Health Vulnerabilities of Mobile Populations and Affected Communities in Selected Ports of Southern Africa – Walvis Bay, Namibia
D
Final Report
Study on Health Vulnerabilities of Mobile Populations and Affected Communities in Selected Ports of Southern Africa – Walvis Bay, Namibia

Prepared for
International Organization for Migration (IOM)
Prepared by
Sustainable Development Africa cc. (SusDAf)

28 November 2014
ACKNOWLEDGEMENT

This study was carried out with the support of International Organisation for Migration (IOM) Southern Africa Regional Office and IOM Mozambique Office as part of a SADC funded initiative to identify HIV risk profiles for four Southern African ports using the concept of ‘Spaces of Vulnerability’ where the interaction of all groups in the space are discussed and key programming issues identified to reduce vulnerability to HIV transmission. The research was carried out in the Walvis Bay.

We would like to thank the people of Walvis Bay who participated and gave freely of their time to provide us with valuable insights into the interactions between residents and mobile populations in the environs of the Walvis Bay in both the quantitative and qualitative surveys.

A special thank you is hereby given to the Chair and members of the country technical steering committee which assisted immensely in ensuring that the study was successfully implemented in Namibia.


ABSTRACT

The study was conducted to contribute to the reduction of HIV among migrants and mobile workers, their families and communities with which they interact in the port of Walvis Bay in Namibia. A mixed-method research approach was employed which included a quantitative questionnaire-based survey and qualitative interviews. GIS mapping of the different areas inside and outside the Port was also produced. The sample size was 409 which included: female sex workers, men having sex with men, male sex workers, truck drivers, local seafarers, foreign seafarers, and town residents. This study was conducted in a small port town wherein the port constitutes the single biggest entity and the town itself is an outgrowth of the port. Consequently, the study records considerable sexual interaction between the town residents and the main mobile populations, truck drivers and seafarers. Walvis Bay is 30kms from a larger town, Swakopmund, and some commercial sex workers (men and women) and local seafarers ‘commute’ between the two towns. There are approximately 530 sex workers operating in the town, most of whom are local residents.

The study reports the existence of multiple concurrent relationships between truck drivers and commercial sex workers with some indication of relations also with other residents such as workers at hotels and bars next to the port. However, there are locations beyond the port in the town’s suburbs where truck drivers stay and have liaisons with commercial sex workers and other residents. The study reports sexual interactions between seafarers and commercial sex workers and other town residents. The international seafarers’ population includes crews from south Atlantic fishing fleets which come regularly to Walvis Bay for refuelling and supplies. A consequence is that there are sexual relationships between the crews and sex workers when the ships are in port. Notably, there are women who have transactional relationships with these men, usually ships’ officers; for example, being supported financially and occupying flats paid for by the officers. Local seafarers are also largely fishermen whose ships are at sea for shorter periods than those of the international fishing fleets and who visit sex workers in Walvis Bay on their return. Generally, the sampled population reported extremely low levels of consistent condom use with spouses and cohabitating partners and inconsistent used by sex workers.
The study reports that majority of informants were very knowledgeable about HIV/AIDS, expressed few prejudices, and use professional medical services when necessary. In this instance, there is an abundance of public and NGO services in the town. Walvis Bay represents a classical port in terms of concurrent, commercial and transactional sexual relationships in the port environs. There is a high risk of HIV and STI transmission in this context.
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<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ASAWA</td>
<td>African Sex Workers Alliance</td>
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<tr>
<td>CAA</td>
<td>Catholic AIDS Action</td>
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<tr>
<td>CSO</td>
<td>Civil Society Organisation</td>
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<tr>
<td>DSP</td>
<td>Directorate of Special Programmes</td>
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<tr>
<td>FBO</td>
<td>Faith Based Organisation</td>
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<tr>
<td>HCT</td>
<td>HIV Counselling and Testing</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>IDI</td>
<td>In-depth Interview</td>
</tr>
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<td>IOM</td>
<td>International Organisation for Migration</td>
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<td>KII</td>
<td>Key Informant Interview</td>
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<td>MARP</td>
<td>Most at Risk Population</td>
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<td>MCP</td>
<td>Multiple Concurrent Partnership</td>
</tr>
<tr>
<td>MFMR</td>
<td>Ministry of Fisheries and Marine Resources</td>
</tr>
<tr>
<td>MOHSS</td>
<td>Ministry of Health and Social Services</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have sex with Men</td>
</tr>
<tr>
<td>MSW</td>
<td>Male Sex Worker</td>
</tr>
<tr>
<td>MWTC</td>
<td>Ministry of Works, Transport and Communication</td>
</tr>
<tr>
<td>NABCOA</td>
<td>Namibia Business Coalition for AIDS</td>
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<tr>
<td>NamPort</td>
<td>Namibia Ports Authority</td>
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<td>NASOMA</td>
<td>Namibia Social Marketing Association</td>
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<td>NDHS</td>
<td>Namibia Demographic and Health Survey</td>
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<td>NGO</td>
<td>Non-governmental Organisation</td>
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<td>NSA</td>
<td>Namibia Statistics Agency</td>
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<td>NSF</td>
<td>National Strategic Framework for HIV and AIDS</td>
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<td>RoN</td>
<td>Republic of Namibia</td>
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<td>SADC</td>
<td>Southern African Development Community</td>
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<td>SFH</td>
<td>Society for Family Health</td>
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<td>STI</td>
<td>Sexual Transmitted Infection</td>
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<tr>
<td>SusDAf</td>
<td>Sustainable Development Africa</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<td>WBCG</td>
<td>Walvis Bay Corridor Group</td>
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<td>WMPRC</td>
<td>Walvis Bay Multi-purpose Resource Centre</td>
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<td>WPP</td>
<td>Work Place Programme (HIV and AIDS)</td>
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1. INTRODUCTION

1.1 Introduction

Migrants and mobile populations are regarded as most at risk populations in relation to Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), Sexually Transmitted Infections (STIs) and Tuberculosis (TB). Understanding such vulnerabilities is essential for the development of effective and efficient response strategies, as well as the implementation and monitoring and evaluation thereof. The Study on Health Vulnerabilities of Mobile Populations and Affected Communities in Selected Ports in Southern Africa aims to inform policies, strategies and programmes towards responding to the health needs of these vulnerable population groups.

Sustainable Development Africa (SusDAf), a Namibian–based social research firm, was commissioned by International Organisation for Migration (IOM) to carry out the study in Walvis Bay. SusDAf employed a mixed–method research approach, combining quantitative and qualitative research methods, which allowed for statistical analysis to be complemented by in–depth data and vice versa.

1.2 Rational for the study

The International Organization of Migration (IOM) is one of the leading inter–governmental organisations that works to help ensure the orderly and humane management of migration, to promote international cooperation on migration issues, to assist in the search for practical solutions to migration problems, and to provide humanitarian assistance to migrants in need, including refugees and internally displaced people. One of the main gaps in effectively responding to the health vulnerabilities of migrants is the limited understanding of different health vulnerabilities as it relates to HIV and AIDS and TB and the nature of sexual networks between migrants and migrant affected households, sea–going personnel, truck drivers, sex workers and other sedentary populations. The IOM has therefore commissioned the above–mentioned study on health vulnerabilities in selected ports in Namibia, South Africa, Mozambique and Tanzania. Walvis Bay was the selected port for Namibia where the proposed study was carried out.
1.3 Goals and objectives of the study

The IOM Research and Information Dissemination Intervention Strategy for East and Southern Africa strive to strengthen knowledge and increase the pool of evidence relating to health vulnerabilities and challenges faced among migrants and migration–affected communities in order to contribute to evidence–based, effective programming and policy development. As part of this strategy, IOM is undertaking a regional research project that seeks to contribute to the reduction of HIV incidence and impact of AIDS among pregnant and mobile workers and their families, and the communities with which they interact in selected port communities in southern Africa.

The specific outcomes of the study will be:

- Strengthened evidence base for future interventions in HIV prevention, treatment, care, and support addressing the specific needs of sea–going personnel, sex workers, and other vulnerable groups they interact with in selected ports in southern Africa; and
- Strengthened information–sharing, networks and partnerships in order to better coordinate the health and HIV response in port settings.

This study will provide a more in–depth understanding of health vulnerabilities, specifically related to HIV and AIDS within spaces of vulnerability as it relate to mobile populations and affected communities, current responses to those vulnerabilities as well as the nature of sexual networking amongst concurrent sexual partnerships that exist among sea–going personnel, truck drivers, sex workers and other sedentary populations around the Walvis Bay Port.

1.4 Key study terminologies

This report makes use of terminologies that need to be understood in the context of this study. Below, please find definitions for key terminologies used in this study.

**Port communities:** Refer to geographical locations comprising villages, towns, cities,
municipalities which the local population define as being directly affected by an officially recognised national seaport.

**Port populations:** Refer to individuals residing at the port on the day of survey. This will include those who are residents and those visitors who spent the night preceding the survey.

**Sex workers:** Refer to persons (male or female) aged 18 years or above who has had 2 or more sexual partners in the last 12 months in exchange of money, gifts or other incentives.

**Mobile populations:** Refer to a large category of persons who may cross borders or move within their own country on a frequent basis for a variety of work–related reasons, without changing place of habitual primary residence or home base. Mobile work involves a range of employment or work situations that require workers to travel in the course of their work such as foreign and local sea–going personnel, and long–distance truck drivers. Mobile workers are usually in regular or constant transit, sometime (regular) circulatory patterns and often spanning two or more countries, away from their habitual or established place of residence for varying periods of time.

**Internal mobility:** Refers to movement from homes to other places within the same country.

**External mobility:** Refers to movement across international borders to a foreign country. These kinds of migrants may have legal status or be undocumented.

**Migration:** It is used to describe mobile populations who take up residence or
remain in another place for an extended period.

**Migrant workers:** Refer to individuals who have moved from their homes for the purposes of employment and have established residency within the local community. This movement may be internal (within the country) or international (cross border). Migrant workers can include contract and seasonal workers for purposes of this study. For purposes of this survey, migrants are those that live in another place for 10 years of less. If more than 10 years, then such a person is regarded as sedentary or no longer a migrant.

**Sea-going personnel:** Refers to all those employed on sea vessels irrespective of their contract duration. Foreign sea-going personnel include those that come on Namibian shores from foreign countries for a short period of time without the intention to reside permanently. Local sea-going personnel are permanent residents of Namibia working on sea-going vessels.

**Sedentary population:** Those people who have moved to a certain place and resided in such an area for more than 10 years. For this survey it would include those between 18 and 64 years of age.

**Spaces of vulnerability:** Spaces of vulnerability are those areas where migrants and mobile populations live, work, pass-through or from which they originate. They may include the following: land border posts, ports, truck stops or hot spots along transport corridors, construction sites, commercial farms, fishing communities, mines, migrant communities and urban informal settlements, migrant-sending sites, detention centres, and emergency settlements (IOM, 2010).
### 1.5 Structure of the study report

The report will start with an introduction of the study in chapter 1. The first discussion on the research approach and methodology will follow in chapter 2. This will be followed by chapter 3 detailing main results from existing literature. Chapters 4, 5, 6, 7 and 8 discuss the main findings focusing on the following subjects:

- **Chapter 4**: Migration and mobility dynamics and employment
- **Chapter 5**: Knowledge, opinions and attitudes towards HIV and AIDS
- **Chapter 6**: Sexual behaviour of migrants and mobile populations
- **Chapter 7**: Nature of sex work in Walvis Bay
- **Chapter 8**: Health seeking behaviour of migrants and mobile populations
- **Chapter 9**: Main summary findings and conclusions

Lastly, the report will conclude with chapter 9 which will focus on findings and conclusions.
2. RESEARCH METHODOLOGY

2.1 Introduction

The collection of valid and reliable data, as it relates to understanding different health vulnerabilities and nature of sexual networks amongst port communities, are central to an accurate and in–depth understanding of the subject at hand. The overall approach of the study was primarily a mixed–method research approach including both quantitative and qualitative research tools, complemented by an extensive literature review of current research, policies and programmes.

The approach was participatory in nature, ensuring the active involvement of key stakeholders and role players. The main research study was preceded by a formative study (see separate Scoping Study Report) that informed the design of the main research study. The overall objective of the study was to implement the country’s component of SADC ports research study on health vulnerabilities of mobile populations and affected communities in selected ports of southern Africa.

The study in Walvis Bay was carried out over a six month period from February to July 2014. The actual fieldwork was conducted in late February and early March 2014. The following research tools were used during the primary data collection exercise:

- Quantitative household questionnaire
- Focus group discussion guide
- Key informant interviews guide
- In–depth interview guide
- Sexual network guide
- Informal observations of places of vulnerability

2.2 Methodology

The study methodology was divided into three phases to ensure effective and efficient implementation, quality control and a reliable and valid reflection of the situation in Walvis Bay.
as it relates to health vulnerabilities of migrant populations and the affected communities. The three phases are: study design and mobilisation; primary data collection; and data analysis and report preparation.

2.2.1 Study design and mobilisation

The design of the study was participatory with inputs from IOM Namibia, National Steering Committee¹, regional IOM office and the other three participating countries. A design workshop was held in Pretoria from 16 – 18 July 2013. The workshop provided an opportunity for the following to be agreed upon: types of data collection tools, questions for data collection tools, quantitative sample, qualitative sample, work plan and the way forward.

The design of the survey was also influenced by a scoping study conducted in Walvis Bay. The main purpose of the scoping study was to inform decision—making regarding the main research study in relation to its design and implementation. The main themes for the scoping study included determination of available literature, main gaps in literature, main themes that should be researched as part of the main research study, identification of main stakeholders and best way that study results can be disseminated. More specifically it was used to contextualise the IOM research protocol and data collection tools.

A field research team was recruited from SusDAf’s database of experienced field researchers. The researchers included quantitative and qualitative officers. They attended a six—day training exercise, which included a one—day pilot test. After completion of the pilot—test, finalisation of the data collection tools and approval from IOM to use such tools, actual primary data collection commenced.

2.2.2 Primary data collection

Prior to commencement of data collection, letters from IOM were sent to the following

¹ The National Steering Committee for this study comprised representatives from MOHSS, Ministry of Fisheries and Marine Resources (MFMR), Walvis Bay Corridor Group (WBCG), IOM, Ministry of Home Affairs, Ministry of Agriculture, Water and Forestry (MAWF)
relevant stakeholders and implementing partners to inform them of the study and to request their blessings to conduct the study:

- Ministry of Health and Social Services (Erongo Regional Directorate)
- Municipality of Walvis Bay
- Namport of Walvis Bay
- Ministry of Fisheries and Marine Resources
- Erongo Regional Council (Walvis Bay Urban Constituency)

The study is a cross-sectional assessment that aims to describe the relationship between health vulnerabilities and other factors of interest as they exist in a specified population at a particular time, without regard for what may have preceded or caused the health status found at the time of the study. The selected quantitative sample size included the entire population (both male and female), regardless of nationality, or who reside in Walvis Bay townships. The following sub-population groups participated in the study: migrants, sedentary population, sex workers (male and female), truck drivers, men having sex with men (MSM), local seafarers, foreign seafarers and key stakeholders. Due to the different migrant and mobile sub-populations residing or visiting Walvis Bay, it was important to purposively sample them. The planned sample criteria are defined in the table below.

<table>
<thead>
<tr>
<th>Migrant Grouping</th>
<th>Current Population</th>
<th>Confidence Level</th>
<th>Prevalence</th>
<th>Margin of Error</th>
<th>Sample Size</th>
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</thead>
<tbody>
<tr>
<td>Walvis Bay Town (2011 Census)</td>
<td>62,096</td>
<td>1.96</td>
<td>0.5</td>
<td>0.05</td>
<td>384</td>
</tr>
<tr>
<td>Female sex workers</td>
<td>± 500</td>
<td>1.96</td>
<td>0.5</td>
<td>0.15</td>
<td>43</td>
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<tr>
<td>Men having sex with men/male sex workers</td>
<td>± 150</td>
<td>1.96</td>
<td>0.5</td>
<td>0.18</td>
<td>30</td>
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<td></td>
<td></td>
<td>1.96</td>
<td>3.8416</td>
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<td>Truck drivers 1</td>
<td>± 2,500 p/m</td>
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<tr>
<td>Local seafarers</td>
<td>Not known</td>
<td>1.96</td>
<td>3.8416</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Foreign seafarers</td>
<td>Not known</td>
<td>1.96</td>
<td>3.8416</td>
<td>0.5</td>
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<tr>
<td>Sedentary population</td>
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<td>(18 – 64 years resident</td>
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<td>42,670</td>
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<td>in the catchment area for</td>
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<td>more than 10 years)</td>
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<tr>
<td>(2011 Census)</td>
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<td>1.96</td>
<td>3.8416</td>
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<td>0.5</td>
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<td>Migrant workers (18 years</td>
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<td>and above resident in</td>
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<td>the area for more than</td>
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<td>3 months but less than</td>
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<td>For sex workers, MSM and</td>
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<td>truck drivers a respondent driven sampling (RDS) approach was</td>
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<td>employed. It is estimated that Walvis Bay houses 500 sex workers, of which about 150 are</td>
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<td>male sex workers. The RDS is a variant of chain referral (snowball) sampling which is based on</td>
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<td>the recognition that peers are better placed to recruit others more efficiently than researchers</td>
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<td>as researchers are not part of that population segment. Local seafarers were approached via</td>
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<td>the companies that they work for when they arrived in Walvis Bay from their fishing trips.</td>
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<td>The migrant and sedentary sub–populations were randomly selected at the household level. The sample</td>
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<td>was selected in three stages to arrive at the sample households and randomly selected respondent. At</td>
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<td>the first stage, the Primary Sampling Unit (PSU) was randomly selected in a systematic manner from the</td>
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<td>2011 Census sample frame. PSUs were selected based on the probability proportionate (PPS) to size</td>
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<td>sampling method. At the second stage, households per PSU were randomly selected by the ‘spinning of the</td>
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<td>bottle’ method. The Kish Grid was used at the third stage to randomly select a sedentary or migrant</td>
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<td>household member. In this design only one member per household was interviewed.</td>
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<td>To counteract for the loss in precision due no response, the sample size was raised by a</td>
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For sex workers, MSM and truck drivers a respondent driven sampling (RDS) approach was employed. It is estimated that Walvis Bay houses 500 sex workers, of which about 150 are male sex workers. The RDS is a variant of chain referral (snowball) sampling which is based on the recognition that peers are better placed to recruit others more efficiently than researchers as researchers are not part of that population segment. Local seafarers were approached via the companies that they work for when they arrived in Walvis Bay from their fishing trips.

The migrant and sedentary sub–populations were randomly selected at the household level. The sample was selected in three stages to arrive at the sample households and randomly selected respondent. At the first stage, the Primary Sampling Unit (PSU) was randomly selected in a systematic manner from the 2011 Census sample frame. PSUs were selected based on the probability proportionate (PPS) to size sampling method. At the second stage, households per PSU were randomly selected by the ‘spinning of the bottle’ method. The Kish Grid was used at the third stage to randomly select a sedentary or migrant household member. In this design only one member per household was interviewed.

To counteract for the loss in precision due no response, the sample size was raised by a
factor of 0.5. Next step was to determine the overall probability of selection required to get the respondents into the sample from all PSUs in Walvis Bay. Nonresponse was assumed to be about 5%. This means that 11 PSUs were randomly selected, while 20 households were randomly selected per PSU.

The sample sizes noted above were achieved, except the sample for foreign seafarers. Insufficient numbers of foreign seafarers docking and their inability to speak English resulted in only four interviews conducted with them. This number was insufficient for inclusion in the quantitative analysis. At the end the sample came to the following totals per sub-population with a total sample size of 383.

### Table 2: Implemented quantitative sample

<table>
<thead>
<tr>
<th>Sub-population</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female sex workers</td>
<td>43</td>
</tr>
<tr>
<td>Men having sex with men/male sex workers</td>
<td>30</td>
</tr>
<tr>
<td>Truck drivers</td>
<td>43</td>
</tr>
<tr>
<td>Local seafarers</td>
<td>47</td>
</tr>
<tr>
<td>Foreign seafarers</td>
<td>0</td>
</tr>
<tr>
<td>Sedentary population (18 – 64 years resident in the catchment area for more than 10 years)</td>
<td>120</td>
</tr>
<tr>
<td>Migrant workers (18 years and above resident in the area for more than 3 months but less than 10 years)</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total sample</strong></td>
<td><strong>383</strong></td>
</tr>
</tbody>
</table>

The qualitative sample included the above sub-populations as well, but also key informant interviews with key stakeholders and role players.

### Table 3: Qualitative sample of study sub-populations

<table>
<thead>
<tr>
<th>Sub-populations and Stakeholders</th>
<th>Qualitative Activities</th>
<th>Planned</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female sex workers</td>
<td>• In-depth interview</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>• Sexual network exercise</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
### Male sex workers
- In–depth interview: 2
- Sexual network exercise: 1
- Focus group discussion: 0

### Truck drivers
- In–depth interview: 2
- Focus group discussion: 1
- Sexual network exercise: 2

### Local seafarers
- In–depth interview: 2
- Focus group discussion: 1
- Sexual network exercise: 1

### Foreign seafarers
- In–depth interview: 2
- Sexual network exercise: 2

### Sedentary population
- Sexual network exercise males: 4
- Focus group discussion (2: male and female separately): 2

### Bar/Restaurant/Club/Hotel workers
- Key informant interviews: 6

### Service providers:
#### Health workers
1. NAPPA: 1
2. Public Clinic: 1
3. WBCG: 1
4. Voice of Hope: 1
5. King’s Daughters: 0
6. Mission to Seafarers: 1
7. WBMPC (SFH): 1
8. LGBTI: 1
9. MFMR: 1
10. NamPort: 1
11. MWTC: 0

### Mapping exercise
GPS Coordinates for all key landmarks in relation to the research: Completed

#### 2.2.3 Ethical research considerations
The research protocol was submitted to the Research Review Board, within the Ministry of Health and Social Services (MOHSS), for ethical review and approval before start–up. See annexure C for the ethical approval document. Ethical considerations for this study
were guided by holistic research ethical principles such as right to privacy, confidentiality, anonymity, right to no harm, honesty, respect and trust among others. Ethics were instituted throughout the entire process of the study and worked towards just, defensible, rigorous and credible outcomes. Consent was sought from interviewees prior to any question asked.

2.2.4 Analysis and report preparation

The Statistical Package for Social Sciences (SPSS) was used to analyse quantitative data. A thematic analysis approach was followed for qualitative data analysis. The two types of data were separately analysed and integrated into one report. The report therefore presents descriptive statistics and qualitative analysis. A Draft Report was prepared and presented to stakeholders for comment. Comments were taken into consideration when the Final Report was prepared.

2.3 Limitations

The samples for migrants and sedentary populations in Walvis Bay can be regarded as representative. However, the RDS sampling procedure used to access sex workers and MSM resulted in samples that cannot be regarded as fully representative. In addition to the above approach, the secret manner in which sex workers operate, especially those from other countries who live in Walvis Bay illegally, resulted in them not being accessible.

Sufficient numbers of foreign seafarers could not be achieved, because of the limited number of foreign seafarers who docked and the language barriers. Views and opinions of foreign seafarers were therefore limited to the qualitative data, which was found to be very insightful.
3. LITERATURE REVIEW

3.1. Introduction

“Walvis Bay is a unique town and need to be treated as such. The community of Walvis Bay, which includes local and foreign seafarers, truck drivers, sex workers and ordinary people, are like vulnerable school of small fish surrounded by sharks. The sharks are the risky sexual behaviours of the key population,” according to one of the interviewees of the Scoping Study.

This section of the report discusses characteristics and vulnerabilities of key migrant and mobile populations based on the literature review and interviews conducted in Walvis Bay. The literature review focused on key mobile and migrant populations residing in Walvis Bay including sex workers, truck drivers, seafarers and men having sex with men (MSM). First, let’s look at Walvis Bay as a space of vulnerability.

3.2. The Port of Walvis Bay: space of vulnerability

The Southern African coastline is approximately 18,000 km in length (IOM, 2010a:7). The coastline consists of 18 major ports with approximately 156,000 employees in 2010 in the fishing sector (IOM, 2010a:7). Ports in Southern Africa are listed in the table below.

Graph 1: Ports in Southern Africa

<table>
<thead>
<tr>
<th>Angola</th>
<th>Namibia</th>
<th>South Africa</th>
<th>Mozambique</th>
<th>Tanzania</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lobito</td>
<td>Walvis Bay</td>
<td>Saldanha</td>
<td>Maputo</td>
<td>Dar es Salaam</td>
</tr>
<tr>
<td>Luanda</td>
<td>Luderitz</td>
<td>Cape Town</td>
<td>Beira</td>
<td>Tanga</td>
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<tr>
<td>Namibe</td>
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<td>Mossel Bay</td>
<td>Nacala</td>
<td>Mtwara</td>
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<td>Port Elizabeth</td>
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<td>East London</td>
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<td></td>
<td></td>
<td>Durban</td>
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<td>Richards Bay</td>
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The main international transportation corridors that connect the different ports are as follows (IOM, 2010a:10a):

- Beira and Zambezi Development Corridors
- Limpopo Development Corridor
- Lobito Development Corridor
- Maputo Development Corridor
- Mtwara Development Corridor
- Nacala Development Corridor
- North–South Development Corridor (also known as the Durban Corridor)
- Tazara Development Corridor (also known as the Dar es Salaam Corridor)
- Walvis Bay Development Corridor

As indicated in the above table, Namibia has two ports along its vast coastline of 1,370km: Walvis Bay and Luderitz. Both are operated by the Namibia Ports Authority (NamPort), established in
1994 after Namibia’s independence. The port of Walvis Bay is situated approximately 400km from Namibia’s capital city, Windhoek. Walvis Bay was part of the Republic of South Africa for three years after Namibia’s independence, after which it was reintegrated into Namibia.

**Figure 2: Port of Walvis Bay**
The population of Walvis Bay grew at an alarming rate since Namibia’s independence as a result of job seekers in the fishing sector. The population currently stands at 63,000 (Namibia Statistics Agency (NSA), 2012). Many people who lived in Walvis Bay in the early 1990s were from South Africa, while a large influx of people was experienced from other parts of Namibia as from the 1990s. As a result, the majority of the Walvis Bay population are not originally from the town. The local Namibians living in Walvis Bay are mostly from the central and north central regions.

Walvis Bay is Namibia’s only deep-water port and is the focus point of a very large commercial fishing industry. In addition to being the commercial hub of the commercial fishing sector in Namibia, Walvis Bay is a key node on the two major highways – the Trans–Caprivi Highway and the Trans–Kalahari Highway – that link Namibia directly with Angola, Zambia, Botswana, Zimbabwe, Malawi, Republic of Congo and South Africa. Indirectly, these highways link the town of Walvis Bay with destinations well beyond its immediate neighbouring states. In addition to African countries, the port also links Namibia internationally mainly with countries such as Spain, Russia and China. “International contact with the harbour of Walvis Bay dates back to the 17th century, when Portuguese seafarers first explored the coast of South-western Africa. The town and surrounding areas were formally annexed as a British colony in 1878 and incorporated into the Cape Colony in 1884. Walvis Bay and the enclave became formally part of Namibia again hundred years later in 1994, some four years after independence in 1990” (Keulder & LeBeau, 2006:1).

