

**NawaLife Trust**  
namibian center for communication programmes

# **HIV/AIDS**

*Strategic Information Report*

**Mid-term HIV/AIDS  
Community Survey**  
Gobabis, Grootfontein, Omaruru  
2008



**Mid-term HIV/AIDS Community Survey Report:  
Gobabis, Grootfontein and Omaruru  
2008**

**Authors**

Warren Parker (CADRE) and Cathy Connolly (MRC)

CADRE

Centre for AIDS Development, Research and Evaluation

[www.cadre.org.za](http://www.cadre.org.za)

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## **FIELD RESEARCH**

### **Quantitative and Qualitative Survey: Project Managers**

Erna Keulder, Lizl Stoman and Pieter Stoman

### **Quantitative survey: Field Supervisors**

Feris Joseph, Veikko Iitembu and Daniel Alberto

### **Enumerators**

Joseph Theodor, Otilie Sheehama, Elina Nghilondo, Titus Joseph, Gertrud Aindongo, Petrus Shikongo, Linda Alexander, David Amundjembo, Aron Sheetekela, Bencina Oarum, Arnold Hekandjo, Albertina Mukanga, Sarah Oarum, Elicia Hanghome, Derik Vilas, Immanuel Nghidengwa, Suama Alexander and Llewelyn Feris

### **Coding Clerks**

Catherine Ntema, Wesley Eberenz, Aubrey Visagie and Nigitta Bezuidenhout

### **Capturing clerks**

Mavis Mbala, Sandra Chika, Athanacio Barlow and Brandon Coetzee.

### **Qualitative Research Moderators**

Alexia !Naris

### **Qualitative Research: Co-facilitators**

Feris Joseph and Veikko Iitembu

### **Focus group transcriber**

Tania Ott

## 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

## CONTENTS

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<b>Key indicators: Respondents aged 15 years and older, 2008</b> .....	7
<b>Executive summary</b> .....	8
<b>Background</b> .....	12
Goals of the research .....	12
Study methodology .....	12
Table 1: Demographic overview of respondents aged 15 years and older .....	14
Quantitative study methodology .....	14
Table 2: Representivity of sample: baseline and midterm .....	16
Table 3: Response rates for the mid-term survey .....	17
Qualitative study methodology .....	17
Limitations of the survey .....	18
Implications for intervention .....	19
<b>HIV and AIDS Knowledge, beliefs and attitudes</b> .....	20
Table 4: Unprompted knowledge of ways to acquire HIV, ages 15 years and older .....	20
Table 5: Unprompted knowledge of ways to avoid or prevent HIV infection, ages 15 years and older .....	21
Table 6: Correct responses to HIV and AIDS knowledge questions, ages 15 years and older .....	21
Table 7: Perceptions of risk of HIV infection .....	22
Table 8: Attitudes to people living with HIV/AIDS, ages 15 years and older .....	23
Table 9: Changes in HIV and AIDS knowledge baseline to midterm, ages 15 years and older .....	24
Qualitative findings: HIV and AIDS Knowledge, beliefs and attitudes .....	24
Implications for intervention: HIV and AIDS knowledge, beliefs and attitudes .....	28
<b>Exposure to HIV/AIDS information</b> .....	29
Table 10: Frequency of media exposure, ages 15 years and older .....	29
Table 11: Media channels exposed to in past week, ages 15 years and older ..	30
Table 12: Sources of HIV/AIDS information in the past year, ages 15 years and older .....	31
Table 13: Exposure to AIDS campaigns, programmes and organisations in the past month, ages 15 years and older .....	32
Table 14: Selected services and resources used in the past year, ages 15 years and older .....	32
Table 15: Unprompted knowledge of services available to people living with HIV or AIDS, ages 15 years and older .....	33
Table 16: Community level exposure and responses to HIV and AIDS in the past year, ages 15 years and older .....	34
Implications for intervention: Exposure to HIV/AIDS information .....	35
<b>HIV testing</b> .....	36
Table 17: HIV testing, ages 15 years and older .....	36
Figure 1: Ever tested and tested in the past year, ages 15 and older .....	36
Table 18: Reasons for not having an HIV test, ages 15 years and older who had not previously had an HIV test .....	37
Table 19: Reasons for having an HIV test, ages 15 years and older .....	37

Table 20: Places mentioned where Counseling for HIV/AIDS was available, ages 15 years and older .....	38
Table 21: Changes in HIV testing, ages 15 years and older .....	38
Qualitative findings: HIV testing .....	38
Implications for intervention: HIV testing .....	39
<b>Sexual behaviours, practices and trends</b> .....	40
Sex and numbers of sexual partners .....	40
Table 22: Ever had sex by site, ages 15-24 .....	40
Table 23: Age of sexual debut by age group .....	41
Table 24: Age of last sexual partner more than ten years older, ages 15-24....	42
Table 25: Reasons for sex, ages 15 years and older .....	42
Table 26: Proportion of respondents who are married, ages 15 years and older .....	43
Figure 2: Proportion of respondents who are married.....	43
Figure 3: Partners in the last year of those who ever had sex .....	44
Table 27: Partners in the last year of those ever had sex, by all ages, sex and age group.....	45
Table 28: Number of sexual partners in the last year by marital status and sex .....	46
Table 29: Changes in number of partners in past year, ages 15 years and older .....	46
Table 30: Sexual partners in the last month, of those who had sex in past year, by all ages, age group and sex .....	47
Figure 4: Partners in the last month of those who ever had sex .....	47
Table 31: Changes in number of partners in past month, ages 15 years and older .....	48
Condom use.....	48
Table 32: Condom use at last sex by age group, sex and marital status .....	48
Table 33: Consistency of condom use, ages 15 and older.....	49
Qualitative findings: Sexual partnerships .....	49
Implications: sexual behaviours, practices and trends .....	52
<b>Alcohol consumption</b> .....	54
Table 34: Alcohol consumption by age group .....	54
Table 35: Perceived dangers of alcohol and ways to drink safely .....	55
Table 36: Changes in alcohol consumption since baseline, ages 15 years and older .....	56
Implications: alcohol and risk behaviour .....	56
<b>Leisure activities in past month</b> .....	57
Table 37: Leisure activities in the past month, ages 15 years and older .....	57
Implications for intervention: Leisure activities .....	58
<b>Circumcision</b> .....	58
Table 38: Circumcision amongst male respondents.....	58
<b>Children and orphans</b> .....	59
Table 39: Parents, guardians and orphans in household, ages 15 years and older .....	59
Implications for intervention: Children and orphans .....	59
<b>Conclusions</b> .....	60
<b>References</b> .....	61
<b>Appendix 1: Midterm questionnaire 2007</b> .....	62

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

Indicator	Gobabis	Grootfontein	Omaruru
Antenatal HIV Prevalence (MOHSS) 2006	7.9%	19.3%	16.0%
Married	25%	30%	19%
Unmarried but living with partner (cohabiting)	15%	4%	12%
Unmarried/single/other	60%	66%	69%
Completed secondary school or more	32%	39%	32%
Employed	37%	42%	38%
Full-time student/learner	11%	24%	22%
Low socio-economic group (respondents lacking two or more of the following: electricity, piped water, indoor flush toilet, telephone, television and radio)	24%	6%	29%
Attend religious services once a week or more	36%	33%	30%
<b>HIV/AIDS awareness and attitudes</b>			
Unprompted HIV prevention knowledge: Always use a condom	75%	87%	88%
Unprompted HIV prevention knowledge: Abstain from sex	77%	76%	93%
Unprompted HIV prevention knowledge: Have only one sex partner	51%	53%	42%
Average correct HIV knowledge scores	78%	78%	85%
Average non-stigmatising attitudes to PLHA	70%	77%	84%
<b>Exposure to HIV/AIDS in past year</b>			
Obtained HIV/AIDS information from radio or television or newspaper	96%	93%	97%
Obtained HIV/AIDS information from Health Care Worker	69%	49%	52%
Obtained HIV/AIDS information from community organization	36%	24%	24%
Attended funeral of person who died of AIDS	52%	47%	75%
<b>Involvement in HIV/AIDS response in past year</b>			
Helped care for a person sick with AIDS	24%	20%	54%
Worn a red ribbon, T-shirt or cap with AIDS message	45%	45%	57%
Volunteered for an HIV/AIDS organization in community	13%	5%	20%
<b>HIV/AIDS-related behaviour</b>			
Ever tested for HIV	64%	50%	51%
Tested for HIV in past year (of ever tested)	60%	53%	61%
Two or more sex partners in past year (of ever had sex)	42%	16%	26%
Two or more sex partners in past month (of those who had sex in past year)	11%	4%	13%
Last sexual partner ten years older (Females, 15-24)	34%	18%	7%
Last sexual partner ten years older (Males, 15-24)	7%	13%	2%
Condom use at last sex (of those who had sex in past year aged 15-24)	78%	89%	87%
Condom use at last sex (of those who had sex in past year aged 25-49)	57%	58%	73%
Condom use at last sex (of those who had sex in past year aged 50+)	4%	19%	29%
<b>Teenage birth</b>			
Females, 15-19, ever given birth	21%	5%	16%
<b>Exposure to alcohol</b>			
Drink alcohol a few times a week or more	18%	16%	35%
Been drunk in the past month (of all)	33%	24%	37%
Gone to a bar or shebeen in past month	49%	34%	60%

## EXECUTIVE SUMMARY

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Since 2003, a number of baseline and mid-term surveys have been conducted in various Namibian communities. 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: Gobabis, Grootfontein and Omaruru, and also draws on baseline 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 not been marked 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.

### ***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. A 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 two 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 mid-term survey has provided useful insights into the HIV/AIDS related knowledge, perceptions, behaviours and practices in the three 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 half of all males being circumcised. This has potentially limited the spread of HIV in the study communities, but it remains that primary risk factors – notably partner concurrency – need to be addressed with urgency.

Daily alcohol consumption has decreased somewhat in two sites, but it remains that alcohol consumption is overall high – particularly being drunk. Frequent alcohol consumption and HIV-related risk behaviours are closely correlated, and a 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 mid-term surveys conducted in the following three communities in Namibia: Gobabis, Grootfontein and Omaruru. Summary data is provided in Table 1.

- Gobabis is located in northern Namibia and has a population of approximately 17,500<sup>1</sup> people. The unadjusted antenatal HIV prevalence was 7.9% in 2006. Amongst the population surveyed, 72% live in brick houses, 25% in shacks, and 3% in houses made of traditional materials. The predominant language is Damara Nama, which is spoken by 27% of respondents and Afrikaans spoken by 26% of respondents. Some 29% have completed secondary school only, whilst a further 3% also have a post-secondary school education. Predominant religious groups include Catholic (41%),

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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%.

Protestant (30%) and 'other Christian' (22%). Just over a third of respondents are employed (37%), whilst 11% are students and 45% are unemployed.

