

Chapter 17

Health

By Richard Kiaka



17.1 Introduction

Article 25 of the **Universal Declaration of Human Rights** (UDHR) recognises the right to health as an element of an adequate standard of living (United Nations General Assembly (UNGA) 1948). A number of other international human rights instruments similarly enshrine the right to health. Of these, the **International Covenant on Economic, Social and Cultural Rights** (ICESCR) of 1966 (UNGA 1966) is understood to be the most expressive and comprehensive (UN Office of the High Commission for Human Rights (OHCHR) and World Health Organization (WHO) 2008: 3). The key concepts relating to the right to health are broad; they include, inter alia, access to basic health services, safe drinking water, sanitation and adequate nutrition (OHCHR and WHO 2008: 3-4).

Since 1978, various international platforms have recognised the emphasis on access to primary healthcare as a key element in achieving “a level of health that permits individuals to live an economically and socially productive life” (OHCHR and WHO 2008: 8).¹ Healthcare also forms a central plank of the UN Millennium Development Goals (MDGs). In the context of the African continent, Article 16 of the **African (Banjul) Charter on Human and Peoples’ Rights** obligates state parties to take the necessary measures to promote and protect the health of their citizens (Organisation of African Unity (OAU) 1982: 5).²

The **United Nations Declaration on the Rights of Indigenous Peoples** (UNDRIP) (UNGA 2008) and **International Labour Organization (ILO) Convention No. 169** (ILO 1989) (to which Namibia is not a signatory) are two of the main international instruments that address the health of indigenous peoples. Article 25 of ILO Convention No. 169 obligates States party to ensure that adequate health services are made available to indigenous peoples, taking into consideration their economic, social, cultural and geographic conditions, and UNDRIP emphasises the need to promote the general principles of health, including sanitation, nutrition and health facilities (UNGA 2008: 9). However, despite the widespread recognition of these rights, both internationally and regionally, the African Commission on Human and Peoples’ Rights (ACHPR) and the International Work Group for Indigenous Affairs (IWGIA), in reporting on their mission to Namibia in 2005 (ACHPR and IWGIA 2008), conveyed that indigenous people in this country, as in so many other places in the world, were still facing poor health conditions. The conditions observed were characterised by inadequate nutrition, limited access to safe drinking water, difficult access to health facilities and increasing rates of HIV infection (ACHPR and IWGIA 2008: 118). There is very little doubt that significant numbers of indigenous communities globally are living in deplorable socio-economic conditions. There is a relationship between poverty, marginalisation and poor health (Gibson 2010: 54). As also noted in many study reports, including that of the ACHPR and IWGIA (2008: 118-119) and this San Study report (see Chapter 14 on livelihoods, food security and poverty), the general poverty, poor nutrition and unhygienic conditions found in most indigenous communities render them susceptible to preventable diseases and health risks and hazards. Additionally, many indigenous communities, especially in Africa, live in very remote areas which have only minimal healthcare and social service coverage, thus treatment of various ailments is frequently constrained by geographical location (IWGIA 2006: 204).

Namibia is a party/signatory to all of the international treaties cited above, except for ILO Convention No. 169. As such, it has an obligation to ensure that all of its citizens – including its marginalised indigenous peoples – have access to adequate healthcare coverage, including quality services. The **Constitution of the Republic of Namibia** asserts the following in Chapter 11 on “Principles of State Policy”:

“Article 95: Promotion of the Welfare of the People

The state shall actively promote and maintain the welfare of the people by adopting, *inter alia*, policies aimed at ... (j) consistent planning to raise and maintain an acceptable level of nutrition and standard of living of the Namibian people and to improve public health; ... ”

The overarching emphasis of public healthcare in Namibia is on the provision of primary healthcare through the establishment of accessible and affordable health clinics. Namibia’s **Third National Development Plan (NDP3), 2007-2012** (NPC 2008: 228) elaborated on this, placing emphasis on

¹ In 1978, the International Conference on Primary Health Care was held in Alma-Ata (then in the USSR) and led to the adoption of the **Declaration of Alma-Ata** (WHO 1978).

² The OAU was replaced by the African Union (AU) in 2002.

community participation in the healthcare system, equitable access to quality healthcare services, affordability of health services and cooperation with sectoral players. Namibia's fourth and current **National Development Plan (NDP4), 2012-2017** (NPC 2012: 57) captures the essence of the ICESCR, in that it focuses on making the healthcare system (including prevention, treatment and rehabilitation) work in the most affordable, accessible and culturally acceptable way. Both NDP3 and NDP4 recognise the need to reach out to the most disadvantaged Namibian communities by ensuring that the national healthcare system is affordable, accessible and culturally acceptable to them.

Notwithstanding the commendable efforts that the country has made in healthcare provision, the health conditions of the San remain a great challenge for the government. In the last decade, the San were reported to be the unhealthiest group of people in Namibia, with a life expectancy of 46 years, which was estimated to be 25% lower than the national average in 2005 (ACHPR and IWGIA 2008: 118). The Government of Namibia has indicated that the San have no specific priority health needs as compared with the rest of the population (Gibson 2010: 52), whereas Health Unlimited reported in 2003 that they were the only group in Namibia whose health conditions had been declining since Independence (Health Unlimited 2003). In his report to the UN Human Rights Council in April 2013, the UN Special Rapporteur on the Rights of Indigenous Peoples, James Anaya, underscored that the San are increasingly facing a multiplicity of health-related problems, largely because of the underlying structural inequalities and recurrent injustices in which the livelihoods of the San are embedded (Anaya 2013: 17-18). This chapter of the San Study report describes the difficult health situation that the vast majority of the San of Namibia currently endure.

