BARRIERS TO ANTIRETROVIRAL THERAPY ADHERENCE
AMONG INMATES LIVING WITH HUMAN
IMMUNODEFICIENCY VIRUS/ACQUIRED IMMUNE
DEFICIENCY SYNDROME AT WINDHOEK CENTRAL PRISON

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE
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By

NAUYELE NANDJILA SHALIHU

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Main Supervisor: Dr. L. Pretorius
Co-supervisor:       Mrs.N.Shifiona

DECLARATION

I hereby declare that, this thesis is my own work and effort and that it has not been submitted anywhere for any award, where other sources of information have been used, they have been acknowledged.

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DEDICATION

This study is dedicated to all the inmates who are affected and infected with the HIV/Aids and are on ARV medication at Windhoek Central Prison.

Secondly this study is dedicated to my Supervisor Dr.Louise Pretorius; this would have not been possible without you.

Another dedication goes to my dear Husband Eliakim Inicko Shalihu for his love, patience and inspiration during this period of studies. Without your assistance for financial support this study would have not materialised.
Finally I would like to dedicate this study to my dearest sisters for all the love and support.

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ABSTRACT

This research aimed at assessing the barriers to ARV therapy adherence among inmates living with HIV/AIDS at Windhoek Central Prison. The researcher was interested in determining what are the barriers to adherence to ARV therapy in
prison, and how these barriers can be addressed to assist inmates in Windhoek Central Prison to adhere to their ARV therapy.

A qualitative, descriptive, explorative, phenomenological and contextual research was conducted to assess the barriers to ARV therapy adherence among inmates living with HIV/AIDS at the Windhoek Central Prison. Data was collected by means of in-depth interviews. Data was analysed manually by the researcher using the coding system that consists of categories, classification, rules and the words assigned to categories. The results of the interviews were divided into themes and categories.

Trustworthiness was ensured throughout the whole process of data collection by using criterion of credibility, dependability, transferability and confirmability to avoid the criticism of lack of control over quality of the findings in qualitative research. Ethical consideration in this research was maintained throughout the study.

During the course of the study the research study managed to identify gaps in ARV treatment and discovered that many factors were at play in hampering the adherence to ARV therapy. Such factors include stigmatization by fellow inmates and prison officials; lack of support groups in prison, lack of watches or wall clocks to stick to the time, lack of sufficient nutritional food and lack of adequate information on ARV.
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Abbreviations

HIV/AIDS – Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
ARV  –  Antiretroviral
ART  –  Antiretroviral therapy
BCC _  Behaviour Change Communication
CHRI _  Commonwealth Human Rights Initiative
IEC _  Information Education Communication
ISKON _  International Society for Krishna Consciousness
LAC _  Legal Assistance Centre
MoHSS _  Ministry of Health and Social Services
STI _  Sexual Transmitted Infection
TAC _  Talk About ARVs
TV _  Television
UNODC _  United Nations Office on Drugs and Crime
WCP  –  Windhoek Central Prison
WHO _  World Health Organisation

CHAPTER ONE
INTRODUCTION

1.1 Background

The Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) have changed the world in general but more specific the face of the Public Health Care Sector in unimaginable ways. About 33, 3 million people were living with HIV as of 2009, 2.5 million (1.6 million – 3, 4 million) of them were children under 15 years, and about 15, 9 million were women (UNISEF 2009, p.1). During the same year (1, 6 million - 2, 1 million) people died of AIDS. Almost two thirds of the worlds’ people infected with HIV live in sub-Saharan Africa, though every region of the globe is affected by the epidemic. The fastest growing epidemics are currently observed in Eastern Europe and Central Asia. HIV is a global problem, affecting people in every country (UNODC, 2008, p.7). Namibia is no exception to this world crisis.

HIV/AIDS has been a leading cause of death since 1996 in Namibia. In 1999 AIDS was responsible for 26% of all reported deaths, and for 46% of deaths in 15- 49 years age group. According to the 2001 housing census, the number of deaths has increased to 80% in the three preceding years. The Ministry of Health and Social Services estimates that in certain parts of the country between 50-70% of hospital admissions were HIV/AIDS related (MOHSS, 2004-2009, p. 4). In 2010, Namibia had an HIV prevalence rate of 18.8% in adults ages 15 to 49, which is lower than 19.9% in 2006( MoHSS 2010, p. 4). However, the figure is still quite distressing. The peak occurred in 2002 when Namibia’s prevalence hit 22%. The most recent survey (MoHSS 2010, p.6,
UNICEF, 2009, p.3) further indicates that HIV prevalence is highest at 27% in the 30-34 year-old age group.

HIV /AIDS pose the most serious development challenge for Namibia during the next 10 to 20 years. The negative impact of the HIV/AIDS epidemic on all sectors of the Namibian economy is already being felt, and is expected to increase considerably over the next decade.

The impact of HIV/AIDS on the Namibian education sector constitutes a major threat to the nation’s human capacity and as a consequence, the country’s ability to sustain consistent and competitive performance and its prospects of attaining its Vision 2030 goals. (Asemota, 2004, p.1).

Economic Impact of AIDS on Households, death results in a permanent loss of income, from less labour on the farm or from lower remittances; funeral and mourning costs; and the removal of children from school in order to save on educational expenses and increase household labour, resulting in a severe loss of future earning potential (Bollinger & Stover, 1999).

Economic Impact of AIDS on Agriculture HIV/AIDS in Namibia “will exacerbate the present decline in farming output and/or per capita food production, widening income disparities, increased food prices and exodus to cities already crowded with unemployment (Bollinger, & Stover, 1999).
All levels and sections of the Namibian population are being negatively affected by the spread of this virus. Adverse effects on social cohesion, human development and economic advancement are some result of the epidemic (MOHSS, 2004-2009, p. 1). Although Namibia has made tremendous strides against the fight of this epidemic, the prison sector is one of those areas that have been the least attended to.

HIV/AIDS is a serious threat to an estimated 10 million people in prisons across the world. In most countries the levels of HIV infection among prison populations are much higher than among the population outside prisons, but the prevalence of HIV infection in different prisons within and across countries varies considerably. In some cases the prevalence of HIV infection in prisons is up to a hundred times higher than in the community (UNODC, 2008, p.8).

The Namibian prisons are no exception to this profile. There are thirteen prisons in Namibia of which the Windhoek Central Prison (WCP), a maximum security prison, is the largest. Namibia currently ranks among the top five African countries with the highest percapita rates of imprisonment, with 267 per 100,000 people currently serving sentences in prison or in pre-trial detention (Legal Assistance Center 2010, p 5).

Although Windhoek Central Prison can cater only 901 inmates, the prison currently accommodates 1300 inmates. Such overcrowded conditions are putting inmates at
risk of becoming infected with different infectious diseases such as Tuberculosis, Hepatitis etcetera. (HIV in prisons and jails, 2010, January 29).

According to the records of the correctional services in Namibia 333 inmates tested HIV positive from 2008-2009 and 122 inmates are on ARV therapy. The researcher was motivated by the high number of inmates on ARV therapy and believed that they, among the inmate population would understand ARV therapy best. For this reason the study was undertaken in Windhoek Central Prison (WCP) (Ministry of Prisons and Correctional Services Prison statistic 2008-2009, p 1).

According to Marais, (2000) HIV/AIDS Charter of Rights, any person diagnosed with HIV/AIDS should have access to adequate health care, affordable treatment and drugs including Antiretroviral Therapy (ART) and prisoners should not be discriminated against on the basis of their HIV status (Marais, 2000, p. 8). This is in relation to the Constitution of Namibia (NID, 2002 Article No: 10) that states that no persons may be discriminated against on the grounds of sex, race, colour, ethnic, origin, religion, creed, or social or economic status (NID, 2002, p.23).

According to the MOHSS (2007) antiretroviral are medicines that inhibit the replication of HIV thereby lowering the level of the virus in the blood and improving the immune system. Antiretroviral therapy is a process of administering ARV drugs to people with HIV and it includes assessing for eligibility, dispensing ARVs, monitoring adherence, managing side effects.
The challenge with antiretroviral therapy lies in the adherence thereof. Adherence refers to how closely patients follow their treatment programmes (Haynes, 2001, p.106). Treatment adherence means adhering to your treatment regimen taking the correct dose of each medication at the correct time and exactly as prescribed. Adherence is very important for successful HIV treatment (U.S. Department of Health and Human Services, June 2011)

It is widely recognised that adherence to antiretroviral therapy is critical to long term treatment success. According to Kimmerling, Wagner and Ghosh - Dastidar (2003) the introduction to antiretroviral therapy in the United State of America in 1966 led to a significant decline in HIV/AIDS related morbidity and mortality in that country. The introduction of antiretroviral medication to the public health sector has been fairly recent in Namibia since year 2003 (Avert, 2011).

Anti-Retro Viral (ARV) therapy had become necessary because of the high number of HIV-positive Namibians and has been described as a success (Avert, 2011).

Despite the success rate in treatment of HIV/AIDS with antiretroviral drugs a lot still needs to be done to inform patients to enhance their understanding and give support to those patients on treatment to enable them to adhere to the scheduled treatment. Being on ARV therapy poses a challenge to patients in different ways owing to the barriers to adherence that exist. According to the World Health Organisation (2006)
the barriers to adherence for prisoners on antiretroviral therapy refers to specific time of medication, side effects of ARV drugs, ignorance and nutritional status. Lack of treatment supporters and re-infection were also pointed out as factors affecting ARV adherence (UNODC, 2008, p.11).

World Health Organisation (2006) states that persons on ARV therapy should receive adherence counselling and should be informed about the effect of their life style and the medication on their body. Continuous counselling should be maintained throughout treatment but this is difficult in prisons because the nurses who are doing the counselling are already overloaded with their general clinical work. Patients on ARV therapy should get support, adequate rest, nutritious food, and exercise and should live in a clean environment to prevent opportunistic infection.

All these issues pose severe challenges to inmates because policies and regulations in the prison setting are mainly aimed at correctional actions. The prison environment is not always conducive for health services per se, because within the correctional services framework, prison authorities are not always health orientated, therefore prisons do not have strong health units (WHO, 2006).

Although there is health professionals in correctional institutions, employed to form a multidisciplinary team, Haoses-Gorases (2007-2008) state that their workload influences the quality of care they deliver. The same problem applies to the nurses who are employed by the prison, because the clinic has beds where inmates who are ill must be cared for in the health centre. These beds are almost always occupied with
sick inmates. This leaves little time to attend to inmates who are on Antiretroviral Therapy (ARV) and suffering from side effects.

1.2. Problem statement

It is the experience of the professional nursing staff in the prison clinic that inmates do not always understand the importance of their treatment because they are not seemingly well informed about ARV and as a result do not adhere to their treatment. Some stop taking ARV therapy or they sell the drugs to other inmates who then smoke it. WHO (2006) states that patients with poor adherence to ARV therapy have increased viral infections and reduced CD4 cell count.

According to the Ministry of Health and Social Services (MOHSS) (2007) people living with HIV/AIDS, who are on ARV therapy, face various challenges. It is in view of the aforementioned information that the researcher was interested to assess possible barriers to ARV therapy adherence among inmates living with HIV/AIDS at Windhoek Central Prison (WCP).

It was clear from observations in the course of contact with inmates that not all were able to comply with adherence to their ART, therefore the researcher was confronted with the question of what are the barriers to adherence to ARV therapy in prison, and how these barriers can be addressed to assist inmates in Windhoek Central Prison to adhere to their ARV therapy.

1.3. Purpose of the study
The purpose of the study was to assess possible barriers to adherence to ARV treatment in the Windhoek Central Prison and to determine how these barriers can be addressed.

1.4. Objectives of the study

Objectives of the study were to:

- Explore and describe barriers to adherence to ARV therapy in Windhoek Central Prison.
- Make recommendations to address the barriers to adherence to ARV therapy in prison and to assist inmates to adhere to their ARV therapy.

1.5. Significance of the study

The results of the study will enable the researcher who is employed by the Ministry of Safety and Security, Department of Prison and Correctional Services, to make recommendations to the prison authorities regarding the requirements of inmates on ARV therapy to enhance the rate of adherence. No similar study could be located that had been conducted within this context in Namibia and recommendations will greatly benefit the prison community who are on ARV therapy since the prison policy may be amended to accommodate the needs of inmates on ARV therapy.

1.6. Definition of concepts

The key concepts that apply to the study are defined as follows in a logic order.
- HIV: Refers to Human Immunodeficiency Virus, a retrovirus that may lead to AIDS in humans. (WHO, 2006).

- AIDS: AIDS refers to Acquired Immune-Deficiency Syndrome which is the advanced stage of Human Immunodeficiency Virus infection. (WHO, 2006)

- Antiretroviral (ARV) refers to the medicines that inhibit the replication of HIV and thereby lowering the level of the virus in the blood and improving immune system. (WHO, 2006).

- Antiretroviral therapy (ART): ART refers to a process of administering antiretroviral drugs to people with HIV (WHO, 2006). In this study this refers to administering of antiretroviral drugs to inmates in Windhoek Central Prison.

- Adherence: Adherence refers to a patient’s ability to take ART medications exactly as prescribed, follow a prescribed care plan, attend follow up visits, and has required laboratory tests done, take medication on time, adopt a healthy life style and avoid risky behaviours (Haoses-Gorases, 2007-2008). This study focused on the adherence of inmates in Windhoek Central Prison to their prescribed treatment plan.

- Barriers: In general barriers are defined as obstacles to access (Soanes, 2008, p.65). This study focused on barriers (obstacles) that prevent inmates in Windhoek Central Prison on ART regimens to adhere to their treatments. (Haoses-Gorases, 2007-2008, p.271).

- Adherence Counselling: According to (MOHSS, 2010) Adherence Counselling and Comprehensive Health Care, barriers to ARV are depression and other psychiatric problems, substance abuse, difficult life conditions, negative or
judgemental attitude of health provider/ any person closer to the patient, system barriers, stigma and discrimination.

This study focused on difficult life condition (imprisonment), Negative or judgemental attitude of health provider/ any person closer to the patient (fellow inmates and prison staff), System Barriers and Stigma and discrimination.
- Correctional: The term refers to the process of correcting something or being corrected (Allen, 2007, p.153). In this study, the term correctional refers to the Windhoek Central Prison facility.

- Inmate: Inmate is a person living in an institution such as a prison or hospital (Soanes, 2008, p.464). For this study the term refers to people who were sentenced to imprisonment for a period of time at Windhoek Central Prison.

1.7. Summary
The research problem that was formulated focused on the assessment of barriers to ARV therapy adherence among inmates living with HIV/AIDS at Windhoek Central Prison. The ultimate aim of the study was to assess possible barriers to adherence to ARV treatment in Windhoek Central Prison, and to determine how these barriers can be addressed. As an employee within the clinic of the Windhoek Central Prison, the researcher also focused on ways to improve the rate of adherence to the wellbeing of the inmates.
CHAPTER TWO

RESEARCH DESIGN AND METHODS

2.1 Introduction

This chapter contains practical information on how the research was designed and how it was conducted. This chapter offers the readers important insights on methodological approaches. Data collection and assessment strategies, interpretation methods and important ethical considerations are also covered in this chapter.
2.2 Research design

A research design is a plan or a blueprint on how you intend conducting the research (Mouton, 2001, p.55). Research design is a systematic plan of what is to be done, how it has been done and how the data has been analysed (Polit & Beck, 2008, p.232). Research design basically shows what the major topics in the research are and their details. It provides an outline how the research has been carried out and the methods that has been be used. It includes an abstract of the research study, descriptors of the research design, dependent and independent variables, the assumption and limitation of the research, research question, sampling design and format for the data showing how data had been presented (Polit & Beck, 2008, p.232).

A qualitative, explorative, descriptive, phenomenological and contextual research design was utilized to assess the barriers to ARV therapy adherence among inmates living with HIV/AIDS at the Windhoek Central Prison.

