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# Indigenous medicinal knowledge of the San people: the case of Farm Six, Northern Namibia

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## Abstract

The San are among the most marginalized people in Namibia. The San have often relied on indigenous knowledge for survival, particularly since access to resources has proved to be difficult. This study explores the use of indigenous knowledge by a particular San community living on Farm Six, located in the Mangetti West area north of Tsumeb. In particular, the study focuses on the use of indigenous knowledge with regard to traditional medicine. Apart from considerations of the commercial and legal issues concerning the exploitation of the devil's claw and hoodia plant, little has been published about the medicinal properties of San remedies. The findings indicate that the community relies on indigenous knowledge as their main means of treating most illnesses. While the community believes traditional remedies are effective in treating several conditions, they have also turned to herbal treatments because of a lack of access to modern health care: the nearest clinic is over 50 km away, transport is scarce, and a Ministry of Health and Social Services outreach team has not visited the camp for over 2 years. However, it was impossible to establish the medical efficacy of most of these remedies as their properties and effects have not been studied in detail.

## Keywords

San people, indigenous knowledge, traditional medicinal knowledge, indigenous knowledge transfer, Namibia

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**The San people of the Farm Six community in Namibia have extensive indigenous knowledge of traditional medicine, but would abandon its use if modern medicine were more readily available.**

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## Background to the study

### *Indigenous knowledge*

*Indigenous knowledge* refers to the traditional knowledge belonging to a specific ethnic group. It has been described as the local knowledge that is unique to a given culture or society (UNESCO, 1999). It is the basis for local-level decision-making in agriculture, health care, food preparation, education, natural resources management and a host of other activities in rural communities (ibid.).

Indigenous knowledge forms the information base for a society, which facilitates communication and decision-making. Indigenous information systems are dynamic, and are continually influenced by both internal and external systems. *Indigenous knowledge* is the knowledge that people in a given community have developed over time, and continues to develop.

It is based on experience, often tested over centuries of use, adapted to local culture and environment, and it is dynamic and evolves (ibid.).

Indigenous knowledge is embedded in culture and is unique to a given location or society. Such knowledge is an important part of the lives of the poor. It is the basis for decision-making by communities on issues relating to food, security, human and animal health, education, and natural resource management (ibid.).

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Indigenous knowledge is shared and communicated orally. It is vulnerable to rapid change – especially when young people acquire values and lifestyles different from those of their ancestors.

Several interrelated aspects appear to be more or less specific to the nature of indigenous knowledge (ibid.):

- It is locally bound, i.e. indigenous to a specific area
- It is culture- and context-specific
- It is a non-formal type of knowledge
- It is orally transmitted, and generally not documented
- It is dynamic and adaptive
- It is holistic in nature, and
- For many people worldwide, it is closely related to survival and subsistence.

Local wisdom can accumulate through long periods of trial and error, enlightened guesses, and adaptation. Knowledge accumulated over a long time allows for sustainable adaptations to local environmental conditions ([http://en.wikipedia.org/wiki/Traditional\\_knowledge](http://en.wikipedia.org/wiki/Traditional_knowledge))

### *The San*

There is no collective indigenous term for the various people that are labelled *San* or *Bushmen*. Almost all labels referring to San collectively were coined by non-San and are pejorative. The term *San*, although also problematic in some respects<sup>1</sup>, is considered the most neutral by anthropologists (Berger and Mazive, 2002:9).

The San are the indigenous people of the Kalahari Desert in southern Africa. The San were and largely still are perceived by their various neighbours to be different from all other people, and are sometimes perceived negatively as constituting an ‘inferior’ or more ‘primitive’ ethnic community. There just over 30,000 San living in Namibia, making up less than 2 percent of the national population. They typically live in small, flexible and dispersed groups in areas with sufficient natural resources, enabling them to live from hunting game and gathering veldt foods (Berger and Mazive, 2002:10). But a lack of land rights and social pressures have led to many San communities becoming increasingly dependent on state welfare rather than their tradition of hunting and gathering.

The groups which currently identify themselves as San characteristically speak Khoe or other San languages.

During the colonial period, less than 3 percent of the San retained even limited rights. While most Namibians defined as ‘non-white’ were, based on their ethnic designation, granted ‘homelands’ with limited rights to self-governance, the San were denied this privilege. Even with the 1971 proclamation of an area termed *Bushmanland*, no such rights were granted. Most areas in which San communities traditionally lived either became commercial farming areas, ‘homelands’ for other ethnic groups, game reserves, or national parks. When Namibia became independent in 1990, the majority of San in the country lacked rights to land and resources and lived in conditions of extreme poverty. After 17 years of independence, only a small proportion of Namibian San have seen significant improvements in their quality of life (Berger and Mazive, 2002:11).

San communities are mostly spread across the north-east of the country. Contrary to popular belief, only a minority of San – about 3,350 people – live in the area formerly known as *Bushmanland* (Berger and Mazive, 2002:11). Although the San in the latter area face problems similar to those outside game reserves and protected areas, they are better off than elsewhere in the country in that they retain adequate access to land and, hence, natural resources. The majority of San communities live in commercial farming areas. Nonetheless, although the San are known to be the poorest community in Namibia, they are also known to be rich in indigenous knowledge.

