SOCIAL AND CULTURAL ASPECTS OF HIV/AIDS

Reports from the Field: 2005

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HIV/AIDS Internship Program
Education, Stigmatization, Implementation:
Challenges to Sexual Health Education for School-Age Learners

By Kate Rice (University of Toronto) and Simon Sikalumbu (University of Namibia)

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Introduction

A knowledgeable and unprejudiced citizenry is integral to both the prevention and treatment of HIV/AIDS. As such, education regarding sexually transmitted disease - and sexuality more generally - is a necessary element of HIV/AIDS-related agendas, all the more so in heavily-burdened nations such as Namibia. In that light, our research pertains to HIV/AIDS and sexual health education aimed at Namibian children and youth. This paper discusses our methodology, research findings, and recommendations for amelioration of educational programs and services in Namibia.

Methods

Broadly-speaking, our research is concerned with sexual health education and youth in Namibia in the context of HIV/AIDS. Accordingly, we attempted to consider a wide range of individuals and organizations that develop and/or implement sexual health education programs that target this demographic. We also attempted to document the opinions and feelings of youth on the subject.

In order to meet these objectives we visited various NGOs, such as Lifeline/Childline Namibia, Namibian Planned Parenthood Association (NAPPA), and the Windhoek Youth Health Development Project. Where possible, we accompanied representatives of these organizations into schools and community centres and observed their programs in action. We also visited schools independently, both in Windhoek, and in the Oshana and Otjozondjupa regions. In each region we conducted interviews with both youth and adults.

Several different research methods were implemented in carrying-out our project. These include interviews, both participant and silent observation, and analysis of written material that was supplied to us by various schools and NGOs. Some elaboration on each of these methods is in order.

Because we were interested in personal attitudes and opinions, interviews were our primary source of data-collection. We interviewed a wide range of individuals, including school administrators, teachers, counsellors, NGO-workers, and, of course, students themselves. Some interviews were formal, one-on-one interviews. This tended to be the case when interviewing teachers and counsellors. Our interviews with NGO-workers were more diverse in nature, sometimes formal and private, other times informal and in a group setting. Our interviews with students tended to be informal, and often took place in a group context. This is because we were interviewing them either at school – often during an HIV/AIDS club meeting or in pre-arranged focus-group, - or at a club-meeting outside of school. Overall, the nature of our interviews reflected the role of the interviewee within the context of sexual health education in Namibia.

Participant and silent observation were also fruitful research methods. We used these methods primarily when visiting schools with NGOs, or when attending meetings.
for HIV/AIDS clubs. As much as possible we participated actively, doing the same activities as learners. This was more feasible with younger learners, however, because both NGO-based programs and curriculum-based programs for young learners tended to be interactive. This interactive component was uncommon in programs aimed at older learners, however, and as a result we took on the role of silent observers.

A final method of research involved collecting and analysing material from NGOs and schools. This included magazines published for youth by NGOs, informational pamphlets distributed by NGOs, and government publications pertaining to the school curriculum. This material is used in the forthcoming in order to support conclusions that we have made based on our interviews and observations.

Research Findings

Learner-Age and HIV/AIDS Awareness

Perhaps our most significant research finding pertains to differences, both in attitudes and generally knowledge pertaining to HIV/AIDS, among young relative to older learners. On the one hand, younger learners were by and large much better informed than their older counterparts, and were much more enthusiastic about the material that was being presented to them. Many young learners needed little encouragement to recount to us what they had learned, and at schools that we returned to on several occasion young learners readily demonstrated that they remembered what they had learned during our previous visits. They were particularly fond of recounting facts which they had learned through educational games that we had played together, as well as singing educational songs that we had learned. Examples include facts such as ‘you can’t get AIDS from hugging or from mosquitoes’ and the ‘my body’s nobody’s body but mine’ song.

Older learners, by contrast, seemed to us apathetic at best to the material that was presented to them. The two most common reactions that we encountered were ones of discomfort and/or disinterest, or else amusement and mockery. For example, students at one secondary school found skits addressing HIV-positive sugar daddies, as well as domestic violence and sexual assault to be amusing rather than distressing or informative. This apathy was also frequently expressed to us by students themselves. For instance, we were informed that “we are sick of hearing about AIDS. Every second person talks about AIDS” (secondary school learner, Windhoek).

Our observation regarding adolescent ambivalence was echoed by virtually all principals, teachers, and counsellors whom we interviewed. For instance, one secondary school counsellor commented that “students don’t care about sexual health. Students don’t come to presentations. They are ignorant.” Even more pessimistically, one teacher at a teacher’s college stated that “the majority of students don’t care, academically and in

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1 By ‘young’ versus ‘older’ learners we refer to learners in primary versus secondary schools. The approximate age of division would be roughly twelve years.
terms of sexual health. Students don’t even come to presentations.” Attitudes such as these are obviously problematic in terms of educating youth.

The Role of the State in Sexual Health Education: Window of Hope Clubs

Windows of Hope is a national-wide educational project launched by the Ministry of Basic Education, Sport, and Culture in 2004. It is in fact divided into two Windows: Junior Window for grades 4-5 and the Senior Window for grades 6-7. At the time of our research the government had only implemented the curriculum for the Junior Window. These clubs have been mandatory in primary schools since 2004 (co-ordinator, Teacher Resource Centre: 2005). This policy is not strongly enforced, however, and some schools do not have a club yet. Moreover, these clubs are run on a volunteer basis, and teachers are not paid for the time that they devote to facilitating club meetings. Nonetheless, Windows of Hope Clubs are up and running in quite a few primary schools in Windhoek, and we had the opportunity to attend several club meetings while in Windhoek. The following is a summary of our amassed information regarding these clubs.

While it is called a ‘club,’ Window’s of Hope seems more like an after-school course. There is a limit on the number of learners that can be in the club, attendance is taken every week, and learners are only allowed to attend if they have been nominated by their teacher. Throughout the year the club-members, under the guidance of a teacher, work their way through four Windows. The first window is the green window, in which the students learn about self-awareness and self-esteem. The second window is the yellow one, in which students learn about their bodies and about various kinds of human relationships. The third, blue window helps the learners to develop their decision-making skills and empowers them to stand by the decisions that they make. The final, red window is about dealing with HIV/AIDS.

The objective of this program is to “teach about bodies so that they can make healthy, and positive decisions with respect to their sexual behaviour and protect themselves against HIV/AIDS” (Yellow Window Workbook: 2004: 3), as well as teach young people to respect and cultivate healthy friendships with individuals of either sex. The program addresses a number of issues indirectly related to HIV/AIDS, however, and seems to be geared towards developing children into well-rounded, self-confident human beings who will, in theory, be able to make positive decisions regarding HIV/AIDS and be supportive friends to those with HIV/AIDS.

Windows of Hope appears to be the only nation-wide, government endorsed-program aimed at educating learners about sexual health and HIV/AIDS. From talking to students and attending club meetings, we were left with a very good impression of the club and of the impact that participation in the club was having on young learners. Nonetheless, there are several limitations that bear mentioning.

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2 At the time of our research, the Ministry of Basic Education, Sport, and Culture has also proposed a speaker series entitled “Making in Real” for all schools in Khomas Region. It had not yet, however, been implemented (Ministry of Basic Education, Sport and Culture Publication: 2005).
The most obvious limitation to the effectiveness of this program is the simple fact that it is aimed only at younger learners, and only the first Window has been implemented. Moreover, our assessment of the scope and success of this program was limited by the fact that we do not know to what degree the program has been launched in other regions —although, according to the Ministry of Basic Education, it should be, - because our research was primarily conducted in Windhoek and because at the time that we visited Oshana and Otjozondjupa regions we were as yet unaware that this program had been implemented. It bears mention that the schools that were visited in Oshana and Otjozondjupa did not have Windows of Hope clubs, which may indicate that these clubs are more prevalent in Khomas region.

We also find it problematic that participation in the Windows of Hope clubs is restricted to learners who have been selected by their teachers as being superior pupils. While many factors may contribute to why this program cannot be offered to all learners, it seems questionable that this sort of information should be a privilege offered only to the particularly adept and well-behaved. Furthermore, I speculate that being denied the opportunity to participate because of poor academic performance may engender ambivalent feelings towards HIV/AIDS education, which may prove detrimental to learners in the long-run. We propose, therefore, that if possible the program be expanded to include a higher number of learners. If this is unfeasible, however, we suggest a less discriminatory means of choosing which students will participate.

Another serious problem incumbent in Windows of Hope relates to the role of the teacher. Although the Ministry of Basic Education explicitly states that this program is required in all schools, little or no funding is offered and, accordingly, teachers who facilitate this course do so on their own time and with no compensation. This is limiting in schools where teachers have other commitments. Moreover, several school administrators confided that many of their teachers are uncomfortable discussing sexuality and HIV/AIDS with their learners, and are therefore unwilling to participate in Windows of Hope. On a related note, one male instructor who taught Windows of Hope lamented that he really needed a female teacher to help him, although no female teachers were willing to take on the task. He felt uncomfortable addressing the concerns and questions of female learners, and stated that these learners also felt uncomfortable discussing these issues with him (Male Teacher, Primary school in Katatura: 2005). On his recommendation we suggest that, wherever possible, Windows of Hope be facilitated by two teachers, one of either sex.

A final and ethically fraught issue pertains to the role of parents in relation to Windows of Hope. Essentially, students who are selected to participate in these clubs must obtain their parents’ written permission to participate. While Namibian parental attitudes towards sexual health and HIV/AIDS education is beyond the scope of our research, our general impression is that some parents are opposed to their children being informed in this regard. Accordingly, in accordance with their parents’ wishes some learners are denied the opportunity to participate. This is a difficult issue to resolve without infringing upon parents’ rights. We offer no recommendations in their regard beyond a greater reflection into the role of the family in the context of HIV/AIDS.
The Role of Teachers

Obviously the role of the teacher is critical within the context of education. We made several relevant discoveries regarding the role of teachers within the Namibian education system, both among teachers themselves and among students at the Windhoek College of Education.³

We visited the Windhoek College of Education several times in July 2005. We met with both the HIV/AIDS club, which is composed of students, as well as several instructors who were actively involved in HIV/AIDS programs at the Teacher’s College. Since this institution trains future teachers, we feel that it is a particularly crucial resource in assessing the nature of sexual health education in Namibia. Our research findings are outlined in the following.

One of our more significant discoveries is that the HIV/AIDS club at the teacher’s college is very small. We were informed by one of its members that “most students are not interested in HIV. Other clubs are more popular” (Male student teacher, 2005). Similarly, another club member stated that “students don’t join this club because of stigma and heavy workload” (female student teacher, 2005). It is worth mentioning that all members of the club stated that their initial interest and involvement in the club stemmed from being affected personally by HIV/AIDS; either these students were HIV-positive themselves or, more commonly, a friend or family-member was positive.

These student teachers offered some valuable insight into the challenges incumbent in incorporating HIV/AIDS into the classroom.

Firstly, these students stated that HIV/AIDS is addressed in the curriculum only in grade 10 life science.⁴ They stated, however, that the cultural beliefs of teachers influence whether or not HIV/AIDS is discussed in the classroom at all; “the problem comes when teachers are not interested. Some teachers won’t talk about sex. Especially older teachers” (Student-teacher, 2005). They found this unfortunate, because they asserted that students really want to know about HIV/AIDS. Moreover, they stated that some teachers at the teachers’ college were uncomfortable discussing HIV/AIDS, so new teachers are often uninformed themselves.

The members of the HIV/AIDS club identified several other, more practical challenges to educating both student-teachers and their future learners. They hoped, for instance, to expand the programs that they themselves offered to their fellow student-teachers, but found funding, time, and office-space to be limiting factors (student-teacher, Windhoek College of Education: 2005). They also lamented that they needed more information themselves in order to teach the other teachers. Perhaps most significantly, however, several students pointed to misconceptions regarding HIV/AIDS as being a major roadblock in educating both their peers at teacher’s college and learners in schools.

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³ The Windhoek College of Education is a teacher’s college, located in Windhoek.
⁴ This contradicts our observations at certain schools.
For instance, “people don’t believe that people with HIV who look healthy actually have HIV. They say it’s a way of getting money from the government” (female student teacher, 2005). They also pointed out that alcohol abuse among both student-teachers and learners is a big problem in the context of HIV/AIDS.

The Teachers Themselves

Assessing the involvement of teachers in sexual health and HIV/AIDS awareness education was difficult, because the teachers who were willing to discuss these issues with us were the ones who were already committed to this sort of education. We learned a great deal about the role of teachers, however, at the Teacher Resource Centre in Windhoek and from school principals and management. The more involved teachers were, of course, extremely helpful themselves.

The Teacher Resource Centre, as its name implies, is an establishment which supplies teachers with materials and information to help them in the classroom. Located in Katatura, it is a comfortable and welcoming facility with a library, reading-space, and several staff to assist teachers in finding the resources they need. In terms of HIV/AIDS resources, we were thoroughly impressed with the material in the library. There were also educational pamphlets and condoms on a table near the door.

We learned from a Coordinator at the Teacher Resource Centre that all schools are required by the Ministry of Basic Education, Sport and Culture to send their teachers to the Resource Centre to attend seminars on incorporating HIV/AIDS into the classroom, and on implementing Windows of Hope Clubs. Moreover, all school administrators are required to attend such seminars. She highlighted some obstacles, however, in realising this objective. Firstly, she states that although in theory all schools are required to send some of their teachers, this often does not happen in practice because attendance at these seminars is voluntary, and there are no consequences for failing to attend. Moreover, the teachers who attend these seminars are nominated by their school principals, so if the principal of a school is apathetic then often no teachers will attend. Moreover, she asserted that many private schools take little interest in sending their staff to these seminars, although private schools are also required to have Windows of Hope Clubs and to address HIV/AIDS in the classroom.

This wide spectrum of enthusiasm—or lack thereof—for sexual health education among teachers and administrators was also apparent to us based on our observations at various schools. Instances of highly positive initiatives on the part of teachers and administrators were abundant in both Windhoek and in Otjozondjupa region. For example, at one secondary school in Katatura the principal was highly trained in addressing HIV/AIDS in the classroom, and visited classrooms every Friday to discuss HIV/AIDS and related issues with his learners. We even visited several schools where teachers were funding HIV/AIDS awareness activities out of their own pockets. This is, of course, extremely problematic, but it illustrates the degree to which some instructors are committed to raising HIV/AIDS awareness among their learners. Some schools, however, exhibited a marked lack of commitment to their learners’ wellbeing. For
instance, at one school with resident learners ranging up to twenty-three years of age, there are no condoms available because the students are deemed “too young to need them” (teacher, secondary school in Khomas region: 2005). This school is far from shops where learners might have the option of buying condoms for themselves. We feel that such schools need to be targeted as sites in need of sexual health and HIV/AIDS education, for the well-being of their learners.

“They Do It Anyway:” Positive Reinforcement Outside the Classroom

One major issue that was repeated to us over and over, both by NGO-workers and teachers was the fact that even if learners receive useful information at school, they do not internalize this information because there is no positive reinforcement outside of their educational institutions. As one teacher emphasizes, most students with erroneous beliefs and misconceptions about HIV/AIDS acquired these beliefs from their parents (teacher, secondary school in Windhoek). We were told at the Teacher Resource Centre that teachers often complain that they do not know what to do when these beliefs are brought up in the classroom. Moreover, we were told on many occasions that these beliefs and misconceptions are “embedded in culture” (HIV/AIDS counsellor, secondary school: 2005).

Prevalence of ‘sugar daddies’ was also repeatedly cited as proof of the lack of positive reinforcement outside the classroom. We were informed by several teachers and counsellors that not only are such relationships not uncommon, but that these relationships “often take place with the parents’ knowledge and blessing” (teacher, Teacher Resource Centre 2005). It is important to mention, however, that we were cautioned against being too judgemental of parental attitudes in this regard, because in many cases parents are unable to financially support their children through school, and the contributions of a sugar daddy can lessen this financial burden.

Several teachers and counsellors pointed even beyond family and peer-group in identifying poor-role models. One counsellor, for instance, stated that “a high-profile person needs to admit that they are HIV-positive. Ministers need to set and example” (counsellor, secondary school: 2005).

Teenagers and Sexual Health Education

As discussed above, Namibian teenagers often respond poorly to the educational material that is offered to them. This conclusion was based upon our own observations, as well as those of teachers and counsellors. To quote one sexual health counsellor, “they know, but they don’t act” (secondary school in Windhoek: 2005). This is a telling observation, but we feel that rather than throwing up one’s hands in exasperation and pointing fingers at youth for being irresponsible, it is important to try to understand why this is the case. Do they really know? And why don’t they act? These questions will be explored in depth in the forthcoming.
The first question, ‘do they really know?’ begs some serious reflection. Based on the information already discussed in this paper, some youth are bound to know more than others because they come from families who are more open to acknowledging the realities of adolescent sexuality and of HIV/AIDS. This is not likely to be the case in all families, however. It follows that many Namibian youth cannot be expected to be knowledgeable based on their home experiences. Furthermore, as also discussed above, many teachers share the same values as these parents, and are uncomfortable discussing sexuality with their learners. For example, at one secondary school in Windhoek we were informed that although all grade 9 and 10 students are required to take a ‘life skills’ class taught by one of two guidance counsellors, and although this course is meant to address sexuality, nonetheless only one class discussed it at all because the other counsellor was uncomfortable with the material. Similarly, at one school in Katatura the instructor teaching Windows of Hope tiredly informed us that he is the only teacher at his school that is willing to teach the course. It seems, therefore, some learners are unlikely to receive much information at all. One wonders, therefore, how much they can be expected to know about HIV/AIDS.

The second point that I would like to address with respect to how much teenagers actually know about sexuality and HIV/AIDS pertains to the way that material is presented to them. Judging by their reactions to presentations, as well as their responses to questions that we asked them about the material that was available, the general response was either bored or frustrated. As previously mentioned, students are “sick of hearing about HIV/AIDS” (male student, secondary school in Windhoek: 2005). I propose that this apathy and frustration stems from the fact that what information is offered is presented in ineffective ways, either intended to scare young people into being chaste, or else is so decontextualized that youth cannot identify.

Disinterest with respect to STD and sexual health education among teenagers is not a uniquely Namibian phenomenon. Neither is an unwillingness to acknowledge that teenagers are sexual beings who can -and often do- engage in sexual activity. I argue that this deluded and paternalistic approach to adolescent sexuality is highly detrimental in the context of HIV/AIDS, because if young people cannot relate to the material that is presented to them, they are unlikely to internalize it and to behave accordingly. I feel that this refusal to acknowledge the realities of adolescent sexuality in sexual health education is a key reason why Namibian teenagers “know, but don’t act.”

As discussed by Louisa Allen, contemporary sex education for youth overemphasizes the ‘sex as risk’ aspect of sexuality while downplaying the elements of desire and pleasure (2004: 151, see also Gilbert: 1996). For instance, she asserts that in sex education courses, genitalia are usually presented as though they have been dissected, that penises are never depicted as erect, and that the clitoris is often unlabeled (Allen: 2004: 155). All this serves to desexualize the body and “dissociate it from embodied feelings of desire and pleasure” (Allen: 2004: 155). This point is further emphasized by Aggleton and Campbell, who note that contemporary sex education for youth equates sexual health with prevention of disease and pregnancy –and only with the prevention of

Ward and Taylor’s study of reactions to school-based sexual education among minority American youth is strongly supportive of these arguments. As one student related, “when you’re in sex education class they just tell you what goes on inside your body. They don’t tell you what goes on” (in Ward & Taylor: 1992: 190-191). Moreover, the fact that sex education tends to ignore the personal and emotive elements of sexuality is strongly illustrated by a student who remarked: “I had sex education. It taught a lot but it doesn’t make you change your feelings” (in Ward & Taylor: 1992: 191). Ward and Taylor concluded that students felt that sex education did not fit with the reality of their lives, because it left out “feelings, fears, passions, inconvenience, embarrassment, and romance that affect sexual decision-making and that occur within a context framed by cultural values and beliefs” (1992: 191). Although they were addressing sexual health education in an American context, nonetheless I feel that their findings are highly relevant in Namibia, as I will now show.

Firstly, there we found considerable evidence that sexual health and HIV/AIDS education in Namibian schools is presented in a distant, risk-emphasizing and overly biological way. As we were informed by one NGO worker in Windhoek, most sexual health education and HIV/AIDS education in Namibia is presented in a top-down way, which does not interest most young people (2005). Given the materials that we saw while visiting schools, our observations support the point of view of this NGO-worker. There are several other reasons, however, why I feel that this is the case.

Aside from our regular visits to schools and NGOs, I conducted a side-project that gave me valuable insight into the thoughts and anxieties of Namibian teenagers with respect to HIV/AIDS. At the school where my fellow interns and I resided while in Namibia, I made an anonymous question box in which learners could insert questions regarding sexuality and HIV/AIDS. Every few days I would type up answers to these questions and display these questions and answers on a bulletin board in the courtyard. It bears mention that I have several years of experience as a sexual health counsellor, and was therefore trained and informed enough to properly answer most of the learner’s questions. In any case, there was a great deal of interest in this box; I would often have seven or eight new questions every three or four days. Both the quantity and subject-matter addressed in these questions is highly significant.

Firstly, I assert that the sheer quantity of questions that I received indicates that teenagers are in fact very interested in matters pertaining to sexuality and sexual health. This contradicts both their behaviour when observed in a structured academic setting, as well as the opinions expressed by their teachers. It supports, however, my argument that

5 The questions that I was unable to answer were of the moral variety or required an understanding of Namibian extended-family relationships. In the case of moral questions, I did not feel that it was appropriate to assert my own opinions to the same degree as I would through my work as a counsellor in Canada. I was of course poorly-situated to address questions that required a thorough understanding of the Namibian family.
teenagers respond poorly to sexual education not because they do not want to know about sex, but because it is not presented in an appealing or realistic manner.

This abovementioned argument is further supported through analysing the subject-matter of the questions that I received. Many of the questions addressed issues of relationships and emotions, asking whether their feelings were normal, and how to deal with or act on them. This emotive aspect of adolescent sexuality was rarely addressed in any of the material that we encountered through NGOs and schools. Secondly, many of the questions pertained to sexual practices themselves. Examples include “my boyfriend likes to have sex so I use birth control pills, but sometimes I forget to take them at the same time every day. Can I get pregnant?” “Is it normal to have sex everyday?” and “is it bad for you to not have sex?” Judging on the educational environments that we encountered at the schools that we visited, these sorts of questions would not have been addressed, nor would such questions have been constructively responded to if asked. Moreover, since many of the teachers are uncomfortable addressing sexuality to begin with, I suspect that few learners would have been comfortable asking such questions. This further illustrates that the material that is discussed in schools is not presented such that learners can relate. This, I argue contributes to the boredom and ambivalence of many teenage learners with regards to sexual health education and HIV/AIDS awareness.

Aside from this question-box, I also conducted several focus-groups and educational seminars with teenage learners, both in Windhoek and in Oshakati. The amount of interest I received was overwhelming. Indeed, in Oshakati I was approached by a group of learners two hours before my seminar was supposed to start, asking if I would be willing to start early. Moreover, more than twice as many learners attended than as been planned for. Indeed, I received so many questions and the learners were so keen to offer answers to my questions that I had to cut the seminar off after four hours due to exhaustion. Clearly, therefore, Namibian youth are very interested in learning about sexuality and sexual health. Accordingly, I infer again that it is the manner in which it is presented that makes them apathetic.

Recommendations

Our recommendations have been addressed either directly or indirectly in the above discussion. In the interest of clarity, however, a brief summary is in order. Firstly, it is of paramount importance that older learners be focused upon as a group that is in need of sexual health and HIV/AIDS information and resources. As I have shown, they tend respond poorly to the information that is available to them in the classroom, yet are hungry for knowledge. I argue that information regarding HIV/AIDS and sexuality more generally must be presented in a manner which acknowledges teenagers as emotive beings capable of and involved in relations which are more complex and profound than the merely biological. The importance of such an approach is shown by the high degree of interest that learners took towards my seminars and question-box.

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6 By older learners I refer to those in their teens.
Increased funding is also an important aspect of improving HIV/AIDS education for youth in Namibia. As previously stated, many teachers facilitate clubs on their own time and out of their own pockets. It has also been stated that there are often not enough teachers willing to take on this extra role. If these teachers were compensated for the time and effort that they put into these clubs and courses, perhaps there would be more interest in HIV/AIDS education within the school system. Moreover, if teachers were paid for facilitating Windows of Hope Club meetings, perhaps teachers who were comfortable teaching these courses could do so in lieu of some of the courses which they currently teach, and these courses could accordingly be taken over by teachers who are uncomfortable addressing HIV/AIDS in the classroom.

A further area for improvement pertains to teacher-training. As stated above, schools are required to send teachers to be trained in HIV/AIDS education at the Teacher Resource Centre, yet many do not attend because this policy is not enforced. More attention to attendance on the part of the Ministry of Basic Education, Sport and Culture, as well as penalties for non-attendance would perhaps ensure that more teachers were trained in HIV/AIDS related material.

We have several recommendations that pertain to the Windows of Hope Clubs. Firstly, given the observed effectiveness of this program, we urge that the Senior Window be implemented as soon as possible. We also recommend, however, that this program be expanded to involve a greater number of learners. We further suggest that academic merit not be held as the prime criteria by which young people are judged worthy of participating in this program.

As a final but highly-important recommendation, we strongly suggest that ongoing attention be paid to the younger generation of learners in terms of their attitudes towards and awareness of HIV/AIDS and those who suffer from it. As we have stated, younger learners tend to be far more open-minded and more aware of the realities of this disease. They have had the unique privilege, however, of having received HIV/AIDS education from a young age. Given that these young learners are too young to be sexually active, as well as too young to be responsible for friends and family who are debilitated by HIV/AIDS, we will have to wait for several years before we will be able to tell whether or not these educational programs have been truly effective. We argue, therefore, that ongoing attention be devoted to these younger learners in the interest of assessing – and subsequently improving- the programs that are currently implemented with regards to their education.

Conclusions

Sexual health education is fundamental to cultivating a healthy and responsible population in the context of HIV/AIDS. Moreover, young people are foundational to the well-being of a society; if nothing else they are the ones who must stay healthy in order to look after the ill and aging. Accordingly, we have investigated sexual health education in Namibia as it is available to children and teenagers in order to assess the current situation and offer recommendations for improvement in the current curriculum. This
paper has outlined our methodologies, research findings, and subsequent recommendations.

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Windhoek Youth Health Development Project

The bulk of our research was carried out at primary and secondary schools in Windhoek, Oshakati, and Otjozondjupa.
Combating HIV/AIDS at Tertiary Institutions in Namibia: A Closer Look at Services and Student Groups

By Ayaana Jean-Baptiste (University of Toronto), Michael Shirungu (University of Namibia) and Simon Iilongo (University of Namibia)

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Executive Summary

In this study, we examined how HIV/AIDS information is incorporated into tertiary level education by focussing on the availability and utilization of counselling services. This research follows up on research conducted over the past two years of the Joint UNAM/UofT internship that focused on tertiary institutions (Mohamed & Kiimbi 2003, Melino & Anton 2004). Our aim was to track the progress in the development of HIV/AIDS advocacy and student services at the University of Namibia (UNAM), Polytechnic of Namibia (PON) and the International University of Management (IUM). We also examined how these services operate at other tertiary institutions not previously studied by research interns, such as the Windhoek College of Education (WCE) Windhoek Vocational Training Centre (WVTC), and the Israel Patrick Iyambo Police College (IIPC).

Our research consisted interviews with both students and Head coordinators of HIV/AIDS programs and support services. We found that HIV/AIDS related policies have been put in place at every institution, however were not always acknowledged nor utilized by the students that attend these institutions. We determined that this may be due to the limited amount of time that students have for extra curricular activities as well as only being informed of such services during the beginning stages of attendance. When speaking with the counsellors we found that the main issues that students would approach them with were pregnancy, financial matters and academic advice. It was rare that a student would come forward with a specific HIV/AIDS related issue. A possible reason for this, as noted by one of our interviewees, was that, “Students don’t feel that their confidentiality would be kept.” That said, every counsellor assured us that confidentiality was guaranteed to their students.

