A HEALTH IN ALL POLICIES (HiAP) CONCEPTUAL FRAMEWORK TO FACILITATE THE PROFILING OF PUBLIC SERVANTS' HEALTH STATUSES IN THE NAMIBIAN PUBLIC SERVICE

A DISSERTATION SUBMITTED IN FULFILMENT

OF THE REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY IN PUBLIC HEALTH

OF

THE UNIVERSITY OF NAMIBIA

BY

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OCTOBER 2024

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ABSTRACT

Background: The Namibian Public Service (NPS) makes no provision to profile the health statuses of its employees/public servants, despite being a legislative requirement. As a result, government will not be able to, for instance, predict work incapacities due to ill-health absence which is a major measurement of performance/productivity. Worldwide, governments have instituted different approaches, within/outside the Occupational Health and Safety continuum, to profile employees 'health/ill health to inform promotion of health in workplaces.

Aim: This study sought to develop a conceptual framework and an implementation guide to enable the profiling of Namibians public servants' health statuses entrenched in the principle of the Health in All policies (HiAP) approach.

Methods: A multi-phased pragmatic study was conducted.

Phase 1 employed an explorative descriptive convergent parallel mixed method design using document reviews, a Focus Group Discussion, a Discourse Analysis, a Cross-sectional and a Knowledge, Attitude and Practice (KAP) surveys. Max Weber Qualitative Data Analysis and the Statistical Package for Social Sciences enabled analysis of data, respectively, herein synthesised by means of triangulation.

Findings: Documents reviewed revealed the existence of public servants' health information sources such as the employees' health recruitment questionnaires, sick leave systems and medical aid, appropriate for profiling. Key Informant's perspective that the HiAP framework was appropriate to facilitate profiling of public servants' health statutes was further echoed by result of the Discourse Analysis. The cross-sectional survey, conducted among 346 public servants' participants established that 83.3% of the survey participants self-reported 'a good' health status. The remainder 16.7% self-reported 'a poor' health status citing the prevalence of Hypertension (27%), Musculoskeletal disorders (30.6%), Stress (55%), Physical in-activeness (38%) and a High Body Mass Index (BMI) (27%). A Chi-square logistic regression test, pegged to a p-value of less than 5% and using: **1.** Good health = self-reported score for Excellent/Very Good/Good; **2.**

Poor health = Fair/Poor/Very Poor: reveals significant statistical associations to poor health in relation to Hypertension (p-value=0.001), Mental conditions (p-value=0.009) and access to electricity (p-value=0.045). No significant statistical association was observed with elevated blood sugar (p-value=0.258≤5%), BMI and income. The KAP study, conducted among 51 Wellness Officers, reported very low HiAP knowledge citing a lack of information and henceforth no application of the HiAP approach, overall.

Phase II focussed on the design, and development of the above-mentioned framework using results emanating from Phase I; enlisting elements of the World Health Organization's (WHO) HiAP Analytical framework alongside elements of the Systems and Practice Oriented Theories, namely: [input (procedures, agent, recipient and dynamics); output (terminus); synergies (agent, recipient, procedures and dynamics) and feedback (context, inputs, outputs, terminus)]. Five purposely selected subject experts who validated the suitability of the developed conceptual frame recommended amongst others aligning it to the legislative provisions of the Public Health and Environmental Act.

Phase III enlisted the WHO's Handbook on developing guidelines and the Public Service Staff Rule format to inform the design of an implementation guide.

Conclusions: The study encapsulates evidence that proofs the gap identified as well devised approach to fill the gap: a conceptual framework to profile Namibian public servants' health statuses embedded in the HiAP principles. Evidence of poor HiAP knowledge could implicate successful implementation. Henceforth a recommendation that the NPS adopts the designed conceptual framework, the introductory and ensued implementation guide using a policy brief, attached hereto, to ensure compliance with the law.

Keywords: Health in All Policies Approach, Conceptual framework, Public Servants, Health statuses, Namibian Public Service

LIST OF CONFERENCE PROCEEDING (S) / PUBLICATION(S)

Amutenya, K.N. (2022). The general health status of public servants in Namibia. **Multi-Disciplinary Research Conference (MDRC)** – University of Namibia (UNAM), Namibia

Amutenya, K.N. (2022). The general health status of public servants in Namibia. **National Research Symposium (NRS)** - National Commission on Research, Science and Technology (NCRST), Namibia

Amutenya, K.N. (2022). A missed opportunity: Timely implementation of a Cabinet Directive on Health in All Policies (HiAP) during the COVID-19 era. **National Student Research Symposium (NSRS)** - National Commission on Research, Science and Technology (NCRST), Namibia

Amutenya, K.N. (2015). An analysis of the development of the 2010 – 2016 Namibia Malaria Strategic Plan and its relations to health promotion, University of the Western Cape, Master's Degree Thesis

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LIST OF ABBREVIATIONS AND ACRONYMS

BMI : Body Mass Index

CVD : Cardiovascular Disease

EIA : Environmental Impact Assessment

GHQ : General Health Questionnaire

HBP : High Blood Pressure

HDI : Human Development Index

HIA : Health Impact Assessment

HiAP : Health in All Policies

HIS : Health Information System

HL : Health Lens

HP : Health Promotion

HRQoL : Health-related quality of life

HS : Health Status

HWGM : Health in All Policies Working Group Members

ILO : International Labour Organisation

IQR : Interquartile ranges

ISO : International Organisation for Standards

KAP : Knowledge, Attitudes and Practices

MAXQDA : Max Weber Qualitative Data Analysis

MBD : Mental and Behavioural Disorders

MGECW : Ministry of Gender Equality and Child Welfare

MMR : Mixed Methods Research

MoHSS : Ministry of Health and Social Service

MVA : Motor Vehicle Accidents

MWT : Ministry of Works and Transport

NCF : National Coordination Framework

NDF : Namibian Defence Force

NDP : National Development Plans

NHP : National Health Policies

NHPF : National Health Policy Framework

NIOSH : National Institute for Occupational Safety and Health

OHS : Occupational Health and Safety

OMAs : Government Offices, Ministries and Agencies

OPM : Office of the Prime Minister

OR : Odd Ratio

OSH : Occupational Safety and Health

OVC : Orphans and Vulnerable Children

PHC : Primary Health Care

PMP : Performance Management Policy

PSC : Public Service Commission

PSEMAS : Public Service Medical Aid Scheme

PSSR : Public Service Staff Rules

QOL : Quality of Life

RCs : Regional Councils

ROI : return on investment

SD : standard deviation

SDG : Sustainable Development Goals

SDH : Social Determinants of Health

SF : Short Form

SPSS : Statistical Packaged for Social Sciences

STD : Sexual Transmitted Diseases

TWG : Technical Working Group

UDHR : Universal Declaration of Human Rights

UN : United Nations

UNFPA : United Nations Populations Fund – Namibia

UREC : University of Namibia's Research Ethics Committee

WHO : World Health Organisation

YLD : Healthy Life Lost Due to Disability

ACKNOWLEDGEMENTS

This academic undertaking was complex, intensive and expensive, yet experiential. Therefore, I praise God, Almighty for instilling calmness, patience and serenity in me. I would probably have given up studying if not for the unwavering belief and support from my main supervisor Dr Hermine N. Iita, as well as the technical guidance by Professor Kabwebwe H. Mitonga one of my co-supervisors. Your affirmations provided an enormous directional compass.

I would like to acknowledge HiAP subject experts, Dr Harriet R. Kagoya, Dr Pandu Hailongo-van Djik, Ms Julia Shipena-Masule and Ms Celia Kaunatjike who evaluated the appropriateness and suitability of the developed conceptual framework.

The study would not have taken place without the ethical clearance from the University of Namibia's Ethical Clearance Committee (UREC) and permission from the Ministry of Health and Social Service (MoHSS), the Office of the Prime Minister (OPM) and the Ministry of Works and Transport (MWT). I will forever remain indebted to all research participants, particularly public servants in the MWT, Human Resource Practitioners, Employee Wellness, Occupational Health, and Safety Focal Person/Officers and HiAP Working Groups members for consenting to participate in the study.

Special affection goes to my fun-filled husband, bubbly children, Ezimo Ekwankala, a dear friend Dr Ndilimeke Nashandi and Room 8 friends for providing a much-needed 'switch-off' environment. Lastly, my utmost gratitude goes to Leonard Mwandingi, Ndamona Haushona, Mr Lazarus Gawazah and Professor Nelson Mlambo for the exceptional statistical and editorial assistance.

DEDICATIONS

This dissertation is dedicated to

Sarah Mwilima,

Who lost her life,

and

Ester Nepolo,

Who, on the same date sustained a spinal cord injury,

on the 29th of January 2019 in a workplace shooting incident in Windhoek, Namibia, for their contribution to my academic and career development.

The workplace shooting incident echoes the importance of workplace safety, support and rehabilitation through health and wellness promotion programmes.

I re-dedicate myself, based on the Nursing Pledge and Principles of Public Health, to the noble call to serve humankind without fear or favour.

DECLARATIONS

I, Kaarina Nduuvunawa Amutenya, hereby declare that this study is a true reflection of my work and was conducted while adhering to all research protocols relating to plagiarism, referencing, and citation.

This study, in part or whole, has not been submitted for any academic qualification at another institution.

I, hereby, grant the University of Namibia the sole right to reproduce this Dissertation, in whole or in part, and in any manner or format, the University deem fit.

Kaarina Nduuvunawa Amutenya		October 2024
Name of Student	**Signature**	**Date**

CHAPTER ONE: INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

Ill public servants are likely to take prolonged sickness absence due to continued ailments requiring frequent healthcare [11] [12]. Such absence poses formidable work incapacities resulting in poor performance and challenged public service delivery if not adequately addressed [13] [14]. Populations, specifically the most vulnerable and marginalised, depend on government services for their basic nutrition, sanitation, healthcare, education, shelter and leisure to maintain good health [15]. Workers' health encompasses a wide range of issues. The World Health Organization (WHO) and the International Labour Organization (ILO) report that musculoskeletal disorders, cardiovascular respiratory diseases, and asthmatic conditions are exacerbated by poor air ventilation, smoking, chemical exposure, mental health and risk factors associated with the prevalence of occupational ergonomics are amongst the common ailments found in workplaces among employees [16] [17] [18] [19]. To promote public servants' health (and safety), governments around the world have instituted approaches such as the '*Health in All Policies*' (HiAP) approach, the '*Healthy Workplaces Framework and Model*' by WHO, the '*Worker's Total Health*' and the '*Worker's Well-Being*', to mention few, as part of or within the Occupational Health and Safety (OHS) continuum to address workplace Social Determinants of Health (SDH) that are exacerbating ill health amongst employees [17] [20] [21] [22] [23]. Health in All Policies, according to the WHO, is *"an approach to public policies across sectors that systematically takes into account the health implications of policy decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health inequities"* [24, p. 1].

The approach advances two principles:

(i) to address the SDH, which are the conditions in which people are born, grow, live and work and that are likely to affect people's access to attain better health outcomes; and

(ii) (ii) Inter-sectoral Action (ISA) which are those deliberate interactions between various actors [24] [25] [26].

Many countries, such as Finland, Sweden, England, Afghanistan, Israel, and: Kenya Lesotho and Swaziland, in Africa, have instituted the HiAP approach [27] [28] [29] [30] [31] [32] [33] [34]. Studies further indicate that the approach has been used to determine sexually transmitted diseases and improve sexual health services for communities around army bases [1]. Another study regards the approach as a flagship to advance the achievement of the Social Development Goals (SDGs) [35]. Recent studies promote the approach as a mechanism that facilitates COVID-19 responses [36].

The Namibian Public Service (NPS) has no explicit OHS framework or a designated approach to profile public servants' health statuses, despite being a legislative requirement. This remains largely non-compliant with the provisions of Chapter 4, Section 39(a) and 41(a), of the Labour Act, 2007 (Act No. 11 of 2007) and neglects its fiduciary duty towards the care and promotion of the health of its employees [37].

Given the above-mentioned, this study sought to develop a conceptual framework that is embedded in the HiAP principles and to also provide an introductory and implementation guide to facilitate the profiling of public servants' health statuses for the NPS.

1.2 BACKGROUND

1.2.1 Rationale for a Health in All Policies Approach

According to Kickbusch & Bucket, HiAP was necessitated by the inadequacy of its precursors, the health promotion strategies, namely, '*Healthy public policies'* '*Orientating health services*'; '*Create supportive environments for health*'; '*Strengthen community actions*' and '*Develop personal skills*', which did not yield the desired equitable health outcomes [38]. The approach was formally devised by the Finnish Presidency in 2006 as that country's whole government's health agenda, requiring all member states to adopt HiAP as a governance mechanism for health [39] [40].

Prior to the above, HiAP-like interventions existed since the 7th century, in the form of isolating foreign travellers suffering from the plague, a practice aimed to curb contamination and the spread of the plague, which to date is referred to as '*quarantine*' in published literature [41]. The trajectory towards advocacy for HiAP worldwide started with the Rio Declaration following the World Conference on SDH in 2011 to mainly promote health equity and accountability for health in all policies across sectors [35].

A legible statement stipulating and recognising multisectoral action as a central element for health promotion was released during the Eighth Global Conference on Health Promotion, in Helsinki in 2013 [24]. Ministers of Health, during the aforementioned session on the Plan of Action for HiAP, took a resolution to adopt HiAP in their respective countries thereafter, including Namibia.

Figure 1.1 below illustrates the historical timeline, development and evolution of the HiAP approach, which led to many countries instituting HiAP interventions [27].

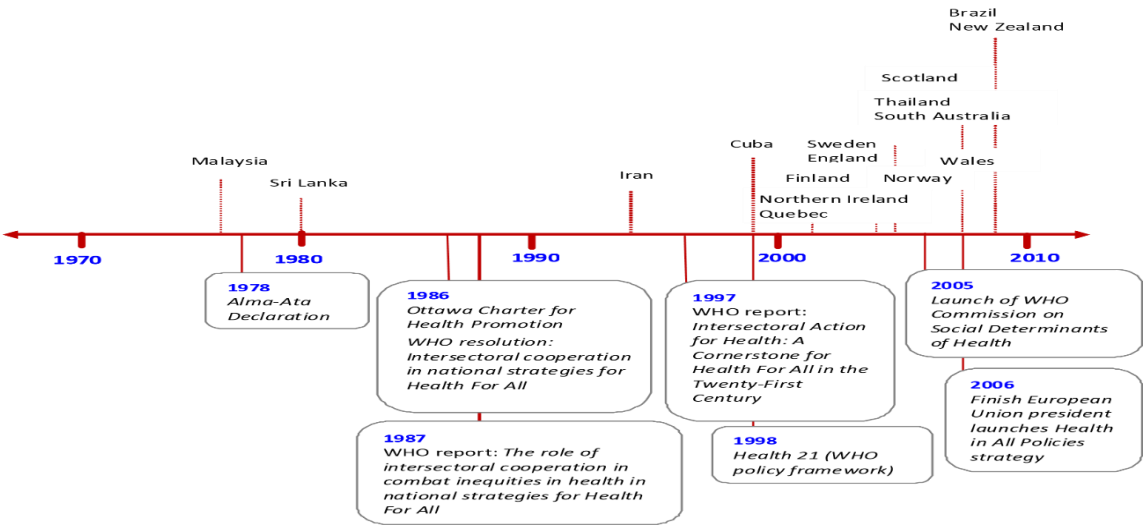


Figure 1.1: Contextual timeline of HiAP and other international milestones

1.2.2 Implementation of Health in All Policies, globally and in Africa

Finland and South Australia adopted HiAP as a whole-of-country approach and springboard for their National Health Policies (NHPS) [42]. In the 1980s, Finland showed lowered blood cholesterol levels, recording an 80% mortality reduction [39] [42]. Finland applied the approach to lower cholesterol in national diets by collaborating with agricultural production, trade, retail, family affairs and sports to mitigate devastating Cardiovascular Diseases (CVD) and other chronic communicable diseases which had reached epidemic proportions in the 1960s and 1970s [42]. A national survey concluded that dietary intake was dominated by saturated dairy fat and salt with a below-average intake of vegetables, resulting in high blood cholesterol as well as high blood pressure [42].

Sweden used the approach to address Motor Vehicle Accidents (MVA) that were reported as 9.1 deaths per 100,000 lives before the application of HiAP in 1990 and which

decreased to 2.8 deaths per 100,000 in 2010 despite an increase in vehicle volumes from 507 vehicles per 1000 inhabitants to 584 vehicles in the same period [43] [44]. Sweden now has the least MVA and safest roads in the world to date [45]. England adopted the approach to its local government structures, settings and contexts; Afghanistan used the approach to facilitate the assessment and examination of the SDH; Israel used it to address and promote physical activeness and a healthy lifestyle, whereas the approach was applied as a policy for laws in the United States [27] [28] [29].

In Africa, Kenya in collaboration with the education sector used the approach to improve deworming coverage in schools, whilst in Lesotho the approach was used to advocate for portable water, sanitation and hygiene with the relevant sector; in Swaziland, it was used to map key determinants of non-communicable diseases; while it also covered the integration of SDH in all public policies in Botswana, all collaboratively with the health and appropriate sectors [30] [31] [32] [33] [34].

1.2.3 Implementation of Health in All Policies in Namibia

Namibia formally adopted HiAP in 2016 through a Cabinet directive, which states that *"The Health in All Policies to be adopted as a principle to ensure that health becomes an integral component of all government policies, strategies and programmes. The MoHSS is to provide leadership and guidance"* [46, p. 1]. To date, the country has developed a National Strategy on HiAP, currently in its draft form [46]. However, the pace at which the approach is being implemented is worrisome, more so as the continued lack of an appropriate health equity response remains among the reasons for Namibia's high inequality status in the world [47]. The approach is envisaged to strengthen the delivery

of healthcare, thereby enhancing the resilience of public service administration to support other socio-economic safety nets required to shield the most vulnerable members of society from the detrimental health and survival effects [48].

1.2.4 Overview of health statuses globally, in Africa and Namibia

According to Berger & Rothman, Health Status (HS) is a process that aims to assess the level of health amongst a specific group of people [49]. In England, health status assessments are mandatory and they are carried out prior to employment and routinely thereafter in compliance with the Act of 1998, on Data Protection and guided by the *'Healthy Workplaces'* framework [50].

The Whitehall studies (I and II), a British longitudinal explicit public servants HS risk factors examination study that existed since 1967, has been collecting data routinely [51]. The study revealed, among others, that public servants in the lower job categories reported health risk behaviours such as smoking, poor dietary patterns, and limited physical activities which were found to be associated with low heath-seeking behaviour and are likely to influence the risk of angina pectoris, ischaemic heart diseases and chronic bronchitis over the years [52].

In Africa, Ghana conducted a retrospective study of 135 Ghanaian public servants' clinic records for the period January 2014 – December 2017, revealing a 36.4% Hypertension prevalence and 19.1% prevalence for Diabetes mellitus-associated physical inactivity risk health, among its employees [53]. The prevalence of Hypertension was higher (59.3%) amongst female public servants in comparison to their male counterparts (40.7%) [53]. A similar study in Nigeria, using anthropometric tests for weight, height, waist and hip

circumference measure as well as biometrics for testing blood pressure and fasting glucose to assess the behavioural and metabolic risk factors amongst public servants revealed high stress and sedentary risk levels risk factors non-communicable ailments such as CVD [54].

There are, however, no explicit public servants' health-related studies conducted in Namibia. However, a cross-sectional self-reported survey amongst 7,666 undifferentiated employees from seven employment sectors revealed that high blood glucose and diabetes had the largest effect on absenteeism (IRR: 3.67, 95%CI: 2.06-6.55), followed by anaemia (IRR: 1.59, 95%CI: 1.17-2.18) and being HIV positive (IRR: 1.47; 95%CI: 1.12-1.95). Working in the fishing or services sectors was associated with an increased incidence of sick days (IRR: 1.53, 95%CI: 1.23-1.90; and IRR: 1.70, 95%CI: 1.32-2.20 respectively). The highest prevalence of diabetes was in the services sector (3.6%, 95%CI:-2.5-4.7). The highest prevalence of HIV was found in the fishing sector (14.3%, 95%CI: 10.1-18.5).

1.2.5 Health statuses profiling using the Health in All Policies approach

The HiAP approach was never applied to profiling public servants' HS. The approach was, however, used to determine what data, policy and community capital existed to improve sexual health and sexually transmitted services for communities living around military bases in Atlanta, Georgia [1]. The study identified HiAP determinants (drug and alcohol marketing, social capital, male incarceration and education and employment) that could be utilised to formulate service agreements with law enforcement [1].

Another similar study also proposed using HiAP to advance the achievement of the SDG by applying governance framework pillars, namely the economic, social and environmental filters [35]. Similarly, COVID-19 advanced HIAP as a socio-economic

response mechanism [36]. The aforementioned argues that HiAP is an integrated approach interlinking health expectations with those of other policies [35].

Many countries have instituted a combination of conceptual and legal frameworks to address workers' health, also mentioned earlier in this chapter: the *'Worker's Well-being Framework', the 'Total Worker Health'*, *'Workplace Health Management'*, as well as the WHO's *'Healthy Workplace Framework and Model'* [21] [17] [16] [18] [55]. The latter provides guidelines on how to conceptualise, plan, organise and implement workplace programmes, including the collection of health information [20].

The aforementioned frameworks were used to collect data about musculoskeletal conditions, cardiovascular and mental health risk factors associated with the prevalence of occupational ergonomics as well as those associated with respiratory health issues such as air ventilation, smoking and chemical exposure which might exacerbate asthmatic conditions in workplaces [20] [21] [22] [23]. The worker's health encompasses a wide range of issues. Commonly, workplace health programmes are delivered through OHS programmes, traditionally directed at workplace hazards and personal risks to overall inspire the promotion and improvement of workers' health [16] [17] [18] [19].

In Namibia, Chapter 4 on Health, Safety and Welfare of Employees, in the Labour Act, 2007 (Act No. 11 of 2007) and particularly Section 39(2)(a)(b) and Section 45(1)(a) and (2) sets the basis for OHS [37]. In addition to the provision of the Labour Act, an explicit Policy on Occupational Safety and Health, advocating for the integration of Employee Wellness into OHS, overall, was formally adopted by Cabinet in 2021 [56]. The latter further stipulates the design of operational standards for various workplace-related

interventions, including the need for HS information, to adequately promote employees' health in various workplaces, nationally [56].

1.3 STATEMENT OF THE PROBLEM

The Namibian Public Service has not complied fully with Section 39(2)(a)(b) and Section 45(1)(a) and (2) under Chapter 4 on Health, Safety and Welfare of Employees of the Labour Act, 2007 (Act No. 11 of 2007) [37] [56]. As a result, there has not been any attempt to assess and profile public servants' HS, before and since independence in 1990, besides anecdotal, un-coordinated, fragmented and undocumented screenings for Blood Pressure, Diabetes and Cholesterol conducted among public servants as part of their workplace health promotion programmes.

The identified gap as mentioned above, if not adequately addressed, may consequently result in unnoticed and under-reported poor performance among public servants, which has the potential to affect the delivery of government services due to, among others, prolonged sickness absence. Ill public servants are most likely to take prolonged sickness absence due to poorly managed acute and chronic ailments which are a result of unresolved ill health. In retrospect, this has the potential to pose formidable work incapacities and daunting challenges in performance resulting in poor delivery of public services [12].

Populations, specifically the vulnerable, marginalised and the poor depend greatly on government services to meet their basic human needs, which include access to nutrition, sanitation, healthcare, education, shelter and leisure, which are all very essential to maintaining good health [15]. A need, therefore, existed to explore and assess the NPS for

appropriate HS-related interventions to amongst others, enable compliance, explicitly understand HS and define related occupational health parameters and measurement, sourced from the most appropriate health data sources within the public service.

Currently, the National Health Information System (HIS), in which all ailments are currently recorded, is only state facility-based and does not segregate data by employee statuses to enable the inference of the disease burden, explicitly for or on the public service [57]. Access to data captured in the Public Service Employees Medical Aid Scheme (PSEMAS), the public service sick leave management system and employment-recruitment health questionnaire, has not readily been available, nor formally authorised for purposes of interventions, albeit there are some legislative provisions.

National Development Plans (NDPs), Public Service Charters (PSC) and Public Service Performance Management Systems, popularly known as PMS (Performance Management System) are probably the most obvious data sources stipulating, broadly, the need and importance of public servants' performance and ensured productivity. Unfortunately, the aforementioned sources contain no indicators, targets or baseline measures, to, for example, infer absenteeism predominantly as a result of prolonged ill health absence as a reason for public servants' poor performance [58] [59] [60].

This researcher advances the HiAP approach as the potential solution for the identified anomaly. Since its adoption in 2016, there have been no tangible results to domesticate HiAP in Namibia, apart from sporadic interventions including a National Strategy currently in draft format. Multiple opportunities, including the identification of health status data sources, exist to use the HiAP approach to, among others, enable a systematic

collection of public servants' health information for profiling. Successful workplace health promotion largely depends on a robust epidemiological data set [61]. Therefore, this study sought to gather empirical data about the public servants' HS in the NPS, using the MWT as a case study to inform the development of a HiAP-based conceptual framework.

1.4 PURPOSE OF THE STUDY

The purpose of this study was to develop a HiAP-based conceptual framework and an introductory and implementation guide to facilitate the profiling of public servants' HS for the NPS as informed by empirical evidence.

1.5 OBJECTIVES OF THE STUDY

The objectives of the phased study, classified here under per research phase were:

1. **Phase I,** through a situational analysis to:
    i. Determine appropriate public servants' HS data sources;
    ii. Describe managers' perceptions about public servants' HS in relation to HiAP;
    iii. Describe the views of HiAP subject experts about the status and role of NPS;
    iv. Discourse HS and best practices of public servants' HS profiling;
    v. Assess the HS and health inequities amongst public servants in the MWT; and,
    vi. Assess the Knowledge, Attitudes and Practices (KAP) of Health in All Policies among Wellness Officers in the NPS.

2. **Phase II:** Develop an HiAP-based conceptual framework to facilitate the profiling of public servants' health statuses, and validate its appropriateness for the NPS.

3. **Phase III:** Develop a guide for the implementation of the developed HiAP-based conceptual framework in the NPS, and:
4. Make appropriate recommendations.

1.6 SIGNIFICANCE OF THE STUDY

Although formally adopted in 2016, the operationalisation of the HiAP approach in Namibia remains in its infancy stages to date. Therefore, this study, first and foremost, contributes to HiAP literature, particularly in Namibia as a fairly new concept, consequently heightening HiAP advocacy and strengthening the role of the NPS in identifying public policy implications and forging stakeholder responses. The study, the first of its kind in Namibia and worldwide, establishes a new methodology for measuring ill health among public servants and inferring ill health amongst reasons for their poor performance. Lastly, the study outcomes can equip public service policymakers with a tool to develop evidence-based workplace health promotion programmes.

1.7 STUDY DELIMITATIONS

The context of this study was the NPS, which was further contextualized to workplace health information. To achieve the overall purpose of this study, an expanded study population included Public Service Wellness Focal Persons/Officers, Health in All Policies Working Group Members (HWGM) and Managerial staff members in the MoHSS who were the focus of the study. Documents with relevance to the study phenomenon were also sampled. The Ministry of Works and Transport (MWT) was sampled, as the case study focus for health collecting empirical evidence about public

servants' health statuses that is appropriate for profiling. Since public servants are a large group, a case study focus was relevant to mitigate time limitations and the overall duration of this study. Initially, the Parliamentary and Cabinet Standing Committee on Public Service was earmarked for a Focus Group, but COVID-19 regulations on the limited number of congregations, social distancing and staying home, impacted that decision.

1.8 PARADIGMATIC PERSPECTIVE OF THIS STUDY

All research studies adopt and or are aligned to a particular school of thought, also known or referred to as a paradigm and or philosophical stance [62] [63]. A paradigm, also known as etymology, defines, explicitly, a commonly agreed belief to better understand and address a phenomenon, usually within a research setting [64] [65] [66].

Sub-paradigms are sub-components of a paradigm identifiable through pre-fixed with meta-para or intra-paradigm phrases to clearly articulate a sub-paradigm [63] [66].

Essential to any research study about sub-paradigms are narratives on the pre-determined knowledge (ontology), how that knowledge is known (epistemology), through what that knowledge is valued (axiology), how that knowledge is presented (rhetoric) and the process of studying that knowledge (methodology) [66].

In contrast to the pragmatic epistemology is the positivist paradigm which believes that factual knowledge can only be derived from a solitary and measurable reality in which the researcher's role primarily adopts quantitative methods [62].

The constructivist paradigm, on the other hand, advances the belief that there exist multiple truths and as such, the primary embedment of constructivism lies in the use of qualitative research approaches and methods [64] [67].

The pragmatic paradigm advances the belief that reality can be constantly renegotiated, debated, interpreted and presented [62] [67] [68]. Below are this study's paradigmatic convictions [69].

1.8.1 Intra-paradigms-meta-theoretical assumptions

Meta-theories, expanded below, are the various layers of world views in which researchers infer their assumptions based on the available evidence in literature [9]. The rationale for a pragmatic paradigm for this study stems from the assumption that health is determined by numerous factors most of which are outside the traditional health realm and those impacting health should collectively address health implications [70] [71] [72]. Health implications are SDH waging wide-ranging conditions, stimuli and factors [70] [71] [72].

1.8.1.1 Epistemological perspectives

"*Episteme*" means knowledge [73, p. 2]. Epistemology seeks to determine what is the truth and how that truth is validated [66]. The truth sought, especially in academic undertakings, can be derived from numerous sources of knowledge such as the empirical, intuitive, authoritative and logical [73]. A pragmatic paradigm advocates for relational epistemology which refers to appropriate knowledge for a study [73].

This study examined the importance of health status measures as a critical component of workplace health promotion design and productivity, hence seeking epistemological aetiology predisposing health statuses within the identified context. In terms of application

to this study, the researcher in the qualitative strand gathered data from various documents, interviews, and group discussions and appraised these against the literature. Quantitatively, the researcher sought data from public servants in the MWT as well as the Wellness Officer on HiAP using structured survey questionnaires. In the above encounters, the researcher, although knowledgeable in the subject matter, kept an open mind and was receptive to the data collected for the research.

1.8.1.2 Ontological (knowledge) assumptions

Ontological assumptions are concerned with the sensible articulation of the nature of reality [73]. Ontological philosophies enable the understanding of whether a phenomenon exists in its social context or is constructed [66]. The pragmatic paradigm does not support mono-paradigms, but advocates for multiple interpretations of the realities of health for instance [73]. This study's ontology stemmed from an assumption that public servants' health statuses are a proxy for performance and productivity. In terms of this study's ontological reality, it was discovered based on empirical evidence derived from using direct quotations of best practices around the world on health examinations, also substantiated by the Cabinet resolution on HiAP, as well as evidence for the multiple realities across other countries' overall OSH. The latter was gathered through data collected using interviews, a review of literature and survey assessments.

1.8.1.3 Methodological assumptions

Methodology is the utilisation of research approaches, designs, methods and procedures to investigate the desired knowledge [73]. For academic undertakings, methodology asks questions about how a researcher will "obtain the desired data, knowledge and

understanding that will enable him/her to answer the research question and make a contribution to knowledge" [73, p. 28]. This study employed a pragmatic philosophy which is embedded in the belief that one research strand is not always adequate to provide evidence in an enquiry. Pragmatic paradigms, therefore, advocate for MMR, thereby enabling the researcher to collect, analyse and interpret data. In this study, data were collected through both quantitative and qualitative research methods. Qualitative research methods, in this study, adopted document reviews, discourse analysis, interviews and surveys. For the quantitative research part, data were analysed using the Statistical Package for Social Sciences (SPSS) and MAXQDA respectively [74] [75].

1.8.1.4 Axiological assumption

Axiology focussed on compliance with basic ethical principles, namely privacy, accuracy, property (also referred to as PAPA), standards and criteria (some of which are fairness, morality, teleology and deontology) which established the value-basis for a given methodology [64] [73]. Pragmatic paradigms sought value-laden axiology [73]. This is contained in the University of Namibia's, MoHSS's and the Office of the Prime Minister's letters approving consent, right of refusal and withdrawal, respect, confidentiality, privacy and handling of research materials for the conduct of the present study. In addition to the approval of consent, this study employed MMR for data collection, analysis and interpretation to enable a balance between objectivity and subjectivity. The researcher, by making known her perspective by stating her interpretations of literature amplified the ethical research principles.

1.8.1.5 Rhetorical assumptions

Rhetorical assumptions are persuasive humanist efforts, such as language, writing style, and personal encounters, used by a researcher to present study outcomes [76]. In this study, the rhetorical assumptions can be traced through the reporting of the various concepts used and those developed during various interfaces. The aforementioned documentations were compared and contrasted to find meaning and during the writing process, the use of language to inform research content and context as well as being able to discuss in terms of similarities and differences to illustrate the various viewpoints.

1.9 THEORETICAL BASIS OF THE STUDY

A theory is a lens through which a phenomenon is viewed as a result of knowledge gathered over some time with the aim of enabling an in-depth understanding of the world views of that phenomenon [77]. Theories, in general, allow for a systematic analysis of the phenomenon using tried and tested concepts/theories [78]. This study used multiple theories to discuss the interconnectedness of the study phenomenon as it relates to theories/philosophy [79].

1.9.1 Health Promotion Theory

Health Promotion Theory is an interdisciplinary and multidimensional concept which has gained global popularity in the *"rich heritage of ideas, actions, and evidence that have emerged since the Alma Ata Declaration on Primary Health Care (1978) and the Ottawa Charter for Health Promotion (1986")* [44, p. 8]. The WHO defines HP as a "*process which enables people to increase control over and to improve their health*" [44, p. 8].

The HP Theory advances the notion that causative factors of health (health determinants) are multi-dimensional, which in the context of HiAP, advance the improvement of health outcomes through its dual process which seeks to *"foster health considerations in other policy areas and takes into account the potential impacts of other sectoral policies on the health of the population"* [80, p. 1]. Overall improvement of employees' health is embedded in HP theories, thereby multidisciplinary interconnectedness and intersectoral actions are a common interface [17] [80].

Another integrated framework that was most relevant to this study is the National Institute for Occupational Safety and Health (NIOSH). *The 'Total Worker Health'* approach is made up of four sub-sections: (a) Occupational health and safety measures, (b) Management of the return to work process of employees who have been on long-term sickness absence, (c) Workplace health promotion, and (d) a corresponding personnel development [81, p. 6].

Figure 1.3 below depicts another framework, the *'Worker Well-Being'*, by the NIOSH, and this was regarded as most relevant to this study [17].

Figure 1.3: Well-Being Framework

Source: https://www.niosh-questionnaire-aimed-at-gauging-enhancing-worker-well-being

Figure 1.3 entails five domains and the most relevant is the health status domain which is further made of the following sub-domains: physical and mental health, health-related behaviour and lifestyle, functionality/disability and injuries [17]. This study sought to develop a conceptual approach using the HiAP principle to enable the profiling of public servants' health statuses in the Namibian public service, which currently is non-existent. The HiAP approach was formally only adopted in Namibia in 2016.

1.9.2 Practice Oriented Theory

The Practice Oriented Theory emanated from a professional knowledge creation base in which research outcomes contribute directly to the discipline [82]. Hermans & Schoeman further clarify that a *"problem does not originate in theory and the knowledge created in the research is not valued because it contributes to theories. It is not knowledge-for-its-own-sake, but the knowledge is valued because it contributes to the improvement of the practice which is considered (by ministers and lay people) to be a problem"* [83, p. 26].

In this study, the researcher utilised Dickoff, James and Wiedenbach's Practice Oriented Theory survey list to guide the development of the conceptual framework [84]. The survey list is a hierarchy of elements substantiated through answering specific questions which serve as steps and direction for the conceptual design narrated as follows: *'Agent'* refers to who performs the activities, *'recipient'* refers to who receives the intervention, *'context'* refers to the setting in which the intervention is performed, *'process'* refers to the techniques applied for the intervention, *'dynamic'* refers to inter- and intra-actions of the process and *'terminus'* refers to the ultimate outcome [84].

The aforementioned elements of the survey list (agent, the recipient, the context, the process, the dynamics and the terminus) informed the basis for conceptualising the present study's outcome as figuratively illustrated in Chapter 5 through the researcher's thought process and design.

1.9.3 Systems Theory

The establishment of the Systems Theory is largely attributed to the Australian biologist Karl Ludwig von Bertalanffy who coined the 'linear-cause-and-effect' system [85]. Originally, this theory was invented to illustrate an equilibrium in the ecological facet [85]. Today, the Systems Theory serves as a meta-theory to portray strings of communication between various components with the intent that symmetric outcomes are possible through a systematic structure [85].

In the context of this study, the Systems Theory's elements namely: '*inputs*', '*outputs*' and '*synergic*' were used to simplify the interdependency amongst the various components explained through feedback loops [85]. In addition, the afore-mentioned elements were used to explain and abridge complex workplace discourses into manageable and relatable conceptual components and create an understanding of concepts such as the '*goals*' and the '*contex*t' which are interlinked to other aspects such as those identified by Dickoff, James and Wiedenbach's Practice Oriented Theory survey list [84] [85].

1.10 CONCEPTUAL FRAMEWORK OF THIS STUDY

1.10.1 Health in All Policies

This is *"an approach to public policies across sectors that systematically takes into account the health implications of policy decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health inequities"* [24, p. 1].

As a concept (as opposed to a framework), Health in All Policies focuses on an enabling environment that addresses health impacts caused by public policies from other sectors such as policies on housing, transportation, education, health and employment [1].

This study adopted both descriptions to address the study objectives.

In addition, the study sought to adopt and use the five elements of the WHO HiAP Analytical Framework as the thematic areas for analysing and discussing the data collected. The four key elements are 1) opportunities for initiation, 2) key drivers of implementation, 3) key domains of an equity lens and 4) key drivers of sustainability [2].

1.10.2 Public Servant

Public servants also referred to as civil servants, worldwide, including in Namibia, and for this study, are people employed by the government to deliver state services such as education, healthcare, infrastructure and cleaning [3] [4].

1.10.3 Health status

Health status is defined as a relative measure of an individual's impairments related to their biological and functional abilities whilst in health or sickness [5]. This study adopted this definition.

1.10.4 Profiling

Profiling is an "*act or process of extrapolating information about a person based on known traits or tendencies*" [6]. This study adopted the aforementioned definition as per Merriam-Webster Dictionary [6].

1.10.5 Conceptual framework

A conceptual framework is a "*crucial process for generating a laborious way of constructing ideas while purposefully and analytically viewing the phenomenon*" [7, p. 2]. Conceptualisation enabled the present study to explain unambiguous meanings of terms used or generated, despite numerous meanings [8]. This study also adopted this definition.

1.10.6 Guide

The Oxford Dictionary defines a guide as an intervention or plan aimed to address and achieve an intended action [9]. This study adopted the WHO's definition of guidelines which states that a guideline is any formal text which provides procedural guidance on how to carry out a health intervention, being clinical and or administrative [10].

1.11 CONCEPTUAL FRAMEWORK OF THIS STUDY

According to Miles, Huberman & Saldana, a conceptual framework seeks to *"explain, either graphically or in narrative the main things to be studied – the key factors, construct or variables – and the presumed relationships among them"* [86, p. 3]. This study adopted the four stages of the WHO HiAP Analytical Framework as the basis for the thematic and content analysis and presentation of key research findings informing the overall conceptual reasoning.

1.11.1 The World Health Organization's HIAP Analytical Framework

The conceptual reasoning for this study was underpinned by the WHO's Analytical framework, using its five stages as the unit of analysis to present research results obtained

from objectives (i) – (ii). The rationale for employing the aforementioned stages was to follow similar contexts where HiAP has been applied [2].

Table 1.1 Stages of the Health in All Policies Analytic Framework

STAGES		**BRIEF SUMMARY DESCRIPTION**
1.	Opportunities for initiation	This stage focuses on aspects related to how policy-related matters are taken up to transform health outcomes and international influences are comparable to contextual factors in an effort to ensure that intersectoral work is aimed to attain health equity
2.	Key drivers of implementation	This stage describes the vision and relationships required to drive the implementation of HiAP within a given context and outlines the roles and responsibilities of the various actors.
3.	Key domains of an equity lens (in policies and interventions)	This stage describes the entry point and the focus and identifies equity gaps and the role of the health sector in the implementation of the HiAP process
4.	Key drivers of sustainability	This stage recognises that the implementation of the HiAP approach is not linear, and that resource allocation might influence the implementation process, structures and organisation of the government. This stage further describes the intersectoral dialogue that is necessary to influence the equity lens and the design of envisaged policies and programmes aimed at addressing the identified social determinants of health.

1.12 STUDY OUTLINE

Chapter One:

The researcher in this chapter, introduces the reader to the study phenomenon by setting the scene of what the reader is to expect by detailing background information around HiAP as well as the health status profiling of public servants' health statuses in the Namibian public service. The researcher goes on to describe the research problem, purpose, objectives, paradigmatic philosophies, and theoretical and conceptual perspectives of the study. In addition, the significance of the study and its contribution to various sectors is set out. This chapter concludes by setting the operational definition of key terms used in the study.

Chapter Two:

In this chapter, the researcher focuses on the application of HiAP by commencing with a description of the term and how the approach is being implemented in various parts of the world. The researcher cites literature about the context and situations in which and for which the approach has been conceptualised around. The researcher also delves into the theoretical framework underpinning the HiAp framework and the interconnectedness of the study concepts, as well as theoretical and conceptual frameworks. The study concludes by detailing the status of HiAp in Namibia by stating various interventions engaged in and how the approach was adopted in the country. The status of public servants' health statuses in Namibia is described in the final section of the chapter. The researcher also provides literature on the same topic around the globe.

Chapter Three:

In this chapter, the researcher provides a detailed account of the research approach and methodologies underpinning this study, inter alia, describing the study design and research methods (population, sampling, data collection and analysis). The research methodology sets out clearly the philosophical standing of this study as the pragmatic stands. The research, herein, makes known that a mixed method convergent parallel design was employed to gain both the qualitative and quantitative understanding of the study phenomenon. The researcher, as per objectives, provides a detailed account of each research intervention by describing the various methods used for collecting data in both qualitative and quantitative research strands. In this chapter, the researcher also narrates the pilot process undertaken to test the content validity of the research instrument as well as the ethical behaviour and moral grounds for participating in the study. It is also in this chapter that the researcher explains the research phases adopted to drive the research actions to be undertaken in Chapters 4 – 8.

Chapter Four:

The researcher presents both qualitative and quantitative research findings in this study. In this chapter, the researcher presents verbatim the research results and provides a description analysis in summary such as the description of the research participants' demographics. Direct quotations and descriptive and statistical amenities such as tables, figures and graphs are used to illustrate the research results.

Chapter Five:

The focus of this study is to discuss the research findings emanating from the mixed methods study presented in chapter four. First, the researcher discusses the qualitative results under themes and sub-themes that emerged from the content analysis process applied in the MAXQDA computer-aided software. Secondly, the researcher provides discussions about quantitative data analysed using SPSS by means of descriptive statistics and correlations. Quantitative research results are further subjected to additional analysis to aid in responding to objective three of the study about the health inequities amongst public servants using data obtained from objective two. The researcher thereafter merged the qualitative and quantitative research findings by importing quantitative results into MAXQDA. This merged data is then interpreted using the elements of the WHO Analytical framework, prior indicated as the unit of analysis.

Chapter Six:

This chapter focuses on the design, development and contextualisation of the HiAP-based conceptual framework. In the beginning, the research findings obtained in chapter five are contextualised using the WHO Analytical framework components/elements as the conceptual design. Thereafter, the conceptualisation is embedded by the elements of the Practice and Systems Oriented Theories to provide adequate meanings and understandings of the research findings as an attempt to further contextualise the framework. A group of subject experts was requested to evaluate the developed conceptual framework and to validate its appropriateness to the target audience. The conceptual framework is therefore presented in this chapter.

Chapter Seven:

Chapter seven commences with a description of how the guide is to be developed. The reasoning map adopted the WHO's Handbook on developing guidelines. The reasoning map further explained the contextualisation of the envisaged guide to the format of existing similar policies in the Namibian public service, referred to as staff rules. In congruence with the WHO format, numerous sub-headings were used to describe the outline of the guide.

Chapter Eight:

This chapter concludes this research report. It contains a summary of the main research findings described per the study objective. It further describes the contribution that the study makes to the overall body of knowledge including how various methodological limitations were mitigated to remain within the set research parameters. Lastly, the chapter makes recommendations based on the study findings and provides a way forward given that this assignment (Dissertation) has ended.

