Health of Indigenous people in Africa

Long article du Lancet sur la notion de "minorité ethnique" dans les programmes de santé publique en Afrique

- Zone Franche -

Summary

Our paper is part of a series focusing on Indigenous peoples' health in different world regions. Indigenous peoples worldwide are subject to marginalisation and discrimination, systematically experiencing poorer health than do majority groups. In Africa, poor health in the general population is widely recognised, but the consistently lower health position and social status of Indigenous peoples are rarely noted. Disputed conceptual understandings of indigeneity, a history of discriminatory colonial and post-colonial policies, and non-recognition of Indigenous groups by some governments complicate the situation. We discuss two case studies, of the central African Pygmy peoples and the San of southern Africa, to illustrate recurring issues in Indigenous health in the continent. We make recommendations for the recognition of Indigenous peoples in Africa and improvements needed in the collection of health data and the provision of services. Finally, we argue that wider changes are needed to address the social determinants of Indigenous peoples' health.

This is the third in a Series of four articles about Indigenous health

Introduction

Africa's 906 million people were the focus of intense international attention in 2005. Health, especially in relation to achieving the Millennium Development Goals, averting health service collapse, and attacking the disease burden, was a recurring topic [1,2] Of this population, however, the Indigenous peoples of the continent have received little attention, although the African Commission on Human and Peoples' Rights (ACHPR) in 2005 described them as "some of the most vulnerable groups on the African continent" whose health situation is "often very precarious and receives very limited attention from the responsible health authorities".[3]

We discuss the disputed conceptual understanding of indigeneity in Africa and the public health importance of securing recognition of Indigenous rights. We describe the position and health of two Indigenous peoples : the Pygmies of central Africa and the San of southern Africa. Evidence from these groups illustrate the difficulties facing Indigenous communities in Africa, especially with regard to land rights. Such evidence indicates that Indigenous health is systematically worse in many respects than that of majority populations, particularly where through loss of land and other natural resources they are no longer able to maintain traditional livelihoods and sustain traditional culture, knowledge, and institutions. However, data are weak because of well recognised drawbacks to obtaining information in remote areas with scattered populations. In central Africa, these difficulties are compounded by war and political instability and the inability or unwillingness of governments to disaggregate data relating to Indigenous and minority groups. We hope this paper will stimulate awareness of the need for appropriate data to be obtained. We conclude with recommendations for key actions that should be taken to secure the right to health of Indigenous peoples in Africa.

Who are the Indigenous peoples of Africa ?

A central issue for Indigenous peoples is recognition, and crucial to this is a common approach to identifying Indigenous groups. The broad and widely accepted working definition of "Indigenous communities, peoples and nations" produced by the UN Permanent Forum on Indigenous Issues emphasises, among other points, the importance of self-definition.[4,5] The term 'Indigenous' is contested strongly by some parties in Africa, and this issue and that of the rights of Indigenous peoples have been the focus of much discussion.[6] The report of the African Commission on Human and Peoples' Rights Working Group on Indigenous Populations/Communities, adopted by the Commission in 2005, discusses the problem of definition at length.[3]

"...the main argument that has always been preferred is that all Africans are indigenous to Africa. Definitely all Africans are indigenous as compared to the European colonialists who left all of black Africa in a subordinate position that was in many respects similar to the position of indigenous peoples elsewhere. However, if the concept of indigenous is exclusively linked with a colonial situation, it leaves us without a suitable concept for analysing the internal structural relationships of inequality that have persisted from colonial dominance."

"...Africa's indigenous peoples have their own specific features that reflect from the specific feature of the African state and its role. They have specific attachment to their land and territory ; they have specific cultures and mode of production that are distinct from the groups that dominate political, economic and social power."[3]

Patterns of migration and settlement in Africa in the pre-colonial era are disputed. However, there is evidence that groups such as the San have lived in southern Africa for 27000 years, long before the migrations of the past 500-1500 years that have shaped current populations.[7,8] The scramble for Africa and the agreement of colonial borders at the end of the 19th century split many ethnic groups, including Indigenous peoples.[9] In the colonies, Indigenous peoples were viewed as primitive and were increasingly marginalised. At independence in the second half of the 20th century the colonial boundaries were preserved, both solidifying the international division of Indigenous communities and maintaining their marginalisation within the new states. To establish a sense of national identity governments sought to disregard ethnic difference and, as Saugestad[10] has argued in the case of Botswana, this action resulted in the elevation of "the culture of the numerically dominant [Tswana] people to a new national, neutral standard."