According to Creswell, (1994) the design of the study begins with a selection of a topic which in case of this study was barriers to the adherence of ART. The research design selected must be based on the rational and nature of the study (Robert, 2004, p.134).

2.2.1 Qualitative research
The qualitative approach is usually chosen when the researcher aims to understand a lived experience for several individuals about a concept or the phenomenon (Creswell, 1998). It seeks to gain insight through discovering the meaning attached to a given phenomenon therefore a qualitative design was found applicable to assess the barriers to ART adherence. These insights can then be used to improve nursing practice (Burns & Grove, 2005, p. 52). This design is therefore considered appropriate for the study because the researcher focused on the inmates’ perceptions and descriptions regarding their own ARV treatment. The study was confined to the Windhoek Central Prison as the specific setting. Locke, Spirduso and Silverman (2000) cite the following characteristics of qualitative research design whereby the researcher applied these to her study in the following way:

- Qualitative researchers work inductively; try to create theories that help them understand their data. In this study the researcher worked inductively from what she observed while working in the clinic of the Windhoek Central Prison.

- In qualitative research participants are studied to understand how they interact with their world, how they experience the world, how they feel, believe, and how they explain structures and relationships. The focus of this research was on how the inmates adhere to their ART. The researcher wanted to understand their world of adhering to their treatment.

- Interview and various forms of observation are used to collect data; data takes the form of interview transcripts, observations, and field notes. Reports contain detailed descriptions of participants. Interviews were conducted in this study and all interviews were transcribed.
The researcher collects the data where the behaviour of interest naturally occurs.

Qualitative research requires ongoing analyses of data gathered. Data for this study was gathered until saturation was reached.

Researchers attempt not to be intrusive towards participants. The researcher adhered to the code of ethics to protect the name of participants. The researcher also refrained from being intrusive.

The primary interest is to understand the social process by which results are created and the final analyses of the researcher is the primary instrument of inquiry.

Qualitative researchers try to be cognisant of the perspective they bring to the study.

The planning of and preparation for qualitative research are carefully considered.

Reports are written in a first person, using expressive language in order to make findings accessible and powerfully persuasive.

This is the study inquiring into the lived experiences of the Barriers to ARV adherence among inmates living with HIV/AIDS at Windhoek Central Prison.

The researcher has been following the phenomenological approach in this research. The researcher is concerned with describing the lived experience of the participants and assessing the meaning of the phenomena as expressed through the individual. De Vos, et al. (2005) states that a phenomenological approach aims to understand
and interpret the meaning that participants give to their everyday lives. The researcher should be able to place herself in the participant’s lived world or real life setting (De Vos, Strydom, Fouche and Delport, 2003, p.273). As the nurse in charge of the clinic, the researcher has come to know the life world of prisoners and could therefore associate with the conditions.

2.2.2. Explorative approach

Shield & Tajalli (2006) states that explorative research is a type of research conducted for a problem that has not been clearly defined. Explorative research helps determine the best research design, data collection method and selection of subjects. It should draw definitive conclusions only with extreme cautions. Exploratory research relies on secondary research such as reviewing available literature or data or qualitative approaches such as informal discussion with employees and more formal approaches through in-depth interview, focus group or case studies. The results of exploratory research are not usually useful for decision making by them, but they can provide significant insight into a given situation. In an exploratory study the researcher has a basic research goal, and researchers frequently use qualitative data (De Vos, Strydom, Fouche and Delport, 2003, p.273). The researcher was interested in exploring the view and experience of the participants in this study with particular interest in antiretroviral therapy. The researcher was motivated to explore the phenomenon because little information is available on this topic (Creswell, 1994, p.10). To ensure that this research was exploratory, in-depth interviews were conducted with inmates living with HIV/AIDS those on ARV at Windhoek Central
Prison on the barriers to ARV adherence among them, to gain the deeper insight into the experience of the inmates those on ARV in particular. The in-depth interview and field notes were transcribed and analysed to produce findings that were used to describe guidelines to address barriers to ARV adherence among inmates living with HIV/AIDS at Windhoek Central Prison.

2.2.3 Descriptive approach

Descriptive research, presents a picture of the specific details of a situation, social setting or relationship (De Vos, et al 2003, p.273). Phenomenological research is done, to help us to understand what is going on in a particular context and to provide clues and pointers to other layers of reality (Silverman, 1994, p.31).

A descriptive study focuses on gaining more information about research conducted within a particular field of study to provide a picture of situations that naturally happen (Burns, & Grove, 2005, p. 232). The study has furthermore been confined to the Windhoek Central Prison as the specific setting.

Descriptive research is where a specific situation is studied to see if it gives rise to any general theories and to see if general theories arise from the specific situation being studied (Goddard & Melville, 2005, p.9). De Vos, et al (2003) state that in qualitative research, description is more likely to refer to more intensive examination of phenomena, and their deeper meanings thus leading to thicker description.
In this research a comprehensive and in-depth description of the barriers of inmates living with HIV/AIDS in the Windhoek Central Prison about their ARV adherence and challenges thereof was investigated.

2.2.4 Contextual approach

Contextual research is a careful study characterised by investigation or inquiries. It is a systematic and repeatable technique used to carefully learn about the circumstances in which events occur (Kolko, 2007, p. 21). The basic message of qualitative researchers is that whatever the sphere in which the data are being collected, we can understand events only when they are situated in the wider social and historical context. The data collected through in-depth interview need to be viewed from the perspective of the participant’s context (Silverman, 1994, p.31). This study was confined to the context of Windhoek Central Prison.

2.2.5 Phenomenological approach

Phenomenology is both a philosophy and a research method. The purpose of phenomenological research is to describe experiences, as they are lived- in the phenomenological terms to capture the lived experience of study participants (Burns & Grove, 2005, p.55). In this study, adherence to ARV therapy in prisons is a phenomenon that was not researched before, and the researcher was aiming to explore this lived experience of the inmates at Windhoek Central prison.
Research Methods

The research methodology is a system of principles or methods of procedure in any discipline such as education, research, diagnosis or treatment. It is the section of a research proposal in which the methods to be used are described. The research design, the population to be studied and the research instruments or tools to be used are discussed in the methodology. The choice of a research design depends on the researcher’s expertise, the problem and purpose of the study and the desire to generalise the findings (Burns & Grove, 2005, p. 40).

2.3 Target population

A population is described as all elements (individuals, objects or substances) that meet some criteria of inclusion in a given universe (Burns, & Grove, 2005, p. 40). The population of interest for this study was all male inmates who are tested HIV positive at Windhoek Central Prison (WCP) and who are on ART. The population consisted of (122) male inmates only aged 18 years and above because Windhoek Central Prison does not accommodate any female prisoners.

2.4 Sampling.

Sampling involves selecting a group of people, events or behaviours or other elements with which to conduct the study (Burns & Grove, 2005, p.40, 341). A non-probability, purposive sampling technique was conducted as a method of selecting the sample. Non-probability sampling implies that not every element of the population has an opportunity to be included in the sample (Burns & Grove, 2005,
This technique was applicable to this study because a selective population from all inmates was taken, namely the inmates with HIV/AIDS on ART. Williams (2006) indicates that purposive sampling is done with a specific purpose in mind. A purposive, also known as selective sampling method was considered applicable to this study because of the focus on inmates who are receiving ART.

Samples must be representative of the population being studied otherwise no general observations about the population can be made from studying the sample (Goddard & Melville, 2005, p. 35). Dawson (2006) state that it may be difficult to specify at the beginning of the research how many participants will be approached. The sample size was determined by data saturation, where no new information was captured.

Creswell (1998) is of the opinion that the researcher must choose participants based on their ability to contribute to an involving theory. The inclusion criterion for this study was that the inmates living with HIV/AIDS should be on ARV therapy for at least six months at Windhoek Central Prison. The sample selection was purposeful therefore purposeful selection of sample was used in this study which were inmates on ARV for six months and above.

**Recruitment of subjects for participation**

Due to the sensitivity of the topic, inmates on ARV therapy were individually recruited for in-depth interview; they have been approached when they came to the clinic for ARV medication review, and this has been done to avoid suspicion among other
inmates if they were approached otherwise. Burns & Grove (2005) indicate that the success of recruitment depends on the approach by the researcher. Their emphasis was on a pleasant, positive, informative and non-aggressive approach. The researcher approached individuals with a non-judgmental and informative attitude to obtain informed consent.

The informed consent was given to each inmate recruited to read and to understand about the in-depth interview to come. The informed consent was read again and signed by the participants on the date of interview. The inmates were given enough time to decide on their participation in the research and they knew that they could withdraw anytime.

2.4.1 Sample size

The sample was taken from the 122 inmates tested between 2008-2010 and who have been receiving ART for at least 6 months. Only inmates that voluntarily consented to participate were included in the study. The researcher believes that these inmates have enough experience on ARV therapy which enables them to answer the research questions. Initially 20 inmates agreed to participate of which 2 withdrew during the data collection. The reason of withdrawal was that they were no longer interested to be interviewed. Therefore 18 interviews were conducted.

2.5. Setting for the study

This study was conducted within the setting of Windhoek Central prison.
2.6. Data collection instruments

An Interview guide was used as the focus of the data collection was on in-depth interviews. The unstructured questions were used supported by the verbatim records that were taken by the researcher herself.

2.7. Data collection

Data collection is the process of gathering data from the subjects. This calls for active involvement by the researcher especially in qualitative research (Burns & Grove, 2005, p.430, 539).

To avoid suspicion and stigma, inmates were approached when they came for review of ARV drugs at Windhoek Central Prison Clinic. The information about their voluntary participation in an interview on ARV therapy, confidentiality and anonymity were shared with them. Enough time was given for such inmates to consider their participation. Signed consent was obtained before the interview started. Since it is the responsibility of the researcher to establish a positive environment for an interview, a quiet room for interview was selected to create this peaceful and conducive environment. Individual in-depth interviews with 18 male inmates on ART were conducted. Interviews continued until no new information or data was received from the participants (saturation of data) (Law, M., Steward, D., Letts, L., Pollock, N., Bosch, J. and Westmorland, M.1998).
All participants were inmates on ARV therapy for at least six months and more and have experience to provide quality information about the topic. Because of the sensitivity of the topic as well as the consideration of the research ethics on interview guide, confidential, in-depth interviews were conducted with inmates at WCP who are on ART on the barriers to ARV therapy adherence for them, and also by recording all the verbatim data collected (Creswell, 1998, p.122). The verbatim records from in-depth interview were transcribed and analysed to produce findings that were used to describe guidelines to address barriers to ARV adherence among inmates living with HIV/AIDS at Windhoek Central Prison.

An unstructured question was asked to inmates about their medication and how they adhere to the treatment (Burns & Grove, 2005, p.539). E.g. are you on ARV therapy? Do you take ARV medication as prescribed?) Probing was done where needed. The information collected was documented by the researcher herself. However the researcher verified with each respondent that what she recorded in writing was the true version of his response.

2.8 Data analysis

Burns & Grove (2005) states that traditionally, qualitative data collection and analysis have been performed manually. Data was analysed manually by the researcher with a coding system that consists of categories, classification rules and the words assigned to categories. Codes are then sorted into sub-themes and main themes based on how different codes are related and linked (Klenke, 2008, p. 96).
According to Tesch in (Creswell 1994) a phenomenological study data analyses are conducted to reduce and organize data, in order to produce findings that can be interpreted by a researcher. In this study the transcriptions from individual in-depth interviews and verbatim were coded and used to reduce the information to themes (Creswell, 1994, p.154).

In this study Tesch’s eight step method of data analyses has been used (Creswell, 1994, p155; Robert, 2004, p.143). These steps and the execution thereof are described as follows:

1. Read through all transcriptions and make notes of ideas as they come to mind.
   The researcher made sure she understood every transcription before going on to the next interview.

2. Pick the shortest or more interesting interview and find underlying meanings.
   Write your notes in the margin.

3. Follow this procedure for a few participants. Make a list of all the topics which arise and cluster similar topics together, and leftovers.

4. Give these topics codes and write the codes next to the appropriate segment of the text, and see if new categories and codes emerge.

5. Find the most descriptive words for the topics and turn them into categories.
   Try to reduce the total list of categories by grouping text that relate together.

6. Make a decision on the abbreviation of categories and alphabetise these codes.

7. Bring the data material belonging to each category together in one place and perform a preliminary analysis.
8. Re-code the data if necessary. Coding ends at the point of theoretical saturation when further coding, enrichment of categories, and so on no longer provides new knowledge (Klenke, 2008, p. 94).

Creswell, (1998, p. 142) suggests that “data analyses is not off-the-shelf, rather it is custom-built, revised and choreographed”. The steps used in the data analysis ensure a systematic approach to data analysis (Creswell, 1994, p.155).

2.9 Literature control

A literature review is an organized written presentation of what has been published on a topic by scholars. The purpose of the literature review/control is to convey to the reader what is currently known regarding the topic of interest. The review/control should be organized into sections that present themes or indentify trends (Burns & Grove, 2005, p.93).

In qualitative research, the purpose and the timing of the literature review varies based on the type of study to be conducted. Phenomenologist believe that the literature should be reviewed after data collection and analysis so that the information in the literature will not influence the researcher's openness (Burns & Grove, 2005, p. 95).

According to De Vos, et al (2005) a review of literature is aimed at contributing towards a clearer understanding of the nature and meaning of the problem that has been identified. Literature is an excellent source for choosing or maintaining focus on
a chosen topic, as it reduces the chances of selecting irrelevant or outdated topics by investigating what has already been done in a particular problem area. A good literature places a research project in context, it shows the path of prior research and how the current project is linked to the former (De Vos, et al 2005, p. 125). The literature review further demonstrates the underlying assumptions of the general research questions. If possible, it should display the research paradigm that undergirds the study and describe the assumptions and the values the researcher enterprises (Marshall & Rossman, 1995, p.43).

The reasons for the literature review in this study were to acquire a clear understanding of what has been done and what could still be done on that topic, to get definitions and concepts in other studies and to support the findings of the interviews (Bless & Higson-Smith, 2000, p.20).

2.10 Strategies to ensure trustworthiness

Trustworthiness is defined as a process to establish validity and reliability of qualitative research. It also refers to a demonstration that the evidence for the result reported is sound and when the argument made based on the result is strong (Bowen, 2009, p. 26) Trustworthiness in qualitative research demonstrates its truth value, it provides basis for applying it and allows for external judgments to be made about the consistency of its procedure and about the neutrality of its findings or decision (Lincoln & Guba, 1985, p.29).
To avoid the criticism of lack of control over quality of the findings in qualitative research, trustworthiness was ensured throughout the whole process of data collection. Trustworthiness refers to evaluating of qualitative data by assessing the criteria of, credibility; this is a strategy to ensure true value as a criterion of trustworthiness, dependability, transferability, and confirmability (Creswell, 1998, p.197).

In qualitative research the researchers routinely employ member checking, peer review or external audits to validate their studies and researchers' paradigm assumptions (Lincoln & Guba, 1994, p.8). In this study the research expert was approached together with the study supervisor, the sensitiveness of the research topic as well as the area were the research was conducted were considered, the structured questionnaire were observed and the confidential in-depth interview with probing was agreed upon.

Table: 1 outlines the strategies by which trustworthiness was established as well as the specific criteria applying to each strategy and its implementation.

