IMPACT OF HIV/AIDS ON THE UNIVERSITY OF NAMIBIA

AND THE

UNIVERSITY'S RESPONSE

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ABBREVIATIONS

DFID	UK Department for International Development
GRN	Government of the Republic of Namibia
GDP	Gross Domestic Product
IPDC	International Programme for the Development of Communication
NGO	Non-governmental organisation
PLWHA	People living with HIV or AIDS
SADC	Southern African Development Community
SRC	Students' Representative Council
STD	Sexually transmitted diseases
MECC	Mountain Empire Community College
MRCC	Multi-disciplinary Research Centre and Consultancy
NANASO	Namibia National Students' Organisation
NERA	Namibia Educational Research Association
NIED	National Institute for Educational Development
NGO	Non-Governmental Organisations
PWA	Parents with AIDS
TB	Tuberculosis
UK	United Kingdom
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNAM	University of Namibia
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Cultural and Scientific Organisation
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Heath Organisation
YHDP	Youth Health Development Programme

EXECUTIVE SUMMARY

This report examines the impact of HIV/AIDS on the University of Namibia Community as well as its response to this impact. It starts with a brief description of history of Namibia; as well as the situation of HIV/AIDS in the country. It also briefly describes the University of Namibia - - its mission, challenges, and vision, programme, as well as enrolment figures of students, and numbers of academic and administrative staff.

The situation of the HIV/AIDS in Namibia is described, and the indication is that Namibia, like sister SADC countries has been truly hit by the pandemic. Statistics for the University of deaths among staff and students are provided, as is the information relating to the situation of absences due to prolonged illness. The general observation is that, though there may be few deaths to dat, the full impact of the general HIV/AIDS situation might hit the University harder in a few years to come.

The university's range of responses are provided, including advocacy, training, and research, as well as numerous programmes set in motion involving students and staff.

In terms of reflections the report advocates the need for visible leadership from above (university administration) and resonance from below (the whole university community). Several areas also need attention such as the need fore more coordinated research; the need for more university-wide workshops on HIV/AIDS, and the need for inter-faculty; inter-institutional, national and regional networking.

The report ends on a hopeful note that individually and severally, our effort should end in the defeat of the HIV/AIDS pandemic, releasing all our creative energies for more developmentally economically oriented activities.

INTRODUCTION

The dangers of HIV/AIDS to all peoples around the world, but particularly to people in Africa are now a matter of public record. So are the dangers posed to institutions such as Universities which are vulnerable to many adverse effects of HIV/AIDS. In recognition of this situation the Working Group on Higher Education (WGHE) of the Association of the Development of Education in Africa (ADEA) decided to undertaken case studies on the way HIV/AIDS affects some individual universities in Africa, and to document the responses and coping mechanisms that these institutions have developed. The purpose of the studies was described as to generate understanding of the way that HIV/AIDS is affecting universities and to identify responses of staff, students, and management that might profitably be shared with sister institutions in similar circumstances.

The universities selected for the case studies include the following:

(i) Jomo Kenyatta University of Agriculture and Technology
(ii) University of Nairobi;
(iii) University of Zambia;
(iv) University of Namibia;
(v) University of Ghana;
(vi) University of the Western Cape;
(vii) University of Benin (Cotonou);
(vii) Universite d'Abobo Adjame (RCI).

The terms of reference were inter alia to respond to the following questions:

1. In what ways have the universities concerned been affected by HIV/AIDS?
2. How have the universities reached to these impacts?
3. What steps are the universities taking to control and limit the further spread of the disease on their campuses?
4. What HIV/AIDS-related teaching, research, publication and advisory services have the universities undertaken?
5. How do the universities propose to anticipate and address the larger impact of HIV/AIDS on the national labour market for university graduates?

The Coordinator for the Working Group on Higher Education (WGHE) provided guidelines on what information should be collected as well as the format of the final report which would include the following sections:

Executive Summary
HIV/AIDS: Country situation
Short summary description of the university and its programmes
The HIV/AIDS situation in the University
The Impact of HIV/AIDS on the University
The Response of the University community to HIV/AIDS
The Integration of HIV/AIDS into the University's teaching, research and advisory/consultancy activities, and into its institutional or strategic planning.
Summary reflections: Examples of good practice, lessons learned, etc.

We briefly refer to the collection of data, and constraints experienced, in undertaking the assignment.

Collection of data

A questionnaire on impact of HIV/AIDS at UNAM and UNAM'S response was developed, using the five questions of the guidelines to this research project as outlined above.

This questionnaire was sent to all academic and administrative staff, including the top administration of the University. Of the over four hundred questionnaires sent out, only four returns were received, for what ever the reason! Apathy? Perhaps! Of the four academics who responded, there was a clear indication that they did not know what the university was doing in this area. This exercise was followed by individual visits to identified persons suggested in the guidelines.

Procedures followed in the investigation included interviews with or obtaining verbal or written information from a cross-section of the University Community, including information from the following offices:

1. The Vice Chancellor's Office
2. The Offices of the Pro Vice Chancellors for Academic Affairs & Research and Administration & Finance;
3. The Registrar's Office
4. The Dean of Student's Office
5. The Office of the Head of Auxiliary Services
6. The Residential Director
7. The University Counsellor, Social Worker and University Nurse
8. The Student Representative Council (SRC)
9. Bursar's Department
10. Personnel Office
11. The Chaplaincy
12. Faculty Officers
13. Department of Social Work and Administration

14. Members of academic and non-academic staff who were willing to provide information and/or statistics.

People consulted outside the University included the Deputy Permanent Secretary of the Ministry of Health and Social Services and the Head of the Epidemiological Unit of the Same Ministry. Contact was also made with the Coordinator Catholic AIDS Action Group.

Some documents were also consulted, particularly the documents on national statistics and the various rich documentation available in the UNAIDS, UNICEF, UNDP, and other United Nations Agencies, as well as Government of Namibia documents. In addition various research reports on HIV/AIDS, and related issues were examined. Advantage was also taken to gather additional information from the Workshop on HIV/AIDS for tertiary institutions in Namibia which took place October 9th - 11th, 2000. The report of that workshop, which will be available

later, should provide additional information, and insights, particularly relating to what kinds of collaboration is possible and feasible in tertiary institutions in Namibia in tackling the HIV/AIDS pandemic. It should also provide additional information on the kinds of research that should be conducted.

Constraints (limitations)

The collection of data and the preparation of the report encountered a number of constraints. The first and most significant constraint has been the **timing** and **time** available for the study. Although the investigation had the full backing of the Vice Chancellor and the Administration, getting responses to a questionnaire prepared for distribution to all staff, as already described above, and gaining access to informants and relevant information proved a little difficult and frustrating.

A significant proportion of teaching staff are white Namibians or whites from other countries. They tended to express reluctance to engage in discussion on the issue of HIV/AIDS, pressumably in the belief that HV/AIDS is not a white person's problem or "It is not my business to pry into students' private and social life; my job stops at teaching in the classroom". For others who were genuinely interested the comment was that they do not have much social contact with students outside the classroom, since all academic staff live off-campus, a tradition adopted from South African practices. A large proportion of non-Namibian staff come from other parts of Africa, mainly from Tanzania, Zambia, and Zimbabwe. At the time of this study an Affirmative Action policy had been announced for implementation on campus, thus exacerbating the xenophobic climate which had been building on campus for some time. Those who were reluctant to contribute to discussion simply stated "I am not a Namibian; go and ask Namibians; this is their university!"

It was not possible to interview the lower category of workers at UNAM (workers in the Kitchen, in the Estates Department, and other sections) mainly due to linguistic difficulties (the majority speak their local language and/or Afrikaans, which the investigator does not know!)

Despite these constraints it is felt that sufficient feedback was received to justify the preparation of this report. It is hoped that it contains information which can be shared on a reciprocal basis with other institutions participating in the **case study project** as well as other African Universities to our mutual benefit.

HIV/AIDS: COUNTRY SITUATION

This section briefly describes the HIV/AIDS country situation. However, it is helpful to produce a brief description of Namibia, before the country situation of HIV/AIDS is provided.

Background on Namibia

Namibia is a vast, predominantly arid country in southern Africa with a population of 1.7 million - mostly concentrated in the wetter far north. More than 70 percent of the population lives in the rural area. After initial colonization by the Germans in the late 19th century, the country was run as a province of South Africa for 70 years. After a long and bitter liberation struggle, the country gained its independence in 1990 with the governing party being SWAPO. Like South Africa, Namibia has about then different cultural groups - predominantly black, but with a significant white settler population. The official language is English, with Afrikaans remaining the main language in most of the country. (Lithete, 2000).

Economically it is indicated that the Gross Domestic Product (GDP) estimated at N$15,115 million (US$3285 million) in 1997 provides a per capita income of N$8 921 (or US$1939) which by world standards would qualify it as a “middle income” country. Independent Namibia inherited one of the most dualistic economies in the world, with the most affluent 10% of the society receiving 65% of income, and conversely, the remaining 90% receiving 35% of the national income (Namibia Human Development Report, 1997, p. 3).

The Government realised that the Namibian economy is small in size, extremely open and characterized by considerable reliance on the production of primary commodities for export. The economy is also dualistic in nature with a modern sector co-existing hand in hand with a subsistence component. A large portion of the Namibia population has been living under subsistence conditions with their active participation conficed to seasonal labour supply. At independence the Government of the Republic of Namibia, in view of unlimited and competing demands on limited resources, identified the following priority sectors:

- Education
- Health
- Housing
- Agriculture.

Therefore Government resources devoted to these sectors continued to account for an increasing share of Government expenditure. The first three sectors constitute part of the overall social sectors and the conviction of Government is that in order to address burning questions of employment generation, poverty reduction and reduction of inequalities in terms of income distribution to ensure quality of the overall living standard, the best way to go was to empower the previously disadvantaged citizens of the country by improving their skills. Provision was also made to ensure that access to both housing and health facilities, was improved.

As the Government was busy addressing the four priorities, almost out of nowhere, a new threat -- a threat which is threatening to wipe out all the benefits of development efforts since independence -- HIV/AIDS. We turn to a description of this pandemic in the next paragraphs.

HIV/AIDS in Namibia

Two special reports of 1997 and 1998 special produced by UNDP document vividly the impact of HIV and AIDS in Namibia, as well as environment and human development. The epidemiological report on HIV/AIDS for the year 1999 adds the latest figures of rates of infection to this grim picture.

The first 4 case of HIV infection were detected in Namibia in 1986. Since then the spread of the virus has occurred at an impressive rate, with now over 30 000 cases of HIV infections. As of the end of December 1993 a cumulative number of 6.562 cases has been reported on NACP, including the 2.517 detected this year (representing an increase 22.8% over the previous year). Though imprecise and rather rough, this indicator documents a consistent number of individuals in the country being already infected and therefore at risk of developing AIDS within the next coming years. It also sows a worsening trend, with increasing figures being recorded each year. There is not accurate data on the true magnitude of fully developed AIDS; the NACP is actively working to implement a surveillance system enabling the collection of appropriate data and information.

* AIDS has become the leading cause of death in Namibian in less than ten years;
* There could be over 108 000 Namibians living with HIV today;
* The epidemic is escalating at an alarming pace. Nearly 80% of all HIV cases have been recorded in the last two years alone;
* Thirty infections occur each day in Namibia; eight are among children;
* Reported HIV infections in the North West Health Directorate have increased eight-fold since 1992;
* Assuming the epidemic continues to spread at its current rate, projections indicate that the number of people with HIV could rise to over 400 000 by the year 2000.