Social scientists have suggested that being Indigenous is mainly concerned with peoples' relations to the state and the dominant economic and social structures.[11,12] In contemporary Africa, Indigenous peoples "experience a range of human rights violations that ultimately boil down to a threat towards their right to existence, and to the social, economic and cultural development of their own choice".[3] Over the past two decades, Indigenous peoples have increasingly sought to overcome the resistance of dominant groups by identifying themselves with the international Indigenous rights movement. A broader, more positive, and more political interpretation of the term Indigenous has developed in Africa as part of the wider international consensus that has emerged in the International Labour Organisation Convention[13] and the draft UN Declaration on the Rights of Indigenous Peoples.[14,15] Here the debate has shifted from the issue of aboriginality to a concept based on self-definition, cultural difference, and marginalisation.[10,13,15] The focus is on rights, especially collective rights to maintain their land, livelihoods, and culture, and to choose their own path to development.

Indigenous is not a "euphemism for primitive",[16]although there is a danger that Indigenous peoples are obliged to emphasise the traditional at the expense of the reality of their situation. Sylvain[17] describes the difficulties faced by the San in Namibia, who are required to present their case for land rights in terms of an "essentialized conception of culture", which ignores their class interests and "the lived practices and beliefs of contemporary San", most of whom are no longer traditional hunter-gatherers. Changes in modes of production, relationships with other groups, trade, and intermarriage should not prevent people from identifying themselves and being identified as Indigenous.

More than 14·2 million self-identifying Indigenous people live in Africa. Historically they have been loosely categorised in three groups :[11] hunter-gatherers, exemplified by the Pygmy peoples of Central Africa and the San of Southern Africa ; fisher people ; and pastoralists who range from the Maasai of Kenya and Tanzania, to numerous communities in Sudan and Ethiopia, Tuareg in west and northern Africa, and the Himba in Namibia.[18]

Recognition and discrimination

A feature of the colonial period, discrimination against Indigenous peoples, has persisted in many parts of Africa. As the ACHPR describes :

"Terms such as 'underdeveloped', 'backward', 'primitive' and worse are regularly applied...Along with the negative stereotyping and discrimination comes dispossession of the peoples' land and natural resources, which leads to impoverishment and threatens their cultures and survival as peoples."[3]

Lack of recognition by government presents a particular problem for Indigenous peoples in Africa. Colchester[19] notes that "prejudicial attitudes to Indigenous peoples' ways of life" in national laws and government policies remain prevalent, in opposition to international human rights law. Outcomes range from general government disinterest in recognising Indigenous peoples,[20,21] to the Rwandan government's ban on use of the term Indigenous and any promotion of ethnic identity, and the outright rejection by the Botswana government of the San peoples' rights to traditional lands and culture.[3,22] Recognition as peoples is contentious because of the legal rights conferred on peoples to self-determination in international law.[15]

Where Indigenous groups are recognised, they frequently face challenges in convincing policymakers to accept their perspectives on development initiatives and appropriate service provision. Paternalistic approaches, regarding Indigenous peoples as primitive or vulnerable who will "benefit from modernization and integration into the dominant society",[23] result in discriminatory and oppressive structures, laws, policies, and practices.

