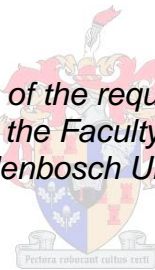


**Factors Influencing the Uptake of HIV Counselling and Testing (HCT) Service: The
Case of the Employees of the Namibian Correctional Service at Elizabeth
Nepemba Correctional Facility.**

by

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*Assignment presented in fulfillment of the requirements for the degree of Master of
Philosophy (HIV/AIDS Management) in the Faculty of Economic and Management Science
at Stellenbosch University*



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March 2013

DECLARATION

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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ABSTRACT

This study explored the factors influencing the HIV counselling and testing (HCT) uptake amongst correctional officers deployed at Elizabeth Nepemba Correctional Facility in Rundu, Namibia. Factors investigated in this study included correctional officers' level of satisfaction with HCT service delivery, their experiences and expectations related to HCT and identify their needs and motives behind HCT utilization.

A sample of 50 participants was targeted to participate in this survey through the completion of self-administered questionnaires. A total number of 31 questionnaires were returned. It was found that the majority of the respondents (74%) accessed HCT services in the past twelve months, of which 31% indicated having tested at Elizabeth Nepemba HIV Counselling and Testing Facility. The study further revealed that the majority of respondents valued HIV counseling and testing as an important component of their general health and wellbeing. Factors such as confidentiality and privacy issues, the condition of service and staff competency along with accessibility, fear of rejection from families and friends, information provision, education, future planning and risky behaviour were identified as having an influence on HIV counseling and testing uptake.

The study concluded that there is a need for more awareness campaigns, information dissemination and involvement of stakeholders to address HIV-related health issues for correctional officers at Elizabeth Nepemba Correctional Facility.

OPSOMMING

Dié studie het die faktore bekyk wat die mate van gebruik van MIV-berading en toetsing (HCT) onder korrektiewe amptenare by die Elizabeth Nepemba Korrektiewe Fasiliteit in Rundu, Namibië, beïnvloed. Faktore wat in hierdie studie ondersoek is, het die bevredigingsvlak onder korrektiewe amptenare met HCT-dienslewering ingesluit, asook hulle ondervindings en verwagtinge in hierdie verband en die identifisering van hulle behoeftes en motiewe wat die gebruik van HCT tot gevolg het.

Deur middel van die voltooiing van selfgeadministreerde vraelyste is 'n monster van 50 deelnemers geteiken om by die opname betrek te word. 'n Totaal van 31 vraelyste is voltooi en teruggestuur. Daar is vasgestel dat die meerderheid (74%) van die respondente in die voorafgaande 12 maande HCT-dienste benut het – 31% van hulle het aangedui dat hulle by die Elizabeth Nepemba MIV-Beradings en Toetsfasiliteit getoets is. Die studie het voorts getoon dat die meerderheid respondente MIV-berading en toetsing as 'n belangrike onderdeel van hulle algemene gesondheid en welstand bejeën. Faktore soos vertroulike en private aangeleenthede, die stand van diens- en personeelbevoegdheid tesame met toeganklikheid, vrees vir verwerping deur gesinslede en vriende, inligtingsvoorsiening, onderwys, toekomstige beplanning en riskante gedrag, is geïdentifiseer as sou hulle die gebruiksmakingfrequentheid van berading en toetsing beïnvloed.

Die studie kom tot die gevolgtrekking dat daar 'n behoefte bestaan vir meer bewusmakingsveldtogte, inligting-verspreiding en betrokkenheid van belanghebbendes om die MIV-verwante gesondheidsaangeleenthede vir korrektiewe beamptes by die Elizabeth Nepemba Korrektiewe Fasiliteit aan te spreek.

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Chapter One: Introduction

1.1. Background

HIV Counselling and Testing (HCT) is the process of providing counselling to an individual to enable him or her to make an informed choice about being tested for HIV, the Jointed United Nation Programme on HIV/AIDS (USAIDS) (2001). Such decision must be entirely the choice of an individual, and they must be assured of confidentiality. An individual's decision to test or not to test for HIV can be influenced by a number of factors both at the individual and service provider level. According to the AIDSMark (2009), people seek HCT if their partner or child dies, due to chronic or recurrent illnesses, planning of getting married or have a baby, to achieve a peace of mind and when they are worried about their partner's behaviour.

As an entry point for prevention and care, it is acknowledged that HCT is an effective strategy for both prevention and care. According to Rogers (1997), Counselling and Testing (CT) is the primary access point to HIV and AIDS clinical care and psychological support and provides an opportunity for education and motivation to modify behaviors aimed at reducing the risk of HIV infection. However, information and education alone have no transitory effect-eroded over time by contradictory pressures. In contrast, knowledge that leads to action, such as HIV and AIDS CT participation, promotes risk reduction through increasing perception of risk, self-efficacy and personal skill through the reinforcement of social norms and responsibilities (Coates, Sangiwa, Balmer, Greogorich & Kamenga, 1997). Hence, HCT is vital in all sectors including correctional settings. This study will investigate how HCT is utilized by correctional officers at Elizabeth Nepemba Correctional Facility (ENCF) and the factors affecting the utilization thereof.

1.1.1. What is HCT?

HCT is a service that is offered to clients who wish to know their HIV status. HCT is centered on the pre-test, testing, post-test and ongoing support. It involves a confidential dialogue between a counsellor and an individual, couple or family. This

process enables individuals, couples, and families to understand and make informed choices on whether to be tested for HIV, to understand the results and facilitate future planning, MoHSS (2011).

According to the Namibian HCT guidelines (2011), there are three approaches to conducting HCT: the client-initiated approach, provider-initiated approach and the home-based approach. Client Initiated Counselling and Testing (CICT) allow clients to seek out the service, while Provider Initiated Counselling and Testing (PICT) empowers the health care worker to recommend HIV testing to patients as part of routine health care services. Home-based HCT brings HCT services to the home. The PICT in health facilities and hospitals can improve diagnosis and save lives. Currently in Namibia, HIV testing is offered to patients in antenatal clinics (ANC's), maternity wards, medical and surgical wards, outpatient departments, sexual transmitted infection (STI) units, and Tuberculosis (TB) clinics, MoHSS (2011:1).

The conceptualization and representation of HIV testing influence HIV test uptake rates. Some factors that have been found to deter people from testing include lack of awareness or knowledge about infection rates in the workplace, demographic, health care, psychosocial, interpersonal and behavioural factors. The AIDSMark (2009) identified factors such as no treatment or cure for the virus, fear of losing partner, lack of perceived confidentiality at HCT centers, unfamiliarity with HCT services, beliefs that HCT is for the dying or sick, as well as the perceived risk of infection as factors that hinders and individual to seek HCT services. According to Creel and Rimal (2011) some factors are at multiple levels impact on HIV-testing rates. There are those factors due to health care reasons; beliefs that tests are inaccurate; or that results are not kept confidential. Other factors include household type and education level, and psychological, interpersonal, stigma and discrimination factors.

1.1.2. HIV and AIDS and HCT: The Global Perspective

HIV and AIDS remains a major public health problem worldwide World Health Organization (WHO) (2010). It is estimated that 2.7 million people were infected with the virus in 2008, indicating a tremendous increase in the HIV prevalence rate compare to the previous years. However, globally the number of people living with

HIV increased – from 33.2 million in 2007 to 33.4 million in 2008 – causing more than two million AIDS related deaths in the same year. The HIV epidemic continues to spread in Sub-Sahara Africa (SSA), it being the most affected region across the globe with an estimate infection rate of 22.5 million people. By the year 2008, the prevalence rates begun to stabilize in the region due to increases in both AIDS related death and new infections WHO (2009).

Data from HCT helps government –particularly those spearheading the health programs– to understand the prevalence, incidence and socio-demographic dimensions of health condition. Thus, HCT is not only useful in knowing your status but it helps in the development of policies, interventions programs and behavioural change campaign geared toward the reduction of HIV transmission (Snow, 2004).

Although there is no cure for HIV, there are available medications to prolong the life of People Living with HIV and AIDS (PLWHA) as it suppresses the condition to a manageable chronic ailment. However, HCT remains the only way to know your status in order to potentially do something about it, whether positive or negative. The WHO (2010) estimated that more than 80% of people infected with HIV worldwide do not know their HIV infection status. Controversy still exists over the best way to increase HCT uptake, particularly in SSA which is the epicenter of the epidemic. In addition, the WHO states that there are gaps in the scientific evidence about how people utilize HCT services in SSA. More information is currently needed to strengthen the international resolutions and guide national HCT policies and programs as well as for the allocation resources to those who need them the most.

1.1.3. HIV and AIDS and HCT: The Namibian Perspective

Namibia is one of the countries with the highest prevalence rate in SSA. The National Testing Day Report (2010) indicates that Namibia covers a large geographic area with an estimated population of two million people. It has a generalized epidemic of which HIV primarily spread through heterosexual sex and mother-to-child transmission. The country's vast distances and low population density are among the barriers affecting the delivery of HCT and other health care services to the entire population.

The Namibian government has been monitoring the prevalence since 1992 through sentinel surveillance of pregnant women at ANC's, followed by the inception of the national testing days. In 2010, the country was estimated to have a prevalence rate of 18.8%. According to MoHSS (2010), there is no significant difference in the prevalence rate between the urban (18.5%) and the rural (19.1%) areas. The prevalence increased from 1992 and peaked in 2002 at 22%; followed by a slight decrease and apparent stabilization between 2004 and 2010, MoHSS (2010:13). The ministry indicated that in 2010, the ANC survey result found that HIV prevalence peaked in the age group of 35-39 years with 29.7%; and in the age group of 30 – 34 with 29.6%.

