“WE DON’T FEEL WELL TREATED”

TUBERCULOSIS AND THE INDIGENOUS SAN PEOPLES OF NAMIBIA

AMNESTY INTERNATIONAL

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GLOSSARY

WORD	DESCRIPTION
INDIGENOUS PEOPLES	According to the UN the most fruitful approach is to identify, rather than define Indigenous peoples. This is based on the fundamental criterion of self-identification as underlined in a number of human rights documents.[1]
MULTI-DRUG RESISTANT TUBERCULOSIS	Multidrug-resistant TB is caused by TB bacteria that is resistant to at least Isoniazid and Rifampicin, the two most potent TB drugs. These drugs are used to treat all persons with TB disease.[2]
SAN PEOPLES	The term 'San', as used in this report, refers to former hunter-gatherer groups in southern Africa.[3] They include the Khwe, the Haillom, the Ju/'Hoansi, the !Kung, the !Xun, the KaollAesi, the Naro, and the !Xóõ, to name a few.
SOCIAL DETERNIMANTS OF HEALTH	The social determinants of health are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. They include income and social protection, education, unemployment and job insecurity, working life conditions, food insecurity, housing, basic amenities and the environment, early childhood development, social inclusion and non-discrimination, structural conflict and access to affordable health services of decent quality.[4]
STUCTURAL DETERMINANTS OF HEALTH	Structural determinants of health are social, economic, and political mechanisms which generate social class inequalities i.e. conditions that generate or reinforce social stratification in society. Social stratification in turn gives rise to an unequal distribution of the social determinants of health.[5]
TUBERCULOSIS	Tuberculosis is an airborne disease caused by Mycobacterium tuberculosis that usually affects the lungs leading to severe coughing, fever, and chest pains.[6]

[1] United Nations Permanent Forum on Indigenous Issues Factsheet, https://www.un.org/esa/socdev/unpfii/documents/5session_factsheet1.pdf
[2] Centers for Disease Control and Prevention, Multidrug-Resistant Tuberculosis (MDR TB), https://www.cdc.gov/tb/publications/factsheets/drtb/mdrtb.htm
[3] Dieckmann, Ute, Maarit Thiem, Erik Dirkx, and Jennifer Hays. *Scraping the Pot: San in Namibia Two Decades After Independence.* , 2014. Print, https://www.worldcat.org/title/scraping-the-pot-san-in-namibia-two-decades-after-independence/oclc/910552692
[4] World Health Organization, The social determinants of health, https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1
[5] Hargreaves JR, Boccia D, Evans CA, Adato M, Petticrew M, Porter JD. The social determinants of tuberculosis: from evidence to action. *Am J Public Health.* 2011;101(4):654-662. doi:10.2105/AJPH.2010.199505, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3052350/
[6] Nicole Fogel, Tuberculosis: A disease without boundaries, Tuberculosis, Volume 95, Issue 5, 2015, Pages 527-531, ISSN 1472-9792, https://doi.org/10.1016/j.tube.2015.05.017.(https://www.sciencedirect.com/science/article/pii/S1472979214206950)

1. EXECUTIVE SUMMARY

"I am Mercina*[7] I am a single mother of five kids and unemployed because I can't work due to my illness. The doctors said that I have very dangerous TB. I fear for my kids and siblings to get infected as we are staying at a very small place and sleep in one house."[8]

Tuberculosis (TB) is an infectious disease that usually affects the lungs, though it can affect any organ in the body. It can develop when bacteria spread through droplets in the air. TB can be fatal, but in many cases, TB is preventable and treatable.[9]

The World Health Organization (WHO) reports that TB is the ninth leading cause of death worldwide and the leading cause of death from a single infectious agent, which ranks it higher than HIV/AIDS.[10] The emergence of Multidrug-resistant TB (MDR-TB) has been referred to by WHO as "a public health crisis and a health security threat" as an increasing number of TB cases are being identified as resistant to Isoniazid and Rifampicin, which are currently the two most effective first-line drugs against the disease.[11] In addition to the health implications of TB – which usually involve severe coughing, fever, and chest pains – further financial and psychological costs are associated with it, these can occur due to discrimination faced by those infected with TB, as well as members of their households. It is common that family, friends and employers may reject TB patients, they may have less than needed social support during treatment, or they may lose their jobs.[12]

There are significant overlaps between poverty, lack of access to human rights and TB, which as the WHO notes, "thrives on the most vulnerable."[13] There is growing consensus that indicates that the prevalence of TB is directly related to the so-called 'social determinants' of the disease. These are non-medical socio-economic factors that increase the likelihood of an uninfected person becoming infected with TB, and they include food insecurity and malnutrition, poor housing and environmental conditions as well as financial, geographic, and cultural barriers to health care access. The increased attention on addressing the social determinants of TB was brought into focus in 2010 when there was a sharp increase in TB cases globally. Certain patterns emerged in relation to the inequitable distribution of reported cases.[14] The majority of cases were clustered among the poor, the hungry, and ethnic minorities. It has now become clear that in order to

[7] Note that pseudonyms are used in this report to protect the privacy of interviewees and are denoted with an asterisk (*)
[8] Amnesty International interview with female respondent with MDR-TB on 7 July, 2021 in Gobabis.
[9] World Health Organization, Tuberculosis, 14 October 2020, https://www.who.int/news-room/fact-sheets/detail/tuberculosis
[10] World Health Organization Regional Office for Africa, Tuberculose (TB), https://www.afro.who.int/health-topics/tuberculosis-tb
[11] World Health Organization, Tuberculosis, 14 October 2020, https://www.who.int/news-room/fact-sheets/detail/tuberculosis
[12] World Health Organization, 2000, The economic impacts of tuberculosis, https://apps.who.int/iris/bitstream/handle/10665/66238/WHO_CDS_STB_2000.5.pdf;jsessionid=A6644F99A74CBC57195E8BF0D4C90B50?sequence=1
[13] WHO, A human rights approach to tuberculosis, https://apps.who.int/iris/bitstream/handle/10665/66701/WHO_CDS_STB_2001.9.pdf
[14] Hargreaves JR, Boccia D, Evans CA, Adato M, Petticrew M, Porter JD. The social determinants of tuberculosis: from evidence to action. *Am J Public Health*. 2011;101(4):654-662. doi:10.2105/AJPH.2010.199505, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3052350/

address TB, countries will not only need to invest in strengthening TB control programs, diagnostics, and treatment but also act on the social determinants of the disease.[15]

TB has had a devastating impact on public health in Africa, in 2020 the WHO stated that a quarter of new cases notified globally in 2019 originated in Africa.[16] An added concern is that the region accounts for over 25% of TB related deaths annually.[17] Additionally, TB is a leading cause of death in women of reproductive age[18] and is a major non-obstetric cause of maternal mortality in southern Africa.[19] Indeed, nearly 15% of maternal deaths in southern Africa are a result of TB.[20]

Namibia currently carries one of the highest burdens of TB and MDR-TB in the world. A 2020 study by Kibuule et al stated "Namibia, with a case notification rate of 442 cases per 100000, is ranked fifth among countries with highest burden of TB."[21]

There are indications that TB incidence in Namibia is not evenly distributed. While they account for a small percentage of the Namibian population (approx. 2%), the prevalence of TB among the Indigenous San peoples of Namibia is nonetheless very high. There is a dearth of official statistics on the prevalence of TB among subpopulations in Namibia, but some studies indicate that the burden of TB among the San is almost 40% higher than the national average. There is also evidence that the San are at a higher risk of treatment failure and have a greater burden of drug-resistant TB relative to the national average. Owing to the prevalence and aggressiveness of TB among the San, they are considered a "Most-at-Risk" population and are a prioritized group for the purposes of the National Tuberculosis and Leprosy Programme (NTLP) in Namibia.

This report examines the human rights impact of the prevalence of Tuberculosis and Multi-drug-resistant tuberculosis among the Indigenous San peoples of Namibia. It looks at the San communities from Tsumkwe District in the Otjozondjupa Region and Drimiopsis village in the Omaheke Region and examines the historical marginalization endured by San persons as well as their current socio-economic conditions in order to understand the root causes which have resulted in their TB and MDR-TB burden, and how it impacts the realization of their right to health.

The report finds that the Government of Namibia has failed to address the structural factors and social determinants that contribute to the San's disproportionate vulnerability to TB and has also failed to provide for appropriate treatment and interventions required to control TB amongst the San – thereby neglecting its obligations to protect, promote and fulfil the San's right to health.

Methodology

Amnesty International undertook four research missions to Namibia in May/June 2018, November 2018, January/February 2019 and June/July 2021. We visited the Otjozondjupa and Omaheke regions and collected information from predominantly San communities located within the catchment area of three primary healthcare facilities – Tsumkwe Clinic in Tsumkwe East, Mangetti Dune Health Centre about 95 Km north of Tsumkwe and Gobabis State Hospital in Gobabis. Here, Amnesty International carried out focus group discussions and individual interviews in healthcare facilities, San villages and campsites. Respondents included San residents, traditional authorities, healthcare providers and civil society representatives.

In addition, we visited Windhoek in the Khomas Region and interviewed a diverse range of stakeholders including activists, researchers, public health specialists and government officials representing the Ministry of Poverty Eradication and Social Welfare, Office of the Vice President: Division Marginalised Communities

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[15] Hargreaves JR, Boccia D, Evans CA, Adato M, Petticrew M, Porter JD. The social determinants of tuberculosis: from evidence to action. *Am J Public Health.* 2011;101(4):654-662. doi:10.2105/AJPH.2010.199505, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3052350/

[16] World Health Organization, Tuberculosis, 14 October 2020, https://www.who.int/news-room/fact-sheets/detail/tuberculosis

[17] World Health Organization Regional Office for Africa, Tuberculose (TB), https://www.afro.who.int/health-topics/tuberculosis-tb

[18] Connolly M, Nunn P. Women and tuberculosis. World Health Stat Q. 1996;49(2):115-9. PMID: 9050189, https://pubmed.ncbi.nlm.nih.gov/9050189/

[19] National Department of Health, South Africa. Saving Mothers 2014 - 2016: Seventh Report on the Confidential Enquiries into Maternal Deaths in South Africa. Short report. Pretoria: NDoH, 2017, https://www.sasog.co.za/Content/Docs/Saving_Mothers.pdf
Zumla A, Malon P, Henderson J, *et al* Impact of HIV infection on tuberculosis *Postgraduate Medical Journal* 2000;**76:**259-268, https://pmj.bmj.com/content/76/895/259
Grange J, Adhikari M, Ahmed Y, Mwaba P, Dheda K, Hoelscher M, Zumla A. Tuberculosis in association with HIV/AIDS emerges as a major non-obstetric cause of maternal mortality in Sub-Saharan Africa. Int J Gynaecol Obstet. 2010 Mar;108(3):181-3. doi: 10.1016/j.ijgo.2009.12.005. Epub 2010 Jan 13. PMID: 20070964, https://pubmed.ncbi.nlm.nih.gov/20070964/

[20] Republic of Namibia Ministry of Health and Social Services, National Guidelines for the Management of Tuberculosis, March 2011, https://www.who.int/hiv/pub/guidelines/namibia_tb.pdf

[21] Kibuule D, Aiases P, Ruswa N, et al. Predictors of loss to follow-up of tuberculosis cases under the DOTS programme in Namibia. *ERJ Open Res.* 2020;6(1):00030-2019. Published 2020 Mar 16. doi:10.1183/23120541.00030-2019, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7073418/

(now the Division Of Disability Affairs and Marginalized Communities), the Ombudsman Office, and the Ministry of Health and Social Services. We also undertook extensive desk research.

Legal and Policy Framework

While the Constitution of Namibia does not contain an explicit provision for the right to health, Article 144 of the Namibian Constitution takes a monist approach and states that unless otherwise provided by the Constitution or Act of Parliament, the general rules of public international law and international agreements ratified by the country are binding upon Namibia. Thus, it is bound by obligations which arise from treaties such as the International Covenant on Economic, Social and Cultural Rights (ICESCR), the International Convention on the Elimination of Racial Discrimination, the Convention on the Rights of the Child, and the Convention on the Elimination of all Forms of Discrimination Against Women which all protect the right to health.

As a State Party to the ICESCR and other international and regional human rights standards, Namibia is bound by a duty to ensure the progressive realization of the right to health for all without distinction or discrimination. This includes promoting conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.[22]

Leaving the San Behind- Understanding the San's Vulnerability to TB

Throughout its history, TB has disproportionately affected people of low socioeconomic status. Even before 1882, when it was discovered that the Mycobacterium Tuberculosis germ is the causative agent of TB, there was an understanding of the relationship between TB and socioeconomic factors such as poverty, malnutrition, and poor living conditions.

Although they are the first known inhabitants of the land in Namibia, historical incursions by other groups have driven the San to the brink and led to institutionalized ghettoization of their existence in order to 'contain' them through administrative zones. As a historically marginalized group, the San do not have ownership of ancestral land, for which they have historically depended for survival and also experience high levels of unemployment, social marginalization and poverty. These factors have given rise to social and behavioural risk factors which exacerbate their vulnerability to TB as they lack the income and resources required to maintain good health. Covid-19 has added an additional layer of vulnerability. Even prior to the current pandemic, San peoples already faced entrenched inequalities, stigmatisation and discrimination. Inadequate access to health care, clean water and sanitation increases their vulnerability to both TB and the coronavirus.

Barriers to Healthcare

There are significant barriers related to the San people's ability to access healthcare. The remote location of many San communities often interferes with their access to healthcare. Although most rural Namibians face similar distance-related barriers to accessing healthcare facilities, the San's multiple socio-economic challenges including the lack of education, financial means and poor access to public transport exacerbates their inability to access healthcare facilities, which we found in some cases to be 80kms away. Despite San communities' difficulties in physically accessing fixed primary healthcare facilities, Amnesty International found that the government had failed to prioritize the provision of mobile health outreach and extension services in the most remote areas.

Primary healthcare facilities in Namibia are under-resourced in terms of physical infrastructure, personnel and material resources such as medications and equipment. While the burden of TB and MDR-TB in predominantly San communities is unquestionably high, we found these healthcare facilities have severe shortages in human, financial and material resources and lack the capacity to respond to the health needs of San communities.

The language barrier between San patients and their healthcare providers, majority of whom are neither San nor fluent in any San languages was another major obstacle standing in the way of the San peoples' realization of the right to health. This is because language barriers contribute to misunderstandings between San persons and healthcare workers, poor patient-provider relationships and negative clinical outcomes associated with patients' inability to explain their symptoms and understand what is required of them to pursue treatment.

Cultural differences also manifest as discrimination against San peoples in the healthcare settings, as San affected individuals and communities alleged experiencing negative treatment by healthcare providers

[22] CESCR General Comment 14.

including verbal harassment, the use of derogatory epithets, and the preferential treatment of patients from other ethnic groups. Some respondents even reported being victims of physical assault and suffered of denial of treatment and medications at the hands of healthcare providers. Further, due to a lack of intercultural healthcare training Amnesty International found that San peoples were hesitant about consulting healthcare providers regarding their traditional medical values and practices, limiting their access to alternative healthcare and also curtailing their ability to ensure complementarity between traditional and biomedical treatments.

Government Failure

Amnesty International has found that the Namibian government has failed to address various structural factors and social determinants that contribute to the San's disproportionate vulnerability to TB and MDR-TB, and has also failed to provide appropriate interventions necessary for TB control amongst the San – in direct violation of its national, regional and international law obligations to protect, promote and fulfil the human rights of Indigenous San persons in Namibia, in particular, their right to health.

When Namibia successfully transitioned from low to upper middle-income status, the country began to receive reduced official development assistance (ODI) and experienced increased levels of 'donor flight'. In 2016, following donor flight, the government introduced austerity measures that weakened the government's ability to mobilise resources for healthcare. Although all Namibians have been affected by the country's economic climate, the San population has been particularly hard hit by government's decision to introduce austerity measures thereby exacerbating the prevalence of TB and MDR-TB in their communities. The donor flight has left the Ministry of Health and Social Services' (MoHSS) as well as non-governmental organizations and faith-based organizations without the crucial sources of funding they depend on. Although the MoHSS has attempted to compensate for the gap in financing created by the decreases in donor funding, the national TB programme is highly dependent on external funding for TB control and as such a number of community-based TB projects run by non-governmental organizations have been forced to scale down their operations, or shut down completely.

Also, although the Namibian government has introduced a number of targeted interventions for the development of the San population, there have been challenges implementing appropriate interventions for the San, largely due to the fact that authorities had adopted a top-down approach to San peoples' development which reflects a failure to respect their rights to self-determination and Free, Prior and Informed Consent.

Further, Namibia has found itself in the clutches of a global pandemic that threatens to impact the nation's development and adversely affect all sectors of the economy. At the time of writing Covid-19 infection rates in Namibia were some of the highest in the world. As a result, Covid-19 will likely have long-lasting impacts on the country's ability to deliver social services, disproportionally affecting those who rely on the government most.

Recommendations

In light of these findings Amnesty recommends the Government of Namibia take urgent action towards respecting, protecting and fulfilling the economic, social and cultural rights of the San peoples. This includes, amongst others, immediately ratifying the ILO Convention 169 on Indigenous and Tribal Peoples and ensuring that its provisions are incorporated into domestic legislation and policy. The government must also urgently develop legislative and/or policy measures that ensure the advancement of San peoples, taking into account their historical marginalization and discrimination.

In upholding the right to health of the San people the Government is also urged to take immediate steps to ensure accessibility of primary healthcare facilities in line with the core minimum human rights standards. This includes the appropriate distribution of healthcare providers between primary healthcare facilities, building the capacity of healthcare providers to provide TB-related services, equipping health facilities with the necessary medicines and equipment, and providing appropriate transportation to primary healthcare facilities, particularly in rural and remote areas. Where the Government of Namibia is unable to do so, it

should seek the support of the International Community, who must provide necessary financial and technical support to the Namibian government to extend appropriate healthcare services to San communities.

Family in Dun Pos village, near Tsumkwe. © Health Poverty Action via Big Lottery Fund.

2. METHODOLOGY

This report is based on desk and qualitative field research carried out in Namibia in 2018, 2019 and 2021. Amnesty International began by conducting research in Namibia with an initial mission to the country from 20 May to 3 June 2018. Informed by the findings of the first mission Amnesty conducted further research in the Khomas, Omaheke and Otjozondjupa Regions of Namibia in November 2018, January/February 2019 and finally in June/July 2021.

With the assistance of Ju/'Hoansi, !Xóõ and !Kung language interpreters, Amnesty International researchers conducted group discussions and interviews with San communities across five villages in the Nyae Nyae Conservancy in Tsumkwe East in Otjozondjupa, the N≠a Jaqna Conservancy in Tsumkwe West in Otjozondjupa, and the Drimiopsis Resettlement Camp in Omaheke.

In 2018 and 2019, researchers interviewed over 120 people, including traditional San leaders and community members, primary healthcare providers, civil society groups, activists, researchers, specialists in the field of communicable diseases, and senior government officials including the office of the Ombudsman. In June and July 2021, Amnesty interviewed an additional 103 San respondents by way of semi-structured interviews.

The interviews were conducted to allow researchers to capture the San respondents' narrative accounts on the experiences of TB and the underlying dynamics in which health services are delivered and accessed.

Throughout the research phase, Amnesty International researchers reviewed policy documents, government statements, and literature - including anthropological literature, reports and international recommendations of regional and international human rights bodies. Statistical data and development indicators were extracted from various national and international databases such as World Health Organization, World Bank, CIA World Factbook, United Nations Development Programme, and the Central Bureau of Statistics of the National Planning Commission of Namibia.

In February 2019 Amnesty International sent a letter to the Ministry of Finance and the Ministry of Health and Social Services, as well as the National Planning Commission and the Office of the Vice President: Division Marginalised Communities to share the initial findings of the report and request further information regarding the key findings. The letter was unanswered. On 20 September 2021, we sent a follow up letter to the government.

Amnesty International thanks local NGOs who enabled us to carry out this research and expresses deep gratitude to the San community members who participated in this research and took the time to share their lived experiences with us. Without them, this report would not be possible.

