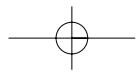
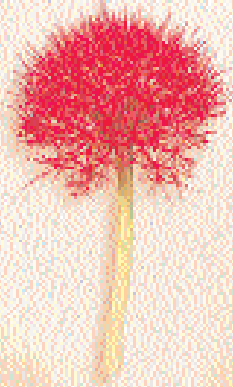
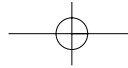


**VII**  
SAND AND WATER  
CHAPTER  
SEVEN

# PEOPLE

On the move





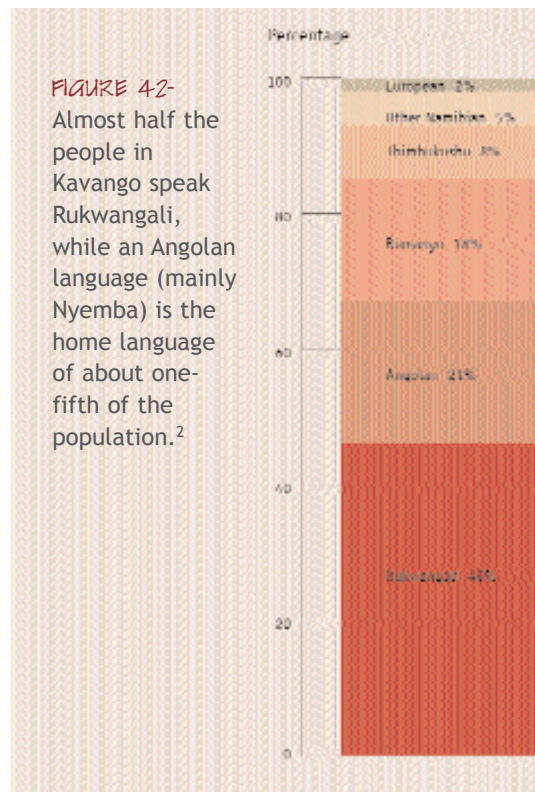
The lives of people in Kavango have changed very rapidly in recent decades. The population has grown substantially to about 201,000 in 2001, and health and education services are now well established and widely distributed in the region. All of this is quite different from conditions a hundred years ago when the population was very small and there were no formal schools. There were also no clinics or hospitals, and the prevalence of a variety of diseases was one reason why the number of people was so small. Population growth rates and life expectancies were kept low by the high death rates.

Nowadays, young people dominate the population because rates of child mortality are much lower. Movements by large numbers of Angolans into the region have also added to the population, but other people have left to seek work elsewhere in Namibia. The majority of people live near the river or along a number of omurambas and the main road to Rundu from the south. But many people have also moved from rural areas into Rundu, which has the only urban population in Kavango. Most rural people live in homes built of wood and grass harvested locally, and wood is the main cooking fuel. The most densely populated areas are best served with schools and health facilities. School classes are dominated by pupils in the lower primary grades and relatively few people have completed higher levels of education. HIV/AIDS, malaria, acute respiratory infections, diarrhoea, tuberculosis, bilharzia and malnutrition are the most significant health problems that beset the people of Kavango these days.

**POPULATIONS**

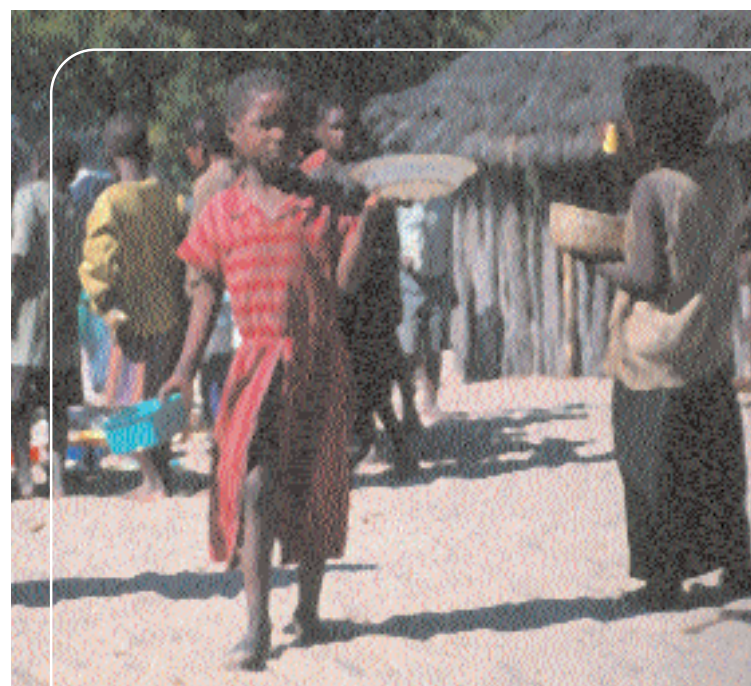
The distribution of people speaking different languages broadly follows the tribal areas shown in **FIGURE 73** (page 113). Almost half of all people speak Rukwangali, which is the language of Kwangali and Mbunza people, while people belonging to the Gciriku and Shambyu tribes speak Rumanyo (**FIGURE 4.2**). Most people reported as speaking 'Other Namibian' languages are Oshiwambo speakers, many of whom reside in Rundu where a great variety of languages are commonly heard as a result of the many origins of people who live there. There were approximately 4,800 San people in Kavango in 1998.<sup>1</sup>

About one-third of Rundu residents and 15% of rural people speak a language of Angolan origin as their mother tongue, reflecting the high rate of immigration from Angola over the last 30 years. Very large numbers of people moved to Kavango during the mid-



**FIGURE 4.2-** Almost half the people in Kavango speak Rukwangali, while an Angolan language (mainly Nyemba) is the home language of about one-fifth of the population.<sup>2</sup>

*Children make up about half the people in Kavango, and the greatest challenge of today is to set conditions that will allow such children to carry their potential into the future.*



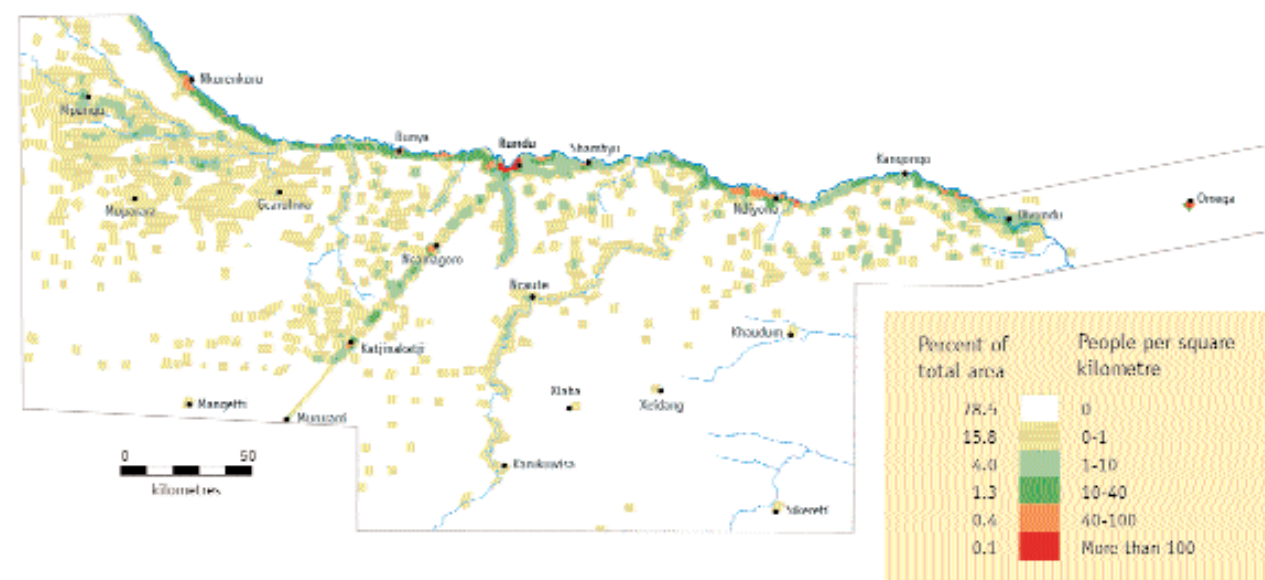
1970s during hostilities associated with Angola's independence war, while other waves of immigrants and refugees followed other bouts of insecurity. For example, many refugees arrived following the failure of the Angolan ceasefire in 2000, and the great majority of about 10,000 people who registered at the refugee centre in Rundu between 1999 and 2002 were from Angola. While many troubles have indeed made people flee Angola, it is also true that many Angolans moved to Kavango because of its comparatively better economic opportunities, services and infrastructure.

