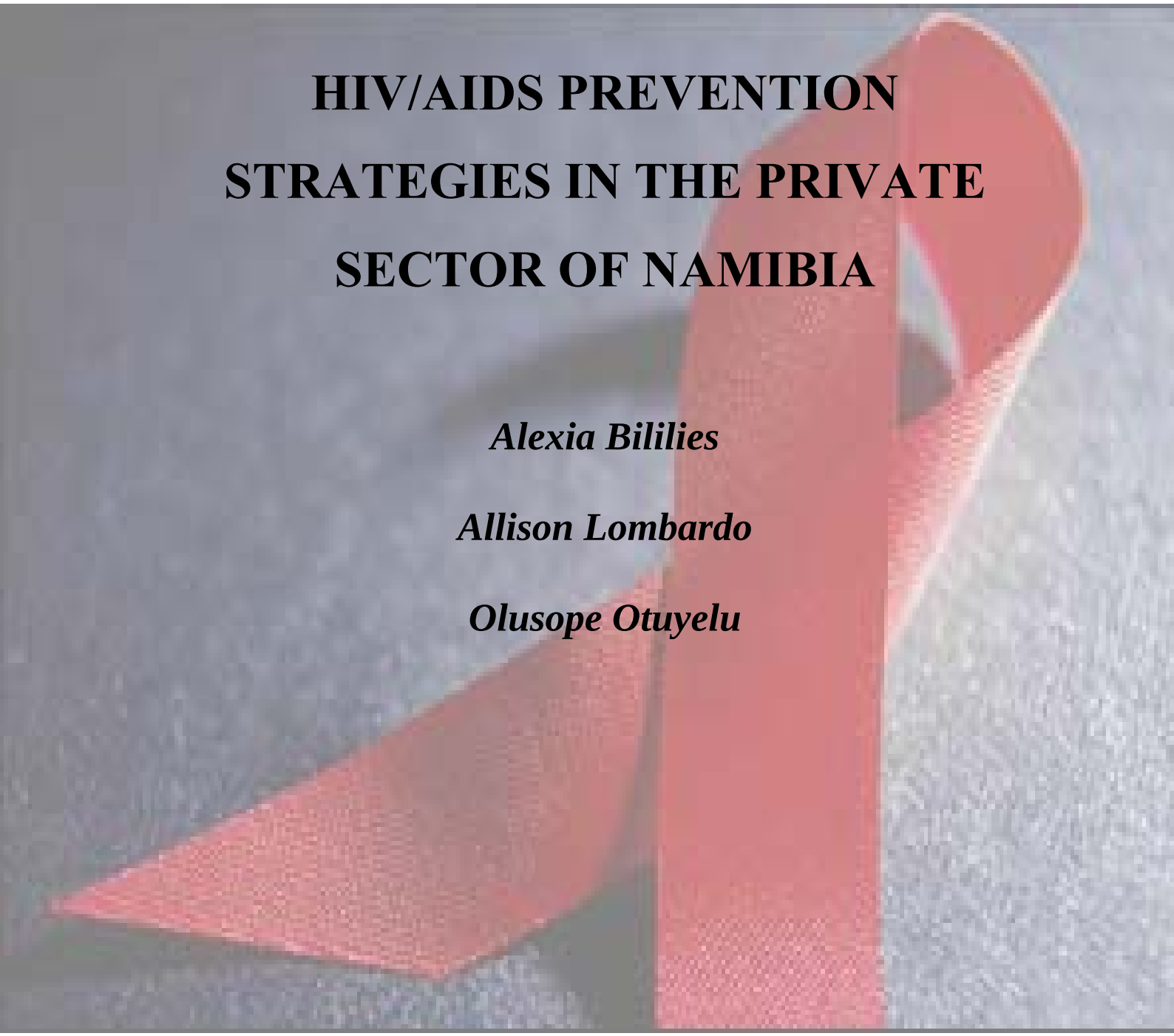
NABCOA
Namibia Business Coalition on AIDS



HIV/AIDS PREVENTION STRATEGIES IN THE PRIVATE SECTOR OF NAMIBIA

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HIV/AIDS Prevention Strategies in the Private Sector of Namibia

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By

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Abstract

The goal of this project was to develop innovative, sustainable HIV/AIDS prevention strategies that can be implemented in Namibia. To achieve this goal, we examined current HIV/AIDS workplace programs in Namibian businesses by conducting interviews with wellness coordinators and other HIV/AIDS stakeholders. Using archival research, we identified innovative HIV/AIDS prevention, care and support, and treatment strategies in other locations. Based on our results, we recommend that NABCOA implement mobile testing units, a national HIV/AIDS hotline, and periodic wellness days.

Authorship Page

Alexia Bililies, Allison Lombardo, and Olusope Otuyelu all contributed to the writing of the project report. Listed below are the original authors of each section, however, each member proofread and edited each part of the paper.

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List of Acronyms and Abbreviations

AIDS: Acquired Immune Deficiency Syndrome

ART: Antiretroviral Treatment

ARV: Antiretroviral Drugs

ACCA: Integrated Workplace Programme Software with hands-on examples for developing in-house KAPB surveys, policies, HIV/AIDS committee structures, managers guidelines etc.

AWiSA: AIDS Workplace Program in Southern Africa

AZT: Azidothymidine (Zidovudine)

CD4: Helper- T lymphocytes

CDC: Centers for Disease Control and Prevention

DSP: Directorate of Special Programs

EVC: Emergency Vehicle Conversions

FDA: United States Food and Drug Administration

GTZ: German Agency for Technological Cooperation

HIV: Human Immunodeficiency Virus

HSSE: Health, Safety, Security & Environment

IEC: Information, Education and Communication

ILO: International Labor Organization

IVDU: Intravenous Drug Users

KAPB: Knowledge, Attitudes, Practices and Behavior

M&E: Monitoring and Evaluation

MEATCO: Meat Corporation of Namibia

MOHSS: Ministry of Health and Social Services

MTP III: National HIV/AIDS Medium Term Plan III

NABCOA: Namibian Business Coalition on AIDS

NAMCOR: National Petroleum Corporation of Namibia (PTY) Ltd.

NAMDEB: Namibian Diamond Corporation (PTY) Ltd.

NANASO: Namibian Network of AIDS Services Organization

NCCI: Namibian Chamber of Commerce and Industry

NGO: Non-Governmental Organization

NHP: Namibia Health Plan

O&L: Ohlthaver & List

OHEP: Oranjemund Health Education Project

OVC: Orphaned and Vulnerable Children

PE: Peer Educator

PEP: Post-Exposure Prophylaxis

PEPFAR: President's Emergency Plan for AIDS Relief

PLWHA: People Living With HIV/AIDS

PMTCT: Preventing Mother-To-Child Transmission

PPP: Public Private Partnership

RCC: Roads Contractor Company

SADC: Southern African Development Community

SME: Small and Medium Enterprises

SSC: Social Security Commission

STD: Sexually Transmitted Disease

STI: Sexually Transmitted Infection

T-cells: Thymus cells

TACAIDS: Tanzanian Commission for AIDS

THAT'SIT: Tuberculosis, HIV and AIDS Treatment Support and Integrated Therapy

UN: United Nations

UNAIDS: Joint United Nations Programme on HIV/IDS

UNGASS: United Nations General Assembly Special Session

UNICEF: United Nations Children's Fund

USAID: United States Agency for International Development

VCT: Voluntary Counseling and Testing

WHO: World Health Organization

Executive Summary

HIV/AIDS has taken the lives of more than 25 million people since its discovery in the early 1980s (USAID, 2007). This epidemic is a societal dilemma that has drastically impacted humanity. Although HIV/AIDS has high incidence rates throughout the world, Sub-Saharan Africa has the highest per capita infection rates. According to the World Health Organization (2007), this region is reported to have roughly 22.5 million adults and children currently living with HIV/AIDS, which is approximately 68 percent of the world's infected population. Namibia, one of the Sub-Saharan countries, has an HIV/AIDS infection rate of 19.9 percent.

Our goal was to evaluate current HIV/AIDS workplace programs and propose alternative methods of HIV/AIDS prevention for the private sector working through the Namibia Business Coalition on AIDS (NABCOA). In order to successfully accomplish this goal, we needed to achieve the following objectives:

Objective One: Identify areas for improvement in current HIV/AIDS workplace programs in local Namibian businesses

Objective Two: Identify innovative HIV/AIDS prevention, care and support, and treatment strategies that can be implemented within Namibia

Due to high infection and mortality rates, HIV/AIDS has negatively affected the economy in many Sub-Saharan African countries, such as Namibia. According to the International Labor Organization, (National Planning Commission, 2001) Namibia is expected to lose 25 to 33 percent of its workers to HIV/AIDS by 2020. Although there have been improvements in HIV/AIDS prevention since Namibia's independence in 1990, the continuing spread of this epidemic is causing a shortage of skilled laborers, leading to a reduction in profits and productivity within the business sector.

This project addressed the issues within the workforce involving the effects of HIV/AIDS on the Namibian economy.

To examine HIV/AIDS workplace programs in local Namibian businesses, interviews were conducted with wellness coordinators or managers from a variety of private sector companies ranging from corporate size to medium size. In addition, research and interviews with experts on mobile testing units, hotlines, and wellness days

were performed to identify innovative HIV/AIDS prevention, care and support, and treatment strategies.

The data gathered from interviews with wellness coordinators exposed the structure, effectiveness, and sustainability of the components of the HIV/AIDS workplace programs. These results showed that most of the companies we have interviewed have implemented workplace programs to spread awareness and educate employees about HIV/AIDS. Through positive relationships with NABCOA, private sector companies have been able to improve their HIV/AIDS programs.

We have concluded that there is a correlation between the size of the company and the comprehensiveness of the company's workplace program. Corporate and large size companies have access to more funding, resources, and experience that enable them to have comprehensive, effective HIV/AIDS workplace programs. Furthermore, throughout the private sector there is a need for increased HIV/AIDS manager training to support successful workplace programming.

There are innovative prevention strategies that are being implemented around the world that could be successful in Namibia. From the research and information collected regarding these HIV/AIDS prevention strategies, we found that mobile testing units, a national HIV/AIDS hotline and periodic wellness days have yet to be used to achieve a more holistic approach to prevention, care and support, and treatment of HIV/AIDS in Namibia. Mobile testing units would conduct VCT and prevalence testing, as well as other routine health tests such as blood pressure, blood glucose, and cholesterol testing in order to brand the vehicle as a wellness van. In addition, a national HIV/AIDS hotline would create a safe, secure, and non-judgmental opportunity for callers to receive information about HIV/AIDS related topics. Finally, periodic wellness days would give companies the opportunity to frequently educate their workforce about HIV/AIDS and living a healthy lifestyle.

The private sector of Namibia is working to further develop prevention programs to reduce the negative effect of HIV/AIDS on the Namibian workforce. Through our recommendations, we hope that NABCOA can be successful in improving HIV/AIDS prevention, care and support, and treatment in Namibia's private sector.

Chapter I. INTRODUCTION

HIV/AIDS has taken the lives of more than 25 million people since its discovery in the early 1980s. Currently, there are approximately 33.2 million people living with HIV/AIDS around the world (USAID, 2007). Although HIV/AIDS has high incidence rates throughout the world, Sub-Saharan Africa has the highest infection rates per capita. According to the World Health Organization (2007), this region is reported to have roughly 22.5 million adults and children living with HIV/AIDS, which is approximately sixty-eight percent of the world's infected population.

Due to high infection and mortality rates, HIV/AIDS has negatively affected the economy in many Sub-Saharan African countries, such as Namibia. According to the International Labor Organization, (National Planning Commission, 2001) Namibia is expected to lose 25 to 33 percent of its workers to HIV/AIDS by 2020. Although there have been improvements with HIV/AIDS prevention since Namibia's independence in 1990, the continuing spread of this epidemic is causing a shortage of laborers, varying in level of skill, leading to a reduction in profits and productivity within the business sector.

Despite the efforts towards greater HIV/AIDS prevention education, this epidemic is continuing to negatively affect Namibia's economic growth. The World Bank estimates that the gross domestic product (GDP) growth of Namibia will decrease from an annual rate of 1.4 to 0.8 percentage points per year as a result of the escalating epidemic (USAID, 2007). The Namibian government, in accordance with aid or donor agencies, such as USAID, is committed to developing strategies to reverse the effects of HIV/AIDS. The specific strategies created by USAID for Namibia that target four key components involved with this epidemic are: behavior changes to reduce the risk of transmission, increased use of services to prevent mother to child transmission, quality care and treatment for people living with HIV/AIDS, and appropriate care and support services for orphans and susceptible children in Namibia. Although these strategies are being applied and are beginning to improve the HIV/AIDS situation in Namibia, other countries around the world have developed more successful prevention programs. For example, Senegal has had success through organizations targeting women, and Cambodia has made progress in the fight against HIV/AIDS through strong political and societal support.

There are many negative stigmas in Namibia associated with the cultural and traditional views attached to being HIV positive. This is a reason why many companies are reluctant to admit the scope of the problem even though the spread of HIV/AIDS is negatively affecting the cost and production of goods and services as well as the attendance of employees. The epidemic has caused increased worker absenteeism due to poor health, taking care of family members, and attending funerals. It also causes companies to have increased costs due to extra recruitment and more frequent training of new workers. Furthermore, the loss of skilled workers may cause wage rates to increase (Barnett et. al., 2006). Because of the adverse consequences of the spread of HIV/AIDS, successful educational and prevention plans need to be put into action within Namibia's private business sector in order to maintain and develop a flourishing workforce.

The first goal of this project was to improve the HIV/AIDS workplace programs in local Namibian businesses. This goal was achieved through interviews conducted with company wellness coordinators to identify strengths and weaknesses of HIV/AIDS workplace prevention programs. The second goal of this project was to develop innovative and sustainable HIV/AIDS prevention strategies to be implemented by the Namibian Business Coalition on AIDS (NABCOA) in the private sector. This goal was achieved through archival research and interviews with HIV/AIDS stakeholders and local experts. The prevention strategies that we identify will hopefully decrease the prevalence of HIV/AIDS among employees, thereby enabling increased profits and productivity within the private sector of Namibia.

Chapter II. BACKGROUND

There are many problems associated with implementing a sustainable HIV/AIDS prevention program in the workplace. In order to understand these problems better, we will describe in more detail what HIV is and the factors affecting the spread of HIV/AIDS.

To adequately understand the importance of this project, we will discuss the effects of HIV/AIDS on the business sector. We will review past and present policies pertaining to HIV/AIDS in the workplace that have been implemented in Namibia, in other countries in Sub-Saharan Africa, and in the rest of the world. In addition, we will compare prevention programs and policies that have been implemented in Namibia in order to evaluate specific successes and failures.

The information provided in this chapter will help to identify the critical elements needed to achieve the success of HIV/AIDS prevention programs in the business sector in Namibia.

2.1 What is HIV/AIDS?

Acquired Immune Deficiency Syndrome (AIDS) is a disease of the immune system caused by the Human Immunodeficiency Virus (HIV). HIV is a retrovirus that infects the human immune system, specifically thymus cells (T-cells) and macrophages (Alimonti, 2003). HIV is transmitted through blood or bodily secretions, such as semen. It can be transmitted through vaginal and anal sex, breast milk, contact with infected blood, and from a mother to her baby through the placenta during pregnancy (Buvé, 2006).

The HIV virus destroys T-cells which are required for the proper functioning of the immune system (Alimonti et al, 2003). As a result the body is no longer able to fight infections and becomes more susceptible to infections of the lungs, intestinal tract, brain, eyes, and other organs. Affected patients also experience debilitating weight loss, diarrhea, neurological conditions, cancers such as Kaposi's sarcoma, and certain other types of lymphomas (US Department of Health and Human Services, 2004).

The average person will begin to show symptoms of HIV anywhere from five to ten years after the initial infection (Rau, 2002). Currently there is no effective drug to cure AIDS. However, there are treatments available which can slow down the effects of

the virus on the immune system for a period of time (Martinez-Picado et al., 2000). These treatments are often referred to as “cocktails” because they are made up of multiple drugs, which include antiretroviral therapy (ART) and protease inhibitors that enable patients with HIV to sustain a fairly healthy immune system. However, these drugs can only keep the virus in check, and so, the virus is able to lie dormant in some parts of the body that the drug cannot access, for example the brain and lymph nodes.

These drugs and treatments should be administered to the patients for the rest of their lives, in order to maintain their health. If the treatment is discontinued, the virus will no longer be suppressed and the patient will start to experience the effects of the HIV infection. There are also problems associated with not following a regular and consistent schedule when administering the ARV treatments. This is caused by the ability of different strains of HIV to mutate and therefore, over time, these strains become resistant to the treatment, if the drugs are not taken regularly (Martinez-Picado et al., 2000).

2.2 History of HIV/AIDS epidemic

The first official diagnosis of AIDS was in 1981 in homosexual men in North America, as a result of reports made to the Centers for Disease Control (CDC) on the discovery of patients infected with Kaposi’s sarcoma and *Pneumocystis carinii* pneumonia (Centers for Disease Control, 1981). It had been observed that Pneumocystis pneumonia in the United States was almost exclusively limited to patients with extremely suppressed immune systems, and the occurrence of Pneumocystis in these previously healthy individuals without being caused by any clinically apparent immunodeficiency was unusual. Therefore, the fact that these patients were all homosexuals indicated an association between a homosexual lifestyle and the incidence of Pneumocystis pneumonia in this population, at that time.

As a result of further research carried out on the basis of these findings, past cases from 1978 and 1979 were re-diagnosed, and it was discovered that HIV was the causal factor of AIDS in 1983 (Buvé, 2006). Until this time, AIDS was thought of as a disease that only affected homosexual men, intravenous drug users (IVDU), hemophiliacs, and immigrants in the United States.

The problem when trying to get a better understanding of the early years of the HIV/AIDS epidemic is that there were no reliable diagnostic tests available until 1985, when the first antibody test for the detection of HIV infection was approved by the United States Food and Drug Administration (FDA) (Buvé, 2006). Until the mid 1980s, the only sources of information that could be used to gain better insight on HIV/AIDS were clinical reports and a few stored serum samples.

After the discovery of HIV/AIDS, it was originally thought of as the "gay plague", caused by the pervasiveness of homosexuality in the western world, but it was observed that the African continent was greatly affected at the onset of the epidemic (Buvé, 2006). When the presence of HIV/AIDS in Africa was investigated, it was seen that a good number of patients diagnosed with AIDS, were neither homosexual nor intravenous drug users (IVDU). As a result, epidemiologists were able to accept that HIV could also be transmitted through heterosexual sexual intercourse. It has been estimated that over 90% of HIV infections in adults in Sub-Saharan African countries are acquired through heterosexual intercourse (Buvé, 2006).

The first report on AIDS in patients from Central Africa was published in 1983 and was followed by investigations within that region (Piot, 1984). By 1986, it was clear that HIV had spread in the populations of numerous countries in sub-Saharan Africa and posed a major public health problem there (Quinn, 1986).

In retrospect, the first cases of AIDS seem to have appeared in Uganda and Tanzania shortly after the liberation war in Uganda in 1978-1979, but were described as "slim disease", because the diagnosed patients experienced extreme weight loss and diarrhea (Serwadda, 1985). The rate of HIV/AIDS prevalence in the Ugandan population climbed to 30 percent in the early 1980's, and as a result, Uganda was seen to be the focal point of the AIDS epidemic (Jackson, 2002).

The onset of the AIDS epidemic in the Democratic Republic of Congo occurred around the same time, nevertheless it is thought that HIV infection may have been present in this population many years before that time, because of the detection of antibodies against HIV in a serum sample collected from a Kinshasa resident in 1959 (Clumeck, 1983).

The first diagnosed case of AIDS in Namibia was in 1986 (The Henry J. Kaiser Family Foundation, 2005). In 2003, HIV/AIDS was the leading cause of death for children and adults in Namibia and was spread primarily through heterosexual contact

and mother-to-child transmission. Since the first diagnosed case, HIV/AIDS has significantly impacted Namibia. The national HIV prevalence rate is 19.9 percent, but there are discrepancies in the prevalence rates in different regions. They range from 39.4 percent in Katima Mulilo to 7.9 percent in Opuwo. Table 1 shows how Namibia compares to Sub-Saharan Africa and the rest of the world as of 2005.

Table 2.1: Statistics of HIV/AIDS in Namibia compared to Sub-Saharan Africa and the world in 2005 (The Henry J. Kaiser Family Foundation, 2005)

Indicator	Namibia	Sub-Saharan Africa	Global
Estimated number of people living with HIV/AIDS, 2003	210,000	25 million	37.8 million
Percent of adult population estimated to be living with HIV/AIDS, 2003	21.3%	7.5%	1.1%
Estimated number of deaths due to HIV/AIDS, 2003	16,000	2.2 million	2.9 million
Women as percent of adults estimated to be living with HIV/AIDS, 2003	55%	57%	48%
Percent of young women, ages 15-24, estimated to be living with HIV/AIDS, 2001	19.4 – 29.1%	8.9%	1.4%
Percent of young men, ages 15-24, estimated to be living with HIV/AIDS, 2001	8.9 – 13.3%	4.4%	0.8%
Estimated number of AIDS orphans, 2003	57,000	12.1 million	15 million
Number of people estimated to be receiving antiretroviral therapy (ART), June 2005	17,000	500,000	970,000
Number of people estimated to be in need of ART, December 2004	32,000	4.0 million	5.8 million

In 2007, the estimated number of persons living with HIV worldwide was 33.2 million [30.6 –36.1 million], a reduction of 16 percent compared with the estimate published in 2006 (39.5 million [34.7 –47.1 million]) (UNAIDS, 2006).

2.3 Factors affecting the spread of HIV/AIDS

In the world today, a growing percentage of the population is infected with HIV, and people are suffering from its effects in various areas within society. HIV/AIDS affects Sub-Saharan Africa more than any other part of the world, but there is a large discrepancy in the incidence rates in these countries. The HIV/AIDS prevalence rates vary from below 1 percent in countries like Madagascar, Mauritius, Somalia, and

Senegal, to rates as high as 20 percent or more in countries like Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia and Zimbabwe (Buvé, 2006). As evident in figure 2.1, of all the Sub-Saharan African countries with high HIV/AIDS prevalence, the majority of them are concentrated in the Southern African region.

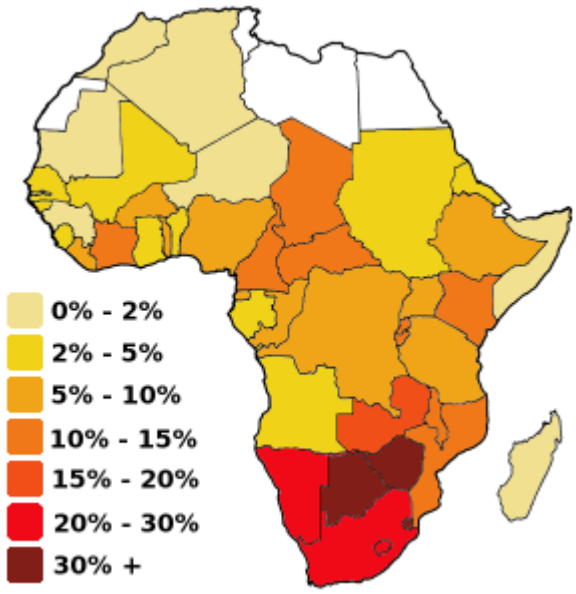


Figure 2.1: National African HIV Infection Rates (No data are available for the areas shown in white) **(USAIDS, 2006)**

In order to understand the disproportionate distribution of HIV infection rates among Sub-Saharan African countries, it is necessary to identify factors that affect the spread of HIV/AIDS. Some of the factors include individual behaviors that increase the risk of contracting HIV/AIDS, cultural and traditional views, internal and external labor migration, education of people on the subject of HIV/AIDS, and the attitudes of the government towards HIV/AIDS.

