

All Risk and No Reward

How the Government and Mine Companies
Fail to Protect the Right to Health of Miners and
Ex-Miners in Botswana

Botswana Labour Migrants Association (BoLAMA)

Center for Economic and Social Rights

Northwestern Pritzker School of Law Center for
International Human Rights



All Risk and No Reward:

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ISBN: 978-1-7352336-1-1

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September 2020

Suggested Citation:

Brian Citro, Mihir Mankad & Kitso Phiri, *All Risk and No Reward: How the Government and Mine Companies Fail to Protect the Right to Health of Miners and Ex-Miners in Botswana*, Botswana Labour Migrants Association (BoLAMA), Center for Economic and Social Rights, Northwestern Pritzker School of Law Center for International Human Rights (September 2020).

Design by Tree Havener.

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Acknowledgements

This report was researched and written by members of the Botswana Miners Right to Health Project.



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The Botswana Miners Right to Health Project extends special thanks to:

Dr. Tlaleng Mofokeng, United Nations Special Rapporteur on the Right to Health;

Hon. Justice Oagile Key Dingake, Supreme Court and National Courts of Papua New Guinea;

Onkabetse Mathaithai, Board of Directors, BoLAMA; **Thandi Katlholo**, Programme Officer, Country and Community Support for Impact, Stop TB Partnership; and **Nicholas Schcolnik**, Legal Assistant, Center for International Human Rights, Northwestern Pritzker School of Law

The Open Society Initiative for Southern Africa (OSISA) provided funding for the Botswana Miners Right to Health Project.



Executive Summary

This report details the findings of the **Botswana Miners Right to Health Project**'s two-year assessment of the right to health of miners and ex-miners in Botswana. This Project is motivated by the fact that while Botswana's mineral wealth has made it one of the richest nations in Africa it remains a deeply unequal country. And the people who have fueled Botswana's remarkable development—miners and ex-miners—suffer severe deprivations of their health. This central truth illuminates the content of this report: *All Risk and No Reward: How the Government and Mine Companies Fail to Protect the Right to Health of Miners and Ex-Miners in Botswana*.

The Botswana Miners Right to Health Project Team comprises the **Botswana Labour Migrants Association (BoLAMA)**, a community-based organization of miners and ex-miners in Botswana; the **Center for Economic and Social Rights (CESR)**, an international human rights organization with staff based in Bogotá, Colombia, Johannesburg, South Africa and New York City, USA; and the **Northwestern Pritzker School of Law Center for International Human Rights**, a practice-oriented academic institution based in Chicago, USA. **The Northwestern Pritzker School of Law Environmental Advocacy Center** based in Chicago, USA also contributed to this Project and report. The Project Team used CESR's **OPERA Framework** as the basis of its assessment, including secondary and primary data collection. Secondary data collection involved extensive desk-based legal and social science research. Primary data collection involved focus group discussions and key informant interviews with more than 50 stakeholders in Botswana.

Mineral revenue is the single largest source of revenue for the Government of Botswana. As of 2020, mineral revenue accounted for more than 30% of the country's total revenue collected at approximately US \$1.6 billion. In 2016, 90% of the country's total export value was from the mining sector, with diamonds alone accounting for 85%, and the remaining 5% from copper-nickel. The mining industry's immense share of the economy and the co-mingling of government and private ownership among the more than 20 mine companies in Botswana make the industry the most powerful in the country. The miners who fuel this economic prosperity undertake dangerous work often living in poor conditions with incommensurate financial returns. In doing so, they experience significant deprivations of their right to health.

The human right to health is recognized in treaties of the United Nations and the African Union and in national constitutions around the world. Botswana officially recognized the right to health in ratifying the *African Charter on Human and People's Rights* in 1986. Among other things, the right to health requires governments to take positive steps with their maximum available resources to ensure that health facilities, goods, and services are available, accessible, acceptable and of good quality.

The *Guiding Principles on Business and Human Rights: Implementing the United Nations “Protect, Respect and Remedy” Framework* provide further guidance on governments’ duty to protect against human rights abuses by businesses and on corporations’ responsibility to respect human rights. Governments must legislate to prevent businesses from violating human rights and they must dedicate sufficient resources to monitor and enforce these laws. At the same time, businesses have a responsibility to avoid causing or contributing to adverse impacts on human rights, and they must address and mitigate all those linked to their operations.

Critical Issues for the Right to Health of Miners and Ex-Miners in Botswana

This section presents a summary of the findings and analysis of the Botswana Miners Right to Health Project’s two-year assessment of the right to health of mines and ex-miners in Botswana. These eight critical issues illuminate both the risks miners undertake in their vital work and the severe, but preventable, consequences.

1. Miners and Ex-Miners Suffer Preventable Injuries and Disease from Working in the Mines

Miners and ex-miners in Botswana suffer from preventable injuries and disease due to a host of factors associated with working in the mines. These include insufficient health and safety measures, inadequate training and equipment, coerced labor under excessively dangerous conditions, and a lack of responsiveness on the part of mine companies to address these and other occupational health and safety hazards. As a result, health outcomes among miners, ex-miners and their communities are worse than the general population in Botswana, especially for injuries, respiratory illnesses, such as tuberculosis and silicosis, and chronic illnesses, including HIV.

2. Mine Companies Interfere in Miners’ Health Care, Lowering the Quality of Their Care and Harming Their Health

Mine companies interfere in miners’ health care, creating a culture of compromised ethics at mine hospitals. Corporate interference significantly reduces the quality of health care miners receive in mine hospitals and leads to poor health among miners and ex-miners. Mine companies’ interference in miners’ health care also violates ethical standards requiring physicians to “do no harm” and to make health care decisions based solely on the health and wellbeing of their patients. Corporate interference in health care involves both direct and indirect pressure to declare sick or injured miners “fit for duty” when they are not and to downgrade the severity of miners’ injuries for reporting purposes.

3. Ex-Miners Often Experience Poor Mental Health, Sometimes Leading to Suicide

Miners, ex-miners and their families often experience poor mental health. In particular, our research indicates that the social and economic impacts of the sudden closure of the Government-owned BCL copper mine in Selebi-Phikwe and the Tati nickel mine near Francistown has led to anxiety and depression among ex-miners and their families. These conditions have also likely led to the suicides of BCL ex-miners. The suffering and suicides among BCL ex-miners and their families is further exacerbated by the critical dearth of mental health professionals and mental health services in Botswana.

4. Health Services Are Often Unavailable or Inaccessible to Miners and Ex-Miners

Miners and ex-miners in Botswana face a number of challenges in accessing health care. These include geographic barriers and difficulties traveling to clinics; the lack of specialist care at mine hospitals; the need to pay out-of-pocket for specialist services and second medical opinions at private clinics; long delays waiting for health care; the loss of health care upon termination or retrenchment; a lack of mental health care; and insufficient access to drugs due to periodic stock-outs at government health facilities.

5. Unfair Compensation Processes Leave Miners and Ex-Miners Underdiagnosed and Undercompensated for Injuries, Illnesses and Deaths

Miners, ex-miners and their family members often receive inadequate and unreliable compensation for occupational injuries, illnesses and work-related deaths. Factors contributing to this issue include the underdiagnosis and underassessment of miners' injuries and illnesses by mine doctors and insurance companies during incapacity designations; the difficulty miners face in accessing their medical records to seek second medical opinions; the lack of miners and ex-miners' participation in decision-making processes related to compensation; and the narrow scope and outdated content of the *Worker's Compensation Act, 1998* that establishes the injuries and illnesses for which miners can obtain compensation.

6. Miners and Ex-Miners Are Not Provided Opportunities to Participate in Decision-Making about Their Health

Miners and ex-miners are not provided meaningful opportunities to participate in decision-making processes that impact their health. Miners, ex-miners, their family members, the Botswana Mine Workers Union, the Chamber of Mines, and the Department of Mines all confirmed that miners and ex-miners are not directly involved in key decision-making processes on their health and safety in government, at mine companies or in the Chamber of Mines. For example, neither the Government nor BCL mine managers provided fair notice or

meaningful consultation to the Union or BCL miners prior to the closure of the Government-owned BCL mine in 2016 in Selebi-Phikwe.

7. Miners, Ex-Miners and Their Communities Experience Housing Insecurity and Disruptions of Indigenous Lifestyles and Traditions

Miners, ex-miners and their family members experience housing insecurity in dwellings provided by mine companies, including insecurity of tenure, high utility prices and hazardous living conditions. Housing insecurity is associated with a range of health conditions, including respiratory illnesses and poor mental health. Communities near mine operations also experience disruptions to their indigenous lifestyles and traditions and even the collapse of their homes as a result of blasting in the mines.

8. Environmental Assessments Ignore Mines' Impacts on Occupational and Community Health

The laws and regulations that require environmental impact assessments for mine operations in Botswana are too narrow in scope. They do not sufficiently consider the health and social wellbeing of miners, ex-miners and their communities. In particular, environmental assessment law and regulation does not account for the impact mines have on occupational and community health. As a result, mine companies are not legally required to assess and account for the ways their operations will affect the health of miners, ex-miners and their communities prior to receiving a mining permit. The limited scope of environmental assessments in Botswana is inconsistent with best practices at international, regional and national levels and fails to meet industry standards.

Critical Issues to Finance the Right to Health in Botswana

This section presents a summary of the findings and analysis of the Botswana Miners Right to Health Project's two-year assessment of the Government of Botswana and Botswana mine companies' efforts to finance the right to health. The Government must equitably generate, allocate and spend sufficient revenue to finance the health infrastructure, health goods and health services required to realize the right to health. In accordance with the *UN Guiding Principles on Business and Human Rights*, mine companies should ensure they contribute their fair share of taxes to support the Government to finance the right to health.

1. The Government of Botswana Does Not Equitably Generate Sufficient Revenue for Health

Though Botswana is an upper-middle income country and one of the wealthiest in Africa, it collects very little tax in relation to the size of its Gross Domestic Product (GDP). The International Monetary Fund also reports that domestic resource mobilization in Botswana,

not including mineral revenues, has fallen to less than 10% of GDP. The weak mobilization of non-mineral revenue is especially concerning given the limited horizon of diamond revenues and the growing calls to diversify the Botswana economy. In an effort to increase revenue, Botswana introduced a value-added tax (VAT) in 2002. But VAT taxes are known to be more regressive than other kinds of taxes, such as corporate taxes. Personal income tax, another key source of non-mineral revenue, is also not collected in the most progressive manner possible. The Organisation for Economic Cooperation and Development (OECD) and the European Union have called on Botswana to improve its corporate tax practices particularly as relates to corporate tax evasion and abuse.

At a bare minimum, the Government must ensure strong enforcement of existing corporate tax laws and mine companies must abstain from efforts to avoid or evade taxation. The pricing of diamonds is of particular concern in this respect. Unlike other minerals which are priced based on independent benchmarks, De Beers prices its diamonds for sale without regulation or oversight. Moreover, diamond mining is taxed in accordance with private agreements between mine companies and the Government, the terms of which are not public. And while the Government provides information on its total mineral revenues, it does not provide disaggregated data for the revenue it receives from specific mine companies or for each different mineral. Botswana has also not subscribed to the Extractive Industries Transparency Initiative (EITI) and does not meet the EITI Standard.

To the credit of the Government of Botswana, it is taking steps to address some of these concerns. The Government has agreed to join the *OECD Multilateral Convention on Mutual Administrative Assistance*. In 2019, Botswana enacted the *Income Tax (Transfer Pricing) Regulations Act*. And the Sunday Standard reports that the Botswana Unified Revenue Service conducted an audit of De Beers. These steps are critical to ensuring that the Government of Botswana is able to raise sufficient resources to finance the right to health, but more must be done.

2. The Government of Botswana Does Not Equitably Allocate Sufficient Resources for Health

Botswana's health expenditure as a percentage of general government spending has increased slowly over the last decade to 14%. It is nonetheless insufficient, below the *Abuja Declaration* target of 15% of general government expenditures for health. Available data also indicates that Botswana continues to rank below the average health expenditure as a percentage of GDP among upper middle-income countries. Moreover, disaggregated data on health spending for particular groups, including miners, ex-miners and their communities, is not readily available. It is therefore not possible to determine whether the Government is equitably allocating health resources. And while the availability of budget-related information in Botswana has increased

in the last few years, Botswana ranks low overall in the International Budget Partnership's 2019 Open Budget Survey. It also receives low marks for both budget transparency and participation in particular.

Our research further calls into question Botswana's resource allocation to finance the right to health. During an interview in December 2018, Department of Mines officials disclosed that the Department exhausts all of its available funds to monitor and enforce the *Mines, Quarries, Works and Machinery Act, 1973* during the first quarter of each fiscal year. This leaves the department unable to implement its statutory and regulatory duties, including to conduct health and safety inspections of mine operations. Department of Mines officials further revealed that the Government of Botswana fails to enforce legal requirements for mine companies to set aside funds in preparation for insolvency or the closure of their operations. The devastating impact of the sudden closure in 2016 of the Government-owned BCL mine in Selebi-Phikwe and the Tati nickel mine near Francistown vividly illustrates the social, economic and health consequences of this failure. In light of the above, the Government of Botswana must equitably allocate more resources to finance the right to health.

Botswana Miners Right to Health Project

This report details the findings and analysis of a two-year assessment of the realization of the right to health of miners and ex-miners in Botswana. The report and related activities are part of the Botswana Miners Right to Health Project. Botswana has become one of the richest countries in Africa from its mineral wealth. Yet despite its wealth, it remains one of the most unequal countries in the world. And the people who have fueled Botswana's remarkable development—miners and ex-miners—suffer severe deprivations of their health. In light of these realities, the Botswana Miners Right to Health Project works to promote the right to health of Botswana miners, ex-miners and their communities.

The Project Team comprises the **Botswana Labour Migrants Association (BoLAMA)**, a community-based organization of miners and ex-miners in Botswana; the **Center for Economic and Social Rights (CESR)**, an international human rights organization with staff based in Bogotá, Colombia, Johannesburg, South Africa and New York City, USA; and the **Northwestern Pritzker School of Law Center for International Human Rights**, a practice-oriented academic institution based in Chicago, USA. The **Northwestern Pritzker School of Law Environmental Advocacy Center** based in Chicago, USA also contributed to this Project and report.

The Botswana Miners Right to Health Project is engaged in two primary activities: assessment and advocacy. The Project's two-year assessment involved research and information gathering to examine the right to health of Botswana miners, ex-miners and their communities. The Project Team used CESR's OPERA Framework as the basis of the assessment, which included secondary and primary data collection. Secondary data collection involved extensive desk-based legal and social science research. Primary data collection involved focus group discussions and key informant interviews with more than 50 key stakeholders in Botswana. The assessment findings, analysis and conclusions form the basis of this report. Greater detail about the OPERA Framework and the Project Team's data collection is available in the **Methodology** section in the Appendix.

The Project's advocacy aspects aim to affect change to promote the realization of the right to health of miners, ex-miners and their communities. This involves efforts to reform and improve the legal and policy environment in Botswana, as well as industry practices and policies. The Project's advocacy further involves efforts to empower miners, ex-miners and their communities to assert their right to health in local, national and international contexts. The Project's advocacy efforts are mentioned in brief in the **Methodology** section in

the Appendix and represented by the **Botswana Miners Right to Health Law Reform Memo** (available for download by clicking on the hyperlink).

The faculty and senior researchers and authors of this report are **Kitso Phiri** (BoLAMA), **Brian Citro** (Center for International Human Rights, Northwestern Pritzker School of Law), **Mihir Mankad** (CESR), **Nancy Loeb** (Environmental Advocacy Center, Northwestern Pritzker School of Law) and Schuette Clinical Fellows in Health and Human Rights **Elise Meyer** and **Alexandra Tarzikhan** (Northwestern Pritzker School of Law). For a full list of individuals and institutions that contributed to this report, see the Acknowledgements above.



The Botswana Mining Industry and the People Who Make It Work: A Snapshot

The discovery of diamonds in Botswana in the 1960s and subsequent development of the mining sector in the 1970s created one of the fastest growing economies in the world. But while Botswana has one of the highest per capita Gross Domestic Products (GDPs) in Africa, it continues to be a deeply unequal country.¹ Botswana is ranked among the ten most unequal countries in the Gini Index, a statistical measurement of income inequality.² More than 16% of people in Botswana live in poverty.³ And, as this report demonstrates, the miners and ex-miners who do the work that fuels the Botswana economy experience severe deprivations of their health. This central truth motivates the Botswana Miners Right to Health Project and illuminates this report: *All Risk and No Reward: How the Government and Mine Companies Fail to Protect the Right to Health of Miners and Ex-Miners in Botswana*.

MINERAL REVENUE as a percentage of BOTSWANA'S TOTAL REVENUE ⁶



As of 2020, **mineral revenue** accounted for **more than 30%** of the country's total revenue collected at approximately US \$1.6 billion.*

* approximate revenue for 2020

¹ U.S. Central Intelligence Agency. *Country Comparison: GDP - per capita (PPP)*. n.d. August 2020. <https://www.cia.gov/library/publications/the-world-factbook/fields/211rank.html> [hereinafter CIA World Factbook]; The World Bank. *GDP per capita (current US\$) - Sub-Saharan Africa*. n.d. August 2020. <https://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=ZG> [hereinafter World Bank Data].

² The World Bank. *GINI Index (World Bank estimate)*. n.d. August 2020. <https://data.worldbank.org/indicator/SI.POV.GINI> [hereinafter Gini Index].

³ Statistics Botswana. *Poverty*. n.d. 2020 August. www.statsbots.org/bw/poverty [hereinafter Botswana Poverty Statistics].

Since the early 1980s, the mining industry has been the largest contributor to Botswana's GDP, accounting for between 20% and 50%.⁴ Mineral revenue continues to be the single largest source of revenue for the Government of Botswana.⁵ As of 2020, mineral revenue accounted for more than 30% of the country's total revenue collected at approximately US \$1.6 billion.⁶ In 2016, 90% of the country's total export value was from the mining sector, with diamonds alone account for 85% and the remaining 5% from copper-nickel.⁷ In 2018, mining accounted for about 34% of gross value added to the Botswana economy.⁸ And in a country of with less than a million people of working age, more than 11,500 are employed in the mining industry.⁹ The mining industry's immense share of the economy and the co-mingling of government and private ownership among the more than 20 mine companies in Botswana make the industry the most powerful in the country.

Of these companies, Debswana Diamond Company Ltd. (Debswana) is perhaps the most powerful. Debswana operates four mines in Botswana in Orapa, Letlhakane, Damtshaa (OLDM) and Jwaneng.¹⁰ It is the largest diamond mining company in the country and the largest private sector employer with over 5,000 employees.¹¹ Debswana is also the largest single contributor to the Government of Botswana's revenues.¹² Debswana is a joint venture between De Beers Group (De Beers) and the Government of Botswana, with the Government holding a 50% stake and equal representation on the Board of Directors.¹³ De Beers is the largest diamond mining operation in the world. De Beers is 15% owned by the Government of Botswana and 85% owned by the AngloAmerican corporation.¹⁴ Headquartered in London, United Kingdom, AngloAmerican is one of the world's largest mining companies, employing 90,000 people and earning about US \$30 billion in annual revenue.¹⁵ De Beers generated US \$1.245 billion in earnings before interest, taxes, depreciation and amortization (EBITDA) in 2018.¹⁶

⁴ Statistics Botswana. *Index of the Physical Volume of Mining Production: First Quarter 2020*. Government of Botswana. Gaborone: Statistics Botswana, 2020.

⁵ Honorable Dr. Thapelo Matsheka, Minister of Finance and Economic Development. *Address before the National Assembly: 2020-2021 Botswana Ministry of Finance Budget Speech*. National Assembly of Botswana. Gaborone, 3 February 2020. [hereinafter Budget Speech].

⁶ *Ibid.*

⁷ The World Bank. *Botswana Mining Investment and Governance Review*. Washington, D.C.: World Bank Publications, 2016.

⁸ Budget Speech, *supra* note 5.

⁹ Statistics Botswana. *Multi-Topic Survey Quarter 1, 2020 Labour Force Module Report*. Government of Botswana. Gaborone: Statistics Botswana, 2020.

¹⁰ Debswana. *About Us: Our History*. n.d. August 2020. <http://www.debswana.com/About-Us/Pages/Our-History.aspx>.

¹¹ *Ibid.*

¹² Benza, Brian. "Botswana's Debswana targets diamond output of 24 mln carats in 2019." *Investing News* 15 March 2019.

¹³ Debswana. *About Us: Board of Directors*. n.d. August 2020. www.debswana.com/About-Us/Pages/Board-of-Directors.aspx.

¹⁴ De Beers Group. *Who We Are: Group Structure*. n.d. August 2020. www.debeersgroup.com/the-group/group-structure.

¹⁵ Anglo American. *About Us: Where We Operate*. n.d. August 2020. <https://www.angloamerican.com/about-us/where-we-operate#/projects-operations-offices-headquarters/diamonds-copper-platinum-coal-iron-nickel-polyhalite>.

¹⁶ Anglo American. *Integrated Annual Report 2019: Re-Imagining Mining to Improve People's Lives*. London: Anglo American plc, 2019.

The former Government-owned BCL Mine Limited (BCL) represents another powerful mine company that wielded significant financial and political clout. In the first half of 2016, BCL accounted for 2.4% of Botswana's GDP.¹⁷ However, in October 2016 after decades of operations BCL initiated the liquidation of its mines in Selebi-Phikwe and near Francistown as a result of a collapse in nickel prices.¹⁸ The sudden decision to liquidate the mines was hastened by the Government of Botswana's decision to back out of a deal with the Russian company Norilsk Nickel (Nornickel).¹⁹ The deal was for BCL to purchase a 50% share in the Nkomati Nickel and Chrome Mine in South Africa payable in cash for US \$337 million.²⁰ According to media reports, the Government pulled out of the deal because it could not afford the cost of the transaction.²¹ The same media reports further claim that the Government then quickly entered the BCL and Tati mines into liquidation to protect them from exposure to creditors related to the failed deal.



