

**NawaLife Trust**  
namibian center for communication programmes

# **HIV/AIDS**

*Strategic Information Report*

**Final HIV/AIDS  
Community Survey**  
Oshikuku, Onandjokwe  
and Rehoboth: 2008



**Final HIV/AIDS Community Survey Report  
in Oshikuku, Onandjokwe and Rehoboth  
2008**

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**Acknowledgements**

The President's Emergency Plan for AIDS Relief through USAID/Namibia funded this study through NawaLife Trust. Nahum Gorelick, Brian Goercke, Bastian Schwarz, Erna Keulder and Lizl Stoman were instrumental in supporting the survey. Thanks to Salen Engelbrecht for background info on sites. Thanks also to Todd Koppenhaver of USAID Namibia for comments on draft versions of the report.

We are grateful to the survey respondents and focus group participants in Oshikuku, Onandjokwe and Rehoboth for their time and assistance.

**Citation**

Parker, W. & Connolly, C. (2008). Final HIV/AIDS Community Survey: Oshikuku, Onandjokwe, and Rehoboth: 2008. Windhoek: NawaLife Trust

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## ACRONYMS

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AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral treatment/therapy
ARV	Antiretroviral (drugs)
CADRE	Centre for AIDS Development, Research and Evaluation
CBO	Community-based organisation
FBO	Faith-based organisation
HIV	Human immunodeficiency virus
JHUCCP	Johns Hopkins University Center for Communication Programs
NGO	Non-governmental organisation
NLT	NawaLife Trust
RFS	Research Facilitation Services
VCT	Voluntary Counselling and Testing

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## KEY INDICATORS: RESPONDENTS AGED 15 YEARS AND OLDER, 2008

Indicator	Oshikuku	Onandjokwe	Rehoboth
Antenatal HIV Prevalence (MOHSS) 2006	23%	23.7%	13.9%
Married	23%	25%	22%
Unmarried but living with partner (cohabiting)	11%	4%	14%
Unmarried/other	66%	71%	64%
Completed secondary school or more	24%	19%	31%
Employed	29%	26%	33%
Full-time student/learner	19%	22%	18%
Low socio-economic group (respondents lacking two or more of the following: electricity, piped water, indoor flush toilet, telephone, television and radio)	89%	76%	23%
Attend religious services once a week or more	28%	39%	32%
Unprompted HIV prevention knowledge: Always use a condom	83%	83%	71%
Unprompted HIV prevention knowledge: Abstain from sex	81%	75%	71%
Unprompted HIV prevention knowledge: Have only one sex partner	30%	63%	53%
Average correct HIV knowledge scores	78%	69%	74%
Average non-stigmatising attitudes to PLHA	75%	67%	58%
Obtained HIV/AIDS information from radio or television or newspaper	95%	94%	93%
Obtained HIV/AIDS information from Health Care Worker	43%	66%	68%
Obtained HIV/AIDS information from community organization	27%	23%	40%
Attended funeral of person who died of AIDS	67%	52%	42%
Helped care for a person sick with AIDS	54%	22%	20%
Worn a red ribbon, T-shirt or cap with AIDS message	49%	43%	44%
Volunteered for an HIV/AIDS organization in community	16%	7%	16%
Ever tested for HIV	47%	46%	53%
Tested for HIV in past year (of ever tested)	61%	68%	58%
Two or more sex partners in past year (of ever had sex)	27%	27%	45%
Two or more sex partners in past month (of those who had sex in past year)	12%	7%	12%
Last sexual partner ten years older (Females, 15-24)	38%	34%	15%
Last sexual partner ten years older (Males, 15-24)	2%	8%	10%
Condom use at last sex (of those who had sex in past year aged 15-24)	87%	84%	83%
Condom use at last sex (of those who had sex in past year aged 25-49)	64%	51%	49%
Condom use at last sex (of those who had sex in past year aged 50+)	26%	15%	53%
<b>Teenage birth</b>			
Females, 15-19, ever given birth	17%	9%	15%
<b>Exposure to alcohol</b>			
Drink alcohol a few times a week or more	34%	23%	19%
Been drunk in the past month (of all)	28%	28%	29%
Gone to a bar or shebeen in past month	54%	47%	40%

## EXECUTIVE SUMMARY

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Since 2003, a number of baseline and mid-term surveys have been conducted in various Namibian communities and this is the first third round final survey report. The surveys focus on persons 15 years and older and the goals are:

- ❑ To track knowledge, attitudes, behaviours and practices related to HIV/AIDS in Namibia over time;
- ❑ To track exposure to community-level experiences of HIV/AIDS;
- ❑ To track the reach of and exposure to HIV/AIDS-related communication interventions in Namibia over time;
- ❑ To utilize survey findings to guide and refine interventions to address HIV/AIDS in Namibia.

The current research involves mid-term surveys conducted in the following three communities in Namibia: Oshikuku, Onandjokwe and Rehoboth, and also draws on baseline data gathered in 2003 and midterm data gathered in 2005.

Analysis of the quantitative survey findings was enhanced through the addition of small-scale qualitative research studies in each community. These comprised two focus groups in each community. Issues for exploration were identified following preliminary analysis of the quantitative data and included:

- ❑ Perceptions of dominant HIV/AIDS communication;
- ❑ Sexual relationships and multiple partnerships;
- ❑ HIV testing;
- ❑ Understanding of antiretroviral therapy.

### ***HIV/AIDS knowledge, beliefs and attitudes***

General knowledge about HIV and AIDS was adequate although unprompted knowledge of the risks of HIV transmission through having multiple partners and transmission from mother-to-child was low. There have been some significant changes in knowledge over time.

The majority of respondents hold non-stigmatising attitudes towards people living with or affected by HIV/AIDS and this is likely to be sustained as a probable product of people having friends and family members who have HIV/AIDS.

In qualitative data, respondents noted that campaign messages were overly repetitive and should be diversified and localised.

### ***Exposure to HIV/AIDS information***

Quantitative and qualitative data indicate clearly that HIV/AIDS information is pervasive in the communities studied. Multiple channels are available to carry HIV/AIDS communication, and the vast majority of respondents receive such information from the broadcast media. Family and friends as well as discussion in schools were also common mechanisms of interpersonal discussion about the disease.

There was an overall high recall of HIV/AIDS campaigns – particularly the Take Control campaign’s ‘Be your own hero’ and promotion of New Start. Catholic AIDS Action and NawaLife Trust were prominent at the community level.

Personal exposure to people with HIV in the past year was relatively high, and there was promising involvement by respondents who reported wearing clothing with HIV/AIDS messages and volunteering at HIV/AIDS organisations. Personal exposure was strongly correlated with individual action, although such exposure had no significant influence on the likelihood of having lower levels of multiple or concurrent sexual partners.

### ***HIV testing***

There has been a promising and significant increase in knowledge of places to obtain an HIV test as well as ever testing for HIV. The large proportion of respondents reporting that they ever tested for HIV were tested in the last year. This indicates that the national rollout alongside promotion of HIV testing services is having an impact.

A fair proportion of respondents indicated that they went for HIV testing at the request of a partner, and this could potentially be emphasized in further campaigns.

A widely held perception amongst survey respondents was that HIV test results were not treated confidentially by staff providing services at public facilities.

### ***Sexual behaviours, practices and trends***

The age of first sex is becoming younger in each generation; this trend needs to be reversed in the context of a high prevalence HIV epidemic. A focus on *delayed sexual debut* amongst teenagers must be intensified.

Amongst young people in their teens and early twenties, there were high levels of sex with partners ten or more years older than themselves. This increases HIV risk considerably and this risk must be emphasized in campaigns.

Having a high turnover of sexual partners is a significant risk factor for HIV infection, as it exposes individuals to wider sexual networks. High partner turnover occurs in all age groups, particularly amongst people aged 15-49 and has increased significantly since the baseline survey. Efforts to reduce partner turnover need to be intensified in the context of a high prevalence epidemic.

Having two or more sexual partners in the past month is a significant risk factor for HIV transmission and such partnerships are common in the study sites. Efforts to promote understanding of the risks of having concurrent partnerships and reducing the number of concurrent partnerships must be intensified.

The respondents' level of reported condom use at last sex is very high in the three sites, and this points to a combined impact of condom promotion campaigns reinforced by effective distribution systems. The number of those who reported that they 'always' use condoms is also high.

### ***Alcohol and risk behaviour***

There is a high overall pattern of alcohol consumption that extends to regular and excessive drinking amongst youth and young adults. Places of drinking are pervasive in the study communities.

It was promising that drinking daily had declined in one of the study sites.

High levels of alcohol consumption were significantly related to HIV-related risk behaviours and this reinforces the need to address alcohol in conjunction with addressing HIV risk.

Bar, shebeen and nightclub attendance is prominent as a leisure activity.

Attending an AIDS support group in the past month was relatively high, and over and above illustrating the availability of such groups, there is a relative openness to involvement in HIV-related interactions.

### ***Conclusions***

This final survey in three sites has provided useful insights into the HIV/AIDS related knowledge, perceptions, behaviours and practices in the study communities.

Whilst general knowledge is adequate, there is very poor 'top of mind' awareness of two key HIV infection risks – having concurrent sexual partners and the risk of HIV transmission from mother to child.

A high proportion of respondents in the three study sites have sexual relationship practices that place them at high risk for HIV infection – notably a high proportion have two or more partners in the past year, and there is also a high proportion who have two or more partners in the past month. Such practices produce concentrated sexual networks that are conducive to rapid HIV transmission, and these relatively small communities are vulnerable as a product of already having high HIV prevalence.

Delay of sexual debut requires emphasis, and campaign goals should include reversing the trend of earlier sexual debut in the present younger generation. Young people also

need to be advised of the risks of having sexual partners who are much older than themselves, as this produces exposure to higher HIV prevalence subgroups.

There were encouraging trends with regard to the uptake of HIV testing, but it was disconcerting to note that there were widespread concerns voiced about the confidentiality of HIV results at HIV test sites.

There were promising levels of respondents reporting that they 'always use' condoms, and also involvement of people in community-level response.

This study explored levels of circumcision in the study sites, with around a quarter to two fifths being circumcised. This has potentially limited the spread of HIV in the study communities, but it remains that primary risk factors including partner concurrency need to be addressed with urgency.

Daily alcohol consumption has decreased somewhat in one site, but it remains that alcohol consumption is overall high – particularly being drunk. Frequent alcohol consumption and HIV-related risk behaviours are closely correlated, and continued and intensified focus on this risk factor is necessary.

## **BACKGROUND**

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Since 2003, a number of baseline and mid-term surveys have been conducted in various Namibian communities. These studies initially fell under the ambit and guidance of Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (JHUCCP) in Namibia, with management and oversight shifting to the newly established NawaLife Trust (NLT) in 2006. The surveys have been complemented by a range of network studies as well as qualitative research in some of the study communities. Survey data has been collected and captured by Research Facilitation Services (RFS). The present study was conducted through the Centre for AIDS Development, Research and Evaluation (CADRE).

### **Goals of the research**

The surveys focus on persons 15 years and older and the goals are:

- To track knowledge, attitudes, behaviours and practices related to HIV/AIDS in Namibia over time;
- To track exposure to community-level experiences of HIV/AIDS;
- To track the reach of and exposure to HIV/AIDS-related communication interventions in Namibia over time;
- To utilize survey findings to guide and refine interventions to address HIV/AIDS in Namibia.

### **Study methodology**

The current research involves final surveys conducted in the following three communities in Namibia: Oshikuku, Onandjokwe and Rehoboth. Two previous survey rounds had been conducted. Summary data is provided in Table 1.

- Oshikuku is located in northern Namibia and has a population of approximately 9,680 people. The unadjusted antenatal HIV prevalence was 23% in 2006. Amongst the population surveyed, 12% live in brick houses, 6% in shacks, and 82% in houses made of traditional materials. The predominant language is Oshiwambo, which is spoken by 98% of respondents. Some 16% have completed secondary school only, whilst a further 7% also have a post-secondary school education. Predominant religious groups include Catholic (56%), Protestant (36%) and 'other Christian' (6%). Just under a third of respondents are employed (29%), whilst 19% are students and 38% are unemployed.

- Onandjokwe is located in northern Namibia and has a population of approximately 28,846<sup>1</sup> people. The unadjusted antenatal HIV prevalence in Onandjokwe was 23.7% in 2006. Amongst the population surveyed, 38% live in brick houses, 11% in shacks, and 51% in houses made of traditional materials. The predominant language is Oshiwambo, which was spoken by 96% of respondents. Some 15% of respondents have completed secondary school only, whilst a further 4% also have a post-secondary school education. Predominant religious groups include Protestant (62%), and Catholic (27%) and 'other Christian' (7). One fifth (26%) of respondents are employed, whilst 22% are students and 42% are unemployed.
  
- Rehoboth is located in Central Namibia, and has a population of approximately 34,590 people. The unadjusted antenatal HIV prevalence was 13.9% in 2006. Amongst the population surveyed, 80% live in brick houses, 18% in shacks, and 2% in houses made of traditional materials. The predominant language is Afrikaans, which is spoken by 61% of respondents. Some 27% of respondents have completed secondary school only, while a further 4% also have a post-secondary school education. Predominant religious groups include Protestant (41%), Catholic (31%) and 'other Christian' (20%). Over a third of respondents are employed (33%), whilst 18% are students and 43% are unemployed.

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<sup>1</sup> This estimate, and estimates for other sites, is obtained by multiplying the 2001 Census population by the estimated annual population growth rate of 2.6%.

**Table 1: Demographic overview of respondents aged 15 years and older**

Demographic Factor	Oshikuku		Onandjokwe		Rehoboth	
	%	n	%	n	%	n
<b>Antenatal HIV Prevalence</b>						
2006	23%	N/A	23.7%	389	13.9%	144
<b>Housing type</b>						
House/brick	12%	71	38%	226	80%	479
Shack	6%	36	11%	68	18%	109
Traditional Material	82%	493	51%	306	2%	12
<b>Age group</b>						
15-24	34%	203	37%	222	44%	266
25-34	23%	135	26%	156	28%	166
35-49	22%	131	21%	127	18%	107
50+	22%	131	16%	95	10%	61
<b>Sex</b>						
Male	49%	296	50%	300	50%	300
Female	51%	304	50%	300	50%	300
<b>Education</b>						
Some primary	31%	187	23%	138	22%	133
Completed primary	22%	129	27%	161	22%	130
Some secondary	24%	143	32%	189	25%	152
Completed secondary	16%	97	15%	89	27%	164
Post secondary	7%	44	4%	23	4%	21
<b>Religion</b>						
Catholic	56%	334	27%	160	31%	183
Protestant	36%	218	62%	374	41%	243
Other Christian	6%	36	7%	43	20%	122
Other / none	2%	12	4%	23	9%	52
<b>Employment status</b>						
Employed	29%	174	26%	156	33%	195
Unemployed	38%	226	42%	251	43%	259
Student	19%	115	22%	134	18%	106
Grant or pension	14%	85	10%	59	7%	40

### **Quantitative study methodology**

A series of baseline, midterm and final surveys have been conducted in selected Namibian communities since 2003. Surveys are conducted in two-year cycles and baseline data for the three communities in the present study was gathered in 2003, mid-term in 2005 and the final survey data was gathered in late 2007.

### **Mapping of sites**

Both baseline and midterm surveys used the same sampling methods. For each of the three sites included in this round of surveys, a ten kilometer catchment area surrounding the local hospital was identified. The sample was designed to report the results at the site level.

### ***Selection of households and substitution***

A random systematic selection method was used to identify households. All households were counted using aerial maps obtained from the National Planning Commission for rural sites and city planning maps from Municipal Town Planning Departments for urban sites. A random starting point was selected and an interval (total number of households divided by the number of interviews) was used to do every *n*th household. If the selected person refused, the entire household was substituted: first to house on the left then the house on the right. Three hundred households were selected per site during the baseline and midterm surveys and 600 households were selected in all sites in the final survey.

### ***Selection of respondents***

Respondents were selected by age (15 years and older), and sex (the enumerators were instructed to survey one male respondent followed by a female respondent), and all interviews were conducted within the given catchment area.

Enumerators approached each selected household and asked to speak with the head or oldest person in the household to explain the study. The enumerator then completed a household roster for all eligible persons in the house (this would be either all the males or all the females, 15 years and older). Each household member was assigned a number, which was written on a slip of paper and put into a box. A person in the house was then asked to draw a number from the box. Only one person was selected per household.