Some elements of the San’s indigenous knowledge have been identified as commercially exploitable, such as the appetite suppressant properties of hoodia, which the San use to suppress appetite during long hunting trips, and the anti-inflammatory properties of devil’s claw. The harvesting and export of these plants are currently the subject of negotiations between pharmaceutical companies, research agencies, and groups representing the San over intellectual property rights and community benefits.

### *Research objectives*

The research objectives of this study were as follows:

- Investigate the indigenous health knowledge held by the San at Farm Six, how they use it and the extent to which they apply it.

- Examine how this knowledge is shared within the community.
- Establish the extent to which the San at Farm Six have access to external health resources and knowledge.
- Identify health needs that require external knowledge and intervention.

## Literature review

### *A gender perspective on the status of the San in southern Africa*

In their 2001 study, Silke Felton and Heike Becker examine a range of issues from a gender perspective, including San health practices and beliefs.

The study finds that the kind of treatment chosen to cure illness – traditional practices or Western medicine – varies greatly between and within communities, and it is determined by a range of factors, with no obvious gender pattern being discernible. However, there are differences in age and degree of education: younger people with some formal education are said to be more likely to hold bush remedies and healing ceremonies in low esteem. Surveys among the San in the Omaheke Region and the Nyae Nyae area conclude that the levels of confidence in the respective merits of indigenous practices and modern medicine are primarily shaped by pragmatic considerations rather than principled preference for the one or the other. Most respondents believed that some serious diseases which are not caused by ‘magical’ forces (especially tuberculosis/TB) could be effectively treated only by medicine, whereas other diseases were best tackled by traditional means (Felton and Becker, 2001:49).

Felton and Becker’s research (ibid.) also highlights the use of traditional knowledge in health practices combined with modern health practices. The study found that bush remedies were still fairly widely known and used by the San, even in areas like Omaheke, which are dominated by commercial and communal cattle farmers. It was also found that the curative properties of certain roots and plants were common knowledge among many men and women of the older generation, and some individuals were seen as expert herbalists.

However, Felton and Becker (ibid.:49) do not investigate in any detail how knowledge of traditional and Western medicine is used, and to what extent there is a reliance on bush remedies *so-called* medicinal plants. Knowledge of traditional healing practices

and transmission of this knowledge to the younger generation varies, partly in accordance with the degree to which a more traditional lifestyle has been retained by communities. For example, in Nyae Nyae, traditional medical practices have remained more important than elsewhere in the country, and the use of medical plants seems to be more widespread than communal and social healing ceremonies (trance dancing) (ibid.:49).

### *New horizons for the San: participatory action research with San communities in northern Namibia*

Research by Berger and Mazive (2002) examined health issues at Epembe and, in more depth, at Ekoka, where workshop participants stated that there had been an improvement in their general health status since 1990. The reasons put forward for these positive changes were the closeness of a clinic, the vaccination of children, and an improvement in hygiene within the community. The situation at Ekoka underlines the importance of accessible health services and education. In contrast, Berger and Mazive (ibid.:31) report that the health status of the people of Onamatadiva, where there is no clinic or mobile services, appeared to have worsened.

In a survey conducted by the researchers (ibid.:32), the need for better access to health services was ranked, by both men and women, among the first four most urgent needs facing San communities. The highest-ranking problem experienced by respondents of all ages was malaria, followed by TB. Some people believed they could not avoid malaria, while others linked the disease to the state of their housing. They knew about bed nets for preventing mosquitoes, but said they could not afford them. They proposed the use of a herbal insect repellent called *endjikawi*, and decided to improve on the state of their houses, although they acknowledged that no house was completely mosquito-proof.

## Research methodology

The study used a matrix tool to explore people’s perception of trends (ibid.). Responses showed that the community expressed optimism about most diseases not being a problem in future due to modern medicine. They appeared to have blind faith in the powers of modern medicine. The participants also expected the incidence of six out of the seven most common diseases within the community, which are malaria, tuberculosis, diarrhoea, measles, chicken pox,

sexually transmitted diseases (STDs) and alcoholism to decrease by 2012. In addition, they believed that alcoholism would increase, and that HIV/AIDS would make its way into the community.

The findings of the research, conducted between March and October 2007, are based on information gathered during individual and group interviews with San women, men, and children living at Farm Six. Farm Six lies 40 km west of Tsintsabis in the Oshikoto Region, northern Namibia.

The community lives on state land that falls within an area where the Namibia Development Corporation (NDC) operates a number of state-owned farms. The area is known as Mangetti West, a name derived from the many mangetti groves in the district. The majority of people at Farm Six are from the Hai//om group, while a small number are from the !Kung tribe. According to Dieckmann (2007:3):

The Hai//om are one of the great ethnographic anomalies of the Khoisan cultural area. As with the Damara, their origin has been subject to speculation. They have been long thought of as !Kung who acquired a Nama-Damara language at some point in the not too distant past. Towards the end of the South African colonial period, the Hai//om were said to be maintaining vociferously their identity as non-!Kung, while officials insisted on classifying !Kung and Hai//om together as members of the same population group.

