Community Mobilization Activities
Rundu, Namibia
November 2004
Acknowledgements

We would like to thank the Ekongoro Youth Camp for providing a venue for our Training of Facilitators. Also we would like to thank the Sauyemwa Junior Primary School for providing the venue for our peer sessions. We also must acknowledge the enormous contributions of our working group of community leaders for their involvement and assistance in planning these events. A special vote of appreciation goes out to the late Mr. Timothy Philimon, who served as our initial point of contact in the Rundu constituency. Also, a hearty thank you goes to the Trainers and Facilitators for their tireless efforts not only through the trainings and peer sessions, but also to translate materials and in meetings for the Peace Corps Volunteers. Thank you very much to the peers in each session for your candid responses. We appreciate the assistance of all community members involved in the research and look forward to our continued relationship as we move forward into our Community Action Forum phase.
# List of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ARV</td>
<td>Anti-retroviral therapy</td>
</tr>
<tr>
<td>CAF</td>
<td>Community Action Forum</td>
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<td>CMA</td>
<td>Community Mobilization Activities</td>
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<tr>
<td>ELCIN</td>
<td>Evangelical Lutheran Church in Namibia</td>
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<tr>
<td>GOVT</td>
<td>Government</td>
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<tr>
<td>HCP</td>
<td>Health Communication Partnership</td>
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<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>M</td>
<td>Men (26-45 years)</td>
</tr>
<tr>
<td>MBESC</td>
<td>Ministry Basic Education, Sport and Culture</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>OM</td>
<td>Older Men (over 46 years)</td>
</tr>
<tr>
<td>OVC</td>
<td>Orphans and vulnerable children</td>
</tr>
<tr>
<td>OW</td>
<td>Older Women (over 46 years)</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Preventing Mother to Child Transmission</td>
</tr>
<tr>
<td>TOT</td>
<td>Training of Trainers</td>
</tr>
<tr>
<td>YM</td>
<td>Young Men (16-25 years)</td>
</tr>
<tr>
<td>YW</td>
<td>Young Women (16-25 years)</td>
</tr>
<tr>
<td>W</td>
<td>Women (26-45 years)</td>
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</table>
Rundu

Rundu, or Runtu as was originally named, began as a German command outpost near the beginning of the 20th Century. However, the area surrounding the Okavango region had been inhabited for many centuries by several warring tribes. When Charles John Anderson first came to Nkurenkuru in 1874, he found numerous Bantu peoples trading with one another as well as with the Portuguese in the area. The Bantu of the area (Vakwangali, Vambunza, VaShambyu, Vanyemba, Vagciriku, and Hamukushu) had by that time displaced the San, who have inhabited the area since approximately 1000 A.D, as the predominant people. It was just one decade later when the area was arbitrarily divided during the Berlin Conference and the region known as Kavango became a part of Southwest Africa.

The first colonial governor, Ludvein, then appointed a man named Von Hishburg to set up the first German command above the red line at Nkurenkuru. Von Hishburg later relocated the command post east to what is present day Rundu. Oral tradition holds that when Von Hishburg arrived, his personal belongings were transported by camels, and it is these camels after which the local people named the post Runtu. Rundu remained a relatively small settlement, primarily subsisting on horticulture, fishing, and cattle.

Through the years of colonial rule, and South African occupation, Rundu has continued to grow as the center of commerce of the Kavango region. After independence in 1990 Rundu was divided into two separate constituencies for the purpose of governance, these were Rundu Urban and Rundu Rural. The informal settlements adjacent to Rundu, were incorporated in Rundu Rural. These settlements include; Kechemu, Ndama, Kaisosi, and Sauyemwa. These settlements surround Rundu town, and over 90% of their inhabitants live with no municipal services. These settlements have grown rapidly since independence, as more people from rural areas migrated to cities in search of employment. As the town of Rundu and the adjacent villages and settlements have grown, service providers have struggled to keep up with demand. Many of those in extreme outlying areas, such as Sauyemwa and Kasote where this research has taken place, still rely on subsistence farming.

Background

To better understand and address the myriad of problems that communities throughout Namibia face in relationship to HIV, the Health Communication Partnership (HCP)1 conducted a series of community participatory assessment exercises in several communities: Rehoboth, Rundu, Oniipa, Walvis Bay and Oshikuku.

The purpose of these exercises was to assist communities in:

- Better understanding the health beliefs concerning HIV/AIDS;
- Identifying and responding to negative norms that fuel the local HIV/AIDS epidemic; and
- Stimulating and identifying local solutions that effectively deal with and diminish the scourge of HIV/AIDS in the community.

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1 Based at Johns Hopkins University Bloomberg School of Public Health/Center for Communication Programs, (JHU/CCP), HCP is a consortium that includes JHU/CCP, The Academy for Educational Development (AED), Save the Children, The International HIV/AIDS Alliance, Tulane University and the University of North Carolina.
To achieve this, HCP supported a three-step community mobilization process in each community:

Step 1 Community participatory assessment
Step 2 Development of Community Action Forums (CAFs) and action plans, and
Step 3 Implementation of these action plans.

Using a community participatory assessment tool designed by HCP, community members participated in 4 half-day sessions that examined the following questions:

- What are the main problems for people like you in your community?
- What are the main reasons people like you are getting infected?
- What are the main influences on sexual behaviors for people like you?
- What do people like you need to live a healthy sexual and reproductive life?

Community members who participated in this assessment process represented six distinct peer groups: young men and young women ages 16-25 years, men and women ages 26-45 years, and older men and older women over 46 years. Each peer group met separately and privately. This allowed for in-depth discussion within the peer group and reflection on some of the sensitive, sociocultural issues driving the spread of HIV/AIDS in Namibia.

Discussion highlights from the peer sessions were reported back to the larger community through community feedback meetings. From these community feedback meetings, Community Action Forums (CAF) were created to begin addressing the main problems identified. These CAF are currently underway in the identified project communities.

These community mobilization activities (CMA) recognize that individuals, households, and communities have the knowledge and skills to improve their situation, and that, by connecting people and facilitating a process of learning and exchange, communities can become active guardians of their own health.

The findings that follow were collected and shared in Rundu, Namibia, and are included in this report with hope that others working in this area can use this information to enhance and improve upon their current HIV/AIDS activities.

The CMA Process

*Introductory meeting with community leaders*
A community leaders meeting was held at the Rundu Town Hall on August 18, 2004. At this meeting, HCP explained the rationale behind the CMA process noting the necessity of involving people in the community in order to truly understand how the community experienced and was affected by HIV/AIDS. Despite the many prevention efforts aimed at addressing this illness, the increase in HIV infection had not been stemmed in Namibia. Given this, a process of inward reflection was critical to understanding what caused HIV transmission and how
HIV/AIDS affected the lives of people in the community. Gathering information from a wide range of people about what they thought, felt and experienced in relation to HIV/AIDS would be extremely useful to the community and other organizations working in this area, and would put the community in a much better position to develop effective interventions.

CMA is a community-driven process. HCP emphasized that the success of CMA depended to a large extent on the participation of the community. Communities have first hand knowledge about their own problems and what is causing them. HIV/AIDS issues in particular, are best discussed and elicited by the community members from the inside given the sensitive and private nature of the disease. HCP assured the group that it would play a supportive role throughout the CMA process.

Community leaders were given a choice of whether they wanted to conduct CMA in their communities. All the members present at the meeting unanimously expressed the view that CMA would be valuable for the people in their community. This was followed by considerable debate concerning the selection of a CMA. Due to the lack of services and poverty in the Sauyemwa community, it was agreed that the assessment should take place there.

With the guidance of HCP staff, community leaders established six peer groups for the purpose of the CMA: young women and men (ages 16-25 years), women and men (ages 26-45 years), older women and men (46+ years). Each peer group would meet privately to discuss the experiences of people like them in their community with regard to HIV/AIDS. Such stratification would lend itself to eliciting sensitive information in a secure environment, hopefully leading to relatively open and uninhibited dialogue. These peer groups would also provide a range of perspectives and create a holistic picture of how HIV/AIDS impacts on the community. With this understanding, the community would be better equipped to develop a more targeted response to dealing with the HIV/AIDS epidemic.
Selecting Trainers
With help from the advisory committee under the leadership of the late Mr. Timothy Philimon, several people were identified to serve as trainers for the Rundu CMA. The HCP staff organized a meeting of potential trainers to explain the CMA process to them and to clarify their role and the nature of their commitment in the process. HCP requested that trainers be respected in the community, have some prior training experience, be able to commit their time to the CMA process and that they be of the appropriate age and gender that mirrored the demographics of the peer groups identified. Selection criteria also included trainers having verbal and written fluency in English and Okavambo (the primary language spoken in Rundu). Trainers were paid a stipend in return for their services.

Training of Trainers
Training of trainers (TOT) was held at the Greiter’s Conference Center outside of Windhoek in September 2004. The purpose of the TOT was three-fold: (1) to introduce the trainers to the participatory tool that would be used to collect information from the peer groups; (2) to equip the trainers with data collection skills and techniques to gather sensitive information from the peer groups regarding HIV/AIDS and (3) to empower the trainers in their ability to impart these skills to facilitators who would assist them in subsequent group sessions.
The CMA process was explained to the participants in detail during the training session. The first half of the training session used observation and role-play to teach data collection techniques with HCP staff acting as trainers and the participants acting as community members. Gradually, participants assumed the role of trainers, facilitating group sessions as well as taking notes. Combining these training methodologies, participants became familiar with both the data collection tool/questionnaire, and the process. Participants also reviewed each of the four data gathering sessions that were to be used to gather information from the various peer groups. They gradually grew adept at using flip charts and markers to draw pictures that represented ideas and concepts thus reducing reliance on words and language, which was essential for using this particular tool.

Participants learned that this tool for data collection transcended language and literacy barriers and made it possible for all to participate in the process regardless of their academic backgrounds. The vicarious nature of data collection was also impressed upon participants. Repeatedly, participants were guided to elicit information from peer groups about issues related to HIV/AIDS that affected people like them. Participants were urged to avoid direct questioning, to use probing techniques and to use this phrase while asking questions: what do people like you think? What do people like you feel? What is the opinion of people like you? Participants were further informed that since this was a data gathering process, it was important for them to avoid giving their own opinions, views and ideas on the issue, but rather to elicit such information from their peers. Participants were also encouraged to take detailed notes during the sessions.

During the second half of the training, each participant assumed an independent role as a trainer, with the HCP staff assuming the roles of observers. Skills to elicit sensitive information and participation from all without being exclusionary were emphasized. Using appropriate probing techniques to elicit sensitive information, dealing with that sensitive information and employing methods to deal with potential conflict within the group were also discussed. Session binders were distributed to participants for their future reference. At the end of the training, HCP staff again emphasized that these participants were the leaders of the CMA process and that the quality and quantity of data collected depended on their ability to adequately train the facilitators to elicit and record information in the peer sessions.

**Selecting facilitators**

The trainers helped select twelve facilitators. The selection criteria for the facilitators were similar to that of the trainers. Emphasis was placed on ensuring that the facilitators’ age and gender mirrored the demographic characteristics of the six peer groups. This was seen as essential in making the different age and gender groups feel more comfortable to discuss and share sensitive information. Unfortunately, some of the facilitators that were chosen were not as conversant in English as had been expected.

**Training facilitators**

The training of facilitators took place in October 2004 at the Ekongoro Youth Camp. The trainers conducted the training of facilitators based on the training format of the training of trainers, as described above.
Prior to the peer session in which data were collected from the community members, HCP staff met with the trainers and facilitators to go over any questions or clarifications. During this meeting, materials needed for peer sessions were also provided to the trainers. A stipend was given to the facilitators for their contribution to the process.

**Selecting peer groups**
Participants in the peer group were recruited based on their age, gender and residence in Sauyemwa. Peers from different parts of Sauyemwa were sought so as to get a representative sample of the entire community. The trainers and facilitators solicited participation from the community through word of mouth and door-to-door visits. Each peer group comprised 12-15 participants.

**Conducting peer sessions**
The peer groups met over four half-day sessions during 11 to 15 October 2004. The timing of these peer sessions was adjusted to accommodate the schedules of the various peer groups including students and workers. Each of the six peer sessions took place in separate class rooms at the Sauyemu Primary School. The sessions were conducted in Lozi by a team of three people including one trainer and two facilitators. This team of people led the discussions, recorded the discussions and translated the notes into English for HCP at the end of the peer sessions.

**Community feedback meeting**
After completing the peer sessions, a community feedback meeting was held at the Sauyemwa Church Hall in February 2005. At this meeting the trainers, facilitators and peer group participants presented the findings from the peer sessions to broader Sauyemwa community, including community leaders, governmental and non-governmental organizations. The purpose of this community feedback meeting was to use the findings from the peer group sessions to create a holistic picture of how HIV/AIDS impacts the community and to move forward and develop interventions and strategies to address some of the issues raised in the peer sessions.

**Understanding the findings**
The findings that follow integrate the notes taken by the trainers and facilitators at the peer sessions, the flip charts that were also used at the peer sessions and the notes taken at the community feedback sessions.
CMA

Community Mobilization Activities

SESSION 1 Questions

1. What are the main problems for people like you in the community?

2. From the perspective of people like you, which peer group in this community is the most vulnerable to HIV/AIDS?

3. What are the reasons why people like you are getting infected with HIV? How common are these reasons for people like you? How are these problems making people like you vulnerable to HIV infection?
SESSION 1

The purpose of this session was to explore the perceptions of the peer groups (grouped by age and gender) regarding the most significant problems that people like them experience in their community. This was important to help appreciate whether or not the various peer groups saw HIV as a significant problem for people like them. This session also explored each peer group’s perception of their risk to HIV relative to other peer groups. The final part of the session focused on understanding the reasons why people like them are becoming infected with HIV.

Question 1

What are the main problems for people like you in this community?

Process

Each peer group’s first task was to brainstorm and discuss problems that they thought people like them faced in the community. Participants then drew a picture or a symbol to represent the problems on flip chart paper.

Problems were then prioritized in terms of importance using a pair-wise ranking matrix. A pair-wise ranking matrix is simply a method to compare each item or in this case each problem against every other problem to determine which is the most significant problem.

Lastly, groups brainstormed a list of institutions/individuals that were trying to help them with each of the problems identified and used the symbols +, ++, and +++ to represent whether the help is perceived to be a little, average, or a lot. Although the results give an impression of what institutions/individuals the peers found most helpful, the results should be read with caution as some institutions mentioned may not have been the most appropriate for dealing with the problem identified. For instance, the police are not directly mandated to help a community with unemployment though they may have been identified as being unhelpful in this problem area.

Findings

Problems are listed, both in the text and in the table, in the order of importance by which they were ranked. The number in the parentheses reflects the number of times that the particular problem surfaced in the pair-wise ranking matrix. Where they are necessary, explanatory notes have been added to the report.

YOUNG MEN (ages 16-25 years)

The main problems identified by the young men’s group include:

1. Hunger (4)
2. High population (4)
3. Unemployment (3)
4. Death (2)
5. Crimes (1)

Table 1: Perceived helpfulness of agencies assisting young men with identified problems
This chart was not provided by the young men’s group, most likely due to time constraints or misunderstanding.

**Discussion highlights**

- The YM group discussed hunger, unemployment and lack of education as related issues, since unemployment can be seen as a result of lack of education. Also, hunger can be seen as a result of poverty and therefore unemployment.
- The group also felt that the death rate is a problem in the community because they feel there will be no male leaders in the future.
- The group discussed crime in the form of rape, murder and theft as a problem in the community.

**YOUNG WOMEN (ages 16-25 years)**

The most important problems facing young women in this community include:

1. Lack of jobs (6)
2. Unwanted pregnancy (3)
3. Clients (3)
4. Poverty (3)
5. Alcohol (1)
6. Theft (1)

<table>
<thead>
<tr>
<th>Key problems</th>
<th>Agencies/helpfulness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Community</td>
</tr>
<tr>
<td>Lack of jobs (6)</td>
<td>+</td>
</tr>
<tr>
<td>Poverty (3)</td>
<td>+</td>
</tr>
</tbody>
</table>

**Table 2: Perceived helpfulness of agencies assisting young women with identified problems**

- The YW feel that the church, NGOs and GRN to a certain extent assist in alleviating problems related to unemployment.
- They also feel that NGOs and GRN to some degree assist in alleviating poverty.
- The YW however feel that little help is coming from the community to alleviate unemployment and poverty.
- YW also feel that the church does very little to alleviate poverty.

