EQUINET Information sheet 4 on COVID-19

Produced by Training and Research Support Centre for the Regional Network for Equity in Health in east and southern Africa (EQUINET)[1]
May 1, 2020

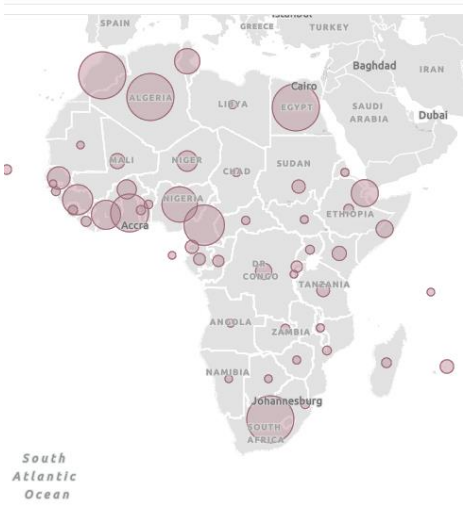
May Day greetings! This May Day comes at a time when the International Labour Organisation has warned that 1.6 billion of the 3.3 billion workers globally are at risk of losing livelihoods due to the economic impact of COVID-19. This fourth information sheet from EQUINET summarises information from and provides links to official, scientific and other resources as of April 29 2020 on selected themes to support individual to regional level responses to COVID-19 on the health, health system and determinants of health that affect equity. *The brief complements and does not substitute information from public health authorities.* The first brief provided basic information on the epidemic, the second brief on the health system, policy and community responses; the macro-economic impacts and various dimensions of (in)equity and the third brief outlined developments on the epidemic, population evidence and initiatives on health technology to respond to COVID-19.

You can read the full brief or go to the section that is most relevant to you. This brief covers:

The focus is on east and southern Africa (ESA), with information from other regions that may be useful for the ESA region or that may raise issues for the region. The information is sourced from World Health Organisation (WHO), official, public health and technical/ scientific sources, and from media and grey literature emailed to EQUINET. The source of information is cited or hyperlinked so readers can read from sources directly or for deeper information on the issues raised. The WHO page on COVID-19 is at https://www.who.int/emergencies/diseases/novel-coronavirus-2019. *We welcome feedback and contribution, including on any errors to be addressed – please send to admin@equinetafrica.org*. To receive future editions if not already subscribed, please subscribe at www.equinetafrica.org/content/subscribe.

1. Developments in the COVID-19 epidemic

In relation to the spread of the epidemic, as of 28 April 2020, of the 2 879 512 cases of COVID-19 globally, the Africa CDC reported that 33 273 cases were reported from Africa (1.15%), more than doubling in the 2 weeks since the last brief and with a case fatality rate (CFR) of 4.4% in the African cases. This is lower than the 5.4% reported in the last brief, probably as wider testing is now identifying more cases, but still suggesting that cases are under-detected. The figure adjacent from the AU CDC website shows the distribution of the cases in Africa.



As a reminder, you can find daily updates on cases, deaths and other information on COVID-19 (hyperlinks provided)

a. From WHO at https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports/
b. From the 'Our World in Data' site
c. From the Johns Hopkins visual dash board.
d. From the daily updates on the Worldometer site

[1] EQUINET is a network of professionals, civil society, policy makers, state officials and others within east and southern Africa implementing research, analysis, information sharing, dialogue and learning from action to promote health equity. This brief is synthesised by TARSC (R Loewenson), with grateful acknowledgement of contributions from within and beyond the region. It is produced under the principles of 'fair use', attributing sources by providing links to authors and websites, whose views do not necessarily represent those of EQUINET or its steering committee.

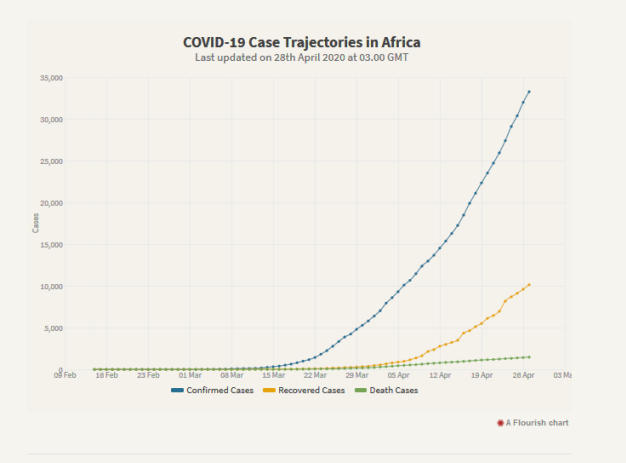
Table 1 shows for ESA countries the cases reported for the period ending 28 April from Worldometer, with comparisons to the earlier report on 12 April. Apart from Lesotho, all ESA countries now report cases. The estimated doubling times of *reported* cases is compared with earlier data from April 12, where a longer doubling represents slower epidemic progression. The findings on cases need to be interpreted with caution given the very different rates in testing in the region shown in *Table 1* and the significant increase in testing in the past fortnight also shown. Comparing doubling times with those in the earlier period suggests, however, that epidemic progression has advanced more rapidly in Tanzania and Zambia and with slowest progression in Mauritius. The expansion in testing is encouraging, as progress towards testing, tracing and quarantine is needed to break transmission chains. The expansion of testing rates has been highest in Uganda, Zambia and Zimbabwe, albeit from lower starting points in the latter two countries. Botswana, Mauritius and South Africa have the highest reported intensity of testing in the region at 2558-11358/mn, coming closer to the 10 038/mn of South Korea that built an effective strategy around testing, case tracing and quarantining, Many ESA countries are, however, still far from this level. *Beyond its use in confirming clinical/ symptomatic cases and contacts, identifying high transmission areas/ groups and high risk workers appears to be necessary to use testing for public health impact, given the limitations in available resources.*