The distribution and density of people can be grouped into three zones (**FIGURE 4.3**). The first is the most densely populated ribbon along the river, where densities are generally higher than 40 people per square kilometre (km<sup>2</sup>) and exceed 100 people per km<sup>2</sup> in some places. There are similar densities along certain sections of the Mururani-Rundu road, indicating that the distribution of people, at least in that part of the region, has been strongly influenced by the presence of good road access (see page 115). Secondly, there is a large area consisting of many small, scattered settlements south of the river and west of the Mururani-Rundu road. Many of these small settlements are also along dry drainage lines or omurambas. Densities around the settlements generally range between 1 and 10 people per km<sup>2</sup>.

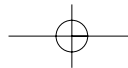
The third zone consists of the very sparsely populated remainder of the region where there are very few or no people. This zone, with population densities of less than 1 person per km<sup>2</sup>, makes up about 78% of the total area. Most large, open areas are in the south-east, south-west and in the Caprivi strip.

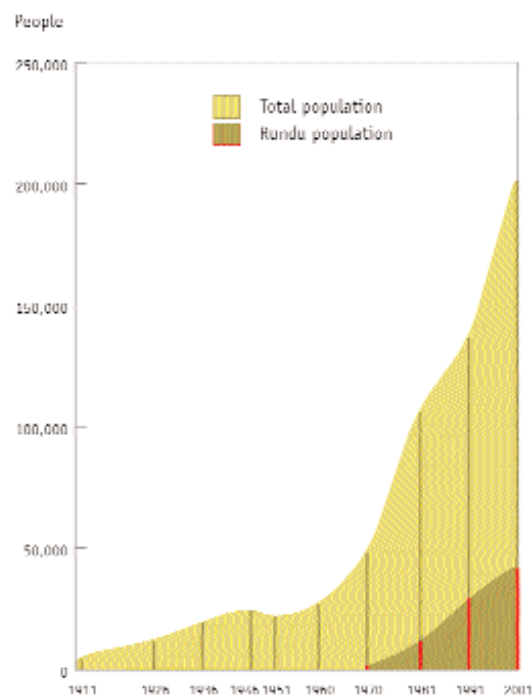
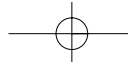
The first estimate of the region's population was made about 90 years ago, when some 4,500 people were reported to be people living along the south bank of the river (another 5,500 were estimated to be on the north bank in Angola (see page 36)). Thereafter, estimates were made in 1925 (12,000 people), 1926 (14,000), 1936 (19,150) and in 1946 (24,100 people). None of these figures were based on systematic population censuses, however, and it was only in 1951 that the first full census was conducted. A total population of 21,873 people was counted. Since then, the population has increased by about nine times to the 201,093 people reported during the 2001 census (**FIGURE 4.4**). Of those counted in 2001, 3,589 people were in institutions (e.g. school hostels) leaving 197,504 other people living in normal homes. The total number of households in the region amounted to 30,359, giving an average of 6.5 people per household.

The overall rate of population growth between 1951 and 2001 was just over 4.5% per year. Indeed, growth has been much higher than elsewhere in the country: for example, the



**FIGURE 4.3-** Most people live in densely populated ribbons along the Okavango River, the main road from the south and along certain omurambas. The map shows the density of people in 2000, while the legend shows the proportions of the region populated with different densities.<sup>3</sup> The approximate number of people (including residents of Rundu) living within 5 km of the river is 145,000 while about another 10,000 people live between 5 and 10 km of the river. This leaves about another 46,000 people living further than 10 km from the river.

