

EQUINET Information sheet 2 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
April 1, 2020

This is the second information brief from EQUINET to summarise and provides links to official, scientific and other resources as of March 30 2020 to support an understanding of and individual to regional level responses to COVID-19. *This brief complements and does not substitute information from your public health authorities.* Please read the [first information brief](#) for basic information on the epidemic. To receive future editions if you are not already on the EQUINET newsletter mailing list, please subscribe at <https://www.equinet africa.org/content/subscribe>.

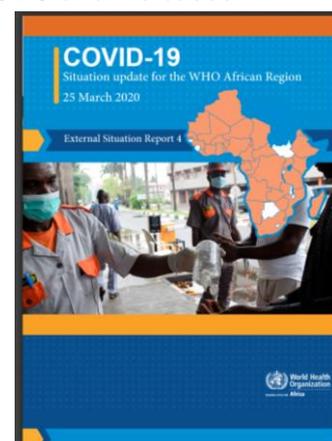
You can read the full information sheet or go to the section that is most relevant to you. This brief covers:

- [1: Developments in the COVID-19 epidemic](#)
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- [3: Policy, politics and rights](#)
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The specific focus is on the east and southern Africa (ESA) region, with information from other regions that may be useful for the ESA region or that may raise issues to discuss and plan for in the ESA region. The information is generally sourced from World Health Organisation (WHO), various official, public health and technical/ scientific sources, and from grey literature emailed to EQUINET. The source of information is cited or hyperlinked. 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@equinet africa.org.*

1. Developments in the COVID-19 epidemic

In relation to the spread of the epidemic, the [Africa CDC](#) reported that as of 24 March 2020, of the 333 393 cases of COVID-19 globally, 1988 were reported from Africa (0.6%) were reported from Africa, with a case fatality rate of 3% in the African cases. *Table 1* overleaf shows for ESA countries the cases as reported for the period ending 24 March from CDC and the cases reported for 28 March from Worldometer, using international and national official data sources. The table shows the increase in cases (doubling or more in some countries) between 24 and 28 March. While two different data sources are used, they both use official sources. This data is also likely to be an undercount of levels of infection, as the number of reported cases depends in part on the level of testing. Testing has been at low levels in many countries. For example, The [March 22 report](#) by Nigeria's Centre for Disease Control indicated only 152 people tested as of that date, compared to South Africa's [over 15,500 tests](#) done. Many ESA countries have faced a shortage of test kits and personnel, although there is report that this is being partially addressed by procurement and international contributions. Hence for example Kenya's Ministry of Health [on March 20 reported](#) plans to conduct testing of anyone exhibiting symptoms in the population. The critical role of testing in control strategies is discussed later in this section.



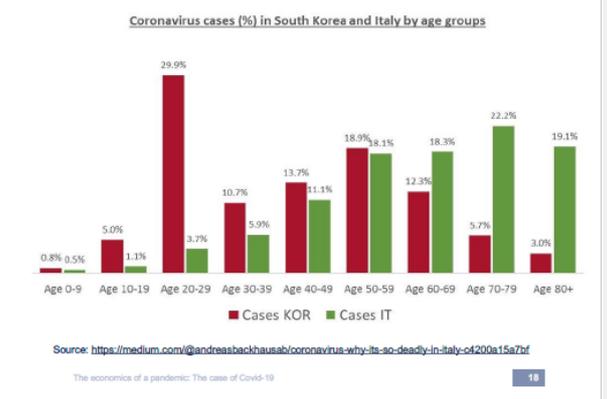
¹ EQUINET is a network of professionals, civil society members, policy makers, state officials and others within east and southern Africa (ESA) implementing research, analysis, information sharing, dialogue and learning from action to promote health equity (www.equinet africa.org). Synthesised by R Loewenson,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

Table 1 Reported COVID-19 Cases in East and Southern Africa countries 24 and 28 March 2020

Country	Total cases 24 March (i)	Total cases 28 March (ii)	Total new cases 28 March (ii)	Total cases/million people 28 March (ii)	Total deaths 24 March (i)	Total deaths 28 March (ii)
Angola	2	5	1	0.2	–	-
DRC	45	65	14	0.7	2	6
Eswatini	5	9	-	8	–	-
Kenya	16	38	7	0.7	–	1
Madagascar	12	26	-	0.9	–	-
Mauritius	36	102	8	80	2	2
Mozambique	1	8	1	0.3	–	-
Namibia	4	8	-	3	–	-
Seychelles	7	8	1	81	–	-
South Africa	554	1187	17	20	–	1
Tanzania	12	14	1	0.2	–	-
Uganda	9	30	7	0.7	–	-
Zambia	3	28	6	2	–	-
Zimbabwe	2	7	2	0.5	1	1

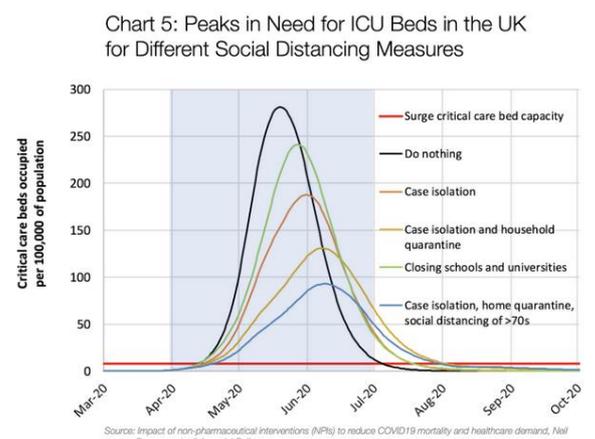
All reporting imported cases only except South Africa and DRC in 24/3. No cases reported from Botswana, Malawi and Lesotho; DRC = Democratic Republic of Congo Source: (i) [Africa CDC](#) 24/3/2020 and (ii) [Worldometer](#) 28/3/2020

WHO AFRO provides regular situation updates, the latest at time of compilation of this brief being [Report 4 dated 25 March 2020](#). These reports point to a rapid upsurge in the number of cases and geographical expansion of the disease in late March week in the region. The report indicates a male to female ratio of confirmed cases of 1.4 and a median age of 41 years, with older males disproportionately affected. Children and young people who are more commonly asymptomatic make up a minority of case reports. Yet Surico and Galeotti (2020)² cite evidence from Korea's testing of a large share of the population that indicates that most carriers there were in the younger age groups, shown in the figure adjacent.



ESA populations have a high share of young people, with only about **3%** of sub-Saharan Africa's population over 65 years old, the age group above which mortality from COVID-19 is significantly higher. This and the different background health status of ESA populations makes it problematic to use predictive models from other countries without reviewing the relevance of their assumptions. To date we have not found public information on Africa-specific modelling.

Tracking and modelling the progression of the epidemic and its projection are useful to plan measures to address it, and the length of time and resources they imply. This is particularly important when the measures chosen have economic and social consequences, discussed later. To date various models have been developed (described in the first brief), that have informed the mitigation ('[flattening the curve](#)') and suppression ('lockdown') strategies discussed in the earlier brief. For example, as shown in the adjacent graphic, [the Imperial College London](#) modelled the impact of



² Surico P, Galeotti A (2020) The economics of a pandemic: the

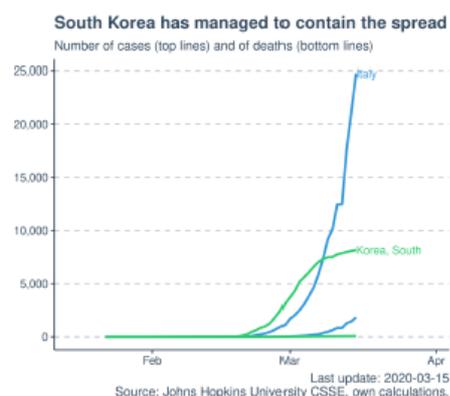
different control strategies in relation to the demand for and supply of intensive care beds. Different assumptions informed the [‘hammer and the dance’ model and strategies proposed by Tomas Pueyo](#). During the ‘hammer’, he suggests that physical distancing and lockdowns may be used to significantly reduce transmission (to get R as close to zero, as fast as possible). Then, in the ‘dance’ transmission is kept low (keeping the R below 1) by massive testing to identify and quarantine cases and contacts before they have symptoms (discussed later), population literacy to identify symptoms earlier and continuing personal distance, hand washing and disinfecting strategies, or if these methods fail, reverting to heavier physical distancing measures. More recent modelling by [Lourenco et al. at Oxford University](#) using data from UK and Italy suggest that ongoing epidemics in these countries started at least a month before the first death, and that in this period a significant number of people were infected and acquired immunity, suggesting if valid a potential of return to work for those with proven immunity.