The biggest employer on the port is NamPort that employs 825 people mostly on a permanent basis (NamPort, 2013:18). Other companies in the port provide port–side and water transport services and ship maintenance services. Adjacent to the port are fishing factories. These factories are responsible for
manufacturing fish products. The fishing industry employs approximately 20,000 people. This number includes permanent and casual workers, locals and foreigners. About 80% are Namibians, while the rest are foreigners. Walvis Bay is also home to other sectors such as the public government administrative sector, retail, trade, service and informal sectors. As indicated earlier, most people living in Walvis Bay come from other parts of Namibia or elsewhere in Africa and beyond. The harbour attracts migrant and mobile populations on a short, medium and long–term basis. Included in the migrant populations are permanent employees, short–term employees, contract workers, unemployed, informal sector workers, truck drivers, fishermen and sex workers.

Walvis Bay contributes greatly to the economic well–being of Namibia as it is the main entry and exit point for cargo to and from the Americas, Europe and Asia. As mentioned earlier, Walvis Bay serves as a link between two main transportation corridors that connects Namibia with several other countries in southern Africa. As a result of the above, Walvis Bay links truck drivers from several different countries in southern Africa and seafarers from mainly Europe and Asia for short periods of time. It brings seafarers and truck drivers into contact with migrant and sedentary populations who have migrated to Walvis Bay either recently or many years back. It therefore provides unique dynamics that could possibly influence HIV infections among seafarers and truck drivers, those they interact with within the Walvis Bay community and the communities where they originate from. The sexual web between seafarers, sex workers, sedentary populations, truck drivers and port workers possibly creates a ‘breeding nest’ for HIV infections with widespread implications not only for those migrant and mobile populations in Walvis Bay, but for those engaged in the entire sexual network of all partners involved. The implications are therefore not confined to Walvis Bay, but cut across borders to countries where seafarers and truck drivers originate from, and to other countries where they dock for short periods of time. IOM agrees with this in its Regional Maritime Report where it noted that, “the sexual web between seafarers, truck drivers and sex workers create a triangle of high–risk sexual behaviour. With the mobility of truck drivers and foreign seafarers, ports are an important node in a regional and international web of risk behaviour (IOM, 2009:6).
According to IOM, “Migration is not a health risk but the conditions surrounding the migration process can lead to increased vulnerability” (2009:14). Migrants tend to arrive into areas that have higher STIs and HIV prevalence, resulting in a greater likelihood of coming into contact with infected individuals. In other Southern African countries, and in Namibia as well, migrant–receiving areas (whether urban communities, mines, work centres or commercial farms) have been documented to have higher levels of HIV infection (Coffee, 2005). “Not surprisingly, some of the highest HIV prevalence areas in Namibia also correspond to locales that receive large numbers of migrants or transient individuals, such as Katutura in Windhoek, Oshakati, Walvis Bay, Swakopmund, Rundu and Katima Mulilo” (De la Torre et al, 2011:33).

Conditions of mobility and migration increase the risk of HIV infection as mobile and migrant populations tend to have a higher number of multiple as well as concurrent sexual partners. While mobility and migration increases individual vulnerability, they also shape the distribution of the epidemic and the rate in which the epidemic spreads. Hence, mobility and migration are both individual and structural risk factors. According to the Namibia Demographic and Health Survey (NDHS, 2006/07), men and women who spend more time away from their home are likely to have multiple sexual partners. Five point sex percent (5.6%) of women and 22.9% of men, who were away from home six times or more in the year before the survey, had multiple partners compared to 2.1% women and 11.1% men who never went away from home (Directorate of Special Programmes (DSP), 2010:34). “A combination of being away from home, with greater anonymity and fewer social constraints, feeling lonely, and having greater access to new sexual partners encourages many migrants to take up relationships on the road or at their destination” (LeBeau 2002; IOM 2006; IOM 2008 in De la Torre, Khan, Eckert & Ulina, 2011:32).

There are at least three key ways in which mobility is tied to the spread of HIV:

1. Mobility per se can encourage or make people vulnerable to high–risk sexual behaviour;
2. Mobility makes people more difficult to reach, whether for prevention education, condom provision, HIV testing, or post-infection treatment and care; and


Other risk factors include:

- Lack of enough money, especially amongst women, and excess cash on the part of some workers, especially men
- Multiple sexual partnerships
- Transactional sexual relationships
- Crowded housing
- Idleness and loneliness
- Inadequate HIV knowledge
- Drug and substance abuse
- Incapacity to access condoms
- Cross generational sexual relationships
- Inability of poor women to negotiate safer sex due to gender power relations (IOM, 2009:26)

3.2.1 Background to HIV and AIDS Walvis Bay

The first HIV infection in Namibia was found in 1986. Namibia started measuring HIV prevalence\(^3\) since 1992 and found a drastic increase in the adult prevalence until 2002 with a peak at 22% after which the adult prevalence plateaued at around 18% as from 2012. Namibia’s prevalence was at one point in time one of the highest in the world.

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\(^3\) Prevalence is based on HIV sentinel surveys carried out every two years among adult pregnant women visiting antenatal clinics.
It should be noted that although Namibia has experienced positive trends in the overall national HIV prevalence, pockets of concern remain. Some geographic areas continue to experience increases. Towns that were previously known as low prevalence towns have become towns with the steepest increases. In addition, prevalence amongst certain age groups continues to be high. The prevalence amongst 35–39 year olds and 30–34 year olds at 33.9 percent and 30.8 percent respectively continue to be the highest. Trends show that prevalence within these age groups continue to grow, while prevalence in other age groups decreases. Lower prevalence rates were found amongst the 15–19 year olds (5.4 percent) followed by 20–24 year olds (10.9 percent).
Figure 4: National HIV prevalence by age group and year of survey, 1992–2012 (percent)

MOHSS, 2012:21

Figure 5 shows that HIV prevalence is highest in urban settings such as Walvis Bay for the following age groups 15–19, 20–24, 25–29 and 35–39. These are also the age groups of the most at risk populations such as sex workers, truck drivers, seafarers and MSM. The adult prevalence in Walvis Bay has been on the decrease since 1998 from 29 percent until 2012 at 17.2 percent. However, 17.2 percent is still one of the highest prevalence rates in the country and is a concern to many.

Figure 5: Urban and rural prevalence (percent)

Source: MOHSS, 2012:21
HIV prevalence among different age groups in Walvis Bay has decreased dramatically for the 15–24 years olds and lessor for the 25–49 year olds. This indicates that the HIV and AIDS response strategies in Walvis Bay are working and resulting in positive changes in HIV incidence and prevalence. Of concern though is that one out of four people within the age group 25–49 are possibly infected with HIV.

Source: MOHSS, 2012: 15

The approach of responding to challenges posed by HIV and AIDS evolved over the years from perceiving HIV and AIDS as a health challenge to a development challenge. Several HIV and AIDS impact assessments show impacts at demographic, social and economic levels that influenced the way Namibia looked at HIV and AIDS. The overall HIV and AIDS response is guided by the national HIV and AIDS policy of 2007 and the short- and medium-term strategic plans. The latest plan is the National Strategic Framework (2011/12 – 2015/16). Namibia established a multi-sectoral response decentralised from national to regional and local levels. All sectors are mandated by the policy and strategic framework to mainstream HIV and AIDS responses in relation to prevention, treatment, care, support, management and coordination. The NSF acknowledges great strides that have been made in terms of treatment, PMTCT, care and support, but also acknowledged that prevention strategies need to be strengthened to ensure that the incidence of HIV infections decrease even further. The prevention response is influenced by years of lessons learned and will focus on preventing STIs, promote voluntary medical male circumcision, promote condom use, involve PLWHIV, focus of social and behaviour change and reduce multiple concurrent partnerships.

Source: MOHSS, 2012: 23
The approach of responding to challenges posed by HIV and AIDS evolved over the years from perceiving HIV and AIDS as a health challenge to a development challenge. Several HIV and AIDS impact assessments show impacts at demographic, social and economic levels that influenced the way Namibia looked at HIV and AIDS. The overall HIV and AIDS response is guided by the national HIV and AIDS policy of 2007 and the short- and medium-term strategic plans. The latest plan is the National Strategic Framework (2011/12–2015/16). Namibia established a multi-sectoral response decentralised from national to regional and local levels. All sectors are mandated by the policy and strategic framework to mainstream HIV and AIDS responses in relation to prevention, treatment, care, support, management and coordination. The NSF acknowledges great strides that have been made in terms of treatment, PMTCT, care and support, but also acknowledged that prevention strategies need to be strengthened to ensure that the incidence of HIV infections decrease even further. The prevention response is influenced by years of lessons learned and will focus on preventing STIs, promote voluntary medical male circumcision, promote condom use, involve PLWHIV, focus of social and behaviour change and reduce multiple concurrent partnerships.

The policy and NSF specifically mentions migrant and mobile populations as most at risk population needing special attention. The NSF includes strategic measures for sex workers, truck drivers, seafarers and MSM. The IOM study strives to support the implementation of the NSF by providing evidence of the vulnerabilities of mobile and migrant populations in Walvis Bay in order to inform advocacy, planning, implementation and monitoring and evaluation.

3.2.2 Characteristics of sex workers in Walvis Bay

Several titles have been allotted to people engaged in sexual relations in exchange for money, gifts or other incentives. Such labels include prostitutes, commercial sex workers and transactional sex. UNDP (2001:119) in LeBeau (2007:263) indicates that “in Namibia, sexual exchanges take two forms: the first is when one person has sex with another person who ‘pays’ with food, clothes and other household support (referred to as transactional sex or a transactional relationship) and the second is commercial sex work when a person openly solicits sex in exchange for money”. The UNAIDS definition
based on an African regional workshop held in 2000 defined sex work as “any agreement between two or more persons in which the objective is exclusively limited to the sexual act and ends with that act, and which involves preliminary negotiations for a price” (UNAIDS, 2000:13). There must therefore be a contractual arrangement (not in writing) between two or more people where sexual service are discussed, consented and where an exchange of money or gifts are made for sex activities. For purposes of this study, those engaged in sex in exchange for money, gifts or other incentives will be referred to as sex workers. It is acknowledged that transactional sex is different from sex work, because of the different dynamics involved in both.

Literature shows that history of sex work in Namibia dates back to the early 1900s. Due to the gender imbalance during colonial times in the early 1900s, colonisers engaged in sexual relations and interracial marriages with local Namibian women. LAC (2002:6) reported that in 1905 mixed race relationships and marriages were banned, because of the colonisers’ concern of the increased births of ‘mixed race’ children. To eliminate relations between white colonisers and Africans, the administration of the time imported single white women that sold sex for money. “The administration encouraged white prostitution, as part of its efforts to discourage sexual relations between white men and African women” (LAC, 2002:7). Reports were also made of white women trafficked from Europe to Namibia to engage in sex work. However, colonisers continued to use African prostitutes. LAC also noted that “after the 1904–7 war, it is claimed that some Herero women were forced to work in a house of prostitution opened by the German military in Windhoek” (LAC, 2002:6). The LAC report also noted that white women engaged in sex work in 1899 and the early 1990s, in established brothels.

Sex work in Namibia is illegal. This influences the manner in which sex workers operate, but also influences the manner in which sex workers are treated by customers, police and the community. Service provision to sex workers is impacted upon by its illegality, enhancing vulnerability to HIV infection and other sexually transmitted infections. The
criminalisation of sex work in Namibia shaped the manner in which sex work is solicited and provided. For example, The Villager (a weekly newspaper), 21–27 October 2013 reported on sex workers who wanted to stage public protest against treatment from clients and the police. “We have decided to gang up and demonstrate and we hope to convince everyone. We need to unite and strike with one voice, or else we will not be heard out there. Some clients even ask us to have sex with their dogs, but there is nowhere to report to” (Methula, 2013:M1). This article further reported on the Inspector General of the Namibia Police explained to the reporter that as soon as the prostitutes go on strike and make known that they are prostitutes, that they will be arrested as prostitution is illegal.

Existing literature find that sex workers in Walvis Bay include female, male and transgendered adults and young people. However, sex workers are mostly women selling sex to men. Interviewees reported a total of 500 sex workers live in Walvis Bay including mostly women, but also men selling sex to men. It was estimated that about 30% of sex workers were men selling sex to men. One interview was conducted with a transgendered sex worker; although it was found that transgendered sex work is insignificant in numbers.

Those who sell sex are heterogeneous, mostly between 18 and 30 years of age (IOM, 2010a:11; Keulder & Lebeau, 2006:6), “with a significant proportion (up to 20%) aged between 15 and 19” (Greenall, 2011a:9). Other literature finds that sex workers are almost always between 16 and 30 years of age (LeBeau, 2007:263). This does not mean that some are not younger than 15 or older than 30 years of age. Greenall (2011a:9) further reported that the average age of sex work initiation is 16, while a study done in 2001 reported girls as young as 14 and 15 selling sex. Sex workers are heterogeneous in the sense that they are female sex workers, male sex workers, transgendered sex workers, young, old, and of different cultural backgrounds. Sex workers mostly reside in the Naraville and Kuisebmund suburbs, while a small portion reside in Meersig suburb. Meersig suburb is considered the richest suburb in town, followed by Narraville, while
Kuisebmund is considered the poorest in Walvis Bay. Most sex workers are poor and have dependents (IOM, 2010a:11).

Namibia does not have legal brothels from which sex workers operate. The settings for sex work range from informal dedicated establishments such as known bars, hotels, B&Bs and clubs close to the port to roadsides, shebeens, truck stops, parks, restaurants and private homes.

Literature showed that contributory factors into sex work is complex and vary between sex workers. The following factors were reported by key informants: social, cultural and economic conditions (poverty, low levels of education, gender inequality, debt, lack of employment opportunities, gender based violence, drug and alcohol abuse), forced sex work and free choice. Poverty and the need to for a better life is the key driver into sex work. Keulder and LeBeau (2006:6) noted that, “most wanted to leave the business [sex work], but claim that it is near impossible. They are aware of the risks involved in their lifestyle, as they have had quite extensive exposure to HIV education programs.” Most cannot leave their ‘profession’, because of lack of employment opportunities that would allow for a decent livelihood. In addition, stigma and discrimination amongst community members and others, makes it close to impossible to start a ‘new life’. Essential to understand is that sex work is in most cases a realistic choice made by the sex worker, except when coerced of forced through human trafficking. UNAIDS (2012:14) noted that “…working in the sex industry is not usually a result of coercion or an irrational act of desperation arising from their economic or social vulnerability. On the contrary, men, women and transgendered people who sell sex are exercising their agency to make a realistic choice from the options available to them”. However, it should be understood that most sex workers are ‘forced’ by their conditions to rationally make the choice that they would otherwise not have made. This includes financially struggling orphans and vulnerable children. Some sex workers do engage in sex work, not necessarily because of desperation, but because of ‘want’ and the greedy desire to satisfy or fill that ‘want’.
This is especially true for younger women from poor households who dream of having what the ‘richer’ girls have. They want the nice clothes, cellphone, jewellery, etc., and engage in sex work to access such goods. An overarching commonality amongst most sex workers was that “sex work was the last and often desperate choice for most the respondents to earn money” (LAC, 2002:12).

The commercial sexual exploitation of children (CSEC) was raised as a concern during the scoping study, although the prevalence of such practices was unknown. MGECW (2009:35) reported that, anecdotal evidence suggests that CSEC in Namibia occurs, but is rarely reported. It refers to evidence that suggests that CSEC occurs in Windhoek, coastal towns of Walvis Bay, Luderitz and Swakopmund, and on main transportation routes”. The same report noted that parents normally played a key role in coercing and/or forcing children into sex work because of poverty. Interestingly, the first report of trafficking in women for sexual purposes was found in the early nineties.

Trafficking persons, specifically has not come up in existing literature. A qualitative baseline assessment of human trafficking in Namibia done by the MGECW found evidence of only one case of human trafficking from Namibia to South Africa. However, concerns were raised that human trafficking and sexual exploitation was taking place in the form of women being trafficked to countries like China, Germany and Iceland (MGECW, 2009:35).

As in many parts of Africa, sex workers are faced with discrimination and stigma and in Walvis Bay, the situation is no different. It was also found that sex workers are faced with discrimination from state health facilities and from the police. This is the main barrier for not seeking health services and protection from these state entities. However, through the NGOs such as Voice of Hope, sex workers are encouraged not to discriminate against themselves by allowing others to discriminate against them.

Violence against sex workers in Namibia was considered high by key informants. One
of the main contributing factors was the legal status of sex workers. Some clients would verbally or physically abuse sex workers, with the knowledge that they are rarely reported to the police. Some police officers are also verbally or physically violent against sex workers, because of their legal status. Many sex workers opt not to report verbal or physical abuse against them, because of past treatment from police officers and the fear to be exposed.

According to the Director of Voice of Hope, an NGO that represents the interest of sex workers, many of the sex workers are migrants from other towns, regions or countries. There are four types of sex workers according to interviews and the literature: high paid, medium paid, low paid and part–time sex workers.

| Professional sex workers/ highly paid sex workers/ high class sex workers | Cater for high–paying clients such as vessel captains and engineers and local and foreign businessmen. Interviewees during the scoping study reported that high–class sex workers could both be male or female, and on many occasions have regular partners who repeatedly use their services. The clients will communicate with them prior to arriving in Walvis Bay in order to solicit their services. Keulder and Lebeau (2006:6) agreed to the above, but added that ‘upper–end’ sex workers’ client would often refer new clients to them. This type of sex worker is normally booked into expensive hotels and at the service of the client for the night or the duration of the client’s stay in Walvis Bay (depending on the arrangement made). Some sex workers in this category have been involved with the same client for more than 5 years. According to one of the transgendered male sex worker (MSM) interviewed during the scoping study, ‘she’ has been engaged in sex work with the same client (foreign seafarer) for more than 7 years and he treats her like his girlfriend. |
### Local sex workers/medium class sex workers:
Caters mostly for local clients and “penny-pinching” foreign clients who do not want to pay a lot of money for commercial sexual services. These clients include both foreign and local seafarers and truck drivers. The medium paid sex workers are popular amongst Chinese foreign fishermen who prefer not to pay much for sex work. These sex workers are mostly women, but can also include men selling sex to other men. Interviews noted that medium paid sex workers operate mainly from two clubs (Rio Copa and Lucullus night clubs) situated in the vicinity of the port. They also operate from other bars, hotels, gambling houses and restaurants located in the centre of town. They have sex with their clients in cars, in dark alleys or take them to their houses or friends’ houses.

### Street sex workers/low class sex workers:
Caters mostly for local seafarers and truck drivers. They operate mainly from shebeens in Kuisebmund or sell their services from the street. They are mostly women, but can also be men selling sex to other men.

### Part-time sex workers/transactional sex workers:
Mostly younger girls working in low-paid jobs, but are sexually engaged with seafarers in exchange for money or gifts. They are normally in steady relationships, but “ditch” their partners when their “clients” are in town.

Sex workers are always aware of arrival and departure dates of vessels and trucks. Some sex workers have connections with those working at the port or fishing factories who inform them of arrival dates. There is also sometimes a placement of notice with the arrival times for the vessels in the local newspaper. Many clubs and bar owners also serve as informants to sex workers, because their establishments benefit financially from sex workers and sex workers’ clients.

Earnings of sex workers varied depending on the ‘type’ of sex worker one is. In a study on sex work done across four major towns in Namibia, LeBeau (2007:266) found that, in comparison to other towns in Namibia, sex workers in Walvis Bay earned the most. Professional sex workers could earn N$500 per ‘round’ or up to N$1,000 per night with one client. Prices for sex normally declined depending of the type of sex worker you are, or the type of client. Medium class sex workers can earn around N$250 to N$350 per ‘round’, while low class sex workers can earn around N$100 per ‘round’.
Vulnerabilities of sex workers

The legal framework and socio-economic settings in which sex workers operate in Walvis Bay has a profound impact on HIV and AIDS risk and vulnerability. The criminalisation of sex work in Namibia and high levels of poverty are two of the main sources of vulnerability of sex workers.

Different types of sex workers have different sources of vulnerability, although similarities cut across all. The main source of vulnerability for sex workers is poverty. Poverty is one of the main causes that force most women and men to engage in sex work, while at the same time reduces the ability of sex workers to negotiate safe sex. Le Beau (2007:256) indicated that, “data for Namibia from sex workers, their clients and stakeholders … show that disempowered sex workers know that they should protect themselves from HIV, but their illegal and impoverished situation means that they often do not turn away clients who refuse to use condoms because they need the money”. Poverty is also linked with reduced access to social services and information resulting in sex workers not being aware of their rights to services. Coupled with poverty is the high levels of unemployment in Namibia, especially for youth with about half being unemployed. This situation is compounded where women mostly have the responsibility to care for children, in many cases without support from fathers (Lipinge & LeBeau, 2005:21; Mafune & LeBeau, 2004:339 in LeBeau, 2007). Keulder and LeBeau (2006:7) reported on the following additional social sources of vulnerability:

- “Cultural and gender practices that reduce their ability to negotiate safe sex;
- Frequent exposure to violence, victimization and stigmatisation;
- Frequent alcohol and drug abuse;
- Inability to communicate with foreign clients;
- Frequent exposure to unprotected sex and high-risk sexual practices; and
- Frequent contact with high risk, highly mobile clients”.


The criminalisation of sex work in Namibia results in human rights violations of sex workers and puts them at risk of HIV infection. Several reports were made in different literature and in interviews with key informants of human rights violation by sex workers’ clients and law enforcement agencies. Reports were made of sex workers being verbally and physically abused by clients and by police officers. “The most commonly cited source of abuse and mistreatment cited by rapid assessment participants in Walvis Bay was the police. Many participants stated that they had been beaten or insulted by the police while working, and also that they had been locked up and raped or forced to have unprotected sex as a condition of release” (Greenall, 2011b:20). Sex workers were not free to approach police officers to report harassment and even rape, because of past experiences with police. Based on the legal status of sex workers, police officers refuse to provide protection.

To make matters worse, when physically abused, sex workers find it difficult to seek health services because of discrimination and stigmatisation. For medical support, some sex workers with sufficient funds attend private facilities; others visit public facilities in nearby towns, while those with no other option brave the visit to the public facility where they might be faced with stigma. However, not accessing health service due to stigma and discrimination puts sex workers more at risk of HIV infections.

Existing literature finds that correct knowledge about HIV and AIDS was high amongst sex workers. They are aware of transmission modes, prevention methods and treatment and support mechanism. Most sex workers prefer to use condoms, but are not always in a position to successfully negotiate condom use. Research in other countries shows that, “Sex workers are more likely to consistently use condoms than the general population of the same age, race and sex.” (LAC 2012 in LeBeau, 2007:269). However, their profession, socio-economic situation, gender inequality and legal status many atimes do not allow them the choice to protect themselves during sexual intercourse. LeBeau (2007:270) found that “professional sex workers who are financially stable were more likely to
enforce condom use than other types of sex workers who were struggling financially. Not using condoms has serious ramifications for the sex worker, the client and the possible casual and regular sexual partners of the sex worker and client”.

Programmes and services available to sex workers

As indicated earlier, sex work in Namibia takes place in a legal, policy and political environment that is not conducive to access protective and social, economic and health services. Stigmatisation, discrimination and violation of sex workers human rights hampers their willingness and ability to seek STI, HIV and prevention, treatment, care and support services. As a result, “sex workers frequently have insufficient access to adequate health services; male and female condoms and water–based lubricants; post–exposure prophylaxis following unprotected sex and rape; management of sexually transmitted infections, drug treatment and other harm reduction services; protection from violence and abusive work conditions; and social and legal support” (UNAIDS, 2012:5).

Although Namibia acknowledges sex work as a vulnerable population in the National Policy on HIV and AIDS and the National Strategic Framework for HIV and AIDS 2010/11–2015/16, absence of guidelines for effective programming makes the overall response and programming challenging. This, as well the environment in which sex work takes place, has resulted in only a small number of organisations providing support to sex workers. Sex workers make use of the following institutions for health care:

- Public clinics
- Private clinics, especially when public facilities fail to provide confidential services
- Traditional healers
- Non–governmental organisations

Organisations such as Voice of Hope, aim towards motivating sex workers to leave their profession and find meaningful opportunities that would allow decent work conditions and income. Such organisations strive to assist sex workers with psycho–social support,
Skills and education in order to find employment. The challenge is that unemployment in Namibia is 27%, with limited opportunities for those with low levels of education and no skills. UNAIDS indicated that every effort should be made by all relevant stakeholders to support sex workers to “exercise free choice, consistent with the full enjoyment of their human rights. Regardless of the legal status of sex work, a human rights approach must always be applied (UNAIDS, 2012:6).

3.2.3 Characteristics of truck drivers

Roads infrastructure in Namibia is regarded as very good, with most roads tarred, while gravel roads are mostly of good quality as well. Freight between ports in Namibia and elsewhere in SADC, between Walvis Bay and other neighbouring countries, and between Walvis Bay and other cities and towns in Namibia is mostly moved by road. Walvis Bay is the transportation ‘hub’ linking the Trans–Caprivi and Trans–Kalahari Highways and to some extent the Kunene Highway to the north–west. Due to this link, Walvis Bay ‘houses’ truck drivers from various places in Namibia, but also various cities and towns from neighbouring countries especially South Africa, Zambia, Botswana, Angola and Zimbabwe. Large numbers of trucks can be found on Namibia’s roads as the need to transport fright increases. As a result, increased numbers of formal and informal truck stops have sprung up, inevitably increasing the number of ‘hot spots’ for high risk sexual activity in Namibia. Increased truck stops are created due to long distances and long waiting periods at ports and border posts. The map below shows hot spots and HIV risk zones.

Characteristics of truck drivers

During the scoping study, five truck drivers were interviewed; two of the truck drivers were from the Republic of Congo, one was from Malawi and two were Namibians. Based on these interviews and literature, truck drivers from various corners of Africa such as Malawi, Angola, Congo, Zambia, Zimbabwe, Tanzania, Botswana and South Africa spend many days and nights on the road away from family and friends. Truck drivers from the Republic of Congo drive approximately 5,000 km to Walvis Bay which takes about 10
days, including overnight stops along the way and possible delays at border posts.

The number truck drivers visiting Walvis Bay is unknown, but is estimated at approximately 2,500 per month. Almost all truck drivers are males. Existing literature did not find data on the age range of truck drivers. They visit Walvis Bay for the purpose of loading or off-loading fright. The number of nights spent at the port town depends on processing of documentation and/or readiness of fright to be picked up. Truck drivers interviewed as part of the scoping study noted that they spend, on average, a minimum of two days and maximum of seven days on a single trip at Walvis Bay. This is similar to data in existing literature. However, it should be noted that truck drivers are away from home for longer periods, as Walvis Bay is the end-point, while they may off-load and continue to other towns and cities and drive back. MWTC (2007:61) found that most truck drivers are away from home for 8 to 21 days at a time. Very few are away for longer than 21 days, while a fair proportion are away for 0 to 7 days.

Truck drivers interviewed noted that some of them prefer to sleep in their trucks at truck ports as this was the cheapest option. However, a large number of truck drivers who spent more than one night in Walvis Bay normally acquire small rooms in backyard shacks in Kuisebmund4. Overnight accommodation in Walvis Bay town is normally unaffordable to most truck drivers, resulting in them seeking alternative cheaper options in Kuisebmund. The rooms in Kuisebmund usually cost between N$75 and N$150 per night. The rooms are normally small in size, with one single bed and with communal bathroom and toilet facilities outside the room. The bathroom and toilet facilities are usually shared by several other tenants or lodgers. The rooms are usually made of corrugated iron, and very congested. The condition in and around the rooms are normally unhygienic. Local bars and shebeens would usually be situated adjacent to such accommodation, resulting in easy access to alcohol and sex workers.