- Grootfontein is located in northern Namibia and has a population of approximately 27, 750 people. The unadjusted antenatal HIV prevalence in Grootfontein was 19.3% in 2006. Amongst the population surveyed, 100% live in brick houses. The predominant language is Oshiwambo, which was spoken by 30% of respondents. Some 28% of respondents have completed secondary school only, whilst a further 11% also have a post-secondary school education. Predominant religious groups include Protestant (50%), and 'other Christian' (24%) and Catholic (21%). Two fifths (42%) of respondents are employed, whilst 24% are students and 26% are unemployed.
- Omaruru is located in Western Namibia, and has a population of approximately 8,400 people. The unadjusted antenatal HIV prevalence was 16.0% in 2006. Amongst the population surveyed, 83% live in brick houses, 11% in shacks, and 6% in houses made of traditional materials. The predominant language is Oshiwambo, which is spoken by 42% of respondents. Some 24% of respondents have completed secondary school only, while a further 8% also have a post-secondary school education. Predominant religious groups include Catholic (41%), Protestant (40%) and 'other Christian' (16%). Over a third of respondents are employed (38%), whilst 22% are students and 22% are unemployed.

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

Demographic Factor	Gobabis		Grootfontein		Omaruru	
	%	n	%	n	%	n
<b>Antenatal HIV Prevalence (MOHSS)</b>						
2006	7.9	227	19.3	244	16.0	256
<b>Housing type</b>						
House/brick	72%	431	100%	600	83%	500
Shack	25%	150	0%	0	11%	66
Traditional Material	3%	19	0%	0	6%	34
<b>Age group</b>						
15-24	38%	225	37%	221	38%	226
25-34	30%	181	25%	148	24%	143
35-49	23%	136	22%	131	20%	120
50+	10%	58	17%	100	19%	111
<b>Sex</b>						
Male	50%	300	49%	291	50%	302
Female	50%	300	52%	309	50%	298
<b>Education</b>						
Some primary	23%	135	11%	63	22%	130
Completed primary	22%	131	23%	136	20%	117
Some secondary	24%	142	28%	168	27%	163
Completed secondary	29%	173	28%	167	24%	143
Post secondary	3%	19	11%	66	8%	47
<b>Religion</b>						
Catholic	41%	248	21%	126	41%	243
Protestant	30%	179	50%	297	40%	242
Other Christian	22%	130	24%	146	16%	96
Other / none	7%	43	5%	31	3%	19
<b>Employment status</b>						
Employed	37%	223	42%	254	38%	227
Unemployed	45%	270	26%	157	29%	172
Student	11%	64	24%	144	22%	132
Grant or pension	7%	43	8%	45	12%	69

## Quantitative study methodology

A series of baseline and midterm 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 2005, and in late 2007 for the mid-term.

### *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 for the baseline survey and 600 households were selected in all sites in the midterm 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>Gobabis</b>	<b>Grootfontein</b>	<b>Omaruru</b>
Population (est.) baseline	16,750	26,400	7,950
Population (est.) midterm	17,500	27,750	8,400
<b>Baseline survey</b>			
Individuals selected	300	300	300
Sampling fraction	1.8	1.1	3.8
<b>Midterm survey</b>			
Individuals selected	600	600	600
Sampling fraction	3.4	2.2	7.1

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 and then the house on the right. This process continued until the quota was completed.

A response rate of 70% or more is considered acceptable. Even the site with the lowest response rate, Gobabis (77%), met this criterion. Overall, the response rate was 87%.

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

	Gobabis	Grootfontein	Omaruru	Total
Selected	600	600	600	1800
Realised	463	530	573	1566
Refused	137	70	27	234
Response	77%	88%	96%	87%

### **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’, ‘from a mother to her baby’, having many sex partners’, and through ‘infected blood’, with some variations between sites.

The risk of infection through having many sex partners was mentioned by half or less of all respondents, with respondents in Omaruru (39%) being less likely to mention this risk than those in Gobabis (49%) and Grootfontein (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**

	Gobabis		Grootfontein		Omaruru	
	%	n	%	n	%	n
Through sexual intercourse	79%	472	81%	483	88%	529
By not using condoms	63%	376	58%	347	56%	338
From a mother to her baby	43%	260	55%	327	58%	346
From infected blood	48%	288	60%	358	42%	249
By having many sex partners	49%	292	50%	302	39%	231
From blood transfusions	38%	226	42%	250	49%	291
Through sharing needles	20%	118	37%	223	41%	244
Unclean medical equipment	8%	50	12%	74	13%	76
Mosquito bites	1%	8	5%	27	1%	5
Other	4%	21	5%	28	1%	8

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 (33%-53%).

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

	Gobabis		Grootfontein		Omaruru	
	%	n	%	n	%	n
Always use a condom	75%	451	87%	523	88%	530
Abstain from sex	77%	462	76%	455	93%	555
Have only one sex partner	51%	304	53%	315	42%	251
Limit or reduce number of sex partners	46%	276	33%	195	33%	195
Be faithful to your sex partner	33%	196	33%	197	43%	259
Use sterilized needles	9%	53	17%	99	14%	83
Have sex only with a partner who is HIV negative	19%	111	26%	154	15%	91
Non penetrative sex/thigh sex	20%	119	15%	88	8%	49
Avoid sex with a sex worker	6%	38	11%	64	5%	27

### **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 Gobabis, there was a lower than average correct response to ‘an HIV positive mother can transfer HIV to her baby’ (67%) and ‘medicines can prolong life of someone with HIV (69%)’. The link between having fewer partners and being less likely to be infected with HIV is less well understood with correct responses ranging from 49%-59% between communities.

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

	Gobabis		Grootfontein		Omaruru	
	%	n	%	n	%	n
People with HIV look sick (False)	79%	475	75%	452	81%	486
Traditional healers can cure AIDS (false)	88%	530	82%	491	96%	574
HIV can be transmitted through mosquito, flea or bedbug bites (False)	82%	494	82%	494	95%	572
A person can get HIV by touching a person with HIV/AIDS (False)	89%	531	83%	498	92%	550
HIV can be passed through sharing eating utensils with someone who has HIV (False)	84%	503	74%	441	87%	521
An HIV positive mother can transfer HIV to her baby (True)	67%	400	76%	456	86%	516
HIV can be transmitted through breastfeeding (True)	85%	510	83%	500	88%	528
Medicines can prolong life of someone with HIV (True)	69%	411	89%	531	91%	544
If you have fewer sexual partners, you are less likely to get infected with HIV (True)	55%	331	59%	355	49%	292
You can reduce the risk of HIV by being faithful to your sexual partner (True)	85%	507	75%	451	84%	504
Average	78%		78%		85%	

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 three quarters of respondents (48%-73%) 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, whilst around a third said they abstained or 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. Respondents in Gobabis were four times more likely to perceive their risk to be high, in comparison to the other two sites despite having lower prevalence.

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

	<b>Gobabis</b>		<b>Grootfontein</b>		<b>Omaruru</b>	
	%	n	%	n	%	n
Low or no risk	48%	289	59%	351	73%	438
Medium risk	6%	35	5%	28	7%	41
High risk	16%	95	4%	24	4%	25
Don't know / Not applicable	30%	181	33%	197	16%	96
<b>Reason for perceived low risk</b>		(289)		(351)		(438)
I abstain	32%	93	35%	122	39%	169
I'm faithful to one partner	60%	172	56%	195	46%	201
Always use condom	32%	92	25%	89	36%	158
Other reason	10%	29	8%	29	3%	14
<b>Reason for perceived medium to high risk</b>		(130)		(52)		(66)
Not always use condom	58%	76	67%	35	26%	17
Have multiple partners	54%	70	37%	19	36%	24
Don't trust partner	63%	82	48%	25	39%	26
Past sexual activity	27%	35	12%	6	14%	9
Current sexual activity	8%	10	12%	6	14%	9
Partner is sick	16%	21	19%	10	6%	4
Other reason	1%	1	4%	2	3%	2

### **Beliefs and attitudes**

With regard to beliefs, the vast majority of respondents disagreed that witchcraft could protect one from acquiring HIV (86%), and a similar proportion said that they were not aware of people who had acquired HIV through witchcraft (85%). However, a lower proportion disagreed that Christian healers could cure AIDS (75%).

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 (75%-90%) and also towards allowing HIV positive children to attend school (65%-78%). In Omaruru, over 80% of respondents said that an HIV positive teacher should be allowed to continue teaching (86%), although this view was less widely held in Grootfontein and Gobabis (68%, 71%). 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**

	Gobabis		Grootfontein		Omaruru	
	%	n	%	n	%	n
If a member of your family became sick with AIDS, would you care for him/her in your household? (agree)	75%	451	84%	506	90%	537
Children who are HIV positive should not go to school (disagree)	65%	391	78%	470	76%	457
If a teacher has HIV but is not sick, should he/she be allowed to continue teaching (agree)	71%	426	68%	405	86%	518
If a member of your family became infected with HIV, would you want it to remain a secret (disagree)	41%	247	61%	364	59%	352
Average	63%		73%		78%	

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

There have been some small but significant downward trends in knowledge in the sites. These include knowledge that HIV could be passed on by sharing eating utensils with someone with HIV (OR<sub>adj.</sub> 0.4; p<0.001); by mosquitoes (OR<sub>adj.</sub> 0.4; p<0.001) and by touching an HIV infected person (OR<sub>adj.</sub> 0.4; p<0.001). There was no significant change in the knowledge that medicines can prolong the life of someone with HIV. Respondents were less willing to care for a member in the household with AIDS (OR<sub>adj.</sub> 0.4; p<0.001); and were also less willing to allow a teacher with HIV to continue teaching (OR<sub>adj.</sub> 0.3; p<0.001). Respondents are, however, more likely to be open about the HIV status of a family member (OR<sub>adj.</sub> 0.8; p<0.04)

**Table 9: Changes in HIV and AIDS knowledge baseline to midterm, ages 15 years and older**

	Gobabis				Grootfontein				Omaruru			
	Baseline		Midterm		Baseline		Midterm		Baseline		Midterm	
	%	n	%	n	%	n	%	n	%	n	%	n
<b>Knowledge questions</b>												
HIV can be passed through sharing eating utensils with someone who has HIV (False)	89%	268	84%	503	93%	280	74%	441	93%	278	87%	521
HIV can be transmitted through mosquito, flea or bedbug bites (False)	95%	286	82%	494	95%	286	82%	494	94%	282	95%	572
A person can get HIV by touching an infected person (False)	94%	281	89%	531	94%	281	83%	498	97%	290	92%	550
Medicines can prolong life of someone with HIV (True)	84%	253	69%	411	80%	240	89%	531	90%	271	91%	544
<b>Attitude questions</b>												
If a member of your family became sick with AIDS, would you care for him/her in your household? (agree)	93%	278	75%	451	91%	274	84%	506	94%	283	90%	537
If a teacher has HIV but is not sick, should he/she be allowed to continue teaching (agree)	87%	261	71%	426	91%	274	68%	405	92%	276	86%	518
If a member of your family became infected with HIV, would you want it to remain a secret (disagree)	46%	139	41%	247	51%	154	61%	364	75%	226	59%	352

### Qualitative findings: HIV and AIDS Knowledge, beliefs and attitudes

Whilst there was recognition that HIV/AIDS campaigns were important, there was a sense that responses to campaign messages were not uniform, and that as a consequence people were dying.

