

NawaLife Trust
namibian center for communication programmes

HIV/AIDS

Strategic Information Report

A mid-term household
analysis of residents in
Oshakati: 2007



**HIV/AIDS Strategic Information Report:
A mid-term household analysis of
residents in Oshakati**

May 2007

Authors

Warren Parker (CADRE) and Cathy Connolly (MRC)

CADRE

Centre for AIDS Development, Research and Evaluation

www.cadre.org.za

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Acknowledgements

The President's Emergency Plan for AIDS Relief through USAID/Namibia funded this study through the Health Communication Partnership, based at Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs and through NawaLife Trust. Nahum Gorelick, Brian Goercke, Bastian Schwarz, Erna Keulder and Lizl Stoman were instrumental in refining the household survey questionnaire and follow-up focus group interview guide. Thanks to Salen Engelbrecht for background info on sites. Thanks also to Todd Koppenhaver and Claire Dillavou of USAID Namibia for comments on a draft version of the report. Thanks to Helen Hajiannis for assistance in formulating data tables.

We are grateful to the survey respondents and focus group participants in Rundu, Walvis Bay, Keetmanshoop and Oshakati for their time and assistance.

Citation

Parker, W. & Connolly, C. (2007). HIV/AIDS Strategic Information Report: A mid-term household analysis of residents in Oshakati, 2007. Windhoek: NawaLife Trust

FIELD RESEARCH

Quantitative survey: Project Managers

Erna Keulder and Lizl Stoman

Quantitative survey: Field Supervisors

Feris Joseph and Veikko Iitembu

Enumerators

Llewellyn Feris, Immanuel Nghidengwa, Joseph Theodor, Suama Alexander, Sarah Oarum, Ester Haikondela, Petrus Shikongo, Linda Alexander, Elvi Noodi, Gertrud Aindongo, Aron Sheetekela, Daniel Alberto

Coding Clerks

Catherine Ntema, Wesley Eberenz, Aubrey Visagie

Capturing Clerks

Ester Haikondela, Mavis Mbala, Sandra Chika, Benjamin Gorelick

Qualitative Research Moderators

Lizl Stoman, Jon Allen and Alexia !Naris

Qualitative Research: Co-facilitators

Feris Joseph, Veikko Iitembu and Daniel Alberto

Focus Group Transcriber

Tania Ott

ACRONYMS

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
PLWHA	People living with HIV/AIDS
RFS	Research Facilitation Services

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KEY INDICATORS: RESPONDENTS AGED 15 YEARS AND OLDER, 2007

Indicator	Rundu	Walvis Bay	Keetmanshoop	Oshakati
Married	24%	21%	25%	22%
Cohabiting	15%	11%	10%	7%
Unmarried/other	62%	69%	65%	72%
Completed secondary school or more	44%	39%	28%	31%
Employed	54%	52%	33%	35%
Low socio-economic group (definition)	30%	10%	13%	33%
Attend religious services once a week or more	42%	40%	30%	17%
HIV/AIDS awareness and attitudes				
Unprompted HIV prevention knowledge: Always use a condom	85%	88%	81%	85%
Unprompted HIV prevention knowledge: Abstain from sex	63%	72%	67%	72%
Unprompted HIV prevention knowledge: Have only one sex partner	43%	34%	34%	46%
Average correct HIV knowledge scores	80%	82%	75%	81%
Average non-stigmatising attitudes to PLHA	85%	85%	78%	76%
Exposure to HIV/AIDS in past year				
Obtained HIV/AIDS information from radio or television or newspaper	91%	96%	92%	99%
Obtained HIV/AIDS information from Health Care Worker	76%	63%	66%	83%
Obtained HIV/AIDS information from community organization	55%	44%	31%	39%
Attended funeral of person who died of AIDS	71%	62%	45%	53%
Involvement in HIV/AIDS response in past year				
Helped care for a person sick with AIDS	48%	43%	30%	40%
Worn a red ribbon, T-shirt or cap with AIDS message	49%	52%	32%	54%
Volunteered for an HIV/AIDS organization in community	26%	16%	15%	26%
HIV/AIDS-related behaviour				
Ever tested for HIV	55%	61%	57%	64%
Tested for HIV in past year (of ever tested)	67%	73%	65%	49%
Two or more sex partners in past year (of ever had sex)	15%	17%	11%	16%
Two or more sex partners in past month (of those who had sex in past year)	10%	12%	10%	13%
Last sexual partner ten years older (Females, 15-24)	37%	34%	23%	20%
Last sexual partner ten years older (Males, 15-24)	5%	13%	15%	14%
Condom use at last sex (of those who had sex in past year aged 15-24)	76%	77%	87%	85%
Condom use at last sex (of those who had sex in past year aged 25-49)	49%	54%	59%	68%
Condom use at last sex (of those who had sex in past year aged 50+)	33%	32%	38%	57%
Teenage birth				
Females, 15-19, ever given birth	17%	10%	15%	8%
Exposure to alcohol				
Drink alcohol a few times a week or more	29%	27%	29%	37%
Been drunk in the past month (of all)	35%	29%	34%	36%
Gone to a bar or shebeen in past month	41%	39%	49%	59%

INTRODUCTION

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 utilise survey findings to guide and refine interventions to address HIV/AIDS in Namibia.

The current research involves mid-term surveys conducted in the following four communities in Namibia: Keetmanshoop, Oshakati, Rundu and Walvis Bay. The findings from Oshakati are presented in this report.

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;
- ❑ The relationship between alcohol and HIV risk;
- ❑ Mobility and migration within communities, and the relationship to HIV risk; and
- ❑ HIV testing.

The findings from all sites are presented in **Appendix 1**.

SITE SURVEY: OSHAKATI

An overall survey report entitled “*HIV/AIDS Strategic Information Report: A mid-term household analysis of residents from Keetmanshoop, Oshakati, Rundu and Walvis Bay, May 2007*” provides information on findings from all four sites. This multisite report is available from NawaLife Trust.

The present report provides detailed tables for Oshakati including breakdowns by sex and age group.

Oshakati is located in northern Namibia, close to the Angolan border, and has a population of approximately 32,000 people. The unadjusted antenatal HIV prevalence in Oshakati was 27% in 2006. Amongst the population surveyed, 70% live in brick houses, 28% in shacks, and 2% in houses made of traditional materials. The predominant language is Oshiwambo, which was spoken by 86% of respondents. Around a quarter (26%) of respondents have completed secondary school, and a further 5% have a post-secondary school education. Predominant religious groups include Catholic (34%), Protestant (36%) and 'other Christian' (30%). Around a third of respondents are employed (35%), whilst 22% are students and 39% are unemployed.

CONCLUSIONS FROM THE OVERALL SURVEY

HIV/AIDS knowledge, beliefs and attitudes

General knowledge about HIV and AIDS is good although there are gaps that require attention.

- There is a need to emphasise delayed debut of first sex;
- There was inadequate knowledge of the risks of having many partners;
- The sexual transmission of HIV and prevention of HIV through using condoms is well understood and promotion of these aspects should be sustained;
- Beliefs that HIV is caused by supernatural means are not widely held;
- 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;

Exposure to HIV/AIDS information

HIV/AIDS information is widely available in the communities studied.