Namibia ranks as one of the three countries most-affected by HIV/AIDS in the world with an overall prevalence of 20% among sexually active adults (see table one). This means that one in five Namibians aged 15-49 is infected and like to die within the next seven years. Over 11 600 new cases of HIV infections were reported in 1997, bringing the total number of cases reported to almost 50 000. Recognising that reported cases are by far the minority of those that actually occur, both the Ministry of Health and Social Services and UNAIDS/WHO estimate that the actual number of Namibians living with HIV/AIDS exceeds 150 000 out of a population of 1.6 million. AIDS has already caused life expectancy at birth in Namibia to fall from 58.8 years in 1995 to 55.8 in 1998 (see chart 1). When costs associated with the rapidly increasing burden of medical care are added to the cost years of productive economic life forgone, the financial burden of the epidemic is staggering. It is estimated that the indirect costs of HIV/AIDS added to the direct costs of medical care will mean a loss of over N$8 billion to the Namibian economy by the year 2001 which is an equivalent of 20% of the GDP.

The seven countries with the highest HIV prevalence globally in adults 15-49, end 1999

COUNTRIES	PERCENTAGE
Botswana	35.80
Swaziland	25.25
Zimbabwe	25.06
Lesotho	23.57
Zambia	19.95
South Africa	19.94
Namibia	19.54

UNAIDS, Report on the global HIV/AIDS epidemic, June 2000

Chart 1: UNDP life expectancy and ranking in the human development index

	1996		1997		1998		1999	
	Life expectancy (years)	HDI rank	Life expectancy (years)	HDI rank	Life expectancy (years)	HDI rank	Life expectancy (years)	HDI rank
Botswana	65	71	52	97	52	97	47	122
South Africa	63	100	64	90	64	89	55	101
Swaziland	58	110	58	114	59	115	60	113
Namibia	59	116	56	118	56	107	52	115
Zimbabwe	53	124	49	129	49	130	44	130
Kenya	56	128	54	134	54	137	52	136
Zambia	49	136	43	143	43	146	40	151
Malawi	46	157	41	161	41	161	39	159

United Nations, Human Development Reports, OUP, New York 1996, 1997, and 1998.

The epidemiological report for 1999 briefly refers to Positive HIV tests; hospitalisations for HIV disease, deaths from HIV/AIDS, blood donors, HIV prevalence in pregnant women. HIV prevalence in STD patients and condom distribution and reported STD cases. We briefly refer to each of these.

Positive HIV tests

In 1999 a total of 14,886 new HIV infections were reported by the Laboratory Services of the MOHSS. This is an increase of about 2,100 as compared to the 12,701 new infections reported in 1998. This brings the total number of HIV positive diagnoses to 68,196 by the end of 1999.

A higher number of women than men were diagnosed with HIV in 1999. Women account for 54% of all reported new HIV cases. Women are also diagnosed at a younger age: the median age

of HIV diagnoses is 30 years for women and 35 years for men.

Hospitalisations for HIV disease

This is an important indicator for the workload in hospitals as well as the overall burden on health services due to HIV diseases. In 1999, a total number of 6,878 persons were hospitalised for HIV/AIDS. This is a continued increase as compared to the 1998 figure of 5,155 hospitalisations.

Deaths from HIV/AIDS

The total reported number of deaths in Hospitals due to AIDS in 1999 was 2,823. This brings the total number of reported deaths due to HIV/AIDS to 8,679 since the beginning of the epidemic.

The number of reported deaths in the age group 15-49 years continues to increase and now accounts for 47% of all deaths in hospitals.

Underreporting of deaths due to HIV/AIDS is thought to be common, due to logistical constraints, reluctance by patients to be tested for HIV, and underreporting of HIV/AIDS as an underlying cause of death.

The age distribution of deaths from tubercolosis, pneumonia and diarrhoea suggests that HIV is an underlying cause in many of these cases (see figure 7).

Blood donors

In 1999, only 0.9% of blood donors were found to be HIV seropositive. This is a further decline as compared to the HIV prevalence of 1.6% in 1998. The HIV prevalence among blood donors is much lower than the estimated HIV prevalence among the general population because of the selection by the Namibian Blood Transfusion Services of low risk and regular voluntary donors. HIV prevalence was 0.2% among regular blood donors and 3.6% among first time donors.

HIV prevalence in pregnant women

Every two years, an anonymous unlinked survey is conducted among pregnant women gives the most reliable information on the HIV epidemic. Results of the 1998 indicate that the highest prevalence was observed in the urban areas of Oshakati (34%) Walvisbay (29%) Katima Mulilo (29%) and Windhoek (23%). HIV prevalence is also high in rural sites close to main roads, such as Onandjokwe (21%) Engela (175) and Andara (16%). In some rural sites and districts, HIV prevalence is still relatively low: Gobabis 9%, Keetmanshoop 7% and Opuwo 6%. Of all acceptable samples, 495 samples or 17.4% tested positive for HIV.

Comparison with previous surveys shows that the HIV prevalence is still increasing in most sites.

HIV prevalence in STD patients

HIV prevalence in STD patients ranged in 1998 from 61% in Katima Mulilo to 10% in Opuwo. Of all 1,780 samples, 686 or 38.5% were HIV positive. There was no difference in overall HIV prevalence in male and female STD patients. Female STD patients, however, are infected at an earlier age. For example HIV prevalence in the age group 15-19 years was 24% in female and 5% in male patients.

Condom distribution and reported STD cases

Condom distribution figures and reported STD cases are useful indicators to monitor behavioural change. The number of free condoms distributed by the Government increased from 8.7 million in 1998 to 14.1 in 1999.

The total number of reported STD cases declined from 76,500 in 1998 to 73,100 in 1999. The decline in STD cases is most consistent for urethral discharge cases, which declined from 36,900 in 1995 to 22,800 in 1999.

TABLE 1: HIV/AIDS IN NAMIBIA:
INFECTIONS, HOSPITALISATIONS AND DEATHS FROM 1988 TO 1999

	'86-'92	1993	1994	1995	1996	1997	1998	1999	Total
Positive HIV Tests by Health Directorate									
Northwest				2243	3322	4045	4779	5918	
Northeast				872	985	997	958	785	
Central				985	1567	1651	1939	2024	
South				416	907	1076	1309	1739	
Windhoek				3241	3795	3839	3716	4400	
Total	4045	2517	4126	7757	10576	11608	12701	14866	68196
Hospitalisations by Health Directorate									
Northwest	156	140	215	782	1402	1842	2725	3948	11210
Northeast	157	153	108	545	423	634	724	614	3358
Central	28	31	46	101	155	340	459	594	1754
South*	72	31	83	56	135	212	333	410	1332
Windhoek (hospitals)				342	505	880	914	1312	3953
Total	**413**	**355**	**452**	**1826**	**2620**	**3908**	**5155**	**6878**	**21607**
Deaths by Health Directorate									
Northwest	52	43	108	258	563	828	1175	1652	4679
Northeast	17	25	76	200	251	243	365	319	1496
Central	8	12	12	41	51	110	198	241	673
South*	9	12	11	31	95	106	152	192	673
Windhoek (hospitals)				98	165	252	289	419	1223
Total	**86**	**92**	**207**	**628**	**1125**	**1539**	**2179**	**2823**	**8679**
HIV Infection in Blood Donors									
HIV positive donors	0.6%	0.9%	0.9%	1.3%	1.6%	1.7%	1.6%	0.9%	
HIV Infection in Pregnant Women									
Oshakati	4%		14%		22%		34%		
Walsvisbay							29%		
Katima Mulilo	14%		25%		24%	26%	29%		
Windhoek	4%		7%		16%		23%		
Onandjokwe			8%		17%		21%		
Engela			7%		18%		17%		
Otjiwarongo	2%		9%				16%		
Andara			2%		11%	17%	16%		
Swakopmund	3%		7%		17%		15%		
Rundu			8%		8%	18%	14%		
Nankudu							13%		
Nyangana			6%		5%	7%	10%		
Gobabis	1%						9%		
Keetmanshoop	3%		8%				7%		
Opuwo	3%		1%		4%		6%		
Namibia	**4.2%**		**8.4%**		**15.4%**		**17.4%**		

* Windhoek Specialised Services included in South Health Directorate up to 1994.

One may ask what has been the Government's response tot he HIV/AIDS pandemic. We turn briefly to describe the expanded national response to HIV/AIDS.

EXPANDED NATIONAL RESPONSE TO HIV/AIDS

Background

The human immunodeficiency virus (HIV)/acquired immunodeficiency syndromE (AIDS) has affected all countries throughout the world. In some countries AIDS has become the major cause of morbidity and mortality. HIV infection can be prevented. So far there is no cure for AIDS. AIDS kills very slowly and quite inevitably, incapacitates the victim. The consequences of HIV infection are loss of economic productivity and income, social liability, loss of a family member and an emergence of an army of orphans.

The first cases of HIV infection in Namibia was recorded in 1986. Ever since, the number of HIV/AIDS cases and related deaths have increased at an alarming rate. By the 31st December, 1997, a cumulative number of 40 629 HIV confirmed cases and 2926 AIDS related deaths were recorded. In 1997 a total of 3635 patients were hospitalised due to AIDS related illnesses. More reliable information on the magnitude of HIV infection among the general population is obtained through regular surveys among pregnant women. In 1996, the HIV prevalence among pregnant women was 15.4%.

In response to the increasing number of HIV/AIDS cases, the newly independent Namibia established the National AIDS Control Programme (NACP) within the Ministry of Health and Social Services. The NACP, as was reflected by the External Review, was largely unsuccessful in reducing the spread of HIV infection, due to deficiencies within the management structure and its relatively low placement in the structure of the Ministry of Health and Social Services.

EXPANDED NATIONAL RESPONSE

The National AIDS Committee, which was supposed to provide policy framework and support to the NACP, did not function at all. The Ministry of Health and Social Services also took cognisance of the fact that the major determinants of HIV transmission lie outside the health sector. It was therefore decided to formulate a national response to HIV epidemic in Namibia. The establishment of the new National AIDS Co-ordination Programme (NACOP) is a concrete expression of this national response. The goal of this programme is to reduce the HIV infection to below epidemic threshed.

The broad objectives of the National AIDS Co-ordination Programme are:

1. To provide broad and adequate national response to HIV/AIDS
2. To provide political commitment and give guidance to the AIDS control activities.
3. To formulate appropriate national policy on HIV/AIDS.
4. To provide appropriate strategies for HIV/AIDS prevention and care of the afflicted individuals, families and communities.

Under this programme tertiary institutions, including the University of Namibia, have been assigned the following tasks:

(iii) To acquire and distribute condoms at secondary and tertiary educational institutions.

(iv) To care for and support the HIV infected persons and their families.

(v) To budget, procure and distribute condoms to staff and learners.

Some of the major activities to be capitalized on by tertiary institutions are: regular research surveys and studies, which should be done by verifying the effectiveness and appropriateness of information disseminated and interventions carried out hitherto.

The development of relevant IEC materials within the sectors at all educational institutions is one of the major roles that should be played by tertiary institutions.

These mechanisms could be carried out effectively in conjunction with the Mass Media Task Force under the chairmanship of the Ministry of Foreign Affairs, Broadcasting and Information. In fact the institutions of learning can produce their own information system, launching new bulletins, which will cater for their youth, tailored towards their taste, and which will be widely circulated by them and for them.

The target population should not only include learners and their teachers, but even institutional workers of these institutions. The situation of young women is worse. They are infected at an early age and have higher rates of infection, surpassing their male cohort. These are the future mothers who, if serious preventive actions are not taken, will leave behind orphans.

Given the situation of HIV/AIDS in Namibia as described above, what is the HIV/AIDS situation at the University? We turn to a consideration of this aspect in the next section of the report.

UNIVERSITY OF NAMIBIA

Before we describe the HIV/AIDS situation at the University of Namibia, it is helpful to describe the University itself.