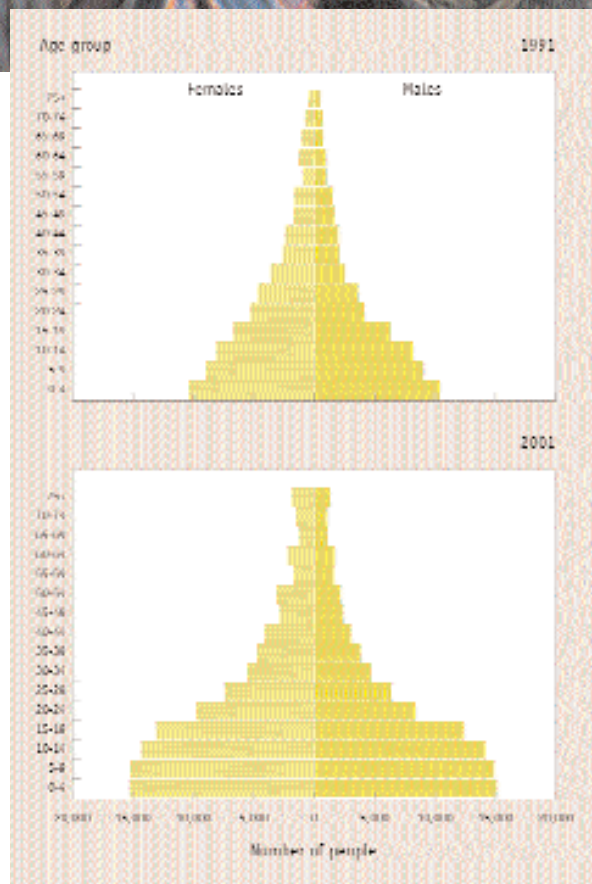




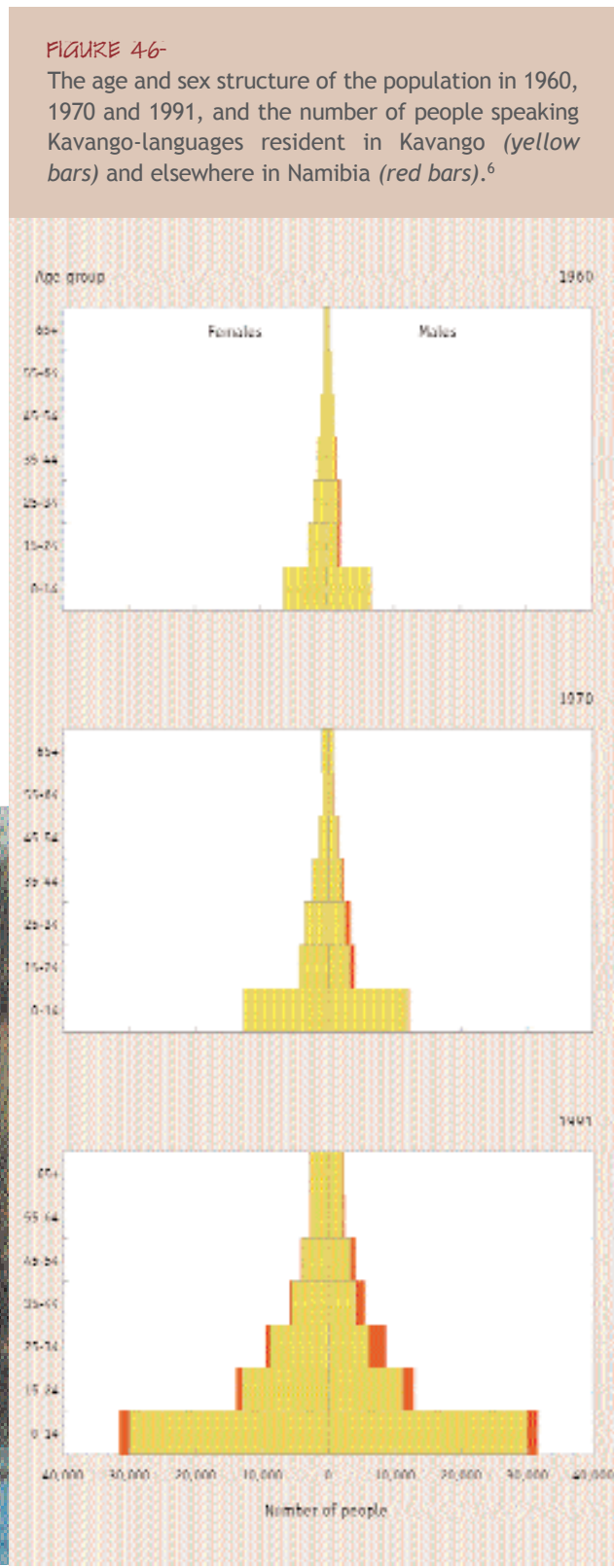
**FIGURE 44-** The number of people in Kavango has grown very rapidly, both as a result of declining death rates and immigration from Angola. The graph shows changes in the whole population between 1911 and 2001, and in Rundu between 1970 and 2001.<sup>4</sup>

total growth rate between 1991 and 2001 in Namibia was 2,62% compared to 3,97% over the same period in Kavango. Between 1970 and 1981 the growth rate in Kavango was a staggering 7,45%, and 5,96% between 1981 and 1991.

Much of this rapid growth was due to the high numbers of Angolans who settled in the region, and growth rates were thus affected as much by immigration as they were by births and deaths. Leaving aside the unpredictable rate of immigrations, two factors suggest that rates of increase will slow. The first is the significant decline in fertility that has occurred over the past 10 years. In 1991, each woman would produce an average of 7,1 children over the course of her life, but this had dropped by a third to 4,2 children in 2000. Some of the decline was perhaps due to family planning programmes, but the increasing number of women who moved from rural, subsistence livelihoods to town and formal employment probably



**FIGURE 45-** The population is dominated by young people, as shown by these age pyramids of the population in 1991 and 2001.<sup>5</sup>



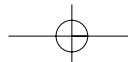
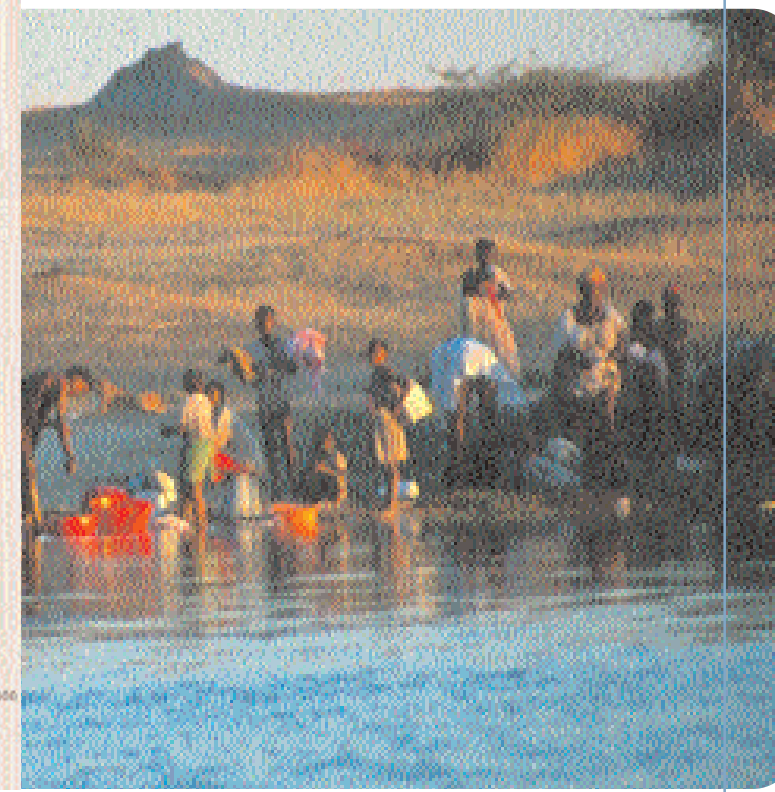
**FIGURE 46-** The age and sex structure of the population in 1960, 1970 and 1991, and the number of people speaking Kavango-languages resident in Kavango (yellow bars) and elsewhere in Namibia (red bars).<sup>6</sup>

had a greater effect on childbearing patterns. The second factor to slow population growth is the increasing numbers of deaths and decline in life expectancy due to AIDS (see page 84). Someone born in 1991 could expect to live for 57 years on average, but this figure had dropped by almost a third to 40 years in 2000 as a result of this disease.

The age and sex structure of the population in 2002 (FIGURE 45) reveals several noteworthy features. Firstly, young people make up a huge proportion of the population: 72% of all people are less than 30 years old and 44% are below the age of 15. Secondly, the number of 0-4 year-olds are about the same as the number of 5-9 year-olds, a reflection of reduced birth rates in recent years and perhaps increased mortality of young children caused by the transmission of HIV from their infected mothers. Thirdly, there are more females than males, especially so amongst adults.

There were also about 22% more women than men aged 20-54 in Kavango in 2001, a difference caused by the fact that more men have left the region to work elsewhere (FIGURE 46). Moreover, these graphs indicate that men started to leave as migrants before women, and that the proportions of men and women now living elsewhere has increased over the past few decades.

*More adult women than men live here because many men have left to work elsewhere in Namibia.*



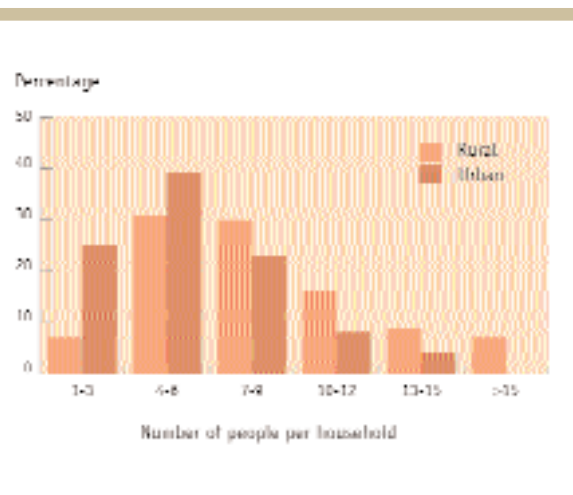


In addition to migration in and out of Kavango, there have been large-scale movements of people within the region. One significant movement is of people from rural areas to the urban area of Rundu, thus contributing to the substantial growth of the town from about 1,500 people in 1971 to 41,400 in 2001 (FIGURE 44). Those changes mean that the overall character of the region's population has changed from one completely dominated by rural people to one with a significant urban group. About 97% of the population was rural and 3% urban in 1971, while in 2001 about 80% was rural and 20% of the population was urban. In 1998, 24% of residents in Rundu had moved there within the past 10 years. Two-thirds of people had moved to Rundu from elsewhere in Kavango, while 12% had come from Ohangwena, Oshikoto, Oshana or Omusati, 5% from Caprivi and the remainder from elsewhere.<sup>7</sup>

Another significant movement is of people between settlements, and 2.8% of people were reported in 1999 as having arrived to live in new villages within the previous three years. Many such movements are from homes along the river to small villages in the inland. The movements occur for a variety of reasons, perhaps the most important being that natural resources (such as grazing, fertile soils and wood for timber and fuel) along the densely populated river are depleted. Many fields in the river valley are infested with a grass (*Cynodon dactylon* or *kweek gras*) and are now difficult to plough. It is also harder to manage cattle and other livestock along the river to ensure that they do not damage crops belonging to neighbours.

