Colonialism and South Africa's COVID-19 Public Health Response

An Examination

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On 30 January 2020, the World Health Organization (WHO) declared the novel coronavirus disease outbreak - COVID-19 - a Public Health Emergency of International Concern (PHEIC) which was soon proclaimed a pandemic that demanded global response.[1] Soon after, 3 February 2020, the WHO proposed a Strategic Preparedness and Response Plan (SPRP) to the international community to prevent the spread of infection.[2] COVID-19 is an infectious respiratory disease that can devastate the human body.[3] It has demonstrated to be particularly lethal for older people and those with underlying medical conditions - such as HIV/AIDS, asthma, diabetes - who are immunocompromised.[4] Good hygiene and social distancing were advised as preventative precautions to protect against infection. As consequence, its emergence has dislocated and disrupted much of modern society and daily life.[5] In light of this pandemic proclamation and dangers of the disease, South Africa declared, on 15 March 2020, a national state of disaster to control the spread of infection.[6]

Subsequently, the WHO's declaration of the COVID-19 outbreak as a pandemic, was more than a biological observation, but a global socio-political act.[7] In this context, it is important to acknowledge that public health responses to systematically intervene against epidemics and pandemics are not new to African communities. These responses have historically involved political, social, ecological, and economic consequences on those societies. For instance, oppressive and exploitative European colonial government responses to pandemics of the past played an influential and enduring role in the development and reconfiguration of African societies.[8] By exploring these historical colonial responses, we can better recognize and understand the underlying imperial, colonial, and capitalist systems and rationale that has informed and which affects the South African response to COVID-19.[9]

Before the 'scramble for Africa' began in the 1870s, European imperial ambition and colonial expansion, with the exceptions in the North and South, were predominantly restricted to African

[1] "WHO Timeline - COVID-19.";
[2] "WHO Timeline - COVID-19.";
[3] Wadman, "How Does Coronavirus Kill? Clinicians Trace a Ferocious Rampage through the Body, from Brain to Toes."
[4] "People Who Are at Higher Risk for Severe Illness | CDC."
[5] "Large-Scale Disruptions from Coronavirus: No Longer 'if' or 'When,' but 'Now.'"
[6] "South Africa's War on COVID-19 | Think Global Health."
[7] Lyons, "From 'Death Camps' to Cordon Sanitaire: The Development of Sleeping Sickness Policy in the Uele District of the Belgian Congo, 1903-1914." P70
[8] Vail, "Ecology and History: The Example of Eastern Zambia." P129
[9] [9] See Federici, Revolution at Point Zero :Housework, Reproduction, and Feminist Struggle, p.94; Federici,S., Caliban and the Witch (New York: Autonomedia, 2004), p.113

coastlines.[10] John Iliffe provides two reasons for this: the first being disease, particularly Malaria, which continually devastated European military and administrative labour forces.[11] The development and introduction of quinine prophylaxis from the 1850s decreased the mortality rates of these labour-forces from malaria which allowed for sustained imperial military and campaigns. The second was a lack of European military advantage.[12] The advancement of military technology, machine guns and heavy artillery, from the 1860s provided European and African mercenary armies with superior military technology to overwhelm resisting African communities.[13]

This shows us that controlling disease and healthcare was a significant factor in advancing European colonialisation as it allowed them to advance, secure, and promote their trade and military interests. As such, colonial authority and technocratic medical policy, which allowed for intervention against malaria, sleeping sickness, rinderpest, and plague epidemics in European African colonies at the turn of the century and in the early twentieth century, can be perceived as significant to constituting and promoting oppressive and exploitative imperial socio-economic and military agendas.[14] These agendas promoted underdevelopment, economic subordination, increased migrant labour, land alienation and racial segregation of indigenous communities, and increased environmental degradation which secured European imperial commercial prosperity.[15] Consequential European penetration in-land, territorial conflicts, and trade rivalry instigated the 1884-5 Berlin Conference. [16] At this conference, these European imperial powers resolved to recognize and partition their African territorial claims amongst each other in line with their wider colonial aims. For example, Britain aimed to protect its strategic sea routes to India and regions of widespread trade, like Nigeria.[17] Through this, we can see that colonial European healthcare was interconnected to securing and reproducing broader imperial trade and military interests.