While these models have informed strategies, they are context dependent, involve uncertainty and [may not address all the factors that affect epidemic dynamics in reality](#). This has led to some [critique of models](#), given that we do not know actual levels of SARS-CoV-2 (the virus that causes COVID-19) in the population. For example, population-wide case fatality rates are argued to be lower than those estimated from patients tested, as using confirmed cases undercounts the denominator, the number of people infected. Some models assume that COVID-19 will rise again as a seasonal epidemic, [but this remains speculative](#). Hence, while modelling makes an important contribution to planning, the assumptions and limitations need to be understood.

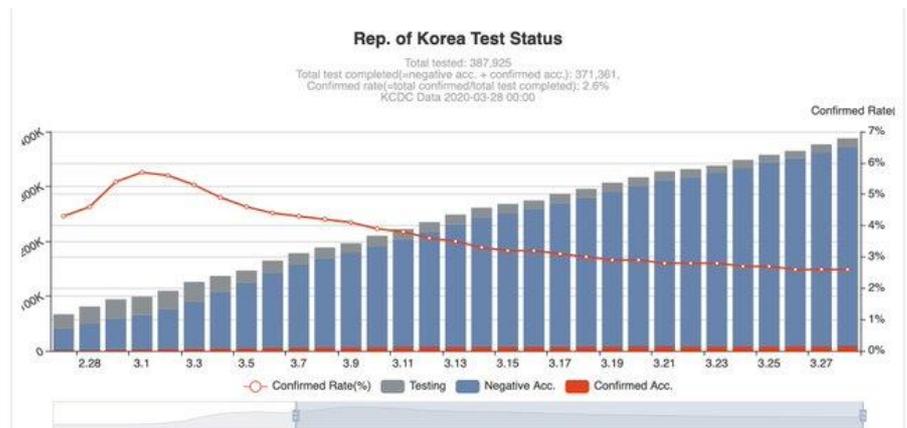
One of the common assumptions is that the virus is not changing significantly and thus that infection confers a level of immunity. This [has been challenged](#) and the duration of immunity is not known. [Studies show that there is immunity after infection, albeit with some significant unknowns](#). The antibodies the body generates after infection are what confer immunity, as they are able to fight off new infections by the same virus. With polio or measles, for example, this immunity can last a lifetime. Antibodies to the coronaviruses that cause the common cold last one to three years; in the SARS epidemic, studies indicate that immunity lasted eight to 10 years; while in MERS it lasted much less time. There is [some report from virologists](#) that immunity to SARS-CoV-2 could last one to two years and that the response in a subsequent infection may be more effective, but this is yet to be tested.

Knowing the level of immunity is important. It could guide what share of the population could return to work, if confirmed in individual tests, especially for key workers such as health workers. The tests used to confirm cases test the presence of the virus (*the antigen*), while assessments of immunity test for *antibodies* to the virus. Studies in China indicate that the antibody test only becomes positive [11-14 days after infection](#). It is thus not a good diagnostic test of *current* infection. It is a test of past infection 2 or more weeks ago. Antibody testing can, however, provide *population* data of past infection and immunity for public health planning. It indicates what progress there is towards herd immunity (see information on herd immunity in the first brief). Antibody tests have been developed and Lourenco et al. recommend large-scale serological surveys (antibody testing) to assess the level and stage of the epidemic. Such surveys can also show where within countries the epidemic is concentrated to inform more focused physical distancing strategies.

Many countries are now applying suppression strategies, with an understanding that the earlier these are applied the sooner they may lead to an effective cut in transmission (an R close to zero). Notwithstanding the variability in epidemic stages many are initially setting national ‘lockdowns’ for 21 days, with the possibility of review and extension. The choices are not simply made on public health grounds, and are also informed by the economic and social impacts and how to manage them, discussed later. From a public health perspective, however, suppression strategies on their own are insufficient, and their duration depends on what else is done. One key measure used successfully in South Korea, is **widening testing beyond people with clinical symptoms** to avoid missing asymptomatic cases that transmit the virus. South Korea’s epidemic, initially the worst outside of



China in early 2020, is now largely under control, given extremely widespread, early and efficient testing, with contact tracing, enforced quarantines and isolations of those testing positive and travel bans, as shown in the earlier figure and explained by [South Korea's Foreign Minister](#). Surico and Galeotti (2020; *ibid*) suggest that testing asymptomatic people, with a test rate of 5 500 tests per million people (compared for example to 750/million in UK), free with a doctors prescription and with active contact tracing and monitoring of infected people, including by a government app played a key role in limiting cases and fatalities. As shown adjacent, negative tests rose and positive tests fell as they controlled their epidemic. The economic help provided is discussed later.



Such widespread testing implies that beyond support for health service management of cases, there is need to ensure quality control of the detection rate of coronavirus testing kits, and to devolve testing capacities and equipment to local laboratories linked to outbreak teams.

Suppression strategies, including lockdowns, enable countries to build health system capacities, reduce fatalities and to buy time for new methods for faster, more accessible testing. A lot of innovative work is taking place on this, such as the test production in Senegal, noted in the previous brief, or reverse engineering for local production of less expensive ventilation equipment, including using [3D printing](#). But there is debate from [high income countries](#) and from [middle and low income countries](#) on the feasibility and *public health* effectiveness of *prolonged suppression* (lockdowns) without such widespread and systemic testing, given also concerns about the economic and social effects of lockdowns, discussed later. The [WHO Director General Dr Ghebreyesus](#), notes that on their own, 'lockdowns will not extinguish epidemics' and should be used as a window of opportunity to introduce other effective measures.

There is also a wider discussion that needs to be sustained even after the epidemic on what we have learned on what is needed to prevent and manage future such epidemics. This ranges from implementing specific measures [to reduce risk of transmission of emerging pathogens from animals to humans in live animal or animal product markets](#) and investing in more proactive public health capacities and systems, to addressing the underlying determinants and consequences of these epidemics, including the political economies that generate them and their unequal effects, discussed further later.

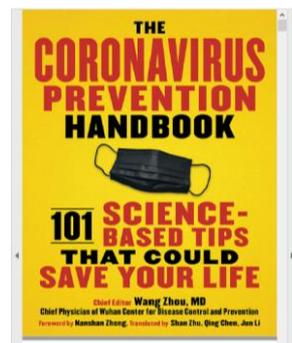
2.The health system response

Care and access to treatment: [An article mapping how the immune system responds to the virus](#) helps to explain how people in different age groups or with underlying health conditions may be differently affected, and what this implies for the health system response. A [paper by Mehra \(2020\)](#) suggests that given the different stages of this disease, how you apply treatment at which phase of the disease will affect patient outcome. For example Mehra(2020) suggests that antiviral drugs be given earlier, when people are just starting to get sick, to prevent them from progressing to the later stages, while those already experiencing the cytokine storm may benefit more from immune-suppressing drugs in combination with antivirals.

There is currently no proven medicine for treating COVID-19. In late March the WHO DG announced that a trial had started in Norway and Spain comparing treatment with the antiviral medicine remdesivir; a combination of two medicines for HIV, lopinavir and ritonavir; lopinavir and ritonavir plus interferon beta; and the antimalarial drug chloroquine.

Given active work underway to develop medicines and a vaccine for COVID-19, on March 23, Costa Rica wrote to the [WHO asking the organisation to create a voluntary intellectual property pool to develop Covid-19 products](#) to widen sharing of regulatory test data and other information relevant to developing medicines, vaccines and diagnostics to widen possibilities for production in different settings and to improve access to these products. Costa Rica proposed that the WHO develop a memorandum of understanding on sharing technologies funded by the public sector and other institutions, allowing free access or licensing on “reasonable and affordable terms, in every member country.” This adds to calls for global collaboration to ensure that any vaccine for COVID-19 be made available free for those who need it. In contrast to this demand for global collaboration, there is [report of the European Union](#) prohibiting exports of tests, pharmaceuticals, and medical devices to meet own needs. As noted earlier, widespread testing, contact tracing and quarantining is essential for the public health response (and to avoid prolonged lockdowns), yet testing levels remain low in many ESA countries. Government ministers across Africa have called for a coordinated response in the logistics and delivery of testing equipment, including through funding partners, such as the Global Fund and with particular attention to lower income states and vulnerable populations. They also called on the international community to support the upgrade of the health infrastructure and to provide direct support to the existing facilities.