The University of Namibia (UNAM) is a small institution with 4,300 students, mostly studying at its major campus in Windhoek. It was established in 1992, developing from a precursor tertiary institution set up by South Africa, and inherited faculties and programmes in such areas as liberal arts, teacher education and the training of public administrators. As the only university in Namibia, UNAM is responsible for both conventional face-to-face undergraduate and postgraduate education and also distance undergraduate education at degree level throughout the country. UNAM has eight centres in smaller towns across Namibia and a second campus in Oshakati, the major urban area in the populous and disadvantaged far north.

UNAM embraces the principles of liberal access to people of diverse socio-economic and cultural backgrounds; commitment to the democratic dream of equality and opportunity; education for practical advancement and personal growth and commitment to excellence in teaching, research and service. Currently enrolling approximately 3500 students UNAM receives an annual government subsidy of about 82 Million Namibian dollars, and has graduated 5600 students since its inception. Through the development and expansion of UNAM's research and training centres,

communities that face challenges of health care, educational reform and economic development are able to receive assistance from the UNAM faculty. Distance-learning opportunities are made available to remote communities through the Center for External Studies. The University has seven Faculties, including Agriculture & Natural Resources, Economics & Management Science, Education, Humanities & Social Sciences, Law, Sciences, and Medical & Health Sciences.

TABLE 2: Actual Student Enrolment, 1992-2000, by Faculty/Centre

FACULTY	1992	1993	1994	1995	1996	1997	1998	1999	2000
Agriculture, Natural Resources and Conservation	-	-	-	-	28	69	104	141	165
Economics and Management Science	268	324	364	477	566	651	703	768	861
Education	347	396	472	597	775	780	697	683	699
Humanities and Social Sciences	271	356	392	436	409	390	405	423	477
Law	-	-	22	45	66	89	100	113	153
Medical and Health Sciences	635	690	758	724	628	533	439	386	334
Science	119	144	161	165	241	298	338	365	478
Centre for External Studies	1994	1705	1408	1769	847	726	965	1403	308
TOTAL	3634	3615	3577	4213	3560	3536	3751	4282	3475

Source: Strategic Planning & Institutional Research

TABLE 3
Academic Staff in Various Faculties/centres According to Regions of Origin

FACULTY/ CENTRE	COUNTRY/REGION OF ORIGIN AND NUMBER OF STAFF MEMBERS					
	NAMIBIA	OTHER AFRICAN COUNTRIES	ASIA	EUROPE	NORTH AMERICA	SOUTH PACIFIC	TOTAL
Agriculture, Natural Resources	14	14	1	3	0	0	32
Economics and Management Science	15	6	2	2	0	0	25
Education	18	14	0	0	0	0	32
Humanities and Social Sciences	40	19	0	13	1	1	74
Law*	3(15)	2(3)	0	1(2)	0(2)	0	6(33)
Medical and Health Sciences	46	0	0	0	0	0	46
Science	22	14	1	6	3	1	47
Centre for External Studies	28	2	1	2	0	0	33
Language Centre	12	4	0	2	0	0	18
Multi-Disciplinary Research Centre**	29	2	0	1	1	0	33
University Library	37	5	0	3	0	0	45
TOTAL	**264**	**82**	**5**	**33**	**5**	**2**	**391**

NOTES:

* The figures in brackets represent part-time staff, recruited because there are no qualified staff to fill required positions.

** Of the staff indicated, 7 are Senior Researchers whose salaries are paid by UNAM, 22 include part-time, contract, staff, and staff development fellows for capacity building purposes.

TABLE 4: Administrative Staff According to Department And Gender

Office/Department	Gender And Number of Administrative Staff		
	Male	**Female**	**Total**
Office of the Vice Chancellor & Pro-Vice Chancellors	8	6	14
Office of the Registrar	9	16	25
Office of the Dean of Students	27	38	65
Centre for External Studies	4	16	20
Auxiliary Services	10	1	11
Civil and Mechanical Services	11	0	11
Computer Centre	6	3	9
Finance	17	14	31
Personnel	4	8	12
Security	15	0	15
Support Services	12	6	18
University Foundation	1	3	4
TOTAL	**124**	**111**	**235**

The University is served by an international staff. For the year 1998 the University had a total academic staff of 391, non-academics (Administrative and non-academic staff were 255 (Table 3).

The University has a Dean of Students Office which handles all social aspects of the students' life --- including sports, Students Clubs, Counselling Services, hostel facilities (for only 1000 students); the Chaplaincy; and Health Care Facilities.

The university's mission statement emphasises its commitment to national socio-economic, cultural, political and human resources development. The key roles can be summarised as:

- To educate high level specialists in critical areas necessary for national development.
- To provide education which is responsive to the needs of the country and which is accessible to all.
- To undertake basic and applied research so as to contribute to the social economic, cultural and political development of Namibia.
- To develop endogenous science and technology in the country.

- To serve both rural and urban communities and provide services to uplift their education and know-how.
- To promote and defend democracy.

If faces significant challenges in fulfilling these key roles.

- Meeting national priorities by developing programmes in applied sciences, agriculture, technology and business.
- Responding to the needs of disadvantaged Namibians often living in rural areas and far outlying regions and attempting to redress the inequities of the past.
- Resolving the constraints tot he expansion of the University caused by the weak academic preparation of students.
- Strengthening applicable research and further developing Namibian academic and research staff.
- Managing in a constrained financial environment where it is becoming increasingly difficult to progress with new developments whilst maintaining existing programmes and services.
- Responding to the dangers posed by the HIV/AIDS among students and staff, and in the larger community. We turn to a brief description of the situation of HIV/AIDS at the University of Namibia, and to the University's response to this situation.

HIV/AIDS SITUATION IN THE UNIVERSITY

A brief statement will first be made regarding the national policy and the legislative framework, before describing the situation in the University.

The national policy and legislative framework

That government has recognised the importance of the link between public health and human rights in the context of the AIDS pandemic is evident from the provisions of the national policy on HIV/AIDS entitled "Positive Responses and Choices: Policies and Guidelines for HIV/AIDS Prevention and Control", adopted by Cabinet in June 1992. This policy places emphasis on education and individual responsibility and outlaws discrimination and the implementation of coercive control measures.

In terms of the policy, testing for HIV should not be carried out without informed consent and without appropriate guarantees of confidentiality in respect of the result. The need for a non-discriminatory and supportive environment is also stressed in the policy. In particular the policy emphasis the need for non-discrimination on the basis of HIV status in access to care and treatment, employment, employment benefits, educational and training institutions, accommodation, immigration and travel.

More recently, in 1998, the Minister of Labour promulgated guidelines in terms of the Labour Act, No 6 of 1992, for the implementation of the National Code on HIV/AIDS and Employment, which are to be followed and adhered to by all employers and employees for the purpose of the application of the relevant provisions of the Labour Act in respect of HIV/AIDS in employment. This National Code on HIV/AIDS and Employment was formulated after consultation between

government, employer organisations and employee organisations and is premised on "the fundamental principles of human rights embodied in the Constitution of the Republic of Namibia".

The guidelines referred to above outlaw discrimination on the basis of HIV status in the context of employment and provide, inter alia, that "there should be neither direct or indirect pre-employment tests for HIV. Employees should be given the normal medical tests of current fitness for work and these sets should not include testing for HIV." They provide, in addition that there should be no compulsory HIV testing for training or promotion and further that HIV infected employees should work under normal conditions so long as they are fit do so and if they can no longer do so, they should be offered alternative employment "without prejudice to their benefits".

Confidentiality regarding HIV/AIDS in the workplace is also guaranteed in the guidelines, which provide that *"persons with HIV/AIDS should have the legal right to confidentiality about their HIV status in any aspect of their employment. An employee is under no obligation to inform an employer of his/her HIV/AIDS status. Information regarding HIV status of an employee should not be disclosed without the employee's written consent".*

We now turn to the HIV/AIDS situation at the University of Namibia.

2. **HIV/AIDS situation in the university**

Following on the national policy and legislative framework the University of Namibia developed policy guidelines on HIV/AIDS which were approved by Senate and Council in 1997. The thrust of the guidelines is directed at prevention of HIV transmission and the needs and of those persons who have HIV or AIDS. Embedded in normative and ethical considerations, the Guidelines, nonetheless, also stress the duties and obligations of persons with HIV and AIDS.

On HIV Test the Guidelines state:

> UNAM respects the privacy of the individual, and adheres strictly to the Human Rights provisions in the Constitution, as well as the following guidelines of the World Health Organization (WHO): "All persons must give informed consent prior to being tested for HIV antibodies, the results of their test (and the fact that they were tested) must be kept absolutely confidential and the person(s) must have both pre- and post-test counselling".

As with any medical condition, information about individuals should be treated as strictly confidential. It is strongly advised that disclosure should take place only on terms agreed with the individual concerned, whose informed consent should be sought on each occasion.

The University recognizes that it is possible to test for the presence of the HIV antibody anonymously and/or confidentially. This can be done locally at clinics and hospitals of the Ministry of Health and Social Services (MOHSS) without referral by a general practitioner.

On needs of persons who have AIDS the guidelines state:

Persons who have AIDS may choose to live and work in the University; University institutions

and the University community are asked to **support them, and to view them in the same light as those suffering from any other chronic medical condition.** As argued above, many such persons enjoy long periods of well-being, during which they may be able to cope with the demands of employment and academic life; however, there may be periods when they need specialized hospital care.

The Guidelines also a **special information** should be developed. It should encompass knowledge of basic epidemiology and an understanding of how HIV is transmitted (and is not transmitted), the natural history of HIV infection (the progressive stages of HIV infection), how HIV develops into AIDS (late symptomatic illness or AIDS defining illnesses such as Tuberculosis), as well as the role and responsibility of students and staff in preventing the further spread of infection.

In addition to the **Information Module** the Guidelines stipulate the design of a module or modules which should focus extensively on strategies for preventing HIV transmission in the University and community setting. The specific objectives associated with the prevention strategies would include:

- More effective STD prevention through knowledge and enhanced awareness.
- Condom social marketing and promotion.
- Life skills training for students and staff.
- HIV/AIDS education for the University community.
- Workplace programmes, and curriculum design.

Finally the Guidelines emphasise the need to develop a counselling skills module, which would be intended to deal with the response of the University community to HIV/AIDS, the ways in which the psychological effects of infection are influenced by this response, and the role of professional- and peer (student) counsellors in limiting these effects, and strengthening community resources. Given these Guidelines which were approved by Senate, what has been the impact of HIV/AIDS on the University, and how has the University Community responded to HIV/AIDS? We turn to a consideration of these aspects in the following paragraphs.

IMPACT OF HIV ON THE UNIVERSITY OF NAMIBIA

An examination of various statistics collected from informers or the UNAM Clinic was made to establish the impact of HIV/AIDS on campus. For instance information was sought on the number of deaths of staff and students between the years 1994 and 2000, and the possible causes of death. Information was also sought periods of prolonged absence of staff and students due to long illness, or absence to attend family funerals. Information was sought on class attendance records and/or absence from examinations or the frequency with which students at "special examinations" due to missing regular examinations. Finally, statistics were obtained from the UNAM Clinic on the various cases reported by students who visited the Clinic. It should be noted that there are students (presumably the well to do) who opt to visit private doctors and in the cases of abortion, who prefer go to South Africa where there are more lax regulations (Information obtained from the Clinic). The results of the information obtained are presented in the following pages.

Number of staff and students who died 1994 - 2000, and statistics from the unam clinic

Information was sought on the number of staff and students who died between 1994 and 2000. Information was also sought on the costs of any funerals paid for from the University, friends, as well as the costs of monies paid out to the relatives of the deceased employees.

