HIV/AIDS:
Who Suffers in Namibia?

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List of abbreviations

AIDS	Acquired Immunodeficiency Syndrome
HIV	Human Immunodeficiency Virus
NGOs	Non-governmental organisations
SADC	Southern African Development Community

1. Introduction

Who suffers when a household member dies from AIDS? The degree to which the household suffers depends on the household member's contribution to the household. This paper attempts to answer this question given that unlike deaths from other causes, deaths from HIV/AIDS have greater effects. A household is affected at the onset of illness and well after the death of the member. Not only does the affected household feel the impacts but also the community members. HIV/AIDS is always fatal and often results in disability and death soon after people recognise that they are ill. AIDS typically affects more than one household member and because it is stigmatised, affected people are not always in a position to access social support mechanisms (Phororo, 2000). As the various household members are affected, precautionary measures are adopted such as setting aside some income to meet possible future needs. This will affect current consumption and expenditure.

HIV/AIDS is a national problem that affects not only women or men or children or poor people or rich people or truck drivers or commercial sex workers or farmers or teachers or professionals or nurses or doctors but it affects the whole population. Even though at the end of 2001, 28.1 million people in sub-Saharan Africa were living with the virus, millions are indirectly affected by HIV/AIDS. There are few households in Namibia that can claim not to be affected by HIV/AIDS. Gone are the days of associating HIV/AIDS as a problem that is endemic to certain groups of people because it is a Namibian problem, which all the inhabitants in the country should be addressing by whatever means possible. Members of households make up communities, which make up tribes, which in turn make up ethnic groups and ultimately makes up the Namibian nation.

The effects of HIV/AIDS at the household level cannot be disassociated from the impacts at the national level, because they are interrelated since the household member is an economic and social actor. HIV/AIDS is not like any other illness since there is an incubation period of about six to eight years reflecting the time between the infection and then the onset of illness. HIV spreads silently through the population and it is only much later that the true impact of the epidemic is felt in terms of AIDS deaths. By that time, the epidemic is in full swing and since there is no cure, the only way that people leave the pool is through death (Whiteside and Sunter, 2000). The fact that the virus spreads mainly through heterosexual intercourse means that there is still an element of stigma and denial. People wonder why after several years of so many AIDS campaigns, the virus continues to spread. Several reasons can be attributed to this trend, namely that HIV/AIDS takes time to manifest therefore people that were long infected are the ones now dying, denial and people's refusal to use condoms. The effectiveness of these awareness campaigns will be evident in younger generations as the spread of the epidemic slows down.

At the household level, the effect of HIV/AIDS is immediate whereas the economic impact will only slowly manifest itself as the number of illnesses and deaths accumulate over time. Models have been run to project the economic impact of HIV/AIDS, but the figures must be observed with caution. The implications of HIV/AIDS are unclear since there is too much uncertainty concerning the data on which the projections are made and there are broad differences in the assumptions made (Whiteside and Sunter, 2000; Gregson et. al., 1998). However, these projections are useful in pointing out the need to reduce the spread of the epidemic and to plan for its impact. As with many projections, the further they go into the future, the more unreliable they become. In Sections 2, 3 and 4, the global, regional and national status of HIV/AIDS is outlined briefly, and then in Section 5, demographic projections for HIV/AIDS have been run for Namibia. In Sections 6 and 7, the impact of HIV/AIDS on the economy and the household is discussed. Even though more still needs to be done to address HIV/AIDS, the efforts of the NGOs, particularly because of their ability to access communities have been recognized. Conclusions are drawn and recommendations are posed to address HIV/AIDS in Namibia.

2. Global status of HIV/AIDS

HIV/AIDS continues to grow and affects the lives of millions and at the end of 2001, approximately 5 million people were newly infected with the virus bringing the global cumulative total of people living with HIV/AIDS to 40 million. According to UNAIDS/WHO (2001), in 2001 the total number of AIDS deaths was 3 million of which 80% were adults and 20 percent were children under the age of 15. More men (53%) than women (47%) were living with HIV/AIDS in 2001. In 2001, sub-Saharan Africa was home to 70 percent of adults and children living with HIV/AIDS and the number of new infections were 3.4 million. The sheer numbers of Africans affected by the epidemic is frightening, especially in the Southern Africa region, which is the most affected region. West Africa is relatively less affected by HIV infection but in countries such as Nigeria and Cote d'Ivoire, the rates are creeping above the 5% mark (UNAIDS/WHO, 2001). In East Africa, the prevalence rates for Uganda are dropping and this shows that a serious HIV/AIDS epidemic can be brought under control if the prevention strategy draws on strong commitment from all leaders.

3. Regional Status of HIV/AIDS

Seven of the sixteen countries in sub-Saharan Africa with more than 10% of the adult population aged 15-49 infected with HIV are in Southern Africa. At least one in five is living with the virus. These countries include Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. The region is facing different epidemics in terms of size and maturity, where at the end of 1999, Botswana had a HIV prevalence rate of 36%, Lesotho had a rate of 24% and Zamiba had a

prevalence of 20%. However, many of the countries report prevalence rates of more than 30% in certain areas. In Swaziland, HIV prevalence among pregnant women in 2000 ranged from 32.2% in urban areas to 34.5% in rural areas and in the Kwa Zulu-Natal Province, HIV prevalence was 36.2% in 2000 (UNAIDS, 2001). However, it is worth noting that there is progress with prevention programmes in the region, which are resulting in declines in HIV prevalence among some groups.