### ***Procedures***

Once a respondent was selected, the enumerator asked to speak with the selected person and introduced the study, read the informed consent information, explained that participation was voluntary and noted that his/her responses would be kept confidential. If the selected respondent was still not available after three visits, the household was substituted. Interviews were conducted up to 21h00 on weekdays and Saturdays.

Face-to-face interviews were conducted in a private place by enumerators using a structured questionnaire that contained both open- and close-ended questions (see Appendix 1 for the midterm questionnaire).

Enumerators worked in teams of six with a supervisor for each team. Each team was matched as closely as possible to the language groups found among the sites – i.e. an enumerator who spoke the language of the potential respondents approached the household members. Supervisors conducted daily check-backs.

### **Questionnaire Development**

Questionnaire revision was carried out in consultation with researchers from JHUCCP and CADRE as well as representatives from NLT, RFS, USAID and various stakeholder groups involved in the HIV/AIDS response in Namibia during 2006. This review included an update of key socio-behavioural and contextual indicators as well as the integration of questions specific to HIV/AIDS including community-level exposure and communication programmes related to the disease. Where applicable, indicators were aligned with the original questionnaire to ensure that comparisons could continue to be made between baseline and later surveys on a subset of indicators. Measures and indicators were also aligned with standardized HIV-specific indicators utilized in surveys regionally.

The questionnaire was piloted and adjusted prior to finalisation.

The final questionnaires were translated into Namibian languages, and Afrikaans and English were used for the present sites. The translated questionnaires were reviewed by an independent person speaking the same language to compare the translated versions with the original English version.

### **Coding and Capturing of Data**

RFS collected and coded the data and data capturing and cleaning procedures were reviewed by a senior statistician.

### **Reliability and validity of the data.**

The degree to which the findings from a household survey such as this one can be generalized to the population of the site depends partly on how representative the sample is, and the sampling fractions for the baseline and midterm surveys are shown in Table 2.

**Table 2: Representivity of sample: baseline and midterm**

	<b>Oshikuku</b>	<b>Onandjokwe</b>	<b>Rehoboth</b>
Population (est.) midterm	9,196	27,403	32,859
Population (est.) final	9,680	28,846	34,590
<b>Midterm survey</b>			
Individuals selected	300	300	300
Sampling fraction	3.0	1.1	0.9
<b>Final survey</b>			
Individuals selected	600	600	600
Sampling fraction	6.2	2.1	1.7

Table 3 shows the response rate per site for the mid term survey. Households realised include those where the selected respondent completed the interview on either the first, second or third visit. Household refusals are those where the selected respondent refused

or was not at home after three attempts. If the selected person refused, the entire household was substituted by the first house on the left then the house on the right. This process continued until the quota was completed.

A response rate of 70% or more is considered acceptable. The site with the lowest response rate, Rehoboth (62%), did not meet this criterion. Overall, the response rate was 82%.

**Table 3: Response rates for the mid-term survey**

	Oshikuku	Onandjokwe	Rehoboth	Total
Selected	600	600	600	1800
Realised	576	533	372	1481
Refused	24	67	228	319
Response	96%	89%	62%	82%

### **Statistical methodology**

The study was designed to report at the site level and the results were tabulated by site. On occasions where numbers in subgroups were very small, the sites were combined and an aggregated total reported.

Chi square and t-tests were used to compare indicators among subgroups. Where differences were significant, logistic regression was used to control for site, age, sex, socio economic group, marital status and sexual behaviour and the odds ratio reported as OR<sub>adj</sub>. Respondents were asked if there was electricity, piped water; indoor flush toilets; telephone; television or radio in the house where they lived. Respondents having four or fewer items were considered to be in a low socio-economic group and those having five or more in a high group.

Demographic differences between the baseline and midterm surveys are reported on selected indicators. Major indicators in each survey were compared using logistic regression adjusting for site and age. Data was entered using SPSS v13 and analysed using STATA v9.

### **Qualitative study methodology**

Quantitative survey data provides important insights into the extent of the relationships between demographic categories and knowledge, attitudes, behaviours and practices relevant to HIV/AIDS. Such findings are largely descriptive and provide a comprehensive understanding of overall patterns, but are less able to provide insights into underlying factors. Whilst not all findings can be supported with qualitative investigations, a number of key areas were identified for further investigation following preliminary analysis of the quantitative data. Issues explored included:

- Perceptions of HIV/AIDS communication
- Sexual relationships – particularly concurrent sexual partnerships
- HIV testing; and
- Understanding of antiretroviral therapy.

### ***Qualitative study design***

The qualitative study was conducted in March 2008. Two focus groups were conducted in each of the three sites with participants grouped by ages 20-30 and 35-50 years. Participants were recruited using varied approaches including through organisations, and household visits.

Groups comprised six participants and included equal numbers of males and females. The discussions were held in a quiet, private area, and were conducted in the participants' language of choice. Duration was approximately two hours and consent forms were signed before the session. Refreshments were provided and a small payment was made as compensation for time. The question guide is included in Appendix 2.

### ***Translation, transcription and analysis***

Languages used in focus groups included English and Afrikaans. English translation was done as part of the group process where applicable. All focus groups were audio recorded and English translations were transcribed. Transcriptions were read for emergent themes and texts were then coded using HyperResearch 2.6 prior to analysis.

### ***Limitations of the survey***

This survey achieved adequate response rates and can be considered representative of the communities studied. Where aggregated totals are used, the aggregated total is not weighted by the population of the site and is therefore not representative of the combined communities and should be used with some caution. The studies are also of only three Namibian communities, and therefore cannot be considered representative of the whole of Namibia.

Interpretation of data has been strengthened by the addition of qualitative focus group discussions in each community. What these discussions point to is the complexity of HIV/AIDS at community level – in particular the interweaving of social, cultural, economic and behavioural factors. This complexity is not readily revealed in quantitative data.

### **Implications for intervention**

This study provides insights into individual level responses to the epidemic, informs changes over time and highlights gaps. Findings have been organized into categories, drawing together statistics related to questionnaire responses, changes in key indicators, and qualitative findings. Implications are then reviewed in each of these categories.

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## FINDINGS

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### HIV AND AIDS KNOWLEDGE, BELIEFS AND ATTITUDES

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Knowledge necessary to respond to AIDS is multifaceted and it is well established that a range of individual, social and contextual factors influence whether or not knowledge can be applied by an individual. This relates both to management and mitigation of infection risk, and also to knowing about resources available for people living with HIV/AIDS.

Basic AIDS knowledge was explored through a number of questions including unprompted knowledge and ‘true-false’ statements.

Beliefs and attitudes were also explored, and findings provide some insight into belief systems that frame people’s understanding of AIDS as well as their attitudes towards people living with HIV/AIDS.

#### ***Unprompted knowledge about AIDS***

Respondents were asked to indicate all the ways they thought a person could be infected with HIV. Most respondents mentioned ‘through sexual intercourse’, followed by ‘not using condoms’, ‘through ‘infected blood’, ‘having many sex partners’, and ‘from a mother to her baby’, with some variations between sites.

The risk of infection through having many sex partners was mentioned by around half of all respondents, with respondents in Oshikuku (45%) being less likely to mention this risk than those in Onandjokwe (54%) and Rehoboth (50%).

Very few respondents mentioned unclean medical equipment, whilst only a very small number mentioned mosquito bites.

**Table 4: Unprompted knowledge of ways to acquire HIV, ages 15 years and older**

	Oshikuku		Onandjokwe		Rehoboth	
	%	n	%	n	%	n
Through sexual intercourse	83%	500	77%	462	71%	428
By not using condoms	55%	327	62%	374	58%	346
From infected blood	42%	253	59%	356	56%	337
By having many sex partners	45%	271	54%	325	50%	299
From a mother to her baby	37%	222	54%	324	42%	253
From blood transfusions	34%	205	36%	217	45%	272
Through sharing needles	35%	210	39%	231	26%	154
Unclean medical equipment	15%	92	13%	78	10%	57
Mosquito bites	2%	9	6%	37	3%	20
Other	5%	31	10%	62	6%	37

Respondents were asked to indicate all the ways they thought a person could avoid or prevent HIV infection. The predominant responses were ‘always use a condom’ or ‘abstain from sex’, which were mentioned by more than three quarters of respondents.

‘Only having one sex partner’ and being ‘faithful to your sex partner’ were mentioned by around half or less of the respondents (28%-63%).

**Table 5: Unprompted knowledge of ways to avoid or prevent HIV infection, ages 15 years and older**

	Oshikuku		Onandjokwe		Rehoboth	
	%	n	%	n	%	n
Always use a condom	83%	499	83%	499	71%	424
Abstain from sex	81%	485	75%	452	71%	426
Have only one sex partner	30%	180	63%	375	53%	316
Be faithful to your sex partner	28%	168	37%	223	36%	214
Limit or reduce number of sex partners	19%	114	27%	162	34%	205
Have sex only with a partner who is HIV negative	8%	50	30%	179	18%	110
Use sterilized needles	12%	73	19%	113	13%	77
Non penetrative sex/thigh sex	13%	80	9%	55	18%	107
Avoid sex with a sex worker	4%	25	15%	87	10%	57

### **Correct responses to basic knowledge questions**

A series of questions were asked to assess correct knowledge in selected aspects of HIV and AIDS. Overall, correct knowledge levels were high, with a few exceptions in some communities. In Onandjokwe and Rehoboth, there was a lower than average correct response to ‘an HIV positive mother can transfer HIV to her baby’ (68%; 67%) and in Rehoboth to ‘medicines can prolong life of someone with HIV (66%)’. The link between having fewer partners and being less likely to be infected with HIV is less well understood with correct responses ranging from 42%-54% between communities.

**Table 6: Correct responses to HIV and AIDS knowledge questions, ages 15 years and older**

	Oshikuku		Onandjokwe		Rehoboth	
	%	n	%	n	%	n
People with HIV look sick (False)	82%	490	62%	373	72%	431
Traditional healers can cure AIDS (false)	93%	558	73%	436	86%	513
HIV can be transmitted through mosquito, flea, bedbug bites (F)	88%	527	70%	419	80%	477
A person can get HIV by touching a person with HIV/AIDS (F)	81%	485	70%	421	82%	491
HIV can be passed through sharing eating utensils with someone who has HIV (False)	81%	484	66%	394	80%	477
An HIV positive mother can transfer HIV to her baby (True)	84%	503	68%	408	67%	404
HIV can be transmitted through breastfeeding (True)	82%	494	77%	462	82%	490
Medicines can prolong life of someone with HIV (True)	81%	483	80%	481	66%	396
If you have fewer sexual partners, you are less likely to get infected with HIV (True)	42%	253	48%	288	54%	324
You can reduce the risk of HIV by being faithful to your sexual partner (True)	65%	392	73%	437	77%	460
Average	78%		69%		74%	

Respondents were asked about their knowledge of services available to people living with HIV or AIDS. The main unprompted responses included a high awareness of medicines to fight HIV (63%-90%), followed by financial support from the government (24%-30%); services from community NGOs (14%-21%) and post-test clubs (7%-16%).

### **Perceptions of risk**

Around half to two thirds of respondents (50%-64%) felt they were at low or no risk of HIV infection. Of those who perceived the risk to be low, around half or more said they were faithful to one partner or abstained, whilst around a third said they always used a condom. Of those who perceived their risk to be high, predominant reasons included not always using a condom, having multiple partners, not trusting their partners or their past sexual activity.

**Table 7: Perceptions of risk of HIV infection**

	Oshikuku		Onandjokwe		Rehoboth	
	%	n	%	n	%	n
Low or no risk	64%	383	50%	301	53%	313
Medium risk	9%	56	7%	41	7%	41
High risk	6%	34	8%	47	14%	86
Don't know / Not applicable	22%	127	35%	211	27%	160
<b>Reason for perceived low risk</b>	(383)		(301)		(313)	
I abstain	41%	156	41%	124	62%	194
I'm faithful to one partner	47%	179	51%	155	70%	218
Always use condom	34%	131	25%	75	38%	118
Other reason	3%	11	9%	28	25%	78
<b>Reason for perceived medium to high risk</b>	(90)		(88)		(127)	
Not always use condom	40%	36	41%	36	67%	85
Have multiple partners	33%	30	33%	29	56%	71
Don't trust partner	34%	31	57%	50	43%	54
Past sexual activity	11%	10	8%	7	17%	21
Current sexual activity	12%	11	9%	8	4%	5
Partner is sick	9%	8	14%	12	21%	27
Other reason	4%	4	2%	2	8%	10

### **Beliefs and attitudes**

With regard to beliefs, the vast majority of respondents disagreed that witchcraft could protect one from acquiring HIV (79%), and a similar proportion said that they were not aware of people who had acquired HIV through witchcraft (80%). However, a lower proportion disagreed that Christian healers could cure AIDS (70%).

The vast majority of respondents hold positive and supportive attitudes towards people living with HIV/AIDS. There was a strong commitment to caring for a family member sick with AIDS (63%-88%) and also towards allowing HIV positive children to attend

school (62%-74%). In Oshikuku, 80% of respondents said that an HIV positive teacher should be allowed to continue teaching, although this view was less widely held in Onandjokwe and Oshikuku (65%, 53%). Around half of all respondents (41%-61%) did not see the need to keep the HIV positive status of a family member secret. Whilst this might suggest a fear of family stigmatization, it may also be related to respect for confidentiality of the individual concerned.

**Table 8: Attitudes to people living with HIV/AIDS, ages 15 years and older**

	Oshikuku		Onandjokwe		Rehoboth	
	%	n	%	n	%	n
If a member of your family became sick with AIDS, would you care for him/her in your household? (agree)	88%	529	85%	511	63%	376
Children who are HIV positive should not go to school (disagree)	74%	445	66%	396	62%	372
If a teacher has HIV but is not sick, should he/she be allowed to continue teaching (agree)	80%	478	65%	390	53%	319
If a member of your family became infected with HIV, would you want it to remain a secret (disagree)	41%	355	61%	321	59%	318
Average	75%		67%		58%	

#### **Changes since baseline: HIV and AIDS knowledge, beliefs and attitudes**

There have been marked changes in responses to most knowledge questions over time. Two questions showed change. There was an upward trend in knowledge that people with HIV do not look sick (Baseline vs Follow-up,  $OR_{adj}$ : 2.5,  $p < 0.001$ ) and that medicines can prolong life (Baseline vs Follow-up,  $OR_{adj}$ : 1.9,  $p < 0.001$ ).

Over time, respondents were less willing to care for a member in the household with AIDS (Baseline vs Follow-up,  $OR_{adj}$ : 0.6,  $p = 0.01$ ), less willing to allow a teacher with HIV to continue teaching (Baseline vs Follow-up,  $OR_{adj}$ : 0.8,  $P = 0.2$ ) and less willing to keep the HIV status of a family member secret (Baseline vs Follow-up,  $OR_{adj}$ : 0.6,  $p < 0.001$ )

#### **Qualitative findings: HIV and AIDS knowledge, beliefs and attitudes**

A number of participants noted the disjuncture between widespread HIV prevention campaigns and the continuing rise of HIV. This rise was attributed to ignorance: ‘I will say it is effective, but the people who are reading the messages is ignorant. That is why the HIV status is rising every minute.’ Others felt that mass media campaigns were overly repetitive: ‘I cannot remember when I have seen a real awareness – it’s just advertisements, advertisements and the old advertisements are still going’, although there was also recognition that people simply weren’t heeding messages: ‘...because sometimes we cannot take things seriously. We can hear what they say, but what we are

implementing is something else.’ Participants also referred to cynicism in relation to young people and HIV/AIDS:

*Female 1: They say AIDS is a uniform for the young people. Facilitator: What is that uniform? Female 1: They say AIDS is uniform for the young people. Female 2: Like everybody it’s wearing it (Oniipa, 20-30).<sup>2</sup>*

AIDS was noted to have severe impacts on the community including orphaning of children, prostitution and loss of livelihoods:

*The main concern about HIV and AIDS in the community from my perspective is that it brings more orphans in the community and it increases a lot of social factors. Some end up in prostitution due to parents who died because of HIV and AIDS. Most people who have to develop the community... they end up dying. Most people with the potential died because of HIV and AIDS. That is very bad (Male, Oshikuku, 20-30).<sup>3</sup>*

The importance of increasing dialogue at community level was noted, with suggestions being made that local leaders should intensify their involvement in awareness activities – including in churches where AIDS was still seen as being rarely mentioned. There was also a perception that communication imagery should be nuanced to fit with local contexts.