WHO has published a detailed, practical manual on [how to set up and manage treatment centres for COVID-19](#).and provided guidance for health workers on [rational use of personal protective equipment \(PPE\) for COVID-19](#), covering the PPE, administrative, environmental and engineering controls to prevent transmission. There are also resources that have been developed by those working in frontline services in more mature epidemics, such as that from Chinese health workers and managers published by Hubei Science and Technology Press in Wuhan, China.



Supporting frontline services and workers: Without a vaccine or specific treatment, the [health care service role](#) in containing the outbreak is based on identifying people who are sick, bringing them to care, following up on contacts, preparing hospitals and clinics to manage a surge in patients and training health workers. The experience from Asian countries is that this calls for [strong public health systems](#), particularly in local primary care services with capable outreach services, including for the success of measures such as contact tracing. The George Institute for Global Health India [synthesised evidence](#) on prevention and control of COVID-19 for frontline workers. The findings highlight the increased risk of these workers in the course of their normal activities and their need for control measures and training. The findings also indicate that frontline personnel face disruption in supply-chains, logistics and supportive supervision and need support on how to manage this situation. They also need psychosocial support, non-performance-based incentives, additional transport allowance, child-care support and recognition for their roles to motivate them in the face of considerable stress. [Experience from the SARS](#) epidemic suggests that health-care workers experienced burnout and post-traumatic stress.

While there is guidance on what *should* be done, there is also evidence of gaps between this and reality in ESA health systems. [Public sector nurses and doctors in Zimbabwe](#), for example, downed tools in March, citing the unavailability of PPE. A private information technology-linked company in Zimbabwe, [EcoSure stepped in](#), equipping medical staff with PPE, providing life and health insurance and offering them safe transport to and from work daily, for 12 months. The Africa CDC is procuring emergency medical equipment stockpiles including test kits, PPE, thermal scanners and other critical equipment to rapidly equip countries that lack capacity. UN Secretary-General Guterres on 25 March launched a US\$2 billion coordinated global humanitarian response plan to fund the fight against COVID-19 across South America, Africa, the Middle East and Asia. Equipment has also come from international contributions.

The epidemic is, however, highlighting a deeper problem in the financing of health systems. Africa carries 23% of the disease burden, but only accounts for 1% of global health expenditure. Health services in our region are underfunded, and have been so since the macro-economic reforms associated with the structural adjustment programmes. The commitment to universal health coverage has generated discussions on improving domestic health financing, but in many ESA countries any financing innovations have not been adequate to address real declines in

budget financing from tax revenue. For COVID the demand is at the frontline, but also at the hospitals providing intensive care – both are needed. Inequalities between private and public services are pronounced at this level. For example, in South Africa, one of the highest income countries in the region, [Boyles \(2020\)](#) noted that in 2008/9, there were 3 533 Intensive care unit (ICU) beds in private hospitals serving 20% of the population, 1 186 in public sector hospitals serving 80% of the population. Public sector ICUs were reported to be already at full capacity even before the outbreak. At a time when access to a ventilator or an ICU bed is a determinant of survival for severe cases, the inequality between private and public sectors and thus between wealthier and poorer households puts the latter at a significant disadvantage unless these resources are pooled in a more equitable manner based on health need.

3: Policy, politics and rights

The COVID-19 epidemic poses a political challenge to respond effectively, in “a political culture that craves certainty and absolutes and a scientific culture that is rooted in uncertainty.”

The [Africa CDC advice](#) to member states is to enhance their surveillance systems at ports and within countries, to notify WHO and the Africa CDC of cases and to provide guidance to the general public on what to do in the event of symptoms. As noted earlier, from that basic platform there are multiple policy decisions to be taken on how to effectively prevent and manage cases, whether imported or through local transmission. [As one journalist](#) noted, this raises a demand...”to make huge life and death decisions, while driving through a fog, with imperfect information, and everyone in the back seat shouting at them.”

Policy and political choices are needed to save lives, avoid overwhelming the health system and to not destroy household and national economies in the process of doing so. Every choice made has a consequence: Do nothing and although a large majority will only have mild symptoms, ill people will overwhelm health services and vulnerable people will die. Close schools and parents may ask elderly grandparents to care for children while they are at work, raising the risk of transmission to vulnerable elderly people. Close workplaces and households, enterprises and economies lose income, sometimes catastrophically. Lockdown areas of high prevalence of COVID-19 and people may flee to less affected areas carrying the virus with them, including to rural areas where more elderly people live and where services may be even more remote.

ESA country measures: In the early stages, ESA countries implemented fever testing at borders, with checks for previous travel to highly affected countries, escalating this to compulsory quarantine or 14-20 day self-isolation of people from affected countries, then to bans of air travel from highly affected countries and finally in many countries to closure of all commercial air traffic for a defined period. Most ESA countries have suspended public gatherings, many have closed schools and recreation facilities and some have imposed travel restrictions within countries. A few (South Africa, Lesotho and Zimbabwe) initiated national lockdowns in March, while others (Kenya, Namibia, Eswatini, Madagascar) implemented partial lockdowns for specific geographical areas or times of day. Table 2 below summarises available evidence on these measures, noting the potential for omissions in a rapidly changing situation.

Table 2 Country measures for epidemic management as of 30 March 2020

Country	Measures to address imported cases	Measures to address local transmission
Angola	All international flights suspended from 20 March. Only returning Angolan nationals or permanent residents allowed to enter after having visited China, South Korea, Iran, France, Spain, Portugal or Italy since December with obligatory 14 day quarantine	No information found
Botswana	Borders closed except to citizens and residents, subject to a 14-day mandatory quarantine period in government facilities. Various airlines have cancelled flights to Botswana. Also closed a number of land border posts with neighbouring countries and only citizens and residents allowed entry.	Declared a public health emergency on 21 March. Suspended public gatherings of more than 100 people for 30 days from 16 March. Advice to members of the public to postpone non-essential travel in-country.

Country	Measures to address imported cases	Measures to address local transmission
DRC	From 20 March, all major international flight routes into and out of DRC suspended. Land and maritime borders closed and only open to cargo. Any entry on an exceptional basis subject to a 14 day quarantine in a health centre.	Gatherings of more than 20 people in public places, including religious ceremonies and sporting activities banned. Schools and universities closed from 19 March for 4 weeks. Bars, night clubs closed. Restrictions placed on the number of people per vehicle for public transport. Virunga National Park home to mountain gorillas, has shut its gates due to possible risk for the gorillas
Eswatini	From 27 March, border restrictions imposed, limiting entry and exit to citizens and residents only, subject to a mandatory 14- day quarantine in designated locations, apart from those permitted to self-isolate.	20-day partial national lockdown from 26 March with army and police deployed to ensure compliance. Measures include: Restricted movement outside of the home perimeter except for healthcare, food and banking services; non-essential travel between towns prohibited; public transport only operating for essential movements; food outlets and banks restricted to 20 people; All bars closed and off licences have restricted hours; public gatherings of more than 20 people prohibited..
Kenya	From 25 March, all international flights to and from Kenya suspended. Cargo flights excepted, but crew must observe strict guidelines. All individuals who entered Kenya between 22 and 25 March must undergo mandatory quarantine for 14 days at government designated facilities at own expense. Any person who has entered Kenya from a country with reported cases since 1 March must self-quarantine for 14 days from time of entry or until symptom-free for 14 days. Kenya-Uganda land border closed to all pedestrians and vehicles, except cargo trucks. Further closures of land borders may follow..	22 March, all bars closed. Restaurants open only for 'takeaway' services. Public places, shops, public transport set a maximum capacity to conform to social distance requirements of at least 1.5 meters. 27 March a daily nationwide curfew from 7pm to 5am during which all persons to stay at indoors, except for essential service workers. All meetings, conferences and international events banned and remote working advised. Random temperature screenings in public spaces by government and those with fever to self-isolate or taken into a state health facility. 29 March, mass testing for all arrivals in the country in the last week and mandatory quarantine with those who test positive taken to a dedicated isolation facility.
Lesotho	29 March - 21 April non-essential travel within and outside the country prohibited except for the transport of food, medical supplies and essential household goods. All travellers screened and if symptomatic placed in an isolation facility in a government hospital. Individuals who have been in affected areas in the past 14 days to self-isolate for 14 days in a government-nominated hotel at own expense.	29 March - 21 April everyone must stay at home except for purchase of food and essential household shopping or to access medial services. Schools are closed and gatherings of more than 50 people prohibited.
Mada-gascar	20 March all international and regional flights suspended for 30 days. Cruise ships will not be permitted to berth in ports for 30 days from 15 March. All individuals arriving within 14 days prior to 19 March to have a medical examination and be tested for coronavirus.	21 March a Health State of Emergency declared. Restrictions (two weeks, but extendable) include closure of all schools and universities, administrative offices, churches, event spaces, bars and restaurants. All sporting fixtures and cultural events cancelled. Public transport halted and sanitary checks established at exit points from major cities. A curfew from 8pm to 5am. 25 March all internal flights are suspended.
Malawi	All arrivals screened and symptomatic people moved into a treatment facility. Mandatory 14 day self- isolation for travellers from countries with confirmed local transmission, with more than 700 cases or more than 100 new cases in 24 hours. Only visitors with residence permits permitted with mandatory 14 day self-isolation, under surveillance by health workers if at home or at a local treatment facility.	20 March State of Disaster declared. Schools closed from 23 March. Gatherings of more than 100 people banned.
Mauritius	From 19 March a ban on entry by any travellers including returning residents.	20 March restrictions on movements throughout the country. Essential services including supermarkets and pharmacies remain open.

