

**An analysis of the development of the
2010-2016 Namibia Malaria Strategic Plan and its relation to
Health Promotion**

Kaarina Nduuvunawa Amutenya

Student No: 2616485

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Supervisor: Dr. Hazel Bradley

Co-supervisor: Dr. Ruth Stern

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ABSTRACT

Background

Malaria was a major cause of mortality and morbidity in Namibia from 1999 to 2001. Malaria epidemics were recorded in 1990, 1996, 2000 and in 2001. In 2001 alone 733, 509 malaria morbidity cases and 1,728 mortality cases were documented. In recent years, however, malaria morbidity and mortality in the country have drastically declined by over 90%. This has influenced the Ministry of Health and Social Services (MoHSS) in Namibia to adopt a malaria elimination approach as opposed to the malaria case management approach. A malaria programme, known as the National Vector Disease Control Program (NVDCP) was instituted and mandated to coordinate malaria case management (diagnosis and treatment) as well as the current malaria elimination focus (elimination of transmission foci). This is all aimed at effectively addressing the current malaria epidemiology and sustain the decline observed over the last decade.

Aim and Methodology

The study's purpose was to analyse how the Namibia Malaria Strategic Plan (MSP) for 2010-2016 was developed and its relationship to health promotion. It employed an exploratory design which included stakeholders involved in malaria programmes and activities in the country. Data collection methods were of a qualitative nature through in-depth interviews and documentary review. Seven people were interviewed representing stakeholders from the public and private sectors. Those interviewed from the public sector were the Ministry of Environment and Tourism (MET), MoHSS's division for Malaria, Policy Planning and Information Education and Communication (IEC). Others interviewed included national and international non-governmental organizations' representatives from the World Health Organisation (WHO) and Society for Family Health (SFH). Documents reviewed include MSP 2010-2016, MSP 2003-2007, Malaria Policy of 2005, National Health Promotion policy 2012 and the Namibian Constitution. Data was analysed using content and thematic processes. Respondents were assured of confidentiality and anonymity.

Key findings

The study found that information with regard to the formulation process of the MSP 2010-2016 was limited to a few superficially described events. These events involved, amongst others, a review of the previous (2003-2007) MSP, a pre-assessment questionnaire and two to three workshops. The events were not explicitly described or documented. The researcher concluded that the evidence to better understand the development processes of the MSP 2010-2016 was deficient. Consequently, the study concluded that the policy formulation aspects of the MSP were inadequate. The literature indicates that policy formulation and analysis is a complex undertaking and the MSP process did not meet these criteria. Amongst the limitations were limited stakeholder engagement and incomplete descriptions of the processes undertaken.

In relation to the MSP's focus on health promotion, the study found varied understanding of health promotion among the stakeholders. Some respondents were not aware of their organisation's health promotion interventions while others believed that health promotion was limited to the health sector only. However, while national documents, such as the Namibian Constitution, advocate for 'health *investment as a just cause*' the MSPs limited inclusion of relevant stakeholders, such as the Ministry of Environment (MET) and the Information, Education and Communication (IEC) unit, restricted the ability of the MSP to offer malaria expansive programmes – that is, those beyond the health realm.

Moreover, the implementation of malaria activities through the involvement of a limited range of actors in the malaria programmes will continue to perpetuate the existing narrow focus of health promotion by these stakeholders, as opposed to a more broad-base understanding. As a result malaria prevention will continue to be delivered as silo events or programmes. This poses serious implications in working towards the MSP goal of malaria elimination.

Recommendations

The Ottawa Charter advocates for '*Building healthy public policies*'. This specifically refers to multi-disciplinary programmes. This study therefore recommends that the NVDCP follow existing international and national guidelines which systematically guide the development of MSPs and official health documents. Doing so would enable a more streamlined policy development process which would describe and contextualize the dimension of policy formulation, namely context, content, process and actors. It also recommends that the MSP is developed through a broad-based collaborative stakeholder engagement process which would facilitate an appropriately integrated inter-sectoral approach to malaria in the country.



DECLARATION

I hereby declare that this study “*An analysis of the development of the 2010-2016 Namibia Malaria Strategic Plan and its relation to Health Promotion*” is my own work and it has not been submitted for any degree or examination to any other university, and that all sources I have used or quoted have been indicated and acknowledged by referencing.

Full Name: Kaarina Nduuvunawa Amutenya

Signature: 

Date: August 2015



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ABBREVIATIONS AND ACRONYMS

DDT	-	Dichloro-diphenyl-trichloroethane
DHS	-	Demographic and Health Survey
IEC	-	Information, Education and Communication
IFRC	-	International Federation of Red Cross
LLIN's	-	Long-Lasting Insecticide-treated bed Nets
MDG's	-	Millennium Development Goals
MET	-	Ministry of Environment and Tourism
MoHSS	-	Ministry of Health and Social Services
MRLGHRD	-	Ministry of Regional Local Government Housing and Rural Development
MSP	-	Malaria Strategic Plan
NHPF	-	National Health Policy Framework
NPC	-	National Planning Commission
NVDCP	-	National Vector Disease Control Programme
PHC	-	Primary Health Care
RMB	-	Roll Back Malaria
SADC	-	Southern African Development Community
SFH	-	Society for Family Health
SSA	-	Sub-Saharan Africa
UNICEF	-	United Nations Children's Fund
UWC	-	University of the Western Cape
WHO	-	World Health Organisation

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CHAPTER 1: INTRODUCTION

1.1 Brief Background

Malaria is caused by a Plasmodium Falciparum parasite, which transmits malaria to humans through a sting of an anopheles mosquito (WHO, 2013). The anopheles mosquitos breed favorably under tropical conditions which is why almost half of the world's population living in tropical areas are considered at risk (WHO, 2013, CDC, 2012). If not diagnosed and treated in a timely fashion malaria can cause death or result in complications such as blindness and hearing loss (CDC, 2012). The World Health Organisation (WHO) provides detailed country information about the status of malaria in over 140 countries annually. In 2013 the WHO reported that 198 million morbidity and 584 mortality cases were recorded globally. The WHO further reports that of all cases recorded, 90% account for malaria cases in Africa (WHO, 2013).

In Namibia, malaria is endemic in over seven regions and is considered a public health threat (MoHSS, 2013; MoHSS, 2010b). The Ministry of Health and Social Services (MoHSS) indicates that malaria was the leading cause of morbidity and mortality from 1999 – 2002. In 2001, alone, 733,509 malaria morbidity cases and 1,728 mortality cases were recorded, making 2001 the worst malaria epidemic year in Namibia (MoHSS, 2005). Since then a gradual decrease in malaria mortality and morbidity has been recorded. Recent statistics for 2013 showed 4,745 morbidity cases and slightly over 20 mortality cases (MoHSS, 2014).

The MoHSS reports that the decrease recorded between 2001 – 2010 represents a 90% decrease in malaria mortality and morbidity country wide (MoHSS, 2010b). In view of the above malaria case decreases a Malaria Strategic Plan (MSP) 2010-2016 was adopted. The 2010 – 2016 MSP is a pre – elimination strategy envisioning freeing Namibia of malaria by 2020. The MSP intent is to “to provide free, efficient, accessible and quality malaria interventions to all people in Namibia” (MoHSS: 12, 2010). Apart from Namibia, South Africa, Botswana, Zambia and Swaziland all developed MSPs and Namibia, South Africa and Swaziland were amongst 23 countries pre-planning malaria elimination (WHO, 2008a; Groep *et al.* 2013).

Malaria case decline in Namibia and worldwide is attributed to a number of factors. It is also well documented that, if managed well, malaria can be prevented, diagnosed, treated, cured and controlled (WHO, 2008a). In Namibia, however, this has not been easy due to the multi-causative effect and management complexities of malaria (MoHSS, 2010c; WHO, 2013). Nonetheless, factors attributed to malaria morbidity and mortality case decline were, amongst others, the establishment of a malaria focus unit, targeted policies and procedures, willingness of communities to cooperate, increased bi-lateral donor funding, technical expertise, proper surveillance, political will, accelerated malaria vector control and case management (MoHSS, 2010b,c). Regardless of the above mentioned interventions, the country remains vulnerable to potential malaria outbreaks mainly due to the multi-causative aspects related to the environmental, biological and socio-economic transmission of malaria (MoHSS, 2014; MET, 2009).

The role of health promotion within the realm of the MSP 2010 – 2016 is to promote the implementation of key interventions necessary for preparing Namibia to eliminate malaria, in endemic health districts, by the year 2020. The MSP calls for capacity building (management and strengthening of surveillances), vector elimination (at community level assisted by technical staff), early sign warning for preparedness and responses, behavior change and mass community mobilization. The overarching goal of the MSP 2010 – 2016 is “to reduce the incidence of malaria to below 1 per 1,000 population in every district of Namibia” (MoHSS, 2010). The districts are stratified into zones according to the level of risk of malaria transmission.

1.2 Study Setting

Namibia lies between the Namib and Kalahari deserts, in the south-western hemisphere of Africa. Geographically this contributes to the dry and semi-arid climatic conditions with mean temperatures between 5-20°C (NPC, 2013c). Seasonal rainfall showers occur between October to April with drought and floods occasionally hitting the north and north-eastern parts of the country (NPC, 2004). The above-mentioned conditions are conducive for malaria-breeding and therefore contribute to the presence of malaria in Namibia (WHO, 2013; MoHSS, 2010b; NPC, 2004; MET, 2013). National statistics indicate that 65% of the population lives in malaria endemic regions and hence are at high risk of contracting malaria (MoHSS, 2013; NPC, 2011).

Namibia adopted the Primary Health Care (PHC) system and approach at independence in 1990 (MoHSS, 2010a). The health delivery system in Namibia is divided in 13 regions and is managed by a Regional Health Director (MoHSS, 2014). The health delivery system in Namibia operates in accordance with the political division (Namibia is divided into 14 political and administrative regions that are further delineated into 121 constituencies) (OPM, 2013a). In total the MoHSS manages 34 health districts encompassing administrative units, 47 hospitals, 40 health centres and 292 clinics, spread across the constituencies and regions. Malaria services are offered at all health care levels, with the national level responsible for policy and funding whereas the hospitals, clinics and health centres provide malaria clinical diagnosis, treatment and rehabilitation (MoHSS, 2010a).

Namibia had a total population of 1,830,330 at independence and had grown to just over 2.2 million during the 2011 population Census (NPC, 2011). The country has a total surface area of 824,292 square kilometres with a very low population density. As a result over 60% of the population lives in rural areas where 13% and 8% of the population travel more than 20 and 11km, respectively, to access the nearest health facility (MoHSS, 2010a; NPC, 2011). The overall ratio of health worker per population was 3:1000 in 2010 in Namibia (MoHSS, 2010b). This is well below the recommended WHO benchmark for Africa which is 2.5, meaning 2.5 health workers per 1000 people (MoHSS, 2010b; WHO, 2010). The MoHSS's aim is to ensure that all citizens are within a 10 km walking distance to a nearest health facility (MoHSS, 1998).

Socio-economically, the majority of the population has access to basic services such as PHC facilities, clean water supply, education, housing, hygiene and sanitation offered through a semi-decentralised system managed by regional councils in the 14 political regions. The elderly, orphans, disabled and war veterans also receive state pension and allowances through government social grants. The majority of the employed adult population receives wages and salaries. However, there exists a high level of unemployment, rural poverty and an increased urban migration mainly in search of employment (Office of the President, 2013b; NPC, 2007). Some of these factors contribute to malaria vulnerability (WHO, 2008a).

Most people infected and affected by malaria live in rural impoverished conditions where they have relatively few resources to access malaria preventive measures as most are unemployed (WHO, 2008a). In Namibia, for example, the Demographic and Health Survey reports that 68% of the population lives in the malaria endemic regions where only 34% of the rural households own at least one mosquito net (DHS, 2013). The average household population in Namibia is 5.6 and the majority of rural inhabitants are unemployed (NPC, 2011). Therefore one mosquito net per household seems inadequate, for an average Namibian rural household, to prevent mosquito bites. Rural inhabitants also face access to health care challenges such as those related to affordability of transportation, long distances and poor terrain to access the nearest health facilities (MoHSS, 2010c). This influences inhabitants' health seeking behaviour, compounded by their lower socio-economic means to, for instance, pay transport to reach a clinic (NPC, 2011; MoHSS, 2010c).

1.3 Problem Statement

Malaria mortality and morbidity rates in Namibia have dramatically decreased between 1999 and 2010. External funding, stakeholder involvement and a multi-sectoral approach to malaria prevention were attributed to being amongst many other factors which contributed to such declines. These successes are fairly well documented, however there is no adequate evidence demonstrating how existing policies relate to these successes. What factors or strategies were developed, and what informed such policy or strategy development? Successful factors or strategies are also not adequately described in order to provide an adequate measure of value ascribed to health promotion within the policies. For example, it is not evident whether all the relevant stakeholders were consulted. Policy formulation is said to be complex and at times can result in a situation where relevant people and institutions are excluded. This exclusion might negatively affect the implementation of a programme, in this case Namibia's malaria programmes. Additionally there is no doubt that malaria will remain a serious public health threat for some time to come mainly as a result of its multi-causative factors, management complexities and other underlying contributing factors such as the socio-economic aspects. It is therefore important for the MoHSS in Namibia to periodically review the status of malaria in the country through creating evidence-based malaria legislation. Recently, the MoHSS formulated and adopted a new MSP covering a five year period 2010-2016. It is not known whether this plan addresses the aforementioned aspects.

1.4 Purpose and significance of the study

The purpose of the study is to explore how the MSP was developed, with the view to recommend improvements in policy formulation, particularly in relation to health promotion. Continually improving various aspects of the malaria policy environment in the country will increase chances of sustaining the success achieved. Although there have been major declines in malaria mortality and morbidity a number of challenges, such as cross-border transmission, donor dependent funding for malaria programme and weak community engagement remain. It is therefore very important for the MoHSS, overall, and the NVCDP, in particular, to coordinate malaria operation, including the aspect of policy-making in the country.

The findings of this study will be very important to the malaria policy environment. First and foremost Namibia (through the MOHS) has set itself high aspiration that of *'Eliminating malaria in Namibia by 2020'* (MoHSS, 2010b). In order to achieve this goal there is a need for concerted efforts from all stakeholders, especially government, who are the custodians of the program. Secondly, the change in approach from a malaria control programme to malaria elimination will require robust interventions, especially at the community and governance level. The health administration level has, over the years, delivered the malaria programme and has made some amendments to suit the current approach.

It was also indicated, in the 2003 – 2007 MSP Review Reviewed done in 2010, that the community engagement and collaboration aspect were not adequately developed and remained the weakest link of the malaria programme in the country (MoHSS, 2010c). These links need to be address through policy means. Although a *'Malaria Communication and Advocacy Strategy'* was developed to aid in this regard, targeted interventions and policy statements are needed to ensure such implementation (MoHSS, 2009).. It therefore remains the overall responsibility of the MoHSS to ultimately ensure, through policy provision that all components are synthesize towards the attainment of the set goal.

1.5 Outline of this report

This report consists of six chapters. A chapter on introduction, literature review, methodology, results, discussions of the results, and a conclusion and recommendation chapter.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter gives an overview of the literature relevant to this research. The chapter begins with an overview of malaria globally and in Namibia. It further clarifies key concepts, provides synopsis relevant to health promotion aspects and discusses policy formulation. This study explores policy development and not health policy in general.

2.2 Overview of Malaria

2.2.1 Malaria epidemiology and policy framework globally

The WHO in 2008 - 2009 reported 515 million morbidity malaria cases worldwide on an annual basis. Sadly 75% of all morbidity cases reported occurred in Sub-Saharan Africa (SSA), a sub-continent already battling the triple-scourge of HIV/AIDS, Tuberculosis (TB) and Poverty (WHO, 2009a). The WHO also reported 3 to 5 million malaria-related mortalities of which 90% occurred in SSA (WHO, 2008a). Children under the age of five and pregnant women were the most vulnerable mainly because of their susceptible immune systems, subsequently increasing the rate of maternal and under five mortality world-wide (WHO, 2008; MoHSS, 2005).

The *2009 WHO World Malaria Report* recognised the importance of increased funding towards malaria control activities. This funding was reported to have increased from an estimate US\$ 0.3 billion in 2003 to US\$1.7 billion in 2009. This is said to have had a direct influence on a downward trend of more than 50% in local malaria transmissions in nine African countries (WHO, 2009a; WHO, 2011a), including Namibia. This subsequently also improved some under-five's overall health rating in these countries (WHO, 2008a, b; WHO, 2009a, WHO, 2011a).