*Some people do take all these messages. Some will practice safe sex and use a condom every time. But not everybody is doing it. Look, if people are abstaining or using condoms every time, we wouldn't have had this HIV rate going up. Because it is not really helping. It is not really helping. Some do practice it, and some don't... It is still spreading, no matter the messages. People are just dying. I don't think it's really working... (Female, Gobabis, 20-30).<sup>2</sup>*

A number of participants found HIV/AIDS communication to be repetitive to the extent that messages were being ignored.

*It is like people are using one and the same messages. It's only one thing over and over again. You don't really get that thing of it's something new. Every time it's just HIV and AIDS. If you don't use a condom, you'll die. They don't really take it seriously (Female, Gobabis, 20-30).<sup>3</sup>*

<sup>2</sup> FGD Gobabis 20-30 April 2008.txt 3440,3979

<sup>3</sup> FGD Gobabis 20-30 April 2008.txt 5597,5865

There was a feeling amongst some that the focus was only on sexual transmission, and not on other modes of transmission, nor on ways that HIV could not be transmitted. This sense of repetition was also framed by a sense of fatalism about the inevitability of the disease. A number of participants mentioned wanting to see visual portrayals of the consequences if HIV infection such as people who were ill or dying. Drama programmes were also mentioned as ways to capture people's imagination and attention.

*We want more serious media - we want pictures of people or videos of people that contracted AIDS and how is he coping. And when he died what did he look like? Things that will sit in your mind - things that will change your attitude, because the condom story, I am telling you, it is not changing our attitude (Male, Gobabis, 35+).<sup>4</sup>*

The incurable nature of AIDS also fostered a sense of confusion and frustration. In particular, a sense of hopelessness that the disease was incurable and that it was affecting breadwinners:

*What I think is that sometimes what the problem is, what's making them think like that is every disease is like most of the diseases that we get here, it has a cure. This is a frustration for everybody – why isn't HIV and AIDS having a cure and why is it killing everybody? For example, you have the breadwinner of the house and it is mostly taking those ones who are like the ones bringing food in the house and this thing is eating people inside. Why isn't this thing having a cure? Is it like a punishment from God and what can one do in case of this to help us go through this? It's like really eating, really eating everybody inside (Female, Omaruru, 20-30).<sup>5</sup>*

When asked about gaps in information, lack of information about how to care for people with HIV/AIDS was identified, as well as specific information about elements of ARV treatment such as CD4 counts, and lack of understanding about the window period.

*People are not having much information about HIV and how to treat a patient. If it is found out the secret that that person is having the virus and everybody is hearing about the sickness of the person and now they start, they want to fire him. People need to handle these issues very carefully. Even the nurses sometimes when they are treating patients, once she is angry with that person then she is telling his friends that person is having the virus. Such things are also happening (Female, Grootfontein, 20-30).<sup>6</sup>*

*People are not understanding window period. Even if they go down there and put a million dollar and ask each and every body what is window period, they will not understand it unless education is done to explain what this is... I think it should be explained. (Male, Grootfontein, 20-30).<sup>7</sup>*

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<sup>4</sup> FGD Gobabis 35+ April 2008.txt 16848,17426

<sup>5</sup> FGD Omaruru 20-30 April 2008.txt 22759,23405.

<sup>6</sup> FGD Grootfontein 20-30 April 2008.txt, 8816,9318

<sup>7</sup> FGD Grootfontein 20-30 April 2008.txt 47574,48352

Whilst some acknowledged that HIV/AIDS information was available in most languages, concerns were also voiced about perceived lack of availability in all languages, and that for some audiences, literacy was a problem.

Apart from mass media, face-to-face interaction was seen as useful, particularly if it included 'doctors and nurses' and 'pictures'. Another possibility was involvement of PLWHA in community-level promotion activities. Songs were also mentioned as a powerful medium and one participant recalled how a song that was previously broadcast on television was sung by 'kids in the street'.

### ***Condoms***

The fact that condoms were a primary means for HIV prevention was well known and was mentioned in all focus groups. Referring to common discussions amongst friends, participants mentioned concerns about condoms being 'not one hundred percent safe'. Reference was made to myths perpetuated by a 'certain church' that condoms contained the virus which was evidenced by putting a condom into hot water and 'then you will see the virus moving in the water'. One participant reported hearing a radio show where condoms were said to have holes in them. When discussing condom use, it was noted that condoms were less likely to be used in a long-term relationship with a person that one loved.

### ***Circumcision***

Respondents mentioned newspaper articles that suggested circumcision prevented HIV infection, although this was treated cynically by some. Others mentioned the preventive effect of circumcision citing percentages they had heard about including 'sixty percent' and 'eighty percent' protection.

### ***Antiretroviral therapy***

There was a high level of overall awareness of antiretroviral therapy. Many participants knew friends or acquaintances who were taking ARVs, and the general experience was that people went from being ill to being healthy once they were on treatment.

Nevirapine was mentioned as an antiretroviral drug for use during pregnancy, although few details were known about how the drug worked.

Some participants mentioned alternative treatments and treatment approaches including praying, faith healing, 'muti' from Zimbabwe, traditional herbs (kamaku), African potatoes, 'Goka 11', and Aloe Vera.

Most participants saw HIV/AIDS and stigma as interconnected and pervasive in Namibian communities, with HIV infection being linked to shame. In particular, there

was a sense that some families would not support family members who were HIV positive because they had brought the disease into the household.

*If one of you know that a family member of yours is infected with the disease, you would be so ashamed to share it with friends. You wouldn't just come out and discuss it. You feel that you won't belong to the group anymore. It's something that you wouldn't even want to talk about. Even if you just go test yourself and you find out that you're positive - it would be very difficult to go tell your friends that you now are infected and this is how it happened. It wouldn't be that easy. You would find it very difficult to discuss it with your friends. And when you don't tell them, they don't know. They will sometimes talk bad about (you) when they see people. And every time you feel so hurt, because they don't even know you are sick (Female, Gobabis, 20-30).<sup>8</sup>*

*Some families don't really get parents and children just sitting and just talking about HIV and AIDS. It's a subject that is not even discussed in the house. Your parent either tell you that if you really want to disgrace me, just bring AIDS into this house. Don't even think about it, and that's the end of the topic. They won't even go into detail about how you get it. You are just told that if you are bringing that disease in my house, forget about this house and just get out of my house (Female, Gobabis, 20-30).<sup>9</sup>*

However, some families were recognized for being more caring, with 'good knowledge' being seen as an important vector for evoking caring attitudes.

*We get families who, especially those families who do know about HIV and AIDS, they are going to support you in every way, every step, telling you that it's not the end of the world, that you're still going to make it (Female, Gobabis, 20-30).<sup>10</sup>*

*I think it has been a very long way that these issues are addressed and some of the people in the community understand really that this is just a chronic disease and not a killer disease. And some of the people are very supportive. Those who are having knowledge, real knowledge about HIV and AIDS, they care. But some of them who don't have any knowledge, they tend to discriminate - stigma and discrimination (Male, Grootfontein, 20-30).<sup>11</sup>*

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<sup>8</sup> FGD Gobabis 20-30 April 2008.txt 19976,20722

<sup>9</sup> FGD Gobabis 20-30 April 2008.txt 22633,23165

<sup>10</sup> FGD Gobabis 20-30 April 2008.txt

<sup>11</sup> FGD Grootfontein 20-30 April 2008.txt 45864,46532

### **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 this is probably realistic in relation to the antenatal prevalence data for each area. Interestingly, respondents in Gobabis had the highest perception of HIV risk although the antenatal prevalence in Gobabis is lower than in the other two sites (7.8% vs 19.3%, 16.0%). Amongst those whose risk of infection was medium to high, realistic reasons were given including inconsistent condom use and having multiple partners.*
- *Beliefs that HIV is caused by supernatural means are not widely held, but only three quarters of respondents (75%) 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 small, but significant declines in knowledge suggest the need to intensify campaign activities.*
- *On the basis of the qualitative data, there are arguments to be made about the diversification of HIV/AIDS communication. There was strong emphasis placed on the need for visual imagery of people who are ill or dying, and this should be considered. The approach to the latter, however, should take into account that such portrayals may intensify fear, fatalism and stigma on the one hand, and diminish understanding of the chronic and long term asymptomatic nature of the disease on the other. The balance potentially lies in visual portrayals being contextualized – for example, in drama programmes, or in contexts where there is interpersonal discussion.*
- *The qualitative data also highlight the importance of expanding information on approaches to AIDS care, as well as providing more explanatory detail around aspects of knowledge such as CD4 counts and the window period.*

## 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 (82%-89%), and two thirds or more watched television four days a week or more (56%-85%). Listenership and viewership were highest in Grootfontein. Newspapers and magazines were accessed four days a week or more by around half of all respondents (42%-55%), with lowest levels occurring in Omaruru.

**Table 10: Frequency of media exposure, ages 15 years and older**

	Gobabis		Grootfontein		Omaruru	
	%	n	%	n	%	n
<b>Radio</b>						
Never	0%	2	0%	1	1%	4
Less than once a week	5%	28	4%	25	6%	34
1-3 days a week	13%	80	6%	38	11%	66
4 or more days a week	82%	490	89%	536	83%	496
<b>Television</b>						
Never	5%	31	0%	2	4%	22
Less than once a week	11%	63	4%	21	21%	125
1-3 days a week	15%	88	12%	69	20%	118
4 or more days a week	70%	418	85%	508	56%	335
<b>Newspaper or Magazine</b>						
Never	4%	22	2%	9	11%	66
Less than once a week	15%	90	18%	107	21%	128
1-3 days a week	27%	160	26%	154	26%	155
4 or more days a week	55%	328	55%	330	42%	251

Exposure to specific media channels in the past week varies considerably between communities. In the case of television, most respondents viewed NBC (69%-90%) with less exposure to the other channels. Local language stations were most prominent. *The Namibian* was most widely read on average, although other publications achieved high ratings in specific communities.

