



The role of South African mines in contributing towards realising the right of access to healthcare services in host communities

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ABSTRACT

Mining has historically played a crucial part in South Africa's development. It is the biggest contributor to the country's GDP. However, some mines operate in impoverished communities with insufficient access to healthcare services. Against the backdrop of the United Nations (UN) *Guiding Principles on Business and Human Rights* (2011), the *Constitution of the Republic of South Africa*, 1996 and the Mineral Petroleum Development Act 28 of 2002 (MPDRA), this study examines the role of South African mines in contributing towards the realisation of the right of access to healthcare services in host communities.

This research is motivated by the fact that in addition to the expectation of corporate social responsibility (CSR), there appears to be a human rights duty on businesses such as mining companies to contribute towards the realisation of human rights. With this objective in mind, the researcher adopted a qualitative research approach that entailed an integrated analysis of the primary sources of law, including legislation, international treaties, case law as well as secondary sources such as academic books and journal articles.

The research showed that while international and African human rights instruments impose both negative and positive obligations on States to realise the right of health care services, non-state actors are only obligated to refrain from violating the enjoyment of the right of access to healthcare services. Therefore, while the government of South Africa bears the primary responsibility to protect and fulfil the right of access to healthcare services, international and African regional human rights instruments do not impose binding legal duties on private businesses such as mines to contribute towards the realization of the right to healthcare services. The study further established that South African human rights law follows a similar approach to the position adopted at the international and African regional level despite the horizontal application of the rights guaranteed in the Bill of Rights. Mining companies do not have a positive obligation in terms of the *Constitution* or legislation to contribute towards

realising the right to health care services in communities where they operate. They must respect the right of access to health care services. However, where they are contracted by the state to provide healthcare services, they bear constitutional duties like the state. In addition, the study shows that CSR is rooted in the *Constitution* and that this imposes responsibilities on juristic persons to contribute towards realising fundamental rights such as health rights for host communities.

While this view gets strong support from some scholars, the duty is not legally enforceable. The study argues that the mining companies can use their social and labour plans (SLPs) prescribed by the MPDRA to respond to community needs such as accessibility of health care services. The study shows that some mining companies, such as Sibanye-Stillwater, expressly provides for health services infrastructure for communities such as clinics in their SLPs. Bushveld Vametco Alloys expressly provide health services to their employees. These mines therefore contribute towards realising the constitutional right to healthcare services through their SLPs. Another example is that of Eland Platinum mine, which provides crucial infrastructure for water services, the treatment of sewage, and they provide housing benefits for their employees. Projects that fall within these categories are important as they speak to key health determinants. Given the findings of the study, recommendations are made to improve the extent to which mining companies can contribute towards the provision of healthcare services to host communities.

KEYWORDS

Mines, South Africa, right of access to healthcare services, corporate social responsibility, host communities; human rights duties of corporations.

LIST OF ABBREVIATIONS

ACHPR	– African Charter on Human and People’s Rights
AU	– African Union
CESCR	- Committee on Economic, Social and Cultural Right
CSR	– Corporate social responsibility
CRC	– Convention on the Rights of the Child
DMRE	– Department of Mineral Resources and Energy
ICESCR	– The International Covenant on Economic, Social and Cultural Rights
IDP	– Integrated development plan
MPRDA	– Mineral and Petroleum Resources Development Act
NHA	– National Health Act
NHI	– National Health Insurance
SDGs	– Sustainable Development Goals
SLP	– Social and labour plan
UDHR	– Universal Declaration of Human Rights
UN	– United Nations
UNGP	– United Nations Guiding Principles on Business and Human Rights

TABLE OF CONTENTS

ACKNOWLEDGEMENT	1
ABSTRACT	2
KEYWORDS ..	3
LIST OF ABBREVIATIONS	4
CHAPTER 1..	9
INTRODUCTION.....	9
1.1 Background.....	9
1.2 The right to health in national and international law	10
1.3 The duty of mining corporations to contribute to the right to health.....	13
1.4 Research objectives	16
1.5 Framework of the Study.....	17
1.6 Research methods	17
1.7 Relevance to the research unit	17
CHAPTER 2..	19
INTERNATIONAL AND AFRICAN REGIONAL HUMAN RIGHTS	19
2.1 Introduction	19
2.2 International law	20

2.2.1	Substantive guarantees of the right to health under international law	20
2.2.2	Normative content of the right to health under ICESCR.....	22
2.2.3	Duties of State Parties under ICESCR.....	24
2.2.4	Duties of non-state actors under ICESCR	26
2.3	African Human Rights law	28
2.3.1	Substantive guarantees of the right to health under ACHPR	28
2.3.2	Normative content of the right to health under ACHPR.....	29
2.3.3	Duties of Member States under ACHPR	31
2.3.4	Duties of non-state actors under ACHPR	33
2.4	Human rights obligations of business after International Bill of rights.....	35
2.4.1	Historical background	35
2.4.2	The UN Guiding Principles (2011)	35
2.4.3	Reflection on the health-related duties of business from UN Guiding Principles	37
2.5	Chapter summary	38
CHAPTER 3..		39
ANALYSIS OF THE CONSTITUTIONAL, LEGISLATIVE, AND POLICY POSITION IN SOUTH AFRICA		39
3.1	Introduction	39

3.2	Constitutional, legislative and policy framework on the right to health in South Africa	40
3.2.1	Constitutional framework on the right to health	40
3.2.2	Legislative framework on the right to health.....	46
3.2.3	Policy framework on the right to health.....	48
3.3	Constitutional, legislative, and policy framework on the duty of mining companies to contribute towards realising health rights ..	51
3.3.1	Constitutional framework	51
3.3.2	Legislative framework	54
3.3.3	Policy framework	58
3.4	Appraisal of SA health rights in relation to international law	62
3.5	Chapter summary	64
CHAPTER 4..		66
ANALYSIS OF THE SOCIAL AND LABOUR PLANS OF SELECTED MINES IN SOUTH AFRICA		66
4.1	Introduction	66
4.2	The SLP of Sibanye-Stillwater Mine	66
4.2.1	Background	66
4.2.2	Sibanye-Stillwater commitments in the SLP	68
4.2.3	Implementation	71
4.3	The SLP of Bushveld Vametco Alloys Mine.....	71

4.3.1	Background.....	71
4.3.2	Bushveld Vametco Alloys commitments in the SLP.....	73
4.3.3	Implementation.....	75
4.4	The SLP of Eland Platinum Mine.....	75
4.4.1	Background.....	75
4.4.2	Eland Platinum Mine’s commitments in SLP.....	76
4.4.3	Implementation.....	78
4.5	Chapter summary.....	79
CHAPTER 5.....		80
CONCLUSION AND RECOMMENDATIONS.....		80
5.1	Background of the study.....	80
5.2	Aim and objectives.....	80
5.3	Findings.....	80
5.4	Recommendations.....	82
5.5	Conclusion.....	82

LIST OF TABLES

Table 1 - Summary of Sibanye-Stillwater Mine LED projects in Madibeng

Table 2 - Summary of Bushveld Vametco Mine LED projects in Madibeng

Table 3 – Summary of Eland Platinum Mine LED projects in Madibeng

CHAPTER 1

INTRODUCTION

1.1 Background

Large scale and profitable mining in South African (SA) started with the discovery of a diamond in the Orange River in 1867. Over the next few years, the mining sector produced around 95% of the world's diamonds. Two decades later, the diamond sector was outshined by the discovery of gold in 1886. Since then, the mining sector has contributed to making SA the most advanced economy in Africa. Two of the world's largest mining companies owe their origins to SA: BHP Billiton and Anglo-American Plc.¹

In 2020, the Covid-19 pandemic plunged the SA economy into a severe slump.² However, mining activities managed to stabilise SA's economy which had slowed down under the stringent lockdown regulations. In 2021, the value of mining production reached a record of over R1 trillion.³ SA holds 75% of the world reserves of the platinum group metals (PGMs).⁴ Five of the largest platinum-producing mines are situated in the North West province, namely, Impala Mine, Marikana Mine (Lonmin), Rustenburg Complex, Kroondaal Mine and Bafokeng-Rasimone Platinum Mine.⁵ In 2021, the production of PGMs increased from 226.5 tonnes to 285.3 tonnes, representing a 26% increase. Export volumes reached 264.6 tonnes.⁶ More than 50% of the world's gold reserves are found in SA, with the largest gold reserves located in the Witwatersrand Basin.⁷ In 2021, the production of gold increased by 9.6% to 105 tonnes from 96 tonnes in 2020. The gold sales recorded a total of R102,2 billion,

1 Africa mining IQ 2023 <https://projectsiq.co.za/mining-in-south-africa.htm>.

2 World Bank 2020 <https://www.worldbank.org/en/news/press-release/2020/06/08>.

3 Minerals Council South Africa *Facts and figures* 4.

4 Platinum Group Metals (PGMs) are six precious metals consisting of platinum, palladium, rhodium, iridium, osmium and ruthenium.

5 Africa mining IQ 2023.

6 Minerals Council South Africa *Facts and Figures* 34.

7 Africa mining IQ 2023.

representing an increase of 18.2%.⁸ SA's three largest diamond mines are De Beer's Venetia's Mine in Limpopo, Petra Diamonds' Finsch Mine in Northern Cape, and Cullinan Mine in Gauteng.⁹ In 2021, the mining sector in SA contributed an added value of R 218.2 billion, around USD11.82 billion to the SA's gross domestic product (GDP). The direct contribution to GDP grew by 36% to R481 billion.¹⁰

Against the backdrop of this wealthy sector, SA still has a high number of mine communities living in poor social and economic conditions, such as poverty, unemployment, inadequate housing, and poor health facilities.¹¹ In 2022, protesters at the SA Parliament handed a memorandum to the government, demanding that mining companies should include schools and healthcare facilities in their continuous five-year plan to develop host communities.¹² On the 16th of August 2012, members of the South African Police Services (SAPS) opened fire on protesters at Marikana mine who were perceived to be engaging in a violent protest. They demanded higher wages and improvement living conditions in the mine's adjacent squalid informal settlements. Members of the SAPS killed 34 protesting mineworkers, leaving 78 wounded.¹³

In view of the above, the aim of this study is to examine the part that mining companies can play in contributing towards the realisation of the right to healthcare services in host communities in SA.

1.2 The right to health in national and international law

The right of access to healthcare services is guaranteed at the international level. The Universal Declaration of Human Rights (UDHR)¹⁴ sets out a comprehensive range of essential human rights and freedoms for everyone around the world. It guarantees the

8 Minerals Council South Africa *Facts and Figures* 42.

9 Africa mining IQ 2023.

10 Statista 2023 <https://www.statista.com/accounts/ca>.

11 Cronjé, Reyneke and Van Wyk 2013 *JDRS* 3.

12 Lali 2022 <https://www.groundup.org.za/article/mining-affected-communities-protest-outside-parliament/>.

13 O'Connor "The Marikana Massacre and Labor Protest in South Africa" 113-136.

14 Adopted by the UN General Assembly in 1948. The UDHR is first international legal document that sets out international fundamental human rights under GA Res 217 A(III).

rights of the people globally without distinction of nationality, residency, gender, religion, language, or any other status.¹⁵ Article 25 of the UDHR provides that “Everyone has the right to a standard of living adequate for the health of himself and of his family, including ... medical care and necessary social services”.¹⁶

SA ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR)¹⁷ in 2015. Article 12 of the ICESCR provides that “the States parties to the Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”.¹⁸ The treaty further imposes the duty on State Parties by stating that the States Parties, in achieving the highest attainable standard of health shall include, *inter alia*, the creation of conditions which would assure to all medical service and medical attention in the event of sickness.¹⁹ States parties are obliged to assume obligations and duties under international law to respect, protect, and fulfil the provisions in the ICESCR.²⁰

Within the African regional human rights framework, the African Charter on Human and People’s Rights (ACHPR)²¹ guarantees everyone the right to enjoy the best attainable state of physical and mental health.²² The ACHPR further imposes a duty on the State Parties to take the necessary steps to protect the health of their people and to ensure that they receive medical attention when they are sick.²³ The ACHPR provides that States Parties shall ensure that the right of access to health facilities, goods, and services are distributed on a non-discriminatory basis, especially for vulnerable or

15 Article 2 of the United Declaration of Human Rights (1948).

16 Article 25(1) of the UDHR.

17 An international treaty adopted by the United Nations General Assembly in 1966 in New York under GA Res 2200A (XXI) and came in force from 1976.

18 Article 25(1) of the International Covenant on Social and Cultural Rights (1966).

19 Article 12 (2) (d) of the ICESCR.

20 See part 2.2.3 in Chapter 2 below for discussion on the obligations imposed on State Parties.

21 An international human rights instrument that promotes and protects human rights and basic freedoms in the African continent. Adopted by the Assembly of Heads of States and Governments of the OAU, (now African Union), in 1981 and came into force in 1986.

22 A 16 of the African Charter on Human and People’s Rights (1981).

23 A 16(2) of the ACHPR.

marginalised groups, and undertake to adopt legislative and other measures to give effect to them.²⁴

In September 2015 member states of the United Nations General Assembly (UNGA) adopted the sustainable development agenda, entitled *Transforming Our World: The 2030 Agenda for Sustainable Development*. Principal to the agenda is the *17 Sustainable Development Goals (SDGs)*.²⁵ Goal 3 of the SDGs advocates adequate access to healthcare services. It aims at ensuring healthy lives and promotes well-being for all at all ages. Although the SDGs do not impose binding legal obligations on countries, they demonstrate global commitment to address a diverse set of wicked transnational challenges. Goal 17 of the SDGs recognises the role of Public-Private Partnership in realising relevant global health-related commitments.

The right to health is also guaranteed in national human rights instruments. The *Constitution of the Republic of South Africa, 1996* is the supreme law of the country. It has a transformative purpose as it is designed to reverse the injustices of the past apartheid regime and to establish a society based on democratic values,²⁶ social justice, and human rights. The Bill of Rights (BoR) contained in Chapter 2 of the Constitution guarantees a variety of justiciable socio-economic and other rights as a mechanism for realising the transformative agenda.²⁷ These guarantees include, *inter alia*, the right of access to health care services. Section 27(1) of the Constitution states that “everyone has the right to have access to— health care services, including reproductive health care”.

In order to achieve the commitment in section 27(1) of the SA Constitution, the BoR impose obligations upon the state to “take reasonable legislative and other measures within its available resources to achieve the realisation of these rights”.²⁸ However, the

24 A (1) and (2) of the ACHPR.

25 Haywood *et al* 2019 *DSA* 555.

26 Refers to values that reflect a society's democratic way of life. Liberty and equality are regarded as the basic values of democratic political systems.

27 Kotzé and Fuo 2016 *JENRL* 286.

28 Section 27(2) of the SA Constitution.

Constitution does not define what should be considered “other measures” within the context of the Constitution. The courts have been bestowed with interpretative duty and the broad remedial powers as custodians of the Constitution to determine what constitutes reasonable legislative and “other measures”.²⁹ In addition, section 7(2) of the Constitution further imposes positive and negative obligations upon the state to respect, protect and fulfil the rights in the BoR. Section 27(3) of the Constitution provides that no one may be refused emergency medical treatment. The duties of the state to realise the right not to be denied access to emergency medical treatment and access to health services were interpreted by the Constitutional Court (CC) in the *Soobramoney*,³⁰ case and the *Treatment Action Campaign* (TAC) case.³¹

1.3 The duty of mining corporations to contribute to the right to health

The responsibility to realise the right to health primarily rests on the state.³² However, the private sector may be expected to come on board to assist the government in realising this right.³³ Mine companies are engaged in activities that negatively affect the surrounding communities and the ecosystem in different and complex ways- air and water pollution, loss of vegetation cover, and destruction of water bodies.³⁴ These have potentially negative health impacts. Some scholars and activists argue that businesses can respond to these socioeconomic impacts in terms of the principle of Corporate Social Responsibility (CSR).³⁵ CSR entails an inclusive range of activities and practices that go beyond lawful requirements and profit-generating. The main objectives of CSR are to advance sustainable development, address societal challenges, and ensure ethical conduct.³⁶ CSR refers to a concept in business principles

29 Mabetlela and Khangala “A critical analysis of the socio-economic rights” 104-112.

30 *Soobramoney v Minister Health* 1998 (1) SA 765 (CC).

31 *Minister of Health v Treatment Action Campaign* 2002 5 SA 721 (CC).

32 Article 2(1) of the Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to Promote and Protect Universally Recognized Human Rights and Fundamental Freedoms GA Res 53/144, UN Doc A53/144 (1998).

33 Goal 17 of the SDGs adopted on 25 September 2015 by the UNGA.

34 Masum, Aziz and Ahmad 2020 *Journal of Accounting Science* 36.

35 Loewenson 2018 *EQUINET* 8.

36 Kotzé and Fuo 2016 *JENRL* 294.

that suggests that business enterprises have a responsibility to contribute to the communities beyond their financial objectives and responsibilities. This implies that the role of business in society is no longer focused on making a profit alone but to also apply business strategies that are ethical, socially friendly, and beneficial to the community when conducting their business.³⁷ Whereas CSR is not comprehensively legislated in SA, the King IV Report on Corporate Governance, published in 2016 is centrally guiding to the concept of CSR.³⁸ CSR is also enacted in the provision of the *Companies Act*,³⁹ and the *National Environmental Management Act*.⁴⁰

Goal 17 of the SDGs focuses on strengthening global partnerships for sustainable development. SDG 17 with its emphasis on Public-Private Partnerships (PPPs) is a “revitalised global partnership for sustainable development”, which should be accompanied by sharing knowledge, expertise, technology, and financial resources between governments, private sectors, and civil society to support the achievement of the SDGs in all countries and in particular developing countries such as SA.⁴¹ SA has aligned the implementation of the SDGs and Agenda 2063 with that of its National Development Plan (NDP).⁴²

The realisation that private sector has become more influential and implicated in a range of gross violation of human rights globally, supported the call for binding international standards that regulate the human rights duties of businesses.⁴³ Despite efforts by the United Nations (UN) to develop a binding instrument to regulate the human rights obligations of business, it was only in 2011 that the *Guiding Principles*

37 Masum, Aziz and Ahmad 2020 *Journal of Accounting Science* 35.

38 Kotzé and Fuo 2016 *JENRL* 301.

39 See section 72 of the *Companies Act* 71 of 2008. Although this section does not specifically refer to CSR, it made an attempt to ensure that CSR becomes implanted in a businesses’ governance structures.

