Female Domestic Workers' Knowledge, Attitude and Practices (KAP) on HIV/AIDS

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DECLARATION

I, the undersigned hereby, declare that the work contained in this assignment is my own original work, and that I have not previously, in its entirety or in part submitted it at any university for a degree.

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Signature: Date:

ABSTRACT

HIV/AIDS poses major health challenge to the global population and continues to be a prominent killer disease despite the fact that ongoing attempts are being made to find a cure for the epidemic. Namibia is one of the most affected countries in the world, and has been very open about this disastrous malady. Although the country has put education programs in place to try and prevent the spread of HIV, a lot remains to be done.

The present study aimed to assess knowledge, attitudes and behaviour/practices regarding HIV/AIDS of domestic workers in the Hochland Park suburb of Windhoek. The purpose of the study was to determine the level of knowledge of domestic workers about HIV/AIDS prevention and evaluate certain beliefs and practices in this regard. Data was collected from a sample of 121 respondents using a structured questionnaire.

The relationship between knowledge, attitude and practices was examined. The findings indicate that the knowledge levels of domestic workers are relatively high. Sources of such knowledge were mainly radio/television, relatives and friends and churches, with a smaller contribution by clinics/health care workers. In addition, the findings show that there is a positive relationship between knowledge about HIV/AIDS and educational level. However, education by itself does not guarantee behavioural change as findings in the present study indicate that does not have a strong positive correlation with behavioural change.

OPSOMMING

MIV/VIGS is n kommerwekkende gesondheids uitdaging aan die wêreld bevolking en is steeds n prominente, dodelike siekte ten spyte van die feit dat volgehoue pogings aangewend word om behandelings te ontwikkel om die epidemie te genees. Namibië is een van die mees geaffekteerde lande in die wêreld, en is van die begin af baie ontvanklik tot die hantering en opvoeding ten opsigte van hierdie katastrofiese siekte. Hoewel die land onderwysprogramme in plek gestel het om die verspreiding van MIV te probeer verhoed, is daar steeds ’n groot taak te verrig.

Die huidige studie was gemik daarop om die kennis, houding, gedrag en praktyke van huishulpe in die Hochland Park woonbuurt van Windhoek te bepaal. Die doel van die studie was om vas te stel wat die vlak van huishulpe se kennis tot HIV/VIGS voorkoming is, en die evaluasie van bygelowe en praktyke rondom die onderwerp. Data is versamel van ’n groep van 121 deelnemers, deur middel van ’n gestruktureerde vraelys.

Die verhouding tussen kennis, houding en praktyk is ondersoek. Die bevindinge dui aan dat die kennisvlakke van huishulpe relatief hoog is. Bronne van inligting is weergegee as hoofsaaklik die radio/televisie, familie en vriende, sowel as kerke, met ’n kleiner hoeveelheid wat gemeld het dat primêre gesondheidsorgwerkers/klinieke ’n rol speel. Die bevindinge bewys dat daar ’n positiewe verhouding bestaan tussen MIV/VIGS kennis en vlak van akademiese opvoeding. Opvoeding alleen waarborg egter nie gedragsverandering nie. Die huidige bevindinge toon nie ’n sterk ooreenkoms tussen opvoeding en gedragsverandering nie.

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AIDS	Acquired Immuno Deficiency Syndrome
HDR	Human Development Report
HIV	Human Immuno Virus
IOM	International Office for Migration
KAP	Knowledge, Attitude and Practices
LAC	Legal Assistance Centre
LARRI	Labour Resource and Research Institute
MDG	Millennium Development Goals
MOHSS	Ministry of Health and Social Services
NACA	National AIDS Coordinating Agency
NAFWU	Namibia Farm Workers Union
NDAWU	Namibia Domestic and Allied Workers Union
PMTCT	Prevention of Mother to Child Transmission
RT	Rapid Testing
SADC	Southern African Development Community
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UN	United Nations
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

CHAPTER 1

Introduction

1.1 Introduction

As HIV/AIDS has taken hold in many communities, it has become clear that those with the least power and the least access to information and health services are most at risk of contracting the virus (Heywood, 2004). According to Joint United Nations Programme on HIV/AIDS (UNAIDS, 2004), in many countries women and girls are bearing a heavier burden than men in terms of rate of HIV infection, stigmatization that results from their being blamed for HIV/AIDS and the burden of the family support and care. Furthermore, women's traditional roles as caregivers in many societies increase both their vulnerability to HIV/AIDS and the impact of the epidemic on their health. The inability of health care facilities to cope with the demands of caring for infected people has pushed responsibility for care into the private domain of the family and the community (Heywood, 2004).

The UNAIDS (2004) estimates that in sub-Saharan Africa, women constitute 58 per cent of people living with HIV/AIDS - a higher proportion than in any other part of the world. In southern Africa, where HIV infections are highest, no group has been as badly affected as women and girls. Disclosure of women's HIV status is likely to cause abuse or abandonment by their families and loss of their rights to children and property. Although physiologically women are at greater risk for transmission, it is their lack of power over their bodies and sexual activity compounded by their social and economic inequality, that makes them most vulnerable to contracting HIV (UNAIDS, 2004).

The United Nations [UN], World Health Organisation [WHO] and UNAIDS (2002) explains that in most cases, women who are known or suspected to be HIV positive are especially vulnerable to violence. Furthermore, young women and girls face special risks with regard to violence and HIV infection because of the erroneous but widespread belief in some parts of sub-Saharan Africa that sex with a virgin can cleanse a man of infection. This puts them at an elevated risk of rape and sexual abuse because they are perceived to be more likely to be free from infection.

Other factors that increase women's vulnerability to HIV infection includes assigned cultural roles, economic dependence and their lack of power to negotiate for safe sex (UN, WHO & UNAIDS, 2002).

According to the Legal Assistance Centre [LAC] (1996), women in Namibia represent the majority of domestic workers in comparison to men at a rough estimation of 85 percent. Through the duality of being a domestic worker and a woman she is at a bottom of the ladder of oppression and such oppression makes her vulnerable to exploitation.

Studies have shown that domestic workers are among the most vulnerable mobile population in Southern Africa due to their poor working conditions and lack of labour rights protection. The LAC (1996) maintains that domestic service in Namibia remains the single largest source of employment for black Namibians apart from the agricultural sector. Clearly, in many Namibian families, housekeeping depends largely on the skills and hard work of domestic workers, yet domestic workers are not in a real sense a part of the households they serve. Their position within these households is largely shaped by the structures, which control the distribution of power and resources in Namibia.

This Knowledge, Attitude and Practices (KAP) study is aimed at assessing the knowledge of participants about HIV/AIDS, and determining their attitudes towards the disease and to those infected and affected by the virus. It is also aimed at assessing their sexual behaviour and practices to determine their risk of infection. Pillay (2005) indicated that as HIV/AIDS rates continue to rise in sub-Saharan Africa it is important that decision-makers take note of how communities and individuals are responding to the disease.

1.2 Background statement to the problem

1.2.1 Global situation of the epidemic

The HIV/AIDS epidemic is a global crisis that requires commitment and action from all sectors. The UN (2002) explains that over the last two decades the epidemic has grown from a localized health concern to a global issue that now looms large in national and international agendas. Sachs (quoted in Beresford, 2001) explains that HIV/AIDS

damages society just as it does the human body: it begins by killing those parts responsible for building society, the women and breadwinners who sustain and safeguard the community as a whole.

UNAIDS (2004) state the following:

> "AIDS is an extraordinary kind of a crisis. To stand any chance of effectively responding to the epidemic we have to treat it as both an emergency and a long-term development issue. This means resisting the temptation to accept the inevitability of AIDS as just another of the world's many problems. The AIDS epidemic is exceptional, it requires an exceptional response that remains flexible, creative, energetic and vigilant". (page13)

The 2005 UNAIDS and WHO AIDS Epidemic Update shows that AIDS has killed more than 25 million people since it was first recognised in 1981 making it one of the most destructive epidemics recorded in history. The epidemic claimed 3.1 million (2.8-3.6 million) lives in 2005 and more than half (570,000) were children. Close to 5 million people were newly infected in 2005 as indicated in Table 1. It further mentions that by December 2005, worldwide women accounted for 46 % of all adults living with HIV, and in sub-Saharan Africa specifically women accounted for 57 %.

