Prostitution, HIV/AIDS and human rights: A case study of sex workers in the township of Katutura, Namibia

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ABSTRACT

Millions of people currently live with HIV/AIDS around the world. Regionally, Sub-Saharan Africa is most affected, with some national HIV-prevalence rates reaching 30%. In Namibia, prevalence has recently dipped to 19.7%, after years of increasing levels. Women in Namibia account for more than half of new infections. Though prostitutes are not included as a group entity in national HIV surveys, it is estimated that HIV-prevalence levels among them are much higher than the national average.

Two forms of prostitution exist in Namibia, both of which are criminalised through the Combating of Immoral Practices (Act 21 of 1980): exchange sex work and classic sex work. Since prostitution is illegal, sex workers are forced underground and become more vulnerable to HIV-infection. However, very little has been written about sex work in Namibia, and therefore no figures on prostitution are available. Failure to monitor HIV-prevalence rates among prostitutes can have the unwanted consequence that rates spread quicker than anticipated.

The AIDS epidemic has highlighted the importance of access to adequate health care. The right to health is included in the UN International Covenant on Economic, Social and Cultural Rights (ICESCR), of which Namibia is a signatory. However, people living with HIV/AIDS (PLWHA) often face discrimination and stigma, in particular those who are engaged in sex work. They suffer discrimination twice over, and may thereby be hindered to access health care. The fieldwork study undertaken in preparation for this thesis found that many sex workers in the township of Katutura, on the outskirts of Windhoek, were denied access to health care. The right to education is also of relevance here; as the 2000 Namibian Demographic and Health Survey (NDHS) concluded that knowledge about HIV/AIDS, and how it can be prevented, correlated with the respondents’ level of education. The respondents had acquired more extensive knowledge about HIV/AIDS had they attended school for several years. The National AIDS Control Programme (NACOP) embraces a human rights approach; however, both the above mentioned rights are violated daily in Katutura. Access to health care is in an HIV/AIDS context key to the possibility to lead a somewhat normal life with the infection. Within the concept of access is the availability of antiretroviral medication (ARVs), the prices of which has recently decreased on the global market but still remain out of reach for many countries. Namibia aims to supply ARVs for thousands of HIV-infected people; however, despite a pledge that this medication is available free of charge this study shows that for the very poor, AIDS treatment still remains out of reach.
ABSTRACT

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Special thanks to Peter Johansson, my most excellent and devoted supervisor at Göteborg University, for keeping me on track and patiently answering all of my questions, even the non-relevant. Thank you also for providing emotional support when I needed it the most.

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Of course, my most grateful thanks go to the women of the townships of Katutura and Babylon, who so willingly spent time with me and told me their life stories. I can only hold a humble hope that this study will benefit you in some way or another.
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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ALU</td>
<td>Aids Law Unit</td>
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<tr>
<td>ART</td>
<td>Antiretroviral therapy</td>
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<tr>
<td>ARV</td>
<td>Antiretroviral (drugs)</td>
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<tr>
<td>ICESCR</td>
<td>International Covenant on Economic, Social and Cultural Rights</td>
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<tr>
<td>CPTEDO</td>
<td>Combating Prostitution through Education and Development Organisation</td>
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<td>CSW</td>
<td>Commercial sex worker</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Syndrome</td>
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<td>KSH</td>
<td>Katutura State Hospital</td>
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<td>LAC</td>
<td>Legal Assistance Centre</td>
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<tr>
<td>MoHSS</td>
<td>Ministry of Health and Social Services</td>
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<td>MBESC</td>
<td>Ministry of Basic Education, Sport and Culture</td>
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<tr>
<td>MTCT</td>
<td>Mother-to-Child Transmission</td>
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<td>MTP (II or III)</td>
<td>(Third) Medium Term Plan</td>
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<td>NACOP</td>
<td>National AIDS Control Programme</td>
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<td>NDHS</td>
<td>Namibia Demographic and Health Survey</td>
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<td>NGO</td>
<td>Non-governmental organisation</td>
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<td>OHCHR</td>
<td>United Nations Office of the High Commissioner for Human Rights</td>
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<td>PLWHA</td>
<td>People Living with HIV and AIDS</td>
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<td>STI/STD</td>
<td>Sexually transmitted infection/disease</td>
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<tr>
<td>SWAPO</td>
<td>South-West African People’s Organisation</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>UNAIDS</td>
<td>United Nations Joint Programme on HIV/AIDS</td>
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<td>UNam</td>
<td>University of Namibia</td>
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<td>UNDHR</td>
<td>United Nations Universal Declaration of Human Rights</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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## GLOSSARY

<table>
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<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td><strong>Antiretroviral drugs (ARVs)</strong></td>
<td>Medication that fight retroviruses, such as HIV</td>
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<tr>
<td><strong>CD4 cells</strong></td>
<td>The CD4 cells, found in the lymphocytes, are critical cells in activating the cellular immune response which is targeted by HIV. A reduced CD4 count indicate that the HIV infection is progressing</td>
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<tr>
<td><strong>Epidemic</strong></td>
<td>An unusually sharp increase in the amount of people falling ill in a certain disease, limited to a relatively short period of time</td>
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<tr>
<td><strong>Pandemic</strong></td>
<td>A global epidemic</td>
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<tr>
<td><strong>Shebeen</strong></td>
<td>An informal drinking house, found mostly in Namibia’s townships or poorer areas. Renowned for being ‘working areas’ for sex workers, some shebeen owners provide a separate room where transactional sex can take place</td>
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1. INTRODUCTION

More than twenty years have now passed since the world witnessed the onset of the AIDS epidemic. During those early years, when AIDS was still believed to affect only gay men or intravenous drug users, no one could predict the devastating impact the disease would cause around the world. We know plenty more about AIDS today: for instance, the ways in which the virus is transmitted and that it can infect any individual, regardless of gender, race and sexual preference. We also know that AIDS is not curable, that it inevitably leads to death, and that this process is long and often painful. However, we have created medication and developed treatments which enhances and prolongs the life of an AIDS-patient – something that was not possible twenty years ago.

Something else we have learnt in the last couple of decades is that violations of basic human rights expose people to an increased risk of contracting the HIV-virus. Already vulnerable people, for instance those who are poor and uneducated, become increasingly susceptible to HIV-infection when they are denied access to education and health care.

Bridging the research gap between HIV/AIDS, prostitution and human rights, this thesis provides a unique analysis of sex workers in Namibia. Sex workers constitute a group of people vulnerable to an increased risk of contracting HIV. Though HIV/AIDS itself is a topic widely researched; in a prostitution context, our knowledge is quite limited. Several studies concerned with both topics exist today; however, no such research focusing on Namibia has yet been published. It is therefore the aim of this thesis to concentrate on prostitution, HIV/AIDS and human rights in a Namibian context. Because no other study has focused exclusively on sex workers from the townships, this thesis will do so, while providing an examination on related human rights violations and its implications for the national attempts to stem the rate of new HIV-infections. No data is available on HIV-prevalence in the Namibian townships alone. The Ministry of Health and Social Services (MoHSS), though having conducted several studies on general health in Namibia, does not possess any figures which reveal HIV-prevalence in the townships; the available data
concerns Windhoek as a whole. Neither does the MoHSS have any data related to prostitution. It is therefore impossible to establish such facts as the number of sex workers operating in Namibia today, and how high HIV-prevalence is among them. Considering that in developing nations infection is mostly transmitted through heterosexual sex, this lack of statistics is very unfortunate.

We also know today that the AIDS epidemic is an unbearable burden for many countries. Underdeveloped nations are now financially crippled with the strains of trying to provide treatment and medication for thousands of people infected with HIV. Poverty is here one aspect of the AIDS epidemic which needs to be taken into account, as poorer nations struggle to be able to afford antiretroviral medication (ARVs) for HIV-positive citizens. Poverty also plays a role on an individual level, since many people are denied access to treatment and medication if they are unable to pay for it. In this context it may be argued that the human rights framework can provide a structure within which an effective response to the HIV/AIDS epidemic can take shape. Therefore, the thesis aims to examine human rights in the HIV/AIDS context, in particular since the Namibian national HIV/AIDS response includes a rights approach.

This thesis is the concluding course component of the Master’s degree in Human Rights at the School of Global Studies, University of Göteborg. The fieldwork study carried out in preparation for the thesis was conducted in Windhoek, Namibia, during April and May of 2005.

1.1 PURPOSE AND QUESTIONS
The purpose of the thesis is to provide an analysis of the link between prostitution, HIV/AIDS and human rights. The thesis will use as its starting point a qualitative study of the accessibility of AIDS treatment for prostitutes in the township of Katutura, Namibia. The questions being asked are: which human rights are most relevant in this particular context? To what extent are these rights upheld in Katutura?
1.2 LIMITATIONS

No other area in the world has suffered as many AIDS-related deaths as Southern Africa. Therefore, geographically focusing on this region in a study of human rights in an HIV/AIDS context seemed a natural choice. Namibia, one of the region’s most hard-hit countries by the AIDS epidemic, has had a National AIDS Control Programme (NACOP) in place since 1990, which encompasses a human rights approach. The combination of these factors makes Namibia an interesting example to study.

Unfortunately, in many parts of the world, people living with HIV/AIDS (PLWHA) are forced to endure daily violations of their basic human rights. Many PLWHA experience discrimination and stigma, and may, for example, suffer rejection from family members and work colleagues. This situation is no different in Namibia. Therefore, human rights in a discrimination context will be discussed in this thesis; however only for the purpose of providing an overall picture of the situation. Focus of the thesis will be on the right to health, the right to education, and access to health care. All of these topics are in an HIV/AIDS context individually concerned with discrimination and stigma.

Prostitution in Katutura has never before been examined in detail. Therefore, this study focuses exclusively on prostitutes living and working there. The study has been limited to a small sample group of fifteen informants. Due to the lack of previous research, to concentrate this study on township dwellers fills a void in Namibian HIV/AIDS research. The informants were not specifically chosen out of a larger group; on the contrary, they constitute those prostitutes who were willing to be interviewed.