Table 1 Reported COVID-19 Cases in ESA countries 12 April and 28 April 2020

Country	Total cases 28 April (i)	Total cases 12 April (i)	Estimated doubling time in days (ii) (12 April time in brackets)	Total new cases 28 April (i)	Total new cases 12 April (i)	Tests per million 28 April (i)	Tests per million 12 April (i)	% increase in testing 12-28 April (i)	Total cases/ million 28 April (i)	Total deaths 28 April (i)	Care Fatality Rate 22 April (iii)
Angola	27	19	22.5 (7.4)	-	0	-	-	-	0.8	2	8.3%
Botswana	23	13	18.1 (nd)	1	0	2558	1325	93%	10	0.4	5.0%
DRC	471	234	15.9 (7.8)	12	11	-	-	-	5	30	7.0%
Eswatini	71	14	6.3 (10.9)	6	2	615	-	-	61	1	4.2%
Kenya	374	197	16.9 (5.4)	11	6	335	139	141%	7	14	4.7%
Lesotho	0	0	-	0	0	-	-	-	-	0	-
Madagascar	128	106	26.5 (7.0)	-	4	85	-	-	5	0	0%
Malawi	36	13	11.6 (nd)	-	1	36	15	140%	2	3	11.1%
Mauritius	334	324	31.1 (10.4)	-	5	11358	5565	104%	263	10	2.7%
Mozambique	76	21	8.8 (10.7)	-	1	54	22	145%	2	0	0%
Namibia	16	16	- (14.0)	-	0	277	142	95%	6	0	0%
Seychelles	11	11	- (20.4)	-	0	-	-	-	112	0	0%
South Africa	4996	2173	13.9 (15.3)	203	145	3119	1350	131%	84	93	1.7%
Tanzania	299	32	3.4 (12.3)	-	0	-	-	-	5	10	3.9%
Uganda	79	54	21.9 (15.6)	-	1	600	110	445%	2	0	0%
Zambia	95	43	7.3 (18.2)	6	3	287	67	328%	5	3	4.3%
Zimbabwe	32	14	14.0 (14.0)	1	0	460	38	1111%	2	4	10.7%

All reporting imported cases only except South Africa and DRC in 24/3. DRC = Democratic Republic of Congo
Source: (i) Worldometer 28/3/2020 (ii) Doubling time estimated from the total case (or death) numbers and days between 12 and 28 April. Not estimated for countries that started with a zero baseline on 12 April (iii) WHO AFRO 22 April

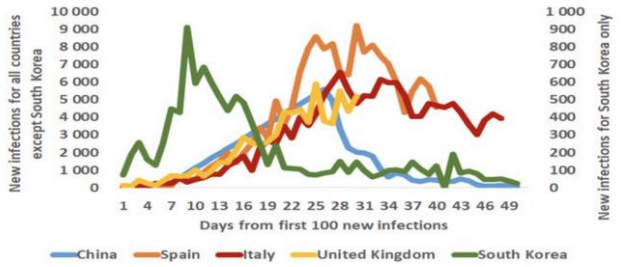
The WHO AFRO Report 8 on 22 April 2020 reports a 43% increase in cases in the week since April 15. In the ESA region, the highest case fatality rates *as of 22 April* were in DRC, Malawi, Angola and Zimbabwe (See *Table 1*) although these high rates may also reflect an under-detection of cases, the denominator in the CFR. The CFRs of 1.7% and 2.7% in South Africa and Mauritius may be closer to actual levels given the higher test and case detection levels in these countries. 'Elephant info', a site presenting data on COVID in Africa in graphics, includes adjacent graphic of the trajectory of cases and deaths post February 2020.



2. Exiting lockdowns – when and what next?

The full or partial lockdowns in ESA countries documented in the second information brief were introduced to suppress transmission and to provide a breathing space to prepare for and ramp up the testing, contact tracing, health service capacities and other actions to manage the epidemic. In many ESA countries lockdowns were applied at early stages of the epidemic, suggesting a potential to rapidly use testing, tracing and quarantine of affected people (infected and their contacts) for more rapid and sustained suppression, compared to generalised lockdowns in countries where widespread local transmission was already present, where the aim was to manage health system demands and bring cases down to levels to be able to use test, trace and quarantine approaches. Van den Heever (2020) in a discussion of risk based strategies for managing COVID-19 plots these different strategies – for S Korea and China that avoided mass national lockdowns and used generalised testing with rapid turnover (12 to 24 hours), contact tracing and quarantining of infected individuals and for Spain, Italy and United Kingdom that used national lockdowns. The sharper and more sustained fall in the former are notable. In most ESA countries, different levels of lockdown/ restrictions were introduced at a time when testing was limited to cases with symptoms and their contacts, detected at borders or health services. Frontline health, care and transport workers and others at higher risk or vulnerability in the community were untested. limiting this arm of prevention. While testing has expanded in most ESA countries, it has not yet reached levels in many required for a more proactive suppression strategy. Mauritius appears to be the only ESA country that used a more proactive, early and wider test, trace and quarantine strategy, with preliminary evidence suggesting that it has had the slowest doubling time (thus epidemic increase) of ESA countries (excluding Lesotho on zero reported cases).

Figure 1: New infections after the first 100 total infections for South Korea compared to China, Spain, Italy and the United Kingdom during 2020



Sources: (European Centre for Disease Prevention and Control, 2020)

Given that, and generally without public evidence of the modelling that informed the decisions, many ESA countries implemented full or partial lockdowns, albeit with differing degrees and locations of curfews or restrictions on movements out of home, on gatherings, travel, closure of education, recreational, commercial, factory institutions, and with exceptions for health, food market, pharmacy and essential utilities. Evidence is emerging on the challenges and social and economic harm of lockdowns for communities and countries, some of which has been documented in earlier briefs, particularly for poorest households, the large number of workers in precarious employment, the smaller enterprises without cash savings and economies and sectors that were already underfunded relative to need with high debt outflows, widening inequality. In Zimbabwe, for example, a survey in mid-April found 34% of companies with zero production and 52% operating at 30-60% of pre-lockdown capacity levels, with revenue losses of between 45% and 100%. Not all have faced losses. Globally, Bezos, the CEO of Amazon, is reported to have increased his wealth by roughly 20% over the last four months to $138 billion in April, given the increase in online purchasing. Other online distributers, internet, online platform and mobile money providers and some wealth fund managers have seen a growth in revenue and profits, leading to some calls for windfall taxes on these profits and wealth taxes to fund COVID-19 related recovery. In the ESA region, different country measures have led to business shifts. For example South Africa's strict lockdown on ports to only essential cargo led mines to divert minerals to ports in Tanzania, Mozambique and Namibia (who did not close ports), significantly boosting the latters' returns. South Africa has since opened its ports to all cargo.

As falling jobs and incomes themselves have health impacts, ESA countries are making difficult decisions around measures to protect health in the immediate with those protecting health and the economy in the medium term. This is leading to a rollback of some aspects of lockdowns, even while extending their duration. In extending the lockdown in Zimbabwe to May 3rd, President Mnangagwa said the government would allow mining companies, which generate the most foreign currency, to resume full operations and manufacturers to work at limited capacity.

In many ESA countries national or partial lockdowns have now been extended and have now lasted a month or more. Their impacts raise questions on their sustainability. The conversation inevitably turns to when and how countries will exit them. South Africa's President Ramaphosa said in introducing their risk adjusted strategy:'*We cannot sustain a nationwide lockdown indefinitely. Our people need to eat, and earn a living. Companies need to trade'*.