Country	Measures to address imported cases	Measures to address local transmission
Mozambique	Travellers from all countries with active transmission required to self-isolate on arrival for 14 days.	Gatherings of more than 50 people banned
Namibia	26 March commercial flights out of Namibia cancelled. Ports and some land border crossings closed to passengers. Entry to Namibia banned for all foreign nationals. Namibian nationals and permanent residents returning from high-risk countries required to enter supervised quarantine in a government facility for a period of 14 days.	28 March, lockdown of Khomas and Erongo regions, including Okahandja, Rehoboth and Windhoek for 21 days. All residents in these areas not allowed to leave homes unless essential, to visit pharmacies, food stores, banks or for medical reasons. Any exercise outside in groups of three or less. Restrictions on the number of persons allowed in vehicles. No social gatherings of more than 10 people permitted. The Social distancing (1 meter between people) required in all public places.
Seychelles	18 March no entry for travellers from Europe, except returning residents, and with travellers from China, South Korea or Iran put in mandatory 14 day quarantine. No marine vessel allowed to enter Seychelles waters if any passenger on board has been to the UK, EU, China, South Korea or Iran in the last 14 days. Cruise ships from any country worldwide not be permitted to berth until further notice.	15 March local contact tracing and testing began. All schools closed for two weeks.
South Africa	26 March to at least 16 April closure of South African airspace to commercial airlines. (no penalty for exceeding 90 day stay as a result of these travel restrictions). Screening processes at all major ports of entry, including airports, for arrivals, departures and transit passengers. If testing required to be done at a designated hospital and if positive followed by quarantine or self isolation	From 26 March all 'non-essential domestic travel' prohibited. Internal flights grounded and public transport not operating. Everybody required to stay at home, except to buy essential food or medicine. Only certain categories of key workers exempt.
Tanzania	Strengthened screening measures at airports for all passengers arriving into international airports (Dar es Salaam, Kilimanjaro and Zanzibar). Mandatory quarantine for anyone arriving from high risk countries, even for those without symptoms.	Public gatherings banned, schools and universities closed and sporting competitions suspended.
Uganda	From 22 March Entebbe International Airport closed to passenger planes and land borders closed except for truck drivers and a crew of up to three people.	25 March public transport (minibus taxis, buses, coaches, passenger trains, tuk tucks and motorbike taxis) suspended for 14 days. Vehicles delivering goods and food plus ambulances, security, refuse and government vehicles and private passenger vehicles carrying up to three passengers exempt.
Zambia	Pre-departure screening and mandatory 14 day quarantine in a government facility for those displaying symptoms and self-quarantine for all others for 14 days. Kenneth Kaunda International Airport in Lusaka open to international flights, but international flights suspended from all provincial airports, as well as International train and bus services.	All schools are closed. Gatherings of 50 people or more restricted. Restaurants only providing take away services and cinemas, bars, gyms etc closed.
Zimbabwe	Closure of all borders to non-residents.	National disaster declared. All schools closed. 30 March countrywide lockdown for 21 days. All required to stay at home except essential visits (for health, food). Only limited public transport operators permitted. Operators in the electricity sector, provision of water, gas, and fuel and information communication technology exempted. Anyone displaying symptoms placed in a Government facility for testing and if positive treated in a government treatment centre.

DRC = Democratic Republic of Congo Source: compiled from [Public domain airline websites](#)

These measures are not without debate. While most of the measures – not all- include exemptions on trade and cargo flows, closing borders increases the cost of supply of essential goods and limits flow of key workers, some of which may be relevant for the management of the epidemic. Closing businesses and requiring informal workers who earn a daily living from daily activities to stay at home have economic costs from household to national level, discussed later. Do too little, and there is a possibility of a backlash from vocal members of the public that expect government to intervene. They may be those more able to stockpile resources, as was the case with Brazil's [five successive nights of protests](#) in 'panelaço' (pan-banging) public expression of dissatisfaction with President Bolsonaro's approach, often from wealthier areas. Do too much, too quickly, or for too long and the harmful effects on people's lives and livelihoods may erode trust and support, especially if not accompanied by effective social support and health care.

[There is an argument that](#) the imposition of a lockdown (as a suppression measure) in late March may be well-timed to avoid the mass outflow from schools and towns over the easter holidays, taking the virus to new areas and across borders. However the duration of a lockdown calls for careful balancing of the public health measures and their socio-economic impacts, discussed later. Researchers at the University of Johannesburg³ have questioned whether 'flattening the curve' is the best approach in ESA countries, given young populations, many informal residents and workers, inadequate water supplies and income security and a health system with an extremely limited coping capacity.

Ensuring necessary government reach: Leaderships are expected to manage the epidemic effectively and strategically and in doing so, to inform and carry populations with them. [Rottenberg and Gordon](#) cautioned governments to avoid a mix of overreach in some areas and insufficient reach in others.

The [WHO DG noted on 30 March](#) that countries implementing measures that restrict the movement of people should "respect the dignity and welfare of all people...keep their people informed about the intended duration of measures...provide support for older people, refugees, and other vulnerable groups...and... ensure the welfare of people who have lost their income and are in desperate need of food, sanitation and other essential services". Governments have a duty to protect social and economic rights in the measures they take, whether in relation to health systems, safe water, basic incomes and forms of shelter, work and transport that do not expose them to risk. [Jayaprakash Muliylil, India noted](#) that this means *political leaderships not only telling the public what they should do, but also what the government was doing for them.*

Various proposals have been suggested on what that implies, such as:

- a. Using the lockdown to visibly introduce effective public health measures, to build decentralised capacities for and to expand testing and contact tracing, to improve health service capacities to manage cases and to protect frontline health workers.
- b. Communicating at multiple levels, from national government to the nation, but also from local government and community level support groups to ensure the messages resonate with people, widen population health literacy and engage communities on public health and social solidarity measures,.
- c. [Using learning from prior infectious disease epidemics](#), including from the 2014 Ebola outbreak, to set multidisciplinary task forces to direct the emergency response as an issue for all of government and not just the health sector, training frontline health workers and, as was done in DRC, rapidly erecting facilities for screening and diagnosis.
- d. Providing a range of social support measures, cash transfers, food supplies and other supports to lowest income communities; supporting employers and small enterprises to retain workers and maintain wages.
- e. Leveraging the high mobile penetration across the continent for early reporting and contact tracing, such as the software used in [Singapore for contact tracing](#) that is now being made freely available to other countries. Mobile technology can also be used to monitor the economic impacts on households, and on the formal and informal sectors.

³ Broadbent A, Smart BTH (2020) Why a one-size-fits-all approach to COVID-19 could have lethal consequences. The Conversation, 23 March 2020

- f. Increasing investment in research and technology partnerships, such as in the production of cheap, [rapid diagnostic testing](#) or ventilation equipment, discussed earlier. Ensuring that solutions developed through global collaborations are locally available, including negotiating now as a regional bloc to secure benefit-sharing of and access to new testing and diagnostic measures, to new treatments and to vaccines.