Table 1
World estimates of the HIV and AIDS epidemic at the end of 2005
(http://www.avert.org/worldstats.htm)

		Estimate	**Range**
Number of people living with HIV/AIDS in 2005	**Total**	**40.3 million**	**36.7 – 45.3**
	Adults	38.0 million	34.5 – 42.6
	Women	17.5 million	16.2 – 19.3
	Children	2.3 million	2.1 – 2.8
People newly infected with HIV in 2005	**Total**	**4.9 million**	**4.3 - 6.6**
	Adults	4.2 million	3.6 – 5.8
	Children	0.70 million	0.63 – 0.82
AIDS deaths in 2005	**Total**	**3.1 million**	**2.8 – 3.6**
	Adults	2.6 million	2.3 – 2.9
	Children	0.57 million	0.51 – 0.67

1.2.2 HIV/AIDS epidemic in sub-Saharan Africa

Sub-Saharan Africa, especially Southern Africa is the hardest hit region in the world. Mark Malloch Brown (quoted in United Nations Development Programme [UNDP], 2004) indicated that

> "the HIV/AIDS epidemic is Africa's most serious development crisis, with Southern Africa bearing the brunt with one in seven of the adult population living with HIV/AIDS. The scale, severity and impact of HIV/AIDS on these societies is destroying the capacity of governments and communities to function effectively". (page5)

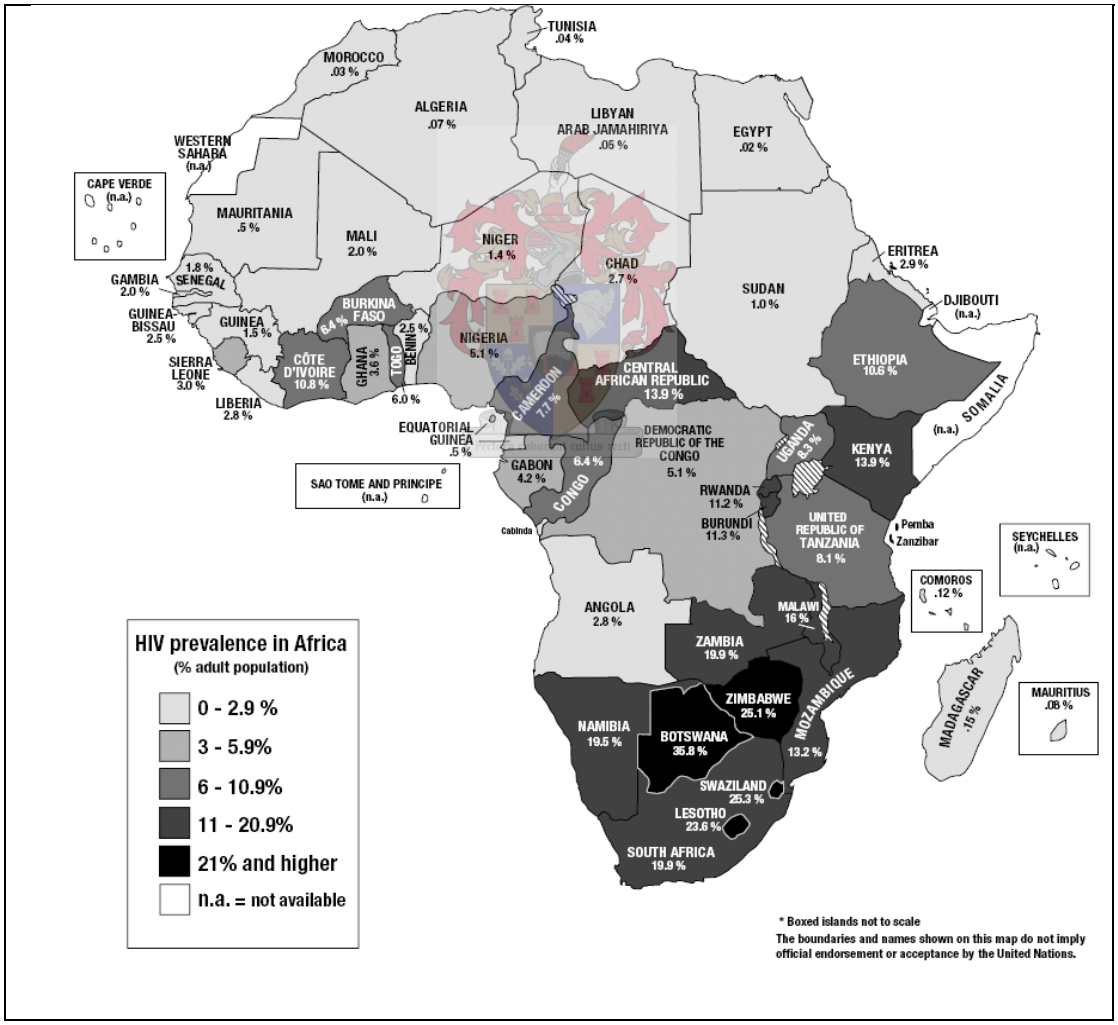


Figure 1. HIV Prevalence in Africa, (Belinda Beresford in the UN Africa Recovery (2004)

Sub-Saharan Africa is home to just over 10% of the world's population but comprises more than 60% of all people living with HIV - that is 25.8 million people. This is evident in Figure 1 above, which indicates the HIV prevalence rates in Africa. An estimated 3.2 million people in the region became newly infected (UNAIDS & WHO, 2005). while 2.4 million adults and children died of AIDS. Southern Africa remains the epicentre of the global AIDS epidemic even though for the first time, there are signs that the epidemic could be ebbing. However, there are still very high HIV prevalence rates, exceeding almost 30 %, being recorded by four countries, namely Botswana Lesotho, Namibia and Swaziland (UNAIDS & WHO, 2005).

1.2.3 HIV/AIDS in the context of Namibia

Namibia is among the countries worst hit by the epidemic and HIV/AIDS continues to pose the number one threat to human development. The challenge posed by the HIV/AIDS epidemic is enormous and the impact to a country's economy can be negative. The Namibia 2004 Millennium Development Goals (MDG) report states that the people of Namibia are suffering from one of the severest HIV/AIDS epidemics in the world. About one in five pregnant women are infected with HIV and the devastating consequences of the epidemic are felt in every community.

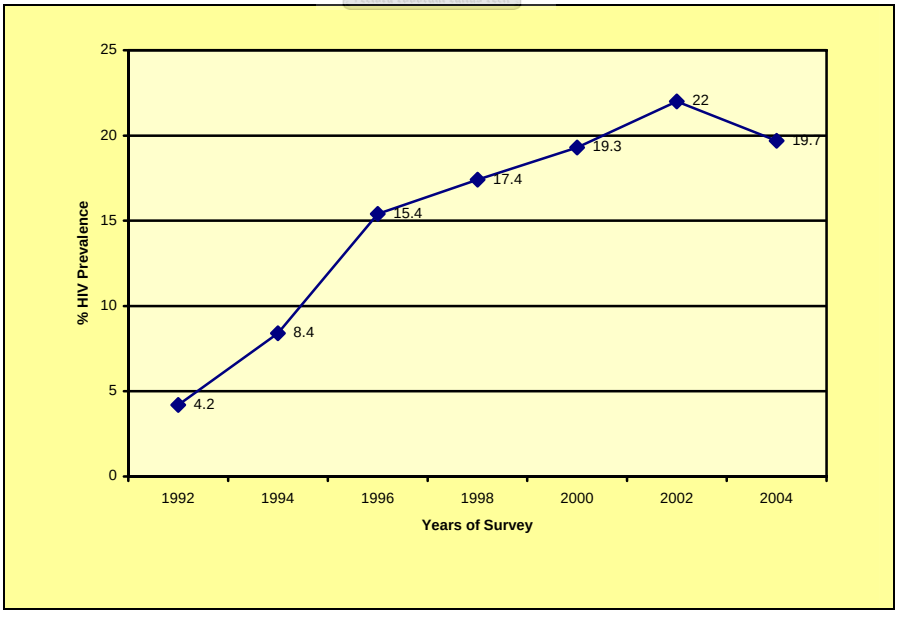


Figure 2. Biannual Survey 1992-2004 of the HIV Prevalence rate in pregnant women in Namibia (Ministry of Health & Social Services [MOHSS], 2004)

UNAIDS and WHO (2005) explain that the HIV prevalence in pregnant women in Namibia varied from 8.5% in the Opuwo region, which is one of the remote areas in the north-west of the country, to over 42% in Katima Mulilo in the Caprivi region. In the ports, Luderitz, Swakopmund and Walvis Bay, the prevalence rates ranged between 22% and 28%. Figure 2 shows data from the report of the 2004 National Sentinel Survey which indicates the HIV prevalence rate in pregnant women from 1992-2004 conducted by the Ministry of Health and Social Services.

1.3 Significance of the study

In the context of Namibia, there have been no known KAP studies on HIV/AIDS and domestic workers. This research project explores the extent of domestic workers' knowledge, attitudes and practices regarding HIV/AIDS. It is of particular interest first, to the HIV/AIDS and public health practitioners, secondly, to the government and unions in Namibia, and thirdly, to the human rights groups sector and beyond.

The study concentrated on female domestic workers as part of the most vulnerable group of migrants by assessing their knowledge and awareness on HIV/AIDS. The findings of the research brought knowledge on issues related to HIV/AIDS and domestic workers. Results may also add to existing knowledge, help improve the working conditions and provide some frameworks for HIV/AIDS awareness and prevention programmes. The results may further assist the researcher in providing information to unions and human rights organisations that would assist in promoting education and awareness to these vulnerable groups.

Based on the results of the study, the researcher recommended solutions and steps to be taken in assisting domestic workers with HIV/AIDS related information. This may help in curbing the spread of the epidemic and provide them with knowledge and education on issues related to HIV/AIDS.

1.4 Research objective

The purpose of the study was to examine the level of awareness and attitudes of domestic workers regarding HIV/AIDS in a suburb within Windhoek. It focused on domestic workers' knowledge, behaviour, practices and attitudes towards the epidemic.

1.4.1 Research questions

The research question driving this study was: "Does increased knowledge on HIV/AIDS decrease domestic workers' vulnerability to the epidemic?"

1.4.2 Research hypothesis

A hypothesis is explained by Christensen (2004) as a predicted relationship among the variables being investigated and for it to be scientific, it should represent the predicted relationship among the variable being investigated. The formulation of a hypothesis follows the statement of the problem because one cannot formulate a hypothesis without a problem. The hypothesis in this study was that increased knowledge on HIV/AIDS decreases domestic workers' vulnerability to the epidemic. In this study, the relationship between the dependant variable (decreased vulnerability to the epidemic) and independent variable (increased knowledge on HIV/AIDS) was being predicted in order to test the hypothesis. By doing the study, a solution would be found to help solve the problem.

