



# HIV AND AIDS STIGMA AND DISCRIMINATION SURVEY IN NAMIBIA

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Namibia

# Namibia

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# Acronyms

<b>AIDS</b>	Acquired Immuno-Deficiency Syndrome
<b>ART</b>	Anti-Retroviral Therapy
<b>ARV</b>	Antiretroviral
<b>CPD</b>	Continuing Professional Development
<b>FGD</b>	Focus Group Discussion
<b>GIPA</b>	Greater Involvement of People Living with HIV and AIDS
<b>GNP+</b>	Global Network of People Living with HIV
<b>HCT</b>	HIV Counselling and Testing
<b>HCW</b>	Health Care Worker
<b>HF</b>	Health Facility
<b>HIV</b>	Human Immuno-suppression Virus
<b>IPPF</b>	International Planned Parenthood Federation
<b>KI</b>	Key Informant
<b>KP</b>	Key Population
<b>LOE</b>	Level of Effort
<b>MIPA</b>	Meaningful Involvement of PLHIV
<b>MOHSS</b>	Ministry of Health and Social Services (Government of Republic of Namibia)
<b>MOHSS/DSP</b>	Ministry of Health and Social Services/ Directorate of Special Programs
<b>MTR</b>	Mid-Term Review
<b>NDHS</b>	National Demographic and Health Survey
<b>NGO</b>	Non-Governmental Organisation
<b>NHSS</b>	National Health Strategic Plan
<b>NSF</b>	National Strategic Framework
<b>NSP</b>	National Strategic Plan
<b>PLHIV</b>	People living with HIV
<b>PMTCT</b>	Prevention of Mother-To-Child Transmission
<b>RH</b>	Reproductive Health
<b>SADC</b>	Southern Africa Development Cooperation
<b>SDG</b>	Strategic Development Goals
<b>SRH</b>	Sexual and Reproductive Health
<b>TB</b>	Tuberculosis
<b>UN</b>	United Nations
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS



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## Executive Summary

The main aim of conducting this Survey was to join the global action to reduce stigma and discrimination related to HIV and AIDS through the creation of a supportive framework that will inform HIV and AIDS policy advocacy and programming. Specifically, the Survey intended to document the experiences of PLHIV regarding stigma and discrimination, examine the context of disclosure and access to treatment, document promising approaches to stigma and discrimination that could be taken to scale, document the experience of health facility staff regarding stigma and discrimination, and compare manifestations of stigma and discrimination in Namibia and other neighbouring countries in the region that have conducted similar Surveys. It is important to note that the other comparative Surveys only looked at stigma and discrimination as reported by PLHIV and not health facility personnel.

The Survey was also intended to generate evidence and gaps that fuel stigma and discrimination among PLHIV as well as profile practices in health care delivery that can be drivers for stigma and discrimination.

For Namibia, this is the first stigma and discrimination Survey. The Survey will therefore serve as a baseline for subsequent related surveys so as to monitor the trends of HIV related stigma and discrimination among PLHIV and the health care delivery settings. The purpose of presenting this data in form of an index was to help the MOHSS and other partners to design interventions that will address problems that affect PLHIV and promote their quality of life in specific contexts. Broadly, the information generated by this Survey will be used as an evidence-based tool for critical advocacy activities to promote values of inclusion, compassion, acceptance of PLHIV as equal members of society while at the same time enhancing positive, health, dignity and prevention among them. The findings of this Survey will also be used to enhance the values of care which are mandated to health care workers.

The information generated by this Survey will also be used by health care workers to self reflect on how best they can deliver care to this significant section of the population in a manner that is acceptable to service recipients and is consistent with good practices of health care delivery.

The Survey adapted a combination of approaches that included documentary review, and standard cross-sectional interviews that targeted PLHIV and health facility staff in seven regions. Focus group discussions (FGDs) and key informant (KI) interviews were also held so as to collaborate the quantitative data generated. For health facility staff, a questionnaire designed by The Health Policy Project (Futures Group, 2013) was adapted for collecting data. For PLHIV, a questionnaire that was developed by the Global Network of PLHIV (GNP+) was adapted as the data collection tool.

A total of 749 interviews were conducted among the PLHIV community. For the health facility based population, a total of 241 interviews were conducted. The majority of PLHIV respondents (80.0%) reported that they had biological children while 25.0% indicated that they had either fostered or adopted children. The Survey therefore indicates that most of the PLHIV in Namibia have significant responsibilities related to child care. Some of these children may be living with



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HIV. In order to support such individuals, there is a need to intensify PMTCT services so that the likelihood of babies acquiring HIV is further reduced.

The PLHIV respondents who reported that they had children indicated that they had a lot of fears related to parenthood. Most of them reported being afraid of dying and leaving their children orphaned. This was followed by a fear of giving birth to an HIV positive baby. On the other hand, the PLHIV respondents were not worried about availability of PMTCT services. However there were 23.1 (n=77) female respondents that reported a lack of knowledge about PMTCT services.

PLHIV respondents did not express concern over lack of qualified staff and unavailability of HIV test kits. Similarly, the issue of cost of the HIV tests was not presented as a concern.

The findings of this Survey indicate that the country is dealing with moderate levels of stigma and discrimination. For instance while a majority of the PLHIV respondents reported that they did not experience specific forms of stigma like exclusion from religious activities and social gatherings, a few indicated that they had experienced some of the forms of stigma and discrimination. The most common form of stigma reported was being gossiped about. Gossiping was defined as ill talk about another person because of their HIV status. A total of 92 respondents (12.4%) reported that they had faced some form of rejection because of their HIV Status. The respondents largely attributed stigma and discrimination to a lack of understanding of how HIV is transmitted by the communities who demonstrate fear of contracting HIV from persons known to live with HIV. Moral judgement was reported as the least cause of stigma in Namibia. On matters related to work, the most common manifestation of stigma and discrimination that was reported was loss of a job and being denied a promotion on the account of one's HIV status.

This Survey found that the existence of stigma and discrimination gave rise to a sense of feeling ashamed by the PLHIV and self blame. Individuals who have these kinds of feelings tend to have low esteem and may take on practices that are not empowering to themselves and others, including exposing their sexual partners to risk of HIV infection. The survey found that in order to deal with stigma, the most common strategy adapted was a decision not to have any more children. This was reported by 27.1% (n=201) of the respondents.

While this Survey found that institutionalized stigma was not the norm, it actually existed nevertheless. Several respondents reported being coerced into undergoing medical procedures without their consent (6.3%, n=47) while others reported that they had been denied health insurance on the account of their HIV status. However, only about one third (34.4%, n=258) of the respondents answered the question related to institutionalized stigma and discrimination.

The majority of the PLHIV respondents for this Survey (59.4%, n=351) reported that they did not take any action to address stigma and discrimination. Similarly, the majority of respondents (58.9%, n=332) indicated that they did not support someone who had experienced stigma and discrimination. For those that reported that they supported someone, the most common form of support was providing emotional support.

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While many organisations and programs exist to address stigma and discrimination in the country, the majority of the PLHIV respondents (58.8%, n= 436) indicated that they did not know any PLHIV support groups. This category of respondents acknowledged that raising public awareness, educating PLHIV on stigma and discrimination and providing emotional, material and referral support were important interventions to address stigma and discrimination.

The most common reason given for taking an HIV test by the PLHIV respondents was simply for one to know their HIV status (69.6%, n= 480). They also reported that taking an HIV test was a voluntary decision (90.5%, 641) one personally took. However, there were a few respondents (0.4%, n=3) who indicated that they took the HIV test either under influence from others or under coercion.

Many respondents (81.2%, n=601) reported that they had discussed their HIV status with their family members as well as HCWs (78.5%, n=582), while a few (12.5%, n=91) reported disclosing their status with colleagues at work. This was consistent with the reactions PLHIV received from colleagues at work which was more discriminatory than that received from any other category of people who got to know of the HIV status of the respondents.

A majority of the PLHIV respondents (91.9%, n=678) reported that they were in good health. Similarly, a majority of the respondents (90.9%, n=660) were on ART regimens of care. However, some of those on ART regimens expressed concern over their inability to get enough food (33.0%, n=240). Some respondents reported missing ART and TB doses. The most common reason given was because they forgot (53.5%, n=54). The issues of sharing medicines and drug stock outs were not prominently reported. Only two respondents reported that they had missed drugs because they had shared them with someone else.

A total of 509 (70.2%) of the PLHIV respondents reported that they had a constructive conversation with their HCWs about treatment options. This indicates that there is a good patient-health care worker relationship. More than half of PLHIV respondents (50.4%, n=368) did not report problems related to accessing reproductive health services. There were a few respondents who reported experiencing some biases from both HCWs and members of the community like being advised not to have any more children. A total of 61 female respondents reported that they were advised that future access to ART was subject to contraception use.

Overall, this Survey revealed that there are measurable levels of stigma and discrimination tendencies within the health care settings. Most of the health care providers did not report any concern over providing care to key population groups. However, some indicated that they were not familiar with the guidelines that were in place to protect patients from stigma and discrimination. Approximately one-third (34.2%) of the health facility respondents indicated that they were worried about HIV infection while helping pregnant others during labour.

For some indicators of stigma and discrimination, Namibia experience was relatively better than other countries. For instance, while only 6.0% of the respondents in Namibia reported having lost a job because of their HIV status, 21.9%, 18.2% and 15.0% reported having lost a job in Zimbabwe, Zambia and Botswana respectively. For other indicators, the Namibia experience is worse off compared to other SADC countries. For instance, while 8.2% of the respondents in



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Namibia reported being excluded from religious activities because of their HIV stats, only 4.0%, 2.0% and 4.3% reported the same for South Africa, Botswana, and Lesotho respectively. Similarly, more respondents in Namibia reported that people were afraid of contracting HIV from them (44.5%) compared to 10.4%, 27.2% and 10.4% in Zambia, Swaziland and Botswana respectively.

This Survey recommends a multi-sectoral approach to responding to community based and health facility based stigma and discrimination by launching an anti-stigma and discrimination campaign, active engagement of local authorities and traditional leaders and deliberate engagement of the faith movement in addressing community based stigma and discrimination. In the health and social sector, the Survey recommends that the MOH intensifies the roll-out of integrated approaches to HIV and AIDS care, strengthening youth friendly services, training health care workers to promote holistic care for PLHIV, promoting policies and protocols related to stigma and discrimination among health care workers, and enhancing community based HIV awareness, as well as strengthening PLHIV support groups.

Because most of the drivers of internal stigma and discrimination are poverty and social oriented, The Survey recommends that the agricultural sector supports PLHIV groups to engage in agricultural activities, the education sector strengthens life skills to include lessons on HIV and AIDS dialogue. Similarly, the youth development sector should strengthen youth drop in centers and having coordinators of such centres HIV competent so as to support young people in being catalysts of addressing stigma and discrimination.



## Chapter 01

### *Introduction*

#### Background of HIV and AIDS stigma surveys

HIV related stigma and discrimination is a process of devaluation of people either living or associated with HIV and AIDS. Discrimination follows stigmatization and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status. No matter which way one looks at stigma, its effects are largely negative and grossly affect the quality of life of PLHIV (UNAIDS, 2003). Most commonly, it restrains prevention, treatment, care and support interventions. The most common form of manifestation of stigma and discrimination include rejection by family, friends and community, reproductive rights abuse, avoidance and isolation, moral judgments and self exclusion.

Ending AIDS by 2030 is an integral part of the Sustainable Development Goals (SDGs), which the United Nations member states adapted unanimously in 2015. The lessons learned in responding to HIV will play an instrumental role in the achieving many of the SDGs notably SDG 3: good health and well-being, and goals on gender equality and women empowerment, reduced inequalities, global partnerships and just and inclusive societies (UN, 2015).

The 2016 Political Declaration on ending AIDS was adopted in June 2016 at the United Nations General Assembly High-Level Meeting on Ending AIDS attended by high level government officials from more than 100 countries (UN, 2016). World leaders made high-level political global commitment to fast track the fight against HIV and to end the AIDS epidemic by 2030. The Declaration's level of ambition, inspired by the Fast-Track approach, is unprecedented with the adoption of the 90-90-90 targets, committing the world to almost doubling the number of People Living with HIV and AIDS (PLHIV) on treatment by 2020 as well as ensuring that 1.6 million children living with HIV are on treatment by 2018. The prevention targets are equally ambitious, committing countries to eliminating new HIV infections among children and ensuring their mothers' health and well-being is sustained, and ensuring that all women and girls and key populations (KPs) are reached by tailored combination prevention services. Aligned with the central message in the 2020 agenda for Sustainable Development to leave no one behind, the Declaration explicitly recognizes KPs at higher risk of HIV, including men who have sex with men, people who inject drugs, sex workers, prisoners and transgender people. To accelerate progress, the Declaration places strong emphasis on acknowledging the vast diversity of epidemics and tailoring responses that focus on the locations and populations most affected. The Declaration further recognized that human rights violations and gender inequality remain major obstacles in the AIDS response, and there is a strong commitment to eliminate HIV related stigma and discrimination and violence against women (UN, 2016).

For the past 30 years, stigma and discrimination have been serious and burdensome issues for PLHIV and those that care for them. Stigma not only makes it more difficult for people trying to come to terms with HIV and manage their illness on a personal level, but it also interferes



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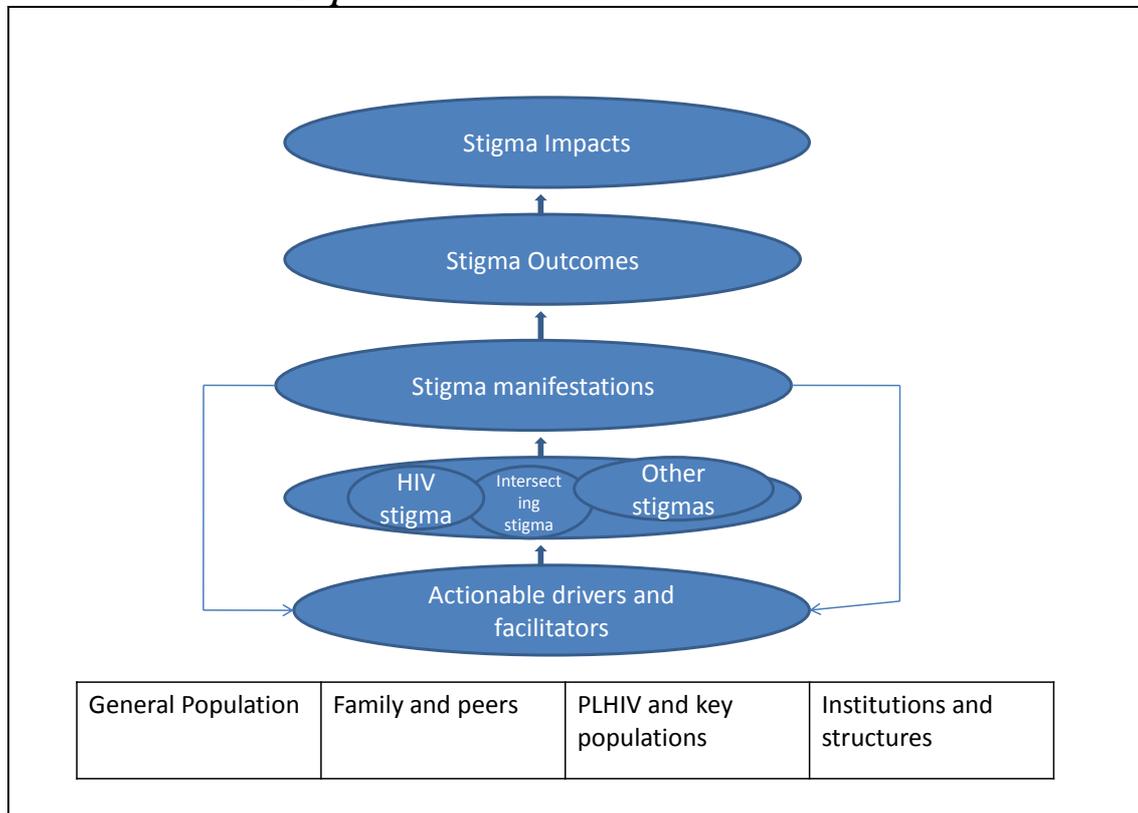
with attempts to fight the AIDS epidemic as a whole (UNAIDS, 2003). On a national level, the stigma associated with HIV can deter governments from taking fast and effective action against the epidemic, while on a personal level, it can make individuals reluctant to access HIV testing, treatment and care. While much has been learned about stigma and discrimination since the beginning of the AIDS epidemic, finding ways to create a widespread decrease in stigma and discrimination unfortunately remain elusive (Parker, R. and Aggleton, P. 2003). According to Ban Ki-Moon (2008), *“stigma remains the single most important barrier to public action. It is a main reason why too many people, are afraid to see a doctor to determine whether they have the disease, or to seek treatment if so. It helps make AIDS the silent killer, because people fear the social disgrace of speaking about it, or taking easily available precautions. Stigma is a chief reason why the AIDS epidemic continues to devastate societies around the world.”*

HIV and AIDS is a life threatening condition which people are afraid of contracting. The various metaphors associated with AIDS also contribute to the perception of HIV and AIDS as a disease that affects “others”, especially those who are already stigmatized because of their sexual behaviour, gender, race, or socioeconomic status, and have enabled some people to deny that they could be at risk or affected.

To understand how stigma and discrimination appear, and the context in which they occur, one needs to also understand how they interact with pre-existing stigma associated with; sexuality (HIV is predominately sexually transmitted in most areas of the world and the epidemic initially affected those with sexual practices different from the “norm” and commercial sex workers); race and ethnicity (racists assumptions about “African sexuality” and perceptions in the developing world about “immoral behaviour” of people in the West; gender (prostitution is deemed as a non-normative female behaviour in some societies and female sex workers are seen as HIV “vectors” whereas in some communities, men are blamed for heterosexual HIV transmission because of assumptions about male sexual behaviour, such as men’s preference or need for multiple sexual partners: and poverty (lack of economic resources increase vulnerability to HIV and AIDS and HIV exacerbates poverty, while in some instances, affluence lifestyle may increase vulnerability to HIV and AIDS) (Parker, R. and Aggleton, P. 2003).

HIV and AIDS related stigma and discrimination take different forms and manifest at different levels: Societal (in form of laws, policies, and administrative procedures, which are often justified as necessary to protect the “general population”), Community (in form of cultural systems that promote individualism which may perceive contracting HIV as a result of personal irresponsibility, and thus individuals are blamed for contracting the infection, whereas communities that put more emphasis on collectivism may perceive a person who contracts HIV infection as bringing shame to the extended family and community as a whole) and individual level (where in highly stigmatized environments, fear of being castigated forces individuals who get infected with HIV to isolate themselves to the extent that they no longer feel part of the family or society and are unable to seek and or access the services and the support they need) (Tomaszewski, E.P. 2012 and Mbatha, B., 2013). Figure 1 below demonstrates the intricate relationship between the drivers of stigma, how it manifests itself and its outcomes as well as its impact in the general population, at family level among PLHIV and key populations, as well at institutional and structural levels (Stangl, A.L., Brady, L., et al, 2012)

**Figure 1: Reducing stigma and discrimination: A Framework for program Implementation and measurement**



Adapted from A. Stangl, V. Go, C. Zelaya, et al, 2010

The stigma index presents an opportunity to quantify levels of stigma and permits comparison of these levels despite the diversity of settings and populations. The PLHIV stigma index is not only a survey but an activity that has been developed and implemented by, with and for PLHIV (IPPF, 2008).

