PERSPECTIVES OF PEOPLE LIVING WITH HUMAN IMMUNODEFICIENCY VIRUS REGARDING THE INTEGRATION OF THEIR CARE INTO PRIMARY HEALTH CARE SERVICES AT OKANKOLO HEALTH CENTER, NAMIBIA.

A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTERS OF PUBLIC HEALTH

OF

THE UNIVERSITY OF NAMIBIA

BY

MAGANO ANGULA

201403050

OCTOBER 2025

SUPERVISOR: PROF. MITONGA KABWEBWE (UNIVERSITY OF NAMIBIA)

ABSTRACT

Integrating HIV/AIDS services with primary health care means that health facilities operate as a single department. Integration involves sharing resources, space, staff, registers, and operating rooms, rather than having separate departments with their own staff and equipment. The aim of the study was to explore the perspectives of People Living with HIV (PLHIV) regarding the integration of HIV/AIDS care with existing Primary Health Services in Okankolo Health Centre (OHC), Onandjokwe District, Oshikoto Region, Namibia. The objectives of the study were to explore and describe the perspectives of PLHIV as well as to understand what input PLHIV have on the integration of the two services. A qualitative research approach with an explorative design was used during the study. An interview guide, an audio recorder, and field notes were used during in-depth face-to-face interviews. Participants were male and female, aged between 18 and 50, who had been collecting their Antiretroviral Treatment (ART) medication at Okankolo Health Centre before and after the system was integrated. A purposive sample of nine PLHIV was selected and interviewed. The sample size was determined by data saturation. Tesch's eight steps of coding was used to analyze data. The study findings showed that PLHIV at Okankolo Health Centre are comfortable with integration system, as it creates bonds between clients and health care workers, reduce stigma and reduce number of visits to the health care centers. Although participants are satisfied with the integration system, they still face challenges such as bad attitudes from nurses, long waiting time at the facility and lack of privacy at the Pharmacy. It is therefore recommended for the ministry of health to keep up integration services, training and education on integration to be offered in

nursing schools, and for Onandjokwe Primary Health Care Supervisor (PHCS) to come up with ways of creating privacy at the pharmacy when medication are being dispensed.

Keywords: viewpoints, patients, clinics and mental health.

TABLE OF CONTENT

LIST OF TABLES

LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune-Deficiency Syndrome
ART	Anti-Retroviral Treatment
AU	African Union
DEC	Decentralized Ethical Committee
HIV	Human Immunodeficiency Virus
MOHSS	Ministry of Health and Social Service
NAPPA	Namibia Planned Parenthood Association
OHC	Okankolo Health Centre
PHC	Primary Health Care
PLHIV	People Living With Human Immunodeficiency Virus
SOHDB	School of High Degree Board
SRH	Sexual Reproductive Health
UNAIDS	United Nations Programme on HIV/ AIDS
UNAM	University of Namibia
UNFPA	United Nations Population Fund
WHO	World Health Organisation

ACKNOWLEDGEMENTS

Thank you Almighty Father Lord for keeping me alive, health and for the strength to accomplish this study. Furthermore, I would like to appreciate the following people:

- My supervisor for this research professor Mitonga Kabwebwe for being there for me whenever I need his help and for providing me with feedback whenever I requested for information regarding this research.

- My friend Nyanyukweni Elina Abner for her support and words of encouragement.

- My friend Selma Frans for helping me with editing my thesis and for professional and academic guidance during this research study.

- The University of Namibia, School of High Degree Board, Decentralized Ethical Committee for approving my research.

- Ministry of Health and Social Services for granting me permission to carry out my study within the ministry.

- Regional Health director of Oshikoto region Josua Nghipangelwa, Sister in charge of Okankolo health center Mrs Maria Shinana for permitting me to conduct this study at Okankolo Health Center.

- People Living with HIV that collect their Anti-Retroviral Drugs (ART) at Okankolo Health Center for volunteering themselves to participate in this study without any hesitation.

- My beloved son Immanuel Mervin Haufiku for being a source of motivation to finish my study on time.

DEDICATION

This study is dedicated to PLHIV in the world and all professionals in the departments of HIV/ AIDS health and special programmers.

DECLARATION

I Magano Hadhela Angula, hereby declare that this study is my own work and is a true reflection of my own research, and that this work, or part thereof has not been submitted for a degree at any other institution. No part of this thesis may be reproduced, stored in any retrieval system, or transmitted in any form, or by means of (e.g electronic, mechanical, photocopying, recording or otherwise) without the prior permission of the author, or the University of Namibia in that behalf.

I Magano Hadhela Angula, grant The University of Namibia the right to reproduce this thesis in whole or part in any manner or format, which The University of Namibia may deem fit.

Magano Hadhela Angula		October 2025
Name of student	Signature	Date

CHAPTER 1

INTRODUCTION AND BACKGROUND

Chapter one covers background, problem statement, objectives, significant of the study as well as delimitations of the study. Terminologies that are used in this study are explained in this chapter.

1.1 Introduction

Primary Health Care (PHC) refers to routine services provided at clinics, health centers and hospital such as screening and treatment, immunisation, family planning, antenatal and postnatal care and wound dressings. HIV/AIDS care services refers to HIV testing, HIV prevention, initiation of patient on Anti-Retroviral Treatment (ART) and provision of care to PLHIV. When this two services are integrated it means that they are joined together in a single process. This involve coordination of all the services, sharing of rooms and all resources at the facility for all the services and there are no specific staff for specific services. The available pharmacy, laboratory and consultation rooms are used for all services, unlike in most health facilities whereby there are rooms for specific services for example, immunisation room, family planning room, ART room, dressing room, treatment room. With integration people are treated in the same room regardless of the service they come for at the hospital on a daily basis.[1]

The accessibility to care and treatment for people living with HIV is a major concern especially in Sub-Saharan Africa, where most of people living with HIV live. Sub-Sahara Africa is still one part of the world recognized to have high rate of HIV/AIDS stigma,

which is inhibiting the success control of the spread of HIV. PLHIV reported to face stigmatization and discrimination through gossiping and verbal insults, which was felt by majority of the participants. Internal stigma was also experienced, whereby half of the PLHIV felt guilty and ashamed to be infected with HIV. [2] This makes the majority of them uncomfortable when seen collecting ARV medication at health facilities. This impact leads to an increased rate of HIV treatment defaulters, poor adherence and an increase in new HIV cases.

South Africa's national department of health responded to the accelerated roll-out of Anti-Retroviral Treatment by adopting a strategy of collaborating HIV/AIDS services with PHC. This system was adopted to stop the issue of providing HIV services separately from other existing facilities as well as to make accessibility of care to PLHIV easier as well as to improve the overall health outcomes.[1] HIV stigma and discrimination have a negative impact on PLHIV's working conditions, health, access to health facilities as well as family life.[3] Most of them do not want to be seen going to the ART clinic, and also many of the services were not offered on a daily basis. Since many people come from remote areas the accessibility at the facility is a challenge, this have stopped some from getting their treatment which resulting to poor adherence and a high spread of HIV and HIV related deaths. Integration service can minimize discrimination and improve adherence in PLHIV.

Most of clinics and health centers especially in rural area have specific dates for health services for example they specify that Monday is the only day they provide immunisation, Tuesday is for antenatal services, family planning is only provided on Friday and some they use to have a day in the month where a specialist for certain conditions such as gynecologist, dentist, HIV comes and see patients. This is done due to inadequate

resources including human resources, and to prevent wasting of resources for example with immunisation, a vial of a vaccine that can be used for ten children can be opened and only one child will come at the clinic for that vaccine, the rest of the vaccine will end up being discarded, but when immunisation is only done once in a week the wasting of vaccines will be minimal. Although there are also advantages for providing health services in unintegrated manner, providing services in this way makes some patients uncomfortable to go seek for medical services, because in this way people can easily guess what you come for at the hospital and with integration people are being served in unlabeled service rooms and all the services are provided all days.

1.2 Background of the study

Gross health inequalities become a global concern when modern primary health care comes into view. Primary health care was therefore endorsed as a way of achieving the World Health Organization (WHO) health for all's goal, after the Alma-Ata declaration was made. It was also identified that primary health is a fundamental human right and a solution in accomplishing equitable health for all.[4]

Primary care is considered the first point of contact of the people with health facilities and services that are coordinated, ongoing and comprehensive in many settings. It mostly concentrated on treating illness when there are needs instead of preventing diseases at first. Modern health interventions aims to protect, prevent as well as to promote health and to make sure that public threats are addressed.[4]

Druetz[4] further explain that, integration of public health approaches with other primary health care can be one of the successful way of stopping disease in the public, as it can

reduce the urge of using services offered at primary care and improve the overall health status of the public. Integration also allows primary health care to provide many promotive, protective and preventive services to a specific population, refine coordination and communication between the integrated parties.

Globally, there is increasing evidence of appreciation by stakeholders and policy makers on why the joining together of HIV, Sexual Reproductive Health (SRH) and PHC services is important. Most countries state that when services of SRH/HIV are integrated, clients don't come to facilities more often, it reduces HIV/AIDS-related stigma, clients don't spend much time waiting at facilities, it reduces the workload for staffs, reduce costs, and quality patient care is delivered.[5]

There was a time in USA where by the country was having a burden of chronic diseases, health care cost, and care delivery was increasing at an alarming rate. These challenges were addressed by policymakers. They prioritize new payment methods and delivery models to incentives better integrated health and social services. One of the activities that was established to advance integration service was to come up with a program that can integrate health, social and community based organisation.[6]

Africa has long-term goals to improve the health of individuals and their families. This will be achieved by providing accessible, acceptable, equitable as well as quality health care that is affordable. HIV is one of the disease regarded as diseases of priority and there was a good link identified between HIV and SRH services in the past years. Many organizations such as UNFPA, WHO, AU and UNAIDS have been collaborating with

African countries to come up with a plan that can nourish the relationship of HIV, SRH and Primary Health Care integration.[7]

In Namibia the implementation of primary health care services was initiated due to inequality, inaccessibility, shortage of staff, long waiting period at facilities and stigmatization within the health care system. The integration piloting in Namibia was held in the seven health facilities; Epako clinic, Hakahana clinic, Nau-Aib clinic, NAPPA, Okankolo Health Centre and Khomasdal clinic, in 2013. The outcome revealed that at all those health centers majority of health care workers were very much happy with the initiative of integration system. They further explained that providing all health related services in the same rooms is very much comfortable, instead of sending clients to other consultation room in the same building.[9]

1.3 Statement of problem

Okankolo Health Centre integrated HIV/AIDS care into PHC services in 2016 as per request from MOHSS national level to fight against stigmatization and discrimination experienced by PLHIV and also to promote good adherence among PLHIV. Okankolo Health Centre implemented integration system after a successfully implementation of integration system at Epako clinic in Namibia. A study conducted at Epako clinic regarding integration showed that integration have improved accessibility, stigma and discrimination by improving provider-patient communication. Waiting time at the facility was reduced by 15% and nurse productivity have improved by 85%.[9]

Okankolo Health Center have a total number of 658 clients enrolled for ART since 2016 and only 227 clients are active. There is no accurate statistics of active patients who have

been collecting their ART medication before and after integration system. After the implementation of the integration at Okankolo Health Centre, there used to be complains in a suggestion box that the waiting time at the facility is too long, there was also an evidence that there was an increase of patients on HIV treatment that are missing their follow up. Lost to follow up rate changed from 13% to 16% for the period of 2020-2022 and some patients are also requesting for transfer letter to other nearest facilities.

