked the infrastructures for key infection prevention measures, or to prevent overcrowding; only 8% had isolation capacities and only a third the capacity to triage patients. HWs may be exposed to asymptomatic patients who attend health facilities for other reasons. COVID-19 management and insufficient HW numbers may result in heavy workloads, fatigue, burnout and stress for HWs, undermining their health and increasing their risk of severe disease.

Workers in the informal economy, many of whom are women, work in poor conditions, often without accessible water and soap and with significant proximity to others. [Women workers are reported to be particularly at risk](#), as they earn less, save less, hold less secure jobs, and are more likely to be employed in the informal sector. Women workers combine their workplace with risk at home from caring roles. As market traders, vendors and others working in local markets, and without savings or social security, informal workers may seek to evade lockdown rules to survive economically, driving their work underground and raising their risk of unsafe conditions and practices. Certain types of informal work, such as waste-picking, are subject to higher exposure to pathogens (germs), while other jobs, such as street vending, may not allow adequate social distancing. [The ILO have raised concerns of an increase in child labour](#) as households face poverty from the pandemic-related impacts, discussed later.

Informal market, Kisumu, Kenya before COVID-19



Source: [A Knox, 2020](#)

In the formal economy, it is largely the higher income workers who do jobs that can be done remotely or from home and who access the internet to do so. This is not possible for most workers. [Recent estimates of the share of jobs which can be done from home in SSA](#) range from 6% in Ghana, to just above 10% in Kenya, to about 14% in South Africa. The increased rate of COVID-19 infection in mineworkers in South Africa suggests possible risk factors in living conditions on mines that do not allow for physical distancing, in the close contact in cages when workers go underground, and in underground mining conditions. The presence of other lung diseases and respiratory conditions due to mine-work may also make mine-workers more vulnerable to COVID-19 related diseases. For example, [one assessment noted a recovery rate of 39% in COVID-19 patients in the mining sector](#) in South Africa, while the national average is 53%. [Disruption of tuberculosis \(TB\) treatment on mines](#) due to closures during lockdowns can also lead to disease and mortality in this group of workers already at increased risk of TB and can lead to drug-resistant TB strains. These issues are inadequately investigated across the region, as are other [documented occupational risks for COVID-19](#) from work in markets, in the tourism, retail and hospitality industry, transport and security workers, and construction workers, or potentially in staff in schools and colleges.

[EQUINET information brief 4](#) and the [International Organization for Migration \(IOM\) reports](#) note that the movement of **migrant workers and cross border drivers** can increase their risk of infection and that of communities, especially when they face forced 'returns' without proper measures for testing, tracking and protection. While aimed at reducing cross-border transmission, [Mbiyozo \(2020\)](#) observes that border closures can lead to an increase in irregular travel routes across the porous borders of ESA countries, and that this could heighten exposure and complicate health screenings and contact tracing.

The [cost of COVID-19 testing was reported in January 2021](#) to have led many migrant workers returning from South Africa to families in Lesotho for Christmas to have used such illegal crossing points to avoid having to get the required test certificate, and cases in Lesotho rose in January. Migrant workers in transit and undocumented migrants in countries have poor living and working conditions and are fearful of being identified. They may lack information in their own languages and to avoid or be excluded from health and support services, all of which intensifies their risk of infection and vulnerability to disease.

As noted earlier, there is inadequate population level data on the distribution of these risks and vulnerabilities in different groups of workers in the region. However, the ad-hoc evidence already available suggests that it is potentially the lowest income, most insecure workers, including women and migrant workers, who experience a toxic combination of working and social conditions that increase their risk of COVID-19 infection.

3. What impact has COVID-19 had on working people?

The COVID-19 pandemic has impacted on working people individually, on their livelihoods and families, and has disrupted sectors and the economies in the region.

[A 2020 review of studies from Africa](#) found that beyond their risk of infection with COVID-19, **HWs** have faced mental stress, physical exhaustion, insomnia, separation from families, stigma, and the pain of losing patients and colleagues. While HWs are perhaps most directly affected by the stress of treating patients with severe disease, other workers in the ESA region may also face high levels of stress and anxiety due to the pandemic and the loss of economic and employment security it has led to. The mental health consequences of COVID-19 in an already stressful context has not been given much attention, whether for the workforce, for young people, or generally, but [studies have shown that there are mental health consequences](#), with the pandemic associated with increased depression, anxiety, distress, and higher rates of harmful substance use and suicide.