WHO criteria for rolling back lockdowns. At least for public health, WHO has outlined six categories of measures that need to be in place before rolling back 'lockdown' measures:

1. COVID-19 transmission is in sporadic cases and clusters of cases, all from known contacts or imported cases, with new cases at a level that the health system has capacity to manage.
2. Sufficient public health workforce and health system capacities are in place to enable a shift from detecting and treating mainly serious cases to detecting and isolating *all* cases.
3. Outbreak risks in high-vulnerability settings are identified and minimised, with measures in these settings to maximise physical distancing and minimise the risk of new outbreaks
4. Preventive measures are established in workplaces.
5. The risk of export and import of cases from high risk settings/ groups is controlled.
6. Communities are fully engaged and understand a 'new normal' in which prevention measures are be maintained and their roles in preventing a resurgence in case numbers.

Hale et al., (2020) using an Oxford University monitoring system (OxCGRT) applying a mix of data sources for four of the six criteria above roughly describe how countries are performing on four of these WHO criteria. They note that the data '*measure countries' stated policies, not how well they implement them*' and that their analysis better indicates which countries are *not* ready than which *are*. The table below extracts the evidence for ESA countries. (The findings for all countries globally can be found at the link above). It suggests that while imported cases are generally well managed, largely due to travel restrictions, there are more variable levels in community understanding and more limited readiness around case control and in test, trace and isolate strategies. *This raises a question of how, in what stages and when ESA countries will identify high risk and high vulnerability settings; advance effective proactive measures for testing with rapid results to isolate or transport cases to services, especially in high risk settings; and set measures to prevent exposures in workplaces, health services and care settings.*

Table 1: Lockdown Rollback Checklist 20 April 2020 (No data for vulnerable settings or preventive measures in workplaces)

Country	Cases controlled	Test trace and isolate	Manage imported cases	Community understanding	Overall based on 4/6
Angola					
Botswana					
DRC					
Eswatini					
Kenya					
Lesotho					
Madagascar					
Malawi					
Mauritius					
Mozambique					
Namibia					
Seychelles					
South Africa					
Tanzania					
Uganda					
Zambia					
Zimbabwe					

Hale et al 2020 https://www.bsg.ox.ac.uk/sites/default/files/2020-04/2020-04-lockdown-rollback-checklist-research-note.pdf .
DRC = Democratic Republic of Congo

Beyond public health criteria. In the absence of a vaccine or effective treatment, there is an understanding that the measures chosen need to prevent a resurgence in cases, while also avoiding knock-on effects of the measures used that themselves generate harm. *Given that it is unlikely that COVID-19 will be completely eliminated in 2020, and with uncertainty on the time frame for a vaccine, decisions on strategies going forward call for an integration of diverse evidence on public health, social protection and socio-economic risks and strategies, including from the lived experience of and reports from communities, sectors and services.*

In more advanced epidemics in Asia and Europe, lockdowns have been eased by variably enabling more frequent outdoor exercise, allowing selected non-essential services, restaurants and shops, public transport and courts to open with strict social distancing measures, restarting manufacturing and opening schools, with close monitoring for recurrent peaks in infection.

A few ESA countries are also beginning to indicate specific areas of easing of lockdowns, such as the example of Zimbabwe noted earlier. The issues may be specific for different countries. For example, as a landlocked country, Uganda will tackle its need for cross border traffic for goods and services and its concern over cross-border spread by allowing each truck to have only one driver who will be tested at the border before entering the country. Uganda's executive is reported to be reviewing sector plans to lift other areas of its lockdown in a phased manner.

The argument has been raised that beyond meeting public health criteria, decisions on these measures to roll back lockdowns should explicitly address how different interests and risks are being balanced and that the principles and values that are informing the decisions and their impacts on people and activities should be made clear.

While macro-economic and sectoral interests may often predominate, one analysis from the Trade and Industrial Policy Strategies institution raises other considerations to include, such as the impact on society and on women's work, the ability of different sectors to manage risk, their labour intensity and social importance, in addition to their importance for the GDP. The adjacent table from TIPS (2020:8) indicates trade–offs to be balanced between these issues in exploring sectors to be prioritised for roll back.

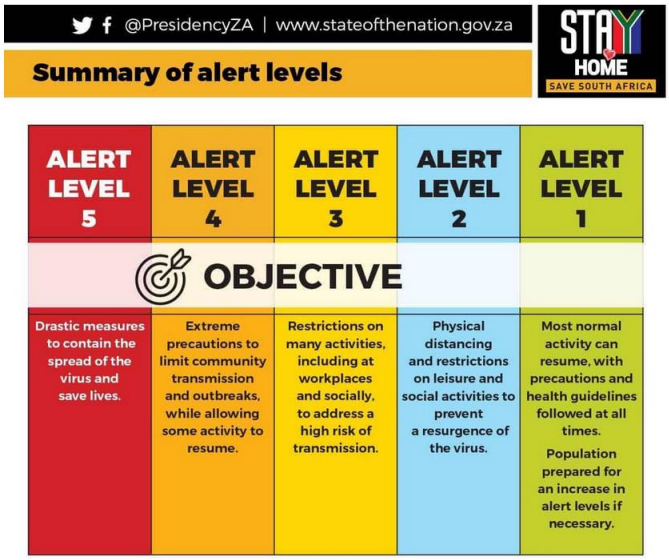
Table 1. Illustration of choices in evaluating the importance and risk of value chains

Note: For each set of criteria, the value is averaged with the risk, on a scale of 1 to 5. The value for the economy is only in terms of production, which understates for instance the enabling role of PPE and telecommunications. The value for society is necessarily subjective. Opportunities for women reflect the share of women in the labour force for the value chain.