To access students already involved in HIV/AIDS initiatives at their campuses, we met and interviewed with students actively involved in the Student/Training Representative Council (SRC/TRC) and HIV/AIDS clubs. Based on our meetings we found that the SRC/TRC tended to be dominated by male students while the heads and members of HIV/AIDS awareness clubs were mostly female students. Some concerns noted as a result of this discrepancy was the extent to which the SRC/TRC represent their female student community and the impact of the inactivity of males in HIV/AIDS clubs. Another gender-specific role that we came across was that the support service counsellors were all women. Students felt more compelled to discuss personal issues with the counsellors that came across as ‘motherly figure’ type individuals. When trying to generate feedback from the masses of students via a live call-in radio program, the response was very high. This implied that an ongoing show of this capacity may prove to be a viable outlet for youth to discuss HIV/AIDS related questions.
Recommendations

Based on our findings we came up with these general recommendations that can be utilised to make HIV/AIDS initiatives more efficient at each tertiary institution:

1. Senior Student Participation.
2. Professional Social Workers at Each Institution.
4. One Representative HIV/AIDS Club for All Institutions.
5. Nursing Student Participation.
6. Weekly Call-In Radio Show.

Introduction

Before embarking on this collaborative internship between the University of Toronto and the University of Namibia (UNAM), on the ‘Social and Cultural Aspects of HIV/AIDS in Namibia’, several preparations were made on my part in an attempt to ease my transition into this foreign country and research to follow. As eager as I (Ayaana Jean-Baptiste) was to come and in Christopher Columbus style, “discover” new and relevant developments in HIV/AIDS interventions at tertiary institutions, nothing prepared me for what I encountered, which ended up being one of the most enlightening and rich experiences of my life at this point. Upon arrival I met instant new friends, due to my association with another student (Rahma Mohamed) who participated in the internship in 2003. These friends greeted me warmly with, “Welcome home sister”, as if understanding right away what that meant to a diasporic African unaware of her exact ancestral origins. Unlike the other Canadian interns, I was fortunate to encounter that I was to be paired up with not just one Namibian partner, but two. This occurrence I believe added to our research, since we had to find a way to mesh our three differing personalities to produce a viable research study.

The first partner that I met was Simon Iilonga, who, after the regular formalities, instantly informed me of his rigid devote Christian values and his interest in gender relations around HIV/AIDS, while providing me with a mini tour of the warm pastel yellow and brick red colour of the University of Namibia buildings. Simon appeared to experience something that I still could not find for myself: finalized ideals and goals for his life. He was certain that some day he would play a significant role in how HIV/AIDS protocol and education will be disseminated within his region. I was quite fascinated by this attitude and came across similar attitudes by more university/college students during my stay in Namibia. My second partner Michael Shirungu, whom I met a week later, was less formal and we quickly succumbed to the same sense of humour about everyday occurrences. He also had strong Christian ideals yet was more open at times to ideals outside this perspective. His interest was more along existing HIV/AIDS services at campuses and how students relate to these services. Michael himself was a member of the Stepping Stones program at UNAM and felt that it was very useful in how it conditioned him to appreciate his responsibility in HIV/AIDS prevention measures. According to the official stepping stones website, “Stepping Stones is a training package in gender, HIV, communication and relationship skills.”
It was quite comforting to note that both of my partners had interests that were connected to tertiary institutions, since this was exactly the area that I was interested in pursuing. We all recognized the importance of tertiary institutions on a society, as was declared in the UNAM HIV/AIDS Policy:

“Tertiary institutions have an ethical and intellectual responsibility to set an example by openly debating HIV/AIDS and finding effective responses to the threat posed by the pandemic. They are essential vehicles for the provision of a united and effective response to the HIV/AIDS pandemic (du Pisani & Otaala, p.vii, 2001).”

After meeting with my two partners several times, we decided that we wanted to take a somewhat participatory action approach at how we would come about to conduct our research study. We wanted to establish the views from both the students and managing faculty at six tertiary institutions in Windhoek, in regards to their (fairly) new policies and activities in HIV/AIDS implemented in response to the epidemic.

Overview

With the HIV/AIDS pandemic increasingly targeting individuals aged 15-25 years, the question of student attitudes towards this pandemic has been a focus of not only the UNAM/UofT Joint Internship, but of a multitude of HIV/AIDS related studies on Sub-Sahara Africa (c.f., Otaala: 2000, Lewis: 2001, Bennell & Chilisa: 2001, Allemano: 2003, lipinge: 2004). Inevitably each report tends to come to the same findings, including gender-related blame, alcohol abuse, lack of confidence in free condoms, and limited HIV/AIDS related activity by the Student Representative Councils. While these research findings represent themes that also came up in our own interview sessions with students and faculty, we decided to direct our research towards students who have already demonstrated an interest in HIV/AIDS related issues. Our basis for determining student’s interest was by examining counselling service utilization and participation, as well as the student and faculty activity in HIV/AIDS initiatives.

To meet our research objectives, we sought to examine how HIV/AIDS information is incorporated into tertiary level education by focusing on the availability and utilization of counselling services and the activity of HIV/AIDS advocacy student groups. This research somewhat follows up on the last two years of research in this collaborative internship project by tracing the progress made in the development of HIV/AIDS related services and curricula at the University of Namibia (UNAM), Polytechnic of Namibia (PON) and the International University of Management (IUM).
To gain further insight and information, we also examined how these services operated at three other tertiary institutions: the Windhoek College of Education (WCE); Windhoek Vocational Training Centre (WVTC); and the Israel Patrick Iyambo Police College (IPIPC).

Methods

With the interest of determining student’s attitudes and behaviours around HIV/AIDS, we conducted several tape-recorded open-ended interviews within the nursing residence that consisted of students attending the University of Namibia and the Polytechnic of Namibia [Please see Appendix A for the list of general interview questions]. We also conducted a live call-in radio show on the UNAM radio station, a station that is listened to by youth all over Namibia, in order to attain some anonymous insights. To get feedback on our research, we asked our audience several HIV/AIDS and relationship related questions [Please see Appendix B for general radio show questions]. Third, to get into contact with students already involved in HIV/AIDS initiatives at their campus, we met and interviewed students actively involved in Student/Training Representative Council (SRC/TRC) and HIV/AIDS clubs. In some cases we were invited to attend meetings, where we witnessed firsthand how these HIV/ADS initiatives are carried out. Finally, in order to examine how student services worked at each institution, we met with the heads of clinics or student services and conducted more interviews. [Please see Appendix A for general interview questions]

Limitations

Due to the timeframe of this research internship, our main obstacle was meeting with students directly, as we began our research when most of the institutions (i.e. UNAM, PON, and WCE) were on an exam schedule, followed by vacation time. This affected our research tremendously as students were either preparing for their exams or had departed Windhoek for their homes elsewhere in the country. Classes only resumed during the last week allocated to this study. Moreover, we were unable to gain permission to meet directly with students at the Israel Patrick Iyambo Police College due to disciplinary training.

Follow up on the tertiary institutions already visited in the past years

We were pleased to find that these institutions were still keeping abreast of HIV/AIDS initiative implementation and have successfully continued to incorporate this as part of their curriculum. However, with the long list of improvements at each institution, there were also a few setbacks.

University of Namibia

One improvement that was noted at UNAM from previous internship reports in 2003 and 2004 was that the “UNAM HIV/AIDS POLICY” was available to every student in a short and nifty “quick facts” booklet. This policy, originally prepared by Professors
Andre du Pisani and Barnabuus Otaala includes an information guide about HIV/AIDS in general, and available HIV/AIDS services at the university. This booklet was readily available during student orientation as well as at the Dean of Students office, who is responsible for student life at UNAM. A second improvement was the pilot visit by NEW START, an anonymous Voluntary Counselling and Testing (VCT) service to offer anonymous testing; several students participated. The demand was so high that students, who were not able to get tested were given vouchers to test at different NEW START VCT clinics around the city. This high demand likely demonstrates that students are becoming less affected by the stigma associated with getting tested for HIV. was noted by some of our interviewees as one noted, “…a lot of people are interested in getting tested now, since they are afraid that people have it on campus”. As a result UNAM is hoping to establish a permanent VCT clinic on campus by 2006. Another improvement at UNAM was the measure by the Dean of Students to incorporate prevention messages into popular culture by inviting Namibian performers such as ‘Gazza’ and ‘the Dogg’ to come and perform at their campus as part of their HIV/AIDS awareness initiatives. In our interviews, some students criticised that their fellow students would tend to ignore the purpose of the concert. However, this does not appear to contribute as a setback, since many students prefer this form of HIV/AIDS awareness.

One of the setbacks noted at UNAM was that in order to obtain free condoms, students now had to either go to the dean of student’s office or to the clinic, thus losing confidentiality. Concern was expressed by counselling staff, explaining that in the past, boxes of condoms were placed in the bathrooms and were misused by the students. For example, condoms would be found blown up into balloons, or whole boxes would be taken from the bathrooms each day. Another setback at UNAM identified was that the active AIDS initiative groups that former research interns Kate Melino and Maria Anton described in their 2004 report were now either sparse or non-existent. In particular, the Stepping Stones initiative, recognized by one of us (Michael Shirungu) as a very beneficial program generating very positive outcomes, had stopped functioning.

Polytechnic of Namibia

At PON, we were always directed to the same office when discussing HIV/AIDS advocacy. This staff member was responsible for the majority of HIV/AIDS initiatives on campus. The PON had just concluded their annual Polytechnic AIDS awareness ceremonies, which were very large scale and involved government based health officials, community based organisations (CBO’s) and several primary school participants. This is a major improvement for the school’s HIV/AIDS programs, as the PON continues to extend some of their HIV/AIDS initiatives outside of their campus. Currently PON is in the process of establishing an outreach programme to a few local orphanages. PON also expects to have an active VCT clinic set up on their campus by October 2005, in order for their students to be more encouraged to get tested directly on campus. Another significant improvement is that the student HIV/AIDS awareness club had renamed their club to PAAC (Polytechnic Aids Awareness Club), and with the new name has come many new activities and more active involvement on campus. This may be due to the fact that 3 of the 8 members of their SRC were part of the PAAC.
PON’s major setback is that there is still stigma associated with joining PAAC, as we were informed by some of the group’s members. Some of the representatives of the PAAC explained that this was because students did not want to be identified as being actually part of the group even if they did attend activities held by PAAC. They noted that the only way to engage student interest in the club was through already scheduled activities and events. Their ideal would be for more students and members of the PAAC to be more involved with the actual planning of these events.

International University of Management

The Faculty of HIV/AIDS at the IUM will have their first cohort of students graduate from the HIV/AIDS Management program in 2005. Mohamed and Kiimbi (2003) and Melino and Anton (2004) spent considerable time observing the development of this program, recognizing its unique perspective to HIV/AIDS than that taken by the UNAM and the PON, that, “the idea of HIV/AIDS was a vehicle for expressing capitalist and nationalist concerns (Melino & Anton 2004: 11). This outlook is well placed seeing as how many of our interviews with students at the varying institutions felt that HIV/AIDS was just a means to make money in their society, hence ignoring the severe impact that the disease is having on the development of their country. Our faculty informant from the IUM provided us with a handout from the program entitled, ‘Antiretroviral Therapy or Micronutrients’, that expresses concern over developing countries (in particular South Africa) shelling out hefty amounts of their budget on ART’s when there is still little known on their effectiveness. The author expressed that “…HAART is a Rolls Royce limousine for a poor African” and that, “…developing nations should initiate scientific-research, studies and data collection to understand the truth.” With such critical thinkers at IUM, it is a good sign that students are encouraged to look beyond the simplistic Abstinence Be faithful Condomize (ABC) campaigns. Also at IUM, the SRC became more involved in HIV/AIDS initiatives on their campus. Representatives from the SRC explained that the committee has been newly active in disseminating HIV/AIDS awareness information through pamphlets, posters and events. This is a vast improvement from the previous years and important as it is the SRC that represents the student body.

The main setback noted at IUM was that the AIDS awareness club was still not properly established. There was mention of a club, but from what we were able to determine from our interviews and attempts to locate them, this club was fairly inactive. This may be due to the limited budget that the university has to dispense for student clubs.

Newly Visited Tertiary Institutions

Windhoek College of Education

The Windhoek College of Education (WCE) is one of the four national colleges of education in Namibia (website 2). Upon completion of the program, the WCE provides
its graduates with a Basic Education Teacher Diploma (BETD). This enables them with the qualifications to teach at the secondary school level in various subject domains. Thus the students enrolled here are the future teachers of Namibia’s youth. Thus, it is imperative for these students to be trained in HIV/AIDS based literature as well as have access to HIV/AIDS support services. To accommodate this necessity, the WCE implements HIV/AIDS training within their curriculum and all of the lecturers are trained in counselling. With all of the lecturers being trained in counselling, there is no full-time counsellor employed by the institution. Student opinions were mixed regarding this lack of a primary counsellor.

Our access to student opinions was through meetings with the executive of the SRC. According to two representatives, some students felt that it was more effective to be able to select a counsellor they were most comfortable with to seek advice on personal issues from all of their lecturers, whereas others would have preferred a separate full time counsellor in order to maintain privacy from their learning environment. As a result of this, one of the future strategies of WCE is to open a clinic on campus where students can access support services. The SRC informed us that there was an active AIDS awareness club that attempted to bring NEW START to campus in conjunction with the SRC for HIV/AIDS testing. With WCE having a small enrolment population of approximately 600 students they did not want NEW START to visit their campus until there was a commitment to attend the service from the students. As not enough students signed up for this service, this project never materialised. The SRC felt that this may have been due to a lack of student interest, but it could also have been due to the technique utilised. Requesting prior sign-up may have invoked a stigma for some students, since their name was required to appear on a non confidential list. Yet our research with other tertiary institutions showed that NEW START testing was very effective and did not require prior signing up.

Windhoek Vocational Training Centre

The Windhoek Vocational Training Centre (WVTC) is one of the six national vocational training centres. The students here are provided with hands on experience in their trade of interest. The Namibia National Training Organisation (NNTO), the institution that governs the WVTC, has set into place an HIV/AIDS policy. According to the NNTO HIV/AIDS policy, “HIV/AIDS is a life threatening illness that will have a severe impact on the workforce of the NNTO, if the company does not educate its employees on measures how to curb the further spread of the disease (NNTO, p.1, 2002).” As a means to accommodate this policy, WVTC provides pre-education workshops on HIV/AIDS to 1st and 2nd year students and to those interested.

Due to WVTC being a trade school, the student population is dominantly male. Thus, it was interesting to note that a significant number of women were active in the institution’s HIV/AIDS Peer Educators Club, similar to both WCE and PON’s AIDS awareness clubs. The WVTC AIDS awareness club is headed by some of the faculty at this institution; in particular by the Head of Training who also serves as a counsellor to
the students and plays an active role in the HIV/AIDS related activities at that institution. Staff involved with the HIV/AIDS activities are well received by the students and are confident that the students there are quite open to HIV/AIDS initiatives. However, staff and student representatives alike were concerned that the HIV/AIDS Awareness club would face the problem of keeping members active in subsequent years. We witnessed this problem of engagement firsthand during one of the planning session meetings for this club. The director of the organization asked the group of students present, “who was here from last year?”; only one student among the group put up their hand. This may not be due to lack of interest, but mostly due to lack of time spent on campus, as students train at several job sites in their senior years.

Israel Patrick Iyambo Police College

The Israel Patrick Iyambo Police College (IPIPC) was the most disciplined tertiary institution that we visited. With strict regulations, it proved to be a challenge simply to get into the compound. Needless to say, we did not get a chance to speak with any of the students enrolled in training for the future Namibian police force. Our means of communication were the clinic on the IPIPC campus.

Our informant explained that in order to train, mandatory physical examinations had to take place, including HIV/AIDS tests. If a student was found to be HIV positive, they would still be able to participate in the strict training however at times their training would not be as strenuous. Their status is not disclosed to any of their counterparts at that institution. If a training session is deemed to strenuous for them, it is usually thought by the other students that they are simply ill that day or coping with a disease. The IPIPC offers courses on HIV/AIDS during training, an aspect of training that the students apparently show a lot of enthusiasm for. Upon our visits to the clinic, it was interesting to note that the main counter at the front contained several free sexual contraceptives. We were surprised because we were informed that the use of contraceptives was not allowed during training as another form of disciplinary training on this campus. The men and women quarters are strategically separated and strictly guarded so as to prevent and monitor any heterosexual contact. Since we did not get a chance to speak with the students we are not aware of how effective this strategy was at this institution.

Student awareness and utilization of support services

After interviewing the head coordinators of HIV/AIDS initiatives at all of the institutions, we found that programs and policies on HIV/AIDS had been implemented at all of the institutions. However after meeting with students at each institution, we found that students are not necessarily aware of these services and do not always utilise them.

Support Services Faculty

Many of the head co-ordinators of HIV/AIDS prevention initiatives at all campuses also played the dual role of counsellor, hence taking up a lot of their time from their other duties. At UNAM, PON and IPIPC, there were clinics present that provided
family planning services, where the nursing sisters would also take on the role of offering counselling services to students. Yet as one sister who had been working at the particular campus for two years informed us, “Not one student has come to talk to me about HIV”. She went on to state that students were more likely to ask questions about pregnancy. This was a reoccurring statement, as most of the head coordinators at each campus discussed the issue of female students becoming pregnant within their first year at school. We were told by two informants that most of their students are accustomed to living at home with their extended family, but, to attend tertiary education, most students depart their extended families to live in town residences. With this newfound freedom, students are not as prepared for relationship situations. As an irin Plus news bulletin, entitled ‘Namibia: Growing controversy over teen pregnancy’ reported:

“According to UNAIDS, 70 percent of the country’s nearly two million people are under 30 years of age, with 33 percent between 15 and 30 years old, and about one in every five pregnancies occurring in the 13-to-19 age group (website 3).”

This report attests to the fact that young women are highly susceptible to becoming pregnant in Namibia, although family planning services and contraceptives are available free of charge due to abortion being illegal in Namibia. Once young students become pregnant it is highly unlikely that they will return to continue their studies. This prevents socioeconomic advancement for large numbers of women.

1st year Orientation Programs

Most of the counsellors we spoke with who offer advice on HIV/AIDS and personal issues at these tertiary institutions complained that few students would come to them for advice. For example, at one institution, the HIV/AIDS counsellor/social worker only met with one student about an HIV/AIDS related issue within her two years of employment there. Instead, students mainly come to seek financial and academic advice. We speculated that this may be due to how these institutions informed their students about these services. Thus we attempted to investigate how this information was provided to the student body.

While all of the institutions make an effort to inform their students of such services, the limitation found in this study was that the institutions tended to provide this information mainly in 1st year orientation programs. These programs used the approach of welcoming new students yet unintentionally bombarding them with several forms of information. This resulted in a limitation, since not every student tends to be present at orientation and this practice does not take into account the lack of awareness among senior students.

Nursing Student Interviews

With the majority of our Namibian research interns being nursing students, we found it quite relevant to explore what these future health workers of Namibia felt about HIV/AIDS prevention measures. Since the majority of the Namibian interns reside in the
Katutura State hospital nursing residence, we conveniently interviewed other nursing students that resided there as well. The nursing students, who gave us permission to interview them on a tape recorder, were senior students and attended either UNAM or the PON.

We asked questions such as:

● “What does your institution do in regards to HIV/AIDS; what are the services that they provide?”
● “Do you think then that the information provided at your institution is useful?”
● “Is your institution active in HIV/AIDS related issues?”
● “Do you personally know where you would go on your campus for counselling services?” [Please see Appendix B for the full list of questions]

The general consensus was that they did not know exactly. There was speculation that there may be somewhere on campus with such services. While this was disconcerting to us, after more consideration when returning to Canada, one of us (Ayaana) asked some of friends and classmates if they knew where they can attain counselling or support services at the University of Toronto (UofT) campus. Similar to students in Namibia, they were not certain. Perhaps, this suggests that students at tertiary institutions may simply have other things on their minds, such as keeping up with the demands of coursework, hence not always paying attention to the support services available to them unless directly needed at the time.

We also asked these nursing students about their thoughts on personal, sexual issues, and condoms in these following questions:

● “Do you have a problem with free condoms; would you use them?”
● “What do you think the attitudes on campus are of the students; are they sexually active in your opinion?”
● “Exactly just how effective are condoms?”

The general consensuses from these questions were that free condoms were not preferable. Students felt that free condoms “were too cheap”, and as one respondent discussed, “free condoms are only good for emergencies when nothing else is available.” This viewpoint held by these students is recognised by the support services faculty. One of the faculty heads who we interviewed confessed that she would purchase name brand condoms using her own resources to provide to students, just so that students would utilise them more. Regarding sexual activity on campus, the interviewees reinforced the knowledge that students were sexually active. One interviewee even mentioned, perhaps, even in defence, “Well, is it not the same in Canada?”

Live Call in Radio Show

To gather more information from the student body, one of us (Michael) suggested that we consider hosting a live call-in radio show. This way we could hear from students anonymously, hoping that this would promote them to be more forthcoming with information. UNAM radio is a popular radio station listened to by youth all over Namibia. In particular, there is a show hosted by DJ Lomo that several students tune into
during the afternoon. Thus, we requested air time during this time frame and with the well wishes and permission of one of the studio directors, we were set to be on air on the 22nd June, 2005. My partners and I were joined by Kate Rice and Simon Sikalumbu, other interns on this project whose interest was in ‘Sexual Health and Youth’ to co-host this show with us and DJ Lomo.

To get things started, we put questions out there to the radio community as follows:

- What are your views about HIV/AIDS services at your institution; do any exist?
- Are there any active student groups/clubs at your institution that advocate for HIV/AIDS awareness programs?
- If you wanted to test your HIV status, where would you go or who would you speak to about it?
- Do you know your HIV status; do you think it is necessary to know?
- Does your institution provide free condoms/contraceptives? If so, do you trust their safety?
- How effective are condoms?

The response was noteworthy. The phones were constantly ringing. Although some of our questions were answered, students decided that they wanted to ask us their own questions. A particular moment on the show was generated by a question on the femidom (i.e. female condom), while we were discussing the use of it as an alternative method of contraception, since the partner of the caller did not always want to use a condom. Upon mentioning how one of us (Ayaana) had attempted to use this contraceptive, there was a very notable expression from the men in the studio. Right away, we were reminded that sexuality, especially personified by a woman, was not something that was always culturally acceptable. The discussion was fine when we spoke of these things generally, but with the personification there were still some cultural qualms. This perhaps explains why, when we were interviewing the nursing students, the women tended to be less expressive about personal sexual activity.

Although the show was a call-in radio show, we also allowed for text messages to be sent in as a way to receive as many responses as possible. As a result, we received text messages for many hours even after the show. Some of the questions (verbatim) asked of us were:

- If I use and cut myself with a blade that was once used by a person with HIV months ago, will I get infected? Please reply.
- Where can you get the morning after pill accept for the clinic?
- Do you think HIV test is helpful and if yes why people still get HIV in a relationship?
- Why do most men refuse to use condom?
- How do you know a guy really loves you and he’s not using you?
- Can you get AIDS by sleeping with many partners, but none of them has AIDS?
- I like to know what do you do if you had sex with a guy and the condom tore’d, is it likely that I could get aids (maybe the guy has AIDS)?
This high response indicated that a show of this kind would be a great outlet for youth to ask questions about HIV/AIDS, health and relationship related issues. This would be particularly useful to discuss topics that students may feel uncomfortable to ask in person at support service centres on their campus.

Gender-specific roles on campus

Although we did not direct our study at gender-related differences, this was an area that constantly came up. We witnessed this through meeting with the HIV/AIDS counsellors who were all female at all campuses, the HIV/AIDS advocacy clubs that predominantly consisted of female members, and, in contrast, through the SRC’s/TRC’s that were predominantly male-oriented.

The ‘motherly figure’

When meeting with the counsellors at each institution we quickly recognised that the counsellors who came across as ‘motherly figures’ tended to be more regularly visited by students seeking advice about sex related issues. Conceivably, this indicates cultural beliefs about mother nurturance abilities. Many of the counsellors reinforced this observation by stating that students felt more comfortable speaking with a motherly type, because they felt that the counsellor was sincerely concerned about their lives, and not just giving them advice as part of their job. This ‘motherly figure’ was usually someone that was older and perhaps more shapely in figure. We found that when we met with the younger counsellors, those who could perhaps pass as a student themselves, were the ones that complained of having fewer students regularly visit them for support services.

Male dominance in SRC/TRC and the feminization of HIV/AIDS

The SRC/TRC representation was predominantly male at all institutions. This was an item of concern in this study, as at most of the institutions, it is the SRC/TRC that is responsible for student participation in HIV/AIDS initiatives. During our meetings with the SRC/TRCs, the representatives would formally advocate for gender equality issues. However, when spoken to informally, they would contradict these comments. An example of this was when during a formal meeting with one of the SRC’s, a representative declared that, “if you educate a woman, you educate a nation”; all of the other representatives present at the meeting nodded their heads in agreement. Whereas after the meeting, informally the same members were agreeing that if a woman keeps tempting men with revealing clothes then this will cause a man not to use a condom during intercourse, hence placing blame on a woman for the spread of HIV. With many of these members feeling this way, how can the SRC/TRC serve as a medium for students, in particular female students, for HIV/AIDS related issues? As Ms. Lucy Edwards a sociologist at UNAM proclaimed:

“We have to confront our sexuality… [Sexuality] is a socio-cultural construct that is practised within unequal gender power relationships in our society. Besides
widespread physical coercion there are very insidious forms of control over women’s bodies that stem from cultural practices, women’s economic dependency and the patriarchal regulation of women’s sexuality and fertility. Some of these forms of control are regarded as a natural and immutable, particularly the ones attributed to culture and tradition (Edwards; 2005: 6).”

Namibia is a patriarchal society therefore it is not that surprising that the leadership roles of the SRC/TRC are male-dominated; when women challenge these ideals they are deemed un-African (Edwards; 2005). With the crisis of HIV/AIDS has come an elevated level of mistrust between men and women, hence blame was cast on each other. This attitude is an example of what Dr. Scholastika Iipinge et al (2004) found in their study based on gender roles in relation to HIV infection in Namibia. They conducted many focus groups of men and women, and one of the most emergent themes that came up was that:

“…there is a large measure of mistrust that exists between women and men [Where] much of this stems from a communication gap that can perhaps be explained by the different worlds in which women and men are raised. A man’s world is one where he exerts his authority, which is not challenged ---- especially by a woman (Iipinge et al, 2004: 71)”.

This does not suggest that all males in SRC/TRC feel this way. However, it still is an area that could perhaps be rectified with more female participation as a means to bridge this communication gap. Based on this, we definitely recognized the importance of the HIV/AIDS awareness clubs that were present at most of the institutions, where both males and females play an active role. Although, we found it interesting that these clubs were mostly headed and attended by females. To explain this phenomenon, one of the representatives from an SRC mentioned that this was due to the fact that, “women talk better than men.” Is it that women talk better than men or is that with the feminization of HIV/AIDS, women have found a place to exercise their voices and be heard?

**Concluding Remarks**

“It must and should be recognised that a university is a complex organisation; that all systems of the University must be aligned with the mission and vision and the crucial issues of the day (such as HIV/AIDS); and that each element (each of us); as individuals, Departments/Faculties/Centres can be used as a strong lever for change in terms of tackling the HIV/AIDS pandemic. (Otaala, 2003: 40).”

This statement is reflective of what each of the institutions that we visited was attempting to accomplish through their HIV/AIDS initiatives and support services. In spite of the fact that students were not always aware of these services, when utilised they appeared to benefit students tremendously, as stated by some of the counsellors and nursing sisters. This demonstrates that more research is required in this area to examine exactly how these students benefit form these services as well as into the impact of HIV/AIDS initiatives on campus.
Despite some constraints that we came across in our study, it is encouraging to note that a great amount of HIV/AIDS related activity has been taking place at all of the institutions that we visited. One particular finding that supports this is that at one of the institutions a student came out about her HIV positive status. For the most part she has been well received by her fellow students, to the point where the HIV/AIDS awareness club at her institution donated most of their funds to assist with her cost of living, and she continues to give talks at their HIV/AIDS awareness events. This we believe is a promising sign that the stigma and discrimination associated with this disease can slowly become eradicated.

Recommendations

1. Senior Student Participation
   More emphasis on senior student participation in HIV/AIDS initiatives (e.g. Stepping Stones) should be implemented. This way students can be reminded of the services available to them that were originally introduced during 1st year orientation programs.

2. Professional Social Workers at Each Institution
   There is a need to have social workers and counselling services at each institution. We feel that it is necessary for each institution to have faculty that is trained to deal with HIV/AIDS related issues. While we found these to be existent, some of the tertiary institutions visited would still rely on heads of faculty to relay these services. This can eventually lead to overwork of these persons due to taking on several duties.

3. MAIN HIV/AIDS Society at Each Institution
   It may be more efficient to have an official HIV/AIDS society that works in conjunction with the head HIV/AIDS faculty. This society can consist of interested students and faculty members at each institution. However a drawback with these clubs is that the majority of students that participate in the club for one school year tend to not participate in the following year. This could be rectified by recognition from the student body for their activities and by having a developed structure for the club.

