Journal für Entwicklungspolitik 4, 1989, S. 59 - 64

Nadia Gevers

HEALTH ORGANISATION IN NAMIBIA*)

1. Law

Protection and promotion of public health falls entirely within the function of the State (including local administrations and authorities). There are a number of Acts that deal with public health matters, such as medical schemes, hazardous substances, housing etcetera, while a number of ordinances deal with hospital, local health affairs and incidental matters.[1] In many cases Acts of the South African Parliament were made applicable to South West Africa.

In 1966 the Promulgation of the State Hospital Ordinance was published in the Official Gazette extraordinary of South West Aufrica, in terms of the SWA Constitution Act (1925) in order "to consolidate and amend the laws relating to state hospitals and private hospitals and matters incidental thereto". The Ordinance deals with the establishment and management of state hospitals and services, with access and admission to and treatment in state hospitals, fees, medical committees and advisory boards, bequests and property, private hospitals, and general and supplementary provisions. Later "many of the Acts made by the Republic were expressely made applicabel to the territory of SWA. As is known, the territory is in its transitional phase towards independence".[2] But laws are still subject to the State President's right of veto, and several rules of sections have been extended or made more stringent since. According to the Hospitals Ordinance No. 14 of 1972 a patient has to furnish information about e.g. his/her population group, and since 1981 he/she has to give the number of his/her identity card too.

Doctors, dentists, nurses and supplementary health service professionals are not state controlled, but the law provides for registration and control of the standards of conduct through professional councils or boards. The nurses are subject to the Nursing Act No. 50 of 1978, while the Medical, Dental and Supplementary Health Service Professions Act No. 56 of 1974 is applicable to the other professionals mentioned.[3]

The South African Medical and Dental Council (SAMDC) has a wide range of general powers, including the registration of all medical and dental practitioners, the control over education and qualifications, and the exercise of its disciplinary powers over persons registered in terms of the Act. The Medical Council is enpowered to exercise professional control also in Namibia.

There is only a held up when a complaint is led to the Council, but for years no allegations are put from the ethnic Administrations.[4] The South African Nursing Council (SANC) may be compared with the SAMD, as far as the nursing profession

*) Aus: Manfred Hinz/Nadia Gevers Leuven-Lachinski, Koevoet Versus the People of Namibia, October 1989, S. 96 - 100.

is concerned. Nurses in Namibia cannot practice unless they are registered by the SANC. Only one third of both statutory bodies consists of elected members (33 and 30 respectively), the others are state-appointed and ex-officio members.

Health care provision in Namibia is characterised by two features:

a) the disproportionate provision of resources for the white community and

b) a health system that is almost totally curative in nature, allowing an average expenditure of only 2 % for preventive medicine.[5]

Until 1980 the health services for the whole of Namibia had been ruled by the white central government and the South African Department of National Health on a segregated basis. In 1980 South Africa introduced a three-tier (level) structure of government for Namibia, under Proclamation AG 8. In agreement with its apartheid policies South Africa divided black Namibians in ten categories, irrespective of where they live, while the different people of the white community continued to be treated as only one ethnic group.

The registration of medical and paramedical personnel, and the control over and registration of medicines and related substances remained the responsibility of the Department of National Health and Welfare, the first-tier of the Central Administration, run by South African officials.[6] The eleven second-tier administrations for the ethnical groups, the "representative authorities", are each responsible for major social services: education, the provision of health care (the organisation of hospitals and clinics, nursing facilities and school health services, the appointment of district surgeons), old age pensions, welfare services and the local administration for their own population group. Thus economical and social inequality is also reflected in the institutionalised racial segregation of the health care system. The third-tier (the municipal) government of the most important towns is dominated by whites.

According to official estimates of population numbers the ethnic administrations oare paid fixed sums per capita (R 37) for social services, including health services. The authorities themselves have to raise taxes from the people under their control, to be spent exclusively for the benefit of this group. Because most official publications tend to provide the average wage figures for employees in all communities, major discrepancies are not shown. There are only few reliable recent figures on comparative wage and salary levels for black and white workers. Research data indicate that most Namibians live below the poverty line. In 1986 the average family income in Katutura township was estimated between R 100 and R 300. It was calculated that a black family of six in windhoek required a household subsistence level (HSL) of R 394 per month. A six person-family living in Katutura would, however, need a minimum income of R 604 to provide for the basic necessities (indlucing house rental, fees for education and health services and some other basic expenses). It is estimated that in 1986 80 % of black wage earners in Windhoek were living below this subsistence level. Many wome nare domestic servants, most of them earning between R 20 and $ 100 per month.[7] In northern Namibia 99 % earn less than HSL.[8]