Several reasons have been advanced for the rapid spread of HIV/AIDS in Southern Africa, namely the complex historical, economic and social linkages between the countries. Labour migration has affected social and family structures as workers have moved from their countries of origin to South African mining industries. These men without their families face incredible exposure to HIV/AIDS and are extremely vulnerable as they are absent from the control of the home environment, are housed in single-sex hostels and are exposed to alcohol and substance abuse to alleviate loneliness and boredom. This can result in their involvement in multiple partner relationships, which exacerbates the spread of HIV/AIDS and when these men go back home periodically, they infect their partners (Collins and Rau, 2000).

4. Status of HIV/AIDS in Namibia

In 2000, Namibia had an HIV prevalence rate of 22.3% among pregnant women (Ministry of Health and Social Services, 2001b). HIV prevalence among pregnant women at different sites shows that the spread of the epidemic in Namibia varies, with very high prevalence rates in the north and very low ones in the northwest. There are significant variations in HIV prevalence in the regions indicating that there are four different levels of maturity of the epidemic, with the highest rates of 31% and 33% in Khomas and Caprivi. In the North Central Areas (Omusati, Oshana, Ohangwena and Oshikoto), the prevalence rates were between 21% and 28% whereas in Kunene and Hardap, the rates varied between 9% and 10% (see Table 1).

Table 1 HIV Prevalence in pregnant women per region in 2000

Region	HIV Prevalence
Caprivi	33%
Erongo	25%
Hardap	10%
Karas	17%
Kavango	16%
Khomas	31%
Kunene	7%
Ohangwena	23%
Omaheke	9%
Omusati	21%
Oshana	28%
Oshikoto	23%

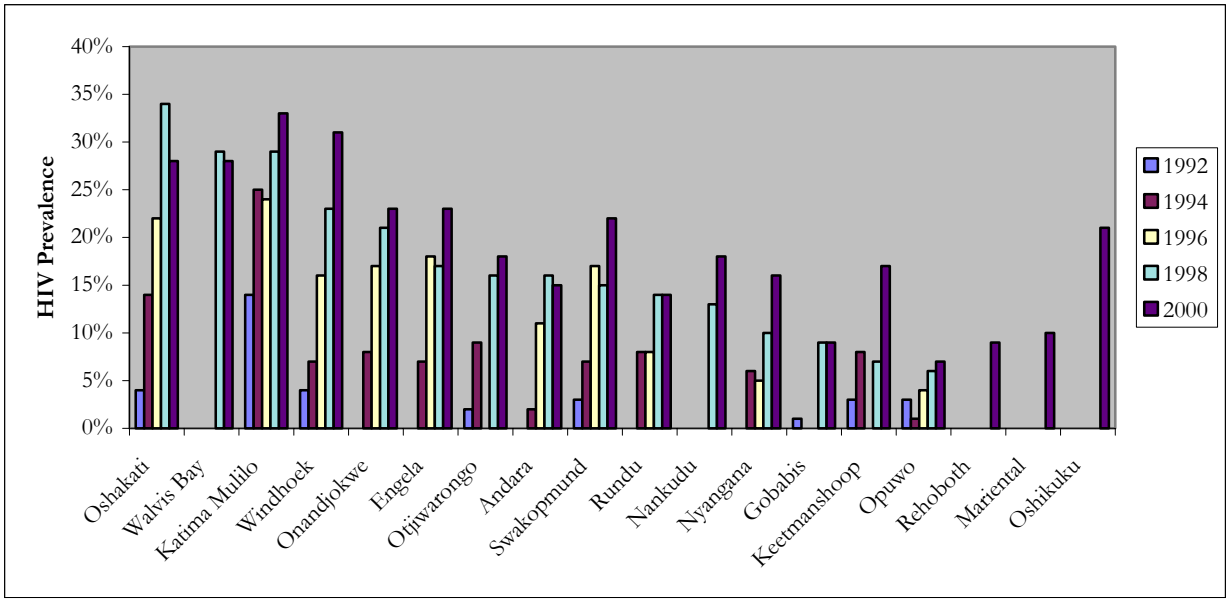
Otjozondjupa	18%
National	**22.3%**

Source: Ministry of Health and Social Services, 2001b

An issue of top priority in the regions with the highest prevalence rates will be how to curb the rapid rise in AIDS cases. If immediate prevention measures were put into place in the regions with low HIV prevalence rates, the rates might not rise to figures like 33%, as is currently witnessed in Katima Mulilo, Caprivi.

Limitations are associated with monitoring the HIV prevalence rates in women attending antenatal clinics but this is the most sustainable and cost-effective way. The prevalence is measured in pregnant women, who represent a specific age group of sexually active women and is not representative of the entire population. However, these rates from the sentinel surveys are then used to estimate the level of prevalence in adult national populations. Five sentinel surveys have been undertaken consistently since 1992 and indicate that the trend for HIV prevalence rates is increasing (Ministry of Health and Social Services, 2001b).