	Econo-mic impact	Social cohe-sion	Wo-men's work	Ability to manage risk	Share in GDP/ exports	Labour intensity/ SMEs	Social impor-tance	Opportuni ties for women
	1 + 2	1+3+4	1 + 5	1	2	3	4	5
Auto	5	3.0	3.0	5	5	1	3	1
metals	5	2.3	3.0	5	5	1	1	1
mining	4.5	2.3	2.5	4	5	2	1	1
machinery	4	2.3	2.5	4	4	2	1	1
food for SA	4	4.0	3.5	4	4	3	5	3
food and wine exports	3.5	3.0	3.5	4	3	4	1	3
healthcare	3.5	4.3	4.0	3	4	5	5	5
freight transport	3	2.3	2.0	3	3	3	1	1
fashion	3.5	4.0	4.5	4	3	3	5	5
telecom-munications	3	3.3	3.5	4	2	1	5	3
security	3	4.3	3.0	4	2	5	4	2
cleaning	3	4.3	4.5	4	2	5	4	5
PPE	2.5	4.0	4.5	4	1	3	5	5
education	2.5	4.0	3.5	2	3	5	5	5
concerts and theatre	2	3.3	2.5	1	3	5	4	4
restaurants	1.5	3.0	3.0	1	2	5	3	5
public transport	1.5	3.0	1.0	1	2	3	5	1
personal services (e.g. hair dressing)	1.5	3.3	3.0	1	2	5	4	5
church services and family gatherings	1	3.7	2.5	1	1	5	5	4

Choices are also not always made on the basis of discreet numbers- there is a socio-political dimension to them and sectors interact. Less highly prioritised sectors like education may have high significance and social value for households and society. Opening food markets without opening the transport to access them may generate informal breaches of measures. Within sectors, smaller businesses may have more limited cash and face more difficulty in meeting requirements for safe conditions, making them vulnerable to take-over by larger companies unless associated credit and legal protections are in place. Reopening an enterprise without reopening the value chains that supply its inputs and use its products may stall recovery. Decisions on value chains often depend on what is happening in other sectors and countries.

It would be important to make clear the risk and strategic evidence, analysis and principles that are informing these decisions, given their consequence for society. For example, in South Africa's risk adjusted strategy, it would appear that the phased recovery announced by President Ramaphosa in April is guided by the risk of transmission (including the ease of implementing mitigation measures); the expected impact on the sector of continued lockdown (including prior vulnerability) and the value of the sector to the economy (such contribution to GDP, multiplier effects, export earnings). Bringing these together with active monitoring of the epidemic may guide the design of phases as the country moves through five alert levels, from the current Level 5, to Level 1, shown in the adjacent graphic. As the same time there may be common measures for all sectors and phases to prevent transmission and protect vulnerable groups, such as prioritising remote working, especially for older workers; symptom, fever screening, testing and disease surveillance at workplaces; social distancing or use of face masks and provision of handwashing facilities and soap.



Trust and transparency matter. These strategies are being phased over many months, and many aspects may affect public and socio-economic life in the future. While decisions will be informed by different forms of evidence, the success of strategies, including rolling back lockdowns, will also depend on voluntary informed consent in the public to comply with appropriate public health measures and on communication, information exchange and adaptive learning between different sectors and systems at all levels. In DRC, a lockdown imposed on the whole of Kinshasa, a city of over 10 million people, rather than the part of the city where most cases were identified, was reported to have been cancelled four hours later, in part due to fear of political protest, and the compulsory wearing of face masks by all in public spaces was applied as a more socially accepted measure. *The public and stakeholders are not by-standers in these phased decisions, and need to be informed of them and make sense of how to implement them, to plan for the epidemic and its impact in their own lives and work. Trust in and support for any strategy for the next phases of response calls for multisector task forces in countries to engage stakeholder and community representatives through genuinely open deliberative processes and to invite and include 'a broad range of evidence and perspectives into their discussions of plans' and their assessment of progress in implementation.*

3. What COVID-19 has meant for risks and returns from migration

Migration within and beyond the ESA region has been present for centuries, whether due to climate, socio-political drivers, conflict, war, a struggle for survival, economic opportunity and innovation. As COVID-19 becomes a story of multiple epidemic profiles in different settings in countries, prevention of outbreaks and equitable and effective responses calls for disaggregated evidence and understanding of how risk and vulnerability are distributed and concentrated for different social groups and situations within countries and in the region. One group of people, and of workers, who may be in more precarious conditions, but have less visibility in some national responses are migrants and displaced people.

Migration is widespread within the ESA region. People migrate across countries in the region for work, education, trade, socio-cultural and other reasons and have done so over centuries. Migration has been one way in which households have secured employment and incomes, and migrant labour has been a key, if sometimes buried feature of the economies in the region. For example, South Africa as a regional migration hub has an estimated 4.2 million migrants, primarily from neighbouring countries. It is estimated by IOM that over 11 million Mozambicans are living abroad, with South Africa one of the top destinations, working in mining and farming jobs, with about 24,000 Mozambicans working in the mining sector. In Mpumalanga province alone, 2004 estimates indicated some 80,000 Mozambicans working in farms there.

African migrants residing in trade hubs such as Kenya and South Africa often work in goods and services that are location-based, many in the informal economy.

The International Organization for Migration (IOM) identify the pandemic as the largest mobility crisis the world has ever seen, with 209 countries affected to date – 52 of these in Africa. Opportunities for movement have reduced drastically, with border closures, suspension of visa processes and severe travel restrictions. These restrictions and collapse of economic activities threaten jobs and incomes of migrant workers and cross border traders, with women noted to be particularly affected in the latter group. As social security systems do not cover workers in these sectors, migrant workers are left to themselves to face the impact. While aimed at reducing cross-border transmission, Mbiyozo (2020) observes that border closures can lead to an increase in irregular travel routes across the regions porous borders, which could heighten exposure and complicate health screenings and contact tracing.

The sudden announcement of lockdowns led to its own surge in cross-border migration, sometimes from countries with higher reported COVID case-loads (such as South Africa) to neighbours with lower case-loads, raising the potential for cross border transmission. For example the lockdown in South Africa late March led to an estimated 23 000 Mozambican mineworkers and an estimated 13 500 Zimbabweans rushing across the main border crossings in the days before the closure. Yet these numbers are dwarfed by those who have remained.

The African Union Labour Migration Advisory Committee noted that African labour migrants stranded in countries of work during COVID-19, especially those in more informal occupations, may fall victim to hardship and exploitation and to extortion in efforts to return to their homes and families. They note that the majority of migrant workers '*are most exposed to the possibility of infection, owing to squalid living conditions, inadequate workplace health and safety protection, and little or no social protection coverage. Domestic workers in particular, face a higher level of exposure to the contagion. Many workers across sectors and industries also survive on daily wages and will suffer huge wage losses due to the stoppage of economic activities'*.

Many migrants work in informal markets, have family members who rely on remittances and are not eligible for economic relief provided by the state. Added to this, as reported by the Institute for Security Studies undocumented migrants may themselves try to remain invisible and are less likely to seek care if symptomatic. *As discussed later on responses, this implies that plans for management of COVID-19 not only need to integrate migrants, but also to overcome the institutional barriers, forms of exclusion and fears that migrants face to effectively reach them.*

Refugees and internally displaced people represent a particularly vulnerable form of migration. *Africa hosts more than 25.2 million refugees and internally displaced people, many in low income countries with under-resourced health systems. Refugees who have fled war or strife may be stressed and malnourished, with compromised immune systems and other comorbidities.*

Africa houses four of the world's six largest refugee camps (in Uganda, Kenya, Tanzania and Ethiopia). Kakuma and Dadaab refugee camps in Kenya together accommodate 411 000 refugees. Zambia also hosts a substantial refugee population, including nearly 50,000 from DRC. In settings where refugees are in camps that are reported to be overcrowded, they have limited options for social distancing, and may lack adequate water, sanitation and hygiene facilities and referral health services.