*In the shebeens you would find it is mostly in English, where you find that this shebeen is predominantly a shebeen, say for, the illiterate group of the society... The pictures which are there are not environment friendly. If you have a shebeen where tombo is usually drunk or traditional beer, then the type of picture should depict the environment so that the people can relate themselves with that particular advert (Male, Rehoboth, 35+).<sup>4</sup>*

There was a general perception that those who were illiterate were not sufficiently reached, and that not all languages were catered for. Participants also emphasized the need to visualize the impacts of the epidemic through television programming:

*I think sometimes it is difficult to understand and believe something without seeing it with your naked eyes. That’s why I am having an opinion. Maybe NBC need to put up a programme on the television that shows the situation, how people are suffering. And they also need to take the televisions in the rural areas, because sometimes people only hear those messages from the radios. And they need to see how people are really suffering, because sometimes they are just saying it’s only the stories. But if you happen to see it... (you should try) to take the real picture to the people (Male, Oniipa, 35+).<sup>5</sup>*

A few participants also noted that it was important to portray Namibians in drama programming, rather than programmes from other countries, ‘because we are not seeing

<sup>2</sup> NLT FGD Oniipa 20-30 April 2008.txt, 15372,15721

<sup>3</sup> NLT FGD Oshikuku 20-30 April 2008.txt 313,703

<sup>4</sup> NLT FGD Rehoboth 35+ April 2008.txt 8669,9302

<sup>5</sup> NLT MT FU FGD Oniipa 35+ 21 April 2008.txt 9238,10042

Namibia on the television, we think that it is not so bad in Namibia. So, we need to see our own people on television'. Mention was also made of a programme called 'Remember Eliphaz', which was seen as engaging and effective.

There was a general sense that discussion of sexual matters, particularly in the family, was seen as inappropriate, although there was a gradual opening up of dialogue on HIV/AIDS.

Condoms were seen as being widely available, and condom promotion was believed to be one of the more prominent prevention messages. It was, however, also noted that consistent condom use was difficult to sustain.

*Condoms are distributed everywhere you go - those are the only available messages for HIV/AIDS. You come in a bar... you find condoms. You go to church... you find condoms. You come in the office... you find condoms and even in Shoprite, also (Male, Oshikuku, 20-30).<sup>6</sup>*

*We are youngsters. So the other one have had sex before without a condom. She tells me it's wonderful. Now I also have to think of using a condom every day (and have) this boring sex while there is a wonderful thing out there. Of course one day I have to try the other one without a condom. So, that's how. And the cases when you get excited, (and) you don't think of the status, your partner's status anymore. You get excited and then it's your mind that's telling you now just do it (Female, Oshikuku, 20-30).<sup>7</sup>*

One participant mapped out a range of issues to do with the control of alcohol venues in Rehoboth, which were seen as HIV risk venues.

*The local authorities are a bit insensitive towards the health stability within society. I am saying this because they approved the establishment of shebeens within residential areas without these shebeens being supervised according to the age restriction, (and) according to the time of opening and closing. They are not considering that this kind of uncontrolled access to alcohol is a trap for HIV infection amongst the school-going youth. Secondly I think that the response initiatives towards HIV and AIDS within the community is not sufficiently aggressive to tell the authorities or to inform the authorities that this is the core problems which is then resulting in the further spread of HIV AIDS. They should be more ordered, or more sensitive towards allocating erven for shebeens - not allowing shebeens to monopolise the entire industry of sales (Male, Rehoboth, 35+).<sup>8</sup>*

Antiretroviral treatment was well known and was seen to encompass a range of lifestyle changes including avoiding alcohol, improving nutrition and avoiding unsafe sex.

*But if you use the treatment, stay away from alcohol and drug abuse and unsafe sex, because, for example, the treatment or the tablets are fighting the virus which is in*

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<sup>6</sup> NLT FGD Oshikuku 20-30 April 2008.txt 2703,3342

<sup>7</sup> NLT FGD Oshikuku 20-30 April 2008.txt 6179,6806

<sup>8</sup> NLT FGD Rehoboth 35+ April 2008.txt 1751,3257

*your body. But if you practice unsafe sex and (are) using the drugs, then you are at risk that the virus will get more and more in your body (Female, Rehoboth, 20-30). NLT FGD Rehoboth 20-30 April 2008.txt 42192,42501*

Taking antiretrovirals was seen as a process that ultimately led to improved health, but this was commonly perceived as being preceded by drug-related side effects. The importance of taking the drugs at regular times and the concept of lifelong treatment was observed. A specific CD4 count to initiate treatment was also noted, although the specific rationale wasn't necessarily accurate.

*In the first stage where they have been given two weeks of tablets, they are getting sick. They are not used to that medicine - they are getting side effects. They are getting sores in the mouth or vomiting when they are taking that medicine (Female, Rehoboth, 20-30) NLT FGD Rehoboth 20-30 April 2008.txt 43095,43874*

*If your CD4 count is up at 800 and if you are HIV positive, then you can't get treatment. There are side effects if you get the treatment - maybe you can get blind. You can get disabled or something can happen to you. Your CD4 count must be below 200 so that you can be put on the treatment (Female, Rehoboth, 20-30).<sup>9</sup>*

Having one's health improve was seen as a factor that reduced stigma and discrimination:

*At least at the time, they will show some care for the person - when the person is getting stronger. And when I am getting stronger, I am on my own again and the family gets different again (Female, Rehoboth, 20-30). NLT FGD Rehoboth 20-30 April 2008.txt 14715,15829*

It was felt that detailed information in local languages was an important component of ART programming:

*People just hear about treatment, but they do not know what it is all about, what is the benefits of the treatment, why should they go on treatment, etcetera. So, this must be explained in the vernacular which the people understands. Advertisements must reach remote areas and informal settlements, because the people in the informal settlements mostly do not get sufficient information around HIV/AIDS treatment (Male, Rehoboth, 35+).<sup>10</sup>*

Amongst participants who knew people who were on ARVs, observations included the importance of consistency including taking the drugs at the same time of day and avoiding alcohol. Shortage of food was seen as a problem, since the drugs went hand-in-hand with good nutrition. Some mentioned people getting 'sexual feelings' when they started taking the drugs. People on ART noted marked improvements in their health:

*First she was thin and she was sick every day in the hospital. Then she said, since she got the counselling and they told her she is HIV positive, and her CD4 counts*

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<sup>9</sup> NLT FGD Rehoboth 20-30 April 2008.txt 47074,47740

<sup>10</sup> NLT FGD Rehoboth 35+ April 2008.txt 24050,24566

*reached the state of to be given the ARV's, then she was telling me how wonderful the thing is. Because she said at the time, it gave her diarrhoeas and all those things, and she was suffering. But now she is even bigger in the body and feeling better (Female, Oniipa, 20-30).<sup>11</sup>*

*You even see them get carried in the wheelbarrows, but now these people you find the walking on their own. So, they are really happy that these ARVs are working for them. That is why some of them... they even encourage others...others who don't want to go for the treatment (Female, Oshikuku, 20-30).<sup>12</sup>*

Alternatives to ARVs that were mentioned included 'Aloe Vera', acupuncture, prayers through church, and traditional healers. With regard to the latter, one participant noted: 'It's true, they are treating HIV AIDS. I've been to Angola and I see how people are recovering'.

#### **IMPLICATIONS FOR INTERVENTION: HIV AND AIDS KNOWLEDGE, BELIEFS AND ATTITUDES**

- ❑ *General knowledge about HIV and AIDS is patchy in the study communities. Whilst there is clarity about the primary mode of transmission and the value of condoms in preventing HIV infection, key aspects of knowledge such as mother-to-child transmission and having many sex partners are less well known. These two aspects are at the core of HIV prevention and must continue to be intensively promoted through HIV/AIDS campaigns.*
- ❑ *Overall risk perceptions of HIV infection were low, and only a relatively small proportion saw themselves at high risk of infection. Amongst those whose risk of infection was medium to high, realistic reasons were given including inconsistent condom use and having multiple partners. Many who saw their risk as low mentioned abstinence and faithfulness to one partner.*
- ❑ *Beliefs that HIV is caused by supernatural means are not widely held, but only three quarters of respondents (70%) believed that Christian healers could not cure AIDS. This requires attention.*
- ❑ *The vast majority of respondents hold non-stigmatising attitudes towards people living with or affected by HIV/AIDS and this is likely to be sustained as a product of people having friends and family members who have HIV/AIDS.*
- ❑ *The significant increases in knowledge between the baseline and final surveys illustrates exposure to campaigns.*
- ❑ *On the basis of the qualitative data, there is a perception that although campaigns have wide reach, they are not sufficiently impactful. Whilst perceptions of rising*

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<sup>11</sup> NLT FGD Oniipa 20-30 April 2008.txt 44209,45586

<sup>12</sup> NLT FGD Oshikuku 20-30 April 2008.txt 54580,54946

levels of HIV were seen as justification for such opinions, there were also suggestions that communications should be more localised.

- Knowledge of ART was overall promising, with many respondents illustrating quite comprehensive knowledge about how the drugs work as well as reporting personal experiences relating to the benefits of such therapy. This is illustrative of how knowledge can be readily conveyed about emerging HIV/AIDS concepts.

## EXPOSURE TO HIV/AIDS INFORMATION

In the context of a widespread HIV epidemic in Namibia, exposure to AIDS-related information occurs through many sources. This includes the broad influence of HIV/AIDS content in the mass media, as well as specific campaigns and the work of AIDS organisations.

### **Exposure to mass media channels**

Most respondents listened to the radio four days a week or more (78%-89%). Watching television four days a week or more varied by site from a low of 14% in Oshikuku to 25% in Onandjokwe to a high of 68% in Rehoboth. Listenership and viewership were highest in Rehoboth. Newspapers and magazines were accessed four days a week or more by differing levels from 13% in Oshikuku to 52% in Rehoboth.

**Table 9: Frequency of media exposure, ages 15 years and older**

	Oshikuku		Onandjokwe		Rehoboth	
	%	n	%	n	%	n
<b>Radio</b>						
Never	1%	4	1%	6	2%	12
Less than once a week	8%	47	5%	29	7%	39
1-3 days a week	12%	71	5%	30	14%	81
4 or more days a week	80%	478	89%	535	78%	468
<b>Television</b>						
Never	28%	168	8%	46	3%	17
Less than once a week	42%	254	46%	276	14%	81
1-3 days a week	16%	97	22%	130	16%	95
4 or more days a week	14%	81	25%	148	68%	407
<b>Newspaper or Magazine</b>						
Never	21%	128	12%	71	5%	31
Less than once a week	43%	257	38%	229	15%	89
1-3 days a week	23%	136	25%	148	28%	168
4 or more days a week	13%	79	25%	152	52%	312

Exposure to specific media channels in the past week varies considerably between communities. In the case of television, most respondents viewed NBC (43%-94%) with

less exposure to the other channels. Local language stations were most prominent. *The Namibian* was most widely read on average.

**Table 10: Media channels exposed to in past week, ages 15 years and older**

	Oshikuku		Onandjokwe		Rehoboth	
	%	n	%	n	%	n
Watched NBC television	43%	258	53%	320	94%	562
Watched One Africa TV	9%	51	24%	145	49%	291
Watched M-Net (DSTV)	5%	28	9%	53	15%	89
Listened to NBC Local Language Station	91%	544	94%	562	65%	388
Listened to Radio Omulunga	54%	324	63%	380	13%	78
Listened to Radio Energy	39%	236	38%	227	27%	163
Listened to National Radio	26%	154	22%	131	17%	100
Listened to Kanaal 7/Channel 7	4%	25	8%	47	22%	131
Listened to Radio 99	8%	46	7%	39	7%	40
Listened to Radio Wave	6%	35	7%	41	8%	47
Read <i>The Namibian</i>	42%	253	45%	270	46%	275
Read <i>Republikein</i>	10%	57	8%	48	65%	388
Read <i>Informante</i>	29%	173	26%	158	25%	147
Read <i>New Era</i>	17%	103	18%	109	25%	151

#### **Sources of HIV and AIDS information**

The most prominent sources of HIV and AIDS information in the past year were the mass media – radio, television and newspapers – which include information disseminated by formal campaigns, but also news and other information not directly disseminated by campaigns. Whilst radio was most likely to be a source (86%-92%), television and newspapers varied by site from 41% for television in Oshikuku to 83% in Rehoboth. The range for newspapers was from 55% in Oshikuku to 78% in Rehoboth. The range for other media including magazines, booklets and pamphlets was similar 45%-76%.

Amongst interpersonal sources, friends (73%-89%) were prominent as were health care workers (43%-68%). Community organisations including local AIDS organisations were sources for around a third of respondents, with the highest mention being in Rehoboth (40%) and the lowest in Onandjokwe (23%). Religious groups were mentioned by less than a half (39%-50%) and community meetings were mentioned by only 14% in Rehoboth compared to 43% in Oshikuku and 47% in Onandjokwe. Very few respondents mentioned traditional healers (2%-4%).

Educational institutions and teachers were important sources for the vast majority of full-time students (89%-96%). In workplaces, the response was more varied, ranging from 26% in Rehoboth to 44% in Oshikuku and Onandjokwe.

**Table 11: Sources of HIV/AIDS information in the past year, ages 15 years and older**

	Oshikuku		Onandjokwe		Rehoboth	
	%	n	%	n	%	n
<b>Mass Media</b>						
Radio	92%	553	89%	535	86%	515
Television	41%	248	56%	333	83%	495
Newspaper	55%	331	63%	379	78%	465
Other media (Magazines, Booklets, Pamphlets)	45%	270	55%	331	76%	457
<b>Community</b>						
Health Workers/Nurse/ Doctor/Clinic/Hosp	43%	257	66%	395	68%	409
Community orgs, AIDS organisations, NGOs	27%	161	23%	138	40%	240
Religious group, church	40%	242	50%	301	39%	231
Community meetings	43%	260	47%	283	14%	85
Traditional healer	2%	9	4%	22	3%	17
<b>Family/Friends</b>						
Friends	89%	533	77%	459	73%	440
Mother/Father/Family members	83%	497	79%	471	67%	402
<b>Sub-populations</b>						
Schools/Universities/Teachers (Of all full-time students)	96%	110 (115)	95%	127 (134)	89%	94 (106)
Workplace (Of all persons employed)	44%	77 (174)	44%	68 (156)	26%	51 (195)

**Exposure to AIDS campaigns and organisations in past month**

Respondents were asked which campaigns and organisations they had been exposed to in the past month. Exposure is relative to reach of mass media, reach of community level activities, intensity of campaign activities, and recency of campaign activities. Most prominent campaigns were ‘New Start’, ‘Be your own hero’ and ‘My Future is My Choice’. Average exposure to campaigns and organisations was highest in Onandjokwe (46%) and lowest in Rehoboth (35%).

Reach of organisations varied in communities, and Catholic AIDS Action and NawaLife Trust were most prominent. The average reach was lowest in Rehoboth (35%).

**Table 12: Exposure to AIDS campaigns, programmes and organisations in the past month, ages 15 years and older**

	Oshikuku		Onandjokwe		Rehoboth	
	%	n	%	n	%	n
<b>Campaigns</b>						
New Start (HIV testing)	68%	405	64%	384	65%	389
'Be your own hero'	68%	406	69%	416	56%	333
'My Future is My Choice'	60%	357	57%	344	56%	333
Smile condoms	58%	347	54%	326	48%	289
Desert Soul	50%	302	49%	292	34%	206
'Alcohol aids HIV'	41%	246	50%	299	28%	169
Take Control mass media	46%	275	38%	228	12%	69
'Be there to Care'	28%	168	22%	133	10%	59
<b>Organisations</b>						
Catholic AIDS Action	58%	350	57%	342	68%	408
NawaLife	34%	202	36%	215	21%	124
Lironga Eparu	30%	182	39%	236	19%	115
UNICEF	28%	170	48%	285	19%	111
Window of Hope	28%	170	35%	209	32%	191
LifeLine/ChildLine	24%	142	22%	133	20%	119
<b>Average</b>	<b>44%</b>		<b>46%</b>		<b>35%</b>	

### **Exposure to campaigns and HIV-related responses**

Exposure to three or more of the following campaigns – 'Be your own hero', New Start, 'My Future is My Choice', 'Alcohol aids HIV' and Desert Soul – was significantly correlated with HIV-related responses when controlling for demographic and other factors:

- 66% (n=564) of respondents who reported exposure to three or more campaigns reported having *had an HIV test in the past year* compared to 55% (n=313) of those who were exposed to less than three programmes (OR<sub>adj.</sub>: 1.4;p=0.03);
- 69% (n=718) of respondents who reported exposure to three or more campaigns reported having *used a condom at last sex* compared to 52% (n=472) of those who were exposed to less than three programmes (OR<sub>adj.</sub>: 1.7; p<0.001).