Figure 1: HIV Prevalence in pregnant women in Namibia (1992, 1994, 1996, 1998, 2000)



Source: Ministry of Health and Social Services, 2001b

Figure 1 above shows that the prevalence rates have steadily increased in Katima Mulilo, Windhoek, Onandjokwe, and Otjiwarongo. In Oshakati, Walvis Bay and Andara, the reported prevalence rates in 2000 were lower than in 1998. No clear reasons were provided by the Ministry of Health and Social Services for these lower rates, except to say that there were not significant differences and could be attributed to chance. However, in Oshakati a decrease in HIV prevalence from 34% in 1998 to 28% in 2000 is significant. It could be attributed to a number of reasons, such as statistical variation, people migrating from the area or the partial decentralisation of services from the hospital to clinics. The latter can be ruled out

because an additional survey was carried out at the clinics and the HIV prevalence was 27.3%, which was close to 28.4% reported at the hospitals (Ministry of Health and Social Services, 2001b).

HIV/AIDS has become a major public health problem with a total of 14,691 new cases diagnosed in 2000 and cumulative 82,887 AIDS cases were reported. This trend continues to grow, placing severe pressure on health facilities. In 2000, a reported number of 3,388 deaths from HIV/AIDS accounted for 28% of reported deaths and for 51% of the deaths in the age group of 15 to 49 year olds. In addition, HIV is an increasing cause of hospitalisation from 355 hospitalisations in 1993 to 7,368 hospitalisations in 2000 (Ministry of Health and Social Services, 2001c). Some of the hospitals have up to 50% of their beds occupied by AIDS patients. In 2000, the reported deaths and hospitalisations were very high in the North Central Areas (Oshana, Omusati, Ohangwena and Oshikoto) with 57% and 59% respectively.

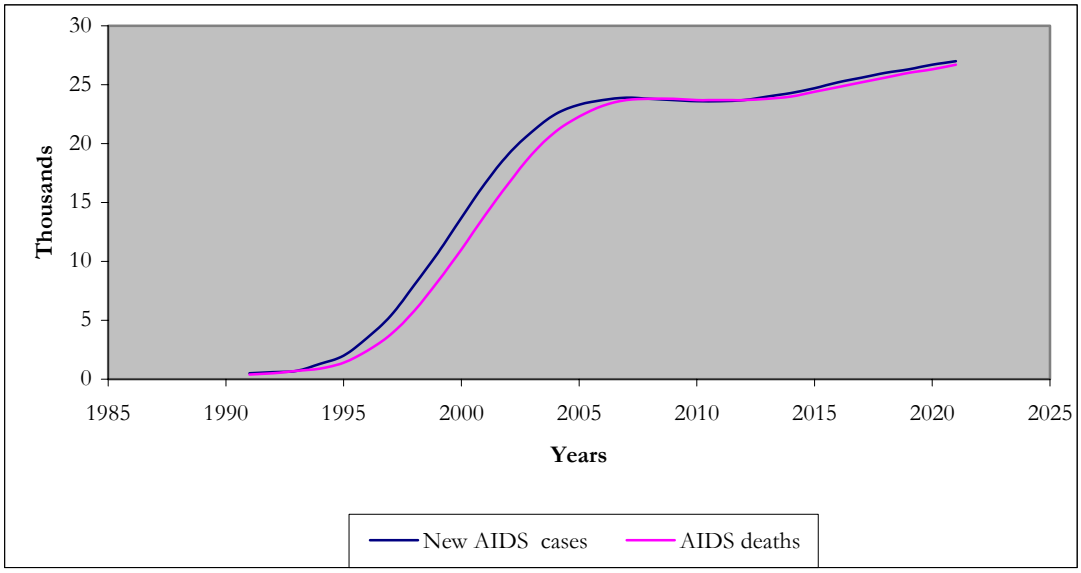
Even though at the global level, more men than women are living with HIV, women generally face a greater risk of HIV infection than men due to a number of reasons: their biological vulnerability and they usually have a lower status in society and in sexual relationships. The interplay of culture, biological and economic factors make young girls particularly vulnerable (UNAIDS/WHO, 2001). In Namibia, it is more women than men who are diagnosed with HIV. Women accounted for 56% of reported new HIV cases in 2000, an increase of 2% from the previous year. Women were also diagnosed at a younger age, the median age of diagnosis was 30 years for women and 35 years for men (Ministry of Health and Social Services, 2001c).