¹⁷ "The Second Meeting of the Fifth Session of the Eleventh Parliament." Daily Hansard: Your Voice in Parliament 8 March 2019 [hereinafter Daily Hansard].

¹⁸ Botswana Chamber of Mines. BCM Member: BCL. n.d. August 2020. www.bcm.org.bw/our-members/bcl; Daily Hansard, *ibid*.

¹⁹ Editor. "Norilsk to Take BCL Mine to Court over Nkomati Mine Deal." Mining and Travel Review 14 October 2016; IndustriALL Global Union. 6,000 jobs to go at state-owned mines in Botswana. 19 October 2016. August 2020. www.industriall-union.org/over-6000-jobs-to-go-at-state-owned-mines-in-botswana.

²⁰ Mining and Travel Review, *ibid*; IndustriALL Global Union, *ibid*.

²¹ Mining and Travel Review, *ibid*; IndustriALL Global Union, *ibid*.

The mine operations in Selebi-Phikwe were some of the first in Botswana, beginning their operations in the early 1970s.²² Prior to the closure of its mines, BCL was the main employer in Selebi-Phikwe, employing about 5,500 people there.²³ BCL also employed 700 workers at its subsidiary company, the Tati Nickel Mining Company near Francistown.²⁴ According to the Botswana Chamber of Mines, BCL still owns about 2,000 residential properties in Selebi-Phikwe, which it used to house its employees.²⁵

As discussed below in **Critical Issue #3** and **Critical Issue #7**, the closure of the BCL mine—and the failure of the Government of Botswana to prepare for and respond to the fallout—have devastated the region. The BCL mine closure has led to mass unemployment, a housing crisis, inconsistent water services, the interruption in children’s education, drug shortages and poor mental health.²⁶ The Honorable Member of Parliament from Selebi-Phikwe West, Mr. Dithapelo Keorapetse, captured this devastation in declaring the closure of the BCL mine a “monumental mistake,” explaining that “Selebi-Phikwe and BCL were like Siamese twins, conjoined twins whose separation was fatal.”²⁷

Miners in Botswana undertake dangerous work, often living in poor conditions, at great risk to their health with incommensurate financial returns. In doing so, they experience significant deprivations of their right to health. Miners are especially vulnerable to occupational injury and disease, including bone fractures, repetitive strain injuries, loss of hearing and sight, spinal cord injuries, lung diseases, such as tuberculosis, and other communicable diseases, including HIV.

For example, while the national tuberculosis prevalence in Botswana in 2013 was 383 people with tuberculosis per 100,000 people, during the same year 741 per 100,000 people had tuberculosis at the BCL mine hospital in Selebi-Phikwe.²⁸ By comparison, the two highest national tuberculosis prevalence rates in the world in 2013 were 715 and 559 per 100,000 people, respectively.²⁹ In another example, the national HIV prevalence rate in Botswana in

²² See Cooper, David. “The Selebi-Phikwe Strike, Botswana 1975: The State, Mine Workers and the Multinationals.” *Institute of Commonwealth Studies* 22 (1978): 143-160.

²³ IndustriALL Global Union, *supra* note 19.

²⁴ IndustriALL Global Union, *supra* note 19.

²⁵ Botswana Chamber of Mines. BCL Limited (in Liquidation) and Tati Nickel Mining Company (Proprietary) Limited (in Provisional Liquidation) (Collectively Referred to as the BCL Group): Proposed Disposal of the BCL Group. n.d. August 2020 [hereinafter BCL Liquidation]. www.bcm.org.bw/proposed-disposal-of-the-bcl-group; Ramokopelwa, Koobonye. “Nation still haunted by the BCL shut-down decision!” *Botswana Guardian* 31 July 2018.

²⁶ BCL Liquidation, *ibid*; Ramokopelwa, *ibid*.

²⁷ *Daily Hansard*, *supra* note 17.

²⁸ Reiprich, Gerlinde, et al. “Draft Country Report: Review of existing legislation and regulations for mine health and safety in Botswana.” Service Package F: Prevention of TB in the mines. TB in the Mining Sector in Southern Africa (TIMS), n.d. [hereinafter TIMS].

²⁹ World Health Organization. *Global Tuberculosis Report 2014*. Geneva: World Health Organization, 2014 [hereinafter 2014 Global TB Report].

TUBERCULOSIS PREVALENCE in 2013 ²⁸

383
per 100,000
In **Botswana**

741
per 100,000
At the **BCL mine hospital in Selebi-Phikwe**

2013 was 18.5%.³⁰ During the same year, HIV prevalence rates in the mining communities of Selebi-Phikwe and Francistown were as high as 27.5% and 24.3%, respectively.³¹ By comparison, the highest national HIV prevalence rate in the world in 2016 was 27.3%.³²

These statistics are just part of the story. As the **Critical Issues for the Right to Health of Miners and Ex-Miners in Botswana** section of this report reveals, the miners and ex-miners that power the country's economy experience severe deprivations of their right to health. The **Critical Issues to Finance the Right to Health in Botswana** section of this report further demonstrates that the Government of Botswana and the mining industry fail to generate, allocate and spend sufficient resources to realize the right to health of miners, ex-miner and their communities.

³⁰ National AIDS Coordinating Agency. *Botswana AIDS Impact Survey IV. Statistical Report*. Government of Botswana. Gaborone: Statistics Botswana, 2013.

³¹ *Ibid.*

³² U.S. Central Intelligence Agency. *Country Comparison: HIV/AIDS Adults Prevalance Rate: South Africa*. n.d. August 2020. <https://www.cia.gov/library/publications/the-world-factbook/fields/363rank.html>.

Critical Issues for the Right to Health of Miners and Ex-Miners in Botswana

This section presents the detailed findings and analysis of the Botswana Miners Right to Health Project’s two-year assessment of the right to health of miners and ex-miners in Botswana. These eight critical issues illuminate both the risks miners undertake in their vital work and the severe, but preventable, consequences.

These critical issues further speak to the Outcomes and Policy Efforts elements of the OPERA Framework. They highlight key aspects of the health condition of the rightsholders—i.e., miners, ex-miners and their communities—and they document gaps in the Government’s efforts to protect and fulfill the right to health. These critical issues also represent key components of the right to health, including minimum core obligations; non-discrimination; the availability, accessibility, acceptability and quality of health facilities, health goods and health services; and process principles, including participation, transparency and accountability. Finally, these issues illuminate the failure of mine companies in Botswana to abide by their human rights responsibilities as clarified in the *Guiding Principles on Business and Human Rights: Implementing the United Nations “Protect, Respect and Remedy” Framework (UN Guiding Principles)*.

For more information about the OPERA Framework, the right to health and the *UN Guiding Principles*, see the **Methodology, Right to Health and United Nations Guiding Principles on Business and Human Rights** sections in the Appendix.

1. Miners and Ex-Miners Suffer Preventable Injuries and Disease from Working in the Mines

Miners and ex-miners in Botswana suffer from preventable injuries and disease due to a host of factors associated with working in the mines. These include insufficient health and safety measures, inadequate training and equipment, coerced labor under excessively dangerous conditions, and a lack of responsiveness on the part of mine companies to address these and other occupational health and safety hazards. As a result, health outcomes among miners, ex-miners and their communities are worse than the general population in Botswana, especially for injuries, respiratory illnesses, such as tuberculosis and silicosis, and chronic illnesses, including HIV.

“It’s like they don’t care about the welfare of the miners because every time [the miners] come here they complain about the dust over there. They complain there’s no protective clothing.”

— **Senior Registered Nurse** at the Medie health outpost during a key informant interview in Medie, Kweneng, December 2019.

These poor health outcomes and health inequities among miners and ex-miners are preventable. They are the result, among other things, of the Government of Botswana’s failure to protect and fulfil the **Right to Health** through appropriate legislative, regulatory and enforcement actions. They are also the result of mine companies’ failure to respect the human rights of their workers in accordance with the **United Nations Guiding Principles on Business and Human Rights**.

Insufficient health and safety measures and inadequate training and equipment in mines contribute to a high risk of occupational injury and disease. Mining involves rock drilling, blasting and dredging. These activities produce significant amounts of respirable dust, composed of crystalline silica and other particles. Our focus group discussions and key informant interviews reveal a widespread lack of appropriate personal protective equipment, including masks, and malfunctioning safety mechanisms, such as water-spraying systems, increasing miners’ exposure to respirable dust.³³ In one example, a retrenched miner at the Minergy Masama Coal Mine in Medie, Kweneng, reported that she and others “don’t have the right masks to wear, so the coal dust affects us badly.” She further stated that she and her coworkers had gone three or four days at a time working in the coal mine without any masks at all.³⁴ The Senior Registered Nurse at the Medie health outpost that treats Minergy miners



³³ Focus Group Discussion with miners, ex-miners and their family members led by Feyi Lawanson (translated by Kitso Phiri) in Jwaneng, Botswana (Dec. 12, 2018); Focus Group Discussion with miners, ex-miners and their family members led by Noam Morris (translated by Kitso Phiri) in Selebi-Phikwe, Botswana (Dec. 11, 2018); Key Informant Interview with Nametso Tsholofelo led by Nikita Kulkarni in Molepolole, Botswana (Dec. 20, 2019); Key Informant Interview with Skerminos Skelago led by Alexandra Tarzikhan in Medie, Kweneng, Botswana (Dec. 19, 2019); Key Informant Interview with Diez Phiku led by Noam Morris in Jwaneng, Botswana (Dec. 12, 2018).

³⁴ Tsholofelo Key Informant Interview (2019), *ibid.*

“Areas in the mine that were known to be unsafe were not recognized by the company until someone was hurt there. And we could not refuse to do work in areas that were especially unsafe, or we’d be deemed insubordinate. Safety experts should have been responsible for creating safe working conditions.”

— Ex-miner during a focus group discussion in Selebi-Phikwe, December 2018.

corroborated this information. He stated that the miners “complain about the dust over there. They complain there’s no protective clothing.”³⁵

Exposure to respirable dust is a major risk factor for many respiratory diseases. Long-term, cumulative exposure to dust leads to silicosis, lung cancer, pulmonary tuberculosis, obstructive airways disease, occupational asthma and other lung diseases.³⁶ In fact, according to the Stop TB Partnership, miners in sub-Saharan Africa experience some of the highest rates of tuberculosis infection in the world.³⁷

As noted in the previous section, in recent years, the prevalence rate for tuberculosis at the BCL Limited (BCL) mine hospital in Selebi-Phikwe was higher than the rate of every country in the world during the same year.³⁸ Similarly, our research reveals that after the opening of Minergy’s Masama Coal Mine in Medie, Kweneng, the number of people being treated for tuberculosis in the area doubled between 2016 and 2018 to approximately 1,200 per 100,000 people.³⁹ The alarmingly high rate of tuberculosis in Medie is likely due, in part, to the lack of safety protections provided to miners in the Minergy coal mine, as described above by Ms. Tsholofelo.⁴⁰

Insufficient health and safety training also leads to preventable injuries and disease among miners. Blasting and drilling into rock, rock bursts caused by the release of built-up stress in the rock mass, loading large boulders onto trucks, continuous and powerful vibrations from drilling, and driving on uneven roads are among the many hazards that cause injuries. These injuries include bone fractures, repetitive strain injuries, hearing and sight loss and

³⁵ Skelago Key Informant Interview (2019), *supra* note 33.

³⁶ See, e.g., U.S. Centers for Disease Control and Prevention. Mining Topic: Respiratory Diseases. 2 October 2019. August 2020. <https://www.cdc.gov/niosh/mining/topics/RespiratoryDiseases.html>; Laney, A. Scott and Weissman, David N. “Respiratory Diseases Caused by Coal Mine Dust.” *Journal of Occupational and Environmental Medicine* 56 (2014): S18-S22; Stuckler, David, et al. “‘Dying for Gold’: The Effects of Mineral Mining on HIV, Tuberculosis, Silicosis and Occupational Diseases in Southern Africa.” *International Journal of Health Services* 43.4 (2013): 639-649.

³⁷ Stop TB Partnership. “Stop TB Partnership Annual Report 2016.” UNOPS, 2017.

³⁸ In 2013, 741 per 100,000 people had tuberculosis at the BCL Limited (BCL) mining hospital in Selebi-Phikwe. TIMS, *supra* note 28. During the same year, the two highest tuberculosis prevalence rates in the world at the national level were 715 and 559 per 100,000 people. 2014 Global TB Report, *supra* note 29.

³⁹ Skelago Key Informant Interview (2019), *supra* note 33.

⁴⁰ Tsholofelo Key Informant Interview (2019), *supra* note 33.

“The mine company didn’t give us proper information about health and safety risks. We learned about the risks from people who had worked in the mines, not from the company or government. Not even at mining school, where we were trained to work in the mines, did we get information about health and safety. We were never formally taught about the dangers.”

— Ex-miner during a focus group discussion in Selebi-Phikwe, December 2018.

spinal cord injuries. Notably, a 2006 study found that although work-related injuries were often reported to the authorities, occupational diseases were very rarely reported, notwithstanding the fact that they are likely to be prevalent in Botswana.⁴¹

Moreover, despite these hazards and risks, the Department of Mines confirmed that there is no national legislation, policy or guidelines for mine workers’ health and safety training.⁴² Instead, health and safety training is solely within the purview of the mine companies. Mine companies are allowed free reign to determine their own protocols in the absence of legal requirements or standards. Ex-miners from the Government-owned BCL mine in Selebi-Phikwe reported dangerous deficiencies in training, hazard identification and management-



⁴¹Ooteghem, Patrick van. “Work-related Injuries and Illnesses in Botswana.” *International Journal of Occupational and Environmental Health* 12.1 (2006): 42-51.

⁴²Key Informant Interview with Rahul Bohra and Hossia Chimbombi of the Department of Mines led by Donna Etemadi in Gaborone, Botswana (Dec. 13, 2018).

“There was a rise in malnutrition after the closure of the BCL mine. Malnutrition is a threat to us. We’re still struggling with this. Sometimes a woman will come in and tell us, ‘no, there’s nothing for us to eat tonight.’”

— **Nurse in the Accident and Emergencies Department** of the Botshabelo Clinic during a key informant interview in Selebi-Phikwe, December 2018.

worker communication that are key to safety in the mines.⁴³ The ex-miners explained that safety supervisors often lacked the experience working in the mines required to ensure a safe working environment. The ex-miners stated that safety supervisors were hired primarily because they had completed higher levels of education than the miners themselves, despite that they lacked the requisite experience. The ex-miners said that the supervisors were then sent into the mines with minimal training to supervise and ensure the safety of miners with considerably more experience.

BCL ex-miners also revealed that their own health and safety training was inadequate.⁴⁴ Rather than receiving accurate and comprehensive information about health and safety risks, including how to mitigate the risk of injury and disease, the ex-miners said they were left to learn on the job and through informal conversations with more experienced miners. Echoing this same experience, a retrenched miner from the Minergy Masama Coal Mine in Medie, Kweneng stated “we’ve never received any form of safety training.”⁴⁵

Coerced labor under dangerous conditions in the mines exacerbates miners’ exposure to occupational injury and disease. Our research reveals that supervisors in the mines coerce miners into laboring in perilous weather conditions, under poor visibility, with malfunctioning machinery and among unmitigated dust, often by threat of disciplinary action. Miners and ex-miners who worked for Debswana in Jwaneng explained that supervisors often forced them to continue blasting and drilling while the water-spraying device, which creates a water curtain to limit dust exposure, was not operating.⁴⁶ They further disclosed that mine supervisors forced them to continue working at night with low visibility and in the rain, as large rocks fell due to the downpours. Debswana miners and ex-miners also stated that miners who were in poor health, including miners with diminished eyesight and fractures, were forced to continue working in unsafe situations in order to meet production demands.

⁴³ Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33.

⁴⁴ Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33.

⁴⁵ Tsholofelo Key Informant Interview (2019), *supra* note 33.

⁴⁶ Jwaneng Focus Group Discussion (2018), *supra* note 33.

BCL ex-miners in Selebi-Phikwe also revealed that they were forced to work in dangerous situations in the BLC mine.⁴⁷ One ex-miner explained that supervisors forced him and his coworkers to repeatedly use a broken elevator to descend into a mine against their objections. Another BCL ex-miner stated that “miners could not refuse to do work in areas that were especially unsafe or they would be deemed insubordinate.”⁴⁸ Mr. Diez Phiku, the Deputy Branch Chairperson of the Botswana Mine Workers Union, confirmed that miners often complain about dust in their working environment and that they are forced to work at night and during the rainy season when roads are slippery and the work environment is generally unsafe.⁴⁹

Dr. Arnold Oneetswe Motsamai, a former Chief Medical Officer at Debswana, who now runs a private clinic in Jwaneng, also corroborated the miners and ex-miners’ claims.⁵⁰ Dr. Motsamai shared several first-hand accounts of treating miners with serious injuries and illnesses sustained as a result of being forced to work in unsafe conditions, often after the mine company was aware they were sick or injured. These included miners with tuberculosis, bone fractures, repetitive strain injuries and eye injuries.

Mine companies’ lack of responsiveness in addressing occupational health and safety hazards contributes to occupational injury and disease. Ex-miners from the Government-owned BCL mine in Selebi-Phikwe revealed that “it would take up to two months before the Inspector of Mines came to investigate” after an accident occurred in the mine.⁵¹ They asserted that this was because the government inspector required approval from the mine company before visiting the mine to start an investigation.

BCL’s lack of responsiveness to health and safety concerns among miners and ex-miners in Selebi-Phikwe continued during and after the closure of the mine there. As discussed below in **Critical Issue #3** and **Critical Issue #7**, BCL completely failed to anticipate and respond to the health, social and economic needs of its workers during and after their mine closure. Among other things, this led to serious mental health problems and in some cases suicides among BCL ex-miners (also described below in **Critical Issue #3**). A nurse in the Accident and Emergencies Department of the Botshabelo Clinic in Selebi-Phikwe also revealed that there was a rise in malnutrition after the closure of the BCL mine among families affected by the closure.⁵² The nurse reported that women had come to the clinic and told her that they did not have food to eat. The nurse summarized these experiences, stating, “Malnutrition is a threat to us. We’re still struggling with it.”

⁴⁷ Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33.

⁴⁸ Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33.

⁴⁹ Key Informant Interview with Diez Phiku led by Noam Morris in Jwaneng, Botswana (Dec. 12, 2018).

⁵⁰ Key Informant Interview with Dr. Arnold Oneetswe Motsamai led by Donna Etemadi in Jwaneng, Botswana (Dec. 12, 2018).

⁵¹ Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33.

⁵² Key Informant Interview with Monkgolodi Polelo and Dianah Tawana led by Donna Etemadi in Selebi-Phikwe, Botswana (Dec. 11, 2018).



2. Mine Companies Interfere with Miners' Health Care, Lowering the Quality of Their Care and Harming Their Health

Mine companies interfere in miners' health care creating a culture of compromised ethics at mine hospitals. Corporate interference significantly reduces the quality of health care miners receive in mine hospitals and leads to poor health among miners and ex-miners. Mine companies' interference in miners' health care also violates ethical standards requiring physicians to “do no harm” and to make health care decisions based solely on the health and wellbeing of their patients.⁵³

Mine companies' interference in miners' health care represents a failure of mine companies to respect the human rights of their workers in line with the **United Nations Guiding Principles on Business and Human Rights**. It further represents a failure of the Government of Botswana to protect and fulfil the Right to Health with appropriate legislative, regulatory and enforcement actions to eliminate corporate interference in miners' health care.

Corporate management at mine companies exerts pressure on doctors—both directly and indirectly—to declare sick or injured miners “fit for duty” when they are not and to downgrade the severity of miners' injuries. Our research indicates that the purpose of this interference is to ensure a sufficient labor force in the mines, to avoid having to report incidents and injuries to the Department of Mines and to reduce potential worker's compensation liability. Direct

⁵³ See, e.g., Hajar, Rachel. “The Physician's Oath: Historical Perspectives.” *Heart Views* 18.4 (2017): 154-159.

“Corporate pressure compromises medical ethics, which compromises health care. There is a lot of this in mine hospitals.”

— **Dr. Arnold Oneetswe Motsamai** during a key informant interview in Jwaneng, December 2018.

interference includes corporate communication with doctors that actively influences or seeks to influence the doctors’ decisions about particular patients. Indirect interference includes implicit pressure—such as threats against career advancement—that mine doctors feel in an environment in which corporate officials expect mine doctors to prioritize production demands over their patients’ health.

Mine companies’ interference with health care in mine hospitals leads to lower quality care and worse health outcomes for miners and ex-miners. Miners, ex-miners, doctors who worked in mine hospitals and a representative of the Botswana Mine Workers Union all reported that mine companies exert pressure on doctors in mine hospitals to designate miners “fit for duty” when they are not.⁵⁴

In Jwaneng and Selebi-Phikwe, miners and ex-miners described numerous situations where they and their coworkers were injured or sick from working in the mines, but doctors at the mine hospitals failed to properly diagnose them.⁵⁵ Instead, they were sent back to work in the mines as “fit for duty.” An ex-miner from the Government-owned BCL mine in Selebi-Phikwe recounted an incident in which a miner was experiencing heart palpitations and high fevers.⁵⁶ This miner had visited the mine hospital for diagnosis and treatment but was sent back to the mine as “fit for duty.” He left the mine shortly thereafter and died a week later. Another BCL ex-miner in Selebi-Phikwe divulged that during exit medical examinations mine doctors sometimes failed to diagnose hearing loss, despite that most miners experienced some level of hearing loss.⁵⁷ The ex-miner explained, “hearing decreases after you’ve worked in the mines, but the exit test will say you are normal. If you took those same results to another mining company, you would not be hired.”

A Debswana ex-miner in Jwaneng explained that he had been injured in a truck accident during which his leg was injured.⁵⁸ He later began experiencing vision problems related to the accident. He recounted that a South African doctor discovered a tumor in his eye and conducted surgery, but his vision continued to deteriorate. He said that he then visited the

⁵⁴ Jwaneng Focus Group Discussion (2018), *supra* note 33; Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33; Phiku Key Informant Interview (2018), *supra* note 49; Dr. Motsamai Key Informant Interview (2018), *supra* note 50; Key Informant Interview with Dr. Khumoetsili Mapitse led by Donna Etemadi in Gaborone, Botswana (Dec. 12, 2018).