Indigenous people also face direct discrimination in their daily lives. Derogatory attitudes held in the general community and shown by health workers can create barriers to accessing health care : "The Babendjelle [of the North-West Congo Basin] are nicknamed out of prejudice "la viande qui parle" (the animal that can speak) and so do not receive the same treatment as others."[3]

The poor formal recognition of Indigenous peoples also poses problems for gathering evidence about their health status. Seemingly clear demographic figures mask complex political issues, which inform when and where data are obtained and by whom, and how (if at all) Indigenous groups are categorised. In public health terms, this bias affects both the numerator and denominator of statistical calculations and limits the scope of epidemiological studies. Information about health status and access to services, and social determinants of health including the right to occupy and use land, clean water, sanitation, and education, is difficult to find. We use the available information for two groups, the Indigenous peoples of the central African forests and the Kalahari Desert, to discuss the challenges facing the health and survival of Indigenous peoples in Africa.

The Pygmies of central Africa

The Indigenous hunter-gatherers of the central African forests, so-called Pygmy peoples, consist of at least 15 distinct ethnolinguistic groups including the Gyéli, Kola, Baka, Aka, Bongo, Efe, Mbuti, western Twa, and eastern Twa living in ten central African countries : Angola, Cameroon, Equatorial Guinea, Central African Republic, Gabon, Republic of the Congo (Congo), Democratic Republic of the Congo, Uganda, Rwanda, and Burundi. Their estimated total number is from 300 000 to 500 000 people.[24] This case study illustrates some of the key health issues in Pygmy groups for whom health data are available.

The term Pygmy can have pejorative connotations, but is used here as a term adopted by indigenous activists and support organisations to encompass the different groups of central African forest hunter-gatherers and former hunter-gatherers, and to distinguish them from other ethnic groups who may also live in forests, but who are more reliant on farming, and who are economically and political dominant. Pygmy peoples' health risks are changing as the

central African forests, which are the basis for their traditional social structure, culture, and hunter-gatherer economy, are being destroyed or expropriated by logging, farming, and conservation projects :

"...since we were expelled from our lands, death is following us. We bury people nearly every day. The village is becoming empty. We are heading towards extinction. Now all the old people have died. Our culture is dying too..."

Twa man displaced from the Kahuzi-Biega National Park, Democratic Republic of the Congo[25]

Traditionally-living Pygmies live in small, mobile, egalitarian groups whose livelihood strategies are based on hunting, gathering, small-scale farming, and exchange of forest products with farming neighbours. They regard themselves as belonging to the forest, intimately connected through the spirits of their ancestors and of the forest. Pygmy communities continue to maintain forest-based livelihoods where possible, but many are spending more time in roadside settlements, with closer contacts with neighbouring Bantu farming communities, and more reliance on farming and wage labour.[26-29] In the Great Lakes area of central Africa, extensive forest clearance has made most Twa Pygmies landless, impoverished, and struggling to maintain cultural identity.[30-31] During decades of violent conflict, they have also been subjected to severe human rights abuses including murder, rape, torture, and (probably) cannibalism.[32-34]

Mortality

Mortality rates in Pygmy communities are high, as are fertility rates.[25,35-38] Low fertility of Efe women in the Democratic Republic of the Congo is associated with high rates of intermarriage with Bantu and prevalence of venereal diseases.[36,37] In Aka communities in the Central African Republic, infectious and parasitic diseases are the main causes of death at all ages, particularly for men and boys.[39]

Infant mortality rates in forest-dwelling Aka in the Central African Republic during the 1980s, and former forest-dwelling Twa in Uganda at the turn of this century, are reported as 20-22% and 20-21%, respectively.[38,40] These rates are more than twice the national infant mortality rates (9·8% and 9·7%, respectively) cited by the World Bank in 2000 ; and in the Ugandan study are 1·5-4 times higher than nearby non-Twa communities. For children younger than 5 years, mortality rates of 27% reported in forest-dwelling Mbendjele in northern Congo in the mid-1990s were 1·5 times higher than neighbouring Bantu.[41] In the study of Ugandan Twa, mortality rates for children younger than 5 years (40%) were 1·8-2·4 times higher than in non-Twa villages.[40] Loss of a forest-based life can be associated with increased mortality. The crucial importance of land for survival is indicated by a reported drop in mortality in children younger than 5 years from 59% to 18% when Twa families in Uganda were given land.[42]