There was also an observation of mismanagement and poor documentation for people living with HIV. When nurses were asked about the cause they responded that it is because of the integration and they wanted integration system to be stopped and start operating in the way they were operating with HIV department isolated from other primary health care department.

Despite the efforts made by the government of Namibia to make easier accessibility to care for people with HIV, there are still challenges faced, particularly in rural areas. The integration of HIV/AIDS care into primary health care services is one of the strategies aimed at addressing these challenges. Okankolo Health Centre staff have been requesting from the Primary Health Care Supervisor (PHCS) if they can change from operating in an integrated setting. This is because of too much work, shortage of staff, lack of knowledge and experience in management of PLHIV care. However, little is known about the perspectives of PLHIV regarding the integration of these two services. With the existing of few case studies in global literature, these studies lack the local Namibian context particularly in the rural areas. Therefore, the researcher wants to address and explore more on the perspectives of PLHIV regarding the integration of HIV related services with other primary health care services at Okankolo Health Centre. By addressing this problem, this

study will provide insights into how PLHIV in Namibia, specifically in rural area feel about the integration system and inform policy, practice and relevant office in the provision of integrated service at Okankolo Health Centre.

1.4 Purpose of the study

The purpose of study was to explore and have understanding of the perspectives of people living with HIV regarding the integration of HIV/AIDS care into Primary Health Care Services in Okankolo Health Centre, Onandjokwe district, in the Oshikoto region of Namibia.

1.5 Research objectives

- To describe the perspectives of PLHIV regarding the integration of HIV/AIDS care into Primary Health Care Services.
- To explore the perspectives of PLHIV regarding their care being integrated into primary health care services.
- To understand what inputs do PLHIV have on integration system.

1.6 Significant of the study

Understanding the perspectives of PLHIV can help identify areas where the quality of care can be improved and inform strategies for addressing these issues.

This study will help the MOHSS to identifying the challenges and barriers faced by PLHIV in accessing care and it can also help to formulate strategies for improving access to care and reducing gaps in their care.

This study will inform the policy makers and program development related to the joining of this two services in Namibia and other similar settings. By giving PLHIV a voice in the design, evaluation and implementation of HIV care services, the study can help empower them and promote their participation in decision-making processes.

This study will as well be available to the undergraduate and post graduate for University of Namibia (UNAM) students that will be conducting studies on a related topic.

1.7 Delimitation of the study

Creswell defines delimitation as boundaries deliberately set by the researcher to narrow the scope of the study. [10] The study focuses on people living with HIV that are on ART and collect their ART medication at Okankolo Health Centre, and have been collecting their ART medication at Okankolo Health Centre before and after integration to give their view on integration system.

1.8 Limitations

Limitations are restriction of the research that are beyond the researcher's control when conducting a study.[11] This study was conducted at Okankolo Health Centre only and data saturation was reached at the ninth participants. All PLHIV that use to collect their medication at Okankolo Health Centre did not get a chance to participate in the study. Due to this the findings of the study could not be generalized to the entire community of Okankolo and all facilities implementing integration system. However, the study findings can be used for reference and in future research.

1.9 Definition of concepts

Concepts explained in this study are generated from the topic of this thesis "Perspectives of people living with Human Immune-Deficiency Virus regarding the integration of their care into primary health care service at Okankolo Health Center, Namibia". They are defined as follow;

1.9.1 Perspectives

A feeling or opinion about something or someone.[12] In this study perspectives refer to how PLHIV feel about their care being integrated into primary health care services.

1.9.2 Human Immunodeficiency Virus (HIV)

The virus that results in a disease called AIDS (a disease that destroy the body's ability to fight infections).[12] In this study HIV mostly was used to refer to people living with it. Because someone living with HIV is different from one who have AIDS. People who have HIV are not sick they only have the virus but can maintain to do daily work while someone who has AIDS is very sick.

1.9.3 Integration

The process of successfully putting together or mixing with variety of group or people.[12] During this study Integration was referred to as a combination of care provided to PLHIV with existing primary care services which are immunization, family planning, screening and treatment as well as dressing. In the past Okankolo health center had two separate clinics one for the care and treatment of people with HIV and one for routine primary health care services. Integration is then referred to combination of this two.

1.9.4 Primary Health Care Services

These are basic medical care provided at clinics that do not require treatment at hospitals.[12] In this study this concept was referred to provision of services including; the promotion of proper nutrition, reproductive health such as maternal, children care and family planning, prevention of infectious diseases through immunisation, proper screening and treatment of major diseases and conditions, education training concerning prevailing health and social problems in the community.[13]

1.10 Structure of the thesis

This thesis consists of four chapters:

Chapter one: This chapter outlines the orientation of the study by giving general introduction and background of the study. Reason why the researcher conducted the study and objectives of the study are highlighted in this chapter as well.

Chapter two: Focus on the literature review of the study as well as the theory that guided the study.

Chapter three: This chapter presents the research designs used, approach, method, process and tools used during data collection. It is in this chapter were ethical consideration and application of ethics in the study explained.

Chapter four: Findings from the study and how collected data were analyzed are discussed in this chapter. Literature supporting the findings are stipulated here as well.

Chapter five: The researcher concluded the study in this chapter, limitations as well as the recommendation from the study were discussed here.

1.11 Summary

The introduction chapter presents the background, what influenced the researcher to conduct the study, objectives, study significant, limitations and delimitations. Concepts concerning the study were defined in this chapter as well how the chapters are aligned in the study. Next chapter is about literature review.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The purpose of the literature review is to deepen the theoretical framework of the research and to equip the researcher with the latest development in the area of the study. Literature review analyses and synthesizes relevant empirical studies, which aimed to answer the research questions as well as provide research-based evidence to support the research topic.[11]

2.2 History of integration of primary health care services

Modern Primary health care emerged when gross health inequalities become a global concern. The declaration of Alma-Ata, endorsed primary health care as the means of achieving the WHO's goal of health for all. It was a global health milestone of the 20th century and crucially identified primary health as a fundamental human right and key factor in attaining equitable health for everyone.[5]

In many settings primary care which is considered as the first contact of the people with health services that are continuous, comprehensive and coordinated, has been focused on treating illness when needs arises rather than preventing diseases in the first place. Modern public health interventions aims to prevent disease, protect and promote health as well as to make sure that the public threats are addressed.[4]

Druetz further explain that, integrating a public health approach into primary care could be an effective way of preventing disease in local communities, thus reducing the demand on primary care and improving the health of the population. Integration also enable

primary care to deliver more protective, promotive and preventive services to a defined population, improving communication and coordination between two parties.[4]

2.3 Improvements that can be brought up by integration strategy

Many health facilities in Namibia have been offering HIV services and other primary health services in silos, this have compromised quality and efficacy in offering primary health care services. As a result Zapata et al, conducted a study in Epoko clinic in Namibia to assess delivery of health care services before and after integration of HIV care with family planning services. The study have showed that integration have improved accessibility, stigma and discrimination by improving provider-patient communication. Waiting time at the facility was reduced by 15% and nurse productivity have improved by 85%. Based on the experience from the study, the researchers recommend African countries to implement integration strategy in their health system to contribute to the achievement of universal health coverage.[9]

2.4 Accessibility to health center with integration and those without integration system

Thomas et al. explain that when services are integrated it sometimes lead to overload of work to the staff at the facility, leading to patients waiting for long to receive the services. This sometimes lead patient to go back to their houses unserved and make them come back the next day or some other day for the service and some take long to come back for their follow up.[14]

Integration means services are provided on a daily basis. Some facilities do not offer all the services every day and have specific days for particular services. ART client with

comorbidities only visits the health center once for all the service and do not need to queue up to many rooms to receive other services, this have reduced their accessibility to health care, less is spend on transport to seek health services.[9]

2.5 Experience of PLHIV on integration system

A study done in Kenya to assess the patient's satisfaction after implementation of integration service shows that, integration does not negatively affect the client's satisfaction. Clients were satisfied with health education that used to be provided at the reception since a variety of topic concerning HIV and HIV free people use to be provided. Participants expressed that care was provided in a confidentially manner before and after integration .Men were comfortable receiving care both before and after integration. Women were less comfortable about receiving care at the integrated clinic since the follow-up samples, included HIV-negative patients, it is possible that this finding relates to their discomfort with integrated care or that it represents continued high levels of apprehension regarding others suspecting one is HIV positive. The effect of integrated care on inadvertent disclosure bears further research.[14]

2.6 Challenges faced with integration

Despite the discussed desired outcome or advantages of integration, there are also some challenges. A study conducted in Kenya 2010, mostly focused on the integration of non-communicable diseases with HIV indicated some of the problems experienced by Kenyans during integration such as frequent staff turnover, and space constrains for additional services. In addition, the study further reveals that some countries especially developing countries where the wider health system does not function well, it makes no sense to change a separate health service or program which works well and integrate it

with others. The same study reveals that there are concerns that allocation of financial resources to health priority may be reduced with integration.[15]

Another qualitative study done in Uganda on the integration of Mental health disorders with primary health care services shows that there was limited appreciation of integration and what it means, the findings shows that some healthcare managers could not afford to train all the health care workers on mental illness and some nurses are not comfortable with integration to be integrated within their facilities. Besides, a negative attitude towards mental health and mental disorders was noted to play a significant role.[15]

A study conducted in Windhoek clinics on perspectives of nurses and patients on integration system revealed that nurses finds integration a challenge as some services that are integrated do not go along. They find it not appropriate to mix sick people with other people that only come to the hospital for other services but are not sick as it will increase spread of communicable diseases. Clients also emphasized that with integration they are not being treated on first come first served. Since people are mixed up the one that seems to be sicker will always be served first.[16]

2.7 Theoretical framework of the study

The study was guided by the Health Belief Model (HBM). HBM is a foundational framework in health behavior research. It was conceptualized in the 1950s to help understand preventative health behavior specifically failure of people to accept disease preventative or screening tests for early detection of asymptomatic diseases. According to the HBM, people's health-related behaviors are determined by their perceptions of

susceptibility to a health threat, the severity of the health threat, the benefits and barriers of taking action, and indications to action.[17]

Applying the HBM: People living with HIV may perceive their susceptibility to the disease and to the potential consequences of not accessing care. (2) Perceived severity: PLHIV may perceive the severity of the disease and the potential impact on their health and wellbeing. (3) to this study of perspectives of PLHIV regarding the integration of HIV/AIDS care into Primary health care services, the following factors will be considered: (1) Perceived susceptibility Perceived benefits: PLHIV may perceive the benefits of accessing integrated HIV/AIDS care, such as improved quality of care and reduced stigma. (4) Perceived barriers: PLHIV may perceive barriers to accessing integrated HIV/AIDS care, such as long waiting times or lack of privacy during consultations. (5) Indications to action: PLHIV may be motivated to access integrated HIV/AIDS care by indications such as health education campaigns, support from relatives and friends, or good experiences with the health care system. By applying the HBM to the study, researchers could identify the factors that influence the perspectives of PLHIV regarding the integration of the two services, and design interventions to improve the uptake of integrated care services.