⁵⁵ Jwaneng Focus Group Discussion (2018), *supra* note 33; Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33.

⁵⁶ Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33.

⁵⁷ Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33.

⁵⁸ Jwaneng Focus Group Discussion (2018), *supra* note 33.

“The health facilities were a threat. The mine hospital never diagnosed miners, though they were sick and dying. Other hospitals would diagnose people with disease when the mine hospital had not.”

— Ex-miner during a focus group discussion in Selebi-Phikwe, December 2018.

mine hospital and despite his failing vision was told he was “fit for duty” and that he should simply “beware at work.” He asserted that it took several more years before doctors at the mine hospital determined he could no longer work due to his compromised vision. The Deputy Branch Chairperson of the Botswana Mine Workers Union corroborated these experiences.⁵⁹ He stated that it was “common” for miners to be sick or injured only to receive a “fit for duty” designation in the mine hospital and to be sent back to work without a diagnosis or treatment.

Two doctors with decades of combined experience working in several different mine hospitals and extensive experience providing care to miners and ex-miners in the private sector described in detail the methods and consequences of mine companies’ interference in miners’ health care. Dr. Arnold Onetswe Motsamai stated that he first observed the results of this corporate pressure working in the Debswana mine hospital in Jwaneng.⁶⁰ He described the consequences as a “downgrading of the severity of workers’ injuries and illnesses so they could continue working.” He added that “the mine tends to keep them, even with a diagnosis, because they want people in the mine.” Dr. Motsamai described instances during which mine



⁵⁹ Phiku Key Informant Interview (2018), *supra* note 49.

⁶⁰ Dr. Motsamai Key Informant Interview (2018), *supra* note 50.

“The welfare of employees at BCL was not a priority. Medical policies and decisions about miners’ health were not controlled by medical professionals.”

— Ex-miner during a focus group discussion in Selebi-Phikwe, December 2018.

managers and contractors applied direct pressure on him as Chief Medical Officer to change his diagnosis of specific miners, so they could be sent back to work. Dr. Motsamai summarized the situation in the following way:

“There is an element of a compromise of ethics. For doctors, normally, ethics is our backbone. We shouldn’t depart from ethics. That’s what protects us. But there is a challenge, in terms of the mines and medical ethics, where you have a company policy, or in order to keep your job, you have to bend your patient care to accommodate the system. There’s a lot of that.”⁶¹

Dr. Motsamai disclosed that he sees miners at his private practice on a monthly basis who have been injured or fallen ill in the mines but who have not been properly diagnosed, despite repeated visits over months or even years to the mine hospital.⁶² He described “a trust issue” between miners and mine doctors, explaining that when miners come to him “their first priority is to get a diagnosis.”



⁶¹ Dr. Motsamai Key Informant Interview (2018), *supra* note 50.

⁶² Dr. Motsamai Key Informant Interview (2018), *supra* note 50.

“No one examined at the mine hospital was ever found unfit to work. They were always given permission to continue working. But many people died from poor health, even after testing at the mines. And when the mine closed, the exit examinations were all negative—no one was diagnosed as sick or injured. But people from the mines continued to be sick and die, despite the negative tests. The mine hospital false diagnoses caused this.”

— **Ex-miner** during a focus group discussion in Selebi-Phikwe, December 2019.

Dr. Motsamai described in detail a case in which a Debswana miner was forced to drive a truck full of heavy boulders downhill, despite that the miner and others knew the brakes were not properly functioning.⁶³ As the brakes went out, Dr. Motsamai recounted that the miner was forced to drive off the road and the steering wheel was thrust into his chest. The miner immediately went to the mine hospital, but Dr. Motsamai explained that the doctor claimed to find nothing wrong with the miner and did not even perform an x-ray. The miner visited Dr. Motsamai’s clinic the next morning complaining of a burning sensation in his chest. Dr. Motsamai performed an x-ray and found a fracture in the man’s sternum. Dr. Motsamai said he reported the injury to Debswana, but management refused to pay for the miner’s surgery. Instead, according to Dr. Motsamai, the miner was forced to raise money from his relatives to pay for a visit to a thoracic surgeon.

In another case, Dr. Motsamai explained that he diagnosed a miner who had suffered a severe eye injury during an accident in the mine.⁶⁴ The miner had visited the mine hospital twice, but mine doctors sent him back to work without a diagnosis both times. The miner finally visited Dr. Motsamai’s clinic where Dr. Motsamai observed that his eye had lost fluid and was smaller in size. Dr. Motsamai said he immediately sent the miner to an ophthalmologist who determined the accident in the mine had detached the miner’s retina. Dr. Motsamai recounted that the ophthalmologist conducted an emergency surgery.

Dr. Motsamai further revealed that he had recently diagnosed five miners with tuberculosis.⁶⁵ He said the miners told him they had been coughing for weeks and each of them said he had visited the mine hospital, but the doctors there failed to diagnose them with tuberculosis. Instead, Dr. Motsamai said the mine doctors prescribed the miners pain killers and inappropriate antibiotics. Dr. Motsamai noted that he has had many more cases like these at his clinic.

⁶³ Dr. Motsamai Key Informant Interview (2018), *supra* note 50.

⁶⁴ Dr. Motsamai Key Informant Interview (2018), *supra* note 50

⁶⁵ Dr. Motsamai Key Informant Interview (2018), *supra* note 50.

“Your hearing decreases after you’ve worked in the mines, but the exit test will say you’re normal. If you took those same test results to another mine company, you would not be hired. This is criminal. Who takes responsibility when a miner’s health has deteriorated?”

— **Ex-miner** during a focus group discussion in Selebi-Phikwe, December 2018.

Dr. Khumoetsili Mapitse, a former mine doctor at Debswana, BCL and other mine operations, confirmed that at times mine company Safety and Health Officers pressure doctors at mine hospitals to downgrade the severity of miners’ injuries.⁶⁶ From 2012 to 2018, Dr. Mapitse served as the head of health services and occupational hygiene at the BCL mine hospital in Selebi-Phikwe. He noted the relationship between mine companies’ efforts to maintain high safety standards and the legal regime requiring that certain kinds of injuries be reported to the Department of Mines, triggering an incident investigation. In this context, Dr. Mapitse explained that mine doctors feel pressure from corporate management to grade injuries lower than the doctors would otherwise grade them. He noted that corporate pressure on doctors was not always explicit. In his experience, management might speak with a doctor about a miner’s injury and ask, “Do you think this is a minor or a major injury? We think it is minor.” Dr. Mapitse asserted, however, that if the doctor was firm in thinking the injury was severe, management would back down. Still, he emphasized that this pressure “was always there, especially with injuries” and that “most doctors would have felt it one way or the other at some point.”

“This one here is a patient with a fracture, but there is no incident report at the mine. He was seen in the mine hospital, but they missed the fracture. Deliberately or not, I don’t know. They missed the fracture. There are a lot of those cases. I have many of examples like that.”

— **Dr. Arnold Oneetswe Motsamai** during a key informant interview in Jwaneng, December 2018.

⁶⁶ Dr. Mapitse Key Informant Interview (2018), *supra* note 54.

3. Ex-Miners Often Experience Poor Mental Health, Sometimes Leading to Suicide

Miners, ex-miners and their families often experience poor mental health. In particular, our research indicates that the social and economic impacts of the sudden closure of the Government-owned BCL copper mine in Selebi-Phikwe and the Tati nickel mine near Francistown has led to anxiety and depression among ex-miners and their families. These conditions have also likely led to the suicides of BCL ex-miners. The suffering and suicides among BCL ex-miners and their families is further exacerbated by the critical dearth of mental health professionals and mental health services in Botswana.

The lack of available and accessible mental health services for miners, ex-miners and their families represents a failure of the Government of Botswana to fulfill their **Right to Health**. Since BCL was a Government-owned corporation, the company's failure to account for and mitigate the severe social, psychological and economic consequences of the sudden closure of its mines in Selebi-Phikwe and near Francistown is further evidence that the Government of Botswana has failed to respect and fulfill the right to health of BCL miners and their families.

Although mental health awareness is increasing in Botswana, stigma associated with mental illness is still prevalent.⁶⁷ There is also a critical shortage of mental health professionals in the country. There are about 18 mental health practitioners per 100,000 people, but the majority are nurses.⁶⁸ Alarmingly, there are only 0.29 psychiatrists and 0.37 psychologists per 100,000 people in Botswana.⁶⁹ As a result, mental health services are largely unavailable or inaccessible for most people who need them.

NUMBER of **MENTAL HEALTH PRACTITIONERS** in BOTSWANA ⁶⁹

0.29
Psychiatrists
per 100,000 people

0.37
Psychologists
per 100,000 people

⁶⁷ Sidandi, Paul, et al. "Mental Health in Botswana." *International Psychiatry* 8.3 (2011): 66-68.

⁶⁸ Maphisa, J. Maphisa. "Mental Health Legislation in Botswana." *BJPsych International* 16.3 (2019): 68-70.

⁶⁹ *Ibid.*

“We are suffering in silence. There are no mental health counseling or support services for us.”

— **Ex-miner** during a focus group discussion in Medie, Kweneng, December 2019.

Speaking for a group of more than a dozen ex-miners during a focus group discussion in Medie, Kweneng, an ex-miner gave expression to this reality when he stated, “We are suffering in silence. There are no mental health counseling or support services for us.”⁷⁰

The Government and the BCL mine managers’ failure to notify or provide support to miners prior to, during and after the closure of its mine in Selebi-Phikwe in 2016 has had devastating social, economic and health consequences for the community. We conducted two focus group discussions with BCL ex-miners, their family members and representatives of the Botswana Mine Workers Union in Selebi-Phikwe in December 2018 and December 2019.⁷¹ BCL ex-miners and Union representatives explained that the BCL mine was closed suddenly with less than a day’s notice. According to these ex-miners and Union representatives, BCL only informed the



⁷⁰ Focus Group Discussion with ex-miners and community members led by Nikita Kulkarni (translated by Kitso Phiri) in Medie, Kweneng, Botswana (Dec. 19, 2019).

⁷¹ Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33; Focus Group Discussion with miners, ex-miners and their family members led by Nikita Kulkarni (translated by Kitso Phiri) in Selebi-Phikwe, Botswana (Dec. 17, 2019).

“As someone who has worked in the medical field, I can tell you that what they offered us was not counseling. You look at the number of people who died and committed suicide, that was not counseling.”

— Ex-miner during a focus group discussion in Selebi-Phikwe, December 2019.

Union of the mine closure the night before it was closed. BCL miners were only informed the morning of the closure, when they arrived for work. Despite the severe consequences of this, BCL ex-miners revealed that BCL did not provide them with counseling, nor did the company connect them with external counsellors or other mental health services. Instead, they explained that BCL simply conducted an exit interview with each miner during which they were made to verbally confirm that they understood they had been terminated.

As a result of the improper closure of the Government-owned BCL mine, ex-miners and their families in Selebi-Phikwe have experienced acute and ongoing mental health problems. Ex-miners spoke openly about their own mental health struggles and those of their friends and former coworkers during our focus group discussions.⁷² The information gathered during these discussions suggests that ex-miners are experiencing anxiety, depression and suicidal ideation and actions. The ex-miners described how they have suffered severe disruptions to their social and family lives after losing their jobs. They spoke of friends and former coworkers who had died by suicide in the months or years after the closure of the BCL mine.

Two BCL ex-miners in our December 2018 focus group discussion revealed that their wives left with their children after they lost their jobs when the mine closed.⁷³ Others explained that their status in their families and community was damaged as they struggled with their personal identities after losing their livelihoods. As one ex-miner who was a husband and father when the mine closed described it, “I needed to provide, but when that status was taken away, I was no longer viewed as a man.”⁷⁴ The widow of a BCL ex-miner cried as she recounted that her husband died in 2018, leaving her with three children and no means to provide for them or herself.⁷⁵ She explained that immediately after the BCL mine closed her husband complained of heart palpitations and anxiety. She said that his conditions continued until his untimely death. However, she disclosed that at the time of the focus group discussion in December 2019, she had yet to receive any compensation or assistance from BCL or the Government related to her husband’s illness and death.

⁷² Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33; Selebi-Phikwe Focus Group Discussion (2019), *ibid*.

⁷³ Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33.

⁷⁴ Selebi-Phikwe Focus Group Discussion (2019), *supra* note 71.

⁷⁵ Selebi-Phikwe Focus Group Discussion (2019), *supra* note 71.

“The Government is responsible for what happened here. The closure of the mine and everything afterward. We have lost faith in the Government. We want the Government to apologize and say they made an error.”

— **Ex-miner** during a focus group discussion in Selebi-Phikwe, December 2018.

Two nurses in the Accident and Emergencies Department of the Botshabelo Clinic in Selebi-Phikwe corroborated the stories shared by BCL ex-miners and their family members.⁷⁶ Following the mine’s closure, the nurses treated ex-miners who were referred to the public clinic by the BCL mine hospital. One of the nurses expressed her conviction that the BCL ex-miners should have been provided mental health counseling after the mine closed. In this respect, she noted that there was a rise in suicides in Phikwe after the BCL mine closed.

Despite all of this, neither the Government nor BCL has ever provided BCL ex-miners or their families access to counseling or other mental health services.

“Looking at the experience post-closure, I felt there was a need for the ex-miners to be taken into counseling, because a lot of them wondered how they would survive without BCL. And there was a rise in suicides in Phikwe. Some still wonder if BCL will reopen the mine.”

— **Nurse in the Accident and Emergencies Department of the Botshabelo Clinic** during a key informant interview in Selebi-Phikwe, December 2018.

⁷⁶ Polelo and Tawana Key Informant Interview (2018), *supra* note 52.

4. Health Services Are Often Unavailable or Inaccessible to Miners and Ex-Miners

Miners and ex-miners in Botswana face a number of challenges accessing health care. These include geographic barriers and difficulties traveling to clinics; the lack of specialist care at mine hospitals; the need to pay out-of-pocket for specialist care and second medical opinions at private clinics; long delays waiting for health care; the loss of health care upon termination or retrenchment; a lack of mental health care; and insufficient access to drugs due to periodic stock-outs at government health facilities. In order to better understand the context in which these challenges arise, see the **Health System** section in **A Note on the Botswana Health System and Worker’s Compensation Regime** in the Appendix.

The lack of available health care and the barriers to accessing health care contribute to poor health outcomes for miners, ex-miners and their communities and represent a failure of the Government of Botswana to protect and fulfill their **Right to Health**.

Miners and ex-miners face challenges in accessing health care facilities, including mine hospitals and government and private health clinics. Our research shows that some miners must travel long distances to reach the mine hospital and that transportation services are often unreliable. Ex-miners from the Government-owned BCL mine in Selebi-Phikwe reported that their homes were located more than 20 km from the mine and that the mine hospital was a further 17 km from the mine.⁷⁷ When the mine was open, they explained that they were required to first report to the mine—20 km from their home—to obtain approval to visit the mine hospital—another 17 km away. They further recounted that they were often forced to wait many hours for transportation, at times resorting to hitch hiking in order to reach the mine hospital.

A Senior Registered Nurse who runs the government health outpost in Medie, Kweneng that serves miners at the Minergy Masama Coal Mine explained that Minergy miners must travel long distances to reach a full-service health clinic in Lentsweletau.⁷⁸ He noted, “Saturday and there’s no nurse here, so the clinic is closed, and those guys are suffering. Just imagine if a person is amputated. He’ll have to travel from here to Lentsweletau without any first aid treatment. It’s a disaster.”

⁷⁷ Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33.

⁷⁸ Skelago Key Informant Interview (2019), *supra* note 33.

“Some miners have to hitch hike just to get health care.”

— **Ex-miner** during a focus group discussion in Selebi-Phikwe, December 2018.

Miners also experience challenges in obtaining required treatments in mine hospitals and reaching government and private health facilities in order to obtain emergency or specialist care, or to get a second medical opinion. Mine hospitals are largely staffed with primary care physicians, rather than specialists. Specialists are doctors that are experts in one area of medicine, such as pulmonologists, orthopedic surgeons and occupational injury specialists. However, miners often need specialist care to treat occupational injuries and diseases. As a consequence, miners, ex-miners and a prominent doctor explained that miners are by and large left to arrange and pay for transportation to government and private clinics themselves to obtain specialist care.⁷⁹ A BCL ex-miner in Selebi-Phikwe asserted, “Specialized medical care should be available in the mine hospital because of the dangers from mining. Airlifting someone to access specialized care is not sufficient.”⁸⁰ A retrenched miner at the Minergy coal mine in Medie, Kweneng and ex-miners living in the community explained that they have to travel more than 20 km, sometimes using donkey carts, to reach the government clinic in Lentsweletau.⁸¹ The only health facility in Medie near the Minergy mine is a government health outpost with limited capabilities, without a licensed physician.⁸²

Dr. Arnold Oneetswe Motsamai, who runs a private clinic that serves miners and ex-miners in Jwaneng, further explained that while miners needing emergency care are transported by ambulances to the hospital, he often receives visits at his clinic from miners who are dissatisfied with the emergency and other care they have received from mine hospitals.⁸³ Dr. Motsamai explained that these visits include miners with severe bone fractures and other injuries sustained in the mines who have not received proper care or diagnosis at mine hospitals.

“Specialized medical care should be available in the mine hospital because of the dangers from mining. Airlifting someone to access specialized care is not sufficient. In the future, specialized care must be available in the mine hospital.”

— **Ex-miner** during a focus group discussion in Selebi-Phikwe, December 2018.

⁷⁹ Jwaneng Focus Group Discussion (2018), *supra* note 33; Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33; Dr. Motsamai Key Informant Interview (2018), *supra* note 50.

⁸⁰ Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33.

⁸¹ Tsholofelo Key Informant Interview (2019), *supra* note 33; Medie Focus Group Discussion (2019), *supra* note 70.

⁸² Skelago Key Informant Interview (2019), *supra* note 33.

⁸³ Dr. Motsamai Key Informant Interview (2018), *supra* note 50.

“Usually, the mine is supposed to pay for health care. But when they come to me, they pay themselves for me to help them, because they have been frustrated by the mine hospital.”

— **Dr. Arnold Oneetswe Motsamai** during a key informant interview in Jwaneng, December 2018.

Miners and ex-miners also face financial barriers to health care, as they are often forced to pay out-of-pocket for medically necessary specialist care and second opinions. While out-of-pocket expenditures on health in Botswana have generally decreased over time, out-of-pocket payments still create significant financial obstacles to health care and catastrophic health expenditures remain a problem.⁸⁴

Miners, ex-miners and their family members in Jwaneng and Selebi-Phikwe reported that they pay out-of-pocket for health services in private clinics, including second opinions that are necessary due to inaccurate or incomplete diagnoses from mine hospitals for injuries sustained in the mines.⁸⁵ Dr. Motsamai also revealed that Debswana miners routinely visit his private clinic in Jwaneng and pay out-of-pocket to obtain second opinions for occupational injuries and illnesses.⁸⁶ Ex-miners in Selebi-Phikwe with injuries from working in the closed BCL mine reported that they no longer have access to the specialist care they require.⁸⁷ They explained that when the mine closed BCL health administrators transferred them to government clinics that do not provide specialized care. In order to obtain the care they need, they said they are forced to pay out-of-pocket at private clinics. Miners and ex-miners in Jwaneng further revealed that compensation for occupational injuries provided under law are much too low to cover their expenses for the specialist care they require.⁸⁸ The issue of insufficient compensation for occupational injuries and disease is addressed below in **Critical Issue #5**.

Miners and ex-miners often face long delays waiting for health care. BCL ex-miners in Selebi-Phikwe explained that when they were working they had to report to the mine to obtain approval from a shift supervisor in order to visit the mine hospital for health care.⁸⁹ This caused unnecessary delays in accessing care and inappropriately delegated decisions about miners’ health care to non-health care professionals, as described further above in **Critical Issue #2**.

⁸⁴ The World Bank. *Out-of-pocket expenditure (% of current health expenditure)* – Botswana. n.d. August 2020. <https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?locations=BW>; Ogunseye, Olusola Olabisi. “Analysis of the Health Financing Structure of Botswana.” *Health Systems and Policy Research* 7.3.5 (2020).

⁸⁵ Jwaneng Focus Group Discussion (2018), *supra* note 33; Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33.

⁸⁶ Dr. Motsamai Key Informant Interview (2018), *supra* note 50.

⁸⁷ Selebi-Phikwe Focus Group Discussion (2019), *supra* note 71.

⁸⁸ Jwaneng Focus Group Discussion (2018), *supra* note 33.

⁸⁹ Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33.

“It can take 2-3 months to get health care. The delays of check-ups are not regulated. If an injury gets infected, what do you do?”

— **Ex-miner** during a focus group discussion in Selebi-Phikwe

Dr. Motsamai reported that miners faced similar problems when he was a doctor at the Debswana mine hospital in Jwaneng.⁹⁰ He claimed that, although he advocated for the mine company to bring in specialists so miners could be assessed and receive specialist care immediately on site, the company refused. According to Dr. Motsamai, this resulted in delayed access to critical care for miners. Moreover, Dr. Motsamai explained that mine doctors often fail to refer miners to outside specialists until an injury or illness becomes so acute that it requires urgent care. He said that he was aware of such miners who had reported to the mine hospital with the same injury for months and even years but who had still not been referred to the specialist care they needed.

BCL ex-miners in Selebi-Phikwe reported that now that the BCL mine is closed it often takes two to three months to access the health care they need.⁹¹ While they wait, the ex-miners said they have little to no option to treat their injuries and illnesses, causing unnecessary pain and suffering.

