

**Cultural and Social Factors Impacting on the Programme to
Prevent-Mother-To-Child-Transmission (PMTCT) of HIV in Namibia:
A Case Study of the Kavango Region**

By

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**A mini thesis submitted in partial fulfilment of the requirements for the degree
of Masters in Medical Anthropology**

University of the Western Cape

**UNIVERSITY *of the*
WESTERN CAPE**

November 2010

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ABSTRACT

The programme to provide prophylaxis to prevent the transmission of the HI-virus from mother to child in the Kavango-region, Namibia, has not been very successful. Up till now the scant research done on this issue has focused mainly on service provision and the roll-out of the Programme for the prevention of mother-to-child-transmission of HIV (PMTCT). This study focuses on socio-cultural issues, which affect Kavango women's decision to participate in the PMTCT programme. It investigates the treatment methods used by HIV-positive pregnant women for themselves and their unborn babies, neonatally, during pregnancy and after delivery, particularly in relation to the prevention of transmission of HIV. The thesis further investigates whether women choose alternative services such as traditional healers for medical attention during pregnancy, birth and post-natally. The research aims to establish and describe the role of local notions and practices concerning anti-retrovirals on the aforementioned programme. Ethnographic and thus qualitative research methods were used to gather and analyze data. I spent three months working as a nurse in two health facilities that offer PMTCT in Rundu, Kavango. I also held semi-structured and open-ended interviews, formal and informal discussions, formal and informal focus groups with nurses, community counselors, pregnant women, women who had recently given birth in the health care facility and traditional health care practitioners. In the case of the latter, I utilized narratives of healing to understand their perception of HIV/AIDS, their beliefs and practices as well as their healing methods. Furthermore, I employed other informal conversations outside the formal research participants. The study shows that there is a paucity of partner involvement and in some cases women have to first seek permission from their partner before enrolling into the programme. My research findings further indicate that women utilized various traditional herbal medicines for themselves and their babies as part of their cultural beliefs and practices. It was evident that some of these, such as *Likuki*, affect women's participation in and adherence to the protocols of the PMTCT programme. The study attempts to establish which factors influence the above women's choices of care. In particular, the research investigates what cultural (including social, gendered, political and economic) interpretations of PMTCT affect the low uptake of the PMTCT programme by HIV positive pregnant women in Kavango.

KEYWORDS:

Kavango,

Women,

Pregnancies,

HIV/AIDS,

Anti-retroviral,

Programme,

Health,

Social,

Cultural,

Barriers.



DECLARATION

I, Michael Shirungu declare that “**Cultural and Social factors impacting on the programme to Prevent-Mother-To-Child-Transmission (PMTCT) of HIV in Namibia: A case study of the Kavango region**” is my own work and has not previously been submitted at any university. All the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

Signature.....Date



DEDICATION

I dedicate this work to my beloved parents; Mr. Shirungu Martinus Tau and Mrs. Shirungu Hildergard Shihako.



ACKNOWLEDGEMENTS

First and foremost, I would like to thank all participants in this study (Pregnant women and Mothers, Nurses, Community Counselors and Traditional healers in Kavango.

I am indebted to my supervisor Prof Diana Gibson for her continuous tireless support, guidance, critical and constructive comments. Thank you for mentoring me.

I gratefully acknowledge Carl Schlettwein Foundation for awarding me the scholarship, without your support it would have been difficult to accomplish this work.

I also would like to thank Prof Heike Becker for supporting and facilitating my application for the Carl Schlettwein Foundation scholarship and also for her moral and academic support.

Great thanks to Kletus Muhena Likuwa, a family member and friend, with whom I always shared stories about school and post graduate education and introduced me to various people at UWC, to him I say, “Shangwe” I appreciate.

Thanks to Michael Uusiku Akuupa, a friend with a big spirit, who provided to me guidelines on how to refine my initial research proposal for application to UWC post graduate studies and continued to play a central role of academic support throughout my sojourn at UWC, you are appreciated

To my friends in the department of anthropology and sociology at UWC; Dr Sakhumzi Mfecane and Kharnitha Mohamed thank you for reading some of my chapters, I highly appreciate your critical comments.

Thanks to DR. Ipinge S, at the University of Namibia for writing me a referral letter and also for her continues academic support.

Furthermore, I would like to thank my siblings; Katiku Constantia, Shirungu Hermes, Kandjimi Pontianus and Nyangana Anselm who waits for my return home.

Finally I would like to thank my girlfriend Klaudia Namutenya and my little daughter Constantia Katiku, who needed my support the most in the process of writing this thesis.

Mpandu (thank you)&*May Karunga* (GOD) BLESS YOU ALL!

ACRONYMS

3TCLamivudine

ANC Antenatal clinic

MTCT Mother-to-Child Transmission of HIV

NVP Nevirapine

PMTCT Prevention of Mother-to-Child Transmission of HIV

MOHSS Ministry of Health and Social Services

HIV Human Immuno-deficiency Virus

AIDS Acquired Immune Deficiency Syndrome

VCT Voluntary Counselling and Testing

ART Antiretroviral Therapy

ARVs Antiretroviral drugs

WHO World Health Organization



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CHAPTER ONE- GENERAL INTRODUCTION

1. Rationale/ background of the problem

Namibia has a relatively small population of two million people, but has one of the highest HIV prevalence rates in the world. Approximately 20% of the sexually active adult population lives with the virus and by 2000 about 160,000 people, aged 15 to 49, were infected. Today HIV is the number one cause of death and accounts for 28% of mortalities in all the age groups.¹ In Namibia, 19.7% of the total population was estimated to be living with HIV by the end of 2004. This is compared to only 4.2% in 2002. Without treatment, around 15-30 percent of the babies born to HIV positive women will become infected with the virus during pregnancy and/or delivery. A further 5-20 percent will become infected with HIV through breastfeeding. In 2007 around 370 000 children under the age of 15 years became infected with HIV, mainly through mother-to-child-transmission (PMTCT 2005 Participant handbook).

Without treatment, transmission rates from HIV positive mothers to their children range from 25% to 45% in Namibia. Out of the 75, 000 deliveries each year, 15, 000 are born to women with HIV and, without treatment, one out of three infants become sero-positive. This means that 5000 HIV positive infants are born each year, and 15 HIV positive babies are born daily in Namibia. The HIV prevalence amongst pregnant women in Kavango is rapidly increasing as evident by the following figures: 8% in 1996, 14% in 2000 and 21% in 2004 (PMTCT in Namibia Participant Handbook 2004). According to the Ministry of Health and Social Services' (MOHSS) 2008 sero-survey for HIV in Namibia, Kavango's HIV prevalence rates of 20.1% are in the top five out of the 13 regions in Namibia. It can be argued that there is low use of biomedical services in the region. In this regard, out of the 10551 expected deliveries in 2007, only 4854 were done in the hospitals/clinics in Kavango. The rest were conducted by traditional birth attendants (thereafter TBAs) at home.² Of the 4854 mothers who delivered in the hospital, 810 were HIV positive. From the latter group, twenty-three

¹ Ministry of health and social services ,Annu report on Monitoring and evaluation of the civil society contribution to tackling HIV/AIDS in Namibia (Windhoek, NANASO 2006).Pg 6

² Kavango region 2007/8 annual report , Ministry of health and social services

babies contracted the HIV virus.³ While these statistics illustrate an enormous public health challenge, they also imply a large political, social and economic tragedy.

In response to this, the Namibian government - through its Ministry of Health and Social Services (MOHSS) - adopted a programme called Prevention of Mother- to- Child Transmission (PMTCT) in 2002. PMTCT aims to prevent pregnant HIV positive women from passing the virus to their unborn babies, during pregnancy or during delivery and breastfeeding.⁴ Despite the implementation of the PMTCT programme in Namibia in 2002, HIV/AIDS related deaths among infants and small children are rapidly rising. Similarly, child mortality rates increased from 62 per 1000 live births in 2000 to 69 per live births in 2006. The infant mortality rate simultaneously increased from 38 per 1000 live births in 2000 to 46 per 1000 live births in 2006. The Minister of Health and Social Services, Richard Kamwi, reported that HIV/AIDS was the cause of these shocking statistics (ALL.Africa.com. New era, Wezi Tjaronda 2008). This means that increasing numbers of babies are born HIV positive, while more infants also contract the HI-virus while breastfeeding

Speculations about factors that influence this increase are rife. Shangula (2006:14) noted that, besides chronic staff shortages, socio-economic factors such as lack of transport to the clinic, unemployment, low incomes and low educational levels contribute to the poor uptake of the PMTCT programme. Shangula further pointed out that few interventions have addressed the cultural and psychosocial determinants related to sexual risk-taking and risk-reducing behavior in Namibia. The above author (ibid), e.g. argues that the information sheets and communication messages for PMTCT designed in Windhoek (the capitol) are largely in English and are not suitable for the many Namibians who cannot read or understand English. Many of the PMTCT messages may not be culturally appropriate either.

2. Aims of the study

This study has the following three main aims:

- (i) To gain an understanding of local understandings concerning PMTCT in Kavango. In this regard, the study examines the local perceptions about antiretroviral medicines for HIV-positive mothers and babies, as well as how these women understand the medicines and its meaning.

³ Kavango region 2007/8 (Ibid)

⁴ Ministry of health and social services (2004) Guidelines for the prevention of mother to child transmission of HIV

- (ii) To ascertain how gender issues affect the PMTCT programme. In this regard, the study explores the gendered nature of PMTCT and the role of gender in choices made by HIV-positive women in relation to the PMTCT programme in Kavango. Thus the study examines how gender impacts on the choices of diagnosed HIV positive pregnant women to participate, or not participate in the PMTCT. It also explores how staff approach the issue of gender in their interaction with diagnosed HIV positive pregnant women and their endeavour persuade women to participate, or not participate in the PMTCT. Lastly how do men influence on their pregnant women's involvement in the PMTCT program?
- (iii) To establish which health care options HIV positive women utilize in relation to pre- and ante-natal care for themselves and their babies who may become HIV positive.

Since people often use both biomedicine, as well as traditional health care, it is important to assess and understand the role of the latter better. Hence, the study investigates the role of traditional healers in the care of HIV positive pregnant women during and after birth. As such, the study explores whether HIV positive mothers use "traditional" medicine for themselves and their babies, what they use, how, when and why they do so. It is equally important to ascertain whether they utilize both traditional plant medicines and pharmaceuticals, in which way they use it, their reasons for doing so, what sense they make of their choices and such. As Nashandi, (2002: 12) cited by Kalimba (2005) emphasized, traditional healers play an important role in the lives of Namibians. Most people visit traditional healers because they have little access to biomedicine and have great belief in traditional healing (SAFAIDS et.al:2003: 8). Nashandi (Ibid; 1) further pointed out that many people in Namibia believe that witchcraft or evil spirits cause HIV/AIDS. The Namibian government, through its Ministry of Health and Social Services, aims to get all pregnant women to use the State health care system during the antenatal period, delivery and post-delivery. However, as shown above, it is apparent in Kavango that the majority of pregnant women prefers to deliver at home and assisted by traditional birth attendants.⁵ As Mbambo (2002:5) argues, in Kavango, despite the successful utilization of health centers such as the hospitals and clinics, it appears that the majority of the local people continue to use

⁵More on the work of Traditional Birth Attendants (TBAs) in Kavango see chapter six 6 (4)

traditional healing. He further notes that traditional healing has played a significant role in the past and still plays an important role in the lives of people in the present.

In relation to the above, it became clear to me during my fieldwork that pregnant women in Kavango still hold strong beliefs about care for themselves during and after pregnancy (what to do and not to do). They also view the ‘traditional’ cleansing of the newborn (known as *Likuki*) as an essential part of their lives. This brings me to the central question that I intend to address; what cultural (including social, gendered, political and economic) interpretations of PMTCT exist that may affect the low or ineffective uptake of the PMTCT programme by HIV positive pregnant women in Kavango? In this regard, I observed that traditional birth attendants act as midwives and are highly trusted and utilized by the local people in the community. The majority of the women preferred to be delivered by (TBAs) and to bring the baby to the clinics/hospitals post-delivery. The question is then why women in Kavango prefer to deliver at home rather than in the hospital. The answer to this is multi-faceted and, in many cases, ambiguous. There are both social and cultural issues affecting women’s choice. Although the Ministry of Health and Social Services encourage pregnant women to deliver their babies in the hospital, underlying issues of poverty, education, and gender inequality can be general impediments to healthcare access, including HIV preventative programmes such as the Prevention of Mother to Child Transmission (PMTCT).

Since my research aims to present local notions and perceptions regarding PMTCT, I prefer to use terms that are utilized by the local people to refer to health and illness concepts. This is to allow the “emic perspective” of the local people (pregnant women, mothers with newborns, traditional healers, nurses, doctors and senior health officers involved in the programme of PMTCT in Rundu that I have worked with and interviewed) to emerge. As Fetterman (1989:30) argues, the insider’s or local perspective is at the heart of most ethnographic research. Therefore, trying to understand local perspectives is instrumental to describe and understand a situation and behaviour of the people under investigation.

3. Analytical framework

This study will draw on a key anthropological construct, namely culture. I will not engage in the debate concerning this term, except to stress that the notion of culture is very complex in anthropological discourse, and there have been a lot of criticism in anthropology, especially concerning the 'old' way of thinking about and analyzing culture. Where anthropologists like Taylor defined culture as including knowledge, belief, art, custom and any other capacity and habits acquired by man as a member of society (Taylor 1871:1; cited by Wright 1998:8) in this dissertation, I will utilize 'new' definitions and meanings of it. Thus, as Wright (1998) shows, culture is not inherent, bounded, or static. I nonetheless expect that efforts (by e.g. the State health care providers) to address 'culture', e.g. in relation to PMTCT, would draw on such stereotypes concerning, e.g. culturally sensitive programmes. This is also why I will specifically look at the way in which such programmes are understood by health care providers and pregnant women in Kavango. For the purposes of this study, I view culture as dynamic, fluid and constructed situationally, in a particular place and time (Wright 1998).

I will also draw on the seminal work of Kleinman (1980) who argues that both patients and healers should be studied in the context of their local cultural environment, as well as cross-culturally. He (Kleinman 1980) argues that health care users and providers may bring different experiences, responses, meanings and practices to ill health. They also draw on varied institutions, patterns of institutional activities and individual behaviour related to health and health care. In every locality there are people we could identify (more importantly, whom the local population would identify) as healers and patients/those seeking healing. While there may be differences, there are also similarities, e.g. concerning the roles of healers and the sick, how illness is constructed and how treatment is selected and organized.

Kleinman (1980) proposed that all health care systems use conceptual models or frameworks and researchers need to analyze this to understand how actors in a particular social setting think about health care. Kleinman argued that notions about sickness, decisions about how to respond to specific episode of sickness, expectations and evaluations of particular kinds of care help researchers to investigate wellbeing and health concerns. Although Kleinman's notion of an explanatory model of health draws on 'old' ideas about culture, it is nonetheless

still a useful framework to utilize as starting point for my own study. I will accordingly loosely draw on the notion of frameworks of health care arrangements to study how people in Kavango deal with sickness in the local social and cultural setting, how they perceive, label explain and treat sickness. I will also look at health care systems in Kavango (biomedical and ‘traditional’) as socially and culturally constructed and simultaneously as creating a social reality that influences interactions, practices, decisions and such.

I find the notion of a framework that people draw on to explain and deal with ill health as potentially useful for my topic of PMTCT in Kavango. It will assist me to explore how HIV positive women in Kavango think about health care, particularly the PMTCT program. It will assist my attempt to understand HIV positive women’s beliefs about HIV/AIDS and PMTCT as well as how they respond to it.

4. Setting the scene

1.4.1 Namibia

Towards the end of my fieldwork, Namibians across the country joined hands in celebrating the country’s 20th independence on the 21st of March 2010. The event, which was broadcast live on national television, NBC⁶, showed SWAPO⁷ President, Lucas Hifikepunye Pohamba, sworn in for the second five year term. Windhoek independence stadium was filled to capacity and various leaders attended the event. Among others, South African President Jacob Zuma, President Robert Mugabe of Zimbabwe, Democratic Republic of Congo’s President Joseph Kabila, the Presidents of Botswana, Tanzania, Mozambique and Zambia attendant. Former Nobel Peace Prize winner and previously the United Nations envoy to Namibia, Martti Ahtissari of Finland, was also present. Namibia received her independence on 21st March 1990 following nearly a century of German and South African rule respectively.⁸ Akuupa (2006:7) points out that, during the 19th century, the country was known as Deutsch Suedwestafrika. The name was later changed to South West Africa, when South Africa took over the mandate from the Germany, after the latter lost World War I. The

⁶NBC stands for Namibian broadcasting cooperation

⁷ SWAPO stands for South West People’s Organization and it’s a political party and former liberation movement in Namibia, SWAPO was founded on 19 April 1960 by Andimba Toivo ya Toivo. It has been the governing party in Namibia since Independence in 1990.

⁸ Republic of Namibia Ministry of health and social services, HIV/AIDS in Namibia; Behavioral and contextual factors driving the pandemic 2009.

word Namibia is derived from Namib, a desert, which some scholars consider as the oldest and one of the driest, hostile deserts in the world (Mbambo 2002:16). With approximately 824,000 square kilometers, Namibia is the second most sparsely population country in the world. There are over ten ethnically defined groups within this nation state.⁹ Namibia shares borders with Angola in the north, Zambia in the northeast, Botswana in the east and South Africa in the south and southeast. The northern area is the most populated. It is a fertile area, watered by two main rivers, the Kavango and Kunene. The southern parts are highland area, sandy, drier and less fertile. The capitol, Windhoek, is situated in the central part of the country. The eastern part and western parts are very arid and include the Kalahari Desert and the Namib Desert. For political and administration purposes, the country is divided into thirteen regions namely; Caprivi, Erongo, Hardap, Kavango, Karas, Khomas, Kunene, Ohangwena, Omaheke, Omusati, Oshana, Oshikoto and Otjozondjupa (Mbambo 2002:16). Since my study focuses on Kavango, in the next section I am going to give an overview of Kavango.

1.4.2 Kavango

Kavango ne mukuro wetu kapishi murudi (Kavango is our river and not a border)

(2005 song by local band:Be Active Group)

Kavango, which means “a small place” in Rumanyo language, is both the name of the region and a river situated in the northeast of Namibia (Likuwa 2005:1). The Kavango area encompasses 48 463 square kilometers, stretches along the river from Katwiti in the west to Divayi (southeast of Bagani) and to the Botswana border in the east over a distance of approximately 430km. To the south lies vast a hinterland, a dry-forest country, valleys and dunes chains which is virtually uninhabited (Mbambo 2002: 32). Akuupa (2005) argues that the early history of settlement in Kavango indicates that the inhabitants entered the current habitat from the palace called Mashi along the Kwando River in the southwestern Zambia. Currently the population of Kavango is geographically unevenly distributed and the majority of the people live along the river. According to the 2001 census statistics the region is inhabited by 202 694 people and has a population growth rate of 3.7 percent. The inhabitants are divided into five ethnically defined groups namely; Hambukushu, Vagciriku, Vasambyu, Vambunza and Vakwangali. The colonial border, the Kavango river, divided people into two countries, Namibia and Angola. The Vakavango nonetheless live on both sides of the river.

⁹ Republic of Namibia (Ibid)

For instance, someone might speak of the Vagciriku, Vakwangali or Vambunza in Namibia and Angola. In the past, the river was not seen as a border between the two countries and traditional authorities had authority on both sides of the river (Mbambo 2003). People in Kavango speak different languages. In this regard, Kwangali and Vambunza groups speak Rukwangali. The Vasambyu and Vagciriku speak Rusambyu and Rugciriku respectively. However, it is believed that the latter two groups (Vasambyu and Vagciriku) were originally one grouping known as Vamanyo. Recently scholars have argued that the two languages spoken in the past (Rusambyu and Rugciriku), should be combined under one collective name, Rumanyo.). In the far east, Thimbukushu is spoken by the Hambukushu. There are also other languages spoken in Kavango, namely Runyemba, Rushiwoke, Umbundu, Afrikaans, English and Portuguese and the two San group languages Rucu and Rumbarakwengo (Mbambo 2002:35).