4. One Representative HIV/AIDS Club for All Institutions
   This was a suggestion made to us by one of the representatives of the SRC at IUM. It would be quite beneficial for all of the tertiary institutions to form a collaborative HIV/AIDS club. This formation can serve as a medium for students to share their ideas on HIV/AIDS initiatives as well as serve to create a more united front by all of the tertiary institutions.

5. Nursing Student Participation
   An interesting challenge as was suggested by one faculty informant would be for tertiary institutions that offer nursing to incorporate their nursing students more in HIV/AIDS initiatives, in particular with peer counselling services. Since these students will be future health practitioners, their training consists of several psycho-social support curricula, which are skills favourable to possess for peer counselling services.
6. Weekly Call-In Radio Show

Based on our high response with the UNAM call-in radio show, it seems practical to consider a weekly call-in show on HIV/AIDS, relationships, and health issues. A show of this kind will provide a useful outlet for youth to discuss and listen to HIV/AIDS related questions and concerns.

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website.1 : http://www.steppingstonesfeedback.org/
website.2: http://www.wce.edu.na/


Appendix A

Interview Questions for Counselors/Faculty

1. How is your institution incorporating HIV/AIDS in their curriculum?
2. What is your opinion about the effectiveness of your HIV/AIDS programs?
3. Do you offer VCT services?
4. If so, do you have any available statistics on the prevalence rates on your campus?
5. Does your institution offer psychological or counseling services?
6. Do a lot of students utilize these services?

Appendix B

Nursing Student Residence Interview Questions

1. What is your understanding of HIV/AIDS? What comes to your mind?
2. What does your institution do in regards to HIV/AIDS, what are the services that they provide?
3. Do you find that they are effective, do they work?
4. What are their campaigns like?
5. Do you think that people have too much information on HIV/AIDS already?
6. Do you think then that the information provided at your institution is useful?
7. Is your institution active in HIV/AIDS related issues?
8. If you didn’t know about HIV/AIDS or if you have a personal problem, does your institution provide counselling services for such matters?
9. If so, how then do they assist you?
10. Do you personally know where you would go on your campus for counselling services?
11. Do you have any suggestions that your institution can carry out for HIV/AIDS initiatives?
12. Do you have a problem with free condoms, would you use them?
13. If yes, then why don’t you trust them?
14. What do you think the attitudes on campus are of the students, are they sexually active in your opinion?
15. Exactly just how effective are condoms?
16. Do you know your HIV status? And if so, where would you go to determine your status? How many times do you get tested?
17. Do you think that there is a cure for HIV/AIDS?
18. Do you personally take part in any of the student group initiatives, dealing with HIV/AIDS?
19. If not, why don’t you take part?
20. Why do you think that other students don’t really take part?
21. Do you think that women are more likely to get tested for their HIV status over men?
22. Why do you think that students are so embarrassed to talk about sex and HIV/AIDS related issues?
23. Do you think it is safe to talk to a counsellor, do you trust that they will keep your confidentiality?
24. What do you think are the contributing factors towards HIV/AIDS among youth?
The Impact of HIV/AIDS on Nurses: Staff Shortage, Resignation and Burnout

By Jing Jing Liu (University of Toronto)
and Nashitye Ndjaleka (University of Namibia)

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In Namibia, the Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) prevalence rate extrapolated from sentinel surveys of Ante-Natal Clinics (ANC) is 18.2 – 24.7 %. The prevalence rate among nurses is comparable. Nurses are a well-educated subgroup on the issue of HIV/AIDS, yet equally vulnerable to the risk of infection. They are not immune to the same cultural practices, religious beliefs and misinformation that contribute to the susceptibility of the general population; neither are they impervious to the reproduction of stigma towards patients and each other. This paper seeks to assess and evaluate the knowledge, attitudes and perceptions of nurses about the impact of HIV/AIDS on their profession. We focused on two public hospitals in Windhoek, Namibia, and collected data using participant observation through volunteer work, survey analysis and in-depth interviews with nurses, government officials at the Ministry of Health and Social Services (MoHSS) and Non-Government Organizations (NGOs). We identified a shortage of nurses resulting from stagnant hiring practices and resignations as a consequence of government policies on resource allocation to programs such as Highly-Active Anti-Retroviral Treatment (HAART), Prevention of Mother-to-Child Transmission (PMTCT) and Voluntary Counselling and Testing (VCT) that divert funding and human capital away from primary health care. The shortage of nurses exacerbates an exhausted health care system, in which nurses perceive AIDS patients to require more physical attention and psychological care than non-HIV/AIDS patients. Increased workload due to staff shortage and fear of contracting HIV due to the intimate nature of their duties cause psycho-emotional stress and exhaustion leading to depersonalization and desensitization toward their patients. Stress impacts on both their work performance and their interpersonal relationships with patients, nursing students and colleagues. Nurses are under tremendous pressure and experience burnout, which further fuels the resignation crisis and contributes to the workload of remaining nurses. Implementation of counselling programs by the MoHSS appropriate to the concerns of nurses is necessary to prevent burnout. Currently, no counselling or support programs are available for nurses. In comparison, NGOs such as the Red Cross provide counsellors for their volunteers and their home-based care providers to deal with emotional and physical stress of caring for HIV/AIDS patients. Nurses are a vulnerable group that have been overlooked by public hospitals and NGOs. A collaboration of resources between NGOs and the MoHSS can fill a crucial niche of support for the mental and emotional well-being of nurses in Namibia.

This paper is an expansion of the preliminary research presented in a forum held at the University of Namibia (UNAM) on July 21st, 2005 to relevant stakeholders and interested parties involved in the Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) epidemic in Windhoek, Namibia. The collaborative research was conducted over a two month period from June to July of 2005 by Nashitye Ndjaleka, a 3rd year nursing student studying at the University of Namibia and Jing Jing Liu, a 3rd year Biochemistry and Anthropology student from the University of Toronto.
Introduction

In Sub-Saharan Africa, and countries worldwide, where HIV/AIDS have a stronghold on the population, with nearly a quarter of the population infected and many more affected, the appropriate response for each country is to provide sufficient health care for its people. Health care includes education for the young and old on risk reduction to prevent the contraction of HIV, the distribution of free Anti-Retroviral drugs for those at the early onset of HIV and home-based care for those near the end of the disease course. Operationally, nurses are at the forefront of meeting these challenges, implementing relevant programs and influencing their success. HIV/AIDS strikes adults in their economically productive prime (15-49 years) (Pendukeni, 2004), with prevalence rates of 37.3% in heavily affected Botswana (UNICEF, 2006) and 3.9% in relatively impervious Angola (UNICEF, 2006). Nurses are no exception as they also fall into the economically viable category and are susceptible to the disease. Malawi and Zambia both report 5-6 fold increases in illness and death in the healthcare sector (McCoy, 2003). Additionally, as HIV/AIDS rates soar, so does patient admittance and hospitals have surpassed their capacities such that expansion projects are too slow to respond and accommodate increased patient load. Overcrowding has its own consequences beyond limiting access to health care services - it increases overall workload for nurses and creates stress for nurses which diminishes their capacity for care-giving (Haoses, 2001).

In Namibia, current adult prevalence rate extracted from sentinel surveys conducted at Ante-natal clinics is 18.2 – 24.7% (UNAIDS, 2004), situating Namibia in the position of the 6th highest adult prevalence rate in the world (CIA Factbook, 2005). Thus, the country is likely to be highly sensitized to the adverse effects of HIV/AIDS on the health sector. A cross-cultural study conducted by Klewer et al. (2001) compared Namibia to two European countries on the perceived HIV transmission risks among health care students. Given similar levels of education and matching for age/gender variables, the perceived risk was much higher among Namibian students. They concluded that the higher HIV/AIDS prevalence rate in Namibia alone influenced the attitudes among nursing students and registered nurses working in the health sector. Complementary to their research, we were interested in investigating other areas in which HIV/AIDS impact nurses and nursing students in the hospital and clinic settings of Windhoek, Namibia. In addition to re-evaluating “increased perceived risk,” we sought to assess the knowledge, attitudes, and perceptions of registered and enrolled nurses and nursing students towards their profession in the context of the epidemic. It was also important for us to determine whether knowledge, attitudes and perceptions of nursing students differed from that of experienced nurses on the issues of HIV/AIDS transmission and patient care. Our findings went beyond the scope of the boundaries established by our objectives and elucidated many complex issues surrounding the impact.

7 The term “experienced nurses” is a relative term; when compared to nursing students, “experienced nurses” is any nurse that has worked for at least one year in the nursing profession. When “experienced nurses” are compared to younger nurses, this usually refers to nurses who have worked for over ten years. These divisions are purely for the sake of simplifying discussion.

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of HIV/AIDS in Windhoek. Due to time and travel constraints, we were unable to explore these questions outside of Windhoek; however, we speculate these issues are of concern to other cities, towns and villages in Namibia. Our focus limits us to the identification of a few stressors exacerbating the impact of HIV/AIDS epidemic on nurses and situates our research at the local level. However, these factors are deeply intertwined with greater global forces; Elaine Carrey in a Toronto Star article on October 28, 2005, gives an example of the poaching of medical professionals from Sub-Saharan Africa by Developed nations, such as the United Kingdom and United States of America which adds fuel to the shortage of nurses. At the end of our paper, we propose several recommendations we believe can alleviate some of the specific issues we have identified and addressed – however, it will require the synchronous acknowledgement of all problems to relieve and reverse the impact of HIV/AIDS on the nursing profession.

Methodology

We began our research by conducting informal interviews with Non-Government Organizations (NGOs) such as the Red Cross and the Ministry of Health and Social Services (MoHSS) to document the current impact of HIV/AIDS on the health sector and the subsequent policies and actions undertaken to lessen its repercussions. Semi-structured interviews were used to gain insight into the attitudes toward HIV/AIDS and patient care of nursing students and registered nurses at Katutura state hospital and nursing residence. Interviews with lecturers from the University of Namibia’s Faculty of Medicine and Health Science illuminated the nurse training curriculum and thus revealed the knowledge disseminated and absorbed by nursing students. Additionally, questionnaires were distributed to compare the different perspectives among nurses at the Sexually Transmitted Diseases (STD) clinic, ante-natal ward (ANC), and medical ward at a State Hospital and a Primary Care Clinic. This was both an efficient and necessary means of data collection from practicing nurses, since we were denied permission from hospital administration to directly interview the majority of nurses. The questionnaires also provided anonymity for nurses known to one of us (Nashitye), since results were collected in groups rather than individually and allowed greater coverage and data extraction from different wards. To directly observe nurse-client relationships, one of us (Jing Jing) volunteered at the street clinic every Friday for four weeks, from early morning to lunch which reflected the busiest times at the clinic. Finally, we administered surveys at the STD clinic and conducted focus group discussions with HIV positive individuals at Lironga Eparu to evaluate the quality of care received in the hospital wards and STD clinic as perceived by the clients themselves.

Findings

In Windhoek, Namibia, certain themes surrounding HIV/AIDS arose during the course of our study which we determined to have both direct and indirect effects on the health sector. Direct effects are defined as the immediate consequences of a high

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8 Lironga Eparu is a peer support organization for women and men living with HIV/AIDS in Namibia.
9 In Windhoek, Namibia, the term ‘client’ and ‘patient’ are used interchangeably, although ‘client’ was used more frequently at the Robert Mugabe Street Clinic and ‘patient’ was used more often in the hospitals.
prevalence rate in the country; while “indirect” effects refer to conditions that follow after the manifestations of direct effects. The direct impact of a high prevalence rate is the shortage of nurses due to government policies regarding resource allocation and resignations of nurses from the profession for a variety of reasons. The shortage of frontline care providers negatively impacts on the entire health care system, affecting quality of patient care and increasing work load for the remaining nurses. In addition, nurses are not exempt from being infected and affected by HIV/AIDS – they experience prevalence rates comparable to that of the general population since they too are included in the economically viable age group. Additionally, high rates may serve to propagate stereotypes and unfounded assumptions about the disease, thus contributing to the stigmatization of colleagues and patients.

Resource allocation contributes to staff shortages and resignations

One of the direct impacts of HIV/AIDS is the shortage of nurses due to government policies relating to resource allocation. Funding and human resources are diverted from primary health care to programs such as Highly-Active Anti-Retroviral Treatment (HAART), Prevention of Mother-to-Child Transmission (PMTCT) and Voluntary Counseling and Testing (VCT). This means that hiring for primary health care nurses is stagnant and pay increase are non-existent.

Additionally, the shortage of nurses is attributed to the increasing rate of resignations of nurses, whose positions are left vacant due to the above budgetary constraints. Resigning nurses in all ranks and years of experience cite job dissatisfaction due to low salaries, added workload and inability to provide adequate patient care as reasons for their resignations. Our questionnaires found other reasons for the attrition of nurses to include “leaving for greener pastures” such as the private sector or moving abroad, or in the best case scenario, upgrading or updating their training. Furthermore, some graduates of the nursing program at UNAM see nursing as a stepping stone to other careers because they do not enjoy the day to day realities of nursing and either quit completely or enter a non-practicing field, such as administrative work in the hospitals. “Not one week passes by that a person is not resigning” laments one elder sister.

Observations of over-crowded waiting rooms in the antenatal clinic and STD clinic suggest a high ratio of patients to nurses. Some nurses assert this ratio to average one nurse to forty patients. It appears that as more foreign aid pours into the country supporting various NGOs in their HIV/AIDS prevention and care efforts, the government may halt investment or pull out their weight in public health care funding. However, foreign aid does not complement salaries of nurses nor provide a voice in MoHSS hiring policies. One recent trend that has developed in response to low salaries involves nurses resigning and returning after collecting their pension to pay off their financial debts.

10 According to one UNAM lecturer, Namibian nurses are in high demand because of their double qualification in both general nursing and midwifery. They are being recruited by countries such as the USA and UK to supplement these countries’ health professional deficits.

11 “sister” is a term that is synonymous with “nurse”. This term is used in both Roman Catholic private hospitals and State operated public hospitals by both professionals and patients.

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Financial support for new programs targeting HIV/AIDS prevention and care is crucial, but what can not be overlooked is the pivotal role nurses play in the implementation of these programs and the consequences of their dissatisfaction due to low salaries and increased workload.

**Prevalence rate among nurses comparable to general population**

Another direct impact concerns nurses themselves becoming infected and affected by HIV/AIDS. They are not invulnerable to the same cultural practices, religious beliefs and misinformation that contribute to the susceptibility of the general population. Their own attitudes and beliefs are shaped by their upbringing and lifestyle and leave little room for the influences of recent HIV/AIDS education and training blitz. According to one UNAM professor, their prevalence rate is comparable to statistics provided for the general population. Their jobs include inherent risks; however, the actual incidence of job related cases of contracting HIV/AIDS from medical procedures such as placing an IV drip, blood transfusion or changing dirty linens is 1% (Klewer et al., 2001). Thus, the threat appears to be minimal; rather, the high prevalence rate implicates lifestyle choices and actions. Our informant from UNAM held certain cultural norms responsible because they support biases in power dynamics and inherent gender inequalities. In particular she used the example of nurses who marry widowed men whose wives have died of AIDS; these women know about what’s happening but don’t accept it or believe it. The professor alludes to economic dependencies as reasons to explain why these women turn a blind eye. Nurses are the most informed and well-educated subgroup in Namibia on HIV/AIDS, yet are an equally vulnerable group to the risk of infection. This begets the bigger question of the efficacy of the bevy of educational campaigns promoting safer sex and knowing one’s status – if nurses are resistant how does that reflect on retention of the education programs by the general population?13

**Stigma among nurses and nursing students**

The high HIV/AIDS prevalence rate contributing to infection is a concern in itself, but even more so, a high prevalence rate contributes to a mounting problem of absenteeism as nurses must take care of themselves and their families and attend funerals of their friends and families. This culminates in reduced productivity, loss of skilled nurses and high workload for remaining nurses, leading to increased resignation rates. Thus, they are propelled into the thick of the HIV/AIDS crisis and deeper into the discourses of HIV/AIDS, especially the discourse of stigmatization. Stigmatization through lenses of morality affect nurses’ attitudes toward their patients and may be problematic if reflected in the provision of care. A 1st year registered nurse told us that:

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12 In this particular example, she is explicitly referring to nurses from rural areas. It is our extrapolation that these anecdotes also resonate within the Windhoek nurses.

13 A study conducted in Canada and USA revealed 1st year female nursing students, who were highly knowledgeable about HIV transmission, nonetheless, engaged in high risk sexual activity (Zimmer, 1998). Thus the correlation between education and prevalence rate must be re-evaluated and re-articulated.

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HIV/AIDS is a highly moralistic disease. If it is contracted through blood transfusion, then one feels pity for that person. However, if they are “running around, having sex,” then that person is thought to have deserved it.

Moreover, in an environment with high rates of infection, observations by nurses of the stigmatization against HIV positive patients by other patients or medical personnel construct their own perception that they too will be stigmatized if they are positive. We were told stories by nurses about other nurses who believed they could contract HIV from sharing phones with an HIV-positive person, regardless of nurse or patient status. According to one MoHSS representative, nurses also fear stigmatization from their families and their colleagues due to the intimate nature of their work.

Often, families don’t want nurses to work with HIV patients. A husband will tell his wife not to be a nurse, rather, to stay at home and cook because he fears his wife will bring home HIV.

Their fear of stigmatization can have harmful consequences regarding nurses’ own personal health. One nurse failed to seek medical attention after pricking herself with a needle after administering an immunization injection for a patient. Culturally perpetuated stigma ultimately overrides knowledge and training as she explains to us that “she wasn’t concerned and didn’t feel she needed to be tested”. The fear of stigmatization becomes ingrained and appears neither remedied by their training nor reduced with additional educational campaigns.

To reiterate, the impact of HIV/AIDS is manifested both directly and indirectly in the health sector and unequally targets nurses to receive the breadth of the consequences. Subsequent to the direct consequences of staff shortages, increased rates of infection among nurses and reinforcement of stigma, is the indirect impact of HIV/AIDS, which place additional stress on both nurses and nursing students. Key stressors include fear of contracting the disease from patients due to the intimate nature of their duties, increased care provision for HIV positive patients and the experience of psycho-emotional stress that is multifaceted in origin. This stress may ultimately lead to occupationally induced burnout, “which is a type of response to chronic stress on the job...[that] can lead to lack of concentration and poor technique” that leads to demoralization and decreased quality of health care delivery (Haoses, 2001).

Nurses fear contracting HIV/AIDS from patients

One occupational hazard for nurses is the risk of contracting HIV/AIDS through medical procedures. However, the actual incidence of contracting HIV/AIDS from patients is only 1% (Klewer et al. 2001). We interviewed a UNAM lecturer who conducted research on this subject in 2001. She suggested that 98% of nurses she spoke with feared contracting the disease. Since then, she believes that the numbers have fallen and according to our own research, 10 of the 16 nurses we surveyed responded ‘yes’ to the question “do you fear contracting HIV from patients?” and provided examples of...
procedures as potential methods for accidental contraction of the virus, such as injections and episiotomies\(^{14}\). The same UNAM lecturer believes the frequent lack of self-protecting supplies such as gauze, gloves and masks available for the protection of nurses is a contributing factor to the fear. Nurses have echoed this sentiment:

“Not enough equipment for patient care”
“Always no stock items.”

These are legitimate concerns, however, illegitimate fears based on stigma and stereotypes also exist that play a role in unsubstantiated fear and concern. More likely, according to a MoHSS representative, nurses’ fears stem from the consequences of contracting HIV/AIDS shared by the general populace and amplified as a result of their daily confrontation and interaction with HIV/AIDS patients: stigma, long-term medication and leaving their loved ones behind.

Nurses believe HIV/AIDS patients require additional care

According to our questionnaires, the majority of nurses believe that clients who are HIV positive or have AIDS require more attention and/or care than other patients with conditions such as malaria. The type of attention or care ranges from more psychological support to increase monitoring of HIV women in labour who require Nevaripine\(^{15}\) treatment 2 hours prior to labour for effective PMTCT. More care was required because:

“HIV positive clients take a much longer period to accept their conditions.”
“They are most helpless and they must [get] more attention...physically and emotionally”
“They need [more] psychological support than other patients. They are more irritated [than] other patients.”

An interview with a 3\(^{rd}\) year nursing student revealed his belief that HIV-positive patients need psychological consideration beyond counselling, such as display of appropriate facial expressions by nurses. The patient should not see a difference or change in facial expressions whether nurses are treating patients positive for Tuberculosis (TB) or HIV. This attitude was reaffirmed by a head nurse in a referral clinic. He observed changes in the facial expressions of nurses when they read through a patient’s health passport\(^{16}\) and learn of the patient’s status. Often, additional care for just one HIV/AIDS patient can overwhelm nurses. One young nurse relayed his experience with an AIDS patient. He took care of a patient with constant diarrhoea and vomiting, but after a week, he would hide whenever he was called to avoid his duties with this patient. The increased care, whether perceived or necessary for treating HIV positive or AIDS patients includes a

\(^{14}\) Episiotomy is a surgical procedure performed during childbirth that enlarges the vagina to ease the delivery process (Wikipedia, 2006).

\(^{15}\) Nevaripine is a reverse-transcriptase inhibitor drug that is used for the treatment of infections with HIV. Nevaripine is used in conjunction with other anti-HIV drugs for HIV treatment.

\(^{16}\) In Namibia, clients/patients carry around their own health records, called health passports.

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spectrum of activities; ranging from changing “natural” facial reactions to increased care provision over a presumed norm, all of which require additional effort on the part of nurses.

Nurses experience work-related psycho-emotional stress

The most salient impact of HIV/AIDS on nurses in Windhoek is occupational burnout, resulting from “interpersonal natures, stress in the workplace, chronic emotional exhaustion, depersonalization and reduced sense of personal accomplishment” (Cordes and Dougherry 1993). The factors that lead to burnout resonate throughout the day-to-day activities of nurses and can infiltrate their psyche. For example, nurses perceive that they are entering a profession lacking solidarity. One young nurse commented on the absence of social cohesion among the staff in her hospital, admitting that her only friends are those from her graduating year at UNAM. The lack of social interaction among nurses adumbrates the depersonalized interactions with their patients. As previously mentioned, resignations leading to the shortage of nurses increase hospital duty, patient care and paper work for the remaining nurses. An overwhelming amount of work decreases job satisfaction as nurses feel guilty because they must rush through their tasks and thus, unable to provide adequate individual patient care. This result in patient’s relatives carrying out some of their work, such as: cleaning, feeding, and bathing. The responses we heard from nurses summarize their sentiments on this issue:

“You desire to give proper care to your clients, [but] due to more clients and less personnel [it is] not possible.”
“You want to finish your work but you cannot because sometimes the patients are [too] many.”
“Staff are not enough…patients are too many.”

Additionally, even though Namibia’s official language is English, the majority of the population speak Afrikaans and indigenous languages such as Oshiwambo, Otjiherero and Nama/Damara (CIA Factbook, 2005). Thus, the language barrier is an additional stressor that adds to the already mounting frustration experienced by nurses.

“More clients [speak] Oshiwambo and [one] nurse of that [language] have to handle more or all [of] those Oshiwambo client[s], it’s a lot for [one] nurse”

Staff shortages and overcrowding denies nurses time for the extra activities that allow them to connect with their patients. Instead, nurses only have time for technical procedures, such as giving injections and medications. According to one UNAM professor, nurses in Namibia are responsible for caring for HIV/AIDS on three levels: self, family and community. The overwhelming responsibility of nursing complemented by lack of psycho-emotional support systems create an environment of emotional exhaustion leading to depersonalization and desensitization towards their profession and the patients they serve. While volunteering at a referral clinic in central Windhoek, one of us (Jing Jing) was privy to the interaction between nurses and patients and observed
the manifestation of depersonalization and desensitization due to emotional stress and burnout. Below is a brief description of her experience:

There were three clients, five nurses and one medical student housed in the one room to which I was assigned. The clients in this room have had a brief encounter with the one doctor in the clinic and have already waited 3-4 hours to receive their treatment. I was in charge of writing down the treatment each client was receiving as indicated in the health passport carried by each client. In this one room, injections, wound-dressing and blood drawing were conducted simultaneously by different staff members. The clients were serviced with treatments in a fashion similar to an assembly line. A patient repeatedly asked if he was going to be “okay”, however, he received no response from the staff and I was not in a position of authority to reassure him. There was a complete emotional disconnect between nurses and patients – a severing of the patient and the procedure that was being performed on that patient. There was no time for words of reassurance when the treatment was painful and there was absolutely no privacy, given the presence of other clients in the room and with the door ajar.

In the same clinic, two weeks later, a nurse working in the room for birth control distribution did not have the “time” to explain the difference between the three available types of birth control pills and other methods of birth control, and their proper usages when asked by a client. The client was told that “they [the pills] were all the same” and was to “just pick one” out of the three kinds of birth control pills displayed on the table. Clients were also asked about their condom use and replies that did not satisfy the nurse such as “sometimes” and “always”, received disapproval from the nurse as she perceived their answers to be untrue. She verbalized her disbelief with hostility and disappointment. She encouraged condom use and reassured their effectiveness against protests and claims of regular use from the clients. However, due to the overcrowded waiting rooms, these encounters were brief (between 3-5 minutes) and could not adequately inform patients of the dangers of risky sexual behaviour. Nurses appear interested in reorienting themselves away from curative medicine to primary health care by focusing on education and prevention, but these practices require sufficient interactive time with patients. In a clinic with just over a dozen nurses, one doctor and one medical student serving hundreds of clients in one day, emotional distance is one strategy to combat emotional exhaustion so that staff can continue to perform their duties. This, combined with the severe time shortages, pressures nurses to choose curative over preventative measures.

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17 These birth control pills were purposely taken out of their boxes and the instructions discarded. I did not inquire about the purpose of this practice, but it seems the clients would benefit more from having the box and the instructions.
Interaction between nurses and nursing students as a source of stress

One UNAM lecturer has attributed the experience of psycho-emotional stress by nurses to the lack of competence and confidence. The consequences of such a deficiency are most apparent in the interaction between nurses and nursing students working in the hospitals to fulfill the practical requirements of their nursing degree. According to one older sister in the maternity ward, nursing students are not helpful to have around, since "more students means more workload" because she has to "follow up everything they do". Other nurses in the same ward commented that "1st years are a waste of time" and the "4th years are a little bit better off." Not all nurses share their sentiments, another nurse in the ANC ward viewed nursing students as a third hand because there was too much to handle alone. However it was better to work with older nurses, those who have worked for 20 years or more because she could "trust them". One complaint from nursing students received by a UNAM lecturer is that "nursing professionals are reluctant to teach nursing students." Nurses become defensive, rude or ignore students when they are asked questions in the hospitals. The nurses will tell students to "ask their lecturers.” An issue of confidence can explain nurses’ unwillingness to teach. One UNAM professor attributes this reluctance to nurses themselves having no knowledge of new techniques and thus unable to answer questions. She believes practical competence is intrinsically linked with confidence, requiring external and internal motivation. For example, external motivators include incentives (pay increase) and promotions and internal motivators include frequent ward rotations to challenge nurses. Nurses themselves complain of their work becoming routine and no longer stimulating; nurses call this “ward-stuck.” Switching to a new ward means receiving new and updated in-service training to foster skills and increase knowledge and thus, correspondingly, builds confidence in nurses.

The precarious relationship between nurses and nursing students is evident in the manner in which gung-ho nursing students are perceived, categorized and treated. Among nurses, these enthusiastic nursing students are referred to as “how long?” That is, how long will it take before they are demoralized. Thus, maintenance of cohesion between nursing students and nurses is absolutely necessary and requires regular interactions between UNAM lecturers and sisters and matrons in clinics and hospitals to discuss student training and update nurses on the current practical aspects of longstanding medical principles and theories. A nurse who heads the in-service training department confirms that in the past, UNAM lecturers made weekly visits to bridge the gap between principles and pragmatics - between what is taught and actually practiced – however, these crucial visits have ceased in the last few months since we spoke in July of 2005. It is difficult to empirically document how much information and human capital development has been lost due to weak or severed communication between teaching hospitals and the University.
Dealing with stress and burnout: two approaches by students at the nursing residence in Katutura

Nursing students appear to be under substantial pressure and also experience stresses similar to registered nurses. One nursing student commented that he observed both 1st and 2nd year nurses and nursing students to drink heavily, “once they [nurses] knock off work on Thursday, they will drink until their shift on Monday”. It should be noted that this shift break is regarded by Nashitye to be an exaggeration and/or non-existent, since there are too many days off in between working days. On the other hand, religion and faith appear to play a large part in dealing and coping with stress for other nursing students. There appears to be a clear dichotomy between the two mutually exclusive approaches in dealing with stress. These observations did not implicate gender differences, as both females and males are equally likely and susceptible to alcohol abuse. Perhaps religious devotion provided a means of catharsis for the stresses of work, similar to the use (and abuse) of alcohol.