In one alarming example, the widow of a BCL ex-miner disclosed that delayed access to health care resulted in the unnecessary amputation of her husband’s leg, shortly followed by his untimely death.⁹² The widow recounted that just before her husband’s death he had his leg amputated due to an injury he sustained during an accident at the mine years earlier. She claimed the amputation was the result of years of poor health care and delayed access to a medical device her husband needed to treat the injury. The device, she colloquially referred to as a “shoe-box,” was an orthotic leg brace that is affixed to the leg for rehabilitation. She said that after more than five years the mine company finally purchased the device. But she explained that it did not arrive in time, and the doctor was forced to amputate the ex-miner’s leg. She revealed that her husband died shortly thereafter. She further disclosed that, as of the time of the focus group discussion, she had not received any compensation from BCL or the Government for her husband’s preventable amputation and death.

Miners often lose access to health care when they are terminated or retrenched by mine companies. This leaves them without access to health care at the mine hospitals and, for some, without the ability to pay for private, specialist care needed for injuries and illnesses sustained working at the mines. During a key informant interview, the Honorable Member of Parliament

⁹⁰ Dr. Motsamai Key Informant Interview (2018), *supra* note 50.

⁹¹ Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33.

⁹² Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33.



“My husband died last month. He had his leg amputated because the ‘shoe-box’ came too late. I haven’t received anything from the mine or the government. I’m struggling now to support my children.”

— **Widow of an ex-miner** during focus group discussion in Selebi-Phikwe, December 2019.

from Jwaneng-Mabutsane, Mr. Mephato Reatile, underscored this problem and called for new legislation legally mandating mine companies to provide health care to their former workers for ten years after workers depart from the company.⁹³ As a model for such legislation, Hon. Mr. Reatile highlighted similar legislation that provides free health care to retired members of the Botswana Defence Force who were disabled during their service.⁹⁴ Hon. Mr. Reatile emphasized that legislation requiring mine companies to provide continued health care for ex-miners should cover and include all aspects of care, not limited only to occupational injuries and diseases currently recognized in law.

Debswana miners and ex-miners in Jwaneng reported that they had access to medicines while working for a mine, but if they left or were terminated they could no longer access medicines or health services.⁹⁵ BCL ex-miners in Selebi-Phikwe explained that the incentive to maintain access to health care is so great that miners choose to continue working in dangerous situations simply to avoid losing access to care.⁹⁶ One BCL ex-miner asserted that exit medical examinations at the time of the BCL mine closure revealed that his and other miners’ health

⁹⁴ Botswana Defence Force Act, 13 of 1977 (Bots.); Defence Force (Regular Force) (Officers) Regulations, 71 of 1977 (Bots.).

⁹⁵ Jwaneng Focus Group Discussion (2018), *supra* note 33.

⁹⁶ Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33.

“As soon as I was terminated by the mine, I could no longer get health care. They made me give back my medical aid. We are struggling as ex-miners.”

— Ex-miner during a focus group discussion in Jwaneng, December 2018.

had deteriorated.⁹⁷ Yet, he said that neither he nor his co-workers were provided access to health care after the tests, nor did BCL recognize their worsened health. This ex-miner suffers from an eye impairment and a leg injury, for which he had a medical device affixed following the injury. However, he claimed BCL had not acknowledged his injuries and that the company had failed to ensure his access to the specialist care he requires to treat his eye and leg.

Termination of employment at the mines even interrupts ongoing treatment, leaving miners and ex-miners without access to health care they desperately need. A Debswana ex-miner in Jwaneng recounted that when she was terminated Debswana halted her access to physiotherapy for an injury she sustained while working at the mine.⁹⁸ As soon as her employment ended, she claimed the mine company demanded she return her “medical aid,” which served as her insurance card for access to care she needed outside the mine hospital. Another ex-miner in Jwaneng explained that he was on medical leave from 2009 to 2012 as a result of a chronic cough.⁹⁹ He said that doctors at the Debswana mine hospital eventually sent him to South Africa for testing and treatment, where physicians determined he had sarcoidosis, a disease that inflames organs in the body. The miner disclosed that he was ultimately terminated by Debswana on medical grounds. He revealed that upon his termination he lost his health insurance. He said he is no longer able to afford the transportation and treatment expenses for the specialist care he requires in South Africa.

As addressed in **Critical Issue #3**, miners and ex-miners lack access to mental health care. Concerns about mental health and mental illness become especially critical when miners lose their employment, due to termination, retrenchment, the closure of a mine, or for other reasons. Ex-miners in Selebi-Phikwe, Jwaneng and Medie, Kweneng all explained that under these circumstances many miners experience anxiety, depression or shame, alongside and as a result of serious disruptions to their social, economic and family lives.¹⁰⁰ As noted in **Critical Issue #3**, BCL ex-miners in Selebi-Phikwe reported that in some cases these experiences and disruptions resulted in the deaths of ex-miners by suicide. Despite these dire circumstances, BCL ex-miners report that they do not have access to mental health services, such as counseling. Even prior to the closure of the BCL mine in Selebi-Phikwe, ex-miners explained that they

⁹⁷ Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33.

⁹⁸ Jwaneng Focus Group Discussion (2018), *supra* note 33.

⁹⁹ Jwaneng Focus Group Discussion (2018), *supra* note 33.

¹⁰⁰ Jwaneng Focus Group Discussion (2018), *supra* note 33; Medie Focus Group Discussion (2019), *supra* note 70.

“We must reform the system and enact a law that makes mine companies responsible for the health care of each and every person who worked in the mines for 10 years after they leave. It has to be like that.”

— **Honorable Member of Parliament from Jwaneng-Mabutsane, Mr. Mephato Reatile**, during a key informant interview in Gaborone, December 2019.

lacked care for anxiety, stress and feelings of depression. Ex-miners in Medie, Kweneng disclosed that they also lack access to counseling and other kinds of mental health services.

Miners and ex-miners in Jwaneng and Medie also revealed that government clinics sometimes do not have the medicines they need.¹⁰¹ Nurses at a public clinic in Selebi-Phikwe and a doctor at a private clinic in Jwaneng confirmed that public health facilities sometimes experience drug “stock-outs.”¹⁰² Government health facilities are relied upon by many ex-miners and their families who have lost access to care in mine hospitals. Despite the fact that ex-miners suffer from a range of occupational illnesses, ex-miners in Jwaneng and Medie divulged that government clinics often only carry simple pain killers, such as ibuprofen and paracetamol.¹⁰³ Dr. Motsamai further explained that while drug stock-outs are rarer in mine hospitals, regulatory licensing issues have even led to national level stock-outs of certain drugs at times.¹⁰⁴

“They spit you out like gum, never to deal with you again when you leave the mine.”

— **Ex-miner** during a focus group discussion in Jwaneng, December 2018.

¹⁰¹ Selebi-Phikwe Focus Group Discussion (2019), *supra* note 71; Jwaneng Focus Group Discussion (2018), *supra* note 33; Medie Focus Group Discussion (2019), *supra* note 70.

¹⁰² Polelo and Tawana Key Informant Interview (2018), *supra* note 52; Dr. Motsamai Key Informant Interview (2018), *supra* note 50.

¹⁰³ Jwaneng Focus Group Discussion (2018), *supra* note 33; Medie Focus Group Discussion (2019), *supra* note 70.

¹⁰⁴ Dr. Motsamai Key Informant Interview (2018), *supra* note 50.

5. Unfair Compensation Processes Leave Miners and Ex-Miners Underdiagnosed and Undercompensated for Injuries, Illnesses and Deaths

Miners, ex-miners and their family members often receive inadequate and unreliable compensation for occupational injuries, illnesses and work-related deaths. Factors contributing to this include the underdiagnosis and underassessment of miners' injuries and illnesses by mine doctors and insurance companies during incapacity designations; the difficulty miners face in accessing their medical records to seek second medical opinions; the lack of miners and ex-miners' participation in decision-making processes related to compensation; and the narrow scope and outdated content of the law delineating the injuries and illnesses for which miners can obtain compensation. To better understand the system in which these problems arise, see the **Worker's Compensation Regime** section in **A Note on the Botswana Health System and Worker's Compensation Regime** in the Appendix.

Miners and ex-miners consistent experience of receiving insufficient compensation for occupational injuries, illnesses and work-related deaths represents a failure of the Government of Botswana to respect, protect and fulfill their **Right to Health**. Among other things, the right to health requires the Government to take steps to eliminate these unfair practices through legislative, regulatory and enforcement actions. Unreliable and inadequate worker's compensation also constitutes a failure by mine companies to respect the human rights of their workers and to ensure their access to remedies, including through operational-level grievance mechanisms, in accordance with the **United Nations Guiding Principles on Business and Human Rights**.

Injured and sick miners are consistently underdiagnosed by mine doctors and underassessed by insurance companies, leading to inaccurate and unfair incapacity designations and insufficient compensation. The Honorable Member of Parliament from Jwaneng-Mabutsane, Mr. Mephato Reatile, emphasized that deficient incapacity designations for occupational injuries and illnesses is a key problem facing miners and ex-miners in his district.¹⁰⁵ He asserted that, following the initial evaluation by the government-appointed Medical Board, it is common practice for insurance companies to seek a second opinion from a private doctor in order to downgrade the percentage of a miner's incapacity. The Hon. Mr. Reatile explained, for example, that "if a miner's incapacity percentage is sitting at 65%, the second opinion from the insurance company is going to drop it maybe to 5%."

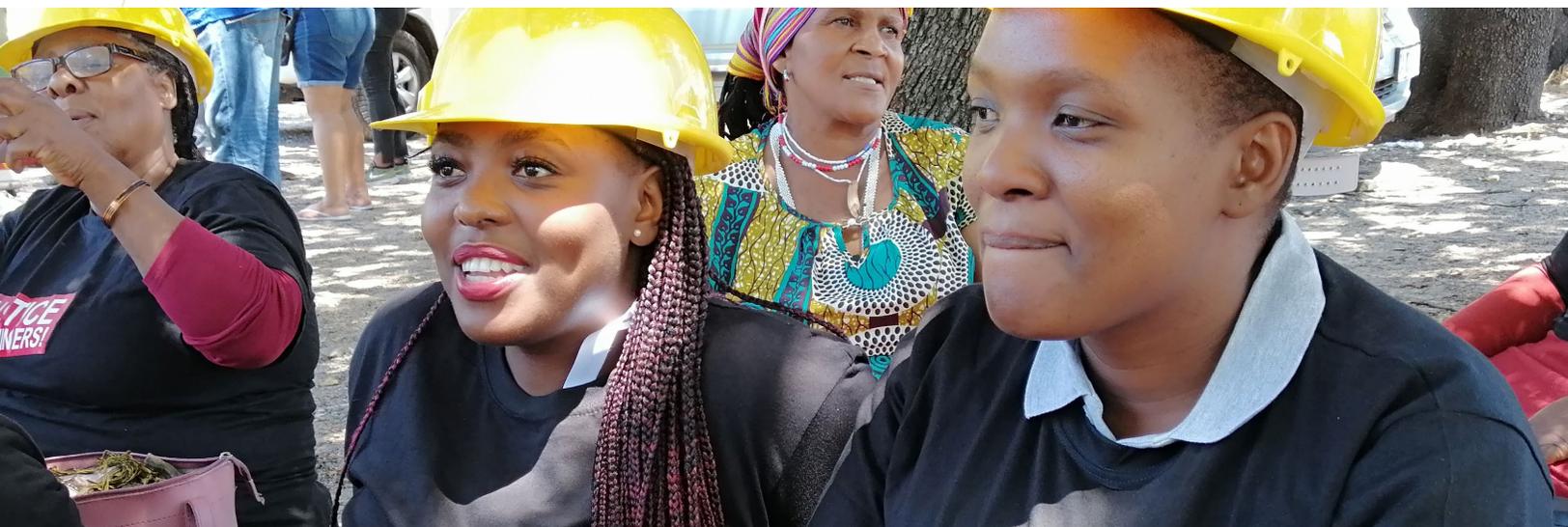
¹⁰⁵ Hon. Mr. Reatile Key Informant Interview (2019), *supra* note 93.

“If a miner’s incapacity percentage is sitting at 65%, the second opinion from the insurance company is going to drop it maybe to 5%. This is a major challenge for miners.”

— **Honorable Member of Parliament from Jwaneng-Mabutsane, Mr. Mephato Reatile**, during a key informant interview in Gaborone, December 2019.

Dr. Arnold Motsamai, a former Chief Medical Officer at Debswana who now runs a private clinic that serves miners in Jwaneng, explained that mine companies have internal medical review panels with the power to review injured and sick miners’ medical reports and to reduce their incapacity percentages or reject their reports entirely.¹⁰⁶ Dr. Motsamai recounted several instances in which he submitted medical reports for injured miners to mine company review panels, only to have his determinations rejected or downgraded without explanation and without an opportunity to challenge or question the panel’s decision. Moreover, Dr. Motsamai explained that the mine company panels do not assess a miner’s health condition themselves and they do not have the requisite technical experts for their work, such as medical specialists and health statisticians.

Further evidence that sick and injured miners and ex-miners do not receive their due compensation has been assembled by Mr. Onkabetse Mathaithai, an ex-miner and member of the Board of Directors of the Botswana Labour Migrants Association (BoLAMA). Through research and communication with ex-miners and Debswana officials, Mr. Mathaithai has developed a list of unresolved worker’s compensation claims for occupational injuries and illnesses sustained by miners working for Debswana.¹⁰⁷ The list of unresolved claims has been



¹⁰⁶ Dr. Motsamai Key Informant Interview (2018), *supra* note 50.

¹⁰⁷ Mr. Onkabetse Mathaithai’s list of unresolved Debswana worker compensations claims is a public document. It is available on file with the authors of this report.

“Four people died on the day the mine was closed. Since then, people affected have not been provided compensation or medical care. There have been a number of suicides among ex-miners after the mine closed.”

— **Ex-miner** during a focus group discussion in Selebi-Phikwe, December 2018.

officially submitted to Debswana, the office of the Honorable Mayor of Jwaneng, Mr. Tsietsi Oodira Kwenje, and the offices of the Honorable Members of Parliament, Mr. Mephato Reatile and Mr. Shauwn Matric Ntlhaile. As of January 2020, the list included more than 70 individual compensation claims that were initially unresolved, some of which were in the process of resolution or had been resolved at the time. Notably, several ex-miners on Mr. Mathaitai’s list passed away before their compensation claims were paid by Debswana. This list of unresolved Debswana worker’s compensation claims does not represent all the unresolved claims against Debswana, nor does it include claims against other mine companies. Nonetheless, it provides an important snapshot of the frequent and complex challenges miners and ex-miners’ face in obtaining fair compensation for injuries and illnesses.

In a letter addressed to the Hon. Mr. Reatile, a representative of the Debswana workers with unresolved compensation claims highlights key problems that miners and ex-miners face in obtaining their due compensation.¹⁰⁸ These include the unwillingness of the Botswana Mine Workers Union to support ex-miners in resolving their compensation claims; the lack of ex-miners’ representation on the National Medical Board that determines incapacity assessments for the Department of Labour and Social Security; Debswana’s tendency to reject miner and ex-miner’s second medical opinions of their incapacity assessments; and Debswana mine hospital doctors’ obstruction and delays in completing and processing “BL 43/03 forms” for injured or sick miners and ex-miners.

Miner, ex-miners and their family members in Jwaneng, Selebi-Phikwe and Kweneng also described difficult compensation processes and procedures, unfair outcomes, and inadequate or untimely compensation for occupational injuries, illness and work-related deaths.¹⁰⁹ In a typical example, the wife of a Debswana ex-miner in Jwaneng described how her husband, who was terminated more than a decade ago after a spinal cord injury sustained operating heavy machinery, did not receive full compensation for his injury. She reported that Debswana agreed only to compensate her husband at 20% incapacity, despite a second opinion from a South African doctor finding that he was 70% incapacitated from the injury.¹¹⁰ In fact, the

¹⁰⁸ The letter is available on file with the authors of this report.

¹⁰⁹ Jwaneng Focus Group Discussion (2018), *supra* note 33; Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33; Selebi-Phikwe Focus Group Discussion (2019), *supra* note 71; Medie Focus Group Discussion (2019), *supra* note 70.

¹¹⁰ Jwaneng Focus Group Discussion (2018), *supra* note 33.

“Some medical records are open, and some are not. Some miners come with records, and some don’t. My opinion, based on what I’ve seen, is that there are certain things that are hidden.”

— **Dr. Arnold Oneetswe Motsamai** during a key informant interview in Jwaneng, December 2018.

woman said Debswana terminated her husband shortly after he received the second medical opinion and only agreed to raise his incapacity designation 5% after the Botswana Mine Workers Union intervened.

As discussed above in **Critical Issue #4**, the widow of an ex-miner from the Government-owned BCL mine in Selebi-Phikwe reported that her husband died shortly after his leg was amputated due to an injury sustained during an accident at the mine years earlier.¹¹¹ She asserted that the amputation was likely unnecessary, as it was the result of years of poor health care and delayed access to a medical device. She recounted that it took more than five years for the mine company to purchase the medical device for her husband. However, she explained that it arrived too late and the doctor was forced to amputate her husband’s leg. She disclosed that her husband died shortly thereafter. She also stated that she has not received any compensation for her husband’s amputation or death.

Also described above in **Critical Issue #4**, a BCL ex-miner in Selebi-Phikwe claimed that exit medical examinations at the time of the BCL mine closure revealed that his and other miners’ health had deteriorated.¹¹² The ex-miner said he suffers from an eye impairment and a leg injury sustained working in the BCL mine, the latter for which he had a medical device affixed following the injury. However, he claimed BCL has not recognized his injuries or provided him compensation, despite his efforts to raise the issue with the District Commissioner, a member of the National Assembly, and the Office of the President of Botswana.

Miners and ex-miners’ often lack access to their own medical records at mine hospitals. Our research indicates that this lack of access makes it very difficult to obtain second medical opinions for occupational injuries and illnesses. This difficulty in obtaining second opinions in turn reduces miners and ex-miners’ incapacity designations and lowers the amount of compensation they receive when they are injured or fall ill. Miners, ex-miners, their family members and doctors and nurses who treat miners in the private and public sectors all confirmed the challenge miners face accessing their medical records.

¹¹¹ Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33.

¹¹² Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33.

“No, we weren’t given medical records. Miners would come with a small card that said what they were being treated for. The card was given to them by the BCL mine hospital. But BCL kept the full medical records. We would prefer to have the records. Sometimes we need them, to know their history.”

— **Nurse in the Accident and Emergencies Department** at the Botshabelo Clinic during a key informant interview in Selebi-Phikwe, December 2018.

Dr. Arnold Motsamai explained that miners who visit his private clinic in Jwaneng for treatment or for second medical opinions are often unable to provide him with their medical records from the Debswana mine hospital.¹¹³ He explained that this makes it difficult to treat miners and to fully account for injuries or illnesses sustained in the mine when completing a diagnosis for a second medical opinion. As Dr. Motsamai stated, “Some medical records are open, and some are not. Some miners come with records, and some don’t. My opinion, based on what I’ve seen, is that there are certain things that are hidden.”



¹¹³ Dr. Motsamai Key Informant Interview (2018), *supra* note 50.

Two nurses in the Accident and Emergencies Department of the Botshabelo Clinic in Selebi-Phikwe explained that BCL miners were referred to them after the closure of the mine.¹¹⁴ However, they reported the miners had not been provided their medical records by the BCL mine hospital. Instead, they recounted that the miners came to the public clinic with a small card provided by BCL that only indicated the condition the person was being treated for at the time the mine closed. One of the nurses maintained that BCL kept full medical records, but that she was not aware of a process by which she could request or obtain such records from BCL. She stated, however, “We would prefer to have the records. Sometimes we need them, to know their history.” Instead, the nurses explained that they were forced to treat sick or injured BCL ex-miners based solely on the minimal information provided on the card and the ex-miners’ own incomplete recollections of their conditions and treatments.

An ex-miner in Jwaneng revealed that the Debswana mine hospital was unwilling or unable to produce his medical records related to an eye injury he sustained working in the mine.¹¹⁵ The ex-miner disclosed that he was also unable to access his accident incident report. He explained that Debswana’s unwillingness to provide him his medical records and incident report seriously hindered his ability to obtain sufficient compensation for his injury. He further noted that when he was seeking compensation, Debswana threatened to terminate him and provide him only one-third of his salary in compensation for this injury. In order to prevent this unjust outcome, the ex-miner maintained that he was forced to travel to Gaborone to visit a document bank where—solely through his own efforts—he obtained his accident incident report. Remarkably, with the incident report he said he was able to attain an increase in compensation to two-thirds of his salary, twice what Debswana had first offered him.

Ex-miners in Medie, Kweneng also revealed that they did not have access to their medical and other documents related to compensation claims for injuries or illnesses sustained working in mines in South Africa.¹¹⁶ Several of them explained that they had maintained paper documents in the past, but as they were not told the documents were necessary for their claims, they did not safely store them and the papers were lost.

Miners and ex-miners are not provided meaningful opportunities to participate in decision-making for their own incapacity designations and compensation determinations, or for the development of the policies that undergird these processes. Our research suggests that this lack of participation leads to worse outcomes for the health and livelihoods of injured and sick miners and ex-miners in the form of incomplete incapacity designations leading to insufficient

¹¹⁴ Polelo and Tawana Key Informant Interview (2018), *supra* note 52.

¹¹⁵ Jwaneng Focus Group Discussion (2018), *supra* note 33.

¹¹⁶ Medie Focus Group Discussion (2019), *supra* note 70.

compensation. And while the Botswana Mine Workers Union represents miners' interests around several key issues, including their salaries and benefits, the Union does not regularly participate in or support miners' in their worker's compensation claims. Moreover, the Union does not represent ex-miners.