1.13 SUMMARY

Chapter One drew the reader's attention to the overall purpose of this study which detailed various areas of research focus, as well as the key terms and concepts used in the study. This introductory chapter further narrated the problem statement, the study's ultimate purpose, as well as the objectives and rationale for using the HiAP approach and its relation to the public service in Namibia. The researcher, overall, signified the importance of OHS and health promotion amongst public servants using the HiAP approach. Lastly, a brief outline of each study chapter was narrated.

CHAPTER TWO: LITERATURE REVIEW

2.1 INTRODUCTION

The researcher, in the first chapter, raised concerns and gaps, that the Namibian public service has no explicit OHS framework to guide the profiling of public servants' health statuses. Globally, countries have adopted HiAP-like integrated approaches to profile employees' health statuses [49]. This chapter delves into the literature to determine how HiAP initiatives have been conceptualised, their relevance to OHS and the profiling of public servants' health statuses.

2.2 CONCEPTUAL APPLICATION OF HEALTH IN ALL POLICIES

2.2.1 Conceptualisation of Health in All Policies Initiatives

Kickbusch & Bucket [87] advance the notion that HiAP is a policy abstract, referring to the approach as '*policy waves',* and thus a health governance model used at a specific developmental era similar to HP concepts (*Healthy public policy* [87]. The 1st policy wave placed emphasis on '*intersectoral action',* the 2nd wave was the *'Healthy public policy',* HiAP is the 3rd wave and is currently in the 4th wave, emphasised as SDGs [87]. Supporting Kickbusch & Bucket's [87] policy notion, Freiler et al. [88] write that a distinct characteristic of the HiAP approach is its enforcement through government structures as a deliberate mechanism to address health impacts.

The WHO classifies six paths on how HiAP can be conceptualised as summarised below [89]:

a) Initiatives about whole-of-country well-being driven by high-level political commitments/mandates, for example, in countries where tobacco-controlled legislations were enacted to regulate sectoral interaction actions between manufacturers, retailers and consumers; as well as labels, public display and use and prosecution for non-adherence;

b) Initiatives which focus on structural discriminatory practices, power relations and resource limitations such as discriminatory policies pertaining to land ownership, access to employment opportunities and livelihood vulnerabilities. These initiatives are mainly found in resource-limited environments, and war-torn and politically unstable or inflicted countries, like Iran. Examples are ISA which is aimed to eradicate poverty through ensuring food production and employment creating opportunities, and the building of access roads towards basic amenities to enable the erection of appropriate shelter, sanitation, and potable water, including nutrition, as implemented in countries like Malaysia;

c) Initiatives which offer intermediate health benefits from determinants affecting the entire population such as factors pre-disposing the development of non-communicable diseases, poor road infrastructure causing disabilities as a result of injuries caused by MVA, as implemented in Sweden, Palau and India and in line with UHC and health equity principles;

d) Initiatives focussing on the living and working conditions and using health-promoting settings such as schools, workplaces and working environments to advocate equitable access to health services, prevent illness and promote overall well-being. Emphasis is placed on health-promoting settings to leverage expertise around skills and resources

through sectoral partnerships in various sectors such as education, transport, and housing, to mention a few;

e) Initiatives focusing on environmental actions aimed to mitigate risks of exposure to hazards and manage both natural and man-made disasters to improve overall health. Pollution, for example, has long been a cause of illness and therefore, a cause of public health concerns. Investment in waste management, water supply and sanitation has been implemented to minimise exposure by mining in countries such as India and Sri Lanka; and

f) Initiatives focussing on engaging health services such as immunization, childhood and maternal growth requiring communities, non-governmental organisations and private institutions to improve coverage, accessibility, affordability and improved health-seeking behaviour, like in Kenya where a mental health drive was initiated targeting high-populated sectors such as the prisons and schools as entry points to welfare.

Freiler et al. [88], and Kickbusch & Bucket [87] identify three areas which are similar to the WHO's classifications, that are core to defining a HiAP intervention. Kickbusch & Bucket [87] added policy implementation, ISA and theoretical replications to the core areas or circumstances where HiAP was implemented, also summarised here below [87]:

a) As a **Government priority**, for example in Sweden where MVAs were the major cause of morbidities, disability and mortalities and ISA was geared towards manufacturing vehicles with added safety features, increased safe driving educational awareness, and enforcement of road traffic regulations which outweighed facility-based health care efforts.

b) **Complex health challenges** affecting the population's health, health equity and health systems and there were other approaches that did not produce the required results as a result of poor access to basic services requiring only ISA policy solutions, lastly:

c) Cases where non-health sectors '**external policies have high health impacts** to significantly reduce health implications, for example, by improving diets for malnutrition and obesity.

In Namibia, HiAP is adopted by means of a Cabinet decision, supra government structure, but this is lessor than a legislative statute with less authority and no predetermined implementers which might potentially reduce the impact [46].

2.2.2 Frameworks to appraise HiAP initiatives

The WHO advanced two HiAP frameworks, namely; the *'WHO HiAP Framework for Country Action'* and the *'WHO HiAP Analytic Framework'* [44] [2]. The aforementioned frameworks as displayed in Table 2.1 below, consist of six and four overlapping components. The '*analytical framework*' was briefly described in chapter one.

Table 2.1: Elements of the HiAP approach and HiAP Analytic Frameworks

WHO-HiAP Framework for Country Action - Six components		**WHO-HiAP Analytical Framework – Four components**	
1.	Establishing the needs and priorities for HiAP	1.	Opportunities for initiation
2.	Framing the planned action	2.	Key drivers of implementation
3.	Identifying supportive structures and processes	3.	Key domains of an equity lens (in policies and interventions)
4.	Facilitating assessment and engagement	4.	Key drivers of sustainability
5.	Ensuring monitoring, evaluation and reporting		
6.	Capacity building		

The *'WHO – HiAP Framework for Country Action'* was developed to guide countries on how to adopt, initiate, practice and implement the HiAP approach whereas the *'WHO HiAP Analytical Framework',* on the other hand, was used to analyse, evaluate and establish literature on HiAP [44] [2] [90]. Another notable and distinct feature of the frameworks is that the framework for *'country action'* is presided over by a pledge of WHO member states at the 8the Global Conference on Health Promotion, in Helsinki, Finland, on 10 – 14 June 2013, as their commitment to adopt and implement the approach in their respective countries. Namibia ratified this protocol by adopting HiAP formally in 2016 [2]. A comparative analysis of the aforementioned frameworks shows that the frameworks are not conclusively similar nor are they distinctly different. For instance, the first stages of both frameworks require that a 'need' be established and or implemented in relation to the approach that has been established [44] [2].

It is only after a need has been determined that it becomes apparent that each stage thereafter seeks contextual specificities. An example of the latter is that the stages of the '*analytical*' framework seem to lean predominantly towards addressing enablers, requiring to address '*key drivers of implementation, an equity lens and sustainability*'. The framework on '*country action'* lays emphasis on the practical implementing actors' structure and expertise. It is further noted that all stages can overlap, horizontally and vertically, as well as across frameworks. The stages are, therefore, not static and countries and or users are at liberty to use and apply the frameworks as they see fit [2] [90].

In the context of this study, the HiAP approach was applied as a co-benefactor to health and a driver of responses across sectors aimed to circumvent the socio-economic impacts brought by restrictive regulations aimed to minimise infections brought by the onset of

the Coronavirus [91]. COVID-19 brought along unprecedented pathways of responding to work disruptions, such as restrictive '*social distancing'* [92].

Dennerlein et al. [36], developed an integrative framework, '*Total Worker Health',* which embraces aspects such as the ergonomics of health and safety and entails six key characteristics to reduce workers' exposure to the COVID-19 virus, thereby improving the overall well-being: working conditions for infection control and supportive environments for increased psychological demands; utilising participatory approaches involving workers in identifying daily challenges and unique solutions; employing comprehensive and collaborative efforts to increase system efficiencies; committing as leaders to supporting workers through action and communications; adhering to ethical and legal standards, and using data to guide actions and evaluate progress.

2.2.3 Critiques and challenges experienced with HiAP conceptualisation

Albeit the successes of HiAP discussed above, impeding challenges, such as a lack of a clear mandate to adopt and implement HiAP, competent implementation structures and the limited involvement of key stakeholders, are narrated amongst many formidable barriers [93]. De Leeuw & Peters [94, p. 990] criticised reviewers of HiAP in Canada for committing *"scholarly sin',* an act of miss-conceptualising and *"substantial conceptual inconsistencies"* in describing HiAP as a policy instead of an action, substantiating further that "*conceptual inconsistencies"* lead to *"confusion"* resulting in "*wrong questions*" asked and subsequently *"deploying an inappropriate system",* therefore, committing *"Errors of the Third and Fourth Type"* [94, p. 991].

Other fundamental criticism of HiAP relates to *'health imperialism'* which refers to the ultimate health outcomes as opposed to leveraging other social aspects such as education and income, as well as *'market control'* as opposed to individual choices [95]. It is the above-mentioned background information upon which the conceptual understanding of HiAP has been discussed, but this remains conclusively elusive for most writers [45].

Critics relating to HiAP as a political and policy tool have identified the lack or absence of an authoritative mandate and legislation coupled with strict requirements/regulations to adhere to as a major obstacle to HiAP implementation [96] [97] [98]. Similarly, the absence of a regulatory framework might negatively influence the institutionalisation and practice of HiAP [96] [97] [98]. Policy making has, therefore, become more and more 'interdependent' and 'multi-dimensional' [96] [97] [98]. Another criticism pertains to the absence of a standard evaluation framework for HiAP implementation and interventions due to a diverse context subsequently resulting in methodological challenges [79] [99];

Sihto et. al. [100] classifies the aforementioned barriers into five categories:

a) The embedment of science in the analytical process of DH rooted not only in epidemiology but also in social sciences complicates the conceptualisation of HiAP, thereby derailing initiatives, because the dichotomy of constructing the meaning of health, especially by sectors beyond the traditional health sector can become contradictory'
b) Contextual complexities in policy-making, particularly in resource and evidence-lacking settings, influenced by debates on the definition of health, medicine, individual behaviour towards prevention, population-based as well as emerging epidemics;

c) Strategies for HiAP vastly differ across contexts and therefore there is a need to reconcile the aims and values of the public policies of other sectors not always supporting the required alliances and partnership, resulting in 'task-shifting' whilst significant requirements for the success of initiatives such as financial resources remained the responsibility of the central government, especially in a context where the decentralisation of public policies was shifted to local authorities without adequate budgetary support;

d) Challenges in the implementation of HiAP were competing with sectoral interests and priorities, examples are initiatives which for example led to a decrease in tobacco sales, thus limiting common spaces as well as individual choices and beliefs, including cost implications for some sectors; and

e) That "*tackling determinants of health does not automatically tackle determinants of health inequalities* [100, p. 7]. Literature narrates, for instance, that HiAP initiatives in Finland have not improved health inequalities and equities as envisaged, because of inappropriate entry points to target, deliberately, vertical and horizontal uneven health gradients, incapacities at the local level, poor stakeholder cooperation and Health Impact Assessment practices not adequately conducted by some sectors [39] [101].

2.3 IMPLEMENTATION OF HEALTH IN ALL POLICIES

2.3.1 Implementation of HiAP Worldwide

The definition of HiAP as stated in the first chapter was coined during the 8th Global Conference on Health Promotion in Helsinki, Finland [90] [102]. Prior to the above-stated, HiAP-like interventions existed, as described under background information [41]. The

Health in All Policies pioneer, namely Finland, has applied the HiAP approach to address alcohol consumption, tobacco smoking and sugar intake by legislating multisectoral responses involving the control and regulation of retailing, taxation and behavioural aspects [42].

In Sweden, HiAP is implemented as a standalone project targeting to address reductions in Motor Vehicle Accidents (MVA) which stood at 9.1 deaths per 100,000 lives in 1990 [44]. That figure decreased to 2.8 deaths per 100,000 in 2010 as a result of HiAP-like interventions. The decrease was recorded despite an increase in vehicle volumes from 507 vehicles per 1000 inhabitants to 584 vehicles in the same time period [44].

To date, Sweden is regarded as the country with the least MVA and with safer roads in the world as a result of HiAP intersectoral interventions [44] [45]. The intersectoral action facilitated through an Act of Parliament (The Road Safety Act, 1997) in Sweden saw the following sectors converging to tackle road crashes [44]:

- The law enforcement agencies execute laws on seat belts, road safety, speed limits and breathalysers,
- Civil society stimulated safe driving,
- The health sector enhances surveillance and emergency response services, and
- The transport sector tackled road design, vehicle surveillance and safety.

In Africa, HiAP has mainly been implemented as a single project in Kenya, and Southern Africa (Botswana, Lesotho and Swaziland) [30] [31] [32] [33] [34]. In Kenya [30], for example, the HiAP project sought to improve deworming coverage in schools using the education and health sectors collaboratively. In Southern Africa, HiAP projects covered

issues of water, sanitation and hygiene, to be precise, in Lesotho [32], addressed key determinants of Non-Communicable diseases in Swaziland [33] and integrated SDH in all public policies in Botswana [31].

Construing from the Botswana [31] case study, it was clear that the focus was much broader in relation to topical case studies in other Southern African countries mentioned in the above paragraph. It can further be deducted from the HiAP initiatives implemented in the Southern African countries mentioned above and the world at large that HiAP initiatives can vary in context, focus and matter [79] [35]. Figure 2.1 below gives a picture of the geographical regions of countries where HiAP and intersectoral action have been implemented.

Figure 2.1: Map of countries where HiAP and Intersectoral action was implemented

2.3.2 Overview of Health in All Policies in Namibia

The HiAP approach in Namibia was formally adopted through a Cabinet Resolution stipulation [46]. A world map in Figure 2.2 depicting Namibia among the HiAP-implementing countries is displayed below.

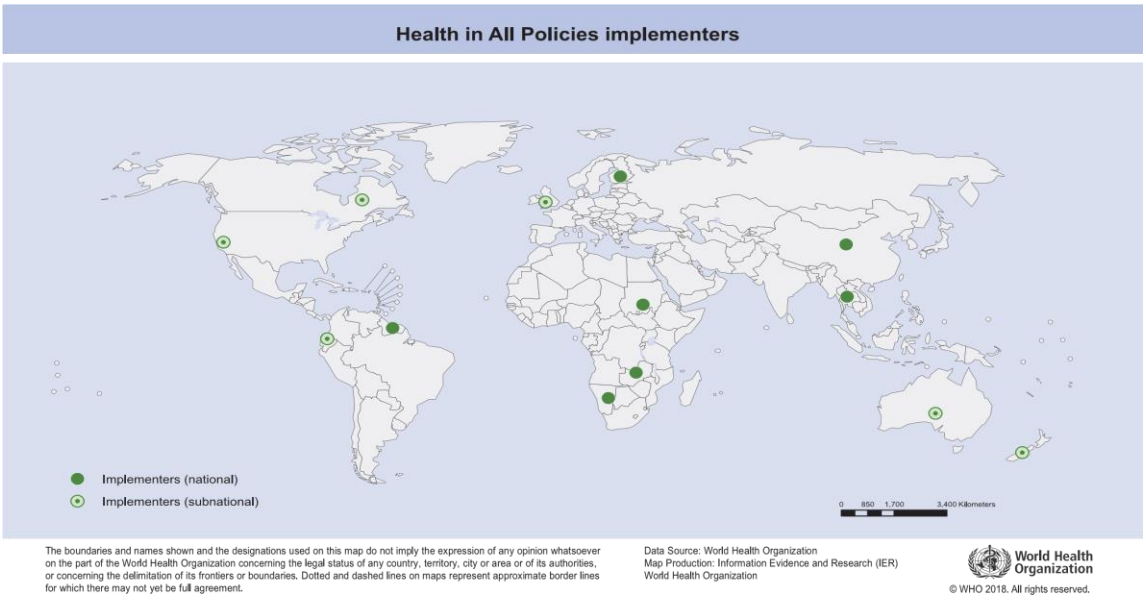


Figure 2.2: World map of countries where Health in All Policies was implemented

To date, the following events and interventions have been conducted: The MoHSS with technical assistance from the WHO country office conducted a preliminary scoping exercise with the aim of determining the context for implementation and setting country priorities [46]. The scoping exercise concluded, amongst other issues:

- That *"there has not been a targeted government-wide approach"* [103, p. 159] to engage sectors to address declining health outcomes, apart from silo attempts such as the *"Healthy Cities initiative, road safety and injury prevention strategies"* [103, p. 159].
- Huge health inequities, discussed earlier in subsection 2.2.3 from pages 36-40, continue to exist and health deprivations estimated by the NPC Census of 2011 are currently being experienced, but not adequately addressed.
- The foundations for the context on which to base the Namibia HiAP were the NDP5 strategies in relation to the SDGs, the health inequities in relation to the

burden of diseases, the policy goals of other sectors in relation to health outcomes and strengthening health in existing governance functions about integration and accountability.

A national stakeholder consultative workshop was thereafter conducted in February 2017 [104]. The workshop aimed to validate the outcomes of the scoping exercise and to *"craft a roadmap for the development of the National Strategy on HiAP"*. [104]. The workshop made two particular recommendations: *"that the Office of the Prime Minister and the National Planning Commission be brought into the governance process in order to ensure appropriate coordination with the other sectors"*. [104]. The MoHSS must continue to *"provide secretariat and catalysing the process"* [103, p. 161].

Following the national consultative workshop, a Technical Working Group (TWG) was established to carry out the Cabinet's and national consultative workshop's recommendations [103]. The TWG comprises the OPM, NPC, COW, UNAM, WHO and MoHSS [48]. Terms of Reference of the TWG exist and in summary, dictate that the role of the TWG is to *"draft the Health in All Policies Implementation Strategy and oversee the first year of activities according to specific prioritised themes"* [103, p. 161].

Terms of Reference additionally stipulated the national consultative workshop's recommendation that the country themes should be based on six policy action areas as identified and prioritised in the scoping exercise for HiAP intervention in Namibia [48]. The policy actions were: road safety, nutrition, education, and other modifiable risk factors contributing to major NCDs such as water and sanitation [48]. Lastly, a HiAP implementation strategy was developed and has been in a draft format since 2019 [48].

The draft strategy provides a situational analysis, and policy action and proposes the formation of thematic groups to coordinate the thematic areas whilst the MoHSS continues to provide secretarial and administrative assistance [48]. The TWG will continue to serve the supra-ministerial decision-making body where each thematic area reports [48]. Even though HiAP was relatively a new concept in Namibia, intersectoral work existed in the country before the adoption of the HiAP approach [105].

HiAP-like initiatives and sectoral collaborations such as road safety campaigns existed although these initiatives were found to be less optimal, not sector-specific, poorly structured, coordinated and yielding poor outcomes [105] [106] [107]. An example of a successful intersectoral initiative in Namibia is the National Coordination Framework (NCF) for HIV and AIDS developed in 2010 which aimed to *"articulate an effective strategy for coordination and management of the national multisectoral HIV and AIDS response"* [108, p. 1].

The aim of the NCF was mainly to leverage technical support and resources to sectors, and the efficient coordination of HIV and AIDS equity [108]. The NCF for HIV/AIDS was also adopted by the cabinet in the early 1990s to clarify the roles and responsibilities of various sectors whilst guiding the MoHSS to drive the outcomes of the devastating effects of the disease at various human existence levels [108]. The NCF strategies were further incorporated into the NDPs [109].

The inclusion of HIV/AIDS mitigation alleviated the pandemic response agenda at the national level where the Office of the President provided the leadership [108]. Since the adoption of the above-mentioned structural multi-sectoral arrangement, the HIV and

AIDS prevalence and incidences have been reduced dramatically, thereby surpassing international targets such as the 90-90-90 and the Prevention of Mother to Child Transmission rates (PMTCT). [110].

The NCF's structures have since been used to address other national health-related issues such as the Agenda for Orphans and Vulnerable Children (OVC) coordinated by the Ministry of Gender Equality and Child Welfare (MGECW) [108]. Similarly, Sectors Steering Committees which is also a structure of the NCF was established to initially advocate the mitigation of HIV and AIDS effects through workplace programmes; to date, it coordinates mainstreaming HIV and AIDS in the workplace [108].

2.4 USING HiAP TO PROFILE PUBLIC SERVANTS' HEALTH STATUSES

2.4.1 Overview of health statuses

Health status is a basic outline of an individual's or group's level of health derived from a health assessment for baseline information, strategic planning and comparison [49] [111]. The American Thoracic Society defines '*health status'* as a relative result that measures an individual's impairment and dysfunction related to their biological and functional ability in the presence or absence of wellness or ill health [5].

There exist numerous health status measuring tools, and the most common are the global, continental and country/population-specific generic measures such as the Global Burden of Diseases (GBD), and the Sickness Impact Profile, a disease or prevalence-specific measure [112] [113]. Common workplace health status assessment measurement tools relevant to this study are the Goldberg questionnaires, the SF-37 and the General Health

Questionnaires (GHQ) focussing mainly on the basic physical, mental and social well-being of workers [114] [115].

Most measuring tools, because they are generic, are self-administered and therefore considered comprehensive and subjective [49]. The subjective narrative of the instruments has advanced their validity, albeit there are some debates about their level of objectivity when self-rated [116] [117]. The WHO recommends the use of self-administered measures because of their '*independent predictors'* and uncomplicated '*wording*' and '*scoring scales*' [118]. Inferring to the above-stated definitions and assumptions, literature about health statuses further reveals that occupational surveillance measuring tools enable employees to detect work-based adverse health outcomes necessary to create targeted workplace controls and primary workplace ill-health prevention measures [119].

Disease-specific measures also inform health promotion programmes on adopting healthy lifestyles, engaging in physical activities and conducting health screenings and others focus on employment suitability [120] [121] [122] [51] [123]. Employees' health status measurements are also conducted to determine the cost of medical care, the rate of absenteeism due to ill health and the achievement of set productivity targets for the company [120].

Over the years, other measuring tools mainly outside of the traditional health sector have also become popular [124] [125]. Some of these tools were the Environmental Impact Assessment (EIA), the Health Impact Assessment (HIA) and the Health Lens (HL) used in the HiAP approach [80] [126] [127]. The aforementioned tools, although similar in that

they were also broad-based interventions, had a distinct difference from earlier disease and or condition-based measures because the latter measured impacts [80] [126] [127].

Other non-traditional health measurement tools mentioned in earlier chapters and most relevant to this study are the broader OHS frameworks such as the 'WHO *'Healthy Workplace Framework and Model',* the NIOSH *'Total Work Health* and the *'Workers Well-being Framework'* which provides a much wider and holistic context of the health status of an employee and not just the epidemiological surveillance side [21]. The impetus of health status profiles is, therefore to provide a multitude of biological, physical, physiological and environmental factors, unlike the broad-based generic tools applied to larger social contexts [49].

The present study did not focus on the actual application of surveillance set out in the above paragraphs but rather sought to establish and propose an approach that can '*authorise*' the practical implementation of such surveillance, in other words, the profiling of health statuses. Occupational health surveillance is defined as a *"process of systematically monitoring the health status of worker populations to gather data about the effects of workplace exposure and using the data to prevent illness or injuries"* [119, p. 500].

A study in Spain examined the role and quality of workers' health surveillance, indicating procedural and clinical limitations about the conduct of the exercise [128]. The study also reported low levels of knowledge, sickness absence data, investigations and accessibility among public servants [128]. A similar study conducted in Korea, where such

examinations are a legislative obligation, found a 56% participatory rate among workers in 2006, increasing to 72% in 2013 [129].

The study also found the prevalence of Diabetes and Hypertension, but there were odd ratios of participation in both primary and secondary routine health examinations [129]. Both studies raised concerns about the lower knowledge regarding the importance of workers' health examinations in the workplace, particularly concerning the overall well-being of workers, amidst work performance and productivity [128] [129].

In Taiwan, a similar study conducted among public servants sought to examine the association of health check-ups with Health-related Quality of Life (HRQoL) [130]. The study reported significant differences in physical component summary (PCS) among research participants [130]. The aforementioned study also found significant associations between the above-stated PCS and mental component summary (MCS) in government-paid health check-ups and self-health check-ups as well as no health check-ups [130]. All mentioned studies are geared towards the essentiality of workers' health examination.

2.4.2 Historical Overview of employees-public Servants' Health

The WHO defines health as *"a state of complete physical, mental and social well-being and not merely the absence of diseases or infirmity"* [131, p. 5]. Workers' health encompasses a wide range of issues and has been a cause of concern for public health practitioners since time immemorial resulting in the advancement of responsive health interventions [18] [132].

Historically, the focus was only on '*workplace safety',* and the demand for workers' health rights only started to gain momentum after 1951 with the signing of the European Coal and Steel Treaty which further demanded decent living and working conditions [133]. Thereafter, the Rome Treaty called for the adoption and implementation of more comprehensive workplace initiatives marking the advent of '*Health and Safety*' focussing on industries and formalised in 1989 [133].

The '*Health and Safety*' era saw the creation of Occupational Health and Safety (OHS) and/or Occupational Safety and Health (OSH) legislation [133].'*Health and Safety* programmes which inspired to promote, prevent and improve workers' health to ultimately maximise productivity [18] [19]. The International Labour Organisation (ILO) distinguishes '*Occupational Health*' from '*Occupational Safety'* by stating that the latter focuses on workplace hazards and injuries as opposed to the well-being of employees [17] [19]. The transition from '*health and safety*' models to incorporate well-being emerged around 2002, necessitated by a need for targeted interventions for vulnerable workers, namely: children, females, ageing, and workers with chronic diseases, disabilities and learning problems [18] [133] [134].

Workers, largely, spend one-third of their lives at work and hence work has been regarded, by the WHO, as an important DH and therefore, a critical setting to promote health [18] [135]. In early chapters, the WHO reported significant medical cost-saving advantages derived from promoting health in the workplace [20]. The WHO further reports that excessive alcohol and tobacco use, alleviated sugar, cholesterol and blood pressure were the top risk health factors among the productive working population [136]. The ILO also

reports that risky attributes such as income, educational levels and the nature of employment are likely to influence workers' behaviour to access health care [137].

Health risk factors are multi-dimensional and predispose people to health disorders [138] [139]. Common workplace health risk factors are either physical (noise pollution, slippery floors), biological (as a result of parasitic, bacterial, viral infections), psychological (workload, work demand, work stress, unresolved fatigue, harassment, stigma), ergonomic (incorrect posture, limited movement, constraints) and environmental (poor ventilation, unsafe equipment's, unhygienic working conditions) in nature [120].

2.4.3 The health statuses of public servants globally and in Namibia

There is a proliferation of public servants' health risk studies in literature, for example, a study using the WHO STEPWISE approach to assess the behavioural and metabolic risk factors in Nigeria, found that public servants experienced high stress and sedentary risk levels to develop non-communicable ailments such as CVD derived from the anthropometric test (weight, height, waist and hip circumference measure) as well as biometric (testing blood pressure and fasting glucose) tests [54].

Another study conducted in Ghana, amongst 135 public servants revealed a 36.4 Hypertension prevalence rate as well as a 19.1% prevalence of Diabetes Mellitus associated with a risk health factor namely physical inactivity. The study recorded and analysed institutional (a clinic) clinical records of public servants for the period January 2014 – December 2017 [53]. The prevalence of Hypertension was higher (59.3%) amongst female public servants in comparison with their male counterparts (40.7%) [53].

The Whitehall (I and II) study is a longitudinal examination of the health status and health risk factors of British public servants which commenced in 1967 to date [51]. The Whitehall studies indicated that public servants in the lower job categories with subsequent low employment salary grading, self-reported, health risks behaviour such as smoking, poor dietary patterns, and limited physical activities associated with low heath-seeking behaviour with the ability that influences the risk of angina pectoris, ischaemic heart diseases and chronic bronchitis [52].

Profiling the health statuses of employees is a legal requirement in Namibia. Paragraph 39(2)(b) contained in Chapter 4 of the Labour Act, 2007 (Act No. 11 of 2007) on the Health and Safety of Employers at Work requires every employer to, amongst others, "*report to a labour inspector in the prescribed manner, whenever, a prescribed disease is contracted at any such places*" [56, p. 5]. Chapter 4 places a "*legal duty to provide a healthy and safe working environment for the workers and any other person who might be affected by their operations*" [37, p. 46].

The above-stated legal provisions are laid out in Proclamation No. 10 of 1997 made under the Labour Act, 1992 (Act No. 6 of 1992), which outlines the regulatory, administrative and implementing measures for the collection and analysis of data on occupational accidents and diseases [140]. In addition, Namibia having rectified Convection No. 187 of 2006 concerning the Promotional Framework for Occupational Safety and Health (OSH) recommends under Article 4(3)(e) to establish a national system which shall include a mechanism to collect OHS data [141].

The Namibian Public Service makes no explicit policy and or legislative provision to reciprocate national legislative requirements, therefore, remaining largely non-compliant [142]. The latter does not mean other sectors are also not compliant or that there exists no surveillance for public servants' health [143]. The literature revealed that Namibia, overall, experienced approximately 920,000 productive life-year losses annually due to ill-health and premature death as a direct result of communicable diseases, maternal, neonatal and nutritional disorders, non-communicable diseases and injuries [136].

Namibia has a historical inheritance of health inequities and inequalities, like in many other developing countries [72] [144]. Namibia's long-term overarching development strategy, called Vision 2030 and the National Health Policy Framework (NHPF), referred to these health aetiologies around health inequities and health inequalities as the '*Diseases of poverty and inequality'* [72] [145].

Namibia overall, has extremely high health and economic levels of inequities and inequalities in the world [146]. The country's historical inequalities and inequities exist as a result of colonial oppression under German and South Africa's apartheid rule [136]. For instance, the health care system in pre-independent Namibia was delivered along racial and tribal lines, where blacks were provided with inferior health care services in comparison with the coloured and the white race. This was in the form of limited health care and service packages, as opposed to the reformed Primary Health Care (PHC) System and approach adopted after independence [147]. Health care services across races were more facility-based, hence more curative and limited attention was provided, and or non-existent preventive services [147].

The provision of housing was also allocated along racial and tribal lines, and as such, suburbs with limited access to schools, hygiene and sanitary conditions, were named according to tribes namely: Wambo, Nama, Herero, and Damara locations, where the name WANAHEDA is derived [136]. The limited provision of hygiene and sanitary care services for the majority black race, living in the informal settlements, continue to exist, after independence [148].

Pre-colonial labour relations, such as working on 12 – 18 month contracts without vacation, were even more restricted to apartheid laws which were strictly controlled based on racial and tribal basis and hence perpetuated inequities and inequalities [149]. Occupational surveillance was limited to advanced industries such as mining and fisheries, thus further perpetuating inequities in the workplace [150].

2.4.4 The application of the HiAP to Health statuses profiling

Integrative frameworks combined workers' health, safety and well-being as opposed to non-collaborative traditional compartmentalised silo safety, health and injury interventions [17] [23]. Integrative frameworks are complementary henceforth effective and efficient [151]. Workers' matters addressed through integrated frameworks are, for instance, health promotion programmes related to musculoskeletal disorders, cardiovascular and mental health risk factors associated with the prevalence of occupational ergonomics as well as those associated with respiratory health issues such as air ventilation, smoking and chemical exposure which might exacerbate asthmatic conditions [23] [20] [21] [22].

The WHO's '*Healthy Workplaces Framework and Model*', the '*Workers' Total Health*' and the '*Workers' Well-Being*' discussed in the earlier chapter are examples of integrated total worker health promotion approaches [23] [20] [21] [22]. Punnet et al. [23] whilst echoing the above stated, indicate that integrated frameworks tend to address specific and common health risks such as cardiovascular, musculoskeletal and mental health disorders, thereby addressing only the physical and psycho-social aspects and not conclusively across all interventions, thereby deliberately excluding environmental aspects [23].

Punnet et al. further found that integrative frameworks, in practice, require organisational changes to systems and structures whilst employees were expected to be included in decision-making to reflect their desire to improve their health, in order to render the frameworks effective [23]. In support of the above stated, Cooklin et al. [151] explained that the tendency of interactive frameworks may result in more compartmentalised responses, which stems from the *"reporting of interventions effects, rather than implementation and processes"* that are derived from the focus, context and setting [151, p. 1].

The aforementioned references, particularly concerning the management of systems underpinned in the philosophy that the workplace should provide a desirable health setting might continue to advocate for alternative HP approaches, such as the experience with COVID-19 restrictive measures on social distancing, an aspect potentially expected to re-orient the working environment [26].

Other common international frameworks which might be regarded as similar to integrative approaches and currently using the HiAP approach as an anchor to derive maximum

benefits and efficiency are the '*Universal Declaration of Human Rights'* (UDHR), the '*Sustainable Development Goals*' (SDGs), the '*Social Determinants of Health Action framework*' and of late, the '*Universal Health Coverage'*, all of which, as a matter of principle, seek to advance '*intersectoral action for health*' through defined health-related rights, obligations, systems and governance frameworks [152] [153].

Given the aforementioned and in the context of this study, the HiAP can also be applied to the OHS management systems in the workplace to prevent infection and address psychological demands while ensuring a safe work environment. Cooklin et al. [151], in a systematic review of over 31 articles covering a wide range of combined OHS/OSH concluded that despite the complementary capacity of integrative frameworks, OSH activities should be evidence-based, to be able to attest to providing the required efficiency gains, particularly where such approaches are a scarcity [151].

Multiple efforts, including OHS/OSH, wellness, and well-being, to safeguard workplace health and safety have not been completely satisfying, because OHS/OSH is increasingly challenged with emerging issues influenced by complex global events such as economic downturns and epidemics [154]. These complexities make the workplace health and safety domain a huge paradox.

As such, it becomes a balancing act to address various dimensions of OHS/OSH, societal and individual workers' risk factors, and promotion of workers' health whilst enhancing workability organisational factors such as return on investments (ROI) (reduced cost of injuries and illness) which has led to the adoption of more comprehensive and technology-

based systems approach such the *'WHO Healthy Workplaces: A Model for Action'* and '*Total Worker Health'* [154].

Comprehensive approaches to organisational health and safety aspects go beyond the environmental and physical workspaces [155]. It brings about a new paradigm to the workplace of OHS/OSH, wellness, well-being and productivity [154]. Comprehensive approaches adopt a public health approach to workplace health and safety efforts [154].

The *'WHO HiAP Analytical Framework'* is based on four key stages and the literature discussed in the previous section 2.3.6 demonstrates how it was implemented. The practised model will be well-defined and more focus discussed further in this study. This framework is exceptionally essential for public health promotion policy because it is solely advanced by public servants through existing structures, stakeholder collaboration and engagement on existing programmes and agreements [94].

Advancing the above-mentioned social-based approaches to workplace health and safety, in lieu of the multi-causative aspects, has provided enormous advantages compared to traditional interventions which disregard broader health non-workplace determinants [155]. These approaches have a broader view and utilise multiple elements to identify workplace health determinants as opposed to a single-stream approach [156]. Profiling public servants' health status further determines potential health risk factors as discussed in the next section [138].

2.5 SUMMARY

The main purpose of a literature review, according to Creswell, is to encapsulate the essence of a phenomenon through scholarly writings based on theoretical underpinnings into condensed, but understandable notes on the study phenomenon [157]. In this chapter, the researcher composed a view of empirical evidence available to substantiate the essence and context of the study's purpose by discussing conceptual views and operational applications. The researcher, therefore, presented and discussed numerous studies about the Health status of public servants.

The researcher also reviewed the literature on where HiAP has been implemented as well as the argumentative view, for and against, the implementation of HiAP. The researcher further made a case for the theoretical and conceptual allocation of health status and HiAP in the existing literature. The researcher concluded the literature review with a discussion of the link, relationship and association between health status and HiAP.

A review of the literature is crucial and is used to substitute assumptions and claims made by the researcher about the study phenomenon [74]. A review of the literature also serves to show current developments in relation to the area of study [158]. This chapter represents the researcher's 'thinking' and therefore serves as the study's philosophical base, the conceptual and theoretical framework in which this entire research study was planned. The next chapter discusses the research design and methods of the present study.

CHAPTER THREE: RESEARCH APPROACH AND METHODOLOGY

3.1 INTRODUCTIONS

Academic research seeks to satisfy the appropriate application of the research methodology, methods, techniques and procedures [159]. Overall, research in itself is a logical and systematic examination of finding solutions/information on a particular phenomenon through study, observations and or experiment [158]. This chapter narrates the methodological process employed to develop a contextualised HiAP-based conceptual framework to facilitate the profiling of public servants' health statuses, guidelines for the introduction of HiAP as well as for the implementation of the develop framework for the Namibian public service.

3.2 RESEARCH APPROACH

To date, three research approaches namely the quantitative, qualitative and mixed methods are commonly advanced [157]. Traditionally there were only two main research approaches namely: the qualitative and quantitative research approaches [160].

3.2.1 Qualitative research approach

A qualitative research approach enables the collection and analysis of perceptions and experiences which are presented in a non-numeric format. It further employs inductive inquiries or reasoning to explore and describe perceptions [161]. Inductive reasoning enables the researcher to extract thematic patterns from life experiences into logically and or theory based conclusions [162].

3.2.2 Quantitative research approach

A quantitative research approach allows the collection and analysis of measurable data, employing, therefore, deductive enquiries which are presented in quantifiable depictions [158]. Deductive reasoning makes predictions based on a consequence of an established theory founded on logical evidence generated through process consummated from a generalised assumption in concordance with the pre-determined and validated evidence of truth [161] [162]. For example, a hypothesis is a set to be examined, tested and validated [161] [162]. Advancements in research and the continued critique of the limitations of solely the quantitative and qualitative research strands led to a paradigm shift resulting in the adoption and use of pragmatic approaches [163]. A pragmatic approach involves the independent utilisation of the most suitable research style, henceforth the emergence of multi-methods and mixed methods [162]. Multi-methods combine the use of quantitative and qualitative data collection methods in one study [163].

3.2.3 Mixed Methods Research (MMR)

A mixed methods research approach employs both deductive and inductive reasoning in one study, thereby enabling the use of both quantitative and qualitative approaches [164]. The use of quantitative and qualitative strands in one study allows the researcher to apply diverse research skills to apportion complex constructs into comprehensible units, analyse and synthesise the constructs through interpretation and other reasoning strategies using, for instance, bracketing, inference and intuition techniques [165] [166] [167]. Data in an MMR study is collected and analysed, either, concurrently or sequentially [74]. Concurrent or convergent parallel, entails the collection, analysis and combination of qualitative or quantitative data at the same time, into one study [168]. The sequential

denomination designates prioritising the qualitative or the quantitative research approach as superior to the other [168]. The MMR approach was found to be most suitable because it enables the researcher to collect diverse, quantitative and qualitative data strands as opposing linear perceptions of solitary approaches and henceforth this was employed as such [157]. Pragmatic paradigms are realist connotations advocating perspective-based methodologies as opposed to those embedded within the positivist and post-positivist philosophies using symbolic interactions, phenomenology and ethnographic explanations [162] [159] [169].

3.3 METHODOLOGY

Methodology is the utilisation of research designs, population, sample procedures, data collection and analysis methods to investigate the desired knowledge required to attain the study aims and objectives [73]. This study's methodology is described in the sections below.

3.3.1 Research design

This study employed an Explorative Descriptive Convergent Parallel Contextual MMR design [157]. A design is a guide to how a researcher plans to achieve research goals [157]. There exists predominantly several common research designs, namely: qualitative research designs (ethnography, phenomenological study, grounded theory study and content analysis) [157]. A design defines how data is to be collected and analysed [157].

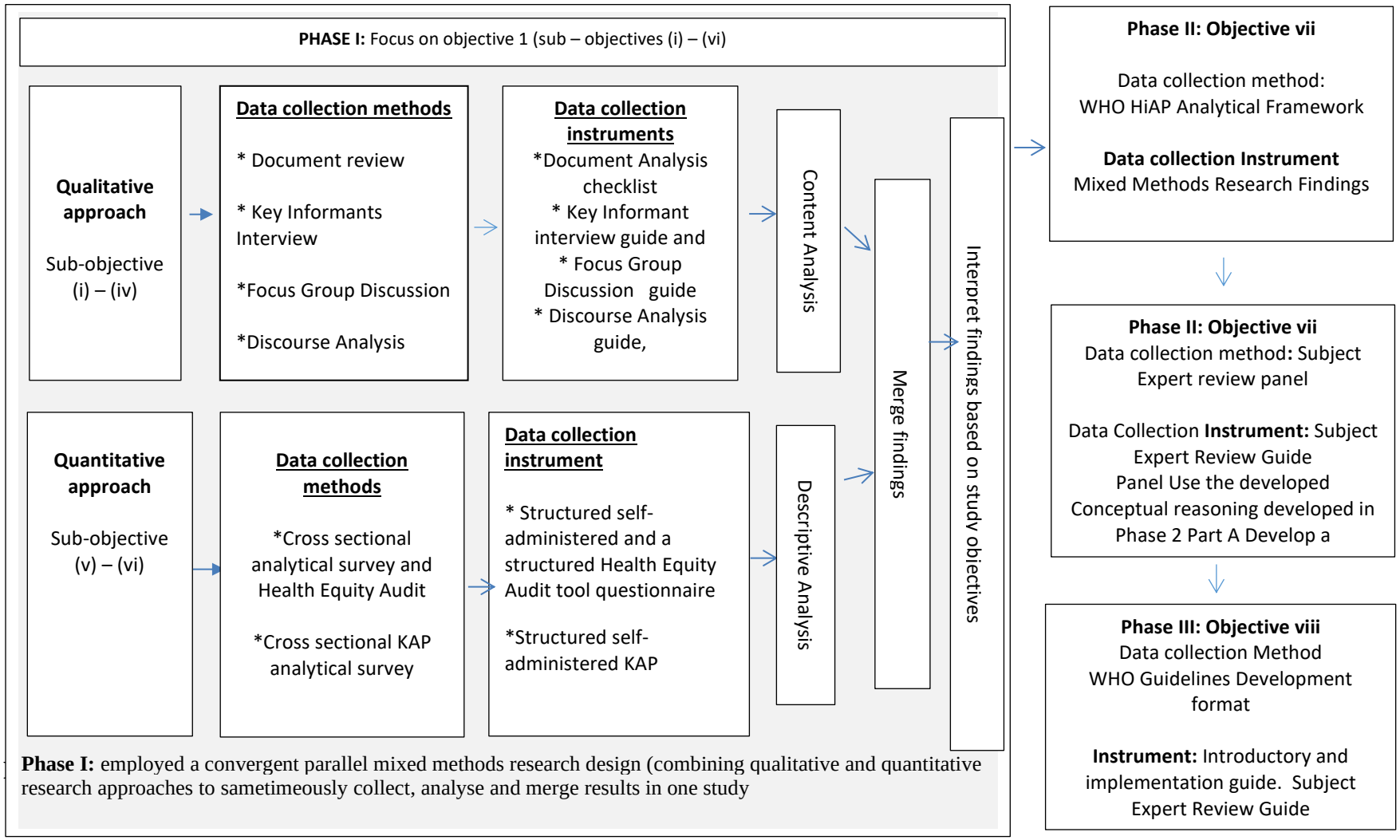
- An **explorative design** is commonly the first investigative process in research expressly where a research problem is fairly unknown and there exists limited literature to infer or confirm through generalisation [170].

- A **descriptive design** on the other hand entails the description of the newly explored perspectives whereas a **contextual design** brings about the circumstantial meaning of the research phenomena [171] [172] [173].
- A C**ombined** Explorative Descriptive Concurrent Parallel Mixed Methods Contextual design enabled the researcher to collect comprehensive foundational data by means of various techniques and dimensions to gain new knowledge or insights [170] [173].

Similar to all MMR studies, the convergent parallel design also enabled the use of both quantitative and qualitative research methods in a single study [168]. It further enabled the researcher to collect data concurrently, analyse each data set separately and the merging of study findings through a process of interpretation [157]. Combining the results of two separate research approaches enabled this researcher to gain an in-depth understanding of the study phenomenon [157] [168] [174].

This study did not prioritise the qualitative or quantitative research approach over the other and hence did not conduct this research as sequential [157] [174]. The researcher sought to collect diverse and adequate data mainly because the study phenomena appeared fairly novel as there existed limited literature. The study context was also fairly unfamiliar with the study phenomena.

Figure 3.1 on the next page illustrates the overall research methodology (design, research methods and data collection techniques) applied throughout the study.