My study was conducted in Kaisosi and Rundu, the latter is the capital of the region situated in northern Namibia, on the Kavango River and thus the border with Angola. Previously, the town of Nkurenkuru in the western Kavango had served as administrative centre from 1910 when the German police station was established at Nkurenkuru.¹⁰ In mid-September 1936, Rundu became the administrative centre and a political capital of the Kavango Region. The oldest houses in Rundu are those in the Katutura area, situated next to the Central Business District and occupied by lower and middle class inhabitants. On the west is Tutungeni, which means "let's build". This area was previously occupied by executives of the white-dominated businesses and today the area is dominated by the black elites. On the eastern side is a location known as Safari, in this area there are the middle-priced houses which were built in the 1970s.¹¹ These three main localities dominated Rundu's residential area until the turn of the millennium in 2000, when new housing projects by O'B David's Properties developed a new residential area named Millennium Park. Afterwards two others have been established by the National Housing Enterprise, called Queens and Kings Parks respectively.

Towards the edges of the town are informal settlements, which indicate rapid urbanization, but also high unemployment rates. Kehemu, Sauyemwa and Ndama are still "informal" areas (without services), but Donkerhoek (Dark Corner) is rapidly becoming "formal" since the

¹⁰ See Shampapi Shiremo, *Rundu, an interesting History*, (New Era newspaper, 26 September 2010)

¹¹ Wikipedia, the free encyclopedia (Ibid)

start of the Build Together Campaign in 1992. The five tertiary Institutions found in Rundu, are; Rundu College of Education, Rundu Vocational Training Centre, Rundu Regional Training Center (Nursing school), NAMCOL¹² and Trumphiet College. At the time of my research I stayed at Kaisosi, about 10 km east of Rundu.

1.4.3 Structure of the thesis

This thesis is made up of seven chapters. Chapter two is the literature review of the study. The chapter starts with an overview of resources in medical anthropology on health and illness in cross cultural settings. It scrutinizes literature on the anthropology of AIDS, particularly in relation to the Prevention of Mother-to-Child- Transmission (PMTCT) of HIV. In this regard, the chapter examines literature on HIV/AIDS in relation to the social, cultural, economic and gender impact on the PMTCT programme. Lastly the chapter explores the role of traditional healers in HIV preventative programmes.

Chapter three attends to various methods and strategies that were used in conducting my research. The chapter raises issues concerning the complexity of doing fieldwork at home in relation to notions of objectivity/subjectivity and half/halfies. The chapter also deals with positioning of self in the study and the notion of being a *mundambo* (local/known person) and various ethical dilemmas that were encountered in the field.

Chapter four describes the Prevention of Mother-To-Child Transmission (PMTCT) of HIV in Kavango. It looks at the following: How do staff involved in the PMTCT programme 'translate' and explain it to the women? How do women who participate in the PMTCT understand the use and working of anti-retroviral for themselves and their babies?

Chapter five focuses on barriers that prevent HIV positive women from participating in the PMTCT programme. The chapter describes culturally and socially informed ideas and practices, as well as gendered issues concerning HIV/AIDS and PMTCT in Kavango.

Chaptersix deals with medical pluralisms. Thus it examines health care options in Kavango and describes how the local people make use of these services as well as what determines their choices in relation to the PMTCT programme. The chapter also discusses the role of traditional healers in the PMTCT program.

¹² NAMCOL stands for Namibia College of open learning.

Chapter seven concludes the thesis; it sums-up the main finding of the study and raises issues for further research.

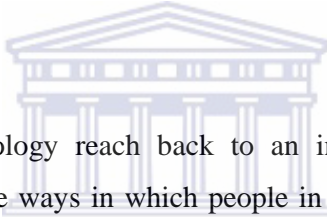


CHAPTER TWO-LITERATURE REVIEW.

1. Introduction

This chapter discusses literature pertinent to my research topic. The chapter explores how medical anthropologists have explained health and illness in various societies. It provides an insight on how medical anthropologists over the years have attempted to understand health issues and the various approaches they employ. It also discusses the anthropological study of AIDS, particularly in relation to the Prevention of Mother-To-Child-Transmission (PMTCT) of HIV. In this regard, the chapter examines literature on HIV/AIDS in relation to the social, cultural, economic and gender impact on the PMTCT programme. Finally the chapter examines the role of traditional healers in HIV preventative programmes.

2. Medical anthropology



The roots of Medical anthropology reach back to an intellectual, academic interest in describing and understanding the ways in which people in different settings have explained illness and tried to give treatment to the sick (Pelto and Pelto 1996; 52). Joralemon (1999: xiii) pointed out that medical anthropology studies the human experience of disease in cross-cultural, historical and evolutionary perspectives. He argues that medical anthropology provides a point of connection for biological, cultural and applied research. What medical anthropologists do, is to explore how sicknesses are culturally constructed, how a society's understandings of and responses to disease are shaped by cultural assumptions about such things as the beginning and end of life, the workings of the human organism and the causes of ill health and misfortune. Joralemon further points out that medical anthropologists increasingly pay attention to the fundamental role that socioeconomic arrangements have on human health. He argues that critical medical anthropologists ask how the distribution of wealth and power and division of labour affect disease patterns and health care access. He emphasises two insights in particular

- (i) That cultural premises, which are often implicit and difficult for the insider to recognize, shape the health-related knowledge and healing practices of every society.

- (ii) Disease patterns, social norms and socioeconomic arrangements are intricately interrelated.

According to Good (1994: 56), medical anthropology developed an important set of studies on how political and economic forces of both global and societal scope are represented in local health conditions and medical institutions. He argues that such studies are an effort to understand health issues in the light of the larger political and economic forces that pattern interpersonal relationships, shape social behavior, generate social meanings and condition collective experiences. Good (1994: 57) further argues that critical medical anthropology forcefully explores the question of when illness representations are actually misrepresentations which serve the interests of those in power be they colonial powers, elites within a society, dominant economic arrangement, the medical profession or empowered persons. Therefore, critical analysis studies on health and illness investigate both the mystification of the social origins of disease wrought by technical terminology and metaphors diffused throughout medical language, as well as the social conditions of knowledge production. He argues that forms of suffering derived from class relations may be defined as illness, medically constructed as dehistoricised objects in themselves and brought under the authority of the medical profession and the state. In this regard, symptoms of hunger or diseases such as diarrhea, tuberculosis and stress resulting from poverty are often medicalized, treated as a condition of individual bodies rather than as a collective social and political concern (Good 1994: 59).

Medical anthropologists often become cultural broker, intermediaries between biomedical practitioners and groups whose cultural assumptions might be at odds with those underlying scientific medicine. While previous work by medical anthropologists have drawn on culture in understanding health in various cultural settings, recent scholars have shown that using culture as an analytic tool is very problematic and has many limitations in understanding health and illness. In this regard, Lock and Nguyen (2010: 6) pointed out that the assumption, held formerly by the majority of anthropologists and others, that, in a named “culture”, everyone participates equally in local socioeconomic arrangements, exhibits similar behaviour patterns and adheres to shared value,s is no longer tenable. The majority of anthropologists now agree that assigning individuals to named essentialised “cultures” is not a valid exercise and maintain that, although many medical anthropologists have in the past given priority to “culture” as an explanatory concept in connection with matters relating to health, it has now become obvious to most that this concept has serious limitations. For

example, in privileging culture, anthropologists have often neglected consideration of political and economic contributions to health and illness, notably the impact of inequities and discrimination on wellbeing and longevity (Lock and Nguyen (2010: 6).

Thus the very notion of “culture” should not be used in isolation as an analytical tool in understanding health and illness, but should include social, economic and political aspect as well. Fassin (2007) argues that “culturalism” can nonetheless imbue social institutions. By this he means that the assumption that culture is a unified entity and may be used to fully account for people’s behaviour, is utilized by powerful individuals in institutions to divert attention from the social, economic and political origins of ill health (Lock and Nguyen (2010: 8). Fassin further argues that in incriminating culture, as certain health authorities willingly do sometimes supported by anthropological data they are in fact blaming victims while masking their own responsibility in the matter. Thus Lock and Nguyen (2010: 9) note that recognizing the way in which “culturalism” contributes to the perpetuation of inequities and injustice within and among societies is crucial, especially when it is documented that the majority of individuals today are no longer immersed in a situation where a dominant cultural ideology exert a hegemonic hold over them.

3. Anthropology of AIDS.

During the 1980s and 1990s a great deal of anthropological research in the field of health and illness centered on pragmatic issues of improving the health and health care situations of people in both Western and non- Western countries (Pelto and Pelto 1996; 52). Schoepf (2001:348) pointed out that the best anthropological research on prevention is both applied and theoretical, rather than bowing to the familiar dichotomy between the two. Schoepf (2001:354) argues that anthropological literature on AIDS, in the international arena from the 1990s, shows researchers’ increasing attention to linkages between local socio-cultural processes that create risk of infection and the life-world of sufferers in relation to the political economy. He further argues that in Africa, where the epidemic has attained catastrophic proportions, some cultural particularisms affected the social production of disease. Global inequalities of class, gender and ethnicity, poverty, powerlessness and stigma propel the spread of HIV.

A great deal of both applied and theoretical work has been done on the anthropology of AIDS and of AIDS-programmes (Thornton 2008, Susser 2009). This is also the case in Southern

Africa. In this regard, Taylor (2004: 60) explored HIV/AIDS treatment and the challenges of implementing HIV/AIDS programmes in the region. The author argues that, while implementing agencies and institutions are familiar with how to procure goods and services for development projects, dealing with HIV/AIDS requires new areas of expertise. In this regard, antiretroviral therapy (ART) has radically changed the outlook for people who can pay for it or use it in well-resourced health care systems. Yet, even when full advantage is taken of the lowest possible prices on the global market, the annual total cost of ART is still more than the national budget for health care in most Southern African countries. The costs will rise even more if drug resistance develops and more expensive, alternative medicines have to be used.

Although more attention is being given by anthropologists to issues concerning anti-viral therapy for adults (Kauffman & Lindauer 2003; Fassin 2007; Fassin & Schneider 2003; Robins 2005; Steinberg 2008; Baxen and Breidlid 2009) almost nothing has been done in relation to mother-to-child-transmission. Jackson (2002) used the term parent-to-child-transmission instead of mother- to- child- transmission and argued that it draws attention to the need to protect the mothers and, by implication, their male partners. This terminology is supposedly more gender-sensitive and implies that both parents have joint responsibility to protect the child. HIV/AIDS programme are nonetheless facing not only medical, but also socio-cultural challenges in Africa. All of these factors have to be involved to provide cost effective, sustainable, feasible and accessible programmes.

Varga and Brookes (2008) noted that, although Prevention of Mother-to-Child transmission (PMTCT) programs are predicated on maternal behavior change, little is known about socio-cultural factors affecting maternal child care practices in this arena. The authors (2008:177) pointed out that most studies are conducted in clinical settings, with aims grounded in medical, epidemiological or health systems concerns. Hence, conclusions about socio-cultural or community influences on the mother's PMTCT-related behavior are usually secondary to the main study objectives and not based on social science methodologies. Varga and Brookes (2008:177) further show that PMTCT studies should increase their effectiveness by also focusing on disease- related stigma, cultural norms that dictate maternal-child behavior and inadequate knowledge and misconceptions about the causes and consequences of HIV/AIDS.

In relation to the above, Nkonki et al (2007) conducted a study to examine missed opportunities for participation in a PMTCT in South Africa. A rapid anthropological

approach was applied to study 58 HIV positive women. The study shows that some women did not take part in the programme due to health systems failure, including non-availability of counselors and supplies such as test kits or consent forms. Women could not participate in the PMTCT program because HIV testing was the entry point. Fear of knowing one's HIV status and disbelief of test results were important reasons for the drop-out from PMTCT services. Health systems constraints related to testing and the provision of results were other key factors for lack of participation.

In Lusikisiki, Eastern Cape, South Africa, Steinberg (2008) wanted to establish whether access points to antiretroviral (ARV) drugs was within walking distance for HIV-positive people, and why many people chose to not participate in ARV treatment. Nearly one in three pregnant women tested HIV positive and at least one was dying of AIDS in the absence of medical intervention. Steinberg found that aspects such as overcrowding, un/under-employment and poverty enhanced the spread of HIV/AIDS in the area. In addition, cultural beliefs and practices are part of the problems facing the implementation of the HIV/AIDS programme. Steinberg (2008) gives examples of a man who refused to go for an HIV tests because he believed that demons were sleeping with him at night and might have infected him with the virus because of jealousy. A close friend of the above man died of AIDS and the people in the village believed that his uncle had bewitched him. Some people viewed HIV/AIDS as a disease of cattle and thought that it would kill them irrespective of whether they used condoms or not. Some blamed the neighbours for using magic to infect beautiful and successful people.

4. Traditional healing

Over the years many anthropologists have given attention to 'traditional' healing practices. Ingstad (1990) showed that traditional healers in Botswana have a role to play in HIV programmes. She argues that the way traditional healers perceive information about AIDS, how they integrate that information into their way of thinking and how they reflect it in their preventative and curative practices may have major consequences for the spread of the disease. Ingstad collected data via interviews with different traditional healers, such as *Ngaka ya diatola*¹³ (doctor of bones), *ngaka ya dishotswa*¹⁴ (doctor of herbs), prophet¹⁵ (profit plural

¹³ Ngaka ya diatola combines divination by a set of carved bones with knowledge and use herbs and it's the most frequent find in Botswana.

baprofit) and *sangoma*.¹⁶ In addition, she followed seven of the traditional healers closely and attended monthly meetings between traditional healers and formal health care section personnel. She found that traditional healers view AIDS as a Tswana or a 'modern' disease caused by misfortune, witchcraft, ancestors anger, and pollution through breaking of taboo. Some healers believed that they can cure AIDS, especially those who call it Tswana disease. On the other hand, those who call it a 'modern' disease referred their patients to the hospital (Ingstad 1990: 32). HIV patients, who were asymptomatic or had mild symptoms that decreased occasionally, easily trusted traditional healers' promises of cure and ended up transmitting the virus to their children and sexual partners (Ingstad 1990:37). Ingstad, argues that it is important not to consider traditional healers as a homogeneous group, but to be aware of their differences in practice and motivation. She shows that some traditional healers cooperated with health care providers and were quite receptive to modern health information, sometimes recognized HIV symptoms and referred the patient to the Hospital. Others believed that they can cure AIDS and even promoted behaviour that were counterproductive to prevention. Nevertheless Ingstad stressed that is important that traditional healers have a role to play in the prevention of AIDS (Ingstad 1990:38). There is very few in-depth anthropological research done on traditional healers in Kavango, however early studies like that of Bosch (1964) and Van Tonder (1966) provide some basic works of traditional healers in Kavango. Recent works like that of Mbambo (2002) provide a more detailed work of traditional healers in Kavango. Mbambo pays more attention to the concept of illness, health and healing among traditional healers in Kavango but he does not deal with HIV/AIDS.

LeBeau (2003) has done research on traditional and western medicine in Katutura, Windhoek, Namibia. She stresses medical pluralism in Namibia. There are diverse systems of thought that coexist, e.g. biomedicine and traditional healing practices. She shows that in Namibia, patient's makes choices between traditional and biomedicine based on their perception of the cause, reason and origin of illness. In Katutura the most important variables in health seeking behaviour are cultural beliefs, which are expressed in the patient's perceptions of the cause of illness and the patient's interpretation of illness symptoms.

¹⁴ Ngaka ya dishotswa epecilizers in one or limited number of illness conditions and are less common in Botswana. And uses herbs

¹⁵ Prophet is the prophet of Independence African Churches related to Zionist movement also more influential and uses holy water, ritual and prayer

¹⁶ The Sangoma (plura: disangoma) uses herbs and factory made "traditional Medicine" the sangoma role in Botswana may be said to represent a strategic choice, combining elements of the Ngaka-role as well as the typical role of the prophet.

LeBeau (2003: 45) argues that the use of traditional healing and biomedicine should not be viewed as at odds but should be seen as coexisting aspects of holistic healing, both with the aim of ensuring the physical, social and spiritual health of a person.

5. Gender and sexuality

In most areas of the world, more girls and women are being infected than boys and men. This is a disease where gender inequality is not only unacceptable, but also fatal. Despite the epidemiological data, and the clear evidence of the greater biological and social vulnerability of women, little attention is given to the gender implications of HIV and AIDS.¹⁷ Women are often diagnosed later in the progress of their disease, resulting in higher viral loads at diagnosis, and have poor access to care and medications. They are most often the caregivers for HIV+ family members, and most likely to be exposed to abuse and violence. Thus, gender inequality underlies the marginalization of women living with HIV, and discussions of maternal health, child survival and feeding must be considered within this context.¹⁸ Women are expected to make choices concerning infant feeding without the enabling support of family and community, with the threat of stigma, and often without treatment for themselves. Moreover, focus is too often on preventing transmission to infants rather than improving overall health outcomes for mothers and their children. The implementation of programs to prevent paediatric HIV can undermine local breastfeeding cultures. Many HIV-infected mothers do not have the economic or social power to make their own fully informed decisions about how to feed their babies, nor are they enabled to carry out their decisions. They should not be blamed for their choices, but rather be acknowledged for having to make difficult decisions and trying to do the best for themselves and their children under challenging conditions, including poverty; racial, socio-economic and gender inequality; lack of sufficient food and shelter; poor access to treatment, drugs and medical care.¹⁹

In anthropology, few current studies exist on mother- to- child transmission of HIV. A paper presented by Angulo and Okong (2002) concerning Mother-to-Child-Transmission (MTCT),

¹⁷A summary report of the conference proceedings 7-9 May 2006, Founders College, York University Toronto, Canada Published by World Alliance for Breastfeeding Action (WABA)

¹⁸Report (Ibid)

¹⁹ Report (Ibid)

in Uganda indicated that participation in PMTCT involves a number of risks for the women. These include concern, depression and stigmatization. Participation also resulted in abuse and marital break-up. Women had to deal with discrimination at home and in the community at large. Unequal gender relations had a big influence of HIV-contraction. At the same time HIV-positive women were afraid to inform their partners and thus had more unprotected sex. Ipinge et al (2004) shows that in Namibia social-cultural factors, including gender relation impact on the spread of HIV/AIDS and argued that distrust that many women and men feel toward each other, and the inability of women to negotiate safer sexual practices put women at risk of contracting the HIV virus. Ipinge et al (Ibid) noted that in Namibia men exercise power over sexual relationships, which make it difficult for women to request for a condom or refuse sex.

Becker (1993: 115) pointed out that the historically-specific trajectories of Namibia society under colonialism have entailed the promulgation of gender ideologies that are currently usually referred to as “traditional”. In this regard, she cited Hishongwa (1993: 77) who shows that a good woman is depicted as being weak, shy, passive- in fact; she does not speak up and has no say. As such the notion of women who, like children are to be seen, not heard has largely informed female gender stereotypes, opposed by that of a “strong” virile man Becker (Ibid). She shows that this dual projection of gender stereotypes is, for instance, expressed in prevailing notions about gender and sexuality. She noted that it is indeed very much part of current gender relations in Namibia that women are not supposed to talk about or even express their own wishes in terms of sexuality while men openly regard their right to sexual intercourse and promiscuity as a matter of course. Thus she argues that these gender stereotype, promulgated by prevailing gender ideologies throughout the country, have been largely internalized by both women and men, i.e. act accordingly and many women regard themselves as inferior and weak. She questions the extent to which these gender identities have been shaped through the imposition of the dichotomy of the two spheres of production-public-male on the one hand, reproduction-domestic-female on the other. As such she argues that the implantation of the male breadwinner vs. female homemaker model has entailed definite accompanying values of female submissiveness, while the indigenous communities were indeed male-dominate, it cannot be denied that women have been further disempowered through the impacts of the colonial state, migrant labour and missionary involvement. She further argues that the specific form this pattern has developed in the

instance of Namibia deeply marks gender relations in the country, regional disparities notwithstanding. In this regard, she note that while the material impacts of the first two factors have implied that women have become the main, in many cases sole, responsible persons for the reproduction of the family – including actual production of the means of live hood- promulgation of the specific gender ideologies implanted by missionary involvement entails a definition of women’s role being primarily that of mother and wife as economic appendage to and dependant of the male breadwinner.

While this gender stereotypes may prevail through Namibia, however Kampungu (1966: 8) argues that a Kavango woman has the right, on matrilineal ground, to speak at public meetings, although out of feminine modesty and perhaps as an extreme expression of the dilemma of matrilineal society in which men are dominant but the line goes through the woman, she is reticent. Thus she can own her own property, can legally sue someone before court (under Kavango customary law) in her own right and may, if she a princess, rule the ethnic group.²⁰ He shows that domestic violence among the Kavango is not encourage. Unlike in some African societies were a husband beating his wife is regarded as part of showing love to his wife, among the Kavango is seen as the lack of love in marriage. Thus woman formally goes away and stay with her family (known as kuteka)²¹ after been beaten by her husband or other ill treatment such as storm quarrels and the like. The woman comes back only when the husband (tekurisa)²² her by going to his in law and smoothed the matter out.

