HIV/AIDS, Poverty and Patriarchy: A Gendered Perspective

Research Report

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Abbreviations and Acronyms

AIDS	**Acquired Immune Deficiency Syndrome**
ART	**Anti-retroviral Treatment**
ASO	**AIDS Service Organisation**
CBO	**Community Based Organisation**
CCN	**Council of Churches in Namibia**
DHS	**Demographic and Health Survey**
FAO	**Food and Agriculture Organisation**
FGD	**Focus Group Discussions**
GDP	**Gross Domestic Product**
HIV	**Human Immunodeficiency Virus**
KII	**Key Informant Interviews**
MoBESC	**Ministry of Basic Education, Sport and Culture**
MoHSS	**Ministry of Health and Social Services**
MTP II	**Second Medium Term Plan on HIV/AIDS**
NACOP	**National Co-ordination Programme**
NANASO	**Namibia Network of Aids Service Organisations**
NASOMA	**Namibia Social Marketing Association**
NGO	**Non-governmental Organisations**
OVC	**Orphans and Vulnerable Children**
PLWHA	**People Living with HIV/AIDS**
PMTCT	**Prevention of Mother-to-Child Transmission**
RACOC	**Regional Aids Co-ordinating Committee**
SADC	**Southern African Development Community**
STI	**Sexually Transmitted Disease**
STI	**sexually Transmitted Infection**
SMA	**Social Marketing Association**
SPSS	**Statistical Programme for Social Sciences**
TB	**Tuberculosis**

TFR	**Total Fertility Rate**
UN	**United Nations**
UNAM	**University of Namibia**
UNAIDS	**Joint United Nations Programme on AIDS**
UNICEF	**United Nations Children's Fund**
UNDP	**United Nations Development Programme**
UNPF	**United Nations Population Fund**
VCT	**Voluntary Counselling and Testing**

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Ms Lucy Edwards interpreted and analysed the data. She also compiled the research report.

1. Introduction

"Coitus can scarcely be said to take place in a vacuum; although it appears to be a biological and physical activity, it is set so deeply within the larger context of human affairs that it serves as a charged microcosm of a variety of attitudes and values to which culture subscribes. Among other things it serves as a model of sexual politics on an individual or personal plane."

Kate Millet, "Sexual Politics" in Issues of Feminism: An introduction to Women's Studies, Mayfield, (1998).

Sixteen years after HIV/AIDS was first diagnosed in Namibia, the latest Sentinel survey results indicate continuous increases in HIV infection rates. Grave predictions of loss of life and socio-economic impacts of the pandemic beg critical enquiry into why it is so difficult to contain the spread of the disease despite mass awareness raising and educational campaigns. The pandemic takes its toll against the backdrop of major social, economic and cultural shifts, characterised by the integration of traditional modes of economic production, social organisation and cultures, with modern urban lifestyles. These changes and continuities provide the socio-cultural context for the rapid spread of the disease.

As in most of Southern Africa, the HIV/AIDS pandemic in Namibia is mainly a heterosexual disease. 70% of infections are transmitted through sexual intercourse. At the early stages of the pandemic there was a tendency to treat AIDS as a medical problem. There is increasing recognition that the disease has key non-biological determinants that contribute to its continued spread.

This research was initiated to explore the socio-cultural and structural determinants of the HIV/AIDS pandemic. One research aim was to understand the relationship between HIV/AIDS and female migration to Windhoek. We hypothesised that social and economic displacement force women to migrate to urban centres like Windhoek, where risky sexual relationships form part of their survival strategies.

Empirical research was conducted in the informal settlements of Windhoek as these areas serve as reception centres for new rural migrants. They therefore provide the vantage points from which the possible intersection between HIV/AIDS and its social-cultural and structural links can be observed.

We hope that the knowledge and understanding gained through the research will contribute towards attaining the objectives set out at the Abuja Conference,[1] namely:

a) to prevent, halt and reverse the spread of the virus;
b) to prevent mother to child transmission;
c) to place treatment and care in everyone's reach and;
d) to protect those made vulnerable by the pandemic, especially orphans.

[1] These are objectives revealed by the UN Secretary General at 2001 AIDS Conference in Abuja, Nigeria as cited by the United Nations Population Fund (UNFPA) (2001)

Since the search for AIDS vaccines is ongoing and there is no known cure, the emphasis remains on prevention. The fact that sexual intercourse is assumed to be the main mode of HIV transmission should propel open public and interpersonal discussions about sex to the fore. However, the discussions on human sexuality are muted by moral, religious and cultural taboos. When such discussions do take place they are often framed in a biological and medical discourse that obscures the socio-cultural and structural dimensions of human sexuality.

There can be no denial that HIV results in AIDS and that literature reviewed on HIV/AIDS in Namibia indicates strong links between the spread of HIV/AIDS and sexual cultures that are rooted in patriarchy, social and economic inequality and poverty. These factors form a complex tapestry upon which a holistic and integrated approach to HIV/AIDS prevention, care, treatment and support should rest. Poverty and gender inequality are two recurring and intersecting threads that run deep through this complex tapestry.

Best practices from Uganda are held up as models to be emulated in HIV/AIDS prevention. The ABC[2] rule that caused significant reductions in HIV prevalence in Uganda forms the cornerstone of prevention campaigns in Namibia. The model puts forward abstinence, monogamy and condom use as the key decisions individuals should make in the practice of safe sex. It is hoped that the positive results it yielded there can be replicated. So far it has not been the case. To understand why one may have to look at how a particular constellation of factors intersect in Namibia. It is clear that models cannot be transported from one country to another without recognising specific local factors that facilitate the spread of the disease.

The key questions are firstly, how free and autonomous are people from their cultural norms and socio-economic circumstances to make such seemingly rational choices? Secondly, what is rational and from whose perspective? International studies show that individuals do not always act out of their own volition. This is particularly so in less individualistic societies where family and societal pressures exert great influence on individuals. Sexuality is not only a matter of individual choice, but is subject to socially and culturally constructed norms and material circumstances that influence individual decision-making. Often, what seems rational and what seems irrational is merely a matter of perspective. The person who risks HIV/AIDS death by trading sex for physical survival may be making a very rational choice from his/her own perspective and circumstances, while the trade-off simply seems to be between death now or later. Under certain circumstances deferred suffering appears to be a very rational choice from the perspectives of those whose immediate survival is under threat.

While the debate on the influence that society and social structures have on individuals goes beyond the scope of this study, it is clear there is some intersection between social, personal and biological factors in the spread of HIV infection.

[2] ABC model stands for abstinence, be faithful and use condoms. This has become a mantra that is used to guide HIV/AIDS prevention campaigns.

A number of anthropological and sexual-cultural studies in Namibia seem to indicate that the ABC rule overlooks the particular and complex social and cultural roots of prevailing sexual cultures in the country.[3]

When it comes to HIV prevention we have to ask whether firstly the ABC rule is not an over-simplification of very complex sets of social and power relationships that overshadow sexuality? Secondly, to what extent does the ABC rule reflect the majority experience or is it simply a minority experience that has been elevated to a norm? Thirdly, how helpful is it in developing a holistic strategy for HIV/AIDS prevention?

It is our contention that sexual behaviour and the resulting spread of HIV/AIDS are influenced by a number of factors. These factors can be divided into three categories. They are: [4]

- Structural and social factors
- Personal preferences and sexual choices
- Biological factors

Solutions for the prevention of HIV/AIDS should therefore be sought in each of these categories of factors.

Structural and Social Factors

These are factors that are external to the individual and that arise out of the prevailing forms of social and economic organisation as well as the prevailing cultural and religious norms. Some of these social, economic and cultural factors that contribute towards the spread of HIV/AIDS in Namibia are:

> Patriarchy, poverty, social and gender inequality, sexual violence, migration, masculine and feminine stereotypes, low levels of sexual literacy, low levels of awareness of sexual and reproductive rights, polygamy, serial monogamy and a culture of silence about sexuality.

Personal Preferences and Sexual Choices

These include factors internal to the individual and over which the individual has a degree of decision-making power and control. Sexuality and sexual choices are regarded as personal and private choices. However, these choices are often not completely free and autonomous since they are framed in a particular socio-cultural context. The degree of sexual autonomy individuals have is often determined by their social status in a particular society, which in turn is influenced by gender, class, race, ethnicity and cultural norms.

Although power is never completely absent from sexual relationships, it is relational, and individuals have relative autonomy which they can use to make some sexual and reproductive choices in order to protect themselves against HIV exposure.

[3] Le Beau, D. et all (1999); Fox, T. (2002);Tersbol, B. (2002); Talavera, P. (2002) and Ipinge, S. (2003)
[4] These categories were adapted from the Jackson (2002) publication, AIDS Africa: Continent in Crisis.

Biological
Biological factors pertain to the particular strains of the virus, the rate of mutation, the prevalence of other STIs, ratios of co-infection and viral loads. The rapid spread of the HIV/AIDS pandemic in Namibia can in part be attributed to the type of virus most prevalent in Southern Africa. This is the HIV-1 C Virus, which appears to spread more rapidly through heterosexual populations, mutate faster and cause bigger epidemics[5] than other strains.

Links Between Biological, Personal and Social-structural Factors
These categories do not exist independently of each other. The social-structural context shapes individual choices and the biological conditions may have social and cultural dimensions. For example, infectivity of people with HIV can be decreased if they live healthy lives with good nutrition and gain treatment of opportunistic infections.[6] Under-nourished people on the other hand become more easily infected, develop higher viral loads faster and become more infectious to others.[7] In Namibia there is a complex interplay between the personal, structural and biological factors that facilitates the spread of the pandemic.

The most important factors that intersect and shape the spread of HIV/AIDS in Namibia are:

- Population mobility (migration)
- Patriarchal gender relations and gender inequality
- Social and economic dislocation and exclusion
- Mass poverty
- Prevailing sexual cultures

This study explores how the above factors influence the spread of HIV/AIDS in Namibia. Chapter 2 outlines the methodological process used to arrive at the research results as well as some of the methodological and conceptual challenges that were encountered during the research process. Chapters 3 to 7 introduce some of the critical issues related to the spread HIV/AIDS. These chapters integrate the literature with the research results and point to the congruencies and inconsistencies between the literature and our actual empirical findings. Chapter 8 summarises the key findings and Chapter 9 provides some recommendations based on the key findings.

[5] Jackson, H. (2002)
[6] Jackson, H (2002)
[7] Ibid

2. Methodology

2.1. Introduction

The key research question this project wanted to explore was whether the increase in female migration to Windhoek leads to risky sexual behaviour and therefore increases female migrants' vulnerability to HIV infection. Some of the literature draws links between women's low social and economic status and their vulnerability to HIV exposure. However, to establish these links empirically was not easy as our experience showed that women are reluctant to talk about their own sexual behaviour.

It was a methodological challenge to establish causal links between migration and female survival strategies and one that we were not completely able to overcome. We had to integrate a number of different research methodologies to deal with sensitivities that inhibit open discussion about sexuality. Different qualitative and quantitative methods of data collection were used to gain as much breadth and depth of information as possible. The different methods of data collection also provided the means of internal validation and cross-referencing.

Research on the social-cultural construction of sexuality remains relatively unexplored in Namibia. Despite the linkages between HIV/AIDS and existing sexual cultures, there is a reluctance to deal with the social and cultural dimensions of human sexuality.

2.2 The Research Process

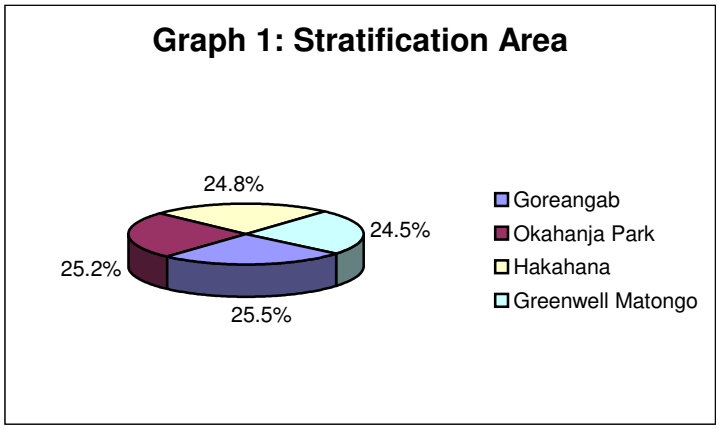
Desk Study
The desk study surveyed the relevant documentary sources. The literature helped define the research questions, enabled us to determine the scope of the study and to design the study.

Field Study
To test the hypothesis a field study was carried out in some of the informal settlements of Windhoek. As a result of our pluralistic methodological approach we applied both qualitative and quantitative data collection techniques.

2.2.1 Quantitative Methods of Data Collection

Baseline Survey
A total of 17 enumerators collected the quantitative data by using a survey questionnaire. The baseline survey was carried out to capture the knowledge, attitudes and sexual behaviour of the research population with regard to the prevention and spread of HIV/AIDS. The baseline survey also provided demographic and social economic data that permitted correlations between sexual attitudes, behaviour and socio-cultural circumstances. A total number of 712 interviews were conducted in four different informal settlements

Locations
The empirical study was conducted in Goreangab, Okahandja Park, Hakahana and Greenwell Matongo settlements for we assumed that new migrants to Windhoek would find themselves in these areas.



Sampling
We derived our research population through a process of systematic random sampling of homes in each stratification area. Initial selection was done through simple random sampling with the spin of the bottle technique. Thereafter every eighth house was selected.

Data Processing
Four data capturers were contracted in to capture quantitative data in the SPSS statistical programme.

2.2.2 Qualitative Methods of Data Collection

A baseline survey can only provide baseline data. It does not allow for probing in order to gain depth. It also has the danger of foreclosure due to its pre-structured response codes. The qualitative methods of data collection allowed probing on sensitive themes. The qualitative research methods used were:

- Focus group discussions (FGD)
- Key informant interviews (KII)
- Mobility mapping
- Income and expenditure matrices.

During focus group discussions men and women were separated into groups because experience showed that in mixed groups men tend to dominate. Male interviewers conducted the key informant interviews and focus group discussions with men, while female interviewers conducted them with women. We assumed that women would be less inhibited when discussing sensitive issues related to their own sexuality if men were not present. This may have been the case, but in comparing the data generated from the male and female focus groups we realised that despite the separation women were still less forthcoming than men. Interviewers reported that women showed reluctance to discuss matters of sexuality.

This indicates that in future research more female-centred methodological approaches should be used to gain more in-depth knowledge of women's perceptions of sexuality and actual sexual practices.

- **Key Informant Interviews (KII)**
  An interview schedule was developed to cover topics like migration, survival strategies, gender relations, sexuality, fertility, sexual behaviour and HIV/AIDS. A total number of 10 key informant interviews were conducted in all the locations.
- **Focus Group Discussion (FGD)**
  Four focus group discussions were conducted in which a total of 33 people participated. Sensitive matters like sexuality, fertility and gender relations were addressed.
- **Tools for Participatory Assessment**
  It is methodologically very difficult to link risky sexual behaviour with survival strategies when the former does not constitute open prostitution. We therefore needed closer relations with the research population to allow for probing and in-depth discussions. Two tools for participatory assessment were used, namely:

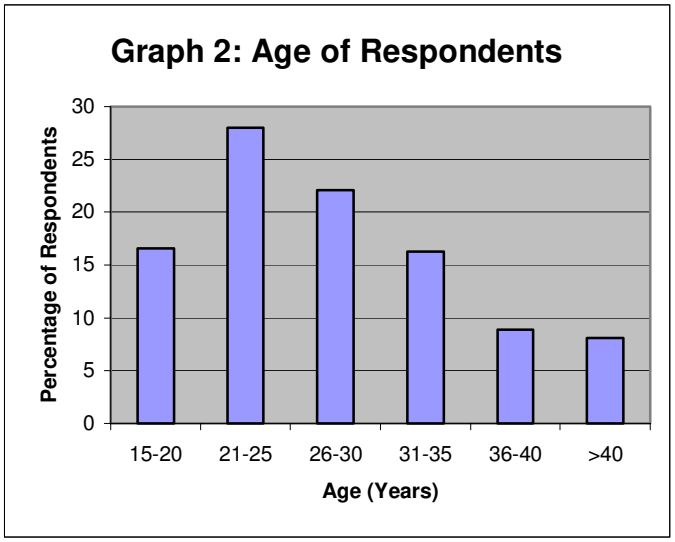
  a) Income and Expenditure Matrix
  The aim of the income and expenditure matrix was to gain more information on survival strategies, level and sources of income and the nature of household expenditure. Once again the groups were separated by gender, for reasons already cited.

  b) Mobility Map
  The mobility map was used to ascertain the extent of rural-urban migration and the risks such migration may hold for women. Participants were asked to draw their own mobility maps over the past year. They then had to answer key questions pertaining to locations they have migrated from, the reasons for the migration, the conditions under which they migrated and the conditions they currently find themselves in.

2.3 Demographic Profile of Baseline Survey Respondents

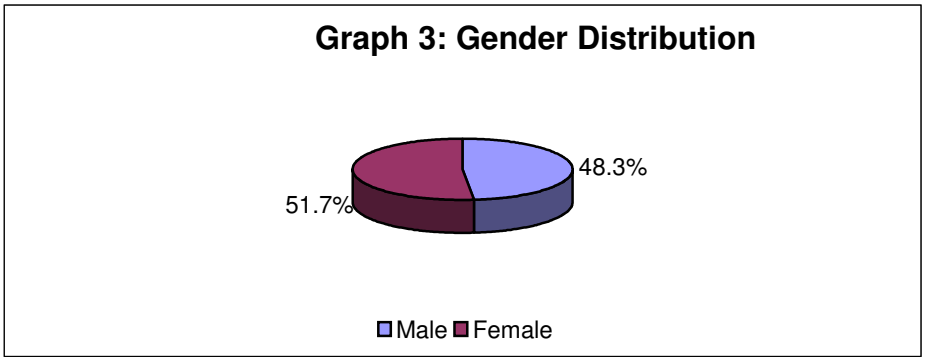
Age

Because we targeted adults the majority of respondents were between the ages of 21 and 35. This is consistent with migration patterns as it is mainly young adults who migrate from the rural areas.



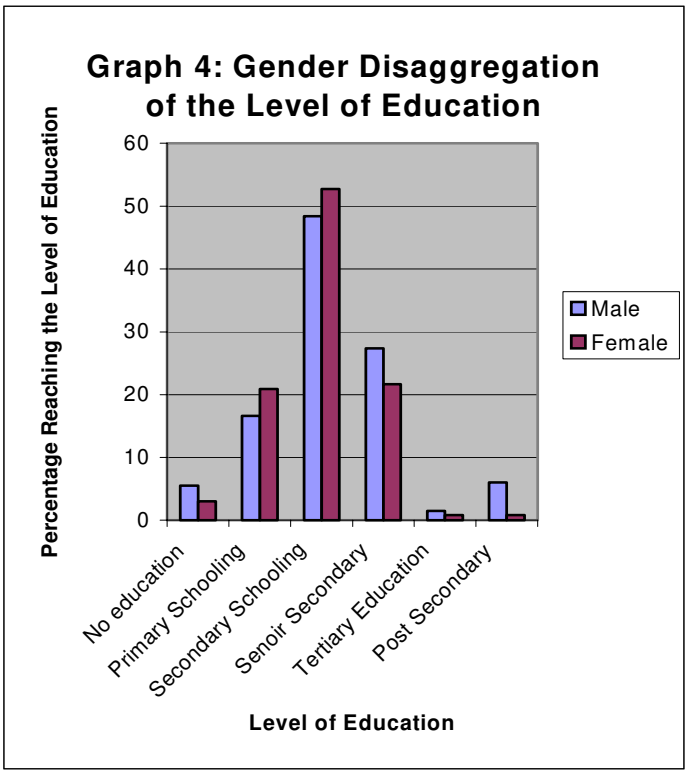
Gender

The sample had a female bias that may have resulted from the fact that interviews were conducted on weekdays and during working hours. Since more women are unemployed or classified as home-makers they were slightly over represented in the sample.



Educational Attainment

73,6% of respondents did not complete secondary education, which could also explain the high unemployment in the stratification areas. The demographic profile of the respondents match that of poor people with high unemployment, low levels of education, low levels of skills, low levels of income and low standards of living.



2.4 Limitations of the Study

2.4.1 Conceptual Limitations

Since the research population came from different ethnic, cultural and language groups, there may have been different connotations to different concepts. These differences in understanding may also have been present along gender lines. Some concepts that may have been differentially understood by different groups of respondents are:

a) **Sexuality, Morality and Consciousness**
While elements of traditional patriarchal sexual cultures are still widespread in Namibia, Christian morality and its sexual norms are also present. The extent to which one or the other dominates consciousness is difficult to ascertain since we did not enter into any psychological research that could explore the complex relationship between sexual cultures, individual consciousness and individual sexual behaviour. It is quite possible that different groups of respondents may have understood concepts like faithfulness, family relations and gender roles differently, because of the influences of culture and religion on different individuals and social groups.

b) Marriage

The notion of being married can be extremely relative and situational. The concept of marriage is often loosely applied based on a continuum that ranges from formal marriage to temporary and intermittent cohabitation. A person may be in a permanent or semi-permanent consensual relationship that to him/her constitutes marriage.