- Mass media allow for widespread reach of HIV/AIDS information and are the predominant sources of such information. There is also a wide range of interpersonal communication about the disease including engaging with health workers, community organisations, friends and family members, as well as within religious institutions. Families and friends talk openly about the disease and are clearly motivated towards addressing various aspects;
- There was high recall of the main HIV/AIDS campaigns;
- HIV/AIDS communication in educational institutions was high and this should be sustained, although workplace AIDS programmes should be expanded;

- Respondents were clearly involved responding to the epidemic by becoming personally involved in response – and the high levels of wearing red ribbons and clothing with AIDS messages, alongside other forms of involvement are promising. This should continue to be encouraged;
- Personally knowing someone who had died was high overall and this significantly contributes to personalisation of risk – as evidenced by increased likelihood of having had an HIV test in the past year – as well as prompting involvement in the epidemic.

HIV testing

- The large proportion of respondents who have ever tested who were tested in the last year attests to the success of the rollout of HIV testing services alongside promotion of HIV testing.

Sexual behaviours, practices and trends

- A relatively high proportion of males and females in the 15-24 year age group have sex earlier than age 16, and the average age of first sex is becoming younger over time. In the context of a high prevalence epidemic, a focus on *delayed sexual debut* amongst teenagers must be intensified;
- 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. 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 partner and such partnerships are common. Efforts to promote understanding of the *risks of having concurrent partnerships and reducing the number of concurrent partnerships* need to be intensified;
- Reported condom use at last sex is very high, and this points to a combined impact of condom promotion campaigns reinforced by effective distribution systems. Condom use at this level is likely to be limiting incident HIV infections in the study communities and efforts should be sustained.

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;

- 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;
- Qualitative research findings illustrate the difficulties in giving up and/or moderating alcohol use and it would therefore be useful to review options for individualised and group support programmes to assist individuals in giving up alcohol consumption or moderating consumption. General promotion of moderating or ceasing alcohol consumption may also lead to improved social acceptance of non-drinkers.

Leisure activities in the past month

- Soccer is a popular sport amongst youth and may provide an access opportunity for HIV awareness programmes;
- 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.

Children and orphans

There is a relatively high number of orphans who have lost both parents living in the households and orphan support programmes should be expanded.

FINDINGS FOR OSHAKATI

HIV AND AIDS KNOWLEDGE, BELIEFS AND ATTITUDES

Overall unprompted HIV infection and prevention knowledge is relatively high in Oshakati and there is a relatively similar knowledge amongst males and females. The older age group has overall lower levels of unprompted knowledge.

Knowledge of services available for people living with HIV/AIDS (PLWHA) is similar by sex and age.

Table 1: Unprompted HIV/AIDS knowledge, beliefs and attitudes, Oshakati

	% All	% Males	% Females	% 15-24	% 25+
Ways to acquire HIV	600	301	299	271	329
Through sexual intercourse	71%	70%	71%	72%	69%
By not using condoms	58%	58%	58%	65%	52%
From infected blood	43%	41%	45%	42%	44%
From blood transfusions	39%	40%	39%	49%	31%
Through sharing needles	31%	30%	31%	35%	27%
By having many sex partners	46%	47%	45%	43%	49%
From a mother to her baby	31%	25%	37%	32%	29%
Unclean medical equipment	8%	9%	8%	12%	5%
Mosquito bites	0%	0%	0%	0%	0%
Ways to prevent HIV					
Always use a condom	85%	86%	84%	90%	82%
Abstain from sex	72%	72%	72%	74%	70%
Have only one sex partner	46%	47%	45%	48%	44%
Be faithful to your sex partner	27%	25%	29%	27%	27%
Limit or reduce number of sex partners	29%	31%	27%	26%	32%
Use sterilized needles	18%	18%	17%	21%	15%
Have sex only with a partner who is HIV negative	7%	7%	8%	8%	6%
Non penetrative sex/thigh sex	7%	7%	6%	5%	8%
Avoid sex with a sex worker	2%	2%	1%	1%	2%
Services available for PLHA					
Medicines that fight HIV	74%	69%	79%	77%	72%
Post-test clubs	16%	14%	17%	13%	18%
Financial support from government	25%	28%	22%	23%	27%
Services from community NGOs	11%	11%	11%	9%	13%
Legal support	11%	11%	11%	9%	12%