Despite the growing public awareness about the burden of HIV and AIDS in the country, HCT uptake seems to be low. It is estimated that just over 20% of the Namibian population have been tested for HIV, UNAIDS and USAIDS (2000). The MoHSS (2011) estimates that 29% females and 18% males reported having gone for HIV testing within the past 12 months of the survey and knew their sero-status; of this number only 5% were couples.

This situation poses major threats to the prevention efforts, including missed opportunities by many eligible Namibians to access treatment, care and support services. Namibia has one of the best developed Antiretroviral Therapy (ART) programs in SSA with free drugs available to 85% of those who are living positively and need them; but with many possible individuals not knowing their HIV status the therapy remains underutilized MoHSS (2011). Furthermore, low level of participation in routine HCT poses significant challenges to prevention, care and treatment programs. Firstly, individuals with high-risk behavioural profiles are at greater risk of contracting and passing on the virus if they are unaware of their or their partner's status. Secondly, delayed enrollment into HIV and AIDS care and treatment programs is associated with worse long-term health outcomes for infected persons. Also, infected persons who delay or avoid starting ART may, as they fall ill, be a greater financial burden on families and the health care system MoHSS (2010:1).

MoHSS (2010) further states that the country has significantly expanded HCT services: Apart from Voluntary Counselling and Testing services (VCT), it has additionally initiated PICT as part of the continuation of HCT in ANC; through the Prevention of Mother to Child Transmission (PMTCT) programs; as well as testing in TB and STI settings. Due to the critical shortage of qualified medical personnel in the country, the MoHSS trained and deployed lay HCT counsellors who are equipped with the knowledge and skills to do both counselling and HIV rapid testing in public health facilities. This was done to complement the overburdened health care providers to enable the facilities to provide both CICT and PICT services. The lay counsellors, commonly known as community counsellors, provide services such as HIV counselling, couples HCT, HIV rapid test, Male Circumcision (MC) counselling and ART adherence counselling MoHSS (2011:2).

1.1.4. HIV and AIDS and the world of work: The Correctional Context

The HIV epidemic poses serious threats to the socio-economic, employment and human rights implications. According the South African Code of Good Practice (2008) HIV and AIDS affects every workforce, with prolonged staff illness, absenteeism, and death impacting on productivity, employee benefits, occupational health and safety, production costs and workplace morale. Moreover, HIV and AIDS are surrounded by ignorance, prejudice, discrimination and stigma. In the workplace, unfair discrimination against PLWHA has been perpetuated through practices such as pre-employment testing, dismissals for being positive and denial of employee benefits.

Just like any other population, HIV transmission is known to occur in correctional population in Namibia. The available data are of inmates' population which estimates a high HIV prevalence in correctional facilities in Namibia, MoHSS (2011). Correctional officers are among the core groups most at risk of HIV transmission and acquisition due to their occupation and lifestyle, MoHSS. It is essential to assess the knowledge, attitudes and perception of correctional officers as they are subjected to high mobility, location, health and other personal risks to themselves and their families, UNAIDS (1999). As far as could be ascertained, there is no data available on the prevalence rate among correctional officers in the Namibian Correctional

Service (NCS), in particular also not at Elizabeth Nepemba Correctional Facility, the focus of this research.

1.1.5. HIV and AIDS and the world of work: Elizabeth Nepemba Correctional Facility (ENCF)

ENCF is equipped with a HCT facility aimed to cater for both correctional officers and the inmate population. Facility records indicate a low utility rate of HCT services amongst correctional officers in the past two years. As correctional officers are considered to be a high-risk group for HIV infection, the low uptake rate of HCT services is a cause for concern.

To date, no study was done to identify factors that may be associated with the HCT uptake at ENCF. Therefore, identifying factors that may be associated with the observed low uptake of HCT in the correctional facility may make a valuable contribution to strengthening the national responses to HIV and AIDS epidemic in the correctional service context. This study will therefore aim to establish to what extent correctional officers utilize such services and what motivates or de-motivates them to do so.

1.2. Research problem

Limited HIV and AIDS activities have been directed towards correctional officers at ENCF. A low uptake rate of HCT services by employees exists at ENCF, in addition to the prevalence rate among correctional officers in Namibia not being known. As mentioned, correctional officers are considered to be a high-risk group for HIV infection.

1.3. Research question

What are the factors contributing to the utilization of HIV Counseling and Testing amongst correctional officers at the Elizabeth Nepemba Correctional Facility?

1.4. Aim and Objectives

1.4.1. Aim

To identify the factors influencing correctional officer's utilization of HIV Counseling and Testing service.

1.4.2. Objectives

- To establish correctional officer's perception on current HCT service.
- Establish to what extent correctional officers utilized the HCT service.
- To analyze the current HCT service.
- To identify correctional officer's HIV and AIDS CT workplace needs.
- To determine the quality of HCT provision.
- To provide guidelines on how to improve the HCT service if necessary.

1.5. Significance of the study

The study may help to identify the extent to which correctional officers make use of the HCT service as well as motivating and de-motivating factors influencing their choices of utility and that of a preferred service provider. Identifying and understanding the individual, social and health factors that influence correctional officer's use of HCT may enlighten management and set directions that will address correctional officer's needs. Additionally, if the NCS is aware of correctional officer's needs, efforts could be directed toward the development and implementation of HIV and AIDS policies and prevention programs. These may increase the HCT uptake and assist with the recommendations of strategies that may help with the mitigation of HIV and AIDS in correctional facilities.

Chapter Two: Literature Review

2.1. Introduction

This chapter reviews literature on HIV and AIDS, specifically the impact of the disease in Namibia, the Namibian response to the disease, Models of HCT delivery, factors influencing HCT uptake and challenges facing HCT in correctional facilities.

2.2. The impact of HIV and AIDS in Namibia

The WHO and the MoHSS often reports that AIDS has taken the lead in the number of deaths in the country since 1996. As mentioned, the ministerial HIV projection estimates that adult prevalence rate of 18%; and approximately 3,350 infants are infected with HIV per annum. The enormous distance and low population density in the country makes health care and HCT services inaccessible to many segments of the population which are considered at risk of HIV infection, MoHSS (2011).

A report by UNAIDS (2012) indicates that HIV and AIDS dramatically affects the labour sector, as the vast majority of people living with the virus are the economically active population aged between 15 and 49 years. Due to the fact that HIV and AIDS have a primary impact on the working population, this hinders the participation and contribution of those infected to the economic development. According to Jantije (2009), this can affect productivity, competitiveness profitability of service and other human resources impacts, which will be felt in the rate of absenteeism, accident rates deaths, early retirement, disability retirements, industrial disputes and emigration which will be felt in all sectors.

In Namibia, AIDS infections were originally concentrated in the urban areas but quickly spread to the rural areas, reducing the infection gap between urban and rural areas USAIDS (2007). The current estimated life expectancy is 42 years. In 2007, 5 100 deaths were due to AIDS related illnesses, MoHSS (2008). As a direct result of HIV and AIDS, it was estimated that 45% of the children orphaned by March 2009 were orphaned by AIDS.

The impact of the epidemic on the country has been disastrous and this has put an increasing demand on health service delivery. Hence, Government adopted strategies to fight the epidemic. The main programs are measures to prevent the incidence of HIV and AIDS as well as reduce the impact of the epidemic. This will be discussed next.

2.3. Namibian response to HIV and AIDS

In the early 1990's, the Namibian government declared HIV and AIDS a national emergency. The Government committed itself to an aggressive, comprehensive and expanded multi-sectorial and multi-level response to fight the epidemic. Together with non-governmental organizations, Government has been at the forefront of fighting the epidemic since 1990 (MoHSS, 1999, 2001; UNAIDS, 2002). Edwards (2004) reported that the Namibian government launched its first National AIDS Control Programme (NACOP) in 1990 and led the national response to the epidemic. The aims of NACOP were to conduct epidemiological surveillance, raise public awareness through educational programmes and establish VCT services. Also included in its objectives were the management of STI and other opportunistic infections.

When the HIV prevalence rate approached 19.3%, the National AIDS Coordination Programme (NAC) and the National Multi-sectorial Committee on HIV/AIDS (NAMACOC) were formed in 1999 to further expand the national response. The focus of the NAMACOC is policy and programme implementation. It composes of all thirteen regional governors, permanent secretaries as well as representatives from non-governmental organizations and the private sector, MoHSS (2007). The Ministry of Health's national responses are guided by three five-year strategic frameworks (Medium Term plans) aimed at enabling environment for people infected and affected with HIV/AIDS to enjoy equal rights; prevention; access to care, treatment and support services; impact mitigation services and integration and coordination of programme management at all levels, MoHSS.

The Medium Term Plans with National Strategies and Policy frameworks have become important instruments for the design and implementation of country

responses to HIV/AIDS (Cohen, 2002). To reduce HIV and AIDS infections below the epidemic threshold, the Government of Namibia has to adopt a multi-sectorial strategic approach in managing the disease, MoHSS (2009). According to The National Strategic Plan on HIV/AIDS Medium Term Plan MTPIII (2004-2009), the NACOP for 1990-1999 was replaced by MTPII (1999-2004) because of the continuous spread of the disease. The MTPIII was established to consolidate access to treatment with anti-retroviral medicines and also to ensure the mainstreaming of HIV/AIDS in all sectors. The MTPIII has become the “road map” designed by the Namibian government, to fight the HIV and AIDS epidemic in society, MoHSS. The MTPIII will be discussed in more detail later in this chapter.

A recent study by Weimers - Maasdorp (2011) found that most large companies in Namibia are undertaking initiatives to combat HIV and AIDS within their workplace. On the other hand, smaller companies were lagging behind. The reason for the lag is that smaller companies lack resources to establish HIV and AIDS programmes due to financial and time constraints. Yet, the business sector is heavily affected by HIV and AIDS, which is a source of employment and income to an approximately 160 000 people. However, the existence of the Namibia Business Coalition on HIV and AIDS (NABCOA) is of great assistance as smaller companies are now provided with posters, information materials, condoms and training of workplace peer educators, counselors and employees.