**MEN (ages 26-45 years)**

The main problems identified by the men’s group were:

1. Alcohol (7)
2. Community meetings (7)
3. Dumping site (6)
4. HIV/AIDS (5)
5. Sugar daddy (4)
6. Dust (2)
7. Lack of water (3)
8. Dust (2)
9. Lack of electricity (1)
10. Robberies (0)

Table 3: Perceived helpfulness of agencies assisting men with identified problems

<table>
<thead>
<tr>
<th>Key problems</th>
<th>Community/helpfulness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Church</td>
<td>++</td>
</tr>
<tr>
<td>NGOs</td>
<td>+++</td>
</tr>
<tr>
<td>Alcohol (7)</td>
<td>++</td>
</tr>
<tr>
<td>Community meetings (7)</td>
<td>+++</td>
</tr>
<tr>
<td>Dumping site (6)</td>
<td>++</td>
</tr>
<tr>
<td>HIV/AIDS (5)</td>
<td>++</td>
</tr>
</tbody>
</table>

Discussion highlights

- The dumping site is intended to be representative of both poverty and lack of education. This is noted in the transcript; “it indicate that people who go at the dumping site don’t have money that is why they are going to look for food and it result not going to school”.
- The group then discussed the “sugar daddy” phenomenon and HIV/AIDS as being related and listed both as significant problems for people like them in their community.
- The remainder of the notes for the group involves mostly discussion around what symbols should be used to represent the various issues.
- The following deductions can be made from the contents of the table:
  - Men feel that the church is doing a lot in their community with respect to the alleviation of the alcohol problem, community meetings, dumping site and most importantly HIV/AIDS.
  - According to M the community is involved a lot in community meetings, which is as could be expected, but to a lesser extent involved in combating alcohol consumption, dumping site scrounging and HIV/AIDS.
  - The M feel that the GRN is to a lesser extent involved in combating alcohol abuse and involved in community meetings.
  - At the community feedback meeting the group explained that the reference to the community meetings was intended to represent the lack of attendance at the community meetings. Also, that the dust creates in unhygienic environment in their homes.

WOMEN (ages 26-45 years)

The most critical problems faced by women in this community are as follows:

1. Poor people
2. Water (sanitation)
3. Sickness
4. Alcohol
5. Lack of clinics
6. Garden
7. Not enough jobs
8. Not enough houses
Table 4: Perceived helpfulness of agencies assisting women with identified problems
This chart was not provided by the women’s group, most likely due to misunderstanding. Unfortunately at the time this particular question was posed to each of the groups, several of the women’s facilitators were not present and the group had waited over 2 hours. The group proceeded without the facilitator and as a result several of the initial questions were misunderstood or not completed. The group also did not complete a pair-wise ranking matrix, so the order in which the problems are listed is arbitrary. It does appear from the notes that the group attempted to complete the matrix but only filled in the first few boxes before giving up the effort.

Discussion highlights
- The group’s discussion appears to have been rather general and all of the problems were considered to be related. The group also discussed that they believe these problems should be solved by the government of Namibia, as well as by foreign governments and NGOs.
- The group seems to have presented the wrong chart for this question at the community feedback meeting as the presenter was discussing several issues not mentioned for this question (including adultery, money and clothes).

OLDER MEN (ages 46 and over)
The main problems identified by the older men in the community include:
1. Water (5)
2. Unemployment (5)
3. Drought relief (3)
4. Criminals (2)
5. Alcohol (1)
6. Disco (0)

Table 5: Perceived helpfulness of agencies assisting older men with identified problems

<table>
<thead>
<tr>
<th>Key Problems</th>
<th>Agencies/helpfulness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Community</td>
</tr>
<tr>
<td>Alcohol (1)</td>
<td>+++ ☺</td>
</tr>
<tr>
<td>Disco (0)</td>
<td>+++ ☺</td>
</tr>
<tr>
<td>Criminals (2)</td>
<td>+++ ☺</td>
</tr>
<tr>
<td>Drought relief (3)</td>
<td>+++ ☺</td>
</tr>
<tr>
<td>Water (5)</td>
<td>+ ☺</td>
</tr>
<tr>
<td>Unemployment (5)</td>
<td>- ☺</td>
</tr>
</tbody>
</table>

Discussion highlights
- The OM group discussed the issues of alcohol and discos as being related and also as contributing factors to the spread of HIV. The group also felt that the reason the youth were engaging in this negative behavior was due to a lack of parental control.
- The group also felt that while the youth were indeed using condoms, alcohol abuse contributed to misuse of condoms.
• The OM group felt that HIV is a penalty that was given to the people as punishment for disobeying the Lord.
• The group then discussed violence and theft as problems facing their community. The next issue discussed was hunger. The group felt that in the past the community had enough food and hunger was not an issue.
• They felt that not enough government assistance in the form of drought relief was provided to their community.
• The group discussed that the problem of water is not a lack of water, but they did not feel the town council should be able to ask them to pay for the water.
• Finally, they felt that the unemployment is very high in their community due to lack of factories and companies. No notes were provided as to the content of the discussion.

The following deductions can be made from the contents of the table:
• OM feel that the community, church and GRN are very helpful in assisting them with the problems of alcohol abuse, discos, criminality and drought relief.
• The OM also feel that the church helps them a lot with combating unemployment.
• The assistance from NGOs was deemed to be very little and inadequate in all respects.
• The community, church and GRN were not very helpful in alleviating water problems.
• Unemployment seems to be the problem receiving the least attention from agencies.

OLDER WOMEN (ages 46 and over)

The main problems identified by the older women in the community include:
1. Poverty (4)
2. Alcohol (3)
3. Crime (2)
4. Adultery (1)
5. Condoms (0)

Table 6: Perceived helpfulness of agencies assisting older women with identified problems

<table>
<thead>
<tr>
<th>Key problems</th>
<th>Agencies/helpfulness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Church</td>
</tr>
<tr>
<td>Alcohol (3)</td>
<td>+++☺</td>
</tr>
<tr>
<td>Poverty (4)</td>
<td>+☺</td>
</tr>
<tr>
<td>Condoms (0)</td>
<td>+++☺</td>
</tr>
<tr>
<td>Adultery (1)</td>
<td>++☺</td>
</tr>
<tr>
<td>Crime (2)</td>
<td>++☺</td>
</tr>
</tbody>
</table>

Discussion highlights
• The group discussed that they believed condoms are a problem for people like them in their community because “it is against God’s will to use condoms”. They also discussed their suspicion as to what may be inside the condoms.
The following deductions can be made from the contents of the table:

- The OW feel that the church is doing a lot with respect to addressing alcohol abuse and problems around the use of condoms. The church is less involved in combating adultery and crime and the least with the alleviation of poverty.
- The GRN is seen to be doing a lot with respect to addressing alcohol abuse, poverty and crime, but doing little about adultery and crime.
- The OW feel that NGOs are doing a lot with respect to addressing poverty and adultery, but little about alcohol abuse and least about condoms and crime.
- During the community feedback meeting the group elaborated on the meaning of “crime” as a problem stating that it included the rape of women. They also clarified that they are afraid to go to New Start and to use condoms.

**Comparative conclusions**

Session 1/Question 1:  
*What are the main problems for people like you in this community?*

The table below provides a summary of the main problems affecting people like them in their community as identified by the different peer groups.

*Table 7: Summary of the problems experienced by the different peer groups in Rundu*

<table>
<thead>
<tr>
<th>Peer groups</th>
<th>Problem 1</th>
<th>Problem 2</th>
<th>Problem 3</th>
<th>Problem 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young men</td>
<td>Hunger</td>
<td>High population</td>
<td>Unemployment</td>
<td>Death</td>
</tr>
<tr>
<td>Young women</td>
<td>Lack of jobs</td>
<td>Clients</td>
<td>Unemployment (poverty, rape)</td>
<td>Poverty</td>
</tr>
<tr>
<td>Men</td>
<td>Community meetings (lack of attendance)</td>
<td>Alcohol</td>
<td>Unwanted clientship (HIV/AIDS)</td>
<td>HIV/AIDS</td>
</tr>
<tr>
<td>Women</td>
<td>Poverty</td>
<td>Water (sanitation)</td>
<td>Illness</td>
<td>Alcohol</td>
</tr>
<tr>
<td>Older men</td>
<td>Unemployment</td>
<td>Water</td>
<td>Drought relief</td>
<td>Criminals</td>
</tr>
<tr>
<td>Older women</td>
<td>Poverty</td>
<td>Alcohol use</td>
<td>Crime</td>
<td>Adultery</td>
</tr>
</tbody>
</table>

**Key findings**

- All groups mentioned the economic status of the community as the highest priority, though each group used a different indicator or name for this issue. However, aside from economic considerations, few issues were cited with any consistency.
- Both OM and OW cited crime as a problem for people like them.
- Also both M, W and OW cited alcohol as a problem in the community.
- The YM group felt that the death rate is a problem in the community because they feel there will be no male leaders in the future.
- The lack of consistency surrounding community problems across groups (with the glaring exception of poverty) may be due to the heterogeneous sample as members of peer groups were taken from two separate communities (Sauyemwa and Kasote).

The variance may also simply reflect the severity of the issue of poverty while other problems appear to wane in the background.
• This seems very credible when considering four of the six groups chose economic troubles (termed differently as hunger, lack of jobs, unemployment, and poverty), as the largest problem in the community.
• Very little attention was given to HIV/AIDS and illness and it was only mentioned by men and women. This could indicate that it is not such a big problem or that the economic problems are more overwhelming.
• The perceived helpfulness of agencies is low. The church seems to be the most involved and providing the most assistance followed by GRN and NGOs at a lower level. The community is not perceived as being very helpful.
• It is clear that the peer groups’ expectations of agencies are too high, they were evaluated incorrectly or that their efforts are really not making the required difference.

**Question 2**

**From the perspective of people like you, which peer group in the community is the most vulnerable to HIV/AIDS?**

**Process**
The participants first drew a picture or a symbol for each of the peer groups who were part of the process and charted them on a flip chart. Next, they discussed which peer groups they thought were most vulnerable to HIV/AIDS and why. Following this discussion, each peer group ranked the groups from one to six, with one being the most vulnerable, and six being the least vulnerable.

**Findings**
The following table lists the results of the ranking exercise. The table below provides an overview on which each peer group thought was most vulnerable to the HIV infection in their community.

*Table 8: Summary of findings of which groups are most vulnerable to HIV according to each peer group*
**Peer groups**

<table>
<thead>
<tr>
<th>Groups</th>
<th>Most vulnerable</th>
<th>2nd most</th>
<th>3rd most</th>
<th>4th most</th>
<th>5th most</th>
<th>Least vulnerable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young men</td>
<td>Young women</td>
<td>Men</td>
<td>Women</td>
<td>Young men</td>
<td>Older men</td>
<td>Older women</td>
</tr>
<tr>
<td>Young women</td>
<td>Young women</td>
<td>Women</td>
<td>Men</td>
<td>Young men</td>
<td>Older men</td>
<td>Older women</td>
</tr>
<tr>
<td>Men</td>
<td>Women</td>
<td>Young men</td>
<td>Young men</td>
<td>Men</td>
<td>Older men</td>
<td>Older women</td>
</tr>
<tr>
<td>Women</td>
<td>Women</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older men</td>
<td>Young women</td>
<td>Young men</td>
<td>Women</td>
<td>Men</td>
<td>Older men</td>
<td>Older women</td>
</tr>
<tr>
<td>Older women</td>
<td>Men</td>
<td>Women</td>
<td>Young men</td>
<td>Young women</td>
<td>Older women</td>
<td>Older men</td>
</tr>
</tbody>
</table>

**YOUNG MEN (ages 16-25 years)**

- The YM group scored the young women as the most vulnerable to HIV followed by the M group. These were identified as the most vulnerable due to the common occurrence of sugar daddies.
- The group discussed that the young women are the most vulnerable due to their desire for support in the form of money and clothes.
- The men (26-45 years) are then also scored as vulnerable due to their ability to provide support to the young women. The men are also seen as vulnerable due to the perceived commonality of alcohol use and consequential irresponsible behavior.
- The YM are then seen as the fourth most vulnerable group since they are exposed to HIV through sexual intercourse with the young women.
- The older men are seen as susceptible again due to their financial status, so that they are able to support young women.
- The older women are then seen as least vulnerable. However, they are still subject to HIV since they may contract the virus from their husbands who may be at greater risk if they have relationships outside of the marriage.

**YOUNG WOMEN (ages 16-25 years)**

- The group did not provide notes as to why they felt these groups were vulnerable and in fact did not clearly denote the ranking order of the groups. However, the order listed is the order the groups appeared on the flip chart, as this was taken to infer the ranking order.
- From the above it could be stated that YW see themselves as the most vulnerable group followed by W, M, YM, OM and OW.
MEN (ages 26-45 years)

- The M group scored the W group as most at risk, followed by the YM and YM group as equally at risk.
- The group discussed the YW and W groups as groups from which many casualties from HIV have been observed in the community. The group apparently felt that the women are at higher risk in general, again due to their desire for financial support from men.
- The M group believe that in their community 70% of those infected with the virus are women.
- The M group also saw themselves as vulnerable because they are able to provide support for women, as well as due to lack of self control.
- Then followed by the OM group and finally by the OW group as the least vulnerable to HIV.

WOMEN (ages 26-45 years)

- While the women did not rank each peer group in order of vulnerability, they clearly denoted themselves as the most vulnerable. The group felt that they were most at risk to HIV due to financial influences on their sexual behavior. The group discussed the pressure they feel from their peers to wear nice clothes and have money to spend.
- The group felt that this pressure encourages them to look for boyfriends to provide for these needs.
- The group also felt that people like them in their community are selling their bodies due to the lack of available jobs, transport, training materials, and unmet hopes of community members.
- The group discussed that they felt people like them were dying of AIDS because they are suffering from poverty, lack of knowledge about condom use and that even when people know about condoms they choose not to protect themselves².
- They also claim that the youth engage in sexual intercourse because it is fun. The group felt that they are the leaders of tomorrow and that they must “try to bring something new into the community” and “feel proud of what they are doing”.
- The felt that “the people see sexuality as a gift from God”. The group also discussed that they feel they do have the right to refuse to engage in sexual activity.
- The group was divided on the issue of the safety of condoms. While some members of the group felt that condoms are 100% safe, others disagreed and stated that the condom can break, slip off, or otherwise be rendered ineffective. However, it was agreed that a condom will help to protect both partners when engaging in sexual intercourse and that the directions should be followed carefully when using a condom.
- The group also felt that having multiple partners increased the risk of contracting HIV.
- The only mention of other peer groups was to the OW group who are seen as being vulnerable to HIV due to alcohol use.

² The notes read, “The causes of death by AIDS to us because we are very poverty and for fun (youth) lack of knowledge about using condom brings and ignorance of us, that is why people is die”. However it should be noted that in the culture the English word “ignorance” is taken to mean the act of ignoring. When it is discussed in regards to HIV, it is accepted to mean engaging in dangerous behaviours when the individual is aware that he/she is putting him/herself or others in danger of contracting the virus. In this way it is accepted as being more closely analogous to “denial”, it is most often applied to individuals who are aware that they are HIV positive but refuse to accept the implications thereof.
OLDER MEN (over 46 years)
• Older men also felt that YW are most vulnerable to HIV because men young and old want them for sex.
• The ranked YM as second vulnerable group followed by W and M.
• Older men ranked themselves at slightly higher risk than OW noting that OM like to sleep with YW, thereby bringing the disease home to the unsuspecting partner.

OLDER WOMEN (over 46 years)
• No discussion notes were provided by the group.

Comparative conclusions
Session 1/Question 2:
From the perspective of people like you, which peer group in this community is the most vulnerable to HIV?

Key findings
• Young women were perceived to be the most vulnerable to HIV infection by three out of six peer groups. The M group ranked YW as second most vulnerable after the W, while the OW ranked YW as fourth most vulnerable group. The women’s group was chosen by two of the six groups. This appears to represent a feeling that in the community women in general are more vulnerable to HIV with YW being the most vulnerable.
• Only OW indicated that M were most vulnerable to HIV infection while YM ranked them second, YW ranked them third and men and OM ranked them fourth most vulnerable.
• Apart from two groups indicating W as most vulnerable, the YW and OW ranked them second and OM third.
• Surprisingly YM were not deemed to be very vulnerable to HIV infection. They were rated second most vulnerable by OM, third most vulnerable by m and OW and fourth most vulnerable by themselves and YW.
• All groups, excepting the OW who rated themselves fifth, rated OW to be the least at risk of HIV infection.
• OM were deemed to be fifth in line with respect to their vulnerability to HIV infection by all groups excepting OW who rated them last.
• There is thus a fair measure of consensus that young women are most vulnerable followed by women, men, young and older men and lastly older women. Any effort to combat infection in the community must take this into account if it is meant to be successful.
Women’s peer group planning session

Question 3

What are the reasons why people like you are getting infected with HIV? How common are these reasons for people like you? How are these problems making people like you vulnerable to HIV infection?