40 107 of 1998.

41 Haywood *et al* 2019 *DSA* 556.

42 Haywood *et al* 2019 *DSA* 556.

43 Chirwa 2006 *AJOL* 21.

on *Business and Human Rights*,⁴⁴ were developed. The *Guiding Principles* are now considered the most contemporary and authoritative principles regulating the human rights duties of business and the obligations emanating from them relate to all human rights guaranteed in international law instruments such as the ICCPR, and the ICESCR.⁴⁵ The details and implications of this instrument on the role of the mining sector in contributing towards the right of access to health care services in host communities will be unpacked in Chapter 2 of this study.

In SA, the horizontal application of the BOR implies that the BoR, where applicable, applies between one citizen or private body and another.⁴⁶ Section 8(2) of the Constitution states that “a provision of the BOR binds a natural or a juristic person if, and to the extent that, it is applicable, taking into consideration the nature of the right and the nature of a duty imposed by the right”. It has been suggested that the purpose of section 8(2) of the Constitution is rather to require private parties not to interfere with or diminish the enjoyment of a right; that is, they must adhere to the negative obligations.⁴⁷ In the *Khaya Sands* case, *Mantame J*, held that the burden placed on the state by section 27(1)(c) of the Constitution cannot wholly shift or extend to private companies.⁴⁸ However, where a contract between an organ of state and a private company expressly states that it undertakes to discharge constitutional obligations, the private businesses are expected to execute positive constitutional duties and to carry out the obligations imposed on the state, including respecting, protecting, promoting and fulfilling the socio-economic right in question.⁴⁹

Despite the above constitutional position, in line with the government’s transformation agenda, the Mineral and Petroleum Resources Development Act (MPRDA),⁵⁰ obliges

44 The *Guiding Principles on Business and Human Rights* (2011) were developed by John Ruggie and endorsed by the Human Rights Council on 16 June 2011. For account of earlier efforts to develop a binding instrument, see Kotzé and Fuo (2016) *JENRL* 297-298.

45 Kotzé and Fuo 2016 *JENRL* 298.

46 Kotzé and Fuo 2016 *JENRL* 298.

47 Kotzé and Fuo 2016 *JENRL* 306.

48 *City of Cape Town v Khaya Projects (Pty) Ltd and Others* 2014 1 SA 421 (WCC), para 36.

49 Kotzé and Fuo 2016 *JENRL* 306.

50 28 of 2002.

every mine to contribute to the development of mining communities.⁵¹ As a result, any mining operation is obligated to submit a social and labour plan (SLP) that explains how it going to carry out its business and benefit the host communities. The SLP sets out what the mining company will do for their employees and the community and how and when such promises will be fulfilled.⁵² Usually, the SLP commitments include infrastructure development and poverty eradication. The contents of the SLP become legal commitments once the application is approved. The commitments stipulated in the SLP become a contract between the company and the community, and if the company, after a stipulated period, fails to deliver on its commitments, the employees and the community are entitled to approach the DMRE with such a complaint.⁵³

1.4 Research Objectives

Against the above backdrop, this study aims to examine the role that mining companies in SA can play in contributing towards realising the right of access to health care services in host communities. Through this exercise, the study also established the extent to which the relevant legal framework enables mining companies in SA to contribute towards realising constitutional health rights. The secondary research objectives of the study are:

- To inspect the extent to which international and African regional human rights law obliges mining companies to contribute towards realising the right to health care in host communities;
- To discuss the extent to which the legal and policy framework in SA obliges mining companies to contribute towards realising the right to healthcare in host communities; and
- To inspect the extent to which three mining companies are contributing to realising the right to health care in their host communities in SA. These mines were

51 Section 2(d) of the MPRDA.

52 Centre for Applied and Legal Studies *Social and Labour Plan Mining Community Toolkit 4.*

53 Centre for Applied and Legal Studies *Social and Labour Plan Mining Community Toolkit 4.*

selected on the basis that they all fall within the Bojanala Platinum District Municipality; their footprint within the host communities is traceable and their SLPs are readily available on their websites.

1.5 Framework of the Study

The dissertation has five chapters structured as follows: Chapter 1 is the introduction to the study. Chapter 2 discusses international and African regional human rights law. Chapter 3 analyses the constitutional, legislative and policy positions in SA. Chapter 4 is an analysis of the SLPs of selected mines in SA to establish the extent to which the selected mines contribute towards realising the right of access to healthcare services in the host communities. Chapter 5 is conclusion and recommendations.

1.6 Research Methods

The study paradigm utilised for the completion of this research is desktop study. This study reviewed and analysed primary and secondary sources of law. The primary sources include the Constitution of the Republic of South Africa, 1996, legislation, international treaties and case law. Secondary sources such as academic books, journals, articles, and reports of specialised UN and AU bodies responsible for ensuring compliance with human rights duties were used. The SLPs of three mines operating in SA were analysed to illustrate the extent to which they respond to the health services needs of the host communities.

1.7 Relevance to the Research Unit

Mining is a mega-million sector that contributes significantly to SA's GDP. However, mine activities have harmful effects on the health of the people and the environment. One of the conditions for granting a mining license is the submission by the mining company of its written commitment to the sustainable development of the affected and surrounding communities. There is an increased global call on the private businesses to take an active role in achieving the objectives of international instruments such as the SDGs and the ICESCR. This research is relevant to the sub-

project on *Vulnerable Societies* under the North-West University of law Research Unit *Law, Justice, and Sustainability* in that it seeks to analyse how the existing legal framework can be used to help mining companies to contribute towards improving the right to health of host communities. The study examines the SLPs of Sibanye-Stillwater Mine, Bushveld Vatmetco Alloys Mine, and Eland Platinum Mine.

CHAPTER 2

INTERNATIONAL AND AFRICAN REGIONAL HUMAN RIGHTS

2.1 Introduction

Although the recognition and protection of the right to health within the UN system can be traced to the adoption of the Universal Declaration of Human Rights (UDHR) and subsequent international human rights instruments such as the International Covenant on Economic, Social and Cultural Rights (ICESCR), these instruments did not impose any binding legal duties on business. As the discussion below will show, the obligations were largely imposed on State Parties. This chapter discusses the nature of the right to health under international and African regional human rights law as well as the extent to which business corporations are required to contribute towards realising the right to health. In order to achieve this goal, the remainder of the chapter is structured into four parts. The first part begins by explaining the nature and scope of the right to health in the ICESCR and explores whether this instrument imposes any concrete duty on non-state actors using relevant literature and General Comments of the UN Committee on Economic, Social and Cultural Rights (CESCR).⁵⁴ The second part briefly explains the nature and scope of the right to health in the ACHPR and explores whether this instrument imposes any concrete duty on businesses using relevant literature and reports of the African Commission on Human and Peoples Rights. The third part discusses the evolution of the human rights duties of business within the UN system from the late 1990s, culminating with the adoption of the *UN Guiding Principles on Business and Human Rights* (2011). It reflects on the extent to which the Guiding Principles oblige the business sector to contribute towards realising the right to health in communities where they operate. Part 4 of the chapter is the chapter summary.

54 The CESCR was established by the UN Economic and Social Council in 1985 under Resolution 1985/17.

2.2 International Law

2.2.1 Substantive guarantees of the right to health under international law

The formation of the UN in 1945 brought the issue of health into international law in its constitutive document, the Charter of the UN.⁵⁵ Article 55 of the UN Charter declares that the UN shall promote, *inter alia*, solutions to international health, and related problems.⁵⁶ The Charter further states that all UN members pledge themselves to take joint and separate action in cooperation with the UN for the achievement of solutions to health and related problems.⁵⁷ It was therefore unsurprising when, in 1946, the drafters of the Constitution of the World Health Organization (WHO) declared that the enjoyment of the highest attainable standard of health is one of the fundamental rights of all without discrimination and that health is a 'state of complete physical, mental and social well-being and not mere freedom from sickness.'⁵⁸

The right to health was later developed in the UDHR as a common achievement for all nations. The UDHR set out the right to health as a fundamental human right that would be universally protected.⁵⁹ Article 25 of the UDHR provides that:

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.⁶⁰

Although the provision of article 25 of the UDHR does not directly define the components of the right to health, it does, however, advocate the right to a standard of living that is conducive to the health and well-being of everyone.⁶¹ Although the UDHR is not a legally enforceable treaty, it, nonetheless, laid the groundwork for the development of the ICESCR, which was adopted by the UN General Assembly in 1966.⁶²

55 The Charter of the United Nations is the founding document of the United Nations.

56 Article 55 (b) of the United Nation Charter.

57 A 56 of the United Nation Charter.

58 The preamble of the Constitution of the World Health Organization.

59 Yamin 2005 *AJPH* 1156.

60 A 25(1) of the UDHR.

61 A 25(1) of the UDHR.

62 OHCHR 2012 the UN Human Rights Treaty System *Fact Sheet No 30* 6-7.

The ICESCR directly refers to the right to health and is explicitly expressed in Article 12. Article 12 of the ICESCR obligates the States Parties to the Covenant to recognise the “right of everyone to enjoy the highest attainable standard of physical and mental health”.⁶³ According to the CESCR, the definition of the right to health under the ICESCR is not limited to healthcare alone. Rather, it embraces fundamental elements of health such as access to safe and potable water and adequate nutrition, food, housing, safe and healthy working conditions, and a healthy environment.⁶⁴ The right to health is reaffirmed as “a fundamental human right” in the 1978 Declaration of Alma-Ata on Primary Health Care, which states that “the attainment of the highest possible level of health is a most important global social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector”.⁶⁵ The Declaration of Alma-Ata was the first document to set out an all-inclusive interpretation of health and emphasised the contribution of health to economic and individual development.⁶⁶

Another instrument that guarantees the right to health is the International Convention on the Elimination of All Forms of Racial Discrimination (CERD).⁶⁷ Article 5 of the CERD provides that States Parties must ensure that every race is free from racial discrimination in the enjoyment of health and medical care.⁶⁸ The right to health is also guaranteed in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).⁶⁹ Article 11 of CEDAW provides that States Parties must ensure that women are protected from any form of discrimination with respect to enjoying the right to health including safe working conditions and safeguarding of the function of reproduction.⁷⁰

63 A 12 (1) of ICESCR.

64 CESCR General Comment Number 14 2000 The Right to the Highest Attainable Standard of Health *Article 12 of the ICESCR* para 4.

65 Marks 2016 *GWILR* 105-106.

66 World Health Organization 2019 *Report of the Global conference on primary health care* (No. WHO/UHC/IHS/2019.62) World Health Organization.

67 The International Convention on the Elimination of All Forms of Racial Discrimination was adopted by the UN General Assembly under resolution 2106 (XX)2 in 1965 and entered into force in 1969.

68 A (5)(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination.

69 CEDAW was adopted in 1979 under Resolution 34/180 and entered into force in 1981.

70 A 11 (1)(f) of the Convention on the Elimination of All Forms of Discrimination against Women.

The right to health of persons with disabilities is guaranteed in the Convention on the Rights of Persons with Disabilities (CRPD).⁷¹ This Convention provides that States Parties recognise that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination based on disability, and further that States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation.⁷²

Lastly, the right to health of children is enshrined in the Convention on the Rights of the Child (CRC).⁷³ CRC recognises a general right to health and a specific right to “facilities for the treatment of illness and rehabilitation of health”.⁷⁴ This imposes an obligation on States Parties to take appropriate measures to reduce infant and child mortality⁷⁵ and provide necessary medical assistance and health care services for the treatment of illness and rehabilitation of health to all children, with emphasis on the development of primary healthcare.⁷⁶

2.2.2 Normative content of the right to health under ICESCR

The most authoritative provision on the right to health in international human law is Article 12 of the ICESCR. A framework that is widely accepted to identify the normative content of the right to health is found in the CESCR General Comment Number 14.⁷⁷ In terms of General Comment Number 14, the right to health does not guarantee perfect health. It does, however, contain both freedoms and entitlements which gives people the freedom to control their health and body as well as the right to take part in making decisions that affect their health and therefore connects health concerns

71 Convention on the Rights of Persons with Disabilities adopted in 2006 under GA Resolution A/RES/61/106, 61st session, Doc A/61/6111 and entered into in 2008.

72 A 25 of the Convention on the Rights of Persons with Disabilities.

73 CRC was adopted in 1989 under GA Resolution 44/25 of the 44th session, Doc No A/44/49 and entered into force in 1990.

74 A 24(1) of the CRC.

75 A 24 (2)(a) of the CRC.

76 A 24 (2)(b) of the CRC.

77 UNESC 2000 General Comment 14: *The right to the highest attainable standard of health Article 12 of the ICESCR* United Nations' Committee on Economic, Social and Cultural Rights Document E/C.12/2000/4.

with lively social responsibilities.⁷⁸ The provision of “the highest attainable standard of health” in article 12.1 of ICESCR does not imply a guarantee of good health or provision of protection against every possible cause of illnesses. Rather, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realisation of the highest attainable standard of health.⁷⁹

Since the adoption of the ICESCR, the scope of the right to health has expanded to include resource distribution and gender differences.⁸⁰ The Committee interprets the right to health as a broad right extending not only to health care but also to the underlying determinants of health.⁸¹ A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels.⁸²

It should also be noted that over the years, the notion of the right to health has developed through consensus statements, declarations and other works. Thus, the decisions reached at the International Conference on Population and Development, Cairo, Egypt, in 1994 and the Fourth World Conference on Women in Beijing, China, in 1995 all contain important affirmations relating to the right to health, including the sexual and reproductive health rights of female persons.⁸³ In 2016, the CESCR adopted General Comment Number 22 on the right to sexual and reproductive health.⁸⁴ In terms of Comment Number 22, the right to sexual and reproductive health extends beyond sexual and reproductive healthcare to the underlying determinants of sexual and reproductive health, including access to safe and potable water and adequate

78 CESCR 2000 *General Comment 14* para 8.

79 CESCR 2000 *General Comment 14* para 9.

80 CESCR 2000 *General Comment 14* para 10.

81 The determinants of health include access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health

82 CESCR 2000 *General Comment 14* para 11.

83 Durojaye 2021 *AHRJ* 757.

84 UN Economic and Social Council 2016 *General comment Number 22 General Comment Number 22: the right to sexual and reproductive health Article 12 of the ICESCR*, United Nations' Committee on Economic, Social and Cultural Rights Document No E/C.12/GC/22

sanitation, access to adequate food and nutrition,⁸⁵ adequate housing, safe and healthy working conditions and environment, access to health-related education and information, effective protection from all forms of violence, torture, discrimination, and other human rights violations that negatively impact on the right to sexual and reproductive health.⁸⁶

The standard of health enshrined in article 12.1 of the ICESCR is explained through a set of interconnected components, the exact application of which will depend on the conditions prevailing in a particular State,⁸⁷ in accordance with the availability of healthcare facilities, goods and services in satisfactory quantity within the State Party;⁸⁸ accessibility of health facilities, goods and services without discrimination;⁸⁹ acceptability in that all health facilities, goods and services must be respectful of medical ethics and culturally appropriate;⁹⁰ and health care facilities, goods, and services that are scientifically and medically appropriate and of good quality.⁹¹

2.2.3 Duties of States Parties under ICESCR

State Parties that have ratified the international human rights treaties have, as a result, created binding obligations on themselves to give effects to these rights within their respective jurisdictions.⁹² The CESCR classified the obligations of State Parties into four categories, namely: general legal obligations, specific legal obligations, international obligations, and minimum core obligations.⁹³

In terms of general legal obligations, States Parties have instant obligations to take steps that are cautious, tangible and directed towards the full realisation of the right to health.⁹⁴ The CESCR interprets progressive realisation, as enshrined in article 12 of

85 CESCR 2016 *General Comment 22* para 1.

86 CESCR 2016 *General Comment 22* para 1.

87 Marks 2016 the *GWILR* 107.

88 CESCR 2000 *General Comment 14* para 12 (a).

89 CESCR 2000 *General Comment 14* para 12 (b).

90 CESCR 2000 *General Comment 14* para 12 (c).

91 CESCR 2000 *General Comment 14* para 12 (d).

92 World Health Organisation and Office of the United Nations High Commissioner for Human Rights the Right to Health *Fact Sheet No. 31* 22.

93 See part II of the General Comment Number 14 of Article 12 of ICESCR of the United Nations' Committee on Economic, Social and Cultural Rights (2000) Document No. E/C.12/2000/4.