Table 4: Reported deaths of staff members by year, number and reported cause of death

Year	Number	Reported cause of death
1994	-	-
1995	1	Severe lung infection.
1996	1	Fracture, haemorragic shock (motor accident)
1997	1	AIDS
1998	2	One extensive bronchopneumonia respiratory failure; one cancer
1999	3	One AIDS, one natural causes; one motor accident
2000*	3	one AIDS; one gastroenteritis

* up to September 2000.

From the records held in the Personnel Office between 1994 and September 2000, a total of eleven staff died. Of these deaths only **three** are reported to be from AIDS. This as recorded in the certificate of death which the University requires before it can pay out any monies due to the deceased' family.

According to the Bursar's records monies paid out to relatives for all the deceased amount to N$111 080. For the AIDS cases only the sum is N$33 370.

Information about students deaths was extremely scanty. In one Faculty the Faculty Officer who was ware of seven deaths of students which had taken place during the time in the Faculty (between 1997 and 2000), of which two deaths were through motor accidents. In another Faculty only two students had died (one in 1996, and one in 2000) through unspecified causes. A member of staff contacted volunteered the formation: "I know of one staff member, and I know of three students' I also know two other recent deaths of students". Another informant stated, "it appears likely that, over the past few years our department has lost some students because of this terminal disease .... And what do you suggest if one hears the rumour that the local bloodbank seems to refuse samples from UNAM student constituency.

Claiming that approximately 75% are positive ...? ... With these few comments I wish you courage when addressing all issues inherent in HIV/AIDS in an uncamooflaged mode". Finally, the Nursing Sisters stated that she was aware of seven students who died as follows:

- 1 student - Killed
- 1 student - AIDS
- 1 student - Meningitis
- 2 students - Malaria
- s students - Motor accidents.

She indicated that when students fall ill she refers them to hospitals and/or private doctors. This is corroborated by the large number of referrals indicated on table ... showing the statistics of illness recorded in the University Clinic. From the hospitals and/or private doctors, if the patients should die (of whatever cause) the University is not normally informed of this. And the students failure to turn up for subsequent classes would not necessarily be attributed to death as there are many other causes which could prevent their return, including failure to pay the necessary fees for registration. And if the reason was death, the parents or relatives would not be obliged to disclose the cause of death.

So all in all, it would appear that few students' death can be directly attributed to AIDS.

Number of students and staff absent due to illness and frequency absence to attend funerals

Information was sought about students and staff absenting themselves for long periods (up to three months) due to illness.

Applicable guidelines for absence from lectures and tests; for maternity leave, funerals; and illness and other reasons are contained in the statutes of the University as follows:

7.14 **Absence from Lectures and Tests**

7.14.1 In order to be admitted to examinations, students are required to attend at least 80% of the lectures and to complete the required elements that make up the continuous assessment mark. Students who are unable to attend classes/tests for any reasons, must complete the necessary application form, and supply the necessary documentation. The application must be seen by all lecturers, who will provide their comments and signatures. Final approval rests with the Registrar's Office. It will be the responsibility of the student to make up for missed events/complete the relevant requirements (including tests). Students who apply for absence from classes in a period in which examinations are also written should refer to the regulations governing special examinations.

7.15 **Maternity Leave**

7.15.1 Students who request absence from classes, tests and examinations for the purpose of delivery, must apply beforehand, providing a medical certificate indicating the expected date of delivery. Students will be expected to attend classes/examinations two weeks prior to and after the date of delivery. Should the date of delivery differ from the expected date students, on resumption of classes, will be expected to furnish a medical certificate stating the new dat. A new, late application for absence from classes and/or examinations must be completed by the student in such cases.

7.16 **Funerals**

7.16.1 Students Who miss classes/tests/examinations due to funeral attendance must, prior to departure, apply for absence from classes. On return, the student must supply satisfactory proof which confirms that the student attended the funeral. On receipt of the above mentioned, the application will be processed further. Students should note that absence from classes/tests/examinations should normally not exceed one week.

7.17 **Illness and Other Reasons**

7.17.1 Students who miss classes/tests due to illness, must produce a valid medical certificate stating the period of absence and nature of the illness. An application for absence from classes must be completed by all students before or not later than five days after the illness, depending on the circumstances. Students who are in possession of surgery dates, etc. will be expected to apply for absence from classes prior to their leave of absence. Permission will be granted for emergency cases. The Registrar's Office reserve the right to reject such applications if the illness does not warrant absence from classes/tests.

7.17.2 Students should note that reasons such as over-sleeping, car trouble, lift problems, misreading the examination timetable, etc. will not be considered as valid reasons for missing tests/classes/examinations.

(General Information and Regulations - - University of Namibia, 2000.)

Given these guidelines we can comment on each of the aspects relating to students absence from lectures and tests; maternity leave; attendance at funerals; and absence due to illness and other reasons as follows:

5. Absence from classes, tests and other assignments have not shown any appreciable increase over the period in question (1994-2000). This is for several reasons. First the present regulations are sufficiently liberal for any student to flont them without detection. Since lecturers do not keep a register of attendance there is no way they can tell who missed more than the allowable limit of lectures. Consequently, in more cases than one, all students usually quality for examination admittance. Missed tests can be re-sat after negotiation with lecturers who usually plead that since the students come from disadvantaged background, they should be given a second chance.

   With respect to attendance at funerals, it is a tradition in Namibia, as in other southern African countries that, funerals take place over the week-ends. This being the case many students would go off on a Friday and return on Sunday to be in time for their lectures during the week.

   One staff members confirmed this when she stated, "I also know about several students who go home, particularly over week-ends to attend funerals."

   The same laxity of rules on special examinations applies as explained below.

Special Examinations

Special examinations are granted where a student was prevented from sitting the ordinary examination. This may be conducted immediately after circumstances which prevented the candidate from sitting for the examination, or at any other time afterwards, as determined by Senate.

The applicable regulations stipulate as follows:

Special Examinations

7.21.18(1) Applications from students for a special examination should reach the Office of the Registrar with recommendations from the relevant lecturer of a Faculty, not later than 7 days after the ordinary examination date.

(2) The following circumstances may be considered for admission to a special examination:

(a) illness or injury immediately preceding, or on the day of the examination, provided that a medical certificate, specifying the nature and duration of the illness or injury, is submitted to the satisfaction of Senate (Senate may, on its discretion, reject any medical certificate);

(b) domestic circumstances, such as serious illness, or death of a close relative at the time of, or immediately preceding the examination, and which, in the opinion of Senate, could adversely influence the achievement of the student concerned, provided that satisfactory proof of such circumstances shall be provided;

(c) any other circumstances which, in the opinion of Senate, justify the examination.

(3) If a student is able, or permitted to write only a part of the examination, that part of the examination written prior to the illness or relevant circumstances, shall be valid.

(4) This examination shall be regarded as a first examination and all relevant rules shall thus apply.

So, all in all, no appreciable absence of students due to long illnesses are recorded or available due to a variety of reasons indicated above.

The case of staff absence from work is governed by the following condition:

E.5.1.9.7 **Sick Leave**

(a) Sick leave shall be granted to a staff member at 120 calendar days with full pay plus a further 120 days at half pay, in a three year cycle

commencing on the date of appointment of the staff member concerned.

(b) Absence with sick leave exceeding 2 (two) consecutive calendar days shall be covered by a satisfactory medical certificate issued by a registered medical practitioner. Where excessive use is made of sick leave for single days, the Head of the staff member concerned may request a medical certificate for each day of absence. Council reserves the right to request a second opinion from another medical practitioner.

(c) Council shall not be bound to pay an employee in respect of absence from work for a period in excess of 2 (two) days unless the prescribed medical certificate is submitted.

So again here, search of personnel records did not indicate any significant increases in absence between the stipulated dates due to prolonged illness.

So all in all in the period 1994-2000 there have been few deaths of staff and students due to AIDS. There are, also few prolonged absences due to illness of students and staff.

The Nursing Sister at UNAM did not know the seropositve infection rate for students and staff since any people volunteering to be tested are tested at the hospital and the results are confidential. But still by the large number of SDT's as indicated on table one could deduce that this poses a danger because of the link between STD's and HIV/AIDS. An analysis of the biology of HIV transmission indicates that STDs are important in the transmission of the disease. "The presence of venereal infection, particularly those which cause ulcerations or lesions, such as syphilis and Genital Ulcer Disease (GUD) increase the likelihood of transmission by up to a factor of four", (Webb 1997:5). In many parts of Africa, STDs are a crucial factor in HIV infection. Increasingly, many of those who have STDs also have HIV. If this is the case, it is possible that they are not likely to seek treatment for STDs, making STDs a serious co-contributing factor of HIV transmission.

The chart below indicates a timescale of the epidemic.

Chart 2: A timescale for the epidemic

From - to (in years)	Minimum	Maximum
First AIDS case to peak of HIV in urban areas	12	25
Urban HIV peak to national HIV peak	8	10
National HIV peak to peak in AIDS cases	5	10
Impact on next generation	10	40
Total	35	85

Statistics from the Unam Clinic

The University of Namibia employs only one Nursing Sister full-time. A medical doctor who is

part-time, reports to the Clinic twice a week. This is clearly a situation of under-staffing in a University of just over 4000 students, 1000 of whom are in residence; and over 600 staff. The Nursing Sister keeps all records of cases reported to her; treats some, and makes referrals to hospitals of other more complicated cases.

Table ---- indicates the various statistics. The cases of STD's (urethral discharge and genital ulcers) strike one as clearly high, for a student group that should be sufficiently well informed in relation to the dangers of unprotected sex. Yet when one reads the results of the research reports and interviews held with students, one realises that a large number of students admit to high risk behaviour in sexual matters. The number of pregnancies would point in the same direction, as would the low number of condoms distributed.

Table 5: **Statistics obtained from Unam Clinic relating to illness, abortion, family planning referrals to hospitals, and condom distribution by case, and year, 1994-2000**

CASE	YEAR						
	1994	1995	1996	1997	1998	1999	2000*
Upper Respiratory Trach Infection	132	824	1206	257	1151	2086	743
Hypertension	12	17	18	13	33	11	8
Malaria	2	47	51	41	36	45	17
** Urethral Discharge	12	181	271	74	116	114	152
** Genital Ulcers	1	13	8	9	7	14	4
Abortion	-	-	-	-	0	3	-
Death	?	?	?	?	?	?	?
Pregnancies	-	17	24	19	38	26	24
Re-visits TB	1	1	1	1	6	2	1
Referral to Hospital	-	428	368	134	384	318	233
Family Planning visits	2	42	19	51	50	40	26
Pills visits	19	95	118	251	201	200	111
Revisits	-	-	-	-	-	-	-
Injection Fert	12	79	76	92	149	54	59
Revisits	3	365	336	497	341	348	225
Condoms distribution visits	48	96	135	310	213	***	***

* To September, 2000.
** STDs recorded according to the guidelines from Ministry of Health and Social Services.
*** Distribution of Condoms was transferred to the Office of the Social Worker in the Deans of Students Office, as well as to SRC.

So all in all one can, although there are as yet few cases on Campus of AIDS deaths (and there are no known or reported cases of people living with HIV/AIDS) state that as long as there is stigma and discrimination on the basis of HIV as there is throughout the country; and as long as the rights of people with HIV/AIDS continue to be abused as they are through out the country, people will not come forward for voluntary testing and counselling, and the rate of infection will remain unaltered, or indeed increase. This now raises the question of how the University Community has responded to the HIV/AIDS. We turn to a consideration of this in the next section.

4. THE RESPONSES OF THE UNIVERSITY COMMUNITY AND INTEGRATION IN HIV/AIDS INTO TEACHING, RESEARCH, ADVISORY/CONSULTANCIES AND STRATEGIC PLANNING

As indicated already the University of Namibia developed HIV/AIDS Policy Guidelines which were approved by Senate and Council. From these Guidelines a number of activities and projects have been developed, aimed mainly at advocacy and prevention. In several public meetings on campus the Vice Chancellor has repeatedly address the vital and leading role the University must play in combating the HIV/AIDS pandemic. Other University Officials as well as students have similarly gone public in their fight against HIV/AIDS.