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4 Kuisebmund is one of the three main suburbs in Walvis Bay. It is the suburb that houses the poorest cohort of the Walvis Bay population. It is situated approximately one kilometre from the port of Walvis Bay.
Walvis Bay, and more specifically Kuisebmund, does not provide a wide range of leisure activities for truck drivers. Truck ports have limited leisure opportunities, while the only leisure activities available to truck drivers in Kuisebmund are bars and shebeens. There are countless bars, shebeens, hotels and restaurants that can be visited. Truck driver interviewees indicated that every 5th house in Kuisebmund is a shebeen. Hotels and restaurants are usually too expensive for truck drivers, resulting in many of them frequenting bars and shebeens. Kuisebmund is well known for its many shebeens, liquor outlets and a night club, called ‘Centre Hot Spot’. These types of places are very likely to be frequented by sex workers, resulting in easy access to commercial sex for truck drivers. These places are also frequented by the sedentary population, creating conducive environments for social interaction between sedentary population (those for the poorer cohort, but also from the middle and rich cohorts of the population) and truck drivers.

Vulnerabilities of truck drivers

Although better road networks link countries, cities and ports with each other and contribute tremendously to economic and social development, it also enhances vulnerabilities for those actively involved in the transport sector. Truck drivers are especially at risk of HIV infection because of their mobility. Due to the nature of their work, they are highly likely to frequent hot spots, sleep in places that are crowded, engage with those who are intoxicated and engage sex workers. According to IOM, “Greater movement of people inevitably creates increased risk of spreading HIV and other communicable diseases, and HIV vulnerability is known to be high along transport routes, particularly around ‘hot spots’ such as truck stops and border posts” (2010b:9). A large proportion of people in Namibia is mobile and spends considerable periods of time away from home for work related reasons. “The oscillatory migration by mobile partners is considered a major factor that influences people having MCPs and HIV infection is passed on rapidly through a chain of inter-connected sexual networks” (RoN, 2010:7).
Many of the truck drivers who overnight in Walvis Bay for a night or more are very likely to engage in high risk sexual acts for numerous reasons. As indicated above, the nature of their employment, including poor living conditions and poor working conditions results in vulnerability. Truck drivers indicated that long delays at ports are frustrating and leave them with not much to do for long periods of time. This results in them being away from home, from wives, girlfriends, children and other family members. Loneliness can lead to people seeking social interaction with others. While being away from home and limited recreational activities in Walvis Bay results in boredom among many truck drivers. Poor living conditions for truck drivers in Walvis Bay, long waiting periods at the port, boredom, loneliness and the proximity of alcohol, sex workers and other people in need of support increases vulnerability of truck drivers to risky sexual activities. The literature review shows that truck drivers are highly likely to engage sex workers in Walvis Bay in order to satisfy their sexual needs, overcome boredom and loneliness or just to have something to do.

Truck drivers interviewed as part of this scoping study, noted that some truck drivers have regular sexual partners in Walvis Bay where they reside during their visits. However, most prefer to engage sex workers, because of the absence of emotional attachments. One truck driver said, “When on the road, we are very tired from the long distance driving. We just want to have a quickie and go to sleep.” Truck drivers within Kuisebmund are also seen as people with money, mainly because of poor living conditions in Kuisebmund. They are therefore approached, not only by sex workers, but also by some other women who may want them to buy food, clothes, beer, etc. This increases the prevalence of transactional sex among sedentary populations in Walvis Bay.

Existing literature reports on low and inconsistent use of condoms by truck drivers during sexual practices. Consistent condom use is jeopardised in many instances by alcohol abuse.
Programmes and services available to truck drivers

According to RoN, “Many factors, such as poverty, gender inequalities, age and alcohol consumption, increase vulnerability to HIV infection. People who are underprivileged socially, culturally, economically or legally, including women and children and vulnerable populations such as orphans, widows and widowers, children and young people, the poor, sex workers, prisoners, people awaiting trial, mobile populations, uniformed services, marginalised or minority groups, street children, people with disabilities, refugees and displaced groups are considerably more vulnerable to the risks of HIV infection and consequently suffer disproportionately from the economic and social impacts of HIV/AIDS. However, other than the above, the National HIV Policy is largely silent on the provision of services to some most at risk populations” (2010:33).

The national policy and planning documents do acknowledge truck drivers as part of mobile populations and therefore a vulnerable group. The policy guides the national response for mobile populations including truck drivers as indicated on page 12.

The National HIV Policy and National Strategic Framework (NSF) for HIV and AIDS recognise truck drivers as a most at risk population, together with other mobile populations. However, inadequate implementation and enforcement of such policies and plan remains weak. Monitoring and evaluation of implementation remains weak as well. There seems to be challenges in relation to coordinating HIV and AIDS responses across the transport sector. The MWTC (2007:11) noted that “the lack of, or presence of limited, coordinative efforts with regards to HIV/AIDS in the transport sector was one of the most commonly cited limitations with regards to the adoption of an effective HIV/AIDS response within the sector”. Limitations of coordination and mainstreaming were experienced at national, regional and local levels.

Transportation companies were slow to provide internal and external HIV and AIDS
response strategies. The bigger transportation companies had HIV and AIDS policies and/or HIV and AIDS workplace programmes in place, but were challenged in terms of implementation. Smaller truck companies reported in the literature not to have such policies and programmes, because of limited finances and small staff cadres. “Of the 20 companies that responded to this survey, only eleven of them were found to have at least one type of HIV/AIDS intervention in place. The more common interventions included condom distribution (9 companies), IEC literature (8 companies), training (7 companies) and peer education (7 companies)” (MWTC, 2007:11). Interestingly, only a few companies used their own resources for implementing HIV and AIDS responses strategies, but depended on external donor or government funding for such implementation.

Other services that are available to truckers are government health centres and the WCG HIV/AIDS desk at Walvis Bay that provides legal advice, support terminally ill employees, access to socially marketed condoms and HIV and AIDS treatment. The NSF noted that, “the WCG, which addresses the high-risk transport sector, has developed a standard group WPP and facilitated interventions such as testing and counselling, and management training and sensitization, for its current 16 transport companies that are members and operate at the port of Walvis Bay and along Namibia’s major transport routes. It has also developed sector-specific tools for instance an information toolkit for drivers and peer educator manuals for transport-sector employees, and has started setting up Roadside Wellness centres that target mobile workers in high-risk areas” (Ron, 2010:104). Other initiatives focus developing IEC materials, information dissemination on HIV and AIDS and social reproductive health, develop and provision of HIV counselling and testing (HCT) services at the Walvis Bay Multiple Resource Centre (WMPRC). HIV Counselling and Testing (HCT) facilities are available at public health facilities and the WBMPRC, but truck drivers seem to be hampered to visit such facilities.

Truck drivers have access to the WBCG Wellness Centre. This centre is strategically located within the vicinity of the port and close to the informal truck port for easy access.
The centre is providing social behaviour change communication and HIV counselling and testing to key affected populations (long distance truck drivers and commercial sex workers). Truck drivers also make use of the state hospital and clinic and private medical facilities for health services.

Truck drivers are less likely to seek health and other social services because they are consistently on the road and not in towns and cities during health service operating hours. There are organisations such as WBCG, WBMPRC, New Start Centres, Public Health Services and others that provide HIV and AIDS support services to Namibian and other truck drivers, but normally between 08h00 in the morning until 5h00 in the afternoon. In addition to time constraints, international truck drivers are at a disadvantage, because of language barriers in cases where they do not speak English or any other local language.

### 3.2.4 Characteristics of seafarers

Poverty, unequal distribution of income across regions, high unemployment especially among the youth and high unemployment in rural areas contribute towards men and women flocking to urban settings, mining and port towns in pursuit of a ‘better life’. Migration and mobility has therefore increased as a result of perceived better opportunities in mining and port towns. Walvis Bay is one of those towns that have grown the fastest since Namibia’s independence in 1990. One of the main reasons is perceived opportunities to be employed in the fishing sector.

**Characteristics of seafarers**

This section of the report will focus on key characteristics of seafarers at the port of Walvis Bay. As part of the scoping study, interviews were conducted with three seafarers; two were locals and one was a foreigner from Spain. Based on interviews and existing literature, it was found that there are two types of seafarers: 1) the local Namibians and; and 2) the foreign seafarers primarily from Russia, Spain and China (IOM, 2010a:7).
The numbers of local and foreign seafarers were difficult to determine during the scoping study, as the numbers coming on shore differs based on seasons. This will be further explored during the main study. However, there are certainly more local seafarers than foreign seafarers.

The movement of foreign and local seafarers and the number of days on and off shore differs. Foreign seafarers are generally on shore for shorter periods of time compared with local seafarers. The duration of local seafarers off shore ranges from one week to six months at a time. The duration of on shore leave days ranges from a day to three weeks. Foreign seafarers normally stay on shore for not longer than a week, but mostly only for a day or two. They are usually flown back to their countries of residents in cases where boats are docked for longer periods of time.

When on shore, most local seafarers live in Kuisebmund, followed by Naraville and then Meersig. Those living in Kuisebmund are likely to live in small housing units or back-yard shacks. They normally do not earn sufficiently to afford housing in Naraville or in the up market suburb of Meersig. Most local seafarers are not originally from Walvis Bay. If on shore for long periods of time, such as a couple of months, then they would move back to their city/town/village of origin and only move back to Walvis Bay when it is time to dock again. On shore leave of only a couple of days, or up to a week, would result in most local seafarers remaining in Walvis Bay. Foreign seafarers would normally stay on vessels or book themselves into hotels depending on the duration of their stay. Most foreign seafarers would stay on vessels if on shore for only a day or two. However, highly paid foreign seafarers are more likely to book themselves into hotels even if just for a night.

While on shore, both local and foreign seafarers like to frequent local hotels, bars, shebeens because they have been off shore for a period of time and yearn for social interaction on shore. Unfortunately, Walvis Bay does not offer much in terms of recreational facilities and activities. While off shore, seafarers are in the company of men only. As a result, when on shore they yearn for the company of female compatriots. Due to being away
from girlfriends and wives, many want to find female company for sexual purposes. Those that may not necessarily look for women to have sex with, can easily change their minds due to alcohol abuse that is associated with on shore leave.

Local seafarers are very likely to frequent bars, shebeens and night clubs in Kuisebmund and Naraville, while foreign seafarers are more likely to be found in two night clubs located in the vicinity of the port and in different bars and hotels in the central business district of Walvis Bay. Highly paid seafarers, such as captains and engineers are more likely to be found in a specific hotel in the CBD that is well—known to have high class sex workers. Some medium to highly paid seafarers stay with local women with whom they have formed regular sexual relations. Some young local women would leave their regular partners when seafarers are on shore and spend this time with seafarer partners in exchange for money, or payment towards flat or other in—kind contributions. “Local seafarers do not frequent the same clubs and bars as the foreign seafarers, although some of the sex workers might move between the clubs and the bars. Therefore, it is possible that local and foreign seafarers could have sex with the same sex worker” (IOM, 2010a:11).

- Highly paid foreign seafarers are therefore more likely to engage highly paid sex workers in hotels, or sex workers who have become their regular sexual partners when on shore for a fee (maybe towards paying a flat, food, clothes, etc.)
- Low paid foreign seafarers are more likely to engage medium class sex workers found in bars and clubs in the CBD and in the vicinity of the port. Some foreign seafarers, who do not want to spend too much money on sex work, are likely to engage sex workers selling services on street corners in the vicinity of the port.
- Many local seafarers are more likely to engage low class sex workers on street corners or those found in shebeens, bars and night clubs in Kuisebmund.

Alcohol abuse among seafarers is one of the main contributing factors to high risk sexual activity. As reported in the previous section, local seafarers/fishermen indulged themselves in alcohol and of course engaging with low and medium class sex workers
in the locations, but mostly in Kuisebmund. This is also true for the foreign seafarers/fishermen; the majority are found in the two night clubs located in the vicinity of the port and in the different bars in the centre of the town. These are also the places where they meet the sex workers.

HIV and AIDS vulnerability of seafarers

Data from existing literature and interviews during the scoping study noted that aspects of seafarers’ demographic profile and working conditions make them more vulnerable to HIV and AIDS than other mobile populations within the transportation sector (MWTC, 2007:74). MCPs, including regular, casual and commercial sexual relations among seafarers are a direct result of them being away from homes, spouses and families for long periods at a time (IOM, 2009:14). Existing literature highlights the following main contributing factors to HIV vulnerability among seafarers:

- Once-off unprotected sex with sex workers
- Multiple and concurrent sexual relations, including with high risk sexual partners
- Short-term and medium-term sexual relationships with sex workers and transactional sexual partners
- Limited HIV knowledge among foreign seafarers with many misconceptions about the spread, transmission and cures
- Exacerbation of the above by the low HIV prevalence in countries where foreign seafarers are from, as they may not be as alert as those from high HIV prevalence countries.
- The inability of foreign seafarers to speak English makes it hard to target when in country.
- Limited HIV and AIDS responses strategies for foreign seafarers in receiving countries such as Namibia
- Alcohol and drug abuse
Vulnerability of foreign and local seafarers is similar in the sense that both are highly likely to engage in high risk sexual activities with sex workers and transactional sex when on short-term shore leave. The difference in vulnerabilities lies with access to various types of high risk sexual partners, access to information, access to health services and the extent to which such seafarers contribute to increased infections in Namibia and outside Namibia. The sexual networks between seafarers and sex workers have devastating consequences for seafarers, immediate port communities, other communities in Namibia where local seafarers are from, and families/communities of seafarers from foreign countries. The sexual networks therefore have consequences for those living immediately next to the ports, those living between the ports and where seafarers originate from.

Vulnerability of foreign seafarers is heightened by the fact that most seafarers to Namibia are from countries with low HIV prevalence. Information dissemination and awareness raising in these countries are likely to be lower than countries where HIV prevalence is high. There are low levels of HIV knowledge among foreign seafarers despite pre-departure orientation, information campaigns, ship visits, and so on (IOM, 2009:14). Empirical data shows that insufficient information about HIV and AIDS is made available on boats. To add to these challenges is the language barriers in Namibia, where seafarers could possibly be informed. Seafarers from such countries will therefore not be well informed, which could increase the likelihood that they would engage in high risk sexual acts without being aware of the high HIV prevalence in the country, and more specifically Walvis Bay.

Condom use among seafarers is considered to be low. Most foreign seafarers are more likely to engage medium class sex workers, who can easily be persuaded not to use condoms, by clients who can pay more for sex without a condom. Those seafarers (captains and engineers) who are more likely to engage high class sex workers may also use condoms inconsistently because they usually have long-standing relationships with their sex workers. Empirical data also shows that local seafarers are likely to have
consistent condom use with sex workers than with their regular partners. However, some of their regular partners may have transactional relations with foreign seafarers or even truck drivers. IOM (2009:24) noted that there are a significant number of women engaged in transactional sex, but would not necessarily define their actions as sex work. This makes those who engage with them even more vulnerable. What makes some local seafarers more vulnerable is the possibility that their longer-term sexual partners may be sex workers as well. Like foreign fishermen, there is widespread alcohol abuse compounded by a lack of recreational activities while on shore leave, separation from family, and inability to communicate while on the ships (IOM, 2009:21).

Programmes and services available to seafarers

HIV prevention must take place along the migration route, across sectors, across countries and with seafarers. The MWTC showed that most companies linked to the harbour had the following HIV and AIDS interventions: policies, VCT service, IEC, condom distribution, training, peer education, while only some had VCT, treatment programmes, OVC support, HIV task team, monitoring, STI care and food supplements. However, foreign vessels and smaller companies were least likely to have comprehensive programmes. According to MWTC, “NamPort is the only organisation that this study revealed to have conducted an HIV/AIDS prevalence survey and more importantly to have used this information to respond effectively to the disease, including provision of treatment to its infected employees and bringing the number HIV/AIDS deaths down from nine in 2004 to zero in 2006” (2007:40). Other services available in Walvis Bay to seafarers are those similar to services available to truck drivers. The challenge is that foreign seafarers are unlikely to speak English and local languages and may not be inclined to seek additional support services due to low levels of knowledge about HIV and AIDS in Namibia. For medical support, foreign seafarers/fishermen seek the services of private doctors. On rare occasions would they seek services at NamPort. The NamPort clinic mostly serves NamPort employees, who are then referred to the WBCG Wellness Centre when needed.
3.2.5 Characteristics of men having sex with other men (MSM)

The understanding of MSM is complex and should be understood in the following different context that they have sex with each other as indicated by Boyce and Isaacs (2011):

- “gay men engage in sex only with men;
- bisexual men engage in sexual acts with men and women;
- male sex workers (MSWs) could be heterosexual males, only engaging in sex with other males for money or other forms of payment, while they have female spouses or girlfriends
- gay males selling sex for money or other forms of payment; and
- transgendered males selling sex to other males for money or other forms of payment”.

MSM is a unique group of people in relation to HIV and AIDS vulnerabilities and need special attention. The scoping study focuses on MSM, but in the context of men selling sex to other men, as many of them migrate to Walvis Bay for this purpose specifically. Interviewees were of the opinion that 30% of sex workers in Walvis Bay consist of male sex workers. They indicated that male sex workers were selling their services mostly to other males, but to females as well. Boyce and Isaacs (2011:7) say that, “The social and subjective contexts of male sex work (in Africa) are far from straightforward – and are not easy to characterise in any uniform or linear sense”. In many cases the main purpose was desperate need for a source of income. Stigmatisation and discrimination towards homosexuals at work and within the community have resulted in many gay men running away from home, and having to sell their bodies to make a living. Boyce and Isaacks (2011) noted the following factors leading MSWs as well:

- “Freedom
- A sense of belonging to a specific sub—culture [on further exploration it was clear that for this cluster of respondents, they claimed an “identity”: we “are moffie sex workers”, where “moffie”, for them was a clear non—discriminatory way of being
received by society, on the one hand, and as gay sex workers on the other.

- Independence
- Education: This was explained in the context that some of them had used the money gained from sex work employment to further schooling. This raised an important question around the age of starting sex work” (p. 34).

The Boyce and Isaacks (2011:33) study further found that the majority of study participants were ‘introduced’ into sex work by an older male or female sex worker. Many of the MSWs are engaged with men or women in non–commercial sexual relationships mostly with men, but also with women. An example was given of a man who normally goes to Walvis Bay to sell sex to other men, and then returns to his wife when he made sufficient money to take care of his family. Truck drivers and fishermen were also found to not only prefer female sex workers, but male sex workers as well. These male truck drivers in many cases would have female partners or spouses ‘back home’.

Interviewees during the scoping study noted that male sex workers frequent the same places as female sex workers, but are not as ‘open’. They are more ‘hidden’, because of the stigma attached to MSM. The different MSW follow the same levels as female sex workers, with some MSW being highly paid, some low paid and some falling in–between. Those that are highly paid, normally has long–term partners. Those being low paid are mostly found in bars or on street corners.

Male sex workers are treated worse than female sex workers, mainly because of stigmatisation against gays in Namibia. Their rights are infringed upon, as their activities are regarded as illegal and deprived of moral value. They therefore have nowhere to go when violated, abused or discriminated against.

**HIV and AIDS vulnerability of MSWs**

MSWs could possibly be more vulnerable to HIV infection that other groups mentioned
above for various reasons. MSM were found to have a 19.3–times greater chance of being infected with HIV than the general population (Baral et al, 2007). It was found that risk factors included lack of condom use; lack of water based lubricants, multiple partners, concurrent sexual relations, low numbers of male circumcision and more money for unprotected sex. “With no waterbased lubricant, as well as more money offered for unprotected sex, they [MSWs] believed they were at high risk for HIV infection, STIs and Hepatitis (Boyce & Isaacs, 2011:36). Existing literature in Namibia is very thin on MSWs, but other vulnerabilities include:

- Increase drug and alcohol abuse (crack cocaine)
- Violence towards MSWs by clients and uniformed personnel
- Client exploitation
- Violence between regular partners was found to be high
- The legal framework within the country does not protect MSWs
- The political framework against MSM and MSWs is hostile because of homophobia
- High levels of poverty as they are isolated by society
- Limited access to health services due to stigma and discrimination by health care workers

Programmes and services available to MSWs

According to the International HIV/AIDS Alliance (2009), “It is especially important to remember that in many cases men who have sex with men in Africa (both those who sell sex and those who do not) have often been excluded from policy and programming processes regarding HIV and AIDS, sexual health and so forth, most often because of prejudice and denial about the existence of such men in many countries, including within civil society and governmental bodies”. MSWs face the same challenges as MSM, albeit exacerbated, because of their ‘profession’. Limited HIV and AIDS programmes and services are available to MSM in Namibia. The legal and political framework around the provision of service to MSM is limited in Namibia because of prejudice and homophobia.
This has resulted in the majority of gay men not having their basic health needs met as it related to MSM, such as STI treatment and HIV prevention and AIDS treatment. Stigma and discrimination exacerbate seeking such services, especially from health care providers. MSM are more like to seek health services from private health providers, because they are treated better and confidentiality is ensure. Gay and lesbian organisations in Namibia are becoming more active in protecting the rights of their members, but under hostile circumstances in Namibia. They have become more vocal over the years, which contributed to their plight being heard by more stakeholders. Organisations that officially provide support to MSM and MSWs include:

- Voice of Hope
- Rights no Rescue
- King’s Daughters
- Stand Together
- LAC
- Lesbian, Gay, Bisexual, Transgender, Intersex Trust Namibia (LGBTI)
- Rights Not Rescue Trust
- The Red Umbrella
4. MIGRATION & MOBILITY DYNAMICS AND EMPLOYMENT

4.1 Introduction

This chapter of the report discusses demographic characteristics of migrant and mobile populations, in relation to population characteristics, movement of people, time living in Walvis Bay, sex, age, education and employment. HIV and AIDS vulnerabilities for different sub-populations living or visiting Walvis Bay are influenced by the dynamics of the process of migration.

4.2 Background characteristics

The total population for Walvis Bay, according to the 2011 Census was 63,000 people. Based on interviews with the sampled populations, most residents of Walvis Bay lived here for more than 15 years. There are numerous households living in Walvis Bay today that have lived in Walvis Bay before Namibia’s independence of 1990. Residents of Walvis Bay are mostly stationary and do not move in and out of Walvis Bay on a regular basis, as might be the case in other harbour towns in southern Africa. Walvis Bay is home for most of her residents and not a place that one goes to for working purposes, albeit for a small percentage of the population, especially foreign truck drivers, local truck drivers, foreign seafarers and some local seafarers. Two thirds of the overall sampled population have lived here for 5 years and more. Close to two thirds (62.9 percent) of the sedentary population reported to have lived here for more than 15 years, while the remaining sedentary population have lived here for 10–15 years. Over one-third (34.4 percent) of the migrant population have lived here for 5 – 10 years with a similar proportion having lived here between 2 – 5 years. Sixty four percent of local seafarers, 60 percent of MSM and 69.8 percent of sex workers have lived here for more than 15 years. This means that most of those who moved to Walvis Bay for various reasons in the past, have actually made Walvis Bay their home.

Only 11.2 percent of the sampled population have lived here for 3 months or less, comprising truck drivers only. Due to the nature of their work, truck drivers come to Walvis Bay for short periods of time depending on loading and off-loading. Close to one third of sex workers interviewed has lived here between 5 and 15 years, while close to one out of ten (9 percent)
sex workers have lived in Walvis Bay between one and five years. They have, therefore been living in Walvis Bay for a very long time.

**Figure 8: Number of years lived in Walvis Bay (percent)**

<table>
<thead>
<tr>
<th>Time Duration</th>
<th>Male Percent</th>
<th>Female Percent</th>
<th>Total Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 3 months</td>
<td>20</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>3–6 months</td>
<td>15</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>6–12 months</td>
<td>10</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>1–2 years</td>
<td>15</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>2–5 years</td>
<td>10</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>5–10 years</td>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>10–15 years</td>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>15+ years</td>
<td>50</td>
<td>40</td>
<td>45</td>
</tr>
</tbody>
</table>

Men tend to stay for shorter periods of time compared to women. Close to half of the sampled women population have lived in Walvis Bay for more than 10 years, compared to the 28.4 percent of men. It was also found that 22.5 percent of men have lived here for less than three months, while only 1.7 percent of women have done the same. It should be mentioned that the male percentages included truck drivers who were not necessarily living in Walvis Bay, but were regular visitors due to the nature of their work. Twice as many males have lived here for 3–6 and 6–12 months compared to women. The proportions of women living here compared with men living here were shifting as from 1 year, with women being in the majority for all time durations, except 10–15 years where the margins were close between the two sexes. The above basically means that men tended to stay for shorter periods of time, while women tended to stay for longer periods of time. Women were therefore more settled in, than men. This is interesting, especially taking into consideration that the fishing sector is male driven, albeit not the fishing factories and the retail sectors. This could be attributed to the types of work available in Walvis Bay, which includes seasonal fishing employment. Employment opportunities in the fishing sector, which is male–driven, attract men on a regular basis.
However, not all find employment (see unemployment rates below) and therefore continue to work in the informal sector or return to regions of origin.

The only proportion of the study population who come and go on a regular basis were all local and foreign truck drivers, foreign seafarers, one (out of 43) sex worker and six out of 30 MSMs. MSM and sex workers who move on a regular basis live in Swakopmund, but some also live in Windhoek. The MSM are also sex workers who come to town when seafarers are on shore. Additional sub–populations who regularly move in and out of Walvis Bay are bus drivers, couriers’ service drivers and local and foreign tourists. Most of the truck drivers come to Walvis Bay one to three times over the past three months. Twenty eight percent come only ones, while 25.6 percent come three times a month. Close to one out of ten come 12 times a month, nine times a month and six times a month respectively. When they come they normally stay for 1 to 21 days depending on the loading and off–loading, whether all paperwork is in order and/or whether the truck is in order. Seven percent of the truck drivers noted that they stayed for 21 days the last time they visited Walvis Bay for work purposes. A high of 25.6 percent noted that they stayed 14 days the last time they were in town. This was followed by 23.3 percent and 20.9 percent who stayed 2 days and 3 days respectively. Another 7 percent stayed for a week.

The quantitative component of the study population of Walvis Bay comprised: Namibians (89.3 percent), South African (1.8 percent), Zambian (6 percent), Zimbabwean (2.1 percent), Congolese (0.3 percent), Angolan (0.3 percent) and Malawian (0.3 percent). Please note that the above excludes foreign seafarers who were excluded from the quantitative sample due to their low numbers. Qualitatively the above nationalities were mentioned, but also Russians, Spanish, Chinese, Philippines, Australians and Batswanas. Of those who lived in Walvis Bay, 2.1 percent were South Africans, while the remainder were Namibians (97.9 percent). Namibians also made up most of the sedentary population, while 3.2 percent were South African. None of the respondents from the other countries were migrants or sedentary. Of the local seafarers, of which most were Namibian (97.9 percent), 2.1 percent were Angolan. Sex workers in
Walvis Bay comprised Namibians mostly (97.7 percent), followed by 2.3 percent South Africans. Other sex worker nationalities according to KII s and sex workers were Zimbabwean and Zambia. MSM were all Namibian. Truck drivers were found to be mostly from Zambia (53.5 percent), Namibia (23.3 percent), Zimbabwe (18.6 percent), Democratic Republic of Congo (2.3 percent) and Malawi (2.3 percent).

