## HEALTH IN THE COMMUNITY

### Our policies

The successful operation of our mines hinges on the health and well-being of our workforce. Since many of our countries of operation are plagued by a combination of high levels of disease and low levels of public spending on healthcare, a key priority of our sustainability efforts is the investment in reliable healthcare for our workforce, their families and the local community.

Our policy is to provide free basic medical care to our workforce, their immediate families and to community members within a 15km radius of each mine.

To achieve this we build health clinics both on site and in villages near each mine, funding their start-up with the aim of passing control and responsibility for community clinics to local doctors and the regional health authorities, once they are established.

Alongside the provision of a basic healthcare service, our health programmes also treat the most pressing community health issues and thus prioritise malaria, HIV/AIDS and waterborne diarrheal diseases. In 2016 we also began a voluntary Hepatitis B screening and treatment programme for workers at our Mali operations (see 'Introducing Hepatitis B screening').

### Our performance

In 2016 our clinics conducted nearly 80 000 medical consultations for employees, their dependents and community members.

Ultimately we want local communities to be able to deliver excellent healthcare independent of our mines, and thus were encouraged that in 2016 the proportion of community members and dependents attending our mine clinics dropped (by 1% and 2% respectively) for a second consecutive year. This is encouraging evidence that better healthcare is now available in the communities, and the town of Durba a good example of this (see case study on the following page).

In 2016 we also started a new initiative to screen local women for cervical cancer at our Loulo mine. Cervical cancer accounts for about 300 000 deaths a year world-wide of which more than 80%[1] occur in the developing world, although with early diagnosis the disease can be treated. We arranged for an experienced midwife from Bamako to join the DK clinic near our Loulo mine, to run the clinic and train local midwives on the detection of cervical cancer. A total of 68 local women were screened and one case of carcinoma was detected. More screenings are scheduled for 2017.

[1] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2802672/*

LET US SPRAY: HOW WE TAKE ON MALARIA

Malaria can be a life threatening disease and sub-Saharan Africa suffers the heaviest global burden from the disease, with the World Health Organisation estimating that 90% of global malaria cases and 92% of malarial deaths in 2015 occurred in that region[1]. It is a major inhibitor of economic growth too. For example, research suggests a 10% reduction in malarial prevalence is associated with 0.3% higher economic growth[2].

For Randgold the cost of malaria is measured in working days lost. In 2016, 5 179 days were lost due to malarial illnesses, representing more than 28% of all absenteeism and thus productivity drives our efforts to reduce malaria incidence around our mines.

In 2016 our anti-malaria efforts included the distribution of more than 13 000 impregnated mosquito nets, working with an entomology consultant to understand which chemicals will be most effective to spray at each site, training and auditing to ensure correct spraying of chemicals and expanding the areas sprayed. In total we spent $590 000 on the fight against malaria in 2016, and are pleased to report a 28% drop in our year on year malarial incidence rate. The rate dropped from 38.9% in 2015 to 28.0% in 2016. See Figure 15 on page 146.

Over the longer term we are encouraged that malaria incidence at all sites is significantly below the original baseline. For example when we opened our Morila mine the malarial incidence rate was a staggering 192%[3], and the rate is now down to just 13%. At Kibali – our youngest mine - the malaria incidence rate has dropped from 113% in 2011, to 26% in 2016. See Figure 15 on page 146.

[1] *http://www.who.int/mediacentre/factsheets/fs094/en/*
[2] *https://www.ncbi.nlm.nih.gov/books/NBK2624/*
[3] *Per capita incidence can be over 100% as an employee might suffer it more than once.*

FIGURE 14: TOTAL MEDICAL CONSULTATIONS

| | **2016** | 2015 | 2014 |
|---|---|---|---|
| Total number of medical consultations | **78 496** | 80 758 | 100 644 |
| Employees | **72%** | 69% | 70% |
| Employee dependents | **16%** | 18% | 18% |
| Local community | **12%** | 13% | 12% |

CASE STUDY

# CO-OP CLINIC DELIVERS AFFORDABLE COMMUNITY HEALTHCARE

Center Hospitalier De Kibali is a health clinic in Durba, DRC, that was initially established by Randgold and in August 2014 was transferred to community control.

Led by Dr Joseph Atanzi, it is now run by a team of four doctors and 25 nurses as a co-operative clinic that offers good quality, affordable healthcare to the community, a combination that has made it very popular in the community. Dr Atanzi estimates that he and his team provide a minimum of 500 consultations every week with the top health issues being malaria, typhoid and respiratory infections.

The cost of a consultation is just $3, a price that is affordable for most of the local community. However, in emergency situations or if patients are unable to pay immediately, the clinic will defer payment for a few weeks or until the patient is well enough to work again and be able to pay for their treatment.