Phase I: employed a convergent parallel mixed methods research design (combining qualitative and quantitative research approaches to sametimeously collect, analyse and merge results in one study

3.3.2 Phase I: To conduct a situational analysis

The aim of objective 1 was to gather rudimentary information on the study phenomenon in order to inform objective 2. Objective 1, also classified as Phase I, focused on collecting data to address a series of sub-objectives, depicted in the schematic sketch presented in Figure 3.1 as sub-objectives (i) – (vi). Sub-objectives (i) – (iv) collected qualitative data whereas sub-objectives (v) – (vi) collected quantitative data.

A situational analysis enables the researcher to systematically collect historical and or current data to gain an in-depth understanding and distinguish what exactly a phenomenon entails [175]. Martin et al. [175, p. 106] further indicate that a situational analysis is best applied *"where the context of implementation has a strong influence on the outcomes of policies and programmes".*

In this study, separate from its research role of establishing rudimentary information using data collection and analysis, a situational analysis aided in the exploration of contextualising the research findings of all sub-objectives. Data was collected separately for each sub-objective analysed and thereafter merged and synthesised into one study to provide a comprehensive encounter of the study phenomenon. Phase I's research findings were used to inform the research process and research methodology for Phase II and III.

3.3.2.1 Sub-objective (i) - Determine appropriate sources of data necessary for profiling public servants' health statuses

Table 3.1: Research Methodology – Document scoping review

Research design	Employed a qualitative research approach using a document content analysis scooping review design.
Population, inclusion & exclusion criteria	Primary and secondary documents related to public servants' health information on the Office of the Prime Minister's intra-net, called e-service, containing authentic documents about public servants' information such as legislative, policy and annual reports were included. Primary sources are the original sources of information whereas secondary sources are those which interpret the original authentic sources or primary sources [176]. Document review and analysis technique in which the content in the documents is reviewed and interpreted to give voice and meaning to a subject, was employed [177].
Sampling, frame & sample size	A convenient purposive non-random sampling technique was employed to select the government intranet and search for the relevant documents [75]. Two (2) primary legislative and three (3) annual reports were selected and reviewed.
Data collection, procedure, instrument, trustworthy, reliability and pilot test	Key keywords ' health' and 'health status' were used to retrieve and select relevant documents. A standardised data extraction tool identifying the: type of documentation, author(s), publisher, systematic examination and evaluation of the text; was performed to appraise and synthesise the required content to collect the following data. Relevant content was colour-coded to ease the identification of emerging themes. The data extracted was described as a narrative and reviewed by the research supervisors
Data analysis, rigour, trustworthiness and reliability of results	Content and thematic analysis, enabled in MAXQDA was performed. Data was further presented alongside elements of the WHO's HiAP Analytical Framework, as an additional unit of analysis to provide adequate detailed evidence. The use of pre-identification of themes, particularly from an existing framework eased the analysis and trustworthiness of the research result.

3.3.2.2 Sub-objective (ii) - Describe the views of management regarding HiAP in relation to public servants' health statuses

Table 3.2: Research Methodology - Key Informant Interview

Research design	A qualitative research approach using an unstructured face-to-face in-depth key-informant interview technique research design, recorded and transcribed verbatim, whilst the researcher took notes.
Population, inclusion & exclusion criteria	The targeted population was all top management cadres in the NPS with a knowledgeable bias about HiAP and public servants' health status. Executive Directors, their Deputies and Directors formed Top Management. A list of management cadres in the public services was obtained from the OPM. Only top management in the MoHSS was regarded as knowledgeable about HiAP, hence included in the targeted population, all other public service top management cadres were excluded from the study.
Sampling, frame & sample size	The purposive snowballing sampling technique, in which one anchored participant directs and suggests additional homogenous participants, was employed and interviewed until data saturation (a mechanism which determines data adequacy when inundation of new insight is reached by observing repetitive information) [157]. Three (3) substantive key-informant interviews were conducted. The Executive Director in the MoHSS was purposively selected as the anchored interviewee and identified one Deputy and a Director responsible and knowledgeable about HiAP and public servants' health statuses.
Data procedure, instrument, trustworthiness, reliability and pilot test	Data collection was concluded within a space of one week following securing appointments with all three key informants. The third interview was conducted via Zoom platform because the snowballed interviewee had travelled outside of town. Other interviews were conducted face-to-face. All interviews were recorded and translated verbatim. Permission was obtained from all respondents to voice record the interviews.
Data Analysis (rigour, trustworthiness and reliability of results)	Thematic content analysis method, enabled in MAXQDA, was used to analyse the data manually transcript from the recorded interviews and interview notes using the Tech's method which aided in the coding process and identification of emerging themes. Pre-identification of themes, particularly from an existing framework eases in analysis and boosts the trustworthiness of the research result.

3.3.2.3 Sub-objective (iii) - Describe the views of subject experts about HiAP status and the role of the Namibian Public Service

Table 3.3: Research Methodology - Focus Group Discussion

Research design	A qualitative research approach using exploratory FGD research design using an un-structure interview guide
Population, inclusion & exclusion criteria	The targeted population were HiAP subject experts. There was only one HiAP Working Group which consisted of multi-disciplinary members. Only members of the group were included in the population because they were regarded to be knowledgeable about HiAP, overall and Namibia in particular.
Sampling, frame & sample size	A purposive, non-random, sampling technique was employed by extending an email, as well as a telephonic invitation, to all subject experts to participate in the focus-group-discussion [75]. A list containing the names of all members of the working group was obtained from the MoHSS and only seven members attended and by consent participated. One FGD was conducted.
Data procedure, instrument, and pilot test	Data was collected face-to-face in one day after securing a venue at the MoHSS, using a non-structure interview guide. The discussions were type-recorded and translated verbatim, notes were also taken. Permission/consent to participate, voice record and take notes was obtained from all respondents, assuring them that the data would only be used for research purposes. Prior to the latter, a mock exercise was conducted with the HiAP secretariat and amendments to the guiding tool were affected. The research supervisors also provided rigorous input in the process.
Data analysis, rigour, trustworthiness and reliability of results	A systematic content analysis method was used, enabled through MAXQDA, to analyse manually transcribed data from the transcript of the recorded discussions and notes, using the Tech's method which aided in the coding process and identification of emerging themes. Pre-determined categories adopting the elements of the WHO's HiAP Analytical Framework were also used as the thematic areas for presenting the results. Pre-identification of themes, particularly from an existing framework eases analysis and boosts the trustworthiness of the research result. Analysis was done under constant supervision by the research supervisors and the use of tested theories, research methods and techniques attest to the credibility, dependability and trustworthiness of the data.

3.3.2.4 Sub-objective (iv) - Discourse best practices of profiling public servants' health statuses

Table 3.4: Research Methodology – Discourse Analysis

Research design	Employed a qualitative approach using a systemic content literature discourse analysis review design. The discourse literature analysis method involves the selection, appraisal and synthesises of the relevant content from documentations [177]. A scoping review enables the researcher to display depth and articulate the phenomenon as per available literature [75].
Population, inclusion & exclusion criteria	The targeted population were all relevant, electronic and print literature documents, such as research articles and reports, about public servant's health statuses. Similar literature on private/corporate employees was excluded. Relevant literature was identified and screened to only thirty research articles that were reviewed for pertinent data. Search terms used were 'public/civil servants health statuses'.
Sampling, frame & sample size	Purposive sampling which is a criterion under the non-probability sampling technique was conducted to include the population that is rich in data for the phenomenon that is under study, hence the researcher aimed for the selection of a sample which is rich in information with regards to the phenomenon under study [75]. The sample for the scoping review comprised 30 peer-reviewed published articles that met the inclusion criterion.
Data procedure, instrument, and pilot test	A key phrase, *profiling public servants' health statuses*" was conducted in major web-based electronic platforms, including Pubmed, Medline, SAGE journals, Science Direct and Google Scholar, which were searched for published articles using as the research theme. The aim of the search was to identify published articles on the study phenomena for use as evidence-based. A total of 5345 articles were identified during the search from the different databases and electronic platforms, and only 30 were reviewed
Data analysis, rigour, trustworthiness and reliability of results	The systemic literature review analysis method was done in MAXQDA. Thirty articles were included in the final analysis. Research results described the characteristics of the surveyed population, the data sources and key characteristics of the health statuses collected

3.3.2.5 Sub-objective (v) - Assess the self-reported health statuses and health inequities among public servants in the MWT

Table 3.5: Research Methodology - Cross-sectional survey

Research design	A quantitative research approach using an exploratory descriptive cross-sectional analytic case study survey design using a structured questionnaire adapted from the CDC Employee Health Assessment, the New England Employee Survey tools as well as the GHQ, also known as the Short Form (SF) 38/26 item questionnaire, with few contextual amendments, was employed. [55] [288].
Population, inclusion and exclusion criteria	The study population were all permanently employed public servants across all 14 regions in the MWT recorded to have been over 120 000 people during the 2016 – 2017 financial year, approximately 1800 (annexure 4) were in the MWT [178].
Sample size	The sample size was calculated using the Monkey Survey online sample calculator in which the researcher applied a 95% confidence interval and a 5% margin of error which ultimately gave a sample size of 320 based on 1 87infinite study population. The actual notation: Z - confidence level score: P - Maximum estimated distribution value: Margin of error (also called precision): q – 1-P: n_0 – sample: n – sample size. $n_0 = \frac{Z^2 Pq}{e^2} = \frac{1.96^2 * 0.5 * (1-0.5)}{0.05^2} = 384.16$ $$n = \frac{n_0}{1 + \left(\frac{n_0 - 1}{N}\right)} = \frac{384.16}{1 + \left(\frac{384.16 - 1}{1878}\right)} = 319.0629942 \approx 320$$ ***Accounting for 10% non-response/refusal*** $$\frac{110\%}{100\%} * 320 = 350.9692936 \approx 351$$

Sampling frame, sampling & sample size calculations	A stratified simple random probabilistic census technique was applied for the three-stage quantitative enquiry sampling. Stratified sampling allowed for the sample to be divided into fourteen strata representing regional research participants [179]. Simple random probability sampling denotes that each member of the study population has an equal chance to participate in the study [179]. The census sampling technique involved the listing and objective selection of all relevant parts [179]. In stage one a list of all government institutions was obtained random pick of the MWT was selected out of the ten major O/M/As. The criteria for selecting an appropriate institution were: a public service institution, multidisciplinary occupational team structure, Employee Wellness Division/Unit on its structure and staff complement of over 1000 public servants. Secondly, a regional sampling was done in which all regions were selected. Lastly, a simple random probability sampling technique was applied to proportionate a regional representation weight depending on the number of public servants per regional office performed using the convenient technique until sampled numbers were reached [157]. The formula and notations used for the regional stratified calculations: W_h - stratum weight; N_h - Total number per stratum; N – Total population; stratum – regions $W_h = \frac{N_h}{N} n_i = W_h \times n$

Data Collection	Qualitative data were collected using a self-administered questionnaire for the cross-sectional and KAP surveys. Both questionnaires contain questions about HS, HE, workplace health programmes and HiAP in various sections of the questionnaire described below: **Section one:** focussed on the research subject' demographic information which includes the sex, age, levels of income; education; gender and employment, as well as specific information relevant to the Namibian public service such as access to PSEMAs, housing and other social amenities like access and close proximities to portable water and sanitation. **Section two**: collected data about the KAP dealt with knowledge questions on HiAP and self-perceived health status, ill-health, chronic diseases as well as other ill-health conditions and perceived health risks information which include variables such as musculoskeletal conditions, BMI; health care, physical activity smoking, stress, nutrition and social protection. **Section three:** focussed on workplace health Issues including employees' health programmes and policies on the public servant's survey and questions that dealt with HiAP implementation and practices in the KAP survey.

Pilot study	The pilot study was conducted at the MWT's head office in Windhoek prior to the main study with the aim of assessing the feasibility of the methods, questionnaire, and data collection processes in relation to answering the research objectives of the main study. Ten (10) questionnaires were randomly disseminated physically by the researcher to the pilot population on the Western wing on the first floor of the MWT located in Windhoek. Questionnaires were re-collected over a five-day period including the weekend. As a 'rule of thumb' Connelly (2008) indicated that a 10% sample size estimated on the sample of the main study would be adequate [181]. Hertzog (2007), however, suggests a 10 to 40 participants range [182]. The 10 to 40 number rule can be can be relaxed especially in resource-limited and time-constrained instances [183]. Categorical questions addressing bivariate aspects including questions on estimated weight and height and disabilities were split to address each aspect separately. Questions added addressed workplace safety and evacuation.
Data Analysis	Data collected was entered into the Statistical Package for Social Sciences version 23 and analysed by simple frequency count, proportions of percentages, means and ratios. Descriptive statistical results were presented using tables and graphs whilst measured variables were analysed by mean and standard deviations. Significant statistical associations between variables were determined with a chi-square test at the 95% confidence level. The Cronbanch's alpha coefficient SPPS test also provided evidence of the reliability of the research instruments.

Table 3.1: Regional stratification sample size calculations

Strata	**Region name**	**Population per region (Nh)**	**stratum weight (W_h)**	**sample per stratum (n_i)**	**Fin. sample per stratum**
1	//Karas	111	0.05911	20.7460	21
2	Erongo	90	0.04792	16.8211	17
3	Hardap	61	0.03248	11.4010	11
4	Kavango East	102	0.05431	19.0639	19
5	Kavango West	10	0.00532	1.8690	2
6	Khomas	834	0.44409	155.8754	156
7	Kunene	84	0.04473	15.6997	16
8	Ohangwena	39	0.02077	7.2891	7
9	Omaheke	67	0.03568	12.5224	13
10	Omusati	50	0.02662	9.3450	9
11	Oshana	127	0.06763	23.7364	24
12	Oshikoto	39	0.02077	7.2891	7
13	Otjozondjupa	155	0.08253	28.9696	29
14	Zambezi	109	0.05804	20.3722	20
	sum (N)	**1878**		**351**	**351**
	sample size (n)	**351**			

3.3.2.6 Objective (vi) - Assess the Knowledge, Attitudes and Practices of HiAP among Wellness Officers NPS

Table 3.6: Research methodology - Knowledge, Attitudes and Practices (KAP) survey

Research Design	A quantitative research approach using a descriptive cross-sectional analytic KAP survey design was employed.
Setting, population, inclusion and exclusion criteria	The targeted population was all public servants responsible for wellness in the 34 public service institutions. Not all institutions had wellness officers and relied on committee members to perform such tasks. There were over 51 wellness and focal persons responsible for wellness programmes in public service according to an Excel-based list of all wellness officers obtained from the Office of the Prime Minister, as the employer, through formal channels of communication.
Sampling frame, sampling & sample size	The census probability sampling method was applied to include all 51 public servants responsible for wellness in the study. Wellness Officers in the private as well as parastatals were excluded from the study.
Data collection procedure, instrument, validity, reliability and pilot test	A self-administered anonymous structured questionnaire, consisting of four sections, namely: Demographic, Knowledge, Attitudes and Practices information, was emailed to all participants. These instruments went through rigorous exploration including verification of the content with the supervisor, and engagement with a homogenise group in the private sector, as part of a pilot test. Research instruments were repeatedly administered for the intended research collection methods that proved and validated instrument reliability. of the questionnaire was conducted with a. Data collection took place
Data Analysis	Data collected was entered into the Statistical Package for Social Sciences version 23 and analysed by simple frequencies, proportions and ratios. Descriptive statistical results were presented using tables and graphs whilst measured variables were analysed by mean and standard deviations. Significant statistical associations between variables were determined with a chi-square test at the 95% confidence level. The Cronbach's alpha coefficient SPPS test also provided evidence of the reliability of the research instruments.

3.3.3 Phase II: Development of the conceptual framework

Objective 2 entailed **Phase II** which sought to (a) design, develop and present HiAP a HiAP-based conceptual framework to guide the profiling of public servants' health statuses in the Namibia public service, as well as (b) to validate the appropriateness of the developed framework. The development of the HiAP-based conceptual framework was developed using research findings obtained from sub-objective (i) – (vi).

According to Squires et al., conceptual modelling *"is the abstraction of elements of reality at an appropriate level of simplification for the problem"* [184, p. 588]. It is the art of cognitively explaining and or formulating a meaning for an abstract concept or idea [184]. In practice, it involves formulating a practical solution to a problem [185]. Common meaning and practice of conceptualisation might be regarded as a linear process. Squires et. al. caution that conceptualisation can be a complex process in the public health discipline because it involves multifaceted notions which necessitate expansive reflections in order to stand the test of validity and credibility [185] [184].

In designing the envisaged conceptual framework research results, amongst others that the HiAP approach, in itself, was a fairly new concept in Namibia, guided the development of the framework. The conceptual process was guided by the elements of the WHO's HiAP Analytical framework as thematic reasoning enlisted the addition of elements of the Systems and Practice Oriented Theories, namely: input (procedures, agent, recipient and dynamics); output (terminus); synergies (agent, recipient, procedures and dynamics) and feedback (context, inputs, outputs, terminus) [2] [82] [85].

The second part of objective 2 was to validate the appropriateness of the developed framework. Validation, according to the International Organisation for Standards (ISO), is the process of ascertaining that the product meets the desired needs and is suitable for use by the intended audience [186]. Validation is further described as a process used to examine whether a product, service and or systems conform to the required standards [186] [187].

A validation tool was developed using ISO 13465 standards on process validation and verification as a guide [186]. The development of the validation guide and verification thereof was conducted under the guidance of the research supervisors. In addition, three, purposively selected Subject Experts knowledgeable about the application of HiAP and are members of the HWG in Namibia conducted the validation, in their personal capacities. Two additional subject experts were added to the above-stated to provide a review of the developed conceptual framework. The validation process was interactive by means of constant emails, and face-to-face and telephone meetings communication. Subject experts confirmed the appropriateness of the framework.

3.3.4 Phase III: Development of implementation guidelines

Objective three (3), entailed Phase II and focussed on developing guidelines for the introduction of HiAP and the implementation of the developed framework for the Namibian public service. The guidelines were developed based on addressing operational challenges identified in Phases I and II. The guidelines were conceptualised using guidance from the WHO. The WHO's *Handbook for the Development of guidelines*', as well as the format of Public Service Staff Rules (PSSR) for Namibia, aided the guidelines

development process. The WHO's '*Handbook for the Development of Guidelines'*, in particular advocates for the inclusion of an overview or background of the subject matter, the purpose, objective, audiences, procedures and intended outcomes in any guidelines. Whilst the PSSR is also developed along the WHO's provisions, its format aided in contextualising the guidelines to the Namibia public service, especially in light of the study findings. Study findings revealed overall limited knowledge among public servants and Wellness Officers, in particular. The study further found that HiAP was relatively a new concept in Namibia and that since its inaugural Cabinet Directive, a draft National Strategic Plan was developed, albeit never implemented. The study also revealed numerous data sources appropriate for profiling.

3.4 MERGING OF RESEARCH RESULTS

Merging in mixed methods research approach, refers to the combination of qualitative and quantitative data, in one study [74] [157]. Merging of data can take on various forms, including triangulation of data collected by various data instruments [75] [170]. Triangulation is the combined application of several research approaches, methods and data sources to increase the soundness of research findings in a study [170]. Triangulation was further used to offset gaps in data from a particular research method [157].

This study converged qualitative and quantitative research results obtained using document reviews, interviews, FGD and surveys that were acquired from diverse sources and contexts. The complement of such diverse data provides for data sufficiency, thus increasing data validity [188] [189]. Basing the study on the premises of existing theories and frameworks, in overall strengthened trustworthiness as the research instruments are

deemed valid and reliable [188] [189]. The researcher applied a joint display of data methods in chapter five, as suggested by Creswell et al. [157].

Creswell et al. [157] indicate that the ultimate purpose of a joint display is to enable a single visual display to ease interpretation and display. Merged data and display thereof, particularly in this study, included key qualitative and quantitative research results obtained through data collected from objectives 1 – 3 [157]. Empirical evidence was synchronised by means of importing the PSS quantitative data into MAXQDA, the qualitative computer-aided software. Synchronised data was thereafter analysed using the four elements of the WHO Analytical Framework as pre-determined thematic areas.

Findings, interpreted and discussed are presented largely for informing the development of the envisaged HiAP-based conceptual framework to facilitate the profiling of public servants' health in the Namibian public service, as the ultimate purpose of this study. Collectively, synchronised findings, supplemented by literature, highlighted systematic designs necessary to advance an in-depth understanding and at times illustrate possible applications of the concept.

3.5 ETHICAL CONSIDERATIONS

Fundamental research principles in general are the duties and obligations of the researcher to be just and do good on the basis of protecting the basic human rights of research subjects from any form of harm and discomfort [190] [191]. Ethical principles stated below were observed because of certain values and morals that may negatively implicate the conduct of the researcher, behaviour and treatment of research subjects [191].

3.5.1 Permission and approval to conduct the present study

A research proposal to conduct an academic study was presented to seek ethical clearance from the University of Namibia's Research Ethics Committee (UREC). The ethical clearance certificate was granted, reference OSHC 483/2018 (Annexure A), which enabled the researcher to further seek approval (Annexure B) from the MoHSS's Research and Ethics Committee. Additionally, approval (Annexure C) was granted by the OPM and the MWT (Annexure D) for accessing the public service. The latter facilitated access to research participants. As there was an adjustment to the scope of data collection and study methods permission to amend the study methodology was sought and granted (Annexure E) (Annexure F). Upon approval of all requests, research information was disseminated and then followed by seeking of consent for data collection from all study subjects.

3.5.2 Ethical principles of justice

Non-invasive studies, similar to this one, do not contain human experimental features or run any trials such as screening for diabetes, drug use or human tissue and thus mounted their ethical stance on professional conduct and rules established at the Helsinki Declaration by the World Medical Association and United Nations' Universal Declaration of Human Rights (UDHR) [192] [193].

3.5.3 Ethical principle of beneficence and non-maleficence

Basic ethical research traits such as to do good, also referred to as beneficence, as well as to do no harm, popularly known as non-malfeasance were further employed. Beneficence refers to the efforts taken to ensure that the research study provides some form of benefit. In relation to this study, efforts to improve population health can be regarded as a benefit

for the study population [170]. Non-malfeasance refers to the ability and efforts to cause no harm to the study subjects by avoiding all potential threats and risks and by ensuring that research subjects are treated with dignity, safety, confidentiality and privacy [170].

3.5.4 Ethical principles of autonomy, anonymity, confidentiality and privacy

The researcher obtained informed consent from research participants after the participants were provided with information regarding the study's purpose and objectives. Research participants were further assured that their identities would be kept confidential and the questionnaire and consent forms were anonymous. This ensured keeping their identities undisclosed, thus maintaining their privacy. All research materials were stored securely in lockable and computer lock-safe storage and all research participants were treated equally throughout the study by administering a fair application process without any bias. Study subjects were informed of their right to participate as well as their right to withdraw from the study at any point during the research process without any questions being asked. The right to voluntary participation was also emphasised. Study subjects were engaged with utmost respect throughout the various research processes (Research Phases). The researcher acted professionally throughout the entire study.

3.6 SUMMARY

The study adopted a Convergent Parallel Descriptive and Contextual Mixed Methods Research Design using Document Review, Key Informant Interviews, a Focus Group Discussion and Discourse Analysis as qualitative research. Knowledge, Attitudes and Practice and cross-sectional analytic survey methods were used for the qualitative approach. The data collected were analysed using computer-aided software which further

enabled the researcher to conduct a mixed methods analysis. A pilot report which enabled the testing of the aforementioned research methods is available on request. The study methodology and its associated methods of research were based on the pragmatic aetiology which was discussed in chapters one and two.

CHAPTER FOUR: RESEARCH FINDINGS

4.1 INTRODUCTION

The researcher, in this chapter, presents qualitative (Section 4.2) and quantitative (Section 4.3) data collected. The methodology and methods of data collection were described earlier in the previous chapter, henceforth, empirical data presented here serves as elementary information, crucial for achieving the ultimate purpose and objectives of this study.

4.2 QUALITATIVE RESEARCH FINDINGS

4.2.1 Objective (i): Research findings from the documents reviewed

4.2.1.1 Characteristics of documents reviewed

The aim of this objective was to investigate the existence of appropriate sources of data required for profiling public servants' health statuses in the Namibian public service, mainly due to a lack of a guiding framework for health status profiling and overall OHS. Documents reviewed emanated from a general literature search of both print and electronic documents about data sources containing public servants' health information in Namibia, the public service, as per eligibility criteria described in the methodology chapter (section 3.2.1.1). The search exclusively targeted documentation from or within the Office of the Prime Minister, as the substantive employer. The search produced five documents, classified into legislative and policy as well as an annual report. Literature defined these types of documents as primary (legislations and policy documents) whereas the annual report is defined as secondary, expanding primary source [177]. O'Leary, Z's 8-step

planning tool was amended to facilitate the extraction of the content, a summary of which is displayed in Table 4.1 [176].

4.2.1.2 Key findings of appropriate data sources status

The Labour Act (Act No. 11 of 1997) stipulates that employers should conduct health assessments and examinations [37]. In reciprocation, the Namibian Public Service by means of Section 5(1), 22(4)(a), 32, 34(1)(e) and 35 of the Public Service Act, 1995; Chapters two (2) and five (5) of the associated Regulations and Public Service Staff Rules (PSSR) on employment and the Public Service Employees Medical Aid Scheme (PSEMAS), sets the tone for consideration of public servants health issues [194, 195, 196].

Section 5(1), read in conjunction with Sections 34 and 35, deals with the functions of the Prime Minister pertaining to the management and administration of human resources in the public service [195]. Section 22(4)(a) deals with discharge from the public service on account of low performance and or prolonged absence due to continuous ill-health [195]. Procedures for medical discharge are clarified in Chapter Two, Section 8 of the Regulations, as well as relevant sections of the PSSR [194, 195, 196].

The latter states that: *"A person who desires to be considered for an appointment in the Public Service, shall – (a) apply therefore in a form as prescribed by the Prime Minister; and (b) sit for such examination as may be prescribed by the prime Minister as a requirement for appointment to the post applied for"* [196, p. 2]. The prescribed form, stated above, consists of two forms, namely: the employment and health questionnaire, attached to this report as Annexure 15. The self-reported questionnaire assesses the status of the body kilogram, height, skin condition, skeleton, eyes, ears, nose, speech, teeth,

heart, circulatory system, chest and respiratory system, digestive system, urinary tract and genital system, nervous and mental afflictions, disability, surgery and other illnesses, at the time of application [194, 195, 196].

In support of the above-stated, Section 18(2)(b) of the aforementioned Act specifies that a public servant must be free from any disease or physical or mental defect likely to materially interfere with their performance [194]. The afore-stated PSSR further stipulates that: [196, p. 2]

> *"(a) a staff member subject himself or herself to a medical examination to determine whether any contamination with contagious or communicable disease has occurred; or"*
>
> *(b) on such conditions as determined by the Ministry of Health and Social Services, a staff member or a member of his or her household be immunized against such diseases to –*
>
> *(i) prevent an epidemic;*
>
> *(ii) comply with international regulations; or*
>
> *(iii) protect himself or herself against contamination with contagious or communicable disease during a visit to or residence in a country or territory where the danger of such infection exists".*

Section 8(8) of the Regulations and associated PSSR relates to substance abuse, stating that: *"if there are reasonable grounds to suspect that a staff member is under the influence of intoxicating liquor or stupefying drugs during his or her official hours of attendance, such staff member shall if so required by the permanents secretary submit himself or herself to an examination by a registered medical practitioner or to any other test which*

may lawfully be performed by any other person in order to determine whether he or she is under the influence of intoxicating liquor or stupefying drugs". [196, p. 2]. Medical examination reports referred hereto, should not be older than three months [194].

In addition to the public service legislative and policy framework described in earlier paragraphs above, annual reports by the Public Service Commission (PSC), reported 31 and nine (9) cases of discharge from the public service on medical grounds for the 2016/17 and 2017/2018 financial year, respectively [197]. The reports, further provide descriptions of public servants whose employment was terminated as a result of death, albeit no quantifications were provided [197].

The above-stated reports also provide information regarding leave, overall, but do not quantify the total sick leave taken, as issues relevant to the context of this study [197]. Similarly, the report provides information regarding PSEMAS, particularly about health issues recommended for deviations and financial support, without going into specifics and or clarity on the particular health issues and or overall disease burden [197]. Info about numerous health conditions by PSEMAS is not freely accessible.

Section 34(d)) of the Public Service Act, read in conjunction with Chapter Five of the associated Regulations provides for the "*establishment and management of and control over a medical aid scheme for public service*" [198, p. 45]. The Public Service Employees Medical Aid Scheme was established with an objective to: *"making provision for the granting of assistance to members in defraying expenditure incurred by them in connection with:*

(a) the rendering of medical, para-medical, nursing, surgical, orthopaedic, dental, or optical services, requirements or appliances; and

(b) the transport by ambulance to and supply of accommodation in hospital, maternity homes or nursing home, to them and their dependent" [195, p. 15].

Table 4.1: Detailed summary of key findings from documents sampled

LIST OF DOCUMENTS REVIEWED	TEXT / AREA OF FOCUS / REVIEWED DOCUMENT	DATA SOURCE HEALTH STATUS INFORMATION COLLECTED
1. Labour Act, No. 11 of 2007	• Chapter 2: Prohibition of discrimination and sexual harassment in employment, Section 5(d)(e) • Chapter 3 on Basic conditions of employment, Part A (basic conditions) & D (Section 24 on sick leave); • Chapter 4 on Health, Safety, and Welfare of Employees, Part A (Rights and duties of employers) & B Health and Safety Representatives and Committees (Section 43 - 47). • Chapter 10 on General provisions, Section 135 (k) notification of notable occupational diseases	• Public Service Workplace Policy on HIV and AIDS • Public Service Staff Rules on administration and management of sick leave and medical certificates systems; • Medical certificate by a medical practitioner or any other evidence of proof of illness as may be prescribed • Regulations and form OD.1 on notification of occupational disease Form OD.1 on notification of occupational disease
2. Regulation 156 of 1997, Labour Act 1992, relating to the health and safety of employees at work	• Chapter 1: Rights and duties of employers, Section 2 (Employer's general duties) – 3 (Employer's health and safety policy and programme); • Chapter 2: Sections 15 – 18 and 23 (Approved codes of practice, Incorporation of health and safety standards, Health and safety procedures and appointment of approved inspection authorities, Notification of occupational disease); • Chapter 7: Medical examinations and emergencies; A on Medical surveillance, Section 219 (Occupational Health Services); 220 (functions of occupational health services).	• Public Service Handbook, Acts and Charters • Regulations on the Public Service Employees Medical Aid Scheme • Public Service Staff Rules on administration and management of sick leave and medical Scheme; • There are no codes of practice on health and safety for the public service • Emergencies first aid kits; • No guidelines on medical surveillance

3. Public Service Act (Act 13 of 1995)	• Section 24 (4a) Retirement and discharge of staff member on medical grounds; • Section 25(j) use of intoxication of liquor; • Section 34(d)(e) on the establishment and management of and control over a medical aid scheme for the Public Service;	Medical reports by medical practitioners on the recommendations for discharge on medical grounds; Reports on intoxication levels and procedure for disciplinary processes Description of circumstances under which medical examination is required and the form of medical reports and certificates Health data, screening on acute and chronic conditions, Regulation of public servants' health and wellbeing through medical scheme, sick leave, work conditions
4. Regulation (Government Notice 211 of 1995)	• Chapter 2, Section 8 medical examinations; • Chapter 5; Section 26 establishment of the scheme.	Medical reports by medical practitioners on the recommendations for discharge on medical grounds; Data sources derived from PSEMAS, sick leave certificates, periodic workplace screening campaigns
5. 2016/17; 2017/18; 2018/19; Public Service Commission annual reports	Health status and health related impacts described/reported in the annual reports,	• Demographic characteristics (employment status - disaggregated by gender); • Conditions of employment – management of sick leave management system • Registration with Health Professional Council of Namibia • Disease data from the Public Service Employees Medical Aid Scheme – Disease burden • Social Security Commission – compensation processes for accidents and ill health.

4.2.2 Objective (ii): Research findings from the Key Informant Interviews

4.2.2.1 Characteristic of key informants

The reference population was all senior managing cadres in the Namibian public service knowledgeable about HiAP and the health status of public servants. The afore-mentioned expertise were selected using the snowball purposive non-random sampling procedure in selecting deliberately knowledgeable and context-appropriate anchor key informants. It is assumed that all high level managers are aware of human resources aspects, but only those at the MoHSS were knowledgeable with the HiAP. The primary sampling consideration for this study was that respondents should be knowledgeable on HiAP and its relevancy to health statuses profiling in general and in particular those of public servants in Namibia. Three respondents, all from within health ministry, with the Executive Director being the snowballing pivot, were interviewed. Two interviews were conducted face-to-face, one was online mainly due to different sites of the researcher and the interviewer. Interviews took a length of between one hour to an 01h30 and they were semi-structured, commencing with a specific lead-question to initiate the discussions and clarification questions were required throughout the interview process. Interviews were typed recorded and transcribed verbatim whereas analysis included colour coding emerging thematic areas for ease of content analysis, discussion, interpretation and reported in Chapter Five (5).

4.2.2.2 Key findings from the Key Informant Interviews

Interviewees were all asked an introductory question pertaining to whether they were aware of a Cabinet Resolution (5th/05.04.16/004) to adopt and implement the HiAP approach. All respondents, except one, were aware of the Cabinet resolution; and the respondent who was unaware indicated that she was fairly newly appointed and elaborated further that its rather the content of the directive which was unfamiliar, but indicated overall awareness of the HiAP approach at Ministerial level.

In response to the introductory guiding question, one of the interviewees, said: *"First of all let me clarify the scope and proper placing of HiAP in the Ministry. The HiAP program is under the Policy Planning Unit and Mr *Ben and his supervisor Mr *Paulus are the people and the Directorate directly responsible for HiAP. This programme is not in the PHC Directorate. I have learnt however, that a stakeholder meeting was conducted at some point and management was briefed. Thus I cannot say much regarding the Cabinet resolution at this point. I am not that familiar with the Cabinet resolution the Policy Directorate will have much more information on this". *not their real names*

In relation to the status of how far the implementation of the HiAP approach was in Namibia, the first interviewee, and also echoed by the other two, said: *"Since, 2016, the MoHSS have updated Cabinet on the process taken to make operational the approach in the Namibian. To date numerous efforts, including stakeholders' workshops were conducted with the technical and financial assistance of the WHO. This year a consultant presented a Draft NSP on HiAP to Top Management. There is progress albeit very slow progress. The PHC and the Directorate Policy Planning have directly dealt with this*

policy issues from within the Ministry, but I was informed the OPM and the National Planning Commission are part of a Committee that drives the process. I will refer you to my Directors for more detail feedback and update".

Another interviewee also said: *"Since the Cabinet directive, a lot has been done albeit on a slow pace. The Ministry concluded the process to develop a strategy that will guide the implementation of HiAP, specifically in line with ministries. Prior to the development of the strategy the Ministry with the assistance of the WHO conducted a rapid assessment process of inter-sectoral actions required or expected. Several OMAs were also visited, as part of the assessment, with the aim to identify public health priorities, to examine existing working relationships, structure, activities and challenges, and to explore possibilities and opportunities for enhance inter-sectoral action towards improved health outcomes. This Ministry therefore conducted another stakeholder meeting in order to engaged a wider range of stakeholders and to further popularise the HiAP country agenda. Another workshop was conducted at the same time as the NDP5 validation workshop, were Ministry personnel briefed participants about HiAP Namibia*".

The researcher further asked what HiAP entails and one of the interviewees said: *"In general HiAP is the presence of health in all public policies irrespective of what sector deals with non-health issues. Each sector should address health in some way. Not necessary provide health – clinical services, but e.g. Agriculture in terms of food services should address the quality of food, issues around access to water. Trade should address issues about alcohol trading and the health elements in the use of alcohol"*.

The researchers also asked who would drive the HiAP process and received the following responses: *"public servants of the various ministry, of course. the framework allows for the implementation of numerous aspect depending on the identified determinant of health and not specifically for a given sector of the public. For the public service the framework need to have an implementation, Monitoring and Evaluation modality – component and make appropriate recommendation such as the routine tracking of those activities"*
On the above stated response, the researcher probed, asking *"What about the health risks factors of public servants, can the HiAP approach, be responsive?".*

One of the interviewees said: *"Public servants are members of the society, so much so, that their health is impacted and negatively affected by social issues (food quality, access to water). Yes, the HiAP framework ought to be responsive. Various aspects can have minimal and or maximum health impact. Literary public servants working conditions might affect their health both medically, and otherwise (pause) the place of work can pose a threat to their health and that is why there are wellness programmes in the workplaces. Wellness programmes needs to be strengthened to ensure that the work places provide access to health, nutritional food, provide healthy lunch places and sitting arrangements, some might opt or seek to provide gym hours and before its dark might provide exercise. The public service ought to promote health of all public servants".*

The researcher probed further by asking what the overall health status was and whether there have been any studies conducted to established and managed ill-health amongst public servants. The interviewees had this to say: *"The health status of public servants, I am not sure if it was ever quantified will give an indicative response to your question, but the PSEMAS data can be extracted to provide an indicative health status as long as the*

data is encrypted not to reveal personal identities of individual public servants. Data on dispensations, habitual stress and average ages can also extract from sources, if available, and be used to determine the health status of public servants. Other sources of health status data can be available from the National Statistics Agency, which provides statistics on employment and specifically regarding occupations (just not sure if includes public service data) or may be the Demographic and Health Survey can provide such data. Public servants' personal files also contain health information, other is the sick leave forms may be the OPM can have access to this information".

Another said: *"The health status of public servants in Namibia I can say it's good, but when quantified does not conform to numerous health issues or categorisation that can be related to issues such as mental health, chronic diseases, abuse both at work and home, ART uptake".*

Whilst another indicated that: *"Honestly there is not much in terms of occupational health and safety in the public service overall. It will be difficult to provide an opinion on the overall health status of public servants. May be PSEMAS will offer such information, but is the information readily available? Moreover, government agencies workplace programme are not robust to go in that detail. But you tell me What are they doing at the Office of the Prime Minister in this regard?".*

How will the HiAP approach, in relation to public servants be introduced? The researcher further probed and one of the interviewees responded: *"In relation to HiAP Public Service Staff Rules offers numerous opportunities for the use of the approach and to be adhere to including aspects related to remuneration, safety in a public building (workspaces),*

wellness services, healthy food, exercise platforms. Implementation of such a rule will result in a cascade".

4.2.3 Objective (iii) - Research findings from the Focus Group Discussion

4.2.3.1 Characteristics of the Focus Group Discussion

The target population for the focus group were people who are knowledgeable and have been involved in HiAP processes worldwide, particularly in Namibia. Participants in the discussions were drawn from the National HiAP Working Group. The latter was constituted following a Cabinet Decision to adopt HiAP in Namibia with the primary role of driving HiAP activities and overseeing the development of a national strategy for HiAP. The group consisting of institutional representatives is attached to this report. An unstructured interview guide containing a leading question to facilitate and guide the researcher during the discussions was used. Discussions were not typed recorded but the researcher took detailed notes and hence no transcription was required.

4.2.3.2 Key Findings of the Focus Group Discussion

An introductory question, '*How did Namibia become aware of and involved in HiAP*? was asked, one respondent said, "*The HiAP approach came to Namibia as a result of the attendance, rectification and report of the 138th Meeting of the Executive Board of the World Health Organisation, 25-30 January 2016 of which Namibia is a member of the WHO".*

Another indicated that: *"Namibia as a member of the WHO rectify the Helsinki Statement on Health in All Policies, and therefore Namibia, as part of the WHO Executive Board Members' 138 Meeting took a collective decision to also adopt and implement the approach".* On probing further, on the question, "*Is the concept of HiAP well understood and accepted in Namibia?*" one respondents said: *"Numerous activities, including a rapid*

assessment and stakeholder's consultations were conducted". Another respondent said: *"There had not been public or population awareness on the introduction of the approach so far. Engagement with various stakeholders, especially government entities, has taken place on numerous occasions".*

Another also said: *"The concept, in my view, is not widely made known in the country. The concept is fairly new and only those directly involved at the Ministerial level are aware".*

On the question "*What was the main driver(s) that led to the adoption of the HiAP approach in Namibia"*? one respondent said: *"Namibia is amongst the top five countries with the highest socio-economic inequalities in the world. As a result of such inequalities health risk factors such as low education level attainment negatively affect those most vulnerable to engage in low income earning jobs which enable them to access proper nutrition, shelter and as a result are predispose to illnesses"*.

Another respondent said: *"A high number of the population live in squatter camps around the county and have no access to basic amenities such as portable water and sanitation, let alone a proper meal a day as many of them only manage to gear an income from a low earning job and or an income generating project such as selling fruits, vegetables and other consumables".*

Another said: *"Overall health outcomes are very poor in the country. Namibian has the highest TB notification and HIV prevalence rates in the world. The nutritional status of children under five is that of poorly malnourished children".*

Whilst another said: *"Poverty is rampant, both in the urban and rural centre to an extent that people are receiving relief food from the government as people are not employed to be able to take care of their basic needs".*

Another respondent said: *"Statistics from WHO indicate that each year, Namibia loses approximately 920,000 productive life-years due to ill-health and premature death as a result of Communicable diseases, Maternal, neonatal, and nutritional disorders, Non-communicable diseases and Injuries. The above-mentioned health and socio-economic attributes are experienced by the most productive members of society". Most of the root cause of the aspect mentioned above falls outside the direct scope of the Ministry of Health and can only be addressed by other sectors. Other sectors are able to address aspects such as household fund production by the Ministry of Agriculture, housing and access to potable water and sanitation by the Ministry of Urban and Rural Development".*

Another related question was '*whether there exists an official directive (policy, programme) on HiAP*. Respondents said that a Cabinet decision directing the MoHSS to put in motion strategies related to the operationalisation of HiAP exists. In addition to the above, respondents were also asked "*What factors, structure and processes are in place to support HiAP leadership*?" A respondent noted that the only structure currently formally available is the HiAP Working Group which consists of public servants in the MoHSS, the Office of the Prime Minister and the National Planning Commission. There is no formal structure dedicated to HiAP at the moment.

On a probing question about "*who is championing the HiAP's efforts?"*, respondents noted that there are no formally appointed champions for HiAp, mainly because the

implementation of HiAP in the country is still in its infant stages. Respondents further said that the success of HiAP in the country, albeit in very small steps has been remarkable and well-received, especially amongst stakeholders.

Upon further probing, respondents indicated that it has been slightly slow to keep the trajectory unhindered mainly because the momentum has not always been consistent, as long as time has passed to do the HiAP activities and hence efforts have not always been sustainable. This has influenced progress so much that earlier efforts are long forgotten and require a complete start-over. By then, institutions have long forgotten their task and need to be reminded which does not always happen.

Another aspect is the absence of dedicated treasury funding for the HiAP activities as financial resources are mainly donor-supported. This is a big hindrance affecting the continuation of HiAP's planned activities.

The researcher further asked "*if there have been collaborative actions amongst stakeholders in the country's HiAP process*". Respondents replied by saying "*Stakeholder workshops were the only platform where engagements were solicited. However, there are no formal structures of collaboration*".

In response to "*What is, to date, the status of the HiAP approach in Namibia*? Respondents said: *"A National Strategy, as per Cabinet directive has been developed and only awaits MoHSS to approve and present it to Cabinet for endorsement".* Another respondent also said: *"As of now, the country has a Draft Strategy on HiAP. The MoHSS will provide directives in relation to the next process".*

In concluding the FGD, the researcher asked respondents "*What have been the biggest successes since the implementation of your HiAP efforts?*". One respondent said: "*The MoHSS was committed to the process*". Another critical success factor mentioned by the respondents was the financial and technical support from the WHO. Participants also indicated that the inclusion of the Prime Minister's office and that of the National Planning Commission was a critical process, especially in the context of the overall implementation of the approach, as a public service offering.

Respondents, upon a request by the researcher, if there were questions from their side, indicated no questions or comments.

4.2.4 Objective (iv) - Research findings of the discourse analysis study

4.2.4.1 Characteristics of articles reviewed

An electronic systematic search of major research online platforms; MEDLINE, Science Direct, SAGE Publishers and Google Scholar, using the phrase '*health statuses of public servants*' was conducted. The search produced 19 appropriate peer-reviewed articles, two (2) of which were substantive about health statuses while the rest focused on singular health issues, social health insurance and the socioeconomic status of public servants. Articles excluded were opinions, news bulletins, press releases magazine articles and those published after the commencement of data collection in 2019.