94 CESCR 2000 *General Comment 14* para 30.

ICESCR, as obligating States Parties to have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realisation of health rights.⁹⁵ In instances where a State Party takes retrogressive measures, such State Party shall bear the onus of proving that every effort has been made to use all the maximum available resources in an attempt to satisfy the realisation of the right to health.⁹⁶

Concerning specific legal obligations, the right to health imposes three-folded obligations on States Parties, namely, the obligations to respect, to protect and to fulfil.⁹⁷ The obligation to respect requires States to desist from direct or indirect interference with the enjoyment of the right to health. This implies that the state should refrain from denying equal access to preventive, curative and palliative health services.⁹⁸ As a result, denying access to necessary medicine or other health products or imposing discriminatory practices that interfere with the enjoyment of the right to health would constitute a violation of this duty.⁹⁹ The obligation to protect requires the State Parties to take measures to ensure equal access to health care and health-related services provided by third parties to ensure that privatisation of the health sector does not constitute a threat to the enjoyment of the right to health.¹⁰⁰ Failure by States Parties to comply with the obligation to protect its citizens to this effect would constitute a violation of the right to health.¹⁰¹ Lastly, the obligation to fulfil requires States Parties to facilitate, promote and provide access to the right to health by taking positive measures, preferably by way of legislative implementation that enable and assist the society when they are unable to realise the right to health by their own means.¹⁰²

In terms of international obligations, States Parties are required to prevent third parties from violating the right to health in other countries, if they are able to influence these

95 CESCR 2000 *General Comment 14* para 31.

96 CESCR 2000 *General Comment 14* para 32.

97 CESCR 2000 *General Comment 14* para 33.

98 CESCR 2000 *General Comment 14* para 34.

99 Chirwa 2003 *SAJHR* 558.

100 CESCR 2000 *General Comment 14* para 35.

101 Chirwa 2003 *SAJHR* 558.

102 CESCR 2000 *General comment 14* para 37.

third parties by way of legal or political means.¹⁰³ States should facilitate access to essential health facilities, goods and services in other countries, wherever possible, provide the necessary aid when required, and further ensure that the right to health is given due attention in international agreements.¹⁰⁴ States Parties should refrain from imposing restraints on the supply of another State with adequate medicines and medical equipment as an instrument of political and economic pressure.¹⁰⁵

In terms of minimum core obligations, States Parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential level of the right to health in the ICESCR, including essential primary healthcare.¹⁰⁶ Minimum core obligations include at least the right of access to health facilities, goods and services on a non-discriminatory basis;¹⁰⁷ nutritionally adequate and safe food,¹⁰⁸ housing and sanitation, supply of safe and potable water,¹⁰⁹ essential medicines,¹¹⁰ equity on all health facilities, goods and services,¹¹¹ and adopt and implement measures addressing the health concerns of the population.¹¹² The state has the onus of justifying that every effort has been made to use all available resources at its disposal to satisfy minimum core obligations as a matter of priority.¹¹³

2.2.4 Duties of non-state actors under ICESCR

Non-state actors (NSAs) are not directly legally bound by international treaties in the same way as states.¹¹⁴ As a result, the primary objective of international human rights instruments is the protection of individuals and communities against states as NSAs are not recognised as traditional objects of international law.¹¹⁵ On the other hand, NSAs such as multinational corporations, international financial institutions, and non-

103 CESCR 2000 *General comment 14* para 39.

104 CESCR 2000 *General comment 14* para 39.

105 CESCR 2000 *General comment 14* para 41.

106 CESCR 2000 *General comment 14* para 43.

107 CESCR 2000 *General comment 14* para 43 (a).

108 CESCR 2000 *General comment 14* para 43 (b).

109 CESCR 2000 *General comment 14* para 43 (c).

110 CESCR 2000 *General comment 14* para 43 (d).

111 CESCR 2000 *General comment 14* para 43 (e).

112 CESCR 2000 *General comment 14* para 43 (f).

113 Chirwa 2003 *SAJHR* 550.

114 Zarei "The Status of Non-State Actors under the International Rule of Law" 233.

115 Zarei "The Status of Non-State Actors under the International Rule of Law" 235.

governmental organisations are increasingly at the forefront as providers of key goods and services that directly impact the enjoyment of human rights.¹¹⁶ The decisions and policies of multinational corporations such as pharmaceutical corporations, insurance companies, medical aid societies and other NSAs have a significant bearing on the accessibility of healthcare and essential medicines.¹¹⁷ Thus, NSAs possess significant effective economic, financial and institutional power yet lack any corresponding legal responsibility.¹¹⁸

Some analysts suggest that NSAs can bear human rights obligations under ICESCR.¹¹⁹ The International Council on Human Rights analysed various international human rights instruments, including the ICESCR, and concluded that these instruments recognise positive and negative obligations of NSAs.¹²⁰ The obligations of NSAs arise through the exercise by the state of the obligation to protect citizens. The duty to protect may require NSAs to refrain from interfering in the enjoyment of human rights as well as to take action to enrich their enjoyment. Nonetheless, indirect obligations of NSAs can be enforced through the state.¹²¹

General Comment 14 provides that international financial institutions such as the World Bank and the International Monetary Fund (IMF) should consider protecting the right to health in their credit policies and contracts. During the inspection of States parties' reports, the CESCR also considers the role of health professional associations and other NSAs in relation to the state's obligations under article 12.¹²²

116 Nolan 2014 *International Journal of Constitutional Law* 62.

117 Chirwa 2003 *South African Journal on Human Rights* 562.

118 Zarei "The Status of Non-State Actors under the International Rule of Law" 233.

119 Chirwa 2003 *SAJHR* 562.

120 Chirwa 2003 *SAJHR* 562.

121 Chirwa 2003 *SAJHR* 562.

122 CESCR 2000 *General comment No 14* para 64.

2.3 African Human Rights Law

2.3.1 Substantive guarantees of the right to health under ACHPR

In 1981, the heads of states under the Organisation of the African Unity (now African Union AU) adopted the ACHPR.¹²³ The guarantee of the right to health enshrined in the ACHPR mirrors article 12 of the ICESCR. Article 16 of the ACHPR guarantees every individual the right to enjoy the best attainable state of physical and mental health¹²⁴ and that Member States are obliged to ensure that their citizens receive medical attention when they are sick.¹²⁵ In 1990, the OAU adopted the African Charter on the Rights and Welfare of the Child (African Children's Charter).¹²⁶ The African Children's Charter guarantees the right to health and health services. Article 14 of the African Children's Charter guarantees the provision of necessary medical assistance and healthcare to all children, emphasising the development of primary healthcare.¹²⁷ The African Children's Charter further acknowledges the importance of health determinants in that Article 14 makes provision for adequate nutrition and safe drinking water for children¹²⁸ and ensures that the society is informed and supported in the use of basic knowledge of child health and nutrition, hygiene and environmental sanitation.¹²⁹

In 2003, AU adopted the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol).¹³⁰ Article 14 of the African Women's Protocol guarantees and states that "Member States shall ensure that the right to health of women, including sexual and reproductive health, is respected and promoted".¹³¹ The protection and promotion of women's health includes, *inter alia*,

123 The African Charter, also referred to as the "Banjul Charter", was adopted by the 18th Assembly of Heads of State of the OAU in 1981 in Banjul, Gambia.

124 A 16(1) of the African Charter on Peoples' and Human Rights.

125 A 16(2) of the African Charter on Peoples' and Human Rights.

126 The African Charter on the Rights and Welfare of the Child was adopted by the 26th ordinary session of the Assembly of Heads of State and Government of the Organisation of African Union and entered into force on 29 November 1999 OAU Doc.CAB/LEG/24.9/49 (1990).

127 A 14 (2)(b) of the African Charter on the Rights and Welfare of the Child.

128 A 14(2)(c) of the African Children's Charter.

129 A 14(2)(h) of the African Children's Charter.

130 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa was adopted by the AU in 2003 in its second ordinary session and entered into force 27 November 2005.

131 A 14 (1) of the African Women's Protocol.

the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS,¹³² and the right to be informed of one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices.¹³³

The African Youth Charter is another instrument that guarantees the right of health in the African regional law.¹³⁴ The African Youth Charter contains significant provisions relating to the right to health of young people. Article 16 of this Charter deals with health and states that "every young person shall have the right to enjoy the best attainable state of physical, mental and spiritual health".¹³⁵ More recently, the AU promulgated the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Older Persons in Africa (Protocol on the Rights of Older Persons).¹³⁶ This was a giant step in the African region, given that in Africa, older people are prone to experiencing discrimination, abuse, neglect and violence.¹³⁷ Health is guaranteed in article 15 of the Protocol on the Rights of Older Persons, which provides that Member States shall guarantee the right of older persons to access health services that meet their specific needs¹³⁸ and further create obligations on Member States to take reasonable measures to facilitate access to health services and medical insurance cover for older persons within available resources.¹³⁹

2.3.2 Normative content of the right to health under ACHPR

In 2010, the African Commission on Human and Peoples Rights¹⁴⁰ adopted the *Principles and Guidelines on the Implementation of the Economic, Social and Cultural*

132 A 14 (1)(d) of the African Women's Protocol.

133 A 14 (1)(d) of the African Women's Protocol.

134 The African Youth Charter was adopted in Banjul, The Gambia on 2 July 2006, entered into force on 8 August 2009.

135 A 16 (1) of the African Youth Charter.

136 The African Charter on Human and Peoples' Rights on the Rights of Older Persons in Africa adopted by the twenty sixth session of the assembly in Ethiopia on 31 January 2016 and entered into force on 17 June 2020.

137 University of Pretoria 2019 *PULP* 9.

138 A 15 (1) of the Protocol on the Rights of Older Persons.

139 A 15 (2) of the Protocol on the Rights of Older Persons.

140 The African Commission on Human and Peoples Rights is bestowed with the function to protect, to promote, and to interpret the African Charter on Human and Peoples Rights.

Rights (the Guidelines) in the ACHPR.¹⁴¹ Much like the General Comments on the ICESCR, the Guidelines gives normative content of the provisions of the ACHPR.¹⁴² In terms of the Guidelines, the right to health under the ACHPR is a broad right that incorporates both health care and the underlying health determinants. The right to health does not mean the right to be healthy.¹⁴³ The right to health care requires an operative and unified health system that is quick to respond to national and local priorities and accessible without discrimination.¹⁴⁴

The provision of health determinants entails access to safe and potable clean water and adequate sanitation, an adequate supply of safe food, nutrition and housing, a healthy workplace and a healthy environment.¹⁴⁵ The right to health encompasses effective access to health-related education and information, including sexual and reproductive health. The right to health also includes the freedoms to have control over one's own body and health which includes sexual and reproductive freedom.¹⁴⁶ People must be free from unnecessary interference and have the freedom to refuse non-consensual medical treatment, experimentation, forced sterilisation and insensitive and humiliating treatment.¹⁴⁷

Article 16 of the ACHPR further mirrors the wording of Article 12 of the ICESCR in that it lays down minimum core obligations on the Member States,¹⁴⁸ which, amongst other things, includes health facilities, goods and services on a non-discriminatory basis, especially for the marginalised groups.¹⁴⁹ Minimum core obligations under the ACHPR require Member States to ensure that people have access to essential drugs,¹⁵⁰ they are immunised against major infectious diseases,¹⁵¹ and take measures to prevent,

141 African Commission on Human and Peoples' Rights (ACHPR) *Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights* (2011).

142 Durojaye 2021 AHRJ 773.

143 ACHPR *Principles and Guidelines* para 61.

144 ACHPR *Principles and Guidelines* para 62.

145 ACHPR *Principles and Guidelines* para 63.

146 ACHPR *Principles and Guidelines* para 64.

147 ACHPR *Principles and Guidelines* para 65.

148 ACHPR *Principles and Guidelines* para 66.

149 ACHPR *Principles and Guidelines* para 67 (a).

150 ACHPR *Principles and Guidelines* para 67 (b).

151 ACHPR *Principles and Guidelines* para 67 (c).

treat and control epidemic and endemic diseases.¹⁵² Member States are required to make available information that concerns the key health challenges in the community and how to combat and control such health problems.¹⁵³

The ACHPR is unique in that it imposes obligations on individuals towards their families and society, the State and other legally recognised communities and the international community.¹⁵⁴ Individuals further have a duty to preserve the harmonious development of the family, to work for the cohesion and respect of the family, to respect their parents at all times, and to maintain them in case of need.¹⁵⁵ The provisions of Articles 27 and 29 are guided by the African philosophy of *Ubuntu*, which says "*Ubuntu ngumuntu ngabantu*", literally meaning "*I am because of other people*".¹⁵⁶

While most provisions of Article 16 mirror those in Article 12 of ICESCR,¹⁵⁷ the provision of Article 14 of the African Women's Protocol is considered ground-breaking in that it expands to include a woman's right to safe abortion.¹⁵⁸ Not even CEDAW contains any provision on abortion. As should be noted, abortion is a very controversial issue and often sparks religious and cultural sentiments whenever it is discussed at any forum.¹⁵⁹ Furthermore, the recognition of the right to health of older persons is also a giant step in the African human rights sphere. Nowhere else is such protection found. Therefore, the African human rights system should be applauded for taking a bold step to address the health needs of women, children, youth and older persons.¹⁶⁰

2.3.3 Duties of Member States under ACHPR

The ACHPR requires State Parties to "recognise" the right to health and its obligations thereof as expressed in the Charter and to adopt statutory or other measures in order

152 ACHPR *Principles and Guidelines* para 67 (d).

153 ACHPR *Principles and Guidelines* para 67 (e).

154 A 27 (1) of ACHPR.

155 A 29 (1) of ACHPR.

156 Mugumbate and Nyanguru 2013 *AJSW* 84.

157 Durojaye 2021 *AHRJ* 760.

158 Article 14(2)(c) of the African Women's Protocol.

159 Durojaye 2021 *AHRJ* 761.

160 Durojaye 2021 *AHRJ* 764.

to achieve objective of the right to health.¹⁶¹ The steps to be taken by the State Parties to achieve the right to health shall include providing protection through constitutionalising the rights, establishing health institutions, and administrative action that offers people appropriate recourse in cases where the provisions of the right to health are violated.¹⁶² For the enjoyment of the right to health the Charter obligates Member States to ensure the availability of the necessary goods and services so that they are sufficient, accessible and also affordable to all, including members of vulnerable and disadvantaged groups.¹⁶³

Member States have a duty to adopt and implement a broad national public health strategy and plan of action that focuses on basic and primary healthcare on a non-discriminatory basis, and that includes all ages and the marginalised.¹⁶⁴ Member States are expected to allocate a minimum of 15% of their annual budget to the improvement of the health sector with a significant portion to be spent on fighting malaria, HIV/AIDS, and tuberculosis,¹⁶⁵ and ensuring accessible medical care and treatment during sickness.¹⁶⁶ Member States have a duty to protect individuals and peoples against environmental, industrial and occupational hazards, preventing air, land and water pollution.¹⁶⁷ The States shall ensure that national plans prioritise members of vulnerable and disadvantaged groups in access to healthcare.¹⁶⁸ They will ensure a national mechanism for the response to epidemic, endemic, occupational and other diseases including in particular malaria, HIV/AIDS, tuberculosis, neglected tropical diseases and other infectious diseases which ensures a coordinated, participatory, transparent and accountable response.¹⁶⁹

Eradication of poliomyelitis in the African continent is an urgent priority through the allocation of adequate human, financial and material resources, including from

161 A (1) of the ACHPR.

162 ACHPR *Principles and guidelines* para 2.

163 ACHPR *Principles and Guidelines* para 3.

164 ACHPR *Principles and Guidelines* para 67 (f).

165 ACHPR *Principles and Guidelines* para 67 (g).

166 ACHPR *Principles and Guidelines* para 67 (h).

167 ACHPR *Principles and Guidelines* para 67 (s).

168 ACHPR *Principles and Guidelines* para 67 (x).

169 ACHPR *Principles and Guidelines* para 67 (II).

NSAs.¹⁷⁰ Member States further have the duty to ensure reproductive, maternal and child health care based on the life cycle approach to health. This includes the rights of women to control their fertility and to freely choose when, whether and with whom they will have sex,¹⁷¹ and whether to have children or not.¹⁷² Prevent child sexual abuse through strict enforcement of legislation criminalising such abuse and adequate punishment of offenders, through community education and mobilisation, education of medical personnel to identify signs of abuse, and through public education.¹⁷³

Just like under international law, African regional human rights instruments also require Member States to respect, protect, promote and fulfil the provisions of the right to health. The meaning of these duties was explained in 2.2.3, dealing with the duties of States Parties under ICESCR above.

2.3.4 Duties of non-state actors under ACHPR

Given that NSAs under international human rights instruments are not positively and legally obligated to protect human rights, nor can they be held directly responsible for human rights violations,¹⁷⁴ it is not surprising that the Principles and Guidelines developed by the ACHPR seem silent on whether the Charter imposes positive obligations on businesses. In the absence of a political will or the inability of the African states to subject multinational corporations to human rights standards, the host states are made to appear as the violators of rights when, in fact, the violations are perpetrated by NSAs.¹⁷⁵ The desperation for foreign direct investment makes it all the more difficult for the host country to insist on the protection of human rights.¹⁷⁶ The *SERAC case*¹⁷⁷ demonstrated that although the African Commission made adverse findings against the Nigerian government, it nonetheless also showed its unwillingness to hold private businesses accountable for violations of human rights.¹⁷⁸ In this case,

170 ACHPR *Principles and Guidelines* para 67 (jjj).

171 ACHPR *Principles and Guidelines* para 67 (III) (1).

172 ACHPR *Principles and Guidelines* para 67 (III) (2).

173 ACHPR *Principles and Guidelines* para 67 (ppp).

174 Busia *The state, non-state Actors and violation of Economic, Social and Cultural Rights* 24.

175 Busia *The state, non-state Actors and violation of Economic, Social and Cultural Rights* 33.

176 Busia *The state, non-state actors and violation of Economic, Social and Cultural Rights* 33.

177 *The Social and Economic Rights Action Centre and the Centre for Economic and Social Rights v Nigeria Government* Case No. ACHPR/ Comm 155/96.

178 *Serac v Nigeria* para 70.

the Shell Petroleum Development Corporation (SPDC), in partnership with the Nigerian National Petroleum Company (NNPC), was accused of exploiting oil reserves without regard to, amongst other things, the health of the local communities of Ogoniland.¹⁷⁹ The Shell Company also failed to maintain its facilities, resulting in toxic spills that contaminated drinking water, soil and air in the area.¹⁸⁰ The Nigerian government was accused of failing to protect the citizens of the region from the harm caused by Shell's activities, and the Government also failed to allow or conduct an assessment of potential health risks caused by such activities.¹⁸¹ As a result, the African Commission upon analysing obligations rested upon the Nigerian government by ACHPR with regard to the right to health and the right to a healthy environment, the Commission concluded that the Nigerian government violated, *inter alia*, Articles 16 of the ACHPR by condoning and facilitating health hazard activities of Shell in Ogoniland.¹⁸²

In contrast, commentator Rachel Murray¹⁸³ holds the view that a subtly different interpretation of the Charter may indicate that NSAs have legal duties which they are required to fulfil. These duties may encompass both negative and positive obligations, in the sense that private corporations are required to refrain from violating rights as well as, in some circumstances, to take positive steps to meet human rights standards in the Charter.¹⁸⁴ She argues that since the notion of the 'private/public' divide did not exist in the African practices before colonisation, the Charter's express inclusion of the duties of individuals in relation to the realisation of human and people's rights includes NSAs. The duties of individuals in the Charter are imposed on 'every individual' without qualification.¹⁸⁵ Accordingly, the ACHPR, if properly interpreted, could be invoked to hold NSAs responsible for the violation of the right to health.¹⁸⁶ As a result, it is likely that the Charter's provision that states and human beings must respect human rights

179 Busia *The state, non-state actors and violation of Economic, Social and Cultural Rights* 20.

180 Busia *The state, non-state actors and violation of Economic, Social and Cultural Rights* 20.

181 Coomans 2003 *International and Comparative Law Quarterly* 754.

182 Coomans 2003 *International and Comparative Law Quarterly* 755.

183 Murray and Murray 2000 *Hart Publishing*.

184 South African Institute for Advanced Constitutional, Public, Human Rights and International Law report (SAIFAC) 2010 *the State duty to protect, corporate obligations and extra-territorial application in the African regional human rights system* 32.