**Table 11: Media channels exposed to in past week, ages 15 years and older**

	Gobabis		Grootfontein		Omaruru	
	%	n	%	n	%	n
Watched NBC television	90%	542	85%	512	69%	414
Watched One Africa TV	56%	337	59%	355	72%	434
Watched M-Net (DSTV)	14%	84	35%	210	22%	133
Listened to Radio Omulunga	30%	179	49%	294	22%	130
Listened to NBC Local Language Station	73%	436	78%	466	78%	468
Listened to National Radio	41%	243	33%	197	36%	218
Listened to Radio Energy	13%	77	26%	158	30%	182
Listened to Kanaal 7/Channel 7	13%	79	21%	123	7%	42
Listened to Radio 99	5%	27	13%	80	6%	34
Listened to Radio Wave	5%	32	12%	71	8%	50
Read <i>The Namibian</i>	56%	333	56%	335	68%	410
Read <i>Republikein</i>	50%	298	40%	241	48%	289
Read <i>Informante</i>	34%	203	51%	307	59%	352
Read <i>New Era</i>	34%	204	19%	111	40%	240

**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 (82%-96%), television and newspapers were also proportionally high (76%-87%). The range for other media including magazines, booklets and pamphlets was 67%-78%.

Amongst interpersonal sources, health care workers were prominent (49%-69%) as were friends (76%-89%). Community organisations including local AIDS organisations were sources for around a third of respondents, with the highest mention being in Gobabis (36%) and the lowest in Grootfontein and Omaruru (both 24%). Religious groups and community meetings were mentioned by less than half of respondents (38%-46%), and very few mentioned traditional healers (2%-3%).

Educational institutions and teachers were important sources for the vast majority of full-time students (86%-96%). In workplaces, the response was more varied, ranging from 35% in Gobabis to 50% in Omaruru.

**Table 12: Sources of HIV/AIDS information in the past year, ages 15 years and older**

	<b>Gobabis</b>		<b>Grootfontein</b>		<b>Omaruru</b>	
	%	n	%	n	%	n
<b>Mass Media</b>						
Radio	95%	569	82%	491	96%	573
Television	77%	463	87%	520	77%	463
Newspaper	80%	478	76%	458	77%	463
Other media (Magazines, Booklets, Pamphlets)	78%	465	67%	401	68%	410
<b>Community</b>						
Health Workers/Nurse/ Doctor/Clinic/Hosp	69%	414	49%	296	52%	314
Community orgs, AIDS organisations, NGOs	36%	214	24%	142	24%	146
Religious group, church	38%	227	45%	269	46%	277
Community meetings	17%	103	28%	167	33%	195
Traditional healer	2%	11	3%	16	2%	11
<b>Family/Friends</b>						
Friends	77%	459	76%	456	89%	532
Mother/Father/Family members	74%	446	73%	439	93%	558
<b>Sub-populations</b>						
Schools/Universities/Teachers (Of all full-time students)	95%	61 (64)	86%	124 (144)	96%	127 (132)
Workplace (Of all persons employed)	35%	78 (223)	41%	105 (254)	50%	113 (227)

***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 were ‘Be your own hero’, New Start, ‘My Future is My Choice’ and Smile condoms. ‘Be your own hero’, ‘Alcohol aids HIV’, Desert Soul, ‘Be there to care’ and ‘Take control’ all had considerably lower prominence in Gobabis.

Reach of organisations varied considerably in communities. NawaLife Trust was particularly well known in Omaruru (58%).

Average exposure to campaigns and organisations was highest in Omaruru (61%) and lowest in Gobabis (37%).

**Table 13: Exposure to AIDS campaigns, programmes and organisations in the past month, ages 15 years and older**

	Gobabis		Grootfontein		Omaruru	
	%	n	%	n	%	n
<b>Campaigns</b>						
'Be your own hero'	52%	313	75%	451	85%	509
New Start (HIV testing)	65%	388	67%	400	69%	411
Smile condoms	64%	381	59%	352	71%	425
'My Future is My Choice'	64%	386	49%	295	73%	436
Desert Soul	40%	240	52%	312	68%	409
'Alcohol aids HIV'	34%	204	59%	354	61%	364
Take Control mass media	12%	73	44%	265	69%	412
'Be there to Care'	10%	59	33%	200	56%	335
<b>Organisations</b>						
Catholic AIDS Action	64%	384	48%	285	71%	424
NawaLife	25%	152	37%	220	58%	347
Window of Hope	23%	135	38%	225	49%	295
Lironga Eparu	25%	152	32%	192	47%	281
UNICEF	20%	118	44%	264	39%	233
LifeLine/ChildLine	18%	106	26%	154	39%	236
<b>Average</b>	<b>37%</b>		<b>47%</b>		<b>61%</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 correlated but not significantly associated with HIV-related responses when controlling for demographic and other factors. For example, 69% (n=560) of respondents who reported exposure to three or more campaigns reported having *used a condom at last sex* compared to 58% (n=232) of those who were exposed to less than three programmes (OR<sub>adj.</sub>: 1.2; p=0.3).

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/Child Line counselor. Use of Smile Condoms ranged from 29%-55%, New Start ranged from 20%-42% and speaking to a LifeLine/Child Line counselor, from 7%-14%.

**Table 14: Selected services and resources used in the past year, ages 15 years and older**

	Gobabis		Grootfontein		Omaruru	
	%	n	%	n	%	n
Used Smile condoms	55%	332	29%	175	54%	325
Gone for HIV testing at a New Start Centre	42%	252	20%	121	35%	208
Spoken to a LifeLine/ChildLine counsellor	11%	66	7%	40	14%	86

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 (63%-90%); fewer mentioned financial support from government (24%-30%), services from community NGOs (14%-21%) and post-test clubs (7%-16%). Legal support, counseling and nutritional support were least mentioned.

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

	Gobabis		Grootfontein		Omaruru	
	%	n	%	n	%	n
Medicines that fight HIV	63%	379	75%	451	90%	538
Post-test clubs	7%	42	10%	61	16%	97
Financial support from the government	24%	143	30%	181	26%	154
Services from community NGOs	14%	86	21%	126	15%	90
Legal support	4%	25	7%	41	3%	18
Counselling	0%	0	2%	9	0%	1
Nutritional support (Giving food)	0%	0	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 of around half to a third – Grootfontein (46%), Omaruru (39%) and Gobabis (37%). Less than half of the respondents reported attending a community meeting about HIV/AIDS (24%-37%).

Personalised exposure to AIDS was high in most communities with over a quarter to over half of respondents reporting a person they know who had said they were HIV positive (23%-61%). 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 (43%-76%). 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, 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 Omaruru (49%), lower in Gobabis (33%) and lowest in Grootfootein (27%).

#### ***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:

- 23% (169) 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 5% (55) of those who did not (OR<sub>adj.</sub>:4.4; 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);
- 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);
- 53% (393) of respondents who personally knew someone who told them they were HIV positive in the last year reported *wearing a red ribbon or clothing with an AIDS message in the last year* compared to 46% (487) of those who did not (OR<sub>adj.</sub>: 1.2; p=0.05);
- 51% (507) of respondents who personally knew someone who died of AIDS in the last year reported *wearing a red ribbon or clothing with an AIDS message in the last year* compared to 47% (373) of those who did not (OR<sub>adj.</sub>: 1.1; p=0.4);

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

	Gobabis		Grootfontein		Omaruru	
	%	n	%	n	%	n
<b>Community level exposure to AIDS</b>						
Heard AIDS spoken about by religious leaders at church/other religious gatherings	37%	222	46%	274	39%	234
Attended a meeting about HIV/AIDS in the community where I live	24%	146	28%	170	37%	223
<b>Personalised exposure</b>						
Someone I know told me they are HIV positive	40%	237	23%	136	61%	367
Personally know someone who has died of AIDS	43%	257	48%	286	76%	455
Attended funeral of someone who has died of AIDS	52%	310	47%	280	75%	451
<b>Personalised involvement</b>						
Worn a red ribbon, T-shirt, cap with an AIDS message	45%	267	45%	270	57%	343
Attended a training workshop on HIV/AIDS	28%	165	10%	62	39%	236
Volunteered for an HIV/AIDS organisation in my community	13%	77	5%	27	20%	120
Helped care for a child whose parents died of AIDS	20%	122	4%	25	30%	179
Helped care for a person who is sick with AIDS	24%	145	20%	117	54%	325
<b>Average</b>	<b>33%</b>		<b>27%</b>		<b>49%</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 broadcast and print media.*
- *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 varied in each community. In the case of mass media campaigns, awareness of most major campaigns was particularly low in Gobabis, suggesting the need for intensification in this area.*
- *Knowledge of organisations is related to organizational activities in each community, and this is likely to underpin variations of exposure between communities. Gobabis has a lower average of recall for all organisations with the exception of Catholic AIDS Action. Catholic AIDS Action and NawaLife Trust were particularly well known in Omaruru.*
- *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 personalization 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

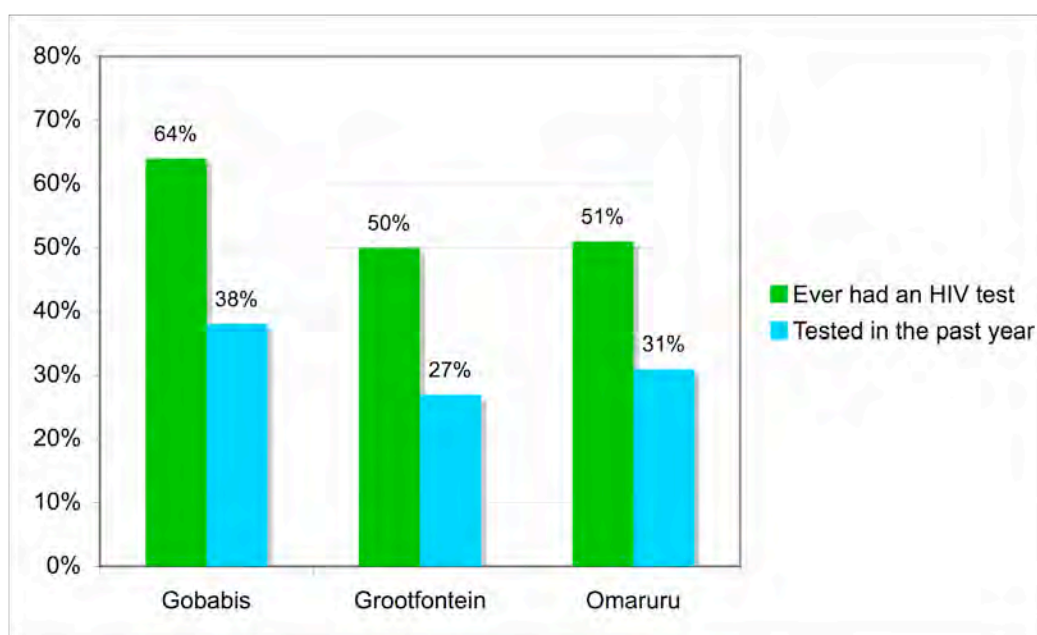
Nearly all respondents knew of a place where they could be tested for HIV (94%-97%) and over half had ever had an HIV test (50%-64%). Males were less likely to have been tested for HIV than females, although this is likely to have been influenced by females being more likely to be tested in the context of pregnancy.