CHAPTER 2

Literature Review

2.1 Introduction

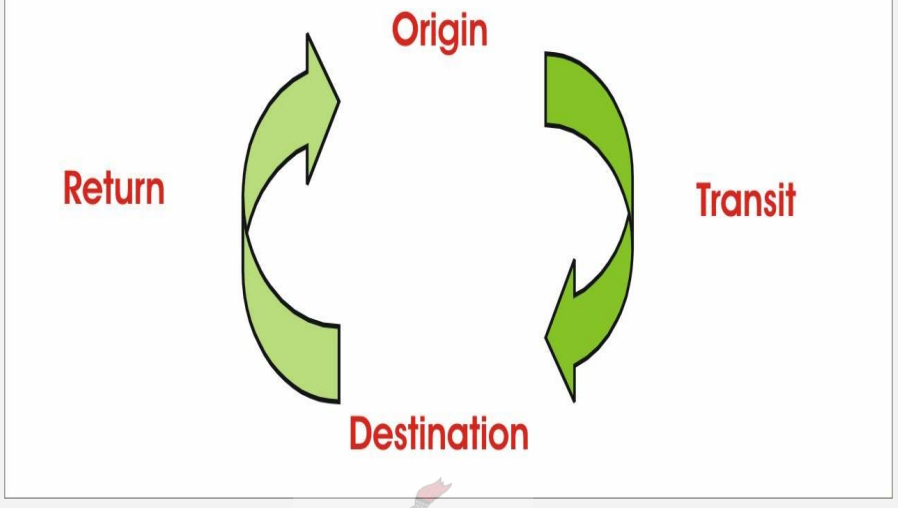
In reviewing the literature, the researcher looked at diverse approaches to the migration and mobile populations and also undertook an in-depth review of existing literature specifically on domestic workers as women and migrants and their vulnerability to HIV/AIDS. It is equally important to note that there is limited published literature on the impact of HIV/AIDS on domestic workers in Namibia.

2.2 Migration and HIV/AIDS

The UNAIDS (2004) explains that the epidemiology of HIV/AIDS is closely linked to the process of migration, migrants and mobile populations which have contributed to the initial spread of the epidemic in the southern African region. In recent years, increasing numbers of people have been on the move from one place to another within their own country or to different countries. The report further shows that there is a strong link between HIV and migration. Even though most people believe that migrants or mobile populations bring AIDS with them, the truth is that most of them move from low prevalence regions to high prevalence regions in search of work thereby increasing their risk of being infected with the virus. Therefore, considering the conditions facing migrant workers, HIV prevention efforts need to be tailored to suit the needs of these different groups. Mobile populations are vulnerable to HIV/AIDS for a number of reasons, which in turn complicate the prevention and mitigation strategies (UNAIDS, 2004).

Migrants and mobile populations are defined by UNAIDS (2004) as people who move voluntarily for professional and economic reasons, and those who are forced to move as a result of war, human rights abuses, ethnic tension, violence, famine and persecution. The International Office for Migration [IOM] (2002) explains that there is enough evidence to associate human mobility with the HIV epidemic and the association is related to the conditions and structure of the migration process than to the actual dissemination of the virus along corridors of migration. From the public health point of view, the key link

between human mobility and HIV is not the origin of the migrant but the conditions of life during transit and site of destination and these are explained in Figure 3 below.



Four Stages of Migration

1. **Origin:** Where migrants come from, why they leave, and the relationships they maintain while away.
2. **Transit:** The places migrants pass through, how they travel and their behaviour while they travel.
3. **Destination:** Where migrants go, the attitudes they encounter and their new living and working conditions.
4. **Return:** The communities and families to which migrants return, and the changes that have occurred and the conditions they find upon their return.

Figure 3. The Process Framework of HIV/AIDS based on four stages of migration (IOM, n.d.)

The IOM (2002) explains that most often migrants are vulnerable to HIV infection at their destination - for example, men who work far from home, live in single-sex hostels, have access to sex workers and little recreational options, as is the case for the majority of mine workers, construction workers, farm workers and military personnel. Furthermore, for others, the greatest risk occurs in transit, such as female informal traders or farm workers who may trade sex for food, shelter or transportation (IOM, 2002). Moreover, for places of origin, spouses of migrants have shown to be at increased risk of infection as they might engage in transactional sex to supplement their income, or become infected by their returning migrant partners. IOM (2002) explains that female migrants are also particularly vulnerable due to their limited access to education, employment, and income

forcing them to resort to commercial or transactional sex in transit and in places of destination.

Migrants are mobile, often work, and live in isolated work environments and in most cases lack legal status. They may fall through the crack of government's and employers' responsibilities in countries of origin, transit, destination and return as depicted in Figure 3, and this is where the IOM comes in to ensure that they are protected (IOM, 2002). The IOM works to prevent and counter the misinformation, misunderstanding and stigmatization that continues to plague the perceived relationship between migration and the initiation and propagation of HIV/AIDS (IOM, 2002). The IOM's response addresses the migrants throughout all stages of their journey - before they leave, as they travel, in communities and countries where they stay and after they return home (IOM, 2002).

The IOM signed a Cooperation framework with UNAIDS in September 1999, which is aimed at ensuring that the needs of migrant and mobile populations are fully integrated into national and regional AIDS strategies. In addition, it ensures that mobile populations and migrants have access to adequate HIV/AIDS prevention as well as support (IOM, n.d). This framework is designed to effectively respond to the spread of HIV and reducing the risk and vulnerability of migrant and mobile populations (IOM, n.d.).

Southern Africa has a long history of cross-border migration, especially for employment purposes for both organised labour migration such as mine workers and informal labour migration, for example commercial farm workers, domestic workers and traders (IOM, n.d). Namibia has also experienced such an influx of people from other countries as well as movement inside the country from rural to urban areas in search of work and better living conditions.

According to UNAIDS and IOM (2003), a Desk Review and Bibliography was conducted on HIV/AIDS and Mobile populations in the Southern African Development Community (SADC) region. This revealed that none of the countries surveyed appeared to have direct

HIV/AIDS policies for domestic workers although Botswana, Namibia and South Africa addressed domestic workers in their general employment legislation.

2.3 Women as domestic workers and their vulnerability to HIV/AIDS

Globally, nearly 20 million women and girls are living with HIV and infection rates among women are rising in every region worldwide (UNAIDS, 2005). According to UNAIDS (2001) women comprise some 47% of migrants and dominate migration in some regions. For example, more than 60 %t of migrants from Sri Lanka are now women, employed primarily in domestic service.

There is enough evidence that mobile populations especially women, may be more vulnerable to HIV/AIDS than populations that do not move, as they may be subject to exploitation, discrimination, and harassment and have little or no legal representation when confronted with difficulties. IOM and Care report (2003) explain that these populations may acquire HIV while on the move and take the infection back with them when they return to their homes and in most cases not knowing they have the virus.

UNAIDS and IOM (2003) states that domestic workers who live on their employer's property can also be subject to sexual harassment and this increases their vulnerability to HIV/AIDS. They do not have the power to say "no" to sexual harassment due to the lack of rights, freedom as well as bribes of being given an increment if they agree to some form of sexual relationships with their employer. Domestic workers consist of mostly young women with little formal education who earn little income and in most cases end up being involved in transactional sex to supplement their income.

UNAIDS (quoted in Heywood, 2004) estimates that in sub-Saharan Africa, women constitute 58 % of people living with HIV/AIDS – a higher proportion than in any other part of the world and in southern Africa, where HIV infections are highest; no group has been as badly affected as women and girls. Women as domestic workers are among the vulnerable mobile population, it is therefore important that the prevention paradigm be broadened to address the underlying factors such as violence, a lack of education and

economic opportunity and inadequate legal protections that impede women's access to, and utilization of, essential AIDS services.

The Botswana Guardian (2006) mentions that the 2005 HIV sentinel survey conducted in Botswana among pregnant women revealed that by type of occupation, domestic workers have the highest infection rate in the country. The reasons given by the Assistant Research Officer at the National AIDS Coordinating Agency (NACA) were that they were not well informed about HIV/AIDS, and that they have no say or control in their sexual relationships and some of the women were forced by their employers to have unprotected sex with them.

Heywood (2004) indicates that the "high vulnerability to HIV and high rates of infection amongst women and girls is an entrenched part of the epidemiology of AIDS in Africa"(page 69). Gender inequalities in terms of social and economic status and access to prevention and care services increase women's vulnerability to HIV. Sexual violence may also increase women's risk, as they are biologically more susceptible to HIV infection than men. Kates and Wilson-Leggoe (2004) maintain that the epidemic has multiple effects on women including added responsibilities of caring for sick families, loss of property if they become widowed and/or infected and even violence when their HIV status is disclosed.

Msimang and Ekambaram (quoted in Heywood, 2004) question why, despite our knowledge of women's vulnerability, little seems to be done to overcome the social and political determinants of HIV infection in women. They further, link their explanation to the inability of women's movements to contest gender inequality in the private spaces of life and argue that HIV shows the need for a movement of poor, unemployed and peasant women to challenge power relations. In addition to physical violence, Msimang and Ekambaram (quoted in Heywood, 2004) explain that the vulnerability of women to HIV infection is increased by the fear of violence and emotional abuse, worrying about their partner's response often makes it very difficult for women to take measures to protect themselves from HIV infection.