185 A 27 (1) of ACHPR.

186 Busia *The state, non-state actors and violation of Economic, Social and Cultural Rights* 28.

encompasses NSAs in the context of individuals.¹⁸⁷ The wording of the duty of individuals to exercise one's rights and freedoms "with due regard" to the rights of others,¹⁸⁸ is equated to the 'due diligence' concept developed in the Special Representative of the UN Secretary-General's (SRSG) 'protection, respect, remedy' framework,¹⁸⁹ discussed in 2.4 below.¹⁹⁰

2.4 Human Rights Obligations of Businesses after the International Bill of Rights

2.4.1 Historical background

The centralised role of the states is shifting to eccentric and categorised guiding forms of governance in which NSAs are also taking part.¹⁹¹ This shift is believed to be influenced by, *inter alia*, the emergence of the international norm-producing functional NSAs such as multinational corporations that enable inter-state cooperation.¹⁹² Governance has become a new approach, providing greater associations of actors from different institutional levels. Most importantly though, is that governance does not make any normative or moral claims, nor does it impose legally binding obligations on NSAs.¹⁹³ In addition, the shift to the notion of governance led to the development of the well-established model of CSR, which relates to the moral obligations of corporations emanating from human rights and social development.¹⁹⁴ The following discussion focuses on how the UN has attempted to address the human rights duties of business.

2.4.2 The UN Guiding Principles (2011)

In 2000, the UN established the Global Compact to facilitate the involvement of multinational companies in assisting, amongst other things, the achievement of

187 SAIFAC Law report 2010 33.

188 A 27 (2) of ACHPR.

189 In 2005, John Ruggie was appointed as the Special Representative of the U.N. Secretary-General (SRSG) to address challenges facing transnational corporations and human rights.

190 SAIFAC Law Report 2010 33.

191 Kotzé and Fuo 206 *JENRL* 292.

192 Kotzé and Fuo 2016 *JENRL* Law 292–293.

193 Kotzé and Fuo 2016 *JENRL* 293.

194 Kotzé and Fuo 2016 *JENRL* 294.

Millennium Development Goals (MDGs).¹⁹⁵ In 2003, the principles of the Global Compact were developed further when the UN adopted the *Norms on the Responsibilities of Transnational Corporations and Other Business Enterprises with Regard to Human Rights* (2003 Norms).¹⁹⁶ The 2003 Norms were intended to provide binding human rights obligations on business enterprises irrespective of where they operate, but they never went as far.¹⁹⁷ The 2003 Norms were abandoned in 2008 when the Human Rights Council (HRC) of the UNGA endorsed the "*protect, respect and remedy*" framework, which was later developed in 2011 by John Ruggie¹⁹⁸ and called the *United Nations' Guiding Principles on Business and Human Rights* (UNGP).¹⁹⁹ The Guiding Principles are now regarded as the most recent and authoritative proclamation adopted by the UN on the human rights responsibilities of corporations. They are based on three pillars: the state's existing obligations to protect, respect, and remedy; the private business obligations to comply with all applicable laws and to respect human rights; and lastly, the need for human rights and obligations to be matched to appropriate and effective remedies when breached.²⁰⁰

The UNGP stipulates that corporations are obligated to respect human rights by avoiding the violation of the human rights of others through their own activities.²⁰¹ The duty on NSAs is thus negatively proclaimed, meaning that they do not carry any expressed positive duties to fulfil human rights obligations as states do, including those related to the right to health.²⁰² However, the duty to respect further requires corporations to take positive measures to put in place mechanisms that can prevent human rights violations.²⁰³

195 Kotzé and Fuo 2016 *JENRL* 297.

196 United Nations, *Norms on the Responsibilities of Transnational Corporations and Other Business Enterprises with Regard to Human Rights* (UN 2003) UN Doc.E/CN.4/Sub.2/2003/12/Rev.2. Approved by UN Sub-Commission on the Promotion and Protection of Human Rights on 13 August 2003 by Resolution UN Doc.E/CN.4/Sub.2/2003/L.11.

197 Kotzé and Fuo 2016 *JENRL* 297.

198 In 2005 John Ruggie was appointed as a Special Representative of the UN Secretary-General's (SRSG) on human rights and transnational corporations and other business enterprises by then UN Secretary-General Kofi Annan.

199 Kotzé and Fuo 2016 *JENRL* 297.

200 Kotzé and Fuo 2016 *JENRL* 298.

201 Principle 11 of United Nations' Guiding Principles on Business and Human Rights (2011) 13.

202 Kotzé and Fuo 2016 *JENRL* 299.

203 Principle 24 of UN' *Guiding Principles on Business and Human Rights* 2011.

According to the UNGP, the duty to protect requires only the state to protect its subjects against human rights abuses by corporations within their territory. This requires states to take appropriate steps to prevent, investigate, punish and redress perpetrators through effective policies, legislation, regulations and adjudications.²⁰⁴

On the other hand, the UNGP stipulate that the duty to remedy is part of the states' duty to protect its subjects against business-related human rights abuses. This requires States to take appropriate steps to ensure, through judicial, administrative, legislative or other appropriate means, that when such abuses occur within their territory those affected have access to effective remedies.²⁰⁵ The UNGP requires that in order to identify, prevent, mitigate and remedy human rights violations, corporate businesses should carry out human rights due diligence. The process should include assessing actual and potential human rights impacts, integrating and acting upon the findings, tracking responses, and communicating how impacts are addressed.²⁰⁶ Human rights due diligence should include the adverse human rights impacts corporations may cause or to which they may contribute through their own activities or which may be directly linked to its operations, products or services by its business relationships.²⁰⁷

2.4.3 Reflection on the health-related duties of business from UN Guiding Principles

Clearly, the primary responsibility to protect human rights, including the right to health, lies greatly with the States. It is the State's primary duty to protect, respect, fulfil and ensure that violations of the right to health, as well as its determinants, are remedied.²⁰⁸ Private businesses are not yet proper objects of international law. Like human rights treaties, the UNGP does not impose any legally binding health rights-related obligations on private businesses beyond that of respecting the right to health of the people.

204 Principle 1 of United Nations' *Guiding Principles on Business and Human Rights* 2011.

205 Principle 25 of United Nations' *Guiding Principles on Business and Human Rights* 2011.

206 Principle 17 of United Nations' *Guiding Principles on Business and Human Rights* 2011.

207 Principle 17 of United Nations' *Guiding Principles on Business and Human Rights* 2011.

208 Goqingco 2023 UN Guiding Principles on Business and Human Rights *Springer Nature Switzerland AG* 3.

2.5 Chapter Summary

The purpose of this chapter was twofold: firstly, to examine the extent to which the right to health is guaranteed in international and African region human rights law; and secondly, to examine the extent to which international and African region human rights law impose duties on NSAs to realise the right to health.

In relation to the first objective, this chapter established that the right to health is guaranteed in a number of international and African regional instruments such as the UDHR, ICESCR and the ACHPR. The wording of the rights and substantive duties imposed on States by international and African regional law has many similarities. For example, article 12 of ICESCR and Article 16 of ACHPR both advocate for the enjoyment of the highest attainable standard of physical and mental health of everyone through the provision of access to, but not limited to, healthcare services, adequate housing, food, clean water and sanitation. International and African regional human rights law imposes duties on the States to protect, respect and fulfil the right to health and to further take appropriate measures for the realisation of the right. Despite this, the ACHPR is unique in that it imposes duties on individuals and families. The normative content of the right to health also has some peculiar requirements. The provision that individuals have obligations to preserve their family and maintain them in case of need is unique in the international and regional human rights instruments.

In relation to the second objective, it was established that while international human rights instruments impose both negative and positive obligations on States, non- state actors are only obligated to not violate the enjoyments of the right to health. Depending on the context, this may require that they put in place measures to prevent possible infringement of the health rights of communities.

CHAPTER 3

ANALYSIS OF THE CONSTITUTIONAL, LEGISLATIVE, AND POLICY POSITION IN SOUTH AFRICA

3.1 Introduction

The African continent is blessed with vast amounts and concentrations of mineral deposits, with large deposits of Platinum, diamonds, gold, titanium, aluminium, copper, and many others found in SA. Despite the vast amount of mineral deposits in the African continent, the scourge of poverty, unemployment, and health challenges in African countries remains a major concern.²⁰⁹ This is true of SA, despite the mining sector significantly contributing to the national economy. This dissertation reflects on the role that mines can play in contributing towards realising the right to healthcare in host communities in SA. The purpose of this chapter is to examine the extent to which the constitutional, legislative, and policy frameworks in South Africa require and enable mines to contribute towards realising the right to health care in host communities. The chapter starts in 3.2 below by briefly discussing the constitutional, legislative, and policy framework on the right to healthcare in SA. The intention is to show what South Africans are entitled to in terms of constitutionally guaranteed health rights and to illustrate what the duties of the state are. It is followed by part 3.3 of the chapter, which analyses the extent to which the constitutional, legislative, and policy positions in SA require and enable mining companies to contribute towards realising health rights for host communities. After this Section 3.4 of the chapter appraises the position of SA human rights law in relation to international law discussed in Chapter 2. The discussion ends in 3.5 with a chapter summary.

209 Dikobe *Mining multi-national corporations and natural resource's governance issues* 16.

3.2 Constitutional, Legislative and Policy Framework on the Right to Health in South Africa

3.2.1 Constitutional framework on the right to health

The right to healthcare is provided for in three sections of the SA Constitution.²¹⁰ These sections provide access to healthcare services, including reproductive health, basic health care for children, and medical treatment for detained persons.²¹¹ Although access to healthcare services and medical treatment is contained in several provisions, it is unambiguously guaranteed in section 27 of the SA Constitution.²¹² Firstly, section 27 of the Constitution guarantees everyone the right to have access to healthcare services, including reproductive healthcare.²¹³ The term "healthcare service" in the Constitution denotes more than just curative service. Healthcare equates to the promotion, maintenance, and preservation of health as much as it does the restoration of health.²¹⁴ It involves a range of aspects, such as water, sanitation, nutrition, and other components that are equally important in ensuring a person's health.²¹⁵ Nonetheless, the interpretation of the phrasing of this right as "to have access to" in section 27(1)(a) of the Constitution signifies that the state is not ordinarily required to provide healthcare services, but must ensure that healthcare services of sufficient quality are reasonably accessible to everyone, including the marginalised, and at affordable prices.²¹⁶

In addition, section 27(1) is internally qualified by three conditions which require the State: (a) to take reasonable legislative and other measures, (b) within its available resources, (c) to achieve the progressive realisation of this right.²¹⁷ The "reasonable legislative measures" were dealt with in the case of the *Treatment Action Campaign* (TAC).²¹⁸ The facts of this case are that the SA government devised a programme to

210 Moyo "Realising the right to health in South Africa" 376-456.

211 Sections 27(1); 28 1) (c); and 35(2) (e) of the SA Constitution.

212 Nevondwe and Odeku *MJSS* 839.

213 Section 27(1)(a) of the SA Constitution.

214 Pearmain *A critical analysis of the law on health service delivery in South Africa* 1339.

215 Gross "The Right to Health in an Era of Privatisation and Globalisation" 295.

216 Heyns and Brand 1998 *Law, Democracy & Development* 159.

217 Section 27 (2) of the SA Constitution.

218 *Minister of Health and Others v Treatment Action Campaign and Others* (2002) 10 BCLR 1033 (CC).

deal with mother-to-child transmission of HIV at birth and identified nevirapine as its drug of choice for this purpose. The programme limited the availability of nevirapine in the public health sector.²¹⁹ The TAC submitted that the restrictions were unreasonable and unconstitutional.²²⁰ At issue was a decision by the government to limit the provision of nevirapine to HIV-positive pregnant women who were about to give birth at two sites in each province of the country.²²¹ The government argued that courts are not supposed to interfere in matters concerning government policies, and more specifically, that it was within the medical authorities to prescribe drugs and not the courts. The Court rejected this argument and ruled that the government's policy to limit the drug to two sites in each of the nine provinces was unconstitutional.²²² The Court ordered the government to remove the limitations that prevented nevirapine from being made available at public hospitals and clinics that were not research and training sites.²²³ The wording "subject to available resources" denotes that the state is not required, as a matter of absolute obligation, to do more than it has the resources to do so. However, it is argued that this interpretation of section 27 should not be construed as a blanket excuse for failure by the State to realise the health right as provided for in section 27(1)(a) of the Constitution.²²⁴

In *Government of the RSA v Grootboom*,²²⁵ the CC established the standard of reasonableness as an appropriate test for legislation adopted to give effect to the socio-economic rights guaranteed in sections 26(1) and 27(1) of the Constitution.²²⁶ According to the Court, measures that seek to achieve the progressive realisation of socio-economic rights have to be reasonable both in their commencement and their execution.²²⁷ The Court stressed that these are obligations that Courts can, and in suitable situations, must implement.²²⁸

219 *Treatment Action Campaign* case para 4.

220 *Treatment Action Campaign* case para 4.

221 *Treatment Action Campaign* case para 18.

222 *Treatment Action Campaign* case para 125.

223 *Treatment Action Campaign* case para 135 (3) (a).

224 Heyns and Brand 1998 *Law, Democracy & Development* 159.

225 *Government of South Africa and Others v Grootboom and Others* (CCT 11/00) 2000 (11) BCLR 1169.

226 Section 26(1) of the Constitution guarantees everyone the right of access to adequate housing.

227 *Grootboom* case para 42.

228 *Grootboom* case para 94.

Although the *Grootboom* case focused on the right to have access to adequate housing, its principles can be applied to healthcare because of similar phrasing of the rights and obligations in sections 26 and 27 of the Constitution.²²⁹ This case reinforced the constitutional obligation of the government to ensure the right of access to healthcare services to especially vulnerable and marginalised people.²³⁰

Section 27(3) of the Constitution guarantees everyone the right to medical treatment in the event of an emergency. It provides that no one may be refused emergency medical treatment. While the horizontal application of socio-economic rights against NSAs is generally controversial, there is an increasing acceptance that the right not to be refused emergency medical treatment does bind private healthcare providers.²³¹ This provision gives special protection to people in need of emergency medical treatment by stipulating that public or private healthcare providers may not deny treatment to anyone in the event of an emergency.²³²

One of the first few cases in which the CC was given the task to demarcate the application of section 27(3) as well as the extent of the positive obligations engendered thereby is the *Soobramoney* case.²³³ In this case,²³⁴ Mr Soobramoney was suffering from renal failure, which required ongoing dialysis treatment to keep him alive.²³⁵ He claimed that because the treatment could save his life, it should be regarded as an “emergency medical treatment” that cannot be denied.²³⁶ The court held that “emergency medical treatment” refers to treatment that is necessary because of a sudden tragedy, which calls for immediate medical attention.²³⁷ A person suffering from a treatable but incurable condition, such as renal failure, cannot be categorised under the provision of section 27(3) of the Constitution but is instead can be categorised under the provision of section 27(2), which requires the government to take all reasonable measures to ensure that access to healthcare services is

229 *Grootboom* case para 93.

230 Pieterse 2010 *Law, Democracy & Development* 248.

231 Pieterse 2010 *Law, Democracy & Development* 243.

232 Moyo “Realising the right to health in South Africa” 376-456.

233 Pieterse 2010 *Law, Democracy & Development* 243.

234 *Soobramoney v Minister of Health (KwaZulu-Natal)* (CCT32/97) [1998] 1 All SA 268 (CC).

235 *Soobramoney* case para 7.

236 *Soobramoney* case para 7.

237 *Soobramoney* case para 20.

progressively realised.²³⁸ The unanimous decision of the Court was that when it came to the use of immensely expensive medical treatment, it could not interfere with the decision of the medical authorities, using rational and fair medical criteria to give preference to the best candidates for renal transplants.²³⁹

The right to healthcare service is also guaranteed in sections 28 (1)(c) and 35(2)(e) of the Constitution, which respectively guarantee the right to basic healthcare services to every child and the right of access to adequate medical treatment by people who are detained within the boundaries of SA at the expense of the state.²⁴⁰ In the case of *Van Biljon*,²⁴¹ four sentenced HIV-infected prisoners applied for a declaratory order for medical treatment for the provision of expensive anti-retroviral (ARV) medications. The government argued that the State could not afford it and that the state's responsibility was to provide the applicants with the same standard of care as was provided in State hospitals, where the use of the drugs was limited. The Court held that lack of State funds cannot be an answer to a prisoner's constitutional claim to adequate medical treatment as this right, like the right of basic healthcare of children, is immediately realisable.²⁴² Consequently, the court ordered that the first and second applicants be provided with such ARV therapy as had already been prescribed for them on medical grounds and only for as long as this treatment is so prescribed.²⁴³

Sections 27(1), 28(1)(c), and 35(2)(e) are interconnected with Section 24 of the Constitution. Section 24 guarantees everyone the right to an environment that is not harmful to their health.²⁴⁴ Section 24 imposes an obligation on the government to protect the environment through reasonable legislative and other measures, for the sake of the people's health and their environment.²⁴⁵ It is submitted the objective of section 24 is to protect peoples' health through the protection of the environment.

238 *Soobramoney* case para 22.

239 *Soobramoney* case para 29.

240 Section 35(2)(e) of the Constitution.

241 *Van Biljon v Minister of Correctional Services* 1997 (6) BCLR 789 (C).

242 *Van Biljon* case para 49.

243 *Van Biljon* case para 61.

244 Section 24 (a) of the SA Constitution.

245 Section 24 (a) of the SA Constitution.

Section 7 of the Constitution obligates the State to respect, protect, promote and fulfil health rights as provided for in the BoR.²⁴⁶ The obligation to “respect” generally requires the state not to interfere with a person’s enjoyment of the right to health.²⁴⁷ The obligation to “protect” requires the State to take steps to prevent third parties from interfering with health rights.²⁴⁸ The obligation to “promote” requires the State to give sufficient recognition of the right in its domestic system, disseminate appropriate information and raise awareness on this right, foster research, and support people to make informed decisions.²⁴⁹ The obligation to “fulfil” requires that the State ensures adequate training of health workers, provides sufficient health-related facilities and provides a health insurance system affordable to all.²⁵⁰

The Constitution provides that the government must adopt and implement realistic statutory and other means to ensure the realisation of health rights.²⁵¹ In the context of the right of access to adequate housing, the Court indicated in the *Grootboom* case that the right of access to adequate housing also suggests that it is not only the state who is responsible for the provision of houses but that other agents within our society, including individuals themselves, must be enabled by legislative and other measures to provide housing.²⁵² This implies that the government should create a conducive legal, policy and economic environment for people to provide houses to themselves and then only step in to provide for desperate people who cannot provide for themselves despite the conducive environment.²⁵³ This has somehow clarified the role of private actors in contributing to socio-economic rights.²⁵⁴ This reasoning can also apply to some aspects of health rights because, with reference to section 8 (2) of the Constitution, provisions of health rights²⁵⁵ bind a natural or a juristic person. In applying the provisions of health rights to private actors, the courts are given the discretion to

246 These obligations under international law are discussed in part 2.2.3 of Chapter 2 above.

247 O'Brien 2013 *Journal of Law and Medicine* 14.

248 O'Brien 2013 *Journal of Law and Medicine* 15.

249 O'Brien 2013 *Journal of Law and Medicine* 16.

250 Chirwa 2003 *SAJHR* 565.

251 Section 27(2) of the SA Constitution.

252 *Grootboom* case para 35.

