VULNERABILITY AND INCLUSION IN THE CONTROL OF ACUTE RESPIRATORY INFECTIONS POLICY IN NAMIBIA

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Abstract

This paper presents the findings on a policy analysis of the Control of Acute and Respiratory Infections (ARIs) of the Ministry of Health and Social Services in Namibia. The policy document was analysed against 21 core concepts of access to health and its effectiveness in 12 vulnerable groups using the EquiFrame, a novel analytical and peer reviewed framework that serves to identify the strengths and weaknesses in current health policies with regard to the degree in which a policy promotes and protects the core concepts and vulnerable groups in society (Mannan et al. (2013, p. 2). The 2006/07 Namibia Demographic and Health Survey (NDHS) reported that close to four percent of children under five years of age show symptoms of ARI in the two weeks preceding the survey, while 17 percent of children under five have been reported as having fever, a major sign of malaria, which contributes to high levels of malnutrition and death in children (NDHS 2006/2007). In 1995, the Ministry of Health and Social Services in Namibia devised a policy programme to reduce ARI mortality by 30%, the incidence by 15%, and the rate of complication by 20% in children under five. EquiFrame was used to analyse the Control of ARI Programme and a data extraction matrix was used to record its quality. EquiFrame was also used to determine the extent to which the ARI policy document would address issues of vulnerability and inclusion in health provision. The overall ranking of the programme showed it to be of low quality, necessitating a revision so that vulnerability and social inclusion components could be adequately addressed.

Introduction

This paper deals with vulnerability and inclusion in the Acute and Respiratory Infections (ARI) policy. Firstly, it will conceptualise vulnerability, where after the concept of inclusion will be used to consider the extent to which the ARI policy in Namibia includes the vulnerable of society. ARI in Namibia, as stated by the Van Rooy, et al. (2009), remains an important public health problem and the government, through the Ministry of Health and Social Services (MoHSS) has regarded it as one of the leading causes of death among children under five. It launched a programme for the prevention of ARI, with

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the aim of reducing mortality by 30%, incidence by 15%, and the rate of complications by 20% in children under five (Van Rooy, et al. 2009).

As stated by the World Health Organisation (WHO) (2010), the consequences for societies and economies are devastating everywhere, but more particularly so for poor, vulnerable and disadvantaged populations. Poor people get ill sooner and they die earlier as opposed to people living in wealthier nations. In most cases their health care is covered by out-of-pocket expenses that can have an impact on the livelihood of these people (World Health Organisation, 2010, p. v).

The focus of this paper is on discovering what groups of vulnerable people are included in the ARI policy and what core concepts it considers. The rationale for this investigation is that, in order to achieve equity and to reach the Millennium Development Goal (MDG) 4 (The reduction of child mortality), there is a need for an inclusive ARI policy that identifies vulnerable groups within the country.

As stated by Enarson, Enarson, and Gie (2005), acute respiratory infections (ARIs) are regarded as the most frequent challenge to lung health. In most cases, ARIs affect young children as well as older people, and are one of the most frequent causes of deaths from lung disease, globally. It is also regarded as the prime cause of death in young children and, in fact, the overall mortality rate in young children is normally a good indication of the size of the problem of acute respiratory infection in a particular community (Enarson, Enarson, & Gie, 2005, p. iii). According to the World Health Organisation statistics of 2013 for Namibia, ARI deaths account for 14% in children under five (Country statistics and Global Health estimates by WHO and UN partners, 2015). Simoes, et al. (2006) and Sarathy (2014) confirms that ARIs are the most common causes of both illness and mortality in children under five, who average three to six episodes of ARIs annually regardless of where they live or what their economic situation is, and that ARIs account for nearly 3.9 million deaths every year globally. In Namibia, as indicated by the Control of ARI Policy Document, at least 205 children suffered from coughs and rapid breathing during the two weeks preceding the survey (Demographic and Health Survey – NDHS, 1992). The highest figure (39%) was in the North East Health Region of the country, while the lowest figure (3%) was in the Central Region. The NDHS also indicated children in the North West on average experienced five episodes of ARI per year, as opposed to only one per year in the Central region (World Health OrganisationHO, 2010). The World Health Organisation (WHO) regards lower respiratory infections (LRIs) as the most common infection relating to severe illness. ARI infection attacks the upper and lower part of the body, the former respiratory infections normally being regarded as non-life-threatening, while the latter are more severe. Such infections include influenza, pneumonia, tuberculosis and bronchiolitis, all considered leading contributors to ARI mortality.