### Table1: The strategies and specific criteria to ensure trustworthiness

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Criteria</th>
<th>Implementation by researcher</th>
</tr>
</thead>
<tbody>
<tr>
<td>Credibility</td>
<td>• Prolonged engagement</td>
<td>Researcher was employed in the prison clinic for a long time before embarking on the study.</td>
</tr>
<tr>
<td>• Triangulation</td>
<td>A group of 18 participants with the same matter of concern (on ARV medication) were used as sources for data gathering. The researcher ensure initial consent process as informative as possible, to keep as much deception out of it as possible. The informed consent was given to each inmate recruited to read and to understand. Enough time was given to the participants to decide on their participation. The freedom of withdrawal at any time was ensured. Peer review was done in this study to verify whether the work satisfies the specifications for review, identify any deviations from the standards, and provide suggestions for improvements.</td>
<td></td>
</tr>
<tr>
<td>• Debriefing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Peer review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transferability</td>
<td>Findings of the study will be shared within all 13 prisons in Namibia. The outcome will thus be meaningful to all Correctional Services in Namibia to enable other prisons to follow same process in own settings.</td>
<td></td>
</tr>
<tr>
<td>Dependability</td>
<td>Audit</td>
<td>Co - coding</td>
</tr>
<tr>
<td>---------------</td>
<td>-------</td>
<td>-------------</td>
</tr>
<tr>
<td>Dense description</td>
<td>Clear description of methods utilised and results were given. The researcher purposively selected the sample as inmates on ARV for 6 months and above at Windhoek Central Prison.</td>
<td></td>
</tr>
<tr>
<td>Purposive sampling</td>
<td>Raw data from interview were colour coded and results were organized into sub themes and themes to be presented in a logic manner according to Tesch's coding. The process of data collection was discussed with the supervisors and other experts to judge the acceptability of the process and procedures. Co – coding was done in collaboration with the supervisor. In order to maintain confidentiality of information, no research assistant was used.</td>
<td></td>
</tr>
</tbody>
</table>

| Confirmability | Audit trial | Individual interviews were conducted. Data were transcribed, analysed to develop themes and sub-themes. No video recording was done. The Researcher constantly reflected on |
2.10.1 Credibility (Truth value)

Credibility refers to the confidence in the truth of data or believability of the data. It establishes how confident the researcher is about the findings based on the research design, respondents and context (Polit & Beck, 2008, p.312).

In this study the following strategies were employed to ensure credibility of the study.

2.10.1.1 Prolonged engagement

The researcher is a supervisor at Windhoek Central Prison clinic for fifteen (15) years now; almost all of the participants were regular clients. Due to the long term services at this particular clinic, a good relationship and trust has been established between the researcher and the clients, hence the clients were comfortable and free to express themselves through interview.

The researcher granted the respondents enough time (two month in advance) to make an informed decision about their participation and to prepare for in-depth interview. The researcher spent an hour to one and half hour with each subject in order to explain the purpose of the study and to conduct interview. The credibility of the findings is enhanced by asking questions and probing for in-depth information.
until saturation of data has been reached. The verbatim information were recorded by
the researcher herself, and the content was verified with the participants at the end of
each interview to internalize the content of the interview.

2.10.1.2 Triangulation
This refers to the use of different sources or different methods in data gathering.
(Polit & Beck, 2008, p. 313). The researcher used in-depth individual interviews and
field notes for purpose of data collection. Due to the sensitivity of the interviews the
researcher could not utilise a tape recorder or research assistant but verified with
each respondent that what she recorded from him was the true version of his
response.

2.10.1.3 Peer review
Though no particular data collection instrument was utilised, peer review was done in
this study to verify whether the work satisfies the specifications for review, identify any
deviations from the standards, and provide suggestions for improvements, the opinion
for an expert in the field of HIV/AIDS, ART and research was utilised.

2.10.2 Dependability
Dependability refers to the stability of data overtime and in different condition (Polit, &
Beck, 2008, p. 315). In this study, dependability was ensured by means of enquiry
audit. This enquiry of audit involved sending the individual transcriptions to
supervisor’s verification and for assistance with data analyses and with the coding of
the data. Consensus discussions took place between the researcher and the supervisor on both categories and themes which emerge from the study. A complete descriptive methodology, a literature control, and verbatim quotes from empirical data were all utilized in data analyses.

2.10.3 Confirmability

Confirmability refers to the objectivity or neutrality of the data in terms of which there would be agreement between two or more independent persons as to the relevance of the data or meaning (Polit, & Beck, 2008, p.315). The researcher sent the field notes, data analyses process and findings to the two study supervisor to establish whether the findings of the study were indeed the product of the study. The two supervisors were working closely with the researcher to ensure confirmability. Triangulation as described earlier also enhances confirmability. Trustworthiness demonstrates its truth value, provides basis for applying it and allows for external judgments to be made about the consistency of its procedures, and the neutrality of its findings or decisions (Lincoln & Guba, 1985, p.29).

2.10.4 Transferability

The research process is densely described to enable other settings to follow the same procedure in their context (Polit, & Beck, 2008, p.316). In this research the sample of male adult inmates were recruited at Windhoek Central Prison and comprises of inmates tested HIV positive and on ARV therapy for 6 months and more.
With the permission of the Commissioner General of prisons the report of this study can be shared among inmates at other prisons in the whole country. Extensive verbatim quotes from empirical data were used in the analyses of the data.

2.11 Ethical Consideration

It is a basic assumption of institutions conducting research, that their researchers are committed to high standards of professional ethical conduct. Researchers have a duty to ensure that their work enhances the good name of their institution and the profession to which they belong. Researchers have an obligation to achieve and maintain the highest standards of intellectual honesty in the conduct of their research. Researchers must be aware of and adhere to ethical principles of justice and veracity and of respect for people and their privacy and avoidance of harm to them as well as respect to non-human subjects of research (Murdoch University, 2006).

Furthermore Chapin (2004) states that the researcher has an ethical responsibility pertaining to all stages of the research namely writing a proposal, carrying out the research, and reporting on the results.

In this study the researcher adhered to the following ethical guidelines:

Due to the sensitivity of the research, the researcher sought permission to conduct the research:

- Preliminary permission was obtained from the Ministry of Safety and Security (Prisons and Correctional Services) and has been obtained. The result of the study is made available to the Prisons and Correctional Services after completion,
though confidentiality will be maintained. Permission was thereafter obtained from the postgraduate committee at the University of Namibia before the study commenced.

- Participants were informed about the purpose and the significance of the study and how the information will be used. The researcher made sure that participants understood that the study will be beneficial to the prison community at large since the recommendations will be based on the research findings. The right to self determination of inmates was respected (Burns & Grove, 2005, p. 181). Data collected was treated with the strictest confidence and anonymity to eliminate the risk that participants withdraw. Privacy of the participants was at all times respected and guaranteed since the whole process from recruitment up to the interview was done private.

2.11.1 Informed consent in respect of conducting the research

Informed consent implies that participants are provided with adequate information, regarding the research study, that they comprehend the information and that they have the power of free choice to enable them either to consent voluntarily to participate in the research or to decline participation (Polit, & Beck, 2008, p. 132, Holloway & Wheeler, 2000, p.43).

In this study information was given to the participants, in simple and easy to understand language so as to ensure their full knowledge and understanding of the research project. The participants were given opportunity to ask questions and these
questions were in turn answered. The researcher then requested the permission from each individual to conduct interview, she explained the purpose of the study and the time that would be required. The consent of the respondents was obtained in writing.

2.11.2 Voluntary participation

The principle of self – determination implies that prospective participants have the right to decide voluntarily whether or not to participate in a study without the risk incurring any penalties or prejudice treatment. It also means that the participants in a study have the right to decide at any point to terminate their participation, refuse to provide information, or to ask for clarification about either the purpose of the study or specific study procedure (Polit & Beck, 2008, p.136). In this study participants were informed that they have the freedom either to participate in the study after they had been provided with all the relevant information or to withdraw.

Participation of inmates was voluntary and the participants were made aware of their freedom to withdraw at any time during the study without any penalty. In this study two of the candidates who first agreed to participate in the study, withdrew from the process due to the fact that they were probably busy that day.

2.11.3 Confidentiality

Confidentiality is a fundamental guiding principle (Holloway & Wheeler 2000, p.95). The respondents were assured that their names will not be disclosed nor linked to any description of information provided. All information received from them was treated with utmost confidentiality. In this study confidentiality was ensured right from
the beginning, from the recruitment of participants when inmates were approached individually and informed about an interview up to the interview itself. The day prior to the interview the participants were approached again individually and informed that they will be called one by one for in-depth interview.

Data collected was treated with the strictest confidence and anonymity to eliminate the risk that participants withdraw. Privacy of the participants was at all times respected and guaranteed on the date of interview. The inmates were given enough time to decide on their participation in the research and they knew that they could withdraw anytime.

2.12 SUMMARY

Before the researcher thought of setting of the study, she did the literature review and formulate the research plan. The research design of this study is a qualitative, explorative descriptive, phenomenological and a contextual approach. The target population was inmates at Windhoek Central Prison Living with HIV/AIDS and on ARV therapy for six month and more. The sample size was 122 inmates on ARV therapy. In-depth interviews with a central question about ARV therapy adherence were conducted. The data analyses were done manually, the verbatim were quoted, categorized in the sub-themes and main themes. The findings were compared with existing literature on the previous study done. Strategies to ensure trustworthiness were employed. Ethical consideration in research was maintained throughout the study (Chapin, 2004, p. 68)
CHAPTER THREE

BARRIERS TO ARV THERAPY ADHERENCE AMONG INMATES LIVING WITH HIV/AIDS AT WINDHOEK CENTRAL PRISON

3.1 Introduction:

In the previous chapter the methodology used in the study was discussed. In this chapter the data analysis is presented and discussed and findings from the study are supported by existing literature. A total of 18 inmates on ARV at Windhoek Central Prison were interviewed for one (1) week. The purpose of the study was to assess possible barriers to adherence to ARV therapy in prison and how these barriers can be addressed to assist inmates in Windhoek Central prison to adhere to their ARV therapy.

Peer review was not used during the interview due to the sensitivity of the topic however an expert in HIV/AIDS, ARV as well as in research has been approached prior the interview for their advice and contributions. Data analysis was done manually according to Tesch’s coding system. In this Chapter, the findings of the study are presented based on the final categories identified as themes and sub-themes with supporting literature control.
3.2 Barriers to ARV therapy adherence among inmates living with HIV/AIDS at Windhoek Central Prison.

A total of 20 inmates living with HIV/AIDS those on ARV for more than six (6) months at Windhoek Central Prison were selected for in-depth interview. Two (2) inmates withdrew. Interviews were conducted with 18 inmates only till the data saturation was reached. After the interview was conducted, the data was analysed using Techs’ coding system, all data with the same meanings were categorised in the four main themes, supported by sub-themes, that the researcher see as the Barriers to ARV adherence at Windhoek Central Prison.

According to Charmaz (2003) coding is a process of analysing the raw qualitative data in the form of words, phrases, sentences or paragraph and assigned codes and labels. In coding the researcher is looking for what is going on, what the people do, what a person is saying, what do these statements and action take for granted. How do structure and context serve to support, impede or change these action and statements. In coding the researcher is looking for behaviours, events, activities, states, strategies, meanings, participations, conditions consequences, settings and reflexives (Lewins, Taylor & Gibbs ,2005, p. 56).

To avoid the criticism of lack of control over quality of the findings in qualitative research, the researchers’ field notes are also incorporated in the analyses of data. The results are supported by exact quotations from the participants and are
substantiated by relevant literature after each theme and subthemes has been described. Tesch's method as a method of data analyses was used (Creswell, 1994, p. 154-155).

The quotations are given word by word without correction, in order to present the experience of the participants as validly as possible, thus even if there are errors in language and expression these has not been corrected.

Due to the fact that not many previous studies which the researcher is aware of have been done about ARV adherence in prison, the study heavily relied on the data from the inmates to determine barriers to ARV adherence in a correctional facility.

Data has been organised into themes and sub-themes, as outlined in Table 2.

3.3 Themes and sub-themes

Related to the outcome of the interview and the findings given, the researcher and her two supervisors have agreed upon the four main themes as barriers to ARV therapy adherence among inmates living with HIV/AIDS at Windhoek Central Prison. A discussion of four themes and their sub-themes is presented in table 2.
TABLE: 2 Main themes and sub-themes on barriers to ARV adherence among inmates living with HIV/AIDS at Windhoek Central Prison.

<table>
<thead>
<tr>
<th>Main themes</th>
<th>Sub themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Stigmatisation and confidentiality experienced</td>
<td>- Institutional rules contribute to stigmatization e.g. specific days for treatment.</td>
</tr>
<tr>
<td></td>
<td>- Fellow inmates and prison officials’ attitudes and behaviours create a feeling of stigmatization among inmates on ARV because they feel they are handled different.</td>
</tr>
<tr>
<td>2. Time monitoring instruments.</td>
<td>- Inmates are not allowed to have watches.</td>
</tr>
<tr>
<td>3. Food and nutrition for</td>
<td>- Televisions and radios are only allowed to some of the inmates according to their level of classifications.</td>
</tr>
<tr>
<td></td>
<td>- Inmates are receiving irregular meals, non balanced</td>
</tr>
</tbody>
</table>
4. Health education about ARV.

- Side effects of medication hamper appetite and this leads to non adherence (Castleman, Eleonore and Bruce 2004, p. 5).

- Inadequate information about ARV to inmates on ARV therapy in Windhoek Central Prison.

- Inadequate information about HIV/AIDS and ARV to Prison officials in Windhoek Central.

### 3.3.1 Theme 1. Stigmatisation and confidentiality
Stigmatization came out clear as something that prevents inmates from taking their medication. Stigmatization according to Oxford English dictionary (2006) is a mark of disgrace associated with a particular circumstances or a person.

The opinion and fact statements stated by participants in this research, reflects their feelings to factors appearing as barriers to ARV therapy adherence among them. These factors are namely institutional rules, attitudes and unethical behaviour for fellow inmates and prison officers towards inmates on ARV. The researcher discovered that besides the contributing factors to non adherence mentioned above, there are inmates who are already stigmatized by HIV status because most of the inmates on ART do not want to be seen in possession of ARV containers. They used to pour ARV medication out of the original containers to the general tablet sachets. They feel that ARV containers indirectly divulge their HIV status, besides some of them are used to hide themselves whenever taking their ARV medications.

Although some reports suggest that a supportive network exists for HIV-positive prisoners other reports indicate that the prison environment is highly stigmatizing (Legal Assistance Centre, 2010, p.36).

Stigmatization is clear by the following verbatim remarks:

“Shyness and fear of others will make a person to take ARV immediately before time or delay it until such a time that he is out of sight.”

“Stigma that associated with fear to
be seen is a contributing factor to delay or taking ARV earlier then on the specific time”.

“Because of shyness I used to wait others to get out of my site or wait for the fellow inmates to pay their attentions on something else for me to take my ARV medications.”

“Stigma is really a problem, I have seen (3) three of my colleagues withdrawn/ stop to take ARV medications because inmates and prison staff are talking bad things about them.”

It is argued that the main reported barriers were denial of existence of HIV or of one's own positive status, stigmatization, and the ability to fit ART into daily life schedules.

The research findings of a study done in Witwatersrand South Africa is presented in two sections: recommendations emerging from the expert interviews, and recommendations emerging from the patient interviews.

The experts highlighted a lack of disclosure as decreasing levels of adherence, as this reduced the extent of support that a patient was able to access. Stigma and discrimination were also highlighted as barriers to adherence, particularly insofar as these processes often result in reduced support. The experts felt that psychological factors such as co-morbid depression and anxiety may complicate a patient’s adherence levels. The challenges facing specific communities were also highlighted (Frank and Duncan, 2009, p. 40).
Sub-theme 1: Institutional rules

The participants felt that some of the institutional rules of Windhoek Central Prison is stigmatising and leads to non-adherence to ARV therapy because it reveals their HIV status.

Wednesday is the day given to the inmates to collect their ARV medication; they used to be taken in a big number in a truck from prison to the public hospital. Inmates feels that their privacy and confidentiality is not ensured. The prison officials as well as their fellow inmates are calling Wednesdays an AIDS day. Due to this, many inmates do not go for follow up or they have stopped to take ARV because they have fears to be known that they are HIV positive and on ARV medications. This is evident in the following statements.