2.3.1 Individual behaviors

Behaviors of individuals can increase the risk of contracting HIV/AIDS. There are multiple modes of contracting the HIV virus, but the most common way of transmission is through sexual intercourse and other sexual behaviors. The prevalence of HIV/AIDS in the world is thought to be a result of the increased sexual activities among the younger population (Buvé, 2006). The attitudes of this age group in regards to sexuality have become more favorable towards behaviors that can increase the risk of contracting HIV

such as first experiencing sex or marriage at a younger age, engaging in sex without condoms, etc.

It has been observed in numerous studies that there is an association between a high rate of sexual partner change and an increased risk of HIV infection in different regions in Sub-Saharan Africa (Buvé, 2006). Also, people were seen to become more susceptible to HIV infection when they engaged in sexual relations with highly sexually active partners, such as commercial sex workers.

Other factors that contribute to an increased risk in contracting HIV are the use of stimulants such as drugs and alcohol. The sharing of needles involved in drug use results in the exchange of bodily fluids which greatly increases the propensity of drug users to become infected with HIV. It has been estimated that over 90 percent of HIV infections in adults are acquired through heterosexual intercourse, but only 2.5 percent of all HIV infections in sub-Saharan Africa are due to inadequate sterilization of a skin piercing instrument (Buvé, 2006). This low estimate of the proportion of HIV infections in sub-Saharan Africa attributable to injections has been challenged, because there are also unsafe injections and piercing instruments in settings aside from drug use.

Violent acts such as rape have increased the population of children that are HIV/AIDS positive. According to D'Adesky (2004), in Uganda rapes have caused over 30,000 pregnancies and many of the children born as a result of these rapes are also HIV-positive (p. 92). In many cases these children are left alone to suffer and never receive proper treatment or medication.

According to UNAIDS (2006), there is increasing evidence that a proportion of the declines in the HIV/AIDS incidence rates is due to a reduction of the number of new infections which is in part due to a reduction in risky behaviors. It was observed that people who practiced abstinence or, if they were sexually active, used condoms and reduced the number of their sexual partners, as well as, those who avoided sharing needles were at a much lower risk of contracting HIV (Visser, 2004; Buvé, 2006).

According to G. Rotello (1997): "HIV is extremely selective and only produces epidemics when a population's behavior provides it with a niche. Without favorable conditions, HIV cannot spread in a given population" (p. 5). He also emphasizes that "large-scale changes in human behavior provided HIV with radically new opportunities to spread" (p. 5). Therefore, only large-scale changes in human behavior will be able to stop the spread of the epidemic and eradicate this disease.

2.3.2 Cultural and Traditional Views

Another major factor affecting the spread of HIV/AIDS is the beliefs and norms specific to people from different cultural and traditional backgrounds. The cultural norms in these societies serve as reference points for the behavior of people in reaction to the wide spread of HIV infections.

There are sanctions and taboos set up to make sure that the members of a community comply with society's attitude towards sexual practices, and these result in negative and punitive consequences for the people who are seen to go against these set societal structures (Fox, 2002). In less developed parts of the world, like Sub-Saharan Africa, there is still an ongoing reinforcement of traditional sexual norms and restrictions, and this has proven to be favorable to the spread of HIV/AIDS and other sexually transmitted infections (STIs). This is because there is stigmatization associated with contracting HIV/AIDS, which is seen to be a result of engaging in socially unacceptable and immoral sexual behaviors (Fox, 2002). This stigma reduces the ability of people to correctly assess the possibility of contracting HIV and take proper precautions like using condoms, in an effort to save face amongst their peers.

With the wide-spread prevalence of HIV/AIDS in this region, there is a need for people to get tested, so that they become aware of their status and are able to alter their behaviors, either to reduce their risk of contracting the virus, if they are found to be HIV-negative, or spreading the virus, if they are found to be HIV-positive. This stigma has become more of a problem because it prevents people from getting tested, a majority of whom simply do not wish to know their status in regards to HIV/AIDS because there is a fear of isolation and being ostracized from society if one is found to be infected with HIV. This causes a lot of Africans to view HIV/AIDS as a "death sentence", not only in the physical sense, but also emotionally and spiritually because they are being rejected by the cultural and belief system that defines them and forms the foundation of their lives (Leclerc-Madlala, 1997).

The associated stigma also poses a problem for the implementation of HIV/AIDS educational and prevention programs in Sub-Saharan African countries like Namibia, in which there have been efforts made to educate people on HIV/AIDS. People are not given

to talking about HIV and AIDS and its effect on them honestly, and this reduces the effectiveness and sustainability of implemented prevention programs.

Results of interviews and surveys show that some prevention efforts were successful in reaching their objectives and society's level of awareness and attitudes towards HIV/AIDS and sexuality is gradually changing (Kalichman, 2003). The problems that these educational and prevention efforts face are based on people's inability to change their behaviors because of fear of denunciation and rejection as a result of admission and acceptance of HIV status. It can be said that these beliefs are not unfounded, and there have been incidents of people being harassed, both physically and mentally, because they disclosed their HIV status. People who are HIV positive are regarded as being unclean and are considered to have brought shame to their community.

2.3.3 Gender Inequality

Unfortunately, gender inequalities have become a significant factor affecting the spread of HIV/AIDS. It has been observed that women are more susceptible to HIV infection than men, and in Namibia, women make up almost 60 percent of new infections (United Nations, 2004), and 55 percent of people living with AIDS (Ngavirue, 2006).

Biologically, women's bodies are more vulnerable to HIV infection, and factors that contribute to this fact are the high HIV concentrations present in seminal fluid, the large vaginal surface area, and the higher incidence of vaginal trauma caused by Sexually Transmitted Infections (STIs) or inserting materials into the vagina in order to facilitate 'dry sex' (Edwards, 2007). These factors make male-to-female HIV transmissions two to five times more likely to occur than female-to-male HIV transmissions.

Also, studies on HIV discordant couples in Europe and the United States have found that sexual intercourse during menses is associated with an increased risk of HIV infection in male partners of females infected with HIV, but not in female partners of males infected with HIV (Buvé, 2006). In addition, it has been observed that anal intercourse between couples in these regions is also associated with HIV infection in women, even in cases where the couples infrequently engaged in it. There is not much known about the association between HIV infection and the practice of anal intercourse in Sub-Saharan Africa, because it is regarded as a cultural and sexual taboo that is not openly practiced.

The roles assigned to women in society also play an important role in their increased risk of HIV infection. Women are culturally expected to have sexual intercourse in order to produce children, yet condom use hinders this expectation (Preston-Whyte, 1999). Within a marriage, the idea of condom use is suggesting that one's partner (in most cases, this is the female) is having sex with multiple partners, suggesting a lack of trust within the relationship (Kazembe, 2000, p. 1).

For the sake of being 'masculine', many men refuse to use condoms because they feel it reduces sexual pleasure (Kazembe, 2000, p. 1). The women are not allowed to make any decisions about condom use because their husbands have the authority in the household, and when the women challenge that authority, the men are prone to use various means of physical and verbal abuse to ensure that the women obey them. Even in cases when the men engage in extra-marital sexual relations, cultural beliefs and societal norms force the women to submit to their husbands. This unequal power distribution inhibits the women from protecting themselves from contracting HIV. This is corroborated by the results obtained from a study carried out by the Southern African Development Community (SADC), which showed that HIV infection rates are six times higher among married women than among single women (Tibinyane, 2003).

2.3.4 Class Inequality

Poverty increases the risk of contracting HIV because it compels people to live in environments where they may be more susceptible to falling sick (Myer et. al., 2003). Often times, these environments consist of unsanitary living conditions with residents earning very limited incomes.

For primarily financial reasons, many men are forced to travel to urban areas to look for better paying jobs and have to leave their families behind because of the absence of family housing and existing migratory restrictions that exist (Edwards, 2007). Because the men are away from their wives for long periods of time, they often patronize commercial sex workers to alleviate their sexual desires and urges, and this increases the exposure of these men to HIV infection, especially in cases where condoms are not used. When these men are allowed to visit their wives and the couples engage in sexual intercourse, there is a resulting increase in the risk of HIV infection in the women.

As a result of low incomes, infected individuals are unable to purchase drugs and treatments for HIV/AIDS related illnesses. This is due to the high costs of antiretroviral (ARV) treatments, and the increased possibility of contracting other HIV/AIDS related diseases like Kaposi's sarcoma and tuberculosis as a result of living in unsuitable and unhealthy environments. This results in many families not having access to the proper medication in order to maintain a healthy lifestyle.

Women in low income situations who find themselves unable to provide for their families often use commercial sex work as a last option. "There are numerous records of women in particular who say that they cannot think of the long-term risks of illness and death when they have to undertake commercial sex work without a condom so as to feed themselves and their children over the next few days" (Barnett et al., 2006, p. 275). As a result of these behaviors, women have a higher risk of contracting HIV/AIDS and transmitting it to their unborn children.

2.4 HIV/AIDS Educational Programs and Government Policies

There is a general lack of knowledge about HIV/AIDS throughout the world, especially in the Sub-Saharan Africa region. The misconceptions concerning transmission and contraction of the virus, prevention methods, and the health effects of HIV/AIDS are causing many people to unknowingly contract this deadly virus. Furthermore, the negative stigmas toward HIV/AIDS and cultural traditions, such as the opposition to birth control methods, are preventing HIV/AIDS education programs from being successfully implemented in schools. Despite these obstacles, some countries have been successful in developing educational programs that specifically target women and children.

2.4.1 Education of people on the subject of HIV/AIDS

Liberia has started educating children through school programs about HIV/AIDS. The year 2006 became the first time that Liberian school children incorporated HIV/AIDS education in the classroom (UN Office for the Coordination of Humanitarian Affairs, 2006). Since the implementation of these programs, more than 10,000 Liberian children have been taught about HIV/AIDS prevention.

Methods of animation-based curricula for children, similar to the one shown in figure 2.2, are currently used in India and other parts of Asia. These curricula are adapted to culturally reflect the country in which they are used.

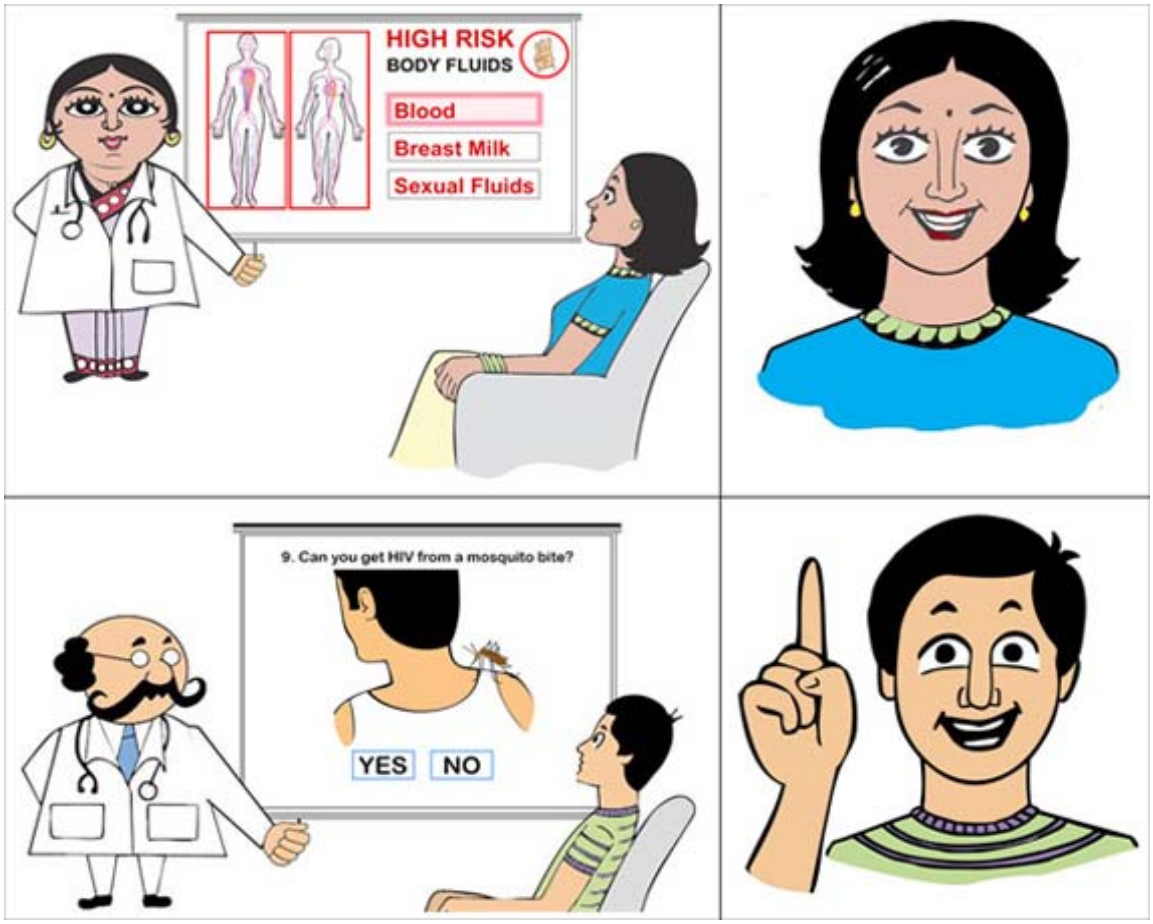


Figure 2.2: HIV/AIDS Animation-Based Curriculum (Jaspal, 2006, p.2)

By specifically tailoring HIV/AIDS prevention programs to younger children, these countries have a greater chance of changing individual behaviors early and therefore reducing prevalence rates in the future.

Another approach of education programs is targeting women. In Russia, it was found through questionnaires that the majority of women had very little overall knowledge about HIV/AIDS and contraception options (Stachowiak, 1994). A committee from the International Conference on AIDS took these data and began to publish educational brochures that were then used by health professionals and for activists in the women's movement to train and educate women about STD/HIV/AIDS.

By concentrating prevention efforts on education and targeting children and women, behavioral changes can be made and incidences of HIV/AIDS spreading due to lack of knowledge will decrease.

2.4.2 Government Policies concerning HIV/AIDS

In most countries, the government has the best capability to combat the HIV/AIDS epidemic. The majority of a country's money and resources lies within the government, which has made government sponsored prevention and treatment policies effective.

A country that has seen positive results from their HIV/AIDS policy is Tanzania. In 2000, the president of Tanzania, Benjamin Mkapa, started the Tanzanian Commission for AIDS (TACAIDS), initiating a multi-sectoral response to HIV/AIDS throughout the country with the help of USAID (USAID, 2002). The governmental branch has targeted the epidemic at the central, regional, and national levels, working to identify the various sectors and their "roles in the prevention, care and support in HIV/AIDS, ethics and principles in HIV counseling and testing, the rights of people l7iving with HIV/AIDS, and the mandate and functions of the TACAIDS in the national response to the epidemic" (National AIDS Commission of Tanzania, 2001, p. 1). By establishing a governmental sector to concentrate on HIV/AIDS, Tanzania's policy is moving the country towards lowering its prevalence rates.

Large international governing bodies, such as the United Nations, have also been successful in implementing policies to prevent the spread of HIV/AIDS. The agency of the United Nations specifically created to address the epidemic, UNAIDS, has adopted an overall policy concerning HIV/AIDS that "provide[s] a vision and specific guidance to policymakers, planners and advocates at all levels" (UNAIDS, 2006, p. 1). Under UNAIDS there are policies exclusively tailored to HIV/AIDS-infected children and orphans as well as for prevention and treatment. By adopting a policy to spread knowledge and prevention to all members of a society, the UNAIDS organization has been extremely successful worldwide.

The majority of countries around the world have implemented some sort of policy pertaining to HIV/AIDS prevention and research. Although these policies are not always effective, their creation and development will evolve as future discoveries are made regarding the HIV/AIDS epidemic.

2.4.3 Attitudes of Government Officials

Government officials have a great deal of impact on the way citizens respond to a stigmatized topic, such as HIV/AIDS. For example, in 2003 the President of South Africa, Thabo Mbeki, was quoted as saying, “Personally, I don't know anybody who has died of AIDS" (Murphy, 2003, p. 1). This statement has since been recalled; however, it gave many South Africans doubts about the legitimacy of the HIV/AIDS epidemic and caused them to disregard any HIV/AIDS prevention campaigns that were being publicized.

China had similar governmental resistance to the HIV/AIDS epidemic. According to the alternative report to the United Nations Committee on Economic, Social and Cultural Rights, “numerous local laws explicitly deny AIDS sufferers the right to marry [and] in the province of Jilin, pregnant women who have AIDS are subjected to forced abortion” (Grilhot, 2005, p. 1). Over the past three years, the Chinese government has become more open about the growing epidemic and is working to keep its citizens safe.

It is evident that the attitudes of a country’s government can significantly alter the opinions of its people concerning HIV/AIDS. Prevention programs pertaining to HIV/AIDS in the workplace can also be negatively affected by the lack of support from the management within the private business sector and government parastatals.

2.5 Effects of HIV/AIDS on the Business Sector

The HIV/AIDS epidemic has negatively affected business sectors, as its effects are shown in figure 2.3. Increased absenteeism due to poor health, taking care of family members, and attending funerals has decreased the profit and productivity of many companies. The large mining giant, Debswana Diamond Company, has calculated that 10.7 percent of its payroll was used towards HIV/AIDS care in 2002 (D’Adesky, 2004). Moreover, there are increased costs due to recruitment and training of new workers since many infected workers die or retire early.

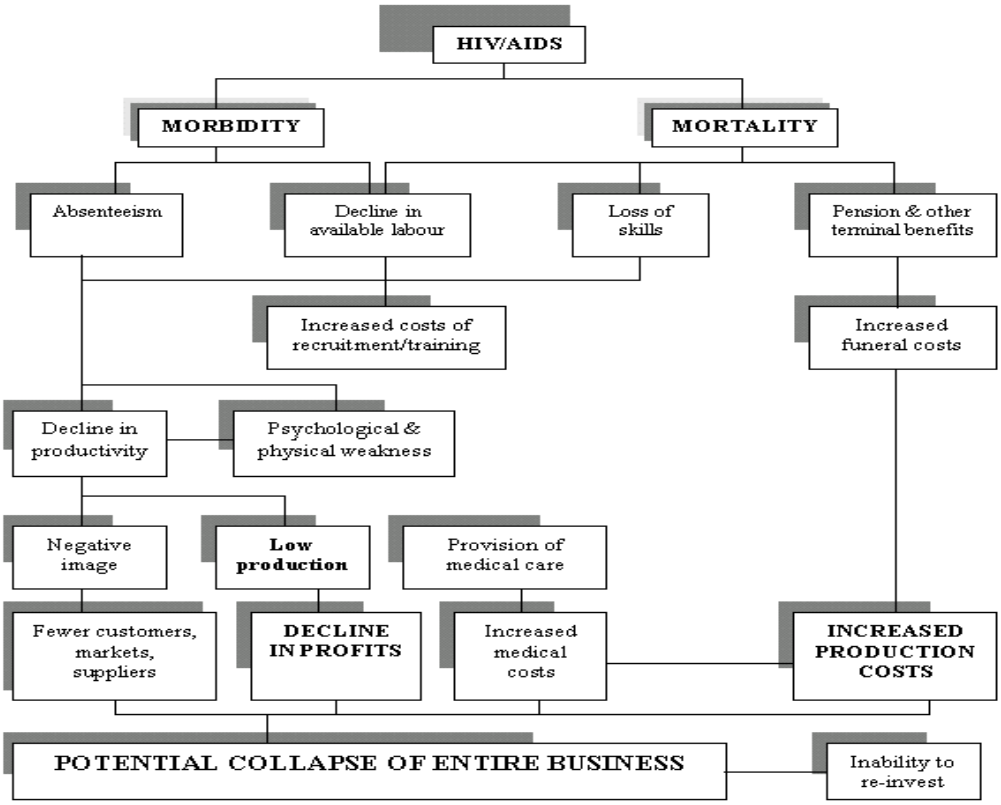


Figure 2.3: Impact of HIV/AIDS on a Business Firm (Rugalema, 1999, p. 1)

The loss of skilled workers has caused wages to decrease (Barnett et al, 2006, p. 262). The absolute number of potential customers is declining, while the indirect, direct, and systemic costs are increasing. These two compounded factors are creating an overall net loss for Namibian companies.

There are many examples within Africa of the impact of HIV/AIDS on companies that result in loss of skilled employees, productivity, and profit. The Uganda Railway Corporation had a 15 percent turnover among workers with more than ten percent of their total force dead due to AIDS related illnesses by the mid-1990s (Rau, 2002). In addition, in a sugar mill in South Africa, workers who were positive for HIV took an average of fifty-five additional sick days per year. In Malawi, the Makandi Tea Estate had an increase of employee death from 4 per 1000 in 1991 to 23 per 1000 by 1995, which cost the company 6 percent of its annual profits (Rau, 2002). There were reports in Zambia that an increased number of employee deaths caused interruptions within the electric supply system throughout the country. Due to an increased cost to insure employees, life insurance premiums in Zimbabwe quadrupled in two years during the mid-1990s (Rau, 2002).

2.6 Past and present policies pertaining to HIV/AIDS in the workplace

Since the initial outbreak of the HIV/AIDS epidemic in the mid 1980s, organizations have approached the problem in a variety of ways. Between the years 1999 and 2000, one of Botswana's largest diamond mining companies, Debswana, carried out an institutional audit to determine how the HIV/AIDS epidemic would affect all facets of company life and operations (Whiteside and Loewenson, 2001).

In Botswana, it was seen that between 1996 and 1999, HIV/AIDS-related morbidity and mortality increased, and ill-health retirements and AIDS-related deaths rose. In 1996, 40 percent of retirements and 37.5 percent of deaths were due to HIV/AIDS. By 1999, the proportion had risen to 75 percent of retirements and 59.1 percent of deaths (Whiteside and Loewenson, 2001).

The company hospitals recorded an increase in the number of patients with HIV related conditions, while there was evidence of workers being absent or under-performing in the workplaces (Whiteside and Loewenson, 2001). It was at this stage that the company made a bold decision in co-operation with the workers to ascertain HIV prevalence. The results were disturbing. HIV prevalence across all employees stood at 28.8 percent. The audit looked at skill levels of employees, ease of training and replacement of relevant skills per job, as well as related costs for potentially replacing employees. It also analyzed risk reduction strategies for critical posts, estimated liabilities and costs associated with benefits, developed systems of productivity monitoring, and considered potential treatment options and costs.