Avoiding government over-reach: When COVID-19 is posed as an existential threat, justifying actions outside the normal bounds of political procedure, it securitises a health issue⁴. Declaring COVID-19 a national emergency, as *Table 2* indicates has happened in many ESA countries, has given governments formidable executive power. [Rottenberg and Gordon](#) caution that emergency measures can be abused, may become permanent and lead to rights and democratic violations. For example, the boom in [surveillance technologies](#) enable population monitoring that may help to manage outbreaks. For example in South Korea, mobile phone usage and bank cards have been used to track people's movements. While this has been used for contact tracing and to monitor compliance with lockdowns, unless it is applied with consent it may breach privacy rights. Measures for public health, whether postponement of local elections, banning assemblies or police powers to enforce social distancing, while potentially necessary, should be regularly reviewed in line with the status of the epidemic and should not be used to curtail basic political and civil rights. While compliance with physical distancing is essential, media reports from South Africa [reporting use of rubber bullets](#) by the police service to disperse pockets of people on the street in one suburb of Johannesburg in the first day of a lockdown raise questions on use of such strong coercive methods for ensuring compliance, and whether this reflects an under-reach in community engagement.

[Experts within the UN Human Rights Council](#) observe that human rights must be maintained in confronting COVID-19, 'without exception'. They note that scarcity of resources should never justify discrimination against certain groups of patients, including people with disabilities, older persons, minority communities, internally displaced people and those living in extreme poverty, as well as people in detention, homeless people and refugees. While supporting public health measures indicated by the WHO, they indicate that states as duty bearers must take additional social protection measures to protect and support those disproportionately affected by the crisis, including the vulnerable groups above, health workers and women who bear a heavy care burden and live with a heightened risk of gender-based violence. They note that corporations have a responsibility to protect human rights, including in their role in ensuring that when a vaccine for COVID-19 is developed, it should be provided without discrimination. This resonates with a wider demand from various countries and sources that any future COVID-19 vaccine be free to everyone and that this be secured through global co-operation.

The responses to COVID at national and global level reflect a tension between collective protection and self-protection. The United Nations and WHO have framed COVID-19 [as a common threat to humanity collectively](#), requiring international cooperation between governments and global coordination of policy responses. The epidemic has, however, also been framed by some political leaderships as a threat to "[national security](#)", with [other countries or people](#) perceived as the source of threat. The response to the pandemic provides an insight on how countries will address the spectrum of global catastrophic risks, whether pandemic, climate change, mass migration and so on. [There are voices](#) raising the issue of how far emergency restraints and controls will wither away as the threat of the pandemic subsides and be replaced by more inclusive forms of social engagement and public investment to build the collective security of society and the planet as a whole, including to better manage future emergencies.

4: Support for and in different communities

Communities are sometimes positioned as 'elements of a control strategy', with concerns about their compliance, or their panic buying of food and other supplies. Taiwan had strict fines up to US\$33000 for non-compliance with home-quarantine. But communities are also active participants in efforts to build awareness of, prevent and manage the epidemic and of the solidarity support needed for this.

⁴ For example this is discussed by [Nathan Sears in the Journal of Global Policy](#)

There are many creative examples of this, such as in the 'Coronavirus alert' song by popular Ugandan musicians [Bobi Wine & Nubian Li](#), or the creative ways people have used to solve problems,



such as those shown for physical spacing or handwashing [from Nischal Rao](#) or [in public transport](#) in India.



The Friendship bench Zimbabwe have [produced information resources](#) to raise awareness on COVID prevention that can be freely downloaded. Groups have begun crowdfunding for community interventions, such as the [Zimbabwe Covid-19 Citizens Healthcare Support Fund](#).



Communities at the centre of the response: In the 'Ashgovnet' mailing list, Francis Omaswa, notes that the restrictions imposed on the movement of people between and inside the countries are time bound measures and not permanent solutions. He argues that the strategies, discussed earlier, of preventing transmission, early detection, contact tracing, isolation, treatment of new infections can only happen through closely inclusive collaborative work, that involves all individuals and households, in a 'whole of society approach'. This starts with, and is created by individuals, their families and the communities, supported, by professionals and by government providing an enabling environment and resources needed that are beyond the capacity of communities. Professor Omaswa observes that communities and community structures are the first line of defence against epidemics within an integrated, primary health care approach, and urges for political and professional leaderships to activate and institutionalize this in a public health system that prioritises health promotion and disease prevention.

Control measures need therefore to reach and be feasible for diverse communities, whether [people with disabilities](#) and their families, or as raised by the Southern African Miners Association on World TB Day in March, for vulnerable groups such as ex-mine workers, who are generally elderly, living in areas where health services are remote and who may have chronic lung diseases from their work. Communities also need support for the psychosocial effects of the epidemic. The sustained challenge posed by the outbreak, the physical distancing, the lockdowns and the [uncertainty can cause stress, anxiety and depression](#), worse so for people that have existing mental health issues. In some countries there are specific resources and [online guidance](#) to support people facing these challenges. *This is an area that is still poorly reported on in ESA countries.*

Nevertheless many initiatives are mushrooming in the region that demonstrate community activism. In Cape Town, [a rapid community response to COVID-19](#) called the Cape Town Together Community Action Network (CAN) are finding ways to keep the universities going and take courses online, volunteering in call centres and supporting prevention and social support. The collective is made up of people from public health, housing, sanitation, soccer coaches, teachers, doctors, artists and others. It connects to a broader city wide network to collectively support locally-led neighbourhood initiatives. For example, one local network did a neighbourhood mapping exercise to identify who needs help, and who has resources to share, such as the support young people provide to shop for elderly folk can stay home. Another local group is setting up hand-washing stations by the train station, and another is setting up a hand-sanitiser factory in a pottery studio.

In rural settings, such as in Uganda, **community health workers** (CHWs) play a key role. [Last Mile Health](#), a U.S.-Liberian nongovernmental organization supporting 3,500 CHWs has [developed a framework](#) for their roles in prevention, detection, and response to the pandemic. [CHWs are reported to be constructing hand-washing stations](#) at communal locations and in people's homes and are connecting with each other using Whatsapp to solve problems. CHWs

have been brainstorming with local leaders and key stakeholders to devise locally generated solutions to challenges faced in implementing prevention measures. The suggested approaches are argued to be more likely to be applied than top-down authoritarian approaches. Learning from their role in the Ebola epidemic, [CHWs are being trained in some countries](#) on COVID as trusted sources of information for community literacy and to support case detection.

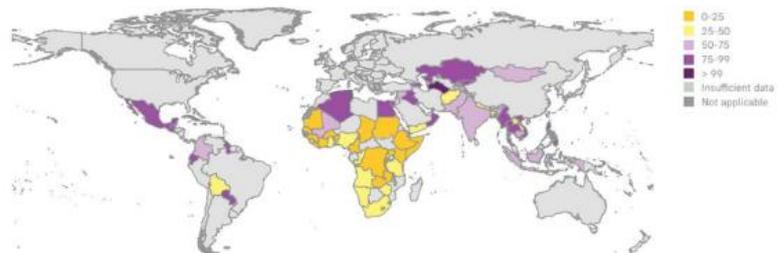
These examples point to forms of community engagement and solidarity that have begun to emerge in the region, often ‘bottom-up’. Communities also need support to play their role. *Across ESA countries this raises issues of water, income security during lockdowns and in some settings food security. Not addressing these issues leaves a significant gap in the public health response.*

Predictable water

supplies: Many urban and rural communities in the region lack predictable water supplies. Many people lack water to wash their hands with soap frequently, lack the money for hand sanitiser. World Water Day on March 22 coincided with a context in which large numbers of people lack the predictable means to implement the most basic element of the control strategy for COVID-19 -

handwashing. Of the 2.2 billion people who lack access to clean water globally, [Sub-Saharan Africa is noted to be amongst the most vulnerable](#) regions, as shown in the map above.

Map 1: Proportion of Population with basic handwashing facilities at home, 2017



Source: Progress on household drinking water, sanitation and hygiene 2000-2017: special focus on inequalities. World Health Organisation.

In some ESA countries, both urban and rural communities face this challenge. In Zimbabwe, for example, some parts of the city have not had piped water for over a decade and [Harare residents report](#) having to go at 3am to fetch water from a borehole, to avoid a queue that builds around the borehole. Congestion at boreholes raises a risk of transmission of the virus. Those using wells and hand pumps face the risk of many hands using the pumps. As long as people do not access water at the household level in areas of high population density, there is a risk of transmission of the virus. When there is not enough water for drinking, people also have to make hard choices about how to use what is available. Recognising the risk this poses, 114 civil society organisations in South Africa on 23 March 2020 called for all households, residential institutions, homeless and informally housed people to have easy access to sanitation, water and safe ablution facilities. They called for “an immediate opening of restricted water meters, mass-provision of safe water access points, with unconstrained flow in areas where there is limited household access to water and mass-distribution of safe ablution facilities to informal settlements, with soap and/or sanitizer and information on the prevention of the virus”. Differences in access to water generate an unfair inequality in risk and health outcomes between richer and poorer communities. But even wealthier communities are vulnerable. The public health response is only as strong as its weakest link, and access to water at the household level is an issue that needs immediate action during and after the epidemic. Unions and civil society organisations in the region have thus called for water shut downs to stop during lockdowns and for a mass public-works programme, to improve access in households to clean water.