6. Conclusion

In this chapter I have examined literature on my study. I have also shown how medical anthropologists have explained health and illness in various societies. Thus I have shown that Medical anthropologists often become cultural broker, intermediaries between biomedical

²⁰In Kavango various ethnic groups they were female ruler’s e.g among the Vashambyu rulers such as Mushinga, Kandimba, Maria Mwendere and the current chief Matumbo Libebe. Similarly Mate and Kanuni among the Kwangari.

²¹ Kuteka literally means to be broken, which is a (stative) verb the custom is thus called probably because by the woman going away, the married life is broken, at least temporarily. In some cases kuteka is for good(Kampungu Ibid)

²² Kutekurisa comes from the reversive verb (kuteka-broken) thus the reversive verb would be (kutekurisa) that is to be restored to statuquo. Thus the man gets back his wife and their marriage is been restored. (Kampungu Ibid)

practitioners and groups whose cultural assumptions might be at odds with those underlying scientific medicine. Simultaneously in this chapter I argue that using culture as an analytic tool is very problematic and has many limitations in understanding health and illness since it often neglected consideration of political and economic contributions to health and illness, notably the impact of inequities and discrimination on wellbeing and longevity. The chapter also shows that inequalities of class, gender and ethnicity, poverty, powerlessness and stigma propel the spread of HIV. Thus HIV preventative programmes such the prevention of mother to child transmission of HIV should explore these issues.



CHAPTER THREE-RESEARCH METHODS AND ETHICAL DILEMMAS, CONDUCTING FIELDWORK AT HOME.

1. Introduction

In this chapter I am going to discuss the complexity of doing fieldwork at home by drawing on my own research. The chapter discusses methodological issues that were encountered in the field. In this regard, I will show various methods that I employed to gain access to the field. In this chapter I also tease out notions of objectivity/subjectivity and half/halfies. It also shows how I negotiated and acquired my status as a researcher and *mundambo* (local/known person). Moreover, the chapter looks at the nurse's reaction toward me as researcher and a co-worker. Lastly it addresses ethical dilemmas that were encountered in the field and how I responded to them as clinical nurse and a researcher.

2. *Shingurukutu kapi shakuyuvanga lidumba lyasho²³ ; Notions of objectivity/subjectivity and half/halfies.*

Numerous anthropological studies have focused on doing fieldwork "at home" (Abu-Lughod 1991; Barrett 1996; Van Ginkel 1998; Van Dongen & Fainzang 1998). The assumption that anthropologists, who do fieldwork in their own societies, have various advantages, have recently been contested. In this regard, Barrett (1996: 201) show that a researcher doing research among his/her "own people" has a range of advantages such as ; (i) being able to easily blend into the cultural setting (ii) a greater capacity to appreciate the nuances of non-verbal, subjective data and a diminished use of stereotypes. In his essay, The repatriation of anthropology: some observations on endo-ethnography, van Ginkel (1998) warns anthropologists who doing fieldwork at home that, while linguistic competence is an asset because it facilitates communication, saves time and enables avoiding distortion by interpreters, it also has problems. Using one's mother tongue does not necessarily mean that communication is unequivocal or that anthropologist can take the words of their participants at the face value (Ibid: 256). He argues that being familiar with the cultural setting can even be deceptive, as participants will not be very forgiving when a local anthropologist breaks local cultural "rules". This is because a local researcher is supposed to be familiar with his/her own local cultural expectations, and behaviour - thus, the margins for blundering are

²³This is a saying among the Vagciriku which means that A stinkbug is not aware of its own bad smell (Mbambo 2002: 10)

quite small. If local anthropologists challenge or transgress certain norms, they risk estrangement or ostracism while outsiders may be granted much more room in this respect.

Van Dongen and Fainzang (1998: 245) show that anthropologists who do fieldwork “at home” are confronted with specific challenges and problems and argue that the main obstacle is the lack of distance needed for analysis and reflection on the data. They point out that these anthropologists might have problems involved in overcoming “insiderness”, such as shared history and personal experiences which may cause unconscious attitudes to one’s participants, such as forceful identification with a participant. Therefore, local anthropologists feel the need to distance themselves in their data analysis and ethnographic writing. The things they choose or need to keep distant, however, vary from person to person. The variety of issues for concern in doing research as a local testifies to the complexity of the problems of anthropology “at home” (Van Dongen and Fainzang 1998: 245).

In the thesis I will draw on my own research to illustrate challenges that I encountered and strategies that I employed in doing fieldwork “at home”. In this regard, I use “home” as doing research in my home country and also within the society where I grew up and still live, namely the Kavango region.²⁴

On the one hand, I had a range of advantages, most of all I speak the local languages in the area (Barrett 1996: 201) Moreover, I was familiar with the general structural setup of the area and the availability of various services like, e.g. the police station, post office, commercial banks, shopping centers, recreation areas, clinics and hospitals amongst others. On the other hand, and despite all these assumed advantages, I cannot claim that they all worked in my favour, that I did not experience any difficulty in accessing the field. I also cannot assert that I did not encounter problems in the field. This was partially because the study was conducted in the hospital/clinic setting a space where notions of confidentiality and privacy are highly advocated to protect patients and health care workers. As such I was required to go through various gatekeepers, before assuming my work as a researcher. My status as a health care worker (Registered Nurse), which allows me to practice as a nurse in the health care setting, did not grant me a free ticket for entry to the field either. Since my purpose for being in the hospital/clinics was not to practice nursing but rather that of a researcher, I was treated like an outsider. I had to follow certain rigorous procedures to gain access to the field. I will return to this point later.

²⁴ More on area of my research settings see chapter one (1.4.1 and 1.4.2).

Since this study was done “at home”, I studied the “other” and “self” simultaneously; I was what Abu-Lughod (1991) in her essay, writing against culture, referred to as being the halfy/halfies. Abu-Lughod used the term halfies to refer to people whose national or cultural identity is mixed by virtue of migration, overseas education, or parentage. However in this thesis I use the term “halfy” to refer to myself as a researcher and a member of the area of my study and that of being the nurse and a researcher. Therefore, my position as a researcher in this study was even more than that of being a halfy. I grew up in this region and my parents and siblings live in the area. Therefore, I had some understanding of the value and meanings associated with the cultural setting within which my study happened. I am also familiar with the health care system in the area.

My knowledge of the health care system stems from four years’ experience as a nursing student and two years as a registered nurse. Hence, I had to deal with, what Mathews (1987: 302) termed, the hazards of being an “expert” observer, that of me having some knowledge of the medical language, action and value of the clinical situation and also of the society that I was studying. The author (Ibid) argues that understanding of the practices and meanings of a clinical setting greatly reduces the time and cognitive effort necessary to adjust to an otherwise “foreign culture” and language. It also enhances the investigator’s credibility as a serious observer of the clinical situation and can help dispel perceptions physicians and nurses may have about the anthropologist’s intent to expose, criticize or disrupt the clinical system. However, such knowledge may reduce the “objectivity” of the anthropologist’s observation. Although anthropological work is generally seen as subjective, I had nonetheless to struggle to maintain some level of objectivity, or to balance in my understanding and representation of my findings. To do so I had to constantly corroborate or even validate my own understanding of clinical practice in relation to the people who enact day-to-day clinical reality (Mathews 1987: 304). For example, I asked health care workers to explain their work and the rationale for their actions even though it appeared to be obvious to me.

Abu-Lughod (1991: 141) remarks that while halfies might have advantages when of doing local ethnography (like myself), they are faced with special dilemmas especially the assumption in cultural anthropology that there is a fundamental distinction between self and other. She argues that one cannot be objective about one’s own society, an issue that affects indigenous anthropologists (Western or non-Western) in particular. Notions of objectivity

and subjectivity are always a greater concern for the researcher doing fieldwork in one's own society.

In this regard the Vagciriku of the Kavango have a saying (that is represented in the subtitle) "*Shingurukutu kapi shakuyuvanga lidumba lyasho*" (a stinkbug is not aware of its own bad smell). Literally the aforementioned implies that a person is unable to see or identify his/her own problems or be unbiased. Similarly, Abu-lughod (1991: 141) pointed out two common, intertwined objections to her work as a feminist, or local or semi local anthropologist. She notes that the first has to do with the partiality (as bias or position) of the observer while the second has to do with the partial (incomplete) nature of the picture presented. She argues that halfies are more affected by the first problem, feminists by the second. Therefore studying one's own society is associated with the problem of gaining enough distance. Since for halfies, the "other" is in certain ways the "self", the danger shared with indigenous anthropologists is that of identification and an easy slide into subjectivity (Abu-lughod Ibid). In my own case, I needed to remain aware that my approach and understanding may be biased in some ways. However, in doing this research I constantly tried to be as neutral as possible by keeping notes and being alert of my own cultural "baggage" as a member of the society and as a health care worker. In this way I hope that the data that I collected and present in this thesis gives insight into the "reality" on the ground, and is not too deeply coloured by my own subjective understandings and feelings.

However, I do draw and reflect on my experience as a nurse and as a member of the society to illustrate or make sense of certain issues when necessary. As Bourdieu (2003,: 291) argues, there is nothing wrong in drawing from our own experiences to make sense of the situations that we observe during fieldwork, as long as we reflect on these experiences and subject them to "rigorous scientific examination" (Mfecane 2010: 32). James Clifford (1986a: 6) argues that ethnographic representations are always "partial truths" and noted that what is needed is a recognition that they are also positioned truths. Hence, I am, for instance, aware that participants in this study might have withheld certain information from me for various reasons. As Mfecane (2010: 32) shows, the investigator's gender, cultural background, age, socio-economic status, and such bear heavily on what kinds of truths he/she is able to generate from the research participants.

3. Entry to the field

Since the study involved humans and dealt with HIV/AIDS, which is a very sensitive topic, I was circumspect and very careful with the participants. Before I went into the field I needed to meet certain ethical requirements. In this regard, my research proposal had to meet the ethical standards of University of the Western Cape, as well as those set out for Social Sciences Health Research and for the Medical Research Council and the Ministry of Health and Social Services in Namibia. As such I anticipated that I might encounter various challenges with the participants' discussion of sexual issues as well as in gaining access to certain data in the hospital/clinics. As Gune and Manuel (2007: 2) pointed out, sexual matters embarrass people - mostly because sexual practices involve some degree of privacy. It thus has ethical implications for scientific study and the publication of findings.

Accessing the field was a greater challenge for me than I anticipated. After my research proposal was approved by the university in June 2010, I started communicating with Mr. Muntenda (Senior Health Administrator in Rundu) through emails. He (Muntenda) asked me to send him an electronic copy of my research proposal, which he was going to present to the research committee in Rundu. He further advised me that I should get an official permission letter from the office of the Permanent Secretary in Windhoek before going into the field. While I was on holiday in December 2010, I visited the Ministry of Health and Social Services' head office in Windhoek to enquire about the permission letter. I went to the office of the Permanent Secretary and I presented my proposal to the receptionist. She referred me to the Director's office. The latter referred me to a Mr. Jakes. It took me a week to get someone to assist me. In many cases I was told that the person who can aid me was attending a meeting. I also learned that some of the staff had already gone on leave. There was a shortage of staff, as well. Finally a member of the Research Committee in Windhoek asked me to write a letter directed to the Permanent Secretary to seek permission to conduct research in public hospital/clinics in Rundu. I was required to attach my research proposal and curriculum vitae.

Despite this effort the status of my application was still pending by the first week of January. I then presented my case to the management team in Rundu. In response they requested a copy of my research proposal. Although I had sent a duplicate of my research proposal to the Senior Health Administrator (Mr. Mutenda), who was still on leave, it appeared that the rest

of the management team did not know about it. Since I did not have a written permission letter from the Permanent Secretary, some of the management staff was concerned. Later that day I was informed by the Central Medical Officer (thereafter CMO), Dr Wambungu, that I have to return the following Monday. He notified me that most of the management staff were still on leave and were expected to be in their respective offices by the next week. He stressed that I should get the Research Committee in Windhoek to fax me a permission letter to conduct research.

While the management staff were busy scrutinizing my proposal, the Primary Health Care Office in Rundu offered me accommodation at Kaisosi clinic - approximately 10 km east of Rundu on the outskirts of the town. I also made daily calls to the office of the Permanent Secretary in Windhoek to enquire about the status of my application. I finally received verbal permission to conduct my research while waiting for the official letter from the office of the Permanent Secretary in Windhoek. Entering the field appeared to be more complex than I had anticipated. Neither being a local person from the area, nor my status as a registered nurse seemed to help much.

Similarly, within the growing body literature on hospital ethnography it becomes apparent that barriers can arise to an anthropologist accessing a hospital or clinic space (Debbi et al 2008). Access cannot be taken for granted. Debbi et al (Ibid) argues that hospitals are highly structured, protected and exclusive/excluding institutional spaces and are not easily accessible to ethnographic enquiry. This was very difficult for me to accept, since I have worked in these institutions for the past few years as a Registered nurse. However, for the purposes of this research I had to pass various gatekeepers. Nevertheless I was very grateful that the management staff finally reached a consensus by the second week of January to grant me the permission to conduct research in Health Care facilities in Rundu.

4. Methodological strategies

Various ethnographic methods were employed during my data collection. As Bohmig (2009:29) shows, doing ethnography requires several techniques and methods in order to gather data, starting with Malinowski's classic text on fieldwork techniques (1922) to Geertz's plea for "thick" description (1973). She notes that ethnography is an activity, a kind of intellectual effort and a narrative style, a process of doing, thinking and writing. The main

method of my fieldwork was participant observation. I worked as a nurse in two clinics in Rundu, the capitol town of Kavango namely Kaisosi clinic and the Center for Disease Control (CDC) clinic.

Akuupa (2006:13), who also did research in Kavango, notes various critiques of qualitative research methods and participant observations particularly, regarding the lack of rigor associated with it. For example, even clinical anthropologists may not be able to truly participate in a hospital context when he/she enters it as a researcher. In this regard, Wind questions the complacency and naïveté of ethnographers who claim to understand the “other” because they practice participation, especially with regards to pain and suffering of the sick (Debbi *et al* 2008: 25). While I do recognize that all methods have their shortcomings, for this study I adopted participant observation as the main method. It made my research possible as it allowed me to get access to more information that an “ordinary” (not medically trained) researcher will get. In this regard, I provided an extra hand to the nurses, and in a way they (nurses) regarded me as one of them. Hence Nurses made their data (patient’s records, routine monthly statistics) available to me without questioning notions of privacy in relation to their patients. I nonetheless maintained strict confidentiality. However, participant observation as a clinician nurse was the best option for me. Similarly, Bohmig (2009:32), herself a nurse, shows that participant observation in hospital settings has positive effects; it helps to reduce workload for clinical staff and she argues that sitting around and asking questions is less productive and limits the willingness of the nurses to deal with a researcher’s presence. I spent the first six weeks at Kaisosi clinic working as a nurse. I spent most of the time in the antenatal care (ANC) and family planning (FP) room.

I used to work every Wednesday and Thursday (known) as ANC days. The rest of the days I went into the community to look for traditional healers, made appointments and conducted interviews with them. The last six weeks of my research I worked in both clinics mentioned above. Wednesday and Thursday I usually assisted at Kaisosi clinic whilst Monday and Tuesday I worked at CDC clinic. My participants (HIV-positive pregnant women) were drawn from women who came to ANC at Kaisosi clinic. HIV+ mothers, who had recently given birth, were recruited at CDC. I held formal semi-structured and open-ended interviews with these women, assisted them, and observed them. Nurses and doctors were too busy during working hours and I conducted a focus group discussion with registered nurses from various clinics that were involved in the PMTCT in Rundu.

There was always a lot of noise in these clinics and I had to take as many notes as possible. I often used a voice recorder to record interviews or activities such as health education sessions, but it was always very noisy. In the case of traditional healers, I utilized narratives of healing to understand their perception of HIV/AIDS, mainly their healing notions, practices and methods. I also recorded these.

5. Conducting field work; positioning of self and being a *Mundambo* (local/known person)

Abu-lughod (1991: 468) pointed out that selfhood or subject hood is always a construction, never a natural entity or found entity, even if it has that appearance. She argues that the process of creating a self through opposition to another always entails the violence of repressing or ignoring other forms of difference. In conducting this study, besides being a halfy, my position of a researcher was not “natural” but rather constructed like Abu-lughod (Ibid) shows. Various issues affected my position as a researcher - amongst others my status as a health care worker (Registered nurse), local person (*Mundambo*) and an introduction made by my aunt to her fellow work-mates and patients. I will unpack this in the next section below.

The 13th of January 2010 was my first official visit to Kaisosi clinic. By then clinic staff already knew who I was and what my purpose at the clinic entailed. I had been offered accommodation at the same clinic. My aunt, who works at the clinic as an enrolled nurse, furthermore introduced me to staff members during one of my visits to the clinic. She spoke in Rumanyo language saying:

This one is my child the child of my biological sister whom I follow. He will be doing his research here in Rundu, but he is not just an ordinary person no, he is also a nurse by profession. In fact he went to the nursing school and completed together with Mr. Kamukwanyama²⁵ at UNAM.²⁶

²⁵Kamukwanyama is the Registered Nurse in charge at Kaisosi clinic however by the time I arrived at the clinic he was on leave and I was informed that he will resume duty the following week. Moreover Kamukwanyama and I knew one another from the nursing school at the University of Namibia (UNAM) and graduated the same year in 2007

²⁶UNAM stands for the University of Namibia.

(Oghunone monande mona mukurwande ogho nakwama ngayaruwana research yendi muno muRundu. Mara kapishi muntu tupu hawe, nayenka nersa. Kumwe vene vayimbire shure yavo nakumananka kumwe nava mister Kamukwanyama)

My aunt's introduction is very crucial and to certain extent impacted on how health care workers treated and regarded me as a researcher/nurse as well as a researcher/*mundambo* (local person). As such, health care workers did not only consider me as one of them (a Nurse) but they also saw me as a *mundambo*.²⁷ When my aunt introduced me to the receptionist (Wayera) she referred to me as *Likoro lyetu*²⁸ (part of our clan). Later she introduced me to an Enrolled Nurse, who started working at Kaisosi clinic toward the end of my research, as "my distant cousin". My relationship to these people was thus different to that of the rest of the staff members. For instance, the receptionist treated me with a lot of respect. Yet, due to our shared clan membership I could not discuss sexual issues with her or in her presence because it is taboo to do so. For example, there were moments when the clinic was not busy especially on public holidays and over weekends when staff members, particularly the younger members, talked about relationships and sex issues. I noticed that, on such occasions Wayera excused herself. I was very cautious about the issues I could talk about in her presence. At times I initiated discussions with health care workers (informal) on a number of issues such as abortion, HIV/AIDS and PMTCT²⁹. When Wayera was present, however, I tried to avoid such topics. It was completely the opposite with the enrolled Nurse whom my aunt introduced as my distant cousin. With him (my distant cousin) I was able to openly engage in any kind of discussions including sexual issues without any concern whatsoever.

After my aunt's brief introduction, staff members warmly welcomed me and said to me "*Tunamutambura maghoko maviri*" (we welcome you with both hands). Staff were very keen to know what exactly I was studying, at which university, how long is the course and what type of work I will be doing after completing my course. Some seemed disappointed when they heard that I can still work as a Registered Nurse after completing my studies. They asked me why I went to study if I would earn the same salary after completing the course.

²⁷ Mundambo is someone who is familiar, known and accepted to the local people in an area.

²⁸ Likoro is a communal relationship tightened by clan affinity (Akuupa forthcoming). *lyetu* meaning "our". Similarly Mbambo (2002: 77) noted that *Likoro* (clan) is composed of people who trace their common descent from a remote founding ancestress who, in most cases, is either completely unknown or merely a legendary figure.

²⁹ PMTCT stand for Prevention of Mother to Child Transmission of HIV.