## Country context of HIV related stigma and discrimination in Namibia

Namibia has one of the highest HIV-prevalence rates in the world, with an estimated prevalence rate of 17.2% (MOHSS, 2016). The country is generally recognized as having a progressive policy and legislative framework that conforms to the rights-based approach to HIV and AIDS. By interpretation, the Constitution outlaws discrimination against people living with HIV and AIDS, as does labour legislation that prohibits, for example, mandatory HIV testing of employees (GRN, 2014). While this does not apply to recruits to the security forces, the latter cannot be turned away or, once recruited, removed from service simply because they are HIV positive. Meanwhile, the Namibian government has gone further than many of its African counterparts in providing services for people living with HIV and AIDS. The government



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provides anti-retroviral drugs at state hospitals, and all PLHIV with a CD4 count below 200 qualify for the government's disability allowance. The Government of Namibia has an aggressive campaign against the AIDS epidemic, which includes surveillance, prevention, treatment, care and support, as well as impact mitigation (MOHSS, 2015). The Government invests substantial resources in the response against AIDS, more than many other African countries.

While these positive steps are commendable, this is just part of the story. Unfortunately, stigma and discrimination remain major issues related to HIV. For, example research conducted by Lironga Eparu, the Network of People living with HIV in Namibia, showed that stigma and discrimination remain rife in Namibia, and that PLHIV are a long way from enjoying the rights that the rights based approach is supposed to uphold and guarantee. The 2013 MTR of the NSF clearly showed that the country is still lagging behind in addressing stigma and discrimination (MOHSS, 2013). Insufficient community mobilization, and ineffective networks of PLHIV has left a void regarding representation and who should champion the issue of stigma and discrimination. A UNAIDS supported assessment of PLHIV support group mapping and a PLHIV consultation workshop in June 2013 provided recommendations among which a Stigma Index Study is key.

These conclusions are supported by text contained in Namibia's National Strategic Framework on HIV and AIDS (2011-2016). Accordingly, the National Prevention Technical Advisory Committee has prioritized the epidemic drivers in Namibia as: multiple and concurrent partnerships, transactional and trans-generational sex, alcohol use, low levels of risk perception, low rates of male circumcision, inconsistent and incorrect use of condoms, and low levels of HIV testing. Other studies have included the underlying structural elements of gender norms and inequality, mobility and migration, income disparities and poverty, educational levels and stigma as factors contributing to new HIV infections. The NDHS of 2013 found that only 62% of women and only 51% of men had comprehensive knowledge of HIV and AIDS. This knowledge gap is a precursor for HIV related stigma and discrimination in the community (MOHSS, March 2015).

## Justification of the Survey

Unlike other countries in the region, there has not been a specific survey on the levels of stigma and discrimination among people living with and affected by HIV in Namibia. Similarly there has been no earlier attempt to document stigma and discrimination among health facility staff and the general population. Smaller studies have attempted to document the existence of stigma and discrimination. However these studies have not been able to quantify stigma and dissemination over large populations and their conclusions may not be generalized to the entire country. What such studies have done is to conclude that HIV related stigma and discrimination are major barriers to accessing HIV prevention, treatment and care services. The lack of quantifiable data on stigma and discrimination impedes proper design of interventions due to lack of evidence-based programming.

# Namibia

This Survey will provide basis for programmatic adjustments of support provided to people living with and affected by HIV and AIDS in Namibia, as well as policy and program improvements in health care delivery. Additionally, the NSF has included the management of reduction in stigma and discrimination as an enabling environment required to intensify the response and achieve the set targets for HIV prevention, treatment, care and support. Provision of quantifiable and reliable data on the prevalence of and determinants of stigma is a key prerequisite for elimination of stigma and discrimination.

Therefore, establishing the level of stigma and discrimination in Namibia will be useful in improving care for PLHIV and affected families. The findings of the Survey provide valuable insights into areas that need to be focused on or improved in programming of care and support for PHIV. Consequently, a more concerted response may help offset barriers to treatment adherence, contribute to treatment success and improve adherence to treatment and prevalence of opportunistic infections thus contributing to the 90-90-90 targets.

## Objectives of the Survey

The overall objective of conducting this Survey was to join the global action to reduce stigma and discrimination related to HIV and AIDS through the creation of a supportive stigma reduction framework that will inform HIV and AIDS policy, advocacy and programming. The specific objectives include:

- i. To measure stigma and discrimination and its impact on the response to HIV especially disclosure and treatment;
- ii. To identify promising approaches to stigma and discrimination that can be taken to scale to achieve sufficient impact across the country;
- iii. To compare the manifestations of stigma and discrimination in Namibia and other countries in the regions that have conducted stigma surveys;
- iv. To generate evidence and identify gaps in HIV programs that may fuel stigma and discrimination;
- v. To assess and document the experiences of PLHIV regarding stigma and discrimination;
- vi. To profile PLHIV and health facility staff based on key stigma and discrimination experiences.

## Methodology

### Survey design and population

The Survey was conducted among two distinct populations: People Living with HIV and AIDS (PLHIV) and health facility staff. The Survey also reached out to representatives of the general population in seven of the 14 regions of Namibia. The population included key stakeholders in the HIV and AIDS response like PLHIV leaders, policy makers, faith leaders, opinion leaders in the community, educationists, local leaders, elders, political leaders, police and law enforcement agents, health care workers, health administrators, lawyers, etc. The Regions in which the

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Survey was conducted include Erongo, //Karas, Khomas, Kunene, Ohangwena, Omakeke and Zambezi. The seven regions were selected to represent the three areas of the country: North, Central and Southern, as well as to have a combination of high, medium and low prevalence rates so as to be able to generalize the findings to the entire country. The respondents included PLHIV on ART and those that not on ART, as well as health facility staff working both in primary health care and those in specialized facilities (e.g. SRH). The Survey was cross sectional in nature where the respondents were interviewed at a point in time using structured questionnaires. In addition to PLHIV and health facility staff, in order to triangulate the findings, KIs were also interviewed. The KIs included PLHIV leaders, policy makers, opinion leaders like faith leaders, educationist, young people, local leaders, elders, political and local leaders, police/law enforcement agencies, HCWs, health administrators and other stakeholders in the HIV and AIDS Response in Namibia. In-depth interviews and focus group discussions facilitated a holistic, detailed and analytical presentation of the drivers, manifestations, as well helped to identify innovative approaches that could be employed to address stigma and discrimination. In-depth interviews were also conducted to help in documenting experiences associated with stigma and discrimination from a broader section of the population. The open ended nature of the questions, coupled with probing allowed for respondents to articulate issues in their own words, in a way that is meaningful to the respondents, rich and explanatory. This helped to relate the drivers to manifestations of stigma, outcomes as well as the impacts of stigma and discrimination. In all 108 KIs were interviewed.

## *Sampling size and sampling procedure*

The Survey had two distinct populations (PLHIV and HF staff), the sample size was determined using Kish Leslie (1965) formula below for determining samples in descriptive studies.

$$n = (Z^2 \times p \times q \times de/d^2)$$

Where,

n = sample size for PLHIV to be interviewed;

Z = Z score corresponding to 95% level of significance is 1.96;

p = Estimated national HIV prevalence based on the NDHS, 2013 (16.9%) (NDHS also provides regional level statistics);

q = Estimated proportion of all staff who exclusively work on HIV and AIDS activities, based on the Statistics of staff available at the Human Resources Department of the MOHSS, and the Statistics of staff assigned to HIV and AIDS activities) 2016 (5.0% average: the range is 2-10% in different regions);

q= 1-p

d = absolute precision of 0.10;

de = design effect of 1.5 used to account for heterogeneity in assessment population;

Substituting in the formula,

$$n = (Z^2 pq/d^2) \times de$$

Based on the Kish Leslie formula and the variables defined above as well as the population per Region, HIV prevalence rate in each Region, and estimated PLHIV population in each Region,

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a sample size of 708 was proposed. This included a provision of 25% which was made for non-responses.

Respondents were selected randomly from lists of members from PLHIV associations in the regions, ART facilities or any other quality source like the Regional/District disability Allowance schedules, or CBO service schedules. For HF staff, they were identified from the service roster of HFs in the regions.

## *Inclusion and exclusion criteria*

All PLHIV aged 18 and above were eligible for the Survey irrespective of their ART status. The PLHIV respondents included any pregnant and lactating mothers. The only exclusion of a person known to be living with HIV was if there was substantive evidence from the respective Association of PLHIV in that locality that the person is of unsound mind. All staff posted to the health care facilities in the respective regions were eligible for inclusion irrespective of their assigned tasks. These included staff working in public and the private sector, as well as those working in ART clinics and those that did not.

## **Quality Control**

Data for this survey was collected by teams that comprised of individuals experienced in quantitative and qualitative data collection. To be consistent with the GIPA/MIPA principle, the data collectors included persons openly living with HIV and AIDS. Data collectors were supported by a supervisor for purposes of quality control and efficiency. The data collectors were people who were known among the PLHIV in the respective areas of the Survey to address any problem of stigma that could arise during data collection. Data was collected using paper based questionnaires. Before the data collection tools were commissioned, they were pre-tested on a selection of respondents in the Khomas Region. In order to ensure that quality data is collected, a supervisor was assigned to every 4 data collectors in a particular Region. The Supervisors and the Trainers facilitated KI interviews during the data collection process. The data collection team underwent training and pretesting of the data collection tools. Finally, data cleaning was done to rid data of outliers and remove any duplicate or incomplete entries. At the National level, the Survey was overseen by a task team that had the highest decision making ability regarding the conduct of the Survey. The task team was supported by an external consultant who had experience in leading descriptive surveys as well as a team of national consultants who had experience in conducting quantitative and qualitative surveys.

## **Data Analysis**

**Quantitative data** that was collected using paper questionnaires was entered into SPSS and then imported into excel, cleaned and then exported back to SPSS for further cleaning, manipulation and analysis.

**Qualitative data** that was transcribed into Word, and then exported into NVIVO11 for coding and generating trends and common themes.



# HIV and AIDS Stigma and Discrimination Survey in Namibia

## Ethical Considerations

### ***Informed consent***

Participation in the Survey was voluntary following an informed consent procedure. Eligible respondents were selected to participate after being informed about the purpose and objectives of the exercise and potential benefits and possible risks of participation. An information sheet was generated and provided to all respondents with a contact for the team leader in case the respondents had any questions during or after the interaction with the interview teams. The respondents were fully informed of the information being collected and the methodology for data collection. They were also informed of confidentiality measures during data collection and management. Finally, potential participants were informed that participation is voluntary, and refusal to participate shall in no way affect their entitlement to receiving any services provided to PLHIV in their respective localities. The individuals who agreed to participate were required to sign an informed consent. Interviewers were trained on how to identifying individual respondents who may need further support on some of the issues that they share. Being from the respective communities, the interviewers were advised to make referrals for such individuals to organisations that provide the kind of services that would support them.

### ***Confidentiality***

All survey team members who had access to both participants and the information in raw form were required to sign consent forms confirming their obligations to holding any information that they come across in total confidentiality.

Data collected at individual level was not communicated outside the data collection/coordination team. The raw data remained in custody of the Task Team and only generalised findings were shared for purposes of generating the report.

No nominal information was recorded on the questionnaires nor any identification numbers (e.g. patient's number on medical card, or National ID number) that could allow tracing back to survey participants.

As much is logistically feasible, most interviews were conducted in such venues as suggested by the respondents so as to guarantee their privacy.

### ***Ethics approval***

The Survey protocol was submitted to the Ethical Committee of the Ministry of Health and Social Services for approval.

## Guiding Principles

The process of conducting the survey was as important as the results generated. The Survey was conducted under the guidance of the broad philosophy of greater involvement and meaningful involvement of people living with HIV and AIDS (GIPA/MIPA). The other principles included

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respect for all involved, inclusion, trust, honesty and openness, compassion, shared responsibility and strict obligation by the survey teams, and fairness and justice to the respondents.

## Survey limitations and challenges

### Challenges encountered during the survey

#### i. Translation

The structured questionnaires and KI guides were written in English. The interviewers had to do on-spot translation. This made it difficult for them to consistently follow responses which were in other languages, while at the same time documenting this in English. In some regions, the interviewers had to use multiple languages during the same interview. For instance, in Erongo, respondents for FGDs spoke Otjiherero, Oshiwambo, Rukavango during the same conversation.

#### ii. Incomplete Responses

Some key informants gave very incomplete responses to particular questions. This made it difficult to draw meaning from such incomplete responses. This could be attributed to time pressure on the part of the respondents or language barriers. It could also be attributed to discomfort in responding to specific questions. For structured questions such incomplete responses were omitted for analysis. Whereas a provision was made for non-responses, in some instances missing entries went beyond the provided threshold of 25%

#### iii. Getting competent interviewers

Getting interviewers who were competent in HIV and AIDS matters was a challenge. The interviewers that were identified were trained and close supervision provided during data collection

#### iv. Time lag between critical phases of the Survey

Due to logistical challenges, there was time lag between critical phases of the Survey. The Concept was developed in February 2017 while data was collected in November 2017. The Report was written in March/April 2018. This time lag resulted in losing the engagement of some of the influential players. The MOHSS/DSP had to step in to ensure consistent flow of the tasks through to the end.

### Limitations of the survey

#### i. Sampling effect

The Survey was conducted in seven of the 14 Regions of Namibia. While efforts were made to ensure that there is a good representation of high, medium and low HIV prevalence regions, there may be unique presentations of stigma and discrimination in the other Regions that were not sampled for purposes of this Survey. However, given the consistency of results from the seven Regions, we believe that the results are largely reflective of the stigma and discrimination situation in the country and can comfortably be generalized as representative for the entire country.

## Chapter 02

### Background characteristics of the respondents

This Chapter presents general background information about the people living with HIV and AIDS, and health facility staff who participated in the Survey. A total of 749 interviews were conducted among PLHIV. A small number of the respondents (n=16) did not give the regions in which they resided. This represents 2.1% of all the PLHIV respondents. Table 01 below details the respondents characteristics, including how long one had known of their HIV status, Region of residence, age, marital status, education level, HIV status and gender of the heads of the households, as well as the age of the heads of the household.

There was varying degrees of completeness of the interviews. Analysis was based on only completed questions which varied between 97.1% to 59.9% of completeness. The majority of the respondents were female (66.1%, n=475).

Majority of the PLHIV respondents (35.9%, n=261) had known their HIV status for more than 10 years. However, for 3.0% of the respondents, the duration of knowing their HIV status was not established. The majority of the respondents (34.0%, n=252) were in the 35-44 age bracket. The age of 7 respondents was not established. The majority of the respondents (74.3%, n=540) indicated that they were sexually active. The high levels of sexual activity were evenly distributed among respondents of all age groups. Similarly, a high number of respondents (68.8%, n=494) indicated that they were in some form of a relationship.

**Table 01: Demographic characteristics of PLHIV respondents**

Variable	n	%
<b>Region</b>		
Karas	54	7.2
Erongo	101	13.5
Khomas	184	24.6
Kunene	32	4.3
Ohangwena	218	29.1
Omaheke	24	3.2
Zambezi	120	16.0
Other	16	2.1
Total	749	100

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<b>Gender</b>		Male (n)	Female (n)		
Karas		13	39		
Erongo		32	63		
Khomas		78	93		
Kunene		10	22		
Ohangwena		68	147		
Omaheke		11	9		
Zambezi		27	93		
Other		5	9		
<b>Total</b>		<b>244</b>	<b>475</b>		
<b>Duration (yrs) of knowing HIV status</b>		n			
Less than 1 year <sup>1</sup>		65	8.9		
1-4 years		235	32.3		
5-9 years		166	22.8		
More than 10 years		261	35.9		
<b>Total</b>		<b>727</b>	<b>100</b>		
<b>Age</b>		n	%		
Less than 25		92	12.4		
25-34		175	23.6		
35-44		252	34.0		
44+		223	30.1		
<b>Total</b>		<b>742</b>	<b>100</b>		
<b>Sexual activity</b>		Yes (n)	%	NO (n)	%
Less than 25		60	65.2	32	34.8
25-34		134	80.2	33	19.8
35-44		217	87.1	32	12.9
44+		129	58.9	90	41.1
<b>Total</b>		<b>540</b>	<b>74.3</b>	<b>187</b>	<b>25.7</b>
<b>Variable</b>		n		%	
<b>Average monthly Income (NAD)</b>					
Less than 2,000		529		75.1	
2,000-5,000		122		17.3	
5,001-10,000		30		4.3	
10,000+		23		3.3	

<sup>1</sup> Many questions asked if respondents had experienced stigma and discrimination because of their HIV status within the last 12 months. If one had not known their HIV status, then one could not have experienced stigma because of it.

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<b>Membership to a PLHIV organisation</b>		
Yes	183	25.3
No	541	74.7
<b>Total</b>	<b>724</b>	<b>100</b>
<b>Education Level</b>		
No formal education	135	18.1
Primary school education	219	29.4
Secondary school education	365	48.9
Tertiary/ University education	27	3.6
<b>Total</b>	<b>746</b>	<b>100</b>
<b>Employment status</b>		
Fulltime employment	155	20.9
Part-time employment	83	11.2
Casual worker	127	17.2
Unemployed	377	50.7
<b>Total</b>	<b>742</b>	<b>100</b>
<b>Heads of Household</b>		
Yes	402	54.6
No	334	45.3
<b>Total</b>	<b>736</b>	<b>100</b>
<b>Age of Heads of Households</b>		
15- 24	7	1.6
25-34	56	12.9
35-44	120	27.6
44+	251	57.8
<b>Total</b>	<b>434</b>	<b>100</b>
<b>Residence status</b>		
Settlement	106	14.4
Village	342	46.5
Town	168	22.8
City	115	15.6
Other	5	0.7
<b>Total</b>	<b>736</b>	<b>100</b>

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<b>Having a disability</b>		
Some disability	200	28.1
No disability	483	67.9
Unknown	28	3.9
<b>Total</b>	<b>711</b>	<b>100</b>

Majority of the respondents (48.9%, n=365) indicated that they had attained secondly education, while 529 respondents (75.1%) reported having earned less than NAD2,000 in the past 12 months. Only 3.3% (n=23) reported having earned more than NAD 10,000. The income status of 45 respondents was not established. The majority of the respondents (50.8%, n=377) indicated that they were unemployed. The employment status of 7 respondents could not be established.

More than half of the respondents (54.6%, n=402) reported that they were the heads of their respective households. The heads of the households of 13 respondents could not be established. A big number of respondents (46.5%, n= 342) reported being village residents while 14.4% reported being residents of settlements.