This start by the University is entirely consistent with the wish of the Vice Chancellor of the University of Namibia who at the 1997 commencement day of the University addressed the students as follows:

> 'As the privileged few of our society, you owe the underprivileged masses, out there, a great deal. My dream for 1997 is to see you, our students, going out to our local schools, going out to our society in general, going out to our youth sensitising them about social evils, such as drug substance abuse, juvenile crime, HIV/AIDS, to mention but a few. I see you, during your holidays, going out to our rural masses, and helping to make the illiterate literate, and sharing your knowledge with them.'
>
> Katjavivi, 1997:2

In the following pages we specifically refer to the following activities promoted by the University in its fight against HIV/AIDS:

- Orientation of First Year Students
- HIV/AIDS Awareness week
- Training of Faculty Officers
- Faculty Mentors Training Workshop and Students as Tutors & Mentors.
- Curriculum changes in carported.
- Information from research studies

Thereafter we shall refer to some examples of good practice, or lessons learned as a way of summarising before making a concluding statement.

Orientation of first year students

Annually, first year students undergo a week's orientation during which various officials of the University -- Deans of Faculties, Faculty Officers, the Social Workers, the Nursing Sister, the Dean of Students, and other officials; as well as members of the Students' Representative Council (SRC) provide information and ideas designed to make adjustment to University life smooth. Issues related to academic life; social life on campus, and other germane matters are

covered. In the last three or four years, however, the focus of orientation has turned specifically on trying to make first year students sensitized to the dangers of pregnancy; sexually transmitted diseases, and particularly the dangers of HIV/AIDS pandemic. Emphasis during orientation is also placed on how the students, especially female students, should protect themselves, as well as how to avoid the blandishments of “senior male” students, as well as some staff members. The orientation typically begins with a major address by the Vice-Chancellor of the University. The President of the SRC usually gives his advice in a “message from the President of the SRC”. This year, in addition to parents of the students being invited to attend orientation sessions, a representative of the parents also gave a major address to first year students.

HIV/AIDS awareness week

Since 1994 the University of Namibia has organised an HIV/AIDS awareness week, mainly organised by the Student’s Welfare Society, with support from the Dean of Students’ Office, and other stakeholders including the Vice Chancellor himself and the Patron of the Society.

During the HIV/AIDS awareness week various events and activities take place. A typical week will include some or all of the following:

1. A seminar led by a specialist on some aspects of HIV/AIDS. In 1998 the guest speaker was from the University of Cape Town. The seminar is typically a presentation by the guest speaker followed by a question-and-answer session in which students are encouraged to ask questions on any aspects of HIV/AIDS -- including myths and traditional beliefs.

2. The Students Welfare Society organises several broadcasts at NBC the purpose of which is to raise awareness, as well as to have its cause at the University generally understood by the community at large.

3. An invited guest from Government -- usually the Minister of Health and Social Services, or the Minister of Women Affairs and Child Welfare -- addresses students (and interested staff) and school children from nearby secondary schools on various aspects of HIV/AIDS and what students can do to protect themselves and others from contracting the pandemic.

4. A cross-section of stakeholders -- UNAIDS; Catholic AIDS Group, WHO, Youth Groups, and Teachers Associations -- conduct a public debate, in from of students, on various aspects of HIV/AIDS. Discussion that ensure typically are heated.

   In addition tot he HIV/AIDS awareness week the Students Welfare Society organises other activities during the course of the academic year, including visits to secondary schools to conduct awareness meetings.

5. The **UNAM Action 2000 Against HIV/AIDS** summarises these activities when it states that during the year 2000 students will:

   * Invite speakers, especially HIV/AIDS infected people to come and address UNAM students.

* Collaborate with the UNAM drama group to stage plays that promote AIDS/HIV awareness amongst students.
* Promote the use of both the condom and the femidom by sexually active students (improve accessibility).
* Work in collaboration with the High School students to increase or raise awareness of HIV/AIDS/STD's amongst the youth of Namibia.
* Provide services that include condom/femidom use, plus provide STD treatment and Counselling.
* Conduct awareness campaigns through the UNAM web-page on a weekly basis on the dangers of unsafe sex and the benefits of practising safer sex among the youth.
* Reach out to the students via the soon to be launched UNAM radio station.
* Talent shows in the UNAM Hostels that address the HIV/AIDS issue.
* Sensitize students and staff through the **Campus Vision**, students' newspaper.

Training of faculty officers

Each of the seven faculties within the University has a Faculty Officer -- an administrative officer whose full-time employment is to handle student records for his/her faculty; to deal with student registrations, including change of subjects or programmes, and, in general, to handle all academic and social life issues of students within a specific faculty on a day-to-day basis. Arising from what was expresed as extreme presure of work on faculty officers an dwhat were observed to be increasing incidents of confrontation between them and students it was agreed that a short course mounted by the Department Psychology be implemented in August, 1999. The course covered various topics such as stress, interpersonal conflict, role expectations, communication, self-confidence, and customer orientation, emphasising the need for the faculty officers to be empathetic in handling their customers -- the students.

The course which was delivered in an interactive manner was rated by all the participants as being extremely relevant to their work and as having been very successfully delivered. There was also an expression for a follow-up workshop which has just been completed this passed August. A sample of faculty officers interviewed expressed the view that they had experienced a change in the way they handle students, particularly in relation to social problems. More students (particularly female students) are now more willing to confide in them and seek their advice and assistance particularly in cases of sexual harassment from fellow (male) students and/or staff (the majority of the faculty officers are female -- six out of seven). Students are also more forthcoming, they report, in discussing issues related to pregnancy or STDs.

Faculty mentors training workshop and students as tutors and mentors

(i) ***Faculty mentors training workshop***

Following on an international conference on students as tutors and mentors held in London in 1997 and attended by two senior academics from the University of Namibia, a three-day training workshop was held for lecturers in all the seven faculties of the University who had expressed interest in instituting a tutoring and mentoring system in their respective faculties. The workshop covered a variety of aspects of mentoring and tutoring, and how to implement the programme either "on campus" or in secondary schools in Windhoek.

Since the training workshop three faculties have had the programme in place “on campus” -- Science, Economics and Management Science; and Education. In addition the Faculty of Education has also instituted the system in secondary schools in Windhoek. The results of how the system operated in school shave since been presented at a major conference in Cross-cultural psychology. And a second set of education students are currently engaged in a six week programme in mentoring and tutoring in another secondary school in Windhoek.

(ii) ***Students as tutors and mentors***

The Students Welfare Society has instituted a special tutoring and mentoring system in the form of **My Future is My Choice**.

UNICEF along with partners from the University of Namibia, The Ministry of Basic Education and Culture, the Ministry of Youth and Sport, and several NGOs formed the Youth Health Development Programme. Through careful research a life skills curriculum called **My Future is My Choice** (UNICEF, 1996) was developed. The curriculum was successfully piloted in the Omusati and Caprivi regions of Namibia.

The curriculum is targeted at youth aged 15-18. **My Future is My Choice** deals with HIV /AIDS prevention and life skills promotion. The curriculum has eleven sessions, and each is approximately two hours long. It is usually taught over five weeks, at a rate of two per week. It is a very interactive and participatory curriculum; one that provides critical information in an entertaining format, provided by master trainers who are usually about the same ages of the older trainees. Once master trainers provide training to a group of say 20 facilitators, these facilitators then work in teams to teach groups of up to 25 students. This means 20 facilitators would create 10 training teams which would teach to 250 students per training cycle. Feedback from trained facilitators has been extremely positive, and emphasising the participatory nature of the training as well as the freedom provided to ask “naughty” questions that adults would normally hit the roof about!

Curriculum Changes to Incorporate HIV/AIDS

As indicated elsewhere, the UNAM Policy Guidelines stipulate introduction of an information module as well as other modules on HIV/AIDS. But todate this has not been done. In the regular four-year degree programmes, not much effort, across the board has been undertaken to introduce issues on HIV/AIDS. However there are already Departments/Faculties were this has been done:

1. In the Faculty o Medical and Health Sciences, all aspects of HIV/AIDS are covered in different nursing courses.

2. In the Department of Mathematics and Science Education which houses the Home Economics Unit in the Faculty of Education, HIV/AIDS issues are covered as follows:

    1. **B.Ed,** Issues in Education, (first year)
    Support and advocacy, mainly focussed on the role of nutritional status in the

improvement of the living standard and support during certain health problems like moth sores and wasting etc. I have only started this year and I had to be very brief. This is to sensitize them.

2. **B.Ed,** Human nutrition and principles in food science (3 modules on third year level)
Support and advocacy, mainly focussed on the role of nutritional status in the improvement of the living standard and support during certain health problems like mouth sores and wasting etc. This is a more in depth study.

3. **Diploma in Comprehensive Nursing and Midwifery Science**, Nutrition module in Community Health Course (fourth year, Third term)
Support and advocacy, mainly focussed on the role of nutritional status in the improvement of the living standard and support during certain health problems like mouth sores and wasting etc. This is a more in depth study.

3. The Department of Social Work and Administration in the Faculty of Humanities and Social Sciences is incorporating HIV/AIDS issues in the special programme in the following ways:

(a) **Theoretical work**
Students in their third and forth year follow a module each where HIV/AIDS as a social phenomena is taken care of. The modules: SWK 3342: Social work and health: Social, Physical and mental health and SWK 3340: Special fields in Social work are used to discuss the phenomena of HIV/AIDS, as well as treatment programmes for prevention, education and counselling.

(b) **Applied social work**
The third and fourth year students do counselling with HIV/AIDS patients and their families. They do their field work in the State Hospitals and at NOG's who specialize in AIDS care. Two final year students are doing an internship at the Office of the Dean of Students at UNAM. The are closely connected to the HIV/AIDS programmes running on campus.

4. The Department of Information Studies in the Faculty of Humanities and Social Sciences will introduce HIV/AIDS issues in its programmes through the UNAM Radio as described elsewhere in this report.

5. In postgraduate work research has been and is being done through mini thesis and dissertations which are placed in the Special Collection in the UNAM Library. Examples include the following:

Titles of Research Studies Undertaken by UNAM Students

- Guidao-Oab J.F. 1997. The usefulness of community theatre in HIV/AIDS education. Unpublished mini-thesis.
- Kurewa P.M. 1999. The needs of aids orphans in Namibia: a study of the plight of aids orphans in Windhoek area. Unpublished MA (SW) dissertation.

- Mukonda R. 1998. Teenage girl's HIV/AIDS awareness and their sexual predispositions and motives in Caprivi. Unpublished mini-thesis.
- Nangolo M.N. 1998. The social and economic cost associated with HIV/AIDS.
- Nasheya, K. 1999. HIV/AIDS and the youth: a study on change in sexual knowledge, attitudes, behaviours and practices. Unpublished mini-thesis.
- Schoom R. 1999. The relation between alcohol abuse and the spread of HIV/AIDS. Unpublished mini-thesis.
- The Basic care given at home to patients diagnosed with full-blown AIDS in the Katutura area. Msc (Nursing Science). In progress.

A more comprehensive curriculum review with a view to incorporating HIV/AIDS aspects in all UNAM programmes is being undertaken by the Task Force on Student and Community Development as described elsewhere in this report.

Unam HIV/AIDS Task Force

The Vice chancellor who has continued to be the source of inspiration for work in HIV/AIDS at the University of Namibia was present in New York when Namibia's Minister of Health and Social Services, presented in very graphic form and passionately the plight of Namibians in the face of HIV/AIDS pandemic. He came away more determined than ever to do something more than had been done at the University -- setting up a task force on HIV/AIDS.