There was *no* significant influence on having two or more partners in the past year, nor influence on having two or more sexual partners in the past month.

Respondents were asked whether they had used Smile Condoms, gone for testing at a New Start Centre and spoken to a LifeLine/ChildLine counselor. Use of Smile Condoms ranged from 35% to 42%, New Start from 22% to 43% and speaking to a LifeLine/ChildLine counselor, from 6% to 22%.

**Table 13: Selected services and resources used in the past year, ages 15 years and older**

	Oshikuku		Onandjokwe		Rehoboth	
	%	n	%	n	%	n
Used Smile condoms	41%	243	35%	209	42%	249
Gone for HIV testing at a New Start Centre	32%	194	22%	131	43%	260
Spoken to a LifeLine/ChildLine counsellor	14%	83	6%	34	22%	132

When asked about services available to people living with HIV/AIDS without prompting, around three quarters or more of respondents mentioned medicines to fight HIV (72%-78%), fewer mentioned financial support from government (20%-39%), services from community NGOs (19%-28%) and post-test clubs (13%-17%). Legal support, counseling and nutritional support were least mentioned.

**Table 14: Unprompted knowledge of services available to people living with HIV or AIDS, ages 15 years and older**

	Oshikuku		Onandjokwe		Rehoboth	
	%	n	%	n	%	n
Medicines that fight HIV	78%	470	72%	434	75%	449
Post-test clubs	17%	100	14%	85	13%	77
Financial support from the government	39%	233	32%	190	20%	120
Services from community NGOs	21%	127	28%	165	19%	112
Legal support	6%	34	7%	41	9%	52
Counselling(New Start)	1%	3	0%	2	1%	6
Nutritional support (Giving food)	0%	0	2%	13	0%	0
Physical Support (clothes, blankets, condoms etc)	1%	7	1%	4	1%	4
Informational support	0%	0	0%	0	1%	6
Health Services in general	0%	1	0%	0	0%	0
Spiritual support (church)	0%	2	0%	0	0%	0

### Community level exposure and responses to HIV/AIDS in the past year

AIDS is being spoken about at religious gatherings to a varying extent in communities, with respondents reporting levels: Onandjokwe (51%), Oshikuku (37%) and Rehoboth (32%). Less than half of the respondents reported attending a community meeting about HIV/AIDS (18%-46%).

Personalised exposure was high in most communities with over a quarter to around half of respondents reporting a person they know who had said they were HIV positive (25%-51%). Personally knowing someone who has died of AIDS and attending the funeral of someone who had died of AIDS ranged from just under half to around three quarters of respondents (42%-73%). Personalised involvement was explored through a number of questions including wearing clothing with a red ribbon or AIDS messages, attending a

training workshop on AIDS, volunteering at an HIV/AIDS organization, and helping care for children of people who had died of AIDS, or caring for a person sick with AIDS. Between one in six and half of respondents reported such involvement.

On average, community-level exposure and responses were highest in Oshikuku (44%), lower in Onandjokwe (32%) and lowest in Rehoboth (28%).

***Personally knowing someone who was HIV positive or who had died of AIDS***

Being told by someone that one knew that they were HIV positive, or personally knowing someone who had died of AIDS in the past year was significantly correlated with HIV-related responses when controlling for demographic and other factors:

- 61% (365) of respondents who personally knew someone who died of AIDS in the last year reported *having an HIV test in the last year* compared to 54% (208) of those who did not (OR<sub>adj.</sub>: 1.4; p=0.01);
- 25% (154) of respondents who personally knew someone who told them they were HIV positive in the last year reported *volunteering for an HIV/AIDS organization in the last year* compared to 7% (77) of those who did not (OR<sub>adj.</sub>: 4.7; p<0.001);
- 18% (179) of respondents who personally knew someone who died of AIDS in the last year reported *volunteering for an HIV/AIDS organization in the last year* compared to 3% (45) of those who did not (OR<sub>adj.</sub>: 3.3; p<0.001);
- 46% (449) of respondents who personally knew someone who told them they were HIV positive in the past last year reported *wearing a red ribbon or clothing with an AIDS message in the last year* compared to 45% (364) of those who did not (OR<sub>adj.</sub>: 1.4; p=0.04);

There was *no* significant influence on risk behaviours including having two or more partners in the past year, or on having two or more sexual partners in the past month.

**Table 15: Community level exposure and responses to HIV and AIDS in the past year, ages 15 years and older**

	Oshikuku		Onandjokwe		Rehoboth	
	%	n	%	n	%	n
<b>Community level exposure to AIDS</b>						
Heard AIDS spoken about by religious leaders at church/other religious gatherings	37%	220	51%	305	32%	191
Attended a meeting about HIV/AIDS in the community where I live	39%	235	46%	277	18%	110
<b>Personalised exposure</b>						
Someone I know told me they are HIV positive	51%	303	25%	152	28%	170
Personally know someone who has died of AIDS	73%	437	54%	323	38%	225
Attended funeral of someone who has died of AIDS	67%	404	52%	311	42%	252
<b>Personalised involvement</b>						
Worn a red ribbon, T-shirt, cap with an AIDS message	49%	293	43%	258	44%	262
Attended a training workshop on HIV/AIDS	26%	154	12%	69	23%	137
Volunteered for an HIV/AIDS organisation in my community	16%	96	7%	41	16%	94
Helped care for a child whose parents died of AIDS	30%	178	11%	65	19%	113
Helped care for a person who is sick with AIDS	54%	321	22%	132	20%	120
<b>Average</b>	<b>44%</b>		<b>32%</b>		<b>28%</b>	

## **IMPLICATIONS FOR INTERVENTION: EXPOSURE TO HIV/AIDS INFORMATION**

- ❑ *There is good mass media reach in all communities, particularly broadcast media, with HIV/AIDS information being noted in radio, with less exposure via television and newspapers, except in Rehoboth.*
- ❑ *Health workers are providing the highest proportion of information on HIV/AIDS at the community level, with religious groups, AIDS organisations and NGOs scoring somewhat lower. Greater intensity of information dissemination is suggested for community level organisations.*
- ❑ *Family and friends are clearly talking about the disease, and in schools HIV/AIDS is clearly intensively discussed. HIV/AIDS communication activities in workplaces should be intensified.*
- ❑ *Exposure to AIDS campaigns and organisations did not vary markedly in each community.*
- ❑ *Knowledge of organisations is related to organizational activities in each community, and this is likely to underpin variations of exposure between communities. Rehoboth respondents had lower exposure to community-based organisations.*
- ❑ *Campaigns are likely to have influenced statistically significant changes in key responses such as HIV testing or condom use over time, but there is a lack of influence on two key epidemic drivers – having two or more partners in the past year and past month. This requires urgent and intensified action.*

- *Personally knowing someone who had died from AIDS was high overall, as was knowing a person who was HIV positive, and these factors significantly contributed to personalisation of risk. However, it remains that fundamental risk-related sexual behaviours – specifically, having multiple partners – are not significantly impacted by such knowledge.*
- *Respondents were clearly involved in responding to the epidemic by becoming personally involved in the response – and the high proportions of respondents wearing red ribbons and clothing with AIDS messages, alongside other forms of involvement are promising. This should continue to be encouraged.*
- *Involvement with PLHA and HIV response suggests that ‘prevention with positives’ campaign orientations should be investigated.*

## HIV TESTING

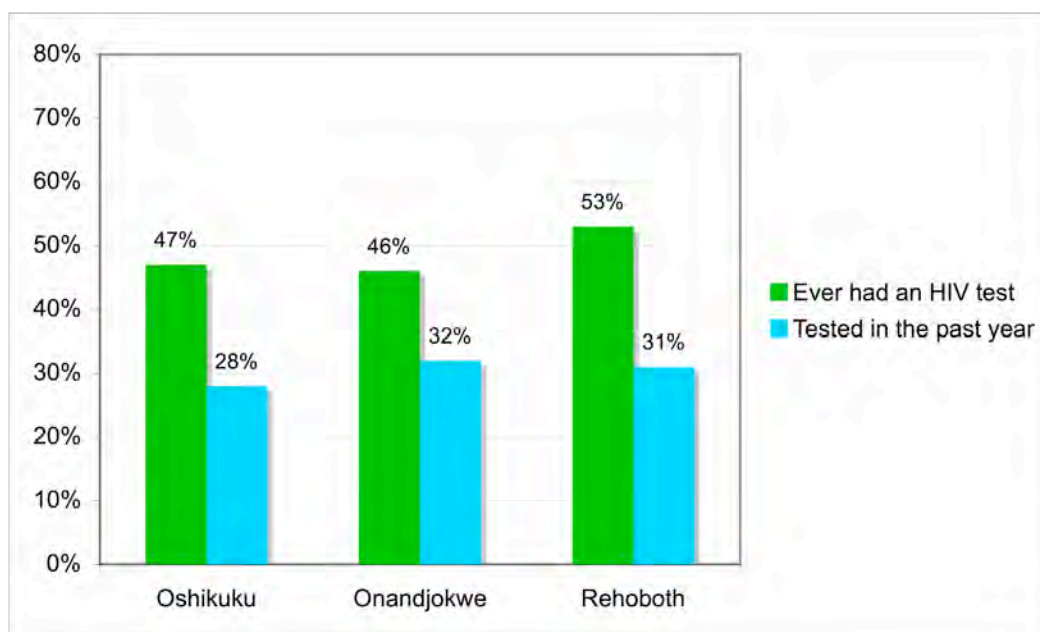
Nearly all respondents knew of a place where they could be tested for HIV (93%-94%) and around a half had ever had an HIV test (46%-53%). Males were less likely to have been tested for HIV than females, although this is likely to have been influenced by females being more likely to be tested in the context of pregnancy.

Of respondents who had been tested for HIV, there was a high proportion tested in the past year – about two-thirds in Onandjokwe (68%), Oshikuku (61%) and around half in Rehoboth (58%). Of all respondents, nearly a third or more in all communities reported having an HIV test in the past year (28%-32%).

**Table 16: HIV testing, ages 15 years and older**

	Oshikuku		Onandjokwe		Rehoboth	
	%	n	%	n	%	n
Know a place where you can be tested for HIV	93%	560	94%	566	94%	565
Ever had an HIV test	47%	279	46%	278	53%	320
Never had an HIV test	54%	321	54%	322	47%	280
Male: Ever had an HIV test	38%	112	42%	126	49%	147
Female: Ever had an HIV test	55%	167	51%	152	58%	173
<b>If ever had an HIV test, when was last test</b>						
In the past year	61%	170	68%	190	58%	185
More than a year ago	22%	61	17%	46	31%	99
More than two years ago	17%	48	15%	42	11%	36
<b>Of all respondents, proportion tested in past year</b>	28%	170	32%	190	31%	185

**Figure 1: Ever tested and tested in the past year, ages 15 and older**



Around a half of all respondents in various sites had never had an HIV test (47%-54%). When asked why they had not been tested, most said they were ‘not at risk for HIV’, although this was more likely in Rehoboth (57%) and Oshikuku (38%), than in Onandjokwe (23%). Other main reasons included ‘I don’t see the need for getting tested’, and ‘I don’t think I am HIV positive’. A smaller proportion reported being ‘scared to be tested’ (6%-16%), trusting their partners (5%-7%) and not having time (0%-2%).

**Table 17: Reasons for not having an HIV test, ages 15 years and older who had not previously had an HIV test**

	Oshikuku		Onandjokwe		Rehoboth	
	%	n	%	n	%	n
I am not at risk for HIV	38%	123	23%	75	57%	159
I don't see the need for getting tested	27%	88	23%	73	16%	45
I don't think that I am HIV positive	10%	31	20%	64	11%	30
I am scared to be tested	11%	34	16%	51	6%	16
I trust my partner	5%	15	7%	23	5%	14
I did not have time	2%	5	2%	6	0%	0
I do not believe test is accurate	2%	7	1%	3	2%	5
I am worried about my test results	3%	11	1%	2	2%	6
I am too young to get tested	0%	1	2%	7	0%	0
I am too old to get tested	1%	2	5%	17	0%	0
I am not ready to get tested	0%	1	0%	0	0%	0
I am not sick	1%	2	0%	0	0%	0
I do not trust the doctors	0%	1	0%	0	0%	0
I don't know where to go	0%	0	0%	0	0%	1
Other	0%	0	0%	1	1%	4

Around a quarter (20%-27%) of females said they were tested because they were pregnant. Amongst both male and female respondents who had been tested for HIV, most said they were tested because their partner requested it (13%-20%). Some 4%-10% said they were tested because they wanted to know their HIV status and a similar proportion tested because they were feeling sick (8%-16%).

**Table 18: Reasons for having an HIV test, ages 15 years and older**

	Oshikuku		Onandjokwe		Rehoboth	
	%	n	%	n	%	n
I was pregnant (of tested females)	26%	72	27%	74	20%	64
My partner requested it	13%	35	20%	55	17%	55
I was feeling sick	8%	23	15%	41	16%	52
I wanted to know my HIV status	10%	27	9%	25	4%	12
I applied for an insurance policy or loan	5%	14	5%	14	5%	16
I am worried about my partner's status/behaviour	6%	17	4%	10	11%	36
I wanted to start a new sexual relationship	9%	25	5%	15	3%	10
I have multiple partners	5%	14	5%	13	12%	38
My employer requested it	3%	9	2%	5	3%	8
I engaged in risky sexual behaviour	7%	19	2%	6	3%	9

Places mentioned where HIV testing was available included ‘at a clinic or hospital’ (59%-85%), at a New Start Centre (31%-59%), and at Catholic AIDS Action (22%-51%).

**Table 19: Places mentioned where Counseling for HIV/AIDS was available, ages 15 years and older**

	Oshikuku		Onandjokwe		Rehoboth	
	%	n	%	n	%	n
At a clinic or hospital	79%	473	85%	511	59%	351
New Start Centre	44%	265	31%	183	59%	354
Catholic Aids Action	39%	231	22%	129	51%	303
Other	4%	25	9%	54	3%	18

### **Changes since baseline: HIV testing**

There have been significant changes in knowledge of places to be tested (Baseline to Midterm:  $OR_{adj.} : 2.1; p < 0.001$ ) (Baseline to Follow-up:  $OR_{adj.} : 2.4; p < 0.001$ ) and where to receive counseling for HIV decreased from (Baseline to Midterm:  $OR_{adj.} : 0.4; p < 0.001$ ) and then increased significantly (Baseline to Follow up:  $OR_{adj.} : 1.7; p < 0.001$ ) with nearly all respondents in all communities now indicating that they know of such places.

The proportion of respondents reporting ever having an HIV test has gone up significantly overall (Baseline to Follow up:  $OR_{adj.} : 1.8; p < 0.001$ ), which illustrates the

increased intensity of HIV testing uptake in recent years. However, the number of respondents who reported ever testing declined in Rehoboth.

**Table 20: Changes in HIV testing, ages 15 years and older**

	Oshikuku				Onandjokwe				Rehoboth			
	Baseline		Follow up		Baseline		Follow up		Baseline		Follow up	
	%	n	%	n	%	n	%	n	%	n	%	n
Know place to be tested for HIV	85%	255	93%	560	89%	267	94%	566	91%	273	94%	585
Know place to obtain counseling for HIV	95%	284	98%	586	96%	287	95%	570	97%	290	99%	591
Ever tested for HIV	21%	63	47%	279	34%	101	50%	278	57%	171	53%	320
% change: Ever tested			26%				12%				-4%	

### Qualitative findings: HIV testing

Perceived lack of confidentiality at state HIV testing facilities was widely mentioned as a factor that undermined confidence in going for HIV testing.

*If you are testing your blood at the testing centres... You didn't even tell your parents that you are HIV positive; you are afraid to tell your parents. But your neighbour already knows that you are HIV positive. They then tell your mother. She will hear from someone else that you are sick. There is no confidentiality(at) the testing centres (Female, Rehoboth, 20-30).<sup>13</sup>*

*There is no confidentiality. Even the other day I was doing testing at the clinic. The results were lying (on the table); there was a table and they were just lying there. (Male, Rehoboth, 20-30).<sup>14</sup>*

Disclosure of one's HIV status was also linked to a fear of discrimination – even amongst one's friends. However, as one participant noted, disclosure was an important aspect to raising awareness at the community level.