5 It should be noted that there were a small proportion of professional, semi-professional and unskilled labourers who lived in Swakopmund who commuted to and from Walvis Bay on a daily basis for work purposes. However, they were excluded from the study, as they were not regarded as high risk per se.
Table 4: Nationality of the study population

<table>
<thead>
<tr>
<th>Nationality</th>
<th>Migrant Population</th>
<th>Sedentary Population</th>
<th>Local Seafarer</th>
<th>MSM</th>
<th>Sex Worker</th>
<th>Truck Driver</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Namibian</td>
<td>97.9%</td>
<td>96.8%</td>
<td>97.9%</td>
<td>100.0%</td>
<td>97.7%</td>
<td>23.3%</td>
<td>89.3%</td>
</tr>
<tr>
<td>South African</td>
<td>2.1%</td>
<td>3.2%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>2.3%</td>
<td>0.0%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Zambian</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>53.5%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Zimbabwean</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>18.6%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Congolese</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>2.3%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Angolan</td>
<td>0.0%</td>
<td>0.0%</td>
<td>2.1%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Malawian</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>2.3%</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

From within Namibia, one quarter of the sampled population was from the Erongo region. The highest proportion (38.9 percent) of the sampled population was born within the four north central regions of the country: Ohangwena (7.6 percent), Omusati (16.4 percent), Oshana (11 percent) and Oshikoto (3.9 percent). Close to one tenth were originally born in Windhoek, while much smaller proportions of people came from the remaining eight regions of Namibia.

Figure 9: Where were sampled population born within Namibia (percent)
The overall study population was divided fairly evenly between males (53.3 percent) and females (46.7 percent). However, the sub-populations have very different sex compositions, except for the migrant and sedentary populations that were fairly even between the sexes. Local seafarers were all male due to the nature of work within the fishing sector, sex workers were mostly female and truck drivers were all male. However, the reader will note that MSM shows 56.7 percent male and 43.3 percent female. This is due to some males regarding themselves as females, although they are biologically male. Their sex is therefore male, but their gender is female.

Please note that some of the MSM are also sex workers. Some of the sedentary and migrants are also male sex workers selling sex to females, but these numbers were considered very small.

The age structure of Walvis Bay follows the age structure of urban settings to some extent, with most of the population concentrated within the productive and reproductive age cohort of 20–39 years of age.
Almost all (97.7 percent) of the respondents have attended some form of formal schooling, while 2.3 percent have not. Fairly high proportions have also attended secondary schooling, with the highest proportion being MSM at 93.3 percent followed by sex workers at 81.4 percent and the sedentary population at 80.6 percent. Migrants, sedentary and truck drivers were more likely to have attended higher education, while none of the sex workers have completed higher education. Of those who attended secondary schooling, not many have actually completed secondary education.

### 4.3 Employment

Half (51 percent) of the sampled population in Walvis Bay were employed either at the port or in Walvis Bay town, while 49 percent were unemployed. Slightly over one quarter (26.6 percent) of the sampled population in Walvis Bay worked at the port. A large proportion of the sampled population who worked at the port were sedentary (29 percent) and migrant (15.6 percent), followed by MSM (10 percent) and sex workers (2.3 percent). All of the local seafarers noted that they worked at the port, although most of their work was actually off the port onto the sea. Close to half (43.3 percent) of the MSM worked in Walvis Bay, followed by the sedentary population (36.3 percent), migrants (27.1 percent), and sex workers (23.3 percent). Please note that the work proportion of sex workers excluded sex work. More than three quarters of all sex workers interviewed were reported to be unemployed.
Of those who indicated that they were employed, 43 percent were permanently employed, 8.6 percent were on contract labour, 8.4 percent casual labourers, 6 percent self-employed, 1.3 percent informal workers and 32 percent none of the above. Close to 5 percent of sex workers were permanently employed while another 5 percent were employed on contract basis (once again, excludes the sex work they do as they have other employment at the same time as being sex workers). Most of the local seafarers (70 percent) were employed permanently, but one-fifth was causals and one tenth on contract. More than two-thirds of truck drivers interviewed were on permanent employment with one quarter was on contract basis.

Sex workers, local seafarers, MSM, migrant population and sedentary populations live in Walvis Bay; none visit the town on a daily basis. Truck drivers and foreign seafarers visited Walvis Bay as part of their work. Some residents in Swakopmund worked in Walvis Bay and vice versa. These residents travelled back and forth on a daily basis, since the two towns are 30 km from each other. Sex workers living in Swakopmund do move in and out of the Walvis Bay on a daily basis, but only when the demand for sex work is low in Swakopmund. A large proportion (66.9 percent) of the sampled population has been working in Walvis Bay for more than two years. Half of the migrant population has worked in Walvis Bay for more than 2 years, while 78.3 percent of the sedentary population did the same. Almost all (91.5 percent) local seafarers have been working here for more than two years. Close to one-third of the migrant population has been working here for less than a year while 70 percent have been living here for more than two years. This is an indication of the unemployment challenge faced by those living in Walvis Bay.
Most of the sampled population worked directly within the fishing sector at 29.6 percent, followed by those who were engaged in the trucking industry (16.9 percent). This is related to shipments of fish and other commodities coming into the harbour on a daily basis, and trucks transporting such commodities to places within Namibia or to land-locked and other countries. Just over one tenth of the workforce worked in the service industry, closely linked to harbour activities as well. The public sector employs about one tenth of the sample, while 5.4 percent were domestic workers.

Of those employed, 65.4 percent were paid by fixed salary, meaning that they have a more secure source of income, compared those who were paid by the hour (10.4 percent), by day (9.2 percent) or by trip (6.9 percent).

Two-thirds of the sampled population were of the opinion that it was difficult to find work around the port. Sex workers and local seafarers were especially concerned about the difficulty of finding work. Over half (56.4 percent) of the respondents reported that there were no discrimination against migrants in the job market. Of those who felt that there were discrimination, close to half (44.2 percent) were sex workers, followed by the sedentary (32.3 percent), migrant (30.2 percent) and MSM (30 percent).
Close to half of the sampled population sent money and/or in-kind contributions home from their earnings in Walvis Bay. All local seafarers interviewed were found to send money or in-kind contributions home, while 52.1 percent and 43.5 percent of migrants and sedentary sub-populations did the same. Sex workers (27.9 percent) were the least likely to send money or in-kind contributions home, followed by MSM (33.3 percent) and truck drivers (37.2 percent). The respondents who were more likely to be in permanent employment were also more likely to send money home.

Figure 13: Send money/in-kind contributions (remittances) home (percent)

One fifth (19.3 percent) of the Walvis Bay sampled population owned the houses they lived in, while one-third rented and another one-third lived with family and friends. Of the one-fifth who owned houses, close to half were part of the sedentary population and one out of ten the migrant population. Close to one-tenth of local seafarers owned their own houses, followed by MSM (6.7 percent) and sex workers (4.7 percent). Truck drivers did not own houses in Walvis Bay, but mostly stayed in their trucks, some rented (4.7 percent) rooms in other people’s back yards and 2.3 percent stayed with family/friends.
5. KNOWLEDGE, OPINIONS AND ATTITUDES ABOUT HIV AND AIDS

5.1 Introduction

“Acquired Immune Deficiency Syndrome (AIDS) is caused by a human immunodeficiency virus (HIV) that weakens the immune system, making the body susceptible to and unable to recover from other opportunistic diseases that lead to death through these secondary infections. The predominant mode of HIV transmission is through heterosexual intercourse, followed by perinatal transmission, in which the mother passes the virus to the child during pregnancy, delivery, or breastfeeding. Other modes of transmission are through infected blood and unsafe injections.” (MOHSS, 2008:191).

This chapter of the report discusses knowledge, opinions and attitudes about HIV and AIDS. It will show that knowledge about HIV and AIDS is high amongst the study population, but that there are concerns about how much foreign seafarers and foreign truck drivers know about HIV and AIDS in Namibia, and more specifically in Walvis Bay. It is also encouraging to have found that most respondents had positive attitudes toward people living with HIV and AIDS (PLWHIV), although it is a concern that high proportions of respondents would prefer to keep HIV and AIDS a secret within the family.

5.2 Knowledge of HIV and AIDS

There are three key variables normally used to assess knowledge of HIV prevention. These key variables are: 1) using condoms every time you have sexual intercourse; 2) having one sex partner who is not infected; and 3) abstaining from sexual intercourse. The same variables were used for this survey.

All FGD and IDI participants, as well as the quantitative respondents, have heard of HIV or the disease called AIDS. Most of them had the right knowledge about HIV transmission modes and prevention methods, except for one truck driver and one foreign seafarer IDIs. Amongst the quantitative sampled population in Walvis Bay, 91.4 percent reported condom use every time one has sexual intercourse as a method to prevent HIV infection. This is higher than the
“HIV is transmitted through unprotected sex, blood transfusion, mother to child through breast feeding and also sharing of needles. One can prevent oneself through engaging in protective sex where you use a condom and by abstinence. Once a person is infected with the virus s/he needs to take their medication on time. If not then his/her CD4 count will decrease and might jeopardise his/her life span.” MSM FGD participant.

Almost all sex workers, truck drivers and local seafarers at 98 percent respectively reported abstinence as a measure of preventing HIV transmission, while smaller proportions of 90.6 percent, 93.3 percent and 93.5 percent of migrants, MSMs and sedentary populations respectively reported the same. On the other hand, the proportion of truck drivers, sex workers and MSMs who mentioned having only one faithful sexual partner was lower than the migrant, sedentary and local seafarer respondents. High proportions (92.9 percent) of the sampled population knew that people can protect themselves from HIV infection by having one faithful, non—infected sex partner.

reported 85.7 and 90.3 percentages for urban females and males respectively during the 2006/7 Namibia Demographic and Health Survey (NDHS) (MOHSS, 2008:194). Almost all sex workers (97.7 percent), MSM (96.7 percent) and local seafarers (95.7 percent) knew of consistent condom use. Lower proportions of knowledge about consistent condoms use were found amongst the migrant population (89.6 percent) and the sedentary population (89.5 percent). Truck drivers were the least knowledgeable about this at 86 percent. The two IDIs with a truck driver and a foreign seafarer found that truck drivers’ knowledge of HIV and AIDS in Namibia was low. One of them even said that he does not know much about HIV and AIDS.
Eight IDIs were asked if there were anything that they would like to do to protect themselves better against STIs/HIV, but not always do. Half (four out of eight) of the IDIs noted that there was nothing more than they can do to protect themselves, as they were already doing everything possible to protect themselves. Two of the four were truck drivers who were married with no other sexual partners. They felt save within their married relationships with a sense of no risk to HIV infection. The third one was a foreign seafarer who felt that he was already practising safe sexual activities, although he has two sexual partners; one in Walvis Bay and one in his home country. He trusts that both partners are faithful to him, as both of them knew about each other. He does not use condoms with them, as he trusts that they do not have any other sexual partners. The fourth was a male sex worker who noted that he was already doing everything he can by wearing condoms every time he has sexual intercourse.

"With less alcohol intake, I’ll be able to do ‘things with my eyes open’. However, this is complicated, because I need alcohol to do what I do. I will not be able to approach clients if I am not drunk. Alcohol gives me the confidence and courage to approach strangers to have sex with in exchange for money. If I don’t drink alcohol and don’t sell my body, then I will not be able to put bread on the table.” Male sex worker.

The remaining four noted that they would prefer to do the following: 1) abstinence; 2) emergency injection that would prevent someone from becoming infected, similar to the morning–after pill; 3) HIV test with all sex for work partners; and 4) less alcohol intake before sex. Others, such as one
female sex worker had a sense of hopelessness saying that she has no choice, but to some-
times practice unsafe sexual intercourse with casual sex for work partners as some clients
prefer it this way and pay more for it, although she practices safe sex with her regular sex
for work partners. The casual (‘touch and go’ partners as they are referred to by sex workers)
partners are needed for the time period when the regular partners are out at sea.

5.2.1 Know someone with HIV or who died of AIDS

Respondents were asked if they knew of anyone or of a close relative who was infected
with HIV or who has died of AIDS. All of the sex workers and close to all MSMs knew of
someone and/or a close relative how were HIV positive or died of AIDS. More than nine
out of ten (93.3 percent) MSMs who were interviewed knew of someone who is HIV
positive or died of AIDS, while 86.7 percent knew of a relative as well. Between 80 and
90 percent of the sedentary population, local seafarers and truck drivers were aware of
someone and a close relative who have died of AIDS. Smaller proportions of migrants
knew of the same; 66.7 percent knew of a relative who is HIV positive or died of AIDS,
while 72.9 percent know of someone who was HIV positive or died.

5.2.2 Knowledge of misconceptions of HIV and AIDS

The following misconceptions about HIV and AIDS were measured: 1) a person can get HIV
from mosquito bites; 2) a person can get HIV by sharing a meal with an infected person;
and 3) a healthy—looking person can be infected with HIV. The figure below shows that
the correct understanding of HIV and AIDS amongst the sampled population was high
with 86.2 percent knowing that mosquitoes cannot transmit the virus that causes AIDS;
93 percent were aware that a person cannot get HIV by sharing a meal with someone
who is infected; and 96.3 percent knew that a healthy-looking person can be infected
with HIV. All of the sex workers interviewed were aware that a healthy-looking person can
be infected with HIV, while 9.3 percent of truck drivers and 8.5 percent of local seafarers
were of the opinion that a healthy-looking person cannot be infected with HIV. Six percent
of the migrant population thought that sharing a meal with an infected person will get
one infected, while another six percent were not certain. MSM (93.3 percent) and sex
Workers (88.4 percent) were the most knowledgeable that HIV cannot be transmitted through mosquitoes.

Comprehensive knowledge of HIV and AIDS is a combination of knowledge between prevention methods and misconceptions. The sampled population had high knowledge of prevention and low levels of misconceptions, although the misconception that HIV can be transmitted via mosquitoes was high at 13.8 percent for ‘yes’ and ‘do not know’ combined. However, most of the sampled population have high levels of comprehensive knowledge of HIV and AIDS. Attitudes towards PLWHIV were overall positive with most of the respondents.

Figure 15: Knowledge of prevention and misconception about HIV and AIDS, sampled population combined (percent)

5.2.3 Knowledge about mother to child–transmission

Knowledge of the transmission of HIV from mother–to–child (MTCT) and prevention of mother–to–child transmission (PMTCT) are additional measures of knowledge about HIV and AIDS. Respondents were asked the following three questions about MTCT of HIV: 1) Can a pregnant woman infected with HIV or AIDS transmit the virus to her unborn baby? 2) Can a pregnant woman infected with HIV or AIDS pass the virus to her child at the time of delivery (child birth)? and 3) Can a pregnant woman infected with HIV or
AIDS pass the virus to her child during breastfeeding? Seventy one percent of those interviewed in Walvis Bay were aware that a pregnant woman infected with HIV can transmit the virus to her unborn child. Almost all of the truck drivers (95.3 percent) and MSM (90 percent) respondents had knowledge about this, while less than half (48.9 percent) of the local seafarer population knew of this. About one quarter and one out three migrant and sedentary respondents respectively reported that they did not know of this type of transmission. Similarly, one out of five sex workers did not know of this type of transmission. The knowledge of transmission from an infected mother to a baby during child birth and during breastfeeding was much higher for the migrant, sedentary and local seafarer sub-populations compared to the knowledge of transmission at child birth. Overall, 83 percent of the sampled population were aware of transmission during child birth and breastfeeding.

Two out of every three respondents were aware of the PMTCT programme offered at public and private health facilities. Just over half of the migrant population knew about this. Sex workers (86 percent) were most knowledgeable about this, followed by truck drivers (77 percent), MSMs (73 percent), local seafarers (70 percent) and the sedentary population (63 percent).
5.2.4 Attitudes towards people living with HIV and AIDS (PLWHIV)

The majority of the respondents in the sampled survey had positive attitudes towards PLWHIV based on the following:

- 97 percent said that a student with HIV, but who is not ill, should be allowed to continue attending school;
- 94 percent said that they would be willing to care for a family member in their household who fell ill with AIDS; and
- 97 percent said that a teacher who has HIV, but is not ill, should still be allowed to continue teaching in schools.

However, the proportion of positive attitudes dropped as follows:

- 59 percent said that they would prefer that the knowledge about an AIDS related ill family member be kept a secret; and
- 67 percent would want to keep it a secret if they were to fall ill with AIDS related illnesses.

Generally MSMs who participated in the survey had more positive attitudes towards PLWHIV as they scored most positive across three of the variables. Sex workers followed very closely with positive attitudes towards PLHIV, followed by local seafarers. Migrants who participated in the survey scored the lowest of all the sub–populations in relation to positive attitudes toward PLWHIV. Close to half (45 percent) of the migrant population respondents said that they would want to keep it a secret if a family member falls ill of AIDS related illnesses; while 39 percent felt the same for when they would fall ill of AIDS related illnesses.
<table>
<thead>
<tr>
<th>Opinions and attitude about HIV/AIDS</th>
<th>Population type</th>
<th>Migrant Worker %</th>
<th>Sedentary Population</th>
<th>Local Seafarer</th>
<th>MSM</th>
<th>Sex Worker</th>
<th>Truck Driver</th>
<th>Total</th>
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<td>If a student has HIV but is not sick, do you think, he or she should be allowed to continue attending school?</td>
<td>Yes</td>
<td>94.8</td>
<td>99.2</td>
<td>97.9</td>
<td>96.7</td>
<td>95.3</td>
<td>95.3</td>
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<td>1.0</td>
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<td>If a female/ male relative of yours becomes ill with HIV, would you be willing to care for his/ her in your household?</td>
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<td>90.6</td>
<td>93.5</td>
<td>97.9</td>
<td>100.0</td>
<td>97.7</td>
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<td>If a teacher has HIV but is not sick, should he or she be allowed to continue teaching in school?</td>
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<td>If you knew a shopkeeper or food seller had the HIV virus, would you buy food from them?</td>
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<td>83.1</td>
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<td>If a member of your family become ill with HIV, the virus that causes AIDS, would you want it to remain secret?</td>
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<td>44.8</td>
<td>27.4</td>
<td>42.6</td>
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<td>11.6</td>
<td>6.8</td>
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<td>If you become ill with HIV, the virus that causes AIDS, would you want it to remain secret?</td>
<td>Yes</td>
<td>38.5</td>
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Is it possible in this port for someone to get a confidential test to find out if they are infected with HIV?

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<th>83.9</th>
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<td>0.0</td>
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<td>16.3</td>
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</table>

5.3 Opinions about the current HIV and AIDS situation in Walvis Bay

The socio-economic situation has changed over the years, especially since the growth of Walvis Bay from around 2008. This has resulted in increased numbers of truck drivers, local and foreign seafarers and resultant increase in the number of sex workers. All qualitative participants voiced their concern about the seriousness of HIV and AIDS in Walvis Bay. Some of the truck drivers and foreign seafarers were less likely to have an opinion compared to those living in Walvis Bay. This is due to the lack of information or communication with foreign seafarers and truck drivers about the HIV and AIDS situation in Walvis Bay. Foreign seafarers and truck drivers noted that they were more knowledgeable about HIV and AIDS in Namibia, but less about HIV and AIDS in Walvis Bay. They get most of their information from listening to local radio services in English while in Namibia, and do not get information from their employers. However, the HIV and AIDS situation was regarded as a serious development challenge by those living in Walvis Bay. Responses from qualitative research participants attributed the following causal factors to the seriousness of HIV and AIDS in Walvis Bay:

- Unemployment and high poverty levels
- High influx of mobile populations
- Continued unprotected sex. Reluctance to change sexual practices – people have an “I do not care” attitude.
- Multiple sexual partnerships

“This place is in trouble. Due to the fishing and transportation sector, there is a lot of money around from both local and foreign men. Many women are unemployed. Selling sex is their only source of income. Many of these women also have boyfriends; so they have multiple sexual partners. HIV and AIDS is a serious problem in Walvis Bay. I know more than 50 people who are either infected or have already succumbed to AIDS.” Key informant.

“HIV and AIDS is very serious problem in Walvis Bay. There are many HIV and AIDS campaigns out there that educate people, however the people are just not serious, they are ignorant.” Male sex worker FGD participant
• Purposive HIV infection of others
• Reluctance to go for HIV testing and resultant low numbers of people who know their status
• High alcohol abuse, especially amongst the younger population
• Sex work
• Movement of people in and out of Walvis Bay

Two of the sex worker IDIs felt that the situation in Walvis Bay in relation to HIV prevention has changed for the better over the past years. They now see more sex workers protecting themselves with the use of condoms and seeking medical support when needed. In addition, male sex workers were also more inclined to use condoms now. It was reported that this change came about primarily as clients saw people they knew (including some sex workers) die of AIDS related illnesses. It was also reported that those infected with HIV visit health facilities more regularly than in the past and take their medication on time. However, other qualitative research participants were concerned that the situation in Walvis Bay has not changed, mainly because the numbers of sex workers have increased and too many of them continue to have unprotected sex. One male sex worker felt that the situation in Walvis Bay has not changed mainly because people continue to have an “I don’t care’ attitude. This was attributed to people not knowing their HIV status and continuing to have unprotected sexual intercourse.
6. SEXUAL BEHAVIOUR OF MIGRANT AND MOBILE POPULATIONS

6.1 Introduction

“I have learned that people at sea and away from home are very lonely; they miss their partners and their children. Lonely people make decisions based on how they feel at the time of the decision, regardless of whether other people think that such choices are silly or irresponsible. I do not justify their actions, but I understand their actions. It is the nature of their work that put them in vulnerable positions and unfortunately not all of them are thinking with their heads. It is a really sad situation when you realise the impact of one weak partner’s decision. It’s a cry for help!”

(Local Seafarer)

This chapter discusses the sexual behaviour of migrants and mobile populations, specifically focussing on sexual history, different sexual relationships, concurrency within such relations with the aim of determining vulnerability to HIV infection.

6.2 Marital status

The sampled population were asked about their current marital status. Thirty percent of the sampled population reported to have been married in the past, while 26.9 percent were currently (at the time of the survey) married. Truck drivers were much more likely (67.4 percent) to be currently married, followed by sedentary population (36 percent) and local seafarers (34 percent). None of the MSM was currently married with one out of ten migrants and sex workers currently married. The average age at first marriage was reported to be 30 years of age. Sex workers tended to be younger than other sub-populations at first marriage at an average age of 25 years, while local seafarers tended to be the oldest at an average age of 37 years. None of the respondents reported to be divorced except for a small percentage (1.6 percent) of the sedentary population. Only two percent of the sampled population were widowed. The sub-population with the highest separation rate was sex workers at five percent. More than half of the sampled population were single at the time of the interviews. High proportions of migrants (77 percent) and MSM (86.7 percent) tended to be single, while only a quarter of truck drivers reported to be single.
Four percent of those currently single, divorced, widowed or separated were currently living with a sexual partner. Highest proportions were sex workers and truck drivers. None of the MSM was living with their sexual partners. Three percent of the married population noted that their husbands or wives were living with other partners; only amongst the sedentary, local seafarer and truck driver sub-populations.

6.3 Sexual history

Almost all of the respondents reported ever having sexual intercourse. Half of the 5.5 percent who reported to never had sex before were 18 and 19 years of age, while the other half were between 20 and 30 years of age, with most being between 20 and 23 years old. In addition, 42.1 percent of those how never had sex before were female. All of those who never had sex before attended secondary school, while only 36.8 percent successfully completed secondary school. Only two went on to attend university. All of the local seafarers and sex workers have had sexual intercourse. Just over one—tenth of the migrant population have not had sexual intercourse.

The mean age at first sexual intercourse was 18 for the sampled population. However, two MSM reported the ages of six and eight years of age at first sexual intercourse. These interviewees
noted that they were sexually abused at these ages. One other MSM also reported 12 years at first sexual intercourse; another reported 13 years, three reported 14 years and six reported 15. One local seafarer reported nine years of age at first sexual intercourse, two local seafarers reported 12 years of age, five reported 14 and seven reported 15. One sex worker reported 12 years of age at first sexual intercourse, six reported 14 years, and five reported 15. Amongst the truck drivers interviewed one reported to have had first sexual intercourse at the age of 12, one at the age of 13, two at the age of 14 and four at the age of 15. One of ten migrant and sedentary respondents reported to have had first sexual intercourse at the age of 15 or younger, with 30 percent being 18 years and younger.

Almost all of the sampled respondents (85 percent, but 6.5 percent did not respond to the question) had sexual intercourse over the last 12 months. Of those who had sexual intercourse over the past twelve months, 35.8 percent had sexual intercourse with someone who was not the spouse or regular partner. However, almost all sex workers (97.7 percent), more than two-thirds (70.0 percent) of MSM, more than half (53.5 percent) of truck drivers and more than one third (38.3 percent) of local seafarers had sex over the past 12 months with someone who was not their regular partner. Slightly more than one out of every ten sedentary and one out of every five migrants had sex with someone who was not their regular sexual partner. Of interest is the finding that one quarter of the migrant and close to one fifth of the sedentary respondents decided not to respond when the question was asked.

Figure 18: Ever had sexual intercourse (percent)
respondents decided not to respond when the question was asked. If the ‘yes’ responses and ‘no responses’ were combined then close to half of the migrant population and close to one-third of the sedentary population would have had sexual intercourse with someone other than their spouse or regular partner.

**Figure 19: Sexual network, MSM**

![Sexual network diagram](image-url)
6.4 Married and cohabiting partnerships

Of the 383 respondents, 26.9 percent were married and 13.3 percent were cohabiting, referred to here as regular partner. All respondents with regular partners had sex with their regular partners in the past 12 months. The migrant and sedentary population with regular partnerships tended to have sex about 20 times over the last 30 days. The numbers of times of sexual intercourse with spouses over the last 30 days were much lower for the other groups: local seafarers with regular partnerships only had sex about two times per month, mainly because they are out at sea most of the time. Sex workers with regular partnerships had sex about six times over the last 30 days with their regular partners, while truck drivers it occurred ten times for truck driver respondents.

None of the currently married migrant or sedentary population reported to have outside sexual relations other than with their spouses, except for two who were cohabiting with other partners. Of those sedentary and migrant populations who cohabited, two had boyfriends/girlfriends, two had casual partners and one had someone whom he paid for sex.

Of the 43 truck drives, 67.4 percent were married and 9.3 percent cohabiting. Of those who were married, 48 percent had girlfriends, one had a girlfriend and a casual partner and another only had one casual partner in the last 12 months. Of the 67.4 percent out of 43 truck
drivers who were married, 18.5 percent had commercial sex over the last twelve months. Of those 18.5 percent, one did not have any commercial sex in the last 30 days, while one did not remember the number of times. One indicated six times, followed by one who said three times and another two times. Sex workers were normally picked up at bars, clubs and the street, while one was called telephonically.

Of the 47 local seafarers, 34.0 percent were married and 12.8 percent cohabitating. Of those who were married, only one reported to have a girlfriend in addition to his spouse; also one reported to have a casual partner and three reported to have had paid for sex in the last 12 months. The rest did not have any other sexual partner, other than their spouses.

Of the sex workers who were interviewed, five were married. Of those five, three reported to have had sex with their husband in the last 12 months while two did not want to respond to the questions. Of the five, one reported no other partners as she is trying to stop working this trade, while one reported to have had a boyfriend, a casual partner and men who paid her for sex in the last twelve months. She had five commercial sex partners over the past 30 days and usually picks them up at clubs. The other three did not have boyfriends or casual partners, but did have commercial sexual partners. The number ranged from one to six commercial sexual partners over the last 30 days. Three out of the five normally telephoned, while one is normally met at a club. Most of the men were regarded as 40 years and older, but a few were 30 to 40 as well.