In non-monogamous unions one party may regard their relationship as stable and refer to the partner as husband or wife, while the other party may consider the relationship as casual and only one of many. Enumerators in fact reported one case in the field where the woman insisted that the man was her husband, while he denied this. The boundary between stable union and casual sexual relations may therefore be quite fluid and understood differently by different people.

Marriage is not always a very formal ceremony. In some cultures people will be regarded as married once the man and the woman's parents agree that they may marry in the future. In some cultures young women will go through collective initiation ceremonies that will legitimate sexual activity and child bearing without being married to a particular man because the initiation ceremony will be considered a collective marriage without husbands.[8]

c) Boyfriends

The term boyfriend is used to denote both romantic affiliations between unmarried couples as well as transactional relations where sex is exchanged for gifts or money. It may at times be difficult to distinguish between the two.

2.4.2 Methodological Limitations

a) Reactivity

We recognise that some of the responses may have been shaped by the presence of researchers. Sensitive matters pertaining to income and sexuality may have been framed to meet the assumed moral standards and norms of the researchers. Although there is no specific indication that this was the case, it is a possibility, particularly when data on sensitive, culturally and morally loaded issues is gathered.

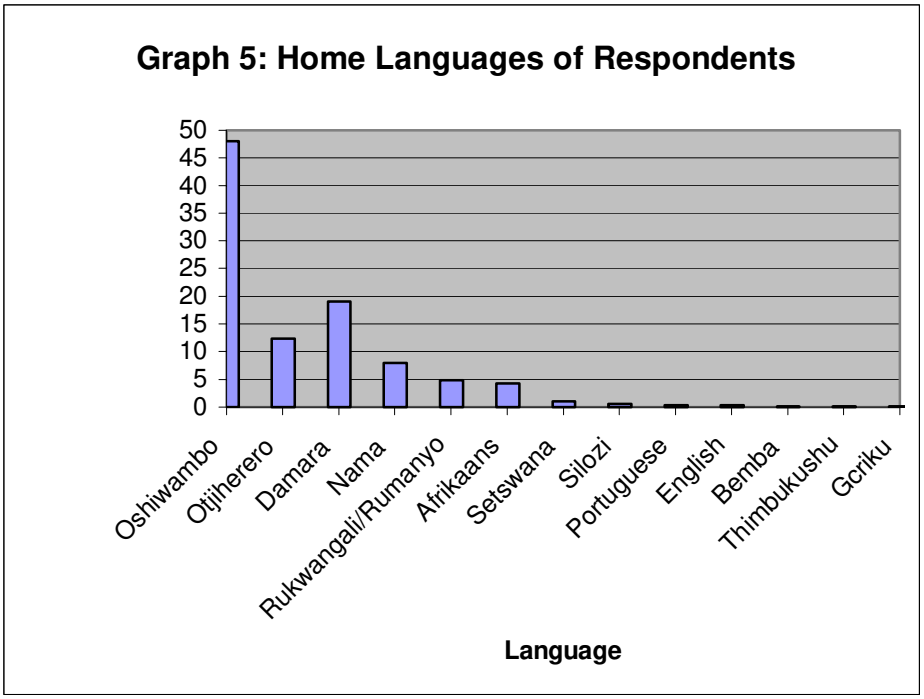
b) Missing Data

Respondents were given the choice of not answering some questions. This accounted for some of the missing data. In a few instances enumerators submitted incomplete questionnaires and field supervision was not always rigorous enough to pick it up and to rectify it. Cases of missing data were eliminated from the analysis.

[8] Becker. H. (1995) explains that in Ovambo groups this is still practiced.

c) Language

Due to the different language groups living in the informal settlements, enumerators and interviewers sometimes had to translate questions from English into other languages. We dealt with many different language groups and in instances, where people could not be interviewed in their home language, Interviews were conducted in another language, such English or Afrikaans. The responses were then translated into English for analysis. Although there was no evidence that the process distorted the data, it remains a possibility.



d) Culture of Silence

Female respondents seemed less willing to discuss sexuality and gender relations. The methodological implication of this is that it may have been better to spend more time with informants prior to the interviews in order to build relationships of trust.

3. HIV/AIDS and Population Mobility

3.1 Literature Review

3.1.1 Introduction

The first Sentinel HIV survey was conducted in 1992 amongst pregnant women in Namibia. It revealed a 4,2% HIV prevalence rate. Ten years later, the 2002 Sentinel survey results reveal a 22% overall HIV prevalence in the country. Although six of the 21 surveyed sites registered declines in HIV prevalence since the year 2000, the overall picture is one of increase. Where declines were registered they were not statistically significant. Intervening variables like migration or increased mortality may well have affected site statistics.[9] With these statistics, Namibia joins the group of high HIV prevalence countries in the SADC region like South Africa, Botswana, Swaziland and Zimbabwe, where HIV prevalence rates exceed 20%.[10]

International studies show links between HIV infection rates and lateral mobility, albeit as a result of short- or long-term migration. Mobile and displaced populations show increased vulnerability to HIV infections because:[11]

a) Displaced people are vulnerable to sexual abuse;
b) Children often become sexually active at an early age;
c) Transactional sex may become a survival strategy;
d) Lack of access to quality health services could lead to transmission through unscreened blood, poor hygiene and the use of non-sterile needles and non-sterile equipment.

The Namibian HIV/AIDS Sentinel Survey results show a correlation between population mobility and HIV prevalence. Geographic variances in prevalence rates can be explained by the population size and levels of population mobility. Regions with a bigger population size and higher levels of mobility also show a more rapid increase in infection rates.

Despite certain risky sexual practices,[12] the northern Kunene region has HIV prevalence rates way below the national average. This is a remote area with a small population and low rates of migration. The Khomas Region with a relatively large population size and high rates of inward migration has more than double the HIV prevalence rates of northern Kunene.

[9] Walvis Bay statistics show a decrease in HIV prevalence. The population is very mobile according to the availability of work in the fishing industry. It is not certain how these migration patterns may have affected survey results since we know that 2002 was a difficult year for the fishing industry.
[10] UNAIDS (2002) Report on the global HIV/AIDS pandemic
[11] Jackson, K. (2002)
[12] Talavera, P. (2002) provides an account of risky sexual practices in northern Kunene embedded in the culture, yet HIV prevalence is way below the national average.

Table 1: Sentinel Survey Results [13]

Sentinel Site	1992	1994	1996	1998	2000	2002
Katima Mulilo	14%	25%	24%	29%	33%	43%
Oshakati	4%	14%	22%	34%	28%	30%
Grootfontein		9%	-	-	-	30%
Ondanjokwe		8%	17%	21%	23%	28%
Windhoek	4%	7%	16%	23%	31%	27%
Oshikuku	-	-	-	-	21%	27%
Walvis Bay	-	-	-	29%	28%	25%
Tsumeb	-	-	-	-	-	25%
Otjiwarongo	2%	9%	-	16%	18%	25%
Uutapi	-	-	-	-	-	23%
Rundu	-	8%	8%	14%	14%	22%
Nyangana	-	6%	5%	10%	16%	22%
Andara	-	2%	11%	16%	15%	21%
Engela	-	7%	18%	17%	23%	19%
Nankudu	-	-	-	13%	18%	16%
Keetmanshoop	3%	8%	-	7%	17%	16%
Swakopmund	3%	7%	17%	15%	22%	16%
Gobabis	1%	-	-	9%	9%	13%
Mariental	-	-	-	-	10%	12%
Rehoboth	-	3%	-	-	9%	10%
Opuwo	3%	1%	4%	6%	7%	9%

Source: MoHSS: Report of the 2002 National HIV Sentinel Survey

The forms of mobility that exist/existed and that contribute towards the spread of HIV/AIDS in Namibia are:

- Economic migration
- Urbanisation
- Displacement due to civil unrest
- External migration

3.1.2 HIV/AIDS and Economic Migration

a) Contract Labour

Before the country's independence, adult males migrated to the urban areas, mines, railways and commercial farms to perform contract labour. Men would return to their rural homes during holidays or when their contracts expired. In most cases men migrated alone, due to colonial restrictions on African female migration. Due to long absences and polygamous sexual cultures migrant workers often had multiple sexual partners.

[13] Sentinel Surveys are conducted every two years to ascertain the HIV infection rates among pregnant women and STD patients. Despite some limitations this can provide an indication of the rates of infection among the general population. The report cites time frames, small sample size and sample representativeness as some of the limitations that may obscure survey results.

Wives remained in the rural areas to attend to family food production and to run rural households. Male migrants often entered into new and additional sexual relationships in the urban centres.

Although the contract labour system was abolished, there are still remnants of this form of migration that impacts on the spread of HIV and other STIs. Studies have shown positive correlations between migration, HIV prevalence and the prevalence of other STIs. In one north western region, two thirds of those who tested HIV positive had sexual relations outside the region within the previous three months. The study shows that an increase in STI prevalence coincides with male inward migration and is highest when migrant workers return over the Christmas holidays.[14]

b) Mobile Occupations

Certain occupational groups like soldiers and truck-drivers are high risk groups on account of their particular occupations that require mobility. High HIV prevalence zones exist around military bases and close to major transport routes as these forms of mobility give rise to an increase in casual and transactional sex.[15] The Namibian Minister of Defence confirmed high prevalence rates of HIV and other STIs amongst the armed forces when he launched the Military Action and Prevention Programme (MAPP) in December 2002.[16]

Border towns and areas close to major trade routes are high exposure locations. The border town of Katima Mulilo has the highest HIV prevalence in the country. It is also at the centre of cross-border trade with three neighbouring countries. This creates a high risk environment as it increases the incidence of casual and commercial sex.[17] A similar trend was observed at the border town of Oshikango which has a high incidence of prostitution and is described as a core HIV Zone. [18]

c) Urbanisation

Since Independence there has been a substantial increase in rural-urban migration,[19] which currently stands at 4%.[20] Most rural migrants who flock to the urban centres of Windhoek, Walvis Bay and Tsumeb come from the populous northern regions of the country. Many come due to a number of push and pull factors. At the core is economic displacement due to land-hunger, droughts and the desirability of urban lifestyles.[21] Most come to the urban centres in search of employment or educational opportunities. The majority of new urban migrants move into the informal settlements[22] on the outskirts of the cities and towns under conditions of extreme poverty, where key services like running water, ablution and health facilities are absent.

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[14] Winterveldt (2002) cites the statistical comparison made at Onanjokwe and Okatana Mission Hospitals.
[15] Le Beau et al (1999) conducted an anthropological assessment of health risk behaviour in northern Namibia that indicated that a labour migration contributes towards risky sexual behaviour and HIV exposure.
[16] Honourable Minister Erriki Nghimtina as quoted in New Era 13-15 December 2002.
[17] Jackson, H. (2002)
[18] Comments by a NGO worker involved in condom distribution as cited in the Namibian 18 November 2003.
[19] Frayne, B and Pendleton, W. (2003)
[20] Population and Housing Census, 2002
[21] Australian Reproductive Health Alliance (1998)
[22] Winterveldt, V. (2002)

Since Independence the increase in female migration has been facilitated by the abolition of colonial restrictions on black women's mobility.[23] Migrants are mainly younger people in the 25 to 44 age group. Although males still form the dominant category of migrants (55%), females are also migrating in large numbers (45%).[24] Given the fact that most women's labour is unpaid or underpaid, there is a need to explore female migrants' survival strategies and their implications for the spread of HIV/AIDS.

3.1.3 Displacement as a Result of Civil Unrest

Internal and external displacement as a result of civil unrest partially explains the high HIV prevalence rates in Katima Mulilo. The displacement came about as a result of a secessionist uprising at the town in August 1999. Some people then fled to neighbouring countries. The rise in HIV prevalence in the town is in part attributed to this civil unrest and the subsequent displacement[25]

3.1.4 External Migration

In addition to Namibia's internal migration, some of the northern regions also experienced long-term or lifetime external migration. Forty seven percent (47%) of people from the Kavango, Ohangwena, Omasati and Oshana regions were born outside Namibia.[26] Some of this long-term migration could be as a result of the porous colonial borders that administratively divided cultural and linguistic groups between countries. These groups still have strong family, kinship and economic ties across national borders.[27] Some still share grazing land.

During the National Liberation Struggle (1960-1990) 40,000 people, mainly from the northern regions, fled into exile. Most have since returned. There is however insufficient research to link these forms of migration to the spread of HIV in the northern parts of the country.

3.2 Results of Empirical Study: HIV and Migration

3.2.1 Geographic Migration Patterns

Results of our study confirm some of the literature reviewed. Our results confirm that most (59,6%) new migrants to Windhoek come from northern Namibia. Most of the people related their decision to migrate to structural and economic factors. Male migrants tend to form additional sexual partnerships while they leave behind a wife or girlfriend and children. Although men still form the majority of new migrants there is an increase in female migration.

[23] Ibid
[24] Frayne, B and Pendleton, W. (2003)
[25] MoHSS: Report of the 2002 National HIV Sentinel Survey
[26] Population and Housing Census 2001
[27] Frayne, B and Pendleton, W. (2003)

Regions respondents migrated from are:

- Omusati: 22,4%
- Ohangwena: 19,3%
- Otjikoto: 8,4%
- Oshana: 9,5%
- Kavango: 4,7%
- Omaheke: 6,4%
- Erongo: 5,6%
- Hardap: 3,7%
- Karas: 5%

An additional 2,2% came from outside Namibia.

3.2.2 Reasons for Migration

a) Push Factors

Only 29.3% of those who migrated still own land the rural areas, this means that many had to find alternative livelihoods. Reasons cited for leaving the rural areas were lack of jobs (32,2%); to join relatives (21,2%); lack of educational and other opportunities (25%); and poverty (11)%.

b) Pull Factors

The pull factors that attracted people to Windhoek mirrored the push factors that led them to leave the rural areas in the fist place. The most frequently cited reasons for coming to Windhoek were: to seek employment (34%); to join relatives (22,3%); educational opportunities (15%); and other opportunities (17%).

During focus group discussions, participants cited the following as reasons why women migrate to Windhoek:

- Unemployment
- Sickness/hospital
- Relatives/ husband/boyfriend/girlfriends
- School/education
- Run away from crimes
- Business/selling kapana/ traditional baskets, etc
- Politics/war/peer-pressure
- Greener pastures/transfer of jobs

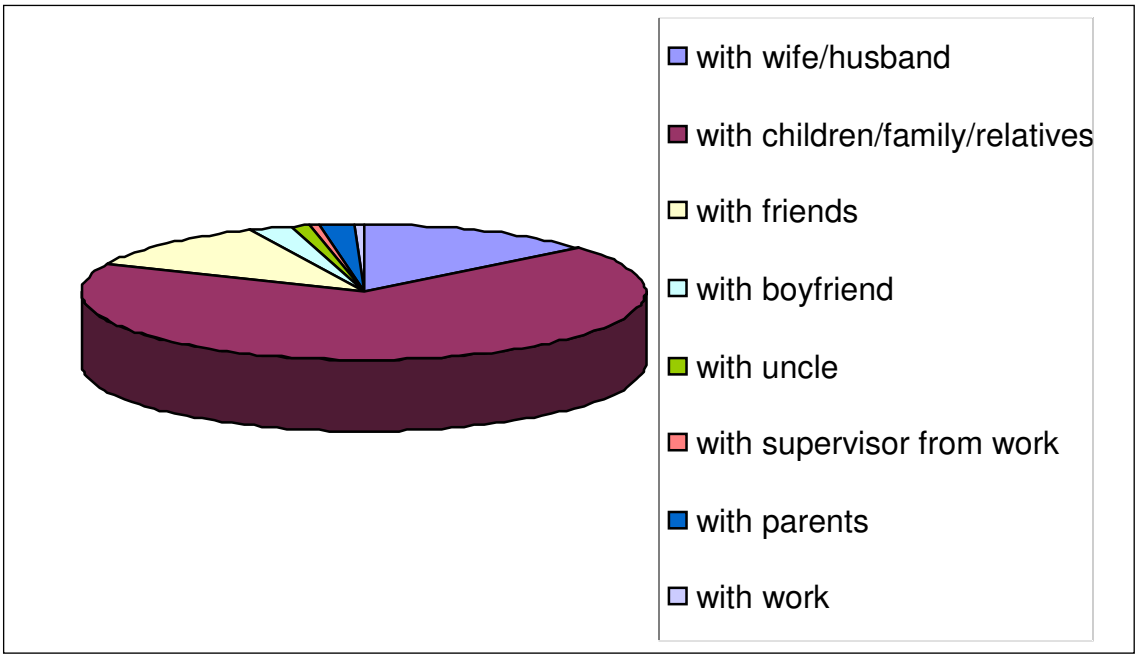
3.2.3 Type of Migration

For most respondents, it is life-time migration, as only 23,5% said that wanted to return to the rural areas and another 5% indicated that they may go back permanently. Although 96,8% indicated that they have close relatives in the rural areas only 28,6% visit their places of origin very often, 8,3% never go back on visits and 34,7 % indicated that they do not go back often.

The majority of respondents (68,9%) moved to Windhoek on their own. Only 4,3% indicated that they came to join a spouse and 21,7% came with children and other relatives.

91% of respondents were below the age of 40. The Sentinel survey results show this to be the age group where HIV infection rates are highest. Only 7% indicated that they still had spouses in the rural areas and this is consistent with the fact that most of the respondents were unmarried. Some men indicated that they left behind a girlfriend or dependent children.

Graph 6: Moved to Windhoek with Others

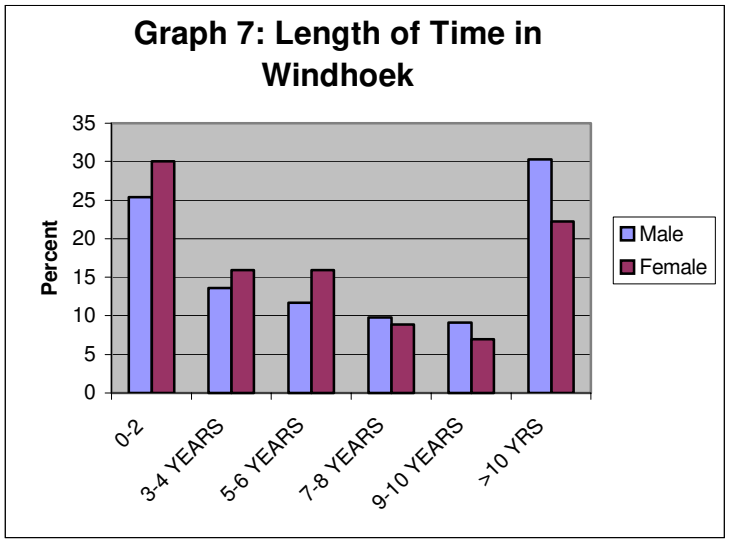


3.2.4 Length of Time in Windhoek

Most respondents were fairly new migrants to Windhoek and 55,6% have been in Windhoek for six years and below. 27,7% only arrived in the last two years.

3.2.5 Gender Aspects of Migration

An interesting result, and one that confirms findings of other studies, is that female migration has increased since Independence. A gender disaggregation of the number of years in Windhoek shows that as the years pass, more and more women are migrating and that female migration has doubled in the last two years.



Individual biographies show that the men moved to Windhoek to find work or gain access to education. Although they migrated alone they left a partner behind. Some started new sexual relationships in Windhoek increasing the size of their sexual networks.

Although some females migrate alone, once in Windhoek they join male relatives, husbands or boyfriends. Some are left on their own, either through the death of a partner or because they separated from their husbands or partners. While they were not questioned on the cause of death, there is the possibility that they are the surviving partners of people who have died of HIV/AIDS related illnesses since HIV/AIDS is the number one cause death in Namibia, particularly amongst people under 40 years.

The stories also reflect the difficulty that housing presents to new female migrants who have to move in with a relative, husband or boyfriend to secure accommodation. This could increase their dependency and vulnerability.

3.2.6 Individual Biographies

Female Migration Stories[28]

The individual biographies provide further insight into the circumstances under which women migrate.

Participant 1 came from Odimbwa, and moved to Windhoek in 1986 because of war and because she was sought by the South Africans. She was forced to separate from her husband because he was a collaborator. She lived in Ovambo-location and in 1988 moved to Shandumbala, to share a rented room with her boyfriend. Meanwhile she also got a job. In 1989 she separated from her boyfriend and moved with her eight children to Greenwell Matongo. She is very happy with her current living conditions and feels very proud because she owns a property. She is currently single because her live-in boyfriend was married and she is tired of dating married men.

Participant 2 came from Ohalushu and moved to Windhoek in 1989 with one child. The reason was to visit her husband who lived in Okuryangava – but he passed away in 1997. She was forced to move to Greenwell Matongo in 1998 because she could not afford to pay for the house. She is unemployed with four children but she is involved in a small business. She makes use of basic facilities such as water and toilets by contributing a certain amount monthly.

Participant 3 came from Oshikuku and moved to Windhoek in 1997. She visited her brother who rented a room in Wanaheda. She later moved to Greenwell Matongo with him. She got a job in 2000 and moved in with her boyfriend who passed away in 2001. Currently she works at an HIV/AIDS caring organisation. She is happy with her living conditions.

Participant 4 is 34 and was born in Ohangwena region. Her brother invited her to Windhoek in 1996 after realising that she did not have a source of income but was just cultivating the fields. She got a job in a bar but soon resigned, as the owner did not pay her. She got a boyfriend and moved in with him. She currently sells alcohol in her boyfriend's shebeen and works casually for a literacy program. They have water and toilet facilities shared among the community. She feels that more women are migrating to Windhoek since Independence as they are following their husbands who came before Independence.