HIV infection. After charting all the perceived reasons their peers are getting infected, the peer groups ranked the reasons/factors in terms of how common they are for people like them. The following symbols were used to express their ideas:

- *** = very common
- ** = common
- * = not very common

Participants then chose the five most common reasons, drew a single diagram to illustrate these reasons and analyzed and discussed why they thought these factors contributed to increased HIV infection for people like them.
Findings

**YOUNG MEN** *(ages 16-25 years)*

Following are the reasons why and how a person in this group might be at risk of HIV infection:

- Alcohol abuse ***
- Condom ***
- Rape
- Women with attractive bodies ***
- Peer Pressure *
- Sex *

**Discussion highlights**

- The group felt that if they were drunk they would propose to girls whose HIV/AIDS status was not known to them.
- The group also felt that they might be at risk if a girl is wearing a short skirt or has very attractive shape.
- The group notes centered on what they believed made a woman beautiful. “A girl to be beautiful must have good clothes, hair, relax, cell-phone, money, jeans, shoes, relax and soap. For turning herself and looking good to men.
- There was increased risk if a condom bursts, is expired, or if they are not using condoms.
- The group felt that having sex without a condom is very dangerous and that using expired condoms is common.
- The group stated that if they are raping girls they wouldn’t know if they are HIV positive, however they feel that rape is not common.
- The group also stated that if they are drunk then they loose the control to have safe sex.

**YOUNG WOMEN** *(ages 16-25 years)*

Following are the reasons why and how a person in this group might be at risk of HIV infection:

- Open wounds and blood transfusion*
- Not using condoms
- Having multiple partners
- Using drugs

**Discussion highlights**
• Younger women’s response provided in the notes indicates a misinterpretation of the question, as it simply describes the symptoms of a person with HIV, who may be suffering from AIDS.

The following can be deducted from the diagram:
• A person coming into contact with open wounds and blood from an infected person was at risk of HIV infection if precautions were not taken.
• Having multiple partners increased your chances of becoming infected as you did not know the HIV/AIDS status of the partner.
• Not using condoms was ignoring the precautions available for protecting against infection.
• Using drugs lowered ones decision-making capacity and increased the chances of unprotected sex as well as being raped.

**MEN (ages 26-45 years)**
Following are the reasons why and how a person in this group might be at risk of HIV infection:

- Beautiful girls **
- Money***
- Multiple partners****
- Alcohol ***

**Discussion highlights**
• The group’s notes centered on what they believed made a woman beautiful. “A girl to be beautiful must have good clothes, hair, relax, cell phones, money, jeans, shoes, relax and soap. For turning herself and looking good to men.”

The following can be deducted from the diagram:
• Men admit to having multiple partners, which increases their chances of infection.
• They are prone to using alcohol and drugs, which diminishes their decision-making capacity, increases their libido and makes them do things they would normally refrain from.
• Men are seduced by girls if men are seen to have money and this put them at risk as well as when they themselves sought women for sex as a result of having money or if they are paid for sex themselves. They were also prone to be stimulated when seeing beautiful girls and would try to seduce them.

**WOMEN (ages 26-45 years)**
Following are the reasons why and how a person in this group might be at risk of HIV infection:

- Poverty ***
- Lack of money ***
- Illiteracy
- Unprotected sex ***
- Lack of jobs
- Unemployment**
**Discussion highlights**

- The group did not provide discussion notes.

The following can be deducted from the diagram:

- Women feel that lack of money, which is part of poverty and related to unemployment and lack of jobs, causes them to take chances to alleviate these problems.
- They have unprotected sex with men who are able to pay them or provide in their basic and or luxury needs to enable them to survive.
- They feel at risk as they are illiterate and are thus unable to get sufficient information to protect themselves from being used and infected by unscrupulous men.
- At the community feedback meeting they discussed forced sex as well as the stratification of power between men and women. They claimed that in general it is the man that controls the sexual behavior in a relationship. They also discussed that women have the power to leave a relationship.
- The group also mentioned that they feel that Taxi drivers are contributing to the spread of HIV as they have money readily available as well as transportation, which allows them to easily support several girlfriends.

**OLDER MEN (over 46 years of age)**

Following are the reasons why and how a person in this group might be at risk of HIV infection:

- Need for Money ***
- Alcohol/drug abuse ***
- Do not use condoms ***
- Lack of information **
- Multiple Partners ***
- Poverty **

**Discussion highlights**

- The older men group felt that poverty causes HIV because women often trade sex for money, food or other material gain. They also felt that women try to attract men to love them so that they will provide them with money.
- They felt that alcohol and drug use contributes to HIV because they engage in indiscriminate sexual behavior when they are drunk.
- The group felt that cars contributed to the spread of HIV because women assume that men with cars have a lot of money and are more likely to have sex with them. They also said that women will trade sex for transportation if they do not have money.
- The group said that sleeping around contributes to HIV infection because men or women with money may have four or five partners. They also said that people ignore the consequences of their actions because they need or want money.
• Poverty and the need for money was thus a great cause of the spread of HIV infections due to the compensation for sex.
• Lack of information on the spread of the disease and precautions that can be taken to prevent the spread were also mentioned. They were however aware of condoms, but were not using them.

**OLDER WOMEN (over 46 years)**
Following are the reasons why and how a person in this group might be at risk of HIV infection:

<table>
<thead>
<tr>
<th>Alcohol ***</th>
<th>Older Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need money **</td>
<td></td>
</tr>
<tr>
<td>Do not use condoms****</td>
<td></td>
</tr>
<tr>
<td>Poverty ***</td>
<td></td>
</tr>
<tr>
<td>Sexual excitement</td>
<td></td>
</tr>
</tbody>
</table>

**Discussion highlights**
• The older women’s group felt that alcohol made them vulnerable to HIV because when they use alcohol they lose control and may do things they would not normally do.
• They also felt that poverty was a contributing factor because if no one in a household is working the women will sell their bodies to attain food and clothing.
• Women feel peer pressure to have cell phones and may engage in casual sex either in return for a cell phone or in the hope that their friends will provide cell phones.
• The group also said that many people in their community feel proud to have numerous sexual partners and therefore put themselves and their partners at greater risk to the virus.
• An additional contributing factor is what the group referred to as “sexual excited”. The group felt that some members of the community “have more sexual excited”, and therefore “always feel to do sexual intercourse”.

**Comparative conclusions**

Session 1/Question 3:
*What are the reasons why people like you are getting infected with HIV? How common are these reasons for people like you? How are these problems making people like you vulnerable to HIV infection?*

The tables below present an overview of the very common and common reasons why and how a person in the different peer groups might be at risk of HIV infection.

**Table 9: Very common reasons contributing to HIV infection**
Table 10: Common reasons contributing to HIV infection

<table>
<thead>
<tr>
<th>Peer groups</th>
<th>Very common reasons</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Young men</td>
<td>Women with attractive bodies</td>
<td>Not using condoms/expired condoms</td>
</tr>
<tr>
<td>Young women</td>
<td>Not using condoms</td>
<td>Multiple partners</td>
</tr>
<tr>
<td>Men</td>
<td>Multiple partners</td>
<td>Alcohol</td>
</tr>
<tr>
<td>Women</td>
<td>Having sex with infected people</td>
<td>Poverty</td>
</tr>
<tr>
<td>Older men</td>
<td>Money</td>
<td>Drugs/alcohol</td>
</tr>
<tr>
<td>Older women</td>
<td>Condoms</td>
<td>Alcohol</td>
</tr>
</tbody>
</table>

Key findings

- Alcohol or drug abuse was mentioned by five of the six peer groups as a very common factor accounting for the spread of HIV among people like them. Only the women’s group did not mention this as a factor.
- Unemployment related conditions, the need for money and poverty, were the second most cited reasons mentioned by four of the six peer groups as the most common reason for putting people at risk of HIV infection.
- Three out of six peer groups mentioned having multiple partners.
Findings related to gender

- Two women groups (W and OW) cited poverty (or money) as a very common reason why people like them are becoming infected with HIV.
- Both men and older men cited money as reasons why people like them are becoming infected. This may offer a glimpse into a larger problem where sex is often used in trade.
- Seeing young and sexy girls was mentioned by young men as a factor that enticed them to engage in casual sex and increasing their chances of infection.

Findings related to HIV/AIDS awareness

- While the young men’s group cited not using condoms or using expired condoms as a reason why people like them are becoming infected, both the older women’s group and the older men’s group cited condoms as a reason why people are getting infected.
- The older men’s group felt that condoms contributed to the spread of HIV because the lubricant of the condoms contains the HIV virus and therefore when a man uses a condom he may contract the virus. Also, they stated that it is possible for the condom to break or tear off during sex, which can allow the virus to be passed.
- The groups also appeared to be well aware of the secondary influences and clearly cited the effects of money and alcohol on sexual behavior as contributing factors to the spread of HIV.

Findings related to Health Care Services

- There were no significant results that were related to Health Care Services.
CMA

Community Mobilization Activities

Session 2  Questions

1. Who or what are the main influences on the sexual behavior of people like you?

2. Over a lifetime, how many sexual partners would people like you usually have or expect to have?

3. Who are people like you having sex with?
SESSION 2
The focus of this session was to explore the community’s expectations about people’s sexuality and the relationships that people have in this community.

Question 1
Who or what are the main influences on the sexual behavior of people like you?

Process
Participants drew a person or symbol to represent people like them in the center of a flip chart and then identified and noted key influences on the sexual behavior of these people. The peer groups then chose the five strongest influences with the greatest impact on the sexual behavior of people like them. Lastly, participants divided into five smaller groups, one for each of the influences and identified the positive and negative messages associated with each influence.

Unfortunately, not all groups followed this instruction; therefore, only two groups (women and older women) listed the five strongest influences. Furthermore, groups did not always indicate the positive and negative messages associated with each influence. This question was interpreted by some groups as the positive and negative consequences of the influences as opposed to the positive and negative messages. Nonetheless, valuable insights were attained from these discussions.

Findings

YOUNG MEN (ages 16 to 25 years)
According to the young men, the main influences on the sexual behavior of people like them in Rundu are:

- Influences (peer)
- Media and television
- Dreams

Discussion highlights
- Friends (peers) are talking about sex, which makes them want to enjoy it themselves, or some will take friends to their girlfriend for sex.
- The cassettes that depict sexual behavior make them want to engage in sexual behavior.
- Dreams about sexual behavior encourage them to engage in sex.

YOUNG WOMEN (ages 16-25 years)
The influences on the sexual behavior of young women in Rundu were identified as follows:

**Interest in sexual activity**
- Media
- Family
- School

**Discussion highlights**
- Many women like them in their community are encouraged by TV to have sex at a young age (16-25), because they’re grown up now, and their feelings must be stated. In addition, they said they have a minimum of four sexual partners from the age of 41-50, one of which is their husband.
- Pressure from other YW at school lead them to have sex

**MEN (ages 26-45 years)**
According to men, the following factors influence the sexual behavior of people like them:

- Video
- Media and entertainment
- Church
- School
- Grandparents

**Discussion highlights**
- Videos, media and entertainment depicts/encourages sexual behavior making it acceptable and enjoyable.
- Pressure from grandparents wanting grant children also lead them to have sex

**WOMEN (ages 25-46 years)**
The influences on the sexual behavior of young women in Rundu were identified as follows:

- Influences (peer)
- Bad friends
- TV
- Money/someone else being rich

**Discussion highlights**
TV had a great effect on women. When watching movies and seeing couples kissing, they were stimulated to want to have sex.

When they saw nice cars, clothes, hair, make-up, beautiful models and jewelry they would want it themselves they were encouraged to also want these. This perceived need would encourage them to join the “sex business”.

They are then more willing to engage in sex because their partners may provide them with money.

The group stated that not having enough clothing made them vulnerable to HIV infection as they would exchange sex for money.

The group said that if a woman is lucky she will be able to become pregnant without the disease but if she is unlucky then she will get pregnant and get the disease.

They stated that they might feel regret if they contract the virus, because they feel that they should have known of the danger involved in having unprotected sex.

The group stated that if a woman walks around too much she would become vulnerable because men will give her money because they always ask sex from her.

**OLDER MEN (over 46 years of age)**

Following are the reasons why and how a person in this group might be at risk of HIV infection:

- Faces
- Older Men
- Short dress
- Breast
- Buttocks

**Discussion highlights**

- Older men stated that whenever they see a beautiful face they think of sex.
- According to older men seeing a woman in a short dress would cause them to have an erection.
- When an older man sees a woman’s breast he wants to have sex with her.
- Seeing a woman’s buttocks when she is walking, standing or sitting, makes them think of sex.

**OLDER WOMEN (over 46 years)**

Following are the reasons why and how a person in this group might be at risk of HIV infection:

- TV
- Older Women
- Naked men
- Two people touching each other
- Handsome men in nice clothes

**Discussion highlights**
A handsome man in nice clothes makes them think of sex.

A naked man would make them want to have sex.

When their husbands touch them they feel sexually excited.

They are influenced by programs they see on TV because it arouses them sexually.

**Comparative conclusions**

Session 2/Question 1:

*Who or what are the main influences on the sexual behavior of people like you?*

The table below provides an overview of the factors influencing the sexual behavior of people like the peer groups in Rundu.

<table>
<thead>
<tr>
<th>Young men</th>
<th>Friends/peers</th>
<th>Sexy girls</th>
<th>Dreams</th>
<th>Media/TV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young women</td>
<td>Interest in sexual activity</td>
<td>Alcohol</td>
<td>Media</td>
<td>TV</td>
</tr>
<tr>
<td>Men</td>
<td>Video</td>
<td>Media/entertainment</td>
<td>Peer pressure</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>Peer pressure</td>
<td>TV/radio</td>
<td>Bad friends</td>
<td>Money</td>
</tr>
<tr>
<td>Older men</td>
<td>Faces</td>
<td>Short dress</td>
<td>Breasts</td>
<td>Buttocks</td>
</tr>
<tr>
<td>Older women</td>
<td>TV</td>
<td>Two people touching in bed</td>
<td>Naked men</td>
<td>Handsome/rich men</td>
</tr>
</tbody>
</table>

**Key findings**

- Five of the six peer groups cited media (TV and radio) as having an influence on their sexual behavior. Only OM did not mention media as a factor.

- Half of the groups also appear to generally agree that the attractiveness of the opposite sex has a strong influence on sexual behavior (YM, OM, OW). It seems as though the visual impact is overwhelming for OM.

- Three of the six peer groups mentioned that peer pressure or friends influenced sexual behavior.

- Alcohol was only mentioned by YW as a factor, although many of the groups earlier discussed this as being a factor contributing to the spread of HIV in the community.

- YW had a high interest in sexual activity.

- OW found touching stimulated and influenced their sexual behavior.

- Although OW mentioned that handsome men in nice clothes influenced their sexual behavior, it was only women who mentioned money as an influence.

*Findings related to gender*
• The responses of the groups did not differ greatly by gender. Both genders cited media as an important influence, as well as the attractiveness of the opposite sex and other social factors.

• Of great importance is that what is seen has such a big influence on the activities of all peer groups – TV material and people dressed seductively. This tendency to be easily stimulated by what they see and hear could be used in programs to convince them to change their behavior.

Question 2

Over a lifetime, how many sexual partners would people like you usually have or expect to have?

Process
Participants wrote down the following age categories on a flip chart: 12-16, 16-20, 21-30, 31-40, 41-50, 51-60, 61-70 and 71+. Next, they discussed how many sexual partners a person in their peer group normally had, or would expect to have during a particular age category. The range and average number of sexual partners is noted for each age category.

Findings
The table below shows the number of sexual partners each peer group reported that people like them had during a particular age range.

Table 12: Number of sexual partners reported per age category.