Approximately one third of the respondents reported some form of disability (28.1%, n= 200) including hearing impairment, visual impairment of physical disability.

PLHIV respondents were asked what kind of relationship existed in their respective households. Table 02 below summarizes the findings.

**Table 02: Relationships within households**

<b>Variable</b>	<b>n</b>	<b>%</b>
<b>Having an orphan in the household</b>		
Yes	239	33.0
No	482	66.6
Unknown	3	0.4
<b>Total</b>	<b>724</b>	<b>100</b>
<b>Disabled or chronically members in the household</b>		
Yes	119	16.6
None	597	83.4
<b>Total</b>	<b>716</b>	<b>100</b>
<b>Bereavement in the household in the past 6 months</b>		
Yes	58	8.5
No	623	91.5
<b>Total</b>	<b>681</b>	<b>100</b>

# HIV and AIDS Stigma and Discrimination Survey in Namibia

While majority of respondents (66.6%, n=482) reported not hosting any orphans in their households, 33.0% (n=239) reported having a child who had lost a parent, with 184 respondents reporting having 1-2 children while 58 respondents reported having 3-4 orphaned children in their households. Such big numbers of children puts more economic pressure to the hosting families, majority of whom having reported very low earning abilities.

Table 03 below presents the way in which respondents identified themselves in terms of belonging to particular special groups who may be more vulnerable to social ills associated with HIV and AIDS including stigma and discrimination.

**Table 03: Self identification with special interest groups**

<b>Group (multiple responses accepted)</b>	<b>n</b>	<b>%</b>
Traditional community	120	16.3
Long distance traders/ workers	21	2.9
Internally displaced persons	13	1.8
Refugee/Asylum seeker	10	1.4
Migrant workers	33	4.5
Sex workers	12	1.6
Prisoner or ex-prisoners	43	5.8
People who use recreational drugs	18	2.5
Men who have sex with men	6	1.0
Women who have sex with women	7	1.1
Transgender people	6	0.8

A total of 241 respondents were interviewed from health facilities. These were drawn from the seven regions as presented in Table 04 below.

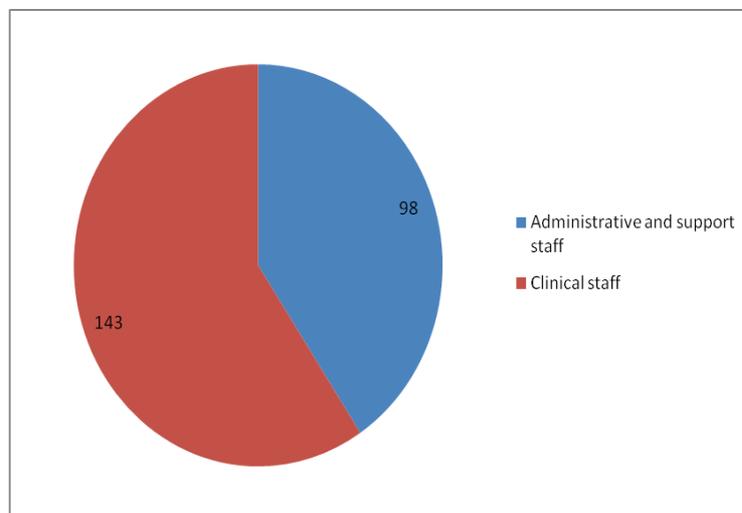
**Table 04: Regional distribution of health facility respondents**

<b>Region</b>	<b>n</b>	<b>%</b>
Karas	31	12.9
Erongo	15	6.2
Khomas	52	21.6
Kunene	40	16.6
Ohangwena	26	10.8
Omaheke	7	2.9
Zambezi	68	28.2
Other	2	0.8
<b>Total</b>	<b>241</b>	<b>100</b>

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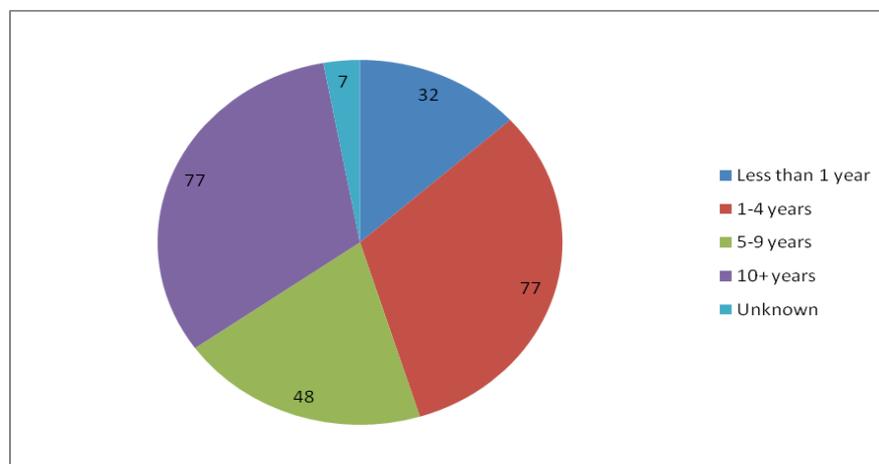


Majority of the respondents from the health facilities were clinical staff (59.3%, n=143). See Chart 01 below.



**Chart 01: Categories of health facility respondents**

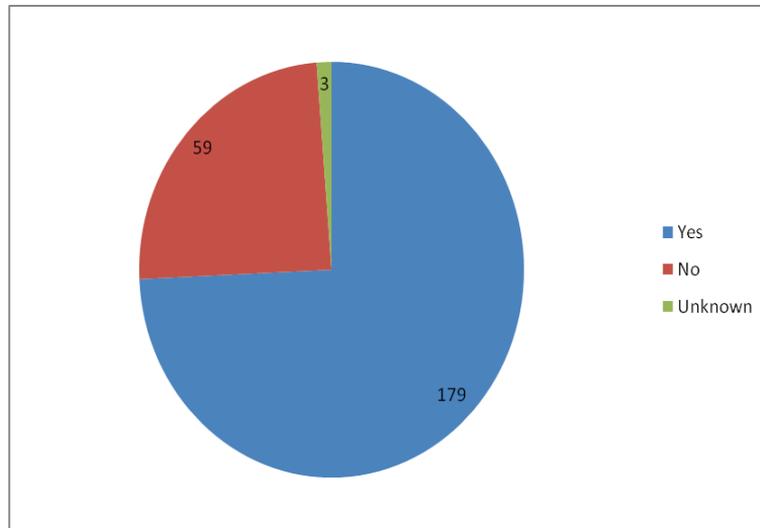
Majority of the health facility respondents had considerable experience in working in health care, with only 13.3% (n=32) reporting that they had been working in health care for less than one year. (See Chart 02 below)



**Chart 02: Reported duration of working in health care**

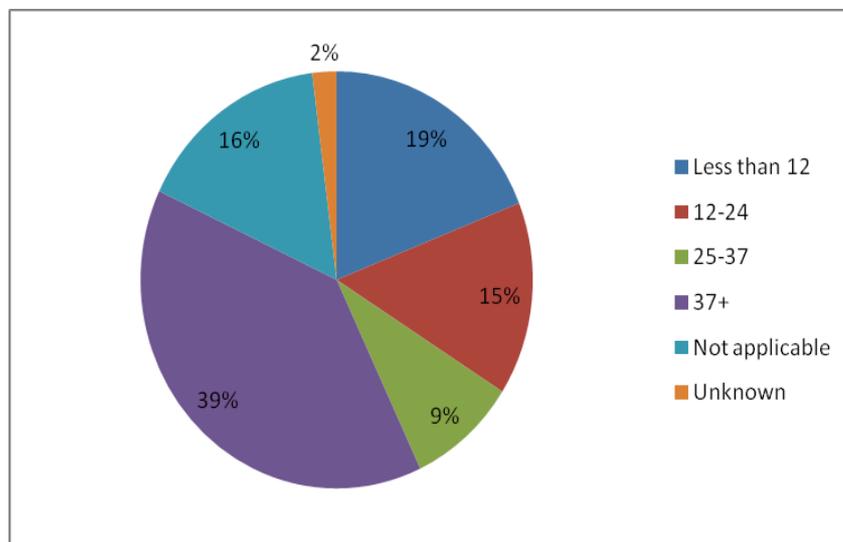
# HIV and AIDS Stigma and Discrimination Survey in Namibia

Similarly, majority of the health facility respondents (74.3%, n= 179) reported that they had past experience of working in a facility that specialized in HIV care (See Chart 03 below).



**Chart 03: Reported experience of working in HIV specialized facility**

A good number of the health facility respondents ( 39.0%, n=91) were working in high volume facilities that received more than 37 patients living with HIV in a typical week (See Chart 04 below).



**Chart 04: Reported volume of patients seen in a week**

## Chapter 03

### Manifestation of stigma and discrimination

#### Experience of HIV related stigma and discrimination

Respondents were asked what manifestations of stigma they had experienced in the past 12 months. Table 05 below shows that being “gossiped about” was the most common manifestation of stigma and discrimination. Gossip is ill-talk about someone because of their HIV status.

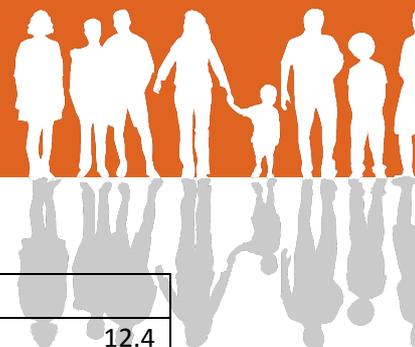
**Table 05: Incidents of stigma and discrimination**

Event	n	%	n	%	n	%	n	%
<i>(Multiple responses accepted)</i>	<b>Never</b>		<b>Once</b>		<b>A few times</b>		<b>Often</b>	
Exclusion from religious activities	681	91.7	21	2.8	23	3.1	17	2.3
Exclusion from social gatherings	710	95.3	14	1.9	8	1.1	13	1.7
Exclusion from family activities	683	91.7	20	2.7	22	3.0	20	2.7
Insulted or physically assaulted	561	75.2	38	5.1	72	9.7	75	10.1
Being gossiped about	645	88.6	58	8.5	19	2.6	6	0.8

#### Rejection associated with HIV positive status

Respondents were asked if they had experienced specific forms of rejection in the past 12 months as a result of their HIV positive status. Table 06 below summarizes the responses. While rejection was largely not common, with 87.6% (n=651) respondents not reporting any rejection, the most common form of rejection reported was having a member of one’s household discriminated against because of the status of the index person. Paradoxically, there was rejection reported from other PLHIV. This could be associated with the general discrimination in the community where PLHIV tend to disassociate themselves from others PLHIV so that the community does not relate them to belong to that group.

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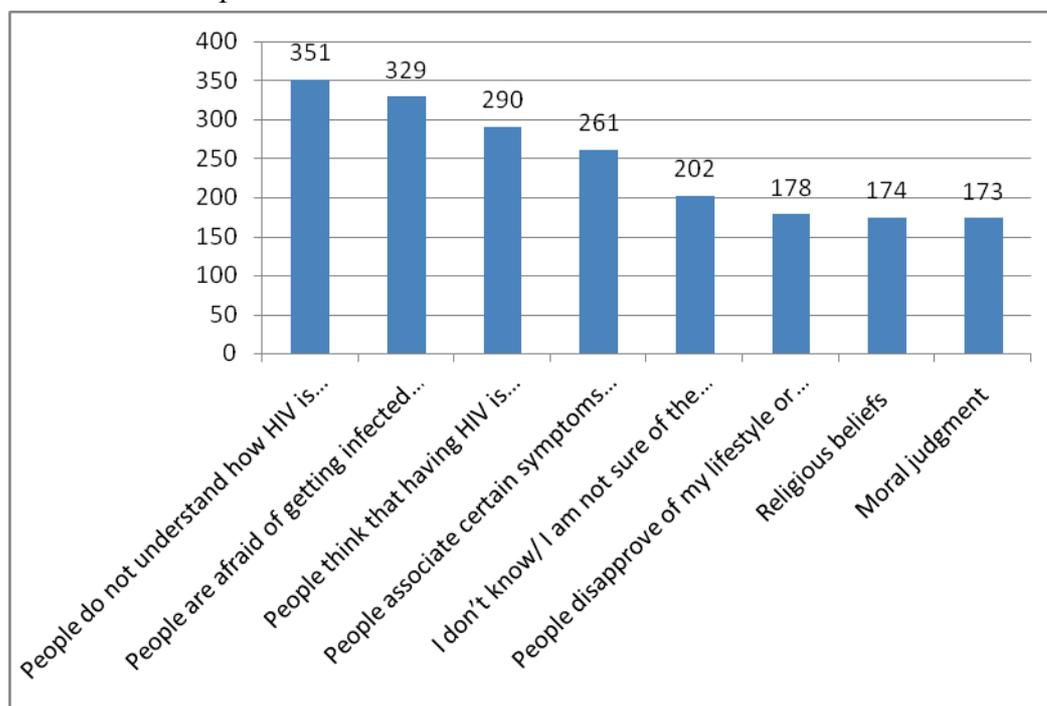


**Table 06: Rejection associated with HIV status**

Rejection in the 12 months		
Yes	92	12.4
No	651	87.6
Total	743	100

## Perceptions on the causes of stigma and discrimination

Respondents were asked for their opinion on why stigma persisted in their respective communities. Graph 01 below summarizes the responses. The most common opinions given were people not understanding how HIV is transmitted and were afraid they would get infected through casual contact and people being afraid of getting infected with HIV from PLHIV. Others felt that people think that HIV is a shameful disease and they should not associate with a person who has it.

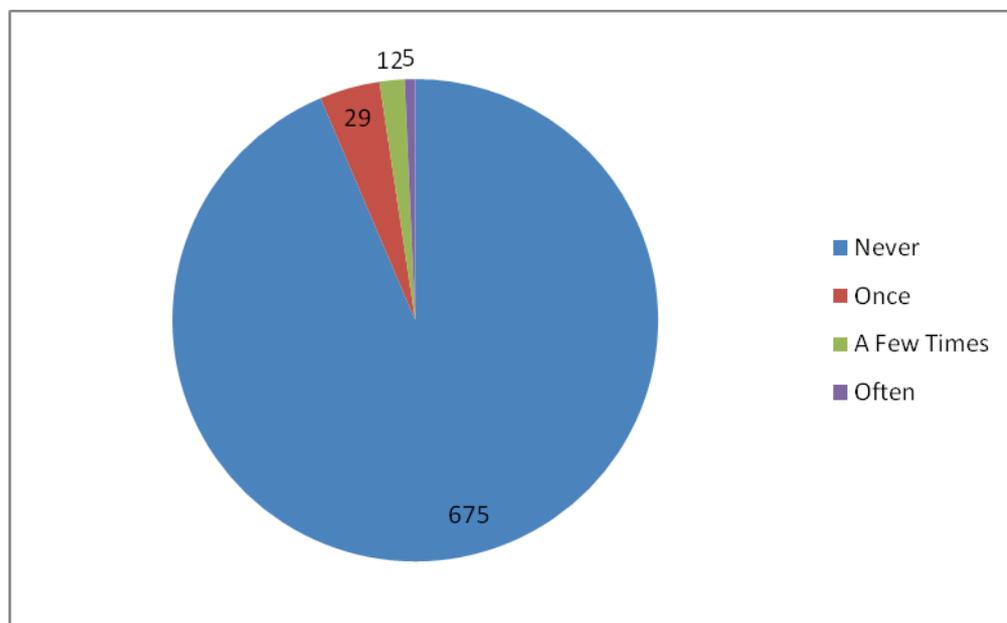


**Graph 01: Opinions on the causes of stigma**

## Access to accommodation

Respondents were asked if they had been forced to change residence or been unable to rent accommodation in the past 12 months. Chart 05 below presents the responses.

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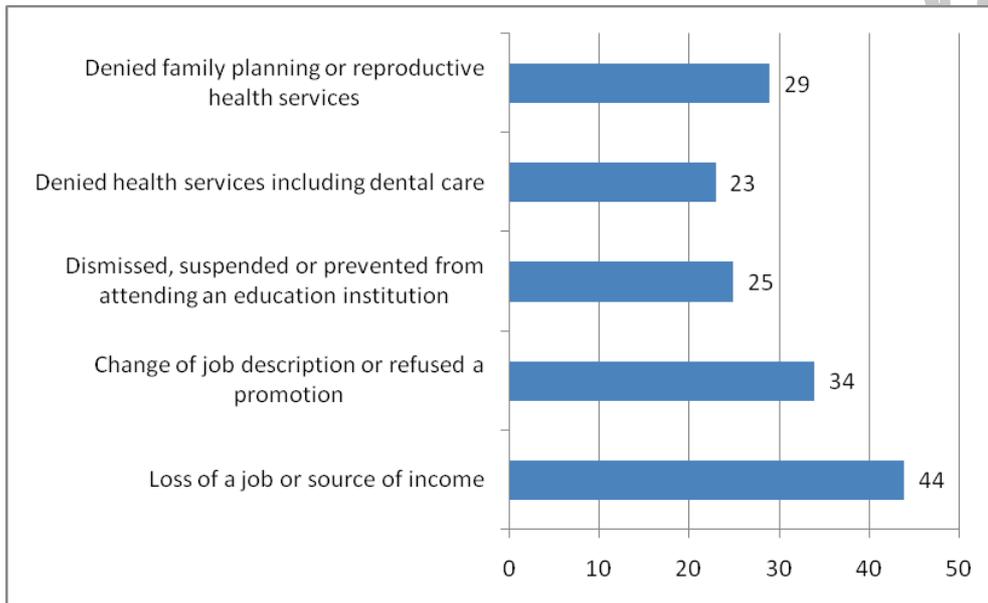
**Chart 05: Experience with accommodation**

While 93.6% (n=675) of the respondents indicated that this form of stigma and discrimination had never happened to them, 4.0% (n=29) reported that it had happened to them at least once.

## Access to work, health and education services

Respondents were asked whether in the past 12 months they had lost a job or source of income, been forced to change jobs or dismissed, suspended from work or prevented from attending an education institution. Whereas majority of respondents indicated that they had not being subjected to discrimination in areas of work or health care services, there were a few respondents who indicated that they had experienced stigma and discrimination in these areas. The most common responses were loss of a job and change of job description and being denied family planning services (see Graph 02 below). Those few that experience discrimination are the source of concern.