A miner in Jwaneng, speaking for a group of miners, ex-miners and their family members during a focus group discussion, stated that the focus group was the first time anyone had asked them their thoughts and perspectives on their health, including concerns related to compensation for occupational injury and disease.¹¹⁷ Moreover, rather than engaging miners and ex-miners on their concerns around worker's compensation, the wife of an injured ex-miner in Jwaneng claimed that the mine hospital regularly colluded with private health care providers to alter miners' health assessments to avoid paying compensation.¹¹⁸ A BCL ex-miner in Selebi-Phikwe gave voice to the Government's lack of engagement of ex-miners on compensation grievances when he declared, "The Government does not want to speak with us. There are ex-miners who are injured and should be put on government financial support, but this has not happened."¹¹⁹ Finally, two officials at the Department of Mines explained that though the law permits their involvement neither miners nor ex-miners participate in the development of government policies related to their health.¹²⁰ Rahul Bohra, Deputy Director of the Department of Mines at the time of the interview, revealed that while "there is a window for public review ... the public is not fully aware when the window opens," and therefore public participation is lacking.

The *Worker's Compensation Act*, 1998 that lists the injuries and illnesses for which miners and ex-miners can be compensated is out-of-date and too narrow.¹²¹ Most importantly, it does not include common occupational injuries and diseases. This leaves miners and ex-miners who are injured or sickened in the course of their work without access to compensation. The *Worker's Compensation Act* has not been revised since its enactment over twenty years ago. A member of the National Assembly of Botswana, officials in the Department of Mines, and former Debswana and BCL mine doctors all raised concerns about the limited scope of the *Worker's Compensation Act* and called for the law to be updated.¹²²

¹¹⁷ Jwaneng Focus Group Discussion (2018), *supra* note 33.

¹¹⁸ Jwaneng Focus Group Discussion (2018), *supra* note 33.

¹¹⁹ Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33.

¹²⁰ Bohra and Chimbombi Key Informant Interview (2018), *supra* note 42.

¹²¹ *Worker's Compensation Act*, 23 of 1998 (Bots.).

¹²² Hon. Mr. Reatile Key Informant Interview (2019), *supra* note 93; Dr. Mapitse Key Informant Interview (2018), *supra* note 54; Dr. Motsamai Key Informant Interview (2018), *supra* note 50; Bohra and Chimbombi Key Informant Interview (2018), *supra* note 42.



The First and Second Schedules of the *Worker's Compensation Act* lists the kinds of injuries and occupational diseases, respectively, for which miners are eligible to receive compensation. Many common injuries and illnesses that affect miners and ex-miners are not listed in these Schedules. Miners and ex-miners with these ailments are therefore not eligible for compensation. Occupational injuries and illnesses that are not included in the *Worker's Compensation Act* include tuberculosis and drug-resistant tuberculosis; HIV; repetitive strain injuries; back injuries, such as sprains, strains, herniated discs and fractured vertebrae; gradual onset hearing loss (short of total loss of hearing in one or both ears); diminished eyesight (short of total loss of sight in one or both eyes); and all forms of mental illness, including depression and anxiety.

The exclusion of these common injuries and illnesses suffered by miners from the *Worker's Compensation Act* represents a critical gap in the legal and policy framework. Our research indicates that this gap contributes to poor health outcomes and prevents miners and ex-miners from receiving their due compensation. The failure of the law to account for common occupational injuries and illnesses further imposes an undue economic burden on miners, ex-miners and their families. They incur both a loss of income from their inability or reduced capacity to work and additional health expenses as a consequence of receiving insufficient compensation to cover their health care. As noted above in **Critical Issue #4**, the Honorable Member of Parliament from Jwaneng-Mabutsane, Mr. Mephato Reatile, highlighted this gap and called for new legislation legally mandating mine companies to provide health care to their employees for ten years following an employee's departure from the company.¹²³ The Hon. Mr. Reatile emphasized that such legislation should cover all aspects of health care and not be limited only to occupational injuries and diseases currently recognized by the *Worker's Compensation Act*.

¹²³ Hon. Mr. Reatile Key Informant Interview (2019), *supra* note 93.

6. Miners and Ex-Miners Are Not Provided Opportunities to Participate in Decision-Making about Their Health

Miners and ex-miners are not provided meaningful opportunities to participate in decision-making processes that impact their health. Miners, ex-miners, their family members and representatives of the Botswana Mine Workers Union, the Chamber of Mines and the Department of Mines all confirmed that miners and ex-miners are not directly involved in key decision-making processes around health and safety in government, at mine companies or in the Chamber of Mines. In particular, miners and ex-miners are not afforded meaningful opportunities to contribute to the development of policies and regulations that govern the industry or the mine companies' own health and safety policies, practices and procedures. Relatedly, at least one mine company actively refuses to consult or cooperate with the health care workers charged with the care of its employees. Moreover, neither the Government nor BCL mine managers provided fair notice or meaningful consultation to the Union or BCL miners prior to the 2016 closure of the Government-owned BCL mine in Selebi-Phikwe. The BCL mine liquidators have also failed to meaningfully engage the Union or BCL ex-miners on health- or compensation-related decision-making during the liquidation process.

Participation of affected communities in health-related decision-making is a fundamental aspect of the **Right to Health**. The lack of opportunities provided for miners and ex-miners to participate in decision-making processes that impact their health constitutes a failure of the Government of Botswana to respect, protect and fulfill their right to health. It also represents a failure of mine companies to abide by the **United Nations Guiding Principles on Business and Human Rights**, which calls on businesses to ensure their workers and the communities affected by their operations are provided opportunities to participate in corporate decision-making that affects them.

During an interview, the then Deputy Director and Principal Engineer of the Department of Mines revealed that though the law permits their involvement neither miners, ex-miners nor the Botswana Mine Workers Union participate meaningfully in the formulation of policies and regulations that govern the mining industry.¹²⁴ When asked whether miners or ex-miners participate directly or through their Union representatives in the development of mining policies and regulations, the officials explained that only the Chamber of Mines participates in policy development. However, the Department of Mines officials explained that the Chamber represents the interests of mine companies, not miners or ex-miners. The officials further noted that though there is a period for public review of Department of Mines policies the public is not fully aware of when this window is open. As described in detail below, miners and ex-miners in Jwaneng, Selebi-Phikwe and Medie, Kweneng corroborated this information during focus group discussions, confirming that the Government of Botswana does not meaningfully engage miners or ex-miners on issues related to their health.

¹²⁴ Bohra and Chimbombi Key Informant Interview (2018), *supra* note 42.

“There are a lot of things going on in Medie that worry me a lot. Things happen here without our input. Even people that we have entrusted to speak on our behalf, don’t take us seriously. This worries us very much.”

— Ex-miner during a focus group discussion in Medie, Kweneng, December 2019.

Mine companies also do not consult or involve miners or ex-miners in the development of the policies, practices and procedures that regulate health and safety in the mines and surrounding communities. As noted above in **Critical Issue #5**, miners, ex-miners and their family members in Jwaneng disclosed that our focus group discussion in December 2018 was the first meeting they had been involved in specifically about their health and health-related concerns.¹²⁵ When asked directly whether the mine companies had consulted with them about their health and safety, a Debswana ex-miner answered, “No.” Instead, he said “there is an unwritten policy that you do not discuss anything bad that happens in the mine outside of the mine.” He further asserted, “Once you leave the mine, it’s very difficult to have any communication with the company or the Government—they do not want to deal with ex-employees.”

Ex-miners living around the Minergy Masama Coal Mine in Medie, Kweneng also stated that they have not been consulted by the mine company about important decisions affecting their health and the health and wellbeing of their community.¹²⁶ As discussed in greater detail below in **Critical Issue #7**, an ex-miner in Medie revealed that the Minergy coal mine and its related operations have disrupted long-standing indigenous lifestyles and traditions, including ancestral burial grounds. Another ex-miner in Medie explained that the road by which coal is transferred out from the mine runs through the community and constitutes a major health hazard. He further explained that blasting at the mine has collapsed houses in the community due to the close proximity of the mine. Despite all of this, the ex-miners and community members asserted that the mine was built and now operates without input from the community. Moreover, they maintained that they have formally requested a meeting with Minergy and local political leaders to discuss these problems, but had not yet been provided the opportunity at the time of our focus group discussion in December 2019.

The Senior Registered Nurse who runs the only health facility near the Minergy coal mine—the government health outpost in Medie—also revealed that Minergy has declined to engage him to discuss the health and safety of Minergy coal miners.¹²⁷ The Minergy does not have a clinic or provide health care services for its miners at the Masama Coal Mine. As a result, the Medie health outpost is the first point-of-care for coal miners at Minergy. Despite this, the

¹²⁵ Jwaneng Focus Group Discussion (2018), *supra* note 33.

¹²⁶ Medie Focus Group Discussion (2019), *supra* note 70.

¹²⁷ Skelago Key Informant Interview (2019), *supra* note 33.

“When we went into work that morning, they told us the mine had closed and we were out of a job. This is how we learned about the BCL mine closure.”

— Ex-miner during a focus group discussion in Selebi-Phikwe, December 2018.

Senior Registered Nurse explained that he had made several attempts to contact the Chief Officer of the mine, but the officer had refused to speak or meet with him thus far. The nurse highlighted the importance of coordinating with the mine company, noting that the size of the Medie community had more than doubled—from 450 to more than 1,000 people—since the coal mine began operating. And he emphasized that the next closest health facility is in Lentsweletau, more than 20 km away from Medie. As mentioned above in **Critical Issue #1**, the nurse further stated that he was concerned about the welfare of the Minergy miners “because every time they come here, they complain about the dust over there, they complain there’s no protective clothing.”

During a key informant interview in December 2018, a representative of the Botswana Chamber of Mines corroborated in part and further clarified the experiences shared by miners and ex-miners regarding their participation in health-related decision-making.¹²⁸ The Chamber of Mines representative explained that only the Botswana Mine Workers Union participates in the Chamber’s bi-annual industry-wide meetings to discuss and make decisions on health and safety in the mines. The representative stated that miners and ex-miners do not participate directly in these discussions. Moreover, he noted that the Union only has observer status and cannot vote during the decision-making processes. However, in a subsequent correspondence the Botswana Chamber of Mines representative asserted that divisions within mine companies hold regular meetings on health, safety and environmental issues. He maintained that the meetings feed into corporate decision-making and are attended by mine workers’ representatives, some of whom may be members of the Union. The representative noted that these meetings are chaired by corporate management and involve discussions on health and safety challenges and strategies to address these challenges.

Our research indicates that neither the Government nor the BCL mine managers notified or consulted BCL miners or the Botswana Mine Workers Union prior to 2016 closure of the Government-owned BCL mine in Selebi-Phikwe. Nor have the mine liquidators involved ex-miners in decision-making processes that impact their health and wellbeing. As noted above in **Critical Issue #3**, during two focus group discussions in Selebi-Phikwe in December 2018 and December 2019, BCL ex-miners explained that they only learned that the mine was closing

¹²⁸ Key Informant Interview with a representative of the Chamber of Mines led by Feyi Lawanson in Gaborone, Botswana (Dec. 13, 2018).

on the day it was closed, when they arrived at the mine for work that morning.¹²⁹ An ex-miner revealed, “When we went into work that morning, they told us the mine had closed and we were out of a job.”

In December 2018, a representative of the Union reported that the Union was only informed the night before the BCL mine’s closure.¹³⁰ In December 2019, another Union representative revealed that it has taken more than a year, on more than one occasion, for the Ministry of Mineral Resources, Green Technology & Energy Security to meet with the Union about the situation in Selebi-Phikwe.¹³¹ He stated that the Union met the Minister twice, in June 2018 and August 2019, but that nothing had changed. BCL ex-miners also complained that the Government has been unwilling to speak with them to understand and address the numerous problems they have faced since the closure of the mine. Ex-miners also described a lack of communication and engagement with both the mine liquidators, remarking that they did not get regular updates from the liquidator and that there was no clear line of communication between BCL ex-miners and the liquidator.¹³² Moreover, ex-miners asserted that they had never been provided access to the BLC mine closure plan.

As described above in **Critical Issue #5**, miners, ex-miners, their family members and the Botswana Mine Workers Union are shut-out of key decision-making processes in the Government and at mine companies around worker’s compensation. Our research indicates that this lack of participation leads to worse health outcomes, inadequate incapacity designations and insufficient compensation for miners, ex-miners and their family members. For example, rather than working with injured or sick miners to ensure they receive due compensation, the wife of an injured ex-miner in Jwaneng claimed that the Debswana mine hospital colluded with private health care providers to lower health assessments, so the company and insurance provider could lower their compensation payments.¹³³ An ex-miner in Jwaneng explained that during his efforts to obtain compensation for an injury he suffered as a miner at Debswana, he had been blocked from accessing critical medical records pertaining to his injury.¹³⁴ He further disclosed that while he was travelling to Gaborone to obtain the necessary documents, the Debswana medical review panel had made a decision regarding his incapacity percentage without consulting him. An ex-miner in Selebi-Phikwe asserted that there were injured BCL ex-miners who needed financial support from the Government, but that the Government refused even to engage with them on the issue.¹³⁵ Finally, in a letter

¹²⁹ Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33; Selebi-Phikwe Focus Group Discussion (2019), *supra* note 71.

¹³⁰ Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33.

¹³¹ Selebi-Phikwe Focus Group Discussion (2019), *supra* note 71.

¹³² Selebi-Phikwe Focus Group Discussion (2019), *supra* note 71.

¹³³ Jwaneng Focus Group Discussion (2018), *supra* note 33.

¹³⁴ Jwaneng Focus Group Discussion (2018), *supra* note 33.

¹³⁵ Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33.

addressed to the Honorable Member of Parliament from Jwaneng-Mabutsane, Mr. Mephato Reatile, a group representing Debswana ex-miners with unresolved worker's compensation claims highlighted the lack of ex-miners' representation on the National Medical Board that determines incapacity assessments for the Department of Labour and Social Security as a major barrier to receiving their due compensation.¹³⁶

7. Miners, Ex-Miners and Their Communities Experience Housing Insecurity and Disruptions of Indigenous Lifestyles and Traditions

Miners, ex-miners and their family members experience housing insecurity in dwellings provided by mine companies, including insecurity of tenure, high utility prices and hazardous living conditions. Communities near mine operations also experience disruptions to their indigenous lifestyles and traditions and even the collapse of their homes as a result of blasting in the mines. Housing insecurity is a household's failure to encompass one or more elements of secure housing: affordability; stable occupancy; or safe and adequate living conditions.¹³⁷ Housing insecurity is associated with a range of health conditions, including respiratory illnesses and poor mental health.¹³⁸ Loss of housing can affect physical health through exposure to the elements, lack of clean air or water, vulnerability to crime and the spread of infectious diseases when sheltering with others. Loss of housing can also contribute to poor mental health, disrupting human relationships, interrupting education and causing anxiety and shame.

Adequate housing is an important social determinant of health and a part of the **Right to Health**.¹³⁹ Miners, ex-miners and their family members experiences of housing insecurity, the disruption of indigenous lifestyles, and the collapse of their homes from mine operations represents a failure of the Government of Botswana to protect and fulfill their right to health. The experience of housing insecurity among miners, ex-miners and their families living in corporate housing also represents a failure of mine companies to fulfill their responsibilities set forth in the **United Nations Guiding Principles on Business and Human Rights** to respect their workers' human rights and to address adverse human rights impacts with which they are involved.

¹³⁶ The letter is available on file with the authors of this report.

¹³⁷ Virgile, Matt, et al. *Cognitive Pretesting of 2019 American Housing Survey Module on Housing Insecurity*. Research Report Series. U.S. Census Bureau. Washington, D.C.: U.S. Census Bureau, 2019.

¹³⁸ Krieger, James and Donna L. Higgins. "Housing and Health: Time Again for Public Health Action." *American Journal of Public Health* 92.5 (2002): 758-768.

¹³⁹ Gibson, Marcia, et al. "Housing and Health Inequalities: A Synthesis of Systematic Reviews of Interventions Aimed at Different Pathways Linking Housing and Health." *Health & Place* 17.1 (2011): 175-184.

“I have three children and a husband who died in the mines. I have nowhere to go.”

— **Widow of an ex-miner** during a focus group discussion in Selebi-Phikwe, December 2019.”

Ex-miners and their family members in Selebi-Phikwe and Francistown have suffered insecurity of housing tenure following the Government’s closure of its BCL and Tati nickel mines in 2016. The Botswana Chamber of Mines reports that BCL’s assets include approximately 2,000 residential properties.¹⁴⁰ In January 2019, BCL liquidators issued letters of eviction to BCL ex-miners and their families who remained in BCL housing.¹⁴¹ A campaign by the Botswana Mine Workers Union led to an agreement whereby the Government agreed to pay rental fees for former BCL workers until February 2020.¹⁴²

A former Union Shop Steward at BCL reported in July 2020 that the agreement would be extended for an additional six months starting at the end of July 2020.¹⁴³ Notwithstanding these agreements, widows of deceased BCL ex-miners revealed that they have been threatened with eviction from BCL housing on multiple occasions during the years following the closure of the BCL mine.¹⁴⁴ A widow with three children in Selebi-Phikwe disclosed that following the death of her husband she received an order from BCL to vacate the company house.¹⁴⁵ As a



¹⁴⁰ BCL Liquidation, *supra* note 25.

¹⁴¹ Dube, Chakalisa. “Ex-BCL mineworkers to retain tenancy.” *Mmegi Online* 19 February 2019.

¹⁴² *Ibid.*

¹⁴³ Information shared directly with authors of this report via WhatsApp in July 2020.

¹⁴⁴ Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33; Selebi-Phikwe Focus Group Discussion (2019), *supra* note 71.

¹⁴⁵ Selebi-Phikwe Focus Group Discussion (2019), *supra* note 71.

“The mine managers and executives were allowed to stay in the mine houses after the closure, and they were given allowances later. But the miners’ allowances stopped as soon as the mine closed. This had consequences. A lot of people defaulted on their rentals, some properties were confiscated, and some went into debt owing large amounts of money to landlords.”

— Ex-miner during a focus group discussion in Selebi-Phikwe, December 2019.

consequence, she stated, “I live in fear that at any time, any day, the letter will be enforced, and I will lose my home.” The widow explained that she receives assistance through a government poverty relief program but that it is not enough. She further claimed that she has not received any assistance from BCL or the mine liquidators.

The Tati nickel mine near Francistown was closed around the same time as the BCL mine.¹⁴⁶ A Tati ex-miner recounted that the Tati mine managers and executives remained in their corporate homes following the mine’s closure. However, he claimed that the mine company stopped providing miners their housing allowances as soon as the mine closed. As a result, he said many Tati ex-miners “defaulted on their rentals, some properties were confiscated, and some went into debt owing large amounts of money to landlords.” Debswana ex-miners in Jwaneng revealed that they experienced housing insecurity when they left the mine.¹⁴⁷ An ex-miner in Jwaneng who is disabled due to an injury sustained working at Debswana recounted that on the day she received her dismissal letter she returned home from the doctor’s office to



¹⁴⁶ Selebi-Phikwe Focus Group Discussion (2019), *supra* note 71.

¹⁴⁷ Jwaneng Focus Group Discussion (2018), *supra* note 33.

“Our bills are always extremely high, as high as 3,000 to 10,000 pula a month. This takes a significant chunk of my salary each month.”

— Miner during a focus group discussion in Jwaneng, December 2018.

find Debswana had cut her electricity and water and refused to allow her to enter her home. Another Debswana ex-miner in Jwaneng declared, “As soon as you leave the mine, the company is done with you.” She explained that she had managed to build a new home after Debswana forced her to vacate corporate housing upon her termination, but her living conditions there were poor and she no longer had consistent access to clean water. Another Debswana ex-miner in Jwaneng recounted a similar experience that had left him homeless. After leaving Debswana, he said he had purchased a plowing field on which to live and sustain himself. But he said that he had been unable to make productive use of the land due to poor weather conditions. As a result, he maintained that he lacks the financial resources to build a structure in which to live. He divulged that he was homeless at the time of the focus group discussion.

Even in cases where miners and ex-miners continue to live in corporate housing in Jwaneng and Selebi-Phikwe, some are burdened by unaffordable utility bills for water and electricity. A miner in Jwaneng observed that, although his housing was acceptable, his utility bills for basic necessities and services were always very high, from 3,000 to 10,000 pula a month.¹⁴⁸ He explained that these expenses represented a significant and prohibitive proportion of his monthly salary. A BLC ex-miner in Selebi-Phikwe recounted a similar problem and the Deputy Branch Chairperson of the Botswana Mine Workers Union corroborated these experiences, noting that miners frequently protest the high price of water in their corporate housing.¹⁴⁹

Some miners, ex-miners and their families endure hazardous living conditions in corporate housing, including exposure to rodent and insect infestations and hazardous substances. A BCL ex-miner in Selebi-Phikwe described unsanitary living conditions in corporate housing.¹⁵⁰

He reported that BCL houses were often infested with rodents and insects, such as roaches, but BCL housing administrators did not properly address these problems. The Union Deputy Branch Chairperson stated that in his view the primary concern related to miners’ living conditions was the presence of hazardous substances in corporate housing.¹⁵¹ He revealed that there was asbestos in some miners’ homes. Asbestos is a term used for several naturally occurring minerals that were previously used in building construction but are now known to be health hazards that cause cancer and other lung diseases. The Union Deputy Branch

¹⁴⁸ Jwaneng Focus Group Discussion (2018), *supra* note 33.

¹⁴⁹ Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33; Phiku Key Informant Interview (2018), *supra* note 49.

¹⁵⁰ Selebi-Phikwe Focus Group Discussion (2018), *supra* note 33.

¹⁵¹ Phiku Key Informant Interview (2018), *supra* note 49.

“Our houses are collapsing because of the blasting. Our ancestral lands have been taken over without proper consultation. We are not against the Government, but against the proximity of the mine to the village.”

— Ex-miner and community member during a focus group discussion in Medie, Kweneng, December 2019

Chairperson said that the affected mine companies were working to replace the asbestos with concrete, but not quickly enough to eliminate the health hazard.

The Minergy Masama Coal Mine in Medie, Kweneng has disrupted the indigenous lifestyles and traditions of the surrounding community and even physically destroyed some of their homes. Ex-miners and community members in Medie explained that the location and operation of the mine has made it very difficult for them to hunt and otherwise make use of their natural environment in accordance with their indigenous traditions and culture.¹⁵² They further noted that the mine is located very close to the land where their ancestors are buried. They said they have requested a piece of land on which to safeguard their ancestors’ remains in order to transfer their culture and traditions to the next generation, but that their request had not been granted at the time of the focus group discussion in December 2019.