Participant 5 is 29, from Omusati region and came to Windhoek in 1999. She came to her boyfriend's place as she did not like the living conditions in her village in Omusati. There she did not have access to clean water, no proper sanitation and the health facility was some distance away. She sells alcohol in a shebeen that belongs to her boyfriend. She expressed the opinion that more young women than men are migrating to Windhoek for new means of survival.

[28] Focus group discussions using mobility maps were conducted in Greenwell Matongo and Okahandja Park by Anna Erastus and Rebecca Mwaetako.

Male Migration Stories[29]

Participant 1 is 24 and comes from Oshekasheka village in Oshana Region. He came with his parents to Windhoek in the year 2000, to look for further study opportunities or alternatively, to find a job. He arrived in Okuryangava at the house of his parents – both of whom were employed in Windhoek. In their house they had water, electricity and a flushing toilet. He felt that the life in Windhoek was good and in 2001, he took a course at Rössing Foundation. He has one girlfriend in Owamboland, and another new one in Windhoek, but is not cohabiting. He has one child with his girlfriend in Owamboland who lives with her mother, and they always see each other when he goes for vacations.

Participant 2 is 26 and came from Iikokola village in Omusati Region. He came to Windhoek in 2002 looking for a job and opportunities to further his education. He came alone, and stayed with his aunt in Kilimanjaro in Katutura. They have communal water and a toilet shared within the neighbourhood but no electricity. He completed his grade 12 at TUCSIN in 2002. He is unemployed and his girlfriend is up north, in Iikokola village. He sees his girlfriend when he visits the north. He feels that the living conditions in Windhoek are still good although he is unemployed.

Participant 3 is 47 and comes from Onamukulo village in Ohangwena Region. He first came to the south of the Cordon Fence in 1976 and worked in Grootfontein and Tsumeb. In 1985 his nephew invited him to start working in Windhoek. He came to Grysblok, leaving his girlfriend up north. His living conditions were good as he was working, he had a good relationship with the house owner, and the house had running water, electricity and a flushing toilet.

But in 1989 when the house owner's girlfriend moved in, things changed and he had to move to Oshandumbala. The housing conditions were the same as before, with basic municipal services available. During this time, he had six children with six different girlfriends in the north. The "permanent" girlfriend used to visit him during holidays. Again the relationship with the house owner got ugly and he had to move to Okuryangava in 1993. In Okuryangava, they had water and a toilet shared by the whole community and no electricity. He got married to a wife from Owamboland and the wife used to visit him regularly, and he also made frequent visits to her. He was still employed and at this time he had 20 children (17 before marriage) by 19 mothers. His wife is still up north. Some of his children's mothers live in Windhoek.

Participant 4 is 28 and was born in Okahandja in Otjozondjupa Region. He moved to Windhoek alone in 1999 in search of employment. He stayed with an uncle in Babylon and visited Okahandja regularly. He is currently self-employed as a plumber. He lives with a girlfriend and has another one in Okahandja whom he visits almost three times a month and has one child with each partner. His girlfriend in Windhoek lived in Rykman's Dorp. He feels that the conditions in Windhoek are not really that good because they have no electricity, water and toilet are shared and he does not secure work often.

[29] Male migration stories were generated through focus group discussion using the mobility map exercise carried out in Babylon/Okahandja Park by Immanuel Iita and Jackson Ndapopiwa.

Participant 5 is 28 and comes from Onangwe village in Ohangwena Region. He came to Windhoek in the year 2000 and stayed with his father in Babylon, deriving income from temporary jobs. His girlfriend is up north in Onangwe village and they have one child. He feels that the living conditions are less favourable than in Ohangwena because he has been unemployed for almost two years. They share a water-point and toilet, and have no electricity in Babylon. There are eight people in their household.

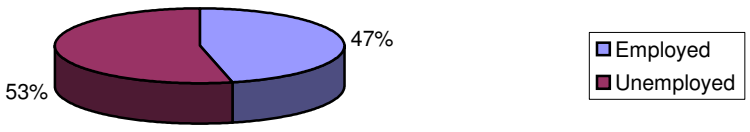
3.2.7 Social and Economic Circumstances of Migrants

We hypothesised that adverse social and economic conditions contribute towards risky sexual behaviour. It was therefore important to investigate the labour market position of migrants, their sources and levels of income and their living conditions.

a) Employment

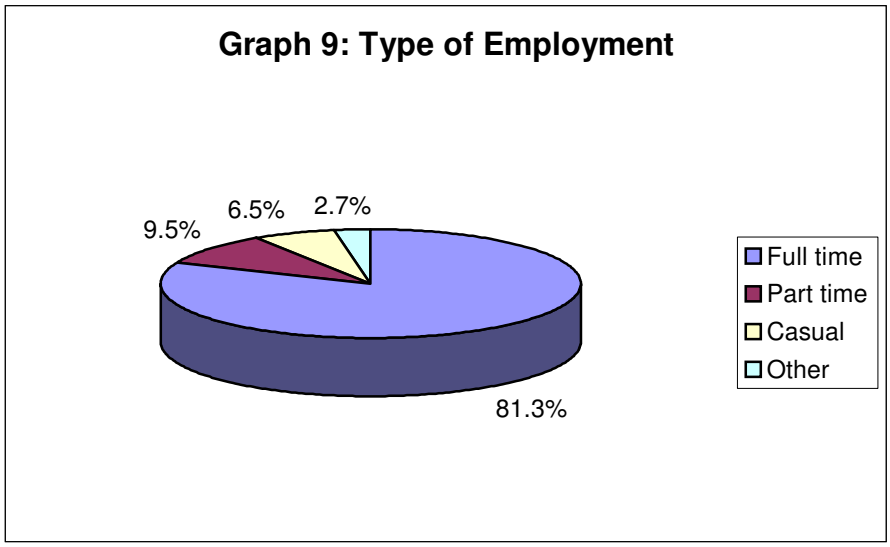
A total of 46.5% of respondents indicated that they were employed and 53,5% were unemployed. More women than men reported that they were unemployed.

Graph 8: Level of Employment



Type of Employment

Most people cited employment prospects as the reason for migrating to Windhoek, but only a minority (2,7%) actually managed to secure full time employment. 81.3% are either unemployed or generate a livelihood through self-employment. This underscores the difficulty new migrants have in obtaining employment. There is a high level of structural unemployment in the country and in addition, most migrants come to Windhoek without a school leaving certificate, which makes entry into a depressed job market very difficult.



More men than women classified themselves as permanently employed. This has income earning implications as those in full time employment are likely to generate more income and have more job security**.** Women are mostly concentrated in casual employment. Casual employment often signals low-skilled jobs that yield lower incomes.

Baseline survey results indicate that those who are employed are engaged in diverse categories of employment. Of all respondents, domestic workers formed the single largest occupational group (118). Other dominant categories were building and construction workers (93), cleaners (72), security guards (60), drivers (35), waitrons (27), taxi drivers (27), Namibian Defence Force personnel (24).

b) Housing

The housing conditions once again bear testimony to the impoverished conditions that rural migrants find themselves in. 20,6% of respondents live in brick houses but the majority live in wooden or corrugated iron shacks. Most do not have inside toilets (54%) and a further 22,7% use the bush due to a lack of ablution facilities. 97% have access to clean running water, either in the form of a private tap or communal taps set up by the Windhoek Municipality. 42,3% of households have access to electricity as a source of energy. The rest rely on firewood, candles, gas and paraffin. Men own 59,1% of all houses and women 40,9%.

4. Awareness, Knowledge, Attitudes and Behavioural Change

4.1 Literature Review

Data from Demographic and Health Surveys (DHS) in 39 countries[30] show a positive correlation between HIV/AIDS prevalence and HIV/AIDS awareness. Awareness is generally higher in countries where HIV prevalence rates are high and can reach over 90% where infection rates exceed 5%. The startling fact is that there are no automatic links between levels of awareness and sexual behaviour modification.[31] This may explain why Namibia's massive awareness campaigns have not translated into a decline in HIV infection rates.

It has been reported that over 70% of HIV infections in Africa occur through sexual transmission.[32] It is therefore necessary to open the discussion on sexuality, sexual cultures and sexual politics to understand why - despite the massive awareness raising and educational campaigns based on the ABC rule - governmental and non-governmental organisations in Namibia were not able stop or reverse the spread of HIV infections.

Fig 1: The ABC Rule[33]

A = abstinence
B = be faithful to one partner
C = use condoms or
D = face death

4.2 Results of Empirical Study: Awareness, Knowledge, Attitudes and Behavioural Change

4.2.1 Awareness

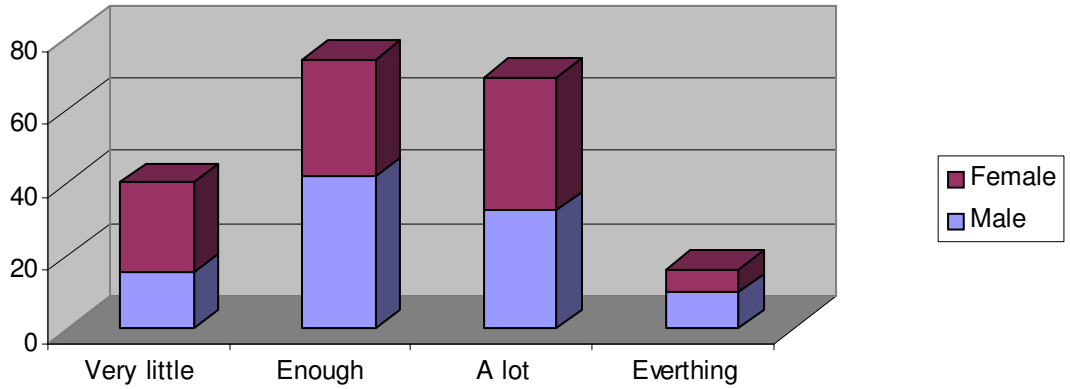
Results from our study are consistent with findings elsewhere and indicate that HIV/AIDS awareness is very high. 99.2% of respondents have heard of HIV/AIDS. When asked to assess their own levels of knowledge about HIV/AIDS, 20,3% said that they know very little, 36,8% felt that know enough, 34,7% said that they knew a lot and 8.3% felt that they knew everything. There were gender differences in how women and men assessed their knowledge about HIV/AIDS. Women consistently reported that they knew less about HIV/AIDS than men. 42,9% of all respondents said that they knew someone who is living with HIV/AIDS. Even more people (70,5%) knew of someone who had died of HIV/AIDS.

[30] United Nations (2002): Department of Economic and Social Affairs Population Division. HIV/ AIDS Awareness and Behaviour Executive Summary presented to the General Assembly on HIV/AIDS in June 2001.
[31] Ibid
[32] Jackson, H. (2002)
[33] Hangula, L. (2003)

This indicates that AIDS is no longer the faceless anonymous concept it was at the HIV stage of the pandemic. With the transition to the AIDS phase of the pandemic people are witnessing its tangible, devastating effects.

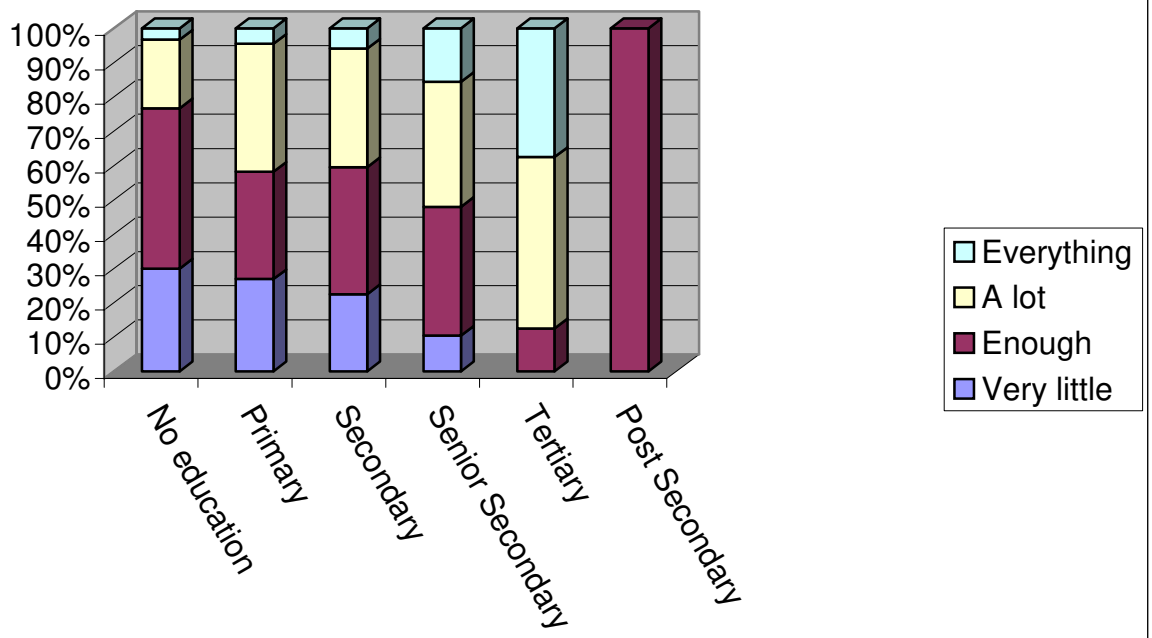
Key informant interviews revealed that HIV/AIDS information sources were diverse and manifold. They ranged from community-based organisations, elected local and regional councillors, newspapers, radio, AIDS service organisations, leaflets from health centres and churches. Informants thought that the information gave clear messages, but that people still chose to ignore these messages. Some key informants felt that the people were still not taking the information seriously enough.

Graph 10: Gender Differences in Self Reported Knowledge of HIV/AIDS



Although the relationship is not quite as linear, there is a positive correlation between level of education and level of HIV/AIDS awareness. The highest percentage of people who reported very little knowledge of HIV/AIDS came from the group with no formal education. People with higher levels education also reported higher levels of knowledge of HIV/AIDS. It remains to be seen whether level of education plays a role in behaviour change.

Graph 11: Level of Education and Knowledge of HIV/AIDS



4.2.2 Knowledge of Modes of HIV Transmission

Knowledge claims of respondents were corroborated by their knowledge of HIV transmission, prevention and care and support services. The majority (84,8%) of respondents knew that there is no cure for the disease. Only 6% felt that a doctor, nurse or traditional healer could cure AIDS.

The myth that sex with a virgin cures AIDS, reportedly widespread in other African countries, was not widely accepted in the research population as only 6,1% of respondents agreed that sex with a virgin could cure HIV/AIDS. Although the Sentinel Survey results point to the age gap between male and female HIV prevalence and male preference for younger women, there is not enough evidence to link it to the notion of virgin cure.

99,6% of respondents agreed that a HIV positive man can transmit the virus to a woman if they have unprotected sexual intercourse. Almost the same percentage (99,4%) agreed that a HIV positive woman can transmit the virus to a man during unprotected sexual intercourse. 28,6% of respondents felt that they could identify someone who has HIV/AIDS and 71,3% felt that they could not.

Despite the high level of knowledge, focus group discussions pointed to areas of ignorance and misinformation. There are still some people who believe that sharing toilets, crockery and cutlery could lead to HIV transmission. It also came to the fore that there is still a belief that HIV/AIDS came about as a result of witchcraft.

There are also some myths about HIV transmission. This includes beliefs that HIV/AIDS can be transmitted by:

- Having sex with women who had miscarriages
- Using public toilets
- Being bitten by mosquitoes
- Having sex with women who had abortions
- Masturbation
- Bestiality

4.2.3 Knowledge of HIV/AIDS Prevention

Respondents were very aware of how one could protect oneself against HIV/AIDS infection. 91% agreed that HIV infection can be prevented by using a condom. When asked what preventative measures they would recommend, 64% said the use of condoms. 19,6% said to be faithful to one partner and 13,4% recommended abstinence. Only 7% said that they did not know what to do. People were also very aware of other forms of transmission and prevention such as avoiding contact with contaminated blood and other body fluids.

Despite the high level of knowledge and awareness there are also some myths about HIV/AIDS transmission. One rather disconcerting response that came from 7,9 % of respondents is the perception that HIV/AIDS transmission can be prevented if one avoids taking care of someone with AIDS. This of course has implications for stigmatisation as well as care and support programmes, particularly home-based care and community-based support programmes, for HIV infected persons. Focus group discussions revealed a high level of stigmatisation which people fear almost more than the disease itself.

We were further interested in how knowledge and awareness translates into behavioural change.

4.2.4 Attitudes and Sexual Behaviour

One of the key research questions was why, despite high levels of knowledge and awareness, people still engage in risky sexual practices. There are indications from survey questionnaire results that people are responding to the messages, but not in sufficient numbers to stop and reverse the spread of HIV. Both focus group participants and key informants were of the opinion that people do not use the knowledge to change behaviour. The reasons cited for this were:

- Some traditional beliefs make it impossible to take the information seriously;
- Some were careless and fatalistic and believed that if they were to die of HIV/AIDS it would be their fate as it is preordained;
- People did not internalise the information to change behaviour;
- Carelessness as a result of alcohol abuse;
- Some believe that HIV/AIDS came about as a result of witchcraft and prostitution; and
- Some people do not understand the information.

One key informant captured this disjuncture between awareness and the lack of prevention measures as follows:

> *"Usually people tend to fear when they suspect they have been infected when they lose weight or when their partner is sick or has died. However I fail to understand why people never fear contracting HIV during sex.'*
>
> Male Key Informant from Greenwell Matongo

5. HIV Prevalence

5.1 HIV/AIDS Prevalence and Age

5.1.1 Literature Review

The 2002 Sentinel Survey shows increased infections rates in all but one age category. Worst affected groups are those between the ages of 25-29 (28%) and between the ages of 30-34 (27%). HIV infection rates are higher in younger women and older men. In 1999 the mean age for HIV positive women was 30 years and for HIV positive men 35 years.[34] The 2002 Sentinel Survey results show a decline in the mean age of HIV positive people to 27 years. This is cause for concern because over the last ten years AIDS education has targeted young people. These age groups form the most economically active part of the population and their infections will have severe impact at household and societal levels. They are also the most likely groups to migrate internally in search of better opportunities in urban areas, which is likely to extend the scope of their sexual networks.

Table 2: HIV Prevalence by Age

Age Group	1994	1996	1998	2000	2002
15-19	6%	11%	12%	12%	11%
20-24	11%	18%	20%	20%	22%
25-29	9%	17%	22%	25%	28%
30-34	9%	18%	19%	21%	27%
35-39	3%	8%	12%	15%	21%
40-44	1%	12%	14%	9%	16%
45+	12%	1%	13%	8%	12%

Source: MoHSS: Report of the 2002 National HIV Sentinel Survey

Current statistics suggest early engagement in sexual activity with teenage fertility contributing 10% to total fertility rates in the country. In addition 45,4% of women have had their first pregnancy by the age of 19.[35] The early onset of sexual activity is corroborated by a 2000 study in which 70% of the 1 200 respondents had their first sexual encounter before the age of 19.[36] Out of the total sample that consisted of persons between the ages of 18-32 only nine people said that they never had sex. The study further found that access to more information did not necessarily decrease risky behaviour as those in the higher educated groups with more access to information were at the same risk as less educated individuals.

[34] UNDP Namibia: Human Development Report 2000/2001
[35] Mustafa, K (2002)
[36] Van Zyl, D. and Spilker, D. (2000)

Despite the messages of abstinence, the study further revealed that youth model sexual behaviour within the established and socially accepted non-monogamous sexual cultures. In certain risk groups males reported an average of 4.58 sexual partners a year, while females reported an average of 3.49 sexual partners a year. [37]

As the pandemic spreads there is a tendency for men to choose younger women as sexual partners. This is to reduce the chances of infection as it is assumed that younger women are sexually less experienced.[38] This, combined with poverty, gives rise to the phenomenon of sugar daddies, whereby men have sexual relations with young girls in exchange for cash or gifts.[39] This is corroborated by the age differentials of HIV prevalence between men and women.[40]

The sugar daddy phenomenon should also be placed in the context of a social change from subsistence to a monetised economy with changing values. Since Independence, values associated with western consumerism have taken hold in Namibia. These values are epitomised by the three Cs: Cash, Cellular phones and Cars.[41] Sugar daddies provide some avenue of gaining access to the symbols of western urban lifestyles.

HIV/AIDS campaigns have targeted young people with messages of abstinence and delay in the onset of sexual activity in the belief that young people have the greatest capacity to alter behaviour. Factors like poverty, youth unemployment, lack of education and training opportunities, widespread alcohol abuse all contribute towards risky behaviour.[42] Youth unemployment stands at 67% in the 15-19 age band and at 59% in the[43] 20-24 age band. The link between unemployment and poverty increases the propensity for transactional sex as a survival strategy amongst young people.

There are two basic approaches with regard to youth and risky behaviour. One is a more open and empowering approach that seeks to equip young people with enough knowledge and life skills long before they engage in sexual activity. This is done to assist them in making informed decisions and to negotiate safer sex. [44] The second approach is more conservative and creates religious and cultural taboos that discourage sexual relations outside marriage.[45] In Namibia we have seen a mixture of these approaches. The religious and cultural taboos around sexuality are juxtaposed against government and NGO programmes that encourage openness. This could create mixed signals that send confusing messages to young people. It also reflects the clashes between traditionalism and modernity that a society in transition is confronted with.