Additionally the Global Malaria Action Plan (2008b, c), amongst many other policy documents developed through WHO, describes a number of crucial health promotion activities undertaken alongside and through many malaria intervention programmes. Amongst these is the recognition of the multi - faceted causation of malaria through community discussion platforms, building

community knowledge of malaria treatment, both biomedical and community interventions, the creation of a supportive environment to promote and sustain behaviour change, roping in various actors through meaningful partnerships, advocacy, and the development of health promotion legislation (WHO, 2002; WHO, 2008b,c,d).

In Africa, and specifically Sub-Saharan Africa (SSA), a recent study examining the substantial decline of malaria in a number of SSA countries, noted that over 50% of the world's population are at risk of malaria. The report reveals that in the year 2008 alone, 863,000 deaths due to malaria were experienced and 91% of these were recorded in SSA. In the same report it is indicated that 40% of country budgets in SSA is spent on malaria related interventions. The report also acknowledged the gains of over 50% reduction in malaria mortality and morbidity in SSA countries and other African countries such as Kenya and Tanzania (Meyrowitsch, Pedersen, Alifrangis et al., 2009).

The continued reduction in malaria mortality and morbidity in some SSA countries has been attributed to a variety of factors such as effective case management, larvicide control and health promotion targeted interventions (WHO, 2009a; MoHSS, 2010c). A review of the NVDCP by WHO-AFRO and research work by authors such as Traore (2005), Russel (2004), Houte, Hoore, Ouendo, Charlier and Deccache (2007) on malaria calls for the empowerment and involvement of communities in malaria interventions which are developed by and focus on people's perceptions and known responses (MoHSS, 2010c). A number of countries, such as Swaziland and Kenya provide community case management of malaria through health extension workers (WHO, 2010). The malaria community case management is yet to be implemented in Namibia.

Globally the WHO's Roll Back Malaria Initiative (RBM) tops the list of malaria policy documents. The RBM directs and guides WHO member state to create and support sustainable malaria country activities. The WHO RBM initiative was initially adopted in Abuja, Nigeria in 2005, during a world conference. The RBM initiative sets out strategies and targets such as the protection of 80% of people at risk from malaria, diagnosis and treatment of 80% of malaria patients within one day (WHO, 2005). The Abuja – RBM's ultimate goal was to reduce the malaria burden by 50% by the year 2010 - globally (WHO, 2005). Furthermore, the year 2010 was set by the 2005 Abuja Summit

and Declaration of the World Health Assembly (WHA), the Millennium Development Goals (MDGs) and the RBM initiative strategy to attain population coverage with bed nets and treatment aimed at reducing malaria mortality and morbidity by 50% (WHO, 2005; MDG, 2011). The RBM initiative, overall, aimed at reducing malaria deaths and ill-health by 75% by 2015 (WHO, 2005 as cited by Namibia Red Cross, 2009). The RBM initiative to date has proved an effective strategic plan because countries such as Namibia have, through their own RBMs, effectively reduced malaria transmission, mortality and morbidity by over 90% over the past decade (MoHSS, 2011).

According to the WHO malaria is highly preventable. Various methods including health promotion interventions can be used. These ranged from using protective clothing to covering body flesh particularly before sunset and sunrise to prevent mosquito bites, consistent and correct use of a mosquito treated bed net (treated with an effective insecticide chemical) and also timely usage of mosquito insect repellents in the form of an ointment, spray, coils, candles and air-conditioners (WHO, 2010; IRFC, 2009). In cases where malaria health preventive approaches are not within reach, treatment is made available at rural clinics. The decision to treat depends on many factors such as pregnancy, the severity of symptoms and age. Delaying treatment can lead to death. Severe symptoms include, and can lead to, shock, liver and kidney failure as well as bleeding. Less severe symptoms commence as a flu-like illness that includes chills, headaches, muscle-aches, sweating, vomiting, diarrhoea and chronic cough (WHO, 2005).

2.2.2 Malaria epidemiology and policy framework in Namibia

The Namibian climate and geographic positioning between the Namib and Kalahari deserts in the south-western hemisphere of Africa makes the country prone to malaria transmission (MET, 2009). Coupled with seasonal rainfall (October to April), drought and floods spells (NPC, 2001). This contributes to the dry and semi-arid climatic conditions, giving rise to high temperatures - 5-20°C (NDP II; MET, 2009). Such situations are said to be conducive to malaria-breeding (MoHSS, 2005). The majority of the population, over 65%, lives in malaria prone areas (MoHSS, 2005, NPC, 2001, MET, 2007). Ninety seven percent of malaria cases in Namibia are due to infection with *Plasmodium falciparum* while traces of *P. Vivax*, *P. Ovale* and *P. Malariae* make up the

remaining 3%. Recent vector sentinel studies revealed that *An. Arabiensis* remains the principal malaria vector, others such as *A. Gambiae* and *A. Funestus* have been eliminated (MoHSS, 2010b).

Malaria epidemics in Namibia were reported in 1990, 1996, and 2000 (with 446,256 cases). The worst epidemic was reported in 2001 with 733,509 malaria cases. Mortality was at 1,728 cases in 2001. Fifteen percent of total child mortality was due to malaria (MoHSS, 2005). However, in the last decade (1999 – 2008), MoHSS recorded a remarkable 90% drop in malaria mortality and morbidity. External funding improved case management at the health facility level and vector control were some of the reasons provided for such decrease, according to the WHO's findings (MoHSS, 2010b, WHO, 2009a).

Twenty-two health districts are prone to malaria epidemics. The NVCDP, since 2005, has widely advocated and distributed Malaria Epidemic Preparedness guidelines across sectors. These guidelines ensure the establishment of malaria preparedness plans at various levels (MoHSS, 2005). Two surveillance data sets exist for collecting and report malaria cases. The Health Management and Information System (HMIS) is a monthly public health facility-based database collecting malaria (and other disease) cases. A more comprehensive weekly database was introduced in 2001 and collects a variety of malaria information such as suspected, tested and confirmed malaria cases. This is, however, only in use during the malaria transmission season which is usually from November to June (MoHSS, 2010c).

Evidence from HMIS indicates a sustained reduction in malaria disease burden over 10 years. The malaria statistics in Namibia provides an overview of malaria trends between the years 2000 – 2013 (WHO, 2013; MoHSS, 2014). The MoHSS attributes sustained malaria case reduction to various interventions. Among these interventions, according to the MoHSS's review of the MSP 2003-2007, is remarkable progress achieving certain targets such as exceeding the Abuja and RBM targets to halve transmission to below 50% by the year 2015 (MoHSS, 2010c).

The reports by MoHSS (MoHSS, 2010c) and the Grant Assessment for Rolling Continuation Channel Qualification of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) suggest

that the main contributions to reduced malaria morbidity and mortality in Namibia were multi-fold, including:

1. Improvements and change in treatment regime from resistant chloroquine to Artemisinin based Combination Therapy (ACT ART-LUM).
2. Advanced or change in diagnosis from a mere suspected malaria case based on clinical suspicion to rapid microscopic diagnostic testing (RDT HRP-2) in 2005.
3. Annual, periodic and targeted capacity building of malaria personnel on malaria case management (diagnosis and treatment), vector control and surveillance.
4. Accelerated distribution of LLINs made possible through a network of partnerships.
5. Strengthened capacity for larvicide surveillance and vector control.
6. Strengthened reporting mechanisms.
7. Increased funding and resource allocation.

Accordingly, the goal to reduce malaria morbidity and mortality by 35% by the year 2007 as compared to 2000 was reached (MoHSS, 2010c). This was achieved through concerted efforts in seven malaria service delivery areas indicated above. Overall improved malaria epidemiologic management conducted by NVDCP has to do with the accelerated efforts through capacity building of all national, regional and district level structures. At a national level, NVDCP was integrated into the Directorate of Special Programmes in 2004. Alongside the HIV/AIDS and TB programme, malaria had comprehensive management and operational structures to formulate operational guidelines including malaria policies, coordinate malaria prevention and control measures, and implement malaria diagnoses and treatment at sub-national clinical structures (MoHSS, 2010c).

Entomology and vector control strengthening were implemented by the NVDCP to further expand its malaria prevention measures through scaling up Indoor Residual Spraying (IRS), distribution and usage of Long Lasting Insecticide Treated Nets (LLIN) and larviciding. This was done by allocating adequate resources to conduct entomology surveillances in all 13 regions with 16 vector sentinel sites. Furthermore, continued capacity building to ensure IRS quality was provided through annual trainings and bioassay tests for the IRS teams which ensured IRS has remained

above 80% since 2005. Larviciding is conducted periodically at vector breeding sites and as the need arises, on recommendation using entomological samplings (MoHSS, 2010c).

Distribution of LLINs has accelerated to over 1,076,535 to pregnant women and children under the age of five years between the years 2005 to 2009. This was achieved with the financial support of the Global Fund (GF). The NVCDP also conducted a Malaria Indicator Survey (MIS) in 2009 which revealed that LLIN usage by the above mentioned groups was below 35% and needed to be increased (MoHSS, 2010c). The NVCDP also engaged and established malaria program delivery partnerships with various institutions such as the Ministry of Defence (MOF) which was tasked to assist during the IRS operations. Non-Governmental Organisations (NGOs) such as the Society for Family Health (SFH) and Development Aid from People to People (DAPP) were tasked to assist with community mobilisation of LLIN usage and distribution thereof (MoHSS, 2010).

Another partnership forged was the involvement of the NVCDP to initiate and establish joint cross-border malaria control initiatives with Angola, Botswana, Zambia and Zimbabwe aimed at curbing malaria trans-border transportation and transmission (MoHSS, 2010c). Namibia has policy documents to address all of the above malaria issues. These include guidelines and operational manuals on the operations, management, control and effective treatment of malaria especially at clinical level (MoHSS, 2010b, c). Most of the malaria operational guidelines in Namibia are in relation to the WHO's Global Roll Back Malaria (RBM) initiative (WHO, 2008c).

2.3 Contextualize health policy formulation

According to Collins (2004), policy formulation is a part of policy analysis. However, the overall scope of policy analysis is vast and complex. The complex nature of policy analysis can be broadly divided into two distinct dimensions: context and content analysis (Parsons, 2005; Collins, 2004; Walt & Gilson, 1994 and Varvasovszky & Brugha, 2000; Buse, *et al.* 2005; Jones 2009). This observation is echoed by Walt and Gilson (1994) that policy analysis can be useful in both prospective and retrospective initiatives because any policy document is meant to serve as a legal guideline for informing certain operations. Several authors indicate that institutions or organisations cannot effectively exist without policies, because they serve as an evaluation of their

intended purposes (Parsons, 2005; Collins, 2004; Walt & Gilson, 1994 and Varvasovszky & Brugha, 2000; Buse, *et al.* 2005; Jones 2009).

Collins (2004) states that that policy process analysis involves examining policy formulation processes while policy content analysis only emphasises policy substance. Although distinctly differentiated by literature, Collins (2004) pointed out that policy content and context analysis share a thin line and often overlap. The methodologies utilised for policy analysis should carry similar characteristics to those derived from policy analysis initiatives (Dunn, 1998; Portney, 1986; Pal, 1992; Parsons, 2004; Bardach, 2000; Walt, 1996; Ham, 1990; Collins, 2004; Leichter, 1979; Buse, *et al.* 2005). The following are steps or approaches for policy analysis:

- Policy making, cause and consequences, policy description.
- Broad questioning.
- Intuition.
- Political context analysis.
- Socio-economic implications.
- Environmental analysis.
- Cultural influences.
- Stakeholder analysis.

(Dunn, 1998; Portney, 1986; Pal, 1992; Parsons, 2004; Bardach, 2000; Walt, 1996; Ham, 1990; Leichter, 1979). Nonetheless, it is advisable that a policy should be formulated by a joint effort of different stakeholders in order to render it inclusive, representative and outcome-oriented (Parson, 2005; MoHSS, 2010; Kramer, Dickinson, Anderson *et al.* 2009; Collins, 2004; Jones, 2009). Equally crucial, all policies should also have a monitoring and evaluation component to render them effective (Parson, 2005; Coulson *et al.*, 1998b, c). A policy is valid and effective only if implemented under required conditions and after adoption and not 'left to automatically transforms itself into action' (Collin, 2004; Coulson *et al.*, 1998b, c; Buse, *et al.* 2005).

Health policies, like all other policies, are public documents explaining the political aspiration of what the governing body intends to achieve for the health of its citizenry (Portney, 1986; WHO, 2003; Sherbournne, 2008; MoHSS, 2010a; Kramer *at el.* 2009). Like all other policies, health policies should be written in simple and easy to understand language. They must be flexible and

able to be reviewed from time to time or as changes in the system or in the epidemiology of a disease occur (Collins, 2004; MoHSS, 2010a; Kramer, *et al*, 2009).

Kramer *et al.* (2009) discussed Decision Analysis as a framework to aid in the formulation of a malaria responsive policy. The Decision Analysis framework has its basis on decision making, and is a 'structure step by step process aimed at analysing the pros and consequences of a health policy' Kramer *et al.* (2009:133). Kramer *et al.* (2009) acknowledge the difficulties experienced by decision makers in controlling malaria effectively. Therefore, Kramer *et al.* (2009) argue that the Decision Analysis Framework will provide the necessary support through its structured approach based on addressing the five critical challenges associated with weak controls of vector-borne diseases. The Decision Analysis Framework thus offers policy makers a comprehensive platform and, at the same time, a systematic policy making tool.

The Decision Analysis Framework has been used in countries such as Tanzania and Kenya and promoted informed research, adequate resources, evolving the malaria knowledge base, the advantages of high-tech environments, and interdisciplinary dialogue (Kramer *et al*, 2009). The Decision Analysis Framework was not only used to inform malaria control policies but many other epidemiological interventions. Research on health related policies is a crucial component of policy formulation and can inform policy in three phases: during the policy formulation process (namely agenda setting), in policy formulation and lastly in policy implementation (Hanney *et al*, 2002; Health Research Policy in South Africa, 2001; WHO, 1999b, 2004). In Namibia and, as indicated in an earlier section, the regional cross-border partnership between Angola, Botswana, Zambia, Zimbabwe and Namibia utilizes Decision Analysis Framework principles to curb malaria trans-border transportation and transmission.

2.4 The role of health promotion

Health promotion is said to be both an approach and a strategy, because by the WHO's definition health promotion, first and overall aims to address determinants of health. Secondly, these determinants are not addressed in a vacuum, but within settings where people live and work (Naidoo & Wills, 1994; 2005; 2009; Ewles & Simnet 2004; WHO, 2003; Munodawafa, 2006).

Health promotion further attributes to two health models: the bio-medical which defines health as the absence of disease caused by an agent and the social model which further elaborates the above definition to include social causations (Baum, 1995; Bowling, 1997; Naidoo & Wills, 1994; 2005; 2009; University of Western Cape (UWC), 2006; Ewles & Simnet, 2004). Although the two models contribute immensely to the improvement of health systems, the bio-medical model limits the ability to explore other health determinants (Naidoo & Wills, 1994; 2005; 2009; WHO, 2003).

The Social model, on the other hand, aligns its definition of health closer to the first definition of health by WHO, to include health as a human rights and developmental issue, hence the importance of social conditions, the physical features and psychological ability as determinants of health (Baum, 1995; Naidoo & Wills, 1994; 2005, WHO, 2003). This description supports the understanding that individuals have the capacity to influence ill-health through determining policy aspects which can improve their health within their living environment. Therefore, the primary roles of health promotion in any given programme are those efforts which positively influence and empower individuals to seek and sustain healthy bodies and environments. This includes developing the communities' knowledge and skills, shared decision making through advocacy and providing supportive systems such as availability of health infrastructure and services (WHO, 2003; Munodawafa, 2006).

2.4.1 Contextualising health promotion in Namibia

The Namibian Constitution, developed immediately after independence in 1990 as the supreme law of independent Namibia, recognises health investment as a '*just and critical social engagement*' (Namibian Constitution, 1990). This concept, as stated in the Namibian Constitution, paved the way for a health promotion approach amidst the non-existence of a Health Promotion Policy. A draft policy was formulated in 2007 and formally adopted in 2012 (MoHSS, 2012). A document complementary to the Namibian Constitution, *Vision 2030*, an economic and social development framework, was also developed and adopted in 2004. *Vision 2030* has the *promotion for health, prevention of diseases and improvement of lives through ensuring a quality of life to all its citizens* as a priority objective (Namibia Vision 2030, 2004).