“Lack of privacy contributing to the stopping or skipping days to take ARVs’

“I know one of my colleagues who stopped taking ARV medication, because there is no privacy, their health passports are read by the prison officials (guards). This guard responds to you that there is no privacy in prison”

Privacy is being violated even at the local hospital whereby the NAMPOL officials are always present while one is consulted by the doctor.”
“Going to the hospital at ARV clinic in a big group in the same car, this has revealed people’s status indirect. This has caused some of my colleagues to stop going for follow up at ARV clinic; they are no more taking their ARVs.” “Stigma is really a problem, I have seen (3) three of my colleagues withdrawn/ stop to take ARV medications”

“The system that is being used to take our ARV medication at ARV clinic is not a secret, confidentiality is not there, many people withdrawn because of this”.

The containers of ARV drugs are known in public; if one sees this container in one’s possession his status is already revealed.

“Wednesday is called AIDS day in prison”

Literatures also confirm this findings as stated below.

A study done in South Africa on structural barriers to adherence to antiretroviral therapy in a resource-constrained setting, the perspectives of health care providers arguing that the main barrier to adherence as identified by participants in the study was the stigma associated with living with HIV, and thus with receiving AIDS treatment (Norton, Amico, Cornman, Fisher and Fisher, 2010).

Institutional barriers were categorized as either “institutional” or “no institutional,” inmates more often reported that the barriers to adherence were institutional. Some of the most common institutional barriers to receiving doses were that medicine was not
available, the patient was not allowed to attend the medicine call, the patient did not want to go to the medication line, the patient was in “lockdown” (i.e., the prisoner was locked in his or her cell and was unable to receive the medication), the patient was moved to another cell, the patient was out of unit. Some of the most commonly reported non institutional barriers were that the patient felt fatigued or sleepy, the patient felt sick, the patient did not want to get out of bed, the patient felt depressed, the patient had a possible adverse event, or there was bad weather (HIV CLINICAL TRIAL, 2007).

Due to all above mentioned reasons inmates are likely not to comply to ARV therapy.

Literature supports the above views of the participants arguing that the issue of confidentiality is important (Mae, 2009).

In some instances, a prisoner’s HIV status is disclosed discreetly to prison officials on a ‘need to know’ basis, and in more extreme situations, prisoner cells or files are clearly marked so that anyone who cared to know would be aware of their HIV status. Maintaining confidentiality of a prisoner’s HIV status is important because of the social stigma associated with the disease. In an independent report issued on the British prison system, the importance of confidentiality was underlined, with the understanding that, “HIV prisoners must not and need not become the pariahs of the prison system” (Goyer, 2003, p. 3).

ARV treatment is complicated and expensive, and the prison environment poses serious challenges to its effectiveness. In addition, the lack of privacy intrinsic to any prison situation means that a prisoner undergoing ARV treatment will have difficulty concealing his or her HIV status from prison officials or other prisoners (Goyer, 2003,
p. 3). This is also happening in Namibia Prisons due to the fact that there is no privacy.

In a study done in Botswana, the barriers to ARV adherence identified are stigma and side effects (Weiser, Wolf, Bangberg, Thior, Gilbert, Makhema, Kebaabetswe, Dickenson, Mompati, Essex & Marlink, 2003). Whereas it was also revealed that no adherence to HAART is a problem in the ARV clinic and that the feeling of being healthy, forgetfulness, and unwillingness to disclose HIV status by People Living with HIV and AIDS (PLWHA) were significant barriers to adherence. Efforts to improve adherence in the clinic will have to address these issues among others (Olowookere, Ibekwe & Adeosun, 2008).

Sub-theme 2: Fellow inmates and prison officials’ attitudes and behaviours

According to the findings of the study inmates on ARV in Prison are discouraged by the attitudes of their fellow inmates and some of prison staff towards them. They feel
that prison staffs as well as some inmates don’t respect those with HIV positive and on ARV therapy.

“Discouragement from people around you, (fellow- inmates and Prison officials) how do they talk about those on ARV.” “I have experienced it myself, I wanted to stop ARV but I know some of my colleagues who have stopped to take it.”

Attitudes of the prison officials are unprofessional and unacceptable towards inmates living with HIV/AIDS and on ARV therapy. Abusive language was used by some of the prison staff towards inmates on ARV when address them. In this research, the following statements were made.

“Oh! Are you also on AIDS treatment?’ This was said in front or in the presence of other inmates and prison warders.”

“Disrespect from prison members who made statements like” I don’t care if you die you die or your life is just depends on medication only”.

“Frustration caused by members of prison can make a person not to take ARV therapy, or it discourages you”.

“Information to be provided to all inmates to respect others, and to stop imposed stigma and discrimination to us those on ARV therapy.”
The above mentioned verbatim quotes on attitudes are from emotional devastated inmates on ARV.

The finding confirmed by the following authors Norton, Amico, Cornman, Fisher & Fisher, (2010) state that HIV/AIDS stigma, which often discourages people from accessing HIV prevention and treatment strategies, occurs both inside and outside of the prison walls. A Non Governmental Organisation official stated that there is correlation between the rate of infection and the level of HIV stigma: In general “In areas where HIV prevalence is low, there is high stigma (Zukoski & Thorburn, 2009)

A study done in Botswana indicated service-cantered barriers included nurses' attitudes and knowledge, health workers' inability to conduct home visits and to contact defaulters, limited clinic hours, delays in getting CD4 and viral-load results (Kip, Ehlers & Van Der Wal, 2009).

In Namibia, some inmates “did not mind [being in close quarters with HIV-positive prisoners] but there were some who didn’t want to mix with those infected with HIV. They didn’t want to drink from the same cup or eat from the same plate.” This means that inmates with HIV are being discriminated by fellow inmates in Prison. One physician stated that many inmates forego both testing and treatment due to stigma: “[Prisoners] get isolated...causing some [inmates] not to come to the clinic [to receive treatment]. Inmates are also afraid of stigma and the lack of confidentiality, which may keep them from taking their ARVs” (Legal assistance Centre, 2010, p. 36).
Finally, respondents trusted the advice and instructions of their health care providers, who regularly emphasized adherence. Wardens also sometimes add to the stigmatization of HIV-positive prisoners. Prisoners reported to a social worker that wardens would not inform HIV-positive prisoners of the time when they needed to take their ART medicine, compromising the strict ART schedule. One former warden described his colleagues’ attitudes at Windhoek Central Prison: “Staff would not touch the guy [who was HIV-positive]. They talked badly about him.... I could tell he was treated differently by what the staff said behind his back and the distance they would keep” “Inmates with HIV and on ARV drugs are called wife by other inmates; they believe they contracted HIV through consensual sex with fellow inmates” (Legal assistance Centre, 2010, p. 36). The study confirms that inmates with HIV are discriminated by prison staff members as well as fellow inmates in prison. One respondent state, “We are called names by fellow inmates such as witches or contract workers simply because we are taking ARV medications.”

AIDS stigma among male inmates, male and female staff at a state prison in the southern region of the USA were prominent. Inmates and staff rated people with AIDS more negatively than someone with other diseases (diabetes, cancer, heart disease and high blood pressure). Inmates and staff were concerned about being treated differently if they tested seropositive. They also described AIDS stigma as a barrier to seeking HIV testing. Both instrumental (inaccurate beliefs about casual contact causing transmission of the virus) and symbolic factors (negative attitudes about
injection drug use) predicted AIDS stigma. Negative attitudes about homosexuality predicted AIDS stigma among Caucasian prison staff and inmates, but not among African American staff and inmates. The results indicate the need to address HIV/AIDS stigma in developing HIV treatment, care and prevention programs in the prison environment (Derlega, Winstead & Brockington, 2007).

According to Legal Assistance Center AIDS Law Unit (2010), HIV/AIDS stigma, which often discourages people from accessing HIV prevention and treatment strategies, occurs both inside and outside of the prison walls. Prisoners reported to a social worker that wardens would not inform HIV-positive prisoners of the time when they needed to take their ART medicine, compromising the strict ART schedule. One former warden described his colleagues’ attitudes at Windhoek Central Prison by saying “Staff would not touch the guy” [who was HIV-positive] (Legal assistance Centre, 2010, p. 36).

Furthermore, it can be expected that in this setting attitudes related to trust in medications and the health care provider and satisfaction with health care in the correctional system may have particular relevance in the acceptance of, and adherence to, antiretroviral medications. Inmates’ lack of trust in the correctional staff that dispenses many of these medications may further decrease adherence. In fact, trust in the prison health care system has been reported as being strongly correlated with drug adherence (Akbar, 2010).

3.3.2. Theme 2: Time monitoring in relation to ART.
The study revealed that time monitoring instruments is a barrier to ARV adherence in prison.

Sub-theme 1: No watches are allowed in prison.

All participants stated that, it is difficult to take ARV on time due to the fact that, watches are not allowed in prison. The following under mentioned are some of the verbatim statements from the participants about time in prison.

“Inmates are taking ARVs by chances or by guessing on time.”

“Inmates are concentrating on unlock and lock up time, to take their medications because they have no watches.”

“I used to take my ARV medication after breakfast though the breakfast does not have exact time.”

“Inmates are guessing on time to take their medication.”

“It is difficult in Prison to take ARVs on time, because no watches is allowed in prison, people are taking it on estimation, we are forgetting after you remember it is already two or three hours later, simply due to the reason that there is no watches.”
The above mentioned verbatim made it clear that, inmates in prison do not take ARV therapy on time due to the fact that nothing is there to direct them on time schedules that is critical for ARV adherence and effectiveness. Therefore they do not take their ARV medication on time.

On a question posed to a HIV/AIDS positive activist on why it is important to take ARV on time everyday for life? She answered that, “if you miss doses regularly, the virus will learn to defeat the ARVs sooner.” “This is called resistance.” “ARV should be taken on a specific time if not, resistance can follow.” Thus the time factor is discovered as a huge barrier to ARV adherence in prison (TAC, 2006)

ARV therapy, the recommended treatment for HIV, is a combination of several drugs, which usually must be taken at specific times with various specific directions as to accompaniment with meals or fluids and other such requirements (Goyer, 2003), but this is not possible in the Windhoek Central Prison due to the fact that watches are not allowed in prison so that they can check on time to take their medication

Abaasa (2008), states that for HIV treatment to be effective, good adherence is very important. Good adherence means taking all your antiretroviral medicines every day, at the right time and with food if necessary. Poor adherence to highly active antiretroviral therapy (HAART) may result in treatment failure and death.

Therefore adherence is essential, which includes taking the right medications, in the right way, at the right time (MoHSS, 2010, p. 4).
A study done on ART in Correctional facilities in Genoa, Italy, reports that a key aspect to obtaining the greatest benefits from ART is full adherence to the prescribed regimen. The special environment in the prison system can offer small and large obstacles. The emerging problem of drug resistance is the unfortunate consequence of HIV medications being taken improperly or inconsistently (Pontali, 2005, p. 25).

Furthermore Council Health Management Team (CHMT) (2006) emphasise that taking the pills on time is important because if a person misses a dose, the virus immediately takes advantage and starts to replicate itself again. These copies will be a little bit different and the ARVs will be less effective against this changed virus. “We have learnt about the importance of good adherence - taking all your pills everyday at the right time”. “We have seen how poor adherence causes resistance, which means that the treatment stops working.” (CHMT, 2006, p. 8)

In Kenya results showed that only 43.2% adhered to the prescribed time of taking drugs. The most commonly cited reasons for missing the prescribed dosing time by the patients were: Being away from home 68.8%, being too busy 58.9%, forgetting 49.0%, having too many medicines to take 32.6% and stigma attached to ARVs 28.9%. There was no significant difference between males and females based on timing of taking medications (Talam, Gatongi, Rotich and Kimaiyo, 2008). On the basis of keeping clinic appointments, all the respondents claimed to adhere to scheduled clinics. However, from hospital records, it was established that only 93.5% of the respondents kept clinic appointments. The most common reasons for poor adherence to clinic appointments
were; being away from home (50%), forgetting (50%), being too busy (50%), stigma
(70%), feeling sick (80%) and changes in work routine (60%) (Talam, et al 2008).

Sub-theme 2: Televisions and radios only allowed to some of the inmates.

Televisions and radios are important items in prison, besides of using it to relieve
boredom; inmates are using it to direct them on time in the absence of watches that is
not allowed in prison.

“Myself I am estimating on time because I do not have anywhere to check the time,
no watches, no radio, no TV. I always take it morning time and afternoon”.

“It is difficult for inmates to take their medications on the right time; we do not have
watches radio or TVs”.

“Yes, I am taking my ARV on time, because i am having an access to the Radio”.

“It is difficult in prison due to the restriction of time, no watches allowed in prison and
not everybody is having an access to Medias.”

“Televisions and radios should be allowed to everyone in prison to direct us on time”.

“Lack of access to watch, radio or TV in communal cells hampers the time allocated
to your medications”.

Windhoek Central Prison operates under the system of Unit Management, this means that inmate’s privileges depends on the level of classification. This includes access to radios and TV in prison to certain “classes”. Inmates on ARV, on a maximum level of classification, are affected because they do not qualify for access the radios or TV, thus nothing is directing them on time to take their ARV. In terms of the Namibian Prison Act No: 17 of 1998 only “A GROUP” prisoners are allowed to have radios. In practical terms prisoners are only allowed to have radios in prisons after they have served a third of their prison term.

The Namibian Prison Act No: 17 of 1998 compliments the findings of Tapley (2009) that prisoners can buy a TV, radio, shaving kit, mouthwash, books, and magazines... all sorts of things really. These privileges can be revoked, though, and are not permitted for every inmate. These privileges do not come automatically to any inmate but will be given according to the level of conduct of an inmate.

The researcher feels that, although one qualified to access radio or TV, it depends if one is able to afford to buy it therefore not everyone in prison can access radio or TV including many who are on ARV therapy. Nothing directs them on time, thus they do not take ARV on time.

According to Tapley (2009) in the USA each state has its own rules regarding granting privileges to prisoners for example in Ohio, if a prisoner were granted the privilege of a TV in his cell, he (or a family member) would have to buy it through the state approved vendor. Unfortunately, not many prisoners are given this privilege.
3.3.3 Theme 3: Food and nutrition for inmates on ART.

According to the research result adequate food and nutrition are part of ARV therapy in general. Lack of adequate food is a main problem in Windhoek Central Prison. Almost every inmate has a problem with the food supplied in prison. Most of them went to private doctors and requested special food to be prescribed to them; some are insisting to be allergic especially to porridge though no allergy was detected through investigations. Moreover inmates insist to buy their own food, or their families provide them with food which is against prison rules because of the security reason. Food problems have caused many conflict situations between inmates and nurses at the clinic as they assume that nurses denied them their food prescriptions.

Sub-theme 1: Irregular meals, non balanced meal, inadequate meals

According to the participant themselves food is not enough for them to take it with ARV, they feels that sufficient food should be provided in prison for them to adhere to their ARV medications. The following verbatim quotes states it

- “Prison to provide inmates on ARV with enough high protein food”.
- “The food that we ought to receive is not always available”
- Inmates to be allowed to buy their boosters”.
- Lack of sufficient food cause dizziness then one will skip some doses.”
- “The prison to provide inmates on ARV medications with enough high protein food, the quantity should be increased; this will assist inmates to take their ARVs well if they have enough food to eat”.
- “Inmates to be allowed to receive food from their families at visiting time.”
According to the United Nations World Food Programme, 13.8 million people will need access to HIV/AIDS care by 2008, and 6.4 million of them will need nutritional support. Out of 6.6 million also needing access to ARVs, 0.9 million will need food aid. The demand for food will increase as more people access ART based on present trends (WE-ACTx 2006).

Extreme poverty threatens to blunt the benefit of HIV therapy for severely malnourished individuals, who are six times more likely to die than those on ART who are not malnourished. Malnutrition decreases one’s ability to absorb HIV medicine and cope with drug side effects, and prolongs the length of recovery to natural immunity (WE-ACTx 2006)

Nutrition interventions should be considered within a continuum of HIV care model, with a range of entry and exit points for interventions at different stages of malnutrition, illness and HIV status. Short-term food aid is a lifesaving intervention for severely malnourished HIV-positive individuals and needed by many starting ART, but should be linked to sustainable food security or income generation programs. Other barriers included the lack of finances for transport to clinics and food insecurity, especially when medication needed to be taken with food (WE-ACTx 2006).

