

ESH

ENVIRONMENT, SAFETY & HEALTH
AFRICA

Women in Safety

INSIDE

Women in Safety

Gender Safety: Exploring Gender Safety
Issues Faced by Professionals
in the EHS Field

Sexual Harassment in the Workplace

The Challenges of Maintaining
OSH in Zimbabwe

The State of Deskless Workforce:
An Eye Opener Needing
our Collective Action

and more...

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It is estimated that every year over 1.1 million people worldwide die of occupational injuries and work-related diseases. In developing countries, the risks that foster ill-health are estimated to be 10 to 20 times higher than in developed countries. In developing countries, only about 10% of workers have access to occupational health services. In Africa, occupational accidents and diseases can cause economic devastation to families, businesses and communities. Safeguarding workers' safety and health is paramount and an integral part of our social and economic development. With the emergence of global trade and increasing informalisation of the workplace environmental, safety and health matters are secondary to survival needs that focus on accelerating the growth, productivity and profitability.

It is on this basis that ESH Africa is determined to promote the lifting of standards, compliance and perception across Africa. This will be achieved through information, training and awareness.



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Are you **Coping?**

With many of us still working from home, we may be overwhelmed by the stress that comes from remote work. Working from home may blur the boundaries between work and family responsibilities, as we struggle with more household chores and caregiving duties. This places additional strain on our wellbeing and productivity. Have you assessed the risks that the New Normal has placed on your workforce? Perhaps now is the time to contact us for help.

In the past, the employment experiences of men and women was different, because women and men were often found in different occupations. Men tend to predominate more visibly heavy and dangerous work, where there are high levels of injury. Women, on the other hand, tend to work in areas where work-related illness arises from less visible, long-term exposures to harm.

Traditionally, health and safety emphasis has been on risk prevention in visibly dangerous work largely carried out by men in sectors such as engineering, construction, and mining, where inadequate risk control can lead to fatalities. Hence you find that work equipment, tools, and personal protective equipment have been traditionally designed for the male body size and shape.

Thanks to the global movement on gender equality which have seen women getting employment in male dominated industries over the years with some managing to score managerial positions. However, women have had several challenges in these professions because of their physical, physiological, and psychological differences from men. Even in the same workplace, with the same job title and carrying out the same tasks, men and women experience different demands, exposures, and effects.

The **Women in SHE** publication is aimed at highlighting these **obstacles and challenges faced by women** and how they can be managed to **promote gender-sensitive approach** that acknowledges and makes visible the differences between male and female workers, identifying their differing risks and proposing control measures and ensure that the health, safety, and welfare of all workers is protected. This is ESH Africa Magazine 3rd issue.

Happy reading to you all.

by Cecilia Mashingaidze

Women in Safety

“When talent meets passion”

By their very nature, women are caring, compassionate and protective, innate qualities which resonate with the desired attributes of a Safety practitioner. Practitioners in the field of safety, health and environment must be able to show genuine concern for people, their well-being and uphold the fundamentals of sustainability. Women in Safety exhibit a classic example of talent meeting passion.

The journey for women in Safety

Women in safety started as a rarity, but the turn of the 20th century saw women trickling into previously male-dominated territories within industry and commerce. The reasons for their exclusion prior to this era remain debatable but can be largely attributed to the patriarchal society which existed, where women were mainly confined to the home and other roles which society deemed to be menial and subservient. However, these societal pressures did not deter some women in making great strides in the field of Safety. Whilst history is awash with male inventors who made invaluable contributions to the world, we owe a significant amount of safety innovations to the women who not only pushed boundaries but did so whilst facing gender base discrimination and fought legal battles for their work to be recognised. Anna Connelly in 1887 was credited with inventing the fire escape which formed the foundation for emergency response systems and building by-laws which are still applicable in contemporary times. Rachel Carson's Silent Spring in 1962 launched environmental movement and awakened concerns for ecotoxicology. The hope for humanity to emerge from the COVID-19 pandemic currently lies with large scale vaccinations and one of the pioneers behind the biotechnology of RNA synthesis is Katalin Kariko.

Success stories

Hard work, networking and an armour of thick skin, has provided an opportunity for some women to become the biggest names in the field of safety, health and environment. Women are actively involved in the Plan, Do, Check, Act cycle of the Safety career as they are playing a significant role in safety, health and environmental innovation, policy formulation, systems implementation, compliance and regulatory management.

The success stories of the following women are an inspiration to the next generation of leaders.

- **Fumni Adegbola:** MD/CEO of Combined Training Solutions Ltd – a leading HSE training and consulting firm in UK and Africa. Founder and President of the Society of Women in Safety, Health and Environment.
- **Dr Eve Gadzikwa:** Director General and Secretary to the Zimbabwe's sole standards and quality assessment and certification organisation Standards Association of Zimbabwe.
- **Theodora Rondozi:** Director of BESA Zimbabwe with over 18 years of experience in ISO systems training, consultancy and auditing.
- **Rumbidzai Kamkazingeni:** SHEQ Manager, Shamva Gold Mine.
- **Juliana Kundiona:** SHEQ Manager, Lafarge Cement

Challenges

Male-dominated industries and occupations such as Safety are particularly vulnerable to reinforcing masculine stereotypes that make it difficult for women to excel. Women working in Safety face a variety of challenges including societal expectations and beliefs about women's leadership abilities, pervasive stereotypes such as the caring mother or office housekeeper who are left to do the administrative jobs compared to their male counterparts.

Mentoring and career development activities are also a mostly a preserve of the male Safety practitioners as leadership roles are mostly occupied by men who easily identify with their fellow male subordinates.

There is a general perception that women should be protected from hazardous environments as they are weak and vulnerable. This ideology presents a challenge for women in safety as they are discouraged from visiting work areas identified as high risk thereby inhibiting them from adequately dispensing of their duties. For example, some women in mining seldom visit areas such as the bottom of the shaft to carry out inspections as these are deemed too risky and unsuitable for them.

Societal pressures still exist and continue to be a major impediment for women in Safety in their quest to break the glass ceiling in their careers. In typical African societies, women are still expected to carry out child-minding and housekeeping chores which makes it difficult for them to work in industries such as mining in which they will be required to be away from home for a significant amount of time. The pressures result in women leaving their jobs in order to satisfy the societal construct.

Women also suffer from what can be termed an "imposter syndrome" in which they are generally viewed as incompetent and that they occupy these roles because of luck, sympathy and being cherry picked for other reasons unrelated to their abilities.

Advice to the aspiring SHEQ Practitioner

My experience has allowed me to be a specialist in SHEQ systems management and a generalist in the industry as I have had a chance to appreciate the mining value chain of different precious minerals. With the support of my mentors, I made it and it is not a glass ceiling for me but a diamond one.

Way Forward

- The girl child should be encouraged to take up a career in Safety through career guidance.
- There is need to harness the support of Captains of industry to take a lead in promoting equal opportunities for employment and career advancement.
- Recruitment policies should embrace gender diversity.
- Creating a conducive environment for and establishing facilities for women to carryout their maternal duties whilst at work, for example, making improvements on maternity leave, establishing lactation camps and day care centres.
- Development of societies and professional bodies for recognising and empowering women in Safety.

Be bold, be attentive, do your best!

by Hellen Wanjiku

Gender Safety: Exploring Gender Safety Issues Faced by Professionals in the EHS Field

“Being the only woman in the EHS Department, my male counterparts always expected me to handle the serving of teas and lunches for the department’s guest trainers and auditors. I wanted to sit, network and pick the guests’ brains.”

In this modern world that preaches equality for all and even has Gender Equality as one of its global goals under the UN Sustainable Development Goals, a close look into the topic within the EHS profession is paramount.

Though the words “gender” and “sex” are widely interchangeable with the difference often been overlooked, it is important to define what gender really is so as to give perspective to the topic. Gender is defined as the socially constructed roles and behaviours that a society typically associates with males and females. Gender can also refer to one’s identity as female or male or as neither entirely female nor entirely male. In contrast, sex is defined by either of the two main categories (male and female) into which humans and most other living things are divided on the basis of their reproductive functions. Therefore, whereas we are broadly defined as either male or female in terms of sex, we can be a whole array of identities under gender.

In the African setup, it was socially expected that males carry out the tough jobs because they were supposed to be strong whereas females were socially expected to carry out lighter duties around home making and nurturing everything around them. The advancement of gender equality in the workplace has been met by a strong pushback which is the traditional gender socialization as well as socially acceptable sexual orientation amongst diverse persons.