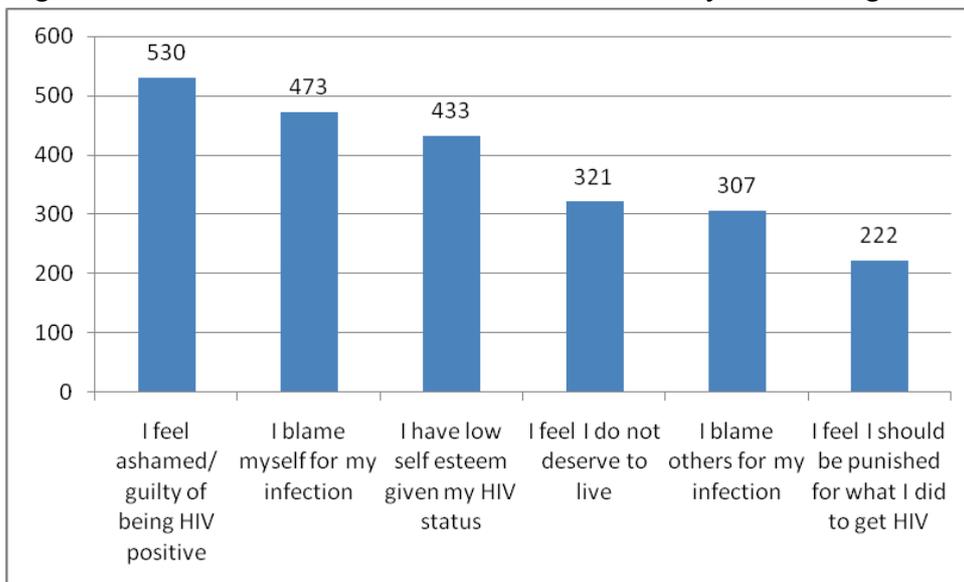
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**Graph 02: Experience with work, health and education services**

## Internal stigma and fears

Respondents were asked how they felt about their HIV status. Multiple options of feelings were provided. Graph 03 below presents that the most common manifestation of internal stigma was self blame for one's HIV status followed by a sense of guilt.



**Graph 03: Feelings about one's HIV status**

Respondents were asked what mechanisms they had adapted to deal with stigma and discrimination in the past 12 months. Table 07 below summarizes the responses.

**Table 07: Actions taken to cope with stigma and discrimination in past 12 months**

Action	n	%	n	%
<i>(Multiple responses accepted)</i>	Yes		No	
Avoided going to a local hospital or clinic	34	4.6	711	95.4
Decided not to have any more children	201	27.1	541	72.9
Decided not to have sex	121	16.3	621	83.7
Decided not to get married	87	11.8	649	88.2
Withdrew from education/ training program	29	3.9	714	96.1
Decided not to apply for a job/ seek promotion	30	4.0	712	96.0
Decided to stop working	32	4.2	706	95.7
Isolated myself from family and friends/ Chose not to attend family gatherings	46	6.2	691	93.8

The most common coping strategies reported were related sexuality and reproduction: 27.1% (n=201) of the respondents reported that they decided not to have any more children while 16.3% (n=121) decided not to have sex, and 11.8% (n=87) decided not to get married. Fewer responded took to abandoning education (3.9%, n=29)

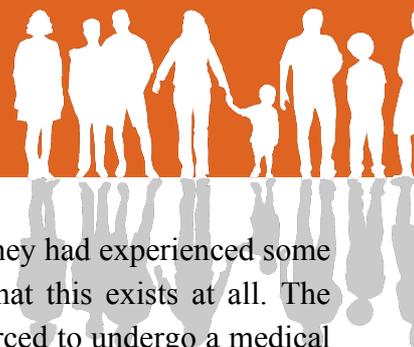
## Rights, laws and policies

In order to quantify the level of institutional level stigma and discrimination, respondents were asked if they had been coerced into undergoing medical procedures, denied health insurance, forced to disclose their HIV status, detained or isolated or arrested on charges related to their HIV status in the past 12 months. Table 08 below summarizes the findings.

**Table 08: Occurrence of institutionalized stigma and discrimination**

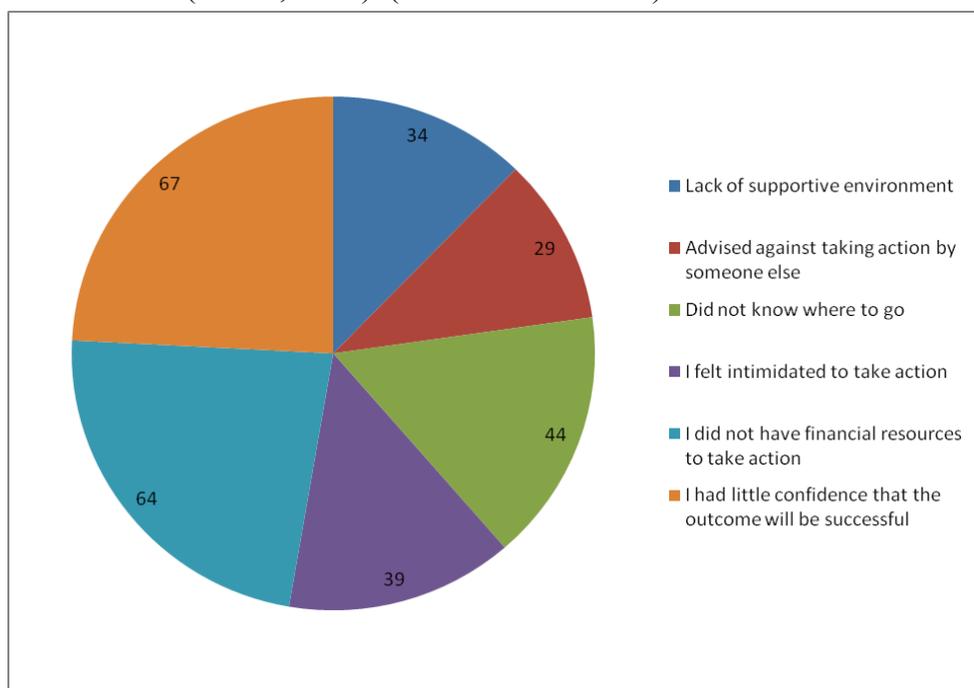
Event	n	%	n	%
<i>(Multiple responses accepted)</i>	Yes		No	
Coerced into undergoing a medical or health procedure	47	6.3	695	93.7
Denied health insurance/ life assurance	16	2.1	729	97.9
Had to disclose my HIV status in order to apply for residence in another country/ travel to another country	14	1.9	731	98.1
Detained, quarantined, isolated or separated because of my HIV status	11	1.5	732	98.5
Arrested or taken to court on a charge related to my HIV status	6	0.8	738	99.2

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While a small number of respondents (less than 10%) reported that they had experienced some form of institutionalized discrimination, there should be concern that this exists at all. The most reported form of institutionalized discrimination was being coerced to undergo a medical procedure, which was reported by 6.3% (n=47) of the respondents who responded to this question. Less than 1.0% (0.8%, n=6) reported having been charged in formal Courts of Law for any charges related to their HIV status.

Respondents who reported that they had experienced some form of institutionalized discrimination were asked why they never sought legal redress. Only a small fraction of the respondents provided responses (34.4%, n=258). The responses provided indicated that the biggest deterrent to seeking legal redress was having little confidence that the outcomes will be successful (26.2%, n=67). (See Chart 06 below).

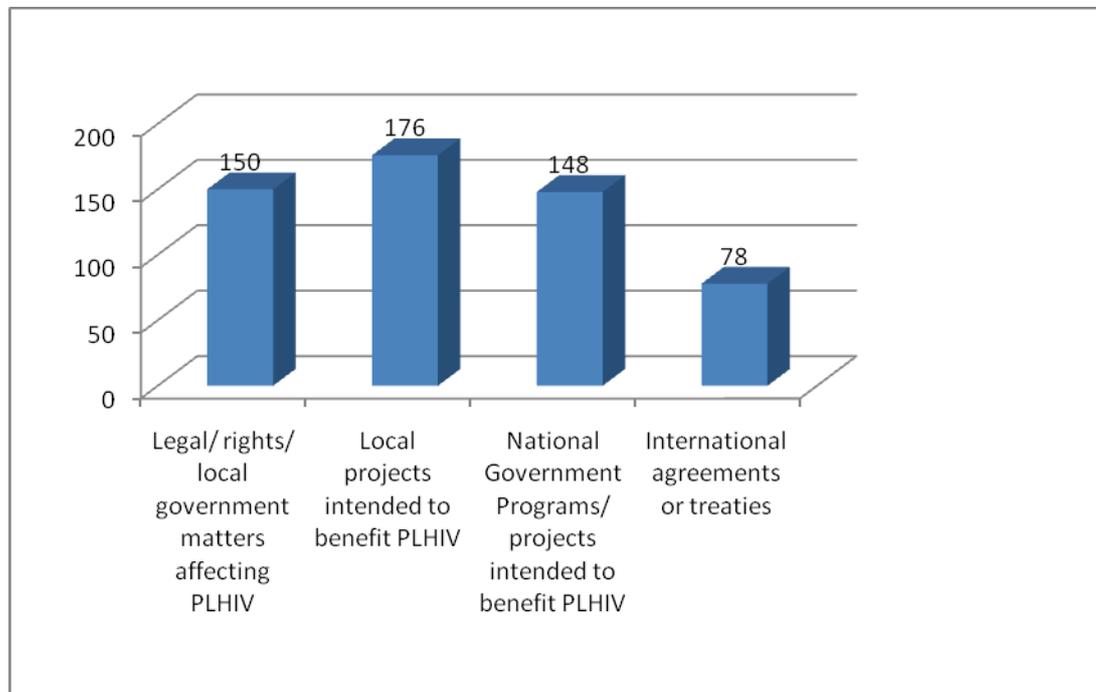


**Chart 06: Experience with the judiciary**

## Influencing legal and program issues

Respondents were asked how they had influenced legal and program issues in the past 12 months. A very small proportion of respondents (maximum 23.8%, n=176) reported having done anything to influence the HIV response in the past 12 months. Among those that reported that they had done something, the most common intervention was engaging with local projects that are intended to benefit PLHIV (See Graph 04 below).

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**Graph 04: Actions to influence legal and program issues**



## Chapter 04

### Addressing stigma and discrimination

#### Effecting change

Respondents were asked whether they had educated someone who was stigmatizing or discriminating against them in the past 12 months. Majority of respondents (59.4%, n=351) reported that they had not taken any action (See Chart 07 below).

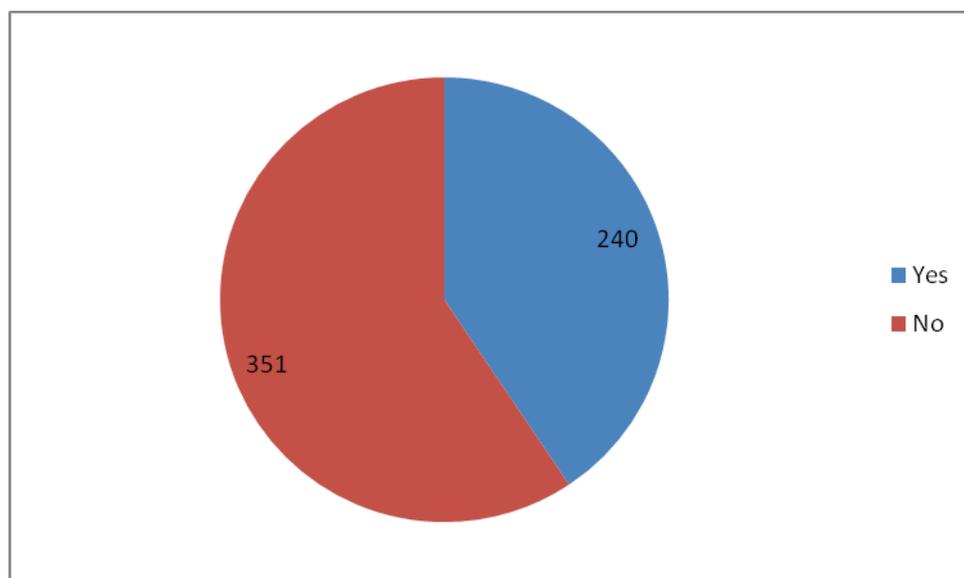
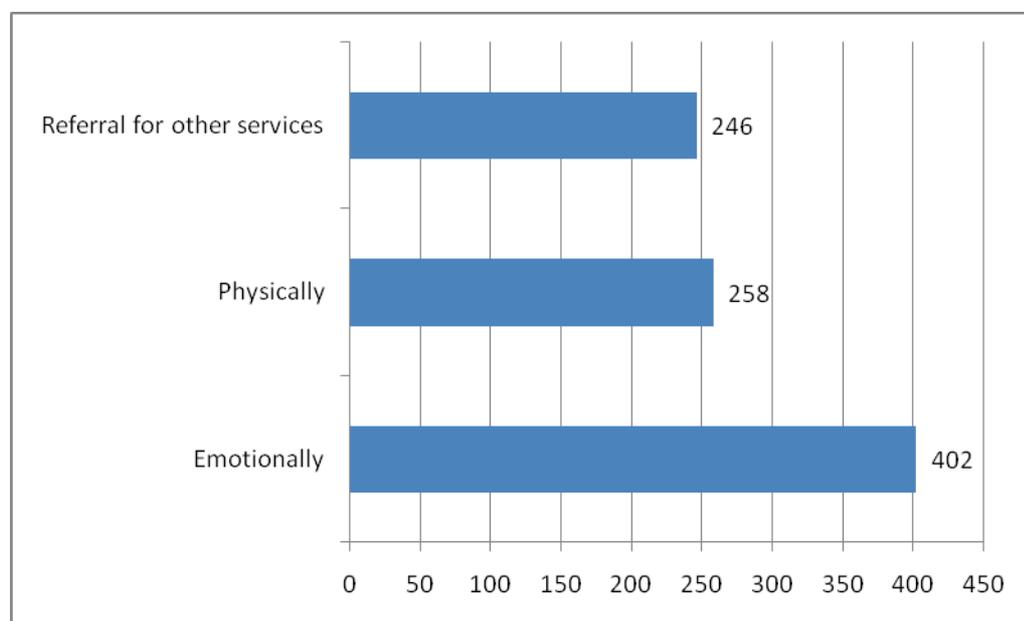


Chart 07: Effecting change against stigma and discrimination

Similarly, respondents were asked whether they had supported some other PLHIV on stigma related issues. Majority of respondents (58.9%, n=332) reported that they had supported someone.



**Graph 04: Supporting someone in the face of stigma and discrimination**

The most common form of support (not mutually exclusive) was providing emotional care (reported by 70.2%, n=402 of the respondents), followed by physical support by providing things like food and money (reported by 51.3%, n= 258 of the respondents). Referral for other services was least reported (by 49.7%, n=246). This could be attributed to lack of information on where complementary services were provided, or that the services were not readily available in the respective communities (See Graph 04 above).

## Organizations that can help in addressing stigma and discrimination

Some programs and organizations exist in Namibia to address stigma and discrimination. Respondents were asked if they knew any of these organizations. The most commonly known organizations were PLHIV support groups and national networks of PLHIV (known by 41.2%, n=306), followed by Government departments and local Governments (known by 34.8%, n=258). Not many respondents could identify that private lawyers could also support them in dealing with stigma and discrimination (see Table 08 below).

# Namibia

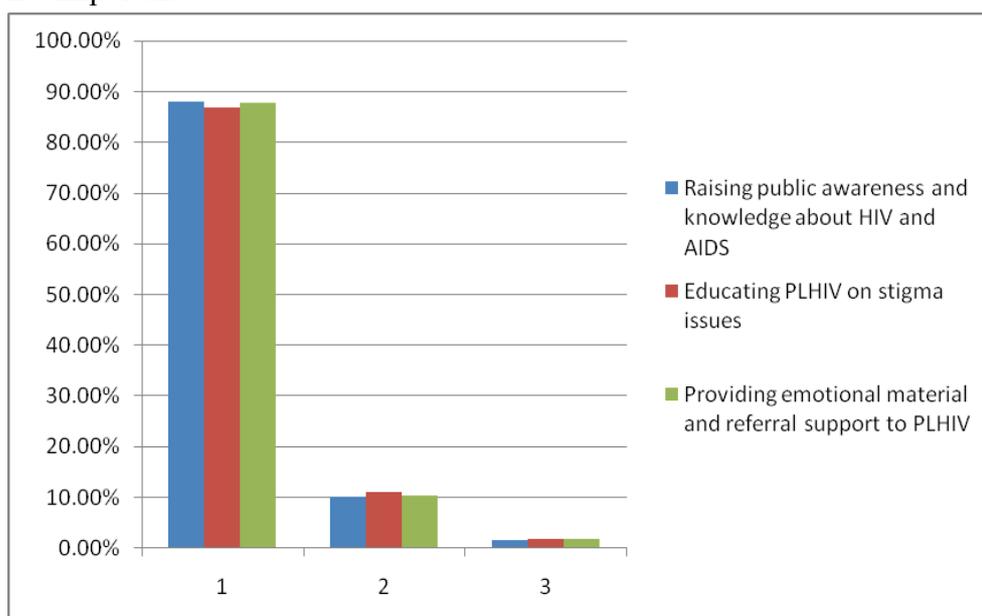


**Table 09: Knowledge of organisations that can address stigma and discrimination**

Organisation	n	%	n	%
<i>(Multiple responses accepted)</i>	<b>Knows</b>		<b>Don't know</b>	
PLHIV Support Groups/National Networks of PLHIV	306	41.2	436	58.8
Local and National NGOs	185	25.0	55.5	75.0
Government Departments and local Government	258	34.8	483	65.2
UN Agencies and International NGOs	138	18.6	602	81.4
Legal practices or private lawyers	93	13.1	617	86.9

## Strategies for addressing stigma and discrimination

Respondents were asked what they thought about public awareness and knowledge about HIV, educating PLHIV on stigma and discrimination issues, and providing emotional, material and referral support to PLHIV as possible strategies to address stigma and discrimination. Graph 06 below presents the findings. More than 85% of the respondents felt that each of the three strategies were very important while only less 2% felt the strategies were not important.