253 *Grootboom* case para 44.

254 Nolan 2014 *Oxford University Press* 81.

255 Sections 27(1); 28(1) (c); and 35 (2) (e)

develop common law to give effect to the realisation of health rights.²⁵⁶ If the government creates an environment where the economy grows, for example, through mega investments in mining and where people have decent jobs and can access private medical schemes, this will meet the requirements of section 27(2) of the Constitution. As a result, the government can include the mines from a constitutional point of view to contribute towards realising the right of access to healthcare services.

It is important to note that although the duties imposed by the health rights fall on the entire state, the responsibilities of the three spheres of government (national, provincial and local government) differ considering the constitutional and legislative distribution of governmental powers. The Constitution highlights functional areas of competencies of the local, provincial and national government. Schedule 4, Part A of the SA Constitution incorporates healthcare services as an area of concurrent national and provincial legislative competency, while Part B of the same Schedule incorporates municipal health services as a local government competency.²⁵⁷ Despite attempts at the allocation of powers to functional areas of competencies of the three spheres of government, the division of powers and functions concerning health is not crystal clear.²⁵⁸ This means that the exact scope of the duties of the three spheres of government to realise health rights can be confusing. This lack of clarity often generates conflicts.²⁵⁹ The dispute that arose in March 2021 between the Gauteng Health Department and the City of Tshwane over the power to provide ambulatory services is illustrative of the lack of this clarification.²⁶⁰ Fuo argues that the framing of health rights, its associated obligations, and the power bestowed on municipalities give municipalities the power to provide health services such as ambulance services.²⁶¹

Nonetheless, all these health rights enshrined in the Constitution are not absolute and may be limited only in terms of law of general application.²⁶² Firstly, these rights can

256 Kotzé and Fuo 2016 *JENRL* 303. See also section 8(3) (a) of the SA Constitution.

257 Pillay 2003 *Law, Democracy & Development* 72.

258 Fuo 2022 *SLR* 486.

259 Fuo 2022 *SLR* 486.

260 See Fuo 2022 *SLR* 484-500.

261 Fuo 2022 *SLR* 486.

262 Section 36 (1) of the SA Constitution.

be limited if the limitation complies with the “general limitation clause” in section 36(1).²⁶³ Secondly, they must be exercised with due regard for rights held by others.²⁶⁴

3.2.2 Legislative framework on the right to health

To further give effect to its constitutional health obligations arising from, *inter alia*, sections 7(2) and 27(2) of the Constitution, the government has enacted legislation and adopted policies. Key legislations include the National Health Act (NHA),²⁶⁵ the Medicines and Related Substances Act,²⁶⁶ the Choice on Termination of Pregnancy Act,²⁶⁷ and the Mental Health Care Act.²⁶⁸ In terms of these laws, the Department of Health is primarily responsible for consistently improving the healthcare delivery system by focusing on access, equity, efficiency, quality, and sustainability.²⁶⁹ Given the limited scope of this research, the legislative framework on health rights is limited to the discussion of the NHA as it provides the most significant translation of the constitutional right to have access to health care services in the public sector.²⁷⁰

The purpose of NHA is to regulate national health and to provide equality to health services across SA by, *inter alia*, establishing a national health system that prioritises access to the best possible health services, within the public and private sectors, for all.²⁷¹ In terms of section 3 of the NHA, the State must, within its available resources, ensure the provision of essential health services, which must include primary health services.²⁷² The NHA defines the responsibilities of national, provincial, and local governments in providing healthcare services.²⁷³ The Act aims to ensure that all South Africans have access to quality healthcare. The national department is generally

263 Section 36 (1)(a)-(e) of the SA Constitution. See also *S v Mamabolo* 2001 (3) SA 409 (CC) para 48.

264 *Satawu v Garvis* 2013 (1) SA 83 (CC) para 51-53; *Hotz v UCT* 2017 (2) SA 485 (SCA) para 62.

265 Act No 61 of 2003.

266 Act No 101 of 1965.

267 Act No 92 of 1996.

268 Act No 17 of 2002.

269 Department of Health of South Africa, *Department of Health 2017 Yearbook*, <https://www.gcis.gov.za/sites/default/files/docs/resourcecentre/yearbook/Health2017.pdf>.

270 Pieterse 2010 *Law, Democracy & Development* 239.

271 Section 2(a)(i)-(ii) of the National Health Act.

272 Section 3(1)(e) of NHA.

273 Section 3 (2) of NHA.

responsible for the implementation of national health policy in so far as it relates to the national department and issues guidelines on how the national health policy should be implemented.²⁷⁴ In terms of the NHA, the national government is responsible for the issuing of, and observance of, norms and standards on health matters, including, *inter alia*, environmental conditions that constitute a health hazard.²⁷⁵

The NHA also makes provision for the establishment of a National Health Council (NHC) made up of, amongst others, the Minister and his/her Deputy, all provincial Members of the Executive Councils (MEC) of Health, and one municipal councillor representing local government.²⁷⁶ The NHC is meant to advise the Minister of Health.²⁷⁷ Within the provincial government, the MECs must ensure that the national health policy, norms and standards in a particular province are implemented.²⁷⁸ The provincial head of the Department of Health must make provision for, *inter alia*, specialised hospital services,²⁷⁹ emergency medical services,²⁸⁰ and provide environmental pollution control services.²⁸¹ The provincial councils consist of members of local and provincial government²⁸² and are responsible for advising the provincial department on health policy.²⁸³ The local government must ensure that appropriate municipal health services²⁸⁴ are effectively and equitably provided in their respective areas.²⁸⁵

It is important to note that some aspects of the NHA remain controversial and are likely to be tested before courts. For example, on 24 May 2024, Solidarity Trade Union

274 Section 21(1)(a) and (b) of NHA.

275 Section 21 (2)(b)(ii) of NHA.

276 Section 22 (2)(a), (b), (c) and (d) of NHA.

277 Section 23 (1) of NHA.

278 Section 25 (1) of NHA.

279 Section 25 (2)(a) of NHA.

280 Section 25 (2)(m) of NHA.

281 Section 25 (2)(u) of NHA.

282 Section 27 (1) of NHA.

283 Section 27 (1) of NHA.

284 Municipal health services include, amongst others, public health nursing, sanitation, communicable disease control, epidemiology, health statistics and records, school health services, and home health care, water quality monitoring, food control, waste management, and health surveillance of premises.

285 Section 32(1) of NHA.

launched an application with the North Gauteng High Court,²⁸⁶ challenging the constitutionality of sections 36 to 40 of the NHA.²⁸⁷ The applicants sought an order declaring that those sections were unconstitutional and invalid in their entirety and ought to be severed from the NHA.²⁸⁸ The applicants argued that provisions of sections 36-40 violate, amongst others, the right of access to healthcare.²⁸⁹ In his judgment handed down on 24 July 2024, Miller J agreed with the contentions of the applicants and ordered that sections 36 to 40 of the NHA are declared invalid in their entirety and are, thus, consequently severed from the Act.²⁹⁰ Other challenges are highlighted in 3.2.3 below.

3.2.3 Policy framework on the right to health

Section 27 of the SA Constitution contemplates that the government should adopt and implement legislation and policies to give effect to health rights.²⁹¹ In August 2011, SA took on a revolutionary step for its national health system with the publication of the government's Green Paper on National Health Insurance (the Green Paper) as a response to universal health coverage (UHC).²⁹² The Green Paper proposed four key interventions: (a) a complete transformation of healthcare service provision and delivery; (b) a total overhaul of the health care system; (c) a radical change of administration and management; and (d) the provision of a comprehensive package of care underpinned by a re-engineered system of Primary Healthcare (PHC).²⁹³

In 2015, SA government drafted the White Paper on National Health Insurance (NHI) policy, which was officially adopted in 2017 detailing the Implementation Structures

286 *Solidarity Trade Union and Others v Minister of Health and Others* (61844/2021) [2024] ZAGPPHC 677 (24 July 2024).

287 Sections 36-40 states, *inter alia*, that no one may, *inter alia*, establish a health establishment or provide prescribed health services without being in possession of a certificate of need obtained from the National Department of Health.

288 *Solidarity Trade Union* case para 1.

289 *Solidarity Trade Union* case para 30.

290 *Solidarity Trade Union* case para 85.

291 Section 27(2) of the SA Constitution.

292 Booyesen and Hongoro 2018 *PAMJ* 2.

293 National Health Insurance in South Africa *Green Paper on NHI* Department of Health Pretoria 2011 Para 6.

for the NHI, thus signalling the start of the long-awaited implementation of NHI.²⁹⁴ Like the Green Paper, the White Paper echoed the government's commitment to NHI as a tool for realising the constitutional right of access to healthcare services.²⁹⁵

The *National Health Insurance Act*, which was passed into law on 15 May 2024 provide a framework for a structured and uniform health system that took into consideration the government's obligations imposed by the Constitution.²⁹⁶ In its preamble, the NHA recognises the socio-economic injustices and inequities of health services of the past, and the need to improve the quality of life for all in the country as some of the main objectives for its promulgation.²⁹⁷ The National Health Insurance Act,²⁹⁸ emanating from the Green Paper and White Paper policy on NHI was developed to serve as a tool to enable the realisation of the right of access to healthcare services.²⁹⁹ The objective of the Act is to establish a National Health Insurance Fund and to set out its powers, functions and governance structures;³⁰⁰ to provide a framework for the strategic purchasing of health care services by the Fund on behalf of users.³⁰¹

The purpose of the *National Health Insurance Act* is to establish and maintain a health insurance fund in SA funded through mandatory prepayment that aims to achieve sustainable and affordable universal access to quality healthcare services by³⁰² purchasing and paying for healthcare services in order to ensure the equitable and fair delivery and use of healthcare services;³⁰³ ensure sustainable funding for healthcare services within the country,³⁰⁴ and provide for equitable and efficient funding of healthcare services, medicines, health goods and health-related products from accredited and contracted health care service providers.³⁰⁵ The NHI Fund is established

294 Booyesen and Hongoro 2018 *PAMJ* 2.

295 London and Sanders 1993 *PHM* 4.

296 Moyo "Realising the right to health in South Africa" 376-456.

297 Moyo "Realising the right to health in South Africa" 376-456.

298 No. 20 of 2023.

299 London and Sanders 1993 *PHM* 2.

300 See the long title of the NHI Act.

301 See the long title of the NHI Act.

302 Section 2 of NHI Act.

303 Section 2 (a) of NHI Act.

304 Section 2 (b) of NHI Act.

305 Section 2 (c) of NHI Act.

as an autonomous public entity³⁰⁶ that is responsible for purchasing and procuring healthcare services, medicines, health goods and health-related products from healthcare service providers, health establishments and suppliers,³⁰⁷ to enter into contracts with accredited healthcare service providers based on the health care needs of users³⁰⁸ and determine payment rates for such providers, establishments and suppliers.³⁰⁹ The primary source of the revenue of the Fund will be monies appropriated annually by Parliament,³¹⁰ which will come from general tax revenue, the reallocation of funding for medical scheme tax credits, payroll tax, and a supplement on personal income tax.³¹¹ Once NHI has been fully implemented, medical schemes may only offer complementary cover to services not reimbursable by the Fund.³¹²

A system intended to cover everyone in a country as big as SA would certainly need to possess significant financial resources to meet even its most basic targets.³¹³ The introduction of NHI is likely to cost SA more than R600 billion at its anticipated commencement in 2026.³¹⁴ The lack of a clear and sustainable funding model for NHI poses serious challenges, and without proper financing, there is a substantial risk that the NHI might not deliver on its promises, leaving citizens without adequate access to quality healthcare services.³¹⁵ Some researchers³¹⁶ warned that the tax increases proposed to fund the NHI are not going to be sustainable without much faster economic growth. Such growth is most unlikely to be achieved.³¹⁷ Another major challenge facing the implementation of NHI in the SA health sector is leadership and

306 Section 9 of the NHI Act.

307 Section 10 (b) of the NHI Act.

308 Section 10 (d) of the NHI Act.

309 Section 10 (g) of the NHI Act.

310 Section 49 (1) of the NHI Act.

311 Section 49 (2) (a) of the NHI Act.

312 Section 33 of the NHI Act.

313 Rammila 2023 *Law, Democracy & Development* 368.

314 Sokutu 2018 <https://www.citizen.co.za/news/south-africa/south-africa-cannot-afford-the-proposed-nhi>.

315 Kommal 22024 <https://www.iol.co.za/business-report/economy/funding-uncertainty-in-national-health-insurance-key-challenges-and-considerations>.

316 The Davis Tax Committee (DTC), chaired by retired Judge Dennis Davis, is a Tax Review Committee elected by the then Minister of Finance Pravin Gordhan on 17 July 2013. The Committee's objective is to assess SA's tax policy framework and its role in supporting the objectives of inclusive growth, employment, development and fiscal sustainability.

317 Sokutu 23 June 2018 <https://www.citizen.co.za/news/south-africa/south-africa-cannot-afford-the-proposed-nhi-expert/>.

good governance. Many public medical facilities suffer from poor management and administration, leading to inefficient delivery of healthcare services.³¹⁸ In addition, it is believed that the implementation of NHI may lead to the collapse of the private healthcare sector.³¹⁹ Kommal is of the view that to overcome the NHI funding uncertainty, the government must embark on Public-Private Partnerships and engage the services of private businesses to identify viable funding options.³²⁰

3.3 Constitutional, Legislative, and Policy Framework on the duty of Mining Companies to Contribute Towards Realising Health Rights

3.3.1 Constitutional framework

Although the provision of section 8 of the BoR is progressive towards the protection of health rights in SA, binding natural and juristic persons,³²¹ the provision of section 27³²² obligates the state to take reasonable measures to achieve the progressive realisation of the right of access to healthcare services.³²³ Moreover, both sections 27(2), 28 (1) (c) and 35(2) (e) of the Constitution impose a positive duty only on the state to provide health facilities and services to its citizenry for the realisation of health rights.³²⁴ The State has been identified for carrying positive and negative obligations of protecting, promoting, respecting and fulfilling the right of access to healthcare services.³²⁵

In this context, imposing positive duties on the mines would be inappropriate for the realisation of health rights.³²⁶ Recent court decisions have demonstrated that SA courts are willing to enforce positive obligations, with direct and substantial monetary

318 Shezi *Perceptions of health care professionals on the feasibility of NHI* 23.

319 Shezi *Perceptions of health care professionals on the feasibility of NHI* 23.

320 Kommal 2024 <https://www.iol.co.za/business-report/economy/funding-uncertainty-in-national-health-insurance-key-challenges-and-considerations>.

321 See part 1.3 above.

322 Section 27 (2) of the SA Constitution.

323 Section 27 (2) of the SA Constitution.

324 Cheadle and Davis 1997 *SAJHR* 60.

325 Ebi *Enforcing the right of access to healthcare services in South Africa* 53.

326 Ebi *Enforcing the right of access to healthcare services in South Africa* 53.

implications, against NSAs.³²⁷ This position was emphasised in the *Juma Masjid* case.³²⁸ In this case, a private property owner, Juma Masjid Trust, successfully sought to evict a public school conducted on its property. The eviction emanates from a commercial dispute between the Trust and the MEC for Education in KwaZulu-Natal. The High Court held that the Trust was not exercising a public function and that it owed no constitutional obligations in relation to the right to basic education, to the MEC or to the learners at the school.³²⁹ When the matter reached the CC, the court was tasked with adjudicating as to whether the Trust owed a constitutional obligation to the learners at the school in relation to their right to a basic education under section 29 of the Constitution.³³⁰ The Court ruled that there was no primary positive obligation on the Trust to provide basic education to the learners; rather, that primary positive obligation rested on the government.³³¹ However, the Court ruled that the private Trust had a negative constitutional obligation to respect, and not impair, the learners' right to a basic education under section 29 of the Constitution.³³² While earlier court decisions demonstrated that SA courts acknowledged that at least some of the duties imposed by socio-economic rights are binding on private parties,³³³ the *Juma Masjid* case did not address the issue of positive obligations on the part of NSAs but emphasised the negative obligations imposed on NSAs.³³⁴

Chirwa³³⁵ argues that the fact that the state is identified in section 27(2) of the SA Constitution as the main player in the realisation of the right of access to healthcare services cannot be used as an excuse to prohibit the responsibility of the NSAs in contributing towards the realisation of the right of access to healthcare services.³³⁶

327 Heyns and Brand 1998 *Law, Democracy & Development* 164. See also *Minister of Health and Others v Treatment Action Campaign and Others* (2002) para 125, and *Van Biljon v Minister of Correctional Services* (1997) para 49.

328 *Juma Masjid Primary School and Others v Ahmed Asruff Essay NO and Others* 2011 (8) BCLR 761 (CC).

329 *Juma Masjid* case para 21.

330 *Juma Masjid* case para 7.

331 *Juma Masjid* case para 57.

332 *Juma Masjid* case para 60.

