INTRODUCTION

Namibia is a vast, sparsely populated country on the South Atlantic coast of Africa, with a population of 1.6 million inhabitants. The average population density is 1.7 persons per square kilometre and it is one of the lowest in Africa. Namibia is bordered by Botswana, South Africa and Zimbabwe in the east, Angola and Zambia in the north and South Africa in the south. More than half of the population live in the northern regions of the country, a semi-tropical district with the highest rainfall. The country is mostly arid and semi-arid and a considerable part of Namibia is labelled desert. The Namib Desert is found along the coastline in the west and covers about 15% of the total landscape. The Kalahari Desert forms Namibia’s border towards Botswana and South Africa in the southeast.

Namibia gained independence from South Africa on 21 March 1990 after having been under foreign rule for more than 100 years. Since independence, Namibia has been plagued by a very high rate of unemployment and poverty mostly attributed to the return of the country’s more than 90,000 refugees from Angola, Zambia, Tanzania and Botswana.

HIV/AIDS IN NAMIBIA: AN OVERVIEW

HIV/AIDS, the killer disease, is rampantly spreading its death trail in most Namibian villages and cities at night. The worst hit age category is between 15 and 40 years, the country’s most sexually and economically active population group. Only recently, the Minister of Health and Social Services coined the phrase that in Namibia “the victim is unfortunately the active at work who is incidentally also the active in bed”. She said that unless there is substantial change in sexual behaviours, the epidemic impact of the disease on the economically active population group will cripple production and the country will rank as one of the highest afflicted nations on earth.

Although the first four cases of AIDS were identified in 1986, more than half of the reported 21,737 infections were reported in the period 1996-1997 alone. Approximately 3,500 of these reported infections involved full-blown AIDS cases. According to sentinel data collected by the Ministry of Health and Social Services from antenatal clinic patients at selected sites, there was a rapid progression of the epidemic during the last half of the 1990’s. The present number of cases is based on diagnostic tests for clinical reasons, screening of voluntary blood donors, voluntary testing for insurance companies and for people applying for external training scholarships. Therefore, these figures may not represent the total picture of the epidemic in Namibia.

The breakdown of these cases by region, age and gender shows the following trend:
1. The regions in the northern part of Namibia (Caprivi, Kavango, and Ovamboland) constitute 51.7% of all reported HIV infections and AIDS cases. The southern part of the country has the least reported cases of 12%;
2. A total of 54% of the reported cases are male compared to 44% who are female;
3. Most of the reported cases (69%) fall within the sexually active and economically active age group of 15-40 years;
4. The most afflicted region is the Caprivi with the peak age group affected being between 20 and 24 years (NACP Report July 1997).
The report also indicated that the principal cause of death in hospitals for the ages of 5 years and older in Namibia is HIV/AIDS. While factors directly attributed to the rampant spread of AIDS in Namibia are said to be manifold, the following sources are perceived to constitute its main death-trap: (i) prostitution involving tourists; (ii) border migration patterns along the newly constructed Trans-Kalahari and Trans-Caprivi highways; (iii) sexual ignorance due to high rate of illiteracy; (iv) lack of public awareness campaigns through media; (v) alcohol abuse; (vi) cultural aversion towards the use of condoms, cultural taboo on open discussion of sex and the resultant adolescent ignorance about human sexuality; (vii) increasing incidence of child rape; (viii) the subordinate social and economic status of women; and (ix) the traditional healing practice involving the use of unsterile cutting instruments (for example, circumcision).

In this chapter, we used data collected through field interviews, official statements and research statistics to investigate and analyze the relationship between alcoholism, rape and sexual defilement of young people and the spread of HIV/AIDS in Namibia.

**OUR FINDINGS**

Since independence, the rush through the metropolitan districts sometimes led to unfulfilled dreams and expectations for many young rural dwellers. Failure to find employment in the city forced them into squatter areas where they live in squalid conditions. Out of frustration women resorted to prostitution and begging while the men mainly resorted to the bottle, crime and drugs. Today, prostitution, substance abuse and mugging are common features of life in the country. The situation is even more exacerbated by the absence of stringent regulations against petty crime. Namibia’s social control agents (such as the courts, police, peers, church, politicians, parliamentarians) seem to lack the will to combat under-age drinking, mugging and prostitution.