5.1.2 Results of the Empirical Study: HIV/AIDS Prevalence and Age

Campaigns advocate that youth delay sexual activity to avoid early HIV exposure. We therefore wanted to ascertain the age structure of those who are sexually active.

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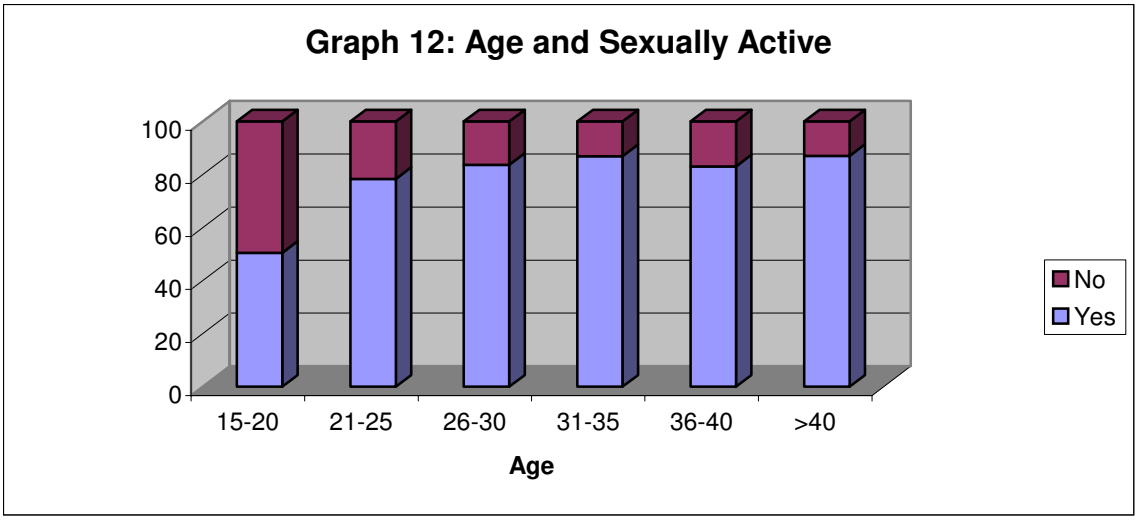
[37] Ibid
[38] United Nations Secretariat (2002) HIV/AIDS and Fertility in Sub-Saharan Africa: Review of the Research Literature
[39] Le Beau, D. (1999) et al
[40] MoHSS: Report of the 2002 National HIV Sentinel Survey
[41] Nelao Martin, a schoolgirl who revealed her HIV positive status which she attributed to the sugar daddy phenomena as cited in The Namibian of 25/08/03
[42] Mufune, P. (2002)
[43] Jauch, H. (2003)
[44] Jackson, H. (2002)
[45] Ibid

Our survey results confirm the findings of other studies that indicate that most people become sexually active in their teenage years (15-20). 50,5% in the 15-20, age group indicated that they are currently sexually active.



5.2 HIV/AIDS and Gender Inequality

5.2.1 Literature Review

International studies indicate that 55% of HIV positive people in Sub-Saharan Africa are women.[46] Likewise 1999 statistics for Namibia showed that women accounted for 54% of all new infections.[47] The 2002 Sentinel Survey results indicate HIV prevalence is consistently higher amongst older males and women below the age of thirty.[48]

Namibian society is constitutionally bound to gender equality. Since Independence a number of policies and laws were adopted that grant women certain rights[49]. However this did not alter women's subordinate status at structural level. There is a strong interplay between the structural inequalities between men and women and women's increased vulnerability to HIV infection.

The Christian morality of monogamous marriage is central to the 'be faithful' aspect of the of the ABC rule. In a number of countries in Africa this constitutes less than half of all sexual unions. Most sexual relations occur in the context of the polygamous family[50] and most Namibian cultures practised some form of polygamy. Only through Christianisation did monogamy present itself as a sexual norm.

[46] UNFPA (2001)
[47] UNDP Namibia: Human Development Report 200/1
[48] MoHSS : Report of the 2002 National HIV Sentinel Survey
[49] National Gender Policy and Programme, Married Persons Equality Act, Affirmative Action Act, Combating of Rape Act, Domestic Violence Act, Ratification of CEDAW
[50] United Nations (2002) HIV/AIDS Awareness and Behavior

Polygamy has been an integral part of traditional social organisation and traditional sexual cultures. It also had important social and economic functions in the traditional pastoralist and subsistence economies. Men could control the labour of their wives and children.[51] This contributed towards men's material wealth and social status. Multi-sexual partnerships in the form of the polygamous marriage was therefore male initiated and socially acceptable.

In most Namibian societies women traditionally only had access to the means of production, i.e. land or cattle, through men. Some anthropological research points to differences in the degree of women's access and control over productive resources in different ethnic groups. This however does not alter the fact that men were the main owners of the means of production and this created the structural inequalities that made women dependent on men.[52] This legacy is still with us. Women's lack of ownership and control over productive assets allowed men to control women's fertility and their labour.[53] In most societies only the male head of a polygamous family could acquire land from the chief. He then allocated land use to his wives. In many of the subsistence farming communities, female access to productive land is still predicated upon her relationship with a male relative, particularly the husband. Land reform programmes have so far not touched customary land tenure patterns, which would be one way of redressing structural imbalances.

Despite its inequality and oppressiveness, the polygamous marriage did give women access to - although not ownership of - the primary means of production namely, land. Shifts in economic organisation and the introduction of wage labour and the monetized economy has led to social displacement. Statistics suggest declines in formal marital unions. This means that fewer rural women can gain access to land and therefore access to livelihoods that are based on land use.

The decline in formal polygamous marriages does not mean an end to polygamous sexual cultures. New urban classes are forming as a result of economic shifts. The figures seem to indicate a trend towards one formal marriage. This however does not preclude multiple non-monogamous sexual relations outside of formal unions. Formal marital unions were traditional alliances between family groups and carried with them certain obligations which the non-formal, stable or casual union does not have. Although wives in polygamous unions had powers and responsibilities in accordance with their seniority, they were provided with a means of sustaining themselves and their children through their access to land, which women in non-formal unions do not have.

Women without access to land are left economically displaced. They may migrate to urban centres or rural towns. Given the high unemployment rates in the non-subsistence economy, some may opt for transactional and multiple sexual relations to sustain themselves. Although classic prostitution, where the person negotiates money from strangers for sex, exists, it is not the most common form of transactional sex in Namibia. The exchange of sex for gifts and cash from boyfriends or sugar daddies is far more common. [54]

[51] Becker, H. (1995)
[52] United Nations (2002) HIV/AIDS Awareness and Behavior
[53] Becker, H. (1995)
[54] Ipinge, E. and Le Beau, D. (1997) Beyond Inequalities: Women in Namibia

Single economically displaced women often enter into serial monogamous relationships as a means of economic survival. [55] A study of such relationships in Ohangwena showed that women will repeatedly enter relationships that have no formal status. Instead of paying a bride price to the woman's kin as would have been case in a formal/traditional marriage, the man undertakes to support the woman financially during their union. Often the woman will have children with the man, who later abandons her to raise the children alone. The cycle can be repeated a number of times as each time the relationship ends the woman has to seek the patronage of another male. [56] Some women will have more than one relationship at the same time to improve their financial position.[57] [58] The ephemeral nature of sexual unions outside marriage forces some women into multiple sexual relationships since they do not have the relative economic stability and access to productive resources that those in traditional polygamous marriages have.

The structural nature of women's inequality only comes into focus when one considers the lack of possibilities women have to attain independent livelihoods. Despite the relatively low marriage rates the National Population and Housing Census (2001) statistics classify 43,1% of the economically inactive population as homemakers. In absolute numbers it amounts to a total of 186 644 people, which is in fact more than the number of unemployed persons in the country (185 258). Out of this 70% are women. [59] Given the absence of a social security net, this means that a large group of women are not employed on their own account, but depend on others for their livelihoods.

Female labour market participation rates are lower than that of males (11% differential) and the total female unemployment rate currently stands at 35,9%.[60] Women in formal employment often occupy positions at the bottom of the labour hierarchy in low skill, low income jobs.

Although female rural subsistence farmers are classified as own-account workers, their labour mainly ensures household food supply and does not provide them with cash income. The need for cash becomes more pertinent in an increasingly monetized economy. Female subsistence farmers traditionally relied on male remittances from the modern wage labour sector for cash income.

Women's unequal status and their dependency constrain their sexual autonomy and ability to negotiate safe sex. Due to the particular way in which economic and cultural factors intersect, women even accept that their partners could enter into other stable or casual sexual relations with other women.

Social and economic changes add to the complex structure of society as new classes begin to form. The new social groups that are coming into being are urban wage workers, informal sector traders, working and non-working poor and urban elites who by virtue of their privileged positions in politics, the administrative system or business have attained considerable income.

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[55] Tersbol, B. (2002)
[56] Ibid
[57] Ibid
[58] There are anecdotal accounts of entire locations consisting of single women who survive in this away like the women of Choto near Katima Muililo.
[59] Population and Housing Census 2001
[60] Population and Housing Census 2001

High income males from privileged positions often become the sugar daddies to young girls and the partners of women in transactional sexual relationships.

Multiple sexual partnerships are gendered. There are different factors that result in male and female promiscuity. Past studies have linked HIV/AIDS to male sexual promiscuity,[61] but with economic displacement women are increasingly forced into multiple sexual relationships as a means of securing livelihoods. This increases the rate of change in sexual partnerships and size of sexual networks. Together it forms a lethal mixture of multiple sexual partnerships responsible for the rapid spread of the disease.

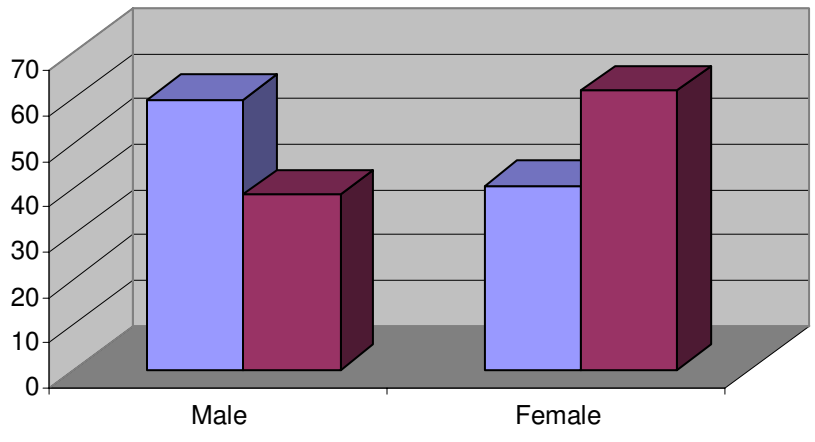
5.2.2 Results of Empirical Study: HIV/AIDS and Gender Inequalities

The results of our empirical research confirm the structural basis of gender inequality and marginalisation women face. The inequalities are manifested in unequal access to productive assets, smaller labour market participation rates, women's concentration in at the bottom end of the labour hierarchy and lower levels of income.

Labour Market Participation Rates

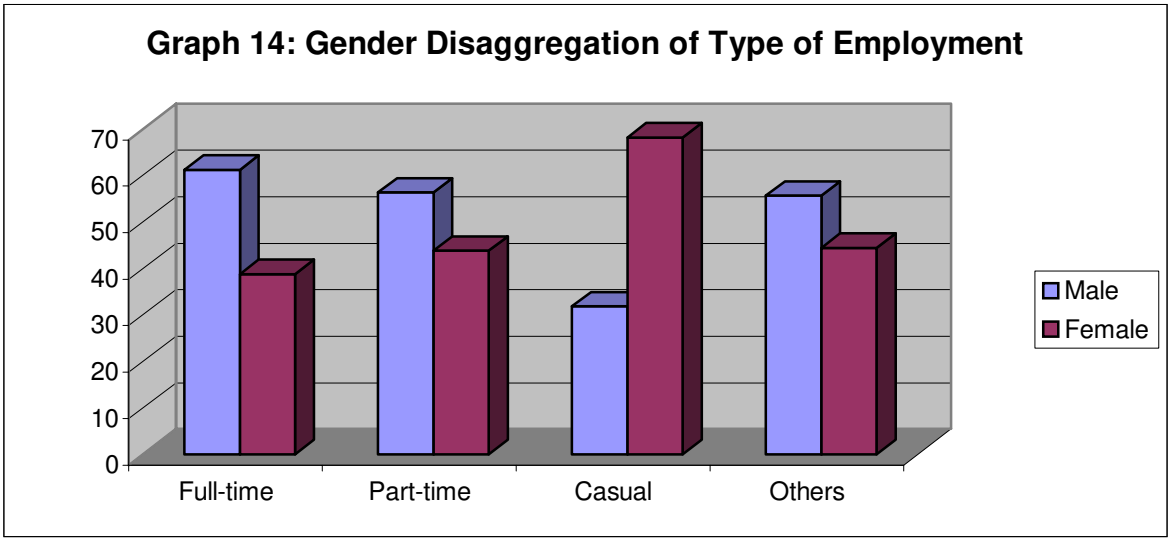
The results show 61,4% unemployment amongst women in the research population. This unemployment rate is much higher than unemployment in the general population which depending on the source is set at between 19% and 34,5%.[62] In addition women are more likely to be in casual employment. This implies less job security, no benefits and often lower incomes.

Graph 13: Gender Disaggregation of the Employed



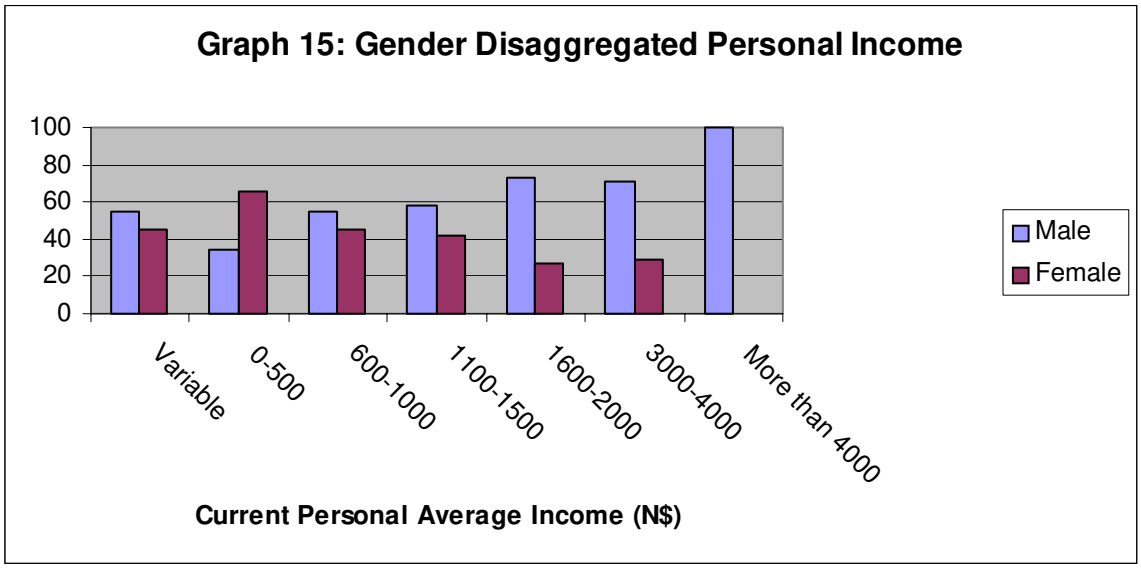
[61] Le Beau, D. et al (1999)

[62] Population and Housing Census of 2001 sets the unemployment rate at 19% but the Labour Force Survey 1997-2000 sets it at 34.5%.



Income

Average household income or respondents was N$ 766.83 per month. There is a gender gap in the income of males compared to the income of females.



66,1% of all women reported a monthly income of below N$ 500 a month. The results also show an inverse relationship between gender and level of income. As incomes increased, the number of women in higher income categories decreased. Not a single woman reported a personal income of N$ 4,000 or more per month.

Sources of Household Income

Besides wages and salaries, respondents were asked to indicate other sources of income in order to establish how income is generated outside formal employment. The majority (34%) reported no other sources of income. Of those who indicated that they did have other sources of income, 31,6% of all female respondents cited boyfriends as another source of income besides wages and salaries. This is the biggest source of other income.

Focus group discussions indicated that shebeens are perceived as big business. This of course makes the reported links between alcohol abuse and the spread of HIV/ AIDS more pertinent. It also refocuses attention on the interplay between securing livelihoods and HIV/AIDS. The sale of traditional food and fruit also provided some people with a form of income.

Focus group discussions revealed that men generally have more skills they could use to generate income like plumbing, electrical repairs and maintenance work. The gender disaggregation of schooling indicates that up to junior secondary level more women have had access to education than men. In the senior secondary and tertiary phases the gender gap reverses in favour of men who then show higher levels of educational attainment. Since most of the respondents did not complete senior secondary education, the level of education alone cannot account for the gender differentials in employment and income. This indicates a high level of sexual discrimination in the job market.

Income and expenditure matrices constructed by men and women reflect slightly different sources of income than those reported in the baseline survey. Where the baseline survey showed that domestic work in private homes is an important source of income to women who have either casual or full-time jobs, this was not reflected in the matrices that women in focus groups constructed. This can be explained by the fact that such a small percentage of people surveyed had jobs and that the many unemployed had to rely on sources other than wages and salaries for a livelihood. Income and expenditure matrices constructed during focus group discussions revealed the following:

Top three sources income for women:

1. Self Employment/ Business (mainly through the sale of food i.e. kapana)
2. Husbands, boyfriends and relatives
3. Remittances

Top three sources of income for men:

1. Self Employment/Business
2. Wages from casual employment
3. Remittances

Income and expenditure matrices confirm women's dependency on male remittances as illustrated by the income and expenditure matrix below.

Results From one Focus Group Discussion
A focus group comprising seven women was conducted. Participants were given 50 stones each representing their total income and 50 representing their total expenditure. They divided these stones according to their income and expenditure. The following emerged as sources of income.

Table 3: Sources of Income

Sources of Income	How informants rated their source of income						
	No 1	*No 2*	*No 3*	*No 4*	*No 5*	*No 6*	*No 7*
Selling "Kapana" meat)	3	3	6	15	5	0	4
Selling products (Golden)	6	2	6	2	5	18	0
Sowing	1	2	3	0	5	0	10
Selling meal drink (oshikundu) and fruits	4	12	7	7	5	10	16
Selling liquor	9	10	5	7	0	5	9
Selling dried spinach from the northern part of Namibia	1	9	6	2	0	7	0
Selling candles, wood and paraffin	6	8	11	0	15	0	0
Teaching literacy classes	5	0	0	0	0	0	0
Kindergarten	3	0	0	0	0	0	0
Support from boyfriends	11	4	4	17	15	10	10
Support from other sexual partners	1	0	2	0	0	0	1

Expenditure
Analysis of male expenditure patterns reveals that men still send remittances to the rural areas. Parents are the main recipients of these remittances. All men who developed the income and expenditure matrices made provision for allowances to wives and girlfriends. All male focus group participants reported precautionary savings to make made provision for possible funeral expenses.

Top five items on men's expenditure lists:
1. Money to wives and girlfriends
2. School fees
3. Drinks and entertainment
4. Food
5. Money to relatives

The top five items on women's expenditure lists:
1. Food
2. School fees
3. Water and energy
4. Hospital and medical
5. Clothing

The differences in expenditure patterns mirror the gendered division of labour. Women are chiefly responsible for the needs of the household such as securing food, energy and clothing.

It also reflects their role in caring for the welfare of the sick. The figures also emphasise men's role as providers, since the highest portion of male income goes to wives and girlfriends. This is consistent with women's reported sources of other income.

The baseline survey showed that only a small percentage of respondents were either married or cohabiting, which means that women who do receive income from men mainly get it from their boyfriends. It is difficult to determine if the boyfriend – girlfriend relationship is of a romantic or transactional nature. Focus group participants reported rather complex and diverse sets of relationships. Some women were initially reluctant to reveal the nature of their relationships with men. Upon further probing, some said that they were single, but had children from men with whom they were in different types of relationships. Some would see their partners twice a month, some of the partners would stay with them a few days a week and then return to their primary residences. Some only visited occasionally and without any regularity. At this point is not possible to ascertain if these diverse types of relationships take place in the context of multiple sexual partnering and broader sexual networks, but empirical evidence presented later points to the high prevalence of non-monogamous relationships. This means that the possibility of broader sexual networks cannot be excluded.

6. HIV/AIDS and Patriarchal Sexual Cultures

The HIV/AIDS campaigns in Namibia are based on prevention through behaviour modification. The question is how prevention campaigns can become more effective given the existing sexual cultures and structural conditions that encourage risky sexual behaviour. The evidence shows that some prevention campaign messages do not relate to existing sexual cultures and that these messages are largely ignored.

The three pillars of prevention have been abstinence, monogamy (be faithful) and condom use. We therefore wanted to ascertain the extent to which these pillars of behaviour modification conform to the prevailing sexual cultures and practices within the research population.

6.1 Abstinence

AIDS campaigns promote abstinence, particularly in young people, who are asked to delay sexual activity. However, sexuality is central to the construction of gender identities. Manhood is often associated with virility and sexual conquest. Despite this, people are bombarded with messages of abstinence. It is hardly possible to open a newspaper, listen to a radio programme or watch a news bulletin without encountering the word abstinence in relation to HIV prevention.