333 Kotzé and Fuo 2016 *JENRL* 305. See also *Grootboom* case para 35;

334 Nolan 2014 *Oxford University Press* 83.

335 Danwood Mzikenge Chirwa is the author of "non-state actors' responsibility for socio-economic rights: the nature of their obligations under the South African Constitution" (ESR Review 2002)

336 Chirwa 2002 *ESRR* 4.

Kotzé and Fuo emphasised the CC's view that the right of access to adequate housing also suggests that it is not only the State that is responsible for the provision of houses, but that other agents, including private businesses, must be enabled by legislative and other measures to provide housing.³³⁷ Kotzé and Fuo further emphasised that such inference by the Court confirms the position that private businesses can have positive obligations towards the realisation of health rights to the extent that they are regulated by policies, programmes and laws promulgated by the government. Consequently, the mines can be obligated to contribute towards the realisation of the right of access to healthcare services through appropriate programmes, policies and statutes.³³⁸

The Supreme Court of Appeal (SCA) also considered the enforceability of the right of access to adequate housing on private entities in the case of the *President of the Republic of South Africa & Anor v Modderklip Boerdery*.³³⁹ In this case, the SCA rejected the earlier conclusion of the High Court that the right of access to adequate housing is not one enforceable against an individual landowner in terms of the Constitution. Justice Harms stated that although horizontality was not applicable to the case in question, circumstances may arise where the right would be enforced horizontally.³⁴⁰ On the basis that sections 26(1) and (2) are similarly worded to sections 27(1) and (2), the reasoning of the SCA suggests that there can be circumstances where mines can be held accountable with respect to contributing towards health rights by invoking the direct horizontal application of section 8 (2) of the Constitution.³⁴¹

In addition, section 27(3) of the Constitution, which states that "no one may be refused emergency medical treatment" also applies to both State and non-state health providers.³⁴² Section 27(3) was interpreted to include non-state health establishments by the CC in the case of *Soobramoney*.³⁴³ In this case, the Court held that "a person who suffers a sudden catastrophe which calls for immediate medical attention should not be refused ambulance or other emergency services which are available and should

337 Kotzé and Fuo 2016 *JENRL* 305. See also *Grootboom* case para 35.

338 Kotzé and Fuo 2016 *JENRL* 306.

339 *President of the Republic of South Africa & Anor v Modderklip Boerdery* 2005 (8) BCLR 786 (CC).

340 *Modderklip Boerdery* case para 31.

341 Kotzé and Fuo 2016 *JENRL* 303. See also part 3.2.1 above.

342 Nolan 2014 *Oxford University Press* 85.

343 See part 1.2 above.

not be turned away from a hospital which is capable of providing the necessary treatment".³⁴⁴ Thus, "a hospital capable of providing the necessary treatment" includes private healthcare providers. The provision in section 27(3) of the Constitution implies that private healthcare providers cannot turn away patients who require emergency medical treatment on the basis that they are unable to pay for such treatment. It is argued that section 27(3) obligates private health providers to assess and stabilise patients who requires emergency medical treatment and only transfer them to other appropriate healthcare facilities when their condition has been stabilised.³⁴⁵

3.3.2 Legislative framework

Among the legislative steps taken by the State to ameliorate the living conditions of mine communities was the promulgation of the MPRDA.³⁴⁶ In terms of the MPRDA, the State recognises the need to promote local and rural development and the upliftment of communities affected by mining. The Act further reaffirms the State's commitment to reform to bring about equitable access to SA's mineral and petroleum resources.³⁴⁷ This Act is the main legislation regulating the mining industry in South Africa and was enacted to give effect to the constitutional provisions in SA.³⁴⁸ The MPRDA aims, amongst other things, to stimulate employment and advance the social and economic well-being of all South Africans³⁴⁹ and most importantly, to ensure that mining licence holders contribute positively towards the socio-economic development of the host communities.³⁵⁰ In giving effect to the constitutional rights, the MPRDA requires that the applicant for a mining licence must submit, as a pre-requisite for the granting of such rights, a SLP.³⁵¹ Compliance with this requirement is a prerequisite for mining licence, and without such a plan a mine cannot obtain authorisation to commence or continue with its operations. In addition, any renewal of a mining licence or right is

344 *Soobramoney* case para 20.

345 *Krammer* 2008 *SAJBL* 54.

346 No. 28 of 2002.

347 See the Preamble of MPRDA.

348 *Igbayiloye* 2021 *AHRLJ* 371.

349 Section 2 (f) of the MPRDA.

350 Section 2 (i) of the MPRDA

351 Section 23 (1) (e) of MPRDA.

conditional on the provision of proof that the mine has complied with all initial contents of its previously submitted SLP.³⁵²

The objectives of the SLP are, amongst others, to promote economic growth in SA,³⁵³ to promote employment and advance the socio-economic welfare of all South Africans,³⁵⁴ and most importantly, to ensure that mining licence holders contribute towards the social and economic development of the host communities as well as labour sending areas.³⁵⁵ In granting the mining right, the Minister of Mineral and Resources and Energy may grant the right if, amongst other things, the mining licence applicant has provided financially and otherwise for a prescribed SLP.³⁵⁶

The DMRE developed the guidelines for the MPRDA regulations with which the mining licence holders should comply when drafting their SLPs.³⁵⁷ According to the guidelines, an SLP should contain six sections consisting of (a) Human resource development programme, (b) employment equity plan, (c) mine community development, (d) measures to address housing and living conditions, (e) processes on the management of downscaling and retrenchment, and (f) financial provision for the identified projects.

The SLP should contain a comprehensive mine community development plan.³⁵⁸ In this section, the SLP should clearly state what the mine will do for the benefit of the communities and how and when they will do this.³⁵⁹ The SLP, and especially the mine community development programme, should mirror the integrated development plans (IDP)³⁶⁰ of the municipality in whose area such mining is taking place. The mine should profile the host communities, and its SLP should contain background information on the communities, which include but are not limited to health and HIV/Aids prevalence,

352 Fuo and Kotzé 2016 *JENRL* 310.

353 Section 2 (e) of the MPRDA.

354 Section 2 (f) of the MPRDA.

355 Section 2 (i) of the MPRDA.

356 Section 84 (1) (g) of the MPRDA.

357 Mineral and Petroleum Resources Development Act Regulations in Government Notice R 527 in the Government Gazette 26275 of 23 April 2004.

358 Regulation 46 (c) (i) in GN R 349 in GG 34225 of 18 April 2011.

359 Centre for Applied legal studies 2022 *Social and Labour Plan community toolkit* 4.

360 Integrated Development Plan ("IDP") is a plan designed for the municipality to address social and economic challenges of a particular municipal communities created in terms of the Local Government: Municipal Systems Act, No. 32 of 2000.

economic profile, education levels, expenditure profile, infrastructure, housing, water and sanitation, as well as electricity.³⁶¹

Depending on a particular community's prioritised needs, health improvement and other health determinants should ordinarily include improvement in healthcare facilities, housing, nutrition, sewerage system, and water and sanitation.³⁶² In order to achieve this, the regulations require that the mine must consult with all stakeholders involved, including the host communities.³⁶³ As the SLP should be reviewed every five years, the result of the review determines whether or not the DMRE approves a new SLP developed for the succeeding five-year period.³⁶⁴ On the other hand, the host community also has the right to request the mining company to provide complete and accurate information on its compliance, including sharing the compliance reports that are submitted annually to the DMRE.³⁶⁵ When a mine submits an application for mining operations, the DMRE must decide if its application should be granted based on these requirements.³⁶⁶

The SLP is basically a promise that the mine makes to the DMRE and all stakeholders, including host communities, on how they will positively contribute to the socio-economic standard of the host communities in their application for a mining licence, which becomes a legal commitments once the application is approved.³⁶⁷

As the mines are required to submit an annual compliance report on their performance in relation to the promises they made in their SLP,³⁶⁸ the DMRE is responsible for monitoring if a mine complies with the provisions of MPRDA and if it is delivering on the commitment it made in the SLPs.³⁶⁹ In instances where it is discovered that a particular mine is not complying with its SLP, the DMRE, as the national department, is capable of applying its authority of enforcement which varies from issuing notices

361 The Department of Mineral Resources 2010 *Revised Social and Labour Plan Guidelines* 4.

362 Dikobe *Mining multi-national corporations and natural resource's governance issues* 173.

363 Reg 3 in GN R349 in GG 34225 of 18 April 2011 read with Reg 3A (1) in GN R 420 in GG 43172 of 27 March 2020.

364 Reg 43 in GN R 420 in GG 43172 of 27 March 2020.

365 Centre for Applied legal studies 2022 *Social and Labour Plan community toolkit* 9.

366 Section 3 (2)(a) of MPRDA

367 Centre for Applied legal studies 2022 *Social and Labour Plan community toolkit* 2.

368 Regulation 45 in GN R 349 in GG 34225 of 18 April 2011.

369 Section 3 (2)(a) of MPRDA.

to a defaulting mine to suspending or canceling the licence.³⁷⁰ In instances where the mine has already been authorised to conduct its operations, the MPRDA requires compliance with the requirements of an SLP from the mining rights holder³⁷¹ and must submit an annual report to the DMRE specifying the degree of such compliance.³⁷² A mine therefore constantly has to demonstrate to the DMRE or any other competent authority that it has satisfied its duties in relation to its SLP in order to continue with authorised operations.³⁷³ In this way, it is ensured that the projects listed in the mine's SLP do not remain a mere rhetoric, but become enforceable goals that must be achieved in terms of a subordinate statute-based plan.³⁷⁴ It can thus be reasoned that the extent to which mines can contribute towards realising the right of access to healthcare services is not measured only upon the willingness of the mine to include health programmes in their SLPs, but also on the eagerness of and dedication by the mine to implement them, as well as the ability and determination of the DMRE to observe and ensure accomplishment of the listed programmes.³⁷⁵ However, the flip side of this is that the DMRE officials tasked with overseeing community development, are more often not clued up about the real challenges of the communities. Seemingly, mine community development appears to be more of a public relations exercise than an appropriate intervention for actual development.³⁷⁶

From the discussion above, it appears that the SLP represents one of the practical instruments that can be utilised by mining communities to address some of their health challenges. As a statutory requirement in terms of the MPRDA, the SLP can be utilised to obligate the mines to provide healthcare services and other health determinants to mining communities through its compliance.³⁷⁷

370 Section 47 (1) of MPRDA.

371 Section 25(2)(f) of MPRDA.

372 Section 25(2)(h) of MPRDA.

373 Fuo and Kotzé 2016 *JENRL* 310.

374 Fuo and Kotzé 2016 *JENRL* 310.

375 Fuo and Kotzé 2016 *JENRL* 310.

376 Dikobe *Mining multi-national corporations and natural resource's governance issues* 52.

377 See section 23 (1) (e) of MPRDA.

3.3.3 Policy Framework

Private businesses are gradually taking responsibility for the economic, social and environmental impacts of their operations. This accountability is articulated through the concept of CSR.³⁷⁸ CSR proposes that the pillar of a company does not solely depend on profit-making but also on reflections in terms of which the successes of a business are measured in economic, social, and environmental terms.³⁷⁹ In essence, CSR has to do with societal expectations of corporate behaviour that is ethical, albeit not necessarily legally, demanded of a business.³⁸⁰ Bowen defines CSR as the moral obligations of businesses to pursue those policies, to make those decisions, or to follow those lines of action that are desirable in terms of the objectives and values of a particular society.³⁸¹ CSR is a concept whereby corporations reflect on the interest of the communities by taking responsibility for the impact of their activities on communities and the environment.³⁸² In this context, it is no longer that businesses are focused on generating profit only but are expected to focus on acting responsibly towards the communities in which their businesses operate.³⁸³

Private businesses are becoming socially responsible towards communities for their actions on the basis that (a) their monetary profits depend on embracing such responsibilities; (b) they could positively contribute to the good of the communities; (c) they need to continually add value to and invest into the very society they benefit from; and (d) that they should enhance the socio-economic and environmental conditions of the communities their businesses operate.³⁸⁴ Apart from the added benefit that a mine would be seen as a good corporate citizen, it could also direct its CSR obligations on the issue that affects most host communities: provision of healthcare services.

378 Fuo and Kotzé 2016 *JENRL* 292.

379 Fuo and Kotzé 2016 *JENRL* 292.

380 Fuo and Kotzé 2016 *JENRL* 292.

381 Carroll 1999 *Sage Publications Inc* 269.

382 Masum, Aziz and Ahmad 2020 *Journal of Accounting Science* 36.

383 Masum, Aziz and Ahmad 2020 *Journal of Accounting Science* 35

384 Fuo and Kotzé 2016 *JENRL* 295.

Besides national policies, the King Committee³⁸⁵ developed reports and codes that seek to regulate private businesses on corporate citizenship in SA. Much like the *Guiding Principles* of the UN,³⁸⁶ the King Reports on Corporate Governance are guidelines for the governance structures and operation of private businesses in SA.³⁸⁷ According to the King Committee, the notion of CSR in SA is rooted in the Constitution, which imposes responsibilities upon juristic persons to contribute towards the realisation of most fundamental rights.³⁸⁸ The fundamental objective of the King reports is to influence, develop and advance corporate governance and directorship by pursuing ethical and effective leadership, thus, serving as the benchmark for corporate governance in SA.³⁸⁹ Thus far, the committee has published four Reports: the King I Report on Corporate Governance for South Africa published in 1994; the King II Report on Corporate Governance for South Africa in 2002; the King III Report in 2009; and the current reigning King IV Report on Corporate Governance for South Africa was published in 2016. King IV Report³⁹⁰ made SA the first developing country to develop a corporate governance code of best practices. It is considered an authoritative policy position in SA in the protection and promotion of CSR.³⁹¹ The King IV Report advocate the idea of interdependency between businesses and all stakeholders, including host communities. According to the King IV Report, the idea of interdependency has its roots in the African concept of *Ubuntu*.³⁹² The Report acknowledges that businesses do not operate in a vacuum but as an integral part of society as a whole, and as such, businesses benefit themselves when they positively contribute to their own society.³⁹³ As an objective to aspire to be at the forefront of corporate governance internationally,

385 The King Committee on Corporate Governance for SA was established in 1992 at an IoDSA Council meeting, chaired by former SCA Judge Mervyn King, to address corporate governance of private businesses in SA.

386 *Guiding Principles on Business and Human Rights: Implementing the United Nations 'Protect, Respect and Remedy' Framework* (UN 2011).

387 King Reports are issued by the King Committee on Corporate Governance for SA private businesses.

388 Fuo and Kotzé 2016 *JENRL* 301.

389 IoDSA "date unknown" <https://www.iodsa.co.za/page/who-we-are>.

390 King IV Report on Corporate Governance for South Africa 2016 *Institute of Directors of Southern Africa*.

391 Anwana *Corporate social responsibility and corporate governance* 93.

392 "Ubuntu" concept says that *Umuntu Ngumuntu Ngabantu* literally meaning "I am because you are and you are because we are".

393 IoDSA 2016 King IV Report on Corporate governance in South Africa 23

the King Committee focuses on the importance of reporting annually on what and how companies have contributed towards the social and economic development of the communities in which their businesses are operating.³⁹⁴ The Committee acknowledges that the communities in which the companies operate their businesses are licensors to the successes of those businesses.³⁹⁵ Therefore, businesses are accountable to their present and future stakeholders, including the communities in which they conduct their businesses.³⁹⁶

One of the most distinctive characteristics of the King IV Report that considerably impacts CSR is the “apply and explain” policy.³⁹⁷ The “apply and explain” policy is simply a matter of asking private businesses such as mines to be transparent in their application of investing to the host communities, in alignment with the objectives of constitutional rights such as the right of access to healthcare services, in which these businesses operate.³⁹⁸ Principle 16 states that the governing body,³⁹⁹ in the execution of its governance role and responsibilities, should adopt a stakeholder inclusivity approach that balances the needs, interests and expectations of material stakeholders in the best interests of the organisation over time.⁴⁰⁰ This principle emphasises the role of the communities in the governance process of businesses by providing that their boards should consider the legitimate and reasonable needs, interests and expectations of such communities as a priority.⁴⁰¹ Such communities are required to hold the boards and the company accountable for their actions.⁴⁰²

The impact of principle 16 of the King IV Report on CSR implementation is that the community is given the opportunity to be involved in corporate decision-making, especially in relation to CSR projects which will affect them. The responsibilities of

394 Thobatsi *The alignment of Social and Labour Plan (SLP) commitments with municipal Integrated Development Plans (IDPs)* 19.

395 IoDSA 2016 King IV Report on Corporate governance in South Africa 4.

396 Anwana *Corporate social responsibility and corporate governance* 93.

397 Part 3 of King IV report *disclosure on application* 37.

398 Anwana *Corporate social responsibility and corporate governance* 96.

399 The governing body is a structure that has primary accountability for the governance and performance of an organisation. It includes board of directors.

400 IoDSA 2016 Principle 16 of the King IV report.

401 Principle 16 of the King IV report.

402 Anwana *Corporate social responsibility and corporate governance* 97.

investors and key shareholders, and the concept of 'responsible investing' have been extended and developed in the King IV Report in line with the responsible investing practices set out in the Code for Responsible Investing in South Africa (CRISA)⁴⁰³ and the United Nations Principles on Responsible Investing (UN PRI),⁴⁰⁴ for entities with a primary listing on the JSE Limited Securities Exchange. Certain aspects of King IV are binding by virtue of the listing requirements imposing obligations on issuers to comply therewith.⁴⁰⁵ Investors in SA have pledged and are committed to incorporating Environmental, Social and Governance (ESG) issues into investment analysis and decision-making processes.⁴⁰⁶ This could be applied to mines as JSE-listed companies so that they do not randomly invest back into the host communities but engage meaningfully with such communities to address and accountably respond to their needs, interests and expectations. This would involve, as it is a challenge facing many mine communities, meaningful contributions towards the realisation of access to healthcare services and other determinants of health.⁴⁰⁷

Consequently, private businesses no longer have the luxury of explaining non-compliance with the recommended principles when it comes to the implementation and compliance with CSR policies. Private businesses are required to ensure that they act as responsible corporate citizens by investing in the development of the communities in which they operate.⁴⁰⁸

403 The first Code for CRISA was launched in 2011 to encourage institutional investors and service providers to integrate environmental, social and governance (ESG) issues into their investment decisions. Since 2011, the world has seen significant advancements in the regulatory and governance context as it relates to responsible investment and stewardship. CRISA 2, launched in 2022, contains five principles for stewardship and responsible investment as a key component of the SA governance framework. The primary objective of CRISA 2 is to affirm CRISA as a key component of the governance framework for SA <https://www.crisa2.co.za/>.

404 In 2005, the then UN Secretary-General Kofi Annan invited international investors to develop the Principles for Responsible Investment. The organisation promotes the incorporation of ESG factors into investment decision-making.