¹⁵² Medie Focus Group Discussion (2019), *supra* note 70.

“I am frustrated by the mine. I was using indigenous knowledge. I lived on natural resources, like hunting, but all the resources have been taken over by the mine. We originally requested the mine not to be operated near the village. The mine has eroded our culture and indigenous knowledge.”

— Ex-miner and community member during a focus group discussion in Medie, Kweneng, December 2019

Ex-miners and other community members in Medie further disclosed that the proximity of the Minergy coal mine to their village has resulted in large amounts of dust in and around their homes.¹⁵³ They also revealed that the blasting in the mine has caused some homes in the community to collapse. In fact, the community members claimed that they had originally requested that the mine be located further from their village, but that their request was rejected. The mine is now located just 2 km away from the village of Medie.



¹⁵³ Medie Focus Group Discussion (2019), *supra* note 70.

8. Environmental Assessments Ignore Mines' Impacts on Occupational and Community Health

The laws and regulations that require environmental impact assessments for mine operations in Botswana are too narrow in scope. They do not sufficiently consider the health and social wellbeing of miners, ex-miners and their communities. In particular, environmental assessment law and regulation does not account for the impact mines have on occupational and community health. As a result, mine companies are not legally required to assess and account for the ways their operations will affect the health of miners, ex-miners and their communities prior to receiving a mining permit. Our research indicates that the consequences of this failure to legally require mine companies to account for occupational and community health include preventable poor health and disruptions to the social wellbeing of communities affected by mining.

As explained further below, the limited scope of environmental assessments in Botswana is inconsistent with best practices at international, regional and national levels and fails to meet industry standards, including those established by the International Council on Mining and Metals. The lack of law and regulation mandating mine companies to account for their occupational and community health impacts also constitutes a failure of the Government of Botswana to protect and fulfill the **Right to Health** of miners, ex-miners and their communities.

This gap in the legal and policy framework further contributes to the failure of mine companies to abide by the **United Nations Guiding Principles on Business and Human Rights**. The *UN Guiding Principles* call on corporations to facilitate “meaningful consultation” with affected communities as part of their responsibility to conduct human rights due diligence for their operations.¹⁵⁴ Mine companies fail to fulfill their responsibility for due diligence when they do not comprehensively assess the impacts of their operations ahead of time. Meaningful community consultation is not possible without a holistic impact assessment that accounts for the health and social wellbeing of affected communities.

The *Environmental Assessments Act, 2011* and *Environmental Assessment Regulations, 2012* establish the legal and regulatory framework in Botswana that governs environmental impact assessments of “planned development activities,” including mine operations. Among other things, the Act establishes the scope, objectives, stages, and actors and institutions involved in environmental impact assessments. The Act states that environmental impact assessments aim “to determine and ... provide mitigation measures” for the “significant adverse impact” of planned development activities and to put in place a monitoring and evaluation process for activities that are already implemented.¹⁵⁵ The Regulations lay out the kinds of activities

¹⁵⁴ Environmental Assessments Act, 10 of 2011 (Bots.) [hereinafter Assessments Act]; Environmental Assessment Regulations, 58 of 2012 (Bots.) [hereinafter Assessment Regs].

¹⁵⁵ Assessments Act, *ibid* Preamble.

and projects that are subject to the Act, and the procedures and forms for conducting an assessment, facilitating public participation and certifying practitioners. The Act includes health and social aspects in the definition of “environment” and in defining what the assessment should “identify and evaluate.”¹⁵⁶ The Regulations mention “health” in defining positive and negative impacts, and mitigation measures, the latter mentioning “the health and safety of workers or employees.”¹⁵⁷

However, neither the *Environmental Assessments Act* nor the *Environmental Assessment Regulations* provide sufficient detail to conduct comprehensive assessments of the occupational or community health impacts of proposed or existing mine operations. Occupational health can be defined broadly to encompass all aspects of physical and mental health and safety affecting miners and ex-miners, with a focus on the identification and elimination of health and safety hazards in the mines and the provision of comprehensive health care, including preventive, primary and specialist care. Community health can be defined broadly to include all aspects of the physical, mental and social health of communities affected by mine operations, including but not limited to those aspects related to the mine’s impact on the natural environment and indigenous lifestyles and traditions.

Our research indicates that standards and best practices at international, regional and national levels, as well as within the extractive industry, incorporate health and social impacts as part of environmental impact assessments of mining and other development activities. In this respect, “Environmental, Social and Health Impact Assessments,” as they are often called, represent a broad, global consensus. The World Health Organization (WHO), recognizes human health as a crucial component of impact assessments for proposed policies, programs or projects.¹⁵⁸ The Development Bank of Southern Africa’s *SADC Environmental Legislation Handbook* urges countries in the Southern African Development Community (SADC) to adopt more comprehensive environmental assessments that include social and health impacts.¹⁵⁹ At the national level, Canada, the United States and Australia all incorporate health in their development impact assessment frameworks. Canada requires mines to conduct “Health Impact Assessments” that consider impacts on health services, working conditions, income, social status, social support networks, physical environments, education and child development.¹⁶⁰ In the United States, the Environmental Protection Agency (EPA) addresses

¹⁵⁶ Assessments Act, *ibid* §§ 1, 9.

¹⁵⁷ Assessment Regs, *supra* note 154, §§ h, j.

¹⁵⁸ Fehr, Reiner, et al. *Health in Impact Assessments: Opportunities Not to Be Missed*. World Health Organization. Copenhagen: World Health Organization, 2014.

¹⁵⁹ Walmsley, Bryony and Saphira Patel. *SADC Environmental Legislation Handbook 2012*. Development Bank of Southern Africa, Southern African Institute for Environmental Assessment & United States Agency for International Development. Pretoria: Development Bank of Southern Africa, 2011.

¹⁶⁰ Health Canada. *Canadian Handbook on Health Impact Assessment - Volume 1: The Basics*. Ottawa: Health Canada, 1999.



health-related concerns in assessments conducted under the *National Environmental Protection Act, 1969 (NEPA)*.¹⁶¹ NEPA requires consideration and analysis of health effects including, changes in community demographics, involuntary displacement of residents or businesses, employment, land-use patterns, changes in modes or safety of transportation, reductions in access to natural resources, and changes in food and agricultural resources.¹⁶² In Australia, Health Impact Assessments are required by law in the territories of Victoria, Tasmania, and Australia Capital Territory.¹⁶³ The physical health effects associated with environmental damage in Australia are considered to include worker health and safety, a group's culture and traditional land use, employment opportunities, and health impacts as they relate to climate change.¹⁶⁴ The International Council on Mining and Metals (ICMM), an organization comprising 27 mining and metal companies and 38 regional and commodities associations, advises mine companies to consider the environmental, social and health impacts of mining projects on the local community and wider society.¹⁶⁵ Occupational health and community health, as defined above, are central to the ICMM's *Good Practice Guidance on Health Impact Assessment*.¹⁶⁶ The Guidance describes how to assess a wide range of mine operations' impacts, including on infectious diseases, chronic diseases, nutritional disorders, physical injuries, mental health and wellbeing, housing and sanitation.

¹⁶¹ National Environmental Policy Act of 1969 § 102, 42 U.S.C. § 4332.

¹⁶² U.S. National Research Council. *Improving Health in the United States: The Role of Health Impact Assessment*. Consensus Study Report. National Research Council of the National Academies. Washington, D.C.: National Academies Press, 2011.

¹⁶³ Patrick, Harris and Jeff Spickett. "Health Impact Assessment in Australia: A Review and Directions for Progress." *Environmental Impact Assessment Review* 31.4 (2011): 425-432.

¹⁶⁴ *Ibid.*

¹⁶⁵ International Council on Mining and Metals. *About us*. n.d. August 2020. <http://www.icmm.com/en-gb/about-us>.

¹⁶⁶ International Council on Mining and Metals. *Good Practice Guidance on Health Impact Assessment*. London: International Council on Mining and Metals, 2010.

Critical Issues to Finance the Right to Health in Botswana

This section presents the findings and analysis of the Botswana Miners Right to Health Project’s two-year assessment of the Government of Botswana and Botswana mine companies’ efforts to finance the right to health. These critical issues speak to the Resources element of the OPERA Framework, in that they examine the steps taken to equitably generate, allocate and spend sufficient resources for the right to health. In doing so, this section provides the underlying economic context for the **Critical Issues for the Right to Health of Miners and Ex-Miners in Botswana** section above.

As noted above, although Botswana has one of the highest per capita GDPs in Africa, it continues to be a deeply unequal country.¹⁶⁷ Botswana ranks among the ten most unequal countries according to the Gini Index, a statistical measurement of income inequality. And more than 16% of people in Botswana live in poverty.¹⁶⁹ Moreover, as this report demonstrates, the miners and ex-miners who do the work that drives the Botswana economy are subjected to severe deprivations to their health. The Government of Botswana’s obligations to finance the right to health are grounded in human rights principles that require governments to utilize their “maximum available resources” to progressively realize social and economic rights.¹⁷⁰

To make use of maximum available resources the Government of Botswana must ensure sufficient revenue to finance the infrastructure, goods and services needed to realize the right to health. This obligation in turn has three dimensions—resource generation, resource allocation and resource expenditure. This section explores two of these dimensions:

- » Resource generation, pertaining to how governments raise money; and
- » Resource allocation, addressing how governments earmark money in their budgets, and who money benefits.

The Government of Botswana should also ensure it raises revenue in an equitable manner through progressive taxation. Among other things, progressive taxation may include:

- » Introducing or substantially increasing taxes on wealthy individuals;
- » Reducing reliance on value added taxes, which place a greater burden on the poor as compared to the wealthy;

¹⁶⁷ CIA World Factbook, *supra* note 1; World Bank Data, *supra* note 1.

¹⁶⁸ Gini Index, *supra* note 3.

¹⁶⁹ Botswana Poverty Statistics, *supra* note 3.

¹⁷⁰ These obligations are primarily established in Article 2(1) of the *International Covenant on Economic, Social and Cultural Rights*. *International Covenant on Economic, Social and Cultural Rights*, Dec. 16, 1966, 993 U.N.T.S. 3 [hereinafter ICESCR].

- » Introducing taxes on particular sectors, such as on luxury goods, financial transactions, or extractives and natural resources; and
- » Raising corporate tax rates and taking aggressive steps to eliminate corporate tax avoidance and tax evasion, including for mine companies.

The Government of Botswana should then allocate its resources in an equitable and efficient manner. In doing so, it should prioritize groups and areas of the health system that are most in need. It should also ensure adequate resources are allocated to the Ministries to fulfill their regulatory, oversight and enforcement duties in relation to the health system and the mining industry.

The *Guiding Principles on Business and Human Rights: Implementing the United Nations “Protect, Respect and Remedy” Framework (UN Guiding Principles)* clarify the responsibilities of businesses under international human rights law. At their core, the *UN Guiding Principles* establish that businesses must respect their workers’ human rights and avoid causing or contributing to adverse human rights impacts through their operations. They must also address and mitigate all human rights impacts linked to their operations. As this report demonstrates, mine companies in Botswana have negatively impacted the right to health of their workers. In addition to improving their corporate policies and practices to mitigate this negative impact, mine companies must ensure they contribute their fair share of taxes to the Government of Botswana to finance the right to health of miners, ex-miners and their communities.

For more information about the OPERA Framework, the right to health and the *UN Guiding Principles*, see the **Methodology, Right to Health and United Nations Guiding Principles on Business and Human Rights** sections in the Appendix.



1. The Government of Botswana Does Not Equitably Generate Sufficient Revenue for Health

The Government of Botswana must generate sufficient resources to finance the right to health of miners, ex-miners and their communities. Though Botswana is an upper-middle income country and one of the wealthiest in Africa, it collects very little tax in relation to the size of its GDP. In 2017, Botswana's tax-to-GDP ratio was lower than the average of all 26 African countries considered in a study by the Organisation for Economic Cooperation and Development (OECD).¹⁷¹ It was also lower than the average among Latin American countries.¹⁷² In fact, Botswana's tax-to-GDP ratio has been trending downwards.¹⁷³ All of this means the Government of Botswana has been "leaving money on the table" and it strongly indicates Botswana can generate greater fiscal space through additional taxation.¹⁷⁴

As outlined in the next section, **The Government of Botswana Does Not Allocate Sufficient Resources for Health**, the Government has taken some steps to increase allocations to health in recent years. But the size of the overall budget has posed limitations on the amount it can allocate, in actual pula. There are a number of strategies the Government should pursue to generate more revenue overall, so it may devote more resources to health and other critical social programs.

Domestic resource mobilization in Botswana is relatively weak. The International Monetary Fund reports that domestic resource mobilization, not including mineral revenues, has fallen to less than 10% of GDP.¹⁷⁵ This is especially concerning given the limited horizon of diamond revenues and the growing calls to diversify the Botswana economy.¹⁷⁶ While diamond revenues make up the bulk of mineral revenues, they are forecasted to be exhausted over the coming decades.¹⁷⁷ In an effort to increase revenue, Botswana introduced a value-added tax (VAT) in 2002.¹⁷⁸ VAT is a consumption tax placed on the purchase of goods and services. VAT taxes are

¹⁷¹ Organisation for Economic Cooperation and Development, African Union & African Tax Administrative Forum. "Revenue Statistics in Africa 2019 - Botswana." 2019.

¹⁷² Ibid.

¹⁷³ The World Bank. *Tax revenue (% of GDP)*. n.d. August 2020. <https://data.worldbank.org/indicator/GC.TAX.TOTL.GD.ZS>.

¹⁷⁴ The United Nations Development Program defines fiscal space as "the financing that is available to government as a result of concrete policy actions for enhancing resource mobilization, and the reforms necessary to secure the enabling governance, institutional and economic environment for these policy actions to be effective, for a specified set of development objectives." Roy, Rathin, Antoine Heuty and Emmanuel Letouzé. *Fiscal Space for What? Analytical Issues from a Human Development Perspective*. Paper for the G-20 Workshop on Fiscal Policy. United Nations Development Programme. Istanbul: United Nations Development Programme, 2007.

¹⁷⁵ International Monetary Fund. *Botswana: Selected Issues*. International Monetary Fund. Washington, D.C.: IMF Publication Services, 2017 [hereinafter IMF Botswana Report].

¹⁷⁶ See, e.g., Shantyaevi, Sanam. "Diamonds aren't forever: Botswana seeks to diversify its economy." FRANCE 24 12 December 2017.

¹⁷⁷ Farole, Thomas. *Botswana: Systematic Country Diagnostic*. The World Bank. Gaborone: The World Bank, 2015.

¹⁷⁸ Ndlovu, Thatshisiwe. "Fiscal Histories of Sub-Saharan Africa: the Case of Botswana." Working Paper Series: No.1. University of the Witwatersrand, 2016.

known to be more regressive than other kinds of taxes, such as corporate taxes, because they put a greater financial burden on poorer households as compared to wealthier ones.¹⁷⁹

DOMESTIC RESOURCE MOBILIZATION NOT INCLUDING MINERAL REVENUES as a percentage of GDP¹⁷⁵



The International Monetary Fund reports that **Botswana's non-mineral domestic resource mobilization** has fallen to **less than 10%** of its total GDP.

At the same time, personal income tax, which is another key source of non-mineral revenue in Botswana, is not collected in the most progressive manner possible. Not only does Botswana collect less personal income tax as a percentage of GDP than its neighbors in the Southern Africa Customs Union (SACU), but also its highest marginal personal income tax rate is lower than the other SACU members.¹⁸⁰ Together, these facts strongly suggest both that Botswana is not generating enough revenue from personal income tax in general and the revenue it is generating is coming disproportionately from poorer households. This is not a surprise given the rate of economic inequality in the country, to which regressive tax policies contribute.

Corporate taxation in Botswana, particularly corporate income tax, poses a special set of problems and concerns. As in many countries, Botswana has created a system of corporate tax reductions, including special holiday tax offerings for corporations and special economic zones, in an attempt to entice foreign direct investment.¹⁸¹ The standard corporate tax rate stands at 22%, which is the lowest rate among SACU members.¹⁸² When taking into account special tax incentives, however, this rate is likely even lower. These corporate tax practices not only make it difficult to raise sufficient revenue overall, but they have also been shown to be largely ineffective at attracting investment.¹⁸³

¹⁷⁹ Tax Policy Center. *Tax Policy Briefing Book: Who would bear the burden of a VAT?* May 2020. August 2020. <https://www.taxpolicycenter.org/briefing-book/who-would-bear-burden-vat>.

¹⁸⁰ IMF Botswana Report, *supra* note 175.

¹⁸¹ IMF Botswana Report, *supra* note 175.

¹⁸² IMF Botswana Report, *supra* note 175.

¹⁸³ Center for Economic and Social Rights. "Dismantling the Dogmas of Austerity and Fiscal Injustice in Latin America." Briefing. Center for Economic and Social Rights, 2019.



Moreover, the OECD and the European Union have repeatedly called on Botswana to improve its corporate tax practices, particularly as relates to corporate tax evasion and abuse.¹⁸⁴ When businesses avoid or even evade their taxes, public services go underfunded and regressive consumption taxes and income taxes on low- and middle-income earners often increase. Under these circumstances, the heaviest tax burdens are borne by the poor, middle and working classes. In Botswana, this includes miners, ex-miners and their communities. At a bare minimum, in order to finance the right to health the Government must ensure strong enforcement of existing corporate tax laws and corporations, including mine companies, must abstain from efforts to avoid or evade taxation.

Botswana currently uses several standard mechanisms to collect mineral rents. These include royalties, dividends, variable-rate income tax on mine companies' profits, and withholding taxes.¹⁸⁵ As highlighted above in *The Botswana Mining Industry and the People Who Make It Work: A Snapshot* section of the report, mineral revenue is still the single largest source of revenue for the Government of Botswana.¹⁸⁶ While some studies claim that the Government collects adequate mineral rents, the reality is likely more complicated.¹⁸⁷ The pricing of diamonds is of particular concern in this respect. Unlike other minerals which are priced based on independent benchmarks,¹⁸⁸ De Beers prices its diamonds for sale without regulation

¹⁸⁴ Tax Justice Network. "Narrative Report on Botswana." Financial Secrecy Index 2020. Tax Justice Network, 2020.

¹⁸⁵ African Natural Resources Center, African Development Bank Group & Immeuble du Centre de Commerce International d'Abidjan. *Botswana's Mineral Revenues, Expenditure and Savings Policy. A Case Study*. Abidjan: African Development Bank, 2016 [hereinafter *Botswana's Mineral Revenues Policy*].

¹⁸⁶ Budget Speech *supra* note 5.

¹⁸⁷ Botswana's Mineral Revenues Policy, *supra* note 185.

¹⁸⁸ Sharife, Khadija. "Botswana's Diamond Deception." Open Society Initiative for Southern Africa, Southern Africa Resource Watch & African Network of Centers for Investigative Reporting, 2016 [hereinafter *Diamond Deception*].

or oversight by an independent authority. This practice opens up the possibility of trade misinvoicing and other questionable practices stemming from value determinations that occur without transparency or oversight.¹⁸⁹

Other aspects of the regulation of the mining industry also make it difficult know whether sufficient revenue is being collected from mine companies.¹⁹⁰ For example, diamond mining is taxed in accordance with the terms of an agreement made between a mine company and the Government of Botswana.¹⁹¹ But the terms of these agreements are not public. The Government provides information on its total mineral revenues, but not disaggregated data for each mineral, company or payment type.¹⁹² In other words, the Government of Botswana does not disclose the money it receives from mine companies. Botswana has also not subscribed to the Extractive Industries Transparency Initiative (EITI) and does not meet the EITI Standard.¹⁹³ A recent report also raised concerns regarding unreported contributions by De Beers to political parties and the lack of disclosure of financial information on the part of companies that is essential to the public interest.

To the credit of the Government of Botswana, it is taking steps to address some of these concerns. For example, the Government has agreed to sign and ratify important multilateral tax agreements, including the OECD Multilateral Convention on Mutual Administrative Assistance.¹⁹⁵ In 2019, Botswana enacted the *Income Tax (Transfer Pricing) Regulations Act*.¹⁹⁶ According to Kenneth Matambo, the Minister of Finance and Economic Development at the time, the law is designed to prevent “attempts by multi-national corporations to minimize their tax liability by transferring profits to low tax jurisdictions in order to pay less tax” and other similar practices.¹⁹⁷ Even before this law was passed, the *Sunday Standard* reported that the Botswana Unified Revenue Service, the primary tax collection agency of Botswana, decided to audit De Beers.¹⁹⁸ The audit provides clear indication that the Government of Botswana is concerned about the tax practices of its most profitable mine companies. These steps are critical to ensuring that the Government of Botswana is able to raise sufficient resources to finance the right to health, but more must be done.

¹⁸⁹ *Ibid.*

¹⁹⁰ *Ibid.*

¹⁹¹ Income Tax Act, 12 of 1995 (Bots.), 12th Schedule, § 43, ¶¶ 4, 11.

¹⁹² Botswana’s Mineral Revenues Policy, *supra* note 185.

¹⁹³ Extractive Industries Transparency Initiative. *The EITI Standard: The global standard for the good governance of oil, gas and mineral resources*. n.d. August 2020. <https://eiti.org/standard/overview>.

¹⁹⁴ Diamond Deception, *supra* note 188.

¹⁹⁵ See European Union. “The EU list of non-cooperative jurisdictions for tax purposes — Report by the Code of Conduct Group (Business Taxation) suggesting amendments to the Annexes of the Council conclusions of 12 March 2019, including the de-listing of one jurisdiction.” *Official Journal of the European Union* C 386.2 (2019).

¹⁹⁶ Income Tax (Amendment) Act, 38 of 2018 (Bots.); see also Online Editor. “Taxman moves against De Beers, multinationals.” *Sunday Standard* 21 July 2019.