By the end of the institutional audit, the company had obtained a model set of policies and responses that were driven by experience (Whiteside and Loewenson, 2001). The result was a landmark policy to cover 90 percent of the cost of anti-retroviral treatment for workers and their spouses and to require suppliers of goods and services to the company to have AIDS programs in place. In addition, prevention measures were given top priority. These institutional audits have been performed in many private sector Namibian companies and are useful in determining the HIV/AIDS prevalence rate among employees. When companies know the HIV status of their employees, they are able to implement programs to best support the needs of their workforce.

2.6.1 International Labor Organization

The International Labor Organization (ILO) is an organization devoted to advancing opportunities for women and men to obtain conditions of freedom, equity, security and human dignity in the workplace (International Labor Office, 2008). Its main aims are to promote employee rights at work, encourage decent employment opportunities, enhance social protection, and strengthen communication in handling work-related issues.

The HIV/AIDS epidemic is a threat to each of the International Labor Organization's four strategic objectives, (which are fundamental principles and rights at work, employment, income generation and skills, social protection, and social dialogue) because a significant percentage of productive working-age persons are infected with HIV, and this results in a reduction in the rate of economic growth in countries due to the epidemic's effect on the potential labor supply (International Labor Office, 2008). This led to the establishment of the ILO Program on HIV/AIDS and the world of work (ILO/AIDS), which functions as part of the Social Protection Sector. Its action is guided by the code of practice entitled, *HIV/AIDS and the World of Work*, and adopted in 2001 with the agreement of governments, employers and workers. As a result, the ILO is committed to promoting the implementation of HIV/AIDS prevention programs and increasing the awareness of the epidemic in the workplace. It has put the following policies and measures in place in order to help combat the wide-spread prevalence of HIV/AIDS in various countries in the world (International Labor Office, 2008, p.18):

- Mobilize governments, employers and workers to become more aware of the causes and effects of HIV/AIDS, and become more proactive towards implementing prevention programs in the business sector
- Recognize the negative implications of the epidemic and frame the international standards to relate directly to the prevention and management of HIV/AIDS
- Implement the code of practice and provide direct assistance at the national level in response to the HIV/AIDS pandemic.

The ILO provides technical assistance to members in order to strengthen their response to HIV/AIDS throughout the workplace (International Labor Office, 2008). The technical cooperation budget of ILO/AIDS grew from US$2 million in 2001 to over US$20 million in the 2006–07 biennium. Projects are financed by a range of countries, in addition to the funding received through UNAIDS and other international organizations.

The common objective is to help build the capacity of the ILO's constituents to contribute to national AIDS efforts by ensuring that the world of work is appropriately placed within the national AIDS plan, developing rights-based workplace policies, and implementing effective programs.

2.7 HIV/AIDS prevention programs in the workplace

With the growing HIV/AIDS epidemic and its negative effect on businesses, prevention programs are necessary to alleviate the resulting financial and social burdens. Countries throughout the world including in Africa have developed different strategies to combat the widespread effects of HIV/AIDS on the workplace.

In Cambodia, a country with the highest HIV/AIDS prevalence rate in the Southeast Asian region, the disease has been a major public health concern. However, now the number of infected people is declining. According to YOUANDAIDS (2006), the reason for HIV/AIDS spread in Cambodia was primarily because of sex workers; however, this has changed with 80 percent of sex workers agreeing to condom use. "After peaking at approximately 3.3 percent in 1997-98, HIV prevalence among national adult population in Cambodia has declined to 1.9 percent in 2003" (YOUANDAIDS, 2006, p. 1). With the supervision of India, Cambodia has been able to start up a similar system of importing and producing its own generic ARV drugs (D'Adesky, 2004). Currently the Cambodian Ministry of Education and Health includes HIV education in its national curriculum for primary and secondary educational institutions. Presently, Namibia does not have the capacity to produce generic ARV drugs in country.

Generic manufacturing of ARVs has been an extremely successful method of treating HIV/AIDS in countries like India. Although this is not a prevention method, generic manufacturing has been used as a way of helping those infected to maintain a healthy lifestyle. The HIV/AIDS epidemic was spreading at a dramatic rate throughout India and government officials estimated that in 2003 between 10 to 12 million people were infected with the disease, although only 4 million were reported cases (Barnett et al, 2006). Drug users and transgendered individuals were the predominant carriers of the disease; however, the unsupportive government did not help. With the help of the World Trade Organization, India began to produce affordable HIV generic drugs domestically. As a means to keep prices low, the domestic availability of the ARV drugs has increased the number people receiving treatment. According to D'Adesky (2004), the brand name

of the drug is not as important as the cost and availability. Although the exact number of people who have access to ARVs is difficult to measure, the generic drug industry has brought major economic benefits to India.

One of South Africa's biggest companies, AngloGold, carefully studied the effects of HIV/AIDS on its workforce. As a result of that study, the company found out that more than 25 percent of its employees were HIV-positive. They started to incorporate education prevention in the workplace, yet they soon found out that prevention was not enough (D'Adesky, 2004). "It [AngloGold] found that providing HIV drugs to its workers with AIDS would add $4 to $6 to the cost of producing an ounce of gold. But if no action was taken, the cost could rise to $9 per ounce" (D'Adesky, 2004, p. 156). This type of cost-benefit analysis made the company realize that by making small adjustments to their method of prevention, they will save money in the future. AngloGold started offering ARVs to a small group of employees, each employee's treatment costing the company $1,500 per year. With time, AngloGold plans to increase the number of employees they are able to provide with ARVs until all employees in need of treatment have been assisted.

The NAMDEB diamond corporation in Oranjemund, Namibia, implemented a comprehensive health promotion plan and HIV/AIDS/STI prevention program in 1990 (Rau, 2002). This company employs more than 4,000 workers from Namibia. It is owned jointly by the government and De Beers Centenary. This corporation developed an HIV/AIDS policy that "ensured nondiscrimination against HIV-positive workers and confidentiality for all workers and their families attending company services" (NAMDEB Diamond Corporation, 2001, p. 1) through the Oranjemund Health Education Project (OHEP). It includes peer education and health and prevention education for children, distribution of free condoms, managing the symptoms of STIs, confidential VCT services such as counseling and testing, community programs, and home-based care and support services. The company had initial success with the program with an increase in condom use, a smaller number of STIs reported, less early staff retirement, and a decrease from 4.9 per 1000 to 3.4 per 1000 of HIV infection within the town of Oranjemund (Rau, 2002). In 2001 the company developed Project Eluwa to fight against the HIV/AIDS epidemic. This project included a prevalence survey that discovered that approximately seven out of every hundred employees are HIV positive, which is less than the national average (NAMDEB Diamond Corporation, 2001). By 2005, NAMDEB had become the

first member of the Oranjemund community to announce the availability of the HIV/AIDS program to its employees and the community and has established an educational theater group consisting of peer educators, community members, and children to spread the word throughout the community about HIV/AIDS, VCT, ART and risk factors.

2.8 Funding for the HIV/AIDS Epidemic

As a result of the HIV/AIDS epidemic throughout the world, many organizations have begun to provide funding to help alleviate this problem. This funding mainly sustains prevention and education programs, community care and support groups, and antiretroviral treatments. Since HIV/AIDS is a global issue, millions of dollars have been invested by government and non-governmental organizations, private foundations, businesses and individual donors to reduce HIV incidence rates and help those already affected by HIV/AIDS (The Global Fund, 2008). Some of the major agencies that contribute funding include the Global Fund, the World Bank, the World Health Organization (WHO), the German Agency for Technological Cooperation (GTZ), the United States Agency for International Development (USAID), President's Emergency Plan for AIDS Relief (PEPFAR), the Bill and Melinda Gates Foundation, the Clinton Foundation, and the PharmAccess Foundation.

2.8.1 The Global Fund

The fight against the HIV/AIDS epidemic is dependent on funding to support prevention and treatment programs. The Global Fund was created to fight three of the most debilitating diseases around the world, AIDS, Tuberculosis, and Malaria (The Global Fund, 2008). This organization was formed to allocate critical funds to subsidize necessary resources and treatment to regions throughout the world that are suffering from these diseases. The Global Fund is only a financial tool and relies on local experts to implement prevention, education, and treatment programs. The Global Fund has currently donated over 10.1 billion U.S. dollars to aid over 136 countries. Through the programs funded by the Global Fund, an average of 1.46 million lives have been saved as of January 2007, and this number continues to grow. Through resources supported by the

Global Fund, 1.8 million people are expected to receive ARV treatments, 62 million will be offered voluntary counseling and HIV testing services, and over one million orphans will be supported through community care and support programs.

One of the countries that benefits from funding from the Global Fund is Namibia. This country received a grant from the Global Fund in 2002 for a total five year maximum of $104,004,211 (The Global Fund, 2008). The Principal Recipient was the Government of Namibia and the Ministry of Health and Social Services. The goal of this grant was to decrease the incidence rates of HIV infection, HIV/AIDS morbidity and morality, as well as reduce the negative social and economic impacts of this epidemic. Through Global Fund programs in Namibia, over 127 percent of their target population has received ARV treatments. This grant was successful; however, it expired in 2007.

2.8.2 Mobile Clinics

Mobile clinics have been used around the world to bring health and medical attention to areas that do not have easy access to clinics and hospitals. These vehicles have been used to provide emergency relief after natural disasters as well as to increase wellness in rural or underserved communities. A particularly effective use for mobile clinics has been to spread HIV awareness and to conduct VCT testing.

In Kenya, for example, the Mpala Community Trust (MCT) was founded in 1999 (Mpala Community Trust, 2006). The main purpose of this clinic is to serve communities that have little or no access to professional healthcare. This clinic has been able to provide a great deal of assistance to many Kenyan people. It is able to attend to approximately 50,000 people per year in 25 locations around Kenya. According to the MCT (2006), the mobile clinic "offers family planning, reproductive health education, childhood immunizations, HIV/AIDS awareness training, and basic health care to thousands of rural Kenyans" (p. 1).

Although general wellness is addressed in these clinics, there is a concentration of programming on HIV/AIDS. The staff includes nurses, health workers, clinical officers, drivers, and administrative assistants. With funding from the Centers for Disease Control, MCT workers are able to use bicycles to help with distributing testing supplies and conducting VCT throughout each community that the clinic visits. Other services that the vehicle provides communities are:

- HIV/AIDS education
- Non-Anti Retroviral Health Services
- PMTC awareness
- Referral networks
- Traditional Birth attendant training
- Initiation and support of “Positive Living” support groups

These services have been very successful within Kenya. According to one of the on-board nurses (Mpala Community Trust, 2006), “Without the mobile clinic we are dead” (p. 1). The clinic does provide patients with medication for TB and other respiratory infections, yet does not provide ARV treatment, due to the difficulty of continuing these services after the mobile clinic has left the area. The clinic staff encourages individuals to seek alternate methods of maintaining a healthy lifestyle.

2.9 Chapter Summary

The prevalence of HIV/AIDS in the world poses a problem to humanity and is seen to affect all sectors of society. HIV/AIDS affects a significant percentage of the working-age population, and so to reduce the effects of HIV and AIDS on this group, it is imperative that sustainable HIV/AIDS prevention programs be developed and implemented in the workplace.

An efficient and sustainable prevention program will have to take into consideration the cultural and traditional views on HIV/AIDS in a particular region, the factors affecting its spread, as well as the effects of HIV/AIDS on businesses in the private sector. It will also have to assess the successes and failures of prevention programs and policies like the ones that we have discussed in this chapter, in order to analyze the elements that are critical to the sustainability of prevention programs in the private sector and determine if they are suitable for application.

In the next chapter, we will provide a detailed description of the methods we will use to fulfill our project goal and objectives.

Chapter III. METHODOLOGY

In order to evaluate and develop innovative HIV/AIDS prevention programs to be implemented in the private sector of Namibia, we needed to achieve the following objectives:

Objective 1- Identify areas for improvement in current HIV/AIDS workplace programs in local Namibian businesses

Objective 2- Identify innovative HIV/AIDS prevention, care and support, and treatment strategies to be implemented within Namibia

This chapter discusses the methods that we used to achieve each of the objectives.

3.1 Objective 1

To complete the first objective, we evaluated HIV/AIDS workplace programs by conducting interviews with the company wellness coordinators and managers from eight Namibian businesses. A description of the role of company wellness coordinators can be found in Appendix B and a list of interview questions can be found in Appendix C.

The companies where we conducted interviews were selected by NABCOA based on their number of employees. We met with company wellness coordinators from NAMDEB, Olthaver & List, Roads Contractor Company (RCC), Air Namibia, MEATCO, Social Security Commission, and NAMCOR. We also met with the managing director of Pewa Investments. NAMDEB, Olthaver & List, and RCC are classified by NABCOA as corporate companies as they have over 500 employees. Air Namibia, MEATCO and the Social Security Commission are large size companies that have between 100 and 500 employees. NAMCOR and Pewa Investments are considered medium size companies by NABCOA because they have between 10 and 100 employees.

In the interviews with company wellness coordinators, we inquired about the components of their HIV/AIDS workplace program. We questioned each interviewee about the strengths and weaknesses of the specific HIV/AIDS programming within their companies. We also evaluated the business relationship between the company and NABCOA. The purpose of this question was to evaluate ways that NABCOA could

strengthen ties with the private sector companies. We concluded each interview with a question that asked the interviewees how they would allocate funding from a potential Global Fund grant within their wellness programs. Conducting interviews was found to be an effective method of collecting data because we obtained information from individuals with an expertise in wellness programs.

To further understand how wellness coordinators view the success of their HIV/AIDS workplace programs, we distributed a rubric to each wellness coordinator through e-mail. The purpose of this rubric was to gain internal insight about the effectiveness of each component of the HIV/AIDS programming.

In order to further understand HIV/AIDS in Namibia, we conducted interviews with HIV/AIDS stakeholders. We met with Ms. Gloria Billy, the Senior Program Officer for UNAIDS Namibia, Abner Xoagub, the head of the Expanded National HIV/AIDS Response Support Program of the Directorate of Special Programs (DSP) at the Ministry of Health and Social Services (MOHSS), and Claire Dillavou, a Monitoring and Evaluation Technical Advisor at the Centers for Disease Control and Prevention (CDC) Namibia. During these interviews, we asked questions about how each organization is contributing to the epidemic in Namibia and how NABCOA can improve the services they offer to private sector companies.

3.2 Objective 2

To complete the second objective, we researched mobile testing units, a national HIV/AIDS hotline, and periodic wellness days as innovative HIV/AIDS prevention strategies for NABCOA to implement within the private sector.

To gain more detailed perspectives from mobile testing vehicle experts, we contacted Jonathan Greenhill, a representative from Emergency Vehicle Conversions in Johannesburg, South Africa; Richard Dinse, a representative from LifeLine Mobile in Carlsbad, California, USA; Douglas Thompson, a vehicle sales manager at M + Z Commercial Vehicles in Windhoek, Namibia; Dr. Margot Trumpelmann-Uys, the THAT'SIT Project Manager in Johannesburg, South Africa; Ingrid DeBeer, a representative from PharmAccess in Windhoek, Namibia; and Mike Haidula, the Managing Director of Genesis Training Consultancy in Windhoek, Namibia.

To gather information about vehicle conversions and obtain sample layouts, we conducted a phone interview with Jonathan Greenhill from EVC and received information from both Mr. Greenhill and Richard Dinse from LifeLine Mobile through email.

The purpose of interviewing Douglas Thompson was to obtain information about the Mercedes Sprinter van. We asked him questions about the cost of these vans and what model would be most practical for the needs of a mobile testing unit. We also talked to him about the possibility of the van conversion occurring in Windhoek.

We spoke with Dr. Margot Trumpelmann-Uys about a mobile testing unit that is currently being used by the THAT'SIT organization to provide tuberculosis, HIV/AIDS treatment, support and integrated therapy. The purpose of this interview was to gain basic information about operating a mobile testing unit.

We interviewed Ingrid DeBeer and phoned Mike Haidula about specific information about the VCT and prevalence testing equipment and services that the mobile a van could provide.

In order to obtain information about hotlines and telephone counseling in Namibia, we interviewed Jane Shityuwete, the National Director of Lifeline/Childline Namibia. The purpose of this interview was to learn more about operational specifics and basic initial costs of a HIV/AIDS hotline in Namibia.

The data obtained from these interviews are presented in Chapter IV. Interview questions and transcripts are located in Appendices H through M.

3.3 Chapter Summary

These methods helped us gather the necessary information to evaluate HIV/AIDS workplace programs in Namibia and to develop innovative prevention strategies for private sector companies working with NABCOA. The results we obtained from our data collection processes are discussed in Chapter IV.

CHAPTER IV. RESULTS AND ANALYSIS

In this chapter, we have documented the results collected from the completion of our project methods. The data gathered through our methods revealed information concerning the structure, effectiveness, and sustainability of currently implemented workplace prevention programs. Our findings will help NABCOA identify the strengths and weaknesses of these HIV/AIDS programs. These findings are the basis for the recommendations found in Chapter V, which will be used by NABCOA and its member companies to facilitate the further development and improvement of these programs.

4.1 HIV/AIDS Workplace Programs

To identify the components of HIV/AIDS workplace programs in private sector businesses of Namibia, we conducted interviews with a variety of wellness coordinators and managers from companies in different industries ranging from corporate sized to medium sized.

We conducted these interviews with the contact person at each company. (The transcripts of these interviews can be found in Appendix D.)

In most instances, this person was the company wellness coordinator. The interviewee who was not a wellness coordinator was Twapewa Mudianima, who is the managing director of Pewa Investments.

Table 4.1 shows the number of employees in each company, the type of company, what industry each company is part of, and the contact person whom we interviewed at each business.

Table 4.1: Companies Interviewed and their characteristics

Company	Number of Employees	Type of Company	Industry	Contact Person
NAMDEB	± 4200	Corporate	Mining	Elsabe Grötzinger
Ohlthaver & List (O&L)	over 4000	Corporate	Investment	Zelda Rukambe
Roads Contractor Company	over 1200	Corporate	Construction	Helen Nicodemus
Air Namibia	492	Large	Transportation	Rachel Freeman
MEATCO	360	Large	Food	Ruth Campbell
Social Security Commission	±300	Large	Parastatal	Taimi Kapelwa
NAMCOR	40	Medium-sized	Petroleum	Moses Kavendji
Pewa Investments	30 (full), 60 (part)	Medium-sized	Salon/Factory	Twapewa Mudianima

Pewa Investments is the only company that we interviewed that does not have an HIV/AIDS workplace program and is not currently a member company of NABCOA. The purpose of the interview with Pewa Investments was to understand the HIV/AIDS workplace programming in a medium sized company.

The first question asked to company wellness coordinators was to list the components of their company's wellness and HIV/AIDS workplace programs, presented in Table 4.2. (A detailed explanation of wellness program components can be found in Appendix B).

Table 4.2: HIV/AIDS Workplace Programs in Selected Companies

Programs	Companies (in decreasing order of size)							
	NAMDEB	O & L	RCC	Air Namibia	MEATCO	Social Security	NAMCOR	Pewa Investments
ARV Treatment	Yes	Yes	Yes	Yes	Yes	Yes	No	No
ARV Treatment Coverage	100%	100%	100%	Partial	Yes	Yes	Partial	No
Condom Distribution	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
IEC Materials Distribution	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Management Training	Yes	No	No	Yes	Yes	Yes	No	No
Medical Board	Yes	No	Yes	No	No	No	No	No
Monitoring and Evaluation System	Yes	No	No	Yes	No	Yes	Yes	No
Peer Educator Program	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Peer Educator-to-Employee Ratio	1:15	1:20	1:60	1:20	1:45	1:19	1:8	No
PMTCT	Yes	No	No	No	No	Yes	No	No
VCT	Yes	Yes	No	Yes	No	Yes	No	No
Wellness Program	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Wellness Coordinator	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No

From the conducted interviews, we found that larger, more established companies have more comprehensive HIV/AIDS workplace programs. Another question we asked in our interviews addressed the possibility of the allocation of Global Fund money to companies from NABCOA as a Principal Recipient; these data are presented in Table 4.3. NABCOA is applying to become the Principal Recipient of the Round 8 HIV/AIDS Global Fund grant representing the non-governmental sector. If NABCOA is successful in its bid to become a PR, they will be responsible for allocating money to private sector companies that apply to become Individual Recipients of this grant.

Table 4.3: Allocation of Global Fund Grant Money to Private Sector Companies

How funds would be used	Companies (in decreasing order of size)							
	NAMDEB	O & L	RCC	Air Namibia	Meatco	Social Security	NAMCOR	Pewa Investments
Capacity Building	No	Yes	No	Yes	No	Yes	Yes	Yes
Community Outreach	No	Yes	No	Yes	No	No	No	Yes
Condom Distribution	No	No	No	No	No	Yes	No	Yes
Event Funding	No	Yes	Yes	Yes	No	Yes	Yes	No
Expanding ART Coverage	Yes	Yes	No	Yes	No	No	Yes	No
IEC Materials Distribution	No	No	No	No	No	Yes	No	Yes
Incentives for Employees	No	No	Yes	Yes	No	Yes	Yes	No
Incentives for Peer Educators	No	Yes	Yes	Yes	No	Yes	Yes	No
Increase Awareness among employees	No	No	Yes	No	No	Yes	No	Yes
Improve Monitoring and Evaluating System	No	No	No	Yes	No	Yes	Yes	No
Management Training	No	No	No	Yes	Yes	Yes	Yes	No
Peer Educator Refresher Courses	No	Yes	No	Yes	Yes	Yes	Yes	No
Peer Educator Training and Development	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Prevention Program Start-Up	No	No	No	No	No	Yes	No	Yes

The chart shows that of the majority of companies interviewed are in need of increased funding for peer educator training and incentives. The trainings would include frequent refresher courses and training of new peer educators. Peer educators are an effective way of spreading awareness throughout the company; however their peer education duties are in addition to their daily responsibilities. Wellness coordinators feel that recognition would increase their motivation and satisfaction to be peer educators. These data also show that the companies we interviewed would use additional funding to improve gaps within their HIV/AIDS workplace programs.

During the interviews, we asked individuals to evaluate their company's relationship with NABCOA. These results are presented in Table 4.4.

Table 4.4: Services Provided by NABCOA to its Member Companies

Services rendered	Companies (in decreasing order of size)							
	NAMDEB	O & L	RCC	Air Namibia	Meatco	Social Security	NAMCOR	Pewa Investments
Promoting Wellness Program	Yes	Yes	Yes	Yes	Not Available	Not Available	Not Available	Not yet provided
Peer Educator Training	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Not yet provided
Peer Educator Refresher Courses	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Not yet provided
Management Training	Yes	Not Available	No	No	Yes	Yes	No	Not yet provided
Liaison between Company and Government	Yes	Yes	Yes	Yes	Not Available	Not Available	Not Available	Not yet provided
Capacity Building for Employee Wellness Offices	Not Available	Yes	Yes	Yes	Not Available	Not Available	Not Available	Not yet provided
Provide IEC Materials	No	Yes	Yes	Yes	Yes	Yes	Yes	Not yet provided
Distribute Condoms	No	Yes	Yes	Yes	Yes	Yes	Yes	Not yet provided

KEY	
Yes	Service needed by company from NABCOA
No	Service not needed by company from NABCOA
Not available	Information about that service not provided
Not yet provided	Information has not been provided by company

In analyzing these data, we found that NABCOA provides a variety of services to its member companies based on their needs. For example, management training is not provided to RCC and Air Namibia because they have newly developed workplace programs; these companies are benefiting more from promoting company wellness programs. From the conducted interviews, we found that all of the wellness coordinators we spoke to felt that their company has a good relationship with NABCOA and that their needs are being fulfilled.

