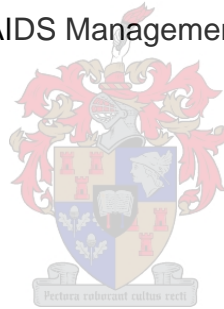


**HIV AND AIDS KNOWLEDGE, ATTITUDES, BEHAVIOUR AND PRACTICES
OF STUDENT TEACHERS IN NAMIBIA**

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Assignment presented in partial fulfillment of the requirements for the degree of
Master of Philosophy (HIV/AIDS Management) at Stellenbosch University



Supervisor: Prof. J.C.D. Augustyn

Date: March 2008

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.

Signature:

Date:

Summary

HIV and AIDS is a major challenge to the Namibian and worldwide population. It continues to be the single major killer disease regardless of the education and knowledge the population has. People's culture, attitude and practices play a major role in turning around the challenge the world faces. Namibia has put extensive education programmes in place to try and control the incidences and prevent further spread of HIV, the study reveals education alone is not enough.

This study was to assess the knowledge, attitudes, behaviour and practices of student teachers in the four Namibian Colleges of Education. The study aimed at determining and understanding the level of the knowledge of these young student teachers who will be the future torch bearers of the education sector, the biggest employer in public sector of Namibia. In the process certain beliefs and practices were evaluated. Data was collected from 100 student teachers from the four student teacher colleges using a structured questionnaire.

The results indicated that although knowledge levels are quite high, this knowledge was mainly from electronic and print media and a very small portion from the health sector which is currently the Ministry tasked with the HIV and AIDS programming? It was also clear that there is a relationship between knowledge about HIV and AIDS and the standard of education of this population. It was clear however, that education and knowledge does not guarantee behaviour change and that a lot still needs to be done and can still be done to reverse this phenomena.

Opsomming

Die doel van hierdie studie is die bepaling van die vlak van kennis, houding en praktyke van studente aan vier opvoedkundiges kolleges in Namibië teenoor MIV en Vigs. 'n Gestruktureerde vraelys is gebruik om data by 100 student-onderwysers te verkry. Die resultate van die studie dui daarop dat kennisvlakke hoog is, maar dat hierdie kennis hoofsaaklik kom van inligting verkry uit die elektroniese- en gedrukte media en nie noodwendig vanaf die MIV/Vigs-programme van die Ministerie van Gesondheid nie.

Die studie kom tot die gevolgtrekking dat hierdie skynbaar hoë kennisvlakke nie tot beduidende gedragsverandering aanleiding gee nie en dat die bestaande MIV en Vigsprogramme verskerp sal moet word voordat wesentlike gedragsverandering hopenlik sal plaasvind.

Disclaimer

The research methodology used in this thesis necessitated reading through publications, some of the materials consisted of writings of other researchers, including the research on Teacher Educators which was undertaken by my employers Academy for Educational Development (AED) Basic Education Support Programme Phase 3 (BES3) at the same time I was undertaking my own research for the purpose of my MPhil. The views and conclusions drawn are those of the researcher and no liability arising thereof is accepted. A lot of background theory was used in this thesis/research since not much has been done regarding Knowledge Attitude Behaviour and Practice (KABP) of Student Teachers in Namibia. Recently emphasis has been placed on qualified and working teachers and teacher educators. If it should be found that in trying to encompass fields of great magnitude covered by the topic, the author erred in some way, no intentional harm was meant.

Acknowledgement

This research paper has by no means been a result of one individual's effort; it is a synergy of many minds, no journey can successfully be completed alone. I therefore wish to extend my most sincere and heartfelt gratitude to a number of people for their inspiration and wisdom:

- First and foremost, I wish to thank the Almighty for giving me health, strength, divine guidance, protection, knowledge, wisdom, patience and perseverance to see this research paper through;
- Professor Augustyn for his direction, input and comprehensive feed back during both the PDM, MPhil studies and finalization of the Research Report;
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- I would like to thank the respondents at all the 4 colleges of education for providing me with the information that contributed to drawing conclusions on the KABP of Student Teachers about HIV and AIDS, resulting in the 100% response rate achieved;
- My friend Manda 'Moses' Saize for taking care of the odd chores while I spend time with my books and on the computer; and
- Finally, my special thanks go to amai (my mother) Susan Kujeke for the most valuable blessing, the blessing of the teaching of God's wisdom, perseverance, and hard work, my sister Candy Patience Netsai Mamvura for her help with input on community knowledge of the epidemic, my children Tendai and Chivimbiso Gava for their cheering, encouragement and support.

I credit all this to the strong community and spiritual influences which surrounded me while growing up in the high density suburb of Highfield, the influences which supported the will to succeed and thereby able to help others succeed.

BACKGROUND

The first case of HIV and AIDS in Namibia was detected in 1986. Numerous attempts have been made by the government to mitigate the impact as well as the spread of the infection, Namibia still ranks as the country with the fourth highest infection rate in sub Saharan Africa. Since 1992 when the first HIV and AIDS sentinel study was conducted, the infection rate has remained alarmingly high. From an initial incidence rate of 4.2% in 1992 that peaked at 22.3% in 2002, the incidence rate dropped in 2004 to 19.7% and rose again to 19.9% in 2006. What this indicates is that not only is the infection generalised in Namibia, but also that not much has been achieved in reducing the incidence rates, despite repeated and ongoing efforts and campaigns in changing behaviour of the citizenry. This has led to the call by the Ministry of Health and Social Welfare (MOHSS) for increased efforts to intensify HIV and AIDS control measures.

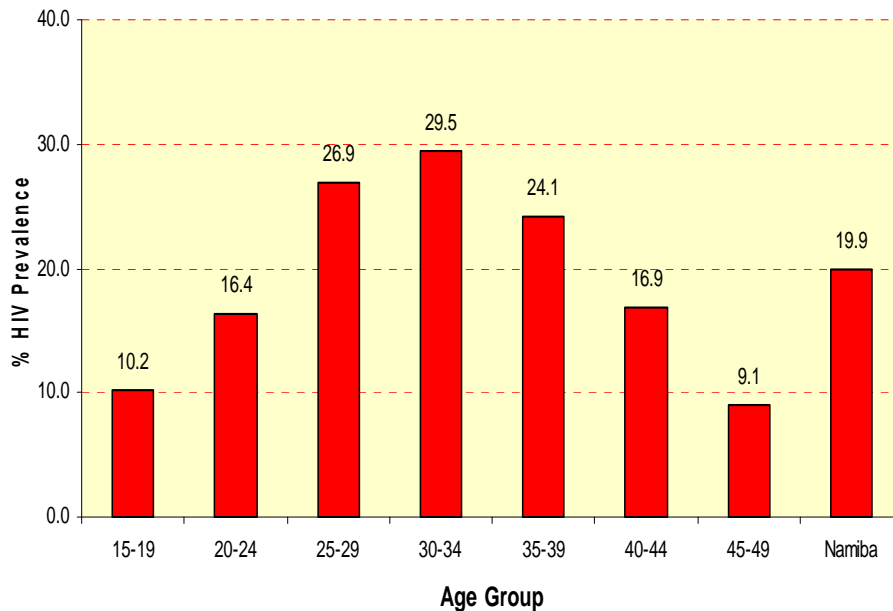
While it is the case that there are now very advanced drugs that can allow infected people to live healthy and fruitful lives, it is the case that in most cases these drugs are expensive. Even when medication is provided by government as in the case of Namibia, the complexity of the drugs entails constant monitoring of the health status of the infected individuals by already stretched health personnel. While there is no documented research that indicates which groups of Namibians are the most infected, anecdotal evidence points to the fact that more and more parents are unable to care for their children. As a result, the numbers of orphans and vulnerable children has increased over the years. Research by the MOHSS as part of the sentinel study does reveal that the incidence rate is highest within the age group of 30-34 years old as well as 35-39 years old age group. In addition, a 2002 survey of the impact of HIV and AIDS in the education sector by ABT associates found that 8.2% of the teaching force is expected to die of HIV and AIDS related illnesses. It is important to remember that to date there is no known cure for HIV and AIDS and as such the best approach still remains change in attitudes and behaviour amongst sexually active members of the community. Currently the Ministry of education has the largest employee base in

Namibia and it makes sense therefore that the Ministry spearheads the efforts to help change attitudes and behaviours as well as improve the HIV and AIDS knowledge amongst its workforce and students. This is seen as one of the most effective ways to reduce infection among HIV sero-negative individuals as well as address secondary prevention among those already positive. Student teachers by implication are role models in the communities they will serve on completion of training. They will not only teach learners on successful completion of training and being deployed, but will also be looked up to by others in the community to set high standards of behaviour. Helping change student attitudes towards risky behaviour and providing them with relevant and correct information about the way the infection is spread and how they can protect themselves, will go a long way in ensuring that they not only practice safe sex but that they also refrain from other risky behaviours that could expose them to infection. Despite various interventions by Ministry of Health and Social Services (MOHSS), the incidence rate has not dropped to any significant level. This could imply that either the interventions were not well planned and properly implemented or the policies that guide the interventions were not consistent and therefore not enough time has been given for one intervention to mature and succeed before it is replaced by another. It is important therefore, that before any program is implemented, an analysis be done to find out what student teachers know and how they behave. This way, a suitable and empirically grounded intervention can be designed that target the gaps identified.