5. Demographic Projections of HIV/AIDS in Namibia

According to Ministry of Health and Social Services (2001a) projections, in 2007 the total new AIDS cases will climb to 23,700 from 600 in 1992. The total new cases will stabilize at around 23,000 until about 2013 and then rise to 27,000 total new cases in 2021. The AIDS deaths will follow the same trend as the new AIDS cases but at a lower level because there is a lag since people do not die immediately but within a period of 5 to 8 years. The AIDS deaths are projected to rise to 26,700 people by 2021 (see Figure 2). The adult prevalence rate is projected to rise to 23.3% in 2007 and stabilize at this level. The South African projections (Whiteside, 1998) reveal that the prevalence will rise to 21.7% in 2010, which seems to be comparable with Namibian figures. After 2013, the adult prevalence rate is projected to rise to 24%. One possible reason why after 2013, the new AIDS cases and annual deaths in Figure 2 rise is that the model does not factor in any effective interventions, such as improved access to medication and increased AIDS awareness campaigns, which might actually cause the curve to fall. It is therefore important that the model be run with the latest data on prevalence rates, population growth rates and mortality rates to examine the effect that they have on the shape of the curves. In addition, it is worth bearing in mind that this is a model and that the

further we project into the future, it becomes difficult to estimate the shape of the curve.

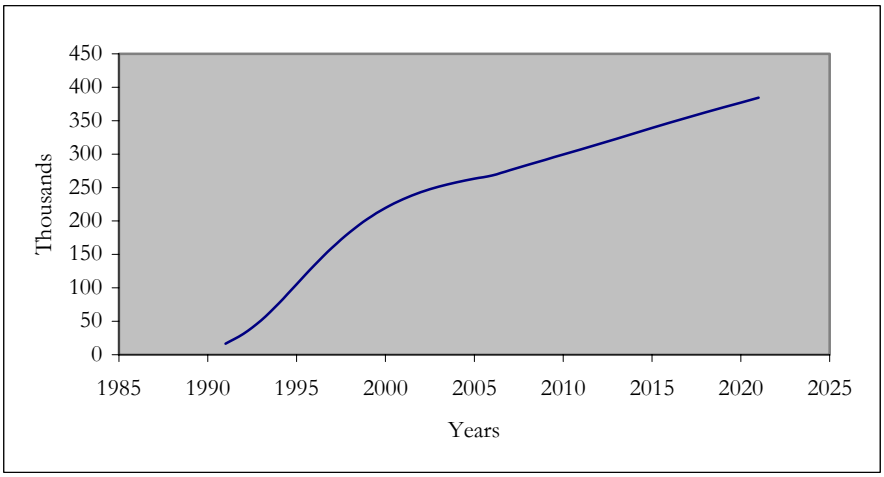
Figure 2 Projected New AIDS Cases and Annual AIDS Deaths in thousands, 1991 - 2021



Source: Ministry of Health and Social Services, 2001a

Figure 3 shows that HIV positive people are projected to rise drastically from 16,600 in 1991 to 384,300 in 2021. The projections show that in 1992, 23,200 people were HIV positive but only 2,050 positive HIV tests were actually recorded in 1992, which represented only 9% of the projected figure. This is a large discrepancy and can be partly explained by the fact that the reported cases are those who are voluntarily tested or are hospitalised but the actual number of people living with HIV, who do not know their status is much greater. It is not clear how close this figure is to the projected figure because not everyone tests for their HIV status. However, the actual HIV cases recorded and projections from the model reveal that an increasing number of people are living and will continue to live with the virus.

Figure 3 Projected HIV Prevalence in the population in thousands, 1992-



2001

Source: Ministry of Health and Social Services, 2001a

Much as these projections give an indication of the severity of the epidemic, it is worth noting that there are uncertainties inherent in compiling these projections. As new information becomes available, more work needs to be done on the modelling process.

6. Economic Impact of HIV/AIDS

The macroeconomic indicators that will be impacted by AIDS are Gross Domestic Product (GDP), savings and investments. The macroeconomic impacts of HIV/AIDS have been projected using models based on assumptions that draw on the existing information, which has deficiencies and gaps. In Namibia, no comprehensive model has been projected to determine how the macroeconomic indicators will be impacted by HIV/AIDS. Projections by Bonnel (2000), in countries such as Botswana, Lesotho, Swaziland, South Africa, Zimbabwe and Namibia with prevalence rates of 20% or greater revealed that the rate of growth of GDP would be some 2.6 percentage points less each year. At the end of a 20-year period, GDP would be 67% less than would otherwise be. More conservative is the projection provided by Over (1992) in a HIV/AIDS study for 30 sub-Saharan Africa countries. He concluded that the net effect of the HIV/AIDS epidemic is likely to be a reduction of the annual growth rate of GDP of 0.8 to 1.4 percentage points a year. The assumption that household incomes will fall as members get infected translates into lower disposable incomes and lower consumption spending.

Savings in households will decrease as more people become infected. When a household member is infected with HIV, the household experiences a shortage in income and is forced to deplete savings and/or to sell assets (Bonnel, 2000; Phororo, 2000). Precautionary savings may increase if the better-off households expect to be affected. Models projected in other countries (Quattek, 2000, Bonnel, 2000, World Bank, 2001) indicated that HIV/AIDS results in increased infections and the health status of the population worsens and reduces domestic savings by governments. The government budget will be adversely affected as expenditures increase because of more treatment and care of AIDS-related diseases, pension-payouts for AIDS-related deaths and training of newly hired employees to replace those who have died. Public savings will be adversely affected by the higher public sector borrowing requirement.