Major causes of childhood death include malaria and measles. In the Central African Republic, a measles epidemic in the late 1970s resulted in 12% of all Aka deaths in the communities studied, regarded as a very high percentage considering the short duration of the epidemic.[39] In Congo, mortality from measles was five times higher in Mbendjele children than neighbouring Bantu communities.[41,43]

Morbidity

Compared with neighbouring Bantu communities, studies of forest-based Mbendjele, Aka, and Baka communities have documented lower prevalence of malaria, rheumatism, respiratory infections, scabies, goitre, syphilis, hepatitis C (three to seven times lower than Bantu communities), high blood pressure, and dental caries. However, leprosy, conjunctivitis, periodontal disease, tooth loss, and splenomegaly are more prevalent than in Bantu communities.[38,41,44-50] High intestinal parasite loads are reported from Mbuti in the Democratic Republic of the

Congo and Baka in Cameroon.[49,51] In forest-dwelling Mbendjele in Congo and semi-sedenterised Kola in Cameroon,[41,49] intestinal parasite rates were lower than or similar to neighbouring farming groups, but predominantly village-based Aka in Central African Republic had higher prevalence of helminth and protozoan parasites than did Bantu co-workers.[52]

Yaws, a painful skin infection that can progress to destruction of soft tissue, cartilage, and bone, is more prevalent in forest-dwelling Pygmy communities than in neighbouring groups.[41,51] In Cameroon, Central African Republic, and the Democratic Republic of the Congo between the 1970s and 1990s, 3-50% of Gyéli, Baka, Aka, Mbendjele, and Mbuti surveyed had clinical symptoms of yaws. Serological examinations showed 20-90% of the population, most of them children, had latent infections.[50,53-56] Prevalence was lower in communities receiving good medical care and information about hygiene.[57]

In Cameroon and Central African Republic during the 1990s, Gyéli, Baka, and Aka were more often seropositive for filoviruses causing haemorrhagic fevers, including Ebola, than were neighbouring subsistence farmers.[58-60] Kola communities in northeast Gabon were badly affected in Ebola outbreaks. However, in the area of an outbreak of Marburg haemorrhagic fever in the Democratic Republic of the Congo, Mbuti surveyed in 2002 were seronegative for Marburg virus despite substantially higher exposure to wild animals, especially bats-one of the presumed reservoirs of filoviruses-than the local population.[61] The risks to Pygmy communities of filovirus infection via their hunting activities are not well understood.

Where forest dietary resources are depleted by destructive logging or commercial poaching and Pygmy people do not have lands on which to grow alternative foods, nutritional status decreases.[35,52] Children and pregnant women are especially vulnerable,[25,49] the problem being exacerbated by the breakdown of traditional food-sharing systems.[25,38,62] Loss of forests also deprives Pygmy communities of their renowned traditional herbal pharmacopoeia, which contains compounds active against diseases including helminthiasis, guinea worm, jaundice, malaria, diarrhoea, toothache, and cough.[63]

As Pygmy communities spend more time outside the forest in fixed settlements, malaria increases and parasites accumulate because of increased population density and poor sanitation.[64-67] Heavy infestations of chiggers (burrowing fleas) cause crippling infections.[52,68] Traditional cultural mechanisms for dealing with tension and discord (such as nocturnal singing ceremonies to restore harmony between the group members and the forest) are eroded ; alcohol abuse and domestic violence against women increase.[30]

Twa communities no longer living in the forest report malaria, intestinal worms, diarrhoea, and respiratory illnesses as their most serious health problems, a morbidity profile similar to that of their non-Pygmy neighbours.[30] In Rwanda and Burundi, 43% and 53% of Twa households were reported to be landless in 2003 and 2001, respectively-3·5 times more than the respective national populations. The situation of the Ugandan Twa is similar.[30,69,70] Without land, Twa are unable to meet family food needs,[30] contributing to the increased childhood mortality. Severely disadvantaged living conditions increase the risk of illness : prevalence of inadequate housing, poor sanitation, and lack of safe drinking water were, respectively, six times, seven times, and two times higher in Rwandan Twa households than the national population in 2003.[69]