However many refugees and internally displaced people in ESA countries are not in camps and live in communities, in urban slums or occupy deserted buildings. For example, according to the UN Refugee Agency close to 1,5 million refugees live in Uganda, largely from South Sudan, Democratic Republic of Congo, Burundi, Somalia, Rwanda and Kenya. The Uganda government supports them with agricultural land where needed and allows them to access education and health services. This locates refugees inside existing communities, which helps to maintain livelihoods. It may also raise additional considerations in managing COVID. For example, nearly 187 000 refugees live in Arua district, 12 km away from the DRC border and 50 km from the South Sudanese border. Arua's strategic location has made the city a destination for migrants seeking social and economic support, but it also has limited resources to take care of the self-settled refugees that make up an estimated 24% of its total population. COVID-19 restrictions

add challenges to maintain livelihoods, and, as Ugandan authorities note, make it difficult to control their internal movements to markets when they receive cash allowances.

In Cape Town, South Africa, over 1,400 people displaced from their homes in Cape Town's inner-city due to the rising cost of housing moved to occupy a closed-down state hospital, Woodstock Hospital, which they have renamed Cissie Gool House. They have a leadership and organisation and have instituted measures to reduce their risk of infection, including health education using Whatsapp and printed media, hygiene measures, isolation and reporting to the public health-line of any with flu-like symptoms. There are several such 'occupations' in the city although not all are as organised. Some have been subject to demands from the city council to vacate the buildings as not suitable for human habitation, and there is report of operations to remove and relocate these occupants, even during the lockdown.

These various forms of refugee situations and displacement of people within the region mean that while these groups need to be integrated within national plans for COVID-19, how this is done depends on the nature of their settlement and conditions within different countries.

Migration from the ESA Region to other regions globally is also affected. What may be even more invisible is the manner in which the epidemic has affected migration for work and security for people from ESA countries to other regions globally. While the regular flow of African migrants is largely from North Africa and the Horn of Africa into the Middle east for work, or through North Africa for migration to Europe, there is also a significant migrant population from ESA countries in different European countries, in Australia and in the USA.

For those moving in annual migrations or through North Africa to Europe, the International Organization for Migration (IOM) report that the response to COVID-19 has significantly reduced the numbers migrating for employment by 25%, as a result of lockdowns and the heightened security at borders and informal entry points. Migrant workers have also been 'returned'. Nearly three thousand undocumented Ethiopian workers – mostly maids and domestic servants with low paid jobs - were reported to have been abruptly sent from the United Arab Emirates and Saudi Arabia back to Addis Ababa in cargo planes in April and further returns are expected, The governments of both Middle East countries reportedly claimed that these Ethiopian workers may be spreading the coronavirus, but sent people back without testing them.

Photo: E Reldy, 2020

Migrants in transit are reported to risk being stranded in crowded conditions in transit and detention centres, together with poor living conditions on the route and poor living and working conditions and exclusion from social safety nets and services in the destination countries. Migrants from Africa in refugee facilities are reported to have less possibility for 'social distancing' and less access to necessities or services as some support services have stopped due to lockdowns. A halt in resettlement amid the travel restrictions has meant that more people are staying in camps and temporary settlements, with less access to resources for hygiene, health care and heightened health risks and psychological stress. There is also scarce culturally accessible information in migrant languages about COVID-19 and about how to protect oneself and others, which further increases risks for refugees and migrants, as well as host populations.

Migrants from Sub-Saharan African countries living in Africa country communities en route, such as migrants in Tunisia, report being unable to practice the casual labour they rely on for essentials such as food and rent after lockdowns. They are over-represented among the homeless population in many destination countries and fearful of being identified in measures applied to address COVID-19. For example, a remotely-controlled police robot patroling the streets of the capital called PGuard (picture adjacent) asking people on the streets to show IDs is popular with local residents, but may be alarming for migrants without papers.

African migrants in Europe include high skill workers, many of whom work in the health and care sectors, where they are at higher risk of infection and mortality. Their role is being recognised and calls are being made in some European countries to speed up the immigration status and recognition of foreign care workers, so they can quickly help increase capacities in hospitals. In the UK, for example, migrant doctors and nurses in the National Health Service have been belatedly acknowledged by the government, and their importance to the health service demonstrated by a Home Office's decision to extend all visas of health workers coming up for renewal by a year. *While this appreciation does not extend to all migrants, it does represent a shift in countries that built a political discourse on migration – rather than austerity- as a cause of decline in the very services they are now seen to support. However, it also raises again the debate on 'ethical recruitment' of health workers at a time when health care systems are under strain in source countries, an issue that calls for coherent response from ESA countries.*

African migrants are also living as undocumented workers in European countries. In lockdowns they are reported to be struggling with no work and no money. Some rely on meager savings, but as discussed below, this has also meant that they cannot send funds back to their families in the continent. As one migrant in France noted- after a month crossing the Sahara Desert to reach Libya, followed by a year in Tripoli earning enough to cross the Mediterranean to Italy and from there to France working on construction sites- '*This coronavirus is a different kind of ordeal, one I cannot really fight. I could see the dangers I had to face when crossing over to France but with this disease I don't know. Only God can decide.'* Others have switched informal activities to services that may be needed in lockdowns, such as making face masks, but cannot go out to market them for fear of being arrested at police checkpoints enforcing lockdowns.

In a different part of the world, a significant African diaspora has grown in the trading hub in Guangzhou in Southern China, with thousands of entry permits having been granted annually to African nationals, including from ESA countries, and some overstaying their visas. Castillo (2020) reports that there are between 4500 and 16000 African migrants in this city alone, including both legal and non-legal residents. Hiding or losing a passport to become an undocumented migrant is always precarious. However with new measures introduced to respond to COVID-19, it has become even more so. Without a legal abode, foreigners 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.