4.2.4.2 Key findings of the discourse analysis study

Articles retrieved and reviewed employed, predominantly, a quantitative cross-sectional analytic design and utilised computer-aided software for descriptive and logistic regression. Participants in the study were all public servants from different demographic characteristics (ages, educational background, type of employment and income statuses), working in various government institutions with sample sizes ranging from 100 to over a few hundred thousand [54] [53] [12] [199] [200] [201] [202] [203] [204] [205] [206].

Some of the studies were retrospective examinations of public servants' health records – sick leave medical certificates, others were self-administered structured questionnaires and some involved full medical anthropometric examinations [54] [53] [199] [200] [201] [202] [203] [204] [205] [206]. Fewer studies focussed on legislation, policy and management procedures, demand for social health insurance, electronic referrals and health information systems [12] [207] [208] [209].

The above-stated studies publicised that profiling of public servants' health statuses has long been an area of great concern to the extent that governments instituted legislation and policies to regulate the health of employees, including that of public servants [210] [200]. It was earlier reported that countries such as South Africa and Ireland adopted explicit frameworks to manage and control public servants' health [211] [212].

One study on '*sickness absence among health care workers*' discovered that there were no appropriate management guidelines and or legislative/policy measures for occupational diseases [12]. Another on the '*patterns and correlations of obesity among public service workers*' as well as one other on '*factors influencing health-seeking behaviour*', both conducted in Nigeria, made recommendations to develop and implement clear policies and procedures on how to manage public servants' health, targeting the most vulnerable employees, particularly in terms of health-seeking behaviour, extension of health insurance schemes to those in predominantly lower income categories, age and gender-specific interventions [205] [213].

Another study found limited participation and poor knowledge of the health services offered by employees among public servants, recommending, therefore, capacity building, routine awareness raising, and benefits for participating and joining medical schemes in workplaces [209].

A similar study in Ghana, about '*overweight and obesity prevalence among public servants*' makes recommendations for the promotion of nutritional diets, physical activity and healthy lifestyles, at least twice a week, or per the recommendation of the WHO – 30 minutes a day in the workplace [53].

All 19 articles reviewed, except two (2) on the national health insurance studying risk factors, including obesity, hastening non-communicable diseases such as Diabetes and Cardiovascular diseases which subsequently has the potential to negatively influence public servants ability to perform productively, consequently resulting in work incapacity, resulting in sickness absence [54] [53] [12] [199] [202] [203] [204] [205] [206].

One article, which studied '*leave and sickness absence in KwaZulu-Natal*' reported substantial challenges to the delivery of public services, in the health sector, due to prolonged sickness absence [12]. The study indicated that ill health among employees in the public service is not adequately addressed, leading to major absenteeism [12]. The n=151 study recorded 7-8 work-lost days beyond the 2-4 international benchmark, cost value equivalent to over R7,3 million [12].

The above-stated study, albeit with a focus on healthcare workers in the health sector, describes challenges and implications associated with a lack and or absence of legislative/policy and or ill-health management guidelines [12]. The South African government, apart from the above-stated framework, developed a policy on how to manage sick leaves and retirement as a result of ill health [12]. The study suggests that sick leave management is largely managed by external entities (Physicians) with little involvement of the public service, apart from the provision for sick leave cycle [12].

Absenteeism, due to prolonged illness, as well the influence on work incapacity is stated among the main reasons and or motivation to conduct routine health examinations among public servants [54] [53] [12] [199] [202] [203] [204] [205] [206].

Other reasons, for carrying out periodic health examinations among public servants, were to promote the health of employees to boost performance, and productivity, reduce profit losses as well and reduction of employees' costs due to care and or absenteeism due to ill health [12] [199]. Occupational workplace health surveillance is critical for devising targeted interventions, but many countries, including South Africa, lack explicit surveillance occupational systems, largely relying on epidemiological profiles which are similar to these research studies being reviewed, national health labour information and compensation for occupational injuries and disease system, if any [214].

Epidemiological profiles are considered a critical indicator of determining the prevalence of health patterns amongst employees [199]. A retrospective (2010 – 2013) epidemiological study, from which data was extracted from medical leave certificates, among public servants in Santa Catarina was conducted to examine the profile of mental and behaviour disorders [199]. Over 40% of 79,306 medical certificates were for the above-stated course (mental and behavioural disorders) [199].

Occupational workplace health surveillance, is, therefore, another common and most preferred mode of collecting public servant's health status information [12] [199]. Workplace health surveillance are statutory prescription in many countries around the world, either as part of OHS legislation and or administrative procedures [214]. Articles reviewed herein recommend clarity of the health surveillance required, as well as additional research, specifically about public servants' levels of awareness of occupational health, roles and responsibilities of the government, as an employer, towards the health of their employees and creation of user-friendly technologies such as e-health electronic systems [215] [207] [208].

In relation to Namibia, health status profiling literature, explicitly for the Namibian public service, is scanty. There exist, however, legislative provisions to collect health status data during recruitment and provision of health care services. Activities about health status data are governed through the Public Service Act, Act 13 of 1995, under sections 5, 18, 34 and 35 [216]. Section 18(2)(b) states that *"a person appointed in a permanent capacity must be free from any disease or physical or mental defect likely to materially interfere with the proper performance of his or her duties"* [216, p. 20].

The above statutory and regulatory provision is further expanded, through regulation 8(1) and (2) of Regulation 211 of 1995 which relates to medical examination upon request in a designated form as recommended by the Public Service Chief Administrator, who is the Prime Minister [217]. This particular provision also extends such medical examination of physical fitness in the instance of requiring workstation suitability [217].

Broadly, the afore-mentioned provision requires that each potential permanent employed public servant should undergo a pre-determined self-rated health questionnaire and only in instances where health questionnaires do not provide an absolute or conclusive state of health would the potential public servant be subjected to a medical examination [218].

The provision of the Public Service Act further states that: *"A public servant dismissed from the public service on the grounds of continuous ill-health cannot be appointed again in a permanent capacity, but can be re-appointed temporarily or part-time"* [218, p. 3]

The interpretation of the aforementioned provision, unlike the one on recruitment and medical examination, expanded in an administrative provision referred to as the Public Service Staff Rule, is unfortunately not explicitly expanded. The rule might have some

implications in that the permanent exclusion from employment might result in an inequitable unjust judgement, especially in cases where medical intervention proves to improve the health condition of a rather young employee, dismissed on medical grounds.

In specific reference to health status data, the self-rated health questionnaire, discussed in preceding paragraphs, seeks to collect the following health-related data: '*height, weight, skin disorder, affections of the skeleton or joins, affections of the eyes, ears, nose, speech, or teeth, affections of the heart and circulatory system, affections of the chest and or respiratory system, affections of the digestive system, affections of the urinary system and or genital organs, nervous affections or mental abnormality, any other illnesses, physical disability or handicapped, other serious operations'* [218].

Potential public servants who state an anomaly to the norm have or had suffered from the above-mentioned conditions are expected to be medically examined and deemed to have recovered before being appointed permanently, as indicated earlier. The Public Service Handbook defines a public servant as *"someone who serves the public" and "any person who works for any part of the central, regional or local Government, or for a parastatal"* or *"any one person employed in any Office, Ministry or Agency (O/M/A) of the Public Service of the Republic of Namibia"* [219, p. 19].

Another study used the term *'civil servants', a term* used interchangeably with the term *'public servants'*. This study adopted the terminology '*public servants'*.

4.3 QUANTITATIVE RESEARCH FINDINGS

4.3.1. Objective (v) - Research findings of the cross-sectional survey

4.3.1.1 Demographic characteristics: Response rate and gender representation

From an estimated n=351 sample size, n=346 employees returned the questionnaires, giving a response rate of 98.6%, n=186 (53.8%) females and (45.7%) males. Forty-four-point-eight per cent (44.8%) of the total respondents were from the Windhoek main office.

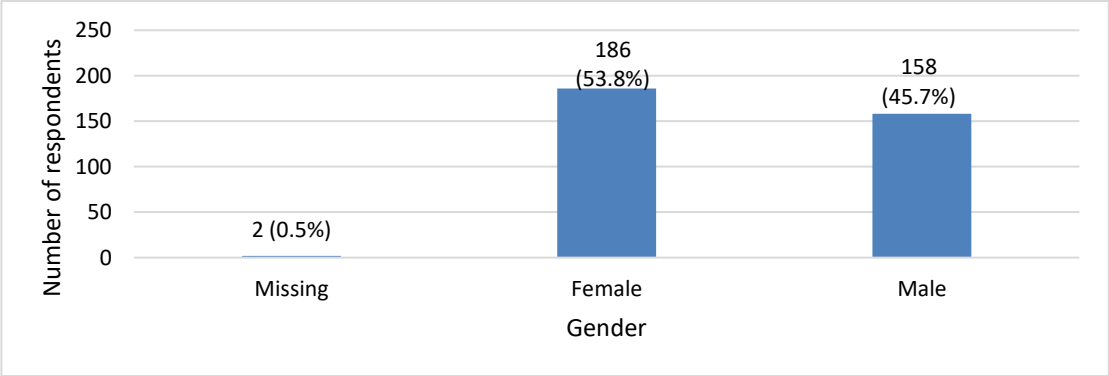


Figure 4.1: Number of respondents by sex

4.3.1.1.2 Educational attainment

Sixty-five percent (65%) of the respondents attained tertiary education whilst 27.7% had attained secondary education.

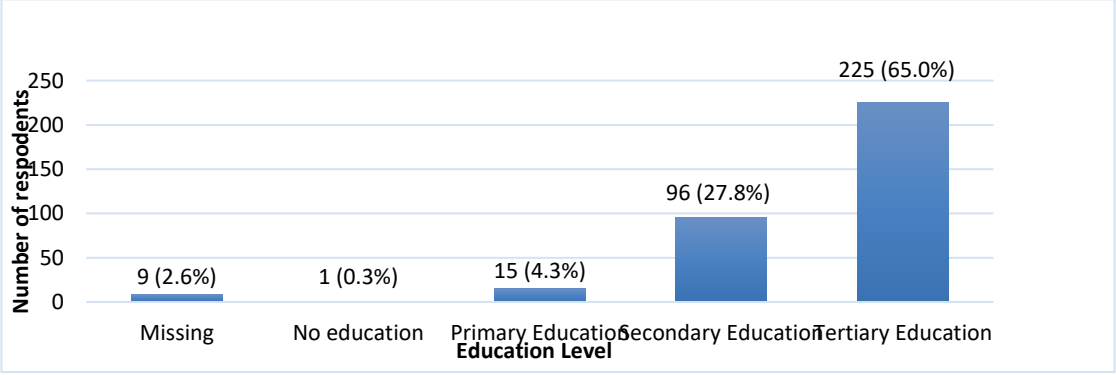


Figure 4.2: Educational attainment

4.3.1.1.3 Job grading and job position

In terms of job grading, an element associated with salaries and position, 20% were in the lower 12th job category, and 17.1% were in the 10th grade (there are 15 ascending job grades with 1 being the greatest). A majority 29.5% were in administrative work, 22.8% in Technical/Specialised work whilst only 4.0% were in managerial positions.

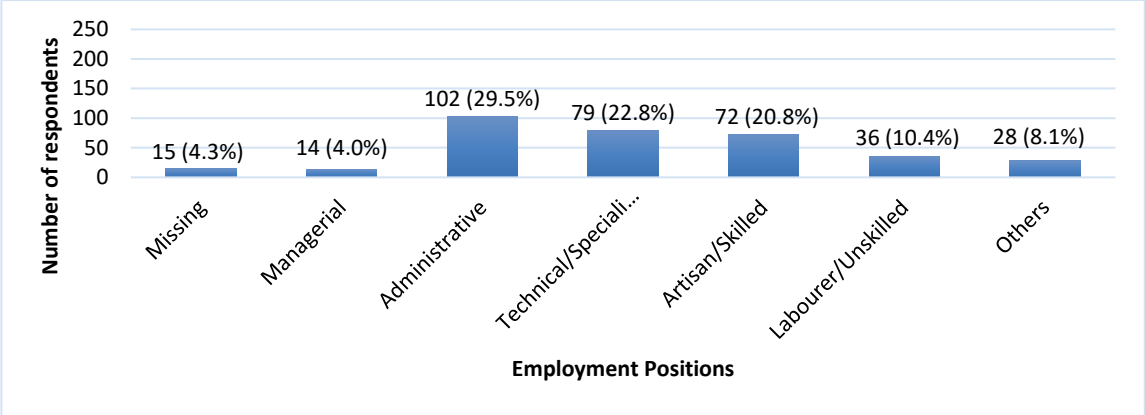


Figure 4.3: Respondents' job grading and job positions

4.3.1.1.4 PSEMAS membership

Ninety-three-point four per cent (93.4%) were members of PSEMAS, a medical aid scheme for public servants in Namibia.

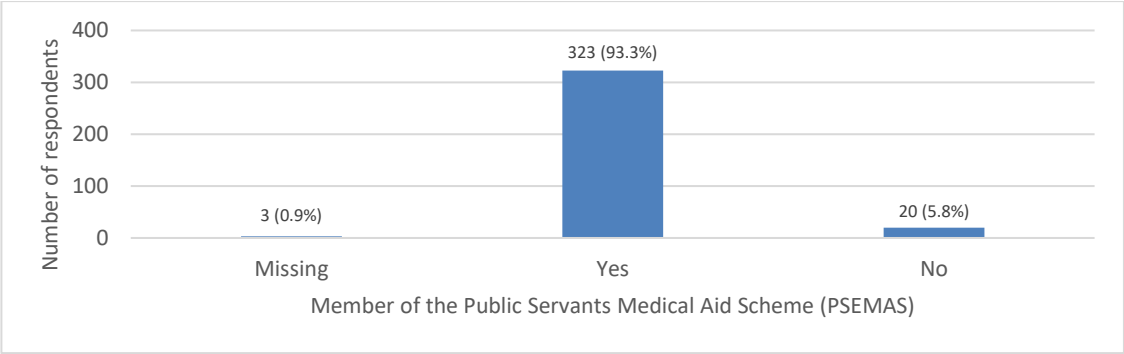


Figure 4.4: Respondents membership in PSEMAS

4.3.1.1.5 Income categories

Almost forty per cent (39.6%) of the respondents indicated a monthly income range of N$ 10,000.00-N$20,000.00, 26.6% (N$ 5,001.00-N$10,000.00), less than 5% range (N$ 40,001.00) (4.3%) and 0.6% indicated a monthly income less than N$3,500.00.

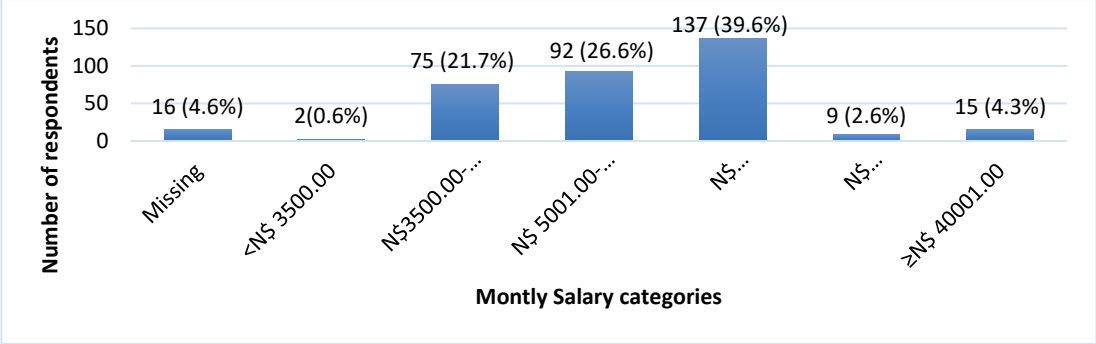


Figure 4.5: Respondents' income categories

4.3.1.1.6 Housing, sanitation and potable water

The majority (81.8%) of respondents resided in brick houses, and 16.8% resided in Zinc/Corrugated iron houses. Another majority (62.4%) resided with 3-6 household members and 3.5% had at least 11 household members. Over seventy per cent (70.8%), 78%, and 85.8% had access to water, flushing toilets, and electricity in their places of residence respectively.

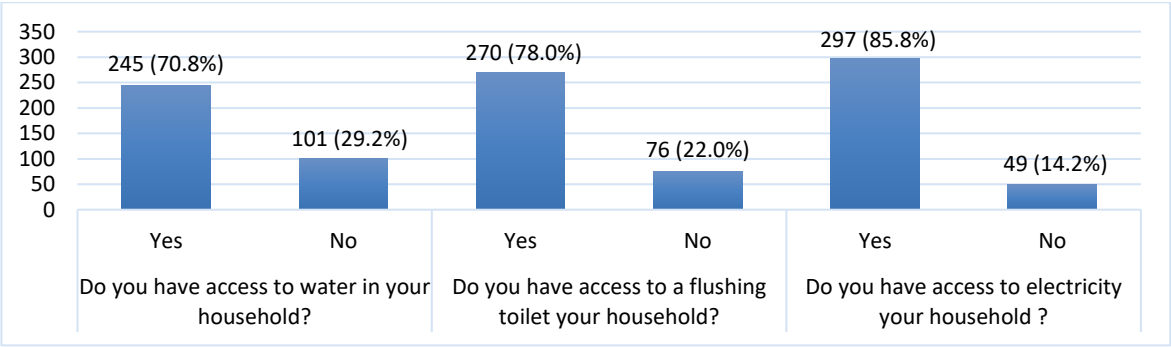


Figure 4.6: The status of respondents' housing, sanitation and potable water status

4.3.1.2 Health status characteristics

4.3.1.2.1 General health

Forty-eight per cent (48%) self-reported their general health as *'good'*, 22% as *'very good'*, 13.2% as *'excellent'*, 12.7% as *'fair'* and 1.2% as '*poor'*. Of those who rated their general health as poor, 54.17% (n=26) were females and 45.83% (n=22) were males. Those who rated their health as good n=157 (54.90%) were females and n=129 (45.10%) were males.

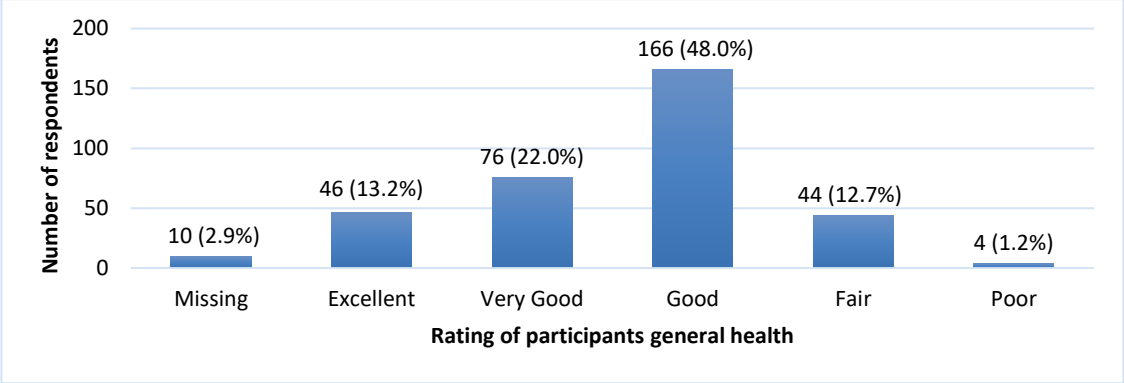


Figure 4.7: Overall general health of public servants

4.3.1.2.2 Health conditions and treatment

Table 4.2: Status of High Blood Pressure/Hypertension amongst respondents

		Has high blood pressure/hypertension been treated?			
		Missing	**Taking medication**	**Diagnosed not taking medication**	**Total**
High blood pressure/ hypertension	**Missing**	19(100%)	0(0%)	0(0%)	19(100%)
	Yes	11(11.7%)	60(63.8%)	23(24.5%)	94(100%)
	No	221(100%)	0(0%)	0(0%)	221(100%)
	Never tested	12(100%)	0(0%)	0(0%)	12(100%)
	Total	263(76.1%)	60(17.3%)	23(6.6%)	346(100%)

Twenty-seven per cent (27%) n=94 [of which n=37 (39.36%) and n=57 (60.64%) were males and females, respectively] had High Blood Pressure/Hypertension of which 17.3% of the 27% of the 27% were on treatment. A low (below 5%) diagnosis of Diabetes and

Cholesterol was reported, overall. Seventeen per cent (17.1%) indicated suffering from Low back disease/ Back spine pain, and 15.3% from Stress/Anxiety/Depression. Of those who reported a diagnosis of other health conditions such as Elevated cholesterol/Cholesterol (4.6%), Low back disease/Back spine pain (7.2%) and Stress/Anxiety/Depression (10.7%) were not on treatment. The majority of respondents (63.9%) showed High Blood Pressure/Hypertension, Elevated Blood Sugar/Diabetes (76.3%), Elevated Cholesterol/Cholesterol (70.5%), Low back disease/Back spine pain (66.5%), Stress/Anxiety/Depression (61%) and or any other health conditions.

4.3.1.2.3 Estimated weight and height

Respondents' weight measurements were between 36kg to 160kg whilst their height in centimetres ranged between 56.70 cm and 198 cm. The estimated weight and height were computer calculated into a Body Mass Index (BMI) score calculated by dividing the person's weight in kilograms by the square of the person's height in meters $\frac{kg}{m^2}$ as per WHO's stipulations. Respondent's weight measurements that were provided were firstly converted to metres before computing their BMIs. Thirty-two point nine per cent (32.9%) had a normal BMI, 27.5% respectively, had a BMI between 25 and 29.9 indicative of being overweight (of which 52% and 49% were females and males respectively) whereas 27.2% (of which 57% and 43% were females and males respectively) had a BMI of over 30 which is classified as obese.

Table 4.3: Respondents' BMI classified by sex

Gender	<18.5	18.5-24.9	25-29.9	>=30	Total
Female	8 (42.11)	57 (50.44)	49 (51.58)	54 (57.45)	168 (52.34)
Male	11 (57.89)	56 (49.56)	46 (48.42)	40 (42.55)	153 (47.66)
Total	19	113	95	94	321

4.3.1.2.4 Disabilities

Twenty-one per cent (21%) n=73 (of which 52% and 49% were females and males respectively) reported living with a disability: eyesight, arms and leg amputation, big toe (gout), partial paralysis. The majority of respondents indicated having eyesight problems.

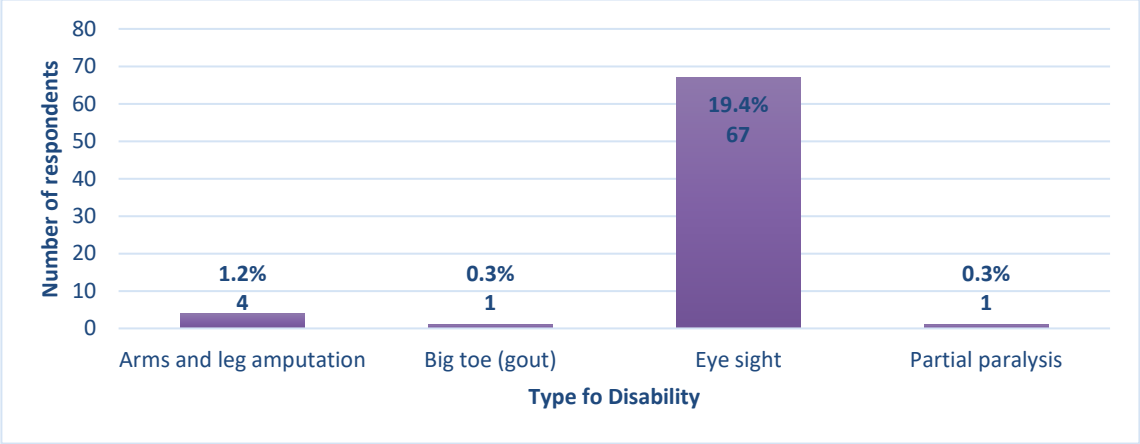


Figure 4.8: Disabilities types reported amongst respondents

4.3.1.2.5 Nutritional status

Only 7.5% of the respondents reported filling their food plate with half fruits and vegetables during every meal as recommended by the WHO, 49.7% do that sometimes, 11% and 10.7 % rarely and never fill their food plate with half fruits and vegetables during every meal.

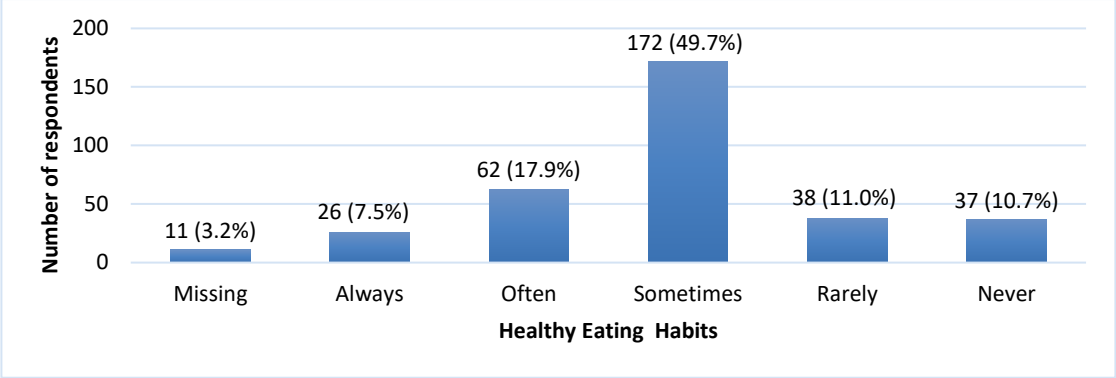


Figure 4.9: Nutritional behaviour amongst respondents

4.3.1.2.6 Physical activities

The majority 46.5% of the respondents occasionally/sometimes do recommend routine physical activities of 30 minutes two to three times a week, 22% do physical activities often, 13.9% always do physical activities 5.8% never engaged in physical activities.

Table 4.4: Physical activities among respondents classified by sex

	Physical Activities					
Gender	**Always**	**Never**	**Often**	**Rarely**	**Sometimes**	**Total**
Female	28 (58.33)	8 (40)	39 (51.32)	15 (57.69)	89 (55.63)	179 (54.24)
Male	20 (41.67)	12 (60)	37 (48.68)	37 (48.68)	71 (44.38)	151 (45.76)
Total	48	20	76	26	160	330

4.3.1.2.7 Status of smoking and alcohol consumption

The majority 85.8% of the participants do not smoke, and 67.6% neither consume alcoholic substances as opposed to 11.6% of those who smoke and 27.5% consuming alcohol.

Table 4.5: Status of smoking amongst respondents classified by sex

	Do you currently smoke		
Gender	**No**	**Yes**	**Total**
Female	166 (56.27)	16 (40)	182 (54.33)
Male	129 (43.73)	24 (60)	153 (45.67)
Total	295	40	335

Table 4.6: Status of smoking amongst respondents classified by sex

	Do you currently consume alcoholic substances?		
Gender	**No**	**Yes**	**Total**
Female	144 (62.07)	31 (32.63)	175 (53.52)
Male	88 (37.93)	64 (67.37)	152 (46.48)
Total	232	95	327

4.3.1.2.8 Levels of stress (question 25, 26, 27)

Self-reported stress during the past two weeks was experienced some days among 55.2% of the respondents, and about 31% never experienced stress. Similarly, only 26% of the respondents felt depressed during the past two weeks of responding whilst 57.2 never felt depressed. Moreover, 52.6% of the respondents were never mind-blocked, but 40.5% reported a bit of stressful workdays and 35% home stressful days. The majority 39.6% and 32.9% reported that they had no hard time doing their jobs, respectively.

4.3.1.2.9 Muscular-skeletal pain-related health status (question 28)

The majority, a combined 62.7% of the respondents reported no pain, numbness, aching or tingling sensation on their hands/wrists the past three months, 52.3% on their upper back, shoulder and neck, 65.4% on their lower back, 60.1% in their knees and 56.9% in their feet. On the contrary, a combined 30.6% have, in the last 3 months experienced pain, numbness, aching or tingling sensation in their upper back, shoulder and neck and 28% in their lower back.

4.3.1.2.10 Sleeping status

The majority of the participants (54.9%) had no trouble sleeping as a result of work-related physical or emotional encounters the past three months and 48.6% rated their sleeping quality/pattern on a typical night as fairly good with the majority 33.5% and 26.9% sleeping 7 to 8 hours per night.

4.3.1.3 Workplace safety, health and wellbeing

4.3.1.3.1 Importance of employee's health, safety and wellbeing

Slightly over thirty-three per cent (33.8%) of the respondents agreed that management considers employees' health, safety, and well-being as an important factor as opposed to 13.6% and 10.4% who disagree and strongly agree respectively. In addition, 28.3% agreed that the ministry does provide opportunities for the workers to live a healthy lifestyle as opposed to the 20.8% who disagreed. Noted, however, was 25.7% of the respondents who neither agree nor disagree (neutral).

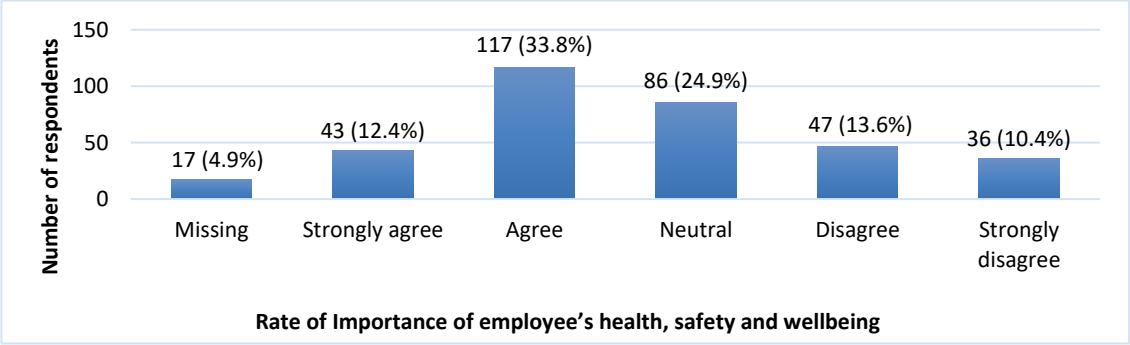


Figure 4.10: Respondents' perspectives on health, safety and well-being

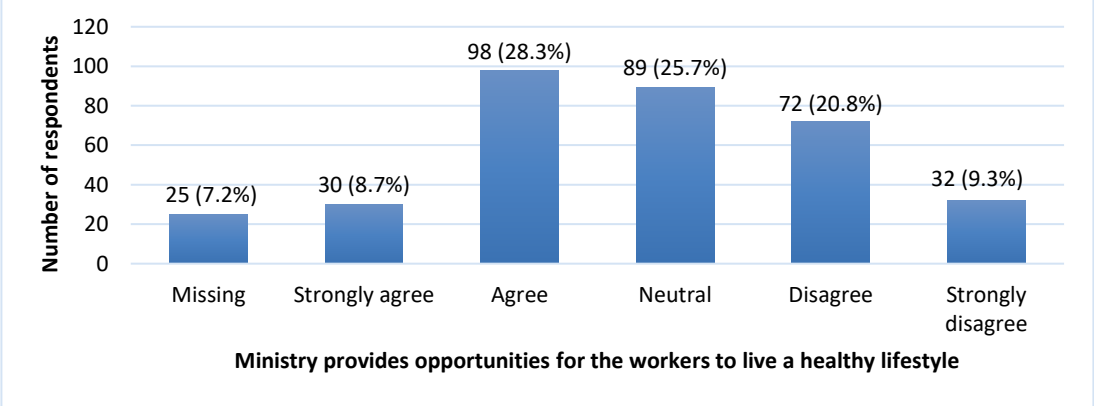


Figure 4.11: Respondents' perspectives on healthy lifestyle opportunities

4.3.1.3.2 Opportunities offered by the employer for health and wellness activities

In terms of opportunities to enhance health and wellness in the workplace, most participants disagree that the Ministry offered physical activities (23.4%), 26.6% disagreed that the Ministry offered motivation on healthy eating, 27.5% disagreed (only about 18.2% agree) that the Ministry offered a tobacco-free zone, and 31.5% and 22% disagree and strongly disagree that the Ministry offered opportunities to manage stress respectively.

Table 4.7: Opportunities offered by the employer

		Missing	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Total
The Ministry offers session(s) on physical activities to enhance wellness	**Frequency**	18	23	73	88	81	63	346
	Per cent	5.2	6.6	21.1	25.4	23.4	18.2	100.0
The Ministry offers motivation on healthy eating to enhance wellness	**Frequency**	21	17	79	77	92	60	346
	Per cent	6.1	4.9	22.8	22.3	26.6	17.3	100.0
The Ministry offers tobacco free zone to enhance wellness	**Frequency**	26	31	63	60	95	71	346
	Per cent	7.5	9.0	18.2	17.3	27.5	20.5	100.0
The Ministry offers education on substance misuse to enhance wellness	**Frequency**	30	20	51	77	102	66	346
	Per cent	8.7	5.8	14.7	22.3	29.5	19.1	100.0
The Ministry offers opportunities to manage stress to enhance wellness	**Frequency**	27	23	46	65	109	76	346
	Per cent	7.8	6.6	13.3	18.8	31.5	22.0	100.0

4.3.1.3.3 Health and wellness activities offered by the employer

Thirty per cent (37%), as well as 39.6%, noted that the Ministry offered Blood Pressure and Blood Sugar screening activities as well as celebrated the World AIDS Day Celebration in the last 12 months at the workplace. Forty-two point eight percent, however, reported that the Ministry did not conduct a Sport and Wellness Day event in the last 12 months.

Table 4.8: Respondents' perspectives on health and wellness offered by the employer

Variables	Categories	Frequency	Percentage (%)
Has your Ministry offered, additionally, screening for blood pressure and blood sugar activities in the last 12 months at the workplace?	Missing	24	6.9
	Yes	128	37.0
	No	130	37.6
	Never	44	12.7
	Not sure	20	5.8
Has your Ministry offered, additionally, World AIDS Day Celebration in the last 12 months at the workplace?	Missing	15	4.3
	Yes	137	39.6
	No	136	39.3
	Never	38	11.0
	Not sure	20	5.8
Has your Ministry offered, additionally, sports and or Wellness Day events in the last 12 months at the workplace?	Missing	23	6.6
	Yes	117	33.8
	No	148	42.8
	Never	38	11.0
	Not sure	20	5.8

4.4.1.3.4 Participation in workplace wellness programmes offered by the employer

A third, approximately 27.7% of the participants reported that they never participated in workplace wellness activities offered by the Ministry and a majority 35% only participate sometimes whilst 17.6% do so occasionally.

Figure 4.12: Respondents' participation rate in wellness programs

4.3.1.3.5 Suggested health promotion programme to be offered by the employer

Question 36: Health promotion programme(s) you would like the Ministry to offer as part of the workplace wellness activities.

Table 4.9: Respondents' health promotion programme to be offered to the employer

		Frequency	Per cent			Frequency	Per cent
Program 1	*Missing*	*118*	*34.1*	**Program 2**	*Missing*	*159*	*46.0*
	Diseases	49	14.2		Diseases	40	11.6
	HIV & AIDS	12	3.5		HIV & AIDS	13	3.8
	Safety	16	4.6		Safety	15	4.3
	Wellness	151	43.6		Wellness	119	34.4
	Total	346	100.0		Total	346	100.00
Program 3	*Missing*	*215*	*62.1*				
	Diseases	30	8.7				
	HIV & AIDS	4	1.2				
	Safety	21	6.1				
	Wellness	76	22.0				
	Total	346	100.0				

4.4.1.3.6 Health and safety compliance (question 37)

Nearly twenty per cent (19.9%) of the participants agree that their duties often interfere with their ability to comply with safety whilst another 19.7% were neutral on the issues. However, 28.6% disagreed. In addition, 30.9% agree that safety was a high priority with

their supervisors and 32.9% agreed that employees at their work complied with the safety measures.

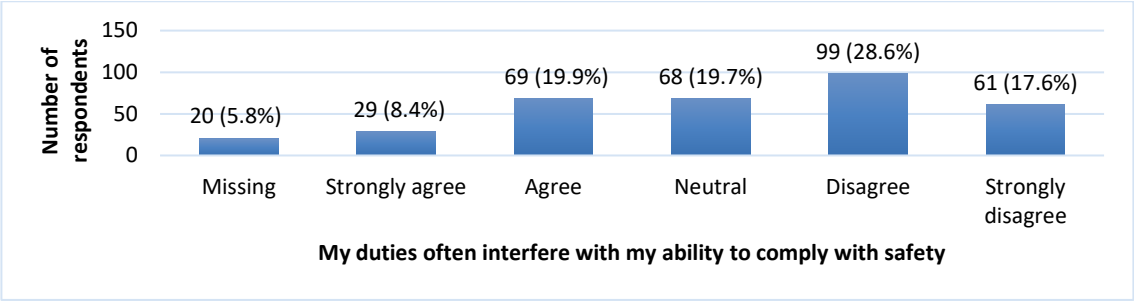


Figure 4.13: Respondents' opinion on safety and health regulations compliance

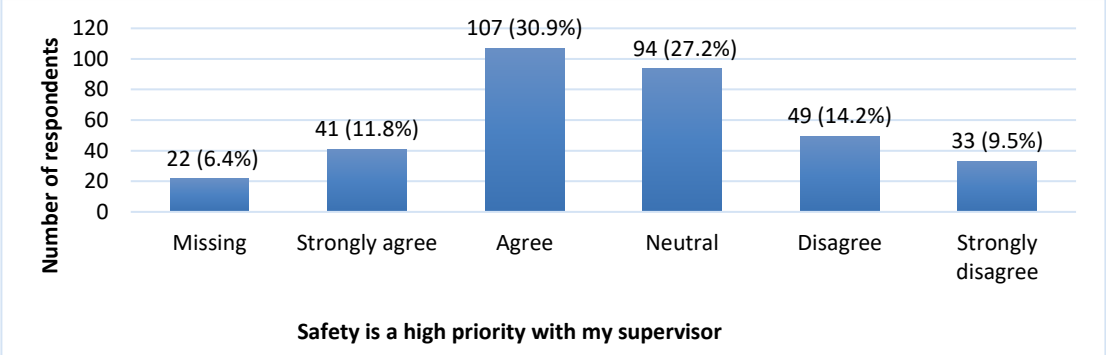


Figure 4.14: Respondents' opinion on supervisors' safety priority

4.3.1.3.7 Emergency exit and evacuation (question 38 – 39)

The majority 64.2% of the participants knew how to exit their workplaces/buildings in case of an emergency such as a fire or flooding. However, 53.5% indicated that their workplaces do not have a visible emergency evacuation plan displayed.

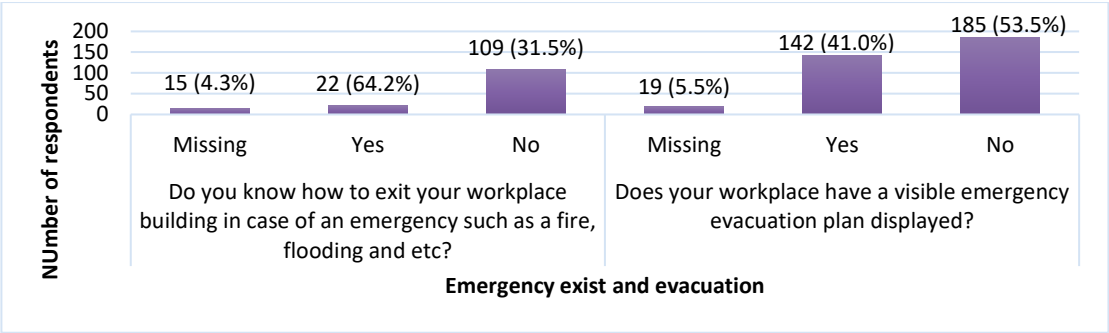


Figure 4.15: Knowledge about exit and evacuation during emergencies

4.3.1.3.8 Overall job satisfaction (question 40)

Slightly over forty percent 43.4% of the participants reported that they got satisfaction from their jobs whilst almost the same percentage (42.5%) would recommend working for their Ministry to anyone.

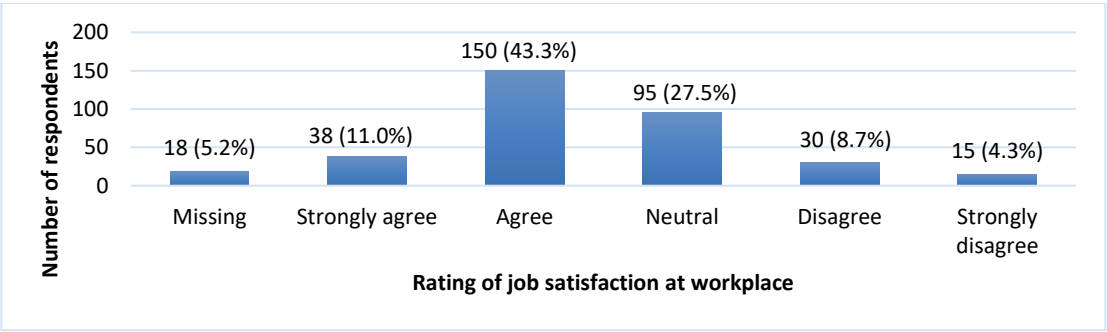


Figure 4.16: Respondents' overall job satisfaction levels

4.3.1.3.9 Travelling to and from work

In relation to the time used to travel to and from work, 46.8% of the respondents travel between 15-30 minutes, 23.4% travel <15 minutes whilst 17.9% travelled between 30 – 60 minutes each day.

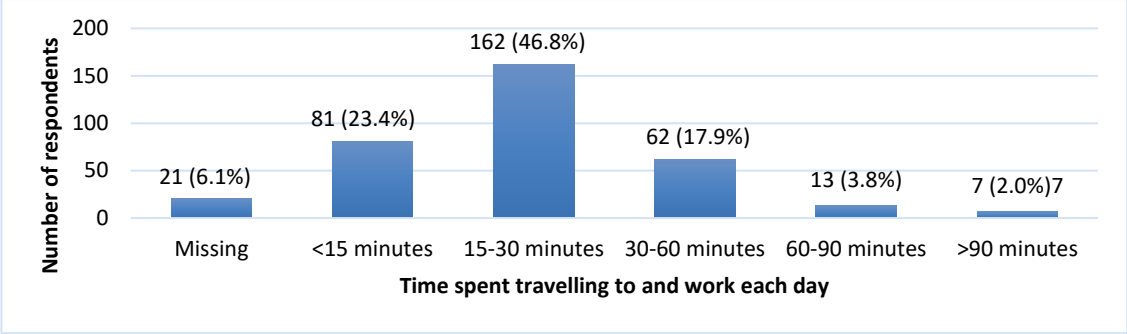


Figure 4.17: Respondents' travelling – distances to and from work

4.3.1.4 Knowledge of HiAP

The majority (65.9%) of the respondents have not heard of HiAP as opposed to 24.9%.

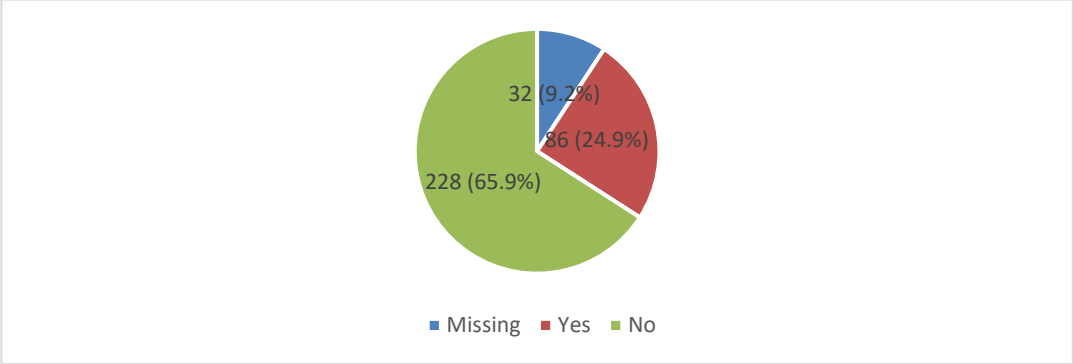


Figure 4.18: Respondents' overall knowledge about the HiAP approach

Those who heard of HiAP provided the following descriptions of HiAP: Have not been taken serious, As important activities, body fitness and living health, Determine health in all policies knowledge, Develop a guide for proper introduction and implementation of the developed health in all policies HiAP conceptual framework, disability and hospitality, Employees health and safety and wellbeing at work place, Essential and comprehensive, Fair, Good, Health at the work place, Health is the most important aspect at work place have healthy workers, Health policies is very important, HiAP sounds caring, I don't know what is HiAP, I need more information about HiAP, in the field of health, informative is

a collaborative approach that integrates and articulates health considerations into policy making across sectors to improve health for all, is a complete physical, mental and social stable, is an approach to policies across sectors that systematically take into account the health implication of decisions, seeks synergies and avoids harmful health impacts in order to improve population health and health equity, it is a collaborative approach that integrates and articulates health for all communities and people, it is a good thing to be done and implemented, it is good to know our status, it is the welfare of public servants in Namibia, it is very important to have a healthy employee because if employees are not healthy it will affect the production, it is a key measure in all policies that play a role to all of us worldwide, It is very important and all people need to be educated or informed about how important it is to be healthy, Make it part of every activity by always considering it first, Need to be revised, No idea, Not clearly rolled out all levels of position, not well described, Physical and mental health, Run, Take care of your health and yourself, The health is remarkable to all members, The issue of health in all policies conclude safety health environment as well as procedures, To keep the wellbeing of people's body, To practice and stay healthy at your healthy place, Very good, Very important, Very poor, Wash hands, flush toilets, Wear protective clothes given, Wash your hands regularly, Well-motivation information

4.3.2. Objective (vi) - Research findings of the KAP survey

4.3.2.1 Demographics characteristics of study subjects

A total of 50 participants n=31 females (62%) and n=19 males (38%) mainly from the Khomas region, completed the KAP questionnaire. Whilst 100% had a tertiary qualification only 26% (n=13) had a qualification relevant to Occupational Health and Safety.