It was easy for me to identify most of the staff such as nurses, cleaners and security guards by the type of the uniform and epilates they wear. However, I only came to realize the roles other staff members, such as TB coordinators and community counsellors later in the week. I explained to the staff that I was also interested in indigenous healing. I planned to have interviews with traditional healers. This piece of information was received with mixed feelings. Some staff members distanced themselves from traditional healing and expressed limited knowledge about its practitioners and their activities in the community. However, the male community counselor who is from the area told me that he knew a number of traditional healers in the community. He was willing to take me to them.

The first week at Kaisosi clinic I worked with Mr. Kamukwanyama, a registered nurse in charge of the clinic. We worked in the antenatal (ANC) and family planning (FP) room. Kamukwanyama told me:

Just like you know we have a serious crisis of staff shortage in nursing therefore there's no time to do things as it is supposed to be done.

I assured him that I was not there to observe mistakes and policy implementation. He asked me to help him do the parameters, to check vital signs (blood pressure, pulse and weight) while he did the palpations and record keeping. He told me;

Wednesday is our first visit, so in this room we only attend to pregnant women who come to the clinic for the first time for the current pregnancy and Thursday (tomorrow) is our follow up visits that means we only attend to pregnant women who come for their follow up visits. For instance the pregnant women whom we are going to see today will be given dates when to come back to the clinic for follow ups depending on the stage of their pregnancy, I mean, you how this things work you are a nurse after all

The room had a lot of medical equipment, a bed, table, chairs and a lot of educational posters on the wall. Whilst the settings was very familiar to me, I had to constantly remind myself that I was an anthropologists and wanted to understand PMTCT from the insider's perspective which is at the heart of most ethnographic research.

Kamukwanyama first took the history of the pregnant women. He always asked the first question: "*kwakuyatameka siviha*" (you have come to start *siviha*?). *Siviha* means the weighing scale. In Rundu, antenatal care is locally referred to as *Siviha*. The notion of

Sivih comes from the word *kuviha* (checking the weight); since, at every visit, pregnant women are weighed. Thus the community uses the word, *Siviha*, to refer to antenatal care period.

The first week that I worked at Kaisosi Clinic I was referred to as *mugenda* (visitor) by the health care worker. In the course of this week I was asked questions such as, e.g. what is that you are doing here? Where are you studying? What are you studying? What type of job will you do after completing your study? Mr. Kamukwanyama frequently asked me what I was writing in my note book. Overtime he stopped noticing my note taking. When I first arrived, he usually explained how clinical procedures were supposed to be done. He then pointed out that, due to staff shortages or lack of equipment, it will be done differently. Yet, in time, he lost this concern to point out to me that, in the everyday world of the clinic, what was done was not always according to protocols or policies.

Health care workers always put money together to buy food a female staff member prepared a meal for us in the clinic kitchen. During my study, although we were four males working in the clinic, only female staff cooked lunch. The female staff assigned the task of cooking among themselves. The person who was assigned to cook usually went for early lunch to prepare the meal. At the beginning I was wondering where staff got the money to buy food. Later I noticed that one of the female staff members went from room to room to collect the money from other staff. At no point I was asked to contribute although I was also eating with them. I sometimes contributed voluntarily if I noticed that they are collecting the money. During lunch time it was a common practice for women to eat together on a separate plate in the clinic kitchen. We (men) ate together on one plate at Kamukwanyama's flat. The meal usually consisted of *mahangu* pap with *mutete* (traditional spinach). The only thing that changed was the relish, which was mainly meat, fish or other local vegetables. This type of practice is common amongst the local people, especially in the villages - where boys eat together on separate plates from girls. Although I had my own flat, I shared the kitchen and bathroom with Kamukwanyama. This was because I did not have water in my flat. I was informed that plumbers from the Ministry of Works and Transport would fix it, but this never happened.

When I first visited the Centre for Disease Control Clinic I already had the letter of permission from the Permanent Secretary. Nevertheless, I was told to first get permission from the hospital matron. The matron told me that she was no longer authorized to give

permission to researchers and she referred me to the Hospital Superintendent. He was away that time and I only got hold of him a week later. I met him in the corridor and I told him that I had been looking for him for a week. He asked me;

Why should they send you to me for that? Anyways a lot of research needs to be done especially with regards to HIV/AIDS, just go ahead tell them I approve.

At the CDC clinic I once again explained to the doctor in charge that I had verbal permission from the Hospital Superintendent. She immediately took me around the clinic (orientation) and introduced me to the nurses. After lunch I joined the rest of the nurses in the nurse's consultation room. Three were in one room sorting out files, drawing blood and doing DNA PCR³⁰ tests on infants. One nurse said to me;

but Mike in this room you won't get anything, because what we do in here is just pick, pick, pick that's all nothing else, it will be more helpful if you can go to the counseling room.

I noticed the discomfort of nurses with my presence. I told her I was fine and I will go to the counseling room eventually. I was not of great help to the nurses, since I could not draw blood because, in case of a needle-stick injury, I would not get post-exposure prophylaxis since I was not an employee of the Ministry of Health and Social Services at that time. At the CDC clinic I spent most of my time in the counseling room, where three counselors conducted sessions simultaneously. To be frank, I was shocked as I continuously witnessed this type of practice and I have never seen such lack of privacy in my entire nursing career. Before I could ask, a senior community counselor, while she was busy with a patient looked me in the eyes and said;

You must write very well, but you have seen it yourself the crowd outside, if one person enters at a time then we will leave this place twelve o'clock at night(*Ntjanga nawa mara ghunavikumonene vene naghumoye ashi weni limumbuka pandje, kene angenangemo muntu ghumwe pashikandonemeshi ndi twelf yiri yamatiku tutundapo pano*)

³⁰ DNA PCR (Deoxyribonucleic acid polymerase chain reaction) test is the test that is mainly used to test babies born to HIV infected mothers at six weeks. Other tests such as ELISA or rapid HIV tests which are mainly used to test adults on the basis of HIV antibodies presence in the blood have been proved to be unreliable in babies. It is noted that maternal HIV antibodies can pass through the placenta during pregnancy; therefore babies born HIV-positive mothers may have a positive HIV antibody test. Moreover it is further noted that the passively transferred maternal HIV antibodies may persist for up to 18 months (PMTCT guidelines 2004: 34).

I came to learn that, at the CDC clinic, notions of privacy and confidentiality is partially adhered to. At times I was in the doctor's consultation room and I played a double role researcher and a translator at the same time. All doctors were foreign and could not express themselves well in the local languages. Therefore, I had to translate for them whenever I was sitting in their consultation rooms.

6. Nurse's general reaction

During my stay and interaction with nurses I observed that they regarded me as one of them. In this regard, during health education for pregnant women; they (Nurses) introduced me as one of them, part of the health care workers. When nurses talked about my roles in the clinic - apart from that of been a nurse they told patients that I was there to do a study on pregnant women. Nurses urged patients to fully cooperate with me. Therefore, Nurses in a way forgot that they were also part of my study, that I was interested to see on how they translate the PMTCT programme to pregnant women. Nurses regarded me as their coworker, *mundambo*, who was conducting a study on pregnant women and traditional healers. I was often called from my flat to assist them in the clinic especially if there were a lot of patients.

7. Ethical considerations

It must be noted that names of the participants have been changed to Pseudonyms and where real names are used a verbal consent was granted by the participants. It is equally important to note that most of the health care workers requested me not to change their names. The hospital/clinics are institutions governed by rules and regulations in the best interest of the patients. During my fieldwork as a novice anthropologist, and while trying to understand the actors in this very complex social space, various ethical issues gnawed at me and I was puzzled and uncertain whether react to these incidents as anthropologists/researcher or as a nurse. Patients asked me for my advice, since I was introduced as a nurse and patients expected me to have answers for the health problems that they were posing to me. One such incident was when one young, HIV positive pregnant, woman in her early twenties asked me:

Mike we were told that the baby can get HIV from breast milk and yet nurses are saying that we should breastfeed for the first four months, is the baby not going to get HIV during that time? She then poses her second question; Mike I really do

not want to breastfeed my baby but I do not have money to buy formula milk, is there no free formula milk in the hospital?

As much as I was willing to respond to her questions, my role in the clinic was firstly that of a researcher. I chose to refer her to Kamukwanyama, the nurse in charge of the clinic, instead. Kamukwanyama told me that he does not like doing pregnancy tests, especially for young girls. He noted that women often come to the clinic for pregnancy tests and, even if the pregnancy test turns out to be positive, they (women) never show up at antenatal care. Later, when you meet these women there no sign of been pregnant. It was just a matter of time before Kamukwanyama's concern was confirmed. One evening, while we were watching soccer around 22h00 at night, the security guard knocked hard on the sitting room door. He informed us that there was a very sick patient waiting at the clinic. We rushed to there and found a woman with vaginal bleeding. While we were attending to her, Kamukwanyama said to me:

You see what I always tell you look (he showed me in the health passport) this woman was tested (positive) for a pregnant test three days ago and now she did an abortion.

The woman told us that she had simply started bleeding. After we stabilized her, an ambulance was called and she was taken to the hospital for further management. Although it was potentially a police case none of us informed the police who are also stationed at the clinic.³¹ Later I heard that the woman's husband works outside the town and has been away for some time, therefore it probably was not her husband's pregnancy and she opted to get rid of it.

Another example was when a happened at doctor from the casualty department referred a woman to be tested for HIV at the CDC clinic. This woman concerned could not speak. Her mother told the community counselor that the woman was not deaf, yet she had become "mute" some weeks before. When I looked in her health passport, it showed that she was diagnosed with major depression a week earlier in Windhoek. She had been on psychiatric treatment ever since. The doctor in Windhoek advised that an HIV test must be done once her condition improved.

³¹In Namibia abortion is illegal, in the case of this woman we were supposed to diagnose her with self-induced threatening abortion, but we only wrote in her health passport "Vaginal bleeding, ? Threatening abortion". By law such a case supposed to be reported to the police.

At the CDC clinic the trainee community counsellor did not know what to do. Her mentor, who was busy with another patient, said to her; “you see that is a challenge for you, tell me what you do in this case”. The trainee counsellor was at a loss. Subsequently the mentor went to the patient and asked her one question after another. The patient was unresponsive and silent. Her mother again stressed that she (the patient) had remained mute for almost a month even though there was nothing wrong with her hearing. The community counsellor went ahead and performed the HIV test. After fifteen 15 minutes, the mother was informed that her daughter was HIV positive. Both of them were sent back to casualty to see the doctor who had referred the woman for the test (once her condition had improved). According to World Health Organization, ARV treatment is not an emergency treatment and patients need to be well informed before being tested and commencing the treatment. Since HIV treatment requires lifelong commitment in the above scenario it was wise to first treat the patient’s psychiatric problem and only commence ARV treatment after the patient’s condition has improved like the doctor in Windhoek has recommended rather than using her mother as a guardian.



8. Conclusion

In this chapter I have shown the complexity of doing fieldwork at home by teasing out the advantages and disadvantages associated with this kind of research in anthropological studies. The general view is that researchers doing fieldwork in their own societies have a range of benefits particularly that of language competency. Nevertheless there are specific challenges and problems that anthropologists who do fieldwork at home are confronted with, like the lack of distance in analysing and reflection on the data. However, in the chapter I argue that, while there is a need to be neutral for anthropologists doing fieldwork in their own society, it is also vital to draw on their own experience as local ethnographers to make sense of the data they collect. The latter should be exercised with cautions since it questions the local anthropologist’s subjectivity and objectivity on the study with regards to the data analysis and presentation.

CHAPTER FOUR- HEALTHY MOTHERS, HEALTHY BABIES, PREVENTION OF MOTHER -TO -CHILD- TRANSMISSION (PMTCT) OF HIV IN KAVANGO.

1. Introduction

Welcome to our clinic. It is good to see pregnant mothers who are taking care of themselves. The fact that you have come in here means you care about yourself and your baby. We would like to see healthy mothers and healthy babies, isn't that so? ³²

I use the above quote to illustrate the central ideas behind the Prevention of Mother-To-Child-Transmission (PMTCT) of HIV programme in Kavango. It operates as follows:

- (i) All pregnant women who come to the Antenatal care (ANC) receive health education in a group.
- (ii) Following group health education, pregnant women go for voluntary HIV counseling and after giving informed consent the pregnant woman is tested for HIV
- (iii) Post-test counseling is provided to all tested pregnant women.
- (iv) Pregnant women who test positive receive a dual therapy regimen - entailing Zidovudine (AZT) from the 28th week of pregnancy until labour and a single dose of Nevirapine (NVP) to be taken at the onset of labour.
- (v) Within 72 hours after delivery, the baby receives one dose of nevirapine 2mm/kg per mouth. If the mother receives neverapine less than two hours before delivery or did not receive neverapine at all, the baby is given a double dose of neverapine.

Since the implementation of the PMTCT programme in Namibia in 2002 it has 90% coverage of all health facilities, 94 % HIV testing uptake coverage, 70% ARV prophylaxis coverage, 95% infant ARV prophylaxis coverage and 11 % percent vertical transmission

³²Kamukwanyama a registered nurse in charge at Kaisosi clinic addressing pregnant women on the 24th of February 2010.

rate.³³ This chapter aim to address and respond to the following questions: How do staff involved in the PMTCT programme in Kavango “translate” and explain the PMTCT programme to the women? How do the HIV positive women and health care worker perceive the PMTCT program? How do women, who participate in the PMTCT, understand the use and working of anti-retroviral for themselves and their babies?

In this chapter I show that health education given by health care workers affect how pregnant women respond to the PMTCT programme. I argue that health care workers convey a message of hope to newly diagnose HIV-positive pregnant women - which in a way is helpful in maintaining high self-esteem and reduces anxiety. While health education has an impact on pregnant women’s perception of PMTCT programme, the wider understanding of the PMTCT programme by HIV positive women should be scrutinized by attending to women’s previous knowledge and experience. It is important to pay attention to health education, which I view as an instrument of social change in the lives of pregnant women in Kavango. Health education can be defined in various ways. In this regard, Simonds (1976:107) shows that health education is aimed at bringing about behavioural changes in individuals, groups and the larger population from practices that are presumed to be detrimental to health, to behaviour that is conducive to the present and future. Similarly, Green et al (1980:7) argue that health education involves a process of assisting individuals to act separately or collectively to make informed decisions about matters affecting their personal health and that of others.

2. Health education, the notion of *kambumburu* (HIV), pregnancy and PMTCT in Kavango.

In Kavango, pregnant women go to the clinic on Wednesdays and Thursdays to attend antenatal care (ANC), locally called *Siviha*³⁴. It is the policy of the Ministry of Health and Social Services that all pregnant women, who attend ANC, must receive health education in a

³³ The Development of Harmonized Minimum Standard For Guidance on HIV Testing and Counseling and Prevention of Mother- To-Child- Transmission of HIV in the SADC Region.(2009)

³⁴ *Siviha* means the weighing scale, in Rundu antenatal care is known by the local people as *Siviha*, the notion of *Siviha* comes from the word *kuviha* (checking the weight), since pregnant women at every visit are being weight the community uses the word *Siviha* to refer to antenatal care period.

group at their first visit. Health education takes place in a private room, where health care workers address pregnant women on various health related topics. These include personal hygiene, maternal nutrition, family planning, malaria prophylaxis, immunizations, prevention and treatment of sexual transmitted infections (STIs), prevention and transmission of HIV, routine counseling and voluntary testing for HIV, sharing result with partners, ARV medicines for PMTCT and therapy, baby care and infant feeding options. These sessions last about 45 to 60 minutes and most of the time is used to talk about *ghuvera waghupe* (the new disease) or *Kambumburu* (HIV/AIDS) as known in Kavango. *Kambumburu* is derived from the word *shimbumburu*. The later means an insect, *kambumburu* is a very small insect. Thus the direct translation of HIV is *Kambumburu* (small insect). Although HIV/AIDS have been around for more than two decades, it is still regarded as (*ghuvera waghupe*) the “new disease”. This concept is used by the health care workers, patients and traditional healers to refer to HIV/AIDS. The notion of *Kambumburu* (HIV) is explained to pregnant women by health care workers. They talk about the causes of HIV, mode of transmission and preventative measures. Health care workers also explained to pregnant women that blood will be drawn into four tubes, two red ones, one purple and one yellow. The first red one is for blood grouping, the second one is for sexually transmitted infection, (STIs) specifically syphilis, the purple one is for Hemoglobin (Iron). The fourth tube (Yellow) is for HIV (*Kambumburu*). During my fieldwork no blood was drawn into the yellow tube for HIV because the HIV rapid test was done.³⁵

Health care workers also discuss the programme of Prevention of Mother-to-Child-Transmission of HIV (PMTCT) as seen below.

If you take a rapid test you will get your result back today. If the HIV test is re-activated then it means you are HIV positive, you have *Kambumburu* (HIV), the virus that causes AIDS. Or if your result says non-reactive, it means you do not have *Kambumburu* (HIV) but sometimes it can mean that you are in the window period. This means that you may have the virus, but it is too soon for your body to have reacted to it. It may take twelve weeks or more, after you become infected with the virus for the test to show reactive or positive. That is why it is important to repeat the HIV test three months after you receive negative results. (Michael

³⁵HIV rapid test is a test for detecting HIV antibodies in human blood that produces results in less than 30 minutes. At Kaisosi this test was carried out by the community counselors.

Sinonge³⁶ giving group health education to pregnant women at Kaisosi clinic on the **24th February 2010**).

If you are willing we will test you for HIV, HIV can be passed from a mother to her baby during pregnancy, labour, delivery and breastfeeding. Why is it important that I should talk about HIV now that I'm pregnant? Why? As I said, a baby can get HIV from the mother, but there is now something that we can do to help protect the baby and to take care of you as well. We have an important program called the Prevention of Mother- To-Child –Transmission (PMTCT) of HIV to help keep our babies from being born with HIV. Know your HIV status. We want to encourage all pregnant women to go for HIV test, but no one is forced. This is what we are saying about PMTCT. (**Paulina**³⁷ giving group health education to pregnant women at Kaisosi clinic on the **20th January 2010**)

So after this talk, those who are willing to be tested, feel free to go for the test, it is good to know your status. Don't deny yourself this opportunity of going for a test. We are shy because of the stigma, because we have this tendency to think that HIV is somebody else's virus. HIV is not somebody else's virus; it yours and mine, my neighbour's virus, my sister's virus. We have to work together to accept HIV like other diseases. (**Treatment Action Campaign Member** giving group health education to pregnant women at Kaisosi clinic on the **24th February 2010**)

PMTCT protect your baby from HIV. To protect your baby it is important to do three things. Number one is to know your HIV status. That is why we are encouraging all mothers to take the test. Number two is to prevent transmission to your baby by taking the short course of ARVs from 28 weeks until you give birth and in addition to that you must take the Nevirapine pill when labour pain starts. So this medication that you get through PMTCT is the medications of hope. The medications can lower the amount of virus in your blood thus it lowers the risk of you transmitting the virus to your unborn innocent baby. (**Ceasar Delia**³⁸ giving group health education to pregnant women at Kaisosi clinic on the **20 January 2010**)

³⁶ Michael Sinonge is a male community counselor at Kaisosi clinic

³⁷ Paulina is a community counselor at Kaisosi clinic

³⁸ Ceasar Delia is novice qualified enrolled nurse.

From the above I argue that health education is used as a tool in which the PMTCT programme is translated and explained to pregnant women in Kavango. The primary purpose of the pregnant women's visit to the clinic is for general check-up, to make sure that the infant inside their womb is well and healthy. However, at the clinic pregnant women are confronted with moments of making a "quick decision" which in turn alters their entire life. I term it "quick decision" because pregnant women have to make a choice whether to take the HIV rapid test or not in a very short period of time. To some of the pregnant women this comes as a shock. However there is little room to manoeuvre because the life of the unborn baby is at stake. As shown above, health care workers encourage all pregnant women to go for the HIV test - and this process is described as a once-off opportunity to save the baby. As Paulina³⁹, a health care worker at Kaisosi clinic put it.

Before you were pregnant, maybe you didn't think about HIV too much. We are all scared to go for a test, because we don't want to hear the result. However now that you are pregnant, you think I want my baby to be healthy. I am scared to know about HIV, but because of my baby let me know my status. Hey? Because now there is help for the baby and by knowing your status you can help take care of yourself, your partner and your family too.