<table>
<thead>
<tr>
<th></th>
<th>12-16</th>
<th>16-20</th>
<th>21-30</th>
<th>31-40</th>
<th>41-50</th>
<th>51-60</th>
<th>61-70</th>
<th>71+</th>
<th>Estimated average # over lifetime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young men</td>
<td>0-2</td>
<td>2-3</td>
<td>3-6</td>
<td>4-6</td>
<td>5-6</td>
<td>5-7</td>
<td>5-6</td>
<td>1-4</td>
<td>25-40</td>
</tr>
<tr>
<td>Young women</td>
<td>0-1</td>
<td>1-2</td>
<td>2-3</td>
<td>2-5</td>
<td>4-7</td>
<td>3-6</td>
<td>2-4</td>
<td>0-1</td>
<td>14-29</td>
</tr>
<tr>
<td>Men</td>
<td>1-2</td>
<td>2-3</td>
<td>5-10</td>
<td>10-12</td>
<td>12-20</td>
<td>20-23</td>
<td>23-27</td>
<td>27-27</td>
<td>100-124</td>
</tr>
<tr>
<td>Women</td>
<td>0-1</td>
<td>2-4</td>
<td>2-5</td>
<td>3-6</td>
<td>4-8</td>
<td>0-1</td>
<td>0-1</td>
<td>0-0</td>
<td>11-26</td>
</tr>
<tr>
<td>Older men</td>
<td>2</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>15</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>52</td>
</tr>
<tr>
<td>Older women</td>
<td>2-4</td>
<td>3-4</td>
<td>5-6</td>
<td>0</td>
<td>7-7</td>
<td>8-10</td>
<td>1-2</td>
<td>1-1</td>
<td>27-34</td>
</tr>
</tbody>
</table>
Comparative conclusions

Session 2/Question 2:
*Over a lifetime, how many sexual partners would people like you usually have or expect to have?*

The crude estimates obtained from the peers combined with the vicarious nature of the questioning method do not allow for any unequivocal interpretation of the data obtained. Yet, the extent that peers think that people like them have multiple sexual relationships throughout particular age periods has important implications for developing community action plans promoting positive sexual and reproductive health.

Young men and young women (ages 16-25 years)

- YW. In terms of the age ranges, there were only two comments in the notes. Many women like them in their community are encouraged by TV to have sex at a young age (16-25) because they’re grown up and their feelings must be stated. In addition they said they would have a minimum of four sexual partners from the ages 41-50, one of which is their husband. This indicates an attitude of selfishness and irresponsibility. They want a husband to look after them and have a family, but reserve the right to experiment outside their union.

- YM. Between the ages 12-16 they justified the number as they felt they were still experimenting. Between the ages 16-20 the numbers increased as they were getting to know what’s happening in the world. By the age of 21-30 there is a further increase because at this age the peers are workers and “they know everything and how a person should survive.” The numbers go up again by the ages of 31-40 because some have houses and are wealthy and “the lady cannot refuse to them.” The same was said of the increase at the ages of 41-50. Between the ages of 51-60 the minimum of five remains but the maximum goes up to seven because, even though they don’t have the “power” that the young men have (in terms of sexual attractiveness), the women might come to them for their money, cars, cuca shops, etc. The maximum goes back down to six between the ages 61-70 because men start to become “a zero grazer” because of age. Above 70 years of age the number of partners decreases to 1-4, because they’re married, and even their children are grown up by then.

- Young men and young women predicted relatively modest numbers of sexual partners.

- There are subtle, but important differences in the number of sexual partners that young men and young women have within a particular age category. Young men report having an average of two sexual partners during their early teens while young women report having an average of one sexual partner during this period. Once past the middle age, both young men and young women predict declines in the number of sexual partners that people like them would have.

- Young women however consistently predict considerably fewer sexual partners than the young men.

- Although young peers said that the media and other activities encouraged them to have sexual relations, it seems as though their estimates are relatively conservative. The role of the media will have to be taken into account in any program to counter the trend of multiple partners.
Men and Women (ages 26-45 years)

- **W.** The women’s peer group justified their predicted number of partners in the first three age ranges (spanning 12 - 30) by saying they’re not thinking about sex. Between the next two age ranges, encompassing 31-50 the numbers increased, but is not as high as it could be because they are at risk of sexual illnesses. From the age of 51 the numbers drop dramatically because by then women like them are not thinking about sex because they’ve had enough already. It is also noted that between the ages roughly of 26-40, they are not expected to have multiple partners, but have to think about money concerns first.

- **M.** There are no notes justifying the numbers the men agreed on. However, it appears as though the men may have interpreted the question somewhat differently than the other groups and may have added across the row to make an average total of 27, rather than 100-124. This seems to make sense, as the numbers would be more congruous with those provided by the other groups.

- Men in the Rundu community consistently have higher numbers of sexual partners compared to women in the same age category. Of all the peer groups in Rundu, men predicted to have the highest number of partners of all. This is a dangerous prediction and would indicate that special care had to be taken in any programs if their pattern of sexual behavior was to be changed.

- Of all the groups, these women predicted the lowest number of sexual partners during their lifetime, even lower than the young women.

Older Men and Older Women (over 46 years)

- **OW.** Between the ages of 12-16 most women like them only have about 2 sexual partners because they are still young and not so sexually active. From the ages 16-25 most have 3 to 4, with some having fewer. Most cited life changes as the reason for the rise. As the years increase to the ages 40-50 most older women start to think they “are still young, so they start to go out with young boys” to satisfy them. From 70 years on all women have one sexual partner, their husband – some might even separate their beds by this point.

- **OM.** This peer group offered no justification for the numbers they provided. It should be noted that they made the last age range 51+, instead of three separate ranges of 51-60, 61-70, and 71+.

- Older men reported fairly high numbers of sexual partners throughout. Older women represented the highest number out of any of the women’s groups. Because this data is based on men and women like them, it can be assumed that these values are based on actual histories of people like them. Although the values may seem quite high, the data must be interpreted as factual since only the older men’s and older women’s groups can truly know the number of sexual partners in a lifetime as they have lived through most of the age categories mentioned in the question.
Men’s peer group

**General Patterns in Data**

- It does not appear to be uncommon for the people in the community to become sexually active before the age of 16 as only three of the groups provided that zero partners was possible in that age range.
- The women’s groups have estimated the number of sexual partners they expect to have as significantly lower than the men for nearly every age as well as in total.
- Results suggest that men and women who belong to the same age group exhibit markedly different patterns of sexual behavior.
- Women consistently report a lower number of sexual partners per age category than men. (However whether this difference is actually significant is subject to statistical analysis.) The numbers of sexual partners per woman also tend to taper down from the age 41 to 60, which was sooner than that of men.

**Question 3**

Who are people like you having sex with?
Process
Participants brainstormed all the people that peers like them were having sex with and drew a matrix using symbols to represent who among those identified were most acceptable, most preferable and most available to have sex with. They also explored who used most force and who gave them the most reward for sex. Reward was not more specifically defined and was therefore open to interpretation by each peer group – money and pleasure were two interpretations. Peer groups then assigned scores to the groups of people that they had sex with: 1 being the most acceptable and 6 the least acceptable.

Findings
YOUNG MEN (ages 16-25 years)
The table below indicates the different groups of people that young men in Rundu have sex with, and who among those identified are most acceptable to have sex with.

Table 13: Ranking sexual partners of young men

<table>
<thead>
<tr>
<th>Rank</th>
<th>Most acceptable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Schoolgirls</td>
</tr>
<tr>
<td>2</td>
<td>Teachers</td>
</tr>
<tr>
<td>3</td>
<td>Policewomen</td>
</tr>
<tr>
<td>4</td>
<td>House workers</td>
</tr>
</tbody>
</table>

Discussion highlights
- The group appears to have misunderstood the question and instead of ranking the groups according to each individual category (most socially acceptable, most preferable, etc.), they simply ranked the groups in general.

The following deductions can be made from the table:
- Young men felt that it was most acceptable in all categories to have sex with schoolgirls as compared to any other group. The reason could be that they were mostly in contact with them and they were thus the most available and approachable.
- Teachers were deemed to be the next acceptable, probably also as a result of seeing them most often, but having the added incentive of money, education and status.
- The third option, policewomen, would be less available but have the advantage of protection, money and status.
- The least acceptable, but probably quite available and accessible were house workers. There would however in these cases be no added value apart from the sex.

YOUNG WOMEN (ages 16-25 years)
The table below indicates the different groups of people that young women in Rundu have sex with and who among those identified are most acceptable, most preferable and most available to
have sex with. The table also reports who according to the young women uses the most force and gives them the most reward for sex.

**Table 14: Ranking sexual partners of young women**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Most socially acceptable</th>
<th>Most preferable to have sex with</th>
<th>Most available to have sex with</th>
<th>Group that uses the most force</th>
<th>Group that gives most reward for sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Husband</td>
<td>Husbands</td>
<td>All</td>
<td>Unclear</td>
<td>Husband</td>
</tr>
<tr>
<td>2</td>
<td>Sugar daddies</td>
<td>Businessman</td>
<td></td>
<td></td>
<td>Women we meet in shebeens</td>
</tr>
<tr>
<td>3</td>
<td>Businessman</td>
<td>Women we meet in shebeens</td>
<td></td>
<td></td>
<td>Sugar daddies</td>
</tr>
<tr>
<td>4</td>
<td>Women we meet in shebeens</td>
<td>Sugar daddies</td>
<td></td>
<td></td>
<td>Businessman</td>
</tr>
</tbody>
</table>

**Discussion highlights**

- The notes discuss how husbands have all the power and can demand sex from you “*any time or any minute*”. Being faithful to him involves no one going outside with unknown girlfriends, so you cannot get AIDS easily. However, it was easy to find a sugar daddy, because they say they don’t really love their husbands. The discussion ended with the hope that “maybe God He can hear us for this disease AIDS, so that he can help us, AIDS it can come down, not up again.”

The following deductions can be made from the table:

- Young women indicated that it was most acceptable to have sex with their husbands and that they gave most rewards.
- The next partners who were socially acceptable were sugar daddies and businessmen, although they didn’t give high rewards. The next preferable to have sex with were businessmen.
- Women they met in shebeens were the least acceptable partners but they did give high rewards. Having women from shebeens as sexual partners would imply having a lesbian relationship. This should also be taken into account in any program to change behavior.
- Young women indicated that any of those mentioned were easily available.

**MEN (ages 26-45 years)**

The table below indicates the different groups of people that men in Rundu Constituency have sex with and who among those identified are most acceptable, most preferable and most available to have sex with. The table also reports who according to the men uses the most force and gives them the most reward for sex.

**Table 15: Ranking sexual partners of men**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Most socially acceptable</th>
<th>Most preferable to have sex with</th>
<th>Most available to have sex with</th>
<th>Group that uses the most force</th>
<th>Group that gives most reward for sex</th>
</tr>
</thead>
</table>
Discussion highlights

- The notes for the men’s group state that they have sex with women who are of similar age, anyone who understands them or with similar behavior. They also have sex with women who are not working.
- They look for women without disabilities so they can “go far” and women who go to church, while some of the group preferred workers or businesswomen, in contrast with the earlier expressed sentiment of having sex with unemployed women.
- Women least socially acceptable and preferable and giving the least reward for sex were students. They were also least available.

WOMEN (ages 26-45 years)
The table below indicates the different groups of people that women in Rundu Constituency have sex with, and who among those identified are most acceptable, most preferable and most available to have sex with. The table also reports who according to the women uses the most force and gives them the most reward for sex.

Table 15: Ranking sexual partners of women

<table>
<thead>
<tr>
<th>Rank</th>
<th>Most socially acceptable</th>
<th>Most preferable to have sex with</th>
<th>Most available to have sex with</th>
<th>Group that uses the most force</th>
<th>Group that gives most reward for sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Prostitutes</td>
<td>Young men</td>
<td>Businessmen</td>
<td>Labolar</td>
<td></td>
</tr>
</tbody>
</table>

Discussion highlights

- The women seem to have interpreted this question as their roles in sexual relationships. The discussion centered on the benefits of marriage (simple, and very healthy) because of the stability of having a man around every day. However, they say being not married, with a boyfriend, is better than marriage because you can get tired of him and you aren’t forced to stay at the same house as him.
- The group concluded that being a prostitute is best, because you can earn something from the person you’re having sex with and not have to worry about material needs.
- They also concluded that “clothes” is not a problem “as long as you use a condom”. It is unclear exactly what the term refers to.
- The women’s preference of being a prostitute should be taken into account when planning interventions with respect to the spread of HIV/AIDS.

OLDER MEN (over 46 years)
The table below indicates the different groups of people that older men in Rundu are having sex with and who among those identified are most acceptable, most preferable and most available to have sex with. The table also reports who according to the older men uses the most force and gives them the most reward for sex. The Older Men only identified the types of people they were having sex with and did not correctly rank them.

Table 16: Ranking sexual partners of older men

<table>
<thead>
<tr>
<th>Rank</th>
<th>Most socially acceptable</th>
<th>Most preferable to have sex with</th>
<th>Most available to have sex with</th>
<th>Group that uses the most force</th>
<th>Group that gives most reward for sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Young girls</td>
<td>Young girls</td>
<td>Prostitutes</td>
<td>Young girls</td>
<td>Young girls</td>
</tr>
<tr>
<td>2</td>
<td>Wives</td>
<td>Wives</td>
<td>Drunk girls</td>
<td>Wives</td>
<td>Wives</td>
</tr>
<tr>
<td>3</td>
<td>Drunk girls</td>
<td>Drunk girls</td>
<td>Wives</td>
<td>Drunk girls</td>
<td>Drunk girls</td>
</tr>
<tr>
<td>4</td>
<td>Prostitutes</td>
<td>Prostitutes</td>
<td>Young girls</td>
<td>Prostitutes</td>
<td>Prostitutes</td>
</tr>
</tbody>
</table>

Discussion highlights

- The older men offered no explanatory notes.

The following deductions can be made from the table:

- Older men indicated that they preferred having sex with a young girl or a wife and that it was socially most acceptable. This choice could indicate their wish to prove themselves sexually or just because of the availability and young women accepting the authority of the older man while a wife is presumed to be available at all times.
- Drunken women and prostitutes were the least socially acceptable as sexual partners.
OLDER WOMEN (over 46 years)
The table below indicates the different groups of people that the older women in Rundu are having sex with. Unfortunately, the question was not correctly understood by the older women’s group and therefore the different sexual partners were not correctly ranked.

Table 17: Ranking sexual partners of older women

<table>
<thead>
<tr>
<th>Rank</th>
<th>Most socially acceptable</th>
<th>Most preferable to have sex with</th>
<th>Most available to have sex with</th>
<th>Group that uses the most force</th>
<th>Group that gives most reward for sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Husband/people we love</td>
<td>Husband/people we love</td>
<td>Husband/people we love/soldiers</td>
<td>Soldier</td>
<td>Rich men</td>
</tr>
<tr>
<td>2</td>
<td>Soldier/rich men</td>
<td>Rich men</td>
<td>Rich men</td>
<td>Rich men</td>
<td>Husband/people we love</td>
</tr>
<tr>
<td>3</td>
<td>Young women</td>
<td>Young women/soldiers</td>
<td>Young women</td>
<td>Young women</td>
<td>Young women</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td>Husband/people we love</td>
<td>Soldier</td>
<td>Soldier</td>
</tr>
</tbody>
</table>

Discussion highlights

- The women of this peer group state that they have sex with people who they love, such as their husbands and boyfriends. Some say, however, that if their husband does not work, they will go with richer men to get cell phones and money. This was an indication of their age and stability in their relationship with their partners although it does not mean that it was mutual. Going for rich men is indicative of their preference for financial assistance and some status.
- Some others mentioned that their sexual desires lead them to have sex with younger boys.
- Husbands are always acceptable/available, don’t use more force, but give the reward of love. Rich men give more material rewards, at the cost of using more force. They expect payback (i.e., sex) in return for the rewards and are not always available because they themselves have wives as well.
- Young men aren’t always available to the women of this peer group, but will come if you give them rewards.
- Soldiers are also not so available, because there is the possibility they might be transferred at any moment.
Comparative conclusions
Session 2/Question 3:
Who are people like you having sex with?

Key findings
It is difficult to further interpret the data when there are so many categories missing. However, it is can be observed that generally speaking, people of the same gender are having sex with the same types of partners.
• The groups each reflected a vast choice of partners for sex in the community
• However, each of the women’s groups as well as the older men’s group mentioned the practice of sex for reward. This was discussed as sugar daddies, rich men, businessmen and prostitutes.
• The discussions around the sugar daddies, rich men and businessmen, refer to sexual favors in a more informal manner than strict prostitution. The groups discussed sex in exchange for cellular phones and clothing as well as money.
• Similarities existed between young men who preferred schoolgirls and older men young girls for sex.
• Husbands or wives were also mentioned as highest priority choices by young women, women, older men and older women. In this case the choice of the young women was surprising due to their young age.
• Men surprised by looking for Christian ladies, office workers or nurses. These choices were very conservative but promised some stability of income and hopefully values.
• Women mentioned young men as the preferred choice of partner.
All men tend to look for young women and wives and all women preferred their husbands, boyfriends or someone with money.
1. What do people like you need to live a healthy sexual and reproductive life?

2. What is your understanding of the following?
   - The ways that you prevent HIV infection
   - Voluntary counseling and testing for HIV
   - Family planning
   - The prevention of HIV infection from an infected mother to her child
   - How to care for and support someone living with HIV/AIDS
   - The kinds of treatment available for someone living with HIV and/or AIDS
   - The care and support of orphans and vulnerable children.
SESSION 3

The aim of this session was to identify the needs of the peers, particularly the services needed for them to manage their sexual and reproductive health, to gage their level of knowledge and understanding of HIV/AIDS and HIV/AIDS services and to determine the sources of information that the peer groups rely on to obtain HIV/AIDS-related information.