17.2 Common diseases among the San

Common diseases that affect the San are those that reflect national health challenges in Namibia generally. However, the situation is especially severe for the San because of the unfavourable socio-economic, political and geographical conditions that they face (Suzman 2001b: 113). The most common diseases identified in our field research were HIV and AIDS (hereinafter "HIV/AIDS"), TB, malaria and gastro-intestinal diseases.

17.2.1 HIV/AIDS

HIV/AIDS has been a major health problem in Namibia since the 1990s, and Namibia has had one of the highest HIV prevalence rates in the world for a number of years. In 2010/11, Namibia's Ministry of Health and Social Services (MoHSS) estimated the HIV prevalence rate in the general population aged 15-49 to be 13.5% or 189 000 people (MoHSS 2012: 17). Compared to the United Nations Development Programme (UNDP) estimate of 20% for Namibia in the late 1990s (UNDP 1998: 18), the 2010/11 rate demonstrates a significant decline, but it remains much higher than the global and sub-Saharan African average rates of 0.8% and 4.9% respectively (United Nations Programme on HIV/AIDS (UNAIDS) 2012: 8).

In the 1990s, the risk of HIV infection in the various San groups in Namibia was not yet recognised as a critical issue, mainly because of their geographical remoteness and isolation. However, Suzman (2001b: 114-115) appraised that the effect of the pandemic among the San in subsequent years would be radical because of their various vulnerabilities. Subsequently, reports of the International Work Group for Indigenous Affairs (IWGIA 2006: 504; 2009: 563) and anecdotal evidence have attested to the fact that the HIV prevalence rate is increasing among indigenous groups in Namibia – especially among the San – and that the impacts of this are far-reaching. Currently there is no disaggregated

data on the increasing HIV prevalence rate among the San groups in Namibia, but a recent specific case report (IWGIA 2009: 563) estimated the rate among the Ju|'hoansi in Tsumkwe District to be between 10% and 12%. In all of the regions visited for this San Study, participants in our focus group discussions (FGDs) cited HIV/AIDS as a disease that is not only common but also severe. Awareness of how HIV is spread, prevented and treated, and the healthcare services available to those infected and affected, varied according to the remoteness of sites and the presence – or otherwise – of HIV/AIDS-related projects. A number of factors were identified as contributing to the vulnerability of the San with regard to HIV/AIDS and its ramifications.

The poor socio-economic conditions in which the San live have made them susceptible to sexual relationships with other people (who, at many of our research sites, were better off than the San at those sites), thereby increasing the San's risk of exposure to the virus. Settlements along highways (e.g. those in Oshivelo in Oshikoto Region and those in West Caprivi) and near urban areas (e.g. Outjo in Kunene Region) presented worrying scenarios whereby San women/girls were sexually exploited by 'sugar daddies', truck drivers or businessmen in exchange for material benefits such as money, soap and clothing. Similar cases have been identified and documented in other studies such as Lee and Susser (2006), and Suzman (2001b: 114). Lee and Susser, for example, link the spread of HIV among the Ju|'hoan San in eastern Namibia to the group's interaction with non-San, where "sex is the medium of transaction" (Lee and Susser 2006: 50).

The poor nutrition that we observed in all San communities may undermine appropriate care for those infected with the virus, who require, inter alia, an adequate and good-quality diet in order to remain as healthy as possible and/or to benefit fully from antiretroviral drugs. Stigmatisation associated with the disease was found to be high in most of the regions covered in our study, and this is highly likely to have far-reaching effects on uptake rates for counselling, testing and treatment. Reportedly a high number of San feared going for HIV testing, and of those who had done so and tested positive, many feared discussing their status, and consequently risked undermining their own access to treatment and healthcare services. By the time of our field research, the geographic isolation referred to above had constrained access to HIV/AIDS prevention, testing, treatment and healthcare services. In such areas – where clinics are largely absent (or if present, are poorly equipped) – FGD participants mentioned as issues the shortage of condoms, limited HIV education programmes, a lack of screening services and the unavailability of antiretroviral treatment (ART).

17.2.2 Tuberculosis

Recently the World Health Organization (WHO) ranked Namibia number four on the list of the world's worst-hit countries in terms of tuberculosis (TB) (Van Gorkom et al. 2013: 23). Nevertheless, remarkable improvements have been reported in the country since 2005 in terms of the case notification rate (CNR) and absolute numbers of cases. The MoHSS reported a major (10%) decrease in the CNR in 2007/08, and the WHO estimates reflect a gradual decrease from 1 287 cases per 100 000 in 1990 to 603 per 100 000 in 2010.³

TB remains a disease linked closely to poverty and its defining characteristics: "overcrowding, impoverishment, poor nutrition and being members of historically disadvantaged communities" (Gibson 2010: 52). Our research has confirmed that these are defining characteristics of the San communities in Namibia; they are accurate descriptions of their common circumstances. Their Human Development Index (HDI) ranking and their per capita income are the lowest compared