As seen above, pregnant women find themselves in a position of not necessarily wanting to know their HIV status, but they want to ensure that the baby they are carrying is healthy. Thus, HIV testing becomes an entry point to the PMTCT programme and pregnant women who test HIV positive sometimes end up questioning their collective identity. Given that the body is a site of social identity, HIV positive women wonder what will happen their status shifts from that of a "healthy" body to that of a "sick" (meaning HIV+) body. The body is central to the experiences of these HIV positive women as human beings and this understanding is questioned once she is diagnose with HIV. As Hughes et al(1987:7) show, society in sickness and in health offers a model of understanding the body. The author (Ibid) argues that, while the healthy body offers a model of organic wholeness, the sick body represents social disharmony, conflict and disintegration.

³⁹Paulina (Ibid)

Pregnant women, who tested positive, told me they were deeply affected by learning that they have HIV (*Kambumburu*). They questioned their whole lives; they worried about what will happen to themselves, their close relationships, families and in particular their children. What is so striking is that HIV posed a dilemma to Kavango women's understanding of themselves and their health. For these pregnant women, knowing their HIV status for the first time had various meanings. As Berer and Ray (1993) write, once you are told that you are HIV-positive, there is no such thing as being asymptomatic. You may not have physical symptoms, but your life is forever changed. The authors (*Ibid*) argue that many women become angry and blame themselves when they learn that they are HIV positive. Women told me similar stories and stressed that, no matter how they became infected; many felt isolated and alone.

In Kavango, after post-test counselling, all pregnant women are sent back into the ANC/family planning room for further management. However, this time around, they enter this space one-by-one. Nurses check the health care passport and the first thing they look for is the HIV results. Pregnant women, who tested negative, gave blood for blood grouping, Hemoglobin and STIs. In the case of pregnant women, who tested positive, additional blood samples were drawn in the purple tube for CD4-counts. Nurses translated CD4-counts as *Vakwayita vomorutu*. *Vakwayita* means "soldiers" and *vomorutu* means "of the body". Since CD4-cells are a type of white blood cell, which fight against HIV. CD4-counts are used as one of the clinical criteria to determine whether HIV positive women are eligible to start ARV-treatment or not. Asymptomatic pregnant women, who had CD4-counts of more than 200/mm³, were enrolled into the PMTCT-programme and received the dual therapy regimen. It entails Zidovudine (AZT) tablets from the 28th week of pregnancy until labour and a single dose of Nevirapine (NVP) to be taken at the onset of labour. Those who had CD4-counts of less than 200/mm³, or WHO stage III or IV, were referred to the Center for Disease Control (CDC) to be initiated onto HAART.⁴⁰

3. Pregnant women's perceptions and understanding of the PMTCT programme.

The word PMTCT was difficult for most of the pregnant women in my study to pronounce and to remember. The majority of them know that there is a programme of hope that can help

⁴⁰ HAART stands for highly active antiretroviral therapy.

and prevent them of passing the *Kambumburu* (HIV) on to their unborn babies. Below are Kavango pregnant women's voices on their understanding of the PMTCT programme.

P1.⁴¹ What? Which programme? I just heard that there is medication which helps the baby, the one in my womb so that he/she does not conduct the virus. So that my blood does not come into contact with my unborn child. (*Ngapi? Asi elikwamo musike? Ame kwazuva asi podili nomutji dokuvatera mukeke ogo akara mezimo asi kapisi agwanene Kambumburu. Asi honde zange nezi zomunona kapisi diligwanekere.*)

P2.⁴² The programme is for medications. The medications which helps the baby to prevent contracting HIV. One has to drink the medication so that the HIV virus in the body will die. (*Likukwamone lyo mutondo. Mutondo ne kuvatera mukeke ashi kanya kambumburu kapishi akawane. Kunwamutondo mposhi shimbumburu shife murutu*)

P3.⁴³ That programme? Yes! They have found the virus. Then I asked them will I die? They told me no. the programme I was told prohibits sexual intercourse unless you use condom, no drinking of alcohol and after birth one can only breastfeed up to four month. (*Olyo likukwamo? nhii Kambumburune vanakawanamo. Napura ashi kufandi? vavo ashi kwato kufa. Likukwamone ashi kapishi kulikundama panyama kwandikuruwanitangumi, kapishikunwa marovu ntani kuyamweka tupu makwedi mane pakushampuruka*)

P4⁴⁴ The Nurses are saying that you must just breastfeed for four months, and then you change to formula milk. In that four month can the baby not contract HIV, if HIV is present in breast milk? (*Mara vavo va nesa kunakurenka ashi kuyamweka tupu dogoro mwedi nee, makura mukeke kumupangoli mashini ghamushitora. Mara omo mu makwedi manee ne nakuvurashikuwana osho shimbumburundi shasho ne mposhili mumashini*)

⁴¹P1 in this regards is referred to pregnant woman number one interviewed at Kaisosi clinic on the 20th of January 2010.

⁴² P2 in this regards is referred to pregnant woman number two interviewed at Kaisosi clinic on the 24th of February 2010.

⁴³ P3 in this regards is referred to pregnant woman number three interviewed at Kaisosi clinic on the 24th of February 2010.

⁴⁴ P4 in this regards is referred to pregnant women number four interviewed at Kaisosi clinic on the 20th of January 2010.

During my interviews the majority of the pregnant women showed little knowledge about the PMTCT programme. However, once they learned that they were HIV-positive, they were eager to get the antiretroviral drugs. They also wanted the medication immediately. As one newly diagnosed pregnant woman narrated to me:

I did ask them if they can help me with the medication and they told me to wait. The nurse said first they have to see the number of virus in my body, may be next time, but I want the medication now.

Despite women's uncertainty about the PMTCT programme it was important to them to access ARVs, known locally as '*nopera detintiko*', which means pills of immunity. Other components and directives that made up PMTCT as a comprehensive programme were not adhered to. Among its critical components are infant feeding options, maternal nutrition, sharing results with a partner and the testing of a partner.

4. Women's understanding of the use and working of anti-retroviral for themselves and their babies.

Pregnant women, who participate in the PMTCT programme, view antiretroviral (ARV) drugs as their last hope. During my interviews the majority of participating women appeared to have little knowledge regarding antiretroviral drugs as pharmaceuticals, yet they understood that ARVs are not a cure for HIV/AIDS. However pregnant women were eager to get ARVs for two reasons. The first relates to the notion of "hope". HIV positive pregnant women believed that the lives of their unborn babies depend on ARVs. Most HIV positive pregnant women told me that they were participating in the programme because they want to save the lives of their unborn babies. As one woman told me at CDC while she was waiting for her child HIV test results;

I came to collect my child HIV results and I am praying so hard that it should be negative, as for me it is ok I accept the disease but my child did not do anything.

Secondly, women perceived ARVs as their last hope to prolong their lives. Once women were told that they were HIV-positive, they saw themselves as being sick, having the disease (AIDS). Therefore, it was important for them to get the pharmaceuticals as soon as possible. Although women experiences fear, stress and depression when they first learn that they are

HIV positive, nurses gave them a message of hope through the ARV drugs. Nurses and community counsellors assured pregnant women that they can still live a long period of time, even more than 20 years if they “live positively”. Women who tested HIV-positive were encouraged by health care workers to live in a particular way that enhanced their chances of staying ‘healthy’, whilst metaphorically being sick, i.e. having HIV as opposed to progressing to full-blown AIDS. Positive living is also used as social criteria before one start taking ARV drugs. These social criteria include the following:

- (i) One should have a fixed resident for the past three months and the next three months.
- (ii) One should not abuse drugs or tobacco.
- (iii) One should come for follow up visits to the clinic or hospital every time when needed.
- (v) One should be committed in taking ARV medications every day for the rest of his/her lives.
- (vi) One should abstain from sex or use condom or femidom. (v) One should have a treatment supporter.

Enrolling into the PMTCT programme requires long-term commitment. HIV+ pregnant women visit the clinic more regularly than pregnant women who tested negative. The former often have to give routine blood samples depending on their CD4-counts. The importance of taking ARV medication to enhance the unborn child’s chances of being born HIV-negative is well understood by pregnant women. In this regard, women who were pregnant for the first time (primigravida) appeared to be less knowledge than multigravida.⁴⁵ Some of the pregnant women had participated in the PMTCT programme in their previous pregnancy, while others were already on ARV treatment. Pregnant women, who were already on ARV treatment, did not participate in the PMTCT programme and did not need the ARVs prophylaxis. However, those that were still waiting to start treatment because their CD4-counts were still high were enrolled into the PMTCT programme for the second time. Pregnant women were often informed about PMTCT by bodies/organizations involved in HIV/AIDS activities in Kavango. In conjunction with the Ministry of Health and Social Services, which provides ARV treatment at Rundu state hospital, various stakeholders, such as non-government organizations, are very much involved in HIV activities. This includes New Start Center, that

⁴⁵ Multigravida` is a woman who has been pregnant more than one time. The births may have been interrupted by abortion, fetal death, or may have resulted in a live birth.

provides voluntary counselling and testing (VCT), as well as ARV treatment. A range of church organizations such as Catholic AIDS Action, are involved in home based care (HBC).⁴⁶

As indicated before, HIV positive women saw ARV drugs as good and as their last hope of survival for themselves and their babies. However, it is important to note that ARV drugs have side effect such as nausea and vomiting, stomach cramps, fat loss (lipoatrophy), insomnia, fatigue, depression, memory problems, sexual dysfunction, diabetes, rashes, hypertension, heart disease, liver damage, nerve damage (peripheral neuropathy), pancreatitis and bone disease (osteoporosis, osteonecrosis) (Persson: 2004:5). Many of these side effects only appear after some time and majority of the women do not connect it to ARV drugs. As a woman who went through the PMTCT programme and has been on treatment for five years at CDC narrated to me:

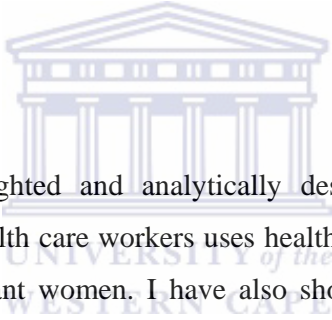
These ARV medications are actually good and I have been taking them for five years now. At the beginning there were minor side effects such as nausea and vomiting but, that did not discourage me. I kept on taking the medications and eventually the side effects disappeared. Since then my health status has vigorously improved (she boost), in fact I even gained some weight and I live a healthy life.

Therefore an improvement in women's health as well as their babies' is seen as significant. HIV positive women understood that ARVs will enhance and prolong their lives. The latter is nonetheless secondary; women took part in the PMTCT programme for their unborn babies. The majority of the HIV positive women felt that a baby is innocent and does not deserve to contract the virus. HIV positive women do not only regard ARVs as a prevention prophylaxis for HIV, but also as life saving because it prevents them from passing the virus to their babies. While some women blamed their partners for the disease; they still felt that is their own responsibility to ensure that the child does not acquire the virus. The ARVs were seen as a form of empowerment enabled women to feel control over their bodies and to meet societal expectations to be able to work, being physically capable, of fertility, and of attractiveness. As Whyte et al (2002: 50) pointed out; pharmaceuticals offer the promise of making disease graspable by casting problems as something tangible and amenable to efficacious action.

⁴⁶ Rundu Town Council HIV and AIDS Coordinating Committee 2009.

Whyte et al (2002: 50) further noted that, medicines in the hands of people in distress seem empowering. At the same time the potential of pharmaceuticals to symbolically define problems as appropriate for medicinal therapy means that those, who produce and prescribe them, have power to influence how people understand and deal with their life situation. HIV-positive women in Kavango regain control of their bodies via ARVs by enhancing the quality of their lives. Hence, by using ARVs, HIV positive women, especially those who were symptomatic - were liberated from bodily discomfort. The pharmaceuticals gave them the means to control natural bodily process from conception to “reproducing” healthy babies, free from HIV. However, as I indicated above, ARV drugs are lifelong regime and have side effects for the users. Therefore in the long run, as Whyte et all (2002:50) have argued, those who produce and/or prescribe them (i.e. doctors and nurses) have power to influence how people understand and deal with their lives and with an irrevocable infection.

5. Conclusion



In this chapter I have highlighted and analytically described PMTCT programme in Kavango. I have argued that health care workers uses health education as a tool to “translate and explain” PMTCT to pregnant women. I have also shown that HIV positive women’s perception and broader understanding of the PMTCT is not only shaped by health education but by the women’s previous knowledge and experience. Women who tested HIV+ worried about societal as well as their own understandings of their bodies in health and illness. Becoming HIV positive affected the women deeply and made them questions their own experiences as human beings. HIV positive women especially feared the long-term outcomes of developing AIDS, and feared for their future once their bodies “failed” them and they were to become both physically and metaphorically sick. In this regard, ARV medication gives HIV-positive women a message of hope; hence ARVs empowered women who took part in the PMTCT in Kavango. As such, HIV positive women in Kavango regain control of their bodies via ARVs as the medication alleviates their health condition. More importantly, these women can still give birth to healthy babies, free from HIV.

CHAPTER FIVE-BARRIERS TO THE PREVENTION OF MOTHER-TO- CHILD-TRANSMISSION (MTCT) OF HIV IN KAVANGO

1. Introduction

In this chapter I will discuss factors that prevent Kavango women, who are HIV positive, from participating in the mother-to-child-transmission (PMTCT) programme. Prevention of new HIV-infection remains a significant public health challenge for Namibia and for the Kavango region in particular, as evidenced by the high infant and child mortality rates due to mother to child transmission (MTCT) of HIV. Since the immune systems of babies are not fully developed, they tend to develop AIDS sooner than adults and many die within one or two years after birth. As a result there is a continued need for the use of antiretroviral drugs (ARVs) by pregnant HIV positive women. Given that the HIV/AIDS epidemic is driven by a complex set of factors which includes social, cultural, political, economic and gendered issues, I argue that prevention intervention strategies of PMTCT should be revisited in order to provide quality services in Kavango. Moreover, HIV/AIDS touches on sensitive issues such as sexuality and identity. Thus it challenges notions of morality and questions our accepted understanding of gender, disease and death.⁴⁷ This chapter seeks to explore what cultural, social, gendered, political and economic aspects and interpretations of PMTCT affect the low uptake of the programme by HIV positive pregnant women.

In 2001 the World Health Organization (WHO) identified four broader strategies to prevent MTCT of HIV, namely:

- (i) Primary prevention of HIV among parents-to-be.
- (ii) Preventing unwanted pregnancies in women with HIV.
- (iii) Terminating pregnancy where this is legal.
- (iv) Preventing HIV transmission from HIV positive women to their infants, (Jackson 2002: 146).

⁴⁷Centre for AIDS Development, Research and Evaluation (CADRE), 2009: literature review on social mobilization and communication in support of prevention of mother to child transmission (PMTCT) of HIV.

It must be noted that the WHO puts great emphasis on primary prevention of HIV, which is based on behaviour change. This is done by advocating condom use and being faithful to one partner.

At the same time there are certain cultural practices and rituals in Kavango which are regularly performed after child birth. The practices, according to health care providers, can potentially put babies at risk of contracting the HI virus. Consequently, I will tease out the practice of “*Likuki/Shipumuna*”, a prominent ritual that is carried out following childbirth. The reason for my scrutiny of this ritual is that, as indicated above, health care workers believed that it undermined the PMTCT programme. However, for the local people “*Likuki/Shipumuna*” is an essential part of their lives. It is perceived as vital for the child’s immunity against various communicable diseases and for the protection of the child from bad spirits. I will show that the “*likuki/shipumuna* ritual” is contested, but also negotiated and re-negotiated by health care workers and women in health care settings. I will draw on my own ethnographic work to explore these issues.

2. Factors that affect the low uptake of the PMTCT in Kavango

There are numerous issues that inhibit women from taking up of PMTCT services, especially in a resource-constrained setting like in the Kavango region. In this regard, literature on strengthening PMTCT through communication outlined the following as barriers to the uptake of PMTCT services in sub Saharan Africa.⁴⁸

- Poor healthcare infrastructure, shortage of staff, poor referral links and a lack of communication between different health services and within the healthcare system. Poor quality counseling and healthcare workers’ poor attitude and interactions with clients.
- Gender-related issues, particularly the role of the male partner in reproductive issues and his involvement in PMTCT services.
- Poverty and structural barriers.
- Cultural factors concerning appropriate behaviour linked to counseling and testing, PMTCT and stigma, including perceptions of poor social support and discriminatory perceptions of PMTCT information and services.
- The reproductive and health needs of youths are not adequately addressed.

⁴⁸ Centre for Aids Development Research and Evaluation (CADRE) 2009; 1.

- Psychological barriers such as denial, fear of death or fear of HIV testing and disclosure.

Most of the above mentioned issues can and do affect the uptake of PMTCT in Kavango. As I have shown in the previous chapter, the PMTCT programme is understood and accepted by HIV-positive women in Kavango. There are however, culturally informed ideas and practices such as “*Likuki/Shipumuna*”⁴⁹ that seems to negatively influence women’s uptake of, and adherence to, PMTCT.

3. Preserving “*mpo yetu*”⁵⁰ (our culture), contestation and negotiation of *likuki/shipumuna* ritual.

To illustrate how the *likuki* ritual is been practiced, contested and negotiated in Kavango, I will draw on three examples. The first case is that of Akuupa’s⁵¹ eye witness account of the *Likuki* ritual in May 2010. The second illustration is based on my observations in the clinics, where women and health care workers discuss, contest and negotiate the *Likuki* ritual. The third example I use, comes from a focus group discussion that I held with Registered Nurses in Rundu on the 6th of March 2010.

Case 1: at the beginning of May 2010 Akuupa collected his daughter, who had given birth to a baby girl, in Windhoek central hospital. He then drove to Kavango, Rundu where he found the grandmother of his wife waiting. The baby was taken into the house and given water soaked with certain plant material to drink. His wife’s grandmother advised them to keep the baby in the house at all times and not to allow people to hold the infant before going through the *Likuki* ritual. Since people, who have had sexual intercourse, are considered as dangerous and spiritually contaminating to the baby, especially young women and men (who are considered to be sexually active) should not touch the baby. Even the father of the newborn can be contaminating if he had had sex. It is believed that the child can “*pumuna*” (acquire

⁴⁹The local people referred to the traditional ritual following child birth as *Likuki* or *Shipumuna*, so the two terms will be used to refer to this traditional ritual following child birth.

⁵⁰*Mpo yetu* in *Rumanyo* or *mpo zetu* in *Rukwangari*. Akuupa (2006:5) argues that in Kavango “*mpo*” is generally used and is done so most commonly by older people to refer to something that is old and different from the modern- in other words, synonymously with tradition. However “*mpo*” is seldom utilized alone; rather, it is generally linked to “*zetu*”, meaning ours. The phrase “our tradition” thus clearly signifies something that carries the authority of the past and that is associated with a particular population. Moreover “*mpo zetu*” is commonly used to refer to practices that are assumed to have been handed down for generations and that need careful protection against foreign influence Akuupa (Ibid).

⁵¹ Akuupa is a Lecturer at the University of the Western Cape, in the Department of Anthropology and Sociology. He is also doing his PHD in anthropology at the same university.

bad spirits) if someone, who had sexual intercourse recently, holds the baby. Akuupa told me:

The following day at around 16h00 my wife and I took the baby and her mother, together with my in-law (the grandmother of his wife) to *Kamboho* village about 20 kilometers east of Rundu. It appeared that my in-law has already made arrangements with the woman who was to carry out the ritual. As soon as we arrived in the household, an old woman in her mid-60s welcomed us and directed us to a private place (shrine). At this place we found fire burning and we were asked to sit around the fire. Then the woman asked my daughter to take off her clothes up to the waist while the baby was undressed completely. Then the woman took a lid of a pot made of clay which she referred to as (*Ntjapo*) and she put some roots and leaves on it together with some charcoal. The woman used the *Ntjapo* to steam the baby and her mother. After steaming she took Vaseline and mixed it with the burned roots and leaves from the *Ntjapo* of which she smeared on the mother and whole body of the baby. After the ritual we gave the woman 50 Namibian dollars as a token of appreciation.

From the above it is clear what the *Likuki/Shipumuna* ritual involves the ingestion of fluids, and sometimes the giving of herbal enema to the baby to “clean it out”. This practice is contested by the health care staff, as seen below in a conversation between a health care worker, Michael Sinonge,⁵² and pregnant women:

If you test HIV positive, then you must decide to either give the baby formula milk (if you can afford) or breastfeed the baby for the first four months, without giving any fluids including water and after four month you must stop breast feeding and introduce soft food. Do you understand? Yaa, do not give the baby enema either, like water it also put the baby at high risk of contracting HIV. (Michael Sinonge).