2.8 Summary

Literature review chapter discussed the literature that shapes the study, it covers the history of integration system globally and locally and how it affects the lives of people that tried to implemented integration at their services. The theoretically framework that have guided the study was through explained in this chapter.

CHAPTER THREE

RESEARCH DESIGN AND METHODS

3.1 Introduction

Research methodology focuses on the type of the research, method and techniques that will be used during the study and how they will be applied.[18] This chapter will explain population sample, data collection and the measures that will be employed to ensure trustworthiness.

3.2 Research approach

Qualitative approach was adopted in this study. This approach was considered appropriate for exploring the perspective of PLHIV because qualitative research allows people to interact with one another to develop their opinions on certain phenomena. These approaches concentrate on the component of qualitative experience, understanding and meanings.[19] Thus the researcher employed this approach in order to explore the perspectives of PLHIV at Okankolo Health Centre. Participants shared their perspectives with the researcher to help the researcher acquire rich information from them in order to understand the situation.

3.3 Research design

Exploratory research design was used during this study. Burns & Grove20 describe exploratory research as a way of studying a phenomenon to identify its variables. Exploratory research was selected for this study because it was needed to explore relationships between different phenomena. During the explorative research stage, the focus is to gain insights into and familiarity of various aspects for later investigation or

implementation. The explorative research in this study was used by applying questions (what, why, how) to explore the perspectives of PLHIV on integration of their care into existing primary health care services.

3.4 Study Setting

A research setting is the physical environment in which the research takes place[18]. This study was conducted at Okankolo Health Centre. Okankolo Health Center is a health center in Onyuulaye constituent in Oshikoto region, it is one of the health center in Onandjokwe district and one of the facilities that operate with integration system in Oshikoto region. It is situated in Okankolo settlement near Onguti Senior Secondary School and Okankolo police station. Okankolo health center operates 24 hours and provide all primary health care services. It has a medical doctor, 6 registered nurses, 8 enrolled nurses, 2 pharmacist assistances, a receptionist, 2 health assistance, a driver, 4 cleaners and 18 community health workers.

The facility consists of four consultation rooms for nurses, one multipurpose room, a dressing room, pharmacy, community health worker room, doctor's consultation room, 2 admitting rooms and a labour (delivering) room.

3.5 Population of the study

Brink define population as a set of people or objects with the same criteria of which the researcher is having an interest in studying.[19] This study was conducted among people living with HIV that collect their ART medication at Okankolo Health Centre. The study mainly focused on adult patients (18- 50) years who have been collecting their ART medication at Okankolo Health Centre before and after integration. The researcher opted

for this age group and category since this age group is matured enough to give accurate information and they have experience of services provision before and after integration. Okankolo Health Centre have a total number of 227 active ART patients. However, there is no accurate statistics of active patients who have been collecting their ART medication before and after integration system.

3.5.1 Inclusion criteria

Participants of the study were adult patients, between the age of 18 to 50 years that are HIV positive, registered in Okankolo ART database and have been collecting their ART medication at Okankolo Health Centre before and after the implementation of integration system.

3.5.2 Exclusion criteria

HIV positive clients under the age of 18, adults above 50 years, pregnant women and HIV clients with mental health problem were excluded from the study, since they are considered as vulnerable group. ART patients who are only visiting at Okankolo Health Centre for their medication refill were also not part of the study.

3.6 Sampling

Sampling is a way of choosing cases, to be the representative of the selected population.[18] The researcher used a non-probability sampling procedure. Participants were picked purposively in a way that only PLHIV who have been collecting their ART medication at Okankolo Health Centre before and after integration system and they are between the age of 18 and 50 were drawn. This group of people are key informants of the integration system. They have experience in the rendering of health care before and after the

implementation of integration system. The researcher went to Okankolo Health Centre and have been alternating between consultation rooms, when ART clients enter the consultation rooms, the researcher check the eligibility of the patient by asking the age and the year they started collecting their ART medication at Okankolo Health Centre and confirm with the client's file. The researcher then explained the study to the client and move to a private room for the interview if the client agreed and have met the eligible criteria to participate in study.

Mulenga[21] stated that, sample size is not statistically significant in qualitative research. Because these kind of studies mostly are not generalized to the entire population. Due to this data saturation determined the size of the study sample. Data saturation is a point reached when new information is no longer being acquired from the participants.8 Nine participants were interviewed and data saturation was reached.

3.7 Data collection

Interview guide, an audio recorder and a note book were used as data collection tools. This helped the researcher to gain more and unlimited information from the participants, through probing. The researcher also recorded the interviews to enable the researcher to transcribe the data. Hence the study is looking at perspectives of people living with HIV, in-depth interviews were conducted and the researcher made field notes.

3.7.1 In-depth face- to -face interview

This is a dialogue between the participant and the researcher, it is one of the greatest method of obtaining data in qualitative study. It helps the researcher to acquire rich and first-hand data from participants.[19]

The researcher asked the participants questions verbally. The in-depth interview allows the participants to open up and give more information when interviewed individually than when interviewed in groups. Participants will be more comfortable and feel free to ask questions for clarifications.

3.7.2 Conducting an interview

The interviews took place at Okankolo Health Centre in a quiet and well-organized room where there was only a researcher and one participant at a time. Prior to the interview, the researcher offered a chair to the participant. The researcher started off by introducing herself and explain the aim of the study to the participant and obtained a written and signed informed consent from participants. The researcher assured the participant that the study is optional and they are free to evacuate from the study anytime they feel like they do not want to answers the questions and were informed that the interview will be voice recorded. Participants were informed to feel free to ask questions and clarification if there is anything they don't understand. The interviews were carried out in Oshiwambo. The main question was "May you please explain to me how you feel about HIV services being integrated into primary health care services?" The researcher probed more according to the answers she was getting from the participants and some probe questions were;

How often do you visit the hospital in a year before integration and after integration?

What is that you like and don't like about integration system?

What changes if there are any that you want to be done in the provision of care with integration system?

The interviews were recorded with an audio recorder to ensure precise transcriptions. The researcher ended the interview by appreciating the participants for their time and efforts to take part in the study and wished them a good day.

Data were collected on 02-03 July 2024 between 10:00 and 16:00. A total of 9 interviews were conducted that lasted for 20-25 minutes. Saturation of data was achieved when no new insights and issues was being identified and there was repetition of information from the interviewees.

3.8 Procedure

The researcher received an ethical clearance certificate from UNAM DEC and was granted a permission from the Ministry of Health, from the health regional director of Oshikoto region to carry out the study within the Ministry of Health and Social Services and at Okankolo Health Center. These were done before the researcher started with data collection. All the participants were given an informed consent to participate in the study and the following ethical principles were assured; autonomy, justice, beneficence and male beneficence.

3.9 Pilot study

This is a mini study done before the main study to identify unforeseen problems as well as to see if the study is feasible.[18] Pilot testing for this study was conducted at Okankolo Health Centre. Two PLHIV who have been collecting their ART medication at Okankolo Health Centre were interviewed with the same interview guide. All the questions were answered, participants did not struggle answering the questions and none of the participants asked for the clarification of the questions. The researcher took note of the

name and file number of those two participants for them to be excluded from taking part in the main study.

Participant were asked the main question and probe more to gain more information. The main question was, tell me how you feel about HIV Care being integrated into primary health care services? Probing questions were; how often do you visit the clinic before and after integration system? What do you like and dislike about the integration system? What inputs do you have regarding the provision of care when these two services are integrated? The interviews were conducted in the language everyone was comfortable with which is Oshiwambo and the transcript were transcribed in English.

After conducting a mini study, the researcher identified that there is a need to add another probing questions of whether participants have anything they want to share regarding integration system other than what they have just shared. This was because all the two clients who were tested end up adding other information regarding integration which were not part of the interview questions.

Pilot study aided the researcher to identify problems with the data collection tools early before the main study. It also assisted the researcher to find out whether the questions in the guide were well understood by the participants and to find out whether the participants can be able to answer the questions accordingly.

3.10 Data Analysis

Data analysis is an analytical organization and combination of research data.[18] Qualitative analysis technique was used in this study, by which words were analyzed instead of numbers. Qualitative analysis technique includes inspecting and interpreting data to come

up with explanation and acquire an understanding from observed data. It includes looking for meaning and relationship among classes and generated themes. Data are further splits into themes and sub-themes, conceptualized and put back together in different ways.[20]

Data obtained from the in-depth face -to -face interview of this study were analyzed based on Tesch's method of open coding.[8] Below is the table that shows how the eight steps of Tesch were used and how they were applied to this study.

Table 3. 1 Tesch's step of data analysis and its application to the study.

TESCH'S STEP OF DATA ANALYISIS	APPLICATION TO THE STUDY
1. Make sense of the whole. Read through the transcriptions and note down some ideas as they come to your mind. Careful repeat reading the transcripts obtained to identify important phrases and words.	The researcher listens to the audio-tape and read through all transcript of the interview. The researcher than get the sense of the whole document and put down the thoughts as they come to mind.
2. Select a document, read through and obtain the meaning.	The first data document was selected to establish the topic or to uncover the underlying meaning of data. The most data document was read to establish meaning rather than content. The researcher continued to note down thoughts in the document margins.

3. Gather and labelling same topics and come up with crucial, unique, and leftover topics.	To sort the main topic, individual topics, and the rest of the topics for a large number of documents, the steps above were followed to create a list of all the topics. The researcher highlighted topics in different colours to simplify the analytical process. After compiling all interview documents, the researcher come up with a list of all words and gather the same ones together and then arrange them differently in a good order.
4. Code all the topics and write them next to the relevant segment of the text.	After topics were arranged in columns, the researcher revised the data, gave codes to the topic and record each code in the appropriate section in the text. The researcher carried out this preliminary system of organising data to see if new categories can be identified.

