TUBERCULOSIS IN SOUTH AFRICA’S GOLD MINES:
A united call to action
ACKNOWLEDGEMENTS

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“Two hundred thousand subterranean heroes who, by day and by night, for a mere pittance, lay down their lives to the familiar "fall of rock" and who, at deep levels ranging from 1,000 to 3,000 feet in the bowels of the earth, sacrifice their lungs to the rock dust which develops miner’s phthisis [tuberculosis] and pneumonia.”

Sol Plaatjes, Activist, Poet & Author, 1914
INTRODUCTION TO TB AND MINING

“If TB and HIV are a snake in Southern Africa, the head of the snake is here in South Africa. People come from all over the Southern African Development Community to work in our mines and they export TB and HIV, along with their earnings. If we want to kill a snake, we need to hit it on its head.”

Aaron Motsoaledi, South African Minister of Health, June 2010

Miners in South Africa’s gold mines have the highest rates of tuberculosis (TB) infection in the world. The rate of TB infection among miners is between 3,000 and 7,000 per 100,000 population—between four and seven times higher than the general population of South Africa, the country with the second highest TB rates in the world.1,2

Every year, half a million men travel from across the Southern African region to work in South Africa’s mines and, in doing so, contract TB as well HIV and silicosis (a degenerative lung disease linked to exposure to silica dust in gold mines).3 This pattern of migration—men arriving at the mines to work, becoming infected with TB and returning home again—has created an enormous public health crisis throughout the region.

In many cases when become sick from TB, HIV or silicosis—or a combination of the three—they will return or be sent back to communities stretching from Angola to Mozambique. Often with no compensation from the mining company, no cross-border health referral and no source of income to support themselves and their families while they are out of work receiving treatment.4 This practice has become so common that it is colloquially known as ‘being sent home to die’.5 Back in their communities, miners don’t always get the treatment they need and either die or continue to spread the disease.

New TB cases due to mining represent one third of all new cases worldwide. It is estimated that the mining industry is responsible for 760,000 cases in the general population each year; aside from HIV, mining is responsible for 100,000 population—between four and seven times higher than the general population of South Africa, the country with the second highest TB rates in the world.4,5

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The consequences of this health crisis are broad and have far-reaching effects. Not only is the health of hundreds of thousands of men slowly being eroded by developing TB, HIV and silicosis, so is the health of their families and their communities (particularly rural communities in Lesotho and Swaziland) as TB and HIV are brought back from the mines by the men.

On top of the health impact of these diseases, the economic consequences they have on the miners’ communities are equally devastating. In many instances a job at the mine is a family’s only viable economic opportunity. A ‘re-entrenchment’ (redundancy), therefore, not only signals a decline in health, it often also means an end to the family’s only stream of income.

On a regional level, the World Bank recently estimated that the annual cost to the mining industry in terms of lost productivity, healthcare costs, losing existing workers and having to train new staff is in the region of $886 million per year.6 Despite the fact that TB among miners has been recognised by researchers and health workers as an issue of ‘urgent necessity’ for over a century,7 it has, until recently, remained low on the agendas of both regional governments and the mining industry.

Fortunately, thanks in part to sustained pressure from civil society, the last three years have seen a positive increase in political will to tackle the problem from heads of state in the Southern African Development Community (SADC).8 In addition, larger mining companies operating in the region have begun to recognise the scale of the problem and have taken tentative steps to reduce the disease burden among their workers.9

Yet despite these positive developments, TB rates in the gold mines of South Africa remain the highest in the world and progress towards genuine, industry-wide change is still moving slowly. In order to achieve significant inroads against one of the world’s top infectious disease killers, stronger approaches are needed.

It is therefore essential that civil society continue to put pressure on the key stakeholders to capitalise and expand on recent gains. This issue spans beyond the mines and mineworkers and requires a united front in developing solutions.10 Civil society must work to support a partnership between the mining industry, SADC governments, the international donor community and, crucially, with the miners themselves.