Protection at work, protecting incomes: As shown in *Table 2*, some ESA countries are implementing physical distancing measures in transport systems by reducing the number of people per vehicle. The Colleges of Medicine of South Africa [NPC Guidance Document1](#) discuss the risks of congested **public ground transport**, where people spend a long time on the transport and when there is inadequate ventilation of the transport system. The guidance document includes measures for passengers and transport providers to reduce risk. Some ESA countries provide hand-washing or hand sanitizer at transport hubs, ensure physical distancing in queues, set limits on the number of people per vehicle and some screen passengers before embarkation. Transport providers should also clean inside surfaces hourly and deep clean vehicles overnight and ensure vehicle windows are open for adequate ventilation.

The first brief outlined measures to minimise workplace risk, including through remote working. The South Africa Department of Employment and Labour has for example produced [guidelines on workplace preparedness for COVID-19](#), addressing a range of PPE, administrative and engineering controls. There is some report of measures in the informal sector through collective positioning of public water points and facilities for handwashing and through physical distancing of work stations. *However, much of the guidance is focused on formal sector workplaces and further guidance and investment is needed for informal sector sites.*

While these measures may help to improve workplace safety, if lockdowns occur the challenges take on a new level. High-skilled workers in certain sectors are more likely to be able to sustain work and incomes remotely than others, such as drivers, cleaners and retail workers. Workers less able to work remotely are also more likely to have insecure incomes and to have less or no savings to fall back on during a lockdown. High income countries have introduced various measures for job retention and wage replacement of workers who, without the support, would be laid off. Some have also provided state support for continuity of state pension and insurance; similar support for self-employed workers; deferment of tax deadlines and loan measures to support businesses. These policies, bailing out people, not just businesses, [are reported to be so publicly demanded](#) that even far right wing parties feel the need to go along with them.

In ESA countries the announcement of lockdowns preceded any announcement of measures to support employment and incomes. [Kenya's government executive](#) agreed to pay cuts, with an 80% pay cut for the President and deputy, and a 20-30% pay cut for ministers and their assistants. The government has lowered interest rates, banned imports of second-hand clothing to protect domestic producers and traders, provided tax relief to low income earners, earning below \$240 and gave tax cuts to individuals, small businesses and corporations. Zimbabwe's government announced it would provide US\$200 million in cash transfers to 1 million vulnerable households. **For informal traders and producers and for small scale farmers and enterprises** having clear social protection measures is critical, as the economic consequences of a lockdown may be even more pronounced. Such people cannot afford to 'stay home' even for a couple of days, forcing them to choose between prevention measures or family survival. ZCIEA, an informal sector association in Zimbabwe, raised this concern over the livelihoods of informal traders during a lockdown and called for measures to protect their incomes and food security. *There is limited public domain information on what ESA countries are doing to support informal sector workers, despite the many full or partial lockdowns announced in late March. The next brief will give more focus to this.*

Civil society and technical institutions have also raised demand for improved measures to protect working people, as the basis for protection and for economic recovery from lockdown measures. In March 2020, the South African Federation of Trade Unions (SAFTU) called for a Basic Income Grant and more timely and effective 'draw-down' on the country's Unemployment Insurance Fund for those who lose their incomes due to physical distancing and lockdown policies. [The South African Institute for Economic Justice](#) has similarly called for support for households, communities, workers and businesses, including through:

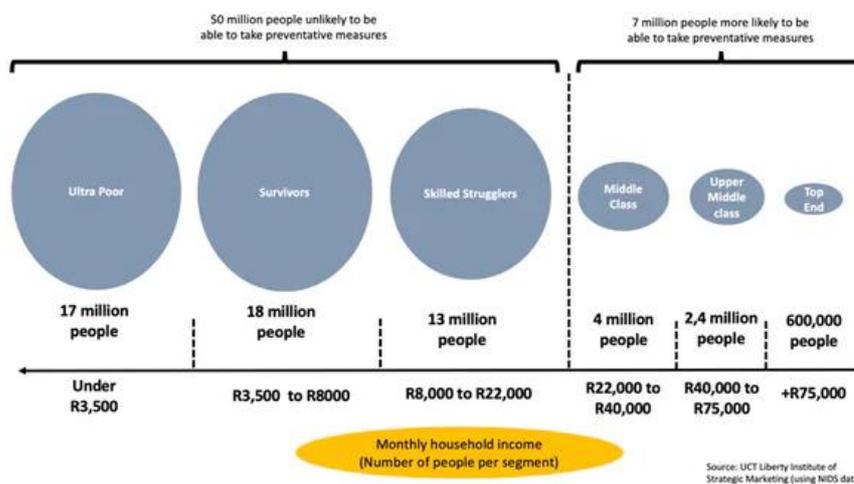
- a. Household support through an emergency universal basic income (UBI) grant; free basic services, reversal of austerity cuts to funding of public services and free mobile data and public internet access;
- b. Support for those, especially women, providing unpaid care work due to the closure of schools and creches and to care for ill people, through increased child support grants, CHW support; access to safe water, safe childcare for ill people and food distribution schemes. Male relatives should step-up and shoulder a greater share of caring responsibilities.
- c. Workers, including temporary workers, having paid sick pay if self-isolated or in quarantine, with protection from loss of employment and benefits and increased level and length of unemployment benefits where job loss is unavoidable.

Inequalities in high prices and scarcities: There are existing challenges to **food security** in the region, including from poor rainfalls in Southern Africa and the desert locust infestation in East Africa. When it comes to [maintaining food systems during the pandemic](#), while farmers may need to be oriented to prioritise the provision of local markets instead of global supply chains, it has been argued that the relatively younger workforce and more robust urban

and small-scale agriculture may protect against food insecurity. However, there is a caution to increase attention on urban areas.

High food prices and scarcities, including those created by stockpiling may affect urban areas. For the lowest income households a lockdown may undermine the income needed for basic levels of food security. A paper explored the winners and losers of the panic buying [took place in many countries in the wake of COVID-19, with evidence from South Africa](#). In the week of 16-20 March 2020 in South Africa there was a large shopping spree marked by daily shortages in many categories. The authors note that wealthier households have the resources to stockpile, while the majority of South Africans do not (see the graphic adjacent from the paper). While inequality exists everywhere,

wealthier economies have a population base that is generally more capable of stocking up their homes when needed. Those who have less capacity to stockpile are also more likely to use public transport, to face food shortages and to have to make more trips to secure smaller quantities of supplies, if available



In South Africa, new [regulations](#) compel retailers and wholesalers to ensure adequate and equitable stock and distribution of essential goods and services, and to keep goods and services affordable, with penalties for those who raise prices to profiteer. Civic organisations, trade unions, organisations of informal workers, faith-based organisations and community structures in South Africa called for direct cash transfers to vulnerable households; a coordinated and safe roll-out of food packages directly to distribution points in food-stressed neighbourhoods and support for locally-organised food systems.

These community impacts may if poorly managed translate into their own negative health impacts, in undernutrition, diseases of poverty, mental disorders, violence and suicide. Taking a public health measure like a lockdown thus needs to be carefully balanced against and address the consequences for economically vulnerable communities. For high income countries fiscal and austerity policies that were treated as without challenge are being cast aside in putting in place measures to address these consequences. Will the same be possible for ESA countries?

5: The macro-economic challenges

As countries with more mature epidemics implement lockdowns of 21 days or longer, [various sources raise](#) that the stricter and more prolonged the lockdown, the deeper the macro-economic consequences, the more the demand to fund the social protection measures discussed in the previous sections. For health, isolation has positive externalities. For the economy, isolation has negative externalities.

There is an assumption that individual governments will mobilize the necessary resources by borrowing. How do ESA governments fund the support measures for health systems, households, workers and enterprises? How far will ESA countries be affected and how far can they borrow and have the *fiscal space* to do so? How will the impacts in high income countries and investor response to COVID affect ESA economies?