Patient perception of the care they receive from nurses

It is also important to touch upon patient perception of the care they receive from nurses and their experiences with nursing students in hospitals and clinics. The information gathered from clients is limited compared to the data available for nurses and nursing students, but an overall picture can be articulated. In the majority of surveys conducted, nurses were described in a favourable light:

“[Nurses] are very fast and one doesn’t really wait long unless … you come late”

Nurses are seen as “helpful” with “fine attitudes” and clients described the service as “friendly” and “nice.” However, patients acknowledge overcrowding, requesting for more nurses, doctors and rooms. Some have had negative experiences, but they appear not to represent the consensus. Speaking with members of Lironga Eparu, all of whom are HIV positive, they too described their hospital stays as positive experiences. From the patients’ perspective, the nurses are doing a commendable job, despite the tremendous stress of overcrowding, fears of contraction, heavy workloads, depersonalization and emotional exhaustion. Indeed, nurses play a pivotal role as mediators between health care implementation and the people of Namibia.

Recommendations

Given these problems, we would like to make several recommendations. We acknowledge that some of these suggestions may be in a process of implementation by

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18 For insightful analysis on how religion plays a role in the lives of people infected and affected by HIV/AIDS, see Nadia O’Brien and Bonita Hileni Nakannyala’s internship “Questioning Faith in a Time of HIV/AIDS.”

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NGOs and/or MoHSS, but thus far, we have not bore witness to the manifestation of any concrete solutions.

Implement counselling programs for nurses

Currently, formal outlets are absent for nurses to discuss their worries and concerns regarding their job and the stresses they experience. Nurses and nursing students are a particularly vulnerable group that has been overlooked by NGOs and the hospitals in terms of support programs. Pastors often leave their phone numbers for patients in wards, but exclude nurses from their religious-based counselling. Psycho-emotional support in the form of individual or group counselling is necessary to prevent burnout. Nurses are not silent about their frustrations regarding their profession, however, providing a forum with representatives from the hospital administration and governance and MoHSS would amplify and legitimize their collective concerns. According to one administrative personnel at Katutura Hospital, an NGO called Childline/Lifeline Namibia\textsuperscript{19} was in the process of implementing a counselling program to support and counsel nurses. However, operational logistics, such as issues with confidentiality and the format of counselling (whether individual or group counselling) have prevented its deployment. However, we are encouraged because the Childline/Lifeline Namibia project has not been completely abandoned and will require the intra- and intersectoral collaboration and support of the NGO and the hospital to aid the project to conception.

There needs to be collaboration between NGOs and MoHSS

Volunteers trained in home-based care by NGOs such as the Red Cross and Catholic AIDS Action (CAA) would be an asset in hospitals to relieve some of the physical duties and emotional support for patients that often overwhelm nurses. There was a small initiative (five volunteers) sponsored by the Red Cross in place in the medical wards at Katutura hospital, but volunteers have been absent for several months. Yet their inherent benefit is still remembered fondly by busy nurses, months after the fact. The Red Cross and CAA implement and actualize many of the counseling and support programs for HIV/AIDS patients in Namibia, but no programs or initiatives are in place for counseling that is directly aimed at nurses. The Red Cross also provides counselors for their volunteers and home-based care providers to deal with the emotional stress of caring for HIV/AIDS patients. The medical staff can no doubt also benefit from this invaluable service. Ongoing networking between NGOs and MoHSS can fill a crucial niche of psycho-social support for the mental and emotional well-being of nurses.

\textsuperscript{19} Childline/Lifeline Namibia is an NGO based in Windhoek responsible for fielding calls from Namibians and providing crisis intervention and psychosocial support. The program is run by citizens who volunteer their time to address concerns over the phone on such issues as HIV/AIDS pre- and post-test counseling, outreach programs and education programs for children (USAIDS, 2005).

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Address the shortage of nurses in Namibia

The shortage of nurses in all hospitals and clinics act as a catalyst that directly increases workload, stress and burnout. High resignations due to low salary and job dissatisfaction need to be further explored, especially when new programs combating HIV/AIDS such as HAART, PMTCT and VCT require additional nurses for proper implementation. Another factor, such as the “brain drain” phenomenon is considered a threat to human resources in the future. The “brain drain” refers to the recruitment and solicitation of Namibian (and South African) nurses and doctors to the United Kingdom, Canada and the United States of America. Sub-Saharan health professionals are leaving the country due to better pay and work conditions. The Government of Namibia must prioritize health care when budgeting and allocating resources in order to sustain a healthy population and a healthy subpopulation of nurses that care for the country.

In-service training programs need to be expanded and standardized

Currently, every ward receives ward-specific training to update nurses on new knowledge and practices, including HIV training. According to the MoHSS representative, PMTCT training is restricted to antenatal wards, HAART training is given to all nurses and VCT is limited to specific nurses involved with counseling. Nurses have voiced complaints regarding training that target specific groups of nurses and believe all nurses should be trained in the three fields of HIV/AIDS expertise. This practice of ward-specific training creates a lag in information in other wards and an imbalance of knowledge among nurses. Every ward should be updated in all new techniques, services and information on health care to ensure a more knowledgeable and holistic approach to patient care.

Strengthen relationships between UNAM and hospitals

One often overlooked aspect is the relationship between UNAM lecturers and students and hospital’s matrons and sisters. Nashi, a nursing student, notes that a stronger cohesion is necessary to bridge the gap between what is taught in the classroom and what is practiced in clinical settings. We suggest greater dialogue and feedback between the two institutions. However, we acknowledge increased workload may not accommodate relationship building and strengthening, thus it seems the relationship between UNAM and hospitals is one that needs to be prioritized by both institutions before it can be properly addressed.

Conclusion

This paper has sought to document the experiences of nurses at the intersection of MoHSS funding policies and NGO operational practices, and set against the many discourses on HIV/AIDS prevalent in the family, institutions and society. What this paper has indeed accomplished is to raise many more issues on the topic of nurses’ stress and burnout that warrant further investigation beyond the time limit of our research period. What we have learned is that resource allocations in response to the AIDS
epidemic in Namibia often fail to account for the daily experiences of nurses. This is not to suggest that government actions have been purposeful in ignoring nurses in their policy; rather, they were forgetful if not negligent. However, we cannot hold institutions solely responsible for the crisis in primary health care; nurses too are becoming infected and affected at rates comparable to the general population. We have hypothesized that the same contributors to infection among the general population also apply to nurses. This leads to the attrition of working nurses who can contribute to patient care. Additionally, the issue of stigma is still a force that pervades education and training, as nurses stigmatize patients and each other. This leads to the breakdown in the cohesive forces maintaining the social networks of hospital personnel. These issues are nonetheless complicated by nurses’ own fears of contracting HIV from their patients, an anxiety rooted more tightly in the stigma surrounding the disease than angst based in facts and statistics. What exacerbates the issue is nurses’ perception of HIV/AIDS patients requiring more time and care than their other patients. This becomes problematic when nurses cannot accommodate care for all patients due to their heavy workloads. All of these factors build upon one another and result in the experience of psycho-emotional stress. So far, our discussion is inclusive of the experiences of both nursing students and practicing nurses; however, another source of frustration and stress is found in the interaction between nursing students and nurses. In particular, nurses are reluctant to teach the students. Students, overwhelmed by their intensive curriculum of both study and practicum, have opted to cope with their stresses either through the use (and abuse) of alcohol or their religious beliefs. The intersection at which nurses have found themselves is ambiguous at best, since no particular institutions or organizations are creating directions and solutions to any of these issues. In Namibia, the emphasis must be on public primary health care. It has a Gini coefficient, which is an indicator of the economic inequality within a nation, of 70.7, one of the highest in the world, with 0 representing perfect social equality (USAID, 2005). This means that without a strong foundation supporting primary health care, newly implemented programs will face hardships and likely suffer in the future.

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References


HIV/AIDS and Home-Based Care: Volunteer Experiences and Challenges

By Nidhee Jadeja (University of Toronto) and Eine Sirongo (University of Namibia)

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Executive Summary

With increased access to ARV therapy in Namibia, the quality of life of People Living with HIV/AIDS (PLWHA) is an issue of growing importance and significance. The purpose of this study was to determine the status of Home-Based Care (HBC) programs in Namibia, and to understand the experiences and challenges that HBC volunteers face. Semi-structured, open-ended interviews were conducted with HBC volunteers, staff of HBC organizations, and PLWHA at support group meetings. Findings indicate that there is a lack of support for HBC programs from the Namibian government and that more collaboration between the government and service providers is needed to develop a standard level of quality care to those in need. Furthermore, there are discrepancies in the assumptions made about care-giving among kin, and about the reality of the situation. Most traditional family structures have been eroded over the years, and poverty remains a serious barrier for families to adequately care for the sick. Finally, the main challenges identified by HBC volunteers were difficult clients and families, economic costs, and burnout. These findings contribute to the growing body of knowledge on HBC and suggest opportunities for improvement in Namibia and elsewhere.

Introduction

With the introduction of ARV therapies and increased knowledge of the benefits of positive living, HIV+ patients in Namibia have had to go from preparing to die to preparing to live. Home Based Care (HBC) was initiated as a response to this change. According to the Namibian Ministry of Health and Social Services (2001), HBC is specifically defined as any form of care given to sick people in their homes. It can mean the practices people might do to take care of themselves or the care given to them by family, volunteers, members of NGOs/FBOs, or by health care workers. The care is aimed at meeting their physical, psychosocial and spiritual needs, and should ideally be supervised by existing support mechanisms in the community. HBC was also introduced to serve as a community response to hospitals that are discharging people earlier than necessary due to a lack of adequate facilities and resources brought on by the rise in HIV sero-prevalence and other health problems. HBC was introduced in Namibia under the assumptions that: (1) the family is the primary “caring unit” in society; (2) patients would probably prefer to die at home rather than in a hospital setting; and (3) that the home is increasingly the option of choice given the rising costs of hospitals and transportation (Olenja, 1999).

One of the purported benefits of HBC is that the community is mobilized through the process of care being controlled by the family and patients. HBC aims to enhance the coordination between families, communities, and district health facilities in the care of people living with AIDS, with the hopes that patients will stay motivated to take their ARV medications and live safely and positively. Indeed, it has been shown that clients who are more engaged with health care providers have reported greater adherence to
medication regimens (Bakken et al, 2000). Services of formalized Home Based Care programs usually include home visits to provide physical, medical, social, spiritual, counseling, and material support to the infected and affected people (MoHSS, 2001).

The problem in Namibia however, as in many African countries, is that HBC programs are primarily the initiatives of NGOs and FBOs. Organizations rely heavily on community volunteers to provide the HBC services, and it is these community members who serve as the key link for People Living With HIV and AIDS (PLWHA) to be able to access information, products and services.

Most research on HIV and AIDS in Africa focuses on issues of behavior and prevention, and little attention is paid to those who have already been affected by the epidemic. The role HBC volunteers play in providing information to PLWHA and assisting them in living positively, safely, and with dignity, cannot be undermined. Yet, few studies have been conducted to understand the experiences and constraints facing HBC volunteers and the effect this has on the quality of care received by patients.

Objectives

This study aims to contribute to the sparse body of knowledge on HBC in Namibia, particularly in regards the experiences of HBC volunteers. It also hopes to understand the organizational and institutional framework of HBC in Namibia. To achieve these objectives, a number of questions have been asked:

(1) What is the status of HBC provision in Namibia? Subsequently, what is the role of the government and non-governmental organizations in the provision of HBC?
(2) Who is the caregiver?
(3) What are the experiences and constraints that HBC volunteers face and how does this affect the quality of care given? In turn, how do these experiences impact the life of the HBC volunteer?
(4) How do the HBC volunteers perceive the attitudes and expectations of their clients?

The data collected were analyzed thematically so as to identify and discuss recurrent issues or problems. The implications of these findings for the future provision of HBC are then discussed.

Methodology

Originally, we aimed to work with specific HBC volunteers and their clients to compare and contrast expectations, experiences and challenges. However, time constraints and issues of confidentiality did not permit us to enter the homes of most clients. Consequently, for six weeks, we collected data in the Khomas Region through semi-structured, open-ended interviews with HBC volunteers, staff of HBC organizations, and PLWHA at support group meetings.
The interview content was designed to cover topics relevant to the research aims. Nonetheless, the interview process also invited individuals to raise and discuss issues that they considered relevant. HBC volunteers were interviewed specifically regarding their experiences in caring for PLWHA. At the PLWHA support group meetings, individuals were encouraged to tell how their stories of HIV/AIDS had impacted their lives in order to understand the issues they face. The interviews with the key HBC organizations and service providers were held with individuals who could provide an outline of each organization’s purpose, activities, and impact. The aim of collecting this information was to gather firsthand knowledge and experiences from service providers about how they perceived the adequacy and relevance of HBC provision. The organizations represented in this process were the Anne-Marie HIV/AIDS Care Organization, Aids Care Trust, The Red Cross, Catholic AIDS Action, and the Tuyakula Group. In general, all organizations were welcoming in their attitudes and provided us with much assistance in setting up interviews for our research.

We also employed techniques of Participant Observation by attending a series of training workshops for HBC volunteers and their supervisors. Participant Observation was an important method because it allowed us to focus on the ways HBC volunteers were taught to deal with the anticipated challenges of their work.

Findings

Home-Based Care in Namibia

The government health facilities in Namibia have limited capacity to accommodate all sick people, especially chronic and terminally ill ones (Ipinge, 2001), and many hospitals are overcrowded, with patients sleeping on the floors. To ease this burden, the government called on communities and organizations to care for their loved ones at home. Yet the contribution of the Namibian authorities in the provision of services for PLWHA at home is disappointing. The extent to which the Ministry of Health and Social Services is involved with HBC is: (1) the production of a Home-Based Care Handbook to be used in the training of volunteers which they partially fund in collaboration with NGOs/FBOs; and (2) the provision of Home-Based Care Kits, containing simple medical supplies (i.e. gloves and bandages) and pain-killer medications for the volunteers to use. This very limited involvement of the Namibian government has resulted in low HBC coverage in Namibia.

Why has Namibia, like so many other African countries, been so complacent in supporting HBC programs? One possible answer can be found in the work of Richard Parker (2000) who argues that the reconceptualization of AIDS in recent years as a question of economic development has resulted in the interests of people living with HIV and AIDS in many African countries to be consistently placed at the bottom of national priorities. Stated crudely, he argues that the exceptionally expensive nature of caring and treating for people living with the disease forces governments to preference ‘cost-
effective’ responses to the epidemic: that is, to prioritize prevention over treatment. Of course, neglecting one over the other is naïve, since the behavior of those already affected directly correlates with the rate of new infections.

The government’s attitude towards PLWHA as economic burdens is best displayed in the MoHSS handbook on HBC in the section describing the benefits of HBC to all those involved (MoHSS, 2001). To the patient, HBC is supposed to permit him/her to receive care in a familiar environment with less stress, allow him/her to participate in the running of family matters, enhance one’s sense of belonging in the household, and allow for the acceptance of one’s condition. For the family, transportation and feeding costs at the hospital are reduced, there is increased acceptance of the infected person, and they would be able to simultaneously respond to their other responsibilities. Finally, to the health system, the benefits are a “reduced demand on the system, reduced potential requests for exemptions from payment for services, and reduced consultations to allow clinicians more time to provide care to others.” It is the second benefit in this latter category that is of particular interest because implicit in the wording of this statement is the portrayal of those who seek care and treatment as a nuisance, as people who enjoy opportunities to seek compensation and tap into government budgets.

In any case, NGOs and FBOs have stepped in on this aspect of HIV/AIDS neglected by the government authorities, and have undertaken the arduous task of administering all HBC programs in Namibia. We found that many HIV/AIDS organizations operating within the Khomas region listed themselves in HIV/AIDS service directories as having HBC programs. Upon further investigation, however, we discovered that most of these HBC services were non-existent at that moment for some reason or other. Other organizations defined ‘Home-Based Care’ in vague ways, and usually involved random distributions of food or clothing to families in need when supplies became available. There were a few organizations nonetheless who remained true to how they defined themselves and had HBC programs that operated in full force. Most programs varied as to whether they concentrated on home visiting, or had a broader approach involving preventive counseling and condom promotion as well as home care.

Catholic AIDS Action (CAA), a well-established FBO in Namibia, has one of the strongest running HBC programs. Established in 1998, CAA has over one thousand HBC volunteers under their umbrella, who each volunteer 4 – 6 hours per week in their own communities. Like most organizations, CAA recruits community members to volunteer to become Home-Based Caregivers. In order to cover the costs of transportation or other additional expenditures associated with serving the clients, each volunteer is offered a stipend of N$200 per month. Yet this has become a contentious issue as many organizations vary on the amount of stipend they can offer volunteers. Therefore, there is the likelihood that community members abandon their volunteer positions (and ultimately clients) at one organization for another by the lure of a higher-paying stipend. Furthermore, awareness among clients about differences in stipends is reflected in their preference to receive services from the larger, better-funded organizations because they imagine that the HBC volunteer would have more funds to spend on them. This has
fostered a sense of competition and animosity among organizations who are essentially trying to accomplish the same goals.

The concern that HBC organizations in Namibia do not work with each other was echoed by a number of NGO/FBO representatives interviewed. At most, HBC organizations interact with each other during training sessions organized by CAA and the MoHSS. However, these training sessions last a few days and are not even mandatory requirements for home-based care programs, therefore opportunities to network, collaborate, and learn from one another are limited. This lack of partnership and coordination often results in overlap in service provision, where two different HBC organizations could be visiting homes right next to each other, while another neighbourhood nearby would remain underserviced.

The fact that HBC services in Namibia rely on volunteers also indicates that there is a national attitude that trivializes the very act of care-giving. In other countries, caregiving is a profession rather than a past-time. Since most HBC volunteers in Namibia have full-time jobs and their own families to take care of, it is important to ask to what extent the quality of care towards the client is being compromised. Our respondents indicated that they each had anywhere from five to ten clients that they were responsible for, and given the time taken up by life’s activities in general, they usually did not interact with all their clients in any given week. Usually, they prioritized their interactions with clients based on who they felt “needed” it most, and dedicated the few hours they had to them.

In effect, the problems that have arisen with respect to HBC programs are related to the inertia on the part of the government to coordinate activities in the country. Ideally, the MoHSS would develop a standardized HBC system, where all volunteers from all organizations would undergo the same training, administer the same services, and receive the same stipend. Discrepancies in the quality of service offered between organizations would be addressed through monitoring and evaluation. The MoHSS is also the ideal candidate for organizing a comprehensive registration program, which would include referrals and follow-ups with clients discharged from hospitals. When we asked clients at a support group meeting about where they found out about HBC services, most of them replied that they were referred by volunteers, friends, and family. Only one individual out of a group of fourteen individuals reported that they had heard about HBC from the hospital. Furthermore, patient follow-up at home from hospitals is non-existent (Iipinge, 2001) and there is no data available on how much the demand for HBC is actually being met in Namibia. This demonstrates how inadequate the government’s interactions with community-based programs are, and how little they are concerned about the administration and effectiveness of HBC initiatives.

The last complaint we heard from representatives of HBC service providers was that foreign donor preferences dictated a lot of what they did, resulting in a lack of decision-making power. The Anne-Marie HIV/AIDS Care Organization, for example, was founded by a woman named Wilhelmina Isaacs, who, after seeing her sister suffer
without any support or care until her death in 1989, decided to build the first hospice in Windhoek for those dying of AIDS. Bristol-Meyers Squibb decided to fund Wilhelmina’s organization, but only on the condition that instead of a hospice, they open a centre for orphans and vulnerable children. There is no doubt that this was a meaningful venture as well, but it simply ignored the capabilities of community members, who had identified a need in their own community to address their own issues with their own solutions.

The Caregiver

All the volunteers we interviewed were working full-time jobs in addition to their volunteering commitments. Based on this information, and by virtue of the fact that they adamantly stated it themselves, monetary gain was not a factor that determined why people choose to volunteer. Instead, the most common motivations given for deciding to volunteer are: (1) a desire to help others, and (2) feeling personally affected by HIV/AIDS either through professional exposure or death of a family member and other loved ones. Furthermore, all identified spirituality as a common driving force for volunteerism and an important aspect of their lives. One Catholic AIDS Action volunteer stated it explicitly: “I volunteer because this is what Jesus would do.” When asked about how religion plays a role in their interactions with the client, she said, “Caring for someone is preaching the gospel. If necessary, we will use words to motivate the client.” Spirituality and care are thus closely intertwined in the Namibian context. Christianity, being the dominant religion in Namibia, has an important role to play in the lives of PLWHA. Indeed, all the respondents we spoke with in the support group meeting described how they found strength and inspiration through spirituality, God, and the church. Yet churches in Namibia remain focused on prevention rather than positive living, a fact acknowledged by Reverend Philip Stryner of the Council of Churches of Namibia. Catholic AIDS Action (CAA) and the Evangelical Lutheran Church AIDS Program (ELCAP) have some of the strongest HBC programs in Namibia but there are still issues of stigma in acknowledging the presence of HIV/AIDS within church communities.

Another common feature of the volunteers we interviewed was that they were all women. In many cultures, care-giving is typically a female responsibility. It seems that this practice has permeated into Namibian society as a whole so that women also bear the responsibility of care towards those who are totally unrelated. Thus care-giving operates within defined gender roles in Namibia. It would be interesting to find out what the gender ratio is of those who seek HBC services and at what stage of their illness they request assistance. One might predict that since women are the traditional care-givers within the family, they would probably be less likely to seek HBC assistance until the later stages of their disease, when there is no one to look after them and when they can avoid the stigma and shame associated HIV/AIDS no longer.

It is also important to examine whether the assumptions made by the government, organizations, and funding agencies about who the caregiver is, are valid. The family and household are often identified as having a crucial role to play in HIV and AIDS-related
care in developing countries (Singhanetra-Renard, 2001) but to what extent is this true in Namibia? We found through our interviews with volunteers that families often reject HBC because there is a high degree of denial at the community level, and people still perceive the hospital to be the best place where care is provided. Joyce Olenja (1999) offers a historical perspective on why this may be. In many communities, people with chronic or infectious illnesses were traditionally secluded and care was reduced to a bare minimum. In such cases, the patient was denied “sick role privileges.” On the other hand, western medicine introduced the institutionalization of health care, and any seriously ill person was removed from the home and only allowed to return once they had been deemed well by the respective institution. Thus, Olenja argues, to a large extent the family’s sense of responsibility for their sick kin has eroded over the years. To reverse this role in caring for kin with a complicated disease such as HIV/AIDS, then, would require a lot of adjustment.

There is no doubt that kin relationships are important in terms of mitigating the impact of HIV and AIDS. Indeed, it has been found that that family cohesion and communication were associated with fewer symptoms of distress and demoralization in HIV-infected mothers (Mellins et al., 1996). Yet, as Olenja (1999) points out, the family structure in Africa has undergone such tremendous transformations over the years, that many of the traditional features of cohesion and communication that were used as a cushion when dealing with dire situations, are slowly eroding or are virtually non-existent. Thus HBC in Namibia rests on the romantic assumption that the patient has someone to look after them at home. Our HBC volunteers indicated that this is not the case, and that far too often it is sheer poverty that prevents families from providing adequate home care, let alone their willingness or preparation to do so.

Volunteer Experiences

In examining the narratives of interviewees, we were able to identify three critical volunteer challenges: difficult clients and families, economic costs, and burnout.

Difficult Clients and Families

All our volunteer respondents maintained that the most difficult aspect of their experience was to deal with difficult clients and their families. One main concern was that clients and their families expected too much. Volunteers identified patients as being very demanding, usually associated with their feelings of victimization. At a training session for HBC volunteers, one participant described how women, more often than men, pitied themselves and believed it “inevitable to be subject to hardship.” Volunteers often complained about patients who would demand things from the HBC volunteer that the family would not normally be able to afford. “The community thinks we have a lot of money!” said Mary, a HBC volunteer with the Red Cross. Self-pity is not only a frustration for volunteers, but it is also an impediment for positive living, self-

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20 This symbol indicates that the name of the respondent has been changed to maintain confidentiality.

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empowerment, and the will to live for the clients him/herself. The most likely reason why clients and their families place high demands on HBC volunteers is because they are probably quite uninformed from the start about what the responsibilities of the HBC volunteer are and what they should expect from them. The HBC volunteer identified their ideal primary responsibilities to be training the family members to perform physical tasks correctly with the client (such as bathing, food preparation, and handling wounds), supporting the client to integrate back into the community, and finally to provide psychosocial support and serve as a resource for information. They did not see their role as being one that takes away from the obligations of the family. One volunteer was so embittered with families that demanded too much that she stated that the families that did this were the “types of clients who are not interested in empowering themselves; rather they are just interested in free help.”

Another difficulty in interacting with the family of the clients was families who disliked HBC visits to their household. This was most often associated with families who either denied their family members’ illness and refused their right to care, or wanted it to be kept a secret from others. Specifically, according to volunteers, this refusal of HBC services is the result of a fear of being stigmatized should the community discover that someone living in their house has HIV/AIDS. Mary described how when she went to one client’s home for the first time, a family member exclaimed to her loudly as if for the neighbours: “Who told you someone here is sick?!” and refused her entry. Another HBC volunteer Fiona, described how she and her support group of volunteers found that clients and their families were more welcoming when the HBC workers did not wear their CAA t-shirts to home visits. Families might also reject HBC because they see it as an insult to their capabilities to take care of a member of their own family, a responsibility that once traditionally fell within the realm of the roles and duties of kin. Of course, this is again the result of a lack of information and awareness about the specific duties of the HBC volunteer. Thus it is important for HBC organizations to be sensitive to social pressures and demands that clients and their families may be facing, and to work harder to promote awareness about the extent of their services.

As if gaining acceptance into households was not enough of a challenge, our respondents described other complications that could arise once a relationship had been established between the HBC volunteer and the client. Feelings of resentment, for instance, were identified as something that developed towards the HBC volunteer and the client, especially within families that struggled to make ends meet. For example, Petra described the situation where family members began to take food from the food parcels that were brought for a client. When confronted about this, they asked, “Why should he [the client] get to have all the fruits?” Dr. Iiping, in a personal interview, identified another phenomenon where some families stopped supporting the patient financially and emotionally after HBC support had started. Mary describes how one family disowned the client entirely, built her a shack and then left her there. She described working with these types of families too be quite problematic because “the family will then even blame you if the person dies under your care.” Thus juggling complex relationships with the family of the client can be quite a challenge for many HBC volunteers.
A fourth, and quite disturbing, concern that arose in our discussions with HBC volunteers about their experiences working with clients was dealing with “problem-clients” who engaged in risky behaviors given their HIV status. This usually occurred once the client’s health improved following ARV therapy. Volunteers described emotional frustration in dealing with these clients because they were no longer interested in keeping in touch with the HBC volunteer. The HBC volunteer felt powerless because they knew that person was engaging in risky behaviors and could be infecting others. A representative from one community-based organization describes how this is largely a problem of information:

“People need to know that there is no cure. They take their ARVs, start to feel healthier, and then think life is back to normal…these people take risks when they start feeling better. We know of people who have infected others. There was one man who infected his wife…she later committed suicide. There are some young girls who we work with who are from poor families and so they resort to prostitution. The problem is that there are these celebrity Americans who are the poster boys of positive living…but they just create a false illusion because they live in bubbles and are filthy rich. The people we deal with here will never have that.”

In other cases, HBC volunteers have found it emotionally difficult to deal with partners or other relations who put the client at further risk. The representatives describes one client of the organization whose husband beat her every time she told him to get tested or to use a condom. They found the situation quite difficult to approach, given his violent nature and feared for her own safety too at one point. Mary described one particularly frustrating situation with a client who stopped taking his ARVs and cut himself off from her when he started going to a church that preached miracle healing.