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1 An academic debate exists over which of the terms ‘prostitution’ and ‘sex work’ should be preferred. The thesis will discuss this topic in a separate section. Throughout the thesis, both ‘prostitute’ and ‘sex worker’ will be used intermittently, as the purpose here is not to establish which term is the most appropriate. Both terms are used here simply for descriptive reasons.
1.3 METHODOLOGY AND MATERIAL

1.3.1 The interviews

In the initial stage of the research, I interviewed clergyman Father Hermann Klein-Hitpass, who managed a Catholic charity centre (hereafter ‘the centre’) open to prostitutes in the Katutura area. Thrice weekly, meetings led by Father Hermann took place here, during which prostitutes could meet up and conduct Bible studies, have a meal, and receive some basic food products. Father Hermann initially met the sex workers while driving around the township area aiming to inform them about condoms and the risk of contracting HIV. (Supplied by the government’s AIDS programme, condoms were also distributed for free at the centre.) The sex workers then received an invitation to join the meetings at the centre. I visited the centre twice a week, whereby Father Hermann facilitated interviews with the sex workers.

Maykut and Morehouse (1994) argue that a randomly selected sample ‘increases the likelihood that the sample accurately represents the [general] population (…)’\(^2\). In this study, it cannot be expected that the sample group is representative of the general population; however, it could be regarded as representative of sex workers in the townships of Windhoek. Though my sample group was small, clear patterns of the rates of HIV infection, the sex workers’ educational background and the reasons why they entered sex work, emerged through my research. Interestingly, these patterns paralleled those found by a 2002 study conducted by the non-profit law firm Legal Assistance Centre (LAC)\(^3\), which represents the only other study on the topics of prostitution in Namibia.

In total, fifteen in-depth semi-structured interviews were conducted with the prostitutes. Though the informants varied in ethnic and linguistic origin, the majority

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\(^3\) Legal Assistance Centre, 2002: *Whose body is it? Commercial sex work and the law in Namibia*, Windhoek, LAC, p. 79ff
of them spoke English to an understandable degree⁴. However, in some instances it was necessary to use the services of a translator. The translator later became one of my informants, using a method described by Maykut and Morehouse as ‘reducing the power differential between the researcher and the research participants by involving the participants as collaborators’⁵. During the initial interviews I did get the feeling that the informants were not entirely comfortable with my presence, but when the translator joined me I saw a noticeable change in their attitude. Being able to speak their own language, and not having to concentrate on speaking English, made some informants relax considerably.

Visiting the centre twice a week was also part of my intention to attempt to ‘reduce the power differential’. Showing up every Monday and Friday at exactly the same time, I hoped to become known to the informants as reliable. It also gave me the opportunity to get to know some informants quite well; as I made sure I had a chat with every informant I had previously interviewed. In addition, I became known to future informants. Some women hesitated to approach me for weeks, and only found the courage to come and talk to me when I had become a familiar face at the centre. Moreover, the private nature of the topics I was interested in discussing made it necessary to strongly emphasise that the informants’ anonymity would be guaranteed. As Bless and Higson-Smith (2000) point out, anonymity does not constrain social research, as the interest lies more in group data than individual statistics⁶.

One difficulty I encountered was to decide if or how to reward the informants for the interviews. Initially, I considered giving them money, though I worried that the news that cash payments were being rewarded for interviews would inspire some prostitutes to come and talk to me for that reason alone. Wanting to avoid situations

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⁴ Since independence in 1990, English is the official language in Namibia; however, Afrikaans is still used extensively as the common language between different ethnic groups.

⁵ Maykut and Morehouse, 1994: *Beginning Qualitative Research*, p. 71

where the informants submitted answers that they thought I wanted to hear rather than what was really the truth, I therefore decided that no rewards would be distributed until all interviews were finished. In collaboration with Father Hermann, the informants were all given a food package, as well as photographs which they had themselves requested.

I found that in-depth interviews were a preferred method to, for example, focus groups or questionnaires. Though the informants were all literate, their knowledge of written English was limited, and a questionnaire would have caused more confusion than it would have assisted in my research.

Having prepared the questions beforehand, all answers and any additional questions were written down by hand during the interviews. To confirm that I had understood everything correctly, I repeated the answers given to me by the informants. Maykut and Morehouse state that it is significant that people’s exact words are written down during interviews, since it is the aim of the researcher to understand the precise setting that is the focus of the study. Therefore, my informants were also offered to read my notes from each interview. This simple but effective method ensured that the information relayed to me was correct. My original intention had been to tape record all interviews, however, as it turned out it was easier without the use of a recorder. Due to the language barriers, it would have been difficult to clearly understand what was said on the tape. In addition, conducting follow-up interviews with the informants, or even meeting with them again for clarifications, would have proven difficult since there was no guarantee that they might be at the centre during my next visit. By verifying all interview answers immediately, I avoided any possible misunderstandings.

Additional interviews include the two founders of the first NGO established with the sole aim to assist and facilitate the lives of prostitutes in Windhoek, the Combating Prostitution through Education and Development Organisation (CPTEDO), as well

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7 Maykut and Morehouse, 1994: *Beginning Qualitative Research*, p. 76
as with the Chief of Health Programs at the Ministry of Health and Social Services (MoHSS) Abner Xoagub, conducted via email.

1.3.2 Secondary resources

Only twice has research been conducted with the specific aim to describe the situation for prostitutes, once in Windhoek and once in the coastal town of Walvis Bay\(^8\). Governmental institutions were involved only as advisors in these research projects, which has the implication that the government has never undertaken any study whatsoever regarding prostitution. Related material (such as general health statistics) was, however, relatively easy to find. The resource centres of the Legal Assistance Centre (LAC), the World Health Organisation (WHO), the MoHSS and the Ministry of Women’s Affairs, were made available to me, which was extraordinarily helpful. However, due to the lack of previous research, the great majority of my first-hand sources are the interviews with the sex workers. Almost exclusively, other sources are secondary.

On site in Windhoek, I made several attempts to meet with members of the Ministry of Health and Social Services (MoHSS). As a response to the increasing threat of HIV and AIDS, a national AIDS control programme (the NACOP) was set up in 1990\(^9\), and I was particularly interested in interviewing its representatives, but despite numerous phone calls I was never granted an interview. By an incredible stroke of luck, however, I met the Chief of Health Programs on the very same day as my departure from Namibia. I was then granted the kind permission to conduct an interview via email, which took place during a couple of weeks in July. Apart from the information submitted to me in that interview, my sources on the NACOP are official documents obtained from the MoHSS.

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\(^8\) Despite the obvious need for more research of this kind, the Walvis Bay study has due to its incomplete nature not been used as a reference here.

The interview with the MoHSS Chief of Health Programs proved invaluable since he supplied me with statistics that I had previously been unable to locate. Survey reports and official documents (such as the National Strategic Plan on HIV/AIDS) also provided necessary data with which to compare findings from the interviews.

1.4 DISPOSITION
After a brief overview of the HIV/AIDS situation in the world, including a presentation of current statistics, this thesis will in chapter two examine HIV/AIDS in a Namibian context. A brief description of Namibia’s road to independence will be provided for the purpose of contextualising the discussions that follow. For similar reasons, a summary of public health law and international health obligations will be presented. The last part of this chapter will discuss HIV/AIDS in a human rights context.

Chapter three will begin by examining previous research on sex work and HIV/AIDS, in a general sense as well as in a Namibian setting. After results from the 2000 Namibian Demographic and Health Survey (NDHS) is revealed, the thesis will discuss the terms ‘prostitution’ and ‘sex work’. A look at the legal instruments concerning prostitution in Namibia will follow. The second half of this chapter concerns the findings of the fieldwork study undertaken in preparation for this thesis.

Finally, chapter four examines the National AIDS Control Programme (NACOP) and several related human rights (and dimensions thereof). For instance, discrimination and stigma, as experienced by many individuals affected by HIV/AIDS, is discussed in detail. In addition, access to health care is looked at, in particular access in Katutura.

In its concluding chapter, the thesis discusses some possible ways forward, and opportunities for future research are listed. Included here is a further discussion on
how human rights are linked to HIV/AIDS, in particular in context of the NACOP. The implications of poverty and how underdeveloped nations are prevented from accessing antiretroviral treatment (ART) are also discussed.

2. BACKGROUND: HUMAN RIGHTS AND HIV/AIDS

This chapter will analyse the links between HIV/AIDS and human rights in several contexts. The discussion begins by providing statistics on the current HIV/AIDS situation in the world, with a focus on underdeveloped nations. HIV/AIDS from a Namibian perspective will then be discussed. The chapter will also examine, in brief, public health law and international law obligations.

2.1 CURRENT FIGURES ON HIV/AIDS

More than twenty years after AIDS was first diagnosed, there is still no cure for the disease, nor for the virus that causes it. Millions of people have already died of AIDS, and, as Barnett and Blaikie (1992) notes, in the absence of a cure and/or vaccine, millions more will perish\(^\text{10}\). In this bleak context, it is particularly important that special attention is paid to the African continent. More than 90% of all adult HIV-infections are in developing countries\(^\text{11}\), and as many African countries are poor and underdeveloped, their already scarce resources are under enormous pressure to cope with adequate care for the sick and dying.

Figures from the United Nations Office of the High Commissioner for Human Rights (OHCHR) reveal that about 38 million people live with HIV or AIDS today, and that over 70% of these live in Africa\(^\text{12}\). Sub-Saharan Africa is the worst hit region in the world by HIV and AIDS, with millions of people living with the virus at the end of 2004. A great majority of the world’s HIV-positive people are found in the age group 15-49 years old, which has devastating effects on several dimensions of


society. As the majority of the workforce, people in this age group constitute the backbone of a nation’s economy. In addition, individuals in this age group are simultaneously parents and caretakers of their own mothers and fathers. Thus the loss of a majority of people 15-49 years old is catastrophic, leading to the creation of thousands of orphans and elderly with no one to care for them. Not surprisingly, the AIDS epidemic has particularly destructive impacts on countries already considered underdeveloped, making individuals increasingly vulnerable to both HIV-infection and deepening the poverty crisis.

2.2 IN CONTEXT: NAMIBIA AND HIV/AIDS

Namibia, formerly known as South West Africa, was granted independence in 1990 after centuries under colonial rule (see Appendix I: Map of Namibia). Germany had initially laid claim on Namibia, but following the end of World War I, the League of Nations gave South Africa mandate to govern the country. South Africa regarded Namibia as its province and ruled it according to apartheid laws. With the creation of the South-West African People’s Organisation (SWAPO), a national movement began to take shape during the 1960s. The struggle for independence lasted until February 1990, when negotiations involving the United Nations and various Namibian political parties, led to the adoption of a Constitution. SWAPO became the majority party in the new independent Namibia, with freedom fighter Sam Nujoma elected as its first president.