A follow-up question asked to interviewees was to obtain information about the services needed by companies from NABCOA. These data are shown in Table 4.5.

Table 4.5: Services from NABCOA Needed by Selected Companies

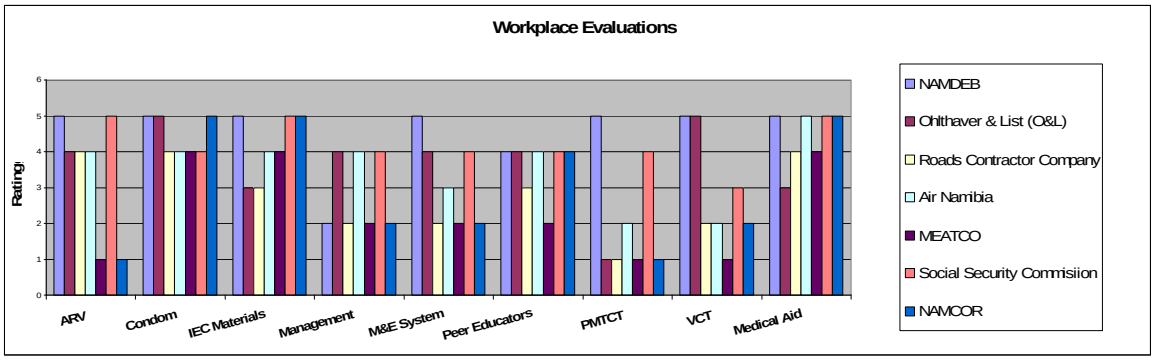
Services needed	Companies (in decreasing order of size)							
	NAMDEB	O & L	RCC	Air Namibia	Meatco	Social Security	NAMCOR	Pewa Investments
Capacity building for wellness offices	No	Not Available	Not Available	Yes	No	Yes	Yes	Not Applicable
Condom Distribution	No	No	Not Available	Not Available	No	No	No	Yes
Community-Wide Outreach	No	Not Available	Not Available	Not Available	No	No	No	Yes
Employee Incentives on AIDS Day	No	Not Available	Yes	Not Available	No	No	No	Not Applicable
Improve Quality of Training Courses	No	Not Available	Not Available	Yes	No	No	Yes	Not Applicable
Mobile Clinics	No	Not Available	Yes	Yes	No	Yes	Yes	Not Applicable
Peer Educator Training	No	Yes	Yes	Yes	No	Yes	Yes	Yes
Peer Educator Refresher Courses	No	Yes	Yes	Yes	No	Yes	Yes	Yes
Management Training	No	Yes	Yes	Yes	No	No	Yes	Yes
Peer Educator Incentives/Recognition	No	Not Available	Yes	Not Available	No	Not Available	Yes	Not Applicable
Workplace Program Start-Up	No	Not Available	No	No	No	Yes	No	Yes
Innovative Prevention Strategies	Yes	Not Available	Not Available	Not Available	No	Yes	Not Available	Not Available

KEY	
Yes	Service needed by company from NABCOA
No	Service not needed by company from NABCOA
Not applicable	Company does not have capacity to currently support services
Not available	Information about that service not provided

From this information, we can see that wellness coordinators would like to see additional training from NABCOA for middle to upper level management. Additionally, wellness coordinators are requesting more training sessions and refresher courses. NABCOA will be able to take these data and use them to improve the services they offer to their member companies.

From the rubric distributed to wellness coordinators, we were able to obtain an evaluation of HIV/AIDS workplace programs someone within the company; this information is presented in Figure 4.1. While collecting this information, we acknowledge that we were limited by time and resources. For example, if we had interviewed managers or other employees, we could have received a different perspective on workplace programs. Although the opinion of wellness coordinators may be biased, as many

individuals in this position have implemented the majority of the HIV/AIDS programs within a company, we felt that they had the best perception of the workplace programs.



KEY	
1	Not applicable
2	Needs improvement
3	Satisfactory
4	Successful
5	Extremely successful

Figure 4.1: Evaluation of workplace programs by wellness coordinators from selected companies

It is evident that all of the companies that returned their evaluations are in need of some services, even though they vary in the size of their workforce and in the length of time that their programs have been operating. For example, although NAMDEB is a company with over 4,200 employees and has had a workplace wellness program for over nineteen years, they are still in need of management training. Air Namibia, which is classified as a large company with 492 employees, has a workplace wellness program that has been in place for approximately six months, and it is in need of strengthening a variety of services, mainly management training. Another example is NAMCOR, which has forty employees and a HIV/AIDS program that has been in existence for eighteen months. It has strong medical aid coverage and efficiently distributes IEC materials and condoms, yet needs ARV, VCT, and PMTCT programs. From these data, it is shown that companies with strong workplace programs still have areas that can be improved upon.

4.2 National and International Programs

Another part of objective one was to research and interview HIV/AIDS national and international government stakeholders in order to fully understand HIV/AIDS workplace programming. In the meeting with Mr. Abner Xoagub, we learned about labor laws in Namibia concerning HIV/AIDS in the workplace and their compliance with safety and occupational health codes. (The interview transcript can be found in Appendix F). It was important for us to get the opinion of Mr. Xoagub as a representative of the MOHSS because he gave us a comprehensive view of the public sector opinion and programs concerning HIV/AIDS in the workplace.

From this interview, we recognized that the MOHSS is not promoting the establishment of separate HIV/AIDS workplace programs. They are encouraging organizations to integrate HIV/AIDS into their existing occupational and health programs. In Mr. Xoagub's opinion, this approach will reduce the stigma of HIV/AIDS and increase awareness of overall wellness rather than concentrating only on individuals who are HIV positive.

Mr. Xoagub also feels companies in the public and private sector should look at sexuality as a source of the spreading HIV/AIDS epidemic. HIV/AIDS experts should promote open discussions on sexual practices and needs.

Through an interview conducted with Claire Dillavou of CDC Namibia, we were able to learn about the different ways the United States government is currently assisting the HIV/AIDS situation in Namibia. (The transcript from this interview can be found in Appendix G). Namibia is a focus country for the PEPFAR grant, which has provided the area with over $108 million. The CDC also provides funding for technical advisors whose services can be used by the MOHSS for human resources support and drug procurement. Another US government-aid organization, USAID, provides general support for prevention and community based programs within Namibia.

Direct support from the United States has been offered to NABCOA through the AIDS Alliance and PACT. These organizations have been able to support NABCOA financially and programmatically. Through US help, NABCOA has been able to facilitate public-private partnerships (PPP) with Namib Dairy for supplemental feedings for orphans and vulnerable children (OVCs). NABCOA is currently raising money in the

private sector to compliment funds donated by PEPFAR and Standard Bank to fund this program. International support has helped NABCOA as well as Namibia to improve and increase HIV/AIDS awareness and prevention programming.

We also met with Gloria Billy, to discuss what the United Nations is doing in regards to HIV/AIDS in Namibia. (The interview transcript can be found in Appendix E). UNAIDS has developed the Universal Access Program, which encourages the country to set goals concerning HIV/AIDS prevention, treatment, and care and support to be achieved by 2010. UNAIDS has encouraged Namibia to develop a systematic method of HIV/AIDS prevention in order to combine all actions by individual agencies to have a national effect. They have achieved this through a program called the Three Ones that has been used to build up a framework for the implementation of programs like Universal Access. This holistic approach strives for HIV/AIDS programs and treatment to be integrated and to have all services centralized in one place, such as a wellness office. The goal of this approach is to eliminate ineffective and poorly funded services while encouraging strong, comprehensive programming.

4.3 Stakeholder recommendations to private sector

From the data collected during our interviews, we found that HIV/AIDS stakeholders had recommendations for the private sector. Mr. Abner Xoagub suggested that NABCOA link up with trade unions to enforce the coordination of HIV/AIDS programs. He also mentioned that companies should have general wellness programs implemented through the human resources department that not only address individuals who are HIV positive but focus on other health issues. Mr. Xoagub's reasoning behind this idea was that companies should not discriminate against employees with other illnesses, such as cancer or heart disease; these companies should also be able to have sustainable support programs with the ability to finance medical services.

Ms. Claire Dillavou recommended that NABCOA create and distribute informational and training packages for companies based on their size. These service packages would include material about how to start up a workplace program and the minimum quality standards for services that the program should provide to its employees. Ms. Claire Dillavou also believed that it is necessary to convince the leadership within

companies that it is worthwhile to invest in HIV programs with tools such as a cost-benefit analysis.

Ms. Gloria Billy conveyed that there is a lack of continuity and sustainability in the HIV/AIDS prevention programs throughout the private sector. She suggested that companies look into integrating a VCT campaign into their HIV/AIDS workplace programs. She also said that the private sector should play the role of an advocate within communities to increase HIV/AIDS awareness.

4.4 Results of Research on Mobile Testing Units, a HIV/AIDS Hotline and Periodic Wellness Days

The purpose of objective two was to research innovative HIV/AIDS prevention, care and support, and treatment strategies to be implemented within Namibia. We learned from our interviews that it is important to have a holistic approach when developing these strategies in order to include all aspects of HIV/AIDS care. Three strategies that we researched included a mobile testing unit, a national HIV/AIDS hotline, and multiple wellness days within private sector companies.

4.4.1 Mobile Testing Units

The idea to create a mobile testing vehicle was presented to us by NABCOA. They received funding from Phase 2 of the Global Fund Round 2 HIV/AIDS grant for the development of a mobile VCT and prevalence testing unit. We researched mobile testing vehicles from selecting a vehicle, designing the internal and external layout of the van, and the necessary equipment required inside the mobile unit.

4.4.1.1 Mercedes Sprinter Van Models

NABCOA prefers to use a Mercedes Sprinter van for this mobile testing unit. The three available options for this unit are the 315 CDI Panel Van, the 416 CDI Panel Van, and the 518 CDI Panel Van. There are advantages and disadvantages to using each of the three Sprinter van models as the vehicle for the mobile testing unit, presented in Table 4.6.

Table 4.6: Pros and Cons of the Sprinter Van Models

Sprinter Van Model	Pros	Cons
315CDI Panel Van	Fuel-efficient	One Exit
	Less Expensive	Only room to counsel one patient at a time
416CDI Panel Van	Two points of entry	Small for two counseling rooms
	High ceilings	
518CDI Panel Van	Two points of entry	Most expensive
	Capacity for two counseling rooms	
	Extra storage space	

This chart shows that each van could be suitable for use by NABCOA for the mobile testing unit; however the larger models are more practical. The 315 model has enough space for one counseling and testing room, which is not ideal to support the number of people that this van may assist. The 416 and 518 models have enough space for two counseling/testing rooms and storage space for the necessary equipment. These two models also have two points of entry for confidentiality purposes. This is extremely beneficial because it would provide each patient room with its own entrance, giving patients more privacy because they would not have to come in contact with another patient while inside of the mobile testing unit.

After interviewing Douglas Thompson, we obtained prices for each of these vans, excluding the price of conversion and VAT. Mr. Thompson informed us that if the vehicle was purchased after May 2008, there would be 5.5% increase in the cost of the van. However because NABCOA is a non-government organization, he would be willing to offer them a discounted price as long as the van was paid in full before any conversion began.

The prices for each van, from smallest to largest, are shown in Table 4.7.

Table 4.7: Cost of Sprinter Van Models

Sprinter Van Model	Price
315 CDI Panel Van	N$267,000
416 CDI Panel Van	N$278,000
518 CDI Panel Van	N$317,000

As shown in this table the 315 CDI Panel Van is the least expensive, yet the smallest in size. Due to size constraints, this model is not ideal for the mobile testing unit. The second Sprinter van model, 416 CDI Panel Van, is larger than the previously mentioned model and has two entrances to ensure that patients will not come in contact with other patients while inside the clinic. The largest option, 518 CDI Panel Van, is the most expensive, yet has the most space available for patient rooms and storage.

These prices exclude the cost of vehicle conversion. Jonathan Greenhill from EVC gave us an estimated quote of R$270,000 for the cost of converting a Mercedes Sprinter Van into a mobile testing unit, including all of the necessary equipment to perform VCT, prevalence testing, and simple diagnostic screening.

4.4.1.2 Possible Van Layouts and Equipment

The following internal layouts were provided to us by Jonathan Greenhill at Emergency Vehicle Conversion (EVC). (The interview transcript can be found in Appendix I). These are sample layouts that can be adapted to vehicles with different dimensions. Figure 4.2 shows a floor plan of a converted short wheel base vehicle; the length is 3.00 meters.

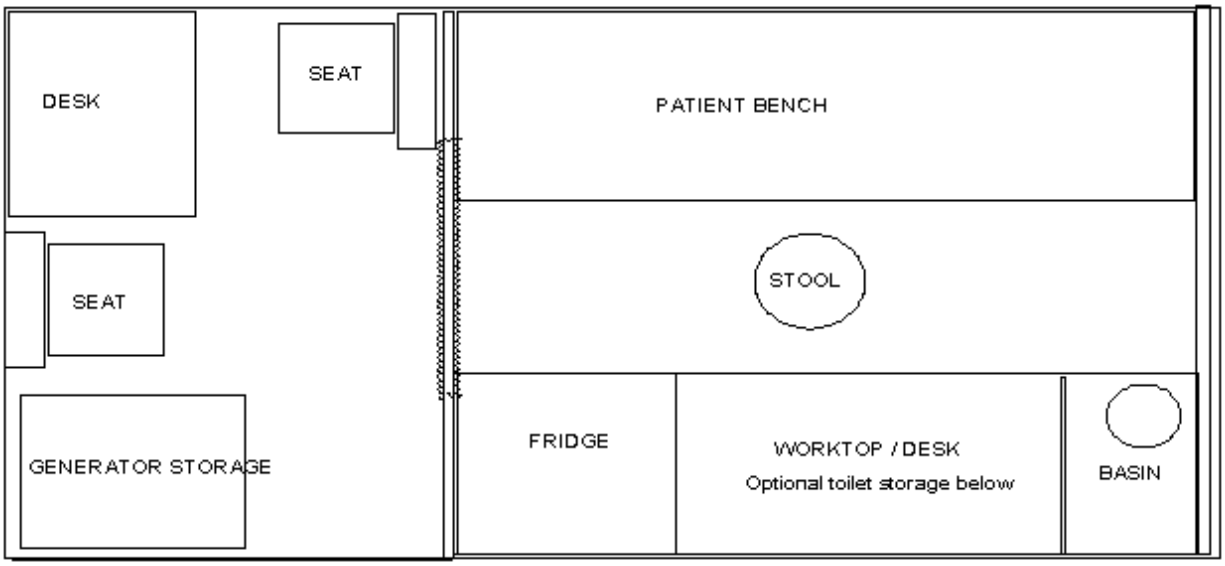


Figure 4.2: Floor Plan of Short Wheel Base Mobile Clinic (EVC, 2008)

A benefit of this design is that it would be able to be adapted to a smaller space, eliminating the need for a larger, more expensive van, yet still being able to store the necessary equipment for VCT and prevalence testing. This layout is not ideal for NABCOA's purposes because it only has space for one counseling and testing room. This would only permit one patient to be seen at a time, which would limit the number of people who could be tested during the day the van was present at a certain location. The space for storage of necessary medical equipment is also limited in this vehicle.

Figure 4.3 shows the floor plan of the long wheel base panel van; the length is 3.4 meters.

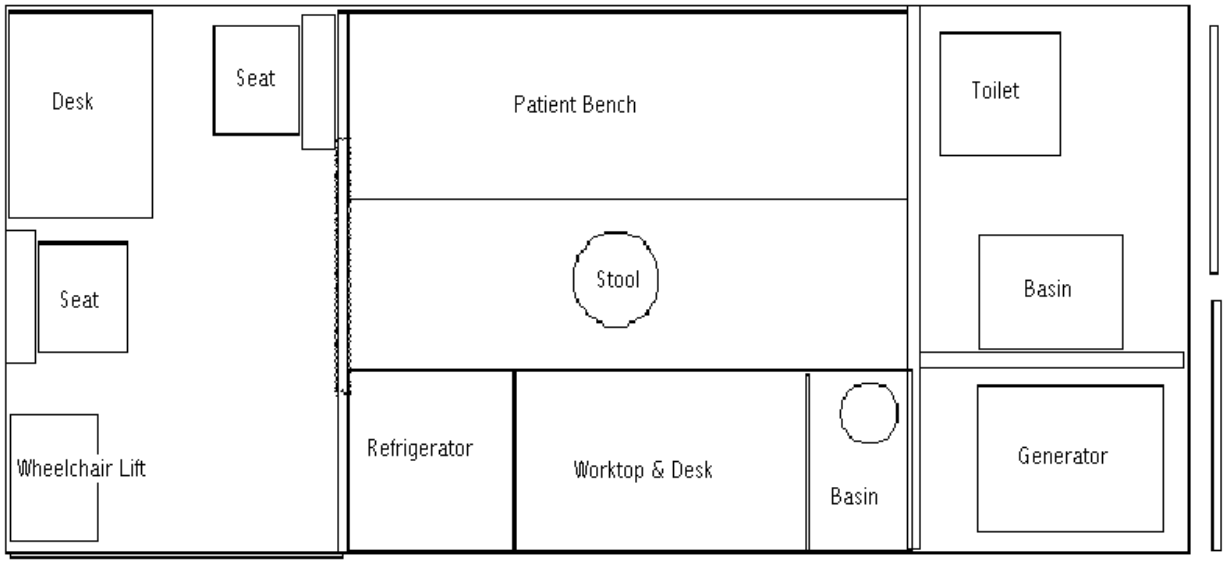


Figure 4.3: Layout of Long Wheel Base Panel Mobile Clinic (EVC, 2008)

The advantages of this design are that it is a larger model and therefore provides enough room to carry out two VCT and prevalence testing as well as other health care services at a time. It also has an extra space that can be used for additional storage space.

A third design from EVC is the internal layout of the extra long wheel base panel van as shown in Figure 4.4; the length is 3.43 meters.

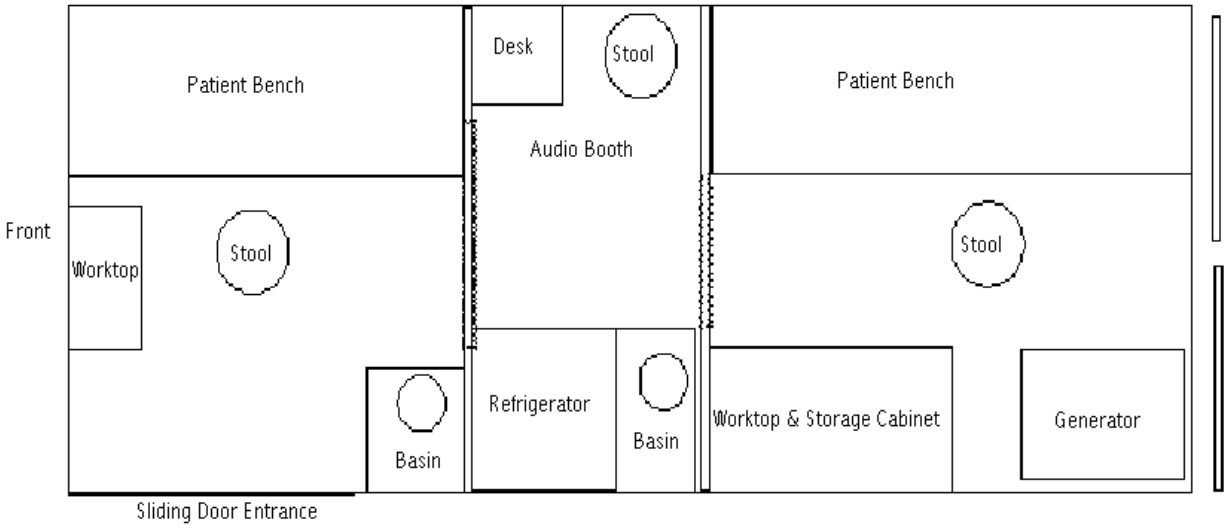


Figure 4.4: Layout of Extra Long Wheel Base Panel Van

This layout is ideal because there is enough space for two patient rooms that would provide the necessary privacy to those being tested and counseled.

Additional figures are floor layouts from Lifeline Mobile in Carlsbad, California, USA. These models can range from 29 to 40 feet long. Figure 4.5 shows a sample floor plan of a mobile unit that was made for HIV Prevention and Research Outreach.

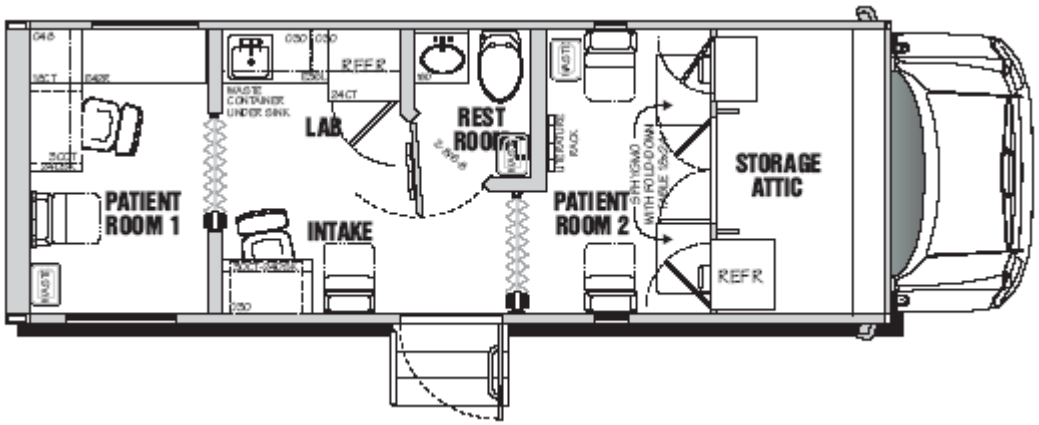


Figure 4.5: Internal Layout of Mobile Unit Plans for HIV Prevention and Research Outreach (Lifeline Mobile, 2008)

An advantage of this model is that there are two patient rooms, a lab, a storage attic, and a restroom inside the vehicle. There is also sufficient room for a lab area. It is also advantageous that two of the patient rooms are on opposite sides of the van to ensure confidentiality and distance from other patients. A negative aspect of this design is that there is only one exit in the unit which increases the chances that the patients may come in contact with each other inside the unit and therefore reduce the comfort level that many patients hope for when getting tested.

Figure 4.6 shows another sample floor plan that was designed for HIV Prevention and Research Outreach from Lifeline Mobile.