Additionally, the successive National Development Plans (e.g. NDP1, NDP2, NDP3 and NDP4) and the national budgets all were found to promote access to health through allocation of funds to the MoHSS, access to medical aid funds, health insurance, national social security services and welfare allowances for the broader Namibian population, with benefits categorised in groups for civil servants, employees in the private sector, orphans and vulnerable children, pensioners, remunerated pregnant mothers and people living with disabilities (NDP3, 2007: MoHSS, 2013).

The Ministerial Annual Report for 2007 revealed that health promotion in Namibia has for a long time been limited to health education, information dissemination and recently to behavioural change communication (BCC) interventions and strategies (MoHSS, 2007). Health Education refers to providing health information to individuals and communities (WHO, 2002a, b). Currently health promotion interventions in the country are fragmented across various sectors with the health sector's health promotion activities implemented through the Information, Education and Communication (IEC) division and guided by the Draft *National Policy on Information, Education and Communication for Health Promotion* of 2006 (MoHSS, 2010b). This draft policy has been replaced by the Health Promotion Policy of 2012. Other sectors such as the local authorities (municipalities) and various industries have health promotion interventions as part of strategic approaches and interventions (MoHSS, 2012).

Another crucial document for health promotion in Namibia is the MoHSS' *National Health Policy Framework (NHPF) 2010 – 2020*. This document identifies and describes various health promotion strategies to be mainstreamed in all health system processes in the country, both in the public and private domains (MoHSS, 2010a), an approach similar to the call for building healthy public policies by the Ottawa Charter (1986). The NHPF 2010-2020 notes the malaria achievements and re-emphasises the commitment towards malaria elimination (MoHSS, 2010a; Noor *et al.* 2013). The WHO defines malaria elimination as a process of locally interrupting mosquito-borne malaria transmission within a defined geographical area (WHO as cited by MoHSS, 2010b).

Furthermore, health promotion in the NHPF 2010-2020 is listed as an area for '*Re-organisation and Strengthening of Health Systems*', similar to re-orientation of health services in the Ottawa

Charter (1986). This could be interpreted that the NHPF 2010-2020 responded to WHO's call for the inclusion of health promotion strategies in clinical and public health endeavours (MoHSS, 2010a). Apart from the Ottawa Charter (a conference paper produced from the proceedings and agreements during the first Conference on health promotion held in Ottawa, Ontario, Canada from November 17 – 21 in 1986) other international health promotion platforms attended by Namibia's health management sector with the aim to strengthen health promotion in the country are mentioned in the following paragraph.

The 7th Global Conference on HP held in 2009 in Nairobi (Kenya) which produced the “*Nairobi Call to Action on closing the implementation gap between Health Promotion and Development, 2009*” (WHO, 2009b). Namibia adopted the Bangkok Charter in 2005, which sought member states to implement strategies aimed at reducing country specific health gaps through results-based interventions on country specific social determinants of health (WHO, 2005). The Bangkok Charter was aimed at health promotion in a Globalised World. Lastly, Namibia also adopted the WHO's Commission on Social Determinants of Health report: ‘*Closing the gap in a generation – Health equity through action on the social determinants of health,*’ aimed at addressing similar issues of closing health equity gaps in member states (WHO, 2008a, d).

Globally, WHO advocates for the inclusion of various models of health promotion for malaria control, such as health education, social mobilization, community participation, multi-sectoral collaboration and communication for behaviour change. The *Home Malaria Management Initiative* implemented in Mozambique's *Roll Back Malaria Initiative* is such an example (WHO, 2002b). In Namibia, the cross border malaria initiative between Angola, South Africa, Zambia and Botswana is such an example (Noor *et al.* 2013).

2.4.2 Health promotion for malaria control

Malaria control focused on decreasing the disease burden (WHO, 2005) through various efforts including malaria policy directives, provision of health services such as control of malaria vector and case management (WHO, 2013; MoHSS, 2010b). Malaria health promotion includes the identification of malaria as an illness caused by an agent, and the understanding that the malaria

parasite depends on environmental conditions and a host to mature (WHO, 2010a, b) thus understanding the biological and socio-economic determinants. Vector controls, such as environmental management, indoor residual spraying (IRS) and insecticide treated bed-nets are amongst other important malaria interventions which require community participation and involvement to succeed and to sustain reduction in malaria cases WHO, 2010, MoHSS, 2010a, b).

Empowerment of the community with knowledge and skills in controlling malaria habitats remain a core health promotion aspect. For example, UNICEF promotes the Integrated Management of Childhood Illness (IMCI) which advocates for treatment of malaria in children with fever and the clearing of long standing water in swamps and areas with thick long grass as part of its Integrated Community Case Management (iCCM) (WHO/UNICEF, 2000). UNICEF (2012) also reports that about 28 Sub-Saharan African countries including The Democratic Republic of Congo, Malawi, Mozambique all promote treatment for malaria through community health workers (UNICEF, 2012). Namibia, supported by the USAID, is about to commence a similar process, this researcher is part of this initiative, as a private consultant.

The absence of the abovementioned initiatives, especially in the past has limited malaria health promotion interventions to the distribution of bed nets and indoor residual spraying. Expanding the scope, lies in the adoption of iCCM, including, for example, the argument by Haoute and Deccahe (2007:2008) for the involvement of parents in the treatment of childhood fever associated with malaria. Haoute and Deccahe believe that such collaboration will not only be useful to malaria management, but will translate into the knowledge and skills transfer necessary to positively impact on the burden of the disease and hence reduce malaria incidence. This tallies with health promotion principles of strengthening community action and developing personal skills (Ottawa Charter, 1986).

Similarly, studies about the social burden of malaria also reference the importance and inclusion of the cultural construction of malaria (Manderson, 1998; Jones and Williams 2004; Mwenesi 2005). This questions the influence of cultural socialisation and its impacts on the response of, for example, home treatment of fever without suspecting malaria. There is therefore a growing emphasis on recognising the policy inclusion of home treatments as a form of community

involvement and engagement in malaria control and management (Manderson, 1998; Jones and Williams, 2004; Mwensesi, 2005).

Anthropological studies such as those conducted by Mwensesi (2005) and Manderson (2008) further described the role of health promotion in malaria efforts through perspectives on the disease's burden as based on the health risk factors that exist within a given socio-cultural context (Jones and Williams, 2004; Manderson, 1998; Mwensesi, 2005). Health promotion seeks to persuade individuals to influence the determinants of ill-health and provide a better understanding of social and cultural factors influencing the biomedical burden of malaria (Ottawa Charter, 1986). Studies such as this current study also expose the multi-dimensional facet of policy coverage.

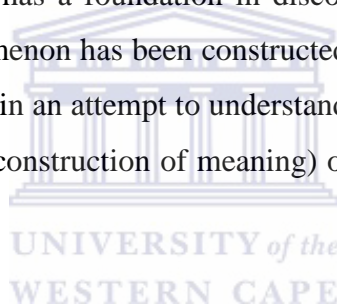
Mwensesi (2005) found that including recommendations from social science research in malaria control efforts often proceed at a slow pace and subsequently delays effective management of malaria. A lack of qualified social scientists and skilled program workers at country level were noted as one factor impeding the applied implementation of research (Abdullah, 2005). These words are echoed by Dr. Kamwi (2006), the former Minister of Health and Social Services in Namibia, who, in his doctoral thesis, argued that knowledge and skills competencies in dealing with malaria are in short supply in Namibia (Mwensesi, 2005; Kamwi, 2006). This lack of internal research capacity means that policy formation is reliant on external capacity. In such cases, the overall approach might not be clear, because it might be externally driven.

Funding is another important factor both as a policy decision and a community resource (to sustain livelihoods, acquire much needed malaria protection, for transport payment to health facilities, and paying for health access while seeking treatment) (MoHSS, 2009, Haoute *et al.*, 2007, Houéto and Deccache, 2008). According to the WHO, (2013) of the 5.1 billion needed for effective malaria control, only 2.8 billion is realised. These shortages are have a negative influence on provision of mosquitos' bed nets, indoor residual spraying and capacity building initiatives (WHO, 2013; UNICEF, 2012). Therefore, ensuring continued and efficient implementation of health promotion strategies, malaria services and control initiatives will also mean moving beyond the focus of medical and professional-centred policies to inclusion of people-centred policies (Haoute *et al.*, 2007, Houéto and Deccache, 2008).

2.4.3 Importance of a health promotion approach in malaria policies and programs

The description above attests to the fact that health promotion is a crucial phenomenon in modern health and overall development. Embedded in health promotion, as an approach, is the sociological epistemologies which are derived from an interpretive standpoint. Health promotion is an interdisciplinary phenomenon which continues to gain momentum in modern health. Interpretivism, which refers to “seeing the world through a different eye” (Secker, Wimbush, Watson & Milburn, 1995:75), translates, in health terms, into the fact that health determinants are not homogenous even in similar health promotion settings (Naidoo & Wells, 1994; Coulson, et al, 1998b, c). The latter attests to the importance of a health promotion approach based in epidemiologic studies and programs.

Health Promotion policy analysis has a foundation in discourse analysis, an approach used to understand how and why a phenomenon has been constructed in a particular way. Like in health promotion, policy analysis is done in an attempt to understand how and why the differences exist in perceptions (understanding the construction of meaning) of people in common social settings (Secker et al, 1995).



The value of health promotion as an approach to malaria control in the country can be derived from the fact that Namibia has surpassed national and international targets to halve malaria mortality and morbidity rates by 2015 (MoHSS, 2010b). However, the MET has indicated that Namibia (specifically the six most northern malaria endemic regions) remains prone to malaria due to favourable climatic conditions such as increased rainfall, stagnant water (favourable for malaria breeding), rising temperatures and excessive drought. As a result, the burden of malaria is likely to be felt for years to come, if rigorous efforts are not implemented (MET, 2009). In this instance, a health promotion approach towards malaria will be situationally assessed and widely challenged through disciplinary networks with the aim of containing or addressing malaria.

Furthermore, the spectrum of partners working on malaria in Namibia is fairly small compared to the network of HIV and AIDS practitioners in the country (MoHSS, 2009). The majority of partners' roles, except for the MoHSS, are limited to the distribution of bed nets, community

mobilization through the production and dissemination of IEC materials such as t-shirts, leaflets and posters under the emblem of health education, as well as the social marketing of mosquito nets. The Ministry has expressed the need to widen this network to include other partners and stakeholders who can help influence and sustain the downtrend in malaria (MoHSS, 2010b). The latter is a crucial health promotion linkage, which can be used both as an approach and a strategy to address malaria. In Namibia, the health promotion approach to malaria control is written in the Malaria Communication and Advocacy Strategy, which states that the overall malaria prevention and control strategy in Namibia is based on social process theory. This theory describes the belief that people's behaviours and perceptions are highly influenced by their surroundings and relationship with which they associate (MoHSS, 2009).

2.5 Summary

This chapter reviewed literature relevant to the study topic. It contextualised malaria epidemiology, health policy formulation and health promotion. Literature revealed that adequate information exists to expand the understanding of malaria health policy formulation. Overall literature revealed that health policy formulation is complex and dynamic. Health policy formulation complexity can either be present in nature or context. Authors from which information was derived also indicate that health policy, like any other policies, should be targeted and problem-solving oriented. To achieve this, inter-sectoral collaboration is a crucial ingredient. Malaria, a multi-causative disease is managed using various approaches, including health promotion interventions. In the literature, a number of tangible example and information are provided which illustrate the interconnection of malaria and health promotion within the health policy formulation realm.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

This chapter deals with the methodology of the study, including the aims and objectives of the study, research design, study population, sample procedure and size, data collection, data analysis and ethical considerations.

3.2 Aims and Objectives

The study aimed to analyse how the Namibia Malaria Strategic Plan for 2010-2016 was developed and the evidence supporting its focus on health promotion. Specific objectives of the study were:

- To describe the factors which led to the formulation of the Namibia Malaria Strategic Plan for 2010-2016,
- To examine the roles and responsibilities of key policy makers in designing the Malaria Strategic Plan for 2010 - 2016,
- To explore the evidence for competing malaria prevention strategies available to policy makers in designing the Malaria Strategic Plan for 2010 -2016, and
- To explain why health promotion strategies were emphasized in the Malaria Strategic Plan for 2010 -2016.

3.3 Study Design

This study used an explorative qualitative research design. Qualitative studies, presented in descriptive formats rather than in numbers, are used to explore people's interpretations of perceptions, explanations of complex issues and interactions amongst study subjects (Baum, 1995; Mays & Pope, 2000; Mays & Pope 2005; Neuman, 2003). Research designs inform the research

agenda and which methods should be utilised to source relevant answers or information about the research questions (Hartley, 2004). Leedy and Ormrod (2010) identified five common qualitative research designs namely case study, ethnography, phenomenological study, grounded theory study and content analysis. This study used content analysis. The study used face-to-face interviews and document review as data collection methods (Neuman, 2003; Kohlbacher 2006).

3.4 Study Population

In this study, the study focused on organisations working in the field of malaria in Namibia. To get a clear picture of organisations involved the researcher requested the NVDCP to provide the details of all organisations working in the field of malaria in Namibia. The NVDCP provided the researcher with a list containing names of 20 organisations represented by individuals in various positions in those organisations. The list, attached to this report as appendix one, was a list of organisations invited to attend the first meeting to discuss the formulation of the MSP 2010 – 2016.

The Ministry of Health and Social Services (MoHSS), in particular, the staff of the Malaria Division, the Policy Planning and Research unit and the IEC Division, was the primary study setting because of its health management mandate and the study phenomenon relevant to health. Other respondents included in the study population were stakeholders in the malaria sector from international institutions with a physical base in Namibia, such as the WHO, Society for Family Health (SFH) and the Red Cross. Other government malaria stakeholders forming part of the study population was the Ministry of Environment and Tourism (MET).

3.5 Sampling procedure and sample size

Sampling is the process of selecting study units from a study population. A study unit is called a sample while a study population is the group under research and (it can be individuals, groups and or objects) from which the sample is taken. Study units selected should have similar characteristic or interest as the study population. The selection of study units from a study population is done following two main methods called probability and non-probability sampling. Probability sampling involves a more structure selection process whereas non-probability is less structured (Patton, 2002).

In this study units are selected following the non-probability sampling method. The study further purposively selects the study units. Purposive sampling is a method under non-probability sampling which entails the selection of units with a particular knowledge, skills or vested interest in the study subject. Study units were thus purposively selected because they work in one way or the other as malaria program officer in their respective organisation.

Before selecting the study units the researcher identified various categories of representation of organisations that were provided. Three major categories emerged namely; government, civil society and international organisations. The government institution category had various government or ministerial divisions. Ministerial divisions outside Windhoek were omitted for reasons of cost and accessibility. This also applied to some civil society organisation based outside Windhoek. The researcher then selected seven individuals representing seven organisations, namely: NVDCP, the IEC, Policy Planning, WHO, MET, Red Cross and SFH from the list, as the sample units. These institutions were within the categories identified in appendix two, a table containing the status of those interviewed.

3.6 Development of Data Collection Instruments & Data Collection Methods

A semi-structured interview guide, attached as appendix three, was developed in English and was used to guide the face-to-face interviews. The interview guide contained demographic information about the name of the organisation and title or position of the key informants. It also had questions to guide the researcher in asking open ended questions about the organisation's malaria activities, knowledge about the MSP 2010-2016 and its formulation processes, knowledge regarding health policy formulation, health promotion as well as health promotion strategies within MSP 2010 – 2016.

Face-to-face interviews with respondents were conducted except for one respondent to whom the study guide and questionnaires were emailed (to which he responded via email) as this informant was out of the country for an extended period. This was necessary for the purpose of this study because this informant was a key stakeholder. All interviews were conducted in English, by the researcher, and were tape-recorded. Permission to record the conversations was requested from

the interviewees. After the interviews were recorded, all interview conversations were transcribed by the researcher.

Data was also collected from various documents. The criteria used to select the documents were that they were relevant to malaria in Namibia. These documents are attached to this study report as appendix four. Information pertaining to stakeholder involvement, reason for formulation of MSP 2010 – 2016 and HP strategies within the MSP were highlighted in the documents reviewed. No specific tool or framework was used to read and analyse the documents, except the manual narrative following the objectives sequence.

3.7 Pilot study

Although qualitative studies do not require pilot testing of data collection tools, the interviewer guide was shared with selected colleagues to gauge whether the data collection tool was appropriate and adequately covered the study topics. This was done to test the appropriateness of the question in the interview guide and to identify possible information gaps, potential omissions and any other technicalities. The interview guide was also emailed to the research supervisor for review and input before finalization. After the pre-testing process and supervisor's assessment of the interview guide few information gaps were observed and rectified. Gaps were mainly around the omission of subjects or discipline specific questions regarding malaria.