In this period, colonial authorities responded to epidemics by drawing on European intervention experiences and practices used against plague and cholera epidemics. [18] These practices involved relying on and implementing imperial metropole understandings of disease to construct colonial public health policy and campaigns. Such practice aimed to simultaneously identify infected populations and

[10] Iliffe, *Africans*. P198
[11] Iliffe. P199
[12] Iliffe. P199
[13] Iliffe. P199
[14] Iliffe. P217
[15] Packard, "Maize, Cattle and Mosquitoes: The Political Economy of Malaria Epidemics in Colonial Swaziland." P206, 212
[16] Iliffe, *Africans*. P195
[17] Iliffe. P195
[18] Lyons, "From 'Death Camps' to Cordon Sanitaire: The Development of Sleeping Sickness Policy in the Uele District of the Belgian Congo, 1903-1914." P75

their locations, contain those populations in quarantines, control and monitor broader population movements into infected areas, and stop the spread of disease into non-infected areas.[19] For example, in 1909 sleeping sickness spread through Zambia forcing the British colonial administration create a 'Sleeping Sickness Zone" in a belated attempt to contain and monitor its spread into surrounding settlement and trade areas.[20] While in 1918, when influenza devastatingly moved through Senegal, British colonial authorities unsuccessfully implemented quarantines and observations around cities to prevent the disease's progression through the region.[21]

However, many of these imported intervention policies and practices were applied without adaption to the local socio-economic and environmental situations of affected African communities. This aggravated the mortality, morbidity, and health vulnerability of disease exposure. For instance, in 1903 in the Congo and 1932 in Swaziland, colonial authorities did not pay attention to the unfolding drought, famine, urban slum conditions, and economic crises conditions faced by local communities.[22] These conditions made communities - and particularly their children- vulnerable to malnutrition and forced mass migration toward food centres which subsequently multiplied the severity and spread of malaria and sleeping sickness outbreaks.[23] At this point during colonial rule, public health and epidemic policy was conducted without consideration of the local contexts where they were applied.

Colonial public health policy was therefore largely aimed at protecting European economic and trade sectors and areas, supplying African labour to these sectors and areas, preservation of European life, and the entrenchment of racially segregated living areas.[24] This was illustrated in Cape Town during the 1901 plague epidemic where the British Cape government used public health policy and police forces to purposely remove Africans from the 'European' city centre to a temporary quarantine. This became a permanent urban settlement (Ndabeni) which ultimately promoted and secured a racist colonial society.[25] In the Belgian Congo from 1903 to 1914, Africans were specifically suspected of being infected with sleeping sickness and were isolated in quarantine camps - 'cordon sanitaires'- for

[19] Lyons. P75
[20] Vail, "Ecology and History: The Example of Eastern Zambia." P141
[21] Clark, "Environmental Decline and Ecological Response in the Upper Senegal Valley, West Africa, from the Late Nineteenth Century to World War I." P489
[22] Lyons, "From 'Death Camps' to Cordon Sanitaire: The Development of Sleeping Sickness Policy in the Uele District of the Belgian Congo, 1903-1914"; Packard, "Maize, Cattle and Mosquitoes: The Political Economy of Malaria Epidemics in Colonial Swaziland."
[23] Packard, "Maize, Cattle and Mosquitoes: The Political Economy of Malaria Epidemics in Colonial Swaziland." P206, 212
[24] Lyons, "From 'Death Camps' to Cordon Sanitaire: The Development of Sleeping Sickness Policy in the Uele District of the Belgian Congo, 1903-1914." P74
[25] White, "Epidemic Orientalism: Social Construction and the Global Management of Infectious Disease." P85

risky treatment.[26] Other interventions taken include the monitoring of labour movements and regulation of entry into European economic areas, observed by colonial medical professionals, to ensure that trade, mining, and military labour and economic were protected.[27]

Socio-economic emergencies created by these unfolding epidemics provided African colonial governments opportunities to further racist and capitalist interests and consolidate authority in the colonial state.[28] Although respective colonial governments' responses to these epidemics varied, we are shown that colonial public health interventions against disease epidemics demonstrated similar population isolation, movement regulation, technocratic, and capitalist characteristics, patterns, and motivations to protect colonial interests to the detriment of African communities under colonial rule.