Namibia has a generalised HIV/AIDS epidemic with HIV primarily transmitted through heterosexual transmission. From 1992 estimate of 4.2%, prevalence rose rapidly over the 4 years to 15.4% in 1996. Prevalence continued to rise, although less rapidly, for the following 6 years to a peak of 22.3% in 2002. National prevalence showed a small but not yet significant decline to 19.7% in 2004 and a slight increase to 19.9% according to the latest 2006 Sero-sentinel survey. This indicates that a continued, strengthened, and more decentralised multi-sectoral response is needed to combat HIV/AIDS. Recent data from the

MoHSS indicates that “the maternal mortality rate in Namibia has increased from 271 in 2000 to 449 deaths per 100,000 live births in 2006

Figure 1



Namibia is implementing the Third Medium Plan on HIV/AIDS (MTP III) which was launched in 2004 and thus started during the implementation of the national development plan II. The MTP III spans over the years 2004-2009 and serves as a guide for multi-sectoral responses to the epidemic, as well as a management and coordination tool for all those involved in the fight against the epidemic. Evidently the MTP II and NDP III are closely aligned. As HIV/AIDS needs a multi-sectoral response, evidently there are many partners whose mandate is clearly outlined in the MTP III following their area of expertise. The Ministry of Regional and Local Government and Housing and Rural Development (MRLGHRD) increasingly takes up the coordination for regional support and the role of Office of the Prime Minister (OPM) and National Planning Commission (NPC) is promoting the implementation of work place programmes in the public sector and mainstreaming in all sectors respectively. Namibia Business Coalition on AIDS (NABCOA) has taken on an active role in establishing work place programmes in the private sector. Ministry of Information and Broadcasting (MIB) coordinates the

Take Control Task Force leading mass and targeted HIV prevention campaigns while the Ministry of Education focuses on Information, Education and Communication (IEC) in schools, Namibia Network of AIDS Service Organisation (NANASO) fulfils a crucial role in coordinating the civil society sector involved in HIV/AIDS and the Ministry of Agriculture, Water and Forestry (MAWF) is strengthening its role in the area of food security. This is by far not an extensive list and there are many development partners (Partnership Forum) and civil society organisations such as Red Cross Society, Social Marketing Association (SMA), Catholic AIDS Action (CAA), (National Social Marketing Association) NaSoMa etc. that fulfil an indispensable role in the fight against HIV/AIDS.

According to the Namibia Demographic Health Survey (DHS) 2000, the knowledge about HIV/AIDS amongst women and men is 98% and 99% respectively. Over 80% of both women and men are aware of the use of condoms as a means of avoiding HIV infection (Update with DHS2006). (*Namibia Demographic Health Survey*)

A look at how this disease progresses

Figure 2: shows the disease stages from day 1, the day of infection to 7 – 10 years.

- Stage 1: untested / undetected (“window-period”)
- Stage 2: detected, but asymptomatic
- Stage 3: shows immune-deficient symptomatology, including recurrent, reversible, opportunistic infections
- Stage 4: Full-blown AIDS symptomatology, with irreversible immune-deficient organic diseases ultimately leading to death

Figure 2

**Typical clinical course of HIV infection 0 - 10 years
Pre-Intervention**

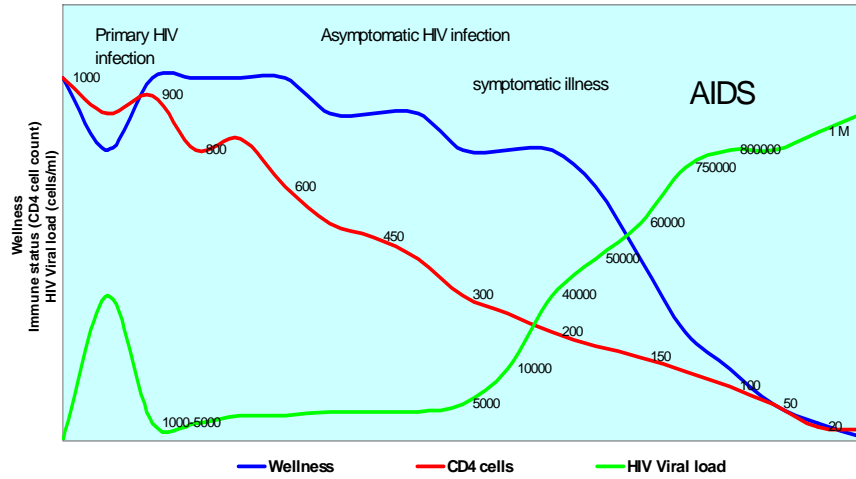
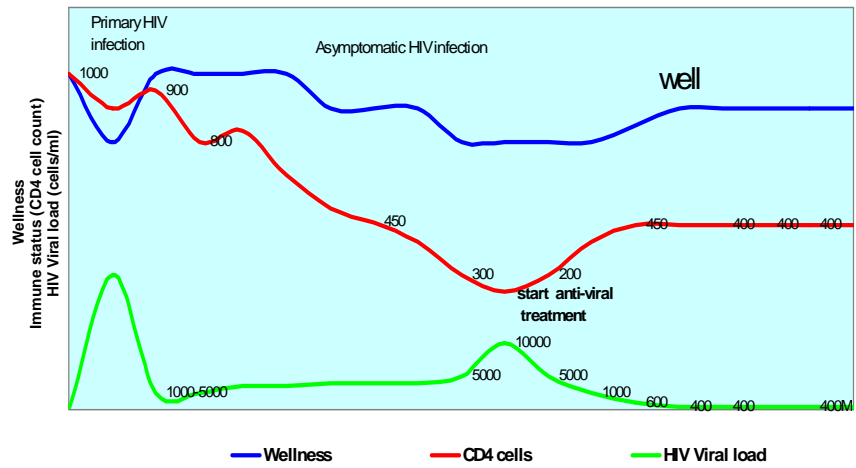


Figure 3

**Typical clinical course of HIV infection 0 - 10 years
Post Intervention**



Lea Roodt – Immunologist and Director of Chervil (Pty) Ltd

Purpose:

The purpose of this study was to gather information from student teachers on HIV related knowledge, attitudes, practices and behaviours, as well as HIV-related health and educational services that are currently being offered to them through their colleges. This information will be used to inform the development of a college intervention aimed at changing the knowledge, attitudes, practices and behaviors of student teachers regarding HIV and AIDS. These changes could result in reduced spread of HIV, and thus, a reduction in new infections.

This study was done parallel to the AEDBES3 KABP study on Teacher Educators.

Methodology

Subjects/sampling

Subjects were obtained from the student colleges in four regions: Caprivi, Kavango, Khomas and Oshana. A presentation was made to student teachers at each of these locations that explained the purpose of the study. It was explained to them that questionnaires were anonymous, as their name would not be linked in any way to the questionnaire. They were informed that upon completion of the questionnaire, it would be placed in an envelope. Those who attended the presentation and agreed to participate were given a self administered questionnaire to be filled out. These were handed to the researcher once respondents completed filling in the form. Out of the 134 forms that were administered all 134 were returned for a response rate of 100%.