3.8 Data analysis

In this study, data analysis started immediately after the first interview was transcribed into notes. The researcher colour-coded with a highlighter, each transcribed interview note and also document reviewed. Colour coding is done to mainly identify commonalities (Bowling, 1997; Pope, Ziebland & Mays, 2000; Saladana, 2012).

A yellow colour was used to highlight all information related to the organisation's information as a stakeholder or as experts. A red colour was used to highlight all factors related to the involvement of the organisation in the formulation of the MSP 2010 – 2016. The green colour was used to

highlight factors related to HP in malaria management and control. Pink and purple were used to highlight issues relevant to policy aspects and concerns respectively. The colour-coded data from various interviews were grouped through a 'cut and paste' method.

The researcher reviewed the grouped colour coded 'cut and paste' notes to confirm the colour themes as identified above several times to make sure that she captured the information correctly. This process of carefully re-organising data into categories is called content analysis (Marshall & Rossman, 1995) whereas the process of categorisation is referred to as thematic analysis (Bowling, 1997; Pope, Ziebland & Mays, 2000). The grouped coloured 'cut and paste' notes were grouped under the following themes:

- Organisations' involvement in malaria control in Namibia (yellow).
- Involvement and particular role in the formulation of the MSP 2010 – 2016 (red).
- Factors which led to the development of the MSP 2010 – 2016 (pink/purple).
- Health promotion included in the MSP 2010 – 2016 (green).

The data analysis process was carried out in such a way as to enable the researcher to gather data relevant to the exploration of the MSP 2010-2016 formulation process and health promotion. Data analysis refers to the process where the volumes of data collected are organised and presented in an orderly and structured form (Patton, 2002).

3.9 Data Trustworthiness

In this study, triangulation (a process where two or more methods are used to collect similar data) was utilized (Rothbauer, 2008). This entailed triangulating data collected from various sources such as the face-to-face interviews (data notes), document review and the literature review. In addition, respondents were provided interview summaries for the purpose of verification and identification of factual miss-representation, omissions, information flaws and any wrongful inclusions from the researcher's side. Lastly, the draft report was e-mailed (some participants requested the report during the interviews) to all participants before it was submitted to the supervisor for a final review and submission.

The above processes of triangulation and respondent validation were aimed at showing the trustworthiness and credibility of the research process and information presented in this study. Data trustworthiness or rigor, in qualitative research, refers to the overall belief and acceptance of the validity of the research findings. Trustworthiness is established through a rigorous process which involves reasonable understanding, interpretation and presentation of information collected and analysed (Schutt, 2014). Credibility refers to the integrity of the research process and acceptance of the research results (Patton, 2002; Meriam, 2009).

3.10 Ethics

The research protocol was submitted and approved by the Senate Research Committee of the University of Western Cape on the 26th of April 2012, attached as appendix five. Similarly approval was also given by the Ethics and Research Committee in the Policy Planning Unit of the MoHSS on the 18th of July 2011 under reference number 17/3/3, attached as appendix six. Some institutions interviewed also provided permission to interview, attached as appendix seven. It is required by the MoHSS to submit the final Mini-Thesis report.

Participants were provided with an information sheet about the purpose and objectives of the study. Participants were also informed that participation was by free will and that they were at liberty to withdraw at any stage without any consequences. Upon agreement to be interviewed respondents were requested to sign a consent form prior to each interview (Durrheim & Wassenaar, 1999). Examples of the information sheet and consent form are attached to this report as appendices eight and nine. All signed consent forms are securely stored in the archives of the researcher.

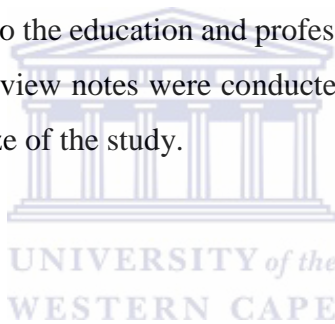
3.11 Methodological Limitations

This researcher is a registered nurse by profession, but works as a freelance consultant. This researcher has never been directly or indirectly involved in malaria work with the study population, however, the researcher attended the same nursing training college as the majority of the research participants, especially those from MoHSS and WHO. This ‘schooling – relationship’ between the researcher and research respondents can be interpreted as a potential limitation, because of the risk

of bias. In order to avoid being biased the researcher conducted herself in a professional manner and followed a rigorous research process throughout this study.

This study's focus was on examining the development process of the MSP 2010 – 2016. It is also worth mentioning that the limited network of malaria stakeholders resulted in a very small sample size being selected for interviews. This poses a challenge because the study population size was limited and where interview delays were experienced it was difficult to secure a replacement interview. For example, the Namibian Red Cross was sampled, but later found that the institution no longer conducts or is involved in malaria activities.

It should be noted here that while English, both grammatically and comprehension-wise, could serve occasionally as a potential barrier, most respondents had a good command of the English language. This could be attributed to the education and professional positions of the informants of this study. All interviews and interview notes were conducted in English. Lastly the scope of a mini-thesis further restricted the size of the study.



3.12 Summary

This chapter dealt with the methodology employed in this research project. The research paradigm, the research design, sampling procedures and the data collection methods and analysis employed were elaborated upon in this chapter. The type of the research has been described as qualitative and the adoption of qualitative research type has been justified. Finally, the need for ethical consideration when collecting data has been also explained. The next chapter focuses on results and findings of the research.

CHAPTER 4: RESULTS

4.1. Introduction

In this chapter the researcher presents results from two data collection sources namely interviews with selected malaria working personnel as well as documents reviewed. Results in this section reveal that many activities were conducted in prelude to the development of the Malaria Strategic Plan in Namibia for 2010-2016, albeit with the absence, especially in a written format, of an explicit step-by-step process. There is sufficient evidence to understand the role of health promotion in the MSP. Related factors such as reasons for developing the MSP, involvement of stakeholders and health promotion strategies are also presented, as study results, in this section. Adequate evidence to support factors such as the omission of key stakeholders in the development process, and failure to capture the process followed in the development process were limited. These and many others are further elaborated in text below.

4.2. Awareness of the development process of the MSP 2010 – 2016

Not all respondents were aware of the existence of the MSP, the formulation process and who had participated in its formulation. One of the MET respondents had this to say when asked if he has heard or seen the MSP 2010 – 2016:

“I had never seen or heard of MSP 2010 – 2016 before, what is it?”

MET respondent

Another respondent echoed the MET statement saying:

“This is the first time I am seeing this document. I only know about the 2005 Malaria Policy.”

IEC respondent

Apart from a few sentences in the acknowledgement and preface there is no documentation about the development processes of the MSP 2010-2016. In fact only the respondent from the MoHSS’s malaria division known as the NVDCP, had adequate information about the MSP. All other respondents provided bits and pieces of information which made it relatively difficult to account

and verify that an explicit processes or step followed in developing the MSP was followed. A respondent from the SFH was one of those who was aware, but had seen the MSP. She had this to say:

“I will only be able to tell you where my organisation was involved and not the entire process”.

SFH respondent

The NVDCP respondent could not understand the reasons why other respondents said they had not heard of the MSP, as he is of the opinion that the formulation process was inclusionary. He said:

“In fact, amongst all malaria documents in the country, the current MSP was developed by a larger group than all other malaria documents. We invited quite a large group. Not all turned up, but still the numbers were larger than in 2003, for example.”

NVDCP respondent

The NVDCP and SFH respondents, who indicated knowledge of the MSP existence showed this researcher their copy of the MSP, while talking about the various contributions they had made in the document. Other aspects of the MSP’s development processes and the role of health promotion are described below under different themes.

4.2.1 Awareness of the malaria burden in the country

There were diverse awareness levels regarding malaria related problems in the country, which answered to the question whether there is indeed a need to formulate malaria related policies. Respondents, except those from the MET, provided concrete evidence about the malaria burden in the country. The NVDCP respondent, in particular, passionately described the history of malaria in Namibia. At one point during the interview he said:

“You know, before independence malaria was a serious problem. People did not reach health facilities on time. There were no rural clinics by then. Thanks to the Namibian government people

with high fever are treated at local health facilities on time. Ten years ago hospitals were packed to capacity during malaria season. Patients used to also sleep on the floors. Now we have very few malaria cases. We are in a position to completely eliminate malaria just like polio”.

NVDCP respondent

Another respondent said:

“You know malaria has seriously declined in this country. We used to distribute a lot of bed nets in Owamboland and the Kavango, but regardless the hospitals will be full of people sick with malaria, sleeping on mattresses on the floor. We were told people used those nets to fish in the rivers. And you see the grass was also allowed to grow high, because the grass is used to cover the roofs of the huts. We conducted educational session in the villages”.

SFH respondent

The 2010 – 2016 MSP revealed that malaria mortality rate declined drastically from 96.5 per 100,000 population in 2000 to 8.4 per 100,000 population in 2008. For instance, actual malaria figures for 2001 were 733,509 morbidity and 1,728 mortality cases where as 128,531 morbidity and 199 mortality cases were recorded for 2008. These figures have continually declined to less than 3,000 cases for morbidity and less than 10 mortality cases in 2013. The current MSP is, based on the above declines and was developed to eliminate malaria in Namibia.

However some respondents, while aware of the disease burden and subsequent decline, were skeptical about the MSP’s vision stated as:

“Namibia free of Malaria by 2020”.

MSP document page 18, 2010

The IEC respondent said:

“Total elimination of malaria might not be possible without behaviour, practice, and attitude and belief changes and as especially not without dealing with issues about community mobilisation and advocacy which should be crucial components to be addressed by the MSP 2010-2016.

IEC respondent

The above statement is relevant to the question about the role of health promotion in the MSP formulation process, which is addressed later in this same results chapter.

Regarding the disease burden and further reduction of malaria the MSP document is further quoted saying:

“The main goal of this strategy is to reduce the incidence of malaria below 1 per 1,000 population in every district of Namibia by 2016”.

MSP, 2010; page 18

The above statement reiterates various opinions, as stated previously in this paper, about the status of malaria in Namibia. Nonetheless, while most respondents acknowledged the ongoing decline in malaria cases from 2008-2014, those in NVDCP supported by information from the documents reviewed, noted that the burden of malaria was at its highest when malaria was the leading cause of death in 1999 to 2001. The NVDCP respondent said:

“Access to health before independence was a challenge. There were no rural clinics and people walked, because transport was rare at the time. Sometimes they will walk for over 150km to reach the nearest health facilities. People were also restricted to travel during the night. In fact, they were killed. As a result most people died. But after independence health facilities were overwhelmed to an extent that people slept on the floor. Hospital wards were filled to capacity. We experience staff shortages as a result”.

NVDCP respondent

Documents reviewed revealed that a policy exists which mandates the MoHSS to construct health facilities and ensure that no person travels more than 10kms to reach the nearest health facility. Similarly the colonial law which prevented people from travelling after sunset was revoked after independence. The Health Policy Statements of 1998, in particular, state that the nature of malaria, which is seasonal and endemic, to nine northern regions in Namibia requires a conducive and travel-free environment. Other factors of concern are the cross border malaria transmissions which the IEC respondent said posed a challenge to current elimination aspirations. One of the IEC respondents noted:

“Namibia is bordered by countries with high malaria cases and cross border travelling is common for the northern regions, especially towards the Angola and Zambian borders. Unless the MoHSS institute some measures to curbed this free flow. It will be difficult to eliminate”.

IEC respondent

The MET respondents were not aware of the various malaria figures, because their work in relation to malaria is limited to the effects to the environment. One of the MET respondents honestly replied:

“We do not treat malaria”.

MET respondent

The SFH respondent said that because malaria is only endemic in some regions and because it is a seasonal problem, it is not regarded seriously or similarly to other illnesses such as HIV and AIDS. Hence the disease burden is underestimated. She also said:

“The malaria stakeholder network in Namibia is very small compared to the HIV/AIDS network. We do not even have well-structured platforms like with HIV/AIDS who have RACOCs, CACOCs and a National Steering Committee at cabinet level”.

SFH respondent

The SFH respondent was referring to Regional Aids Coordinating Committees and Constituencies Aids Coordinating committee which reports to the regional governors and the Governor reports to the cabinet’s National steering committee.

4.2.2 Awareness of the existence of the MSP

As indicated the above results revealed that some respondents had never heard or seen the MSP document before the interview. Respondents from the MET and the IEC division saw the MSP document for the first time when this researcher referred to it during the interviews. The IEC respondents were particularly surprised, saying:

“Ooh, that’s the MSP?”

IEC respondent

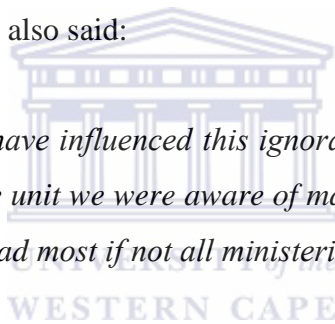
The MET respondent informed the researcher that the lack of awareness and lack of knowledge about the MSP might be derived from the fact that little collaboration exists amongst the two institutions and hence the MET involvement in malaria operational matters was nonexistent. Moreover, one of the MET respondents further said that:

“I think the reasons why we do not know about the MSP is because the MoHSS has its own environmental unit which deals with malaria and other health and environment related matter.”

MET respondent

Respondents from the IEC division also said:

“Our operational mandate might have influenced this ignorance. You see before the split of the malaria division into a stand-alone unit we were aware of malaria related policies and activities because we were tasked to spearhead most if not all ministerial documentations.”



IEC respondent

The IEC division is an integral part of the MoHSS and its respondents further narrated that most MoHSS divisions were restructured from one PHC unit into stand-alone divisions therefore most divisions produced their own IEC related materials and documents. The above-mentioned interpretations explained the IEC’s lack of awareness. Respondents from the MoHSS’s malaria and policy unit as well as WHO and SFH respondents were fully aware of the MSP existence and indicated their involvement and participation during the MSP development processes. The SFH respondent in particular praised her organisation’s involvement in the formulation process, saying:

“SFH assisted MoHSS putting together this MSP. We also own this document and are directed by it. For example, we are particularly geared towards the fifth objective”.

SFH respondent

4.2.3 Awareness of the MSP formulation process

Of those familiar with the MSP, there were varying degrees or levels of awareness of the development process. This ranged from respondents being aware of the various processes to only knowing those processes in which their organisation were involved. For example the SFH respondent said:

“My organization is fully aware of the MSP, but did not participate in all processes. I only know of the questionnaire which was sent to us sometime before we got an invitation to participate in 2-3 workshops to be involve or be part of the MSP formulation processes. We were also informed that the MSP 2003-2007 had long expired.”

SFH respondent.

Similarly, WHO respondents made it categorically clear that their organisation was aware of the MSP and its content. One of the WHO respondents said:

“WHO’s mandate in relation to the MSP development realm was limited to providing technical expertise and we were only following the decision by the MoHSS, following a joint review of the 2003 – 2007 MSP review, to place a focus and emphasis on a pre-elimination.”

WHO respondent

The WHO respondent informed the researcher that the pre-elimination approach, as opposed to previous MSP, which focused on case management, was adopted mainly because of the change in malaria epidemiology, especially in direct relation with the current declines. The WHO respondents, however, made it clear that they will only able to tell the researcher about the activities in which their organisation participated. Those interviewed at WHO were the Health Promotion Officer and the Technical Advisor to the MoHSS. The WHO Technical Officer, via email, indicated that:

“The WHO provided technical assistance to the NVDCP during the entire MSP formulation process. This was mainly geared towards pre-elimination since it was a fairly new thing in malaria”.

WHO respondent

The NVDCP respondent said:

“The MSP 2010 – 2016 comes along way. You see it was in development since the expiry of the MSP 2003 – 2007 and a number of activities such as distribution of a questionnaire, workshops and meetings were amongst many other events and platforms used to formulate the MSP”.

NVDCP respondent

Unfortunately, the above mentioned events are not documented anywhere. Documents reviewed, except in the acknowledgement and preface, contained no paragraph or chapter on methodology. Respondents from WHO informed this researcher that there exists a guideline and a proto-type malaria strategic plan which WHO member states are encouraged to utilise. The MSP document is also formulated along those lines. The WHO respondent for Health promotion said:

UNIVERSITY of the

“A number of Sub-Saharan countries including Botswana have used the same format for its Malaria Strategic Plan.”