San groups, include the #Khomani, Khwe, !Kung, Hai//om, Ju|'hoansi, were once hunters and gatherers, who enjoyed the freedom of the entire territory between the Atlantic and the Indian Ocean (Hoering, 2004:6). According to older members of the community at Farm Six, they settled in the Mangetti West area after being removed from the Etosha National Park in the early 1950s, as the colonial authorities sought to establish the park as a tourist attraction based on its wildlife population and not the people who had lived there for centuries. The San were driven off their land, away from their ancestors' graves, and away from their sacred sites (Hoering, 2004:7). In their new location in Mangetti West, they were initially still able to practise hunting and gathering. However, their lifestyle was gradually restricted as commercial farming became dominant, land was fenced, and hunting rights and the movement of people were restricted. As a result, the San in the Mangetti West area found themselves mostly confined to Farm Six or working as labourers on farms.

During the current study, there were between 280 and 300 people living at Farm Six, making up about 50 households.

A qualitative research method was used. This method was based on anthropological fieldwork methods including participant observation, structured and semi-structured interviews, and informal observations. The research subjects were the individual members of the Farm Six community. Most interviews and discussions were conducted in the local San language, with the researcher using local translators.

Four types of interviews were completed: individual interviews with adults, interviews with children and young people between the ages of 10 and 19, focus group discussions, and interviews with opinion leaders. Interviewees and members of the focus groups were selected according to their availability and willingness to participate.

More women than men were willing to participate in the study. It was very difficult to persuade some male members of the community to take part as many spent their days at the local *shebeen*. When asked why they did not want to participate, the men replied that they did not want the police to come and arrest them – despite being given the reasons for the study. In addition, because the community lives mainly on hunting and gathering fruits and other plants this meant some community members were unavailable as they were out in the field for much of the time.

## Presentation of the research findings

### *Perceived health threats*

The first part of the interview questions sought to determine the common symptoms and diseases experienced at Farm Six. Participants were asked to highlight which diseases and symptoms are most common within the community and what they thought the causes of these conditions were. It should be noted that community members often confused symptoms and diseases, and that the information reflects their responses to questions, notwithstanding their lack of medical knowledge. This helps to establish what they perceive as possible health threats and what treatments they believe are appropriate.

Most of the participants indicated TB as the most common disease or symptom within the community, followed by malaria, stomach ache, and coughing. The least common conditions and symptoms were high blood pressure and chest pains. Participants were

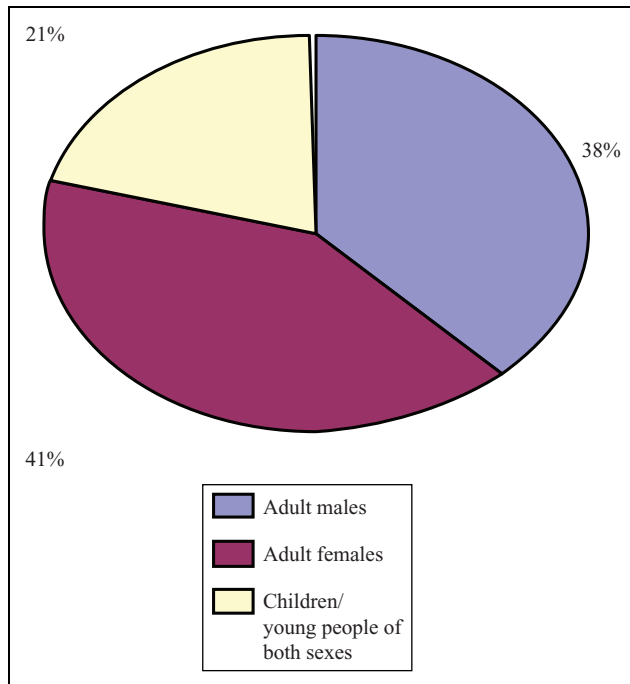


Figure 1. Survey participants

then asked to indicate what they thought were the causes of the symptoms or diseases they mentioned.

Participants indicated that the highest causes of diseases were cold weather conditions, followed by windy weather conditions, germs, and smoking. These were followed by alcohol abuse<sup>2</sup> and the onset of the rainy season. They indicated that TB was caused by smoking and drinking alcohol; stomach ache was caused by germs and consuming dirty water; malaria was associated with the rainy season; and coughs, colds and flu were linked to cold weather.

The second emphasis in the interview questions was on treatment. These questions aimed to establish how diseases and symptoms were treated and how knowledge transfer about remedies and treatments occurred.

### Traditional treatments

Table 1 presents plants in relation to traditional medicines. Traditional names are based on local spellings. Where possible, English and Latin equivalents have been given, but it was not possible to identify certain plants such as *edada*, *khoaba* and *tima* botanically.