Instrument

The survey was in the form of a self-administered questionnaire that included pre-defined response categories for ease of completion. The questionnaire contained 100 items, including demographic information. It took approximately 30 minutes to complete. Instrument design was guided and influenced by various

studies and is based on the Theory of Planned Behavior (TPB). The Theory of Planned Behavior was developed by Azjen and Fishbein, and suggests that behavior is driven by intentions. These intentions are driven by their attitudes and beliefs towards the behaviour, beliefs about how people close to them view the behavior (subjective norms), and how easy it is to perform the behavior (perceived behavioral control). Specific topics covered included:

- Current exposure to HIV and AIDS education and resources
- College HIV policy
- Condom use - knowledge, attitudes, behaviours, subjective norms and perceived behavioral control
- HIV and AIDS - knowledge, attitudes, behaviors, subjective norms, perceived behavioral control, and locus of control
- Practice of other safe sex behaviours

Knowledge, attitude and behaviour questions were either in the form of Yes/no questions or point Likert-type response set. (See Annex A) is the questionnaire.

RESULTS

The following section discusses the relevant results. Annex A contains the questionnaire used, Annex B is the Regional map of Namibia and that of Africa, Annex C contains the survey results and analysis.

Demographics

A total of 134 student teachers from all 4 colleges of the country were given questionnaires to complete. All student teachers returned the survey: 27 % (36) from Kavango, 31% (41) from Caprivi, 16% (21) from Oshana, and 25% (34) from Khomas. 46% (61) of the respondents were male and 54% (73) were female. The age of the respondents range from 17 to 42, but age clustered at about 21 years of age and the mean is 23, the median is 22. The number of

years respondents have been in college ranged from 1 to 3 with a mean of 1.73 and median of 2 years.

It was interesting though to note that although the general perception in Namibia is that the people from Caprivi region do not want anything to do with discussion about HIV and AIDS, this study saw the highest response rate come from the Caprivi Teachers College at 31% (41) of the respondents spread over the above mentioned 4 regions. The teacher educator survey got a response of 6 from the Caprivi College.

The age group of respondents is reflected in frequency table the majority being in the age group of 21 years.

Figure 4 Age group as reported by respondents

Category	Frequency table: Q1.1 Age			
	Count	Cumulative Count	Percent	Cumulative Percent
17	1	1	0.75	0.75
19	14	15	10.45	11.19
20	17	32	12.69	23.88
21	21	53	15.67	39.55
22	14	67	10.45	50.00
23	18	85	13.43	63.43
24	12	97	8.96	72.39
25	7	104	5.22	77.61
26	6	110	4.48	82.09
27	3	113	2.24	84.33
28	1	114	0.75	85.07
29	3	117	2.24	87.31
30	3	120	2.24	89.55
31	1	121	0.75	90.30
32	1	122	0.75	91.04
35	1	123	0.75	91.79
42	1	124	0.75	92.54
Missing	10	134	7.46	100.00

There were more female respondents than male all the difference was not substantial.

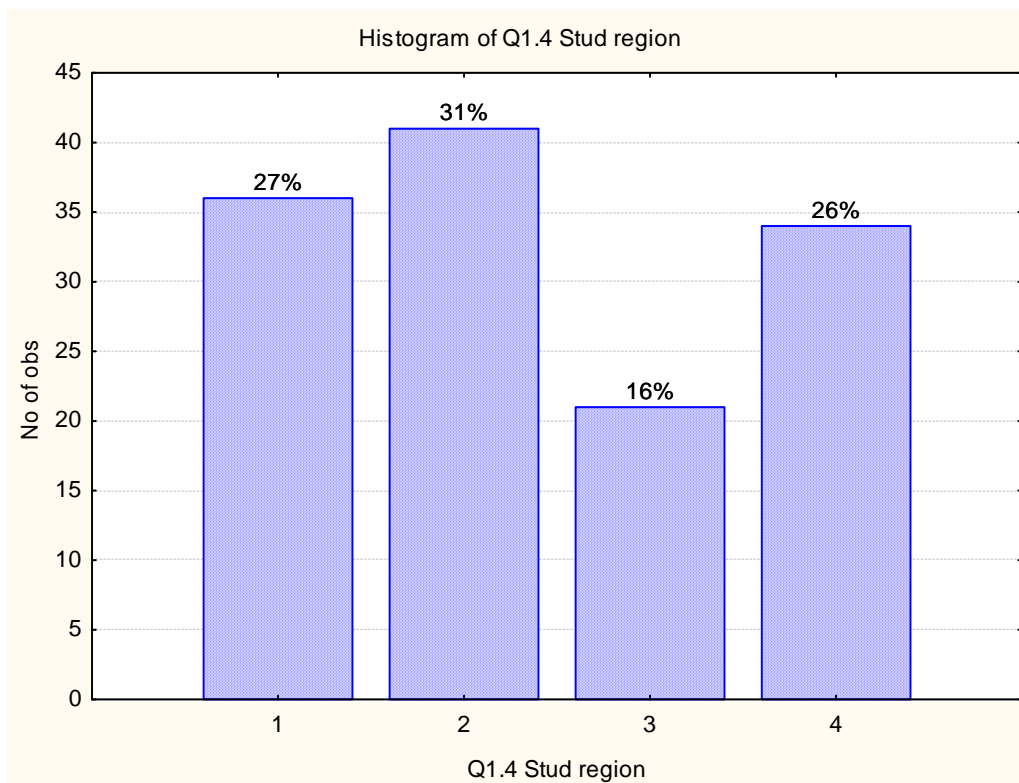
Figure 5 Gender

Frequency table: Q1.2 Gender				
Category	Count	Cumulative Count	Percent	Cumulative Percent
F	73	73	54.48	54.48
M	61	134	45.52	100.00
Missing	0	134	0.00	100.00

Histogram fig 6 shows the study regional respondents as well as frequency fig 7 with Caprivi Region topping the response list on this particular study.

Histogram of Q1.4 Stud region

Figure 6 Regional Responses



Region: 1 – Kavango ; 2 Caprivi; 3 Ohangwena. 4 Khomas**Figure 7 study regions**

Frequency table: Q1.4 Stud region				
Category	Count	Cumulative Count	Percent	Cumulative Percent
1	36	36	26.87	26.87
2	41	77	30.60	57.46
3	21	98	15.67	73.13
4	34	132	25.37	98.51
Missing	2	134	1.49	100.00

Available College Resources

Within the past 12 months, only 51%% (68) of respondents had received formal AIDS education at the college. Almost 56% (76) had received informal AIDS education at college. 67% (91) of respondents had condoms offered to them free or at low cost at the college. Of these people, 38% (51) had male condoms available to them and 16% (22) had both male and female condoms available to them. Fifteen percent (15%) (21) of respondents had themselves or a family member received treatment for an STI either at their college, or a college referral service. During the past 12 months 4% (6) of the respondents received, or a family member or partner received, voluntary HIV counseling and testing (VCT) at the college or by referral. 29 of these individuals (21%) report obtaining this service by referral. During this same time period 20% (27) received, or family members received, drug or alcohol treatment at the college or by referral.

College HIV and AIDS Policy

Results of the survey show that most if not all colleges do not have a formal HIV and AIDS policy, most students - 72 – 53% feel that their college should have an HIV and AIDS policy. While 25% of respondents do not report discriminatory policies at the colleges, these discriminatory policies do exist. If one takes into consideration that 41% of the respondents do not know their college policies, as well as the large number of respondents that did not answer the questions

related to their knowledge of protections against HIV and AIDS discrimination in their college policy, there may be more college discrimination than was reported.

Figure 8 response to College HIV and AIDS Policy

Frequency table: Q3.1a				
Category	Count	Cumulative Count	Percent	Cumulative Percent
1	72	72	53.73	53.73
2	25	97	18.66	72.39
3	10	107	7.46	79.85
Missing	27	134	20.15	100.00

Q3.1a: 1 – Yes; 2 – No; 3 – Don’t know/Not Sure

Most colleges do not have a formal HIV and AIDS policy, whether this is protective or harmful, which could mean more college discrimination that what would be reported figure 9 summaries these findings.

