

HIV Voluntary Counselling and Testing in Namibia: Status, Successes, and Barriers

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Abstract

Voluntary Counselling and Testing is one of the strategies to respond to the increasing number of Human Immunodeficiency Virus/Acquired immunodeficiency syndrome (HIV/AIDS) new infections. The purpose of this study was to assess the current status of HIV Voluntary Counselling and Testing (VCT) in Rundu urban and identify the barriers to fully effective service. The objectives of the study was to identify the barriers that prevents effective HIV Voluntary Counselling and testing services; asses its success and determine its status in urban, Namibia. A qualitative explorative and descriptive design was employed in this study where all health care and HIV/AIDS professionals including hospital nurses, employees and New Start VCT Centres, and representatives from relevant NGOs, Community-Based Organizations (CBOs), and the Ministry of Health and Social Services (MoHSS) providing Voluntary Counselling services in Rundu urban in Namibia were interviewed. In this study, in depth individual interview structured in accordance with interview guide was used. Content analysis method was employed to analyze the data. Themes that emerged from this study includes: Fear of a positive results (stigma that accompanies seropositivity) and lacks of perceived benefit to getting tested. In addition, financial barriers affecting the poorest populations in Rundu. To increase access and relevance of VCT services, it is recommended that the Ministry of Health and Social Services should develop more detailed counselling guidelines and increase the scope of counselling by addressing the inadequacies of current risk reduction. Despite these hopeful possibilities a number of barriers remains before VCT can be fully effective.

Keywords: HIV, counselling, voluntary counselling and testing, barrier, success, status

1. Introduction

HIV remains one of the biggest public health challenges globally and especially in Sub Saharan Africa and in Namibia. The UNAIDS (2014) fact sheet on Global Statistics indicate that to date 15 million people are accessing antiretroviral therapy (ART) by March 2015, 36.9 million people globally were living with HIV, 2 million people became newly infected with HIV and 1.2 million people died from AIDS related illness. Sub- Saharan Africa has 25.8 million people living with HIV, of which women account for more than half the total number of people living with HIV (UNAIDS, 2014). It is estimated that 1.4 million new infections in 2014 and these new infections account for 60% of the global total of new infections.

Namibia has achieved high treatment coverage of 86% using the CD4 count of 350 with 50% decreases in estimated new infections and number of AIDS related deaths (MoHSS, 2013). Following the first reported cases in 1986, data compiled by the Ministry of Health and Social Services (MoHSS) show that AIDS became the leading cause of death in Namibia in 1996. The 2008 MoHSS HIV projections show an estimated adult prevalence rate of 18%. Approximately 3,350 infants are infected with HIV per annum. The vast distances and low population density in Namibia make health care and HCT services inaccessible to many segments of the population who are at risk of HIV. Recent estimates indicate 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. Only 5% of those attending HIV Counselling and Testing (HCT) did so as couples (MoHSS, 2013).

There are three approaches to voluntary counselling and testing. Client-initiated HCT means that the client is the

one that seeks out the services. The knowledge of status, and the counselling that accompanies it, can be a powerful catalyst for behaviour change. Provider-initiated means that health care workers recommend HIV testing to patients as part of routine health care services. The provision of provider-initiated HCT in health facilities and hospitals can improve diagnosis and save lives. Testing should be offered to patients in antenatal clinics, maternity wards, medical and surgical wards, outpatient departments, Sexual Transmitted Infections (STI) units, and Tuberculosis (TB) clinics. Finally a third approach, home-based HCT brings HCT services into the home (MoHSS, 2011).

The MoHSS (2014) Sentinel Surveillance among pregnant women estimates the second highest HIV Prevalence was Rundu (24.1%) after Katima mulilo (36%). Namibia has significantly expanded HCT services, through traditional VCT for people who seek to know their HIV status. It also has initiated Provider initiated Testing and Counselling (PITC) through HIV testing in antenatal clinics (ANC) through the prevention of mother to child transmission (PMTCT) programmes and through testing in TB and STI settings. Because of the critical shortage of qualified medical personnel in Namibia, the MoHSS trained and deployed lay HCT counsellors who are able to do both counselling and rapid HIV testing in public health facilities to complement the overburdened health care providers and provide both VCT and PITC services. The lay HCT counsellors, known as 'community counsellors', provide services such as HIV counselling, couples HCT, HIV rapid testing (if certified), male circumcision (MC) counselling and Anti-retroviral Therapy (ART) adherence counselling.