NABCOA (2009) supports the development of a comprehensive organizational response to HIV and AIDS within the workplace as an essential component in the fight against HIV and AIDS. Such response operates in the interest of both affected and infected employees and employs stigma reduction activities at all levels. It further states that top management commitment, full employee participation and development of an inclusive HIV and AIDS policy to serve as a guideline for managing HIV and AIDS at the workplace are all essential for achieving programme success. NABCOA further asserts that with an effective HIV programme, the overall result for the organizations should show an increased knowledge employees have on HIV and AIDS-related issues; greater acceptance of those infected with HIV, resulting in reduced stigma and a reduced number of new infections and greater utilization of company programme resources.

2.4. HCT Response: Introduction

MTPIII supported HCT as one of the most effective methods to prevent the spread of HIV, as the Namibian government regards HCT as directly linked to the promotion of behavioural change MoHSS (2008). The expansion of HCT enabled those infected to enroll for treatment, care and support programmes, MoHSS (2004:39). In order to obtain a coherent and functioning HCT service there was a need for an integrated approach where roles and responsibilities in relation to HCT are shared. According to the Namibian National Strategic Framework (NNSF) (2011), the Government has formulated different committees, councils and policies actively involved in HCT direction and implementation of the National Multi-sectorial Monitoring and Evaluation plan for HIV and AIDS. National, regional, district and facility levels committees were developed, and are discussed below:

2.5. HCT Response: National Level

The Namibian government formed the National AIDS Committee (NAC) to provide guidance and leadership for national multi-sectoral HIV/AIDS response. Also in existence is the National AIDS executive, which offers technical guidance and leadership in planning and implementation of multi-sectoral responses.

Another component responsible for national responses is the National office of the MoHSS. Six committees with different mandate falls under this level namely, Directorate for Special Programmes (DSP), Technical Advisory Committee for HIV Prevention (TAC), Namibia Institute of Pathology (NIP), HCT Technical Working Group (HCTTWG), Central Medical Stores (CMS) and the Human Resource Management and General Services, MoHSS (2011).

2.6. HCT Response: Regional and District Level

The multi-sectoral regional, district and constituency AIDS committees (RACOC, DACOC and CACOC) are composed of different stakeholders and are responsible for implementation and coordination of HIV and AIDS activities. Members of these committees are drawn from the public and private sector, as well as civil society. The

committees are expected to plan, implement, supervise and evaluate HCT activities at both district and regional levels. As part of the regional management team, the Health Regional Director is responsible for the coordination of DSP activities in the region and plans the outreach and home-based HCT activities in the region. To accommodate the efforts of the private sector, chief and senior health program administrators are given the responsibility to coordinate organizations outreach or home-based activities, MoHSS (2011:11).

2.7. HCT Response: Facility Level

Regardless of HCT facility location, it should be managed by the person in charge of the facility or department where HCT services are provided. The person in charge should have planning and management skills, as well as skills in counseling and testing, MoHSS (2011). To ensure efficient and effective delivery of HCT services as well as complementing the efforts of site managers HCT service providers, data entry personnel, peer educators and community leaders are employed to ensure that people are mobilized to seek HCT services and receive the services they deserve.

In the year 2000, the Namibian HIV and AIDS Charter of Rights were introduced by MoHSS as a pivotal response the epidemic. The Charter stipulates the basic rights that all people should enjoy and which should not be denied to people living with HIV and AIDS. The Namibian HIV and AIDS charter was adopted in 2004 and emphasizes that voluntary and confidential counseling and testing for HIV should be encouraged. The establishment of affordable and accessible voluntary, confidential counseling and testing sites is one of the essential components of the charter, MoHSS (2004:2). According to the charter it remains the facility's responsibility to provide quality pre and post-test counseling through a qualified counsellor, and VCT should only be done with the informed consent of an individual.

As alluded to earlier, the initiation of HCT was accompanied by the PICT through HIV testing in ANC's as well as through the PMTCT programs together with testing in TB and STIs. In response to the shortage of medical personnel in the country, also mentioned earlier, the MoHSS trained and deployed lay HCT counsellors at public

health facilities to complement health care workers in the provision of HCT and PITC services, MoHSS (2011).

The National Strategic Framework highlights some of the achievements in the fight against HIV and AIDS on facility level. These include the fact that from 2006 to date, community home based care providers have reached 39 330 PLWHA in all 13 regions of the country. As a result of the ART roll out, community home based care programs are moving forward towards preventive and adherence support as well as broader issues of primary health care.

2.8. HCT Response: Non-Governmental Level

To complement the Namibian government's efforts, international donors significantly increased funding of HIV and AIDS programs. The increased funding lead to the implementation of various prevention programs, as well as the introduction of HCT service in public health facilities and stand-alone sites countrywide. In spite of attempts to mitigate the impact as well as the rate of HIV infection, Namibia remains a highly affected country. Multiple and concurrent partnerships, inter-generational sex, transactional sex, HIV risk perceptions, low and inconsistent condom use, low male circumcision, alcohol abuse, mobility and migration patterns as well as sexual partnership norms remains the contextual factors driving the epidemic, MoHSS (2011).

Furthermore, the complexity of the epidemic required a holistic, multi-disciplinary approach to address the epidemic. In Namibia, there are numerous agencies entrusted with responsibility to mitigate the impact of HIV and AIDS through programme development as well as linking them to available workplace resources such as access to treatment for low-income groups.

2.9. HCT Response: Correctional Facility Level

As far as could be ascertained, few campaigns and programs are aimed to fight HIV and AIDS in correctional facilities targeting correctional officers, including correctional officers at ENCF. Since the correctional population represents a mobile

population, it is among the uniformed services at the risk of HIV transmission. According to MoHSS (2011), it is important to provide HIV counselling and testing services to this group in consideration of the following:

- Establishment of counseling and testing services in all correctional facilities that provides services to inmates, correctional officers and their partners.
- Provision of Outreach/Mobile HCT services where facilities could not be reached or static services are unavailable.
- Integrating MC with HCT where possible.
- HCT promotion among correctional personnel.
- Availability of effective referral to care and support.
- Partner/Spouse referral.

2.10. Factors influencing HCT uptake

A number of complex issues serve as factors influencing HCT uptake. Numerous studies have been conducted to identify possible factors that can impede or facilitate utilization of HCT services in different population groups at different part of the globe. This varies from service to client-related factors.

According the MoHSS (2005) these factors include stigma and discrimination, literacy and HCT in the workplace, knowledge, attitude and practice about HIV and AIDS and HCT, accessibility and availability of HCT services. Literature indicates that factors leading to the low use of HCT can also be related to individuals' psychological or socio-economic circumstances or the HIV counseling and testing service provider. Chilisa and Bennel (2001) found that HIV and AIDS CT have limited success in the Sub-Saharan region due to different challenges associated with it. These challenges include existing attitudes and beliefs that are psychological barriers toward low usage of HIV and CT. The scholars further concluded that there is a positive relationship between the rate of people's HCT utilization and their attitude towards others being at high risk of HIV infection. Below follows a further discussion of the said factors as well as a further elaboration on some the factors already mentioned.

2.10.1. Socio – Demographic factors

These factors include marital discord, gender, age, higher household wealth, living in a high cost housing area, and higher education. A study by Getachew (2005) showed a high HCT acceptance among educated, married, high income women as well as among women whose husbands live at home. This was attributed to the fact that educated mothers could be better assessors of the benefits of testing and may have information on HIV testing and treatment options as well as married women possibly being more confident compared to single women (due to marital commitment) to access HCT services. The presence of a husband at home was thought to have facilitated or made discussions on HIV related issues easier and therefore resulted in a more positive acceptance towards HCT.

Another study done to identify the factors that affect HCT utilization among the youth in Ethiopia found that being female, older youth, educational level of secondary (and higher) as well as being sexually active were factors that contributed to such individuals being more likely to test for HIV. It was suggested that these respondents might have engaged in high-risk sexual activities (compared to younger and sexually inactive youths) and this might have prompted them to wanting to know their status (Yimam, 2005). In another study, secondary and above educational status, singleness and non-polygamous union factors showed a statistically significant and positive association with HCT utilization (Wondimagegn, 2004).

A national household-based survey of HIV and AIDS (2002) found that adults aged 25-49 years who were highly educated or who had a friend or relative living with the virus, discussed HIV and AIDS prevention with their partners more often and were more likely to go for HCT. According to Yihey (2006:13), self-efficacy, distance away from HCT and effectiveness of HCT services were the major points leading to the use of HCT services.

Low or high prevalence areas may also have an influence on HCT uptake. In a study by Glick (2005) it was found that in low prevalence settings, where peacekeepers do not perceive themselves to be at high risk of HIV infection, the uptake of HCT have

been found to be high. For peacekeepers in higher prevalence settings, the HCT uptake may be lower, USAIDS (2001).

2.10.2. Sexual behavioural factors

Studies have shown the effect of past sexual exposure on HCT uptake. Prior sexual risk, such as inconsistent condom use, history of STIs and involvement with commercial sex is negatively related to testing, presumably due to higher perceived risk of getting HIV (Creel et al, 2012:902). A study done to address determinants of counselling and testing acceptance found that acceptance was significantly higher among persons at high risk of HIV transmission than those at low risk of transmission. Factors such as client's perception of HIV risk, acknowledgement of risk behaviour, confidentiality, presentation of the counseling and testing and its benefits are factors that are associated with high HIV testing acceptance rate (Yimam Z, 2005).