Figure 9 College HIV and AIDS policies as reported by Respondents

Frequency table: Q3.1				
Category	Count	Cumulative Count	Percent	Cumulative Percent
1	11	11	8.21	8.21
2	55	66	41.04	49.25
3	41	107	30.60	79.85
Missing	27	134	20.15	100.00

Q3.1: 1 – Yes; 2-No; 3- Don’t know/Not Sure

Stigma

It was not clear if colleges demonstrate stigma toward HIV+ individuals, because only 4 respondents 3% said yes and 33, 25% said no; 1 did not know and the rest 96, 72% respondents did not respond to the question. This did not give a clear picture of discrimination or non discrimination.

Figure 8 Beliefs related to HIV and AIDS Stigma

Frequency table: Q3.3				
Category	Count	Cumulative Count	Percent	Cumulative Percent
1	4	4	2.99	2.99
2	33	37	24.63	27.61
3	1	38	0.75	28.36
Missing	96	134	71.64	100.00

Q3.3: 1 – Yes; 2 – No; 3 – Don't Know

Knowledge

Respondents have received basic AIDS information from a number of sources. The overwhelming majority (94%) of respondents have received AIDS information from the mass media. In addition, only 0.75% (1) received AIDS information from their college manager/supervisor 2 – Doctors, nurses or public health workers; 3 Traditional healers, 4-co workers; 5 – Manager/supervisor or other professional at college; 6 – labour union representative; 7-church; 8-family member or friends, 9- never heard of or received information on HIV and AIDS; 10-11 Other

Figure 9 HIV & AIDS Knowledge, Attitudes, Behaviour

Frequency table: Q4.1r1				
Category	Count	Cumulative Count	Percent	Cumulative Percent
1	126	126	94.03	94.03
2	2	128	1.49	95.52
5	1	129	0.75	96.27
7	1	130	0.75	97.01
10	3	133	2.24	99.25
Missing	1	134	0.75	100.00

A number of questions regarding specific knowledge about different aspects of AIDS were asked. Questions were asked on a scale of 1 to 5 where 1 equals Strongly Agree and 5 equals Strongly Disagree. Most respondents know the

fundamental AIDS information that tends to be common knowledge such as looking healthy while your HIV positive.

Figure 10 Knowledge about contracting HIV/AIDS Frequency table:

Frequency table: Q4.2				
Category	Count	Cumulative Count	Percent	Cumulative Percent
1	118	118	88.06	88.06
2	14	132	10.45	98.51
3	1	133	0.75	99.25
5	1	134	0.75	100.00
Missing	0	134	0.00	100.00

Can Have HIV and Look Healthy 118, 88%

Reduce the chance of contracting HIV if have only one partner 72, 54%

A person can reduce their chance of getting the AIDS virus by having one uninfected sex partner who has no other partners

A person can reduce their chances of getting the AIDS virus by using a condom every time they have sexual intercourse

A Person can become infected with aid virus by sharing food or utensils with a person who has AIDS

More vulnerable to contracting HIV if have other STD

Using a condom with a non-regular partner helps prevent contracting HIV

Using an oil-based lubricant with condoms is safe circumcised man has a lower risk of contracting HIV than a non-circumcised man

Once again, this indicates the need for further education. While there is some knowledge that is widely known among the respondents, not one survey knowledge item received 100% agreement. This may be due to the fact that most knowledge about HIV/AIDS was gleaned through the media. The media is more likely to impart more basic information.

Respondents were asked on a Likert-type scale, their knowledge about HIV (the virus that causes AIDS) and AIDS and condom use. This scale ranged from 1 (Strongly Agree) to 5 (Strongly Disagree). Table 11 Asked whether – A healthy-looking person can be infected by the virus that causes AIDS and most people were knowledgeable about this fact whether they then insist on knowing the status of a healthy looking partner before getting intimate is another thing.

Figure 11 Can a Health Looking person be infected by HIV

Category	Frequency table: Q4.2			
	Count	Cumulative Count	Percent	Cumulative Percent
1	118	118	88.06	88.06
2	14	132	10.45	98.51
3	1	133	0.75	99.25
5	1	134	0.75	100.00
Missing	0	134	0.00	100.00

Table above answers the question a healthy looking person can be infected by the virus that causes HIV

The majority of respondents would feel at least somewhat feel comfortable studying alongside a fellow student who is HIV+. Almost 68% of respondents strongly agree, or agree that they would have no problem studying with someone with AIDS.

Figure 12 Comfort working alongside an HIV Positive Student

Frequency table: Q4.49				
Category	Count	Cumulative Count	Percent	Cumulative Percent
1	52	52	38.81	38.81
2	39	91	29.10	67.91
3	20	111	14.93	82.84
4	10	121	7.46	90.30
5	6	127	4.48	94.78
6	5	132	3.73	98.51
Missing	2	134	1.49	100.00

Above table answers the question of feeling working alongside a student who has the virus that causes AIDS.

Although there is some secrecy associated with HIV, most respondents (81%) either strongly disagree or disagree that people should be ashamed if they are HIV+ (Mean = 70%). Finally, most people do not blame others for bringing HIV to Namibia. Seventy percent (70%) of respondents either strongly disagree or disagree that people with HIV should be blamed for bringing it to their community.

Figure 13 Is it shameful to have the HIV Virus

Frequency table: Q4.52				
Category	Count	Cumulative Count	Percent	Cumulative Percent
1	5	5	3.73	3.73
2	4	9	2.99	6.72
3	7	16	5.22	11.94
4	16	32	11.94	23.88
5	93	125	69.40	93.28
6	5	130	3.73	97.01
Missing	4	134	2.99	100.00

Table above answers the question people with the virus that causes AIDS should be ashamed of themselves.

Vulnerability

Feelings of vulnerability towards HIV/AIDS, 1-5 point scale.

I am at risk for contracting HIV – most people are afraid of the risk of contracting HIV with 50% strongly agreeing and agreeing to the feelings of vulnerability to contracting HIV.

Figure 14 Feelings of Vulnerability towards HIV & AIDS, 1-5 point scale

Frequency table: Q4.55				
Category	Count	Cumulative Count	Percent	Cumulative Percent
1	35	35	26.12	26.12
2	31	66	23.13	49.25
3	31	97	23.13	72.39
4	19	116	14.18	86.57
5	12	128	8.96	95.52
6	5	133	3.73	99.25
Missing	1	134	0.75	100.00

I am probably HIV+; 26% said neither agree nor disagree, 31% strongly disagree, 13 – 10% strongly agreed or agreed, this could be an indication that these have taken an HIV test. It is not clear whether the 31% has been tested resulting in them strongly disagreeing and disagreeing.

Figure 15 Unsure feelings about HIV

Frequency table: Q4.56				
Category	Count	Cumulative Count	Percent	Cumulative Percent
1	7	7	5.22	5.22
2	6	13	4.48	9.70
3	35	48	26.12	35.82
4	25	73	18.66	54.48
5	41	114	30.60	85.07
6	18	132	13.43	98.51
Missing	2	134	1.49	100.00

Above table responds to the question I probably already am infected with HIV. People like me do not get HIV – From the response in the table below most students 86 – 64% know that they could get infected, it is hoped that this knowledge will assist in behaviour and practice change.

Figure 16 Feelings of Denial

Frequency table: Q4.57				
Category	Count	Cumulative Count	Percent	Cumulative Percent
1	6	6	4.48	4.48
2	3	9	2.24	6.72
3	9	18	6.72	13.43
4	20	38	14.93	28.36
5	86	124	64.18	92.54
6	8	132	5.97	98.51
Missing	2	134	1.49	100.00

Contracting HIV would be the worst thing to happen – 54% of the students feel contracting HIV would be the worst thing to happen to them as indicated by the strongly agree and agree responses. 15% neither agree nor disagree, and 28% disagree or strongly disagree.