Corporate savings will suffer, as some of the higher wage bill will be financed out of the operating surplus and savings. Total domestic savings will decrease and this will result in lower investment. Companies will switch away from labour to capital-intensive means of production and this will be compensated by a reduction in the demand for residential buildings leaving overall investment low. The fall in savings will be met by an increase in foreign loans thus widening the current account deficit.

If foreign loans are not available, the higher investment demand will result in heightened upward pressure on interest rates, thus further slowing the economy (Quattek, 2000; Whiteside and Sunter, 2000).

An increase in HIV/AIDS-related illness will lead to a less productive labour force as absenteeism, sagging morale and reduced profits will result. Companies and the public service will encounter cost pressures through higher benefit payments and replacement costs. As employees bear some of the AIDS-related costs, their incomes will drop and this will result in lower expenditure. The demand for health services will increase and governments will be forced to cut services, such as child maintenance and foster parent grants or to spend more on health services at the detriment of other sectors. Rising healthcare expenditure will put pressure on households and companies. The companies will pass some of the higher costs onto consumers in the form of higher prices and will absorb some costs. Higher costs may be borne by the employee, particularly skilled and high skilled by way of lower wages and this leads to a drop in demand for services and durables (ILO, 2000; Love Life, 2000; Whiteside and Sunter, 2000).

Research has revealed that how seriously an economy will be affected by HIV/AIDS depends upon whether it is unskilled, semi-skilled and skilled labour that is infected. Several of the countries in the Southern Africa Development Community (SADC) region face a situation where there is a large pool of unskilled labour available, but labour shortages at the skilled and highly skilled level manifest. At the higher skills level, the replacement of employees who have died is more difficult than replacing labour with very few skills. For high skill, labour intensive industries it will be very costly to replace staff, whereas for low skilled industries it will be easy to find replacement labour, even at the peak of the epidemic (Whiteside and Sunter, 2000; Love Life, 2000; World Bank, 2001). An ILO (2000) study projected that in 2020 the workforce in Namibia would be 22% lower than it would have been without the AIDS crisis, even after population growth was taken into account. Namibia is already battling with a skills shortage, which will be worsened by AIDS (World Bank, 2001). The vulnerability of companies will depend on the type of businesses and production processes.

As the mortality rates increase, the incentive to invest in long-term training and schooling is reduced. High prevalence countries, such as Zambia are beginning to experience a loss of a generation of educated civil servants, teachers, health workers and professionals when skills are still in short supply (Collins and Rau, 2000). If this shortage of skills leads to higher wages for skilled labour, the return to schooling and training would increase. However, the shorter life expectancy means that the benefits of training and education can only be recovered over a shorter time horizon, which reduces the rate of return on investment in human capital. A reduction in life expectancy to 30 years makes long-term investment in human capital financially unprofitable. Rather than investing in long-term training, it would be more cost effective to have short-term and on the job training.

7. Impact of HIV/AIDS on Households and Communities

HIV/AIDS places serious stress on infected individuals and their families, who are faced with caring for the seriously ill and with the trauma of death. In addition, the economic burdens of health care and funeral costs have to be borne by the household. A more serious issue that has to be dealt with by the family is the stigma and discrimination that comes with an HIV infected person. The severity of HIV/AIDS on the household depends on what the household member contributes to the household. If the HIV infected person is a working adult, a source of income will be lost and or labour productivity may be reduced. If the sick person is a mother, the children may not be as well cared for as normal and if it is a sick child, additional demands will be placed on family members. Households with little or no access to assets and landless households who depend upon wage labour are likely to be most vulnerable to the sickness and death of a working adult unlike a household that has land or livestock that are sold regularly (White and Robinson, 2000).

Given that HIV/AIDS is always fatal and has severe consequences, the household will be affected at four different stages – at the *onset of the disease*, where there are infrequent and short bouts of illnesses and the household may start to take measures, such as setting aside a portion of income to meet possible future needs. *During the illness*, the person particularly if a working adult will become less productive and is absent from work or if working in agriculture will no longer be productive and will have to be replaced. The household will incur expenses for health care and medicines. *Immediately after death*, the major expenses will be for the funeral and adjustments will have to be made in the household. There is a *long-term impact* associated with HIV/AIDS, which may incorporate a restructuring of the household where some household members have to go and stay with relatives (World Bank, 1991).

Table 2 Economic Impact of an Adult Fatal Illness (AIDS) on the Household

Type of Economic Impact	Timing of Impact			
	Prior to HIV/AIDS	**During illness**	**Immediately after death**	**Long-term impact of death**
Production and Earnings	Organisation of economic activity	Reduced productivity of affected person Reallocation of labour	Lost output of deceased member	Reallocation of land and labour
Consumption and Investment	Insurance Preventive health care Precautionary savings Transfers to other households	Medical cost of treatment Dissavings Changes in consumption and investment Receipt of transfers	Funeral costs Receipts of transfers Payment of legal fees	Changes in type and amount of consumption and investment
Household Health and Composition	Household size Fertility	Change in allocation of time to health maintenance	Loss of member	Dissolution or reconstitution of household Migration Poor health of survivor
Psychic Costs		Disutility of ill individual	Grief of survivors	

Source: M. Over et al, 1989.

