

# ASPECTS OF THE HEALTH CRISIS IN NAMIBIA

This article is based on portions of a Doctoral thesis, entitled "Aspects of Urban Change in Windhoek, Namibia, During the transition to Independence". Aspects of the health crisis in Namibia will be highlighted, with particular reference to Windhoek, due to the heavy concentration of health facilities and administrators in the urban areas. Therefore comprehensive research into central aspects of the crisis, such as the population's state of health in the rural areas, is limited to a brief overview.

## INTRODUCTION

Namibian health services are in a state of crisis. Staff shortages - particularly in the rural areas - are chronic; health policies are inappropriate to local circumstances; and state - run services remain totally segregated. Political resistance to change (on a level paralleled only in education) stands out as the dominant feature and problem since 1977.

## BACKGROUND

There has been no health legislation directed constructively towards socio-political change since the appointment of the first Administrator-General for the transition to independence in 1977.

The major changes relate to administrative reorganisation in terms of the three - tier government structure introduced in 1978 - 80. In practice, there has been little change other than ethnic fragmentation. By 1980/81, the differences in per capita health expenditure for each "ethnic" group had not altered, being R233.70 for whites, R56.84 for Kavangos, R37.06 for Caprivians, R24.85 for Ovambos, R15.02 for Damaras and R4.70 for "Basters".

Accurate information on the state of health and medical facilities in Namibia is almost unobtainable, because of the official blanket concealing all socio-economic data.

Official annual reports (South West Africa Administration 1977, 78 & 79 and SWA Administration for whites 1980) divulge virtually nothing of importance other than crude total occurrences of certain notifiable diseases. Semi-official sources (Africa Institute 1980) provide only crude national averages, which mask regional political and social inequalities.

Background data is therefore fragmentary. Interviews with Windhoek senior administrative and medical officials expose the levels of frustration at conditions in the health services resulting from political manipulation and the "new dispensation's" ethnic fragmentation.

### ELEMENTS OF THE CRISIS

#### 1) Physical facilities

Medical facilities are too large, prestigious and costly for the territory's population or resources, a problem exacerbated by racial duplication of facilities.

For example, plans for the Gobabis white hospital in Keetmanshoop cost R22.5m without the projected black and 'coloured' blocks. In 1980 - 81, the existing 34-bed white hospital had only 27.5% occupancy, while other population groups' beds were 37.14% full over the same period.

In view of their size, cost and segregation, the new white hospitals have been criticised as "politicians' prestige projects", inappropriate to local conditions.



Furthermore, health services are geared towards curative, not preventative medicine. Even rural clinics are inappropriate to the needs of the majority of Namibia's population because many people live up to 100km from the nearest clinic. Ambulances also remain segregated.

## 2) Long Term Staff Shortages:

In recent years, the staff shortage problem has worsened in the urban centres and especially in the rural areas due to poor salaries and the low standard of medical facilities.



Windhoek State hospitals and clinics are partly controlled by non - medical bureaucrats, such as the military, who also dominate services in the rural areas. In light of the ongoing liberation struggle fought by guerillas in the rural areas, who have the support of the rural population, the presence of the army - even in a civilain context - is regarded with distrust. Also, the dominant role of the SADF against the popular Namibian liberation movements cannot promote trust between rural patients and military personnel.

South Africa's presence in Namibia is regarded as illegal by the majority of the population, and therefore constitutes unwelcome interference in the internal affairs of another country.

Although there are no official records of diseases such as kwashiorkor, in the urban areas, malnutrition and child neglect is rife. This is a consequence of imbalanced diets and children having to fend for themselves in the absence of adequate creches and schools, while their parents seek employment.

Furthermore, the state hospital functions as a South African satellite training institution, because of an agreement with Stellenbosch University, under which additional medical staff and expertise from the university are employed in Windhoek.

All hospitals staff are segregated and there is a disparity between accommodation standards for the different population groups. For example, there is a severe shortage of nurses accommodation at the Katutura Hospital, but a surplus at the white state hospital.

### 3) The State of Health of the Population

The state of health of the population is linked directly to inequalities within the socio-economic context. These inequalities affecting the majority of the population are exposed through lower standards of housing, chronic accommodation shortages and overcrowding, inadequate sanitation and amenities, as well as poor and inappropriate health services.

Low incomes and rising unemployment also contribute to the crisis which has resulted in an epidemic of poverty-related diseases. Available mortality statistics reveal that TB, kwashiorkor and gastro-enteritis are major killers among the rural population, and the incidence of TB has risen annually.