2.10.3. Knowledge, Attitude and Perception factors

Positive attitudes and salient beliefs toward HIV testing benefits are predictors of seeking HIV counseling and testing services. This was found in a study conducted by Fauci (2001), who reported that the majority (86%) of pregnant women in Southern India would agree to test for HIV in order to protect their unborn babies. Other respondents, however, indicated they will not test as they do not perceive themselves at risk of HIV infection or they first need their husband's permission to undergo a test. A population-based HIV survey in Zambia (1996) found that the perceived risk of HIV infection was a predictor of HIV testing readiness among young people (Glick, 2005).

2.10.4. Stigma and discrimination factors

Negative attitudes related to stigma and discrimination has an influence on HCT uptake. This is due to the fact that attitudes are deep-rooted in the community and appears to be difficult to eliminate. Stigma and discrimination is mostly driven by social and family pressure (Khan, 2000). In many occasions, people living with the

virus are labeled by their relatives or community members where they reside. Stigma is driven by cultural or religious norms and values as well as by fear of HIV and AIDS and secrecy (Khan, 2000). Studies revealed that fear of positive results and the stigma attached to HIV and AIDS are major reasons for the low uptake. Many people are prevented from negotiating safer sex, seek CT, partner disclosure or seek treatment, care and support by stigma (Yimam, 2005). A study conducted in teaching hospitals in Nigeria, found that reasons for disapproving of HCT or low uptake was related to fear of stigmatization, isolation and marriage security (Creel et al, 2011).

In Namibia, in many cases people living with the virus are discriminated against once their status is known; they lose their jobs, friends, properties as well as their families. In some regions it was found that most women have the desire to test in order to protect their unborn babies, however, they regularly fear stigma and rejection in case they test positive, MoHSS (2004).

2.10.5. Confidentiality and HCT service organisation factors

A study by Shangula (2006) revealed that people are sometimes anxious about HIV testing because of the fear of confidentiality and feel that health workers might refuse to render them the necessary health care if their status are known. In another study, it was found that some health workers disclose the HIV status of their client without their consent (Lancaster & Stanhope, 2000). Furthermore, patients appeared to reject being counselled by a counselor younger than them and this increase the demand of limited available HCT services, MoHSS (2004).

Other factors such stigma, discrimination and fear of positive patients to disclose their status to health workers may equally contribute to the low and inconsistent utilization of HCT services. In addition, the quality of care offered by a health facility also has an influence on the future utilization of HCT services by that person. The mode of service delivery is a crucial determinant of acceptability, reflecting concerns about confidentiality and perhaps also a general lack of faith in local health service quality (Yimam, 2005:15).

2.8.5 Challenges facing HCT interventions in a correctional setting

According to UNAIDS (1999) the HIV and AIDS epidemic presents major challenges and penal institutions have grossly disproportionate rates of HIV infection and confirmed AIDS cases. Prison population worldwide tends to have much higher HIV prevalence rates than the general population for complex reasons (Cox, 2011). Globally, prison populations are growing at a rapid rate with high incarceration rates leading to overcrowding, a phenomenon that poses significant health concerns with regard to control of infectious diseases, including HIV, UNAIDS (1999).

Lack of knowledge is among the challenges facing the fight against HIV and AIDS in correctional facilities. In a study conducted by the National Institute on Drug Abuse (NIDA) (2010) on harm reduction knowledge and belief among armed prison guards in Albania, 34% of respondents reported having no information on HIV, and 90% had no information on Harm Reduction (HR) concept and programmes. Also, 88% of respondents had no knowledge on condom use and 50% stated they had never used condoms.

There are a number of other challenges and limitations which continue to hamper the effective implementation HIV and AIDS interventions in correctional facilities. These include lack of political will, lack of resources, strategic implementation failure, and challenges related to the provision of prevention, treatment as well as care IrinPlus (2003). According to the United Nations Office on Drugs and Crime (UNODC) (2012) for example, the effectiveness of HIV prevention policies in correctional settings are hampered by the denial of HIV and AIDS existence and this contributes to the spread of the virus.

As previously stated, little information is available HCT uptake and HIV-related interventions aimed towards correctional officers in Namibia.

2.11. Summary

Besides the responses to the HIV at different levels already implemented in Namibia, campaign and programs aimed to fight HIV and AIDS seem to overlook correctional officers who are at the forefront of almost all service delivery in a correctional facility setup. Factors such as demographics, sexual behaviour, knowledge, attitudes and practices, as well as stigma and discrimination, confidentiality, and the organization offering testing have an influence on the individual's decision to test or not to test for HIV. This study will ascertain the extent correctional officers are influenced by some of these identified factors and what other issues might influence their uptake of HCT services.

Chapter Three: Research Design and Methods

3.1. Introduction

This chapter outlines the research design and methods used in this study as well as the rationale behind such design, the study setting, study population including its sample and the instrument used to collect data. In conclusion the ethical consideration where the study was conducted will be discussed.

3.2. Research design

The purpose of this study was to identify the factors influencing the HCT uptake amongst correctional officers at ENCF. In attempting to meet the research objectives, describe the behaviour, opinions and attitudes of the sample group, the study employed a quantitative approach. The approach is preferably efficient and inexpensive in collecting data from a large number of respondents in a survey (Jonson, Onwuegvuzie & Tuner 2007). Christensen, Jonson and Tuner (2011:29) define quantitative research as a “research based on numerical data”. The quantitative research study was used to collect data through the use of questionnaires to establish correctional officer’s perception, identify correctional officer’s needs as well as identify motives behind the use of HCT services. According to Jenkins (2009), it is believe that this is the best approach to utilize for this study as it offer results in precise measurements and data collected are in the form of numbers and statistics.

3.3. Research setting

This study was conducted on correctional officers deployed at ENCF, which is situated 20 kilometers South of Rundu Town along the Trans-Caprivi Highway. Before independence, the South African Regime used it as a refugee camp housing mainly Angolan nationals. In the 1970’s, it was commonly known as 10 miles refugee Camp. A few years later it was transformed into a military base to train Koevoets, a reserve force of black recruits into the South African Police Force, NCS (2012).

According to the Correctional Journal (2012), in the early 1980's the site was used to continue with training police recruits; it was given a new mandate of detention of SWAPO political detainees until independence in 1990. After independence the camp was later converted into a Juvenile Rehabilitation Centre on the 25th August 1995 and renamed after Hompa Elizabeth Nepemba, a local prominent figure of the Mbunza tribe of the Kavango region. By then, the Centre accommodated juvenile offenders as offenders aged 18 – 21 years to protect them from negative influence of more entrenched in criminal lifestyles older offenders.

The Centre was later converted to ENCF and inaugurated on the 3rd of March 2011 as a result of the NCS's integration of the offender risk management correctional strategy. This strategy is a comprehensive and scientifically based framework, structuring the elements of service delivery to offenders and aligning the roles of staff members to contribute as active team-members of the process. It is a medium security facility with an available unit for maximum security. The facility holds a rotational population of 270 – 300 inmates at a given time. Offenders in this correctional facility are all males, living in four units, namely: Minimum, low medium, medium and the provision of maximum for occasional offenders. Furthermore, the facility has about 172 correctional officers, NCS (2011).

3.4. Population and Sampling

3.4.1. Target population

A research population is generally a large collection of individuals or subjects that the main focus of a scientific query (Castillo, 2009). This well-defined collection of individuals is known to have similar characteristics. The target population according to Christensen et al (2011:187) refers to it as a “larger population to which the researcher would like to generalize the study results”. For the purpose of this study, the researcher focused on correctional officers deployed at ENCF.

3.4.2. Sampling

Participants were randomly selected from the employee list. A total number of 50 data collection instruments were prepared and circulated to all selected correctional officers at the facility.

3.5. Data collection

Data was collected using a questionnaire which was presented in English. Provision to explain the questionnaire to officers who do not understand English was made and questions were explained in the language they understand. Out of 50 questionnaires which were distributed to participants, a total number of 31 questionnaires were completed and returned.

3.5.1. Research instrument

The data collection instrument used in this study was a self-administered questionnaire. It was chosen based on its simplicity of circulation to a large number of respondents. The questionnaires were distributed to correctional officers who were randomly selected from the employee list and gave consent for voluntary participation. The literature survey in Chapter 2 was used as a guide for the questionnaire development (specifically factors influencing the utilization of HCT uptake). The themes covered in the questionnaire includes demographic information of participants, previously tested for HIV, knowledge, attitude and practice of HIV testing and additional information related to their suggestions on improving HIV counseling and testing services at the facility. These themes are considered to provide information on correctional officer's current practice as well as their feelings and expectations on the provision of HIV and AIDS information and services. Due to the lack of information regarding HCT uptake at correctional facilities in Namibia. In general, the researcher also incorporated HIV-related information regarding the facility itself (e.g. the extent to which the HCT facility is utilized) as part of the questionnaire.

3.6. Ethical consideration

HIV and AIDS are considered as sensitive issues due to the nature of the stigma and discrimination surrounding the disease. Christensen et.al (2011:96) defines research ethics as “a set of principles that assist the community of researchers in deciding how to conduct ethical research.” Within the social and behavioral sciences, ethical concerns are categorized in three categories: relationship between society and science, professional issues, and treatment of research participants.

It is recommended that before a researcher undertakes a research project must be aware of the ethical issues one may face. Participants in this study were assured confidentiality and anonymity. They were not obliged to divulge their names or personal particulars except their gender, age and educational background. An informed consent form was considered prior participation. Participants were assured that research material and all documents with their response are going to be kept safe in an area only accessible to the researcher.

The fact that humans are subjects in social research requires the researcher to be extra cautious of the ethical standards that guide the information gathering and data collection method. Ethical consideration came into play at three stages of the study; when participants were recruited, during intervention and when results obtained will be released.

Chapter Four: Results findings and Analysis

4.1. General results presentation

This chapter presents the study results from completed questionnaires. As mentioned, off the 50 distributed questionnaires and circulated to correctional officer who gave concerns for voluntary participation, 31 questionnaires were completed and returned. No questionnaire was spoilt and this effectively translates to 62% positive response.