Added to these institutional and economic challenges, IOM, and Knoll and Bisong (2020) report that migrants are also being scapegoated by local media and political actors blaming COVID-19 on them, or labelling them as carriers of diseases. There was report, for example, of African migrants in Guangzhou in China being blamed for the coronavirus spread and mistreated. There has, however also been report of harassment and attacks on people from Europe and China in some African countries, where some citizens perceive them to be responsible for the spread of the virus. In a context of a globalisation that has accelerated the movement of goods, services and capital across countries, El Ouassif (2020) observes how in people's minds the pandemic has been associated with the freedom of movement of people that allowed a virus that emerged in China to spread globally and claim lives in other countries. This association is argued to feed the 'fear of outsiders' and xenophobia. Populist discourses have fed this fear, widening the gap between the 'us' and 'them'. Stigma raises a further barrier to uptake of public health measures and services in migrant communities. *In global platforms, ESA countries thus not only need to raise the material and social protection systems migrants should obtain during COVID-19, discussed later, but also challenge xenophobia within the region and internationally, including as a problem for public health.*

Remittances from migrants are a significant source of household support in ESA countries- what will COVID-19 do to them? While the discussion on migration often refers to migration controls and needs, this masks the significant economic contribution migration makes in ESA countries. Migrant annual remittance inflows to ESA countries and their share of GDP in 2017 are shown in *Table 3* overleaf, showing the significant contribution remittances make to the economies of some countries and as financial inflows to households. Within Africa, the World Bank estimates that migrant workers send remittances in excess of US$14 billion dollars each year. Migration within Africa has grown faster than that outside the continent, and intra-African remittances were 20% of global remittance flows in 2018. The majority of these remittances are

sent 'offline', as cash. Money is taken to a physical agent, usually subject to high fees, and delivered to recipients as cash. Africa has the highest costs for remittance transfers globally, averaging 9% for a $200 transaction compared to the global average of 7%, and transfers within Southern Africa have the highest costs in Africa, as shown in the adjacent figure (KNOMAD, 2020: 34).

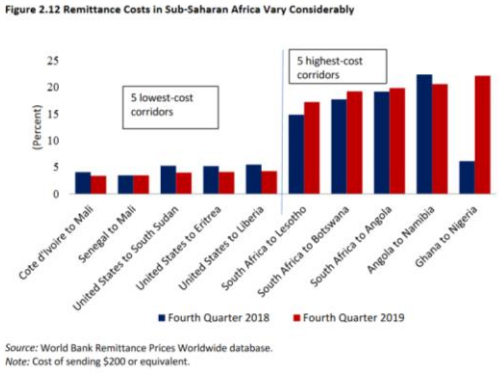


Table 3 Reported remittances in ESA countries, 2017

Country	Annual remittance inflows, 2017, US$ 000s	Remittances as a percent of GDP, 2017, Percent
Angola	.4 000	0.00
Botswana	20 000	0.12
DRC	5 000	0.00
Eswatini	19 000	0.50
Kenya	1 811 000	2.40
Lesotho	367 000	15.00
Madagascar	259 000	2.50
Malawi	37 000	0.60
Mauritius	250 000	2.00
Mozambique	94 000	0.80
Namibia	2 000	0.00
Seychelles	23 000	1.60
South Africa	756 000	0.20
Tanzania	433 000	0.80
Uganda	1 182 000	4.30
Zambia	41 000	0.20
Zimbabwe	Not available	Not available

Source: UN cited in Africa Renewal issues on COVID-19

The African Union Labour Migration Advisory Committee (AULMAC) notes that lockdowns and economic impacts on businesses in recipient countries mean falling remittances, decreasing at a time when remittance recipients are most likely to need the money. The World Bank projects that remittances will fall globally by 20% and by 23% in Sub-Sarahan Africa as a result of COVID-19 and shutdowns, the steepest fall in recent history. In end March it was noted that remittance flows had already dropped around 40% as a result of COVID-19, with migrants having insufficient funds and agents being closed. *The impact of these losses are not yet clear or adequately assessed in ESA countries, but for countries and households where remittance flows are high, such as the US$1bn annually in Uganda, it may be projected that the impact will be significant, including on households' ability to meet economic and social and health care needs.*

Various options have been proposed to protect and facilitate remittance flows including to

- Declare remittances services as essential in sending and receiving countries, so they remain functional during lock downs and restrictions
- Encourage digital transactions and extend digital payment systems in receiving countries, keeping cash-out options for rural and other areas that do not have digital systems.
- Revise and relax regulations that are a barrier to cross-border digital transactions.
- Waive or reduce fees on transfer costs, as is already being applied to certain mobile money transactions in some ESA countries, and monitor pricing to avoid profiteering by agents.

These measures make remittance flows more feasible during COVID-19, but do not address the drop in incomes that migrants face with COVID-19 related job losses, particularly if they are excluded from social protection schemes. This needs further responses, discussed later.

Responding to the risks and returns from migration during COVID-19. Despite their significant contribution to households in many countries and to sectors such as mining, the AU LMAC expressed its concern in April on the welfare of African migrant workers, refugees and

internally displaced persons as people 'caught in the 'cross-fire' of COVID-19'. Kluige et al, (2020) argue that there can be no public health without refugee and migrant health and recommend an inclusive approach to refugee and migrant health that leaves no one behind during the pandemic.

Agnes Igoye, with 20 years of experience in immigration services in Uganda, observes in a paper that '*the response to COVID-19 has exposed the limited institutional and operational capacity of many states overall, let alone to these specific problems'*. She describes the initial confusion after the first case and the expectation sectors had of leadership from the Ministry of Health, noting that prior training on migration health as a core subject would have helped to better prepare people from other sectors, such as at different points of long and complex land borders that had no or limited presence of health personnel. She also notes that COVID-19 has stimulated rethinking on how migration is managed, towards a more comprehensive approach and inter-agency co-operation. Others concur and call for deliberate efforts to ensure that refugees, displaced people and migrants living in communities - as in Uganda - are included in an organised way in plans and programmes, *before* epidemics occur.

The AU LMAC has called upon regional communities, states and others to address the fact that these groups are still not adequately catered for, notwithstanding the efforts being made in some countries. They call for countries crafting strategies to incorporate migrants within their COVID-19 responses, using the interim guidance released by their Inter-Agency Standing Committee.