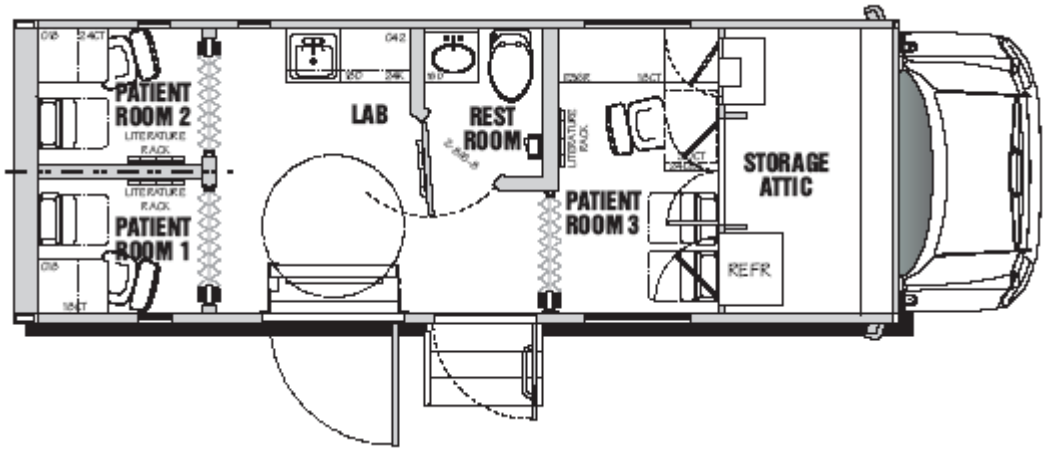


Figure 4.6: Internal Layout of Mobile Unit Plans for HIV Prevention and Research Outreach (Lifeline Mobile, 2008)

Some of the benefits of this model are that there are three patient rooms, a lab, a storage attic, a restroom, and two ways of entering or leaving the van.

These designs could be adapted to fit the needs of the Mercedes van and NABCOA's goal of creating mobile testing vehicles.

4.4.1.3 Mobile Testing Unit Services

The primary services that this van could provide are VCT and prevalence testing. These vans could also provide referral services for patients to state hospitals or private clinics who receive a preliminary positive test and are in need of follow-up care.

The mobile testing units could also provide additional health services such as blood pressure, blood glucose level, and cholesterol level testing, as well as health education programs to present to private sector companies while they are visiting to perform testing. These programs could be offered to peer educators or employees containing information about general wellness, HIV/AIDS, and making positive life choices.

We conducted an additional interview with Dr. Margot Trumpelmann-Uys. We found that the THAT'SIT mobile vans have a staff that consists of a professional nurse, one or more counselors, a driver with a code 10 license, and a doctor, depending on the areas the van is visiting and what services it is providing.

After speaking with Ingrid DeBeer from PharmAccess, we developed a comprehensive list of the necessary equipment needed in the mobile testing unit. The basic equipment that the van will need to include are two fold-out tables, two fold-out examination beds, stools, a wash basin, a portable incinerator, and areas for storage space. Table 4.8 shows the equipment needed to perform VCT and prevalence testing as well as the cost of these items.

Table 4.8: Equipment needed for VCT and Prevalence Testing

Equipment	Cost	Quantity
Alcohol Swabs	N$100	100
Test Kits	N$20	1
Latex Gloves	N$53	100
Kit with needles, blood tubes and storage containers for drawing blood	N$20	1

These data show that it is possible to obtain some of the necessary equipment in large quantities in order to decrease daily operating costs of the mobile testing unit. The alcohol swabs, test kits, and latex gloves would be used for VCT and prevalence testing. The kit containing needles for drawing blood may be used if additional HIV testing needs to be performed.

Since this mobile testing unit will include simple diagnostic services in addition to VCT and prevalence testing, other equipment needed for these tests is shown in Table 4.9. If the van has more than one counseling and testing room, there would need to be additional sets of equipment.

Table 4.9: Equipment needed for Additional Medical Screening

Equipment	Cost	Quantity
Digital weighing scale	N$450	1
Acutrend machine	N$2,500	1
Glucose test strips	N$5	1
Cholesterol test strips	N$15	1
Blood Pressure Monitor with Cuff	N$500	1

The equipment shown in Table 4.9 is needed to perform simple diagnostic tests, such as testing blood pressure, blood glucose, and cholesterol levels. The digital weighing

scale and the Acutrend machine would be needed for calibration of the diabetes and cholesterol strips.

These lists include basic information on the equipment needed in the mobile testing units, however the equipment can be modified depending on the needs of the company the mobile unit is visiting.

To get a better idea of the length of time it takes for a person to go through the process of VCT testing, we interviewed Mike Haidula. (The interview transcript can be found in Appendix L). The VCT should take between 1 hour and 1 hour and 30 minutes. The pre-test counseling should take approximately 25 to 30 minutes. The actual testing process, which includes taking blood samples, should last approximately 15 to 20 minutes, and the post-test counseling would take between 25 to 35 minutes.

Pre and post test counseling are important for the patient during the VCT process. In speaking with Mr. Haidula, he felt that the same counselor should carry out the pre- and post-test counseling on one person.

This is because during the pre-test counseling, the patient shares information about their risky behaviors and other personal information with the counselor. All this information would be useful in the post-counseling process, because the counselor already would have a better understanding of the person and his/her history, and, depending on the results of the test, the counselor would be able to have a more informed conversation with the person and give better advice and referrals for further treatment, care and support.

4.4.2 HIV/AIDS National Hotline

Another innovative HIV/AIDS prevention strategy that we identified was to develop a national HIV/AIDS hotline in Namibia. This idea was a result of our interview with Gloria Billy from UNAIDS Namibia. During this interview she stated that the Namibian people respond positively to call-in radio programs as a means to ask questions and get advice about HIV/AIDS related topics. Currently, Namibia does not specifically have an HIV/AIDS help line.

We researched an HIV/AIDS hotline in South Africa and found that this help line has become one of the most important HIV/AIDS intervention strategies in South Africa.

Lifeline South Africa provides anonymous, confidential and accessible information, counseling and referral telephone service on a national level (Lifeline South Africa, 2007). The helpline began operating in 1992 and receives an average of 3,000 calls per day. Lifeline South Africa is in partnership with the Department of Health of South Africa and operates out of 16 call centers throughout South Africa. Lay-counselors offer assistance and information to callers in eleven different languages. All counselors are trained to provide facts and emotional counseling concerning HIV/AIDS. In 2004, the services of Lifeline South Africa were extended to incorporate an ARV treatment line manned by nurses and medical staff where people can ask questions about medication.

There would be many benefits associated with developing a HIV/AIDS hotline within Namibia. This hotline would empower callers to feel safe and secure to get the information they need. The ongoing support of the nurses and counselors would improve the lives of callers and provide them with critical HIV/AIDS facts, care and support, or treatment information. It would be completely anonymous and confidential in order to create a non-judgmental, objective environment.

We conducted an interview with Jane Shityuwete, the National Director of Lifeline/Childline Namibia. (The interview transcript can be found in Appendix M). Lifeline Namibia provides face-to-face and telephone counseling in crisis situations. Childline provides many outreach services to children to promote education and awareness about sexual abuse, molestation, domestic violence and HIV/AIDS. The purpose of this interview was to initiate communication between NABCOA and Lifeline Namibia so the two organizations would be able to form a partnership and work towards developing this national hotline.

Ms. Shityuwete stated that the reason a hotline has not been previously implemented within Namibia is because of the large costs associated with the start-up of such a help line, as shown in Table 4.10.

Table 4.10: Estimated Costs of Start-up Services for an HIV/AIDS National Hotline

Service	Estimated Costs
Technical Appraisal	N$20,000
Study visit to South Africa and Namibia	N$25,000
Internal Training	N$22,000
Equipment	N$175,000 +
Computer Training for Counselors	N$80,000
Follow-up visit from Lifeline South Africa	N$12,000
Information Technical Consultant	N$36,000
Branding of hotline	N$150,000
Total	**~N$520,000**

All of these costs are one time fees associated with the start up of the HIV/AIDS hotline in Namibia. One of the required services is a technical appraisal, which would be done at the Namibian call center and would involve a technical consultant to assist with the basic set-up of the hotline as well as set up the equipment needed to run this hotline.

A visit to Lifeline South Africa is budgeted in initial costs for Lifeline Namibia to understand how the HIV/AIDS hotline runs and how to adapt this to their needs. This cost includes an expert from Lifeline South Africa to visiting Namibia to further assist with the set-up of this hotline.

Internal training costs would consist of training counselors on specific HIV/AIDS issues. This line item includes the training of approximately 20 counselors.

The equipment needed to run this hotline would include the installation of three to four telephone lines with private booths for counselors to conduct calls. Each of these booths would also contain a computer to enable counselors to input voluntary caller information into a data base form. This form can be referred to during follow-up or referral counseling sessions.

Computer training for counselors is necessary so they will be able to correctly input data and feel comfortable using these computers on a regular basis.

A follow-up visit from Lifeline South Africa is necessary for monitoring and evaluating the success of the HIV/AIDS hotline in Namibia.

An information technology consultant is needed for troubleshooting and computer assistance at the start-up of the hotline to prevent further problems from occurring during daily operation.

Additional start-up costs would include marketing and branding the hotline as a non-judgmental, objective tool where one can receive help and information about HIV/AIDS related topics.

Although these are estimated costs to start-up a HIV/AIDS hotline, they are relatively accurate, as Ms. Shityuwete based them off of the cost of starting a similar hotline for Childline Namibia.

4.4.3 Periodic Wellness Days

A third prevention strategy that we researched is to have periodic wellness days within private sector companies. The majority of companies in Namibia celebrate World AIDS Day on December 1st; however it is important that the topic of HIV/AIDS and wellness is discussed more frequently. Wellness days will give companies the opportunity to increase HIV/AIDS and other health education for their workforces as well as monitor and evaluate their workplace programming on a more frequent basis.

4.5 Summary

From our research, we were able to gain a better understanding of the HIV/AIDS prevention programs currently being implemented in the workplace in various private sector businesses, as well as develop innovative prevention ideas to be adapted to Namibia.

In our conclusions and recommendations chapter, we used the results of our research to propose innovative and sustainable prevention, care and support, and treatment strategies that NABCOA and its member companies can use to further develop their HIV/AIDS programming, to reduce the negative effect of HIV/AIDS on the Namibian workforce.

CHAPTER V. CONCLUSIONS AND RECOMMENDATIONS

In this chapter, we present our conclusions and recommendations to NABCOA to assist them in evaluating current HIV/AIDS workplace programs and in developing innovative and sustainable HIV/AIDS prevention strategies.

The recommendations we made are a result of our research. To make comprehensive recommendations to NABCOA, we took into consideration the suggestions provided by all of the HIV/AIDS stakeholders that we have interviewed, including experts and wellness coordinators.

We recommend that NABCOA begin to use mobile testing units, an HIV/AIDS national hotline, and periodic wellness days as innovative prevention strategies to be implemented by the private sector of Namibia.

5.1 HIV/AIDS Workplace Programs

Through the eight conducted interviews with wellness coordinators at various Namibian businesses, we have concluded that the more comprehensive HIV/AIDS workplace programs are in large to corporate sized companies. This is because these larger businesses have more funding and resources to effectively provide their employees with HIV/AIDS education, care and support, and subsidized ARV treatment. For example, NAMDEB, a company with approximately 4,200, has a budget of approximately N$2 million allocated for their wellness and HIV/AIDS workplace programs. Although NAMDEB is a member company of NABCOA, they are able to provide employees with NAMDEB published IEC materials, condoms based on the preference of the employees as opposed to government issued condoms, and on-site medical services. Approximately 96 percent of NAMDEB employees participate in the HIV/AIDS workplace programming, which shows that the company has been successful in spreading HIV/AIDS awareness and breaking down the stigma associated with HIV/AIDS among the majority of their employees.

As a result of our research, we conclude that larger companies have the capacity to support inclusive workplace programs. They have more employees and therefore are able to have a higher peer educator to employee ratio. The peer educator to employee ratio should be one peer educator to approximately fifteen employees. Large and

corporate size companies such as NAMDEB, O&L, and Air Namibia have peer educator to employee ratios of between 1:15 and 1:20. These companies have more successful programs because peer educators are able to concentrate their efforts on spreading HIV/AIDS information to a smaller group of individuals.

Larger corporations have the financial capabilities to employ a wellness coordinator to manage HIV/AIDS programs, ensuring their effectiveness.

From our research, we found that companies with successful HIV/AIDS programs have had their programs for an extended period of time. NAMDEB has had their HIV/AIDS program for over nineteen years, which has enabled this company to efficiently monitor and evaluate each component and make positive changes to their workplace programs over time. Some of the corporate and large size companies have more experience, which enables them to have comprehensive, effective HIV/AIDS workplace programs with the hope of eventually lowering HIV/AIDS prevalence rates among employees.

Despite the funding, resources, and experiences these larger corporations have to support their HIV/AIDS workplace programs, there is still a need for improvement within many companies in the private sector. From the companies we interviewed, we saw a need for an increase in training and awareness among managers about HIV/AIDS workplace programs and the effects of HIV/AIDS on their workforce. Without the support of management, it is difficult for wellness coordinators to carry out successful workplace programs. Positive reinforcement from managers about participating in HIV/AIDS workplace programs encourages employees to become more proactive in these programs themselves.

All of the companies we have interviewed have a positive partnership with NABCOA. NABCOA provides services to their member companies according to their specific HIV/AIDS programming needs. Each company has different needs that NABCOA is able to cater to. For example, NAMDEB does not need many of the basic services from NABCOA such as condom distribution and IEC materials because they are able to provide these services to their own employees. However, they do take advantage of NABCOA's peer educator refresher courses. In contrast, Air Namibia currently has a developing workplace program and therefore needs additional assistance from NABCOA to further expand many of the components of their HIV/AIDS workplace programs. Among the eight companies we have interviewed, another desired service from

NABCOA would be to improve peer education programs by providing regular refresher training opportunities. NABCOA can also help private sector company's peer education programs by providing ideas and suggestions about incentives for these employees. An example of incentives for peer educators could be company apparel and weekend trips.

5.2 Innovative Prevention Strategies

Innovative prevention strategies are being implemented around the world and could be adapted to the Namibian workforce. These services could provide sufficient information to help prevent the spread of HIV, as well as provide care, support, and treatment options to people of Namibia. Of these strategies, we are recommending mobile testing units, a national HIV/AIDS hotline, and periodic wellness days within private sector companies.

5.2.1 Mobile Testing Units

From the research that we have conducted, we have identified a need for mobile vehicles to visit companies in areas that do not have access to wellness services. The mobile testing unit for the private sector of Namibia should be branded as a wellness van; however, it would concentrate on HIV/AIDS VCT and prevalence testing. Due to the stigma associated with HIV, it is important that people do not associate the mobile testing unit directly with HIV/AIDS. For this reason, we recommend that the vehicle have the ability to test an individual's blood pressure, blood glucose levels, cholesterol levels or other simple diagnostic procedures.

NABCOA has already received funding from Phase 2 of Round 2 of the Global Fund, to be allocated for the mobile testing unit. NABCOA has decided to use a Mercedes Sprinter van as the vehicle for the testing unit, however they are deciding between three different model options. We recommend that NABCOA use the 518 CDI Panel Van for the mobile testing unit because it is the largest model and therefore has the most space for patient rooms and storage.

The vehicle conversion is based on the needs of NABCOA and its partners for VCT, prevalence testing, and other health services. Figure 5.1 shows our recommendation for a layout for the mobile testing unit. The proposed dimensions of the van are also shown and based off of the dimensions of the Mercedes 518 CDI Panel Van.

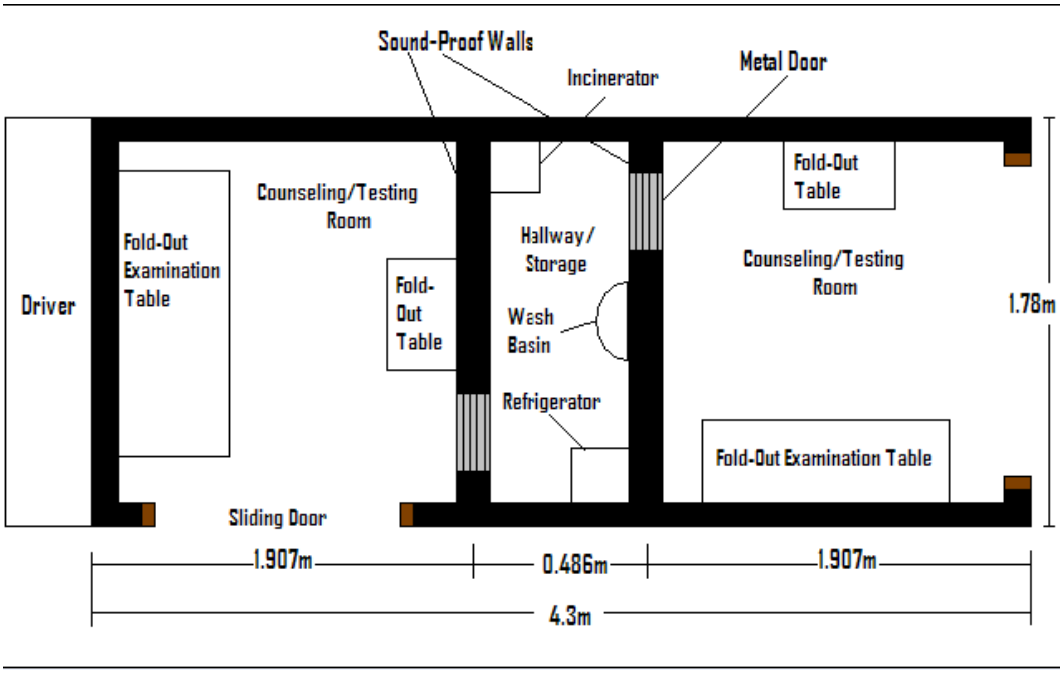


Figure 5.1: Recommended Layout for Mobile Testing Unit

To conduct services of this type, the most practical floor layout for the van should consist of two counseling/testing rooms with a small hallway between the rooms for storage of the necessary equipment. Storage space is essential because it is important to have sufficient space so that the testing rooms do not seem cluttered or dirty when conducting medical tests. We recommend that the small hallway should also be used as overhead storage for larger items. These items would include a tent that could be used for pre-test counseling, a table for testing registration, and folding chairs that can be used for individuals awaiting the services of the testing unit.

The equipment inside the small hallway should be: a generator, a refrigerator, a portable incinerator, a wash basin, and storage space. The generator will allow the mobile unit to be self-sufficient when arriving at companies. The staff will be able to plug the generator into a power source to maintain lighting and air-conditioning. The refrigerator will be used when an individual chooses to undergo the more thorough HIV test that requires blood to be drawn and transported to another facility to be tested. A portable incinerator would be an essential component of the mobile clinic because the patient samples need to be disposed of within a 24-hour period. The wash basin is necessary for sanitary purposes for both mobile testing unit staff and patients.

Each counseling/testing room will have a fold-out table, a fold-out examination table, and stools. The patient beds would fold into the wall and give patients the option of lying down while they are being tested or seen by the counselor. There would be a fold-up table in each of the testing rooms for the nurse or counselor to use as a workspace while working with a patient to complete paperwork and facilitate counseling. By using facilities that fold into the sides of the vehicle, it allows the mobile testing unit to be versatile in its services. The stools will be used for staff and patients to sit on during the counseling and testing process. There will be three stools in each examination room for the counselor, patient, and another in the case that the patient requests that a spouse or partner be present.

It is necessary to have an air conditioning system in the vehicle because the HIV testing kits need to be kept at a cool temperature. The air conditioning will also help to make patients and staff comfortable while working inside the van as it will get warm, since the doors will need to stay closed for reasons of confidentiality.

To ensure anonymity, each of the testing rooms will have soundproof walls to enable patients to feel comfortable discussing medical information inside the mobile testing unit. To increase privacy, the layout of the vehicle includes a separate entrance for each of the testing rooms. In the Mercedes Sprinter van 416 CDI and 518 CDI models, there are sliding side doors and a back door. This makes certain that individuals being tested do not have direct contact with fellow employees at any time while inside the mobile clinic.

We recommend that the mobile testing unit staff consist of two counselors who are able to conduct the medical testing as well as a driver with a code 10 license. By having the same person perform testing and counseling, this allows a trusting relationship to form between the staff member and the patient. A medical doctor is not necessary for VCT and prevalence testing, however if the mobile unit expands its health services, this position could be contracted. Additional staff could include a trainer for peer educators and a HIV/AIDS speaker, depending on the needs of the company.

As part of VCT, the mobile testing unit staff will need to conduct pre-test and post-test counseling. We suggest that pre-test counseling be conducted in groups of between fifteen and twenty individuals because this is more time efficient. Pre-test group counseling will take approximately 15 to 20 minutes, as opposed to individual pre-test counseling that may take 40 minutes per patient. Also during a group session, people will

have the opportunity to ask questions and learn from responses provided by a counselor. We suggest that the pre-test counseling can be conducted in a large tent outside the mobile testing unit.

Post-test counseling is important because it is the first opportunity for the individual to talk about their status. For additional post-test counseling, mobile testing unit staff would be able to refer individuals to state hospitals, private clinics, counselors, and churches where they can receive the services they need. We recommend that the staff distribute informational packets about HIV/AIDS to each patient and contact information of local clinics.

5.2.2 HIV/AIDS National Hotline

NABCOA and Lifeline Namibia are interested in forming a partnership to develop a national HIV/AIDS hotline. The staff of NABCOA has an expertise in HIV/AIDS related topics, while the Lifeline Company has experience in telephone counseling on topics like emotional wellness and emergency crisis response. NABCOA can also assist the counselors at Lifeline Namibia by providing them with IEC materials and HIV/AIDS training, similar to the peer education training they do for their member companies. With a partnership between the two organizations, they can implement a sustainable hotline for the people of Namibia.

The purpose of this hotline would be to answer questions from callers concerning HIV/AIDS in a safe, secure, and non-judgmental environment. The counselors should be able to provide support and counseling in Afrikaans, English, and other tribal languages to make callers feel comfortable when asking their questions or expressing their concerns. Also we recommend that the hotline have a toll-free number to encourage people to call because it will be easily accessible and free. In addition, the hotline should be marketed to everyone, regardless of their HIV status.

We recommend that the hotline use a computer data collection system to input data about the caller and provide follow up services. This would allow the counselor to create a file for the caller that could be referred to during subsequent calls. For callers that do not feel comfortable identifying themselves, an anonymous number identifying system should also be used. The option to identify the caller through a number only should be

offered to gain the trust of the caller and make him/her feel at ease when asking for information.

The hotline should be centralized at Lifeline Namibia. Lifeline Namibia currently has the capacity to hold the hotline call center at their facilities. They have a medium sized room in the office that would be able to be easily converted to a call center by installing privacy booths and additional telephone lines.

We suggest that the hotline have four telephone booths operated by eight counselors, so there is adequate staffing. The hotline call center should be open every day from 8am to 10pm. If the hotline is successful, the hours of operation can be extended to 24 hours a day.

We recommend that the hotline be included in NABCOA's application for the Round 8 Global Fund grant as a source of initial start- up funding.

Another recommendation we have for this hotline would be to have an HIV positive counselor. This would allow the caller to ask personal questions such as what it feels like to be HIV positive, how they told friends or family, or how they deal with the illness on a daily basis. This relationship will benefit both the caller and the counselor by allowing both individuals to exchange information and speak freely about their HIV status.