You are saying that we should not give anything to the child, including water, what about *shipumuna*? If the child is not given *shipumuna* to drink then the child will get sick and make no mistake to take the child to the hospital because nurses and doctors will put the child on a drip. However the child will continue to cry

⁵²Michael Sinonge is a community counselor.

and eventually will die the same day; rather take the child to the *nganga* so that the child can be given traditional medicine. (Woman 1)

You cannot breastfeed and at the same time give water that is a big mistake. Because giving water to the baby may cause gut infection and irritation that will make the baby more susceptible in contracting HIV from the breast milk. (Michael Sinonge).

We cannot even give enema, but breast milk do and can make the baby to have stomach cramps, that is why it is important to give *shipumuna* so that the baby can expel the first breast milk out to avoid stomach cramps. Besides breast milk makes the baby's throat to be dry, so one has to give water. (Woman 2).

If the baby gets stomach cramps then you can bring the baby to the clinic, Nurses and Doctors knows will treat the baby, is it clear? With regards to *shipumuna*, do not give water or enema like I told you, however you may apply *shipumuna* on the baby's body. (Michael Sinonge).

Applying *shipumuna* on the baby's body does not protect the baby fully from the bad spirits, *shipumuna* normally works well only if it is given by mouth or per rectum. (Woman 3).

As another woman⁵³, during an interview with me, strongly pointed out that:

In the absence of *shipumuna* the baby is always at greater risk. For instance like the way I came to the clinic today, I am most likely to meet people that I know. Suppose I was having a baby it is obvious that people will want to see and hold the baby. However some of them might have committed adultery then by holding the baby, the baby will *pumuna* and start getting sick. The child will start vomiting and having diarrhea.

From the above it is apparent that *shipumuna* is seen as a form of protection for the baby. It is in essence a way in which mothers try to ensure the physical and spiritual well-being of a newborn. The latter, so close after birth and not fully regarded as human yet, is still in a dangerous in-between period until it is formally named and welcomed as member of society.

⁵³The interview was held at Kaisosi clinic on the 24th of February 2010.

A woman who takes her newborn for such protective measurements, is fulfilling her duties and responsibilities as a good, caring mother, concerned with all facets of the enhancement of her child's physical and spiritual wellbeing. While this practice is viewed by mothers as essential, health care staff perceives it as detrimental to the health of the baby and also as potentially increasing the risk of HIV- infection for the infant. Health care staff puts this ritual firmly within the domain of "culture" – for them it is about "beliefs" (albeit culturally important), whilst their own nursing practices are about the "science" of prevention and health care. These issues were clearly articulated by staff as seen below from a focus group discussion with health care workers held at Rundu on the 6th of March 2010.

Cultural factors are also barriers to PMTCT, for example when it comes to breastfeeding options. In the region what we are experiencing is that. Mike you are from this region nee? They use to give *shipumuna* but here at the hospital they opted for exclusively breastfeeding. This *shipumuna* is just water and this water is not sterile, so it might destroy the gastrointestinal tract (the opening from the mouth to the anus). In the milk there is the HIV virus, so the virus gets a chance to get in and the child gets infected. (Sister Barade⁵⁴)

Sister Hamutenya⁵⁵ similarly argued that *shipumuna* is a big problem, she said:

In fact it's not just water that these women are giving to their babies. It's actually enema that they use to give to the babies making the baby more susceptible in contracting the HIV virus. It's better when these herbs are applied on the body but otherwise it's very dangerous Mike.

Mr. Sacky⁵⁶ similarly argued that:

Shipumuna results in diarrhea and increases the chances of the baby getting the HIV. However *shipumuna* is also important to these women because it's believed that it chases away witches and protects the baby from bad spirits.

It is important to note that, while anthropologists view culture as dynamic, fluid and constructed situationally, in a particular place and time (Wright 1998), health worker's notions of "tradition" and "culture" is more simplistic. Throughout my study they tended to

⁵⁴Sister Barade is a Registered nurse working at maternity ward in Rundu state hospital.

⁵⁵ Sister Hamutenya is a registered nurse working at mile 10 clinic at the outskirts of Rundu.

⁵⁶ Mr Sacky is a Registered Nurse working at Nkarapamwe clinic, a location in the township of Rundu.

represent "culture" as rather homogeneous, unchanging, and related to a particular bounded group of people, in this case the people of Kavango. Similarly, women referred to *Likuki* as *mpo yetu* (our culture), i.e. as something that they have to do to preserve and observe their "traditional" way of life. Women stressed that they "belong" to a particular group and have to adhere to, and promote their *mpo* (culture). However, in their encounter with biomedicine, certain cultural practice like that of *Likuki* is contested and negotiated and have changed over time.

The examples above elucidates that the *Likuki/shipumuna* ritual is part of a rite of passage for the newborn and is fundamental to the beginning of the life of the baby and its initiation into becoming a full social member of society in Kavango. In a study of such rites in a hospital, Davis Floyd (1994: 1) stressed, in line with van Gennep (1960) and Turner (1975) that a rite of passage generally consist of three stages. First is the separation of the individual from his/her preceding social state – in the case of the newborn from the world of the unborn, the spiritual and the ancestors. Secondly, there is a period of transition in which they are neither one thing nor the other in the case of the baby, it had been born, but is not fully a socialized human yet. Finally in the integration phase, they (babies) are absorbed into their new social state through various rites of incorporation. The mother equally goes through a rite of passage. In this regard, among the Kavango the first stage (separation) occurs when the pregnancy of the woman is announced and she becomes subject to a variety of dietary and behavioural taboos. When the baby is born she is secluded. Re-integration of both baby and mother starts via the *Likuki* ritual, which is usually three to five days after the birth of the baby, and afterwards the name-giving ritual. I do not discuss the rituals related to the mother in this thesis.

From the above, it is apparent that pregnancy in Kavango is not merely seen as a biological experience but also social and spiritual event and the woman (especially with a first birth) goes through the transition from the social status of a woman to that of a mother (or of a mother with a second/third etc. child). During pregnancy, the woman is in a state of transition between these two social statuses. In this state of limbo she is often considered to be in an ambiguous and socially abnormal situation, vulnerable to outside dangers and sometimes dangerous to other people. Hence the pregnant woman withdraws from social activities and lives somewhat apart from other people, subject to certain taboos about diet and behaviour, as intimated above. These taboos are designed to protect the pregnancy, but they are also ways of making the transition between social statuses (Helman 2001: 160). In Kavango a pregnant

woman is suspended from heavy duties and should shy away from drinking alcohol. It must be noted the women do not smoke cigarettes; therefore it has not been identified by health care providers as a problem associated with pregnancy. Pregnant women have to be faithful to their partners as well. It is believed that, if a pregnant woman has sexual intercourse with another man (not the father of baby to be,) then such a woman will have a difficult delivery (prolonged labour) which will result in a stillbirth. Moreover, pregnant women do not eat certain foods, e.g. it is believed that, if a pregnant woman eats eggs during pregnancy, the baby will be born without hair. Similarly pregnant women avoid eating sweet things because it is believed that the baby will have a lot of saliva when it is born.

The unborn, and then newborn, child is also in a dangerous period between the world of the ancestors and that of the living. Until the necessary rituals have been done, and it is given a name, it is alive, but not fully human and thus in a position of uncertainty. As such, the Kavango women view birth as a very dangerous in between moment and the newborn is particularly vulnerable and in need of protection and purification which is done through *Likuki*. In this regard, the baby is seen as not a complete being yet, but as still closely linked to the spiritual world.

Following childbirth, as seen above, the baby and her mother have to undergo *Likuki/Shipumuna*, which has been practiced for centuries. *Likuki* involves giving the newborn baby traditional medicines *shipumuna*⁵⁷ (herbs) to drink and some medication (*mukekete*)⁵⁸ to apply on the body. Moreover, during the ritual some of the roots and leaves are burned on the lid of the pot (*Ntjapo*) and the baby is steamed with smoke coming from the *Ntjapo*. This process is known as *kudjamba*.⁵⁹ Various indigenous plants are used as medication during *Likuki*, besides *Shipumuna* and *mukekete*, other plants such as *uvhungu*

⁵⁷As I have shown in the second case study, woman 2 pointed out that the first breast milk (*Lihenga*) causes stomach cramps. Therefore it is necessary to administer *shipumuna* to expel the first breast milk. In this case the medication (*shipumuna*) is used for cleansing and purification of the child. It must be noted that *shipumuna* works as enema.

⁵⁸*Mukekete* herbal plants is burned with charcoals and thereafter it is mixed with oil (Vaseline) and it applied on the baby's whole body and that of the mother like in the first case study. The purpose of this medication is to protect the baby from acquiring bad spirits and any other diseases from people whom the baby will come in contact with.

⁵⁹The purpose of *Kudjamba* is to introduce the child to the *Vadimu* (ancestors) so that they (ancestors) can welcome and accept the new born baby into their spiritually world. It is believe that if the ancestors are not honored through the *Likuki* ritual they can become angry and when they do the baby will start getting sick. Until such ceremony of the *likuki* ritual is performed the baby will not be healthy and if the ceremony is not performed the baby will eventually die. Thus during the *Likuki* ritual it is important to lit fire which signify and represent the new life of the baby.

vhungu, *Lidongo* and *Nandundu* can also be utilized.⁶⁰ *Likuki* should be performed soon after the birth of the child (three to five days). The ritual is usually done by the traditional healer, locally known as *Nganga*. However, when the *nganga* is not available, some elder members of the community (mostly traditional birth attendants) can carry out the procedure.

I focus on *Likuki* because it is seen as potentially harmful (by health workers) for the baby when the mother is HIV positive and breastfeeds. In the time of HIV/AIDS it has become a form of knowledge and a practice that is contested between health care workers and pregnant women. At the same time it is being negotiated in the clinic and hospital spaces. Health workers feel that, first of all, a HIV positive mother must prevent Mother-To-Child-Transmission (MTCT). This involves a choice which must be strictly adhered to in order to protect the child against the virus. Thus health workers view *Likuki* as in contradiction to the prevention of the (MTCT) programme. Health workers argue that *Likuki* increases the risk of mother to child transmission of HIV. *Likuki* involves giving water to the baby to drink, which is regarded as mixed feeding, and can interfere with the digestion and absorption of nutrients. According to the MOHSS⁶¹ PMTCT guidelines (2002:27,) if a HIV positive mother chooses to exclusively breastfeed, she should do so for four months and thereafter she must switch to exclusive replacement feeding. Giving the baby anything to drink, including plant diffusions (as in *likuki*) may cause gut infections and irritation that will make the baby more susceptible to HIV transmission from his/her mother's breast milk.

Mothers of newborns, on the other hand, feel that a good mother will not only feed and care for her child by keeping the child physically healthy but will also protect the child against bad spirits and make sure that the proper rituals, like that of *Likuki*, are followed to incorporate the child socially, culturally and spiritually into the society. Therefore breastfeeding options, HIV/AIDS and *Likuki* become the central point of knowledge and practice contestation between health workers and pregnant women, which I will show in the next section.

4. Breast feeding options versus *likuki*.

While breastfeeding is considered to be the best way to feed an infant, if the mother is infected with HIV, it is preferable to replace breast milk with formula feeding to reduce the

⁶⁰These plants are readily available in Kavango and are known to the local people, including the lay persons.

⁶¹ MOHSS stands for Ministry of Health and Social Services.

risk of HIV transmission to her infant.⁶² Thus health workers and counselors are expected to assist HIV infected pregnant and lactating women, who choose not to breast-feed, to identify safe, affordable, sustainable, feasible and acceptable alternatives to breast milk. The majority of the women I talked to was unemployed and could not afford to buy formula milk. It is thus difficult for them to try to reduce the transmission of HIV to their babies through this choice. Some of the women walked about ten kilometers to get to the clinic and could not even afford transport money, and even less formula milk, which is a continuous expense over time. For the requirement and estimated costs of infants' formula for the first six months see the table below.

Age (months)	Quantity	Cost N\$ (500gm tins at 30 N\$)
First month	2.5 kg (5 tins)	30 x 5 = 150.00
Second month	3.0 kg (6 tins)	30x 6 =180.00
Third month onward	4.0 kg (8 tins)	30x 8 = 240.00
TOTAL		570.00

Source PMTCT guidelines MOHSS (2004:30)

From the above it is not surprising that many mothers choose exclusive breastfeeding as a better option. In this regard, health care workers advised HIV positive women, who choose exclusive breastfeeding, to breastfeed on demand at least 8 to 12 times in 24 hours - including night feeds. It is equally important that the mother should not give anything else, besides breast milk. Giving the baby any drinks, water or foods other than breast milk, as well as the use of pacifiers, dummies or artificial teats, interferes with exclusive breastfeeding. The former may cause gut infection and irritation and make the baby more susceptible to HIV transmission. However, even when women have opted for exclusive breastfeeding, they are advised to stop breastfeeding when the baby turns four months of age. This early cessation of breastfeeding reduces the length of exposure to the virus in breast milk. The longer the baby breastfeeds, the higher are the chances of the baby becoming infected with HIV. The risk of transmission rate is set out in the table below

⁶²PMTCT guidelines 2004, MOHSS, Republic of Namibia.

	Transmission ratio %		
HIV transmission by stages	No breastfeeding	Breastfeeding for 6 months	Breastfeeding for 18-24 months
During pregnancy	5-10%	5-10%	5-10%
During labour	10-20%	10-20%	10-20%
Through breastfeeding			
Early (first 2 month)		5-10%	5-10%
Late (After 2 month)		1-5%	5-10%
overall	15-30%	25-35%	30-45%

Source PMTCT guidelines MOHSS (2004)

Exclusive breastfeeding can nonetheless be adhered to and breast milk is readily available, inexpensive and does not require any special skills to prepare it. In addition breast milk can provide an infant with good nutrition for growth and development. However, in the Kavango, exclusive breastfeeding in the first days of an infant life is understood as not enough for the infant's survival. As I have shown in the first example, newborn babies, including those born to HIV positive mothers, are given water to drink as part of the *Likuki* ritual. Health workers regard *shipumuna*, the medication given to newborn, as mixed feeding, which increases the risk of the mother passing HIV to her newborn baby. While *shipumuna/Likuki* is regarded as contradicting the PMTCT programme, health care workers nevertheless acknowledge the significance of the *Likuki* ritual and its meaning for local people in Kavango. Some Traditional healers performed the *Likuki* ritual for nurses' children on various occasions. They (Nurses) themselves argued that *Likuki* is safe when the mother of the child is not infected with the HI virus. However, they opine, if the mother of the child is HIV-positive,

then it is preferable to just apply or rub the baby with herbal decoctions. Nevertheless, some women (like woman 2 above) believe that applying herbs on the body does not protect the baby from the bad spirits and argues that the medication works only if the child passes urine and stools after the ritual.

Likiki in the times of HIV/AIDS leads to various questions e.g. whether an alternative method such as applying the herbs on the baby's body should be employed. I regularly witnessed dialogues and debates surrounding *Likiki/shipumuna* between health workers and local inhabitants. Both health workers and mothers presented the *Likiki* ritual as a "traditional" practice, which is highly valued. For mothers, in particular, and the local community, in general, *Likiki* has an encompassing meaning as a booster or preventative against communicable diseases as well as against bad spirits. Although health care workers see the ritual as embedded in the local people's ideas and practices, they want to negotiate different ways of doing it, i.e. by not giving the baby an infusion/enema. They try to change the practice over time in an attempt to minimize the baby's risk of contracting HIV. While the majority of the women prefer for their babies to be given oral medication (*shipumuna*), some of them maintained that because of their HIV status, they will perhaps only rub the herbs on the babies. I see the above as a contestation or dialogue between health workers and pregnant women and as a "conversation" over indigenous knowledge. In the next section I will show how and why I regard *Likiki* as indigenous knowledge.

5. *Likiki* and traditional knowledge (TK)

I present *Likiki* practice as part and parcel of local or indigenous knowledge, currently an area of a great deal of research, politics and marketing in Southern Africa and especially in South Africa. I argue that *Likiki*, the indigenous plants used and the related local philosophies about health, illness and healing, have, in the times of HIV, become a complex terrain of contestation and adjustment of knowledge traditions (Green 2007) between health care workers and HIV positive women. *Likiki* is increasingly in a process of renegotiation through the PMTCT programme as health care providers (and sometimes HIV positive women) seek for alternative ways to practice it in the interest of the well-being of newborn's.

It is of important to note that, in the past few years, the notion of indigenous knowledge (IK), which in Namibia it is called traditional knowledge (TK), has been promoted by the World Health Organization and even the Namibian government. In Namibia, according to earlier drafts (2004) of the Access to Genetic Resources and Related Traditional Knowledge Bill, TK includes biogenetic resources, is defined as being “accumulated” and developed over the years in local communities. It includes traditional medicines, technologies, land use practices and philosophical knowledge (Gibson and Oosthuysen 2009: 9). In this regard, in Namibia, Traditional knowledge (TK) seems not to be much linked to nature, but rather to people in and of the environment (Gibson and Oosthuysen Ibid). In Kavango the use of indigenous plants as medicines, like those utilised for *Likuki*, namely *Shipumuna*, *mukekete* and *uvhungu vhungu* falls under this 2004 Draft Bill as traditional medicines and is protected by the state. In this regard, such knowledge, e.g. of these plants for *Likuki* used by the Kavango, vest in the local community who holds such knowledge. However Gibson and Oosthuysen (2009: 10) show that the state has ownership of biogenetic resources and argue that, in response to the national Convention on Biodiversity (CBD), the “traditional” (skills, practical know-how and cultural) has been increasingly dislodged from the “science” (biogenetic) resources, or the socio- from the environmental. As such, “traditional knowledge” is now rather “brought in” at moments “when it is clearly used to shortlist” bio-prospecting targets”.

While *Likuki* can arguably be viewed as traditional knowledge (TK), the indigenous plants utilized for the ritual, like most of the other plants that are used by the *Vanganga* for healing, have not yet entered the global market. However, Gibson and Oosthuysen (2009: 9) noted that many extracts of plants from Namibia, the knowledge of which largely originate in “TK”, are nonetheless available on the international market for “natural products”. This includes marula oil, juice and pulp, baobab oil and pulp, !Nara oil, Mopane essential and Commiphora resin (perfume). For the “natural medicine” market, indigenous medicinal plant products, such as Devil’s claw, Hoodia and Terminalia root bark are promoted and produced.

However, little is known about certain indigenous plants like that of *Likuki* and in most cases health workers mistrust and may have negative attitude on their usage. More importantly, if there are no scientific studies done to “prove” the safety of the plant, it is often regarded as potentially dangerous - as in the case of health care workers who perceive *likuki* (and the plant infusions used) as a barrier to the PMTCT programme.

Nonetheless my research show that issues of sexuality and gender also greatly impact on the PMTCT programme. I will discuss related issues below and will try to show how gender relations affect PMTCT.

6. Gender, sexuality and prevention of mother-to-child-transmission (PMTCT) in Kavango.

As I have shown at the beginning of this chapter (5.1), one of the World Health Organization's (WHO) primary prevention strategies is to avert the transmission of HIV among parents-to-be and from mother-to-child. This means that couples, who want to conceive, are advised to have an HIV test before having unprotected sex (sexual intercourse without using a condom). If either or both are negative, they may be motivated to stay negative. If either or both are positive, they may rethink their decision about pregnancy or, if they go ahead and has a baby,⁶³ they are counselled on how to minimize the risk of sexually transmitted infection (STI) and re-infection among themselves (Jackson 2002: 147). However, in Kavango, couples planning to have a baby do not go to the clinic to seek counselling as per WHO requirement. Instead, women who seek family planning are those that do not wish to have children at that specific time. Women thus only go to the clinic to get contraceptives. Women who want to have children show up at antenatal clinic (ANC) when they are already pregnant.

During my research these women came to the clinic for antenatal care by themselves. However, according to the PMTCT guidelines (2004: 22), women who attend ANC must be accompanied by their partners (fathers- to-be) in order for both parents to be counselled and tested for HIV. If either or both are negative, they will be counselled on how to remain negative; if either or both are positive, then both parents can receive counselling and, if indicated, antiretroviral treatment can commence. Moreover, according to the WHO guidelines, follow-up for the pregnant woman and her partner should be done simultaneously. During counselling the pregnant woman and her partner need to be informed about the importance of using a condom every time they have sex. This is to prevent re-infection for both partners.

⁶³If one partner is positive and the other one is negative such couples are known as discordant couple. If the couples still wants to conceive, they can reduce the risk of infection by having unprotected sex only on the fertile time of the month (13-15 days after the start of the last menstruation period) and use condoms for the rest month.