Some workers may also face abuse and violence: [HWs have been documented to face violence](#) from angry patients and family members, and to have been excluded from families and society when due to perceptions that they are possible carriers of the virus. They are, however, not the only workers to face stigma. As noted in [EQUINET information brief 4](#), migrant workers have faced discrimination, xenophobia and forced returns. They have faced stigma as carriers of the virus, and the stress of being trapped in destination countries by travel restrictions, with few options to return home.

In a context of a globalisation that has accelerated the movement of goods, services and capital across countries, [El Ouassif \(2020\)](#) observes that people's perception that a virus that emerged in China was able to spread globally and claim lives in other countries because of freedom of movement has fed a 'fear of outsiders' and xenophobia. Populist discourses have further fed this fear, widening the gap between the 'us' and 'them'.

Beyond these immediate individual and social impacts, COVID-19 has amplified and exacerbated the insecurity in employment and incomes that had already grown in the neoliberal reforms associated with structural adjustment, including in the rise of insecure, precarious and informal work, the decline and absence of social protection and the growth of unemployment. When governments implemented lockdowns in 2020, they stopped the transport systems workers needed to go to work; closed the schools that attended to their children, the markets and public and private workplaces where people worked and blocked many small enterprise activities that generated income.

[According to the International Labour Organisation \(ILO\)](#) by September 2020, 94% of workers globally were residing in countries with workplace closures of some sort. Lower and middle-income countries like those in the ESA region had an estimated 23% decline in working hours and workers' incomes had fallen by 15% in these countries. The ILO estimated that the percentage of working hours lost to September 2020 was highest in March-June 2020, at 20% in Southern Africa and 14% in East Africa. Even after stringent workplace closures were relaxed, working-hour and income losses continued. Lockdown closures have been reintroduced in many Southern African countries in January 2021. The ILO note that the limited opportunities for remote/ teleworking in countries such as those in the ESA region and the gap in meaningful social protection, especially for the high share of informal workers and young workers, has made the downturn worse for these workers.

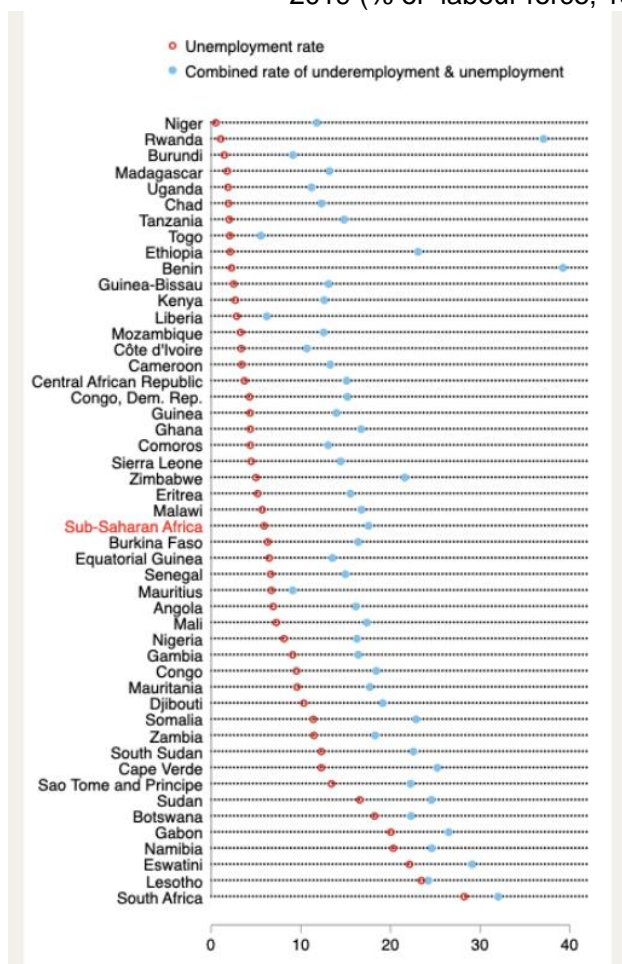
According to the [ILO](#), the pandemic has had a marked effect on **young workers**, exacerbating the employment challenges they already face by disrupting their education and training and delaying their transition into the labour market. This is particularly so for young women. One in six young people are reported to have lost employment. With 93% of young people working in informal employment, even those in work face insecurity due to pandemic effects noted earlier in this sector.

Figure 2: Unemployment and underemployment rate, 2019 (% of labour force, 15+)

Both formal and informal sector workers have been affected in sectors such as hospitality, commerce, and where affected by lockdowns, in manufacturing and services. Middle income southern African countries affected by job losses have added this to existing high levels of unemployment, as shown in *Figure 2*.