Question 1

What do people like you need to live a healthy sexual and reproductive life?

Process

The participants drew a picture or a symbol representing their peer group in the center of a flip chart and brainstormed a list of the different things that they felt they needed to live a healthy sexual and reproductive life. They filled in a matrix to indicate whether the service exists, is accessible, is helpful towards people like them or not and the percentage of the group who have used this service.

Findings

YOUNG MEN (ages 16-25 years)

Table 18 presents the services that young men feel people like them need to lead a healthy sexual and reproductive life. The existence, accessibility, helpfulness and utility of the services are also noted.

<table>
<thead>
<tr>
<th>Services</th>
<th>Exist</th>
<th>Easily accessible for people like me</th>
<th>Helpful/not helpful toward people like me</th>
<th>% of the group who have used this service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faithful partners</td>
<td>Yes</td>
<td>Yes</td>
<td>Helpful</td>
<td>40%</td>
</tr>
<tr>
<td>Contraceptives</td>
<td>Yes</td>
<td>Yes</td>
<td>Helpful</td>
<td>60%</td>
</tr>
<tr>
<td>Abstinence</td>
<td>No</td>
<td>No</td>
<td>Helpful</td>
<td></td>
</tr>
<tr>
<td>Cleanliness</td>
<td>Yes</td>
<td>Yes</td>
<td>Helpful</td>
<td>75%</td>
</tr>
<tr>
<td>No forced sex</td>
<td>Yes</td>
<td>No (acceptable)</td>
<td>Not Helpful</td>
<td>20%</td>
</tr>
</tbody>
</table>

Discussion highlights

- The young men’s peer group interpreted the second question as whether this need was “easily acceptable to people like me”, as opposed to what the question actually asked, whether services fulfilling that need were “easily accessible”. In light of this, they said that faithfulness, condoms and the ability to wash themselves exist in their community, and was “acceptable” among their peers.
- They found faithful partners, contraceptives and cleanliness to be helpful, but claimed only 40% of their peers were faithful and only 60% used condoms. They said that about 75% washed themselves regularly.
They also said that abstinence did not really exist in the community, because it was very difficult and not really an acceptable option amongst their peers.

Interestingly, peers included forced sex in their “need to live a healthy sexual and reproductive life”, but the discussion seemed to center on how they needed for that to NOT be in the community. They claimed it did not exist much in the community, but that maybe 20% of their peers participated in forced sex.

**YOUNG WOMEN (ages 16-25 years)**

The table below presents the services that young women feel people like them need to lead a healthy sexual and reproductive life. The existence, accessibility, helpfulness and utility of the services identified are also noted.

<table>
<thead>
<tr>
<th>Services</th>
<th>Exist</th>
<th>Easily accessible for people like me</th>
<th>Helpful/not helpful toward people like me</th>
<th>% of the group who have used this service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy food</td>
<td>Yes</td>
<td>Yes</td>
<td>Helpful</td>
<td>(83%) 10/12</td>
</tr>
<tr>
<td>Water</td>
<td>Yes</td>
<td>Yes</td>
<td>Helpful</td>
<td>(67%) 8/12</td>
</tr>
<tr>
<td>Faithfulness</td>
<td>No</td>
<td>Yes</td>
<td>Helpful</td>
<td>(33%) 4/12</td>
</tr>
<tr>
<td>Family planning</td>
<td>No</td>
<td>No</td>
<td>Helpful</td>
<td>(25%) 3/12</td>
</tr>
<tr>
<td>Church</td>
<td>Yes</td>
<td>Yes</td>
<td>Helpful</td>
<td>(58%) 7/12</td>
</tr>
</tbody>
</table>

**Discussion highlights**

- Young women claimed that healthy food, water and church existed in their community, and that they were easily accessible. A percentage of 83% had healthy food, 67% had access to clean water and 58% went to church.
- In contrast, faithfulness didn’t exist according to this peer group, but was easily accessible (possibly indicating that, while it didn’t exist, they felt it was easy enough to bring about) and helpful. Only 33% women felt their partners were faithful.
- Family planning did not exist; thus, it was not accessible, though the peer group thought it would be helpful. 25% of the young women had used family planning methods such as contraception or injections.

**MEN (ages 26-45 years)**
Table 20 presents the services that men feel people like them need to lead a healthy sexual and reproductive life. The existence, accessibility, helpfulness and utility of the services are also noted.

Table 20: Needed services: their existence, accessibility, helpfulness and actual utility

<table>
<thead>
<tr>
<th>Services</th>
<th>Exist</th>
<th>Easily accessible for people like me</th>
<th>Helpful/not helpful toward people like me</th>
<th>% of the group who have used this service</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV test</td>
<td>No</td>
<td>Yes</td>
<td>Helpful</td>
<td>50%</td>
</tr>
<tr>
<td>Condoms</td>
<td>Yes</td>
<td>Yes</td>
<td>Helpful</td>
<td>75%</td>
</tr>
<tr>
<td>Faithfulness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gloves</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnant women able to have babies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Discussion highlights

- The men’s group only charted two services (as the example in the manual only showed a chart with two services), those being condoms and testing for HIV.
- They said condoms existed, were easily accessible and were helpful to them. About 75% of them used condoms.
- In reference to being tested, the group said it does not exist in their community, but was easily accessible (the testing site in Rundu-town is about 10km away). Again, they thought it was helpful and said about half had used the service.

WOMEN (ages 26-45 years)

The table below presents the services that women feel people like them need to lead a healthy sexual and reproductive life. The existence, accessibility, helpfulness and utility of the services identified are also provided.

Table 21: Needed services: their existence, accessibility, helpfulness and actual utility

<table>
<thead>
<tr>
<th>Services</th>
<th>Exist</th>
<th>Easily accessible for people like me</th>
<th>Helpful/not helpful toward people like me</th>
<th>% of the group who have used this service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tests at the clinic</td>
<td>Yes</td>
<td>No</td>
<td>Helpful</td>
<td>(83%) 10/12</td>
</tr>
<tr>
<td>Ability to have children</td>
<td>No</td>
<td>No</td>
<td>Helpful</td>
<td>(33%) 4/12</td>
</tr>
<tr>
<td>Condoms</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family planning</td>
<td>No</td>
<td>No</td>
<td>Helpful</td>
<td>(0%) 0/12</td>
</tr>
</tbody>
</table>

Discussion highlights
The following is based on an interpretation of the chart, as explanatory notes were not included.

- The woman’s group seemed to think that access to testing existed, but wasn’t readily accessible, despite the fact that 83% of the participants had used those services.
- Services for family planning and the ability to have children successfully (possibly in terms of good pre-natal care) did not exist nor were accessible, according to the group. Only 33% of them had received pre-natal care (as interpreting “ability to have children”) and none had participated in family planning.
- Though not expressed on the first chart, women added monetary needs for a healthy sexual life and that it existed, but was not accessible.
- As to helpfulness, this peer group ranked money the most helpful of all, followed by testing and family planning with pre-natal care third.
- Condoms were not charted either indicating no interest in them or apathy with respect to its accessibility and helpfulness.

**OLDER MEN (over 46 years)**

The table below presents the services that older men felt people like them needed in order to live a healthy sexual and reproductive life. The existence, accessibility, helpfulness and utility of the services identified are also provided.

<table>
<thead>
<tr>
<th>Services</th>
<th>Exist</th>
<th>Easily accessible for people like me</th>
<th>Helpful/not helpful toward people like me</th>
<th>% of the group who have used this service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Love</td>
<td>Yes</td>
<td>Yes</td>
<td>Helpful</td>
<td>(100%) 9/9</td>
</tr>
<tr>
<td>Medical attention</td>
<td>Yes</td>
<td>No</td>
<td>Helpful</td>
<td>(22%) 2/9</td>
</tr>
<tr>
<td>Drugs</td>
<td>No</td>
<td>No</td>
<td></td>
<td>(0%) 0/9</td>
</tr>
</tbody>
</table>

**Discussion highlights**

- The older men’s group claimed that they were well loved, as it existed, was easily accessible and very helpful. All of the participants (100%) claimed they received love.
- Medical care existed, but was not readily accessible as only 22% had used it before.
- Drugs were deemed to be completely non-existent as not one of the participants had had access to drugs before.
OLDER WOMEN (over 46 years)
The table below presents the services needed by older women to ensure a healthy sexual and reproductive life. The existence, accessibility, helpfulness and utility of the services identified are also provided.

Table 23: Needed services: their existence, accessibility, helpfulness and actual utility

<table>
<thead>
<tr>
<th>Services</th>
<th>Exist</th>
<th>Easily accessible for people like me</th>
<th>Helpful/not helpful toward people like me</th>
<th>% of the group who have used this service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tablets</td>
<td>Yes</td>
<td>Yes</td>
<td>Helpful</td>
<td>0</td>
</tr>
<tr>
<td>House hygiene</td>
<td>Yes</td>
<td>Yes</td>
<td>Helpful</td>
<td>90%</td>
</tr>
<tr>
<td>Healthy food</td>
<td>Yes</td>
<td>Yes</td>
<td>Helpful</td>
<td>60%</td>
</tr>
<tr>
<td>Clean clothes</td>
<td>Yes</td>
<td>No</td>
<td>Helpful</td>
<td>100%</td>
</tr>
<tr>
<td>HIV test</td>
<td>Yes</td>
<td>Yes</td>
<td>Helpful</td>
<td>40%</td>
</tr>
<tr>
<td>Clinics/hospitals</td>
<td>Yes</td>
<td>Yes</td>
<td>Helpful</td>
<td>60%</td>
</tr>
<tr>
<td>Clean utensils</td>
<td>Yes</td>
<td>No</td>
<td>Helpful</td>
<td>40%</td>
</tr>
<tr>
<td>Clean bodies</td>
<td>Yes</td>
<td>No</td>
<td>Helpful</td>
<td>90%</td>
</tr>
<tr>
<td>Love/care from husbands</td>
<td>Yes</td>
<td>Yes</td>
<td>Helpful</td>
<td>90%</td>
</tr>
</tbody>
</table>

Discussion highlights
- The older women claimed that all the things they needed to lead a healthy sexual and reproductive life existed and were helpful, but not all of them were accessible such as clean water, clean clothes, clean utensils and clean bodies. They need to buy soap to clean them, which was difficult due to lack of money. Despite this 90% had applied house and personal hygiene, 100% have clean clothes and 40% have clean utensils.
- They also said that it is difficult to "get [a] perfect husband" and 90% had had a loving/caring husband. This high percentage could be ascribed to the fact that these were older women who possibly some time during their lifetime had had a faithful partner.

The following deductions can be made from the table:
- Although 60% of the group had made use of a clinic/hospital, none have had tablets and only 40% have had HIV/AIDS tests done.
- Healthy food was used by 60% of the older women.

Comparative conclusions
Session 3/Question 1:
What do people like you need to live a healthy sexual and reproductive life?

The table below provides an overview of the factors and services identified by the peer groups as necessary to maintain a healthy sexual and reproductive life. There are fundamental differences and interesting similarities in peer group perceptions about what services they need, the existence of such services in the community and the ease of accessing these services.

Table 24: Services needed to promote healthy sexual and reproductive lives

<table>
<thead>
<tr>
<th>Peer groups</th>
<th>Young men</th>
<th>Young women</th>
<th>Men</th>
<th>Women</th>
<th>Older men</th>
<th>Older women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services Needed</td>
<td>Faithful partners</td>
<td>Healthy Food</td>
<td>HIV test</td>
<td>Condoms</td>
<td>Tests at the clinic</td>
<td>Love</td>
</tr>
<tr>
<td></td>
<td>Contraceptives</td>
<td>Water</td>
<td></td>
<td>Faithfulness</td>
<td>Ability to have children</td>
<td>Medical attention</td>
</tr>
<tr>
<td></td>
<td>Abstinence</td>
<td>Faithfulness</td>
<td></td>
<td>Gloves</td>
<td>Condoms</td>
<td>Drugs</td>
</tr>
<tr>
<td></td>
<td>Cleanliness</td>
<td>Family planning</td>
<td></td>
<td>Pregnant women</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No forced sex</td>
<td>Church</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Key findings

- Five of the six peer groups (YM, YW, M, OM and OW) mentioned being faithful to one partner, loving and caring husbands as an important principle to comply with to help them live a more healthy sexual and reproductive life. The women’s group was the only one not to mention it. Faithfulness would however be a difficult principle to instill in the greater community due to their admitted preference for multiple partners, but an effort should be made to convince them of its merits.

- The ability to know one’s status through HIV tests, hospitals, clinics and medical attention mentioned by men, women, older men and older women emphasized the importance with which most participants viewed these institutions as role players to maintain a healthy sexual and reproductive life.

- The use of contraceptives and abstinence were mentioned by four of the peer groups as important services needed to maintain a healthy sexual and reproductive life.
Family planning organizations, where information and training with respect to family planning in all its facets could be presented, emerged as a significant service required by two of the peer groups as was the role of healthy food.

Question 2

What is your understanding of the following?
- The ways that you can prevent HIV infection
- Voluntary counseling and testing for HIV
- Family planning
- Preventing HIV infection from an infected mother to child
- How to care and support someone living with HIV/AIDS
- The kinds of treatment available for someone living with HIV/AIDS
- The care and support of orphans and vulnerable children.

**YOUNG MEN (ages 16-25 years)**

1. **The way you can prevent HIV infection**
   This peer group knew that to prevent HIV you had to have one partner only, use a condom or abstain from sex. They obtained this information from the radio and hospital/clinics.

2. **Voluntary counseling and testing for HIV**
   The knowledge of voluntary counseling and testing for HIV in this peer group included pre-test counseling, the actual testing of the blood and the use of counseling rooms, which might imply knowledge of the confidential nature of testing. They obtained this information from New Start centers, their male relatives and hospitals.

3. **Family planning**
   In terms of family planning the group knew of the use of birth control pills and condoms until school was completed and employment could be obtained. They also mentioned the “depo provera” (contraceptive) injection as a method of family planning. This information was obtained from hospitals, clinics and traditional healers.

4. **Prevention of HIV infection from an infected mother to child**
   To prevent transmission of HIV from an infected mother to her child, the group offered the idea of anti-retroviral pills. They also suggested eating healthy foods and to get family support. They obtained this information from hospitals.

5. **Supporting people living with HIV/AIDS**

   Not all groups completed every single topic. Only the topics completed by the groups are mentioned in this report.
To provide support and care to someone living with HIV/AIDS, the group said they must provide them with soap, food, clothes and family involvement. They obtained this information from neighborhood workers (such as home-based care workers), family and friends.

6. Kinds of treatment available for someone living with HIV/AIDS
The kinds of treatment available for people living with HIV/AIDS were identified as tablets, from the hospitals or organizations dealing with HIV/AIDS, regular cleaning and proper nutrition. This information they obtained from hospitals.

7. Care and support for orphans and vulnerable children (OVCs)
To care for orphans, the group decided that they needed food, clothes and blankets and needed to go to school. They believe orphans should get guidance in these areas from the government education office, police officials and the President.

YOUNG WOMEN (ages 16-25 years)

1. The way you can prevent HIV infection
To prevent HIV infection, the young women’s group seemed to misinterpret the question and put down ways you could get HIV, which they listed as sexual intercourse, traditional healers, misuse of condoms, sharing needles in references to poor hygienic practices by nurses in hospitals and from wounds. They obtained this information from churches, school, radio, television and New Start (VCT) centers, with television being the most important source.

2. Voluntary counseling and testing for HIV
With regards to voluntary counseling and testing, they knew about the counseling being offered, scripture reading and that they had to go for HIV tests. They obtained this information from New Start centers, church, radio and hospitals, with hospitals being the most important source of information.

3. Family planning
With regards to family planning, they knew that it involved birth control pills, condoms, and injections to prevent pregnancy. They obtained this information from hospitals, radio and the Red Cross, with the radio and Red Cross as the most important sources.

4. Prevention of HIV infection from an infected mother to her child
Again, regarding the prevention of HIV transmission from a pregnant mother to her baby, the group instead gave the methods through which HIV is passed on from mother to child. They mentioned breast-feeding and the actual birthing process. They obtained this information from the radio, television and hospital, the last being the most important source.