Figure 1: Unprompted HIV prevention knowledge, Oshakati

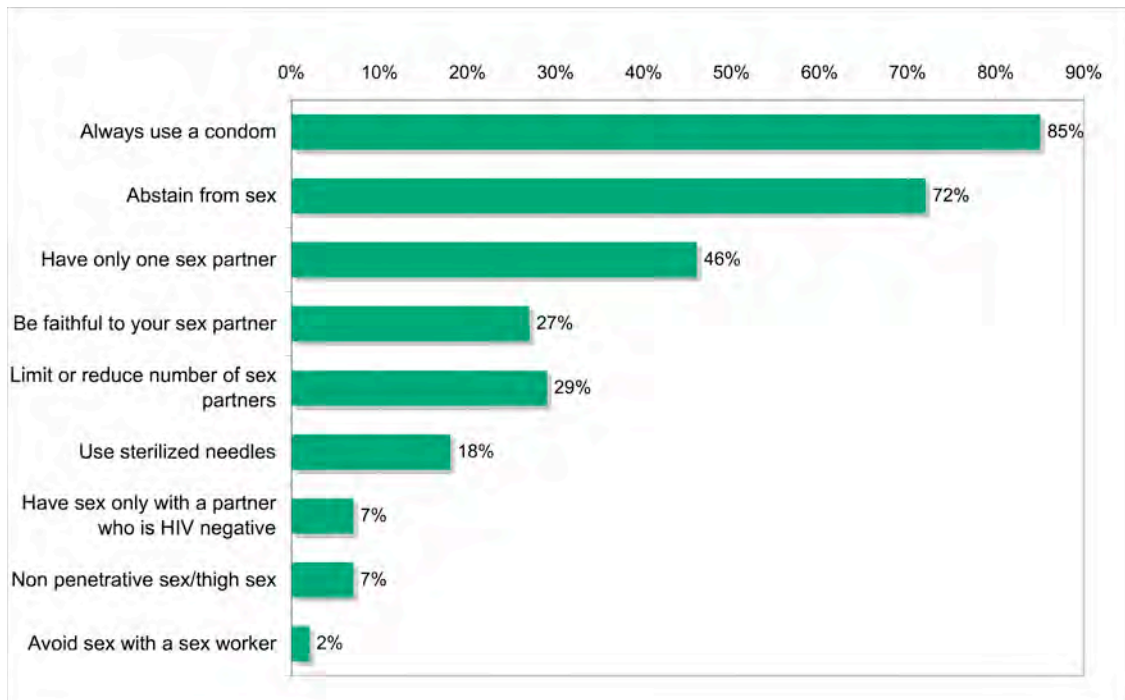


Figure 2: HIV/AIDS knowledge, Oshakati

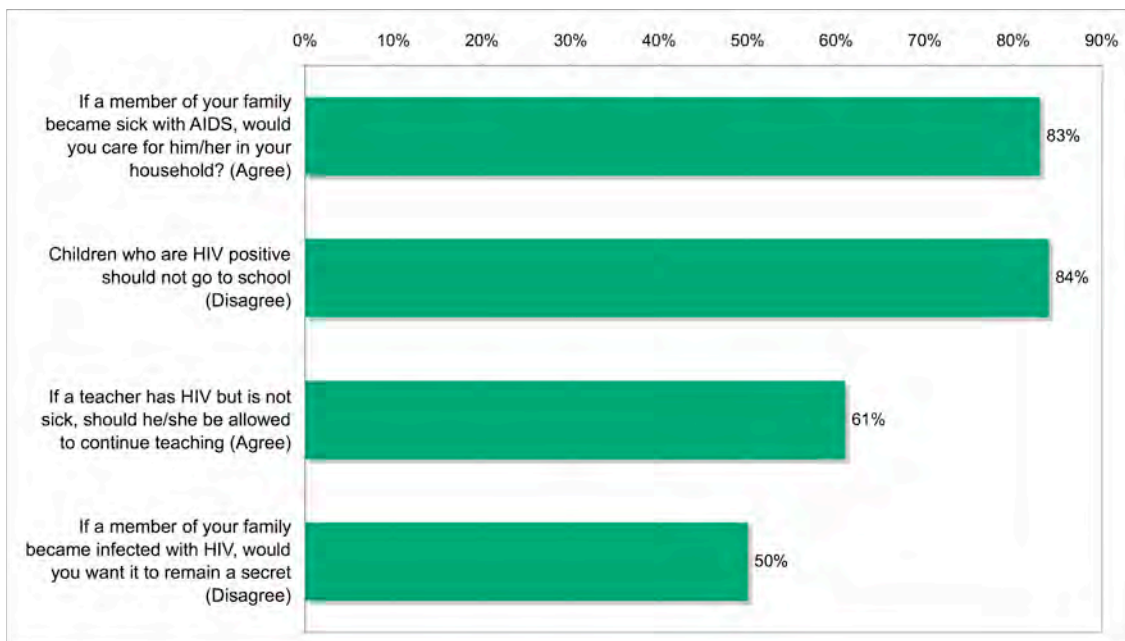
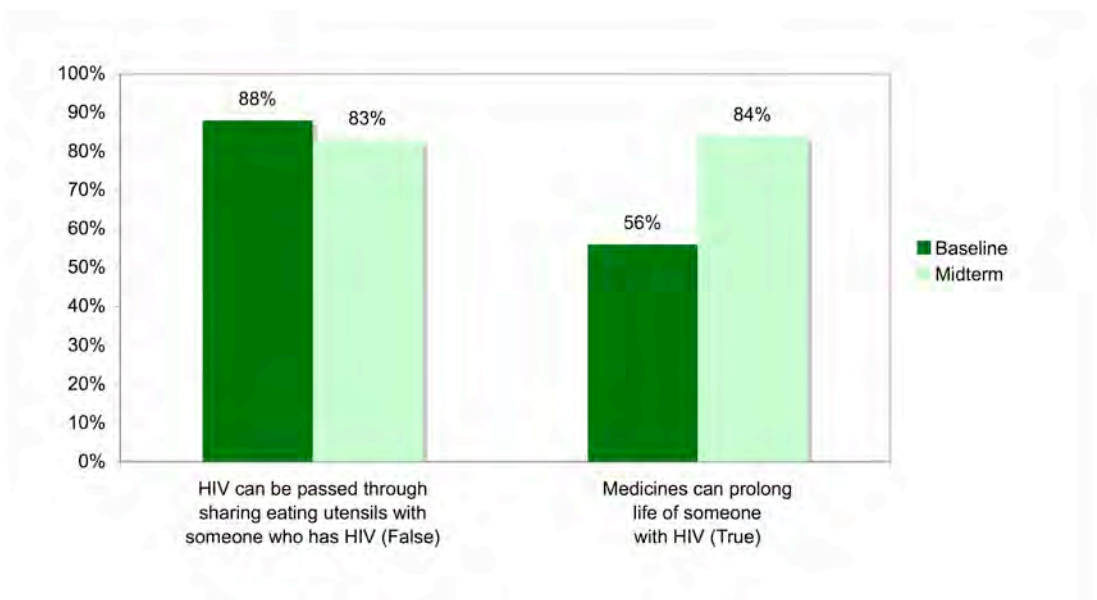


Table 2: HIV/AIDS knowledge, beliefs and attitudes, Oshakati

	% All	% Males	% Females	% 15-24	% 25+
HIV/AIDS Knowledge (True/False)	600	301	299	271	329
People with HIV look sick (False)	75%	71%	79%	74%	76%
Traditional healers can cure AIDS (false)	91%	92%	90%	91%	92%
HIV can be transmitted through mosquito, flea or bedbug bites (False)	84%	84%	84%	83%	85%
A person can get HIV by touching a person with HIV/AIDS (False)	88%	88%	89%	89%	88%
HIV can be passed through sharing eating utensils with someone who has HIV (False)	83%	80%	86%	82%	83%
An HIV positive mother can transfer HIV to her baby (True)	70%	63%	77%	71%	70%
HIV can be transmitted through breastfeeding (True)	86%	78%	93%	87%	85%
Medicines can prolong life of someone with HIV (True)	84%	81%	87%	86%	82%
If you have fewer sexual partners, you are less likely to get infected with HIV (True)	62%	63%	61%	62%	62%
You can reduce the risk of HIV by being faithful to your sexual partner (True)	82%	82%	83%	79%	85%
HIV/AIDS Knowledge (Agree/Disagree)					
If a member of your family became sick with AIDS, would you care for him/her in your household? (Agree)	83%	77%	89%	77%	87%
Children who are HIV positive should not go to school (Disagree)	84%	86%	82%	79%	89%
If a teacher has HIV but is not sick, should he/she be allowed to continue teaching (Agree)	61%	59%	63%	54%	66%
If a member of your family became infected with HIV, would you want it to remain a secret (Disagree)	50%	51%	48%	49%	50%

Figure 3: Changes in knowledge since baseline study, Oshakati



Since the baseline study in 2005, there was a slight decline in knowledge about sharing eating utensils, but a considerable increase in knowledge that medicines could prolong the life of someone with HIV.

EXPOSURE TO MASS MEDIA CHANNELS

Mass media exposure is similar by sex and age, whilst the data on media channels provides insight into particular media access patterns in Oshakati. The majority of respondents listen to the radio or watch television four or more times a week. More than half the respondents watched NBC on television, with the same proportion reading *The Namibian* in the past week.

Table 3: Frequency of media exposure and channels accessed in past week, Oshakati

	% All	% Males	% Females	% 15-24	% 25+
Frequency of media exposure	600	301	299	271	329
Listen to radio					
Never	1%	0%	2%	0%	2%
Less than once a week	7%	7%	7%	6%	7%
1-3 days a week	10%	12%	8%	9%	11%
4 or more days a week	82%	81%	83%	84%	81%
Watch television					
Never	16%	14%	17%	13%	17%
Less than once a week	14%	16%	11%	14%	13%
1-3 days a week	15%	18%	12%	9%	20%
4 or more days a week	56%	52%	59%	63%	49%
Read newspaper or magazine					
Never	3%	3%	3%	1%	5%
Less than once a week	18%	19%	16%	18%	18%
1-3 days a week	30%	31%	29%	32%	28%
4 or more days a week	49%	47%	52%	49%	50%
Media channels accessed in past week					
Watched NBC television	79%	81%	76%	80%	78%
Watched One Africa TV	15%	17%	13%	18%	12%
Watched M-Net (DSTV)	11%	9%	13%	10%	13%
Listened to Radio Omulunga	73%	80%	66%	74%	72%
Listened to NBC Local Language Station	38%	32%	43%	28%	45%
Listened to National Radio	42%	41%	42%	49%	36%
Listened to Radio Energy	47%	47%	47%	60%	37%
Listened to Kanaal 7/Channel 7	3%	2%	4%	3%	3%
Listened to Radio 99	4%	3%	5%	4%	5%
Listened to Radio Wave	6%	6%	6%	7%	5%
Read <i>The Namibian</i>	79%	74%	85%	80%	78%
Read <i>Republikein</i>	19%	17%	20%	18%	19%
Read <i>Informante</i>	28%	28%	28%	33%	24%
Read <i>New Era</i>	25%	21%	28%	27%	23%