This report focuses on the important role that civil society within the region and in donor capitals must play in ensuring that TB in the mines is prioritised by both political leaders and the mining industry. By highlighting the movements for change in responding to the TB epidemic in the mines, this urges civil society to join the call to action. The report’s authors, RESULTS UK and the AIDS and Rights Alliance for Southern Africa (ARASA), have included practical actions that civil society partners can take to help drive the issue forward and to maintain momentum.

Tuberculosis (TB) is an infectious disease caused by the bacteria mycobacterium tuberculosis. It most commonly attacks the lungs but can be found in any part of the body. Like the common cold, TB is spread through the air when an infected person coughs, sneezes, laughs or even sings. A person with TB can infect on average 10 to 15 people a year. Left untreated, TB can be fatal. Every year, 1.3 million people worldwide die from the disease.

WHY ACT NOW?

February 2014 will be marked by two major events that have the potential to catalyse genuine change towards reducing the burden of TB and other occupational lung diseases among miners. A Mining and TB Summit is being organised by the Stop TB Partnership, which will bring together SADC Ministers for Health, Labour, Mining and Finance to meet with CEOs of the major mining companies and mine worker representatives to decide on a programme of action with practical steps and targets for industry and government to take.11 This summit will be directly followed by the annual Mining Indaba, the largest regional conference on mining and mine investment. In addition to the Mining and TB Summit and the Indaba, the World Bank will release an economic analysis of the regional impact of the TB epidemic in the mines. This analysis is expected to highlight the financial incentive for mining companies to invest more in TB prevention, diagnosis and treatment.

In order to maximise the opportunities these events present, civil society, both in the UK and across the Southern African region, need to maintain their calls on governments and mining companies to make strong, transparent and accountable commitments to bringing about real change for the health of miners and their communities. Although February 2014 will be crucial, there will be much work to be done in the wake of these events, and the asks at the end of this report relate to the periods before and after the summits.
TUBERCULOSIS: A THREAT TO A VITAL ECONOMIC SECTOR

The gold mining industry has played a fundamental role in driving South Africa’s economic growth and development. For many years, South Africa was by far the world’s largest gold producer, accounting for 68 percent of global output by 1970. Despite a decline over the past 30 years, mining still contributes close to 10 percent of South Africa’s annual GDP and provides work to hundreds of thousands of people from across the region.xvi At the same time, TB has remained a constant problem within the industry from the earliest days of exploratory digging.

“The extent to which Miners’ Phthisis [TB] prevails at the present time is so great that preventive measures are an urgent necessity, and that such a large number of sufferers in our midst is a matter of keen regret.”

Miner Commission Report, 1903

THE ‘PERFECT STORM’ OF DISEASE

The extraordinarily high rates of disease among miners are a consequence of a combination of closely interlinked biological, physical and socio-economic factors which combine to create the ‘perfect storm of disease’.

Biological

Between 25 and 30 percent of Southern African miners are living with HIV which, due to their weakened immune systems, makes them up to five times more likely to develop TB.xvii It is estimated that one in three miners will become infected with HIV within 18 months of working at a mine.xviii

Miners suffering from silicosis – an occupational lung disease caused by exposure to silica dust in gold mines – face an almost three fold risk of developing active TB compared to miners free from the disease. HIV and silicosis together have dramatic consequences for the health of miners: HIV positive miners suffering from silicosis are 15 times more likely to develop TB than HIV negative miners free from silicosis.xix

Physical

Miners are characteristically hot, cramped and unventilated environments to work in. In the South African gold mines, conditions are worsened due to the depths of the mines; some close to four kilometres deep, working gold seams that may be only one to two metres wide.xix These conditions mean that preventative TB strategies, such as air circulation and ventilation are hard to implement. As a result, the TB bacteria easily transmit from one miner to another. The compact, unventilated nature of the mining shaft also means that it is extremely difficult to effectively remove silica dust, the inhalation of which – even in tiny amounts – can cause small tears in the lungs and lead to silicosis. Protective equipment, such as respirators, are of little use in practice – partly due to poor enforcement and partly because it makes breathing in the hot, cramped environment even more difficult.xxx