5. Supporting people living with HIV/AIDS
In terms of caring and supporting someone living with HIV/AIDS, the group mentioned they needed to give them healthy food, wash them regularly, say prayers and by eating together, not

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4 “To use injection, two people in the same moment”
5 It should be noted that most of the facilitators came from a home-based, faith-based organization and thus, many of the peers in the sessions, whom they picked, were very familiar with this aspect.
separately, in an effort to discourage discrimination. They got this information from home, the hospital and the radio. They did not indicate which was the best source of information.

6. **Kinds of treatment available for someone living with HIV/AIDS**
The kinds of treatment available for someone living with HIV/AIDS were given as (only) antiretroviral treatments. This information was obtained from the hospital, the only source of information.

7. **Care and support for orphans and vulnerable children (OVCs)**
With regards to caring for and supporting orphans and vulnerable children, the group said that they must be given food, sent to school, washed and given encouragement to live with other people and behave well. They obtained this information from hospitals, New Start centers and the church, with the last being the most important source.

**MEN (ages 26-45 years)**

1. **The way you can prevent HIV infection**
To prevent HIV, the men’s group offered abstinence, condom use, faithfulness and using less alcohol, as effective methods to combat HIV. Condoms were the method most available in villages. Some of the group expressed distrust of condoms because they were not always one hundred percent effective, even if used correctly. This information was obtained from clinics, newspapers, schools and the radio, the radio being most important.

2. **Voluntary counseling and testing for HIV**
With regards to voluntary counseling and testing, the group discussed going to the clinic and, having an HIV test done. Other support structures were private hospitals and the Red Cross. They obtained this information from the television, radio, school and New Start center.

3. **Family planning**
The group’s knowledge of family planning involved the idea of limiting the number of children in the family, the use of birth control tablets, condoms and injections. This information was obtained from hospitals, NGOs, newspapers and television, with the television being the most important source.

4. **Prevention of HIV infection from an infected mother to her child**
This question was not completely answered.

5. **Supporting people living with HIV/AIDS**
This question was not completely answered.

6. **Kinds of treatment available for someone living with HIV/AIDS**
Available treatment for HIV, according to the group, included “devil’s claw”, a plant that could be obtained at the forestry ministry, ARVs, chloroquine and fruits to keep healthy. They could obtain these things from gardens, hospitals and NGOs. They obtained this information from
clinics, newspapers, Red Cross, hospitals, television and radio, with radio being the most important.

7. Care and support for orphans and vulnerable children (OVCs)
Caring for orphans and vulnerable children was seen as the responsibility of the GRN (Government of the Republic of Namibia), the church, the NGOs and the community. This information was gathered from television, radio and community meetings on the subject.

WOMEN (ages 26-45 years)
1. The way you can prevent HIV infection
The notes indicate a reluctance to discuss how to prevent HIV transmission, but offered that the condition of being male or female influenced this. However, they said people get infected through having sex with an infected partner, having many sexual partners and using too much alcohol. They obtained this information from the media, the community and organizations in their community.

2. Voluntary counseling and testing for HIV
With regards to voluntary counseling and testing, the group stressed the importance of confidentiality ("make sure that there won’t be any interruptions") and counseling. Consent forms were mentioned, as well as the actual testing for HIV/AIDS. It seems that a trained counselor for a VCT center was a part of the peer session, as the notes of the discussion take a first person point of view on how to counsel someone coming for an HIV test, as opposed to taking the perspective of someone going for an HIV test. They obtained this information from New Start centers, the church, the radio and the hospital, with New Start being the most important.

3. Family planning
The group’s knowledge about family planning involved pills and injections, but also mentioned the idea of traditional methods of family planning such as certain leaves and roots. The group stressed the fact that none of these methods would prevent HIV/AIDS and thus condoms/femidoms were the best method. If used correctly they prevented both HIV and pregnancy. They obtained this information from the television, New Start centers, hospitals and the community, with the New Start center again being the most important source.

4. Prevention of HIV infection from an infected mother to her child
With regards to the prevention of mother to child transmission the group discussed the process of conception at length. This included that the mother and child did not share the same blood and thus the main risks of HIV infection of the child was during childbirth, where the child was exposed to the mother’s blood and, to a lesser extent, during breast-feeding. The group also said that the risks of malnutrition were greater to a non-breastfed child than the risk of HIV to a child being breastfed. They got this information from the New Start center, the clinic, radio and television, with New Start as the most important source.

5. Supporting people living with HIV/AIDS
How to care for and support someone living with HIV/AIDS was offered as making sure to dress all wounds on the infected person, to keep them clean and well fed, to use proper precautions
when caring for the person, including a mask and gloves and to burn those clothes after use. Emotional support was also mentioned as important, as well as not to put the person under stress. They obtained this information from hospitals, radio, television and newspapers, with the most important being the radio.

6. Kinds of treatment available for someone living with HIV/AIDS
With respect to kinds of treatment available for someone living with HIV/AIDS, the group proposed solutions to common ailments of a person with HIV/AIDS, such as supporting them on pillows for coughs and chest congestion, meticulous care of the person’s hygiene, drinking plenty of liquids and to eat garlic and yogurt. They obtained this information from the media, television, clinic and New Start centers.

7. Care and support for orphans and vulnerable children (OVCs)
Regarding the care of and support of orphans and vulnerable children, the group said that they must talk to them as their own children. They needed spiritual support, encourage them to take care of each other and to buy them everything they need. They learned this from the television, radio, clinic, community and the church.

OLDER MEN (ages 46 and over)
1. The way you can prevent HIV infection
Among older men, the main methods of prevention of HIV/AIDS that were expressed were abstinence, staying away from alcohol and staying away from their friends who were a bad influence on them. Much of the group stressed being alone so as not to be tempted by beautiful faces or alcohol. They obtained this information from the hospital and newspapers, as well as from the churches and radio.

2. Voluntary counseling and testing for HIV
What the older men knew about counseling and testing was that it involved drawing blood, cost N$10 and involved going to the hospital or New Start center. They also knew that the centers offered counseling. They obtained this information mainly through the radio, but also from the hospital and churches.

3. Family planning
The older men’s group offered sterilization as a method of white people with regards to family planning, once they realized they had enough children. However, they claimed that black people like themselves, used contraceptives such as injections or condoms, but that they should look into sterilization too. They obtained this information from the hospitals and the radio.

4. Prevention of HIV infection from an infected mother to her child
The older men said that, when a woman realizes she is pregnant, she must visit the clinic and get help if she is HIV positive. Preventing the infection of a child with HIV from the infected mother mainly consisted of her getting medicine to prevent the fetus from becoming infected.

6 It should be noted that the trainer for the older men’s group worked at a voluntary counseling and testing centre.
They also mentioned that women should stop drinking during pregnancy and drink milk and vitamins, in the belief that this would also help prevent the child from being infected. During pregnancy they also thought a woman should stop having sex to prevent HIV infection. The men said they obtained this information from the hospital.

5. **Supporting people living with HIV/AIDS**
To care for and support a person living with HIV/AIDS, the older men suggested referral to the hospital for treatment. At home they needed to be washed and properly fed and given extra special care for them to feel that they are an important part of the family or community. This included visiting them. The men obtained this information from the radio, television and hospitals.

6. **Kinds of treatment available for someone living with HIV/AIDS**
The older men knew of no ways to treat a person for HIV/AIDS. As far as they were aware of, there was no treatment for HIV/AIDS. They said they received this information from radio, hospitals and churches.

7. **Care and support for orphans and vulnerable children (OVCs)**
Orphans and vulnerable children needed assistance such as food and clothes, as well as people to take care of them. It was important to the older men that there was proper care to ensure they did not go to the drinking places or discos and behave badly. They obtained this information from the government and churches.

**OLDER WOMEN (ages 46 and over)**

1. **The way you can prevent HIV infection**
The main methods this group felt could prevent HIV/AIDS were having a blood test and knowing your status, using condoms and abstaining from sex. Some of the group members believed testing was the only way to prevent HIV. In addition, much of the group did not trust condoms, as they didn’t know what was “inside the condom”. They obtained their information from hospitals, clinics, testing centers, radio and television, but the most important source was the hospital.

2. **Voluntary counseling and testing for HIV**
The knowledge of this peer group about voluntary counseling and testing involved testing blood for HIV/AIDS, that knowing their status allowed them to fight HIV and prevented them from playing around. They obtained this information from television, hospitals and books/pamphlets, but mostly from the hospitals.

3. **Family planning**
The group knew that family planning was a method to determine how to plan the number of children they would like to have. They said that the nurses at the hospitals could give them tablets and injections to prevent pregnancy, but they also mentioned the use of African roots in
drinks. They obtained this information from the radio, pamphlets and, most importantly, from the hospitals.

4. Prevention of HIV infection from an infected mother to her child
The prevention of HIV infection from an infected mother to her child was achieved by not breast-feeding and only bottle-feeding. They said pregnant women should go for blood tests and if positive, then they can get drugs to prevent the disease. It was also noted that mothers and babies should always be under covers if there were injuries. They obtained this information from pamphlets, television, radio and mainly hospitals.

5. Supporting people living with HIV/AIDS
To care for and support someone living with HIV the older women made various suggestions. These things were love, healthy food, hygiene, care and support, ARV tablets and prayer. They had heard this from television, church and pamphlets and mostly from hospitals.

6. Kinds of treatment available for someone living with HIV/AIDS
When asked what available treatments there were for HIV/AIDS the older women’s group stressed that there is no cure for HIV/AIDS. Most of them knew about ARV treatment to keep them strong and healthy, whereas others said the only treatment is just to pray and give good food to the person. Some believed there was an injection that could help. They obtained this information from the church, the media and mainly from the hospital.

7. Care and support for orphans and vulnerable children (OVCs)
All the older women said that to care for and support vulnerable children and orphans they should be treated like their own children. They needed enough support and care, much love, and material things such as clean clothes and enough food. Also added was the need for school and a good education. This information was obtained from the school, hospitals, media and churches, but mainly from the schools and hospitals.

**Comparative conclusions**
Session 3/Question 1:
*What is your understanding of the following?*
The table below presents the sources of HIV/AIDS-related information most frequently cited by the peer groups that people like them seek.

**Table 25: Sources of HIV/AIDS-related information by peer groups**

<table>
<thead>
<tr>
<th>Young men</th>
<th>Young women</th>
<th>Men</th>
<th>Women</th>
<th>Older men</th>
<th>Older women</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Hospitals (5)</td>
<td>Hospitals (7)</td>
<td>Radio (4)</td>
<td>TV (5)</td>
<td>Hospital (6)</td>
<td>Hospitals (7)</td>
</tr>
<tr>
<td>3 Clinics (2)</td>
<td>New Start (3)</td>
<td>Newspapers (3)</td>
<td>Radio (4)</td>
<td>Church (4)</td>
<td>Television (4)</td>
</tr>
<tr>
<td>4 Radio (1)</td>
<td>Church (3)</td>
<td>Schools (2)</td>
<td>Clinics (3)</td>
<td>Television (1)</td>
<td>Church (3)</td>
</tr>
<tr>
<td>5 New Start (1)</td>
<td>Television (2)</td>
<td>Hospitals (2)</td>
<td>Hospital (3)</td>
<td>Newspaper (1)</td>
<td>Radio (3)</td>
</tr>
<tr>
<td>Traditional healers (1)</td>
<td>School (1)</td>
<td>Clinics (2)</td>
<td>Community (3)</td>
<td>Government (1)</td>
<td>Media (2)</td>
</tr>
<tr>
<td>Friends (1)</td>
<td>Red Cross (1)</td>
<td>New Start (1)</td>
<td>Church (2)</td>
<td>School (2)</td>
<td></td>
</tr>
<tr>
<td>Community workers (1)</td>
<td>Home (1)</td>
<td>NGOs (1)</td>
<td>Media (2)</td>
<td>Clinics (1)</td>
<td></td>
</tr>
</tbody>
</table>

- Four of the six peer groups mentioned hospitals as the source from which they obtained most information. In many cases they stated that it was their most important source.
- Radio and television was also very often mentioned as sources of information as well as the media in general. In addition two groups also mentioned newspapers.
- Clinics, the New Start centers and churches were also cited as good sources of information.
- Although most peer groups had a fair idea of what family planning was and how to follow it through, YM and OW had other ideas as well. Young men had obtained their information on family planning from hospitals, clinics and from traditional healers. Women suggested the use of traditional methods of family planning that included the use of certain leaves, while older men suggested the use of African roots.
- Women mentioned the use of ARVs, devil’s claw, plants and chloroquine in the treatment of HIV/AIDS.
- The church and other community-based social networks seem to be important to all ages of both genders in obtaining knowledge about the different aspects surrounding HIV/AIDS. This indicates that the church is serious in its effort to support and protect its members.
• The spread of information through informal channels in the community indicated that word of mouth was an important channel for disseminating information. Although some of this information may not be entirely correct, it is important to recognize that these means of communication have already been established.

• It is important that the main sources of information on sexual behavior and risks of irresponsible actions to their health and reproductive capacity be made aware of their important role in safeguarding the population. They must be included in any planning with regard to improving the health status of the population to ensure that plans are coordinated and aimed at achieving the best results.
1. What have been the significant changes that people like you have experienced over the past twenty years?

2. What changes would you like to see in three years time in this community for people like you, particularly in relation to HIV and AIDS?
SESSION 4

The aim of this session was to help the peer groups reflect on changes in their community over time and to identify key changes necessary for them to achieve a collective vision for their future.

**What have been the significant changes that people like you have experienced over the past twenty years?**

Participants listed the following dates horizontally at the bottom of a large chart: 1980, 1985, 1990, 1995, 2000 and 2004. Groups then chose a symbol for the following, and charted these symbols along the vertical axis on the chart.

- Violence between men and women
- Relationship to church and religion
- Levels of unemployment
- Use of alcohol
- Access to education
- Use of drugs
- Presence of illness/disease in the community
- Inter-racial tension
- Percentage of people married in a civic or religious ceremony
- Percentage of people in a traditional marriage
- Percentage of people having more than one sexual partner at any one time

Participants then drew a line across the entire page and under each of the issues to be discussed. Once the chart was ready they reflected on how people like them experienced a particular issue at each of the dates given. Participants used the space between the upper and lower line of each issue to represent the size of the problem. They drew a vertical line to indicate how much of the problem they experienced: a full vertical line between the horizontal lines indicated 100%; a half line 50%; a quarter line 25% and so on. Then participants moved to the next date and continued until they had discussed all the problems.

**Findings**

7 Although the Peer Session manual entitled “Participatory Community Peer Assessment Tool” was utilized, there were some problems with the formatting. The first category in this question should be “economic well-being”, however due to formatting difficulties this was not seen as a question and therefore participants did not answer this question.
YOUNG MEN (ages 16-25 years)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Violence between men and women</td>
<td>85%</td>
<td>75%</td>
<td>65%</td>
<td>60%</td>
<td>36%</td>
<td>15%</td>
</tr>
<tr>
<td>Church participation</td>
<td>15%</td>
<td>25%</td>
<td>45%</td>
<td>65%</td>
<td>80%</td>
<td>85%</td>
</tr>
<tr>
<td>Unemployment</td>
<td>10%</td>
<td>25%</td>
<td>45%</td>
<td>65%</td>
<td>80%</td>
<td>85%</td>
</tr>
<tr>
<td>Alcohol</td>
<td>15%</td>
<td>20%</td>
<td>40%</td>
<td>65%</td>
<td>80%</td>
<td>90%</td>
</tr>
<tr>
<td>Education</td>
<td>5%</td>
<td>15%</td>
<td>40%</td>
<td>75%</td>
<td>85%</td>
<td>90%</td>
</tr>
<tr>
<td>Drugs</td>
<td>4%</td>
<td>8%</td>
<td>45%</td>
<td>60%</td>
<td>75%</td>
<td>90%</td>
</tr>
<tr>
<td>Inter-racial tension</td>
<td>90%</td>
<td>90%</td>
<td>60%</td>
<td>30%</td>
<td>15%</td>
<td>10%</td>
</tr>
<tr>
<td>Religious/civic marriages</td>
<td>5%</td>
<td>10%</td>
<td>45%</td>
<td>60%</td>
<td>80%</td>
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<tr>
<td>Traditional marriages</td>
<td>90%</td>
<td>80%</td>
<td>60%</td>
<td>45%</td>
<td>10%</td>
<td>5%</td>
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<tr>
<td>Multiple partners</td>
<td>5%</td>
<td>10%</td>
<td>15%</td>
<td>20%</td>
<td>50%</td>
<td>70%</td>
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- The young men’s group seemed to center their discussion around inter-racial tension, which shaped their view on other issues. They said that there was a “respective time” (respectful time) because independence was coming, which helped to alleviate tension. Inter-racial tension had over the whole period gradually decreased from 90% to 10%.
- The young men were of the opinion that violence between men and women had gradually decreased from a high of 85% in 1980 to 15% in 2004.
- Church was a place where they would run into white people, which explains the unwillingness of people to go to church before independence. With independence people “have to give thanks to the Lord”, an interpretation that corresponds with the increase in church participation from 15% in 1980 to 85% in 2004.
- If they worked and studied hard under the old regime, they could quickly get a job from the white people, unlike now, post-independence. With independence, people could educate themselves even further (they were afraid of “white come with their gun” but got support from the GRN when the country became independent), but with needing “qualifications” for work, it has become harder to get a job, as opposed to in old times, where work was more informally given. Young men feel that unemployment has increased from 10% in 1980 to 85% in 2004.
- Before independence young men were afraid white people would beat them if they found them drinking alcohol. However, after independence “everyone have got the right”, which encourages everyone to drink freely. This has lead to a sudden increase in alcohol consumption from 1995 (65%) to 2004 (90%).
- Access to education was deemed to have been only 5% in 1980, but has increased considerably from 1995 (75%) to 2004 (90%).
- Drugs in general were not well known in the 1980s when only 5% of the young men were using it. There has been a steady increase until 2000 (50%) and a slight decrease since (2004 – 40%).
• The incidence of illness rose after 1990 and has increased considerably from 1995 (60%) to 2004 (90%). Apart from the greater mobility of the Namibian population over the last two decades and the free movement of other nationals over the border (especially Angolans, Zambians, Zimbabweans and Tswanas), the growth of the Namibian population has also played a role.