Voluntary Counselling and Testing is one of the strategies to respond to the increasing number of HIV/AIDS new infections, it provides the opportunity to know about ones status and acts as an entry point to access treatment, care and support services. Despite the efforts of the MoHSS to increase the number of health facilities providing VCT services and the increase of HIV Voluntary counselors in Namibia. It is not clear as to what causes the number of people who use VCT services to be low. Results indicated that 72% of all HIV tests reported to the Ministry of Health and Social Services (MoHSS) were conducted at Public Health Facilities (PHF). National Testing Day (NTD) and Standalone facilities conducted 15% and 12% of the tests respectively with workplaces recording the lowest proportion of 0.9%. The highest HIV positivity rate of 21% was identified at workplaces followed by PHF with 9% and 5% for NTD. Despite the increase of health facilities providing VCT services and the increase in Voluntary counsellors. There is a need for the increase of HIV Counselling and Testing service to be utilised to the maximum to know the HIV status timely to make crucial life decisions. The researcher is not aware of any study conducted in Namibia on this topic: HIV Counselling and testing at Rundu Intermediate Hospital in Kavango East Region: Status, Barriers and Success. The above phenomenon has led to the formulation of the research question: What is the status, barriers and success of HIV counselling and testing at Rundu Intermediate Hospital in Kavango East Region.

2. Goals and Objectives

The goal of the study was to assess the current status of HIV Voluntary Counselling and Testing (VCT) in urban Namibia and identify the barriers to fully effective service. The objectives of the study was identify the barriers that prevents effective HIV Voluntary Counselling and testing services; asses its success and determine its status in urban Namibia.

3. Research Design and Methods

3.1 Design

A cross-sectional qualitative and explorative design.

3.2 Study Population

The study population included all health care and HIV/AIDS professionals including hospital nurses, employees and New Start VCT Centres, and representatives from relevant NGOs, Community-Based Organizations (CBOs), and the Ministry of Health and Social Services (MoHSS), Namibia.

3.3 Inclusion and Exclusion Criteria

All health care and HIV/AIDS professionals including hospital nurses, employees and New Start VCT Centres, and representatives from relevant NGOs, Community-Based Organizations (CBOs), and the Ministry of Health and Social Services (MoHSS). In addition, health care and HIV/AIDS professionals including hospital nurses, employees and New Start VCT Centres, and representatives from relevant NGOs, Community-Based Organizations (CBOs), and the Ministry of Health and Social Services (MoHSS) who were not willing to participate were also excluded in the study.

3.4 Sampling and Sample Size

In qualitative studies the size of a sample is guided by the purpose of the inquiry. Therefore in this study there was no specification of the sample size but data saturation was determined by the sample size. Data saturation was reached with eleven (11) participants. Maree (2016), describe purposive sampling as a strategy that is used in qualitative studies whereby participants are grouped according to predetermined criteria that are relevant to a particular research question. Purposive sampling was used to select participants in this study.

3.5 Data Collection Tool

In this study, in-depth interviews were used as the primary source of data collection. This data collection method was used for the study, as it is considered to be a relevant tool to use when the researcher seeks to learn about people's feelings, thoughts and experiences (Maree, 2016).

3.6 Data Collection Methods

The researcher conducted face to face in-depth interviews with health care and HIV/AIDS professionals including hospital nurses, employees and New Start VCT Centres, and representatives from relevant NGOs, Community-Based Organizations (CBOs), and the Ministry of Health and Social Services (MoHSS).

3.6 Data Analysis

In this study, in depth individual interview structured in accordance with interview guide was used. Content analysis method was employed to analyze the data.

4. Ethical Considerations

HIV and AIDS are considered as sensitive issues due to the nature of the stigma and discrimination surrounding the disease. 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.

5. Results

Table 1. Characteristic of Participants

Age	Total
27-30	5
31-40	4
41-50	1
51-60	-
Unknown	1
Marital Status	
Single	5
Married	3
Co-habiting	3
Widowed	-
Educational Level	
Grade 1-7	3
Grade 8-12	4
Tertiary Education	4
No education	0
Employment	
Employed	5
Unemployed	5

Professional rank

Registered nurse	3
Enrolled Nurse	3
VCT counselors	4
NGO Representative (Social Marketing Association)	1

5.1 Socio Demographic Description of Study Participants

Participants were health care and HIV/AIDS professionals including hospital nurses, employees and New Start VCT Centres, and representatives from relevant NGOs, Community-Based Organizations (CBOs), and the Ministry of Health and Social Services (MoHSS). All participants were under the age of 40 years old. Marital status of participants varied some were single, married and the others co-habiting. Educational level of participants also varied with less of them schooling till grade 7, most of the participants reached secondary school and some even went as far as tertiary education, only one participant had no schooling. It is evident from the table that participants were equally unemployed and employed, with the unemployed doing voluntary services at hospitals and mostly with the NGO's and Community-based Organizations.