In theory at least, racial segregation no longer exists in Namibia; however, only fifteen years have passed since independence and it is still obvious that black and white people do not share the same standard of life. Not even one out of ten Namibians is white (normally of South African, German or Portuguese origin), but the black population is generally poorer than the white. Almost without exception, Windhoek townships dwellers are black, though of different ethnic origin. A total of eleven ethnic groups live in Namibia, the biggest being Owambo, constituting more than half of the total population of almost 2 million. All ethnic groups speak different languages, though Afrikaans and English is still spoken extensively.
As a result of the South African induced apartheid policies, black people were allocated limited urban areas in which to live. The main one of these ‘locations’ is Katutura (see Appendix II: Map of Windhoek and surroundings), which in the Otjiherero language roughly means ‘the place we do not want to settle’\textsuperscript{13}. The move to Katutura was organised by Windhoek municipal authorities, with the intention to move the black population away from an area destined for other purposes. As a result, Katutura houses are built of cement blocks and have both running water and electricity. By contrast, neighbouring townships which have mushroomed as the result of increased urbanisation, have no electricity and ‘houses’ here are simple sheds made out of sheets of corrugated iron. There is running water; however, none of the sheds have toilet facilities. The majority of these townships have not been authorised by the municipality, but are regarded as permanent living areas. Accordingly, even the smallest footpath or gravel road has been equipped with a street name and a proper sign.

\subsection*{2.2.1 HIV/AIDS in Namibia: facts and figures}

Since 1996, AIDS has been the most common cause of adult death in Namibia\textsuperscript{14}, and it has lowered life expectancy at birth by several years. Despite national efforts to halt the spread of HIV, 2003 figures from the Joint United Nations Programme on HIV/AIDS (UNAIDS) showed that HIV prevalence in Namibia had reached 21.3\%\textsuperscript{15}. However, more recent data from the Namibian Ministry of Health and Social Services (MoHSS) reveal that prevalence is now on a slight decline, with a national average of 19.7\% in 2004\textsuperscript{16} (see Appendix III: HIV prevalence in pregnant women). This is the first time since the national surveys began that a decline is observed. It should be noted, however, that since no studies have been undertaken to establish

\begin{flushleft}
\textsuperscript{13} Pendleton, W.C., 1993: Katutura: A Place Where We Stay, Windhoek: Gamsberg Macmillan, p. 3ff
\textsuperscript{14} Interview via email with the Chief of Health Programs, Mr Abner Xoaqub, July 11, 2005; see also The Namibian National Strategic Plan on HIV/AIDS, Third Medium Term Plan 2004-2009, p. 4
\textsuperscript{15} http://www.unaids.org/en/geographical+area/by+country/namibia.asp, as of July 25, 2005
\textsuperscript{16} Ministry of Health and Social Services, Republic of Namibia: Report of the 2004 National HIV Sentinel Survey, p. 4
\end{flushleft}
the HIV-prevalence among sex workers, the national prevalence figure could presumably be considerably higher. Long-term charity worker in the township of Katutura, Father Hermann Klein-Hitpass, estimates that 75% of the sex workers in the townships are HIV-positive\textsuperscript{17}. This figure correlates with my own findings, where approximately 73% of the informants had tested positive for HIV.

Of new infections in Namibia, women account for more than 50%, a development coherent with a current global trend whereby more than half of people infected with HIV are women and girls. This is notable for a number of reasons. Firstly, when the HIV/AIDS epidemic first became known, men greatly outnumbered women among people newly infected. AIDS was initially a disease which mostly, though not exclusively, affected men who had sex with men. Later it branched out and spread among groups of intravenous drug users. In developed nations, it is still considered a low risk to contract the virus from a heterosexual partner, though this form of transmission is on the increase. By contrast, in the developing world the majority of newly infected people contract the virus through intercourse with a heterosexual partner\textsuperscript{18}.

Secondly, the trend whereby women and girls comprise the largest group newly infected with HIV is worth discussing because women are affected by HIV/AIDS in a variety of ways not applicable to men. For instance, women bear the largest burden in caring for family members who are sick with AIDS. This applies to women all over the world, young and old alike. UNAIDS (2004) argues that young girls may be forced to leave school to care for sick family members, or because the cost of school fees cannot be afforded by an AIDS-affected family already under great financial strain\textsuperscript{19}.

Older women bear the burden of care when their adult children become ill\textsuperscript{20}. In addition, they may have to become foster parents for orphaned children, even

\textsuperscript{17} Interview with Father Hermann Klein-Hitpass, April 19, 2005. This figure is based on information obtained by Father Hermann for the purpose of creating a data base of sex workers visiting the centre.


\textsuperscript{20} Ibid, p. 43
if they are not closely related. Younger women who become widowed through AIDS may lose entitlements to their property and land when their husbands pass away, even if inheritance legislation is in place to prevent it. As UNAIDS points out, widows are often responsible for producing food for their families and if it becomes impossible to manage alone, they may be forced to engage in sex work.

2.3 A THEORETICAL APPROACH TO HEALTH: THE DEVELOPMENT OF PUBLIC AND INTERNATIONAL HEALTH LAW

The right to health, Article 12 of the United Nations Covenant of Economic, Social and Cultural Rights (ICESCR), does not establish that people, to put it simply, have the right to be healthy\textsuperscript{21}. It does, however, state that people have the right to ‘the highest attainable state of health’\textsuperscript{22}, which is relative to several external factors (such as environment, heredity and health interventions). The concept of health is subjected to legal regulations, which are not always adherent with human rights norms. The process of legally regulating health has a longer history than the development of human rights, which means that public health law lacks references to individual rights\textsuperscript{23}. Public health law on a national level aims to reduce health risks, including preventing exposure to disease, and to improve the ability of individuals to cope with health risks.

Internationally, the development of public health legislation has been guided by national norms. Several international organisations deal with health issues, most notably the World Health Organisation (WHO). In addition, a number of United Nations instruments encompass aspects of health, such as social welfare or protection of the mentally ill\textsuperscript{24}. Recently, it has become apparent that in the development of public health law, a human rights approach is increasingly adopted, in particular regarding the AIDS pandemic. The impact of AIDS highlights the


\textsuperscript{22} Tomaševski, K., \textit{op. cit}, p. 125

\textsuperscript{23} Ibid.

\textsuperscript{24} Ibid, p. 127
importance of access to adequate health care. Simultaneously, however, it was not always certain that access to health care should be encompassed in the right to health. At the time of drafting the ICESCR, the WHO was reluctant to agree with the suggested obligation for governments to provide adequate health care for individuals. This, the WHO argued, would force governments to adhere to a particular method of providing health care, something that should be left for each government to decide. As a result, the WHO still refuses to acknowledge the individual right to access to health care \(^{25}\). Neither does this right enjoy global recognition, the reasons for which are twofold. Firstly, many governments are reluctant to make such large investments in health care as the realisation of equal access for all would require. Secondly, to ensure access to sufficient health care necessitates that many other development factors are fulfilled, such as basic sanitation, employment opportunities, and adequate housing \(^{26}\). Access to health care in itself is not enough to raise the general level of health among citizens. Tomaševski (1995) argues that ‘improvements in water and sanitation, nutrition, or housing, have been far more beneficial for the enhancement of health than curative, or preventative, health measures’ \(^{27}\). However, access to health care remains a vital component of the ability to live a healthy life. Human rights require governments to provide health care for its citizens, even in this day and age where we experience an increase in the privatisation of health care services \(^{28}\). This has the implication that health care is increasingly designed according to the competition of the market. In other words, the provision of health care services become to a larger extent a money-making venture, than a government’s obligation to ensure that individuals have access to adequate care. A system where one is required to pay for health care services consequently precludes those who cannot afford it. Tomaševski notes that such a system is incompatible with human rights norms, in which access to health care is included.

\(^{25}\) Tomaševski, K., *op. cit.*, p. 127

\(^{26}\) Ibid, p. 128

\(^{27}\) Ibid, p. 126

\(^{28}\) Ibid, p. 134
2.4 HIV/AIDS FROM A HUMAN RIGHTS PERSPECTIVE

That there is a connection between HIV/AIDS and human rights is established by UNAIDS (2004):

‘(…) the promotion and protection of human rights constitute an essential component in preventing transmission of HIV, reducing vulnerability to infection and the impact of HIV/AIDS’

However, this connection is multi-faceted and all its aspects need attention; the most important of which in this context is discrimination and stigma. The United Nations Office of the High Commissioner of Human Rights (OHCHR) states that people with HIV/AIDS are often stigmatised and thereby suffer discrimination. According to the Legal Assistance Centre (LAC), people living with HIV/AIDS (PLWHA) in Namibia face discrimination daily. They face rejection both at home and at their workplace, and suffer violations of their rights to freedom from discrimination. In addition, similar violations may diminish their access to adequate treatment, which means that they do not receive care and medication needed. In addition, fearing rejection from family and friends, people may avoid taking an HIV test, since they are not only concerned about their health, but also have to worry about future stigma and discrimination. This creates a vicious circle, whereby an HIV positive person who is unaware of his or her status but refuses to get tested, may infect others with the virus. An environment in which the right to freedom from discrimination is truly respected, therefore, enables for a greater control over how to stem the spread of HIV.

Discrimination and stigma also affect sex workers to a large extent. As UNAIDS (2004) points out, sex work is disapproved of in most societies. This has the

30 Legal Assistance Centre, 2002: Whose body?’, p. 177
unfortunate implication that epidemiological surveillance studies frequently ignore people engaged in sex work – despite that they may be more likely to be exposed to HIV infection\textsuperscript{32}. National HIV prevention efforts should therefore pay particular attention to sex workers, as well as to other groups in society who suffer from similar marginalisation (such as drug users and men who have sex with men). Since these behaviours are being frowned upon by a general population, people engaged in such acts are ostracised – which, from an HIV perspective, creates a dangerous situation. An increasing spread of HIV among marginalised groups, thereby ignored by national prevention efforts, will ensure that all such prevention efforts fail. The spread of HIV can thus not be stopped. UNAIDS establishes that only those prevention efforts which comprise monitoring of HIV-rates among marginalised groups, including sex workers, stand a good chance to create a truly effective response to the epidemic\textsuperscript{33}.