HIV-1

Studies in the 1980s and 1990s in Cameroon and the Republic of the Congo showed a generally lower baseline prevalence of HIV-1 in Baka and Aka people (range 0-1·6%) than in neighbouring populations (range 0-5·4%).[46,47,53,56] The lower prevalence of HIV (and hepatitis C) infection in Pygmy communities could be because intermarriage with Bantu people is infrequent and monogamy is more common than among Bantus.[30,38] Where intermarriage occurs it is almost always Pygmy women marrying out of their communities, their lower bride

price and perceived higher fertility making them a more attractive prospect for Bantu men.[30,36]

Nevertheless, HIV prevalence is increasing in Pygmy populations, probably through increased contact with Bantus.[71] Between 1993 and 2003, HIV infection reportedly increased from 0·7% to 4% in Baka Pygmies in the Yokadouma region of eastern Cameroon.[72] The spread of sexually transmitted diseases increases with the influx of transient labour employed on logging camps, road building, and infrastructure projects. Pygmy women are at particular risk of HIV infection through rape, especially in zones of armed conflict, and also because of the belief of other ethnic groups that sexual intercourse with a Pygmy woman protects against backache, AIDS, and other ailments.[30,73]

Access to health care

In much of rural central Africa, primary health services are absent, function only in a rudimentary way, or have been destroyed during conflict. Even where health care facilities exist, many Pygmy people do not use them because they cannot pay for consultations and medicines, do not have the documents and identity cards needed to travel or obtain hospital treatment, or are subjected to humiliating and discriminatory treatment.[30,41,74] More than inaccessibility, public health services can fail to reach Pygmy communities because of active discrimination. Vaccination campaigns in Congo during 1996 prioritised the Bantu community, and treatments dispensed by health posts reach the Bantu community more than Pygmies. Bantu intermediaries responsible for delivering leprosy medication to Pygmies can extort payment or labour from them.[41,43,74]

The high mortality of Pygmy children from measles and the higher prevalence of endemic diseases such as yaws and leprosy in Pygmy communities than in Bantu communities indicates their exclusion from government health services.[75] The prejudice against Pygmy people, coupled with their poverty and inadequate government policies, prevents them from gaining basic citizens' rights including access to health care and land, and to education, employment, and justice.[30,70,72,73,76] In the absence of government policies and programmes providing equitable access to health care, Pygmy communities often depend on missionaries, non-government organisations, and development agencies. Some programmes have trained Pygmy primary-care workers and established dispensaries that are run by the community.[24,41,65,77] With proper planning, health campaigns can reach Pygmy communities, despite their mobility and remoteness. In the mid-1990s, a privately organised campaign gave hundreds of Aka people in northern Congo the single shot of penicillin needed to cure yaws.[53] In 2002, UNICEF vaccinated Pygmy children in the Democratic Republic of the Congo, Congo, and Central African Republic against poliomyelitis.

Over the past 5 years, attitudes of health staff in some areas have begun to change,[30,42] and through the raising of awareness more Pygmy communities now know about free services provided by the government. In Rwanda, 68% of Twa women have received antenatal vaccinations, and 90% of children younger than 5 years have received one or more of the DTaP (diphtheria, tetanus, and pertussis), polio, tuberculosis, and measles vaccinations.[69] Economic empowerment programmes run by non-government organisations are enabling Twa to generate incomes and so join local health insurance schemes and improve their living conditions.

Pygmy peoples have shown themselves to be resilient ; for centuries they have been adapting to new situations while maintaining their cultural distinctiveness, as long as they can still have access to forests. Pygmy groups who are still able to lead a largely forest-based life have better health in several respects than nearby farming groups. Forests are also where they feel at ease, a vital component of their sense of wellbeing, and mental and spiritual health. By contrast, loss of forest lands and resources, and the consequent sedenterisation, increases Pygmy communities' risks of inadequate nutrition, infectious diseases, parasites, and HIV/AIDS without necessarily increasing their access to health care. To protect and improve Pygmy peoples' health, governments, development agencies, missionaries, and non-government organisations must work to secure Pygmy peoples' rights to their customary lands and

resources, and develop policies and programmes that ensure equitable access to health care, on the basis of consultations with Pygmy communities about their concept of wellbeing and good health.