Because of the extreme income disparity the wealthy white "ethnic group" can spend more than any of the black groups: the white administration's funds are almost twice as much as those of the rest of the administrations together, while the white

community is only 6 % of the total population.[9] The limit of income for taxation is R 250. Because most people earn less, the Central Government Provision is the sole allocation for health. Implementation of health programs thus was impossible.[10] In 1981 figures for per capita spending on Health Services show R 5 to R 57 for blacks, and R 234 for whites. "Apartheid has pervaded the whole system of health, welfare and education" and "Doctors chould challenge scientific division of people in ethnic groups, but they don't", some doctors said.[11]

The result of the fragmentation of the health services (eleven administrations being responsible for only one and a half million people) was chaos, corruption and inefficiency. By 1984 the White Administration in fact runned all but three of the services on an agency basis (Ovamboland was one of the homelands which retained control). This started in 1980, when come ethnic Administrations asked the White Administration for help in running their clinics and hospitals. At the end of each year the Administrations are charged for these services (operations, admissions, laboratory facilities, ambulance service etcetera). Reserve funds often are insufficient and there is no central on what services are actually rendered. The Central government makes up the deficit. Preventive services are also provided for on agency basis, which again have to be paid for.[12]

The adverse effects of the fragmentation were: serious shortages of doctors, nurses and other trained staff, lack of repair and maintenance of facilities, and there have been repeated allegations of patients being neglected or being refused treatment. There was a shortage of specialists, and hospitals were dependent on visiting specialists from South Africa. The shortage of nurses also affected the hospitals for the whites. In 1983 the Broeksma Commission, appointed by the Administrator-General to look into the health system, recommended a return to a single integrated national service. Only the Administration for Whites recommended the retention of the system. Continuation of segregation, however, was also recommended by the Commission, through the reservation of wards "for the exclusive use of a particular population group".[13] Because of the lack of funds the Ovambo medical service was threatened with collapse and this fact was used by the South African Defence Force to take over control in 1983.

2. Hospitals and clinics

The existing hospitals and clinics are run by the Central Administration, by the Churches, and to a lesser extent by mines and private practitioners. There are 58 hospitals and some 30 clinics, including 23 mission hospitals, eight private hospitals and three hospitals run by mining companies.[14] State services are concentrated in the urban areas, especially around Windhoek, and at the major military establishments in the North. The mission hospitals and clinics are situated mainly in the northern rural areas. Hospital facilities for whites are marked by high technology, and hospital occupation rates vary from 46 % to 27 %. Hospital bed provision is difficult to interpret. Officially the rate is one bed per 130 people, but floor mats provided to blacks in their overcrowded facilities are included in this figure.[15]

Medical treatment is not free in Namibia. According to their income people are classified as private patiens and, depending on the type of institution, charged fees. Non-private patients are charged a fixed fee, irrespective of their income. The ethnic group to which they belong is written on the registration card and all patients are required to show identity cards before treatment.

The health system in Namibia could not function without the contribution of Church hospitals. The Central Government pays for the salaries of the personnel and may give some grants. But the State can by law exert power and control on the organisations, by takind them over, or by simply closing them, or by transferring personnel to other hospitals.[16]

3. Doctors and nurses

There are approximately 180 civilian doctors in Namibia, most of them white South Africans, including interns, and about 57 army doctors. Only 30 doctors are indigenous.[17] There is a great disparity between black and white doctor/patient ratios. The rural ratio is estimated to be 1 : 25.000 or even 1 : 35.000, and the urban ratio approximately 1 : 4.000.

Military doctors in hospitals are obliged to wear their uniforms and pistols, which does not facilitate a positive doctor-patient relationshop.[18] "The minority of doctors are found where a majority of people are staying and vice versa. The distribution of Namibian doctors correlates well with the AG 8 dispensation, which means that the Ovambo-speaking Namibian doctor is prohibited to work in Khorixas, and this also applies to a Damara-speaking Namibian doctor. The State hospital in Windhoek and Kettmanshoop are almost exclusively reserved for the white Namibians and non-Namibian doctors", Dr. Amadhila, a paediatrician, reported to a newspaper in 1987. In Namibia the Government allows specialists to work only in the four reference hospitals, i.e. in Windhoek (where practically all of the specialists of Namibia work), Keetmanshoop, Rundu (Kavango) and Oshakati (Ovambo). In the other so called district hospitals only general practitioners may work. In Windhoek there is the only psychiatric hospital staffed by one foreign psychiatrist and one psychologist. The psychiatrist is also consultant to other hospitals, like the Oshakati State Hospital. Public services are left for a great deal to inexperienced military personnel. None of the 16 dentists (official figure from 1979) is working in the rural areas.