Less than one third (28.2 percent) of those currently married or cohabitating used condoms the last time they had sex with their spouses. Only one in ten truck drivers used a condom the last time they had sexual intercourse with their regular partner. Amongst all sub—populations, it was mostly (65.9 percent) a joint decision to use condoms. Those who did not use condoms noted the following reasons in order of highest to lowest rank: trust in partner, did not think it was necessary, partner objected and use of other contraceptives to prevent pregnancy.
In general more than half (55.8 percent) of the currently married and cohabiting respondents reported that they never used a condom with their spouses over the last 12 months. Of concern, were the extremely high proportions of married truck drivers (81.8 percent) and sex workers (38.5 percent) who did not use condoms with spouses in the last 12 months, because they have high proportions of multiple concurrent partnerships.
6.5 Boyfriends/girlfriends

Of the 383 respondents, 41 percent reported to have boyfriends/girlfriends. Most (58 percent) boyfriends and girlfriends were between 19 and 29 years of age; followed by 29.3 percent who were between 30 and 39 of age. Four percent were younger than 19 years of age. All sub-populations reported to have had sex with their boyfriends/girlfriends over the past 12 months. Most of them reported to only have had one boyfriend/girlfriend over the last twelve months. Twenty percent of sex workers, 46 percent of MSM, 12.5% of local seafarers and 20 percent of truck drivers had two boyfriends/girlfriends over the past 12 months. It was only MSM and truck drivers who reported three partners and one truck driver who reported six regular partners over the last 12 months. Almost all of the MSM (84.6 percent) with boyfriend/girlfriend also had casual partners. Close to half 45.8 percent) of local seafarers with boyfriends/girlfriends had casual partners, while sex workers (20 percent) and truck drivers (15 percent) reported the same. The numbers of casual partner for migrants and sedentary were lower at 19 and seven percent across the two respectively.
Of those who had boyfriends/girlfriends, 20% of truck drivers, 12.5 percent of local seafarers, 38.4 percent of MSM and all sex workers had commercial sex in the last 12 months. Only two of the migrant and sedentary population noted use of sex work. All of those who engaged in commercial sex paid for such sex, except for all sex workers and four out of five MSM who received payment in return for sex. The number of commercial sex partners over the last 30 days varied between 0 and 5 for local seafarers, 1 and 27 for sex workers, 1 and 3 for MSM and 1 and 2 for migrants and sedentary populations.
Only 7.6 percent of the boyfriend/girlfriend population received something in exchange for sex the last time they had sexual intercourse with their regular partners. Forty percent of boyfriends/girlfriends of sex workers gave them something in exchange for sex; the same with 23 percent of MSM, 4.2 percent of local seafarers and 4.2 percent of migrants. None of the sedentary or truck drivers received any thing in exchange for sex the last time they had sex with their boyfriends/girlfriends. Of those who received something, migrants mostly received food and clothes, while the rest received money.

Close to three quarters of the study population who had boyfriends/girlfriends used condoms the last time they had sexual intercourse. All of the MSM used condoms followed by 81.3 percent of migrants with their boyfriends/girlfriends the last time they had sexual intercourse. Worryingly, a low of 60 percent of sex workers and truck drivers used condoms with boyfriends/girlfriends. Half of the study population initiated condom, while joint decisions were made by 42.0 percent. Close to one out of ten (8 percent) partners initiated condom use. Those who did not use condoms noted the following reasons in order of highest to lowest rank: did not think partner had a disease (47.7 percent), did not think it was necessary (13.6 percent), wanted pregnancy (11.4 percent), partner objected (6.8 percent), used other contraceptive (6.8 percent).

In general, only one out five (19.9 percent) never used a condom with his or her boyfriend/girlfriend. Of concern was the 33.3 percent of sex workers who always (consistency) used condoms with boyfriend/girlfriend in comparison to all the other population groups who had proportions higher than 50 percent (although still low).
6.6 Casual partnerships

Less than one fifth (16.7 percent) of the sampled population engaged in casual sex over the past 12 months before the survey. More than half (58 percent) of the casual sexual partners were between 19 and 29 years of age, followed by 23.2 percent being between 30–39, 8.7 percent were 40 years and older and 4 percent were younger than 19. A small percentage (2.9 percent) did not know the age of their casual partners.

The numbers of casual partners per person ranged between one and 29 over the past 12 months with the average number of partners being three. The sub–population with the highest proportion of casual sexual partners was MSM.
Close to two-thirds (63.3 percent) of MSM had causal partners. Very low numbers of migrants and sedentary populations engaged in casual sex. Slightly over one out of ten (11.6 percent) truck drivers, one out of five (20.9 percent) local seafarers and one quarter (25.5 percent) engaged in casual sex. The average number of times that respondents had sex with casual sexual partners over the past 30 days ranged from one to three with MSM and sex workers having the highest number and local seafarers, truck drivers and sedentary population having the lowest.
None of the migrant and sedentary population who engaged in casual sex also engaged in commercial sex. However, all sex workers who had casual partners also engaged in sex work, except for one. Three of the nine local seafarers with casual partners also engaged sex workers. Six of the nineteen MSM with casual partners also engaged sex work, while only one of the truck drivers did the same.

Respondents were asked if they received anything from the casual partners the last time they had sex with them. Most (87 percent) said that they did not receive anything. However, 40 percent of sex workers, 14.3 percent of migrants, 10.5 percent of MSM and 7.7 percent of local seafarers did receive money from casual partners the last time they had sexual intercourse.

Nine out of ten respondents reported to use a condom the last time they had sexual intercourse with their casual sexual partners. In more than half of the cases (58.1 percent), the respondents suggested condom use, followed by 35.5 percent where it was a joint decision and 6.5 percent when it was the partner. Half of the sex workers who did not use condoms indicated that they wanted to get married, while the other half did not think that it was necessary to use a condom. Please note that some sex workers have indicated that they do not need condoms as they are already infected with HIV. One third of MSM reported that they trusted their partners, the other one third did not think that it was necessary and the remaining one third did not think of it. Of those who did use condoms, eight out of ten respondents said that they always use condoms with their casual partner, 13 percent said sometimes and 7.2 percent said never.
Of the 383 respondents of this study, 17.4 percent engaged in commercial sex in the past 12 months; meaning that they either gave or received something in exchange for sex. Only 1.8 percent of migrant and sedentary respondents reported to have engaged in commercial sex in the past 12 months; the same with 12.7 percent of local seafarers, 30 percent of the MSM, 16.3 percent of the truck drivers and all of the sex workers (except for two who did not want to respond to the question).

All of the truck drivers and local seafarers who engaged in commercial paid for such sex and did not receive payment for sex in any way or form. Close to one out of five (22.2 percent) MSM also paid while the remainder received payment. Migrant and sedentary populations who engaged in sex work, normally paid, while some received payment in goods (food and clothes). All of the sex workers received payment, instead of them paying.

The number of times that commercial sex occurred over the past 30 days varied between one
and 30 times. Sex workers and MSM had very high numbers of sexual activity, because some of the MSM were also male sex workers. Local seafarers reported between zero and five times over the past 30 days, truck drivers between zero and six, migrants and sedentary between one and two, and sex workers and MSM between one and thirty. The average number of times across the sampled population was nine.

Figure 27: Sexual network, female sex work
Respondents were asked how they normally contacted their commercial sexual partners. The graph below shows that most local seafarers go to bars; sex workers are more likely to use bars, club and the telephone; MSM are more likely to use bars, clubs, restaurants and the telephone; truck drivers are more likely to go to the street or use telephone contacts; while migrants/sedentary population were more likely to go to restaurants or use place of work to contact them. Interestingly was the finding that some sex workers and MSM, although low in number, make use of the internet. Not many respondents used hotels, presumably only the high class sex workers.

Figure 28: Ways of contacting commercial sex partners by research sub–population (percent)

Respondents were asked about the age groups of those who paid them for sex and those who they paid for sex. Interestingly, those who paid the respondents for sex were older, while those who were paid were younger. Forty-three point one percent of those who paid sex workers for sex were between 30 and 39 years of age, while the same proportion were 40 years and older. Only 5.9 percent were between 19 and 29 years of age. One the other hand, 52.9 percent of sex workers that respondents paid were 19–29 years of age, 23.5 percent were between 30 and 39, and the remaining ages were unknown.

More than nine out of ten (92.5 percent) respondents who were engaged in commercial sex reported the use of condoms the last time they had sex. In most cases (58.1 percent) the respondent suggested condom use; it was a joint decision for 35.5 percent, while 6.5 percent noted that their commercial partners suggested it. Of those who did not use a condom the
last time they engaged in commercial sex, 60 percent noted that their clients offered more money. Twenty percent reported that condoms were unavailable and the rest did not know why condoms were not used. Reported consistent condom use with sex workers over the past 12 months was extremely high for most sub-population respondents, except for sex workers, local seafarers and MSM.

**Figure 29: Reported consistent condom use by with sex workers (percent)**
7. NATURE OF SEX WORK IN WALVIS BAY

7.1 Introduction

The sex work industry in Walvis Bay was considered ‘very big’ by all qualitative participants. The following responses were given when the question was asked, “In your opinion, how big is sex work in Walvis Bay? The responses were:

- “Hoooh, very big, amazingly big”
- “It happens often”
- “It is very big”
- “Very big”

This chapter discusses the size of the sex work industry, different types of sex workers, age range of sex workers, clients, payment, violence, alcohol and drugs and the legal framework in which sex work takes place.

7.2 Number of sex workers

No one knows the numbers of sex workers operating in Walvis Bay mainly because of the secrecy of the trade based on moral issues and illegality of sex work in Namibia. Different numbers were used when respondents were asked about the number of sex workers in Walvis Bay. Some said about 100, others said about 500 and one said about 1,000. It is difficult to determine the number of sex workers due to the nature of sex work. Some sex workers operate openly with family and friends knowing about it, others operate in public but family and friends do not know about it, some operate privately from home with friends knowing about it, while others operate privately from home with family and friends not knowing about it. Determining the number is therefore a very difficult task. The average number from the number of sex workers mentioned was 530. This is similar to findings in other reports on the number of sex workers as well as the finding of the scoping study. However, it should be noted that there are also sex workers living in Swakopmund and Windhoek who travels to Walvis Bay to sell their sexual services, especially when fishing vessels dock. An instance was also reported of a married man who lives in Windhoek who comes to Walvis Bay once every two months to sell his sexual services to other men. Most of these sex workers are female,
although other types of sex workers are also active in town.

7.3 Reasons for engaging in sex work

Five sex workers were asked, what make them do sex work. Their stories differed with one common factor: involuntarily engagement in sex work due to circumstances. Summaries of how they began are summarised below:

**Female sex worker:** “My father, the breadwinner of the family passed away some time ago. My mother had many children and could not take care of all of us. I started doing sex work in order to help out with household needs. With my income I pay school fees of my siblings, buy food and clothes”.

**Female sex worker:** “I started much later than other ladies. I started when I was 43. My husband left me for another woman. He left me with absolutely nothing to fend for myself. I was forced into this to take care of myself and my children”.

**Male sex worker:** “I do this to take care of myself. No employment. No family support. I experienced serious financial difficulties and had to start selling myself. I also do this to meet more gay men, and hopefully a rich boyfriend with whom I can settle. I do this to make money. If I do not work, who will give me money”.

**Transgendered sex worker:** “I started when I was 12 years old. I was abused by my mother and sisters, because I was different from other boys. My family did not have money. I initially started this at age 12 in order to pay for school fees and to feed myself”.

The main contributing factors to sex work was regarded as poverty, mainly due to lack of
unemployment opportunities in Walvis Bay, coupled with the demand to sell sex to those that come to Walvis Bay to use the harbour (truck drivers, fishermen, business men). Other contributing factors according to FGD participants included:

- Greed, meaning that some sex workers may not necessarily need the money, but want extra money to purchase material things.
- Clients being away from home for long periods of time, such as truck drivers and seafarers.
- Clients who come to Walvis Bay for a good time only.
- Alcohol and drug abuse amongst the different sub–populations.
- Opportunities for men to have sex with men as there are a perceived large number of male sex workers operating in Walvis Bay.
- Lack of recreational activities in Walvis Bay.

### 7.4 Types of sex workers

Sex workers are a heterogeneous group of people including the following:

- Females selling sex to males
- Homosexual females selling sex to females
- Males selling sex to females
- Homosexual males selling sex to males
- Transgendered males selling sex to males

The above are the main categories of sex workers; however there are different types of sex workers within most of the main categories as well. It was difficult to determine the numbers of sex workers by type of sex worker, for the same reasons as given above. Coupled with this, is the enhanced secrecy around sex work that involves males selling sex to females and females selling sex to females. However, opinions from different IDIs were used to come up with broad proportions for each category of sex workers. The assumption is that there are about 530 sex workers of different types operating out of Walvis Bay. Of the sex worker population, the largest proportion is females selling sex to males. They constitute about more
than half of the sex worker population at 57 percent. The second largest sex worker type is males selling sex to other males. One out of five sex workers are males selling to other males. This is followed by transgendered male (15%), males selling sex to females (5 percent) and females selling sex to females (3 percent).

The age of sex workers vary. It was found that most (67.4 percent) female and male sex workers, who participated in this study, were between the ages of 20 and 34 at the time of the survey. However, it was found that some of the male and female sex workers had their sexual debut at 12 years of age and younger in some limited cases. Reports were given by sex worker IDIs and FGD participants of sex workers who are currently 14 and 15 years of age. One transgendered sex worker said that he started sex work when he was 12 years of age. On the other hand, another female sex worker noted that she started when she was 43 years of age. In addition, one IDI noted that he knew a 52 year old male sex worker who sells sex to other males.

“Yes, males and females younger than 18 years of age are involved in the sex trade.” Female Sex Worker, FGD participant.
Table 6: Average age by sex worker types

<table>
<thead>
<tr>
<th>Type of sex workers</th>
<th>Average age range of sex workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Females sex workers selling to males</td>
<td>18–34 years of age</td>
</tr>
<tr>
<td>Females selling to females</td>
<td>DK, but the assumption is that they are young (18–30 years)</td>
</tr>
<tr>
<td>Males sex workers selling to males</td>
<td>18–34 years of age</td>
</tr>
<tr>
<td>Transgendered males selling to males mostly</td>
<td>18–34 years of age</td>
</tr>
<tr>
<td>Males selling to females</td>
<td>DK, but the assumption is that they are young (18–30 years)</td>
</tr>
</tbody>
</table>

Most of the sex workers reside in Kuisebmund, followed by Naraville and then Meersig. Meersig is the more affluent suburb with Kuisebmund being the poorest. Half of the sex workers who were interviewed were born in the Erongo region; most were born in Walvis Bay. As for those born outside Walvis, most were born in the Khomas region, followed by Karas, Ohangwena, Hardap and Kunene and lastly Oshana and Otjozondjupa regions.

Figure 31: Map of Walvis Bay showing the three main suburbs
7.4.1 Types of female sex workers

This sub-section elaborates on the differences between female sex workers and their characteristics in relation to where they operate from, where they have sex, types of clients, fee and types of partnership. Qualitative research participants reported on six different types of female sex workers operating in Walvis Bay as per the table below.

Table 7: Different types of female sex workers

<table>
<thead>
<tr>
<th>Types of female sex workers</th>
<th>Where clients solicited</th>
<th>Where sex takes place</th>
<th>Types of client</th>
<th>Fee for sexual act</th>
<th>Type of sex work partnerships</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) High class sex workers</td>
<td>Hotels or regular partners on boats, social networks</td>
<td>Hotels, guest houses, B&amp;Bs</td>
<td>Foreign seafarers (captains, engineers) and business men</td>
<td>N$2,000–N$3,000*</td>
<td>Mostly regular, in some cases long term</td>
</tr>
<tr>
<td>2) Middle class sex workers</td>
<td>Clubs (Rio Copa and Luculus), bars, restaurants, sometimes hotels. Go to ‘central’** during ‘dry season’</td>
<td>Own rooms, B&amp;Bs, sometimes cars</td>
<td>Foreign seafarers (labourers), local business men, sometimes truck drivers</td>
<td>N$400–N$600</td>
<td>Mostly casual, but sometimes have regular partners</td>
</tr>
<tr>
<td>3) Low class, also known as truck girls</td>
<td>Clubs, street, shebeens and bars at ‘central’</td>
<td>Trucks, Truck stops, streets, cars, public toilets</td>
<td>Truck drivers, local seafarers, local men</td>
<td>N$150–N$300</td>
<td>Casual</td>
</tr>
<tr>
<td>4) Shebeen ladies</td>
<td>Shebeens and bars at ‘central’</td>
<td>Street, public toilets, cars</td>
<td>Truck drivers. Local seafarers, local men</td>
<td>N$20–N$100 or only drinks</td>
<td>Casual</td>
</tr>
<tr>
<td>5) Part–time sex workers/transactional sex</td>
<td>No specific place</td>
<td>Own rooms</td>
<td>Foreign seafarers</td>
<td>Money or gifts</td>
<td>Regular and sometimes long term</td>
</tr>
</tbody>
</table>
6) **Females selling sex to females**

<table>
<thead>
<tr>
<th></th>
<th>Very secretive: from word to mouth</th>
<th>Own or client’s place</th>
<th>Regular homosexual females</th>
<th>Not known</th>
<th>Regular</th>
</tr>
</thead>
</table>

*This is not necessarily per sexual act, but for the time that foreign seafarer client are in town, which is normally a couple of days. They would normally earn around N$1,000 per day that they spend with a client. But they can also charge around N$1,000 per sexual act if the client is not a regular client.*

**Central is an area in Kuisebmund with many shebeens and bars, where sex workers pick up clients. It is a very busy area, especially over weekends, and more so over month-end weekends, because many people receive monthly salaries at month-end and sex workers know this.**

Many of the high class sex workers have formal jobs. They operate mostly from hotels, but have regular clients calling them before arrival in Walvis Bay, especially those on boats. Their clients are normally vessel captains or other high ranking vessel personnel, such as vessel engineers, although they also service local or other international business men. They are usually paid the highest in comparison to other sex workers. They are normally treated to dinner and a ‘comfi’, meaning talk and cuddle. They have regular sex worker clients most of the time, who are out at sea and visit them when on shore. Some high class sex workers have been with their clients for more than five years. Their clients are normally from other countries, but also business men from other towns in Namibia and from Walvis Bay itself. Some clients also tend to support their regular sex worker partners regularly with payment towards household goods and services, such as electricity or water.

It was found that most middle class sex workers operate mostly from clubs, bars and sometimes hotels. They usually take their clients back to their own rooms, but are also sometimes taken to local guesthouses, B&Bs or have sex in clients’ vehicles. Middle class sex workers cater mostly for foreign seafarers, local business men and sometimes truck drivers. Foreign seafarers are mostly labourers and not the high ranking officers mentioned above. Local business men were reported to be medical doctors and owners of businesses amongst others. They were said to be from different tribes within Namibia and elsewhere (both ‘black’, ‘white’ and ‘brown’ skin colours were mentioned). Most
middle class sex workers have different casual clients. However, some also have regular partners that return to them, such as business men who call them before arriving in Walvis Bay. Some middle class sex workers become low class sex workers during certain times of the month (mostly during middle of the month) when money is short and clients are low in demand. This means that middle class sex workers also go to ‘central’ in pursuit of clients when in desperate need. In these cases, they would accept amounts lower than their usual amount, because the clients are different.

One the other hand, low class sex workers would sometimes become shebeen ladies when they are desperate for money, or in some cases desperate for drugs. High class sex workers normally stick to their regular partners, but do solicit casual sex for money when money dries up.

Low class sex workers mostly operate from truck stops/ports, clubs, streets and shebeens in Kuisebmund. They normally are not taken to guest houses or B&Bs for sex, mainly because their clients cannot afford it, or the sex workers appearance would not allow entry into such place. Sex normally takes place in cars, trucks, public toilets or behind buildings. They were found to mostly solicit sex for money from truck drivers, local seafarers or local men. They normally do not have regular clients, but mostly once off casual clients.

Shebeen ladies, as they are called by fellow sex workers, are different from low class sex workers, as they operate mainly from shebeens in Kuisebmund, while their sexual services not expensive. Sometimes, they will have sex in exchange for a couple of drinks according to FGD participants. They mostly operate from the area called ‘central’, which is an area in Kuisebmund with many shebeens and bars.

Part-time sex workers are those ladies who do not necessarily go out looking for partners to have sex with in exchange for money or other goods. They are mostly younger girls working in low—paid jobs, but are sexually engaged with seafarers in exchange for money
or gifts. They are normally in steady relationships, but “ditch” their partners when their “clients” are in town.

It was difficult to place females who sell sex to other females, because this was such a unique group. Not many qualitative research participants spoke about this type of sex work, although some did bring it up. This type of sex work was perceived, by those participants who brought it up, as very secretive. Female clients normally contact their female sex work partners via telephone and prefer to use the same partner on a regular basis, because of the secrecy around this homosexual interaction. Soliciting sex work of this nature was based on referrals by other clients as well. It was unknown how much they charge, but the assumption by qualitative research participants was that it was similar to middle class sex workers.

It was also reported that a few under-aged girls would engage in sex with men met at shebeens who buy alcohol for them. This was a concern to FGD participants as it was found to be too prevalent. This was not necessarily seen as sex work, but the intention of buying and accepting the drink was to have sex. This type of exchange was prevalent between some young girls and especially taxi drivers or other local men.

There are also male and female sex workers, who sell their sexual services on vessels while out at sea. Three FGD participants in one discussion reported that both married men and women leave their spouses at home and claim to go off—shore to work on vessels, but in actual fact they go off—shore to sell sex for money out at sea. They sometimes earn as much as N$16,000 on a trip (two to three week trips). These are usually big container ships. It was also reported that female sex workers are sometimes smuggled onto vessels for purposes of sex work while at sea. One foreign seafarer noted that this is an illegal act, as women are not allowed on vessels as per their policies.
7.4.2 Male sex workers

Qualitative research discussion participants noted three types of male sex workers in Walvis Bay. Male sex workers do not fall within the same categories as female sex workers in relation to high class, middle class and low class although there are similarities about the amounts charged for sexual exchange, places of solicitation for services and similarities amongst clients.

Table 8: Different types of male sex workers

<table>
<thead>
<tr>
<th>Types of male sex workers</th>
<th>Where clients solicited</th>
<th>Where sex takes place</th>
<th>Types of client</th>
<th>Fee for sexual act</th>
<th>Type of sex work partnerships</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Transgendered males having sex with males</td>
<td>Hotels, guest houses, clubs, bars or telephone regular partners</td>
<td>Hotels, guest houses, B&amp;Bs, cars, trucks</td>
<td>Foreign seafarers, local business men, local men, truck drivers – straight men</td>
<td>N$600–N$1000</td>
<td>Mostly casual, but some regular</td>
</tr>
<tr>
<td>2) Males having sex with males</td>
<td>Clubs, bars, street, shebeens at ‘central’</td>
<td>Trucks, Truck stops, streets, cars, public toilets</td>
<td>Truck drivers, local seafarers, local men</td>
<td>N$500–N$800</td>
<td>Mostly casual, but some regular</td>
</tr>
<tr>
<td>3) Males having sex with females</td>
<td>More of word to mouth</td>
<td>Own rooms, B&amp;Bs, sometimes cars</td>
<td>Local women</td>
<td>N$500–N$700</td>
<td>Mostly casual, but some regular</td>
</tr>
</tbody>
</table>

Transgendered males who have sex with males for money normally have a wide range of clients. Their clients range from high ranking foreign seafarers, to local business men to truck drivers and local men. The number of men seeking male sex workers is much lower than the number of men seeking women sex workers. This low demand results in male sex workers having to ‘spread their wings’ wider to get clients. In their pursuit to attract a wide range of clients, they operate from hotels, guest houses, clubs, bars and shebeens on rare occasions. They mostly have sexual intercourse in hotels, guest houses, B&Bs, but also in cars and sometimes trucks. Some of them have regular partners that they have been servicing for years, but this is not sufficient to meet their financial needs,
resulting in soliciting sex from casual partners as well. Some transgendered males noted that they only sell sex to heterosexual males and not homosexual males, because they are ‘women’. One transgendered male interviewee (who regards himself as a female) noted that ‘she’ only sleeps with straight men and not with homosexual men. Their clients also include married males.

Another category of male sex workers are those that sell sex to other males, including bisexual and homosexual males. They normally do not solicit clients from hotels or guesthouses, but from clubs, bars, shebeens or street corners. The clients are normally some local seafarers, some local men (married men as well) and some truck drivers. In some cases, they also solicit high ranking foreign seafarers, but not usually. They have similar challenges in terms of demand of men seeking male sex workers and therefore need a wide range of solicitation practices. Their partners are mostly casual, although they have regulars as well. They seemed to charge less than transgendered sex workers most of the time, because transgendered sex workers are seen as different. They are more feminine than male sex workers.

There are male sex workers who do not have sex with other males, but only with women. There are also male sex workers who have sex with males and females: bisexual. Males having sex with females are a group that research study participants did not know much about. Many participants did not know how much they charge or how their services were solicited. One way was for them to advertise themselves in newspaper classified as someone seeking a romantic relationship. When they are called up then they inform the caller that they want to be paid for their services. It was found that the amount paid for sex with a male sex worker by a female is normally similar to middle class female sex workers, but a bit higher. Most of these sex workers have had regular partners who they sold their services to. Females who engage male sex workers normally come back to the same sex worker as the numbers of sex workers are very low, and they operate secretively.
7.4.3 Young male sex workers

Of concern to FGD participants and IDIs was the perceived high number of young boys who have sex with older men in exchange for money, clothes, alcoholic beverages, and other materialistic things. The average age of these young boys were said to be 14 to 15 years of age, that is why they were referred to as the “Ben 10s” by MSM. Male MSM FGD participants noted that young male sex workers who have sex with other males are especially easy to find at ‘central’. The young boys are said to want material support; it is a status thing, FGD participants said. One MSM FGD participants said, “… and the young boys these days do not want to wear the normal undies [male underwear], they want the ‘hotpants’ from Markham store’, which is sooooo expensive”. The MSM participants in this FGD spoke as if all of them had young boys with whom they have sex with and whom they paid in one way or the other. Young boys were said to approach older men for sex, rather than older men approaching them in most cases. All GD participants have been approached by these young boys. The exchange mechanism for sex with these young boys is not always money, but can be alcoholic drinks as well. The young boys will mostly perform oral sex only for a beer, as they are not at the penetrative sex stage yet, according to another FGD participant. As noted above, sometimes payment is done in–kind. There seems to be regular sexual relations between these men and the young boys. One FGD participants noted, “my dear, one cannot refuse if the rain falls on you, …. while you have been waiting for the rain for such a long time”. Another MSM FGD participant shared the following, “with me, just walking out of my house is a problem. If these young boys see me leaving the house to go out for the night, they will ask if they can come along. I mean, what am I supposed to do in such cases when they offer themselves to me?”
7.4.4 Parents/guardians selling sex with children

Another concern raised by qualitative research participants is the increasing numbers of young girls roaming shebeens and reportedly having sex for as much as an alcoholic drink. “I noticed a lot of youngsters involved in sex work, because they are very poor and do not attend schools. In Kuisebmund, there are underage girls, very young ones who just wants you to buy them alcohol in exchange for sex,” Truck Driver IDI. This was also true for young homosexual boys. Reasons for young girls to engage in sex work according to FGD participants included:

- Poverty and lack of employment opportunities for parents to take care of children.
- Need for money to acquire basic needs such as food, school fees and clothes.
- Peer pressure to have niceties, such as cellphones, jewellery, nice clothes, iPad, laptops, Brazilian hair, expensive shoes, handbags, etc.
- Financing drug and alcohol habits.
- Parents force girls to engage in sex for money to help support the family or for other reasons.