3. THE CONTEXT OF THE SAN PEOPLES IN NAMIBIA

The term 'San,' as used in this report, refers to former hunter-gatherer groups in southern Africa. The use of this term is derived from the agreements made by representatives of several San groups across southern Africa in the late 1990s, who settled on the term to replace the derogatory 'Bushman' and refer collectively to the diverse former hunter-gatherer groups who belong to the broader Khoisan (or Khoesan) cultural and linguistic family.[23] San identity is context-bound and highly dynamic as most former hunter-gatherers identify themselves according to their particular ethnic cultural and linguistic groups such as !Xun (or !Kung), Ju/'Hoansi, Naro, Khwe, Haillom, and !Xóõ to mention a few.[24]

3.1 A BRIEF HISTORY OF SAN PEOPLES IN NAMIBIA

The San were the earliest inhabitants in a number of countries in southern Africa.[25] Archaeological evidence dating as far back as the Middle Stone-Age shows that they were the sole occupants of the majority of southern Africa where they lived as nomadic hunters and gatherers in areas with fertile land and sufficient natural resources.[26] The control of productive resources among the San peoples during this time was based on communal ownership in relation to rights to land, water sources, and other resources.[27]

In the sixteenth and seventeenth centuries, diverse Bantu-speaking groups migrated into southern Africa, with many settling in the area that is present-day Namibia. Bantu-speaking Ovambo, Kavango, Damara and Herero groups settled mostly in the central and northern regions of Namibia where they provided for their basic needs by herding cattle, sheep and goats, as well as through small scale subsistence agriculture. The pastoral and agrarian activities of the Bantu-speaking migrant groups were inconsistent with the hunting and gathering practices of the pre-existing San peoples, as their livestock and crops depleted natural grasses and disrupted wildlife migration which threatened the traditional food sources of hunter-gatherer groups. As a

[23] Following the recognition of the use of the problematic terms to refer to former hunter and gatherer groups in southern Africa in 1996, representatives of several San groups across southern Africa met in Namibia and agreed to use the term "San" to denote a single group. In 1997 this agreement was reaffirmed in a meeting on "Khoisan Identities and Cultural Heritage" in Cape Town, South Africa. Also see: Dieckmann, Ute, Maarit Thiem, Erik Dirkx, and Jennifer Hays. *Scraping the Pot: San in Namibia Two Decades After Independence.* , 2014. Print, https://www.worldcat.org/title/scraping-the-pot-san-in-namibia-two-decades-after-independence/oclc/910552692

[24] Dieckmann, Ute, Maarit Thiem, Erik Dirkx, and Jennifer Hays. *Scraping the Pot: San in Namibia Two Decades After Independence.* , 2014. Print, https://www.worldcat.org/title/scraping-the-pot-san-in-namibia-two-decades-after-independence/oclc/910552692

[25] The San are found in South Africa, Botswana, Namibia, Angola, Lesotho, Zambia, Zimbabwe.

[26] Wallace, M. and J. Kinahan. "A History of Namibia: From the Beginning to 1990." (2011), https://www.semanticscholar.org/paper/A-History-of-Namibia%3A-From-the-Beginning-to-1990-Wallace-Kinahan/034dc31751bac65304e0e64b78dbeb3a38ed474a

[27] Wallace, M. and J. Kinahan. "A History of Namibia: From the Beginning to 1990." (2011), https://www.semanticscholar.org/paper/A-History-of-Namibia%3A-From-the-Beginning-to-1990-Wallace-Kinahan/034dc31751bac65304e0e64b78dbeb3a38ed474a

result, San communities were forced to move to the more remote parts of the country or in some cases were forcibly assimilated into other cultures.[28]

As such, the arrival of Bantu-speaking peoples in Namibia led to the large-scale displacement of San peoples, which continued with increased severity under successive German and South African colonial administrations.[29] During the 'Scramble for Africa' in 1884-85, Germany and Portugal negotiated the border between present-day Angola and Namibia, with Namibia (then known as South West Africa) being declared a colony under the German empire.[30] The German colonial administration enforced unmitigated discrimination against the San and Bantu peoples, in favour of European settlers,[31] and by 1907 had established ownership of two-thirds of Namibian land.

When the First World War broke out in 1914, South Africa captured Namibia during the South West Africa Campaign.[32] After the war, the newly formed League of Nations gave South Africa the mandate to administer Namibia as part of the Union of South Africa.[33] Recognising Namibia as a so-called 'fifth province,' South Africa's colonial administration applied Apartheid[34] policies of racial discrimination in all areas of social, political and economic life.[35] In 1963 the Odendaal Commission recommended the ethnic division of Namibian society and led to the creation of ten so-called 'homelands' or 'Bantustans' for each African ethnic group. The San were allocated a homeland called 'Bushmanland,' on the edge of the Kalahari, in what is now the Otjozondjupa region.[36] The creation of homelands led to the continued displacement of San communities whose ancestral lands were turned into homelands for other ethnic groups, commercial farming areas, game reserves and national parks.[37] By 1970s fewer than 3% of all San peoples in Namibia had rights to land, either individually or collectively.[38]

From the mid-1960s to the late-1980s resistance against South Africa's colonisation of Namibia intensified. The South West African People's Organization (SWAPO) led a protracted armed struggle for national liberation; meanwhile, international anti-apartheid movements also mounted increasing political pressure on the South African government.[39] In August 1988, after more than two decades of armed struggle, Namibia's liberation movement triumphed, and on 21 May 1990, Namibia formally achieved its independence with SWAPO at the helm.[40]

SWAPO has remained the governing party of Namibia in the three decades since independence.[41]

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[28] Harring, S. L., Odendaal, W., & Legal Assistance Centre (Namibia). (2006). *Our land they took: San land rights under threat in Namibia*. Windhoek, Namibia: Land, Environment, and Development Project, Legal Assistance Centre, https://searchworks.stanford.edu/view/6997543

[29] Suzman, J & Legal Assistance Centre (Namibia). (2001) An Assessment of the Status of the San in Namibia. Windhoek, Legal Assistance Centre, http://www.lac.org.na/projects/lead/Pdf/sannami.pdf

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[34] *Advisory Opinion on the Legal Consequences for States of the Continued Presence of South Africa in Namibia*, International Court of Justice (ICJ), 21 June 1971, https://www.refworld.org/cases,ICJ,4023a2531.html

[35] Chripanhura, B., Niño – Zarazúa, M., & Kalimbo, HN. (2014) *The Dynamics of Poverty and Inequality in Namibia: A Critical Evaluation of the Development Plans*. Windhoek: University of Namibia Press, https://www.wider.unu.edu/sites/default/files/Events/PDF/Slides/Chiripanhura-poster.pdf

[36] Harring, S. L., Odendaal, W., & Legal Assistance Centre (Namibia). (2006). *Our land they took: San land rights under threat in Namibia*. Windhoek, Namibia: Land, Environment, and Development Project, Legal Assistance Centre, https://searchworks.stanford.edu/view/6997543

[37] Harring, S. L., Odendaal, W., & Legal Assistance Centre (Namibia). (2006). *Our land they took: San land rights under threat in Namibia*. Windhoek, Namibia: Land, Environment, and Development Project, Legal Assistance Centre, https://searchworks.stanford.edu/view/6997543

[38] Suzman, J & Legal Assistance Centre (Namibia). (2001) An Assessment of the Status of the San in Namibia. Windhoek, Legal Assistance Centre, http://www.lac.org.na/projects/lead/Pdf/sannami.pdf

[39] Du Pisani, A. (2010). 'State and society under South African rule.' *State, society and democracy: A reader in Namibian politics*, p. 49-76, https://www.kas.de/wf/doc/kas_18730-544-2-30.pdf

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[41] Daniels, C. (2003). 'The struggle for indigenous people's rights.' *Re-examining Liberation Namibia: Political Culture Since Independence,* p.47-68, http://www.diva-portal.org/smash/record.jsf?pid=diva2:241396

3.2 THE SAN TODAY

Demographic data on the number of San people in present-day Namibia varies considerably. The Namibia Household Income and Expenditure Survey 2015/16 reported the number of people whose main language is Khoisan to be 34,171 or 1.5% of the population.[42] Some studies suggest that the number of San in Namibia is 27,000, while others suggest that the San population is closer to 32,000 or 38,000.[43] These demographic variations demonstrate a lack of reliable statistics on the San peoples in Namibia. What is clear, however, is that the San, who represent less than 2% of the population, are one of the smallest minority groups in the country.

As previously stated, successive colonial regimes in Namibia dispossessed Indigenous San peoples of nearly all of their ancestral land that was a source of their livelihoods, their cultural identity and customary ways of life for centuries.[44]

Some of the immediate consequences of the San's dispossession were the disruption of cultural practices (such as the collective management of natural resources), inability to cultivate land, loss of food security and high mobility.[45] The San's dispossession also left them vulnerable to being economically dependent on other ethnic groups in areas where they had little control of and access to land.

After independence the Namibian government adopted numerous measures to redress the widespread dispossession and loss of land in the country. In 1991 the Namibian Government established the Ministry of Lands, Resettlement and Rehabilitation, and subsequently enacted legislation on the facilitation of land reform and redistribution in the country. These include the Agricultural (Commercial) Land Reform Act of 1995, the National Resettlement Policy of 1997, the National Land Policy of 1998 and the Communal Land Reform Act (Act No. 5) of 2002.

Under the Communal Land Reform Act, the government reorganised former homelands into communal resettlement areas including as conservancies, resettlement farms, and national parks[46].

In general terms, the Act confers land ownership on the state but endows Land Boards with powers concerning land management and allocation in the communal areas. As such, former 'Bushmanland' in the Otjozondjupa Region was renamed Tsumkwe District and converted into customary land for the San people, with a majority Jul'Hoansi -speaking peoples living in the Nyae Nyae Conservancy in the east and !Kung-speaking peoples in the N‡a Jaqna conservancy in the west. San communities in the Tsumkwe District of the Otjozondjupa Region in Namibia still predominantly live a traditional hunter-gatherer way of life which includes the full spectrum of their traditional heritage.

The Nyae Nyae Conservancy was founded in 1998 and covers approximately 6,300 square kms on the eastern side of Tsumkwe District. The Nyae Nyae Conservancy is home to a majority Ju/'Hoansi population of around 2,000 people spread across 30-35 villages.[47] Founded in 2003, the N‡a Jaqna conservancy is situated on 8,457 square kms on the western side of Tsumkwe, and is home to a majority !Kung population in 24 villages.[48]

While San peoples constitute the majority population in Tsumkwe District, it is important to note that only 10 percent of all San in Namibia live in Tsumkwe District. Therefore, the majority of San people in Namibia lack customary land rights and are forced to live as minorities in small areas on communal lands, in remote 'camps' or on white-owned farms and in urban areas.[49]

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[42] National Statistics Agency (2016). Namibia Household Income and Expenditure Survey 2015/16, https://catalog.ihsn.org/index.php/catalog/7437

[43] Suzman, J & Legal Assistance Centre (Namibia). (2001) An Assessment of the Status of the San in Namibia. Windhoek, Legal Assistance Centre, http://www.lac.org.na/projects/lead/Pdf/sannami.pdf also see ACHPR & IWGIA, Mission to The Republic of Namibia, https://www.iwgia.org/iwgia_files_publications_files/ACHPR_Namibia_UK.pdf

[44] UN Human Rights Council (2013). Report of the Special Rapporteur on the rights of indigenous peoples, Addendum: The situation of indigenous peoples in Namibia, 25 June 2013, A/HRC/24/41,https://www.refworld.org/docid/522db4014.html

[45] Dieckmann, Ute, Maarit Thiem, Erik Dirkx, and Jennifer Hays. *Scraping the Pot: San in Namibia Two Decades After Independence.* , 2014. Print, https://www.worldcat.org/title/scraping-the-pot-san-in-namibia-two-decades-after-independence/oclc/910552692

[46] Communal Land Reform Act, 2002 (Act No. 5 of 2002), https://www.ecolex.org/details/legislation/communal-land-reform-act-2002-act-no-5-of-2002-lex-faoc064022/

[47] Namibian Association of CBNRM Support Organisations, (Updated). 'Nyae Nyae Conservancy', http://www.nacso.org.na/

[48] Namibian Association of CBNRM Support Organisations. (2017). Na Jaqna: Annual Conservancy Audit Report, http://www.nacso.org.na/

[49] Suzman, J & Legal Assistance Centre (Namibia). (2001) An Assessment of the Status of the San in Namibia. Windhoek, Legal Assistance Centre, http://www.lac.org.na/projects/lead/Pdf/sannami.pdf

In the report on its mission to Namibia in 2005 the African Commission on Human and People's Rights notes the Namibian government's responses to the San's land dispossession and the issues that arose from it have been inadequate, remarking that:

> **"Through land dispossession San communities have lost their food security; they have become economically dependent on other ethnic groups and government food aid, they have experienced a loss of dignity, disruption of their social fabric, and degradation of their environment by intruders with large cattle herds; and, in sum, they remain a marginalized population."[50]**

In addition, following a mission to Namibia in 2005 the African Commission Working Group on Indigenous Populations/Communities observed that:

> **"the San are undeniably the worst-off ethnic group in Namibia and their level of poverty is unmatched by that of any other ethnic group in the country."[51]**

In recent years United Nations Bodies and other human rights organizations have raised concern on these conditions. In a report to the United Nations Human Rights Council, the Special Rapporteur on the rights of Indigenous peoples stated that the San "are understood to be the most vulnerable of the Indigenous peoples in Namibia."[52]

In early 2017 the Office of the Ombudsman conducted a nation-wide consultation to understand the extent of the impact of racism and discrimination in Namibia.

The consultations culminated in a report titled *'A Nation Divided: Why do Racism and Other Forms of Discrimination Still Persist after Twenty-Seven Years of Namibian Independence'*. The report notes that the majority of San communities in the most rural and remote parts of Namibia live in dire situations characterized by high rates of poverty and unemployment. San communities generally lack access to essential social services such as healthcare and education, and where these services exist, the Ombudsman's report found that San people are subjected to discrimination and ill-treatment by government officials from other language groups.

As is common with Indigenous people across the world San *women* are further marginalized[53], facing what the Advancing Rights in Southern Africa (ARISA) calls "the triple discrimination of their gender, ethnicity and economic status."[54] As primary caregivers San women provide family care responsibilities but also work to support their families, and due to their lack of access to traditional livelihoods and formal education San women commonly occupy the low-paid, precarious jobs in the informal economy.

Further, once called the 'least sexist society'[55] due to their egalitarian social order, gender inequality is becoming a growing problem among the San community. A 2020 report by ARISA states that local women's groups have witnessed increases in domestic violence against San women in Drimiopsis. According to the report, these increases in domestic violence were witnessed after San farm labourers[56] were laid off without

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[50] African Commission on Human and Peoples' Rights & International Work Group for Indigenous Affairs. (2008) Report of The African Commission's Working Group on Indigenous Populations/Communities: Mission to The Republic of Namibia, p 89, https://www.iwgia.org/images/publications/ACHPR_Namibia_UK.pdf

[51] African Commission on Human and Peoples' Rights & International Work Group for Indigenous Affairs. (2008) Report of The African Commission's Working Group on Indigenous Populations/Communities: Mission to The Republic of Namibia, https://www.iwgia.org/images/publications/ACHPR_Namibia_UK.pdf

[52] UN Human Rights Council (2013). Report of the Special Rapporteur on the rights of indigenous peoples, Addendum: The situation of indigenous peoples in Namibia, 25 June 2013, A/HRC/24/41, https://www.refworld.org/docid/522db4014.html

[53] United Nations Office of the Special Adviser on Gender Issues and Advancement of Women and the Secretariat of the United Nations Permanent Forum on Indigenous Issues, Gender and Indigenous Peoples' Human Rights, https://www.un.org/esa/socdev/unpfii/documents/BriefingNote6_GREY.pdf Also see 'COVID 19 and Indigenous Peoples' Resilience', https://www.un.org/en/observances/indigenous-day.

[54] Advancing Rights in Southern Africa (ARISA) Special Report 2020 COVID-19 & the Rights of Indigenous Peoples in Southern Africa, Freedom House and USAID, https://freedomhouse.org/report/special-report/2020/covid-19-rights-indigenous-peoples-southern-africa

[55] Heike Becker (2003) The Least Sexist Society? Perspectives on Gender, Change and Violence among southern African San*, Journal of Southern African Studies, 29:1, 5-23, DOI: 10.1080/0305707032000060557, https://www.tandfonline.com/doi/abs/10.1080/0305707032000060557

[56] Advancing Rights in Southern Africa (ARISA) Special Report 2020 COVID-19 & the Rights of Indigenous Peoples in Southern Africa, Freedom House and USAID, https://freedomhouse.org/report/special-report/2020/covid-19-rights-indigenous-peoples-southern-africa Anecdotal evidence suggests that incidents of domestic violence and wife-beating among San are higher in areas where San communities have adopted modern ways of livelihoods such as in the farming areas than elsewhere, and certainly substantially higher than they were in the past. That more San women now find themselves at the knuckled end of their husbands' or lovers' fists can be partially ascribed to the fact that San women are among the few groups on which socially marginalized San men can take out their frustrations. See: Suzman: An Assessment of the Status of the San in Namibia.

pay due to Covid-19 lockdowns, noting that the lack of income has put "a lot of pressure and frustration in households."

3.3 HEALTH CHALLENGES FACED BY SAN PEOPLES

> **"I know how it feels if you are sick with TB – it's … worse if you did not take your medication as prescribed and with a hungry stomach. I plead to the government, for we are not working and some are now pensioners, to help us with food, clean water and some money to be able to maintain ourselves and families in emergencies" [57] – Female San Respondent in Gobabis, July 2021**

San peoples are the only ethnic group in Namibia whose health status has declined since independence in 1990.[58] San people display some of the worst health indicators, including higher rates of malnutrition as well as childhood and maternal mortality, and a higher burden of disease.[59] As such the life expectancy of Indigenous San peoples is considerably lower than the national average.[60]

Of growing concern is the prevalence of Tuberculosis and Drug- or Multi-Drug Resistant Tuberculosis among San peoples. The Namibian government identified San peoples as a Most-At-Risk-Population and have repeatedly illustrated their vulnerability to TB and MDR-TB.[61] Accordingly, other studies conducted on TB in Namibia indicate that there is a significantly higher burden of TB among the San, relative to other groups. In 2003 the NGO *Health Unlimited* estimated that the prevalence of TB among the San population in Namibia was 1,500 per 100,000 people,[62] which was almost 40% more than the national average of 912 per 100,000 in the same year.[63] A 2013 Minority Rights International report further noted "the San region of Tsumkwe has high levels of MDR-TB because they live in remote places and often leave their homes and go on long hunting expeditions, which means they do not finish courses of medicine."[64] The situation does not appear to have changed since: Health workers and other interlocutors interviewed by Amnesty International repeatedly cited TB as one of the most common diseases among the San, and noted the incidence of MDR-TB as equally concerning.