The field of Environment, Occupational Health and Safety (EHS) is very diverse with different specializations within the profession. These specializations include but are not limited to: Occupational/ Industrial Hygiene, Fire Fighting, OSH Specialists, EHS Advisors, Compliance auditors/inspectors, EHS Trainers, Occupational nurses, Emergency Responders, Safety engineer, Security managers amongst others. While there are challenges that are unique in these different specializations in the profession, there are those that are experienced across the board by almost all professionals in the field.

Some of the common EHS issues faced by professionals in the field include veteran syndrome, acquisition of proper PPE especially for people on either extremes i.e. 10th and 90th percentile of body types/sizes, the working environment or the hazards present, physical violence as well as work-related stresses.

One of the most common challenge faced by males in the profession is physical violence. In recent years, there have been recorded incidences of physical violence meted against men in the profession; particularly EHS Officers in the construction industry. Another common challenge is the traumatic injuries that are common in the profession. While most workplaces identify psychological trauma as an effect of injuries/accidents and provide for necessary support, it is still uncommon to find male EHS professionals

seeking help because of the societal conditioning that “men should not talk about their emotions”. Other challenges faced by men include normative expectations relating to masculinity/ hyper-masculinity, “moving presentations” and women bosses.

With EHS being more of a male dominated field, there are more perceived challenges for females. Acquiring fitting PPE tops the list of challenges faced by women in this field. Most manufactures tend not to focus on female's smaller fit for shoes. Furthermore, protective clothing tend to be made considering the male physique then made a size smaller for females. This does not put into consideration the wide array of curviness amongst women as well as pregnancy friendly PPE.

Lack of/insufficient mentorship and support programs for females is a major challenge too. There are not as many women in the field that are well advanced in their careers. There is poor retention of women as time goes by in this field. As such, young and upcoming women do not have enough women who can hold their hands. Of course this is improving as years go by. It is also common for women professionals in the field to be overlooked in support programs such as scholarships and professional trainings as most employers have the notion that the investment in the woman will be “lost” when they leave the organization and/or profession.

Cultural beliefs have also been a hindrance to the women in this field. In most African communities, it is considered a taboo or bad luck for a woman to go into a mine or the surrounding areas. This has negatively impacted the professional growth of female EHS professionals that find themselves in such industries.

Societal expectations of the role of women has also been a challenge. While there has been enormous efforts on pushing females to follow their dreams, the expectations that surround their lives outside work have been a big impeding factor. Women are expected to be fabric that holds together the family unit, support the spouse and take care of the children. This may be challenging to females whose work sites are

away from home such as in the mining industry. Additionally, some workplaces might have odd working hours such as night shifts and weekend work; all which require a representation from the EHS department. Women in the EHS roles might feel torn between their professional duties and their family duties.

Other challenges that females in the profession face include: sexual harassment and absence of/weakened reporting systems, skepticism and misconceptions on their abilities, gender bias, imposter syndrome, gender pay gap that often demoralizes females, female under-representation in leadership positions as well as different perception of risks.

In addition to the issues faced by either males or females, individuals in the profession who identify themselves as being in the LGBTQIA community face unique gender specific challenges. These challenges include discrimination e.g. for opportunities, violence, sexual harassment and even sexual assault.

While the issues discussed here are not complete and there might be many more gender-specific challenges faced by professionals in the field, there are some solutions suggested from some of the issues raised. These solutions include emboldened recruitment and retention efforts especially for women, manufacturing/sourcing for fitting PPE that adequately protects the user, formalized mentorship and sponsorship programs especially for women, diversity and inclusion in workplaces with more women in leadership, properly defined workplace violence, zero tolerance policies to prevent behaviours like sexual harassment and violence, building emotional intelligence (EI) capacity by all as well as provision of support systems/programs for traumatic experiences that might occur in the workplace.

When differences are taken into account so as to address challenges faced by different groups of people, everyone benefits. This is not about special treatment. If groups of people do not have a voice at the table, then their perspectives are lost; along with the opportunities to protect the workforce at large. Diverse perspectives are needed for diverse problems.

Guidelines for Gender Mainstreaming in Occupational Safety and Health

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1

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RESEARCH

Occupational safety and health research should properly consider gender differences.

by Tarisai Muchini

Sexual Harassment in the Workplace

Sexual harassment in the workplace has remained a topical issue. However, people have different views as to what sexual harassment is, what it consists of and what needs to be done when one is sexually harassed at the workplace. Vulnerability to sexual harassment within the workplace has been construed to affect both men and women, however the risk factors for women appear to be more adverse. There has been growing consensus on the link between power dynamics and sexual harassment within the workplace. Sexual harassment within the workplace, is construed to be not primarily about sex, rather it concerns power and control. Sex is described as the facilitating factor for perpetrators to exert and exercise power and control over a victim in a work setting. Sexual harassment isn't something that just happens because of fleeting circumstance or desire. It is driven in all sectors by imbalances in power. Men hold far more positions of power in all sectors of the economy. Even in female-dominated fields, men are more likely to be supervisors, principals, and managers. In the Zimbabwean society, the patriarchal system, has led to more men occupying strategic positions which allow them to exert power and influence over women. This has led to recurring patterns of exploitation, which are further reinforced by social norms and weakened response systems which fail to protect the most vulnerable.

Adolescent girls and young women have been disproportionately exposed to the scourge of sexual harassment in the workplace. At the very start, their potential for employment is not measured in regard to their acquired skills, qualifications or experience, rather senior cooperates often look at the potential to which a young person may be exploited. It often begins

with the little things, the subtle comments on how they look, how they dress, walk or talk, all of which give off the impression that their competence is based on aesthetics. Sexual harassment in the workplace can take many forms, such as, a completed or attempted non-consensual sex act for example, sexual abuse, abusive sexual contact, for example, unwanted fondling or non-contact sexual abuse for example threats of sexual violence, conduct that produces a hostile work environment, pervasive telling of lewd sexual jokes and unwelcome, abusive, or harassing misbehaviour. This makes it difficult to easily identify acts which constitute sexual harassment.

The notion of gender dynamics is embedded in sexual harassment within the workplace. Sexual harassment also includes gender-based harassment, which is hostile behaviour that is devoid of sexual interest but is undertaken because of the gender of the target. Sexual harassment and violence are a symptom of a greater epidemic of gender disparity, as well as other inequities in our society that impact workplace culture. Examples of gender-based harassment include: a female or male colleague being called derogatory names basing on their sex, making sexist comments, jokes that are derogatory to women, men, or lesbian, gay, bisexual, and transgender individuals or comments that women do not belong in management or leadership positions, or other comments based on gender stereotypes.

The confluence of gender and sexual harassment has become well defined. The socially ascribed roles between men and women often form the basis of power relations within the workplace, and this has culminated in one group being subjected to more violations than the other.

Allovertheworld,indevelopedandunderdeveloped nations alike, cases of sexual harassment are neglected or unreported altogether. The reason why these problems have remained as an invisible pandemic for so many years is that women still compete in environments where male sexuality dictates their values. Particularly for non-elite women across the world, the prospect of facing sexual harassment while climbing the ladder to success is widely accepted as an inevitability, or even as standard practice. Most women still have little awareness of their own rights and often do not realize that they are a victim of sexual harassment. When confronted with the ethical dilemma of succumbing to a supervisor's sexual advances versus losing promotion opportunities, most women ultimately choose to give in.

Despite social progress in terms of legal protection and equal rights, women still assume a lower-status role in many traditionally patriarchal societies around the world. Regardless of one's affluence or social standing, women are often subconsciously expected to serve men, either as domestic or sexual objects, which results in the normalization of sexual harassment at the workplace. Anti-harassment policies and one-off training designed to limit employer liability do not adequately confront power and control and its impact on the workplace, especially when compounded by broader societal inequities. While high profile cases start much-needed conversations in mainstream media, we can't forget about the millions of incidents that go unreported because the victims and perpetrators are not famous.

Issues relating to sexual harassment are further exacerbated by generational conflicts as older individuals, both men and women alike, are generally more unfeeling towards the concept of sexual harassment and gender equality compared to young people. In Zimbabwe, most older people often see, gender equality or equity as washing away cultural values. It is therefore difficult to get support for women when they face sexual harassment, when the societal belief in itself, holds high the standard that women should be confined in the household. The support from older generations matters, especially in Zimbabwe, where the older generations have more access to strategic decision-making positions, affecting policies and procedures relating to sexual violence.