There are no training facilities for doctors in Namibia. For medical education students are dependent on South Africa. Foreign doctors, have to apply for a working permit every six months.

Membership of the SWA branch of the Medical Association of South Africa (MASA) is not compulsory, and no Namibian doctors will be found as members. Discussions on the third world situation of the blacks, including social and medical ethical issues on this matter, never are discussed. The members of the Association do not seem not to be at all interested on these subjects, but more on technical medical-issues.[19]

Approximately 3.300 nurses are working in Namibia, 1.000 of them being registered nurses. Official figures quote one registered nurse for 15.000 people. This

gives a false impession; in rural areas fewer registered nurses are working, mainly in the hospitals. The others are enrolled nurses.

It is compulsory for nurses to be a member of the SANC and the South West African Nurses Association (SWANA). SWANA has no clear function; there is no discussion about the specific problems of nursing needs in Namibia, while the education standards required are urban oriented and not suitable for rural health. To become a qualified registered nurse requires a four year academic study after attaining a school-leaving matriculation certificate. However the low standard of education for blacks in Namibia means that few can qualify for the nurses training programmes according to SANC and SWANA standards.[20]

Apart from qualified registered nurses, what is needed are more women with a lower standard of education to be employed in all clinics as enrolled nurses. There is no national health, no money for health education, and not enough nurses trained for primary health care fieldwork.[21] The shortage of qualified nursing staff has serious implications, since nurses are often the first contact for patients and in the absence of a doctor they must be able to deal with minos ailments. The shortage of senior black nurses reflects the lack of training facilities provided by the South African regime in Namibia. The shortage of nurses in white hospitals existed mainly because the administration refused to employ black nurses.

Following the decision to allow treatment of Coloured and Baster patients in the Windhoek State Hospital for Whites (in segregated wards) some 150 qualified Coloured and Baster health workers were transferred from Katutura hospital to the State hospital, worsening the shortage of nurses in Katuture hospital (2.000 beds for a population of 60.000). In October 1988 172 nurses protested against the presence of SADF members "rendering medical services" at this hospital. They reportedly asked for the immediate and unconditional whithdrawal of the army. The fact that soldiers work in army uniforms was seen as provocative; the standard of health services needed had dropped, as they were not trained to render the required type of assistance and the nurses reportedly accused members of the armed forces not keeping professional secrecy. They referred to those assisting in the maternity section, who allegedly told their friends "how whose wife was deliverd". The Chief medical superintendant reportedly admitted the work of uniformed men in maternity section was wrong. He reportedly explained that the army men were not working under the Nursing Act, but were directly operating under the Surgeon General of the Defence Force. But he also said, as was quoted, that if the prople do not want the army working in uniform, then all army members, including the doctors, must be withdrawn. The consequence of this would be that certain vital specialist divisions have to be closed.[22] "The Nurses' Association serve the nurses interest but what is the use? What is done with our money? The only thing I know is that your family gets R 1000 when you die!" a nurse said. "When accused of an offence the organisation does not support its members. Recently two nurses allegedly were arrested, accused of arson of a school. After a two weeks detention they were proven innocent and released. The SWANA did nothing to help them." The Apartheid also reflects in the Board of the SWANA: only a few black nurses are members of the board; top level positions are dominated by the whites.[23]

4. Social services

The state social work departments concentrate on case work, which does not solve the problems. Getting help again is ethnic based, and one has to produce one's identity card. "Social welfare pensions are unequal and inadequate: whites get R 159 per month, the black ethnic groups R 122 to R 50", a social worker said, "and it can take two years of waiting for it."

When Administrations cannot provice pensions, according to the people's need, many old people are starving. National Welfare only pay R 50 per month. Although the costs of living has risen 200 % over the past six years, National Welfare pensions did not increase.