Three case studies from the Oshana region are outlined below to illustrate how various household members are affected.

Case Study 1
A child headed household comprises 4 children, who before their parent's death had 6 cattle, 14 sheep and goats, 16 chickens, cropped 5 hectares and produced just enough grain. After the death of their parents, the household had 4 cattle, since 2 were slaughtered for the funeral, 10 sheep and goats since 4 died due to poor management, only 2 hectares is cultivated and far less than what is required is produced as a result of a little manure and no fertilizer is used and very poor crop and weed management was undertaken.

Case Study 2:
A woman with 6 children is widowed when her husband dies from AIDS. There is one other adult living in the household. Before her husband's death, the family had 130 cattle, 198 sheep and goats, 28 chickens and produced more than enough grain to meet the household's annual requirements. Four hectares were cropped and some income was generated from the sale of home made bread. After her husband's death, she has no cattle and 80 sheep and goats left because her dead husband's family took them away. She is still cropping 4 hectares but only just enough grain is produced relative to the household's requirements because there is no longer any draught power and manure available. Her income generating

business has ceased to exist, since she can no longer buy flour to make the bread.

Case Study 3
A man is widowed when his wife dies from AIDS. There are four children. Before the death of his wife, the family had 55 cattle, 20 sheep and goats, more than 20 chickens, planted 2.5 hectares and more than enough grain to meet annual requirements. Only one household member is employed off-farm. After the death of his wife, the only change that the household experiences is that 5 cattle are slaughtered for the funeral (Taken from FAO, 2000).

In all three households, some adjustments had to be made. As observed, the death of an adult or adults has a dramatic impact on the family structure and function, particularly where children are left to run the household. In Case study 1, the children are unable to manage the remaining household assets and this will result in food security problems. Education ceases to be an option for these children for they cannot afford the fees and their survival is of uttermost importance. Some of the children will end up on the streets and get involved in risky behaviours, such as commercial sex work to earn an income. They become vulnerable to contracting STDs and ultimately HIV/AIDS. The issue of orphans is a serious reality and is addressed later in this section.

The impacts of HIV/AIDS are not only felt when the household member dies but from the onset of illness, as noted in Table 1 where incomes are diverted to the purchase of medication and special foods thus affecting current consumption and spending. Given that women are faced with the greatest burden of work, a HIV infected husband who ultimately dies means an additional burden is placed upon the woman. The traditional responsibilities of a woman includes producing food, collecting water, fetching firewood, caring for the family, assisting in clearing and ploughing fields and participating in income-generating activities, which must be maintained while at the same time caring for her sick husband. In many instances, the woman is also involved in community activities.

When the woman is nursing a sick husband, her involvement in these activities will decline and other family members will have to perform these tasks. Research has indicated that youth will increasingly perform work previously undertaken by men, such as ploughing and heavy duty tasks. Girls will bear the burden of caring for sick family members and household related activities (White and Robinson, 2000). The inability to afford school fees is a problem and also other tasks need to be undertaken, hence education is no longer a priority and children are withdrawn from school. The lack of education has serious implications.

The situation worsens when the household member dies, particularly where the person is a primary breadwinner. The survival of the household could be jeopardized. In Case Study 2 when the husband dies from AIDS, the household faces a loss in income and assets and the possibility that the spouse is infected. A mobile source of wealth represented by the livestock for use in the time of crop

failure is taken away and household food security is also threatened due to a loss of draught power, which implies untimely sowing and the loss of manure. The level of grains produced decreases.

Case Study 3 suggests that the impacts are less severe in the case of the loss of a wife from AIDS, however considering the multifaceted role that women play indicates that the household will be seriously affected. The same areas will be cultivated but some labour re-allocation will take place, whether labour will have to be hired, children will do more work or relatives will be asked to assist. These adjustments have certain implications, such as hiring labour involves a cash outflow, children doing more household work will spend less time on their schoolwork or in some cases will be withdrawn from school and where relatives assist, they will need to be compensated.

The impacts of HIV/AIDS are more acute for some households, such as female headed households since they are poorer than others and landless or resource poor households, who have very few options to fall back on. However, the three case studies clearly demonstrate that all household members are affected and that the status of the household worsens. The death of a household member from AIDS means that labour has to be re-allocated and this can result in a drop out from schooling and the marginalisation of other tasks. The psychic costs are often forgotten even though in the long run they could be the highest.

Not only households but also communities are affected by HIV/AIDS. As adults get sick and die, children will need to be taken care of and in many cases, the burden will fall on grandparents and other community members. Several communities that are hardest hit by HIV/AIDS are severely disadvantaged with serious poverty, poor infrastructure and little access to services. In these communities, the labour pool is reduced as adults die and this results in changes in the population structure. The number of orphans and children living in adoptive families, who do not necessarily get the attention that they need is one of the consequences of HIV/AIDS (Whiteside and Sunter, 2000; Hunter and Williamson, undated). Support from extended family, neighbours or other non-formal networks in the form of provision of labour, care of dependents and financial loans or gifts play an important role in reducing the stress associated with HIV/AIDS. Research undertaken in Kagera, Tanzania revealed that private transfers to households that experienced a death were significant and greater than assistance from government and NGO programmes (White and Robinson, 2000).