³ See www.who.int/profiles_information/index.php/Namibia:Analytical_summary_-_Tuberculosis.

with those of the other language groups in Namibia, and less than half of the national average in both respects (Gibson 2010: 52). Furthermore, our research has confirmed the findings of previous studies that the San of Namibia are affected by acute food insecurity, landlessness, poor access to education and constrained access to means of achieving a cash income. Paul Farmer (as cited in Gibson 2010: 52) argues that these are the factors that predispose people to active TB. It is therefore not surprising that a study in 2003 found the TB infection rate among the San of Namibia to be the highest in Namibia and one of the highest in the world, i.e. 1 500 cases per 100 000 people (Health Unlimited 2003). Furthermore, Wiessner (as cited in Gibson 2010: 52) estimated that by 2003, more than 50% of the adult deaths among the Ju|'hoansi were associated with TB.

FGD participants at all of our research sites identified TB as a severe disease among them. Likewise, health workers in each region covered unanimously stated that TB was one of the most common diseases among the San, and that its prevalence among San was higher than among the other ethnic groups in these regions. The high prevalence rate was linked to a number of factors. Poverty in San households (characterised by malnutrition, among other things) lowered people's immune systems and provided conditions for TB to thrive. The small and overcrowded shelters in which the San generally live have also contributed to the spread of TB. Gibson (2010: 52) emphasised that TB "is a disease that marks social inequalities, lack of power and poor or insufficient nutrition", so it is small wonder that its prevalence is reportedly higher among the San than among other ethnic groups. According to health workers whom we interviewed, tobacco smoking and alcohol abuse – common practices among the San – not only created conditions for the disease to thrive, but also lowered the effectiveness of treatment drugs, contributing to drug-resistant strains of TB. In many places, such as some of our research sites in Ohangwena Region, smoking pipes and drinking glasses are often shared, which may also contribute to the spread of this disease. Despite their dire need of TB treatment and healthcare services, a great many San individuals were deprived of these because of their geographic remoteness but also their mobility (see also Anaya 2013: 17; and Gibson 2010: 52). San participants in our FGDs found travelling from their homes to healthcare facilities problematic, due not only to the scarce and unreliable means of transport, but also the high costs involved. In areas where their mobility was high (e.g. Kavango, Ohangwena and parts of Omaheke), the treatment of those already diagnosed was often interrupted. Such realities may contribute to the development of multi-drug-resistant TB (MDR-TB), which is a major health problem and obstacle to effective treatment globally (Riks et al. 2012: 1). Geographical remoteness and mobility which constrains timely and regular treatment administration should be given significant consideration when planning for TB healthcare provision to the San. However, San individuals' failure to adhere to TB treatment regimens was more often than not blamed on 'the San culture' – perceptions of which have often led public healthcare workers to adopt an antagonistic attitude to San patients, as Gibson also observed in Tsumkwe District (Gibson 2010: 58-59). This adversarial attitude, and healthcare workers' tendency to deem the San patients culpable for the treatment failure based on their own notions of San culture, exacerbated the San's mistrust of healthcare workers.

17.2.3 Malaria

Malaria is a major public health problem in Namibia. The rate of transmission of malaria in this country is estimated to be 15% in low-risk areas (central, north-central and eastern Namibia) and 55% in high-risk areas (Caprivi and Kavango Regions).⁴ Most of the San of Namibia live in these high-risk areas. A national policy on malaria was introduced in 1991, but with time it was broadened to cover other vector-borne diseases. The Namibia Malaria Strategic Plan 2010-2016 targets five

⁴ See www.who.int/profiles_information/index.php/Namibia:Analytical_summary_-_Malaria

areas of intervention: programme and operations management; diagnosis and case management; surveillance, epidemic preparedness and response; integrated vector control; and behaviour change communication and community mobilisation (MoHSS 2010b). Participants in our FGDs identified malaria as a serious and common disease, i.e. to varying degrees, depending on the region or geographical location and the season. The San groups living in malaria-prone areas, for example the Khwe and !Xun in Caprivi and the !Xun in Kavango and other north-central areas, rated malaria as a high health risk, especially in the rainy season, whereas the !Xun and Ju|'hoansi in eastern and southern areas rated it as a low health risk. Knowledge about malaria (causes, spread, symptoms and treatment) was high at all of our research sites except Omundaungilo settlement and Onane village in Ohangwena Region. In Omundaungilo the cause and spread of malaria were linked to eating bad food and having “too much air in the stomach” rather than to mosquitoes as a vector, and participants in Onane did not know what causes and spreads malaria. In any case, the San in Onane and Omundaungilo had some of the worst school enrolment rates compared to those at the other research sites in Ohangwena.

San vulnerability to malaria was expected to be high, considering their prevailing socio-economic deprivation. For example, they had limited means of preventing transmission of the disease as most of them did not have access to treated mosquito nets. In Kavango and Ohangwena Regions, where the San lived in extreme poverty, we observed that many lived and slept in temporary shelters with porous walls and roofs that could not keep out mosquitoes and other insects. In Onane village in Ohangwena, some of the San even slept outside in the open, making exposure to mosquito bites unavoidable. At some sites (e.g. in Omusati Region), the San burned wild herbs to keep mosquitoes away – but this measure could pose the risk of exposure to respiratory health challenges, especially in infants and children. Malaria had devastating effects on those living in very remote areas where it was difficult and costly to access healthcare services for early diagnosis and timely treatment.