Most of the interviewees stated that there was no herbal traditional medicine that could treat TB. They indicated that the only way to receive treatment was to go to the clinic at Tsintsabis, 40 km away. There

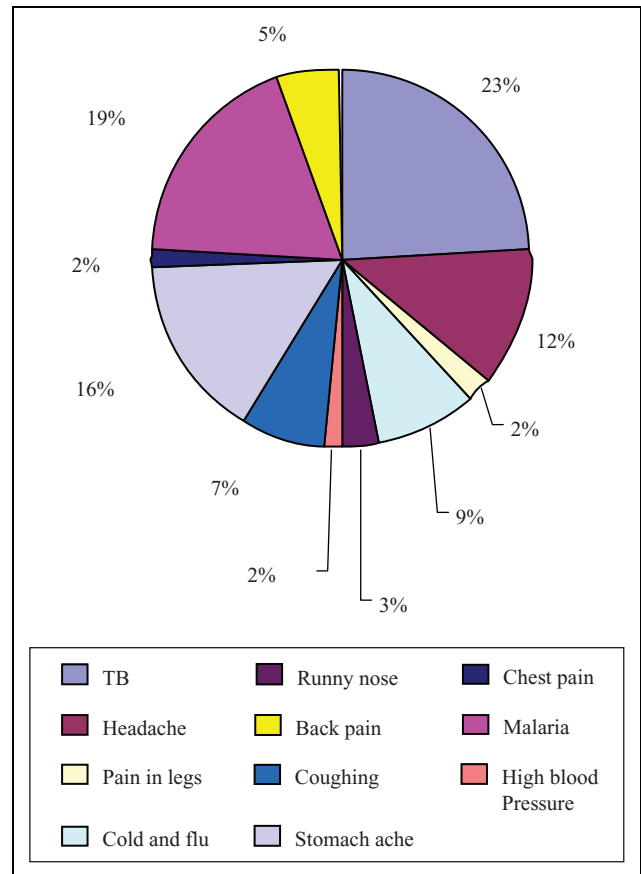
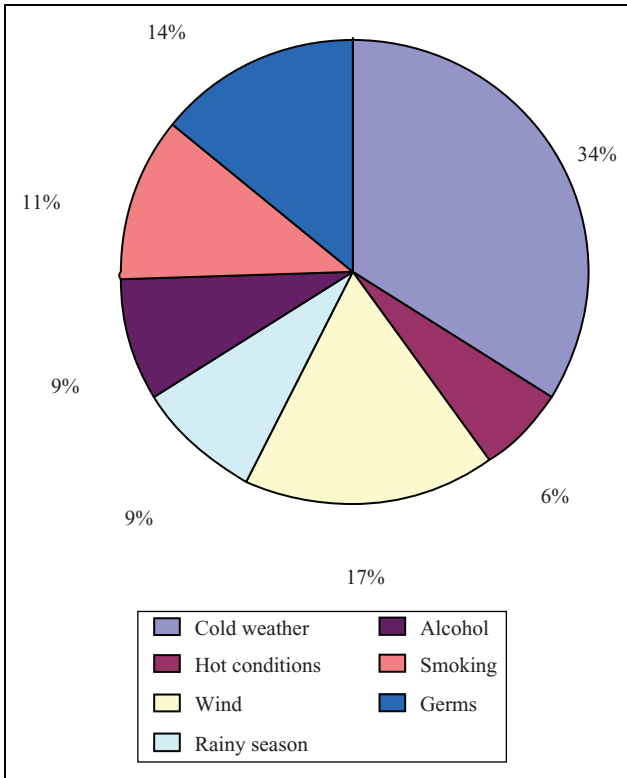


Figure 2. Common symptoms and diseases

appeared to be little knowledge about how TB was transmitted via coughing, speaking, sneezing, spitting, etc. With households of five to seven people occupying small living spaces, the chances of infection are raised. It may also be that some members of the community ascribed other conditions affecting the lungs and the throat to TB. TB can only be medically diagnosed through a tuberculin skin test, which is normally only available at clinics or hospitals.

Interviewees indicated several ways of treating malaria. Some referred to using a herb called *//ganab* or cooking *quaroba* tree stems and then drinking the infusion. Another option was to dissolve a herb called *tima* (“mother”) in boiling water and inhale the steam. Most of the male interviewees did not know of traditional treatments for malaria.

Various herbal remedies are used for stomach ache, including chewing the roots of *aruba* called *!gomaba*. (*!gomaba* is the name of the root, not the plant) or by cooking them and drinking the infusion. The roots of the *edada* or *#aroba* bush shrubs can also be boiled and the infusion taken orally.