5. Find descriptive words of the topic and group them into categories.	The total list of categories was reduced by grouping the related concepts together. The researcher proceeded to capture interrelationship by drawing lines between the categories and generate themes.
6. Make a conclusion on the abbreviation of each category.	A conclusion regarding the abbreviations for each category was made and codes were alphabetised.
7. Assemble the data belonging to one category in one place and do a preliminary analysis.	To properly code all relevant text for later recording, the researcher, compiled the data and analysed each category in terms of content relevant to research objectives and questions.
8. Re-codes existing data if there is a need for recoding.	The researcher grouped the perspectives into clusters of phenomena to form the themes and subthemes.

Interviews held during this study were precise. By listening to the audio recorded interviews, the researcher wrote down all the words, exactly the same way they are being said by the interviewees. Since the interviews were conducted in Oshiwambo, all transcriptions were transcribed in English written format. The researcher read through all transcripts one by one and took note of similar views as expressed by the participants. The researcher therefore created a list of themes, put together similar themes and allocated the identified themes an appropriate descriptive wording of each theme. Three main themes, and eight sub themes were identified and are described in details in the next chapter.

3.11 Measure to ensure trustworthiness

Trustworthiness refers to the quality of reliability to which qualitative researcher have confident in their collected data. Trustworthiness for this study was ensured by four strategies: credibility, dependability, confirmability and transferability.[18]

3.11.1 Credibility

Polit and Beck define credibility as a measure of the true value of qualitative research. It measures whether the study findings are correct and accurate. The activities which increase the possible credible of findings were triangulation, prolonged engagement, participant checks, referential adequacy and peer debriefing.[18]

3.11.1.1 Triangulation

Data were collected from different participants who are from different villages and with different understanding to avoid potential biases. Information on transcripts was merged with the one on field notes as means of data collection tools.

3.11.1.2 Prolonged engagement

The researcher tried to create a rapport with the participants. At the beginning of the interview the researcher explained the aim of the study, assured the participant that the interview will be recorded and the reason for recording. Participants were assured that confidentiality and their anonymity would be maintained. The researcher had also read to the participants the main questions of the interview before the actual interview began. The researcher is a nurse by profession and has worked at Okankolo health center before, thus there was a trust from the participant.

3.11.1.3 Participant checking

Debriefing was conducted at the end of the interview with each participant. Each participant was given a chance to listen their recorded audio for them to correct their errors and they were asked if they have additional information at the end of the interview.

3.11.1.4 Referential adequacy

The audio recorder was used during data collection to ensure referential adequacy. Participants were assured about the audio recorder and the reason for recording.

3.11.1.5 Peer debriefing

Peer debriefing provides an external check of the research process. This was done through the presentation of the research proposal in a research seminar and reporting of findings to the study supervisor.

3.11.1.6 Research Authority

The University of Namibia and the MOHSS all gave their approval for the study to be conducted.

3.11.1.7 Structural coherence

This study focused on the perspective of PLHIV and People living with HIV were the first sources of the data. The findings were then used for the research's intended purpose.

3.12.2 Dependability

Dependability is the measure of the extent to which a study can be replicated by a different researcher with same setting and participants and reveal the similar findings.[18] In this study dependability was sustained through audit inquiry, whereby the researcher received intense guidance from the study supervisor. The study methodology including data collection tools where fully explained, sent to the supervisors, presented in research seminars and sent to the School of Higher Degree Board (SHDB) for examination. Field notes and all material used during the study were kept for inquiry.

3.12.3 Confirmability

Confirmability is the degree to which the study findings accurately reflect the participants' information instead of being biased by the researcher's perspective.[18] In this study, confirmability was maintained through the recording of individual interviews and taking notes during interviews. Data collected were transcribed verbatim and sent to the supervisor who is an expert in the qualitative research design to determine whether the conclusion, interpretation and recommendations can be traced to their source and if they were in support with their enquiry. The researcher's data interpretations were also confirmed with the use of literature control.

3.12.4 Transferability

Transferability is the measure of how qualitative findings can be applied to other situations.[18] A sample of perspectives of PLHIV was purposively selected as suitable to meet the study's aims. Thick description was also used in order to obtain rich information for the research objectives. A thick description of the research design, verbatim statements and literature review were used to ensure clarity. The researcher tried to provide the background information of the study participants as well as the research context and settings in order to let others to observe how transferrable the findings were and whether conclusions can be transferred or not.

3.13 Research ethics

3.13.1 Ethical clearance and permission to conduct research

Ethical clearance certificate was obtained from the University of Namibia Decentralized Ethics Committee as evidenced in appendix A. The researcher requested for a permission to conduct a research from the Ministry of Health, the Oshikoto health regional directorate and from Okankolo Health Centre Supervisors. They all granted a researcher with a permission letter to carry out the study.

The researcher explained to the participants what the study was all about, including the procedures to be followed, study benefits and potential risk. The researcher also briefed participants that their participation in the study is voluntary and they can withdraw from participating without any harm. All participants that took part in the study signed the informed consent after being briefed and agreed to take part in the study. The following ethics were ensured during the study.

3.13.1 Autonomy

Participants were enlightened about the aim of the study, and before they participate the research sought informed consent from participants by giving them consent form to agree on a paper that they agreed to participate. Clear explanation was provided that nothing will happen to those that do not want to take part in the study, and they are free to leave anytime they feel like.

3.13.2 Respect for person

Respect is the right to self-determination.18 Participants were fully informed and were given the right to decide to participate or not. Participants were ensured that participating in the research was voluntarily and there will be no guilt for those not willing to participate in the study. They were instructed that can feel free to draw out from the study anytime they feel like.

3.13.3 Beneficence

Beneficence refers to making sure that the benefits of the study must take precedence over the risk, by doing good.[20] This study was conducted to be able to give HIV participants to give their view on the integration system. Interviews were conducted in the vernacular language (Oshiwambo), which everyone was conformable with. Participants were assured that there will be no exchange of goods for participation in the study and there will be no direct utility from the study, however the findings of the study will be handed over to the Ministry of health for possible improvement of service care delivery.

3.13.4 Non maleficence

Non maleficence means refraining from doing things that are harmful.[20] Participants were informed that they are protected from harm and discomfort. Potential harm and discomfort were minimized in a way that interviews took place in a closed room where there was only the participant and the researcher at a time. Information from the participants was only shared to the supervisor and the relevant bodies. Participants that refused to take part in the study were not forced to take part and they were assured that nothing will follow up on them by refusing to participate in the study. Furthermore, no clinical trial was done during this study to avoid harms.

3.13.5 Justice

Justice refers to participants' right to fair selection.[19] Participants who participated in the study were chosen fairly not just because they were readily available. All people who qualify to take part in the study had an equal chance of being chosen to participating. All participants were asked similar questions to ensure justice.

3.13.6 Privacy, Anonymity and Confidentiality

During data collection, the interview took place in one of the consultation rooms, whereby it was closed during the interview. Participants' real names were not used; therefore, participant only sign the consent form without writing their names on it and they were told not to make their signature legible. Data collected was not made available to anyone, apart from the researcher's supervisor. All participants were made aware of the voice recorder, which was used during interview, and consent was obtained from each participant. The recorded audios and field notes were kept safe so as not to be accessed by anybody.

3.14 Summary

Qualitative, explorative and phenomenological design used were described in this chapter. It further explains the study population, sampling method, researcher instrument and the setting of data collection were explained. Method of data analysis used and manners in which trustworthiness was ensured were explained as well. Furthermore, ethical principles were also discussed.

CHAPTER FOUR

DATA ANALYSIS AND DISCUSSION OF RESULTS

4.1 Introduction

In this chapter a thorough explanation of research findings and how they were analyzed is presented. Data collected from interviews with similar meanings were grouped together to form themes and sub themes and were related to the research objectives. Tesch's method of data analysis was used to analyze data. Thematic form was used to present findings and literature control was implemented.

4.2 Demographic details of participants

A total of nine participants were interviewed. Participants were three males and six females who had been collecting their ART medication at Okankolo Health Center before and after integration system. Participants' ages varied from 26-45 years. Two participants had primary education only, four had secondary education and three had tertiary education. Six participants were unemployed, two were self-employed and one was employed.

4.3 Themes and sub-themes

The process of data analysis included the splitting of the data into themes and sub-themes based on the categories they represented. In this study, three themes and eight sub-themes were identified according to the participants' answers when they were interviewed on their perspectives regarding the integration of HIV care being integrated into Primary health care services. A coding system was used, whereby participants were assigned with codes instead of using their real names.

Literature control tactic was used to relate the findings of the study to the current information on the integration of HIV care into primary health care services. Literature control also helps to develop the researcher's experience of the researched topic from multiple perspectives and this includes an assessment of sources in which the situation is described.[16] The following table shows themes and sub-themes that were identified from this study.

Table 4. 1 Study objectives, themes and sub-themes

OBJECTIVES AND THEMES	SUB-THEMES
4.3.1 Objective 1: To describe the perspectives of PLHIV regarding the integration of HIV/AIDS care into Primary Health Care Services. THEME 4.3.1.1 Participants (PLHIV) are in support with the integration system.	4.3.1.1.1 Reduced discrimination 4.3.1.1.2 Integration creates a bond between nurses and patients. 4.3.1.1.3 Integration reduces the time patients spend coming to the hospital and waiting time at the facility.
4.3.2 Objective 2: To explore the perspectives of PLHIV regarding their care being integrated into primary health care services. THEME	4.3.2.1.1 Dispensing of medicine at the pharmacy 4.3.2.1.2 Long waiting time at the facility. 4.3.2.1.3 Bad attitudes from nurses

4.3.2.1 Challenges participants (PLHIV) have with the integration system.	
4.3.3 Objective 3: To understand what inputs do PLHIV have on integration system. THEME 4.3.3.1 Inputs Participants (PLHIV) have on the integration system	4.3.3.1.1 Dispensing of medication with integration 4.3.3.1.2 Cleanliness in the community

4.3.1 Objective 1: To describe the perspectives of PLHIV regarding the integration of HIV/AIDS care into Primary Health Care Services

This objective was to describe how PLHIV at Okankolo health center feel about their care being integrated into existing primary health care services. One theme and three sub-themes where emerged from the study and they are explained below;

4.3.1.1 Theme 1: Participants are in support of the integration system

Integration of HIV care into Primary health care involves the sharing of services and resources for HIV care and Primary care. Meaning people are being treated in the same rooms regardless of what they come for at the health centre.[1] Unlike with unintegrated care where there are specific rooms for example a room for dressing, immunisation, treatment, and HIV clinic. With integration all consultation rooms offer all the services being rendered at that particular facility.