According to some estimates, about 55.8% of health care seeking-children under five years of age in Namibia suffer from ARIs, while 73% of these use oral rehydration therapy or ORT (World Health Organisation, 2010). Table1 details child survival indicators in Namibia, showing that among all ages HIV/Aids is the cause of the highest number of deaths (MoHSS, 2006)

Table1: Ten leading causes of death amongst in-patients, 2005/06 for all ages

Conditions	Number of deaths in '000
HIV/AIDS	3,735
Gastroenteritis (Diarrhoea)	2,495
Pulmonary TB	1,961
Pneumonia	1,623
Malaria	951
Respiratory systems diseases	755
Anaemia	482
Heart failure	473
Hypertension	256
Malnutrition	265

(*Source: Ministry of Health and Social Services, Annual Report 2005/06*)

As stated by the UNICEF (2010-2013, p. 12), "Namibia appears to be on track to meet some MDG targets, but it will fall short of those in the areas of health and survival. Even though child survival rates fell after the mid-1990s, the gains made in more recent years remain inadequate to meet 2015 targets as set" (UNICEF, 2010). The reason given is that respiratory infections are increasingly difficult to successfully treat because of the combination with HIV and under-nutrition, as well as co-infections (UN Information Centre; Namibia makes progress on the Millennium Development Goals 2009).

According to Zere et al., (2006), the provision of health services in Namibia is split among three main providers: Government (70-75%), Church missions (15-20%), and the private sector (5%). The MoHSS, however, coordinates all activities related to human health and has the following programme activities related to ARI prevention:

A National Strategic Plan on HIV/AIDS that focuses on the prevention and control of the spread of sexually transmitted diseases, including HIV/AIDS.

A National Malaria Campaign with a focus on vector control, carried out in malaria-prone areas to strengthen epidemiological surveillance and applied research.

National Public Health Programmes that focus on immunization activities, the control of diarrheal diseases, acute respiratory infections, and reproductive health care. (United Nations, n.d.)

Vulnerability

The term 'vulnerability' derives from the Latin verb, *vulnerare* (to wound) and the noun *vulnus* (wound), meaning to be hurt or ignored, or to be helped (Aday, 1993). The WHO (1948) defined 'health' as a state of complete physical, mental and social wellbeing **(The Definition has not been amended since 1948**). By implication, the WHO definition implies that health can be measured along the continuum of seriousness and socio-economic status; however, the argument here is that not all citizens are at risk at the same time. According to Eiser et al. (2012), attention needs to be paid to how people's interpretations of risks are shaped by their own experience, personal feelings and values, cultural beliefs, and interpersonal and societal dynamics. As a result, poor physical health, poor psychological and poor social health can be regarded as factors that contribute to a person's vulnerability.

With regard to vulnerability in the context of child health, there is a perception that disorders in children result from family structures and socio-economic status, notably parental practices, life events and instability in the family, which largely contribute to a continuation of health problems in children (Raphael, Stevens, & Pedersen, 2006). In seeking healthcare on behalf of children and for the best interventions to be adopted, families should understand the rights of children and their own rights and responsibilities (Cody, 1996), and only if this equation is understood by families will the impact on the vulnerability of children be lessened. Appleton (1994) concludes that vulnerability in the context of the National Health Service suffers from legitimacy, and if health workers cannot clearly articulate the concept they cannot provide the appropriate services. Spiers (2000) argued that, from a health perspective, vulnerability is mostly defined within epidemiological principles of population-based relative risk, meaning it is geared towards those groups mostly at risk of harm. From a nursing perspective there is a need to understand and define the meaning of the concept of vulnerability in healthcare. Spiers (2000) also introduced "emic (intrinsic) and etic (extrinsic)" approaches to understanding vulnerability, the former pertaining to experiential perception, personal integrity, universality and mutuality; the latter pertains to social values, objective harm, endangerment and social sanctions for intervention. If nurses understand both the etic and emic approaches to vulnerability, they should be in a position to challenge normative assumptions and bring new ideas and development to their nursing career (Ruof, 2004).