In Namibia, no official study has established the rate of HIV among sex workers. The Chief of Health Programs, Abner Xoagub, reports that their epidemiological surveillance studies base the study sample on pregnant women who attend antenatal clinics, people with other sexually transmitted diseases, as well as selected populations from different regions of the country. Effective though this system may be, it inevitably omits people engaged in sex work – especially those who live in desperate poverty, and who cannot afford to visit health clinics. It can therefore be concluded that despite extensive efforts to ensure that a human rights approach is adopted in the Namibian work against HIV/AIDS, clear violations of certain rights still occur on a daily basis. Sex workers operating in the townships, for instance, and then especially those who have tested positive for HIV, suffer from discrimination twice over: firstly because of their occupation, and secondly on the basis of their HIV-status. Some of my informants had experienced discrimination during visits to health clinics, and been treated badly by the nursing staff. One

\textsuperscript{32} UNAIDS, 2005: op. cit., p. 25

\textsuperscript{33} Ibid.
informant was shouted at by the nurses when it became known what she did for a living, another was denied to see a nurse at all.

Namibia joined the United Nations (UN) after gaining independence in 1990, and is therefore liable to adhere to Article 25 of the Universal Declaration of Human Rights (UNDHR):

> ‘Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services.’

As previously stated, article 12 of the ICESCR states everyone’s right to ‘... the highest attainable standard of health’. This particular choice of words becomes especially important in an HIV/AIDS context, since this disease requires constant monitoring and treatment. There is medication available for people with HIV, so called antiretroviral therapy (ART), which can prolong and normalise the life of the sufferer. However, in order to access this medication, HIV-positive people must have access to adequate treatment facilities. The terms ‘access’ and ‘accessibility’ have several dimensions, but will here primarily be regarded as meaning ‘physical accessibility’. A WHO clarification of the term states that ‘[h]ealth facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable and marginalised groups, such as (...) people with HIV/AIDS’. Lack of physical accessibility to treatment services for HIV/AIDS sufferers, therefore, constitutes a clear violation of a basic human right. The connection between the accessibility of HIV/AIDS treatment and human rights now becomes distinct; indeed, as the OHCHR points out: ‘human rights are inextricably linked with the spread and impact of HIV/AIDS’. When certain groups are denied

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34 [http://www.un.org/Overview/rights.html](http://www.un.org/Overview/rights.html), as of August 10, 2005 (emphasis added)


36 Ibid, p. 12

37 [http://www.ohchr.org/english/issues/hiv/introhiv.htm](http://www.ohchr.org/english/issues/hiv/introhiv.htm), as of September 1, 2005
full realisation of their basic human rights, they become increasingly vulnerable to contracting HIV/AIDS. For instance, individuals who are denied the right to education may not be able to gain vital information about how the HIV-virus is spread and what measures to take to protect oneself from infection. Violations of the right to education (Article 26 of the UNDH) therefore increase the likelihood that people who have been denied schooling become infected with HIV.

2.5 CHAPTER SUMMARY
This chapter has provided a background picture of human rights and HIV/AIDS. In particular, HIV/AIDS related rights were examined in a Namibian context. The chapter pointed out that although racial discrimination is illegal in Namibia since independence, segregation is still prevalent throughout the country. Most obvious does the discrepancy in life standard between the white and black population become in the townships, where an overwhelming majority of residents are black.

Current statistics on HIV/AIDS in Namibia were also revealed in this chapter. Data show that HIV-prevalence is on a slight decline, for the first time since start of the national surveys. However, it was also emphasised in the chapter that sex workers, as a group, were not specifically included in the national surveys, which given the high estimates of prevalence among them could mean that the national HIV-prevalence is higher than expected.

The last part of the chapter summarised the development of both public and international health law. It was highlighted that human rights obligations uphold that governments ensure that health care is available to all. However, the chapter also pointed out that the ability to access health care is in itself not enough to improve the general level of health among people; the provision of other factors such as proper sanitation and adequate housing are also of importance.

3. PROSTITUTION IN A NAMIBIAN CONTEXT
In this chapter, previous research on sex work and HIV/AIDS will be discussed, both in general and in the Namibian context. Data from the 2000 Namibian Demographic and Health Survey (NDHS) is presented. In addition, prostitution in Namibia will be
examined through a look at current law and legislation. Lastly, this chapter presents the findings of the fieldwork study conducted in preparation for this thesis.

3.1 PREVIOUS RESEARCH ON SEX WORK AND HIV/AIDS
The links between the spread of HIV and sex work are poorly researched in a Namibian context. This fact has implicated my research to the extent that there is only one other Namibian study with which to compare my own findings. That study was published by the Legal Assistance Centre (LAC) in Windhoek in 2002, and so far comprises the only comprehensive research on sex work in Namibia. The LAC study was undertaken to produce an overall picture of sex work in the country, and its sample group originates from rural as well as urban areas. It does not deal with any specific group of sex workers; neither does it concentrate solely on HIV/AIDS issues. As an integrated study of prostitution and HIV/AIDS in Namibia, this thesis is therefore the first of its kind.

McKeganey and Barnard (1996) argue that ‘(p)rostitution and AIDS make a volatile mix, combining our interest in sex with our fear of illness and death’39. Given the ways the virus is spread, studying HIV/AIDS in the context of prostitution is necessary for treatment and prevention purposes. Prostitution has been on the public health agenda since the HIV/AIDS first emerged40. Prostitutes, traditionally portrayed as carriers of sexually transmitted diseases, have since the onset of the AIDS epidemic become accused of spreading the HIV virus as well. In a Namibian context, this has had the direct implication that legislation aiming to combat prostitution is wrongly regarded as also being able to reduce the risk of HIV transmission41.

38 Please refer to: Legal Assistance Centre, 2002: Whose body is it? Commercial sex work and the law in Namibia, Windhoek, LAC.


40 Ibid.

41 Legal Assistance Centre, 2002: Whose body?, p. 175
Undeniable links exist between sex work and the transmission of HIV/AIDS. In order to fully understand the linkages in a Namibian context, a few facts need mentioning.

Firstly, the vast majority of sex workers in Namibia are women; and women suffer a greater risk of contracting the HIV virus from men than vice versa. Biological differences between female and male genitalia (due to the larger areas of vulnerable tissue found in the vagina) ensures that the risk of becoming infected with HIV is 2-4 times higher for women than for men. In other words, male-to-female transmission is much more common than female-to-male. Women are also more vulnerable to other sexually transmitted diseases (STDs), which, if left untreated, increase the risk of contracting HIV. Contrary to popular belief, therefore, a (female) sex worker suffer an enhanced risk of becoming infected with HIV from a (male) client, than he does to contract the virus from her.

Secondly, other studies conducted in various African countries have concluded that HIV-prevalence is by no means higher among sex workers than among the general population. Though this study has found that HIV-prevalence among sex workers in Katutura is more than three times higher than the national average, the LAC points out that ‘there is no reliable evidence that sex workers are any more likely to be infected with HIV than other segments of the population’. Although no specific pattern has been identified in how high the HIV-prevalence is among prostitutes, McKeeganey and Barnard argue that the highest prevalence levels ever recorded have been found among prostitutes in some African countries, compared to levels among the general population. McKeeganey and Barnard mention the example of Kenya, where a 1991 study discovered that HIV-prevalence rates were more than twice as high among sex workers, than among other women.

42 Legal Assistance Centre, 2002: op. cit, p. 175
43 Ibid.
44 Ibid, p. 178
45 Ibid.
46 McKeeganey and Barnard, 1996: op.cit., p. 58-59
tested\textsuperscript{47}. Interestingly, a similar conclusion can be made from studying the prostitutes in Windhoek, where some estimates put HIV-prevalence at 75\%, or more than three times higher than the national average\textsuperscript{48}.

The method of testing sex workers for HIV/AIDS constitutes a vital aspect of monitoring the spread of new infections; however, this is not suggestive of theories that HIV is commonly found among prostitutes anywhere. Due to the nature of prostitution, and the fact that HIV in Africa is for the most part sexually transmitted, it is important to create a clear picture of how high prevalence levels among sex workers are. It should, though, be emphasised, that the studies reported by McKeganey and Barnard show that in some African and Asian countries, HIV-prevalence is lower among sex workers than indicated by the national average\textsuperscript{49}. Despite the topic being considered sensitive, which makes obtaining accurate information all the more difficult, McKeganey and Barnard argue that generally, low HIV-prevalence among sex workers means that condoms are used extensively. Other less researched theories have speculated that lower levels of prevalence indicate that some people (whether engaged in sex work or not) may be less likely or resistant to acquire infection, but we still lack sufficient evidence to know this to be true\textsuperscript{50}. With the evidence available to us today, it can be concluded that extensive condom use equals lower HIV-prevalence among sex workers in most contexts. The reasons why this is not always the case are varied; however, they remain irrelevant for the outcomes of this thesis, and will not be discussed further.

Simultaneously, however, various studies in other countries have shown that sex workers use condoms more consistently than other groups of similar age, race and sex. As the LAC study of sex workers in Namibia concludes, more than 67\% of respondents claimed to use condoms with clients, while only 28\% regularly used

\textsuperscript{47} McKeganey and Barnard, 1996: \textit{op cit}, p. 58-59

\textsuperscript{48} Interview with Father Hermann Klein-Hitpass, April 19, 2005

\textsuperscript{49} McKeganey and Barnard, 1996: \textit{op. cit}, p. 63

\textsuperscript{50} Ibid, p. 60
condoms with partners. It therefore seems more likely that these women may contract the HIV virus from a regular partner than from a client.

3.1.1 The 2000 Namibian Demographic and Health Survey (NDHS)

Statistics show that in Namibia, awareness of AIDS and knowledge about how to prevent infection is almost universal. In the 2000 Namibian Demographic and Health Survey, over 80% of both male and female respondents cited condoms as an effective means to avoid becoming infected with HIV. The second most cited means to avoid HIV was to have only one sexual partner, with over almost 29% of men and 31% of women listing this as an effective method.