Table 2. Themes and sub-themes of data analysis

Themes	sub-themes
5.1 Views of counselors regarding HIV counselling and testing of clients	5.1.1 Determining the risks of getting infected with HIV (Revealing of HIV status)
	5.1.2 Fear of infected due to unsafe sex practices
5.2 Participants different views regarding testing of partners	5.2.1 Involvement of partners in HIV testing
5.3 PMTCT	5.3.1 Difficulties in joining PMTCT programme
5.4 Clients rationales regarding HIV counselling and testing (difficulties and success of counselling)	5.4.1 New relationships and marriages
	5.4.2 Counselling and testing of a sick person
	5.4.3 Other factors for counselling and testing
5.5 Barriers to HIV counselling and testing	5.5.1 Stigma
	5.5.2 Spatial and Financial Barriers to New Start HIV VCT Services
	5.5.3 Ideology and Services
	5.5.4 Ideology and Services
	5.5.5 Referrals between institutions
	5.5.6 Gender, Income, and VCT

*5.1 Views of Counselors Regarding HIV Testing**5.1.1 Determining the Risks of Getting Infected With HIV (Revealing of HIV Status)*

The counselors revealed that most clients are visiting the testing centers mainly to be tested and informed about their HIV status. To make the counselling and testing easier, it is always good to firstly find out from the clients the reasons why they are visiting the testing centers.

"Knowing clients' reasons for getting tested allows us to determine their risk of having been exposed to HIV, personalize the information given during the counselling".

The counselors further revealed that it is not always easy to get right answers from the clients

"...determining why clients had come to the clinic could be difficult: often they were ashamed or embarrassed about why they had come".

5.1.2 Fear of Infected Due to Unsafe Sex Practices

The counsellors also revealed that people were most often getting tested for HIV because had practiced unsafe sex and were unsure of their sexual partner's HIV status or sometimes they were drunk

"Clients blamed their behaviors on being drunk at the time and thus "couldn't remember all of the details of what happened".

According to unpublished statistics given to the researchers by SMA, this accounted for approximately 44% of the visits to New Start Centres. Often people just wanted to know their status as they were worried they might have caught HIV. Counsellors said that they would respond to clients' anxieties by being "warm and open" and especially non-judgmental, repeatedly telling clients that they were not there to judge or criticize but educate and support. They often noted that as the counselling session progressed, clients would open up as they became more comfortable.

5.2 Participants Different Views Regarding Testing of Partners

5.2.1 Involvement of Partners in HIV Testing

The next most frequent reason cited was that of partner risk. This accounted for approximately 814% of visits to New Start Centres. Clients would tell the counsellor that although they had been faithful, they suspected their partner of "cheating" on them and were worried about HIV.

"I suspect my partner of "cheating" on me".

This problem proved to be very difficult for counsellors: while they could help clients learn their HIV status, it was often very difficult to help them find ways to change behaviours. Many clients said that their partner would leave them or be suspicious if they asked to use condoms, so this was not an option.

"I was frequently getting tested without my partner's knowledge".

This concern was most pressing for women, an issue that will be discussed in detail in the Gendered Experience of the HIV Test section on page 61.

5.3 PMTCT

5.3.1 Difficulties in Joining PMTCT Programme

With regards to pregnant women, a major motivation to be tested, and thus a focus of the counselling, was the prevention of mother-to-child transmission (PMTCT) program now offered at hospitals. Pregnant women who go to the hospital are offered a chance to participate in the PMTCT program whereby they are tested for HIV and if HIV positive, given a large dose of Antiretroviral (ARVs, HIV-fighting drugs) prior to and during delivery. The baby is given also given a dose of ARVs soon after birth. This decreases the chances of mother-to-child transmission of HIV during the birthing process. Counsellors revealed also that it is not easy to make the mother understand the importance of joining PMTCT programme.

"Many mothers wanted to get tested for HIV at the center first before deciding whether they wanted to participate in the PMTCT program or not".