*I will say that maybe I've been tested HIV positive and I want to disclose to my friends. But I think if I go now to disclose it, then they will be gossiping and they will stigmatise me, discriminate against me and it is very difficult to disclose it towards your friends. Sometimes it helps to disclose, but sometimes not (Female, Rehoboth, 35+).<sup>15</sup>*

*I feel one of my concerns is stigma when it comes to HIV AIDS. We victimize the infected people in our community. This brings them to the point that they withdraw from the community instead of being active in the community and the community being there to support them mentally and physically. So what happen is that they keep their status to themselves and as humans we have to wake up and realize that HIV/AIDS is real and it's here with us. And we have to accept it and we have to find*

<sup>13</sup> NLT FGD Rehoboth 20-30 April 2008.txt 16000,16866

<sup>14</sup> NLT FGD Rehoboth 20-30 April 2008.txt 40683,41998

<sup>15</sup> NLT FGD Rehoboth 35+ April 2008.txt 20236,20566

*means of living with it, rather than fighting it or rejecting it (Male, Oshikuku, 20-30).<sup>16</sup>*

There was a sense amongst some younger participants that sticking to one partner was a good HIV prevention strategy and that HIV testing need not be feared because even an HIV positive diagnosis was moderated by availability of treatment. It was also noted that in the case of discordancy, partners should discuss their status to avoid infection.

*Nowadays, people are sticking to one partner and most of the people are afraid. Most of them, they will tell you 'I don't want to mess up my life, I am still young or I don't want to die. I am having my girlfriend, I am having my boyfriend...' And most of the time, those they used to go to clinics for the test, so they get tested and they know their status. Most of them they are saying. I am not afraid, because if I get tested and I find out that I am HIV positive, I can go for the treatment - I think it is reaching the community (Female, Oniipa, 20-30).<sup>17</sup>*

*And the other way, that if the one partner is infected, he must try to go and discuss it, (and) talk about it if the other partner is not infected. If the one partner is infected and the other one is not infected, if they do have unprotected sex, then the other one will infect the other partner who is not infected (Female, Oniipa, 35+).<sup>18</sup>*

Whilst there was a general perception that finding out one was positive could be addressed through HIV treatment, there was also a recognition that some people explored faith-oriented alternatives.

*Sometimes the people who are tested positive, they tend to go to the spiritual churches in the belief that God will heal the disease. The emphasis should be put on that God will never do that, but we must get pills, medication or the cure for it (Female, Oniipa, 20-30).<sup>19</sup>*

Support groups were seen as a valuable resource at the community level, but that these needed to be strengthened through assistance with management skills and income generation.

*So, that is a big concern for me. Furthermore, people living with HIV/AIDS and their support groups... These support groups is not sufficiently strengthened in terms of capacity development of the people managing such support groups. They want to indulge into income-generating projects which could offer some kind of incentive or interest from other people which is living with HIV and AIDS. But, project management skills, project funding, this kind of thing, the capacity is not there. I think it must be a priority to help the people in that regard (Male, Rehoboth, 35+).<sup>20</sup>*

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<sup>16</sup> NLT FGD Oshikuku 20-30 April 2008.txt 995,1555

<sup>17</sup> NLT FGD Oniipa 20-30 April 2008.txt 4505,5045

<sup>18</sup> NLT FGD Oniipa 35+ April 2008.txt 5170,5697

<sup>19</sup> NLT FGD Oniipa 20-30 April 2008.txt 36087,38350

<sup>20</sup> NLT FGD Rehoboth 35+ April 2008.txt 1751,3257

### **Implications for intervention: HIV testing**

- *The large proportion of respondents who had ever tested who were tested in the last year indicates that the national rollout of HIV testing services alongside promotion of HIV testing is having an impact.*
- *The increase in the number of respondents who had ever tested for HIV is an important change over time and 'Prevention with positives' programmes could potentially be rolled out alongside VCT interventions.*
- *There has been a promising and significant increase in knowledge of places to obtain an HIV test and of ever having had a test. It was also interesting to note that a prominent reason for having an HIV test was because one's partner requested it. This is potentially worth emphasizing as a campaign message.*
- *Perceptions of lack of confidentiality in state facilities were mentioned in all three study communities and this suggests attention should be given to service provider training as well as promotion of the rights to confidentiality at community level.*

## **SEXUAL BEHAVIOURS, PRACTICES AND TRENDS**

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Although this survey has not measured HIV prevalence in the study population, a range of sexual behaviours and risk-related practices that contribute to HIV infection have been explored.

### **Sex and numbers of sexual partners**

The following findings explore whether or not respondents have had sex before, as well as characteristics of sexual partnerships. A proportion of respondents refused to answer the question and were excluded from further analysis (Oshikuku – 4%; Onandjokwe– 14%; Rehoboth – 16%). Males and females were equally likely to refuse to answer this question. Refusals increased with age – for example, in the age group over 50, 25% of respondents refused to answer compared to only 4% amongst those younger than 25. A small number also refused to answer more detailed questions.

### ***Ever sex, sexual debut and teenage pregnancy***

Most respondents reported having sex before, with those who had not had sex mainly being in the younger age group. In Oshikuku and Rehoboth around two thirds of 15-24 year olds have had sex (63% and 64%) in comparison to about half in Onandjokwe (55%).

Early sexual debut exposes young people to the risk of HIV infection, and in the context of a high overall HIV prevalence, it is necessary to intensively promote delayed sexual debut.<sup>21</sup>

Of respondents who had sex before, around a third of young males aged 15-24 (37%) and over a quarter of females (27%), have had sex at the age of 15 or younger.

Table 21 explores trends in age of sexual debut by looking at how respondents in each age group reported their age at first sex. What this reveals is that there have been changes in the average age of sexual debut by age groups over time, clearly showing that the age of sexual debut is becoming younger. Thus, current 15-24 year olds are far more likely to have had sex at 15 or younger than respondents in older age groups. For example, for males, 37% of those aged 15-24 report having had sex at age 15 or younger, compared to 21% for males currently aged 25-34, and only 16% of males aged 35-49. A similar pattern is found amongst females.

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<sup>21</sup> Pettifor et al, 2004; Harrison et al, 2006; Gregson et al, 2002.

**Table 21: Age of sexual debut by age group**

	15-24		25-34		35-49		50+	
	%	n	%	n	%	n	%	n
<b>Males</b>		211		192		152		119
<b>Age at first sex</b>								
<13	6%	12	3%	5	4%	6	1%	1
13	4%	8	3%	5	0%	0	2%	2
14	8%	16	5%	9	3%	5	3%	4
15	20%	42	11%	21	8%	12	9%	11
<b>First sex at 15 or younger</b>	<b>37%</b>	<b>78</b>	<b>21%</b>	<b>40</b>	<b>15%</b>	<b>23</b>	<b>15%</b>	<b>18</b>
16	21%	45	13%	25	12%	18	7%	8
17	16%	34	17%	33	9%	13	10%	12
18	11%	23	17%	33	18%	27	8%	10
19	9%	18	14%	27	13%	20	13%	16
20	4%	8	10%	20	14%	21	16%	19
>20	2%	5	7%	14	20%	30	30%	36
<b>Females</b>		209		200		161		94
<b>Age at first sex</b>								
<13	4%	9	2%	4	1%	1	1%	1
13	2%	5	1%	2	1%	2	0%	0
14	6%	13	2%	4	1%	1	2%	2
15	14%	29	10%	20	10%	16	1%	1
<b>First sex at 15 or younger</b>	<b>27%</b>	<b>56</b>	<b>15%</b>	<b>30</b>	<b>12%</b>	<b>20</b>	<b>4%</b>	<b>4</b>
16	19%	40	9%	18	12%	19	4%	4
17	20%	42	12%	24	14%	23	7%	7
18	18%	38	21%	41	17%	28	13%	12
19	6%	12	12%	23	15%	24	11%	10
20	5%	10	16%	31	15%	24	22%	21
>20	5%	11	17%	33	14%	23	38%	36

***Youth with partners more than ten years older***

Female antenatal HIV prevalence in Namibia is highest in the 25-39 year age group, and trends in other countries show that HIV prevalence for males tends to peak in a similar but slightly older age group. Consequently, youth who have sex with partners more than ten years older than themselves are exposed to a higher prevalence age group, and thus risk of infection is higher than if their sexual partners were within the same age range.<sup>22</sup> Around one in ten young males and nearly one in four young females who had ever had sex reported that their last sexual partner was more than ten years older than themselves. This pattern was similar amongst teenagers and young people in their early twenties.

<sup>22</sup> Gregson, S., Nyamukapa, C.A., Garnett, G.P., Mason, P.R., Zhuwau, T., Caraël, M., Chandiwana, S.K., & Anderson, R.M. (2002). Sexual mixing patterns and sex-differentials in teenage exposure to HIV infection in rural Zimbabwe. *The Lancet*, 339:1896-1903

**Table 22: Age of last sexual partner more than ten years older, ages 15-24**

	15-19			20-24			15-24		
	%	n	Total	%	n	Total	%	n	Total
<b>Males</b>	8%	6	78	7%	9	133	7%	15	211
<b>Females</b>	34%	30	89	23%	28	120	28%	58	209

**Teenage births**

The number of teenage girls surveyed who have given birth is relatively low up to the age of 16, but this increases to 14% for 17 year olds and 23% for 18 year olds. (Note: teenage pregnancy was not measured and is likely to occur at higher levels, given that not all pregnancies result in birth).

**Reasons for sex**

Reasons for sex were explored, and whilst it is recognized that this is a complex and layered issue, broad responses are presented in Table 23. Multiple responses were possible, and the table refers to those who have had sex in the past year. Both males and females predominantly reported love of their partner and satisfying a sexual need as their main rationale, whilst ‘satisfying expectations of others’ and being ‘forced to’ were also mentioned by only small proportions of both sexes.

**Table 23: Reasons for sex, ages 15 years and older**

	Oshikuku		Grootfontein		Rehoboth	
	%	n	%	n	%	n
<b>Females</b>	(n=207)		(n=187)		(n=184)	
Because I loved him/her	71%	147	63%	117	64%	117
To satisfy a sexual need	37%	77	42%	79	46%	85
To satisfy expectations of others	11%	23	12%	22	8%	14
Because I was forced to	2%	5	5%	9	2%	4
Other reasons	4%	9	6%	10	3%	5
<b>Males</b>	(n=226)		(n=194)		(n=193)	
Because I loved her/him	64%	144	59%	115	56%	108
To satisfy a sexual need	46%	103	54%	105	49%	94
To satisfy expectations of others	9%	20	9%	18	7%	14
Because I was forced to	2%	4	1%	2	1%	2
Other reasons	3%	6	8%	15	4%	6

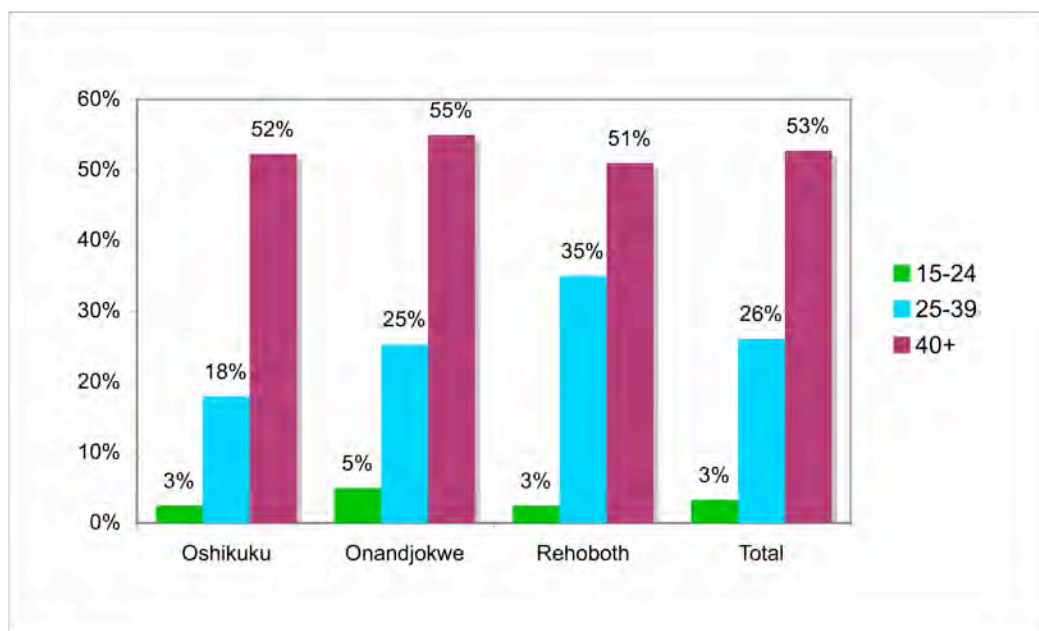
**Marital status**

One factor influencing exposure to sexual networks is marital status, and as Table 24 illustrates, less than one-quarter of 25-29 year olds are married, and less than half of 35-39 year olds are married. Even amongst respondents aged 50 years and older, only around half are married (41% - 54%). There is also a fair amount of variation in marital status by age group between sites.

**Table 24: Proportion of respondents who are married, ages 15 years and older**

	Oshikuku			Onandjokwe			Rehoboth		
	%	n	Total	%	n	Total	%	n	Total
<20	2%	2	124	1%	1	140	1%	1	125
20-24	3%	2	79	9%	7	82	4%	5	141
25-29	3%	2	66	11%	9	80	20%	21	107
30-34	20%	14	69	24%	18	76	47%	28	59
35-39	31%	18	58	41%	19	46	38%	18	48
40-44	63%	24	38	56%	27	48	54%	19	35
45-49	49%	17	35	55%	18	33	58%	14	24
50+	45%	59	131	54%	51	95	41%	25	61
Total	23%	138	600	25%	150	600	22%	131	600

**Figure 2: Proportion of respondents who are married, ages 15 years and older**



### ***Sexual partners in the past year***

Numbers of sexual partners amongst respondents who had sex before were explored.<sup>23</sup>

Around one in ten respondents who had previously had sex reported not having sex in the past year (secondary abstinence) – Oshikuku (13%); Onandjokwe (10%) and Rehoboth (9%). As can be seen from the table, secondary abstinence occurs in all age groups, but is predominant amongst respondents aged 50 years and older.

Of the remaining respondents, approximately three-fifths of respondents in all sites reported having had one partner in the past year.

Having two or more partners in the past year was highest in Rehoboth (30%), followed by Oshikuku (17%) and Onandjokwe (17%).

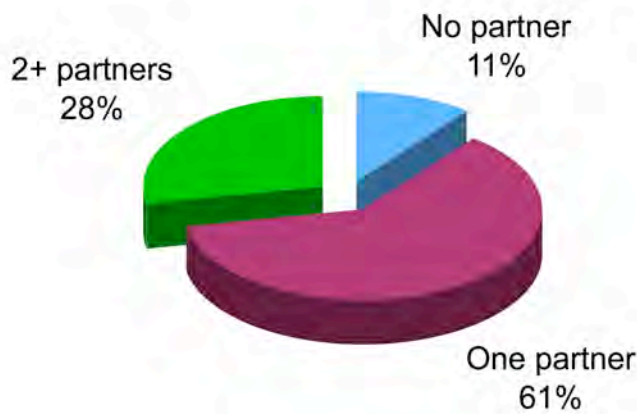
<sup>23</sup> Six respondents refused to answer questions in this category and were excluded from the analysis.

Slightly more females reported secondary abstinence than males, and males were more likely to report having two or more partners in the past year, with around a quarter reporting more than two partners – Onandjokwe (43%); Rehoboth (42%) and Oshikuku (38%).

When analysed by age group, youth aged 15-24 and young adults aged 25-34 and 35-49 showed similar patterns, with around a third or more reporting two or more sexual partners in the past year.

Amongst people 50 years and older, over three quarters reported either having no partner in the past year or one partner in the past year, with a relatively small proportion reporting two or more partners.