The survey also showed that HIV/AIDS knowledge varied according to the level of education completed by respondents. More extensive knowledge of HIV/AIDS was attained by those who had reached a higher level of education. Similar patterns of knowledge were found among my informants, all of whom cited that they first learned about HIV/AIDS at school. The majority of informants had gained a deeper understanding of HIV/AIDS at the centre where they had their weekly gatherings, in particular about the importance of regular condom use. However, many informants were unsure of the variety of ways in which the virus is spread. For instance, though aware that HIV is sexually transmittable, many claimed not to know about mother-to-child transmission (MTCT). Through pregnancy, childbirth and breastfeeding an infected woman can pass the virus on to her child; however, this can be avoided, for instance through the replacement of breast milk for infant formula. When asked about MTCT, most of the informants stated that they had not previously been informed about it. Interestingly, the NDHS shows that 86% of respondents were aware of MTCT, though a lesser percentage knew that the virus can be transmitted through breastfeeding. An obvious discrepancy therefore exists

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51 Legal Assistance Centre: Whose body?, p. 178

52 Ministry of Health and Social Services (MoHSS), 2000: The Namibian Demographic and Health Survey (NDHS), p. 155-156

53 Ibid, p. 156

54 Ibid, p. 159
here, where the knowledge about HIV/AIDS among my informants is much less extensive than among the NDHS respondents (who were selected to represent the entire Namibian population).

Several other aspects of HIV/AIDS knowledge revealed in the NDHS are of interest in this context. For instance, the survey showed that 25% of male respondents argued that a woman did not have the right to tell a man to use a condom. Presumably, this is applicable in any sexual relation, and not dependent on whether or not the woman in question is being paid for sex. In a nation so severely affected by the AIDS epidemic, this figure is worrying – especially since condoms remain the most effective way to prevent infection.

3.1.2 Prostitution or sex work?

The ‘traditional’ term used to describe someone who sells his or her body for money is ‘prostitute’. However, the expression ‘sex worker’ is also used extensively. This issue is complex, since no definition of the term prostitution has to date been accepted internationally. The term itself derives from the Latin word for ‘stand’, referring to the practice of publicly standing around to attract and solicit clients. Modern definitions of prostitution offer a wide description of what has been called the world’s oldest profession, and include the exchange of money, the power of command over someone’s body by another person, and the use of someone’s body as a commodity to be bought and sold.

In the literature, prostitution is just as often referred to as ‘sex work’. This much broader term was coined in the 1970s and is often favoured because it recognises prostitution as a form of labour. Thereby it establishes that sex work is an activity, rather than an identity. Additionally, less attention is paid to moral

55 Ministry of Health and Social Services (MoHSS), 2000: op. cit., p. 180
56 Legal Assistance Centre, 2002: Whose body?, p. 1
57 Ibid.
58 Ibid, p. 3
judgements. Often, it is preferred to use the term sex work in a legal context, as it can be argued that it constitutes work as any other\textsuperscript{59}.

\subsection*{3.2 PROSTITUTION IN NAMIBIA}

As previously mentioned, astonishingly few studies have been undertaken concerning prostitution in Namibia. As a direct result of this, the UNAIDS/WHO Epidemiological Fact Sheet (2004 Update) completely lacks figures on HIV-prevalence among prostitutes in Namibia. Rao, Gupta and Jana (2000) argue that the difficulty in obtaining accurate data on sex work it is due to its illegal status, which has lead to a general lack of studies regarding sex work and HIV/AIDS\textsuperscript{60}. Simultaneously, however, plenty of studies have over the last two decades emerged which cover various topics related to HIV/AIDS, making it even more obvious that the links between sex work and HIV/AIDS are poorly researched. Considering the consensus that commercial sex work comprises a central part of the spread of HIV in the developing world\textsuperscript{61}, this absence of related research is worrying.

This thesis deals exclusively with women who have ‘chosen’ to become prostitutes because no other option of earning money is available to them. Among my informants there was never a ‘choice’ to be made: poverty and an obligation to provide for family members (in most cases children) have driven these women to earn their money from transactional sex. In this sense, ‘prostitution’ has become ‘survival sex’. Without exception, all my informants stated that they had become prostitutes out of sheer desperation, and that they would prefer to earn their money by some other means. A lucky few did have other sources of income, mostly from doing light housework for other families in the area, but the overwhelming majority would be left completely destitute had they not gone to the streets.

\textsuperscript{59} Legal Assistance Centre, 2002: op.cit, p. 3


\textsuperscript{61} Legal Assistance Centre, 2002: op. cit, p. 3
Findings of the LAC study from 2002 confirm that ‘(t)here seem to be almost no sex workers in Namibia who have chosen the job freely’\(^\text{62}\). Similar conclusions have been drawn from studies undertaken in Thailand, whereby the major reason for entering sex work was poverty\(^\text{63}\). The Thailand study also argues that women bear a great economic burden and are often responsible for providing for family members. An Indian study from 1992 shows similar findings, where 49% of respondents had entered sex work due to poverty\(^\text{64}\). What emerges from this simple analysis is a picture of where, no matter where in the world, acute poverty may therefore force women into prostitution.

In a Namibian context, Ipinge and LeBeau (2004) identify two forms of prostitution: exchange sex work and classic sex work\(^\text{65}\). Exchange sex work refers to the practice of receiving gifts in return for sexual favours, whereas classic sex work is defined as sexual acts carried out solely for the purpose of receiving a monetary payment. In Namibia, exchange sex work is the most common form of prostitution. However, both forms of prostitution occur regularly and involve both women, children, and, to a lesser extent, men. The existence of exchange sex work is highlighted by the ‘sugar daddy’ phenomenon, which involves a sexual relationship between a young girl, often of school age, and an older man. In return for sexual favours, the man provides the girl with material rewards. Though the sugar daddy concept is not unique for Namibia, it is recognised as a common form of prostitution. Talavera (2002) argues that the sugar daddy phenomenon is ‘directly linked to socio-economic

\(^{62}\) Legal Assistance Centre, 2002: op. cit, p. 185


\(^{64}\) Rao, V., Gupta, I., and Jana, S., 2000: Sex Workers and the Cost of Safe Sex: The Compensating Differential for Condom Use in Calcutta, p. 5

\(^{65}\) Ipinge, E., and LeBeau, D., 2004: Beyond Inequalities: Women in Namibia, received electronically from author, p. 51
opportunity\textsuperscript{66}, meaning that it is more commonly found among girls from poorer backgrounds. Their poverty makes them particularly vulnerable and receptive to efforts by older men to sway them. For the girls, a situation is created whereby they perceive sex as a tool to access material goods\textsuperscript{67}. These girls later risk getting involved in ‘traditional’ sex work, if they have become familiar with a lifestyle provided for them by the sugar daddy, which they do not wish to leave. In order to maintain this lifestyle, and in particular since their attitude towards sex is already altered to the point where they become aware of how to use sex to attain rewards, they may become engaged in sex work.

Issues of power are also of relevance here. A girl involved with a sugar daddy is immediately subject to unequal power relations, where the man, being older and the one who provides the rewards, inevitably is in possession of power. Thereby the girl is accustomed to situations, in particular in sexual relationships, where she has limited possibilities to voice her own wishes. Sexual relations in a sugar daddy relationship and in a ‘traditional’ sex work transaction may therefore be experienced as similar, wherein the girl has little or no say. In an HIV/AIDS context, this becomes particularly problematic since it may hinder that condoms are used consistently.

3.2.1 Prostitution and the law in Namibia

Though it may not be highly relevant for the conclusion of this thesis whether or not Namibian legislation allows prostitution, this brief overview of the legal status of sex work has been included for the purpose of providing a general picture of prostitution in Namibia. By no means does this thesis aim to provide an analysis of the legal instruments covering prostitution in Namibia. It should also be emphasised that this thesis is concerned only with prostitutes living and working in the townships, where, presumably, police presence is less prevalent than in the city. The 2002 study


\textsuperscript{67} Ibid, p. 69
conducted by the Legal Assistance Centre concerning sex work in Namibia reports that police brutality has been encountered by many prostitutes, though among my informants this figure appeared to be quite low.

No Namibian law makes it illegal *per se* to engage in sexual acts for monetary rewards. However, a number of legal instruments exist for the purpose of criminalising prostitution. The most important of these is the Combating of Immoral Principles Act (Act 21 of 1980), which covers various aspects of sex work. For instance, the Immoral Principles Act makes it illegal to ‘knowingly live wholly or in part on the earnings of prostitution’ and to ‘become a prostitute’\(^{68}\). It is also illegal by common law to commit acts of sodomy, which particularly affects male sex workers.

Prostitution is also covered by the Combating of Rape Act (Act 8 of 2000), which establishes that all forms of obvious coerced sex are illegal. Rape is also committed if the act involves a person under the age of 14, and a person more than three years older. This applies to transactional sex as well, meaning that anyone who is seventeen years or older and who buys sex from a person below 14 years of age is automatically guilty of rape\(^{69}\). Clearly, one of the purposes of the Rape Act is to combat child prostitution; however, the LAC argues that it would be difficult, if not impossible, to find a complainant in a rape case. If both client and prostitute have agreed to transactional sex, the fact that their respective ages establishes their sexual encounter as rape will not alone make anyone press charges. Among my informants no one was as young as 14, though some of them spoke of being raped (by clients as well as family members). Two of the informants had become pregnant as a result of rape, and one had given birth to a child who now suffers from post-natal AIDS. None of the informants who had been forced to have sex with clients had considered informing the police. Only one informant, who was raped by her stepfather when she was still a teenager, pressed charges against her assailant, which resulted in him being jailed.

\(^{68}\) Legal Assistance Centre, 2002: *Whose body?*, p. 62

\(^{69}\) Ibid, p. 67
3.3 FIELDWORK FINDINGS

3.3.1 The sample group

Given the difficult circumstances under which sex workers operate, and the varying life situations they are in, it would be a mission impossible to obtain a study sample which would be representative of all sex workers in Namibia – in particular since it is not known exactly how many sex workers operate in the country. It should therefore be emphasised that this study does not claim to be representative of sex workers in Namibia in general. Its focus lies solely with sex workers originating from, and operating within, the township of Katutura, on the outskirts of Windhoek. This study sample was chosen mainly for reasons of accessibility, as I soon after my arrival in Windhoek made contact with my informants. It also became apparent that these sex workers had very limited access to HIV/AIDS treatment, which, given the initial focus of my research, made them an interesting sample group.