Economic Costs of Being a HBC Volunteer

One recurrent and unexpected challenge volunteers found themselves dealing with was the realization of how expensive it was to volunteer. They all expressed that the N$200 provided as a monthly stipend was barely enough to cover the expenses. In fact, they spent a great deal of their own money on transportation and cell phone costs. Furthermore, they often admitted to buying extra food or supplies for clients who were particularly in need. Food security is a major issue in discussions about the health of PLWHA because ARVs cannot be taken on an empty stomach. Ultimately, the issue of poverty is central to the success of HBC. When HBC volunteers visit a patient, and see that he/she cannot afford the nutritious fruits and vegetables he/she needs in order to stay healthy, they are ultimately faced with a moral dilemma. They often offer to stretch their own means in order to help the client.
Burnout

The issue of volunteer burnout is a major challenge in the provision of quality HBC. On top of the pressures placed on current volunteers as a result of the shortage of HBC recruits in Namibia, the job itself can be quite emotionally tolling. One volunteer reported that she was responsible for ten clients on top of having a full-time job and raising her own family. Yet respondents felt that too often, they found the situations of their clients so desperate that they often felt they had to sacrifice their own well-being to do something, anything they could for their clients.

We did not fully understand how emotionally stressful being an HBC volunteer could be until two HBC volunteers at Aids Care Trust took us to visit the home of one of their clients. Visiting her gave us a glimpse into the complex challenges many people living with HIV/AIDS in Namibia face, and how difficult it must be for the HBC volunteer to help the clients while trying to stay sane themselves. Here is a description of my experience:

Linda* lives in a small shack of pieces of metal and cement wall in an area of Katutura. She has been living with HIV for the last seven years and is on ARV therapy, along with her two sons and her nephew. She brought her nephew into her own home following the death of her sister and her husband in 2003 of AIDS. Her nephew is a shy boy who clings to his aunt when we come. She tells us that he does not go to school because her husband refuses to pay for his schooling. Instead, she points out, he prefers to spend his money on alcohol and forgets to take his medications. She says her nephew is ostracized among the neighbourhood children who refuse to talk or play with him. Just yesterday, the barber refused to cut his hair because he had heard the whole family had AIDS. Linda tells us that she must keep busy during the day otherwise she becomes depressed. Sometimes, she says, she’ll go and cry by herself in her room when she thinks about it too much. She fears what happened to her sister will happen to her, and then she worries about who will look after the children. Her only sources of support are the HBC volunteers and her friends at the support group meetings she attends. Through them, she says, she finds encouragement to be strong. The HBC volunteers sit with Linda, listen understandingly to a story they know too well, and play with the nephew. I am overcome with emotion through this experience and try to fight back tears while searching desperately for any words to say that would have meaning at that moment. There are none. As we leave, I feel sad, angry at the world, inspired, and powerless. How HBC volunteers deal with such stress on a regular basis amazes me, and I have the ultimate admiration and respect for their abilities.

According to Charles Garfield (1995:172) caring for PLWHA is, in many ways, a test of endurance. A large amount of strength is necessary not only to survive and fulfill the responsibilities, but also to undergo the realization of what one cannot do. Tony
Jungo, a CAA volunteer describes this issue in detail in a CAA Handbook for self-care for HBC volunteers (2001:38):

“One of the consistent factors in HBC is that we cannot control is the fact that there is an element of constant loss – the loss of a parent, child, health, income, or the ability to work, life, etc. As caregivers, we are in the presence of grief and grieving people daily. It is not something we can ignore because it affects us personally as well. Caregivers who want to avoid burnout must therefore address life and death issues in their own lives in order to be able to deal with their client’s grief. If we deny our own emotional needs, we will go into burnout. Dealing with issues around life and death is an integral part of taking care of yourself.”

Tony Jungo, Catholic AIDS Action

The term burnout is used to describe physical and emotional exhaustion (Garfield, 1995:174) and for caregivers working with people with AIDS, the process of psychic numbness is one way the mind attempts to deal with the stress of the job. Burnout is problematic because the caregiver may start demonstrate cynicism towards their client, or may start to be insensitive to their feelings and troubles.

Our respondents identified that their modes of coping with the stress of caregiving and avoiding burnout involved spirituality, setting personal limits, and support group meetings. All of the HBC volunteers we interviewed reported they derived a great amount of support from their belief in God. They discussed the importance of their faith in helping them cope with stress. Self-care and how to prevent burnout was a significant theme at the training session for HBC volunteers as well. One particularly interesting debate involved volunteers trying to determine whether it was okay or not to cry with a patient when he was describing his hardships. In the end, they established that maintaining some degree of emotional distance is important and that crying in front of the client was not a good idea because the client may have to end up counseling the volunteer! Support groups for HBC volunteers were identified as the most valued form of releasing stress, avoiding burnout, and coping with difficulties associated with caregiving. These support group meetings occur about once a month and volunteers from the same area convene to discuss their experiences and share suggestions and ideas. One volunteer stated that she had once missed a few support group meetings and noticed that she began to feel indifferent to the situations of her clients.

In order to provide the reader with the opportunity to better understand the HBC volunteer, we have included the narratives of two HBC volunteers below to conclude the discussion of our findings. We feel that these samples describe, contextualize and summarize all the issues presented above in an appropriate manner:

“The client will ask ask ask and even ask for your heart...”

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“I am a Real Estate Agent by profession. I decided to volunteer as a home-based care worker in 1999 after my brother passed away from AIDS. Clients mostly need me for counseling. I have six clients and it is a very enriching experience. In fact, I would say I prefer it over my dayjob! There are some clients who have no one to look after them. Then the problem of hygiene sometimes arises because there needs to be someone to help them bathe or to clean up vomit etc. Sometimes, they have no money to buy food. Some families used to think that home-based care means that the volunteers would come and do everything. But I think they hope this because they are just tired of looking after the sick person. This is why you must establish everything with the client before you start, or else, the client will ask ask ask and even ask for your heart. As the family can get tired of a patient, so can we! In this case, we will sometimes exchange clients among each other if we get sick of a particular one. Support groups are very important and helpful for us, as much as for the client. Otherwise, we can get cranky! When they clients are fine, nobody wants to see you! But they are adults, they have their choices. So I will just give them a phone call from time to time. I think that clients need spiritual support more than anything. Some people will leave the Catholic Church and go to the Universal Church or another one because they tell them about miracles and give them this type of hope…”

“…you bond like family…”

“My name is Londa* and I am a Registered Nurse. I was trained as a volunteer with Catholic AIDS Action and I have been volunteering since June 1999. As a nurse, I see how helpless people with AIDS are…they don’t know what to do. I thought I could use my skills to help these people. I have ten clients. But I work eight-to-five everyday and I am very busy. So I will give the weaker ones priority first. Most of my clients are not too needy and most of them are not bed-ridden, they are working people. But there are some clients who are just naughty by nature and these ones are lazy or they just want manna from heaven. Especially this one girl, but she is an adult. She stays in a decent shack-house. She was renting out one of her rooms to a man. One day I went for a visit and caught her in bed with this man. The other day the same thing happened again! I talked to her seriously about viral load and taking risks. But what more can one do? Some males sometimes will go at it as a form of revenge. I had another client who I offered a job doing housework for me. She never came! I gave her the opportunity to get money and then I realized that she was just someone who wanted free help. Another man one day one man had hurt himself while jumping over a fence and he called me and wanted me to drive him to the hospital in the middle of the day. At that point I realized that he just thought I was like a driver or something and that he just wanted to use me. But there are other types of clients too. There is this one man who is adamant about being on his own two feet and supporting his wife and child.
He is a pleasure to work with. I provide mostly moral and psychological support. Sometimes they get depressed and burst out into tears. Sometimes we get depressed too. In 2000 I lost four clients. At that point I felt like leaving this. I stayed at home for a month. Then I started feeling bad. You bond like family and then you feel that there is something missing from your life. I find the support group meetings helpful. We are five volunteers in a group and we meet once a month. We look forward to meeting one another and we also discuss our own personal problems. By the time we go home we feel relieved. Four of us on the team are personally affected by AIDS: 1 has lost a father, 2 lost a brother, 1 has a brother with HIV. But at the start of us meeting, only 1 of these people was positive…the rest happened since then. The government needs to do more but we as volunteers should mobilize ourselves too.”

Recommendations

(1) The Namibian government and the Ministry of Health and Social Services need to prioritize the care and treatment of people living with HIV/AIDS. They should display leadership in supporting, co-ordinating, standardizing, and monitoring Home-Based Care Programs.

(2) HBC Organizations, the government, and clients and families need to increase communication and collaboration with each other to network, share skills, prevent overlap, and maintain a common level of quality HBC.

(3) Foreign donor agencies need to provide HBC organizations on the ground with more autonomy in identifying their own community’s needs.

(4) More awareness about HBC services and programs needs to generated, and men need to be encouraged to be volunteers.

(5) Patients and families must be offered a choice between HBC, hospital care, or any other preferred type of care, and all should be accessible.

(6) The roles, responsibilities, and expectations of HBC volunteers must be clearly defined by organizations to clients and their families at the start of programs.

(7) Stipends offered to HBC volunteers must be increased to realistically cover the costs associated with the responsibilities.

(8) More initiatives to prevent burnout among volunteers should be prioritized, for example, assigning fewer clients per volunteer, thus allowing volunteers to have more time for themselves as well as support group meetings.

Conclusion

This study was undertaken as part of the University of Toronto-University of Namibia Joint HIV/AIDS Internship Program offered through the Department of Anthropology. Over the six weeks of the internship, we were able to gain experience in anthropological fieldwork and techniques while trying to understand the complex issues surrounding home-based care and the experiences of the volunteers. Our findings indicate that there needs to be much more support from the government for HBC programs and volunteers, and greater collaboration between all the groups involved. In trying to
understand the experiences of HBC volunteers, we found that they encounter three
critical volunteer challenges: difficult clients and families, economic costs, and
burnout. The limitations of this study were the limited geographical area, the small sample
of respondents, time constraints, and the inability to interview the clients of the HBC
volunteers we worked with. Obtaining information from the clients about their
experiences with the HBC services would have allowed us to understand how service
providers and their clients interact, and whether their perceptions of each other align. If
so, what sort of recommendations would clients have made for the improvement of HBC
services? Namibia has the opportunity to set an example for many other African countries
on how people who live with HIV/AIDS can be helped to lead decent, dignified, and
fulfilling lives. However, major changes will only occur when the needs of those who are
living with HIV/AIDS, who are often disadvantaged in many ways, are prioritized.
Rather than being creative in looking for solutions, the government has written off care-
giving as an economic burden, failing to recognize and respect its value for society.
Indeed, as Sir William Osler so eloquently advised: “The practice of care-giving is an art,
not a trade. It’s a calling, not a business: a calling in which your heart can be exercised
equally with your head.”

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Psychosocial Support to HIV/AIDS Affected and Infected Children:
“Love Boxes” and “Hero Books”

A study analyzing services available to children at the government level and through various NGOs in Windhoek, Namibia

By Ilona Kosova (University of Toronto) and Leevi Komeya* (University of Namibia)

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* This report is dedicated to the memory of Leevi Komeya, who passed away in May 2006.

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Executive Summary

In this paper, we explore our initial research interest in services available at the grassroots and national levels in Windhoek to children who are affected and infected by HIV/AIDS, and recommend how to further improve and strengthen the service delivery. In the course of our research, we felt compelled to inquire into psychosocial support methods. Psychosocial support helps children to overcome the trauma of losing parents or being abused, and thus, opens a window of hope for the children affected and infected by the HIV/AIDS pandemic. We critically analyze two prominent and controversial psychosocial techniques employed by Namibian organizations, namely “Love Boxes” and “Hero Books.” Both techniques tend to be viewed in opposition; we will outline the weaknesses and strengths of the differing techniques.

Introduction

According to UNICEF (United Nations Children’s Emergency Fund), by 2021 the Namibian orphan population will reach over 250,000, which means that every one in three children will be orphaned (The Namibian 2005: 2). With adults dying from AIDS, there is a growing generation of orphaned and other vulnerable children. In June 2002, the Second National Conference on Orphans and Vulnerable Children (SNCOVC: 54) adopted a definition of orphans and other vulnerable children as “children under the age of 18 whose mother, father or both parents or primary caregiver has died, and/or who is in need of care and protection.”

Literature offers examples where children whose parents died of AIDS are often subject to stigma and discrimination from family and community members. They face such problems as malnutrition, property loss, school drop out, lack of care, love and support, and become highly vulnerable to exploitation, abuse and HIV infection (Badcock-Walters 2002; Giese 2002; Guest 2003; Ghosh and Kalipeni 2004). In Africa, the number of child-headed households is increasing (Ankrah 1994; Giese 2002; Kelly 2003: 72-74). An advocacy officer at the Namibia Network of AIDS Service Organizations (NANASO) stated that children from child-headed households are not prepared for challenges to live alone and are “struggling to make a living.” Sadly, many children in Namibia are denied the joys of childhood. During the Catholic Aids Action workshop on “Home Based Care and Community Outreach,” which we attended, it was emphasized that the HIV pandemic threatens basic human rights of children to survival, development, protection, and participation, as defined by the 1989 United Nations Convention on the Rights of the Child.

It should be noted that both a pilot study (Haihambo et al 2004) and one of our organizational informants brought to our attention that children do not like being called orphans. Since the term “orphan” in Namibia is a social label which carries stigma, we refer where possible to all orphaned and other vulnerable children as simply children, or children who are affected and infected by HIV/AIDS.
Methodology

Fieldsite

To examine services which are available to children in need at the community level, we conducted open-ended interviews with representatives of NGOs directly or indirectly working with children: Catholic AIDS Action, Namibia Red Cross Society, Tuyakula Group, Family Hope Sanctuary, Anna-Maria HIV/AIDS Caring Organization, Dolam’s Children Home, Khomas Women in Development, Pashukeni Kindergarten and Orphanage, Venancius Rukero AIDS Orphans and Vulnerable Children Foundation, and NANASO. These NGOs differ in the number of staff (volunteers and workers), source of funding, and programs they offer to affected and infected communities: kindergartens, soup kitchens, study sessions, income generating projects for HIV positive people, home-based care, support to HIV/AIDS affected and infected children, education and prevention of HIV/AIDS, and voluntary test and counselling.

Talking to a social worker and a legal educator from the Legal Assistance Centre (LAC) helped us understand the role that the government of Namibia plays in the assistance of children and their families.

Our methodology also involved participant observation. By playing games and helping children with their homework during study sessions, we were able to observe differences in children’s behaviour, their abilities to grasp new information and their activity level, and to connect these to services offered to children. We also interviewed children who did not receive psychosocial support. Every time before interviewing children, we received their’s and their caretakers’ permission. We conducted our research in Katutura, a former black township north of Windhoek, where most of our stakeholders are located.

Limitations

During our six weeks of research, we encountered certain challenges. One of these difficulties includes access to children who received psychosocial support in the form of “Love Boxes” and “Hero Books.” These two approaches are relatively new to Namibia. Some organizations began to include them in support programs only recently, and our research time did not coincide with the National Conference on OVCs in February 2005 where two children from each region of Namibia were introduced to “Hero Books.” Furthermore, due to the sensitivity of the subject, we did not get permission to visit counselling sessions for children who deal with the trauma of losing parents. For this reason, the results of our research are based primarily on formal and informal interviews with a social worker and NGO members trained in providing psychosocial support to children.

Language was a barrier for us on occasions when our informants did not speak English. To take notes, we had to rely on Leevi’s translations from Oshiwambo. No
matter how skilful a translation is, the intricate details on what is being said might be lost. In addition, more time would be helpful in getting to better know the children that we worked with, as they were shy when answering our questions. The questions that we asked the children were not of a sensitive nature since we lacked the psychosocial support training to deal with the potential emotional outbursts of children.

**Assistance Available to Children at the Government Level**

**Questioning Reliance on the “Family-Centered Care”**

The Namibian approach to taking care of children, who lost their parents, is not institutionalization but is traditionally community-based. Ms. Petronella Masabane, the Deputy Director of Social Welfare Services at SNCOVC, expressed the preference of the government of Namibia for “family-centered care,” since “institutionalization causes children to develop communication and behavioural problems, and makes reintegration into society and forming relationships difficult for them.” Phiri and Tolfree (2005) make a strong case in favour of the family-based support system and against institutional care, which they argue contributes to discrimination and stigma, lacks personal attention and affection, and impedes children from learning culturally appropriate roles of behaviour, and surviving outside the institution. Although these arguments are valid, and extended families ideally offer supportive environment for children who lost parents, relying solely on communities to take care of their youngsters often means overburden of families and individuals who are struggling to take care of their own children.

The exhausted grandparent-headed households constitute an example of the weakening family safety net, as aunts and uncles suffer from AIDS and thus become unavailable to support these children (Foster and Williamson 2000: S278-S280). In Namibia, over 61% of children who lost their parents live with their grandparents and 4% of children with their siblings (Monasch 2003). Even though 4% is not a high number, the rising numbers of child- and sibling-headed households indicate that the extended family network is not as strong as it used to be (Foster et al 1997; Kelly 2003: 72-74; Ghosh and Kalipeni 2004). There is a danger for children to fall through the overburdened safety net of the grandparent-headed households and end up living in child-headed households, on streets, or themselves working to survive (Foster and Williamson 2000: S278-S280). In other words, the extended family networks do not always offer the social and economic security for children. It is important to consider other options for the care-taking of youngsters in the context of HIV/AIDS.

**Observations and Discussion**

In our research, we came across remarkable orphanages that made us question the reliance of the government of Namibia on the “family-centered care.” We feel that it is important to acknowledge successful examples of orphanages as an alternative care method for children and understand reasons of such success. We volunteered at the Dolam Children’s Home (DCH), where orphaned children find sanctuary, guidance, and
material assistance. Karen, a retired teacher from Germany, and Maria, a house mother, are the primary caretakers of the children. Our duties at DCH involved helping the children with their reading and their homework. The Dolam children are bright, energetic and well-mannered. In contrast with children from other NGOs, the Dolam children amazed us with their mathematical and reading skills, their awareness of HIV/AIDS prevention, and their language skills (they speak their home languages, English, and Afrikaans). We believe that care and support services available to children at this NGO correlate closely with their ability and their will to learn.

Although arguments are often made against institutions as an appropriate way to raise children, we witnessed the amount of positive energy at the Dolam Children’s Home. There, siblings can live together, the children feel safe and loved, and they learn to make meaningful relationships with other children and with the adults that take care of them. “I like the way we live here,” Tuamanguluka, an 8 year old boy living in the house, told us. It is important to ask children their opinions on their living circumstances for it gives them a voice and it helps researchers to understand how they feel.

Ideally, extended families provide children with a sense of belonging and a caring environment to grow up in. However, Pillay (2003: 111) illustrates the mistreatment that children experience from living in extended families and from their neighbours, such as being stigmatized and having to wake up early in the morning to do household chores, thus not having time for school. During our visits to a family caring for their own children and an orphaned child and living in an impoverished area of Katutura, we observed differences in the way the children were dressed. Every time we came, an adopted girl was always in the same clothing which appeared dirty and old, while family children were wearing clean clothing in good condition. In addition, the orphaned child showed clear signs of malnutrition. These observations indicate that extended families do not always fulfill expectations of perfect caretakers, since the poverty that they are subjected to makes affected and infected children even more vulnerable than they already are to diseases and mistreatment.

DCH offers a completely different picture. The Dolam children have a caring house mother, stable meals, and go to school every day. Twice a month, to remember their family roots, children visit their extended relatives living in Windhoek. Karen noted, “We don’t want them [children] to lose their roots.” However, sometimes after coming back from a weekend visit children start swearing and fighting with each other. Karen and Maria explained that living in a family, where verbal and physical abuse is common, teaches children this kind of behaviour. Some children do not like talking about their weekend experiences and refuse to visit their extended families the next time around. In other words, families and communities that often struggle to take care of their own children may not be the best option to the orphan situation.

The important factor responsible for the success of the DCH in comparison to the system of the extended family is that the former has a stable funding from private

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Here and after, to protect children’s privacy, their names have been changed.

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German donors, while the latter often struggles to make ends meet. However, reliance on foreign funding is not a solution for poverty alleviation. Instead, there needs to be the empowerment of Namibian communities. Phiri and Tolfree (2005: 16-25) agree that families and communities should be strengthened to avoid reliance on institutions for the support of children affected and infected by HIV/AIDS. Before throwing children into the hands of their grandmothers and aunts, the government of Namibia should first ensure that its communities and extended families are equipped for the care of children affected and infected by the pandemic. This can be done through developing grassroots initiatives such as vegetable gardens, soup-kitchen projects, community schools, and jewellery, clothing, and craft artisans. Mobilizing and developing communities would also avoid dependency on the social welfare system.

One of the researchers (Ilona Kosova) believes that the problem with children being unable to fully integrate into society, is not with institutionalization per se, as the government sees it, but is with the providing of the necessary care and support for them. If children continue to live in their communities with extended families that do not have the means and sometimes even the will to raise them, then the question is whether these children will become productive members of the society, which is the issue that Ms. Petronella Masabane of the SNCOCV raises when she argues against orphanages as an appropriate way to raise children. This is not to say that I would like to see orphanages all over Namibia. What I advocate for is creating supportive, caring, and stable environments for children to grow up in. Since communities and individual families suffer from poverty, violence and abuse, orphanages with financial stability and staff committed to helping children offer an alternative route for children affected by the AIDS pandemic. The government, instead of assigning responsibilities of raising children to extended families, should be focusing on the development and the empowerment of local communities.

Social Assistance


Those families that take in children whose parents passed away are eligible for the Maintenance and Foster Grants. However, as our key informant, a social worker whom we were very fortunate to know because of her outgoing nature and willingness to help, pointed out, “Information about available grants is not disseminated [to the people].” She added that many elderly people do not know anything about their rights to pensions. In other words, if the caretakers of children are unaware of social assistance for themselves, then they are highly unlikely to be aware of the same for the children in their care. The UNICEF report in 1998 (http://www.caa.org.na/orphan.htm) showed that only 12% of surveyed orphan households receive any type of government assistance. In our
informant’s experience, 80-90% of applicants do get grants; therefore the explanation for the low number of recipients of social assistance would be that the majority of the people are not informed about their rights.

Namibia faces an extreme shortage of social workers. “A social worker visited us only once and we are waiting for that social worker to come back ever since,” noted one of our stakeholders. Our social worker informant complained of being overwhelmed as she has to handle 8-10 cases at a time. The increase of social workers would not only ease the workload and the stress experienced by social workers, but it would assure that more children and families are reached with crucial information and the social assistance that they require.

Identifying Vulnerable Children

To get a perspective on how law defends the rights of children affected and infected by HIV/AIDS we contacted a legal educator from the AIDS Law Unit: Legal Assistance Centre (LAC). LAC is a NGO that has close ties with other NGOs, CBOs and FBOs, and advocates for people living with and affected by HIV/AIDS. “There are certain areas that law has seriously overlooked,” referred our informant to the official definition of vulnerable children. When a child is exposed on a daily basis to verbal and physical abuse, hunger, alcoholism and lack of parental guidance, a child is vulnerable in practice, but not in theory because parents of this child are alive. That is where LAC steps in and defends the rights and needs of children, who are affected and infected by the pandemic, for social assistance, foster care and education. The lack of social workers exacerbates the problem of identifying vulnerable children. With the level of poverty in some areas of Katutura, where most families live in small aluminium huts, have poor infrastructure, and limited access to drinking water, almost every child should be defined as vulnerable.

The official definition of the vulnerable child is a child up to 18 years old without a primary caregiver or is younger than 21 years old and is still in school, and excludes children in the age category of 18-21 years old who do not attend school. A social worker told us that they try to put these children in school, but often they “cannot cope with school” due to the age difference with their classmates and usually drop out. “We will try to put them into Life Changing Sessions,” where children learn skills such as car washing, she explained, but often “we just let them slide, or they slide.” Disturbingly, children who are vulnerable become even more vulnerable to poverty and everything that it entails when they do not fit the official definition of vulnerable children.

Access to Primary and Secondary Education

The Namibian law protects the rights of orphaned and other vulnerable children to free primary education. However, many of them do not attend school because of hidden costs such as teacher-parent fees, and fees for uniforms, books, and stationary supplies. In Namibia, as in any other African country, fewer children without parents than those with
parents attend schools (UNICEF 2004: 5). Secondary education is not free, and many of those who reach high school and cannot pay for school fees drop out or risk their health by staying. One of our informants told us that to pay for his high school and exams he had no choice but to engage into commercial sex with men. That is how he believes he contracted the HIV infection. In other words, children whose families cannot afford to pay for school get punished for their poverty by being denied one of their basic human rights, a right to education. Lack of access to education increases poverty, powerlessness, and the HIV infection rates among the growing generation of children affected and infected by HIV/AIDS.

The opportunity to attend school brings stability, hope, and confidence to children who forget their daily worries while in a class (Kelly 2005: 71). Donovan (71) explains the positive role that school has in the lives of children, “School restores structure to young lives; it provides a measure of stability in the midst of chaos; it trains the mind, rehabilitates the spirit, and offers critical, life-sustaining hope to a child in the face of an otherwise uncertain future.” I could not agree more with this statement. If the government of Namibia is serious about growing generations of healthy and optimistic children, then all school fees and costs for primary and secondary education should be abolished. Kelly (2003:87) argues that making schools free to all children would avoid stigmatization of orphaned children “through privilege” to education. After all, education should not be a privilege, and children should not experience the loss of their parents to have access to a learning environment.

**Assistance Available to Children at the Grass Roots Level**

**Learning Experience: Study Sessions and School Readiness Program**

Even though by law children who have lost their parents are entitled to a free primary education, school administrations often expel them for not paying or do not grant these children exempt from school fees. Members of the Family Hope Sanctuary (FHS) advocate for children and their families by writing letters to school boards and referring them to the Ministry of Gender Equality and Child Welfare for social assistance. FHS’s outreach activities also include the School Readiness Program (SRP) where 30 children are registered and where we volunteered during our research. To re-enter the school curriculum, out of school children and youth get social and academic preparation by learning reading, writing and English skills. Students of the SRP receive snacks in the morning and lunch in the afternoon. Evan Wilson, Coordinator of the SRP at the time, told us that many children are out of school because their families migrated from rural areas and so the children were late in registering for the next school year, or their parents cannot afford to pay for their school fees. As well, many orphaned children are not in schools.

Evan articulated the main objective of the FHS as to “try to strengthen individuals and empower people.” This message we heard many times during our fieldwork. Indeed, when vulnerable members of society do not get equal access to resources, be it education...
or social assistance, they need the knowledge and skills to lobby for their human rights. Many NGOs that we volunteered with offer the people of Katatura such assistance.

The Anna-Maria HIV/AIDS Caring Organization (AMHACO) once a week offers study sessions where we volunteered by individually helping the children with reading, mathematics, and homework. Every week there was a group of, more or less, ten students 8 to 12 years old. They sometimes brought their younger siblings and neighbours along to play with while they studied. We were asked by the organization to keep students motivated to succeed by “encouraging them to become lawyers.” Indeed, children that we talked to expressed aspirations for higher education, as it is evident in a response of an 11-year-old Mariama: “I want to become a doctor. I want to help people.” The children also told us that they enjoy coming to study sessions. “I like help to get to other grade and I like to play games here,” answered a 12-year-old Naihura to our question of what she likes about the AMHACO. These wonderful examples of learning experiences available to children at the grass roots level illustrate hope, encouragement, and high expectations that community leaders instil in children. Indeed, creating a positive and supportive environment through organizing similar study centers where children can fulfill their potential should be the first priority of national and local leaders.

Food and Learning

Poverty is a daily reality of children affected and infected by the AIDS pandemic. Only twenty percent of parents at the Pashukeni Kindergarten and Orphanage (PKO) can afford to provide their children with lunch boxes, and, subsequently, eighty percent of children remain hungry during the day, since the kindergarten cannot afford to feed them. While volunteering for the kindergarten, we painfully observed how the Pashukeni children could not concentrate on playing their favourite games and on learning new ones. Poverty leads to hunger, and hunger to low energy level and malnourishment. To raise healthy children in times of HIV/AIDS pandemic, children should have access to a secure food supply, especially if they are infected.

If small NGOs like Pashukeni do not have funds to feed children, there are others like the Khomas Women in Development (KWID) that do provide enrolled children with meals and snacks. The differences in children’s learning performance at these two organizations were obvious. The KWID have three classes for children ages: 2-3, 4-5, and 6 years old. We sat a couple of times during the pre-primary class of 6-year-olds. Children were eager to participate in class activities and displayed a good concentration level. Comparing the performance of children during a learning process – new games at the PKO or in-class activities at the KWID – helped us to see a direct connection between the availability of food and the improved quality of the learning experiences of children.