Figure 17 Feelings of despair if one were to infected

Frequency table: Q4.58				
Category	Count	Cumulative Count	Percent	Cumulative Percent
1	41	41	30.60	30.60
2	31	72	23.13	53.73
3	20	92	14.93	68.66
4	19	111	14.18	82.84
5	18	129	13.43	96.27
6	3	132	2.24	98.51
Missing	2	134	1.49	100.00

Figure 18 Knowledge of condom collection centres

Frequency table: Q4.59				
Category	Count	Cumulative Count	Percent	Cumulative Percent
1	127	127	94.78	94.78
2	1	128	0.75	95.52
3	1	129	0.75	96.27
Missing	5	134	3.73	100.00

Above table explains that 95% of the students knew of a place where condoms could be found.

Unlike the previous knowledge questions that were asked on a 5 point Likert-type scale, questions pertaining to knowledge about mother-to child transmission were asked on a yes/no scale. As frequency tables below shows:

Figure 19 Knowledge about PMTCT

Frequency table: Q4.74Test				
Category	Count	Cumulative Count	Percent	Cumulative Percent
1	94	94	70.15	70.15
2	1	95	0.75	70.90
Missing	39	134	29.10	100.00

Most respondents are well informed about ways to prevent a mother from transmitting HIV to their baby. Almost 76% of the respondents know there are special drugs a pregnant mother can take to prevent mother to child transmission, and 76% of the respondents also believe it is beneficial for a pregnant woman to receive HIV testing to prevent PMTCT. This suggests that respondents know HIV can be transmitted to their baby.

Frequency Tables above show responses to Knowledge about PMTCT on a Yes No Scale

It is beneficial for a pregnant woman to receive HIV testing to prevent PMTCT

It is beneficial for a pregnant woman to receive individual post test information

HIV pre-test information/counseling to prevent PMTCT

It is beneficial for a pregnant woman to receive HIV posttest counseling to prevent PMTCT

It is beneficial for a pregnant woman to receive counseling on infant feeding to prevent PMTCT

It is beneficial for a pregnant woman to receive counseling on maternal nutrition to prevent PMTCT

There are special drugs (ARVs) HIV+ people can take to help them live longer

Beliefs

Circumcision

The majority of males are mostly neutral to positive about circumcision. Out of the 61 males who answered the question about whether they are circumcised,

13% (17) are circumcised and 33.% (44) are not circumcised. Out of the 44 men who are not circumcised, 24% (32) report that if there was proof that circumcision reduced the chance of contracting AIDS, they would definitely or probably want to be circumcised. Out of 68 who answered the question, 35% (47) would definitely want their son to be circumcised, 4% (5) would probably want their son to be circumcised, 6% (8) would maybe want their son to be circumcised, and 6% (8) would not want their son to be circumcised. Nine percent (16%) of the 69 who answered strongly agree or agree that circumcised men earn respect from their peers. Fourteen percent (14%) (19) of the men report that they are neutral about the subject, and 19% (25) disagree or strongly disagree that circumcised men earn respect from their peers. In addition, out of 69 who answered the question, 17% (22) strongly agree or agree that most women prefer circumcised men. Fourteen percent (14%) (19) are neutral about the subject, and 13% (18) of them disagree or strongly disagree that most women prefer circumcised men. Finally, 17% (22) strongly agree or agree that circumcision enhances sexual performance. Nineteen percent (19%) (25) of the men are neutral about the subject, and 11% (15) of the men either disagree or strongly disagree with the statement that male circumcision enhances sexual performance.

Women were asked the same series of questions regarding their partner. Of the 60 women who replied, 17% (23) report that their partner is circumcised, 11% (16) report that their partner was not circumcised, and 14% (19) do not know. Women were also asked if they would want a circumcised partner. Twenty five percent (34) state that they would want a circumcised partner, 5% (7) state that they would prefer that they were not circumcised, 11% (15) replied that they did not know, and 2% (3) said this situation was not applicable to them. 28% (38) would definitely want their partner circumcised, 4% (6) report that they probably would want their partner circumcised, 7% (10) would maybe want their partner circumcised, and 3% (4) report they would not want their partner circumcised if they had proof that circumcision reduces a man's chance of getting HIV. Women tend to be neutral regarding how people perceive circumcised men. Sixteen

percent (16%) (22) of the women feel neutral about whether circumcised men earn respect from their peers. 13% (18) of the women agree to some extent, 10% (14) disagree to some extent. Almost similar results are found for whether most women prefer circumcised men. 15 percent (15%) (20) are neutral, 15%.(21) agree to some extent, 9% (13) disagree to some extent. Finally, when asked whether male circumcision enhances sexual performance, 21% (28) are neutral, 10% (22) agree to some extent, 9% (12) disagree to some extent.

Condom Use

As Tables below indicate, most respondents think it is justified to ask a spouse to use a condom or abstain from sex if that spouse has an STD. There is no significant difference between sexes.

Figure 20 Abstaining from Sex

Frequency table: Q4.88				
Category	Count	Cumulative Count	Percent	Cumulative Percent
1	69	69	51.49	51.49
2	47	116	35.07	86.57
3	1	117	0.75	87.31
Missing	17	134	12.69	100.00

Figure 21 Condom use everytime

Frequency table: Q4.89				
Category	Count	Cumulative Count	Percent	Cumulative Percent
1	80	80	59.70	59.70
2	28	108	20.90	80.60
Missing	26	134	19.40	100.00

Respondents report that it is more difficult to use a condom with their regular partner than a casual partner. Similarly, respondents report it is easier to say “no” to a casual partner when they don’t want to have sex, than to a regular partner. It

should be noted that according to an Analysis of Variance, women have a significantly harder time saying “no” to a regular partner than men do. Most people agree that a woman has a right to say “no” to a partner, whether regular or casual, if she does not want to have sex. The majority of respondents either strongly agree or agree that they would not have sex with someone if they did not know their HIV status. Additionally, the majority of respondents (75%) would not have sex without a condom.

Perceived behavioural control regards to condom use.

Difficult to use condom with regular partner

Difficult to use condom with casual partner

I can say “no” to regular partner

I can say “no” to casual partner

A woman has a right to say “no” to their regular partner

A woman has a right to say “no” to their casual partner

I would not have sex w/o condom if don't know HIV status

I'd rather have sex w/o a condom if I would be rejected otherwise

I'd rather masturbate than have sex w/o a condom

Behaviors

Recent Sexual History

It is the aforementioned knowledge, attitudes, beliefs and circumstances that lead to the behaviors of the respondents. The following section reports on their behaviors. The majority (30%) of people report that the last person they had sex with was their regular partner. Almost 4% report that the last person they had sex with was a casual partner. (See Table)

Figure 22 Relationship with last sexual partner

Frequency table: Q4.24Last				
Category	Count	Cumulative Count	Percent	Cumulative Percent
1	3	3	2.24	2.24
2	28	31	20.90	23.13
3	40	71	29.85	52.99
4	5	76	3.73	56.72
5	1	77	0.75	57.46
6	10	87	7.46	64.93
Missing	47	134	35.07	100.00

The table below shows respondents had multiple partners in a year's time, some of these individuals reportedly have had multiple partners at the same time as indicated in the two tables above.

Figure 23 Number of sexual partners in the last 12 months

Frequency table: Q4.20				
Category	Count	Cumulative Count	Percent	Cumulative Percent
0	8	8	5.97	5.97
1	46	54	34.33	40.30
2	21	75	15.67	55.97
3	15	90	11.19	67.16
4	6	96	4.48	71.64
5	4	100	2.99	74.63
6	4	104	2.99	77.61
7	1	105	0.75	78.36
8	1	106	0.75	79.10
11	1	107	0.75	79.85
14	1	108	0.75	80.60
15	1	109	0.75	81.34
20	1	110	0.75	82.09
Missing	24	134	17.91	100.00

Condom Use

Not only people who currently have multiple partners need to wear condoms. It is important that sexually active people wear condoms at all times to protect oneself

from HIV and AIDS, as individuals do not necessarily know the past or present activities of their partners.

Forty seven percent (47%) (63) of the respondents report using a condom with their most recent sexual partner every time they had sex within the last 12 months. Ten percent (10%) (13) report not using a condom with their most recent sexual partner every time they had sex within the last 12 months. Forty four percent (44%) (73) did not answer.