These factors are compounded by miners’ poor living conditions. Many of the migrant miners live in overcrowded, poorly ventilated, single-sex, hostel-style accommodation, which provide perfect conditions for air-borne TB bacteria to be transmitted. Studies by the International Labour Organisation (ILO) have identified these hostels as a key driver of sex work activity which in turn leads to an increase in HIV transmission.xxxi

Socio-economic

High levels of regional poverty and lack of economic opportunity in neighbouring countries, combined with a circularity of labour migration pattern with men travelling from home to the mine and back again, has allowed TB to spread beyond the mines and South Africa into the poor rural communities of surrounding countries.

When miners become too sick to work, whether from TB, HIV, silicosis or all three, they are often ‘retrenched’ or made redundant by the mine, which results in depriving the miner’s family of a primary source of income.xix With no financial compensation provided by most mines, these men have little means to support their families while they undergo at least six months of TB treatment. Furthermore, in many rural and isolated communities individuals with TB are not always able to access health services and may not get the care they need.xix Miners are therefore sent home sick with TB, do not necessarily have access to TB medication, and continue to suffer and remain contagious and infect others.

TENTATIVE PROGRESS

Despite the seemingly intractable nature of this problem, and after over a century of investigation into the TB epidemic in the mines, the issue has recently begun to climb the political agenda of the governments within the Southern Africa region. Regional governments are slowly taking steps to tackle the problem.

Southern African Development Community

In August 2012, the 15 SADC heads of state signed the SADC Declaration on TB and the Mining Industry. The declaration commits to “moving towards a vision of zero new infections, zero stigma and discrimination, and zero deaths resulting from TB, HIV, silicosis and other occupational respiratory lung diseases”,xxxii

A ‘Code of Conduct’ is currently being developed to accompany the declaration. This document will provide the legal framework to hold mining companies accountable for improving working conditions and specifically for addressing TB. The delay in developing the ‘Code of Conduct’ is unfortunate but has been necessary since representation from the mine-worker and ex-mine-worker community was left out of the initial consultation process. ARASA are currently supporting SADC governments by putting them in touch with ex-mine-workers who can give critical insight into how to resolve the TB epidemic in the mines.

Following the signing of the SADC Declaration, the Swaziland Statement signed in March 2013 saw representatives of 15 Southern African and Caribbean mining companies joining by members of the donor community (including the UK) and multilateral organisations like the World Bank, Global Fund, International Organization for Migration, UNAIDS and International NGOs. The document is a pledge to renew efforts in the last 1,000 days of the Millennium Development Goals to halt and reverse the spread of TB, including TB in mining specifically. Around the signing of the statement, signatories also brought forward to range of measures for increasing the regional response to the TB epidemic. The Global Fund to Fight AIDS, Tuberculosis and Malaria announced that it would commit US $102 million of new funding to TB programmes in SADC countries. The UK Department for International Development pledged US $220,000 to matching fund for tackling TB from the private sector. The International Organization for Migration announced a US $6.5 million programme on health and mobility in the Southern African mining sector. Finally the World Bank announced that the Bank would “conduct economic analysis on TB and mining to inform industry and government decisions; implement an action plan to harmonize the management of mining-related TB, and develop a costed, industry-led investment strategy to increase TB case finding and treatment”xxxiii

The Mining Industry

In addition to an increase in political commitment, there have been some tentative steps taken by the mining industry towards better protecting the health of their workers,xxiv including AngloGold Ashanti, Harmony Gold Mining and Gold Fields. These mines have enhanced their onsite diagnostic and treatment facilities and can offer a higher standard of care than some health clinics in the region.xxxv

In terms of health and safety standards, the larger mining companies have begun to take stricter action on miners’ exposure to silica dust. With improved ventilation technology and monitoring controls, exposure can now be more easily limited.xxxvii

However, these positive measures remain localised within a few mines and have yet to be scaled up across the industry.