A 2020 SATUCC study² found that by mid-2020, over 42 000 labour contracts had been suspended in Mozambique; 680 000 employees had lost jobs in Malawi, and 70 000 in Zambia. An [assessment](#) by the East African Confederation of Trade Unions (EATUC) found that by mid-May 2020, one million jobs in the informal economy and over 200 000 formal jobs had been lost in Kenya in the wake of the pandemic.

An [ILO assessment in 2020 on COVID-19 and the informal sector](#) found 180 million informal sector workers facing workplace closures in Africa, or 46% of all informal sector workers in Africa, with 68% of informal workers living in countries with full or partial lockdowns affecting their work.



Source: [ILO Stata 2020 in Naidoo 2020 online](#)

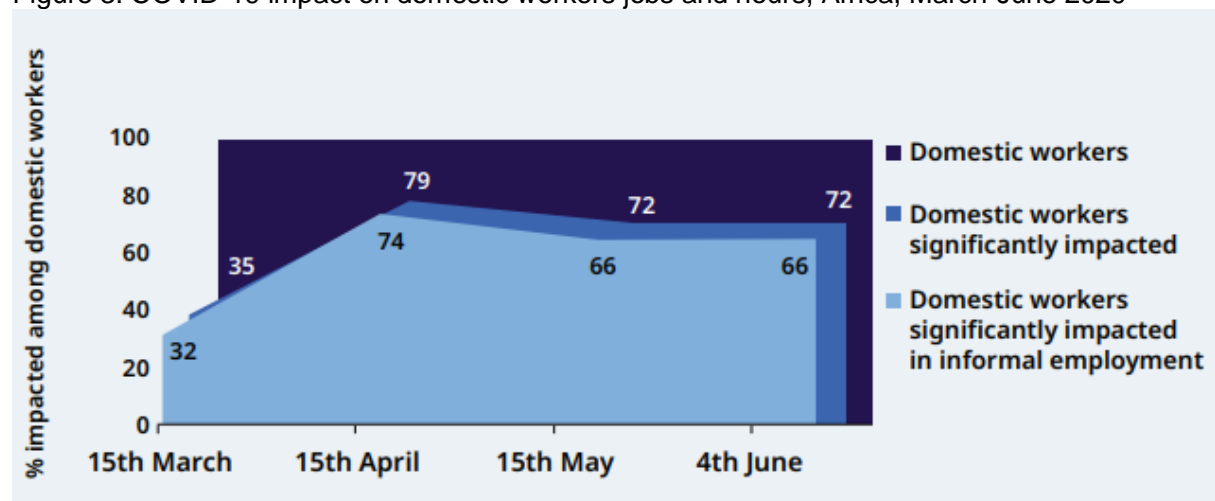
Of the 469 million total **informal sector workers** in Africa, the ILO found 325 million or 83% to be highly impacted by lockdowns and movement restrictions, the majority of these being 'own-account' workers.

²SATUCC (2020). Impact of COVID-19 pandemic on workers in Southern Africa. SATUCC, Gaborone

The majority of these [were reported by the ILO](#) to have been vendors and other traders without fixed location, small craftsmen in the clothing, leather or carpentry, transport workers and associated activities such as car mechanics, workers in personal services including catering, hairdressing and beauty salons and domestic workers. Small scale farmers also faced challenges in selling their produce due to transport barriers posed by pandemic measures. Informal workers lack unemployment insurance, so any loss of work immediately leads to lost income. Their risk of impoverishment rises for each day of closures. The finding of an average level of 30% of chronic under 5 year [undernutrition reported in an earlier EQUINET- ECSA HC brief](#) points to the combination of food insecurity, poverty, employment and income insecurity that may discourage workers from staying in quarantine and off work, if it further deepens this insecurity.

As noted earlier, **formal sector workers** have also been affected by closures, [with reports indicating](#) that higher skills jobs that can be done remotely and public sector jobs have been less affected. While ESA countries relaxed strict measures after mid-2020, some have reintroduced them and formal sector workers in sectors vulnerable to supply chain impacts have lost working hours, incomes and jobs, such as in tourism or hospitality. Formal jobs have been affected directly due to workplace closures, but also indirectly due to the contraction in purchasing power due to falling household income. For example, [ILO report reduced working hours and job losses amongst domestic workers](#), particularly those who are migrant workers, due to such contraction in household income and demand. In Africa, only 35% of domestic workers were significantly impacted by 15 March, but this rose to 79% by 15 April and remained high thereafter (See *Figure 3*).