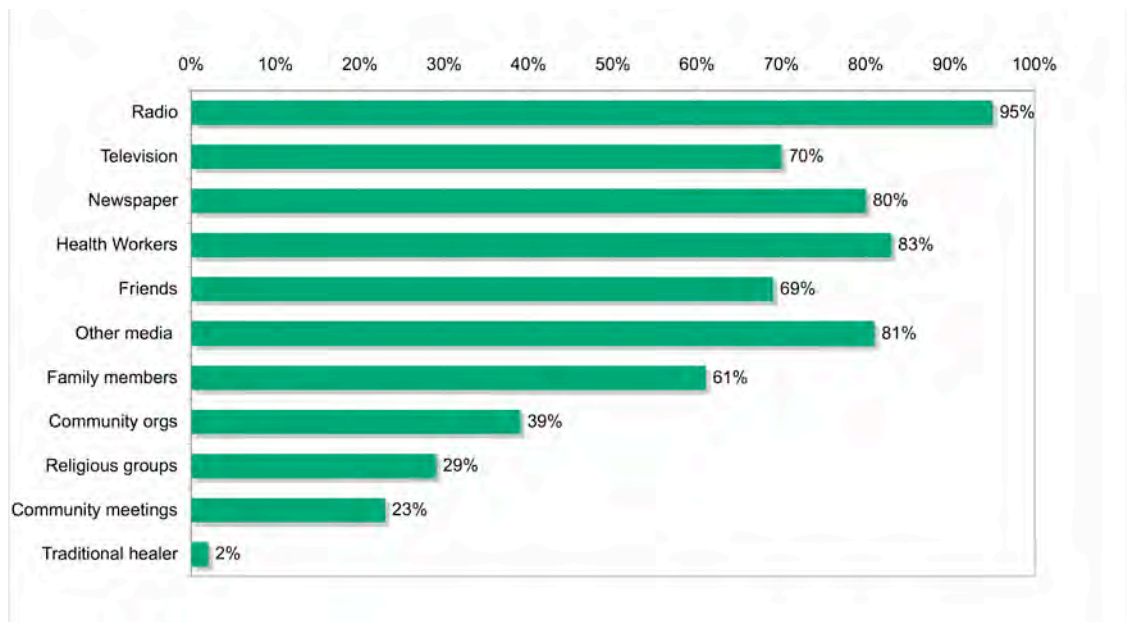
EXPOSURE TO HIV/AIDS INFORMATION

Radio and television were the highest mentioned mass media sources for HIV/AIDS in the past year, whilst friends and family members were the most common source at community level. Schools rated highly amongst full-time students. 'Be your own hero' was the most mentioned campaigns recalled in the past month.

Table 4: Sources of HIV/AIDS information in the past year, Oshakati

	% All	% Males	% Females	% 15-24	% 25+
Source of HIV/AIDS information in past year	600	301	299	271	329
Radio	95%	95%	95%	95%	95%
Television	70%	68%	72%	76%	65%
Newspaper	80%	81%	79%	84%	78%
Health Workers/Nurse/ Doctor/Clinic/Hosp	83%	83%	84%	82%	84%
Friends	69%	69%	69%	70%	69%
Other media (Magazines, Booklets,Pamphlets)	81%	81%	81%	80%	82%
Mother/Father/Family members	61%	60%	62%	62%	60%
Community orgs, AIDS organisations, NGOs	39%	37%	41%	36%	41%
Religious group, church	29%	28%	30%	28%	29%
Community meetings	23%	21%	25%	21%	25%
Traditional healer	2%	1%	2%	1%	2%
Sub-populations					
Schools/Universities/Teachers (Of all full-time students)	84%	84%	84%	83%	87%
Workplace (Of all persons employed)	32%	29%	35%	32%	32%
Exposure to AIDS campaigns, programmes, and organisations in the past month					
'Be your own hero'	82%	83%	81%	87%	78%
New Start (HIV testing)	61%	59%	62%	63%	58%
'My Future is My Choice'	54%	53%	56%	63%	47%
Smile condoms	58%	59%	56%	65%	52%
Catholic AIDS Action	43%	41%	45%	46%	41%
UNICEF	21%	20%	22%	18%	24%
Lironga Eparu	29%	23%	35%	22%	34%
'Alcohol aids HIV'	18%	15%	20%	17%	18%
Window of Hope	16%	17%	16%	16%	17%
LifeLine/ChildLine	10%	7%	13%	12%	9%
Desert Soul	24%	23%	25%	24%	24%
NawaLife	17%	18%	20%	13%	19%
Used Smile condoms, other services in past year					
Used Smile condoms	64%	68%	59%	61%	66%
Gone for HIV testing at a New Start Centre	57%	52%	61%	49%	63%
Spoken to a LifeLine/ChildLine counsellor	11%	7%	15%	12%	10%

Figure 4: Sources of HIV/AIDS information in the past year, Oshakati



In the past year, just over a third all respondents had heard HIV/AIDS talked about at religious gatherings. Just over half personally knew a person who had died of AIDS, and more than half had worn a red ribbon or other article with an AIDS message.

Table 5: Sources of HIV/AIDS information in the past year, Oshakati

	% All	% Males	% Females	% 15-24	% 25+
Community level exposure to AIDS	600	301	299	271	329
Heard AIDS spoken about by religious leaders at church/other religious gatherings	38%	35%	41%	34%	42%
Attended a meeting about HIV/AIDS in the community where I live	27%	22%	32%	22%	31%
Personalised exposure					
Someone I know told me they are HIV positive	39%	38%	40%	27%	49%
Personally know someone who has died of AIDS	53%	52%	55%	38%	66%
Attended funeral of someone who has died of AIDS	53%	51%	56%	40%	64%
Personalised involvement					
Worn a red ribbon, T-shirt, cap with an AIDS message	54%	51%	56%	55%	52%
Attended a training workshop on HIV/AIDS	29%	24%	34%	29%	29%
Volunteered for an HIV/AIDS organisation in my community	26%	23%	29%	22%	30%
Helped care for a child whose parents died of AIDS	32%	29%	34%	21%	40%
Helped care for a person who is sick with AIDS	40%	38%	42%	28%	50%
Orphans in household (asked of parents only)					
Parent or guardian of children in household	600	301	299	271	329
Yes	38%	32%	43%	13%	58%
Number of children cared for in household (asked of parents only)	227	97	130	35	192
1	12%	9%	15%	7%	16%
2	11%	8%	13%	3%	17%
3	7%	5%	8%	0%	12%
4+	9%	10%	8%	3%	15%
Of households that were caring for children, 18% were caring for orphans. Proportion of orphans who have lost both parents in these households	41	20	21	6	35
0	35%	39%	32%	32%	36%
1	49%	43%	54%	42%	51%
2	9%	10%	9%	5%	10%
3	3%	4%	2%	5%	2%
4	3%	4%	3%	16%	1%

Key recommendations: Exposure to HIV/AIDS

- There are high levels HIV/AIDS information exposure in schools, but lower exposure in religious institutions and relatively low exposure in workplaces. Religious leaders and management at workplaces in Oshakati should be encouraged to develop workplace HIV/AIDS programmes;
- There is good community level response to HIV/AIDS and this should be expanded and intensified. Family support programmes should be considered;
- Orphan numbers are high, and orphan support programmes should be developed and/or sustained.

HIV TESTING

Knowledge of HIV testing services was overall high as was ever having been tested and being tested in the past year. Most respondents were tested for HIV because they wanted to know their status.