In terms of the law, Discrimination against women is defined in international law, particularly the Convention on the Elimination of All Forms of Discrimination Against Women, as any distinction, exclusion, or restriction made on the basis of sex that has the net effect of denying women their human rights on an equal footing with men in any sphere of life. Section 24 of the Zimbabwe Constitution is an aspirational guarantee of the right to work under national law. In light of this provision, Section 65 grants everyone the freedom to work and specifically mentions the right to fair and safe methods and standards. By definition, sexual harassment is a breach of the constitutionally protected right to fair labour standards, as well as a violation of the law. The Labour Act [Chapter28:01], whose major objective is to regulate the employer-employee relationship, guarantees the right to fair and safe working conditions. By inference from Section 8(h), which prohibits unfair labour practices, the Act narrows the definition of sexual harassment. Engaging in unwelcome sexually determined behaviour toward an employee is prohibited under this rule Sexual harassment falls under the category of unfair labour practices, with the following penalties: discontinuation of the practice, remuneration for such acts, and criminal penalties for the perpetrator. All of the prescribed treatments, however, are insufficient Section 4 of the Public Service Regulations S.I 1 of 2000 provides for "discourteous behaviour" during the course of duty, which includes sexual harassment, for personnel in the public sector. Discourteous behaviour is defined as disrespectful, ill-mannered, or impolite behaviour in the context of the Regulations. Sexual harassment is not clearly defined in the regulations; however, it is mentioned in the context of forbidden conduct.

Employers, coworkers (especially men), unions, and advocates must analyse their workplace culture for gaps in gender equity, consistently train on bystander intervention, and adopt best practices in prevention that assure confidentiality and protections against retaliation. Only then will workplace culture shift away from the silence and alienation that fosters sexual harassment and violence, and move toward accountability, respect, equity, and safer workplaces for all.

After COVID-19 Vaccine Jab

Do not panic
about the side
effects

Use your
vaccinated arm

Keep your
vaccine card
(Do not
laminate)

Rest up and
stay hydrated

Adhere to
covid-19 control
measures

by Nonhlanhla N. Yalala (OSH Practitioner)

The Challenges of Maintaining OSH in Zimbabwe

Occupational safety and health performance in Zimbabwe has not been good for the past 5 years with the average annual injury frequency rate sitting at 3.00 with the highest lost time injury frequency rate (LTIFR) recorded in 2018 at 3.58 (NSSA, 2019). The country recorded a total of 5,082 serious injuries and 49 fatal accidents in 2019 with an LTIFR of 3.42.

ITEM	2016	2017	2018	2019
Serious Injuries	5,364	5,007	5,965	5,082
Fatals	63	65	70	45
LTIFR	3.22	3.00	3.58	3.42

Adapted from NSSA Annual Reports

CHALLENGES

Production changes taking place

Zimbabwe has experienced unprecedented production declines in recent years due to a myriad of problems including but not limited to lack of re-tooling etc. The results of this decline have therefore led to a dualistic production system characterised by a poorly capitalised and unregulated small scale and/or informal sector and a formal sector concentrating on primary processing of mining and agricultural goods (Karanja et al, 2003).

Which have led to new occupational safety risks ...

The proliferation of the informal sector brings about a whole new set of chemical, psychosocial and physical hazards. As labour markets have been liberalised, it has shifted towards more insecure forms of employment and a reduction in real wages for those in the informal sector mainly (Loewenson, 1997). Regulation and enforcement of regulations in this sector becomes difficult for authorities leading to non-provision of services in this area. Even the most comprehensive reporting system may not be able to cover them.

Which are poorly monitored or reported ...

As most of the businesses found in the small-scale sector are family run ones, they tend to function outside the main regulatory framework for occupational safety and health. This means that they are rarely supervised. Where they may be covered by the law, they hardly meet registration requirements, such that any incidents occurring in their line of work are not reported and therefore compensation may be unavailable. It may be difficult to deliver services the way they are delivered in the formal sector. In the formal sector, monitoring of occupational health practise and outcomes is poor. Most organisations do not conduct environmental monitoring; doctors may not be collecting comprehensive occupational histories when attending to workers.

Leading to OSH not being prioritised in planning . . .

When there is a general lack of systematic data collection on OSH performance in an organisation, occupational safety and health outcomes may not be included as factors in production decision making. This results in lack of prioritisation when programme planning is conducted by the organisation. Regulation is necessary in any set up, it is deterred by the low levels of penalties obtaining currently. It has therefore resulted in it being an insufficient mechanism to coerce organisation into investing meaningfully in OSH systems management. The use of penalties to coerce organisations and as a reactive mechanism to a system failure is an indicator of failure to incorporate OSH into the core activities of an organisation.

Inadequate surveillance of occupational diseases has led to them being underestimated

There has been a general under estimation of occupational disease contraction and disease related fatality in the system over the years and this has been a major source of information bias in reported data. Pneumoconiosis is recorded in the country as the law (Pneumoconiosis Act Chapter 15:08) requires employers to undertake testing for employees for fitness to work in dusty occupations. Very few organisations are recording other occupational diseases and those who report have somewhat comprehensive occupational health systems available with qualified personnel manning them.

Contract labour

Contract labour is in 2 faces i.e., employers taking workers from outside their premises to do work for a short period of time e.g., from a few days to up to 3 months at a time and the other one where organisations outsource certain jobs and tasks such as cleaning to an intermediary or head contractor who has some employer responsibilities towards the workers supplied. The first group of contract labour contributes to accidents and injuries statistics due to several factors including:

- Lack of work procedures induction, on the job clothing, team briefing/team talk and close supervision.
- Lack of knowledge in safety and health hazard identification procedures resulting in work attempts that may have poor outcomes e.g., operating machinery without authorisation.
- Induced fatigue resulting from work intensity due to working more hours in trying to finish or achieve set targets
- Lack of physical fitness due to malnutrition because of low wages leading to occupational injuries and diseases.
- Lack of safety and health controlling monitoring mechanism and reporting procedures.

The second group of contractors also used to contribute to the poor OSH performance of companies but an innovation by the organisations has tried to reduce these by demanding that contractors show proof of competence of their employees, proof of OSH training of employees, they are registered with the relevant authorities, have a safety coordinator amongst the team to do work on their premises, show proof of OSH structures in the organisation, provision of PPE/C etc. This has assisted NSSA in supervising small enterprises and has greatly encouraged the uptake of OSH services by these contractors.

What can be done?

All is not lost, OSH management can be strengthened and improved through several initiatives, but it requires a multistakeholder approach to achieve it. There is need for effective risk control which emphasises the need to deal with the work environment (engineering controls) organisation of work (administrative). OSH promotion must be included and form part of the core business of planning and implementation in production investment.

We need to invest in stronger legal standards. The current legislation is currently fragmented resulting in difficulty in enforcement in certain quarters of the economy. Legislative reforms must address the inclusion of coverage in all workplaces including the informal sector. Local Authorities and various stakeholders working with small scale industries can be roped in to play an oversight role in the informal sector on behalf of the regulatory authority as these have databases of the informal workers and where they are situated. A partnership in this direction would enable delivery of OSH services to this sector thereby enhancing their regulation.

Combating the underestimation of occupational diseases requires a partnership with public health practitioners. The country has over the years offered training through the OSH Division in NSSA to public health practitioners on the recognition and recording of occupational diseases. The Nurses and Doctors Courses run by the division have been instrumental in skills imparting to practitioners both in the private and public sector. The problem lies in the population vs staff ratios for key categories of occupational health practitioners are far too high to offer meaningful service.

Investment in occupational safety and health professional development would also alleviate problems in staff development of key OSH practitioners. OSH professionals include occupational safety professionals, engineers, inspectorates, occupational nurses, occupational medical practitioners, and occupational hygienists. Currently, Zimbabwe does not offer speciality courses to cover the needs of these professionals hence they need to access such in South Africa. Strides are being made by Universities in Zimbabwe to introduce these courses with namely NUST now offering a Masters in Environmental Health.

For contract labour usage, there is need of the establishment of a well-defined legal status for independent contractor and contract labour. A more systematic approach to supervision, control and enforcement of rules and laws to combat contract labour abuse. Establish an efficient system of contract labour spot control by increasing labour inspectorate.

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How are you
disposing your
face masks?
Is it the
safest way?



by Ehi Iden (OSHAfrica)

The State of Deskless Workforce: An Eye Opener Needing our Collective Action

I have worked within the field of Occupational Health and Safety for over 2 decades, the most interesting part of this profession is the dynamism and quick unearthing of new subject areas. I find this exciting above everything else.

A short while ago, I came across a report titled **“The State of Deskless Workforce 2021”**, the word “Deskless” caught my attention and made me read the entire report which opened my mind to a new dimension of knowledge.