• Religious marriages were rare in 1980 (5%) because people did “not know it [was] that important.” It was common to have three wives per man at that time, but the church stimulated a move to monogamy and everyone was happy comply because the church was very convincing. Since then the popularity of religious marriages has steadily increased to 90% in 2004.

• Traditional marriages declined inversely to the rise in religious marriages, from 90% to 5% over the same period.

• The percentage of people having multiple partners increased from the 1980s (5%) when traditional leaders controlled the number of wives a man could have. Now, post-independence, there is no control over the number of wives per male and “everyone [is] doing what he/she need”. This has lead to the situation where 70% of the population is deemed to have multiple partners.

YOUNG WOMEN (ages 16-25 years)

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<tbody>
<tr>
<td>Church participation</td>
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<td>55%</td>
<td>60%</td>
<td>70%</td>
<td>70%</td>
<td>80%</td>
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<tr>
<td>Unemployment</td>
<td>50%</td>
<td>50%</td>
<td>60%</td>
<td>65%</td>
<td>50%</td>
<td>40%</td>
</tr>
<tr>
<td>Alcohol</td>
<td>40%</td>
<td>30%</td>
<td>40%</td>
<td>45%</td>
<td>45%</td>
<td>50%</td>
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<tr>
<td>Education</td>
<td>25%</td>
<td>35%</td>
<td>45%</td>
<td>50%</td>
<td>50%</td>
<td>55%</td>
</tr>
<tr>
<td>Sickness</td>
<td>5%</td>
<td>5%</td>
<td>20%</td>
<td>25%</td>
<td>25%</td>
<td>30%</td>
</tr>
<tr>
<td>Single partner</td>
<td>5%</td>
<td>5%</td>
<td>10%</td>
<td>15%</td>
<td>35%</td>
<td>45%</td>
</tr>
<tr>
<td>Religious/civic marriages</td>
<td>4%</td>
<td>5%</td>
<td>10%</td>
<td>15%</td>
<td>25%</td>
<td>35%</td>
</tr>
<tr>
<td>Traditional marriages</td>
<td>10%</td>
<td>15%</td>
<td>20%</td>
<td>15%</td>
<td>10%</td>
<td>5%</td>
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• The young women’s group claimed that their grandparents did not want to go to church, in their day, but want to go now. However, people now go to many different churches, instead of maybe two different churches.

• Unemployment was not a big problem a long time ago, but it got worse after independence and has improved again since then.

• Alcohol use was perceived as noticeably more abusive now, stating that even a child could drink now. This led to more violence and sexual violence, according to the peer group.

• Education is deemed to have improved somewhat from 25% to 55% from 1980 to 2004.

• Sickness is definitely perceived as a more problematic issue now than in the 1980s.

• The general shift has been from traditional to religious marriages, as well as the practices which come with religious/civic marriages, such as monogamy, whereas in traditional marriages “one husband he married 6 wife so that he can build a big home.”

62
The men’s group offered no explanatory notes as to how they arrived at these numbers. However the following is evident from the information provided by the men about their perceptions on the subjects shown in the table:

- Economic well-being has declined over the period from 1980 (100%) but the decline was considerably steeper from 1990 (70%) to 2004 (20%).
- Violence between men and women increased considerably from 1990 (50%) to 2004 (99%).
- Church participation increased dramatically from 15% in 1980 to 100% in 2004, with the steepest increase from 1995 (65%) to 2004.
- The men feel that unemployment decreased slowly from 100% in 1980 to 75% in 1990. From then the decrease was steeper to reach the level of 15% in 2004.
- The use of alcohol in 1980 was deemed to have been 20%. It initially increased slightly but from 1995 quickly increased form 65% to 90% in 2004.
- This peer group felt that only 5% of them had access to education in 1980. From then onwards there has been a steady increase in their perception of access to education from 40% in 1985 to 100% in 2004.
- Drugs were perceived to be fairly unknown in 1980 when it was used by only about 2% of this peer group. Drug use slowly increased but from 1990 (35%) increased considerably to the level of 70% in 2004.
- The prevalence of illnesses was felt to be at 15% in 1980. The level of illnesses suffered by peers from 1985 (20%) increased to 80% in 2004.
- This group felt that inter-racial tension in the early days (1980-1985) stood at 100%. From then onwards they perceive a dramatic downward trend from 85% in 1990 to 15% in 2004.
- Marriages in a civic or religious ceremony were very unpopular in 1980 (5%). This type of marriage increased from 1990 (25%) to 2004 (70%). This increase corresponds with the increase in church participation mentioned by this peer group.
- As the number of civic/religious marriages increased, the number of traditional marriages decreased. Where the level of traditional marriages was felt to be at 100% in 1980, it gradually decreased to 95% in 1990 and thereafter declined steeply to 40% in 2004.
The number of peers who had multiple partners was felt to be 100% in 1980. The numbers decreased slightly to the level of 60% in 1990 and then slowly increased again to reach the level of 99% in 2004. It seems as though the role of the church and church participation did not make much difference here.

**WOMEN (ages 26-45 years)**

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<tr>
<td>Church participation</td>
<td>20%</td>
<td>30%</td>
<td>40%</td>
<td>65%</td>
<td>85%</td>
<td>100%</td>
</tr>
<tr>
<td>Alcohol use</td>
<td>10%</td>
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<td>100%</td>
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<tr>
<td>Education</td>
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<td>50%</td>
<td>65%</td>
<td>80%</td>
<td>95%</td>
</tr>
<tr>
<td>Drug use</td>
<td>5%</td>
<td>10%</td>
<td>30%</td>
<td>40%</td>
<td>60%</td>
<td>75%</td>
</tr>
<tr>
<td>Sickness</td>
<td>5%</td>
<td>20%</td>
<td>45%</td>
<td>55%</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td>Inter-racial tension</td>
<td>15%</td>
<td>25%</td>
<td>30%</td>
<td>50%</td>
<td>70%</td>
<td>90%</td>
</tr>
<tr>
<td>Religious/civic marriages</td>
<td>100%</td>
<td>80%</td>
<td>60%</td>
<td>35%</td>
<td>20%</td>
<td>5%</td>
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</table>

- The women’s group said that there are too many churches nowadays, back in the 1980s, there were only two churches (Catholic, and ELCIN), now there may be upwards of 20 types of churches.
- Alcohol use has risen because in the old days people believed women should not drink, but now they are not afraid of alcohol.
- Education was rare in previous years, but it meant that if you finished Grade 10, you would become a teacher, whereas now, finishing Grade 10 means “you will not go to school again, that’s war.” According to the new educational system Grade 10 drop outs are not taken back to repeat the grade.
- Drug use rose starting in 1985, which is why “you get more people coming crazy due to the use of drugs.”
- Sickness was not a bad problem up through 1995, but increased to 100%, making hospitals too small to accommodate the sick. According to the peer group much of the rise in sickness is due to alcohol/drugs, hunger and poverty.
- Inter-racial tension was high about the years 1980-1995, because “white people they could not want black people”, even the bread given to black people was not allowed to be white, but had to be brown. A black person eating white bread was grounds for being beaten. This was to treat “us like a animals”, subjecting them to low wages and insults. Now everyone “eats together” and things are much better.
- The prevalence of religious or civic marriages has decreased considerably from 100% in 1980 to 5% in 2004. This result is peculiar if the increase in church participation is taken into account.

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8 Economic well-being, violence between men and women, unemployment, % of people married in traditional marriages and % of people with multiple partners, were not included in the notes.
9 Judging from the notes, it seems likely that the group has interpreted this as how good the relationship between the races was, instead of how tense.
The older men’s group did not give percentages, but gave an indication of degree in terms of where levels of the topic at hand went up or down. They used upwards facing arrows (indicated as a ^ for sake of graphics) and downwards facing arrows (indicated by a V), ranging from one to six arrows for any one box.

10 The only notes regarding this question involves how back in 1980, men like them were cultivating the lands with a hoe and life “was high” because people were cultivating the land and “the rain was enough”. Since then, life has slowly improved (in general) until 1990, at which point the notes stop. However the following is evident from the information provided by the men about their perceptions on the subjects shown in the table:

- Economic well-being seems to have been fair up to 1990 when it took a downward turn, which persisted.
- Violence between men and women was perceived to be bad in 1980 to 1985. It then started to improve and showed a marked improvement up to 2004.
- Church participation was fair in 1980 but steadily declined from 1985 onwards and was at a low in 2004.
- Unemployment was fair in 1980 but started decreasing in 1990 and continued the decreasing trend until 2004.
- Alcohol consumption and drug use was fair in 1980 and 1985. As from 1990 alcohol and drug abuse increased considerably, with the level of drug abuse slightly higher that that of alcohol.
- Access to education was initially deemed to have been low but increased steadily from 1990 to 2004.
- The incidence of illnesses used to be very low, but has increased steadily from 1990 and is now at a high level.
- Inter-racial tension was deemed to be quite low in 1980. It however started increasing slightly over the period under review and is at present at a high.
- The occurrence of religious and civic marriages in 1980 was quite low. It started increasing in 1990 and in 2004 stood at a fairly high level. This is in contrast with the reduced participation in church activities indicated above.

11 The men drew an upward and downward facing arrow in this box, possibly indicating that economic well-being was up, but was starting to trend downwards. However, there are no notes indicating why the symbols were drawn this way.
• The occurrence of traditional marriages was fair in 1980. It increased slightly in 1985 and thereafter started a considerable decrease, reaching a low in 2004.
• The peer group felt that a fair number of them had multiple sexual partners in 1980, it steadily declined from then onwards to a low in 2004.
As a result of the peculiar way this peer group had recorded their evaluation of the different factors, it is possible that it could be misinterpreted.

OLDER WOMEN (over 46 years)

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<tbody>
<tr>
<td>Economic well-being</td>
<td>40%</td>
<td>40%</td>
<td>35%</td>
<td>30%</td>
<td>12%</td>
<td>20%</td>
</tr>
<tr>
<td>Violence between men and women</td>
<td>20%</td>
<td>20%</td>
<td>30%</td>
<td>50%</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>Church participation</td>
<td>30%</td>
<td>30%</td>
<td>40%</td>
<td>50%</td>
<td>70%</td>
<td>90%</td>
</tr>
<tr>
<td>Unemployment</td>
<td>50%</td>
<td>50%</td>
<td>40%</td>
<td>30%</td>
<td>25%</td>
<td>20%</td>
</tr>
<tr>
<td>Alcohol use</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>30%</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>Education</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
<td>10%</td>
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<tr>
<td>Drug use</td>
<td>5%</td>
<td>5%</td>
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<td>10%</td>
<td>20%</td>
<td>40%</td>
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<tr>
<td>Sickness</td>
<td>15%</td>
<td>15%</td>
<td>50%</td>
<td>40%</td>
<td>50%</td>
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<tr>
<td>Inter-racial tension</td>
<td>30%</td>
<td>40%</td>
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<td>20%</td>
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<tr>
<td>Religious/civic marriages</td>
<td>20%</td>
<td>20%</td>
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<tr>
<td>Traditional marriages</td>
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<td>80%</td>
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<tr>
<td>Multiple partners</td>
<td>10%</td>
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<td>55%</td>
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<td>80%</td>
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• The older women’s group said that in terms of economic well-being, there was more money in earlier years, even though it was rarely enough, it could buy more than it can now. They thus felt that they were better off previously then they were now.
• With independence, violence between men and women and unemployment rose. Nowadays, even children can get their hands on alcohol.
• This group also noted the rise in the number of churches, corresponding with a rise in attendance of church over the past twenty years.
• The older women felt that access to education was open to everyone now, unlike the old days where black people could not go up through Grade 12 or study science.
• Drug use has risen from 5% to 45%, possibly with the influence of television.
• The rise in sickness, from 15% to 70%, is described as the result of the lack of a cure for the current diseases afflicting their community, while in the 1980s, malaria and tuberculosis could be cured.
• Inter-racial tension rose during the struggle for independence, but since 1995 it has started to slow down again.
• Only since 1990 have people really started getting married in churches, which corresponds to a drop in traditional marriages.14

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12 Not supplied in notes.
13 Judging from the notes, which state “people like them [the peer group] in their community said unemployment started rising since Independence”, which indicates that the numbers given probably reflect “level of employment” as opposed to “level of unemployment”.
14 This does not correspond to the numbers given, which indicate a rise in traditional marriages.
• In the 1980s, men especially often had polygamous relationships, however, if a man had two wives, he stuck solely to those wives. Now, even married people have “lots of outside sexual partners”.

**Comparative conclusions**

Session 4/Question 1: 

*What have been the significant changes that people like you have experienced over the past twenty years?*

Presenting the findings of the peer groups as percentages provides a crude estimate of perceived social change over time. However, these overall trends can be very informative.

• Across age and gender, there were few consistent patterns. Use of alcohol, education, drugs, illness and traditional marriage were the only categories that showed consistent results across all of the ages and genders. The use of alcohol and drugs and incidence of illness increased dramatically across all peer groups excepting young women where the increases were not so large and they omitted a measure for the use of drugs. The occurrence of traditional marriages decreased considerably among the male peer groups and slightly among the young women. Women and older women didn’t complete this question. Access to education had according to all the peer groups increased and provided them with more career options and better education possibilities than before.

• The increased incidence of illness could be the consequence of a number of factors. The increase in alcohol and drug abuse, coupled with the frequency of multiple partners, the increase in the Namibian population numbers, the greater mobility of the Namibian population over the last two decades, the free movement of other nationals over the border (especially after the opening of the trans-Caprivi route), the social ills present across the border in Angola, Zambia, Zimbabwe and Botswana and the inability of the health structure to provide for all, to a greater or lesser extent contributed to the increase in illnesses amongst the population.

• Most groups reported that while traditional marriages decreased, the number of marriages in a civic or religious ceremony increased. Only the women’s group reported a decrease in the incidence of civic or religious marriages.

• There was no recognizable trend with respect to the perceptions of inter-racial tension or having multiple sexual partners.

• The young men were the only ones to feel that there had been a decline in violence between men and women. This could be due to them not having been in the conflict zone long enough to know or that they themselves had not been exposed to it sufficiently yet. The other peer groups that had reacted to this factor were of the opinion that it had increased considerably over time. A very steep increase in this type of violence was reported by the young women. Possible reasons could be the increase in the population over time, greater competition for available jobs due to the emancipation of the Namibian women, the increase in the misuse of alcohol or a combination of all these factors.
• It is known that alcohol does play a major part in violence, but the effect of the other factors must not be ignored.

• The only peer group that did not report a considerable decline in unemployment was the young men’s group, which felt that unemployment had increased. Although the older women’s group indicated an increase in unemployment, their notes indicated a decrease. When compared to other mentions of unemployment in the study, the lack of consistency in the opinions of the different groups suggests that the question may not have been correctly understood. The uncertainty thus remains if indeed there has been a significant decline in unemployment over the past twenty years.

• Some of the peer groups reported an increase or decrease in the percentages but the values eventually returned to their original level. For example the men’s percentage of people having more than one sexual partner at any one time started at a high of 100% in 1980, dropped to 60% in 1990 and returned to 99% in 2004.

• Church participation was seen by all excepting the older men to have increased considerably. This could be the result of greater hardship being experienced as a result of unemployment, an increase in general and family violence and the increase in illnesses. This trend toward greater religious participation has also lead to the increase in civic and religious marriages that implies a stronger tie with the values and norms of the church. This trend should be followed in order to establish in what way it could be extended to support any plans to combat the problems being experienced by the Namibians.