According to TAC, (2006) an HIV positive activist Nokhwezi Hoboyi states, “people with HIV, whether or not they take ARVs, need to eat well to give the immune system the energy it needs to fight the virus.” “Be careful of people who claim that particular foods such as garlic or African potato treat AIDS.”
“There is no food that is known to treat AIDS’. ‘Eat normal healthy foods. Try to drink as little alcohol as possible or none at all’.” Smoking is not good for people with HIV because of the chest diseases we are more likely to get.

Complaints about the quality and quantity of food in both pre-trial detention facilities and prisons were common among most former inmates and staff interviewed (Legal assistance Centre, Namibia, 2010). This literature confirm the result of the study.

An ex-inmate of Windhoek Central Prison interviewed in (2008) states that, “in the morning, we would get a liquid porridge. You could almost drink it. It was not powerful. You would drink it and then half an hour later you need to go to the bathroom and it’s gone. Lunch would be at 3:00 p.m. Once you finish it, it was back to the cells until tomorrow morning. Lunch was millet beans, peas. It was the only menu that you eat every day. On Wednesdays and Sundays, though, we would get a little piece of meat; only about a mouthful. This was the only time we get meat. “You can have water anytime” (Legal assistant centre, 2010, p.19).

One former warden at Windhoek Central Prison acknowledged that despite a prescribed menu, inmates did not always receive required items. Instead, he offered what he said was a more accurate menu: At 6 a.m. they get five slices of bread, porridge that is not well cooked, and soup. Around 1 p.m., they eat the bread from the morning or gamble with it. At 4 p.m., fish with porridge and soup, which is tasteless but sometimes nice, it depends. Water is available inside and they can make their own tea (Legal assistant Centre, 2010, p.21).
Inmates diagnosed as HIV-positive are entitled to additional food, including protein rich items not generally available to all prisoners. While some former inmates report that such items are available to prisoners suffering from HIV or other diseases, other inmates report that additional food is not consistently offered to even the most seriously ill. Access to additional food is inconsistent throughout the system. A physician at Windhoek Central Hospital told interviewers that he commonly sees malnourished inmates, whether HIV-positive or not, and often concludes that the best available treatment for some is simply an increase in caloric intake. Several complaints about food, however, are sometimes counterproductive (Legal Assistance Centre, Namibia, 2010).

As one former inmate explained, “Complaining about the food sometimes adds more problems for you. They [the wardens] may deny you a meal so that you do not get any food at all.” While adequate nutrition is essential for the treatment of HIV-positive inmates, the issue appears to go beyond just those facing health issues. One government official noted that while officials make some allowances for the ill, food for the general prison population is inadequate (Legal Assistance Centre, Namibia 2010).

An ex-inmate of Windhoek Central prison interviewed in (2008) stated, “I wonder why nutritious food is given only to the sick; every prisoner should get nutritious food. Nutritious food is given only to the sick because of the belief [by the general public] that prisoners should not get food—there must be a move away from punishment to rehabilitation” (Legal assistant Centre, 2010, p. 22). The Legal assistant Centre
(2010) continuously highlighted that the challenge with adequate food and nutrition in prisons has to do with the issue of food handling practices.

Inmates are responsible for food preparation in facilities with no specified handling procedures. Several interviewees raised issues of food handling and hygiene at many of the system’s thirteen prisons. One noted, “No gloves were used to serve food and the dining halls are not hygienic; they have cockroaches and flies; there were no utensils (Legal assistant Centre, 2010).

Adequate nutrition, basic hygiene and sanitation are the cornerstones of overall good health. Penal institutions are encouraged under the Standard Minimum Rules for the Treatment of Prisoners to provide for minimum living conditions. One basic necessity detailed under Rule 20 is access to portable water and nutritional food: “(1) Every prisoner shall be provided by the administration at the usual hours with food of nutritional value adequate for health and strength, or wholesome quality and well prepared and served. (2) Drinking water shall be available to every prisoner whenever he needs it.” Although the Ministry of Safety and Security earmarked funds “to ensure continuous supply of basic needs such as food, water and electricity, clothing, health care, shelter and sanitation,” the majority of interviews conducted with former inmates suggest that the ministry is not meeting its own expressed goals and it’s domestic and international oblige (Legal assistance Centre, 2010, p. 45).

A prison guard at Chikurubi Maximum Prison in Zimbabwe states that most inmates are going for days and months without proper food. This has led to a deterioration of
health for most inmates, especially those living with HIV. Some are not provided with regular counseling and treatment which further compromises their health (The Zimbabwean, 2010).

Anti-retroviral (ARV) therapy is a combination of several drugs, which usually must be taken at specific times with various specific directions as to accompaniment with meals or fluids and other such requirements (Goyer, 2003)

Malnutrition, food insecurity and poverty remain critically overlooked factors in the global HIV pandemic. According to the UN World Food Programme, 13.8 million people will need access to HIV/AIDS care by 2008 and 6.4 million of them will need nutritional support. Out of 6.6 million also needing access to ARVs, 0.9 million will need food aid. Extreme poverty threatens to blunt the benefit of HIV therapy for severely malnourished individuals, who are six times more likely to die than those on ART who are not malnourished. Malnutrition decreases an HIV-positive person’s ability to absorb medicine and cope with drug side effects, and prolongs the length of recovery to natural immunity (D'Adesky, 2006).

Without food, people are often reluctant to start ARVs, which may be difficult to take without food, or they struggle to maintain good health if they lose access to food (WE-ACTx 2006).

The Government of Karnataka provides two kinds of diet to everyone lodged in the prisons. Though people consume rice across the state, wheat is the staple diet in north India, and ragi (millet) in the south. Hence, a combination of both rice with
wheat and rice with ragi are provided. Till recently, under trial prisoners in the state were allowed to procure their own rations and they occasionally cooked food from private sources, albeit subject to certain restrictions. However this was prohibited in 2007 by an executive order on discovery of poisoned provisions which were being supplied to eliminate rival gangs in the prison. In every prison that CHRI visited, we heard complaints from inmates about the quality of food. Even those in Bangalore Central Prison where the diet is supplemented by the Akshaya Patra Foundation of the International Sri Krishna Consciousness (ISKON), complained about the monotony of the diet. Except in the prisons of Karwar, Shimoga and Bangalore, chapattis made of wheat are usually dried in open spaces and hung from the window grills (Murali, 2010).

The dried bread is then used as fuel for cooking which is prohibited, of course, but the practice continues. This clandestine cooking often results in the barracks getting stained with thick black soot, giving the cells a dirty look. As in other parts of India, breakfast, lunch and dinner are served at 7 and 11 a.m. and 4 p.m. respectively; meaning the inmates are forced to consume food provided at short intervals and then go without any thing to eat between 4 p.m. and 7 a.m. This, combined with the poor quality of victuals, often leads to large numbers of inmates, especially in the central prisons, to form groups in order to build fireplaces and use steel glasses and utensils to cook or to simply reheat the food or to add spices to make it more palatable.
However, these kinds of practices are not allowed within the Namibian prison context.

The spices and other ingredients are procured from the prison canteens or stores or from outside. More influential inmates are able to prepare a diet of their liking in the prison kitchen itself. Some inmates openly cooked food all over the prison and others cooked their food in the central kitchen with articles procured from the prison. When this was drawn to their attention, the prison staff casually and sympathetically referred to the abnormal diet timings and the monotony of prison food as reasons for not objecting to such practices. Other than the questionable legality of these practices, another important issue needs to be addressed here, and that is corruption. The corruption endemic in prisons means that inmates pay for everything they receive and can obtain anything for a price. Majority of inmates dependent on prison diet are considered ultimate losers (Murali, 2010).

With regards to the medicine regimen, the patients at the WCP felt that the quantity of medication, the dietary requirements associated with ART, and the side effects of medication (ARV) were all barriers to adherence. In addition, alcohol and substance abuse, itinerant lifestyles, as well as a failure to take responsibility for one’s life, were all contributors to poor adherence. It was also argued that once the disease symptoms had disappeared, patients were more likely to be non-adherent to their medication (Frank & Duncan, 2009, p. 71).

The lack of resources can cripple efforts to combat HIV/AIDS in the prison system. Partly due to the double stigma that results from being both a prisoner and a person who is HIV-
positive, HIV-positive prisoners and their health care are often the last ones considered (Legal Assistance Center (LAC) 2010).

Lastly, the patients stated that forgetfulness was also a significant barrier to adherence; prisoners should have access to confidential voluntary counselling and testing. No prisoner should be discriminated or segregated on the basis of his or her HIV sero-prevalence status (Frank & Duncan, 2009, p. 71)

*Nutritious diet* is vital for antiretroviral drugs to work properly. In resource-poor communities prison authorities are often unable to provide nutritious meals for inmates, which means they will be less likely to benefit from the medication and more likely to experience disease progression. As a prison guard at Chikurubi Maximum Prisons, Zimbabwe stated, “most inmates are going for days and months without proper food. This has led to a deterioration of health for most inmates, especially those living with HIV. Some are not provided with regular counseling and treatment which further compromises their health” (Avert, 2011, p. 5).

All the given literature above verified that nutrient food is not available in prisons, not only in the Namibian prison but also in various countries prisons in the world, therefore lack of sufficient nutrient food is the barriers to ARV therapy adherence in Windhoek central prison as well.

Good nutrition is essential to good health. This is particularly true for people with HIV and AIDS. The South African government has in place a series of programs to improve nutrition and food fortification among its people including those living with TB,
HIV and AIDS and other chronic debilitating diseases. The new program will be fully integrated with the existing program (Tshabalala-Msimang, 2009).

3.3.4. Theme 4: Health education about ARV.

The study result reports the importance of information about the issues related to HIV/AIDS including ARV among inmates and prison officials. The researcher feels that adequate information will assist these people to understand ARV therapy, the importance of confidentiality, human rights, respect of others, among both prison officials as well as inmates in order to refrain from their bad attitudes that impose stigma and discrimination towards inmates on ARV therapy at Windhoek Central prison.

Sub-theme 1: Inadequate information and ignorance about ARV adherence to inmates on ARV therapy in Windhoek Central Prison.

Despite adherence counselling that is given to inmates on ARV prior to the commencement of ARV therapy, the findings identified inadequate information and ignorance among inmates on ARV therapy.

The following verbatim reflects the lack of adequate information and ignorance among the inmates on ARV.
“The second inmate I know stayed for 3 month without medication, because he went to work at the outside stations.” (other prisons)

“I know many of those who dropped ARV except one whom I convinced and he went back to ARV again, the rest have thrown them away.”

“Denial or don’t mind attitude, resulted to inmates skip ARV follow ups.

“Selling of ARV drugs in exchange with sex”.

“Selling of ARV medications to the drug dealers in prison for smoking it.

“Negligence and ignorance by the user of ARV medication.”

“Discouraging information from peer concerning ARV medications.

No literature was found that support the above mentioned quotations due to the fact that no study of this nature was done in the prisons setting.

Sub- theme 2: Inadequate information about HIV/AIDS and ARV to Prison officials in Windhoek Central Prison.

During interview most of the participants were complaining about the negative behaviours and attitudes of some of the prison staff against inmates on ARV. This attitude caused frustrations, psychological humiliation and discouragement to continue with ARV therapy. The research finds that more information about ARV is needed among the prison staff; this was supported by the participants who felt that
Prison officials lack information on the issue related HIV/AIDS and ARV and suggested them to be educated or trained, this is evident in the following verbatim quotes:

- “No physical, emotional or psychological support is provided to me from the prison officials even the time I need it.”
- “Prison officials don’t understand the importance of taking ARV drugs consistent, they refuse to take you to the hospital even if you say the ARV drugs are about to finish.”

The research findings revealed that, the prison officials were not polite enough when handling inmates in general, knowingly or unknowingly they have contributed to non-adherence to ARV therapy among inmates.

The following literature emphasised on the importance of knowledge, education and information about HIV/AIDS and ARV in prison setting and in general.

Patient-centred barriers to ART adherence included inadequate knowledge about ART, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), CD4 cell and viral-load results, stigma, travelling costs, waiting times at clinics, side effects of ART, use of traditional (indigenous or folk) medicines, and abuse of alcohol. Service-cantered barriers included nurses’ attitudes and knowledge, health workers’ inability to conduct home visits and to contact defaulters, limited clinic
hours, delays in getting CD4 and viral-load results (Kip et al, 2009; Malta, et al 2005)
Inadequate knowledge and negative beliefs about HIV/AIDS and ARV effectiveness are also considered as barriers.

Both sides of the debate on segregation agree that education is one of the most important ingredients of an effective HIV/AIDS in prison policy. However, HIV/AIDS education in the prison environment presents specific challenges which are unlike those for the general population. The personality profile of many prisoners often includes a deep-seated suspicion of anything ‘official’ or government related, which can negate the efforts of programmes which enjoyed significant success in the general community (Malta, et al, 2005).

In addition, mass education programmes have not proven effective at changing behaviour because they are not presented in the context of specific lifestyles. The prisoners perceive them as irrelevant and will not relate the information to their own lives. Scare tactics have also proven ineffective, and may possibly be counterproductive to the extent that they elicit a denial response. Also, prisoners in South Africa are normally members of the lower socio-economic strata, and have had very little formal education. Education materials must cater to the wide diversity of languages spoken in prisons, and need also take into account the low literacy rate of the prison population (Goyer, 2003).
Watermeyer and Penn (2009) state that patient comprehension of dosage instructions is an essential condition for adherence to treatment regimens. The study aimed to describe and discuss the effectiveness of various strategies for verifying patients' understanding of ARV dosage instructions in a cross-cultural context. Various strategies for verifying patient understanding were identified in the data, including eliciting a demonstration of understanding, using specific questions to verify understanding, using response solicitations and monitoring patients' verbal and non-verbal responses. These strategies are illustrated with relevant data extracts. Interviews revealed that patients appeared to have good understanding of ARV-related concepts. In Watermeyer and Penn. (2009) it is concluded these strategies for verification of patient understanding appear to be effective tools which enable pharmacists to identify misunderstandings or initiate clarification sequences.

Threats to the successful treatment and safety of outpatients attending regional and district clinics and their finding inadequate knowledge among staff and lack of staff are the barriers to adherence for patients take ARV treatment (Armitage, Hodgson, Write, Ashley, Neary and Hollingsworth, 2011).

In an African American context ex-offenders stated that while most respondents reported that HIV/AIDS/STD education was available in prison, they noted that it was not mandatory. While some respondents emphasized that the information was there if you wanted it, others were concerned that too many people who needed the information chose not to access it. For HIV positive individuals it was noted that more
education needed to be provided on treatment options. HIV positive inmates need to be educated so they can make informed decisions about their treatment needs (Mark & Tyndall, 2006). It is important to note that most of the challenges that inmates experience are beyond their control. These are challenges of an external nature that need prison administrative intervention strategies.

The unfortunate truth is that an increase in HIV/AIDS related knowledge is not always translated into altering or reducing high risk behaviour. HIV/AIDS information needs to be specifically targeted, and take into account the common characteristics or lifestyles that put prisoners at risk for HIV. The influence of peer groups has proven to be essential in any successful intervention strategy as the credibility of the communicator has a significant impact on the capacity of the message to engender behavioural change. This credibility should be determined within the context of the prison population, because what might be valued by the average citizen outside of the prison is not the same as that appreciated by the average prisoner. The general consensus regarding peer education is that, “accepted norms of the target group play a larger part in influencing behaviour than does outside intervention by authorities or health educators” (Goyer, 2003, p.225).