The San of southern Africa

"The San are widely recognised as the most impoverished, disempowered, and stigmatised ethnic group in Southern Africa"[17]

The San are the Indigenous people of the southern African region who have inhabited the land for around 27000 years.[7,8] Different local histories and post-colonial approaches by governments have shaped the differing situations of San groups across southern Africa today. At the start of European colonisation in the mid-17th century, there were up to 300000 Khoesan peoples. Most were eradicated, caught between the European settlers and Bantu migrants from the north and east. By the beginning of the 20th century the San were concentrated in remote areas around the Kalahari basin.[78] Today this population group is known in different areas as the San, the Baswara, or Kalahari Bushmen. These names have developed from derogatory terms used in different languages, showing entrenched discrimination against the San. Most groups refer to themselves by their community names but have currently accepted the collective term San. Suzman[78] estimates that there are between 85000 and 90000 San spread across six countries with a population growth rate of around 2%. Small populations live in Angola (1200), South Africa (4350), Zambia (300) and Zimbabwe (2500) ; here we focus on the vast majority in Botswana (47000) and Namibia (32000).[3]

In Botswana, the National Constitution refers to the eight main tribes of Botswana but does not include the San, and the government acquires no census data on an ethnic basis.[78] Suzman's debated 2001 population estimate of 47000 San makes up 4% of the national population, located chiefly in Ghanzi and Kgalagadi districts but also living in other areas including the major towns.[78] Although Botswana has the fourth highest income per head on the African continent,[79] income inequality within the country is high, with the poorest 10% of the population receiving only 0·7% of the nations' income.[80] This group largely consists of the San and related minority communities whose position is the result of a long history of subordination pre-dating colonisation.[82] After independence, the main thrust of government policy has been integrationist, seeking to incorporate the San into mainstream society, but relegating them in reality to the bottom of the social hierarchy as a subordinate underclass :[78,81]

"How can you have a stone-age creature continuing to exist in the time of computers ? If the Bushmen want to survive, they must change, otherwise, like the dodo they will perish."

Festus Mogae, President of Botswana[78]

Land issues have propelled the San of Botswana into international limelight in recent years. A long and controversial process of removing and resettling San from their lands in the Central Kalahari Game Reserve and dissolving their hunting and gathering rights is currently being challenged in the courts.[82]

In Namibia, history took a different course. Anthropologist Renée Sylvain[17] describes two diverging pathways of the San population in Namibia over the past century ; "For some groups colonial rule and apartheid meant segregation in geographically remote areas which formed part of their traditional lands (or in game parks) ; for the majority of Namibian San, however, they meant incorporation as a landless underclass of farm labourers, domestic servants and squatters". Post-independence Namibia has followed a pluralist approach, allowing for the establishment of conservancies where "communities can achieve a level of control over some of the natural resources and thereby generate income from game management and tourism".[82] Although some San have managed to take advantage of

this control and two conservancies have been established, they only account for a very few living an adapted form of traditional life. Most continue to work as labourers and domestic workers on commercial farms or the cattle posts of Bantu-speaking agro-pastoralists.[83] New labour laws have resulted in many being forced off the farms into resettlement camps where poverty and welfare dependency have increased.[78]

The health status of the San across Southern Africa is closely linked to their poverty shows the position of San speakers in the Namibian Human Development Index (HDI) during the late-1990s.[78,84,85] The HDI score combines measures of life expectancy at birth, education (adult literacy and school enrolment), and income (gross domestic product per head). Not only are the San in the lowest position, but also they are the only group whose HDI score falls over the 2-year comparison.

Health in the resettlement areas indicates the problems seen in other places where Indigenous peoples have been displaced and resettled.[87,88] Conventionally recorded morbidity and mortality data are scarce, with the most evidence gathered from the work of anthropologists and non-government organisations.