**Figure 3: Partners in the last year of those who ever had sex**



**Table 25: Partners in the last year of those ever having sex, by all ages, sex and age group**

	Oshikuku		Onandjokwe		Rehoboth	
	%	n	%	n	%	n
		(n =498)		(n = 422*)		(n=411)
<b>None</b>	13%	65	10%	41	9%	37
1	60%	297	63%	267	61%	249
2+	27%	136	27%	114	30%	125
<b>Males</b>		(n=256)		(n = 205)*		(n=210)
None	12%	30	5%	11	9%	18
1	50%	128	51%	104	49%	103
2+	38%	98	43%	90	42%	89
<b>Females</b>		(n = 242)		(n = 217)*		(n = 201)
None	14%	35	14%	30	9%	19
1	70%	169	75%	163	73%	146
2+	15%	38	11%	24	18%	36
<b>15-24 age group</b>		(n=127)		(n=122)		(n=170)
None	2%	2	7%	9	5%	9
1	66%	84	69%	84	59%	100
2+	33%	41	24%	29	36%	61
<b>25-34 age group</b>		(n = 125)		(n = 140)		(n=126)
None	2%	3	4%	6	6%	7
1	63%	79	61%	85	70%	88
2+	34%	43	35%	49	25%	31
<b>35-49 age group</b>		(n=127)		(n=102)		(n=81)
None	6%	7	8%	8	5%	6
1	65%	83	66%	67	43%	49
2+	29%	37	27%	27	24%	26
<b>50+age group</b>		(n=119)		(n=58)		(n=34)
None	45%	53	31%	18	44%	15
1	43%	51	53%	31	35%	12
2+	13%	15	16%	9	21%	7

Table 26 shows the relationship between marital status and number of sexual partners in the past year amongst respondents who had ever had sex. Respondents who were unmarried were more likely to have not had a sexual partner in the past year. A quarter (24%) of married males reported having two or more sexual partners in the past year, as did 6% of married females. Around half (54%) of males who were cohabiting reported two or more partners, as did around one in five (16%) cohabiting females. Overall however, respondents who were unmarried were more likely to have had more than one sexual partner in the past year.

**Table 26: Number of sexual partners in the last year by marital status and sex**

	Married		Married		Cohabiting		Cohabiting		Unmarried		Unmarried	
	(Males)		(Females)		(Males)		(Females)		(Males)		(Females)	
	(n = 160)		(n = 178)		(n = 81)		(n = 74)		(n = 430)		(n = 408)	
	%	n	%	n	%	n	%	n	%	n	%	n
None	9%	14	10%	17	0%	0	3%	2	10%	45	16%	65
1	72%	105	85%	151	46%	37	81%	60	45%	193	65%	267
2+	24%	41	6%	10	54%	44	16%	12	45%	192	18%	76

**Changes since baseline: Number of partners in past year**

There has been an increase in the number of people with two or more partners in the past year between baseline and follow-up, particularly in Oshikuku (11% to 27%) and Rehoboth (10% to 30%). This increase is statistically significant ( $OR_{adj.} : 2.2, p < 0.001$ )

**Table 27: Changes in number of partners in past year, ages 15 years and older**

	Oshikuku				Onandjokwe				Rehoboth			
	Baseline		follow up		Baseline		follow up		Baseline		follow up	
	%	n	%	n	%	n	%	n	%	n	%	n
None	13%	22	13%	65	5%	10	10%	41	22%	44	9%	37
One	76%	132	60%	297	72%	155	63%	267	68%	133	61%	249
2+	11%	19	27%	136	23%	49	27%	114	10%	19	30%	125

**Concurrent sexual partnerships**

Having sexual partnerships that overlap in time is referred to as having concurrent sexual partners. Partner concurrency is a significant factor for HIV infection as it produces densely interlinked sexual networks, which, when combined with high viral loads associated with recent HIV infection, result in rapid HIV incidence in a community.<sup>24</sup>

Table 28 shows respondents who have had sex in the past year in relation to sexual partnerships in the past month. Around one in ten respondents had concurrent partners – (11%): Oshikuku (12%); Rehoboth (12%) and Onandjokwe (7%). Concurrent sexual partnerships have a high risk of HIV transmission as a product of a higher likelihood of exposure to individuals who have recently been infected with HIV and who have a high viral load.<sup>25</sup>

The majority of respondents who had sex in the past year also had sex in the past month, and most respondents had only one partner. Respondents who had more than one partner were mostly males. When analysed by age group, concurrency varied by district: in Oshikuku and Onandjokwe concurrency predominantly occurred amongst youth aged 25-

<sup>24</sup> Parker, Makhubele & Ntlabati, 2007

<sup>25</sup> Morris and Kretzchmar, 2000

34 (16%) and (12%) whereas in Rehoboth there was more concurrency in older adults aged 35-49 (17%).

**Table 28: Sexual partners in the last month, of those who had sex in past year, by all ages, age group and sex**

	Oshikuku		Onandjokwe		Rehoboth	
	%	n	%	n	%	n
		(n = 433)		(n = 381)		(n = 375)
<b>None</b>	6%	28	9%	35	6%	21
<b>1</b>	81%	352	83%	318	82%	308
<b>2+</b>	12%	53	7%	28	12%	46
<b>Males</b>		(n = 226)		(n = 194)		(n = 193)
None	5%	12	8%	16	6%	12
1	77%	173	78%	152	74%	143
2+	18%	41	13%	26	20%	38
<b>Females</b>		(n = 207)		(n=187)		(n=182)
None	8%	16	10%	19	5%	9
1	90%	179	89%	166	91%	165
2+	6%	12	1%	2	4%	8
<b>15-24 age group</b>		(n=125)		(n=113)		(n=162)
None	12%	15	14%	16	6%	10
1	76%	95	82%	93	80%	129
2+	12%	15	4%	4	14%	23
<b>25-34 age group</b>		(n=122)		(n=134)		(n=119)
None	6%	7	7%	10	6%	7
1	79%	96	81%	108	89%	106
2+	16%	19	12%	16	5%	6
<b>35-49 age group</b>		(n=120)		(n=94)		(n=75)
None	3%	3	9%	8	4%	3
1	84%	101	84%	79	79%	59
2+	13%	16	7%	7	17%	13

#### Changes since baseline: Number of concurrent partners

There has been an overall increase in the proportion of respondents who have had two or more partners in the past month since the baseline study in all sites (OR<sub>adj.</sub>: 1.8; p<0.001).

**Table 28: Changes in number of partners in past month, ages 15 years and older**

	Oshikuku				Onandjokwe				Rehoboth			
	Baseline		Follow up		Baseline		follow up		Baseline		follow up	
	%	n	%	n	%	n	%	n	%	n	%	n
None	35%	59	6%	28	14%	29	9%	35	17%	31	6%	21
One	62%	104	81%	352	77%	165	83%	318	80%	149	82%	308
>2	2%	4	12%	53	9%	19	7%	28	4%	7	12%	46

## Condom use

Condoms provide an effective barrier to HIV when used consistently and correctly. Reported condom use at last sex is a useful indicator for understanding the impact of condom promotion and dissemination campaigns. Whilst it doesn't illustrate consistent or correct use, it is a useful marker for trends over time, and overall condom uptake. Amongst respondents who had sex in the last year, condom use at last sex is high in all sites, with very high levels reported amongst young people aged 15-24 (83%-87%). Over half to three quarters (50%-75%) of respondents aged 25-34 also reported condom use at last sex. Although males were more likely to report condom use at last sex, condom use amongst females was also high. Condom use was highest amongst people who were unmarried and not cohabiting.

**Table 29: Condom use at last sex by age group, sex and marital status**

	Oshikuku			Onandjokwe			Rehoboth		
	%	n	Total	%	n	Total	%	n	Total
<b>Total</b>	65%	282	433	57%	216	381	63%	238	377
15-24	87%	109	125	84%	95	113	83%	134	162
25-34	75%	91	122	64%	86	134	50%	59	119
35-49	54%	65	120	31%	29	94	46%	35	76
50+	26%	17	66	15%	6	40	50%	10	20
Males	66%	150	226	63%	122	194	70%	135	193
Females	64%	132	207	50%	94	187	56%	103	184
Married	38%	44	117	14%	15	106	27%	23	86
Unmarried - cohabiting	56%	35	63	43%	10	23	58%	39	67
Unmarried	83%	195	236	80%	185	232	81%	164	203
Widowed, divorced	47%	8	17	30%	6	20	57%	12	21

Around a third to a half of respondents who had sex in the past year said they always used condoms (39%-45%) and more than half said they usually or always used condoms.

**Table 30: Consistency of condom use, ages 15 and older**

	Oshikuku		Onandjokwe		Rehoboth	
	%	n	%	n	%	n
Never	12%	54	7%	27	18%	67
Rarely	13%	55	14%	54	5%	17
Occasionally	11%	48	22%	82	15%	57
Usually	24%	103	19%	71	18%	67
Always/every time	40%	173	39%	147	45%	169

## Qualitative findings: Sexual partnerships

Names for people who had concurrent sexual partners were relatively positive for men, including terms such as ‘player’ and ‘Casanova’, in contrast to ‘prostitute’, ‘oshipumbu’ (prostitute), ‘bitch’ and ‘slut’ when referring to women. Community attitudes were noted to be more negative about women than men in such relationships.

*I think that society will, in most cases, accept when the man is in such a relationship. But when it is a woman indulging in such kind of behaviour, then you will find that people are outspoken about it. It is socially not accepted that women behave that way. So, it is more unacceptable when a woman is behaving as such. But with men, (that is) not (so) (Male, Rehoboth, 35+).<sup>26</sup>*

*I will not say the community accepts it, but they are silent about it. But it is more not condemning it as such as they will condemn it in the case of a woman, because of the male traditional figure that portray the man as the hunter, the provider, the leader. Maybe, so it's not that they accept it as right (Male, Rehoboth, 35+).<sup>27</sup>*

Older partners were referred to in economic terms including ‘sugar daddy’, ‘sugar mommy’, ‘sweet pies’, ‘suppliers’, whilst younger counterparts were referred to as ‘gold-diggers’. Another term raised was ‘fusa’ which was said to mean ‘the type who eat anything that walks, that crawls... It’s an animal that eats anything. They don’t care.’

Risks were seen to include HIV infection, unplanned pregnancy, illegitimate children, dropping out of school, alcohol abuse, marital breakup, suicide and violence including murder.

Rationale for having concurrent partners included the notion that such relationships were ‘the fashion’ amongst men, but also something that occurred amongst women.

*It's almost like the fashion, and I don't know - it's fashion. And you have to be in style to have two girlfriends or three girlfriends. Then you are the man, you are the main man (Female, Rehoboth, 20-30).<sup>28</sup>*

*Some ladies, they are not in love with their boyfriends... Maybe the man is with work outside the place then she is looking for someone. And when he comes, that's where the HIV starts. They know that, her boyfriend knows that he was clean before he went out. But his girlfriend which is behind, is taking someone (Female, 20-30, Oshikuku).<sup>29</sup>*

Insecurity and lack of trust in one’s partner was seen as a reason underpinning the seeking out of other partners.

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<sup>26</sup> NLT FGD Rehoboth 35+ April 2008.txt 30266,31202

<sup>27</sup> NLT FGD Rehoboth 35+ April 2008.txt 31443,32343

<sup>28</sup> NLT FGD Rehoboth 20-30 April 2008.txt 26901,27574

<sup>29</sup> NLT FGD Oshikuku 20-30 April 2008.txt 39832,40315

*If you are in a relationship and I know that he is mine, but he is having at least someone else again. So sometimes jealousy can drive you to do something that you are not supposed to do. I might end up sleeping with other people because I am maybe stressed or frustrated because I know he is having relationships with other people. I know he did not call me, maybe he is with her. He did not come to me, maybe he is with her. So I might also end up doing those other things (Female, 20-30, Oshikuku).<sup>30</sup> 5*

Other reasons put forward for having concurrent sexual partners included boredom, wanting to be seen as sexually desirable, seeking sexual pleasure, being away from home, and economic need.

### **IMPLICATIONS: SEXUAL BEHAVIOURS, PRACTICES AND TRENDS**

- *The finding that the age of sexual debut is becoming younger over relatively short periods of time suggests that, in the context of a high prevalence epidemic, programmes focusing on delayed sexual debut amongst teenagers must be intensified and should be central to youth-oriented campaigns.*
- *Amongst young people in their teens and early twenties there were high levels of sex with partners ten or more years older than themselves – especially amongst females. This increases HIV risk as a product of exposure to higher HIV prevalence in older age groups. Sex between teens and much older partners should be highlighted as a high risk factor for HIV infection.*
- *Whilst a proportion of people who are married report multiple partners in the past year, levels are lower for people who are single or cohabiting. Cohabiting with one's sexual partner did not appear to inhibit the likelihood of having multiple partners in the past year, when compared to people who were married.*
- *Having a high turnover of sexual partners is an important risk factor for HIV infection, as it exposes individuals to wider sexual networks. Having multiple partners in the past year was high overall (more than one quarter of all respondents) and this requires attention.*
- *Having multiple partners increased significantly since baseline. Efforts to reduce partner turnover need to be intensified in the context of a high prevalence epidemic.*
- *Having two or more sexual partners in the past month is a significant risk factor for HIV transmission, and is known epidemiologically to be an important factor that drives the HIV epidemic. Risks may be reduced through consistent and correct use of condoms. However, for people in longer-term relationships, condom use tends to fall away. Whilst concurrency predominantly occurs amongst males, females are not excluded from this practice and it is of concern that this has increased significantly since the baseline survey. Efforts to promote*

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<sup>30</sup> NLT FGD Oshikuku 20-30 April 2008.txt 39832,4031

*understanding of the risks of having concurrent partnerships and reducing the number of concurrent partnerships need to be intensified.*

- *Condom use at last sex is very high in the three sites, particularly amongst youth, and this points to a combined impact of condom promotion campaigns reinforced by effective distribution systems. Last sex condom use amongst respondents who are married is also high, as is the proportion of respondents who said they usually or always used condoms – with more than half falling into this category. Condom promotion efforts are clearly working and should continue to be sustained.*
- *Qualitative data illustrates how pervasive multiple and concurrent sexual partnerships are in the study sites. Women in such relationships were more likely to be viewed negatively. It was noted that communities were complacent about such practices, particularly amongst men. It was acknowledged that HIV risk was high in such relationships.*

### **Alcohol consumption**

Alcohol consumption, particularly excessive consumption, is a risk factor associated with sexual risk-taking.<sup>31</sup> Overall consumption of alcohol was high with around a fifth to more than a third of respondents (19%-34%) reporting drinking alcohol a few times a week or more. A third of all respondents reported being drunk in the past month (28%-29%). Amongst youth aged 15-24, only around five percent drank alcohol daily (2%-9%), but up to over a third reported being drunk in the past month (18%-29%). Higher levels of consuming alcohol a few times a week or more occurred in the young adult group aged 25-34, and between a quarter and nearly a half reported being drunk in the past month (27%-40%).

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<sup>31</sup> Weiser et al, 2006; Zuma et al, 2003; 14:814-817.

**Table 31: Alcohol consumption by age group**

	Oshikuku		Onandjokwe		Rehoboth	
	%	n	%	n	%	n
<b>All ages</b>						
Daily	17%	101	5%	27	5%	27
A few times a week	17%	103	19%	111	14%	84
<b>A few times a week or more</b>	<b>34%</b>	<b>204</b>	<b>23%</b>	<b>138</b>	<b>19%</b>	<b>111</b>
Once a week	8%	48	17%	99	13%	76
Less than once a week	14%	81	12%	74	19%	114
Never drink	45%	267	48%	289	50%	299
Been drunk in past month (excluding those who never drink)	51%	169	55%	170	57%	173
Been drunk in past month (of all respondents)	28%	169	28%	170	29%	173
<b>15-24 age group</b>	(203)		(222)		(266)	
Daily	9%	19	2%	5	3%	9
A few times a week	11%	22	15%	33	12%	31
<b>A few times a week or more</b>	<b>20%</b>	<b>41</b>	<b>17%</b>	<b>38</b>	<b>15%</b>	<b>40</b>
Once a week	9%	19	12%	26	12%	31
Less than once a week	11%	22	10%	23	19%	51
Never drink	60%	121	61%	135	54%	144
Been drunk in past month (excluding those who never drink)	44%	36	62%	54	64%	78
Been drunk in past month (of all respondents)	18%	36	24%	54	34%	78
<b>25-34 age group</b>	(135)		(156)		(166)	
Daily	21%	28	5%	8	2%	4
A few times a week	20%	27	24%	38	13%	22
<b>A few times a week or more</b>	<b>41%</b>	<b>55</b>	<b>29%</b>	<b>46</b>	<b>16%</b>	<b>26</b>
Once a week	9%	12	22%	34	17%	29
Less than once a week	17%	23	18%	28	23%	38
Never drink	33%	45	31%	48	44%	73
Been drunk in past month (excluding those who never drink)	60%	54	55%	59	48%	45
Been drunk in past month (of all respondents)	40%	54	38%	59	27%	45

***Perceptions of dangers of alcohol and ways to drink safely***

When asked about the dangers of alcohol, most respondents said that it led to violence, damages health or leads to unsafe sexual behaviour. Drinking in moderation and drinking in a safe environment were the main ways identified to drink safely.