The analysis of focus group discussion suggested that ignorance, lack of awareness, and misconceptions were main sources of stigma and discrimination towards people living with HIV and AIDS. Comprehensive awareness-raising programs using culturally appropriate Information Education Communication (IEC)
and Behavioural Change in Community/Society (BCC) materials are effective approaches. On the other hand, involvement of religious leaders (disseminating messages through mosques, temples and churches) and media are effective approaches to address sensitive issues. Effective communication and addressing misconception are key success factors to initiate such sensitive programmes in prison settings. We realise that peers are able to speak easily to other prisoners about ways to reduce the risk of contracting infections (Akbar, 2010).

Peer educators are able to realistically discuss the alternatives to risk behaviour that are available to prisoners; Prison staff plays a crucial role in HIV prevention, treatment, care and support programmes in prisons and they need to be trained concerning the use of universal precautions. Stigma and discrimination also exists among service providers and should be addressed. Substandard living conditions can increase the risk of HIV transmission among prisoners by promoting and encouraging drug use in response to boredom or stress. (Akbar 2010).

Akbar (2010) suggested the following as key elements to preventing and responding to HIV/AIDS in prisons: Introducing comprehensive HIV prevention measures; providing equivalent health services in prisons to those in the community, including provision of antiretroviral; improving prison conditions and undertaking other prison reforms and reducing prison populations. Prison authorities should take all necessary measures, including adequate staffing and appropriate disciplinary measures, to protect prisoners from sexual violence and coercion (Akbar, 2010).
Other studies in Africa revealed that threats to the successful treatment and safety of outpatients attending regional and district clinics and their finding inadequate knowledge among staff and lack of staff are the barriers to adherence for patients take ARV treatment (Armitage, 2011; Kip, et al 2009).

According to Nsimba, Irunde, and Comoro, (2010) the study done in Arusha and Dares salaam Tanzania in particular state that the contributing factors to non adherence of ART are lack of food, long waiting time, transportation, social supports, lack of education about anti-retroviral therapy (ART) or ARVs, lack or inadequate counselling, drug related side effects, and even knowledge about AIDS were barriers. Structural impediments such as stigma by untrained hospital care workers towards clients, over worked health care staff, and lack of space for confidential consultations, lack of availability of diagnostic and laboratory equipments were also cited as barriers (Nsimba, Irunde, and Comoro, 2010).

It was also found that Patient-centred barriers to ART adherence included inadequate knowledge about ART, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), CD4 cell and viral-load results, stigma, travelling costs, waiting times at clinics, side effects of ART, use of traditional (indigenous or folk) medicines, and abuse of alcohol. Service-centered barriers included nurses' attitudes and knowledge, health workers' inability to conduct home visits and to contact defaulters, limited clinic hours, delays in getting CD4 and viral-load results (Armitage, 2011; Kip, et al 2009).
Educating people about HIV/AIDS can prevent new HIV infections, improve the quality of life of HIV positive people and help to reduce stigma and discrimination. It is usually considered an essential component of HIV prevention (Avert, 2011).

HIV education within prisons is one of the least controversial prevention methods. Due to the higher risk of HIV transmission within prison, and transmission once released from prison, it is essential that inmates receive information about HIV. Many prisoners are from groups of society that are hard to reach for HIV prevention programs and so prison settings provide an ideal opportunity to target these groups. In this regard the WHO recommends that prisoners and prison staff should be informed about HIV/AIDS and about ways to prevent HIV transmission, with special reference to the likely risks of transmission within prison environments and to the needs of prisoners after release (Avert, 2011)

A key aspect to obtaining the greatest benefits from ART is full adherence to the prescribed regimen. The areas of drug administration and adherence to ART should be carefully examined and specific solutions should be found to optimize adherence to treatment and to adapt strategies to the different country guidelines, kind and size of prison and availability of staff and trained staff.

The challenge is how to assist patients to fully adhere to antiretroviral regimens. This complex issue involves the entire health care team, in which nurses may play a key role. Although new drug treatments are designed to be easier to take, patients may still be non adherent to even the simplest regimens. The emerging problem of drug resistance is the unfortunate consequence of HIV medications being taken improperly
or inconsistently. It has been reported that high viral loads in treated prisoners in the absence of drug-resistant mutations can be related to very poor treatment adherence. Actually, in the prison setting, one can expect that patients’ attitudes related to trust in medications and the health care provider and satisfaction with health care in the correctional system may have particular relevance in the acceptance of, and adherence to, antiretroviral medications (Pontali, 2005, p. 25).

Across the world, inmates do not receive an adequate level of HIV education. In the UK, over half of the prison healthcare managers in one study said they were dissatisfied with the educational HIV and hepatitis material available to them (Avert, 2011). In a Californian prison, former prisoners reported that they received no HIV/AIDS education whilst incarcerated (Avert, 2011). However, information is not enough to reduce HIV transmission within prisons. The commodities needed to prevent HIV, such as condoms and clean needles, are often not available. Although education may provide inmates with the knowledge about HIV prevention, frequently needed resources are not there for inmates to protect themselves. HIV education is only one part of HIV prevention and other supplementary methods are needed, therefore there is a need to increase HIV/AIDS education for prisoners and prison officials. This training should include information on treatment, testing, counseling, and prevention. A special emphasis must be placed on addressing the stigma surrounding HIV/AIDS (Legal Assistant Centre, 2010, p. 9).

In support of the above it was also found that lack of communication and information about ART, lack of follow up and counselling, forget fullness, stigma, discrimination and disclosure of ARV status, lack of confidentiality in the treatment centre, and lack
of nutritional support, were considered barriers to adherence in a Zambian Correctional Facility (Sahara, 2008, p. 29).

3.4 Summary

A key aspect to obtaining the greatest benefits from ART is complete adherence to the prescribed regimen. The areas of drug administration and adherence to ART should be carefully examined and specific solutions should be found to optimize adherence to treatment and to adapt strategies to the different country guidelines, kind and size of prison and availability of trained staff. The challenge is how to assist patients to fully adhere to antiretroviral regimens. This complex issue involves the entire health care team, in which nurses may play a key role in conjunction with the entire prison administration. Although new drug treatments are designed to be easier to take, patients may still be no adherent to even the simplest regimens. The emerging problem of drug resistance is the unfortunate consequence of HIV medications being taken improperly or inconsistently. It has been reported that high viral loads in treated prisoners in the absence of drug-resistant mutations can be related to very poor treatment adherence (Pontali, 2005, p.29).

Eighteen (18) inmates living with HIV/AIDS and those on ARV therapy at Windhoek central prison were interviewed through in-depth interview about the barriers to ARV adherence among them. Most of them mentioned aspects like the negative attitudes of the prison officials towards those on ARV therapy, lack of privacy and confidentiality, inadequate nutrient food as the main concerns, because drinking
medications on an empty stomach caused a big problem to them. Lack of time in prison was also identified a barriers to adherence to ARV therapy.

However all inmates reflected their interest to adhere to ARV therapy due to the fact that they fully understand the importance of the ARV therapy despite the barriers that hamper the smooth running of the system. The participants also mentioned that many inmates stopped to go for follow-up and some have thrown ARVs away, other inmates on ARV therapy do sell ARVs to the drug dealers for smoking it and some are exchanging ARV medication for sex.

Based on the barriers to ARV adherence mentioned, the study identified the following main themes namely, HIV/AIDS information or HIV/AIDS treatment literacy in prison, time monitoring instrument in prison, food and nutrition, and stigmatization and confidentiality.

Conclusions, limitations and recommendations to the study will be discussed in chapter four.
CONCLUSIONS, LIMITATIONS, AND RECOMMENDATIONS

4.1 Introduction

The previous chapter dealt with a description of the themes and sub themes derived at after the analysis of the interview data.

The sub-themes and main – themes were described and the findings were integrated into the existing literature on the barriers to ARV therapy adherence among inmates living with HIV/AIDS those on ARV therapy at Windhoek Central Prison. Stigmatization, time, adequate food and nutrition, and information where indentified as the main barriers to ARV adherence in prison.

4.2 Conclusion.

Objectives of the study were to:

Explore and describe barriers to adherence to ARV therapy in Windhoek Central Prison, make recommendations to address the barriers to adherence to ARV therapy in prison and to assist inmates to adhere to their ARV therapy.

Lack of confidentiality
Most of the respondents have referred to some of the institutional rules that divulge inmates HIV status indirect as barriers to ARV adherence in prison. They feel that this hampers them to go for follow-up and collect their ARV medications. Most of the inmates refused to go for follow up, due to the fact that they are taken there in numbers with a big truck organised only for that day, due to the fact that the specific day is called AIDS day in prison. The study findings concluded that, this practice is in total contravention to the right of privacy to their (inmate's) HIV status.

Ignorance and attitudes of the officials

Most of the respondents referred to the negative attitudes of the prison officials as well as fellow inmates towards those living with HIV/AIDS and on ARV in prison as the barriers to ARV adherence among them. The findings of another study done in Namibia concur with the negative attitudes of the prison officials and inmates towards the fellow inmates living with HIV/AIDS in Prisons as barriers to ARV therapy adherence (Legal Assistant Centre 2010). The research findings therefore conclude that stigma and discrimination plays a significant role as barriers to ARV adherence.

Food and nutrition
Many respondents also emphasised that the food is not enough and not sufficient for them, to take their ARV as prescribed, most of them states that without food ARV make them feel sick.

The study done in Namibia by Legal assistance Centre, Namibia (2010) with ex-inmates as well as former prison warders stated that, complaints about the quality and quantity of food in both pre-trial detention facilities and prisons were common among most former inmates and staff interviewed.

According to the existing literature mentioned on the previous chapters, adequate nutrient food is needed to those on ARV therapy to assist the body to fight the virus. People with HIV, regardless of their health, need to eat well to give the immune system the energy it needs to fight the virus. Therefore a lack of sufficient nutrient food was considered as a barrier to ARV adherence at Windhoek Central Prison.

Time monitoring

The monitoring of time was also identified as a barrier since most of the respondents took ARV by guessing the time which caused them to frequently forget. This is because they are not allowed to have any watches, televisions or radios to indicate time to them.

Adherence to ARV therapy implies taking the right doses of ARV every day, consistently, in the right way and at the right time. The research findings reports that ARV in prison is taken at different times. Therefore within the context of Namibia
correctional facilities, time is identified as one of the barriers to ARV adherence in prison.

Adherence counseling

ARV adherence is accompanied by adherence counseling, which aims at equipping the patients with adequate information concerning ARV therapy but among the inmates the research findings concluded that besides adherence counseling, inmates with HIV/AIDS and those on ARV are misusing ARV drugs, by smoking it, or selling them in exchange with sex. Most of the inmates have stopped to take ARV for even three months; some have started again after they were convinced by others to start again. Therefore the research findings concluded that besides adherence counselling that is provided before the commencement of ARV therapy, the inmates on ARV therapy do not understand the importance of adherence, neither the importance of taking ARV consistently, nor do they understand the consequences of defaulting ARVs, This might be due to a lack of enough information on issue related HIV/AIDS and ARV therapy.

4.3 Limitations.

The participants’ reaction to the researcher or the condition of the study is a threat to the integrity of research. Tactics need to be used to limit the distortion of data. The researcher has identified the following as the limitations of this study:

- Existing literature
The study findings reports that due to the fact that no similar study has been conducted in Namibia prisons on the same topic, no literature exist in Namibia. The study relied heavily on limited literature studies done at various other countries on the topic of ARV adherence in correctional facilities.

- **Data collection**

  Due to the sensitivity of the topic and due to the fact that confidentiality should be ensured throughout the whole study the researcher did not involve an expert, neither tape recorded the data. However the researcher clarified her procedure with experts before commencing with the interviews.

- Possible personal bias (as the researcher is part of the system).

**4.4 Recommendations to:**

1) The Ministry of safety and Security
2) The health workers
3) The prison management/administration

The study was conducted in the closed environment of correctional services; therefore recommendations are mainly targeted at the concerned Ministry of Safety and Security, department of Prisons and correctional Services. The following recommendations will be made to the Ministry of Safety and Security:
• The Ministry of Safety and Security Department of Prisons and Correctional Services should come to an agreement with the Ministry of Health and Social Services to dispense ARV medication in prison. This will eliminate stigma and discrimination among the inmates on ARV therapy, and ensure adherence to ARV therapy among inmates living with HIV/AIDS at Windhoek Central Prison.

• The prison management/ administration should assess the staff establishment of Windhoek Central Prison to implement the needed programs that should be developed to enhance adherence to ARV therapy among inmates on ARV therapy at Windhoek Central Prison. (E.g. ARV medication to be distributed in prison, information about HIV/AIDS, ARV therapy to be disseminated to inmates and prison officials on weekly basis from unit to unit).

• Support groups consisting of inmates should be utilized as peer educators to the fellow inmates to enforce and enhance understanding issues surrounding HIV/AIDS and ARV therapy. The program should emphasise and discourage the negative attitudes and behaviours of inmates and prison officials that impose stigma and discrimination to inmates and prison officials living with HIV/AIDS. This study shows that such attitudes discouraged inmates to adhere to ARV therapy.

  Moreover these attitudes reflect the need of education and information on issue related HIV/AIDS and ARV among inmates as well as prison officials at Windhoek central prison.
• An investigation being done into catering services at Windhoek Central Prison to ensure that balanced nutrient meals is provided to inmates to boost up their immune system.

• To overcome the time barrier that was indentified in this study, it is recommended that each cell be equipped with a wall clock, within the safety policy and guidelines so that inmates be able to keep track of time, especially those on ARV.

This study has discovered that, besides adherence counseling that each and every inmates starting ARV therapy under going, inmates do not understand and have no adequate information on issues related HIV/AIDS and ARV therapy. It is therefore recommended that health workers at the Department of Prison and Correctional Services should increase health education on HIV/AIDS for prisoners and prison officials. This training should include information on treatment, testing, counseling, and prevention. A special emphasis must be placed on addressing the stigma surrounding HIV/AIDS in prison. Additionally, health providers should identify ways to minimize barriers in communication with patients with whom they have no common language (Mark & Tyndall 2006).

This research study concluded that there is a need to find effective ways to support adherence to ART even if the individual does not accept biomedical concepts of HIV disease (Dahab, Charalambous, Hamilton, Fielding, Kielman, Churchyard and Grant (2008).

4.5 Summary

While the Namibian government is to be applauded for implementing a
comprehensive HIV testing, counseling, prevention and treatment program for the benefit of the public, a comprehensive and standardized approach to controlling adherence to ARV therapy in the prison system is lacking.

Incarcerated populations affected by HIV achieve similar clinical outcomes compared with populations in the community when ARV therapy is available. Nevertheless, numerous barriers to HIV treatment for inmates still exist. High costs, difficulties in maintaining confidentiality, lack of trust in correctional staff as well as the social dynamics of correctional facilities have all been implicated as barriers to ARV therapy in correctional settings. This highlights the need to integrate HIV prevention and treatment services within correctional institutions. Furthermore, integration of care must include discharge planning for HIV-infected inmates. Discharge planning needs to address continuity of care as inmates are released back into the community (Zaller, Thurmond, Rich 2007).

The main reported barriers were denial of existence of HIV or of one's own positive status, perceived severity of side-effects, feeling better on treatment and long waiting times at the clinic. The key facilitators were social support, belief in the value of treatment, belief in the importance of one's own life to the survival of one's family, and the ability to fit ART into daily life schedules.
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ANNEXURES
Annexure A: Research proposal approval

UNIVERSITY OF NAMIBIA
Private Bag 13301, 340 Mundaue Nimshilove Avenue, Pietermaritzburg, Windhoek, Namibia

FACULTY OF MEDICAL AND HEALTH SCIENCES

Letter of permission:
Post graduate students

To: Post graduate students
From: Prof A van Dyk

Date: 13 Aug 2010

Dear Student: Ms N N Shalihu (ID: 8613559)

The post graduate studies committee has approved your research proposal.

Title: Barriers to antiretroviral therapy adherence among inmates living with HIV/AIDS at Windhoek Central prison

You may now proceed with your study and data collection.