Great demographic diversity exists among sex workers in Namibia, for the most part depending on their place of residence and their clientele. However, the prostitutes originating from Katutura are among the poorest of the poor. For instance, a sex worker operating in central Windhoek can charge up to N$300 for one sex act, whereas it is common that as little as N$10 is charged by a sex worker in the townships.

For purposes of confidentiality, only information that cannot be traced back to the informants is omitted here. The age span of the informant group is 20 to 55 years old, however, as the majority of the informants possessed similar levels of knowledge, their individual ages are not relevant to the outcomes of the study. An overwhelming majority of commercial sex workers in Namibia are women who practice heterosexual sex. The 2002 study made by the Legal Assistance Centre (LAC), found that 94% of sex workers were women. The vast majority,

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70 Legal Assistance Centre, 2002: Whose body?, p. 75

71 The Namibian dollar is tied to the South African Rand (ZAR). One Swedish Krona was in August 2005 valued at approximately 0.82 ZAR. All prices will in the text be quoted in Namibian dollars.

72 Legal Assistance Centre, 2002: op. cit, p. 75
92.2% of sex workers regarded themselves as heterosexual\textsuperscript{73}. Accordingly, among my sample group of fifteen informants only one was male, and he was alone in the group to practice homosexual sex.

In regards to the level of highest education, the findings of the LAC study also corresponded well with my own. The LAC found that more than 80% of respondents had attended some level of secondary school\textsuperscript{74}, whereas all my informants had done so. As LAC concludes, it would be misleading to think that attending secondary school guarantees that a job can be secured after graduation. Clearly this is not so, as Namibia has an unemployment rate of 35%\textsuperscript{75}. In fact, the only work the respondents could find were unskilled labour (domestic work, waitressing), and even these jobs were few and far between. In other words, even the respondents who had a satisfactory level of schooling found themselves forced into sex work in absence of other means to make a living.

Out of my sample group, all the informants had dependents, a conclusion which is confirmed by the LAC study findings (78% of LAC respondents had dependents of various kinds\textsuperscript{76}). Most of these dependents consisted of children of the informants; however, commonly they would also support other relatives such as parents and siblings. Of my informants, only two did not have children of their own; they were instead responsible for the care of their mothers and brothers.

The informants’ overall level of knowledge of HIV/AIDS was in general incomplete and unsatisfactory. For instance, one informant expressed confusion and surprise that she was not prescribed antiretroviral treatment immediately after testing positive for HIV\textsuperscript{77}. Many informants were also unsure of where to go to receive treatment, though most of them knew that several clinics and a state hospital can be

\textsuperscript{73} Legal Assistance Centre, 2002: \textit{op. cit}, p. 79

\textsuperscript{74} Ibid, p. 80

\textsuperscript{75} \url{http://www.unaids.org/en/geographical+area/by+country/namibia.asp}, as of July 25, 2005

\textsuperscript{76} Legal Assistance Centre, 2002: \textit{op. cit}, p. 81

\textsuperscript{77} Antiretrovirals (ARVs) are in Namibia prescribed only once the patient shows one or more symptoms of AIDS. The purpose of ARVs is to slow down the rate of infection spreading in the body.
found in the Katutura area. Three out of fifteen informants currently received treatment with ARVs, and these three were the only ones who knew exactly where to get medication from and how much it cost. However, their biggest complaint was that they did not have enough food to eat and that as a result, the medication made them feel weak and ill. Another woman claimed to suffer from AIDS-related symptoms, but that she was unable to afford treatment. It seemed that unless directly affected by HIV/AIDS, either personally or through a family member who was positive, the informants had attained very low levels of knowledge about it.

3.3.2 HIV-status and condom use among the informants

HIV-prevalence among Windhoek sex workers is frighteningly high. Among my informants prevalence was more than 70%, a figure more than three times as high than the national average. Almost all informants who had not previously been tested for HIV knew where to go for a test, a conclusion which is confirmed by the Namibian Demographic and Health Survey (NDHS). Among NDHS respondents, 73% of untested women knew where HIV-tests were carried out\(^{78}\). Those among my informants who had been tested had done this during a pregnancy, when the test is automatically carried out for free.

Tested or not, most of the informants were unsure of how much an HIV-test costs. That they were unaware that they could get tested even if they did not have money was obvious, because those who did know the exact price also mentioned that it was too expensive for them. Time and again, the informants repeated that other expenses were prioritised, such as food, clothing and school fees. This applied also for the prices of antiretroviral therapy (ART). Not one of the informants knew that ART is supplied free of charge once a proof of HIV-status is obtained and a medication plan is designed\(^{79}\).

Four of the informants claimed that they ‘always’ used condoms with their clients. Among these only the male sex worker said he could insist on using condoms with every client. If the client refused, the informant would walk away.

\(^{78}\) Ministry of Health and Social Services, 2000: *The Namibian Demographic and Health Survey*, p. 168

\(^{79}\) For details, please refer to section 4.1: *The National AIDS Control Programme*
from the deal, no matter how much money was on offer. However, the remaining three informants who maintained that condoms were used on every occasion of a sexual transaction did not reinforce their claim in such a convincing manner. This may be because a man could find it easier to negotiate condom use with a (male) client. Many of the female informants, by contrast, stated that they would attempt to use a condom with every client, but as they were offered more money for unprotected sex, often agreed not to use one. The vulnerability of these women becomes especially apparent in this situation. The offer of an increased fee can become irresistible to a woman who has not eaten properly for days and has hungry children waiting for her at home. Several informants simply shrugged their shoulders and said that it was impossible to use condoms on every occasion - it often seemed as if they were tempted to give up trying.

3.4 CHAPTER SUMMARY
The focus of this chapter has been prostitution in Namibia. It has been argued that a lack of research exists regarding the connection between the spread of HIV and sex work in Namibia, which is unfortunate given the ways in which HIV is transmitted, in combination with the nature of sex work. A number of aspects of these connections were discussed. For example, the chapter pointed out that women suffer a greater risk than men to become infected with HIV; and that the majority of Namibian sex workers are indeed women. Another point in question was the argument by McKeeganey and Barnard (1996) that no global pattern has emerged whereby higher HIV-prevalence levels are found among sex workers, in comparison to the general population. It should therefore not be assumed that groups of prostitutes are found to be more likely to become infected with HIV.

This chapter also summarised the findings of the Namibian Demographic and Health Survey (NDHS). The survey showed that awareness of AIDS is almost universal in Namibia and that knowledge about how to prevent infection is extensive. It was also revealed that knowledge of HIV/AIDS often reflected the level of education the respondent had completed, something that was
confirmed by my own study findings. Among my informants, almost their entire knowledge about HIV/AIDS was acquired at school.

A discussion of the terms ‘prostitute’ and ‘sex worker’ were also included in this chapter. Historically, the term ‘prostitute’ has been utilised universally, but ‘sex worker’ is now used extensively. In a Namibian context, two forms of prostitution were identified and discussed, where what Ipinge and LeBeau (2004) call ‘exchange sex work’ is more common. Included in this part of the chapter was also a summary of the legal status of prostitution in Namibia, where the Combating of Immoral Principles Act (Act 21 of 1980) is the most important.

In its last part, this chapter discussed the findings of the fieldwork study. It was argued that all informants who took part in the study had become sex workers out of desperate poverty. They all had dependents, for the most part children, whom they were obliged to support financially. It was revealed that the informant group had an HIV-prevalence of over 70%, and that many of them had difficulty in using condoms with every client.

4. HUMAN RIGHTS AND THE NACOP

The National AIDS Control Programme (NACOP) is presented and discussed in this chapter. Different dimensions of human rights related to HIV/AIDS, such as the right to health and the right to education, will also been looked at. In addition, health care in Katutura is examined.

The thesis has so far argued that violations of basic human rights facilitate the spread of HIV/AIDS. It is therefore relevant to examine these rights in a Namibian context.

The Namibian national response to the AIDS epidemic has to a large extent been developed according to provisions set forth in Chapter 3 of the Constitution. This chapter ensures the protection of fundamental rights and freedoms of Namibians, including those living with HIV/AIDS. In particular, the chapter upholds that the dignity of all individuals should be ensured, and that they

80 http://www.grnnet.gov.na/Nam_Nutshell/Constitution/Const/chapter_3.htm, as of September 1, 2005
should enjoy freedom from discrimination\textsuperscript{81}. Moreover, the right to privacy is mentioned, which in an HIV/AIDS context involves the opportunity to take an HIV test only with informed consent, as well as ensuring that a person’s HIV status is not disclosed to someone else. In principle, therefore, every Namibian is guaranteed constitutional protection of their rights to dignity, equality, privacy and freedom from discrimination; regardless of their HIV-status.

However, while the Namibian Constitution establishes the protection of several AIDS-related rights, it does not make provision for a basic right to health\textsuperscript{82}. The closest constitutional guarantee to a right to health is Article 95, which reads ‘(…) consistent planning to raise and maintain an acceptable level of nutrition and standard of living of the Namibian people and to improve public health’\textsuperscript{83}. In addition, Namibia had signed the ICESCR and is, therefore, obliged to uphold the right to the highest possible standard of health for its citizens.

In their 2002 study, the LAC notes that Namibian policies have established that the promotion and protection of human rights are both fundamental aspects in the fight against HIV/AIDS\textsuperscript{84}. The LAC writes that ‘(t)he protection and promotion of human rights are necessary both to the preservation of inherent dignity of persons affected by HIV/AIDS and to the achievement of public health goals of reducing vulnerability to HIV infection, lessening the adverse impact of HIV/AIDS on those affected and empowering individuals and communities to respond to HIV/AIDS’\textsuperscript{85}. When the LAC in 2000 created ‘The Namibian HIV/AIDS Charter of Rights’, a document listing all human rights contextually relevant to HIV/AIDS, government ministries were involved in the consultative process. In addition, the 2004-2009 ‘National Strategic Plan on HIV/AIDS’ (MTP III), published by the MoHSS, lists various documents which are relevant in the struggle against

\textsuperscript{81} Legal Assistance Centre, 2002: \textit{Whose body?}, p. 176

\textsuperscript{82} Ibid.