According to SIAPAC (2001), Namibia was estimated to have 90,000 orphans in 2001, of which half were orphans due to AIDS and the burden of caring for them is already falling on an already vulnerable group, the elderly who are unable to pay school fees. A national study on orphans undertaken for the Ministry of Health and Social Services and UNICEF (Steinitz, 1998) indicated that 64% of household heads mentioned that they could not afford school fees. These pressures make it difficult for the extended family to provide for itself. The Oshakati State Hospital has an

orphanage, which caters to AIDS orphans and HIV positive babies, who have no caregivers. As the pandemic progresses and the number of orphans increases, it will become increasingly difficult to cope (LeBeau et al. 1999). AIDS orphans are affected in several ways, including psychological trauma associated with the illness, loss and in some cases separation from siblings, trauma related with the death of a parent from HIV/AIDS, which is surrounded with stigma and secrecy and AIDS related poverty, which worsens the family's circumstances (LeBeau et al, 1999, Love Life, 2000; Whiteside and Sunter, 2000). According to LeBeau et al (1999), AIDS babies who are taken care of by the extended family may not get the necessary medical attention and food. Not only do these expenses drain the limited resources but also some feel that it is no point to expend so much on a child that will die from AIDS.

Organisations in the community often play a very important role in care and support for people living with AIDS. Internal migration in Namibia as a result of people moving from the northern regions to towns like Walvis Bay, Windhoek and Oranjemund in search of job opportunities means that when they get HIV infected, they go back to their villages of origin to be nursed. The burden of looking after these infected people is placed on the communities and in the long term as the scale of the epidemic increases, this may not be a viable option. The return of migrant workers to their villages when they get infected could explain the high hospitalisation and death rates (almost 60%) in the North Central Areas of Namibia. However, this relationship needs to be further examined. Community initiatives in Namibia may assist in making provisions for orphans and AIDS babies as is the case in countries, such as Tanzania. One feasible intervention is to develop community-based support systems, which will focus on the most vulnerable households, such as the establishment of micro-enterprises or community development initiatives (Collins and Rau, 2000).

It has been argued that if the number of orphans increases, the community will not be in a position to cope and therefore without parental support and supervision, these children will turn to crime. Without any role models, the crime rates could worsen and many children will be vulnerable to abuse and pressures to engage in sex work or other survival strategies that put them at high risk of infection (Love Life, 2000; Whiteside and Sunter, 2000). They are also at a greater risk of developing antisocial behaviour and of being less productive members of society.

Non-governmental organisations can play a very important role in the fight against HIV/AIDS simply because of their access and ability to reach out to communities, previous experiences with disadvantaged communities and the trust that they have established with communities (UNAIDS & UNDP, 1998). In Namibia, two main NGOs are associated with HIV/AIDS in Namibia, namely AIDS Care Trust and the Catholic AIDS Action, which are active in training, counselling and home-based care. Much as Catholic AIDS Action is active in 10 regions, it is not possible for it or AIDS Care Trust to serve all communities in Namibia. The tasks that the two major NGOs are carrying out are commendable, but there is a need for other NGOs to get

involved. Other NGOs could get involved in other areas, such as voluntary counselling and testing, peer education or income-generating activities for people living with AIDS. Churches are also beginning to see the need to get more involved in the prevention of HIV/AIDS, particularly when it comes to their ability to penetrate the rural areas. It has been observed in other countries that one of the major roles of NGOs is to effectively deliver AIDS prevention and care, particularly to marginalized groups. However, many of the projects are only implemented on a small scale that do not have effects on the overall epidemic and the activities selected are not necessarily those that have the greatest impact (Ainsworth and Toekul, 2000). Employees of these NGOs can be similarly infected by HIV/AIDS and this will affect their effective performance.

8. Conclusions and Recommendations

The answer to the question posed at the onset of the paper of who suffers when a household member dies from AIDS is that particularly women, children and the grandparents feel the direct impact, as illustrated from the case studies. HIV/AIDS takes its toll by disrupting the lives of people as it places severe stress on infected individuals and their families, who have to care for those who are ill. Since an individual can be ill for a long period of time prior to death, it emotionally and physically drains the caregivers and affects their ability to cope with their lives. The psycho-social support that they provide cannot be marginalized and ignored because in the long run if it is not available, it can pose to be one of the biggest threats to alleviating the impact of HIV/AIDS. These caregivers also require support to deal with the stress and it introduces another dimension that entails financing the coping mechanisms. Economically, the households are worse off as they have to divert funds to increasing health care and funeral costs. If we are going to succeed in the fight against HIV/AIDS, there will be a need for Namibians to recognize that HIV/AIDS is our problem and to move away from views that allude to the fact that as long as I am not HIV infected, it is not my problem.