It has been explained that being mobile in itself is not a risk factor for HIV/AIDS, but rather the situations encountered and behaviours possibly engaged in during mobility or migration that increase vulnerability and risk regarding HIV/AIDS (UNAIDS, 2001). Some of the findings in the UNAIDS and IOM report (2003) show that many migrating women move to urban areas in order to achieve economic and social independence. Therefore, due to lack of education many of them are restricted to informal trading sector and domestic work. IOM and Care's (2003) study of two townships in South Africa shows that domestic workers cited health problems, like HIV/AIDS and TB, as being prevalent in their community.

2.4 Domestic work in Namibia

The LAC (1996) report explains that domestic work has been undervalued over the years and it was grounded in the inequalities of racially-based labour practices. The report further says that after Namibia gained its independence in 1990, several important developments took place, which would affect the future of domestic work in the country. The first was the advent of the Namibian Constitution which outlaws race and sex discrimination and protects fundamental worker rights including the right to form trade unions and the right to strike. The report further states that the protection of workers in the Constitution were made more concrete by the new Labour Act which was enacted in 1992, which was a product of tripartite consultations between government, employers and employees. This Act placed domestic workers on an equal footing with other workers for the first time.

Gender research conducted by LAC (1996) collected quantitative information on domestic workers from three urban regions in the country. It revealed that there are about 22,000 to 24,000 domestic workers in Namibia 43 % of whom live in rural areas and 57% in urban areas. The results also showed that about 85% of domestic workers are women and about 10% of all employed women work as domestic workers. The survey showed that 1 out of every 20 Namibian women over the age of 15 is a domestic worker. The

study further shows that domestic workers' knowledge of the Labour Act was very limited because only 23% has heard of the Act and 12% had an awareness of its contents.

2.4.1 Union established for domestic work

The Labour Resource and Research Institute [LARRI] (1999), explains that the Namibia Domestic and Allied Workers Union (NDAWU) was officially established in 1990. The members are domestic workers, cleaners, and employees of businesses such as dry cleaners, hairdressing salons and private kindergartens. It further says that most NDAWU members are employed on an individual and informal basis in private homes. At present, the membership is very difficult to control as the computerized system is not yet fully functional. Consequently, it is also very difficult to keep track of members that have been dismissed or have changed jobs due to the nature of employment.

In the Namibian case, informing the workers of their rights again played an important role in unionisation. Only a few years after its establishment, NDAWU succeeded in organising as much as one-third of the domestic workers throughout the country. However, it could not overcome financial difficulties, as its members earn very little and cannot pay their dues regularly (LARRI, 1999).

2.4.2 Legal protection of domestic workers not enough

Even though it is noted that domestic workers are vulnerable to HIV/AIDS in Namibia, there seems to be no direct HIV/AIDS programmes on domestic workers even though this group have been addressed in the general employment legislation. In Namibia, although laws have been passed to protect every employee, enforcement in the domestic workers sector is still very weak. LAC (1996) explains that a few domestic workers have brought cases to the District Labour Courts but due to the isolated nature of their working environment, there is usually no witness to support their cases, therefore making it difficult for them to make successfully claims. There has been some training conducted for this sector, but not in the field of HIV/AIDS.

The Namibian (July 2004), a local newspaper reported that the Secretary-General of the Namibian Farm Workers Union (NAFWU) had explained that NDAWU‘s activities have been moved to the offices of the NAFWU. The report further says that in 1999, the Commission of Inquiry into Labour-Related Matters Affecting Farm and Domestic Workers issued several recommendations aimed at transforming the working conditions of both farm and domestic workers. NDAWU mentioned that the exploitation of domestic workers continues unabated in the country with employers having cut the income of their employees through reduced working days. Moreover, the report says that the fate of more than 25,000 domestic workers throughout Namibia has remained unclear and NAFWU’s Secretary-General could only call on the Government to introduce the minimum wage for domestic workers.

Lourence (personal communication 17 June 2006) maintains that domestic workers unlike other workers in factories, offices, and mines, are not protected by any of the Acts of Parliament that offer a form of protection to these workers, these acts control matters such as wages, hours of work and other working conditions. She further says that the most common form of recruitment in domestic work is by word of mouth and the terms and conditions of employment are rarely recorded, thus leaving the domestic workers unprotected in cases of labour disputes. Lourence suggests that laws and policies be developed that would protect women against physical and sexual violence.

2.4.3 Recommendations by UN, WHO and UNAIDS on HIV/AIDS pandemic’s implications on gender

At the Expert Group meeting on HIV/AIDS pandemic and its gender implications held in Windhoek from 13-17 November 2000, the UN, WHO and UNAIDS recommended the following:

- Laws should be enacted, implemented and enforced that grant women equal rights to inheritance and ownership of property and land to improve their economic status for them to be able to deal with HIV/AIDS and enhance development.

- Government should ensure provision of accurate and culturally sensitive prevention education, service and technologies (including male and female condoms) within the gender sensitive framework with particular emphasis on adolescents and young adults. This work should prove to promote gender equality in relationships and provide information and resources to promote the practice of safer sex and human rights. Government and private sector must ensure that all forms of media promote non-discriminatory gender sensitive images and messages of women and men.
- Governments, international organisations and civil society should work together with religious and traditional leaders to identify cultural and religious practices that influence gender relations and to eliminate practices that increase the vulnerability of women, young girls and children to HIV/AIDS.
- Government and civil society should implement programmes that work with women and men to promote gender equality in relationships and norms supportive of non-violent ways of resolving inter-personal conflicts.

CHAPTER 3

Research Methodology

3.1 Introduction

In accordance with Brink's (2006) recommendations, the purpose of this chapter is to report how the investigation is done. It gives a clear picture of what the researcher did to answer the research question. It considers the population, approach and technique used, as well as the data collection method.

3.2 Selecting a design

The research design was chosen in keeping with Mouton's (2004) guidelines that the design should ensure that acceptable answers are provided to the research question. In the present study the research design is understood to be an outline, plan or strategy specifying the procedure to be used in seeking an answer to the research question and furthermore, a specification on how to collect and analyse data. One of the purposes of the research design is to control unwanted variation (Christensen, 2004).

The design used for the present study is a qualitative approach, which is 'a case study design'. A qualitative approach was chosen because according to LoBiondo-Wood and Haber (1998) it embraces the wholeness of human, focusing on human experiences in naturalistic settings. A case study design involves an extensive exploration of a single unit of study, such as a person, group, community or institution or a very small number of subjects who are examined intensively (Burns & Grove, 2001). The researcher employed this method to compile a picture of how domestic workers feel and think about HIV/AIDS.

The principle data collection methods included interviews and a literature review. A descriptive study in this design is used to collect data from the subjects and in turn will be used to assess current conditions or make more meaningful plans for improving the working conditions of domestic workers. Structured interviews were done and questions used were prepared in advance and the respondents were asked these questions in face-to-

face interview. The interviews were conducted in pursuit of a genuine response, hence open-ended questions were used as they offer the person being interviewed the opportunity to respond in their own words and to express their own personal perspectives.

3.3 Population

The overall population for the study was all domestic workers in Windhoek but due to constraints such as time and funds to conduct the research, the researcher only concentrated on a section of one suburb in Windhoek. All domestic workers in a specific section of Hochland Park, irrespective of their age, race and educational level formed part of this study.

3.3.1 Setting

The study was conducted in domestic workers' workplaces, which are houses within Hochland Park in Windhoek, and also in their own homes. A section of Hochland Park was identified where the study was conducted. Hochland Park is about 2km from the city centre.

3.3.2 Permission

Permission to conduct the study at the workplace of the participants and in their own homes was obtained from both their employers and the domestic workers themselves. The purpose of the study was explained verbally to the respondents and their employers where possible. Participation was voluntary.

Respondents were assured that their names would not be revealed in the research reports. The transcripts and interpretation would be shared with participants and the report would be made available to both the employers and the respondents if need be.

3.4 Ethical considerations

The respondents were given sufficient information on which to base their decision and give their consent to participate in the study freely. They were given the right to know what would happen during the research and participated voluntarily in the research. This is supported by Polit and Hungler (1999), support this and argue that ethical concerns are especially prominent in the field of nursing and the collection of research information.

The respondents were also informed that the information would be confidential and only people who are involved in the research would have access to it. The report findings would be published in such a way that the participants would remain anonymous. The respondents were informed that they might choose to withdraw from the study during the course of the survey. The reason for leaving would be recorded on the questionnaire. Respondents who would not comply during the research would also be asked to withdraw.

3.5 Data collection

In pursuit of answers to the investigation, the researcher adopted several complimentary instruments that were likely to provide adequate answers to the research question. According to Fisher and Foreit (2002), a combination of quantitative and qualitative data collection methods is used to obtain the most accurate and realistic picture of a program situation. In-depth interviews with domestic workers in the suburb were used, with the purpose of understanding their knowledge, awareness and attitudes towards HIV/AIDS.

CHAPTER 4

Findings and Discussions

4.1 Introduction

The findings, processing and interpretation of data in figures, tables and other forms of display is presented. The researcher ensured that the data was appropriately analyzed and indicates the results found during the study. For any weaknesses that have been identified, recommendations are made to ensure that they are addressed in future studies.

4.2 Data analysis

After the data was collected, a data coder was asked to go through all the questionnaires to make sure that they were filled out correctly and to make sure that each question had an answer or a missing value ticked off. Once the process was finished, the information on the questionnaires was analysed and entered into a computer. Mouton (2004) explains that data analysis involves breaking up the data into manageable themes, patterns, trends and relationships. Descriptive statistics were used to analyse data because according to Burns and Grove (2001) it allows the researcher to organise data in ways that give meaning and facilitate insight and examines a phenomenon from a variety of directions to understand clearly what is being studied.