“We Don’t Like Stigma Here”

A number of studies show that HIV/AIDS affected and infected children are stigmatized and discriminated against by their communities and relatives (Badcock-
Walters 2002: 98; Guest 2003: 133). The same can be said of Namibia. “We don’t like stigma here,” we were informed by one NGO worker. He said that if parents of healthy children knew that his organization takes care of HIV-positive children, they would not let their children go to his program. This would put the financial stability of the organization in jeopardy and undermine its ability to support HIV/AIDS infected and affected children on a charitable basis. Sadly enough, to protect the rights of HIV-infected children to care and support, this NGO is forced to perpetuate stigma by concealing information about children’s status. Talking about HIV/AIDS would challenge the view of the society that infected people are dangerous and should be kept apart. Going against societal “normality” in this case would mean risking the access of infected children to services essential for their development. To protect interests of infected children, NGO workers choose not to talk about HIV-positive children in their midst.

Are All Children Treated Equally?

Twice in the course of research one of us (Ilona Kosova) witnessed that not all children are treated equally. One organizational informant told Ilona that they do not separate parentless children from those with parents. Since parents give their children lunch boxes, and children without parents do not have any food to take out when everyone else eats, workers prepare sandwiches for them. However, I was very surprised to see that children still without lunch boxes were seated separately from the rest of the class in the corner of the room, while everyone else was already enjoying their food. The preparation of sandwiches began late, and the lunch-less children only finished eating when the rest were running around in the playground. In other words, often good intentions for equal treatment result into a visible separation between the children. Clearly, to promote equality among all children at this NGO, food preparation should be more organized so that all children eat at the same time.

The second instance occurred on a separate occasion in a different NGO that provides kindergarten services to a local community. A teacher was putting her baby to sleep when Alisa, a 3-year-old orphaned girl whom I was carrying on my hands, started yearning and whimpering. I decided to bring her to the room where children usually have their naps. The teacher put both children on the floor mat and covered only her baby with a blanket, while Alisa went to sleep uncovered. While asking the teacher the other day if she thought orphaned and other children are treated equally at this NGO, she replied positively. However, as this example shows, NGO workers give preferred treatment to their own children while children, who lost their parents, remain neglected and invisible.

Story-Telling and Sensitivity

One event in particular brought to our attention the importance of sensitivity when caring for children affected and infected by HIV/AIDS. During our visit to an organization where we hoped to volunteer, we witnessed how caretakers disregarded the emotional needs of children. The children displayed clear signs of distress when they
heard horrible stories of their past told to us – complete strangers -- in Oshiwambo, their home language. We felt that the caretakers used emotional and physical pain that the children experienced as an attraction for potential donors. I wonder how much my presence as a foreigner exacerbated the situation. Would caretakers tell insensitive stories to a different audience? When is it appropriate to tell stories?

**Psychosocial Support**

The realization of one of our (Ilona Kosova) privilege to grow up in a caring and loving family with both parents made her sensitive to the plight of children who lost one or more of their parents. That is how her interest in doing research on HIV/AIDS and children was born. As a preparation for research in Namibia, she read Emma Guest’s book “Children of AIDS: Africa’s Orphan Crisis,” which initially exposed her to “Memory Boxes” (2003:36). This form of psychosocial support to HIV-affected and infected children made her ask: How do children affected by this terrible pandemic cope with their trauma of losing parents and being abused, and how do NGOs deal with emotional suffering that orphaned children experience?

Psychosocial support becomes important when delivering services to HIV/AIDS affected and infected children. A number of researchers demonstrated that as a result of parental loss and stigma surrounding HIV/AIDS, children develop psychological distress, such as low self-esteem, anxiety, depression, anger, and confusion which lead to antisocial behaviour (Foster and Williamson 2000: S281-S282). While in Namibia, curiosity about psychosocial support led us to inquire of staff at various NGOs whether they implemented support programs. Luckily enough, three organizations whose representatives we interviewed delivered psychosocial support to children and their families in the form of “Hero Books” and “Memory Boxes”: Catholic Aids Action (CAA), Namibia Red Cross Society, and the Tuyakula Group. Talking to representatives from these NGOs was very inspiring and eye opening on the experiences that HIV/AIDS affected and infected children go through.

At the CAA, we were fortunate to talk to a very busy Director who had been trained in both psychosocial support techniques. During our interviews, we got to know this woman as someone who is very passionate about helping children, and is an inspiring person to talk to. Whenever she spoke of children, she did it with deep insights, love and kindness. She was the first person to emphasize to us that psychosocial support is essential when helping children to overcome the trauma of being abused or loosing parents. “We have to support children holistically,” she emphasized. The Holistic approach means helping children not only physically, but also emotionally. According to her, caregivers should adopt a “strong focus on emotional support to children affected by the loss” of their parents, and “Hero Books” offer such support. Talking to Geraldine brought to our attention the controversy around “Memory Boxes” and “Hero Books,” which I will be discussing below.
We also spoke to a representative at the Namibia Red Cross Society. This woman conducts support sessions across the country where she works with HIV-positive parents, and infected and affected children. She employs the psychosocial techniques of “Memory Books” and “Hero Books” to help her clients. She is a genuine person with a kind heart who is really involved in the work she does. Every time we spoke with her, she radiated passion, enjoyment and commitment in working with children. To help us understand the concept behind “Hero Books,” she made, from scratch, a “Hero Book” and told us stories about children’s empowerment through this psychosocial method.

A coordinator for a support group, in her calm and insightful manner explained to us “Memory Boxes” or as she prefers to call them – “Love Boxes.” Once a week, the Tuyakula Group has support group meetings for parents living with HIV/AIDS, one of which Leevi was able to attend. During these meetings, HIV-positive parents share their experiences, learn how to make “Love Boxes” and encourage each other to live positively.

“Memory/Love Boxes”

The first “Memory Boxes” were made in Uganda by HIV-positive parents (Guest 2003: 36). It was emphasized that these are “Love Boxes,” since they express parents’ love for children who might be too young to remember parents who passed away. HIV-positive parents, usually mothers, make these out of shoe boxes which they personalize by decorating them with paint, grass, feathers, flowers, and pictures from magazines. After their parents’ death, children tend to remember an image of a sick and bed-ridden parent. Thus, pictures of a healthy parent may have a significantly positive effect on a child’s memory.

“Love Boxes” have an important communication component to them. Parents place letters to their children in boxes that tell their children how much they love them, emphasizing that they did everything to stay alive. Furthermore, letters provide parents with the opportunity to deal with issues of blame surrounding the contraction of the virus. Pillay (2003: 108-116) explores the African tradition of storytelling in connection with “Memory Books,” which are a book version of “Love Boxes.” They argue that the communication between parents and children about death and dying, and the transmission of the virus are healing to both generations. Love letters also contain descriptions of the parents, their life story, the child’s family tree, and parents’ dreams for their children. In other words, “Love Boxes” serve as a source of inspiration, and even advice for children who need parental guidance in their decision making.

By creating “Love Boxes”, parents take care of their children even after death. “Love Boxes” usually contain important documents that ensure social security of orphaned children in the form of access to social assistance. For example, it is common to find wills, property ownership, birth certificates, and important numbers in the box. To avoid losing the originals of these documents, some parents leave inside the box the name of the person who was entrusted to keep them. In this way, creating “Love Boxes” can
have a therapeutic effect for parents by ensuring protection for their children after their death.

“Hero Books”

The idea behind “Hero Books” is to help children overcome the trauma of loosing parents or being abused. Jonathan Morgan from the 10 Million Memory Project (10MMP) created “Hero Books” as an empowerment tool for children in need (www.10mmp.org). The child is the hero who has to solve problems and face challenges. Children write stories of their lives and draw pictures in the books. During the support group meeting, counsellors give children a choice of sharing their experiences with each other. According to Skinner Cook et al (2003: 96), the “expression of grief” is a successful strategy to deal with emotional losses. One informant noted that children cry a lot when talking about what happened to them. Being able to cry and grieve openly has a soothing effect on a traumatized child. Sharing positive and negative experiences in a group where children go through similar troubles demonstrates to children that their troubles are not unique and that there are ways to overcome them. In other words, this method of psychosocial support brings closure to emotional stress and builds resiliency and confidence in children.

One informant noted that “Hero Books” “help children, so that they later help themselves.” Using this method, children do not forget the horrors of their past but learn to overcome them. The psychological closure of trauma helps children to see “the light at the end of the tunnel,” and assists them to “walk straight by taking off their shoulders a bag of rocks,” where “rocks” represent burdens and emotional problems of a child. In other words, “Hero Books” help kids to learn to survive and succeed even after being orphaned, or physically abused.

Controversy

There is a controversy surrounding the two methods of psychosocial support to HIV/AIDS affected and infected children. On the one hand, organizations that use “Hero Books” as the main technique helping children overcome the trauma of parental death refuse to implement “Love Boxes.” The common critique of “Love Boxes” is that it does not have any healing power for a child who has just lost a parent. It helps adults to deal with the issue of death more than it helps children in grief. As a member of one organization put it, “The [“love”] box is an empty object”; when it is handed to a child it means nothing, since it does not replace a parent.

On the other hand, those organizations that employ “Love Boxes” argue that one must first focus on parents and caregivers through support group meetings and “Love Boxes”, and afterwards on children through “Hero Books.” Although organizations that use “Love Boxes” do not fully reject “Hero Books,” they argue that “Hero Books” alone are of little use in instances where the home environment of children must be changed.
Children need a positive atmosphere to grow and develop in, which can only come through working with parents first.

Conclusions

It is important to remember that no matter how much agency and will to improve their own lives children have; poverty remains the underlying cause of sufferings and injustices that they experience in their daily lives. To truly improve the lives of children affected and infected by HIV/AIDS, there is a need for an approach that breaks the evil cycle of poverty by integrating community empowerment, psychosocial support, food security, and free education. Moreover, keeping as many HIV-positive parents alive as possible by providing them with life-prolonging antiretroviral drugs would prevent the numbers of orphaned children from escalating. For future research, it would be interesting to get children’s perspectives on psychosocial support. Looking at the role of the church in the lives of HIV/AIDS affected and infected children, strategies that the Faith Based Organizations and traditional healers have to alleviate stress that children experience would shed a new light on issues surrounding children and HIV/AIDS.

No matter how grey the current situation of children affected and infected by HIV/AIDS is, there is room for hope. During my stay in Namibia, I met wonderful and inspirational people who dedicate their lives to helping children, instil hope in children and show researchers like me that positive changes do come. Children orphaned and vulnerable due to the AIDS pandemic deserve a better present, a better future, and a happy childhood without worries about school fees and daily lunches.

Recommendations

1. More research is needed to compare the effects that “Hero Books” and “Memory Boxes” have on children, and assess whether integration of these two psychosocial techniques would be beneficial to children and would solve the tension between the two methodologies.
2. Improve networking between organizations. Conferences serve as a good opportunity for organizational representatives to come together and share their experiences, ideas, successes, and failures. It is important that networking continues after conferences as well.
3. Improve study group attendance and performance of children at NGO study sessions by increasing the interaction between students and teachers, which would also motivate children to succeed in their studies. Giving children the encouragement and placing on them high expectations for higher education should be continued.
4. Make food delivery to children at the NGO level stable and continuous. This would ensure that the children grow healthy and concentrate on learning.
5. To avoid stigma and discrimination orphaned and non-orphaned children should be treated equally.
6. The Dolam Children’s Home has a policy of not shouting at children as it brings back painful memories of the past, and children tend to shut out. We suggest every organization to follow the same policy; it works well, as may be seen from the children’s learning abilities and behaviour.

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References


# Questioning Faith in a Time of HIV/AIDS

By Nadia O’Brien (University of Toronto)  
and Bonita Hileni Nakannyala (University of Namibia)

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Executive Summary

Namibia’s HIV rate has reached 21.3%, making it one of the highest rates in the world. Namibia is also a religious society with 90% of the population adhering to Christian beliefs (World Fact Book). In addition, the largest AIDS organization in the country is a faith-based organization: Catholic AIDS Action (CAA). The Church plays a powerful role in Namibian Society. To ignore the role religion plays in the spread of HIV would be to disregard an essential part of Namibian life and would prevent proper understanding of the terrain in which AIDS spreads. Recognizing the importance of religion, coupled with the relatively few studies on the subject determined our research topic; the role of religion in the time of AIDS.

Introduction

Under the direction of Professor Richard B. Lee (University of Toronto) and Scholastika Iipinge (University of Namibia), Bonita Hileni Nakanyala and Nadia O’Brien conducted six weeks of Anthropological research in Windhoek and the surrounding township of Katutura in June and July of 2005. Our research looked at the intersection between faith and AIDS by exploring how Faith Based Organizations (FBOs) shape AIDS prevention and care programs. We also examined how faith can act as a motivator for staff and volunteers working in FBOs. An aspect of this project was to analyze how HIV positive people relate to religion and draw upon faith: is faith a source of strength or does it contribute to further social stigmatization?

Methodology

To approach this topic we contacted various FBOs in Windhoek and Katutura: the Evangelical Lutheran Church AIDS Program (ELCAP), the Protestant Unity Church, Scripture Union, the Young Women’s Christian Association (YWCA), the Council of Churches in Namibia (CCN), Greater Love Ministries, and Catholic AIDS Action (CAA). We also interviewed pastors and reverends, attended church services, and spoke with HIV positive people from Lironga Eparu (the National Organization for People Living with AIDS). Our research was based on anthropological methods; we gathered qualitative information through interviews and participant observation by attending church services and volunteering in FBOs.

In this paper we will use the term Church to refer to the religious community that is comprised of varied denominations, varied beliefs, and varied actors including Pastors, Reverends, volunteers and congregations. This simplification is not meant to generalize but rather an abbreviation for all the denominations and programs stated above. We also chose to use this term as a means to protect the confidentiality of the people interviewed who would be identifiable if we specified the particular denominations. We will also use the term faith to mean religious belief.
Findings

The Changing Role of the Church

AIDS has reached epidemic proportions in Namibia. This growing tragedy has been met with an increased response from international organizations, academics, and local groups involved in the efforts to stop the spread of this disease. In various interviews with staff, volunteers, and students in Namibia, a common response was echoed - one cannot remain complacent when so many are dying. This mounting community participation is also reflected in the various churches in Namibia and the FBOs involved with the community.

The role of the Church toward HIV/AIDS has shifted since the emergence of the disease. Initially, the Church condemned or ignored the spread of the virus, but slowly their views have started to change. The religious community realized that it could not remain complacent while members of their congregations were dying of AIDS. As one minister put it; “the people are the Church, and the head of the church is Jesus. If the people have AIDS, then the Church has AIDS, which means Jesus has AIDS”. Another minister commented that the Church had to at least attempt to stop the spread of HIV. He stated that; “the government has tried and failed, NGOs have tried and failed, now it’s our turn to try our hand at stopping the virus”. Others involved in Church community programs became involved with the efforts to stop the pandemic after they were personally affected. One youth leader became involved in an AIDS program after he buried his sixth cousin in less than one year. The Church now sees it as their responsibility to get involved in efforts to stop the spread of HIV and to help those who are affected.

In an effort to help Pastors cope with the new challenges AIDS presents to their work, Catholics AIDS Action published a booklet of useful information aimed at Christian clergy and religious leaders. The new position taken by CAA is an indication of the changing view of the Church towards HIV/AIDS. Of notable interest was the section on condom use, of which an excerpt follows:

It is a fact that properly used condoms during 100% of all penetrative sexual acts significantly reduce HIV transmission. It is important that religious denominations discuss all aspects of the role of condoms in HIV infection prevention and not become defensive over the issue.

Faith Based Programs

The Church, through faith-based organizations, has created various HIV/AIDS programs. These include home-based care, orphan support, and prevention education following the ABC model—Abstain, Be faithful, and Condomize. The main strength of these initiatives is that they are rooted within existing communities. Working within communities ensures that the organizations are familiar with the community’s needs that must be addressed. In a context where international aid is relied upon to fund AIDS

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projects, having programs that are created by local community groups strengthens the projects themselves. It also helps to ensure that projects are responding to the community’s most pressing needs, not those that an external organization has deemed important. Moreover, the Church’s influence provides a funding base for these organizations in the form of donations from local churches and sister churches abroad. The Lutheran AIDS program for example receives funding from Lutheran Churches in Germany. FBOs are also strengthened by the existing volunteer base and the sense of duty promoted by Christian ideals of helping those less fortunate.

FBO programs also focus on the community as a whole. There are programs designed to assist all vulnerable children not only AIDS orphans. They create after school programs, hot meal distribution, marriage enrichment workshops, and daycare facilities. FBOs strive to strengthen community, making it more resistant to AIDS. Throughout our research, it became apparent that AIDS does not happen in a vacuum, but rather it most severely affects the vulnerable groups of a society; such as the poor, the marginalized, women, and sexually-oriented minorities. If a community supports those in need, it may help those who are the most at risk for infection.

Daycare programs that welcome all children are a great way to help both children and parents. It allows parents, especially women, to work while at the same time providing youth with a place to go after school. In addition these programs ensure that children are given at least one meal a day and some educational support. A director of a faith based organization considers the daycare and after school programs, which are run out of her church, as some of the most successful. She bases this success on the popularity of the program and their ability to respond to the community’s particular needs. She also considers these programs as important since they provide a space where one can be educated about HIV/AIDS.

The status and importance of the church also gives these programs authority within Namibian communities. Due to this position of respect, the church can be a powerful tool for disseminating AIDS education. Illustrative of the power of the religious community in Namibia, a religious youth group leader described the contentious abortion law that was under review in 2001. He explained how religious leaders got together to protest that abortion remain illegal; “The Churches represent the community.” The powerful lobbying influence of the church succeeded in canceling the bill for the legalization of abortion.

In addition to their position of respect and power within Namibian society churches can also be used as a great medium for education. In rural areas, churches may be the only space where people gather as they are often the only community center. Churches also have the ability to speak to a large number of the population on a weekly basis. One minister stated: “You can reach hundreds on any given Sunday”.

However, with this great power and this great setting for spreading information on HIV/AIDS also comes great responsibility. The role of the church may provide it with an incredible opportunity to reach the Namibian population, but with this opportunity comes
the burden of disseminating correct information; information that will help, not hinder, the effort to stop the spread of AIDS.

Negotiating Sexual Morality

Prevention programs undertaken by FBOs operate according to the ABC model of education. Depending on the religious denomination, they vary in their emphasis of the ABCs, but all promote abstinence as the best solution for avoiding the HI virus. Some FBOs teach proper condom use but do not promote or distribute them. Others teach only abstinence or faithfulness within marriage. One organization, which did promote and distribute condoms, explained their rationale as follows: “the person who is not prepared to abstain will not be helped [by abstinence based education] we must teach all three [condom use, abstinence and faithfulness] so the person is helped.” Other faith-based organizations continue to view AIDS as a disease of morals. The comments of a minister of an FBO indicate this continuation. During an interview on the role of religion in Namibia he stated that: “AIDS is not just a health problem but a moral problem as well.”

Also reflective of the morality and negative connotations that AIDS holds in Namibia is a young woman’s comment during an informal conversation about how AIDS had personally affected her life. She discussed how her sister had passed away from AIDS a few years earlier. She commented that her sister: “was a good girl; I don’t know what when wrong”. This conversation struck me as incredibly sad, she perceived her sister as having been good in the past but she no longer though of her sister in this light, as if her dying of AIDS had permanently tainted her value.

AIDS continues to be seen as a moral disease in Namibia and this belief is supported by the promotion of ‘proper’ lifestyle choices and ‘desirable’ behaviour by FBOs. Promoting prevention programs in these terms is problematic. It categorizes ‘good’ and ‘bad’ behaviour and consequently places full responsibility on individuals to avoid infection. This responsibility is easily translated into blame for the infected person since it is believed that they made wrong lifestyle choices or that their ‘bad’ behavior resulted in their infection.

The following are some excerpts from an FBO publication used in youth HIV/AIDS education. This section specifically discussed the use of condoms and multiple partners.

We must help them to understand the consequences of sexual immorality. If they don’t listen and continue to have sex with several partners, it might be right to tell them to use condoms. Condoms, when properly used, give some protection against the spread of AIDS and other sexually transmitted diseases. Using a condom doesn’t make sex outside marriage look any different in the eyes of God, but it does slow down the spread of death and, in the end, it will give some protection to both the innocent and the guilty. [Emphasis mine]
The information in this publication is not value-free. Due to religious beliefs, condoms are not encouraged. What is disturbing is that the reliability of condoms is called into question: “Condoms, when used properly offer some protection.” This suggests that a condom will not always protect you from contracting the HI virus. A minister at a youth conference also questioned condoms’ effectiveness in 2004. The following quotation was published in a newspaper following the conference and was posted on the wall of an FBO that preached abstinence. The article quoted the minister as saying: “No sex before marriage must be practiced, it is not safe. Some people claim that sex is safe with a condom but who can tell me tonight how safe a condom is?” Condom use is already difficult to encourage due to unequal gender relations, cost, availability, and preference for skin-to-skin intercourse, let alone now with their reliability being wrongfully questioned.

Additionally, the other problem with the wording of the above-quoted publication is its moralization of AIDS, sex, and condoms. Terms like innocent and guilty suggest that HIV positive individuals are in some way guilty. This further stigmatizes individuals, which has dire consequences for treatment and testing. Talking about AIDS in these terms also adds to the shame associated with HIV which impedes educational efforts and open dialogue about a disease which affects too many in Namibia.

This questionable wording is also present in a true or false quiz meant to dispel myths about HIV transmission. One of the questions was: “You can be infected through sexual intercourse with a person who has slept with many partners”. The correct answer was stated as true. This quiz implies that sexual promiscuity cause AIDS, when in fact a single unprotected sexual experience with an infected partner can transmit the virus, and hundreds of sexual experiences with negative partners, or while using condoms for protection, will not lead to a positive status. This educational initiative is meant to reduce the rate of people contacting the AIDS virus but it actually makes the situation worse by making sex shameful. This shame directly translates into the stigmatization of the disease and those who are infected.

This is not to say that messages of abstinence are intrinsically harmful to AIDS prevention. During a conference named “God’s Answer to AIDS” a young man discussed the benefits of abstaining from sex. Though abstinence may not seem like a popular option, in a country where one out of four individuals are HIV positive, the amount of fear that must be involved in sexual intercourse may make this option more attractive to Namibian youth (UNAIDS). The young man during his speech stated that:

We have a concern for our survival- more than any other generation…[remaining abstinent] is a choice, there is temptation- but there is a choice...sex is good, God created it- but it is not vital, one can enjoy it but within boundaries, within the boundaries of marriage.

What this research indicates is that the importance of education campaigns is not necessarily the promotion of abstinence or the promotion of condom use but rather to
create an open and accurate discussion of all the options available for individuals to choose to protect themselves against this deadly virus.

Part of the challenge of safe sex education is that sex itself is seldom discussed; it is usually considered a taboo topic or one fraught with morality. In order to address this challenge, one faith-based organization has launched a program that holds regular discussions with youth on the topics of love and sex. These discussions are held during regular class time and mediated by a youth from their age group and neighborhood. We attended one session where the discussion surrounded the differences between love and lust. These efforts are vital to AIDS prevention since they allow people to talk frankly about a very sensitive topic. In a time of AIDS people need to feel comfortable talking about sex, accessing free condoms, talking to a health practitioner about potential STDs, or to their partner about fidelity and condom use. The view that open discussion about sex is needed was expressed in the CAA pastor’s handbook in reference to the North American response to the AIDS crisis in the 1980s. It stated: “Only when condom distribution was combined with education and discussion on relationships, intimacy, sexuality and substance abuse did the rate of transmission decrease.” Therefore, a vital stepping-stone to safe sex is a frank communication about sex itself.

**Socio-Economic Factors**

Prevention outlooks must consider how socio-economic forces influence sexual choices and limit an individual’s negotiating power. Prevention programs such as the ABC promotion campaign often overemphasize individual agency and ignore the structural and cultural forces of gender inequality and poverty. Women do not always have the power to make sexual decisions, especially within their home. A home-based care volunteer expressed that gender imbalance is the greatest impediment to the HIV struggle. She said: “Men must be the heroes of the home”. Wives are not able to demand condom use, even if they think their husbands are sleeping with other women. Financial needs are also ignored in the preaching of abstinence. Prostitution and Sugar Daddy relationships may be an individual’s only source of income. A program director made this statement, connecting economic need and health; “if you are poor you die early”.

To illustrate the struggles that many Namibians face, especially women, is a description of a walk that one of us (Nadia) took in one of the poorest neighborhoods of Katutura. Her guides were two home-based care volunteers from a local faith-based organization:

> I am invited into a woman’s home in an informal settlement on the outskirts of the township. The home has three rooms and is made from metal siding. The door is made out of a recycled car door while curtains divide the kitchen from the two bedrooms. In each bedroom three children sleep with their mothers. Individuals who live in this neighborhood do not have legal rights to the land; they have built their houses here because they cannot afford the rental fees or land fees in other areas. There are no washrooms in the homes so people use the riverbed. One of the volunteers comments that: “You have to do what you
need to do to survive.” People complain about the smell but their illegal status greatly diminishes their ability to demand assistance from the government. Due to their illegal status they also live under the constant possibility of eviction. The two women who are showing me their neighborhood have come here after escaping abusive relationships. They say that living here at least they can protect their children from the same abuse. They enjoy living in this community, but here life is hard. Each woman has two sons, both from different fathers. The two women joke around saying that men in general are bad news. Each receives no assistance from her children’s fathers and has to struggle to make enough money on her own. The children’s fathers claim that they do not know their children’s needs, but both mothers say that this is not a valid excuse. I ask her what her most pressing needs are. She mentions struggling to pay for school fees (NS$150 a year), for enough food, for water cards (NS$20 a month), or to pay for cooking fuel (NS$5 a month).

I ask how people make an income in this neighborhood. My guides take me for a walk around their neighborhood to show me the various economic transactions that take place. For example, the service of carrying water is NS$1, washing clothes is NS$20; selling fruit, meat and firewood is also common work and brings in a valued income. I am then taken to the local Shebeen (an informal drinking settlement). The building is the newest in the area; all the metal siding is new. “That the rich man in town” one woman says laughing. She describes that every night around six the place fills with people drinking and dancing. Young schoolgirls also come here to sell their bodies she adds. I ask her how much that would cost. She says that it isn’t like that, that sex is not always exchanged for money; sometimes it’s exchanged for beer.

At this point one of the women mentions that she would take me to the homes where she is a home-based care volunteer but that her patients all died within the last two weeks. I ask her where condoms are available. She says that one can buy a condom for NS$2.50 at the local Shebeen. Otherwise the nearest clinic that distributes condoms is a thirty-minute walk. She also mentions that the local FBO distributes condoms- though I have seen no sign of that in the past weeks. She adds that condom accessibility is not the biggest problem. Women’s lack of power in their relationships with men presents the biggest challenge. Her last patient, she says, was HIV positive and though her husband had been her only partner she refused to believe that he had infected her. It was easier for her to deny this probability then to confront her husband. “A women needs to be lower - smaller than her man…let’s say she has a grade one education and he has a grade ten education, she has to go down to that level.” “And if she doesn’t? I ask. “He will beat her”.

Efforts to stop the spread of AIDS must take these economic and gender inequalities into consideration. Preaching moral behavior to those who have few choices offer those involved in unequal sexual relationships with no solutions, and contributes to the reproduction of blame and social stigmatization surrounding HIV infection.
Strength and Motivation

Though the messages that are disseminated by FBOs can contribute to the social stigmatization of HIV/AIDS they can also be a source of strength and hope for those infected and affected by the disease. During interviews, infected individuals and those working in FBOs identified their churches and faiths as motivating factors in their lives. FBO volunteers and organizers expressed that their faith helped them cope with their difficult work. A program director added that as a Christian it is an obligation to help those in need. “Christianity teaches that it is not our role to judge. Judgment is God’s role, not ours…we must stop judging those who are infected.” A pastor during a religious service reminded his congregation of their religious responsibility:

There are 200,000 orphans in Namibia. That is scary. Though we would like to run away from the world we have a purpose. We have to be the light in the darkness. We must do this, not by praying but by being involved in our community. You are a shining light under a bucket.

A nursing professor at the University of Namibia, during a discussion of home-based care, emphasized the importance of spiritual and psychological healing in the treatment of HIV. Healing and wellbeing must include a spiritual component as well as ARV treatment and other medical interventions.

The importance of emotional and spiritual support is well illustrated by the account given by a Windhoek businessman. His cousin had been diagnosed with HIV and was gradually getting sicker. As his cousin’s health was failing, his roommates decided to send him back to the North where his family would be able to take better care of him during his final days. (This is a regular practice as many young men come to Windhoek for work and their family support systems remain in their villages.) Upon hearing of this arrangement, the ill cousin contacted the businessman and asked for assistance. After a few months of good food, rest, and emotional support the cousin’s health improved dramatically. He gained weight, was able to work again, and both men attributed his well being to the support and attention he was given.