To a great extent, I have lived with the knowledge that some people work in spaces where they do not necessarily sit behind a system or the luxury of having a desk, but I never knew they were an already categorised population of global workforce that falls within this bracket. According to the 2021 report from Quinyx, 2.7 billion workforces are deskless and this is nearly 80% of global workforce. These workers are so important, they are the heroes that keep our lives and economies running, they are the frontline workers found in healthcare systems, delivery drivers, bartenders, grocery store workers, security personnel, janitorial service workers and workers from manufacturing companies etc.

A deskless worker can be defined as anyone who does not sit behind a desk or computers to perform their job. These set of workers played a very crucial role during the pandemic when many countries were on lock-down, they did not have the luxury of working from homes instead they were daily on the roads serving us all and ensuring life goes on even when 22% of them do not feel safe at work because of COVID-19. They have been described in some studies as the forgotten workforce, underserved with technology and poorly managed by their employers. The deskless workforce honestly deserve to be better managed, have fair work schedules and a better work-life balance. As documented in the 2021 report, 51% of deskless workers go to work sick because they cannot afford to take time off, 21% do not feel appreciated at work, 57% said their personal care time suffers due to work schedule while 50% reported noticing understaffing issues mostly when you have to cover for a staff who did not come to work yet without an extra pay, these all put together affects these set of workers in a number of ways. These can also be linked to the high staff turnover suffered by organisations where this set of workers are employed.

As stated in this report, 29% said they had to leave their jobs because of lack of notice in scheduling changes, I have personally seen this happen severally in the years I spent managing hospitals. We should not forget; workers feel more comfortable and secured in places where they feel appreciated and cared for. Because they are mostly not considered in the use of technology in their workplaces, communication between managers, staff and colleagues can therefore suffer. One key question that should be asked is, are this set of workers also considered in the future of work? While we make apps, cloud platforms and SaaS offerings for desk-based workers, only 1% of business spending currently focus on deskless technologies. This was again validated with the 43% who said Managers do not have a tool or mobile app that makes it easy to swap shift with colleagues. It will be ideal to see more investments made in this direction towards alleviating most of the threats currently faced by the deskless work population.

Only 23% of deskless workers have paid sick time while 51% go to work sick because they cannot afford sick time off. Majority of them hardly have time for recovery from ill health because there is no paid sick time, and this has a high possibility of triggering employees' burnout and increased stress. It is high time that opinion leaders and wellbeing policy experts started lending their voices to the plight of this category of workers in terms of fair labour policies and flexibility of work. As already documented in the 2021 report, 35% of the workers said they would rather have flexible schedule than higher pay. This is the extent of these concerns.

Allowing employees to have control over their jobs is a strong ingredient towards mitigating psychosocial risks, human beings are not robots, they need that freedom to be expressive and if this is not happening, their creativity will be dampened, and this is not in anyone's best interest. Deskless workers who feel pressured to take shifts that they do not want was placed at 37%, while 32% of workers are unable to swap shifts with co-workers except they have to call their managers first as reported by 55% of the study population. I think this has a high degree of contributing to presenteeism and rate of accidents among workers, optimal performance in workplace has a lot to do with the psychological readiness of employees and this must be clearly understood by both employers and line managers.

Motivation and incentive programs are mostly found lacking in most workplace management systems where profits are prioritized over the safety, health, and wellbeing of employees. This report also shows that 50% of respondents noticed understaffing issues, mostly when you must cover for workers who are absent from work without an extra pay. This body language again shows lack of care towards employees, we must keep in mind that employees flourish and make sacrifices in systems where they feel cared for and not otherwise. Also in this report, this has clearly obvious with 21% of the workers reporting that they do not feel appreciated at work and of this percentage of workers, 58% of them further indicated that their employers see them as disposable hence they contact workers during off hours for scheduling issues as reported by 79% of the population surveyed. This has a huge negative impact on employees' morale and self-esteem leading to high staff turnover. I am happy to see some countries already putting up legislations that do not make employees accountable to respond to official emails after work hours. We have seen France being documented in 2017 as the first country to sign into law the "Right to Disconnect". Under this law, the employee is not obligated to respond to emails from employers after work hours. We have seen countries like Philippines, Spain, and a few others implement this law while countries like Belgium, The Netherlands, Luxembourg, India, Quebec, and the Federal Government of Canada have all proposed laws considering adopting this right.

We really need to draw a clear line between personal time and work time, it is disrespectful to encroach into employees' personal time which most times are done even without any consideration.

The truth is, when we read the entire Deskless Workforce Report 2021, you will agree with me that these are indeed the underserved majority who are neither considered in technological investments by organisations and in some instances, they are also poorly legislated for in most countries, yet they are a nerve in global growing economies. Can thought leaders, captains of industries, policy makers, labour administrators, technology inventors and many others sit back for once and consider these sets of people in our designs, policy formulation processes, management systems and business processes? It is better to consider their plights now and find ways around mitigating them than having an aged, retired population of over 2 billion people characterized with work related illnesses to deal with in the future.

We can be good leaders if we consider empathy in our management systems and this will go a long way in reducing the prevalence of most of these workplace conditions such as stress, burnout, poor work-life balance, understaffing and non-flexible work schedule as rightly highlighted in this report. The need for a safe and decent workplace culture that places value on humanity above everything else. The deskless workforce are people we see daily around us, if we cannot fix their issues, let's not also make their conditions more difficult for them by treating them less than humans. Empathy is placing yourself in another person's shoes, apathy is showing lack of interest or concern in another person's condition. If we must fix this growing concern, we all need to show honesty and agree that this is a workplace problem.

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SAFETY SPEAKERS ZIMBABWE

- *Are you passionate about Health and Safety?*
- *Do you have a story that changed your life and would want to share it to help prevent similar accidents and others recover from their situations?*

WHO WE ARE AND WHAT WE DO

We are workplace injury survivors who can come to share our story with your employees through safety presentations. We are willing to assist you on your journey to safety by sharing how a personal injury transformed our life and affected many others. While we are not safety experts, our safety presentations provide you a better understanding of the real-world impact of workplace injuries and encourage you to reexamine your safety obligations.

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by Lawrence Zinyoro

Women in SHE VS Leadership

Women are the primary caretakers of children in every country of the world. International studies prove that when the economy and the political organisation of a society change, women take the lead in helping the family to adjust to new realities and challenges. They are likely to be the main initiators of outside assistants and play a significant role in easing changes in family life.

The role of women is defined as the front and end of the chain of improvements, women are not restricted only to improving the community and family's long-term capacity but have a greater role to play in the workforce, since they contribute a median share of 45.4% of the global workforce.

Reviews from an article **“Gender Shouldn’t Matter, But Apparently It Still Does”** by Jack Zenger and Joseph Folkmen (2012), showed that women in leadership are equally effective as men. Women are as competent as men in the workforce, however, in the field of safety women can be a rare face particularly in leadership roles. Failure to reach mentorship has been attributed to the lower percentage rate for women gaining leadership positions in their respective professions.

Adele Abrams a certified mine safety professional and president/owner of a Washington based law firm focused on occupational and mine safety and health in an article encourages women saying:

“Network, network, network. Look for ways to be involved in associations to improve your visibility. It seems like women must be more qualified somehow to hold the same position. My answer is become more qualified, get your professional certification. Get your OSHA instructor card. That gives you some portability so you can move a little easier from one industry to another or one employer to another. Keep your skillset current. Go to things like the National Safety Council Congress and the educational sessions. Go to professional development conferences. Through networking you hear what companies are more favourable to women, what obstacles other people have met, how they circumvented those obstacles to be successful. For the older women, be a mentor. For the young women, seek a mentor. It doesn’t have to be a woman, but you may find that they will be more helpful to you.”



**Women
are as competent
as men in the
workforce.**

by Robert Mandeya

Women and Safety in the LPG Industry in Zimbabwe

With the rise in the consumption of LPG energy in the households, women in Zimbabwe have become the biggest users of LPG for cooking yet they are generally not involved in the LPG supply chain safety programmes. Traditionally, many women's income-generating activities in Zimbabwe such as food processing, depended on their labour and thermal energy, therefore, the introduction of LPG in Zimbabwe as an alternative source of energy must be equally matched with increased safety consciousness among the most group of users of this vital energy.