WHO respondent

The NVDCP respondent also said:

“The NVDCP was assisted by WHO to craft the MSP”.

The NVDCP respondent further narrated that they compiled a list consisting of organisations involved in conducting malaria activities. This list served as an invitation list to solicit participants to attend the above-mentioned activities. Regarding the various events, the NVDCP respondent said:

“Mainly workshops were utilised as a vehicle to formulate the MSP. However, you must know that this MSP was well researched before it was even produced. You see when the 2003 – 2007 MSP expired, we conducted a review which revealed that the disease burden has drastically decreased. There was no reason to continue as usual. The Aide Mémoire placed emphasis on three things if declined malaria statistics are to be sustained: creating and enabling environment (formulating policies, guidelines, building capacity and supporting implementation); communication (advocacy, IEC/BCC and community mobilisation) and surveillance (entomology and vector control). Especially in direct relation eliminate”

NVDCP respondent

The invitation list was also given to the researcher and was used as the sampling frame for the study population and selection of the sample size. The list named government entities, private businesses, non-governmental and international organizations. Unfortunately, no written documentation exists to verify or collaborate all the above events.

4.2.4 Participation in the MSP formulation process

While participation was limited, as implied by the lack of knowledge and awareness noted earlier, some respondents indicated that they did participate in meetings and workshops for the development of the MSP. Respondents from the SFH, WHO and the malaria unit all said they participated.

“We participated in meetings and 2-3 workshops”

WHO respondent

“We participated in 2-3 workshops and as an outcome we were also invited to the adoption of the MSP after it was printed”

SFH respondent

“We spearheaded the entire MSP development process. We have been like the secretariat even before the NVDCP was established. Malaria was under the PHC banner. We made the invitations,

logistical arrangements, coordinated all workshops. Printed this document. With the help of WHO”

NVDCP respondent

Unfortunately, some of this formulation process and the events, especially the meetings and workshops, preceding the adoption process have only been sporadically documented. There were no minutes of these events, as respondents in the malaria unit indicated that the MSP draft served as the minutes in all workshops and meetings, because it was the main aspect discussed.

The NVDCP respondent furthermore said:

“You see the draft MSP was always send to those invited weeks prior to the commencement of the workshops. There was no reason for separate minutes. The aim was to discuss, seek inputs from the respective organizations, and adopt the final version. Many who participated can attest to all this process”

The SFH and WHO respondents corroborated with the NVDCP respondent’s version of events. One of the WHO respondents further said:

“WHO organized, through NVDCP, various meetings with malaria stakeholders apart from the MSP development workshops. The aim was to compile these MSP drafts before being distributed”

While there seems to have been clear events in which stakeholders participated, there was a feeling of dissatisfaction in the level of participation amongst some respondents. The malaria unit respondents, in particular, expressed it in this way:

“Most of those invited did not attend a single workshop regardless of the invitations send to many institutions, including those of higher learning. Some would come and only participate or rather attend for two hours only.”

NVDCP respondent

The NVDCP respondent singled out WHO, SFH, DAPP and some district and regional health teams as being amongst those who participated on a consistent basis. The NVDCP made it clear that there was a need for more stakeholder participation mainly because the MSP strategic shift was seen as being different from the case management approach, which predominantly had focus on diagnosis and treatment rather than prevention.

“Eliminating malaria, especially in the northern regions where it’s endemic, the involvement of communities is crucial. The actual onset of malaria is to be considered here. That is the basis for the MSP. The ministry is more on diagnosis and treatment. We need structures lined to the communities such as traditional authorities, but they did not participate at all”

NVDCP respondent

The NVDCP respondent also reiterated that the questionnaires, sent to various institutions prior to the commencement of the workshops did not derive the expected results which was mainly to identify and subsequently create a broad-base resource pool. The respondents from WHO and SFH echoed the above sentiments indicating that the human resource pool for malaria, as oppose to HIV/AIDS, was very small and might have influenced the low participation.

“All the donors only fund HIV/AIDS programs, except for the Global Fund. That is why all NGOs in Namibia are conducting HIV/AIDS activities. Only two NGOs SFH and DAPP assist government with malaria, thanks to Global Fund support”

SFH respondent

Additionally the SFH respondent also said:

“May be the fact that malaria is seasonal and only endemic in some regions its prominence in Namibia is seen to be relatively low and hence the limited participation. Also the deaths from HIV/AIDS is country wide were as malaria is mainly in the northern regions”

SFH respondents

Therefore, the NVDCP respondent was pleased, despite the attendance being small, that those who participated, including the SFH respondent, participated throughout the process during the first

workshop were the NVDCP disseminated a draft document of the MSP 2010-2016 as well as during the review document of the MSP 2003-2007 process. In both instances, the documents were introduced and discussed in detail.

On the other hand, respondents from the MET and IEC who did not participate in the MSP formulation processes had this to say:

“We were not invited”

MET, IEC respondents

Asked if they saw the need to participate, the MET respondent said:

“May be or maybe not. You see the MoHSS have its own environmental division. We were never involved in any MSP. Although we at MET conduct environmental forecasting most of it is not related to malaria alone. We focus mainly on global warming related issues. We could, however, inform the malaria unit about malaria preparedness planning, but I am sure the MoHSS also will be able to do the same”.

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MET respondent

The NVDCP indicated that the MoHSS’s IEC and Policy units were not invited and hence not expected to participate. The NVDCP respondents stating that:

“The IEC only deals with communication related aspects and not necessary involved in policy formulation. This unit used to be a part, but its functions are limited and focused. On the other hand, the Policy unit only get involved after the document is due for finalization. This make sure that it’s compatible with other government regulations.”

NVDCP respondent

The above statement might have been true because the Policy unit respondent indicated that their involvement in most MoHSS documentation processes were limited to the final adopted or agreed documents, as stated by the Policy unit respondent:

“This unit has no expert information about diseases, but provide guidelines to all units on how to developed official health documents. In fact, there is an official guide to follow.”

Policy unit respondent

Documents reviewed revealed that the MoHSS indeed has a policy on developing official health documents. It is titled *“Guideline for the preparation and format of official documents”* (MoHSS, 1998). The guideline stipulates precisely what each document should contain, including the processes and methodologies. The guide also stipulates that all official documents should be tabled with the policy unit before printing and dissemination.

The IEC unit, on the other hand, indicated that its involvement would have been fruitful.

“This unit contributed in producing all ministerial documentation that we see today. The MSP should not be an exception, especially with regard to the elimination aspirations. Look at polio IEC played a very crucial role to inform the communities about what was needed of them. This exclusion in the MSP is worrisome”

UNIVERSITY of the
WESTERN CAP

IEC's longest serving respondent

4.2.5 Roles and responsibilities of those involved in the MSP formulation process

While all the respondents who participated had their various roles and responsibilities, in general, respondents also had various specific roles and responsibilities to play in the formulation process of the MSP. These specific roles and responsibilities were not documented, but described, verbally by the respondents. They ranged from providing technical expertise and sharing experiences to delivering malaria related services. Similarly the roles and responsibilities appeared to have been influenced by the respondents' organizations involvement in malaria activities.

In the case of WHO, its general role was to monitor health trends of populations and report at global level. In this exercise and according to the designated respondents from WHO, their organisation's involvement was mainly to provide technical expertise to the malaria unit and to

ensure that the MSP was developed following international guidelines. One of the WHO respondents put it this way:

“Our role is more of overseeing. Having been involved in the actual NVDCP review for determination its viability for pre-elimination we were basically also rightly suited to provide expertise”.

WHO respondent

Another WHO respondent further stated:

“WHO assisted the ministry with the review of the previous MSPs, including the 2003-2007 MSP. WHO produced a guide how to develop malaria strategic plans for countries in Southern Africa. Botswana and Zambia went through a similar process like Namibia to develop its malaria strategic documents”.



WHO respondent

Another WHO respondent said:

“WHO’s role continues post formulation of the MSP. We continuously assist the ministry to improve malaria delivery systems especially through national, regional and district health levels”.

WHO respondent

The WHO respondents explained that health systems' strengthening involved training health personnel in the requirement of the MSP strategies, and support with the ongoing surveillance with the aim to monitoring malaria morbidity and mortalities. The respondents also reiterated that the WHO developed malaria global principles, tools and standards that member states adopt such as pharmaceutical issues (medicine), all of which form part of technical expertise provide during the development of the MSP.

”Malaria activities in which SFH was involved-such as participation in the commemoration of the annual malaria national days, developing malaria IEC materials, conducting tracer surveys,

dissemination of preventive information and bed nets-might have been seen as a key contributor to inclusion in the MSP.”

SFH respondent

Documents reviewed revealed that SFH started its operation in Namibia in 1997 and conducted malaria activities with assistance from the Global Fund in 2005. Documents reviewed also indicate that SFH was mainly tasked to distribute mosquito bed nets to children under five and pregnant women. The documents also further revealed the vast experience of SFH in malaria activities in more than 60 developing countries worldwide.

The SFH respondent summarised it in this way”

“It is only befitting that SFH was one of the major players in the formulation of the MSP. SFH is funded by the Global Fund and through that the MSP covers most SFH operational areas.”

The SFH respondent, while acknowledging that most if not all of their activities were adequately covered within the MSP, expressed a concern that some of their suggested inputs were not incorporated.

“SFH feels strongly about community involvement and participation. This point is not well articulated in the MSP. In fact it is the only area discussing community involvement, but is not well detail, because it does not talk about long standing water in the villages, also used as grazing and feeding ponds for the cattle. The questionnaire was not sufficiently addressed”.

SFH respondent

The questionnaire seems to have left the SFH respondent puzzled about the need or the aim of such questionnaire. The NVDCP, apart from the questionnaire being used to gauge the level and number of stakeholder involved in malaria operation in Namibia, provided no clear indication what exactly the questionnaire looked like or explained its purpose.

Nonetheless, documents reviewed and comments by the MET respondents revealed that the MET's malaria activities are slightly different from those conducted by SFH, WHO and other MoHSS's units who might have contributed to the content of the MSP. While the malaria policy development (diagnoses, treatment, awareness raising) limited distribution of mosquito bed nets and indoor spraying were seen as traditional malaria activities, the MET's malaria activities are limited to environmental issues.

“MET's malaria related activities are slightly different from those delivered by MoHSS. For instance MET examines the effects of DDT on the environment. DDT is a substance used by MoHSS for indoor residual spraying to control malaria larvae. DDT forms part of the Persisted Organic Pollutants (POPs) monitored and reported by MET to international partners. As indicated because of no existing or direct collaboration, these results are not shared with MoHSS”.



MET respondent

Additionally, another MET respondent said:

“This ministry monitors high and wet lands geographic forecasts aimed at creating awareness of wet summers and extreme winters. I believe this is very crucial for malaria surveillance and MoHSS can use this type of information to develop annual malaria preparedness plans.”

The MET respondent further indicated that MET documents exponential malaria outbreaks and malaria prone areas. These are crucial factors in malaria prevention planning, however it was not clear whether the MoHSS's NVDCP made use of this information.

It was earlier explained that the IEC and policy division in the MoHSS do not work directly with the malaria unit, however the respondents from these units said that they would have liked to contribute in the earlier stages. One of the IEC respondents was of the opinion that they could have contributed through ensuring that the MSP content and messages are intentionally and deliberately targeted to audiences, which is one of its key roles.

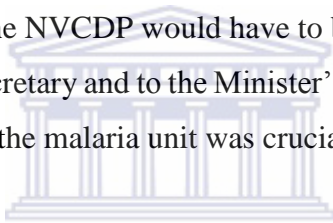
“The IEC unit has a well set out dissemination platform which could have benefited the MSP adaptation and distribution process”.

IEC respondent

The IEC respondents further said that:

“In the past, the IEC unit used to assist the malaria division with development of documents, community targeted messages and other IEC materials such as posters, pamphlets, leaflets and even specific materials like T-shirts, caps for malaria day. The IEC division is still willing to perform this task for all units in the MoHSS”.

Documents reviewed indicate that the MoHSS’s policy division’s general mandate is to ensure that each health unit has developed appropriate strategic plans and policies based on existing frameworks. Although the policy unit has no direct involvement in malaria activities ultimately all guiding documents developed by the NVDCP would have to be scrutinised by the policy division and forwarded to the Permanent Secretary and to the Minister’s office for final approval. Therefore the role of the policy division with the malaria unit was crucial.



4.2.6 Awareness of the reasons for the formulation process of the MSP

There were varied reasons for formulating the MSP. The most obvious, it appeared, was that it was a natural progression since the previous MSP for 2003 – 2007 had expired.

“MSP are five (5) year operational plans guiding the work of the NVDCP. The first MSP was developed in earlier 1990s under the PHC umbrella. The second MSP 2003 -2007 was also developed by the PHC programme. It was during the MSP that the NVDCP was coined and established. The current is the MSP 2010 – 2016”.

NVDCP respondent

According to the respondent interviewed above and documents reviewed, Namibia had so far produced three (3) MSPs, the first having been produced in the early 1990s followed by the 2003 – 2007 and the current one for 2010 – 2016. The first two MSP focused mainly on diagnosis and treatment. The last MSP focused on elimination and it’s overall approached was interpreted to be

advocacy to sustain the current low malaria statistics. The overall goal according to the current MSP document is to:

“Reduce the incidence of malaria to below 1 per 1,000 population in every district of Namibia by 2016.”

MSP, 2010; page 18

Each of the MSPs had a different target, with the most recent focusing on pre-elimination. The previous MSPs, according to this respondent, were answerable to ‘reducing malaria beyond epidemic proportions’ experienced during 1999-2001. Documents revealed that the current MSP saw the NVDCP change of approach-orientated the programme from the reduction of the disease burden to that of consolidation of control efforts and elimination of transmission. This was mainly as a result of noticeable achievements and successes revealed through a reviewed of the MSP 2003 – 2007 in 2009.

The latter was also echoed by the WHO respondent who said they were very much involved and instrumental in supporting the MoHSS’s malaria unit in its development of the MSP. At some point during the interview one of the WHO respondents said this:

“You see WHO is an international organisation with over 140 members’ states. It has worked with many organisations in the field of malaria some of which have successfully eliminated malaria. We hope to assist the Namibian government in this regard, but need a vehicle such as the MSP to plan for that”.

WHO respondent

More information from documents reviewed support the reasons for the development of the current MSP. The 2009 MSP 2003-2007 review further stipulated that massive reductions, of above 90% in malaria mortality and morbidity, required a different approach. This is because the 2003-2007 MSP strategies no longer suited the current realities where the country experiences pockets of malaria cases, especially in the health district in the Kavango regions as opposed to the entire northern regions in the past.

This was echoed by the SFH respondent who informed this researcher that she was well aware of the approach taken by the MoHSS, because the low malaria cases in the country was indicative of the need to re-focus the malaria programme in the country. This same SFH respondent further alluded to another reason for formulating the current MSP, which she explained in this way:

“Apart from other reasons it was also a direct requirement to have a policy document, when seeking funding from the Global Fund’s Malaria Global Round 2 and Round 6 funding”.

SFH respondent

Documents reviewed further indicate that Namibia has been a recipient of Global fund money for ‘Special Diseases’ categorized as Tuberculosis, Malaria and HIV/AIDS. The NVDCP respondent indicated that the NVDCP unit has immensely benefited from the Global Fund. The respondent mentioned an estimated figure to be above 3 million Namibian dollars by 2014.

The NVDCP respondent did not confirm or dispute the SFH comments about the donor fund requirement to develop the MSP. He stated that:

“The main reasons for formulating the MSP was that there was no malaria policy directives after the expiry of the 2003 – 2007 MSP”.

NVDCP respondent

The NVDCP respondent also indicated that the only guideline present was the 2005 Malaria policy which is in the process to be amended because it did not support current malaria events or the low prevalence figures.

4.3 The role of health promotion in the development process of the MSP

There were varying degrees of understanding and interpretation of health promotion amongst respondents. The brief results below are presented in broad base categories to illustrate

respondent's interpretations of health promotion in relation to the formulation processes of the MSP 2010 – 2016.

4.3.1 Awareness of health promotion in the MSP

Firstly, some respondents were fully aware of health promotion as a concept and in relation to the MSP. Others were unaware of health promotion in general, including being unaware that what their organizations were involved in is in fact health promotion. Notably, respondents from the WHO provided sufficient evidence to illustrate their understanding of health promotion as an intervention and as an approach. At one stage during the interview one of the WHO respondents said the following:

“Health promotion in the MSP was used both as an overall approach and a strategy”.

WHO respondent

Another respondent, also from WHO, had this to say.