Despite the fact that HIV/AIDS is proving to be such a great challenge, there is still hope for Namibia. Tools to prevent the spread of HIV/AIDS are in place, such as condom promotion and procurement, coordinating structures that take into account the mutli-sectoral approach and more recently, the initiative to provide drugs to prevent mother-to-child transmission. These strategies have proven to be effective in several developing countries. Evidence from Thailand has shown that if national programmes are targeted to prevent transmission among those from whom the reproductive rate is high, the spread among the whole population can be constrained (Ainsworth and Teokul, 2000).

However, leadership at all levels is still needed in Namibia in order to effectively address the spread of HIV/AIDS. The ability of leaders to lobby and advocate is crucial so that the nation can perceive high commitment levels towards the fight against the disease. The multi-sectoral approach needs to be further streamlined and strengthened (The Economist, 11-17 January 2002). The multi-sectoral

approach spearheaded by the National AIDS Coordination Programme focuses on prevention, treatment, and policies and programmes to mitigate the impact of AIDS and calls for more interventions to several constituencies on a national scale. However, there is limited capacity to act, particularly in cases where focal people are assigned in various Ministries since they are expected to do their regular job and HIV/AIDS issues is another responsibility. In cases where there is insufficient information and support, people are even more reluctant to take up HIV/AIDS issues and they do not address HIV/AIDS matters. Government efforts need to be focused on building capacity by providing people with the necessary training and skills in being able to incorporate HIV/AIDS into work plans.

There must be a political constituency for programmes to help people at the margins of society. In most cases, it is the NGOs that have tended to target these people. Governments have tended to target programmes for which there is political pressure such as safe blood supply, the provision of anti-retroviral drugs and treatment to prevent mother-to-child transmission. Such programmes have important benefits, but do not have a significant impact on the course of the epidemic fuelled by sexual transmission.

It is imperative that the government should target these high-risk groups with direct and focused programmes. However, these groups need to be identified and should not be perceived as groups which only the NGOs can target. Even though, it is government's responsibility to provide public goods, such as improved health information, STD treatment or subsidised condoms, it can work through the NGO's structures.

The Government can mitigate the impacts of HIV/AIDS by providing free schooling for orphans, paying out higher social pensions to enable grandparents to care better for AIDS orphans and to pay out higher child maintenance and foster parent grants. However, NGOs like Catholic AIDS Action in collaboration with USAID are paying out fees for AIDS orphans therefore these are not initiatives that should be left solely to Government but other partners can be involved.
The Ministry of Health and Social Services should continue to encourage other Ministries to see HIV/AIDS not as a health issue, but as a developmental problem. Other Ministries should be seen to open national HIV/AIDS workshops and launch initiatives, such as Lironga Eparu, which is a support organization for People Living With AIDS. As long as the Ministry of Health and Social Services is in the forefront, HIV/AIDS is perceived as another health issue and not as a serious problem for the economy. Political consensus among key decision-makers could remove one of the main constraints to effective programmes.

The complex issue of the relationship between HIV/AIDS and poverty needs to be addressed. Not only is more research needed to establish the link but also HIV/AIDS needs to be integrated into the poverty alleviation strategy. When the economic effects of HIV/AIDS are studied, the tendency is to focus on what should be done to assist AIDS patients and their families. It is important to determine how

households and communities are coping with the effects of HIV/AIDS and how their livelihoods are affected. It will be important to determine whether policy should be focused on those affected by AIDS, the poor in general or the poor who are affected by AIDS? There is a need to understand how existing antipoverty programmes and strategies help those affected by AIDS and then to see how AIDS can be integrated into programmes (Ainsworth and Teokul, 2000; Collins and Rau, 2000).

The availability of antiretroviral drugs is an important issue for many countries. Namibia is prepared to avail them on a pilot basis, which is a good idea since the effective administration of the drugs assumes that certain infrastructure is in place, such as an effective way of monitoring the use of these drugs, people have access to a good diet and clean water. It is important that people have access to the drugs but at the same time, there are dangers associated with the provision of such drugs if the enabling infrastructure is not in place.

Clearly, there is a need for more comprehensive and in depth studies on how the public sector, private sector and the households will be impacted by HIV/AIDS. The results need to be quantified, so that cases can be strengthened and strategies can be more focused. In order to use models to create projections of the future course of HIV/AIDS and the likely impact, reliable information is needed. Research should not be done for the sake of doing it, but it needs to be useful in providing information that can be utilized for programme design or policy development and it is essential that prior to any research being undertaken, researchers must work closely with programme planners, policy makers and advocates to ensure that the findings will be relevant to their needs. Collins and Rau (2000) have identified three main categories:

- Contextual issues – research which can help policy makers, programme planners and managers to understand and respond better to the factors that are driving the pandemic.
- Impact issues – issues that are critical to understanding effective mitigation and support programmes for affected households and communities and realistic responses from international organisations.
- Programming issues – research that can aid in the design and implementation of prevention, care and mitigation efforts.

HIV/AIDS is a serious challenge facing all households in Namibia. In order for the HIV prevalence to drop, it will need each person to take up the responsibility and to become actively involved in the fight against HIV/AIDS. It is not the responsibility of the government, NGOs or people living with AIDS, but it means that we should work together to encourage a change in sexual behaviour, to remove the denial, stigma and discrimination associated with HIV/AIDS and to instil hope for those people living with AIDS.

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