6.1.1 Results of Empirical Study: Abstinence

At a cognitive level people tend to see the advantages of abstinence in relation to HIV/AIDS prevention. They however find it difficult if not impossible to practice.

During key informant interviews and focus group discussions, participants agreed that abstinence would be the most effective way of preventing HIV/AIDS spread, but thought that it was unrealistic in practice because:

Men's Responses:

- There is peer pressure on men. Men who abstain from sex would be regarded as abnormal by their peers.
- There is a perception that it is not natural or healthy to abstain from sex.
- Abstinence is only practical for those who studied and believe in the Bible.
- Women are financially dependent on their partners and can therefore not refuse sex, even unprotected sex.

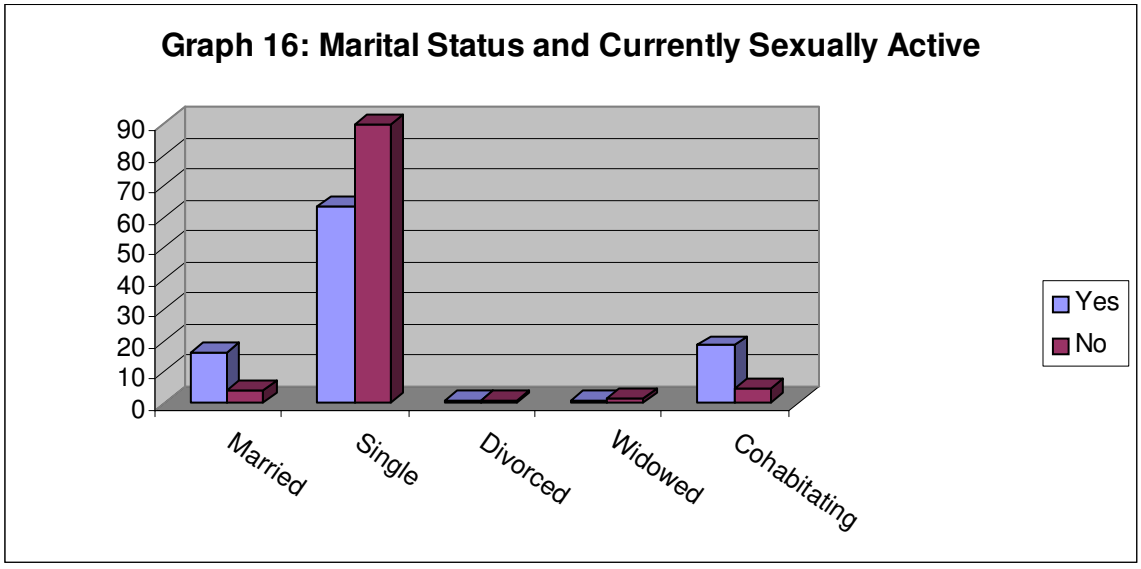
Women's Responses:

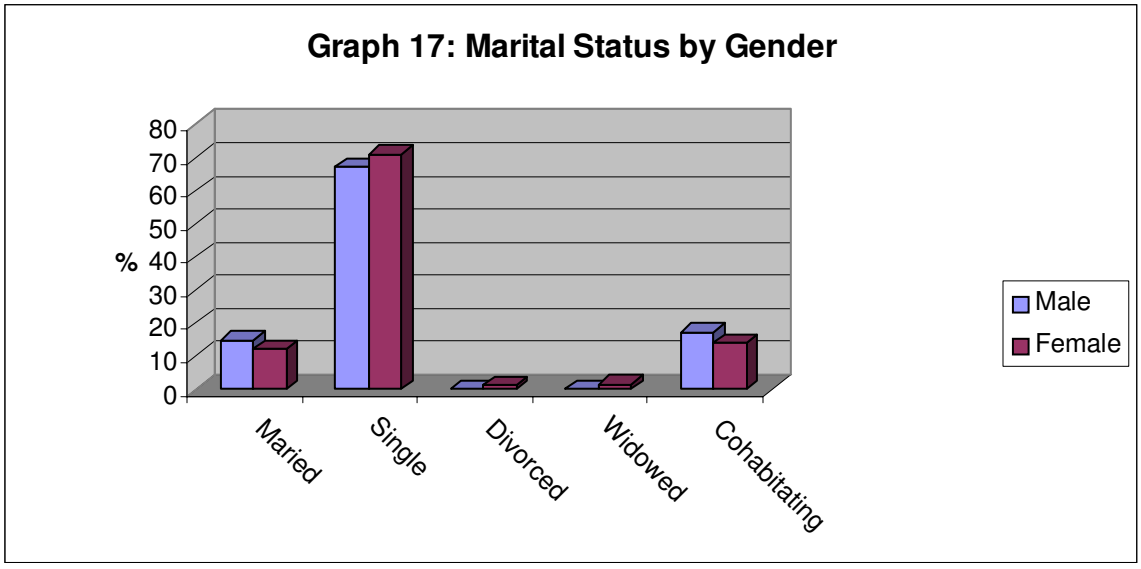
- Abstinence is perceived as a crazy way of living.
- Women will abstain when they become aware of their status, but men won't. Men continue with their normal lifestyle despite infecting others.
- It is considered a good option when one is no longer sexually active.
- Abstinence is a good thing, but people's minds are occupied with a high desire for sex.
- One cannot say abstinence across the age groups: should the elders, married people, couples or youth abstain?
- To some sex is a means of survival, they therefore cannot abstain.

The responses indicate that people see sex as natural, and therefore abstinence is seen as unnatural. It also points to a socio-cultural construction of sexuality and the societal pressure, particularly on men, to prove manhood by being sexually active. It also points to the economic factors of basic survival that force people - particularly women - into sexual relations.

Our prevention campaigns target people who are not in stable unions with messages of abstinence. Our results show most sexual relationships occur outside stable unions. 92% of all respondents said that they have had sex while 77,8% reported that they are currently sexually active. Gender disaggregation of those who are currently sexually active show that 80,8% of all men and 74,8% of all women reported that they were currently sexually active. If stable unions could be defined as marriage or cohabitation then the minority of sexual relationships occur inside stable unions. In fact over 70% of those who are sexually active are not in a stable union.

Graph 16: Marital Status and Currently Sexually Active





Only 13,4% of all respondents reported that they are married and a further 15,5% indicated that they cohabiting with a partner. Although only 13,4 % recommended abstinence as a means of HIV/AIDS prevention, the notion of abstinence before marriage is not widely practised within the research population.

6.2 Sexual Violence and Coercion

6.2.1 Literature Review

Gender-based violence is widespread in Namibia. Violence and coercion denies women any choice in sexual decision-making particularly with regard to abstinence. There is a correlation between low HIV prevalence and greater female sexual autonomy since greater autonomy allows women to refuse sex or to negotiate safe sex. [63]

As a gendered phenomenon, sexual violence reflects the pre-existing social, cultural and economic inequalities and unequal power relationships between men and women.[64] Common forms of gender-based violence are domestic violence, rape and femicide.[65] It is reported that a rape occurs every sixty minutes and that victims range between the ages of six months and eighty five years.[66] Other forms of sexual coercion are marital rape and date rape[67]. The latter is sometimes a prelude to gang rape.[68]

[63] Ipinge, S. (2003)
[64] Gordon, P and Crehan, K. (1999)
[65] Ipinge, E. and Le Beau, D. (1997)
[66] Namibian Attorney General Iivula-Ithana's speech to parliament on 11 November 2003 as cited in Namibian 12 November 2003.
[67] A study by Le Beau and Mufune (2000) as cited in UNDP (2000/1) shows the seriousness of data rape and how boys believe they have the right to force girls into sex even on the first date.
[68] Date rape and gang rape are under-researched topics, but anecdotal evidence suggests that it happens mainly to young girls whose date would arrange with his friends to rape the girl once he has had sex with her. In some parts of the country this is called a tournament and in other parts it is called convoy.

A study on domestic violence in Windhoek confirms that 36% of women experienced some form of physical or sexual violence, often from their partners.[69] The study further reported that young girls are particularly vulnerable, as 40% of girls between the ages of 15-19 experienced some form of physical or sexual violence.

Contributing factors to gender based violence are:

- Culture of violence stemming from Namibia's repressive colonial history.[70]
- Traditional patriarchal cultures that sanction the use of violence to exert effective male control over wives and children. [71]
- Economic inequalities between men and women
- Alcohol abuse
- Poverty and unemployment[72]
- Media representations of women and violence [73]

6.2.2 Results of Empirical Study: Sexual Violence and Coercion

The notion of abstinence implies choice and the autonomy to choose to have sex or not. Numerous studies point to a high degree of gender-based violence in Namibia and that sexual coercion impedes the choices women and children have with regard to their sexuality. In this study we were interested in probing rape and gang rape because we had anecdotal accounts of date rape as a prelude gang rape. We wanted to test if this is in fact widespread and if people were aware of the practice. Responses constituted a mixture of acknowledgement and denial.

Men's Responses:

- Men talk about tournaments on the radio, but it is not an acceptable practice.
- Men never talk about gang rape; it is not an acceptable practice.
- Men talk about tournaments; it used to be practiced in their rural areas where they came from and was never done in public because it was regarded as unacceptable.
- Men talk about tournaments, some still practice it, but it is not an acceptable sexual practice.

Women's Responses:

- Men do not talk openly about rape because it is a shameful thing to rape a person when women are freely available. Still many young men are involved in rape.
- There are girls who support the gangsters and end up having sex with all the boys, it is unacceptable.
- Young women provoke men in their way of dress.
- We do not really know about it, but it is taking place in this area.
- We do not know about it, but women at times do have different partners.

[69] Namibian 3:12:2003 cites a multi-country study by the World Health Organisation
[70] UNPD : Namibia : Human Development Country Report 2000/1
[71] Ipinge, E. and Le Beau, D. (1997)
[72] Ibid
[73] UNDP: Namibia: Human Development Report 2000/1

Although people have heard of the practice it is not acceptable. We could not ascertain how widespread it is. It is however interesting to note that in the opinion of female respondents women provoke rape by the way they dress. Women are also more reluctant to acknowledge the existence of the gang-rape phenomenon than men are.

6.3 Polygamous Sexual Cultures

6.3.1 Literature Review

Only 29% of the adult population are currently in formal marriages. Of these only 19% have marriage certificates. A further 7% consider themselves to be in a stable consensual relationship without having gone through a legal or traditional marriage. 56% of adults have never been married.[74] This represents a decrease in the number of people who are married compared to the 1991 Population Census statistics where 30% of the adult population were legally married, 12% considered themselves consensually married and 50% were never married.

The "be faithful" aspects of the ABC rule refers to the practise of monogamy. The existing sexual cultures in Namibia place great doubt on whether monogamy is a majority sexual experience or whether it is a minority experience that has been elevated to a norm through HIV/AIDS campaign messages.

There are still cultural practices that promote multiple sexual relations and increase the risk of HIV/AIDS exposure, such as:

Polygamy

Some traditions do not recognise adultery as offensive towards women. It is for this reason that adultery has historically been something that only happens to men. When one man had sexual relations with the wife of another man, then adultery was committed against the male spouse of the woman involved in the adulterous affair and not against the female spouse(s) of the man who had the adulterous affair. [75] This places the notion of being faithful in a very particular cultural and historical context.

HIV/AIDS campaigns from religious and secular sources recommend abstinence and monogamy as part of the prevention regime. These may be options for people in casual or non-permanent relationships, but would be difficult for women in stable unions that are equally at risk because of polygamous sexual cultures. Despite their own monogamy, women in stable unions are not safer than single unmarried women because of male promiscuity. A SADC study revealed that HIV infection rates are six times higher among married women than among single women.[76] Anecdotal evidence suggests a high level of anxiety among married women who fear the inevitability of HIV infection because of male promiscuity and their own feelings of powerlessness to protect themselves. [77]

[74] Population and Housing Census 2001
[75] Becker, H. (1995)
[76] Tibiyane (2003) as cited in The Namibian 9 December 2003
[77] This was revealed in a discussion with a HIV/AIDS trainer who was training senior nursing staff from MoHSS. They were fully aware of the dangers of HIV, but felt that they were not able to protect themselves.

Wife/husband Lending

Although in decline there are still certain practices like wife lending and husband lending. The practice of okujepisa or oupanga makes it socially acceptable for a husband to lend his wife to a male friend or person of high social status to strengthen the male friendship.[78] The reverse is also acceptable when a wife invites her husband to sleep with her female guest.[79]

Wife Inheritance

Some cultures still practice wife inheritance, where the brother will inherit the wife of a deceased brother. This, of course, holds a danger if the brother died of HIV/AIDS related diseases.[80]

6.3.2 Results of Empirical Study: Polygamous Cultures

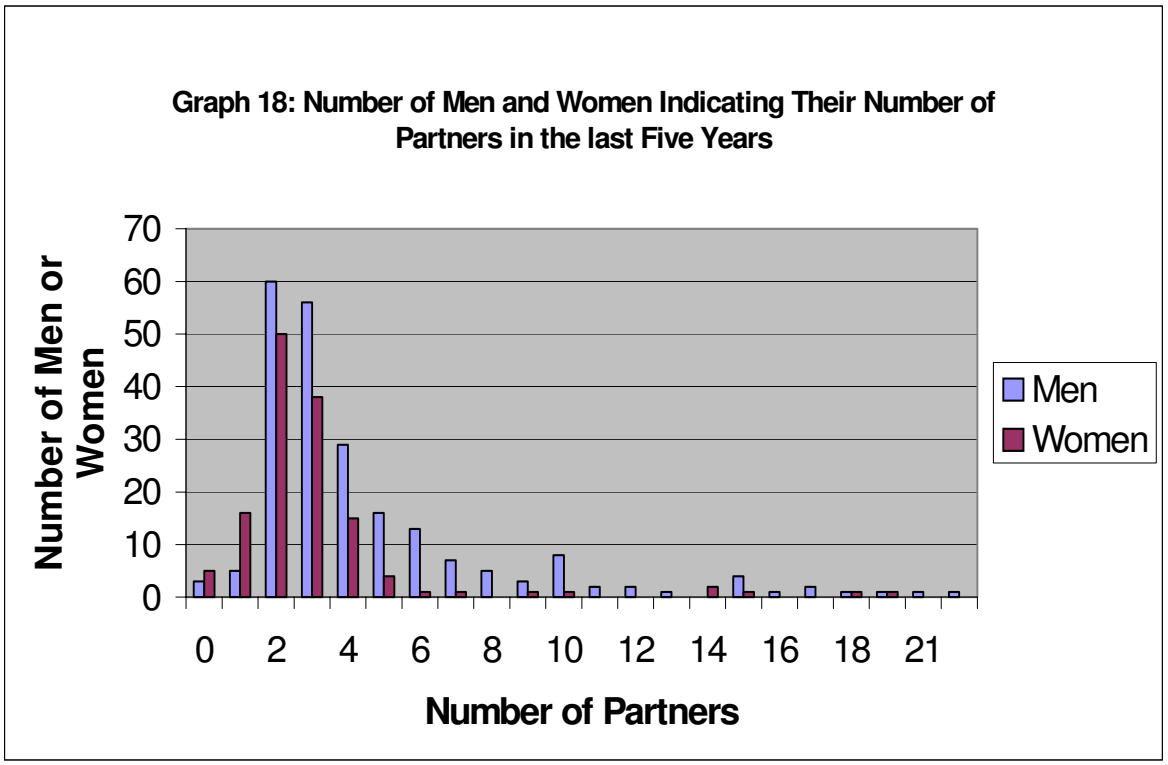
The empirical results point to widespread non-monogamous sexual cultures that result in diverse and complicated sexual networks. As mentioned previously, although most of the respondents were sexually active, their sexual relations take place outside a marriage. 49% of all respondents reported that they have had sexual relations with more than one partner over the last five years. More men (64,9%) than women (34.4%) reported that they have had more than one partner over the last five years.

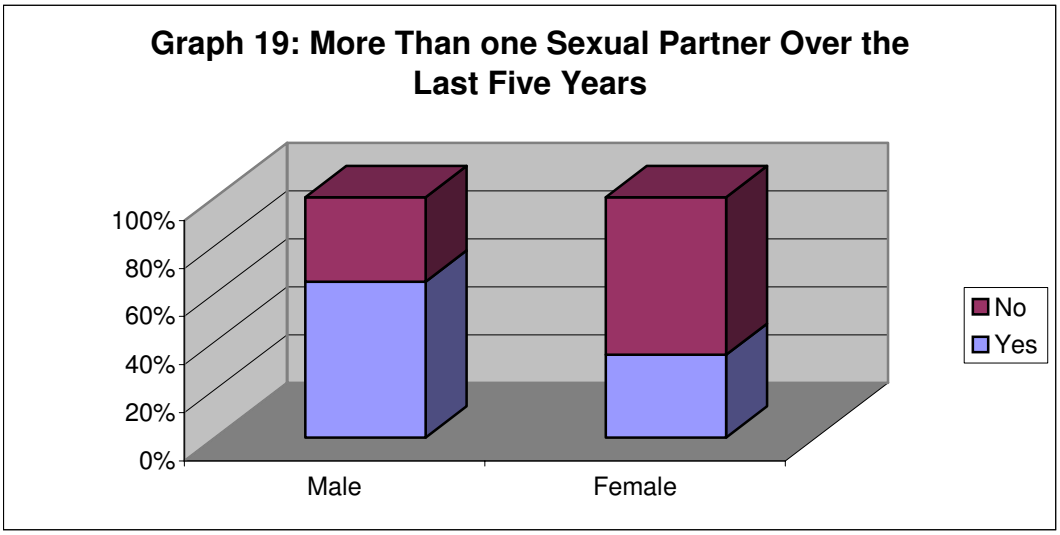
With regard to the number of sexual partners, we had to rely on self-reporting. There is a correlation between gender and the number of sexual partners. Men reported more sexual partners over the last five years than women. This is consistent with the key informant interviews and focus group reports show that men tend to be more promiscuous than women are.

Risk perceptions of people in stable unions are less than those outside stable unions. The empirical evidence suggests that women in stable unions are vulnerable because of polygamy and other forms of non-monogamous sexual practices. Indications are that some may have a false sense of security in long-term relationships, and if that partner looks healthy.

21,4% of all respondents knew that their sexual partners also had other sexual partners. A further 28,7% said that they were not sure. 49% said they were sure that their sexual partners did not have other sexual partners. This means that quite a large percentage of people accept or have to accept multiple sexual relationships from their sexual partners despite the risks. In focus groups and key informant interviews (cited below) there was constant reference to the cultural and socio-economic bases of multiple sexual relationships. This indicates that it is not simply a matter of personal choice.

[78] Talavera, P. (2002)
[79] Ibid
[80] Ibid





Reasons for Non-monogamous Relationships

Key informant interviews and focus group discussions provided some explanations for why people engage in multiple sexual relations despite the risks involved:

Men's Responses:

- People do not understand the concept of sticking to one partner because culturally men used to have more than one wife.
- Culturally it is acceptable for men to have more than one wife and therefore women accept this as normal practice.
- Sticking to one partner is just a concept like many other concepts; it does not really have an influence on people's lives.
- Men never stick to one partner because they inherited this from their forefathers.
- It is mainly men who do not stick to one partner or who engage in casual sex. They sometimes know the consequences but are overcome by their desires for a woman and can therefore not control their sex drives.
- Women tend to stick to one partner because they are economically dependent on men and therefore tend to be obedient. Those who do not tend to abuse alcohol.
- Being faithful to one partner refers to women being faithful to their men, but men can have more than one wife.
- Women love money and therefore continue to engage in sex even when they suspect that their partners have other sexual partners.
- Women do not stick to one partner because of promises of cash in return for sex or the temptations of engaging in relations with high income earners.
- There are too many women without partners who look for survival through relationships with working men. The temptations for multiple sexual activities are too much.
- To be faithful to one partner only refers to married people, it does not include the youth.

Women's Responses:

- It is tradition; our parents engaged in these practices and it is therefore regarded as a normal way of life. Women believe men could have more sexual partners.
- People understand the concept "be faithful", but they do not apply it, especially men who want to have as many partners as suits them.
- The majority of women stick to one partner, but some women have more than one partner because they want money from these partners.
- Many good women who are faithful to their partners get infected by their partners.
- Traditionally men should have more partners in order to show manhood and to have more children.
- Some say there are a lot of women therefore men can have more than one wife.
- Young men are very competitive and want to be known as having many girls.
- Few women have more than one partner and those who do not stick to one partner do so because of poverty.
- Women continue to have relationships with their partners even if they know that they have other partners because they fear that they will be murdered by their partners.

6.4 Condom use

6.4.1 Literature Review

Given the widespread rejection of abstinence and the existence of polygamous and non-monogamous relationships, condom use remains the most important weapon against HIV infection. It was therefore important to ascertain attitudes and sexual practices with regard to condom use.

Patriarchal power relations and economic dependency often make it impossible for women to negotiate condom use. Past research reported a number of male objections to condom use on the grounds that condoms:

- Reduce sexual pleasure [81]
- Break inside the woman[82]
- Obstruct fertility.

Most were unable to express their own sexual desires or to even discuss sexual matters with their partners. Culturally women are taught to show a passive disinterested aloofness in sex to confirm male sexual dominance in relation to female innocence and ignorance.[83] One study relates the story of a woman who refused to use condoms because she did not want to offend her HIV-positive husband.[84] The story to a certain extent illustrates the subordinate status women find themselves in as well as how women have internalised that status. It also reflects a fatalistic resignation to the inevitability of HIV infection.