Macro-economic impacts and immediate responses: Surico and Galeotti (2020; *ibid*) note the economic impacts already emerging in more advanced epidemics in high income countries. They include a decline in stock markets; in flights and in tourism and restaurant and car sales; a disruption in global supply chains and consumer product activity; an investor search

for safe havens such as in gold trading and oil price declines. These *supply shocks* are projected to be followed by falling demand, as workers lose jobs and income; households increase precautionary savings and firms lack liquidity to invest. In a negative loop this then further affects supply, with firms dependent on cash flows lacking liquidity to fulfil commitments filing for bankruptcies and workers who lose jobs from businesses closures further depressing demand. They suggest that this negative loop would lead to a global recession, with significant losses in GDP. Not all are suffering losses: wealthy investors who sold stock before the decline make money, online order firms and supermarkets have seen escalating demand as have delivery companies and remote conferencing software have seen stocks rise, such as Zoom which had a sharp increase in its stock price during the first few months of 2020.

The measures to support enterprises, workers and households are thus not simply for social protection- they are also to mitigate macroeconomic decline. They include measures to

- a. Ensure that households have funds through controlling price increases, preventing job retrenchment, providing income support and tax relief.
- b. Supporting enterprises, especially small enterprises that forms the bulk of business in ESA countries through tax holidays and rebates; cutting interest rates; providing cash grants and supporting wage replacement for worker retention
- c. Ensuring public spending on health services to avoid impoverishing point of care costs

These are all identified as 'now and massive' measures to match output losses and to prevent significant economic decline. Governments in Europe that promoted austerity and rigorous fiscal targets, often with declining health system capacities and social protection, have abandoned these targets and announced significant areas of spending on these areas. For example, the UK announced a package worth about 15% of GDP.

[Kenya's executive is reported, for example, to have slashed liquidity ratios and lowered interest rates.](#) [South Africa's Institute for Economic Justice](#) estimated that South Africa's GDP could contract by between 1.8 and 7% and called for economic stimulus measures that support households and communities, protect workers, sustain businesses to lay the foundation for economic recovery. They call for policies to control capital flight, and measures that not only respond to the crisis but that can support the long-run transformation of the economy. This includes investing in the local production of emergency equipment and supplies that can be bought by the state locally and exported; putting more people to work if conditions allow in a massive public works programme on prevention, social welfare and health-care functions, investing in a high quality, decongested public transport system, shortening work hours, and a sequencing of fiscal stimulus measures to advance an environmentally-sustainable structural transformation, such as by prioritising 'green' investments in economic and employment recovery packages as part of a Green New Deal.

What options for resourcing economic strategies? Surico and Galeotti (2020; *ibid*) report that wealthier high income countries are borrowing to meet these measures, especially given currently low interest rates, backed by central banks using their own reserves and printing money. But what are the options for ESA countries?

Some ESA countries were already off course of the 8% GDP growth needed to meet global targets under the UN's Sustainable Development Goals, and talks in Addis Ababa aimed at completing the African Continental Free Trade Area scheduled to launch on July 1 have been postponed. The [United Nations Economic Commission for Africa \(UN ECA\)](#) observe that African countries are two to three weeks away from the worst of the epidemic and estimate an emergency economic stimulus of US\$100 billion to be needed for the combination of prevention, health system support and social measures needed. [A rapid scan of budget mechanisms by WHO personnel](#) identified ways in which public spending can be reprioritised toward bolstering the health system, households and the economy, if governments identify:

- a. **The immediate spending actions** on first measures that can be taken with existing budgets, such as by reprioritising through virements; halting non urgent spending and activating contingency funds;
- b. **How to secure further budgets** for the response through revisions in finance laws and use of emergency budgets to overcome more time consuming appropriation laws; including with emergency regulations to authorize urgent spending for an immediate response within existing budgets through simplified approval mechanisms, grouping supplementary

expenditures and line item budgets into a pooled budgetary programme / temporary lump sum budget line dedicated to the response and capable of receiving supplementary funds from private and public sources; and

- c. **What can be done to accelerate budget execution and funding reaching the frontlines**, such as by providing flexibility in execution rules, providing advance payments and adjusting control procedures (using ex-post and/or focus on high costs that are more susceptible to fraud) to enable increased budget transfers to sub-national levels and purchasers and delegating authority for healthcare spending with rules on use of funds for the response.

While these measures relate to *existing* budget resources, the measures discussed earlier to meet health system, household, enterprise and macro-economic stimulus needs call for significant *new* resources. Where will this come from?

The standard public spending cutbacks and devaluation measures don't apply. Countries that seek to self-protect against economic shock by imposing negative spillovers on other countries ignore the reality of globalisation connecting all. Various options are thus being proposed and pursued, even while public health debate continues on how deep and wide any 'lockdown' should be and what measures need to be implemented to shorten it, given the level of income insecurity in ESA country populations.

We have the means- Debt relief and return of outflows: The widest call is for suspension of debt interest payments, with some calling even further for debt relief and for recirculating the money that is fleeing ESA countries back to them. To put this in context, [ActionAid](#) note that many low-income countries are now spending over 20% of their government revenue on repaying their debts, with Angola spending over 55%. [This is decimating public spending](#). Those countries with debt repayments of over 13% of government revenue are showing falls in per capita public spending, while those with debt payments below 13% of government revenue are showing rising per capita public spending. The associated International Monetary Fund (IMF) measures such as public sector wage and employment freezes have led to deficits in health service personnel, despite health need. These debt payments are extracted at a time when the net extraction and outflow of resources from Africa are estimated to lead to an annual net loss of US\$150 billion from the continent⁵. They are lost in illicit financial flows, diverse forms of resource extraction not matched by reinvestment of the profit drawn from that wealth, natural capital depletion and damage from pollution.

[UNECA indicate](#) that almost half of the funds needed for prevention, health services and safety net measures could come from [waiving interest payments](#) to multilateral institutions. African finance ministers have thus [called for the suspension](#) of debt interest payments, while also waiving the principal and fragile states. An immediate emergency economic stimulus needed of US\$100 billion could in part be met by a waiver of all interest payments, estimated at US\$44 billion for 2020, not only of interest payments on public debt, but also on sovereign bonds.

The World Bank and the International Monetary Fund have [expressed support for this debt relief measure](#), applying a debt relief and aid mechanism such as that used during the 2014 Ebola epidemic. [The World Bank and IFC approved in late March a US\\$14 billion package of fast-track financing](#) to assist companies and countries in their efforts to prevent, detect and respond to COVID-19. However when David Malpass, head of the World Bank, linked support of a suspension of all debt payments for the poorest countries to the implementation of free-market economic policies, it was noted by the Jubilee Debt Campaign and [Overseas Development Institute](#), amongst others, that this is in direct contrast to the sharp rise in state intervention taking place in high income countries and that lenders should not be putting conditionalities on emergency assistance at a time like this. If relief is not available, Bond (2019) argues that debt default is necessary, and that the IMF should redesign its existing Rapid Financing Instrument to meet current needs. [South Africa's Institute for Economic Justice](#) add that financing the range of economic measures needed will also require solidarity taxation; introducing prescribed assets; greater borrowing; crowding in private-sector funds; leveraging non-state public-funds, and greater contribution from wealthy enterprises and households.

⁵ Bond P (2019) Luxemburg's critique of capital accumulation, reapplied in Africa *Journal für Entwicklungspolitik*, Vienna

International solidarity and regional co-operation as a necessary element: A number of other measures are being taken and discussed, with some debates on their implications. For example, there is general agreement that the private corporate sector and the private health sector should contribute to the response, not least by cancelling dividends to shareholders and protect job security and wages. [A letter from the WHO DG, the Secretary-General of the International Chamber of Commerce \(ICC\) and Saudi Arabia chair of Business 20](#), was sent to G20 Heads of State and Government on the private sector contribution prior to their virtual summit in late March. The letter called for improved *experience sharing* and monitoring, avoiding short-sighted trade restrictions on medicines and other health technologies; encouraging private sector support of government services for both diagnostics and surveillance, managed by national authorities; ramping up production of necessary health technologies and addressing pricing, import tax, quota, hoarding, air cargo and other government-imposed costs and logistic barriers impeding medicine supply chains. The letter also calls for co-ordinated and streamlined investment in R&D and a significant scale-up of financial assistance to fund public health programs and broader social and economic interventions in low income countries. While many of these measures resonate with those called for in ESA countries, there is concern that any private health sector participation be by participating private hospitals being placed under government control; and that R&D outcomes not be subject to patent monopolies that undermine access in low income countries.