17.2.4 Gastro-intestinal diseases

Ailments such as diarrhoea and abdominal pains, and ailments related to unhygienic conditions specifically, were common health concerns at almost all of our research sites. Similarly, healthcare workers whom we interviewed in state hospitals and clinics deemed gastro-intestinal ailments to be more prevalent among the San than among people of other ethnic groups. These ailments are linked to the poor hygiene that stems from the poor living conditions of the San, their poor diets, and the untreated water which they used for domestic consumption. FGD participants and healthcare workers expected these conditions to be exacerbated by poverty, low levels of education and general marginalisation. Our findings at most of the sites corroborated Suzman's assertion that diarrhoea and other stomach ailments are some of the main causes of death among San children (Suzman 2001b: 115).

17.3 Government support and access to health services

Over the last two decades, the Namibian Government, through the Ministry of Health and Social Services (MoHSS), has laboured to improve the highly unequal healthcare system that it inherited at Independence. By 2009 there were “46 hospitals (district, intermediate; including public, faith-based and private), 49 Health Centers, and approximately 350 clinics and other healthcare service points” (MoHSS and ICF Macro 2010: 11) – these figures may have changed subsequently. These facilities are distributed across all regions of the country, but specialised services are concentrated in hospitals in urban areas. Promoting healthcare is one aim of **Namibia's Vision 2030** (NPC 2004a),

and the government has put in place the **National Health Policy Framework (NHPF) 2010-2020** (MoHSS 2010c) to guide the healthcare-promotion process. The NHPF emphasises the need for the expansion, promotion and delivery of accessible, sustainable and equitable quality primary healthcare through community-based health services.

Healthcare in rural areas, where the majority of the poor live, is often overstretched and under-resourced, despite the government's ambitions and its guiding policies and strategies. The San, who in general are the poorest of the rural poor (Arowolo et al. 2011: 52; and this report) face some challenges with access to health services.

17.3.1 Distance to healthcare services

The long distances to clinics and hospitals, albeit with considerable variation from place to place, are one of the main barriers to San access to healthcare. Those living near urban settlements such as Rundu (Kavango Region), Katima Mulilo (Caprivi Region), Oshivelo (Oshikoto Region), Oshikuku (Omusati Region), Outjo (Kunene Region) and Gobabis (Omaheke Region) had shorter distance to cover to reach healthcare facilities, but only a few San villages outside urban settlements had a healthcare facility nearby. The ACHPR/IWGIA mission to Namibia in 2005 established that 80% of the San in Namibia live at an average distance of 80 km away from health facilities (ACHPR and IWGIA 2008: 21). This overall figure may have changed marginally since 2005, but our study verified this figure at several research sites in 2012/13. Worryingly, some San settlements in Kavango and Ohangwena Regions are over 50 km away from the nearest clinic. The San found transportation to clinics largely unaffordable, always assuming that they could find a vehicle to take them there in the first place, thus they depended heavily on finding a ride when they needed to go to a healthcare facility, and spent a long time waiting for rides. Although the government mobile clinics visited many of the remote villages, in most cases the visits were irregular (see also Anaya 2013: 17). Also, at some sites it was said that the mobile clinics targeted only a particular segment of the populace (usually infants, children and/or old people), and/or provided only a couple of specific health services, such as immunisation and high blood pressure treatment. In areas where we found that the San are still mobile (e.g. Xeidang in Kavango Region and Onane in Ohangwena Region), mobile clinics were usually not an effective means by which to reach the San communities.

17.3.2 Costs of public healthcare services

Clinic or hospital costs were the same for everyone, but reportedly unaffordable for the majority of the San, considering the extremely limited availability of cash within their households and their general inability to earn cash (see Chapter 14 on livelihoods, food security and poverty). Government clinics and hospitals charged N\$4 and N\$8 respectively to attend to a patient on weekdays. It appears that these fees covered both the consultation plus a course of medicine/s. People with special needs, such as orphans and vulnerable children (OVC), pensioners and marginalised communities (e.g. the San), are supposedly exempted from paying the fees charged for clinic and hospital visits, however we found that the implementation of the exemption policy varied considerably from site to site: the policy was being implemented in only a few areas – generally where the San had a strong traditional authority (TA) and/or community leaders (e.g. parts of Omaheke Region and in Tsumkwe East and West in Otjozondjupa Region), most likely because the TA/leaders negotiated for the exemption. Most of the San, however, reported that they did not get any exemption. In Omusati Region, for example, we found the application of the medical fee exemption for San to be virtually non-existent – a scenario that could be linked to the perceived high levels of integration between the San and the Owambo people in that region.

17.4 Discrimination and access to health

Ingrained discrimination against the San continues to blight their access to healthcare, and the San at all of our research sites expressed a perception of unfair treatment at the state health facilities. Across the study regions there were reports of verbal abuse of San patients by some healthcare workers. According to many FGD participants, a healthcare provider might refer to a San patient's poor economic status, relatively poor hygiene and/or alcoholism in a negative manner and in direct contravention of professional ethics (see also individual case studies in Gibson 2010: 49-50). Such behaviour naturally makes San people reluctant to visit clinics and hospitals, and it should be noted that similar complaints were received by the UN Special Rapporteur on the Rights of Indigenous Peoples in Namibia (Anaya 2013: 18).