5.2.3 Periodic Wellness Days

Another recommendation for NABCOA is to incorporate periodic wellness days within private sector companies. During this day, wellness coordinators would choose a particular health issue to focus on to spread awareness and education to employees. The topics could range from depression to eating disorders, yet there should be an emphasis on HIV/AIDS. We propose that these wellness days occur at least every three months, however, the exact occurrence of these wellness days is at the discretion of individual businesses. We suggest that mobile testing units be part of the wellness day events to promote HIV/AIDS testing as well as other testing for other medical procedures.

During wellness days, we suggest that companies monitor and evaluate their workplace programming. By having multiple days per year focused on wellness events, companies would be able to examine their current programming and aim to improve it on a regular basis. We recommend NABCOA staff conduct peer educator training sessions

and refresher courses to keep them abreast of the most current HIV/AIDS issues so that they can provide up-to-date information to their peers. Companies could use these days to recognize peer educators for their volunteer work and reward them with gifts of appreciation.

5.3 Chapter Summary

The purpose of our recommendations is to strengthen HIV/AIDS workplace programs throughout the private sector by monitoring and evaluating current programs and the relationship between these companies and NABCOA. Our research has led us to identify innovative prevention strategies that can be implemented by the private sector in Namibia. We are presenting these recommendations to NABCOA to support their new strategic vision of expanding the provision of VCT and other HIV/AIDS programming in the private sector.

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Appendix A: Sponsor Description

The mission of Namibia Business Coalition on AIDS **(**NABCOA), a private organization, is to provide services that implement HIV/AIDS prevention and education programs in companies throughout Namibia (World Economic Forum, 2006).

To reduce the effect of HIV/AIDS spreading in the business sector is NABCOA's main focus. In Namibia, one in five adults is infected with HIV (Republic of Namibia Ministry of Health and Social Services, 2005b). According to the International Labor Organization, Namibia is expected to lose one quarter to one third of its workers by 2020 (National Planning Commission, 2001).

The NABCOA consists of approximately fifty-five different companies and institutions. Members include private and non-private sector organizations (i.e. non-governmental organizations, government organizations, observers, and unions), as well as, twelve multinational corporations (World Economic Forum, 2006).

The organization is governed by the NABCOA Board, which consists of twelve members including: seven representatives from the private business sector in Namibia, one representative from an association of people living with HIV/AIDS (PLWHA), one member from a non-governmental organization (NGO), one senior government representative (appointed by the Minister of Health and Social Services), and two UN representatives who have been granted permanent observer status (World Economic Forum, 2006).

As of June 2006, the organization employed ten people including: a Program Manager, an office manager, a technical adviser from GTZ (the German Agency for Technical Cooperation), an office administrator, two project coordinators, a senior project officer, and a training officer, and two office assistants (World Economic Forum, 2006).

The HIV/AIDS prevention strategies project team will be working with the Program Manager, Peter van Wyk, and his colleagues.

To address the problem of the spread of HIV/AIDS in the private business sector in Namibia, the organization provides information in various forms. These include the quarterly bulletin, *AIDSBRIEF*, seminars, and forums in which new methods of dealing with HIV/AIDS are presented and discussed (World Forum, 2006). The organization has a website, www.nabcoa.org that is not functional.

NABCOA also provides trained staff and consultants from their members, companies, government institutions and sponsors to help with outreach to the community and local companies (World Forum, 2006).

The organization receives money through membership dues and corporations seeking their services. Grants and donations received from various government and non-governmental organizations also provide income to further NABCOA's mission (World Economic Forum, 2006).

Other organizations that work to promote HIV/AIDS prevention in the business sector in Namibia are AIDS Workplace Programs in Southern Africa (AWiSA), Pan-African Business Coalition (PABC), and Namibia Network of AIDS Service Organization (NANASO). NABCOA implements the AWiSA HIV/AIDS prevention program in Namibia. PABC (World Economic Forum, 2006) is strongly supported by NABCOA. NANASO is a partner implementer for NABCOA.

Appendix B: What is a Wellness Program?

What is a wellness program?

The primary objective of a wellness program is to educate employees about their health and general welfare (NABCOA, 2007). It is a holistic approach to addressing employee wellness in that it addresses the treatment, prevention, as well as care and support of employees with various diseases and illnesses.

The components of a wellness program are carried out to achieve various objectives and goals a company has in regards to the well-being of its employees. These components focus on issues that range from general wellness, like nutrition and fitness, to those that are life-threatening like HIV/AIDS and its related illnesses.

Wellness Coordinator

This person is appointed to be in charge of developing the HIV/AIDS prevention and general wellness programs and directing a company's resources and support towards these programs (NABCOA, 2007). The main responsibility of a wellness coordinator is to ensure the health and safety of all employees according to National Occupational Health and Safety Labor Acts

A wellness coordinator should have an extensive understanding of the HIV/AIDS epidemic and its related factors in the business sector, e.g., economic impact, issues affecting HIV/AIDS in the workplace (NABCOA, 2007). The coordinators should be familiar with the dynamics of the particular workplace, so as to implement programs that would be well received in that workplace.

Wellness coordinators should work under the HR department so they are able to access information about training/development, employee benefits, absenteeism, medical care, etc., that would give them a better idea of the effects of HIV/AIDS and its related factors in the workplace.

Components of a comprehensive wellness program

The components of a company's wellness program vary depending on factors like access to adequate financial resources, number of employees in the company,

management support, etc. These components should be selected to address the prevention, care and support, and treatment needs of a company's employees.

ARV Treatment

This component of wellness programs involves a company's provision of anti-retroviral (ARV) treatments to its employees who are HIV positive, through its on-site medical services or by obtaining the drugs from outside vendors for the employees' use.

ARV Treatment Coverage

The ARV treatment coverage component of a wellness program is how much a company covers of the costs of ARV treatments for employees. For example, some companies offer 100% coverage of ARV treatment, which would mean these drugs are free of charge for employees, while other companies only cover 80% of the costs of these treatments, which means the employee would need to pay for the remaining 20% of the treatment costs.

Condom Distribution

The condom distribution component of a wellness program is a company's provision of condoms (both male and female) to its employees, either free of charge or at subsidized rates, in order to encourage the employees to practice safe sex and ensure their general wellness. The member companies of NABCOA source their condoms from the MOHSS or buy condoms that employees express interest in having for internal distribution.

Information, Education and Communication (IEC) Materials Distribution

The IEC materials distribution component of a wellness program is the provision of materials like brochures, calendars, pamphlets, etc. that contain information that is useful to the employee in regards to their health and general well-being. The member companies of NABCOA source their IEC materials from NABCOA, the MOHSS or even create their own IEC materials for internal distribution.

Management Training

The management training component of a wellness program involves increasing top and middle management's awareness and knowledge of HIV/AIDS, in order for them to fully understand the extent of its effects on their employees. They are also briefed on the company's HIV/AIDS policies. This will help in garnering their support, as well as their participation in other components of workplace programs such as the peer educator program and other wellness related programs and events.

On-site Medical Services

The presence of on-site medical personnel and facilities increases the ease by which employees have access to these services. These medical services reduce problems of absenteeism, increased travel costs, and loss of income for the days employees were not at work. The company also experiences a reduced risk of losing skilled workers, and thereby reduces the chances of increased production costs.

These medical services can provide basic health services such as conducting tests for blood pressure levels, blood sugar levels, and cholesterol levels, as well as HIV/AIDS services such as VCT, provision and distribution of ARVs, condoms, and IEC materials. Medical services personnel can also carry out the following activities (NABCOA, 2007):

- Post-exposure Prophylaxis (PEP) for those employees who are accidentally exposed to HIV as a result of injuries sustained at work;
- Treatment of opportunistic infections (OIs) related to HIV/AIDS such as tuberculosis (TB), pneumonia, skin cancers/rashes such as Kaposi's sarcoma, etc.;
- Prevention and treatment of other sexually transmitted diseases/infections (STD/I), which helps reduce employees' susceptibility to HIV/AIDS

Monitoring and Evaluation System

This is a system put in place to monitor and evaluate the effectiveness of the wellness program, in order to measure whether it fulfills the target goal and objectives stated in the company's HIV/AIDS and wellness policies (NABCOA, 2007).

Measuring the effectiveness of the program can be done by conducting the following activities:

- Obtaining employee feedback on their experiences in the program and its related activities. The program evaluations are carried out in the form of structured

surveys and/or focus group discussions, which are conducted by outside consultants;

- Tracking changes in indicators like absenteeism, employee turnover, company benefits, etc., and reporting the results on a regular basis.

Peer Educator Program

The peer educator program is one where various employees volunteer or are elected to act in the capacity as peer educators. They do not get any financial compensation for volunteering, but in some companies, the peer educators receive incentives like t-shirts, lunch etc. Peer educators are people who create awareness and disseminate information to other employees on HIV/AIDS and other health issues. They undergo regular training about basic facts about HIV/AIDS and other health issues and their effects on the employees and the workplace in general.

They organize regular meetings, where they facilitate focus groups and serve as sources of information for their peers on different health topics as well as HIV/AIDS. They also refer their peers for counseling and testing.

For this program to be effective in reaching out to the employees, there should be 1 peer educator assigned to 15 to 20 employees. This allows the employees to become more comfortable in a smaller group where they are more willing to voice their opinions and share their ideas with the peer educator and the other members of their groups. These focus groups help to reduce stigmas and discrimination associated with HIV/AIDS and make people more comfortable in settings where such topics are brought up. The small size of the groups also help to create trust between the employees and the peer educators, and in effect, these groups serve as a support network for the employees who are infected, as well as, affected by HIV/AIDS.

Preventing Mother-To-Child Transmission (PMTCT)

The PMTCT component of a wellness program involves providing the anti-retroviral drug, Zidovudine, to pregnant mothers who are HIV positive to prevent them from transmitting the virus to their unborn babies through the umbilical cord. The company can either provide the treatment to these women through their on-site medical services or provide medical insurance that can cover all or some of the costs associated with procuring this drug.

Voluntary Counseling and Testing (VCT)

The VCT component of a wellness program involves employees volunteering to get tested in order to know their HIV status (NABCOA, 2007). The employee has to go through counseling before and after the actual testing process. Pre-test counseling provides the employees with the necessary information around HIV/AIDS and makes it possible for them to make an informed decision in regards to whether they get themselves tested or not.

Post-test counseling provides the employees with their test results and reiterates the information given in the pre-test counseling session (NABCOA, 2007). It also can refer the employees to other facilities where they can get extra support and treatment.

Appendix C: Interview Questions for Wellness Coordinators

1. What is your current HIV and AIDS workplace program?

2. Are all of the effects of HIV and AIDS on the employee covered within your policy? (e.g. if the employee needs time off for health reasons or to go to a funeral)

3. What is the strongest component of your workplace program?

4. What is the weakest component of your workplace program?

5. What do you think could be done to fix this issue? Is it possible to solve within your company or would you require outside assistance?

6. Do you have a designated employee or committee that is in charge of monitoring and evaluating this system?

7. If yes, how often does this person or committee monitor your program?

8. What are the standards to measure the success of your program?

9. Would help from NABCOA or other consulting agencies be beneficial when developing a more efficient monitoring and evaluating system? (if it is needed)

10. What kind of assistance would you expect from NABCOA?

11. If NABCOA was successful in its bid to become a PR for Round 8 of the Global Fund grant, how would you spend money that would be allocated to your HIV/AIDS program?

Appendix D: Interviews Minutes from Meetings with Wellness Coordinators

Interviewee: Ms. Elsabe Grötzinger, NAMDEB Employee Wellness Coordinator
Date: 17 March 2008
Time: 11H00 – 12H00

Interview Minutes

- As of 2007, the HIV prevalence at NAMDEB was 5.5%
- Their HIV/AIDS program is 19 years old
- The HIV/AIDS program is a part of the Holistic wellness program implemented at NAMDEB
    - It used to just focus on HIV/AIDS but expanded to general wellness because of problems with stigmatization of employees who went to the HIV center
    - Involves the voluntary participation of employees
    - They organize alcohol and drug testing at regular intervals
    - They give free vaccinations e.g. flu shots during winter, provide drugs for diseases like TB, and also offer general medical check-ups
    - The NAMDEB building is smoke-free
- It offers a variety of programs which includes an HIV/AIDS strategy, which looks at the following:
    - Prevention (Keeping negatives negative)
        - Peer Education (PE) training
            - There is 1 peer educator to 15 employees
            - The meetings of the PE's and employees are to occur at least once a month and topics discussed are based on the yearly wellness calendar
            - PE training occurs twice a year
            - PE's are chosen based on recommendations from managers and employees that fulfill the criteria needed to be PE's

        - Have feedback forms to determine the efficiency of the PE's
        - Give out trophies and certificates to the PE's to encourage them to keep volunteering
- IEC materials gotten from sources like the government, UNICEF
    - Why not NABCOA?
- Condom use
    - Employees felt that the condoms gotten from the MOHSS broke easily, and so didn't like to use them
    - They carried out surveys to find out which ones the employees like and gave both male and female condoms out for free
    - They monitor condom use per site on a monthly basis
    - They also have professional nurses carry out condom use demonstrations
- VCT (Voluntary Counseling and Testing)
    - VCT campaigns are carried out regularly till company's target goals are reached and this varies depending on the site
        - Carried out monthly at sea and less to employees in the offices
    - They organize both on-site and external testing for HIV
    - They also have both on-site and external psycho-social support
        - Both of these work depending on the situation and the moods of the persons involved
        - Employees referred outside are covered fully by the company
- PEP (Post-Exposure Prophylaxis)
    - Some of the employees were found to have concerns about getting infected at work
- PMTCT (Preventing Mother-to-Child Transmission)

    - Key performance indicators are people participating in an effort to “better themselves”
    - Positive living (Care and Support of positives)
        - They offer the following to HIV positive employees
            - 100% coverage for ART for employees and their spouses
            - Full blood test including CD4 count every 6 months for positive employees to monitor the state of their health
            - Vitamins
- Measuring and Monitoring Programs
    - They have an effective monitoring and evaluating (M&E) system in place, and are constantly making changes to improve their program based on the results they obtain
    - They use surveys to create the company’s HIV/AIDS Assessment , which is based on the Chrysler survey and the NABCOA ATTA Tool
        - The surveys are anonymous and voluntary
        - Are carried out based on age groups and job grades
        - Include questions on sexual/individual behaviors (KAP survey)
        - Focus on problem areas e.g. condom use, instead of being very lengthy and are the questionnaires are easy to fill out
        - Both employees and outside contractors participate in the surveys
        - Monitored the people taking the survey
- The wellness coordinator has access to the information of those employees that are HIV positive, so they can carry out M&E and get people’s consent to register them for ART
    - There has been seen to a discrepancy between the number of people registered for ART and the number of HIV positive employees
        - Need to be able to work to reach the rest of the employees
    - They also monitor exhausted sick leaves and deaths in the company in order to see if they are as a result of employees having HIV/AIDS
- Financial Containment
    - Have $2 million fund for people who exhaust their medical aid and need help covering their ART costs

    - They raise money for PLWHA and orphans during events in the company
- Communication
    - Look at general wellness and health instead of just HIV/AIDS e.g. nutrition, alcohol and drug use etc.
    - Have campaigns and give out incentives e.g. t-shirts to encourage employee participation
        - They feel that the price of these incentives is far less than the money lost when they lose skilled workers to HIV-related sicknesses or death
    - Use posters and flyers placed in different locations in the building
    - Are working towards making HIV/AIDS an open topic and seem less intimidating to the employees
    - Let people know that they are protected by the company's HIV/AIDS policies
- Training and Education
    - The company is involved in educating their employees and pays for formal tertiary courses i.e. masters, diplomas
    - They identify programmes in the community that need support
    - The training programs offered are open to the public
- Management is willing to participate and support these strategies 100%
- Business relations with NABCOA
    - NABCOA does a good job in selling the NAMDEB workplace program to the public
    - NAMDEB has bypassed NABCOA in their place as a middleman to get to the government
    - NABCOA needs to do more for the company, because NAMDEB feels that they keeping giving without recieving anything back
    - NAMDEB is tired of not going forward in this regards to HIV/AIDS prevention and treatment strategies and looking to adopt some new and innovative methods of implementing programs geared towards HIV/AIDS prevention and treatment

Interviewee: Ms. Zelda Rukambe, Ohlthaver & List Employee Wellness Coordinator
Date: 18 March 2008
Time: 09H00 – 10H00

Interview Minutes

- O&L is an umbrella company for a group of small businesses, such as retail, fishing, dairy, technology, restaurants, hotels, etc.
- They are currently employing over 4,000 employees and have adopted holistic approach towards addressing HIV/AIDS and general wellness in the workplace
- Their currently implemented wellness program was started between 2003 and 2004
    - They started off with only HIV/AIDS program then expanded the program to include a entire wellness program
    - The VCT campaign was started in 2006 and introduced ARV treatment, care, and support programs
        - The VCT campaign was a month and a half long to cover all of the businesses within the company
        - They contracted medical personnel from outside the company for confidentiality purposes
        - They use the rapid test in order to get results that same day
        - For the testing, employees are given bar codes instead of using names or ID numbers for confidentiality purposes
        - There is currently a team that consisted of nurses and qualified counselors that can go around to each O&L location
            - People are trusting the process because they want to know they status

- O&L agreed to sponsor employees with free ARV treatment, and they called this initiative, vitality medical support
- There are some employees that have medical aid but those that don't, she refers to the government for help
- The wellness program has been quite successful in terms of participation: the first year (2006), there was 63% employee participation and in 2007 that increased to 96% employee participation

- Peer Educators
  - There is criteria that the potential peer educators have to fill and they go through a screening process before they can become peer educators
  - O&L organizes a week long training about all types of wellness issues
  - MS. Rukambe monitors and evaluates through site visits, once a week or once every other week for companies in Windhoek and monitors companies farther away about once or twice a month
  - The peer educators receive refresher training courses
  - Some of the challenges the peer educators encounter is that other colleagues don't listen to them and they don't have management support
- Management Training
  - This involves supervisors and managers undergoing some form of training on HIV/AIDS and other wellness related issues
    - This is done so that they understand what employees are going through and how HIV/AIDS affects the company in order to support program
    - They also learn how to identify and give empathy to HIV positive employees

- O&L has good relationships with Newstart (a local VCT center), MOHSS, NABCOA
- Condom distribution
    - They get them from the government
        - This is dome to educate employees and make condoms available but condom use is not forced on anyone
- Comprehensive Wellness Program
    - 27 March is the company wellness day
    - Service providers are called in to come in to bring people on site for a day to do consultations
    - The managers agree that if wellness programs aren't in place, production is negatively affected
    - The managers signed a letter of commitment pledging to be committed to these programs
        - This is part of the HR initiatives
- Changes she would like to see implemented in the wellness program are listed as follows:
    - O&L wants to have a KAP study to look at attitudes, knowledge, behavior, practices of the employees
        - It will depend on the budget whether or not the company or an outside company does the research
    - They would like to extend ARV provision to families of employees and their supply chain
        - ARVs are only for employees but MS. Rukambe links families with the Ministry of Health for help

        - They also only contract outside of the company when necessary
    - O&L has donation projects where they donate money, food, dairy products, cool drinks, fish etc, to schools and orphanages

- Global Fund
    - If money from Global Fund was available to O&L, Ms. Rukambe would like to see the money used for incentive programs for the peer educators (e.g. t-shirts, certificates, shoes, hats, recognition, etc.)
    - It would be used to enable the company to cover casuals or part-time employees and provide them with ARVs
    - It would be used for the development of peer educators
    - O&L would also like to extend their wellness program into the community
    - They would use the funds for training and development, capacity building
        - For example, peer education training in coastal areas

Interviewee: Ms. Rachel Freeman, Air Namibia Employee Wellness Coordinator
Date: 18 March 2008
Time: 10H30 – 11H30

Interview Minutes

- Air Namibia is a national airline which has 14 stations, of which 4 are in Windhoek
- The HIV/AIDS program was just recently started in November, and it is a part of the Holistic employee wellness program, which falls under the HR department
    - 50% of the program is sponsored by GTZ
    - They work with parastatals, NGO's and the government
- Their HIV/AIDS policy is being revised so that it covers all HIV/AIDS related issues around the workplace e.g. confidentiality of HIV status, gender equality, no discrimination
- Peer Education (PE) training
    - There are 29 trained peer educators (22 of them are local and 7 are located in other outside stations)
        - 15 trained in November and 15 trained last week
    - There is 1 peer educator to 20 employees and they undergo an intensive one week training session
    - The meetings of the PE's and employees are to occur at two or three times a month and the PE's are regularly sent IEC materials
    - The wellness coordinator keeps contact with the PE's to provide with moral support and encouragement
    - This program is monitored through monthly reports submitted to the employee wellness coordinator on the 20th of each month
    - PE's are chosen based on recommendations from managers and employees that fulfill the criteria needed to be PE's
    - Give incentives to the PE's to encourage them to keep volunteering e.g. t-shirts, caps, bags
    - The PE's also benefit from the NABCOA refresher sessions

        - Air Namibia also budgets for a huge refresher event every 6 months within the company
    - There is a need for an improvement in the support gotten from managers, especially middle management
    - There is also a need for more off-site meetings for PE's to serve as incentives to encourage more employees to volunteer
- IEC materials gotten from sources like NABCOA
    - There is a need for more IEC materials for distribution to employees
- Condom use
    - They distribute government condoms (both male and female) and regularly replenish their supply
    - There are 24 distribution points for condoms and the condoms are placed in the toilets for easy access
- Air Namibia Leadership Campaign
    - They started from top down i.e. first targeted executive management in order to garner their support for program
    - The campaign used these 5 points of action
        - HIV is everyone's problem
        - Know your cost/impact
        - Know your status
        - Positive living
        - Good health
    - They then targeted the following:
        - Middle management
        - Peer educators
            - Organizing refresher courses, assisting them during their sessions
        - Taskforce
            - This is an advisory that evaluates the wellness program and there are 11 members
    - The executive members also signed a letter of commitment promoting no discrimination or stigma, confidentiality

- Medical Benefits
    - The company covers only 85% of medical aid for employees
    - “My health is vital” is a campaign to provide ART for HIV positive employees
    - Discounts on gym fees
    - General health care tests are carried out on monthly basis
        - E.g. blood pressure, cholesterol, diabetes etc
    - Employee wellness assistance through counseling
        - The employees prefer to see the wellness coordinator who will facilitate the process for a short period of time
        - After this, the employee will be referred to an outside psychologist for long-term treatment
- VCT
    - The company’s VCT campaign commences in May and will run for 3 months
    - They plan to develop VCT resources and raise awareness among employees
- On-site medical personnel
    - There is a need for on-site VCT clinic and medical personnel in order to consolidate all medical services in one central location
    - This will provide these services to the employees, and save the company time and money
- Communication
    - Looking to educate the employees on general wellness and health instead of just HIV/AIDS e.g. nutrition, alcohol and drug use etc.
    - Give out incentives to encourage employee participation and keep the program going
        - E.g. T-shirts, balloons, bags, badges etc.
        - They feel that the price of these incentives is far less than the money lost when they lose skilled workers to HIV-related sicknesses or death
    - Use posters and flyers placed in different locations in the building
    - Celebrations on international/national days