Polit and Hungler (1999) explain that statistical procedures enable the researcher to reduce, summarise organise, evaluate, interpret and communicate numeric information. Therefore, proper statistical procedures were used in this study to ensure that the research question is answered. Statistics were calculated in different kinds of percentages and presented in the form of charts and tables to get a message across to the reader and give a picture of what the data look like.

4.3 Results

The study examined domestic workers knowledge, attitude and practices regarding HIV/AIDS in one suburb area in Windhoek. Given the importance of domestic work for women in Namibia, and the potential for their working conditions, this might affect their

access to health care and increasing their vulnerability to HIV/AIDS. The study explored questions around knowledge, attitude and practices or behaviours on HIV/AIDS. The study interviewed 121 female domestic workers in the Hochland suburb in Windhoek. The following findings were made:

4.3.1 Background information

The majority of the respondents (48%) interviewed during the study were above 34 years old. The respondents' ages (N=121) ranged from: 18-21 years, (7%), 22-25 years (9%) and 26-29 years (14%), 30-33 years (21%) as depicted in Table 2 below.

Table 2
Age Category of Respondents (N=121)

Ages	Frequency	Percent
18-21 years	9	7%
22-25 years	11	9%
26-29 years	17	14%
30-33 years	26	21%
34-above years	58	48%
Total	121	100%

The study also looked at the respondents' relationship status and it showed that the majority (77%) of them were single as shown in Table 3. This supports the findings of the survey done by the LAC (1996) which found that domestic workers are far less likely to be married that the rest of the population. Of the respondents, 19% of the women were married while only 2% were widowed and 2% separated or divorced respectively.

Table 3
Marital status of Respondents (N=121)

Marital status	Frequency	Percent
Married	23	19%
Single	93	77%
Widowed	3	2%
Separated/divorced	2	2%
Consensual union/cohabitating	0	0%
Total	121	100%

For those who were single, widowed or divorced about 57% of them indicated that they had boyfriends and 25% mentioned that they did not have boyfriends at all. The study also found out that the majority of the respondents had formal schooling. Out of the total number interviewed, 71% stated that they had passed secondary school and 19% had completed primary school. Only 4% said that they had some form of tertiary education and about 6% did not have any education at all.

When asked about the number of children that they have, 21% said that they did not have any children, another 21% had one child and 19% indicated that they had two children. Another group of 19% had three children and 21% mentioned that they have more than three children. See Figure 3 below.

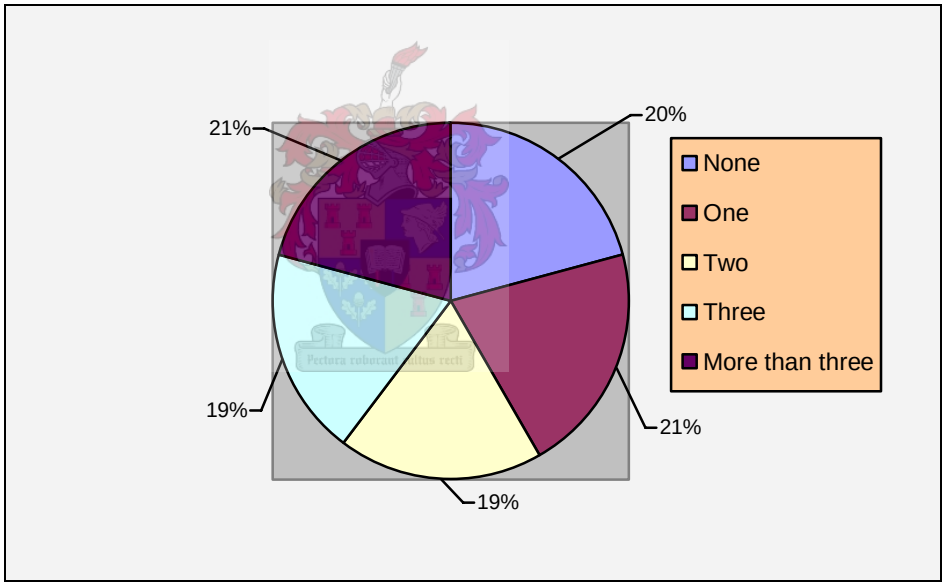


Figure 4. Number of children

The study also looked at the number of months and years that these domestic workers have been working for their current employers. Of the total number of respondents asked (N=121), 31% mentioned that they had worked between 3-5 years, 22% had worked for more than five years and 21% had worked for less than 6 months. 15% of the respondents had worked between one and two years whilst 12% had been working between six months and a year.

4.3.2 Level of knowledge about HIV/AIDS

Questions were included in the questionnaire in an attempt to establish the respondents' knowledge of HIV/AIDS. Seven of the questions in this section required respondents to indicate more that one correct answer. Respondents (N=121) were asked to indicate whether they had heard of HIV/AIDS. A large majority (97%) stated that they had heard of it and only 3% replied no to this question.

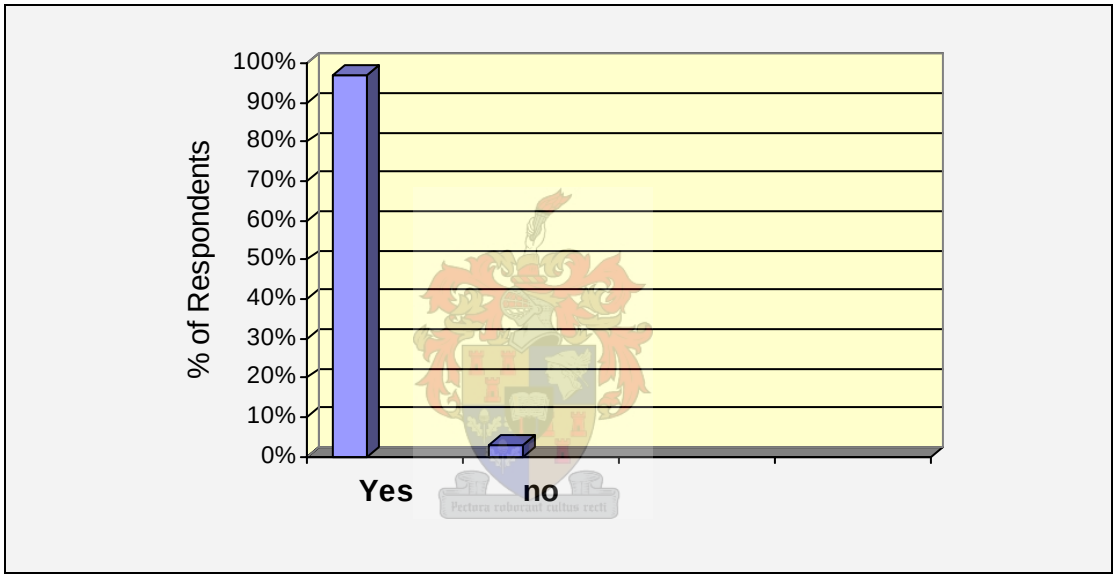


Figure 5. Heard about HIV/AIDS

A question that followed was for the respondents to indicate where they had heard about HIV/AIDS. Some of the respondents said that they heard about the epidemic through radio and television (82%), relatives and friends (56%) and here one respondent said, *"my boyfriend died of it three years after we broke up"*.

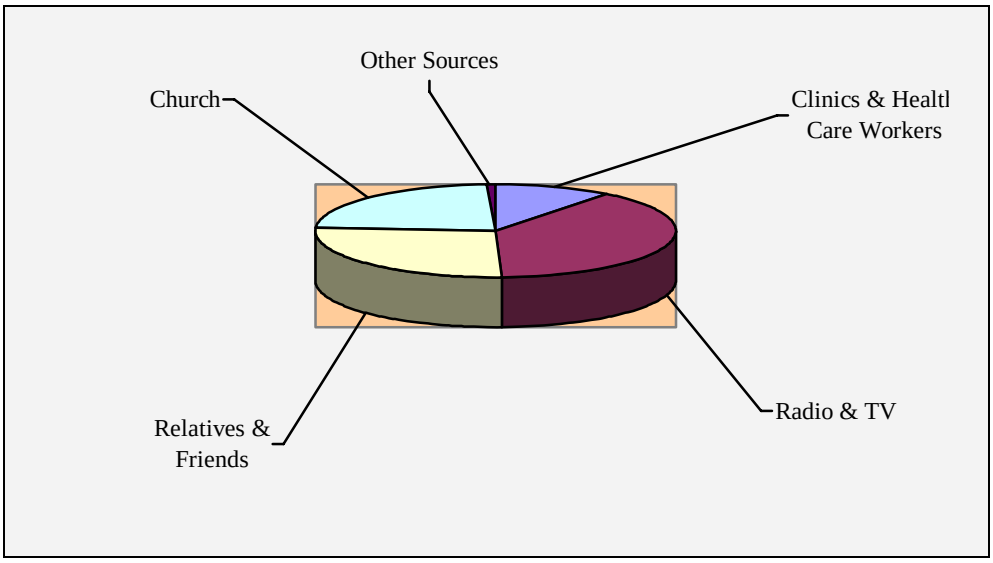


Figure 6. Respondents' source of information about HIV/AIDS

Some heard about it from their churches (48%) but only 22% mentioned that they heard it from the clinics or health care workers. And 2% of the respondents said that they heard about the epidemic from other sources like books and one said *"I saw it with my own eyes"*. The researcher wanted to know whether the respondents had knowledge on the question of whether every person with HIV has AIDS. In response to this question, the percentage was almost similar in every choice given as indicated in Figure 7 below.

