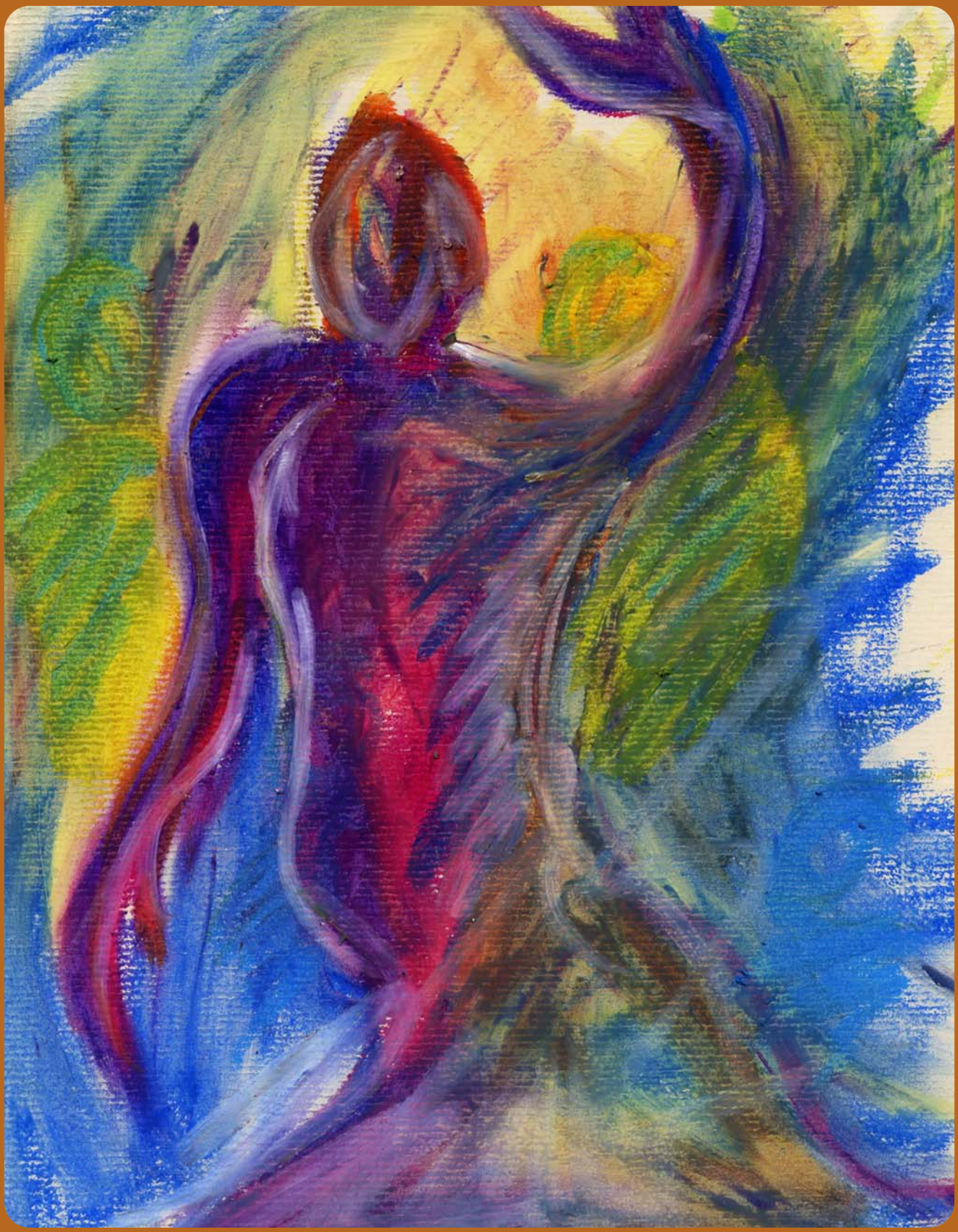


"Anita"

Anushka Virahsawmy

CHAPTER 7
HIV and AIDS

Article 27

March to commemorate World AIDS Day in Arandis - December 2010. *Courtesy: Sarry Xoagus-Eises*

KEY POINTS

- At 71 %, the SGDI on HIV and AIDS puts the country at number four out of the SADC region in terms of progress towards achieving the SADC Gender Protocol targets relating to the sector based on empirical data.
- The citizen score is lower at 66% based on citizens' perception of government's performance in the area. Namibia is one of only five SADC countries where citizens' score is lower than the SGDI.
- Namibia has a low HIV and AIDS prevalence rate of 13% of the population HIV positive.
- Gender inequalities continue to drive the pandemic in Namibia.
- In 2011, more than 90% of HIV-positive mothers received anti-retroviral drugs for PMTCT.