        - Present opportunities to distribute information

- Measuring and Monitoring
    - They carried out a HIV prevalence survey last November
        - This was piloted in the 4 local stations and the results were very concerning
    - The programs are evaluated on a monthly basis by the taskforce
    - They are currently using the PE meetings and reports obtained from the PE's to evaluate the success of the program
    - In the future, they are looking to administer surveys to the employees and managers
- Business relations with NABCOA
    - There is a need for constant peer educator training
        - There should be an increase in the quality of training courses
    - NABCOA should offer the following:
        - Capacity building of employee wellness offices
        - Opportunities to debrief managers on employee wellness – conference
        - Brainstorming conferences for wellness coordinators
        - Management training to increase their commitment
            - Targeting executive management
    - Mobile clinics with awareness
        - NABCOA should create pool of medical service providers who can work with companies

Interviewee: Ms. Helen Nicodemus, Roads Contractor Company (RCC) Employee Wellness Coordinator

Date: 26 March 2008

Time: 10H30 – 11H30

Interview Minutes

- Ms. Nicodemus is the employee wellness coordinator, but she is a nurse by profession
- The main objective of RCC is to build roads throughout all of Namibia.
    - Their employees travel all over Namibia to complete the roads. Since these projects take them all over Namibia, the informal settlements that are along the road are a risk to these employees.
- They employ approximately 1200 employees.
- Their currently implemented HIV/AIDS program was started in 2006
    - The HIV intervention program is referred to as a vitality program
        - Some of the benefits of the vitality program are that employees get medication (ARVs) free of charge and they also receive treatment for HIV/AIDS related illnesses
    - Medical Aid for employees is subsidized by the company and ARVs are provided for HIV positive employees
        - Of all the HIV positive employees, only 72 people are actually registered with this program
        - Those who aren't registered and want help, go to clinics or state hospitals instead
    - NABCOA really helped in the start-up of their workplace program
    - Peer Educators
        - They train foremen in the field to help raise awareness when workers are away from home

        - They conduct training sessions after work
        - Every 4 months is peer educator training
    - They are 15 peer educators total plus 5 Human Resources representatives that are trained
        - The HR people are in four districts and are trained because they are the first people who notice signs that someone may have HIV as they can detect absenteeism etc.
        - The peer educator program is the most successful part of the workplace program
    - Peer educators are supposed to meet with employees or do activities once a month
        - It is difficult for the peer educators to meet with the employees when they are traveling for work and need to make deadlines
    - The peer educators are chosen by employees
    - Ms. Rukambe goes to peer educator activities to monitor what is going on
        - She believes they need to improve on peer education training and awareness i.e. change training from every 3 months to ever 2 months
- The company's medical board is made up of 3 doctors
    - They carry out testing every 3 months
        - If someone notices that an employee is getting weaker, they notify the doctors who make assessments
        - Then the doctors put that employee on a program for 6 months to be reviewed

        - They have a policy used to prevent discrimination

- RCC hasn't done prevalence surveys yet but it is on the agenda to be completed before June of this year

- There is still a lot of ignorance about HIV within the company which may affect employee participation

    - Example: A man from Northern Namibia would not believe that he was HIV positive and refused to cooperate with doctors as he believed in his traditional healer from his home and that he was sick because his wife bewitched him

- Ms. Nicodemus believes that the company is not ready to have a VCT campaign

- There are health corners with information, pamphlets, condoms, etc

    - There are male and female condoms and some are also placed in the bathrooms

- Ms. Nicodemus wants to get management more involved in employee wellness

- MS. Nicodemus has basic counseling skills but refers employees for counseling if it is a serious matter and the company pays for it

Services needed from NABCOA

- They would like t-shirts or other incentives to give out on World AIDS day to increase employee participation and also give Peer Educators rewards

Global Fund Grant

- They would use funding received for World AIDS day activities and incentives

Interviewee: Ms. Twapewa Mudianima, Managing Director, Pewa Investments

Date: 28 March 2008

Time: 10H30 – 11H30

Interview Minutes

- Pewa Investments started with 2 hairdressing/beauty salons in 2001 and they started manufacturing cosmetics 3 years ago
- They also have a beauty training school
    - This was created for disadvantaged students in terms of their financial problems
    - The target market are youths in Katatura who fail grades in school and can't go to PoN or UNAM
- They are also creating a cultural centre and opening a new shop, both of which will be open in 2 months
- They have 30 full-time employees and 60 part-time employees, who are women who earn their income from selling the products but are not on the pay roll
- They just lost an employee of over 6 years to AIDS this January
    - Having problems replacing him as an employee and friend
- Workplace Programs
    - They currently have no workplace programs in place
    - They would need a champion (wellness coordinator-type person) to implement these programs
    - They would also need to fully understand in totality what these programs will entail
    - Emphasis should be placed on home-based care
        - This can help in increasing outreach to more people and regions
    - They need to have a "holistic" approach towards addressing these problems
    - They would need to advertise aggressively on the presence of the workplace program at every branch of the shop, in order to communicate the larger picture to the community

- Training the hair dressers to serve as sources of information to their clients
    - This will provide them with opportunities to impact people's thoughts and lives
- Get employees to participate in VCT
    - Providing access to being able to know their status
    - They also have a nearby clinic (about 3 minutes walk)
- Pre and post counseling is not enough to overcome the stigmas associated with having HIV/AIDS
    - It's meant for more mature minds than are easily found in most people today
- Get manager's understanding and support for the program

- Peer Education (PE) training
    - Need to add a chapter on peer education to their training modules
- Health Corner
    - It should contain the following:
        - IEC materials (gotten from NABCOA or MOHSS)
        - Maybe condoms (gotten from MOHSS)
            - They used to have condoms at the salons but it just stopped
    - Will have 2 stands – inside and outside the shop in order to reach a larger audience
- Global Fund
    - There will be a need to analyze all the components involved
    - The funding would be used to start program and implement health corner
        - This would help to increase awareness on so many issues and illnesses as well as HIV/AIDS, i.e. support general healthy lifestyles
        - They would also organize demonstrations and workshops on health and wellness be included in the training programs
- NABCOA can provide consultants that can be useful in community-wide outreach
    - These consultants can provide counseling and should be easily related to
    - They can also provide mental coaching and encouragement

Interviewee: Mr. Mose Kavendjii, NAMCOR Health, Safety, Security & Environment (HSSE) Manager

Date: 24 April 2008

Time: 15H00 – 16H00

Interview Minutes

- Mr. Kavendjii is the focal person in charge of NAMCOR's HIV/AIDS workplace program
    - He is also the company's HIV/AIDS coordinator
- NAMCOR currently has 40 employees
- The HIV/AIDS program at NAMCOR is one and a half years old
- They started the process of setting up this program with drafting the company's HIV/AIDS policy
    - They obtained input from the employees on issues that should be covered in the policy
    - They also got assistance in the policy development from the AIDS Law Unit of the Legal Assistance Centre in Windhoek
        - Revisions were made to the draft so that it covers all HIV/AIDS related issues around the workplace e.g. confidentiality of HIV status, gender equality, no discrimination
    - NABCOA, and other experts on HIV/AIDS policy development also went over the drat policy and gave input on changes that could be made to it
    - The company's HIV/AIDS policy can be found on their Intranet and all employees have access to it
    - Mr. Kavendjii also organizes regular meetings with the employees to thoroughly explain the company's HIV/AIDS policy and all the issues covered in it
- Mr. Kavendjii also established a HIV/AIDS committee
    - This committee consists of management and employee representatives

- The current chairperson is the company's Managing Director, but the position is rotated so that other employees (peer educators) can be empowered as chairpersons of the committee

- Their currently implemented HIV/AIDS program is made up of the following components:
  - Peer Educators
    - The peer educators are also part of the HIV/AIDS committee
    - There are currently 5 peer educators in the company i.e. there is 1 peer educator to every 8 employees
    - Mr. Kavendjii is also a peer educator
    - The peer educators meet once every week to empower each other, gather more information and knowledge from their colleagues
    - Mr. Kavendjii chose peer educators that spoke different languages, so that all the other employees could be able to understand and relate to the information that is being shared
    - NAMCOR has a peer educator exchange program
      - They invite peer educators from other companies they work with, to come and share information about their own program and the issues they are focusing on
      - This helps to strengthen the peer educator programs and make the peer educators themselves more comfortable discussing uncomfortable topics like HIV/AIDS
    - NAMCOR has contracted Phillipi Trust Namibia to offer "Christian counseling" training to the peer educators with emphasis on HIV/AIDS
  - Employee involvement and events
    - They have bi-weekly information sessions for the employees in which they watch videos and discuss the health topics that the company is focusing on for that period
      - They give out anonymous questionnaires to the employees to find out their KAPB in regards to HIV/AIDS

        - NAMCOR has set a date of November 2008, as the target for when all their employees will be well versed and aware of HIV/AIDS
    - They have a library/health corner that contains IEC materials (gotten from the MOHSS)
    - They also provide condoms (both male and female) for the employees to use
        - The condoms are available in the library and in the toilets
    - They have a national HIV/AIDS events calendar for the fiscal year (it runs from April to April)
        - Recognize national and international HIV/AIDS days
        - Have had PLWHA come in to give talks and have discussions with the employees
    - They are engaging employees to participate in the company's prevalence test
    - They are bringing in Newstart, a local VCT centre, in the 2nd week of May, to give presentations about VCT (its benefits and drawbacks)
- Management Involvement
    - The management has been very supportive of the workplace programs
    - Formal HIV/AIDS training for the management will occur later this year
- Community Outreach
    - They are working with OVC
        - Have organized visits to orphanages and donated food and other supplies to them
        - They go to hospitals once a month to visit the patients, and are planning on going to some schools
- ARV Treatment
    - The company's medical aid offers partial coverage for ARV treatment

        - The company is bringing in experts to educate the employees on ARV and the issued surrounding ARV use and adherence
    - General Employee Wellness
        - NAMCOR is trying to set up an employee assistance program that would focus not only on HIV/AIDS, but also on other health and medical issues
            - One of the peer educators is a nurse, and so she talks to the other employees on other health issues like nutrition, heart problems, alcohol and drug use etc.
        - The company also organizes family days where employees go on a outing where they can get some form of exercise
- A weak component in their HIV/AIDS program is attending breakfast meetings organized by NABCOA, for either exchange forums or peer educator training and refresher courses
- The services NABCOA provides to the company are:
    - Provided guidance in the development process of the workplace programs
    - Made some revisions to the company's draft HIV/AIDS policy
    - Organize peer educator training and refresher courses
    -
- The services NAMCOR still needs from NABCOA are:
    - Cost-Benefit Analysis
    - Management Training
    - NAMCOR would like to get allocate some Global Fund money for the development of their workplace programs
- Global Fund
    - They would organize more training for peer educators and management
    - They would have technical assessments and audits done on their workplace programs by external consultants/contractors
    - They would provide free ARVs to their HIV positive employees
    - They would provide incentives to encourage peer educator and employee participation in the workplace programs

Interviewee: Ms. Taimi Kapelwa, Head of Training, Social Security Commission (SSC)
Date: 25 April 2008
Time: 11H00 – 11H45

Interview Minutes

- The SSC currently has ± 300 employees
- Ms. Kapelwa's main function in the company is training and organizing training sessions/events
- The SSC is just trying to start up a comprehensive workplace program
    - They just finished training with the MOHSS to come up with a work plan
    - They are taking the National HIV/AIDS Medium Term Plan III \(MTP III) into consideration when creating this work plan
    - The new work plan will focus on HIV/AIDS prevention, care and support, and treatment
    - It will also cover other health issues and chronic diseases like heart problems, alcohol and drug abuse, smoking etc.
    - They already have a HIV/AIDS policy in place
    - They have a HIV/AIDS Social Security Committee which is made up of 6 members
        - This committee plans HIV/AIDS activities for the year
- Condom distribution
    - They provide male condoms in boxes in the toilets because they don't have the dispensing machines
        - They get these condoms from NABCOA
    - The cleaners have access to these boxes and are able to replace the boxes when the condoms are finished
        - They make sure that the employees have enough condoms
    - They currently don't provide female condoms because a lot of the employees do not know how to use them
        - They want to organize demonstrations and training to show the employees how to use the female condoms

- Peer Educators
    - They currently have 16 peer educators i.e. 1 peer educator to every 19 employees
    - The peer educators are chosen from different departments and are periodically sent for NABCOA training courses
        - The peer educators undergo this training to update them on current HIV/AIDS related issues
        - Other employees apart from the peer educators are also sent to undergo HIV/AIDS training
    - Employee awareness
        - They attached the MOHSS document on workplace programs to the employee pay slips
            - This has been done in branches in the Southern, Central and Northern regions
        - On World AIDS Day, the SSC partners up with the Ministry of Labor to organize activities for their employees
    - Employee medical aid
        - The medical aid covers ARV treatment provision under the NHP program
            - Family members are also provided with ARVs
            - PMTCT is covered by the medical aid
            - Employees are also encouraged to undergo VCT and this is also covered by the medical aid
                - They provide references on VCT locations
        - The information provided when employees are on this program is kept confidential
    - Management support and training
        - The program has some management support, and the SSC is organizing HIV/AIDS training for the management
    - The HIV/AIDS programs are evaluated every October
- The services NABCOA provides to the company are:
    - Providing IEC materials and condoms for distribution to the employees

    - Organizing peer educator training and refresher courses
    - Provide support to the wellness coordinator
        - Give advice and assist in capacity building for the wellness office
    - Help in generating HIV/AIDS awareness among the employees
    - Organize NABCOA stakeholders seminars on HIV/AIDS research and share information on various restructuring initiatives
        - Give progress reports on projects and involve their member companies in the process of completing the projects
- The services the SSC still needs from NABCOA are:
    - Provide advice and technical support in the process of implementing the new work plan
    - Connect the wellness office at the SSC with other international HIV/AIDS organizations
- Global Fund
    - They would fully start-up the new workplace program
    - They would fund events with PLWHA as speakers
    - They would provide more training and refresher courses for peer educators
    - They would provide training in first aid and psycho-social support for all the employees

Interviewee: Ms. Ruth Campbell, Wellness Coordinator, MEATCO

Date: 25 April 2008

Time: 14H15 – 14H35

Interview Minutes

- MEATCO currently has 360 employees
- Their current HIV/AIDS workplace program is made up of the following components:
    - Peer Educators
        - They currently have 8 peer educators i.e. 1 peer educator to every 45 employees
        - They gave information to the employees for them to volunteer
    - They have done prevalence testing at their Windhoek branch but not at their Okahndja branch
    - ARV Treatment and Provision
        - They currently don't provide ARVs for their HIV positive employees
        - The employee medical aid covers cost for ARV treatment under the NHP program
    - They distribute condoms and IEC materials to the employees
    - Management Training
        - They have done some management training
            - 2 managers went to a training course to learn how to set up HIV/AIDS workplace programs
- The services NABCOA currently provides to MEATCO are:
    - Offering continuous peer educator training and refresher courses
    - Organize the Exchange forum for wellness coordinators and managers to interact and brainstorm
- MEATCO currently does not need any extra services from NABCOA
- Global Fund
    - They would organize more management training

- They would organize more peer educator training and refresher sessions, especially at the Okahandja branch
    - They would also like to have on-site capacity for training the peer educators

Appendix E: Interview Questions and Minutes from UNAIDS Meeting

Interviewee: Ms. Gloria Billy, Senior Program Officer, UNAIDS Namibia
Date: 03-13-08
Time: 14H30 – 15H30

Interview Questions

1. We understand that the Universal Access program is to give universal access of prevention programs, treatment, care, and support by 2010, and to develop and maintain monitoring and evaluation frameworks for countries, but can you elaborate more on how this will be achieved?

2. How can the Universal Access program benefit the private business sector?

3. Does this program vary from company to company or is there an blanket policy that applies to all companies and then these companies specifically adapt the policy to tailor their needs?

4. How does the Universal Access plan effect or work with Namibia's MTP III?

5. What are some new initiatives that are being currently implemented that we may be able to help establish within the private business sector?

6. One of our ideas was to form focus groups within the private business sector; do you think this idea is a plausible prevention strategy? (explain focus groups either before or after the question)

7. What is your current HIV and AIDS workplace program?

8. What are the strongest and weakest components of your HIV/AIDS programs?

9. Do you have a designated employee or committee that is in charge of monitoring and evaluating your HIV/AIDS prevention program?

10. If yes, how often does this person or committee monitor your program?

11. What are the standards to measure the success of your program?

Interview Minutes

- The maxim behind the Universal Access Initiative is to "Set targets and be ambitious"
- It is a continuation of 3 by 5 program i.e. treating 3 million people by 2005 (scaling up treatment)
- There used to be universal access to reproductive and primary health services
- It is based on the Millennium Development Goal #6: HIV & Poverty
- The United Nations "Three Ones" was used to build up a structure/framework for the implementation of programs like Universal Access
- UNAIDS is realizing that countries have done a lot in terms of HIV/AIDS response, however it has not been in an organized, sequential manner in line with the country's National Strategic Plan
    - This initiative allows countries to have systematic timeline of implementing prevention methods, and integrate all efforts by individual bodies to have a national effect i.e. one national body with one strategic plan
- All prevention efforts are included under the national strategic plan created by the government
    - This plan covers all sectors of society and includes national targets showing where Namibia is in regards to HIV/AIDS prevention, treatment and care
    - Universal Access is an improved mechanism that acts like a monitoring and evaluating system which the countries will use to track their progress in implementing HIV/AIDS prevention strategies. It will show them where the gaps are in their prevention strategies, so that they can make their programs more effective and sustainable so as to achieve the interests of all the stakeholders
        - Looks at strengths, weaknesses, target goals, etc. so that the interests of the stakeholders is achieved

- It is also looking at HIV/AIDS prevention and treatment from a holistic approach i.e. all prevention/treatment programs are integrated in the same places, and all medical services are centralized, with these efforts having target populations
    - Countries need to scale up their HIV/AIDS prevention efforts to the same par as their treatment programs
        - In Namibia, there is no definite national plan/targeted response or focus on HIV/AIDS prevention
- Mobil Clinics can be a useful tool in scaling up both prevention and treatment efforts, because accessibility to treatment and lack of human resources are a problem. They can be used for the following:
    - For prevention purposes of TB, HIV/AIDS, Malaria
    - Give people access to treatments, VCT, IEC
- These mobile units can be staffed with retired pharmacists, nurses, doctors, and other medical staff
- There is a need for buy-in at the government level on the initiative i.e. political will
- A government license would also be required for mobile clinics
    - SOS, a medical aid company, has this type of license
- Other prevention strategies
    - POP (Prevention of Positives) - to prevent their re-infection with different HIV strains
    - Male circumcision
    - VCT (Voluntary Counseling and Testing)
    - ART (Antiretroviral Treatment)
    - PMCT (Preventing Mother-To-Child Transmission)
- Private sector can play a role of an advocate and increase awareness in people
    - The majority of employees work in the private sector and they have access to better healthcare facilities
    - There is a lack of continuity/sustainability in the prevention programs i.e. lack of VCT while one gets ARVs
- There is a need for alternative sources of funding other than foreign donors

    - This is where the private sector could play a role in terms of funding HIV/AIDS prevention and treatment efforts
        - Look at ways they can support the government and civil society
- Public sector also implements workplace programs
- There has been a positive response to the radio shows that discuss HIV/AIDS and other related issues like sexuality, relationships etc.
    - People feel comfortable to call into the station and ask general questions during an HIV/AIDS programming hour
        - There is a possibility of creating an anonymous, toll free hotline
- Namibian traditional languages
    - The word for “Faithfulness” does not exist in local languages

Appendix F: Interview Questions and Minutes from MOHSS Meeting

Interviewees: Mr. Abner Xoagub: Head of the Expanded National HIV/AIDS Response Support Program of the Directorate of Special Programs (DSP); Mr. Alfred Timo
Date: 3 April 2008
Time: 10H00 – 11H00

Interview Questions for Ministry of Health and Social Services (MOHSS) Meeting

1. Can you tell us about the general awareness of Namibians concerning HIV/AIDS?

2. We read about the MTP III but can you give us an update as to how it is currently going?

3. What different ideas are you currently pursuing towards prevention of HIV/AIDS in Namibia?

4. We know that you have been a PR in the past, NABCOA is applying to become a PR for Round 8 and we are trying to help them develop their application, do you have any suggestions or advice to help us with this process?

5. Do you have any ideas that could help improve the situation in the private sector?

We also proposed our recommendations to him, in order to obtain feedback on the feasibility of these initiatives

Interview Minutes

Interview with Mr. Xoagub

- NABCOA as a Principal Recipient
    - The TCC (Technical Coordinating Committee)and the Global Fund Secretariat will set the criteria to be a PR
    - Information in terms of capacity of a potential PR is available on the Global Fund website

- Workplace Programs
    - Companies need to make sure that their programs on HIV/AIDS in the workplace complies with safety and occupational health codes
        - They should address the issue of HIV as stated in Labor Acts
    - There should be an agreement made between trade unions, employers, and the employee federation
        - Companies should link up with trade unions, and can use contracted NGOS as stewards
            - This would be useful in implementing mainstream programs concerning accidents at the workplace and health education
    - "NABCOA should link up with trade unions to enforce the coordination of HIV/AIDS programs"
    - Monitoring and evaluating needs to be conducted to determine how effective these programs are
    - Each company needs a "champion/steward to ensure that the employees needs and welfare are attended to"
    - Less than 1% of companies in Namibia have wellness programs
    - The Ministry hopes that by 2010 all government institutions will have wellness programs
    - The Ministry of Heath and Social Services is not promoting starting vertical HIV/AIDS workplace programs but encourages organizations to integrate HIV/AIDS into their existing occupational and health programs

        - Companies should have general wellness programs implemented into the Human Resources Department, and these should also address HIV/AIDS
            - This strategy would be more cost-effective in implementation in SMEs
- Sex is a basic need of human beings
    - "People should talk about sex openly and teach people how to prepare for sex in order to bring about changes in sexual behavior"
        - Then they will be able to make informed decisions in regards to sexual activity
    - "It is necessary to change people's behaviors, stress the importance of people understanding their own sexual needs, and taking the risk from exposing themselves to the infection"
    - "HIV/AIDS programs are only as important as the content discussed"
        - "Programs need empower parents to discuss sexuality with their children"
        - "It is important to encourage partners to get down to human sexuality"
    - There is little to no HIV/AIDS education in schools
    - "Workplace programs cater to workforce, but also need to cater to managers because they have sex too"
    - There is a need for "people to apply what they teach and stop paying lip service"
    - "HIV/AIDS has created a lot of jobs and opportunities"
- The MOHSS encourages their partners to look at sexuality
    - "People need to change the content of information in accordance to the present state/issue surrounding the epidemic"
        - "It is important to talk about maintaining good relationships"
            - Encourage spouses to attend company days because if more people know the spouse, the employee will be less likely to cheat
        - Discuss issues dealing with sexuality and death

- Employees should be assisted through the HR department or company's legal department to learn how to write wills
    - Companies can mandate that all employees have a will

- The wellness programs in companies should not focus only on HIV positive employees
    - By only focusing on HIV positive people, this increases the stigma
    - Companies that have small, vertical programs are paying for ARVS but not blood pressure medication
        - In this case, they are discriminating against HIV negative employees
    - "They need to normalize the situation to cover all employees"
        - "People feel they need to be HIV positive if they want attention from their company administration"
            - "Counseling and other support mechanisms should be available to everyone"
    - There should not be a different policy for HIV positive employees; companies need to make decisions to be able to have sustainable support programs with the ability to finance medical services
        - They will be able to answer questions like "how long will my company be able to pay for drugs?"
        - "Companies need to pay all or nothing, it is important for them to learn from past mistakes"

Interview with Mr. Alfred Timo

- Mr. Timo works with NABCOA on implementing workplace programs in the public sector
    - Companies need to be committed to these programs
    - They need to encourage employees to participate in medical aid schemes
    - They also need to include medical aids and psychological support in their medical aid schemes

Appendix G: Interview Questions and Minutes from CDC Meeting

Interviewee: Ms. Claire Dillavou, Monitoring and Evaluating Technical advisor of the CDC Namibia
Date: 3 April 2008
Time: 11H00 – 12H00

Interview Questions for CDC Namibia Meeting

1. How are you involved with the Global Fund?

2. What are the CDC and PEPFAR doing in Namibia in terms of HIV/AIDS prevention and treatment?

3. What is your relationship with NABCOA?

4. Since NABCOA is applying to be a PR for Round 8 of the Global Fund Grant, what are some suggestions you have to make their bid successful?