**Table 32: Perceived dangers of alcohol and ways to drink safely**

	Oshikuku		Onandjokwe		Rehoboth	
	%	n	%	n	%	n
<b>Dangers of alcohol</b>						
Leads to violence	33%	196	32%	194	29%	174
Leads to unsafe behaviour	38%	228	20%	117	12%	70
Damages health	8%	48	25%	148	14%	84
Impairs judgment	8%	50	15%	92	19%	116
Puts one at risk of rape	17%	99	12%	70	11%	64
Causes accidents	13%	75	15%	91	7%	44
Causes financial problems	6%	36	7%	44	6%	38
Risk of HIV	8%	45	2%	9	3%	20
Leads to teen pregnancies	8%	48	1%	3	0%	2
Not sure / don't know	5%	29	9%	53	4%	23
Other reasons	7%	42	22%	130	16%	98
<b>Ways to drink safely</b>						
Drink in moderation	54.2%	325	50.3%	302	44.2%	265
Drink in safe environment	4.2%	25	26.0%	156	19.3%	116
Abstain from alcohol	23.5%	141	6.8%	41	16.8%	101
Someone take care of you	4.0%	24	8.8%	53	7.5%	45
Avoid mixing	2.2%	13	7.3%	44	6.2%	37
Not sure / don't know	8.3%	50	15.2%	91	8.8%	53
Other ways	10.0%	60	29.2%	175	8.7%	52

**Alcohol and risk**

Alcohol consumption was significantly correlated with HIV-related risk behaviours.

- 44% (n=174/396) respondents who reported drinking a few times a week or more reported having *two or more sexual partners* in the past year compared to 22% (n=201/935) of those who drank once a week or less (OR<sub>adj.</sub> : 3.2 ;p<0.001);
- 19% (n=72/373) of respondents who reported drinking a few times a week or more reported having *concurrent sexual partners* (two or more partners in the past month) compared to 7% (n=55/816) of those who drank once a week or less (OR<sub>adj.</sub> :3.5 ;p<0.001);
- 42% (n=217/372) of respondents who reported drinking a few times a week or more reported *not* using condoms at last sex compared to 36% (n=297/818) of those who drank once a week or less (OR<sub>adj.</sub> : 1.2; p=0.2).
- 40% (n=293/738) of respondents who reported going to a bar or shebeen in the past month reported having two or more sexual partners in the past year compared to 14% (n=82/593) of those who drank once a week or less (OR<sub>adj.</sub> : 4.3; p<0.001).
- 15% (n=105/709) of respondents who reported going to a bar or shebeen in the past month reported having concurrent sexual partners (two or more sexual partners in the

past month) compared to 5% (n=22/439) of those who drank once a week or less (OR<sub>adj.</sub> : 2.9; p<0.001).

### **Changes since baseline: Alcohol consumption**

Drinking alcohol daily has remained similar in Oshikuku (18%-17%) and Rehoboth (2%-5%), but has declined in Onandjokwe (23%-5%).

**Table 33: Changes in alcohol consumption since baseline, ages 15 years and older**

	Oshikuku				Onandjokwe				Rehoboth			
	Baseline		Follow up		Baseline		Follow up		Baseline		Follow up	
	%	n	%	n	%	n	%	n	%	n	%	n
Daily	18%	53	17%	101	23%	69	5%	27	2%	5	5%	27
A few times a week	10%	29	17%	103	11%	34	19%	111	9%	26	14%	84
Once a week	6%	18	8%	48	8%	23	17%	99	5%	16	13%	76
Less than once a week	7%	21	14%	81	8%	24	12%	74	16%	47	19%	114
Never	60%	179	45%	267	50%	150	48%	289	69%	206	50%	299

## **IMPLICATIONS: ALCOHOL AND RISK BEHAVIOUR**

- ❑ *There is a pattern of high levels of alcohol consumption that extends to regular and excessive drinking amongst youth and young adults in all sites, and being drunk is common. Levels of frequent drinking were higher in Oshikuku, but all sites could benefit from interventions addressing alcohol.*
- ❑ *High levels of alcohol consumption were significantly related to HIV-related risk behaviours and this reinforces the need to address alcohol in conjunction with addressing HIV risk. This would include the need to intensify the ‘Alcohol aids HIV’ campaign and to emphasise the risks of having multiple and concurrent partners.*
- ❑ *It is promising to see that daily alcohol consumption has decreased in one site. However, it remains that efforts continue to be concentrated on this risk factor.*

## **LEISURE ACTIVITIES IN PAST MONTH**

Playing soccer was the predominant activity of young males aged 15-24 in all communities, whilst young females reported playing sports to a lesser extent.

Around half of all respondents had gone to a bar or shebeen in the past month (40%-54%), with a lower proportion going to a nightclub (12%-41%). Going to a bar or shebeen was particularly common amongst 15-24 year olds in Rehoboth (49%).

A relatively high proportion had watched a drama group in Oshikuku (22%), but this was less frequent in Onandjokwe (8%) and Rehoboth (6%).

A fair proportion of respondents reported attending an AIDS support group – 6%-23%. This may include respondents who are living with HIV as well as those who are not HIV positive.

**Table 34: Leisure activities in the past month, ages 15 years and older**

	Oshikuku		Onandjokwe		Rehoboth	
	%	n	%	n	%	n
<b>All ages</b>						
Played soccer	25%	149	24%	146	22%	132
Played other sports	24%	146	29%	176	18%	108
Gone to a bar or shebeen	54%	321	47%	284	40%	240
Gone to a night club	17%	103	12%	74	41%	247
Watched a drama group	22%	134	8%	48	6%	35
Gone to a multipurpose community centre	14%	83	9%	53	10%	57
Gone to an AIDS support group	16%	97	6%	34	23%	136
<b>15-24</b>	(202)		(222)		(266)	
Played soccer (males)	81%	76	85%	94	63%	84
Played other sports (males)	46%	43	56%	62	25%	34
Played other sports (females)	60%	65	69%	77	37%	49
Gone to a bar or shebeen	43%	87	40%	89	41%	110
Gone to a night club	15%	34	10%	23	50%	134
Watched a drama group	27%	61	12%	27	6%	15
Gone to a multipurpose community centre	12%	28	13%	29	8%	20
Gone to an AIDS support group	14%	32	7%	15	16%	43
<b>25-34</b>	(135)		(156)		(166)	
Played soccer (males)	50%	30	37%	29	26%	22
Played other sports (males)	18%	11	14%	11	5%	4
Played other sports (females)	17%	13	17%	13	11%	9
Gone to a bar or shebeen	70%	95	60%	93	36%	60
Gone to a night club	28%	38	24%	35	37%	62
Watched a drama group	26%	35	8%	12	8%	13
Gone to a multipurpose community centre	19%	26	12%	18	11%	19
Gone to an AIDS support group	21%	28	8%	12	23%	39

### **IMPLICATIONS: LEISURE ACTIVITIES IN THE PAST MONTH**

- *Soccer is clearly an access point for young males aged 15-24, and also to some extent males aged 25-34. Sport is also relevant for interventions that may wish to reach younger females through leisure activities.*
- *Bar, shebeen and nightclub attendance is high, and this is corroborated by the data related to alcohol consumption.*
- *Attending an AIDS support group in the past month was high except in Onandjokwe. Over and above illustrating the availability of such groups, that there is a relative openness to involvement in HIV-related interactions.*

## CIRCUMCISION

Male respondents were asked if they had been circumcised and to provide details about the circumcision. Around a third (24%-40%) had been circumcised. In Oshikuku and Onandjokwe, most males had been circumcised in their preteens (89%, 79%); in Rehoboth, more than half were circumcised in their teens or later (55%). The procedure was more likely to have been done by a medical doctor in the case of Onandjokwe and Rehoboth residents, but was more likely to have been done by someone other than a medical doctor in Oshikuku.

**Table 35: Circumcision**

	Oshikuku		Onandjokwe		Rehoboth	
	%	n	%	n	%	n
<b>Been circumcised</b>						
Yes	24%	70	36%	92	40%	113
No	76%	216	64%	167	60%	167
<b>Age of Circumcision</b>						
<=12	89%	62	79%	55	45%	44
13-16	6%	4	6%	4	32%	31
>=17	6%	4	16%	11	23%	22
<b>Who carried out circumcision</b>						
Medical doctor	30%	21	51%	47	57%	64
Someone else	70%	49	49%	45	43%	49

## CHILDREN AND ORPHANS

Respondents were asked whether or not they were parents or guardians of children in the household, with around a third to half of respondents indicating that they were (41% - 56%). Numbers of children cared for in each household were also determined, and respondents who were parents or guardians were also asked how many orphans there were in each household. Table 36 shows the number of orphans who have lost both parents living in households, and around half of all households had at least one or more orphans living in the household.

**Table 36: Parents, guardians and orphans in household, ages 15 years and older**

	Oshikuku		Onandjokwe		Rehoboth	
	%	n	%	n	%	n
<b>Parent or guardian of children in household</b>						
Yes	59%	353	44%	266	52%	310
No	41%	247	56%	334	48%	290
<b>Number of children parent or guardian of living in this household</b>						
1	20%	70	17%	45	40%	123
2	17%	60	23%	61	31%	96
3	18%	63	17%	46	19%	58
4+	45%	160	43%	114	11%	33
<b>Number of orphans (who have lost both parents) in household</b>						
0	27%	164	16%	94	11%	63
1	15%	88	11%	65	9%	51
2	4%	22	3%	17	2%	13
3	0%	1	1%	7	0%	2
4	0%	0	0%	2	0%	1

#### **IMPLICATIONS: CHILDREN AND ORPHANS**

- *Whilst this study is not specifically focused on understanding parenting or guardian relationships, it is of interest to see levels of orphan care. However, there was not a high proportion of orphans being cared for who had lost both parents.*

## CONCLUSIONS

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This final survey in three sites has provided useful insights into the HIV/AIDS related knowledge, perceptions, behaviours and practices in the study communities.

Whilst general knowledge is adequate, there is very poor ‘top of mind’ awareness of two key HIV infection risks – having concurrent sexual partners and the risk of HIV transmission from mother to child.

A high proportion of respondents in the three study sites have sexual relationship practices that place them at high risk for HIV infection – notably a high proportion have two or more partners in the past year, and there is also a high proportion who have two or more partners in the past month. Such practices produce concentrated sexual networks that are conducive to rapid HIV transmission, and these relatively small communities are vulnerable as a product of already having high HIV prevalence.

Delay of sexual debut requires emphasis, and campaign goals should include reversing the trend of earlier sexual debut in the present younger generation. Young people also need to be advised of the risks of having sexual partners who are much older than themselves, as this produces exposure to higher HIV prevalence subgroups.

There were encouraging trends with regard to the uptake of HIV testing, but it was disconcerting to note that there were widespread concerns voiced about the confidentiality of HIV results at HIV test sites.

There were promising levels of respondents reporting that they ‘always use’ condoms, and also involvement of people in community-level response.

This study explored levels of circumcision in the study sites, with around a quarter to two fifths being circumcised. This has potentially limited the spread of HIV in the study communities, but it remains that primary risk factors including partner concurrency need to be addressed with urgency.

Daily alcohol consumption has decreased somewhat in one site, but it remains that alcohol consumption is overall high – particularly being drunk. Frequent alcohol consumption and HIV-related risk behaviours are closely correlated, and continued and intensified focus on this risk factor is necessary.

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**APPENDIX 1: MID-TERM QUESTIONNAIRE 2007**

**2007 FOLLOW-UP HOUSEHOLD SURVEY**

**SECTION 1: DEMOGRAPHIC DETAILS**

**Q1) MQ1 QUESTIONNAIRE NUMBER (0001 – 3600)**

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**Q2) MQ2 CATCHMENT AREA**

Oshikuku	1	Rundu	6	Windhoek	11
Onandjokwe/Oniipa	2	Walvis Bay	7	Gobabis	12
Rehoboth	3	Keetmanshoop	8	Grootfontein	13
Andara	4	Oshakati	9	Omaruru	14
Nyangana	5	Katutura	10	Otjiwarongo	15

**Q3) MQ3 DATE OF INTERVIEW**

DAY	MONTH	2007

**Q4) MQ4 HOUSEHOLD NUMBER IN SAMPLING HOUSEHOLD LIST**

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**Q5) MQ5 RESULT OF INTERVIEW**

	HOUSEHOLD 1	HOUSEHOLD 2	HOUSEHOLD 3
Interview completed	1	1	1
Postponed	2	2	2
Refused	3	3	3
Partially completed	4	4	4
Person not at home at time of visit	5	5	5
Other	6	6	6

Q6)	NAME:	CODE:
<b>MQ6a</b> INTERVIEWER		
<b>MQ6b</b> SUPERVISOR		
<b>MQ6c</b> CODING CLERK		

**SECTION 2: RESPONDENT BACKGROUND**

**Q7) NQ1 What is the majority of the building material used on the respondent's home? MARK WITHOUT ASKING.**

House or brick structure	1
House made of traditional materials (mud/thatch/wood)	2
Shack made of corrugated iron or wood	3
Other (SPECIFY):	

**Q8) MQ9 Is the respondent male or female? MARK WITHOUT ASKING.**

Female	1
Male	2

**Q9) MQ10 How old were you at your last birthday?**

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<b>Q10) MQ11 What was the main language you spoke at home when you were growing up? (ANSWER ONLY ONE)</b>	
Afrikaans	1
English	2
German	3
Oshiwambo	4
Otjherero	5
Damara Nama	6
Kavango	7
Other	8

<b>Q11) NQ2 What is the highest level of education you have completed?</b>	
None	1
Literacy Course	2
Some primary school	3
Completed primary school	4
Completed grade 10	5
Completed grade 12, matric	6
Completed post-school technikon, college, university qualification	7

<b>Q12) NQ3 What religion are you?</b>	
None	1
Catholic	2
Protestant (Lutheran, Methodist, Anglican, Dutch Reformed)	3
Other Christian (Baptist, Pentecostal, Universal, 7 <sup>th</sup> Day Adventist, Jehovah's Witness, etc.)	4
Muslim	5
Traditional religion	6
Refused to Answer	7
Other (SPECIFY):	

<b>Q13) NQ4 How often do you attend religious services (i.e. church services, prayer meetings, choir practice, Bible study groups, Mosque)?</b>	
Never	1
Less than once a month	2
1-3 times a month	3
Once a week	4
More than once a week	5

<b>Q14) MQ16 What is your present employment status? (ANSWER ONLY ONE)</b>	
No job/Unemployed	1
Homemaker/Housewife	2
Full-Time student/Pupil/Learner at school	3
Full-Time Student at College/Technikon/University	4
Volunteer (earning no income)	5
Hawker/informal trader	6
Day labourer / farm worker	7
Shopkeeper (not owner)	8
Health care worker / Nurse / Doctor	9
Business owner	10
Receiving old age pension	11
Receiving a social welfare grant for dependents	12
Other (SPECIFY):	

<b>Q15) MQ155 Does the place where you are living now have...</b>	<b>Yes</b>	<b>No</b>
a) Electricity	1	0
b) Piped water (in the home or yard)	1	0
c) Indoor flush toilets	1	0
d) Telephone (landline or cell phone)	1	0
e) A working Television set	1	0
f) A working Radio	1	0

<b>Q16) NQ5 What is your marital status?</b>	
Married (living with husband/wife)	1
Married (not living with husband/wife)	2
Not married (living with boyfriend/girlfriend, fiancé)	3
Going steady (in a committed relationship, but not living with boyfriend/girlfriend, fiancé)	4
Single	5
Divorced	6
Widowed	7
Other (SPECIFY):	

<b>Q17) NQ6 How many children have you given birth (females) to or fathered (males)?</b>		

<b>Q18a)</b>	<b>Are you the parent or guardian of children living in this home?</b> (Child is any person under 18 years.) (Parent or guardian is parents, grandparents, foster parents, young people looking after younger siblings)	<b>Yes (If yes, answer Q18b)</b>	<b>No (If no, Skip to Q19)</b>
		1	2

<b>Q18b)</b>	<b>How many children are you the parent or guardian of?</b>		

<b>Q19) NQ26a Are there any orphans living in your household? Please state the number of orphans living in your household. (An orphan is a child under the age of 18 who has lost either his mother, father, both of them or the primary caregiver). IF NONE, ENTER "00".</b>	<b>Number of orphans</b>	

<b>Q20) If "Yes," please indicate if this was the child's mother, father or both parents who died</b>  <b>PLEASE RECORD UP TO FOUR CHILDREN</b>	<b>CHILD NUMBER</b>	<b>Mother</b>	<b>Father</b>	<b>Both Parents</b>
	a) 1	1	2	3
	b) 2	1	2	3
	c) 3	1	2	3
	d) 4	1	2	3

**SECTION 3: HIV AIDS AWARENESS, BELIEFS, ATTITUDES AND PARTICIPATION**

I'm now going to ask you a few questions about the disease known as HIV AIDS.