Since the baseline survey in 2005, there has been an increase in knowledge of a place to be tested for HIV, knowledge of a place to obtain HIV counseling, and ever testing for HIV.

Table 6: HIV testing, Oshakati

	% All	% Males	% Females	% 15-24	% 25+
HIV testing knowledge and practice	600	301	299	271	329
Know a place where you can be tested for HIV	94%	92%	96%	92%	95%
Ever had an HIV test	64%	57%	71%	55%	71%
If ever had an HIV test, when was last test					
In the past year	49%	54%	45%	51%	48%
More than a year ago	38%	35%	41%	39%	38%
More than two years ago	13%	11%	15%	11%	14%
Of all respondents, proportion tested in past year	31%	31%	32%	28%	34%
Reasons for not having an HIV test (of those never tested)	217	130	87	121	96
I am not at risk for HIV	52%	48%	57%	58%	45%
I don't see the need for getting tested	18%	22%	13%	19%	18%
I don't think that I am HIV positive	8%	7%	9%	7%	8%
I am scared to be tested	6%	7%	5%	5%	7%
I trust my partner	8%	8%	8%	7%	10%
I did not have time	1%	2%	1%	1%	2%
Reasons for having an HIV test (of those ever tested)	383	171	212	150	233
I wanted to know my HIV status	53%	57%	50%	59%	49%
I was pregnant (of tested females)	33%		33%	26%	36%
I was feeling sick	8%	9%	8%	10%	7%
I applied for an insurance policy or loan	4%	5%	3%	4%	3%
My partner asked me to	6%	8%	5%	7%	5%
I wanted to start a new sexual relationship	3%	5%	0%	1%	3%
My partner requested it	2%	4%	5%	1%	3%
My employer requested it	1%	3%	0%	1%	2%
I engaged in risky sexual behaviour	2%	5%	0%		4%
Sources mentioned where HIV/AIDS counseling available	600	301	299	271	329
At a clinic or hospital	72%	67%	77%	70%	73%
New Start Centre	51%	50%	51%	54%	48%
Catholic Aids Action	37%	38%	37%	34%	39%

Figure 5: HIV testing trends, Oshakati

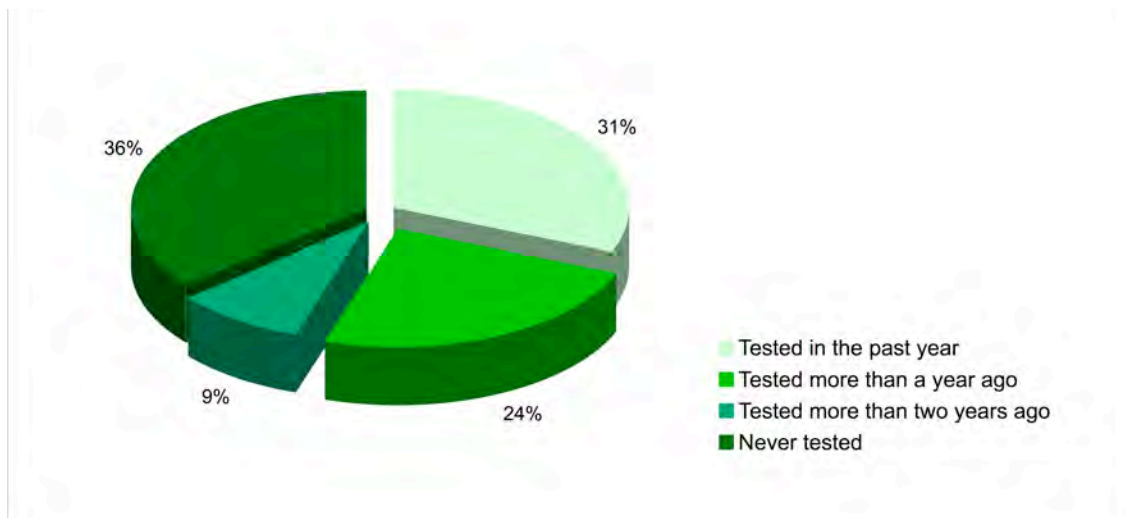
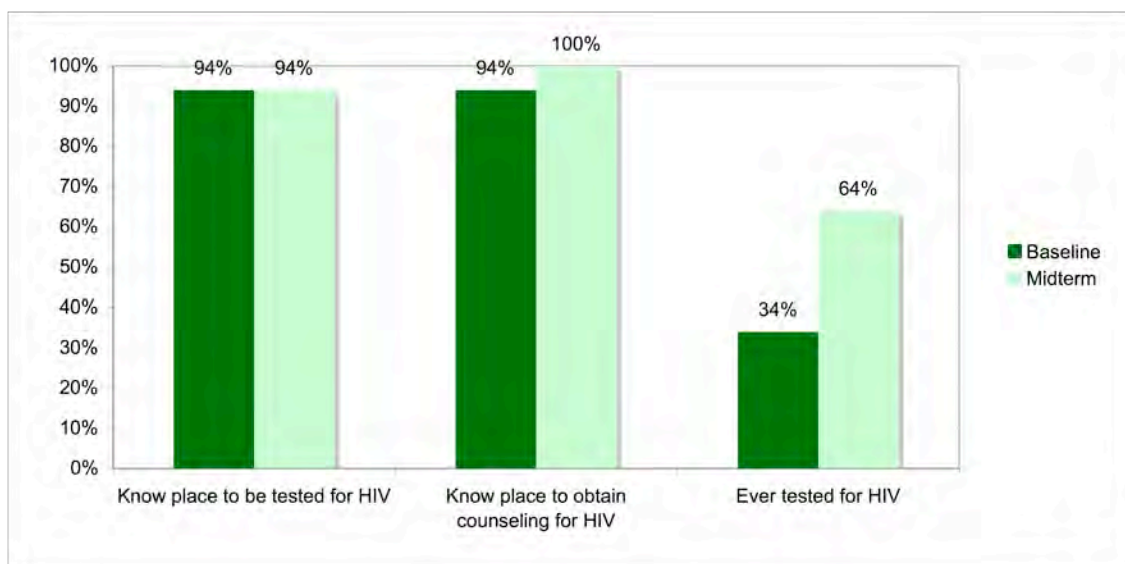


Figure 6: HIV testing changes since baseline, Oshakati



Key recommendations: HIV testing

- There is an overall high response to HIV testing over time. Emphasis should continue to be placed on supporting people who undergo HIV testing and are HIV positive. Such support should explore related support to partners and/or family members and build links to support services and resources such as ART where relevant.

SEXUAL BEHAVIOURS AND RELATED PRACTICES

Younger people are more likely to report having their sexual debut earlier than previous generations. There is also a high turnover of sexual partners, particularly amongst males, and very high levels of having concurrent sex partners.

Reported last sex condom use is high overall, with reasonable levels of consistent condom use. Having two or more partners in the past month has increased markedly over time.