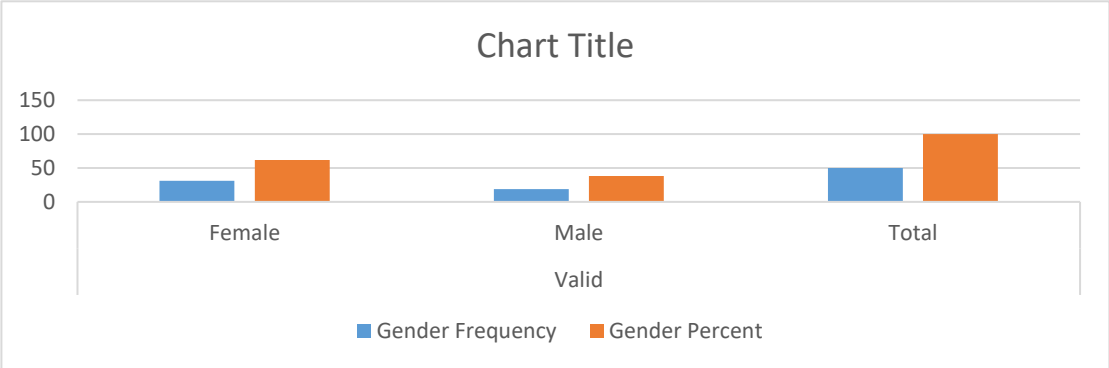


Figure 4.19: Sex of participants in the KAP survey

The majority 26% (n=13) and 24% (n=12) were graded at levels eight and six, respectively. However, only n=1 (2%) held a job designation titled Wellness Officer, and the majority n=13 (26%) job title was HR practitioner. Other job titles were messenger, secretary, driver, IT technician, and learning officer. The majority n=29 (58%) of the respondents rated public servants' overall health as good whilst 26% said it was fair.

Table 4.13: Relevant qualification to occupational work and position

	Do you have a qualification in Workplace Employee Wellness, Occupational Health and Safety?			
Type of work	**No response**	**Yes**	**No**	**Total**
Managerial	0	1	5	6
Administrative	1	6	26	33
Technical/Specialized	0	3	3	6
Artisan/Skilled	0	1	1	2
Others	1	2	0	3
Total	2	13	35	50

Almost all, 88% of the respondents were members of PSEMAS and had an average of 2-4 days absenteeism due to ill health. Respondents further indicated that 54% (n=27) of the institutions they represent have no formal OHS Division, but in n=43 (86%) of the institutions represented had Wellness Committees. The respective institutions represented provide various workplace wellness activities.

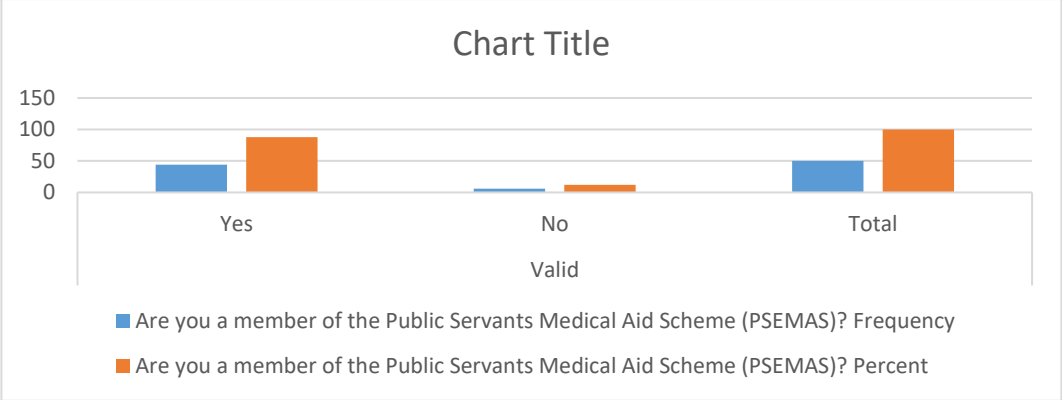


Figure 4.20: Participants status of PSEMAS membership

4.3.2.2 Participants' Knowledge of the Health in All Policy (HiAP)

Seventy-four per cent (74%) n=37 of the respondents had not heard about HiAP and neither are they aware of anyone in their respective institution with knowledge of HiAP. Of those who indicated knowledge of HiAP, (36%) were employed in the administrative field. Thirty-nine per cent (39%) are not aware of any Cabinet policy directive on HiAP,

whilst 24% (n=12) indicated that the MoHSS was the institution responsible for driving the HiAP approach in the country.

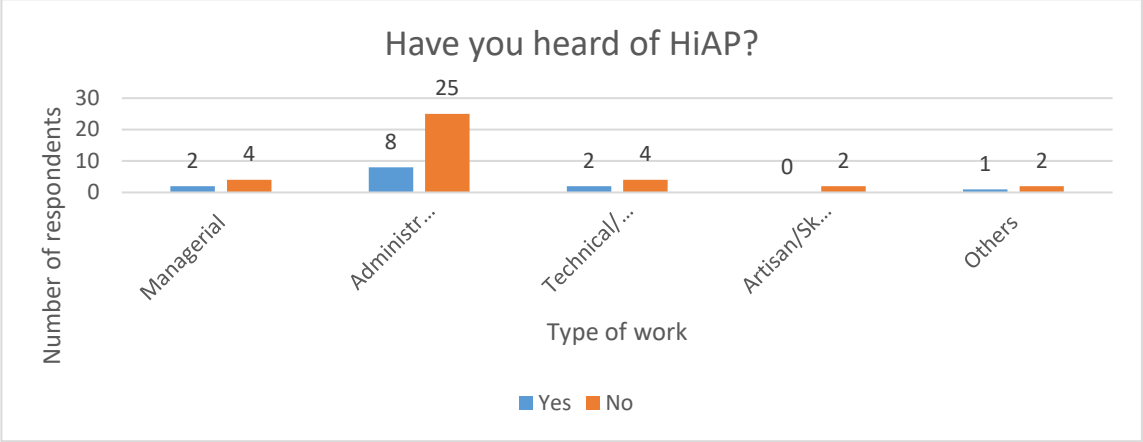


Figure 4.21: Respondents' knowledge of HiAP

Seventy-six per cent (76%) n=38 indicated that the Namibian population overall, had no knowledge of HiAP or were familiar (84%) with the concept of HiAP. Forty per cent (40%) reported that the HiAP concept was not accepted whilst 44% indicated the opposite. Eighty-two per cent (82%) and 72%, respectively, had not received or read HiAP-related materials. Of those who have received (2%) and read HiAP (6%) related materials have participated in national HiAP-related activities. The majority, 96%, will welcome HiAP-related materials such as materials on what HiAP entails. The majority, 68% never heard of SDH whereas ninety-two percent (92%) were confident that HiAP will contribute to public servants' health.

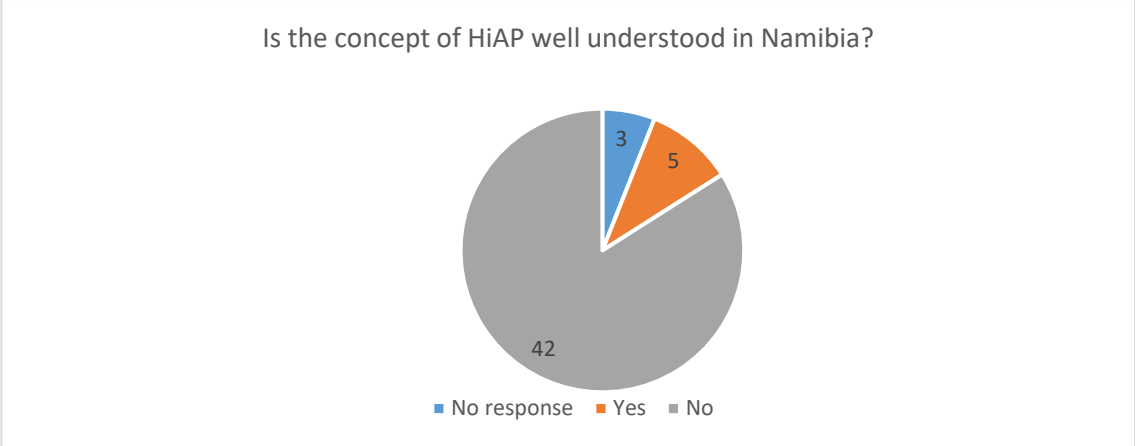


Figure 4.22 Respondents' perception of how HiAP is understood in Namibia

4.3.2.3 Participants' attitudes towards the Health in All Policy (HiAP) approach

The majority of the participants, 92%, indicated that HiAP can be used to address public servants' health, including diseases, 62%, mental health issues, 74%, smoking cessation 30% and adopting a healthy lifestyle 74%. Ninety per cent (90%) of the participants further indicated that HiAP can be used to address public servants' health risk factors 90% such as issues related to Gender Based Violence (GBV), water and sanitation (56%), financial literacy (66%), housing (34%) and transport-related aspects were 16%.

Table 4.14 HiAP Processes in country

Which of the following HiAP Country processes has you/they participated in		**No response**	**Yes**	**No**	**Total**
HiAP Working Group activities	Frequency	43	5	2	50
	Per cent	86	10	4	100
HiAP Stakeholder Consultation Workshop	Frequency	42	6	2	50
	Per cent	84	12	4	100
HiAP Stakeholder Consultation Workshop	Frequency	42	6	2	50
	Per cent	84	12	4	100

4.3.2.4 Participants' perspectives on practices around the Health in All Policy (HiAP)

Only 10% of the participants and 14% of the represented institutions participated in the country's HiAP activities. Neither were the majority, 88%, aware of the Draft National Strategy on HiAP. Ninety-four per cent (94%) are willing to take part in HiAP activities and 72% indicated that their respective OMAs will have a definite role to play in national HiAP-related aspects such as advocacy, data collection, relationship building, inter-sectoral action and behaviour change.

4.4 SUMMARY

The researcher, in this chapter, presented qualitative and quantitative results collected using document analysis, in-depth interviews, FGD, discourse analysis and cross-sectional survey technique methods. The study revealed the existence of numerous sources of data containing public servants' health status information and useful for the exercise, although the aforementioned sources were fragmented.

Key informants confirmed the existence of the above-mentioned sources, but indicated that there exists no explicit OSH framework to guide the utilisation of such sources. Informants as well as FGD participants, further indicated that HiAP will be an appropriate approach for guiding health status profiling. Exploration of the discourse on best modalities to profile public servants' health statuses indicated health records as well as epidemiological surveillance amongst the most common methods used in the workplaces.

Quantitative data from the cross-sectional survey conducted in the MWT established the prevalence of Hypertension, Diabetes, and mental afflictions as well as numerous health

risk factors such as smoking, obesity and consumption of alcohol. The same study found that workplace programmes are currently offered, however, uninformed by public servants' health status Another survey, the KAP study revealed poor HiAP knowledge among public servants' wellness officers overall.

CHAPTER FIVE: DISCUSSIONS OF RESEARCH FINDINGS

5.1 INTRODUCTION

Research results pertaining to the study phenomenon and in particular the health statuses of public servants and its relation to using the HiAP approach as a guiding mechanism presented in Chapter Four are herein analysed, discussed, interpreted and presented. Analysed data was thereafter merged, synthesised and further analysed into one study. The evidence presented in this chapter is very crucial towards achieving the ultimate purpose and objectives of this study. Qualitative results are presented first, followed by quantitative, and thereafter the synthesised results.

5.2 DISCUSSION OF STUDY RESULTS

5.2.1 Objective (i)

Documents reviewed revealed numerous sources of data collecting public servants' health information in the NPS. Types of health information collected include a health questionnaire covering respiratory, circulatory, digestive, and nervous, as well as conditions of the skin, skeletal, dental, genitals and of the eyes, ears, nose, speech, urinary tract, disability, height and weight, during recruitment. The latter is collected as per the Public Service Act (Act 13 of 1995).

Above stated findings corroborated with the longest civil servants' health statuses study commenced in 1967 which assesses *demographic information* (age, education levels, marital status), *health outcome*s (disease history, recent symptoms, sickness absence leave, stress levels, etc.); *lifestyle* (exposure to risk factors – smoking, substance use),

work and or employment status (type of work, income level, work hours/shift, etc.) [51]. The Whitehall study stated above is conducted in many first-world countries and is similar to many more studies which also gather health-specific conditions including: '*overweight and obesity'*, '*non-communicable diseases*' and '*mental disorders*', in addition to those reported in the Whitehall study [51] [54] [53] [204] [206] [220].

Documents reviewed further revealed the collection of vital health information such as morbidity and mortality rates reported in annual reports. There was specific literature on demises and morbidity information. There was, however, literature pertaining to the management of sick leave, medical certificate records for both acute and chronic conditions, as well as those on mental health. Health information derived from the leave management system and employees' medical aid scheme, all required targeted permission from relevant authorities as per the reviewed literature. For instance, a study in the RSA about the challenge of incapacity sick leave concluded that management of such leave must be outsourced to private institutions due to a lack of capacity in the public service as well as limitations in the curriculum of health professionals training in management courses [12]. The study acknowledges institutional approaches and administrative measures pertaining to sick leave absence but indicates the absence and continued monitoring and management of those affected [12].

Medical aid schemes for public servants, in some countries, referred to as social health insurance, aimed to defer a portion of health care cost to governments, with minimal out-of-pocket upfront payments from the members, are a common practice and a form of service benefit and or conditions of employment in Southern African and the world over [221] [222].

5.2.2 Objective (ii)

Interviews conducted with three managers in the public service produced, broadly, three aspects, which turned into themes about their views regarding HiAP and how the approach relates to the HSs. Those interviewed expressed knowledge of the supra ministerial mandate to adopt and implement the HiAP approach in Namibia saying that *"Since, 2016, the MoHSS have updated Cabinet on the process taken to make operational the approach in the Namibian.* Health in All Policy mandates is not a new thing, it has become increasingly popular in Western countries and has been promoted across disciplines in the US, for example. The approach has been found useful in attaining health equity and for instance, the approach was used to map interventions for Health Equity, Sexual Transmitted Diseases (SDTs) and to advance the promotion and achievement of the Sustainable Development Goals (SDGs) [1] [35] [223].

Prioritised policy actions were road safety, nutrition, education, modifiable risk factors contributing to major NCDs, and water and sanitation [48]. Conceptually, HiAP is described by WHO as *"an approach to public policies across sectors that systematically takes into account the health implications of policy decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health inequities"* [102, p. 1]. Interviewees echoed the same sentiments indicating that *"In general HiAP is the presence of health in all public policies irrespective of what sector deals with non-health issues.*

Each sector should address health in some way. Not necessarily providing health-clinical services, but e.g. Agriculture in terms of food services should address the quality of food

and issues around access to water. Trade should address issues about alcohol trading and the health elements in the use of alcohol".

The implementation of HiAP has been described as very slow by one of the interviewees saying, *"Since the Cabinet directive, a lot has been done albeit on a slow pace.* Literature indicates that HiAP, as a system, entails a dual process which seeks to *"foster health considerations in other policy areas and secondly take into account the potential impacts of other sectoral policies on the health of the population"* [35].

Interviewees further indicated that public servants would be expected to implement the approach. The researchers also asked who would drive the HiAP process and received the following responses; *"public servants of the various ministries, of course. the framework allows for the implementation of numerous aspects depending on the identified determinant of health and not specifically for a given sector of the public. For the public service, the framework needs to have an implementation, Monitoring and Evaluation modality – component and make an appropriate recommendation such as the routine tracking of those activities".*

One interviewee noted that there has not been an exercise to introduce HiAP in the public service. *''The health status of workers is a main factor affecting company productivity"* [224]. As a result, General Health Statuses (GHS) are common periodic assessments/examinations and or occupational epidemiological surveillances practised, worldwide in the workplace to detect diseases, and associated risk factors and inform

workplace health promotion programming that is ultimately expected to improve workers' performance and productivity [225] [226].

One of the interviewees said: *"Public servants are members of the society, so much so, that their health is impacted and negatively affected by social issues (food quality, access to water). Yes, the HiAP framework ought to be responsive. Various aspects can have minimal and or maximum health impact. Literary public servants working conditions might affect their health both medically, and otherwise (pause) the place of work can pose a threat to their health and that is why there are wellness programmes in the workplaces. Wellness programmes need to be strengthened to ensure that workplaces provide access to healthy, nutritional food, healthy lunch places and sitting arrangements, some might opt or seek to provide gym hours and before it is dark might provide exercise. The public service ought to promote the health of all public servants".*

A Health Status, according to Berger & Rothman [49], is a systematic process that aims to assess the level of health amongst a specific group of people. The Medical Dictionary for Health Professionals and Nursing [111] similarly describes HS as the health profile of an individual or group of people derived from a Health Assessment (HA) process based on the rationale why the HSA was required. Health status data entails socio-demographic, medical, financial and workplace safety and health generated as per intent. Health data on personal records includes disease history, examinations sick leaves as well as invoices [227].

Another respondent said: *"The health status of public servants in Namibia I can say it's good, but when quantified does not conform to numerous health issues or categorisation*

that can be related to issues such as mental health, chronic diseases, abuse both at work and home, ART uptake".

Whilst another indicated that: *"Honestly there is not much in terms of occupational health and safety in the public service overall. It will be difficult to provide an opinion on the overall health status of public servants. Maybe PSEMAS will offer such information, but is the information readily available? Moreover, government agencies' workplace programmes are not robust enough to go into that detail. But you tell me What are they doing at the Office of the Prime Minister in this regard?".*

Occupational injuries and diseases, amongst public servants, contribute largely to ill health which likely results in prolonged sickness leave absence jeopardising the government's developmental trajectory and abilities to deliver quality public services timely [228]. The International Labour Organisation (ILO) indicates that over two million workers die annually as a result of occupational illnesses and injuries [229]. According to the Occupational Health Services Convention (C161) of the ILO, industries must protect workers' health [230]. In Namibia, a Policy on Occupational Health services reiterated the latter [231].

In view of the absence of an explicit framework for profiling public servants' health National Development Plans (NDPs), over the years, referenced *PUBLIC SERVICE PERFORMANCE* assumingly as a measure of public servants' performance through a Public Service Management and Performance System [232] [233]. The latter (NDPs) had unfortunately no verifiable indicators or targets to measure the expected performance of

public servants [232]. This is another potential area for institutionalising periodic general health status examinations.

5.2.3 Objective (iii)

Health in All Policies subject experts, interviewed as part of a focus group discussion, were of the opinion that Namibia, Namibia's involvement in HiAP came as a result of being a member of the WHO. The country is featured on the world map amongst countries implementing HiAP, described in numerous articles that the approach has been operationalised in many countries as a whole of government's approach, a stand-alone project and or a specific targeted intervention [96] [234].

Literature indicates that in its 'seemliest' form, the HiAP approach existed since the 7th century in the form of quarantines of detained sailors suffering from the plagues around 1980 before the formal adoption of the HiAP concept by the Finnish EU Presidency, as that country's 'whole of government approach' to health in 2006 [39] [41]. In Namibia, the approach was only formally introduced in 2016 and it's not currently clear if the approach will take on a 'whole of government's, a stand-alone and or intervention-specific project.

There exist differences in the interpretation of how HiAP has been conceptualised in relation to 'the whole of government's approach, a stand-alone project and or target a specific intervention. Freiler et al., Kickbusch & Bucket advance, for example, HiAP as a *policy wave* and policy assessment tool [88] [87]. The 1st wave was the '*intersectoral action',* the 2nd wave was the approach to policies *'Healthy public policy'* whilst in their 3rd wave they referred to the HiAP approach and the 4th being SGDs [87]. In relation to

Namibia, the country is yet to formalise its contextual approach for HiAP, a situation also experienced in most African countries, specifically those with no specific reference to HiAP, except for Kenya where HiAP is a part of that country's health policy [235]

De Leeuw & Peters, also dispute the conceptualisation of HiAP, indicating that: *"Both publications of this team suffer from substantial conceptual inconsistencies, in which 'policy is confused with action (HiAP is considered similar to "intersectoral action'), policy development is a form of 'policy implementation' (whereas the policy theory literature would claims the reverse: implementation is a form of development), and behaviourist constructs are applied to political phenomenon",* in reference to Kickbusch & Bucket above [94, p. 3].

The above can be equated to the absence of clarity regarding the contextualisation of HiAP in Namibia. The scoping exercise in Namibia indicates that:

- *"There has not been a targeted government-wide approach" to engage sectors to address declining health outcomes, apart from silo attempts such as the "Healthy Cities initiative, road safety and injury prevention strategies"* [103, p. 159].
- *Health inequities continue to exist in the country resulting in health deprivations with no explicit strategies to address them.*
- *The foundational context for the Namibian HiAP would be the National Development Plans (NDP) focusing on strategies which relate to attaining the SDGs, the Burden of Diseases, health inequities and strengthening population health using existing governance structure integration and accountability.*

Related to the above, literature indicates, further, that HiAP builds upon HP ideologies advancing the Alma Ata (1978), Ottawa Charter (1986) and the Rio Declaration (2011) dogmas narrated since the inception of the WHO in 1948 [102]. Literature also specifies that *'healthy public policy'* and *'inter-sectoral action',* are conceptual precursors of HiAP [88] [236]. In confirmation to the above HiAP experts were of the opinion that Namibia's involvement in HiAP processes was heavily supported by the WHO's country office in Namibia and the support was geared towards the scoping exercise, priority setting, determining the context and implementation.

The above set the stage for the contextualisation of HiAP in Namibia, however, such a stance remains elusive in the absence of a formal policy intent. Although experts indicated that a national stakeholder consultative workshop was conducted to validate the outcomes of the scoping exercise and to *"craft a roadmap for the development of a National Strategy on HiAP"* a formal statement by authority remains absent [104].

In terms of structure, subject experts said a TWG, consisting of the OPM, NPC, City of Windhoek (COW), University of Namibia (UNAM), WHO and MoHSS as the Secretariat was established to coordinate the production of a National Strategy on HiAP, in the draft since its narration in 2019 [48]. Literature makes reference that countries are compelled through supra-governmental mandates to intensify deliberate and systematic responses and policy actions, absence of legislative obligations might render the approach non-functional [44].

Coronavirus disease supra-governmental mandates are an exceptional example of HiAP multi-sectoral responsive interventions involving socio-economic incentives in the form of a basic income for businesses and those hardest hit as a result of total lockdowns

brought by the pandemic, social distancing and vaccinations [91] [36] [237] [238]. South Africa, for instance, used an existing Act, the Disaster Management Act, 2002 [239] [240]. Mozambique and Madagascar used a constitutional mandate to declare a State of Emergency, whereas Namibia applied a combination of a constitutional and legislative approach [240] [241]. The Central African Republic, Rwanda and Somalia did not enact legislation nor utilise constitutional powers, but imposed lockdowns, across the island, through unconventional methods, regarded as impromptu or 'spur of the moment' based on no constitutional/legislative and or policy base such as 'statements' (Presidential/Cabinet) which does not necessitate parliamentary consensus [240].

5.2.4 Objective (iv)

Varied genres (discourses) of health statuses exist in the workplace, some competing and others in parallel. *''The health status of workers is a main factor affecting company productivity"* [224]. As a result, General Health Statuses (GHS) are common periodic assessments/examinations and or occupational epidemiological surveillances practised, worldwide, in the workplace to detect diseases, and associated risk factors and inform workplace health promotion programming that is ultimately expected to improve workers 'performance and productivity [225] [226].

Articles reviewed, further revealed that health status can be viewed as a single domain, measuring a singular aspect such as sickness absence, presentism, disease prevalence and or condition [242] [243]. Other common health status domains are physical and psychological health, and other domains are social health and workplace safety [244]. [245]. Within the above-mentioned health status genres, the physical and psychological

health status measures are defined differently by different authors. For instance, an example of a physical health status measure which focuses on the workplace is the prolonged sitting among white-collar workers [246]. On the other hand, physical health measure refers to assessing blood pressure, blood glucose and cholesterol [210].

In the instance of a singular health status measure, at times, a self-rated health status assessed using a single-item five Likert score method (*'very good, good, fair, bad and very bad'* or *'excellent to poor'*) was used [247]. This single-item method is classified as simple to administer and analyse and therefore, has been used globally, among World Health Organisation (WHO) member states and partners, across populations [248].

Critiques, however, indicated that although a self-rated health status is subjectively researched, its objective empirical results remain debatable [247]. Occurrences where health status was used a single item to measure for instance sickness absence, presentism and or disease prevalence predictors such as morbidity and mortality were used to infer other aspects such as the economic cost of sickness for an organisation, to predict work incapacities and or inform the design of workplace health programmes [242] [243].

Another discourse on health status can be viewed as an entire system such as a comprehensive surveillance, an approach to assess inequalities, the burden of work-related injuries and as an overall general health status measure [249] [210]. A system-based health status discourse used, for instance, to generalise an overall employee state of health may result in an empirical Health Status Profile of workers in different workplaces [210].

A Health Status Profile may for instance contain numerous physical and psychological health information about workers, such as disease profile, nutritional status, physical

mobility and mental state which, in addition, can be related to WHO's definition of health which is a *'state of complete physical, mental and social well-being and not merely the absence of disease'* [210] [250].

Similarly, another system-based health status can be an approach to overall workplace health also known or referred to as *'Employee well-being'*, *'Occupational Health Services'* (OHS), *'Occupational Safety and Health'* (OSH) and of late *'Employee Wellness'* [251] [252]. Particularly, discourses on workplace injuries and illness surveillance data provide fundamental statistical information on the burden of work-related injuries and diseases by avoiding underreporting and incorrect projections [249].

Discourses of workplace health, in themselves, reveal competing genres. Allender et al. [252] identified two competing discourses of workplace health namely: health as safety and health as a lifestyle. Whilst the above-mentioned competing discourses are not 'directly' part of this study, the phenomenon of health status operates within the domains of workplace health. It is therefore important to describe the context of workplace health status of this study.

In Namibia, employers are obligated to ensure that designated employees undergo general health examinations periodically in accordance with Chapter Four of the Labour Act, 2007 (Act No 11 of 2007) and the Public and Environmental Health Act (Act 1 of 2015) [253] [254]. Regulations relating to the Health and Safety of Employees at Work made under the Labour Act, 1992 (Act 6 of 1992) provide guidelines on how health examinations are to be conducted [255] [256].

Health and Safety at Work Regulations, in Namibia, also make provision for profiling the health and hazard exposure of general workers [255]. The law provides for industries to devise mechanisms to procedurally conduct occupational examinations/surveillances and as such health profiles feature the notification of diseases, examination by a physician and confidential storage information databases amongst many other features [231] [256].

Section 18(2)(b) of the Public Service Act, 1995 (Act 13 of 1995) indicates that a person employed permanently in the public service *'must be free from any disease or physical or mental detect which is like to materially interfere with the proper performance of his or her duties'* [257]. The above-mentioned Section further stipulates that if required a medical examination should be performed in terms of applicable provisions [(in terms of Section 5(2(j) which enabled the Prime Minister to approve rules governing the administration related to health examination of government employees read in conjunction with Section 5(3)] [194].

Public Service Staff Rule (PSSR) B.II on filling of posts (recruit, selection and placing) describes the scope of application and delegation as well as the administrative procedure of this Rule on medical health examinations by means of a Health Questionnaire (form attached to this research report as Annexure A), medical examination and dismissal on grounds of continued ill-health [257].

The Health Questionnaire and medical reports stipulate health status measures such as skin disorders, affections of the skeletons/joints, eyes, hearing, speech including handicaps, height and mass, heart and circulatory, respiratory, urinary and nervous systems. The latter also includes the administration of sick leave [257].

The Public Service Medical Aid Scheme (PSEMAS) issued and approved by the Prime Minister in terms of Section 35 of the Public Service Act, 1995 on the recommendation of the Public Service Commission (in terms of Section 5 of the said Act) is another potential health status marker for profiling the general health status of public servants in Namibia [194].

General occupational health examinations in Namibia are carried out by the Ministry of Health and Social Services under the auspices of the Chief Medical Officer, subdivision of Occupational and Environmental Health [231] [258]. In relation to compensatory issues related to occupational injuries and diseases in the course of employment as well as insurance payments towards maternity leave, prolonged sickness and deaths the Social Security Commission acts in that capacity [259].

Whilst public servants participate in Social Security provisions as per the aforementioned Act, there appears to be no explicit framework for complying with legal provisions of conducting periodic general health status profiling amongst public servants as prescribed by the Public and Environmental Health Act as well as the Labour Act as the country is yet to promulgate an independent Occupational Safety and Health (OSH) / Occupational Health and Safety (OHS) legislation. Namibia has also no centralised OSH Information System like in other countries such as the United States, Korea and or Spain [258].

Similarly, health impacts amongst public servants cannot be inferred as the reason for unsatisfactory and poor delivery of public services although evidence of poor performance and unsatisfactory delivery of public services in the country is contained in an Afrobarometer and a Citizen satisfaction surveys conducted in 2017 [260] [261]. The

aforementioned studies found poor performance in providing basic services such as housing, land, water, health care and sanitation [260] [261]. The studies unfortunately did not provide reasons related to ill-health as factors influencing performance and thus warrants supplementary exploration.

In view of the absence of an explicit framework for profiling public servants' health National Development Plans (NDPs), over the years, referenced *PUBLIC SERVICE PERFORMANCE* assumingly as a measure of public servants' performance through a Public Service Management and Performance System [232] [233]. The latter (NDPs) had unfortunately no verifiable indicators or targets to measure the expected performance of public servants [232]. This is another potential area for institutionalising periodic general health status examinations.

Public servants in Namibia, and by default the world over, are a group of workers employed by a government to deliver state services such as teaching in public schools, the provision of public healthcare, maintenance of public infrastructure, provision of civil registration, water, sanitation, safety and security [219] [262]. Public servants are engaged in multiple life-supporting public services and hence are often exposed and involved in occupational injuries and diseases which potentially affect their capacities to perform state services if not adequately addressed [262] [263] [53].

5.2.5 Objective (v)

Hereunder, the researcher provides a descriptive encounter of the research findings obtained from the cross-sectional survey (section 4.4.1 in Chapter 4). Discussions are

based on a major summary and synthesis of the structured questionnaire used to obtain data.

5.2.3.1 Demographics of public servants in the MWT in Namibia

5.2.3.2 The general health status of public servants in the MWT in Namibia

Overall, the study found out that acceptable physical, psychological and socio-economic health-related aspects regarded as GHS markers are present amongst the majority (n=286 - 83.3%) of the public servants in the MWT. A comparable study of the GHS of workers amongst different workplaces in Qom Province, Iran found similar acceptable GHS amongst different occupational categories [264]. The Qom Province study used the standardised General Health Questionnaire (GHQ 28) and t-test, ANOVA and the Pearson correlation coefficient module was used in SPSS to analyse data.

The aforementioned study recorded an acceptable GHQ-28 score of 17.87±10.93. The present study recorded a combined 13.9% of poor GHS amongst public servants with physical ailments ranging from hypertension: mental ailments to stress/depression, musculoskeletal to lower back pain and socio-economic induced ailments such as sedentary lifestyle, obesity, smoking and consumption of alcohol [264].

Physical, mental and social health determinants impact workers' ability to perform in the workplace which subsequently might influence service delivery.

Despite an acceptable GHS, the present study revealed numerous concerning health risk factors which might influence workability (performance and productivity) and which might result in absenteeism due to ill health were observed conversely providing empirical

evidence. A study in South Africa reported a generally unhealthy employee status due to poor living squatters and poor diets [265].

Below is a description of the multiple health determinants that negatively affect and influence the acceptable GHS description of public servants in the MWT in Namibia.

5.2.2.2 Sex (gender segregation)

Study results show a fairly equal vulnerability between females (n=26) and males (n=22) to hypertension, cholesterol, diabetes, stress/depression, musculoskeletal disorder, BMI, physical activities, smoking and alcohol consumption. Literature on the health of male workers indicates that their mental health care aspect is neglected in the workplace [266]. Literature on female workers, on the other hand, indicates that female workers are generally more at risk as compared to men [267]. As earlier mentioned, the present study showed health vulnerability to both male and female public servants.

5.2.2.3 Hypertension and High Cholesterol

Twenty-nine n=29 (67.4%) of those who rated their health as poor suffered from elevated blood pressure/hypertension and a significant statistical association (p-value<0.001), was found between general health and High blood pressure/hypertension as well as with Elevated cholesterol/Cholesterol (p-value=0.003). The prevalence of hypertension in the present study is comparable to a study that was conducted in Nigeria amongst public servants which reported 27.1% [268]. A four-year retrospective study of public servants' physical inactivity and associated risk factors in Accra, Ghana found a 36.4% hypertension prevalence [206]. Hypertension and Cholesterol are factors associated with

Cardiovascular diseases (CVD) potentially a result of physiological blood vessel changes linked to ageing and or as a result of mobility and a sedentary lifestyle [221].

The majority of respondents in the present study were public servants engaged in the administration services which by default are sedentary and thus a risk to CVD. Cardiovascular disease, a classification category under non-communicable diseases, is recorded as the leading cause of death in the working population [203]. Composite risk factors of CVD include tobacco use, harmful use of alcohol, physical inactivity, and unhealthy diets which might all give rise to Hypertension, Cholesterol and Diabetes mellitus [269].

5.2.2.4 Diabetes

The present study found no significant statistical association (p-value=0.258 >5%) between general and elevated blood sugar/diabetes and only less than 5% of the participants reported having a confirmed diagnosis of Diabetes. However, a study in Namibia on the impact of Diabetes on absenteeism revealed significant statistical associations [270]. The Accra study found a 19.1% prevalence rate [206].

Diabetes Mellitus is associated with poor dietary habits, low physical inactivity and obesity factors all found significantly associated with poor general health in this study. The present study did however not conduct a random blood glucose screening which is perceived as the most appropriate method to diagnose raised blood glucose and which might have revealed different results [270].

Diabetes Mellitus, a part of Non-Communicable Diseases, is among the most common public health threats and causes of mortality amongst productive (working) populations

imperative to be included in workplace health assessments and health promotion programmes [204].

5.2.2.5 Musculoskeletal Disorders

Musculoskeletal disorders are afflictions of the muscular system commonly characterised by low back pain, wrong posture due to prolonged standing and repetitive work especially among health workers in clinical settings [271]. Significant statistical associations (p-value<0.001) between general health were also found with Low back disease/Back spine pain. Musculoskeletal disorders, according to the WHO, are common ailments amongst different occupational categories which account for over a third of back pain [131]. A study on the health status of construction workers in Lahore, Pakistan recorded a 60% muscular fatigue [272].

In Namibia, a similar study of construction workers recorded a 91% prevalence of musculoskeletal disorders [273]. Another similar study of nurses, who are public servants in Namibia, found 78.2% musculoskeletal disorder prevalence [274]. The majority of public servants in the present study were administrative workers, a trade performed mainly in a sedentary prolonged sitting posture which requires ergonomic fittings to minimise significant health hazards chronic risks and disorders [275]. A study in Ibadan, Nigeria, identified musculoskeletal disorders amongst many other Health Seeking Behaviours among civil servants [276].

5.2.2.6 Mental Condition

Mental and Behavioural Disorders (MBD) are a major disease classification of the International Classification Code (ICD-10). In a study of 71 educational state agencies,

40.14% of all retrospectively who studied medical certificates (sick leave certificates) were for MBD [220]. Mental and Behavioural Disorders are caused by changes in psychological chemical changes as a result of increased distress [221]. Worldwide 25% of female and 18% of male workers reported high levels of stress due to work-related pressure [221]. The present study found a statistical association with stress (p-value=0.011) and as well as a combined significant statistical association between general health with Stress/Anxiety/Depression (p-value=0.009). The present study found out that the majority of the participants who rated their health as poor felt stressed some days during the past two weeks 30 (62.5%) of conducting the study. Most of the participants who rated their general health as good also indicated that they were stressed some of the days in the past two weeks 157 (56.88%) of conducting the study. The Qom province study found social interface risk factors such as communication, innovation and creativity [264].

5.2.2.7 Smoking, Alcohol Consumption

The present study found no significant association between general health with smoking and alcohol consumption probably mainly because of the statistical analysis module performed because all p-values were greater than 5% level of significance as stated in earlier sections. It is a well-known WHO standpoint that lifestyle health-impacting factors include smoking and excessive alcohol consumption [201]. In a study of civil servants in China on HRQoL, univariate analysis revealed significant statistical associations ($P \leq 0.05$) among multiple health determinant factors including smoking and alcohol consumption [201]. This study used the Short Form 36-item General Health Questionnaire [201]. Another study amongst civil servants in Ibadan, Nigeria on the prevalence of

communicable diseases found risk associations similar to those in the China Study but analysed with multivariate logistic models with adjusted odd ratios and reported as follows 6.5% (95%CI:4.5-8.5) for smoking and 7.8%(95%CI:5.1-10.5) for harmful use of alcohol [204].

5.2.2.8 Physical Activities

Literature provides evidence of reduced mortality due to CVD with increased and regular physical activities [221]. Empirical evidence also indicates an improved immune system, enhanced bone strength and delay of type 2 Diabetes with regular physical activities and body mobility [53]. In the present study, general health was statistically associated with physical activities (p-values=0.043) as most respondents (n=138 or 49.64%) who rated their health as good only do routine physical activities sometimes. Similarly, another high proportion of respondents who rated their general health as poor also exercise only sometimes. A high proportion of respondents who exercise often n=67 (24.1%) and those who exercise always 41 (14.75%) rated their general health as good.

5.2.2.9 Obesity

Both overweight and obesity were detected amongst public servants of different socio-demographic backgrounds in this study. Previous studies suggest a statistically significant association between obesity and high socio-economic status such as a study amongst public servants in Ghana which found 29.9% overweight and 4.8% obesity [53]. Another study in Niger Urban also found public servants at high risk of overweight and obesity, a subsequent marker of health vulnerability to hypertension and diabetes [277]. A high BMI is a known risk factor for hypertension and diabetes mainly because the increase in body

weight can lead to an increase in insulin resistance and or defects in insulin secretion [139].

Therefore, it is anticipated that respondents with elevated blood sugar and or blood pressure were more likely to be overweight and obese as opposed to those with non-elevated similar conditions [277]. In relation to awareness and a high educational level (65%) amongst respondents in the present study, the above-stated result can be termed somehow as counter-intuitive, but in light of the empirical evidence which suggests that people with higher education levels have greater opportunities for obtaining healthy behavioural change information and attitudes [139]. Thus expecting favourable outcomes for better lifestyle health indicators associated with BMI. It should however be noted that whilst inferential descriptive statistics applied to the present study provide an indicative indicator between socio-economic with overweight and obesity, the present study did not directly investigate this correlation, but simply ascertained a plausible association based on self-reported demographic data, a general health status marker and workplace health and safety information.

5.2.3.3 Workplace information on health and safety

Slightly over 33% of respondents in this study reported that management at the MWT considered employees' health, safety and well-being as an important factor. A study on the management of employee wellness in South Africa also rated managers' support of workplace wellness programmes as *'Excellent'* and *'Good'* respectively [278]. In the present study, the results indicated that the Ministry offered health awareness-raising related activities such as screening for elevated blood pressure and glucose in the last 12

months. Participation of the respondents in those activities was, however, only 27.7%, a case regarded as unsatisfactory levels of participation. In South Africa, a similar study indicated employee participation rates of between 20% - 35% [278]. The International Labour Organisation (ILO) sets an acceptable participation rate of at least 50% [137].

On the awareness of emergency exit points, respondents had a high awareness rate of 64%, but 53% indicated that safety evacuation plans and protocols, as per the country labour law, were not visibly exhibited by the MWT. Additionally, the majority of the respondents further indicated that the MWT does not offer opportunities for living a healthy lifestyle, including a Tobacco-free zone (31.5%). Literature revealed that most countries in Southern Africa lack comprehensive OSH/OHS legal frameworks and that only 5% of employees, and 15% worldwide have access to workplace OSH/OHS [279] [280]. In the above-mentioned South African study, it was revealed that participating organisations had no baseline mechanisms to measure the effectiveness of their Employee Wellness Programmes [278].

A profile on OSH/OHS in Namibia, similar to the above-stated studies, echoes the same sentiments, reporting OSH/OHS legislative and operational gaps, including the absence of an OSH/OHS centralised information system, required to guide health status examinations and strengthened safety and health responses in Namibia [258]. There exists no explicit OSH legislative status in Namibia whereas the existing National Occupational Health Policy has existed since 2006 without review [258] [281]. South Africa, as well as numerous countries around the world, have OSH/OHS-specific legislation [278]. In Namibia, the Labour Act govern employment matters including issues pertaining to employee safety and health [258]. Despite the above-mentioned OSH/OHS limitations,

43.4% of the respondents reported job satisfaction. Job satisfaction is among many other factors affecting productivity and performance among workers [278]. According to a study that was conducted in Ibadan, Nigeria, job satisfaction positively influences workability and is rarely a factor that negatively influences the health-seeking behaviours of civil servants [276].

On the question of whether they (respondents) knew Health in All Policies (HiAP), a mechanism which seeks to establish the health impacts of public policies, the majority of the participants, 65.9% were not in the know [282]. This question on HiAP was asked mainly because this study forms part of research to inform the development of a HiAP-based conceptual framework for profiling public servants' health status in Namibia.

5.2.3.4 Additional analysis and discussion of research findings of sub-objective (v)

Hereunder, the researcher provides a descriptive encounter of the research findings obtained from the analysis of the cross-sectional survey. Research findings obtained from objective 2 were synthesised and only findings relevant to the focus of this objective were included in the analysis and discussion hereunder.

5.2.3.41 Inferential Statistical Analysis Result

In order to assess the association between covariates and general health, Chi-square tests were performed. Initially, general health which can be rated either as Excellent/Very good/Good/Fair/Poor/Very Poor, for the purpose of examining and describing association with multiple health determinants, was categorised into two groups, namely:

1. Good Health for options Excellent, Very Good and Good and
2. Poor Health for Fair, Poor, and Very Poor.

Variables with a p-value less than 5% level of significance were regarded as significantly associated with general health. In addition, for the results of a chi-square test to be valid, the expected values should be at least 5, and this was satisfied in all the tests.

Table 4.11a, below, presents a cross-tabulation of socio-demographic characteristics and the participants' self-reported categorised general health status. General health was found to be statistically associated with Education level (p-value<0.001), Type of work (p-value=0.021), type of houses in which participants reside (p-value=0.034), and access to electricity (p-value=0.045). The majority n=197 (70.11%) of the participants who rated their health as good attained Tertiary education, followed by those who attained Secondary education n=76 (27.05%.) whilst n=21 (45.65%) of those who rated their health as poor never attained Tertiary education.

In addition, most of the participants n=89 (32.25%) who rated their health as good do administrative work and n=11 (23.91%) who rated their health as poor also do administrative work. Two hundred and forty-two n=242 (85.21%) of the participants who indicated that they reside in brick houses rated their health as good. Most of the participants n=253 (87.85%) who rated their health as good have access to electricity in their household.