The response in ESA countries evidently needs to combine national, regional and international responses, including to ensure that principles and measures being applied in high income countries are also applied in their interactions at global level. The shared concerns in ESA countries with those [in other regions](#) suggest that there is also scope for south-south dialogue and co-operation in forging a solidarity driven global response.

We are constantly told that viruses do not respect national borders. The epidemic is testing the capacity and relevance of our regional and global institutions. A **coordinated regional and global strategy** would be far more effective than each country acting by itself, to enhance the procurement and local production of health and other technologies, to effectively engage with the many cross border interactions and liabilities in our region and to negotiate on global issues such as external debt or access to vaccines.

6: What does all this mean for equity?

Equity issues infuse all parts of the information presented in this brief.

To start with there is **social inequality in the factors that make people susceptible to exposure and more vulnerable to the severity of infection**. This is found in the lack of safe water supplies to wash hands, in overcrowded public and private transport systems and living conditions and in the immune systems weaknesses due to recurrent diseases of poverty and undernutrition that many low income communities face in ESA countries. It arises from work in dusty, poorly ventilated working environments, air pollution from traffic and cooking fuels that elevate the risk of respiratory diseases, asthma and occupational lung diseases that make people more susceptible to severe effects of the virus. We have known that these factors make people sick for nearly 200 years, but continue to live in a world and a region where they are the reality for a large share of people globally and in our region. Yet, as [Kapczynski and Gonsalves \(2020\)](#) point out, as the epidemic spreads and affects daily life in the richest countries in the world and the richest communities in poor countries, there is a realisation that epidemics like COVID affect all, even if the poorest get the worst of it. Unless communities are to live in a state of sustained lockdown, exposure to a virus like SARS-CoV-2 follows the various ways different countries and communities intersect over work, trade, travel, domestic and public life.

Second there are **social inequalities in access to effective health system responses to COVID**. In ESA countries the underfunding of and weaknesses in public health services already have worst impact on vulnerable poorer communities. This includes those in urban areas and those earning poverty wages in work who cannot afford the costs at point of care of private providers or the contributions to private insurance schemes. This is not

only the case for low income countries: it is also [true of low income communities and marginalised groups in wealthy countries like the USA](#) who do not have universal health insurance and whose access to health systems depends on what they can pay. In ESA countries public health and primary health care outreach have played a key role in improving health equity. They have, however, faced widening deficits as budgets have fallen for public health services, while a small share of the wealthier people have used costly and largely segmented private care services or travelled to other countries for care. Yet here too a lesson is emerging that it is the public health infrastructure that keeps *all* healthy and safe, and that prevention is primary.

The absence of safe water at household level at a time when handwashing with soap is the major means that people have for personal protection; the delays in access by health authorities and local services to testing kits at a time when public health knowledge makes clear that testing is a critical element of an effective public health strategy; the deficits and inequalities in access to PPE for health workers and ventilators, medicines and other commodities for health services and the escalation of prices for commodities like hand sanitisers and face masks when need for them grows signal fundamental flaws in our systems for the protection of public health.

Researchers in China⁶ raise how in that country, government and insurers guaranteed that the out-of-pocket medical expenses of all patients suspected and confirmed to have COVID-19 would be subsidized by the government, removing financial barriers to care. Yet even with a well-resourced, comprehensive and highly organised public health response, there were issues of equity in access. Social media provided an important platform to alert to cases and link to hospital care, but excluded elderly people and others less well connected online. Lower community capacities and mobilization in more deprived regions are suggested to have been a bottleneck to reporting and care. The researchers note that any management strategy for the epidemic needs to be alert to and to gather evidence, including from community sources, to tackle health inequities during the COVID-19 outbreak. In their words: *The scarcity of health-equity assessment during the current outbreak will halve the disease-control efforts*. They also indicate that health equity should be at the center of policies designed to strengthen future social, health system and emergency responses to future public health events.

Thirdly, there are **social inequalities in the burdens resulting from COVID and indeed from the control measures used**. This begins in the almost invisible burden of care workers and women at home who care for people under physical distancing, the invisibility of undocumented migrants in some countries that fear exposure and are excluded from care systems, or the hidden vulnerability of retired workers with occupational lung disease.

UNFPA discusses how pandemics such as the current one make existing inequalities worse.⁷ In relation to gender, they note that women represent 70% of the health and social sector workforce globally, that increased household tensions during lockdowns and physical isolation may raise the risk of domestic violence for women and girls, and that women's front-line interaction with communities and their participation in much of the care work raises their burdens and risk of exposure. Their roles also mean that they have experience and learning to positively contribute to the design and implementation of responses and that they should be involved in doing so.

The brief describes further how public health measures such as lockdowns differently impact the self-employed, specific groups of formal workers and small enterprises and traders who are more dependent on daily or weekly earnings for survival and have less possibility of remote working than many higher income professionals. If their livelihood, food security and social protection are not addressed, they may not adhere to lockdowns at risk to themselves, their families and those they serve.

As Anand Giridharadas is quoted by Kapczynski and Gonsalves (2020): *Your health is as safe as that of the worst-insured, worst-cared-for person in your society. It will be decided by the height of the floor, not the ceiling.*

⁶ Zhicheng Wang and Kun Tang Research Center for Public Health, School of Medicine, Tsinghua University, Beijing, China.

⁷ UNFPA (2020) Technical brief: Protecting sexual and reproductive health and rights, and promoting Gender equality UNFPA, New York

Given this, [it is argued that](#) the most marginalised and vulnerable should be at the core and not the periphery of policy design. This would seem to apply as much to the design of policy responses globally, as it does within countries.

A demand and opportunity for change: The determinants of inequality in exposure, in the experience of health systems and in socio-economic burdens and access to social and income protection are highlighted in various parts of the information brief. There has been evidence in some countries globally of unjust responses, such as in communities blaming and victimising ‘foreigners’, in efforts by one country to buy exclusive access to vaccine developments and in communities with the resources to do so to panic-buy and overstock basic supplies.

It is not difficult to get buried in the outpouring of evidence, information and experiences that COVID-19 is generating. Yet some issues come through relatively strongly from the information in this brief. *There is deep concern on the harm of ‘lockdown’ measures that do not address social, income and economic protections and on the inadequacy of such measures if they do not use the time to organise resources and capacities for wide testing, contact tracing, quarantining and treatment. There is concern that political leaderships not only tell the public what they should do, but also what the government is doing for them, and that communities and frontline workers are recognised and supported as the first line of defence in any epidemic. There is urgency to address the outflow of resources from ESA countries, including through debt repayments, to fund the measures for health and social protection and for economic recovery. There is alarm that inequalities will grow within and between countries unless these issues are addressed, despite the lesson that everyone’s health is as safe as that of the poorest, worst-cared-for in society.*

Yet equity, solidarity and social justice are also implicit in many of the proposals and actions raised in the brief. It is argued that [pandemics can also catalyze new thinking and social change](#). Governments have dropped austerity policies that they clung to as inevitable. Businesses have enabled [working from home](#) that they previously rejected. The consequences of underfunding public health services and health workers is suddenly real for everyone. The brief presents some report of how countries that experienced the Ebola epidemic were able to respond more quickly to health needs. Asian countries that had lived through SARS are also reported to have public consciousness about epidemics that stimulated a more rapid response.

There is already a discussion growing, perhaps still somewhat muted by the enormity and experience of the immediate, of what this means for the future, for ending austerity and investing in a green and community-led transition with recognition of workers’ rights, secure jobs and social protection systems that sustain people even during times of crisis and with public services treated as essential public goods. [Researchers at the Grantham Institute and London School of Economics](#) noted that the response to the 2008 financial crisis exacerbated inequality as mitigation resources flowed to the wealthy, including with a boost to the industries driving climate change. In contrast, the economic recovery that will need to follow COVID-19 could focus on green investments that have greatest and widest public benefit, including between countries globally.

Trade unions under SAFTU observed in their March press statement that COVID is forcing a relook at the old mantras of exporting raw materials and deindustrialising manufacturing. They question whether the current neoliberal model can simply be tweaked to address the scale of the crisis that COVID poses for the region, when it has in part caused the worsening inequality, precarious labour, capital outflows, underfunded and commercialised health systems and utilities and the ecological crises that make communities vulnerable to epidemics and that undermine states’ capacities to respond.

This information brief highlights that even with the uncertainty of COVID as a new epidemic, we have the knowledge for actions such as providing safe water, ensuring wide access to testing and case tracing, equipping health services, protecting health workers, securing jobs and incomes and supporting business. SAFTU suggest that what we need to remember and reflect more in the choices made that “we are who we are through each other”.