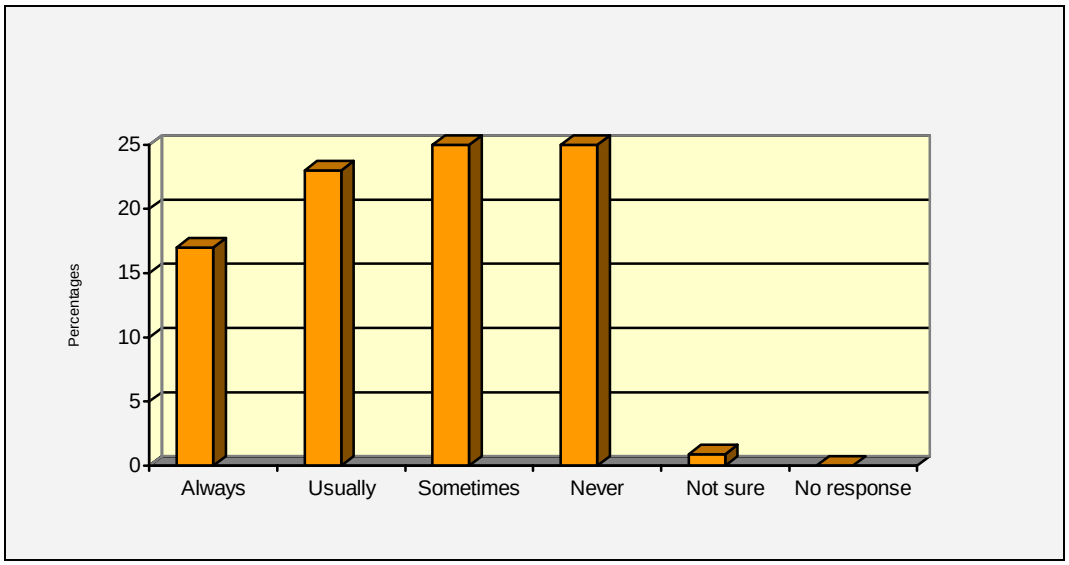


Figure 7. Responses on whether every person with HIV has AIDS.

Of the respondents, 25% indicated that sometimes a person with HIV has AIDS and another 25% said that every person with HIV never has AIDS. 23% of the respondents said that usually a person with HIV has AIDS and 17% mentioned that every person with HIV has AIDS while 9% stated that they were not sure about the answers to this question. Given the responses to this question, it is clear that a lot of education and campaigns still need to be done to inform the community about HIV/AIDS. Some people in our communities still do not know that a person with HIV does not necessarily have AIDS. There is still no knowledge about the distinction between HIV and AIDS.

One of the questions asked was for the respondents (N=121) to indicate who gets infected with HIV/AIDS. The majority (66%) mentioned that anybody can get infected with HIV and 25% of the respondents mentioned that people with multiple partners gets infected with HIV/AIDS, only a small percentage (5%) mentioned university students and 7% mentioned truck drivers while 2% mentioned others such as alcoholics. One would think that people still think that HIV/AIDS only affects a certain group of individuals. This myth should be cleared and people should be informed that HIV/AIDS affects everyone irrespective of their culture, race, age, marital status, etc.

Of all the respondents, about 92% indicated that HIV/AIDS is transmitted via sexual intercourse. Thirty three (27%) mentioned that it could be transmitted during birth from mother to child. This was very interesting because the majority of women did not indicate this answer. This is critical since all people interviewed were women and still in the childbearing age, one would expect to get this answer from the majority of them. It is therefore, evident that most women still do not know that pregnant women can transmit the infection to the unborn baby or during delivery despite the Prevention of Mother to Child Transmission (PMTCT) Programme being in the country for more than three years now. Two percent of the respondents mentioned that casual contact with infected person could lead to HIV/AIDS infection. And the other 2% mentioned that HIV/AIDS could be transmitted through other means such as having sex with someone infected without using protection and through blood.

A question on whether a person can get HIV/AIDS by working or sitting next to a person with HIV/AIDS, was answered correctly by 72% of the respondents who indicated that they strongly disagree. About 17% said that they disagree and 5% stated that they agree and 0.8% strongly agree while 4% said that they neither agree nor disagree.

An attempt was also made to try and find out whether the respondents knew the signs and symptoms of HIV/AIDS. The responses here were as follow: TB (60%), loss of weight (59%), diarrhoea (45%), persistent cough (41%), and other signs and symptoms like sores on lips (2%).

Respondents were also asked to mention how one can prevent the transmission of HIV/AIDS from one person to the other. Some indicated that the use of condoms (68%) was one way of protecting oneself from getting infected and one of the respondents said: *"In these days it is the only hope"*. Others indicated sticking to one faithful partner (31%) and abstaining from sexual intercourse was mentioned by (13%) of the respondents.

One of the questions was on whether a healthy person can have HIV and the majority (92%) of the respondents indicted a "yes" answer to this question and 6% mentioned that a healthy person cannot have HIV and only 2% said that they were not sure about the answer to the question.

Most of the respondents (64%) know that the only way a person can know about his/her HIV status is to go for a test and about 2% mentioned that a person can go to the health facility/hospital and another 1.6% indicated that one can go to the counselling and testing facility. About 91% of the respondents stated that one can go to the hospital or clinic to be tested, (6%) mentioned the doctors, while (2%) said that a person can go the pharmacy for a test. And only 1% of respondents mentioned that one could go to New Start Centres for a HIV test and no respondent mentioned church as depicted in Figure 8.

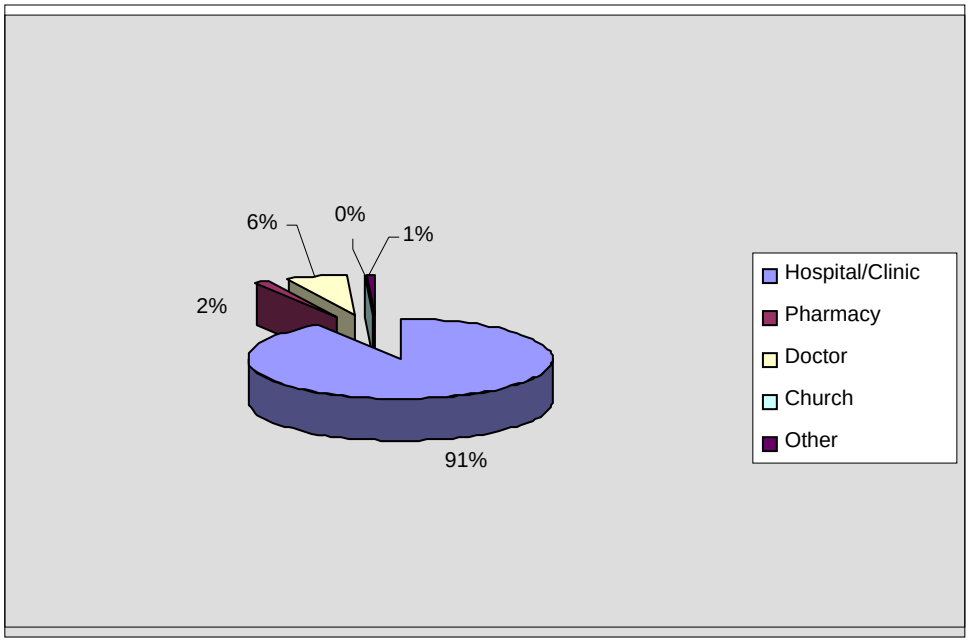


Figure 8. Where to go for a HIV test

4.3.3 Attitudes towards HIV/AIDS

Of all the respondents (N=121) who were interviewed, 87% have seen someone with HIV/AIDS and 13% stated that they have not yet seen a person with HIV/AIDS. One of the respondents said that she has seen someone with HIV/AIDS and it was her ex-boyfriend. A question on whether they discuss HIV/AIDS issues with their partners/husbands was also asked and 42% of the respondents said that they always discuss HIV/AIDS issues. Other respondents mentioned that they usually (26%), sometimes (19%), never (12%) and rarely (0.82%) discuss HIV/AIDS issue with their husbands/partners.

Respondents were also asked to indicate how they feel about being tested for HIV/AIDS. 37% said that they feel extremely comfortable and 24% indicated that they are sometimes comfortable. Some of the respondents mentioned that they were not very comfortable (17%) and very comfortable another 17% and only 5% said that they are somewhat comfortable about being tested for HIV/AIDS.