The intervention of local breweries in sports through sponsorship seems to contribute to under-age drinking. Castle Brewery’s sponsorship of the national soccer team provides the company with access to the youthful population who consume cans of Castle beer during soccer matches. Zeenao Hoveka, the Deputy Director in the Ministry of Youth and Sports, said:

“The impact of alcohol advertisement during these games is negative and is directly linked to the heart of other social ills such as teen pregnancy, drugs, deviants and the spread of AIDS. We cannot afford to isolate the AIDS epidemic from all other sources of social degradation. Unfortunately, everyone of the big shots in the brewery business is chasing profits at all costs and at the expense of society”.

(Personal interview on 17 August 1998).

Local experts are convinced that the spread of HIV/AIDS in Namibia is relatively faster in higher alcohol consuming regions. For example, A.K. Mwilima, the Acting Medical Superintendent in the Caprivi region, believes that the increasing number of rape occurs under the influence of alcohol. Similarly, police spokesperson Ratjindua Tjivikua said that most incidences of rape involving the youth are committed under the influence of intoxicating substance. Therefore, more resources should be committed to social awareness campaigns in Namibia. The same call was made by Libertine Amathila, the Minister of Health and Social Services in an interview on 28 August 1998. The Minister also told a press conference held in Windhoek on 7 November 1997 that, in the face of the astoundingly high HIV/AIDS rates, Namibia must double her efforts to make AIDS prevention information accessible to everyone through campaigns.

Furthermore, a survey initiated by the Namibian Network of AIDS Service Organizations (NANASO) on knowledge, attitudes and sexual practice among the youth showed that approximately 80% of young Namibians are aware of the HIV/AIDS transmission. But,
despite this high level of awareness, the latest figures indicate that the epidemic continues to double every two years. These figures prompted the Deputy Minister of Health and Social Services, Zedekia Mujoro, to remark:

“It seems as if at this stage, the correlation between HIV/AIDS awareness and behaviour change is weak. That is precisely why I propagate an intensification of our prevention efforts and at the same time challenging all of us to come up with indigenous, innovative and efficient approaches to get our people to act on this high level of awareness. Approaches that will strengthen the correlation between knowledge and behaviour change.”

(Telephone interview on 26 August 1998).

The epidemiological report published by National AIDS Control Program (NACP) in 1998 under the title “Let’s Crash AIDS” contains devastating statistics. It summarizes the total number of deaths due to AIDS, hospitalization due to AIDS and rate of infection detected during pregnancy. The data indicates that in 1997 a total of 11,608 new HIV infections were added to the list of the Laboratory Services of the Ministry of Health and Social Services (MOHSS). This was a slight increase compared to the 10,576 infections reported for 1996. However, this is a substantial increase if compared to the 4,045 reported in 1992.

The rate of HIV-related hospitalization had also increased in the same period. According to the report, this represents “an important indicator of the increasing workload, costs and an overall burden on the health service of Namibia”. In 1997, a total of 3,908 persons were hospitalized for this condition, compared with the 2,620 who were hospitalized in 1996. The data also show that the total reported number of deaths in hospital due to AIDS in 1997 had also surpassed that reported for both 1996 and 1992. However, these figures do not include deaths which occurred at home or in private hospitals. On the basis of ongoing survey results, the MOHSS estimates that there is a total number of 150,000 persons living with HIV/AIDS in Namibia.

Keneth Abraham, a private medical practitioner, said the picture painted by these statistics is alarming. He warned that the present government policy on AIDS is inadequate to “crash” it. According to him, the information campaigns conducted by the Ministry of Health and Social Services should not focus on the use of condoms alone. He said:

“The AIDS awareness campaigns should not de-emphasize extraneous and intervening factors such as alcoholism, drugs, homelessness and unemployment in society. They remain the causal incentives to unprotected sexual behaviours. The information campaigners should not treat some causes as less causal. They all lead to death”. (Personal interview on 28 August 1998).

Similar views were expressed by Andreas Oberholzer, the Windhoek Medical Superintendent (interviewed on 20 August 1998), who said that the use of substance normally lowers the rationale of the addict and thereby his defence against rape or unsafe sex.