The fact that condoms can prevent HIV/AIDS transmission, prevent the transmission of other STIs and prevent pregnancy should make them attractive to women because they grant sexual and reproductive freedom. It was therefore important to see if fertility desires play a role in women's decisions to have unprotected sex.

Decisions about fertility are often not matters of personal choice, but made to meet family and social-cultural obligations.[85] Fertility desires often outweigh health considerations, be it relation to HIV exposure or the possibility of mother-to-child transmission.[86]

Currently Namibia's fertility rate stands at four children per woman. Although this represents a decline from 1991 when the total fertility rate (TFR) was 6.1[87], it is still high compared to global fertility rates of 2.8 children per woman.[88] Overall, contraceptive use is low with a contraceptive prevalence rate of 29%.[89] It is anticipated that fecundity will decrease with the increase in HIV/AIDS infections.

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[81] Tersbol, B. (2002) and Le Beau et al (1999)
[82] Ibid
[83] Ibid
[84] Le Beau et al (1999)
[85] United Nations Secretariat (2002) HIV/AIDS and Fertility in Sub-Saharan Africa
[86] Ibid
[87] Household and Population Census 1991
[88] Mustafa, K. (2000)
[89] Ibid

This will reduce total fertility rates.[90] However, fertility desires are still central to the construction of masculine and feminine identities. Fatherhood is often synonymous with manhood and motherhood synonymous with womanhood. This creates pressure to prove fertility through unprotected sex.[91]

In African literature and other cultural forms, African womanhood is exalted by motherhood and women's humanity is recognised in relation to their motherhood. Some Namibian languages do not distinguish between womanhood and motherhood since they are regarded as synonymous.

There is further speculation that women may want to prove their fertility and thereby good health, to hide their HIV-positive status in the fear of abandonment or stigmatisation by their spouses and families. [92] This may explain why some have unprotected sex, risk pregnancy, ill health, and possible HIV transmission to their unborn children.

Fertility desires and the resulting lack of contraceptive use also translates into a lack of condom use. Inside stable or casual unions condom use is mostly inconsistent and situational. [93] Often people will only use condoms at the beginning stages of the relationship, but will stop after a while without being certain of the partner's HIV status and his or her sexual behaviour.[94] This, of course, exposes people to possible HIV, other STIs and pregnancy.

6.4.2 Results of Empirical Study: Condom Use

Our study shows that at a cognitive level, most people seem to have no problem with condoms. 83% of all respondents reported no difficulty with using condoms. Respondents listed condoms as the most effective way of preventing HIV/AIDS. Although respondents indicated that they use condoms, the evidence indicates that condom use depends on particular situations and the nature of the sexual relations. Condom use also reflects unequal gender power relationships. The survey results show that more men than women use condoms which indicates that condom use is subject to male preference.

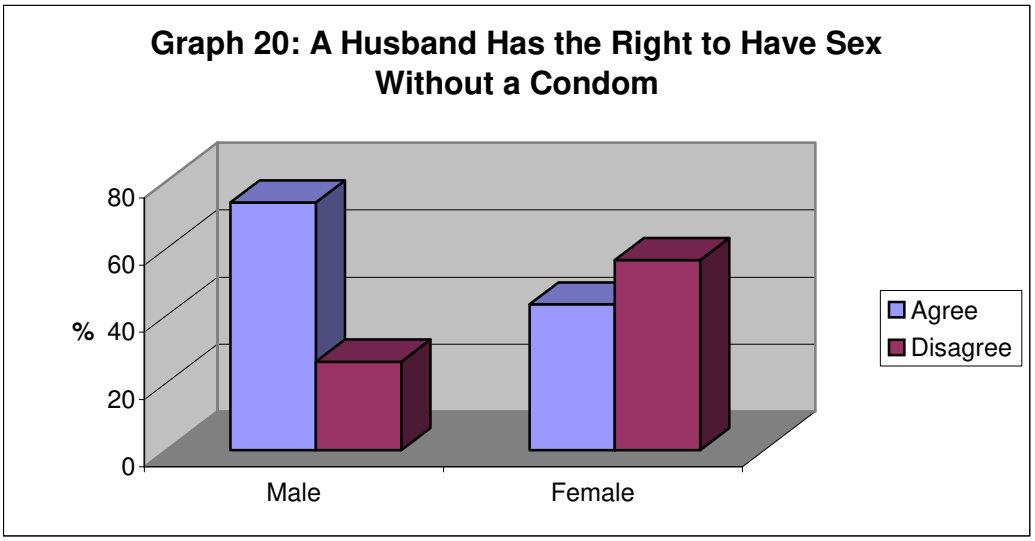
Key informant interviews and focus group discussions revealed that condoms are widely available from a number of places like shebeens, health care centres and AIDS service organisations. Some condoms are distributed free of charge. Where they are sold most felt that the price (around N$ 1.50) was affordable. Some felt N$ 3.00 would be too much. They also accepted that the costs were linked to the quality of the condoms. There was an indication that for men brand names do play a role when deciding which condoms to use. Some expressed regret that the more desirable brands are also the more expensive ones. Some informants were of the opinion that the free and cheap condoms are at times of bad quality and break during sexual intercourse.

[90] United Nations Secretariat (2002) HIV/AIDS and Fertility in Sub-Saharan Africa: A Literature Review
[91] McFadden P. (1992)
[92] United Nations Secretariat (2002) HIV/AIDS and Fertility in Sub-Saharan Africa: A Literature Review
[93] Ipinge, S. (2003)
[94] Ibid

Condom use in Stable Unions

In the light of evidence of multiple sexual partnering in "stable unions", condom use is relevant since stable unions do mean monogamy. 39% of those who are married reported that they use condoms when having sex with their husbands or wives. 68,8 % of all respondents reported that they usually a use condoms with their boyfriends or girlfriends. This unfortunately does not give an indication of the consistency of condom use.

74,6 % of all men and 90,6% of all women of agreed that a woman could refuse to have sex with her husband if he does not wear a condom. This suggests the recognition of married women's sexual autonomy and therefore their right to have sex when they choose. The paradox however comes through when the wife's right to choose is juxtaposed against the husband's rights to demand unprotected sex from their wives. 73,7% of all men and 43,3% of all women thought that a man has a right to have sexual intercourse with his wife without a condom.



Condom use in Casual Relationships

The baseline survey indicated high condom use in casual relationships. 84% reported that they use condoms with casual partners. 64% of those who reported multiple sexual partners said that they used condoms with their other partners.

The empirical evidence suggests that condom use is relative to male preference. Since female condoms are not as freely available as male condoms, women do not have the same degree of choice. A relationship stability continuum influences condom use. This continuum ranges from stable permanent relationships to casual relationships with various degrees of permanence in between. In casual relationships or relationships with non-permanent partners, women consistently reported lower condom use than men. 89,7% of male and 55% of female respondents reported condom use with casual partners while 93,3% of males and 52,4% of females reported condom use with other partners.

Condom Use, Masculinity and Sexually Transmitted Infections

Since there is a high rate of co-infection between HIV/AIDS and other sexually transmitted infections (STIs), we wanted to ascertain what people's perceptions are of STIs. There was anecdotal evidence that suggested that traditionally men boasted about their STIs as if they were a badge of honour that denoted virility. We wanted to either confirm or refute the claim that STIs represent a sign of masculine sexual conquest.

The results among both men and women were very mixed and the claim that it enhances masculinity could not be confirmed. Some felt that men were fearful of STIs and others felt that they were not because STIs are treatable. Men considered women as the carriers of STIs. Women who have STIs are also regarded as prostitutes. However, we did not find sufficient evidence to confirm that the contraction of STIs was desirable or that it affirms masculinity.

Reasons for the Lack of Condom use

Condom use in casual relationships is much higher than condom use in stable unions. The problem is still that it does not give us the consistency of condom use and this may require investigation in future research. We also still needed to find out why some people, despite high levels of awareness and the affordability of condoms choose not to use them despite the risks. Focus group and key informant interview participants offered the following reasons:

Men's Responses:

- There has traditionally been no culture of condom use in the country. It will take time for that culture to take root
- Social circumstances play a role in condom use
- Peer pressure can play a role in condom use
- Women are under the control of their partners and they fear if they refuse to have unprotected sex partners would leave them or beat them up
- Alcohol abuse leads to carelessness and unprotected sex
- It is mainly male condoms that are freely available; this places men in a more powerful position with regard to condom use
- People believe that condoms are not necessary in long-term relationships
- Some unknown organisations are involved in condom distribution. People do not know these organisations and therefore mistrust them
- Churches do not support condom use and have labelled it immoral
- Some feel it was immoral to use condoms
- Some think that condom use is a ploy by foreigners to prevent an increase in Namibia's population size

Women's Responses:

- Ignorance and survival. Men are totally ignorant. They believe in the power of sex without negotiating safer practices. Women are prone to men's decisions

- People do not want to die alone
- Some men say they cannot eat sweets that are wrapped
- Women may insist on condoms but, men want konyama, that is “skin on skin” because they feel think they can’t feel anything with a condom
- Some believe that condoms weaken men’s sexual performance
- In most cases it is men not women who have control over condom use
- Some people have a negative view of condoms; they believe that condom lubricants could destroy their private parts
- Some people especially women believe that if men ejaculate outside the vagina they will not need condoms because they cannot be infected
- Women do not have the guts to insist on condom use because they are afraid of being beaten and being told that they are unfaithful
- Some do not use condoms because they trust one another and judge HIV status by looking at appearance

Condom Use and Level of Education

Our survey results showed that condom use is not always positively related to level of schooling. 100% of respondents with no formal education reported condom use with partners and 65% of those with primary education reported condom use with partners compared 68% of those with secondary schooling.

With regard to condom use in girlfriend/boyfriend relationships, the results show a positive correlation between condom use and level of education. 50% of those with no education indicated that they use condoms with boyfriends and girlfriends compared 56,4% of those with primary schooling, 71,1% of those with junior secondary education, 74,6% of those with senior secondary education and 80% of those with tertiary. A similar correlation exists between level of education and condom use with casual partners.

6.5 Fertility Desires and the use of Contraceptives

Because fertility desire play an important part in the use or non-use of condoms it was important to gain some information on the use of contraceptives.

Access to Contraceptives

Key informants were of the opinion that contraceptives are freely available and that people know where to find them. Health facilities in the residential areas offer them free of charge. Some were however of the opinion that the attitudes of health workers discourage contraceptive use because they are judgemental, particularly to young and unmarried women’s desires to control their fertility through the use of contraceptives.

Young people and women may also fear that health personnel who work in the health care facilities would report them to their relatives if they used came to the centres for contraceptives.

Some men felt that fertility decisions and the use of contraceptives should be the woman’s choice. Others felt that it should be a decision for both partners to make on a basis of equality. We were interested in finding out why women choose to fall pregnant despite the risk of HIV infection and mother-to child transmission.

Men's Responses:

- Men regard women who do not bear children as just eating the man's money
- Sometimes women do not know the risk of infecting the baby
- Women engage in unprotected sex to ensure that they get support from men. Men only tend to support when they are satisfied
- Women engage in unprotected sex because of poverty, not to risk their lives, but to ensure better living conditions
- Some women engage in risky behaviour out of their free will and not because of poverty
- Women try to express their love and loyalty through unprotected sex
- Some women feel ashamed of using contraceptives
- Some do not go to health facilities to obtain contraceptive because they fear that their partners may be upset if they find out they are using contraceptives
- Ignorance amongst women about how contraceptives work. They therefore fear side-effects. Some fear damage to their reproductive system
- Women do not always consider the consequences of their sexual activities
- Men still dominate fertility decisions, women are too shy to discuss these matters with men and therefore use contraceptives in secret
- Rural people still believe that they should have big families and wealth would flow from the children to their parents

Women's Responses:

- Women are aware of contraceptives and the fact that they can be obtained from health centres
- In some cases men and women agree on the use of contraceptives, but most women visit the clinics without their partner's consent
- Children are part of the culture and a blessing to women
- Women are not free to decide. They will be accused of having extra-marital affairs or becoming independent
- There is the perception that it is a good thing to have babies because it signifies wealth
- Contraception is not culturally acceptable
- Men show a preference for not using family planning
- Sometimes women are aware that they have HIV and they are shy to talk about it. To create the impression that they are not infected, they fall pregnant
- Women fall pregnant because they are afraid of being stigmatised. Even if they are HIV positive they will continue bearing children to cover it up
- Some women are negligent due to drunkenness
- Some believe if they fall pregnant they will get financial support from men
- Some fall pregnant because they fear if they don't produce children they will be chased away by the men

6.6 Sexual Politics and the Culture of Silence

Patriarchy is central to the spread of HIV/AIDS in Namibia. Yet there remains this ominous silence about patriarchy and its impact on the spread of HIV/AIDS. The silence itself reflects the unequal power relationships between men and women, since it serves the interests of those who benefit from such inequalities. [95]

Time and again women's continued dependency and subordination is justified in terms of tradition and culture. Women's attempts to assert constitutionally guaranteed equality, sexual and reproductive rights are often labelled un-African. What is African and what is un-African is usually determined by men, but through their own socialisation women often accept the gender norms associated with African patriarchy.

There is a tendency in sexual politics to revert to the authority of traditionalism to protect male dominance. Yet when it comes to other cultural, social and economic changes there is greater acceptance of non-African inventions, values and modes of social organisation in the name of development. For example, the individual pursuit western consumerism is seen as sign of individual progress and development and not deemed un-African.

Since HIV/AIDS is mainly transmitted through sexual intercourse we needed to understand the nature of sexual power relationships. Sexuality and sexual power relationships are central to HIV/AIDS prevention because they are the locus of the problem. However, issues cannot be addressed if people are reluctant to discuss them. We therefore wanted to find out what people thought of the power relations between men and women.

6.6.1 Results of the Empirical Study

Through key informant interviews and focus group discussions, we probed questions of gender power relationships, sexuality and HIV/AIDS. Responses were as follows:

Men's Reponses:

- Men are still regarded as the heads of households
- Men have more power because women are financially dependent on them
- Men and women ought to be equal, but because men have been dominant for centuries it is not easy for them to give up their power
- Women cannot openly discuss sex with their partners because they fear being labelled as prostitutes
- People only engage in sex without discussing it
- Only women with education, employment and sufficient information are able to negotiate safe sex

[95] Wieringa, S. (2002)

Women's Responses:

- The majority of women believe what their partners tell them to do in the name of love or the money they get in return for sex
- Infrequently people are able to discuss sexual matters with their partners
- It is rare to talk openly about sex, but because of the disease (HIV/AIDS) people are a bit more responsible and sometimes discuss their status, but it is very difficult to give a straight answer
- Presently people are able to talk about sex because of HIV/AIDS, but in the past it was a taboo
- Men always dominate. Traditionally women don't initiate the sexual process, they wait on men to take the initiative and therefore men end up in control
- Sometimes women are able to negotiate condom use. It depends on the relationship and the extent of dependency of both partners
- Women do not risk talking about sex in their relationships. Men may go as far as to beat them

7. Impact of HIV/AIDS and the National Response

7.1 Impact of HIV/AIDS

Namibia is at a relatively early stage of the HIV/AIDS pandemic since the pandemic lags behind increasing infection rates by 8-10 years.[96] Already the impact of HIV/AIDS can be felt at both household and societal levels.

7.1.1 Impact on Households

The psychological and emotional trauma caused by HIV/AIDS cannot be enumerated. The uncertainty and loss caused by infections, illness and death affect both the infected and their families. There is still a great deal of stigmatisation and at times relatives abandon HIV/AIDS infected persons because they fear stigmatisation.[97] Stigmatisation has also led to an increase in suicide rates, particularly in the northern parts of Namibia.[98]

The cyclical link between HIV/AIDS and poverty is widely reported. A number of factors point to links between poverty and risky sexual behaviour that leads to HIV exposure. At the same time HIV/AIDS increases household poverty because affected households experience a decline in income as a result of illness and death.[99] In addition households have to cope with increased expenditure on food, transport, medical and funeral costs.[100] Children may experience the loss of one or even both parents and that gives rise to vulnerability, displacement and in some cases child-headed households.

Household food security is threatened, particularly in the subsistence farming area where households are responsible for their own food production. Studies elsewhere have shown that the death of the household head may lead to a 60% decline in the value of household crop production.[101] A FAO study estimated that available agricultural labour declined by 26% between 1985 and 2002 because of HIV/AIDS in Namibia.[102] Abate et al (2002) in a study on the impact of HIV/AIDS on farming communities in Namibia reported how labour scarcity manifests itself in subsistence agriculture:

- Less labour inputs into farming operations as a result of reduced household labour
- Less land being cultivated as a result of the decline in labour supply
- Child labour is used to replace the loss of adult labour due to illness and death
- The provision of extension services to farmers has declined due to illness and death among extension officers
- Households are also forced to sell assets like livestock to pay for school fees and other household expenses. 10% of respondents reported the sale of livestock to pay for HIV/AIDS related illnesses and funeral costs

[96] Abt Associates South Africa (2002) Impact of AIDS on Education in Namibia: Draft Summary Report
[97] Le Beau et al (1999)
[98] Ibid
[99] Le Beau et al (1999)
[100] Le Beau et al (1999) and Abate et al (2001) show that affected people see these as increased expenditure items
[101] Barnett, T. and Topouzis, D. (2003). The information comes from a 2002 study done in Kenya.
[102] Schubert, B. (2003)

- In some instances wives are allowed to continue farming after the husband's death, but there are also still cases where the land is grabbed by the husband's relatives and the wife is forced to return to her family.[103]

7.1.2 Impact at Societal Level

7.1.2.1 Demographic Impact

Namibia is already confronted with the demographic impact of HIV/AIDS which has resulted in increased mortality and lower life expectancy. HIV/AIDS is the single largest cause of death in Namibia and in 1999 accounted for 26% of deaths in hospitals.[104] Given the increase in infection rates and the fact that not all deaths occur in hospitals, this figure is likely to have increased, but the forthcoming epidemiology report will confirm this. Comparisons between the 1991 and 2001 census show that life expectancy has already dropped from 63 years to 59 years for females and from 50 years to 48 years for males.[105]

HIV/AIDS will also increase the dependency ratio as adults die leaving behind children under the age of 15. The large number of orphans and street children throughout Namibia suggests that the dependency burden is making itself felt as extended family structures are stretched and even collapse under the pressure of taking care of the rising number of orphans.[106]

7.1.2.2 Economic Impact

It is estimated that the direct and indirect costs of HIV/AIDS already comprises over 16% of Namibia's GDP.[107] Resources are diverted towards mitigating the impact HIV/AIDS. HIV/AIDS increases levels of poverty as household income and savings decrease. This in turn will lead to declines in aggregate savings and investment. The impact on the country's health system is most severe, as HIV/AIDS takes up more than 17% of the country's health budget. [108]

At industry level HIV/AIDS has led to loss of productivity as a result of absenteeism due to illness, to care for sick relatives and to attend funerals. HIV/AIDS also eats into profits as resources that would have been used productively are now diverted to additional medical costs and in training of additional personnel.[109] The loss of skills has led the Namibian Minister of Basic Education Hon. Mutorwa to conclude that "AIDS is eating away educational gains." [110]According to predictions, Namibia will most likely loose up to a third of its workforce in all economic sectors by 2020.[111]

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[103] Abate et al (200) also report that in cases where both parents have died, children are distributed to the wife's relatives while the husband's kinsmen will take over the assets.
[104] Namibia: Human Development Report 2000/1
[105] Population and Housing Census 2001
[106] Schubert, B. (2003)
[107] UNDP Namibia Human Development Report (200/1)
[108] Ibid
[109] UNAIDS: Report on Global HIV/AIDS (2002)
[110] Hon. Mutorwa made this statement in his 2003 budget speech as cited in the Namibian of 9 April 2003.
[111] Steinitz, L. (2003) in an article entitled the *Response of Civil Society to HIV/AIDS in Namibia*

7.1.2.3 Impact on Education

A 2002 study[112] predicted that HIV/AIDS will lead to:

- A reduction in school enrolment rates as fertility rates decline and child mortality rates increase. HIV/AIDS has already led to a levelling of absolute numbers in the 0-4 year age bracket [113]
- Higher drop out rates as a result of orphan-hood
- The educational system's declining capacity to deliver educational services as more educators are infected with the HIV virus
- Increased costs related to staff losses and staff replacement
- Poorer quality of teaching by chronically ill educators

7.2 National Response

7.2.1 Governmental Programmes

In 1990, the Namibian government launched its National AIDS Control Programme (NACP), whose aim was to conduct:[114]

- Epidemiological surveillance
- STI and HIV/AIDS case management
- Counselling and awareness raising

This was in the early stages of the epidemic in Namibia and the programme reflects a bias towards the medicalisation of the epidemic since illness and death were the most concrete manifestations of the disease. Since then there has been an alarming increase in infection rates.[115]

The Second Medium Term Plan on HIV/AIDS covering the period 1999-2004, set out the objectives, activities and institutional actors that would prevent further infections, treat illnesses, and mitigate the impact of the pandemic. A multi-sector approach[116] that involves different government and non-governmental agencies reflected a shift away from the medicalisation of HIV/AIDS. The fight against HIV/AIDS was no longer the exclusive preserve of the Ministry of Health and Social Services. The Medium Term Plan includes: [117]

Social Mobilisation:
This includes the development of information, education and communication (IEC) material. This translated to the Take Control Campaign and the Open Talk Initiative.