4.2. Demographic information of Participants

4.2.1. Gender

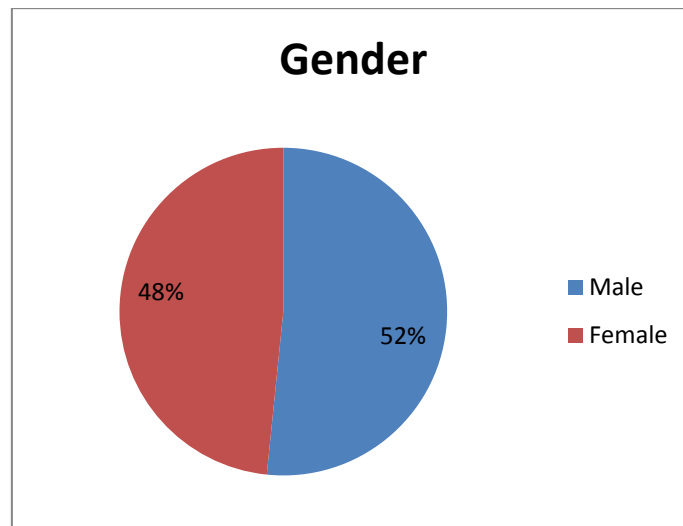


Figure4.1. Gender distribution of respondents

Figure 4.1 outlines the gender ratio of males and females who took part in the study. It indicates that more males compared to females participated as revealed by 52% (16) against 48% (15) females.

4.2.2. Age distribution

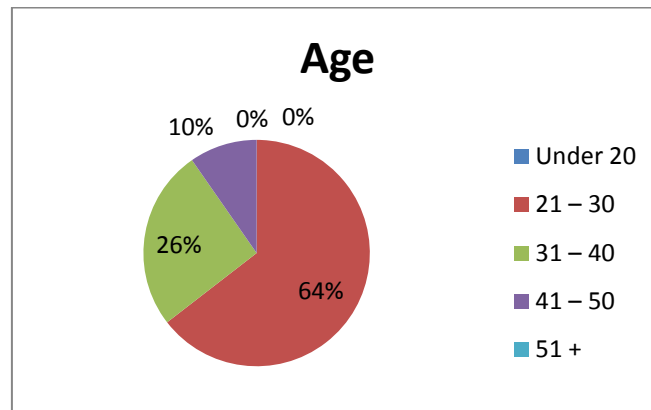


Figure4.2. Age distribution of respondents.

Figure 4.2 outlines the distribution of respondents by age. There were no participants under the age of 20 and above the age of 51. The majority of respondents (in total 20) are between the age of 21 – 30, with 26% in the age range of 31 -40 and only 10% in the range of 41 – 50.

4.2.3. Marital status

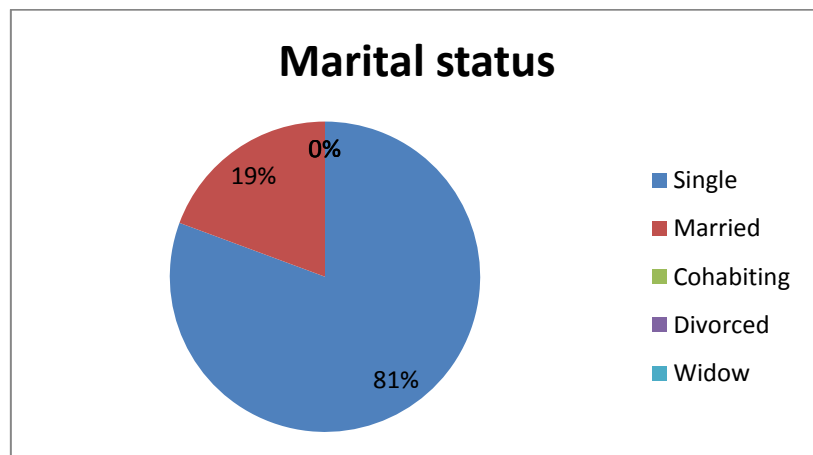


Figure4.3. Distribution of respondents by marital status.

Figure 4.3 indicates the marital distribution of respondents in the study. None of the respondent fell under the category of cohabiting, divorced and widow. Most of the respondents fell in the single category as indicated by 81% with six respondents married (19%).

4.2.4. Educational background

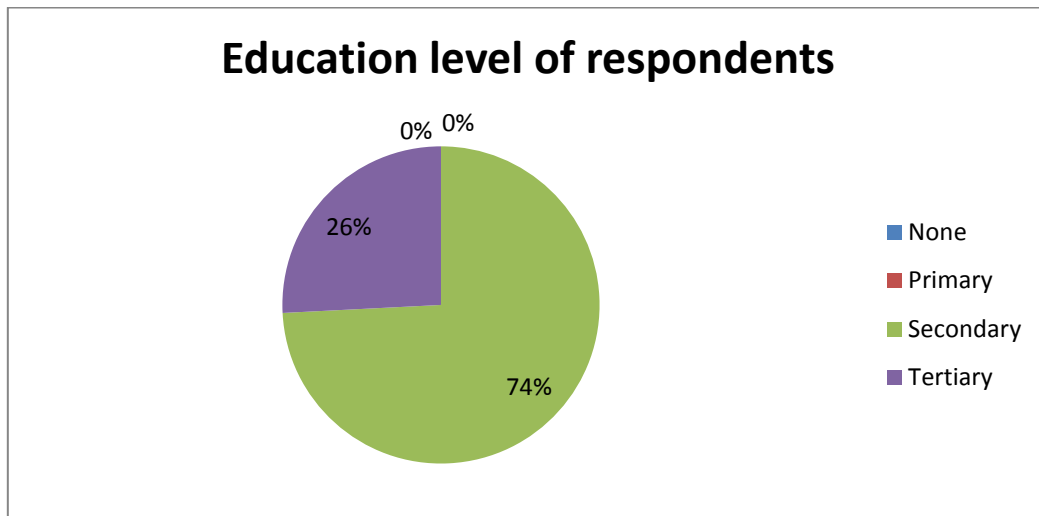


Figure4.4. Distribution of respondents according to educational level

Figure 4.4 indicates that the majority of respondents have secondary educational qualification. This translates to 74% of the total respondent. Trailing is eight respondents with post-matric qualification that represent 26%. None of the respondent was without educational qualification or with primary educational level.

4.3. Rank ratio

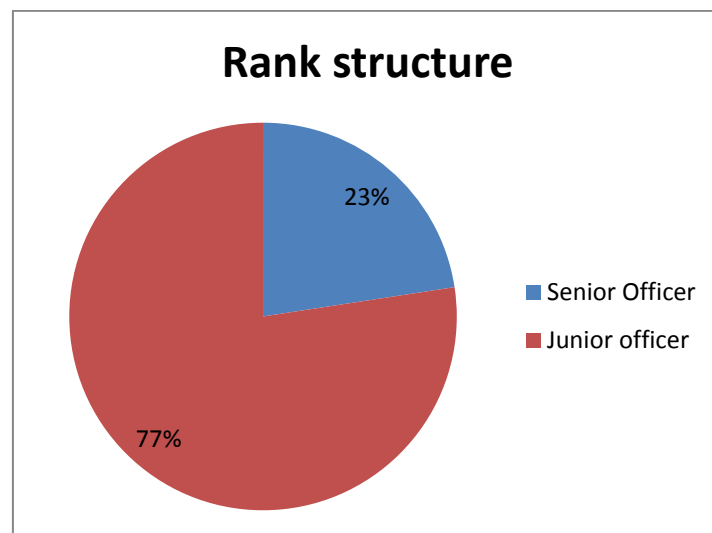


Figure4.5. Distribution of respondent by rank.

Figure 4.5 shows analysis of the sample by rank. It is indicated that the majority of the respondents are junior officers, translating to 77%. Of note is that only seven respondents (23%) were senior officers.

4.4. Previous testing

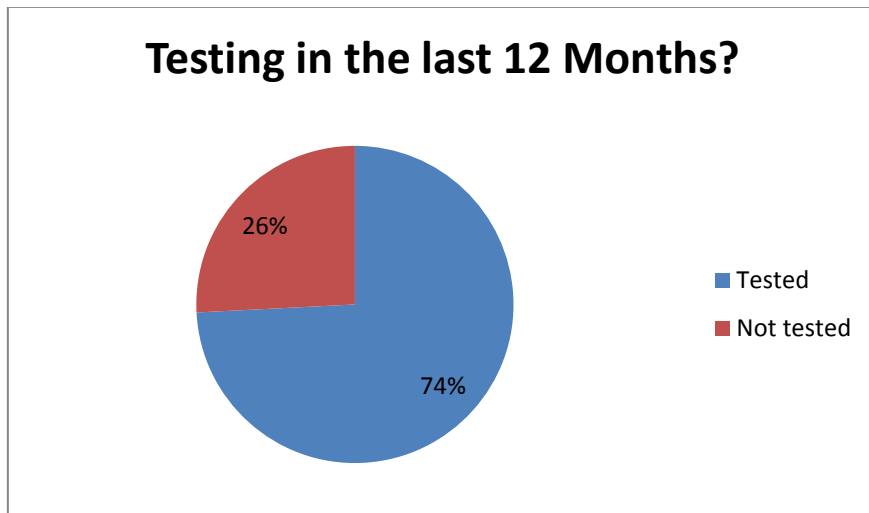


Figure4.6. Distribution of respondent by previous testing.

Figure 4.6 outlines the distribution of participants in the study by previous HIV testing. The majority of respondents (23 in total) went for an HIV test in the past twelve months, translating to 74%. Only eight respondents (26%) indicated they were not tested in the last 12 months.