Various responses are proposed:

a. As raised by IOM and others, assessing the impact of border controls, lockdowns and other measures in response to COVID-19 on refugees and migrants and ensuring that such actions do not prevent people from accessing safety, health-care services, and information. This implies including migrants and the communities hosting them in public health planning, response measures and messaging. 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. They aimed to ensure they are reached with key prevention and quarantine messages and made efforts to find out about their and their family members health, reaching by April over 850 migrants and over 4,100 relatives.
b. Providing any refugee camps and transit centres with adequate hygiene and health facilities, including to prevent catastrophic outbreaks, providing hand washing stations, health information, food and non-food items, mental health and psychosocial support and medical checks in transit sites, and engaging with both migrant and host communities to prevent misinformation and fear. In Kenya's refugee camps, for example, information is being sent to camp residents via mobile phone apps such as WhatsApp to limit social gatherings and to reduce fear from misinformation. The amount of rations distributed has been increased to reduce the frequency as this is a point where people can converge. Health facilities and COVID-19 isolation facilities in the camps and in nearby Kenyan host communities are open to both refugees and local residents.
c. As raised by Refugee International, decongesting camps and camp-like settings and restructuring food distribution and related services to avoid large gatherings.
d. Adapting and strengthening screening for COVID-19, using fever screening and then antigen tests, especially for all new arrivals in the camps, with suitable options for quarantining.
e. As implemented by the UN Refugee Agency (UNHCR), among refugee communities, addressing the needs of about one million refugee students currently out of school by working with government and non-government and private partners to secure online platforms and provide distance-learning and digital-learning programs, as is being done in Kenya, South Sudan, Tanzania and Uganda.
f. Ensuring that health and care workers in camps are given personal protective equipment to prevent their exposure. In Tanzania, agencies working in refugee camps also identify a need to increase staff and supplies, isolation and treatment capacities.
g. Linking with non-state actors on information support to migrant and refugee communities on issues that affect them during lockdowns or other restrictions. For example, Scalabrini, a non state organisation in South Africa, provides information or support – online during the lockdown- on asylum or refugee documentation, child protection and documentation, evictions, financial relief packages available to foreign citizens, legal advice, rental support and welfare assistance.

While these represent examples of measures, it is generally recognised that Ministries of Health and other government authorities and the WHO specifically include refugees, asylum-seekers and internally displaced people in national response plans of all countries, in any emergency social protection schemes (including in high income destination countries), with additional measures if needed to overcome institutional barriers and support for the most vulnerable.

Integration of migrants reflects public health, rights and solidarity. *The inclusion of these groups in national programmes and strategies is a matter of public health principle, as the exclusion of any segment of society ultimately undermines national public health efforts. It is also a human right. Constitutions in many ESA countries indicate that no-one should be refused emergency medical treatment and with COVID-19 declared a national or public health emergency in many countries, every person, whatever their nationality or status, should be included in services, and should not suffer adverse consequences from using services.* Article 25 of the Universal Declaration of Human Rights protects the right to health under all hostile circumstances including pandemics, while the 1951 UN Convention relating to the Status of Refugees protects the rights of refugees and migrants. This means that national prevention, testing and treatment measures are available to all, regardless of nationality or immigration status. Ahmed(2020) in the Jurist recommends that refugees and migrants in destination countries be treated equally as permanent citizens during COVID-19 pandemic, with access to public services, socio-economic welfare benefits, healthcare, including mental healthcare, water and energy. Portugal, for example, recently changed its national policies to grant all migrants and asylum seekers living there permanent residency to ensure their access to health services, social safety nets and the right to work within plans for COVID-19.

Measures that require proof of registration or residence or exclusion of those without formal papers contradicts this intention. The Centre for Human Rights, and Centre for Applied Legal Studies in South Africa note therefore that this requires a commitment that no undocumented migrant will be prosecuted when they present themselves for screening, testing and treatment; that they will not be excluded from these services; that non-nationals will not be discriminated against in provision of food aid and other essential services; that foreign nationals and undocumented migrants are not discriminated against and singled out during the de-densification of informal settlements and other over-crowded areas; that asylum seekers whose papers were not processed before lockdowns are protected and that non-nationals involved in economic activities are not discriminated against during lockdowns.

The measures taken should also not lead to discrimination or stigma. For example, in South Africa, which has had experience of xenophobic violence, the government initially announced in the lockdown that small shops known as spaza could remain open, but only if they were South African-owned, suggesting that this was for quality control of food. On the first day of the lockdown, immigrant-owned shops were shut down by police. This was not only discriminatory, but Moyo and Zanker (2020) reported that it meant that many township residents had to go much further to buy necessities, increasing the likelihood of spreading the virus. On 6 April, a new directive permitted all spaza shops to remain open.

In destination countries there are also social networks that have defended against the stigma of migrants, such as the #*Jenesuispasunvirus* ("*I am not a virus*") movement in France, initiated to defend against stigma of Asian migrants. Negative discourses are being countered by the production of a positive, evidence-based narrative that highlights the proven benefits and contribution of migration. As noted by the Chief Executive of the International Rescue Committee, the first ingredient of an effective health response is not a health facility. It's trust. If there's no trust among people about the messages being given to them about how to stay well, then there will be no support for those measures.

4: An update: Access to medicines and vaccines

The third information brief discussed barriers to **access to medicines and vaccines** that raise public health and equity concerns for COVID-19 that need to be tackled now. WHO announced in April that the Medicines Patent Pool and UNITAID have included medicines and diagnostics for COVID-19 in their licensing pool, while over-coming patent, data exclusivity and trade secret

barriers to procure and produce COVID-19 vaccines is a key equity issue. Producing technologies locally has been raised as one means to address some concerns around health technologies and Senegal is now implementing trials for its local production of a COVID-19 test kit that is reported to give results in 10 minutes and cost US$1 to produce, as reported in this news video, with the aim once approved to produce test kits for itself and other African countries.

The ACT Accelerator: On 24 April WHO its "landmark collaboration" for "equitable global access to innovative tools for COVID-19 for all." Called the Access to COVID-19 Tools Accelerator ("ACT Accelerator"), it involved WHO, the World Bank, vaccine and pharmaceutical industry groups, and external funders, including the Gates Foundation and Wellcome Trust. The EU announced that it would lead an effort to raise EUR 7.5 billion for it, albeit without certainty that these funds will be raised. The Accelerator is described as "time bound", suggesting that commitments and collaborations will cease when the pandemic is declared over by WHO. Hammond (2020) in Third World Network notes some issues on the ACT that have impact on ESA countries. While South Africa's President Ramaphosa described it as encompassing diagnostics, antiviral drugs and vaccines, as did French President Macron, other European leaders (Germany and UK) limited their focus to vaccines, so the scope is unclear. *ESA countries would need to ensure the full scope of diagnostics, antiviral drugs and vaccines.*

The ACT Accelerator initiative is silent on the issue of intellectual property. President Quesada of Costa Rica said that a WHO repository would make intellectual property available for wider use, but without noting specifics on licensing terms, manufacturing capacities and know-how to effectively and affordably utilize any patents that enter the repository. Who will make COVID-19 vaccines where won't be fully known until it is clearer which candidate vaccines receive regulatory approval. *Yet, unless the ACT addresses intellectual property and national-level export prohibitions, ESA countries may not access the vaccines that they need, notwithstanding promises of equitable access*. Over 260 civil society organizations have thus written to the UN Secretary-General and WHO Director-General to operationalize fair and equitable benefit sharing for COVID-19- related medical products, as intended in the UN Convention on Biological Diversity and the Nagoya Protocol.