\textsuperscript{83} Legal Assistance Centre, 2002: \textit{op. cit.}, p. 176; see also http://www.grnnet.gov.na/Nam_Nutshell/Constitution/Const/chapter_11.htm, as of September 1, 2005

\textsuperscript{84} Legal Assistance Centre, 2002: \textit{op. cit.}, p. 177

\textsuperscript{85} Ibid.
HIV/AIDS. Included in this list is the Bill of Rights in the Namibian Constitution and the before mentioned HIV/AIDS Charter of Rights. In other words, the Namibian government is well aware of the crucial links between human rights and HIV/AIDS and the importance of creating an environment in which rights are respected and ensured.

Another highly relevant human right to examine in a Namibian HIV/AIDS context is the right to education (Article 26 of the Universal Declaration of Human Rights):

‘Everyone has the right to education. Education shall be free, at least at the elementary and fundamental stages. Elementary education shall be compulsory.’\(^{86}\)

However, basic education is not free in Namibia. Without exception, all of my informants who had children of school age complained that they were often unable to pay school fees. Though fees vary from school to school, one primary school in the township of Babylon (not far from Katutura) charged N$120 per child per term. Note that many of my informants had more than one child, which inevitably increased the burden of paying school fees. Some informants had taken their older children out of school simply because they were unable to pay the fees. These children were often young teenagers who were now left with little or no opportunity to find work. In a long-term perspective, they became stuck in a cycle of poverty.

In 1997, about 89\% of Namibian children between the ages of six and sixteen were enrolled in primary or secondary education\(^ {87}\). In other words, about one in ten children did not attend school at all – despite the pledge by the Ministry of Basic Education, Sport and Culture (MBESC) that a policy of ‘Education for All’ is advocated\(^ {88}\). The right to education is therefore violated twice over – first because

\(^{86}\) http://www.un.org/Overview/rights.html, as of August 10, 2005 (emphasis added)

\(^{87}\) http://www.op.gov.na/Decade_peace/b_edu.htm, as of September 1, 2005

education is not free, and secondly because thousands of children were not attending school, despite that the UNDHR declares that school should be compulsory. Moreover, the Namibian Constitution establishes that state-run primary education should be provided free of charge\textsuperscript{89}. Despite this, several of my informants cited that they were forced to pay school fees for their children, no matter how destitute they were\textsuperscript{90}. One woman told of an episode where she had personally approached the head master of the school her two sons attended, in hope to get the school fees for that term waived. Her request was denied at the time, but she was eventually able to pay the fees with assistance from the Catholic Church charity centre.

UNAIDS (2004) reports that the inability to pay school fees is the primary reasons why children in all parts of the world are denied basic education\textsuperscript{91}. This causes particular implications for households already under great financial stress due to AIDS, since many are simply unable to afford sending their children to school. Fuelled by poverty, in a long-term perspective, this creates a dangerous downward spiral. Families who cannot pay school fees are forced to raise children who without education lack necessary knowledge about HIV/AIDS. The children face a bleak future where it is difficult, if not impossible, to find a job and earn an income. Growing up under these circumstances, the children become increasingly vulnerable to HIV and many of them will in all likelihood get infected.

The right to education in the UNDHR states that school, at least in its ‘elementary and fundamental stages’\textsuperscript{92}, should be free and compulsory. However, when this right is violated and people cannot afford to attend school, they lose out on more than an opportunity to gain an education and, later, a job. In countries hard-hit by the AIDS epidemic, people who do not complete school are also at risk of being ill-informed of HIV and how to prevent infection. In addition, lacking an education

\textsuperscript{89} Mutorwa, J., 2004: \textit{Access to Education}, p. 11; see also \url{http://www.grnet.gov.na/Nam_Nutshell/Constitution/Const/chapter_3.htm}, as of September 1, 2005

\textsuperscript{90} Father Hermann Klein-Hitpass confirmed that payment of school fees created an unbearable burden for these women, particularly for those who were HIV-positive and in need of money for treatment


\textsuperscript{92} \url{http://www.un.org/Overview/rights.html}, as of August 10, 2005
and the possibility of securing a job can force people to engage in sex work. This is especially true for women, who are often burdened with responsibilities for their children, siblings, or other family members.

Moreover, this study found that a majority of informants first learned about HIV/AIDS, and its prevention, at school. Many of them made a point to tell me for how many years they had attended school, as long schooling was a source of pride. And though many of them had attended school for several years, only a couple had completed year ten (basic secondary education). All of the informants had left school when their families no longer could afford to pay school fees, and none had attended tertiary education. As previously mentioned, their general knowledge about HIV/AIDS was therefore often inadequate.

Since women now account for more than half of new HIV-infections globally, it is significant that a gender perspective is applied to any study of the HIV/AIDS epidemic. Women often become increasingly vulnerable since they traditionally have a more limited access to economic resources than men\textsuperscript{93}. Thus women are dependent on men for access to such resources, which are vital to their survival. Increased poverty and/or the inability to individually become economically self-sufficient may therefore force women into sex work.

4.1 THE NATIONAL AIDS CONTROL PROGRAMME (NACOP)

Four years after the first reported AIDS cases in Namibia, the National AIDS Control Programme (NACOP) was set up in 1990. Its aims are to increase awareness of HIV/AIDS, create prevention programs, and provide treatment for those affected. Every five years a strategic plan is published, which establishes goals and provides incentives for the national HIV/AIDS struggle. The current plan, the National Strategic Plan on HIV/AIDS: Third Medium Term Plan (MTP III) 2004-2009, was released last year.

\textsuperscript{93} Legal Assistance Centre, 2002: \textit{Whose body?}, p. 177
According to the NACOP, an HIV-test costs N$10 for those who can afford it, for those who cannot it will be carried out for free. For township dwellers, the test can be carried out in different locations in Katutura: the Katutura State Hospital (KSH) or any of the community clinics. Namibia provides antiretroviral treatment (ART) free of charge for its HIV-positive population, on the condition that the patient lives up to certain criteria\textsuperscript{94}. Among these are:

1) The patient must show at least one major symptom of an AIDS infection, and the CD4 count must have fallen below 300\textsuperscript{95}.

2) The patient must have a home address where he or she will be living for more than six months. It is also advised that the patient has the support of family members to go through with the treatment as recommended.

A treatment plan will then be developed with the patient, his or her family members, and a medical team. The plan includes drug education, counselling and a follow-up programme to monitor the progress of the patient\textsuperscript{96}. According to the MoHSS, 17000 Namibians will by the end of the year 2005 be on ARVs.

It is encouraging to note that Namibia aims to provide treatment for HIV/AIDS patients for free. However, imposing required criteria of this kind on patients may have the unwanted consequence that not all AIDS affected people can be encompassed by the treatment program. It should be emphasised that most countries require the patient to fulfil some criteria, no matter what type of disease treatment is being sought. Nevertheless, efforts should be made to ensure that all patients are still

\textsuperscript{94} Interview via email with the Chief of Health Programs at the MoHSS, Abner Xoagub, July 11, 2005

\textsuperscript{95} The so-called CD4 cells are found in the lymphocytes. Measuring the number of CD4 cells in the body is a way to evaluate the progression of an HIV infection. The lesser the number of CD4 cells, the greater the damage on the immune system. Thus a lesser number of cells can indicate if the infection has developed into AIDS.

\textsuperscript{96} Interview via email with Abner Xoagub, July 11, 2005
able to access treatment. In Sweden, for instance, antiretroviral therapy (ART) is prescribed to a patient almost immediately following an HIV-positive diagnosis\textsuperscript{97}; there is no need to wait until symptoms of AIDS begin to appear.

In addition, the second requirement set by the NACOP may have unfortunate implications for people who live in poverty. Though the townships are equipped with street names and the possibility of providing a proper address is valid, for many individuals it is not that simple. Several of my informants had no permanent address, and whilst none of them slept on the streets, they completely lacked the ability to own or rent property. As a result, it was common among my informants to live with relatives or friends, and some of them frequently moved around. One informant even slept at different houses every night.

It is of course important to emphasise that a comparison between Sweden and Namibia is slightly unfair, on the basis of the respective wealth of each country. Interestingly, though, this brief analysis shows that poverty aspects become obvious even on a national level. The inability to provide ART to all individuals soon after they have tested positive for HIV may be indicative of a general/national level of poverty, which could, if eradicated, contribute to an improvement of the national AIDS response. In other words, the obliteration of poverty would enhance the lives of people living with HIV/AIDS on more than an individual level, as they would become the benefactors of an AIDS programme of greater proportions.

\subsection{4.1.1 Health care facilities in Katutura}

Though traditional medicine is still widely practiced in the township of Katutura, only medical doctors within the Western system of medicine are recognised by Namibian legislation\textsuperscript{98}. This means that only Western practitioners are allowed to work at the state-run hospitals and clinics; and also that all current and available research on HIV/AIDS-related health care is Western orientated. The Ministry of

\textsuperscript{97} \url{http://www.rfsl.se/?p=1395}, as of August 11, 2005

\textsuperscript{98} LeBeau, D., 2003: \textit{Dealing with disorder: Traditional and Western medicine in Katutura (Namibia)}, Köln: Rüdiger Köppe Verlag, p. 45
Health and Social Services (MoHSS) have organised workshops to implement knowledge of traditional healing in the National AIDS Control Programme (NACOP), however, the emphasis within the NACOP is on Western medicine. For these reasons, this thesis will discuss only the Western health care options available to Katutura residents, though at the same time recognising the importance of traditional medicine.

The Namibian Ministry of Health and Social Services (MoHSS) writes in the 2000 survey report: ‘Access to health care is a basic indicator of the quality of life. (…) An important aspect of the accessibility to health care services is cost. Services that are too expensive become unavailable.’\(^99\) Though positive that the MoHSS recognises that access to health care is vital to the general wellbeing of the population, far from everyone enjoys easy accessibility to a health care facility. Indeed, statistics from the 2000 Namibian Demographic and Health Survey (NDHS) show that only about 25% of the population live within a ten kilometre radius of a government health facility\(^100\). More than half Namibians live within 20 kilometres of a health care facility, even if in most cases this means a smaller clinic rather than a hospital. Hospitals are in general less accessible in rural regions than in urban areas.