Question 2

What changes would you like to see in three years time in this community for people like you, particularly in relation to HIV and AIDS?

Once the group had a good understanding of what the drama portrayed, they engaged in a discussion on how they would like this situation to change in three years time. After this discussion and a brainstorming session on significant changes needed, participants developed another drama to demonstrate the changes they desired to see in their community. When all the significant changes had been identified, a pair-wise ranking matrix was used to choose the five most important changes this peer group said they would like to see in three years time. These changes are noted in order of importance in the table below.

Findings

Table 26: Needed changes prioritized by peer groups

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15 The number in each bracket refers to the total number of times that that particular problem was mentioned by the group in the pair-wise matrix.
Comparative conclusions
Session 4/Question 2:
What changes would you like to see for people like you in this community in three years time, particularly in relation to HIV and AIDS?

- The peer groups each ranked the problems they would like to see addressed individually, yet some trends were visible. Five of the six groups cited the improvement of education as an area where attention was required.
- Four of the groups would like to see measures put in place to encourage a decrease in the consumption of alcohol, while two groups would like the same to happen to drugs.
- The wish for more jobs, less unemployment and poverty were mentioned by four of the groups. Such steps would have a beneficial effect on the prevalence of crime and violence.
- Three of the groups wished to see greater access to healthcare and less sickness in the community.
- The issues of greater church participation and faithfulness each were seen as high priority by two groups. Increasing the positive influence of the church could be to the benefit of the whole country and all its peoples.

In order of priority the top four problems for people living in Rundu that they want changed are
- Education
- Alcohol abuse
- Improved access to healthcare (reduced incidence of illness) and
- Unemployment.
Other problems mentioned although to a much lesser extent include drugs, church participation and violence.

**OVERALL SUMMARY & ANALYSIS**

The following Rundu findings will help program planners, community leaders and community members in focusing their own community mobilization activities to combat the HIV epidemic and to improve the general health and welfare of their community.

**Main problems**

*What are the main problems for people like you in this community?*

Each peer group identified the main problems they experienced in the community. They were then compared to identify the top problems in the community. The problems identified were related to the economy, crime and alcohol abuse as the largest problems.

All groups mentioned the economic status of the community as the highest priority, though each group used a different indicator or name for this issue. However, aside from economic considerations, few issues were cited with any consistency.

Three groups cited alcohol as a problem in the community while two stated that crime was a problem for people like them.

The lack of consistency surrounding community problems across groups (with the glaring exception of poverty) may be due to the heterogeneous sample as members of peer groups were taken from two separate communities (Sauyemwa and Kasote). The variance may also simply reflect the severity of the issue of poverty while other problems appear to wane in the background. This seems very credible when considering four of the six groups chose economic troubles (termed differently as hunger, lack of jobs, unemployment, and poverty), as the largest problem in the community.

Very little attention was given to HIV/AIDS and illness and it was only mentioned by men and women. This could indicate that it is not such a problem or that the economic problems are more overwhelming.

The perceived helpfulness of agencies is low. The church seems to be the most involved and providing the most assistance followed by GRN and NGOs at a lower level. The community is not perceived as being very helpful towards one another.

It is clear that the peer groups’ expectations of agencies are too high, they were evaluated incorrectly or that their efforts are really not making the required difference.

**Risk of infection**

*From the perspective of people like you, which peer group in this community is the most vulnerable to HIV?*
The groups did not appear to show a general pattern in their delineation of the most vulnerable groups, however they did appear to rank women as more vulnerable to HIV than men.

Young women were perceived to be the most vulnerable to HIV infection by three out of six peer groups, second most vulnerable by another and fourth most vulnerable by another group. The women’s group was chosen as most vulnerable by two of the six groups. This appears to represent a feeling that in the community women in general are more vulnerable to HIV with YW being the most vulnerable.

There is thus a fair measure of consensus that young women are most vulnerable followed by women, men, young and older men and lastly older women. Any effort to combat infection in the community must take this into account if it is meant to be successful.

**Why people are getting infected**

*What are the reasons why people like you are getting infected with HIV? How common are these reasons for people like you? How are these problems making people like you vulnerable to HIV infection?*

Alcohol or drug abuse was mentioned by five out of the six peer groups as a very common factor accounting for risky sexual behavior being exhibited and encouraging the spread of HIV among people like them. Only the women’s group did not mention this as a factor.

Unemployment related conditions, the need for money and poverty, were the second most cited reasons mentioned by four out of six peer groups as the most common reason for putting people at risk of HIV infection. This may offer a glimpse into a larger problem where sex is often used in trade.

Three out of six peer groups mentioned having multiple partners.

The use of condoms was in dispute as to its role of preventing or assisting the spread of HIV/AIDS. While the young men’s group cited not using condoms or using expired condoms as a reason why people like them are becoming infected, both the older women’s group and the older men’s group cited condoms as a reason why people are getting infected. The older men’s group felt that condoms contributed to the spread of HIV because the lubricant of the condoms contains the HIV virus and therefore when a man uses a condom he may contract the virus. They also stated that it is possible for the condom to break or tear off during sex, which can allow the virus to be passed.

The most common reasons why people became infected were through carelessness after alcohol or drug abuse, having sex for money, having multiple partners and not taking the required precautions. This indicates a need for concerted efforts toward promoting awareness and behavior change. Presenting life skills programs on the following could help to improve the situation:
Efforts targeted toward promoting awareness on these issues would need to take into account lack of access to education for the older men and women and thus for illiteracy.

**Main influences on sexual behavior**

*Who or what are the main influences on the sexual behavior of people like you?*

The most common responses as to who or what the main influences on the sexual behavior of people like them were, were media (TV and radio) and the physically attractive attributes of the opposite sex. The responses of the groups did not differ greatly by gender or age. Other influences mentioned were peer pressure or friends, alcohol, physical closeness and money.

Five of the six peer groups cited media (TV and radio) as having an influence on their sexual behavior. Half of the groups also appear to generally agree that the attractiveness of the opposite sex has a strong influence on sexual behavior. It seems as though the visual impact is overwhelming for older men.

Three of the six peer groups mentioned that peer pressure or friends influenced sexual behavior. Alcohol was only mentioned by one group, although many of the groups earlier discussed this as being a factor contributing to the spread of HIV in the community.

Of great importance is that what is seen has such a big influence on the activities of all peer groups – media material and people dressed and/or behaving seductively. This tendency to be easily stimulated by what they see and hear could be used in programs to convince them to change their behavior to minimize the risk of infection.

**Multiple partners**

*Over a lifetime, how many sexual partners would people like you usually have or expect to have?*

The responses of the groups with respect to the number of partners people like them would expect to have during their lifetime and at different ages, differed greatly by age and gender.
It does not appear to be uncommon for the people in the community to become sexually active before the age of 16 as only three of the groups provided that zero partners was possible in that age range.

Women consistently reported a lower number of sexual partners per age category than men for nearly every age as well as in total. (Whether this difference is actually significant is subject to statistical analysis.) The numbers of sexual partners per woman also tended to taper down from the age 41 to 60, which was sooner than that of men. However, both groups appear to be more sexually active after the age of 40, with most groups expecting to have the largest number of partners either between 41-50 or 51-60.

Sexual partners

*Who are people like you having sex with?*

Many of the categories for comparison were missing. This had a limiting effect on the interpretation of the data.

The responses to the question, who people like them were having sex with varied greatly, with the most common theme being the reference to the practice of sex for reward, with nearly all of the groups mentioning either prostitution directly or a more informal sugar daddy scenario. The only other group mentioned across peer groups was the preference for spouses.

Generally speaking, people of the same gender were having sex with the same types of partners as themselves. However, each of the women’s groups as well as the older men’s group mentioned the practice of sex for money. The discussions around the sugar daddies, rich men, and businessmen, refer to sexual favors instead of strict prostitution. The groups discussed sex in exchange for cellular phones and clothing as well as money. The underlying drive for this behavior was unemployment resulting in the need for money to survive and need for status.

Similarities existed between young men who preferred schoolgirls and older men young girls for sex.

Husbands or wives were also mentioned as highest priority choices by young women, women, older men and older women. In this case the choice of the young women was surprising due to their young age.

Men surprised by looking for Christian ladies, office workers or nurses. These choices were very conservative but promised some stability of income and hopefully values.

All men tended to look for young women and wives and all women preferred their husbands, boyfriends or someone with money.

**Living a healthy sexual and reproductive life**

*What do people like you need to live a healthy sexual and reproductive life?*

The most commonly stated needs for a healthy sexual and reproductive life were faithful partners, access to HIV testing and medical facilities, contraceptives, abstinence and family planning. The availability of each of these was also addressed specifically by each group.
Five of the six peer groups mentioned being faithful to one partner, loving and caring husbands as an important principle to comply with to help them live a more healthy sexual and reproductive life. The women’s group was the only one not to mention it. Faithfulness would however be a difficult principle to instill in the greater community due to their admitted preference for multiple partners, but an effort should be made to convince them of its merits.

The ability to know ones status through HIV tests, hospitals, clinics and medical attention mentioned by men, women, older men and older women emphasized the importance with which most participants viewed these institutions as role players to maintain a healthy sexual and reproductive life.

The use of contraceptives and abstinence were mentioned by four of the peer groups as important services needed to maintain a healthy sexual and reproductive life.

Family planning organizations, where information and training with respect to family planning in all its facets could be presented, emerged as a significant service required by two of the peer groups as was the role of healthy food.

The mention of HIV testing facilities and access to medical care is an indication of the insight the groups had in the necessity of these services if one is to have a healthy life amidst the negative influences. This should be mobilized and included in preventative plans.

**Sources of HIV/AIDS-related information most frequently cited**

The following represent the sources of HIV/AIDS-related information most frequently cited by the peer groups.

- Four of the six peer groups mentioned hospitals as the source from which they obtained most information. In many cases they stated that it was their most important source.
- Radio and television was also very often mentioned as sources of information as well as the media in general. In addition two groups also mentioned newspapers.
- Clinics, the New Start centers and churches were also cited as good sources of information.
- Although most peer groups had a fair idea of what family planning was and how to follow it through, women, young men and older men had other ideas as well. Young men had obtained their information on family planning from hospitals, clinics and from traditional healers. Women suggested the use of traditional methods of family planning that included the use of certain leaves, ARVs, devil’s claw, plants and chloroquine in the treatment of HIV/AIDS, while older men suggested the use of African roots as well.
- The church and other community-based social networks seem to be important to both genders and all ages in obtaining knowledge about the different aspects surrounding HIV/AIDS. This indicates that the church is serious in its effort to support and protect its members.
- The spread of information through informal channels in the community indicated that word of mouth was an important channel for disseminating information. Although some
of this information may not be entirely correct, it is important to recognize that these means of communication have already been established.

- It is important that the main sources of information on sexual behavior and risks of irresponsible actions to their health and reproductive capacity be made aware of their important role in safeguarding the population. They must be included in any planning with regard to improving the health status of the population to ensure that plans are coordinated and aimed at achieving the best results.

**Changes in the community**

*What have been the significant changes that people like you have experienced over the past twenty years?*

Across age and gender, there were few consistent patterns that emerged over the past twenty years. Use of alcohol, education, drugs, illness and traditional marriage were the only categories that showed consistent results across all of the ages and genders. The use of alcohol and drugs and incidence of illness increased dramatically across all peer groups excepting young women where the increases were not so large and they omitted a measure for the use of drugs. The occurrence of traditional marriages decreased considerably among the male peer groups and slightly among the young women. Women and older women didn’t complete this question. Access to education had according to all the peer groups increased and provided them with more career options and better education possibilities than before.

The increased incidence of illness could be the consequence of a number of factors. The increase in alcohol and drug abuse, coupled with the frequency of multiple partners, the increase in the Namibian population numbers, the greater mobility of the Namibian population over the last two decades, the free movement of other nationals over the border (especially after the opening of the trans-Caprivi route), the social ills present across the border in Angola, Zambia, Zimbabwe and Botswana and the inability of the health structure to provide for all, to a greater of lesser extent contributed to the increase in illnesses amongst the population.

Most groups reported that while traditional marriages decreased, the number of marriages in a civic or religious ceremony increased. Only the women’s group reported a decrease in the incidence of civic or religious marriages.

There was no recognizable trend with respect to the perceptions of inter-racial tension or having multiple sexual partners.

The young men were the only ones to feel that there had been a decline in violence between men and women. This could be due to them not having been in the conflict zone long enough to know or that they themselves had not been exposed to it sufficiently yet. The other peer groups that had reacted to this factor were of the opinion that it had increased considerably over time. A very steep increase in this type of violence was reported by the young women. Possible reasons could be the increase in the population over time, greater competition for available jobs due to the emancipation of the Namibian women, the increase in the misuse of alcohol or a combination of all these factors. It is known that alcohol does play a major part in violence, but the effect of the other factors must not be ignored.
The only peer group that did not report a considerable decline in unemployment was the young men’s group, which felt that unemployment had increased. Although the older women’s group indicated an increase in unemployment, their notes indicated a decrease. When compared to other mentions of unemployment in the study, the lack of consistency in the opinions of the different groups suggests that the question may not have been correctly understood. The uncertainty thus remains if indeed there has been a significant decline in unemployment over the past twenty years.

Church participation was seen by all excepting the older men to have increased considerably. This could be the result of greater hardship being experienced as a result of unemployment, an increase in general and family violence and the increase in illnesses. This trend toward greater religious participation has also lead to the increase in civic and religious marriages that implies a stronger tie with the values and norms of the church. This trend should be followed up in order to establish in what way it could be extended to support any plans to combat the problems being experienced by the Namibians.

**What changes would you like to see for people like you in this community in three years time, particularly in relation to HIV and AIDS?**

The peer groups each ranked the problems they would like to see addressed individually, yet some trends were visible. Five of the six groups cited the improvement of education as an area where attention was required.

Four of the groups would like to see measures put in place to encourage a decrease in the consumption of alcohol, while two groups would like the same to happen to drugs and four of the groups wanted to see the creation of more jobs, less unemployment and poverty. Such steps would have a beneficial effect on the prevalence of crime and violence.

Three of the groups wished to see greater access to healthcare and less sickness in the community.

The issues of greater church participation and faithfulness were seen as a high priority by two groups. Increasing the positive influence of the church could be to the benefit of the whole country and all its peoples.

In order of priority the top four problems for people living in Rundu that they want changed are:

- Education
- Alcohol abuse
- Unemployment and
- Improved access to healthcare (reduced incidence of illness).

The community members collectively noted increased education, decreased use of alcohol and greater access to healthcare (reduced illness), as the changes they would most like to see in the community over the next three years.
CONCLUDING COMMENTS

In conclusion, one alarming and pervasive trend throughout the data is the effect of secondary factors such as economic status and alcohol use on infection rates of HIV. The general development of the community can therefore be seen as inextricably tied to the reduction of infection rates of HIV. The community has not identified HIV/AIDS as a main problem in the community or a main area for improvement over the next three years in spite of the high incidence of infections and HIV/AIDS related deaths.

This result may also only indicate that, while HIV does present an enormous challenge to the community, it takes a back seat to larger more pressing everyday issues, such as hunger and poverty. In Maslow’s hierarchy of needs, a person is not capable of attending to higher order needs, such as long-term health, in the face of more basic short-term needs, such as today’s empty stomach. This should be taken into account when reviewing the data presented, that, while HIV is an issue that must be addressed in the community, the challenge would be to make it the primary issue of concern to members of the community.

Addressing problems of access to education, alcohol abuse, unemployment and improved access to healthcare is a priority since it contributes to risky behavior that may lead to HIV infection. As seen above, many people in Rundu are having sex with multiple partners and are in many cases are driven by the need for rewards, including food and money, when choosing a sexual partner.

The lack of information is an issue that has to be addressed. The general education level of the Rundu community as a whole will have to be taken into account when planning any intervention as literacy is low, presenting an additional hurdle to be overcome.

This report gives insight into the situation in Rundu alone. To achieve a long-lasting positive result in the greater Kavango area, the situation in the more isolated areas of this constituency will also have to be looked into.

As solving the main problems fall in the area of responsibility of the Namibian government, any strategies and plans to alleviate or solve the problems must be liaised with the government to ensure their cooperation and support of the actions.

These findings demonstrate the importance of collecting, analyzing and sharing data and information at community level. While larger quantitative surveys are helpful, they do not show the patterns in behavior that appear in people’s decision making at community level. Emergency Plan partners working in Namibia are encouraged to use these findings, in addition to their own research findings as well as other HCP network findings, to enhance their current activities and address the priority problems identified by the community of Rundu.