Most FGD participants and IDIs noted that some young girls are used by their parents to sell sex in exchange for money. This does not happen often, but a few of the FGD participants could give examples of known cases. One sedentary population female FGD participant noted that she knew of a man who usually gave money to a mother with two beautiful teenage daughters who were still in school, for the daughters to spend the night with him. He in turn would then sell the services of the girls to other men. The FGD participant noted that one of the girls contracted a STI and that her health deteriorated to such an extent, that the FGD participant thought that the girl might have died by now. Another MSM FGD participant noted that he knew of a young girl who was brutally killed last year. This girl was thought to be about 15 years of age. The FGD participant noted that she was very pretty and sent out by her mother to have sex with men in exchange for money. She used to attract many clients because of her beauty, the participant said. Another participant in a male sedentary FGD noted that he knows of some people who
visits a certain bar, pick up young girls and then pay the mother of the girl for sexual activities. They felt that these are normally not the biological parents, but guardians. One noted that sometime girls are send from the other parts of the country to Walvis Bay, not knowing that they will be made to have sex for money. This was only mentioned by one FGD participants; others did not know about it.

7.4.5 Paying for sex – how does payment work?

Payment for sex work is made in the form of cash most of the time. Payment is sometimes accepted in the form of alcoholic drinks by especially younger sex workers or in the form of drugs if the sex worker is addicted. Some younger male sex workers also accept some other in–kind payments, such as clothes.

In most cases, sex workers decide the price depending on the sexual act. Sex workers stick to their fixed prices most of the time. In some cases, especially when sex workers are desperate for money, then they negotiate with clients who cannot afford their prices. In many cases, when the client cannot pay the fixed amount, then sex is not provided. They normally apply what they call the ‘no pay, no sex’ policy.

Sex worker interviewees have all experienced clients who refused to pay, after the sexual act. Sex workers can normally not do much about it, as it is illegal to sell sex. However, some of them use other strategies of making clients pay, such as requesting a local gang to beat up the client in exchange for payment.

Different sexual acts attract different prices. Penetrative sex is most expensive, while fondling and touching is the least expensive. Several different sex workers gave different prices for different acts. Compiling such data gave the results laid out in the table below. Please note that there are sex workers who receive more or less than indicated in the table below. The prices below are averages based on data collected during qualitative research.
Table 9: Average prices for different sex work acts

<table>
<thead>
<tr>
<th>Sexual Act</th>
<th>Transgendered Sex Worker</th>
<th>Male Sex Worker</th>
<th>Female Sex Worker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kissing only</td>
<td>N$250</td>
<td>N$300</td>
<td>Not done</td>
</tr>
<tr>
<td>Blow job with a condom</td>
<td>N$400</td>
<td>N$500 – N$700 (even without condom)</td>
<td>N$200</td>
</tr>
<tr>
<td>Hand job to the client</td>
<td>N$350</td>
<td>Not said</td>
<td>N$150</td>
</tr>
<tr>
<td>Penetrative sex with a condom</td>
<td>N$500 – N$1,000</td>
<td>N$500 and above</td>
<td>N$400–N$500</td>
</tr>
<tr>
<td>Fondling by the sex worker or to the sex worker while inside a club</td>
<td>N$150</td>
<td>N$100–N$150</td>
<td>N$100–N$150</td>
</tr>
<tr>
<td>Sex without a condom</td>
<td>Do not do it without condoms</td>
<td>N$500 and above</td>
<td>More than the usual amount</td>
</tr>
<tr>
<td>Other income</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Total average income from sex work</td>
<td>N$3,000–N$4,000</td>
<td>±N$7,000</td>
<td>±N$2,500 – N$7,000</td>
</tr>
</tbody>
</table>

Sex workers regarded their income as ‘good’ most of the time. Some sex workers also have other forms of income, with small proportion being formally employed. Their monthly income from sex work varies depending on the type of sex worker they are, but also on the availability of clients. One transgendered sex worker makes between N$3,000 to N$4,000 a month from sex work and N$1,000 from his formal employment. This gives her a total of about N$4,000 to N$5,000 per month. However, sometimes clients pay in US$, which then brings in a lot more. High class sex workers normally perceive sex work income as supplementary to their other income, while other may see formal employment income as supplementary income to their sex work earnings.

Most sex workers that participated in the qualitative component of the research noted that the money they earn from sex work is more than what they would receive in a formal job with their low qualifications. Many of them are able to help their family out with their sex work earnings. Most sex workers indicated that they help out their mothers with paying household services, such as water and electricity or paying off household debts such as furniture debts. Some do not help out family, because they have been isolated.
from their families due to the nature of their work. Most indicated that sex work earnings help them paying off personal debt, but that it is insufficient to safe from.

Table 10: Some of the uses of sex work earnings

<table>
<thead>
<tr>
<th>Use of Sex Work Money</th>
<th>Transgendered Sex Worker</th>
<th>Male Sex Worker</th>
<th>Female Sex Worker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Help family from sex work income</td>
<td>Not really, sometimes mother</td>
<td>Yes, pay mother’s debt</td>
<td>Yes, mother</td>
</tr>
<tr>
<td>Sex work earnings help with paying off personal debt</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Sex work earnings go towards savings</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

7.6 Sex workers working hours

Sex work normally takes place seven days a week and normally starts at around 22h00 and ends in the early hours of the morning. Sex workers normally sleep from around 05h00 until mid-day. They then start preparing for the evening of work that normally starts as indicated above.

7.7 Clients of sex workers

The demand for sex work in Walvis Bay was regarded as smaller than the supply, which many times led to physical and verbal confrontation between sex workers. One MSM IDI said, “Here we don’t have much of a choice, it’s all about client’s preference, service satisfaction, status and money. For example, a client might like you the first evening and after that he decides to move on to another person; so there is not much a sex worker can do about it. It just means that whoever is offering you money for your services you sometimes just have to go for them because the choices are limited”. Although clients come from different countries, different regions in Namibia, different denominations and different professions, they are regarded as insufficient in number for the number of sex workers available. Clients are divided into the following categories:
### Foreign truck drivers:
- Truck drivers who participated in this study were from South Africa, Botswana, Zambia and Zimbabwe. But there are also truck drivers from Democratic Republic of Congo, Malawi and Tanzania who uses the port of Walvis Bay.
- They are all men.

### National truck drivers:
- They are mostly from Khomas region, but to lesser extent other regions as well.
- They are from all different cultures.
- They are all men.

### Foreign seafarers:
- They are mostly from Spain, France, Netherlands, Italy, Russia, China, Philippines and Australia.
- They are all men.
- They are on average between 30 and 40 years of age.

### Local seafarers:
- They are mostly Oshiwambo and Otjiherero speaking, while other language groups are in smaller numbers.
- They are all men.
- They are on average between 20 and 45 years of age.

### Foreign formal business persons:
- They are mostly from South Africa, but an increased number are from China as well.
- They are all men.
- They are mostly married.

### Local formal business persons:
- They are mostly from Windhoek.
- They include doctors, engineers and business owners.
- They are all men.
- They are black, white and brown.
- They are mostly married.

### Informal business persons:
- They are mostly from the northern parts of the country.
- They are all men.
- They are mostly married, except for most taxi drivers who are single.
- They are normally older, except for taxi drivers who are younger (19–29 year of age on average).

### Regular local men:
- They are from all walks of life.
- They are all men.
- They are normally between 30 and 60 years of age.

### Regular local women:
- They are from all walks of life.
- They are all women.
- They are normally between 30 and 50 years of age.
When asked, what gender is in demand by clients, a MSM interviewee indicated, “In this town, there is no such thing as straight men. It is first come first serve, type of thing. If a male client comes in and see me first, then they go for me. If they see a women sex worker first, then they go for her.”

When participants were asked why people seek sex work, they reported the following:

- Married men seek their services because men claim that their wives do not understand them, their wives do not sexually satisfy their desires such as kinky sex and fantasies which sex workers do.
- Truck drivers, seafarers and foreign business people are away from home for long periods of time and seek sex work as it is easily available, quick and no strings attached.

FGD participants, KIIs and IDIs were asked what types of clients were more at risk of HIV infection. Their responses were as follows:

- ‘Dronkies’ (drunkards) are more at risk of HIV infection, because they normally forget to wear condoms or find it difficult to put the condom on their penises that is not sufficiently hard.
- Any clients who prefer not to use condoms, and are willing to pay more for sex without a condom.
- Any clients who are in a hurry and do not pay attention may have sex without a condom.
- Clients who sleep with sex workers who are complacent about condom use. In some cases sex workers, who are HIV positive, are complacent about condoms use, because they feel that they cannot be infected again. They are not aware of re-infection and the dangers thereof.
- Any client who feels that condoms are too big in size for their penises. One sex worker said that Chinese fishermen claimed that condoms were too big for them, resulting in them opting not to use condoms.
• Some truck drivers and seafarers from other countries refuse to use condoms, because they feel that they do not have AIDS in their countries and are therefore safe from infection.

• Truck drivers and foreign seafarer’s mainly because they are not always aware of the HIV and AIDS situation in Walvis Bay. They may not be able to speak English or any of the local languages to be informed about the HIV and AIDS situation in Walvis Bay. One truck driver said that he normally listens to Namibia radio station when driving through Namibia, and picked up on the HIV and AIDS situation in the country. However, he did not learn anything over the radio about the HIV and AIDS situation in Walvis Bay.

• Truck drivers and foreign seafarers are at risk because of the nature of their work; they travel extensively. They travel through different towns and countries where some of them probably also engage sex workers. They may also have wives and/or girlfriends back home, who could be infected if they are infected on their travels.

• Foreigners who do not speak English cannot read newspaper articles, pamphlets and other material on HIV and AIDS even if it is available in the country. They can also not listen to radio or television in country as most information on NMC is in English or a local language.

7.8 Sex work operational area

Qualitative research participants were asked where sex workers in Walvis Bay operate from and where sex with sex workers actually takes place.

Table 11: Places in Walvis Bay where sex workers operate from and where they have sex

<table>
<thead>
<tr>
<th>Place were sex workers operate from</th>
<th>Places where sex with sex workers take place</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generally at establishments close to the harbour</td>
<td>Hotel rooms of clients</td>
</tr>
<tr>
<td>Luculus Night Club</td>
<td>Rooms of sex workers</td>
</tr>
<tr>
<td>Rio Copa Night Club</td>
<td>B&amp;Bs, guesthouses, bungalows rented for sex purposes only</td>
</tr>
</tbody>
</table>
- Crazy Mama
- Raft
- Restaurants close to the harbour
- Hotels, especially Protea Hotel
- B&B, lodge, guesthouses nearby Luculus Night Club
- Bars
- **Shebeens in Kuisebmund (central)**
- Bars in Kuisebmund (central)
- Street, Paparazzi, next to Trust Market and Trust Market itself, or on street corners close to harbour
- Dark street corners (mostly low class sex workers)
- Trucks or at truck ports (mostly low class sex workers)
- Public toilets (clubs, restaurants, service stations)
- On ships
- Public places such as beaches and parks
- Harbour entrances

Workers of formal establishments, such as hotels, clubs and bars, normally inform sex workers when ships come in. This is done because when sex workers attract seafarers, then seafarers spend money at the establishments where sex workers roam.

**Figure 32: Map of hotspots in vicinity of Walvis Bay Port**
7.9 Perceptions of sex work

Sex workers call their type of ‘work’ sex work, but the general public still calls it prostitution. Sex workers are referred to by most community members as prostitutes, ‘jumpers’ and ‘whores’. These are all terminologies that carries with it negative connotations. The perceptions of self were also negative for most female sex workers, but positive for many male sex workers.

All of the female sex workers noted that they did not like to engage in sex work, and normally needed a couple of drinks to give them the courage to approach men for sex or to allow men to approach them for sex. They noted that they would prefer to earn a normal income rather than to sell their bodies for income. One sex worker noted that she did not like what she was doing, because it was not out of her own free will. She felt forced to do what she was doing. Another sex worker noted that she hates what she was doing because it was life—threatening. She said, “Every day I am exposed to all sorts of physical and emotional dangers, threats and abuse”. One of ladies wanted to stop and aspires to become an accountant one day.

However, the perceptions of self by some male sex workers were different from that of female sex workers. One of the male sex workers noted that he really liked what he was doing. He noted that sex work gives him stability, freedom to work for himself and determine working hours, to make money and to have access to all sorts of men. Other male sex workers noted that they did it, because it provided them the opportunity to have sex, mainly because gay sex is in limited supply. Others hoped to find a rich man who will take care of them for the rest of their lives. The younger male sex workers did it to get access to nice clothes, shoes, cell phones, etc. A transgendered sex worker noted, “with sex work I can do what I want. I get paid in foreign currency, e.g. Yen, Euro, Pounds and US$ – I often score more than I was to get initially. Sex work maintains my living conditions. Socially, I meet many different
people. I get to learn about different cultures, different languages. I get to learn about laws and how sex workers are treated and not treated in other countries. My job gives me confidence and pride. I feel like a working individual who earns my own salary. It raises my awareness about health issues and teaches me to take control of my health”. However, there were some male sex workers who absolutely hated what they were doing, and felt forced by their circumstances.

7.10 Abuse within the sex industry

Sex workers found it difficult to speak of sexual abuse against them, but felt more comfortable speaking of abuse experienced by other sex workers. One female sex worker explained that she was sexually abused by a client when she started sex work, but then noted that it is still too traumatising and that she preferred not to talk about it, even though it happened many years ago. Verbal, physical and sexual abuse of sex workers were reported by all sex workers that participated in the study. The migrant and sedentary population who participated in the survey were less aware of such abuse of sex workers.
Abuse by clients: When one sex worker was asked if he has ever been abused by a client, he said, “no, not yet”, implicating anticipation that it can happen at any time. Sex workers are always at risk of being abused by a client, as they do not know their clients most of the time. The dominant role of clients put them at risk of abuse, meaning that the client has power as the client has the money. Places where sex work usually take place also puts sex workers at risk, as sex normally takes place in isolation from others. One sex worker noted that another risk is that clients are sometimes many at the same time, posing the risk of gang rape. Most sex workers have been verbally or physically abused by clients at one point or another in their ‘working’ lives. They mentioned that:

- they have been robbed by clients;
- they have been accused of robbing clients and beaten up as a result;
- some clients have refused to pay them after sex;
- some clients force sex workers to have sex with them and beating them up during the process;
- they are unable to lay criminal or civil charges against clients as sex work is regarded as illegal; and
- some clients expected un–natural ways of sexual intercourse.

One truck driver felt that sex workers are beaten up by clients because men do not have respect for women of this nature – ‘promiscuous women’.

Abuse by sex worker to client: It was reported that some sex workers would rob their clients. Such robberies are sometimes organised ahead of time with accomplices of sex workers. Clients are normally beaten up during the process. Clients normally do not report such robberies as it is difficult to explain the incidence to the police or their family/friends.

Abuse by other sex workers: There is high competition amongst sex workers for clients due to the high supply of sex workers in comparison to the demand. This fear of competition amongst sex workers have resulted in verbal and physical confrontation amongst them. Some of the abuse includes the following:
- It was reported that some of them apply *muti* (witch craft) to their bodies in order to attract men.
- Some would inform clients about the HIV status of others in order to get clients to go with them and not others.
- Some girls would physically fight over clients.
- Incidences were mentioned where some sex workers would ‘spike’ the drinks of other sex workers in order to steal clients.

One sex worker said that “this is a fight for survival”.

**Abuse by public:**

They are normally verbally abused by the general public, merely because of their trade. Verbal abuse usually takes the form of name calling such as ‘whores’.

FGD MSM indicated that physical abuse of sex workers happen very often. Sex workers noted that there is a trend that some criminals, using taxis, target sex workers to abuse and steal from. One male sex worker reported that he got into a taxi to take him home. Instead, the taxi driver and his accomplices drove to the lagoon where the male sex worker was beaten up and robbed of his money. They noted that taxi drivers are becoming more abusive towards them.

One sex worker noted that sex workers worked odd hours and dressed very provocatively resulting in some sex workers having been raped on their way home (during the early hours of the morning) by people (what they call ‘tsotsies’) within the neighbourhoods where sex workers live. Male sex workers spoke about the rape of males as well by people within the community. One MSM FGD participant said that male sex workers do not report rape, because of stigma, but also because they prefer not to.

**Challenges with families:**

Some have been totally isolated from families because of the nature of their work. Normally, families are very poor and cannot provide financial support, which normally leads to sex work by some household members. Many times family do not approve of what sex workers do, but they accept money from sex workers when in need.
Abuse by police: All of the sex workers who participated in the study could speak of sex workers who were beaten up by the police, while some of them reported that they have heard of sex workers who were raped by the police and left behind in the ‘field’. They further reported that they are powerless against police brutality, because of the illegality of their ‘profession’. One sex worker noted, “the police do not take us seriously when we report abuse. Police would say that we deserve to be beaten up because of what we do”. Another sex worker noted that police brutality stems from the Constitution of Namibia, which does not acknowledge sex work as work. The same sex worker said that the constitution regard male sex work as sodomy, which in turn is regarded as illegal. “The Constitution blatantly disregards my rights as a human being”, she concluded.

Abuse by health workers: Many of the sex workers interviewed reported that the attitude of health workers have become more positive over the years, mainly because health workers have become used to them. Please see section on health seeking behaviour for more information.

Abuse by regular partners: Some sex workers are abused by their regular partners who know what they are doing, and who expect them to bring money home. If sex workers bring less money home than usual, then she gets a beating from her regular partner who expects her to bring a certain amount of money home after a ‘day’s work’.

Gender based violence amongst the general public is a serious concern in Namibia, especially violence against women and children. However, FGD participants with sedentary population were not very concerned about GBV in Walvis Bay as it was felt not to happen very often. Sedentary FGD participants noted that GBV do take place, but is kept behind closed doors. Although not a serious concern at the moment, GBV was regarded to be slightly on the increase in Walvis Bay.

Normally sex workers do not report abuse to the authorities as the police do not do anything about it. Sex workers reported that they normally speak amongst themselves as they understand each other. They do not regard the police as protection for them, while others are unaware of their rights. In retaliation to abuse, sex workers would normally physically fight back. One sex worker stabbed another person with a knife when he tried to abuse her.
Sometimes, sex workers would hire a gang from the neighbourhood to take care of the person who did them wrong; this is called a ‘dirty job’.

### 7.11 Drugs and alcohol

Two female sex workers, two male sex workers, two local seafarers, two foreign seafarers and two truck drivers were asked about their drinking and drug habits. Only one, a female sex worker reported to be currently using drugs, while the rest indicated that they were not currently using drugs. All but one of the respondents (truck driver) noted that they use alcohol. Six out of the ten respondents felt that they abuse alcohol, while one local seafarer, two foreign seafarers and one truck driver noted that they did not abuse alcohol.

“Alcohol abuse certainly contributes to risky sexual behaviour. People who are drunk do not have clear minds, are never minded and do not remember or do not care to wear a condom. They are also more likely to engage in sex with more than one partner. Some people think that they perform better in bed when they are drunk resulting in them drinking before having sex.”

Female sedentary FGD participant.

Four out of four sex workers noted that they needed alcohol in order to do what they do. They needed alcohol to relax them and to ‘soften their inhibitions’ so that they could approach clients and have sex with them. However, most sex workers noted that they do not get drunk while at ‘work’ as it is off putting to clients. Respondents were asked if alcohol and drug abuse contribute towards risky sexual behaviour. All of those who responded, strongly agreed that it does contribute towards risky sexual behaviour, mainly because when intoxicated, people tend to not mind having sex with more than one partner and are very likely to forget to wear a condom or likely to use the condom incorrectly. People under the influence become complacent in their sexual actions and acts, because high levels of alcohol disorientate their ways of thinking and behaving.
## Table 12: Alcohol and drug habits

<table>
<thead>
<tr>
<th>Use alcohol</th>
<th>Female Sex Worker</th>
<th>Female Sex Worker</th>
<th>Transgendered Sex Worker</th>
<th>Male Sex Worker</th>
<th>LSF*</th>
<th>LSF</th>
<th>FSF*</th>
<th>FSF</th>
<th>TD*</th>
<th>TD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Abuse alcohol</td>
<td>She drinks every time they go out for work</td>
<td>She drinks every time they go out for work</td>
<td>He drinks every time he goes out</td>
<td>Yes</td>
<td>No</td>
<td>Yes, he gets drunk</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Use drugs</td>
<td>Yes, three times in last month (cocaine)</td>
<td>Yes, but years ago</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

*LSF: Local seafarer  *FSF: Foreign seafarer  *TD: Truck driver

Sex workers who were interviewed noted that most sex workers in Walvis Bay use drugs. One sex worker who uses drugs said that she uses them to give confidence and courage to negotiate with clients. She further noted that drugs make her ‘emotionally numb’ to clients’ assaults. Some sex workers, notably younger ones, would have sex for alcohol or drugs.

### 7.12 Social networks

Social networks of sex workers are primarily constituted by friends in the area, who are also sex workers. Sex workers form ‘clicks’ (groups), normally with those who speak the same languages as they do. Sex workers do not operate alone as it is safer for them to operate in groups. They prefer to go to clubs with colleagues, as their colleagues can see who they go with in case something happens to them. Their sex worker friends are normally a solid part of their social networks.

Most of the sex workers who participated in qualitative component of the survey noted that they had family in the area, while one did not. Most still had contact with some members of
their families, except for one who was treated as an outcast because of his work and being a transgendered person. Although most family members do not approve of sex workers, some count on their sex worker family members for financial support. One sex worker said that her family calls her a ‘whore’, but normally come to her for money. A few examples of support by sex workers are listed below:

- Transgendered sex worker – “Other sex workers and community members who know me well come to me for help. An example is of this lady, whom I knew, gave birth, but did not have any money for the hospital, transportation to the hospital and food on discharge from hospital. I gave her money for this.
- Male sex worker – “I help my mum with the water bill and furniture debt account”.
- Female sex worker – “I help my family and friends. Last month I paid the rent of my friend who was short of money”.
- Female sex worker – “My sister and my niece count on be for help”.

Table 13: Social networks of sex workers

<table>
<thead>
<tr>
<th></th>
<th>Female Sex Worker</th>
<th>Female Sex Worker</th>
<th>Transgendered Sex Worker</th>
<th>Male Sex Worker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Close friends in area</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Are colleagues also friends</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Family in area</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Contact with family</td>
<td>Yes, always together</td>
<td>Yes, once or twice month</td>
<td>Not really</td>
<td>Live with them</td>
</tr>
<tr>
<td>Who counts on you</td>
<td>Some family</td>
<td>No one</td>
<td>Other sex workers and community members</td>
<td>Family and friends</td>
</tr>
</tbody>
</table>

Sex workers were asked who they would count on for support. The table below shows that sex workers almost equally count on themselves or their families, except for one who mostly count on himself or some friends for support.
### 7.13 Stigma and discrimination

All of the male and female sex workers with whom IDIs were done, reported that their family and friends were aware of their sex work. Most of their family members disapproved of them doing sex work, although one male sex worker noted that some of his family members have come to accept it. Most of the sex workers noted that their family treated them differently compared to other family members, because they were sex workers. The transgendered sex worker’s family has been estranged from him from nine years; a female sex worker was usually referred to as the ‘whore’ of the family; another said that she was treated as if she was a ‘nothing’; while another male sex worker noted that his family stayed out of his way, as they were ‘afraid’ of him. The transgendered sex worker reported that his family saw him as a ‘total disgrace’. They were therefore stigmatised based on their way of making a living.

Sex workers who participated as part of the qualitative component of the survey were asked if they experienced any problems with the police in the past months. None of the sex workers who participated in the discussion had any problems with the police in the past month. They seemed to be reluctant to speak about their personal experiences with the police, but did refer to sex worker friends who were treated unfairly by police officers. They could give examples of police brutality towards sex workers, while some even noted rape by some police officers.
They noted were treated unfairly because of their occupation and the illegality thereof.

They have all used health services recently. Most of them noted that they were treated well by health care workers. Two said that they were treated well because they personally knew the health worker; another said that the health workers did not know her occupation and therefore did not treat her differently than any other patient. One of the male sex workers noted that the nurses were rude to him.

<table>
<thead>
<tr>
<th></th>
<th>Female Sex Worker</th>
<th>Female Sex Worker</th>
<th>Transgendered Sex Worker</th>
<th>Male Sex Worker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do family/friends know about work</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>What do they think</td>
<td>Unhappy</td>
<td>Disapprove</td>
<td>Disapprove</td>
<td>Some okay, some not</td>
</tr>
<tr>
<td>How do they treat you</td>
<td>Say she is a whore</td>
<td>Like she is nothing</td>
<td>Estranged for 9 years</td>
<td>They are afraid to say something</td>
</tr>
<tr>
<td>Contact with police in the past 12 months</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Why</td>
<td>NA</td>
<td>NA</td>
<td>Cell phone theft – misunderstanding</td>
<td>Car accident</td>
</tr>
<tr>
<td>Use health service</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>How treated by health worker</td>
<td>Treated fine</td>
<td>Well, they don’t know me</td>
<td>Well, but not by all</td>
<td>Rude</td>
</tr>
</tbody>
</table>
8. HEALTH SEEKING BEHAVIOUR OF MIGRANT AND MOBILE POPULATIONS

8.1 Introduction

This chapter focuses on health seeking behaviour of migrant and mobile population. It discusses types of health facilities and service provision and perceptions of such health services. It then specifically provides insights into health seeking behaviour regarding condoms and condom use, HIV testing and STIs.

8.2 Type of health facilities

Walvis Bay has several hospitals, health centres, clinics and pharmacies open for use to the public. Walvis Bay has seven public and five private health facilities, as well as eight workplace health facilities. This gives a total of 20 health facilities. Table 16 lists all facilities available to the public, excluding numerous private pharmacies. Participants of this survey mostly make use of public facilities, which were regarded as affordable and easy to reach.

Table 16: Health facilities available in Walvis Bay

<table>
<thead>
<tr>
<th>Public Health Facility</th>
<th>Private Health Facility</th>
<th>Workplace Health Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Narraville Clinic</td>
<td>2. Welwitchia Hospital Immunization Clinic</td>
<td>2. NamPort Health Centre</td>
</tr>
<tr>
<td>5. Coastal Clinic</td>
<td>5. Erongo Imaging Clinic</td>
<td>5. Hangana Seafood Clinic</td>
</tr>
<tr>
<td>6. Walvis Bay Prison Clinic</td>
<td></td>
<td>6. Eatle Clinic</td>
</tr>
<tr>
<td>7. Walvis Bay District Hospital</td>
<td></td>
<td>7. Merlus Clinic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8. Gendor Clinic</td>
</tr>
</tbody>
</table>

All workplace health facilities are located within the harbour area and only accessible to workers of those firms, which are mostly fishing factories. Most of the private health facilities are located within the more affluent suburbs of Walvis Bay, called Meersig, with one private outlet located in Kuisebmund. There are also a clinic and a health centre in Kuisebmund and a clinic in Naraville, the two main less affluent neighbourhoods. The more affluent neighbourhood with a smaller population has three times more health facilities than the
two less affluent neighbourhoods combined, including the public hospital. The map on the following page shows the distribution and type of health facility across Walvis Bay.

There are also 19 non–governmental organisations (NGOs) and faith–based organisations (FBOs) that complement the services provided by government and the private sector, especially in the fields of HIV and AIDS, STIs, TB and reproductive health. The following NGOs and FBOs are active in Walvis Bay, while only a few has actual offices in town:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>NAPPA</td>
<td>2.</td>
</tr>
<tr>
<td>19.</td>
<td>King’s Daughters</td>
<td>20.</td>
</tr>
</tbody>
</table>
A wide range of health services are provided in both public and private sectors. Referrals are made to facilities in Windhoek or South Africa in cases when specialised services are unavailable in Walvis Bay. Private health care is unaffordable to more than 80 percent of the population. Monthly instalments for private health insurance range from N$2,000 and above. Many cannot afford this, especially with the reported high unemployment rates in Namibia, but more specifically Walvis Bay. Public health facilities are regarded as affordable by all FGD participants of this study at N$4 for a visit to the clinic, N$8 to a health facility and N$15 to the hospital. Vulnerable populations, such as OVC, San and pensioners are provided with health services free of charge. Foreigners are expected to be more than nationals at public facilities, but they mostly pay the same at private facilities. Workplace health facilities enhance access to service, but they are limited in their scope.