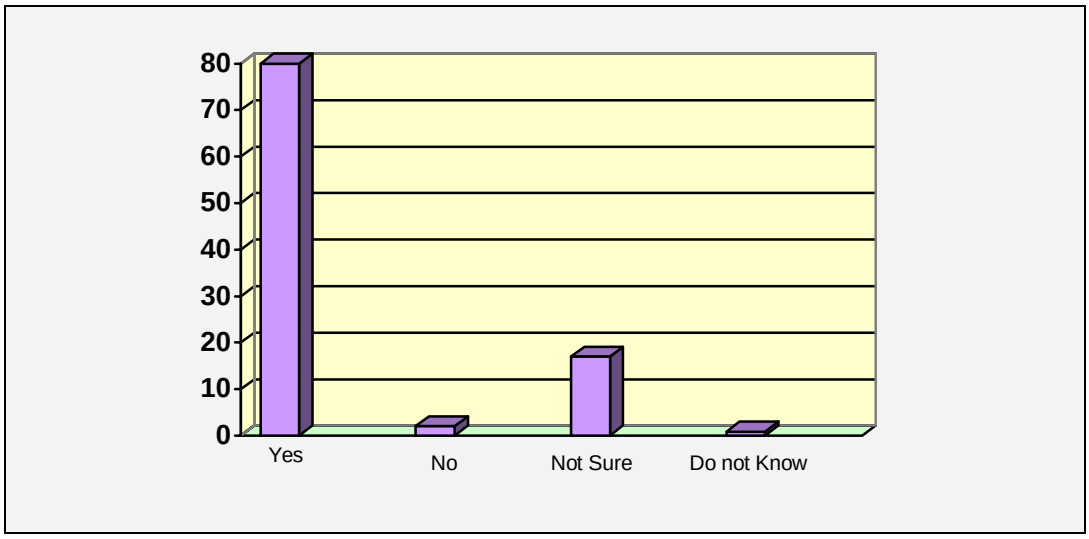


Figure 9. Responses on whether respondents will provide care to a HIV positive person

Another question was asked to see how the respondents' attitudes were towards someone infected with the virus. The response to this question was that 80% would provide care to someone or a relative who is sick with HIV/AIDS. This is supported by a study done by Raijmakers and Pretorius, (2004) where the results indicated that the majority of students felt positive about taking care of someone with HIV/AIDS. This is encouraging as it will have a positive impact on addressing stigma and discrimination attached to those who are infected and affected by HIV and AIDS as most of the respondents (87%) have seen someone with HIV/AIDS before. About 17% in Figure 8 indicated that they were not sure and 2% said that they will not provide care at all and only 0.8% indicated that they did not know.

On a question of whether they have been tested for HIV/AIDS, (74%) of the respondents mentioned that they have been tested and one of them said that *"After I found out about the cause of death of my ex that was in 1995 ever since I got tested"*. Other respondents (26%) said that they have not yet been tested. For those who went for a test they were further asked to indicate whether they would tell their employers/husbands/boyfriends about their HIV status if tested positive. About 70% of the respondents indicated that they would and 13% mentioned that they would not and another 13% said that they were not

sure. Only (2.4%) mentioned that they did not know. For those who would not tell their employer/husbands/boyfriends after testing positive, they were asked to indicate the reason why and a few respondents answered this question. For those who responded to the question, 5% said that they will lose their jobs, 10% fear of stigma and discrimination, 4.1% boyfriend/husband will leave me, 9% do not know and 0.82% mentioned other reasons such as *"I have not slept around and I trust my partner"*.

4.3.4 Practices

In this section, respondents were asked questions on the use of condoms. Since there have been many negative comments about condoms in some parts of the country, the researcher wanted to establish how the respondents felt when using condoms with their partners. The first question here was on how often they use condoms when having sexual intercourse with their husband or boyfriends. About 37% of the respondents as indicated in Figure 10 said that they always used condoms, 31% mentioned that they usually use condoms and 16% indicated that they sometimes use condoms. The other 7% said that they rarely use condoms and about 8.2% indicated that they never use condoms when they have sexual intercourse.

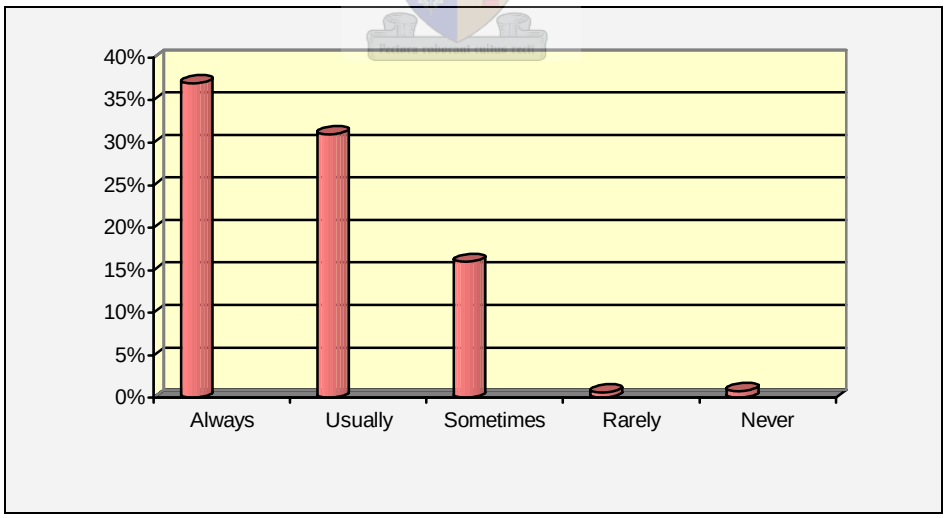


Figure 10. Condom usage when having sexual intercourse

For the respondents who indicated that they use condoms, a further question was asked about why they use a condom during sexual intercourse. Most of the respondents (60%)

mentioned that they used condoms to reduce the possibility for HIV infection. One respondent had a boyfriend who died from HIV/AIDS related illnesses and she said *"I saw how this guy looked that time. I was very young. I am now a mother and want to see my kids grow up"*. And the other 33% stated that they use condoms for family planning purposes. Another 4.1% said that they use condoms because of menstruation and another 4.1% gave other reasons such as they were married, because *"it is just a practice that one has to get used to"* and other one mentioned that *"they trust each other"*. And only one (0.82%) respondent said that she used condoms because she had a sexually transmitted infection (STI).

To those who said that they did not use condoms, a further question was posed as to their reasons. Of the respondents that do not use condoms, 22% mentioned that condoms were not available, 11% said that the partner refused. It is clear here that women feel threatened by their husbands/boyfriend when negotiating for safe sex. They fear their husbands/boyfriends, because they are accused of mistrust. Since the women have no control over their bodies and partners, if their partner does not want to use a condom then she cannot refuse otherwise she will be beaten. The other 11% gave other reasons such as *"married", "too old to use condoms", "no partner", "I trust him because he is the one who gave it to me*", the last reason was that *"the guy I am with now, we are dating for 7 years and we agreed to make children"*. And 4.1% of them responded that they did not like condoms and 2.4% do not have partners currently.

One of the questions in this section was to know whether respondents would have sex without a condom if their partners were HIV positive. The majority (83%) stated that they would not have sex without a condom and 7.4% of them said yes they would, while 5% said that they were not sure and 2.4% did not know and only (0.8%) did not give a response to this question.

The last question that was asked was about how they feel when their partners use condoms and 38% of the respondents mentioned that they feel good, 31% feel excellent, while 23% feel very good. Of the respondents, 3.3% said that they feel bad and another

1.6% indicated that they feel very bad when their partners use condoms. Some remarks that were made by respondents were that: *"I told him about my ex., actually he knows him so we are very open and we are getting married in December 2006. He works for the government as a driver"*. Three (2.4%) of the respondents did not indicate how they felt because they have never used condoms before and some do not have partners.

CHAPTER 5

Summary, Recommendations, Limitations of the study and Conclusions

5.1 Introduction

In this chapter a summary of the investigation, conclusions and recommendations derived from the study are presented. The conclusion focuses on what has been discovered during the study and where future research should be directed.

5.2 Summary

The interpretation of results indicates a significant knowledge about HIV/AIDS amongst respondents. This conclusion is supported by the majority of the respondents (97%) who indicated that they have heard about HIV/AIDS. It is also clear that media in the form of radios and televisions is playing a role in educating people about HIV/AIDS in Namibia as indicated by 82% of the respondents. Given the responses from the study on how they heard about HIV/AIDS, there is an indication that health facilities and health care workers are doing little in educating clients about HIV/AIDS when patients visit clinics as only 22% of the respondents indicated health facilities and health care workers as their source of information.

Attitude towards HIV/AIDS is also critical as this can contribute to the discrimination and stigmatization of those infected and affected by the epidemic. On assessing their feelings about being tested 37% indicated that they feel extremely comfortable about being tested. An effort should be made by all sectors to ensure that the right message is sent to the community. All stakeholders need to aggressively promote the existing Voluntary Counselling and Testing (VCT) services in the country. should be done aggressively by all stakeholders. Some people feel that it is not worth going for a test as one only adds to the existing statistics and nothing is given to those who are HIV positive. Facilities that offer VCT services should ensure that a number of different resources are available, for example Rapid Testing (RT), drugs and support services. On the question about their attitude towards those infected the majority (80%) indicated that they would care for someone or a relative who is HIV positive and another 17%

mentioned that they were not sure. Practices and behavioural change is critical if the spread of the HIV virus is to be prevented. Some questions were aimed at assessing knowledge of the nature and severity of HIV/AIDS. On the use of condoms only 37% indicated that they always use condoms and the majority said they sometimes, rarely or never use condoms. The reason for not using condoms was for some refusal by their partners. It is known that condoms, when used properly and consistently, are one of the leading methods of protection against HIV infection. Women should be empowered to make decisions in their lives and be able to negotiate for safer sex with their partners.

5.3 Recommendations

The study cannot be generalized to the entire domestic workers in the country, it can serve as a point of reference for future research and policy issues in terms of HIV/AIDS. None of the following recommendations will provide lasting solutions without political commitment, adequate recourse, good governance and democratic participation. Nevertheless, they provide a starting point for more effective future measures to counter the global pandemic. From the researcher's point of view the following things should be done:

(i) Future Research

Since there has been limited research on domestic workers and HIV/AIDS in Namibia, further studies need to be conducted to have a better understanding and general view of the domestic workers knowledge, attitude and practices. The future research could further examine the level of knowledge and rights on HIV/AIDS and employment. Moreover, KAP studies on domestic workers in Namibia and their vulnerability to HIV/AIDS still need to be conducted so that gaps can be identified and interventions planned accordingly.