**Figure 3.** Perceived causes of symptoms/diseases

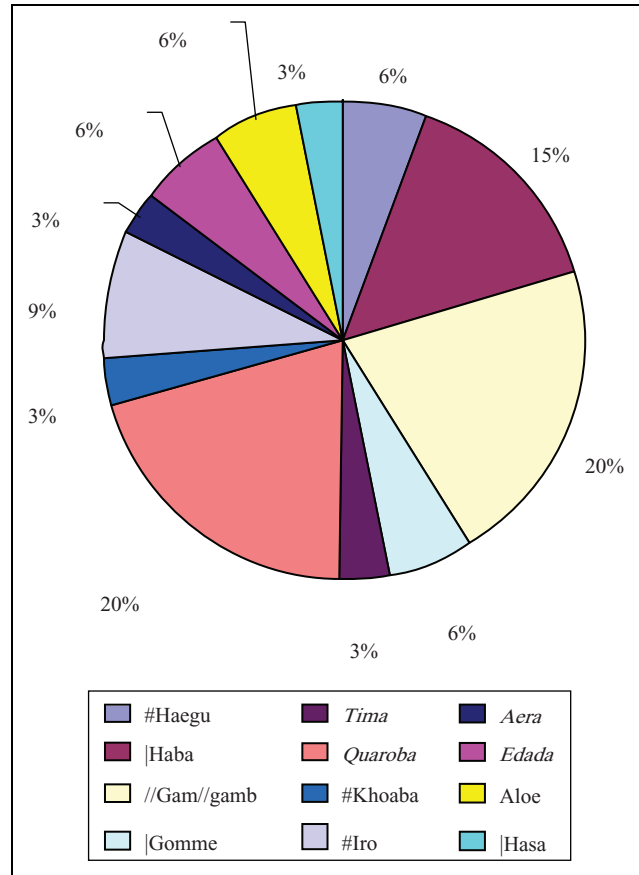
*Naruba*, *//gam//gambe*, and *tima* herbs are used to treat headaches by boiling the roots and drinking the infusion.

To treat a cough, the leaves of the *quaroba* (marula) are boiled and the infusion is taken orally. Alternatively, the liquid that is squeezed out of the roots can be taken orally. Other plants that can be used to treat coughs are the */gomme* and */hasa*.

Members of the community said they relied on traditional medicine to treat a variety of other ailments as well. However, they also stressed the pragmatic point that they felt they had to use traditional options since modern medicine was not accessible due to the lack of a clinic in the community and the long distances involved in reaching formal medicine and medical practitioners (the nearest hospital, at Tsumeb, is 120 km away). As one of the respondents said:

There is a lack of transport to go to the hospital, so we rely heavily on traditional medicine as it is the only one we have.

Many respondents emphasized that traditional medicine was still valued because there was no transport to take community members to Tsintsabis, 40 km away, where the nearest clinic was.



**Figure 4.** Most commonly used sources of traditional medicine

Residents at Farm Six also used trance dancing, which they called */gaisa* or */khoeba* (“elephant”), as a means of treating illnesses. Trance dancing is used when a traditional healer is called to treat someone who has not recovered despite the administering of traditional medicine. The women sing and dance while the rest of the community sit around a fire. The healer attends to the patient by “taking the sickness out of the person’s body”. If the trance dancing does not work, the patient is sent to the clinic.

Traditional healers who use the trance dancing method do not live at Farm Six, but are called in from other areas by community elders.

The plants used as the source of traditional medicine at Farm Six are either collected from the surrounding area or foraged from deeper in the bush. These remedies are easier to obtain during the rainy season, when leaves and roots are easily available. Most plants are used to treat more than one condition. Figure 4 illustrates the extent to which certain popular medicinal plants are used.



**Table 1.** Plants used for traditional medicine and their English and Latin names

Traditional name	English name	Latin name
#aroba	buffalo thorn	<i>Ziziphus mucronata</i>
/arosa, /aro, /arusa	aruboom, blinkblaar, wag-'n-bietjie (Afrikaans)	<i>Corallocarpus triangularis</i>
aera	–	–
aloe	zebra aloe	<i>Aloe zebrina</i>
arub, aruba	worm-bark albizia	<i>Albizia anthelmintica</i>
edada	–	–
//gam//gambe, //gam	–	Genus <i>cucumis</i>
//ganab	camelthorn	<i>Acacia erioloba</i>
gomme	mangetti	<i>Ricinodendron rautanenii</i> Schinz
#haegu	–	–
haba	silver terminalia	<i>Terminalia sericea</i>
hasa	leadwood	<i>Combretum imberbe</i>
#iro	sour plum	<i>Ximenia caffra</i>
#khoebebe	large-leaved commiphora	<i>Commiphora anacardiifolia</i>
kube	blue-green sour plum	<i>Ximenia americana</i>
quaroba; quaros	marula	<i>Sclerocarya birrea</i>
tima	–	–

Source: Leffers (2003), Le Roux (1971)

//Gam, //gamb, quaroba, Aloe and edada seem to be the most commonly used sources of medicine within the community, with the /hasa, #iro also being regularly used. The more commonly used plants are also the most easily accessible. All remedies are extracted either from the leaves, roots, seeds or stems of the plants. They are then boiled, roasted, or chewed raw.

The community did not refer to the two plants being commercially exploited – hoodia and devil's claw. This is because hoodia is unlikely to grow in Mangetti West, although it is possible that devil's claw grows there.