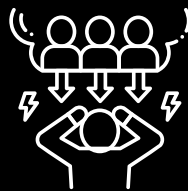
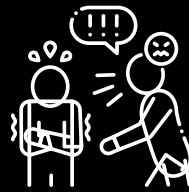
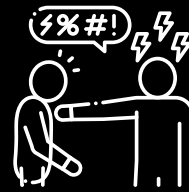
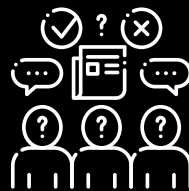
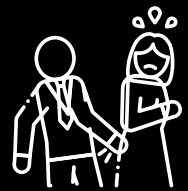
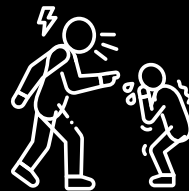
Used correctly, LPG is one of the safest, cleanest and most sustainable energy sources currently available, yet issues of safety in the consumption of this vital source of energy by this critical group (women) of our population has not been seriously considered. Women and Safety concerns are some of the most important issues LPGSAZ seeks to address in the LPG industry. The issue of women and access to modern energy services is real. Therefore a focus on energy and women's health is critical for reducing domestic accidents, child mortality and improving maternal health in a tangible, scalable, and sustainable way. One of the many ways we can meet the national target of providing safe, clean and reliable access to alternative energy is transitioning to domestic and industrial safe use of Liquefied Petroleum Gas (LPG).

Furthermore, LPG produces none of the smoke and soot that can damage the lungs of families as that faced when using coal or wood. Therefore, safety issues, related to the consumption of LPG need to be addressed head on for the sake of women who have become the greatest consumers of LPG energy in the households. That means operators in the LPG industry must make women and safety a strategic priority if they want to promote safe, sustainable consumption of the LPG and in turn attract profitability. LPG penetration for Zimbabwe households now sits at about 10% and this is set to increase given the growing demand for LPG due to urban residential expansion, shortage of thermal energy and rise in environmental protection concerns. However, the gender gap in the safety profession appears to be wider as few women are involved in the design and roll out safety programs particularly in the LPG industry.

If players in the LPG industry want to truly address issues of safety in the consumption of LPG and enjoy the benefits of increased use of this alternative energy, then they must make sure they are including women in safety programmes as to promote confidence and encourage proper use of LPG in the households and industry. At the same time, approaching safety from a gender point of view will bring a different perspective from the women side of things which will enrich efforts in dealing with safety issues in the industry.

Robert Mandeya is the interim President of the Liquefied Petroleum Gas Safety Association of Zimbabwe (LPGSAZ). He can be contacted on admin@lpgzim.co.zw, www.lpgzim.co.zw

Know if you're being violated.



by Elingah Magada (NSSA)

Managing the COVID-19 Infodemic at the Workplace

The COVID-19 pandemic has not just created a health and socio-economic crisis but an information crisis as well. Since the onset of the pandemic there has been an overabundance of both factual and non-factual information on all aspects of the virus, that is, information pertaining to its origins, causes, transmission, prevention and treatment. Additionally, much of the information is also often contradictory and confusing that it makes it increasingly difficult to distinguish between facts and fiction. Consequently, this creates an information crisis that has a detrimental effect on people's decisions and behaviours regarding their safety and health which further propagates the pandemic. This phenomenon is known as an information pandemic or an infodemic.

What is an infodemic?

The World Health Organization (WHO) defines an infodemic as, "an overabundance of information- some accurate and some not- that makes it hard for people to find trustworthy sources and reliable guidance when they need it," (<https://iris.paho.org>). This phenomenon usually occurs whenever there is a pandemic. It is a resultant effect of frequent changes and gaps in information, particularly during the early stages of a pandemic, when very little will be known about it. These information gaps and changes give way to myths, misconceptions and conspiracy theories which lead to misinformation and disinformation about the pandemic. Misinformation is the unintentional spread of inaccurate information while disinformation involves its deliberate creation and propagation which puts people's lives at risk (Sell *et al*; 2021).

In light of the COVID-19 pandemic, technology has been a significant driver of misinformation and disinformation- internet and social media platforms have made it easier and faster to circulate information globally. Furthermore, the social isolation due to the pandemic has led to an increase in internet and social media use which means daily billions of people are being bombarded by inaccurate information about the pandemic.

Impact of the infodemic on the COVID-19 response in workplaces

The infodemic poses a significant impediment to the effective management of the COVID-19 crisis. This puts the safety and health of workers at risk as it:

- Affects management's decision making and response to the crisis. An infodemic makes it difficult for management to identify reliable and trustworthy information for guidance which may lead to delays and/or errors in decision making and crisis response.
- Reduces workers' confidence in public health interventions e.g. most organizations' efforts to promote COVID-19 vaccination as part of their return to work strategy have been countered by anti- vaccine conspiracy theories. These conspiracy theories have contributed to vaccine hesitancy/resistance among workers.
- Alters health seeking behaviours - it leads to delayed health seeking behaviours among workers as they resort to unproven, fake or even harmful COVID-19 remedies before seeking professional medical help.
- Increases at-risk behaviours - certain myths and misconceptions about prevention and treatment of COVID-19 may trigger false

confidence exposing workers to at risk behaviours e.g. increased use of alcohol and/or cannabis to prevent or treat COVID-19.

- Triggers panic and anxiety leading to mental health issues - some of the conspiracy theories create a sense of doom and hopelessness which may lead to stress and depression among workers.
- Promotes stigma and discrimination – e.g. conspiracy theories on the origins fuelled social stigma against workers' of Asian descent.

Infodemic Management - workplace interventions

In light of the impact of the infodemic at the workplace, it is crucial for organisations to recognise it as a serious threat to their COVID-19 response. While it may not be possible to prevent or eliminate it entirely but organisations can put in place interventions to minimise its impact on their COVID-19 response. These interventions include but are not limited to;

*Identifying and using **trusted and authoritative** sources of information in health and risk communication and management.* Sources can be persons such as health experts who are well knowledgeable on COVID-19 or health authority bodies/organizations (domestic and/or international e.g. WHO, Ministry of Health etc), websites, literature etc.

Intensifying risk communication - provide frequent, real time and factual information from trusted or authoritative sources. It is important to **repeat and reinforce** this information to promote understanding of the pandemic. Risk communication should persist even during periods of lockdowns and alternative working arrangements. Avoid entirely leaving workers to look for information on their own as this makes them susceptible to misleading or inaccurate information.

Direct workers to factual and authoritative sources of information. Organisations may need to educate and provide workers with a list of authoritative sources on the pandemic.

Build workers' resilience to misinformation and disinformation. This can be done by enhancing health and digital literacy. It empowers workers with the knowledge and skills to distinguish between facts and fiction and authoritative and non-authoritative sources of information. It also empowers them to act on and propagate factual information and, conversely, to resist acting on and propagating misinformation or disinformation.

Finally, it is also important to *promote and maintain worker engagement* to strengthen joint efforts in curbing the infodemic at the workplace - remember workers should not be considered as passive recipients but active partners in infodemic management.

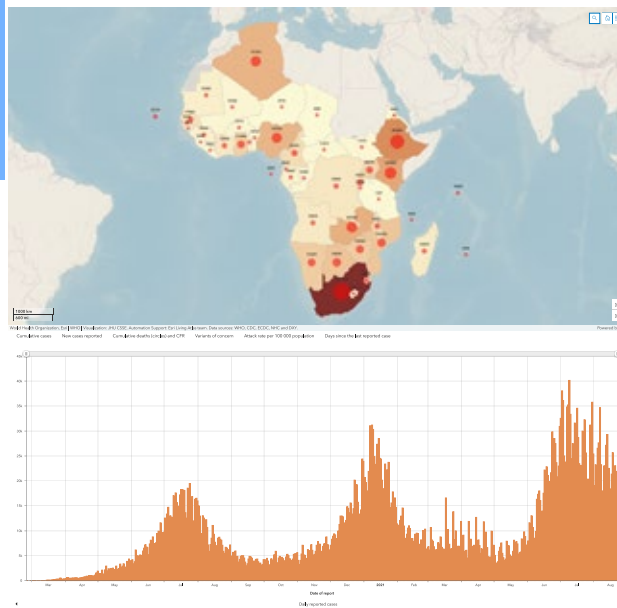
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Last update: 8/23/2021, 2:00 AM

WHO African region
 **5,411,063**
 Cumulative cases

Last 24 hours
 **17,738**
 New confirmed case(s)
 **386**
 New deaths
 **130,308**
 Cumulative deaths
 **4,833,767**
 Recoveries (cumulative)
 **446,988**
 Active cases



African continent
 **7,510,385**
 Cumulative cases

African continent
 **189,197**
 Deaths

African continent
 **6,649,821**
 Recovered

South Africa
 10,748 new cases reported.
 2,690,973 cumulative cases (49.73 % of all the cases in the region).
 Attack rate of 4746.18 per 100 000 population.
 12,111 cases on average last seven days, 18% of change in the number of cases last seven days (as compared to previous seven days).
 170 new deaths reported, 79,421 cumulative deaths with a CFR of 2.95%.
 2,444,409 cumulative recovered (90.84% of cumulative cases), 167,143 active cases.