Discrimination also arose due to San patients and healthcare workers speaking different languages: in clinics and hospitals in some areas, the healthcare workers could speak confidently only in a Bantu language and/or English, whereas the San could express themselves only in a San language or Afrikaans. This communication barrier often led to misunderstandings between patient and healthcare worker, and sometimes caused difficulties in administering the medication prescribed (Anaya 2013: 18). Allegedly there were instances of healthcare workers lacking patience with San patients and blaming them for misunderstanding treatment instructions. However, in areas where the San could speak the language of the ethnic majority, such as Omusati and Ohangwena where they could speak Oshiwambo, communication was not an impediment to accessing healthcare.

17.5 Traditional/indigenous medicine

The use of traditional/indigenous medicine was practised to a limited extent at most of the research sites in all the study regions except Omusati. The San employed traditional medicine either before seeking access to conventional treatment, or in tandem with conventional treatment. At the sites where traditional medicine was used, there seemed to be clear knowledge as to what diseases could be treated with these, and medicinal herbs were often cited as the means employed to cure diarrhoea, other stomach ailments and coughing (the latter especially among children). Although traditional medicine could be regarded as a cultural practice among the San, the FGDs at some sites (e.g. in Ohangwena Region) suggested that a poverty-driven inability to afford conventional treatments compelled the San to use medicinal herbs as alternatives. This was also an observation of Gibson (2010) in Tsumkwe, where the Ju|'hoansi used traditional medicine to treat the symptoms of TB – even though they knew that they should not use traditional medicine together with their TB medication. A certain amount of knowledge of traditional medicine was still present among the San participants in our FGDs, especially the elderly. However, with limited access to natural resources in many areas following systematic injustices vis-à-vis land rights, it is expected that there will be an eventual decrease in the use of traditional medicine products and other resources, and that in turn this will reduce the building and sharing of indigenous knowledge regarding their use.

Reliance on traditional healers was limited and varied from region to region. Many San in Caprivi Region, and in areas around Outjo and Okaukuejo in Kunene and Oshana Regions respectively, reported visiting traditional healers in times of need, whereas at other sites there was hardly any mention of consultation of traditional healers, or no mention at all. Administering of traditional medicine by traditional healers also seemed to be on the wane, possibly because of a rising mistrust in the practice due to its commercialisation, as was noted in Oshivelo (see Chapter 6 on Kunene, Oshikoto and Oshana Regions, page 219).

17.6 Maternal health and teenage pregnancy

A number of reports show that maternal health has improved considerably in Namibia in recent years as compared with the 1990s. The Namibia Demographic and Health Survey (NDHS) 2006-2007 found that skilled health personnel attended 81% of births in the survey period compared with 68% in 1992 (MoHSS 1993: 97; MoHSS 2007: 124). The number of pregnant women attending antenatal care (at least four visits in the pregnancy period) has also been increasing since the 1990s (MoHSS 1993: 93; MoHSS 2007: 116).⁵ Notwithstanding a positive national trend, our study found that the majority of San women across all regions studied gave birth at home, mostly under the care of unskilled health personnel or with no assistance at all. The socio-economic positioning of the San in society is a key reason for this state of affairs: the cost of transportation to a healthcare facility for delivery was prohibitively high in many cases, especially for those in remote areas, and many were also unable to pay the N\$20 charged for delivery at a healthcare facility. Although the San are in theory exempted from paying the delivery fee, it was a generally expressed concern that the exemption was not implemented at some healthcare facilities. In addition, there were reported cases of verbal mistreatment/abuse by the birth attendants in government clinics, health centres or hospitals – which understandably discouraged the San women from giving birth at these places. Consequently, it was not surprising to learn that even San women at sites closer to a health facility mostly preferred to give birth at home. Home births can be very risky, especially in cases of emergency or complications which increase the danger to the mother and baby. Furthermore, home births increase the risk of mother-to-child transmission of HIV. Accessing antenatal and postnatal care depended on the availability of a healthcare facility nearby, the implementation of the fee exemption, and the nature of the relationship between the San and the healthcare staff.

The rates of use of birth control among the San were generally low – this could be linked to their challenges in accessing healthcare services. However, in some areas (e.g. Kavango Region), cultural norms affected the use of birth control, i.e. people believed in having as many children as possible, and the use of contraceptives was regarded as a western cultural practice.

High teenage pregnancy rates are a national problem in Namibia. However, among the San, the impacts of teenage pregnancies tend to have more far-reaching effects than among other ethnic groups. Reportedly a significant number of San girls have dropped out of school due to pregnancy (see Chapter 16 on education). The government allows female learners who have fallen pregnant to continue with their education both prior to and after giving birth, but in spite of this authorisation,⁶ not many San girls have returned to school after giving birth. This could be attributed partly to the limited efforts made in respect of counselling and motivation. Children born to teenage mothers are often left with a grandmother who depends on a pension, and this situation can bring about the neglect of San children that was said to be a problem for some children at some of our research sites. Although this situation also arises in other ethnic groups, San grandmothers are often even more overburdened than those in other ethnic groups because they have little or no financial support from social networks – usually there is very little to share within a San community. Reproductive health education efforts among the San thus need to be intensified and broadened to cover teenage pregnancy, in order to address this challenge which constrains girls' education, household income, and psychological wellbeing.