In this regard, re-infection can, and do, occur when an HIV positive person has unprotected sex with another person who is also infected with HIV. Since there are several strains of HIV, when exposed to a variety of medication regimens, HIV changes or mutates over time. If a person is re-infected with a strain of HIV that is different from the strains already present, or if a mutated HIV type is introduced into the body through unsafe sex, treatment will be much more complex and potentially ineffective. For example, a person may be treated for HIV; the medication may be effective and reduce the viral load to undetectable levels. However, if that person has unprotected sex with another person living with HIV, he/she gets re-infected and thus develops a “new” strain e.g. that is resistant to most antiretrovirals. Over time, the new strain will flourish in the body. Eventually viral load skyrockets and the CD4 count will decrease. Simultaneously, the risk of the mother passing HIV to the unborn baby increases. Therefore it is vitally important that both parents-to-be should attend the clinic be counseled.

However, during my research women came alone to the clinic for antenatal care, despite health workers’ strong call for the father’s involvement in the PMTCT programme. There is a general paucity of male participation in the PMTCT programme in Kavango. During the focus group discussions with Registered Nurses from various clinics, it was noted that partner involvement is one of the biggest challenges facing the implementation of PMTCT in the region. According to the Kavango region routine raw data⁶⁴, out of the 3,071 clients tested for HIV at antenatal care, only 69 were male. Thus Kavango shows strong gendered patterns with regards to health care seeking behavior in this regard and it is a problem for the PMTCT programme. Men perceive the PMTCT programme as the responsibility of women and particularly of mothers, since they (women) are pregnant and perceived to be in need of medical attention.

During my study I regularly observed health workers who asked pregnant women where their partners were. The women usually said that their partners were at work or not able to attend the clinic. Whilst men do not come to the clinic they (men) nonetheless have a strong influence on their partners with regards to their participation into the PMTCT programme. Some women have to first get permission from their male partners before taking part in the PMTCT programme. As sister Hamutenya pointed out during the focus group discussion:

Implementing the PMTCT programme is very difficult, for example at my clinic, some women refuse to take part in the programme and have to first seek

⁶⁴Routine Raw Data Report Kavango Region 2009/01/01 -2009/10/31

permission from their partners before enrolling into the programme. Although most of the men grant their women permission to take part in the PMTCT programme they (men) do not show up at the clinic. Mike I also had a case at my clinic where a woman totally refused to participate in the programme. She just refused but later I heard the rumours in the community that her-ex boyfriend died of HIV.

Most women take the HIV test, which is an entry point to the PMTCT programme. Health workers encourage women to notify their partners about their HIV test results and also to tell their partner to come accompany them on their next follow up visit.⁶⁵ Some women *do* tell their partners (the majority are those that test negative). Others withheld their HIV test results from their partners, especially those that tested HIV positive. HIV positive women, who did not disclose their status to their partners, told me that they feared the partner's reaction. In this regard, women feared rejection by their partners and also domestic violence. Sister Hamutenya during the focus group discussion puts it this way;

Partner notification sometimes can cause problems. Women telling their partners about their HIV status especially when they are HIV positive is a problem. When a woman tells her husband that she is HIV positive, her husband thinks it is her disease and the child's disease, since the woman is the one who brought the disease into the house. In fact I know of cases where women were beaten after disclosing the HIV status to their sexual partners. Therefore some women could rather keep their HIV status to themselves and of course it affects their health negatively.

The majority of HIV positive women do not tell their partners about their HIV status, because, as one HIV positive woman reiterated, "I did not tell him, because I was scared and I did not know how he was going to react to the news".

My research furthermore shows that the partners of pregnant women tend to associate themselves with their partners' HIV test results (if they are informed about it). For example, if a pregnant woman tests HIV negative, the partner of that woman assumes that he is negative as well. Thus the man does not see the need to take the HIV test; instead he

⁶⁵The schedule for follow up of HIV positive women is the same as in routine antenatal care; (i) from 0 to 28 weeks follow up visit monthly (ii) from 28 to 36 weeks follow up visit every 2 weeks (iii) from 36 weeks follow up visit every week until the woman delivers.

celebrates and embraces the negative outcome of the (mother's-to-be) results. However, when the test outcomes are positive, and if the women disclose this, they may have to deal with violence from their partners. During follow-up visits, nurses always ask pregnant women if they told their partners and whether their partners have any plans to come to the clinic for counselling and testing. One pregnant woman, who tested HIV negative, told the nurse on her follow up visit as follows:

My partner was very much happy when he saw my results and I do not think he will come for the test, because he said if I am negative that means he is also negative.

Another pregnant woman, who tested HIV-positive, was asked the same question and she responded as follows:

I showed him the result and I told him that he should also come to the clinic to be tested, but he shouted at me and said he is busy and does not have time to come the clinic.

Some men did not only become hostile, but physically abused their partners. This kind of response and reaction by men (partners) was consistent. The problems often started when women tested HIV positive, as shown above, and as will be further elaborated below.

7. Conclusion

The biggest challenge facing HIV/AIDS preventative programmes like that of PMTCT is that these are largely biometrically driven and pay little attention to the social, cultural, economic and political factors that impact on the implementation of preventative programmes. Therefore, what is needed in preventative programmes like that of PMTCT is an approach that takes seriously the social context in which people negotiate their lives like that of the “*Likuki* ritual”, which has become a terrain of much knowledge contestation, but also of some renegotiation in hospitals and clinical spheres in Kavango. Equally PMTCT programme implementers (Nurses, Doctors and Community Counselors) need to continuously create platforms and have dialogues that engage the local people in order to develop an appropriate, relevant and contextualized programme. Such an approach promotes collective discussion and debate, in addition to individual reflection and self-awareness and simultaneously

attempts to address social, cultural, economic and political factors to create a health enabling context.⁶⁶

While users (HIV pregnant women and breastfeeding mothers) of the PMTCT programme in Kavango are willing to adhere to the programme in general, changes or disagreements at one level may be facilitated or obstructed by another level. For example, a woman may choose to make use of prevention of mother-to-child-transmission services such as formula feeding. This is most likely to happen if her partner is aware and supportive of her status and thereby enables the use of formula feed.⁶⁷ Finally, gender related issues - particularly that of male partner support - is needed to strengthen the PMTCT programme in Kavango. Since women come to the clinic alone, not all of them disclosed their HIV status to their partners. In this regard, women fear discrimination, abandonment, rejection, divorce and physical violence from their partners which might result from disclosing their HIV status.



⁶⁶ Centre for Aids Development Research and Evaluation (CADRE) 2009; A review of literature, Strengthening PMTCT through communication.

⁶⁷ CADRE 2009 (Ibid)

CHAPTER SIX- MEDICAL PLURALISMS.

1. Introduction

The improvement of health status is a goal shared by individuals, national governments and international agencies. The World Health Organization (WHO), for example, opened the 1980s by calling for Health for all by the year 2000. Developing countries around the world are responding to this call in a variety of ways (Stebbins 1987: 3). In the process of globalization and modernity people in Kavango have been exposed to biomedicine, however this does not mean that they have automatically abandoned their local beliefs and “traditional” healing methods. As Reihling (2008: 2) shows, access to information and education based on “scientific facts” do not replace local understandings and health practices. He argues that, while some local medical treatment regimens may vanish over time, others may be transformed, revitalized and reinvented. Hence in this chapter I will discuss the characteristics of these medical pluralisms in Kavango by looking at the available health care options and how the local people make use of these services. The chapter also describes factors that influence the local people’s choice on health care. I do this particularly in relation to the prevention of Mother -to-Child-Transmission (PMTCT) programme. Lastly, the chapter discusses the role of traditional healers in the PMTCT programme and look, albeit briefly, at possible collaboration between traditional healers and professional health care staff in Kavango concerning PMTCT.

2. Available health care options

In Kavango the types of health care services available are biomedicine and traditional healing which function at different social levels (medical pluralism). People who become ill and who are not helped by self-treatment make choices about who to consult between various available health care systems. In Kavango the formal sector comprises of biomedical health care services, and these are centered at Rundu state hospital, which is an intermediate hospital.⁶⁸ The institution serves the entire region, and on a daily basis patients are referred from the district hospitals in the region, namely, Nyangana hospital, Andara hospital,

⁶⁸Intermediate Hospital is equivalent to a referral hospital. In this regard, cases that cannot be managed at the clinics, health centers and district hospitals are being referred to Rundu hospital.

Nankundu hospital and Nkurenkuru hospital. Moreover, the various clinics and health care centers also refer patients for further management to Rundu state hospital. The latter provides various health care services such as primary health care, x-rays, testing and screening of blood at the Namibia institute of pathology (NIP)⁶⁹. Similarly, the hospital houses various departments such as casualty, surgery, maternity, paediatric, physiotherapy and pharmacy. In addition, it has various administrative services. Therefore, biomedical health care in Kavango is available to the majority of the population although it is not always within walking distance as it was evidenced during my research.

People who are ill also use the services of traditional health practitioners. In Namibia attention is increasingly given to the study of the latter (Lumpkin 1994; Mbambo; 2002; LeBeau 2003; Chinsebu 2009) but, there no official register indicating the number of traditional healers in the country in general, or regions in particular. In 1990 the government embarked on a project to register traditional healers in the country under the Allied Health Services Professions Act (20 of 1993).

However, registration of traditional healers only commenced in 1996, but came to a standstill following various complaints from government officials and the general public. According to Chinsebu (2009: 16) government authorities were seemingly getting impatient with traditional healers that claimed to cure HIV/AIDS, and who were believed to be only using the epidemic to sell their own unproven remedies. There had also been public protests after media reports about HIV-infected adults that had sex with minors ostensibly because they were advised by their traditional healers that sex with virgins would cure HIV/AIDS. Therefore, in 2004, the Allied Health Services Professions Act of 1993 was replaced by (Act no. 7 of 2004), and the Traditional Healers Council was subsequently dissolved. A Traditional Healers Bill was then proposed, but it is still under discussion (Chinsebu 2009). These dynamics have left many Namibian traditional healers in a legal quagmire and created a lacuna. As such, the majority of traditional healers in Kavango at the time of my research were not registered by the Allied Health Professions body. However, most of them are registered with the local traditional authority to authenticate their operation in the area.

⁶⁹Namibia institute of pathology is a private company which provides medical laboratory health care services to state hospitals in Namibia. The company took over all the Ministry of Health and Social Services laboratories in the year 2000.

The local people reported to me that they make use of the traditional healers for various illnesses. Similarly traditional healers confirmed that they treat patients on a regular basis, including patients suffering from HIV/AIDS. In this regard, Lumpkin (1994: 65) shows that 75 % of the community member in Kavango stated that they prefer to visit traditional healers about health problems - before going to the clinic or hospital.

3. Choice and use of health care options

Lumpkin (1994: 65) argues that local people in Kavango visit traditional healers since are in closer proximity to community member's homes than biomedical health care. However, my research shows that local people make choices based on the type of illness they are suffering from and that the distance to health care facilities is just part of the problem. Therefore, the system that is chosen is not only determined by a patient's understanding of causation and the classification of the moral or spiritual aspects of the condition, but also by what a particular medical system has to offer and the patient's personal circumstances (Herselman 2007: 64). For example, while local people understand HIV as a natural illness that can be treated and managed using antiretrovirals they also believe that HIV can be caused by witchcraft. As one newly diagnosed HIV positive patient responded:

(AIDS) is caused by having sex with a person who is infected with the virus. Yaa but someone can also throw the virus on you, like a witch, it's true and it happens. Some people can also take advantage of the disease, for example if the witches know that someone is HIV positive they can target that person and start bewitching him or her and people will not know that the person is bewitched but instead they will think it's just HIV.

Therefore local people may consult a traditional healer before, during or after medical treatment. Hence, local people's choice on health care options is commonly determined by signs and symptoms, which are interpreted in relation to local beliefs and practices, which are expressed in the patients' perceptions of the cause of illness.

According to LeBeau (2003:5) there are diverse systems of thought that co-exist in Namibia. These include the biomedical and traditional health systems in Namibia. She shows that patients make choices between the above based on their perception of the cause, reason and

origin of illness. Similarly, Mbambo (2002: 268) argues that among the Kavango, the type of sickness suffered mainly determines the selection of healing or treatment options. In line with the above argument, I am reluctant to regard any of these health care systems as “alternative” to each other. Local people select a particular health care system based on symptoms and their interpretation of it. Moreover, local people categorise illness as either “African” or “Western” in origin (and thus treatment). According to local understanding, African illness can only be treated by traditional healers. In this regard such conditions include; epilepsy, genital herpes, impotence, haemorrhoids (*Mushira*), infertility, epistaxis (*Madambe*), STDs and HIV/AIDS (Social origin)⁷⁰. Diseases (a medically defined condition) such as malaria, tuberculosis, cardiovascular diseases (hypertension/hypotension, diabetes mellitus, ear (otitis media) and eye (conjunctivitis, cataract) problems, migraine and diarrhea, among others, are taken to medical health practitioners.

4. Traditional birth attendants (TBAs)

I have argued earlier that the majority of women prefer to be delivered by the TBAs.⁷¹ Health care workers urged pregnant women to deliver their babies in the hospital instead. When pregnant women were asked by health care workers about their previous home deliveries, women cited two reasons for their choice. Firstly, the long distance to the clinic and lack of transport were contributing factors. Secondly, the delivery came as an emergency. However, during my interviews women also gave ill treatment from nurses at the maternity ward or obstetric facility as reason. In this regard, one woman told me that;

Mike some nurses are rude at maternity ward and at times shout at you. Just imagine you are in labour pain and someone who supposes to help you shout at you. How will you feel and will you ever come back.

Some women asserted that they prefer to be delivered by the TBAs, who support them throughout labour pain. Women also argued that, at the hospital, nurses can disappear for hours and at times some women deliver without any assistance from them (nurses). The

⁷⁰ Local people believe that certain natural illness such as STD, HIV/AIDS are also caused by their social relationship with other people e.g. neighbors, friends and their relatives, who might be jealous of them. For example, it is believed that a jealous person may curse his/her neighbor. As a result that he/she can become promiscuous and be infected with an STD and HIV/AIDS. In general local people take illness, believed to be caused by bewitching or by ancestors being angry, to traditional healers.

⁷¹ See chapter 1. 1.1 On the number of home deliveries done by TBAs.

above reasons given by women for their delivery decisions were strongly contested by nurses. While nurses acknowledged the transport problem, they argued that the number of home deliveries in the region is overwhelming and that some women live close to the clinics but prefer to deliver at home. In this regard, Kamukwanyama argued that;

I think as much as we are trying to enhance health care in the region we are also shooting ourselves in the feet. For example, we do train traditional birth attendants (TBAs) to conduct delivery at home in case of emergency, but I think these TBAs got their own customers in the community. It's true they got customers because nowadays everyone wants to make money, so it becomes a business.

Similarly, another registered nurse Sacky followed suite and argued that;

You know Mike; at my clinic every week we get at least 2-3 home delivery babies and the mother always says "it was an emergency". Now one wonders how come the emergency only happens to black women. Ya, because white women always deliver in the hospital.

I would argue that health care workers in Kavango regard the issue of transport and long distance to the clinic as a minor problem and see women themselves, as well as TBAs, as the major predicament. They approach the high prevalence of home births from, what Lock and Nguyen (2010: 8) call, a viewpoint of culturalism. It is the assumption - that culture is a unified entity and may be used to fully account for people's behavior - is made by powerful individuals and in institutions to divert attention from social, economic and political origins of illness. It was striking that traditional birth attendants (TBAs) are seen as a problem rather than a solution, since TBAs, especially those that are trained by the Ministry of Health and Social Services, play a supportive role to the PMTCT programme. In this regard, trained TBAs ensure that HIV-positive pregnant women take their nevirapine tablet before conducting the deliveries. This reduces the transmission of HIV from the mother to the baby as required by the PMTCT programme. Moreover, after delivery TBAs sent the women and their babies to the clinic for immunizations and ARVs prophylaxis.

At the time of my research there were 702 TBAs trained and registered by the Ministry of Health and Social Services in Kavango.⁷² The training of TBAs was a result of the World Health Organization's initiatives to enhance Primary Health Care (PHC), especially in the times of HIV/AIDS. Helman (2001: 122) shows the WHO supported and promoted the training of TBAs. The instruction was aimed at increasing their numbers and also to consult with them, and eventually, to integrate them into overall health care programmes in developing countries. Helman (2001) notes that this was done in a way that would ensure the continuation of a traditional "art" and in respect for their (TBAs) roots in "traditional" cultures. He further states that, after training, it was intended that TBAs would take on other roles in the community such as providing first-aid, giving advice on family planning and the distribution of oral rehydration solution (ORS) in cases of infantile diarrhoea. Moreover, TBAs are expected to be health educators, to educate women on nutrition, prevention of HIV infection, the importance of personal and environmental hygiene, the need to bring babies and children to health clinics to monitor their development and to get vaccinated. This WHO vision in Kavango is yet to be realized because there are many TBAs in the region who are not trained in relation to the WHO's protocols. The training of TBAs as proposed by the World Health Organization (WHO) can be interpreted in various ways. As shown above, the primary purpose of the WHO in training for TBAs is to improve maternal and child health care. While some TBAs see this as empowering them with skills and knowledge; others regard it as disempowering. The TBAs are in a difficult position since they are also perceived as a risk to health behaviour (because women prefer home births which are not supervised by nursing staff) TBAs are also expected to change or adjust to new (biomedically prescribed) ways of practicing their profession. Thus, some TBAs view the training as way of assimilating them into the professional health sector, rather than as recognizing that they can actually provide these services on their own and in their own spaces. Since TBAs recognise themselves as experts in the area of childbirth and care for pregnant women, to ask them to play a secondary role to health workers may feel like demotion.

Apart from TBAs, pregnant women can also consult a variety of other healers in Kavango. They range from "diviners" to herbalists. I discuss such healers more in-depth below.

⁷²Routine raw data report: Kavango region 2009/10

5. Traditional healers (the *Vanganga*) and their role in the PMTCT programme

Mbambo (2002: 180) defines a *nganga*⁷³ as a person who becomes a member of the group of people believed to be specialists in healing all kinds of sickness and diseases. Like Mbambo, I prefer to use the vernacular terminology (*nganga/vanganga*) since the English expression (traditional healer/healers) is not totally synonymous with the Kavango terminology. It must be noted that the term *nganga* is used to cover a variety of specialists. The term has been translated into various English terms, such as medicine man, herbalist, diviner and even rainmaker (Mbambo, 2002: 180). During my research, I found that the type of *vanganga* frequently found in Kavango today is the diviner/herbalists. The latter seeks to diagnose or find a solution to a problem via the technique of the *Katamba*⁷⁴ and uses herbs to treat patients. The *Katamba* is a very important diagnostic tool for the *nganga* and it holds ultimate power in relation to the patient's health problem. It is used to diagnose all kinds of illnesses and it also tells the *nganga* what therapeutic actions to take or whether to refer the patient to another *nganga* or to the hospital. Mbambo (2002: 197) argues that *Katamba* is an important dimension of the *nganga*'s healing activity because it is the way in which (s) he analyzes and diagnoses sickness and misfortunes. The *Katamba* is so important that many people believe that a *nganga* without a *Katamba* is not a *nganga*.

Another type of *vanganga* which is less common is *nganga wandandani*⁷⁵ (herbalist) and *nganga wamahamba*.⁷⁶ Most of the *vanganga* in Kavango today are diviner-herbalists, and they seem to hold more power than the other *vanganga*. Diviner-herbalists specialize in various illnesses and use *Katamba* to diagnose illnesses. It gives them certain powers and consequently gains patients' trust. Most of the *vanganga* are male and they told me that they do not conduct deliveries because it is a female's job. Not surprisingly all TBAs registered by the Ministry of Health and Social Services are female. However, the *vanganga* play a significant role in the lives of women during pregnancy and during the postnatal period. They are consulted for prevention of complications that might occur during delivery if certain local beliefs and practices are not adhered to, or when taboos are transgressed. As part of the

⁷³Nganga (singular) and Vanganga (plura) in Rumanyo, Mbambo (Ibid)

⁷⁴A *Katamba* can be a ground shell, a walking stick, a mirror, a cup or even a Bible (Mbambo 2002: 194).

⁷⁵This type of *nganga* specializes in various herbs. They are considered as house doctors who deal with, less serious problem Mbambo (Ibid).