Through this we can recognize that in Africa, population quarantine and movement control (lockdown) responses to epidemics are not exclusive to the COVID-19 pandemic. Similarly, an entangled social, political, and economic relationship between public health epidemic intervention and state interest is not new. In acknowledging this historical relationship, we can identify colonial legacies and capitalist structures and systems that inform South Africa's COVID-19 public health response. If we do not, we risk the danger of constituting and widening the socio-economic inequality, morbidity, and mortality prevalent in South African society.[29]

South Africa is considered to be one of the most unequal societies in the world where poverty, migrant labour, underdevelopment, and violent crime are widespread.[30] Furthermore, it has also been experiencing periods of extended and perpetual drought in recent years that has further increased inequality, labour movement, and food insecurity.[31] In addition to these particular socio-economic and environment conditions, South Africa continues to suffer from the HIV/AIDS epidemic and has the highest HIV prevalence in the world.[32] It is under these concurrent socio-economic, environmental, and disease crises that the South African government has responded to the COVID-19 pandemic in March 2020, after its first reported cases.[33]

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[26] Lyons, "From 'Death Camps' to Cordon Sanitaire: The Development of Sleeping Sickness Policy in the Uele District of the Belgian Congo, 1903-1914." P75

[27] Lyons. P78-80

[28] Phoofolo, "EPIDEMICS AND REVOLUTIONS: THE RINDERPEST EPIDEMIC IN LATE NINETEENTH–CENTURY SOUTHERN AFRICA."P139-140

[29] "Deep Inequalities of Social Distancing in South Africa – in Pictures | Global Development | The Guardian."

[30] "GINI Index (World Bank Estimate) - South Africa | Data."; "Violence in South Africa: The Search for Root Causes."

[31] "Cape Town 'drought Possibly Not over' as Dam Levels Decline by 0.6%, Says City | News24."

[32] Shrader et al., "'I'd Rather Use a Refuse Bag:' A Qualitative Exploration of a South African Community's Perceptions of Government-Provided Condoms and Participant-Preferred Solutions."

[33] "South Africa's War on COVID-19 | Think Global Health."

Soon after the first reported cases, the South African government declared a State of Disaster, on 15 March, to manage the rates of infection so as not to overburden available medical and health services.[34] This resulted in public health campaigns and policy, steered by a selected committee of experts (technocrats), that aimed to track, isolate and treat cases. Intervention policy and practice included quarantine, monitoring, and regulation of population movements at homes and international gateways of entry, such as airports and seaports, and limiting the number of people gathered together.[35] With reported cases continuing to rise, South Africa followed the intervention recommendations of the WHO and instituted an initial 21-day national lockdown, on March 27, to better control spread of the disease. [36] To achieve this, people were restricted to their homes, limited to travel under specific circumstances, advised to maintain good hygiene and social distance. To enforce these lockdown rules, the South African defence and police forces were deployed, the country's borders to international travel were closed, and mobile testing units and community health workers were sent out to track and assessment the spread of the disease.[37] These public health interventions remained in place throughout April and May. [38] In an attempt to protect commercial activity and alleviate economic distress, the South African government implemented a staged system to lift these restrictions.[39]

The South African government has been praised for its swift response to slow down the COVID-19 infection rate. However, the implementation and imposition of this public health intervention policy has not been without issues and itself represents many South African's health and wellbeing which are still affected by colonial and Apartheid social-engineering.[40] Colonial and Apartheid authorities segregated South African cities and created African labour settlement reservoirs which were not adequately readdressed in post-Apartheid. As such, many of the working-class, poor, and migrant labourers still live in close-quartered, densely populated, and neglected townships and informal settlements, like Khayelitsha and Alexandra, which do not have access to reliable water, electricity, work, and food.[41] Consequently, the imposed lockdown and quarantine endangered the food security of these communities and put their residents at risk to malnutrition.[42] Furthermore, many residents live in overcrowded rooms, share communal toilets and bathing facilities, and lack access to healthcare