⁵ The fifth UN Millennium Development Goal (MDG5) aims at a minimum of four visits in the entire pregnancy – see for example <http://mdgs.un.org/unsd/mdg/Metadata.aspx?IndicatorId=0&SeriesId=763>

⁶ As set down in the *Education Sector Policy on the Prevention and Management of Learner Pregnancy* (MoE 2012b). One main goal of this policy is to increase the number of learner-parents who complete their education.

17.7 Water and sanitation

Poor water and sanitation conditions, and the spread of diseases that such conditions can cause, undermine people's inherent dignity and thus the realisation of the dignified life envisaged by the **International Covenant on Economic, Social and Cultural Rights** (ICESCR). The right to water and sanitation is explicitly recognised internationally through **UN General Assembly Resolution 64/292 of 2010, "The human right to water and sanitation"**, which commits governments to put measures in place and to use the maximum resources available to ensure "safe, clean, accessible and affordable drinking water and sanitation for all" (UNGA, A/RES/64/292, July 2010). Namibia has put great efforts into improving access to water and sanitation through government institutions such as NamWater, local authorities and the Ministry of Agriculture, Water and Forestry's Directorate of Water Supply and Sanitation Coordination (DWSSC). Recent statistics show that 80% of all Namibians – 98% of the urban population and 63% of the rural population – have access to safe water. Those in rural areas who do not have access to a supply of safe water rely on rivers, streams and unprotected wells. These statistics also show that 74% of rural households have no access to toilet facilities, and where there is a pit latrine, there is a high share ratio (Namibia Statistics Agency 2012: 77). People living in urban informal settlements also have no access to sanitation facilities.

The rural areas where the majority of the San live are serviced by the DWSSC and most have at least a communal water supply – boreholes, closed and open wells, open canals, earth dams, and piped water (supplied by NamWater). Our study found that access to safe water varied from site to site, depending on a number of factors, but mainly the distance to the water point and the levies charged by the water point committee (WPC). Areas with external support (e.g. resettlement projects) had boreholes and treated closed wells, some of which were operated by a hand-pump and some by diesel-engine pumps, and most of these water points were within walking distance of the site, i.e. within 1 km. At some of our research sites, even though safe water was available from sources managed through community-based institutions, many San alleged that they could not afford the levy charged (which varies from one WPC to the next). In such areas they opted to use unsafe water sources such as open untreated wells and canals, which rendered them vulnerable to water-borne diseases. San participants in our FGDs in Omundaungilo (Ohangwena Region) reported that they preferred to use the unsafe water in open earth ponds because it had a better taste than the NRCS-treated water in the hand-pump-operated well.

Sanitation facilities were usually lacking in the areas where the San live – but this is a problem for many other rural and urban informal settlement populations. Ouholamu in Ohangwena Region had pit latrines, but these were in poor condition and thus were seldom used. The hygiene of the San households was generally poor compared to that of their neighbouring communities' households, except at sites in Omusati Region and a few other places. Overall, poor living conditions – marked by inadequate housing and overcrowding – are a key factor that undermines hygiene for the San. Poor hygiene was also attributed to the San's inability to buy soap and other cleaning products; the little cash income that San families managed to raise was spent instead on priority items such as food – and perhaps alcohol, which the San in some areas regarded as an alternative to food.

17.8 Malnutrition

On the whole, the San in Namibia frequently lack sufficient food (see Chapter 14), thus a high prevalence of malnutrition might be expected. It cannot be overemphasised that food insecurity among the San is closely linked to the social, economic and cultural disruption that resulted from their loss of land rights and access to land and related resources (Anaya 2013: 7).

San access to nutritious bushfood through traditional hunting and gathering is now virtually impossible in many areas, and the resultant changed livelihoods patterns have altered their dietary intake over time. Surviving in the mainstream economy has proved enormously difficult for the San, and the livelihood strategies available to them have proved incapable of meeting their nutritional needs (Suzman 2001b: 119). The government has made attempts to integrate the San into Namibia's food-crop production system, but the results of these attempts have been far below expectation due to structural and cultural challenges. In general, hunger and undernourishment have been significant distinguishing features of poverty among the San, as a consequence of their limited access to either a cash income or a regular source of food. Our study found the picture to be better only at sites in Omusati Region. The diets of the vast majority of our FGD participants were limited in both adequacy and variety. A study in Drimiopsis and Skoonheid (Omaheke Region) in 2009 also revealed a limited diet among both San communities, which arose from the limited variety of food consumed throughout the year (Bufford et al. 2009). Like Bufford et al. (2009: 36-37), we found the average San person's diet to be limited to maize-meal with just a few supplementary foodstuffs. As this diet does not provide essential nutrients, it renders the San susceptible to illness or a worsening of existing illnesses (e.g. TB and HIV/AIDS). We found that the frequency of food intake varied from one household to another, but most people ate only one or two meals a day.

Although we did not undertake epidemiological surveys as part of this study, we saw commonly recognised signs of malnutrition (e.g. pot bellies) at some sites, especially among children. As a short-term solution to the challenge of hunger and malnutrition, the government provides a laudable intervention in the form of food aid. However, as Anaya observed, "food aid [was] often unreliable and insufficient, leading to situations of persistent hunger among San communities, which compromises their immune systems and their ability to resist disease" (Anaya 2013: 17). Therefore, the San remain highly susceptible to health problems stemming from malnutrition or even starvation, such as stunted growth and the compromised neurological development of children. Addressing food sufficiency among the San is a fundamental public health concern that should move beyond the 'quick fix' of food subsidies.