San women of a reproductive age are at a heightened risk of TB, as research has shown that pregnancy may increase the risk of pregnant women developing TB compared with non-pregnant women. Due to the disproportionally high incidence of TB among the San, San mothers and infants face serious health consequences, and pregnancy-associated TB can be associated with maternal mortality of up to 40% if untreated.[65]

The advent of Covid-19 has increased the risk of poor health outcomes in the Indigenous peoples.[66] Owing to the remoteness of the settlements they live in, San communities already experience poor access to healthcare, sanitation, and other key essentials, such as clean water, soap and disinfectants which are necessary for the prevention of Covid-19. Covid-19 has also added additional strain on already fragile healthcare systems, as resources are being diverted to Covid-19 interventions and treatment for TB has become even less accessible. In the words of a respondent in an interview conducted in July 2021: "before

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[57] Amnesty International interview with female respondent on 6 July 2021 in Gobabis.
[58] African Commission on Human and Peoples' Rights & International Work Group for Indigenous Affairs. (2008) Report of The African Commission's Working Group on Indigenous Populations/Communities: Mission to The Republic of Namibia, p 89, https://www.iwgia.org/images/publications/ACHPR_Namibia_UK.pdf
[59] African Commission on Human and Peoples' Rights & International Work Group for Indigenous Affairs. (2008) Report of The African Commission's Working Group on Indigenous Populations/Communities: Mission to The Republic of Namibia, p 89, https://www.iwgia.org/images/publications/ACHPR_Namibia_UK.pdf
[60] Suzman, J & Legal Assistance Centre (Namibia). (2001) An Assessment of the Status of the San in Namibia. Windhoek, Legal Assistance Centre, http://www.lac.org.na/projects/lead/Pdf/sannami.pdf
[61] Namibia Coordinating Committee for AIDS, TB, and Malaria (NaCCATuM). The Global Fund to Fight AIDS, Tuberculosis and Malaria Proposal Forms, https://data.theglobalfund.org/investments/documents/NAM
[62] Health Unlimited (2003). 'Indigenous Peoples – Health Issues: Summary of Presentations at Indigenous Peoples and Socioeconomic Rights Expert Workshop, 20-21 March 2003'.
[63] World Bank. 'Tuberculosis case detection rate (%, all forms)' *World Bank World Development Indicators*, https://databank.worldbank.org/source/world-development-indicators
Figures based on researcher's own calculations.
[64] Minority Rights Group International, *State of the World's Minorities and Indigenous Peoples 2013 - Case study: Innovative mobile tuberculosis treatment reaches Namibia's nomadic San community*, 24 September 2013, https://www.refworld.org/docid/526fb70f21.html
[65] Loveday, M et al. Figures of the dead: A decade of tuberculosis mortality registrations in South Africa. South African Medical Journal, [S.l.], v. 109, n. 10, p. 728-732,Sep. 2019. ISSN 2078-5135, <http://www.samj.org.za/index.php/samj/article/view/12734>. doi:10.7196/SAMJ.2019.v109i10.14073.
[66] United Nations (2020). 'COVID 19 and Indigenous Peoples', https://www.un.org/development/desa/indigenouspeoples/COVID 19.html

it was easier if you come for TB treatment or any other illness, you were treated as such, but today every sickness is Covid-19 and everyone who dies it's Covid-19 related death."[67]

While the Namibian government has acknowledged Indigenous San people's health disparities and vulnerability to TB and MDR-TB, there is a pervasive lack of national health and epidemiological data on Indigenous San peoples. Health statistics and epidemiological studies are used by governments to understand the health and disease conditions in a country and as the evidence base that informs public health policy and disease prevention. Therefore, the lack of data on San peoples not only limits the understanding of the health status of Indigenous San peoples but also excludes them from national priority setting and policymaking.[68]

Although Namibia's statistics can be broken down by region, there are few disaggregated, population-level statistics available that we could use to evaluate the prevalence of TB among particular groups. For example, the Demographic Health Survey – Namibia's most extensive mechanism for collecting health data – does not capture respondents' self-reported ethnicity.[69] Similarly, the nationwide TB drug resistance survey which was held in 2008 to assess the prevalence and trends of MDR-TB, did not use patients' ethnicity as part of the demographic information recorded.[70] So, although national health data shows that Namibia has made significant improvements in terms of TB control over the past decade (with the MoHSS reporting that the TB case notification rate decreased by 50% from 2005 to 2016).[71] it is important to note that these statistics are aggregated national estimates and do not provide information on TB among certain groups. This means that the true extent of TB among the San is mostly not known.

SAFINAH'S* STORY[72]

"TB is also a killer disease, but it can be cured if you take your medication every day. You need vegetables some fruits and healthy diet to fight back TB.

I know how it feels if you are TB patient, it is not easy and it's very painful. I don't know how to express myself but it's not well with us here. We are running around to get my sick granddaughter something to eat as I don't want my grandchild to miss out on her medication. I am her grandmother; she is my son's daughter and is now sick for very long time.

I wish I was … younger …. I could have taken her to the farm where I was employed to stay with me."

[67] Amnesty International interview with female respondent on 6 July 2021 in Gobabis.
[68] Gibson, D. (2011). Negotiating the search for diagnosis and healing tuberculosis in Namibia. A case study of a Ju/'hoansi speaking man, https://www.semanticscholar.org/paper/Negotiating-the-search-for-diagnosis-and-healing-in-Gibson/1e9f0aa5cd1e3d7da2675f4e59ecbc535bf7ca51
[69] Ministry of Health and Social Services (MoHSS) and ICF International. 2014. *The Namibia Demographic and Health Survey 2013,* https://dhsprogram.com/pubs/pdf/fr298/fr298.pdf
[70] Ruswa N, Mavhunga F, Roscoe JC, Beukes A, Shipiki E, van Gorkom J, Sawadogo S, Agolory S, Menzies H, Tiruneh D, & Makumbi B. (2019) Second nationwide anti-tuberculosis drug resistance survey in Namibia.' *The International Journal of Tuberculosis and Lung Disease*, 858-64, https://pubmed.ncbi.nlm.nih.gov/31439119/
The demographic information recorded in the survey was limited to patients' age, sex, district name, name, date sputum specimens were collected, HIV status and history of previous TB treatment
[71] Ministry of Health and Social Services. (2017). *Third Medium Term Strategic Plan for Tuberculosis and Leprosy 2017/18 – 2021/22*, https://www.namhivsociety.org/media/hivsoc/Pdf/National-Guidelines-for-the-Management-of-Tuberculosis-Fourth-Edition-2019.pdf
[72] Amnesty International consultant interview with female respondent on 5 July 2021 in Gobabis.

4. LEGAL AND POLICY FRAMEWORK

4.1 DOMESTIC LEGISLATION AND POLICY

The Namibian Constitution is the supreme law of the land which guarantees fundamental rights and freedoms.

While there is no clear articulation of the right to health in the Namibian Constitution, Article 95 of the Constitution, affirms the State's duty to "actively promote and maintain the welfare of the people" by, among other things, adopting policies that "raise and maintain an acceptable level of nutrition and standard of living of the Namibian people and to improve public health."[73] To this end, the Namibian Government has adopted a number of policies to ensure that the health needs of its people are met. The National Health Policy Framework (NHPF) 2010-2020 explicitly states: "all Namibians have the right to enjoy good health through access to primary care and referral level services according to need."[74]

The NHPF sets forth the general goals and strategic agenda of the Namibian Ministry of Health and Social Services (MoHSS) for the period 2010-2020.[75] It builds upon/ follows the Namibia Vision 2030, which is the policy framework for Namibia's long-term national development and sets out key targets and identifies broad strategies and milestones for the realization of Namibia's development aspirations by the year 2030.[76] Concerning the right to health, Vision 2030 identifies population health as a central concern and articulates a vision of Namibia in 2030 as "a healthy and food-secured nation in which all preventable, infectious and parasitic diseases are under secure control; people enjoy a high standard of living, good quality life and have access to quality education, health and other vital services."[77]

In addition, the MoHSS launched a revised Patient Charter in 2016 which outlines its commitment to healthcare and delineates the expectations and responsibilities concerning the delivery of safer and more effective health services in Namibia.[78] The Patient Charter forms part of a series of initiatives for the improvement of the quality of healthcare in Namibia and highlights access; dignity and respect; safe and effective services; communication and information; participation and privacy among the fundamental principles of public health services in the country.[79]

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[73] Namibia: The Constitution of the Republic of Namibia [Namibia], 21 March 1990, https://www.refworld.org/docid/47175fd361.html

[74] Ministry of Health and Social Services, National Health Policy Framework 2010-2020, p. 5, http://staging.nationalplanningcycles.org/sites/default/files/planning_cycle_repository/namibia/namibia_policy_framework_2010-2020.pdf

[75] Ministry of Health and Social Services. (2010). *National Health Policy Framework 2010-2020*, http://www.nationalplanningcycles.org/sites/default/files/country_docs/Namibia/namibia_national_health_policy_framework_2010-2020.pdf

[76] Office of the President. (2004). *Namibia Vision 2030: Policy framework for long-term national development*, https://www.namfisa.com.na/wp-content/uploads/2017/10/Vision-2030.pdf

[77] Office of the President. (2004). *Namibia Vision 2030: Policy framework for long-term national development*, https://www.namfisa.com.na/wp-content/uploads/2017/10/Vision-2030.pdf

[78] Ministry of Health and Social Services. (2016) *Patient Charter: 'Your Health Our Concern'*, http://www.mhss.gov.na/documents/119527/120639/Patient+Charter.pdf/e4a6d336-de3d-40ce-b886-c23d5abc8e2c

[79] Ministry of Health and Social Services. (2016) *Patient Charter: 'Your Health Our Concern'* http://www.mhss.gov.na/documents/119527/120639/Patient+Charter.pdf/e4a6d336-de3d-40ce-b886-c23d5abc8e2c

4.2 REGIONAL HUMAN RIGHTS LAW

Namibia is a monist state.[80] Article 144 of the Namibian Constitution incorporates international law into domestic law and states that unless otherwise provided by the Constitution "the general rules of public international law and international agreements binding upon Namibia form part of the law of Namibia." This indicates that all general rules of public international law and international human rights treaties ratified by Namibia are directly applicable to Namibia's domestic legal system.

Namibia is party to several treaties within the African regional human rights system that are relevant for the right to health and other economic, social and cultural rights. These include the African Charter on Human and People's Rights, the African Charter on the Rights and Welfare of the Child, and the Protocol to the African Charter on the Rights of Women.

The African Charter on Human and Peoples' Rights (ACHPR) guarantees the right of every individual to "enjoy the best attainable state of physical and mental health" [81] (Article 6). Consequently, States Parties to the ACHPR are urged to "take the necessary measures to protect the health of their people and ensure that they receive medical attention when they are sick."[82]

In 2010 the African Commission adopted the Guidelines and Principles on Economic, Social and Cultural Rights in Africa which recognise that the right to health is not merely about physical and mental health, but also entails the right of every individual to enjoy the underlying determinants of health without discrimination.[83] States Parties to the ACHPR are urged to take into account these determinants; however, because these Guidelines are not legally binding, they have a weaker basis for domestic mobilisation.

On the other hand, the African Charter on the Rights and Welfare of the Child (ACRWC) delineates a list of rights of the child to which State Parties are obliged to recognise and give effect. Concerning the right to health. Article 14 of the ACRWC states that "every child shall have the right to enjoy the best attainable state of physical mental and spiritual health" according to available resources. [84] Although the ACRWC does not set any minimum standards of quality healthcare, the Charter reiterates States' obligation to take all possible measures to protect the realization of the right to health of the child, with particular emphasis on disadvantaged groups.[85]

Similarly, the Protocol to the African Charter on the Rights of Women in Africa (the Maputo Protocol), reaffirms the right to health and entitles women to the highest attainable standard of health.[86] In this regard, the Maputo Protocol emphasises women's' rights to sexual and reproductive health; calls for the elimination of harmful practices; and urges States Parties to make provisions of adequate, affordable and accessible health services.[87] Given that TB risk is heightened in pregnant women, particular attention must be paid to it as part of States Parties obligations to realize women's sexual and reproductive health.

4.3 INTERNATIONAL HUMAN RIGHTS LAW

In addition to domestic and regional law, the Namibian government is obliged under a range of international human rights laws and standards to respect, protect and fulfil the right to health and other economic, social and cultural rights, which arise from its ratification of a number of treaties. These include the International Covenant on Economic, Social and Cultural Rights (ICESCR), the International Convention on the Elimination of Racial Discrimination (ICERD), the Convention on the Rights of the Child (CRC), and the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW).

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[80] In States with a monist system international law does not need to be translated into national law. The act of ratifying an international treaty immediately incorporates that international law into national law.
[81] Organization of African Unity (OAU), *African Charter on Human and Peoples' Rights ("Banjul Charter")*, 27 June 1981, CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), https://www.refworld.org/docid/3ae6b3630.html (Hereinafter: AU, *African Charter on Human and Peoples' Rights*)
[82] AU, African Charter on Human and Peoples' Rights.
[83] ACHPR Working Group on Economic, Social and Cultural Rights. (2010). *Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter*. (Hereinafter: ACHPR, Principles and Guidelines on the Implementation of ESCR).
[84] Organization of African Unity (OAU), *African Charter on the Rights and Welfare of the Child*, 11 July 1990, CAB/LEG/24.9/49 (1990), https://www.refworld.org/docid/3ae6b38c18.html. (Hereinafter: AU, African Charter on the Rights and Welfare of the Child).
[85] AU, African Charter on the Rights and Welfare of the Child.
[86] African Union, *Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa*, 11 July 2003, https://www.refworld.org/docid/3f4b139d4.html . (Hereinafter: AU, African Women Protocol)
[87] AU, African Women Protocol.

Article 12 (1) of the ICESCR obliges all States Parties to recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. In addition, the ICESCR also stresses the obligation upon States to ensure that the right is exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinions, national or social origin, property, birth or other status.[88] The recognition of the right to health in the ICESCR built upon one of the earliest iterations of health as a fundamental human right in the United Nations' Universal Declaration of Human Rights (UDHR). Article 25 of the UDHR states 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."*

As the Committee on Economic, Social and Cultural Rights (CESCR) – the UN expert body responsible for providing an authoritative interpretation of the ICESCR – has clarified, the right to health, like other rights, imposes three levels of obligations on States Parties: Firstly to *respect* the right to health by refraining from direct violations, such as systemic discrimination within the health system; secondly to *protect* the right to health from interference by third parties, and lastly to *fulfil* the right to health by adopting deliberate measures aimed towards the full realization of the right.[89]

The CESCR also identifies certain core obligations under the right to health which include non-discriminatory access to health facilities, particularly for marginalized groups; the provision of essential drugs; the equitable distribution of all health facilities, goods and services; the adoption of national public health strategies and plans of action with clear benchmarks and deadlines; and the implementation of measures to prevent, treat and control epidemic and endemic diseases.[90]

According to the CESCR, the minimum requirements for the right to health include availability, accessibility, and acceptability. Availability refers to the government's resourcing for adequate standards of public healthcare services and facilities.[91] In terms of accessibility, the CESCR holds that all health facilities, goods and services within States Parties' jurisdiction must be fully accessible to everyone without discrimination.[92] Lastly, acceptability refers to the quality of health services, personnel, equipment and medication, which, according to the CESCR, ought to fit with the highest possible standards.[93] Namibia's core obligations under the ICESCR, therefore, are to avail the resources necessary for adequate standards of public healthcare services and facilities; to provide health services that are accessible and non-discriminatory, and to ensure that public health facilities, personnel, equipment and medication are of the utmost quality.[94]

This obligation was clarified in 1990 when the CESCR, gave greater definition to Article 2(1) of the ICESCR by recognising minimum core obligations. The notion of a minimum core obligation holds that while resources may be too limited for states to fulfil socio-economic rights immediately, states are required to fulfil the minimum essential level of each right. [95] Concerning the right to health, states have an obligation to take steps towards the progressive realization of this right and must demonstrate that they have made every effort to use their maximum available resources, including those that may be available through international co-operation and assistance. The CESCR emphasises that progressive realization applies even in times of severe resources constraints caused by adjustment, economic recession or other factors, and asserts that once a state has taken a step to realize the right to health, it cannot take any retrogressive measures such as removing or reducing the availability of that measure.[96]

Namibia is also party to the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), which echoes the UDHR's stance against discrimination and obliges State parties to ensure that no distinctions based on race, colour, descent, or national or ethnic origin detract from the realization of individuals' fundamental freedoms and human rights.[97] Concerning the right to health, Article 5 of the ICERD requires State Parties to eliminate racial discrimination in the enjoyment of economic, social and cultural rights in general, and "the right to public health, medical care, social security and social services" in particular.[98] ICERD stresses that States must prohibit and eliminate racial discrimination in guaranteeing the

[88] Article2, UN General Assembly, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3, https://www.refworld.org/docid/3ae6b36c0.html *(*Hereinafter: UN, ICESCR*).*
[89] CESCR General Comment 14, para 33.
[90] CESCR General Comment 14, para 43.
[91] CESCR General Comment 14, para 12.
[92] CESCR General Comment 14, para 12.
[93] CESCR General Comment 14, para 12.
[94] UN, ICESCR.
[95] UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 3: The Nature of States Parties' Obligations (Art. 2, Para. 1, of the Covenant)*, 14 December 1990, E/1991/23, https://www.refworld.org/docid/4538838e10.html (Hereinafter: CESCR, General Comment No. 3).
[96] CESCR, General Comment No. 3.
[97] UN General Assembly, *International Convention on the Elimination of All Forms of Racial Discrimination*, 21 December 1965, A/RES/2106, https://www.refworld.org/docid/3b00f1931c.html. (Hereinafter: UN, ICERD)
[98] UN, ICERD.

right of everyone to public health and medical care.[99] Concerning Indigenous peoples, the Committee on the Elimination of Racial Discrimination calls on States Parties to ensure the equal participation of Indigenous peoples in public life, to obtain their informed consent when making decisions on matters related to their wellbeing, and recognise their right to own, develop, and use their communal lands and resources.[100]

Other conventions concerning specific groups to which Namibia is party include the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). Article 24 of the CRC recognises health as a fundamental right for children in particular and sets out several steps for the realization of the right to health.[101] The CRC enjoins State Parties to "strive to ensure that no child is deprived of his or her right of access to such health care services" and emphasises infant mortality, primary healthcare, disease and malnutrition, maternal health, preventative and health education as key areas of consideration in this regard.[102] Similarly, Article 13 of the CEDAW compels States Parties to adopt adequate measures to guarantee non-discriminatory access for women to health and medical care, with particular emphasis on access to sexual and reproductive health.[103]

4.4 RIGHTS OF INDIGENOUS PEOPLES

Because of their history of dispossession and their heightened vulnerability to discrimination and human rights violations, accumulated over generations, international human rights instruments consider the recognition of Indigenous people's rights as a fundamental necessity.

The Constitution of Namibia prohibits discrimination on the grounds of ethnic or tribal affiliation; however, it does not make any specific recognition of the rights of indigenous and tribal people or ethnic minorities. Instead, the Namibian government has preferred to use the term "marginalized communities" when referring to the San (and other Indigenous peoples such as the Otavue and Ovatjimba).

Moreover, the government of Namibia has not enacted any national legislation which specifically protects the rights of Indigenous peoples, nor is Namibia a signatory to any international conventions recognising the rights of Indigenous peoples – most notably the International Labour Organization (ILO) Convention 169, which is the only legally binding international instrument on Indigenous and Tribal peoples' rights.[104]

Nonetheless, Namibia voted in favour of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) in 2007. Although the UNDRIP is not a treaty, it is considered by the United Nations and by indigenous peoples' organizations as an important standard for the recognition, promotion and protection of Indigenous rights.[105] It encourages states to "comply with and effectively implement all their obligations as they apply to Indigenous peoples under international instruments, in particular, those related to human rights."[106] The UNDRIP refers to a collective experience among Indigenous peoples that includes the dispossession of lands, territories and resources, cultural and linguistic distinctiveness, historical and pre-colonial presence in certain territories, and current political and legal marginalization and recognises the individual and collective rights of Indigenous peoples to the full enjoyment of all rights under international human rights law. As such, the Declaration explicitly prohibits discrimination against Indigenous peoples and promotes their right to self-determination and implies that the realization of the right to health entails providing individuals and communities with opportunities to participate in decisions that affect their health and well-being. [107]

[99] UN, ICERD.
[100] United Nations Office of the High Commissioner (2011) United Nations Human Rights Fact Sheet No. 9 Rev. 2, Indigenous Peoples and the United Nations Rights System, New York: 2013: 21,https://www.ohchr.org/documents/publications/fs9rev.2.pdf
[101] UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, p. 3, https://www.refworld.org/docid/3ae6b38f0.html (Hereinafter: UN, CRC).
[102] UN, CRC.
[103] UN General Assembly, *Convention on the Elimination of All Forms of Discrimination Against Women*, 18 December 1979, United Nations, Treaty Series, vol. 1249, p. 13, https://www.refworld.org/docid/3ae6b3970.html
[104] International Labour Organization. (2019). 'Up-to-date Conventions and Protocols not ratified by Namibia', https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:11210:0::NO::P11210_COUNTRY_ID:103008
[105] UN General Assembly, *United Nations Declaration on the Rights of Indigenous Peoples : resolution / adopted by the General Assembly*, 2 October 2007, A/RES/61/295, https://www.refworld.org/docid/471355a82.html (Hereinafter: UN, UNDRIP).
[106] UN, UNDRIP.
[107] UN, UNDRIP.

Additionally, under Art. 22 of ACHPR,[108] San people are entitled the right to development as both the African Commission and African Court have clarified that all the "rights of peoples" in the Charter apply specifically to Indigenous peoples[109].

Indigenous children are also protected by the Committee on the Rights of the Child's General Comment No. 11,[110] which illustrates how the Committee interprets the state's legally binding obligations under the Convention. It outlines that: "States Parties should take the necessary steps to ensure ease of access to health care services for indigenous children. Health services should to the extent possible be community based and planned and administered in co-operation with the peoples concerned. Special consideration should be given to ensure that health care services are culturally sensitive and that information about these is available in indigenous languages".[111]

Local women doing a traditional dance at Dun Pos, one of the remote villages near Tsumkwe. © Health Poverty Action via Big Lottery Fund.