According to the National Botanical Institute of Namibia (Steve Carr, personal communication, 8<sup>th</sup> November 2007), a lack of laboratory facilities in the country means plants cannot be tested for possible palliative or curative effects. Moreover, research was very expensive, and opportunities were rarely available. The Institute was only able to identify plant species and their distribution. However, the Institute had not completed any studies on plants within the Mangetti area (ibid.).

Although the Government and development aid agencies support botanical research, it is hampered by a lack of trained staff and inadequate funding (Huntley, 1994:93).

A study by Arno Leffers (2003) on traditional plant use by the Ju|'hoansi in north-eastern Namibia highlighted some plants that were used for medicinal purposes. The following are mentioned by Leffers and

PhytoTrade Africa as having beneficial medical effects:

- *Acacia erioloba* (camelthorn): The fresh, fine roots of the camelthorn give off a rather strong odour. They are chewed in the case of any strong pain being experienced in the chest, stomach or head, or are taken to combat severe disease. (Leffers, 2003:17).
- *Aloe zebrina*: The utilization of this plant for medicinal purposes was found to be very variable, with treatment often differing from village to village. In one village the clear gel that is secreted when a leaf is broken was mentioned as a remedy for eye ailments. For example, it can be applied directly to the eye. The leaf gel was also recommended for the treatment of burns and skin ailments (ibid.:31).
- *Combretum imberbe* (leadwood, /hasa): Chewing *comberetum imberbe* leaves is regarded as a remedy for coughing or a bad cold (ibid.:68).
- *Terminalia sericia* (silver terminalia, /haba): The plant is valued for its ability to cure bad colds and persistent coughing. People can often be seen chewing strips of bark for this reason. Chewing the leaves serves the same purpose. In more severe cases of coughing a root decoction is taken. A leaf infusion is taken as an anti-malaria drug and to reduce fever (ibid.:186). Making a

**Table 2.** Comparison of the use of traditional medicine at Farm Six with uses mentioned in other sources

Names of traditional herbs	Medicinal use at Farm Six	Medicinal use in other communities
<i>aruba</i>	To treat stomach ache	To stop nosebleeds
<i>//ganab</i>	To treat malaria	To relieve pain
<i>/hasa</i>	To treat coughs	To treat coughs and bad colds
<i>quaroba</i>	To treat malaria and coughs	To treat malaria, diarrhoea, diabetes and fever

Source: Leffers (2003), PhytoTrade Africa

**Table 3.** Statistics on patients from Farm Six

Disease/condition	Number of cases reported
Tonsillitis	9
Oral candida	1
Musculoskeletal disorders	8
Trauma (insect bites, snakebites, scorpion stings)	12
Gastrointestinal problems (including diarrhoea and vomiting)	17
High blood pressure	6
Breast infections	1
Skin disorders (including rashes)	5
Malaria	3
Chest pains	2
Eye disorders	2
Upper respiratory infections (including coughing)	23
Pneumonia	1
TB	4
HIV/AIDS	2
Total	96

Source: Tsintsabis Clinic

decoction from the roots or chewing bark from this tree not only treats headaches, but is also considered an effective treatment for malaria (ibid.:186).

- *Ximenia americana* (blue-green sour plum, *kube*): When the seed kernels are roasted, they are not only used as a remedy for flu in children, but are also considered effective in healing wounds. The roasted seeds are crushed and applied directly to the wound (ibid.:195).
- *Ximenia caffra* (sour plum, *#iro*): The kernels are used for preparing a valued ointment for healing wounds. A root decoction can also be taken to treat chest ailments (ibid.:196).
- *Sclerocarya birrea* (marula, *quaroba*): The bark is widely used medicinally to treat diarrhoea, diabetes, fever and malaria, and the roots are used

to treat sore eyes. ([http://www.phytotradafrica.com/downloads/Antioxidant\\_properties\\_of\\_marula\\_oil.pdf](http://www.phytotradafrica.com/downloads/Antioxidant_properties_of_marula_oil.pdf))

- *Albizia anthelmintica* (worm-bark albizia, *aruba*): The plant's medicinal properties are that it stops nosebleeds. While the roots are being burnt to ash, the smoke is inhaled (ibid.:30).

### Knowledge transfer

At Farm Six, there are several methods through which people acquire indigenous knowledge. Older members of the community play a major role in the sharing and acquisition of knowledge. Children are taught at home about traditional medicine. As one participant related:

The children would sit together with their parents, parents would make them medicine, and they would ask what it is they are preparing. They would be told, "Our parents also used traditional medicine and they would tell us that this medicine is from this tree and it can be used for this disease."

Through this process, children are taught which herbs to collect, where to find them, and what their medicinal effects are. Children also learn about traditional medicine through observation, particularly when a sick relative is being treated for a certain ailment.

Traditional healing is complex, involving rituals and spiritual aspects as well as the use of plants for medicinal purposes. Many modifications seem to exist in the preparation of treatments, and a wide variety of plants and plant parts such as leaves, leaf gel, and bark are used medicinally. Plants roots play a particularly significant role (Leffers, 2003:8).