4.4.1. Previous testing facility

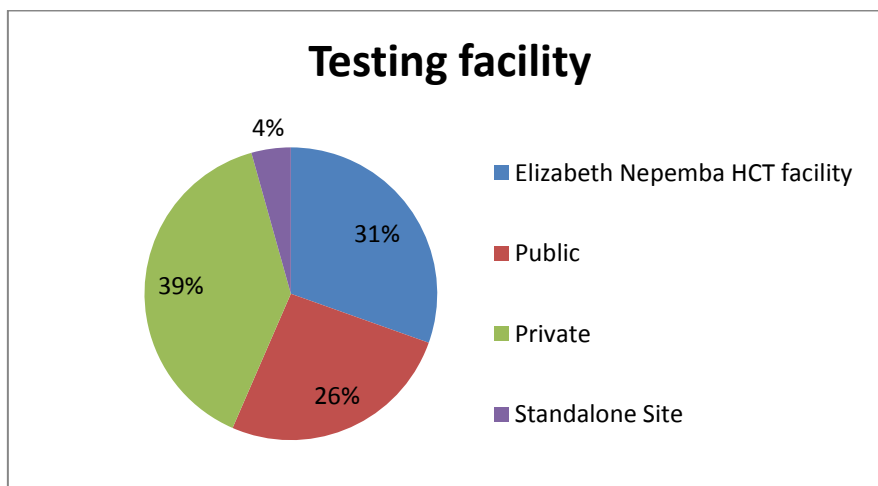


Figure4.7. Facility where respondents were previously tested.

In response to the question where respondents were tested in the past 12 months, seven participants (31%) indicated having tested at Elizabeth Nepemba HIV

Counselling and Testing Facility. A total number of six respondents indicated that they were tested at public health facilities; and most of the respondents (39%) were tested at private health facilities. Four percent of respondents were tested at a standalone site.

4.4.2. Reasons for HIV testing

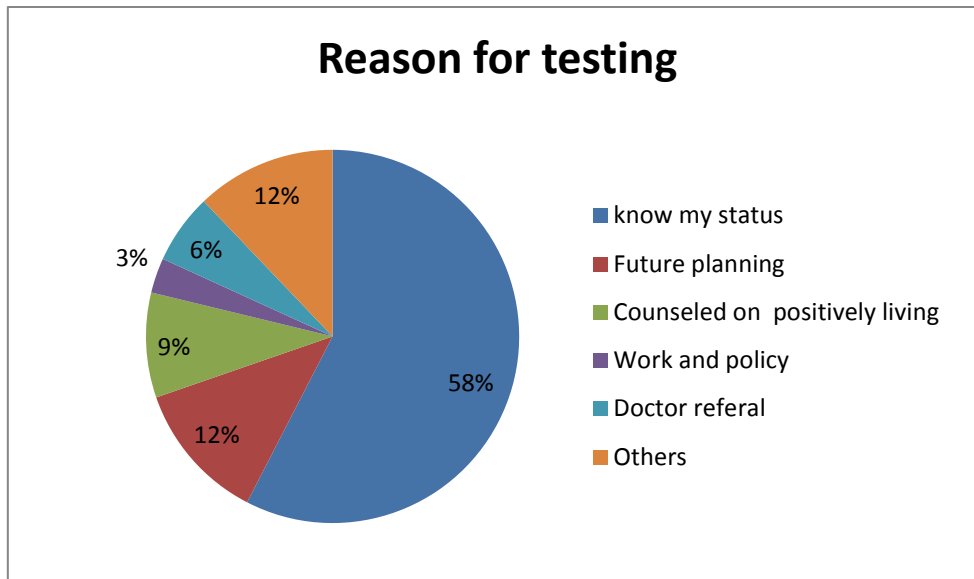


Figure4.8. Distribution of respondents in terms of testing reasons.

When asked about reasons they went for HCT, the majority of the respondents (19 in total) indicated that they went for an HIV test just to know their status, which translate to 58%. Twelve percent of the respondents went due to future planning and other reasons, 9% due to counselling and positive living reasons and 6% were referred by the doctors. Only 3% of the respondents were tested because of work and policy reasons.

4.4.3. Reasons for selecting a facility

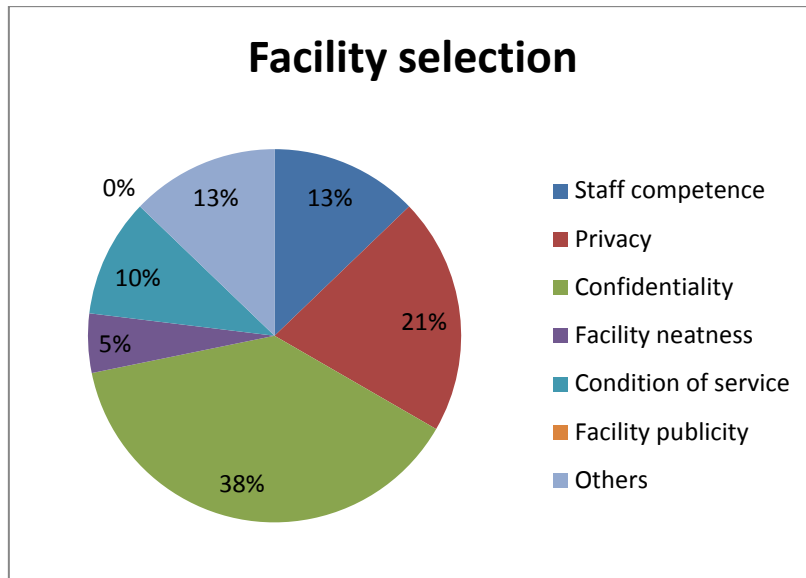


Figure4.9. Distribution of respondents by facility selection.

In response to the reason(s) why they selected a particular HCT facility for HIV testing, majority of respondents by 38% chose a facility due to confidentiality. Trailing behind is the eight respondents because of privacy, representing 21%. Five respondents chose because of staff competence and other five indicated other reasons, which constitute 13% each. Ten percent of respondents selected a facility due to condition of service and only 5% did their selection based on facility neatness (i.e. two participants out of the total sample).

4.4.4. Service received

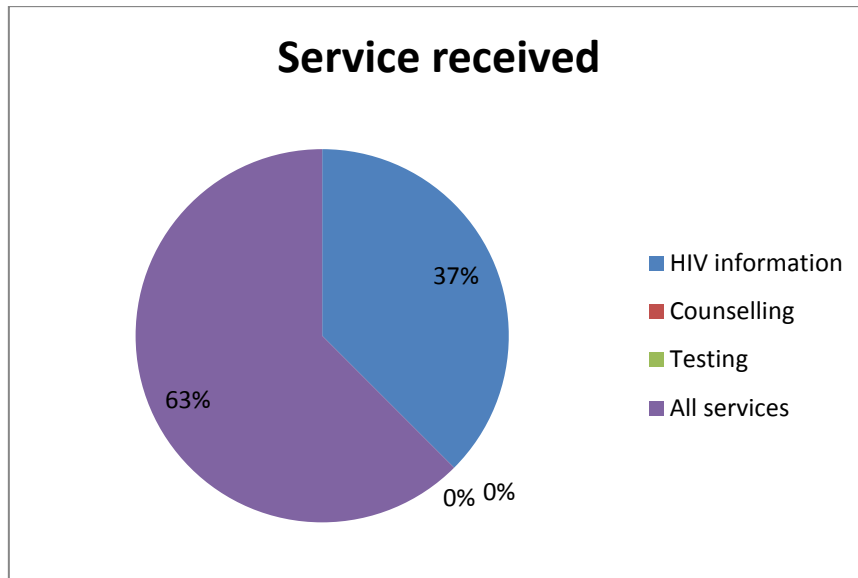


Figure 4.10. Distribution of respondents by services received.

Results show that fifteen of the respondents who participated in the study received all HCT services the last time they visited (63%); while 37% of the respondents accessed general HIV related information during their last visit.

4.5. HIV testing

4.5.1. Testing accessibility

Response	Testing services accessibility	Percentages
Strongly Agree	2	7%
Agree	2	6%
Neutral	2	6%
Disagree	13	42%
Strongly Disagree	12	39%

Table 4.1. Testing service accessibility.

Findings reveal that 25 respondents disagree that they would do not test for HIV because testing services are not accessible, this translate to 81% of respondents. Only four respondents agreed and two are neutral unsure whether to agree or disagree.

4.5.2. Fear of rejection

Response	Fear of rejection	Percentages
Strongly Agree	5	16%
Agree	11	36%
Neutral	6	19%
Disagree	6	19%
Strongly Disagree	3	10%

Table4.2. Fear of rejection.

Asked whether people do not test for HIV because they fear rejection from family and friends, 16 of the 31 respondents (52%) indicated that they agree that many people fear being rejected. Twenty nine percent disagreed with the existence of rejection fear. Only six respondents were neutral, translating to 19%.

4.5.3. Fear of losing a job

Response	Fear of losing a job	Percentages
Strongly Agree	3	10%
Agree	7	22%
Neutral	4	13%
Disagree	9	29%
Strongly Disagree	8	26%

Table4.3. Fear of losing a job.

In response to whether employees do not test for HIV due to the fear of losing their jobs if employer finds out, 17 out of 31 participants (55%) disagreed that people do not test due to the fear of losing their jobs. Ten respondents agreed that people do not test because they fear losing their jobs if employer find out.

4.5.4. Confidentiality

Response	Confidentiality	Percentages
Strongly Agree	7	23%
Agree	15	48%
Neutral	4	13%
Disagree	2	6%
Strongly Disagree	3	10%

Table4.4. Confidentiality.

Results indicate that most of the participants (22 in total) agree that people would not test for HIV if their results are not kept confidential, this constitute 71% of the total sample. Only 16% of the respondent disagreed and two were unsure.