General health was, however, not found as statistically associated with gender, being a member of PSEMAS, access to water, access to flushing toilet, BMI, and monthly incomes all with p-values greater than 5% level of significance (Table 1a).

Table 4.11a: General Health by socio-demographic characteristics

	General Health			
Gender	**Poor Health n (%)**	**Good Health n (%)**	**Total n (%)**	**P-value**
Female	26 (54.17)	157 (54.9)	183 (54.79)	0.925
Male	22 (45.83)	129 (45.10)	151 (45.21)	
Total	**48**	**286**	**334**	
Education level				
No education	1 (2.17)	0 (0.0	1 (0.31)	<0.001*
Primary Education	6 (13.04)	8 (2.85)	14 (4.28)	
Secondary Education	18 (39.13)	76 (27.05)	94 (28.75)	
Tertiary Education	21 (45.65)	197 (70.11)	218 (66.67)	
Total	**46**	**281**	**327**	
Type of work				
Administrative	11 (23.91)	89(32.25)	100 (31.06)	0.021*
Artisan/Skilled	10 (21.74)	60 (21.74)	70(21.74)	
Labourer/Unskilled	10 (21.74)	26 (9.42)	36 (11.18)	
Managerial	5 (10.87)	9 (3.26)	14 (4.35)	
Others	3 (6.52)	23 (8.33)	26 (8.07)	
Technical/Specialty	7 (15.22)	69 (25.00)	76 (23.6)	
Total	**46**	**276**	**322**	
Scheme (PSEMAS)?				
No	4 (8.33)	15(5.24)	19 (5.69)	0.393
Yes	44 (91.67)	271 (94.76)	315 (94.31)	
Total	**48**	**286**	**334**	
What type of house do you reside?				
Brick house	35 (72.92)	242 (85.21)	277 (83.43)	0.034*
Zinc/Corrugated iron	13 (27.08)	42 (14.79)	55 (16.57)	
Total	**48**	**284**	**332**	
Do you have access to water in your household?				
No	19 (39.58)	79 (27.43)	98 (29.17)	0.086
Yes	29 (60.42)	209 (72.57)	238 (70.83)	
Total	**48**	**288**	**336**	
Do you have access to a flushing toilet in your household?				
No	15 (31.25)	55 (19.1)	70 (20.83)	0.055
Yes	33 (68.75)	233 (80.9)	266 (79.17)	
Total	**48**	**288**	**336**	
Do you have access to electricity in your household?				
No	11 (22.92)	35 (12.15)	46 (13.69)	0.045*
Yes	37 (77.08)	253 (87.85)	290 (86.31)	
Total	**48**	**288**	**336**	
Monthly Income				
<N$ 3500.00	0 (0.0)	2 (0.72)	2 (0.62)	0.126
N$3500.00-N$5000.00	16 (34.04)	56 (20.29)	72 (22.29)	
N$ 5001.00-N$10000.00	15 (31.91)	75 (27.17)	90 (27.86)	
N$ 10000.00-N$200000.00	13 (27.66)	122 (44.2)	135 (41.8)	

	General Health			
Gender	**Poor Health n (%)**	**Good Health n (%)**	**Total n (%)**	**P-value**
N$ 20001.00-N$40000.00	0 (0.0)	9 (3.26)	9 (2.79)	
≥N$ 40001.00	3 (6.38)	12 (4.35)	15 (4.64)	
Total	**47**	**276**	**323**	
BMI Categories				
<18.5	0 (0.00)	17 (6.37)	17 (5.43)	
18.5-24.9	13 (28.26)	99 (37.08)	112(35.78)	0.094
25-29.9	14 (30.43)	78 (29.21)	92 (29.39)	
>=30	19 (41.3)	73 (27.34)	92 (29.39)	
Total	**46**	**267**	**313**	

*significant at a 5% level of significance

Table 4.11b, below, presents a cross-tabulation of health conditions and the participant's self-reported categorised general health status. The majority (72.8%) of the participants who rated their health as good do not suffer from blood pressure/hypertension whilst n=29 (67.4%) of those who rated their health as poor suffered from blood pressure/hypertension.

General health was found to be statistically associated with High blood pressure/hypertension (p-value<0.001), Elevated cholesterol/Cholesterol (p-value=0.003), Low back disease/Back spine pain (p-value<0.001), and Stress/Anxiety/Depression (p-value=0.009). However, a statistical association was not found between general health and elevated blood sugar/diabetes (p-value=0.258 >5%).

Table 4.11b: General Health by Health Conditions

General Health	**Never Tested n (%)**	**No n (%)**	**Yes n (%)**	**Total**	**P-value**
High blood pressure/hypertension					
Poor Health	0 (0)	14 (32.56)	29 (67.44)	43 (100)	<0.001*
Good Health	12 (4.35)	201 (72.83)	63 (22.83)	276 (100)	
Elevated blood sugar/Diabetes					
Poor Health	1 (2.63)	32 (84.21)	5 (13.16)	38 (100)	0.258

Good Health	16 (6.18)	226 (87.26)	17 (6.56)	259 (100)	
Elevated cholesterol/Cholesterol					
Poor Health	5 (13.16)	23 (60.53)	10 (26.32)	38 (100)	0.003*
Good Health	24 (9.2)	214 (81.99)	23 (8.81)	261 (100)	
Low back disease/Back spine pain					
Poor Health	3 (6.98)	21(48.84)	19 (44.19)	43 (100)	<0.001*
Good Health	20 (7.63)	203 (77.48)	39 (14.89)	262 (100)	
Stress/Anxiety/Depression					
Poor Health	7 (17.5)	20 (50)	13 (32.5)	40 (100)	0.009*
Good Health	33 (12.84)	186 (72.37)	38 (14.79)	257 (100)	

*significant at a 5% level of significance

Table 4.11c, below, shows that there was no significant association observed between general health and disability, smoking and alcohol consumption since all the p-values were greater than 5% level of significance.

Table 4.11c: General Health by disability, smoking and alcohol consumption

General Health	Yes n (%)	No n (%)	Total n (%)	P-value
Do you suffer from any disability, including wearing eyeglasses?				
Poor Health	29 (61.7)	18 (38.3)	47 (100)	0.247
Good Health	195 (70.14)	83 (29.86)	278 (100)	
Do you currently smoke				
Poor Health	37 (80.43)	9(19.57)	46 (100)	0.083
Good Health	252 (89.36)	30 (10.64)	282 (100)	
Do you currently consume alcoholic substances?				
Poor Health	27 (61.36)	17(38.64)	44 (100)	0.132
Good Health	200 (72.46)	76(27.54)	276 (100)	

Most of the participants who rated their health as good do routine physical activities only sometimes 138(49.64%). Although a high proportion of the participants who rated their general health as poor indicated that they exercise sometimes, a high proportion of

individuals who exercise often 67(24.1%) and always 41(14.75%) were also observed among participants who rated their general health as good. As a result, general health was statistically associated with physical activities (p-values=0.043). General health was however not significantly associated (p-values=0.502) with eating healthy (Table 4.11d).

Table 4.11d: General Health by healthy eating and physical activities

General Health	Always n (%)	Never n (%)	Often n (%)	Rarely n (%)	Sometimes n (%)	Total n (%)	P-value
Health Eating							
Poor Health	3 (6.52)	6 (13.04)	10 (21.74)	8(17.39)	19 (41.3)	46 (100)	0.502
Good Health	22 (7.83)	29 (10.32)	50 (17.79)	30 (10.68)	150 (53.38)	281 (100)	
Physical activities							
Poor Health	7 (15.22)	5 (10.87)	8 (17.39)	8 (17.39)	18 (39.13)	46 (100)	0.043*
Good Health	41 (14.75)	14 (5.04)	67 (24.1)	18 (6.47)	138 (49.64)	278 (100)	

*significant at a 5% level of significance

The majority of the participants who rated their health as poor felt stressed some days during the past two weeks n=30 (62.5%), however, about 17% were never stressed. Whilst most of the participants who rated their general health as good also indicated that they were stressed some days in the past two weeks n=157 (56.88%), and n=96(34.78%) were never stressed in the past two weeks. As a result, general health was found to be statistically associated with stress (p-value=0.011). However, there was no statistical evidence indicating that general health was associated with depression (Table 4.11e).

Table 4.11e: General Health by stress and depression

General Health	Always n (%)	Never n (%)	Often n (%)	Some days n (%)	Total n (%)	P-value
How often you have felt stressed during the past two weeks?						
Poor Health	2 (4.17)	8 (16.67)	8 (16.67)	30 (62.5)	48 (100)	0.011*
Good Health	3 (1.09)	96 (34.78)	20 (7.25)	157 (56.88)	276 (100)	
How often you have felt depressed during						
Poor Health	0 (0)	22 (48.89)	5 (11.11)	18 (40)	45 (100)	0.159
Good Health	2 (0.77)	169 (64.75)	15 (5.75)	75 (28.74)	261 (100)	

*significant at a 5% level of significance

The results in Table 4.11e show that there was no statistical association between general health and stress levels at work and home, p-value=0.365 and p-value=0.173, respectively.

Table 4.11f: General Health by stress at work and home

General Health	A bit stress n (%)	Extremely stressed n (%)	Moderate n (%)	No stress n (%)	Substantial stress n (%)	Total n (%)	P-value
Rate the average amount of stress at work							
Poor Health	25 (54.35)	1 (2.17)	9 (19.57)	8 (17.39)	3 (6.52)	46 (100)	0.365
Good Health	114 (41.61)	8 (2.92)	54 (19.71)	85 (31.02)	13 (4.74)	274 (100)	
Rate the average amount of stress at home							
Poor Health	19 (42.22)	2 (4.44)	9 (20)	15 (33.33)	0 (0)	45 (100)	0.173
Good Health	99 (37.08)	4 (1.5)	34 (12.73)	120 (44.94)	10 (3.75)	267 (100)	

In order to assess the combination of covariates that are associated with general health, a logistic regression model was fitted for covariates that were found to be statistically associated with general health in the univariate analysis (chi-square test). Results of the modelling exercise are presented in Table 4.12 below as Odd Ratio (OR). Additionally, variables that are known to be associated with poor general health such as smoking, alcohol consumption, and physical activity from literature were also included in the multivariable logistic regression model.

The odds of reporting good health among those who attained Tertiary Education were 15.159 significantly higher than those who attained primary school education, keeping all the other variables in the model constant (OR: 15.159, 95% CI: 1.264-181.778, p-value: 0.032). Additionally, the odds of reporting good health among those who reported not having high blood pressure (HBP) were 24.221 higher than those who reported HBP, keeping all the other variables in the model constant (OR: 24.221, 95% CI: 4.386-133.751, p-value: <0.001).

Regarding smoking, the odds of reporting good general health were 0.190 among non-smokers as compared to smokers, indicating that there is a negative association between not smoking and good health in this setting (OR: 0.190, 95% CI: 0.043-0.839, p-value: 0.028). The odds of reporting good health were 3.296 times higher among those who do not consume alcohol than those who consume alcohol (OR: 3.296, 95% CI: 1.283-8.469, p-value: 0.013).

Among those who reported not having low back pain the odds of reporting good health were 4.399 times higher than those who reported experiencing low back pain keeping all the other variables in the model constant (OR: 4.399, 95% CI: 1.410-13.724, p-value: 0.011). In addition, the odds of reporting good health among those who sometimes do physical activities were 6.410 times higher than those who rarely do physical activities (OR: 6.410, 95% CI: 1.301, 31.570, p-value: 0.022). However, gender, type of work, type of housing and being a member of PSEMAS were not found to be statistically associated with general health as their p-values were more than 5% level of significance.

Table 4.12: Multivariable Logistic Regression Model

Variables	**General Health**	**Odds Ratio (OR)**	**P-value**	**95% Confidence Interval**	
	Intercept	0.016	0.013	0.001	0.412
Gender	Ref: Female				
	Male	0.692	0.484	0.247	1.941
Educational Level	Ref: Primary School				
	No education	1.000			
	Secondary Education	7.082	0.067	0.875	57.337
	Tertiary Education	15.159	0.032*	1.264	181.778
Type of Work	Ref: Administrative				
	Artisan/Skilled	1.093	0.909	0.240	4.975
	Labourer/Unskilled	0.438	0.365	0.074	2.610
	Managerial	0.185	0.221	0.012	2.766
	Others	0.820	0.884	0.056	11.899
	Technical/Specialized	1.215	0.822	0.222	6.633

House Type	Ref: Bricks				
	Zinc/Corrugated iron	0.386	0.144	0.108	1.382
PSEMAS	Ref: Yes				
	No	10.860	0.137	0.470	251.048
BMI Categories	Ref: 25-29.9				
	<18.5	1.000			
	18.5-24.9	5.704	0.055	0.966	33.677
	>=30	3.239	0.217	0.501	20.952
Smoking	Ref: Yes				
	No	0.190	0.028*	0.043	0.839
Alcohol Consumption	Ref: Yes				
	No	3.296	0.013*	1.283	8.469
High Blood Pressure	Ref: Yes				
	Never tested	1.000			
	No	24.221	<0.001*	4.386	133.751
Low Back Pain	Ref: Yes				
	Never tested	0.242	0.086	0.048	1.222
	No	4.399	0.011*	1.410	13.724
Physical Activities	Ref: Rarely				
	Always	0.981	0.983	0.165	5.823
	Never	1.749	0.639	0.169	18.087
	Often	3.988	0.088	0.814	19.538
	Sometimes	6.410	0.022*	1.301	31.570

*significant at a 5% level of significance

5.2.5 Objective (vi)

5.2.5.1 Knowledge about HiAP

The study found that only less than 20% of respondents had knowledge of the HiAP approach, the Cabinet directive on adopting HiAP as well as what SDH means. Low knowledge levels exhibited in this study contradict the findings of other studies where literature revealed that in countries where HiAP has been implemented successfully, supra-ministerial mandates such as in Finland and Sweden and government structures where major drivers for initiation and sustenance of the approach [39] [35] [283].

Literature emphasised the role of Ministries of Health, albeit criticism of health bureaucracy, as a major role player in the successful implementation of the approach, because of its knowledge and technical capacity to drive health awareness [40] [96]. Although Namibia appears to have adopted the supra-ministerial mandates through its Cabinet directive limited knowledge of the approach might implicate successful implementation across government institutions [284] [1].

5.2.5.2 Attitudes about HiAP

In addition to the general knowledge among critical stakeholders like the Ministry of Education, Transport and Housing, the study identified limited awareness about the implementation of the HiAP approach, overall. There seems to have been no awareness creation carried out as a result the Public Service would have been adequately sensitised, constituting cross-awareness levels to drive interest and involvement. The study also picked up that it is not yet clear how, when and by whom HiAP is going to be implemented in Namibia, as the National Strategy remains largely in the draft format. It is indicated in the literature that the failure of similar initiatives, including the '*Healthy policy*' phenomenon provided a limited guiding mechanism for implementers which resulted in silo operations, limited resources and work overload [284] [35] [223] [235]

5.2.5.3 Practices of HiAP

The Cabinet resolution (Decision number 5th/05.04.16/004) directed the MoHSS to enable the adoption of HiAP, stating: *"The Health in All Policies to be adopted as a principle to ensure that health becomes an integral component of all Government policies, strategies and programmes. The MoHSS to provide leadership and guidance"* [46, p. 1].

In reciprocation, the Ministry drafted a National Strategic Plan on HiAP which has been in draft format since 2019. Although the plan stipulates institutional implementers, the operational structures are yet to be identified limiting, therefore, the ability to provide clearer implementation guidelines. In countries where HiAP has been implemented government structures were utilised to implement the approach [39] [45]. Regardless, the majority of the participants indicate a willingness to be involved in the implementation of the approach, given appropriate capacity building.

5.3 MERGING OF RESEARCH FINDINGS

Phase I, objective (i) – (vi), sought to gather empirical evidence that informed the development of a HiAP-based conceptual framework to facilitate the profiling of public servants' health statuses in the NPS. Data gathered, presented herein in chapter four will now be synthesised by means of triangulation, which is the ability to compare and or construct data from various research methods [285]. In so doing, three themes, described below emerged. Consummate, therefore trustworthiness of the research finding.

5.3.1 Public servants' health statuses

The study discovered that 83,3% of the participants self-reported an overall good health status. The remainder 16,7% self-reported a poor health status citing the prevalence of Hypertension (27%), Musculoskeletal disorders (30,6%), Stress (55%), Physical in-activeness (38%), high Body Mass Index (BMI) (27%), Smoking (11%) and Alcohol consumption (27,.5%). The aforementioned findings are similar to numerous studies conducted worldwide amongst public servants, such as the one conducted among state workers in Goiás, Brazil who reported a general good health status among 77,3% of

participants [286]. Sixty-six point seven per cent (66.7%) reported getting six (hours of sleep, regarded as insufficient whilst 53.6% do not engage in physical activities, way beyond the WHO's 30 minutes of exercise per day [20].

In Accra, Ghana, and China, studies found +- 36,4% prevalence levels of hypertension amongst civil servants associated with lifestyle risk factors such as smoking, sedentary and poor nutrition [201] [206]. A high prevalence of overweight and obesity was also found amongst public servants in Nadowli, Ghana, predicted to create vulnerability towards NCDs associated with their sedentary lifestyles [53]. The latter found significant associations of poor health with Hypertension, Mental conditions, low level of education, type of work, type of shelter and access to electricity, similar to this study.

Overall, unhealthy diets, lack of physical activities, excessive use of alcohol and tobacco smoking were identified as high-risk factors associated with a poor GHS amongst public servants predisposing them to hypertension, diabetes and obesity/overweight [135]. The aforementioned studies were measured using disease-specific measures which focus on the prevalence of a specific health condition [287].

The above-mentioned measuring tools were employed mainly because of their suitability to the Namibian public service context and ability to study a wide range of employee health issues and not only disease or conditions-specific aspects. There also exist generic measures such as the WHO Quality of Life (QOL) which enable generalisation and comparison amongst different settings [287]. The WHO STEPwise approach and QOL measures have proliferated into various other HS measures such as the 38 and or 26-item Short Form (SF) scales used around the world [289].

Other generic and most common HS measurements are the United Nations (UN) Human Development Index (HDI), the Health-related quality of life (HRQoL) and the WHO STEPwise approach for surveillance of non-communicable diseases (NCDs) [290] [291] [292]. The latter although validated and regarded as reliable generic GHS instruments are not suitable for workplace-related occupational employees' health profiles, but are more suitable to the overall country context and disease-specific information [287].

5.3.2 Data sources appropriate for profiling public servants' health statuses

This study identified three sources of public servant's health data appropriate for profiling in the Namibian Public Service namely: the health questionnaire, sick leave certificates and PSEMAS data, if appropriately guided and made readily available. The afore-stated findings are similar to the description in the literature that indicated that the HS of employees is commonly measured by the cost and nature of medical care paid by the institutions, the rate of absenteeism due to ill health, the social-cultural and economic factors directly influencing employees' levels of productivity [120].

According to literature, Horace Dobell was the first physician to suggest health screening for asymptomatic employees in the United Kindom, regarded as the onset of workplace health examinations [293]. Similar exercises were, thereafter, conducted in the United States in line with quarantine guidelines amongst immigrants [294]. Since then, general health examinations and profiling have proliferated amongst the general population and designated groups to control infectious diseases and outbreaks expanding to cover not only Tuberculosis, as the most common communicable and transmittable disease, but include injuries, acute and chronic diseases [289] [135].

The ultimate aim of workers' general health examination and profiling thereof is to translate into improved performance and heightened productivity [16]. Workers' general health examinations in Korea, consisting of 178 itemised hazardous substances exposure and additional specified physical aspects for both industrial and administrative workers is an obligated legislated practice in accordance with that country's Safety and Health Act [129]. This study found similar legislative provisions described in the Namibian Labour Act, albeit not explicitly reciprocated in the Public Service Act.

Apart from Korea, health examinations among employees are a common practice around the world, including among public servants [201] [206] [264]. In Spain, Directive 89/391/EEC governed health and safety, in practice carried out voluntarily amongst workers, unlike in the Namibian public service where such practice is non-existent [128]. Moreover, the ILO states that workers' health surveillance should be based on sound ethical principles and should be conducted using credible scientific procedures [227].

The Namibia Public Service, despite the existence of numerous health data collection sources appropriate for use to profile public servants' health statuses, similar in nature to afore-mentioned countries, lacks appropriate guiding approaches, including an explicitly clear policy directive to operationalise legislative provisions as per the Labour Act. Henceforth the importance of, first and foremost, seeking to understand and conceptualize health status profiling for the Namibian public service.

5.3.3 Conceptualisation of public servants' general health statuses

There exists no explicit definition and or conceptual description of the general health status of public servants in the Namibian Public Service. A similar guiding mechanism

seems to be lacking in many Southern African countries, apart from the presence or existence of national OHS policies and legislative provisions, particularly with an emphasis on health surveillance, which seems a common practice in first-world countries [295] [214] [296].

According to the literature, the term Health Status broadly refers to a combination of multiple health information, in the context of this study, crucial for occupational health and safety efforts in the workplace [297]. To arrest ill-health amongst public servants and to create a desirable work-life balance, governments all over the world have instituted periodic health examinations to determine the HS of public servants as a measure of performance and productivity [206] [224]. Developed countries such as the United States of America and the United Kingdom have computer-based occupational systems differentiating occupational categories and segregating employees' information under numerous classifications [298]. The latter enables, for example, the determination of proportional numbers of exposure to occupational hazards and infectious diseases per specific job category, income, educational status and other amenities such as medical aid [298].

Albeit the absence of an explicit conceptualisation of public servants' health statuses reported in this study, as well as the absence of related management standards pertaining to public servants' health (and safety), the Labour Act and ensued National Occupational Safety and Health Policy sets legislative requirement as a basis, similar to countries worldwide. Act 13 of 1995 regulates the establishment, management and administration of the aforementioned crucial aspects (medical aid, sick leave system and associated health examination during employment purposes) essential for profiling public servants'

health statuses. The aforementioned health status data sources are not readily available neither are procedures in place to guide management and profiling in the Namibian public service.

The Namibian Public Service needs to conceptualise public servants' health statuses alongside readily available data sources, for example, medical scheme data as well as sick leave information can be segregated by age groups, sex, income, educational levels, employment type and agency, risks factors to infer and or predict morbidity, chronic illnesses, such as hypertension and Diabetes which might result in cardio-cerebrovascular diseases potentially derived from lifestyle conditions such as obesity, such as in the Whitehall Study [51].

The Whitehall study is the longest longitudinal retrospective collection of health information amongst 10,308 public servants in Britain, commenced in 1967 and provides a comprehensive narrative forecasting the burden of diseases on the health of the targeted employees as well as associated expenditures and interventions to mitigate and or the prevent health conditions, particularly those occurring through lifestyle [243].

This study reported that there were estimated 120 000 public servants in Namibia, during the 2018/2019 financial year, making the government the largest employer, similar to many governments across the world, and an environment regarded as a contributor to a disproportionate of up to 90% exposure to diseases, injuries and fatality, thus contributing, therefore, to overall disease burden worldwide according to the WHO, the Work Bank and ILO [299] [20] [19] [138]. The enhancement of safety and health amongst the working population is therefore essential to overall population health [299] [20].

Governments around the world have instituted, in addition to national OSH instruments, policies, standards and procedures aimed to mitigate exposure to heavy metals, physical hazards and diseases through targeted health and safety promotion programs in the workplace [23]. Similar frameworks, including occupational health examinations, are yet to be constituted in the SADC, with the exception of the RSA [295].

The Namibian Public Service, which at this point cannot establish or infer the distribution of exposure, disease burden and risks, as a result of the absence of procedures and or frameworks, is no exception. Empirical evidence gathered and discussed herein is designated to inform the conceptualisation of an approach to facilitate the profiling of public servants' health statuses in the Namibian Public Service, captured in the following chapters.

5.3.4 Using HiAP to profile public servants' general health statuses

Adequate empirical data to advance the use of the HiAP approach, as discussed in earlier sections (5.2.1 – 5.2.4) was gathered and here under synthesis as per WHO Analytical Framework elements, described in chapter one, briefly. Numerous data sources as well as the actual reported prevalence of diseases present '*Opportunities for initiation'* of the HiAP approach. More so public servants' health information gathered from various research methods from public servants presents '*Key drivers of implementing'* as the approach. In there, research results lie in '*Key domains of an equity lens'* as well as '*Key driver of sustainability'*. The next chapter describes the elements in detail as it pertains to the research results.

5.4 SUMMARY

This study revealed a rich history of relevant and appropriate information, as well as data sources, pertaining to the HS of public servants in the Namibian Public Service appropriate for profiling. The results indicate acceptable levels of good health among research participants, but in those with health conditions, the study showed similar trends with existing literature. Health status data sources also showed similarity with existing tools such as the CDC Employee Health Assessment and the New England Employee Survey tools which are similar to the WHO STEP-wise questionnaire as well as the GHQ known as the Short Form (SF) 38/26 item questionnaire [288] [55].

The aforementioned HS measurement tools were employed mainly because of their suitability to the Namibian public service context to study a wide range of employee health aspects. Based on the information provided, the Namibian public service ought to normalise health status profiling given the current institutionalised mechanisms, prevailing supportive legislative provisions and available data sources.

CHAPTER SIX: FRAMEWORK CONCEPTUALISATION

6.1 INTRODUCTION

In this chapter, the researcher describes the design, and development and presents the envisaged conceptual framework using empirical evidence emanating from Phase I, objective (i) – (vi). The chapter commences with the researcher's reasoning, followed by a description of how key concepts were applied to the study phenomenon and lastly how the WHO Analytical Framework elements, alongside those of the Systems and Practices - Oriented theories aided the conceptualisation of the framework and contextualization to the NPS. Perspectives of HiAP Subject Experts, who validated the appropriateness of the framework, are also described herein. This chapter forms Phase II.

6.2 RESEARCHER'S REASONING

This study drew wisdom from the pragmatism epistemology which believes that reality is not vested in a single approach, but in "*multiple ways of seeing and hearing, multiple ways of making sense of the social world, and multiple standpoints on what is important and to be valued and cherished*" [300, p. 20]. Empirical evidence was therefore gathered using an MMR approach employing a Descriptive Convergent Parallel Contextual research design to collect qualitative data by means of Document review, FGD, KII and DA methods as well as cross-sectional and KAP survey quantitative methods. Rudimentary findings established with the assistance of computer-aided software (PSS and MAXQDA), revealed the existence of public servants' health status characteristics from befitting sources of data in the current contextual situation to support and inform the development of the envisaged framework.

With regard to pragmatism, the researcher envisioned the below illustrated mental map encapsulating the application of the WHO Analytical Framework alongside elements of the Systems and Practices-Oriented theories aiding in the development of the envisaged HiAP-based.

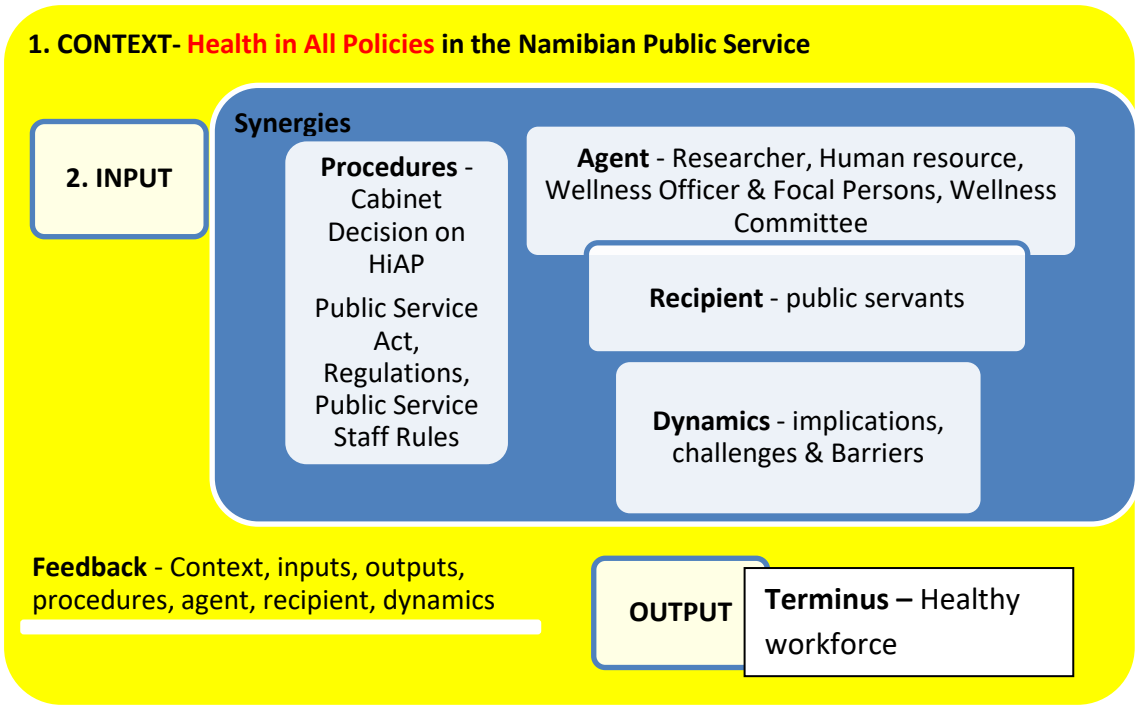


Figure 6.1 Researcher's rudimentary conceptual understanding of the envisaged framework

The illustration above depicts three major segments: '*context, inputs and outcome*'.

1. The '*context*' refers to the application of HiAP in the Namibian Public Service, and various 'feedback' loops;
2. *'Inputs'* consist of numerous *'synergic'* sub-segments including the *'agent's'* deliberations with the *'recipient'* assumingly resulting in *'dynamic'* interaction and during the exchange of numerous procedures facilitated as a '*process*'; and lastly
3. The expected *'outcome'/'terminus'* is envisaged because of the interaction if the process remains constant across contextually.

This study, further advocates for a conceptual framework embedded in the HiAP principles and therefore a need exists to contextualise, discuss and understand the empirical evidence in the context of the approach) [24]. Henceforth the researcher, aided by the elements of the WHO HiAP Analytical Framework provides here below (Figure 6.2) a summarised illustration of the research results, for ease of reference.

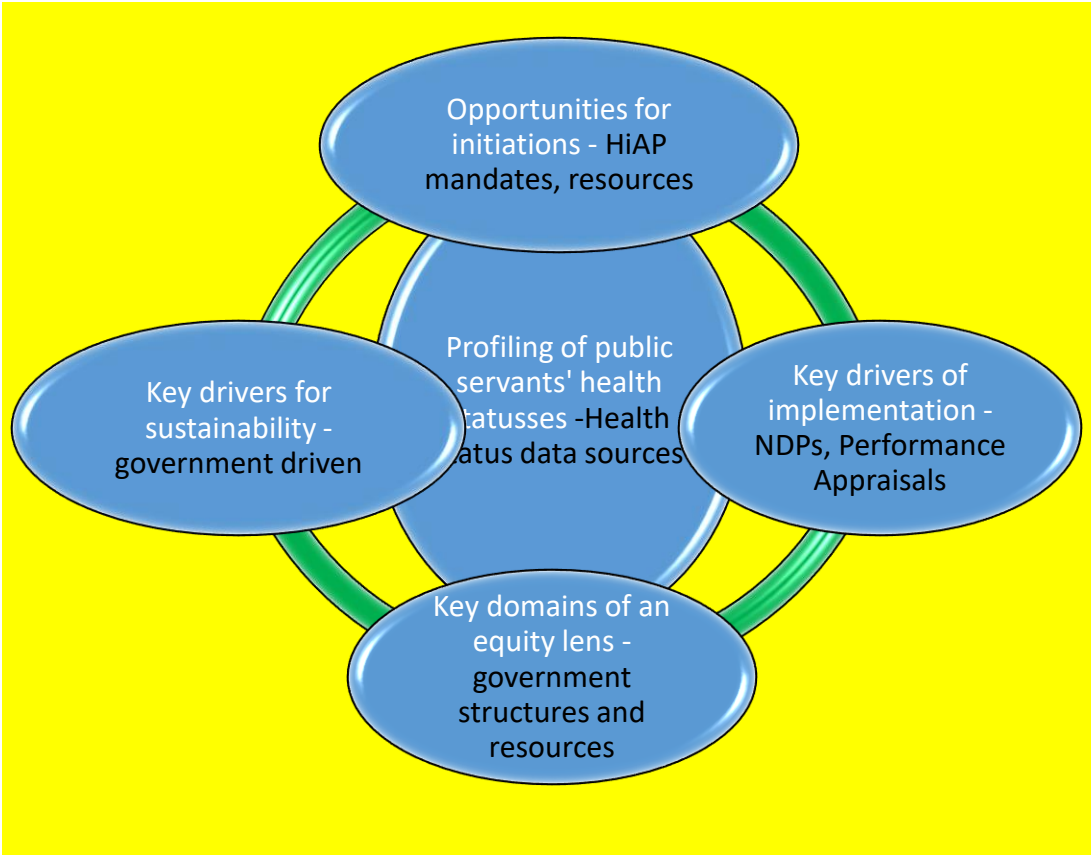
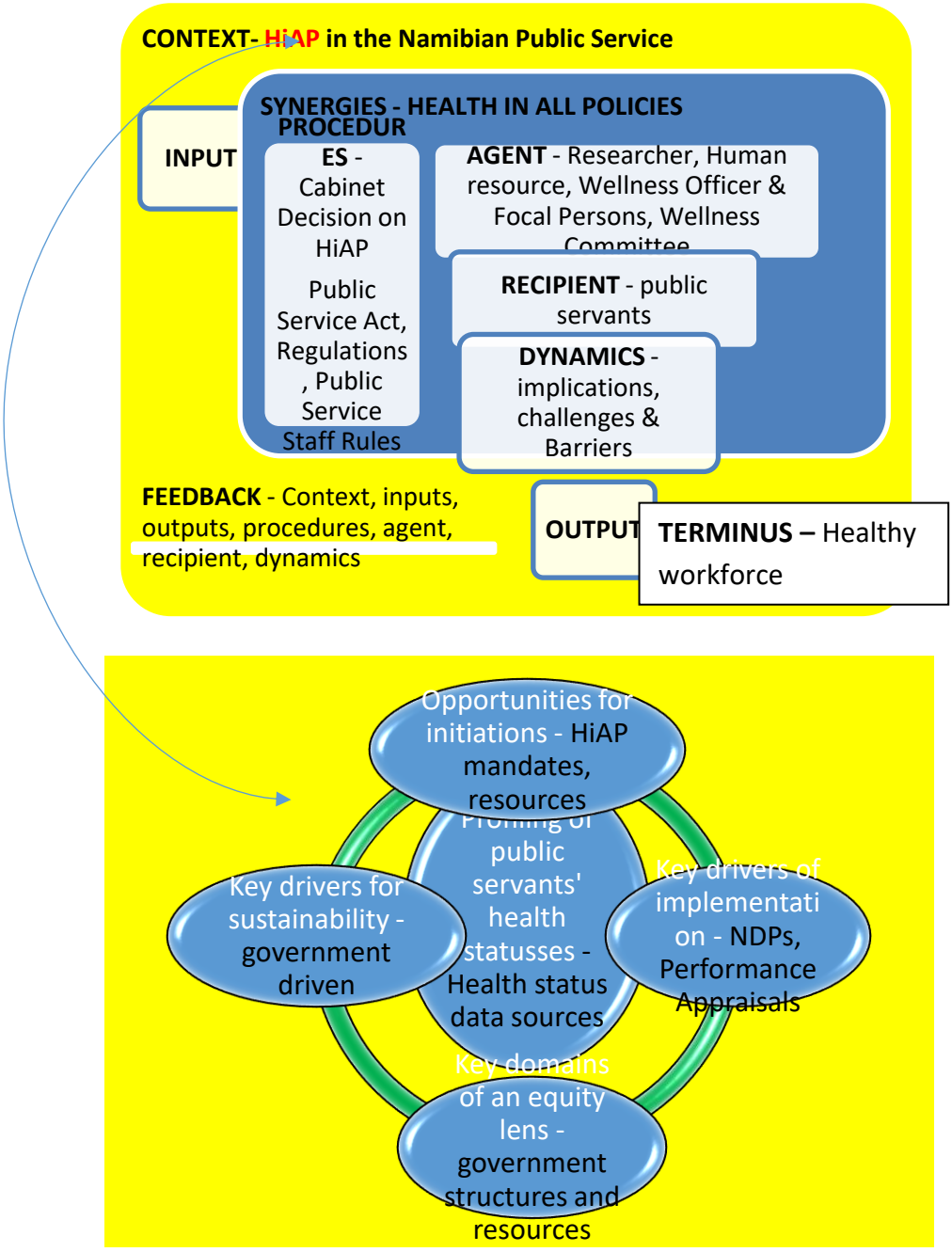


Figure 6.2 Researcher's HiAP-based conceptual framework

Figure 6.2 serves to illustrate the application of HiAP principles and the overall approach into the framework depicted in Figure 6.1 and study context. The approach, as the conveyor belt of all 'processes' is described using the research result obtained in Phase I. Justification for using the WHO HiAP Analytical Framework to guide the conceptual process is described in-depth in the section below.

The illustration below serves to depict HiAP in detail using the elements of the WHO HiAP Analytical Framework



6.3 APPLICATION OF THE WHO ANALYTICAL FRAMEWORK

Figure 6.1 above provides a 'bird's view' of the envisaged framework. Figure 6.2 serves to expand the provision of HiAP as part of the overall framework depicted in Figure 6.2 by providing added details on how the approach is mainstreamed using the elements of the WHO HiAP Analytical framework. Figure 6.2 illustrates, further, the conceptual flow and theoretical embedment of HiAP-principles, described in-depth below.

6.3.1. Opportunities for initiation

The aforementioned WHO Analytical Framework element, namely 'opportunities for initiation' seeks to identify policy windows/opportunities that might be influenced by national and international HiAP practices and interventions [2]. The results of this study described the adoption of HiAP in Namibia among such practices [46]. The study further revealed that Namibia has since the formal adoption of HiAP, initiated a National Strategy on HiAP currently in a draft form since 2019 [46] [48]. Another key finding is the NDP's mandate to foster service delivery amongst public servants, albeit with no performance indicators to measure the performance of public servants [58]. All of the aforementioned are indications of opportunities for initiating HiAP.

The Public Service Act (Act 13 of 1995), The Labour Act (Act 2 of 2012), Cabinet resolution 5th/05.04.16/004 on HiAP, the NNHP as well as the Namibian Constitution, Vision 2030 and the NDPs are legal directives further mandating that employees' health should be promoted [198] [37] [46] [145] [301]. All of the above-mentioned aspects provide for a window of opportunities, ideally as a 'policy window' imperative to establish the health status of public servants in Namibia as per Kickbusch & Bucket [87].

In addition, the employment context of public service in Namibia is coordinated by the OPM which further endorses structures through a hub namely the PSC, following a collective agreement with the bargaining unions [302]. Public servants' conditions of employment are developed and coordinated by the OPM [198]. The hub can enhance the application of HiAP as it serves as a central unit for coordination in the sectoral system.

Historical figures on the mortality of public servants including the spending of over 2 billion on PSEMAS are but some of the health-related aspects worthy of consideration and might be required to inform the comprehensive health status provided amongst public servants in the framework and application of Hi [302].

The NSF for HIV and AIDS, Namibia HiAP and the NCD Multi-Sectoral Strategies are also some, in addition to the health status marker and data sources, amongst many of the government initiatives including what the health sector, through the MoHSS, coordinates and might further require the involvement of other sectors [108]. For instance, the MoHSS indicated that the following risk factors: poor diet, limited physical inactivity, smoking and misuse of substances are fuelling the increase of NCDs such as obesity, hypertension, and diabetes. This can be described using existing data sources [303].

Sources of health information from PSEMAS and leave absence due to ill health as revealed by this study, can be used to provide more insights into the HS of public servants. Such information can also strengthen the planning towards a more coordinated sectoral response. Currently, some OMAs have conducted activities such as World AIDS Day celebrations and Wellness days, which is an indication that such activities are budgeted for and funded.

6.3.2 Key drivers of implementation

This element of the WHO Analytical Framework seeks aspects which relate to the overall outlook on health and the various relationships required to foster such actions [2]. As indicated in the earlier section, the NDP has set the *"Build Capable and Healthy Human Resources* and *"Effective public service delivery"* amongst its critical goals, albeit with no key indicators and or targets in sight [58].

The aforementioned goals are critical 'key drivers of implementing' interventions aimed to achieve the stated goals. Currently, public service personnel policies, referred to as Public Service Staff Rules (PSSRs), can be viewed as potential drivers of HiAP [195]. These policies, developed and coordinated by the OPM and administered by OMAs, are at the centre and can be regarded as a hub which may serve as a potential gateway for all other policies affecting public servants [195].

Similarly, the national coordination of the NSF for HIV and AIDS has two structures that might be beneficial for addressing public service health-related aspects. These structures are the Cabinet as the highest policy-making body for HIV and AIDS, as well as the Meeting of Senior Civil Servants which is a meeting for all Executive Directors and has two main roles, [108]:

a) *"Ensuring harmonisation and alignment of national response with government policy framework, in addition to overseeing the HIV mainstreaming in different public sectors"*,
b) *"At the individual sector level, Executive Directors are responsible for reviewing and approving sector specific HIV mainstreaming action plans and budgets"*.

Additionally, the Multi-Sectoral Strategy on the prevention and management of NCD can inform the general health status profiling for public servants in Namibia. Critical factors for implementing successful workplace health and safety programmes require multi-government and non-governmental structures [303].

6.3.3 Key domains of an equity lens (in policies and interventions)

A number of policy statements and interventions, discussed under findings, indicate that an explicit intention exists to influence health equity amongst public servants in Namibia [195]. For instance, the Namibia Public Service Charter requires inter-sectoral action and collaboration amongst public servants in an effort to deliver effortless public services. This is critical as an entry point for enhancing equity [2].

Further on, the principles of the Namibia Public Service Charters and the Civil Service Charter, discussed in the literature review chapter albeit outward looking and geared towards the citizen, require the public servants to show a united front in order to deliver public services [59]. Similarly, the Namibia Customer Service Charter which provides a principle for fair and just treatment provides an equity lens [59]. In addition to the aforementioned, a number of legal pieces such as the Tobacco Control Act, the Motor Vehicle Accident Fund, and Staff rules regarding remote areas allowances, vehicles and housing form part of the conditions of employment under the central personnel hub at the OPM [304]. These policies target all public servants and have contributed to easing the engagement of their families and communities.

The OPM on an annual basis devises and disseminates an Annual Wellness, Occupational Health and Safety Calendar [302]. Additionally, the Affirmative Action Policy provides

for the recruitment of marginalised groups such as women, people living with disabilities and minority ethnic populations [305]. It is a tradition that all OMAs have workplace Committees addressing public servants well-being. Workplace committees address a variety of issues.

The current multi-sectoral strategy on the prevention and management of NCDs, driven by the health sectors has its aim that requiring workplace Committees to address NCDs [303]. In addition, the collaborative bargaining mandate of workers' unions enables for the negotiation of better wages and working conditions, especially for public servants at the lower income brands [195]. This can serve as a platform to discuss workers' health too.

Albeit the above-mentioned activities and inter-sectoral collaboration, there exists no legal authority mandating the above-mentioned intent. The present study suggests that the developed conceptual framework be adopted. The OPM in association with the MoHSS, which assumed chairmanship due to its health expertise, can act as the secretariat for the envisaged conceptual framework. On the regional and global level, the country and the Namibian public service have shown commitment to universal policies including HiAP. Thus, its operationalisation might be feasible.

6.3.4 Key drivers of sustainability

This element seeks to foster dialogue, budget integration and non-linear structures that will ensure the sustainability of interventions and a trajectory for achieving health outcomes set [2]. In terms of budgetary provisions, the aforementioned health

interventions such as the Wellness Division in the OPM are structures budgeted under state revenue and guaranteed continuous funding [306].

Similarly, although not explicit, existing inter-ministerial relationships represented through various committees such as the Wellness Committees can be viewed as major drivers for sustaining the inter-sectoral work of public servants in Namibia and which have a strong ground in the Public Service Charter and the NDP5. These mechanisms can further be supported by structures such as the existing inter-sectoral Parliament and Cabinet Committees which are mandated with policy aspects and thus a key issue for sustainability.

Other numerous inter-ministerial committees that exist, can also function as multi-sectoral collaborative mechanisms, especially when institutionalised. Although most of these committees might be ad hoc in nature, their purposive have far-reaching advantages. For example, many policy-initiating processes are established in multi-ministerial bodies with common interests and hence key and critical drivers for sustaining efforts.