5.4 Clients Rationales Regarding HIV Counselling and Testing

5.4.1 New Relationships and Marriages

Beginning a new relationship and marriage were two other relatively common reasons people were getting tested for HIV.

"We want HIV test before having sex so that we could know each other's status and thus prevent transmitting HIV".

Here the biggest issue that came up for counsellors was the possibility of discordant results, where one person is HIV positive and the other HIV negative. This situation incited a fair amount of discussion at the four day training conference, in which counsellors debated about whether they should counsel couples together or separately. Counselling couples together can be valuable because the counsellor can help them make decisions together and discuss condom negotiation. Counselling two people together, however, is often much more difficult than counselling them individually and some counsellors did not feel adequately trained for this type of situation. In the end it was left up to the individual counsellors whether they felt comfortable counselling couples together or separately.

5.4.2 Counselling and Testing of a Sick Person

A final reason people were getting tested (often one of the more difficult ones for counsellors) was illness: a client would come in experiencing symptoms of an STD or opportunistic infection having decided to get an HIV test to see if this was the cause.

“I just want to be test, just to see whether this is the sign of HIV infection”.

SMA noted in its New Start statistics that 7% of their clients cited illness as their reason for getting tested, and a further 3% were being tested because their partner or child were ill. This was another issue brought up during the role playing session at the central training. A counsellor from the Katima New Start Centre said that “most clients that come to the centre are already quite sick.” Some were so sick that they couldn’t sit upright during the counselling, had difficulty walking, and would even vomit or defecate on the floor. This proved to be highly problematic for counsellors in a number of ways. Many counsellors felt that they weren’t trained to deal with a sick patient, and that it was difficult to give them the right kind of counselling as the patient often required more immediate medical attention. One counsellor said: *“patients were sometimes so ill that they were hard to understand and could barely speak”.*

5.4.3 Other Factors for Counselling and Testing

These reasons were simply the most often mentioned while the researchers were doing the research, and certainly don’t cover everyone’s reasons for getting and HIV test. Some other motivations were: getting insurance, employment, school admission and scholarships, planned pregnancies, family planning, shared needles, blood transfusions and exposure in the workplace. Most counsellors indicated that their works are challenging, but very important.

“Knowing why people get tested for HIV is important – not only does it allow for more effective counselling, but it also gives us an opportunity to provide focused, targeted education and risk-reduction strategies”.

With this background of reasons people do get tested, the researchers would now like to launch into a discussion as to why counsellors and other HIV/AIDS workers felt people are not getting tested for HIV. The researchers main conclusion was that stigma (leading to lack of awareness, education, and understanding) is one of the biggest factors preventing people from deciding to get tested.

5.5 Barriers to HIV Counselling and Testing

HIV VCT faces a number of barriers that affect its overall effectiveness. Some are simply the consequence of larger social issues (such as the stigmatization of HIV), while other problems are specific to VCT. Getting people to a testing center is not the only hurdle that must be overcome: for VCT to be considered fully effective, clients must also return to the centre for their results. According to New Start’s statistics, at some centres as many as 25% of clients do not return for results, while at other centres the “no-return” rate is just above 0%.

5.5.1 Stigma

There is no doubt that HIV is a highly stigmatized disease. It is very common in Namibia to hear of people losing their partners, being shunned by their friends, family, and community, or losing their jobs – all because they were HIV positive.

“Even us who work in HIV/AIDS-related fields feel the strong effects of stigma: they often told us of people are speaking behind their back, saying that we were HIV positive and spreading nasty stories”.

Stigma can be such a concern for some people that it makes anxious to even be seen in or around a New Start testing centre. Counsellors revealed also that clients were worried that someone in their community would see them entering or leaving the centre. One counsellor said that the client told her that *“I am afraid to leave with any sort of papers or pamphlets, as people thought that I am HIV positive”.*

Not surprisingly, the most common reason many people do not want to get tested for HIV is fear of a positive result. Of course, fear of differential treatment by friends, family and community is the most recited story. Many people the researchers spoke to believed that this fear was exacerbated by the lack of attention paid to confidentiality in hospital settings prior to the availability of New Start centres. They said that fears of rejection by others could be reduced if people felt they could learn their status completely independently, without anyone else knowing. However, the legacy of broken confidentiality persists and makes a number of people wary of any HIV testing at all.

Counsellors also told the researchers that some patients were afraid of being tested for HIV because they believed that once they found out that they were HIV positive they would die soon. This was especially the case when people didn’t feel that they had reliable access to ARVs, which slow down the progression of the HI virus in the

body. Therefore a sense of hopelessness (whether misplaced or not) was deterring people from getting tested for HIV.