“Health promotion issues should be evidence based for advocacy and decision making and this evidence should be able to indicate the most appropriate intervention that require high impact behaviour change”.

WHO respondent

The above statements by the WHO respondents were said in direct reference to the goal and key objectives of the MSP quoted as follows:

“To reduce malaria cases to below 1 case per 1,000 people in each health district”.

MSP, 2010; page 18

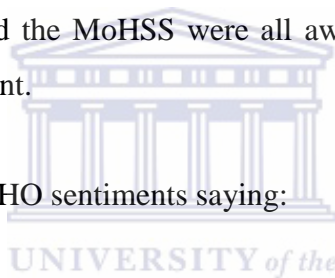
The WHO respondent said that the emphasis in the current MSP is to *‘reduce malaria cases in each district’* as oppose to *‘reducing malaria cases to below epidemic threshold’* which was considered an epidemic (MSP, 2010, 18). The WHO respondent reiterated that the shift came about after(?) the massive reductions in malaria, as indicated in earlier sessions and thus malaria was no longer an epidemic in Namibia.

The WHO respondent also indicated that during the malaria epidemic era service delivery concentrated mainly on the curative aspects. The current MSP's focus is elimination of the malaria foci, thus elimination of the causative agent. The WHO respondent mentioned that the NVDCP, through the 2003 – 2007 MSP review, guided the current MSP towards a multi-sectoral approach involving various stakeholders as oppose to a usually MoHSS dominated curative approach.

The WHO respondent thus indicated that it was expected, through the MSP, that communities, non-governmental organisations and private companies will assist the NVDCP to achieve the MSP set goals. In this regard, review of existing documents revealed that the current MSP clearly stipulate community actions, advocacy and control of malaria larvae as strategic key interventions.

Respondents from SFH, WHO and the MoHSS were all aware of the change in approach and participated in the MSP development.

The SFH respondent echoed the WHO sentiments saying:



“The strategic plan addresses a major paradigm shift from previous malaria management, to plans for re-orientation and restructuring of the NVDCP from a focus of reduction of the disease burden to that of consolidation of control efforts and elimination of transmission foci conducted looking beyond the medical approaches used earlier to achieve the set goals”.

SFH respondent

The above statements by WHO and SFH respondents could be interpreted as both respondents were looking at the MSP's current focus of pre-elimination as geared more towards a health promotion approach than in previous MSPs which were focused on a medical approach based on diagnosis and treatment.

As indicated earlier in this study, prior to formulating the current MSP the NVDCP, assisted by WHO, undertook a review of the malaria program, thus the NVDCP.

“The reason was to evaluate the successes and challenges of the previous MSP (2003-2007) and seek an approach which will address current realities about malaria in the country. Malaria figures have drastically decreased and we could no longer only stick to diagnosis and treatment. There was an overall consensus that malaria can be eliminated. Malaria cases are very few - 39 morbidity cases in a year and only 4 mortality. Our health facilities have responded well. We must now look where those few cases are coming from, focusing on district”.

NVDCP respondent

Unfortunately, apart from SFH, WHO and NVDCP, there were those who were unaware of the above. Some, like the IEC and MET respondent indicated that they have not been part of the formulation of the MSP.

Regardless of the above, some of those who were aware of the paradigm shift appeared to have limited understanding of health promotion. This was derived from their descriptions about health promotion in general. Regardless of their institutions found to be involved in, or conducting activities which illustrated the importance of health promotion. They were adamant that health promotion is broader. For example, despite prodding about health promotion interventions, the SFH respondent simply indicated that her organisation was the only institution which provided and distributed mosquito bed nets to all pregnant women and children under five at all rural clinics in the malaria endemic regions. This respondent further reiterated that:

“Health promotion is very broad. SFH has been distributing bed nets in Kavango region and lately in Oshana and Oshana Namibe region. We also conduct education session in the villages to teach people how to use the bed nets and clear the long grass from the stagnant water. But you must understand that people in the Kavango region use the long grass for many things to make roofs and also sell”

SFH respondent

Similarly the NVDCP said:

“The MoHSS is involved in conducting indoor residual spraying in northern and north eastern Namibia. The aim is to clear malaria parasites and reducing mosquito human contact”.

It appeared that the NVDCP was not aware that this particular activity is indeed health promoting in nature. This is because, despite prodding, the NVDCP was adamant that such activities are not health promotion but rather part and parcel of malaria case management.

The same could be said for the MET respondents who adamantly said:

“MET is not involved in health aspects, its scope is limited to the environment”.

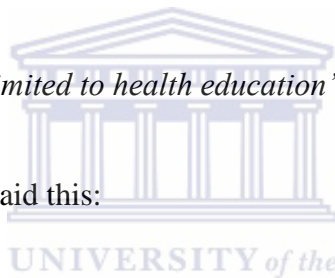
MET respondent

It is also worth mentioning that respondents from the IEC division were quite clear regarding the status of health promotion in the country. They informed the researcher that there was no Health Promotion Policy in the country. They also said:

“Health promotion in Namibia is limited to health education”.

IEC respondent

One of the MET respondents also said this:



“Although it is health promotion, the MoHSS needs to spearhead this interventions”

MET respondent

This was said after the researcher indicated that part of what MET does was initially health promotion in nature. Not convinced by the researcher’s statement, the MET respondent felt generally that anything health related, including malaria, should be tackled and coordinated by the MoHSS. One of the MET respondents indicated that there is a lack of proper malaria activities coordination, putting it this way:

“Poor collaboration amongst stakeholders might limit the MoHSS’s health promotion efforts. Other institutions need to provide assistant to the MoHSS to carry out its functions”

MET respondent

The above statement revealed various interpretations of health promotion. Direct involvement in activities, coordination, collaborative initiatives and interventions are variously interpreted. Limited or skewed understanding about health promotion, including the role being undertaken by the different organisations was misinterpreted by MET as the sole organisation to carry out health promotion interventions.

“If health promotion means what each institution does to capacitate people to be healthy than health promotion is fragmented across many sectors. Look at malaria, for example, our tourism sector creates malaria awareness through developing pamphlets. The Ministry of Home and Foreign Affairs also encourages Namibian travelling abroad to take anti-malaria tablets. It is cross cutting”

MET respondent

During interviews the MET and IEC respondents noted that a number of crucial functions related to health and other disciplines were widely fragmented which may have led to misunderstanding and misconceptions about health promotion. To further illustrate this misconception and misinterpretation about health promotion, one of the IEC respondents, explained in this way:

“IEC is an integral part of health promotion, but it does not feature entirely into various MoHSS units, including the NVDCP”.

IEC respondent

This respondent is of the opinion that health promotion needs to feature in each MoHSS division which might not necessarily be the most appropriate intervention. This same sentiment is expressed by the MET respondent above who indicated that it is not only the MoHSS have to deal with health promotion.

4.3.2 Health promotion as an enabling tool

There was varied awareness of health promotion being an enabling tool. One respondent alluded that health education is a key determinant of health.

“The SFH’s most important activities are community education. These activities are conducted mainly under trees where people are educated about malaria signs and symptoms and how to protect themselves”

IEC respondent

The above statement was echoed by one of the MET respondents who said that:

“All tourists entering Namibia are given malaria brochures and their passports are checked for anti-malaria medication.”

MET respondent

Education was used by the IEC, NVDCP and SFH to enable people to seek health care against malaria. These respondents indicated that their organisations conducted various activities using health education through events such as the celebration of the malaria day, dissemination of T-shirts, caps, posters and pamphlets as well as formulation of awareness creation messages such as “Roll Back Malaria” and “Namibia free of malaria by 2020”.

There was also a recognition that investing in health promotion is an important strategy to maintain the decrease in malaria cases and subsequently eliminate malaria in Namibia. Respondents from the WHO, NVDCP and SFH considered external funding, specifically from the Global Fund, as a key contributor to the sustained reduction in malaria cases. The Namibian constitution states:

“Health investment is a just and social course”.

Namibian Constitution Chapter 11, Article 95,

It is notable here that the Namibian Constitution calls for initiatives supporting health promotion. This includes state funding through national annual budgets to especially the MoHSS. The MoHSS has had the second highest budget in the country.

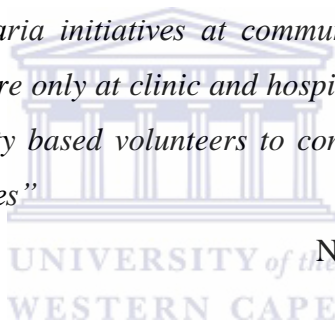
Another document reviewed, as part of the health promotion policy framework in Namibia, was the ‘economic and social development road map’ called Vision 2030 which advocates for:

“The promotion of health, prevention of diseases and improvement of lives through ensuring a quality of life of all Namibian”

Namibian Vision 2030:3

Another aspect noted, by both respondents and documents reviewed, is the recognition that multiple approaches promoted in the various strategies enables reforms of health programs and initiatives. The reform of the current MSP is such program. One of the NVDCP respondents indicated that the significant drop in the malaria disease burden had an influence on the change in approach from a case management focus to an elimination focus.

“The current MSP calls for malaria initiatives at community level. At the moment malaria diagnosis and treatment services are only at clinic and hospital level. The new Health Extension initiative aimed to train community based volunteers to conduct case management and health education of malaria in communities”



NVDCP respondent

“The Aide Mémoire stipulates specifically that policy guidelines, advocacy and surveillance was limited in previous MSP, but very crucial for any elimination process if low transmission is to be sustained”

NVDCP respondent

“The MSP objectives are specifically targeted towards building the knowledge, skills, delivery aspect of various key stakeholders including the community”.

NVDCP respondent

“The mission of the programme is to provide free, efficient, accessible and quality malaria interventions to all people in Namibia”

MSP, 2010; page 12

The MSP document and respondents precisely stipulate that key interventions in the MSP are directed towards sustaining reduced malaria statistics. The current MSP is said to be responsive to these realities.

“The approaches undertaken by a control program and by an elimination program will vary significantly. Namibia will undergo a programme reorientation to gear up for elimination”

MSP, 2010; page 10

Moreover, as indicated in earlier discussions, there existed a need to refocus the malaria program following significant malaria reduction statistics, as quoted above. The MSP also states that:

“Previously, the objectives of national control efforts was to reduce the burden (morbidity and mortality) of malaria, whereas the new focus will be the consolidation of control efforts and elimination of transmission foci”

MSP, 2010; page 10

The NVDCP respondent, in response to a question about how health promotion is relevant to the MSP, indicated that the MSP document first of all provides a situational analysis of malaria in the country. He described the lessening of the disease burden and related this to one of the MSP objectives as an effective advocacy tool. The MSP objectives in direct relation to health promotion strategy and devising potential programme was said to be:

“To achieve a ‘95% usage of at least one malaria prevention measure by the year 2013’.

MSP, 2010; Objective 5, page 18

Key intervention strategies in the MSP for this particular objective calls for collaboration in this aspect. Although the *Aide Mémoire* indicated that this link is weak, there seems to be some recognition of the importance of inter-sectoral collaboration. It was also observed during an earlier session that a certain level of stakeholder collaboration indeed does exist, particularly among the SFH, MoHSS and the WHO.

The document review found the *Malaria Communications and Advocacy Strategy (2009)*, a document supportive of the MSP which noted that:

“No malaria communication program can succeed if well-articulated national policies and service delivery guidelines are not adequately disseminated and understood”

MCA, 2009,

The above statement speaks to the limited stakeholder network and whether such limitation has a potential to serve as a barrier in achieving MSP key interventions. The IEC respondent in earlier sessions also stated that:

“Total elimination of malaria might not be possible without behaviour, practices, and attitudes and belief changes and as especially not without dealing with issues about community mobilisation and advocacy which should be crucial components to be addressed by the MSP 2010 – 2016.

IEC respondent

The above statements are very crucial, especially when considering stakeholder involvement and participation. This is a fundamental policy formulation issue. The organizations not included in the policy development process, that is, respondents from the IEC and MET, indicated that they felt a little left out, for example. This was particularly because they believed that they were able to provide information or contribute in the fight against malaria. The MET respondent specific said this:

“We are aware of the MoHSS work in malaria, but we have never worked together.”

MET respondent

Asked if they saw a need to work together, the respondents from MET indicated that:

“May be, may be not “.

IEC respondent

However, the IEC respondents were quite clear about the need for collaboration. The IEC respondents were of the opinion that IEC related activities are fundamental health education components and despite being only part of the wider integrated health promotion approach they were convinced that IEC approaches were needed in the MSP.



CHAPTER 5: DISCUSSION

5.1 Introduction

The aim of this study was to explore the formulation processes of the Namibia MSP 2010-2016. The study also explored how health promotion featured in the MSP development process. For the purpose of this study, and in the absence of a current *Malaria Policy* in Namibia, the MSP 2010-2016 was used and discussed referred to it as a policy. The existing *Malaria Policy* was formulated in 2005 and was deemed outdated as it does not address current malaria epidemiological realities.

The reason for studying this topic was to provide an understanding of how policy formulation is initiated and conducted in a situation where the disease burden has changed over time. This included understanding the processes involved in formulating a responsive policy. The literature review indicated that malaria mortality and morbidity in Namibia has changed dramatically. For example, malaria mortality in 2001 was recorded at 1,728 deaths compared to only four deaths ten years later (MoHSS, 2010). A number of factors were attributed to this decline, but the process for developing the MSP was not considered – and therefore not adequately documented.

There is evidence that the MSP featured health promotion as an approach and a strategy. However, despite information supporting events and activities involved in the policy formulation and its inclusion of health promotion, a number of factors also emerged which might serve as barriers to effectively developing policies and derail health promotion strategies as an approach. This study, through interviews and the documentary review, found that amongst those barriers are the lack of awareness, limited stakeholder participation and collaboration in policy development. The discussion below focus on two main issues: policy formulation and the role of health promotion in malaria policy development.

5.2 MSP policy formulation

While there were many valuable processes undertaken in the development of the MSP, when comparing these to those documented in the literature, it is clear that there are several limitations.

The study found that the MSP was developed by a limited group of stakeholders. Furthermore, the study also found that a number of key stakeholders were excluded from the formulation process and that there was inadequate information about the steps or events which led to its formulation. While reasons were provided for the above-mentioned exclusion, such inadequacies or limitations are likely to negatively influence the effectiveness and expected outcomes of the MSP.

The Ottawa Charter (1986) particularly calls for the establishment of '*healthy public policy*' which refers to broad based health policies created outside the health care system, but which facilitates health promotion of health across sectors. The MSP adheres to these notions in that various stakeholders were involved in its development. The Ottawa Charter also reiterates that healthy public policies should adequately ensure that such policies comprehensively address the phenomenon. In this case the exclusion of key stakeholders, such as the IEC and MET, might have limited the MSP's ability to address itself beyond the narrow definition of health. The IEC, for example, could have addressed issues around communication, whereas the MET could have addressed environmental impacts on malaria and the multi-causative aspects and human–nature practices such as in the case where rural communities utilize malaria breeding areas (long standing water and the thick grass) for human and cattle consumption. Currently, the MSP does not contextualise these multi-causative aspects, neither does it address human–environment tensions. Instead, it broadly describes the aspiration to eliminate malaria without due cognisance of the factors mentioned above.

In addition, the roles of those who were involved in the formulation process were not explicitly documented, but only mentioned verbally. That is, the stakeholders were left to 'second-guess' their roles and contributions to the formulation process. Thus, MSP processes were in contrast to the literature which revealed that policy formulation should take place when the content, context and process are clearly laid out and there is active participation by all key stakeholders (Collins, 2004; Parson, 2005; Jones, 2009; Buse *et al.* 2005; WHO, 2004; Hanney et al. 2003).

The study revealed that a questionnaire and workshops were used as a platform to formulate the MSP. Unfortunately, further details to clarify what transpired during these events were not documented or explained during the interviews. Therefore, this study cannot explicitly point out

the steps or processes followed to develop the MSP. In the literature it is suggested that policy formulation is three-dimensional: the context, process and content (Buse *et al.* 2005).

Elsewhere, Buse *et al.* (2009) indicate that the three dimensional approach is linked to and activated through a process of actor engagement. Buse *et al.* (2005:4) define actor as “*individuals, organization or even the state and their actions that affect policy*”. Although this study found evidence of actor involvement, such engagement was limited to the events or platforms mentioned above. In addition, the actors involved had limited influence on the process of formulating the MSP as well as the MSP content, as it was set by MoHSS’s malaria unit. Furthermore, those who were not involved, such as the MET, revealed that there was no engagement whatsoever with the NVDCP, mainly because the MoHSS, has its own environmental unit. Unfortunately, this limited and lessened the opportunities of various disciplines working together to create supportive environments, as recommended in the Ottawa Charter (1986). Similarly the advantage to address the multi-causative factors of malaria might not be realized.