There is an increasing evidence of appreciation by many stakeholders and policy makers on the importance of integration of HIV/AIDS services and other Primary health care services, as it claims that integration reduce stigma associated with HIV, reduces time patients wait at facilities, reduces work constrain for health care providers, cut costs and improves the quality of services provided to clients.[7]

A study conducted in Kenya to assess patient satisfaction after implementation of integration service shows that, integration does not negatively affect client's satisfaction. Clients were satisfied with the health education that used to be provided at the reception since a variety of topics concerning HIV and HIV free people use to be covered. Participants expressed that, care was provided in a confidentially manner before and after integration. Men reported that they were happy receiving care with either services being integrated or neither. Women were less comfortable about receiving care at the integrated clinic since their follow up mostly includes HIV testing. It is possible that this finding relates to their discomfort with integrated care or that it represents continued high levels of fear regarding others suspecting one is HIV positive. The effect of integrated care on inadvertent disclosure bears further research.[14]

In this study, all the participants who were interviewed on their perspectives regarding their care being integrated into existing Primary health care services were in support with the integration system. The following were identified as sub-themes for why the participants were in support with integration system.

4.3.1.1.1 Reduced discrimination

Discrimination refers to a process of making inequitable or hurting distinctions between people based on their race, groups, classes and other classifications.[12] Discrimination is one of the crucial challenges faced by PLHIV in the world and it negatively affects the prognosis of their condition. HIV/AIDS related stigma and discrimination were recognized in Sub-Sahara Africa where most of PLHIV live. In this setting, the great problem faced by PLHIV with regard to stigma and discrimination were the spreading of rumors and insults which made PLHIV feel guilt and ashamed of being infected with HIV.[2]

Many health facilities in Namibia have been offering HIV services and other primary health services in silos, this have compromised quality and efficacy in offering primary health care services. As a result, Zapata et al, conducted a study in the Epoko clinic in Namibia to assess delivery of health care services before and after integration of HIV care with family planning services. The study has shown that integration has improved accessibility, stigma and discrimination by improving provider-patient communication.[9]

The participant in this study expressed that they feel good about their care being integrated into Primary health care services as there is no discrimination with services being integrated. The following statements in italic were verbatim statements from the participant that serve as evidence.

"*I feel good about integration because there is no discrimination, as we are now considered as other patients. There was no privacy when services were not integrated*" (P1).

"I feel good about it because no one sees what you come for at the hospital, as we are now all treated in same consultation rooms with other people who come for different services at the hospital. Unlike before integration when we use to be treated at our separate rooms, when people see you going there, they already know that you are infected with HIV since only HIV people used to be treated in that room'' (P5).

HIV related discrimination not only directly affects PLHIV. HIV related discrimination has also negatively impacted the attaining of the World Health Organization target of reducing HIV cases and increasing HIV/AIDS related deaths. When people are not happy taking their medication there will be poor adherence and this increases the chances of spreading the virus, leading to an increased number of HIV cases and deaths.

4.3.1.1.2 Integration creates a bond between nurses and patients

A study conducted in 2022 at two clinics in Windhoek (Okuryangava and Wanahenda) on the perceptions of healthcare workers and patients regarding the integration of PHC services shows that both nurses and patients have observed that integration has improved the relationship between patients and nurses.[16]

Nurses have developed good relationship with their patients, as most of the time these patients are seen by a same nurse over and over until they know more about the patients. Nurses said "creating a bond with a client is very important as it contributes to the recovery process of the patients".[16]

Patients explained that, "the system of obtaining services at one place by the same nurse has improved their relationship with nurses as they get used to that particular nurse, get comfortable with them and are open to them whenever they are seeking for medical

services. Nurses get to keep track of the prognosis of a patient's condition, because most of the time it is the same nurse that attends to you every time you come to the hospital".[16] The findings from this study are in support of the above literature as evident by the following statements from the participants.

"I have a strong bond with my nurse that treats me in room 3. She is very helpful and always ask how I am doing and every time I tell her any problem, I am experiencing with my condition, she always give me advices and ask me on my next follow up on how I am coping with it and whether the problem had resolved or not". (P9)

"*Being treated by one nurse is good, because nurses tend to know you more, and they hardly talk to us in bad ways because we are used to each other. All services being provided in the same room also reduce our time coming at the hospital because that particular nurse will just put all your follow ups in the same day*". (P1)

"I use to have a problem of coming to the hospital when we use to get our medication at the separate room because there was a nurse who had bad manners, she does not listen to people even if you try to explain yourself to her. I use to feel bad every time I am coming back from the hospital because she even calls me bad words. This made me even to stop coming to collect my medicine some times, but after the services started being provided together, I was lucky that the nurse I was assigned to realized that I have a problem and she has been asking me what I was going through, at first, I did not open to her but as time goes, I develop good bond with her and open up to her. She gave me advice and I started doing well emotionally and from there I never skipped my follow-up date". (P5)

These verbatim comments from the participants are clearing indicating that, integrating HIV care into Primary health has promoted a good relationship between nurses and clients. Being attended by the same nurse with regular visits to the clinic enhances communication and helps build a nurse-patient relationship as they tend to know each other and open up to one another.

4.3.1.1.3 Integration reduces time patients come to the clinic and the waiting time at the facility

Zapata. et al conducted a study at Epoko clinic in Namibia to assess the health care delivery system after the implementation of the integrating of HIV care with sexual reproductive health (SRH). The study findings showed that integrated services improved accessibility, stigma and quality of care delivery services by improving the provider-patient communication and reducing the time that patients stay in the clinic and waiting time. This literature supports the findings of this study, as evident by following statements from the participant.[19]

"Before integration I use to visit the clinic many times compared to after integration, because the hospital use to be full. If I collect my ART medication from the ART clinic and I still have a child that need to be immunized, by the time I will finish with my medication I will still have to go queue for the immunisation of my child, sometimes it uses to be late I just have to leave the clinic and bring back the child one day for immunisation. Integration has reduced the number of times I come at the clinic because all services are provided in one room". (P4)

"With integration the time we spend at the clinic is little because there are four operating rooms, service is fast unlike before integration whereby we queue up at one room and we use to be a lot sometimes". (P7)

"Integration save me from spending a lot on transport money, because all services are provided every day and in all the rooms, I always ask my nurse to put all my follow up in one day by that I even skip some months without coming to the hospital". (P3)

These verbatim illustrate that since ART services are integrated into Primary health care clients don't visit the clinic more often. All services are provided in all the consultation rooms and no need to queue up more than once.

However, Thomas et al., [14] stated that when services are integrated it sometimes led to overload of work to the staff at the facility, resulting in patients waiting for a long time to receive services. This sometimes led patient to go back to their houses unattended and come back some other day and some will never come back for their follow-up. In this study some participants have experienced long waiting times at the facility as well, the following are their words;

"The clinic uses to be full since all people coming to the clinic are just treated at the same place, due to this, we spend long time waiting at the facility especially when there are few nurses at the clinic that day." (P8)

"Waiting time at the pharmacy is very long and the staffs that works in the pharmacy are very slow since the facility now only use one pharmacy for all people that come to the clinic, the pharmacy use to be full and sometimes there used to be only one person helping

in the pharmacy. Before integration we use to have our own pharmacy and we don't spend much time at the pharmacy". (P2)

According to the study findings, all participants showed that integration has reduced the time they visit the clinic. Some participants also experienced that the time they spend at the facility is reduced compared to the time they use to spend at the facility before integration. However, some participants felt that with integration, the time they spend at the facility is very long.

According to Paulus, the waiting time at the facility is long with integration because the nurses use to spend much time with patients and they do a lot to a patient. The nurse will take vital signs, take history and do examination. If there is no an assistance to help the nurse, it will take the nurse long time to attend to patients resulting in long waiting hours at the facility.[16]

4.3.2 Objective 2: To explore the perspectives of PLHIV regarding their care being integrated into primary health care services.

The second objective was to dig more and gain initial insight from PLHIV at Okankolo health center regarding the integration system brought up at their service in order to identify issues to develop a deeper understanding of this phenomena. Through exploring, participants were repeating the same issue addressed in the first objective. Though they are happy with the integration system, they still face some challenges with the integration system. They expressed themselves that if these challenges can be addressed, they will enjoy integration system to the fullest.

4.3.2.1 Theme 2: Challenges participants (PLHIV) have with integration system.

Despite the advantages experienced by patients and health care workers at piloted facilities and centers where studies were conducted on integration, there are also some facilities whereby clients expressed challenges they faced with integration. A research conducted in Kenya 2010, which focused on the integration of HIV and non- communicable diseases shows challenges experienced by staff with integration such as frequent turnover of staff, and there was not enough space to offer some services. The study also reveals that some countries in developing countries where the wider health system does not operate well, it will not make sense to join a health care program that is already functioning well with the one that is struggling to render quality care. The same study reveals that, there might be a reduction or difficulty of financial resources allocations when services are integrated.[15]

A qualitative study was done in Uganda focusing on mental health disorders and Primary health care services being integrated. The study shows that, integration of these two services was not really appreciated. The findings showed that some healthcare managers could not manage to train healthcare workers on mental illness and some nurses are not comfortable with integration to be integrated within their facilities. Besides that, a negative and bad attitude from most of healthcare workers and community towards mental health illness and disorders was noted to be a main issue.[15]

The following were the challenges experienced by PLHIV at Okankolo Health Centre with the integration system;

- Dispensing of medicine at the pharmacy
- Long waiting time at the facility

- Bad attitudes from Nurses

4.3.2.1.1 Dispensing of medicine at the pharmacy

Integration means sharing of all resources at the facility with all health care delivery, this includes; consultation rooms, staffs, pharmacy, equipment, laboratory services and many more.[1] PLHIV at Okankolo Health Centre feel good about integration system because with integration all services are being provided in all consultation rooms, no one will see what you come for at the hospital. However, participants have expressed that whenever they are collecting their medication at the pharmacy privacy is not ensured. This is highlighted by the following statements.

"I always feel bad when I am going to collect my medication at the pharmacy. Our pharmacy is very open to everyone and is facing the waiting area. Most of the time, staff do not put something that will not make others not to see what medication you are collecting at the Pharmacy." (P6)

"There is no privacy at the Pharmacy, people in the waiting area are always checking what medications you are getting at the Pharmacy. ART medications are always in containers, so whenever you are given that container people can already tell that you are infected with HIV and they make noise when you are picking them up. I always feel uncomfortable collecting my medications at the Pharmacy especially when the hospital is full". (P9)

"Staff do not put order at the facility, when the hospital is full and people have nowhere to sit, they are always standing in the hospital collidor, some even close to the Pharmacy checking what medication others are getting at the pharmacy. Even though we do not go

to our old ART clinic people will still tell that you are infected with HIV because they will see you collecting ART medications at the Pharmacy". (P2)

Ensuring of Privacy especially when it comes to sensitive conditions such as HIV/AIDS is very important. Lack of privacy can make people ashamed of coming to the hospital leading to high treatment defaulter as a result people will have poor adherence and high chance of spreading the virus.