[108] AU, African Charter on Human and Peoples' Rights, Art. 22.
[109] African Commission on Human and Peoples Rights v Kenya (006/2012) [2017] AFCHPR 28; (26 MAY 2017), African Commission on Human and Peoples Rights v Kenya (006/2012) [2017] AfCHPR 28; (26 May 2017) | African Legal Information Institute (africanlii.org)
[110] UN Committee on the Rights of the Child (CRC), *General comment No. 11 (2009): Indigenous children and their rights under the Convention [on the Rights of the Child]*, 12 February 2009, CRC/C/GC/11, https://www.refworld.org/docid/49f6bd922.html
[111] Ibid, Para 51.

5. LEAVING THE SAN BEHIND: ASSESSING THE SAN'S VULNERABILITY TO TB

"My mother is no more because of TB. She died of TB."[112]

In 2009, the Namibian Government's Coordinating Committee for AIDS, TB, and Malaria submitted a funding proposal to the Global Fund to Fight Aids, Malaria and Tuberculosis (Global Fund) in which they stated that "the worst affected by poverty is the population of the San, whose people are among the poorest in the country." The proposal linked the San's socioeconomic status to their TB burden, noting that the San "also constitute a disproportionately large number of TB patients," and that "their low level of education and their semi-nomadic lifestyle, make them a hard-to-reach population, and given their susceptibility for TB, a Most-At-Risk-Population." [113]

In analysing the root causes behind the burden of TB among the San, it is essential to consider the underlying factors that heighten their vulnerability to the disease. Because, along with the well-known risk factors and comorbidities associated with TB, there is increasing awareness of the role of socio-economic factors such as poverty, malnutrition and environmental conditions in increasing the susceptibility to infection and poor treatment outcomes.

5.1 THE SAN'S SOCIOECONOMIC STATUS

5.1.1 EDUCATION

The length and quality of education is crosscutting and significant indicator of future well-being. Education is the primary vehicle by which poor and marginalized people can obtain the means to participate fully in their communities, find employment and lift themselves out of poverty.[114] However, the San remain the least educated group in Namibia. The findings of a 2017 UNICEF report show that almost 60% of San children

[112] Amnesty International interview male San respondent at Gobabis, 8 July 2021.
[113] Namibia Coordinating Committee for AIDS, TB, and Malaria (NaCCATuM) (2009). 'The Global Fund to Fight AIDS, Tuberculosis and Malaria Proposal Forms', https://data.theglobalfund.org/investments/documents/NAM
[114] CESCR, General Comment 13, para 1.

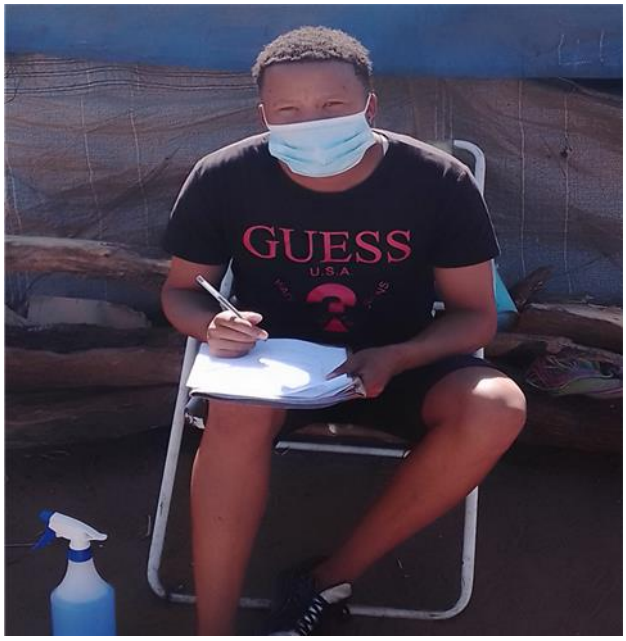
are out-of-school and that, with a 1% completion rate to Grade 12, San learners have the highest school drop-out rates in Namibia.[115] As such, the literacy rate among the San is just 23% compared to a national literacy level of 66%.[116]

Although the number of San children in formal education is growing the San continue to face barriers that prevent them from getting an education. As some studies have noted, right from the first day of schooling, San children have to contend with a myriad of challenges, from culture and language shock, to unprecedented levels of discrimination by both teachers and fellow learners, to bullying, economic barriers and the long distances walked to get to schools.[117]

This lack of education, according to multiple interlocutors, leaves the San with little to no access to channels of empowerment and causes them to remain materially dependent on others for their livelihoods. In quoting the Councillor of Drimiopsis, Ignatius Gariseb:

> **"The Damara and Herero have means to survive. They can have something to eat and drink. There's a way for them. But for the San, a big number are illiterate, unemployed and exploited."[118]**

However, it must be noted that in its recent 7th Periodic Report (2015-2019) on The African Charter on Human and Peoples' Rights and the Second Report Under The Protocol to The African Charter on Human and Peoples' Rights on The Rights of Women in Africa (submitted to the AU in February 2021) the government of Namibia stated that in an effort to improve access to education for marginalized children, the government, in collaboration with non-government organizations has introduced programmes such as the Nyae-Nyae Village School programme in Otjozondjupa Region where the curriculum is community based and the San language is the medium of instruction. The government has decided on Ju/'Hoansi an umbrella San language and stated that school materials such as textbooks are being developed to reflect the culture and context of the communities.[119]



↑ *Young San man in Drimiopsis. 2021. © Amnesty International.*

[115] A Public Expenditure Review of The Basic Education Sector in Namibia Ministry Of Education, Arts and Culture Republic of Namibia October 2017, https://www.unicef.org/esaro/PER-of-Education-in-Nambia-(2017).pdf
[116] African Commission on Human and Peoples' Rights. (2005) Working Group of Experts on Indigenous Populations/Communities. *Report of the African Commission's Working Group of Experts on Indigenous Populations/Communities,* https://www.achpr.org/specialmechanisms/detail?id=10
[117] Rethinking indigenous education. 20 June. Open. Society Initiative for Southern Africa, http://www.osisa.org/printpdf/. Also see: Suzman, J An Introduction to Regional Assessment of the San in Southern Africa (2001) Legal Assistance Centre, Windhoek, Namibia, https://books.google.gm/books/about/Regional_assessment_of_the_status_of_the.html?id=LCFUSAAACAAJ
[118] Hon. Ignatius Gariseb, Amnesty International interview in Drimiopsis, 24 May 2018.
[119] The 7th Periodic Report (2015-2019) on The African Charter On Human And Peoples' Rights And The Second Report Under The Protocol To The African Charter On Human And Peoples' Rights On The Rights Of Women In Africa, https://www.achpr.org/public/Document/file/English/Republic%20of%20Namibia%207th%20Period%20Report(2015-2019)_Eng.pdf

FRANS'S* STORY[120]

"My name is Frans Janman*, 24 years of age, my home language is San I am a student at Komeho Institution. I failed grade 10, it doesn't stop me to move on, I am always optimistic full of courage. I see progress and a brighter future if I work hard. Being creative and active keeps me going. I wanted to be somebody in life, one who looks after elders, because poverty is the bigger obstacle. I am from most disadvantage group, I grow up with my grandma because my mother has the disease but fills my mind with positive thoughts.

My primary school life was partly fine up to Grade 7. When I moved to secondary school at Johannes Dohren High school 2011 to continue Grade 8 to 2015… It really feels the real life. Imagine being in class and you don't even have proper uniform, your shoes are torn and toiletries quite a challenge. I make it through very difficult secondary school life and I couldn't reach the required pass marks in Grade 10. I am willing to further my studies and better my grades if the government or any sponsor can help me. I love music, sports and reading. I am an artist I do hip-hop, kwaito and gospel.

My current status is I am at agricultural school. Tried to be creative hoping to create myself a job and employ my fellow San drop outs. I do understand the pandemic and trying to explain to my elders in our own language for them to understand the danger we are in.

We don't have proper facilities at home and to study from home is quite a challenge for me especially at night. We have to run off to the bush if nature calls and it's not always safe."

5.1.2 OCCUPATION AND INCOME

The vast majority of San communities have been unable to retain and practice their culture and traditional occupations due to historic discrimination and dispossession of their land. Compounded by their marginalization and lack of access to education, this has led to many San being unemployed or forced into low-paying, unsafe and unprotected jobs.

> **"I am looking for work because I am unemployed and needs work. Can the government help me get back on my feet please?"[121] – Male San Respondent, Gobabis**

N≠A JAQNA CONSERVANCY

The majority of !Kung respondents interviewed in the N≠a Jaqna Conservancy are without formal employment. Some respondents in the N≠a Jaqna Conservancy said they were earning money through the Conservancy's tourism-related activities and by selling crafts; however, they expressed that the income generated from these activities is insufficient. For example, a group of women in Kanovlei Village told us that the baskets they make only sell for N$25 (US$1.70) to N$100 (US$6.72),[122] while focus group participants from the Living History Museum (now called the Ju/'Hoansi San Living Museum) in Grasshoek Village expressed that the tourism-related income they receive from the museum is inadequate and irregular, explaining that:

> **There is no real income. The only source [of income] is from people who visit the museum and the amount depends on the visitors who pay N$150 (US$10) per person, which is shared with dancers and 30 actors."[123]**

[120] Amnesty International interview with male San respondent at Gobabis, 6 July 2021.

[121] Amnesty International interview male San respondent at Gobabis on 8 July 2021.
[122] Kanovlei Village, Amnesty International focus group discussion in Tsumkwe West, May 2018.
[123] Grasshoek Museum, Amnesty International focus group discussion in Tsumkwe West, 30 May 2018.

DRIMIOPSIS RESETTLEMENT CAMP

Many members of the Ju/'Hoansi and !Xoo community in the Drimiopsis Resettlement Camp in Omaheke, are also unable to find well-paying jobs because of their lack of education. In May 2018, Joseline, a resident of the Drimiopsis Resettlement Camp, discussed the challenges that San people in her community face when it comes to finding employment, telling Amnesty International that:

> **"It's so difficult for us to get jobs. People from outside are educated, so they get jobs. The government should give us training to be able to do jobs."** [124]

She clarified that for the San, being employed does not necessarily mean being fairly compensated as San people are frequently exploited as cheap labourers by local Herero and Kavango, and paid pittance or sometimes paid in kind with food or alcohol:

> **"We work for teachers they pay us less because we are not educated – only N$200 (US$13.42) to N$400 (US$26,86) for housework a month. Sometimes we are paid in alcohol."** [125]

The negative mental health impact and idleness associated with the lack of employment opportunities and the continued lack of access to their customary livelihoods has also made the San susceptible to alcoholism and drug abuse, which in turn, may contribute to their poor health status and susceptibility to TB. The lack of livelihoods and experiences of poverty, according to interlocutors, causes low self-confidence among the San and is a breeding ground for these negative social issues. In an interview with Amnesty International a representative from USAID said that:

> **"Most San live on the bottom of the social ladder in unacceptable conditions of poverty leading to alcoholism, violence, disease and despair"** [126]

Due to Namibian government lockdowns and restrictions to contain the spread of the coronavirus, the tourism industry, which provides livelihoods for many San, came to a standstill in 2020 – plunging San communities even further into poverty. Reports from the Nyae Nyae and N‡a Jaqna Conservancy Management Committees and from the Kyaramacan Association confirmed that tourism and safari hunting substantially declined in 2020 in the Nyae Nyae and N‡a Jaqna Conservancies and in Bwabwata National Park, and noted that there was also a decline in community craft sales[127].

5.1.3 SOCIAL PROTECTION

In the context of rampant unemployment, the San are highly dependent on social assistance programmes from the state. Namibia's social protection system comprises of multiple social security and social assistance programmes. At present social protection in the form of social grants and food aid (discussed below at *Food and Nutrition*) from the state are essential sources of non-labour income and food security for the San.

Under the National Pension Act,[128] the Ministry of Labour and Social Welfare remits a monthly cash transfer to older persons (60+), called the Basic Social Grant (BSG). At the time of Amnesty International's visit to Namibia, the value of the BSG was N$1,250 (US$83.95) per recipient; however, it has since increased by N$50 (US$3.36).[129] While the grant is small and inadequate, during interviews with San individuals, we found that the BSG contributes substantially to the household income of San grant recipients. Although it is meant for the recipient, in most cases this grant money is used to support the livelihoods of entire families and the immediate community, as Byron, a 75-year-old man from N≠a Jaqna Conservancy explained, saying:

> **"the grant also helps with other relatives if they need it. I can't use it alone I have to share."** [130]

Another important source of household income for the San are child grants. There are four types of child grants administered by the Ministry of Gender Equality and Child Welfare in Namibia. The majority of San respondents interviewed by Amnesty International are eligible to receive the Maintenance Grant of N$250 (US$16.79), which is intended for caregivers who are either single parents or have been identified as

[124] Amnesty International household interview in Drimiopsis, 24 May 2018.
[125] Amnesty International household interview in Drimiopsis, 24 May 2018.
[126] USAID, Amnesty International interview in Windhoek, 19 November 2018.
[127] Reports from the Nyae Nyae and N‡a Jaqna Conservancy Management Committees and from the Kyaramacan Association, August-December, 2020.
[128] Act 10 of 1992.
[129] Matthys, D. (2019) 'Government increases social grants by N$50,' The Economist 15 August 2019, https://economist.com.na/46524/community-and-culture/government-increases-pensions-by-n50/
[130] Amnesty International interview in Tsumkwe West, May 2018.

indigent.[131] Illustrating the importance of child grants for poor San households N!ani, a 25-year-old San woman who lives in a household of six people in the Nyae Nyae Conservancy, reported that no one in her household is employed, and told us that their only source of regular income is the N$500 (US$33.58) they receive in child grants for two children.[132]

Although social grants are an essential source of income for many San people, we discovered numerous obstacles that the San face in accessing these grants, most of which include the delays involved in the grant's application process, the lack of access to government officials required to assist in accessing grants and the lack of official documents such as birth certificates and Identity Documents (IDs) which are essential for obtaining grants.

Focus group participants from Grasshoek Village in the N≠a Jaqna Conservancy told Amnesty International that only two people among the 22 participants receive grants. They claim that although others had applied for child grants months prior, they were yet to receive them:

> **"We applied for child grants in July [2017] for four kids. We [are] still waiting."[133]**

Similarly, only one participant in the focus group discussions in Kanovlei Village receives the BSG. Another respondent told us about the delays they have experienced in applying for the BSG for their mother:

> **"We applied last year April but up to now, nothing. Only one person here receives [a] pension grant."[134]**

The procedure for applying for grants is complicated and often requires the assistance of doctors, social workers and other public officials to complete. The majority of people interviewed had no literacy or numeracy skills. However, we were told that these officials were sometimes reluctant and unwilling to help, and sometimes request money from San applicants, as explained by a focus group participant in the Nyae Nyae Conservancy:

> **"When a person is getting closer to 60, then the doctor asks for N$100 for forms to apply for disability or old-age pension."[135]**

In other, more troubling cases, San people find themselves unable to receive grants because they lack the formal documentation required to apply. According to Human Rights Lawyer Norman Tjombe, the lack of official documentation is a significant barrier to social protection.[136] Those who wish to apply and claim for grants have to submit official identification. This process is a barrier for many San pensioners who do not possess birth certificates nor IDs and are unable to travel long distances to obtain documents such as birth certificates, school reports, death certificates, police reports, and medical records.[137] Confirming the lack of documentation as a real barrier, a focus group participant from Makuri Campsite in the Nyae Nyae Conservancy told Amnesty International:

> **"I applied for children's grant, but I didn't get it because it requires a police report, parents' ID and kids' birth certificate. We don't all have these documents, and it's hard to get them."[138]**

These difficulties extended to Covid-19 relief packages. Due to the economic impact of Covid-19 the government of Namibia provided Namibians with onetime N$750 (+/-US$50) stimulus packages during the first lockdown. However there were reports that certain marginalized groups, including the San, had not benefitted from this assistance due to the fact that they did not have cell phones nor IDs which they needed to register for the package.[139] These claims were confirmed during Amnesty International interviews and discussions conducted in July 2021, where although some respondents in a community discussion in Tsumkwe West claimed to have received the assistance, other community members said:

> **"Not all the people received it as they do not have national documents and some could not receive it because something was wrong with their documents."[140]**

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[131] Ministry of Gender Equality and Child Welfare. (2010) 'The Effectiveness of Child Welfare Grants in Namibia.' Available at: https://www.unicef.org/namibia/MGECW_2010_Child_Grants_Report_Vol_1_summary.pdf
[132] Amnesty International interview in Tsumkwe East, 16 November 2018.
[133] Grasshoek Village, Amnesty International focus group discussion in Tsumkwe West, 30 May 2018.
[134] Kanovlei Village, Amnesty International focus group discussion in Tsumkwe West, 31 May 2018.
[135] Makuri Campsite, Amnesty International focus group discussion in Tsumkwe East, 28 May 2018.
[136] Tjombe, Amnesty International interview in Windhoek, 22 May 2018.
[137] Sister Namibia. (2014). 'Child Welfare Grants in Namibia', https://sisternamibiatest2014.files.wordpress.com/2016/11/child-welfare-grants-in-namibia-3_28.pdf
[138] Makuri Campsite, Amnesty International focus group discussion in Tsumkwe East, 28 May 2018.
[139] Himbas, San left out of N$750 grant, New Era, 12 May, 2020, https://neweralive.na/posts/himbas-san-left-out-of-n750-grant
[140] Amnesty International community discussions in Tsumkwe West on 30 June 2021.

Respondents in community discussions in Tsumkwe East expressed similar difficulties. Many said that they were unable to apply online for the assistance packages due to cell phone network issues in the region. Others said they did not have cell phones.[141]

5.1.4 FOOD AND NUTRITION

There is a corelation between food insecurity, malnutrition and susceptibility to TB. Because undernutrition weakens the immune system, it exacerbates the effects of TB infection, increases the risk of developing active disease, and heightens treatment failure, and mortality.[142]

In interviews with Amnesty International, numerous interlocutors acknowledged that malnutrition and food insecurity are prevalent among the San and are major contributing factors to their high incidence of TB. While there is little empirical evidence about the extent of food insecurity and malnutrition among the San in Namibia, Amnesty International research in San communities found that a significant proportion of the San households consulted have low levels of food consumption. Most stated they had one meal of mealie meal porridge a day while others had two meals comprised of maize meal porridge without any condiments.

For some San individuals and households, the average number of meals is even lower. In the Drimiopsis Resettlement Camp in Omaheke we met Maria, a 53-year-old San woman who lives in a food-insecure household. As a TB patient, it is crucial for Maria to have a healthy balanced diet, however, due to her lack of resources, she reported a disturbingly low level of food consumption, way below the recommended nutrient intake for TB patients. She explained:

> **"Here at home we just take tablets with water. We have no vitamins. Sometimes if we are lucky, we eat maize meal once a day."[143]**

As part of its social protection system the Namibian government, through the Ministry of Poverty Eradication and Social Welfare has several food aid programmes with one, called the San Feeding Programme, explicitly targeted at the San.[144] Under the programme, the Ministry distributes basic food rations to San beneficiaries which include 10 kg of maize meal; 1,600g of tinned fish; 1,200g corned meat; 750ml vegetable oil; 100g pulses; Yeast; 2,5kg of bread flour; 2kg of brown sugar and 750g of laundry soap per household.[145]

While the San Feeding Programme is supposed to distribute food according to a regular monthly schedule, we found that logistical and other failures mean that the food does not reach all San beneficiaries, particularly those in the more remote areas. This is the case in Kanovlei Village in the N≠a Jaqna Conservancy where focus group participants reported to never receiving food rations from the government, stating that:

> **"They don't give us food. We are free to go to the veld to get food, but we only have berries and fruit."[146]**

Elsewhere in G/aqo!oma village in the Nyae Nyae Conservancy, we met with a TB patient who told us that although he does receive food rations from the San Feeding Programme, distribution to his village is irregular. According to him:

> **"The food is not consistent. Last month the food was not available, but this month it is."[147]**

We also found that in some cases where the rations are distributed, it is the quality and quantity of the food that is insufficient. Some respondents claimed not to receive rations of beans and fish, while focus group participants from Makuri Campsite in the Nyae Nyae Conservancy expressed their dissatisfaction with the food rations they receive, telling us that:

> **"There is not enough food. We receive 10kgs of maize meal and one can of fish per family of 6 or 7 every month. Sometimes it is expired food with a bad smell and kids have running stomach after eating the food. We want to know where the food is from. If it is food for human beings or chickens?"[148]**

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[141] Amnesty International interviews with community members in Tsumkwe East 2 July 2021.
[142] Balinda IG, Sugrue DD, Ivers LC. (2019) 'More than malnutrition: a review of the relationship between food insecurity and tuberculosis.' Open forum infectious diseases Vol. 6, No. 4, https://pubmed.ncbi.nlm.nih.gov/30949541/
[143] Amnesty International interview in Drimiopsis, 13 November 2018.
[144] Republic of Namibia, 'Namibia Zero Hunger Newsletter, Vol 1. Issue 2',https://www.npc.gov.na/?wpfb_dl=280
[145] Republic of Namibia, 'Namibia Zero Hunger Newsletter, Vol 1. Issue 2',https://www.npc.gov.na/?wpfb_dl=280
[146] Kanovlei Village, Amnesty International focus group discussion in Tsumkwe West, 31 May 2018.
[147] Amnesty International interview in Tsumkwe East, 16 November 2018.
[148] Makuri Campsite, Amnesty International focus group discussion in Tsumkwe East, 16 November 2018.