It may be required that you need to apply for additional permission to utilize your target population. If so, please submit this letter to the relevant organizations involved. It is stressed that you should not proceed with data collection and fieldwork before you have received this letter and got permission from the other institutions to conduct the study. It may also be expected that these organizations may require additional information from you.

Please contact your supervisors on a regular basis.

Prof A van Dyk

Annexure B: Permission to conduct a research
Republic of Namibia

Ministry of Safety and Security

Enquiries: DCP T. HANGULA
Tel No: (+264 61) 284 6111
Fax No: (+264 61) 238 469

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

My Ref: Your Ref:

19 April 2010

The Officer in Charge
Windhoek Central Prison
Private Bag 14004
Bachbrecht

RE: PERMISSION TO CONDUCT A RESEARCH: MRS SHALIHU N.N

Permission is hereby granted to Registered Nurse Shalihu N.N to conduct a research on Barriers to ARV adherence among inmates living with HIV/AIDS at Windhoek Central Prison.

You are advised to share your findings with this office.

Yours sincerely

[Signature]
E. Muskango
COMMISSIONER OF PRISONS

Annexure C: Informed Consent
The research study on: BARRIERS TO ANTIRETROVIRAL THERAPY ADHERENCE AMONG INMATES LIVING WITH HUMAN IMMUNE VIRUS/ACQUIRED IMMUNE DEFICIENCY SYNDROME AT WINDHOEK CENTRAL PRISON.

I……………………………………………………………………………………………………..hereby agree to participate in this study of an assessment of barriers to antiretroviral therapy adherence among inmates living with Human Immune Virus/Acquired Immune Deficiency Syndrome at Windhoek Central Prison.

I have been informed verbally by the researcher and had opportunity to ask questions on the study and any question that I have asked have been to my satisfaction. I understand that, if I decide to participate, my name and all the information I have said will not be revealed with other people rather, information will only be used for data analyses and further the report will be shared with the researcher’s school The University of Namibia as well as the Commissioner of Prisons and Correctional Services.

Signed………………………………………………………………………………………………

Place……………………………………………………………………………………………………..
1. Do you know what Antiretroviral (medicine) is?

On this question almost all inmates interviewed except one, responded that they know ARVs as the medication boosted up the immunity and prolong life. This indicates that inmates on ARV do understand the importance of ARV therapy besides the barriers that prevent adherence to ARV therapy. These were indicated by the following:

“ARVs are medicine used by people with HIV+ to prolong their lives if used in a proper way”

“It is an antiretroviral drug given to people living with the virus, to strengthen their immune system and to prolong their lives.”

“Yes, I know ARV is medications that strengthen your immune system and helps to prolong life”

“Yes I do know, ARV is tablets that minimize the viral load in the body of an infected person.”

“Yes I know what it is but at the same time I do not know, because if one starts take ARVs you were just told that you will starts with ARV and that is it, no further information about it.”

2. Do you take ARV medication?
“Yes, I am taking ARV medications.”

“Yes, I started with it last year”.

Yes, I do every day.”

“Yes I do”

“Yes, I am”.

3. Do inmates on ARVs therapy take their ARVs on time?

- “Not for sure, most of them do not take ARV on time, because not all of them have radios or TVs to consider time.”

- “We cannot say they do take Arv on time, due to the fact that inmates are not equipped with watches, they take ARVs by chance or by guessing on time.”

- “It is not easy for the inmates on ARV to take it on time, how can I say people are taking “ARVs on time if they have no time? Obviously they take it at the wrong time.”

- It is difficult in Prison to take ARVs on time, because no watches is allowed in prison, people are taking it on estimation, we are forgetting after you remember it is already 2 (two) or 3 (three) hours later, simply due to the reason that there
is no watches.”
- “I used to take my ARV medication after breakfast though the breakfast does not have exact time.”
- Inmates are taking ARVs by chances or by guessing on time.”
- “Inmates are concentrating on unlock and lock up time, to take their medications because they have no watches.”

4. Do inmates on ARVs take their ARVs in front of others?

“Yes, they do take it, in front of others, because there is no other way, no other place is there for one to take your ARV in privacy, due to this other inmates knows those who takes ARVs, No privacy, no confidentiality.”

“For inmate to take ARV in privacy, it is a very big problem, especially in communal cells. You will wait for others to pay attentions on something else for you to drink your ARVs, otherwise stigma and the fear of discrimination by others is always there”.

“There is no privacy in Prison, but I personally used to hide myself under the blankets or go to the toilet and take my ARV medication otherwise I will stay without taking it if there are people closer to me”.

“I used to take my ARV drugs together with other ordinary medications like Panado, or anti-hypertensive medications, others will never know what kind of treatment I do take.”
“I used to wait others to get out of my site or wait for the fellow inmates to pay their attentions on something else for me to take my ARV medications.”

5. What support do inmates on ARVs get in prison?

“The support is not that much, to be honest with you, but myself got support from my friends if I feel down and mostly from my family and nothing from prison.”

"Food stuff only and nothing else.”

“No any kind of support to those on ARV therapy is found in prison.”

“I do not see/hear anything, reading materials or anyone who came to talk to them about their status and ARVs except when they went to outside hospitals.

“Prison is facilitating our consultation to at ARV clinic to have access to ARV drugs”.

6. “Do you know anything that prevents inmates on ARVs to take their ARVs as prescribed?

“Fear of others will make a person to take ARV immediately before time or delay it until such a time that he is out of sight.” "Stigma is a contributing factor to delay or taking ARV earlier then on the specific time”.

“Lack of access to watch, radio or TV in communal cells hampers the time allocated
to your medications”.

“Denial/don’t mind attitude, I know about one inmate who do not go for ARV follow ups even if the medication got finish. I did not talk to him because i am not closer to him”.

“Selling of ARV medications to the drug dealers in prison, some drug dealers are HIV+ some are not for smoking it”.

“Selling of ARV medications in exchange with sex”.

“Demoralization and stigma from other inmates who discriminate them, they do not want to associate with witches as they called them”

“Forgetfulness due to the conflict between prison officials and inmates is one of the barriers to ARV therapy adherence.”

“Discouraging information from peer concerning ARV medications.

“Lack of privacy contributing to the stopping or skipping days to take ARVs”.

“I know one of my colleague who stop taking ARV medication, because there is no privacy, their health passport are read by the prison officials (guards). This Guard responds to you that there is no privacy in prison.”

“Privacy is being violated even at the local hospitals whereby the NAMPOL officials
are always present while one is consulted by the doctor.”

“Going to the hospital at ARV clinic in a big group in the same car, this has revealed people’s status indirect. This has caused some of my colleagues to stop going for follow up at ARV clinic; they are no more taking their ARVs.”

“Stigma is really a problem, I have seen (3) three of my colleagues withdrawn/ stop to take ARV medications”

“The system that is being used to take our ARV medication at ARV clinic is not a secret, confidentiality is not there, many people withdrawn because of this”.

“The containers of ARV drugs are known in public; if one sees this container in one’s possession his status is already revealed”.

“Food that we are ought to receive is always not available, take ARV on empty stomach make you weak “Side effects of ARV drugs make somebody to stop taking ARVs because it makes you sick”.

“Demoralization and stigma from other inmates who discriminate them, they do not want to associate with witches as they called them.”

“Stigma is really a problem, I have seen (3) three of my colleagues withdrawn/ stop to take ARV medications”

“Forgetfulness due to the conflict between prison officials and inmates is one of the
“Side effects of ARV drugs make somebody to stop taking ARVs because it makes you sick”.

- “People on ARV therapy should have more information about ARV medications
  - “The second inmate I know stayed for 3 month without medication, because he went to work at the outside stations” (other prisons).
  - “I know many of those who dropped ARV except one whom I convinced and he went back to ARV again, the rest have thrown them away.”

“Prison to provide inmates on ARV with enough high protein food”.

- “The food that we ought to receive is not always available”

- Lack of sufficient food cause dizziness then one will skip some doses.”

- Oh! Are you also on AIDS treatment? This was said in front or in the presence of other inmates and prison warders.”

- “Disrespect from prison members who made statements like” I don’t care if you die you die or your life is just depends on medication only”.

- “Frustration caused by members of prison can make a person not to take ARV therapy, or it discourages you”.

barriers to ARV therapy adherence.”
- “Discouragement from people around you, how do they talk about those on ARV? “I have experienced it myself, I wanted to stop ARV but I know some of my colleagues who have stopped to take it.”

7. What do you think that can be done to motivate inmates on ARV to adhere to ARV therapy?

“Our clinic to talk more about illnesses with inmates including ARVs, how to take it, why it is so important to take it on time, and what is the consequences for not taking it on time.” “This will encourage inmates on ARV to talk about their problems.

“Introduce more awareness campaigns on the use of ARV drugs and its importance”
“Inmates on ARV to formulate support groups to motivate and educate others.”

“People on ARV therapy should have more information about ARV medications.”
“Watches to be allowed in prison.”
“Prisoners must be allowed to have time in prison in order for them to take their ARVs on time.”
“Watches to be provided.”
“Prison to provide inmates on ARV therapy with enough high protein food, the quantity must be increased; this will assist inmates to take their ARV medication well if they have enough food to eat.”
“Inmates to be allowed to receive additional nutrient food from their relatives at visit.”

“Inmates to be allowed to buy their boosters.”

“Provide sufficient food.”

“Prison officials to be educated on the rights and confidentiality of inmates on ARV.”

“NAMPOL and Prison officials to be educated to respect the right of inmates on privacy and confidentiality.”

“The prison guarders (Warders) to be taught how to be peacefully with inmates and to respect inmates’ human dignity.”

“Prison officials to be sent for training on assertiveness.”

8. What is your view about ARVs in general?

In this question the interviewer wanted to test the participants’ understanding about the importance of ARV therapy.

Almost all the participants understands the importance of ARV drugs in their lives, they provided their positive comments on ARV therapy using different perceptions despite the barriers on ARV in prison known by them.

“ARVs is helping those who take it properly, it prolong people’s lives, it is important for people on ARV therapy to take it as ought to be in order to stay healthy.”

“ARV medications provide a second chance for the people infected to live normal
lives.”

"ARV is really helping, myself got sick several times after I got ARV medications, I become very physical fit then those who do not take it."

"ARV is important we just have to understand, how it works, and we should know how to live with it."

"ARVs have extended many people’s lives, I saw some of my colleagues stopped ARV and their health status degraded, in general the medication is helping.

"ARVs is helping because it has increased my CD4 counts."

"ARV is helping us a lot, we were in darkness but ARV has sustained our lives."

"Thank you to a person who established or produced this medication ARVs, he really contributed to our lives by keeping us alive."

"ARV is too effective, it brings back the strength so that you can do your work well, I am happy for it."

"ARV has been assisting people, and their lives were sustained, it also removes the virus totally out of the blood to be tested negative."

"ARV is good medication, as long as you are taking your ARV, daily and eats food you will live longer and normal."
“ARV is helping a lot, I was very sick when, started my ARV I become healthy and strong.”

Annexure E: Transcriptions of in-depth interview

Twenty participants (Inmates) recruited to take part in the above mentioned interview took place at Windhoek central Prison. 18 inmates participated and two (2) inmates withdrawn. Data saturation reached, thus in-depth interview ended with the 18th participant.

Participant: 1

1) ARVs are medicine used by people with HIV Positive to prolong the life if used in a proper way.

2) Yes

3) Not for sure, most of them do not take ARVs on time because not all of them have radios or TVs to consider time. No watches allowed in prison except to those in a minimum (level Unit 1 only).
4) Yes, they do take ARVs in front of others because there is no other way; no other place is there for one to take ARVs in private. Due to this, inmates know those who take ARVs. No privacy, no confidentiality in prison.

5) I did not see or hear anything like reading materials or anyone who came to talk to inmates who are on ARVs about their status except whenever they went to outside hospitals (Katutura/Windhoek Central Hospital).

6) Fear of others will make a person to take ARVs immediately before time, or delay it until such a time that he is out of site.

Stigma is a contributing factor to the delaying or to the earlier taking of ARVs than on a specific time. Denial or the don’t mind attitude will also contributing to the delaying or to earlier taking of ARV medication.

I know about one inmate in our Unit, who do not go for follow ups even if his medication got finish, I did not talk to him because I am not closer to him.

The second inmate I know remains for three months without medication because he went out to the outside stations to work. I do not know whether he get his medication easily where he went.

7) - Our clinic at Prison to talk more about illnesses with inmates including ARVs, how to take it, why is it important to take it on time and the consequences for not taking it on time. This will encourage inmates on ARVs to develop the confident to talk about their problems.
- Prison to provide inmates on ARV therapy with enough high protein food. The quantity must be increased, this will assist inmates to take their ARVs if they have enough food to eat.

8) ARVs helps those who take it properly. It prolongs people’s life, therefore it is very important for people on ARVs to take it as it ought to be taken in order to stay healthy.

**Participant: 2**

1. It is an antiretroviral drug given to people living with the virus to strengthen their immune system and to prolong their life or to enable them to live a normal life. ARVs is also called a killed me softly due to the fact that, if you do not have enough food to take, slowly it will kill you.

2. Yes, I do take ARVs.

3. We cannot say they do take ARVs on time due to the fact that inmates are not equipped with watches they take ARVs by chances or by guessing on time.

Not everyone have Radio or TV, due to the classifications of inmates and that not everyone can afford to buy radio or TV even if it is made a privilege to him to have it. So, most of the time an inmate is relying on other inmates who have an access to the radios to remind him with the time to take his ARVs. This will rise suspicious and a person is always forced to reveal his status not that he is really trust that person, but simply because that he can’t do otherwise.
4. The majority take it in privacy e.g. by go to the bathroom, or under the blankets, some are pour it out from the usual containers and put it I ordinal plastics to kill suspicious. The minority are taking it in front of others because they came to term with it.

5. Inmates on ARVs don’t get any support in prison, Privacy and confidentiality is violated on daily basis. During searching routines prison officers used to pour out inmates ‘s ARVs as they are searching for prohibited items. By so doing, I come across to an inmate being intimidated by the prison officer as follow-

Oh, are you also on AIDS treatment? This was said in front/in the presence of other inmates and other officers. Due to this inmates on ARVs who observed this attitude will be discouraged and throw the drugs away.

Prison officers have attitudes of telling inmates in a group shouting, e.g. those for ARVs get ready. By so doing they broadcast people’s status.

The routine collection of ARV medication that is done on Wednesdays from prison is regarded as AIDS day.

6. Attitudes of prisoners

Lack of nutrient food.

Psychologically humiliation for inmates by prison officers

Demoralization and stigma from other inmates that resulted to isolation of the victims since they don’t want to associates with the witches as they used to call them.
Selling of ARV medications to the drug dealers and drug users in prison, some are HIV positive but not on ARVs as yet, and others are buying it for smoking it.

Selling of ARVs in exchange with sex. There are those who have permanent sexual partners, in attempt to try to protect their partners from getting infected with the virus they buy ARV drugs for them.

Lack of sufficient information concerning ARVs from the health workers.

Discouraging information from peers concerning ARV drugs.

7. Prison officers to be educated on confidentiality and the rights of inmates on ARVs.

Inmates to be allowed to receive additional nutrition food from their relatives at visit.

Watches must be allowed in prison.

All inmates to be supported with exercise equipments

Entertaining activities for inmates to be made possible in prisons e.g. fun days, talent show etcetera.

Regular check up for inmates on ARV especially the new starter, to prevent them from giving up their medication due to side effect.

8) ARV is essential; it is a necessity because it helps to prolong the life of the people who are suffering from AIDS.
ARV gives a second chance for people to live a normal life

IN order to win a war for the success of the usage of ARV, inmates must support each other vehemently.

Participant: 3

1) Yes I know what it is and at the same time I do not know, because if someone starts taking ARV you were just told that, you will start with ARV, that’s all. No further information about it. ARV is drugs that that help the body to fight the virus.