Interviews were carried out with children and young people aged between 11 and 19. The main aim of the interviews with children was to verify how children acquire traditional knowledge.

Participants were asked to indicate what type of illness they had suffered from the last time they were sick. The most common complaints were malaria, headache and influenza, with toothache and stomach ache being the least common ailments.

They were then asked to indicate how the illnesses had been treated. A small number mentioned having received treatment or medicine from the clinic, while most said they had received traditional treatments from the elderly members of the community, especially their grandparents and parents. Some 60 percent of the youth claimed to know how to use the treatments without guidance from elders, while 40 percent said they could not; that is, they had some knowledge but could not practise it without guidance. About 20 percent of the children and young people stated that they had been taught this traditional knowledge in groups. Participants were also exposed to health education at school.

#### *HIV/AIDS: the missing issue*

It was somewhat surprising that the issue of HIV/AIDS was not raised during interviews and discussions about health threats and their possible treatments. It was expected that HIV/AIDS would be mentioned along with TB during discussions about diseases that required external intervention.

In order to gain insight into why HIV/AIDS was not an apparent concern in the community, the author interviewed Kleophas Geingob, an employee of the Working Group of Indigenous Minorities in Southern Africa (WIMSA) who has carried out various educational programmes and activities in the Farm Six community. These programmes covered legal education on human rights, awareness of the Namibian Constitution, and HIV/AIDS awareness. Geingob stated that it had emerged during education campaigns at Farm Six that the level of understanding about HIV/AIDS was “very low”:

They were afraid to discuss matters with regard to HIV/AIDS, which could relate to why they failed to mention HIV/AIDS during the interviews.

Indeed, when HIV/AIDS education work had taken place at Farm Six in March 2006, community members had not known anything about the virus.

A former teacher at the community primary school said teachers had carried out a programme within the community called the Window of Hope, which dealt with HIV/AIDS awareness. Participation in this

programme was very low for the first session, and no one even showed up for the following session. It should also be noted that the community at Farm Six has not received an outreach visit from Ministry of Health and Social Services staff for over 2 years. As a result, it appears that despite national efforts being made concerning HIV/AIDS, very little awareness-raising has taken place at Farm Six. This explains why community members did not raise HIV/AIDS as an immediate health issue, but this is a matter of concern.

#### *Statistics from Tsintsabis Clinic*

The Tsintsabis Clinic is the nearest clinic to the community – some 40 km away. A visit to the clinic and an interview with nursing staff provided information and statistics on visits from the members of the Farm Six community.

During the interviews with the community members, they had stated that transport was the main factor preventing them from making regular visits to the clinic. The nurses there raised the same issue. In 2006, the number of visits from the Farm Six community was higher than in 2007 because NDC staff members working on nearby farms used to transport patients to the clinic about twice a week and in cases of emergency. However, from the beginning of 2007 the number of visits had dropped, as NDC staff were no longer able to assist Farm Six residents with transport. In 2007, the nurses said patients from Farm Six arrived about once a month and were usually suffering from severe sickness by the time they came.

The lack of transport affects the treatment of TB patients in particular: those diagnosed with TB receive an initial batch of tablets, but are then unable to make follow-up visits. As a result, they often stop their treatment. In theory, staff at the outreach programme from the Tsumeb Hospital should visit Farm Six every 2 months, but no such visits had taken place at the time the research was conducted.

Statistics from the Tsintsabis Clinic show that 88 people from Farm Six had visited the clinic between January and October 2007. The chart below shows the number of cases for each ailment reported. The number of cases (96) exceeds the number of clinic patients (88) because some patients showed symptoms of more than one disease or condition.

Statistics also showed that six patients with severe health problems were transferred to the Tsumeb Hospital. These were patients suffering from severe

TB, lung cancer, pneumonia, malnutrition, and cerebral malaria.

### *Health outreach services*

An outreach programme is rendered to communities in the Tsumeb District by staff at the Tsumeb Hospital. The programme offers typical clinic services to communities such as Farm Six that do not have easy or close access to a clinic. Among such services are the treatment of minor illnesses, immunization, TB treatment, family planning, antenatal care, and sex education. They also carry out hearing and visual screening for learners, and conduct educational programmes focussing on hygiene, nutrition and sexually transmitted infections. According to the Ministry of Health and Social Services' 2004 Annual Report for the Oshikoto Region (Ministry of Health and Social Services, 2004), outreach services were provided regularly whenever a vehicle was available. However, it was conceded that it was not possible to visit all the outreach points as planned because transport was not always available. (Ministry of Health and Social Services, 2004).

The outreach programme schedule for 2007 indicated that Farm Six was to have been visited. However, according to the Primary Health Care Supervisor, programme activities planned for 2007 such as the immunization of newborns at Farm Six had not been carried out due to a lack of transport. The Supervisor added that the programme had in fact been suspended since the period of 2005 to 2007 for this reason. However, should a vehicle become available through donation or otherwise, a schedule is arranged.