In addition to increasing the risk of TB progression, food insecurity and malnutrition, Amnesty International's consultations with San TB patients found that aspects of food insecurity may negatively affect treatment adherence in TB patients. Since the concomitant intake of food and medication counters some of the side-effects of TB treatment, several respondents told us that they stopped taking their medication when they could not access food. In the San Resettlement Camp in Omaheke, for example, we met Simon, a grandfather who shared his concerns about his 16-year-old granddaughter with TB. He explained that although nurses made it clear that his granddaughter needed to take her medication daily, she experiences severe side effects when she takes her medication without food and sometimes has to skip doses. According to him:

> **"The nurses explained you must take every day. She takes every day, but sometimes she skips days. If there's no food, she skips."[149]**

Even during Covid-19 communities in Tsumkwe West said they did not receive food parcels during parts of the pandemic. With a respondent saying: "Even some of the food that the government was providing to the community didn't reach to most of the villages."[150]

Tea is about to be served as the sun sets in Dun Pos. Most cooking is done outside due to lack of ventilation in homes. © Health Poverty Action via Big Lottery Fund.

[149] Amnesty International interview in Drimiopsis, 13 November 2018.
[150] Amnesty International interview in Tsumkwe West, 30 June 2021.

The importance of socio-economic factors dictating successful TB treatment can be showcased by a young woman respondent from Drimiopsis we interviewed in July 2021 who told us that she had been diagnosed with MDR-TB but was struggling to adhere to the treatment schedule due to the fact that her family was food insecure, with a single breadwinner. She also said she was unable to work due to her illness and was extremely concerned about spreading TB to her family as they lived in a very congregate setting: 15 people in a single dwelling (4 adults and 11 children, between 1-16 years of ages). This is Janie's story:

JANIES* STORY[151]

"I am sick for a very long time now (It's years) I cannot tell how many maybe two or three years. My parents get me to the state hospital to see a doctor and I am now on medication for almost 2 months. I have my medication and taking them, but it's not always that we have food to eat. My father, he is the only bread winner, is trying his level best to provide for us here.

Yes I am on treatment. Sometimes the health care takers come to our house they are aware of the situation, but most of the times I have to go to the clinic. I haven't received any parcel from them or nothing.

I went through severe pain every day and night, it's really difficult to sleep at night, during the day I have to sit around in the sun and a little under the shadow [shade] for my body become very weak.

I am looking for some help for I need to eat, drink my medication to help my body to battle with this TB as they (Doctors) said it is a very dangerous and can be easily spread.

At least for my kids to be register with the social grants with Gender, it will bring a change for they will be able to get education and have something to eat because I can't work anymore to provide for the kids."

5.1.5 HOUSING, WATER AND SANITATION

According to the World Health Organization, lack of access to water, unsanitary living conditions and poor environmental hygiene are associated with poor health outcomes and have been identified as risk factors in the incidence of TB.[152]

Global trends have indicated that on average, Indigenous peoples tend to have poorer living conditions and less access to social services, including housing, water and sanitation[153]. While Amnesty's research was unable to unearth specific data on San peoples in Namibia we found that the San are confined to poor living conditions and do, in fact, lack access to adequate housing, water and sanitation which adds to their vulnerability to TB.

HOUSING

Poor housing conditions such as overcrowding, inadequate ventilation, and the presence of mould, smoke and pollutants contribute to poor respiratory health in general and heightens the risk of the exposure to and development of active TB.[154] Due to the San lack access to land and other resources for the most part, we found that they have an increased tendency of living in household units with a high household occupancy, and are likely to live in poor quality dwellings.

Reflecting on some of the barriers faced in managing the high incidence of TB among the San, Dr Hege Mustard from the N/a'an ku sê Lifeline Clinic in Omaheke confirmed that the San's poor dwelling conditions have a direct impact on their vulnerability to TB. He noted that:

[151] Amnesty International interview in Gobabis, 7 July 2021.
[152] World Health Organization, Addressing poverty in TB control
[153] United Nations Housing Rights Programme Report No. 7, Indigenous peoples' right to adequate housing A global overview HS/610 (un.org)
[154] Beggs CB, Noakes CJ, Sleigh PA, Fletcher LA, Siddiqi K. (2003). 'The transmission of tuberculosis in confined spaces: an analytical review of alternative epidemiological models,' in The international journal of tuberculosis and lung disease, 1;7(11):1015-26, https://pubmed.ncbi.nlm.nih.gov/14598959/

"The housing situation is dire. There is no ventilation…Everyone is at risk of TB."[155]

Likewise, Ignatius Gariseb, the Councillor in Drimiopsis, observed that a lot of San people "don't have a place to call home and are sleeping in shacks," adding that in this context "the chance of contracting TB is so high."[156]

During household interviews across Drimiopsis, Tsumkwe East and Tsumkwe West, Amnesty International found that it is common for households occupied by multiple people to live in dwellings of only one or two rooms. For example, in Drimiopsis a two room house with one bedroom had more than 12 people living in it. In the Nyae Nyae Conservancy we visited a household of eight people who lived together in a one-roomed hut. During an interview with the 26-year-old San woman who is a member of this household, she revealed that both her husband and their two-year-old child had died from TB years earlier.[157]

San woman boils water outside her homestead in Drimiopsis. 2018. © Amnesty International.

WATER AND SANITATION

Namibia has an arid climate and experiences frequent droughts.[158] In addition to water scarcity, Namibia also has one of the lowest levels of sanitation coverage in southern Africa, especially in rural regions where there is a rampant lack of toilet facilities and sanitation practices. According to the Demographic and Health Survey in 2013, only 17% of households in rural Namibia have improved sanitation toilet facilities that are not shared, while 74% of households in rural areas lack any toilet facility.[159] The survey also demonstrated that almost 25% of rural households do not have access to an improved source of water, nor do they have a place for washing their hands.[160]

Again, while specific data on San peoples does not exist, their situation appears worse than the general rural population. The poor water and sanitation conditions in Namibia's rural areas have acute implications for the San's health status and vulnerability to TB. To illustrate this, the Chairperson of the N≠a Jaqna Conservancy criticised the Namibian Government for failing to implement projects to develop water and sanitation infrastructure in the rural and remote areas where the San live, explaining to Amnesty International that:

"People were drinking from the same pond as cattle. Government drilled boreholes but has not installed them for four years. The Kavango River is infested with crocodiles. The Minister of agriculture approved plans for pipes to be laid to villages, there is no implementation.[161]

The need to access adequate water supplies and sanitation has become more urgent in the advent of Covid-19. A United Nations Department of Social and Economic Affairs (UNDESA) report recommended that as an

[155] Amnesty International interview in Windhoek, 3 June 2018.
[156] Amnesty International interview in Omaheke, 12 November 2018.
[157] Amnesty International household interview in Tsumkwe East, 16 November 2018
[158] Wallingford, H. R. (2003). 'Handbook for the Assessment of Catchment Water Demand and Use.' Department for International Development, HR Walingford Limited, https://www.samsamwater.com/library/handbook_catchment_water.pdf
[159] Ministry of Health and Social Services, & ICF International. (2013) 'The Namibia demographic and health survey, 2013', https://dhsprogram.com/pubs/pdf/fr298/fr298.pdf
[160] Ministry of Health and Social Services, & ICF International. (2013) 'The Namibia demographic and health survey, 2013', https://dhsprogram.com/pubs/pdf/fr298/fr298.pdf
[161] Amnesty International interview in Tsumkwe West, 17 November 2018.

integral Covid-19 response, countries need to "improve the access and management of clean water and sanitation, particularly for Indigenous peoples living in remote communities, to avoid further spread of the virus. This should include relevant indigenous practices such as watershed management"[162] an issue that a community member in Tsumkwe West noted:

> **"We are also concerned about our water pumps, we are supposed to keep clean, especially our hands but the government is not looking into that. We do not know if we can be able to prevent ourselves from- Covid-19. What we need from the government is to repair our water pumps, so we get water and keep healthy and hope for the best."[163]**

A community sit around the fire while sharing health messages with the local field staff from Health Poverty Action who regularly run informal sessions with the whole community in Dun Pos to ensure they understand their rights © Health Poverty Action via Big Lottery Fund.

[162] United Nations Department of Social and Economic Affairs, Indigenous Peoples & The Covid-19 Pandemic: Considerations, 2020, https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2020/04/DESA-COVID-19-Considerations.pdf
[163] Amnesty International interview in Tsumkwe West, 30 June 2021.

6. BARRIERS TO HEALTHCARE

The Ministry of Health and Social Services, through the National TB and Leprosy Programme (NTLP) is responsible for coordinating the implementation of TB prevention and treatment services in Namibia. These services include diagnostic tests and TB treatment under the Directly Observed Treatment, Short Courses (DOTS) strategy, which was implemented nationwide in 1995. In principle these services have been freely available to all through the country's network of primary healthcare facilities- these include hospitals, health centres, clinics and outreach points.

Despite the various legislative mandates, political commitments and healthcare programmes geared towards ensuring that healthcare is accessible to all people, the MoHSS has, by and large, failed to respond to the needs of the San community in respect of adequate health services. Amnesty International documented significant barriers that hamper San people from accessing healthcare services in the communities in which they live. These barriers are related to the availability and accessibility of healthcare and include long distances to healthcare facilities; user fees; overburdened and under-resourced facilities; discrimination; language barriers; and inadequate and inaccurate information.

6.1 AVAILABILITY

According to the ESCR Committee, the availability of healthcare requires the state to arrange for an adequate number of functioning healthcare facilities, services and goods, as well as skilled healthcare providers who are trained to perform the full range of health services, this is inclusive of TB treatment. Contrary to these minimum requirements, primary healthcare facilities in Namibia's rural areas are notoriously overstretched, as demonstrated in the regional inequality of the ratio of healthcare workers per number of patients. According to the latest Household Income and Expenditure Survey of 2016, more urbanised regions such as Khomas and Orongo have one registered doctor per 3,129 people in contrast to more rural regions such as Omaheke, Zambezi and Ohangwena where the ratio stands at one doctor per 22,144 people.[164] This is far from what the WHO would consider sufficient health care professionals (10 doctors per 10,000),[165] and even significantly lower than the density in Namibia as a whole (5.9 per 10,000). [166]

However, MoHSS National Policy on Community Based Health Care together with the implementation of the Community Health Workers Programme and the health extension activities of NGOs has the potential to mitigate understaffing issues in healthcare facilities by strengthening community-based responses to support health, especially in rural settings. In many cases San communities rely heavily on mobile outreach, which Amnesty International found to be poorly equipped and understaffed.

[164] National Statistics Agency (2016). Namibia Household Income and Expenditure Survey 2015/16, https://catalog.ihsn.org/index.php/catalog/7437
[165] World Health Statistics Overview 2019, https://apps.who.int/iris/bitstream/handle/10665/311696/WHO-DAD-2019.1-eng.pdf?ua=1, at 8.
[166] World Health Statistics Overview 2021, https://apps.who.int/iris/bitstream/handle/10665/342703/9789240027053-eng.pdf, at 102.

6.1.1 RESOURCES

Primary healthcare facilities in Namibia are under-resourced. According to Herbert Jauch, an expert in Namibia's political economy, this issue is most acute in more rural and remote regions of the country, and the facilities available to the San live are especially limited and "even if they have clinics they're not equipped properly."[167]

The lack of material resources in these facilities makes it challenging for communities to be provided with adequate health services as respondents reported that the facilities lack essential equipment and experiences frequent drug-stock outs.

Although the uninterrupted access to essential medicines is nestled in the right to health and is a prerequisite for successful TB treatment, the Chief Director for Special Programmes revealed to Amnesty International that because of funding issues primary healthcare facilities across Namibia have experienced shortages of medication over the last few years.[168]

Multiple respondents from the Nyae Nyae Conservancy including a nurse from Tsumkwe Clinic, reported that Tsumkwe Clinic experiences frequent stock-outs of TB medication. In Bense Kamp Village, for example, a TB patient told us that when she had last gone to the clinic to collect her medication they were out of stock and she had to sleep over at a nearby relative's house in order to collect her medication the next day.[169]

In addition to essential medications, we found that Tsumkwe Clinic also lacks critical resources and equipment, as the senior nurse explained:

> **"We treat about 800 to 1000 patients a month, but we lack the capacity to accommodate them. There is no medication, no suction machine, incubators, ventilators, or ambulance."[170]**

Similarly, respondents also criticised the lack of equipment at the Mangetti Dune Health Centre, which, according to the Chairperson of the N≠a Jaqna Conservancy, has recurring power outages and an ongoing lack of equipment which leads to patients having to be referred to Grootfontein Hospital almost 300Km away

One of the most troubling aspects is the lack of diagnostic resources. These services are to be found at Grootfontein hospital. A number of San respondents from Tsumkwe and Drimiopsis reported long delays between being screened for TB and when they received their results, while some claim to never receiving their results as illustrated in the case of a respondent from the Drimiopsis Resettlement Camp who told Amnesty International:

> **"Everyone was tested but we don't know what happened with the results."[171]**

Focus group participants in Kanovlei Village in the N≠a Jaqna Conservancy told us that a similar experience had a more fatal outcome for one member of their community:

> **"A man was tested at Mangeti Dune [Health Centre] but he didn't get the results. He got very sick and was referred to Grootfontein. He was told he was too sick. I don't think he even had 2 days before he died."[172]**

6.1.2 TRAINED HEALTHCARE PROVIDERS

TB management has been incorporated into the primary healthcare model in accordance with the government's DOTS strategy as well as the NTLP. While the provision of these services at community, district and national level has evidently increased TB patients access to treatment, Amnesty International found that

[167] Amnesty International interview in Windhoek, May 2018.
[168] Amnesty International interview in Windhoek, 21 November 2018.
[169] Amnesty International interview in Tsumkwe East, 16 November 2018.
[170] Amnesty International interview in Tsumkwe East, 16 November 2018.
[171] Amnesty International interview in Drimiopsis, 14 November 2018.
[172] Kanovlei Village, Amnesty International focus group discussion in Tsumkwe West, 31 May 2018.

the healthcare workers stationed at these facilities are not all trained on the guidelines and procedures related to TB care and management. For instance, despite providing care for large volumes of TB and MDR-TB patients, Tsumkwe Clinic does not have a TB specialist and none of the clinic's personnel are trained as TB nurses.[173]

This lack of properly trained healthcare providers undermines the effectiveness of TB services as patients might not get diagnosed or treated in the appropriate way.

NYAE NYAE CONSERVANCY

In May 2018 Amnesty International visited Tsumkwe Clinic in the Nyae Nyae Conservancy. At the time of the visit we were told that the Clinic had recorded 34 cases of drug-susceptible TB and 15 cases of multiple drug resistant TB among the 2000 residents in the Conservancy: a very high rate (equivalent to 2450 per 100,000). While the Conservancy has among the highest burdens of MDR-TB in the country, interviews and observations conducted at Tsumkwe Clinic revealed that the Clinic's capacity to respond to this burden is inadequate, due to severely limited human, financial and material resources.

Tsumkwe Clinic has no admission ward for MDR-TB patients who require second line treatment.[174] Instead, these patients are placed in tents that were donated by NGOs or corporates. In almost all cases, the patients had visitors sometimes staying with the patients as they would have travelled a long way. Under these conditions the spread of the disease is typically harder to contain. Amnesty International interviewed the Senior Nurse at Tsumkwe Clinic who explained that:

> **"It's difficult to contain MDR-TB in hospital tents. There is over-crowding in the tents that are provided, and you find entire families sleeping there. Some of the patients are sharing cigarettes, so infection is continuous... It is constant. There are unknown patients continuously infecting others."[175]**

At the time of the research Tsumkwe Clinic had a staff complement of 8 people including one senior nurse, two assistants, and five health extension workers.[176] There were no doctors stationed at Tsumkwe Clinic, and the Clinic's staff complement was too limited to accommodate all patients from the 2,000 people who live in the 30+ villages throughout Nyae Nyae Conservancy. The lack of staff, especially the lack of doctors, was also raised as a major concern by San respondents, who complained about not receiving some medications because the nurses did not have the authority to prescribe them.[177]

We also found that Tsumkwe Clinic's capacity to carry out contact tracing and follow-up services for TB patients was limited due to a shortage in the number of health extension workers as well as a complete lack of transport. We found that these workers sometimes walked 20 km to attend to patients. The situation was further compounded by a freeze on the employment of trained community health workers due to lack of funds. According a nurse in Tsumkwe Clinic:

> **"We only have five community health care workers when we need about 15 to 20. They cover four villages per person and since they have no transport, they have to find their own way. Outreach transport would be useful."**

It is the responsibility of the regional governor to ensure that the clinic is appropriately staffed and resourced. However, many interviewees said that seeing government officials in Tsumkwe was rare, expressing that "politicians come and go" and make promises that never materialise. To illustrate this point, one interviewee noted that the Minister of Health and Social Services at the time[178], had promised to build a hospital in Tsumkwe years prior, which, to date, has not materialised.

N≠A JAQNA CONSERVANCY

In May 2018 Amnesty International visited the Mangetti Dune Health Centre and learnt that it has a staff complement of one doctor, four nurses, and an unidentified number of health extension workers. It was also equipped with 15 beds for TB patients, 15 beds for general use, a maternity hall and an ambulance.[179]

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[173] Amnesty International interview in Tsumkwe East, 24 May 2018.
[174] Second line drugs are the TB drugs that are used for the treatment of drug resistant TB.
[175] Amnesty International interview in Tsumkwe East, 28 May 2018.
[176] Amnesty International interview in Tsumkwe East, 28 May 2018.
[177] Amnesty International interview in Tsumkwe East, 28 May 2018.
[178] Bernard Haufiku was Minister of Health until 2018, when he was replaced by Kalumbi Shangula.
[179] Amnesty International interview in Mangetti Dune, 29 May 2018.

Our interviews and observations at the Mangetti Dune Health Centre found that the Health Centre is over-burdened and has an inadequate capacity to accommodate the volumes of visiting patients.

We observed that San residents from villages in the N≠a Jaqna Conservancy bear the brunt of this staffing shortage as they experience long queues and lengthy waiting periods before being attended to by healthcare providers at the Mangetti Dune Health Centre. Some interviewees said they spent entire afternoons waiting after having walked all morning to reach the centre. The Chairperson of the Conservancy explained that "people wait for a long time before they are helped," adding that they are made to wait even longer on weekends.[180]

Amnesty International found that the availability of community healthcare in the N≠a Jaqna Conservancy is also limited. In an interview with a former TB health extension worker from Mangetti Dune, we learnt that the community-based TB outreach programmes that began in 2004, with the mandate of conducting screenings, delivering medication, raising awareness, and monitoring TB patients' adherence to treatment, have since been terminated predominantly due to funding challenges.[181]

> **"We carried test equipment in villages, also education programmes. We could also bring in those infected to the clinic every month… But now it's over."[182]**

As such, TB outreach programmes in the N≠a Jaqna Conservancy are now solely conducted by the Mangetti Dune Health Centre which uses its ambulance to deliver medications to TB patients. However, because of its limited resources the Mangetti Dune Health Centre does not have the capacity to deliver medications to all villages in the Conservancy. Focus group participants in Grasshoek Village reported to Amnesty International that "if there's a TB patient they bring the medicine but not regularly."[183]

DRIMIOPSIS RESETTLEMENT CAMP

In May 2018 Amnesty International visited the San Resettlement Camp in Drimiopsis, a village located 40kms north of the regional capital Gobabis in the Omaheke Region. There are no local clinics nor health centres in Drimiopsis; instead, residents rely on Gobabis State Hospital as their main primary healthcare facility. Built in 1991, Gobabis State Hospital is the only public hospital in Omaheke, it has 150 beds and is one of the facilities in the country that provides maternal waiting rooms for pregnant mothers in the third trimester.