The connection between mind and body seems to have an effect on the healing process. This testimonial supports the idea that physical treatment alone is not the best course of action, but that spiritual and emotional components must be considered as well. If this is true, than the role of faith and hope in helping HIV positive individuals cannot be ignored.

Talking to HIV positive individuals also indicated the importance of spirituality in their lives. In Namibia, living positively is increasingly being encouraged and practiced. This includes focusing on life not death, eating well, taking one’s medication, and practicing safe sex. The rollout of anti-retro viral therapy (ARV) in Katutura is also helping some individuals to live a healthier, longer life, despite their positive status. Gradually some individuals are braving social stigma and disclosing their status to their
community. One such individual has been a pioneer in dispelling myths about being HIV positive. She urges others to disclose their status and get tested. She also offers a message of hope to those who are positive. She spoke her message of inspiration at an event organized by a church group. “Children of God we have so much to offer. I know your pain but we must heal, pray, bless, and give back. There is so much we can do...more and more people are getting together. I will not die alone...the church is the house where we are all transformed give your problem to God and he will take it away.”

Individuals at Lironga Eparu (the national organization of people living with AIDS) discussed with us the struggles of living with AIDS. The organization encourages individuals to live positively and offers support systems such as group and individual counseling. The role of religion seemed to be a given in many of these women’s lives, and their relationship to their churches was generally a positive one even after they disclosed their status. One woman mentioned that she helps friends in their group counseling session to understand that their situation is “not a punishment from God”. Another women, when asked what she dreamt for her life, said that she wanted to be a pastor. She wanted others to learn from her mistakes. She also said that her church was a safe space for her, and that her pastor was aware of her HIV status. Their testimonies are an indication that spirituality can be a major component of living positively.

Religion is even used to encourage women’s empowerment. A faith-based women’s organization uses the story of Adam and Eve to illustrate equality between men and women. Our informant explained that God had dominion over all; not that men had dominion over women. In a context where women do not enjoy the same status as men and where religion plays a strong role in everyday life, it is interesting to note how the bible is interpreted and used as a tool to inspire women’s empowerment.

The role of religion in Namibia is complex, but in a milieu where many Namibians already adhere to Christian beliefs and where the church has a position of status, it is important to note all the benefits that religion offers in the fight against AIDS: from motivating workers; to inspiring individuals to live positively.

Faith is Not a Cure

Messages of inspiration however, must not contradict medical facts concerning HIV. A church in Katutura held workshops on the role of religion in the HIV struggle. The poster promoted the event in these terms; “God’s Answer to AIDS: Discover the 2000 Year Old Vaccine.” One guest speaker was invited to tell her story of HIV recovery. She believed that God reverted her HIV status from positive to negative and that faith in God could cure others. Her message was well received by the audience. The room was full of people, responding in ‘amen,’ standing, agreeing, nodding and praying while she explained the power of God to cure AIDS. She used scripture to support her argument; “he forgives all my inequities and heals all my diseases”. She also added “he heals all our diseases including HIV. God is my healer, Christ is my healer”.

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The audience’s enthusiastic response indicates how much people need faith, how much people need hope. The AIDS epidemic is affecting close to one in four Namibians, and a message of a cure from God may help appease the fear and desperation so many people face. In discussions with audience members we were told how people feel that they have been let down by the government and their health system. Others have begun to question why the authorities have been powerless to stop the spread of this deadly disease. The way society operates, in its marginalization of women and the poor, affects how AIDS is spread, but AIDS is also increasingly changing Namibian society.

Though this story of faith as a cure for AIDS can afford HIV positive people hope, it also holds intensely negative consequences for prevention programs. If one believes that there is a cure for AIDS then what impact will this have for safe sex education, ARV treatment, and for a person’s faith once they realize that God is not curing their disease? It must be clearly understood that faith is not a cure for AIDS!

Donor Priorities

Without fail, when I asked what challenges FBOs faced, procuring enough funding was always the greatest struggle. Various Namibian endeavors must clamor for grants from the same donors. Project proposals which request funding must then cater to the funding agencies’ policies and beliefs if they are going to receive any assistance. In an environment where faith based organizations must rely on external funding, it makes local policies and plans vulnerable to external priorities. This financial dependency results in international funding agencies and sister churches abroad determining what kinds of programs are carried out in Namibia. For example, decisions about condom distribution may not be determined by volunteers and program directors who are working on the ground, and therefore best aware of the needs of local populations, but by funding agencies who are influenced by international health trends, government policies, and removed morality.

Individuals within Policies

Though individuals work in agencies that are subject to institutional policies, it is important to note that individuals may bend the rules and act differently than policies may convey. A nurse described an experience when working the late shift at a religious-based hospital. A man came in and asked if the hospital distributed condoms. As a Catholic hospital, it was against hospital policy to distribute condoms. The man was desperate since he was on a date and none of the shops were open. The nurse gave the man a condom from her purse, understanding the urgency. She explained her actions by saying that it was a matter of life and death. A senior nurse who was also on duty was appalled at her behavior and reported her to her supervisor. Her supervisor did take time to meet with her about the incident but explained that her actions were not under hospital jurisdiction since she had given a condom that was her own private property. This is a great example of how individuals work within certain structures, but as individuals operating within the reality of HIV/AIDS and negotiate their own rules.
Namibia Divided

Views about religion’s role in the response to AIDS are diverse and passionate within Namibia. At the end of our research we presented our findings at the University of Namibia to an audience of AIDS workers, nursing students, academics and community members. Our findings generated varied responses—yet all respondents were zealous. One man stood up during the question period and refuted our claim that faith can be a source of strength for HIV positive individuals. “I will never believe that!” As an orphan and a street youth he had lived with a Pastor for 10 years. When he disclosed his status to his Pastor and long-term guardian, he was kicked out of the home. He added that Pastors gossiped about peoples’ HIV status in Namibia. A woman in the audience took a radically different standpoint; she objected to our claim that God cannot cure AIDS. She was insulted that we dared question the power of God. “How can you say faith is not a cure for AIDS? Miracles do happen! Everyone believes in God.”

It is clear that these religious institutions and their programs are powerful within Namibian society and their role in HIV/AIDS contentious. Whether individuals find that religion is oppressive or they find strength in religion, what is important is that a dialogue has been created. This debate gives Namibians an opportunity to support faith-based organizations, change faith-based organizations, or choose other avenues such as non-governmental organizations and government programs to help address this epidemic.

Conclusion

The church after all will remain the church, and liberal changes may come, but they will do so slowly. However, this should not mean that the church should be removed from the challenges of the AIDS crisis. Rather, their beneficial contributions be used as much as possible and their language and messages be debated, critique and changed wherever appropriate to best help the fight against AIDS. In an epidemic such as this, where so many are infected with a deadly disease, all components of society should be involved in efforts to help stop the transmission and best treat those already affected. The entire society should be implicated, from governments, to schools, churches, and private corporations.

The relationship between faith and AIDS is indeed complex and warrants further research attention, particularly in a country where religion holds such an important place in everyday life. Faith can be a source of motivation, strength and hope for both HIV positive people and those working in AIDS organizations. However, preaching morality in the context of AIDS can translate into further stigmatization. What seems certain about the role of religion, in the advantages it provides and the challenges it presents, is its powerful influence on the fight against AIDS.
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Sport, AIDS and Development: More than “Playing Around”

By Alexander Teleki (University of Toronto)
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Executive Summary

Sport is not a leisure activity reserved for the elite, nor a privilege deserved only by Olympians; it is a crucial part of life for everyone. Sport is “instrumental in the prevention of disease, the enhancement of psychological and physical well-being, and the development of social cohesion” (Keown). In this study we set out to scrutinize NGOs that use sport as a tool for development and HIV/AIDS education. We found that although these organizations are necessary and effective, they face many limitations and barriers that prevent them from maximizing their impact on the population of Namibia. External limitations include lack of funding, an absence of coordination with the Ministry of Education and their HIV/AIDS and physical education curriculum, and the weakness of “sport culture” in Namibian society. Some internal limitations are: lack of communication between similar organizations and among staff members; and a lack of participation in the program by women and girls.

Introduction

The World Cup of soccer in 2002 was the most watched televised event in History. Rugby matches in South Africa leave citizens frozen as they watch with undivided attention. The Namibia vs. South Africa (June 2005) match was no exception.

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Corporate sponsors of sport such as cigarette and beer companies have long realized the power of sport as a tool to spread information. However, the forum provided by sport can also be used to disseminate messages of greater social value than simply “taste the good times.” Sport has already been recognized as a forum for skills building and public health information dissemination. Nevertheless, it has only recently begun to be used at the community level for physical development and the targeting of youth for HIV/AIDS education. Sport has the unique capability of transcending socio-economic and cultural barriers in reaching the public. Not only can sport be used for the mass dissemination of vital public health information, but it can be essential to promoting a healthy lifestyle. Sport can empower young people to have a healthy relationship with their own bodies. Sport fosters physical and emotional health and creates valuable social connections. It can provide a safe space for the development of young people and an alternative to substance abuse and criminal activity. This was particularly the case in our work with Windhoek street youth involved in a soccer team.

Methodology

Our research was informed by interviews with the staff of Physically Active Youth, Sports Coaches Outreach, the Big Issue Soccer Team and educators in Oshakati, Ohangwena and Windhoek. We also engaged in participant observation with Physically Active Youth and The Big Issue Soccer team for a period of six weeks.

The aim of our study was to observe and evaluate the implementation of community outreach programs in Windhoek, Katutura, and Ohangwena Region that used sport as a vehicle for the dissemination of public health information and for the promotion of a “sport culture” among youth. We identified four programs of this sort and worked extensively with three.

Findings

Sports Coaches Outreach

The Sports Coaches Outreach program (SCORE) was in the process of staff transition and we were unable to see it in action. According to informants, SCORE is the most well-established and organized of these programs. They receive interns from abroad for periods of 6 months to a year. While these placements allow for consistency and stability that other programs do not have, the absence of Namibian staff prevents local ownership of the program. Nevertheless, since we did not have a chance to observe the program in action, any remarks on SCORE are hearsay. However the contrast is important because the other organizations (PAY, KAO and the homeless soccer team) were made up entirely of permanent Namibian residents at the time we studied them. As an area of possible future research, a comparative analysis of organizations made up of local workers versus foreign workers or a mix of both would be useful. NGOs are often criticized for imposing their views and importing their methods, philosophies and personnel. Although none of the organizations were entirely local (as they received
foreign funding or staffing), it seems necessary to include local participation for a successful program to be possible and sustainable.

Physically Active Youth

We participated in and observed the Physically Active Youth (PAY) program in Katutura for several weeks. It is a tutoring program for tenth graders at risk of failing school (as identified by their teachers) and it provides a loosely organized sports component. This is the organization we came to work with most intensively in the latter part of our research. As participant observers, we had the opportunity to implement the program ourselves while experiencing firsthand its limitations and strengths.

PAY tutoring session

Every day after school the students arrived for tutoring, where volunteers from the University of Namibia would help out with math, history, French, English, biology and other subjects that the students needed help with. Before the beginning of the sport component, sandwiches were given out. For an academic tutoring and sport program, the provision of food is an essential component. An example from other research in Katutura brings to light the importance of food security in education. “Only twenty percent of parents at the Pashukeni Kindergarten and Orphanage (PKO) can afford to provide their children with lunch boxes, and, subsequently, eighty percent of children remain hungry during the day, since the kindergarten cannot afford to feed them.” “Comparing the performance of children during a learning process […] helped us to see a direct connection between the availability of food and the improved quality of the learning experiences of children” (Kosova and Komeya, 2005: 17).

The sport regime included a rotation of soccer, basketball, other sports, and fitness, although soccer was by far the most popular. There is an attempt being made to introduce sports other than soccer in order to reach a wider audience among youth.
Not only did we get a chance to participate with PAY in order to enrich our research, but we had the opportunity of debriefing those involved in the implementation of the program. The exchange we had with the PAY and SCORE staff at the debriefing stage was a critical point, as it highlighted the impediments to the proper functioning of the organizations. At first we were not so sure that our input would be of value or well-received, but after we had shared our findings, some key issues came to light. Our findings were of little surprise to them, but although they were aware of these problems, none of them had been systematically or formally addressed. “We know the problem, but we need to sit down and solve it.” It was expressed that there was very little work going into planning and evaluating the work they were doing. This is not to say the programs were ineffective. PAY has an extremely high success rate in helping the tenth graders pass to the next grade. The students are happy and seem to have an excellent rapport with the staff. Things are good, but can only be improved if there is a process in place to identify problems and solutions. This issue requires only periodical meetings to share information between organizations and staff working in the same field.

Inter-organizational collaboration is a recurrent theme in the world of NGOs and HIV/AIDS initiatives. Sometimes many organizations with similar missions operate in the same area and compete for the same funds without knowing about each other. Interestingly, there was much informal collaboration between Kicking AIDS Out, PAY, and SCORE. The people who took part in the organizations knew each other and were friends with each other, but there was no formal coordination (except regarding their part in the Kicking AIDS Out network) or joint decision making. It would be a complicated scenario to accomplish, recognizing that each organization is funded and run separately and has many different stakeholders, but the coordinators of the respective NGOs saw it as a necessary action.

Kicking AIDS Out

Kicking AIDS Out (KAO) is a network of sports NGOs, with which SCORE and PAY are partnered. This is the only sport program that specifically and exclusively addresses HIV/AIDS education through sport and movement games. In our experience, this program is not community-based; rather, it is a small group of peer educators that travel throughout the country. Both SCORE and PAY involve KAO activities in their own activities. SCORE and PAY focus mainly on sports, education and development, but do involve HIV/AIDS education insofar as they coordinate with KAO facilitators. As we observed, it was the same KAO facilitator (working with the Ministry of Youth) who coordinated with SCORE and PAY. It is important to note that there are few KAO facilitators, because part of the KAO program is to constantly train new facilitators so as to expand the scope and impact of the program.

For one week, we accompanied the Rural Youth Program Coordinator (from the Ministry of Youth) to a secondary school in Ohangwena in order to implement the Kicking AIDS Out program. The program coordinator put together a team of seven volunteers and we all went north for the AIDS awareness week where we were lodged at University of Toronto/University of Namibia HIV/AIDS Internship Program
the school in which we worked. We were to have access to grade 8, 9 and 11 students during the week.

The first issues we identified as problematic was when we worked with the 8th graders. The Kicking AIDS Out approach is more than adequate for reinforcing knowledge and getting kids to talk about difficult subjects like sex, gender roles and illness, but teaching in the context of athletics is difficult. As it is a “sports” environment, participants are really not in learning mode as they would be in a classroom setting, so messages must be clear and not overly complex. Thus, we felt the program could only serve as a reinforcement of a well established AIDS awareness, prevention and education curriculum in the schools themselves. This curriculum, however, did not exist. 8th graders, already forming their ideas about the opposite sex, AIDS and sexuality, had no real knowledge of HIV and AIDS. They knew some key words and catch phrases, but could not discuss the subject in depth. Once they had told us what “HIV” and “AIDS” stood for, “stay away from sex” and “use condoms” as prevention strategies, there was not much more to say. There is clearly much left unsaid. As much of the education system at that age is driven by a memorization model, analysis and discussion are not encouraged. The fact that the subjects are taboo does not help. “Stay away from sex” and “use condoms” are both acceptable prevention strategies, but the message without a discussion to put it into context is utterly confusing. This confusion permeates much of the national debate around prevention: Abstinence versus condom use. The first message (abstinence), when coupled with the stigmatization of all things sexual in a population with a strong Evangelical influence, undermines the second strategy (condom use) and confuses those who receive the message, especially children and youth. Many ministers and members of the Evangelical Lutheran Church are on the record as opposing condom use and the inclusion of condom awareness in sexual education campaigns, while at the same time some in the church are shifting to a more accepting approach in which condoms are not promoted but not condemned either. This quote from a faith based organization in Windhoek borrowed from Nadia O’Brien and Bonita Nakannyla aptly illustrates the difficult position the church finds itself in regarding condom use.

“We must help them to understand the consequences of sexual immorality. If they don’t listen and continue to have sex with several partners, it might be right to tell them to use condoms. Condoms, when properly used, give some protection against the spread of AIDS and other sexually transmitted diseases. Using a condom doesn’t make sex outside marriage look any different in the eyes of God, but it does slow down the spread of death and, in the end, it will give some protection to both the innocent and the guilty.” (O’Brien and Nakannyala, 2006)

In contrast, other religious organizations that long held the same position now advocate that:

“It is important that religious denominations discuss all aspects of the role of condoms in HIV infection prevention and not become defensive over this issue.”

University of Toronto/University of Namibia
HIV/AIDS Internship Program
When working with 9th graders, we noticed better communication skills and a greater knowledge of HIV and AIDS, but still no real appropriation of the knowledge. They were simply better at memorizing. They still held many ideas that were plainly untrue about HIV. One girl thought having sex with a virgin could cure AIDS. In terms of condom use, many students expressed that using them was good, “it is OK for girls to carry condoms”, but they also felt that carrying them made it contradictory to refuse sex; “Saying no is everyone’s right... unless you carry condoms.”

The 11th graders, after supposedly having been exposed to HIV and AIDS education for 2-3 years longer than the other grades we spoke with, should have had much more knowledge of the issue. In fact they had been hearing the same messages for much longer than the other groups, but the knowledge was not deepened. They seemed to be closed off from the repetitive nature of the incessant ABCs (abstain, be faithful, condomize) being drilled into their heads. They were the most disappointing of the groups. In the case of the young men, at this stage sexually active in many cases, they were overtly misogynistic and openly disrespectful of their female classmates. The only difference between them and the other groups is that their ideas about gender roles and sexuality were much more entrenched. 80% of boys in the group agreed (in the presence of women) that “I will force her” when asked what they would do if their girlfriend said “no”. “If she carries condoms, then she is a bitch”, this after a female classmate admitted to carrying condoms. “When girls say no, they are just shy, they need you to go deeper and they say yes.” One step away from parent-hood, their ideas about sexuality and gender were seriously destructive in the context of the AIDS pandemic.

Gender equality is not seen as necessarily connected to HIV transmission and is thus not seen as a priority. While safe sex, nutrition, and non-discrimination (based on HIV status) are seen as important issues, gender equality is seen by many as an unrelated topic. Even while recognizing that the ability to negotiate condom use depends on the relative equality of women, to many it is not always connected to equality in every day interaction. As a result, sexist attitudes were not deemed problematic when discussing health issues related to HIV. For example, while girls admittedly had the power to refuse sex, that did not entail a change in her subservient position in a relationship. This structure of inequality, when equality is only admitted in the realm of personal health, is not sustainable, as the situations in which a woman has a choice must be chosen carefully and cannot always be systematic. “She can say no a few times, but after a while, you have to show her who is in charge”. She must choose those few times carefully. In the long run, that is no power at all.

In an interview with the principal of the school, we discovered how the national HIV/AIDS curriculum worked in the region. All schools are required to teach about HIV/AIDS, and the way it is supposedly done is across the whole curriculum. In math, geography, social science, physics, biology, etc, HIV is brought into it. This approach
seems to make sense at first, as there are many aspects of the pandemic: biological; economic; social; and geographical. The problem is that all those teachers may not have the training or the will to teach properly. There is no specific HIV/AIDS class, but with the proper training, the trans-curriculum approach could work. How is training done then? All the regional school principals are taught the material at a single workshop, then it is the job of the principals to teach the teachers and then the teachers must implement it in the classroom. If you are familiar with “broken telephone” you will immediately appreciate the possibility for confusion and failure. The information that finally reaches the students is filtered through the agendas and ideologies of every actor in the chain of information.

![Diagram of HIV/AIDS Information Dissemination]

**HIV/AIDS Information Dissemination**

In the case we observed, there were difficulties for the principal, as a white, religious woman in a position of authority, in speaking about sex and illness to her staff who were mostly male and Ovambo. They considered her attempts to teach them about such intimate matters inappropriate and she personally did not agree with pre-marital sex at all. As a result, the subjects were not taught in the classroom very effectively. The purpose of this analysis is not to criticize those involved, but to identify a fundamental flaw in the system of information dissemination. The pyramid scheme of teaching students through classroom teachers who are taught by principals who are taught by experts is more cost effective in the short run as those experts do not have to go to each classroom, but in the long run, the information does not actually have an effect on the behaviour of students, making the cost incalculable in both economic terms and human terms. This is the context in which programs such as Kicking AIDS Out operate. Education is imperfect and sometimes absent, making it impossible for peer educators who have little time and resources to teach about HIV/AIDS, positive sexuality and gender roles.
The Big Issue Soccer Team

Lastly, we followed the progress of a soccer team made up of Windhoek street youth who worked for the magazine “The Big Issue” as sales men and women. This group, which is particularly vulnerable to violence and substance abuse, was training to go to the Homeless World Cup in Scotland at the time we were there. Although this program was not of the same type as SCORE, PAY and KAO, the coach and organizers had in mind similar goals of personal development and improved conditions for participants. More importantly, the team members got real benefits out of the program.

First were the psychological benefits of belonging and having an exciting event to look forward to. As was declared in a statement on a poster in the office of The Big Issue, “sport helps defeat the mental element of homelessness.” There was also the benefit of having regular physical activity for youth that have a lot of idle time.

There were rules in places strictly forbidding drunkenness and drug use. Drug use among street youth is a problem and is related to the transmission of blood borne infections such as HIV. It has also been suggested that other, non intravenous drugs may contribute to behaviour that leads to unsafe sexual practices. The rules were not idle threats. Some people were not allowed to play as a result of breaking rules surrounding drug use and the code of conduct. It is a shame that some people were dealt with in this way and turned away from the team, but it set a precedent that the coach’s threats were not empty. He expressed that strictness and structure were important, as many of the members of the team had never had a positive authority figure such as a parent or teacher. This environment gave them the necessary structure to stop using drugs, even if it was temporary in order to stay on the team and go to Scotland. It also gave them a non-drug using peer group and a non-abusive authority figure to look up to.

In the end they went to Scotland. Unfortunately, after the tournament they returned to their lives as homeless young adults and teenagers on the streets of Windhoek. However, this is a yearly event, which is being held in Capetown in 2006. This program is exemplary of how sport can change behaviour and be a safe space for change for at risk youth.

Limitations and Strengths

Although the conditions in which PAY (and other programs) operate are imperfect, the program itself has many benefits. Using sport to teach teenagers and even younger children is a refreshing alternative to the often dry and boring environment of traditional classroom settings. An association of learning with having fun is positive and could foster not only a sport culture but a stronger culture of learning.

Peer educators rather than regular teachers are often easier to talk to about subjects such as sex and death, and the sensitivity of the subjects is also mediated by physical activity and laughter, making for a less tragic environment. Most people are
touched by AIDS in some way, and although nobody is completely unaware of the subject, speaking about it is delicate. Some would say that the fun, physical environment of sport trivializes such a serious matter. It is a valid concern, but if seriousness is to prevent an open dialogue, adding some fun is far more desirable.

The objective of the exercises is not only to disseminate information, but to get young people talking to each other. Peer educators in most circumstances become facilitators rather than lecturers. It is a difficult reality to face, but in the context of a 20% prevalence rate, courtship and relationships among peers are transformed into a potentially deadly affair. Communication among peers should foster not only safe practices in order to protect oneself, but should promote group responsibility in protecting each other.

A possible shortcoming of sport as a tool for education is its implicit gender bias. Men in Namibia, as in many other places, have been socialized into sports from an early age more so than women. It is not hard to imagine what would happen if boys and girls played a contact sport like rugby together. In one case this actually happened, and a no-contact game quickly turned into full contact rugby. Some girls loved it, but others were not pleased. Many stepped aside while the boys played. In other sports like soccer and basketball, boys performed much better than the girls to the point that girls would many times give up and leave. This does not mean that boys and girls should play separately, nor that contact sports can never be played. This simply means that girls’ structural disadvantage must be taken into consideration. Teams should be somewhat equal and measures should be taken to prevent games from getting too physical if it could become a problem. It is only in the short term that the disadvantage of girls is a problem, because they can become discouraged and decide not to participate in sports. In the long term, it is only in participating with the boys that the structural disadvantage will disappear. If girls are socialized as athletes we do not doubt they will become good athletes, but as that is not the prevalent case today; thus, the disadvantage has to be kept in check through the intervention of facilitators. We are not claiming that boys are better than girls at sports, but rather that in our experience, boys were more likely to be physical and girls were likely to shy away from competing with boys as a result. As a result of rare participation it is not surprising that the sports skills of the girls were often deficient.

The reader should note that in Windhoek, there was less misinformation and the program ran more smoothly than in the rural setting that we studied. Windhoek learners sometimes displayed the same memorization learning model regarding (for example) prevention of HIV/AIDS, but in general were much more knowledgeable than their rural counterparts. Presumably this can be attributed to the lack of regular contact with HIV education and prevention programs. While Windhoek has permanent campaigns incorporated in organizations like PAY, rural areas are dependant on visiting programs that spend a week at one school and must then leave. Supplementary programs aside, the HIV/AIDS related curriculum in schools seems to be more consistently applied in Windhoek (Rice, 2005) than in northern rural areas such as Oshakati and Ohangwena.
This correlates with the availability of voluntary testing centers (VTC) and condom distribution sites.

Recommendations

With specific reference to PAY, with which we were interned for some weeks, we communicated some critical recommendations. Some volunteers are unaware of the “sports and development” philosophy and treated the sports component as play time, thus diminishing the power of sport as a tool for personal development. For example, PAY participants at times expressed their discontent and confusion at being pulled out of their math tutoring session for mandatory “playing around” on the field or court. A consistent program must ensure that the staff is capable of addressing these concerns in order to successfully promote a sport culture. We therefore recommend that every entering volunteer be given a short training workshop before he/she works with students. Moreover, they should be clearly educated on the use of sport as a tool for education and development. They are not just playing around to unwind after tutoring; it is meant to be as equally a valuable learning experience as the tutoring component. Although the volunteers’ teaching skills were valuable, many did not share the opinion that sports was an essential part of the program and were not educated about its importance. This disjuncture is a result of simple deficit of communication between the organizers and volunteers of PAY. It is an important problem, but not so serious that it could not be solved by a short training session, which in fact does happen, but not necessarily from the beginning.

Secondly, when it comes time to do the sports component of the day, which lasts approximately one hour, girls tended to be seen chatting by the sidelines. Alongside these girls were the female volunteers who rarely participated and who were often wearing high heels and clothing unsuitable for sport-related activity. One volunteer, after being told she should set a better example for the other girls, said playing a sport such as rugby was a bad example for the girls. While the girls watch the boys play, a boy will occasionally stop to flirt with a girl. The girls become peripheral, and the boys show off for the girls. Rather than breaking down barriers and empowering girls, sport, in such instances, reinforces gender differentiation and exclusion. This can be easily addressed in a short training workshop that stresses the importance of the involvement of girls. The volunteers themselves could serve as stronger role-models if properly educated. In short, we strongly recommend the increased participation of girls in sports-related activities in these programs.

Many of the problems faced by organizations like PAY and SCORE are external limitations that the organizations themselves have little control over. A primary obstacle is lack of funding. On the trip to Ohangwena with the Ministry of Youth representative, we had no materials with which to organize games. Balls were made of garbage and the games were implemented anyways, but it took more time and were less organized than would have been the case had balls been available. Funding requirements for these supplies would not have been large.
Another external limitation is the role of the education system in HIV/AIDS education. As expressed earlier, primary education seems to follow a memorization model instead of a critical thinking model. Discussions based upon memorized information tend not to be very fruitful, although beneficial nonetheless. If the educational system does not address HIV/AIDS education effectively, then programs that aim to reinforce health information like PAY, SCORE and KAO must operate at a much larger scale in order to become more than supplementary programs and actually have an effect on the knowledge base of those who are targeted by the programs.

In addition to the limited effectiveness of the HIV/AIDS curriculum in schools (especially in rural areas), there is little importance given to sport. This, more than a shortcoming of the school system, is the cultural value given to sport. Physical education is not an important part of the curriculum. Parents say that it is a waste of time. In fact, even students participating in the PAY program expressed that sports should not take up so much time because they needed more time for academics. That sport is seen as a waste of time greatly affects the possibility of these programs being effective.

Most importantly, there is an absence of a mechanism for spreading the programs in a self-sustaining manner. Although a stated mission of the sports NGOs is to teach young people how to teach in order to spread the scope of the program, this area leaves much to be desired. Peer educators are greatly needed especially in rural areas, but this requires a stronger effort on the part of groups like KAO who travel to different schools in rural areas. Small groups of educators can only be effective if they promote the development of new educators to carry their message farther and wider. During visits to rural schools, there should be an effort placed into identifying and recruiting motivated individuals who would be willing to keep the programs running. The impact of the program would be much greater if it was not limited to the infrequent visits of educators from Windhoek.