The lack of an easily accessible clinic and programmed outreach visits are a cause of great concern to Farm Six residents. However, as reported by the Chief Control Officer in the Guinas Constituency, there were no plans to build any health facilities at Farm Six although the Oshikoto Regional Council could, theoretically, request the Ministry of Health and Social Services to build a clinic there. Moreover, the Office of the Deputy Prime Minister, which has taken a keen interest in the welfare of San communities, said it was not currently empowered to establish health facilities.

### **Conclusions and recommendations**

The members of the Farm Six community hold an extensive amount of indigenous knowledge concerning traditional medicine. The study found that the

community emphasized the importance of traditional medicine, because modern treatments were seen as unavailable: while many communities in the country can rely on access to modern medicine, this is not easily available to residents at Farm Six because of a lack of easy access to a clinic nearby. Most participants indicated that they preferred modern medicine and that, if modern medicine was readily available, many would abandon their use of traditional medicine. This might be due to perceptions among the San that knowledge external to their way of life was more advanced and effective, combined with a failure to appreciate the value of their own indigenous knowledge.

The knowledge held by the community at Farm Six was compared with other limited formal studies, and it was found that some of their remedies were also used elsewhere – often for the same or similar conditions.

Older members of the community play a major role in sharing knowledge within the community. Within each family unit, grandparents and parents share indigenous knowledge with the young members of the community. From about the age of five or six, children are taught to identify plants and extract treatments. This sharing of knowledge is crucial for maintaining options for the use of traditional medicine, particularly as modern medicine remains for the most part beyond the community's reach.

The recommendations cover two main areas: the need to preserve and protect the community's indigenous knowledge, particularly as it pertains to medical treatments, and the importance of enabling access to formal medical treatment at Farm Six.

### *Health facilities*

It is recommended that Government urgently examine the possibility of establishing a clinic at Farm Six. This would be in line with the Government's constitutional obligations, as stated in Article 95 (e) and (j), which read as follows (Republic of Namibia 1990):

The State shall actively promote and maintain the welfare of the people by adopting, inter alia, policies aimed at the following:

...

(e) ensurance that every citizen has a right to fair and reasonable access to public facilities and services in accordance with the law; ...

(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[.]

### Outreach programme

As an interim measure, pending the establishment of a community clinic at Farm Six, it is recommended that regular outreach visits to that community and others in the vicinity be reinstated as a matter of urgency. These outreach visits are vital if patients are to receive medical check-ups, immunizations, follow-up medication, and health education. It would seem the main impediment to the restoration of outreach visits is the lack of a vehicle, which should be urgently provided through Ministry funds or donor support.

### Transport

It is recommended that an arrangement be made with the NDC or neighbouring farmers for the provision of transport so that community members have the possibility of visiting the clinic at Tsintsabis until Farm Six has its own medical facilities.

### Health education

In addition to regular outreach visits, there is a need for intensive health education campaigns to take place at Farm Six and similar communities. Currently, the Farm Six community have only haphazard access to vital health information. A health education programme for Farm Six should integrate HIV/AIDS awareness campaigns and be planned over the long term to avoid the problem of one-off workshops and campaigns that are never followed up, and the effects of which are never monitored.

### Biopiracy and the protection of indigenous knowledge

The San are at risk of biopiracy. That is, there is a real danger that San traditional medicine will be hijacked by profiteers. Their indigenous knowledge concerning what has been called their 'open-air pharmacy' is in demand. Western pharmaceutical firms want access to that knowledge so that they can sell natural remedies and tonics to the global market. It is possible that the San themselves will reap few or no benefits from commercial exploitation of these natural treatments.

It is recommended, therefore, that San communities, including the one at Farm Six, should be educated about the intrinsic and potential commercial value of their traditional medicine. In particular, they need to be made aware of their intellectual property rights and their right to benefit from any marketing of their traditional medicines.

It is further recommended that working mechanisms be put in place to ensure the San benefit from any commercial exploitation of their knowledge of the medicinal use of local plants. Profits from the use of traditional remedies by pharmaceutical companies should be shared with grass-roots communities—communities who are involved in the decision making process of selecting plants for commercial use.

### Further research

This study found that little research has taken place on verifying the medicinal properties of plants used as treatments by the Farm Six community, and that Namibia lacks the facilities and staff to conduct such research.

It is recommended, therefore, that Government undertake scientific studies into the medicinal benefits of these traditional remedies by creating the capacity within Namibia to test the effects of the various treatments, and through collaboration with international research institutes. This will help to ensure that benefits stemming from any future commercialization of such treatments is shared equitably among stakeholders – principally indigenous communities.

### Notes

1. *San* means "outsider" in the Nama language and can be understood as a reference to animals. However, since the 1970s it has been widely adopted by Western anthropologists and academics, replacing the more politically incorrect *Bushman* (<http://en.wikipedia.org/wiki/Bushmen>).
2. Two homesteads at Farm Six brew the traditional alcoholic drink known as *tombo*, which is the only form of alcohol available in the community.

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