4.3.2.1.2 Long waiting time at the facility

According to Paulus, integration prolong the time a patient is served, as a result patients spend much time at the facility. Prolonged waiting time at the facility can be caused by shortage of staff, lack of equipment or malfunctioning of equipment such as thermometers, weighing scales and blood pressure machines. When there are few staff at the facility one or two rooms will be close and only few will be operating, this makes the system to be very slow. Lack of equipment will make nurses to be walking around the clinic looking for the equipment as they are being shared among all consultation rooms.[16]

Thomas et al.[14] explain that when services are integrated it sometimes led to overload of work to the staff at the facility, leading to patients waiting for long to receive services. This sometimes led patient to go back to their houses unserved and make them come back the next day or some other day for the service and some take long to come back for their follow up.

Integration means services are provided on a daily basis. Some facilities do not offer all the services every day and have specific days for particular services. PLHIV with comorbidities only visits the health center once for all the service and do not need to queue

up to many rooms to receive other services, this have reduced their accessibility to health care, less is spent on transport to seek health services.[9]

"*When services started being provided together, we started spending more time at the facility. Nurses comes to work late. The clinic is supposed to open at 8:00 but they will start helping us at 10:00. Some of us stay very far from the clinic and we struggle getting transport back to our places especially when you spend much time at the clinic, you will find all the transport that were available that day gone already. This make us sometimes to leave the hospital unattended and come back one day which is money consuming".* (P8)

"When we use to be treated at our old ART clinic, we do not use to spend much time especially at the pharmacy because we do not use to be a lot. Only people infected with HIV where being treated there. Unlike when the service are now together all the people are being served at one pharmacy. Waiting time use to be long especially when there is only one staff helping at the pharmacy that day". (P2)

"*Sometimes when there is an emergency at the facility all the nurses or many of them use to leave their consultation rooms and go attend to the emergency leaving us to wait for hours. Sometimes a patient can come to the clinic requiring a lot of services, since all the services are provided in all rooms and every day, that particular patient will spend much time in the room making us wait for a long time".* (P4)

The verbatim from the participant is a clear indication that prolonged time at facilities with integration of services happens mostly due to shortage of staff and limited equipment.

4.3.2.1.3 Bad attitudes from nurses

Despite the good progress in the treatment and care of HIV positive clients, their family and community education on HIV related topics, stigma and discrimination toward PLHIV still continues to prevent people from accessing HIV testing, treatment and care. This type of Stigma within the health sectors is one of the contributing factor to poor health outcome particularly in the field of HIV related care services.[22]

Most health care provider are noted to have limited knowledge and skills thus finding it difficult to cope with people living with HIV. They lack experience in rendering health care to patients with HIV, they have fear of being infected with HIV, concern about possible consequences and lack of self confidence in care provision. These factors can negatively affect providers' performance, expose their safety and compromise the care of the patients.[23] This literature is in support with the findings of this study as evidenced by the following statements from the participants.

"I do not like the way some nurses treat us; they do not touch us with bear hands and sometimes our cards also". (P7)

"Some nurses shout us bad words, not knowing that some of us did not get infected with HIV at our own fault. It is very painful when someone saying to you that that is the reason you got infected with HIV". (P3)

"*I feel like some nurses do not know much in managing our condition (HIV), because we don't get same treatments from them. Especially the new one, a year can pass by without being taken blood for investigation, and when you try to collect them, they will answer*

you bad and sometimes they do not complete our blue files. When we use to collect our medication at our old clinic everything used to be in order". (P4)

Nurses use to have fear of being infected with HIV when providing care to people living with HIV. Social stigma and discrimination against PLHIV aggravate nurses' sense of fear of contracting HIV. Appropriate HIV/AIDS education and training for nurses can improve their attitudes, emotions and self-confidence while providing care to PLHIV and increasing the quality of care provided.[23]

Savina et al.,[22] suggest that bad attitudes including stigma and discrimination from health care workers toward PLHIV are less experienced from health care workers who have been serving in the field of HIV/AIDS program for a long time. The assumption is that through working with PLHIV, health care providers gain more knowledge and experience and familiarize themselves with HIV/AIDS and thus acquire greater willingness to provide better care to PLHIV.

4.3.3 Objective 3: To understand what inputs do PLHIV have on integration system.

The third objective was to find out from participants the inputs they have on the integration system. A theme and two sub-themes where materialized from the study and are described below;

4.3.3.1 Theme 3: Inputs participants have on the integration system.

4.3.3.1.1 Dispensing of medication with integration

Majority of participants expressed that they do not like the way medication are dispensed at the pharmacy because there is no privacy ensured. The pharmacy is facing the waiting

area and there is nothing blocking people to see what medication people are collecting at the pharmacy. Participants really feel good about the integration system since it has reduced discrimination and people would not realize what you come for at the hospital since all the services are being provided in the same rooms. However, people sometimes will notice that you come to get HIV medication or see that you are infected with HIV by seeing the medication you are collecting at the pharmacy. Therefore, participants suggested the following regarding the dispensing of medication.

"Integration is very good, but at least when it comes to dispensing medication at the pharmacy the government must build or put up something to provide privacy so that no one should see what medication others are getting". (P3)

"People must start getting their medication inside the rooms where they are served instead of going to the pharmacy". (P6)

"People working at the pharmacy must stop giving us tablets in those containers as they make noise and most of the people know that those medications are for HIV, instead they must put the tablets in plastic bags like for other tablets". (P5)

Although participants are not happy receiving ART in their original containers, the pills are purposefully packed by manufactures to maintain medication stability and for other therapeutic benefits. The original packaging gives protection against adverse external conditions such as light and moisture, which may be particularly important in tropical climate. Original packaging also comes with information intended to help patients in taking their medication such as instructions about maintaining consistent, timing of taking

the medication, side effects and what to do in case of experiencing them, expiring date and details that may prevent counterfeiting example branding and serial codes.[24]

The mainly factor that participant do not like with integration is lack of privacy at the pharmacy when medication are being dispensed.

4.3.3.1.2 Cleanliness in the community

"The area is very dirty especially from the hospital to Cucashop. I am kindly requesting my fellow people to please stop throwing away ART medication containers just everywhere as the area is not looking good at all. The ART medication containers are just lying around and they are not looking good". (P4)

"The headman must at least organize a cleaning campaign every year for the community to help with cleaning of the area". (P1)

Participants were asked; why do they think people throw away the containers and what must be done to improve it?

Participant number three said:

"I think is because the noise that containers make when they have pills. That noise is very much uncomfortable. I am suggesting the government to provide us with medication in plastic bags in steady of containers".

Despite improvements in treatment for example combination of pills to reduce taking of many pill at a time, ART is dispensed in socially inefficient and uneconomical packaging. To make the ART medication to be hardly identified and to decrease the risk of being stigmatized, PLHIV often engage themselves in the practice of transferring ART from

their original packaging to their own packaging that they feel comfortable carrying them around. This is done to avoid easily identification, heavy bulkiness and because of the noise the ART medication bottles makes when carryied.[24]

This practice has been noted to cause poor adherence and failure to achieve the targeted viral load suppression. While much of the literature on ART packaging have been identified as one of the contributing factor to poor ART adherence, patient's preferences for ART packaging and packaging attributes that influence the observed ART non-adherence are being studied.[24]

4.4 Summary

This chapter outlined the themes and sub themes from data discussion obtained from interview conducted among PLHIV at Okankolo Health Centre regarding their perspectives on their care being integrated into Primary health care services. Three themes were formulated from data discussion and eight sub-themes were identified and discussed under the themes. Participants were so positive with the integration, though there are still some factors that need to be improved with integration. The following chapter will discuss the study conclusion, limitations and recommendations.

CHAPTER FIVE

CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

5.1 Introduction

Chapter four focuses on discussion and presenting of findings of the study. This chapter defines the results of the study, limitations and conclusion to respond to the main question. This chapter will focus on the recommendations based on the findings presented in chapter three.

5.2 Conclusions

The conclusions of this study are based and linked to the study objectives as indicated below:

Objective 1: To describe the perspectives of PLHIV regarding the integration of their care into primary health care services.

The following statements were drawn to conclusion from the findings regarding the above objective;

- Participants expressed themselves positively regarding the integration system than when they were having an isolated clinic for HIV/AIDS services, because with integration discrimination is reduced, patients feel considered like other patients and in this way, no one sees what you come for at the clinic since all the services are being provided in all the rooms every day.

- Participants also expressed that integration helps them creating bonds with nurses and reduce number of visits to the clinic.

- Although, most of the participants had positive feedback on the integration system, some still face challenges with integration system which includes, long waiting time at the facility, bad attitudes from nurses and lack of privacy at the pharmacy.

Objective 2: To explore the perspectives of PLHIV regarding the integration of HIV/AIDS care into Primary health care services.

During the study data were collected with in-depth face to face interview in order for the researcher to gain more information and understand the perspectives of PLHIV regarding their care being integrated into primary health care services. A total of nine interviews were conducted before data saturation was reached. Among the nine participants that were interviewed, eight of them feel good about integration system and only one who had a neutral feeling regarding the integration system. Rich information on participant's perspectives regarding their care being integrated into primary health care was obtained and is described under objective two.

Objective 3: To understand what inputs, do PLHIV have on integration system.

Following were inputs PLHIV have on the integration system:

- Pharmacy to create privacy when medications are being dispensed.
- Medication to be dispensed in the consultation rooms.
- ART medication packaging needs to be changed to packing that is convenient to everyone which people will hardly identify that it's ART medication.
- People to maintain cleanliness of the community by stopping to throw away medication bottles just everywhere in the community.

5.3 Recommendations

Recommendations are relying on the findings of the study as well as on suggestions made by participants during interviews.

5.3.1 Recommendation to the Ministry of health and social services

- The ministry needs to keep up the integration system at Okankolo Health Centre since patient are in support with it.

- Training and education of integration system should be provided in nursing schools. This will allow the student to collaborate with one another and find ways on how to prevent stigma associated with PLHIV.

- Education on care and discrimination of PLHIV should be provided more often in nursing schools.

- Basic care for HIV/AIDS management to be part of education curriculum in all Nursing schools.

5.3.2 Recommendation to nurses

- Nurses should stop being rude to patients, because this will affect the patients to come to the hospital for their routine services.

- Nurses should familiarize themselves with special programme e.g. online training to gain more knowledge in management of HIV/AIDS.