[112] Abt Associates of South Africa Inc (2002) Impact of HIV/AIDS on Education in Namibia
[113] Ibid
[114] Hangula, L. (2003)
[115] Namibia: Human Development Report 200/1
[116] Hangula, L. (2003)
[117] UNDP Namibia: Human Development Report 2000/1

Prevention:

- The prevention of the sexual transmission of HIV/AIDS and other STIs
- Ensuring safety of blood supplies
- Reduction of mother-to-child transmission
- Prevention of transmission due to unsafe health practices in hospitals
- Distribution of condoms

Access to Services:

- Counselling
- Support services
- Expansion of testing services
- Home based care programmes
- Support for orphans and other vulnerable children (OVC)
- Provision of antiretroviral drugs

7.2.2 Programmes of Non-governmental Organisations

In addition to programmes mentioned above, there is a plethora of programmes and activities implemented by regional and local governments, civil society organisations, aids service organisations and faith-based organisations. These activities can be classified along the following lines: [118]

Mobilisation: Creation of Regional, District and Village AIDS Committees.

Awareness-raising: In addition to government's work, civil society organisations, business organisations, trade union and churches have become involved in awareness raising activities.

Condom Distribution: Social marketing associations like SMA and NASOMA distribute condoms and promote condom use.

Care and Support Activities:
a) Provision of counselling and testing services
b) Treatment of opportunistic infections
c) Formation of support groups like Liroga Eparu for people living with aids (PLWA)
d) Home-based care programmes
e) Provision of antiretroviral drugs and vitamin supplements
f) Hospices for the terminally ill
g) Care and support for orphans and other vulnerable children
h) Post-exposure prophylaxis for rape survivors
i) Income generation activities for PLWA

[118] Otaala, B. (2003)

7.3 The Use of Care and Support Services

There are links between HIV/AIDS prevention, support, care and treatment. The possibility of accessing care, support and treatment may encourage people to go for voluntary testing and counselling. Knowledge of their status may lead to behaviour change. There is a plethora of AIDS service organisations (ASOs) in Namibia. We wanted to find out if people are aware of these services and if they use them.

Results of empirical study: Use of Care and Support Services

Due to the number of ASOs, most key informants were aware of care and support services in their communities. Some of these services are either provided by government through the primary health care centres or through non-governmental organisations. They were also aware of the TB clinics where drugs are distributed. There was awareness that drugs that prevent mother-to-child transmission are available at health care centres. Most however said that did not know anybody who used these services. Some argued that because people are not always aware of their HIV status they do not use these services; others indicated that people may be afraid to use the services because they fear the stigma of being identified publicly as being HIV positive.

Some argued that of the organisations that provide care and support services, the government health care facilities are the ones most trusted by members of the community because they have faith in services provided by government agencies. There appears to be some mistrust of other organisations that do not have roots in the communities.

Time and again fear and stigmatisation were raised in relation to accessing the care and support services provided. There is the perception that those who have HIV/AIDS prefer to suffer in silence until they become very sick rather than seek care and support and risk others knowing their status. Those who use the care and support services can easily be identified and therefore stigmatised.

7.4 Voluntary Testing and Counselling

Knowing one's HIV status is important in sexual decision making. This can influence decisions about unprotected sex. If tests show negative results people may decide to be more careful in future. If people test positive they are aware of their status and may decide to avoid unprotected sex for fear of infecting others or of re-infection. Knowing one's HIV status can therefore be a point of departure in behavioural change. It was therefore important to assess attitudes towards voluntary counselling and testing.

7.4.1 Empirical Results: Voluntary Testing and Counselling

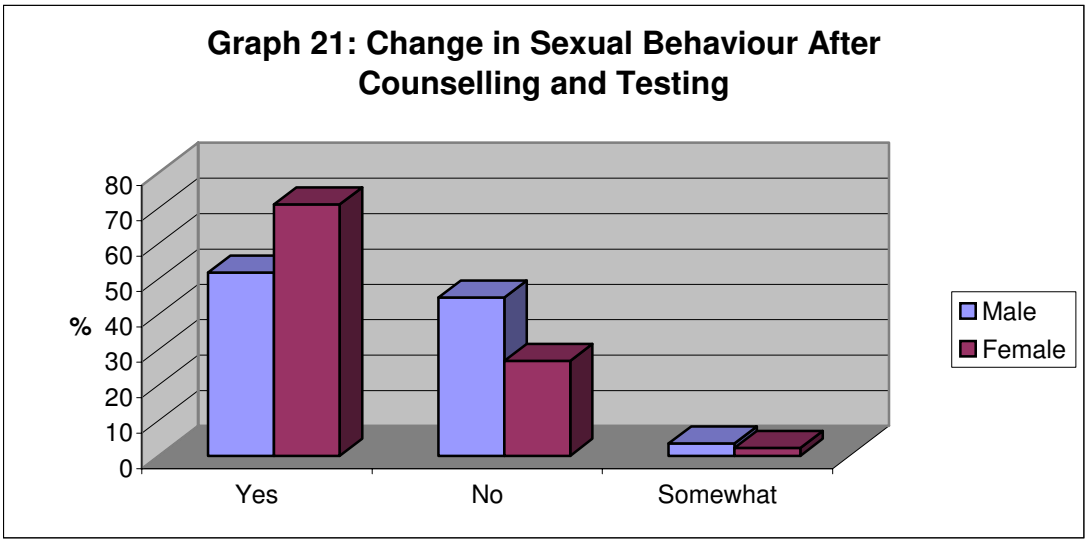
Our research results confirm reported experiences that knowledge of one's HIV status leads to behavioural change and that the availability of drugs encourages voluntary testing and counselling.

37,4% of all respondents reported that they had gone for HIV/AIDS tests, of which only 51,4% received the test results. The rest did not return to obtain results. 62,6% have never had a test.

This means that a large number of sexually active people do not know their HIV status. 51,4% of all respondents indicated that they would be willing to go for voluntary testing and counselling. A large minority of 48,6 % said that they would not.

A total of 61% (51,8% men and 71% women) who went for tests and received the results said that they altered their sexual behaviour after they received their test results.

Graph 21: Change in Sexual Behaviour After Counselling and Testing



Women seem more likely than men to change sexual behaviour after they have gone for testing and counselling.

Further probing of key informants about people's attitudes towards voluntary testing and counselling revealed that:

- Many people were still not aware of voluntary testing and counselling facilities and the benefits that testing and counselling could bring.
- Some knew about the *New Start* facility in Katutura.
- People are scared of the possibility of testing positive and therefore prefer not to know their HIV status.
- Some felt that VTC centres are too few and far from their residences.
- Some feared that if people knew that they were HIV positive they would commit suicide.
- Most felt that people would be encouraged to go for VTC if they had access to Antiretroviral Drugs (ARVs). It was repeatedly mentioned that people are still not aware of government's plans to make the drugs available and this knowledge would encourage people to go for HIV tests to benefit from life-prolonging drugs.

8. Conclusions

From the outset we wanted to ascertain the links between increased female migration and risky survival strategies that increase women's vulnerability to HIV exposure. In the process of the research we discovered that female migrants are in fact vulnerable because of their economic dependency on men and because of patriarchal sexual cultures. However, there is a number of other vulnerable and high-risk groups that also require attention. Currently, our HIV prevention strategies are too general and do not address the gender specific conditions of HIV spread or the particular social, economic and cultural factors that affect the sexual behaviour of certain high risk and vulnerable groups.

Our findings support the initial hypothesis of increased female migration and that risky sexual behaviour forms part of women's survival strategies. The combination of gender inequality and poverty is at the core of female risk taking. Inequalities are manifested both at structural and personal levels and severely constrain women's sexual and reproductive autonomy.

8.1 Structural Factors in HIV/AIDS Prevention and Spread

It is mainly due to economic displacement that younger women without husbands migrate to Windhoek. Our findings further show that female migrants are vulnerable because of their low social and economic status. At a structural level they face higher levels of unemployment than men do. When they do have employment it is more likely to be of a casual nature. The majority of women who are employed do domestic work in private homes, while others earn a living through petty trading, which keeps them at the margins of the economy.

Female incomes are lower than male incomes and the majority of women earn below N$ 500.00 per month. The majority of these women are unmarried or outside of stable unions. In the income matrices women listed remittances from boyfriends as the highest source of other income. Boyfriends are therefore important to women's economic survival. This reinforces inequality and dependency. It also constrains women's sexual and reproductive autonomy.

8.2 Links between structural, personal and inter-personal factors

At a personal and inter-personal level vulnerable women have little chance of abstaining from sex, or of negotiating safe sex.

8.2.1 Abstinence

Sexuality is not merely a personal matter, but is also socially and culturally constructed. At a social-cultural level abstinence is regarded as unnatural. Since sexuality is also central to gender identities, there is pressure, particularly on men, to prove manhood through sexual activity.

Women in marital relations and stable unions have little chance to abstain because sex, even unprotected, is regarded as a man's right and a woman's duty.

Abstinence is also difficult for women outside stable unions because many rely on male patronage for survival. Although the decision to abstain from sex is ultimately a personal decision it takes place in a broader socio-cultural context. At an interpersonal level it occurs within sexual power relationships. At a personal level the decision to abstain depends on the relative autonomy individuals have from the socio-cultural pressures and the power they have within relationships.

8.2.2 Faithfulness

The findings show there are different understandings of the concept of faithfulness and that it does not necessarily mean monogamy. There is therefore not a homogenous notion of faithfulness that applies to all groups in the same way. People enter into different types of sexual relationships and the Christian monogamous marriage is not the only or even the most common form of sexual union. There are diverse forms of sexual unions and once again there are structural reasons as well as personal reasons for this diversity.

Non-monogamous sexual practices apply to both men and women. Although women in stable unions tend to practice monogamy they often cannot enforce it on their male partners. The degree of control they have over the multi-partner sexual networks, which they involuntarily engage in as a result of male promiscuity, once again depends on the particular relationship that exists between the man and the women. Even women who are economically independent live in fear of infection because they cannot control male sexuality or enforce monogamy.

There is a socio-economic and cultural basis for both male and female promiscuity. Although male migrants arrive alone, they often leave behind a female partner in the rural areas. As illustrated in the male migration biographies, this does not preclude new sexual relationships. This increases the possibility of males becoming infected, but also the possibility of them infecting female partners they have left behind in rural areas. This may explain why women in stable unions are also a high risk group.

Women often enter into serial monogamous or multi-partnered sexual relations to retain male patronage because of dependency on male incomes. This was vividly illustrated by the individual female migration biographies which clearly show that after the loss of a partner through desertion or death, women find other male partners. The picture becomes more daunting if we consider the possibility that those partners could have died of HIV related causes.

Historically polygamy was culturally acceptable and this legacy makes women tolerant of male promiscuity despite anxieties about possible exposure to HIV. We are thus faced with:

a) Longstanding patriarchal sexual cultures that support male promiscuity.
b) Adverse socio-economic conditions that support female promiscuity.

8.2.3 Condom Use

Of all the prescriptions contained in the ABC rule, condom use is the one most practiced by the research population. Condoms are also accessible and acceptable to most. The problem is that condom use is still inconsistent and dependent upon male preference. It therefore places women in a disadvantaged position in protecting themselves. Men have greater control over condom use because of the availability of the male condom. This explains why men in different types of relationships consistently reported higher condom use than women. Within relationships there is a stability continuum that influences condom use. The higher the degree of permanence, the lower the condom use and conversely, the more casual the relationship the greater the probability of condom use.

Results further show that male and female fertility desires affect condom use. Men may want to control their female partner's sexuality by controlling their fertility. Men and women may also enter into protected sex because of their own desires to bear children since fatherhood and motherhood are so closely linked to socially constructed gender identities.

The baseline survey results point to relatively high reported condom use, which is an encouraging sign. Given the complexity and multiplicity of sexual networks, situational condom use still represents risks. The challenge lies in promoting increased and consistent condoms use.

There are also particular high risk groups with little bargaining power to negotiate condom use. These include women in stable unions where polygamy and other forms of non-monogamous sex are practiced as well as women who enter into transactional sexual relations or who use sex as means of securing a livelihood. The challenge lies in providing women with safe sex options they can control such as the female condom or other female initiated prevention methods.

Male condom use is influenced by men's sexual preferences, i.e., the notion of skin on skin. It is also influenced by desires to control female fertility and female sexuality. This is corroborated by the secret use of female contraceptives. Male condom use is also influenced by the brand of condoms available. There is the perception that the cheaper condoms are inferior and could tear.

8.2.4 Knowledge, Awareness and Sexual Behaviour

Our study shows a high degree of knowledge about HIV/AIDS. This pertains to the knowledge about the modes of transmission and modes of prevention. As in studies done elsewhere, awareness and knowledge do not necessarily translate into behavioural change.

We have already detailed the structural and personal factors that influence sexual behaviour. This challenges notions of linear causality between awareness and behavioural change. This does not mean that awareness, information and educational activities are superfluous. The reported levels of condom use suggest that it has had an impact on at least one aspect of sexual behaviour. There are still areas of ignorance that require clarification and myths that should be dispelled.

Awareness campaigns are blunted by messages that do not speak to people's reality and the particular circumstances that vulnerable and high risk groups find themselves in. In the main, awareness campaigns have been silent about patriarchy and gender inequality - the very core of the spread of HIV.

Christian values and Christian morals provide the context for awareness campaigns. This may lead to increased levels of guilt among Christians, but not all Namibians are Christians and not all Namibians are practicing Christians in a western cultural mode. While faith-based organisations have the right to promote religious values, they must be mindful of the fact that they may exclude rather than include through their advocacy of moral codes that contradict social realities. In the context of non-monogamous sex and the rejection of abstinence, condoms provide the only protection. Religious doctrines that reject condom use deny vulnerable groups the only possibility of protection.

8.2.5 Voluntary Testing and Counselling

The most encouraging finding is the link between voluntary testing, counselling and behavioural change. For prevention strategies it is significant that over 60% of people who have gone for testing and who received their test results reported behavioural change. This suggests that voluntary testing and counselling should become an important part of prevention campaigns.

The results however show ignorance about the benefits of testing and counselling. This could explain why so many said that they would not go for testing and counselling. Results further indicate that testing and counselling services should be linked to treatment care and support services as people are likely to go for testing if they can get help if they test HIV positive. The results further show that knowledge about one's HIV status could increase the individual's ability to act. One could either protect oneself or prevent infection of others. The knowledge of one's HIV status, albeit negative, can thus be empowering.

8.2.6 Care and Support

Although people are aware of care and support options and the organisations that provide these services, there seems to be a reluctance to use some of the services. There are two factors that influence the use of care and support services:

a) Mistrust

- People mistrust NGOs that come from outside to provide services.
- Government services seem more acceptable and trusted.

b) Stigmatisation

Stigmatisation still remains a big problem in the fight against HIV/AIDS. It stands in the way of voluntary testing and counselling and prevents people from seeking care and support. It also prevents people from providing care and support to others.

8.2.7 Culture of Silence

It is difficult to address a problem if one is not able to discuss its causes. Despite the fact that sexual intercourse is the main mode of HIV transmission, people still seem unable to discuss sex at public and inter-personal levels. Sex is still something that people do, but do not talk about. It is the absent-present. It is there but people do not acknowledge its existence.

The culture of silence about sexuality prevents women from expressing their own sexual preferences. At both public and inter-personal levels there is a silence about sexual and reproductive rights. Without this knowledge women cannot begin to assert such rights.

8.2.7 Gender Relations

Despite the centrality of gender relations to the spread of HIV/AIDS, patriarchy remains unchallenged. The research findings confirm how gender inequality and poverty interface at structural and personal levels to aid the spread of HIV infection. It should therefore follow that prevention strategies should take account of the gendered nature of the HIV/AIDS pandemic and gender specific strategies should be developed. Strategies should aim to bring about gender equality.

9. Recommendations

9.1 Integration of Prevention and Mitigation Programmes

- All agencies involved in HIV/AIDS prevention, counselling, testing, care, support and treatment should register with one lead agency to facilitate access to theses services
- The lead agency should set up a comprehensive directory of service providers to facilitate referral to these services
- Prevention and mitigation programmes should be linked through counselling and testing programmes
- MoHSS, faith-based organisations and NGOs should increase cooperation and pool resources in order integrate their programmes into holistic prevention, care and support packages, preferably through one stop call centres

9.2 HIV/AIDS Awareness and Education Campaigns

- Campaign messages should be steeped in the particular social, cultural and historical context, so that people can relate the messages to their own circumstances
- There should be a greater segmentation of vulnerable and high risk groups to enable differential targeting of such groups. Currently campaigns are far too broad to capture the different conditions that affect different high risk and vulnerable groups. There should be specific campaigns that address the circumstances of:
  a) mobile populations
  b) married women or women in stable unions who involuntarily form multi-sexual partnerships
  c) people who engage in transactional sex
  d) youth
  e) vulnerable children
  f) high income earning males who engage in multiple sexual partnerships like sugar daddies
  g) men and women in polygamous marriages
- Campaign messages should address questions of gender inequality as well as sexual and reproductive rights
- Education campaigns should address the myths about HIV transmission and prevention
- Campaigns should inform people about the benefits of voluntary testing and counselling
- Campaigns should address the issues of stigmatisation

- Information and Education Campaigns should address human sexuality in its social and cultural context and not treat it as a purely biological and physical activity
- Integration of sexual education in school curricula

9.3 Sexual Behaviour Modification

Sexual behaviour can only be modified over time, because of the structural and personal factors that influence sexual behaviour. We should therefore address these structural and personal factors:

9.3.1 Structural Level

a) Address the structural imbalances connected to poverty and gender inequality by giving women access to means of production through:
   - land reform programmes
   - access to credit
   - access to skills
   - access to technology

b). Improve women's labour market position through:
   - skills development
   - enforcement of anti-discriminatory legislation (e.g. affirmative laws)

c). Recognise women's labour by rewarding non-market productive work like household food production and women's reproductive functions in the household. Socially vulnerable women should be able to access basic income grants from the state in recognition of their unpaid domestic labour and underpaid productive work

d) Intensify income generating and poverty eradication programmes

e) Intensify rural livelihoods programmes to cater for economically displaced rural men and women

9.3.2 Personal Level

- Educate women in their sexual and reproductive rights
- Provide women with safe sex options they can control like female condoms
- Address the relationship between alcohol abuse and risk behaviour
- Provide opportunities for personal development so that women are better able to negotiate safe sex
- Guide young people to alternative lifestyles to break the cycle of poverty, alcohol abuse and risky sexual behaviour
- Introduce life-skills programmes that focus on substance abuse, particularly alcohol abuse

9.4 Voluntary Testing and Counselling (VTC)

- Leaders in politics, religion, civil society, sport and business should publicly endorse voluntary testing programmes and voluntarily undergo testing themselves in full public glare. This should mobilise public support for VTC and undermine the stigmatisation associated with it
- The number of voluntary testing and counselling facilities should be increased to broaden access to the services
- Voluntary testing and counselling should be linked to care, support and treatment options

9.5 Care and Support

- To reduce mistrust, AIDS service organisations (ASOs) should seek community endorsement before they enter the field
- ASOs should include local leadership in governance and decision-making structures
- ASOs should consult communities on their programme implementation
- ASOs should cooperate with government service providers to rationalise service provision, avoid duplication and to gain the trust of communities
- Extend access to treatment to all those who need it
- Link treatment options to prevention strategies
- Promote cross-sector cooperation

9.6 Suggestions for Future Research

The study revealed that there are still areas that require further research:

- Stigmatisation
- Links between HIV/AIDS and alcohol abuse
- Transactional sexual relations
- Gender inequality and human sexuality

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11. Annexes

Annex 1: Key Informant Interviews

Name of interviewer_____
Note taker_____
Others_____
Location of discussion_____
Position of interviewee_____
Starting time_____ Finish time_____ Total time_____
Interviewer self-check_____

Introduction

My name is _____ _____.
I am conducting these interviews on behalf of !Nara Training Centre. The interviews form part of a study into the links between female migration and the spread of HIV/AIDS. Because of your particular position and knowledge of this community we feel that you are able to provide us with information that will give use better insight into the questions we are studying. Please note that all information provided will be treated as **highly confidential**. Your honest and reliable response will be highly appreciated. We assure you that your responses will not be used against you in the future and will not be used for any other purpose but the study we are currently conducting.

We thank you for the time that you are willing to set aside for this purpose.

1. HIV/AIDS

1.1 Where do people gain their information about HIV/AIDS? (*Probe for the sources of information like newspapers, radio, t v, posters, brochures at public places etc*.)

1.2 How do they react to all this information? (Probe *to find out if the information has any effect on the person: e.g. makes them think of certain things, or change behaviour)*

1.3 Do they use this information to protect themselves against possible HIV infection?

1.4 What do they do to protect themselves against infection? (*Probe for prevention strategies that individuals actually use)*

1.5 Why, despite lots of information, do men and women still engage in unprotected sex? (*Probe for the reasons that people do not use condoms, for example.)*

1.6 Do people have a fear of contracting HIV/AIDS?

1.7 How do men and women deal with their own fears of contracting HIV/AIDS? (*Probe for strategies like protected sex, denial counselling etc*.)