Some movements away from the river are apparently initiated by wealthier people, who establish cattle posts in unsettled areas and then recruit family members and other people to live at the posts. The new settlements become more permanent and developed as the new settlers clear land for crops, and boreholes are drilled nearby. However, it is also evident that many such small settlements do not last long, their residents either moving back to the river or to other new villages in the interior.

The majority of people live in rural households consisting of about 6-7 people, while urban homes in Rundu are smaller on average, consisting of 5-6 people (FIGURE 47). However, there are also substantial numbers of bigger homes of 10 and more people both in rural areas and in Rundu. About 70% of households are headed by men, both in rural areas and Rundu. Most households have about one active



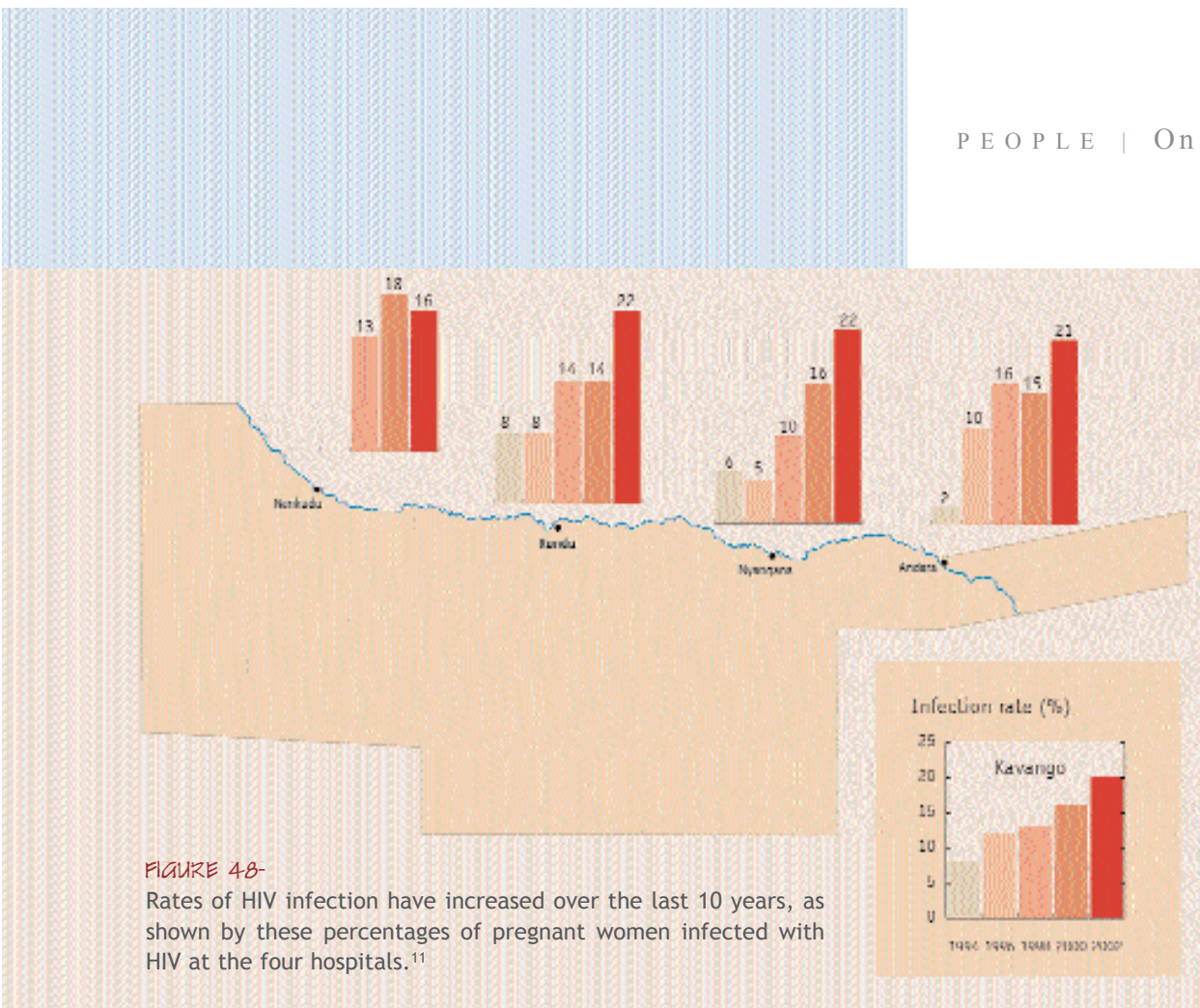
**FIGURE 47-** Most homes consist of between four and eight family members, but there are also many smaller and larger households, as shown by the percentages of rural and urban households of different sizes.<sup>8</sup>

person for each dependant in the home. A dependant is someone under the age of 15 or older than 64, and dependency ratios are calculated as the total number of dependants as a percentage of the total population. In 1991 the dependency ratio was 51%, while an estimate in 1999 gives the ratio as 46%.

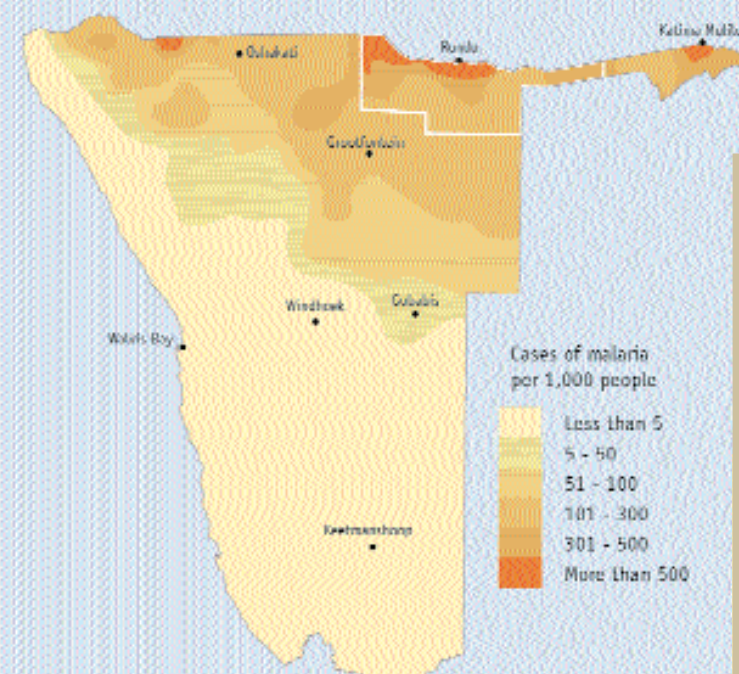
As might be expected, the great majority of homes rely on locally available natural resources for fuel and building materials. Thus, 97% of homes use wood for cooking, and 92% have the walls of their houses made of wood or mud. Eighty four percent of houses have grass roofs, most others being of iron (9%) or wood or sticks.<sup>9</sup> A slight improvement in the use of safe (piped and borehole) compared to unsafe (well and river) domestic water is shown in the following table.