Of respondents who had been tested for HIV, there was a high proportion tested in the past year – about three-fifths in Omaruru (61%), Gobabis (60%) and around half in Grootfontein (53%). Of all respondents, nearly a third or more in all communities reported having an HIV test in the past year (27%-38%).

**Table 17: HIV testing, ages 15 years and older**

	Gobabis		Grootfontein		Omaruru	
	%	n	%	n	%	n
Know a place where you can be tested for HIV	94%	566	96%	577	97%	582
Ever had an HIV test	64%	381	50%	301	51%	303
Never had an HIV test	37%	219	50%	299	50%	297
Male: Ever had an HIV test	59%	178	46%	141	39%	115
Female: Ever had an HIV test	68%	203	55%	160	62%	188
<b>If ever had an HIV test, when was last test</b>						
In the past year	60%	228	53%	161	61%	184
More than a year ago	28%	105	36%	107	27%	81
More than two years ago	13%	48	11%	33	13%	38
<b>Of all respondents, proportion tested in past year</b>	<b>38%</b>	<b>228</b>	<b>27%</b>	<b>161</b>	<b>31%</b>	<b>184</b>

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



Around a third to nearly half of all respondents in various sites had never had an HIV test (37%-50%). When asked why they had not been tested, most said they were ‘not at risk for HIV’, although this was more likely in Omaruru (44%) and Gobabis (36%), than in Grootfontein (24%). 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’ (8%-13%), trusting their partners (5%-13%) and not having time (0%-2%).

**Table 18: Reasons for not having an HIV test, ages 15 years and older who had not previously had an HIV test**

	Gobabis		Grootfontein		Omaruru	
	%	n	%	n	%	n
I am not at risk for HIV	36%	78	24%	73	44%	130
I don't see the need for getting tested	19%	42	20%	59	24%	70
I don't think that I am HIV positive	12%	26	23%	70	10%	29
I am scared to be tested	8%	18	13%	38	9%	27
I trust my partner	13%	28	11%	32	5%	14
I did not have time	2%	4	0%	1	1%	2

Around a third to nearly half (38%-49%) 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 (11%-17%). A fairly low proportion, 6%-17%, said they were tested because they wanted to know their HIV status and a similar proportion tested because they were feeling sick (12%-17%).

**Table 19: Reasons for having an HIV test, ages 15 years and older**

	Gobabis		Grootfontein		Omaruru	
	%	n	%	n	%	n
I was pregnant (of tested females)	49%	99	38%	61	46%	86
My partner requested it	17%	66	17%	50	11%	33
I was feeling sick	17%	64	15%	45	12%	36
I wanted to know my HIV status	6%	23	8%	24	17%	53
I applied for an insurance policy or loan	5%	18	11%	32	4%	13
I am worried about my partner's status/behaviour	7%	28	4%	11	6%	17
I wanted to start a new sexual relationship	4%	14	6%	18	7%	21
I have multiple partners	9%	36	1%	2	1%	4
My employer requested it	3%	10	6%	17	3%	10
I engaged in risky sexual behaviour	4%	16	3%	9	4%	12

Places mentioned where HIV testing was available included ‘at a clinic or hospital’ (81%-91%), at a New Start Centre (31%-36%), and at Catholic AIDS Action (23%-30%).

**Table 20: Places mentioned where Counseling for HIV/AIDS was available, ages 15 years and older**

	Gobabis		Grootfontein		Omaruru	
	%	n	%	n	%	n
At a clinic or hospital	81%	486	86%	514	91%	546
New Start Centre	36%	218	33%	200	31%	187
Catholic Aids Action	30%	181	23%	135	27%	163
Other	4%	22	4%	22	4%	22

**Changes since baseline: HIV testing**

There have been significant changes in knowledge of places to be tested (OR<sub>adj.</sub>: 3.1; p<0.001) and where to receive counseling for HIV (OR<sub>adj.</sub>: 13.1; 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 (5%-17%; OR<sub>adj.</sub>: 1.9; p<0.001).

**Table 21: Changes in HIV testing, ages 15 years and older**

	Gobabis				Grootfontein				Omaruru			
	Baseline		Midterm		Baseline		Midterm		Baseline		Midterm	
	%	n	%	n	%	n	%	n	%	n	%	n
Know place to be tested for HIV	87%	261	94%	566	90%	269	96%	577	91%	272	97%	582
Know place to obtain counseling for HIV	96%	288	98%	590	64%	191	99%	592	97%	290	99%	591
Ever tested for HIV	47%	141	64%	381	36%	108	50%	301	45%	136	51%	303
Ever tested, percentage change			17%				14%				5%	

**Qualitative findings: HIV testing**

Participants felt that HIV testing was a good idea in a relationship, although it was a difficult choice to make. Some suggested that testing be offered on a house-to-house basis. The most significant concern about HIV testing, however, was a strong perception of a lack of confidentiality. This was mentioned in all three research communities. Lack of privacy was partly due to the physical organization of the testing facility, but also to a perceived lack of discretion amongst counsellors and nurses. As a consequence, there is a lack of trust in the services.

*It's like you are in public. There is not a room for the two of you only. People are coming in and out - that confidentiality is not there and I think that is why people are so scared of going to the clinic (Female, Gobabis, 20-30).<sup>12</sup>*

*And at hospitals, you are sitting waiting for the results, they are announcing, the results are here! The results are here! And if you are in there, and you are HIV positive, people will basically know once you are out, because of your sad face. But*

<sup>12</sup> FGD Gobabis 20-30 April 2008.txt 38407,39762

*the way they announce it, ah the results are here, come in and get the results! It's not even good (Female, Gobabis, 35+).<sup>13</sup>*

New Start Centres were seen as places where confidentiality was potentially addressed through the use of pseudonyms:

*There is some centres, New Start Centres, that you don't have to give your real name. You don't have to give your real identity. You can use a nickname. But you have to give your nickname, so when you come back to them you give your nickname and they go and look and they say you are positive or negative (Female, Gobabis, 20-30).<sup>14</sup>*

### **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.*
- ❑ *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.*
- ❑ *'Prevention with positives' programmes could potentially be rolled out alongside VCT interventions.*
- ❑ *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.*

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<sup>13</sup> FGD Gobabis 35+ April 2008.txt 35111,35467

<sup>14</sup> FGD Gobabis 20-30 April 2008.txt 47683,48893

## SEXUAL BEHAVIOURS, PRACTICES AND TRENDS

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 (Gobabis –16%; Grootfontein – 17%; Omaruru – 6%). Males and females were equally likely to refuse to answer this question. Refusals increased with age – for example, in the age group over 50, 28% of respondents refused to answer compared to only 6% 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 Gobabis and Omaruru, more than two thirds of 15-24 year olds have had sex (70% and 73%) in comparison to less than half in Grootfontein (45%). Some respondents in the older age groups refused to answer this question and have been excluded from this analysis. In the 25 year and older age group, 17% (193) respondents across all sites refused to answer this question.

**Table 22: Ever had sex by site, ages 15-24**

	Gobabis			Grootfontein			Omaruru		
	%	n	Total	%	n	Total	%	n	Total
15-24	73%	152	225	45%	96	221	70%	152	226

Of respondents who had sex before, around a third of young males aged 15-24 (31%) and over a quarter of females (26%), have had sex at the age of 15 or younger.

Table 23 explores trends in the 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 average age of sexual debut by age group 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, 31% of those aged 15-24 report having had sex at age 15 or younger, compared to 19% for males currently aged 25-34, and only 12% of males aged 35-49. A similar pattern is found amongst females.

**Table 23: Age of sexual debut by age group**

	15-24		25-34		35-49		50+	
	%	n	%	n	%	n	%	n
<b>Males</b>		180		208		165		113
<b>Age at first sex</b>								
<13	4%	8	4%	8	1%	2	0%	0
13	3%	5	1%	3	2%	4	0%	0
14	8%	14	3%	7	2%	4	3%	3
15	16%	29	10%	21	5%	9	6%	7
<b>First sex at 15 or younger</b>	<b>31%</b>	<b>56</b>	<b>19%</b>	<b>39</b>	<b>12%</b>	<b>19</b>	<b>9%</b>	<b>10</b>
16	22%	39	12%	25	12%	20	8%	9
17	24%	44	17%	35	18%	29	5%	6
18	11%	20	22%	45	21%	35	16%	18
19	7%	13	13%	26	10%	16	14%	16
20	4%	7	10%	21	10%	16	12%	14
>20	1%	1	8%	17	18%	30	35%	40
<b>Females</b>		220		215		150		79
<b>Age at first sex</b>								
<13	2%	4	1%	3	1%	1	0%	0
13	2%	4	1%	3	0%	0	1%	1
14	6%	14	2%	5	1%	2	3%	2
15	16%	35	10%	21	9%	13	3%	2
<b>First sex at 15 or younger</b>	<b>26%</b>	<b>57</b>	<b>15%</b>	<b>32</b>	<b>11%</b>	<b>16</b>	<b>6%</b>	<b>5</b>
16	23%	50	13%	29	12%	18	6%	5
17	21%	46	13%	29	11%	16	4%	3
18	16%	36	23%	49	17%	26	16%	13
19	9%	20	16%	34	15%	23	16%	13
20	4%	8	10%	22	19%	28	19%	15
>20	1%	3	9%	20	15%	23	32%	25

### ***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>15</sup> Around one in ten young males and nearly one in five 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.

15 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 24: 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>	9%	7	79	5%	5	101	7%	12	180
<b>Females</b>	19%	20	103	19%	22	117	19%	42	220

**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 15% for 17 year olds and 26% for 19 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 25. 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 sexual need as the main rationale, whilst ‘satisfying expectations of others’ and being ‘forced to’ were also mentioned by only small proportions of both sexes. ‘Satisfying expectations of others’ was however considerably higher in Omaruru.