Similarly, such bodies existed for the initiation of public health, and mental health in health settings such as those which relate to OHS/OSH and addressing teenage pregnancy in schools and incorporated in School policies. Statutory inter-ministerial councils also exist. For example, structures for TB, Malaria, NCDs, HIV and AIDS.

6.4 APPLICATIONS OF THE SYSTEMS AND PRACTICE-ORIENTED THEORY

The Systems and Practice-Oriented theories were adopted and used, as a stepping stone, to encapsulate logical reasoning for presenting the framework [307]. The researcher

adopted elements of the Systems Theory, namely: '*inputs*', '*outputs*' and '*synergic*' alongside, as well as interchangeable, those of the Practice Oriented Theory, and to be precisely the '*agent', 'context', 'process', 'dynamic' and terminus* to describe the development of the envisaged framework, making henceforth the following assumptions [84] [85].

As per the researcher's vision, the following citation was adopted, as described below in detail: The *'context',* as a unit, has *'inputs'*. The *'inputs'* are *'dynamic'* in nature, creating and allowing therefore *'synergies'* amongst the various processes facilitated by the '*agent*' through various activities with the '*recipient*', in order to expect certain *'outputs'*. *'Feedback'* of the '*process*' described in the preceding processes will be required to inform the ultimate *'outcome' / 'terminus'.*

6.4.1 The Context

The *'context'* in which the envisaged framework will be operationalised is the public service in Namibia. The public service, described in chapter three, consists of government OMA which involves the administrative structure of all government institutions managed by the OPM. In the diagram below the colour yellow represents the context (Public Service). All human resource personnel policies are developed centrally at the OPM and operationalised in all OMAs. Figure 6.3 provides an illustrated description.

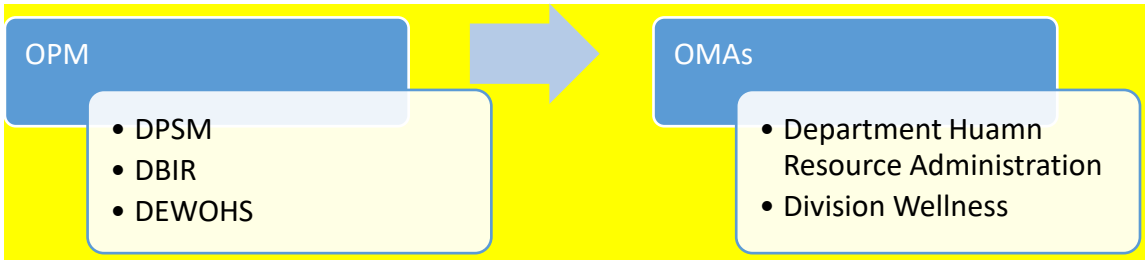


Figure 6.3 Proposed outlines of the agent

The study discovered numerous health statuses and human resource policies appropriate for profiling such as personal files, performance appraisals, sick leave administration and recruitment policies that can be used for epidemiological markers thus making the contextual environment suitable and favourable for applying HiAP assessment. Below are the characteristics of an optimal context:

a) **Optimal environment:** a conducive environment in the form of HR and recipient interaction through communication for the provision of information and written materials on staff rules impacting the health of public servants in the Namibian public service
b) **Resources:** availing of adequate human, financial and structural resources to enable public servants to live a healthy lifestyle in order to remain productive and lessen ill health absence. The HiAP-based framework is envisaged to be implemented as part of the mainstream into the existing human resource procedures, particularly those on personal filling, sick leave administration and recruitment.

6.4.2 Inputs

As indicated above the *'inputs'* are the current health status-related sources such as sick leaves and PSEMASherein classified as *'procedures'* and reflected as PSSR currently facilitated by the *'agent'*, who are the human resource practitioners through engagement with the '*recipient'*, in the context of this study who would be public servants' using various interactive activities such as the workplace wellness initiatives herein termed *'synergies'* and *'dynamics'*. Figure 6.4 illustrates the aforementioned description.

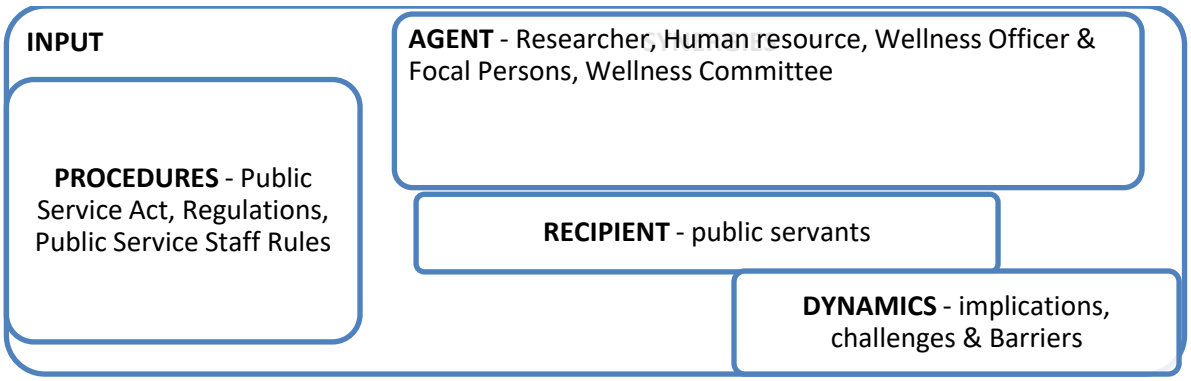


Figure 6.4 The input – elements

6.4.3 Procedures:

Public services around the world are governed by legislative and policy procedures and guidelines. This study is proposing the periodic collection and collation of epidemiological data from public servants to inform the design of workplace health promotion programmes aimed at improving performance and subsequently public service delivery for the Namibian Public Service. The proposed procedure is expected to be mainstreamed with existing procedures already collecting and collating health status data such as sick leave administration and recruitment as per research findings. Below the research provides added clarity to the afore-stated:

6.4.4 Agent:

The researcher proposed a two-tier agent structure. The first tier is that in which the researcher designed and developed the framework as an agent whilst in actual workplace practice numerous agents exist, including the Human Resource Practitioner, the Wellness Officer and or the Focal Person, who will facilitate the narration of profiling public

servants health statuses through data collection and collation, as the other tier. Figure 6.5 below depicts an elementary description.

Figure 6.5 Proposed outlines of agent

The role of the researcher as an agent will be limited and restricted to designing and developing the conceptual framework. The researcher is experienced in both public and occupational areas including having an understanding of the scope and operations of the public service management in Namibia. The researcher recommends the development of a conceptual framework through the appropriate decision-making levels of government. Once in the jurisdiction of the public service, the role of facilitating lies with HR through the Division of Employee Wellness. Below are the essential characteristics of the agents:

a) **The researcher:** expected characteristics would include subject knowledge, and ability to communicate

b) **The HRP, Wellness Officer, Focal Person and or Wellness Committee:**

6.4.5 Recipient:

Public servants and the overall public service will be the beneficiaries and or receivers of this intervention designed by the researcher and facilitated by the HRP, Wellness Officers, Focal Persons and Wellness Committees (the agents).

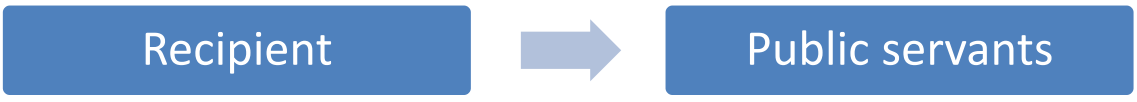


Figure 6.5 Proposed outlines of this recipient

6.4.6 Dynamics and synergies

There exists various interfaces amongst the different components in the public service (context) system. The dynamics were the different challenges which served as barriers amongst the interactions between the context (public service), the agent (human resources personnel) and the recipient (public servants) involved in the implementation of the conceptual framework.

Figure 6.6 Proposed outline of recipient dynamics and synergies

The mutual interfaces schematically interact between and amongst the various components as a character of involvement within a system (context). The related processes (dynamics and synergies) brought as a result of the personnel procedures being implemented require interactions as fulfilment of tasks/functions. The study results revealed administrative challenges including poor participation which might negatively affect the agent's (human resource officers) and the recipient's (public servants) mutual symmetric engagement.

6.4.7 Feedback

Optimal feedback on all inputs and outputs on the implementation in the context should be sought by the agent and given to the context and the recipient using briefings and summaries at appropriate venues.

6.4.8 Output/Terminus

The desired output and end result of the conceptual framework (output) will be the envisioned HiAP-based conceptual framework. The ultimate goal is to foster healthier and capable public servants resulting from informed workplace health promoting wellness programmes for fostering improved performance.

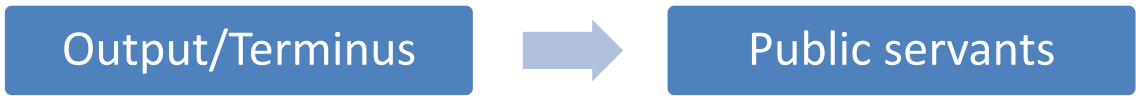


Figure 7.7 Proposed outlines of recipient

6.5 APPLICATION OF KEY CONCEPTS TO THE FRAMEWORK

6.5.1 Health in All Policies

This study established that HiAP focussed on the health impacts of public policies [282]. Public policies, in the context of a workplace environment, might refer to policies governing the work environment, including personnel/human resource policies with the potential to harm the health of employees [308]. The above description relates closely to the conceptualisation of OHS frameworks discussed in early chapters and accounts for various notions including those on injuries, hazards, safety, organisational systems and external environments [17].

The literature revealed that contemporary OSH/OHS efforts proved insufficient, hence the development of integrated approaches to respond to multiple workplace health and safety issues [17]. Integrated such as the sociotechnical systems approach to workplace safety and the Worker Well-Being Framework featuring Health Status amongst its domains were

found to be holistic approaches in nature, focussing and combining multi-level systems and workplace environments [155] [309].

Developers of the socio-technical approach to workplace safety, for instance, sought *"to understand the environmental, organisational and work system that contributes to workplace safety to develop more effective and integrated solutions to deal with persistent workplace safety systems"* [155, p. 548]. These developers, however, cautioned that *"Workplace safety is not the absence of work-related injury"* [155, p. 549] and that *"An enterprise can operate for a long period of time without mishap. However, that does not necessarily make it safe it may simply be a stroke of good fortune, a statistical artefact"* [155, p. 549].

The developers also recognise that the introduction of the sociotechnical approach does not remove workplace hazards, but rather makes a distinction between workplace safety as a standalone strategy and workplace safety as a part of a broader system [155]. The above stated relates to the operation definition of HiAP by the WHO adopted for this study, which states that the approach focuses on identifying the health impacts of public policies [282]. Public policies, in the context of this study, were the various human resource policies [1].

A subject expert responsible for validating the appropriateness of the developed framework narrated the following: "HIAP *is meant to address health equity and social determinants of health through an all-government approach involving and holding to account multiple stakeholders on how their policies and strategies affect the health of the*

population". The findings of this study identified human resource policies on recruitment, sick leave, recruitment as well as housing and transportation allowances.

The researcher further stated an operational definition of HiAP for this study coined by who was required to evaluate the developed conceptual framework, stating that in the context of this study, the envisaged framework sees HiAP as an integrative approach expanding the paradigm to facilitate the profiling of public servants health statuses. This study, therefore, advanced the application of HiAP to the component of health status profiling aimed to enhance the overall, employer, employee and organisation system.

6.5.2 Public servant

Public Servants in this study are referred to as public servants in Namibia and they are a group of people employed by the Namibian government to deliver state services such as education, health care, human resources, policy-making, maintenance and cleaning [3].

6.5.3 Health status of employees

The literature described Health Status as a basic outline of an individual or group's level of health derived from a health assessment for baseline information, strategic planning and comparison [49] [111]. Literature indicates that health status profiling involves the collection, collation, storage and utilisation of workers' physical, mental, health-related behaviour and lifestyle issues including nutrition, substance use, incapacities (disabilities) and injuries [49]. In terms of concepts, health status profiling is not necessarily an abstract term, however, its measure is argued to either be subjective or objective [116] [310].

The literature further described various health status measurements [112], [113]. [114] [115]. This study also stated that employees' health statuses may exist in multiple domains such as physical, mental, health-behaviour, lifestyle, functionality/disability and injuries [17].

Research findings advanced numerous notions from current paradigms described in the literature and required to facilitate health status profiling. Namely; conceptualising the academic concept of health status to country context, need and audience as well as reframing such notions within legal and policy provisions. However, the researcher also understands that others might argue that such an academic distinction might not be necessary.

The present study, however, does not qualify and or focus on the above-mentioned two perspectives of objective and subjective measurement but proposes to take a dual view of the concepts mainly to cater for work-based needs as well as upliftment of the quality of an individual worker's life. Therefore, in broader terms health status data can include both work and non-work data and numerous studies discussed in the earlier chapters attest to the collection and collation of, for instance, disease and condition-specific information, health-seeking and lifestyle information, workplace health promotion and community support health systems information [114] [53] [272] [290].

6.5.4 Profiling

The Merriam-Webster Dictionary defines profiling as an "*act or process of extrapolating information about a person based on known traits or tendencies*" [6].

One Subject Expert narrated as follows, resonating with the aim and thus befitting as an operational definition of profiling for this study:

- *"The application of the approach to the public servants in a workplace context is an innovation and worthy of commendation.*
- *It uses the existing policy and legal framework to enhance the health and well-being of civil servants through a systemic approach which allows for easy coordination and monitoring.*
- *With time, it will allow for the government to see if all benefit equally from health promotion activities and health services available irrespective of position or location ensuring that all have equal and quality access to health information and health promotion activities thereby reducing ill-health and allowing for a healthier workforce in the public sector.*
- *It will be interesting to see over time how the prevalence rates of certain diseases are changing over time, how sick leave is affected, and if the public servants are adopting new behaviour in relation to physical activities, healthy diets, alcohol consumption and smoking".*

6.6 VALIDATION OF THE APPROPRIATENESS OF THE FRAMEWORK

The International Organisation for Standards (ISO) and the WHO define validation as a process used to examine that a product, service and or systems conform to the required standards of the audience [187] [186]. Furthermore, the ISO indicates that validation is the process of ascertaining that the product meets the desired needs and is suitable for use by the intended audience [186].

6.6.1 Validation of the developed conceptual framework

As discussed in the methodology chapter, the structural conceptual framework was designed, constructed and presented under the guidance and constant supervision of the researcher's supervisors and a panellist of five subject experts. Subject experts were purposively selected, three were selected by the researcher and two by the research supervisor. Subject expert evaluations are appended as annexures at the very end of this study report (Annexure 39 – 41).

Subject experts and research supervisors were fully acquainted with this study's theoretical and conceptual basis and they have monitored the developmental process of the data collection, and the construction of the structural conceptual framework and they have made valuable recommendations. The panel of experts was particularly solicited to provide subject matter content and guidance to both the reasoning structure and conceptual framework. The following criteria formed the basis of the validation process:

1. Does the draft develop a structural conceptual framework and measure well in terms of practicality and interpretation with the intended audience?
2. Does literature reliably support and validate developmental reasoning in a logical and reputable manner?
3. Is the developed draft structural conceptual framework feasible or measurable through practical tools?

6.6.2 The population of the subject expert members

The panel consisted of five subject matter experts, three were collectively members of the HiAP Working Group and health professionals in respective individual capacities whilst

two were academics in the capacity lecturers to be exact. The panel was purposively and conveniently selected by the researcher. Permission to act as subject experts and a member of the panel was solicited via email from each member individually and a collective consensus, also via email, was lobbied. Attached to this report as (Annexure 39 - 41) is the email communication to attest to the above.

6.6.3 Validation arrangement process

Initially, subject experts were supposed to have formed a panel, however, due to COVID-19 implications and numerous methodological study amendments, subject experts reviewed the appropriateness of the developed conceptual framework individually.

The panel process was cancelled mainly because additional preparatory arrangements, including the provision of a venue, transportation, copying of the documentation as well as the event's programme might have proved inadequately resourced from the side of the researcher.

Each subject expert was formally invited to participate. The draft contextualised conceptual framework was emailed to each subject expert with a pre-designed guiding tool attached to review the developed framework. The pre-design guiding tool and checklist verified by the supervisor are attached as Annexure 14 to this study report.

6.6.4 Verification of validation arrangement process

Due to the change in methodology regarding the conduct of a panel of subject experts, another layer of verifying the validated outputs (a proposal) to seek an academic opinion through peer review and or any other expert to provide an opinion on the verification

process and outcomes of the reviewed develop framework and ensued process, hence the inclusion of two highly rated academics.

6.6.5 Summary of the Evaluations by the Subject Experts

In summary, subject experts indicated the following:

- The HiAP framework, overall, is a critical and appropriate approach to public health.

- The researcher/student's attempt is a great initiative. The application of the approach to the public servants in a workplace context is an innovation and worthy of commendation, However;
    - It is assumed that the framework that was illustrated in "*Figure 5.1, the Researcher's conceptual reasoning and understanding*". The candidate needs to update the caption for Figure 5.1 for accurate reference in order to foster understanding.
    - The candidate made a significant effort to describe and present the framework. There is however need to improve the framework and guidelines for its implementation. The scope of implementation, implied in the reviewed draft, needs review considering feasibility. Suggestions for improvement are included in the reviewed document, namely in chapters 5 and 6. It was a bit hard to understand the HiAP framework, the conceptual framework by virtue of a limited introduction and acronyms not written in full or explained. The candidate may consider writing the acronyms in full at the first occurrence in the chapter, given their importance and the fact that some readers may dive straight into the chapter without reading earlier sections.

- The framework implies that there is a need for a catalyst to facilitate its implementation. Human resource officers and wellness focal persons would then be the catalyst to ensure that the framework is implemented.
- There is a need to make reference to the Public and Environmental Health Act 2015, taking into consideration that it forms part of the legal framework/or tools through which the HiAP could be traced back.
- It may be useful to maximise on what is currently happening with regards to the implementation of HiAP in Namibia. I have gathered some ideas under the HiAP conceptual framework for your perusal and approval. You may twist them to suit your context.
- *"I might be wrong on this, but I would like to highlight this. I am aware that the concept framework being developed is for the Namibian Public service. however, I wanted to ask if it is not possible to have some linkages with other stakeholders? so as to demonstrate the relations to the outside environment other than that of the GRN. Just thinking aloud".*
- What was the context, some of these words are hanging and need contextualisation – such as procedures, agent, and recipient synergies. Kindly provide context. This entire chapter seems to be just a write-up not supported by literature, but nor by the findings from your own research, which is a very key shortcoming
- "I am still confused, as the major part of the write-up is still on theories, methodologies etc. I have added some comments - sorry did not do spell check"

- There seems to be a lack of connection between some sections. See details within the document
- It was difficult to comprehend section 5.4 in relation to the framework. It seems to be a standalone section, unrelated to the framework described in earlier sections. The candidate needs to relate sections to each other.
- Summaries should draw from content within the text and not bring out new aspects.
- Consistency of citation format within the text: some are with page numbers and others are without. Update to one consistent style.

- Comments to enhance clarity, feasibility and implementation of the HiAP-based framework and its guide are given in the table below, and in the reviewed document

6.7 SUMMARY

This chapter focussed on developing, describing and advancing a contextualised HiAP-based Framework for the Namibian public service pertaining to profiling public servants' health statuses using familiar and common formats of human resource-based policy context The HiAP-based conceptual framework designed and developed, in this chapter, was described and is presented in the next chapter. The logical reasoning map used to design, develop and present the conceptual framework was structured based on the theoretical concept used in the System and Practice Oriented Theories and the WHO Analytical Framework described throughout the study. The aim of contextualisation is to enable envisaged implementers of the developed framework with a tool, similar and familiar to coexisting and current operational procedures. Chapter seven presents the guide for the appropriate introduction and implementation of the designed HiAP-based framework.

CHAPTER SEVEN: DEVELOPMENT OF GUIDELINES

7.1 INTRODUCTION

This chapter describes the development of a guide for the introduction of HiAP among Wellness Officers and the overall implementation of the developed HiAP-based conceptual framework for the NPS. The aforementioned guidelines were developed using study findings emanating from Phase I and Phase II (objectives 2). This chapter addresses Phase III which commenced with the researcher's reasoning philosophy, rationalising the design of the guide pertaining to (a) the introduction of HiAP, and (b) the implementation of the developed HiAP-based conceptual framework. The developed guide is further contextualised to the NPS through a purpose, a goal, objectives, strategies and activities. The researcher, also, describes potential implications that might hinder the effective introduction, implementation and developed conceptual framework. Lastly, the dissemination process of the guide and framework is also explained.

7.2 The researcher's reasoning philosophy pertaining to the development of guidelines

A guideline, according to the WHO, is any formal text which provides procedural guidance on how to carry out a health intervention, being clinical and or administrative [10]. The researcher adopted the outline of the WHO's Handbook on development of guidelines to conceptualise the design of the envisaged guides which was further contextualised using the outline of human resource policies in the Namibian Public Service.

7.2.1 Conceptualisation of the envisaged guidelines

Guidelines are developed with the aim of introducing HiAP and operationalising profiling of public servants' health statuses in the Namibian Public Service. The sequence of the developed conceptual framework takes three components in mind; the context, the input and the outcome/terminus as informed using elements of the WHO HiAP Analytical framework alongside those (elements) of the Systems and Practiced Oriented Theories, captured in RED in Figure 7.1 below.

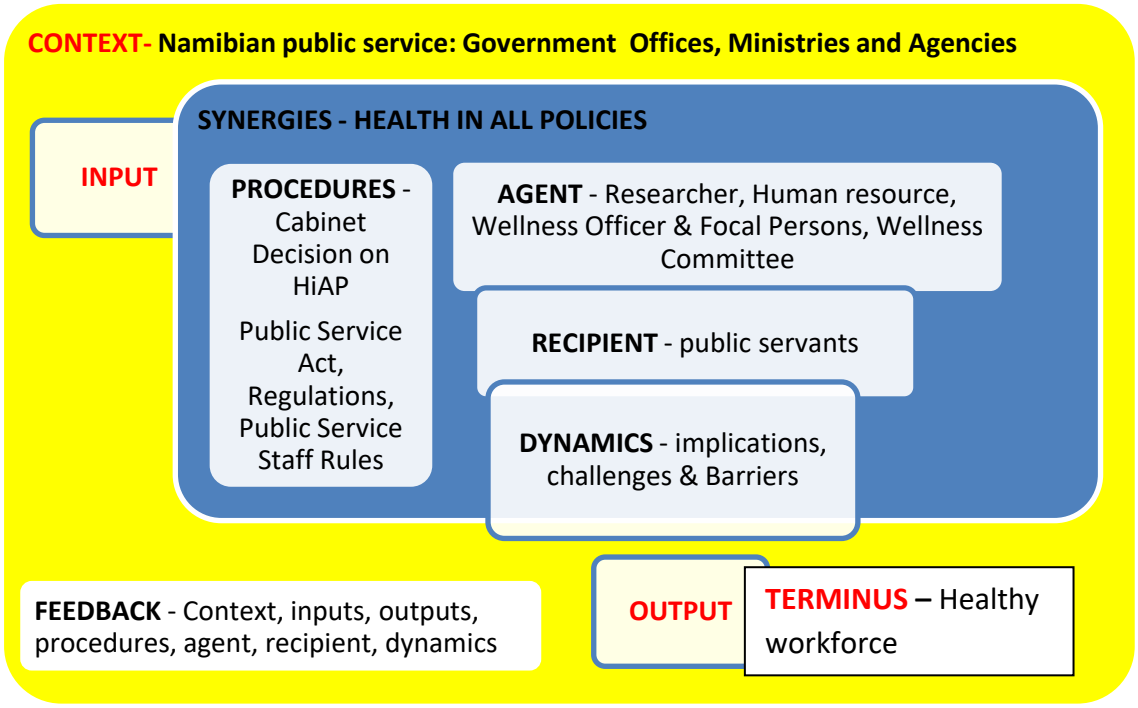


Figure 7.1 Conceptual framework

The above figure depicts the conceptual understanding of facilitating profiling of public servants' health statuses in the Namibian Public Services, as narrated in detail in the previous chapter. The figure provides a basis for discussing the aims and activities of each guideline in the three phases, namely Context, Input and Outcome/Terminus. Singularly;

- ✓ The **Context**: is the environment in which the envisaged interventions are to be operationalised.

- ✓ **Input**: envisaged producers and processes to achieve expected outcome/terminus.

- ✓ **Outcome/Terminus**: intended to ultimately foster a healthy and capable workforce.

In this instance, as described above, the researcher's reasoning and henceforth, developmental understanding of the proposed guidelines described and presented in the following sections are devised with sound theoretical foundations in the HiAP, Systems and Practice Oriented Theories. The presiding statement based its perspective on the study findings captured in Chapter Five and discussed in Chapter Five, specifically the finding that revealed that historically NDPs have set performance and public service delivery amongst its goals, albeit without specific targets and or indicators to be achieved and or measured against.

Similarly, research findings, noted that the public service performance management system devised to measure public servants' performance should have been linked to support the intent of the aforementioned NDPs' expectation to have a capable and healthy workforce. To an extent, such linkages would serve appropriately as targets and or indicators for measurement.

Another research finding, informing the basis of developing the envisaged guidelines is the low level of HiAP knowledge amongst potential implementers, in this study the Wellness Officers, that can have potential implications on the operationalisation of the developed framework. Having developed the structural conceptual framework (figure

7.1), the researcher's reasoning and the quest for the development of a draft conceptual framework the following section is a description of the basis for contextualising the envisaged guidelines.

7.2.2 Contextualising the envisaged guidelines to the study context

The context of this study was the Namibian Public Service. Envisaged guidelines, described herein, were contextualised using the existing public service human resource management outline, policy and legal frameworks. In summary, public service human resource-related policies are centrally developed by the Office of the Prime Minister and are referred to as Public Service Staff Rules, in short PSSR [194].

Once appraised by the Prime Minister, a recommendation to implement an HR-related PSSR is sought from the Public Service Commission (PSC) [194]. On recommendation of the PSC, the Prime Minister, through the Office of the Secretary to Cabinet, notified Executive Directors, by means of a circular to all government Offices, Ministries and Agencies (OMAs) [194]. Government Offices, Ministries and Agencies' Human Resource Directorates, in turn, implement the circular guided by the PSSR on the matter, in the case of this study assuming, therefore, in case of profiling public servants' health statuses [194].

In an attempt to describe the introduction of HiAP in the Public Service and subsequent operationalisation of the developed HiAP-based conceptual understanding/framework presented in chapter six, the researcher commenced by stating the goal/terminus of the framework. Thereafter, the researcher, herein, describes the scope/setting within which the developed framework is to be implemented. The researcher, further, proposes that the

introduction of HiAP should preside over the operationalisation phase, in cognisance of the reported low levels of HiAP knowledge reported context.

Cognisance is further taken on how human resource-related policies are appraised, developed and implemented in the Namibian public services [194]. This study employed the administrative procedure (format) of implementing PSSR in Namibia [194]. Public Service Staff Rules are administrative personnel measures pertaining to managing public servants in a public institution [198] [219]. Staff Rules entail bi-directional procedures in what should be the how, pertaining to a certain service, benefits and or conditions of employment [194].

The Public Service Medical Aid Scheme (PSEMAS) as an example, is a service benefit for all public servants, albeit on a voluntary basis. Public Service Staff Rule D.IX, approved under Regulation K of 1980, sets out procedures, amongst others, on membership. Another example is the Annual leave PSSR. Staff annual leave, unlike study leave, in the Namibian public service context, is a condition of service/employment, which all staff members are obligated to take, within a 12-month calendar [306].

Another example of a PSSR is the one pertaining to the management and administration of leaves, contained in PSSR D.I Part III, particularly on sick leave [306]. The Human Resource Directorate, in each OMA, administers the above-mentioned PSSR as per the administrative process set out [194]. In summary, research findings revealed that PSSRs exist on numerous health status-related data and sources, including those on PSEMAS, the Health Questionnaire and Discharge on condition of ill-health, all relevant and suitable for usage as sources for profiling public servants' health statuses. Other existing and

relevant PSSRs are the ones on Housing, Transportation, Education (Training) and maternity leave.

7.2.3 Assumption regarding those who will benefit from the envisaged guidelines

Broadly, envisaged guidelines are expected to benefit the public service in its entirety in terms of context, but gains are particularly focussed towards OHS/OSH as well as strengthening and, in particular, contribution towards realising expectations of the Draft National Strategy on HiAP which subsequently augments and propels efforts by the MoHSS, and in so doing ensuring that the Cabinet directive on adopting and implementing the HiAP in Namibia is attained. Below the researcher makes assumptions, and describes the benefits to be derived from this study's interventions.

7.2.3.1 The Office of the Prime Minister

Increased contextualised knowledge and skills about the HiAP approach, and in particular on the benefits of profiling the health status of public servants, expressly as a tangible proxy for public service performance (productivity) and workplace wellness promotion programming. Create a policy platform and framework to comprehensively address existing fragmented health-related human resource and personnel policies such as the proper collection and collation of PSEMAS data to provide an overall health status profile and estimate the Burden of Diseases amongst public servants in Namibia, subsequently adopting an integrated framework to manage ill-health in the Namibian public service.

7.2.3.2 Benefits to Government Offices, Ministries and Agencies

Provide an integrated platform for managing multi-disciplinary OHS/OSH in OMAs aimed to improve the overall health and well-being of public servants expected to reduce

health-related absenteeism, workplace accidents (and injuries) to subsequently boost productivity and the effective and timely delivery of public services by a knowledgeable and competent human resource directorate.

7.2.3.3 Benefit to the public servant

Through awareness and sensitisation, engagements have a knowledgeable and informed public service envisaged to increase health-promoting behaviours and attitudes.

7.2.3.4 Benefit to the National Planning Commission

Provide a framework for setting verifiable indicators, targets and or baseline information regarding public service delivery and public service performance as part of the National Development Plans Performance Management, Monitoring and Evaluation framework to be able to infer ill-health and related sickness absenteeism to the non-attainment of public service delivery service stated in the NDPs.

7.2.3.5 Benefits to the Ministry of Labour and Industrial Relations

Create a platform for a national, and public service specific, integrated OHS/OSH framework for the public service aimed to improve the relationship between workers' health and productivity and pave the way for current demands of 'stay-at-work-programmes aimed to decrease absenteeism and presentism and increase productivity. Provide an opportunity to advocate for a whole of workplace approach to employee wellness as opposed to the conventional offering of untargeted overall health-promoting programmes, nationally. The whole in workplace approach refers to multi-hierarchical levels/systems which resulted in the development of a contextualised HiAP conceptual

framework for the public service employment sector. Traditional workplace wellness response strategies have to reach their utility.

7.2.3.6 Benefits to the Ministry of Health and Social Services

Appraise various HiAP interventions as per Cabinet decision, number 5th /05.04.16/004, to adopt and implement the HiAP approach in Namibia. Similarly, advance various modes of HiAP implementation in the country, with specific reference to the Namibian public service.

7.2.3.7 Benefit and opportunity for research

Create an opportunity to advance HiAP-related research and application in the country and not just limited to the public service.

7.3 ASSUMPTION REGARDING POTENTIAL IMPLICATIONS

Interventions, specifically those which relate to sensitive and confidential health information might have a potential for legal and administrative implications [61]. In relation to this study, administrative measures in the Namibian public service are developed based on the provisions of the Public Service Act and related regulations pertaining to the staff rules [198] [194] [219]. The researcher makes the following assumption as potential implications relevant for consideration in this study.

Currently, the Namibian Public Service has not made policy provisions and there exist no administrative procedures for the human resource departments in all government institutions for profiling the health statuses of public servants. This might implicate and negatively influence the willingness of institutions and human resource practitioners due to a lack of a mandate. In addition, administrative heads have no authority to enforce the

practice unilaterally, even in the event the institution experiences an incident. Henceforth, recommend recognising available sources, including the self-rated health questionnaire, sickness absence leave and PSEMAS data to be used as a basis.

With regard to the above, and the evidence of the existence of legislative and policy provisions, practising health status profiling, as is currently implicating adherence to the Labour Act, will largely facilitate compliance [253] [258]. Similarly, profiling of public servants' health statuses falls, largely, within the framework of the Cabinet Resolution, as described in the introductory chapters, on the adoption of HiAP, and by default the role of the Public Service in facilitating the operationalisation of the approach.

With the latter paragraph in mind, it gave rise to the question: 'What does HiAP mean for the Namibian public service and the public servant, in particular?' Research findings reveal limited knowledge about potential implementers. The study also revealed that there exists no clear structure for the operationalisation of the approach [107]. The Draft National Strategy on HiAP does not describe administrative processes, apart from the description of the enteric governance structure [48]. The slow pace of finalizing the strategy is concerning.

It is crucial to note that the HiAP approach is a fairly new concept in Namibia, formally adopted in 2016, but largely remains in its infancy [46] [48]. Coupled with the above-stated evidence about low levels of knowledge amongst potential implementers and limited involvement by critical stakeholders, the operationalization of the approach depends on targeted advocacy, building and strengthening structures and seeking buy-in. The Public Service system involves complex bureaucratic and operational processes that

negatively delay implementation, beyond the researcher's control. Implementation of any given approach comes with the need for massive financial and human resource needs, governments are financially constrained rendering, already complex systems that are difficult to implement, specifically in the absence of clear legal and policy procedures.

Health status profiling, is also an entirely new phenomenon for the Namibian Public Service, albeit a common practice around the world and the existence of a myriad of health data sources as well as integrated approaches. The objective and subjective nature of self-reported health status measures, which take away the possibility of having a clear and exclusive boundary to any data system, might complicate the operationalisation of the envisaged study interventions further.

It is, therefore, of paramount importance to advance efforts to clarify complexities related to methodology, conceptual as well as theoretical applications, in the form of research [79]. The use of the Systems and Practice Oriented Theories in this study, for example, enables the researcher to demarcate concepts into linear elements in order to form a system, therefore the structural conceptual framework developed does not necessarily claim to be adequate in its reasoning nor conclusive in its contextual (academic, workplace and social) endeavour [86].

Handling of health status data for existing health data sources identified as study findings, mainly self-rated health questionnaires, sickness absence leaves and PSEMAS health condition, usage therefore is not clearly stipulated to establish the burden of sickness in the public service. Practically, the current staff rule which requires that a district surgeon provide formal fitness clearance where a public servant suffers or has suffered a condition

prescribed in the self-rated health questionnaire does not provide adequate measure. In fact, to date the rule does not, for example, define the term '*District surgeon*', leaving it up to multiple interpretations [195]. Lastly, little exists on OSH/OHS in the Public Service leading to anticipation reluctance to adopt new approaches with little or no historic operational experiences, henceforth a need for vigorous advocacy efforts.

7.4 ASSUMPTION REGARDING THE DISSEMINATION OF THE GUIDELINES

Envisaged guidelines will be expected to be disseminated through the Office of the Prime Minister, as the central hub of human resource management for government institutions [301]. Study findings dissemination to this Office during the validation processes as well as in response to the conditions of permission to conduct an academic study, provided before the commencement of the study (Annexure 3). The Office of the Prime Minister's existing structure for dissemination of human resource-related matters is called the HR Forum and the e-service. It is at the aforementioned platforms (HR Form and the e-service) that practitioners will be introduced to the HiAP approach, the developed framework and the strategies for implementation.

7.5 GUIDELINES FOR THE INTRODUCTION OF HiAP

7.5.1 The goal of the developed HiAP-informed conceptual framework

The ultimate goal/terminus of the developed HiAP-informed framework is to facilitate the profiling of public servants' health statuses with the aim to inform workplace health-promoting wellness programmes in all public institutions with the aim to eventually boost performance by a capable and healthier workforce.

7.5.2 The purpose of the introductory guide

The purpose of the implementation guidelines is to facilitate the execution of the developed HiAP-informed conceptual framework, as developed and presented in Chapter Five, contextualised to the Namibian public service personnel management context. In addition, the purpose of the guidelines is to provide clear strategies on how to address key research findings.

7.5.3 The objectives of the introductory guide

a) Create overall awareness about the HiAP approach in Namibia, and what it means for the Namibian public service and the public servant, in particular.
b) Introduce the developed HiAP-based conceptual framework as a mechanism to facilitate (enabling) profiling of the health status of public servants.
c) Describe the developed profiled health statuses of public servants in the Ministry of Works and Transport.

d) Explain the modalities and administrative procedures for the implementation of the developed HiAP-based conceptual framework in relation to the type of health status information to be collected and collated to form a profile.

e) Amplify structures and resources required for implementing the HiAP-based conceptual framework

7.5.4 The strategies, activities and responsible implementing agent

Table 7.1 Guidelines, strategies, activities and responsible implementing agent

GUIDELINES (WHAT)	STRATEGIES (HOW)	ACTIVITIES	IMPLEMENTOR
1) Lack and limited knowledge about the HiAP approach	Build the capacity building of HR	Half-day awareness creation workshop for OMAs human resource practitioners on the HiAP	
2) Fragmented health status sources	Identify appropriate data sources	Virtual online sessions with human resource practitioners	
3) Creation of Health status data profiles	Identified health status data to be collected, collated into a profile	Computer – virtual presentation and exercise on how to complete a health status template	
4) Absence (lack) of a framework to collect and collate health status data	Promote the implementation of the HiAP-based conceptual framework in various government entities	Half-day session to pilot the developed conceptual framework	
5) Roll-out conceptual framework	Promote the implementation of the HiAP-based conceptual framework in various government entities	Adjust implementation methodology and scale–up intervention	

7.6 GUIDELINES FOR THE OPERATIONALISATION OF THE FRAMEWORK

7.6.1 The goal of the developed HiAP-informed conceptual framework

The ultimate goal/terminus of the developed HiAP-informed framework is to facilitate the profiling of public servants' health statuses with the aim to inform workplace health-promoting wellness programmes in all public institutions with the aim to eventually boost performance by a capable and healthier workforce.

7.6.2 The purpose of the introductory guide

The purpose of the implementation guideline is to facilitate the execution of the developed HiAP-informed conceptual framework, as developed and presented in Chapter Five, contextualised to the Namibian public service personnel management context. In addition, the purpose of the guideline is to provide clear strategies on how to address key research findings.

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c) Describe the developed profiled health statuses of public servants in the Ministry of Works and Transport.

d) Explain the modalities and administrative procedures for the implementation of the developed HiAP-based conceptual framework in relation to the type of health status information to be collected and collated to form a profile.

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7.7 SUMMARY

In this chapter, the researcher described the assumptions under which the guides were developed to introduce HiAP and the effective implementation of the developed HiAP-based conceptual framework to facilitate the profiling of public servants' health statuses in the NPS. The guides were grafted based on data and research findings emanating from Phase I and II: that there exists minimum knowledge of HiAP in the public service in Namibia. The guides were written for the NPS setting using the WHO Handbook for guidelines development and contextualised alongside PSSR administrative guidelines and outlines. The researcher further described the assumptions as critical success factors for the proper introduction of the HiAP framework in the NPS context, without which the implementation and operationalisation of the developed conceptual framework would likely not succeed. The next chapter is the last and conclusive summary of this study.

CHAPTER EIGHT: CONCLUSIONS AND RECOMMENDATION

8.1 INTRODUCTION

The purpose of this study was to develop a HiAP-based conceptual framework and a guide for the introduction and implementation of the developed framework to facilitate the profiling of public servants' health statuses in the NPS. Currently, there exists no framework despite this being a Labour Act legislative requirement. This study, a first of its kind, gathered empirical evidence examining health status-related aspects among role players in the NPS to inform the development of the aforementioned conceptual framework. This chapter is describing the research processes and makes recommendations based on the research findings.

8.2 CONCLUSIONS

8.2.1 Phase I - Objectives (i) – (vi)

The study found that conducting health status assessments is a common workplace worldwide practice that aims to detect occupational incapacities due to exposure to workplace hazards and diseases, as well as use to inform the promotion of health and safety in order to maintain and improve performance and productivity. The study established that health status profiling entails the collection, storage and use of employees' health-related data. The study further found that public servants' health profiles are non-existent in Namibian Public Service and neither does there exist a framework to guide and conduct such profiles. Despite health status-related information and sources such as information on workplace injuries, medical health and socio-economic such as

transportation, and housing allowances. The study found evidence of legal and policy requirements for conducting health status profiling.

Health status information and data sources such as information on public servants' medical aid contribution, gross income, transport and housing allowances were readily available whilst workplace injuries, occupational and overall disease profiles, and socio-economic and living conditions of public servants were not publicly available. Overall, an acceptable health status amongst public servants in the MWT in Namibia was observed. Prevalence of diseases such as hypertension and cholesterol, mental health conditions, including stress, as well as health risk factors, such as obesity and smoking, however, showed significant association with poor health. Diseases and health risk factors perpetuate ill-health absence, subsequently influencing performance and productivity and hence delaying the delivery of public services, if not adequately addressed. Some key research evidence was:

- A 98.6% self-reported response and a combined 83.3% acceptable health status amongst participants were registered, respectively. The remainder, of the latter, 13.9% poor health reported, further substantiated by the prevalence of Hypertension (27%), musculoskeletal disorders (30.6%), stress (55%) and disabilities (21%).
- The study also found an average of 4-8 days' sickness absence, 38% physical inactivity, 83% nutritional anomalies, 27% obesity according to the Body Mass Index (BMI), 11% smoking and 27.5% consumption of alcohol, amongst participants.
- Significant statistical association to poor health was further recorded for hypertension (p-value=0.001), Cholesterol (p-value=0.003), musculoskeletal pain (p-value=0.001) and for mental related conditions (p-value=0.009).

- No statistical association was observed with elevated blood sugar (p-value=0.258≤5%). The study also reported high workplace safety awareness.

There exists poor knowledge, attitude and practices on HiAP among Wellness Officers, a cadre in the public service entrusted with the overall coordination of occupational safety, health and employee wellness in the Namibian public service. This holds implications for the implementation of HiAP, overall, in Namibia, because HiAP drivers are primarily public service structures.

8.2.2 Phase II: Development of a HiAP-based conceptual framework

Phase II which represents the developed HiAP-based conceptual framework used the WHO Analytical Framework and the elements of the Systems and Practice Oriented Theories namely: context (public services); inputs (agent, recipient and procedures); feedback and dynamics (amongst the agent, recipient and procedures) and the outputs (terminus). The developed conceptual framework and the introductory and implementation guidelines were peer-reviewed and validated by five subject experts who suggested amendments to the scope, content and context of the framework.

8.2.3 Phase III: Development of guidelines

The developed conceptual framework and guidelines to inform the proper implementation of the developed framework were discussed and presented in chapters five, six and seven respectively. The guidelines were developed in conformity with the WHO's principles on guidelines development. The guidelines used by internal as well as external implementations are based on the human resource context of the Namibian public service.

8.3 CONTRIBUTION TO THE BODY OF KNOWLEDGE

There has not been a study examining the health status of public servants in Namibia. The present study is the first of its kind that can be utilized to inform additional research as well as used to devise targeted occupational classified health assessments/examinations, health promotion and disease prevention programmes. The present study can influence and inform public service health policy reforms through improved workplace safety, and the adjustment of current wellness workplace programmes and performance improvements. Despite methodological and conceptualization limitations discussed in the next section, this study serves as a valuable baseline for public servants' health status information. The present study provides comprehensive literature on the aspects related to the overall health status of public servants in Namibia. It revealed crucial data sources for profiling public servants' health. The study further provides a conceptual understanding for proposing and developing a conceptual frame for profiling public servants' health status. The study further applied a methodology design that was not utilised in many studies before. Upon an extensive literature review, the present study is the first of its kind in Namibia and provides a base for similar studies in the future. The HiAP approach has not been applied to examine epidemiological surveillance.

8.4 STUDY LIMITATIONS

Although the ultimate purpose and objectives of this study were attained, the onset of COVID-19, from the middle of 2019 to date (December 2021), brought along restrictive regulations including social distancing, isolation and the quarantine of suspected and confirmed cases. The aforementioned impact mitigating strategies led to the delay in data collection and subsequently requested amendments of some data collection methods and

procedures as discussed in chapter three. The above stated were in addition to challenges of the government's authoritative and multi-layered decision-making bureaucratic systems for granting research permission.

Methodological limitations include potential selection bias, mainly because the population which was not selected to participate in the study might have provided different perspectives to the study. Conceptual limitations refer to the description of the general health status where in some studies such as in Spain and Korea, refers to workers' general health examination and or workers' general health screenings/workers' general health surveillance in the United States of America [224] [311] [312].