405 Harduth and Sampson 2016 *Werksmans Incorporated* 25.

406 Principle 1 of the Code for Responsible Investing in South Africa

407 Anwana *Corporate social responsibility and corporate governance* 97.

408 Anwana 2020 *HTS Theological Studies* 4.

3.4 Appraisal of South Africa's Health Rights in Relation to International Law

In analysing how the SA Constitutional provision of health care services should be defined, the WHO's definition of health is regarded as an informative point of reference. The WHO's Constitution defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".⁴⁰⁹ However, the SA Constitution narrowed this definition of health as envisaged by WHO to "health care services".⁴¹⁰ To withstand a "state of complete well-being" as projected by the WHO, and "the standard of living adequate for health",⁴¹¹ the SA Constitution included several health determinants intended to support the vision of physical, mental and social well-being.⁴¹² These include sufficient water of adequate quality for consumption,⁴¹³ a clean and healthy environment,⁴¹⁴ children's right to basic nutrition, shelter, basic healthcare services and social services.⁴¹⁵ Nonetheless, from the definition of healthcare services as provided for in section 27(1) (a) of the SA Constitution, it is clear that these definitions were adopted, although narrowed, from the WHO's definition of health, specifically with the development of the common understanding of health beyond the narrow biomedical model.⁴¹⁶ However, in examining further the manner in which the socio-economic rights are phrased in the BoR, it becomes clear that these rights are classified into rights with a standard list of internal qualifications and those without these qualifications.⁴¹⁷ While the rights envisaged in sections 29 (1) (c) and 35(2)(e) are direct access to social goods, the right envisaged in 27(1)(a) is to be achieved "subject to available resources", and that only "reasonable legislative and other measures" are to be taken towards the "progressive realisation" of these right.⁴¹⁸ The phrasing of these qualifications in the

409 See Preamble of the Constitution of the World Health Organization.

410 Pillay 2003 *Law, Democracy & Development* 58.

411 See part 1.2 above.

412 See section 27 (1) (b) and (c) of the SA Constitution.

413 See section 27(1)(b) of the SA Constitution

414 See section 24(a) of the SA Constitution.

415 See section 28(1)(c) of the SA Constitution.

416 Pillay 2003 *Law, Democracy & Development* 59.

417 The standard qualifications referred to typically provide that only "access" to the social good in question needs to be provided.

418 Section 27(2) of the SA Constitution.

BoR is similar to that of the qualifications attached to economic and social rights in the ICESCR. However, the phrasing of health rights in section 27(1) of the SA Constitution as rights to have "access to" rather than as direct rights to health, does not mirror the phrasing of health rights in the ICESCR or other international instruments, where health rights are phrased as direct rights.⁴¹⁹ In interpreting SA health rights to international rights, both require the creation of an empowering environment rather than a direct right to the provision of health services.⁴²⁰

The BoR places a duty on the government to "take reasonable legislative and other measures" to realise the right of access to health care services.⁴²¹ This phrasing is similar to those mentioned in article 2(1) of the ICESCR.⁴²² Many other measures can be appropriate or in the SA context, "reasonable", depending on the circumstances.⁴²³ In the *Grootboom case*, Yacoob J provided some valuable guidance on the broad principles that should guide what can be considered reasonable.⁴²⁴ These principles can be complemented by certain essential elements with respect to healthcare rights in relation to General Comment No. 14.⁴²⁵ Although the CESCR does not exactly use the wording "standard of reasonableness", it is argued that these essential elements asserted by the CESCR in any manner epitomise a reasonable standard that needs to be met in relation to health care services.⁴²⁶ The standard declared by the CESCR stresses the need for health services to be available, accessible, acceptable and of good quality.⁴²⁷

While the BoR binds a natural or a juristic person,⁴²⁸ the *UN Guiding Principles* provide that private businesses must refrain from interfering with the health rights and should

419 See part 2.2.1 above.

420 Heyns and Brand 1998 *Law, Democracy & Development* 158.

421 Section 27(2) of the SA Constitution.

422 Article 2(1) of ICESCR states that each State Party undertakes to take steps, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights by all appropriate means, including particularly the adoption of legislative measures.

423 Heyns and Brand 1998 *Law, Democracy & Development* 160.

424 *Government of the Republic of South Africa v Grootboom* para 46.

425 CESCR 2000 *General Comment 14* para 12.

426 Pillay 2003 *Law, Democracy & Development* 64.

427 CESCR 2000 *General Comment 14* para 12 (a)-(d).

428 Section 8 (2) of the SA Constitution.

address adverse health rights impacts with which they are involved.⁴²⁹ The notion may be supported by Principle 23 of the *UN Guiding Principles*, which requires business enterprises to adhere to legislations, to respect and promote internationally recognised human rights in all spheres of their operations, and seek solutions that uphold international human rights principles when confronted with a conflicting expectations.⁴³⁰

3.5 Chapter Summary

The purpose of this chapter was to discuss the constitutional, legislative, and policy framework on the right to healthcare and analyse the extent to which the constitutional, legislative, and policy positions in SA require and enable mining companies to contribute towards realising health rights for host communities.⁴³¹ This chapter established that although health rights are guaranteed in several provisions of the SA Constitution, section 27 (1) of the Constitution explicitly guarantees this right. This section includes, *inter alia*, the right to reproductive healthcare. It was, however, established that section 27 (1) is qualified by three conditions: (1) that the State must take reasonable legislative and other measures; (2) within its available resources; (3) to achieve the progressive realisation of this right.⁴³² It was established that the formulation of the health right in section 27(1)(a) of the SA Constitution does not unequivocally dictate the State to directly deliver healthcare services but to create an enabling environment for its citizenry that would, in turn, enable them access to this right. Nonetheless, this chapter demonstrated that the SA judiciary is willing to enforce the constitutional obligations of the government to ensure public access to essential health services.⁴³³ This chapter also highlighted that recent case law demonstrated that the judiciary is also willing to enforce socio-economic rights on NSAs.⁴³⁴ The chapter established that the SA government enacted the *National Health Insurance Act* aimed at establishing a structured and uniform health system that is aligned with the

429 United Nations Guiding Principles on Business and Human Rights (UN 2011) para 13.

430 Fuo and Kotzé 2016 *JENRL* 299.

431 See part 3.1 above.

432 See part 1.2 and part 3.2.1 above.

433 See part 3.2.1 above.

434 See part 3.3.2 above.

objectives of Universal Health Coverage.⁴³⁵ This chapter further established that mines can be obligated to contribute towards the right of access to healthcare services through SLPs, which is a compulsory requirement for the commencement or continuation of mining operations.⁴³⁶ The chapter established that private businesses are willing to comply with the guidelines of certain policies such as CSR and the King Reports on Corporate Governance, which are aimed at guiding businesses on how to conduct themselves and contribute positively to the benefits of the communities in which their businesses are operating. While the King Reports are not legally binding instruments, it is submitted that there is a need to develop its enforcement because the directors' decisions in every company affect all stakeholders. Arguably, the guidelines in the King Reports can be used to bring the mines on board to effectively contribute towards realising the right of access to healthcare services in the host communities.

435 See part 3.2.3 above.

436 See part 3.3.3 above.

CHAPTER 4

ANALYSIS OF THE SOCIAL AND LABOUR PLANS OF SELECTED MINES IN SOUTH AFRICA

4.1 Introduction

This dissertation examines the role that mining companies in SA could play in contributing towards the realisation of health rights in host communities. As illustrated in Chapter 3, although the Constitution does not impose a positive duty on mines to contribute towards realising any of the rights in the BoR, it is now established that the principle of CSR requires mining companies to invest in the socio-economic and environmental well-being of host communities. This can take the form of contributing to providing health services to communities. Besides, in terms of the MPDRA, all mining companies must adopt and implement an SLP that speaks to host communities' socio-economic realities. These SLPs are supposed to be adopted after consultation with host communities. Therefore, a host community can identify health-related needs that should be addressed in an SLP.

This chapter aims to analyse the extent to which three mines (Sibanye-Stillwater Mine, Bushveld Vatmetco Alloys Mine, and Eland Platinum Mine) use their SLPs to contribute to the development of the host communities with particular attention to health rights and health determinants. To achieve this objective, the discussion in 4.2, 4.3 and 4.4, respectively, focus on the Sibanye-Stillwater, Bushveld Vatmetco Alloys, and Eland Platinum mines. Each part begins by providing an overview of the socio-economic and environmental context within which these mines operate before exploring commitments in their SLPs. The chapter ends with a summary in 4.5, where I compare and contrast the findings from the three mines.

4.2 The SLP of Sibanye-Stillwater Mine

4.2.1 Background

Sibanye-Stillwater (SSW) was established in 2013. It is the third-largest producer of platinum and palladium, and is also a top-tier gold producer. It also produces gold and

platinum group metals (PGMs).⁴³⁷ Sibanye-Stillwater owns and operates a group of high-quality operations and projects, which are located and managed in two regions: the Southern African (SA) region and the United States (US) region. The Southern Africa operations consist of underground mining operations in Marikana,⁴³⁸ Kroondal, and Rustenburg, collectively called Eastern Platinum Limited (EPL). EPL operation is situated within Bojanala Platinum District Municipal (BPDM) and falls within Madibeng Local Municipality (MLM) and Rustenburg Local Municipality (RLM) in the North West province.⁴³⁹

This SLP was submitted on behalf of SSW Mine for the financial period of 2019-2023. The objectives of SSW's SLP are: to promote economic growth and mineral and petroleum resources development in SA; to promote employment and to advance all South Africans' social and economic welfare; to improve the socio-economic conditions of the communities within MLM area; to utilise and expand the existing skills base for the empowerment of Historically Disadvantaged South Africans (HDSAs) and to serve the community.⁴⁴⁰ The company is committed to addressing the socio-economic developmental challenges and needs of the host communities and labour-sending areas, as informed by the IDPs of Madibeng and Rustenburg local municipalities.⁴⁴¹

As at 2020, EPL operation had a total workforce of 4625 people of which 82% were of SA origin. About 38% originated from the Eastern Cape province and about 32% were sourced within the North West province.⁴⁴² The SSW mine is surrounded by informal settlements.⁴⁴³ These communities face some socio-economic challenges, such as

437 PGMs comprises 6 elements, which are platinum, palladium, rhodium, ruthenium, iridium, and osmium. They have high melting points, high heat resistance, high corrosion resistances, and unique catalytic properties.

438 Former Lonmin Plc Mine which was acquired by Sibanye-Stillwater in 2019.

439 Section 1.1 of Sibanye-Stillwater Mine's SLP 8.

440 Section 1.2 of SSW Mine's SLP 8. The listed objectives are in compliance with Regulation 41 of the MPRDA Regulations.

441 Section 1.2 of SSW Mine's SLP 9.

442 See Table 2 on Section 1.4 of SSW Mine's SLP 11.

443 These informal settlements include Maditlhokwa informal settlement, Skierlik informal settlement, Braampie informal settlement, Big house informal settlement, Stomhuis informal settlement, Group 5 informal settlement, Nkaneng informal settlement, Khamatwana informal settlement, and Mamba informal settlement

unemployment, poverty, low economic growth, HIV/AIDS prevalence, food security, inadequate physical infrastructure, and illiteracy. Mining is the backbone of the economy in these areas. The areas are surrounded by several mining operations, with the major ones being Sibanye-Stillwater, Anglo American Platinum, Samancor, Northam Mine, Tharisa, Impala, Glencore and Royal Bafokeng Platinum.⁴⁴⁴

4.2.2 Sibanye-Stillwater commitments in the SLP

4.2.2.1 Background

The Sibanye-Stillwater's SLP provides that IDP serves as a vehicle upon which developmental needs in both Madibeng Local Municipality (MLM) and Rustenburg Local Municipality (RLM) are identified, implemented and monitored. These plans are developed in consultation with stakeholders in order to provide an operational plan that seeks to highlight development priorities. The Local Economic Development projects identified in this SLP are informed by the MLMs and RLMs IDPs of 2017–2021 and 2017–2022, respectively. Thus, the projects listed in the company's SLPs are sourced from the municipalities' IDPs.⁴⁴⁵ The identified projects aim to address key challenges and focus on each municipality's key priorities. The SLP states that where a particular project is not listed in the IDP, the respective municipalities have received and approved an amendment application for its inclusion. Further to the acquisition of Lonmin operations by Sibanye Stillwater in June 2019, more consultations were made with stakeholders, including municipalities, local councillors, traditional leadership and NGOs, to reconfirm the identified projects.⁴⁴⁶

The IDP of MLM 2017-2021 is said to be a product of wards participation held during October and November 2016. It is submitted that the needs of the communities and projects were identified and prioritised on six levels: water and sanitation, roads and storm-water, electricity, social services, land and housing, and local economic development.⁴⁴⁷ Likewise, the RLM 2017 - 2022 and 2019-2023 IDPs were formulated

444 Section 4.2.2 of SSW Mine's SLP 34.

445 Section 4.3 of SSW Mine's SLP 46.

446 Section 4.3 of SSW Mine's SLP 46.

447 Section 4.3.1 of SSW Mine's SLP 46.

as a result of the host communities' needs and priorities. RLM Local Economic Development (LED) Strategy sets out seven key areas of performance in ensuring that they achieve their intended developmental goals, especially in the following areas: quality basic services and infrastructure; economic growth and job creation; ensuring municipal financial viability and management; maintain a clean, green, safe and healthy environment for all; transform and maintain a sustainable rural development; uphold good governance and public participation principles; and drive optimal municipal institutional development, transformation and capacity building.⁴⁴⁸

Community's projects that are addressed in this SLP targeting the development priorities of RLM and MLM as identified in their IDPs. LED projects in this SLP cuts across the following three focus areas:⁴⁴⁹

i. Education and Skills Development. This aims to alleviate poverty and unemployment within the host communities.

ii) Community Health and Safety. This seeks to ensure that the health and safety of host communities are taken care of. This includes the installation of high mast lights, and the construction of clinics, roads and sewer systems. If the clinics are constructed, they could be used to provide health services to contribute towards the health rights in the Constitution.

iii) Agriculture. This is a response to the UN's call to elevate the role of smallholder farmers as stewards who manage and protect natural resources and drive sustainable development.⁴⁵⁰

4.2.2.2 Sibanye-Stillwater LED Projects

Sibanye Still-Water identified, in consultation with different stakeholders, the following projects as being appropriate for the development of the host communities.

448 Section 4.3.2 of SSW Mine's SLP 46-47.

449 Section 4.4 of SSW Mine's SLP 47.

450 Section 4.4 of SSW Mine's SLP 47.

Investment into these projects correlates with the current production levels and associated profit levels of the mine.⁴⁵¹

Table 1 – Summary of SSW LED projects in MLM

Project name	Project type & focus area	Municipality	Beneficiaries	Proposed budget FY2019 - FY2023
Sonop Secondary School	Infrastructure - Education	MLM	School Sonop Community	R18 000 000,00
Installation of high mast lights in wards 7, 25,27,28,31 and 40	Infrastructure - Community Safety	MLM	MLM communities of wards 7,25,27,28,31 and 40	R6 000 000,00
Upgrading of Bapong and Wonderkop Clinics and Sewage System	Health institutional support	MLM	Bapong and Wonderkop	R 3 800 000.00
Total LED budget				R 27 800 000.00

The data above shows that a significant contribution is made towards education at 65%, which is four times higher than contribution made towards health facilities at 13%. Nonetheless, this is indicative of the commitment of the mine to complying with the requirement of the SLP as guided by the municipality’s IDP and the Constitution.

In terms of the housing and living conditions,⁴⁵² Sibanye-Stillwater in partnership with key stakeholders, was in the process of implementing the company’s Facilitated Employee Home Ownership Programme (FEHOP) to support its employees to improve living conditions and meet their own accommodation aspirations.⁴⁵³ In terms of FEHOP, the mine will provide the following support to employees: housing benefit in the form

451 Section 4.4.1 of SSW Mine’s SLP 48.

452 Regulation 46 c (iv) of the MPRDA.

453 Section 5.1.1 of SSW Mine’s SLP 55.

of, *inter alia*, a discount and subsidised rental at the company-owned rental units and access to competitively priced home loans.⁴⁵⁴

4.2.3 Implementation

Sibanye-Stillwater Community Engagement and Development (CED) department is suitably resourced and armed with the necessary skills and tools to successfully manage the implementation of the identified projects in host communities.⁴⁵⁵ The company provides that as a responsible corporate citizen, its development and implementation strategy is rooted in consultation with stakeholders, the most important is the host communities.⁴⁵⁶ The mine's development and implementation of LED projects is characterised by stakeholders' participative decision-making. Engagements with communities are conducted in a timely, accurate and relevant manner. There is continuous monitoring, reviewing and improvement of engagement activities. This includes progress reporting to DMRE.⁴⁵⁷

4.3 The SLP of Bushveld Vametco Alloys Mine

4.3.1 Background

Bushveld Vametco Alloys (BVA) is owned by Bushveld Vametco Holdings (Pty) Ltd. It is located in the Madibeng Local Municipality (MLM), Bojanala Platinum District Municipality (BPDM), in the North West province. The mine lies about 6.5 km to the northeast of Brits, 1 km from Mothutlung, 5 km North West of Garankuwa and 4 km South of Lerulaneng (Rabokala). BVA mines vanadium-bearing magnetite ore and commenced its operation in 1967.⁴⁵⁸ The mine applied for conversion of an old order mining right to a new order mining right in MLM in 2004. The new order mining right was executed in April 2013 and the approval of the SLP.⁴⁵⁹

454 Section 5.3.4 of SSW Mine's SLP 64.

455 Section 4.4.1 of SSW Mine's SLP 47.

456 Section 4.4.1 of SSW Mine's SLP 47.

457 Section 4.4.1 of SSW Mine's SLP 48.

458 Section 1.1 of BVA Mines' SLP 8.

459 Section 1.1 of BVA Mines' SLP 9.

The mine has a total number of 520 employees, excluding core contractors.⁴⁶⁰ About 164 (31%) employees come from Mothotlung, followed by Brits with 102 (19%), Mmakau with 56 (10%) and Rankotea with 38 (7%).