17.9 Alcohol use

The issue of excessive use of alcohol among the San and its consequences in Namibia and other countries in southern Africa is widely documented. Nyang'ori et al. (2006: 1943) and Suzman (2001b: 116) related that induced poverty has led to extensive alcohol consumption (as is also seen in other displaced aboriginal communities elsewhere in the world). Excessive alcohol use by the San was observed and reported throughout our research, and especially in areas where livelihoods were extremely difficult to maintain (see also Suzman 2001b: 116). For example, !Xun living in parts of Ohangwena Region, and other San groups living on the peripheries of urban settlements (e.g. in Kanaan neighbourhood in Epako, Omaheke Region, and at Makaravan informal settlement in Katima Mulilo, Caprivi Region) were more addicted to alcohol than the San in Omusati Region, whose livelihood opportunities were better. In many extremely poverty-stricken San populations, alcohol was regarded as an alternative means to alleviate hunger in the absence of food (see also Nyang'ori et al. 2006: 1943). In general the San consumed locally brewed alcohol (*otombo* or *okanyatau*), which was cheap and generally made by non-San people (except in a few isolated cases in Omusati Region where San women also owned *otombo* and *okanyatau* shebeens). The impacts of alcohol among the San included bodily harm as well as social problems. Much as excessive alcohol consumption among the San has been influenced by poverty, it also creates conditions for deprivation, thus it locks many San into a poverty cycle, and indeed, at many research sites, alcohol consumption was identified as one of the factors that made 'poor' people 'very poor'. Household

labour input into livelihood maintenance was adversely affected by alcohol consumption in many areas, but especially in Ohangwena Region. For example, people were reported and observed to be spending the better part of the day drinking in shebeens, and in some instances piecework was remunerated with alcohol, which deprived households of income. FGD participants also reported cases of deaths which were attributed to excessive alcohol consumption. Violence among the San was widely linked to alcohol abuse; this was reported at many of our research sites and also by Sylvain (2006). Domestic violence related to alcohol abuse was reported to be rampant at all of our research sites. Nyang'ori et al. (2006) linked alcohol-induced violence in San households to gender-based violence which in turn relates to marginalisation and historical injustice:

“Deprived of their traditional livelihoods and forced into resettlement camps, San women have gradually lost their traditionally equal status with men. Excessive alcohol consumption plays a major part in a rise in gender violence, a trend which ... is an increasing problem among young people.”
(Nyang'ori et al. 2006: 1943)

Many healthcare workers interviewed for our study contended that drinking and smoking elevated the risk of TB infection and curtailed its treatment efficacy among the San. This could have far-reaching implications for the development of the multi-drug-resistant strain of TB, which is a health problem not only in Namibia but globally. Alcohol abuse among the San – and its probable effects on sexual behaviours – was also reportedly creating the social conditions for the spread of HIV/AIDS, which, as discussed earlier, has increased in the last decade among the San in Namibia. The San in Ohangwena Region were by and large observed to be the most affected by alcohol abuse, and a worrying development in this regard was the manner in which most of the San children were exposed to alcohol consumption. We observed at various research sites in all of the study regions, except Omusati, that many San parents took their children (including some under five years of age) to shebeens where they gave them alcohol ‘to ward off hunger’. Thus for many San children, long-term damaging effects might be expected – not only impaired neurological development, but also negative social effects, such as low school enrolment and attendance, and the early development of addiction. In Omusati, reports and observations of children drinking alcohol were rare, if not altogether absent.

17.10 Support from NGOs and other external groups

The role that NGOs play in supplementing government (i.e. MoHSS) efforts to improve the health of the San is crucial, but varies across and within the regions. It should be noted that most NGOs support the entire population of the area(s) that they cover, providing a wide raft of support services: public health education on HIV/AIDS, TB and malaria; water and sanitation services; provision of equipment and supplies; and training of community health workers.

17.10.1 Namibia Red Cross Society (NRCS)

The NRCS works in the areas of HIV/AIDS, community TB care, malaria, first aid, water and sanitation, and hygiene promotion.⁷ Among the regions covered in this San Study, the NRCS runs projects in Kunene, Ohangwena, Oshikoto, Kavango, Caprivi, Otjozondjupa and (to a limited extent) Omusati. In selected areas the NRCS has trained volunteer community health promoters who assist TB patients with adhering to their treatment regimens. The NRCS also treated wells in selected areas in Ohangwena to increase the safety of the drinking water. Unfortunately most of the

⁷ See <http://www.redcross.org.na/aboutus.php?id=22&title=Health%20and%20care>

NRCS's work has been affected by declining funding, resulting in the cessation of certain activities such as community public health promotion and home-based care for people with HIV/AIDS.