**Table 25: Reasons for sex, ages 15 years and older**

	Gobabis		Grootfontein		Omaruru	
	%	n	%	n	%	n
<b>Females</b>	(n=199)		(n=175)		(n=229)	
Because I loved him/her	80%	159	66%	116	69%	159
To satisfy a sexual need	40%	79	42%	74	46%	105
To satisfy expectations of others	3%	6	6%	11	15%	35
Because I was forced to	2%	3	1%	2	3%	7
Other reasons	1%	1	5%	8	3%	7
<b>Males</b>	(n=216)		(n=180)		(n=219)	
Because I loved her/him	64%	139	62%	111	63%	138
To satisfy a sexual need	50%	108	49%	89	50%	109
To satisfy expectations of others	6%	13	5%	9	12%	27
Because I was forced to	1%	2	1%	1	3%	7
Other reasons	0%	1	5%	10	2%	4

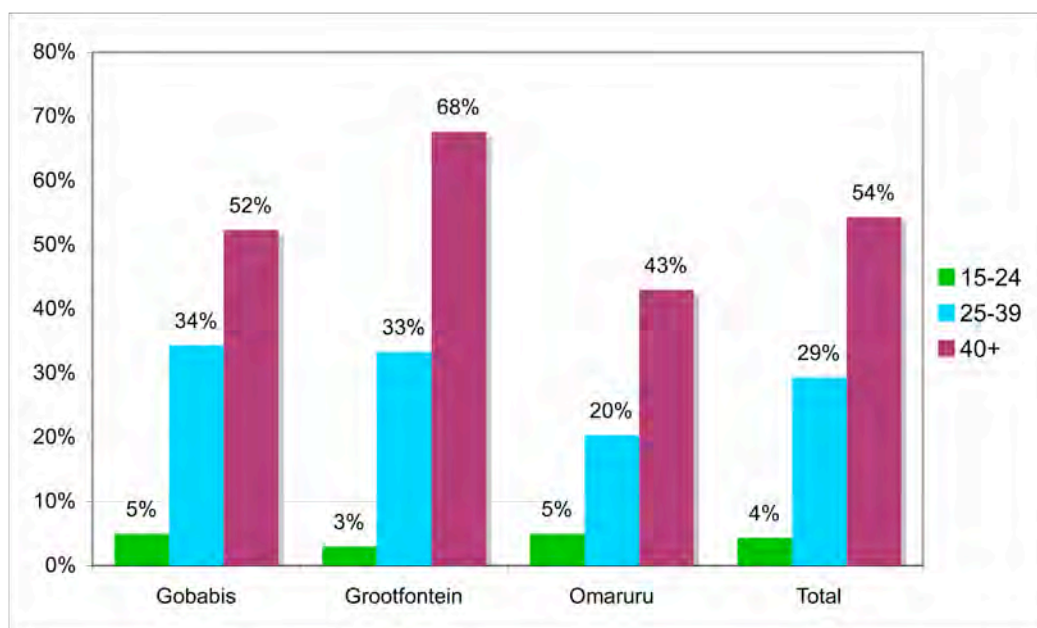
### Marital status

One factor influencing exposure to sexual networks is marital status, and as Table 26 illustrates, less than one-quarter of 25-29 year olds are married, and less than half of 35-39 year olds are married in Gobabis and Omaruru. Even amongst respondents aged 50 years and older, only around half are married (41%-64%). Marriage levels are however higher in Grootfontein.

**Table 26: Proportion of respondents who are married, ages 15 years and older**

	Gobabis			Grootfontein			Omaruru		
	%	n	Total	%	n	Total	%	n	Total
<20	0%	0	104	0%	0	161	0%	0	145
20-24	5%	6	121	3%	2	60	5%	4	81
25-29	24%	26	108	15%	13	86	6%	5	86
30-34	40%	29	73	29%	18	62	25%	14	57
35-39	39%	26	66	56%	35	62	30%	14	47
40-44	69%	27	39	74%	32	43	44%	17	39
45-49	48%	15	31	65%	17	26	44%	15	34
50+	40%	23	58	64%	64	100	41%	46	111

**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>16</sup>

Around one in ten respondents who had previously had sex reported not having sex in the past year (secondary abstinence) – Gobabis (7%); Grootfontein (7%) and Omaruru (10%). As can be seen from the table, secondary abstinence occurs in all age groups, but is more common amongst respondents aged 50 years and older.

Slightly more females reported secondary abstinence than males. Males were more likely to report having two or more partners in the past year, with around a quarter reporting more than two partners – Grootfontein (18%); Omaruru (33%) and Gobabis (54%).

Of respondents who had sex in the past year, 77% in Grootfontein and 64% Omaruru reported having had one partner in the past year compared to just over half (51%) in Gobabis.

Having two or more partners in the past year was very high in Gobabis (43%), followed by Omaruru (26%) and Grootfontein (16%). In Gobabis, more than half of youth aged 15-24 (58%), and more than a third of respondents in the 25-49 year age group also had two or more partners in the past year.

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



<sup>16</sup> Six respondents refused to answer questions in this category and were excluded from the analysis.

**Table 27: Partners in the last year of those ever had sex, by all ages, sex and age group**

	Gobabis		Grootfontein		Omaruru	
	%	n	%	n	%	n
		(n =445)		(n = 381*)		(n=498)
<b>None</b>	7%	30	7%	27	10%	50
1	51%	226	77%	294	64%	317
2+	43%	189	16%	60	26%	131
<b>Males</b>		(n=225)		(n = 193)*		(n=244)
None	4%	9	7%	14	10%	25
1	42%	95	74%	143	57%	138
2+	54%	121	18%	36	33%	81
<b>Females</b>		(n = 220)		(n = 188)*		(n = 254)
None	10%	21	7%	13	10%	25
1	60%	131	80%	151	70%	179
2+	31%	68	13%	24	20%	50
<b>15-24 age group</b>		(n=152)		(n=96)		(n=152)
None	3%	4	8%	8	5%	7
1	40%	61	79%	76	68%	103
2+	58%	87	12%	12	27%	42
<b>25-34 age group</b>		(n = 157)		(n = 127)		(n=135)
None	4%	7	6%	7	2%	3
1	56%	88	76%	96	65%	88
2+	39%	62	19%	24	33%	44
<b>35-49 age group</b>		(n=102)		(n=100)		(n=113)
None	6%	6	2%	2	4%	4
1	56%	57	82%	82	68%	77
2+	39%	39	16%	16	28%	32
<b>50+age group</b>		(n=34)		(n=58)		(n=98)
None	38%	13	17%	10	37%	36
1	59%	20	69%	40	50%	49
2+	3%	1	14%	8	13%	13

Table 28 shows the relationship between marital status and number of sexual partners in the past year. Unmarried males, and cohabiting males both had very high rates of two or more partners in the past year – 46% and 50% respectively. Females had lower rates, but still quite high levels in the cohabiting and unmarried categories (16% and 19%).

A quarter (24%) of married males reported having two or more sexual partners in the past year, as did 6% of married females.

**Table 28: Number of sexual partners in the last year by marital status and sex**

	Married (Males) (n = 174)*		Married (Females) (n = 171)*		Cohabiting (Males) (n = 80)*		Cohabiting (Females) (n = 89)		Unmarried (Males) (n = 408)*		Unmarried (Females) (n = 402)*	
	%	n	%	n	%	n	%	n	%	n	%	n
None	5%	10	8%	11	1%	2	2%	2	12%	36	18%	46
1	72%	126	86%	137	49%	49	81%	66	42%	201	63%	258
2+	24%	38	6%	23	50%	29	16%	21	46%	171	19%	98

**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, particularly in Gobabis, where there was an increase from 26% to 43%. This increase is statistically significant ( $OR_{adj.} : 1.6, p < 0.001$ ).

**Table 29: Changes in number of partners in past year, ages 15 years and older**

	Gobabis				Grootfontein				Omaruru			
	Baseline		Midterm		Baseline		Midterm		Baseline		Midterm	
	%	n	%	n	%	n	%	N	%	n	%	n
None	4%	10	7%	30	14%	34	7%	27	1%	3	10%	50
One	71%	183	51%	226	71%	168	77%	294	76%	197	64%	317
2+	26%	65	43%	189	14%	33	16%	60	22%	59	26%	131

**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>17</sup>

Table 30 shows respondents who have had sex in the past year in relation to sexual partnerships in the past month. Around one in ten respondents in Gobabis (11%) and Omaruru (13%) had concurrent partners. In Grootfontein, levels were lower at around one in 20 (4%). Concurrent sexual partnerships have a high risk of HIV transmission as a product of a higher likelihood of individuals being part of densely clustered sexual networks. Individuals who have recently been infected with HIV have a high viral load and as a result HIV spreads rapidly through the network.<sup>18</sup>

Respondents who had more than one partner were mostly males. When analysed by age group, concurrency varied by site: in Gobabis concurrency predominantly occurred

<sup>17</sup> Parker, Makhubele & Ntlati, 2007

<sup>18</sup> Morris and Kretzchmar, 2000

amongst youth aged 15-24 (18%); in Omaruru in young adults aged 25-34 (15%); and in Gobabis and Omaruru the reported level was 13% and 17% in the 35-49 year age group.

**Table 30: Sexual partners in the last month, of those who had sex in past year, by all ages, age group and sex**

	Gobabis		Grootfontein		Omaruru	
	%	n	%	n	%	n
		(n = 415)		(n = 355)		(n = 448)
<b>None</b>	9%	37	8%	30	6%	29
<b>1</b>	80%	332	88%	311	81%	361
<b>2+</b>	11%	46	4%	14	13%	58
<b>Males</b>		(n = 216)		(n = 180)		(n = 219)
None	11%	23	6%	11	6%	14
1	71%	153	88%	158	75%	165
2+	19%	40	6%	11	18%	40
<b>Females</b>		(n = 199)		(n=175)		(n=229)
None	7%	14	11%	19	7%	15
1	90%	179	87%	153	86%	196
2+	3%	6	2%	3	8%	18
<b>15-24 age group</b>		(n=148)		(n=88)		(n=145)
None	7%	11	15%	13	6%	8
1	75%	111	82%	72	86%	124
2+	18%	26	3%	3	9%	13
<b>25-34 age group</b>		(n=150)		(n=121)		(n=132)
None	10%	15	8%	10	7%	9
1	85%	127	87%	105	78%	103
2+	5%	8	5%	6	15%	20
<b>35-49 age group</b>		(n=96)		(n=98)		(n=109)
None	5%	5	5%	5	6%	7
1	82%	79	91%	89	77%	84
2+	13%	12	4%	4	17%	18

**Figure 4: Partners in the last month of those who ever had sex (n=1,218)**



### **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>: 2.5; p<0.001).

**Table 31: Changes in number of partners in past month, ages 15 years and older**

	Gobabis		Grootfontein		Omaruru							
	Baseline		Midterm		Baseline		Midterm					
	%	n	%	n	%	n	%	n				
None	14%	36	9%	37	28%	60	8%	30	34%	86	6%	29
One	80%	199	80%	332	70%	150	88%	311	62%	158	81%	361
Two or more	6%	14	11%	46	2%	5	4%	14	5%	12	13%	58

### **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 (78%-90%). Over half to more than three quarters (57%-81%) 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 32: Condom use at last sex by age group, sex and marital status**

	Gobabis			Grootfontein			Omaruru		
	%	n	Total	%	n	Total	%	n	Total
<b>Total</b>	59%	262	445	60%	231	387	66%	331	498
15-24	78%	118	152	90%	86	96	88%	133	152
25-34	57%	90	157	70%	92	131	81%	109	135
35-49	51%	52	102	42%	42	100	62%	70	113
50+	6%	2	34	18%	11	60	19%	19	98
Males	64%	144	225	61%	120	197	68%	165	244
Females	54%	118	220	58%	111	190	65%	166	254
Married	31%	36	115	28%	36	127	34%	36	105
Unmarried - cohabiting	56%	46	82	60%	12	20	72%	50	69
Unmarried	80%	172	215	80%	173	217	86%	235	273
Widowed, divorced	24%	8	33	43%	10	23	20%	10	51

Around a third to two-fifths (37%-43%) of respondents who had sex in the past year said they always used condoms and more than half said they usually or always used condoms.