Figure 3: COVID-19 impact on domestic workers jobs and hours, Africa, March-June 2020

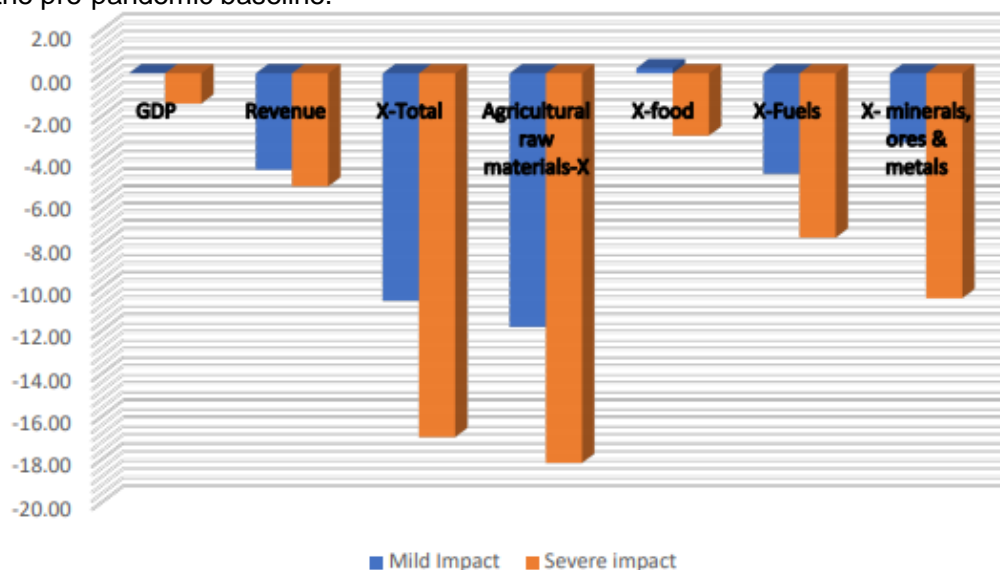


Source: [ILO, 2020:5](#)

The response to these impacts is discussed in the next section. However the impact on workers is linked to the wider **economic impact of COVID-19 in ESA countries**, many of which have faced decades of challenge and macro-economic volatility from engaging with largely unfavourable terms in a neoliberal globalization. [UNCTAD in 2020](#) estimated that COVID-19 will lead to a fall of 1.4%-7.8% in GDP in African countries, as a result of the impact on exports, a 17% contraction in exports, and about 5% losses to public revenues (See *Figure 4* overleaf). Other [EQUINET information sheets](#) have noted rising household, enterprise and national debt.

More directly for households, **African migrant worker remittances** play a significant role in family incomes in the different ESA countries, as shown in *Figure 5* overleaf from an [earlier EQUINET and ECSA HC brief](#). For countries like Zimbabwe, Lesotho, Madagascar, DRC and Uganda, these financial flows could play a key role in reducing vulnerability to the impacts of COVID-19. Yet evidence suggests that remittances may fall, due in part to lockdowns. [The World Bank \(2020\) projects that remittances will fall](#) by 23% in SSA, due to a fall in migrant worker employment. This is the steepest fall in remittances in recent history.

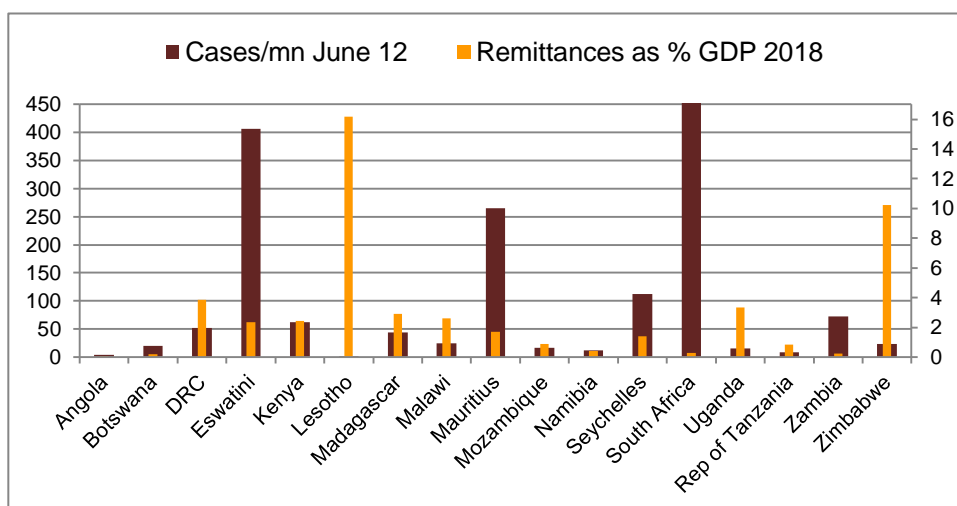
Figure 4: Impact of COVID-19 on Africa's GDP, revenue and exports: percent deviation from the pre-pandemic baseline.