5.5.2 Spatial and Financial Barriers to New Start HIV VCT Services

The two principal factors restricting the accessibility of HIV testing are what the researchers have dubbed spatial and financial barriers. These barriers mostly affected the poorest populations in Windhoek, which should be of concern to both SM and PSI as their mandate is to reach the most 'at risk' populations.

While SMA highly subsidizes their VCT services, New Start Centres are still advertised as charging N\$10 per HIV test, which includes the pre- and post-test counselling as well as counselling for the following three months. This fee was not completely obligatory: SMA often promoted New Start centres in newspapers with a voucher for a free HIV test. Various centres would also sometimes waive fees if the client had been referred by a priest or if they could show that the services were too expensive for them to afford otherwise.

"For those who do not (or cannot) read the newspaper or come across a free voucher and do not know which centres will waive fees, however, even a subsidized fee of N\$10 can be too much".

When taxi fare to and from the centre, lost work time, and lost time spent with children or other family members are all factored in, the cost grows from a mere N\$10 to something much greater. If rapid testing is not available the results must be picked up on another day, which means twice the travelling and twice the time commitment.⁴

A second hurdle to accessing New Start centres is their physical location. New Start centres operate only in urban centres. *"People living in more rural communities must travel a long distance to get tested".*

Again, if the test results cannot be given on the same day, this means that the trip must be taken twice or that accommodations must be found for the waiting period. Another aspect of physical location that affects people's likelihood to attend a New Start testing Centre is its location and visibility within a community. If the centre is in a high-traffic area or located directly in the community it serves, people will be less likely to attend it as they will be seen coming and going: again, the fear of stigma rears its ugly head.

5.6 Trustworthiness

Trustworthiness of this study was ensured by using the criteria of Lincoln and Guba namely: credibility, transferability, dependability, and conformability of the study (Guba & Lincoln, 1985).

6. Discussion

In discussing this findings, it has been established that clients' reasons for getting tested allows counsellors to determine their risk of having been exposed to HIV, personalize the information given during the counselling, and help them start thinking about ways they can reduce their future risk of contracting the diseases to reduce the risk of becoming infected or transmitting HIV. HIV testing empowers the uninfected person to protect himself or herself from becoming infected with HIV; assist infected persons to protect others and to live positively and offers the opportunity for treatment of HIV and associated infections. (NDHS, 2013) It empowers individuals and couples to adopt measures to prevent the transmission or acquisition of HIV infection. These study findings are similar with those of Velikoshi, Davis, and Ashipala (2018) where they found that in the case of correctional officers their main desire to seek HCT services was 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.

This study finding revealed that HIV VCT faces a number of barriers that affect its overall effectiveness. Some are simply the consequence of larger social issues (such as the stigmatization of HIV), while other problems are specific to VCT. Getting people to a testing center is not the only hurdle that must be overcome. Barriers related to social and behavioral factors that were mentioned by the participants of this study-included fear of positive results, stigma, and risky sexual behavior. Societal factors that contribute to men not utilizing VCT services include stigma and men's gender socialization. Institutional factors include poor treatment by nurses and confidentiality concerns were raised by Shipanga, Nauseb, Kloppers (2018).

This study results pointed out at Social stigmatization and lack of perceived benefits as not the only reasons some people don't get tested. The two principal factors restricting the accessibility of HIV testing are spatial and financial barriers. These barriers mostly affected the poorest populations in urban areas such as Windhoek, which should be of concern to both SM and PSI as their mandate is to reach the most 'at risk' populations. Notably, studies have demonstrated that health care workers often do not have adequate infrastructure or workforce to ensure completely confidential services, despite their willingness or desire to do so (Bott, Neuman, Helleringer, Desclaux, Asmar, & Obermeyer, 2015).

The challenge that comes along with this sort of organizational structure is ensuring consistency across New Start centres in terms of quality and breadth of the services provided. SMA has addressed these concerns by providing standardized guidelines, protocols, training, monitoring, and quality assurance. Despite this standardization, however, a number of inconsistencies remain. Institutional factors include poor treatment by nurses and confidentiality concerns came up in the study done Rouraa, Watson-Jonesa, Kahawitaa, Fergusond, and Rossa (2013).