**Table 33: Consistency of condom use, ages 15 and older**

	Gobabis		Grootfontein		Omaruru	
	%	n	%	n	%	n
	(445)		(384)		(498)	
Never	17%	75	8%	31	14%	70
Rarely	11%	47	15%	58	7%	35
Occasionally	15%	67	23%	90	15%	75
Usually	14%	63	17%	64	21%	105
Always/every time	43%	193	37%	141	43%	213

### Qualitative findings: Sexual partnerships

There were many names mentioned for relationships where people had multiple concurrent partners. These included names that framed the relationships as less important than those with one's main partner – for example, 'second class lover', 'second in charge', 'temporary', 'part-time', 'spare wheel', a 'happie' (bite) and 'entertainment'. Names were also linked to aspects of material transaction – for example, 'triple C' (car, cash, cellphone), 'sugar daddy', 'sugar mommy', 'coffee mommy', 'money makers', 'kamboroto' (bread), and a 'sponsor'.

A one-night stand was also referred to as a 'missed call', and was explained as: "you just grab her for one night and then the next morning, you don't see each other - you see each other, you are no more interested". Whilst males who had multiple partners were referred to more positively as Casanova's and players, females were referred to disparagingly as whores, bitches and prostitutes.

Men who paid money for sex, and insisted on sex without condoms were referred to as 'B1 butcher's' because they were involved in killing through HIV.

Concurrent relationships were understood as being risky in the context of HIV, but that AIDS was not a deterrent for such practices.

*That's what's going on. It is reality. It's not something that is to be reasoned away or something like that. But the people are aware of the disease which is present - it's just they cannot change (Female, Grootfontein, 35+).<sup>19</sup>*

Whilst it was acknowledged that people in communities had concurrent partners, such relationships were seen as being secretive and frowned upon.

*I can't say these things are accepted, because all these funny things are secrets... This thing is wrong, so these things are not accepted. These sugar daddies... When I am having one I won't go public about him, because I know that it's wrong. It is only for me, because I must survive from it. But these things are not accepted (Female, Gobabis, 20-30).<sup>20</sup>*

<sup>19</sup> FGD Grootfontein 35+ April 2008.txt, 24057,26666

<sup>20</sup> FGD Gobabis 20-30 April 2008.txt 33330,34101

At the same time, however, it was recognized that such relationships might be legitimated on the basis of economic need as a product of people in poor circumstances 'not having a choice'. For example, when the facilitator asked: "So why do you think they accept those kind of relationships?", the response was: "Poverty... That man is coming with groceries to the house". This endorsement also occurred in a family context:

*Maybe I can tell my sister, go take that guy – he is having some cash. Then I know each and every month I will get groceries, my electricity and water is paid. Or I can be transported wherever I want to (Male, Gobabis, 20-30).<sup>21</sup>*

Rationale for sexual exchange were also intertwined with fatalism about the risks of HIV/AIDS:

*If you are hungry, you have to look for food. The only way of getting food is you have to sleep with someone to survive. That is the main thing. Another thing is also, we have been born before AIDS was a problem – we were fortunate to be in that area. We cannot take it just as 'AIDS is a problem'. Now everybody has to die (Male, Grootfontein, 35+).<sup>22</sup>*

Economic need was seen as being more typical of relationships where people were not married, whereas extra-marital relationships were seen mainly as a product of lack of sexual satisfaction within marriage: "The husband will just go out and look for another one who can satisfy him sexually. I think it all has to do with sex. The main reason why they always cheat is because of sex. That's all."

The main partner was the person who was loved, whereas a second partner was not loved but who was used through sex to secure other aspects of need, particularly financial needs:

*There are ladies going out with this guy because he is having money. I don't love you, I'll have another one at the same time, because I love that one, but he's got nothing. I am having this one who is having everything.. He is supporting me. But the other one I am seeing, I love him (Female, Gobabis, 35+).<sup>23</sup>*

Mobility was noted to play a role in fostering conditions that are conducive to concurrent sexual partnerships.

*You go and visit people in different towns, or when you come in different towns, there's always going to be a guy who will want you. Obviously you don't want to be staying single in that town forever. Especially when you talk about guys, in each and every town you might, you should have a girl there. It's like a must. I don't know what it is, but for a guy it is a must for them to have a girl in each and every town they go in (Female, Omaruru, 20-30).<sup>24</sup>*

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<sup>21</sup> FGD Gobabis 20-30 April 2008.txt 30931,31801

<sup>22</sup> FGD Grootfontein 35+ April 2008.txt 1725,2284

<sup>23</sup> FGD Gobabis 35+ April 2008.txt. 21807,22097

<sup>24</sup> FGD Omaruru 20-30 April 2008.txt 40059,41818

In some contexts, peer pressure fostered unfaithfulness. For example, where friends were out together, a person wanting to stay faithful to their partner was teased and said to be a coward.

*Friends are also contributing. Say for instance I am having a partner, say for instance I am a boy. Now I am a guy; she's now my girlfriend. I am going out with my boy; we are having an outing somewhere. My girlfriend, she's at home. Then, from my friends, they will decide all of them they are having other girlfriends besides and then I have decided I can't do that to my girlfriend then they will start teasing me by saying you are a coward, how can you do that? Just do it. So, mostly friends are also encouraging one another (Female, Omaruru, 35+).<sup>25</sup>*

Tradition was also invoked as a justification for these types of relationships – specifically traditions of men having many wives, with the suggestion being made that even in the era of AIDS, tradition offered strong justification for concurrent sexual partnerships:

*I just want to go back to the effectiveness of the message. You see, it's also an old custom in our tradition. But the person believes I can stay with more than three to four wives or ladies. But, although he knows that AIDS is real and this lady that maybe he is cheating with can be infected. Maybe she is having another boyfriend or somebody else. But the person is so reluctant because of the customs which you inherit (Male, Grootfontein, 35+).<sup>26</sup>*

Whilst some participants said they were aware of messages about concurrent sexual partnerships, others felt that the secretive nature of such relationships meant that it was difficult to communicate about the issue:

*I never heard about those messages. That message will never be there, be created by someone, because we pretend there is nothing like such relationships. So where does the message come from, when we pretend as if it is not there? (Female, Gobabis, 20-30).<sup>27</sup>*

Messages about multiple partners that were known were seen as lacking emphasis in comparison to more prominent messaging about condoms, and was infrequent:

*I remember a kind of drama about a sugar daddy who is a school teacher and I think it's ten dollars and a yellow dress. They once showed it, but it's something that's being showed very rarely. It's not something that you can see every day like Take Control. It's like once in every year.... Ten dollars and a yellow dress... [about] a rich man who is with a school kid. He gave her ten dollars; later on he bought her a yellow dress; later on bought her a necklace, and so it went on and on. And he was HIV positive and she also contracted HIV and she was pregnant (Female, Gobabis, 20-30).<sup>28</sup>*

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<sup>25</sup> FGD Omaruru 35+ April 2008.txt, 26548,27171

<sup>26</sup> FGD Grootfontein 35+ April 2008.txt 8344,8773

<sup>27</sup> FGD Gobabis 20-30 April 2008.txt 36177,37262

<sup>28</sup> FGD Gobabis 20-30 April 2008.txt 36177,37262

*All what we do now is use the condom, but we are not talking about the sugar daddy with five girlfriends and so on. So, more motivation (is needed) (Male, Gobabis, 35+).<sup>29</sup>*

Participants were also able to visualize the HIV risk produced by interconnected relationships, with one participant describing it as a chain along which HIV moved.

*The risk is high... It's very high... because you have got five boyfriends. Those five boyfriends have got also maybe five or four girlfriends. There is a chain moving from you to your five boyfriends, from them too it is moving – it's a chain. So, you don't know with whom this one has slept (Female, Gobabis, 35+).<sup>30</sup>*

Other risks of multiple partnerships that were mentioned included STIs, unwanted pregnancy, divorce, suicide and violence as a product of jealousy. Although the high HIV infection risk was acknowledged by some participants, the secrecy surrounding such relationships also constrained communication.

*The risk is very high, because when you don't accept that you are doing a thing, you never correct yourself, or you never get good information about it. It's a secret. No one will come to you and tell you that this thing is wrong. You will never tell someone that you are doing this thing and you never accept it. Just because of secrecy it's a very big risk, because this is only for you to hide. You don't talk about it. Communication plays a very big role in talking openly about everything. But these things, we don't talk openly about it and it's a very big risk. That's why it is spreading, because people don't want to talk about the main thing causing AIDS (Female, Gobabis, 20-30).<sup>31</sup>*

*Nowadays, everybody is doing it. Everybody knows who is doing it, but nobody wants to talk about it. Sex out of marriage is so dirty that they find that very sensitive – they don't want to really talk about it. And if we don't talk, AIDS won't stop - AIDS will still grow (Male, Gobabis, 35+).<sup>32</sup>*

Availability and abuse of alcohol was seen as pervasive, and this was partly attributable to a general lack of recreational facilities. Alcohol was noted to inhibit control over behaviour and in particular, influencing the likelihood of not using a condom.

## **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.*

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<sup>29</sup> FGD Gobabis 35+ April 2008.txt 27434,28272

<sup>30</sup> FGD Gobabis 35+ April 2008.txt

<sup>31</sup> FGD Gobabis 20-30 April 2008.txt 34104,34882

<sup>32</sup> FGD Gobabis 35+ April 2008.txt 15915,16578

- *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 higher amongst 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 particularly high in Gobabis, 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 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, 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. The way such relationships are named suggests that having other partners are thought of as being casual as well as being a necessary means for financial support, although women in such relationships were more likely to be viewed negatively. The possibility of HIV infection was seen as not being of sufficient concern in such relationships, although it was acknowledged that HIV risk was high. Messages about such were however few and far between. One participant provided a useful description of people being linked together through concurrent relationships 'like a chain' and this explanation could potentially be built upon for campaign messaging.*

## ALCOHOL CONSUMPTION

Alcohol consumption, particularly excessive consumption, is a risk factor associated with sexual risk-taking.<sup>33</sup> Overall consumption of alcohol was high with around a fifth to more than a third of respondents (18%-35%) reporting drinking alcohol a few times a week or more. Between a quarter and over a third of all respondents reported being drunk in the past month (24%-37%). Amongst youth aged 15-24, only around five percent drank alcohol daily (2%-10%), but up to over a third reported being drunk in the past month (19%-35%). 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 (25%-43%). Levels of frequent drinking were higher in Omaruru.

