09 July 2020

Webinar Series Solidarity in the time of Covid-19

Webinar 1: Accessing health care: Mobility, inclusivity, sustainable health systems and the control and eradication of communicable disease (HIV/AIDS, TB and COVID-19)

Dear Participant,

We would like to invite you to join the first of a series of five webinars on building solidarity in the time of COVID-19.

Theme: Accessing health care: Mobility, inclusivity, sustainable health systems and the control and eradication of communicable disease (HIV/AIDS, TB and COVID-19)

Date: 17 July 2020

Time: 09:00-11:00

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Please email bea@totem-media.net to receive the zoom link.

Below is a framing document for this webinar and attached to your email invitation is a summary info graphic of this framing document, poster invitation and panellists biographies.

We look forward to you joining us.

How do we enable productive livelihoods, tap into community activism, protect rights and human dignity and build on historical expressions of solidarity for all people, particularly when it comes to:?

Access to basic health care for all who live in South Africa, and ensuring that universal measures are put in place for infection control. Provision of health services and eradicating disease. The global economy has led to the rapid spread of COVID 19 into a pandemic. Infection control must become the order of the day. Inclusive approaches to accessing health care are central to eradicating communicable diseases in South Africa and the SADC.

Framework for discussion

1. Non-citizens have generally faced barriers in accessing health as a result of access to documentation, differing patient fee schedules, and both social and institutional xenophobia.
2. This exclusion has been heightened in the national response to COVID-19. Responses to include non-citizens have been mostly been provided by civil-society organisation and humanitarian programmes with little engagement from the state on how to ensure an inclusive response that accommodates the well-known, but often ignored nature of movement and mobility, both internally and across the SADC region.
3. To ensure sustainable public health for South Africa both pre and post COVID-19, health policy and preventative practices for communicable disease in South Africa and the region has to include mobility/ migration-aware policies.

Background to discussion:

1. SADC is a region characterised by historical and continuing, varied migratory flows, involving both internal and cross-border migration. SADC experiences a range of population movements that include: forced migration, labour migration, livelihood seeking migration, temporary migration, and permanent migration. Importantly, those that migrate within these different categories are themselves varied: men and women, young and old.
2. Migrant labour – Colonial violence and coercion that needs to be integrated into a global history of mass violence[i].
    a. Marginalisation, punishment and a racialised system of forced labour.
    b. In Southern Africa, the history of internment under dehumanising conditions would be incomplete without mentioning the history of the labour compound.
    c. Many Africans in South Africa were subjected to the lethal combination of dehumanising living conditions in confinement, hard labour and physical exhaustion.
    d. The harsh conditions in the labour compounds at the Kimberley diamond mines in the Cape claimed a considerable human toll. Since the discovery of diamonds in the 1860s, the mines had attracted thousands of migrant African labourers. During the early stage of diamond mining from 1870, up to 20,000 African workers were accommodated in open compounds.[ii] Closed compounds at the Kimberley diamond mines were introduced in 1885.Not surprisingly, Rhodes endorsed enthusiastically "harsh limitations on the mobility of mine workers".[iii]
    e. The compounds were not only surrounded by fences but also covered by mesh wire in order to prevent the smuggling of diamonds out of the camps. By 1889, 10,000 mine workers lived in closed compounds in conditions of complete isolation.
    f. Many workers were not even afforded the minimal protection that resided in the contract system, which made the premature abandoning of the compound a legal offence. Thousands of workers were not given contracts at all and therefore remained in "a legal no-man's land".[iv] The effect of all of this was to corroborate existing stereotypes of Africans as inherently criminal in the minds of white settlers.
    g. It was not surprising that the bad reputation of the compound system spread to other areas via the networks established by migrant labourers. African workers did

not simply accept these conditions and the response of employers to protest and resistance was harsh, including flogging and the killing of riotous labourers.[v] In 1901 African dockworkers in Cape Town went on strike because they feared that the plague epidemic that was ravaging the city at the time would be used as an excuse to put them into closed compounds like those at Kimberley.[vi]