This is an area where ESA countries regionally need to secure their interests, in preparing / using national patent laws, keeping open the option of compulsory licensing and getting protocols for this ready, registering as legitimate importers with the World Trade Organisation, supporting international open license patent pools and promoting joint regional procurement. These issues can be integrated in discussions on the continent. Vawda and Baker (2020) report that under the auspices of the African Union Development Agency (AUDA-NEPAD), the African Pharma Conference has convened a meeting of stakeholders on a possible continental COVID-19 response in order to assure and sustain supply lines. Countries can also act directly. The South Centre has published a revised Guide for the Granting of Compulsory Licenses and Government Use of Pharmaceutical Patents that may assist in checking that the laws and procedures are in place.

5: Resources, COVID-19 and the creative economy

This last section provides links to resources that have been shared since the last information sheet, in areas not covered in this brief. We will maintain this so please email us resources that would be useful for others, not limited to the areas below.

Community, social and labour resources:

- Centre for Health Human Rights and Development is holding a Webinair Session on 4 May on COVID-19, Health and Human rights in Uganda
- The Southern Africa Trade Union Co-ordination Council (SATUCC) has issued a message for the World Day for Safety and Health at Work that addresses the measures to protect workers at work from COVID-19. It notes that the ILO Employment and Decent Work for Peace and Resilience Recommendation, 2017 (No. 205) adopted by all constituents emphasizes respect in emergency responses for all human rights and the rule of law, including rights at work and international labour standards

On evidence, guidance and research related to COVID

- The Elephant has produced a web page with visual graphics mapping the epidemic in Africa that is updated daily.
- The African Centre for Biodiversity has produced a resource on the medicines and vaccines for COVID-19 to inform positions and actions to improve Africa's access to these resources.
- The UN Economic Commission for Africa (UNECA) has produced a new report on Covid-19 in Africa, analysing the impact on lives and economies, with projections and policy proposals.
- The WHO provide technical guidance in a range of areas related to the COVID response.
- The African Union CDC provides a range of resources on the response to COVID-19, including guidance on testing, surveillance and contact tracing.

COVID-19 and the creative economy

The creative economy is a resource for health and wellbeing. It provides a medium communicating health and social messages, a space for provocation and reflection of experience and insights, including of the ways that COVID-19 has taken hold of our collective consciousness. It is also a source of production, employment, income, especially for young people. *The examples below hopefully encourage and inspire. Let us know stories of creative economy contributions to people's response to COVID-19 in your country and we will share them.*

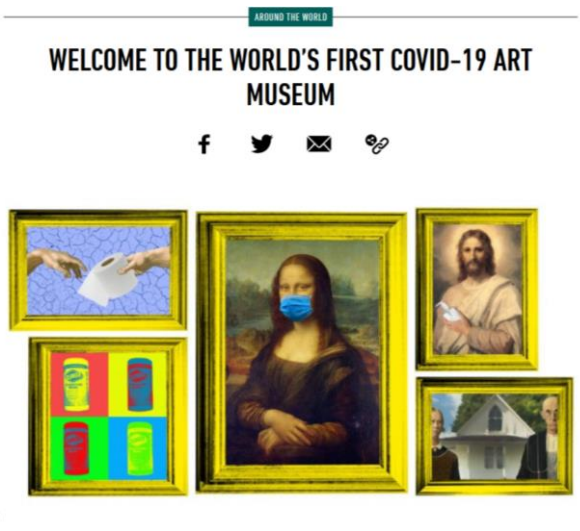
In a country with a low literacy rate, art can help spread important information about how to stay safe

Graffiti artists in Dakar have painted Dakar's city walls to send messages on COVID, with images and messages such as "Together against COVID-19," and "A big thank you to the caregivers." They see visuals as a means of communicating information for many people who are illiterate. In another artist collective, Radikl Bomb Shot, about 30 artists are creating murals around Dakar to illustrate proper hygiene practices and to encourage people to stay home and respect the curfew. They focus on the picture so if people can't read the writing, they can read the image. The collective formed in 2012 to respond to social issues in a way that would be accessible to youth. The first COVID-19 mural was done in partnership with Dakar's Cheikh Anta Diop University, on the school's campus, commissioned by the university as a location as the area gets a lot of foot traffic. As people don't have time to stop for long, a mural gives impact to the message.

Liberian youth are finding creative ways to fight COVID-19 while also generating an income for themselves, creating face masks from African prints. As they said: '*After seeing the various masks around the world, I was inspired and I decided to take it to our local culture by creating an African version*'. They use local Ankara fabrics to make the masks, sending a visually clear message on the reality of COVID-19 in the community. "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".

A group of Tanzanian artists use music to share awareness on COVID-19, releasing a track 'Songa Mbele' which is Swahili for 'move forward,' with messages on what to do to prevent infection. The song was a tribute to two fellow African singers who succumbed to COVID-19. They aim to raise money for those who have lost loved ones to the virus.

'*Artists are the interpreters and narrators of our ever evolving identity*'.



Galleries and institutions are finding ways to support art online, such as the National Art Gallery of Namibia online platform to showcase and enable artists to sell their work, or South Africa's relief fund to assist artists with online displays. For example in the 101 Collecting Conversations: Signature Works of a Century exhibition at the Javett Art Centre at the University of Pretoria, South African artists narrate the last 100 years of South Africa's history to show that there are as many different perspectives of reality as there are people who experience that reality. In a time of COVID-19 they want to draw attention to how South Africans have diversely traversed many difficulties and battles.

While people are restricted by physical distancing, art has also connected people's ideas and experiences across countries, languages and regions. With populations around the world locked inside, the Barcelona-based Covid Art Museum (CAM), provides a platform for artists from different countries to showcase work by artists who have something to say about how society and daily life is changing as a result of the epidemic. Popular themes include creative pleas for consumers to stay home, playful takes on face masks, photographs, illustrations, installations and much more in the museum's quickly growing archive, as a free platform for art, social expression and social solidarity.

Finally, WHO has released a new story book that aims to help children 6-11 years old understand and come to terms with COVID-19, produced as a collaboration of more than 50 organizations, including the WHO, UNICEF, UNHCR, the International Federation of Red Cross and Red Crescent Societies and Save the Children. With the help of a fantasy creature, Ario, '*My Hero is You, How kids can fight COVID-19!'* explains how children can protect themselves, their families and friends from coronavirus and how to manage difficult emotions when confronted with a new and rapidly changing reality. During the early stages of the project, more than 1700 children, parents, caregivers and teachers from around the world shared how they were coping with the COVID-19 pandemic. It is being released as an online product and audio book, in English, in French, in Portuguese and other languages.