Rogers (1997) identified segments of society that are vulnerable to ill health as the young, aged, women, and racial minorities; those who lack social support, have little education and low income, and the unemployed. She argued that if nurses did not understand the context of the vulnerable proper care could not be provided. From the onset, nurses need to be informed and be aware of a person's vulnerability and its barriers to healthcare, if they are to provide a holistic and comprehensive care to their clientele. Vulnerability is an ill-defined concept in healthcare as it is situational and mostly

influenced by personal perceptions (Ruof, 2004). A concept that describes human-made conditions on one hand, and natural circumstances on the other, Aday (1993) saw vulnerability as rooted in the bonds of human communities, leaving the individual vulnerable to others when he/she is in a position to be hurt or ignored, or is being helped by "others". Some are vulnerable with regard to their physical needs: for example, high-risk mothers and infants, chronically ill persons and the disabled, and persons living with HIV and Aids. Others have psychological needs, for example, the mentally ill and disabled, alcohol and substance users, the suicidal or homicide prone. The social needs groups also deemed vulnerable are abused families, the homeless, immigrants, and refugees (Aday, 1993).

Based on the literature reviewed above, there is no single indication of what exactly vulnerability constitutes within the framework of health. The Namibian MoHSS understands it from an epidemiological point of view, and when there is an outbreak of a disease, it can mobilise national and/or international resources to help in a short time. The same cannot be said when they have to deal with vulnerability in terms of those that are seeking healthcare. As argued by Appleton (1994), health providers should change their thinking and begin formulating a working definition of vulnerability, for all who seek health care, but particularly for children. This paper, in part, argues that children become vulnerable because families and their structures often do not attend to their physical or psychological needs, resulting in high rates of morbidity and mortality in children.

Methods

The analysis of Namibia's ARI policy on vulnerability was based on EquiFrame, develop by Mannan et al., (2010). They looked at health policies and assessed their ability to address universal and equitable access to healthcare for vulnerable people in resource-poor settings, such as those in Southern Africa. The framework analyses policies along core concepts and for vulnerable groups. It has identified 21 core concepts listed along the vertical axis and 12 vulnerable along the horizontal. Core concepts are defined by key questions and a key language on which a given concept is based and vulnerable groups assessed. The 21 core concepts are based on health as a human right, and they encompass the domains of equity in health care and access to it, while incorporating physical, informational and economic access (see Table 2). The policies are analysed based on scores relating to the extent to which they cover core concepts and vulnerable populations. The number of times a core concept and a vulnerable group occurs in a policy, if identified, is reported as a ratio expressed as a rounded percentage (See Mannan et al. 2010 for details). The scores are summarised as three rankings, according to the following criteria:

High - if the policy achieved ≥50% on all three scores

Moderate - if the policy achieved ≥50% on two of the three scores

Low - if the policy achieved <50% on two or three of the three scores.

Table 2: Core concepts and vulnerable groups

Core concepts	
Protection from harm	Integration
Prevention and amelioration	Productivity and contribution
Autonomy	Service coordination and collaboration
Privacy and Confidentiality	Professional and system capacity building
Empowerment/participatory decision making	Classification
Liberty	Capacity based services
Antidiscrimination	Individualised Appropriate Service
Cultural responsiveness/Acceptability	Accountability
Family integrity	Quality
Family centeredness	Access (physical. Information, economical)
	Efficiency
Vulnerable groups	
Limited resources	Youth
Increased Relative Risk for Morbidity	Ethnic Minorities
Mother Child Mortality	Displaced population
Women Headed Household (WHH)	Living away from Services
Children (With Special Needs)	Suffering from Chronic Illness
Aged	Disabled

Researchers from the Namibian team independently applied EquiFrame to the ARI policy document and the quality of the scores regarding vulnerable groups was identified and calculated. In the same vein, the overall ranking of the policy with regard to the core concepts was calculated. A consensus with the broader team was reached when there appears to be some form of disagreement with regard to scoring.

Results

As indicated in Table 3, the policy in itself is inadequate in addressing vulnerable groups. The vulnerable groups of *people with limited resources, aged, youth, ethnic minorities, displaced population, and those living away from services, suffering from chronic illness, and disabled* are not mentioned in the policy. According to the analysis, *women-headed households and children with special needs* are mentioned three times, while *increased relative risk of morbidity is mentioned twice, and mother-child-mortality* are mentioned only once in the policy.