4.5.5. Religious convictions

Response	Religious convictions	Percentages
Strongly Agree	0	0%
Agree	1	3%
Neutral	5	16%
Disagree	11	36%
Strongly Disagree	14	45%

Table4.5. Religious convictions.

Table 4.15 indicates that the majority of respondents (25 in total) disagree that people do not test for HIV because of religious convictions, this represent 81% of the total. Only one respondent agreed and five were neutral.

4.5.6. Cultural believes

Response	Culture	Percentages
Strongly Agree	1	3%
Agree	1	3%
Neutral	4	13%
Disagree	11	36%
Strongly Disagree	14	45%

Table4.6. Culture.

Results indicates that most of the respondents (81%) disagreed that culture have an influence in once decision to test for HIV. Four participants were neutral and two agreed that they may be influenced to test for HIV by their cultural believes.

4.5.7. Lack of information

Response	Lack of HIV and AIDS information	Percentages
Strongly Agree	8	26%
Agree	11	36%
Neutral	4	13%
Disagree	6	19%
Strongly Disagree	2	6%

Table4.7.Lack of HIV and AIDS information.

When asked whether people do not test for HIV because they lack HIV and AIDS related information, 19 participants (62%) agreed to that. Four respondents disagreed that people do not test because of lack of HIV information.

4.5.8. Education

Response	Better education	Percentages
Strongly Agree	14	45%
Agree	10	32%
Neutral	3	10%
Disagree	2	6%
Strongly Disagree	2	7%

Table4.8. Better education.

In response if people would test for HIV if they are better educated on HIV testing, 77% respondents indicated they agree that people need to be educated on HIV and AIDS in order to make a decision to test. Four participants who constitute 13% of the sample disagreed that education can influence one's decision to test for HIV and 10% are not sure if it influence them or not.

4.5.9. Operational hours of the testing facility

Response	Facility accessibility	Percentages
Strongly Agree	1	3%
Agree	11	35%
Neutral	4	13%
Disagree	12	39%
Strongly Disagree	3	10%

Table4.9. Facility accessibility.

Table 4.9 presents participants' response with regard to facility's accessibility for longer hours. Some of the participants (49%) agreed they would test if the HIV testing facility operates for longer working hours, others (38%) disagreed that accessibility is not a concern to them and four participants remained neutral.

4.5.10. Attitudes of health workers

Response	Helpfulness of HCT worker	Percentages
Strongly Agree	9	29%
Agree	16	52%
Neutral	2	6%
Disagree	1	3%
Strongly Disagree	3	10%

Table4.10. Helpfulness of HCT worker.

In total, 81% of respondents agree that they would test for HIV if health workers are more helpful. Four participants (or 13% of the total) disagreed.

4.5.11. Knowledge and skills of health workers

Response	Skill and professionalism of health worker	Percentages
Strongly Agree	10	32%
Agree	8	26%
Neutral	6	20%
Disagree	6	19%
Strongly Disagree	1	3%

Table4.11. Skill and professionalism of health worker.

When asked whether people would test for HIV if they have faith in the skill and professionalism of health workers, 18 participants agree that they will test, which translate to 58%.

4.5.12. Role models

Response	Role models	Percentages
Strongly Agree	8	26%
Agree	11	35%
Neutral	4	13%
Disagree	4	13%
Strongly Disagree	4	13%

Table4.12. Role models.

In response to the question whether people would test for HIV if they have seen those they trust and look up to going for HIV testing, 19 participants (61%) agreed that role models have an influence in one's decision to test for HIV, while eight participants believe they would not be influenced by role models. Few respondents (four in total) indicated that the presence or absence of role models does not have much influence on their testing behaviors.

4.5.13. Motivation

Response	Motivation to use HCT service	Percentages
Strongly Agree	6	19%
Agree	14	45%
Neutral	7	23%
Disagree	3	10%
Strongly Disagree	1	3%

Table4.13. Motivation to use HCT service.

When responding to the question whether people would test for HIV if they believe that their colleagues are motivated to equally use the HCT facility, 20 out of the total sample (64%) indicated that they would test if the majority of people are motivated.

4.5.14. Health concerns

Response	Health concerns	Percentages
Strongly Agree	15	49%
Agree	13	42%
Neutral	1	3%
Disagree	1	3%
Strongly Disagree	1	3%

Table4.14.Health concerns.

A question was asked whether people would seek HCT services if they have health related concerns. A total of 28 of the 31 respondents (91%) agree that they would test if they are concerned with their health.

4.5.15. HIV status

Response	Believe being negative	Percentages
Strongly Agree	3	10%
Agree	3	10%
Neutral	10	32%
Disagree	5	16%
Strongly Disagree	10	32%

Table4.15. Believe being negative.

A statement was posed to find out if people would test for HIV if they believe they are HIV negative. The responses were that 10 respondents (32%) strongly agreed, 10 neutral, five participants disagreed, three agreed and another three participants strongly agreed with the statement.

4.5.16. Future planning

Response	Informed choices by knowing status	Percentages
Strongly Agree	19	61%
Agree	11	36%
Neutral	1	3%
Disagree	0	0%
Strongly Disagree	0	0%

Table4.16. Future planning.

Results reveal that 30 out of the total sample agree that people would test for HIV if they believe that knowing their status will help them make a difference in their life, this translates to 97% of the respondents.

4.5.17. Risk behaviours

Response	Risk of contracting HIV	Percentages
Strongly Agree	7	23%
Agree	15	48%
Neutral	3	10%
Disagree	6	19%
Strongly Disagree	0	0%

Table4.17. Risk of contracting HIV.

Respondents were asked if people would test for HIV if they think they are at risk of contracting HIV. The majority of respondents, 22 in total, agreed that they will seek HCT services if they are considered being at risk of HIV infection. Six of the participants disagreed that they would test with regards to the risk of contracting HIV, whereas three of the participants are not sure whether they will be influenced by the risk or not.

4.5.18. Support by others

Response	Encouragements by friends and co-worker	Percentages
Strongly Agree	12	39%
Agree	17	55%
Neutral	1	3%
Disagree	1	3%
Strongly Disagree	0	0%

Table4.18. Encouragements by friends and co-worker

Results show that 29 of the respondent (94%) agreed that they would test for HIV if they are encouraged by friends and co-workers.

4.5.19. Reliability of testing instruments

Response	Accuracy of testing instruments	Percentages
Strongly Agree	6	19%
Agree	15	48%
Neutral	7	23%
Disagree	3	10%
Strongly Disagree	0	0%

Table4.19. Accuracy of testing instruments.

Findings in this study reveal that 21 respondents agreed people would test for HIV if the testing instrument is accurate, which represents 67% of the respondents sample. Only three participants disagreed that the accuracy of the testing instrument would have an influence on their decision to test or not to test for HIV, while seven of the respondents remained neutral.

4.5.20. Provision of information on positive living

Response	Positive living	Percentages
Strongly Agree	18	58%
Agree	13	42%
Neutral	0	0%
Disagree	0	0%
Strongly Disagree	0	0%

Table4.20. Positive living.

It can be noted that all respondents (100%) agreed that educating people on how to live positively will influence their decision to seek HCT service.

4.6. General information

Respondents were asked to give comments on what can be done to motivate correctional officers at ENCF to utilize their HCT facility. The following responses were cited:

- Workshops, information dissemination and workplace programmes for correctional officers.
- Awareness campaigns and distribution of HIV and AIDS materials.
- Conducive time schedule and HCT facility for members.
- Involvement of stakeholders and the use of vernacular in HIV education.
- Monthly campaigns and/or inclusive of HIV information sharing during monthly meeting.
- Functional of AIDS committee and establishment of support system.

4.7. Discussion of Main Findings

The demographic characteristics of the study sample indicate that there were more males who took part in the study. This could be as a result of more male compared to female correctional officers at ENCF, or simply that males were more willing to participate in this study.

The study found that the majority of correctional officers who participated in the study were in the age range of 21 – 40. Furthermore, the majority of respondents have secondary education. It was cited that being older youth and having an educational level of secondary and above are factors having a positive correlation with willingness to test for HIV. A similar conclusion could therefore possibly be drawn for this study, as most correctional officers can be categorized in a younger cohort and have secondary education, which is the category associated with high testing. This was indeed the case, as the study found that 74% of participants tested for HIV in the last 12 months at private, Elizabeth Nepemba and public health facilities. With regard to correctional officers rank ration, it was noted that more junior officers took part in the study than senior officers. This can be due to the fact that there are few senior officers at the correctional facility.

There are several reasons that can persuade an individual to seek HCT services and their decision where to utilize such services. In the case of correctional officers as derived from this study, their main desire to seek HCT services were to simply know their status; while treating information as confidential had the biggest influence on respondents' decision to select a particular facility to utilize the said services.

Section B of the questionnaire focused on HIV testing. Section B's aim was to identify employee' needs in terms of HIV testing; as well as the motivational strategies that can provide guidelines on how to improve HCT services in general.

The study found that 81% of correctional officer's decision to test for HIV would not be influenced by the accessibility of the testing facility. This could be because ENCF is equipped with a HIV testing facility; as well as the relatively easy access to other public and private testing sites within the vicinity of Rundu.

Most correctional officers would not to test for HIV because they fear rejection from family and friends. Thus, the fear of rejection from family and friends could be considered as a barrier to HCT services utilization. The possibility of losing their jobs was not a factor deterring them from testing. This may indicate a high level of job security among respondents.

The majority of correctional officers agreed that knowing that one's result will be kept confidential would motivate them to test for HIV. In addition, the majority of the respondents agreed that the skills, level of professionalism and attitudes of health workers will have an influence on whether they will test or not. This is in line with quoted literature in this regard Shangula (2006), which states that people are sometimes anxious about HIV testing if they fear there are confidentiality issues, while if it is not the case they would be more inclined to test.