5. Do you have any ideas that could help improve the situation in the private sector?

We also proposed our recommendations to her, in order to obtain feedback on the feasibility of these initiatives.

Interview Minutes

- Ms. Dillavou is the Monitoring and Evaluation Technical Advisor for CDC Namibia. She is affiliated with the PEPFAR, and also participated in the Gap Analysis for the Global Fund Round 8 proposal.
- Namibia is a focus country for the PEPFAR grant, and $108 million has been provided to the country
    - The CDC provides money for technical advisors within the MOHSS, HR support, and drug procurement while USAID does more with prevention and community based programs
- The reasons why focus countries are chosen is linked to foreign policy and politics issues more than epidemiological needs
- PEPFAR is moving to Phase 2 without having definite focus countries
- The financial amount of support given will continue at a steady level and half of the money from PEPFAR goes to the Global Fund
- PEPFAR has the following:
    - Semi-annual and annual reports required for monitoring and evaluation
    - National indicators are in line with the Global Fund indicators
- She has just begun to work with NABCOA and the CDC is formally engaging with them to help grow what they are currently doing in the private sector
- She suggested we look at the UK AIDS Alliance Report/Assessments
- The CDC looking to support some aspects of PharmAccess
- They can support NABCOA through the AIDS Alliance and PACT
    - This support can be financially or programmatically
    - They help to facilitate partnerships: NABCOA is in PPP with Namib dairy for supplemental feedings for OVCs. NABCOA is raising money in the private sector to compliment funds donated by PEPFAR and Standard Bank
- Recommendations on what the private sector can do to improve prevention
    - Create standard packages of service (checklists) for companies based on their size (large, medium or small)

- Include minimum standards of quality service, what companies need to do to start a workplace program
- Show that it is worthwhile for companies to invest in HIV programs to convince leadership

Appendix H: Interview Questions and Minutes from Phone Interview with Emergency Vehicle Conversions

Interviewee: Mr. Jonathan Greenhill, Co-Owner, Emergency Vehicle Conversions
Date: 10 April 2008
Time: 13H00 – 13H30

Interview Questions

- Do you provide services to Namibia?
- Can you build a van with VCT capabilities? (Explain VCT)
    - What would be the cost of this vehicle, excluding VAT?
    - What would be the cost of fitting the equipment into vans provided by NABCOA?
- Can you build a van with prevalence testing capabilities?
    - What would be the cost of this vehicle?
    - What would be the cost of fitting this equipment into vans provided by NABCOA?
- Can you fit all this equipment into a standard ambulance van?
- Do you/Can you provide all the medical equipment?
- What are the regulatory requirements associated with transporting the vans between Johannesburg and Windhoek?
    - What are the transporting costs per such vehicles between Johannesburg and Windhoek?
- Can you send us a catalogue showing the specifics and layouts of similar vehicles?
- Can you send us guidelines on licensing applications if that is possible?
- Do you have any cancellations? (And is it possible for us to take their place?)
- Any other suggestions?

Interview Minutes

- They offer their services to Namibia
- They can convert a van so it has VCT capabilities
    - The cost excluding VAT would range from R350,000 to R1,000,000 (highest quality)
- They can convert a van so it can be used to carry out prevalence testing
- All these equipment can be fit into a Mercedes sprinter van
    - There are different types and sizes of sprinter vans
- They can provide all medical equipment
- There are no really stringent regulatory requirements for transporting the vehicle from South Africa into Namibia
    - There will be a fee at Namibian border
    - Someone will also need to pick the vehicle up from Johannesburg to drive it back to Windhoek
        - They can get the services of a transport company
- The delivery time from getting the van to shipment back to Windhoek is about 3 to 4 weeks
- Work can be started on the van immediately and they can compromise to our requirements
- They are not versed in the licensing guidelines, but feel that we can get the vehicle dealer to help us with the licensing and registration
- They are going to send email to us with plans and layouts

Appendix I: Interview Questions and Minutes from Meeting with M + Z Commercial Vehicles

Interviewee: Mr. Douglas Thompson, Vehicle Sales Manager, M + Z Commercial Vehicles

Date: 15 April 2008

Time: 15H00 – 16H00

Interview Questions

- What is the cost of a 315 Diesel or 4 series Sprinter van?
- What are other options besides the 315 that could be used as a mobile clinic?
- Have you seen/supplied vans used as mobile clinics?
- Do you get your vans from South Africa?
- Do you have any idea where we could customize the van to serve as a mobile clinic?
- How would we license this vehicle?
    - With the dealer?
    - With the customer?
- After customizing the vans, would this affect the licensing of the vehicle?

Interview Minutes

- The conversions for the vehicle can either take place here in Windhoek or in South Africa
    - This depends on the complexity of the conversion, and it will be easier to guarantee the vehicle if it is converted in Windhoek
- They recently finished converting a mobile clinic/ambulance for the Cancer Association
    - The van was fitted with the following:
        - Examination bench with straps
        - The left headboard was closed for patient confidentiality
        - A 220 volt air conditioner that was plugged into a 12V source
- If the van needs to be fitted with an air conditioner, the door has to be kept closed
    - Since people will be walking in and out of the van, the AC can be moved to the back and kept behind a curtain to keep the van cool
        - The cost for a dual AC is N$40,000
- The most basic vehicle conversion costs about N$30,000
    - To determine the price, they will need to know the types of equipment we intend of fitting in the van
- Mercedes gives discounts to non-governmental organizations, but the vehicle costs have to be paid in full before the conversion can commence
- The prices for the Sprinter van models with high roofs are listed below:
    - Model 315 – N$267,000
    - Model 416 – N$278,000
    - Model 518 – N$317,000
- The 315 model which we saw first was very small and did not have adequate standing room for a person of average height
- The 416 model which we saw second was slightly bigger than the 315
    - It had a sliding door on the side and a back door which would be ideal for confidentiality purposes
    - It allows for space for a crew cab conversion for the staff sleeping area

    - There is no outside storage area, so there may need to be a trailer attached to the back of the van
    - It can carry about 2.2 tons
- The 4x4 model was 5m x 2.5m
    - It can go through sandy areas
    - The cost is N$237,000 for single tires and between N$7,00 –N$30,000 for extra tires
    - Using a van body costs N$60,000
    - Using a bus body costs N$180,000 extra
    - The total price for this vehicle is similar to the prices for the 416 and 518 Sprinter van models
    - It is also a good option if the mobile testing units is traveling long distances for long periods of time
- The 518 Sprinter van model which we looked at last was the biggest of the three
    - It has a V6 engine, making it very fast
    - It has a nicer cab and bigger sliding door on the side
    - It can carry about 2.5 tons
    - It has overhead storage space
    - There is also a super high roof option available for extra storage space
- The vans shouldn't weigh more than 3 tons empty and it will cost more for the extra weight
- The driver will need to have a code 10 license, and the Mercedes can get the license for the client
    - The registration fee is N$1500
- When registering the vehicle, the number of passenger seats is registered and should be adhered to
    - Mercedes can do it correctly for their clients
- As another option, we can look at getting a freight carrier and fitting a van or bus body on it.
    - There would be more space and storage area
- It would take 2 weeks to get the vehicle and 4 – 12 weeks to convert it

Appendix J: Interview Questions and Minutes from Phone Interview with THAT'SIT

Interviewee: Dr. Margot Trumplemann-Uys

Date: 14 April 2008

Time: 15H00 – 16H00

Interview Questions

- Can you tell us a little bit about your program?
- What capabilities do the mobile vehicles have?
    - Can these features be modified to carry out VCT and prevalence testing?
- What areas do you work in?
- Who do these services focus on?
- Do you work with companies or other institutions?
- What types of vehicles do you use?
    - Where do you source the vehicles from?
    - What are the daily/monthly costs involved in running these vehicles?
- Where do you source your medical equipment from?
- What types of trained medical personnel do you employ?
    - How many do you currently employ?
- Do you have any lay personnel?
    - What training do you have for them?
- What is the average ratio of medical personnel to patients when the vans are in use?
- What follow-up measures, if any, do you have in place?
    - In regards to post ARV treatment, support, and counseling?
- What is your policy on confidentiality in regards to HIV positive patients?
- What other measures do you have in place to ensure the confidentiality of patients' information?
- What is the delivery time for the trucks and/or equipment?

Interview Minutes

- They use their mobile clinics for VCT, visiting TB patients, and delivering ARV medication to disabled patients
- The teams they send out with the mobile clinics are made of the following personnel:
    - Driver (with code 10 license)
    - Counselor (2 or 3)
    - Nurse
    - Doctor (depending on areas they are visiting and what the mobile clinic is being used for)
- They have only one patient in the van at a time for sake of confidentiality
    - They also set up tents outside where they can see other patients
- Having 2 exits in the mobile unit is a feasible option and having sound-proof partitions is good for confidentiality
- The cost of the 315 model of the sprinter van is R270,00 and the cost for the conversion is R200,000
- The mobile unit would need to have AC and generator (or battery)
- Their mobile clinics contain the following equipment:
    - Ear, Nose and Throat (ENT) machine
    - Fridge/icebox for storing samples
    - Fire extinguisher
    - Oxygen mask
    - Drawers
    - Examination couch/bed
    - 2-seater in front for talking with patients/counseling
- The front part of the clinic is used for talking to patients, and back part is used for examinations and tests
- Their vans don't have staff sleeping quarters
- The daily cost for running these clinics includes:
    - Staffing costs
    - Fuel costs – R6,000 per month for the 200km diameter area they cover

        - Clinics go around a lot so running the vehicles on diesel is more cost-effective than fuel
- It is more cost-effective to buy van here in Windhoek , because we can get a good guarantee and the dealers and converters would be willing to service the vehicles
- Some follow-up measures that can be put in place are as follows:
    - If the company is affiliated with GP's, then the employees can go there, and if not, they can go to government clinics
    - Counselors give referral letters to disabled patients

Appendix K: Interview Questions and Minutes from Meeting with PharmAccess

Interviewee: Ms. Ingrid DeBeer, Country Director, PharmAccess Namibia
Date: 18 April 2008
Time: 11H00 -11H45

- PharmAccess has done on-site testing at companies, but have not used mobile clinics
- They are currently looking at setting up primary health care mobile units for companies which would be provided by certified nurses
- The equipment needed for carrying out VCT depend on protocol and type of testing used. They are listed as follows:
    - Running water
    - Cool environment - Air Conditioner
    - Rapid test – Need kit and alcohol swabs
    - Disposal units - biomedical waste units and maybe incinerator
        - Used samples should be disposed of in 24 hours
    - Tables and chairs
    - Equipment to draw blood and refrigerator
        - Some people would want full blood tests to be sent to doctors
        - Keeping rapid test kits at ideal temperature
    - Disposables
        - Aprons, gloves
        - Cotton swabs, plasters
    - Waterless hand cleaners
    - Examination table – only if van is offering primary chair
    - Storage space
    - Power source
        - Generator
        - Rechargeable battery
    - Laptops for data capture
    - Blood pressure kits

    - Glucose (N$6.50) and cholesterol strips (N$16/17)
        - NABCOA can get a discounted price if they are purchased in bulk
        - Can be obtained from Medlab
    - Calibrators for basic tests e.g. blood sugar tests
        - This should be done to reduce stigma of visiting “HIV/AIDS” vans
        - The process only takes a short period of time
- The following may need to be installed into the van:
    - Water basin
    - Incinerator
    - Air Conditioner
    - Refrigerator
- The medical personnel not necessarily need accommodations included in the van
    - They can easily get accommodation from locals around the area the van visits
    - They can also have tents and sleeping bags, which they can set up at night
- The patients can have 2 tests done, and this process would take 20 minutes
    - Rapid test
    - Confirmation test
        - This is normally done when the result of the rapid test is positive
        - It should be done for both positive and negative results
        - The standard cost for both tests – N$20
        - All the tests have been validated as long as protocols are right and the temperatures are ideal
- They counseling should not occur separate from testing
    - Would be better protocol for the same person to do both counseling and testing
- The counselors can do group counseling for answering FAQ’s for the pre-counseling process
- They should also give referrals for preliminary positive results
- NABCOA should consider having a standard package to offer to people for them to opt out from some options

- To carry out prevalence testing, there is a need for just need enough space for oral swabbing, as well as running water/alcohol swabs
- They only need the mobile units if NABCOA wants to carry out prevalence testing with finger prints

Appendix L: Interview Questions and Minutes from Phone Interview with Genesis Training Consultancy

Interviewee: Mr. Mike Haidula, Managing Director, Genesis Training Consultancy
Date: 04-11-08
Time: 10H00 – 10H30

Interview Questions

- How long does the entire VCT process take?
- What medical personnel should carry out the pre- and post-counseling and the actual testing?

Interview Minutes

- The whole VCT process takes about 1 hour
    - Pre-test counseling takes 25 – 30 minutes
    - The actual testing process, including sample taking runs for about 15 – 20 minutes
    - Post-test counseling takes 25 – 35 minutes.
- He felt that the same counselor should carry out the pre- and post-test counseling on one person. This is because during the pre-test counseling, the patient shares information about their risky behaviors and other personal information with the counselor. All this information would be useful in the post-counseling process, because the counselor already has a better understanding of the person and their history, and depending on the results of the test, the counselor is able to have a more informed conversation with the person, and give better advice and referrals for further treatment, care and support.

Appendix M: Interview Questions and Minutes from Phone Interview and Meeting with LifeLine Namibia

Interviewee: Ms. Jane Shityuwete, National Director, LifeLine/ChildLine NAMIBIA
Date: 10 April 2008
Time: 14H00 – 14H30

Interview Questions

- What services do you currently provide?
- Do you have a HIV/AIDS hotline within Namibia?
    - If not, why?
    - If so, what are the specifics?
        - Is it successful?
        - How many calls are received per day?
        - What is your policy on confidentiality?
        - What other measures do you have in place to ensure the confidentiality of callers' information?
        - How do you train your operators?
        - How many trained operators do you have on call?
        - What is the present capacity of your hotline i.e. numbers of operators currently employed?
- We are recommending to NABCOA the set-up of a national HIV/AIDS hotline, which would also address issues like sexual behavior, relationships, etc. Would you be interested in being involved in this project because of the success of Lifeline South Africa?
- How would you recommend we begin setting up a national hotline, regardless of where the hotline is run from?
- What would the daily operating costs of a national hotline be?
- Would you be interested to enter into a joint venture (JV) with NABCOA?
- Any other suggestions/recommendations?

Interview Minutes

- The services they currently provide are as follows:
    - Their core business is counseling and counseling training
        - They have a national crisis telephone line that runs from 8am-10pm daily, for 365 days a year
        - They take calls from children, offer basic information on HIV/AIDS and general counseling
    - They organize national training programs in which they train people to be lay counselors, and this helps for internal growth for LifeLine/ChildLine
        - They offer training on all HIV/AIDS modules
            - PMTCT
            - VCT
            - ARV adherence
    - They also run counseling services in clinics where people can drop in for counseling
        - They also offer pre- and post-testing counseling
    - Community mobilization/involvement
    - Have 2 VCT centers in Oshikango and Rundu
- They have 2 offices in Windhoek and Odangwa
- Prevention
    - They are looking at a holistic approach to prevention
    - ChildLine has a team of actors that go to different schools around and have dramas for the kids. They organize:
        - Puppet shows for kindergarten
        - Interactive Drama for primary and high schools
    - They teach children about their rights and increase their awareness
        - Try to instill these fundamental messages in children
            - The right to say no
            - The right to privacy
            - The right to ownership of their own bodies

    - Do kits on alcohol, drugs, sexual behavior to be able to interact with them and inform them on what to do in different situations
    - Give them information on places they can receive help
- They have a national children's radio station
    - They have a team of children (who audition and are on the show for a year or two) that discuss topics that are affecting children
        - HIV/AIDS
        - Relationships
        - Sexual behavior
        - Bereavement
    - The show goes on nationally every week and the children do interviews
    - Children are able to relate and are given good information they can use to make good decisions
    - They don't lecture, but give good quality, non-judgmental information to children, and also refer them to places where they can get help
- They are also doing gender work with men and boys
    - They found that women have a lot of empowerment training, but men are not regarded as being in need of these types of programs
    - They help men think through masculinity and the effects the harmful practices they participate in have on them and their families
    - They have also realized that a holistic approach towards HIV/AIDS involves getting men to think through their behavior in regards to sex and the decisions they make in social and familial settings
    - They also look at identifying and understanding cultural norms in regards to gender roles
- They want to start up a national HIV/AIDS hotline
    - A reason for this is because their background and area of expertise is phone counseling
    - They also have existing facilities can be used in implementing this program
    - They want to model the hotline after LifeLine South Africa
    - They have included this initiative in their strategies and are looking for funding and partners

- Global Fund money would be useful in helping to support this endeavor
  - LifeLine Namibia is interested in working with NABCOA on this initiative, and would want to put in a joint application with Global Fund

- Our project team has a face-to-face meeting with Ms. Shityuwete on Monday, April 14th at 2:30pm

Interviewee: Ms. Jane Shityuwete, National Director, LifeLine/ChildLine NAMIBIA
Date: 14 April 2008
Time: 14H30 – 15H30

- Lifeline Namibia has been in contact with Therapeutics Information and Pharmacovigilance Center (TIPC), who are a U.S. organization with PEPFAR funding
    - TIPC is also looking into implementing a hotline as an intervention to increase ARV adherence
- The main reason for Lifeline Namibia not setting up an HIV/AIDS hotline is the cost of implementation
    - Lifeline Namibia have thought about this as an intervention and have recognized the gap
        - Ms. Shityuwete joined Lifeline Namibia over a year ago
        - Before that, she used to work with PLWHA, and recognizes that they need a non-judgmental, bias-free setting in which they can ask questions and obtain information
- Currently, counseling is done through:
    - Land lines – This line has run for 28 years
    - SMS [callers send texts to the counselors, who in turn call them back]
    - They currently don't have efficient data capturing methods, but they are working on it
- Lifeline Namibia is looking to set up 2 hotlines
    - One for children – They have already sent in requests for funding
        - Cost breakdown for setting up the child helpline (excludes costs for running and maintaining helpline)
            - They currently don't need funding for the space because they already have a space in mind

COST BREAKDOWN FOR SETTING UP THE CHILDREN"S HELPLINE

Item	**Cost**
Strong Technical Advisor/Person	N$20,000
Study visit to Lifeline South Africa • Includes return visit for technical person to set-up hotline	N$10,00
Internal Training • Covers venue, travel and feeding costs for 20 counselors	N$22,000
Total technical cost of setting up of 3 calling booths	N$175,000
Computer training for counselors	N$80,000
Second visit to Lifeline South Africa	Amount not provided
IT consultant for trouble shooting	Amount not provided
Branding of hotline	Amount not provided
Running 3 full-time booths with 6 counselors • Includes management and overhead	
TOTAL ESTIMATE	**≈ N$500,000**

- One for HIV/AIDS – Still looking for funding
  - Lifeline South Africa has offered technical assistance i.e. specialists to help set up the hotline
    - Lifeline South Africa currently has 40 calling booths and their hotline runs 24/7 with the operators working in shifts
    - They use computers to capture data and these are linked to a supervisor who has access to any of the calls and information collected at any time
  - Lifeline Namibia would need extra funding for manpower and hardware
  - Lifeline Namibia would need to hire more counselors and extend their calling times
    - Currently, they have 6 – 8 counselors and the crisis hotline runs from 8am to 10pm

        - They are asking for funding to expand the program to run for 24/7
- They would need to offer more in-depth HIV/AIDS training for counselors
    - They already have adequate in-house capacity to offer this training
        - Currently, they have a group of 8 trainers
    - The training is agenda-free except that LifeLine Namibia wants what is best for those on the other side of the phone line
- They want to gradually phase in the HIV/AIDS hotline into the other phone counseling services they offer
- They may be able to get PLWHA, especially those on treatment, to operate the helpline
    - They know more about the topic of LWHA than any other people
    - They can give advice on issues like ARV adherence
    - The advice given will have a better sense of practicality to it rather than seeming medical
    - People often need practical, simple, non-judgmental, objective responses that they wouldn't be able to get from their doctor or family and friends
- Ideally, the help-line should run for 24/7
    - It would be modeled after Lifeline South Africa
    - It will be hard to expand times to 24/7 because of compliance with labor laws in regards to worker's shifts
- Another problem will be encountered in making the number toll-free
    - There a lot of ongoing costs associated with setting-up toll-free services and they also need to contact Telecom
    - The government does not currently cover the costs from hotlines, but they should

        - In Kenya, the government pays all fees associated with their hotline
- Lifeline Namibia is also looking into online counseling
    - One of Ms. Shityuwete's colleagues is trained in setting-up such services
- They are looking to have a feasibility study done on how possible it is to have counseling services via cell phone [> 90% of people have access to a cell phone in Namibia]
    - Can there be online counseling services provided via mobile phone?
    - Most of these calls would be used for informational services rather than counseling
- Follow-up measures
    - It is very difficult to follow-up and see if they used the information provided via the crisis helpline
    - The counselors will have to work with giving referrals
    - There is a greater potential for follow-up with the HIV/AIDS helpline
- Confidentiality
    - Supportive and non-judgmental relationship between counselors and callers
- The helpline will not only be for those who are HIV positive, but as a prevention tool for anyone regardless of whether or not they know their status
- Needs
    - They need to carry out a technical assessment to determine what they need to set up the helpline
        - This can be done through surveys that NABCOA can administer to its member companies
    - They need to know what the capabilities of the hotline and what other outlines are doing around the world

- They may need NABCOA to assist them in getting a technical consultant
- They may also need NABCOA's assistance in creating a taskforce with Lironga Eparu and other key players and this can act as a steering group for this initiative
- They also need to get information on potential sources of funding

Appendix N: List of Contacts

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