Uganda
 817 new cases reported.
 98,270 cumulative cases (1.82 % of all the cases in the region).
 Attack rate of 200.34 per 100 000 population.
 164 cases on average last seven days, 12% of change in the number of cases last seven days (as compared to previous seven days).
 14 new deaths reported, 2,960 cumulative deaths with a CFR of 3.01%.
 95,310 cumulative recovered (96.99% of cumulative cases), 0 active cases.

Ethiopia
 785 new cases reported.
 295,504 cumulative cases (5.47 % of all the cases in the region).
 Attack rate of 262.16 per 100 000 population.
 1,204 cases on average last seven days, 7% of change in the number of cases last seven days (as compared to previous seven days).
 8 new deaths reported, 4,561 cumulative deaths with a CFR of 1.54%.
 269,132 cumulative recovered (90.98% of cumulative cases), 22,111 active cases.

Kenya
 446 new cases reported.
 229,009 cumulative cases (4.23 % of all the cases in the region).
 Attack rate of 437.75 per 100 000 population.
 315 cases on average last seven days, 58% of change in the number of cases last seven days (as compared to previous seven days).
 30 new deaths reported, 4,497 cumulative deaths with a CFR of 1.96%.
 212,036 cumulative recovered (92.59% of cumulative cases), 12,476 active cases.

Ghana
 627 new cases reported.
 114,584 cumulative cases (2.12 % of all the cases in the region).
 Attack rate of 375.24 per 100 000 population.
 315 cases on average last seven days, 58% of change in the number of cases last seven days (as compared to previous seven days).
 7 new deaths reported, 968 cumulative deaths with a CFR of 0.84%.
 106,969 cumulative recovered (93.35% of cumulative cases), 6,647 active cases.

Togo
 486 new cases reported.
 19,614 cumulative cases (0.36 % of all the cases in the region).
 Attack rate of 237.38 per 100 000 population.
 235 cases on average last seven days, 43% of change in the number of cases last seven days (as compared to previous seven days).
 0 new deaths reported, 172 cumulative deaths with a CFR of 0.88%.
 16,105 cumulative recovered (82.11% of cumulative cases), 3,337 active cases.

Algeria
 412 new cases reported.
 191,583 cumulative cases (3.54 % of all the cases in the region).
 Attack rate of 445.41 per 100 000 population.
 645 cases on average last seven days, 26% of change in the number of cases last seven days (as compared to previous seven days).
 20 new deaths reported, 5,004 cumulative deaths with a CFR of 2.61%.
 129,950 cumulative recovered (67.83% of cumulative cases), 56,629 active cases.

Rwanda
 393 new cases reported.
 83,023 cumulative cases (1.53 % of all the cases in the region).
 Attack rate of 632.92 per 100 000 population.
 477 cases on average last seven days, 9% of change in the number of cases last seven days (as compared to previous seven days).
 11 new deaths reported, 1,021 cumulative deaths with a CFR of 1.23%.
 45,544 cumulative recovered (54.86% of cumulative cases), 36,458 active cases.

Nigeria
 388 new cases reported.
 187,023 cumulative cases (3.46 % of all the cases in the region).
 Attack rate of 90.27 per 100 000 population.
 668 cases on average last seven days, 2% of change in the number of cases last seven days (as compared to previous seven days).
 8 new deaths reported, 2,268 cumulative deaths with a CFR of 1.21%.
 168,455 cumulative recovered (90.07% of cumulative cases), 16,300 active cases.

Mauritius
 284 new cases reported.
 8,093 cumulative cases (0.15 % of all the cases in the region).
 Attack rate of 627.03 per 100 000 population.
 264 cases on average last seven days, 97% of change in the number of cases last seven days (as compared to previous seven days).
 2 new deaths reported, 25 cumulative deaths with a CFR of 0.31%.
 4,477 cumulative recovered (55.29% of cumulative cases), 3,596 active cases.

Mozambique
 261 new cases reported.
 142,784 cumulative cases (2.64 % of all the cases in the region).
 Attack rate of 446.26 per 100 000 population.
 597 cases on average last seven days, 36% of change in the number of cases last seven days (as compared to previous seven days).
 15 new deaths reported, 1,800 cumulative deaths with a CFR of 1.26%.
 126,041 cumulative recovered (88.27% of cumulative cases), 14,943 active cases.

Zambia
 212 new cases reported.
 204,549 cumulative cases (3.78 % of all the cases in the region).
 Attack rate of 1081.22 per 100 000 population.
 323 cases on average last seven days, 3% of change in the number of cases last seven days (as compared to previous seven days).
 1 new death reported, 3,574 cumulative deaths with a CFR of 1.75%.
 198,559 cumulative recovered (97.07% of cumulative cases), 2,416 active cases.

Côte d'Ivoire
 189 new cases reported.
 53,645 cumulative cases (0.99 % of all the cases in the region).
 Attack rate of 209.56 per 100 000 population.
 179 cases on average last seven days, 76% of change in the number of cases last seven days (as compared to previous seven days).
 6 new deaths reported, 395 cumulative deaths with a CFR of 0.74%.
 52,405 cumulative recovered (97.69% of cumulative cases), 845 active cases.

Mauritania
 180 new cases reported.
 31,822 cumulative cases (0.59 % of all the cases in the region).
 Attack rate of 699.94 per 100 000 population.
 251 cases on average last seven days, 12% of change in the number of cases last seven days (as compared to previous seven days).
 1 new death reported, 673 cumulative deaths with a CFR of 2.11%.
 28,167 cumulative recovered (88.51% of cumulative cases), 2,982 active cases.

Eswatini
 172 new cases reported.
 40,455 cumulative cases (0.75 % of all the cases in the region).
 Attack rate of 2976.67 per 100 000 population.
 63 cases on average last seven days, 10% of change in the number of cases last seven days (as compared to previous seven days).
 13 new deaths reported, 1,004 cumulative deaths with a CFR of 2.48%.
 29,710 cumulative recovered (73.44% of cumulative cases), 9,741 active cases.

Zimbabwe
 165 new cases reported.
 122,652 cumulative cases (2.27 % of all the cases in the region).
 Attack rate of 702.90 per 100 000 population.
 376 cases on average last seven days, 32% of change in the number of cases last seven days (as compared to previous seven days).
 13 new deaths reported, 4,249 cumulative deaths with a CFR of 3.46%.
 106,810 cumulative recovered (87.08% of cumulative cases), 11,593 active cases.

Senegal
 155 new cases reported.
 71,927 cumulative cases (1.33 % of all the cases in the region).
 Attack rate of 412.13 per 100 000 population.
 194 cases on average last seven days, 60% of change in the number of cases last seven days (as compared to previous seven days).
 12 new deaths reported, 1,671 cumulative deaths with a CFR of 2.32%.
 57,394 cumulative recovered (79.79% of cumulative cases), 12,862 active cases.

Guinea
 155 new cases reported.
 28,802 cumulative cases (0.53 % of all the cases in the region).
 Attack rate of 200.68 per 100 000 population.
 98 cases on average last seven days, 52% of change in the number of cases last seven days (as compared to previous seven days).
 6 new deaths reported, 314 cumulative deaths with a CFR of 1.09%.
 26,212 cumulative recovered (91.01% of cumulative cases), 2,276 active cases.

Angola
 128 new cases reported.
 45,945 cumulative cases (0.85 % of all the cases in the region).
 Attack rate of 157.13 per 100 000 population.
 183 cases on average last seven days, 39% of change in the number of cases last seven days (as compared to previous seven days).
 23 new deaths reported, 1,153 cumulative deaths with a CFR of 2.51%.
 42,384 cumulative recovered (92.25% of cumulative cases), 2,408 active cases.

Democratic Republic of the Congo
 110 new cases reported.
 54,009 cumulative cases (1.00 % of all the cases in the region).
 Attack rate of 57.42 per 100 000 population.
 108 cases on average last seven days, 51% of change in the number of cases last seven days (as compared to previous seven days).
 0 new deaths reported, 1,053 cumulative deaths with a CFR of 1.95%.
 30,858 cumulative recovered (57.13% of cumulative cases), 22,098 active cases.



Namibia
98 new cases reported.
123,581 cumulative cases (2.28 % of all the cases in the region).
Attack rate of 4504.10 per 100 000 population.
148 cases on average last seven days, -26% of change in the number of cases last seven days (as compared to previous seven days).
9 new deaths reported, 3,342 cumulative deaths with a CFR of 2.70%.
118,085 cumulative recovered (95.55% of cumulative cases), 2,154 active cases.