In a focus group discussion with residents from the Drimiopsis Resettlement Camp San participants shared their experiences of having to wait in long queues at Gobabis State Hospital. According to the participants these long queues squander the time that patients have to consult with doctors[184]

Gobabis State Hospital has a cohort of approximately 80 health extension workers who are deployed to provide primary health services in Gobabis and surrounding villages. However, in an interview with a health extension worker we learnt that a lack of resources had created a shortage of outreach transport and other equipment which has resulted in the hospital's inability to adequately conduct outreach activities. According to her:

> **"The outreach team from the MoHSS comes once a month. In between visits, TB patients have to go to the hospital collect their medication." [185]**

To supplement the shortfall from the government, NGOs such as CoHeNa and the N/a'an ku sê Lifeline Clinic in Epukiro[186] play a significant role in expanding the provision of TB services in the region, including screening for TB, providing health education, supporting DOTS and monitoring patients' adherence to treatment. However, because of a decrease in funding from the government, international donors and other benefactors, these NGOs' outreach efforts have become increasingly limited.

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[180] Amnesty International interview in Tsumkwe West, 29 May 2018.
[181] Amnesty International interview in Mangetti Dune, 29 May 2018.
[182] Amnesty International interview in Tsumkwe West with former TB health extension worker, 29 May 2018.
[183] Grasshoek Village, Amnesty International interview in Tsumkwe West, 30 May 2018.
[184] Drimiopsis Resettlement Camp, Amnesty International focus group in Drimiopsis, 24 May 2018.
[185] Amnesty International interview in Omaheke, 14 November 2018.
[186] The Lifeline Clinic based in Epukiro provides free primary health care services to more than 3,500 patients every year – through both clinic-based healthcare and our outreach around the region. More than 40% of the patients treated there are children and more than 90% are San.

For example, Robert Tino from CoHeNa informed us that the programme only has two outreach vehicles provided by the government. Tino explained that since the programme is transport based, these two vehicles were inadequate and do not allow CoHeNa personnel to service all villages in Omaheke,

Following CoHeNa's funding constraints, the TB outreach efforts are amongst the programmes which have become increasingly irregular and unpredictable. The San in the Resettlement Camp in Drimiopsis – with their much higher TB rates – bear the brunt of this as it forces TB patients to have to rely solely on the services provided to them at the fixed healthcare facilities in Gobabis.

6.2 ACCESSIBILITY

According to the ESCR Committee, accessibility requires that healthcare should be accessible to all individuals without discrimination and without the procedural, practical and social barriers that might interfere with access. This means that healthcare facilities must be in physical reach and economically affordable for all. Cultural appropriateness and health information in home languages is also an integral aspect of health accessibility, as this ensures information accessibility and non-discrimination in the provision of healthcare.

6.2.1 DISTANCES TO HEALTHCARE FACILITIES

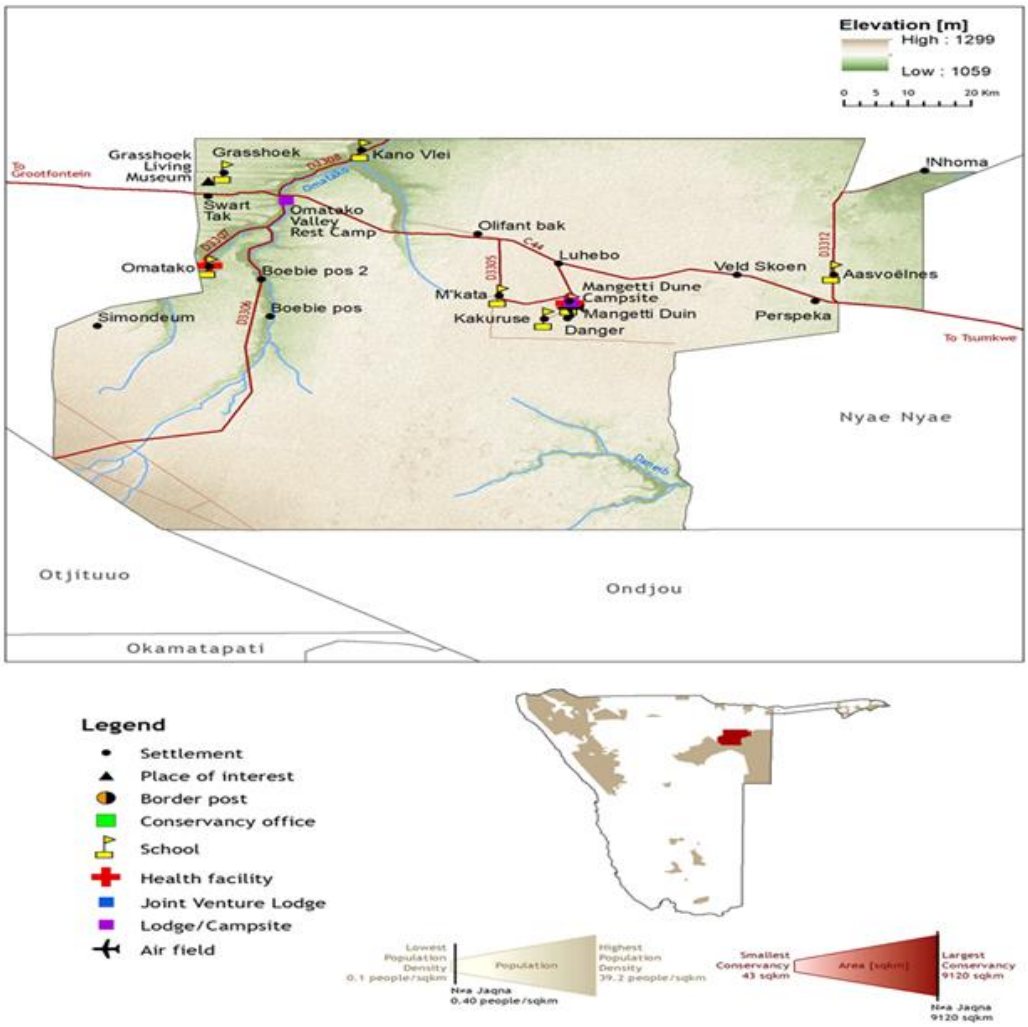

Figure 1. Source: Namibian Association of CBNRM Support Organisations

"When you're far flung [away] it's a problem, there's no access to healthcare."

Zwakie Chakwanda, former community health worker in Otjiwango

Amnesty International met with the founder of the Ana-djeh San Trust and member of the San Council who told us that one of the most significant barriers to health for San people in Namibia is their inability to access healthcare services because their "geographic location is far" and "there are not many health workers in San communities." [187] Researchers travelled around several villages and were able to confirm this claim. The lack of affordable transportation is a barrier that limits San communities' access to healthcare in general and limits the ability of those infected with TB to access medications and sustain their treatment. As a result, a disproportionate number of them have MDR-TB. Specialists informed us that treatment for MDR-TB could last up to two years and a number of San people found it hard to stay in hospitals that long or travel to health care centres as they were too far.

The literature on healthcare in Namibia demonstrates that distance-related barriers are more prevalent in rural areas than urban areas in the country, presumably because the population is more sparse and lives further away from road and transport networks that connect these communities to urban areas.

Although most rural Namibians face similar distance-related barriers to accessing healthcare facilities, other barriers relevant to the San, such as their lack of financial means for reliable transportation, exacerbate their inability to access healthcare facilities.

NYAE NYAE CONSERVANCY

"I want to finish treatment. But due to transport, I do not."

TB infected respondent, G/aqo!oma, Nyae Nyae Conservancy

The main primary healthcare facilities for residents of the Nyae Nyae Conservancy are Tsumkwe Clinic which is located in Tsumkwe Town at the centre of the Conservancy, and the Mangetti Dune Health Centre which is located 80 kms north-west. During the focus group discussions and individual interviews that Amnesty International conducted in villages within the Nyae Nyae Conservancy, San respondents ranked the distances to healthcare facilities as one of the leading barriers to healthcare that they experience.

There is only one vehicle that is used as an ambulance to transport patients from the Nyae Nyae Conservancy to the Mangetti Dune Health Centre. Although this vehicle is meant to be used during emergencies, Amnesty International found it is not fitted with any ambulance equipment. The vehicle covered over 200 villages and clinic personnel had to make calls on whether they could pick up a patient in distress depending on whether or not the car had broken down.[188] In some cases, San patients in the Nyae Nyae Conservancy said that the ambulance operates at a fee and they were asked to pay N$100 (US$6.72) to hire the car or pay for fuel.[189]

Further, in areas where there is no public transport service people are forced to walk or hike to the clinic in Tsumkwe Town. In G/aqo!oma Village focus group participants reported to having to walk a considerable distance to reach Tsumkwe clinic, explaining to us that:

> **"If a person is sick, you walk or hitchhike to Tsumkwe. It takes 4 hours to walk, 6 hours if you're with a sick person."[190]**

[187] Amnesty International interviews in Windhoek, 20 May 2018.
[188] Amnesty International interviews in Tsumkwe East, 28 May 2018.
[189] G/aqo!oma village, Amnesty International focus group discussion in Tsumkwe East, 28 May 2018.
[190] Grasshoek, Amnesty International focus group discussion in Tsumkwe West, 30 May 2018.

In addition to being physically strenuous, walking long distances to Tsumkwe can prove to be unsafe. Researchers encountered elephants walking on the route used by villagers. Focus group participants from the Living History Museum in Grasshoek referred to the threat of being attacked by wild animals:

> **"It is not safe. There are leopards, wild dogs, elephants, lions. One man and his wife left their food to run from an elephant. These attacks are common. Two women, two boys, and one old man were killed by an elephant 2009."**[191]

N≠A JAQNA CONSERVANCY

> **"Most complaints are related to the distance to the health centre."**
>
> Sarah Zungu, Chairperson of the N≠a Jaqna Conservancy

Amnesty International met with the chairperson of the N≠a Jaqna Conservancy who explained that San communities in villages throughout Conservancy have limited access to healthcare facilities and that most of the health-related grievances she receives as Chairperson are related to the long distances to Mangetti Dune Health Centre.[192]

While the Mangetti Dune Health Centre has an ambulance and a cohort of health extension workers, San people who reside in the N≠a Jaqna Conservancy have poor access to these services as respondents interviewed by Amnesty International reported that they are either ignored or not taken seriously when they request an ambulance to Mangetti Dune.

With no access to ambulance services, San communities in the N≠a Jaqna Conservancy have to hitch-hike or walk to reach the Mangetti Dune Health Centre, with focus group participants in Kanovlei Village located in the Northern region of the N≠a Jaqna Conservancy stating:

> **"We start walking at 5 am. It takes 1 to 2 hours to walk to the hiking spot 3kms away, or we walk to Mangetti, which is 15kms away."**[193]

Since the discontinuation of community outreach programmes in the N≠a Jaqna Conservancy the only way that residents of the Conservancy can collect their medications and access other services is by travelling directly to Mangetti Dune, which, especially for those living in the most far-flung villages, can be hours away. According to Pieter Steenkamp from the NGO Health Poverty Action, San patients' adherence to TB treatment is linked to their ability to access their treatment. Steenkamp believes that because the San in Tsumkwe lack the means to travel to healthcare facilities and have no access to community outreach in their villages, TB patients default on their treatment[194] which escalates the spread of TB and MDR-TB in these communities."[195]

DRIMIOPSIS RESETTLEMENT CAMP

Drimiopsis has many former farmworkers who also lack access to healthcare services due to the fact that the regional hospital in Gobabis is located 40kms away. During focus group discussions with the San residents of the Drimiopsis Resettlement Camp, participants described how they have to hike, ask for lifts or pay for taxis to travel to Gobabis Hospital, telling us:

> **"If you have money you can pay for a taxi. Sometimes you take a sick person to the main road and wait for lifts."**[196]

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[191] Grasshoek, Amnesty International focus group discussion in Tsumkwe West, 30 May 2018.
[192] Amnesty International interviews in Tsumkwe West, 29 May 2018.
[193] Kanovlei Village, Amnesty International focus group discussion in Tsumkwe West, 31 May 2018.
[194] Default from treatment for is defined as interruption of TB treatment for two or more consecutive months. This is a problem that is reported by TB control programmes globally that is associated with high mortality and drug resistance and is a major driver of the TB epidemic.
[195] Amnesty International interview in Omaheke, 13 November 2018.
[196] Drimiopsis Resettlement Camp, Amnesty International focus group discussion in Drimiopsis, 24 May 2018.

They reported that the average cost of taxis to Gobabis is N$80 (US$5,37) for a return trip, and mentioned that this is not always an option as they are denied lifts because "people are afraid [of people with TB]."[197] Ambulance services are also not always an appropriate option for the San in the Drimiopsis Resettlement Camp, as respondents reported that the ambulance service from Gobabis hospital is unreliable and sometimes requires patients to pay:

> **"We get help from the Gobabis ambulance now and then but sometimes they charge N$100 (US$6,72)… When we call for the ambulance, we are asked if we have N$100 (US$6.72) and we often tell them we have even when we don't… If we don't have money, we give the last N$10 (US$0.67) we have."[198]**

A 19-year-old TB patient in the Drimiopsis Resettlement Camp said since the community health workers from Gobabis State Hospital do not visit his village on a regular basis, the only way he can receive his treatment is by collecting it directly from the hospital, once a month. In order to do so he needs money to hike to the hospital, explaining to us that:

> **"Sometimes when I have no money for the hike to the hospital I get it on credit. Sometimes when my mother gets paid from piece jobs I pay back."[199]**

The infrequent visits of mobile clinics and community health workers means that TB patients in the Drimiopsis Resettlement Camp and surrounding villages still have to travel to Gobabis State Hospital to collect their medication. This has had adverse implications on TB patients' adherence to their treatment as a former health extension worker explained that San patients "generally adhere when they start with the treatment" and that "the only problem is when they have to collect because of transport."[200]

6.2.2 AFFORDABILITY

> **"The majority of the San don't have jobs or other means of livelihood, so transport is a challenge and paying hospital fees is a challenge."**
>
> Frans Douseb, San Activist and Fixer for the Focus Group Discussion in Drimiopsis.[201]

A growing number of African governments have introduced out-of-pocket user fees in the public healthcare sector as a means to raise revenue and increase financing for health services.[202] The Namibian Ministry of Health and Social Services regulates user fees according to a classification system, where patients are charged depending on the level of the health facility they visit and the treatment they receive.[203] These user fees can entail a combination of pharmaceutical and medical supply costs, as well as charges for consultation, admission, accommodation and amenities.[204]

Although the government has recognised that user fees can cause households to bear a significant financial burden, the country's recent economic decline has led to it continuing to rely on user-fees as a source of healthcare funding.[205] The San, as the rural population with the most limited economic resources in the

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[197] Drimiopsis Resettlement Camp, Amnesty International focus group discussion in Drimiopsis, 24 May 2018.
[198] Drimiopsis Resettlement Camp, Amnesty International focus group discussion in Drimiopsis, 24 May 2018.
[199] Amnesty International interview in Omaheke, 13 November 2013.
[200] Amnesty International interview in Omaheke, 14 November 2018.
[201] Amnesty International interviews in Omaheke, 23 May 2018.
[202] Gilson, L. (1997). 'The lessons of user fee experience in Africa.' *Health policy and planning.* 1;12(3):273-85, https://pubmed.ncbi.nlm.nih.gov/10176263/
[203] Ministry of Health and Social Services. (2010). Regulations relating to classification of state hospitals, admission of patients to state hospitals, and fees payable by Patient receiving treatment in, at or from state hospital: Hospitals and health facilities act, 1994, https://gazettes.africa/gazettes/na-government-gazette-dated-2010-04-15-no-4459
[204] Ministry of Health and Social Services. (2010). Regulations relating to classification of state hospitals, admission of patients to state hospitals, and fees payable by Patient receiving treatment in, at or from state hospital: Hospitals and health facilities act, 1994, https://gazettes.africa/gazettes/na-government-gazette-dated-2010-04-15-no-4459
[205] Ministry of Health and Social Services. (2017). Namibia 2014/15 Health Accounts Report, https://www.afro.who.int/sites/default/files/2017-10/Namibia%20Health%20Accounts%20Report%202014-2015%20-%20final%202017.09.07.pdf
Nashuuta, L. & Kapembwa, J. (2018) 'Namibia, Zambia strive for universal health coverage,' *The Southern Times* 20 April 2018, https://southerntimesafrica.com/site/news/namibia-zambia-strive-for-universal-health-coverage

country, are therefore affected most by this financial burden which serves as another barrier in their ability to access healthcare.

Patients are charged N$8 (US$0.54) during weekdays and N$20 (US$1.34) on the weekends when they visit Tsumkwe Clinic. The clinic, which is located in Tsumkwe Centre, is the only clinic in the District and is the primary healthcare facility for villages in the Nyae Nyae Conservancy. During research missions Amnesty International learned that in some cases when San patients are unable to pay they are denied treatment, with a focus group participant in Makuri Campsite reporting that "if we say we don't have money they say go back home."[206]

In the N≠a Jaqna Conservancy, San community members reported similar experiences. Describing their encounters at the Mangetti Dune Health Centre. Focus group participants from Kanovlei Village explained how their ability to pay for health services determines the level of care they receive. According to the respondents, nurses request fees ranging from N$4 (US$0.27) on weekdays to N$20 (US$1.34) on weekends and have made it clear to some patients that "*if you cannot pay you will not get medicine."*[207] Other respondents told us that when patients do not pay for treatment at the Mangetti Dune Health Centre, nurses refuse to give them full portions of their medication, stating that:

> **"They only pour half of our medicine in the bottle because we don't pay."[208]**

In Drimiopsis, San patients are charged between N$8 (US$0.54) and N$20 (US$1.34) at Gobabis State Hospital. During focus group discussions respondents from the Drimiopsis Resettlement Camp reported that because they lack the financial means to afford the hospital's user fees, they are also poorly treated by the healthcare providers who work there. An elderly respondent from the focus group discussion was reminded of an occasion when they were taunted by a healthcare provider at Gobabis Hospital, for this reason, relaying to us that:

> **"At the hospital, a Herero lady said 'It's finished now, you old people must also start paying...' I felt humiliated"[209]**

States have an obligation to ensure that health facilities, goods and services are affordable for all. Although it is a common form of healthcare financing, the use of user-fees in the healthcare facilities that San people rely on compromises the quality of care that San patients receive at these facilities. User-fees may also compromise the San's utilisation of healthcare facilities and, in turn, weaken their health. The abolition of user fees for San people, therefore, is a crucial step in making healthcare more affordable to them, thereby reducing at least one of the barriers to healthcare that the San face and ensuring that they have improved access to quality care.

6.2.3 DISCRIMINATION

> **"We don't feel well treated"**
>
> Focus Group Participants, Grasshoek Village

The protection against discrimination is provided for in the Constitution of Namibia, the ICCPR the ICESCR, and the ACHPR[210] Despite these protections, discrimination against the San has continued in Namibia and is entrenched at institutional and community level.

The most pervasive form of discrimination against the San is the perpetuation of negative stereotypes and prejudices that perceive San peoples as being undeveloped or uncivilised and shun their identities, cultures and ways of life. The United Nations Special Rapporteur on the Rights of Indigenous Peoples explains that healthcare providers' discriminatory attitudes towards Indigenous peoples "figure into the poor health of

[206] Makuri Campsite, Amnesty International focus group discussion in Tsumkwe East, 28 May 2018.
[207] Kanovlei Village, Amnesty International focus group discussion in Tsumkwe East, 31 May 2018.
[208] Kanovlei Village, Amnesty International focus group discussion in Tsumkwe East, 31 May 2018.
[209] Drimiopsis Resettlement Camp, Amnesty International focus group discussion in Drimiopsis, 24 May 2018.
[210] Namibia: The Constitution of the Republic of Namibia [Namibia], 21 March 1990, https://www.refworld.org/docid/47175fd361.html, ICCPR, ICESCR, ACHPR.

members of their communities."[211] Indeed, Amnesty International found that allegations of discrimination and prejudicial attitudes by healthcare providers ranked as one of the leading barriers to healthcare reported to us. Some of the discriminatory behaviour that respondents cited repeatedly includes verbal harassment, the use of derogatory epithets, and showing preferential treatment to patients of other ethnic groups. Other respondents reported that healthcare providers' discriminatory attitudes sometimes escalated to physical assault and the denial of treatment and medications, in contravention of professional ethics.