If a Kibali employee or their dependent goes to the co-operative clinic, Kibali arranges direct payment of consultation fees there to relieve pressure on the mine's clinic. Management of the co-operative clinic recently reinvested much of its income back into the clinic, and in 2017 is due to open a proud new 100-bed hospital on the same site, at a cost of $209 000. The hospital includes maternity care facilities and intensive care facilities, including monitoring equipment and respirators.

Dr Atanzi explains, *"We get some support from the government for public health issues such as leprosy and tuberculosis, but no assistance for the maintenance or development of facilities. Kibali has helped transform healthcare for us. I used to work at a government clinic in Durba and there is no comparison between the facilities there and at our co-operative clinic. Kibali has been a good partner. It provided us with some new facilities and the opportunity to improve healthcare for our community. Now we are working to make sure it is sustainable, because we know the mine won't always be here and we are preparing already."*

FIGURE 15: MALARIA INCIDENCE

| % | Baseline | **2016** | 2015 | 2014 |
|---|---|---|---|---|
| Morila | 192.0 (2000) | **12.6** | 22.5 | 26.3 |
| Loulo | 51.1 (2005) | **27.8** | 44.2 | 33.6 |
| Gounkoto | 74.0 (2011) | **39.7** | 48.4 | 51.3 |
| Kibali | 113.1 (2011) | **26.4** | 35.7 | 65.7 |
| Tongon | 132.7 (2010) | **32.5** | 42.2 | 50.7 |
| GROUP | | **28.0** | 38.9 | 49.9 |

# MASS ADMINISTRATION OF ANTI-MALARIALS

Malaria incidence rates dropped across the group in 2016 and we saw the most significant reductions at our Mali operations.

We attribute this largely to the trial of a mass drug administration programme across our Malian operations which for the first time offered free anti-malarial drugs for the workers at our Loulo, Gounkoto and Morila mines during the high malarial transmission season as a preventive measure.

The programme was well received. Between 30 - 50% of workers chose to take the anti-malarial medication (depending on site) and the effectiveness of this programme is evidenced by a:

- 44% drop in malarial incidence at Morila;
- 37% drop at Loulo; and an
- 18% drop at Gounkoto (where the workers were less adherent).

The reduced rates of malaria are not only good for the individuals; it is directly good for business as it reduces absenteeism and improves productivity. Total absenteeism caused by malaria in 2016 decreased by 57%, 31% and 18% at Morila, Loulo, and Gounkoto respectively compared to 2015.

Based on the success of this programme, we plan to improve adherence in the Malian operations and to extend it to our operation in Côte d'Ivoire in 2017.

## Reducing HIV prevalence in our communities

HIV transmission rates are dropping in the rest of the world, but the virus remains prevalent across sub-Saharan Africa, with the region now accounting for more than two thirds of the world's HIV infections.

Our HIV programme seeks to slow and ultimately halt the spread of the disease through awareness raising and education. We encourage safe sex by distributing free contraception and promote Voluntary Counselling and Testing (VCTS). VCTs are a particularly important way to halt the spread of the virus, as it is estimated that more than half of people infected in sub-Saharan Africa are not aware of their HIV status. This is why increasing the number of VCTs we conduct every year is a KPI we monitor and report on.

Following the success of our partnership with HIV/AIDS specialist NGO Soutoura at Loulo in 2015, we worked to establish similar partnerships at Tongon and Kibali in 2016. At Tongon in Côte d'Ivoire this has already helped more than double the number of VCTs conducted. We also seek to train peer educators for community counselling.

In total our HIV/AIDS programme in 2016:

- Distributed more than half a million condoms, nearly 20% more than 2015.
- Provided 7 068 free VCTs (to both our workforce and local communities), a 37% increase on 2015.
- Reduced HIV prevalence by more than 30% across the group.

FIGURE 16: HIV PREVALENCE RATES

| % | Baseline | **2016** | 2015 | 2014 |
|---|---|---|---|---|
| Morila | 0.6 (2000) | **0.1** | 0.2 | 0.6 |
| Loulo | 0.7 - 1.3 (2005) | **1.6** | 1.8 | 1.1 |
| Gounkoto | 0.7 (2011) | **0.9** | 0.5 | 0.3 |
| Kibali | 17.7 - 37.6 (2010) | **3.4** | 7.3 | 11.3 |
| Tongon | 3.2 (2011) | **1.7** | 0.0[1] | 0.8 |
| GROUP | | **1.6** | 2.3 | 3.4 |

[1] *Zero incidence rate at Tongon in 2015 is attributable to a low number of VCTs conducted at Tongon during the year.*