Burundi
79 new cases reported.
11,333 cumulative cases (0.21 % of all the cases in the region).
Attack rate of 85.99 per 100 000 population.
176 cases on average last seven days, 11% of change in the number of cases last seven days (as compared to previous seven days).
0 new deaths reported, 10 cumulative deaths with a CFR of 0.09%.
10,880 cumulative recovered (96.00% of cumulative cases), 443 active cases.



Malawi
72 new cases reported.
59,471 cumulative cases (1.10 % of all the cases in the region).
Attack rate of 297.38 per 100 000 population.
215 cases on average last seven days, -36% of change in the number of cases last seven days (as compared to previous seven days).
15 new deaths reported, 2,074 cumulative deaths with a CFR of 3.49%.
45,552 cumulative recovered (76.60% of cumulative cases), 11,845 active cases.



Cabo Verde
52 new cases reported.
34,738 cumulative cases (0.64 % of all the cases in the region).
Attack rate of 6289.12 per 100 000 population.
49 cases on average last seven days, -1% of change in the number of cases last seven days (as compared to previous seven days).
3 new deaths reported, 305 cumulative deaths with a CFR of 0.88%.
33,806 cumulative recovered (97.32% of cumulative cases), 11,845 active cases.



Gambia
31 new cases reported.
9,470 cumulative cases (0.18 % of all the cases in the region).
Attack rate of 405.44 per 100 000 population.
39 cases on average last seven days, -73% of change in the number of cases last seven days (as compared to previous seven days).
5 new deaths reported, 301 cumulative deaths with a CFR of 3.18%.
9,049 cumulative recovered (95.55% of cumulative cases), 120 active cases.



Guinea-Bissau
22 new cases reported.
5,518 cumulative cases (0.10 % of all the cases in the region).
Attack rate of 260.46 per 100 000 population.
56 cases on average last seven days, 18% of change in the number of cases last seven days (as compared to previous seven days).
4 new deaths reported, 103 cumulative deaths with a CFR of 1.87%.
4,592 cumulative recovered (83.22% of cumulative cases), 823 active cases.



Burkina Faso
14 new cases reported.
13,713 cumulative cases (0.25 % of all the cases in the region).
Attack rate of 66.40 per 100 000 population.
5 cases on average last seven days, -29% of change in the number of cases last seven days (as compared to previous seven days).
0 new deaths reported, 171 cumulative deaths with a CFR of 1.25%.
13,461 cumulative recovered (98.16% of cumulative cases), 81 active cases.



South Sudan
9 new cases reported.
11,310 cumulative cases (0.21 % of all the cases in the region).
Attack rate of 76.22 per 100 000 population.
17 cases on average last seven days, 55% of change in the number of cases last seven days (as compared to previous seven days).
0 new deaths reported, 120 cumulative deaths with a CFR of 1.06%.
10,948 cumulative recovered (96.80% of cumulative cases), 242 active cases.



Niger
9 new cases reported.
5,770 cumulative cases (0.11 % of all the cases in the region).
Attack rate of 15.85 per 100 000 population.
6 cases on average last seven days, 24% of change in the number of cases last seven days (as compared to previous seven days).
0 new deaths reported, 196 cumulative deaths with a CFR of 3.40%.
5,490 cumulative recovered (95.15% of cumulative cases), 84 active cases.



Mali
8 new cases reported.
14,758 cumulative cases (0.27 % of all the cases in the region).
Attack rate of 71.90 per 100 000 population.
8 cases on average last seven days, 17% of change in the number of cases last seven days (as compared to previous seven days).
3 new deaths reported, 954 cumulative deaths with a CFR of 2.23%.
14,053 cumulative recovered (95.22% of cumulative cases), 169 active cases.



Madagascar
3 new cases reported.
42,845 cumulative cases (0.79 % of all the cases in the region).
Attack rate of 154.14 per 100 000 population.
5 cases on average last seven days, -32% of change in the number of cases last seven days (as compared to previous seven days).
0 new deaths reported, 954 cumulative deaths with a CFR of 2.23%.
41,891 cumulative recovered (97.77% of cumulative cases), 0 active cases.



Eritrea
3 new cases reported.
6,623 cumulative cases (0.12 % of all the cases in the region).
Attack rate of 111.68 per 100 000 population.
3 cases on average last seven days, +12% of change in the number of cases last seven days (as compared to previous seven days).
0 new deaths reported, 37 cumulative deaths with a CFR of 0.56%.
6,565 cumulative recovered (99.12% of cumulative cases), 21 active cases.



Comoros
2 new cases reported.
4,050 cumulative cases (0.07 % of all the cases in the region).
Attack rate of 458.58 per 100 000 population.
1 cases on average last seven days, 71% of change in the number of cases last seven days (as compared to previous seven days).
0 new deaths reported, 147 cumulative deaths with a CFR of 3.63%.
3,888 cumulative recovered (96.00% of cumulative cases), 15 active cases.



Botswana
0 new cases reported.
146,461 cumulative cases (2.71 % of all the cases in the region).
Attack rate of 5978.92 per 100 000 population.
583 cases on average last seven days, -65% of change in the number of cases last seven days (as compared to previous seven days).
0 new deaths reported, 2,081 cumulative deaths with a CFR of 1.42%.
134,260 cumulative recovered (91.67% of cumulative cases), 10,120 active cases.



Cameroon
0 new cases reported.
82,454 cumulative cases (1.52 % of all the cases in the region).
Attack rate of 295.70 per 100 000 population.
0 cases on average last seven days, 0% of change in the number of cases last seven days (as compared to previous seven days).
0 new deaths reported, 1,338 cumulative deaths with a CFR of 1.62%.
80,920 cumulative recovered (98.14% of cumulative cases), 196 active cases.



Gabon
0 new cases reported.
25,667 cumulative cases (0.47 % of all the cases in the region).
Attack rate of 1339.73 per 100 000 population.
15 cases on average last seven days, 1% of change in the number of cases last seven days (as compared to previous seven days).
0 new deaths reported, 165 cumulative deaths with a CFR of 0.64%.
25,437 cumulative recovered (99.10% of cumulative cases), 65 active cases.



Lesotho
0 new cases reported.
14,371 cumulative cases (0.27 % of all the cases in the region).
Attack rate of 638.40 per 100 000 population.
18 cases on average last seven days, -68% of change in the number of cases last seven days (as compared to previous seven days).
0 new deaths reported, 400 cumulative deaths with a CFR of 2.78%.
6,763 cumulative recovered (47.06% of cumulative cases), 7,208 active cases.



Comoros
2 new cases reported.
4,050 cumulative cases (0.07 % of all the cases in the region).
Attack rate of 458.58 per 100 000 population.
1 cases on average last seven days, 71% of change in the number of cases last seven days (as compared to previous seven days).
0 new deaths reported, 147 cumulative deaths with a CFR of 3.63%.
3,888 cumulative recovered (96.00% of cumulative cases), 15 active cases.



Botswana
0 new cases reported.
146,461 cumulative cases (2.71 % of all the cases in the region).
Attack rate of 5978.92 per 100 000 population.
583 cases on average last seven days, -65% of change in the number of cases last seven days (as compared to previous seven days).
0 new deaths reported, 2,081 cumulative deaths with a CFR of 1.42%.
134,260 cumulative recovered (91.67% of cumulative cases), 10,120 active cases.



Cameroon
0 new cases reported.
82,454 cumulative cases (1.52 % of all the cases in the region).
Attack rate of 295.70 per 100 000 population.
0 cases on average last seven days, 0% of change in the number of cases last seven days (as compared to previous seven days).
0 new deaths reported, 1,338 cumulative deaths with a CFR of 1.62%.
80,920 cumulative recovered (98.14% of cumulative cases), 196 active cases.



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25,667 cumulative cases (0.47 % of all the cases in the region).
Attack rate of 1339.73 per 100 000 population.
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Lesotho
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14,371 cumulative cases (0.27 % of all the cases in the region).
Attack rate of 638.40 per 100 000 population.
18 cases on average last seven days, -68% of change in the number of cases last seven days (as compared to previous seven days).
0 new deaths reported, 400 cumulative deaths with a CFR of 2.78%.
6,763 cumulative recovered (47.06% of cumulative cases), 7,208 active cases.



Congo
0 new cases reported.
13,493 cumulative cases (0.25 % of all the cases in the region).
Attack rate of 226.76 per 100 000 population.
14 cases on average last seven days, -10% of change in the number of cases last seven days (as compared to previous seven days).
0 new deaths reported, 179 cumulative deaths with a CFR of 1.33%.
12,909 cumulative recovered (95.67% of cumulative cases), 405 active cases.