5.3.3 Recommendation to Onandjokwe Primary Health Care Supervisor

- The supervisor should come up with a better way on how to dispense the ART to patients at the pharmacy since patients feels uncomfortable receiving their medication there.

5.3.4 Recommendation for future research

This study was carried out in rural area were PLHIV have less access to information regarding their care. Therefore, the researcher recommends the same study in the urban area to understand the perspective of PLHIV.

Future studies should also focus on the following:

- Perspectives of nurses and other health care workers regarding the integration of HIV/AIDS into Primary health care.

- Perspectives of PLHIV regarding their care being provided in isolation department at health facilities that are not implementing integration.

- Preferences for packaging of Anti-Retroviral-Therapy for people living with HIV.

- A model to be followed when implementing integration system at health services need to be developed.

5.4 Contribution of the study

This study made a contribution to the Ministry of Health and Social Services in particular. Information from the study findings can help the Ministry of Health and Social Services with guidance to plan for implementation of integration system and to assist with improvements at facilities already implementing integration system in the country. The

information obtained also have identified area of improvement for Okankolo Health Centre regarding the integration system.

5.5 Summary

This chapter covered the conclusions, limitations and recommendation of the study. Recommendations for future research and contributions of the study were also highlighted.

REFERENCE LIST

1. Tshili. lo, A.R., Mangena-Netshikweta, L., Nemathaga, L.H. & Maluleke, M., 'Challenges of primary healthcare nurses regarding the integration of HIV and AIDS services into primary healthcare in Vhembe district of Limpopo province, South Africa', Curationis. 2019. 42(1), a1849. https://doi.org/10.4102/curationis.v42i1.1849

2. Li, X., Wang, H., Williams, A., & He, G. Stigma reported by people living with hiv in south central china. Journal of the Association of Nurses in Aids Care. 2018; 20(1), 22–30. https://doi.org/10.1016/j.jana.2008.09.007

3. Dos Santos, M. M., Kruger, P., Mellors, S. E., Wolvaardt, G., & van der Ryst, E. An exploratory survey measuring stigma and discrimination experienced by people living with hiv/aids in south africa: the people living with hiv stigma index. Bmc Public Health, 2014, 80–80. https://doi.org/10.1186/1471-2458-14-80

4. Druetz T. Integrated primary health care in low-and middle-income countries: a double challenge. BMC medical ethics. 2018 Jun;19:89-96

5. WHO, Astana Declaration on Primary Health Care: From Alma-Ata towards Universal Health Coverage and the Sustainable Development Goals. 28 June 2018.Available at http://www.who.int/primary-health/conference-phc/DRAFT-Declaration on primary health care.

6. Sandhu, Sahil et al. "Integrated Health and Social Care in the United States: A Decade of Policy Progress." International journal of integrated care vol. 21,4 9. 29 Oct. 2021, doi:10.5334/ijic.5687

7. Evans,J.M., Baker, R.G., Berta, W & Jan, B. The evolution of Health Care Strategies'' Annual Review of Health Care Management: Revisting The Evolution of Health Systems Organisation (Advances in Health Care Management, vol.15), Emerald Group Publishing Limited, Leeds, 2018 pp 125-161.https://doi.org/10.1108/S1474-8231 (2014)0000015011

8. Creswel.J W & Creswel . Research design; Qualitative, quantitative and mixed method approaches. (5th ed). UK:SAGE publications; 2014 Mar 31.

9. Zapata, T., Forster, N., Campuzano, P., Kambapani, R., Brahmbhatt, H., Hidinua, G., Turay, M., Ikandi, S. K., Kabongo, L., & Zariro, F. How to Integrate HIV and Sexual and Reproductive Health Services in Namibia, the Epako Clinic Case Study. International journal of integrated care, 2017. 17(4), 1. https://doi.org/10.5334/ijic.2488

10. Creswell. J & Poth. C. Qualitative inquiry and Research design: Choosing among five approaches (4th eds). SAGE publication Inc. 2018

11. Du Plooy-Cilliers, F, Davis, C & Bezuidenhout, R. Research matters. Cape town: Jutta & Company ltd.2014

12. Oxford English dictionary online. Oxford university press. New York. 2018. Accessed 19 May 2024

13. Republic of Namibia ministry of health and social services website. Primary Health Care Services. https://mhss.gov.na. N.D

14. Thomas A. Odeny, Jeremy Penner, Jayne Lewis-Kulzer, Hannah H. Leslie, Starley B. Shade, Walter Adero, Jackson Kioko, Craig R. Cohen, Elizabeth A. Bukusi. 2016 "Integration of HIV Care with Primary Health Care Services: Effect on Patient

Satisfaction and Stigma in Rural Kenya", AIDS Research and Treatment, vol. 5 2016, Article ID 485715. https://doi.org/10.1155/2013/485715

15. Hanlon, C., Nagendra, P., & Martin, P. Challenges and Opportunities for implementing integrated Mental Health Care: A district level Situational Analysis from five Low- and Middle – Income countries. Retrieved from:http://www.ncbi.nlm.nih.gov.2014

16. Paulus.B. Assessing the perseptions of clients and nurses regarding integration of the primary health care services, Okuryangava and wanahenda clinics Windhoek .The University of Namibia .2022

17. Alyafei A, Easton-Carr R. The Health Belief Model of Behavior Change. [Updated 2024 May 19]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK606120/

18. Polit, D.F & Beck, C.T . Nursing research: Generating and assessing evidence for nursing practice. (11th ed. London, England: Lippincott Williams & Wilkins. 2020

19. Brink, H., & Van Rensburg, G. Fundamentals of research methodology and healthcare professional (5th ed). Cape Town, South Africa Juta & Company LTD. 2022

20. Grove, S.K.,Burns. N. & Gray, J. R. The practice of nursing research: Appraisal,synthesis and generation of evidence (9th ed). China: Saunder Elsevier. 2020

21. Mulenga. E. An educational programme to empower mothers and caregivers feeding practives of children under the age of 5 in Oshikoto region Namibia; The University of Namibia: Namibia: 2018

22. Savina V.,Masamine J.,Kimiyo K., Junko Y.,Keiko N.,Jo D & Vanphanom S. An investigation of stigmatizing attitudes towards people living with HIV/AIDS by doctors and nurses in Vientiane, Lao PDR. BMC health services research. 2017 Doi 10.1186/s12913-017-2068-8.

23. Mashallahi A.,Rahmani F., Gholizadeh L & Ostadtaghizadeh A. Nurses's experience of caring for people living with HIV: a focused ethnography.2021

24. Muiruri C,. Jazowski S,. Semvua S,. Karia F,. Knettel B,.Zullig L., Ramadhani H,.Mmbanga B,.Bartlett J & Bosworth H. Does Antiretroviral Therapy Packing Matter? Perceptions and Preference of Antiretroviral Therapy Packiging for people Living with HIV in Northenrn Tanzania. PubMed Central. 2019 doi10.2147/PPA.S238759.

Appendix A: Ethical clearance letter from the University of Namibia

UNAM
UNIVERSITY OF NAMIBIA

ETHICAL CLEARANCE CERTIFICATE

Ethical Clearance Reference Number: DEC OSH 0120 **Date:** 16/04/2024

This Ethical Clearance Certificate is issued by the University of Namibia Ethics Committee (REC) in accordance with the University of Namibia's Research Ethics Policy and Guidelines. Ethical approval is given in respect of undertakings contained in the Research Project outlined below. This Certificate is issued on the recommendations of the ethical evaluation done by the ethics committee.

Title of Project: PERSPECTIVES OF PEOPLE LIVING WITH HUMAN IMMUNODEFICIENCY VIRUS REGARDING THE INTEGRATION OF THEIR CARE INTO PRIMARY HEALTH CARE SERVICES IN OKANKOLO HEALTH CENTER, ONANDJOKWE DISTRICT OSHIKOTO REGION NAMIBIA

Principal researcher: MAGANO HADHELA ANGULA

Staff Number/ Student number: 201403050

Remarks: Low Risk and Approved with minor corrections

Centre for Research Services

Take note of the following:

1. Any significant changes in the conditions or undertakings outlined in the approved Proposal must be communicated to the ethics committee. An application to make amendments may be necessary.
2. Any breaches of ethical undertakings or practices that have an impact on ethical conduct of the research must be reported to the ethics committee.
3. The Principal Researcher must report issues of ethical compliance to the ethics committee (through the Chairperson) at the end of the Project or as may be requested by the ethics committee.
4. The ethics committee retains the right to:
   i) Withdraw or amend this Ethical Clearance if any unethical practices (as outlined in the Research Ethics Policy) have been detected or suspected,
   ii) Request for an ethical compliance report at any point during the course of the research.

The ethics committee wishes you the best in your research.

Prof Hans J Amukugo (Oshakati Campus Chairperson Decentralized Ethics Committee)

Prof. Davis Mumbengegwi (Head, Multidisciplinary Research)

Appendix B: Permission letter from the Ministry of Health and Social Services

REPUBLIC OF NAMIBIA

MINISTRY OF HEALTH AND SOCIAL SERVICES

Ministerial Building
Harvey Street
Private Bag 13198, Windhoek

OFFICE OF THE EXECUTIVE DIRECTOR

Tel: No: 061 -203 2507
Fax No: 061-222 558
Andreas.Shipanga@mhss.gov.na

Ref: 22/4/2/3
Enquiries: Mr. A. Haufiku

Date: 28 May 2024

Ms. Magano H. Angula
PO BOX 259
Ondangwa
Namibia

Dear Ms. Angula

Re: Perspectives of people living with Human Immunodeficiency Virus regarding the integration of their care into Primary Health Care Services in Okankolo Health Centre, Onandjokwe District Oshikoto region Namibia.

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**
   - 3.1 The data to be collected must only be used for academic purpose;
   - 3.2 No other data should be collected other than the data stated in the proposal;
   - 3.3 Stipulated ethical considerations in the protocol related to the protection of Human Subjects should be observed and adhered to, any violation thereof will lead to termination of the study at any stage;
   - 3.4 A quarterly report to be submitted to the Ministry's Research Unit;
   - 3.5 Preliminary findings to be submitted upon completion of the study;
   - 3.6 Final report to be submitted upon completion of the study;
   - 3.7 Separate permission should be sought from the Ministry for the publication of the findings.
4. All the cost implications that will result from this study will be the responsibility of the applicant and **not** of the MoHSS.

Yours sincerely,

EXECUTIVE DIRECTOR

BERNHARD NANGOMBE
EXECUTIVE DIRECTOR

All official correspondence must be addressed to the Executive Director.