**Table 34: Alcohol consumption by age group**

	Gobabis		Grootfontein		Omaruru	
	%	n	%	n	%	n
<b>All ages</b>						
Daily	4%	24	3%	18	18%	110
A few times a week	14%	83	13%	79	17%	101
<b>A few times a week or more</b>	<b>18%</b>	<b>107</b>	<b>16%</b>	<b>97</b>	<b>35%</b>	<b>211</b>
Once a week	15%	87	18%	110	13%	75
Less than once a week	19%	115	11%	65	12%	69
Never drink	49%	291	55%	328	41%	245
Been drunk in past month (excluding those who never drink)	63%	196	53%	145	62%	220
Been drunk in past month (of all respondents)	33%	196	24%	145	37%	220
<b>15-24 age group</b>		(225)		(221)		(226)
Daily	2%	5	3%	6	10%	22
A few times a week	12%	27	9%	20	17%	38
<b>A few times a week or more</b>	<b>14%</b>	<b>32</b>	<b>12%</b>	<b>26</b>	<b>27%</b>	<b>60</b>
Once a week	14%	32	11%	24	14%	31
Less than once a week	19%	43	7%	15	10%	23
Never drink	52%	118	71%	156	50%	112
Been drunk in past month (excluding those who never drink)	74%	79	66%	43	61%	69
Been drunk in past month (of all respondents)	35%	79	19%	43	31%	69
<b>25-34 age group</b>		(181)		(148)		(143)
Daily	6%	10	5%	7	24%	35
A few times a week	12%	22	14%	20	18%	26
<b>A few times a week or more</b>	<b>18%</b>	<b>32</b>	<b>18%</b>	<b>27</b>	<b>43%</b>	<b>61</b>
Once a week	15%	27	31%	46	16%	23
Less than once a week	19%	35	13%	19	13%	19
Never drink	48%	87	38%	56	28%	40
Been drunk in past month (excluding those who never drink)	49%	46	62%	57	60%	62
Been drunk in past month (of all respondents)	25%	46	39%	57	43%	62

<sup>33</sup> Weiser et al, 2006; Zuma et al, 2003; 14:814-817.

### **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 35: Perceived dangers of alcohol and ways to drink safely**

	Gobabis		Grootfontein		Omaruru	
	%	n	%	n	%	n
<b>Dangers of alcohol</b>						
Leads to violence	29%	171	29%	175	47%	279
Damages health	24%	142	34%	202	18%	105
Leads to unsafe sexual behaviour	12%	69	15%	92	26%	158
Causes driving accidents	6%	34	16%	93	20%	117
Impairs judgment	20%	119	11%	67	8%	49
Puts one at risk of rape	10%	62	6%	38	21%	128
Causes financial problems	6%	34	8%	45	8%	45
Puts one at risk of HIV	3%	19	3%	18	11%	63
Has negative impact on relationships	7%	42	8%	50	2%	11
Not sure / don't know	4%	24	10%	58	6%	33
Other reasons	6%	36	16%	98	23%	136
<b>Ways to drink safely</b>						
Drink in moderation	41%	244	41%	244	45%	268
Drink in safe environment	21%	126	22%	133	16%	94
Abstain from alcohol	18%	107	4%	26	18%	110
Avoid mixing	11%	67	9%	53	4%	24
Have someone to take care of you	9%	54	8%	47	6%	36
Don't drink & drive	2%	14	15%	89	2%	14
Not sure / don't know	5%	28	19%	115	11%	64
Other ways	10%	61	21%	125	8%	47

### **Alcohol and risk**

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

- 37% (133) of respondents who reported drinking a few times a week or more reported having *two or more sexual partners* in the past year compared to 26% (247) of those who drank once a week or less (OR<sub>adj.</sub>: 2.0;p<0.001);
- 16% (54) 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% of those who drank once a week or less (OR<sub>adj.</sub>: 2.2;p<0.001);
- 39% (133) of respondents who reported drinking a few times a week or more reported *not* using condoms at last sex compared to 33% of those who drank once a week or less (OR<sub>adj.</sub>: 1.6; p=0.003).

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

Drinking alcohol daily has increased markedly in Omaruru (12%-18%), but has declined in Gobabis (9%-4%) and in Grootfontein (14%-3%). However, there has also been a small decline in the number of respondents who never drink – with less respondents reporting ‘never’ drinking in Gobabis and Omaruru.

**Table 36: Changes in alcohol consumption since baseline, ages 15 years and older**

	Gobabis				Grootfontein				Omaruru			
	Baseline		Midterm		Baseline		Midterm		Baseline		Midterm	
	%	n	%	n	%	n	%	n	%	n	%	n
Daily	9%	27	4%	24	14%	42	3%	18	12%	37	18%	110
A few times a week	14%	42	14%	83	24%	73	13%	79	13%	39	17%	101
Once a week	10%	29	15%	87	12%	35	18%	110	14%	41	13%	75
Less than once a week	12%	37	19%	115	6%	19	11%	65	18%	55	12%	69
Never	55%	165	49%	291	44%	131	55%	328	43%	128	41%	245

### **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 Omaruru, 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 two sites. 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 (34%-60%), with a lower proportion going to a nightclub (19%-38%). Going to a bar or shebeen was particularly common amongst 15-24 year olds in Gobabis (61%) and Omaruru (57%).

A relatively high proportion had watched a drama group in Omaruru (28%), but this was less frequent in Gobabis (5%) and Grootfontein (10%).

A fair proportion of respondents reported attending an AIDS support group – 4%-17%. This may include respondents who are living with HIV as well as those who are not HIV positive.

**Table 37: Leisure activities in the past month, ages 15 years and older**

	Gobabis		Grootfontein		Omaruru	
	%	n	%	n	%	n
<b>All ages</b>						
Played soccer	18%	105	26%	153	26%	156
Played other sports	15%	88	27%	161	27%	164
Gone to a bar or shebeen	49%	291	34%	206	60%	358
Gone to a night club	38%	230	19%	116	38%	226
Watched a drama group	5%	29	10%	58	28%	168
Gone to a multipurpose community centre	15%	87	6%	33	15%	90
Gone to an AIDS support group	16%	93	4%	24	17%	104
<b>15-24</b>		(225)		(221)		(226)
Played soccer (males)	60%	65	77%	83	75%	76
Played other sports (males)	16%	17	50%	54	50%	51
Played other sports (females)	30%	35	60%	68	46%	58
Gone to a bar or shebeen	61%	137	25%	55	57%	129
Gone to a night club	57%	129	17%	38	36%	81
Watched a drama group	5%	11	15%	34	34%	76
Gone to a multipurpose community centre	16%	36	6%	13	14%	31
Gone to an AIDS support group	16%	35	3%	7	19%	42
<b>25-34</b>		(181)		(148)		(143)
Played soccer (males)	27%	25	37%	28	63%	42
Played other sports (males)	12%	11	25%	19	31%	21
Played other sports (females)	12%	11	14%	10	18%	14
Gone to a bar or shebeen	45%	81	51%	75	70%	100
Gone to a night club	33%	59	29%	43	55%	79
Watched a drama group	5%	9	8%	12	31%	44
Gone to a multipurpose community centre	9%	16	7%	10	23%	33
Gone to an AIDS support group	11%	20	6%	9	24%	34

## Implications for intervention: Leisure activities

- ❑ *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, and 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. A total of 7% (65) male respondents refused to answer this question. Over a third to half (38%-53%) had been circumcised.

When asked their age of circumcision, 16% (58) said they could not remember. Of the remaining respondents, most had been circumcised in their preteens in Grootfontein and Omaruru (82%, 86%) whilst in Gobabis more than half were circumcised in their teens or later (53%).

The procedure was more likely to have been done by a medical doctor in the case of Gobabis and Grootfontein residents, but was more likely to have been done by someone other than a medical doctor in Omaruru.

**Table 38: Circumcision amongst male respondents**

	Gobabis		Grootfontein		Omaruru	
	%	n	%	n	%	n
<b>Been circumcised</b>						
Yes	40%	117	53%	138	38%	111
No	60%	172	47%	123	62%	181
<b>Age of Circumcision</b>						
<=12	47%	51	82%	73	86%	96
13-16	31%	34	11%	10	5%	6
>=17	21%	23	7%	6	8%	9
<b>Who carried out circumcision</b>						
Medical doctor	59%	69	62%	86	33%	37
Someone else	41%	48	38%	52	67%	74

## 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. 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 39 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 39: Parents, guardians and orphans in household, ages 15 years and older**

	Gobabis		Grootfontein		Omaruru	
	%	n	%	n	%	n
<b>Parent or guardian of children in household</b>						
Yes	58%	348	45%	270	53%	315
No	42%	252	55%	330	48%	285
<b>Number of children parent or guardian of living in this household</b>						
1	34%	119	24%	64	29%	90
2	34%	119	30%	81	24%	75
3	20%	69	17%	47	20%	63
4+	12%	41	29%	78	28%	87
<b>Number of orphans living in this household</b>						
0	77%	459	85%	507	68%	409
1	12%	69	8%	50	20%	118
2	6%	37	4%	23	8%	46
3	4%	22	3%	18	3%	17
4	2%	10	0%	2	1%	7
6	0%	1	0%	0	0%	2
7	0%	2	0%	0	0%	1
<b>Number of orphans (who have lost both parents) in household</b>						
0	91%	547	94%	563	85%	508
1	6%	36	6%	34	13%	79
2	1%	7	1%	3	1%	8
3	1%	8	0%	0	1%	5
4	0%	2	0%	0	0%	0

### Implications for intervention: 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 mid-term survey has provided useful insights into the HIV/AIDS related knowledge, perceptions, behaviours and practices in the three 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.

The high proportions of respondents who know people who are HIV positive alongside relatively high involvement in response and low overall stigma suggests that ‘prevention with positives’ interventions should be explored. This could potentially be included alongside VCT interventions, given high levels of VCT uptake.

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 half of all males being circumcised. This has potentially limited the spread of HIV in the study communities, but it remains that primary risk factors – notably high partner turnover and concurrency – need to be addressed with urgency.

Daily alcohol consumption has decreased somewhat in two sites, 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: Midterm questionnaire 2007**

**2007 MIDTERM 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:
MQ6a INTERVIEWER		
MQ6b SUPERVISOR		
MQ6c 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
Otjiherero	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>		
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<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>		
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<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 (ARV's/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.