Central African Republic
0 new cases reported.
11,270 cumulative cases (0.21 % of all the cases in the region).
Attack rate of 54.35 per 100 000 population.
1 cases on average last seven days, -76% of change in the number of cases last seven days (as compared to previous seven days).
0 new deaths reported, 99 cumulative deaths with a CFR of 0.88%.
11,125 cumulative recovered (98.71% of cumulative cases), 46 active cases.



Benin
0 new cases reported.
10,183 cumulative cases (0.19 % of all the cases in the region).
Attack rate of 81.54 per 100 000 population.
160 cases on average last seven days, -100% of change in the number of cases last seven days (as compared to previous seven days).
0 new deaths reported, 119 cumulative deaths with a CFR of 1.17%.
8,402 cumulative recovered (82.51% of cumulative cases), 1,662 active cases.



Equatorial Guinea
0 new cases reported.
9,049 cumulative cases (0.17 % of all the cases in the region).
Attack rate of 935.05 per 100 000 population.
11 cases on average last seven days, 267% of change in the number of cases last seven days (as compared to previous seven days).
0 new deaths reported, 123 cumulative deaths with a CFR of 1.36%.
8,803 cumulative recovered (97.28% of cumulative cases), 123 active cases.



Sierra Leone
0 new cases reported.
6,352 cumulative cases (0.12 % of all the cases in the region).
Attack rate of 89.21 per 100 000 population.
2 cases on average last seven days, -63% of change in the number of cases last seven days (as compared to previous seven days).
0 new deaths reported, 121 cumulative deaths with a CFR of 1.90%.
4,335 cumulative recovered (68.25% of cumulative cases), 1,896 active cases.



Liberia
0 new cases reported.
5,527 cumulative cases (0.10 % of all the cases in the region).
Attack rate of 108.47 per 100 000 population.
3 cases on average last seven days, -37% of change in the number of cases last seven days (as compared to previous seven days).
0 new deaths reported, 245 cumulative deaths with a CFR of 4.43%.
5,232 cumulative recovered (94.66% of cumulative cases), 50 active cases.



Chad
0 new cases reported.
4,985 cumulative cases (0.09 % of all the cases in the region).
Attack rate of 22.11 per 100 000 population.
0 cases on average last seven days, -25% of change in the number of cases last seven days (as compared to previous seven days).
0 new deaths reported, 174 cumulative deaths with a CFR of 3.49%.
4,805 cumulative recovered (96.39% of cumulative cases), 6 active cases.



Sao Tome and Principe
0 new cases reported.
2,524 cumulative cases (0.05 % of all the cases in the region).
Attack rate of 1198.41 per 100 000 population.
5 cases on average last seven days, 100% of change in the number of cases last seven days (as compared to previous seven days).
0 new deaths reported, 37 cumulative deaths with a CFR of 1.47%.

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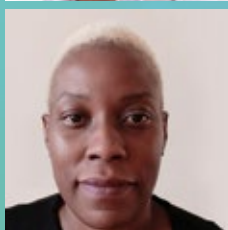
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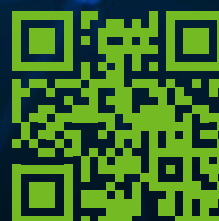
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by Tinashe Ruzani

Workplace Violence

Workplace violence is “any act or threat of physical violence, harassment, intimidation or other threatening disruptive behaviour that occurs at the work site.” Workplace violence typically falls into one of four categories which are, **Customer, Worker-on-Worker, Criminal Intent** and **Personal Relationship**. It is well acknowledged that the healthcare profession is the most vulnerable to workplace violence, which is frequently perpetrated by rowdy or dissatisfied patients. However, it is well acknowledged that working in retail are mostly affected.

CUSTOMER

When a violent individual has a genuine connection with a company, such as a customer, client, patient, student, or convict, and turns violent while being served by the firm.

WORKER-ON-WORKER

The perpetrator of this violence is a current or former employee of the company who assaults or threatens other current or former employees in the workplace.

CRIMINAL INTENT

The offender in this type of violent incident has no genuine link with the firm or its workers. The violence is typically unintentional and occurs as a result of another crime, such as robbery, theft, or trespassing. Terrorist acts are also included in this category.

PERSONAL RELATIONSHIP

In these situations, the assailant normally does not have a link with the business but does have a relationship with the intended victim. Victims of domestic abuse who are assaulted or intimidated at work fall into this category.



Stopping workplace violence begins with identifying and classifying it. Workplace violence encompasses a wide range of behaviours and themes, including physical acts of violence, threats, intimidation, and various forms of harassment. Preventing such a wide range of activities may appear difficult, but it is feasible with adequate staff education and training. It is also preferable to have a strong policy and process in place, as well as to strive for healthy working relationships among employees. This can go a long way toward avoiding workplace violence. Finally, if workplace violence becomes an issue, make sure you know your rights! Making your workspace more comfortable is essential for generating your best work.

by Tichaona Mungazi

Where it's all about you

Cited as the root cause of many significant accidents including the Clapham Junction rail disaster, Chernobyl, the Texas City Oil Refinery Explosion, the Exxon Valdez Oil Spill and the loss of the Challenger space shuttle, fatigue has gained so much limelight when dealing with behavioural-based safety. To prevent such risks and effects of exhaustion, management and people need to work together. However, the only cure for fatigue is sleep, but it's best not to get fatigued in the first place.

Fatigue is a state of feeling very tired, exhausted, weary, or sleepy. This results from a lack of sleep and can be heightened from prolonged mental activity or long periods of stress or anxiety. Boring or repetitive tasks can also increase feelings of tiredness. The immediate signs and symptoms of fatigue, includes tiredness or sleepiness, memory lapses, difficulty concentrating and slower reaction times. All this is translated into reduced ability to make decisions, poor communication skills, reduced attention, reduced ability to handle stress, slow reaction time as well as poor performance and productivity. All these manifestations tend to escalate into increased errors in judgement, increased sick time, absenteeism, and rate of turnover, increased medical costs.

In a workplace, to get ready of such circumstances, management should:

- Manage the workplace environment and practices to minimise the factors that could contribute to fatigue. Make sure employees understand why they need to manage the risk of fatigue and how to minimise their fatigue level. Encourage staff to manage their personal out of work fatigue risk factors.

Likewise, employees should:

- Work with the employer to manage fatigue-related risks in the workplace by, varying work tasks so you stay alert, taking regular breaks and notifying your supervisor or manager if you're feeling fatigued.
- It is also advisable that when you are outside of work as an employee:
 - Make sleep a priority, improve the quality and quantity of your sleep.
 - Have a regular bed time routine, make sure your bedroom is dark, cool and comfortable.
 - Get treatment for sleep disorders, choose what you eat and drink carefully: eat light nutritious meals (heavy meals make you drowsy); drink plenty of water; minimise your caffeine and alcohol intake as well learn the warning signs of fatigue and to recognise them in yourself, so that you can take a break or have a powernap.

ISO 45000 FAMILY Occupation Health and Safety

According to the International Labour Organization, more than 7,600 people die from work-related accidents or diseases every single day. That's why an ISO committee of occupational health & safety experts set to work to develop an International Standard with the potential to save almost three million lives each year. Structured in a similar way to other ISO management systems, the approach will be familiar to users of standards such as ISO 14001 or ISO 9001. ISO 45001 builds on the success of earlier international standards in this area such as OHSAS 18001, the International Labour Organization's ILO-OSH Guidelines, various national standards and the ILO's international labour standards and conventions.

<https://www.iso.org/iso-45001-occupational-health-and-safety.html>

DID YOU KNOW?

Around the world,
in every **15 seconds**,
153 workers
are involved in work-related
accidents and **one (1)**
of them **die**.

Events and Global Observances

OBSERVED

9 Aug	International Day of the World's Indigenous People
12 Aug	International Youth Day
19 Aug	World Humanitarian Day
23-24 Aug	An initiative to bring Harmony to the Natural Environment
29 Aug	International Day against Nuclear Tests

UPCOMING

6-7 Sept	9th Global Summit Expo on Pollution
13-14 Sept	2nd Annual Congress on Biofuels and Biopolymers
20-21 Sept	International Women Conference in Women's Safety and Health at Workplace
21-22 Sept	World Congress on Environmental Toxicology and Pharmacology
20-23 Sept	XXII World Congress in Safety and Health at Work 2021

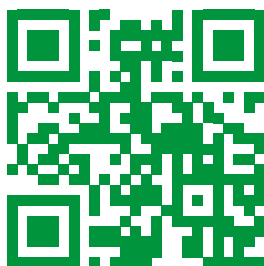


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