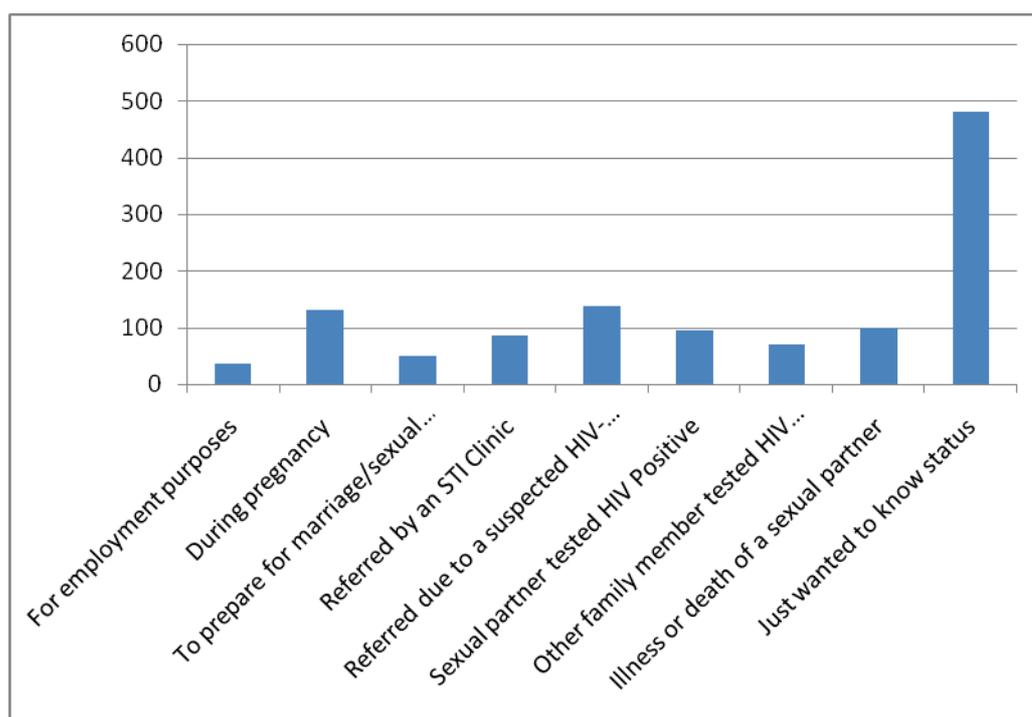
**Graph 06: Possible strategies to address stigma and discrimination**

## Chapter 05

### Experience of testing, disclosure, treatment, reproductive health and having children

#### HIV Testing and Diagnosis

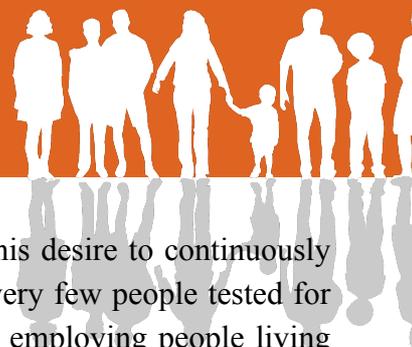
Respondents were asked as to what motivated them to take an HIV test. Graph 07 below summarizes the responses.



**Graph 07: Reasons for taking an HIV test**

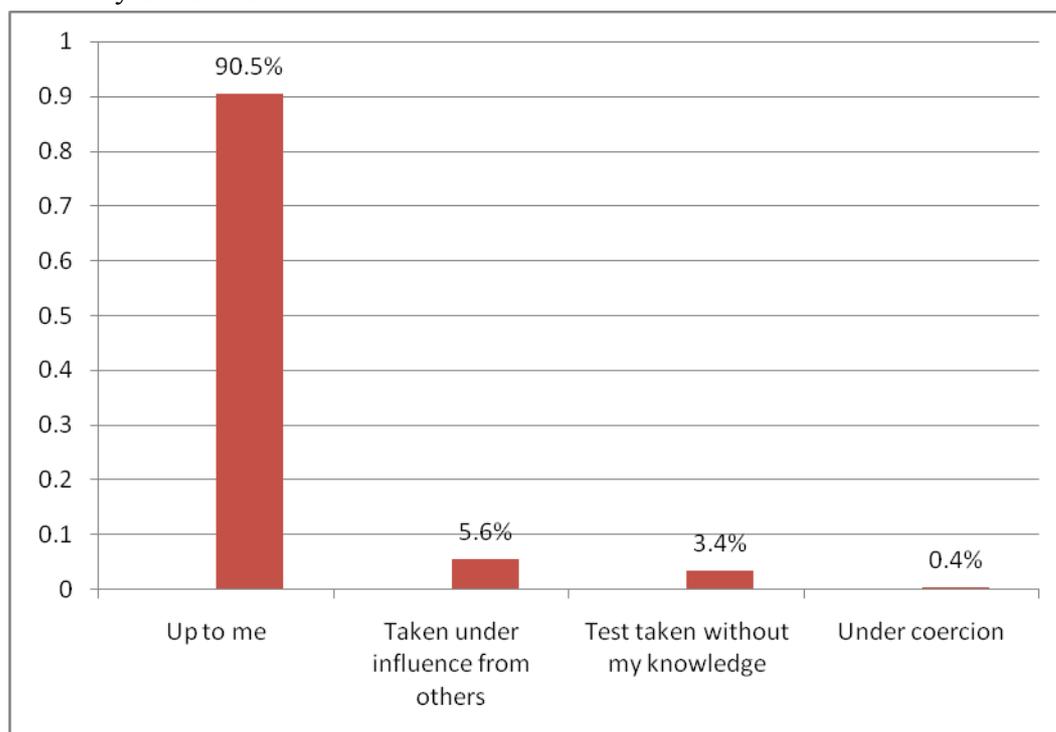
Many respondents (69.6%, n=480) reported that they just wanted to know their HIV status. The other most common reason for testing were during pregnancy (19.5%, n=538). The most least reported reason for taking an HIV test was for employment purposes (5.2%, n=37). The results of the Survey suggest that there is a personal reason for many PLHIV to know their

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HIV status and the health care delivery system could leverage on this desire to continuously make testing services available to the population. The finding that very few people tested for employment purposes suggest that there are fewer biases related to employing people living with HIV in Namibia. This was followed by testing to prepare for marriage (7.0%, n=49). This finding suggests that there should be an intensified public awareness campaign that sexual contact is the most risky factor that exposes individuals to HIV infection, thus partners ought to test and also know each other's HIV status.

Respondents were asked how they made the decision to take an HIV test. The majority of those that responded to this question (90.5%, n=641) reported that it was a personal decisions (See Graph 08 below). Only very few respondents (0.4%, n=3) reported that they took the test under coercion. The findings suggest that those individuals who are conscious about HIV take voluntary decisions to test.



**Graph 08: Decision making for taking an HIV test**

## Challenges related to testing and diagnosis of HIV

Respondents were asked what problems they encountered in relation to testing and diagnosis of HIV. The most common problem that was reported by respondents was fear of stigma and discrimination. This was reported by 27.6% (n=202) respondents. This was followed by a fear of giving birth to an HIV positive baby (25.7%, n=186), and long distance to testing facility which was reported by 25.6% (n=188) respondents. The least common concerns were issues at the health facility like unqualified staff (5.8%) and lack of test kits (5.8%). This could be largely

because HIV testing services are available in the public sector at no direct cost to the patients.

## Disclosure and confidentiality

Respondents were asked whether they had disclosed their HIV status to key people in their life. They were also asked if they told them by themselves or whether someone else did. Table 10 below summarizes the responses. Many respondents (81.2%, n=601) reported that they had disclosed their HIV status with to family members. This was followed by sharing with HCWs (78.5%, n=582), sexual partners (77.5%, n=571) and social workers (76.4%, n= 559). These high disclosure levels show that the PLHIV who took part in this Survey were quite empowered. However, the numbers that reported having shared with business colleagues and religious leaders were very small (14.4%, n=106 and 12.5%, n=91 respectively). Similarly, the fraction of respondents who reported that this category of associates does not apply to them is also very high (51.1%, n=377 and 49.0%, n= 358 respectively). The findings mirror the high unemployment levels that the respondents reported.

**Table 10: Disclosure to key people**

Relationship	n	%	n	%	n	%	n	%
<i>(Multiple responses accepted)</i>	<b>I told them</b>		<b>Have not told them</b>		<b>Someone else told them with my consent</b>		<b>Someone else told them without my consent</b>	
Health care workers	582	78.5	64	8.6	1	0.1	21	2.8
Social workers/ counsellors	559	76.4	69	9.4	1	0.1	18	2.5
Other PLHIV	356	48.5	195	26.6	9	1.2	24	3.3
Sexual partner/wife/husband	571	77.5	45	6.1	5	0.7	8	1.1
Other adult family members	601	80.2	63	8.5	20	2.7	23	3.1
Friends	377	51.2	190	25.8	9	1.2	18	2.4
Children in the family	402	54.3	171	23.1	6	0.8	16	2.2
Other people in close contact	251	38.1	158	24.0	8	1.2	24	3.6
Religious leaders	186	25.4	240	32.8	15	2.1	16	2.2
Business clients/ colleagues at work	91	12.5	161	22.1	2	0.3	11	1.5
Employers/Bosses	106	14.4	151	20.5	1	0.1	6	0.8
Local government officials	105	16.0	223	33.9	3	0.5	16	2.4

Respondents were asked about the opinions of those they disclosed their HIV status to or got when their status was made know to those categories of people. Table 11 below summarizes

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the responses.

**Table 10: Reactions of others to disclosure**

Relationship	n	%	n	%	n	%
<i>(Multiple responses accepted)</i>	<b>Discriminatory</b>		<b>No different</b>		<b>Supportive</b>	
Sexual partner/wife/husband	54	9.3	41	7.1	485	83.6
Other adult family members	32	4.9	51	7.8	575	87.4
Friends	25	5.4	99	21.2	342	73.4
Employers/Bosses	20	11.4	49	28.0	106	60.6
Business clients/colleagues at work	15	9.9	56	36.8	81	53.3
Local government officials	12	5.2	61	26.4	158	68.4
Other people in close contact	30	7.8	105	27.1	252	65.1
Children in the family	17	3.5	98	20.2	369	76.2
Religious leaders	10	3.4	112	38.5	169	58.1
Other PLHIV	15	3.3	123	27.2	314	69.5
Health care workers	19	3.1	59	9.7	529	87.1

The category that was reported to be most discriminatory was employers and work related colleagues. Therefore there is a need to intensify workplace HIV awareness so as to reduce the unfounded fears. Respondents reported that family members (87.4%, n=575) followed by HCWs (87.1%, n=529) were the most supportive categories of relations to those that disclosed their HIV status. However, only a fraction of respondents gave response to this question with a range of between 20.2% to 87.8%.

Largely, respondents reported minimal pressure to disclose their HIV status with only 10.5% (n=76) reporting that they were pressurized to disclose by individuals not known to be living with HIV like HCWs, family members, social workers and NGO workers. A total of 67 respondents (9.2%) reported that they were pressurized by fellow PLHIV to disclose their HIV status See Table 12. This points to the need to strengthen the quality of peer support provided by PLHIV to others.

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**Table 12: Influence from others to disclosure**

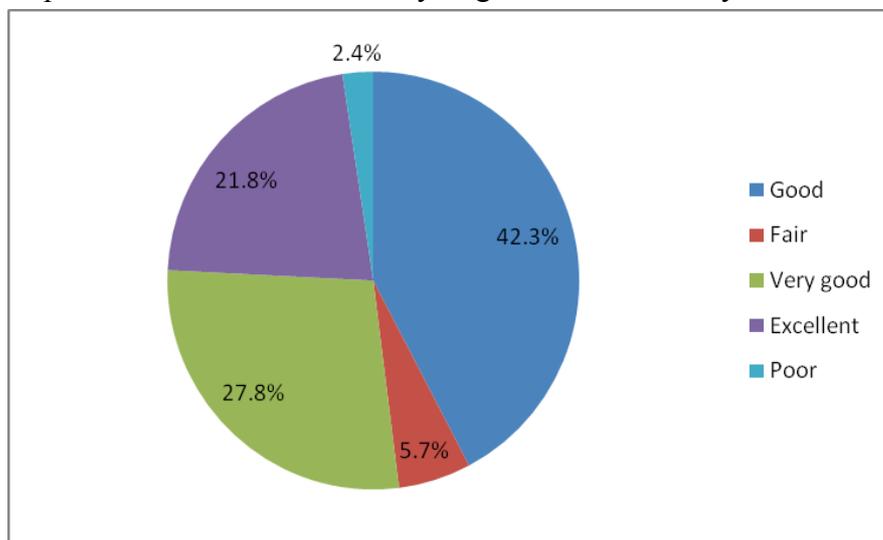
Relationship	n	%	n	%
<i>(Multiple responses accepted)</i>	<b>Yes</b>		<b>No</b>	
PLHIV	76	10.5%	648	89.5
Non-PLHIV	67	9.2%	661	90.8

## Problems and challenges related to disclosure and confidentiality

Respondents were asked what problems they had in relation to disclosure and confidentiality. The most common challenge reported was fear to transmit HIV (35.0%, n=255) followed by limited support for disclosure (23.8%, n=174), and limited information on disclosure (23.1%, n=168).

## Treatment Issues

Respondents were asked how they felt at the time of the interview for the Survey. Chart 08 summarizes the response. The majority of the respondents (91.9%, n=678) who provided responses to this question reported that they were good, very good or excellent. Only 8.1% (n=60) reported being either poor or only fair. This may indicate either that the majority of PLHIV in Namibia are seeking care to improve the quality of their health, or only healthy respondents were unintentionally targeted for the Survey.

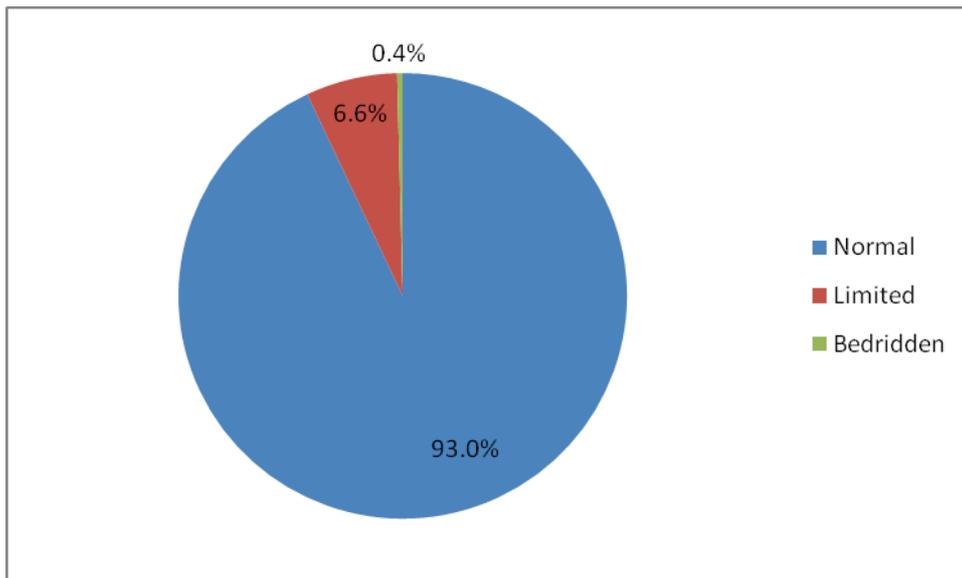


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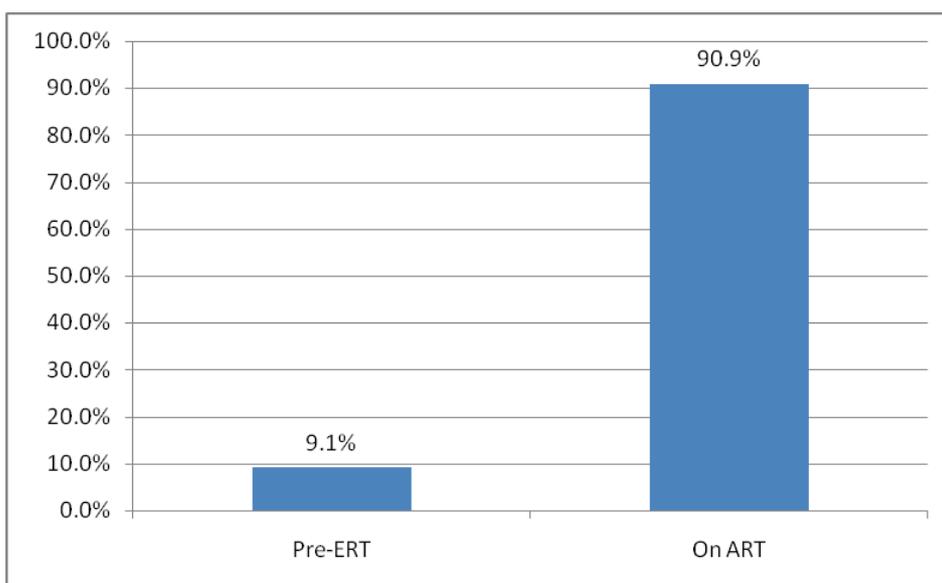
**Chart 08: Quality of health of the PLHIV respondents**

Indeed 93.0% of the respondents reported to be “normal” s presented in Chart 09 below. These findings are collaborated by the responses given when asked whether one was on ART or Pre-ART care program.



**Chart 09: Self assessed wellness**

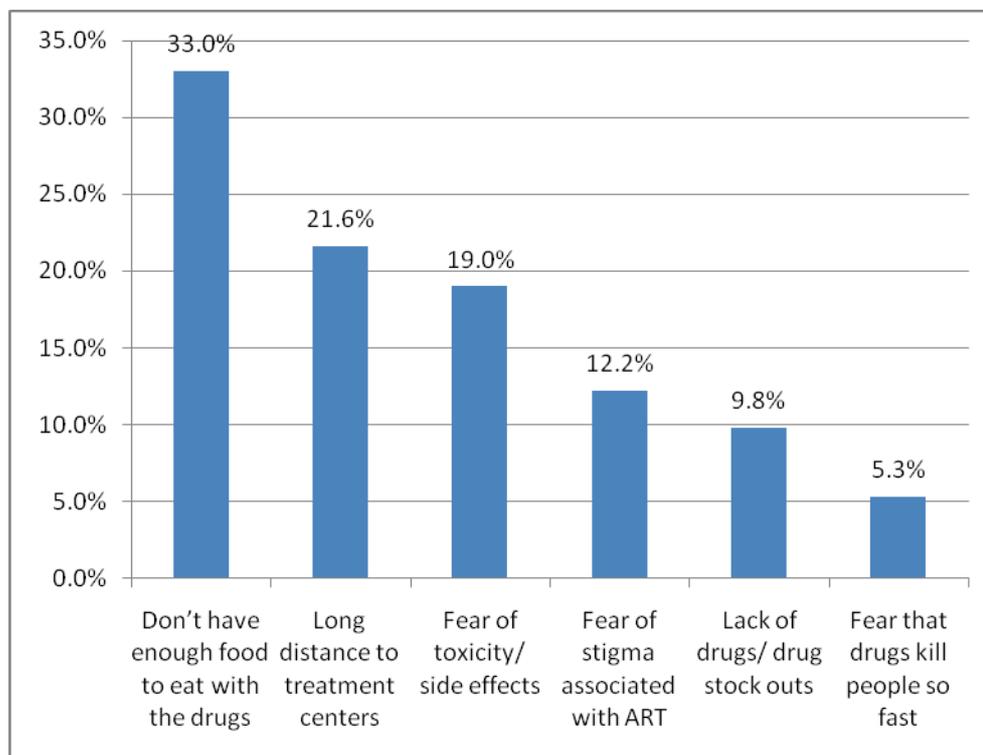
Only a very small fractions (9.1%, n=66) reported being on a pre-ART regimen while 90.9% (n=660) being on ART (See Graph 09 below).



**Graph 09: Treatment regimens**

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Among the respondents who reported to be on an ART regimen, 14.5% (n=103) reported that they had missed some doses in the past 30 days. The respondents on ART were asked what were the challenges they experienced while taking ART. Responses are summarized in Graph 10 below. The most common reason given was not having enough food to eat with the medicines (33.0%, n=240), followed by long distances to health facilities (21.6%, n=158). Least of the concerns was a myth that ARVs kill people so fast (5.3%, n=39) and a concern about drug stock outs, which was reported by only 9.8% (n=72) of the respondents.