h. The introduction of closed compounds was welcomed by the mining industry and by contemporary observers because it promised more efficient supervision of the labour force. Furthermore, it was assumed that the accidents and diseases which were rife before the introduction of closed compounds could be more efficiently controlled. The debilitating effects of a smallpox epidemic that spread from the Cape to reach the Kimberley area in 1883, running its course until 1885, were compounded by the reckless attitude of the white authorities towards black workers. Mine owners conspired with medical doctors, "most of whom had financial interests in mining", to deny the existence of a contagious disease because they feared labour shortages. Although they were fully aware of the true nature of the smallpox epidemic, mine operators and doctors claimed that the illness was not contagious and affected only black people. Sick workers were not quarantined but were prevented from receiving medical treatment. The conspiracy collapsed when the smallpox epidemic spilled over into the white parts of Kimberley.[1]

i. Initially, the expectations that more efficient control of the movement of African labourers would lead to more sanitary living conditions were not met. In 1888, it was estimated that the mortality rate had risen from 80 per thousand in the late 1870s to 100 per thousand.[2] Contemporary medical experts were aware that the majority of casualties during the closed compound era were due to pneumonia and not accidents, and thus the result of neglect, poor diet and overcrowding in the compounds. William H. Worger states that by the early 1890s two thirds of the deaths recorded in two De Beers hospitals were due to pneumonia. There were statistical fluctuations, but African mortality in Kimberley rose from 41 per thousand to 55 per thousand between 1891 and 1892, which was double the mortality rate for other urban Africans on the Cape.[3]

3. Linkages between urban and rural areas through circular migration processes have been identified as critical to the comprehension of health concerns within SADC. Urban–rural linkages – mediated through circular migration both within countries and across border – present a range of urban and rural health implications to SADC member states.
4. Communicable diseases including COVID-19, TB, HIV and Ebola require that investment be made in basic infection control measures at all public health facilities and public spaces. COVID-19 has forced a change in behaviour with heightened awareness of the need to do basic things to prevent the spread of communicable diseases including hand washing and social distancing, and even using a mask. But infection control must also be extended to how

[1] William H. Worger, South Africa's City of Diamonds. Mine Workers and Monopoly Capitalism in Kimberley, 1867-1895, Craighall, A. Donker, 1987: 43.
[2] Ibid
[3] Worger, City of Diamonds : 265.

policies are implemented and respect for human rights and human dignity. The management of movement in Southern Africa is of grave concern with respect to this. Persecution of migrants by immigration officials and law enforcement agents, as people are hunted down for being undocumented, hampers any health initiative to curb the spread of communicable diseases and in the case of TB to eradicate the spread of TB, which is both treatable and curable. This criminalises movement of people and forces people underground. Under these conditions people are afraid to come forward for treatment, resulting in the person being vulnerable to infection or of spreading the disease.

5. Ensure regional health policies include movement and mobility frameworks. One possible solution is a health passport with a bar coded ID which contains information related to your specific health needs. This ensures confidentiality and can make a major contribution to ensuring continuity of care as medical staff can access this information and know what treatment you are on if a top up is required if you are not in your country of origin.
6. Linked to this as a measure to regularise movement is the SADC visa, which could also be a document using bio-metrics, and is accessible to all living in SADC. This is presented in the White Paper on International Migration as a suggested proposal that has been supported by civil society.

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[i] Dedering, T. (2013). Compounds, camps, colonialism. *Journal of Namibian Studies : History Politics Culture*, *12*, 29-46. Retrieved from https://namibian-studies.com/index.php/JNS/article/view/26

[ii] Rob Turrell, "Kimberley's model compounds", Journal of African History, 25 (1), 1984: 59-75 (61).

[iii] Robert I. Rotberg, The Founder. Cecil Rhodes and the Pursuit of Power, Johannesburg, Southern Book Publishers, 1988: 220

[iv] Turrell suggest that the official numbers of 700 dead out of 2 311 certified cases of illness are too low, Rob Turrell, Capital and Labour on the Kimberley Diamond Fields, 1871-1890, Cambridge, Cambridge University Press, 1987: 139.

[v] Ibid

[vi] Robert K. Home, "From barrack compounds to the single family house: planning worker housing in colonial Natal and Northern Rhodesia", Planning Perspectives, 15 (4), 2000: 327-347 (337).