The WHO provides guidance to member countries through a prototype MSP (WHO, 2011). The NVDCP followed the WHO’s structure which addresses, amongst other factors, the malaria epidemiology, strategic interventions, implementation modalities and resource aspects. Although not in its entirety, the WHO guidance was adopted via consensus by those involved. The literature also indicates frameworks such as the Decision Analysis Framework, a structured model addressing five critical malaria areas (epidemiology, prevention, control, transmission and surveillance) which can be used as a systematic policy making tool (Kramer *et al.* 2009).

The study found that the context of the MSP was related to the malaria epidemiology. Literature revealed that malaria was the leading cause of mortality and morbidity in earlier years before and immediately after independence. These statistics have declined to below 90% after 10 years of rigorous malaria case management with an emphasis on medical care.

Authors of policy studies indicate that the context of any health policy is determined by various factors which influence the phenomenon. These factors include, amongst others, socio-economic issues, cultural practices, political influences and aspirations (Collins, 2004; Parson, 2005; Jones,

2009; Buse *et al.* 2005; WHO, 2004; Hanney *et al.* 2003). The formulation of the MSP was influenced by a number of local administrative and political systems, including the development of the five-year strategic plans, the changes in programme orientation and as a requirement by funding agencies. It was also formulated following recognised international and national guidelines, notably the WHO MSP prototype and the MoHSS guidelines for developing official ministerial documents (MoHSS 1998, WHO, 2011). Furthermore, the malaria disease burden, reasons for formulating the MSP, awareness of the existence and MSP development process are all part of policy context and at some level influenced the content and process of formulating the MSP.

The WHO (2004) refers to this broad-based setting as the '*policy environment*' Buse *et al.* (2005:4) describe it as the policy context with its "*systematic factors – political, economic, social or cultural, both national and international – which may have an effect on health policy*". Similarly, and in relation to the policy formulation process, the study revealed that amongst processes used to formulate the MSP a programme review, particular review of the previous MSP 2003-2007 was conducted. These combined processes have set the approach for the MSP, illustrating a degree of decision making which authors such as Kramer *et al.* (2009) promote in relation to health policy formulation.

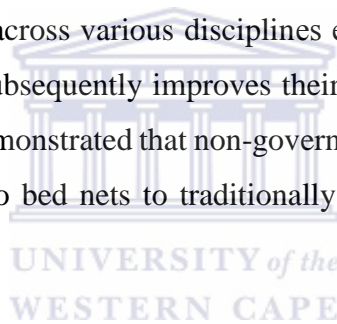
Buse *et al.* (2005) also bring in the aspect of power (ability to influence and control) as a part of decision making by the actors who state that such power can either be by 'authority', 'rationality' and 'elitism'. This too can be seen in the development of the MSP, which was government driven with external technical and funding support by WHO and the Global Fund.

5.3 MSP focus on health promotion

The primary function of health promotion is considered as those activities, events and efforts which enable people to enhance their abilities to ensure health (Ottawa Charter, 1986). In this study, however, the researcher found that respondents had varied understandings of health promotion. The respondents from the NVDCP, SFH, MET and IEC did not consider activities performed through their organisations as health promotion interventions. As a result malaria activities and

programmes delivered by these institutions, although they were geared towards the reduction of malaria, were not recognised as health promotion. In addition, there appeared to be limited connection, especially between the IEC, MET and the NVDCP. Consequently, activities by these organisations were seen as parallel organisational roles without any interconnectedness with the broader picture. This limited understanding of health promotion is likely to have implications on addressing health determinants. For example, the lack of a broader understanding limits the ability to work intersectorally with relevant departments from the NVDCP, IEC and MET to address environmental and social health determinants.

The limited understanding also underscores the ability for stakeholder engagement and identification of roles. This is important to effectively address health determinants, especially in conditions similar to malaria where multi-causative streams are found. The literature indicates that the promotion of health practices across various disciplines enables people's abilities to address various health determinants and subsequently improves their health (Naidoo & Wills, 2005). In some instances, however, it was demonstrated that non-governmental organisations (SFH) assisted the NVDCP to distribute mosquito bed nets to traditionally known hospitals and clinics based health services.



Other malaria prevention and control measures related to health promotion and described in the MSP were indoor residual spraying and control of malaria larvae. Use of mosquito bed nets, indoor residual spraying and elimination of malaria larvae have contributed immensely to the reduction of malaria mortality and morbidity in Namibia (MoHSS, 2010). However, the distribution of bed nets is limited to pregnant women and children below the age of five. While this is useful it is limited because it does not reach the other segments of the rural population in malaria endemic districts.

Moreover the clearing of mosquito larvae – mainly drainage of swamps (clearing of long standing water and long thick grass) is regarded as an effective way to minimise malaria transmission through the elimination of the malaria foci (WHO, 2009). While strategies to identify and clear malaria breeding areas are described in the MSP, the multi-causative aspect of malaria which reflects the interactions between the parasites, human host and the vectors, are not effectively

addressed. The human – swamp conflict (rural inhabitants utilising the stagnant water for human and cattle consumption while the animals graze on grass) is also not adequately addressed. These human and environmental conflicts are best addressed through departmental intersectoral collaboration. In this case the NVDCP, MET, SFH and IEC would have been a suitable vehicle to address these determinants.

The MSP could have addressed the health promotion role of institutions effectively in this regard. The absence of a stakeholder analysis in the MSP also limited the understanding of a broad based health promotion programme to address health determinants beyond the health care sector (Ottawa Charter, 1986). For example, the IEC respondents were of the opinion that health education is an effectively advocacy tool. Though addressed in the MSP, it fell short of identifying a relevant stakeholder or parallel agency to spearhead that process.

The Ottawa Charter (1986) supports the reorientation of health services where multi-disciplinary teams collaborate to strengthen systems responsive to people's health needs. The study found that health promotion featured both as an approach and strategy in the MSP. In the above paragraphs malaria prevention strategies were described. Evidence supporting the health promotion approach in the MSP indicates that the 'elimination goal' is people-centred, because it emphasizes the importance of eliminating the malaria foci. While the above-mentioned statement seeks overall to influence and provide remedies aimed at contributing to people's health in their own surroundings, it unfortunately does not adequately translate into tangible strategies. The MSP, for example, does not adequately address community involvement in malaria prevention and control, neither does it clarify community roles in relation to malaria control and prevention.

Similarly, while there was some enthusiasm among those interviewed for the above-mentioned approaches, there was also the view that the MSP will not achieve their objectives given the limited understanding and lack of stakeholder collaboration. Moreover, the limited understanding and interpretation of health promotion restricts the extent to which the malaria programme can address some very important aspects of malaria prevention, such as the swamp drainage mentioned above. The review of literature reveals that in some African countries health extension workers extend

these services to communities, whereas in Namibia these services are limited and accessed at hospitals and clinics only.

In relation to an overall health approach, the study found that Namibia, through various strategic documents such as the Namibian Constitution (1990) and the PHC approach, does in fact seek to invest in health and increasing standards of living. The Ottawa Charter (1986) indicates that health is attainable where certain fundamentals conditions such as peace, education, nutrition and a stable ecosystem prevails. The health history of Namibia was that of segregation along tribal and racial lines in which people in traditional rural areas were prevented from travelling after sun-set and access to health facilities was compounded by distance and unavailability of health services.

In the creation of MSPs, rural clinics served as a correction measure. While these actions are applauded and designed to strengthen health systems, in order to improve the implementation of policy guidelines and aspirations, a number of factors needs to be improved. The overall limitation in the formulation processes of the MSP might have implications in adequately addressing health promotion strategies in malaria and overall health documents and programmes. While international and national guidelines exist to guide the development of these important policy documents, it is also crucial to follow such processes.

5.4 Conclusion

The study concluded that there is inadequate evidence to understand the formulation and development process of the Namibia MSP. While some evidence exists to understand the extent and focus of health promotion in the MSP development, there are several gaps which compromise understanding. These factors are, amongst others, the limited understanding of health promotion, involvement of key stakeholders in the policy formulation process, stakeholder engagement and community involvement.

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

Malaria, a disease caused by the Plasmodium Falciparum parasite, remains a global public health threat, killing over three million people annually (WHO, 2009). In Namibia, malaria was a leading cause of mortality and morbidity during the 80's and up until 2001. Malaria epidemics, in Namibia, were recorded in 1990, 1996, 2000, and in 2001. A decade later, however, data from 2002 to 2008 indicated a remarkable 90% downward trend in malaria morbidity and mortality in the country. These declines were also experienced in a number of other SSA countries, to such an extent that a number of these countries are currently working on eliminating malaria completely.

Amongst factors associated with these declines are robust malaria prevention and control programmes (NVDCP) supported by increased donor funding for a diverse range of malaria activities. These multi-dimensional malaria activities and management aspects are being implemented through five year MSPs. This study explored the development processes of the current MSP (2010-2016) in Namibia and its relation to health promotion. The study sought to understand, amongst others, factors which led to the development of the MSP, the roles and responsibilities of stakeholders involved, malaria prevention strategies and health promotion strategies emphasised in the MSP.

This study found inadequate evidence to understand the development process of the MSP. According to the literature policy development comprises three distinct dimensions: policy context, policy process and policy content, and these three dimensions are interlinked through a process of stakeholder involvement. Significantly, the above aspects were not distinctly clear in the MSP and respondents varied in their reasons for formulating the MSP. While a number of stakeholders were involved in the formulation process, a number of significant stakeholders were also left out. This limited stakeholder engagement impacted on the potential to address the multi-causative aspects of malaria as well as the diverse malaria management procedures.

The study found that health promotion featured as an approach in the MSP (2010 – 2016). Evidence in relation to the overall approach is derived from the focus of the current MSP 2010 – 2016 which, in contrast to previous MSPs, is people-centred. The current MSP focuses on the elimination of the malaria foci, which refers to efforts aimed at eliminating all aspects of malaria transmission. Previous MSPs had focused on malaria case management, diagnosis and treatment.

The study also found that the MSP described various malaria prevention measures. This includes, amongst others, the use of mosquito bed nets, residual indoor spraying and clearance of the malaria foci. While the MSP expressed the need to improve these measures, it unfortunately did not adequately express the roles of various actors explicitly. The MSP does not describe stakeholder roles and responsibilities (a stakeholder analysis) despite the fact that respondents narrated the various roles their organisations played during the formulation of the MSP. For example, the WHO provided funding and technical advice, while the SFH indicated they were responsible for distributing bed nets to pregnant women and children under five. The omission of stakeholder roles might pose a major limitation in terms of delivery of malaria services by actors outside the health sector, such as the MET whose role is directed to environmental forecast. This also indicates that there exists no engagement between the MoHSS a number of crucial actors such as MET and IEC to advance the delivery of malaria related interventions.

6.2 Recommendations

There are a number of factors which limits effective malaria programme delivery and management in Namibia and omissions during the MSP development process have significant implications for malaria elimination in the country. Considering the above, the following recommendations are made:

- The MoHSS and the NVDCP need to clearly describe the formulation or development process of the MSP in order to aid the analysis and understanding of varied issues involved in policy development, including the aspect of stakeholder involvement and collaboration. Existing international and national guidelines such as the *'Namibia Guidelines on how to develop official health documents'* of 1998 can aid in this regard.

- Adequate stakeholder involvement and collaboration as crucial factors for effective and integrated programme implementation should be maximized, in order that limited or absent stakeholder involvement should not constrain effective delivery of programmes.
- An increased understanding of the concepts of health promotion and its application. This is crucial, because it influences various aspects of programme delivery. Furthermore a lack of a broad base understanding has implications for stakeholder positioning and overall engagement and delivery of programmes, especially those outside the health realm.



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APPENDICES

Appendix 1: Stakeholders Invitation List

MoHSS- National Vector-borne Disease Control Programme
National Stakeholder Meeting, 12-14 January 2010

Name	Organization/Ministry	Tel/cell	e-mail address
1. Mr. Michael Likando	MoHSS/ Caprivi	0811248758	mohsscpr@iway.na
2. Dr. Jean -Paul Tshitende	MoHSS/ Hardap	0812883515	Mukeba_tshitende@yahoo.com
3. Ms. Lucia Nghishongwa	MoHSS/ Oshana	0812877674	ngishongwai@yahoo.com
4. Ms. Martha Asser	Eenhana Town Council- Ohangwena	0811486890/ 065- 263092	asser.m@eenhanatc.org.na
5. Ms. Anna Marime-Mitowo	MoHSS/ Hardap	063-245500	bkenarime@yahoo.com
6. Mr. Hausiku Paulus Mppoko	MoHSS/Kavango	0813067459	hausiku2007@yahoo.co.uk
7. Ms. HNT Haijinge	MoHSS/ Omusati	0811225507	hnthaijinge@gmail.com
8. Ms. Alna David	MoHSS/ Omusati	0812183652	
9. Ms. Selma Shiyamba	NIP- Wlk	0811275961	selma@nip.com.na
10. Ms. Selina PN. Neumbo	MoHSS/Omusati	081232731	selinanuukongo@yahoo.com
11. Dr. N. Siame	MoHSS/Oshikoto	081232731	noelsiame@yahoo.com
12. Mr. Jamela Dube	MoHSS/caprivi	0812321234	jamela-dube@yahoo.com

13. Ms. Linda L. Nambundunga	MohSS/Kunene	0811227194	
14. Ms. Mendai IM	MohSS- Kavango	0811280138	imendai@yahoo.com
15. Ms. Mabuku IM	MohSS/Caprivi	0812710125	mwakalm@yahoo.com
16. Dr. Tshiteta P.S.K	MohSS/Erongo	064- 4106007	tshiteta@iway.na
17. Ms. Linea Naango	MohSS/NVDCP/WHK	061- 2035079	naangol@nacop.net
18. Dr. Steve Okokwu	UNICEF	061- 2046384	sokokwu@unicef.org
19. Dr. Bruno Moonen	SAMEST/CHAI	+254733331119	bmoonen@clintonfoundation.org
20. Mr. F. Hango	SFH	0811497232	fhango@sfn.org.na
21. Ms. M. Nangolo Rukoro	SFH (SMA)	0811484740	mnangolo-rukoro@sfn.org.na
22. Ms. K.N. Pohamba	MohSS/ Ohangwena	0811420134	kanopohamba@yahoo.com
23. Ms. L.N Nampupala	MohSS/ Ohangwena	0811277978	
24. Mr. Frans Ijipinge	MohSS/Ohangwena	065- 266604/ 0811497676	
25. Ms. Judith Hellweg	Mossi Nets	0813451285	helliweg@iway.na
26. Mr. Geoffrey Ndengu	MohSS/ Ojizondjupa	0812000595	geoffndengu@hotmail.com
27. Mr. B. Ntomwa	MohSS/ NVDCP/Oshakati	065- 2222210	
28. Mr. T. Kapoff	MohSS/ Khomas		
29. Ms. J de Putter	MohSS/ PMU/GF	061-2092757	ideputter@globalfund.com.na
30. Dr. D. A. Truneh	WHO	061- 2046111	

Appendix 2: Profile of institutions and key informants selected and interviewed

Name of institutions selected	Name of institution, positions and divisions responsible for malaria	Total number of candidates to be interviewed	Status of such interviews	Actual and total number of people interviewed	Actual number who participated in the MSP formulation Process
MOHSS	• NVDCP	• two (2)	• interviewed	• One (1)	• Five (5)
	• IEC	• One (1)	• interviewed	• Three (3)	• none
	• Policy Planning and Human Resource	• One (1)	• interviewed	• One (1)	• none
	• Environmental Health Officer	• One (1)	• Not conducted	• none	• unknown
WHO	• Malaria Officer • HP officer	• Two (2)	• interviewed	• Two (2)	• Two (2)
SFH	• Malaria Officer	• One (1)	• Interviewed	• One (1)	• One (1)
RED CROSS	• None (never provided)	• One (1)	• Not conducted	• none	• unknown
MET	• Directorate of Environment	• One (1)	• Interviewed	• Two (2)	• none
UNAM	• Masters of Public Health • Senior lecture for Health Promotion	• Two (2)	• Not conducted	• none	• none
TOTALS		• Twelve (12)	• Six institutions interviewed	• Ten (10)	• Eight (8)

Appendix 3: Key Informant Interview Guide

Information	Details
Sample Respondent No as per interview schedule (circle appropriate number)	[1]: [2]: [3]: [4]: [5]: [6]: [7]: [8]
Name of Interview Location	
First Name Interviewer	
Surname of Interviewer	
Title of Interviewer (Mr., Mrs., Ms., Dr., Rev., etc.)	
Position / Job Title of Interviewer	
Name of Organisation where Interviewer is employed / represent	
Contact details of interviewer	Phone: Email:
Categorisation of Organisation / of interviewer	____ - 1 Government / Ministry: Specify: _____ ____ - 2 International Organisation: Specify: _____ ____ - 3 Civil Society Organisation : Specify _____ ____ - # Other (specify): _____

Date and Time of the Interview	Date: _____ Time: _____
Researcher's Observation in terms of Interviewer's overall co-operation; participation; involvement in the interview process	_____ - 1 high _____ - 2 medium _____ - 3 low
Supervisor's Comments and overall remarks in terms of detail provided through this interview	

Dear Participant

My name is Kaarina Nduuvunawa Amutenya, a student (student no: 2616485) pursuing a **Master's Degree in Public Health** at the University of Western Cape in the Republic of South Africa. I am a Registered nurse by Profession and aspired to become a Public Health Specialist and Qualitative Researcher. I currently managed a non-governmental organisation called !Nara Training Centre. An institution established to build the capacity of civil society organisation through participatory training and assessment.