**Graph 10: Reasons for missing ART and TB doses**

Respondents who indicated that they had missed some ART and TB doses were further asked what were the main reasons for them to miss their medication. Table 13 below summarizes the findings. The most common reason given for missing ART and TB doses was forgetting (53.5%, n=54) followed by a concern over side effects of these drugs (23.6%, n=21). The least common reason was sharing of medicines (2.2%, n=2) followed by drug stock outs in health centers (6.5%, n=6).

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**Table 13: Reason for missing ART/TB drugs**

Issue	#	%	#	%
<i>(Multiple responses)</i>	<i>Yes</i>		<i>No</i>	
Side effects	21	23.6	68	76.4
Forgot	54	53.5	47	46.5
Too ill/ Nausea	12	13.2	79	86.8
Medicine got finished/ cannot afford the medicine	7	7.7	84	92.3
Difficulty in reaching the health centre	11	12.1	80	87.9
Health centre ran out of medicine	6	6.5	86	93.5
Not able to get food to eat with the medicine	16	17.8	74	82.2
Shared my medicine with someone else	2	2.2	88	97.8
Felt better	7	7.9	82	92.1
Feared someone may see me taking them	10	11.1	80	88.9
Depression	10	10.6	84	89.4
Lack of appetite	10	11.2	79	88.8
Other reasons	14	17.9	64	82.1

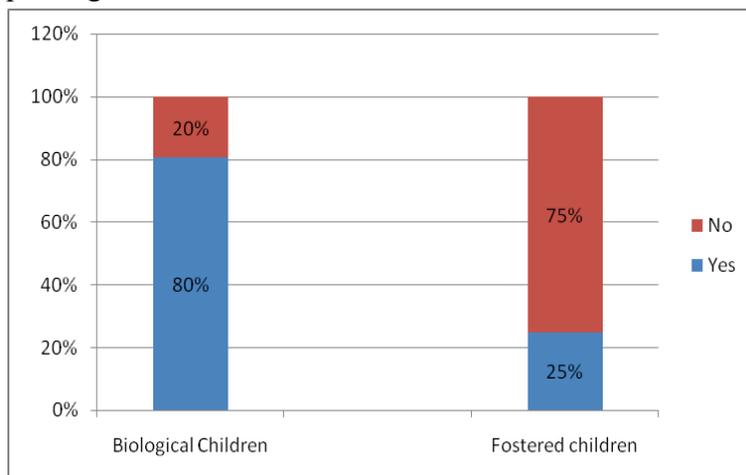
These findings call for intensified counseling for PLHIV on long term treatment so as to enhance their adherence levels. This is because the reasons given for missing doses were largely patient centered and not health care delivery system centered, with only 6.5% of the respondents reporting that the health facilities ran out of drugs. To collaborate this situation, respondents were asked if they had access to ART even when they were on a Pre-ART regimen. The majority of the respondents (86.5%, n=636) of those who gave a response to this question suggested that they had access. Similarly, they were asked if they had access to drugs for opportunistic infections and 83.2% (n=612) reported that they did.

Respondents were further asked if they have had a constructive conversation with HCWs in the past 12 months about their treatment options. Majority of those that provided response (70.2%, n=509) indicated that they talked to their HCWs about treatment options. However the number of respondents who reported having had a conversation with their HCWs over other health concerns, while quite high (63.1%, n=443) was relatively lower than those that had engaged HCWs on HIV related issues.

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## Experience with reproductive health and children issues

Respondents were asked about their experience with children and reproductive health matters. Graph 11 below summarizes the responses. Majority of the respondents who provided responses to this question (80.0%, n=426) indicated that they had biological children while 25.0% (n=167) reported that they had taken in other children by way of adoption or fostering. These findings show that the majority of PLHIV in Namibia have responsibility to look after children in their households. Some of these children may be living with or directly affected by HIV and AIDS. There is a need to intensifying PMTCT services so that there is a reduction in the risk of parents passing HIV to other unborn babies.



**Graph 11: Having children**

Respondents were asked about their experience with accessing reproductive health services and the experience their children have had to endure because of their HIV status. Table 14 below summarizes the responses.

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**Table 14: Experience with Reproductive Health and children issues**

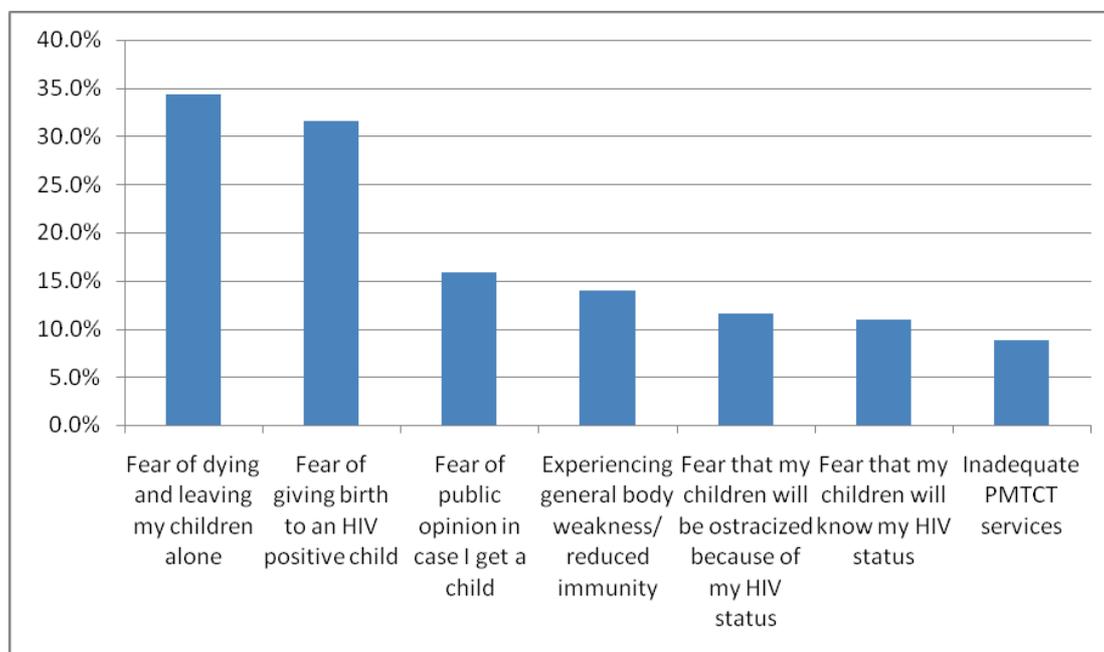
Experience	#	%	#	%	No	%
<i>(Multiple responses accepted)</i>	<b>Yes</b>		<b>No</b>		<b>Not applicable</b>	
Received RH counselling in the past 12 months	324	44.6	368	50.7	34	4.7
Children reported being insulted	24	3.5	595	86.0	73	10.5
Been advised not to have children	74	10.1	631	86.0	29	4.0
Advised that access to ART is subject to contraception**	61	8.4	638	87.6	29	4.0
Been advised to permanently stop having children	36	4.9	655	89.6	40	5.5
Children forced to take an HIV test	24	3.4	607	85.6	78	11.0
Been advised to have an abortion in the past 12 months**	9	1.5	5.5	85.3	80	13.2

\*\* Only female respondents: # included the male respondents

Only 44.6% (n=324) respondents reported having received reproductive health counselling in the past 12 months. Majority of the respondents did not have negative experiences related to reproductive health. However, the few negative experiences reported are a reflection of biases of a few HCWs as well as members of the general community about reproductive health among PLHIV. For instance, 10.1% (n=74) respondents reported that they had been advised not to have any more children.

Respondents were asked about concerns they have over their children. The most concern given was a fear of dying and leaving their children orphaned. This was expressed by 34.3% (n=250) of the respondents. The second most common fear was giving birth to an HIV positive child (31.3%, n=230). The least of the concerns was availability of PMTCT services, which was expressed by only 8.8% (n=63) respondents. This gives an impression that PMTCT services are widely known by the PLHIV community. Few respondents (10.9%, n=80) expressed concern of their children knowing their HIV status. Graph 12 below summarizes the responses.

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**Graph 12: Concerns over children**

## Access to ART for preventing vertical transmission of HIV

Whereas 479 female respondents were interviewed for the Survey, only 333 provided responses to the question as to whether they had received ART during any pregnancy. Among those that provided responses, 71.8% (n=239) reported having received ART in the past. Of concern, are the 23.1% (n=77) who reported lack of knowledge of ART in pregnancy. These findings give a mixed impression of the ART services in the country. While many women living with HIV have been reached, there are those that do not have knowledge of the intervention that can protect unborn babies from contracting HIV from their mothers.

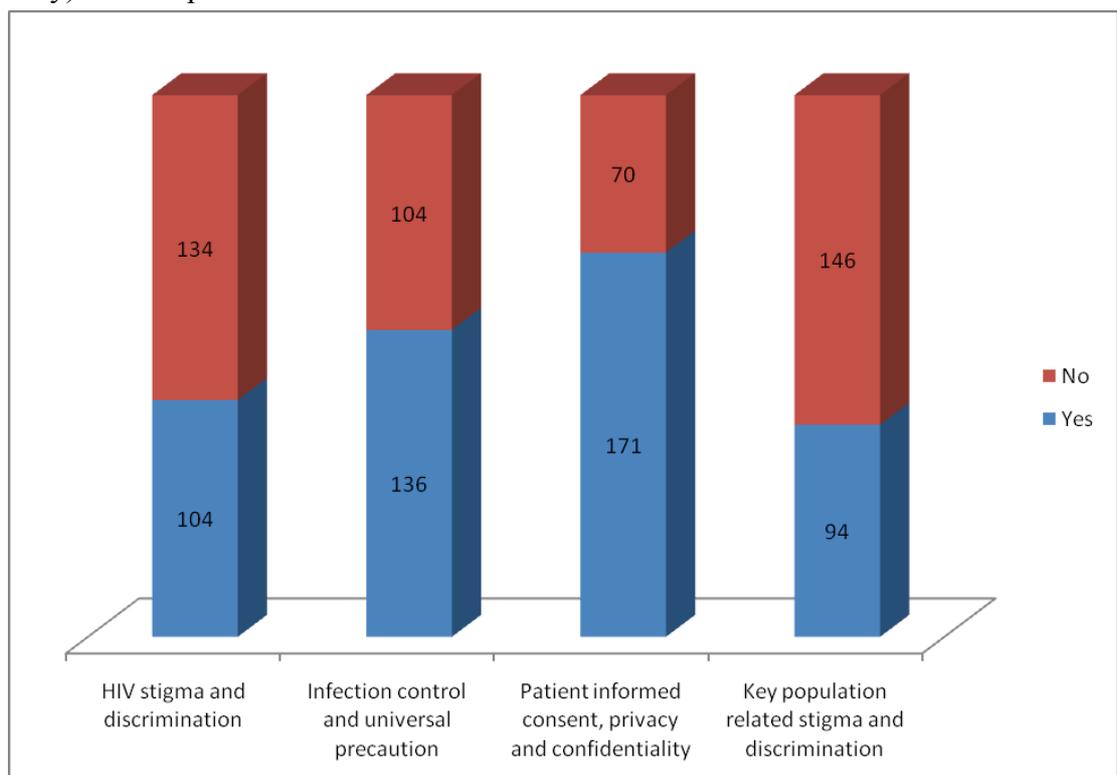


## Chapter 06

### Health Facility Environment and preparedness to manage stigma and discrimination in health care

#### Training to handle stigma and discrimination

More health facility respondents reported that they had received training to manage infection control and patient informed consent process (56.7%, n=136 and 71.0%, n=171) respectively, while fewer respondents reported that they had received training to deal with stigma and discrimination and key population related stigma (43.7%, n=104 and 39.2%, n=94) respectively) See Graph 13 below.



**Graph 13: Training to handle stigma and discrimination related issues**

#### Health Facility environment

Health facility respondents were asked how worried they were about HIV infection during

routine clinical practices. The responses are summarized in Table 15 below.

**Table 15: Worry about HIV infection during routine clinical practices**

Activity	Not worried		A little worried		Worried		Very worried	
	n	%	n	%	n	%	n	%
Touched clothing or bedding of a patient living with HIV	190	88.0	11	5.1	11	5.1	4	1.9
Dressed wounds of a patient living with HIV	119	62.6	40	21.1	20	10.5	11	5.8
Drew blood from a patient living with HIV	113	64.2	27	15.3	26	14.8	10	5.7
Took temperature of a patient living with HIV	169	94.4	9	5.0	1	0.6	0	0

Majority of the health facility respondents reported that they were not worried to undertake routine practices like touching clothing of patients living with HIV (88.05%, n= 190) or taking their temperature (94.4%, n=164). They were also asked about any extra precautions they take while attending to patients living with HIV. The responses are summarized in Table 16 below.

**Table 16: Extra precautions taken while attending to patients living with HIV**

Activity	Yes		No	
	n	%	n	%
Avoid physical contact	24	11.5	185	88.5
Wearing double gloves	32	15.4	176	84.6
Wearing double gloves during all aspects of patient care	72	35.8	129	64.2
Use of special infection control measures with patients living with HIV that are not used for other patients	41	20.8	156	79.2

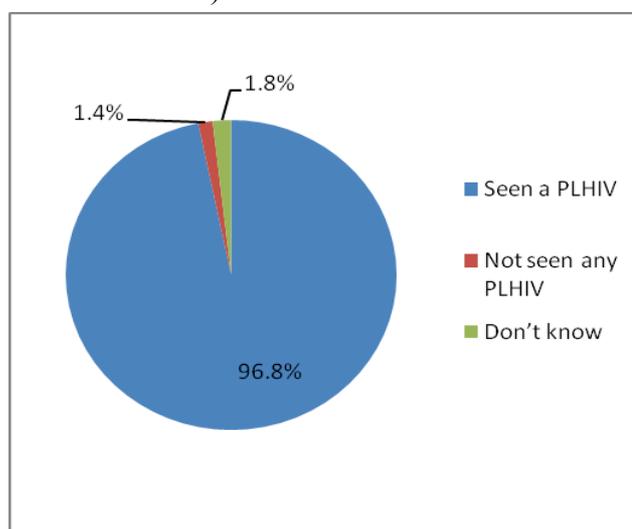
Majority of the respondents reported taking no extra precautions like avoiding physical contact (88.5%, n=185) or using double gloves (84.6%, n=176).

Health facility respondents were asked if they had seen a persons living with HIV in their respective health facilities. Majority of the respondents (96.8%, n=210) reported that they had

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seen them (see Chart 10 below).



**Chart 10: Familiarity with people living with HIV**

The health facility respondents were further asked if they had observed discriminatory behavior from health care workers towards patients living with HIV. Majority of respondents (ranging between 96.2% to 86.6%) reported that they had never observed any discriminatory behavior towards patients living with HIV or health care workers caring for them. Similarly, the health facility respondents were asked if they observed any discriminatory behaviors towards colleagues living with HIV. Majority of those that responded (88.5%, n=208) reported that they had not observed any. The responses are summarized in Table 17 below.

**Table 17: Observed discriminatory tendencies towards patients living with HIV**

Behavior	Never		Once or twice		Several times		Most of the time	
	n	%	n	%	n	%	n	%
Health care workers unwilling to care for a patient living with HIV	206	86.6	11	4.6	15	6.3	6	2.5
Health care workers providing poorer quality care to a patient thought to be living with HIV	211	88.7	11	4.6	9	3.8	7	2.9
Health care workers talking badly about patients with or thought to be living with HIV	208	87.4	12	5.0	8	3.4	10	4.2
Other people talking badly about you because you care for patients thought to be living with HIV	208	87.4	14	5.9	6	2.5	10	4.2
Being avoided by friends or family because you care for patients living with HIV	229	96.2	2	0.8	3	1.3	4	1.7
Being labeled because you provide care to people living with HIV	203	87.1	6	2.6	12	5.2	12	5.2

## Health Facility policies to prevent the occurrence of stigma and discrimination

Health facility respondents were asked about their opinions on existence of policies and practices to protect them from getting infected with HIV in their respective health facilities. The responses are summarized in Table 18 below.

**Table 18: Opinions about policies and guidelines to protect personnel from HIV and deter stigma and discrimination**

Opinion	Strongly agree		Agree		Disagree		Strongly disagree	
	n	%	n	%	n	%	n	%
It is not acceptable to test a patient for HIV without their knowledge	141	59.7	64	27.1	6	2.5	25	10.6
There are adequate supplies in my health facility to reduce my risk of becoming infected with HIV	117	48.8	103	42.9	12	5.0	8	3.3
There are standard procedures in my health facility that reduce my risk of becoming infected with HIV	133	55.4	97	40.4	8	3.3	2	0.8

Majority of respondents (75.9%, n= 183) reported that their health facilities had written policies to protect patients living with HIV from discrimination. However, only 55.5% (n=133) of the respondents acknowledged that they were aware of such policies. Majority of the health facility respondents (93.2%, n=220) reported knowing that there were repercussions if patients under their care were discriminated against.



## Chapter 07

### Opinions about people living with HIV and AIDS, and key populations

Health facility respondents were asked for their opinions about people living with HIV. The responses are summarized in Table 19 below.

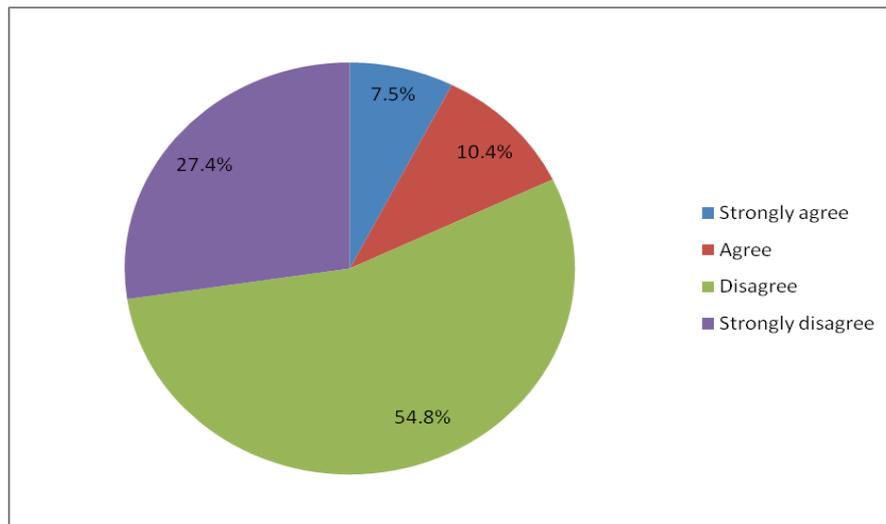
**Table 19: Attitudes towards people living with HIV**

Opinion	Strongly agree		Agree		Disagree		Strongly disagree	
	n	%	n	%	n	%	n	%
Most people living with HIV do not care if they infect other people	51	21.2	98	40.7	68	28.2	24	10.0
People living with HIV should feel ashamed of themselves	8	3.3	22	9.2	121	50.4	89	37.1
Most people living with HIV have many sexual partners	23	9.6	50	20.9	102	42.7	64	26.8
People get HIV because they engage in irresponsible behavior	34	14.3	70	29.4	87	16.6	47	19.7
HIV is a punishment for bad behavior	12	5.3	17	7.5	89	39.4	108	47.8

Most of those who gave responses (61.9%: Strongly agree and Agree) thought that PLHIV do not care if they infect other people. However, majority of the respondents (87.2%: Disagree and Strongly disagree) indicated that they did not think HIV was a punishment for bad behavior.