Further, mining companies have shown poor commitment to working with governments to form a harmonised response to the issue. This is evident from their notable absence in the signing of the Swaziland Statement.
CONSOLIDATING GAINS THROUGH CIVIL SOCIETY ACTION

In order to ensure that the steps being taken by governments and mining companies become industry and region-wide strategies for tackling TB, a strong and unified civil society response is essential. For any response to the TB epidemic to be effective, any action needs to bring together the diverse range of regional and international stakeholders involved in the response.  

The urgent need for this campaign is evident in the following quote by Professor Jaïne Roberts, who said:  

“Researchers rarely ask about occupation when studying the distribution and determinants of illnesses such as TB — and the result here is a hidden epidemic of silicosis-related TB among former gold miners in South Africa.”

RECENT CIVIL SOCIETY ACTION IN THE UK

London has traditionally been a centre for extractive industry investment. In light of this, and given the leading role the UK plays in international development in the Southern African region, there have been a number of groups campaigning for change both in the UK context and in support of South African civil society.

Challenging the mining industry

UK civil society has been calling on mining companies registered on the London Stock Exchange to recognise their responsibility and to take concrete action to address TB and silicosis among their workers. Based on the World Health Organisation’s best practice guidelines for dealing with TB, civil society in the UK, including RESULTS UK, has been calling for mines to implement the following changes to improve conditions for mine workers. This package of interventions has been referred to as ‘Prevent, Find, Treat’.

Objective 1

PREVENT workers from developing diseases that compromise their immune systems as an end in itself and a means by which to reduce the development of opportunistic infections like TB.

Preventing Silicosis

The gold mining industry as a whole has a poor record in terms of compliance with health and safety standards relating to the prevention of exposure to silica dust.

“When the rock is blasted in a mine we should wait for two hours before doing the job at such a place, but before two hours sometimes we are asked to do the job and when we mention that the law does not allow it, we are told that one is big-headed and should go home.”

Tseliso Phakisi, ex-gold miner, Lesotho

“...as the audits confirm... there is a pervasive culture of non-compliance to legislative requirements.”

Mine Health and Safety Audit , 2008

To compound the problem, the current legal levels of silica dust in mines (0.1mg/m3) are out-dated and derived from ineffective recommendations that don’t prevent the development of the disease.

The American Conference of Governmental Industrial Hygienists (ACGIH) recommends that silica dust levels in mines be reduced to 0.025mg/m3 as a way of preventing over-exposure.

This can be done by preventing air contamination, removing by exhaust ventilation or by diluting contaminated air with uncontaminated air.

Given the significantly increased risk of contracting TB when one has silicosis, we can assume that reducing silica dust levels – and thus reducing silicosis – will have significant knock on effects for reducing TB rates among miners.

Preventing HIV

Although mining companies are not entirely responsible for the HIV status of their workers, there are measures they can take to help curb infection rates. The most impactful of these, supported by the National Union of Mineworkers South Africa, is for mines to dismantle single-sex hostels and to promote family-style housing in order to reduce sex worker activity and reduce transmission of HIV.

Miners should offer HIV treatment for miners who are HIV positive as soon as they are diagnosed, rather than waiting to see how the virus progresses, as new evidence has shown that individuals living with HIV are 96 percent less likely to transmit the virus when they are on antiretroviral therapy.

Objective 2

FIND and diagnose current and former mine-workers who have contracted occupational silicosis and TB while working in mines.

Mines need to improve their practices around diagnosing TB among their workforces. Early identification of TB means treatment can start earlier, which increases chances of recovery. It also reduces transmission rates of TB, as an individual with TB stops being contagious after about two weeks of treatment.