It was found in this study that women are more like to attend a New Start VCT centre than men. It is interesting, then, that women also often have the most to lose by getting tested. Men seem to always be afraid of facing their HIV results and being seen visiting VCT centers. It was mentioned that knowing one's results would cause damage to an individual when he is confronted by bad results that might lead to depression. Fear of stigma was dominantly reported by men as the stumbling blocks to the uptake of HIV testing. It is therefore apparent that stigma and discrimination remain barriers to HIV testing as found in a study done by Shipanga, Nauseb, and Kloppers (2018).

Financial barriers do not only affect whether a client will be able to afford getting to and from the centre to get tested and pick up the results. Similar findings were also found by Mwangi, Ngure, Thige, Ngure (2014) stated that income also influence how effective counselling can be in terms of future risk reduction, living healthily after discovery of a positive result, and accessing health services. A study conducted to determine the cost of VCT services in Kenya.

In addition, income levels can greatly affect the ability of some clients to reduce their risk of HIV in the future. This was also noted that lower income is associated with an increased likelihood of HIV infection among some groups, few studies have explored how structural factors such as poverty can influence an individual's ability to access services such as VTC services (Meyerson, Barnes, Emetu, Bailey, Ohmit, & Gillespie, 2014)

7. Conclusions

7.1 Conclusions

Despite these hopeful possibilities a number of barriers remain before VCT can be fully effective.

The future of New Start VCT in Namibia looks quite promising: more and more centres are opening up and the number of clients being tested each month continues to increase. As time goes on the "word will get out" as to the quality of the service provided and New Start VCT will be given the opportunity to assist ever-growing numbers of Namibians in their attempts to deal with HIV. A number of the issues faced by centres and clients alike, such as stigma and lack of open discussion about HIV/AIDS are addressed simply by the existence of New Start centres. Each client that goes to a New Start centre is taught valuable details about HIV including how it is (and is not) transmitted, what it means to be HIV positive or live with someone who is, and the value to talking to partners and loved ones about the disease. The hope is that these clients will go out into their respective communities and talk about HIV with their peers, increasing general levels of awareness about HIV and decreasing the often intense stigma associated with the disease.

7.2 Recommendations

Based on the study findings, the following recommendations are made:

- Simplify and standardize fee deferral. Financial barriers can be a strong preventive factor for the poorest segments of the population.
- Establish more mobile VCT services. People who live far away from the centre, especially those living in rural communities, might find the trip to a New Start centre restrictive with regards to cost or time required
- Expand the availability of rapid testing. When test results are available to clients on the same day, issues such as the cost and time required to get to and from the clinic are greatly reduced
- Develop training for counselling couples and dealing with discordant results. Currently the option to counsel couples separately or together remains up to each individual counsellor and is based on their comfort level and training. Greater preparation to deal with these situations will increase the effectiveness of VCT for couples who come to the clinic to get tested as part of their relationship or marriage or if they want to have children.
- Address the inadequacies of current risk reduction strategies. The oft-heard mantra of Abstain, Be Faithful, and Condomize is simply not relevant to many clients, especially those of a lower socioeconomic status.

- Increase the scope of counselling to address larger socioeconomic and social concerns. Issues such as drug dependency and obtaining money, food and health care are of considerable concern to a number of clients
- Standardize condom distribution policy. Instructing clients how to use condoms and then opposing their distribution can often be confusing. Implement services appropriate to the population being served at locations where there are currently no services other than VCT offered.
- Integrate post-test counselling with other services such as employment finding or income generating programs, food programs, home-based care and assistance in seeking health care
- Formalize a third counselling session as part of the VCT procedure to take place sometime after the disclosure of results. A third counselling session would enable counsellors to follow up with clients, find out how they have been doing since they got their results, and ensure that their clients have been successful at accessing the services they were referred to.
- Improve communication with surrounding resources to inform them of the services provided at New Start Centres. By communicating more with other HIV/AIDS organizations, SMA could ensure that their clients were treated well at institutions to which they were referred, and those institutions could also refer people looking for testing back to a New Start centre.
- Intensify pressure on (especially male) political leaders to be vocal about VCT and issues related to HIV/AIDS in general.

7.3 Study Delimitations and Limitation

The study was delimited to the health care and HIV/AIDS professionals including hospital nurses, employees and New Start VCT Centres, and representatives from relevant NGOs, Community-Based Organizations (CBOs), and the Ministry of Health and Social Services (MoHSS). The two greatest hindrances to this study were that of time and the (understandable) emphasis on confidentiality placed on VCT services by SMA.

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Competing Interests Statement

The authors declare that there are no competing or potential conflicts of interest.

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