In the San Resettlement Camp in Drimiopsis for example, the majority of focus group participants reported that when they queue at Gobabis State Hospital, they are ignored by healthcare providers who allow patients from other ethnic groups to jump the queue ahead of them.[212] For the same reason there was widespread perception among the participants that in many cases the only medication that San patients are given at the Hospital is paracetamol (Panado), unlike non-San patients – it is prescribed to the San for any and all ailments.[213]

Reflecting on a shared experience, respondents in the Nyae Nyae Conservancy reported to have been subjected to poor quality of care, harassment and even physical assault at Tsumkwe Clinic and Mangetti Dune Health Centre. Focus group participants from Makuri Campsite claimed that:

> **"Healthcare providers always treat the San people bad and treat non-San people better."[214]**

Some respondents attributed this mistreatment to their physical appearance and described instances where they were sent back home by healthcare workers for being "dirty," and others described the callous treatment healthcare workers subjected them to, with a TB patient from Makuri village telling us that she was initially denied treatment because nurses in Tsumkwe Clinic assumed that she was lying about her symptoms for financial gain:

> **"I told them that my back is paining, they told me I want to get a TB grant that's why I was complaining about chest and back."[215]**

The entrenched discrimination and prejudicial attitudes have created a reluctance and lack of confidence among the San in demanding their right to health, and is a major factor that contributes to their poor health status and, by extension, their burden of TB. According to a nurse in Tsumkwe Clinic, San patients are "afraid to come to the clinic" and "don't stand up for themselves" when they are mistreated. [216]

This mistreatment has appeared to continue even in relation to treatment for Covid-19. A 2020 report by ARISA on the impact of Covid-19 on Indigenous persons in Southern Africa states that the San continue to face stigma and discrimination from staff and other nonindigenous citizens when accessing health facilities during the pandemic. The report noted that the Women's Leadership Centre in Namibia had informed ARISA that they had received reports of San patients denied entry into clinics or hospitals because they did not have masks, infringing on their right to access adequate health care.[217]

"There are no translators at the clinics, it is a huge problem. We can't be understood"

Chief Tsamkxao of the Ju/'Hoansi San

Language barriers present as an additional form of discrimination affecting the San.The quotation above is derived from a focus group discussion with the community of the G/aqo!oma village in the Nyae Nyae Conservancy. During the discussion, Chief Tsamkxao and other respondents identified language barriers as a major obstacle to accessing their right to healthcare.

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[211] UN General Assembly. (2013). 'Report of the Special Rapporteur on the rights of indigenous peoples, James Anaya', https://www.business-humanrights.org/en/latest-news/report-of-the-special-rapporteur-on-the-rights-of-indigenous-peoples-james-anaya/
[212] Drimiopsis Resettlement Camp, Amnesty International focus group discussion in Drimiopsis, 24 May 2018.
[213] Drimiopsis Resettlement Camp, Amnesty International focus group discussion in Drimiopsis, 24 May 2018.
[214] Makuri Campsite, Amnesty International focus group discussion in Tsumkwe East, 28 May 2018.
[215] Makuri Campsite, Amnesty International focus group discussion in Tsumkwe East, 28 May 2018.
[216] Gideon, Amnesty International interview in Tsumkwe East, 28 May 2018.
[217] Advancing Rights in Southern Africa (ARISA) Special Report 2020 COVID-19 & the Rights of Indigenous Peoples in Southern Africa, Freedom House and USAID, https://freedomhouse.org/report/special-report/2020/covid-19-rights-indigenous-peoples-southern-africa

International guidelines highlight that patients need to be given clear information on their TB diagnosis including how they should administer their medication, how often they should collect their medication, when their next sputum sample is needed and how to avoid transmission at home and in the community.[218] Accordingly, the MoHSS' Third Medium Term Strategic Plan for Tuberculosis and Leprosy asserts that it is the responsibility of all health facilities in the country to provide "patient education and treatment support, ensuring that each patient understands all aspects of treatment."[219] However, interviewees claimed that there were few San-speaking healthcare providers in clinics and hospitals, and services are mostly provided in administrative and majority ethnic group languages such as English, Afrikaans, Herero, Damara and Tswana.[220]

Many San respondents told us that they are unable to speak or understand these languages and thus lack confidence in their ability to communicate with their healthcare providers. We also found that the MoHSS has not made provision for translators or any other interpretation services at healthcare facilities which exacerbates San peoples' challenges in communicating their ailments and understanding treatment instructions.

To make matters worse, respondents explained that because there are no translators at the clinic it is the patients' individual responsibility to communicate their health problems in a way that nurses understood. For instance, a Ju/'Hoansi traditional authority remarked in an interview that:

> **"Nurses talk to us in English and also give facial expressions that let you know that they don't want to help. When they speak to me in English I try to speak in English mixed with Afrikaans."[221]**

Often, many patients rely on unqualified interpreters, such as family members, cleaners or nearby strangers, to assist with translations. San patients' use of unqualified interpretation can create complications, as the senior councillor of the N≠a Jaqna Conservancy explained to us that unqualified interpreters "don't understand medical terms," which can lead to San patients getting the wrong medications or doses. Focus group respondents from the Drimiopsis Resettlement Camp reported that because of the language barriers they encounter with the majority of the healthcare providers at Gobabis State Hospital, San patients are unable to express themselves, and as result have been misdiagnosed and, in some cases, given the wrong medications.[222]

In addition to causing negative clinical outcomes, poor communication caused by language barriers also hinders meaningful relationships between San patients and their healthcare providers and may contribute to the San's reluctance to consult healthcare facilities out of fear of discrimination. Reflecting on San people's attitudes towards healthcare, San activist Kileni Fernando explained to Amnesty International that the San generally "don't go to healthcare centres because of language barriers and fear of stigma."[223]

Language barriers have continued to be a challenge during Covid-19. Although some communities said they had received information pamphlets[224] in their language this was not the case in all villages. Various respondents in community discussions said they did not receive information about the pandemic in San language with one respondent saying:

> **"No, we only hear people speaking about Covid-19 in other languages not San"[225]**

6.2.4 LACK OF INTERCULTURAL HEALTH PROGRAMMING

Culture affects all aspects of human life, from housing, food, and the relationship with land and the natural environment, to health care, and education. According to the ESCR Committee, upholding economic and social rights requires that the environment in which these rights are enjoyed be consistent with those cultural practices that individuals and communities wish to retain. Accessible healthcare, therefore, requires that all

[218] World Health Organization (2019). 'WHO Guidelines on tuberculosis infection prevention and control 2019 Update', https://apps.who.int/iris/bitstream/handle/10665/311259/9789241550512-eng.pdf
[219] Ministry of Health and Social Services. 'Third Medium Term Strategic Plan for Tuberculosis and Leprosy', https://www.who.int/hiv/pub/guidelines/namibia_tb.pdf
[220] G/aqo!oma Village, Amnesty International focus group discussion in Tsumkwe East, 28 May 2018.
[221] G/aqo!oma Village, Amnesty International focus group discussion in Tsumkwe East, 28 May 2018.
[222] Drimiopsis Resettlement Camp, Amnesty International focus group discussion in Omaheke, 24 May 2018.
[223] Amnesty International interview in Windhoek, 20 May 2018.
[224] Amnesty International interview in Tsumkwe East 3 July 2021, Amnesty interview in Tsumkwe West, 30 June 2021.
[225] Amnesty International interview in Gobabis on 6 July 2021.

healthcare be respectful of the culture of all peoples, as well as sensitive to gender, age, disability, sexual diversity and life-cycle requirements.

Cultural acceptability is a particularly important issue in health programming among historically marginalized populations who have been discriminated against based on their ethnic and cultural identities because it is based on equal recognition of and mutual respect for traditional health values alongside biomedical health systems. It also gives Indigenous people the opportunity to ensure complementarity between traditional and biomedical treatments.[226] Despite this Namibia's public health network is based solely on Western biomedical health systems and fails to pay equal recognition to indigenous health values.[227]

Throughout their history, the San have developed traditional healthcare practices that correlate with their natural environment and resources. These practices include the consumption of a number of medicinal plants that allow the San to maintain their health as well as treat and prevent disease. In general, we found that San respondents believe in the efficacy of their traditional health practices, but also accept Western biomedical approaches as a reliable form of healthcare, particularly in the case of diseases such as TB. Some respondents in Tsumkwe who have sought treatment within the public health system have not neglected their traditional healthcare practices and continue to consume traditional medicinal plants, demonstrating that for the San, synergy between biomedical and traditional healthcare is common practice.

However, respondents expressed concerns about the lack of cultural understanding among the personnel in healthcare facilities and admitted to being hesitant about consulting healthcare providers regarding their traditional ethnomedical values and practices. According to the doctor at the Mangetti Dune Health Centre, younger San patients are even more hesitant in this regard, as she explained that:

> **"Traditional medicines are used mainly by women and they are very good. But the young ones are ashamed."[228]**

In an interview with Amnesty International Uhuru Dempers of the Lutheran Church of Namibia, maintained that the San's lack of access to culturally appropriate medications contributes to their disproportionately poor health status. Dempers explained:

> **"The health system has not understood Indigenous San communities and their indigenous knowledge system. The Indigenous San have no connection to modern medicine due to language barriers and poor education, and they also have limited access to traditional medicine." [229]**

6.2.5 ACCESS TO INFORMATION

> **"Government fails to educate on rights to health in rural areas"**
>
> Kileni Ferando, San activist

Studies have indicated that patients who have poor knowledge related to their diseases report sub-optimal treatment adherence and poorer clinical outcomes.[230] Although the MoHSS affirmed the importance of TB awareness and education in the NTLP,[231] it has failed to ensure San peoples' ability to seek, receive, and

[226] Moshabela, M & Zuma, T. (2016). Bridging the gap between biomedical and traditional health practitioners in South Africa. South African Health Review. 2016. 83, https://www.researchgate.net/publication/312888821_Bridging_the_gap_between_biomedical_and_traditional_health_practitioners_in_South_Africa/citation/download

[227] Meincke, M. (2018). Public health and traditional medicine in Namibia. *Nordic Journal of African Studies, 27*, 24-24, https://www.africabib.org/htp.php?RID=A00005190 Also see: Chinsembu, K.C. Model and experiences of initiating collaboration with traditional healers in validation of ethnomedicines for HIV/AIDS in Namibia. *J Ethnobiology Ethnomedicine* 5, 30 (2009). https://doi.org/10.1186/1746-4269-5-30

[228] Amnesty International interview in Grootfontein, 29 May 2018.

[229] Amnesty International interview in Windhoek, 20 May 2018.

[230] The World Health Organization The End TB Strategy Global strategy and targets for tuberculosis prevention, care and control after 2015, https://www.who.int/tb/strategy/End_TB_Strategy.pdf

[231] National Tuberculosis and Leprosy Programme

obtain TB-related information, and as a result the San lack knowledge of their vulnerability to TB, as well as the health services available to them and the scope of their right to obtain them.

When it comes to TB in particular, the TB programme officer in Gobabis State Hospital confirmed that San communities are "knowledge poor" as their general illiteracy "affects how they receive the information."[232] As a result, the San continue to lack the knowledge of their health risks and how to respond to them.

In Grasshoek Village, focus group participants reported that while they had previously received TB-related information from the MoHSS' promotional activities, these have since stopped. Comparatively, multiple San residents from the Resettlement Camp in Drimiopsis claimed that the MoHSS had irregularly implemented any TB-related promotional activities in their community, and that as a result they lack knowledge, awareness of TB. Discussing the misinformation on TB in her community, Maria said:

> **"Not much has been explained. We were told TB comes from dirt, when your house is dirty. That was a long time ago, maybe last year."[233]**

With the advent of Covid-19, we found that although the government had made attempts to inform the communities about Covid-19 they had not done so in a way that communities fully understood. As a result, these communities were living in fear because they felt that they were especially vulnerable as they knew that Covid-19 affected the lungs as does TB. Respondents in Tsumkwe East told Amnesty International in July 2021:

> **"The only problem is that the TB patients are afraid since TB is affecting the lungs and Covid-19 is also affecting the lungs. The government must take more measures for the TB and Covid-19 situation in Tsumkwe East area."[234]**

It appears these fears were well founded. Below is the testimonial of a San woman who had TB previously and caught Covid-19. She also believed that her previous TB infection had exacerbated her Covid-19 symptoms. This is her story:

JOANNA'S* STORY[235]

"I know coronavirus and TB very well. I was diagnosed with TB before many years back, I can feel that very same pain which I have before when I was told by the doctors that I have TB. I can't really mention the years now because I never went to school. When I was told the first time that I must test for Covid-19 and quarantine for 14 days, I got very sad, my tears were running by themselves. There was nothing that I can do at that moment and I got admitted at the state hospital at a very scary apartment. I was alone and can hear how voice went through my mind that has made my first night very uncomfortable. The doctor I meet before was also rude and she really makes me think that I am going to die.

After few days while waiting on my results, I get transferred to a guesthouse which was used to quarantine Covid-19 results awaited persons. It was good at this place and after almost two weeks the results comes out negative and I got discharged and went home. The second time I got sick it was almost two month back, I am telling you I was in fire. By arrival at the hospital I was send straight to an isolation room which a Covid-19 patient was in and the person was moved to high care room, because she was seriously sick.

My experience was terrible I got a lot of pain, one month can't taste any food, my nose gets blocked and it was a lot I couldn't mention all now. I spend some time in hospital and get transferred to Covid-19 patient hospital where no one can visit you or you cannot have any contact with anyone. There again I spend someday and get transferred to a hotel where Covid-19 patient where isolated. I stay strong and keep moving around and I always keep myself busy when I got strength I make sure that I mountain it, make sure that I eat enough for my body to fight back. If I was a writer I could've mention every pain by name one by one."

[232] Taderera, Amnesty International interview in Grootfontein, 13 November 2018.
[233] Stander, Amnesty International interview in Drimiopsis, 13 November 2018.
[234] Amnesty International interview in Tsumkwe East, 1 July 2021.
[235] Amnesty International interview in Drimiopsis, 7 July 2021.

Additionally, many respondents also stated that the Government had not consulted San communities on their specific needs during Covid-19, expressing that their communal living conditions made it difficult to observe Covid-19 protocols. A community member Tsumkwe West lamented:

> **"We have heard about Covid-19 and we are living in fear at the moment, because we do not know how to protect ourselves and when Covid-19 might hit us. We stay so close together and preventing this disease is a mystery and we are just hoping that we don't get cases here"[236]**

A female respondent in Gobabis echoed similar sentiments about limited information about Covid-19 throughout the pandemic, stating:

> **"About Coronavirus I need someone to explain me the safety ways. If you listen to the Radio every morning you heard about how Covid-19 is killing our loved ones. In this short time many have passed on"[237]**

Lack of appropriate information about Covid-19 the San community has also caused a decrease in health seeking behaviour in relation to TB. Community discussions in Tsumkwe East revealed that some TB patients were reluctant to go to clinics for check-ups and medication because they were afraid to contract Covid-19 at the clinics. With one respondent saying:

"People were just afraid to go to the clinic because they believe Covid-19 is at the clinic and are afraid to be infected"[238]

San woman, in Berpos, prepares for her long journey to the to the medical clinic for TB treatment. 2019. © Amnesty International.

[236] Amnesty International interview in Tsumkwe West, 30 June 2021.
[237] Amnesty International interview in Gobabis, 5 July 2021.
[238] Amnesty International interview in Tsumkwe East, 02 July 2021.

7. GOVERNMENT FAILURE TO FULFIL THE RIGHT TO HEALTH

7.1 FAILURE TO MOBILISE SUFFICIENT AND SUSTAINABLE FINANCING FOR THE RIGHT TO HEALTH

Namibians are living through one of the worst recorded economic recessions since independence. Prompted by a number of domestic and external factors, the Namibian economy has been in decline since 2016, and the country now faces the reality of austerity measures which threaten over two decades of human development, poverty eradication and human rights protection across the country.

7.1.1 NAMIBIA'S ECONOMIC CRISIS AND AUSTERITY

As a commodity-driven economy, Namibia is heavily dependent on the extraction and utilisation of its vast natural resources. Although Namibia has generated positive economic growth since independence, this growth remains largely dependent on the minerals sector and is therefore vulnerable to fluctuations in world commodity prices.[239] This vulnerability has been brought into focus over the last few years, when the performance of the primary sector declined as a result of prevailing drought conditions, low commodity prices and contractions in diamond mining, which negatively contributed on the performance of the economy.[240] Meanwhile, declining Southern Africa Customs Union (SACU) returns, and the adverse global economic environment at the time also had a negative impact on Namibia's other sources of revenue. [241]As a result, the Namibian economy experienced a downturn.

In 2016 the Namibian government, introduced austerity measures to address the budget deficit and national debt, and announced that they would achieve this primarily through reductions in state spending. At the time politicians presented austerity measures as a necessary reaction to the country's economic climate, with President Geingob announcing that: "Our problem of poverty has been exacerbated by the fact that we

[239] Kostiainen, A. (2018). 'Taxation and Legitimacy: Namibia in Focus' University of Helsinki, https://helda.helsinki.fi/bitstream/handle/10138/236857/Kostiainen_Kehitysmaatutkimus.pdf?sequence=2&isAllowed=y
[240] Bank of Namibia. (2016). Economic Outlook Update, November 2016, https://www.bon.com.na/getattachment/fe09194a-7090-4cad-9522-9f69ca902f9d/Economic-Outlook-November-2016.aspx
[241] World Bank. (2018). Namibia, http://pubdocs.worldbank.org/en/161551492188166591/mpo-nam.pdf and International Monetary Fund. (2018) IMF Country Report No. 18/56: Namibia, https://www.imf.org/~/media/Files/Publications/CR/2018/cr1856.ashx

are currently in the midst of financial headwinds, which have necessitated that certain austerity measures be put in place."[242]

In the 2016 Budget Statement speech delivered to Parliament to set out the government's spending priorities for the year, Namibia's Minister of Finance Calle Schlettwein, revealed that Namibia's expenditure for 2016 was cut by more than N$2 billion (approx. US$135 million) from the previous year.[243]

Since Schlettwein's landmark announcement in 2016, the Namibian government continues to pursue austerity by reducing public expenditure. Although austerity measures are not violations of human rights per se, their negative economic impacts can affect the enjoyment of human rights, both directly and indirectly. Because austerity measures lead to cuts in social spending they undermine the resources that states need to fulfil basic human rights. Austerity also raises questions around the protection of economic, social and cultural rights, particularly with regard to the principles of minimum core obligations, non-retrogression, progressive realization, and non-discrimination.[244]

Despite the fact that the government spends an increasing share of general expenditure on health, the value of this investment is lower in nominal terms.[245] Higher-than-inflation cost increases in human resources and medical products, as well as growing health needs in the context of decreased financing from donors, households and private companies means that the actual budget for healthcare per person is shrinking.[246]

Herbert Jauch, stated that austerity resulted in significant budget cuts to critical public service ministries such as health and education:

> **"Combined education and health sectors were allocated 40% of the budget, but since the 2016 structural adjustment programs their allocation declined to 35% - 20% for health and 15% for education."[247]**

As a result of these budget cuts MoHSS and non-governmental partners have been forced to scale-down their provision of healthcare and other social services. The mandate of the Directorate of Special Programmes in the Ministry of Health and Social Services exists to reduce the impact of HIV/AIDS, TB and Malaria on the Namibian population. Yet, budget cuts have weakened the department's ability to deliver on its mandate. Anne Marie Nitschke, Chief Director of the Directorate explained to Amnesty International that austerity has led to a decline in allocations for human, financial and physical resources to the directorate:

> **"75% to 80% of the budget for Special Programmes is from the government. In fact, most programmes, up to 80% are funded by the government, but over last five to seven years austerity has hit. We have been experiencing difficulties, particularly around a lack of healthcare workers, and medication. We now rely on donors to support programmes and ensure sustainability."[248]**

This underfunding has been noted by the WHO which stated in its *2020 Global Tuberculosis Report* that Namibia required an additional US$43 million for TB care and further noted that amongst upper-middle-income countries evaluated in the report, Namibia is providing amongst the lowest proportion of domestic funding, stating "The proportion in Namibia has fallen owing to austerity measures that have been put in place during a recession."[249]

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[242] Republic of Namibia (21 March 2017), Statement by H.E. President Hage G. Geingob, President of the Republic of Namibia on the Occasion of the 27th Independence Day Celebration, Kavango-East, https://www.un.int/namibia/sites/www.un.int/files/Namibia/Documents/speech_by_h.e_geingob_27th_independence_day.pdf
[243] Republic of Namibia, (25 February 2016), Budget Statement Presented by Calle Schlettwein, MP Minister of Finance (Hereinafter: Namibia, Budget Statement 2016), https://www.parliament.na/phocadownload/media/2016/budgetstatement2016.pdf
[244] Center for Economic and Social Rights (2018). *Assessing Austerity: Monitoring the Human Rights Impacts of Fiscal Consolidation,* 2018, https://www.cesr.org/assessing-austerity-monitoring-human-rights-impacts-fiscal-consolidation and United Nations Human Rights Office of the High Commissioner. (2014) Report on austerity measures and economic and social rights, https://www.ohchr.org/documents/issues/development/rightscrisis/e-2013-82_en.pdf
[245] World Bank. (2019). *Namibia Health Sector Public Expenditure Review*, https://openknowledge.worldbank.org/handle/10986/32111
[246] World Bank. (2019). *Namibia Health Sector Public Expenditure Review*, https://openknowledge.worldbank.org/handle/10986/32111
[247] Jauch, Amnesty International interviews in Windhoek, 20 May 2018.
[248] Amnesty International interviews in Windhoek, 21 November 2018.
[249] The World Health Organization GLOBAL TUBERCULOSIS REPORT 2020, https://apps.who.int/iris/bitstream/handle/10665/336069/9789240013131-eng.pdf

7.2 DONOR FLIGHT AND ITS IMPACT ON RIGHT TO HEALTH

While government spending is the main source of Namibia's public healthcare financing, donor funding contributes a considerable proportion of Namibia's health sector financing. Since independence the Ministry of Health and Social Services' has relied heavily on donor funding for some its key programmes, most notably the national HIV/AIDS response which in 2017 received 36% of its funding from donors.[250] Donors are also a crucial source of funding for non-governmental organizations and faith-based organizations.[251] These donors include a range of various international technical and funding agencies such as the WHO, Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), USAID, Centers for Disease Control and Prevention, International Training and Education Center for Health (I-TECH), GLC Group, The Union and The Leprosy Mission International.[252]

Upon transitioning to upper-middle income status Namibia began to receive decreased levels of ODI, a phenomenon referred to as 'donor flight'. The national TB programme is highly dependent on external funding for TB control, as such, a number of community-based TB projects run by non-governmental organizations have been forced to scale down their operations or shut down completely.