17.10.2 Health Poverty Action (HPA) / Health Unlimited

Health Unlimited – known as Health Poverty Action (HPA) at the time of our field research – has run projects in Epako informal settlement in Gobabis, Omaheke Region, and in Tsumkwe District in Otjozondjupa Region. In the past, Health Unlimited – in partnership with the MoHSS – trained community-based resource persons (CBRPs) who handled home-based health care, and traditional birth attendants (TBAs), especially in Omaheke. The aims of the CBRPs project were to improve access to healthcare services in remote areas located far away from clinics, and to enhance communication between the local health service providers and the San communities. Since 2006, Health Unlimited has run a project aimed at improving San adolescent sexual and reproductive health in the remote areas of Omaheke and Otjozondjupa. This project trains village health committee representatives, teachers and peer counsellors to encourage discussion in the local community on adolescent health, HIV/AIDS and other STIs.⁸

17.10.3 Other NGOs

Other NGOs that provide health support to the San include Total Control of the Epidemic (TCE) and Catholic Aids Action (CAA). TCE provides support in respect of HIV testing and condom distribution. CAA trains community health workers to assist community members with various health matters, assists with referrals, and provides HIV counselling and testing services.

17.10.4 Volunteer groups and individuals

Apart from these NGOs, there are voluntary groups and individuals running health programmes in some areas where the San live. Most of these group and individual volunteers are qualified medical practitioners. Examples are Dr De Kok who runs a charitable private clinic at Skoonheid Resettlement Project in Omaheke Region under the San Alive crafts project, and the N/a'an ku sê Foundation which operates the Lifeline Clinic project at Epukiro in Omaheke. The Lifeline Clinic provides primary healthcare services to about 3 500 patients per year, 40% of whom are infants and children.⁹ This clinic also occasionally provides public health education to the San children at Skoonheid, and transports patients with serious medical conditions to Gobabis State Hospital (about 120 km from Epukiro).

Despite the fact that each of the NGOs and support groups and individuals provided much-needed assistance to the San communities – even though not specifically targeting the San in some cases – there appeared to be a woeful lack of coordination between them, and this situation undermined the formation of synergies and the sharing of experiences and resources. Furthermore, there was very little evidence that the NGOs and support groups sought to tap into the community members' knowledge of indigenous/traditional healthcare and medicine (where such knowledge existed). Dwindling donor funding opportunities are already hampering the crucial role that NGOs play in promoting the right to health among the San.

⁸ See www.healthpovertyaction.org/where-we-work/africa/namibia/treating-and-preventing-tb-in-remote-namibian-communities.

⁹ See www.naankuse.com/naankuse-lifeline-clinic.html.

17.11 Conclusion and recommendations

The health status of the San is generally poorer than that of other communities in Namibia. The findings of the African Commission on Human and Peoples' Rights (ACHPR) and International Work Group for Indigenous Affairs (IWGIA) mission to Namibia in 2005 affirmed that the San are the only ethnic group in Namibia whose health status has been declining since Independence (ACHPR and IWGIA 2008: 119). Our study, and others – e.g. those of Arowolo (2011: 26-30) and Gibson (2010: 52) – found the poor health of the San to be an indicator of the poverty prevailing across the San groups surveyed. There is also compelling evidence that this poverty is linked to the systematic injustices as regards land tenure, which for decades have been altering their livelihoods for the worse. Food production among the San was found to be unsustainable, and they depended mainly on government food aid to survive, thus the communities were very food insecure. The San were also constrained in terms of acquiring gainful employment, and their sources of cash income were restricted to piecework and social grants. As a result, there was a high prevalence of persistent levels of hunger that weakened their immune systems. Physical marginalisation also worsened the San's health conditions: most of them lived in remote rural areas that were badly served by health facilities. The MoHSS provides mobile clinics, but their visits are irregular and they are ill-equipped to handle most ailments. The discrimination and stigmatisation that the San generally experience at the hands of other ethnic groups in Namibia present social barriers to improving the health of the San.

The overarching inference to be drawn from all this is that the health challenges that the San face are interlinked and require tackling through an integrated approach that addresses poverty as a priority strategy for achieving success. Notwithstanding the interdependencies between health and other socio-economic factors, the following specific direct interventions to improve health are recommended:

- 1) The government should ensure that basic healthcare services and facilities are made accessible to the San communities by establishing health facilities within walking distance of their homes. Where the option of mobile clinics is favoured, the government should ensure that they visit regularly, are well equipped, and meet national standards.
- 2) The exemption of San from the payment of healthcare fees should be clarified and implemented uniformly, and awareness of this exemption should be promoted among the San and within the healthcare community.
- 3) Measures should be taken to ensure that healthcare workers are sensitised to cultural differences. The government should take further measures to ensure that healthcare workers are culturally sensitive to the San, and that they adhere to professional healthcare ethics in their dealings with San.
- 4) Affirmative action should be extended to community healthcare in order to include the San in different categories of healthcare providers in the public health sector. This will ensure that there is someone at the relevant healthcare facilities who can communicate with the San in their own language, and will thus improve communication with San patients.
- 5) Efforts should be enhanced to extend reproductive health education to the San so as to provide information on teenage pregnancies and sexually transmitted infections.
- 6) Malnutrition and hunger should be addressed beyond the limits of food aid (as described in more detail in Chapter 14 on livelihoods, food security and poverty).
- 7) Coordination of institutions and organisations (governmental and non-governmental) that work on San-related issues should be improved so as to build synergies and enhance service delivery.
- 8) Concerted efforts should be made to enhance and ensure effective monitoring and evaluation of the impacts of the programmes aimed at improving the health of the San.