Note: X = exports.

Source: [UNDP, 2020:12](#)

Figure 5: Covid-19 cases/mn and remittances



Sources: Worldometer 2020; World Bank, 2020; South Africa= 1045 cases

4. What responses are there to workers' risk and vulnerability?

The individual and immediate prevention measures for COVID-19 are clear, including: handwashing, mask-wearing, physical distancing, ventilation and hygiene of indoor spaces, and the test, track and protect measures to identify and prevent onward transmission from cases. The care measures are also clear, with a widening range of therapies and the new inclusion of vaccines to prevent severe illness and fatalities. Affordable, equitable access to vaccines as global public goods is a significant issue that will be covered in a separate brief.

There are measures specific to particular occupational settings. The [WHO has provided guidance on infection prevention and control \(IPC\) measures for HWs](#) as a part of clinical management, including the use of PPE (facemasks, disposable gloves, plastic aprons, face shield/goggles). In addition to standard IPC measures WHO recommend additional hygiene measures for preventing contamination through surfaces and equipment, the separation of cases with distancing between patients and suspected cases, the use of medical masks by patients, and the use of precautions against airborne transmission (appropriate PPE, including gloves, long-sleeved gowns, eye protection, and fit-tested particulate respirators (N95 or higher) when performing procedures like intubation the generate aerosols. Where

there is co-morbidity, such as with TB, further guidance is provided on additional measures needed, while guidance is also provided for laboratory personnel.

There is a gap between this guidance and the situation in some health services, with protests by frontline HWs in some ESA countries over inadequate PPE and safety measures, in March 2020 in [Zimbabwe](#), in August 2020 in [Kenya](#), and in September 2020 in [South Africa](#). [A 2020 review from Africa](#) found inadequate supplies of PPE in Africa, and ‘physical distancing’ to be a challenge in overcrowded primary health care clinics. While many ESA countries are noted to have stepped up preparedness, learning also from the experience of Ebola, [WHO assessments](#) have noted shortages of HWs, critical care beds, equipment and laboratory capacity. Countries have increased the number of HWs for COVID-19 management, such as by moving staff from other areas to medical wards, fast-tracking medical students to join the workforce, cancelling HW leave and drawing on retired HWs. Community volunteers have also provided support and linkages to the formal health system, although with concerns around their protection, communication with the health system and compensation. HWs are a priority group in the distribution of vaccines, and monitoring fair access to vaccines is a key issue in 2021.

Other groups of workers also face challenges in accessing prevention and care measures. The [ILO outlines challenges faced by migrant workers](#): They often do not access testing or treatment measures or the wage subsidies, unemployment benefits or social security and other social protection measures accessed by other workers. They may be the first to be retrenched, and when living as undocumented workers in host countries may avoid reporting for prevention or care measures if this exposes them. For example, the up to 16 000 [African migrants reported to live in Guangzhou in Southern China](#) includes both legal and non-legal residents. Those without a legal abode cannot apply for the Alipay Health Code, a system that assigns a colour code to users that indicates their health status and determines their access to public spaces, such as malls, subways and airports. Sudden announcements of lockdowns have been associated with surges in cross-border migration of formal and informal workers and others, raising the potential for cross border transmission. For example, an estimated 23 000 [Mozambican](#) mineworkers and 13 500 Zimbabweans rushed across the main border crossings in the days before the South African lockdown in late March 2020, and the impacts of cross border movements over December 2020 were noted earlier. Workers with disabilities have faced challenges in accessing information on how to prevent COVID-19 or respond to illness when it is not made available in sign languages, video captioning, or other forms that they can access. [One study found](#) that the vital support needed to live and work safely was disrupted for 45% of Kenyans with disabilities.

Beyond the lockdowns, ESA governments have implemented a range of responses to mitigate the impacts of COVID-19 on workers, within measures to support businesses and vulnerable groups. These have varied across ESA countries, as shown in *Table 1* below.

Table 1: Measures to mitigate the impacts of COVID-19 on employment, ESA countries

Measure	Countries applying it
<u>Removal of income tax</u> for low income earners	Botswana, Uganda
<u>Refund of VAT</u> to small-medium scale enterprises	Mozambique, Rwanda.
<u>Reduction of taxes</u> like VAT for specific services/commodities	Uganda, Mozambique.
<u>Distribution of food items</u> and other basic goods to lowest income groups	South Africa, Angola, Botswana.
<u>Implementation of wage subsidy schemes</u>	Botswana, Namibia.
<u>Reduction in bank rate</u> , waiver of penalties, rescheduling of loan repayments	Botswana.
<u>Extension of deadline</u> to file and pay the corporate income tax	South Africa, Namibia, Angola, Malawi, Rwanda
<u>Subsidies</u> on public utilities such as water	Namibia.