The Task Force has the following membership:

1. Coordinator of the Unit for Improving Teaching and Learning -- Chairperson.
2. Head, Department of Psychology
3. Head, Department of Social Work and Administration
4. Head, Department of Sociology.
5. Head, Department of Educational Psychology and Special Education
6. Dean, Faculty of Medical and Health Sciences
7. Dean, Faculty of Economics and Management Science
8. Dean of students
9. Director of Multi-disciplinary Research Centre
10. Head of Adult and Non-formal Education
11. Dean, Faculty of Agriculture and Natural Resources
12. Head, Department of Information Studies
13. Representatives of the Students Representative Council
14. Representatives of non-academic staff.

The Task Force, which has powers of co-option, has terms of reference which include the following (among others):

- Conducting awareness meetings at UNAM.
- Coordinating HIV/AIDS activities at UNAM.
- Seeking funding for research and community outreach.
- Collaborating with sister institutions in the region in the area of research, and publications as well as networking.
- Collaborating with all stakeholders within the country, within the region, and

internationally in our effort to arrest the HIV/AIDS pandemic.
- Assisting and encouraging students and staff to form and utilize self-support groups to encourage positive living with HIV/AIDS as a coping strategy within and outside the campus.
- Establishing and encouraging peer education on STDs/HIV/AIDS on campus to combat the transmission and the spread among students and staff.
- Providing pre and post HIV testing counselling for individuals within the University community needing such services.
- Providing supportive therapy for members of the University community with HIV/AIDS or whose family members are HIV positive or suffering from AIDS.
- Fostering positive attitudes towards people with HIV/AIDS amongst members of the University community.
- Embarking more on behaviour modification and behaviour change strategies in addressing the transmission and spread of HIV/AIDS.
- Offering guidance and moral support to those providing care of people living with HIV/AIDS.

The first step taken by the Task Force was to write to all South African Universities, and Universities in other SADC countries (particularly Botswana, Lesotho, Swaziland, Zambia and Zimbabwe) requesting information and documents on HIV/AIDS, as well as a list of activities and programmes that the institutions were running to arrest the HIV/AIDS pandemic. Several documents have since been received, catalogued and placed in the Library, the MRCC, as well as in the Chairperson's Office.

The second activity that the Task Force is under taking is to run a workshop on HIV/AIDS for tertiary institutions in Namibia, as a first step towards regional collaboration in dealing with issues related to HIV/AIDS in tertiary institutions in the SADC region.

Information From Research Studies by Unam Staff and Students

Some information has been generated from preliminary studies and research conducted by academic staff and students of the University. These studies have provided some explanations pertaining to our understanding of the HIV/AIDS situation either in Namibia in general, or at the University of Namibia, in particular. We shall refer specifically to studies on:

1. Student/Youth Sexual Behaviours
2. Awareness of HIV/AIDS and sexually transmitted diseases among students of the University of Namibia
3. Impact Study Project on Improving non-formal Basic Education Programmes in Namibia.
4. Taking Risks - - Taking Responsibility: An Anthropological Assessment of Health Risk Behaviour in Northern Namibia
5. The Fogarty Projects in Namibia.

[There are other studies undertaken by UNAM staff which may not be directly relevant to the issues at hand but which have educational implications for issues related to HIV/AIDS - - e.g. Zimba and Mostert (1990); Zimba, Auala and Scott (NERA and UNESCO, 1994) Mostert and

Zimba (1990); Landsdown (1995); Otaala, Myers and Landers (1988); Otaala (2000) Zimba and Otaala (1995); Otaala (1996).]

1. **Student/Youth Sexual Behaviours**

A group six students (Tutalife, et al, 2000) from the University of Namibia Students Welfare Society who had taken part in the training of **My future is my choice** programme, undertook to investigate the views, beliefs and attitudes of fellow students at the University of sexual behaviour. Supported financially by UNICEF, the study was conducted at the main campus in Windhoek, at the Neudam Agricultural College and at the Northern Campus in Oshakati.

The objectives were:

1. To find how students perceive sexuality and why they engage in sexual activities before marriage;
2. To determine knowledge on prevention strategies;
3. To determine the role family members can play in providing sex education.

The results can be summarised as follows:

- **How Students Perceive Sex**

  (a) **Female students**

  (i) Sex is for sharing love and consolidating a relationship
  (ii) it is for economic reasons: you have to "sell" your body to have money;
  (iii) sex is for reproduction.

  (b) **Male students**

  (i) sex is for fun and pleasure or relieving stress and providing exercise "because if one has sex, they lose calories".

  (ii) In a more traditional African context people have sex to gain status in society and to manifest their manhood and maturity. One student replied, "If an man hasn't had sex, he is not a real man, and is likely to be mentally disturbed.

- **Engagement in sex**

  (i) boys advocated having more than one partner in case one partner was not available when needed or was not performing satisfactorily sexually. Some female students endorsed this view.

Another reason for having move them one partner was that in Namibia there were more women than men, and so men view it as their responsibility to cater for those women who would be lift out because there were not enough men.

And it was also pointed out that having more than one partner was being "cool" - - a status symbol

All respondents acknowledge that having more than one partner was involved risks of contracting STD's and HIV/AIDS.

(ii) **Knowledge of HIV/AIDS**

Students admitted having knowledge about causes of HIV/AIDS, and indicated need for more information. They also state that they had not really seen **live** AIDS victims to really believe that AIDS exists (seeing is believing!".

- **Reluctance in practising safe sex**

  (i) It is too time consuming (in the case of putting on a condom).

  (ii) It totally disturbs for foreplay which is a great enjoyment.

  (iii) It is not easy, especially when the body has already responded to the excitement as a result of foreplay.

  (iv) Most of the respondents (male and female) admitted to having had sex. For girls, by age 15, they had already had their first intercourse.

- **Communication about sex with parents and friends**

  There was a general observation that an open-talk between parents and their children was still considered taboo. There is therefore a "thick wall" between parents and their children when it comes to matters pertaining to sex. More girls indicated having had discussions with their parents (mothers) about menstruation, pregnancy, STD's and HIV/AIDS, but it is in contemporary Namibian culture a combination of both religious and cultural influences not to talk about sex with parents.

  From their research the students made the following recommendations.

Recommendations

1. AIDS education needs to address the whole subject of sexuality.

2. Young people need to be taught decision-making skills that can enable them to

protect themselves, and their sex needs ought to be seen in a positive light.

3. Schools should teach not only about sex and contraception but also about the development of personal relationships.

4. HIV/AIDS education needs to be integrated into such a curriculum and not treated as an isolated case.

5. Cultural attitudes towards the existence of HIV/AIDS must be evaluated and given greater attention.

6. It is essential that reliable knowledge is obtained about the behaviours and patterns of sexual responses among specific groups of people sot hat appropriate responses are employed.

7. If the relatively well educated young people were uncertain or lacking in understanding on a range of issues, this is surely an indication of widespread uncertainty or lack of knowledge among young people in general.

8. The findings from this study are important not only for the insight they give into students' beliefs and attitudes, but also for their potential impact on educational policy and practice.

7. **Awareness on HIV/AIDS and Sexually Transmitted Diseases Among Students of the University of Namibia**

Conducted by two academics, (Haoses, Unam) and van der Veen (NACOP/EC) the objective was to raise awareness on STDs and HIV/AIDS among students of the University of Namibia. A two-page questionnaire was submitted to all registering students in the 1999 academic year. After they had completed the form, educational materials and condoms were handed to each student. 1832 students (47% of those registering) completed the questionnaire.

Analysis of the questions revealed the following.

- The questionnaire. In general, the students seemed to have good knowledge about the basic facts of HIV transmission. Many respondents (33%) think, however, that persons with HIV have identifiable symptoms and die within 3 years after infection.

  Most students (88%) have a good knowledge on the main STD symptoms, although 26% also think that delayed menstruation may be a symptom of STD.

  There are still shortcomings in the basic knowledge on HIV/STD prevention. Of all respondents 105 (6%) think that oral contraceptives prevent HIV transmission, 643 (375) believe that HIV virus can pass through "holes in the condoms" and 366 (21%) think that Vaseline can be used as a lubricant with condoms.

The majority of responding students (68%) is sexually active and more male (78%) than female (58%) students confirm being sexually active. Of the sexually active students, 82% used a method to prevent pregnancy and 73% mentioned using a condom during the last sexual intercourse. Sexual activity increases according to the academic year from 51% for first year students to 8% for the fourth year. Knowledge on HIV/AIDS and STD and frequency of condom use, however, are not related to academic year of faculty.

The general conclusion of the researchers is that there are still some important shortages in basic knowledge on STD and HIV. Further interventions aiming at specific behavioural change (promotion of abstinence, contraception, condom use and reductions of number of partners) are needed to reduce the risk of STD/HIV and unwanted pregnancies.

3. **Impact Study Project on Improving Non-formal Basic Education Programmes in Namibia**

Indabawa, Avoseh and Shimpoleni (2000) is a study sponsored by UNESCO under the auspices of the Educational Research Network for Eastern and Southern Africa (ERNESA) used a Last Programme Beneficiaries and Impact Assessment Schedule to determine the possible impact of the non-formal education programmes that respondents had attended.

The authors state "We can now safely conclude that, as far as our respondents were concerned, non-formal basic education programmes in Namibia are helpful in transforming their lives for the better. The programmes have define impact on them. However, the degree of the impact varies according to impact indicators. Some have highest scores such as the following:

- Writing ability (96% or 376 responses);
- Reading ability (93% or 364 scores); and
- Care for victims and patients suffering from HIV/AIDS (93% or 364 responses)".

The above clearly indicates that the National Literacy Programme in Namibia, which seeks to make people able to read and write, especially in the vernacular in succeeding. Also, the wide spread campaigns on care for HIV/AIDS patients is equally making some positive impact on the people. The use of condom for safety and prevention of HIV/AIDS is also making positive impact with a score of 80% or 314 total responses. This should encourage the government and non-governmental bodies that are engaged in these campaigns to do even more, assured that the public are willing to listen and act to save themselves and others from the devastation of HIV/AIDS.

4. **Taking Risks - - Taking Responsibility: An Anthropological Assessment of Health Risk Behaviour in Northern Namibia**

This major consultancy study was undertaken by Le Beau, Fox, Becker and Mufune

(1999) under the sponsorship of the Department for Cooperation and cultural Affairs of the French Embassy in Windhoek.

Namibia has the third highest growth rates in the world for HIV infections. The regions of Namibia experiencing the highest rates of increase in the new HIV infections are the four regions int he former 'Ovamboland' - - Ohangwena, Otjikot, Omusati, and Oshana (the four "O").

The region was selected for an anthropological analysis of cultural factors which could affect health and risk-taking behaviour. Most of the information was collected through qualitative approach. Some of the major findings include the following:

(i) Some of the general concerns voiced were the nurses' apparent lack of concern for patient well being (especially Patients with AIDS(PWA)) and the belief that medicines prescribed were not given to them but were stolen by medical personnel.

(ii) Traditional healers were seen as a supplement to Western-based medicine. While respondents preferred a hospital or clinic for the treatment of most illnesses, certain health problems (e.g. infertility, epilepsy, and mental illness) were seen as the exclusive pressure of traditional medicine.

(iii) The most common adult health concerns mentioned were STDs, AIDS, TB, malaria and alcohol-related diseases. For children Diarrhoea, malnutrition, coughs, and colds were identified as health concerns for children. These health concerns roughly coincide with the major causes of mortality and morbidity in Namibia. The leading causes of death of adults are AIDS, TB, and malaria. And the leading causes of mortality of children under five (excluding neonatal deaths) are diarrhoea, undernutrition, ARI, and malaria.