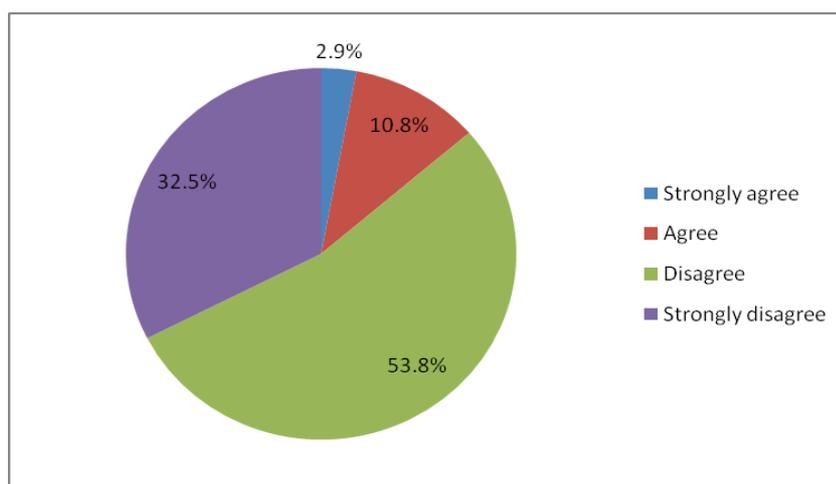
Health facility based respondents were asked whether, if they had a choice, they would not provide services to people who inject drugs. Majority of the respondents (82.2%: disagree and strongly disagree) indicated that they did not have a concern over providing services to patients who inject drugs (see Chart 11 below).

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**Chart 11: Attitudes towards people who inject drugs**

Health facility based respondents were asked whether, if they had a choice, they would not provide care to male and female sex workers. Majority of those that offered opinion (86.3%) indicated that they did not have a concern over providing services to CSWs (see Chart 12 below).



**Chart 12: Attitudes towards CSWs**



## Chapter 08

### Stigma and discrimination in maternal health care

Health facility based respondents were asked if they worried about contracting HIV while assisting women living with HIV during labor. Majority of those that offered response to this question indicated that they were not worried (see Chart 13 below).

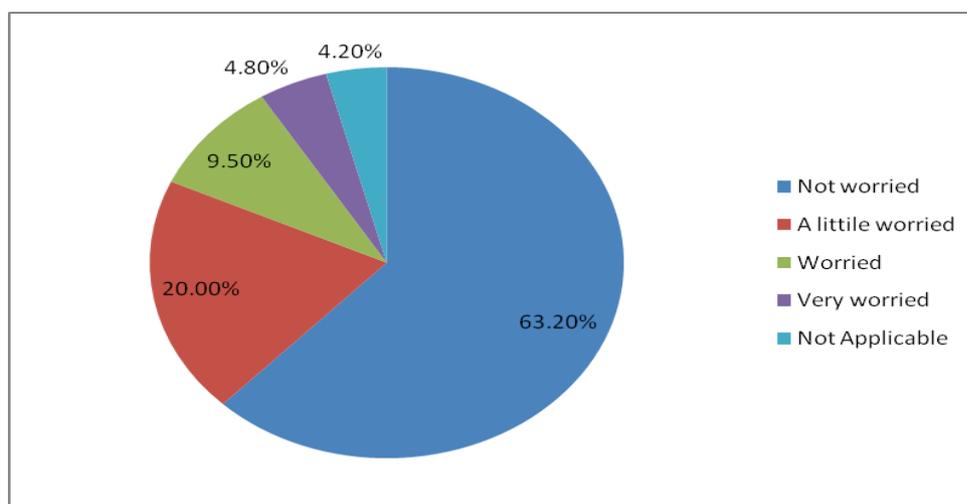


Chart 13: Worry while attending to women living with HIV

This category of respondents was asked what stigmatizing practices towards pregnant women living with HIV that they had observed. The responses are summarized in Table 20 below.

**Table 20: Stigmatizing practices towards mothers living with HIV**

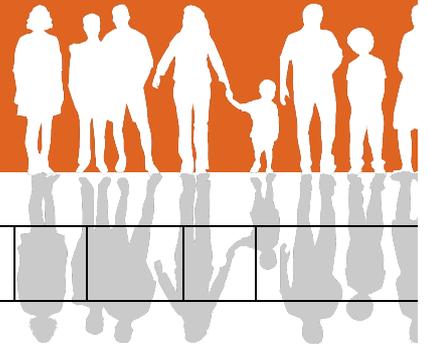
Practice observed among HCWs	Never		Once or twice		Several times		Most of the time	
	n	%	n	%	n	%	n	%
Performing an HIV test on pregnant women without their consent	100	98.0	0	0.0	0	0.0	2	2.0
Neglecting a women living with HIV during labor and delivery because of her HIV status	100	98.0	1	1.0	1	1.0	0	0.0
Using additional infection control procedures with a pregnant woman living with HIV because of her status	79	78.2	12	11.9	5	5.0	5	5.0
Disclosing the HIV status of a pregnant woman living with HIV to others without her consent	93	91.2	4	3.9	2	2.0	3	2.9
Making HIV treatment for woman living with HIV conditional on her use of family planning methods	88	86.3	1	1.0	6	5.9	7	6.9

While majority of the respondents (98.0% to 78.2%) reported that they had never observed any stigmatizing practices towards mothers living with HIV, 21.8% reported that they had observed some health care workers using additional infection control procedures while attending to pregnant women living with HIV because of their status. Others (13.7%) reported that they had observed other health care workers making the provision of HIV treatment conditional on woman living with HIV being on contraceptives. The health facility based respondents were asked about their opinions on HIV and pregnancy. The responses are summarized in Table 21 below.

**Table 21: Opinions about pregnancy and HIV**

Opinion	Strongly agree		Agree		Disagree		Strongly disagree	
	n	%	n	%	n	%	n	%
If a pregnant woman is HIV positive, her family has a right to know	12	11.8	26	25.5	35	34.3	29	28.4
Pregnant women who refuse HIV testing are irresponsible	31	30.7	25	24.8	25	24.8	20	19.8
Women living with HIV should not get pregnant if they already have children	3	2.9	7	6.9	40	39.2	52	51.0
It can be appropriate to sterilize a	1	1.0	1	1.0	38	37.3	62	60.8

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woman living with HIV, even if this is not her choice									
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While the respondents to this question were predominantly supportive of reproductive rights among women living with HIV (ranging between 98.0% to 62.7%), 55.4% of the respondents thought that pregnant women who refuse HIV testing were irresponsible.

## Chapter 09

### Comparisons of selected stigma constructs with other African countries

Stigma and discrimination are some of the major barriers for countries to effectively respond to the HIV and AIDS epidemic. In recent years (2009-2014), with support from the GNP+, UNAIDS and others partners, many countries have documented stigma and discrimination so as to devise strategies to deal with it. Selected constructs from SADC countries have been compared with the findings from this Survey conducted in Namibia in November 2017. The purpose of this comparison is to identify countries from which Namibia may draw positive lessons regarding particular areas of addressing stigma and discrimination. In as much as the broader framework for the index is similar, countries have adapted it to their local contexts. In addition, depending on the preference of the people who conducted the Surveys, some of the constructs have been reported upon differently. It is possible to make a direct comparison for some of the variables, but it is not possible to do so for others. For Namibia, indices from neighboring counties (Zimbabwe, 2014; Zambia, 2012; Swaziland, 2011, South Africa, 2014, Botswana, 2014, and Lesotho, 2014) have been selected for comparison, with an understanding that these countries may have a few things in common with Namibia.

#### Manifestations of stigma and discrimination

As far as the manifestation of stigma and discrimination are concerned, experiences with stigma and discrimination, perceptions on the causes of stigma and discrimination, access to work; health and education services; internal stigma; coping mechanism against stigma and discrimination; and rights, laws and policies have been selected for comparison.

#### Experience with stigma and discrimination

Table 22 below compares the responses from the four countries to whether respondents had ever experienced incidents of stigma and discrimination in the past 12 months.

# Namibia



**Table 22 : Comparison of experience with stigma and discrimination**

Experience	Namibia (%)	Zambia (%)	South Africa (%)	Botswana (%)	Lesotho (%)
Exclusion from religious activities/ places of worship	8.2	-	4.0	2.0	4.3
Exclusion from social gatherings	4.7	11.6	10.0	6.0	16.1
Being gossiped about	11.4		42.0	30	41.1
Exclusion from family gatherings	8.4	6.7	8.0	5.0	6.7
Verbally insulted, harassed and/ or threatened	24.9	16.3	35.0	10.0	26.8

The reported experience of being excluded from religious activities was higher in Namibia compared to South Africa, Botswana and Lesotho.

## Perceptions on the causes of stigma and discrimination

Table 23 below presents a comparison of what PLHIV think are the underlying drivers of stigma and discrimination in four countries: Namibia, Zambia, Swaziland and Botswana.

**Table 23 : Comparison of the causes of stigma and discrimination**

Reasons	Namibia (%)	Zambia (%)	Swaziland (%)	Botswana (%)
People are afraid of getting HIV from me	44.5	10.4	27.2	10.4
People do not understand how HIV is transmitted and are afraid I will infect them through casual contact	47.4	0.4	31.4	13.1
People think that having HIV is shameful and they should not associate with me	39.3	1.1	13.1	16.2
Religious beliefs and moral judgment	23.6	0.8	3.3	5.3
People disapprove of my lifestyle or behavior	24.2	0.7	4.2	5.2
I look sick with symptoms associated with HIV	36.5	4.8	6.4	4.6
I don't know/ Not sure of the reasons	70.6	82.0	22.5	64.3

# Namibia

More respondents in Namibia felt that people were afraid of getting HIV through casual means compared to respondents in Zambia, Swaziland and Botswana.

## Access to work, health and education services

Table 24 below presents a comparison of what PLHIV experienced in regard to access to work health and education services four countries: Namibia, Zimbabwe, Zambia and Botswana.

**Table 24 : Comparison of experiences related to work, health and education services**

Experience	Namibia (%)	Zimbabwe (%)	Zambia (%)	Botswana (%)
Lost a job or source of income	6.0	21.9	18.2	15.0
Change of job description or refused a promotion	4.6	9.6	16.5	2.0
Dismissed, suspended or prevented from attending an education institution	3.3	12.1	6.5	1.0

Respondents in Namibia were less likely to have lost a job compared to the other three countries.

## Internal stigma and fears

A comparison of how PLHIV felt about their HIV status was made between Namibia, Zimbabwe, Zambia, South Africa and Botswana as presented in Table 25 below.

**Table 25 : Comparison of the feelings about HIV and AIDS**

Feelings	Namibia (%)	Zimbabwe (%)	Zambia (%)	South Africa (%)	Botswana (%)
I feel ashamed	23.3	16.5	45.1	29.0	15.0
I feel guilty	23.3	17.2	44.1	28.0	18.0
I blame myself for my infection	30.4	17.3	39.9	31.0	23.0
I have low self esteem given my HIV status	19.6	19.3	33.7	22.0	13.0
I feel I should be punished for what I did to get HIV	7.2	3.8	10.3	-	4.0
I blame others for my infection	18.6	19.9	29.2	19.0	12.0
I feel I do not deserve to live	5.5	5.0	12.1	11.0	0.0

# Namibia



Negative feelings about the respondents HIV status were relatively comparable in all the 5 countries above, with a sense of self blame being high in all the countries.

## Coping with stigma and discrimination

A comparison was made on how PLHIV dealt with stigma and discrimination between Namibia, Swaziland, South Africa and Botswana as presented in Table 26 below.

**Table 26 : Comparison of coping mechanisms against stigma and discrimination**

Coping mechanisms	Namibia (%)	Swaziland (%)	South Africa (%)	Botswana (%)
Decided not to have any more children	27.1	45.0	32.0	29.0
Decided not to have sex	16.3	22.0	14.0	9.0
Isolated myself from family and friends	6.2	13.8	10.0	3.0
Avoided going to local hospital/ clinic	4.6	4.1		3.0
Withdrew from education/ training program	3.9	4.1	-	1.0
Decided not to apply for a job/ seek a promotion	4.0	5.4	-	1.0
Decided to stop working	4.2	5.5	-	1.0
Decided not to get married	11.8	17.5	15.0	7.0

The coping strategies reported by respondents in the four countries were quite similar, with deciding not to have any more children being the highest reported strategy.

## Experience with testing, disclosure, treatment and having children

A comparison was made between PLHIV in Namibia and those in its neighboring countries. In particular, reasons for testing, disclosure patterns with key relationships, reactions of relationships to disclosure and experience with RH and children issues were compared.

### HIV testing and diagnosis

Table 27 below gives the reasons PHIV in the different countries gave for undertaking an HIV test.

# Namibia

**Table 27 : Comparison of the reasons for testing for HIV**

Reason	Namibia (%)	Swaziland (%)	Botswana (%)
Just wanted to know my status	69.6	41.3	-
Illness or death of a sexual partners	14.1	24.0	-
Sexual partner tested HIV positive	13.4	4.5	-
Referred due to HIV related symptom	19.3	13.5	55.0
Referred by an STI Clinic	13.2	2.8	4.0
During pregnancy	19.5	14.1	39.0
To prepare for marriage/ sexual relationship	7.0	0.8	1.0
For employment purposes	5.2	1.8	1.0

Respondents in Namibia were more likely to take an HIV test for purpose of preparing for sexual relationships compared to those in Swaziland and Botswana. They were also more likely to have been referred by an STI clinic to take an HIV test compared to the other two countries.

## **Influence to take an HIV test**

Table 28 below makes a comparison of how the respondents made a decision to take an HIV test.

**Table 28 : Comparison of the influence to test for HIV**

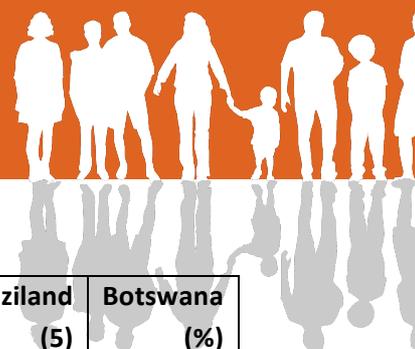
Reason	Namibia (%)	Botswana (%)	Lesotho (%)
Took the decision myself	90.5	94.9	87.0
Took the decision myself but under pressure from others	5.6	2.0	3.0
Was coerced to take an HIV test	0.4	3.0	5.9
Was tested without my knowledge/ found out after the test was done	3.4	1.0	2.3

Respondents in Namibia reported that they were least likely to have been coerced to take an HIV test compared to those in Botswana and Lesotho.

## **Disclosure and confidentiality**

Table 29 below presents a comparison of who PLHIV in the different countries shared their status with.

# Namibia



**Table 29 : Comparison of disclosure to different relations**

Relation	Namibia (%)	Zimbabwe (%)	Zambia (%)	Swaziland (5)	Botswana (%)
Health care workers	78.5	53.1	81.0	71.8	86.0
Social workers/ counselors	76.4	59.6	66.5	59.7	46.0
Other PLHIV	48.5	85.4	75.2	68.9	75.0
Husband/wife/sexual partner	77.5	77.9	87.6	75.8	94.0
Other adult family members	81.2	70.2	74.4	69.7	89.0
Friends	51.2	68.3	28.9	53.9	60.0
Children in the family	54.3	81.6	49.0	58.0	76.0
Religious leaders	24.4	30.8	35.2	20.4	40.0
Business clients/ colleagues at work	12.5	35.0	36.9	20.0	45.0
Employers/ Bosses	14.4	22.3	49.4	16.0	46.0
Local government officials	16.0	31.4	16.9	22.4	13.0

Like Botswana, Zambia and Swaziland, PLHIV in Namibia were more likely to share their HIV positive status with HCWs, and sexual partners. They were least likely to share status with employers and colleagues at work. They were more likely to share with counselors and social workers compared to other countries.

## Reactions of the relations to disclosure

Table 30 below presents a comparison of the reactions PLHIV in the different countries got when they shared their HIV positive status. The very discriminatory variable has been used for this comparison.

**Table 30 : Comparison of reactions disclosure to different relations**

Experiencing discrimination	Namibia (%)	Zimbabwe (%)	Zambia (%)	Botswana (%)	Lesotho (%)
Husband/wife/sexual partner	9.3	11.2	12.8	5.8	5.0
Other adult family members	4.9	9.2	11.7	6.0	3.5
Friends	5.4	7.6	13.3	5.0	3.1
Employers/ Bosses	11.4	5.1	5.7	1.0	1.0
Business clients/ colleagues at work	9.9	4.4	5.1	6.0	3.7
Local government officials	5.2	5.8	2.3	3.0	1.9
Children in the family	3.5	8.2	3.2	1.0	1.0
Religious leaders	3.4	5.0	3.7	2.0	3.3
Other PLHIV	3.3	5.8	1.4	1.0	1.5
Health care workers	3.1	5.5	2.7	1.0	2.7

Employers and bosses were more likely to be discriminatory in Namibia compared to those in Zimbabwe, Zambia, Botswana and Lesotho. For the other relations, the patterns of discrimination are comparable in all the five countries.

### Experience with children and reproductive health issues

Table 31 below presents a comparison of the experiences PLHIV in the Namibia and Zimbabwe (data was only available for Zimbabwe) had regarding reproductive health and matters related to children in the past 12 months of the Surveys.

**Table 31 : Comparison of experience with children and reproductive health issues**

Event	Namibia (%)	Zimbabwe (%)
Received RH counseling	44.6	88.2
Advised not to have any more children	10.1	42.8
Advised to permanently not have children	4.9	10.1
Advised that access to ART is subject to contraception	8.4	11.4

Respondents in Namibia reported that they were less likely to have received reproductive health counseling compared to those in Zimbabwe. They were also less likely to have been advised against having children because of their HIV status compared to those in Zimbabwe.

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## Chapter 10

### Conclusion

Stigma does not benefit society but harms the people including those that it is intended to protect as well as those that are the targets of discrimination. Going by the notion that whatever has a name exists, and looking at the many derogatory names and gestures that were reported to refer to PLHIV, it is evident that the country is dealing with some moderate levels of stigma and discrimination. This Survey suggests that Namibia is faced with a combination of individual prejudices against people living with and affected by HIV and AIDS; community instigated stigmatization and institutionalized discrimination. Individual prejudices were manifested through the reception PLHIV receive from their families, places of work, friends, and some places of worship. Community instigated stigma manifested itself in almost universal names and gestures like the four fingers that are used to refer to PLHIV. Similar gestures were reported from different regions where the Survey was conducted. In addition, PLHIV in the different regions endure the same ostracization from members of the community. From this Survey, one of the key findings is that gossiping about other's HIV status was recorded as very high. This ill-talking about someone because of their HIV status affects the decisions that such an individual makes about their lives and their sexual health. Often, such stigmatized individuals feel so insecure to disclose their HIV status to their sexual partners which is likely to result in engaging in unsafe sex, thus putting the other partners at risk of contracting HIV.