Source: [UNCTAD, 2020](#)

[UNCTAD report](#) some support from international finance institutions for these measures, such as World Bank support of USD 160 billion to mitigate the effects of COVID-19 on small scale businesses and vulnerable populations until 2021.

[Trade unions](#) have welcomed these economic and social policy measures, but have also noted their limitations and problems. They noted in some countries such as Namibia and Botswana that some businesses in tourism and service sectors provided with wage subsidies still imposed unpaid leave on employees or effected retrenchments, contrary to the terms of the schemes. Growing urban populations, a large informal economy, an absence of data and a focus in some schemes on those in formal employment have led to gaps and distortions in the distribution of these support schemes, excluding those who most needed support and many informal sector workers. Unions have also noted that while Botswana, Namibia and South Africa used national reserves to fund the emergency responses, many ESA countries drew on international funds to reschedule debt repayments and on concessional loans, with conditions that may lead to downstream problems, including for labour and employment.

Table 2 outlines some of the trade union responses in the region.

Table 2: Selected trade union responses to COVID-19 in ESA

Country	Trade union response
Botswana	Botswana Federation of Public Sector Unions and Botswana Federation of Trade Unions submitted a joint position paper to the tripartite task force on COVID-19 outlining measures for protection of workers.
DR Congo	The Secrétariat des Syndicats de IndustriALL and Travailleurs Unis des Mines, Métallurgies, Energie, Chimie et Industries Connexes coordinated a strike by mineworkers over allowances after a two month quarantine at a copper and cobalt mine.
Kenya	Central Organisation of Trade Unions issued a position paper that led to a tripartite agreement on responses to COVID-19 covering PPE, job security and income guarantees. COTU provided PPE to frontline HWs.
Madagascar	FEKRIMPAMA, a federation of unions in the education sector, carried out awareness raising activities on COVID-19
Namibia	The Trade Union Congress of Namibia issued a set of measures including the immediate establishment of tripartite sectorial committees to ensure all employees receive wages during the 2020 lockdown.
South Africa	COSATU demanded reduced interest rates for loans to be more affordable to struggling businesses and for loan funds to be used for salaries. COSATU held a nationwide stay away in October 2020 to protest job losses, wage curbs and corruption related to the pandemic. The South African Federation of Trade Unions issued a number of statements on the lockdown, social protection, and on vaccines to protect workers' access to measures.
Tanzania	Tanzania Union of Industrial and Commercial Workers filed a dispute with the Commission for Mediation and Arbitration in 2020 and held a strike over a three month closure and 50% wage cut by a company due to COVID-19.
Uganda	The National Organisation of Trade Unions of Uganda and its affiliates demanded adequate provision of PPE for workers.
Zambia	Trade unions in the health sector jointly lobbied for social protection for affected HWs and cash transfers for workers who lost employment. The Mineworkers Union of Zambia negotiated termination of a month-long COVID-19 quarantine at a copper mine under unsafe living conditions.
Zimbabwe	The Zimbabwe Congress of Trade Unions Called for a national lockdown in March 2020 and initiated discussions on COVID -19 at the Tripartite Negotiation Forum urging the government to declare the pandemic a national disaster. The Zimbabwe Diamond and Allied Minerals Workers Union and the National Union of Mineworkers of Zimbabwe carried out national awareness campaigns and monitored employer compliance with COVID-19 prevention regulations and to ensure that workers had adequate PPE and hygiene facilities.

Source: SATUCC, 2020, ITUC, 2020; EATUCC, 2020

Trade Unions in ESA have themselves taken action to respond to the impact of COVID-19 on their members and other working people. In Malawi, Kenya, Botswana and South Africa, trade unions participate in and have made inputs to national government structures or social dialogue mechanisms on the pandemic response. Trade unions in all ESA countries have provided information to members and the wider public to raise awareness about COVID-19.

Workers have played a role in prevention efforts, including manufacturing PPE and ventilators in both the formal and informal sectors. As noted in earlier EQUINET information briefs, workers are an asset for local production of health technologies, if adequately supported. Youth in informal sectors [have found creative ways to combat COVID-19](#) while also generating an income, creating face masks from local African prints, sending a message that “We have almost all we need to fight this virus. We just need to think out of the box, be more creative, make use of what we have and believe that it is real”. Workers in the creative economy have communicated health and social messages through art, music and theater, as described in a [prior EQUINET brief](#).