(iv) Among the health concerns are what can best be described as diseases of poverty; diseases caused by infections and parasites --

(v) People clearly fear AIDS but this does not appear to have a radical impact on sexual practice. Condoms were being used, but men who were interviewed said that they did not use them for every sexual encounter. The influence of alcohol was frequently a reason for this.

(vi) Given women's relatively low socio-economic status in Owambo society, it is highly unlikely that a women can refuse husband's sexual advances. Poverty is intimately linked to sexual risk-taking behaviour, especially for women. Due to women's relatively lower socio-economic position vis-a-vis men, women are frequently forced to participate in sexual risk-taking behaviours: either in the form of exchange or classic prostitution or by their inability to enforce safe sex practices.

(vii) In addition to sexual violence in relationships, young girls and women are also exposed to rape.

(viii) The official position of most church organisations in Namibia is that condoms should not be used outside of marriage and that sex education is not good for adolescents, since it is thought to encourage premarital sexual relations which are against church doctrine.

(ix) Although many people now know that AIDS kills; there are still significant gaps in the level of and accuracy of knowledge community members posses. For instance there are certain misconceptions about AIDS such as: "You can get AIDS from drinking from the same cup"; "sex with a child or virgin can cure AIDS" and "AIDS is caused by witchcraft".

(x) By now most people have relatives and friends who have either died or suffer from full-blown AIDS. Due to strongly held prejudices, many people with AIDS are isolated in their own huts or rooms, in remote parts of homesteads or confined to the outskirts of villages. They are isolated in a way that shows a strong fear of contamination by non-AIDS persons.

5. The Forgaty Projects in Namibia

Finally we refer to the Forgaty Programme for International Public Health which has been operating a programme on the epidemiology of HIV/AIDS in South Africa since 1990. In 1996 the programme was extended to Namibia and Botswana, and in addition to the epidemiology of HIV/AIDS the researchers explored social science approaches to the cultural and social science approaches to the cultural and social aspects of HIV/AIDS - - aspects which increasingly seen as crucial to bring the epidemic down in the hardest hit countries in Southern Africa.

In the Namibian Project teams of researchers including staff and students from the Faculty of Medical and Health Sciences of the University of Namibia and front line health professionals in the AIDS field were given training in under taking research in HIV/AIDS. Four research teams were assembled to investigate topics organised around the following themes:

- Research on women's power in sexual and domestic situations,
- Research on particular problems of women and their children and infants, including issues of vertical transmission and breast-feeding,
- Research on problems of youth, values and expectations regarding sexual negotiations, condom use, and other issues;
- Research on men, a relatively neglected area of research, at least in the Namibian context, where men are often unwilling to be subject in research projects regarding sexual matters.

The rationale for understanding the research applying social research approaches was that although understanding social and cultural forces is important in the control of HIV/AIDS everywhere, three factors make it particularly necessary to understand social

and cultural forces in the African AIDS context. First the sociology of the disease is so different from that of the First World, second the seropositive rates are so much higher, and third the medical budgets are so much smaller. Current medical treatment via new combinations of expensive drugs are simply out of reach of all but a small minority of Africa's AIDS victims.

Therefore it has long been recognized that the only way that the countries of SADC region can bring the epidemic under control is through behavioural change. To do this people of the region must have a deeper understanding of the social, cultural, and economic factors that appear to be driving the spread of HIV/AIDS. Further the resources of the overseas agencies and international NGOs are limited, so it is necessary for the research communities of each country to build capacity to carry out their social research more effectively.

The results of the research conducted in Namibia are available in reports which have been distributed the University of Namibia Library, to the Faculty of Medical and Health Sciences at the University of Namibia, to the Ministry of Health and Social Services, and to other stakeholders.

There is a high degree of support for the Fogarty programme at the University of Namibia and based on financial support begin forthcoming future plans world include:

1. The Faculty of Medical and Health Sciences, University of Namibia, world like to continue annual research workshops as currently being conducted.

2. Exploring the possibility of post-graduate study opportunities for selected members of staff who would return with further degree to enhance the quality and quantity of research in HIV/AIDS.

3. Collaboration with the University of Botswana which also operated the programme as well as with other SADC Universities and institutions with similar interests.

The results of the various studies described above have been shared at seminars and workshops on campus, as well as in meetings within the country. In addition all the various authors have presented the results of their work in various regional and international conferences, the most recent of which the International Conference on HIV/AIDS held in Durban South Africa. Journal articles as well as chapters in books have also been produced. And all of these are placed in the Special Section of the University of Namibia Library.

We now briefly turn to some observations before providing a summary of reflections.

SOME OBSERVATIONS

From the above descriptions of the University of Namibia it is clear that the University has made some significant strides in addressing the issue of the HIV/AIDS pandemic. Examples of these include:

(i) Recognition of the Office of the Vice Chancellor that HIV/AIDS is a major threat to the University.

(ii) Establishment of an HIV/AIDS Task Force with clearly articulated terms of reference.

(iii) Existence of a Students' Welfare Society which specifically deals with issues related to HIV/AIDS, through a programme called **My Future is My Choice**.

(iv) Passage by Sane of University guidelines on HIV/AIDS; and,

(v) More recently after the workshop on HIV/AIDS for tertiary institutions in Namibia, a directive by the Vice Chancellor that:

  (a) Each Department and Faculty should constitute an HIV/AIDS Committee which will link up directly with the University HIV/AIDS Task Force;

  (b) a special research fund be set aside as from 2001 for HIV/AIDS related activities; and

  (c) a special research fund be established as from 2001 for research related to HIV/AIDS.

But some of the University actions have been wanting in some areas. For instance the present policy guidelines leave something to be desired:

- In their present form, the Policy Guidelines on HIV and AIDS, constitute a "status quo" response to the disease. The Guidelines are primarily directed at prevention, counselling and information dissemination. Important as these are, however, experience elsewhere has shown that there is a need for what Mary Crewe from the University of Pretoria, calls "a new language" on HIV/AIDS. In her language, there is a need to "mainstream" AIDS, through a "culture of critique", curriculum design (based on the notion of 'social critique'), testing understanding in community structures through projects undertaken by trained student volunteers, fostering research around sexuality and HIV/AIDS in multi-cultural contexts and providing student counselling services around the clock in hostels.

- The policy does not enjoy the ownhership of the university community; only pockets of the University are doing something.

- In addition to the above issues, it is equally important to remind ourselves that for any policy to work, such a policy would require *substantial funding and inter-faculty management. It is simply not good enough to expect from deans and centre directors to implement policy*. Inter-faculty and inter-disciplinary committees need to **report** directly to senior management. **Students** should play a central role in the design and implementation of policy. Deans and other managers ought to undergo training and courses on subjects such as "HIV/AIDS in the workplace". The University may also wish to explore matters such as a hospice/care facility for infected students and staff, as well

as appropriate insurance cover.

It would therefore be appropriate to take stock of what we have done right, and what we as a university still need to do to ensure a promising future for our University Community against the battle of the HIV/AIDS pandemic.

Arising from these observations some lessons/recommendations are made which would constitute a way forward. We turn to a consideration of these.

5. SUMMARY OF REFLECTIONS: EXAMPLES OF GOOD PRACTICE

Introduction

> "... the AIDS pandemic confronts us with a full range of development issues ... issues of poverty, entitlement and access to food, medical care and income, the relationships between men and women, the relative abilities of states of provide security and services for their people, the relations between the rich and the poor within society and between rich and poor societies, the viability of different forms of rural production, the survival strategies of different types of household and community all impinge upon a consideration of the ways in which an epidemic such as this affects societies and economies" (Barnet and Blaikie 1992:5).

> "Across Africa, evidence for the seriousness of ... downstream effect is accumulating rapidly; given the nature of the disease and the shape of the epidemic curve ... now is the time to take action to mitigate the worst effects in the next two decades. Because this is a long wave disaster, ... the effects we are seeing now in Uganda and elsewhere are the result of events (personal, communal, regional, national, and international) that occurred a decade or more ago. Action taken now cannot change the present, nor can it change the immediate future. It can change the way the situation will look in the years after 2010" (Barnet and Blaikie 1992:167).

This crisis facing Namibia and the University of Namibia of which it is part, is now well established. The Vice Chancellor, the Dean of Students and professional Faculties such as Education and Medical and Health Services, have from 1992 onwards conducted a number of workshops and seminars designed to sensitize mainly students to the dangers of HIV/AIDS. Some Faculties and Departments, as well as individuals have incorporated into their programmes aspects covering HIV/AIDS issues.

The University's current policy guidelines on HIV/AIDS, though approved in 1997, covered areas that the Namibia Government had drafted and adopted legislation on. Yet, as Figuera (2000) has observed:

> “Despite the establishment of a fairly comprehensive policy framework designed to promote a non-discriminatory environment in respects of HIV/AIDS, in practice people living with HIV/AIDS in Namibia suffer widespread rights abuses at the hands of family members, health care workers and employers. Employers are denied access to employment solely on the basis of their HIV status. Women with HIV are forced out of home with their small children and made to live in a car wreck in the backyard. The HIV status of patients is disclosed to family members, friends and sometimes complete strangers by health care workers who have no regard for confidentiality. People are tested for HIV without their consent, both at the instance of employers and by health care workers who see it as “just another test in the diagnostic process”. The prohibitive costs of anti-retrovirals dictate that the majority of Namibians do not have access to these drugs which prolong and improve quality of life. The list is endless. And the vicious circle continues - as long as there is stigma and discrimination on the basis of HIV and as long as the rights of people with HIV/AIDS continue to be abused, people will not come forward for voluntary testing and counselling and the rate of infection will remain unaltered.” (P.13)

In this last section we shall first indicate some of the principles which can be identified for future work to prevent HIV infection. We shall identify a number of areas that need to be tackled as we draw lessons from the present exercise (project).

Principles for Success with Work with Young People

- There is evidence to suggest that in Namibia and the University of Namibia, young People engage in sex earlier than in the past, for a variety of reasons.

- Formal programmes of sex education and HIV-related education are most successful when they include messages about safer sex as well as abstinence.

- Teachers/lecturers also require training in delivering sex education and developing confidence in talking to young people about sex. Supportive environments, including support from policy makers and educationalists, are important in helping teachers to deliver effective programmes of HIV-related education.

- There is evidence to suggest that peer education programmes (such as **My future is my choice)** support young people in making changes to their behaviour.

- Programme designers and others concerned with HIV-infection must promote a greater awareness of sexual and reproductive decision making, including rights and protection of young people as well as improved access to education and health services.

- Young people, particularly girls and those living in precarious circumstances (such as those focussed in the environs of cities such as Windhoek) need protection from rape, sexual exploitation and coercion.

- Improved access to non-judgmental and user-friendly sexual health services is crucial for young people. Training in adolescent and youth health issues should be provided to health workers in the field of sexual and reproductive health.

- Young people particularly at UNAM need improved and increased access to good quality condoms (and femidoms!)l it is important that confidential and non-judgmental provision is improved for young people on campus.

All of the above principles have programme implications. HIV-related prevention with young people should continue to be given high priority, since by working with them it will be possible to have a significant impact on the future course of the epidemic. The most effective programme:

- respond to diversity of young people and their needs;
- encourage youth participation in design and implementation;
- work in a climate of openness that recognizes realities that young people face;
- focus on young men's sexual health needs as well as those of young women;
- focus on the positive aspects of sexual health needs as well as unwanted pregnancy and sexually transmitted infections;
- promote greater awareness of sexual and reproductive health rights; and
- offer improved access to education and health services.

(Piot and Aggleton, 1998)

> "Activities implemented now that focus on behaviour change and that are based on realistic understanding of the changes required to reduce the spread of infection will generate enormous benefits in terms of avoidance of future costs ... Low prevalence countries are in a position to act now with effective policies to prevent the spread of HIV and thus toa void its economic, social and psychological costs ... it is crucial to act now, and not to wait until a point where these costs become unavoidable. The returns from effective HIV prevention activities in all countries, with high or low seroprevalence, will in most cases substantially exceed those from other investments" (Cohen n.d.: 12, 27).