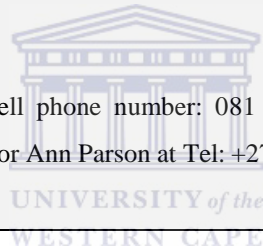
You have been purposively selected to participate as a **Key Informant Interview** in this research Study titled: 'How a health-related policy in Namibia is researched and adopted? A Case Study analysing the development of the 2010-2016 Namibia Malaria Strategic Plan and its relation to Health Promotion'. Therefore thank you for taking time off your busy schedule to participate in this interview. This research study, in a form of a mini-thesis, is part of the requirement for a Masters in Public Health (MPH).

I particularly invited you to participate in this research project because as a key person in the fight against malaria, your insight into this topic will provide a better understanding of the role of health promotion in the Namibian Malaria Strategic Plan for 2010-2016 and the role policy makers and stakeholders in developing health strategies.

Your participation is entirely confidential. However job titles might be used due to the nature of the study topic. All information obtained will be securely stored and protected. You will be required to complete a consent form, attached to this questionnaire guide.

The aim of the study is to analyse how the Namibia Malaria Strategic Plan for 2010-2016 was developed and its relation to health promotion. The study has the following objectives: *(1) To describe the factors which led to the formulation of the Namibia Malaria Strategic Plan for 2010-2016, (2) To examine the roles and responsibilities of key policy makers in designing the Malaria Strategic Plan for 2010 - 2016, (3) To explore the evidence for competing malaria prevention strategies available to policy makers in designing the Malaria Strategic Plan for 2010 -2016, and (4) To explain why health promotion strategies were emphasized in the Malaria Strategic Plan for 2010 -2016.*

For further clarity before the interview please contact me at cell phone number: 081 2575 914 or email to nduuvu.2009@gmail.com alternative contact my research supervisor Ann Parson at Tel: +27 21 959 9389, Fax: +27 21 959 2872 and email aparsons@uwc.ac.za



Introductory Questions

Note: these questions are guidelines. Issues arising during the interviews may be probed in greater depth.

- 1) [All] What are the main activities of your organisation / your department/ your job title?
- 2) [All] Please provide an overview of malaria in the country and your particular involvement in the fight against malaria? [Ask for reports, statistics and any relevant documents]
- 3) [All] What programmes/projects/activities do you have related to malaria? [Probe on plans, M&E, funding, technical expertise, research, documents, protection, support, health, grants, etc?]

Knowledge about the Malaria Strategic Plan 2010 – 2016

- 4) [All] Are you familiar/What do you know about the Malaria Strategic Plan 2010 – 2016 and what is or have been your involvements in its formation (if anything)? Please describe.
- 5) [All] (if anything) what is your organisation's roles and responsibilities related to the Malaria Strategic Plan 2010-2016? [Probe on membership, roles and responsibilities, number of meetings, venue, what other bodies did this Forum work with, etc.]
- 6) What specific organisational factors do you think led to the development of the Malaria 2010-2016 Strategic Plan?

Assessment of health-related policy development in Namibia : MoHSS Policy Division

- 7) [MoHSS] What makes one health-related policy more effective than another one? List these aspects/key requirements that make for a well-developed policy. [Probe on existing policy planning, formulation and implementing guidelines, standing committees, roles and responsibilities, process, what other bodies they work with, communication channels, reporting, etc.]

- 8) [MoHSS] How do you perceive the Malaria Strategic Plan 2010-2016? Does it adhere to these guidelines? Please elaborate (extensively regarding the process followed to developing and adopting it)
- 9) [MoHSS] Do you foresee any challenges in its implementation? Probe for risks, assumptions and limitations [If need be do a ‘mini’ SWOT analysis or Spidergram to illustrate the challenges, risks, limitations and assumptions]
- 10) [MoHSS] What is the status of the Malaria Strategic Plan currently? Probe for related documents, political will, capacity of its custodian, etc.

Health Promotion (WHO)

- 11) [WHO-Malaria] What/which malaria prevention strategies are encouraged/described in the Malaria Strategic plan 2010 – 2016 and why those?
- 12) [WHO-Health promotion) What or which health promotion strategies are described in the Malaria Strategic Plan 2010-2016 ?
- 13) [WHO-Malaria/Health Promotion] What support / technical expertise do you provide regarding the Malaria Strategic Plan 2010-2016 to the custodian? [if not]What guidelines or line of support will you recommend?

Environment and Tourism

- 14) Please elaborate on the environment related conditions influencing Malaria in the country. What is the current status of these conditions in relation to what is contained in the Malaria Strategic Plan 2010-2016?
- 15) What health promotion activities could/should your own organisation/department embark on as mentioned in the Malaria Strategic Plan 2010-2016 or what further support/service should be developed in this regard?

Civil Society Organisations (CSOs)

16) What role do you think Civil Society played in the formation of the Malaria Strategic Plan 2010-2016?

17) In your opinion, how important is community mobilization in implementing the Malaria Strategic Plan 2010-2016, as opposed to formal interventions such as clinical treatment or provision of bed nets?

Closing Questions

18) Any other comments / advice before we close?

19) Do you have any documents/data/reports/policies related and particularly to this research [Try to get electronic copy if possible; if not hardcopy]

20) Who else should I talk to in relation to this study (in Windhoek, in the regions)?

21) Do you have any questions for me? Or any other comments/advice before we close?



Appendix 4: Malaria documents reviewed

PRIMARY SOURCES	SECONDARY SOURCES
1) Malaria Strategic Plan 2010 – 2016.	1) National Health Policy Framework 2010 – 2020.
2) Malaria Programme Performance Review towards a Malaria Free Namibia (2009).	2) A Guideline for the preparation and format of official documents (1998).
3) National Malaria Monitoring and Evaluation Plan 2010 – 2016.	3) Namibian Constitution (1990).
4) Malaria Communications and Advocacy Strategy (2009).	4) Vision 2030 (2004).
5) Malaria Strategic Plan 2003 – 2007	5) Draft National Policy on Health Promotion.
	6) Malaria Indicator Survey (2009)

Appendix 5: Ethics approval letter

**OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH
DEVELOPMENT**

Private Bag X17, Bellville 7535
South Africa
Telegraph: UNIBELL
Telephone: +27 21 959-2948/2949
Fax: +27 21 959-3170
Website: www.uwc.ac.za

26 April 2011

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape has approved the methodology and ethics of the following research project by: *Mrs./he* K Amutenya (School of Public Health)



Research Project: An analysis of the development of the 2010-2016
Namibian Malaria Strategic Plan and its relation to
Health Promotion

Registration no: 11/3/19


Mr. Peter Syster
Manager: Research Development
University of the Western Cape

Appendix 6: Permission to conduct research in the MoHSS





REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198

Windhoek

Namibia

Enquiries: Ms. E.N. Shaama

Ministerial Building

Harvey Street

Windhoek

Ref.: 17/3/3

Tel: (061) 2032510

Fax: (061) 227786

E-mail: eshaama@mhss.gov.na

Date: 08 July 2011

OFFICE OF THE PERMANENT SECRETARY

Ms. Kaarina N. Amutenya

P.O. Box 40240

Ausspannplatz

Dear Ms. Amutenya



Re: How a health-related policy in Namibia is researched and adopted using a case study of the role of health promotion in the development of the 2010-2016 Namibia Malaria Strategic Plan

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**
 - 3.1 The data to be collected must only be used for completion of your MPH Degree;
 - 3.2 No other data should be collected other than the data stated in the proposal;
 - 3.3 A quarterly report to be submitted to the Ministry's Research Unit;
 - 3.4 Preliminary findings to be submitted upon completion of study;
 - 3.5 Final report to be submitted upon completion of the study;
 - 3.6 Separate permission should be sought from the Ministry for the publication of the findings.

Yours sincerely,

[Signature]
MR. K. KATHURE
 PERMANENT SECRETARY



Appendix 7: Letter seeking permission to conduct research and respondents response

20 May 2011

The Permanent Secretary; **Mr. Kahijoro Kahuure**

For the attention of The Director Policy Planning and HRD (Ms. B Katjivena)

The Ministry of Health and Social Services (MoHSS)

Private Bag 13198

Windhoek

Dear Permanent Secretary

Permission to conduct Research: Ethical Clearance and Permission to conduct Interviews with Key Personnel of Policy Planning and HRD, IEC and Malaria Division / Directorate

This letter serves as **formal application** to the Research and Ethics Committee in the MoHSS to review the attached research protocol , ethical consideration and supportive documents from the University of Western cape under this study. Once such has been approved to grant **permission to conduct interviews** with Key personnel in the IEC, Policy Planning and HRD and Malaria division / directorate.

My name is Kaarina Nduuvunawa Amutenya, a student (student no: 2616485) pursuing a **Master's Degree in Public Health** at the University of Western Cape in the Republic of South Africa. I am a Registered nurse by Profession and aspired to become a Public Health Specialist and Qualitative Researcher.

The research is titled: ***'How a health-related policy in Namibia is researched and adopted? A Case Study analysing the development of the 2010-2016 Namibia Malaria Strategic Plan and its relation to Health Promotion'*** and seek to study and address the following objectives. (1) *To describe the factors which led to the formulation of the Namibia Malaria Strategic Plan for 2010-2016,* (2) *To examine the roles and responsibilities of key policy makers in designing the Malaria Strategic Plan for 2010 - 2016,* (3) *To explore the evidence for competing malaria prevention strategies available to policy makers in designing the Malaria Strategic Plan for 2010 -2016,* and (4) *To explain why health promotion strategies were emphasized in the Malaria Strategic Plan for 2010 -2016.* The aim of the study is to analyse how the Namibia Malaria Strategic Plan 2010-2016 was develop and examine the evidence supporting its focus on health Promotion in overall relation to the research title.

For further clarity please contact me at 081 2575 914 or nduuvu.2009@gmail.com alternative contact my research supervisor Ann Parson at +27 21 959 9389 and email aparsons@uwc.ac.za

Yours Sincerely,

Kaarina Nduuvunawa Amutenya (Mrs.)

Student at the University of Western Cape - RSA



Permission to conduct interview with WHO Health Promotion Officers



Office of the WHO Representative for Namibia
UN House, Stein Street 38
Klein Windhoek

REF.: Mal.18/551

21 October 2011

Dear Mrs Amutenya,

Subject: Permission to conduct Interview with Health Promotion Officer and Officer responsible for Malaria at WHO for academic research purpose

Reference is made to your letter dated 29 September 2011 regarding the above-mentioned subject.

We are pleased to confirm that the following two Technical Officers are available to conduct an interview with you:

- Mrs Taimi Amaambo, Health Promotion Officer, her contact details are:
Tel: 061-255121; Cell: 081 269 2670, Email: amaambot@na.afro.who.int and;
- Dr Desta Tiruneh, Diseases Prevention Control Officer, his contact details are:
Tel: 061-255121; Cell: 081 298 1919, Email: tirunchd@na.afro.who.int.

Best regards.

Yours sincerely,

A handwritten signature in black ink, appearing to read "Dr Robalo".

Dr Magda Robalo
WHO Representative

Mrs Kaarina Nduuvunawa Amutenya
Student at the University of Western Cape
Box 40240
Ausspanplatz
Windhoek



UNIVERSITY *of the*
WESTERN CAPE

Appendix 8: Participant Information Sheet



UNIVERSITY OF THE WESTERN CAPE

School of Public Health

Private Bag X17 • BELLVILLE • 7535 • South Africa

Tel: 021- 959 2809, Fax: 021- 959 2872



Participant Information Sheet

Dear Participant,

Thank you for taking time off your busy schedule to listen and participate in this research project. The research is being conducted for a mini-thesis which is part of the requirement for a Masters of Public Health (MPH) that I am completing at the University of the Western Cape.

Title of the Research

How health-related policy in Namibia is researched and adopted using a case study of the role of health promotion in the development of the 2010-2016 Namibian Malaria Strategic Plan.

What is this study about?

This is a research project being conducted by Kaarina Nduuvunawa Amutenya at the University of the Western Cape. I invite you to participate in this research project because as a key person in the fight against malaria, your insight into this topic will provide a better understanding of the role of health promotion in the Namibian Malaria Strategic Plan for 2010-2016 and the role of key stakeholders in developing the strategy. The purpose of this research project is to explore how health policy decisions are made in Namibia.

What will I be asked to do if I agree to participate?

You will be asked to participate in two face to face interviews using a topic guide that will be given to you days before the initial interview. Each interview will last approximately 1 hour. The researcher will call you to set a day, time and venue appropriate to you. If you agree to be interviewed, please sign the consent form provided. By signing, it will be understood that you have consented to participate in the project.

Would my participation in this study be kept confidential?

This is an entirely confidential interview process. To help protect your confidentiality, only job titles will be used. Only information consented to by you or which is already in the public domain will be published. All information obtained during the process of this study will be treated with confidence and kept confidential, solely for the purpose of this study. Interview notes will be stored in locked filing cabinets and entered onto a password protected computer and secure server. If we write a report about this research project, your identity will be protected to the maximum extent possible.

What are the benefits and costs of this research?

There will be no direct benefits to you from this study. However, the results will assist the investigator in clarifying and creating a better understanding of the importance of health promotion strategies in the fight against malaria. Your input may be used to inform future malaria intervention in future. There are no costs for participation in this study other than the time that will be spent in being interviewed.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary you have the right to stop the interview at any point. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If there is anything that you prefer not to discuss please feel free to say so. I will not be offended and there will be no negative consequences if you would prefer not to answer a question or withdraw from the study. You can withdraw at any time during the process and there will be no consequences.

What if I have questions?

This research is being conducted by Kaarina Nduuvunawa Amutenya, a Masters of Public Health student at the University of the Western Cape. If you have any questions about the research study itself, please contact me as follows:

Kaarina Nduuvunawa Amutenya

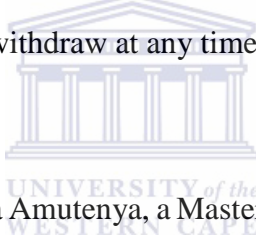
Cell: (264) 81 2575 914

Email: nduuvu.2009@gmail.com

Or my supervisor: Ann Parsons

Tel: +27 21 959 9389

Fax: +27 21 959 2872



Email: aparsons@uwc.ac.za

Should you have any further questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department: Prof U. Lehman

Dean of the Faculty of Community and Health Sciences: Prof. R. Mpofu

University of the Western Cape

Private Bag X17

Bellville 7535



Appendix 9: Participant Consent Form



UNIVERSITY OF THE WESTERN CAPE

School of Public Health



Private Bag X17 • BELLVILLE • 7535 • South Africa

Tel: 021- 959 2809, Fax: 021- 959 2872

CONSENT FORM

Title of Research Project: How health-related policy in Namibia is researched and adopted using a case study of the role of health promotion in the development of the 2010-2016 Namibian Malaria Strategic Plan

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

Participant's name

Participant's signature.....

Witness

Date

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact me as follows:

Kaarina Nduuvunawa Amutenya

Cell: (264) 81 2575 914

Email: nduuvu.2009@gmail.com

Or my supervisor:

Ann Parsons, University of the Western Cape School of Public Health

Tel: +27 21 959 9389,

Fax: +27 21 959 2872, mail: aparsons@uwc.ac.za