¹⁹⁷ *Sunday Standard*, *ibid.*

¹⁹⁸ *Sunday Standard*, *ibid.*

2. The Government of Botswana Does Not Equitably Allocate Sufficient Resources for Health

The Government of Botswana must equitably allocate its revenue and resources to finance the right to health, with a focus on those most in need. At 14%, health expenditure as a percentage of general government spending in Botswana has increased slowly over the last decade.¹⁹⁹ Botswana is nonetheless below the *Abuja Declaration* target of 15% of general government expenditures for health.²⁰⁰ Available data also indicates that Botswana continues to rank below the average health expenditure as a percentage of GDP among upper middle-income countries.²⁰¹

Disaggregated data on health spending for particular groups, including miners, ex-miners and their communities, is not readily available. This makes it difficult to determine whether sufficient resources have been allocated to serve the health needs of these communities. However, the data and information on poor health outcomes and health system failures presented in the **Critical Issues for the Right to Health of Miners and Ex-Miners in Botswana** section above strongly suggest that more needs to be done to finance the right to health of miners, ex-miners and their communities. And of the budgetary information that is available, it is difficult to determine precisely which health programs and services are provided allocations. The manner in which the budget is constructed obscures many of the specific health allocations.²⁰²

While the availability of budget-related information in Botswana has increased during the last few years, budget transparency and public participation in budgetary processes is still very low. The International Budget Partnership publishes an annual assessment and ranking of the openness of budgets in countries around the world called the Open Budget Survey. The Open Budget Survey ranks countries based on a variety of criteria across a range of categories to determine the extent to which a country's budget is open.²⁰³ The categories comprise budget transparency, participation in budgetary processes, and the extent and nature of budget oversight. Botswana ranks low overall in the Open Budget Index 2019 Survey and receives low

¹⁹⁹ World Health Organization. *Global Health Expenditure Database*. n.d. August 2020. <https://apps.who.int/nha/database/ViewData/Indicators/en>.

²⁰⁰ Organisation of African Unity, *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*, OAU Doc. OAU/SPS/ABUJA/3 (27 April 2001); United Nations Children's Fund, Botswana. *Botswana Budget Brief 2018: Health*. Gaborone: UNICEF, 2018.

²⁰¹ World Health Organization. *Global Health Observatory Data Repository: Current health expenditure (CHE) as percentage of gross domestic product (GDP) (%)*. n.d. August 2020. <https://apps.who.int/gho/data/view.main.GHEDCHEGDP-SHA2011v?lang=en>.

²⁰² Dutta, Sheila, et al. *Botswana Health and HIV/AIDS Public Expenditure Review*. Technical Report. The World Bank. Washington, D.C.: The World Bank, 2016.

²⁰³ Torbert, Sally. *Open Budget Survey 2019*. International Budget Partnership. Washington, D.C.: International Budget Partnership, 2019.

marks for both budget transparency and participation in particular.²⁰⁴ Botswana is clustered alongside other countries for which budgetary data is scarce, such as Angola, Bangladesh, Mali and Vietnam.

Information we gathered during key informant interviews and focus group discussions further calls into question Botswana's resource allocation to finance the right to health of miners, ex-miners and their communities. In December 2018, Department of Mines officials disclosed that each year the Department exhausts all of its available funds during the first quarter of the fiscal year to monitor and enforce the *Mines, Quarries, Works and Machinery Act, 1973* and the *Mines, Quarries, Works and Machinery Act Regulations, 1978*.²⁰⁵ This leaves the Department unable to implement its statutory and regulatory duties, including conducting health and safety inspections of mine operations. Department of Mines officials further revealed that the Government of Botswana fails to enforce legal requirements for mine companies to set aside funds in preparation for insolvency or the closure of their operations.²⁰⁶ As described in **Critical Issue #3** and **Critical Issue #7**, the devastating impact of the sudden closure in 2016 of the Government-owned BCL mine in Selebi-Phikwe and the Tati nickel mine near Francistown vividly illustrates the health, social and economic consequences of this failure. Neither BCL nor the Government of Botswana allocated sufficient financial and other resources to mitigate the consequences for BCL and Tati miners and their families. As a result, more than 6,000 people were suddenly unemployed. Many of them have since experienced poor physical and mental health and housing insecurity, and many have taken their own lives through suicide.



²⁰⁴ Ibid.

²⁰⁵ Bohra and Chimbombi Key Informant Interview (2018), *supra* note 42; *Mines, Quarries, Works and Machinery Act, 20 of 1973 (Bots.)*; *Mines, Quarries, Works and Machinery Act Regulations, 127 of 1978 (Bots.)*.

²⁰⁶ Bohra and Chimbombi Key Informant Interview (2018), *supra* note 42.

Recommendations to Realize the Right to Health of Miners and Ex-Miners in Botswana

The Botswana Miners Right to Health Project proposes the following recommendations to address the problems outlined in the **Critical Issues for the Right to Health of Miners and Ex-Miners in Botswana** and the **Critical Issues to Finance the Right to Health in Botswana** sections of this report:

Miners and Ex-Miners Suffer Preventable Injuries and Disease from Working in the Mines

- 1. The National Assembly of Botswana should enact a *National Occupational Health and Safety Act* to establish national standards for occupational health and safety in accordance with the right to health**, with direct input from miners, ex-miners and the Botswana Mine Workers Union. The Act should also grant authority to the Minister of Minerals Resources, Green Technology & Energy Security, the Minister of Health and Wellness, and the Minister of Employment, Labour Productivity and Skills Development, with direct input from miners, ex-miners and the Botswana Mine Workers Union, to jointly develop, implement, monitor and evaluate a *National Occupational Health and Safety Management Plan*, in line with **Section III(A)** of the **Botswana Miners Right to Health Law Reform Memo**.
- 2. The National Assembly of Botswana should enact a *Botswana Mine Health and Safety Act*** as a component of the proposed *National Occupational Health and Safety Act* to develop, consolidate and improve national mine health and safety standards, protocols and practices, in accordance with the right to health and accepted international standards.
- 3. The Government of Botswana should establish a *Mining Health and Safety Community Oversight Board* comprised of a majority of miners, ex-miners and mining community members**, with additional representation of the Botswana Mine Workers Union, the Ministry of Health and Wellness, the Department of Mines, and the Botswana Chamber of Mines. The *Community Oversight Board* should develop its own mandate, which should include, among other things, providing direct input into the development of workplace health and safety standards at the government and corporate levels, and monitoring and evaluation of mine companies' implementation of these standards.

4. **Mine companies should establish operational-level grievance and redress mechanisms through which workers may file complaints and receive prompt redress for health and safety concerns.** Grievance and redress mechanisms should include at least two levels of internal review and appeal, allow for anonymous filing, guarantee a response within 14 days with detailed plans for redress, and provide strong protections to prevent retaliation against workers filing complaints. Unsatisfactory resolutions should be subject to appeal to both the *Mining Health and Safety Community Oversight Board* described in Recommendation #3 and to a court of law with appropriate jurisdiction.
5. **Mine companies should permit the Botswana Mine Workers Union to carry out independent investigations into all serious injuries and fatalities** that occur in the mines, in coordination with the mine's Chief Mining Engineer and the Mine Safety and Health Manager.

Mine Companies Interfere with Miners' Health Care, Lowering the Quality of Care and Harming Their Health

6. **The Government of Botswana should conduct a national investigation into the widespread practice of corporate interference with miners' health care in mine hospitals** with a focus on medically inappropriate "fit for duty" designations and the practice of downgrading the severity of miners' injuries and illnesses for reporting purposes. The investigation should be undertaken by an investigation committee comprising a majority of miners, ex-miners, the Botswana Mine Workers Union and their legal representatives. The investigation should be conducted in a transparent manner, so that all proceedings, reports and recommendations are public. The investigation should lead to the development of concrete recommendations to eliminate corporate interference in miners' health care.
7. **The National Assembly of Botswana should codify in law the prohibition of corporate interference in health care in mine hospitals**, in line with Section III(B) of the Botswana Miners Right to Health Law Reform Memo.

Ex-Miners Often Experience Poor Mental Health, Sometimes Leading to Suicide

8. **Mine Companies should hire and maintain a staff of licensed mental health professionals in mine hospitals, to which workers have access at all times during their employment.** Mine companies should utilize mental health staff to provide entrance and exit counseling services for all workers, upon their hiring and their termination

or retrenchment, and in the event of the closure or liquidation of a mine operation. All medical records associated with mental health services provided in mine hospitals, including diagnoses, treatments and prescriptions, should be strictly confidential; corporate and all other non-health staff should not have access to mental health records, unless required in the case of a medical emergency. Moreover, information concerning the mental health of an employee should only be used in the treatment of the employee and should never be used as grounds for dismissal, termination or any other punitive and discriminatory action.

- 9. The Government of Botswana should conduct a public investigation into the social, economic and health impacts on ex-miners, their families and the surrounding communities from the 2016 closures of the BCL and Tati mines in Selebi-Phikwe and near Francistown, respectively.** Among other things, the investigation should consider the circumstances and decision-making processes involved in the decision to close the mines; poor mental health and suicides among ex-miners from the BCL and Tati mines; outstanding worker's compensation claims stemming from the BCL and Tati mines; access to appropriate health care for ex-miners and their families; and housing insecurity experienced by ex-miners and their families in the surrounding communities. The investigation should be conducted in a transparent, participatory manner. All proceedings, reports and recommendations related to the investigation should be open and available to the public. The investigation should lead to, among other things, restitution for aggrieved ex-miners and their families, including families who have lost family members due to suicide.

Health Services Are Often Unavailable or Inaccessible to Miners and Ex-miners

- 10. The Government of Botswana should take all necessary steps to eliminate barriers miners and ex-miners face accessing health care.** These include increasing the health budget overall; allocating additional health funds to ensure mental health services are available and accessible in public health facilities and to provide free transport to health facilities for those living in rural or remote areas; ensuring miners and ex-miners have access to specialized health care free-of-charge for all occupational injuries and illnesses; and reviewing and improving the national drug procurement and distribution system to eliminate drug stock-outs in public health facilities and to ensure drugs are available for common occupational injuries and illnesses.

11. **As proposed by the Honorable Member of Parliament from Jwaneng-Mabutsane, Mr. Mephato Reatile, the National Assembly of Botswana should enact legislation requiring mine companies to provide all health care free-of-charge for their former workers for a period of 10 years after a worker leaves the company.** Among other things, this should include bi-annual check-up examinations targeting common occupational injuries and illnesses, such as respiratory illnesses, repetitive strain injuries and chronic pain, but also all necessary medicines, medical devices, and specialist and other care. The National Assembly may choose to create a pooled fund administered by the Minister of Finance and Economic Development into which mine companies contribute funds annually in proportion to the number of workers they employ, or some other contributory financial mechanism, from which health care providers are reimbursed for services they provide individuals who qualify for health care under the law.
12. **Mine companies should hire and maintain a staff of licensed medical specialists in mine hospitals** to ensure miners have access to necessary specialist care in mine hospitals, rather than requiring miners to seek specialist care outside of mine hospitals. Specialists should include physicians trained in diagnosing common occupational injuries and illnesses associated with mining, such as respiratory illnesses, repetitive strain injuries, eyesight and hearing loss, and back injuries, such as sprains, strains, herniated discs and fractured vertebrae.

Unfair Compensation Processes Leave Miners and Ex-Miners Underdiagnosed and Undercompensated for Injuries, Illnesses and Deaths

13. **The National Assembly should revise the *Worker's Compensation Act, 1998* to:**
 - a. **Expand and improve the First and Second Schedules to list a comprehensive set of occupational injuries and diseases covered by the law as eligible for compensation.** The National Assembly should determine these additions in consultation with the Minister of Health and Wellness, physicians with experience treating miners and ex-miners, and other relevant experts. At a minimum, they should include tuberculosis and drug-resistant tuberculosis; HIV; repetitive strain injuries; back injuries, such as sprains, strains, herniated discs and fractured vertebrae; gradual onset hearing loss; diminished eyesight (short of total loss of sight in one or both eyes); and all forms of mental illness, including depression and anxiety. This should also include a revision upward, based on expert consultation and international best practices, of the percentages of incapacity for specific injuries and illnesses;

- b. **Explicitly allow for workers to obtain a second, independent medical examination** from a licensed physician to be reimbursed in full by the mine company or insurance company and to require the Commissioner and Medical Board to accept and consider during determination proceedings a worker's second, independent medical examination as equal to the employer-sponsored examination;
 - c. **Expand the composition of the Medical Board to include a current miner, an ex-miner and a representative of the Botswana Mine Workers Union** elected in an inclusive process to ensure the miner, ex-miner and Union representative reflect the interests and concerns of their peers;
 - d. **Establish a legal right to appeal to a court of law with appropriate jurisdiction** the Commissioner and Medical Board's determination of the levels of incapacity and compensation for a worker's compensation claim;
 - e. **Provide for financial penalties for employers and insurance companies that unreasonably delay worker's compensation proceedings or that fail to provide financial compensation or health services** as directed by the Commissioner and Medical Board in a timely manner, such as after 30 days following the Commissioner and Medical Board's determination;
 - f. **Regulate the operations and authority of mine company's internal medical review panels to ensure they do not exert undue influence** over the Commissioner and Medical Board's determination of a worker's compensation claim; and
 - g. **Allow mine companies and the Botswana Mine Workers Union to extend the mandate of their Joint Negotiation Consultative Committees (JNCCs) and Operational Consultative Committees (OCCs)** to operate as quasi-judicial bodies to adjudicate miners and ex-miners' grievances related to worker's compensation claims, both eventually reporting to the Commissioner and Medical Board.
- 14. The Government of Botswana should commission a study to determine whether a pooled fund for worker's compensation claims, established under the Worker's Compensation Act, 1998, to which all mine companies are legally mandated to contribute in proportion to their size would provide a more fair and just mechanism** than private insurance by which to ensure mine companies provide miners and ex-miners sufficient and timely compensation for occupational injury and illnesses.

Miners and Ex-Miners Are Not Provided Opportunities to Participate in Decision-Making about Their Health

- 15. The Government of Botswana should actively facilitate the meaningful participation of miners and ex-miners** through consultations and other accessible platforms in the formulation, implementation, monitoring and evaluation of all health and safety policies and protocols that apply to the mining industry, including policy development associated with the *Mines, Quarries, Works and Machinery Act, 1973* and the *Mines, Quarries, Works and Machinery Act Regulations, 1978* and in line with the proposed *National Occupational Health and Safety Act* and the proposed *Botswana Mine Health and Safety Act* in Recommendations #1 and #2.
- 16. Mine companies should actively facilitate the meaningful participation of their workers** through consultations and other accessible platforms in the formulation, implementation, monitoring and evaluation of all corporate health and safety policies and protocols, including in developing all health and safety training materials, in line with the proposed *National Occupational Health and Safety Act* and the proposed *Botswana Mine Health and Safety Act* Recommendations #1 and #2.
- 17. The Government of Botswana and mine companies should provide support for the establishment of an Ex-Miner's Benefits Forum**, chaired by the Commissioner of Labour, representatives of the Joint Industrial Council and BoLAMA, in which ex-miners and their family members can meaningfully engage the Government and mine companies on post-employment challenges, including occupational health issues and concerns related to worker's compensation claims and terminal benefits.
- 18. The Government of Botswana should prohibit mine companies from excluding the Botswana Mine Workers Union from health and safety-related decision-making platforms**, such as through Memorandums of Agreement, to ensure the Union's ability to represent miners in health and safety-related negotiations.
- 19. The Botswana Chamber of Mines should grant the Botswana Mine Workers Union voting status during decision-making processes related to health and safety** held during bi-annual industry-wide meetings convened by the Chamber.
- 20. The Botswana Mine Workers Union should ensure the participation of ex-miners in the Union's health and safety-related decision-making**, including processes involving the Botswana Chamber of Mines, and the Joint Negotiation Consultative Committees (JNCCs) and Operational Consultative Committees (OCCs).

Miners, Ex-Miners and Their Communities Experience Housing Insecurity and Disruptions of Indigenous Lifestyles and Traditions

- 21. The Government of Botswana should ensure housing security for miners, ex-miners and their families**, particularly when miners lose their housing due to the closure of mine operations, termination, retrenchment or other situations that cause housing insecurity. This could be in the form of alternative temporary housing or financial support to secure other housing.
- 22. Mine companies should develop operational plans and set aside adequate funds at the outset of their operations to facilitate the smooth transition of workers from company housing** in the event of a mine operation's closure, the termination or retrenchment of their workers, or any other situation in which workers are forced to vacate company housing.
- 23. The Government of Botswana should periodically inspect all housing provided by mine companies to ensure it is safe and habitable**, including to ensure it is free of asbestos and other environmental hazards.
- 24. The Government of Botswana, local authorities and mine companies should meaningfully consult with indigenous communities prior to breaking ground** for any mine operation that proposes to operate on or near land utilized by indigenous communities. The Government of Botswana, local authorities and mine companies should ensure such communities are fully informed of the ways the proposed mine operation may affect their indigenous lifestyles or traditions. The Government of Botswana, local authorities and mine companies should also provide affected communities an opportunity to oppose the operation in full or provide specific input to amend the planned operation to mitigate its effect on their community.

Environmental Assessments Ignore Mines' Impacts on Occupational and Community Health

- 25. The National Assembly of Botswana should revise and expand the Environmental Assessments Act, 2011 and Environmental Assessment Regulations, 2012**, with input from the Minister of Health and Wellness, to consider the health and social wellbeing of miners, ex-miners and their communities and, in particular, to assess and account for the impact of proposed mine operations on occupational health and community health, in accordance

with international standards and best practices for Environmental, Social and Health Impact Assessments, and in line with Section III(H) of the Botswana Miners Right to Health Law Reform Memo.

The Government of Botswana Does Not Equitably Generate Sufficient Revenue for Health

- 26. The Government of Botswana should reform its tax code to ensure all taxes are progressive, including consumption and income tax, to increase the effective tax rate of companies operating in Botswana, and to eliminate special tax treatment of mine companies, including eliminating tax holidays and other tax exemptions granted to them.**
- 27. The Government of Botswana should take all necessary steps to identify and eliminate evasive and abusive tax practices by mine companies, other corporations and high-net worth individuals, including through more frequent corporate audits by the Botswana Unified Revenue Service and ratification of relevant international tax agreements.**



28. **The Government of Botswana should make public, in an accessible manner, all mineral licenses, permits and concessions, all information related to mine company tax allowances, tax practices, royalties, pricing procedures and tax amounts, and all other financial information relevant to the public interest.**
29. **The Government of Botswana should require that all persons holding government office and those providing official counsel to officer-holders make public and either divest their holdings in companies operating in Botswana, or put them in a trust for the time they are in office.**
30. **Mine companies in Botswana should disclose all financial information relevant to the public interest, including information on their tax practices and payments, the nature and location of their holdings, their payments to government officials or political parties, information on their negotiations of mineral licenses, permits and concessions licenses, and information on their pricing practices.**

The Government of Botswana Does Not Equitably Allocate Sufficient Resources for Health

31. **The Government of Botswana should increase its health spending as a percentage of its overall government spending to meet or exceed the Abuja Declaration 15% target, and it should disaggregate all health spending in its budgets and budget reporting to show its line item spending throughout the health system.**
32. **The National Assembly of Botswana should exercise its budgetary authority to allocate greater resources to the Department of Mines to ensure the Department is capable of fulfilling its regulatory duties to, among other things, monitor and enforce health and safety-related law and regulations for mine operations.**

Appendix

Methodology

This report is the product of a two-year assessment conducted by the Botswana Miners Right to Health Project from August 2018 to August 2020. The assessment utilized the OPERA Framework and involved secondary and primary data collection in Botswana.

OPERA Framework and Project Design

This Botswana Miners Right to Health Project’s research methodology is based on the **OPERA Framework** developed by the Center for Economic and Social Rights (CESR). CESR created the OPERA Framework to support researchers in understanding, analyzing and investigating economic and social rights violations and governments’ related legal obligations. OPERA clusters human rights standards together across four dimensions: Outcomes, Policy Efforts, Resources and Assessment.

The first step of OPERA—Outcomes—considers the problem of interest from the perspective of the rightsholders—i.e., the people whose human rights are at stake. In doing so, the Outcomes dimension considers the human rights norms of minimum core obligations, non-discrimination and progressive realization.

Where problematic outcomes have been identified, the second step—Policy Efforts—determines how government action (or inaction) has affected the problem. This dimension examines whether the government is complying with its duty to take steps that are deliberate, concrete and targeted. The Policy Efforts dimension also considers whether the government’s actions have increased the availability, accessibility, acceptability and quality of the relevant goods, services or infrastructure at the ground-level in the country. It also scrutinizes whether the government has been transparent in its formulation and implementation of policies, whether rightsholders have meaningfully participated in decision-making processes, and whether accountability mechanisms are in place and effective.

An essential aspect of governments’ obligations under Policy Efforts is to make use of maximum available resources. The third step of OPERA—Resources—examines this obligation by assessing how government resources are raised, allocated and spent. This step also examines the government’s budget cycle from the perspective of participation, transparency and accountability.

Finally, the Assessment dimension of OPERA considers the relevant constraints, then makes an overall assessment of whether the government has met its human rights obligations. This final step identifies broader social, economic, political or cultural factors that prevent people from enjoying their rights, as well as limitations on the government’s ability to enact policies and allocate resources to fulfill these rights. In the end, OPERA provides a holistic assessment of the government’s compliance with its economic and social rights obligations.

OPERA encourages the use of a broad range of data and interdisciplinary tools and techniques. The framework prompts researchers to consider a series of questions to determine what must be measured and what information is relevant to a particular norm, such as non-discrimination or maximum available resources. OPERA then provides tools and techniques, such as human rights indicators and benchmarks, to collect and analyze information to reveal the status of a government’s compliance with the norm.