Alcohol and domestic violence

Increasing consumption of alcohol in San settlements has been reported over the past two decades, attributed to cultural upheaval and loss of land, resources, and community networks.[88] Alcohol consumption in resettlement areas in Botswana is described as "no longer primarily for pleasure...there are reports of excessive use of alcohol as an analgesic for both existential and physical pain".[89] Sylvain[83] describes the effect of alcohol on the landless San in Omaheke in Namibia. Home-brewed beer is sold by the non-San poor to the San for whom it is "the cheapest form of sustenance" to "kill the hunger". 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 Sylvain notes is an increasing problem among young people. This situation is not confined to the San but is a noticeable feature of dispossessed aboriginal societies everywhere. Ultimately, it is a problem of poverty stemming from the loss of land and livelihoods without a viable alternative.

HIV/AIDS

As elsewhere in sub-Saharan Africa, HIV/AIDS is a major cause of death in Namibia and Botswana. In Namibia, national adult prevalence rose from 4·2% in 1992 to 23·3% in 2002,[90] accounting for over 25% of deaths in health facilities.[91]

In 2004, Botswana had the worlds' highest mortality rate (28 per 1000 population) and lowest life expectancy at birth of 35 years, with very high adult HIV/AIDS prevalence of 37·3%.[79] Although formally disaggregated data are not available, in 2002 the rate for the San in Ganzi was lower at 21·4% than the national average of 35·4%,[92] indicating that the remoteness of the San, particularly in the Central Reserve, might have protected them from the high rates recorded elsewhere.

The outlook in the resettlement camps is disturbing. Although no official data are available, anecdotal evidence from the camps gathered by representatives of non-governmental organisations indicate that residents are aware of increasing exposure to HIV/AIDS :

"JCBs and caterpillars are working here now but they aren't doing development, they are bringing in AIDS. All these guys come here, they have a lot of money, they meet with Bushman women, buy them alcohol, sleep with them, and bring them AIDS. There's development and AIDS, but there's more AIDS than development. According to our culture, we didn't know all these diseases. I didn't think I would die at my age, I thought I'd die only when I was very, very old.

We only expect old people to die, but right now we are dying like never before."

Roy Sesana, a San leader in New Xade resettlement camp, Botswana, 2003[93]

In Namibia, accurate data for the San population are not available. Unconfirmed reports suggest that prevalence in the more isolated north is much lower, and there are fears that the displaced San population, especially in the areas along the newly opened trans-Kalahari highway in the Omaheke region, are increasingly vulnerable. Discussing the vulnerability of San women because of a "widespread belief that 'Bushmen' women are highly promiscuous and generally sexually available"[83] and the unregulated and lawless environment in which they live, Sylvain points to the high risk of a substantial rise in HIV/AIDS prevalence in the San in the future.[83]

Discussion

The two cases presented here illustrate the problems that need to be addressed to improve the health and well being of Indigenous peoples in Africa. Providing better and more accessible health services is essential. But if the underlying causes are to be addressed, wider social, political, and economic issues need to be tackled. There is a desperate need to improve the social and economic position of most of Africa's population. Health services are at best inadequate for most and entirely absent for many. We have highlighted the problematic lack of recorded disaggregated data and original research about Indigenous peoples' health in Africa. Far more information needs to be gathered and analysed to compile an accurate picture, but what is known about Indigenous peoples' access to health services suggests that poverty, marginalisation, and discrimination compound the problems experienced by the rest of the population. The ACHPR describes Indigenous peoples' situation as follows :

"The infrastructure in most areas occupied by Indigenous peoples is either lacking or is inadequate. Social services such as schools and health facilities are few and far between, while the roads and other physical infrastructure is equally poor. This has had a negative impact on the staffing levels and quality of services offered. As a result, illiteracy levels and mortality rates in such areas are higher than national averages."[3]