All miners should have screenings for TB symptoms every six months, which include chest X-rays and testing for TB using new technology such as the GeneXpert machine. This latest diagnostic tool gives a much more accurate diagnosis than examining samples under a microscope and can give a much more accurate result in 90 minutes.

In addition to working more closely to prevent and diagnose disease among their current workforce, mining companies also have a responsibility to help locate former miners who may have contracted occupational TB and silicosis while working in their mines. Often it takes someone between 20 to 30 years of exposure to silica dust to show signs of silicosis.

Similarly, TB can be contracted but remain dormant within an individual and become active years after initial exposure.

“I did not suffer from TB while working. I got sick after I arrived home. I have suffered from TB since leaving the mines, and I was admitted for three months in the hospital here. My chest is painful as we speak. It gets tight when breathing and I am often out of breath.”

Somisewu Mookozo, ex-mine worker, Lesotho

A standardised and robust system of referral for miners and former miners with TB is needed to keep track of these highly mobile mine workers. Some mining companies with on-site treatment facilities provide patients with a ‘referral card’, but this is not standard practice and these cards don’t usually capture all the necessary patient history that is required for health centres to know how to continue care.

Miners can refer miners with TB in any phase of care to the national referral system, where they will be assigned a personal case management worker who will ensure that their healthcare needs are met.

Comprehensive patient-held records for miners (where the miners would be in possession of their patient history, TB and HIV status and current treatment regiments) would mean that investigation and treatment can continue even when a miner crosses a border. Mining companies must therefore partner with health services to ensure that the correct information is included in patients’ personal records. Alongside this, miners themselves need to be given clearer information of the key points of care in their local area along with information to enable self-referral if necessary.

Objective 3

IMPROVE treatment for workers with TB by improving monitoring and support for TB patients taking medication based on the World Health Organisation’s Directly Observed Treatment Short-course (DOTS) best practices.

Mining companies should provide full support to miners receiving treatment for TB. The current regime is long and arduous and can have serious side-effects. Individuals not receiving proper care and treatment can develop multi-drug resistant TB (MDR-TB). Drug-resistant strains are much more difficult and costly to treat and can spread just as easily as a standard case of TB.

All mining companies should support the WHO’s DOTS (Directly Observed Treatment) method that requires that patients are observed when taking their medication during the first two months of treatment and are monitored for effects.

Encouraging leadership from the UK

In addition to the mining industry’s role in responding to the epidemic, UK civil society has been working to encourage the UK Government to play its part in addressing the problem.

Since several of the major mining companies operating in Southern Africa are either headquartered in the UK or listed on the London Stock Exchange, the Government has a legitimate role in holding these companies accountable. According to the UN Guiding Principles on Business and Human Rights:

With regards to UK companies operating overseas:

“States should set out clearly the expectation that all business enterprises domiciled in their territory and/or jurisdiction respect human rights throughout their operations”

In the context of South Africa:

“States must protect against human rights abuse within their territory and/or jurisdiction by third parties, including business enterprises.”

UN Principles on Business and Human Rights

RESULTS UK has been actively calling on the UK Government to play a leading role in addressing the epidemic by building support from the general public, academics and Members of Parliament, the Department for International Development (DFID) has been urged to take action on the issue. In June 2013 a group of MPs met with the Rt. Hon Justine Greening MP, Secretary of State for International Development, to discuss the issue. In addition to contributing $220,000 in a match-funding initiative for TB and mining, DFID is now working in collaboration with the World Bank on a plan to tackle the crisis.
Launched in 2008, the AIDS and Rights Alliance for Southern Africa (ARASA) began a campaign to fight for the rights of migrant mine workers in relation to TB and silicosis. A report, titled ‘The Mining Sector, Tuberculosis and Migrant Labour in Southern Africa’, aimed to address the human rights and health issues faced by migrants – both within South Africa and the wider SADC region (namely, rural Eastern Cape, Lesotho, Swaziland and Mozambique) – in relation to TB and silicosis.xlvii

Complimenting RESULTS UK’s efforts, which have focused on healthcare interventions and policy change, ARASA’s TB and Mines campaign asks the uncomfortable questions surrounding the liability of the mining companies where compensation for occupational lung disease and the overall human rights of the mineworkers is concerned.