The OPERA Framework

Outcomes	<p>Measure rights enjoyment overall</p> <hr/> <p>Minimum Core Obligations</p>	<p>Measure differences between populations</p> <hr/> <p>Non-discrimination</p>	<p>Measure changes over time</p> <hr/> <p>Progressive Realization</p>
Policy Efforts	<p>Identify legal and policy commitments</p> <hr/> <p>Take steps</p>	<p>Evaluate how policies have been implemented</p> <hr/> <p>AAAQ Criteria</p>	<p>Analyze the policy-making process</p> <hr/> <p>Participation, transparency, accountability</p>
Resources	<p>Analyze how resources are allocated and spent</p> <hr/> <p>Maximum Resources</p>	<p>Analyze how resources are generated</p> <hr/> <p>Availability of Resources</p>	<p>Analyze budget processes</p> <hr/> <p>Participation, transparency, accountability</p>
Assessment	<p>Identify other determinants</p> <hr/> <p>Indivisibility and Interdependence</p>	<p>Understand state constraints</p> <hr/> <p>Respect, Protect, Duty to Cooperate</p>	<p>Determine state compliance</p> <hr/> <p>Obligation to Fulfill</p>

In accordance with the OPERA Framework, the Botswana Miners Right to Health Project Team collected and analyzed qualitative and quantitative data across a range of indicators to understand the status of miners and ex-miners' right to health in Botswana. This work is described in detail below.

Secondary Data Collection and Desk-Based Research

As part of our preliminary research, the Project Team collected and reviewed existing data, scholarship and other information through desk-based research. This secondary research captured quantitative information, including socio-economic statistics, and informed the design of the Project's primary data collection.

Using the OPERA Framework, the Project Team identified key areas of inquiry through its desk-based research and formulated them as questions and indicators. In essence, the Project Team asked the question—what information is necessary to understand whether the Government of Botswana is realizing the right to health of miners and ex-miners in the country? BoLAMA and its members led in the identification of priority areas of concern to answer this question. In light of these priorities, the Project Team then reviewed the data and information collected by desk-based research and added additional areas of inquiry to pursue through primary data collection.

Primary Data Collection and Field Work

The Project Team collected primary data to validate information gathered through desk-based research, to fill in critical gaps in the secondary data, and to collect qualitative and other information from a wide range of stakeholders in Botswana. These efforts comprised two ten-day research trips in Botswana—the first in December 2018, the second in December 2019. Led by BoLAMA, the Project Team conducted a series of key informant interviews and focus group discussions with more than 50 individuals. These included miners, ex-miners, their family members, government officials, health care workers and others (see the lists below). The Project Team also conducted site visits to mine areas, community health facilities, the Department of Mines and other government offices. The Project Team developed the questionnaires used during key informant interviews and focus groups discussions to clarify critical issues and address gaps in the secondary data. These questionnaires are on file with the Project Team and available upon request.

Key Informant Interviews

Key informant interviews are interviews with people who have specialized knowledge about a topic to obtain detailed insight, information and firsthand accounts. The Project Team obtained informed consent prior to each key informant interview and later obtained permission from the key informants quoted by name to use their names in the body of this report.

Key informant interviews support the OPERA framework analysis in two primary ways:²⁰⁷

- » By collecting data on policy efforts, such as on the implementation of laws and policies; and
- » By collecting data for use in the Assessment step, to understand the broader contextual factors affecting the realization of social and economic rights.

The Project Team conducted 11 key informant interviews:

December 2018

1. Dr. Botshelo Kgwaadiram, Chief Medical Officer, Ministry of Health and Wellness (Gaborone);
2. Mr. Rahul Bohra and Mr. Hossia Chimbombi, Deputy Director and Principal Engineer, respectively, Department of Mines (Gaborone);
3. Mr. Chalres Siwawa, Chief Executive Officer, Chamber of Mines (Gaborone);
4. Dr. Khumoetsile Mapitse, former Health Services Manager, BCL (Gaborone);
5. Mr. Patson Dibotelo, District Commissioner, Selebi-Phikwe (Selebi-Phikwe);
6. Mr. Monkgolodi Polelo and Mrs. Dianah Tawana, Nurses, Botshabelo Clinic, Accident and Emergencies Department (Selebi-Phikwe);
7. Dr. Arnold Oneetswe Motsamai, Private Doctor, Director of Healthscope Medical Clinic and former Chief Medical Officer, Debswana (Jwaneng);
8. Mr. Diez Phiku, Deputy Branch Chairperson, Botswana Mine Workers Union (Jwaneng).

²⁰⁷ See Corkery, Allison. *Defending Dignity: A Manual for National Human Rights Institutions on Monitoring Economic, Social and Cultural Rights*. Center for Economic and Social Rights. Brooklyn, 2015.

December 2019

9. Hon. Mr. Mephato Reatile, Honorable Member of Parliament from Jwaneng/Mabutsane (Gaborone);
10. Mr. Skerminos Sekeleko, Senior Registered Nurse, Medie Government Health Outpost (Medie, Kwaneng); and
11. Ms. Nametso Tsholofel, Miner, Minergy Masama coal mine (conducted by telephone at the BoLAMA office in Molepolole).

Focus Group Discussions

Focus group discussions are a qualitative research method involving a guided discussion among a small group of people about a specified topic to generate information about various aspects, opinions or experiences related to the topic. Focus group discussions emphasize the interaction between the group members and the moderator (i.e., interviewer) to provide researchers a unique understanding of the participants' perceptions and experiences. Focus group discussions often put "a human face" to quantitative data, illuminating lived experiences that are less accessible in one-on-one interviews. The Project Team obtained written informed consent from each participant in the focus groups discussions. Completed consent forms are available on file with the Project Team. In order to ensure confidentiality and to protect the identities of focus group participants, however, the Project Team will not provide the names of the participants.

Focus group discussions contribute to the OPERA framework analysis in two primary ways:²⁰⁸

- » By collecting data on policy efforts, such as on the implementation of laws and policies; and
- » By collecting data for use in the Assessment step, to understand the broader contextual factors affecting the realization of social and economic rights.

²⁰⁸ See *ibid.*

The Project Team conducted four focus group discussions with more than 40 miners, ex-miners and their family members:

December 2018

1. Jwaneng Focus Group Discussion—14 participants, comprising miners, ex-miners and their family members, conducted at the offices of the Botswana Mine Workers Union; and
2. Selebi-Phikwe Focus Group Discussion—8 participants, comprising miners, ex-miners, their family members and representatives of the Botswana Mine Workers Union, conducted at the offices of Silence Kills, a Botswana non-governmental organization.

December 2019

3. Selebi-Phikwe Focus Group Discussion—7 participants, comprising miners, ex-miners, their family members and representatives of the Botswana Mine Workers Union, conducted at the offices of the Botswana Mine Workers Union; and
4. Medie, Kwaneng Focus Group Discussion—12 participants, comprising ex-miners and community members, conducted at the Medie Customary Court.

Other Stakeholder Engagements

In addition to key informant interviews and focus group discussions, the Project Team gathered primary data and built relationships through other kinds of stakeholder engagements:

December 2018

1. Meeting with Senior Lecturer in Law and Dean, Department of Law, University of Botswana, Mr. Dr. B.R. Dinokopila (Gaborone); and
2. Meeting with Senior Consultants, Institute for Development Management, Dr. Ellen N. Mokalake and Malebogo Gaebepe (Gaborone).

December 2019

3. Civil Society Roundtable with the Botswana Council of Churches, Ditshwanelo (The Botswana Centre for Human Rights), Stork Fort Health, Yoo Dithetsenyana Association, Youth for Tax Justice, Botswana Watch and BOCONGO at the Cresta President Hotel (Gaborone);
4. Meeting with the Honorable Member of Parliament from from Selebi-Phikwe East, Mr. Kgoberego Nkwana (Gaborone);
5. Meeting with the Honorable Member of Parliament from Maun West and Vice President, Umbrella for Democratic Change, Mr. Dumelang Salishendo (Gaborone);
6. Meet and Greet with the CEO of the Botswana Chamber of Mines, Mr. Charles Siwawa (Gaborone); and
7. BoLAMA Board of Directors Strategy Session, with Members of the BoLAMA Board of Directors (Molepolole).

²⁰⁹ ICESCR, *supra* note 170; Office of the High Commissioner for Human Rights. *Status of Ratification Interactive Dashboard*. 28 July 2020. August 2020. <https://indicators.ohchr.org/>.

Right to Health

The right to health is recognized in international, regional and national law around the world. Article 12 of the *International Covenant on Economic, Social and Cultural Rights*, ratified by 170 States, establishes the international human right to health:²⁰⁹

1. States Parties to the Convention recognize the right to everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
 - a. The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
 - b. The improvement of all aspects of environmental and industrial hygiene;
 - c. The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
 - d. The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

The right to health is given further content by the UN Committee on Economic, Social and Cultural Rights in its *General Comment 14: The Right to the Highest Attainable Standard of Health (Art. 12)*.²¹⁰ General Comment 14 provides a list of six core government obligations to respect, protect and fulfill the right to health. These are non-discriminatory access to health facilities, health goods and health services; access to nutritionally adequate and safe food; access to basic shelter, housing and sanitation, and safe and potable water; provision of essential drugs; equitable distribution of health facilities, health goods and health services; and adoption and implementation of a national public health strategy and plan of action.²¹¹

In addition to these core obligations, the Committee on Economic, Social and Cultural Rights explains that the right to health requires that health facilities, goods and services are available, accessible, acceptable and of good quality.²¹² As discussed above in the section on **Critical Issues to Finance the Right to Health in Botswana**, this in turn generates a positive obligation for governments to mobilize their “maximum available resources.”²¹³ This means that governments are required to ensure sufficient financial resources are generated through fair and progressive tax regimes and that they allocate those resources equitably throughout the health system without discrimination.

²¹⁰ U.N. Committee on Economic, Social and Cultural Rights, *Gen. Comment No. 14 on the Right to the Highest Attainable Standard of Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)*, U.N. Doc. E/C.12/2000/4 (11 August 2000).

²¹¹ *Ibid* ¶ 43.

²¹² *Ibid* ¶ 12.

²¹³ *Ibid*; ICESCR, *supra* note 170, art. 2.1.

Botswana is yet to sign and ratify the *International Covenant on Economic, Social and Cultural Rights*. However, the rights established in ICESCR convey significant authority due to their ratification by 170 countries, making Botswana an outlier in its failure to ratify the treaty.

At the regional level, the *African Charter on Human and People's Rights* (*African Charter*), ratified by 55 countries in the African Union, establishes the right to health in article 16.²¹⁴ Botswana ratified the *African Charter* in 1986.²¹⁵ Article 16 of the *African Charter* states that:

1. Every individual shall have the right to enjoy the best attainable state of physical and mental health.
2. State Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

At the national level, the Botswana constitution does not include a provision on the right to health. This also makes Botswana an outlier in the global community—137 countries enshrine the right to health in their constitutions.²¹⁶

United Nations Guiding Principles on Business and Human Rights

To ensure that human rights are recognized, respected and protected by business entities, the United Nations created the *Guiding Principles on Business and Human Rights: Implementing the United Nations “Protect, Respect and Remedy” Framework* (*UN Guiding Principles*).²¹⁷ The framework includes 31 principles and rests on three pillars:

1. State duty “to protect human rights abuses by third parties, including business enterprises, through appropriate policies, regulation, and adjudication.”²¹⁸
2. Corporate responsibility “to respect human rights, meaning business enterprises should

²¹⁴ Organization of African Unity, *African Charter on Human and Peoples' Rights*, 27 June 1981, 1520 U.N.T.S 271 (entered into force 21 October 1986); African Commission on Human and Peoples' Rights. *State Parties to the African Charter*. n.d. August 2020. <https://www.achpr.org/statepartiestotheafricancharter>.

²¹⁵ *State Parties to the African Charter*, *ibid*.

²¹⁶ Constitute Project. *Right to Health Care*. n.d. August 2020. https://www.constituteproject.org/search?lang=en&key=health&status=in_force.

²¹⁷ Special Rep. of the Secretary-General on the Issue of Human Rights and Transnational Corporations and Other Business Enterprises, *Guiding Principles on Business and Human Rights: Implementing the United Nations “Protect, Respect and Remedy” Framework*, ¶¶ 11, 13, U.N. Doc. A/HRC/17/31 (March 2011) (by John Ruggie).

²¹⁸ *Ibid* at 4.

²¹⁹ *Ibid*.

²²⁰ *Ibid*.

act with due diligence to avoid infringing on the rights of others and to address adverse impacts with which they are involved.”²¹⁹

3. Victim access to effective remedy “both judicial and non-judicial.”²²⁰

The *UN Guiding Principles* lay out government obligations and corporate responsibilities for human rights. Governments must legislate to prevent business entities from violating human rights and they must dedicate sufficient administrative resources to enforce these laws and monitor business activities for violations. Governments must also ensure that all commercial entities that are owned or partially owned by the state, or with which the state does business, conduct human rights due diligence for their operations.

At the same time, businesses have a responsibility to avoid causing or contributing to adverse human rights impacts, and they must address and mitigate all those linked to their operations. This responsibility requires businesses to establish and implement operational steps. These include a policy commitment to respecting human rights; due-diligence processes to address and mitigate human rights impacts when they occur; and remediation processes for people affected by adverse human rights impacts which the business caused or contributed to.

Companies also have obligations to formally report on the form and frequency of human rights impacts to facilitate an external evaluation.

The *UN Guiding Principles* also establish measures to remedy human rights impacts. Governments must make both judicial and non-judicial mechanisms available to people affected by businesses’ human rights impacts. Companies must “establish or participate in effective operational-level grievance mechanisms for individuals and communities.”²²¹ The *UN Guiding Principles* further establish that the performance and design of such operational-level mechanisms should be based on engagement and dialogue with stakeholders that utilize the mechanism.

²²¹ Ibid at 25.

A Note on the Botswana Health System and Worker's Compensation Regime

This section provides a brief overview of the Botswana health system and worker's compensation regime to contextualize the section above on **Critical Issues for the Right to Health of Miners and Ex-Miners in Botswana**.

Health System

The Botswana health system is pluralistic.²²² It includes public, private for-profit, private non-profit and traditional medicine health services. The Ministry of Health and Wellness is responsible for the administration, regulation and oversight of the health system. The Ministry is also responsible for the provision of health services in the public sector through a wide range of health facilities and management structures. The public sector constitutes the largest part of the Botswana health system. Public health expenditure accounted for approximately two-thirds of all health expenditure in 2017 in Botswana.²²³ Most health goods and services in the public sector are free for citizens.

Health care is delivered through a decentralized model with an extensive network of health facilities. The Ministry of Health and Wellness provides primary health care services through District Health Management Teams. These Teams are responsible for a network of health facilities in 27 health districts. These include hospitals, clinics, health posts, mobile stops, and community-based preventative and promotive services. In particular, the public health system comprises three national referral hospitals, 15 district hospitals, 17 primary hospitals, 105 clinics with beds, 206 clinics without beds, 351 health posts and 931 mobile stops. The Ministry of Local Government also provides some public health services, including environmental health services.

Health care is also provided through private hospitals, private health practitioners, mine hospitals, non-governmental organizations and religious missions facilities. The Ministry of Health and Wellness regulates and monitors private health facilities under the *Private Hospitals and Nursing Homes, 1989 law*.²²⁴ According to a 2013 United States Agency for International Development (USAID) study, there has been a steady growth in the number of

²²² See Botswana Ministry of Health and Wellness. *Our Health System*. n.d. August 2020. https://www.moh.gov.bw/health_care.html.

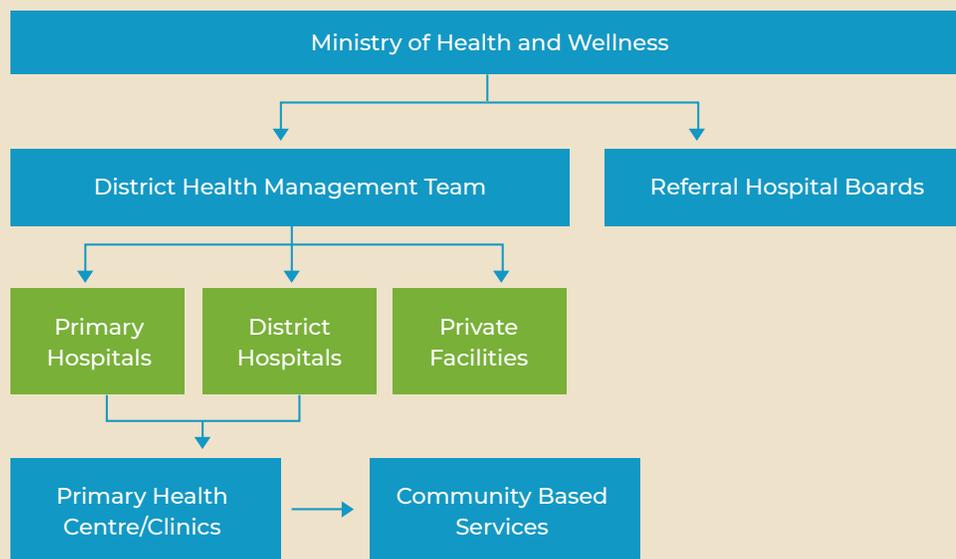
²²³ The World Bank. *Current health expenditure (% of GDP) - Botswana*. n.d. August 2020. <https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=BW>.

²²⁴ Private Hospitals and Nursing Homes Act, 18 of 1989 (Bots.).

private health facilities in Botswana since the early 2000s.²²⁵ At the time of the study, about 40% of health facilities in Botswana were in the private sector (excluding public mobile clinics). Most of these were private surgery centers or pharmacies located in urban areas, such as Gaborone or Francistown. Prior to the closure of the BCL hospital in 2016, there were three hospitals run by mine companies in Botswana, in Selebi-Phikwe, Orapa and Jwaneng.²²⁶

The Botswana Defence Force, Police and Prisons Services also provide health services to the people in their care. Traditional medicine is also widely used in Botswana. The Ministry of Health and Wellness engages traditional and faith-based practitioners on health issues, but the field of traditional medicine is not yet regulated.

Organisation of Health Service Delivery in Botswana



Source: MOHW, National Health Policy: Towards a Healthier Botswana, 2011, p22.

²²⁵ U.S. Agency for International Development. *Botswana Private Health Sector Assessment*. Brief. Strengthening Health Outcomes through the Private Sector. Bethesda: USAID, 2014.

²²⁶ Statistics Botswana. *Health Statistics: Stats Brief 2007-2015*. Gaborone: Statistics Botswana, 2017.

Worker's Compensation Regime

The worker's compensation regime in Botswana is governed by the *Worker's Compensation Act*, 1998.²²⁷ The law establishes the regime's system of governance, decision-making authorities and processes, and methods for determining eligibility and calculating compensation.

The law includes two schedules that set forth the occupational diseases that are eligible for compensation and the percentage of incapacities that correspond to specific occupational injuries. The law establishes a Commissioner of Worker's Compensation, appointed by the Minister of Labour and Home Affairs to act as the lead authority in charge of administering the worker's compensation regime. The Commissioner has a broad range of authority and discretion and is responsible for the key functions of the regime. These functions include determining a worker's right of compensation; adjudicating worker's compensation claims; computing a worker's earnings; determining the necessity, quality and sufficiency of a worker's medical aid; and deciding all questions related to a worker's degree of incapacity, amount of compensation, and payment revisions, discontinuances or suspensions.

The *Worker's Compensation Act* also establishes a Medical Board, appointed by the Minister of Labour and Home Affairs. The Medical Board decides all medical questions arising in relation to a worker's claim for compensation and it adjudicates disputes on degrees of incapacity. The Medical Board is comprised of (i) three medical doctors; (ii) one attorney; and (iii) one person "qualified and experienced in a labour related profession."²²⁸

The procedure to file a worker's compensation claim is as follows. First, an injured or sick worker notifies the employer that they intend to make a claim, providing the relevant details. Second, the employer may offer the worker (within ten days of the worker's notification) a free medical examination to determine the nature of the worker's injury or illness. If the employer does so, the worker must submit to this examination. The worker is entitled to have their own physician present during the employer-sponsored medical examination at the worker's expense. Following the employer-sponsored medical examination, the Commissioner, in coordination with the Medical Board, reviews the results of the examination to assess and determine the worker's claim. Finally, based on the Commissioner and the Medical Board's determination, the employer or its insurer will provide payment to the worker. Notably, the law does not establish whether a worker may obtain or whether the Commissioner or Medical Board will consider a second, independent medical examination.

²²⁷ Worker's Compensation Act, *supra* note 121

²²⁸ Worker's Compensation Act, *supra* note 121, art. 6.

The Worker's Compensation Act also regulates the expenses associated with health services prescribed for sick or injured workers. The law establishes that fees and charges for medical aid obtained in Botswana shall "be in accordance with such scale as may be prescribed, and no claim for an amount in excess ... shall lie against any worker or his employer."²²⁹ The law further states that "[w]here medical aid for any worker is not obtainable in Botswana, the fees and charges ... shall be in such amount as the Commissioner, following consultations with the Medical Board, may, in each case, determine."²³⁰

²²⁹ Worker's Compensation Act, *supra* note 121, art. 30.

²³⁰ Worker's Compensation Act, *supra* note 121, art. 30.



The Botswana Labour Migrants Association (BoLAMA) is a non-profit organization registered in accordance with the laws of Botswana. The organization is comprised of former migrant mineworkers and their beneficiaries. BoLAMA's vision is to protect, promote and advance the interest of all former migrant mineworkers and their dependents by ensuring they live a dignified life. BoLAMA's mission is to advocate for better social protection and to promote and protect the rights of all former migrant mineworkers and their dependents.



The Center for Economic and Social Rights (CESR) was established in 1993 and is an international nongovernmental organization that fights poverty and inequality by advancing human rights as guiding principles of social and economic justice. Working in collaboration with partners around the world, CESR uses international human rights law as a tool to challenge unjust economic policies that systematically undermine rights enjoyment and thereby fuel inequalities. Our international and interdisciplinary staff team based in Bogotá, Johannesburg and New York comes from the human rights, development and social justice movements in different parts of the world.

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