Percentages of homes using different sources of domestic water in 1991 and 1999.<sup>10</sup>

Year	Piped water	Wells	Boreholes	River water
1991	14%	12%	24%	48%
1999	18%	7%	24%	41%

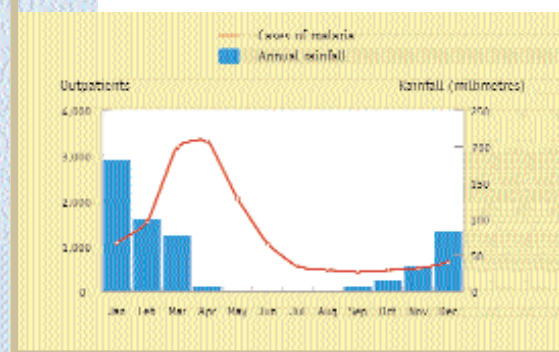


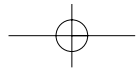
**FIGURE 48-** Rates of HIV infection have increased over the last 10 years, as shown by these percentages of pregnant women infected with HIV at the four hospitals.<sup>11</sup>



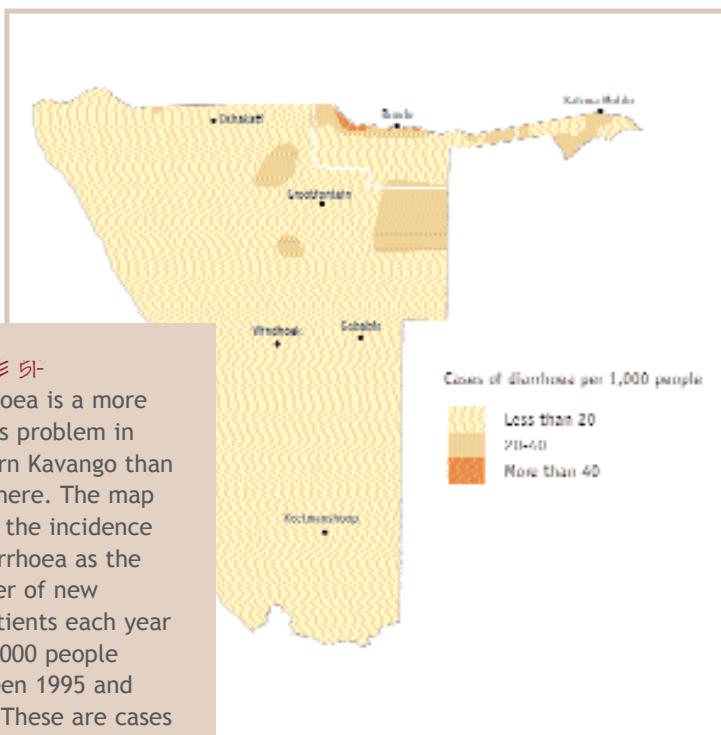
**FIGURE 49-** Kavango suffers from very high rates of malaria, with more than half the population being treated for the disease each year.

**FIGURE 50-** Most cases of malaria occur between two and three months after the peak rainy period, as shown by this comparison of the number of malaria outpatients treated at Rundu with average rainfall.

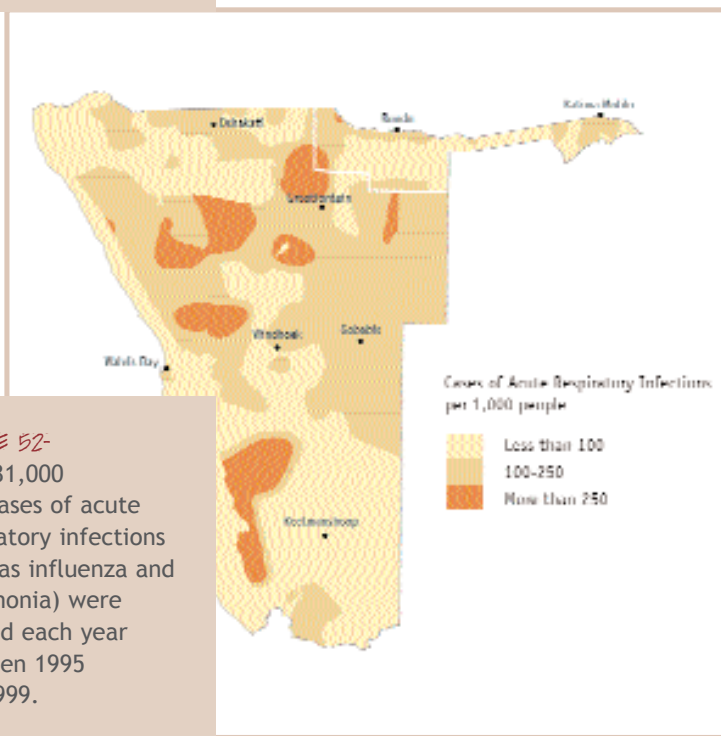




SAND AND WATER



**FIGURE 51-** Diarrhoea is a more serious problem in western Kavango than elsewhere. The map shows the incidence of diarrhoea as the number of new outpatients each year per 1,000 people between 1995 and 1999. These are cases of more severe diarrhoea which are accompanied by bleeding.



**FIGURE 52-** Over 31,000 new cases of acute respiratory infections (such as influenza and pneumonia) were treated each year between 1995 and 1999.

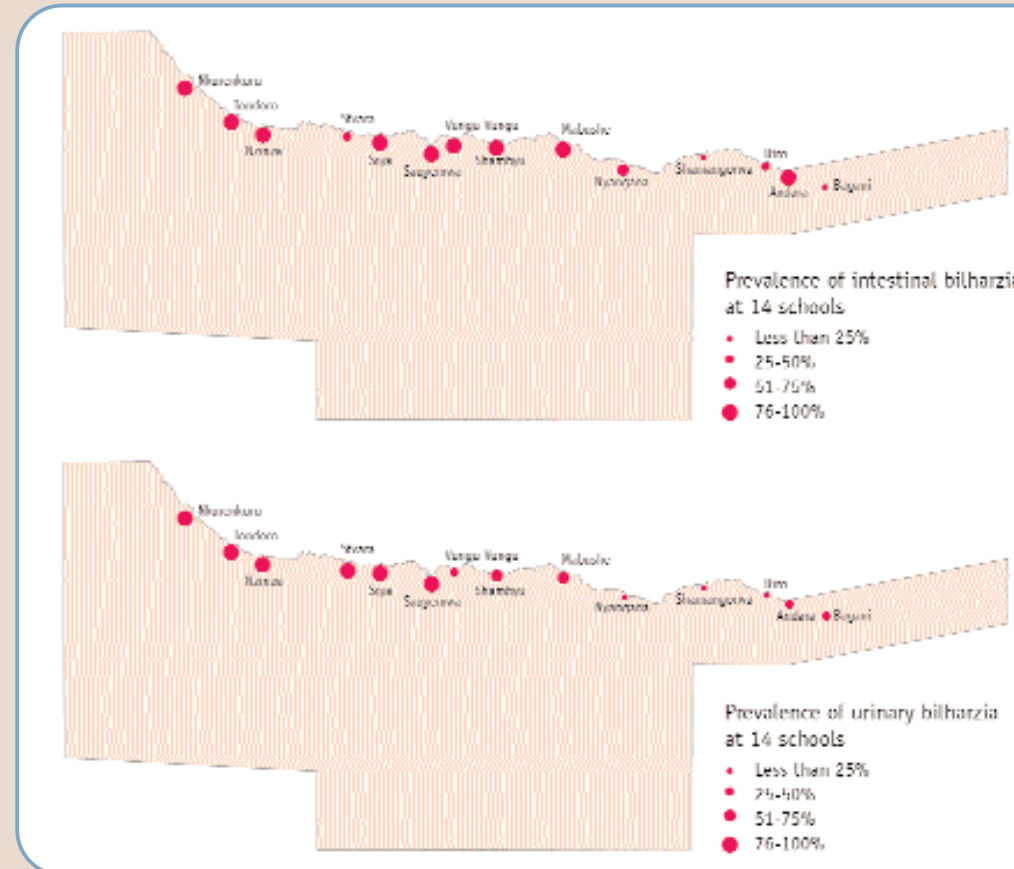
**HEALTH**

People in Kavango suffer from a variety of diseases and health conditions, many of which are associated with rural and subtropical environments. The most important of these challenges are HIV/AIDS, malaria, acute respiratory infections, diarrhoea, tuberculosis, malnutrition and bilharzia. For some interesting – but unknown – reason, health problems are generally more severe in western than eastern Kavango, and the incidence of malaria, acute respiratory infections, urinary bilharzia and diarrhoea are all highest in the west.<sup>12</sup>