Table 7: Age of sexual debut and number of sexual partners, Oshakati

	% All	% Males	% Females	% 15-24	% 25+
Age at first sex (of ever had sex)	437	228	209	170	267
<13	1%	1%	0%	1%	0%
13	1%	3%	0%	3%	0%
14	4%	5%	3%	5%	4%
15	9%	7%	11%	14%	7%
First sex at 15 or younger	15%	16%	14%	23%	11%
16	12%	12%	11%	16%	9%
17	22%	22%	21%	26%	19%
18	15%	14%	16%	19%	12%
19	18%	19%	16%	11%	22%
20	8%	8%	9%	4%	12%
>20	10%	8%	12%	2%	15%
Number of sex partners in past year (of those who ever had sex)	437	228	209	170	267
None	6%	6%	7%	5%	7%
1	62%	48%	79%	65%	61%
2	15%	18%	12%	18%	13%
>2	16%	29%	3%	12%	19%
Number of sex partners in past month (of those who had sex in past year)	409	215	194	161	248
None	9%	10%	7%	12%	6%
1	78%	67%	91%	80%	77%
=> 2	13%	22%	3%	8%	16%

Figure 7: Number of sexual partners in past year, Oshakati

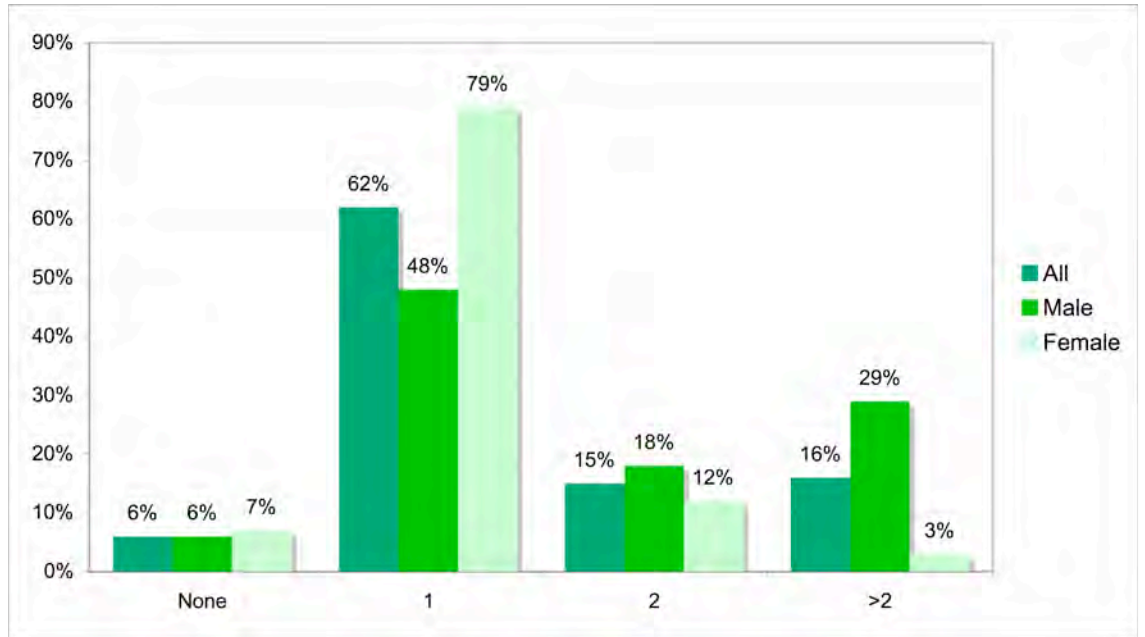


Figure 8: Number of sexual partners in past month, changes since baseline, Oshakati

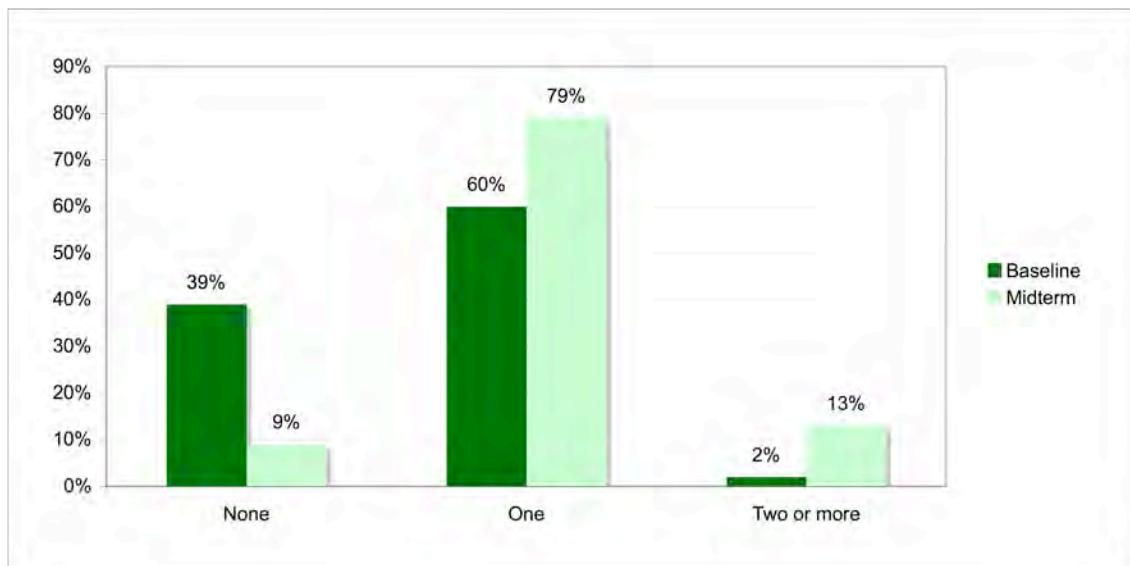


Table 8: Condom use at last sex and consistency of condom use, Oshakati

	% All	% Males	% Females	% 15-24	% 25+
Condom use at last sex (of those who had sex in past year)	409	215	194	161	248
All	75%	78%	71%	85%	68%
Married	50%	51%	50%	50%	50%
Unmarried	87%	89%	85%	88%	87%
Consistency of condom use (of those who had sex in past year)					
Never	9%	8%	9%	5%	11%
Rarely	10%	11%	9%	3%	15%
Occasionally	17%	13%	23%	11%	22%
Usually	25%	26%	25%	25%	26%
Always	39%	42%	35%	57%	27%
Usually / always	64%	68%	60%	82%	53%

Key recommendations: Sexual behaviours and related practices

- Young people should be encouraged to delay their first sexual debut;
- High partner turnover and concurrency are major risk factors for the spread of HIV. People who are partners of individuals who have other partners are potentially unaware that they are exposed to HIV infection risk in this way;
- The proportion of respondents reporting two or more sexual partners in the past month has increased considerably since baseline. The high risk of HIV infection when one has two or more sexual partners in the same month requires very strong emphasis;
- Whilst consistent condom use with a ‘main’ partner or spouse is not easily achieved, it is vital that condoms are used correctly and consistently with casual partners, and consistent and correct use should be intensively promoted.