Table 7.1: HIV and AIDS SGDI and CSC scores		
	SGDI	*CSC*
Scores	71%	66%
Ranks	4	7

Table 7.1 shows that at 71 %, the SGDI on HIV and AIDS is higher than the CSC at 66%.

The SGDI measures: comprehensive knowledge on HIV and AIDS; the proportion of women who are HIV positive as a percentage of all people who are HIV-positive; and HIV-positive women receiving Prevention of Mother To Child Transmission (PMTCT) treatment as a percentage of all HIV positive pregnant women.

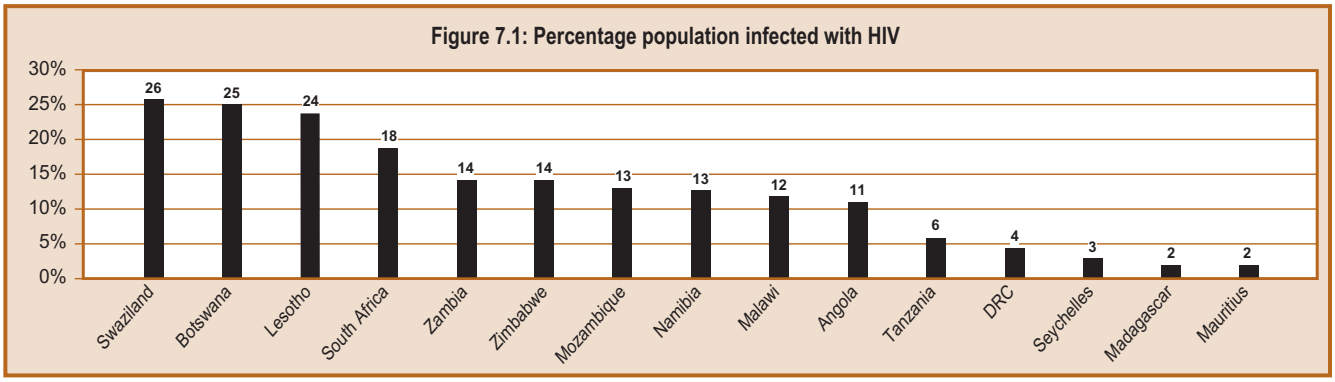
Despite the government's huge investment in the HIV and AIDS response, the SGDI is lowered by the continued high HIV prevalence rates among pregnant women.

The lower citizen score could be attributed to the fact that they recognise the increased access to treatment and the quality of support and care for people living with HIV and AIDS but they feel more can be done to reverse the effects of the epidemic.

Table 7.2: Key Gender, HIV and AIDS Indicators		
	% women	**% men**
Extent of comprehensive knowledge on HIV and AIDS	83%	86%
HIV infection	13%	
Share of HIV infection	59%	41%
Voluntary Counselling and Testing	68.8%	31.2%
On ARV treatment	84%	
HIV positive pregnant women receiving PMTC	90%	

Source: 2012 SADC Gender Protocol Barometer; UNGASS 2010 country report; IAS 2009 fact sheet on HIV and AIDS in sub-Saharan Africa.

The current situation



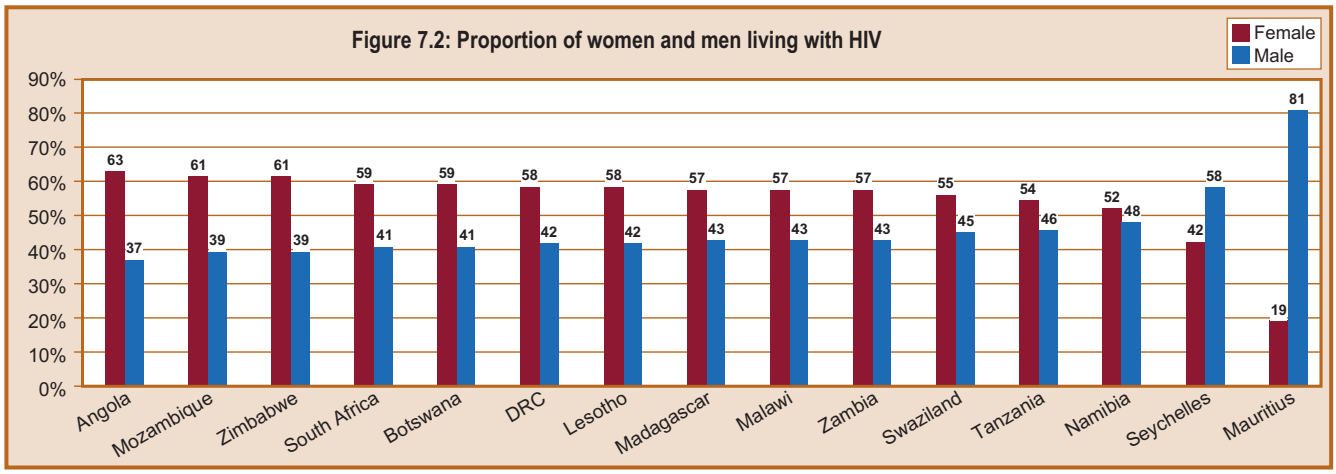
Source: 2012 SADC Gender Protocol Barometer.