Street artists, Senegal



Source: [Reuters, Z Bensemra, 2020](#)

[In Mozambique, a network of community health workers](#) linked to IOM worked in the southern provinces to identify returnees from South Africa in their home communities to ensure they are reached with key prevention and quarantine messages and services. Similar support was given to returning migrant workers by international and local organisations [in Mangochi district Malawi](#). In [Kenya, the Ministry of Labour and Social Protection](#) indicated that regular migrant workers who lose their jobs as a result of COVID-19 would continue to have their residence and work permits valid for the full period. In South Africa, [FoodFlow](#), a local non state organization worked with both small-scale food producers close to communities, often owned and run by black South African farmers, as well as smaller community-based organizations already based in vulnerable communities to link producers and communities to support food distribution.

Screenshots from Foodflow website



Source: [FoodFlow, 2020](#)

While there is evidence of worker, community and organisational initiative in responding to the pandemic, workers organisations and the operations of trade unions have been negatively affected by the pandemic and lockdowns, as highlighted in the 2020 SATUCC and EATUCC studies noted earlier. The loss of working hours and jobs related to COVID-19 has undermined trade union membership numbers and union negotiations for increased pay, despite economic hardships. The travel restrictions in lockdowns have undermined trade union organising, recruitment, grievance handling and representation and union monitoring that support measures reach workers. Although online activities were possible in principle,

the cost of internet data and poor connectivity have impeded this in practice, especially for the lowest income workers in many ESA countries.

In many countries, trade unions have not been included as 'essential services' or 'key workers'. In some countries, such as Botswana and Zimbabwe, a state of emergency imposed during the pandemic meant that trade unions and workers could not take industrial action, and thus use strikes to defend their rights at work, as set in international labour standards. Unions were involved in social dialogue on COVID-19 with government and others, but in some countries the scope of these discussions excluded labour market issues..

5. What have unions and other organisations advocated for?

Generally, the COVID-19 pandemic demands [comprehensive public health responses](#), "implemented through the participation, the organised efforts and informed choices of society, state and non-state organisations", that address the causes of and prevent infection and respond to illness in an equitable manner for all. It also demands protection against the impoverishing impacts of COVID-19. While recognizing the efforts being made, the previous sections highlight shortfalls in aspects of such a comprehensive response in ESA countries, including deficits in access to safe living, community and working conditions, and to affordable testing, appropriate care and social protection. Yet, the innovations and initiatives raised earlier point to the potential for building stronger responses in the region, including by effectively engaging and supporting working people.

An effective public health response is not possible without **HWs**, and measures to protect them and provide safe work. Protecting all HWs, including community health workers, from infection and mortality must be a core element of any pandemic response. [The 2020 review of responses in Africa](#) identified that HIV counselors and community healthcare workers merit their own attention and protection. It recommended that HW motivation and retention be enhanced through consistent control measures and provision of PPE and training for HWs; managed risk 'allowances' or compensation; giving HWs priority in testing, care and vaccination strategies; locating vulnerable HWs in less risky deployments and providing for the psychosocial needs of HWs within pandemic strategies.

Health workers in South Africa



Source: [Deutsche Welle, 2020](#)

Online platforms that provide mutual support between HWs and relieve stress and anxiety, such as the [Vula platform](#) in South Africa, could be extended to other countries, as can WhatsApp groups among HWs to share advice and provide mutual support. HWs who need alternative accommodation to avoid spreading the virus to family members can be accommodated in vacant hotels and student accommodation or be given rearranged schedules. The 2020 review noted above points to the importance of trust: Maintaining staff motivation may be challenging where levels of trust in government and employers are low. This calls for measures to ensure transparency in and fair access to public resources and inclusion of HW organisations in decisions on strategies that affect them.

Without this, as countries scramble for resources to support their health system responses, disgruntled HWs from the region may be recruited for higher income countries. These and other retention measures are thus important, as is the need for the region to engage (again) on ethical international recruitment of HWs so it does not leave critical deficits in the region. Equally, delivering on these measures for HWs demands increased investment in public sector health services, and a more equitable distribution of essential health technologies as [global public goods](#).

Beyond the focus on HWs, [ILO sets out the fundamental principles and rights at work](#) relating to COVID-19 for **all workers**, with a set of 4 policy pillars summarised in *Figure 6*.