This SLP for Bushveld Vametco Alloys (BVA) for the period 2018-2022 is submitted in terms of the requirements of the MPRDA Regulations,⁴⁶¹ with the aim of, amongst other things, promoting employment and advancing the social and economic welfare of all South Africans; ensure that the mine improve the socio-economic conditions of the host communities and labour sending area; and use and expand the existing skills base for empowerment of the host communities.⁴⁶²

Section 2.2 of the SLP addresses skills development plans, which provide skills development for employees to achieve the mine's business strategies and objectives.⁴⁶³ The objectives for skills development are amongst others, improving the employees' quality of life and providing core and critical skills opportunities to enhance employees' capabilities and competencies in line with their responsibilities.⁴⁶⁴ The mine is committed to continue providing Adult Education Training (AET) to increase the company's and its local community's literacy and numeracy levels.⁴⁶⁵ As of 2019, there were only two employees who did not have formal schooling and about 143 had matric and higher certificates.⁴⁶⁶ About 27 employees have been identified to attend AET over the 5-years of this SLP.⁴⁶⁷ The company is committed to offering AET training to interested community members, which will increase their literacy level for potential employment. Should an employee reject the AET training, such an opportunity will be offered to the community member.⁴⁶⁸ The company is committed to offering bursaries

460 Section 1.5 of BVA Mines' SLP 13.

461 Regulation 10(1) (g) and Regulation 42(1) (a) of MPRDA.

462 Section 1.1 of BVA Mines' SLP 8. The listed objectives are in compliance with Regulation 41 of the MPRDA Regulations.

463 Section 2.2 of BVA Mines' SLP 15.

464 Section 2.2 of BVA Mines' SLP 15.

465 Section 2.2 of BVA Mines' SLP 16.

466 See Table 7 of BVA Mine's SLP 17.

467 See Table 9 of BVA Mine's SLP 18.

468 Section 2.4 Table 10 of BVA Mine's SLP 19.

to qualifying learners from the host communities, as well as employees and their dependents, to further their studies at higher institutions.⁴⁶⁹

4.3.2 Bushveld Vametco Alloys commitments in the SLP

4.3.2.1 Background

The mine's LED projects are aimed at job creation, alleviating poverty, and socio-economic development of the host communities and labour-sending areas. The identified projects are a result of consultation with the district and local municipalities and, as such, are informed by the IDP of relevant municipalities.⁴⁷⁰ The main priorities for MLM IDP, are water and sanitation, roads & storm water, electricity, social services, land and housing, and local economic development.⁴⁷¹ Thus, the mine is committed to contributing to LED through the established IDP frameworks within its available financial resources.⁴⁷²

4.3.2.2 Bushveld Vametco Alloys LED projects

BVA sourced its LED projects from MLM, except for the construction of a sports ground in Rankotea. The need for the ground was established by the mine during its meeting with Rankotea community representatives. The mine stated in its SLP that it will inform the Municipality of the project even though it is not in the municipality's IDP.⁴⁷³

According to the mine's Healthcare and Nutrition Plan, it will put the following measures in compliance with the MPRDA:⁴⁷⁴ meal options recommended by dietician, an HIV-Aids awareness campaign, the Voluntary Counselling and Testing (VCT) programme, and EAP programme through which the mine enables financial provisions for potential future medical costs and employee support programmes, assistance HIV-positive employees, and Aids patients to develop and adhere to supportive diets

469 Section 2.11 Table 26 of BVA Mine's SLP 33-34.

470 Section 3.1 of BVA Mine's SLP 41.

471 Section 3.6 of BVA Mine's SLP 51.

472 Section 3.7 of BVA Mine's SLP 53.

473 See tables 49-54 of BVA Mine's SLP 56-62

474 Regulation 46 (c)(v) in GN R 349 in GG 34225 of 18 April 2011.

through an HIV/Aids programme, and assessment of the quality, cost and appropriateness of medical services available to the employees.⁴⁷⁵

In terms of the housing and living conditions, the mine emphasised that it is committed to developing a housing and living conditions plan that seeks to comply with the laws. At the time when the SLP 2019-2023 was drafted, employees were only receiving home-ownership subsidies and housing allowance.⁴⁷⁶

Table 2 below provides a summary of the LED projects as informed by the Madibeng Local Municipality IDP.

Table 2 –Summary of BVA LED projects in MLM (2019-2023)

Project name	Focus area	Municipality	Proposed budget FY2019 - FY2023
Installation of high mast lights	Rankotea, Switch-Thetele & Mothotlung	MLM	R 4 700 000,00
Roads & stormwater	Ward 21, Rankotea & Switch-Thetele	MLM	R 3 000 000,00
Sports & facility	Mothotlung ward 20	MLM	R 3 000 000.00
Provision of clean water	Rankotea	MLM	R 2 000 000.00
Sports ground	Rankotea	MLM	R 500 000.00
Heritage site	Mmakau	MLM	R 400 000.00
Widening of walkway	Brits	MLM	R 400 000.00
Total LED budget			R 11 300 000.00

The mine committed to spending approximately R85 million for the implementation of its SLP 2019-2023, of which only about R8,5 million, according to Table 2 above, is allocated to projects that are only connected to the determinants of health.⁴⁷⁷

475 Section 3.10 of BVA Mine's SLP 64.

476 Section 3.9 of BVA Mine's SLP 63.

477 Section 5 of BVA Mine's SLP 73.

As evident from the discussion above and in Table 2 above, there is no express commitment to providing health facilities such as clinics to communities in general. The SLP shows a commitment to providing certain health services to employees.

4.3.3 Implementation

According to the SLP, the implementation of the identified projects will be monitored to record progress, and recording shall depict information such as the number of jobs created, the number of beneficiaries and the financial expenditure on the projects and reported in the mine's annual SLP report.⁴⁷⁸ Regular meetings will be held with community' representatives such as ward councillors.⁴⁷⁹ The proceedings of the meeting and the report on the progress of the projects will be communicated to the Regional DMRE for evaluation of progress. The mine shall have a record of Stakeholder Engagement report about LED projects and the socio-economic impact of the mine.⁴⁸⁰

4.4 The SLP of Eland Platinum Mine

4.4.1 Background

In 2018, Eland Platinum Proprietary Limited and Northam acquired the Eland Platinum Mine (EPM) from Eland Platinum Mines (Proprietary) Limited and Glencore Operations South Africa Proprietary Limited. Eland Platinum Proprietary Limited (EP) is a wholly-owned subsidiary of Northam Platinum Limited (Northam). Northam is an independent, fully empowered, mid-tier and integrated PGM producer. Having commenced initial operations in 2007, substantial capital investment was invested in 2019 to re-establish the Eland Platinum Mine as a PGM production unit with a 30-year life.⁴⁸¹ The company's primary products are the three main PGMs: platinum, palladium and rhodium. Eland Platinum Mine is located 14 kilometres east of Brits town situated in MLM within BPDM in the North-West province, and has an estimated lifetime of a minimum of 30 years.⁴⁸²

478 Section 3.7 of BVA Mine's SLP 53.

479 See Table 47 of BVA Mine's SLP 54.

480 Section 3.7 of BVA Mine's SLP 53.

481 Section 1 of EPM Mine's SLP 9.

482 Section 2 of EPM Mine's SLP 12.

This SLP was submitted by EPM and is valid for the 2019-2023 financial year. The SLP was developed through consultations with key stakeholders.⁴⁸³ At the time of drawing this SLP, the mine was at its build-up stage and had a limited workforce. However, it is expected that the labour force will be sourced primarily from MLM areas.⁴⁸⁴ At the time of formulating this SLP, the mine had a total workforce of 997, of which 870 were sourced from the North West province, and 644 were sourced from the MLM areas.⁴⁸⁵

The SLP states that the objectives of this SLP are to: promote economic growth and mineral and petroleum resources development in the SA, to promote employment and advance the social and economic welfare of the society, to contribute towards the socio-economic development of the MLM area, and to use and grow the existing skills base for the empowerment of Historically Disadvantaged South Africans (HDSAs) and to serve the host community.⁴⁸⁶

4.4.2 Eland Platinum Mine's commitments in SLP

4.4.2.1 Background

In order to have an informed view of the primary needs of the communities and focus areas of MLM, the company assessed the latest IDP of MLM. The IDP identified key focus areas with which the MLM aims to improve the living conditions of the host communities. The MLM's needs and subsequent priority areas were determined as follows:⁴⁸⁷ water and sanitation,⁴⁸⁸ roads and storm water, electricity, and housing.⁴⁸⁹

4.4.2.2 Eland Platinum Mine LED projects

The mine identified Ward 21 near Mothutlung and Damonsville as the area most affected by its operations. As a result, contributions towards socio-economic development will focus on these communities. The company identified water projects

483 In terms of MPRDA, stakeholders includes host communities.

484 Host communities include Damonsville Mmakau Mothotlung, Oukasie, and Elandsrand.

485 See section 2 Table 2 of EPM Mine's SLP 13.

486 Section 1 of EPM Mine's SLP 10. The listed objectives are in compliance with Regulation 41 of the MPRDA Regulations.

487 Section 4.4 of EPM Mine's SLP 81.

488 See part 4.4.1.1 above.

489 Section 4.4 of EPM Mine's SLP 82.

as their main focus in MLM. The company noted that EPM is not the only mine in the area,⁴⁹⁰ and in addressing community needs, EP engaged the surrounding mines to ascertain their project commitments. This was done to limit uselessness and promote efficiency in identifying projects. The mine provides that it has conducted rigorous consultations with the surrounding communities, the municipality and government stakeholders to ensure that it adds maximum value to the host communities. Based on the aforementioned priorities, the following initiatives were identified.⁴⁹¹

Table 3 –Summary of EPM LED projects in MLM (2019-2023)

Project	Municipality	Budget
Water supply for local communities	MLM	R 6 359 028.00
Agri-school and LED Project	MLM	R 4 240 580.00
Brits Small Town Regeneration Project	MLM	R 1 800 196.00
Renovation of Mmakau clinic	MLM	R 3 200 196.00
Renovation of Oukasié Sports Complex	MLM	R 1 239 459.00
Renovation of Elandsrand Community Hall	MLM	R 1 120 235.00
Renovation of infrastructure in adjacent communities	MLM	R 2 941 306.00
Hub of opportunity: skills development centre	MLM	R 759 000.00
TOTAL		R 21 660 000.00

The above figures show that as the area experienced water shortage, the company allocated around R6,3 million towards water supply and R3,2 million was allocated to health infrastructure. The commitment to renovate the Mmakau clinic is significant in contributing towards realising health rights. The Mmakau clinic building is dilapidated and the structure needs to be restored. The clinic caters for all the communities in Mmakau. The clinic operates with four professional nurses, three assistant nurses and

490 See part 4.2.3 above.

491 Section 4.5 of EPM Mine's SLP 83.

one outreach nurse, and attends to almost 200 patients daily. Currently, the clinic operates for eight hours, but it used to operate for 24 hours when the clinic and the nurses home were still in good condition and had a maternal ward.⁴⁹² If several mines can commit to making this kind of contribution towards healthcare facilities, such contributions could have a significant positive impact towards realising the right of access to healthcare services.

In terms of the housing and living conditions, the company is committed to applying a three-fold strategy to address housing for its employees. 1) home-ownership – this will entail home ownership options such as soft loans, and homeowner bond cover; facilitation of RDP and social housing jointly with the government; 2) security of usage – for critical skills employees, EPM could facilitate the security of tenure, including rental options; and 3) accommodation allowance.⁴⁹³ Currently, EPM employees qualify for Living Out Allowance as follows: Category 2-8 receives R3 515 and Category 9-10 receives R5 323.⁴⁹⁴ EPM does not have employee accommodation or hostels on the mine premises. A plan to improve nutrition for employees is not applicable in this regard.⁴⁹⁵

4.4.3 Implementation

In terms of implementation, the mine established an External Stakeholder Engagement Forum (ESEF) which consists of Madibeng Local Municipality, ward councillors, small, medium and micro-enterprise (SMME) representatives of the host communities, the land claimants and the Tribal council, to provide continuous information on the progress of the mine and implementation of the SLP.⁴⁹⁶ The mine is committed to regularly consulting with its Future Forum and updating key stakeholders, including the host communities, in attendance on the progress of the targets and commitments made in this SLP.⁴⁹⁷ An annual report shall be submitted to the DMRE, and following ramp-up and achievement of greater clarity of the envisioned growth, amendments

492 Section 4.6 of EPM Mine's SLP 92.

493 See Table 48 of EPM Mine's SLP 106.

494 Section 5.2 of EPM Mine's SLP 106.

495 Section 5.3 of EPM Mine's SLP 107.

496 Section 6.1 of EPM Mine's SLP 110.

497 Section 1 of EPM Mine's SLP 10.

may be submitted to the DMRE pertaining to various components of the submitted SLP during the financial years 2019-2023.⁴⁹⁸

4.5 Chapter Summary

The purpose of this chapter was to examine the extent to which three mines, Sibanye-Stillwater, Bushveld Vatmetco Alloys, and Eland Platinum, use their SLPs to contribute to the development of the host communities with particular attention to contributions made towards realising the right to health.

This chapter established that Sibanye-Stillwater expressly provides for health services infrastructure such as clinics in their SLP. Although the actual budgetary allocation may be small, this is a significant finding because it shows that mines are actively contributing towards realising the rights to health in SA.

In addition, some mines, such as Bushveld Vametco Alloys, expressly provide health services to their employees such as health care and nutrition plans. This is also a further contribution to realising the right of access to health services in the Constitution.

Mines such as Eland Platinum provide crucial infrastructure for providing water services, treatment of sewage, and housing benefits for their employees. Projects that fall within these categories are important as they speak to key health determinants.

Of the three SLPs examined, it appears that Sibanye-Stillwater's is the most comprehensive in relation to the topic under investigation. This is because upgrading health facilities such as clinics is explanatory of the role that SA mines can play in contributing towards realising the right of access to healthcare services in host communities.

498 Section 1 of EPM Mine's SLP 10. The listed objectives are in compliance with Regulation 41 of the MPRDA Regulations.

CHAPTER 5

CONCLUSION AND RECOMMENDATIONS

5.1 Background of the study

The right to healthcare services is one of the most important fundamental human rights. International and African regional human rights instruments impose a duty on States to realise the right of access to healthcare services. In SA, this right is guaranteed in Section 27 of the Constitution, which imposes positive and negative duties on the government. Due to different reasons, the private sector is expected to contribute towards realising the right to health care services. Given the importance of the mining sector to SA's economy and its proximity to communities, this study explored whether mines could be legally obliged to contribute towards realising the right to health services for host communities in SA.

5.2 Aim and Objectives

This study aimed to examine the extent to which SA mines can contribute towards realising the right to have access to healthcare services guaranteed in section 27 of the Constitution. To this end, this study examined International, African regional and SA human rights instruments to see whether the mines can be obligated through legislative measures to contribute towards realising the right of access to healthcare services within the host communities.

5.3 Findings

In order to achieve the objectives of this study, the dissertation was divided into five chapters. Chapter 1 provided the background and justification for the whole study. It also justifies the research methodology.

Chapter 2 discussed international and African regional human rights law with the aim of showing that the right to health is guaranteed in a number of international and African regional instruments such as the UDHR, ICESCR and the ACHPR. The chapter showed that while international human rights instruments impose both negative and positive obligations on States, NSAs are only obligated to not violate the enjoyments

of the right to health. It was established that in terms of the ICESCR and the ACHPR, states such as SA are obliged to respect, protect and fulfil the health rights for the enjoyment of their people. It was further revealed that international and African regional human rights instruments do not impose binding legal duties on private businesses such as mines to contribute towards the realisation of the right to health care services. As a result, the primary responsibility to protect, and fulfil the right of access to healthcare services lies solely with the States. It was established that in terms of the UN Guiding Principles, the States are required to comply with all applicable laws and to respect human rights.

Chapter 3 analysed the constitutional, legislative, and policy framework on the right to healthcare in order to establish the extent to which these instruments require and enable mining companies to contribute towards realising health rights for host communities. The chapter established that in SA, the notion of CSR is rooted in the Constitution, which imposes responsibilities upon juristic persons to contribute towards the realisation of most fundamental rights, such as health rights. In addition, recent court decisions have illustrated that private businesses such as mines have a positive duty to respect and protect health rights.

Chapter 4 established that Sibanye-Stillwater expressly provides for health services infrastructure such as clinics in their SLP. Although the actual budgetary allocation may be small, this is a significant finding because it shows that mines are actively contributing towards realising the rights to health in SA.

In addition, some mines, such as Bushveld Vametco Alloys, expressly provide health services to their employees, such as healthcare and nutrition plans. This is also a further contribution to realising the right of access to health services in the Constitution.

Mines such as Eland Platinum provide crucial infrastructure for providing water services, treatment of sewage, and housing benefits for their employees. Projects that fall within these categories are important as they speak to key health determinants.

Of the three SLPs examined, it appears as if Sibanye-Stillwater's is the most comprehensive in relation to the topic under investigation. This is because upgrading health facilities such as clinics is explanatory of the role that SA mines can play in contributing towards realising the right of access to healthcare services in host communities.

5.4 Recommendations

From the discussion above, it is recommended that

1. District municipalities should prioritise the provision of municipal health care services in their IDPs. This will ensure uptake by mining companies since their SLPs are supposed to be aligned with IDPs;
2. Some mines should be aware that where a community faces significant health challenges, this should be prioritised in their SLPs and provision should be made for the community and not just mine workers;
3. Mines should give better attention to the living conditions of employees and their families since this has an impact on their health, which can impact productivity;
4. The legal status of SLPs should be clarified. It is not clear if the commitments can be enforced in a court of law;
5. The DMRE should monitor more effectively to ensure that mines implement their SLPs.

5.5 Conclusion

Currently, the horizontal application of human rights is not clearly defined. The SA Constitution only places a duty on the government to realise the right of access to healthcare services. There are no legally binding instruments that impose a positive duty on the mines to contribute towards the realisation of healthcare services. However, there are legislation and policies regulating mines that include initiatives that seek to improve the social and economic conditions of the host communities. The MPRDA, CSR and the King Report on corporate governance play a significant role in

requiring the mines to comply with the requirements for community development. These instruments require the mines to report their performance on their social, economic and environmental responsibilities and contributions on a yearly basis. In addition, if the mine does not comply with the provision of the MPRDA, the Minister of Mineral Resources and Energy, has the authority to cancel or suspend the mining licence. This further assists with compliance with the SLPs.

In terms of CSR, SA policies do not clearly and specifically dictate how CSR goals should be achieved. Thus, the mines are left with huge discretionary power to comply with the policy according to their interpretation. In essence, the mines voluntarily choose to comply with the policy. Nonetheless, it is submitted that implementation of those policies seems to be a very challenging task. It is suggested that this might be emanating from the lack of monitoring and evaluation in the implementation of these policies, particularly the implementation of the mines' SLPs. It is further submitted that the lack of coordination and cooperation between mining companies, host communities and government departments in the formulation and implementation of SLPs also poses a very serious challenge.

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