HIV infection rates have risen dramatically in recent years, as reflected by rates of infection among pregnant women tested at four hospitals (FIGURE 48). These figures are reliable indicators of infection rates among all sexually active people, and they show that about 20% of these people have HIV. People between the ages of 15 and 49 are normally taken as the sexually active part of the population, and that group makes up about 48.5% of the total number of people in the region. Given a population of about 201,000 people in 2001 means that there are over 20,000 people in Kavango carrying HIV, and all of those people may die of AIDS within the next 5–10 years. Another concern is that most deaths occur among people aged 25 to 40 who are often the most economically active people in the region. Household economies will therefore be badly affected by the disease. Demands on the region's health services will also increase, not only as a result of the number of AIDS patients but also because the ability of people with HIV to withstand other diseases – such as tuberculosis and gastroenteritis – is reduced.

Although tuberculosis (TB) is not a particularly common disease, it is often prevalent among San people and often has fatal consequences. Kavango is only second (behind Karas) in having the highest rate of infection in Namibia. Rates of infection have also increased in recent years, mainly because many TB sufferers also have HIV.

While most cases of malaria are over within a few days, some infections lead to death and malaria affects more people than any other serious disease. Between 1995 and 1999 an average of about 118,700 new<sup>13</sup> cases of malaria were treated each year in Kavango, and more than half the population can be expected to get



**FIGURE 53-** Very large numbers of people have intestinal (top) and urinary (bottom) bilharzia as reflected by these percentages of infected pupils at 14 schools across the region.<sup>14</sup>

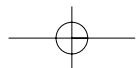
the disease each year. This is particularly true along the western areas of river (FIGURE 49). Most cases follow the onset of the rains and the accumulation of standing water in the omurambas, marshes and ditches in which mosquitoes breed. The highest numbers of malaria patients are thus treated in March and April each year (FIGURE 50).

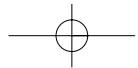
Many parasites cause acute respiratory infections (influenza and pneumonia, for example) and diarrhoea (FIGURES 51 AND 52). Both are important and often serious health conditions and, other than malaria, more people were treated as outpatients for acute respiratory infections between 1995 and 1999 than any other condition. Diarrhoea was the third most important condition leading to hospitalization. As a leading cause of death, gastroenteritis (a form of diarrhoea) was third only to AIDS and malaria during those five years.

There are two kinds of bilharzia in the region: urinary and intestinal bilharzia, and both types are extremely prevalent along the river (FIGURE 53). Most infections occur when people swim or bathe in river water, and the main effect of both diseases is a debilitating weakness that lasts for long periods. A survey in 2000 found that the majority of school pupils to the west of Rundu were infected with both kinds of

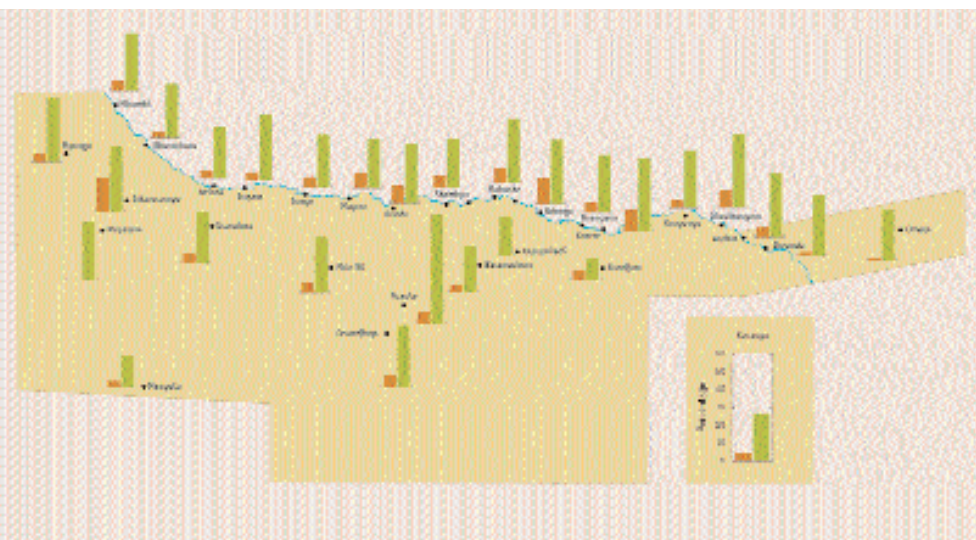
parasite, whereas to the east of the town there were much lower rates of infection by urinary bilharzia. The high infection rates found in 2000 were also many times higher than infection rates of less than 10% found during a survey in 1967. Why infection rates have increased so much is not known.

Many of the diseases described above affect children more than adults, and large numbers of children also suffer from malnutrition. An estimated 28% of children under the age of five were severely underweight in 2000; of the 13 regions in Namibia, only two others had higher proportions of underweight children than Kavango. However, mortality rates have decreased markedly in recent years: from 83 infant deaths per 1,000 live-births in 1992 to 23 in 2000, and from 56 child deaths per 1,000 one-year-olds in 1992 to 31 deaths in 2000.<sup>15</sup> Moving to a slightly older group, Kavango also suffers from high rates of teenage pregnancy. For example, more than a third of all women receiving antenatal care at many clinics were aged 15 to 19 and many were under 15 (FIGURE 54). One of the several undesirable consequences of these teenage pregnancies is that many girls drop out of school and fail to obtain a reasonable education.





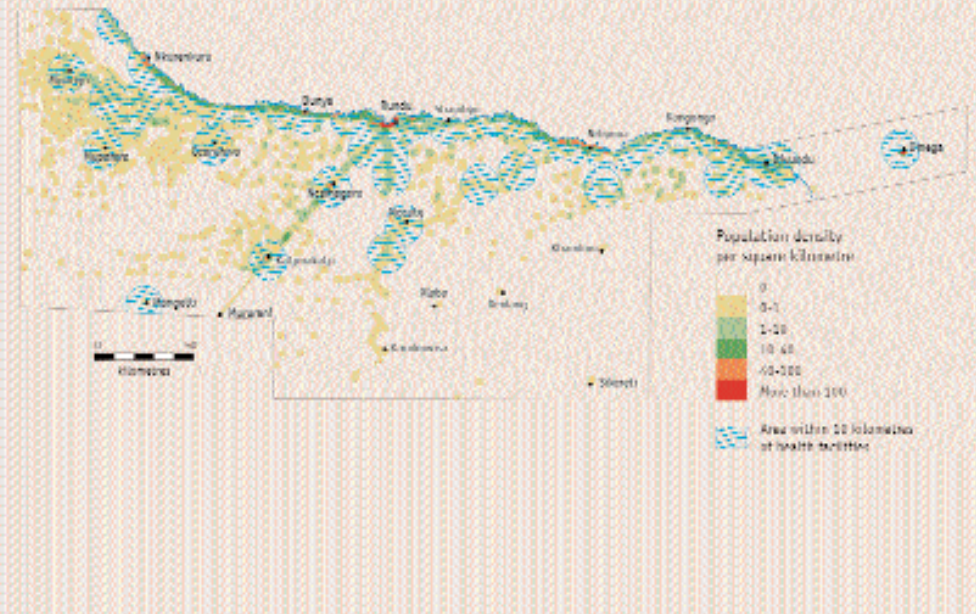
**FIGURE 54-** There are high rates of teenage pregnancy, a fact reflected in this map showing the proportions of all mothers having antenatal care who were under the age of 15 (brown columns) or between 15 and 19 years (green columns).