Figure 7.1 shows that Namibia has the eighth highest HIV and AIDS prevalence rate in the region. HIV prevalence in Namibia is measured through data collected from pregnant women. In 2008, HIV prevalence was 17.8%, a decrease from 22% in 2002. The highest prevalence rate is reported amongst people aged 30-34 years. Although the prevalence of infection appears to be increasing in adult age groups, the prevalence of HIV infection in those aged 15-19 and 20-24 years has decreased from 11% to 5.1% and 22% to 13.9% respectively between 2002 and 2008. The prevalence rate for urban and rural residents is similar.[1]

In line with the CEDAW committee general recommendation number 15,[2] the National Policy on HIV and AIDS released in 2007, includes provisions on creating an enabling environment for women and girls to prevent HIV infection.[3] The policy is accompanied by a multi-sectoral national plan with a monitoring and evaluation framework.[4] The report recognises the need to collect gender disaggregated data. The Government also runs information campaigns through the media and extensively distributes free male and female condoms as discussed above.

1 Ministry of Health and Social Services. (2008). *Report on the 2008 National HIV Sentinel Survey*. Windhoek, Namibia: Ministry of Health and Social Services. At pages vii and 15.
2 Committee onthe elimination of discrimination against women. (1999). General Recommendation No. 24 (seventh session, 1988). Available at: www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom15 Last accessed 14 February 2010.
3 Ministry of Health and Social Services. (2007). *National Policy on HIV and AIDs*. Windhoek, Namibia: Ministry of Health and Social Services.
4 Directorate for Special Programmes. (2006). *Plan for National Multisectoral Monitoring and Evaluation of HIV/AIDS*. Windhoek, Namibia: Ministry of Health and Social Services.

The MoHSS held a women's leadership conference in 2008 entitled "Namibian women in leadership taking action against HIV and AIDS". One of the outcomes of the meeting included the observation that the lack of male involvement in HIV and AIDS related prevention activities is still a challenge.[5]



Source: UNAIDS 2010.

Figure 7.2 shows that women are more vulnerable to HIV infection than men in all SADC countries except the island countries Seychelles and Mauritius. Women make up 59% of those living with HIV in Namibia compared to 41% men. The fact that it is more women who access treatment, counselling and are on ARVs and PMTCT is also worth noting but it is not entirely surprising as most HIV tests are done on pregnant women and the prevalence rate of HIV is higher with women.

Prevention

The Protocol requires that by 2015, state parties shall develop gender-sensitive strategies to prevent new infections, taking account of the unequal status of women, and in particular the vulnerability of the girl child as well as harmful practices and biological factors that result in women constituting the majority of those infected and affected by HIV and AIDS.

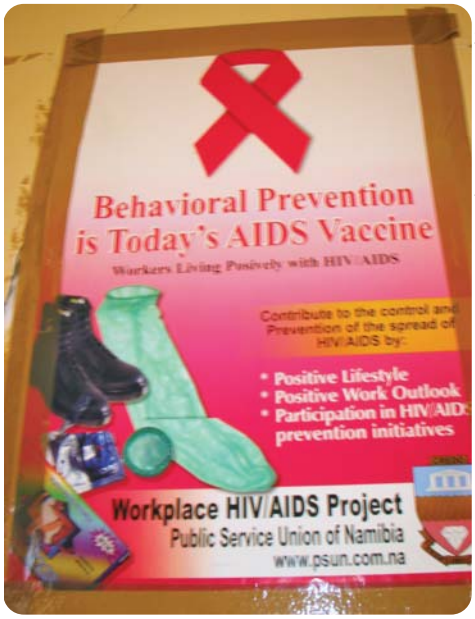


Photo: Sarry Xoagus Elsies

The key drivers of HIV and AIDS in Namibia have been identified as multiple concurrent partnerships; high risk sex; intergenerational sexual partnerships; alcohol usage and high risk behaviours. Gender inequality lies at the heart of these drivers and needs to be addressed head on in prevention campaigns.