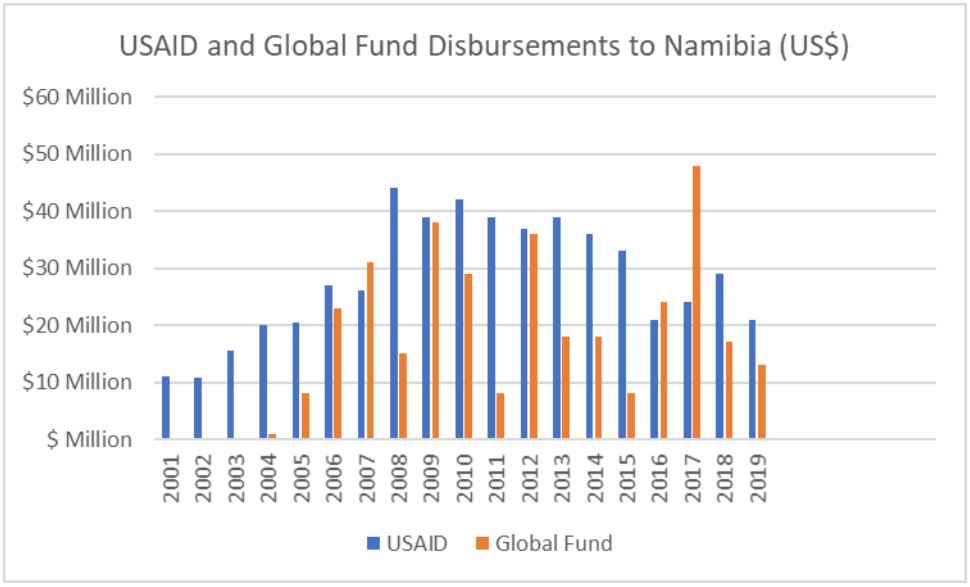

Figure 2
Source: OECD. (2019). Aid (ODA) disbursements to countries and regions

Figure 2 tracks the trends in disbursements to Namibia from two of the Ministry of Health and Social Services' key donor partners, USAID and the Global Fund. The graph shows that aid disbursements from both donor sources are largely on the decline, with the USAID demonstrating a declining trend in funding and the Global Fund responsible for a large decline from above US$30 million in 2009, to below US$20 million 2019.

The Global Fund is a crucial partner for Namibia's national TB programme. From 2014 to 2018 Global Fund funding to Namibia amounted to US$120 million – US$7 million of which was channeled specifically to the TB programme and had a specific focus on community health interventions in Namibia's rural and remote regions.[253] However, this funding has been decreasing progressively over the past few years, and in 2018 the Global Fund announced that funding to Namibia would decrease further to only US$29 million for 2018 to

[250] Health Policy Project. (2016) Health Financing Profile: Namibia, May 2016, https://www.healthpolicyproject.com/pubs/7887/Namibia_HFP.pdf
[251] Ministry of Health and Social Services. (2016) National Tuberculosis and Leprosy Programme Annual Report 2015-2016, https://ntlp.go.tz/site/assets/files/1046/annual_report.pdf
[252] Ministry of Health and Social Services. (2016) National Tuberculosis and Leprosy Programme Annual Report 2015-2016, https://ntlp.go.tz/site/assets/files/1046/annual_report.pdf
[253] Amnesty International interview in Namibia, 19 November 2018.

2020, representing an almost 70% decline, with the Ministry of Health and NGO, NANCISU as the only two principle recipients of funding. Interviews suggested that part of the reason there had been a decline was the government's inability to absorb the funds.

Pieter Steenkamp, a representative from Health Poverty Action, another NGO providing community based healthcare activities in Tsumkwe told us that the lack of continuity from the Global Fund had reduced the organizations capacity to provide outreach services.[254] According to Steenkamp, the ministry of health has been unable to fill the Global Fund's gap and provide Health Poverty Action with the necessary support, which has had unfavourable outcomes on the spread of TB as well as the defaulting of treatment for San patients in Tsumkwe resulting in an increase in MDR-TB cases.[255]

Xao and her son in the back of a donkey ambulance on their way to the health facility for check-ups. © Health Poverty Action via Big Lottery Fund.

7.3 LACK OF CONSULTATION AND PARTICIPATION – FAILURE TO PROTECT THE RIGHT TO FREE, PRIOR AND INFORMED CONSENT

The Namibian government has introduced a number of targeted interventions for the development of the San population. However, there are challenges in assessing the institutional capacity, of relevant ministries, and development partners to develop and implement appropriate interventions for the San. Among these are the fact that authorities had adopted a top-down approach to San peoples' development which reflects a failure to respect their rights to self-determination and Free, Prior and Informed Consent.

Over the past few decades, the international development community has increasingly recognized the need to tailor development interventions to local contexts, to allow Indigenous peoples to protect their cultural identities, determine their own development pace and paths, and preserve social and cultural diversity.[256] This recognition has prompted new conceptual frameworks, such as 'ethno-development' and 'development with identity', which stress the importance of finding socially and culturally appropriate development alternatives for Indigenous peoples that allow them to be in control of their own development.[257]

[254] Amnesty International interview in Omaheke, 13 November 2018.
[255] Amnesty International interview in Omaheke, 13 November 2018.
[256] UN, UNDRIP.
[257] UN, UNDRIP.

Contrary these perspectives, the government's approach to the development of the San population has focused on assimilation and integrating San peoples into the mainstream society and economy in accordance with the national development policy, Vision 2030. This is evidenced in the creation of the San Development Programme in 2005 which, in 2009, was transformed into the Division of San Development within the Office of the Prime Minister. The stated intention of these programmes is to "ensure that the marginalized people in Namibia are fully integrated in the mainstream economy of our society" in the areas of lands and resettlement, education, economic development and food security.[258] Operating with a budget that by 2018 was cut down to N$60 million (approx. US$4 million), the San Development Programme collaborates with ministries such Health and Social Services; Education; and Gender Equality and Child Welfare to improve the livelihoods of San peoples through activities such as purchasing land for resettlement; purchasing coffins for burials; providing university scholarships for San children who have completed high school; and running feeding schemes for San communities in resettlement farms and conservancies.[259]

In addition, the government established the Ministry of Poverty Eradication and Social Welfare (MPESW) in 2015. With the mandate to lead and coordinate national efforts to eradicate poverty, the MPESW is responsible for initiating, implementing and supporting poverty-eradication programmes in Namibia. Towards this end, some of the programmes that the Ministry is responsible for include the old age and disability grant, the implementation of food bank programmes and other special programmes.

Although the creation of the Division of San Development and the Ministry of Poverty Eradication and Social Welfare has the potential to improve the lives of the San, the implementation thereof has been a major challenge. For example, there is no specific policy document geared towards the eradication of poverty for San and other Indigenous peoples.[260] In an interview with Amnesty International the Minister of Poverty Eradication and Social Welfare Bishop Zephania Kameeta, said "there was nothing except the name" when the ministry was established in 2015, and there continues to be little support from parliament to address the systemic challenges faced by the San.[261] The poor coordination between government ministries, lack of political representation for the San in parliament and poor implementation of intervention programs and policies for the San are as a result of lack of meaningful consultation and participation.

The dehumanisation of the San and determination to integrate them into different ways of life was evident to researchers when an officer in the Division of the Marginalised in the Vice President's Office noted that the intention of the Office was to "integrate them into the mainstream" and convincing them that "this *is how you live."*[262] In explaining the failure of government intervention programs aimed at improving the living conditions of the San he cited the reluctance of the San to abandon their customary way of life as the main cause, claiming that:

> **"…these people do not want to be part of the mainstream economy."[263]**

These comments are representative of the authorities' general approach to the development of its San population which have tended to focus on assimilationist methods that assume that the San's way of life needs to change. The language used by the office in the Vice President's office when referring to the San also demonstrates the entrenched institutional discrimination against the San based on prejudicial assumptions that the San's way of life is primitive and needs to change.

As laid out in the United National Declaration on the Rights of Indigenous People (UNDRIP), the principle of Free, Prior and Informed Consent recognises Indigenous peoples' prior rights and authority over their lands and resources and requires that third parties respect this and enter into an equal and respectful relationships with them based on the principle of informed consent. Moreover, free, prior and informed consent requires "processes that allow and support meaningful choices by Indigenous peoples about their development path."[264] Even though instruments such as the UNDRIP and the African Charter obliged Namibia to respect, protect and fulfil the rights to self-determination and the principle of free, prior and informed consent, the government has failed in this regard.

Dr Lucy Edwards-Jauch, the Head of the Sociology Department at the University of Namibia, pointed out that the San lack political representation and are therefore unable to challenge the institutionalised discrimination

[258] Office of the Prime Minister (undated). 'San Development Programmes', http://www.opm.gov.na/san-development-programmes
[259] Amnesty International interview in Windhoek, 22 May 2018.
[260] Norman Tjombe, Amnesty International Interview in Windhoek, 22 May 2018.
[261] Amnesty international Interview in Windhoek, 22 May 2018.
[262] Amnesty international Interview in Windhoek, 22 May 2018.
[263] Amnesty international Interview in Windhoek, 22 May 2018.
[264] UN Sub-Commission on the Promotion and Protection of Human Rights 2004, https://www.ohchr.org/en/hrbodies/sc/pages/subcommission.aspx, p.5.

and marginalization that they face at local, regional and national government levels.[265] She added that their lack of representation in parliament has also led to development policies and laws in the country being passed on their behalf without any meaningful consultation.[266]

Accordingly, the San respondents that Amnesty International interviewed in Tsumkwe and Drimiopsis all reported unsatisfactory degrees of consultation with authorities. For example, a leader from the San resettlement camp in Drimiopsis who is also a member of multiple local committees, expressed to us that the inputs made by her and other community members are largely ignored by the government, remarking that: "Sometimes they come and consult but when they go, they do what they want. We are not familiar with Office of the Marginalized. We just hear the name"[267]

Another one of the camp's residents criticized the slow pace of consultations and accused the government of prejudicial behaviour, telling us:

> **"We want the government to work directly with us. We lose hope as consultations take long. We feel belittled, we feel rejected."[268]**

When it does take place, the governments engagement with San communities is largely about informing them about the projects that it will be undertaking instead of consulting with communities about what their needs are. Chief Bobo in Tsumkwe East reported that **"we are voiceless"** during their engagements with government. Similarly, the Chairperson of the N≠a Jaqna Conservancy in Tsumkwe West told Amnesty International that community development projects undertaken by the state in the conservancy have a top-down approach where community members are told of the projects to be carried out without their consent. This has an impact on how they are able to enjoy services such as health care. To illustrate this point she told us that the government has been attempting to impose a livestock project within the conservancy instead of building a solar plant for electricity generation that would provide electricity and water pumping for local community and prevent power cuts at the local primary health care facility.[269]

As part of the treatment regime, TB patients require good nutrition, however focus group respondents from the Drimiopsis Resettlement Camp reported to us that the local food garden project which would have provided food to feed TB patients was unsuccessful after the local municipality failed to consult the community and charged water pumping and usage at the community food garden when majority of households could not afford to pay the user-fee, leading to the food garden project being halted.[270]

[265] Amnesty International interviews in Windhoek, 22 May 2018.
[266] Amnesty International interviews in Windhoek, 22 May 2018.
[267] Amnesty International interviews in Drimiopsis, 25 May 2018.
[268] Amnesty International interviews in Drimiopsis, 25 May 2018.
[269] Amnesty International interview in Tsumkwe West, 17 November 2018.
[270] Drimiopsis Resettlement Camp, Amnesty International focus group discussion in Omaheke, 24 May 2018.

8. CONCLUSION AND RECOMMENDATIONS

Dating back to their initial displacement by Bantu-speaking migrants in the pre-colonial era and their subjugation under the successive colonial administrations in the 20th century, the San have been lived through a long history of displacement, mistreatment and marginalization. With historically poor access to the country's political and economic institutions, the San's marginalization has produced conditions of landlessness, poverty and dependency, which have created substantial gaps in their development.

This report has found that these conditions have increased the San's vulnerability to TB and MDR-TB in particular.

In Namibia, the MoHSS, through the NTLP, is responsible for coordinating the implementation of TB prevention and treatment services. Although, in principle these services are freely available to all through the country's network of primary healthcare facilities which include hospitals, health centres, clinics and outreach points, the MoHSS has, by and large, failed to respond to the health needs of the San community.

This report has found that there are significant barriers related to the availability and accessibility of healthcare for the San generally, and to TB treatment specifically, thereby increasing their susceptibility to TB and MDR-TB. The San face barriers in relation to distances from healthcare facilities, access to information, language and often receive low quality care, because although protection against discrimination is afforded in the Constitution, discrimination against San peoples still occurs in Namibia through an entrenched social stigma associated with San identity, and these patterns of discrimination play out in the healthcare system.

In this context this report argues that the burden of TB and MDR-TB in particular among the San not only constitutes a public health crisis, but that it is a cause and consequence of the San's marginalization. It also highlights the failure of the Namibian government to address the structural barriers and social determinants that contribute to the San's burden of TB.

And, although it is noted that the government has introduced a few targeted interventions for the development of the San peoples, in assessing the institutional capacity of the government, relevant ministries, and development partners to develop and implement appropriate interventions for the San population this report has identified several challenges. Among these are the adoption of a top-down approach to San peoples' development which reflects a failure to respect their rights to self-determination as well as Free, Prior and Informed Consent.

In holding Namibia to its obligations under national and international law Amnesty International recommends:

TO GOVERNMENT OF NAMIBIA

- Immediately ratify ILO Convention 169 on Indigenous and Tribal Peoples and ensure that its provisions are incorporated into the Constitution and other domestic legislation and policy.
- Strengthen the capacity of the Office of the Ombudsman to carry out its mandate, particularly regarding the development of the Draft White Paper on the Rights of Indigenous Peoples in

Namibia, ensuring it is developed in consultation with San communities, and ensure compliance with its recommendations.

- Establish sensitization programmes for civil servants, and healthcare workers in particular, on issues relating to anti-discrimination, particularly concerning San peoples and increase the representation of San peoples in governance structures at national, regional and local level.
- Take immediate steps to ensure the development of primary healthcare facilities in line with the core minimum human rights standards, including building the capacity of healthcare providers to provide TB-related services, equipping health facilities with the necessary medicines and equipment, and ensuring appropriate transportation to primary healthcare facilities, particularly in rural and remote areas to ensure accessibility.
- Develop targeted programmes aimed at the health needs of San peoples including TB and MDR-TB initiatives by expanding and strengthening community-based health care services and ensuring that mobile clinics and health extension workers visit San communities regularly and remove healthcare user-fees for San peoples to ensure affordable access to healthcare.
- Improve access to culturally appropriate information in San communities about their health rights and the grievances processes available to them. Undertake capacity development initiatives to train and capacitate persons with knowledge of local San languages to work as interpreters at healthcare facilities and undertake capacity development initiatives train and capacitate San peoples with the skills to be healthcare providers.
- Ensure that San women have access to appropriate health care services related to pregnancy and family planning.
- In cooperation with San activists/ community leaders undertake research and gather updated, disaggregated data on the health status and needs of San peoples; in particular on the prevalence and trends of TB and MDR-TB.
- Develop poverty alleviation, economic empowerment and social protection strategies accessible to the San, in consultation with San communities including the addressing of current barriers that limit the coverage of the Basic Social Grant and Child Grant, particularly by supporting San people with their particular difficulties with documentation requirements.
- Administer food aid to San peoples regularly and monitor the quality and quantity of the foodstuffs distributed and immediately ensure consistent water supply and sanitation facilities in San communities; This should include setting up initiatives that help with food security to help them deal with the weakness TB treatment imposes on hungry patients.
- Ensure the Covid-19 response to San's persons is context specific by ensuring information, testing and treatment is accessible to them as well as prioritizing them for Covid-19 vaccinations.
- Seek the support of the International Community where the Government of Namibia is unable to provide funding and other support for necessary healthcare for San people.

TO THE INTERNATIONAL DONOR COMMUNITY

- Continue and intensify support to promote the welfare of San communities in Namibia and provide necessary financial and technical support to the Namibian government to extend appropriate healthcare services to San communities.

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CONTACT US

info@amnesty.org

+44 (0)20 7413 5500

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TUBERCULOSIS AND THE INDIGENOUS SAN PEOPLES OF NAMIBIA

This report examines the human rights impact of the prevalence of Tuberculosis (TB) and Multi-drug-resistant tuberculosis (MDR-TB) among the Indigenous San peoples of Namibia. Combining political economy and root-cause methodology, the report explores the socioeconomic factors that make the San vulnerable to TB and limit their access to adequate health services.

The San’s insurmountable resilience and cultural strength has enabled them to overcome many colonial obstacles, for the most part they have managed to retain their languages, traditions and religious beliefs. However, due to historically poor access to political and economic institutions, Namibia’s San population has been reduced to an underclass which lacks land rights, experiences high levels of unemployment, social marginalization and poverty. This report has found that these factors have led to poor health outcomes in their communities owing to ongoing discrimination in service provision, geographic isolation and language barriers. The result has been that the San suffer disproportionately high rates of TB and MDR-TB in comparison to the general population.

Amnesty International argues that the burden of TB among the San not only constitutes a public health crisis, but that it is also a cause and consequence of the San’s marginalization. The report also highlights the failure of the Namibian government to address the structural barriers and social determinants that contribute to the San’s burden of TB which constitutes as a failure to fulfil its national, regional and international human rights obligations, especially in relation to the right to health.

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