In response to the questions on role models and motivation: Results showed that most respondents agreed that they would test for HIV if they were motivated by those they look up to testing. Equally, the majority of correctional officers agreed that if they have health concerns they might be positively influenced to go for HIV testing. Results further found that the majority of correctional officers agreed that they would test for HIV if they believe they are at the risk of contracting HIV. This is in line with quoted studies where it was cited that past exposure have shown an effect on HCT uptake (Creel et al, 2012).

The majority of respondents agreed that peer's support, reliability of the testing instrument and information provision on positive living would have a positive influence in their testing behaviour. This is in line with the literature, which indicated that clients should be helped to e.g. understand how antibody tests work and be provided with the necessary information so to make informed decisions (e.g. weighing the pros and cons of HIV testing). Access to information prepares individuals for difficulties they may face in future (Stone, 2001).

The majority of the general comments by correctional officer in this study were centered on education, information provision, confidentiality, and awareness

campaigns to influence officers to test for HIV. It was noted to note that most correctional officer prefer including HIV information sharing during the monthly meeting as well as a conducive time and facility for discussions. They also felt the need for more workshops and called for the invitation of expertise to address the on HIV and AIDS related matters. Furthermore, they also suggested the establishment of support groups for correctional officers who test HIV positive and for those living with the virus.

It was also found that some correctional officers seemed not to be aware of the existence of the facility's AIDS committee. This was revealed by their constant request of the formulating a committee that will be mandated with HIV and AIDS related affairs. Together with those that are aware of its existence, the correctional officers believed many of them will be better motivated to test if the communication and testing was done in their vernacular.

Chapter Five: Summary and Recommendations

5.1 Summary

In terms of HIV counseling and testing, 74% of participants reported accessing HCT services in the last twelve months. The study revealed a number of factors that influence the HCT uptake of correctional officers, ranging from confidentiality issues, and privacy issues to the condition of service and staff competency. It further identified factors such as facility accessibility, fear of rejection from family and friends, information provision and education, future planning and risky behaviour as factors which can influence HCT uptake.

The study also showed that there is a need for awareness campaigns, information dissemination and involvement of stakeholders in order to enhance behavioural change and address health and high risk issues for correctional officers. In particular, more awareness around the functioning of the existing AIDS Committee should be done and the establishment of support mechanisms for HIV-related issues should be established. The study also revealed that more needs to be done to address the apparent fear of rejection from family and friends if they would test positive that respondents seem to display.

5.2 Recommendations

From the findings of the study the following recommendations can be made:

- The AIDS Committee should spearhead workshops, information dissemination and educational programmes for correctional officers, so to improve their visibility and influence as well as improve HCT uptake. The facility should involve stakeholders both at senior and junior level. It is necessary that correctional officers should be informed of the existence of the intensified awareness programs.

- Regular workshops and seminars should be organized to empower correctional officers with the knowledge and skills related to HIV behavioural change; as well as resolve any issues related to fear of stigma or rejection by family members because of their HIV-status.
- The study revealed that correctional officers are influenced by the competencies of health workers. Regular training or refresher courses for health workers are recommended. In achieving this goal, additional health workers may need to be employed.
- Facility leadership also needs to take more initiative or ownership and find ways to motivate employees to seek HCT. From the study findings, if they do take the initiative, motivating their members (i.e. those that look up to them) could be a successful way to increase HCT uptake.
- A comparative study on a larger scale needs to be conducted in other correctional facilities explore similar influences in those facilities so to draw comparisons to the current study.

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6.2. Appendix 1: Self-administered questionnaire
Namibian Correctional Service
Employees Questionnaire

This questionnaire is anonymous. Please do not write your name, service number or personal particulars on this document. Please note that responses are confidential and cannot be used to identify individuals.

Kindly note that some questions may be sensitive but we request for utmost honest in your responses.

Section A – Demographic Information

Please answer the following question by circling the number corresponding to the most appropriated options.

- | | | |
|-----------------------------------|------------|---|
| 1. Gender | Male | 1 |
| | Female | 2 |
| 2. Age | Under 20 | 1 |
| | 21 – 30 | 2 |
| | 31 – 40 | 3 |
| | 41 – 50 | 4 |
| | 51 + | 5 |
| 3. Marital status | Single | 1 |
| | Married | 2 |
| | Cohabiting | 3 |
| | Divorced | 4 |
| | Widow | 5 |
| 4. Highest education level | None | 1 |
| | Primary | 2 |
| | Secondary | 3 |
| | Tertiary | 4 |

5. Rank	Senior Officer	1
	Junior officer	2
6. Have been tested for HIV in the last 12 months?		Yes 1
		No 2
6.1. If yes, where?	Elizabeth Nepemba HCT facility	1
	Public	2
	Private	3
	Standalone Site	4

7. Reason(s) for using HCT services

Wanted to know my status	1
Future planning based on the results	2
I was counseled on how to live positively and decided to test	3
For work and policy reasons (mandatory)	4
Referred by Doctor	5
Other reasons not listed	6
Please specify reason(s).....	

8. Reason(s) for selecting the particular services

Staff competent in providing HCT services	1
Privacy (no one can tell I went for a test)	2
My information will be treated confidential	3
The facility was neat	4
Condition of service they offer	5
Publicity of the facility	6
Other reasons not listed	7
Please specify reason(s).....	

9. **Sort of service(s) you obtained** General HIV information 1
 Counseling 2
 Testing 3
 All of the above 4

Section B – HIV Testing

State whether you Strongly Agree (SA), Agree (A), are Neutral (N), Disagree (D) or Strongly Disagree (SD) with the following statements by circling your feelings toward each statement.					
1. People do not test for HIV because testing services are not easy accessible.	SA	A	N	D	SD
2. People do not test for HIV because they fear being rejected by family and friends.	SA	A	N	D	SD
3. People do not test for HIV because they fear they might lose their jobs if their employer find out.	SA	A	N	D	SD
4. People do not test for HIV because they fear their results will not be kept confidential.	SA	A	N	D	SD
5. People do not test for HIV because of their religious convictions.	SA	A	N	D	SD
6. People do not test for HIV because of their culture.	SA	A	N	D	SD
7. People do not test for HIV because they lack information about HIV and AIDS.	SA	A	N	D	SD
8. People will test for HIV if they were better educated on the subject matter.	SA	A	N	D	SD
9. People will test for HIV if HCT testing facility is accessible for longer working hours.	SA	A	N	D	SD
10. People will test for HIV if staffs at the HCT facility are more helpful.	SA	A	N	D	SD
11. People will test for HIV if have faith in the skill and professionalism of the HCT worker.	SA	A	N	D	SD
12. People will test for HIV if they have seen those they trust and look up to also going for HIV testing.	SA	A	N	D	SD
13. People will test for HIV if they believe other workers are motivated to use HCT Service.	SA	A	N	D	SD

14. People will test for HIV if they are concerned about their health.	SA	A	N	D	SD
15. People will test for HIV if they believe they are HIV negative	SA	A	N	D	SD
16. People will test for HIV if they believe that knowing their status will make a difference.	SA	A	N	D	SD
17. People will test for HIV if they believe they are at risk of contracting HIV.	SA	A	N	D	SD
18. People will test for HIV if they are encouraged by friends and co – worker.	SA	A	N	D	SD
19. People will test for HIV if they trust the accuracy of the testing instruments.	SA	A	N	D	SD
20. People will test for HIV if they are educated about positive living	SA	A	N	D	SD

21. What can be done to motivate more employees to test for HIV at E Nepemba HCT facility?

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6.3. Appendix 2: Letter to the Officer In Charge

Private Bag 2129
Rundu
31st March 2011

The Officer In Charge
Elizabeth Nepemba Correctional Facility
Rundu

Dear SSP Amutenya

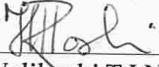
Re: Permission to carry out research at Elizabeth Nepemba Correctional Facility

I am Tangeni Immanuel N.O. Velikoshi an employee of the Namibian Correctional Services at the above mentioned Facility and at the same time a Master of Philosophy (HIV/AIDS Management) candidate at the University of Stellenbosch in South Africa. As per the University requirement, I am expected to submit a thesis. Hence, I would like to investigate the *"factors contributing to low use of HIV/AIDS Voluntary Counseling and Testing services amongst employees of the Namibian Correctional Services at Elizabeth Nepemba"*.

The study will only be carried out for academic purposes in partial fulfillment of the Master Degree. It is against this background that I humbly request for the permission to carry out this study on 60 employees through self administered questionnaires as well as 6 interviews of top managers and those spearheading the VCT service provision.

Thank you in advance for your support. I hope and trust that your respective officer will treat my request with urgency and with almost importance.

Yours faithfully,



Velikoshi T.I.N.O. SSP
Student No: (16260635)
0811488216

6.4. Appendix 3: Letter from the Commissioner General



Republic of Namibia



Department of Prison Service

Ministry of Safety and Security

Enquiries: DCP T. HANGULA

Tel. No: (+264 61) 284 6111

Fax No: (+264 61) 238 469

My Ref:

Your Ref:

*Office of the Commissioner
Namibian Prison Service
Private Bag 13281
WINDHOEK
NAMIBIA*

06 April 2011

The Officer in Charge
Elizabeth Nepemba Correctional Facility
Private Bag 2129
Rundu

**RE: PERMISSION TO CARRY OUT A RESEARCH ON HIV/AIDS AT ELIZABETH
NEPEMBA CORRECTIONAL FACILITY: SSP VELIKOSHI T.I.N.O**

Permission is hereby granted to SSP Velikoshi T.I.N.O to conduct a thesis regarding the factors contributing to low use of HIV/AIDS Voluntary Counselling and Testing Services amongst employees of the Namibian Correctional Service at Elizabeth Nepemba Correctional Facility.

You are advised to share your findings with this office.

Yours sincerely

**E. SHIKONGO
COMMISSIONER-GENERAL
NAMIBIAN CORRECTIONAL SERVICE**