Majority populations must find a way to ensure equity for Indigenous peoples. Active participation of communities in the development, management, and delivery of services is crucial. In creating an Indigenous-owned process to establish appropriate health systems, there is a huge challenge of "developing partnerships in an unequal world".[94] The key is for Indigenous peoples to be empowered to participate equally in debate and decision-making. The debate has to address not only the provision of health care, but also the social determinants of health. Such debate should seek to find a framework that draws on useful elements of state infrastructure and services, but ensures the economic and cultural survival and development of Indigenous peoples in Africa. Meeting that challenge is crucial to achieve the ambition set out for the Second International Decade of the World's Indigenous Peoples that :

"Access to comprehensive, community-based and culturally appropriate health care services, health education, adequate nutrition and housing should be ensured without discrimination. Measures to guarantee the health of Indigenous peoples must be seen as a collective and holistic issue involving all members of the communities and including physical, social, mental, environmental and spiritual dimensions."[95]

Introducing the WHO Commission on Social Determinants of Health, Michael Marmot states : "if the major determinants of health are social, so must be the remedies."[96]

The two case studies in central and southern Africa show the challenges of recognition, marginalisation, and

discrimination. In the post-colonial period, attempts have been made to suppress ethnic differences in the interests of building national conscience, and to cast Indigenous peoples both as a danger to national survival and as a block to development. As a result the major determinants of their poor health status are dispossession from their lands, destruction of their culture, discrimination, and marginalisation leading to poverty and the associated high prevalence of both communicable and non-communicable disease. In the case of the Pygmies, the situation has been exacerbated by widespread conflict.

Indigenous people define themselves in terms of their relationships with their land, environment, and community, making their environment essential not only for physical provisioning and regulating services but also for physical and cultural survival. Land rights are continually cited as a primary barrier for Indigenous people in Africa, and are described by the ACHPR as "fundamental for the survival of Indigenous communities".[3] The Minority Rights Group states that "conflicts over land rights and access to land are the source of many violations of the rights of minorities and Indigenous peoples".[97] Defining their relationship to the land and participation in decisions on its use does not imply a wish to secede or maintain themselves in a primitive state, but a recognition of the right to choose a concept of and path to development within the modern nation state.

Unless Indigenous peoples are recognised and empowered to negotiate on equal terms with majority populations, they will not able to secure an equitable settlement with the dominant group. The forced removal of the San from the Central Kalahari Game Reserve in Botswana provides a stark example both of prejudice and the exercise of majority power, and of the consequences to the social structure and health of the dispossessed. The creation of National Parks has led to the exclusion of the Twa from the forests in Uganda[98] and many other parts of Central Africa.[28] Local contexts vary but the importance of establishing equal rights and an end to discrimination remains constant.

By focusing on marginalisation and exclusion, we recognise that we have not been able to give a proper account of the contribution Indigenous peoples can make. Indigenous knowledge includes the effective use and preservation of land and natural resources in environments that are often hostile. Traditional medicines and practices could be harnessed for the benefit of the wider society. The emergence of an Indigenous peoples movement in Africa as part of a wider international process signals the determination of such peoples to secure recognition of both their existence and their potential contribution.[15]

In seeking solutions, other African states could start by looking at the example provided by South Africa in recognising claims to land, and the adoption of a memorandum creating the first Indigenous peoples' policy process in Africa.[82] The adoption of the report of the African Commission on Human and Peoples' Rights offers further encouragement, but much remains to be done. Achieving equity and justice in health will need wider changes to meet the rights claimed in the draft UN Declaration on Indigenous issues.[99] As Maybury-Lewis[11] argues, this could "entail a rethinking and re-organization of most states of the world". Certainly it requires new approaches to dealing with diversity, cultural difference, and self-determination.

Search strategy

Indigenous health in Africa is not widely researched and publications are sparse. Sources cited in this paper have been identified through electronic searches of health, development, and social science databases including Medline, PubMed, African Healthline, Eldis, and ID21, and publicly available online datasets, hand searches of selected journals, and individual contact with relevant non-governmental organisations. Published peer-reviewed studies of Indigenous health in Africa are rare, hence we include non peer-reviewed and grey literature.

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