ALCOHOL CONSUMPTION AND LEISURE ACTIVITIES

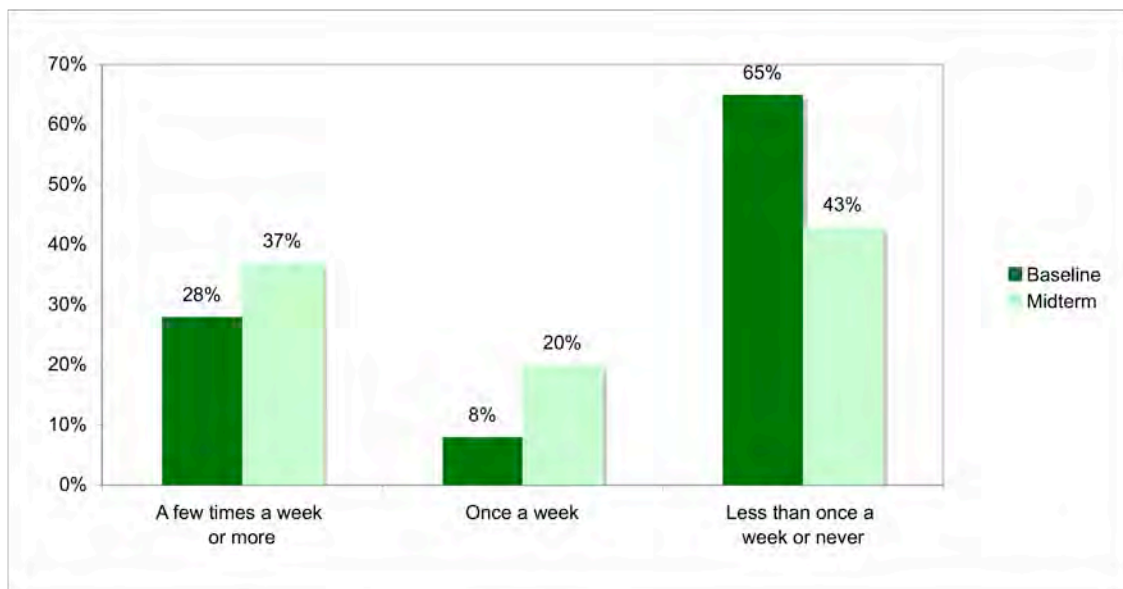
Alcohol consumption is very high in Oshakati, with more than a third of respondents drinking a few times a week or more. Males are more likely to consume alcohol regularly than females, as are people over the age of 25. A very high proportion of both sexes reported being drunk in the past month. Going to a bar, shebeen or nightclub is also a regular activity.

When explored over time, there have been promising positive changes in Walvis Bay, with a decline in the proportion of people drinking once a week or more and a slight increase in the number of people who seldom or never drink.

Table 9: Alcohol consumption and leisure activities, Oshakati

	% All	% Males	% Females	% 15-24	% 25+
Alcohol consumption	600	301	299	271	329
Daily	13%	17%	9%	6%	19%
A few times a week	24%	27%	21%	18%	29%
<i>A few times a week or more</i>	37%	44%	30%	24%	48%
Once a week	20%	26%	14%	20%	21%
Less than once a week	8%	7%	9%	12%	5%
Never drink	35%	23%	46%	44%	26%
Drunk in the past month	55%	64%	42%	56%	54%
Alcohol consumption and alcohol venues	% Student	% Employed	% Unemployed	% Married	% Unmarried
	134	208	258	171	429
Daily	2%	14%	18%	18%	11%
A few times a week	14%	29%	25%	22%	24%
<i>A few times a week or more</i>	16%	43%	43%	40%	35%
Once a week	19%	27%	15%	40%	35%
Less than once a week	10%	8%	8%	22%	20%
Never drink	54%	22%	34%	5%	9%
Gone to a night club in past month	28%	39%	38%	32%	35%
Gone to a bar/shebeen in past month	36%	72%	61%	57%	60%
Leisure activities in the past month	% All	% Males	% Females	% 15-24	% 25+
Played soccer	14%	26%	2%	23%	7%
Played other sports	16%	14%	17%	24%	9%
Gone to a bar or shebeen	59%	70%	48%	53%	64%
Gone to a night club	36%	41%	31%	31%	40%
Watched a drama group	21%	16%	25%	17%	24%
Gone to a multipurpose community centre	25%	22%	28%	20%	29%
Gone to an AIDS support group	23%	21%	25%	23%	23%

Figure 9: Alcohol consumption, changes since baseline, Oshakati



Key recommendations: Alcohol consumption and leisure activities

- There has been an increase in alcohol consumption in Oshakati over time. Developing and/or expanding programmes reducing alcohol dependence should be explored, and these should be integrated with HIV/AIDS programmes and interventions.
- Awareness of the risks of unprotected and casual sex in conjunction with drinking alcohol should be promoted;
- Sports activities are a potential access point for HIV/AIDS education activities, particularly soccer in relation to males.

APPENDIX 1

Findings from focus groups in Keetmanshoop, Oshakati, Rundu and Walvis Bay

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;
- The relationship between alcohol and HIV risk;
- Mobility and migration within communities, and the relationship to HIV risk; and
- HIV testing.

The findings from all sites are presented here.

Qualitative study methodology

Issues explored in the qualitative study included:

- Perceptions of dominant HIV/AIDS communication;
- Sexual relationships;
- The relationship between alcohol and HIV risk;
- Mobility and migration within communities, and the relationship to HIV risk; and
- HIV testing.

Qualitative study design

The qualitative study protocol was piloted prior to implementation. The study was conducted in March and April 2007. Two focus groups were conducted in each of the four sites with participants by age clusters of 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. Of the total of 48 participants, 38 were single

(79%), 30 had children (63%), 23 were employed (48%), 21 were unemployed (44%), and 4 were students (8%).

Translation, transcription and analysis

Languages used in focus groups included English, Oshivambo, Afrikaans and Rukwangali. 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.

Qualitative findings: HIV and AIDS Knowledge, beliefs and attitudes

Whilst knowledge was not explored extensively in the focus groups, many participants spontaneously mentioned key knowledge areas including condom use for HIV prevention, abstinence, and being faithful to one's partner or sticking to one partner. There was no mention, however, of delaying debut of first sexual intercourse. Whilst knowledge was seen as empowering, there was also a sense of denial about the disease when knowledge was applied in context:

Mostly people used to be worried when we are talking like this or wherever it is mentioned. When you are watching TV advertisements, that time you are worried – but when it goes to practical, there you forget about what you heard or saw (Male, 35-50, Oshakati).¹

Qualitative findings: Exposure to HIV/AIDS information

Participants were asked about sources of HIV/AIDS information, the nature of information and the relative importance and value given to various sources.

The content and source of information was seen as varied and could be viewed as either contradictory or complementary. For example, perceptions of emphasis within the context of religion in comparison to friends, or perceptions contrasting information derived from the media and from friends:

I will give you an example. In the church, the pastor is always saying you have to wait for marriage before you have sex. And with your friends, they just want to tell you 'use condoms.' (Female, 20-30, Keetmanshoop).²

Yes, there is a difference, because when you are with your friends, mostly all you talk about is that AIDS can kill you and that you will get sick. But from media, they always go into details about it. They say how can you prevent it, what can

¹ NLT Oshakati 35-50.txt, 11385,11658

² NLT Keetmanshoop 20-30.txt, 10088,10281

*you do. Friends, they don't tell each other what they can do (Female, 20-30, Oshakati).*³

Some participants however, were proactive about talking to their friends about the importance of caring for people living with HIV, and were supportive of those dealing with its consequences.

*I always talk to my friends about HIV. I tell them how to take care of someone who has the virus, people who suffer from it, to talk to them in a way that will not break their courage - you have to help them with self-motivation (Male, 20-30, Walvis Bay).*⁴

With regard to mass media communication, participants expressed the notion that the message was 'loud and clear', HIV is 'dangerous', and to 'protect yourself', but there was also a sense that people 'understand the message, but are ignoring it'. Reference was also made by several participants to hearing and seeing programmes featuring people living with HIV, and this was seen as helping to personalise the epidemic.

Participants also referred to information derived from community level 'counsellors' who helped to elaborate HIV/AIDS information, including information related to prevention, care, treatment and support.