2) Yes, I am taking ARV medications.

3) It is not easy for inmates on ARV to take it on time, how can I say people are taking ARV on time if they have no time, definitely they are taking it at the wrong time. Inmates are concentrating on the lock up and unlock time to take ARVs and I am 100% sure that they are taking it at different wrong times. Sometimes they take it at five, six or seven even at 8 o’clock. This is very dangerous because it cause resistance.

4) To me it is easy to take ARV in private because I am staying at single cells, but I know it is difficult to those in the general units to have privacy.

5) As far as I know no any kind of support to those on ARV is found in prison.

6) Lack of privacy contributes to stopping or skipping days of taking ARVs. I know one of my colleagues who stop to take his ARVs because there is no privacy in
prison, their health passport are read by prison officials, most of the time whenever
you complaint these guards answer you that there is no privacy in prison. I referred
him to the Namibian constitution on the issue of privacy. Privacy is being violated
even at the local hospitals whereby the NAMPOL officials are present when we
consult the doctors.

Going to ARV clinic in numbers in the same car at the same time, has revealed
people’s status indirect, this has caused some of my colleagues to stop going for
follow up at ARV clinic. He is no more taking ARV since then.

7) People on ARV should have enough information about ARVs.
Inmates to be allowed to buy their boosters outside at the private pharmacies
Enough food to be given to inmates on ARVs to prevent people to stop their ARVs
because of hunger.
Inmates must be allowed to have time in prison in order to take their ARVs on time.
NAMPOL and Prison Officials to be educated to respect the rights of inmates on
Privacy and confidentiality.
ARVs are really helping e.g. me I used to get sick on several times, after I started
with ARVs I became very physical fit then those who are not taking it.

Participant: 4
1) Yes, I know. ARV is the medication that will strengthen your Immune system and
help to prolong life.
2) Yes I started with it last year.
3) It is difficult in prison to take ARV on time, because no watch is allowed in prison, inmates are taking ARVs by estimating on time. Sometimes we forget, when you remember two or three hours passed already simply because there is no watch.

Fear of stigma when taking ARVs especially in the communal cells. I have seen people talking about other’s status

Lack of Privacy

4) Inmates are taking ARV privately, this is very difficult in communal cells because you have to wait for others to pay attention on something else so that you can drink your ARVs, otherwise stigma and fear of discrimination by others is always there.

5) Prison is facilitating our consultation at ARV clinic to have access to ARV drugs. We are provided with high protein diet though it is not sufficient.

6) Stigma is really a problem in prison, I have seen 3 of my colleagues withdrawn, and they have stopped to take ARVs.

The system that is used to collect our ARV at ARV clinic is not a secret. Confidentiality is not there, many people withdrawn because of this.

The food that we supposed to have is not always available; take ARVs on empty stomach makes you weak.

7) Awareness campaign among all prisoners about ARV and HIV in general, People should emphasize on the issue of stigma.
Single cells to be provided to those who want to be alone and have privacy.

Watches to be provided to inmates.

8) ARVs are effective besides the side effects

**Participant: 5**

1) Yes I know that ARV is tablets that minimize the viral load in the body of an infected person

2) Yes I do everyday

3) No, I am not taking ARV on time, because I have no watch. Shyness is also the cause of us not to take ARVs on time because we are many together with those who are not infected. Sometimes I take my ARV in the toilet. I used to take ARV after breakfast because I cannot take it on empty stomach though breakfast does not have exact time. Sometimes it comes earlier sometimes late.

4) There is no privacy in prison, but I personally always tried to hide under the blankets or in the toilet as I said at the beginning, otherwise I will stay without taking if there are people closer to me.

5) Additional food but most of the time they are not available.
   - ARVs that we receive free of charge.

6) Lack of privacy
   - The containers of ARV are known in the public, ARV containers made people’s status known to the public.
   - Side effect of ARV drugs are known as barriers to ARVs adherence.
7) Inmates to be allowed to stay at single cells on request.
   - Sessions to all inmates about ARVs.
   - Medias to be made available to inmates to be equipped with information on HIV/AIDS and ARV.

8) ARV is very important, we just need to understand how it works and we must know how to leave with it.

**Participant: 6**

1) ARV is medicine that is given to the people who were tested HIV positive, after received counselling from the health workers. It is given only if you adhere to ARV.

2) Yes I do

3) It is difficult for inmates to take this medication on the right time; we do not have watches, radios or TVs. It is also Problematic because of privacy since we are among many people. We use to take ARVs the time if those among us are focusing on something else. Prison which is full of situational circumstances e.g. the time of your medication you might be engaged with other activities apart from your medication, this contributes to the delay to the time of medications. The question of time is difficult to address because prison is differ from home life.

4) The majority does not take it in front of others, once you do that it resulted in humiliation and lose of dignity.

5) ARV that we get in Prison
- Those who have money are allowed to buy their booster and food staff to boost up their immune system.

- Emotional support that we receive from the health workers especially when you are critical ill.

- Referral is also provided at prison if one gets sick and need special attention.

6) Fear of humiliation and lose of respect and dignity from fellow inmates.

- Shyness and lack of privacy in a communal cells hamper time allocated to you medication.

- Lack of access to radios, TVs and watches resulted in estimating of time when take medication.

7) It is difficult for one to identify a person who do not adhere to ARV so that he may be addressed therefore general information concerning ARV should be introduced in the form of video cassette showing those adhere and those who do not adhere, to educate people to make decisions in their heart to adhere to ARV.

- 8) ARV is just medication like others without ARV is easy for any disease to wipe you away or to lose your life. ARV has extended the life of many people. I saw some of my colleagues who stopped ARV then their health status degraded. In general ARV is helping.

Participant: 7
1) Yes I know that ARV are tablets that I always drinking to reduce HIV in my body

2) Yes I do

3) Not always, it is difficult in prison to take ARV on time; one of the barriers is lack of correct time to take ARV.
   - Lack of sufficient food
   - Stressful condition in Prison
   - Lack of freedom
   - Disrespect from prison members who used to make statements such as “I don’t care if you die, u die or your life hangs on medication only.”
   - Conflict between inmates and prison warders (prison officials.)

4) No, inmates do take ARV secretly as long as you do not expose yourself to others.

5) Nothing

6) Forgetfulness due to conflict between members and inmates in prison.

7) Provide sufficient food
   - Prison must allow hand watch or radios to direct us on time.
   - The prison warders to be taught how to socialize peacefully with inmates and to respect inmate’s human dignity.

8) ARV is helping because it has increased my CD4 count.
**Participant: 8**

1) ARV is the treatment for HIV

2) Yes I do

3) No, there is no specific time in prison; we used to guess on time when taking our ARVs which is a problem.

4) No they do not take ARV in front of others, because everybody has his own place though they are living in communal cells. Like myself I am living at single cells.

5) Additional food.

6) ARV is managed better by inmates while in prison comparing to those outside prison.

There are no barriers in prison that prohibit you to take your ARVs if you are serious with your life

7) The prison hospital management must encourage people to take their ARV as prescribed

8) ARV is really helping

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**Participant: 9**

1) ARV is tablets that help to sustain your life.

2) Yes I am

3) Myself I am estimating on time because I do not have anywhere to check the time. No watch, radio or TV. I take it always morning time and afternoon.
4) No, myself I make sure that nobody sees me take ARV though I am living in communal cells. I used to take ARV together with high blood pressure treatment, and then people won’t be suspicious.

5) Food staff (additional one)

6) No time in prison (watches)
   - No privacy (shyness)
   - Insufficient food
   - Insufficient sleep (noise) caused by fellow inmates.
   - Prison environment (space) too small to exercise because my doctor told me to have much exercise in order to live healthy on ARV.

7) Prison to provide materials to exercise.
   - Watches to be provided or to be allowed in prison.
   - Sufficient food to be provided.

8) ARV is helping us a lot. We were in darkness with the virus but with ARV in place our life are sustained.

Participant: 10

1) Yes ARV is medication that helps a person to live longer with the virus in his body.

2) Yes

3) No they do not have watch to check their time, in my cell people are looks on the sun in the morning and to the stars in the evening to determine time
4) No, they do it secretly, they are taking ARV in small quantity and put it in a usual tablet plastic bags and hide it under the pillow.

5) Additional food

6) Frustration caused by members made a person not to take treatment or you will be discouraged to take it.
   - Stressful condition in prison, e.g. anger will make you to forget to take ARV on time, as you remember time has passed already.
   - Time in prison, No watches.

7) Prison officials to be sent for training of assertiveness.
   - Watch to be provided in prison

8) ARV is a life support medication, it also protect the future generations from get HIV from the mothers.

**Participant: 11**

1) Yes, ARV is the tablets that can sustain my healthy.

2) Yes, I am.

3) At my side I can say yes, I take my ARV on time, because I have access to the radio, those who do not have accesses to the Medias, they use the cultural method which is sunset.

4) No, we prevent others to be suspicious because we take ARV together with other tablets at the same time. They will never know what exactly are you taking, but you yourself know what you are taking.
5) Additional food that is provided by prison and nothing else

6) Lack of sufficient food caused dizziness and caused someone to skip some doses.
   - Lack of proper information to the people on ARV e.g. There are those who
     feel that that they are strong and fat, and ARV is not needed anymore; and they stop
     taking it, but then they will again start taking it if they become sick.
   - Negligence and ignorance by the inmate on ARV.
   - Lack of time to check on a specific time.

7) Provide sufficient nutrient food
   - Proper information concerning ARV treatment should be done regular in prison
     to motivate inmates to care for themselves.
   - Prison to release those on ARV but very sick, to be managed by their families.

8) Thank you to a person who introduced this medication, ARV really contributed
   much to our lives, by keeping us alive.

**Participant: 12**

1) ARV is a medication I use to neutralize HIV in my body

2) Yes I do

3) No, because you do not have time, watches are not allowed in Prison so we do
   take it at different times.
4) I can ensure you that myself and any colleague I know those in my cell we do not take ARV in front of others.

I take ARV before the sun rises while others still asleep and night time after ever body fell asleep.

5) Food staff additional

Nothing else

6) Discouragement from people around you, how they talk about those on ARV. I have experiencing it myself, I wanted to stop ARVs but I know some of my colleagues who stopped to take ARVs.

-Side effects

7 - The government to provide people with sufficient food, even the cooked one.

- Prison staff to be trained how to handle and how to work with people.

- For the counsellors to come and talk about ARV in general

8 - ARV is helping and it saves life

Participant: 13

1) ARV is a tablets that decrease the activity of the virus in the human body

2) Yes I do

3) I do not know with others, but myself I have a radio, I listen at the time from there then I took my tablets.
4) No one is taking it privately; everyone knows the tactics he used not to be seen when taking his treatment.

5) Food staff only and nothing else

6) I have not detected any barriers in Prison that can prohibit inmate to take their ARVs as prescribed. Because myself does not have any problem.

7) People on ARV to be treated with love, privacy to be ensured to each and everyone in prison

   - People (inmates) on ARV to be treated the same way as those on ARV in the Community (equal rights).

8) ARV is really helpful

Participant: 14

1) Medications that are given to people with HIV/AIDS to help them to prolong their lives

2) Yes, I am

3) It is difficult in Prison due to the restriction of time, no watches allowed in Prison and not everybody is having an access to medias
4) Not always, unless that specific person has disclosed his Status

5) No support of any kind is given to the inmates on ARV as far as I know, except the counselling information from the counsellor in Prison if you approach them.

Prison officials do not understand the importance of taking ARV consistent, most of them refuse to take you to the hospital even if you say the ARV drugs are about to finish.

6) Lack of proper information about ARV
   - Lack of Privacy due to the Prison situation

7) - The Government or relative institutions to introduce the ongoing Education on ARV
   - Sufficient food to be provided
   - Prison hospital to allow those on ARV to come for treatment regularly and freely when they are sick, (Sometimes we have feared to come to prison clinic due to attitudes of particular nurses).

8) ARV is helping a lot, I was very sick when I started any ARV’s, I become healthy and strong.

Participant: 15
1) I understand it as a pills given to people with HIV/AIDS

2) Yes am

3) Yes, myself I used to take it on time, using the radio

4) No, I take my ARVs privately due to the fear of stigma

5) Yes, Prison does give support to us who are on ARV, for example food staff addition to the normal Prison food.

6) - Discrimination from the fellow inmates

   - Enough food must be provided so that one cannot take ARV on empty stomach, because ARV can make you dizzy.

7) Education to all inmates to respect others to stop impose stigma and discrimination to us those on ARV.

8) ARV is too effective, it brings back the strength so that you do your work well, I am happy for it.

Participant: 16

1) Yes it is the tablets that assist a person who live with HIV/AIDS to prolong his life.

2) Yes I am

3) Not precisely in Prison, because there is no watch, they do predict on time.
4) No, they do not take it publicly they know their way of taking it secretly.

5) Follow up to ARV clinic is on time and is accurate.
   - Additional food on top of Prison ration.
6) Lack of time (watches)
7) ARV to be supplied at the Prison Clinic.
   - Prison system must allow watches in the communal cells.
8) ARV has been assisting people and their lives were sustained. It also removes the virus totally out of blood to be tested negative.

**Participant: 17**

1) ARV is the medication that can help my immune system to go up

2) Yes I do

3) There are in three categories
   - Those who take it on time
   - Those who do not take it at all
   - Those who forget to take them on time

I know many of those who are dropped ARV’s except one who I convinced to take and he went back to ARV again. The rest have thrown them away.

4) - There are some of those accept the situation and are being reminded by their friends those whom they trust.
- There are those who take it secretly and on their own time

5) The support is not so much to be honest but myself I got support from friends only if I feel down, and mostly from my family and nothing from prison.

   No physical, emotional or psychological support is provided to me from prison officials even in the time i need it.

6) - Lack of food in Prison

- Side effect of ARV

- Inmates do smoke while on ARV, this seems as taking ARV with a glass of beer.

7) More support groups to be established in Prison, to support inmates on ARV to adhere and understand their situation.

   - Prison staff to be involved in training to have knowledge about issues related to HIV/AIDS and ARV’S in order to help the inmates in the right way.

   - Counsellors to facilitate the continuation counselling regularly.

8) ARV are good medication, as long as you are taking your ARV daily and eats food, you will live longer and normal.

Participant: 18
1) Yes, it is the medication that prevent for one to become weak if you take it on time, the virus will be reduced and your CD4 will go up. It also helps you to live longer.

2) Yes, I do take it.

3) I cannot say, but in my case, not always, because I do not have watch sometimes I take it late and sometimes I am earlier.

4) In my case I do take it in front of others, though people used to throw stones because they see me taking ARV (stigma). I have nowhere to hide and other reason is that I want people around me to see so that they can help me.

5) I do not see any support rather than extra food that we are provided even if it is not constant. I went to the extent of consult the dietician who prescribed me to be given e.g. juice but I am not getting it.

6) Myself I do not see any barriers for one to take his ARV, because if you are willing to take it, then you will do it.

Other thing that I can think is maybe stigma because people used to throw stones e.g. you are sick and your life only depends on the tablets but mostly this happens to those who are hiding their conditions.

Behaviour of the prison staff and fellow inmates, inmates on ARV are used to be called names by prison staff and fellow inmates. “We are called names by fellow inmates such as witches or contract workers simply because we are taking ARV medications.”
The way inmates on ARV are carried from prison to ARV clinic like a bunch of wood in one truck is inhuman.

The list that prison clinic used to send down to the units with the names for inmates for ARV lands in many hands, officials as well as inmates working in the offices. Due to this, inmates might stop to take his ARV in order to kill suspicious.

7) The prison hospital list not to indicate where a person will be taken rather to indicate the names only.

- Inmates not to be taken in numbers to ARV clinic and the days must be separated.

8) Madam, You know me very well, there is a time that I was very sick, but it helps me a lot therefore I put ARV highly on a praise. I really do appreciate them. If it was not for ARV I would have died already.