Abner Goagub, the Director of NACP, disagrees. According to him, there is a genuine need for concern. But he does not think that it is right to raise the alarm bell because of the 1997 epidemiological report. There are more reported cases today because of improved diagnostic methods, openness and willingness to be tested. For example, the support and compassion that Sara Kamapoha, a very attractive and courageous young woman, received when she declared that she was HIV-positive, has helped to reduce the stigma attached to HIV/AIDS in Namibia. Sara went on to demystify HIV/AIDS in a television documentary funded by the United States Information Agency in 1998. She courageously declared that, although the HIV stigma is not easy to live with, she had become more comfortable and at peace with herself for “going public”. An HIV patient at Katutura Hospital who preferred anonymity said, “She represents Namibia’s resistance against the killer disease and also the role model for many of us.” (interviewed on 12 August 1998).
She also accused the Namibian Broadcasting Corporation (NBC) of lack of commitment to the cause of AIDS. She said:

“If I had the information that I have today about the right to say no to sex or to use the condom, I would have been a healthy person with a future. If there is a war that the NBC should highlight, it should be the one against AIDS inside our own borders but not the one in Congo. We are slowly dying from AIDS. Without information, more people will die just like me. There are still many people out there who are ignorant like I was when I got infected”.

The problem of alcohol among the youth is also confirmed by Pohamba Shifeta, the President of the National Youth Council, who said that five out of 10 young people between the age of 16 and 25 are alcohol addicts (interviewed on 27 August 1998). He agreed that high unemployment rate in Namibia often leads the youth to commit street crimes such as pick-pocketing and mugging.

National policy on HIV/AIDS

Namibia’s response to the AIDS epidemic won the highest political endorsement when President Sam Nujoma personally launched the National AIDS Control Programme on 4 July 1990. The national policy is based on two key plans:

Short-term plan
The implementation of a strategy whose development mainly evolved from the following Global AIDS Strategies of the World Health Organization:

1. the setting up of a sound management structure for the programme;
2. the appointment and training of regional administrators;
3. the development of regional testing sites;
4. the training of counsellors and health workers;
5. the promotion of AIDS education in schools; and
6. the conducting of a baseline information survey on AIDS.

Long-term plan
It is a comprehensive five-year plan that is currently being implemented to achieve the following objectives:

i. the prevention of HIV transmission;
ii. the reduction of the social impact of HIV infection;
iii. improved counselling skills;
iv. advocating community-based home care;
v. improved epidemiological surveillance; and
vi. provision of safe blood.

Previous campaigns

Although national campaigns against HIV/AIDS started immediately after independence, the year 1996 heralded joint activities aimed at AIDS prevention by institutions such as the Ministry of Basic Education, Ministry of Youth and Sports, NANASO, University of Namibia, Polytechnic, Ministry of Broadcasting and Information, Juvenile Justice Programme and UNICEF. It was also realized that since MOHSS campaigns were mostly carried out on an ad hoc basis, there was no sustainability despite the huge amount of donor funds allocated for that purpose. For example, an Independent Review Team concluded that the Information, Education and Communication (IEC) programme run by the NACP for the Ministry was a complete failure and that the materials they produced were sometimes inappropriate. In response to why the IEC programme was not successful, the team was informed that the funds were in fact not for material development.

The UNAIDS initiative was also launched in Namibia as a joint effort by country representatives of all the United Nations agencies to assist national efforts. Its strategies were information collection, analysis and exchange. These included the sharing of information on HIV/AIDS activities in Namibia prevention, care and research. The UNAIDS campaign,

which was part of a major global programme focused on advocacy and promotion of political commitment and multi-sectoral involvement in combating the AIDS epidemic in Namibia.

As part of the information collection function, a long-term study was commissioned for the period 1996-2000 to investigate the impact of HIV/AIDS on the Namibian economy. Preliminary results indicated that the Namibian government would need US$100 million for that period to meet all the expenditure on HIV/AIDS prevention.

**CONCLUSION**

While there are possibly many other ad hoc findings that could be derived from this report, the major conclusions are the following:

1. The in-depth interviews confirmed that there is an alarming high rate of alcohol consumption among the youth that increases the likelihood of rape and unprotected sexual intercourse.
2. There is a general sense of apathy and hopelessness as a result of poverty and unemployment which motivate the youth to find consolation in alcohol.
3. There is a general feeling that most national information campaigns against HIV/AIDS are not sustained and, therefore, do not always achieve the desired effects.
4. Despite an increasing social awareness, the official statistics show an unabated increase of AIDS in Namibia, particularly in the Northwestern and Northeastern regions.

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