Appendix C: Requisition letter for permission to conduct a research study

Magano Hadhela Angula
P O Box 259
Ondangwa

12 May 2024
The Permanent Secretary
Ministry of Health and Social Service
Private bag 13198
Windhoek

Dear Sir
RE: REQUEST FOR A PERMISSION TO CONDUCT A RESEARCH

I am Magano Angula, a second year UNAM student pursuing my study towards a master in public health. I am writing this letter seeking for a permission to conduct my research within the ministry of Health and Social Services.

The title of my study is "**Perspectives of people living with Human Immunodeficiency Virus regarding the integration of their care into primary health care services in Okankolo health centre, Onandjokwe district Oshikoto region Namibia.** The study will focus on people living with HIV/AIDS from 18 years and above that collect their antiretroviral drugs at okankolo health center before and after integration system.

Thank you in advance for granting me this permission.

Yours sincerely

Magano Angula

UNAM student

Appendix D: Permission letter from the Oshikoto Regional Health Director

REPUBLIC OF NAMIBIA

MINISTRY OF HEALTH AND SOCIAL SERVICES

Ministerial Building
Harvey Street
Private Bag 13198, Windhoek

OFFICE OF THE EXECUTIVE DIRECTOR

Tel: No: 061 -203 2507
Fax No: 061-222 558
Andreas.Shipanga@mhss.gov.na

Ref: 22/4/2/3
Enquiries: Mr. A. Haufiku

MINISTRY OF HEALTH AND SOCIAL SERVICES
OSHIKOTO REGIONAL OFFICE
2024 -07- 01
PRIVATE BAG 4005,
OMUTHIYA
OSHIKOTO REGION
REPUBLIC OF NAMIBIA

Date: 28 May 2024

APPROVED!
01/07/2024

Ms. Magano H. Angula
PO BOX 259
Ondangwa
Namibia

Dear Ms. Angula

Re: Perspectives of people living with Human Imunodeficiency Virus regarding the integration of their care into Primary Health Care Services in Okankolo Health Centre, Onandjokwe District Oshikoto region Namibia.

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**
   - 3.1 The data to be collected must only be used for academic purpose;
   - 3.2 No other data should be collected other than the data stated in the proposal;
   - 3.3 Stipulated ethical considerations in the protocol related to the protection of Human Subjects should be observed and adhered to, any violation thereof will lead to termination of the study at any stage;
   - 3.4 A quarterly report to be submitted to the Ministry's Research Unit;
   - 3.5 Preliminary findings to be submitted upon completion of the study;
   - 3.6 Final report to be submitted upon completion of the study;
   - 3.7 Separate permission should be sought from the Ministry for the publication of the findings.
4. All the cost implications that will result from this study will be the responsibility of the applicant and **not** of the MoHSS.

Yours sincerely,

EXECUTIVE DIRECTOR
MINISTRY OF HEALTH AND SOCIAL SERVICES

BERNHARD NGOMBE
EXECUTIVE DIRECTOR

All official correspondence must be addressed to the Executive Director.

MyNAMIBIA

Appendix E: informed consent in English

CONSENT FORM TO PARTICIPATE IN A RESEARCH

TITLE: PERSPECTIVES OF PEOPLE LIVING WITH HUMAN IMMUNODEFICIENCY VIRUS REGARDING THE INTEGRATION OF THEIR CARE INTO PRIMARY HEALTH CARE SERVICES IN OKANKOLO HEALTH CENTER, ONANDJOKWE DISTRICT OSHIKOTO REGION NAMIBIA.

I……

agreed to participate in this study. The study has been described to me in a language that I understand. My questions about the study have been answered and I understand that my identity will not be disclosed to anyone at any level of this study. I understand that I may withdraw anytime without any penalty. I am informed that my participation will take approximately 10-15 minutes.

Participant's signature……..

Date…….

Researcher's signature……..

Appendix F: Informed consent in Oshiwambo

EGANDJOZIMININO OKU KUTHA OMBINGA MEPEKAPEKO

OSHIPALANYOLO : EKONAKONO LYOMAIYUVO GAANTU TAALUMBU NOMBUTO YOHIV MOSHIKUMUNGU SHEPANGO LYAWO LYILI MUMWE NOMAPANGO GAKWALUKEHE MOSHIPANGELO SHAKANKOLO, NAMIBIA

Ongame……

ondi itayele oku kutha ombinga mepekapeko ndika. Onda lombwelwa uuyelele kombinga yepekapeko ndika melaka ndi handi popi, na ondeli uvako nawa. Omapulo gandje kombinga yepekapeko ndika oga yamukulwa, nonda kwashilipalekwa kutya kapena gumwe ta vulu oku mona kutya onda kutha ombinga mepekapeko muka.Onduuvithwa ko kutya ondina uuthemba wuku kala inandi kutha ombinga mepekapeko muka kaapena oshilanduli shasha. Onda yelithilwa kutya omapulapulo otaga ka kwata ethimbo lyominute 10-15.

Eshayinokaha lyomukuthimbinga……..

Esiku…….

Eshainokaha lyomupekapeki……..

Appendix G: Interview guide in English

RESEARCH TOPIC: PERSIPECTIVES OF PEOPLE LIVING WITH HUMAN IMMUNODEFICIENCY VIRUS REGARDING THE INTEGRATION OF THEIR CARE INTO PRIMARY HEALTH CARE SERVICES IN OKANKOLO HEALTH CENTER, NAMIBIA.

Introduction

1.1 Greet the participants and introduce myself.

My name and surname

My work place

Clearly explain the purpose of the study and that it is voluntary

Obtain the verbal consent from the participant him/herself

Explain to the participant that the results of the study will strictly only be used for the stated purpose.

Obtain the demographic data of the patient; age, gender, educational level and Occupation.

Main question Central question

May you please explain to me how you feel about HIV services being integrated into primary health care services?

Possible probe questions

How often do you visit the hospital in a year before integration and after integration?

What is that you like and don’t like about integration system?

What changes if there are any that you want to be done in the provision of care with integration system?

Thank you for your time, have a nice day.

Appendix H: Interview guide in Oshiwambo

OMBAPILA YOKUWILIKA OKU NINGA OMAPULAPULO

OSHIPALANYOLO: EKONAKONO LYOMAIYUVO GAANTU TAALUMBU NOMBUTO YOHIV MOSHIKUMUNGU SHEPANGO LYAWO LYILI MUMWE NOMAPANGO GAKWALUKEHE MOSHIPANGELO SHAKANKOLO, NAMIBIA

Efalomo

1.1 Epopitho lyomukuthimbinga, neyipotso lyomupulapuli.

Edhina nofani yandje

Ehala mpa handi longele

Efatululo lyelalakano lyepekapeko, noshowo kutya epekapeko itali li dhengele.

Egandjo ziminino oku kutha ombinga mepekapeko okuza komukuthimbinga.

Ekwashilipaleko komukuthimbinga kutya iizemo yoshikumungu shike otayi kalongithwa owala mpa shuuthwa.

Uukwatya womukuthimbinga; oomvula, omukwashike kokantu, uulongelwe we, neyithano lye.

2. Enenodhiladhilopulo

Owuvitile ngiini oshinima shepango lyaantu taalumbu nombuto yoHIV, lyi li mumwe nomapango gakwalukehe?

Omalandulithopulo

Koshipangelo oho yako iikando ingapi momvula manga omapango inaaga tulwa mumwe nokonima sho omapango gatulwa mumwe?

Oshike wu hole naashi kuuhole moshinima shomapango geli mumwe?

Omadhiladhilo geni wuna po, wahala ganingwe shinasha nomapango ngano eli mumwe?

Tangi unene ke kuthombinga lyoye, esiku nali kale ewanawa.

Appendix I: Sample of a transcript

TRANSCRIPT OF AN INTERVIEW ON PERSPECTIVES OF PEOPLE LIVING WITH HIV REGARDING THE INTEGRATION OF HIV CARE INTO PRIMARY HEALTH CARE SERVICES AT OKANKOLO HEALTH CENTER, ONANDJOKWE DISTRICT OSHIKOTO REGION

PARTICIPANT NUMBER: 8

DATE: 02 JULY 2024

TIME: 14:50 to 15:20

PLACE: OKANKOLO HEALTH CENTER

LANGUAGE: OSHIWAMBO (Translated to English)

AGE: 42

RESEARCHER: Good afternoon sir?

PARTICIPANT: Afternoon madam?

RESEARCHER: My name is Magano Angula, I am a registered nurse by profession. I am currently pursuing my study toward master in public health. I am conducting a research study on perspectives of people living with HIV regarding the integration of their care into primary health care services at Okankolo health center. The aim of the study is to explore the perspectives of people living with HIV with their care being integrated into primary health services. The study is voluntary and nothing will happen if you refuse to participate in the study. I therefore asking you to grant me a permission to interview you on this

matter. Your identity will not be relived and the result of the study will only be used where it is needed.

PARTICIPANT: Yes madam, I am willing to take part in the study we can proceed.

RESEARCHER: Thank you for granting me the opportunity to interview you. May you please tell me your age, your highest qualification and what you do for a living?

PARTICIPANT: I am 42 years, I only have a grade 12 certificate and I am a health assistant.

RESEARCHER: Okay, how do you feel about the HIV care being integrated into primary health care services?

PARTICIPANT: I personally feel good about it, because in the past us that are living with HIV have been isolated from others because we use to have our own clinic. With integration all the people are being treated I the same rooms, you get treated there and all the services are provided in that room and no one will notice what you come for at the clinic. When the clinic was isolated people use to be shy going there and some end up defaulting their treatment.

RESEARCHER: Is there a different in the numbers of times you visit the clinic before and after integration?

PARTICIPANT: Yes, there is really a different, before integration I use to visit the clinic many times in a month sometimes because, our clinic was isolated from the main clinic and our clinic does not offer all the services. I use to find myself coming for my routine follow up, the following week I have to come back for hypertension follow up and the

other week for TB follow up. When we started with integration, I only visit the clinic once for all my services because the nurse knows me well and all my follow up are merged together. It really saves us a lot because many of us this side travel long distance to the clinic and we pay a lot of money for transport.

RESEARCHER: What is that you like about integration, or you want it to remain with integration?

PARTICIPANT: mhhh…. I prefer integration to remain, it is really helping, it must not be changed, and it is really helping.

RESEARCHER: Is there anything you don't like about integration?

PARTICIPANT: Aaag.. now that all people are being treated in the same facility, most of the people know the labelling of Anti-Retroviral pills. I do not like the way medication are being issued at the pharmacy. Most of the time people use to see the medication you are getting at the pharmacy. I am therefore suggesting at least to be done something that will prevent others from seeing what others are collecting at the pharmacy.

RESEARCHER: Okay sir, we come to the end of our interview, do you have a question or anything you want to add?

PARTICIPANT: No I do not have anything to ask nor to add.

RESEARCHER: Alright, thank you sir for your time have a nice day.