[34] "SA Irons out Details of Its National State of Disaster."
[35] "South Africa's War on COVID-19 | Think Global Health."
[36] "South Africa's War on COVID-19 | Think Global Health."; "COVID-19: Lockdown across India, in Line with WHO Guidance | | UN News."
[37] "South Africa's War on COVID-19 | Think Global Health."
[38] "Ramaphosa: South Africa Coronavirus Lockdown to Ease from June 1 | South Africa News | Al Jazeera."
[39] "Ramaphosa: South Africa Coronavirus Lockdown to Ease from June 1 | South Africa News | Al Jazeera."
[40] "Covid-19: Police Use Rubber Bullets to Stop Homeless People Leaving Camp | GroundUp."
[41] "PHOTOS: South Africa's Unequal Coronavirus Lockdowns : Goats and Soda : NPR."
[42] "#CoronavirusSA: Barriers to ARV Access during Lockdown | Health-E."

services.[43] These conditions make them vulnerable to infection and exposure, making it is difficult for residents to adhere to government public health hygiene and sanitation guidelines. Police and the army forces patrolled many of these communities and have used violent force to enforce government lockdown policy to control the spread of COVID-19.[44] Moreover, the Cape Town local government used this public health emergency as an opportunity to remove homeless people into inadequate temporary tents camps at Strandfontein Sports Grounds. These camps lacked the necessary public health facilities, services and access to underlying health treatments such as those for HIV/AIDS.[45] As a result, many disadvantaged HIV-positive and undiagnosed South Africans have been unable to travel to appointments, receive treatments, be tested, or buy condoms.[46] Non-government organizations, like the C19 Peoples Coalition, have had to step-in to organize and coordinate support for these vulnerable and marginalized socio-economic communities who have been neglected by the government's response.[47] The more affluent suburbs, such as Sea Point and Bedfordview, and important commercial and economic areas of South Africa have been protected from such problems and dangers.[48] In spite of the continued threats of COVID-19 to those in poverty, isolated from medical services and vulnerable to infection, the South African government continues to lift protective measures in response to commercial interest and economic security to the detriment of broader South African public health.[49]

Through this, we find that the South African government responded to the threat of COVID-19 in similar ways and with similar motivations to European colonial authorities who dealt with epidemic threats with an effort to protect their economic and security interests. The uniform implementation of the WHO's public health epidemic intervention policy without local adaption by a technocratic steering committee in Post-Apartheid South Africa to protect against COVID-19 is problematic. The intervention policy reinforces colonial and Apartheid socio-economic systems and structures that have yet to be dismantled. Such public health intervention practice endangers the livelihoods of the socially and economically vulnerable, entrenches capitalist structures and systems that exploit and oppress the disadvantaged and widens the prevalent inequality which consequently places many further at risk to the health threats of COVID-19.

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[43] "PHOTOS: South Africa's Unequal Coronavirus Lockdowns : Goats and Soda : NPR."

[44] "Deep Inequalities of Social Distancing in South Africa – in Pictures | Global Development | The Guardian."; "S Africa Court Issues Orders to End Police Abuse during Lockdown | News | Al Jazeera."

[45] "Covid-19: Police Use Rubber Bullets to Stop Homeless People Leaving Camp | GroundUp."

[46] "#CoronavirusSA: Barriers to ARV Access during Lockdown | Health-E"; Shrader et al., "'I'd Rather Use a Refuse Bag:' A Qualitative Exploration of a South African Community's Perceptions of Government-Provided Condoms and Participant-Preferred Solutions."; "COVID-19: Pandemic Puts Pressure on Medicine Supply • Spotlight."

[47] "About Us – C19 People's Coalition."

[48] "PHOTOS: South Africa's Unequal Coronavirus Lockdowns : Goats and Soda : NPR."

[49] "Ramaphosa: South Africa Coronavirus Lockdown to Ease from June 1 | South Africa News | Al Jazeera."

From this, we can acknowledge and better understand the influence of colonial public health disease control strategy, rationale, and motivations in current policy and practice in modern day South Africa which promotes and exploits enduring imperial capitalist structures and systems. This informs and helps us challenge oppressive facets of public and global health pandemic and epidemic intervention practice and policy. Such understanding will assist decolonizing efforts in South Africa and promote a more just and equitable society.

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