8.3 Perceptions of health facilities in Walvis Bay

The public, private, workplace, NGOs and FBOs health service providers complement one another well and provide a wide range of services, including both primary and secondary health care. Respondents were asked what types of health facilities they would use if they are to fall ill. Slightly over two thirds (77.5) of the study population would go to the public hospital or clinic, 18.3 percent to a private clinic/hospital/doctor, 1.8 percent would use the WBCG Wellness Centre, 0.3 percent would use the private clinic at work, while another 0.3 percent would purchase medicine from a pharmacy. About one quarter of the sedentary population, local seafarers and MSM would go to private facilities. Only one out of ten of the migrants would use private facilities. This is the case because migrants are generally less settled in and do not have as highly paid jobs as the sedentary population.
Two thirds of the respondents (62.7 percent) were happy with the health services in town. Close to half (45.9 percent) rated health services as good, while 16.8 percent rated it as excellent. Only 8.7 percent rated it as bad/weak, while 19.7 percent rated it as between good and bad and 8.7 percent did not know. MSM and the sedentary population were more likely to rate the services as weak, while truck drivers and seafarers were least likely to rate it as weak. More than half (55.8) of the sex workers rated health service as good, while 18.6 rated it as excellent. Only 7 percent of sex workers rated it as bad/weak. Challenges are experienced by all these service providers in their pursuit to provide a good service to the public. Some of the key challenges experienced by patients, according to different sub-populations included:

**Sedentary population**

**Operating hours of all health facilities:** Most private, public and non–governmental health clinics, health centres and offices normally operate from 08h00 to 17h00. Most sedentary and migrant FGD participants felt that this timeframe inhabited visits, especially for employed
patients as they work from 08h00–17h00. A few participants did not have problems with operating hours.

Waiting time: Waiting time in queues to be attended to by health personnel at public facilities was regarded as too long mainly because public facilities were overloaded with high numbers of patients and insufficient numbers of medical personnel and medical equipment. This was not regarded as a concern at private and non–governmental facilities.

Attitude of health personnel: The sedentary FGD female participants noted that public health nurses were ‘extremely’ rude. Issues were also raised about stigmatisation towards those infected with HIV. Some nurses were said to be openly rude towards patients in the ART clinics. Concerns were also raised about negative attitudes towards sex workers, although sex workers reported that nurses’ attitudes towards them have changed for the better over time, especially since they are now known to nurses. Attitudes of nurses at non–governmental facilities were perceived as much better, especially by sex workers, MSM and transgendered males. I visited my cousin in the public hospital some time ago. I heard a very old man calling for the nurse with his frail voice. He complained about the intense pain he had in his leg. I thought that the nurse on duty did not hear him, so I called her to attend to the old man. The nurse answered me, saying that the old man was lying and only looking for attention. I could not believe the nerve of this nurse. She went on and said that she was very tired and did not have time for nonsense." Female sedentary FGD participant.

Communication: Communication, especially at the ART clinics was regarded as problematic with foreign doctors who cannot speak English or who have different accents that are difficult to understand by patients. FGD participants noted that foreign doctors make use of nurses to translate, but this has resulted in perceived wrong diagnosis and misunderstandings. Most of the health personnel at private and non–governmental facilities were easy to understand. No translations were needed at these facilities, most of the time.

Perceived limited of involvement of churches in the overall HIV and AIDS response came up many times during discussions. Participants felt that churches have an important role to play
in preventing further infections and helping to take care of those who are ill.

**Sex workers**

Challenges by male and female sex workers are similar, although transgendered males reported to have experienced a bit more discrimination because of who they are – transgendered. It should be noted that sex workers felt that the treatment received by health professionals have improved over time, especially as some health workers know them or have become accustomed to them. It should also be noted again that only 7.0 percent of sex workers felt that health service provision to them was bad/weak, while two-thirds felt that it was excellent and good. The challenges below are mostly directed to public health facilities, as all sex workers make use of public facilities most of the time.

**Operating hours:** Health facility operating hours is not necessarily a concern to sex workers, as sex worker operating hours are mostly between 10h00 to 05h00.

**Waiting time:** Similar challenges to those voiced by sedentary and migrant population FGD participants.

**Privacy:** Health facilities are constructed in such a manner that consultation rooms provide privacy. However, the reported lack of respect that some nurses have for sex workers has resulted in them discussing sex workers’ health problems in the corridors with other nurses, but where other patients can also hear.

**Confidentiality:** Sex workers noted that confidentiality was ‘extremely poor’. They reported that some nurses will even discuss their private health issues with them in public at shebeens when different people are there to drink (including the nurse). One sex worker gave the example of when he had an STI, visited the clinic and was attended to by a nurse. The nurses then lashed out at him at a shebeen about his STI.
Attitude: Sex workers reported that nurses were in general mean to them. They noted that not all public facility nurses were the same and that the situation has changed for the better, but that they were still treated in unfair and rude manners. One sex worker said, “When nurses notice that a sex worker is in a queue awaiting help, nurses would on purpose delay in attending to us and will either go on a break or attend to other patients. A transgendered sex worker noted that, “Some of them [nurses] will even humiliate you and talk about your illness in front of you with their colleagues. I had one nurse who asked me why do you have sex ‘there’ pointing to my anus and not ‘there’ pointing to the vagina area, knowing fully that I’m a transgendered person”. Sometimes nurses will automatically send sex workers to the HAART clinic even for general illnesses. Sex workers noted that the attitude of doctors at public facilities were professional and non-discriminatory.

Sex workers noted that they were treated much better at NGO facilities such as WBCG, NSF and NAPPA and other NGOs. NGO facilities were regarded as sex worker friendly, but concerns were raised about their limited service provision in the fields of HIV, STIs and family planning.

Some MSM felt that the lack of male sex workers contribute towards their perceived unfair treatment, as male nurses would treat female sex workers better, while MSM would be more comfortable being attended to by male nurses, instead of female nurses.

Knowledge of health personnel: Sex workers reported that health workers were knowledgeable, but they were challenged by lack of quality medicine for illnesses. Many distribute Panado pills for too many different illnesses, because of the perceived lack of other medicine.

Availability of information about HIV and AIDS and STIs: This was regarded as sufficient by FGD participants. Sex workers felt that government and NGOs were doing very well with the distribution of information and educating the public in general, and sex workers more specifically.
Truck drivers

Truck drivers, who participated in the study, could not informatively speak of HIV and AIDS and health facilities in Namibia. Two truck drivers were asked about health services during the qualitative study: one never had the need for them, while the other did visit a public health facility in Walvis Bay. The one truck driver who visited a health facility was very impressed with the infrastructure, but not the long waiting time for service provision.

Truck drivers were mainly concerned about not having access to information about HIV and AIDS and available health services, but more specifically Walvis Bay. They reported that their employers did not provide any information about HIV and AIDS and health facilities in Namibia to them. They normally learn about HIV and AIDS, accidentally, by listening to local radio services while driving through Namibia. Language was not a concern as most of them could understand and speak English, and in the case of South Africans, many could speak Afrikaans. However, some truck drivers knew of the WBCG as an organisation that provides information about HIV and AIDS. Truck drivers also spoke of the distribution of condoms are border posts in Namibia.

Local seafarers

Local seafarers who participated in the survey were aware of the following available service: HIV information, education, condom distribution, counselling and testing. However, 70.2 percent felt that they did not have adequate information to HIV and AIDS. They were aware of public and private health services, as well as NGO such as the WBMPC and workplace clinics that provide health services. Two thirds of them felt that health service provision in Walvis Bay was excellent (8.5 percent) and good (63.8 percent). Only 4.3 percent felt that it was bad/weak. They felt that the services were sufficient and effective at non—governmental and workplace facilities. However, they felt that the number of nurses available to seafarers on dock was insufficient, especially when boats docked and all seafarers needed medical check—ups. During this time, nurses were reported to be extremely overloaded. Some local
seafarers complained that there have not been any condoms on boats for the past six years, although condoms are available at workplace clinics at the port.

Local seafarers regularly receive medical check-ups (every six months) by fishing factory health personnel to ascertain their medical fitness. These medical check-ups do not include HIV and AIDS tests. A medical doctor is also available on the vessel while out at sea to attend to illnesses. Sea vessels are normally taken to the nearest port when illnesses are serious and cannot be attended to on ships. There are also nurses available 24 hours a day on shore for support. Nurses on shore normally refer local seafarers to public facilities when they cannot treat certain illnesses.

Local seafarers voiced their opinions about public health facilities as well. Although they were happy with the general service provision at public health facilities, they were concerned about lack of confidentiality and the complacent attitude of some nurses. One seafarer reported that, “One time I visited the clinic, I complained to the nurse about something that I was unhappy about, but the nurse just laughed it off”.

**Foreign seafarers**

Foreign seafarers normally do no spend much time at Walvis Bay Port or in Walvis Bay and do not normally use health facilities in Walvis Bay. They have qualified doctors on vessels that are available 24 hours a day. Foreign seafarers normally use doctors in their countries of origin for other illnesses. As a result they have very little knowledge of health facilities in Walvis Bay. Foreign seafarers were happy with the services available to boats and in their countries.

They seemed to have little knowledge of the HIV and AIDS situation in Walvis Bay as they are not informed in their countries, while language barriers prohibit them to learn about it while they are in Namibia. When they get off boats to visit Walvis Bay, most only have ‘sex’ on their minds and not other issues.
There is a seafarer’s club called Mission for Seafarers where all foreign seafarers come together to socialise. Sessions on HIV and AIDS is offered by this club. The club also distribute condoms.

8.4 Need for other health services

Most participants felt that the required services in Walvis Bay as it relate to HIV and AIDS are available to the public. They felt that government, private sector and NGOs were already implementing many different strategies to respond to the various challenges posed by HIV and AIDS. However, 44.9 percent felt that they did not have adequate information regarding STIs and HIV and AIDS. Of concern was the 70.2 percent of local seafarers who felt that they did not have adequate information about STIs, HIV and AIDS. High proportions of migrant and sedentary population respondents were also concerned that they did not have adequate information on STIs, HIV and AIDS.

**Figure 35: Adequate information on STIs, HIV and AIDS (percent)**

![Figure 35: Adequate information on STIs, HIV and AIDS (percent)](image)

“*The efforts from different stakeholders have been tremendous in availing different types of resources for people to have access to condoms and to know how to use condoms. There is no one who can say they do not know what a condoms is, why it is needed and how to use it. It all depends on the choices that an individual make. Like the saying goes, “You can lead a horse to the waterhole, but you cannot make it drink.”*” Key Informant.
FGD participants and IDIs preferred that organisations continue to do the same, as per the main recommendations below.

Continue with the HIV and AIDS and STI awareness campaigns
- Voluntary HIV testing and counselling should be expanded to take place at bars and clubs
- Parents need to become more involved in their children’s lives – education needs to start at home
- More house visits need to be done by HIV and AIDS support groups
- Keep some health facilities open for 24 hours a day, seven days a week
- Find ways to shorten queues at public facilities
- Need churches to become more involved in HIV and AIDS responses
- Provide PEP at all health facilities

8.5 Access to condoms and condom use

Respondents who participated in the quantitative survey were first asked if they used condoms with their most recent sexual partner. Detailed results on condom use with most recent sexual partner were already discussed in Chapter 5 above. However, to recap, respondents were least likely to use condoms with their wives/husbands or cohabiting partner. This is understandable due to the nature of married relationships and the notion of trust and monogamy within such relationships. Responses of condom use with wives/husband or cohabiting partners were mostly 30 percent or lower across the different sub-populations, except for the sedentary population that had slightly more than 30 percent of respondents who used condoms. Condom use during the last sexual act with boyfriends/girlfriends was higher than married couples and even higher with casual partners. Condom use was highest during the last sexual act with a sex worker. Of concern was the low numbers of condom use by local seafarers and MSM when engaged with sex workers. All of the migrants, sedentary population and truck drives reported condom use for those who engaged sex workers. Generally, condom use amongst sex workers during last sexual act seems lower for sex workers in comparison to all other sub-population for all relationship types except married relationships, where they
were higher than truck drivers and local seafarers. Sex worker IDIs were asked if they were concerned about being infected with HIV. Three of the four sex workers felt that they were at risk of HIV infection, but one felt that he was not, because he used condoms all of the time when having sexual intercourse.

Figure 36: Condom use in different sexual relationships with most recent sexual partner during last sexual act (percent)

All the respondents who did not use a condom the last time they had sexual intercourse (as indicated above) were asked during the survey if they ever used a condom in the past. More than two-thirds (78.1 percent) indicated that they have, while 21.9 percent have not. All of the MSM and sex workers have used condoms in the past. Truck drivers were least likely to report never using condoms at 22.7 percent, followed by 27.8 percent local seafarers, 26.7 percent migrants and 21.4 percent sedentary population.

Almost all of the respondents (93.4 percent) were aware of places where condoms can be obtained. All of the sex workers, MSM and local seafarers have this awareness, while more than one—fifth (22.2 percent) of truck drivers, 4.5 percent of migrants and 4.2 percent of the sedentary population did not know. Most of the respondents could access condoms within 15 minutes when needed.
FGD participants and IDIs felt that the general population in Walvis Bay was well aware of the advantages of condoms and how to use them. The challenges with consistent use of condoms included the following: being in a trusting relationship, being under the influence of alcohol or drugs, being coerced or forced, ignorance and preference of having sexual intercourse without a condom.

Respondents noted that condoms can normally be picked up at clubs, bars, service stations, shops, hotels, clinics, hospitals, NGOs (SFH, WBMPC, WBCG), pharmacies and some shebeens. All condoms on the market are commercially available, except for the ‘Smiley’ condom, which is free of charge and provided by government. Prices of condoms range from N$15 to about N$30, although socially marketed condoms are also available at a different price structure. Some condoms can cost around N$120 for flavoured brands, according to one interviewee.

Attitudes towards condoms were:

- Multiple concurrent partnerships
» One quarter (24.5 percent) of the respondents felt that condom use allow one to have more sexual partners. Close to half of the sex workers agreed with the above statement.

» Almost none (3.9 percent) of the respondents felt that having many sexual partners make a ‘real man’.

» Three quarters of all respondents reported that they aim to reduce their number of sexual partners over the next year. The sub-population that was least likely to reduce number of sexual partners was truck drivers.

» A large proportion (83 percent) of respondents intended to have one sexual partner over the next year. The sex worker sub-population was the least likely to report the intent to have one sexual partner, followed by truck drivers and MSM.

> “Yes, I am at risk of HIV infection even though I use condoms all the time. Anything is possible in this type of work. Sometimes I find clients who like rough sex or kinky sex through spanking. If it is hard core and blood is involved in the process, then I can contract it, especially if I have an open wound as well.” Female sex worker.

• Prevention

» Three quarters of the respondents indicated that they use condoms all of the time. Sex workers were the most likely to report use of condoms all of the time, followed by MSM and migrants.

» Two thirds noted that they would use a condom the next time they have sexual intercourse. MSM had the highest intend to use condoms the next time, followed by sex workers and local seafarers.

» Three quarters reported that the use of condoms help improve sexual hygiene.

• Prevention of HIV

> Almost all (96.9 percent) were aware that condom use is not a cure for HIV/AIDS.

> Almost all (93 percent) agreed that condom use can reduce the risk of HIV infection.
Slightly more than two thirds said that condoms provide 100 percent protection from HIV.

Eight out of ten respondents agreed that condoms protect female sexual partners.

- **Pleasure**
  - Close to one quarter (23.8 percent) of the respondents felt that condoms take enjoyment out of sex. Close to half (46.5 percent) of the truck driver respondents agreed with the above, followed by the sedentary population (26.6 percent) and MSM (23.3 percent).
  - One quarter (25.3 percent) noted that they did not like using condoms. More than half of the truck drivers (51.2 percent) agreed with the above, followed by the sedentary population (29.8 percent).

Although percentages of condom use above are reported to be quite high, the challenge lies in consistent use of condoms every time one has sex with a partner. Sex workers’ ability to use condoms every time they have sex is negatively influenced by their social and economic circumstances. Sex worker IDIs noted that some clients prefer not to use condoms and offer more money for such an act. Sex workers claimed that they would have sex with clients without condoms for the following reasons:

- In desperate need of money;
- Want for extra money;
- Complacent, because they are already infected with HIV;
- Partner fools them into not using a condom;
- No condom available at the place where sex is taking place; and
- Male dominance during sex.
8.6 HIV testing

Respondents were asked if they ever had a HIV test, whether they received their test results and reasons for testing. Close to one out of 10 (87.5 percent) respondents noted that they have had a HIV test before, with only 12.5 percent who noted that they have not. High proportions of sub-populations have gone for HIV testing: all sex workers reported to having had a HIV test, followed by 96.7 percent of MSM and 93.6 percent of seafarers. Slightly more than three quarters of migrants had a HIV test, 81.4 percent of truck drivers and 87.9 percent of the sedentary population. Of those that took the test, nine out of ten voluntarily took the test. All (99.4 percent) of the respondents who took the HIV test, received results of their tests.

Figure 38: Ever had a HIV test (percent)

Of the 12.5 percent who have never had a HIV test, eight out of ten noted that they would be interested, 18 percent were not, and two percent did not know. Although all of the MSM and local seafarers noted that they would be interested, slightly less than three quarters (73.9 percent and 73.3 percent) of migrant and sedentary population respectively noted their interest. The rest did not. Half of the 18 percent who were not interested never had sex before, one-fifth reported to only having had sex with one partner, another one-fifth reported to always use a condom while one-tenth were concerned about confidentiality at testing facilities. All of the respondents noted that they knew where to go for a HIV test.

“Sometimes the public ridicule sex workers, but we are probably the most careful ones, because we really try out best to protect ourselves better.” Female sex worker.

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8.7 STIs and health seeking behaviour

Most (92.2 percent) of the respondents have heard of infections that can be passed through sexual intercourse. All of the MSM respondents have heard of such infections; 97.7 percent of sex workers, 93.5 percent of sedentary respondents, 90.6 percent migrants, and lesser local seafarers (89.4 percent) and truck drivers (83.7 percent). Of those interviewed, 95.6 percent reported not having a leakage (genital discharge) in the past year. Most occurrences of genital discharge were reported amongst 16.3 percent of sex workers and 7 percent truck drivers interviewed. Of the 4.4 percent who reported a leakage, one third said that it happened twice in the past year, 8.3 percent said that it happened more than 3 times and 58.3 percent said that it only happened once. Almost all respondents (96.6 percent) reported not to have had a genital ulcer/sore during the past 12 months. Most occurrences of genital ulcers/sores were reported amongst sex workers (7.0 percent) followed by MSM (3.3 percent). Of the 2.6 percent who reported genital ulcers/sores, 60 percent said that it happened once in the past 12 months, 10 percent said twice and 30 percent said more than three times.

“I have never had a STI. But, if I had one I would immediately go to a clinic. It is something that I would not play with, because I witnessed a friend of mine who had an STI, and it was terrible and painful. She had sores all over her genital and an abnormal discharge.” Female sex worker
Most of the migrant and mobile population in Walvis Bay were aware of STI services. Of concern was the high proportion of truck drivers who did not know where to go for STI services. While this could be understood to some extent since they are not from Namibia, it is of concern that approximately two out of ten migrants, local seafarers and sedentary population also did not know where to go for STI treatment.
None of those who had STIs sought treatment immediately when they realised the symptoms. They all took between two to three days between beginning of symptoms and seeking care. STIs have resulted in zero to two work days lost during the past six months.

Research respondents were asked what they did the last time they had a genital discharge or sore. Two thirds (66.7 percent) sought advice and/or medicine from a government clinic or hospital. All of the migrants, local seafarers and MSM used public facilities. Slightly over one third (38.1 percent) sought advice and/or medicine from private pharmacy while 42.9 percent visited a private clinic/hospital. One third of the sedentary population, one quarter of sex workers, 80 percent of the sedentary population and all of the truck drivers went to private facilities. None of the local seafarers and MSM visited private facilities for such treatment. None of the sub-populations interviewed made use of workplace clinics or local church clinics or hospital because there are no church facilities in Walvis Bay. None visited traditional healers, while less than 5 percent sought advice and/or medicine from non-trained medical people or bought capsules/tables on the street. One out of ten who had such infections made use of medicine at home. The last time respondents had a STI their first source of treatment was mostly public health facilities followed by treatment at private facilities, but only for truck drivers and the sedentary population.

Figure 41: First source of treatment for STI during last infection
Seventy-six percent of those infected stopped having sex during the time when they had the symptoms. Of those, only half of the sex workers and half of the MSM stopped having sex when they had the symptoms. Only half of the MSM and 62.5 percent of sex workers always used condoms when having sex during the time they had symptoms. All of the local seafarers and migrants wore condoms all the time, but only 80 percent of sedentary respondents did the same. Not many told their sexual partners about these STIs. None of the truck drivers, but all of the local seafarers told their sexual partners.
9. CONCLUSIONS

9.1 Introduction

This chapter provides a summary of the main findings and conclusions for each. It aims to respond to key research questions regarding vulnerability of migrant and mobile populations in Walvis Bay.

9.2 Migration and mobility dynamics and employment

Key question: Who are the different migrant and mobile population groups of Walvis Bay, where are they from, how long have they lived here, how mobile are they, what are they doing here, what are their levels of education and employment and how do the above influence vulnerability to HIV and AIDS?

Summary: The population of Walvis Bay mostly resides within Walvis Bay and do not regularly move in and out of Walvis Bay except for two sub-population groups: truck drivers and foreign seafarers. Most people who moved to Walvis Bay have eventually stayed and lived here for more than 15 years. Most of those who moved to Walvis Bay for various reasons in the past, have actually made Walvis Bay their home. Most people originally came to Walvis Bay for employment purposes, especially employment within the fishing sector, public sector and businesses and retailers that primarily provide services to the fishing sector or those working within the fishing sector. The economy of Walvis Bay is primarily driven by the lucrative fishing sector. Walvis Bay is considered to be one of the busiest ports in Southern Africa, and currently undergoing an infrastructural expansion based on current demands.

The sedentary population is the largest population group and have all lived here for more than 10 years, with the majority having lived here for more than 15 years. This is followed by migrants who have lived here between 3 months
and 10 years. Migrants and the sedentary population include unemployed people, formally and informally employed people by various sectors, sex workers, local fishermen and MSM.

Foreign fishermen and truck drivers normally visit Walvis Bay for short periods of time, for business purposes only. Their duration of stay depends on several factors, but their stays normally range from a couple of nights to three weeks. International truck drivers seem to visit Walvis Bay one to three times a month, depending on which country they are from. Local truck drivers visit Walvis Bay up to 12 times a month. Limited numbers of male and female sex workers, who live in Swakopmund and Windhoek move to Walvis Bay for short periods of time on a regular basis when ships come in and the demand for sex is increased.

Most of the study population was Namibian (89.3 percent), followed by South African, Zambian, Zimbabwean, Congolese, Angolan and Malawian. However, Walvis Bay is also visited by foreign seafarers from Spain, Russia, China, Australia and Philippine. Truck drivers are also from other countries such as Tanzania and Botswana. From within Namibia most (89.3 percent) residents of Walvis Bay were from the four north central regions, followed by Erongo and Komas regions.

The overall study population is fairly evenly divided by male and female, but huge differences were found amongst key populations. Local and foreign seafarers were all male, truck drivers were all male, sex workers were mostly female, while MSM were male and transgendered male.

The age structure is similar to other urban settings with most people falling within the productive age cohort, between 20 and 39. This is unfortunately also the same age cohorts that have high HIV prevalence rates. Almost all have
attended school, with fairly high proportion attending secondary schooling, but not many have completed it. Migrants, sedentary and truck drivers were more likely to have gone further than secondary schooling in comparison to the other groups.

Most of the study population have worked in Walvis Bay for more than two years, meaning that people residing in Walvis Bay are settled in, and here to stay. Interestingly, the highest proportion of those who worked here for more than two years were local seafarers, sedentary and sex workers. Most the study population work in the fishing sector, followed by the trucking industry and the service industry, which is closely linked to harbour activities. One-tenth was employed in the public sector.

**Conclusion:** Regular movement of people in and out of Walvis Bay is limited to truck drivers and foreign seafarers, and to a limited extent sex workers, MSM and national and international business men. Local seafarers and sex workers have mostly settled and lived in Walvis Bay for numerous years. The sedentary population which is the largest proportion, which include public and private sector employees, have lived in Walvis Bay for more than 10 years, with a large proportion having been here more than 15 years. Even many of the sex workers and MSM have settled in Walvis Bay. The short-term movement of people are therefore limited to truck drivers and foreign seafarers who travel here regularly and stay for 1 to 21 days at a time.

The time duration for stay overs in Walvis Bay, coupled with the time duration that foreign seafarers and truck drivers have been travelling to get to Walvis Bay port, takes them away from their homes for long periods of time. Being away from home for such long periods of time, coupled with limited recreational activities in Walvis Bay, loneliness, and not knowing anyone provides enhanced opportunities to engage in sexual relationships with local
people and/or sex workers. Due to regularly travelling the same routes, some have even engaged in regular sexual partnerships away from home. The nature of their work therefore increases their vulnerability to HIV infections.

Most of the foreign truck drivers and foreign seafarers are from countries with very low HIV prevalence rates, some of which are not even considered a HIV epidemic. These countries include European and Asian countries, but also some African countries such as Tanzania. Foreign truck drivers and foreign seafarers therefore move regularly from countries with low HIV prevalence to Namibia were close to one out of five adults are HIV positive. Some of the truck drivers and most of the foreign seafarers come from very far, travelling through several countries and numerous cities, towns and villages to reach the port of Walvis Bay. If truck drivers travel from Dar es Salaam to Walvis Bay, then they move through countries such as Zambia and maybe Zimbabwe that has higher HIV prevalence rates. Some of the cities that they would be travelling through, such as Lusaka are considered hotspots. They are therefore very likely to engage with people who are infected. Being from another country and travelling through numerous cities, towns and village provides the opportunity for social interaction with a wide range of people. The same with foreign seafarers who may stop over at various ports before reaching Walvis Bay. This social interaction is likely to turn into sexual interactions that connect countries of origin of truck drivers and foreign seafarers, with cities, towns and villages in countries in transit and cities, towns and villages in Namibia, the end destination. Their movements therefore influence HIV infections not only in Namibia, but in transit countries, towns, cities and villages and in their own countries of origin.

Unemployment amongst the study population was found to be extremely high, with 49 percent being unemployed. This is much higher than the
national average of 27 percent. Unemployment and high levels of poverty were regarded as two of the main contributing factors to sex work.

Although Walvis Bay has experienced a decrease in overall adult HIV prevalence, concerns are flagging due to the age structure of the population. Most of the people are within the age cohorts with high HIV prevalence rates, while the rates are even increasing for some. In 2012, it was found that the adult HIV prevalence for the 35–39 year olds was 35 percent and 29 percent for the 30–34 year olds. One out of five of the 25–29 year olds were HIV positive. These are very high rates. It has decreased significantly for the 15–24 year olds though.

9.3 Knowledge, opinions and attitudes towards HIV and AIDS

Key questions: What are the current levels of HIV and AIDS knowledge, opinions and attitudes of migrant and mobile populations and how does that influence vulnerability of migrant and mobile populations?