**FIGURE 55-** There were 42 clinics, nine health centres and four hospitals in Kavango in 2001.



**FIGURE 56-** About 85% of people live within 10 kilometres of health facilities. The map shows the density of people in areas further than the ten-kilometre range to provide indications of where new facilities could be provided.



The first level of service of primary health care is provided by the 42 clinics in the region (FIGURE 55), although nurses from some clinics visit outreach centres from time to time. There were also nine health centres in 2001, which are larger clinics equipped with some beds for the overnight treatment of patients. At a higher level for the treatment of the most serious cases are the region's four hospitals at Andara, Nyangana, Rundu and Nankudu. Only 21 doctors, 121 registered nurses and 885 hospital beds served the whole region of about 201,000 people in 2000.

FIGURE 56 provides an indication of the breadth of coverage of health facilities. This is based on the assumption that people within 10 kilometres of these facilities have adequate access to health services. Using the underlying density of people (FIGURE 43), estimates suggest that about 85% of people live within 10 kilometres of a health facility, leaving 15% of the population beyond reasonable reach of health services.

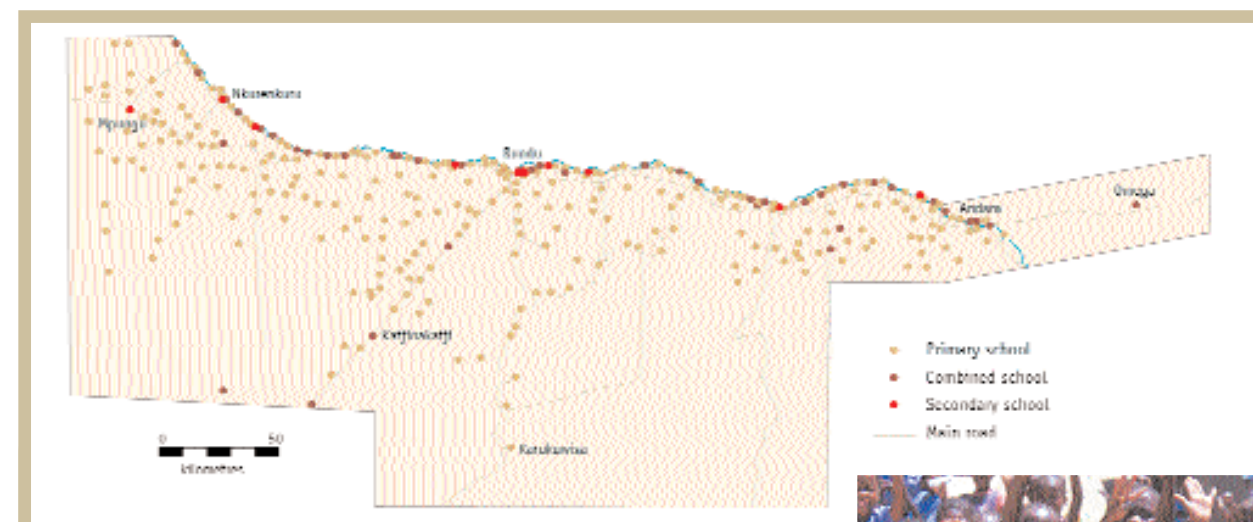
**EDUCATION**

Compared with other regions in Namibia, the education system in Kavango is extremely poor in many respects. Teachers are less qualified than elsewhere, there are few secondary schools, buildings at many schools are in bad shape, most adults have received little formal education, and relatively few children complete their schooling. At the beginning of 2002, there were

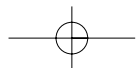
some 68,000 children taught by 2,179 teachers at 331 schools (FIGURE 57). Of these, 271 were primary schools, 47 were combined schools (offering some primary and secondary grades), and 12 were secondary schools. In addition, there is a vocational school and a teacher training college in Rundu. The many schools along the river and the road between Mururani and Rundu are comparatively large, while those elsewhere in the inland areas are much smaller. Almost all the small, inland schools offer only lower primary grades, so most children in those areas either drop out of school after completing the first few grades or leave home and move to a school along the river.

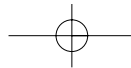
In addition to the lack of schools offering upper primary grades in the inland areas, there is also a lack of schools providing secondary grades along the river. This is one reason why there are so many more pupils in primary than in secondary grades (FIGURE 58). There are also more boys than girls in secondary grades, largely because many girls drop out of school as a result of teenage pregnancies.

Levels of education amongst adults are extremely low, especially for women and older people (FIGURE 59). In 1996, only 4% of men and 1,5% of women aged 15 and older had completed Grade 11 or any higher level of education. Taking the completion of Grade 4 as an indicator of literacy, most men older than about 50 years and most women older than about 40 cannot read or write.

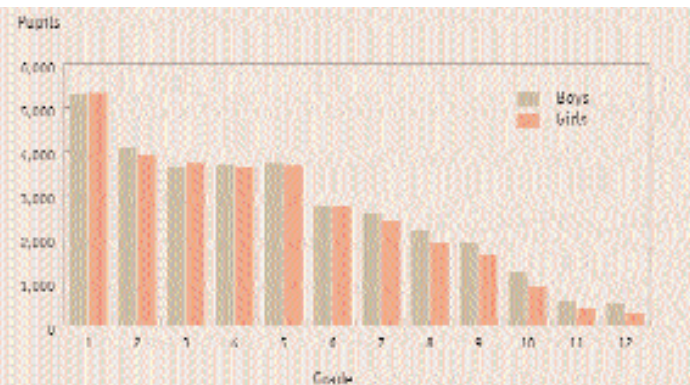


**FIGURE 57-** The distribution of schools offering primary grades and secondary grades, and combined schools. Note that many schools offer only a number of the primary or secondary grades, for example Grades 1-5 or Grades 8-10.<sup>16</sup>