HIV Testing

More specific questions regarding AIDS prevention behaviors were also asked. One type of behavior that was addressed was being tested for HIV. Fifty three percent (33%) (71) of the respondents reported they have been tested for HIV, and 46% (62) had not been tested. Of those that have been tested, 31% (41) have been tested less than a year ago, 12% (16) were tested between 12 and 23 months ago, 12% (16) were tested over 2 years ago, and 0.75% (1) does not know when they were tested (see table 4.33 above)

4.34 Number of respondents who have been tested for AIDS

Figure 24 When last tested for HIV

Frequency table: Q4.34				
Category	Count	Cumulative Count	Percent	Cumulative Percent
1	41	41	30.60	30.60
2	14	55	10.45	41.04
3	16	71	11.94	52.99
4	2	73	1.49	54.48
5	49	122	36.57	91.04
6	1	123	0.75	91.79
Missing	11	134	8.21	100.00

What would encourage you to go for an HIV test

Having access to treatment using ART

Being unknown at the specific clinic where the test is conducted
 Assured confidentiality about my HIV status
 Availability of pre-and – post test counseling service
 Assured of not losing a place if I were positive

Respondents were also asked if they know a place where they can be tested should they want to be:

Frequency table 4.35

Figure 25 Knowledge of testing centres

Frequency table: Q4.35				
Category	Count	Cumulative Count	Percent	Cumulative Percent
1	128	128	95.52	95.52
2	3	131	2.24	97.76
Missing	3	134	2.24	100.00

DISCUSSION AND RECOMMENDATIONS

Knowledge

As a testament to the need to perform this needs assessment, not even 2% of our respondents received any formal AIDS education training at college. Most of our respondents received their information from the media. There were very few people who received HIV testing or drug and alcohol treatment either at college or at a referral service from work. It is unclear however, if these resources are hard to access, or only a few people needed these services. It is recommended that more of these services become available and widely advertised to the employees. Similarly, it was reported that most students were not aware of a college HIV/AIDS policies but believed their employer should have one.

Recommendations: College HIV and AIDS policies should be implemented, disseminated and again advertised among students. Most respondents have

some degree of comfort studying alongside fellow student with AIDS. It is important to note however, that there is still secrecy involved in having HIV and AIDS. Even though respondents would be willing to take care of a sick family member, these same respondents would keep it a secret that their family member was ill.

College management should reinforce the idea that HIV and AIDS is not something to be ashamed of. It appears as though a small percentage of the respondents are indeed HIV positive from responses of not tested or don't know. Fortunately, most people do not think that people like them cannot contract HIV, and people do tend to understand the gravity of the situation if they were to contract HIV. However there is still much more room for education in this matter.

Education regarding what puts a person at risk for contracting AIDS should be intensified. People tend to know the basic knowledge regarding HIV and AIDS prevention such as it being safe to share eating utensils, wearing condoms is protective, and limiting yourself to one partner is protective. This is probably due to the fact that respondents derive much of their information from the media, and this is just the type of information the media can impart. Information that was less understood was that it is not safe to use an oil-based lubricant with a condom, circumcision helps reduce the risk of contracting AIDS, and having another STD makes it easier for you to contract HIV. There was some uncertainty about the fact that using a condom with a non-regular partner helps prevent the transmission of HIV. Such information should be highlighted in any program or intervention developed. Although the majority of people had basic knowledge about contracting AIDS, not everyone did. This is information that is so important that there should be no ambiguities. Therefore it is recommended that even the most basic information be reviewed and continuous education even of basics to be continuously disseminated even to 2nd and third years students.

Less widely understood information such as it is not safe to use an oil-based lubricant with a condom, circumcision helps reduce the risk of contracting AIDS, and having another STD makes it easier for you to contract HIV and how to prevent mother-to child transmission should be part of continuous education in all colleges.

Beliefs

The majority of men were not circumcised, and the majority of women's partners were not circumcised. It appears that the social norms regarding circumcision are more negative than positive. Except for one tribe in Namibia (the Herero) most tribes shun circumcision. This is true for both the men and the women. There was a minority of people who say they would feel more positively about circumcision if there was proof that the practice will help prevent a man from contracting HIV. Since we now know that this indeed is the case, it is recommended that the benefits of circumcision be taught. It is probably not realistic to expect many adult men to agree to be circumcised, but the circumcision of baby boys and teenagers should probably be reinforced through knowledge acquisition as well as through personal testimony. Emphasis nonetheless should be put that circumcision alone does not deter HIV infection if no other precaution is taken.

The circumcision of baby boys should be reinforced through knowledge acquisition as well as through personal testimony. There is still a lot to be done in Namibia regarding this development because circumcision is frowned upon by the majority of the Namibia population.

Both males and females think it is acceptable to either refuse sex or ask their spouse to use a condom if that person has an STD. However, it is not as easy to make these requests if there is no STD suspected, especially for women. As one would suspect, it is more acceptable to ask a casual partner to wear a condom than it is to ask a regular partner. The majority of respondents would not have

sex with someone if they did not know their HIV status, or if they refused to wear a condom. While most (but not all) people understand the importance of wearing a condom with a more casual partner, it will be very important to reinforce the notion of wearing a condom with a regular partner. It is also important to teach women to have the power to refuse sex or insist on their regular partner wearing a condom. Men also need to be educated that it is acceptable for a woman to do this.

Education that it is advisable to wear a condom with a regular partner. And encourage through teaching women to have the power to refuse sex or insist on their regular partner wearing a condom. Educate men that it is acceptable for a woman to do this and good for protection of both partners.

Behaviours

The majority of respondents reported that the last person they had sex with was a regular partner (spouse, live-in partner or boy/girlfriend). Only a few stated that their last sexual encounter was with a casual partner. None of the respondents reported having sex with a prostitute. While the majority of respondents who have a spouse or regular partner do not have another partner as well, it was not uncommon for a person to have another partner besides their primary partner. In fact about 11% of respondents had 2 partners within the last 6 months. If you ask about the number of partners in the last year, these numbers increase. Among those who report that they had more than one partner at a time, only a few used a condom with their regular partner every time and report using a condom with the non-regular partner every time. Given this information, it is very important that monogamy be advocated in any curriculum. The importance of wearing a condom with any partner, but especially a casual partner must be emphasized. This is especially important in light of the fact that many respondents reported not wearing a condom with a regular partner whilst having a casual partner. This is even more distressing given the fact that many respondents often must travel overnight away from home, sometimes for more than one month at a time. In

these situations, it is common to have an encounter with a non-regular sex partner, and if protection is not used, this can be fatal.

Reinforce the importance of wearing a condom when away from home thirty one percent (31%) of the respondents reported having had an HIV test. Some of those people however, were tested more than 2 years ago. Over 95% of the respondents knew a place where they could be tested for HIV. The majority of respondents would be motivated to get tested if they could be sure the results would be kept confidential. Access to VCT and ART, availability of pre and post-test counseling and assurance that they won't lose their college place were also motivating factors. It is therefore important that whether a person be tested through a college program, or at an outside facility, they are assured that these factors be offered. Student teachers must be informed that these services are available. If a student -educator is at-risk for losing their place at the college for being tested or for testing positive, it is imperative that college policies be altered so this does not occur.

Whether he or she be tested through a work program, or at an outside facility, a person must be assured they will have access to ART and pre- and post-test counseling as well as be given assurance that they won't lose their job While many respondents reported performing behaviors in the last three months that help protect oneself from contracting HIV, there were enough respondents that did not perform these behaviors for it to be worrisome.

The following protective behaviors should be re emphasised:

- Abstaining from sex
- using condoms
- Taking an HIV test
- Reducing the number of sex partners
- Discussing HIV with a partner
- Having sex with only one partner

- Not having sex while drunk
- Going to a health facility if an STI is suspected
- Having an HIV test with a partner before having sex.