Summary: The overall decrease of the HIV adult prevalence in Walvis Bay over the years is evidence that positive changes are being made to levels of knowledge, opinions and attitudes amongst Walvis Bay residence. The overall knowledge of HIV prevention was high, attitudes towards PLWHIV were overall positive, misconceptions about HIV and AIDS were low and levels of knowledge about MTCT were fair.

The sampled population’s knowledge of HIV prevention was higher than that of urban dwellers interviewed during the latest NDHS in 2006/7. This shows that the sampled population in Walvis Bay have learned more about HIV and AIDS over the years and have applied it to various degrees based on the stabilisation of the adult HIV prevalence rate. Knowledge amongst different sub–populations differed slightly as follows:
• Sex workers, local seafarers and MSM had slightly higher levels of knowledge of consistent condom use compared with migrant and sedentary population. **Truck drivers were the least knowledgeable about consistent condom use as a HIV preventative measure.**

• Sex workers, truck drivers and local seafarers were more knowledgeable of abstinence as a preventative measure than migrants, MSM and sedentary population.

• Migrants, sedentary and local seafarers mentioned one faithful sexual partner as a preventative measure more than MSM, sex workers and truck drivers.

Overall, it seems that sex workers and local seafarers are most knowledgeable about preventative measures, while **truck drivers and foreign seafarers were the least knowledgeable.** This increased knowledge (compared with the NDHS or urban populations) seemed to have had some positive effect on the behaviour of the Walvis Bay population since the prevalence of those 15–49 years olds have decreased from a high of 29 percent in 1998 to 17.2 percent in 2012.

Most of the research participants have known of someone who has HIV or died of AIDS, while high proportions have had a relative who is HIV positive or died. Actually, between two-thirds and 100 percent knew of someone or a relative who had HIV or died of AIDS. Knowing someone who has HIV or who died of AIDS has had a positive effect on many clients seeking sex work, according to sex worker interviewees. This made clients of sex workers more careful about requiring unprotected sex, according to some sex worker respondents.

There were low levels of misconceptions about HIV and AIDS amongst the
sampled population, although it was worrisome that close to one out ten thought that a healthy looking person cannot be infected with HIV. Combining knowledge about prevention and knowledge of misconceptions about HIV is regarded as a good indicator for comprehensive knowledge of HIV and AIDS. The sampled population had high levels of knowledge about prevention methods and low levels of misconception. The conclusion is that the sampled population has high levels of comprehensive knowledge of HIV and AIDS.

Overall knowledge of HIV transmission of mother to child through various forms was on average around 80 percent, which should be regarded as low. Not many (one third) knew of PMTCT, which should be regarded as low as well. The majority of the sampled population reported positive attitudes toward PLWHIV, although concerns were raised about high percentages of respondents who preferred to keep it a secret if someone was infected with HIV. MSM and sex workers were more likely to be positive towards PLWHIV while migrants were least likely to be positive.

Respondents had lower levels of knowledge about MTCT and PMTCT. Close to three quarters were aware that HIV can be transmitted from mother to child via child birth, while eight out of ten know of transmission via breastfeeding. Of concern was that less than half of the truck driver respondents were aware of MTCT via child birth. High proportions were aware of PMTCT.

The majority of the sampled population had positive attitudes towards PLWHIV in relation to HIV positive students attending school, HIV positive teachers teaching in schools, and taking care of a family member who is ill with AIDS. However, much lower proportions of the study population would want others to know of an AIDS related ill family member or of their own AIDS related illnesses. Generally, MSM had more positive attitudes towards PLWHIV, followed by sex workers and local seafarers. MSM and sex workers have had
more experience with PLWHIV, as a few of them are infected themselves.

**Conclusion:** The different population groups within Walvis Bay are well informed about the three main preventive measures and misconceptions, meaning that they have high levels of comprehensive knowledge about HIV. This is a result of the numerous awareness campaigns, coupled with personal experiences of people knowing someone who has HIV or has died of AIDS. However, there are concerns about some aspects of knowledge amongst truck drivers and foreign seafarers, especially about the use of consistent condom use as a preventative measure amongst truck drivers. Foreign seafarers and truck drivers reported that they receive little information about the HIV and AIDS situation in Walvis Bay, although they knew about the situation in the country. Lack of knowledge about HIV in Walvis Bay by foreign travellers may negative influence condom use during sexual acts in Walvis Bay. One of the preventative measures that need attention is PMTCT, as only one third of the study population were aware of it. Their attitudes toward PLWHIV were also very positive, except for not wanting others to know family members’ or own HIV and AIDS status.

### 9.4 Sexual behaviour

**Key question:** *How does sexual behaviour of migrants and mobile populations influence vulnerability to HIV and AIDS?*

**Summary:** Most of the sampled population were reported to be single, with migrants, sex workers and MSM more likely to be single in comparison to local seafarers, truck drivers and the sedentary population. Truck drivers were actually more likely to be married than not. Five of the 43 sex workers were married, while practising sex work, although one of the five was in the process of quitting sex work. None of the MSM was married as it is illegal in Namibia for same sex people to get married. About one out of ten people were cohabiting.
Almost all of the respondents had sexual intercourse in the past. The mean age of sexual debut was 18 years of age. Of concern were several reported cases of sexual debut at much younger ages. The youngest was six followed by eight years of age. Many also reported to have had first sexual intercourse at the ages of 12, 13, 14 and 15. The early sexual debut is of great concern, because 43 percent of MSM had first debut when they were 15 years of age or; similarly with 31.9 percent of local seafarers, 27.9 percent of sex workers, 18.6 percent of truck drivers and 10.9 percent of migrant and sedentary population. Thirty percent of the sedentary and migrant population were 18 years and younger when they first had sexual intercourse.

Multiple sexual partnerships amongst the sampled population occurred amongst one third of the respondents, which should be considered as high, especially since HIV infection rate amongst the reproductive age groups were high as well. Extremely high proportions of multiple concurrent sexual partnerships occurred amongst sex workers, MSM and truck drivers. Lesser proportions of local seafarers engaged in multiple sexual partnerships in the past 12 months of the interviews. The sedentary population had the lowest proportions followed by migrants. However, this should be taken with caution as high number of sedentary and migrant respondents did not want to respond to the question about ‘other’ sexual partners. Concurrent sexual partnership was found to be very high for sex workers, MSM, high for truck drivers and local seafarers and lower for the sedentary and migrant population.

**Regular partnerships**

Of the 383 respondents, 26.9 percent was married, while 13.3 percent were cohabiting. Slightly more than one-third had sex with someone who was not their regular partner. Much higher percentages of sex workers, truck drivers and MSM had sex with someone other than their regular partner. Almost all
sex workers have done this due to the nature of their work. The same with MSM as some of them are also sex workers. The sedentary and migrant population were not likely to have sexual intercourse with someone other than their regular sexual partner. Of interest, the sedentary and migrant population had more sexual intercourse with their spouses and regular partners than the other survey sub-populations, mainly because other sub-populations were more likely to have other sexual partners outside of marriage or cohabitation.

One truck driver noted that there was a misconception that all truck drivers have sex with sex workers, and that this was not the case. Of the 23 truck drivers who were married, 23.8 percent had engaged commercial sex over a 12 months period. The proportion for local seafarers was much smaller at less than 10 percent.

Condom use amongst regular partners was low at less than one third of the sampled population and even lower for truck drivers. Condom use was mostly a joint decision or initiated by the respondent. Trusting each other was one of the main factors for not using condoms with this regular relationship.

**Boyfriends/Girlfriends**

Close to half of the respondents engaged in boyfriend/girlfriend relationships. Age range of boyfriends and girlfriends were normal taking the age range of the sampled population into consideration. However, it was a concern that four percent of the boyfriends and girlfriends were younger than 18 years of age.

All had sexual intercourse with their boyfriends/girlfriends over the past 12 months, while most reported to have had only one boyfriend/girlfriend. All sub-populations had some respondents who reported to have two
boyfriends/girlfriends, while only MSM and truck drivers reported to have three to six boyfriends/girlfriends (concurrency) over a 12 months period prior to the survey. The main concern lies with MSM and local seafarers with extremely high numbers engaging casual partners at the same time as having boyfriends/girlfriends. Concurrency was therefore found to be very high. Of interest, commercial sexual activity was slightly higher amongst this group than with the spouse/cohabitating group above.

Overall low numbers of respondents received something in exchange for sex from their boyfriends/girlfriends except for sex workers and MSM. The exchange was in the form of money for sex workers and MSM and food and clothes for migrants. This shows possible transactional sex taking place.

Condom use was regarded as low at three quarters overall, although it was higher for MSM and migrants. Very worrying was that more than half of the sex workers did not use condoms the last time they had sex with their boyfriends/girlfriends.

**Casual partnerships**

Less than one in five respondents had casual partners. Most of the casual partners were between the ages 19–29 years of age. The average number of casual partners across all groups was three over the past twelve months, although some had up to 29 partners. All had sexual intercourse with their casual partners in the past twelve months.

Low numbers of migrants, truck drivers and sedentary populations engaged in casual sex. Of concern was that close to two thirds of MSM engaged in casual sex. Slightly higher proportions of seafarers and sex worker engaged in casual sex, with sex workers being more.
None of the migrant and sedentary population who engaged in casual sex also engaged in commercial sex. But this was not the same for the other population groups. Actually, all sex workers, and three out of nine local seafarers, six out of nineteen MSM who had casual sexual partnerships also had commercial sexual partnerships with the lines between casual partners and sex worker partners being blurred sometimes. Close to half of the sex workers’ casual partners gave them something in return for sex the last they had sexual intercourse. One out of ten casual partners and seafarers also exchanged something for sex with their last casual partner.

Most reported to use condoms with casual partners. It was mostly respondents who suggested condom use. Of those who used condoms, eight out of ten said that they always use condoms with casual partnerships.

Sex work partnerships

Much lower numbers of people engage in commercial sex work as initially anticipated. Extremely low numbers of migrant and sedentary population respondents reported engagement with sex workers. There are some migrants and sedentary respondents that seemed to engage in transactional sex for food and clothes, but it was difficult to determine actual numbers. Low numbers of local seafarers (12.6 percent) and truck drivers (16.3 percent) participated in sex work. However, one out of three MSM engaged in sex work, with respondents being the ones that normally received payment as they are male sex workers as well. All of the sex workers engaged in sex work over the last 30 days, except for one who is trying to stop being involved with sex work. The number of sex work acts ranged from zero to 30 over the last 30 days before the interview, with MSM and sex workers having the highest numbers of sexual acts. Local seafarers and truck drivers reported up to six sex work acts over a 30 day period before the interview. Migrants and
sedentary only had between one and two incidences.

Respondents preferred younger sex workers, while clients were normally older. Almost all of the sex workers used condoms. Sex workers normally suggest condom use in more than half of the sex acts. The main reason for not using condoms was that clients preferred not to use condoms and paid more for it. Some also noted unavailability of condoms.

**Conclusions:** Of great concern is the young age of sexual debut and reported sexual abuse at young age. The mean age for sexual debut was 18 years of age, but some respondents had their first sexual experience when they were as young as 6, 8, 12, 13, 14 and 15. Vulnerability to STIs, including HIV and AIDS at this age is extremely high, because sex is sometimes forced, certainly not consensual and condoms are very likely not to be used, because of the circumstances under which sex at this age takes place.

The above shows that multiple concurrancies are high amongst those sub–populations who are mobile (truck drivers and seafarers) and those who engage in sex work (male and female) and MSM. It also shows that sex work is mostly done with mobile populations (truck drivers and seafarers) and not so much with the migrant and sedentary population, although it does take place. Sex workers are especially interested in foreign seafarers, because they have money, but will also have sex with local seafarers, especially when the demand for sex is low. Vulnerability of HIV infection amongst the above mentioned groups are therefore much higher, than for the migrant and sedentary population. This conclusion should be cautioned, because a high percentage of migrant and sedentary respondents did not want to respond to the question of sex outside of marriage.

High levels of multiple concurrancies, combined with low levels of consistent
condom use increased vulnerability to STIs, including HIV. Generally, the sampled population had extremely low levels of consistent condom use with spouses and cohabitating partners. The levels of consistent condom use increased amongst boyfriends and girlfriends, and increased even more amongst casual partners and sex work partners. Reported consistent condom use was high during the more at risk sexual relations. However, of concern though was the extremely low level of consistent condom use by sex workers, MSM, truck drivers and local seafarers with their regular partners, as they were more likely to engage in multiple concurrent partnerships with boyfriends/girlfriends, casual partners and sex work partners.

9.5 Nature of sex work

Key question: What is the nature of sex work in Walvis Bay and how does this influence vulnerability of migrants and mobile populations.

Summary: The sex work industry in Walvis Bay was regarded as ‘big’. There are approximately 530 sex workers operating in Walvis Bay, with most being resident in Walvis Bay. Limited numbers of the sex workers who operate in Walvis Bay live in Swakopmund and Windhoek, but most have settled in Walvis Bay, with some having lived there for more than 10 years. Sex workers in Walvis Bay are a heterogeneous group of people; a result of the sexual demands of clients. Most of the sex workers are females selling sex to male clients, followed by male sex workers selling sex to homosexual males and in some cases to heterosexual males, transgendered males selling mostly to heterosexual males, males selling to females and females selling to females.

The average age of sex workers were found to be on average between 18 and 39 years of age across the different types of sex workers, with an alarming number of sex workers being reported to be 14 and 15 years of age and younger in some instances.
There are different types of sex workers within each of the categories mentioned above, with different levels of vulnerability based on the type of sex worker one is. The lower class sex workers seem to be more vulnerable in comparison to the higher class sex worker because of the environment in which sex work takes place and the types of clients engaged. Higher class sex workers tend to have more regular partners and more consistent condom use than lower class sex workers. Lower class sex workers are also more vulnerable to abuse because they have sex behind shebeens, cars, behind shops and public parks.

The lines between different types of sex workers sometimes become blurred depending on demand. Middle class sex workers sometimes become low class sex workers, and low class sex workers sometimes become shebeen ladies. This means that the clients are exposed to different types of sex workers even if they choose one type to have sex with. This increases vulnerability, because vulnerability increases with lower levels of sex workers.

Of great concern were the very young boys and girls who engaged in sex work. Of greater concern was the finding that some parents/guardians use young girls to sell their bodies for financial gain to the parent. Concerns were also raised of young boys who sell themselves to other men for niceties, such as expensive clothes, cell phones, etc.

Payment towards sex work in Walvis Bay differed depending on the type of sex worker. The range of payment varies from N$20 or a beer to N$1,000 per act on average. The high class sex workers are sometimes paid for a duration, instead of an act and can earn as much as N$3,000 for a couple of days. The earnings were much more than other places such as Oshikango where sex workers get N$51 and N$150 per act (NASOMA Study, 2008). A significant proportion of low class sex workers and shebeen ladies received payment in
other forms as well, such as alcohol or in some cases drugs. Earnings from sex work allow sex workers to make a living and in some cases support family members, but insufficient to safe. However, earnings were regarded as more than what a sex worker would earn if employed elsewhere mainly due to their school qualifications and lack of professional work experience.

The clients of female sex workers, and to a lesser extent male sex workers, are international truck drivers from places as far as Democratic Republic of Congo, Tanzania and Malawi, but also from neighbouring South Africa, Botswana, Zambia, Zimbabwe and Angola. Foreign seafarers were mostly from Spain, Russia, China, but also from Netherlands ad Italy. Local clients were said to be mostly Oshiwambo speaking people followed by Otjiherero speaking people. This is in line with them having the highest population proportions according to the last census. Local clients included men of all walks of life including local seafarers, formal and informal business men and regular men. The clients of male sex workers were not different from female sex worker clients.

Sex work takes place across the different suburbs of Walvis Bay, although most sex workers are picked up in the business area close to the harbour and places within Kuisebmund where there are many bars, clubs and shebeens. Sex takes places in various places as well; the higher the class the sex worker the nicer the place where sex takes place. High class sex workers are normally booked into hotels and taken out to restaurants. They are also more likely to be from the Meersig neighbourhood. In some cases, clients are taken to the homes of high class sex workers. Middle class sex workers are more likely to have sex in their own rooms, B&Bs, guesthouses and sometimes in cars. Low class sex workers have sex in trucks, streets, cars and public toilets, while shebeen ladies are more likely to have sex behind shebeens, public toilets
and cars. The above shows that the lower the class of sex worker the more dangerous the location where sex takes place.

Sex work continues to be frowned upon by sex worker families and the general public, although nurses seemed to have become used to them. Sex workers are normally referred to as ‘whore’s and ‘prostitutes’, which carries with it negative connotations. Most sex workers did not like what they were doing, but reported that their financial situation forced them into this trade. Most felt forced and wanted out. There were a few however, especially male sex workers, who enjoyed being sex workers and who would not change it for another form of employment.

Sex workers are discriminated against by their family, the community and representatives of institutional structures. Some of the sex workers, not all, complained about the indifferent manner in which health officials and police officers treat them. Police officers were said to ignore civil and criminal complaints laid by sex workers, while in some cases police are accused of abuse and raping sex workers. Sex workers also suffer abuse by some of their clients. Sex workers themselves verbally and physical abuse each other, in their pursuit to attract clients. Alcohol and drug abuse seem to go together with sex work, as many indicated that they cannot do sex work without having an alcoholic drink first. They have very weak social networks and rely mostly on themselves, followed by family and friends/colleagues.

The legal environment in which sex workers operate does not provide protection against stigma, discrimination and abuse.

**Conclusions:**  Sex workers come from different walks of life. Similarly, their clients are from a wide range of social, economic and cultural backgrounds. Some sex workers willingly do this, others feel forced by their circumstances while
others, especially younger sex workers are forced by their parents/guardians to engage in this trade. Some starts at a young age while others start at a much older age. Some have known only tough times in their lives, while others have known better times, such as being married, having a good home and children who are well taken care off. They are therefore a diverse group of people that bring with them different forms of vulnerabilities.

First of all, they are all highly vulnerable to HIV infection, primarily due to the type of work that they do. Sex work necessitates that sex workers engage different sexual partners around the same time. They are more vulnerable than other sub-population groups because they do not always have the power (due to sex worker/client relations, male/female relations, illegality of the trade and the desperate need for money due to high unemployment and poverty, inability to communicate with foreigners, frequent alcohol and drug abuse) to decide on condom use. They are more vulnerable because they do not always have the power to decide where sex will take place, putting them in danger and compromising their ability to negotiate safe sex. They are more vulnerable, because of inadequate support provided by health facilities and protective services due to their trade. Several reports were made by sex workers of known cases of police brutality towards sex workers, rape of sex workers by the police and incarceration if sex workers refused sex. This leads to increased vulnerability of infection. Their level of vulnerability is also determined by the type of sex worker they are, meaning that the lower the class of sex worker, the higher the vulnerability of HIV infection. Sex workers are also sometimes their worst enemy as they become complacent due to their livelihood. It has been reported that many sex workers who are already infected are complacent about insisting on condom use.

The sexual networks created by sex workers together with their partners
have far reaching consequences for those living in Walvis Bay, those living in other towns in Namibia and those living in other countries. Many of the clients of Walvis Bay sex workers are not from Walvis Bay. They are from other towns within the country and from other countries. Clients of sex workers are from all corners of Namibia, but mostly from the north central regions and the eastern part of the country. They are also from different continents including Asia, Australia, Africa and Europe. Clients are mostly from countries with very low HIV rates, except for some countries in southern Africa, such as Botswana and South Africa. The likelihood of HIV infections to spread from sex workers in Walvis Bay to other towns in Namibia, other towns in Africa and other towns on three different continents is evident. In contrast, the likelihood of HIV infections to spread from other countries via foreign truck drivers and seafarers to towns in Namibia and to Walvis Bay, more specifically, is evident as well.

Sex workers are the highest HIV risk group in Walvis Bay, because of inconsistent use of condoms and multiple concurrent partnerships. The sexual networks created by sex between sex workers and other population groups is extremely wide, enhancing vulnerability of STIs and HIV amongst all sub–populations in Walvis Bay. If sex workers are the highest risk group, then those who engage them are also at high risk if they do not use condoms. These sub–populations include truck drivers, local seafarers and foreign seafarers. Those who are married are at high risk as well, mainly because consistent condom use is extremely low in married and cohabiting relationships.

9.6 Health seeking behaviour

Key questions: What is the health seeking behaviour of migrants and mobile populations, coupled with access to health services in Walvis Bay and how does this influence vulnerability to HIV and AIDS?
Summary: Walvis Bay is blessed with 20 different health facilities: 7 public, 5 private and 8 workplace health facilities, excluding private pharmacies. Most of the study population in Walvis Bay and those visiting Walvis Bay make use of public health facilities. Only 18.3 percent make use of private health facilities, which is in line with other reports on access to private health services, such as the Abt Associates Report. Most of the health facilities are located in the more affluent suburb, Meersig, with three out of the 12 public and private health facilities located in the less affluent but more populated suburbs of Naraville and Kuisebmund. Public and private health care is complemented by about 20 NGOs and FBOs providing HIV, STI, TB and reproductive health support to Walvis Bay residents and visitors, even if most do not have offices in Walvis Bay.

Private health services are unaffordable to most people due to high costs associated with it. Most people therefore use public facilities and services provided by NGOs and FBOs. Most of the sampled population were happy with the health services they received. Less than one out of ten (7.0 percent) sex workers were unhappy. However, a high of 16.7 percent of MSM were unhappy with the health services they receive.

Key challenges that stood out for the sedentary and migrant population were the 08h00–17h00 operating hours, long waiting time, lack of privacy and confidentiality, unfavourable attitude of health workers. Close to half of the sedentary and migrant population felt that they had inadequate information regarding STIs, including HIV and AIDS. Lack of privacy, confidentiality and unfavourable attitude of health workers were concerns raised by sex workers and more so by MSM sex workers and transgendered males. Close to one-third of the sex work respondents felt that they had inadequate information regarding STIs, including HIV and AIDS.
Truck drivers were mainly concerned about not having access to information about HIV and AIDS and available health services in Namibia, but more specifically Walvis Bay. One third of the truck drivers felt that they did not have adequate information to STIs, including HIV and AIDS, mainly because of the lack of information available to them. Employers of trucking companies are not active in relation to HIV and AIDS response initiatives, especially the smaller firms. The same was true for foreign seafarers who indicated that they had little knowledge about HIV and AIDS in Namibia. They were also not well aware of the HIV and AIDS situation and health services in Walvis Bay, but not concerned about this as they receive health services on vessels and in their countries of origin. It was found that some foreign seafarers argue that they are not as risk of HIV infection, since HIV infection rates are very low in their countries of origin.

Local seafarers were generally happy with the health services provided to them, but an extremely high number of 70.2 percent felt that they had inadequate information regarding STIs, including HIV and AIDS.

**Condom use**

Almost all respondents knew where to obtain condoms and could obtain a condom within 15 minutes in times of need. Free, socially marketable and commercial condoms can easily be obtained from various government, non-government and private outlets across Walvis Bay. The challenge with condom use does not seem to be access, but the type of relationship one is in, behaviours of partners and attitudes towards sex and condom use. Consistency were hampered by the following:

- being in a trusting relationship;
- being under the influence of alcohol or drugs;
• being coerced or forced;
• ignorance;
• preference of having sexual intercourse without a condom, due to perception that sex with a condom is less pleasurable;
• commercial condoms were regarded as too expensive, while free condoms were not trusted to protect as it was perceived to break easily; and
• high proportions of respondents felt that condom use allow one to have more sexual partners.

The ability of using condoms was complicated in married and sex worker relationships. Almost all sex workers have had sex with a client without the use of a condom, because of the unequal power relations, alcohol abuse, client forcing sex without a condom, client paying more for sex without a condom or sex worker being complacent because she/he is already infected with HIV. Married partners find it difficult to negotiate condom use even when one partner knows of the infidelity of the other, because the suggestion of condoms use points towards accusing the partner of being unfaithful, or alluding that the one initiating condoms use is unfaithful.

HIV testing

Almost all of the respondents (87.5 percent) have had an HIV test before. Sex workers and MSM were more likely have gone for HIV tests, while they are also the one more likely to engage in risky sexual behaviour. The migrant population were least likely to have gone for an HIV test. All of the respondents new where to go for an HIV test. Of those who were not interested in HIV test, half have never had sex before, one–fifth reported to only have had sex with one partner, another one–fifth reported to always use a condom while one–tenth were concerned about confidentiality at testing facilities.
STIs

Almost all respondents have heard of infections caused by sexual intercourse. Only 4.4 percent of those interviewed had ever had a STI, of which most occurred amongst sex workers, followed by MSM. Of those who had experienced STIs, most reported to experience it only once over the past 12 months. Although most of the survey population knew where to go, of concern was the high numbers of truck drivers who reported that they did not know. In addition, two out of ten migrants, local seafarers and sedentary populations also did not know where to go for STI treatment.

Those who were infected all waited for too long before seeking treatment. The hope is that the problem will go away as people are ashamed of it, resulting in patients not seeking treatment immediately. Most sought treatment from a public health facility, followed by private facilities and pharmacies. None made use of workplace facilities.

Conclusion: The Walvis Bay population that participated in the study were generally happy and very happy with the health service provision. Many indicated that the public, NGO and FBO health service providers have played an active role in informing and educating the public about HIV and AIDS. Qualitative research participants felt that they were very knowledgeable about HIV and AIDS. The knowledge section of the report also showed that research respondents had comprehensive knowledge about HIV and AIDS. However, the quantitative component shows that high proportions (44.9 percent) of the study population were of the opinion that they did not have adequate information about HIV and AIDS. This is a very positive finding, because although research participants actually do have comprehensive knowledge, their appetite for more knowledge about HIV and AIDS is an opportunity to engage them more.
Access to condoms is not necessarily the main challenge as condoms can be obtained within 15 minutes when needed, while most people are well aware on how to use it and of the benefits thereof. Consistent condom use is however influenced by factors that sex partners may not have control over, or by their own risky attitudes, behaviour and actions.

Current and past efforts in Walvis Bay to get people to undertake HIV tests has resulted in most of the respondents having gone for a test. However, more efforts are needed to inform the public of the need for continued HIV tests. Special attention needs to be made with migrants, sedentary and truck drivers who have never gone for a HIV test.

Not many people in Walvis Bay have experienced a STI, while most seemed to be well aware of where to go for STI treatment. It seems that government facilities play an important role in treating STIs, although concerns were raised about lack of privacy and confidentiality by some participants. More awareness is needed in relation where STI services are officer, the importance of seeking medical support immediately and continued awareness on prevention.
APPENDIX A: RESEARCH ETHICAL APPROVAL LETTER

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Ministry of Health and Social Services

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Enquiries: Ms. E.N Shaama
Ref: 17/3/3
Date: 23 January 2014

OFFICE OF THE PERMANENT SECRETARY

Ms. Ruusa Mushimba
Migration Health Project Coordinator
International Organization for Migration (IOM)
38 – 44 Stein Street
Klein Windhoek
Namibia

Dear Ms. Mushimba

Re: Research on Health Vulnerability of Mobile Populations and Affected Communities at Walvis Bay Port of Namibia

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. Kindly be informed that permission to conduct the study has been granted under the following conditions:
   3.1 The data to be collected must only be used for operational purpose;
   3.2 No other data should be collected other than the data stated in the proposal;
   3.3 A quarterly report to be submitted to the Ministry’s Research Unit;
   3.4 Preliminary findings to be submitted upon completion of the study;
   3.5 Final report to be submitted upon completion of the study;
   3.6 Separate permission should be sought from the Ministry for the publication of the findings.

Yours sincerely,

MR. ANDREW NDISHISHI
PERMANENT SECRETARY

"Health for All"


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