With regard to the core concepts, *protection from harm, autonomy, privacy and confidentiality, liberty, anti-discrimination, cultural responsiveness, integration, productivity and contribution, classification, individualised appropriate services, accountability and efficiency* **are not mentioned.** *Prevention and amelioration* is mentioned **six times**, *professional and system capacity building* is mentioned **four times**, and *empowerment/participatory decision making, family centeredness and capacity based services* are each mentioned **twice**. *Family integrity and unity, service co-ordination and collaboration, quality and access* are all mentioned **once**. In the discussion of *children with special needs, women headed households, increase relative risk of morbidity, prevention and amelioration* issues are fundamental in the policy, according to the equitable criteria. The core of this policy is *prevention and amelioration* followed by *professional and system capacity building*. Prevention and amelioration place emphasis on vaccination of children against measles, diphtheria and whooping cough in order to reduce the number. In addition, the severity of ARI, i*mproved housing, prevention of exposure to cold and wet conditions in young infants and to protect them from draughts* is a major educational challenge to the programme. Professional and system capacity building addresses the training module to be used in the training of mid-level managers at regional and district level.

Table 3: Policy: Control of Acute Respiratory Infections (ARI) Programme

	Core concepts	Number of times concept occurs in	1 Limited resources	2 Mother child mor-	3 Increased relative risk for morbidity	4 WHH	5 Children (with special needs)	6 Aged	7 Youth	8 Ethnic minorities	9 Displaced populations	10 Living away from services	11 Suffering from chronic illness	12 Disabled
1	Protection from harm													
2	Prevention & Amelioration	6			3	3	3							
3	Autonomy													
4	Privacy & confidentiality													
5	Empowerment/participatory decision-making	2		2										
6	Liberty													
7	Anti-discrimination													
8	Cultural responsiveness													
9	Family integrity & unity	1												
10	Family centeredness	2				3								
11	Integration													
12	Productivity & contribution													
13	Service coordination and collaboration	1												
14	Professional & system capacity building	4												
15	Classification													
16	Capacity based services	2												
17	Individualised appropriate services													
18	Accountability													
19	Quality	1												
20	Access	1												
21	Efficiency													
	Number of times vulnerable groups mentioned in document			1	2	3	3							

Overall, the policy scored 33% in terms of the vulnerable groups but concerning the quality of the policy by looking at the core concepts that scored between three and four it scored 10%, meaning the policy is described as **low** in terms of the EquiFrame assessment.

Conclusion

As emphasised by Appleton (1994), there is a need for health workers to change their thinking when dealing with vulnerability in the context of delivering healthcare. The ARI policy stipulates the following indicators as key indicators for addressing ARI: *access to management, access to standard ARI drugs, maternal knowledge, health workers/providers knowledge, and health workers compliance with ARI recommended drugs.* In essence, it lacks the necessary definition of vulnerability and is therefore silent on addressing those who are vulnerable. As indicated above, only four of the twelve vulnerable groups as listed by the EquiFrame, were mentioned in the policy.

Women-Headed Households seem to be one of the core foundations of Namibia's ARI policy, the rationale being that as the primary caretakers of children they are also responsible for their health. They are seen as primarily responsible for childbearing, child rearing and caregiving (Rogers, 1997). In addressing *women-headed households* the policy makes reference to "improving home care for children with ARI" to "educated mothers and caretakers of children on home care" and on "what they should do when taking children to a health facility". The policy refers to "*children with special needs"* as those who need vaccination against diseases, such as measles, diphtheria and whooping cough in order to reduce the impact of deaths related to ARI. With regard to "*mother-child-mortality,* the policy prioritises case management of pneumonia in children under five years of age when in clinics and or hospitals. Its primarily focuses on the role of mothers/caretakers and the associated use of drugs and preventive measures.

The terminology of *increased relative risk for morbidity* in the policy acknowledges that the country severely suffers from ARIs. The Namibian Demographic and Health Survey of 2006/07 reported that fewer children had ARIs (4%) than the 18% of the 2000 NDHS. Importantly, the same survey reported that 17% of children under five suffered from fever. By looking at their nutritional status, children under five were found to be *stunted, wasted, and underweight*. The 2006/07 NDHS reported 29% to be stunted, 8% wasted, and 17% underweight. This is indicative of ARI deaths related to children; therefore our conclusion is that the Namibian ARI policy needs revision in order to improve the extent to which it addresses social inclusion and human rights issues.

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