Amongst youth, there was a strong sense that parents cared about HIV infection risks amongst children and were readily entering into dialogue around this issue:

*Our parents are talking about it: sexual activity – you must protect yourself. They are telling you to stick to one partner, to use condoms and if you have too many partners it might be risky... (Female, 35-50, Oshakati).*⁵

*I just wanted to say I have experienced an improvement since most of the parents are no longer scared to discuss HIV with minors. Let me say, the children under age. So it is an open thing. (Male, 35-50, Oshakati).*⁶

This included formal discussions, as illustrated by a youth participant in Rundu who referred to regular family discussions on the issue, whilst another contextualised family discussion as being motivated by concern and love, and thus far more serious and relevant in comparison to information obtained via mass media:

To me, my family, we really have a big discussion where we sit Sunday after church. And we really talk about HIV and AIDS. My parents, they encourage us to be very careful. [Moderator: What do they say?] They always tell us if you are with your girlfriend, and you really want to have sex, either you go and be

³ NLT Oshakati 20-30.txt, 3613,3926

⁴ NLT Walvis Bay 20-30.txt, 3411,3646

⁵ NLT Oshakati 35-50.txt, 3307,3749

⁶ NLT Oshakati 35-50.txt, 3752,3967

tested or you use a condom. But if you are not sure, you abstain and you know what you are doing. (Male, 20-30, Rundu).⁷

Yes, there is a difference. Because, when you talk to your parents, you really know that you can trust them. They are telling you, you have to do this and you follow them. And sometimes, people who are addressing us on the radio or the television, they are just telling us, the young ones or the community, not to do that... I really won't take it seriously. So, the message is very, very different. The parents, they are really telling us out of truth and love – but for the other person, it is [said because] of money, because it is his job (Male, 20-30, Rundu).⁸

Qualitative findings: HIV testing

There was an overall perception that HIV testing was readily available in communities, and that a number of options existed for testing including through hospitals, clinics and New Start centres, with testing being promoted through a range of media.

Although fears of confidentiality were not raised by many respondents in the quantitative survey, there were concerns expressed by focus group participants that information about HIV status wasn't being kept confidential, and that some people who were HIV positive in the community had been identified as a product of breaches of confidentiality. This was particularly mentioned in Keetmanshoop.

Being scared of finding out one's status was also not widely mentioned in the quantitative survey, but focus group participants mentioned fear as a disincentive for testing. Finding out one's status was also recognised as a complex issue that affected people's relationships.

HIV testing centres were seen as useful sources of information about HIV/AIDS and participants noted the importance of pre- and post-test counseling.

Qualitative findings: Sexual partnerships

Focus group participants noted that having multiple sexual partners was linked to self-esteem and concepts of 'manhood' – '*so I can boast to my friends that I am really a man*', feeling '*so proud to have a lot of ladies*'.

The consequences of unfaithfulness in relationships were seen to be severe and included unfaithfulness as a form of revenge, ending the relationship or divorce (if married), physical violence such as beating, and was also reported to extend to murder. Alternative strategies were seen to be talking through the issue, insisting on an HIV test, or

⁷ NLT Rundu 20-30.txt, 3953,4372

⁸ NLT Rundu 20-30.txt, 5289,6044

consulting elders, although sustained infidelity was perceived as being difficult to forgive.

Having multiple partners was linked to factors including exposure to potential partners as a product of boredom with a current partner, lack of sexual satisfaction, a lack of self-control, meeting people at clubs or parties, consuming alcohol, mobility as a product of work, work-seeking or visiting other communities, and financial needs.

Contextual factors played an important role in the perceived likelihood of infidelity, particularly if a partner was away for a long period of time:

If your man goes to sea for three months, maybe it is difficult for a woman, and that is when she takes these 'skelm draaitjies' (unfaithful ways) – she does things she wouldn't normally do... you don't even know if this person is healthy or not and this can have a disadvantage to your health (Female, 35-50, Walvis Bay).⁹

Multiple partnerships also occurred as a product of mobility as a product of work, work-seeking, and studying.

For young people, multiple sexual partnerships were seen as something that had changed over time, and this was related to peer pressure:

In these modern times, the problem is peer pressure. It was different for our parents... Today you will find that it is funny for people to be faithful if they have been in a relationship for some time. Some will just desire others, and cheat on someone. Despite the trust that is there, someone, somewhere, is not faithful (Male, 20-30, Rundu).¹⁰

There was also a sense of inevitability of promiscuity as a product of lack of trust – “because now everyone thinks ‘my partner also cheats’, so what’s the use of being faithful” (Male, 35-50, Walvis Bay).¹¹

Financial imperatives were seen as a product of the contemporary era – “Nowadays, it’s all about money. If I don’t treat my lady well, she will go to other men” (Male, 20-30, Keetmanshoop)¹²; and “Nowadays, it is too much. Women do it because they like the money” (Female, 35-50, Oshakati).¹³

One participant spoke about being a ‘player’, but as a product of knowledge of HIV risk and responsibility for his children, he was motivated to change. Another participant said “I think if they have the mentality of sticking to one partner, they will be faithful” (Female, 20-30, Walvis Bay).¹⁴

⁹ NLT Walvis Bay 35-50, 7584,8016

¹⁰ NLT Rundu 20-30.txt, 7488,7915

¹¹ NLT Walvis Bay 35-50, 7387,7582

¹² NLT Keetmanshoop 20-30.txt, 10882,11023

¹³ NLT Oshakati 35-50.txt, 10360,10448

¹⁴ NLT Walvis Bay 20-30, 10252,10869

Qualitative findings: Alcohol and risk behaviour

Participants in focus groups saw alcohol use as pervasive in their communities, and was seen as a common activity amongst youth. A number of participants saw this phenomenon as linked to boredom, frustration and stress as a product of unemployment such as *'sitting at home and not getting a job'*. This was further linked to difficulties in obtaining employment – *'when someone is unemployed they turn to alcohol'*. As one participant put it:

Sometimes it is the circumstances that this person is in. It is mostly unemployment. The only thing a friend can give you is alcohol. I might look for a job in the morning and in the afternoon you go past your friend's house and then you get alcohol there. I am frustrated because I don't get a job, but I have tried looking for one (Female, 35-50, Walvis Bay).¹⁵

Alcohol consumption was related to risk of having unprotected sex as a product of increased feelings of confidence, as well as *'losing control'* and not being able to *'reason things properly'*. Whilst some participants referred to drinking as being relative to the amount of money one had, others noted that venues for drinking were widely available in their communities including bars, shebeens, and private houses, and that it was not always necessary to have money to drink. Some participants referred to responsible drinking as *'drinking at home'*. For others, not drinking was seen as a way to lose friends, to become *'Mr Lonely'* or being *'a saint... a Mary's child'*.

Giving up drinking was seen as extremely difficult, with moderation being seen as an unsuccessful strategy, as described by one participant:

Keeping your limit does not exist with me. I cannot keep a limit. I cannot have a glass of beer and say this is okay. So, to my mind it is better for me if I don't touch it at all... I have tried many times. I have told myself now I will not stop taking alcohol – I will consume it and I will do it responsibly. But every time I try I have failed. This year I told myself: 'Brother, don't take this alcohol, quit the consumption of alcohol.' I told myself from the first of January I wouldn't touch any beer or wine. It's only for some few weeks that I am not consuming alcohol. But I am scared; it is difficult to tell someone to set a limit on consuming alcohol... When we talk about responsible drinking, we must see it from both angles. Talking about limit – some people will manage to keep their limit. In many cases, people will fail to keep their limit. For the failures – it will be better for them to rather abstain totally from consuming alcohol (Male, 35-50, Keetmanshoop).¹⁶

¹⁵ NLT Walvis Bay 35-50.txt, 18219,18561

¹⁶ NLT Keetmanshoop 35-50.txt, 23959,25312