Two hospitals and a number of community clinics are available to Katutura residents, all of which are state-run\(^101\). Located a few kilometres from the city of Windhoek, the Katutura State Hospital (KSH) is the closest hospital facility to township residents. A visit here costs N$12. The same charge applies for a visit at the community clinic. The clinics are scattered around the Katutura area and aims to treat patients with minor ailments. It is also possible to have an HIV-test at the one of the community clinics.

\(^99\) Ministry of Health and Social Services (MoHSS), 2000: Namibian Demographic and Health Survey (NDHS), p. 185

\(^100\) Ibid.

\(^101\) Ibid, p. 126.
4.1.2 Accessing health care in Katutura

In 2000, the NDHS revealed that almost half of participating women had no physical access to a health care facility102. The biggest problem was a difficulty to obtain transport to health care services, cited by 46% of respondents. Almost as many, 43%, had no health care facility nearby at all, while 40% stated that one major issue was the attitude of unfriendliness by nursing staff103. LeBeau (2003) reports similar findings from a 1993 study, which also revealed that nurses had a reputation for being ‘rude’104. In addition, as cited by 37% of respondents, paying for treatment was a serious obstacle to accessing health care. With this data in mind, it is perhaps not surprising that the informants in my study cited the same problems when discussing the accessibility of health care. Though my study focused exclusively on the access to specific HIV/AIDS treatment, the informants described the same problems as listed in the 2000 NDHS. However, one discrepancy should be acknowledged. Whereas the great majority of my informants had physical access to a health care facility, meaning that they knew where to find the nearest hospital or clinic and could travel there, their biggest complaint was that they did not have money for treatment. Even a price as low as N$10, the cost of an HIV-test at one of the community clinics, was too steep for most of my informants. Knowing this, the clergyman Father Hermann Klein-Hitpass, who ran the charity centre where many of the Katutura prostitutes gathered, supplied them with a form with which they would attempt to get the N$10 fee waived. On the form Father Hermann had written vital information about the woman in question, including reasons why the fee could not be paid105. On occasions this system worked fine, allowing the sex workers to have an HIV-test free of charge. However, several informants stated that they had been refused a test, despite bringing the filled out form. On such occasions, the impolite attitude of the nursing staff caused embarrassment and shame for the sex worker. One informant stated that

102 Ministry of Health and Social Services, 2000: *op. cit*, p. 126
103 Ibid, p. 126-127
104 LeBeau, 2003: *Dealing with disorder*, p. 48
105 Interview with Father Hermann Klein-Hitpass, April 19, 2005
she had been ushered to leave after it had become obvious what she did for a living, and that she was unable to pay the N$10 fee for the test. Interestingly, however, according to the NACOP, an HIV-test should be carried out free of charge should the patient voluntarily seek to have it done, but be unable to pay\footnote{Interview via email with the Chief of Health Programs at the MoHSS, Abner Xoagub, July 11, 2005}. Clearly, even this small sample shows that this policy is not respected. Though it may be tempting to conclude that my informants had been discriminated against on the basis of their source of income, it should be noted that, in the 2000 NDHS, the 40% of respondents who claimed to have experienced unfriendly nursing staff were not sex workers, but women from all groups of society. Negative attitudes among nursing staff therefore seem to be a problem of a wider variety, as it affects almost half of all women who visit health care facilities.

4.2 CHAPTER SUMMARY

In this chapter, the National AIDS Control Programme (NACOP) was introduced and discussed. A human rights approach has been adopted in the Namibian Constitution, and is encompassed in the NACOP as well. In addition, Namibia has signed the International Covenant on Economic, Social and Cultural Rights (ICESCR) and is thereby obliged to ensure that the highest possible standard of health can be attained. Though a basic right to health is not included in the Constitution, the Namibian government is obviously aware of the links between human rights and HIV/AIDS.

Another human right relevant to HIV/AIDS and discussed in this chapter is the right to education. The Universal Declaration of Human Rights (UNDHR) states that education should be provided free and that it should be compulsory; however, school fees are common in Namibia. As an implication of this, many people who are unable to afford the fees are deprived of the opportunity to receive an education, which in turn has implications for the struggle against HIV/AIDS since many people obtain most of their HIV/AIDS knowledge at school.

Health care in Katutura was also examined in this chapter. It was emphasised that though traditional medicine is still practiced in Katutura, the focus
of the NACOP lies with Western medical practice. Further findings from the Namibian Demographic and Health Survey (NDHS) were revealed, in particular in relation to access to health care. An interesting discrepancy between NDHS findings and my own study emerged here. Among my informants the largest obstacle in accessing treatment was a lack of money, whereas a majority of NDHS respondents cited that they simply did not have the ability to physically reach a health care facility. Again, it was made obvious that my informants suffered greatly due to the acute poverty they were forced to live in.

5. CONCLUSION

This thesis has discussed the links between HIV/AIDS, prostitution and human rights, with particular focus on the situation for prostitutes from the township of Katutura, Windhoek. The first of its kind, this thesis has compared findings with the one other Namibian study of related topics that has ever been published. It can, simply, be concluded that prostitution in an HIV/AIDS context is poorly researched in Namibia. It has become blatantly obvious that more research of sex work and HIV/AIDS in Namibia is needed, in particular considering that the estimated HIV-prevalence among sex workers in Katutura is more than three times as high as the national average.

Several dimensions of the link between human rights and HIV/AIDS have been examined in this thesis, in particular in context of when vulnerable groups, such as sex workers, are prevented from accessing relevant treatment. Despite embracing a human rights approach and aiming for an environment in which all HIV-positive people in Namibia will receive AIDS care, the National AIDS Control Programme (NACOP) consistently fail in providing treatment for prostitutes in the townships. The N$10 charge for an HIV-test, which according to NACOP policy should be waived if the patient is unable to pay, is too expensive for the very poor. Informants experienced discrimination by nursing staff and a fear of visiting health clinics, should the truth about their occupation become known. In addition, they told of incidents where they had been turned away when they could not pay for
a test, despite the NACOP promise of waiving the fee. None of the informants was aware that the test could be carried out free.

Since sex work is illegal in Namibia, prostitutes have no access to legal instruments with which to better their work situation. Having no opportunity to seek help and support, they are at great risk of becoming exploited and abused. The Legal Assistance Centre (LAC) points out that legislation that ban sex work (and sodomy) only contributes to the marginalisation of prostitutes, forcing them to go underground, where they are increasingly exposed to HIV-infection\(^{107}\). By no means has it been the intention of this thesis to argue for or against decriminalisation of prostitution, however, such a scenario should be researched in detail. The number of sex workers would perhaps not decrease noticeably, but if prostitution got rid of its illegal status it would enable the government to monitor and control the spread of HIV among them.

This thesis discussed briefly the implications of the discrimination and stigma suffered by people living with HIV/AIDS (PLWHA). Though everyone has the right to freedom from discrimination, a right included even in the Namibian Constitution, it has been made obvious that PLWHA in Namibia, in particular those engaged in sex work, do not enjoy this right to the fullest. The informants participating in my study claimed that they during visits to a health clinic had experienced discrimination on two levels: both as sex workers, and as HIV-positive. When discrimination and stigma is that prevalent in a society, it may form a major obstacle to accessing adequate health care. This is particularly problematic in an HIV/AIDS context, since the rate at which the progression of the disease is entirely dependent upon the level of access to health care an HIV-positive person enjoys. The right to health, as laid out in the Covenant on Economic, Social and Cultural Rights (ICESCR), requires signatory nations to ensure its citizens the highest possible level of health. However, when access to health care is denied, for whatever reason, this becomes impossible.

\(^{107}\) Legal Assistance Centre, 2002: *Whose body?*, p. 182
The thesis also discussed poverty aspects of the AIDS epidemic, on an individual as well as a national level. It was suggested that the eradication of poverty would contribute to the improvement of the national AIDS response, since treatment and medication could then be made available to a greater part of the HIV-positive population. Providing medication has for governments of many developing nations proven to be almost a mission impossible. The cost of antiretrovirals (ARVs), which by the patient should be taken as a ‘drug cocktail’ including several pills daily, is still too high. Though ARV prices have been reduced in recent years, patent legislation and trade agreements ensure that developing countries still struggle to be able to afford them. In some nations, such as Brazil and Thailand, governments have begun manufacturing generic versions of ARVs, often whilst fighting legal battles with the pharmaceutical companies over patent rules. Though producing generic brands of ARVs may not be an option for Namibia, the NACOP would greatly benefit from further price drops. Indeed, perhaps the criteria that the NACOP require of the patient to fulfil could be lessened if the availability of ARVs increased. As of June 2005, the World Health Organisation (WHO) estimates that between 25-49% of HIV-positive Namibians has access to ARVs\(^{108}\) (please refer to Appendix IV), however, should the general level of poverty decrease, this figure could become even higher.

What has become distinctly clear is that in a Namibian context, the links between prostitution, HIV/AIDS and human rights need to be researched in greater detail. Though it is fortunate that Namibia has encompassed a human rights approach in its AIDS program, the NACOP has so far failed to get a grasp of the actual HIV-prevalence among sex workers, an aspect so important to the national AIDS response that one might argue that the whole program is at risk of failing its mission. What is left is a somewhat flawed national AIDS response, and plenty of windows of opportunity for future research.

\(^{108}\) [http://www.who.int/hiv/facts/ARVcov05web.jpg](http://www.who.int/hiv/facts/ARVcov05web.jpg), as of August 17, 2005
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Riksförbundet för Sexuellt Likaberättigande, RFSL (‘Swedish Organisation for Sexual Equality’)
www.rfsl.se/?p=1395 (in Swedish; August 11, 2005)
APPENDIX I

Map of Namibia

Source: http://geography.about.com/library/cia/blcnamibia.htm, as of August 10, 2005
APPENDIX II

Map of Windhoek and surroundings

Source: http://encarta.msn.com/map_701517658/Windhoek.html, as of August 10, 2005
APPENDIX III

HIV prevalence rate in pregnant women, biannual surveys 1992-2004, Namibia

APPENDIX IV

Source: http://www.who.int/hiv/facts/ARVcov05web.jpg, as of August 17, 2005