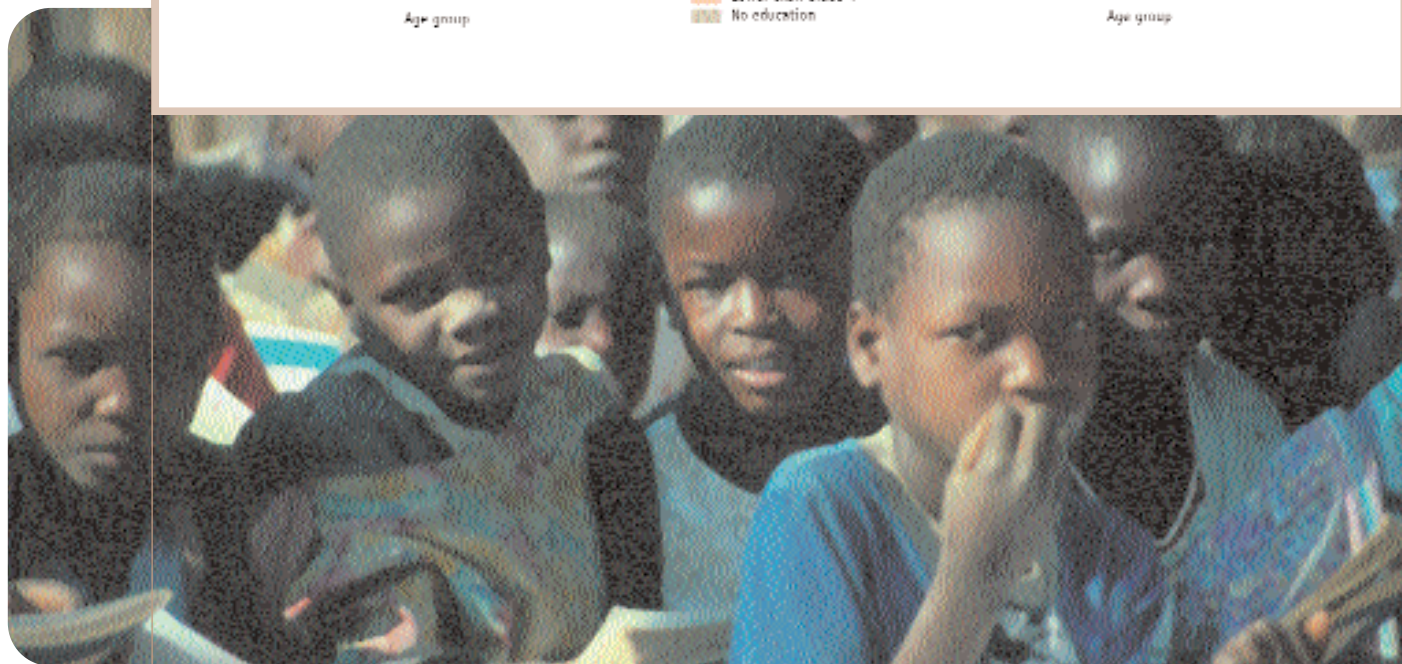
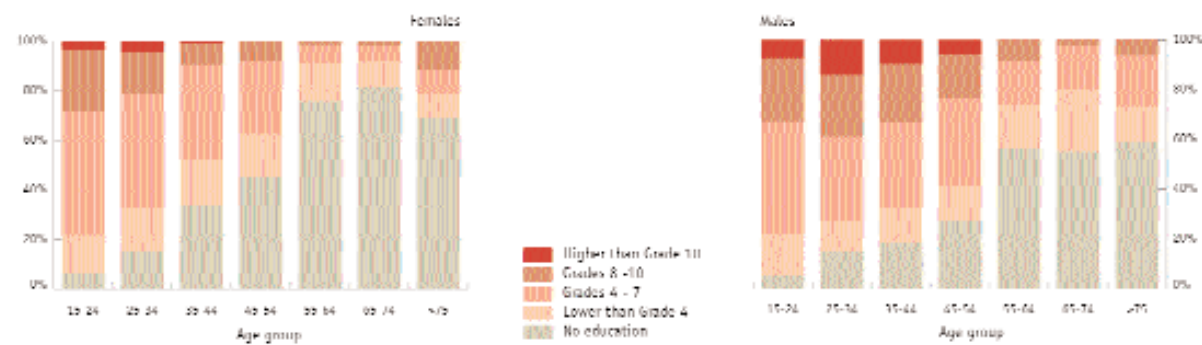




**FIGURE 58-**  
There are many more pupils in the lower than in the higher grades, and more boys than girls in the higher grades. These are enrolments in 2001.



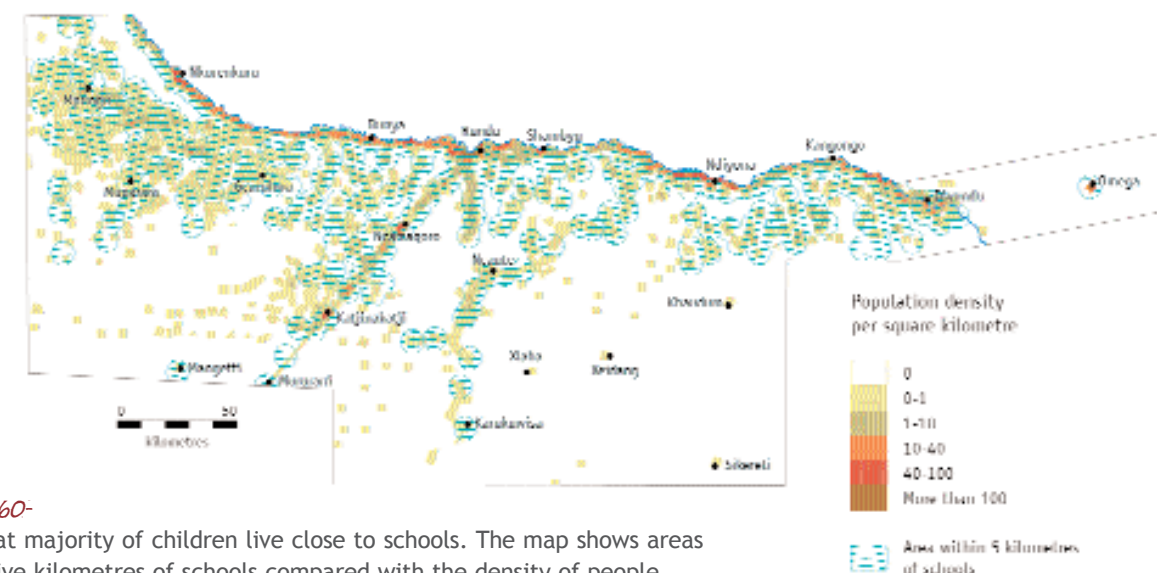
**FIGURE 59-**  
Very few adults have completed higher levels of education, as shown by these percentages of people aged 15 and older who have completed various levels of education.<sup>17</sup>



Total enrolments in the 12 grades have increased from about 41,100 pupils in 1992 to 68,000 in 2002. Part of that increase has been due to population growth, but enrolments also increased because more children now remain at school for longer to complete higher grades. For example, numbers of Grade 6 pupils doubled from 2,700 in 1992 to 5,400 in 2001, and there were only 212 Grade 12s in 1992 compared with 755 in 2001. By contrast, numbers of Grade 1s dropped because of policy changes introduced to prevent pupils from failing and

repeating the same grades; the lower grades were previously over-enrolled with many repeaters before these changes.

**FIGURE 60** provides an indication of the breadth of coverage of schools. This is based on the assumption that people within five kilometres of schools have access to education. Using the underlying density of people, estimates suggest about 96% of people live within five kilometres of a school, and 4% live beyond a distance of five kilometres of schools.



**FIGURE 60-**  
The great majority of children live close to schools. The map shows areas within five kilometres of schools compared with the density of people.

### Key notes

- The first schooling was offered at Nkurenkuru in 1909.
- About 155,000 people live within 10 kilometres of the river. This includes about 41,400 people in Rundu.
- The population increased by 4,5% per year between 1951 and 2001. Much of this rapid growth was due to the many Angolans who settled in Kavango.
- Young people dominate the population, with 72% of all people being under 30.
- Fertility rates and life expectancies have declined by a third over the past 10 years.
- The most significant health problems are HIV/AIDS, malaria, acute respiratory infections, diarrhoea, tuberculosis, malnutrition and bilharzia. Several diseases are more prevalent in western than eastern Kavango.
- About 20% of all sexually active people have HIV, and about one-third of all expectant mothers receiving antenatal care are teenagers.
- Most people have access to health and education services: about 85% of people live within 10 kilometres of a health facility and 96% live within five kilometres of a school.
- The education system is deficient in many respects: teachers are often not qualified, there are few secondary schools, many school buildings are in bad shape, most adults have received little formal education, and relatively few children complete their schooling.