Figure 6: Policy framework on COVID-19 and labour rights



Source: [ILO, 2020:14](#)

For **informal sector workers**, this implies identifying vulnerable groups and setting up a social dialogue with public authorities that involves workers and employers' organizations on how to implement the measures shown in *Figure 6* to protect these workers. As immediate measures, these and other precarious workers need increased social assistance coverage, food distribution and food price regulation, access to healthcare and the widespread provision of masks, safe water and hand washing facilities and sanitizers. The [Food and Agriculture Organisation recommend recognising all agricultural workers](#) as essential service providers given their vital contribution to food security, including to enable their safe movement within and across countries. Informal sector workers and enterprises need microfinance and reduced lending rates, low interest loans, and temporary subsidies for utilities and rents.

For **migrant and cross-border workers** it implies ensuring that they and their families access health care, income and other forms of social protection, suitable working and living conditions in line with health standards, and relevant information on COVID-19, including through labour agreements. The African Union and IOM have urged that border controls, lockdowns and other measures are discussed with representatives of migrants to ensure that they do not raise risk or prevent people from accessing safety, health-care services, and information. As exemplified in an [EQUINET report from Uganda](#), local digital innovations, such as those developed in response to Ebola in East Africa, can be used to ensure access to testing and tracking and to provide a digital proof of status that is recognised across the region. This can enable long distance truck drivers to carry out their work. Various options have also been proposed to [protect and facilitate remittance flows](#), including classifying remittance services as essential services; widening digital payment systems across countries and waiving or reducing fees on transfer costs, as is already being applied to certain mobile money transactions in some ESA countries.

For **young workers**, implementing the measures outlined in *Figure 6* calls for hiring subsidies or youth guarantees, investment in sectors that are more likely to absorb young job seekers; providing affordable access to data/internet; providing unemployment insurance benefits cover, apprenticeships and internships and public works programmes for young people who have lost jobs. Access to benefits needs to be easier to support for those actively looking for work.

For all workers, the costs to livelihoods and unintended risks and health consequences from blanket and prolonged lockdowns means that lockdowns should be tailored to suit local contexts, localised to circumscribed hotspots, backed by evidence and providing clear exit strategies. They should not be used as a substitute for the range of measures needed to reduce the risk of infection in communities and workplaces. Social protection for the lowest income workers and community members (in-cash or in-kind income) is necessary during periods of lockdowns, including to support adherence to measures, with social dialogue and communication on measures and why they are needed to build trust.

In August 2020, trade unions, civil society and churches in Southern Africa in the 16th Civil Society Forum (CSF) on COVID-19 discussed the application of these rights in the region, and issued a [joint statement](#) to the SADC Heads of state and government summit calling for rights- and equity based measures for COVID-19. Amongst other issues, the statement calls for responses to COVID-19 to be developed and implemented in consultation with civil society and the most representative employers' and workers' organizations; for all workers, including migrants, to have access to public health services and dignified treatment, and for access to PPE where needed. The forum called for measures for effective oversight, transparency and accountability in loan negotiations and agreements related to financing COVID-19 responses, particularly with multi-lateral and private lending institutions.

Between September and November 2020, the SADC Employment and Labour Sector as a tripartite regional social dialogue platform in Southern Africa held three consultative sessions on a labour policy framework (2020-2030) that included ensuring that fiscal and monetary measures promote job and income security, strengthen safety and health systems and enhance state capacities to manage pandemics.

These measures call for sustained national and regional advocacy, alliance building, social dialogue and oversight to negotiate for and protect the rights of different working people and their communities in the pandemic, including for female, young and various precarious workers. We also need to monitor that the state and private actors deliver on these rights. There are international instruments that support such negotiations, such as the [ILO Employment and Decent Work for Peace and Resilience, Recommendation No. 205](#) of 2017 stipulating that crisis responses should respect human rights and the rule of law, including rights at work and international labour standards.

Workers face risks in the pandemic, are affected by it, but also play a vital role in an effective response to it. The inclusion of workers' organisations and representatives of affected workers in dialogue platforms and decisions on the responses to COVID-19 is thus essential.

COVID-19 has been a challenge for workers. It has exposed long-standing deficits in rights and social protection for workers, especially for women, migrant, health, young, and other workers. These have made workers vulnerable to the pandemic, but they also make the whole of society

vulnerable. The issues affecting workers must thus be addressed as a response to this pandemic, including to prevent risk and vulnerability in future pandemics. The region needs to shape its economies in ways that generate decent employment, support local production and fair benefit from productive resources, extend social protection and ensure decent and safe conditions across all areas of work.

Health extension workers visiting families carrying vaccines



Source: [UNICEF Ethiopia](#) , 2012 under CC