NOTES

[1] S. A. Strauss, Legal handbook for Nurses and Health Personnel, 1987.
[2] Ibid. (note 1): 142.
[3] Ibid. (note 1): 32 ff.
[4] Personal interview with Dr. K. G. Abrahams, Windhoek, October 1988.
[5] the Economist Intelligence Unit (EIU), Country Profile, Namibia 1987/88: 11.
[6] IDAF, A Nation in Peril. Health in Apartheid Namibia. Fact Paper on Southern Africa No. 13, London 1985: 19.
[7] Christine van Garnier, Katutura revisited, Windhoek 1986: 56.
[8] EIU (note 5): 18.
[9] Caroline Moorehead, Namibia. Apartheids forgotten Children, Oxford 1988: 3.
[10] Personal interview with Dr. K. G. Abrahams a.o., October 1988.
[11] Ibid.
[12] Ibid.
[13] IDAF (note 6): 20.
[14] EIU (note 5): 12 and Moorehead (note 9): 15.
[15] Tom Lobstein and the Namibia Support Committee Health Collective, Namibia. Reclaiming the people's health, London 1984: 14.
[16] Personal interview with Carl Scholz.
[17] Personal interview medical doctors.
[18] Personal interview with Dr. K. G. Abrahams, Windhoek, October 1988.
[19] Ibid.
[20] Personal interview with nurses in Ovambo and Katutura.
[21] Ibid.
[22] Namibian, October 1988.
[23] Personal interview with nurses in Katutura, October 1988.

Nadia Gevers, Bizet Laan 32, 2253 CN-Voor Schoten, Holland

Journal für Entwicklungspolitik 4, 1989, S. 65 - 96

Walter Sauer und Theresia Zeschin
ÖSTERREICHISCHE BEZIEHUNGEN ZU NAMIBIA

Im eher weitmaschigen Geflecht der österreichischen Beziehungen zur Region Südliches Afrika[1] nahm (und nimmt) Namibia bis zur Erlangung seiner politischen Unabhängigkeit aufgrund seiner spezifischen völkerrechtlichen Situation eine Sonderstellung ein.

Seitdem die UNO-Vollversammlung im Oktober 1966 das Südafrika vom seinerzeitigen Völkerbund verliehene Verwaltungsmandat beendet und der Internationale Gerichtshof im Juni 1971 die Anwesenheit südafrikanischer Organe in Namibia für illegal erklärt hatte, stand die frühere deutsche Kolonie Südwestafrika theoretisch unter der Verwaltung der Vereinten Nationen; die Vollversammlung hatte zur Wahrnehmung dieser Agenden den UN Council for Namibia als völkerrechtlich rechtmäßige Verwaltungsbehörde geschaffen. Faktisch jedoch hielt die südafrikanische Präsenz in Namibia in administrativer, ökonomischer und zunehmend auch militärischer Hinsicht dennoch an, ja wurde sogar noch erheblich gesteigert; der UN Council konnte das ihm zur legitimen Verwaltung übertragene Gebiet nie betreten und mußte sich auf einzelne prinzipielle Hoheits- und Verwaltungsakte von New York aus beschränken. Internationale Übereinkünfte zur Regelung der Namibia-Frage durch Entlassung des Territoriums in die Unabhängigkeit (vor allem die Res. 385, 432 und 435 des Weltsicherheitsrates) wurden von Südafrika erfolgreich boykottiert und konnten erst aufgrund des von den USA vermittelten Grundsatzvertrages zwischen Südafrika, Angola und Kuba von Ende Dezember 1988 - und auch dann nur teilweise[2] - realisiert werden.[3]

Angesichts dessen haben sich Beziehungen zum Territorium Namibia nicht nur einer völkerrechtlichen Beurteilung dahingehend zu unterziehen, inwieweit durch sie die illegale Präsenz der südafrikanischen Besatzungsmacht in Namibia bzw. die ebenso illegale Existenz der von ihr geschaffenen Verwaltungsinstitutionen implizit oder explizit als legitim anerkannt wurde.[4] Sie haben zugleich auch in politischer Hinsicht Rechenschaft darüber abzulegen, ob und inwieweit sie der völkerrechtswidrigen südafrikanischen Präsenz Vorschub geleistet und dadurch den international verurteilten Kolonialstatus Namibias vertieft, den Übergang der - seit der Befreiung Zimbabwes 1980 - letzten Kolonie des Subkontinents in die politische Unabhängigkeit verzögert haben. Am Beispiel Österreichs soll im folgenden eine Klärung dieser Fragen versucht werden.

1. Die österreichische Außenpolitik und Namibia

"Österreich betrachtet - im Einklang mit den Rechtsgutachten des Internationalen Gerichtshofes - die Verwaltung Namibias durch Südafrika als illegal und