It is not only imperative that the importance of these behaviors be emphasized in any new college curriculum, but it is also imperative that student teachers be taught how to go about performing these behaviors. People will need to be taught how to negotiate with their partners when requesting condom use or refusing sex. Additionally, people need to be taught where to access STI clinics as well as HIV testing centers. People also need help accessing condoms. While most respondents had an understanding about the importance of wearing condoms, condoms were not always easy to access. Most, but not all of the respondents knew where they could access condoms. Seven percent (7%) of respondents reported that it takes them between an hour and a day to get to the closest shop to condoms. In addition, some respondents reported that there had been times when they could not buy condoms because they couldn't afford them.

Provision of no-or-low cost condoms at an accessible location, would help to decrease the spread of HIV and AIDS.

Limitations

The limitations in view of the scope of the study were as follows: Results were generalized to the student teachers community with regards to the HIV and AIDS knowledge, attitudes, and practices and yet only a % of the student population had volunteered to be part of the research study.

Interviews were conducted after classes in the evenings so this meant those students staying out of campus did not mostly participate as they would have gone home or if they are willing only a few would sacrifice their transport and wait, as they were in a hurry to go home.

Summary, Discussion, Recommendations, Conclusion

Summary

The results of this survey demonstrate that knowledge is important and necessary, but not sufficient to change a person's behavior. Most people queried knew basic information about protecting themselves from HIV, yet, they were not necessarily practicing the behavior. While it is necessary to review the information regarding the facts pertaining to protecting oneself from HIV, it is also important to address the attitudes, beliefs, and environment surrounding these behaviors. With the recent reports on the drop of new incidents in both rural and urban Zimbabwe and urban Kenya it is also possible in Namibia with education and correct BCC messages to reduce incidents, re infections and polygamous relationships. The survey results also show that large numbers of HIV-infected individuals are undiagnosed as very few have taken HIV tests. Earlier diagnosis could reduce new infections and re-infections having noted that one of the respondents had up to 20 partners in 12 months.

Discussion

Michelle Faul says: Zimbabwe has registered a 2.5 percent decline in HIV infection rates, and the number of Aids deaths is also dropping, but analysts are skeptical given the lack of medical care in the country in crisis. The HIV rate dropped from 18.1 percent in people aged 15 to 49 years last year to 15,6 percent this year, Zimbabwe's Ministry of Health said on Thursday. Aids deaths also have decreased, down to 2 214 a week from around 2 500 a week, according to the new statistics. The government said its figures had been verified by the United Nations. But UNAIDS said that was not the case. "It looks like they've used the methodology that we recommended; however, as we haven't received this data officially, we cannot validate it," said spokesperson Sophie Barton-Knott. A researcher at London's Imperial College who helped work on the report said the trends presented were as accurate as possible given the available data, according to college spokesperson Laura Gallagher. Others were doubtful

of the figures and the assumptions, pointing to Zimbabwe's economic and infrastructural meltdown, lack of medical care and medication, and the difficulties of relying on statistics when as much as a third of the population has abandoned the country. "I think with the current state of affairs in Zimbabwe, one would be kind of skeptical about statistics, which could also be caused by an undercount, by mass migration....," said Dr David Bourne, an epidemiologist at the University of Cape Town.

If such a turn of events is possible in Zimbabwe, Namibia with all the resources and support should make bigger strides in reducing incidencies. If it was possible to support and maintain the delay in sexual activity then a big change would occur in Namibia.

Aids figures for India dropped considerably this year after expanded surveys and an improved methodology allowed experts to fine-tune their estimates. Bourne said experts expected to see a peak and decline in prevalence rates, which would occur naturally even without intervention, but the fact that the number of deaths was declining was "very surprising." In Zimbabwe, as in much of Africa, many Aids deaths are attributed to secondary causes such as tuberculosis, and many victims go to rural villages where they die, uncouncted. Nathan Geffen, policy co-ordinator for South Africa's Aids Treatment Action Campaign, said it was extremely difficult to measure Aids mortality in a country where the infrastructure has fallen apart. "A drop in sero-prevalence rates can mean many things, including that people with HIV are dying," he said. An independent Zimbabwean Aids researcher, who spoke on condition of anonymity because of the sensitivity of the subject, said the declines could be credited partly to changes in people's behaviour. She said it had been documented that many Zimbabweans are postponing their sexual debut, waiting until they are 18 or 19 years old, and that the use of condoms has increased exponentially.

The new figures would mean that about one in seven Zimbabweans is believed to be HIV-positive, down from a peak of one in four at the height of the AIDS pandemic in the 1990s. Zimbabwean authorities said they have increased the number of people in a low-cost antiretroviral program in recent months, with the number accessing the life-prolonging drugs now standing at about 86,000. But a report on state radio last week said some beneficiaries were so desperate for money that they were selling their medication on the streets. In an economic meltdown, Zimbabwe is suffering inflation between 7 000 and 25 000 percent according to official and unofficial estimate. Its impoverished citizens are unable to afford what little medication is available on the black market. Hospitals and clinics have been hit by power, water and staff shortages, as many trained staff have abandoned the country. A five-minute consultation with a private doctor this week cost Z\$4-million, more than half the take-home salary of a police officer. Sub-Saharan Africa has one of the world's highest Aids rates and Zimbabwe's neighbour, South Africa, has the highest number of people living with HIV, some 5.5 million. In Zimbabwe, more than 1.3 million people are now estimated to be HIV-positive out of a population of about 11,6 million. Thursday's announcement came from Health Minister David Parirenyatwa, who was quoted by the official Herald newspaper as saying that the country's HIV rates were "still very high." "While we welcome it, we should still caution ourselves that this is still an alarming figure that we must address," the minister was quoted as saying.

www.zwnews.com <<http://www.zwnews.com>

Namibian journalist Surihe Gaomas quoted, in the New Era newspaper of Monday, 26 November, 2007 wrote: HIV and AIDS infection occur everyday in Namibia; the burden of Sexually transmitted Infections has risen to 80,000 cases being reported every year with more young people engaging in risky sexual behaviour and more men are more reluctant to go for voluntary counselling and testing (VCT) as compared to women. She goes on to say that these are some of the findings contained in the in Namibia's HIV and AIDS Situation Analysis Survey presented during a National Tripartite Consultation on HIV and AIDS in

the World of Work, in Windhoek last week. Delivering the survey to several labour inspectors Gebhard Timotheus of the National AIDS Centre under the Ministry of Health and Social Services said the biggest obstacle in preventing the rapid spread of HIV infection in the country is the reluctance by Namibians to change behaviour towards the pandemic. A finding also found in this particular study.

He emphasised: “The problem is behaviour change. We are struggling to get people to change their behaviour (safe sex)”. I think he should have also emphasised on one faithful partner. “When it comes to knowledge about HIV and AIDS, people know about it, but changing one’s sexual behaviour is a problem, especially among men.” Explained Timotheus.

Statistics in that survey showed that men tend to have more than two sexual partners (a situation also revealed in this study), raising the risk of spreading HIV infection. This is obviously further worsened by the gender inequality factors where men tend to take the decision making role in sexual relationships.

Recommendations

Health experts believe more multi-sectoral and concerted efforts are needed to fight this pandemic head on, more so with the men folk since the burden of the disease lies heavily on women. Based on above the Ministry of Health and Social Services is planning to hold a conference in March 2008 where male leaders, traditional leaders and councillors will gather in support of their womenfolk when it comes to HIV prevention (*The Namibian newspaper November 26, 2007*).

With last week’s major story on the UNAIDS announcement that it is reducing its estimate of global HIV infections by six million, to 33 million, and that new infections are falling. It is felt that this read be included in this report to inform the readers on how UNAIDS arrives at its rates and figures. The announcement has been criticized by some because it seems to undermine the global urgency of the

epidemic – encouraging the uninformed to think: “If new infections have already peaked, won’t AIDS be over soon?”

It is important to understand how UNAIDS calculates its figures – and the extent to which it is reliant on national governments to provide accurate information (an issue downplayed by UNAIDS in its own press briefings).

The big change that led to the reduction of the new infections estimate – and the suggestion that infections have peaked – comes as a result of the discovery that the average time from infection to death in the developing world is longer than previously assumed. Because epidemiologists use a method called back calculation to estimate when infections happened, this change is critical. If people are living for eleven years rather than nine years, this must result in a lower estimate of the numbers infected each year, calculating back from death rates and trends in deaths.