(ii) Specific prevention strategies

The study recommends that specific prevention strategies be identified that could create the necessary awareness and reinforce behavioural change. It is very important to focus

on the women given their vulnerability to the epidemic, and in particular domestic workers who are low-income earners. Hence, the prevention of HIV/AIDS should be a collective and collaborative effort from domestic workers union and the national government response plan.

It is further recommended that a special purpose intervention plan be developed with the Namibian Domestic and Allied Workers Union. Such an intervention plan must be specifically tailored to respond to the particular needs of domestic workers and their vulnerability to the disease. As such, the intervention will require continuous monitoring and evaluation so that as progress is being made in the implementation of various activities, adjustments may be made to respond to emerging issues.

5.4 Limitations of the study

The limitations in view of the scope of the study were as follow:

(i) The generalisation of results and outcomes of the studies to the broader domestic workers in the country with regards to HIV/AIDS knowledge and practices posed a challenge, as this was small sample of the respondents.

(ii) Since many interviews were conducted in the early morning hours when they were going to work, most of the respondents indicated that they would be late to work and declined to be interviewed. The researcher did not manage to get most of the interviews done in the morning hours, hence interviews were conducted in the afternoon when domestic workers were on their way home. This also was a bit difficult as most of them were in a hurry to get home. But the researcher managed to convince them to spend their few minutes on being interviewed.

(iii) The attitudes of some respondents who refused to be interviewed when they were told that the study was on HIV/AIDS was also a limitation. They felt that it was not important to them at that time, as they were too

old to listen to HIV/AIDS issue but indicated that they could be interviewed in the next study if possible.

5.5 Conclusions

The study concludes that the knowledge levels of domestic workers are relatively high. Sources of such knowledge were mainly radio/television, relatives and friends and churches with a smaller contribution by clinics/health care workers. The study further concludes that there is a positive relationship between knowledge about HIV/AIDS and educational level. However, education by itself does not guarantee behavioural change as findings in the present study indicate that knowledge does not have a strong positive correlation with behavioural change.

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APPENDIX A

QUESTIONNAIRE FORM

Interview Number: ☐

UNIVERSITY OF STELLENBOSCH

Africa Centre for HIV/AIDS Management

MPhil (HIV/AIDS Management)

Research on:

Female Domestic Workers' Knowledge, Attitude and Practices on HIV/AIDS

I appreciate your willingness to be interviewed for this research project.

- Your involvement in this study is voluntary, you are not obliged to divulge information you would prefer to remain private and you may with draw from the study at any time
- The researcher will treat the information as confidential, you will not be identified in any document, including the interview transcripts and the research report by your surname, first name or by any information. You will be referred to in the document under a code name. No one other than the researcher will be informed that you participated in this research
- The research findings will be made available to you, should you request them. Should you have any questions about the research now and in future, you are welcome to contact the researcher.
- Thank you for taking the time to answer questions in this questionnaire.

_____

Alexinah Muadinohamba
Student no: 14434369

Please answer all questions by ticking the appropriate box

Identification of the Respondent Name of the Respondent (optional): _____ Interview Status: 1=Completed 2=Partly completed 3=Refused	Code: ☐
To be Completed by the Researcher / Interviewer Time Interview started: _____ Completed: _____ Signature:_____ Comments:	*Date of Interview* Day: ***day*** ☐ Month: ***month*** ☐ Year: ***year*** ☐

SECTION A: BACKGROUND INFORMATION		
A1	How old are you?	1. 18 - 21 years old 2. 22 - 25 years old 3. 26 - 29 years old 4. 30 - 33 years old 5. 34 - above years old
A2	What is your relationship status? *(Circle one)*	1. Married 2. Single 3. Widowed 4. Separated/divorced 5. Consensual union/cohabitating
A3	If single, widowed, separated or divorced, do you have a boyfriend?	1. Yes 2. No
A4	What is the highest grade you have passed?	1. Primary 2. Secondary 3. Tertiary 4. None 5. No response
A5	How many children do you have?	1. None 2. One 3. Two 4. Three 5. More than three
A6	How long have you worked at this house?	1. Less than 6 months 2. 6 months - 1 year 3. 1 – 2 years 4. 3 – 5 years 5. More than 5 years
SECTION B: LEVEL OF KNOWLEDGE ABOUT HIV/AIDS		
B1	Have you ever heard of HIV/AIDS? *(If no skip to Section C)*	1. Yes 2. No
B2	If yes, how did you first hear about it? *(Circle all that apply)*	1. Radio and TV 2. Relatives and friends 3. Church 4. Clinic/health care workers 5. Others *(please specify)*
B3	Does every person with HIV have AIDS?	1. Always 2. Usually 3. Sometimes 4. Never 5. Not sure
B4	Who gets infected with HIV/AIDS?	1. University students 2. Truck drivers 3. People with multiple partners 4. Anybody 5. Other *(please specify)*
B5	How is HIV/AIDS transmitted*? (Circle all that apply)*	1. Sexual intercourse 2. During pregnancy/birth (from mother to child) 3. Mosquito/insect bite 4. Casual contact with infected person 5. Others *(please specify)*

B6	Can a person get HIV or AIDS by working or sitting next to a person with HIV or AIDS?	1. Strongly disagree 2. Disagree 3. Neither agree or disagree 4. Agree 5. Strongly agree
B7	What are the signs and symptoms of AIDS? *(Circle all that apply)*	1. Loss of weight 2. Persistent cough 3. Diarrhoea 4. TB 5. Others *(please specify)*
B8	What can a person do to prevent the transmission of HIV/AIDS?	1. Stick to one faithful partner 2. Use condoms 3. Abstain from sexual intercourse 4. Avoiding sharing food with an infected person 5. Other *(please specify)*
B9	Can a healthy looking person have HIV?	1. Yes 2. No 3. Not sure 4. Do not know
B10	How can a person find out if he or she has HIV?	1. Go for a HIV test 2. Go to the health facility/hospital 3. Go to the traditional healer 4. Go to the counselling and testing facility 5. Other *(please specify)*
B11	Where can you go for an HIV test?	1. Hospital/clinic 2. Pharmacy 3. Doctor 4. Church 5. Other *(please specify)*
SECTION C: ATTITUDE TOWARDS HIV/AIDS		
C1	Have you seen someone with HIV/AIDS?	1. No 2. Yes
C2	Do you discuss HIV/AIDS issues with your partner/husband?	1. Always 2. Usually 3. Sometimes 4. Never 5. Rarely
C3	How do you feel about being tested for HIV/AIDS?	1. Extremely comfortable 2. Very comfortable 3. Sometimes comfortable 4. Somewhat comfortable 5. Not very comfortable
C4	Would you provide care to someone/relative who is sick with AIDS?	1. Yes 2. No 3. Not sure 4. Do not know 5. No response
C5	Have you been tested for HIV *(if no skip to Section D)?*	1. Yes 2. No
C6	If you tested HIV positive, would you tell your employer/husband/boyfriend?	1. Yes 2. No 3. Not sure 4. Do not know

C7	If no, why not?	1. Lose my job 2. Fear of stigma and discrimination 3. Boyfriend/husband will leave me 4. Do not know 5. Others *(please specify)*
SECTION D: PRACTICES		
D1	How often do you use condoms when you have sexual intercourse?	1. Always 2. Usually 3. Sometimes 4. Rarely 5. Never
D2	If you did, what was the reason?	1. Family planning 2. Menstruation 3. Had a sexually transmitted infection 4. Reduce possibility for HIV infection 5. Other *(please specify)*
D3	If you did not, what was the reason?	1. Not available 2. Partner refused 3. Do not like condoms 4. Do not have a partner currently 5. Other *(please specify)*
D4	If your partner was HIV positive, would you have sex without a condom?	1. Yes 2. No 3. Not sure 4. Do not know
D5	How do you feel when your partner uses a condom?	1. Very bad 2. Bad 3. Good 4. Very good 5. Excellent

Thank you for participating and taking time to answer these questions!!!

APPENDIX B

Ms. Alexinah N. Muadinohamba
P.O. Box 25919, Windhoek, Namibia
Telephone: 061-243268 (h) or 081-124-0330

Participant Consent Form

Research Title
Female Domestic Workers Knowledge, Attitudes and Practices on HIV/AIDS

I appreciate your willingness to be interviewed for this research project. I will contact you to arrange a date and time when the interview will take place.

- Your involvement in this study is voluntary, you are not obliged to divulge information you would prefer to remain private and you may withdraw from the study at any time.

- The researcher will treat the information you provide as confidential. You will not be identified in any document, including the interview transcripts and the research report by your surname, first name or by any other information. You will be referred to in the documents under a code number. No one other than the researcher will be informed that you participated in this research.

- The research findings will be made available to you should you request them. Should you have any queries about the research, now and in future you are welcome to contact the researcher at the above address.

I appreciate your willingness to be involved in this research project.

Thank you.

_____
Alexinah N. Muadinohamba

Participant's Reply

(Please fill in and/send it back to the researcher at the above mentioned address)

I understand the contents of this document and agree to participate in this research.

Name: _____ ***Signature:*** _____

Date: _____ ***Time:*** _____

APPENDIX C

Map of Namibia and its regions (Namibia Millennium Development Goals Report, 2004)

Map of Africa (http://www.cia.gov/publications/factbook/docs/refmap./htm)