A total of 164 609 people registered for counselling and testing in 2008-2009. More females (68.8%) than males (31.2%) accessed these services. Access was highest in the Oshana and Oshikoto regions (30% of the national total) and lowest in the Hardap region (3%).[6]

5 Directorate of Special Programmes. (2009). *Progress report on the third medium term plan on HIV/AIDS*. Windhoek, Namibia: Ministry of Health and Social Services. At page vi.
6 Directorate of Special Programmes. (2009). Progress report on the third medium term plan on HIV/AIDS. Windhoek, Namibia: Ministry of Health and Social Services. At page ix.

PMTCT

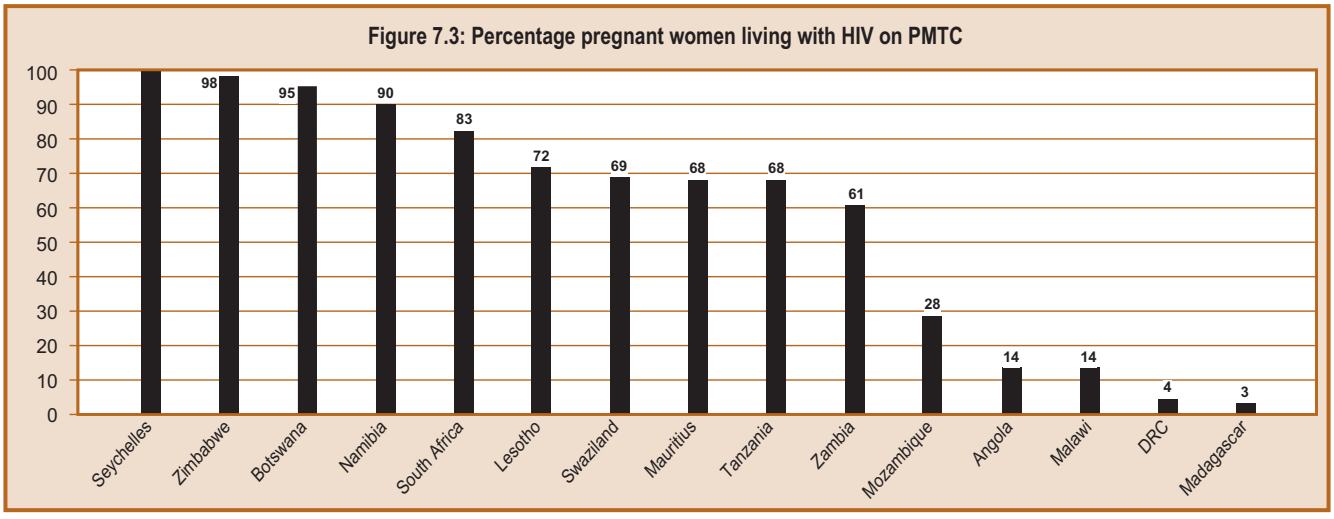
The Government has also prioritised the prevention of mother-to-child transmission. According to a recent report on the 20 countries in the world with the highest rates of HIV infection, Namibia is only one in four countries that has achieved the target of providing approximately half of all HIV-positive pregnant women with this treatment.[7] All pregnant women are routinely offered syphilis testing.[8]

According to the MDG Namibia report of 2008, in 2006, 92% of women who started antenatal care (ANC) took and an HIV test. Seventy -nine percent of pregnant women who delivered knew their HIV status and of all HIV positive mothers who delivered 64% took ARV prophylaxis. These numbers also show that there is room for improvement in getting more pregnant women to test for HIV, and also if found to be positive, to ensure that ARV treatment is taken. Even though the roll out of ARV treatment and PMTCT services has been extensive, there is a need for a further scaling up of these services in order to reach all people in need of such treatment. The report also states that 21% of women who have given birth do not know their HIV status. In Namibia HIV testing is voluntary, while in countries like Swaziland it is mandatory.

Treatment

The Protocol requires state parties to ensure universal access to HIV and AIDS treatment for infected women, men, boys and girls.

The HIV and AIDS national policy provides for the access to HIV and AIDS treatment. There is a huge gender gap in terms of access to treatment this mainly received by women who go for voluntary testing and get PMTCT.