The greatest criticism of all the sports NGOs is a testament to their worth. We found that their impact is much smaller than it should be, as they have limited facilities, staff and resources. Programs that promote sport as an essential component of life and use it as a tool for the dissemination of vital public health information should be available to everyone and today they have limited impact and it is limited largely to Windhoek, with some programs running in rural areas. Programs of this sort are “practical and cost-effective tools to achieve objectives in development and peace” (UN, 2003) and of developing Namibian youth physically and mentally and socially.
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**Walk Like a Man, Talk Like a Man: Men, Masculinity, and the transmission of HIV/AIDS**

By Fotis Kanteres (University of Toronto) and Job Iyambo (University of Namibia)

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Executive Summary

Namibia is a country that has one of the highest HIV/AIDS rates in the world; this disease is exacerbated by the gender inequality that exists and the social roles it supports. This paper investigates the masculine gender role and its role in the transmission of HIV/AIDS. In addition this paper considers the feminization of HIV/AIDS in terms of its perception and discourse. In researching this topic we accompanied Namibian Men for Change (NAMEC) during their discussion groups. NAMEC, an NGO, provides a platform to educate and empower men and boys on issues of manhood and gender, with the aim of mitigating gender-based violence. We also conducted discussion groups and interviews with students and NGOs in the Karas, Northern, and Khomas Regions. This paper considers masculinity as a concept that carries negative connotations in rural and urban settings with severe implications for gender inequality and the transmission of HIV/AIDS.

Introduction

“I don’t show my manhood with my fists.”
—Abdallah Hussein Mwakembeu, Director and co-founder of NAMEC

With that statement, Abdallah addressed the issue of sexual and gender-based violence while also trying to renegotiate the definition of what it means to be a man. Namibia, a young country born from the ashes of a brutal apartheid regime, is still far from being free of this oppressive past as it continues to deal with many inequalities; the most glaring of which are economic and gendered. In this society men hold greater power and status than women. This is characterized by a pronounced division of labor, unequal employment opportunities and subsequent access to resources, and, of key relevance to this paper, influence in personal relationships. There have been numerous accounts of sexual and gender based violence such as domestic violence, verbal abuse and rape. Women also find themselves at a major disadvantage in negotiating condom usage and male sexual partners with promiscuous lifestyles have made females in committed relationship a very high risk HIV/AIDS group. Endemic poverty, characterized by high levels of unemployment and a significant stratification of socioeconomic classes, has exacerbated the aforementioned problems. Alcohol abuse, also a major problem, is seemingly poured over an already volatile situation. There is an imbalance in how people relate and interact and these are issues that demand comments like that of Abdallah’s quoted above. Yet how does such a statement come to be? In a sense that is at the heart of the questions we asked and the research we conducted; therein we attempted to examine how masculinity was defined, developed, and operated against the backdrop of the HIV/AIDS pandemic in order to explore its role in the transmission of the disease.

Methodology

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HIV/AIDS Internship Program
We explored this topic by formally contacting and working with Non Governmental Organizations (NGOs), Community Based Organizations (CBOs), and educational institutions. We spoke informally with Namibians in several regions of the country as well as in our day to day lives. Building upon research conducted in the previous years of this program we contacted Namibian Men for Change (NAMEC) and Lironga Eparu, an association of people living positively with HIV/AIDS; we accompanied NAMEC on two workshop excursions to the Karas and Oshana Regions and interviewed members of Lironga Eparu. We also accompanied the University of Namibia Student Representative Counsel (UNAMSRC) on an information speaking tour held at various high schools throughout the North Central Regions. Through this, we were able to hold five discussion groups with students, as well as interview educators. The discussion groups consisted of male students in grades 11 and 12 between the ages of 15 and 19. In Windhoek, we held five similar discussion groups at The University Centre for Studies in Namibia (TUCSIN), a university preparatory school, where one of us (Fotis) resided during our stay in Windhoek. These led to more informal conversations throughout our stay as we formed a rapport with the students. In addition we interviewed representatives and volunteers of the New Start HIV/AIDS volunteer counselling and testing center, the Rainbow Project (TRP), Namibian Women’s Network (NWN), and the publication of Sister Namibia. We also conducted informal research at several shebeens in Katutura, Windhoek and the North Central Regions.

Findings

New Start: The Feminization of HIV/AIDS

New Start is a nationwide HIV/AIDS voluntary counselling and testing center. It may seem strange to start this report with a description of New Start considering all the time and focus we devoted to other groups, but the great deal of information provided by New Start was an excellent introduction into our research and in retrospect, provided a good contextualization of men’s perspectives and attitudes to the disease. The client ratio is 60-40% with women as the slight majority; this applied to both testing and counselling. Our informants noted that women were more open than men to the idea of HIV/AIDS testing and counselling. They were more likely to take the initiative and come in by themselves or with a supportive person. Men who came in usually did so with a partner. Feelings of pressure or challenges to their position of strength, individuality and autonomy by their partner jeopardized men’s attendance. Men were thus more likely to come to New Start if it were suggested in a delicate, non-confrontational and supportive manner. The counselling worked best when couples came in together and were open to fair and equal dialogue about the issues and towards one another. As education is an important factor in determining who uses New Start’s services, the likelihood of this open and equal dialogue was more common in urban than rural areas.

We then discussed a concept of major importance to this study: the feminization of HIV/AIDS. This is a concept that has received a fair amount of attention in recent
years as the burden of the disease has been seen to be felt more and more by women (Annan 2002). But it is usually a figurative or statistical view in which women’s increasing seroprevalence rates are discussed, or in a biological one where women are said to be more vulnerable to the acquisition of the disease during sexual intercourse. Another dimension to this view was expressed by New Start through our informant’s focus on how the perception and discourse of HIV/AIDS are primarily associated with women. Support groups, advertising campaigns, and public speakers are mostly made up of women. This has led to a majority representation by women in HIV/AIDS work, and to HIV/AIDS having a ‘women’s face’. In addition previous and current labels as purveyors of the disease may have opened a medium for discourse and expression and a need for social support networks that reinforce this focus and view. Men on the other hand have kept quiet about the disease and lack groups solely devoted to them, as well as male role models, and recognized avenues of expression. Other than NAMEC, there are no other significant national men’s support groups in Namibia. Lironga Eparu, which will be discussed in detail below, is open to all people but has very few male participants.

This concept was illustrated with the example of a funeral for a person who has died of HIV/AIDS. Women attending are free to express themselves in words and tears, yet men cannot, as they would be seen as weak. There is also a greater chance that the women would have spent time with the person before their death compared to the men. Women play the role of primary caregiver, therefore they are not only allowed, but expected to, spend time with people living and suffering with HIV/AIDS. Thus, women are better able to understand the disease and educate themselves on how to deal with it intellectually and emotionally; men do not have this opportunity.

This personal relationship that women have with HIV/AIDS is not counterbalanced by a formal or professional relationship bestowed upon men may have through their placements in positions of authority such as doctors. This unique relationship between women and AIDS can only be equaled in men through a change in cultural views and attitudes. Even in the professional sphere, Namibia’s hospital doctors, already not exclusively men, are greatly outnumbered by female nurses according to fellow research interns Nashitye Ndjaleka and Jing Jing Liu, whose research focused on Nursing. The feminization of HIV/AIDS is a distinct phenomenon that has had a great influence on how the disease has been spoken about and who in turn does the speaking.

NAMEC: Sexual and Gender Based Violence; Gender Roles

NAMEC is an NGO inspired by the White Ribbon Campaign against violence against women. Established in the year 2000, NAMEC provides a platform to educate and empower men and boys on issues of manhood and gender, with the aim of mitigating gender-based violence. We accompanied NAMEC to two separate workshops in the North (Oshana Region) and South (Karas Region) of the country. The long commutes to the workshop locations from Windhoek (both approximately 1000km) also gave us a great opportunity to discuss a range of topics surrounding the organization and life in Namibia which complemented and enriched our understandings. The NAMEC
workshops were a mix of seminar and discussion format. They involved the representative from NAMEC presenting a lecture for the first hour to hour-and-a-half, followed by audience participation and discussion. During the first excursion, we attended one schoolboy’s and two men’s workshops, the first two were Aus and the latter in Lüderitz. On the second excursion we attended a schoolboy’s workshop in the village of Okahao in the Oshana region.

“What is Masculinity?”

This question is at the heart of both our research and national campaign. The question was also used by the NAMEC speakers to begin the workshops, followed a list of questions about gendered social roles, including the division of labor, sexual and gender based violence, and HIV/AIDS (see Appendix 1). This broad question worked well to introduce the topic, deconstruct the definitions, and investigate their subsequent meanings and effects. Masculinity was discussed in biological terms that highlighted the differences between men and women’s bodies, as well as in sociological terms. The division of labor was also identified and addressed.

The role of socialization was introduced in the workshop by asking the audience what kind of toys they would purchase for children of differing sexes. Together the group decided that boys would get cars and guns and girls would get dolls. They were asked if it would be correct to reverse the gifts and the audience responded that it would not be. In one talk men were asked whether it would be right for their son to be dainty (soft or feminine) illustrated by the presenter through a mock ballet step; the crowd responded with laughter but said no. The presenter used this moment to identify the complicity of parents and society in ascribing gender social roles. The inclusion of this subject is very important; however an increase of clarity and depth could do a great deal to strengthen it. This could be done with questions such as “Why is it important to recognize socialization?”, “Is this something that can be changed?”, or “Can it be changed?”

The main focus of the workshops and the group itself is the eradication of sexual and gender based violence against women. To illustrate the severity of the problem the presenters referred to recent events such as the rape and murder of two young children in Walvis Bay (Barnard 2005). In Lüderitz, the police commissioner attended the workshop and addressed the group with a range of figures about crime and violence. The main point of this was that perpetrators are almost always men. The NAMEC speaker added that crime rates tend to increase at the end of the month to coincide with people getting paid and tending to buy alcohol and get into problematic situations.

The build-up to abuse and violence was introduced through scenarios presented to the participants who were then asked to discuss their reactions to infidelity or marital irresponsibility by their spouses. Examples ranged from cheating to coming home to find dinner not prepared; these reasons are often cited to justify domestic violence. The presenter also asserted that abuse came in forms other than physical violence, such as
emotional and economic, explaining that men could be abusive with their words and actions or lack thereof. He stressed that communication, respect, and responsibility were the keys to solving their problems and exemplified this saying, “Talk with your wife” and “Don’t get mad at your wife if she never cooks for you, if you never brought her food”. Alternative methods of dealing with problematic spousal situations were also suggested; these included using social networks such as family, friends, or elders to mediate and as a last resort, leaving. “Don’t force matters; the results could be you in prison and her in the grave.”

Emphasis on legal recourse brought to light Namibia’s legal system and new legislation; specifically the Married Persons Equality Act, Combating of Rape Act, and the Combating of Domestic Violence Acts. The legal system is changing so that women now have greater legal recourse than in the past and men can be held accountable or at disadvantages in disputes. On the positive side, the system could be very useful in problematic situations; where men and women had the option of going to the police instead of ‘doing something stupid.’

The topic of HIV/AIDS was introduced at the Lüderitz workshop by the head of the HIV/AIDS ward at the community hospital, through presentation of the 2004 testing and treatment statistics. The presenter then informed the group about the services available to the community. In the men’s workshops, promiscuity was stressed as a major problem which added to the spread of HIV/AIDS. In the workshop and in interviews we heard how men in committed relationships had affairs yet refused to wear condoms with their spouses. When asked about condom usage they would argue that they were unnecessary as the relationship is a committed one and accuse the woman of cheating if she wanted to use condoms. This makes women in committed relationships vulnerable. The presenter questioned why a man would want multiple partners and reminded participants to the prior discussion on abuse that if a man has a problem in his relationship there are other solutions. It was suggested that if a man is not satisfied sexually or domestically, they should communicate this and take action to change the situation, rather than do something that could make it worse for their family. The schoolboys were told to respect their female peers and that sex is something that can wait until their studies were finished and they were older and married.

One of the NAMEC’s goals is to change the definition of what it means to be a man; they wish to transform it from a strong silent type to a strong, responsible, provider and protector. Yet if one were to take out the biological component and its connotations, the same list of noble characteristics could be ascribed to a woman. If this fact were identified and discussed there could be a great deal of improvement in lifting the shackles of gender labels and stereotypes on both sexes.

All of the participants responded positively to the ideas presented to them; in Aus the most poignant moment came at the end of the discussion when a community elder stood up and discussed all of the social ills and violence that were occurring in his community and demanded that there needed to be change. Everyone felt the power of his
words and spirit; this personified the hope that comes from the group and its participants. To further the cause and goals the workshops all culminated with a consensus of the need to act on the issue of sexual and gender based violence with NAMEC. Representatives such as vocal or active members in the audience, previous contacts, or high achieving students were selected and with that a local community NAMEC chapter was born.

The very existence of NAMEC provides men with a medium for education and sensitization; men can get together and discuss very serious and pressing issues. The group also provides a platform for expression and information dissemination. Its main mandate of ending gender and sexual based violence is highly relevant to the current social problems, especially in regards to the transmission of HIV/AIDS. It gives men public representation in Namibia. Furthermore, its links to the international White Ribbon campaign link NEMEC to the international movement against gender-based violence.

Student Discussion Groups: Rural Versus Urban; Kicking with #2

After accompanying NAMEC on the second workshop excursion we returned to the Oshana region with the UNAMSRC for their informational speaking tour. This gave us access to many secondary schools in the Region where we spoke with students and educators and held discussion groups on the topics of gender roles, relationships and HIV/AIDS. Following the positive outcomes of the workshops in Oshana Region, we applied the same idea in Windhoek and held similar workshops at a university preparatory centre. The discussion groups usually consisted of 10 male students between the ages of 15 and 19 in the North, whereas in Windhoek, where we had more time and access, we were able to hold both male only and mixed discussion groups.

-What does it mean to be a man?

In the student’s view, gender has a predominantly biological definition; men are men because of their biological makeup and women respectively so. A man is supposed to be responsible, the head and provider for the family, and to “not do women’s work” (i.e., cooking and cleaning). The key characteristic in differentiation is strength; men are bigger and stronger than women; this idea was also extended to non-biological concepts as well, such as will, mind and spirit.

To trace the development and construction of gender in their lives, we asked how men and women were raised. Students said that girls, who were seen as weaker or softer, were treated more delicately “like angels”. Boys on the other hand had to do an assortment of chores around the house; they also received encouragement to attend school. A tangible division of labor began around the early teen years; until then it was more about the concepts of hard and soft. Girls we spoke with shared this opinion. In discussing when a boy begins being considered a man, the consensus was that in rural settings, a boy becomes a man when he is able to perform the tasks of a man; an example

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22 We were also told that currently both sexes are encouraged to attend school
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of this is the arduous labor of managing cattle along their regular day-long grazing route. In the city, where such physical determinations of manhood are unavailable, there is emphasis on characteristic realization, such as the boy being able to be responsible for the family or becoming employed.

Throughout this description, they mentioned that these more rigid and divisive views are traditional and are starting to change. This was with the introduction of a distinction and conflict between the rural and urban settings. The traditional view is one of a socially conservative patriarchal system, historically including polygamy, which has long been held in rural areas and applies to the division of labor that accompanies a subsistence or agricultural system. The urban view represents education, equal rights, modernization, and westernization.

The views that the students held were fluid and dynamic, they agreed with some of the ‘traditional’ views as well as the ‘urban’ ones. As ideologically important as these labels are, in reality they are highly impractical. There is in fact no real social rural-urban division; people traverse the country on a weekly basis. People who are currently ‘urban’ may have only become so in recent years and have by no means left ‘rural’ roots, as people are constantly returning to rural locations to visit family. This constant travel is due in part to an historic migrant culture where people, mostly men, traveled vast distances for employment; this concept still applies today where people travel from rural to urban centers (Frayne 2005). Namibia has a very small population and although it is spread out over a vast area, travel and an emphasis on social ties keeps people from becoming isolated.

There is also an increasing modernization that has been occurring throughout the country. Windhoek has all the amenities as well as the atmosphere of any western city. The rural areas are by no means behind on these same amenities, a drive through the region will show many houses with television satellites dishes on their roofs. The same ‘50Cent’ rap music can be heard in Oshakati as in Windhoek or Toronto, and the listener can be seen wearing the same Nike Air running shoes.

One of the main issues connecting manhood to the transmission of HIV/AIDS is the norm of men taking multiple sexual partners. Respondents stated that most men have multiple girlfriends, and that they “kicked around” (cheated on their girlfriends). They said that social status was gained with relationship success, measured through having multiple girlfriends (as opposed to having one very good relationship). One respondent replied to our questions by saying that a man needs to have several girlfriends and provided a model for them: “Number one is the queen, number two is when you don’t have any money, and number three to take to the mall, to show off”. Many others recognized this model when we brought it up at separate workshops. They reasoned that women could not be trusted to be faithful or honest and that they have high material needs. Travel and extended periods of absence (i.e. one month) were also cited as reasons they would take other sexual partners. Many felt that having one girlfriend was not regarded (socially) as enough. “A man with one wife is like a man with one eye” was
a phrase that was used to exemplify this idea. We asked if it were possible to have one girlfriend who could satisfy all criteria and desires. There was no clear response to this and we were then told that no man wants to have the same sex story with the same girlfriend (all the time) to share with the boys on Monday mornings when everyone else has several exploits to share.

Sugar Daddies are men who have relationships with younger women on the basis of material benefits; in Namibia they are exemplified by the “3 C’s”: Cash, Cars, and Cell phones. This is a phenomenon that has received a great amount of attention and is credited with increasing the spread of HIV/AIDS and exacerbating gender inequality. Women find themselves in these relationships for a variety of reasons, a major one being economic desperation. In such a relationship, women lack the power to negotiate condom usage and are thus highly vulnerable to HIV/AIDS. The boys had very strong feelings towards the entire situation, blaming Sugar Daddies for the spread of the disease and for taking their women. Conversations on this topic included respondents threatening violence and even death against a girlfriend who cheated on them with a Sugar Daddy.

When we asked about condom usage and negotiation, we were told about the “one month rule”—if someone had been dating a girl for one month, then it was fine to have sex without a condom. This correlated with a general view of not using a condom with their main girlfriend, but instead with other sexual partners. Respondents also held alcohol accountable for condomless sex. In general, sex without a condom was reserved for the prime girlfriend, “the queen”. Condomless sex is in fact quite prized and respondents shared several sayings to refer to the pleasures of condomless sex: /oshipa koshipa/ (skin to skin), /omyama komyama/ (meat to meat), and /foti/ (sex without a condom; highly enjoyable climax). This attitude condoned if not encouraged measures to both avoid, as well as justify not, using condoms. Alcohol was often cited as another inhibitor to condom usage, “When you’re drunk, (you) don’t think of (a) condom especially if she looks so good in the short skirt.”

Another Perspective: Lironga Eparu; the Rainbow Project; Female Students

Lironga Eparu “Learn to Survive”, is a national association of People Living with HIV/AIDS in Namibia, established by a group of Namibians in 1999. We attended a speaking event during HIV/AIDS awareness week at the Windhoek College of Education and interviewed members of this organization. The membership is predominantly female and in speaking with members of the group we saw how gender inequality and the pain of the disease were experienced by women. They are living examples of the stories and scenarios we heard about men being dishonest and promiscuous. The women we spoke to told us of the negative experiences they had with men, often relating this to their acquisition of HIV. They told stories of men being dishonest about their status and/or promiscuity, and how the women felt powerless in these situations. One woman speaking at an HIV/AIDS awareness week event told the story of how she learned she was positive: she was married and had been faithful, and while pregnant with her third
child she decided out of general concern to get tested. On discovering her positive status she did not accuse her husband of infidelity as she did not want to dwell on it. She characterized him as a proud Oshiwambo man who cared about power and prestige and it was these feelings that led him to commit suicide after discovering his status. She lost her third child and was left with two to care for and had attempted suicide four times in the past year.

The women of Lironga Eparu may have gone through extremely difficult pasts that have left them with negative views on men and sex, but they are by no means embittered. This was exemplified by commentary that they still had or wanted partners and that companionship was still important. The idea of this group is a positive attitude towards the disease and life; this was graciously exemplified throughout our talks as our informants lightened the most heart-wrenching matters with sprinkles of humor and laughter.

“Does your dick make you a man?”
-Female high school student

This is a question that came up during a mixed gender student discussion group; it is a direct challenge to the biologically based gender definition. The women we spoke to agreed with the problems caused by gender inequality; but being the ones at the disadvantaged position they were able to give an even more elaborate account. Female students talked about non-physical aspects such as the social and emotional abuse experienced by being teased by boys at school and being lied to and cheated on by their boyfriends.

The Rainbow Project (TRP) is a NGO working for the recognition and promotion of the equal human rights of lesbian, gay, bisexual and transgender (LGBT) people in Namibia. In speaking with the organization we were able to attain a non heterosexually-centered view on sex and gender. Homosexuality is taboo in Namibia, as such it was not a subject we felt would be easily approached in our limited time and scope. Nonetheless, we felt the area was very important, and we are lucky to have been able to speak with this group. We spoke to three female members and one male. One woman told of her relationship experiences and how even in a same sex relationship there was a masculine and female role distinction; she self-identified as a ‘butch’ and took on the masculine role. In her past, she identified and practiced the macho masculine role by being promiscuous and tough to the point of physically subduing her partners. The male discussed how roles were very important in male homosexual relationships and that gender roles were also given; he identified with a feminine role saying “I feel like I am a woman”. He added that men who were ‘givers’ in male-male sexual activities felt they could maintain their heterosexual identities. They all agreed that the masculine and feminine concepts had definite social groundings and were not solely biological and that male and female gender roles are reproduced in homosexual relationships.

A Night at the Shebeen
Shebeens are informal taverns where alcohol is sold at very low prices. One litre of beer was on average 7 rand (approx $1 US) - less than the price of commercially sold water, which is also never sold in shebeens. A great deal of these establishments can be found throughout Namibia, most notably in the Katutura district of Windhoek. Katutura was one of the major black districts during the apartheid era. Consisting mostly of informal housing conditions, it is home to about two thirds of Windhoek’s 300,000 residents. The patrons of shebeens are predominantly men and the few women who do attend are most likely working as servers, or according to anecdotal evidence as formal or informal sex workers. In order for their attendance to be socially acceptable, women would have to be unmarried, and the only times they could go to shebeens would be on weekends and holidays, while men could be found there at all hours of the day. Our work at shebeens was very informal; due to ethical and safety concerns it was not an initial area of focus but became one as we could not ignore the fact that our personal experiences there were extremely relevant to our topic.

The most significant experience we had came days before the end of our research and presentation to community stakeholders. We went to a shebeen where Job was familiar with the owners and patrons; it was similar to going to one’s regular neighborhood pub. While sitting in the outdoor patio area we were approached by a girl. ‘Donna’23 came and sat down on a nearby milk crate, similar to those on which some of us were also sitting, and she started talking to us. She had a lot to say about gender issues, religion, unemployment, and education. We discussed her situation as a young female in Namibia and the difficulty of gaining employment, even though she had attended a post secondary institution. She said that the church was doing negative things by distracting people and giving them empty answers as opposed to actually addressing HIV/AIDS and that alcohol was a major problem as people turned to it when they had little to do and little hope. We discussed the high degree of gender inequality and incidence of sexual and gender based violence and how alcohol abuse exacerbated the situation.

Later on ‘Donna’ was at a table helping herself to a group’s alcohol against their objections. In a short period, she went from having calm interactions with people to being slightly aggressive and belligerent. The group said she was ‘bad news’ and had done things like setting people up to get robbed. They proceeded to scold her for taking their alcohol and for harassing us, but in the process, began to harass her. We were in a state of confusion and shock; we went from having an intelligent conversation with this girl to a difficult and unruly situation. She started to cry and then someone offered her a drink in consolation. She then wandered off and collapsed the sheet metal that surrounded the toilet area. About ten meters away from us, in front of the shebeen and in the midst of the patio area, one of the regulars, who also helped out there, approached her and began accosting and scolding her for her actions. This lasted for a few minutes and concluded with him grabbing her by the hair, throwing her to the ground and dragging her around it. This was accompanied by laughter from several of the people there.

23 Pseudonym

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including most of the people at our table, and most notably the female waitresses. The patrons as usual were almost all men and of the few women there, most were waitresses. The waitresses that were at our table commented that she got what she had coming and deserved it. When it was over, a small group of about three women rushed her up without consolation and hurried her into a taxi, in which they put her in alone. The whole situation felt sad, the laughter and inaction seemed the normal reaction. Those who felt that such a violent action was wrong and intervention necessary seemed to hold opinions that were out of place. The saddest irony was that ‘Donna’ foreshadowed the events that occurred in our initial discussions where she complained of the ugliness of gender inequality and alcohol abuse, and then got caught in the cycle herself.

**Recommendations**

*Increased support and funding for NAMEC for staffing, training, and the opening of branch offices in key centers of the country*
This is a national organization with an estimated membership of 10,000, primarily run by Abdallah Hussein Mwakembeu and Gift Kazombaue who are also its main speakers. These two men provide workshops throughout the country while also responsible for daily operations of the organization in Windhoek. According to staff and our observations, the organization is understaffed and under-resourced. During the first workshop excursion, both speakers fell ill; the director on the first day and then the assistant on the next. There are also linguistic limitations as the director does not speak Afrikaans nor Oshiwambo, the two major languages spoken both in rural and urban settings. Their claims of lacking resources and personnel are valid.

*Increased focus on HOME BASED CARE (HBC) workshops by NAMEC*
It was brought to our attention that NAMEC had an HBC stream of workshops. This is highly significant; according to a male nurse specializing in community outreach whom we interviewed, the majority of this work is done by women while the recipients of it are almost equally men and women. This is a new program still being developed and support and funding are crucial. NAMEC stated that from their donor’s perspective the focus of their group is on gender and sexual based violence and the workshops that exemplify that. As such it has not received enough support to provide this program on a consistent basis.

*Outside evaluations for NAMEC*
Our commentary represents our own opinions and ideas regarding presentation and programming; qualified and experienced evaluators could provide a great deal of information on advances and advice for improvement. In addition they could provide training for staff in such ideas.

*Further partnerships between NAMEC and other organizations*
NAMEC, the Namibian Women’s Network (NWN) and Women’s Active for Development (WAD) are all members of a consortium which receives funding from the Embassy of Finland in Namibia and the Bristol-Myers Squibb Foundation. A part of this
arrangement is a division of foci in which all the group’s mandates and strengths have been taken into account and streamlined in a fashion where there is wide contribution to the community with little redundancy while still encouraging partnerships. We believe these partnerships could lead to the creation of new projects and linkages between the groups and further encourage gender relations and discourse.

Support group for HIV+ men
Lironga Eparu is inclusive to both sexes but the membership is predominately female. Such a group’s development could be aided with groups such as Lironga Eparu and NAMEC working together to pool their strengths and resources.

Alcoholism support group partnerships with HIV organizations
Alcohol abuse is a major problem in Namibia. It was also linked to many problems including sexual and gender based violence, promiscuity, and the transmission of HIV/AIDS. There is a definite connection that must be taken into account; this can be done be establishing partnerships between organizations focused on the respective topics such as Lironga Eparu and Alcoholics Anonymous, or by establishing a new organization who would have this focus.

Forum for discussion about rural and urban culture and their interactions
To address the increasing cultural diversity and conflict, there should be a forum for cultural discourse. Given their program objectives, we feel that NAMEC can be instrumental in further challenging negative attitudes toward women and sexual practice in Namibian society.

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Appendix

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Lüderitz Community Men’s Workshop on Gender-Based Violence and HIV/AIDS
Sunday the 19th June 2005

Definitions of Manhood and Womanhood as Related to Violence, Abuse and HIV/AIDS

1) What are the expected roles of a man in a society?
2) What are the woman’s expected roles in a society?
3) What is masculinity?
4) What is feminism?
5) What is gender equality?
6) What is gender equity?
7) What is gender sensitivity?
8) What is gender division of labor?
9) What is violence and abuse?
10) What are the different forms of abuse?
11) What are the causes of SGBV?
12) What are the cultural and traditional practices that you think contribute to the spread of HIV/AIDS?
13) What negative myths about HIV/AIDS do you know?
14) What roles do you think a man should play in the upbringing of his child/ren?
15) How can a man support or maintain his child/ren to learn from you?
16) What example would you like your child/ren to learn from you?
17) How do you deal with your unruly/arrogant/rude child/ren?

References


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