<b>Q21) MQ24 Please mention all the ways in which you believe a person CAN GET INFECTED with HIV</b>	
<b>(DO NOT READ OUT. PROBE ONCE BY ASKING: "Anything else?" MARK ALL THAT APPLY)</b>	
a) Through sexual intercourse	1
b) By not using condoms/Sex without a condom	1
c) By having many sex partners	1
d) From a mother to her baby (pregnancy or birth or breastfeeding)	1
e) From infected blood	1
f) From blood transfusions	1
g) Through sharing needles (drug use)	1
h) Unclean medical equipment	1
i) Mosquito/Insect bites	1
j) Casual contact with infected person (i.e. sharing food, cup, glass, handshake, hugging, clothes)	1
k) From witchcraft	1
l) God's will	1
m) Don't know or don't remember	1
n) Other (SPECIFY):	

<b>Q22) MQ25 Please mention all the ways in which you believe a person CAN AVOID/PREVENT GETTING INFECTED with HIV. (DO NOT READ OUT. PROBE ONCE BY ASKING: "Anything else?" MARK ALL THAT APPLY)</b>	
a) Abstain from sex	1
b) Non penetrative sex/Thigh sex/Mutual masturbation	1
c) Always use condoms	1
d) Limit or reduce number of sex partners	1
e) Have only one sex partner	1
f) Be faithful to your sex partner	1
g) Have sex only with a partner who is HIV negative	1
h) Use sterilized needles	1
i) Avoid sex with a sex worker/prostitute	1
j) Have sex with a virgin	1
k) By being protected through witchcraft	1
l) Through believing in God	1
m) Don't know or don't remember	1
n) Other (SPECIFY):	

<b>How do you feel about the following statements</b>	<b>Strongly Disagree</b>	<b>Somewhat Disagree</b>	<b>Not Sure</b>	<b>Somewhat Agree</b>	<b>Strongly Agree</b>
<b>Q23) MQ27</b> If a member of your family became sick with AIDS, would you be willing to care for him or her in your household?	1	2	3	4	5
<b>Q24) MQ29</b> If a teacher has HIV but is not sick, should he or she be allowed to continue teaching in school?	1	2	3	4	5
<b>Q25) MQ30</b> If a member of your family became infected with HIV, would you want it to remain a secret?	1	2	3	4	5
<b>Q26) NQ7</b> Children who are HIV positive should not go to school.	1	2	3	4	5

<b>Q27) MR31 Are the following statements True or False.</b>	<b>True</b>	<b>False</b>	<b>Don't know/ Unsure</b>
a) People with HIV (the AIDS virus) look sick	1	2	3
b) Traditional healers can cure AIDS	1	2	3
c) HIV (the AIDS virus) can be transmitted through mosquito, flea, or bedbug bites	1	2	3
d) A person can get HIV by touching an infected person	1	2	3
e) HIV can be passed through sharing eating utensils with someone who has HIV	1	2	3
f) An HIV positive mother can transfer HIV to her unborn or newborn baby	1	2	3
g) HIV can be transmitted through breastfeeding	1	2	3
h) Medicines from a hospital or clinic can prolong the life of someone who is infected with HIV	1	2	3
i) If you have fewer sexual partners, you are less likely to get infected with HIV	1	2	3
j) You can reduce the risk of HIV by being faithful to your sexual partner	1	2	3

<b>Q28) MQ151 Please tell me how strongly you Agree or Disagree with the following statements</b>	<b>Strongly Disagree</b>	<b>Somewhat Disagree</b>	<b>Not Sure</b>	<b>Somewhat Agree</b>	<b>Strongly Agree</b>
a) Witchcraft protects one from getting infected with HIV	1	2	3	4	5
b) I am aware of people who have gotten HIV because of witchcraft	1	2	3	4	5
c) If a person gets HIV it is God's will	1	2	3	4	5
d) Christian healers can cure AIDS	1	2	3	4	5
e) Only men should decide when condoms are used	1	2	3	4	5
f) Some men put holes in condoms to unknowingly infect or impregnate others	1	2	3	4	5
g) Condoms should not be used in serious relationships (couples dating 6 months or longer)	1	2	3	4	5

<b>Q29) MQ40 What types of services are available for people living with HIV or AIDS?</b>	
<b>DO NOT READ OUT. MARK ALL THAT APPLY</b>	
a) Medicines that fight HIV (ARVs/Antiretroviral drugs/AIDS drugs) from hospitals and clinics	1
b) Financial support from the government	1
c) Post-test clubs (or support groups)	1
d) Legal support	1
e) Other services from community NGOS	1
f) Don't know	1
g) Other (SPECIFY):	

<b>Q30) NQ9 From which of the following sources have you obtained information about HIV AIDS IN THE PAST YEAR?</b>	<b>Yes</b>	<b>No/Not applicable</b>
a) School/Universities/Teachers	1	0
b) Friends	1	0
c) Mother/Father/Family members/Relatives	1	0
d) Newspaper	1	0
e) Radio	1	0
f) TV	1	0
g) Other Mass Media (Magazines, Books, Pamphlets)	1	0
h) Health Care Workers/Nurse/Doctor/Clinic/Hospital	1	0
i) Community Meetings	1	0
j) Community organizations, local AIDS organizations, NGO's	1	0
k) Traditional healer	1	0
l) Church/Church group/Religious gathering	1	0
m) Workplace	1	0

<b>Q31) NQ10 Which of the following apply to you IN THE PAST YEAR</b>	<b>Yes</b>	<b>No/Not applicable</b>
a) I have attended a training workshop on HIV AIDS	1	0
b) I have attended a meeting about HIV AIDS in the community where I live	1	0
c) I have heard AIDS spoken about by religious leaders at church/mosque	1	0
d) Someone I know has told me they are HIV positive	1	0
e) I have attended a funeral of someone who has died of AIDS	1	0
f) I personally know someone who has died of AIDS	1	0
g) I have helped care for a person who is sick with AIDS	1	0
h) I have worn a red ribbon, T-shirt, cap with an AIDS message or slogan	1	0
i) I have volunteered for an HIV AIDS organization in my community	1	0
j) I have helped care for a child whose parents have died of AIDS	1	0
k) I have gone for HIV testing at a New Start Centre	1	0
l) I have used Smile condoms	1	0
m) I have spoken to a Life Line or Child Line counsellor	1	0

**SECTION 4: COUNSELLING AND TESTING – BELIEF AND KNOWLEDGE**

<b>Q32) MQ51 Do you know of a place where you could go to be tested for HIV, the virus that causes AIDS?</b>		
No		0
Yes		1

<b>Q33) NQ11 Have you ever been tested for HIV?</b>		
No	0	<b>CONTINUE TO Q34</b>
Yes	1	<b>SKIP TO Q35</b>

<b>Q34) NQ12 What was the MAIN reason you have not had an HIV test?</b>		
<b>DO NOT READ OUT. MARK ONLY ONE. AFTER COMPLETING SKIP TO Q37</b>		
a) I am not at risk for HIV		1
b) I don't see the need for getting tested		1
c) I do not think that I am HIV positive		1
d) I trust my partner		1
e) I am scared to be tested		1
f) I don't believe the test is accurate		1
g) I am worried about my test results being kept confidential		1
h) Other (SPECIFY):		

<b>Q35) NQ14 When was your most recent HIV test? AFTER COMPLETING, ANSWER Q36</b>		
In the past year		1
More than a year ago, but less than two years ago		2
More than two years ago		3

<b>Q36) NQ15 What is the MAIN reason for your most recent HIV test</b>		

<b>DO NOT READ OUT. MARK ONLY ONE.</b>	
a) I have multiple partners	1
b) I was/am pregnant	1
c) My partner asked me to	1
d) I applied for an insurance policy or loan	1
e) I was feeling sick or unwell	1
f) I engaged in risky sexual behaviour	1
g) I am worried about my partner's status/behaviour	1
h) My employer requested it	1
i) I wanted to start a new sexual relationship	1
j) Other (SPECIFY)	

<b>Q37) MR61 Where in your community can you go to get counseling about HIV AIDS?</b>	
<b>DO NOT READ OUT. MARK ALL THAT APPLY.</b>	
a) Nowhere	1
b) At a clinic or hospital	1
c) Catholic Aids Action	1
d) New Start Centre	1
e) Other (SPECIFY)	

<b>Q38a) Based on what you know about how HIV is spread, what would you say are your chances of infection? Would you say they are high, medium, low or none?</b>		
None/no chance	(go to 38b)	1
Low	(go to 38b)	2
Medium	(go to 38c)	3
High	(go to 38c)	4
Don't know/uncertain	(skip to Q39)	5
Other (SPECIFY)		

<b>Q38b) If your chances are "none" or "low" in 38a why do you think you are at this level of risk?</b>		
<b>(TICK UP TO THREE)</b>		
Abstain entirely		1
Faithful to one partner		2
HIV/AIDS is not here		3
Can tell if one is HIV+		4
Always use a condom		5
Other (SPECIFY)		

<b>Q38c) If your chances are "medium" or "high" in 38a, why do you think you are at this level of risk?</b>		
<b>(TICK UP TO THREE)</b>		
Don't always use a condom		1
Have multiple partners		2
Don't trust partner(s)		3
Past sexual activity		4
Partner is sick		5
Current sexual activity		6
Other (SPECIFY)		

## **SECTION 5: SEXUAL BEHAVIOURS AND PRACTICES**

*This section of the survey focuses on sexual activity. We know it may be embarrassing to talk about it but it is important to get your honest answers so that we can develop better health programs for Namibia.*

*For the purposes of this survey, when we say sexual intercourse, we mean penis into the vagina or the anus.*

<b>Q39) MQ99 How old you were when you first had sexual intercourse. ONLY ONE RESPONSE</b>														
a) Never had sex										0		<b>Skip to Section 6</b>		
b) Refused to answer										99				
c) Age at first sex														
<b>CHECK BOX BELOW AND TICK ONLY ONE CATEGORY. ASK RESPONDENT TO ESTIMATE THE AGE IF NOT SURE.</b>														
Younger than 12 (Code 1)	12	13	14	15	16	17	18	19	20	21	22	23	24	Older than 24 (Code 2)

<b>Q40) NQ14 Have you had sex in the past year?</b>	
No	0
Yes	1
Refused to answer	99

<b>Q41) NQ15 If yes, why did you have sexual intercourse? (More than one answer may be circled)</b>	
Because I loved him/her	1
To satisfy a sexual need/desire	2
To satisfy expectations of others (peers, family, partner)	3
Because I was forced to	4
This person paid me or offered me a gift	5
Other (SPECIFY):	

<b>Q42) NQ16 How many sexual partners have you had in the past year?</b>							
0	1	2	3	4	5	6	More than 6 (Code 7)
Refused to answer							99

<b>Q43) NQ17 How many sexual partners have you had in the past month?</b>							
0	1	2	3	4	5	6	More than 6 (Code 7)
Refused to answer							99

<b>Q44) NQ 18 Have you ever used a condom before?</b>	
No	0
Yes	1
Refused to answer	99

<b>Q45) MQ105 Did you use a condom the last time you had sex?</b>	
No	0
Yes	1
Refused to answer	99

<b>Q46) MQ106 How frequently, if at all, do you use condoms when you have sex?</b>	
Always/Every time	5
Usually	4
Occasionally	3
Rarely	2
Never	1

<b>Q47) NQ 19 Was the last person that you had sex with...</b>	
10 or more years OLDER than you	1
10 or more years YOUNGER than you	2
Same age or less than 10 years age difference	3

**SECTION 6: LIFESTYLE AND EXPOSURE TO INTERVENTIONS**

<b>Q48) NQ 20 How often do you listen to the radio?</b>	
Never	0
Less than once a week	1
1-3 days a week	2
4-6 days a week	3
Every day of the week	4

<b>Q49) NQ21 How often do you watch TV?</b>	
Never	0
Less than once a week	1
1-3 days a week	2
4-6 days a week	3
Every day of the week	4

<b>Q50) NQ22 How often do you read a newspaper or magazine?</b>	
Never	0
Less than once a week	1
1-3 days a week	2
4-6 days a week	3
Every day of the week	4

<b>Q51) NQ23 IN THE PAST WEEK, have you...?</b>		<b>Yes</b>
a) Watched NBC Television		1
b) Watched ONE AFRICA TV		1
c) Watched M-NET		1
d) Listened to National Radio		1
e) Listened to NBC Local Language Station		1
f) Listened to Radio Energy		1
g) Listened to Radio Wave		1
h) Listened to Radio Omulunga		1
i) Listened to Radio 99		1
j) Listened to Kanaal 7/Channel 7		1
k) Listened to Live FM		1
l) Read the Namibian		1
m) Read Republikein		1
n) Read New Era		1
o) Read Informante		1

<b>Q51a) If yes to Q51a (Listened to NBC Local Language Station), which local language radio station did you listen to?</b>	

<b>Q52) NQ24 In the past month, have you participated in any of the following leisure activities in your spare time?</b>	<b>Yes</b>	<b>No</b>
a) Playing soccer	2	1
b) Playing other sports (netball, athletics, etc.)	2	1
c) Going to a bar or shebeen	2	1
d) Going to a night club	2	1
e) Visiting shopping centres	2	1
f) Going to the Cinema	2	1
g) Going to an AIDS support group	2	1
h) Reading magazines	2	1
i) Going to a multipurpose community centre	2	1
j) Watching a drama group	2	1
k) Other (SPECIFY):	2	1

<b>Q53) NQ 7 How frequently do you drink alcohol? By alcohol I mean beer, wine, tombo, wine coolers, whisky, brandy, vodka, spirits – anything with alcohol in it.</b>	
Daily/Every day	1
A few times a week	2
Once a week (weekly)	3
Less than once a week	4
Never drink	5

<b>Q54a) NQ 8 In the past month, have you been drunk?</b>	
No	0
Yes	1
Not applicable (seldom/never drink)	2

<b>Q54b) NQ8 What ways do you know how to drink safely and responsibly?</b>	

<b>Q54c) NQ8 What do you think are the biggest dangers of drinking too much alcohol?</b>	

<b>Q55) NQ25 IN THE PAST MONTH, which of the following have you heard of or seen?</b>	<b>Yes</b>
a) "Be your own hero"	1
b) NAWA LIFE	1
c) ALCOHOL AIDS HIV –	1
d) Desert Soul	1
e) My Future is My Choice	1
f) Catholic AIDS Action (CAA)	1
g) New Start [HIV testing]	1
h) Smile condoms	1
i) Lironga Eparu	1
j) Life Line/Child Line	1
k) Window of Hope	1
l) UNICEF	1
m) "Be there to Care"	1
n) Take Control Mass Media Campaign	1

**SECTION 7: THIS LAST SECTION TO BE ANSWERED BY MALES ONLY**

<b>Q56 Have you been circumcised?</b>	
No	0
Yes	1
Refused to answer	99

<b>Q57 If yes, how old were you when you were circumcised?</b>	

<b>Q58 Who carried out the circumcision?</b>	
A qualified medical doctor at a clinic or hospital	0
Someone else who is not a medical doctor	1

<b>Q59 Was the entire foreskin of the penis completely removed?</b>	
No	0
Yes	1
Refused to answer	99

**END**

This is the end of the questionnaire. Thank you for participating in this study. We truly appreciate the time that you have taken to make this study possible.