Source: UNAIDS 2010, WHO 2011, ZHDS 2010-2011.

Namibia comes fourth in providing access to PMTCT: Across the SADC region coverage ranges from 3% to around 100%, with the lowest percentages in DRC and Madagascar. In Namibia at least 90% of pregnant women living with HIV receive PMTCT.

Care work

During 25-29 May 2009, GEMSA conducted a policy audit of care work in Namibia. GEMSA aimed to evaluate current and future policy provisions for care-givers in

[7] A Report Card on Prevention of Mother-to-Child Transmission of HIV and Paediatric HIV Care and Treatment in Low- and Middle-Income Countries: Progress on scaling-up 2004-2006, Executive Summary, November 2007; Ministry of Health and Social Services (2008). *Namibia United Nations General Assembly Special Session (UNGASS) Country Report: Reporting Period April 2006 - March 2007*. Windhoek, Namibia: Ministry of Health and Social Services.

[8] World Health Organisation. (2009). *Maternal and child health in Namibia*. Second edition. Namibia: World Health Organisation. At page 26.

the country, to identify policy gaps, and to provide recommendations on how stakeholders can strengthen the care work programme.

The findings from the report contributed to a model home-based care policy for the Southern African Development Community (SADC) region.

Process

By way of background, GEMSA held two focus group meetings and a series of interviews. Researchers identified participants through desktop research and discussions with organisations involved in care work.

The first meeting brought together five community home-based care organisations, as well as larger care work groups like the Namibia Red Cross Society. GEMSA conducted separate meetings and interviews with two of the largest home-based care groups in Namibia: AIDS Care Trust and Catholic AIDS Action.

The second focus group drew five civil society organisations involved in gender and HIV and AIDS, such as the Namibia Network of AIDS Organisations (NANASO) and the International Community of Women Living with HIV and AIDS (ICW). Finally, GEMSA held interviews with the Global Fund, with three members of the Primary Health Care (PHC) Directorate (which oversees community based health care (CBHC)) in the Ministry of Health and Social Services (MoHSS), and with the permanent secretary from the Ministry of Labour and Social Welfare. Through these meetings and desktop review, GEMSA retrieved key research, policies, guidelines and commentary on care work in Namibia.

Discussions revealed that the MoHSS in Namibia has developed a new policy on CBHC released in March 2008; it provides ample support and recognition of caregivers in the country.

The new policy aimed to standardise and professionalise home-based care. Government and key stakeholders have made efforts to operationalise the policy. Some of the major challenges include resource and capacity constraints, as well as a lack of awareness of the new policy. Coordination and planning between all stakeholders on how to mobilise resources and address potential negative consequences of the programme will ensure successful and sustainable policy implementation. Table 7.3 provides an assessment of progress made so far.

Table 7.3: Progress in addressing care work in Namibia

ISSUE	RECOMMENDATION
Remuneration	Current CHBC policy calls for a monthly incentive of N$250-N$500 (roughly USD $31-62).
Logistical and material support	Namibia has been affected by the dwindling global funding basket with implications on the ability of NGOs and CBOs to continue providing remuneration and other forms of financial and logistical support for care givers.
Training and professional recognition	Under the current policy, the government has undertaken to re-train all care-givers using a standardised manual. Lobbying of Namibian Qualification Authority and Ministry of Health and Social Services for accreditation of carers is underway.
Psychological support	The CHBC policy attempts to address the psychological needs of care-givers. Ministry of Health and Social Services promotes this provision for care-givers. There is a need to link various kinds and sources of psycho-social support together, most notably community-based psycho-social support.
Gender equality	Although the policy acknowledges gender disparity in care work and encourages the involvement of men, there is regression in terms of achieving gender equality. The HIV and AIDS consortium is continuing its discussions to address this issue.

Next steps

- There is need to find innovative ways to address the gender dynamics that fuel women's vulnerability to getting infected by HIV.
- Although HIV awareness is high, traditional leaders need to be engaged to help eliminate negative traditional and cultural beliefs and practices that increase women's vulnerability to HIV and AIDS.
- IEC campaigns should effectively mainstream gender concerns to empower girls and boys on the importance of negotiating and practicing safe sexual relations.
- The Government, NGOs and churches need to increase support for the rising number of orphans.
- The government needs to broaden the focus of CHBC to address the needs and wellbeing of volunteers.
- The government needs to promote men's involvement in in care work to ease the burden of home and community based care on girls and women.