Through strategic campaigns targeting the South African Government and the mining industry, including by providing concrete recommendations on avenues to reform current health, human rights and safety legislation faced by mine workers, ARASA’s campaign has reinforced the principle of working with affected groups in order for them to serve as agents of their own change.

Compensation

“Thandile Qvalela died in 2009, aged 48, in a TB ward in a remote part of the Eastern Cape. He had worked for 17 years as an underground gold miner, was sent home with TB, and received no compensation or occupational health surveillance after leaving the mine.”

Jaine Robertson, Mail & Guardian, July 3rd to 9th 2009

ARASA’s work on compensation for former migrant mine workers has assisted in the strategic litigation currently being undertaken by lawyers, including by Richard Meeran and Richard Spoor.xlix Meeran and Spoor, lawyers from the UK and South Africa respectively, have been building a case against Anglo American (former part owners of AngloGold Ashanti) for failing to protect and adequately compensate tens of thousands of ex-miners who are now suffering from occupational TB and silicosis.

Earlier this year 23 miners who contracted TB and silicosis while working at an Anglo American South Africa (AASA) mine won an out of court compensation settlement. This decision has provided hope for the tens of thousands of other miners who are suing AASA and other mining companies for compensation for occupational lung diseases in a class action lawsuit also being brought by Spoor and Meeran. ARASA has been working alongside the lawyers to identify potential claimants from across the region.

Alongside supporting these legal efforts, ARASA is also advancing the compensation agenda at a regional level. Although former mineworkers who were employed in South African mines are entitled to compensation under South African law, this is only the case if they can demonstrate that they developed TB as a result of their work in the mines.

The second piece of legislation in South Africa is called the Occupational Diseases in Mines and Works Act (ODMWA). ODMWA applies to miners and anyone who has worked in a ‘classified’ workplace. This legislation is the law that applies to compensation for occupational TB.

ODMWA is a complex piece of legislation and is very important to the health and wellbeing of former mineworkers. The monitoring of health of miners still employed in the mines remains the responsibility of mining companies. Employers of miners are responsible for the surveillance of active miners’ health under the Mine Health and Safety Act of 1997. However, when a miner no longer works in the mines, ODMWA still applies and miners are still entitled to compensation under the law.

Unfortunately, accessing compensation under ODMWA for former miners and their families is hugely problematic and the system is difficult to understand and access for the vast majority of former mineworkers. Upon being examined and if it is found that the disease is present but does not disable an individual, there will be no compensation. In contrast, with COIDA, even when the disease does not disable an individual, there will still be compensation.

CIVIL SOCIETY ACTION IN SOUTH AFRICA

The UK has also shown significant leadership in global health funding, pledging up to £1 billion to the Global Fund to Fight AIDS, TB and Malaria for 2014-2016. This amount will help deliver TB treatment to over 1 million people. This is an incredible contribution, yet more targeted work needs to be done as there remain a high percentage of miners who go undiagnosed and never receive TB treatment. One study, which used autopsy reports on ex-miners found 40% of subjects to have had active undiagnosed TB.xli

The Stop TB Partnership has a unique funding initiative called TB REACH that deals specifically with finding TB cases among hard to reach populations. TB REACH provides grants for projects that go into remote communities around the world and use innovative techniques for finding and treating TB cases such as sending horseback riders into rural communities in Lesotho to take sputum samples and relaying diagnostic information by mobile phone.xlviii

Since it launched in 2010, TB REACH projects have delivered an overall 33% increase in case detection, while some individual projects have achieved more than a 100% increase finding and diagnosing thousands of cases which would have otherwise gone undetected.xl

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Lynne Featherstone, Parliamentary Under Secretary of State, DFID

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Given the current momentum around TB and mining, there are a series of actions that civil society can take, whether in the UK, southern Africa or elsewhere in the world, that would help gain justice for the miners, ex-miners and their communities in southern Africa.