2. Links Between Care and Prevention

2.1 Are people aware of support services available to those infected and affected by HIV/AIDS? *(Probe for the kind of services people are aware of and if they know where and how to access these services*)

22 Do they make use of some of these services? (*Probe to find out which services they are aware of)*

2.3 If they do, which services do they use? *(Probe for the nature of the services and the service providers)*

2.4 Are they aware of any voluntary counselling and testing (VCT) services?

2.5 If they are, do people use these services?

2.6 Do people see any benefits in VCT? (*Probe to see if there are any incentives that motivate people to go for voluntary counselling and testing)*

2.7 If any, what are the benefits of VCT?

2.8 Are people aware of drugs that can prevent mother-to-child transmission?

2.9 Do people know where they can obtain these drugs?

2.10 Are people aware of the government's plan to make ARV treatments available?

2.11 Do you think the availability of these drugs will encourage people to go for voluntary testing and counselling?

3. Gender Relations

3.1 Why do you think women continue to engage in sex with their partners when they know/ suspect that they have other sexual partners as well?

3.2 Are people able to discuss sex with their partners? (Probe *for the culture of silence that surrounds sexual issues and the taboos*)

3.3 Who makes the decisions about condom use in the relationship? (Probe *to see the power relationships and where the decision making power lies within the relationships)*

3.4 Are women able to negotiate condom use? (*Probe to ascertain the amount of control women may have over condom use)*

3.5 Are condoms accessible to people? (*Probe to find out if people know where to get them, and if they are available in the area.)*

3.6 Where do people get their condoms from? *(Probe for institutions or organisations that provide them to the community)*

3.7 Are condoms affordable? (Probe *to find out if people pay for them and what it costs, or if people find them to expensive to buy)*

3.8 What prevents people from using condoms? *(Probe to find out if there are any cultural, social or economic factors that prevent or hamper condom use*)

4. Sexuality

4.1 What do people understand by the concept "be faithful to one partner?"

4.2 Do men stick to one partner? (*Probe for reasons for the answer given*)

4.3 Do women stick to one partner? (*Probe for reasons for the answer given)*

4.4 What is you view on abstinence? (Probe *to see what people understand by abstinence and if it is a real option)*

4.3 How do men view sexually transmitted diseases amongst men? (*Probe to find out if they boast about it or are fearful of it*)

4.4 How do men see sexually transmitted diseases amongst women? (*Probe to find out if there are different standards for men and women.)*

4.5 Have you heard men talk about tournaments? (*Probe to find out if gang rape is often talked about by men and if it is an acceptable sexual practice)*

5. Fertility

5.1 Why do women still fall pregnant when they know the risks of infecting their babies if they are HIV positive? (Probe *to find why they still want to bear children despite the risks of unprotected sex to themselves and the risk of infecting the baby)*

5.2 Who decides on the use of contraceptives within the relationship? *(Probe to find out whether women make this decision or if their partners do)*

5.3 Are women free to decide to use contraceptives if they so wish? *(Probe to find our the extent to which women are able to exercise the right to choose)*

5.4 Do women have easy access to contraceptives? (Contraceptives *include condoms, pill, injection, IUDs)*

5.5 Where do they get contraceptives? *(Probe for knowledge about the availability*)

5.6 What are the stumbling blocks to the use of contraceptives? (*Probe for any cultural, social or economic factors that may prevent or inhibit the use of contraceptives)*

Thank you for your time.

Annex 2: Mobility Map

General Objective

To determine whether the female migration to Windhoek's Hakahana, Okahandja Park, Goreangab Dam and Greenwell Matongo informal settlements is on the increase in relation to factors contributing to poverty and risky sexual behaviour which leads to infection and transmission of HIV/AIDS.

Specific Objective

Import: The increase in female urban migration holds greater risk for women to contract HIV.

The increase in female urban migration holds greater risk for female HIV/AIDS transmissions

To determine whether women migrating to Windhoek into Hakahana, Okahandja Park, Greenwell Matongo and Goreangab Dam informal settlements engaged in risky sexual behaviours in order to ensure survival and whether those risky behaviours leads to an increase in the spread of HIV/AIDS.

Informants: Women and Men (divided into 2-3 subgroups)

Process:

1. Explain the objectives of the exercise to the informants
2. Introduce the mobility map based on the objectives
3. List mobility indicators (reasons for migrating, living conditions, etc)
4. Divide informants into subgroups based on categories of gender, marital status and employment
5. Ask the informants in subgroups to draw up their mobility maps over a period of month/year. Groups present result in plenary
6. Record subgroup results on a representative mobility map guided by the key questions (in consultation)

Key Questions for Female Migration

1. Are more females migrating to Windhoek than before Independence?
2. What are the main reasons for migration?
3. Do they normally migrate with or without relatives?
4. To whom do they migrate / Are there relatives to whom they are migrating?
5. Are the female migrants older or younger women?
6. Do they migrate with children (by sex, age)?
7. What kind of condition are they trying to escape?
8. Are the conditions they leave behind worse or better than the one they are moving to?
9. Does the area in which they live currently have basic facilities like housing, running water, toilet and electricity?

Annex 3: Income and Expenditure Matrix

General Objective

To determine survival strategies of people living in Hakahana, Okahandja Park, Goreangab Dam and Greenwell Matongo in relation to sources of income versus expenditure as factors contributing to poverty/risky sexual behaviour which leads to infection and transmission of HIV/AIDS.

Specific Objective

Import: The increase in female urban migration holds greater risk for women to contract HIV.

The increase of female urban migration holds greater risk for female HIV/AIDS transmissions

To determine whether women, migrating to Windhoek into Hakahana, Okahandja Park, Greenwell Matongo and Goreangab Dam informal settlement engaged in risky sexual behaviours in order to ensure survival and that those risky behaviours leads to an increase in the spread of HIV/AIDS.

Informants: Women and Men (divided into separate groups)
(Two groups in each of Hakahana, Okahandja Park, Greenwell Matongo, Goreangab Dam).

Process:

1. Explain the objectives of the exercise to the informants

2. Ask the informants to list their sources of income, eg:

    - Employment formal or informal (civil service cleaner/clerk/manager)
    - Commercial sex work
    - Wife/husband/girlfriend/boyfriend/sugar daddies/sugar mommies
    - Others

3. Collect 300 stones to represent the whole income for the community for the year.

Income

4. Ask the informants to divide the stones according to income. Let the informants deicide who (women or men, old or young, educated or non-educated) should have what proportion of the 300 stones by consensus and agreement. Record their ways of making decisions.

5. Draw the matrix in the sand using the sources of income as the horizontal axis and the informants as the horizontal axis.

   E.g.

Sources of Income / **Informants**				
Young Women (YW 1) (YW 2) (YW 3) (YW 4) (YW 5)				
(YW 6)				

6. Ask the informants to stand on the matrix as the vertical axis with their stones at their feet

7. Ask them to place their stones on the matrix to show from which sources they got income and how: directly or indirectly, including outsourced financial support – boyfriend/girlfriend/sugar daddies/sugar mommies – where they got their start up capital if involved in small trading

8. Record the matrix - count all the stones

Expenditures

9. Ask the informants to list all their expenditures, including their savings - were they get the capital from –sugar daddies/sugar mummies – how they pay for central water taps – ablution facilities.

10. Change the horizontal axis of the income matrix to an expenditure matrix

11. Ask the informants to collect back their income stones and allocate them to show their expenditures.

12. Record the matrix – count the stones.

13. Create a crisis (illness, funeral, food theft) and ask them to remove 10-15 stones each from the matrix to show where they would find the money (income) to cope.

E.g. **Case scenario:** Time: March 2004

Choose two people (a female and male to form a couple living in that particular informal settlement) from the pool of informants.

The female falls ill and she is admitted to Katutura hospital. Later that afternoon, just when he was arriving from the hospital, he received a message that his mother passed away in Oshikoto region.

NB: Make sure you record exactly where the informants took the stone from

14. Discuss the impact of the crisis and the coping strategies of the informants (where they took the stones from) – how will it effect their future? Were there other options available to them – identify those options.

15. Draw on the case scenario to answer the specific objective/hypothesis.

Survival Indicators/Questions

- What comprises income?
- What forms of income generation or employment do they engage in?
- Need to dig deeper: e.g. if they say government, determine whether they are clerk, cleaner, manager and so on
- If they engaged in small trading, where do they get their starting up capital from?
- Is there any knowledge of women who have entered into risky behaviours in order to ensure survival (transactional sex/sex in return for food/money)?

Annex 4: Survey Questionnaire

HIV/AIDS Survey

Administrator Box
Enumerator Check
Supervisor Check
Other Check

1. Name of Enumerator_____ No: _____
2. Starting Time_____ Finishing Time _____Total Time ___
3. Date _____
4. Stratification Area _____

Introduction

My name is _____ and I am carrying out a survey on behalf of !Nara Training Centre. The survey intends to find out how people who have moved to Windhoek make a living here. Also, because HIV/AIDS is such a big health risk to everyone living in Namibia, we want to find out how people are coping with the disease. I would like to ensure you that all information you give will be confidential. Some of the questions asked here may be personal and intimate and I only hope that you will be fine with this. I hope that you agree to answer all questions as openly and honestly as possible.

1. Demographic Information

1.1 Gender	
a) Male	b) Female

1.2 When were you born?	

1.3 Where were you born?	

1.4 Marital Status				
a) Married	b) Single	c) Divorced	d) Widowed	e) Living with partner
Other (Specify)				

1.5 What is your home language?

a) Oshiwambo_____ g) Setswana _____
b) Otjiherero _____ h) Afrikaans _____
c) Damara_____ i) English _____
d) Nama _____ j) German _____
e) Rukwangali _____ k) San language _____

1.6 What is your last grade passed

a) ___No education
b) ___Primary schooling (Grade 1-7) Specify _____)
c) ___Secondary schooling (Grade 8-10) Specify_____)
d) ___Senior secondary (Grade 11-12) Specify _____)
e) ___Tertiary education (Includes university and technikon)
f)____Post secondary training (all other training besides university and technikon)
g) ___Others (specify) _____

1.7 Are you the head of the household?	
a) Yes	b) No

1.8 Who makes the major decisions in the household?						
a) Respondent	b) Husband	c) Wife	d) Father	e) Mother	f) Aunt	h) Other relative (specify)
Other (Specify)						

1.9 Are you employed?	If yes, go to 1.10. If no, go to 2
a) Yes	b) No

1.10 (i) Type of employment:

a) ___ full time
b) ___ part time
c) ___ casual (2 days or less per week)
d) ___ other (specify)

1.10 (ii) Type of employment:

a) Supervisory office worker	
b) Non manual office worker	
c) Foreman/supervisor	
d) Skilled manual worker	
e) Semi skilled manual worker	
f) Unskilled manual worker	
g) Services worker	
h) Domestic worker	
i) Child minder	
j) Trader, hawker, vendor	
k) Member of military/security personnel	
l) Other (Specify)	

2. Migration

The following questions to be asked only to those not born in Windhoek

2.1 How long have you been living in Windhoek?					
a) 0-2 years	b) 3-4 years	c) 5-6 years	d) 7-8 years	e) 9-10 years	f) More than 10 years

2.2 From which region do you come	
a) Omusati	h)Otjozondjupa
b) Ohangwena	i) Erongo
c) Kavango	j) Omaheke
d) Caprivi	k) Khomas
e) Kavango	l) Hardap
f) Caprivi	m) Karas
g) Oshana	

2.3 Name the village or town that you come from

2.4 How long have you been staying in this house?					
a) 0-6 months	b) 7 months to one year	c) 2-3 years	d) 4-5 years	e) 6-7 years	f) more than 7 years

2.5 Who is the owner of the house?

2.6 Is the owner from Windhoek ?	
a) Yes	b) No

2.7 If no, specify where the owner of the house is originally from?

2.8 Where did you live when you first moved to Windhoek?	
a) Same house in this location	
b) Different house in same location	
c) Different location	
d) Other (Specify)	

2.9 After moving away from your home village or town, did you move somewhere else before moving to Windhoek? If yes, specify where

2.10 In order of priority, name up to three reasons why you left your home town

a) Lack of job _____
b) Poverty _____
c) Drought _____
d) To join spouse/family/relative _____
e) Lack of education/training _____
f) Lack of entertainment _____
g) Lack of health/medical facilities _____
h) Lack of access to water/electric, etc _____
i) Lack of opportunities (self employment, income, and so on _____

2.11 In order of priority, name up to three reasons for choosing to move to Windhoek

a) Looking for a job_____ g) Get by: by any means __
b) To join spouse/family/relative_____ h) Entertainment_____
c) Education and training _____ i) Other (Specify) _____
d) Opportunities _____

2.12 When you moved to Windhoek did you move			
a) On your own	b) With husband/wife	c) With children, relatives, family	d) With friends
Other (specify)			

2.13 Are you considering going back to your home town / village		
a) Yes	b) No	c) Maybe
Remarks:		

2.14 If yes, under what conditions would you move back to your home area:
Specify

2.15 If no, what are the factors that will cause you not to want to leave Windhoek
Specify

2.16 Do you still have relatives in your home village / town?	
a) Yes	b) No

2.17 If your answer for 2.16 is 'yes' please specify relation			
a) Parents	b) Siblings	c) Spouses	d) Other (Specify)

2.18 How often do you visit your place of birth/home town per year?

a)___ Very often (How many times)_____
b)___ Never
c)___ Not often (How many times)_____

2.19 Do you have any land in your home village?	
a) Yes	b) No

2.20 If yes specify ownership

3. Households

3.1 Ownership of House			
a) Self ownership	b) Renting	c) Relative's house	d) Live in worker
Other (Specify)			

3.2 Owner of the House	
a) Male	b) Female

3.3 What type of job does the owner of the house have (specify)
If the respondent lives in a company compound, name the company here:

3.4 How many rooms are in the house?				
a) one	b) two	c) three	d) four	e) five

3.5 How many people are usually in your house

3.6 Are there any persons older than 60 years old living with you?	
a) Yes	b) No

3.7 How many people living in the house get a government pension?
Specify:

3.8 If any, how many children under 16 are living in the house?
Specify:

3.9 How many people in your household work?

3.10 How many people in your household contribute financially to the household?

3.11 Are there any other financial contributions to your household?	
a) Yes	b) No

3.12 If yes, specify

4. Housing

4.1 Type of house				
a) Bricks	b) Wood	c) Corrugated iron	d) Plastic	e) Other

4.2 What type of energy is available in the house?

4.3 What source of energy is being used in your house for cooking

4.4 What type of toilet facilities is available at your house?			
a) Inside toilet	b) Outside toilet	c) Communal toilet	d) Other

4.5 Availability of Water			
a) Private tap	b) Communal water point	c) Buying from neighbours	d) Other

4.6 What types of problems do you experience with the house?
Specify?

5. Income

5.1 What type of job have you been doing before this (over last five years)? Specify
a) Supervisory office worker
b) Non manual office worker
c) Foreman/supervisor
d) Skilled manual worker
e) Semi skilled manual worker
f) Unskilled manual worker
g) Services worker
h) Domestic worker
i) Child minder
j) Trader, hawker, vendor
k) Member of military/security personnel
l) Other (Specify)

5.2 What is your personal average monthly income currently? (In N$)
Indicate:

5.3 What is your personal average monthly income (N$) currently?					
a) 0-500	b) 600-1000	c) 1100-1500	d) 1600-2000	e) 3000-4000	f) more than 4000

5.4 List the sources of income that you personally have (eg: contributions from friends and family members, selling things on streets, other)					

5.5 What is the total household income per month - including your own income - before you pay expenses? In other words, what is the income from other family members?

5.6 What do you like about living in Windhoek? List up to three things

5.7 What do you not like about living in Windhoek? List up to three things

6. Expenditure

6.1 About how much money (N$) do you spend on food pr month?					
a) 0-100	b) 150-200	c) 300-500	d) 600-700	e) 800-900	f) More than 1000

6.2 Per month, how much money do you spend on:			
a) Rent, prepaying house bond:	b) Energy:	c) Transport	d) Education
N$	N$	N$	N$

6.3 Do you send money home on a monthly basis	
a) Yes	b) No

6.4 If yes, how much money do you send on average?
N$

7. Sexual Behaviour

*Enumerators: From now on the questions that I will be asking may be very personal because they deal with sex and HIV/AIDS. As I said at the beginning, I'll be asking personal questions. I hope that you will be fine with this and will try and answer all questions as honestly and openly as possible. All responses will be confidential.

7.1 Do you think women can refuse to have sex with a man?

a) Yes	b) No

7.1. If yes, under what circumstances do you think a women can refuse to have sex with a man? List up to three reasons.

7.3. If you think a woman cannot refuse to have sex with a man (either husband or someone else) why do you think this? List up to three reasons.

7.4. Have you ever had sex?	
a) Yes	b) No

7.5. Are you currently sexually active?	
a) Yes	b) No

7.6. Have you had more than one sexual partner over the last 5 years?	
a)Yes	b)No

7.7. If, yes, how many sexual partners have you had over the last 5 years?

7.8. Do you usually use a condom when having sex with:							
a) Husband/ Wife		b) Boyfriend / Girlfriend		c)Causal sex (one night stand)		Any other (specify)	
i) Yes	ii) No	i) Yes	ii) No	i) Yes	ii) No	i) Yes	ii) No

7.9. Do you know if your sexual partner has had (or is having) any other sexual partners besides you?		
a) Yes	b) No	c) Maybe

7.10. Do you have difficulties using a condom when having sex?	
a) Yes	b) No
c) Sometimes (specify)	

7.11. How do you feel about using a condom when having sex?				
a) Feel good	c) Feel comfortable	c) Feel uncomfortable	d) Don't like it	e) Never used a condom before

8. Knowledge of HIV/AIDS

8.1. Have you heard about HIV and AIDS?	
a) Yes	b) No

8.2. If yes, how much would you say you know about HIV/AIDS?			
a) Very little	b) Enough	c) A lot	d) Everything

8.3. Can you easily identify people with HIV/AIDS?	
a) Yes	b) No

8.4. If yes, how? List at least three ways.

8.5. What do you think you can do to protect yourself from getting HIV/AIDS?
Specify.

8.6. In order of priority where do you normally get information about HIV/AIDS?

_____a) radio
_____b) newspaper
_____c) clinic/hospital
_____d) posters/leaflets/outdoor advertising
_____e) family/relatives (specify) _____
_____f) other (specify) _____
_____g) television
_____h) spouse

8.7. Would you go for a voluntary counselling and testing (VCT)?	
a)Yes	b)No

8.8. Have you ever gone for an HIV/AIDS test?	
a) Yes	b)No

8.9. If yes, have you ever received your test results?	
Yes	No

8.10. If yes, has your HIV/AIDS results changed the way you feel about relationships, sex, etc.?

_____a) yes
_____b) no
_____c) somewhat (specify) _____

8.11. Do you think HIV/AIDS is a major health risk in the area you live in?

_____a) Yes (give reason) _____
_____b) No (give reason) _____

8.12. Do you know of anyone who has HIV/AIDS?

____a) Yes (specify relation) _____
____b) No

8.13. Do you know of anyone who has died of AIDS?	
a)Yes (specify)	b) No

8.14. What do you think are men's rights when it comes to HIV/AIDS? Specify.

8.15. What do you think are women's rights when it comes to HIV/AIDS? Specify.

8.16. Do you think HIV/AIDS is a threat to your health?
a) Yes (specify reason)
b) No (specify)

8.17. How can you protect yourself from contracting HIV/AIDS? * *tick up to five*	
a) do not know	r) keep mosquitoes away
b) none, there is no way to protect yourself	s) do not have sex with animals
c) use condom all the time when having sex	t) do not use public toilets
d) use condom with casual partners	u) use other contraceptives (non-condom)
e) use condom with regular partners	v) do not use the same plates/ utensils
f) use condom if you do not trust the other person	w) stick to one partner at a time
g) avoid blood – unspecified	x) stick to one partner for life (marry)
h) avoid blood – razors/needles	y) avoid prostitutes
i) avoid blood transfusion	z) avoid taking care of someone with AIDS
j) do not have sex with women who had miscarriages	aa) use condoms properly
k) avoid contact with infected person's urine/faeces	bb) get traditional healer to protect you
l) do not have casual sex partners	cc) purposely damaging condom during sexual intercourse
m) abstain from sex	dd) have sex with animals
n) avoid touching someone with HIV/AIDS	ee) masturbation
o) avoid traditional scarification	ff) wearing gloves when attending to AIDS patient or when in contact with blood
p) avoid homosexuality	gg) do not have sex with a woman who had an abortion
q) avoid infected person's saliva	hh) Others (specify

8.18. How would you rate your risk of contracting HIV/AIDS?		
a) low (why)	b) medium (why)	c) high (why)

8.19. Statement	Agree	Disagree
a)An HIV/AIDS positive man can give the HIV virus to a woman when having unprotected sex with her		
b)An HIV/AIDS positive woman can give the HIV virus to a man when having unprotected sex with him		
c) A child can become HIV positive		
d) There is a cure for HIV/AIDS		
e) A doctor / nurse / traditional healer can make you healthy again after you have contracted HIV		
f) HIV infection can be prevented by using a condom when having sex		
g) A husband has a right to have sex with his wife without a condom when he feels like it		
h) A wife has a right to insist that her husband uses a condom when having sex when she feels like it		
i) A women can refuse to have sex with her husband/partner if the husband / partner does not want to use a condom		
j) Sleeping with a virgin can cure AIDS		
k) Women who carry condoms sleep around		
Remarks:		

**Enumerator*
It was nice talking to you. I would like to thank you for giving your time to answer these questions. I would like to assure you that all information will be dealt with confidentially.

Thank you once again.