The language used by some of key informants interviewed during this Survey was leaning towards being discriminatory. Some of the respondents could only refer to PLHIV as "those people".

There was a notion that emerged from this Survey that all PLHIV should be encouraged to disclose their HIV status. Stakeholders working on HIV should be on the lookout for forced disclosure and continuously reassure PLHIV that disclosure is not an event but a journey that one has to walk with support from others. The HIV and AIDS stakeholders also need to be on the lookout for some religious leaders who preach the faith of quick fixes for all problems including HIV through prayer and those that preach the gospel of healing against scientifically proven interventions, thereby diverting some PLHIV from continuing taking their ARVs.

Overall, this Survey revealed that there was minimal stigma and discrimination tendencies harbored by health facility based personnel. Similarly, most of the health facility personnel did not report concern over providing care to any of the key populations groups (IDUs, CSWs and MSM) that were presented to them. The only area that needs emphasis is the existing guidelines on stigma and discrimination that should be publicized among individuals working on health

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facilities including clinicians and administrative staff.

While most of the health facility based respondents indicated that they were sensitive to stigmatizing practices especially while helping mothers living with HIV during labor, some discriminatory practices were reported (21.8%), including using additional precaution while attending to mothers living with HIV. Similarly, while health facility based respondents were predominantly supportive of the reproductive rights of women living with HIV. However, some bore ill feelings towards pregnant women who do not take an HIV test.

The manifestation of stigma and discrimination in Namibia is quite similar to what was seen in the other SADC countries, with some countries showing higher indices for some of the variable than Namibia. The only difference is that the other countries conducted their surveys some years back. The point of interest should be that what was documented in the neighboring countries 4-7 years ago is what is seen in Namibia in 2017.



## Chapter 11

### Recommendations

Addressing stigma and discrimination calls for a multifaceted effort including all stakeholders. This is because stigma is perpetuated from all angles of society. The GIPA principle should be promoted by all stakeholders so as to enhance inclusion of PLHIV in all spheres of life. For purposes of attribution, an attempt is made to make some suggestions so as to target specific sectors. The recommendations are made in light of The National Strategic Framework (NSF) for HIV and AIDS Response in Namibia (2017/8 to 2021/22) which aims to reduce new HIV infections and AIDS related deaths by 75% by 2022 from 2015 levels. The NSF acknowledges that there is a need to galvanize and catalyze development sectors to undertake HIV mainstreaming in their internal and external programs and projects (MOHSS, 2017).

### Cross cutting recommendations

#### Launch an anti stigma and discrimination campaign

A high level advocacy campaign to address stigma and discrimination should be launched at the national level involving the highest political authorities in the country. The general population respects politicians and their word is often not disputed by those who subscribe to their views. Such a word becomes a point of reference in routine conversations and undertakings. High profile social personalities like music celebrities can be engaged as ambassadors against HIV and AIDS stigma and discrimination. These are personalities with whom many people from different walks of life wish to associate and they can go a long way in promoting the ideals of acceptance of PLHIV in the community. These high profile personalities can be recruited to promote values of respect and discourage practices of hate and rejection based on HIV status of individuals. While leveraging on the **media attention** such a campaign can attract, it will be very instrumental in not only addressing stigma but addressing the underlying drivers of new HIV infections, stigma being one of them. Such a campaign could be promoted as follow-on to the *Getting to Zero Campaign* which has three pillars, discrimination being one of them. With such a national campaign, different public sectors should be encouraged to set their own indicators for eradicating stigma and discrimination.

#### Active engagement of local authorities and traditional leaders

Local authorities are near to the masses. Regional Authorities as well as Constituency Counsellors should be engaged in promoting the values of compassion, acceptance and inclusion of PLHIV in their respective communities. Such efforts could be directed through the Local Authorities Council of Namibia so as to reach the lowest levels of their membership. This is more so as a good number of respondents have indicated that they feel comfortable to disclose their HIV status to Constituency Counsellors. Similarly, traditional leaders like the Headmen should be engaged in the *Getting to Zero Discrimination Campaign* because they are highly regarded in the respective localities and they are often crowd-pullers whenever they mobilize masses for any social cause.

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## **Deliberate engagement of the faith-based movement**

Faith leaders were suggested as both perpetrators of stigma and discrimination, and facilitators of disclosure. They were among the category of those that discriminated against people living with HIV. They were also suggested as some of the motivators for PLHIV to default from ART through their faith approach to healing. However, most members of the general public hold faith leaders in high respect. There are ongoing efforts by some faith institutions like the Catholic AIDS Action which were reported to be doing immerse work in the areas they operate. Such efforts should be galvanised and expanded to reach more areas in the country. The faith movements are well organised from the grassroots to the national level. Such structures can be facilitated and engaged to get on board the *Getting to Zero Discrimination Campaign* through preaching values of compassion, acceptance and inclusion of PLHIV in their respective communities and articulating the impact of judgemental attitudes to this vulnerable section of the community.

## Health and Social Services Sector

### **Intensify the integration of HIV and AIDS care delivery approaches**

In light of the findings of this Survey which has demonstrated that stigma and discrimination impacts on uptake of existing prevention and care services, the health sector should intensify the roll-out of integrated HIV and AIDS care delivery approaches so as to weigh the risks and benefits as well as the costs involved in delivering HIV services in a parallel way as compared to having fully integrated health care delivery. There are clear benefits of delivering HIV care in a stand-alone way including efficiency, but these need to be explored further in light of acceptability by target population.

Similarly a family centered approach to HIV care should be explored. This is because most respondents and key informants indicated that PLHIV normally disclose their HIV status to family members. This existing support network can be leveraged upon in the delivery of care for PLHIV. As appropriate, counselling training and programs should include modules of supporting disclosure and engaging family members in the care of the index client, in such a way that does not stigmatize both the client and the family. The service delivery points should be promoted widely so that the general population knows multiple places where services are provided.

Home based care should be delivered in an opt-in/opt-out approach so as to allow the beneficiaries opportunity to decide if this approach works for them or not. Differentiated care approaches for different categories of PLHIV should be rolled out. For instance those PLHIV who are more stable with undetectable viral loads could be encouraged to join adherence clubs where they only visit the health facilities once in 6-12 months or when they have a health complaint. As appropriate, PLHIV should be enrolled as peer supporters and counsellors or

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counselling aides in the mainstream service delivery. PLHIV draw a lot of confidence engaging with their fellow PLHIV and this enhances self esteem and reduce self stigma.

The “test and treat” all approach should be intensified so that the general population realizes that HIV is not for a small section of the population but for all.

Internal fears were demonstrated by a number of respondents. These included self blame and sense of guilt. There should be an increase in the counselling offered to PLHIV irrespective of the duration they have known their HIV status. Such counselling would help PHIV to come to terms with their HIV status and address the fears that they have, so as to live an empowered life.

The Survey found that among those who missed ART and TB medicines, the biggest reason was forgetting (53.5%, n= 54). The health care delivery system can devise means of intensifying counselling for both newly enrolled patients and those on long-term care so as to boost their adherence levels. Locally feasible mechanisms like engaging treatment buddies can be devised so that PLHIV can realize 100% adherence and consequently suppression of the viral loads on cheaper ART regimens.

## **Strengthening youth friendly services**

This Survey indicated that young people, both those that are living with HIV and those that are not, face obstacles associated with discrimination including provider bias when seeking for HIV related services. Because young people are the ones who are most at risk of new HIV infections and more marginalized when they have HIV, there should be deliberate efforts to strengthen provider competence in caring for this group of people including youth specific counselling approaches that build self esteem among the young people.

The Survey indicates that 69.6% of the respondents took an HIV test simply to know their HIV status. This desire to know one’s status should continue to be facilitated by making HIV testing services more available to all people of all age groups, especially the young people.

In order to address the stigma associated with seeking for prevention services from facilities that are ‘hospital’ in nature, some of the non-biomedical services could be decentralized to other sectors like youth development, tertiary institutions or sporting programs. Such services which could easily be decentralized include contraception, counselling and condom delivery.

## **In-service training for HCWs to promote holistic care for PLHIV**

This Survey indicates that a good number of PLHIV feel comfortable to disclose their HIV status to HCWs (78.5%, n=582). Majority of respondents (70.2%, n=509) reported that they had had a constructive conversation with their HCWs about their treatment options. A relatively lower number (63.1%, n=443) had engaged their HCWs on other health matters. On the other hand some PLHIV have expressed concern that some HCWs tend to disclose their HIV status without consent to unintended persons. The MOHSS therefore should institute managing stigma and discrimination in health care delivery as one of the continuing professional development (CPD) modules for HCWs so as to support them deal with the dynamics of providing HIV care including providing service in such a way that minimises stigma and discrimination.

## **Promote policies and protocols related to stigma and discrimination among HCWs**

This Survey indicates that a small fraction of health facility personnel are familiar with existing policies and guidelines that are intended to protect health care personnel from contracting HIV while in the line of duty, as well as those guidelines that are intended to deter occurrence of stigma and discrimination of patients living with HIV who report for care. Therefore, the MOHSS should intensify the promotion of these policies as part of CME so that the intended benefits are fully realized. This Survey revealed that 34.2% of the health care workers that participated in the survey worried about HIV infection while helping mothers living with HIV during labor. The health care managers should support such personnel by providing support and revising precaution that they should take so as to significantly reduce their risk of contracting HIV during the line of duty and hence address such worries. Similarly, health care managers should support line staff to promote HIV testing among pregnant women in a rights-sensitive manner as well as using a health-benefit approach and a social construct framework, so as to address blame feelings that may exist and branding those that decline an HIV test as being irresponsible.

## **Enhancing community based HIV and AIDS awareness**

The Survey indicates that some of the key manifestations of stigma and discrimination in Namibia include rejection, isolation and moral judgment. There are also major misconceptions like believing that HIV is for prostitutes and people with immoral behaviours, or poor people who get it because they are looking for something to eat. The most highly noted reason for the persistence of stigma and discrimination is low levels of awareness about HIV in the community. One of the biggest perpetrators of stigma and discrimination against PLHIV were reported as family and community members. These behaviours arise out of misinformation and unfounded fear of infection. These practices can be attributed to limited knowledge of how HIV is transmitted and how one can protect themselves from contracting HIV. Once the community is supported with accurate information, this could contribute to the reduction of all forms of community, structural and individual level stigma and discrimination. Family and community members who learn of HIV positive status of individuals would be more capable to support others without unfounded fear of infection. The MOHSS together with stakeholders should strengthen community based programs by deploying innovative measures like social media and door-to door programs especially in the country side while targeting the general population with messages that promote acceptance of PLHIV and defraying unfounded fears of infection.

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## **Strengthening PLHIV support groups**

This Survey has indicated that a good number of PLHIV live in isolation and fear of being rejected. The Survey also indicated that PLHIV blame themselves for their status and others are guilty because they are HIV infected. These feelings affect their self esteem and ability to be agents for HIV prevention. Such fear has a direct impact on the national HIV prevention efforts. The Survey also indicated that more than half of the respondents (59.5%, n=351) did nothing to educate or challenge someone who stigmatised a PLHIV. In order to address this isolation, the MOHSS could work with the different stakeholders involved in the HIV response to strengthen support groups of PLHIV at all levels starting from the grassroots to the national level. Through the support groups, PLHIV can provide ongoing counselling and emotional support to each other. The Survey found that 9.2% (n=67) of the respondents felt pressurized by fellow PLHIV to disclose their HIV status. The quality of peer support provided by PLHIV should be strengthened.

When PLHIV have a sense of identity, they are not only able to cope with stigma and discrimination, but can be a formidable resource for addressing the vice in their respective communities, and are able to support others who face stigma and discrimination. Such empowered support groups can lead in campaigning against stigma and discrimination at all levels, and also contribute to campaigning for HIV prevention in the community.

The support groups can come up with innovative ways of campaigning against stigma and discrimination, like organising beauty galas at different levels, including the national level. Such galas involve a cross-section of the community and can promote awareness about the impact of stigma and discrimination. Therefore the networks of PLHIV should be re-invigorated as part of the community systems strengthening efforts to respond to HIV, so that they have an active representation at the national level where they are able to actively participate in policy formation.

The Survey showed that only 49.7% of the PLHIV were able to refer others for services. If the support groups are strengthened, they could play an active role in complementing service delivery and referring other PLHIV to available services in their respective communities. Similarly, majority of PLHIV respondents reported that they did not take action to address stigma and discrimination. PLHIV need to be empowered as the first respondents to all forms of HIV related stigma and discrimination in their respective community.

## Agricultural Sector

### **Supporting PLHIV support groups to engage in agricultural activities**

PLHIV respondents have indicated that poor nutrition (33.0%, n=240) is one of the highest challenges they face, which makes them more susceptible to stigma and discrimination from the general community. Through agricultural extension programs in the respective Regions, PLHIV should be targeted as beneficiaries of inputs and technical advice on how to engage in some form agricultural production so as to supplement their food supplies. Agricultural activities would also

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bridge some of the employment gaps that exist for PLHIV in the country side. Such initiatives would greatly benefit groups of PLHIV which are in the country side where land may easily be accessible.

## Education Sector

### **Strengthening life skills lessons to include HIV and AIDS dialogue**

Withdrawing from educational programs was a least likely (3.9%, n=29%) coping strategy in the face of stigma and discrimination. Given that a good number of young people below 25 years of age are still undergoing some form of training. Education institutions at all levels should strengthen curriculum for skills building so as to intensify dialogue around HIV among the learners. Such lessons, depending on the age of learners, will help in demystifying HIV and help in addressing HIV related stigma and discrimination while helping the young people to be equipped with knowledge on how to protect themselves from HIV. Targeting young people in schools has a tremendous multiplier effect to their respective families and communities.

## Youth Development Sector

### **Strengthening youth drop-in centres**

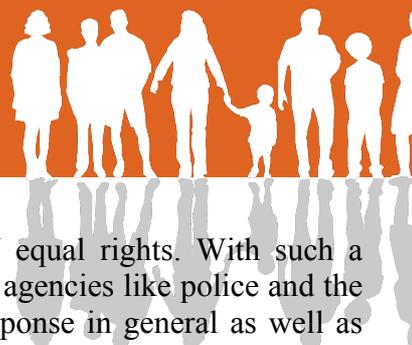
Young people are at the greatest risk of HIV infections. When they contract HIV, they are more vulnerable to stigma and discrimination because of their social standing. They are often unemployed and are economically dependent on other people. In addition to support groups for PLHIV, facilitated youth drop-in centres for all young people can be instrumental in engaging young people in all matters related to civic issues including HIV. These can fend off stigma because they are open to all young people irrespective of their HIV status. Having Coordinators at these Centers who are skilled in supporting young people with HIV issues can have a multiplier effect to their families and the general community. Such Coordinators can make referrals for more specialised services like HIV counselling and testing. They will also help young people deal with other social vulnerabilities like alcohol and drug use while promoting delay of sexual activity among young people as well as promoting HIV prevention in general.

## Justice, Law and Order Sector

### **Strengthening the legal and policy framework and engagement of law enforcement agencies in the HIV response**

Whereas there is a National Strategic Framework for HIV and AIDS Response, there is no HIV policy that can be reinforced in the Courts of Law. Such a Policy if developed would create a

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legal framework that prohibits discrimination and accords PLHIV equal rights. With such a policy in place, coupled with active engagement of law enforcement agencies like police and the judiciary, would address a structural gap that exists in the HIV response in general as well as stigma and discrimination in particular. Law enforcement agents will become AIDS competent in executing their day-to-day duties. Constitutional provisions should be evoked (Art 8.1, 8.2b) where all citizens of Namibia are accorded dignity<sup>2</sup>.

## Labor and Welfare Sector

### **Promoting inclusion in the workforce**

Places of work were identified as some of the leading perpetrators of stigma and discrimination among PLHIV in Namibia. The Ministry of Labour should spearhead the promotion of equal opportunities for all by sensitizing employers and employees on the values of having people employed on merit and not HIV status.

### **Strengthening HIV awareness in places of work**

The findings of this Survey have showed that employers were the most discriminatory towards a person whose HIV positive status is shared (11.4%). Therefore, workplace HIV prevention and awareness programs should be strengthened so as to address unfounded fears of employing or working with a person living with HIV. Such programs would reach a good number of adults, some of whom are at a relatively high risk of contracting HIV. Such efforts will have a multiplier effect to entire community. In addition, policies that can be reinforced by the law should be developed by the Ministry of Labour so as to facilitate mainstreaming HIV in the places of work.

### **Strengthening family and community safety-net systems**

Many respondents (80.2%, n=601) indicated that the first person they would disclose their HIV status is a member of their family. Similarly, a high number of respondents indicated that family members were supportive. Working with other stakeholders, the social welfare sector should promote the family systems and values of inclusion, compassion and openness not only for HIV but as a safety net for all individuals. Humans live in families. The Social Sector should promote family systems at all levels because HIV is a long term disease and only families have the ability to stand with an individual with HIV for the long term. Other stakeholders can support but for limited periods of time. Families should be given the accurate information on a regular basis so as to demystify fears associated with moralism and non-scientific claims of infection. Many respondents (34.3%, n=250) expressed a fear of dying and leaving their children orphaned. If there are strong family systems, such fears would be less, knowing that there were close family members who can support the children if the parent is not alive.

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<sup>2</sup> The Constitution of the Republic of Namibia (Art 8.1, Art 8.2b)

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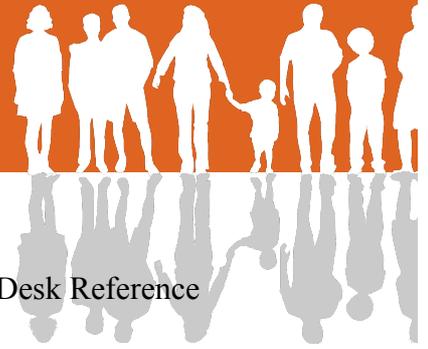
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## Disclaimer:

The PLHIV Stigma Index is designed as a research tool for capturing data on the experiences and perceptions of PLHIV regarding stigma and discrimination. In this regard, the results can be said to comprise a snapshot of the level of HIV-related stigma and discrimination in a certain place and time. Through its implementation, the tool also serves to educate and empower PLHIV on human rights related to HIV. Survey questions therefore focus on experiences and perceptions and do not represent factual investigations, with follow-up questions, into particular allegations, incidents or events nor are the answers to the questions subject to independent verification. The respondents in this survey have a right to anonymity and confidentiality regarding their responses. In addition to the empowerment function, appropriate uses of the data are for advocacy and in order to inform stigma/ discrimination reduction programming and policy responses in the national response to HIV. The data is not available as a source of allegations of individual instances of wrong doing.