1. **UK Government**: Reach out to Justine Greening, Secretary of State for International Development. Thank her for granting 1 million people access to TB treatment through the UK’s commitment to the Global Fund and urge her to continue the UK’s leadership in the fight against TB by funding TB REACH. Tell Ms Greening of the TB epidemic fuelled by the mining industry, the huge numbers of ex-miners who go undiagnosed and never receive treatment and the vital need for initiatives like TB REACH. If the UK makes a $20 million pledge per year to TB REACH then the initiative can continue to fund its innovative case-finding projects in labour sending communities in Southern Africa and other remote areas across the globe.

2. **UK Government**: Join the call for the UK to use its considerable regional influence to drive collaboration and participation by industry and governments in initiatives like the Stop TB Partnership’s TB in Mining Summit, and to support the enthusiasm and actions proposed by those struggling with the issue. Contact felix1@results.org.uk to find out about our latest actions.

3. **Mining companies**: Call on UK headquartered mining companies (like Anglo American) and UK listed companies (like AngloGold Ashanti) to adopt the ‘Prevent, Find, Treat’ strategy to better meet the needs of their employees and former employees.

4. **ARASA compensation reforms**: Urgent call for a clear roadmap for the restructuring of the South African compensation system for former mine workers, to ensure responsiveness & efficiency. We call on civil society and former mine workers associations to put pressure on the South African government to expeditiously review the two conflicting compensation legislations, in order to promote a seamless compensation system for former mineworkers. A further call to the South African Medical Bureau for Occupational Diseases (MBOD) to increase access to medical examinations for former mineworkers can check whether they qualify for possible compensation. Email lynette@arasa.info

5. **SADC Secretariat**: To accompany the SADC Declaration on TB and Mining, a legally enforceable ‘Code of Conduct’, aimed at codifying the behaviour of mining companies in relation to occupational TB, was due to be delivered in early 2013. It hasn’t been. The SADC Secretariat has claimed this is due to a lack of funding to convene regional consultative meetings. Call on SADC Ministers and the SADC Secretariat to prioritise the development and implementation of the Code, to give teeth to the noble words of the Declaration, and to guarantee the legal protection of miners and their health.

6. **SADC Ministers**: Make an urgent call for SADC Health Ministers to expedite the process of coordinating cross-border management of TB & implement the Declaration on TB in the Mining Industry, with a focus on: harmonisation of TB treatment, care and support policies & guidelines (esp. in former miner workers); promote the implementation of referral systems between countries. Action from Civil society is needed to place additional pressure on specific Ministries of Health (within SADC) to classify TB as an occupational disease to be compensated throughout SADC.

7. **Mining Indaba and Mining Summit**: Call on ministers and CEOs to enter the Mining Summit and Indaba ready to address the key issues described above with concrete actions, not more planning, discussions, or summits. Strong civil society involvement in addressing the issue is crucial to driving change during these sessions. New financial commitments and adoption of industry wide best practices should be sought from companies; renewed political impetus and progress on the completion and adoption of the Code of Conduct from states; and renewed commitments to working with civil society and ex-miners from both parties.
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xx Ibid.


xxiii Ibid.

xxiv SADC, Declaration on Tuberculosis in the Mining Sector’, 30 Aug 2012, Johannesburg.


xxviii Ibid.

xxix Ibid.


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xxvii Ibid.


xxviii Stop TB Partnership, Externally evaluated results of Wave 1, 2011, p. 15


l ii A classified workplace is a workplace that is not a mine or part of a mine, but at which ‘risk work’ is undertaken. This can include some underground work places, work in certain laboratories or in reduction plants. From: National Institute of Health ‘Compensation for Deceased Miners and Ex-Miners’ http://www.nich.ac.za/assets/files/autopsy-compensation-booklet1.pdf