UNAIDS has been criticized in the past by others for inflating its estimates, some say deliberately. Dr James Chin, a former UNAIDS epidemiologist, has even published a book detailing how UNAIDS has got it wrong. But other epidemiologists who were involved strongly reject this accusation. What haven’t been remarked on are the huge holes in data collection at country level. In India for example, UNAIDS epidemiologists were reliant on skewed antenatal prevalence surveys until 2005, in the country with one of the largest projected epidemics in the world. When a more accurate household survey was carried out, it resulted in the halving of estimated HIV prevalence in India and made a big dent in this year’s global figures. This sort of survey data are still missing for countries like Nigeria, Mozambique, Russia, Ukraine, China, Vietnam and Indonesia.

Until donors can persuade or support national governments to carry out such surveys on a regular basis, global statistics will be skewed and information for

national prevention programmes will be seriously lacking. [If you don't know your epidemic, how can you change it?](#)

www.aidsmap.com/en/main/emailupdate.asp

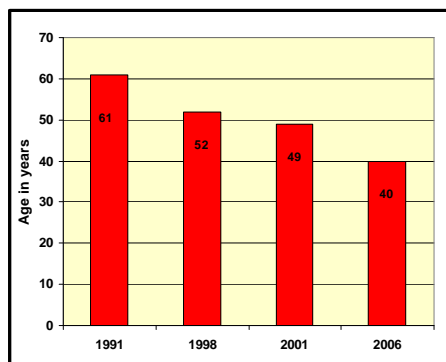
The Under Secretary for Lifelong Learning (LL) and Programme Manager for the Education and training Sector Improvement Plan (ETSIP) in the Ministry of Education Justin Ellis during the World AIDS day commemoration and launch of the MoE Workplace Policy quoted two articles in the Namibian Newspaper of Wednesday 28 November, 2007 by Fredrico Links and March Hofer titled "Guys Don't Really Care". The article read "Men are the key drivers of the epidemic through their involvement in multiple and concurrent sexual activities with low or no use of condoms coupled with the fact that in Africa men are the decision makers regarding when, where and how sex should happen." These two reporters were quoting an anger laden article by Lois Chingandu of SAfAIDS. The article went on to say "men need to reduce partners, men need to use condoms at all times and must be faithful." The article went on to say: "Sexual relations between men and women in Namibia and elsewhere are influenced by a complex web of economic factors, which have been shown to greatly impact the spread of HIV. The same reporters in a different article in the same daily headlined "Transactional Sex Driving HIV" report on the current wave of older men in Windhoek dating college girls because of the basic material provisions they are able to provide these vulnerable children who at the same time have younger boyfriends at Colleges, caught up in this cross generational sexual relationships, where older men are looking for gratification and the younger girl for material and financial gains. This obviously fuels the spread of HIV and AIDS as the younger male partners who are unsuspecting are caught up in the spread of the disease.

At a Gala dinner the same day the Deputy Director in the Planning Directorate of the MoE Twaunda Keeja mentioned that people in general do react to powerful messages if they listen to message over and over. In order for people

(Namibians in general) to engage in an attitudinal change and or behaviour, audio materials in the form of CDs and cassettes need to be recorded and distributed freely so that a variety of people can have access to them. In Namibia, generally there is a growing listening culture for people with radios, be it music or messages. He went on to say “The message that sent by the two eminent and remarkable people (motivational speakers) Brett Anderson and Roger, can easily be captured in such material to further strengthen the fight against the pandemic. To this end, resources (financial) have to be mobilized to ensure the production of the CDs. Additionally, audio visual materials are another possibility to be explored, in our search to ensure the rightful audience receive the intended HIV and AIDS information meant for them. With the wide Namibian spaces it is difficult to reach every member of the population through the print media but the above will go a long way to alleviate this as these are records which can be played over and over and can be shared or watched by a group of people at the same time. This also encourages group discussion and sharing of information, experience and knowledge.

The above was confirmed by the results of the study and it is therefore encouraging to see the management of the MoE playing a major role in the HIV and AIDS education and communication.

Life expectancy in Namibia is also falling drastically due to the HIV and AIDS epidemic.



In concurrence with the Deputy Director Planning other ways of imparting HIV and AIDS information should also be looked at e.g.

- Guest speakers
- Posters and Pamphlets
- Group discussions
- Drama groups

Just as there are many different types of information out there that might be of use to employees and students, the ways in which this information is delivered to the students is also important. Above, are listed four different ways of sharing information. There are obviously other ways. These listed ways have pros and cons while sharing information that the Ministry can identify through further and or prior surveys and discussion.

Conclusion

The study concludes that the knowledge levels of student teachers are quite high, with most of this information being received from radio/television. It was also obvious that there was a relationship between knowledge and level of education, but not necessarily behaviour and practice. This obviously points to the fact that education alone does not guarantee behaviour change.

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ANNEX A

Questionnaire Number: _____ Qno

**KNOWLEDGE, SKILLS AND ATTITUDES ABOUT HIV and AIDS IN STUDENT
TEACHERS**

Purpose: We request your help in completing this questionnaire to determine what student teachers understand about HIV and AIDS and where they get their information. The information from this questionnaire will help us assist your college with developing a program that will help you protect yourself and loved ones from the virus that causes AIDS.

Confidentiality and Consent: Some personal questions will be asked about your sexual behaviour and what you think about HIV and AIDS. Your answers are completely anonymous and your name will not appear on any part of this survey. We will not tell anyone else your answers to the questions. You do not have to answer any questions that you do not want to answer, but it is most helpful if you answer all the questions in the included questionnaire. Your honest answers to these questions will help us better develop a college wellness program for the Ministry of Education.

We would greatly appreciate your help by taking part in this survey. The questionnaire will take about 45 minutes to complete. Please complete each question indicating your choice by circling the correct response, or by writing an answer in the open space.

If you need more information, please contact Ms Victoria Sipiwe Mamvura-Gava at vikki@iway.na or vikki@africaonline.com.na/ 061 252290/221598/081 1295773

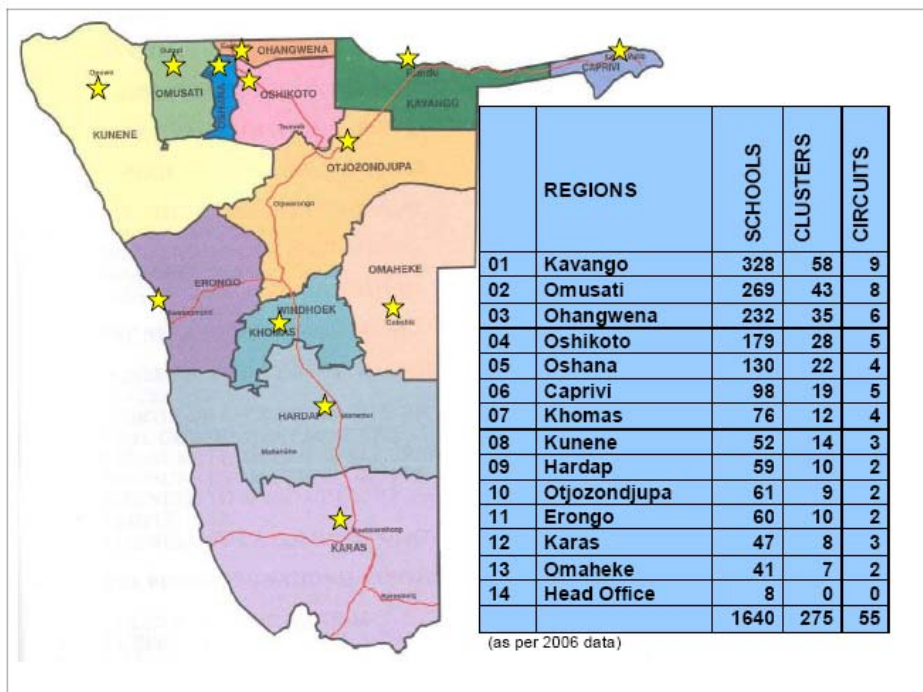
By completing this questionnaire, you give consent to participate in the survey.

Start time [please indicate hour and minutes]: _____ Stime

ANNEX B



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



ANNEX C



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