We briefly no describe lessons or areas that need emphasis.

1. **Leadership and Coordination**

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.

To this end leaders at all levels of the University that are committed to change and educational reform may find it useful to reflect on the following questions:

1. Are we keeping the "big picture", the mission and vision in mind?

2. Is the attention to how the various elements of our institutions relate to the reform process? What are the various synergies - - the connections - - between various strategies that assist and nurture reform?

3. Is the reform process embedded throughout the units of the institution? In what ways are people at all "levels" of the institution involved.

4. Are we approaching change or reform in a systematic, and strategic way?

The Vice Chancellor needs to give leadership as he has done in the past, in keeping the "big picture" of the issues of HIV/AIDS at the University in mind. Coordination should be at the Vice Chancellor's Office level, with preferably a **Unit on HIV/AIDS** created and placed under the **Unit for Improving Teaching and Learning**.

2. **Resources**

The Office of the Dean of Students in which work on guidance and counselling is undertaken and in which the health clinic is placed clearly understaffed for the enormous task of overseeing the health and social needs of over 4000 students (1000 of whom are residential) and nearly 700 academic and administrative staff. Accordingly financial provision for the Dean of Students' Office needs urgent review.

3. **Health and Prevention**

Information obtained from the University of Namibia through the current investigation, does not provide a full picture of the HIV/AIDS epidemic on campus. It is important, through further work, to establish as far as possible the extent to HIV infection in the whole campus community, and to predict probable future patterns and levels of infection.

In terms of institutional culture, it is important to note that in some cases, the existing HIV/AIDS prevention and education work is being countered by other sanctioned activities that are elements of the campus culture. For example, alcohol abuse is known to contribute to HIV/AIDS infection, and yet alcohol tends to be freely available on campus, as witnessed by the incidents in the recent "cultural week" as well as "HIV/AIDS Awareness week" when students use alcohol liberally during campus dances designed to "bring about HIV/AIDS awareness".

There is a need for more HIV/AIDS workshops for all the University Community. Such

workshops would be designed to create and implement an HIV/AIDS strategy in the workplace and it could contain the following three components:

(i) **Understanding the Impact HIV/AIDS will have on the University of Namibia workforce**:

* Highlighting the Namibian picture: present and future implications
* Developing a collective SADC approach to tackle HIV/AIDS.

* Prioritising the Namibian Government's pro-active approach to tackling HIV/AIDS.
* We know the statistics - what is the next step?

(ii) **Assessing and countering the Impact of AIDS in the workplace**

Examining the Epidemiology of AIDS

Analysing the Current State of the Epidemic
* Examining patterns and trends
* Discussing the socio-economic determinants
* Understanding the epidemiology

HIV/AIDS a Clinical Disease
* An overview of the clinical perspective
* Examining new therapeutic developments
* Implementing costs-effective HIV care
* Mother to child HIV transmission prevention
* HIV and STD (Sexually Transmitted Disease) - the association
* Opportunities for prevention

HIV/AIDS a Business Perspective
* Monitoring and quantifying the epidemic within a workforce
* Understanding and examining the legal issues
* Attitudes about HIV/AIDS
* Strategies for addressing the epidemic in a workplace - strategic planning, prevention and coping with the impact.

(iii) **Developing and implementing an HIV/AIDS Corporate Strategy**

* How to gain board and union level commitment
* Identifying your corporations needs with relation to HIV/AIDS
* Developing the Strategy with regard to:
* Epidemic containment
* Economic containment
* Living with AIDS
* Research and education
* Implementing the strategy.

As the above-named workshops are being run as well as other HIV-related preventive measures are being taken, it is important to keep in mind ethical issues involved in developing HIV/AIDS awareness programmes. The positions of Jos Holtzhauzen and Lucy Steinitz speak for themselves, in this regard (see boxes)

WAYS TO ADDRESS HIV-AIDS

1. In the light of the devastating effects of HIV-AIDS pandemic on the economic, political, social and spiritual life of the nation we call upon the Government, non-governmental organisations and the Church to:
   I. Acknowledge the seriousness and far-reaching effects of this life-threatening disease;
   ii. Intensify re-educational programmes of abstinence, morality and chastity;
   iii. Acknowledge that condoms do not guarantee 100 per cent so-called 'safe-sex' under conditions and therefore cannot protect people from contracting this and other sexually transmitted diseases.

2. We call upon the leadership of the body of the Lord Jesus Christ, the Church, to demonstrate its determination to make a difference in society by setting new standards in mentoring and role-modelling moral behaviours and values for the youth, who are the future of our nations.

3. We call upon this generation of young people to stand up and accept the challenge to be different by setting a new standard of leadership through high moral behaviour and conduct by staying sexually pure.

   They should embrace sexual purity through abstinence until marriage and thereafter through faithfullness to their partner.

Jos Holtzhausen
National Director: Youth for Christ
Windhoek

VIRGINITY IS NOT A DIRTY WORD

In the past few weeks, we have witnessed a growing debate on the "Take Control" advertisements on NBC television, which promote condom use to prevent HIV-AIDS and other sexually transmitted diseases.

It seems that many viewers worry that these advertisements cause young people who are not yet sexually active to become so, at a much too early age. "Promoting condoms pushes one into sexual activity", they say, "like promoting the Internet pushes one to buy a computer". Others argue, "No, young people (and others) are having sex anyway, and it is better to use a condom than risk unwanted pregnancy, illness, and death".

I would argue that this is not an either- or debate. Much as TC influences thought-patterns and behaviour, young people are influenced to a far greater degree by the teachings and role-models provided by their parents, guardians, and peers. On the other hand, if the "Take Control" campaign ONLY emphasises condom use, then it misses half the point.

Young people want choices. In fact, we all do. This is part of living in a democratic society. Parents

and community-leaders must also understand that the world in which young people live today is very different than the world of twenty or thirty years ago. It is no longer sufficient just to tell our young people what to do; rather, we must listen to their concerns in order to offer them different options from which to make their own best choice.

One of the problems with the current advertising campaign on condom-use is that the choice they pose is between “condom use” and “no condom use”.

Not only is this approach repgunant to many traditional religious values, it suggests a dangerous and deadly games: a “Russian Roulett” between life and death, in which the risk of HIV infection continues to loom large.

Why not, instead, provide MORE CHOICES to young people? I’m not suggesting that the advertisements for condom-use be eliminated - certainly for those people who are already sexually active (outside of a faithful marriage), condom use is still the better option. But what about those who are not?

Let’s be clear: Not everyone is having sex. Virginity is not a dirty word. Neither is abstinence. These concepts deserve equal time in our media campaigns, especially when targeting young teenagers or people who are between relationships.

Young girls, especially, stand the greatest risk of HIV infection if they are not yet sexually or physically mature.

When I think of teenage children in this context, I also worry about their emotional maturity. Abstinence is most certainly the preferred option for them, at this time of their lives.

But abstinence doesn’t just apply to our young people. For example, abstinence can - and should - also be promoted for those of us who are married but who must sometimes work or travel far away from our spouses.

And for those of us who are between serious relationships, instead of engaging in casual sex.

We need more balance in our “Take Control” campaign. Let’s not lose sight of the fact that the “A” (for Abstinence) and the “B” (for Be faithful in marriage) comes before “C” for Condom.

How about some ads reminding us that Virginity is not a dirty word, and that Abstinence - in some situations - is a sign of real control?

The author of this opinion, Lucy Y Steinitz, PhD, is with Catholic AIDS Action.

4. Curriculum Development

The UNAM HIV/AIDS Policy Guide emphasises the need to develop informational modules as well as other modules related to HIV/AIDS issues. Currently, as already noted elsewhere, a few individuals and Departments/Faculties have incorporated aspects of HIV/AIDS issues into their programmes. Clearly there is need to develop teaching and learning materials, and there is need for courseware development, curriculum development and development of postgraduate programmes to enable Namibian gain further training in the area of HIV/AIDS.

5. Strengthening the Role of Research

Research already conducted by students and staff is quite impressive and significant, and covers early childhood, adolescents and youth, and some categories of adults. Clearly there is need by the University to engage in cutting edge research that addresses critical issues posed by HIV/AIDS and to connect its teaching and research in creative and effective ways with people and communities, particularly rural and urban communities. A variety of areas could be covered including the following: epidemiology, prevention, care, counselling, social mobilisation, community development and policy and human rights and socio-economic impact. The research should particularly focus on children, youth, women and special g roups, reproductive health, and the role that men and cultures play in the spread of HIV/AIDS.

A strong enduring infrastructure for HIV/AIDS should be established, possibly housed at the University's Multi-disciplinary Research Centre and Consultancy (MRCC) to ensure that the University of Namibia is able to carry out its leadership role on an ongoing basis.

A strong and effective research voice depends on an ongoing organizational home (such as the MRCC), a reliable funding base, and strong institutional relationships with the external research community. In consultation with external researchers and the UNAM community, the University should conduct a thorough review of the alternatives for providing these key elements of the infrastructure. Key issues to address would include:

- Development of an organizational structure to support MRCC research programme;
- Assurance of sufficient financial and personnel resources to carry out a strong research programme;
- Development of strong and lasting relationships with the external research community;
- Development of a data infrastructure, through the establishment of a data archive and continual updating, synthesis, and dissemination of the literature; and
- Assurance of ongoing input from researchers as well as practitioners, through one or more working groups that can provide advice in the planning and design of the research agenda and individual studies.

We now turn to concluding remarks.

Concluding Remarks

The University of Namibia, like the rest of Namibia, faces the threat posed by the HIV/AIDS pandemic, and how to respond to this threat. The magnitude of this task is enormous, and, consequently, so is the responsibility taken by the University community through various present and future activities designed to stem and arrest the spread of HIV/AIDS. We believe that the message is not at all bleak, for the future doe snot have to be like the past. HIV spread can be prevented and we can deal with the consequences of AIDS. We believe that with strong and visible leadership from the University Administration there will be resonance from below. In the words of Human and Tafelberg (2000).

> Our key message is that, along with visible leadership from government and big business, the rest is up to each and every one of us making a small contribution in our own way. The battle against HIV and AIDS will only be won by millions of initiatives at grassroots level. Some will be more effective than others, but *every little bit will count*. In the process, we have a good chance of creating a civil society - civil in the orthodox sense of building strong and sustainable institutions which are independent of the state; but civil too in the sense of instilling a genuinely caring ethic and feeling of fellowship among all the citizens who make up this remarkable country.

Finally, Figueira (2000) has argued, that the need for a rights-based response is clear and that the link between human rights violations and vulnerability to AIDS "creates opportunity to intervene at the deepest societal level, and thereby combat the epidemic".

If we are to achieve success in this regard however we must not relent in our efforts to mainstream HIV/AIDS as a human rights issue in Namibia.

To borrow from the words of Mr Justice Michael Kirby in his closing address at the First National Conference on Legal Rights and AIDS held in South Africa in 1993:

"The day will come when HIV/AIDS is consigned to a footnote to human history. We will not be overcome by HIV/AIDS. Death will not dominate us. Life will assert its dominion. In the end, with the spirit of co-operation amongst people of every nation, every race, every age group, every expression of sexuality, every walk of live: we will overcome HIV/AIDS. And then death will have no dominion:

'And death shall have n dominion.
Dead men naked they shall be one
With the man int he wind and the west moon;
When their bones are picked clean and the
Clean bones gone,
They shall have stars at elbow and foot;
Though they go mad they shall be sane,
Though they sink through the sea they shall
Rise again;
Though lovers be lost love shall not;
And death shall have no dominion.'

(Dylan Thomas)

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