⁷⁶*Nganga wandandani* specializes in fighting off attacks of diseases and sickness that are caused by witchcraft or ancestors Mbambo (Ibid).

treatment, the *vanganga* advise the women on how to take care of themselves during pregnancy. The treatment involves performing rituals, steaming with boiled herbs, adhering to certain taboos about behaviour and diet. The *vanganga* told me that during the antenatal and postnatal period pregnant women seek medical health care for various reasons which will be further explored below.

6. During antenatal and postnatal care

The *vanganga* told me that during pregnancy women come to them if they (women) had sexual intercourse with more than one man. This is known as *Kuvatuka*. A woman who engages with multiple sexual partners during pregnancy will inform someone she trusts; usually her mother. The latter will take her to the *nganga* to receive treatment. The treatment in this case is performing a ritual which involves the boiling of various herbs and steaming the woman while calling the ancestors for forgiveness. Local people believe that, if the ritual is not performed before delivery, such a woman will experience complications during labour e.g prolonged labour. Should the *nganga* not be called in to rectify the situation, the baby will eventually die.

The *vanganga* also help pregnant women with certain complications in pregnancy, for instance with breech presentation⁷⁷ or when the foetus lies in a transverse position. Thus the *nganga* diagnoses a patient using the *katemba* to determine the foetus' position and presentation. Once the *nganga* has made the diagnosis he/she can initiate the ritual. The pregnant woman is asked to lie on her back (supine position) and the *nganga* applies oil on his/her hands to palpate the abdomen. While palpating the woman and using a manoeuvre technique the *nganga* turns the foetus into the right/left occipital anterior position⁷⁸ (ROA/LOA) with a vertex presentation.⁷⁹ During the ritual the *nganga* constantly communicates with the ancestors to facilitate the process.

⁷⁷Breech presentation is when the foetus presents (face the birth canal) with the buttocks as opposed to normal vertex (head), presentation.

⁷⁸ These positions (ROA and LOA) are normal and usually are the easiest way for the fetus to traverse the birth canal. During labour the fetal head descends, the occiput usually rotates anteriorly, as the head delivers.

⁷⁹ Vertex in medical terms which means the head, therefore vertex presentation means a baby facing the birth canal with the head, which is the most common and normal presentation. All other presentations are abnormal which are difficult to deliver or not deliverable my natural means.

One of the *nganga* told me that they (*vanganga*) usually avoid giving oral medication to the pregnant women. However, the *katemba* might indicate that the woman should be given herbal decoctions in order to be completely cured from the condition that she is suffering from. In such cases, herbal decoctions need to be administered, but in very small dosages (one tea spoon per day). The duration of the treatment should be short, not more than three days. It must be noted that such herbal decoctions is usually administered to the pregnant women when the *nganga* suspects that the foetus itself is sick and not the mother. The *vanganga* also treat women for a condition known as *Ndume* (miscarriage). If a woman experienced a miscarriage she and her husband have to be treated by the *nganga* otherwise her next pregnancy will also result in a miscarriage.

In the times of HIV the work of *vanganga* with pregnant women is questioned by professional health care workers. Nurses claimed that the *vanganga* give treatment to pregnant women and promise that they will be cured of HIV. Therefore, pregnant women stop their ARV prophylaxis, thereby putting their lives and that of their babies at greater risk. Moreover, nurses felt *vanganga* have increasingly become involved profit-making and have lost their moral ethics.

Similarly the Namibian HIV/AIDS Charter of Right warns that some “cultural” and “traditional” practices put people, especially women and young people, at risk of HIV infection. According to the Charter these cultural practices should be identified and steps must be taken to address it through education and/ or legislation. While, the Charter negates “traditional” beliefs and practices, it simultaneously states that “traditional” authorities should play an important role in HIV/AIDS prevention strategies. Therefore traditional healers and traditional birth attendants should be “educated” and informed about the transmission of HIV/AIDS and related issues. Equally, traditional and non-traditional health care workers should collaborate on the care and management of HIV/AIDS.⁸⁰

The *vanganga* are familiar with HIV/AIDS and, like health care workers, they refer to it as the “new disease” (give the Kavango word). *Vanganga* perceive HIV/AIDS in various ways as indicated below.

⁸⁰Namibia HIV/AIDS Charter of rights, (2000) Legal Assistance Centre, Windhoek

Nganga A.

I do treat all kind of illness, except this new disease which has come. This new disease can only be treated by our colleagues with the white skin. I do not treat HIV but I can diagnose it using my *katemba*, then I sent them to the clinic for treatment. You know what my son, sometimes HIV cannot be diagnosed at the hospital even if the person is infected with the virus. The reason for that is because such a person has been bewitched therefore it's only the *nganga* who is able to see it. In such cases the *nganga* has to first remove the bad spirit (demons). Once the demons are removed then the patient can go back to the clinic, just one tube and the virus will be detected.

Nganga B

I do treat all illnesses and the only disease that I cannot treat is this 'new disease AIDS'. I went to see another *nganga* from Zambia and he showed me certain herbs that can be used to treat AIDS but it did not work for my patients, so I do not tamper with AIDS patients. If AIDS patients come to me I always refer them to the hospital because I am not aware of any *nganga* in the area who can treat AIDS at the moment, not yet.

Nganga C

HIV diagnosed women do come to me and my brother I do treat them. After three months they go back to the clinic and their results turn out to be negative. I have medicine for HIV but I cannot show it to you and I cannot mention the name. However, I want to approach the hospital to give me 10 HIV positive patients and I will treat them but I will not tell them my medicine unless they give me money, a lot of money I cannot tell you nor can I show you my medicine, no I cannot do that. I have treated a number of people here including pregnant women and they are now having healthy babies.

Nganga D

No my brother, I cannot treat HIV, I just can't. However, I can treat some of the STDs such as syphilis. Women come to me for various reasons, for instance, those who are not able to have children. All my medications are just herbs which

I collected from different countries such as Kenya, Zambia and Uganda. These medicines are very hard to find here, one might find them but with difficulties because you might find one here and another one there. I do not treat babies unless the baby is attacked by a bad spirit. For example, there was a case where a baby was seriously sick and the family took the baby to the hospital, but after three days in the hospital there was no improvement, so they came to me and I checked and I discovered that the baby was possessed by bad spirits. So I gave them herbal medications and they took the medication and they bathed the baby with the medication in the hospital. Later they reported to me that the baby got better after they had used the medications and was discharged from the hospital.

The four *vanganga* above gave different versions of their involvement with HIV/AIDS patients, particularly with pregnant women and their babies. In order to understand how and why these *vanganga* gave different versions, it is important to know about their backgrounds, as individuals and their relation with biomedical health care system. *Nganga* A and B are both diviner herbalist who use *katemba* for divination as well as herbs and rituals for healing and prevention. Both of them are local healers and they also have attended one or two meetings with the Ministry of Health and Social Services regarding HIV prevention and treatment. *Nganga* A is a local Kavango, he has travelled around the country and lived in Windhoek for quite some time. He obtained a certificate from the Health Allied Council to practice as a traditional healer. He also has a certificate from the local *Hompa* (Chief) of the Shambyu, Matumbo Libebe, that allows him to practice in the area as a *nganga*.

Nganga B is also a local Kavango. Like *nganga* A, he has a certificate to practice as a *nganga* in the region. He does not have a certificate from the Health Allied Council of Namibia. Both *nganga* A and B said that, at the very start, when HIV/AIDS emerged, they (*vanganga*) mistook it for an illness known as *Kanamurama*⁸¹. They treated AIDS patients as if they were suffering from *Kanamurama*. However, their patients never improved and later they realized that these patients were suffering from something different. *Vanganga* in the region are now aware about AIDS and, if such patients show up, they send them to the hospital for treatment, since the *vanganga* cannot treat it.

⁸¹*Kanamurama* is a slimming illness that causes a person to lose weight. It is believed that a person suffering from this illness had a Ghost called *Kanamurama* tied on his back by a witch. Thus the Ghost called *Kanamurama* eats all the food given to the person causing him/her to lose weight and if the *nganga* does not treat quickly such a person grows thinner and eventually will die (Mbambo, 2002: 116).

I am reluctant to refer to healer C and D as *nganga*. They do not have roots in Kavango. In fact, healer C referred to himself as a traditional healer while healer D called himself a traditional doctor.

Healer C was born and raised up in Caprivi.⁸² He travelled to neighboring countries such as Botswana, Zambia and Angola where he got herbs that he uses to treat HIV/AIDS. He was the only healer who claimed to have treatment for HIV. He refused to show me the herbs that he in his treatment. Towards the end of my research, on my last visit to his place, he told me that he was out of stock and he needed to go to Botswana to get plant ingredients, since it cannot be found in Namibia. He even promised to introduce me to some of his patients, whom he had treated for years (for AIDS) but he later changed his mind due to confidentiality issues. He did not have any certificate to practice as a traditional healer in Kavango, *likenganga* A and B.

Healer D referred to himself as a traditional doctor. I got his advertising pamphlet from a lady in town. She was distributing them to anyone passing by the main entrance to the shopping centre. I called him on his mobile and I told him I wanted to see him. When we arrived at the house where he had his practice, we found two people in the sitting room. I greeted them and he (the healer D) invited me into one of the bedrooms. I was welcomed by the smell of various herbs he uses to treat patients. The room was empty, and there were no chairs or tables except for the curtain that divided the room into two. He asked me to sit down on the floor, and before I could speak, he told me that he already knows the purpose of my visit.

I sat down on the floor. He closed his eyes while nodding and mumbling softly to himself. He told me that I had come to see him for various reasons. He said he could see that I have a lot of problems, including troubles with my colleagues at my work place, debt problems and jealous neighbours. I tried to interrupt him but he insisted that I must not say a word, because he can see my problems. I decided to interrupt him when he tried to burn some herbs. I was worried that he might ask me to pay for it. I said to him “sorry Dr. D, I am here for another reason, to have a talk with on how you treat your patients not as a patient myself”. His face immediately changed as he put back his herbs. He told me that he was a very busy man and he would appreciate it if I could make my interview as short as possible, since he was

⁸²Caprivi is one of the 13 regions in Namibia. Kavango is neighbored with Caprivi in the far north-east of the country.

expecting patients. During the interview he told me that he is from Kenya and like healer C, travelled to other parts of Africa, where he gets his medical plants, herbs and mixtures. He told me that he does not treat HIV/AIDS. However, he treats sexually transmitted diseases, infertility and many other illnesses.

The *vanganga* reported to me that women consult them post-delivery as well. Women take their newborn babies to the *vanganga* to receive treatment such as *Likuki*, which I discussed in chapter five. Similarly, women also seek treatment from the *vanganga* if they experienced miscarriage. During post-delivery, women's visit the *vanganga* less frequently than during the antenatal period.

7. Conclusion

My interaction with traditional healers indicated that those *Vanganga* who have contact with health professionals are more cooperative than those who do not have any contact with the health professionals. The *Vanganga* who have contact with health professionals also recognize that HIV/AIDS is incurable. Healer C, who does not have any contact with health professionals, believes that he can treat and cure HIV/AIDS. However, what is important to note is that all traditional healers provide treatment to women during pregnancy and post-delivery, regardless of their HIV status. As such, traditional healers play a role in the PMTCT programme since women feel they have to adhere to certain local beliefs and practices. This raised the issue of collaboration between traditional healers and professional health care practitioners. Collaboration between these two health care systems is not necessarily a simple process and it will require more engagement, tolerance and acceptance of each other.

Health care workers, for example, appear to have a negative attitude toward traditional healers, especially when it comes to issues concerning HIV/AIDS. Traditional healers in Namibia are perceived to use the HIV/AIDS epidemic for their own profitable enterprise. Moral issues are thus at stake (Chinsembu 2009: 9). Such complaints and negative attitudes from health care personnel also led to the abolishment of the traditional healer's council.⁸³ However, the majority of traditional healers are willing to collaborate with professional health care practitioners. Very often they refer patients to the hospital - particularly those that

⁸³ See 6.2 on traditional healer's registration process in Namibia.

they suspect are suffering from HIV/AIDS. The one exception was healer C, who claimed to have a cure for HIV/AIDS.

It became clear to me that women in Kavango consult traditional healers and TBAs for various reasons, especially during antenatal and postnatal periods. They utilize various systems simultaneously as well. The latter is what Herselman (2005: 64) referred to as dual consultation. This represents a strategy to maximize the chances of recovery. She highlights various reasons to account for dual consultation namely:

- To know how best to cope; patients want different perspectives on their condition.
- A physician is consulted for medication that alleviates symptoms and the indigenous healer to identify a cause or to ensure that a condition does not recur.
- Treatment by one practitioner may be working too slowly and the patient consults the other for treatment with more rapid effects.
- A patient's relative may insist on dual consultation, even by removing the patient from the hospital so that a healing ritual can be performed before hospital treatment is continued.

These reasons are very prominent in Kavango, particularly with regards to chronic illnesses like HIV/AIDS. In this regard, diagnosed HIV positive pregnant women seek health care treatment from traditional healers for themselves and their babies for various reasons as I have shown above. The local healers (*Vanganga*) perform rituals for women during the antenatal period as well as for their babies post-delivery. The *Vanganga* made it clear that they do not treat HIV/AIDS. However, they perform rituals to remove the bad spirit(s) and thereafter refer the patient to the hospital to receive treatment.

Traditional healers were generally reluctant to disclose the type plants/herbs they use to treat any type of illness. Nonetheless, some of the healers like healer A and B accept that they cannot cure HIV/AIDS. They seem more willing to collaborate with biomedicine and they have already attended several meetings with the Ministry of Health and Social Services. This could be a starting point for possible collaboration between the two health care systems, namely, biomedicine and traditional health care.

CHAPTER SEVEN- GENERAL CONCLUSION

This thesis has dealt with the prevention of mother-to-child-transition of HIV (PMTCT) in Kavango. In particular, the study critically looked at the cultural (including social, gendered, political and economic) interpretations of PMTCT that affect the low uptake of the PMTCT programme by HIV positive pregnant women. The main findings of the study are summarised below

Health care workers, uses health education as a tool to “translate and explain” the PMTCT programme to pregnant women. The majority of participating women appeared to have little knowledge regarding antiretroviral drugs as pharmaceuticals, yet they understood that ARVs are not a cure for HIV/AIDS. Pregnant women were eager to get ARVs for two reasons. The first relates to the notion of “hope”. HIV positive pregnant women believed that the lives of their unborn babies depend on ARVs. Secondly, women perceived ARVs as their last hope to prolong their lives. Once women were told that they were HIV-positive, they saw themselves as being sick, having the disease (AIDS). Therefore, it was important for them to get the pharmaceuticals as soon as possible. Thus ARV medication gives HIV-positive women a message of hope; hence ARVs empowered women who took part in the PMTCT in Kavango. As such, HIV positive women in Kavango regain control of their bodies via ARVs as the medication alleviates their health condition to meet societal expectations to be able to work, being physically capable, of fertility, and of attractiveness

Secondly the study shows women also utilised traditional medicines for themselves and their babies. Women use traditional medicine during pregnancy by going through various rituals as part of exercising and adhering to their cultural beliefs and practices. Local people believe that, if these rituals are not performed before delivery, such a woman will experience complications during labour e.g prolonged labour. Should the *nganga* not be called in to rectify the situation, the baby will eventually die. The *vanganga* also help pregnant women with certain complications in pregnancy, for instance with breech presentation or when the foetus lies in a transverse position.

Thirdly following childbirth, the baby and her mother have to undergo through a prominent ritual namely, *Likuki/Shipumuna*. Women regard *shipumuna* as a form of protection for the baby from bad spirits and also serve as a booster for the baby’s immune system. It is in

essence a way in which mothers try to ensure the physical and spiritual well-being of a newborn. However, health care workers see *Likuki* as potentially harmful for the baby when the mother is HIV positive and breastfeeds. Since *Likuki* involves giving the baby water to drink health workers argue that *Likuki* increases the risk of mother to child transmission of HIV. In this regard, they argued that giving the baby anything to drink, including plant diffusions (as in *likuki*) may cause gut infections and irritation that will make the baby more susceptible to HIV transmission from his/her mother's breast milk. Thus *Likuki* has become a form of knowledge and a practice that is contested between health care workers and pregnant women. At the same time it is being negotiated in the clinic and hospital spaces. Health workers feel that, first of all, a HIV positive mother must prevent Mother-To-Child-Transmission (MTCT). This involves a choice which must be strictly adhered to in order to protect the child against the virus. Thus health workers view *Likuki* as in contradiction to the prevention of the (MTCT) programme.

Finally the study shows that there is paucity of male involvement in the programme to prevent mother-to-child transmission of HIV. During my research women came alone to the clinic for antenatal care, despite health workers' strong call for the father's involvement in the PMTCT programme. However, some women needed to get permission from the partners before enrolling into the PMTCT programme.

This study raises a number of issues that needs further research on PMTCT in Kavango. In particular, further research is needed to understand the cultural beliefs and practice like that of *Likuki* which is been contested, negotiated but also re-negotiated between women and health care workers. There is also a greater need to explore HIV and masculinity with relation to the PMTCT programme in Namibia. The latter will give male perspective of ARVs and PMTCT in Namibia which will enhance interventions that are inclusive and different needs of both genders Mfecane (2002: 3). In this regard, Mfecane (2002: 3) argues that the dominant mindset that informs most research and intervention work with men sees them as a problem, rather than part of the solution in the fight against HIV. Thus he calls for a shift in the mindset by engaging men as partners in the fight against HIV and recognizing that men are also infected with HIV thus, have certain needs and fears that must be addressed.

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APPENDICES

Appendix I: Consent form

Title of Research Project: Cultural and social factors impacting on the programmes to prevent mother to child transmission of HIV in Namibia: a case study of the Kavango Region.

I⁸⁴ ... have been explained in the language that I understand about the nature and purpose of the study. Therefore, I am participating in the study own my own will and I can withdraw from the study at anytime I wish to. The researcher has explained to me that this information will be treated as confidential and my name will be anonymous. I understand that the information will be used for academic purposes.

I therefore give my consent to take part in this study.

Participant's signature



Date.....

For any enquiries regarding the study or wish to report any problems you have experienced related to the study, please contact the study coordinator.

Study Coordinator's Name: Mr. Michael Shirungu

University of the Western Cape

Private Bag X17, Belville 7535

Cell phone Number (SA)⁸⁵ +2279 234 1932

Cell phone Number (Nam)⁸⁶ +264 2355 093

Fax: (021) 959-3686

⁸⁴ Full Name of the participant.

⁸⁵South Africa

⁸⁶Namibia.

Appendix II: Approval letter from the University of the Western Cape

**OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH
DEVELOPMENT**

Private Bag X17, Bellville 7535
South Africa
Telegraph: UNIBELL
Telephone: +27 21 959-2948/2949
Fax: +27 21 959-3170
Website: www.uwc.ac.za

2 October 2009

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape has approved the methodology and the ethics of the following research project by:
Mr. M Shirungu (Dept. of Anthropology/Sociology)

Research Project: Cultural and social factors impacting programmes to prevent mother to child transmission of HIV in Namibia: A case study of the Kavango Region

Registration no: 09/7/4



Peter Syster
Manager: Research Development Office
University of the Western Cape

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Appendix (iii) Permission Letter from the Ministry of Health and Social Services.

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REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198
Windhoek
Namibia

Ministerial Building
Harvey Street
Windhoek

Tel: (061) 2032562
Fax: (061) 272286
E-mail: hilmanangombe@yahoo.com
Date: 21 January 2010

Enquiries: Ms. H. Nangombe Ref.: 17/3/3/AP

OFFICE OF THE PERMANENT SECRETARY

Mr. Micheal Shirungu
P. O. Box 96427
Windhoek
Namibia

Dear Mr. Shirungu,

RE: Cultural and Social factors impacting programmes to prevent mother to child transmission of HIV in Namibia: A case study of the Kavango Region.

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. Kindly be informed that approval has been granted under the following conditions:
 - 3.1 The data collected is only to be used for academic purpose;
 - 3.2 A quarterly progress report is to be submitted to the Ministry's Research Unit;
 - 3.3 Preliminary findings are to be submitted to the Ministry before the final report;
 - 3.4 Final report to be submitted upon completion of the study;
 - 3.5 Separate permission to be sought from the Ministry for the publication of the findings.

Yours sincerely,


MR. K. KAHUURE
PERMANENT SECRETARY



"Health for All"