The study used an amended version of the 38/28-item questionnaire, the GHS Questionnaire blended with WHO STEPwise and thus did not entirely use standing standard scoring and scaling scores, but devised its own scoring and description classification. Therefore, this study did not evaluate health outcomes or the prevalence of different diseases and health disorders. It simply stated the GHS of public servants in the MWT broadly, including inferential statistical significance. The data collection tool was a self-administered structured questionnaire which might have been a limitation in attaining actual readings because research participants were left to describe their own health status as there were no oriented interviewers to clarify or further probe insights in order to answer questions comfortably. Self-rated health measures are common epidemiological assessments used worldwide [313]. Self-administered questionnaires are used to collect personal and sensitive health information that may potentially result in associated information bias as study subjects might likely provide inaccurate health information, thus further presenting a risk of recall and reporting bias [313]. To minimise

the above-mentioned risk, questions were designed to limit speculation and the tool was piloted prior to actual data collection to ensure content and face validity.

Ideally, certain health aspects such as blood pressure, sugar levels, cholesterol, weight, and height could have been assessed physically to determine baseline indices, but limited funds, time frame and logistical resources were a challenge. Lastly, cross-sectional studies similar to this one utilise convenience sampling and thus casual associations and causation could not be determined between independent variables and the outcome (good health) [49]. Moreover, the study was meant to inform the development of a conceptual framework and not to detect casual associations.

8.5 RECOMMENDATIONS

The study concludes that HiAP is a fairly new concept in Namibia despite its popularity globally, henceforth a recommendation is made to advocate for the expedition of HiAP implementation among the Wellness Officers. In view of the research findings, two broad-based recommendations are advanced here below:

8.5.1 Recommendations for HiAP Practice

This study developed a conceptual framework embedded in the HiAP principle to facilitate the profiling of public servants' health statuses in the NPS. The OPM, as the employer, is urged to play an active role in the implementation of the developed framework. Taking cognisance of the study findings, technically, the developed framework is to be implemented by the Wellness Officer, who, by means of this study, has low levels of knowledge of HiAP. The OPM is further urged to utilise the introductory guide to train Wellness Officers in HiAP.

The MoHSS, as the custodian of health matters and by Cabinet directive, overseers of HiAP implementation in the country can be engaged to facilitate such training. On the premise that a gap might continue to exist mainly because there exists no explicit OHS framework for the NPS to amongst others enable a systematic profiling of public servants' health statuses. The OPM should conduct research on the development of an OHS conceptual framework. A policy Brief is attached for guidance.

8.5.2 Recommendations for future research

The researcher recognised that the findings and conclusions reached in this study have given rise to new possible topics and areas for further research as presented below.

- The OPM to expand and conduct a similar study across all public service institutions to determine public servants' disease burden.
- Encapsulate occupational diseases from the MLIREC to expand on the findings of the cross-sectional survey.
- Conduct disease surveillance using anthropometric and biochemical measures among public servants through existing workplace wellness programmes.
- Future studies by the OPM, MoHSS and MLIREC, should also focus on early detection of occupational determinants of health.
- Conduct retrospective studies using data extracted from pre-employment health questionnaires and PSEMAS to inform current wellness workplace programmes.
- In order to effectively address public servants' health determinants (diseases, lifestyle and well-being) the public service, represented by the OPM, should adopt an integrated approach such as Health in All Policies in the continuum of OHS.

A lost opportunity - implementation of a Cabinet Directive: Decision number 5th/05.04.16/004, on the Health in All Policies (HiAP) in Namibia

Kaarina N. Amutenya, explored the development of a conceptual framework to facilitate the profiling of public servants' health statuses, currently non-existence despite legislative requirement. Cabinet Decision nr. 5th/05.04.16/004 enabled the adoption of the Health in All Policies approach in Namibia as a Social Determinants of Health mitigating mechanism using multi sectoral actions to avert socio-economic hardships/deprivation and subsequent livelihoods losses due to the negative health impacts of public policy decision e.g. epidemic infection control policies on social distancing brought by COVID-19 which resulted in major job losses. Evidence of poor HiAP knowledge across government structures, as an anchor, might implicate the institutionalization of the designed framework if not align to legislations such as the Public Health and Environmental Health Act, Act No. 1 of 2015. The pace of implementing HiAP is currently worrisome.

Findings: Namibia is featured on the world map amongst countries implementing HiAP and, therefore, expected to contribute to HiAP literature overall. No tangible interventions have been reported to date, apart from a scooping exercise and a Draft National HiAP Strategy with no legislative backing, despite ravaging health inequities, considering the country's classification as the second most unequal nation in the world. The WHO define HiAP as "an approach to public policies across sectors that systematically takes into account the health implications of policy decisions, seeks synergies, and avoids harmful health impacts to improve population health and health inequities".

National Development Plans should be the foundational context for HiAP, which historically contains no performance measures/targets/indicators informing attainment of Vision 2023 and the broader SDGs. Government structures would be the accountability frame. COVID-19 unprecedented austerities communicated, unequivocally a message for resilience. A critical opportunity to operationalise HiAP, using Cabinet resolution was missed. Namibia used a constitutional mandate to declare COVID as a State of Emergency read in conjunction with Section 30(3) of the Disaster Risk Management Act, 2012 (Act No. 10 of 2012). Beyond the constitutional provisions, COVID-19 regulations were issued per Public & Environmental Health Act, 2015 (Act No.1 of 2015).

Policy Takeaways: HiAP remains a foreign concept, despite its supra mandate. HiAP is an economic opportunity cost, that needs to be expedited. HiAP bounds government structures, intensifying deliberate policy driven SDH actions. An opportunity still exists, in the midst NDP6 to institutionalise and operationalise HiAP using the Part 3 of the Public and Environmental Health Act, 2015 (lesson learnt from the COVID era). The HiAP approach appears most suitable and viable to legitimise multidisciplinary engagements. Whilst efforts for a National HiAP Strategy are applauded, the pace at which HiAP institutionalisation/operationalization is worrisome with no tangle measure, targets and or indicators for accountability. References (available on request)

8.6 SUMMARY

This chapter drew this study to a conclusion by narrating its limitations and presenting recommendations to fill the gap, that is, the absence of an explicit framework to facilitate the profiling of public servants' health statuses as per legislative requirements and subsequent promotion of health in the NPS. A conceptual framework for advancing health status profiling and an introductory guide for the Namibian public service was developed. It is this researcher's contention that the implementation of the developed framework will enhance public servants' health outcomes and subsequently improve performance and overall delivery of timely and quality public services. Health status profiling, a sub-set of epidemiological surveillance in the workplace, is an indispensable action to propel public servants' productivity. The exposition of health status factors such as gender, nutrition, physical activities, disease burden and education are indicators for aggravated health conditions that lead to the subsequent decrease in productivity. Hence deliberate and significant efforts ought to be taken to reciprocate health implications. This study provided the NPS with the required knowledge, tools and mechanisms to better understand and manage public servants' health implications in the form of a conceptual framework and an implementation guide.

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Annexure 1: Ethical Clearance Certificate from UNAM

Annexure 1 Ethical Clearance Certificate

Annexure 2: Letter of permission to conduct study – MoHSS

Annexure 2A
permission to condu

Annexure 3: Permission to conduct study in the public service – OPM

Annexure 3
permission to condu

Annexure 4: Permission to conduct study – MWT

Annexure 3
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Annexure 5: Permission to expand data collection scope – MoHSS

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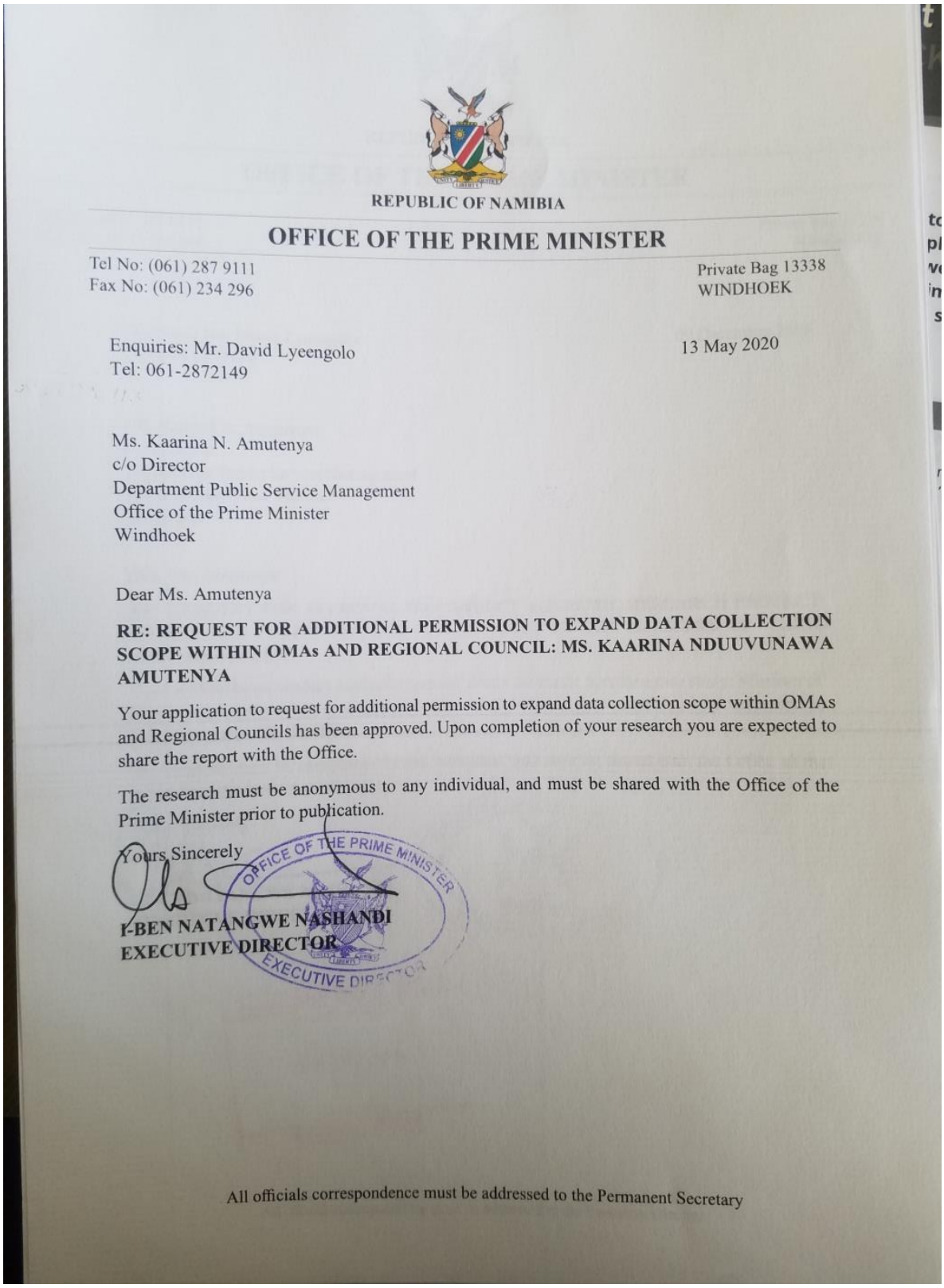
Annexure 6: Permission to expand data collection scope – OPM



REPUBLIC OF NAMIBIA

OFFICE OF THE PRIME MINISTER

Tel No: (061) 287 9111
Fax No: (061) 234 296

Private Bag 13338
WINDHOEK

Enquiries: Mr. David Lyeengolo
Tel: 061-2872149

13 May 2020

Ms. Kaarina N. Amutenya
c/o Director
Department Public Service Management
Office of the Prime Minister
Windhoek

Dear Ms. Amutenya

RE: REQUEST FOR ADDITIONAL PERMISSION TO EXPAND DATA COLLECTION SCOPE WITHIN OMAs AND REGIONAL COUNCIL: MS. KAARINA NDUUVUNAWA AMUTENYA

Your application to request for additional permission to expand data collection scope within OMAs and Regional Councils has been approved. Upon completion of your research you are expected to share the report with the Office.

The research must be anonymous to any individual, and must be shared with the Office of the Prime Minister prior to publication.

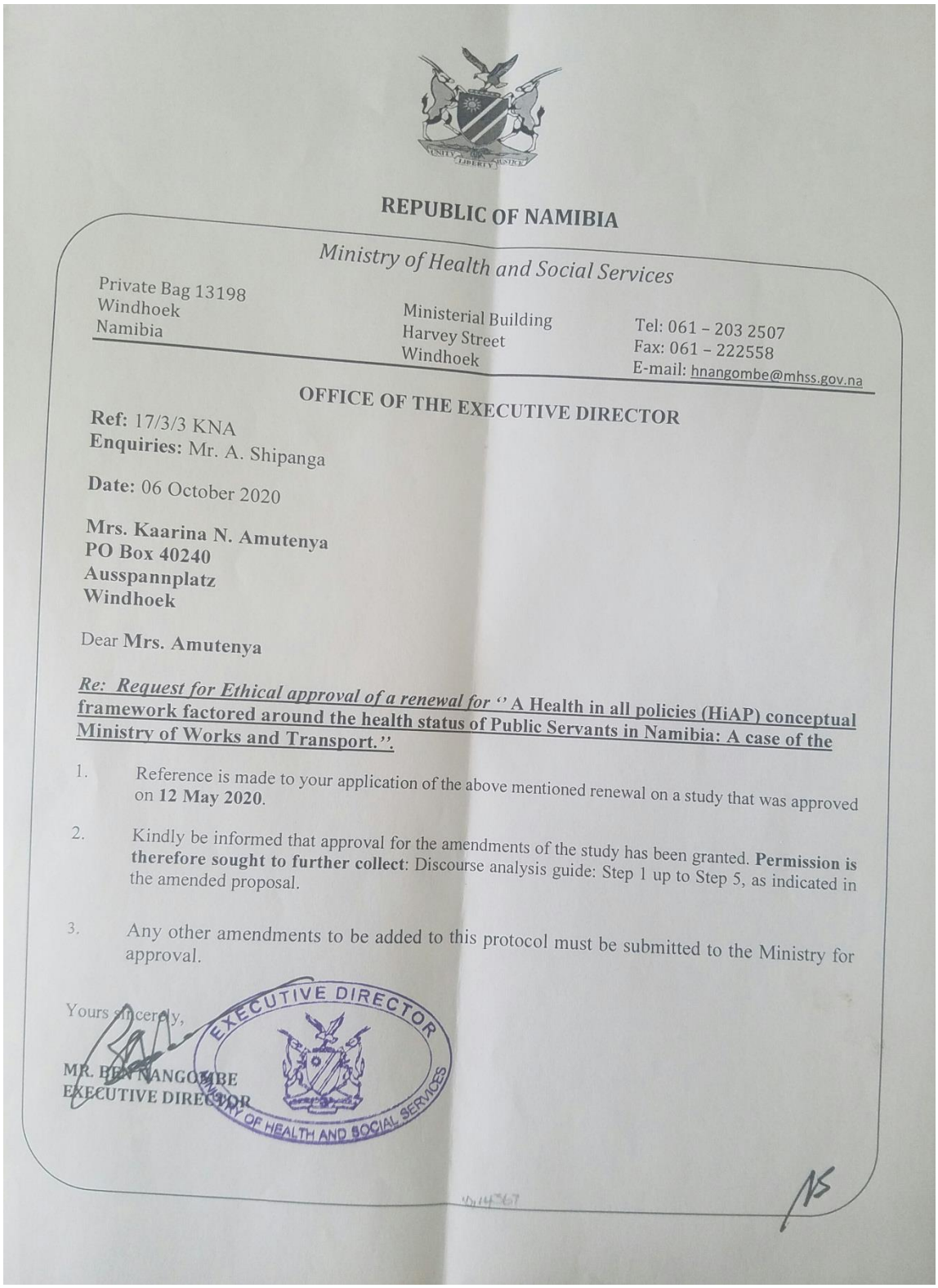
Yours Sincerely

OFFICE OF THE PRIME MINISTER
EXECUTIVE DIRECTOR

I-BEN NATANGWE NASHANDI
EXECUTIVE DIRECTOR

All officials correspondence must be addressed to the Permanent Secretary

Annexure 7: Permission to amend research study methodology



REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198
Windhoek
Namibia

Ministerial Building
Harvey Street
Windhoek

Tel: 061 – 203 2507
Fax: 061 – 222558
E-mail: hnangombe@mhss.gov.na

OFFICE OF THE EXECUTIVE DIRECTOR

Ref: 17/3/3 KNA
Enquiries: Mr. A. Shipanga

Date: 06 October 2020

Mrs. Kaarina N. Amutenya
PO Box 40240
Ausspannplatz
Windhoek

Dear **Mrs. Amutenya**

Re: Request for Ethical approval of a renewal for **'' A Health in all policies (HiAP) conceptual framework factored around the health status of Public Servants in Namibia: A case of the Ministry of Works and Transport.''.**

1. Reference is made to your application of the above mentioned renewal on a study that was approved on **12 May 2020**.

2. Kindly be informed that approval for the amendments of the study has been granted. **Permission is therefore sought to further collect**: Discourse analysis guide: Step 1 up to Step 5, as indicated in the amended proposal.

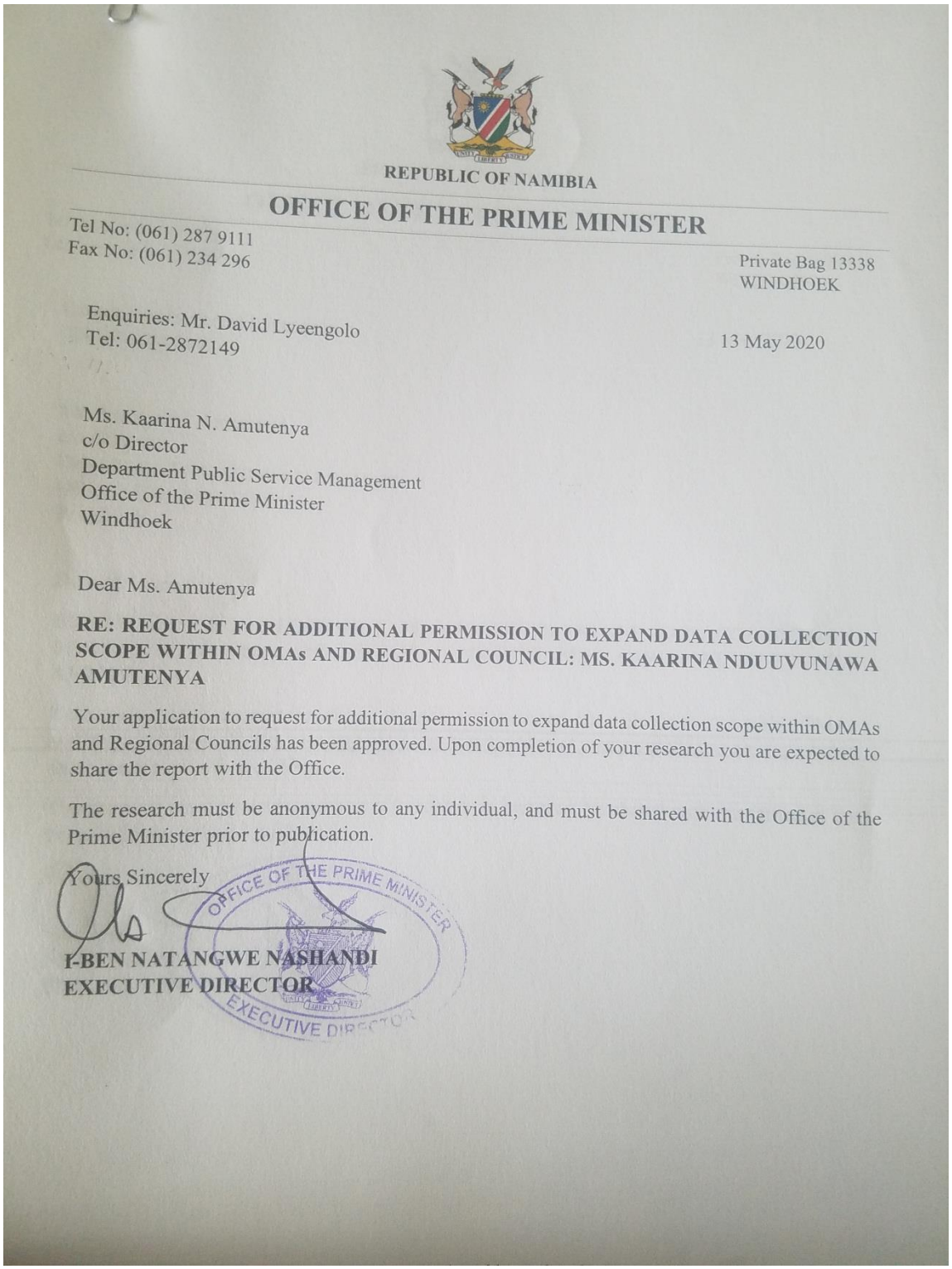
3. Any other amendments to be added to this protocol must be submitted to the Ministry for approval.

Yours sincerely,

EXECUTIVE DIRECTOR
MINISTRY OF HEALTH AND SOCIAL SERVICES

MR. BEN NANGOMBE
EXECUTIVE DIRECTOR

Annexure 8: OPM Permission to expand scope of data collection



REPUBLIC OF NAMIBIA

OFFICE OF THE PRIME MINISTER

Tel No: (061) 287 9111
Fax No: (061) 234 296

Private Bag 13338
WINDHOEK

Enquiries: Mr. David Lyeengolo
Tel: 061-2872149

13 May 2020

Ms. Kaarina N. Amutenya
c/o Director
Department Public Service Management
Office of the Prime Minister
Windhoek

Dear Ms. Amutenya

RE: REQUEST FOR ADDITIONAL PERMISSION TO EXPAND DATA COLLECTION SCOPE WITHIN OMAs AND REGIONAL COUNCIL: MS. KAARINA NDUUVUNAWA AMUTENYA

Your application to request for additional permission to expand data collection scope within OMAs and Regional Councils has been approved. Upon completion of your research you are expected to share the report with the Office.

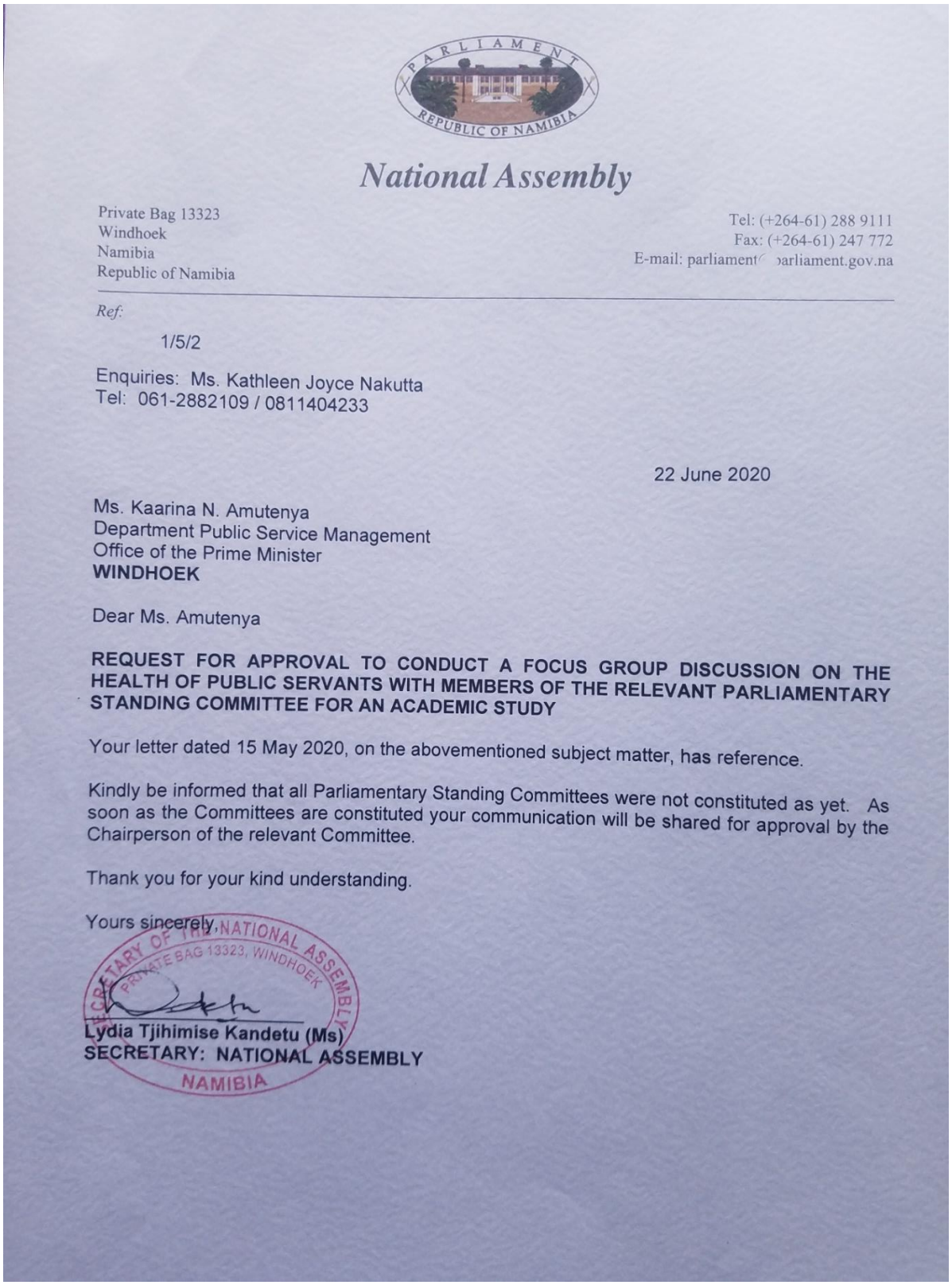
The research must be anonymous to any individual, and must be shared with the Office of the Prime Minister prior to publication.

Yours Sincerely

OFFICE OF THE PRIME MINISTER
EXECUTIVE DIRECTOR

I-BEN NATANGWE NASHANDI
EXECUTIVE DIRECTOR

Annexure 9: Response from National Assembly regarding data collection



PARLIAMENT
REPUBLIC OF NAMIBIA

National Assembly

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Republic of Namibia

Tel: (+264-61) 288 9111
Fax: (+264-61) 247 772
E-mail: parliament@parliament.gov.na

Ref:

1/5/2

Enquiries: Ms. Kathleen Joyce Nakutta
Tel: 061-2882109 / 0811404233

22 June 2020

Ms. Kaarina N. Amutenya
Department Public Service Management
Office of the Prime Minister
WINDHOEK

Dear Ms. Amutenya

REQUEST FOR APPROVAL TO CONDUCT A FOCUS GROUP DISCUSSION ON THE HEALTH OF PUBLIC SERVANTS WITH MEMBERS OF THE RELEVANT PARLIAMENTARY STANDING COMMITTEE FOR AN ACADEMIC STUDY

Your letter dated 15 May 2020, on the abovementioned subject matter, has reference.

Kindly be informed that all Parliamentary Standing Committees were not constituted as yet. As soon as the Committees are constituted your communication will be shared for approval by the Chairperson of the relevant Committee.

Thank you for your kind understanding.

Yours sincerely,

SECRETARY OF THE NATIONAL ASSEMBLY
PRIVATE BAG 13323, WINDHOEK
NAMIBIA

Lydia Tjihimise Kandetu (Ms)
SECRETARY: NATIONAL ASSEMBLY

Annexure 10: List of Government Offices, Ministries and Agencies

Office of the President
Office of the Attorney General
Office of the Auditor General
National Assembly
National Council
Office of the Judiciary
Prime Minister
Ministry of International Relations & Cooperation
Ministry of Home Affairs, Immigration, Safety and Security
Ministry of Defence & Veterans Affairs
Ministry of Finance
Ministry of Industrialisation & Trade
Ministry of Agriculture, Water & Land Reform
Ministry of Urban and Rural Development
Ministry of Health and Social Service
Ministry of Education, Arts and Culture
Ministry Higher Education, Technology & Innovation
Ministry of Works & Transport
Ministry of Environment, Forestry and Tourism
Ministry of Mines & Energy
Ministry of Fisheries & Marine Resources
Ministry of Justice
Ministry of Labour, Industrila Relations & Employement Creation
Ministry of Public Enterprises
Ministry of Sport, Youth & National Service
Ministry of Information & Communication Technologies
Intellengence Services
National Statistics Agency
Anti Corruption Commision

Annexure 11: MWT Regional composition of public servants per region

REGION	Division/Subdivision / Section	Number of staff	Total in region
HARDAP	1. Maintenance 2. GRN Garage 3. GRN Stores	61 0 0	61
KUNENE	1. Maintenance 2. GRN Garage 3. GRN Stores	50 34 0	84
OMAHEKE	1. Maintenance 2. GRN Garage 3. GRN Stores	51 16 0	67
//KARAS	1. Maintenance 2. GRN Garage 3. GRN Stores	71 28 12	111
OTJOZONDJUPA	1. Maintenance 2. GRN Garage 3. GRN Stores	85 56 14	155
ERONGO	1. Maintenance 2. GRN Garage 3. GRN Stores	69 21 0	90
KAVANGO EAST	1. Maintenance 2. GRN Garage 3. GRN Stores	47 34 21	102
KAVANGO WEST	1. Maintenance 2. GRN Garage 3. GRN Stores	10 0 0	10
ZAMBEZI	1. Maintenance 2. GRN Garage 3. GRN Stores	53 38 18	109
OHANGWENA	1. Maintenance 2. GRN Garage 3. GRN Stores	39 0 0	39
OSHIKOTO	1. Maintenance 2. GRN Garage 3. GRN Stores	39 0 0	39
OSHANA	1. Maintenance 2. GRN Garage 3. GRN Stores	58 38 31	127
OMUSATI	1. Maintenance 2. GRN Garage 3. GRN Stores	50 0 0	50

Total other regions: 1,044

Annexure 12: HiAP Working Group members

Annexure 13: Details of Key Contacts on Wellness, HIV and AIDS

#	Name	Surname	Tel/Cellphone	OMA	Position	Email
	Nichlas	Mbingeneeko	811288446	MGECW	Director/Focal Person	Nichlas.Mbingeneeko@mgecw.go.na
	Gina	Swartbooi	081 289 9975	MOF	Focal Person	Gina.Swartbooi@gov.mof.na
	Salmi	Uupindi	081 251 3857	MET	Focal Person	salmi.hidulika@met.gov.na
	Joseph	Kaveto		MIRCO	Deputy director	
	Antoinette	Platt	081 167 9770	National Correctional Service	Focal Person	prisonaep@yahoo.com
	Vaapi	Kaenda	811500744	Parliament	Focal person	vkaenda@gmail.com
	Lottie	Bock	812720402	National Correctional Service	Focal Person	l.bock@parliament.go.na
	Vaino	Muvale	061 2812016	MOJ	Focal Person	vainomuvale@yahoo.com
	Tangeni	Ilovu	813741889	OAG	Focal Person	Tangeni.Ilovu@oag.gov.na
	Johannes	Joseph	081 216 2358	ACC	Focal Person	jjohannes@accnamibia.org
	Peter	Iitembu	081 272 9474	ECN	HRD	niitembu@ecn.na
	Herbert	Mouton	081 212 8073	MOEAC	Focal Person	herbert.mouton@moe.gov.na
	Hileni	Mudhika	081 226 0594	MICT	SIO	Hileni.mudhika@mict.gov.na
	Tresia	Hangula	818327244	MOPE	Focal Person	Tresia.Hangula@mope.gov.na
	Getrude	Magongo	081 498 6242	MOPE	Commitee member	getrude.molongela@mope.gov.na
	Victoria	Hofnie	081 143 3313	MITSMED	Focal person	iileka@mti.gov.na
	Elise	Garises	081 237 1294	MME	Focal Person	egarises@mme.gov.na
	Ihana	Kaangundue	814801930	MWT	Focal Person	ikaangundue@mwtc.gov.na
	Julius	Nghifikwa	081 149 5977	MOEAC	Deputy Director	julliuus@yahoo.co.uk
	Martha	Kabozu	081 160 8114	OP	Focal person	mkabozu@op.gov.na
	Tobias	Uirab	081 277 5227	MLR	Focal Person	tobias.uirab@mlr.gov.na
	Mariane	Muvangua	081 256 3593	MoD	Focal Person	mmuvangua@gmail.com
	Ernesto	Namuhuya	081 298 4864	MoD	Assistant Head DSP	enamuhuya@gmail.com
	Vivienne	Henckert	081 122 1941	NCIS	Deputy Director	henckert@doas.gov.na
	Kachana	Kamwi	061 376 205	ECN	Deputy Director	kkhomba@ecn.gov.na
	Maretz	Tjitemisa	061 435 5013	MPESW	Focal PErson	maretz.tjitemisa@mpesw.gov.na
	Rinjona	Benjamin	814672328	MPESW	Committee Member	rinjona.benjamin@mpesw.gov.na
	Uaeta	Muzuma	061 208 7582	MAWF	Focal PErson	muzumau@mawf.gov.na
	Ivory	Uirab	081 252 1008	MFMR	Sector Focal Person	ivox452000@yahoo.com
	Richard	Hasheela	811441930	OPM	Chief learnig and DO	richard.Hasheela@opm.gov.na
	Sakaria	Iipinge	812470010	Judiciary	Focal Person	Salkaria.Iipinge@jud.gov.na
	Tusnelde	Kaishungu	813001571	Msport	Focal Person	Eikaishungu@gmail.com
	Caroline	Buchane	812539971	MHA&I	Focal Person	Caroline.Buchane@mha.gov.na
	Mesag	Haukena	081 243 6225	MURD	Focal Person	mhaukena@murd.gov.na

Annexure 14: Document review guide

DOCUMENT REVIEW – PROCEDURE

Adopted from O'Leary, Z. (2014). The essential guide to doing your research project (2nd ed.).

Thousand Oaks, CA: SAGE Publications, Inc.**)**

1. Create a list of texts to explore (e.g., population, samples, respondents, participants).
2. Consider how texts will be accessed.
3. Acknowledge and address biases.
4. Develop appropriate skills for research.
5. Consider strategies for ensuring credibility.
6. Know the data one is searching for.
7. Consider ethical issues (e.g., confidential documents).
8. Have a backup plan.

O'Leary, Z. (2014) Steps 8-step planning

1. Gather relevant texts.
2. Develop an organization and management scheme.
3. Make copies of the originals for annotation.
4. Assess authenticity of documents.
5. Explore document's agenda, biases.
6. Explore background information (e.g., tone, style, purpose).
7. Ask questions about document (e.g. Who produced it? Why? When? Type of data?).
8. Explore content.

Annexure 15: Articles systematically rreviewed

	TITLE OF ARTICLE	
1.	Health Status of Senior Civil Servants in Kuala Lumpur	1997
2.	General Health status of workers among different workplaces in Qom Province, India	2015
3.	Employee health and wellness in South Africa: ?The role of legislation and management standards	2009
4.	The Prevalence of Cardiovascular Disease Risk Factors among Employees in the Kingdom of Bahrain between October 2010 and March 2011: A cross-sectional study from workplace Health Campaign	2014
5.	Status and influencing factors of physical exercise among civil servants in China: a systematic review and analysis	2019
6.	Lifestyle and health-related quality of life: A cross-sectional study among civil servants in China	2012
7.	Physical Inactivity and its Associated Disease Prevalence Among Civil Servants in Accra, Ghana: A Retrospective Study	2018
8.	Pattern and correlates of obesity among public service workers in Ondo State, Nigeria: a cross-sectional study	2017
9.	Factors influencing health seeking-behaviour among civil servants in Ibadam, Nigeria	2018
10.	Knowledge and Attitudes of civil servants in Osun State, South-western Nigeria towards the National Health insurance	2010
11.	Overweight and obesity prevalence among public servants in Nadowli district, Ghana, and associated risk factors: a cross – sectional study	2017
12.	The prevalence and associated factors of non-communicable disease risk factors among civil servants in Ibadan Nigeria	2018
13.	Epidemiological profile of public servants absent from work due to mental disorders from 2010 - 2013	2015
14.	Employee Health and Wellness Strategic Framework for the Public Service	2019
15.	Civil Service Health and Wellbeing Framework	
16.	Civil servants' demand for social health insurance in Northwest Ethiopia	2018
17.	Disabling health: the challenge of incapacity leave and sickness absence management in the public health sector in KwaZulu-Natal Province	2016
18.	Transforming Public Servants' Health Care Organization in Greece through the Implementation of an Electronic Referral Project	2013
19.	A study to assess prevalence of obesity among government employees of medical college in Madhya Pradesh, India	2018

Annexure 16: Structured Questionnaire

SECTION 1: DEMOGRAPHIC INFORMATION

1. Are you male or female (please tick where appropriate)?

Male		Female	

2. How old are you? (please write the exact age number)

…….. years

3. What is your highest level of education? (please tick where appropriate)

No Schooling		Secondary Education	
Primary Education		Tertiary Education	

4. What is your current job grading? (please tick where appropriate)

Job Grade	1	2	3	4	5	6	7	8	9	10	11	12

5. What type of work do you perform? (please tick the appropriate option)

Managerial		Technical/Specialized		Laborer/Unskilled	
Administrative		Artisan/Skilled		Others …….	

6. In which region do you work? (Please name the region and town where you work)

!Karas -		Khomas -		Oshana -	
Erongo -		Kunene -		Oshikoto -	
Hardap -		Ohangwena -		Otjozondjupa -	

Kavango East -		Omaheke -		Zambezi -	
Kavango West -		Omusati -			

7. Are you a member of the Public Servants Medical Aid Scheme (PSEMAS)?

YES	NO

8. In what type of house do you reside? (please tick where appropriate)

Brick house		Zink/Corrugated iron house	

9. How many people/live/stay/reside in your household?

……..people

10. Do you have access to the following services in your household (please tick appropriate?

Portable water		Flushing Toilet		Electricity	

11. Kindly indicate your TOTAL individual monthly income (please give an exact amount)

N$3,500.00 – N$5,000.00		N$10,001.00 – N$20,000.00	
N$5,001.00 – N$10,000.00		N$40,001.00 or above	

SECTION 2: HEALTH INFORMATION

12. In general, how would you rate your general health? (please tick where appropriate)

Excellent	Very good	Good	Fair	Poor	Very Poor

13. Did you ever suffere from any of the following conditions? (tick where appropriate)

	YES	NO	Never tested
High blood pressure/Hypertension			
Elevated blood sugar / Diabetes			
Elevated cholesterol/ Cholesterol			
Low back disease/ Back spine pain			
Stress/Anxiety/Depression/			

14. If you had suffered from any of the above mentioned condition(s), is (are) the conditions being treated – are you on treatment? (tick where appropriate)

	Taking medication	Diagnosed not taking medication
High blood pressure/Hypertension		
Elevated blood sugar / Diabetes		
Elevated cholesterol/Cholesterol		
Low back disease/Back spine pain		
Stress/Anxiety/Depression		

15. Do you suffer from any other condition(s) or Diseases not mentioned above in Question 13 and 14? Please specify?

Please name the condition (s) or disease (s) you are currently suffering from

16. Is the condition(s) or diseases(s) you are suffering from being treated? Please specify?

Please name the condition (s) or disease (s) you are suffering from	Taking medication	Diagnosed not taking medication

17. What is your estimated weight (kg) (please write your weight)?

…….. Estimated Weight (kg)

18. What is your estimated height (cm) (please write your height)?

…… Estimated Height (cm)

19. Do you suffer from any disability, including wearing eye glasses?

YES	NO

20. If you suffered from a disability, please indicate the type of disability

Type of disabilities:

21. It is recommended, by Nutrition experts, to fill your food plate half with fruits and vegetables during every meal. How do you meet this goal? (tick where appropriate)

Always	Often	Sometimes	Rarely	Never

22. Routine physical activities for 30 minutes, two to three times a week is recommended. How do you meet this goal? Routine physical activities is the ability to expedite energy through dancing, climbing stairs, gardening, walking and etc. (tick where appropriate)

Always	Often	Sometimes	Rarely	Never

23. Do you currently smoke? (please tick where appropriate)

YES	NO

24. Do you currently consume alcoholic substances? (please tick where appropriate)

YES	NO

25. How often did you feel this way during the past two weeks? (tick appropriate)

	Always	Often	Some days	Never

a) I felt stressed				
b) I felt depressed				
c) Had trouble keeping my mind on task(s)				

26. Indicate your perceived levels of stress based on the questions below? (tick appropriate)

	No stress	A bit of stress	Moderate stress	Substantial stress	Extreme stress
a) Rate the average amount of stress at work?					
b) Rate the average amount of stress at home?					

27. Kindly answer the following question relating your health (tick were appropriate)

	Strongly Agrees	Agree	Neutral	Disagree	Strongly disagree
I am having a hard time doing my work because of my health?					

28. Have you experienced pain, numbness, aching or tingling sensation on the listed body part the past 3 months? (tick where appropriate)

	Strongly Agrees	Agree	Neutral	Disagree	Strongly disagree
a) Hand/wrists					
b) Upper back, shoulder and neck					
c) Lower back					
d) Knee(s)					
e) Foot/Feet					

29. Have you had difficulty sleeping as a result of work related physical or emotional encounter the past 3 months? (please tick where appropriate)

No difficulties	Mild difficulties	Moderate difficulties	Severe difficulties	Much difficulty could not sleep

30. Please indicate your typical sleep duration below? (tick where appropriate)

≤ 6 means less than or equal to 6 hours	**≤ 6hrs**	**7hrs**	**8hrs**	**9hrs**	**10hrs or more**
a) Typically sleep per 24 hour period during a work week?					

31. Rate the quality/pattern of your sleep on a typical night? (tick where appropriate)

Very good	Fairly good	Fairly poor	Very poor

SECTION 3: WORK PLACE INFORMATION

32. Please choose the most appropriate answer/statement about your place of work

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
a) Management considers employee's health, safety and wellbeing as an important factor					
b) The Ministry provides opportunities to live a heathy lifestyle					

33. Please respond, by ticking the most appropriate statements regarding your Ministry?

The Ministry offers the following opportunities to enhance wellness	Strongly Agrees	Agree	Neutral	Disagree	Strongly disagree
a) Session(s) on physical activities					
b) Motivation on healthy eating					
c) Tabaco free zone					
d) Education on substance misuse					
e) Manage stress					

34. Has your Ministry offered, additionally to aspects raised in question 29 above, the following wellness activities in the last 12 months at the workplace?

Activities	**YES**	**NO**	**NEVER**	**NOT SURE**
a) Screening for Blood Pressure and Blood Sugar				
b) World AIDS Day Celebration				
c) Sports and or Wellness Day event				
d) Others (please specify):				

35. Do you participate in any of the wellness workplace programs offered at your work? (please tick where appropriate)

Never	**Occasionally**	**Sometimes**	**Often**	**Always**

36. Please indicate 3 health promotion programs you would like your Ministry to offer as part of the workplace wellness activities

1.
2.
3.

37. Please respond to the following statements regarding safety at your work place.

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
a) My duties often interfere with my ability to comply with safety					
b) Safety is a high priority with my supervisor					
c) Employees at my work comply with the safety rules					

38. Do you know how to exit your workplace building in case of an emergency such as a fire, flooding and etc.? (please tick where appropriate)

YES	NO

39. Does your workplace have a visible emergency evacuation plan displayed?

YES	NO

40. Please respond to the following statements about your job.

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
a) I get satisfaction from my job					
b) I would recommend working for my Ministry to any one					

41. How much time do you spend travelling to and from work each day?

< 15 minutes	15 – 30 minutes	30 – 60 minutes	60 – 90 minutes	> 90 minutes

42. Have you heard of HEALTH in All Policies (HiAP)? (please tick where appropriate)

YES	**NO**

43. How will you describe Health in All Policies (HiAP)?

44. Kindly please/provide or ask any questions or comment(s).

Question guide Reference: **<u>For office use only</u>**	

Annexure 17: Focus Group Discussion Guide

1. Date: Start time:
2. Attendance registers: Introductions: - consent form

FGD QUESTION GUIDE:

Introductory statement: In 2016 Cabinet took a resolution (resolution number 5th/05.04.16/004 – to be given as a handout: annexure to this tool) to adopt and implement the Health in All Policies (HiAP) Approach as a suitable mechanism to address social determinants of health by non-health sectors:

1. How did Namibia become aware of and involved in HiAP?
    a. Is the concept of HiAP well understood and accepted in Namibia? Substantiate?
    b. What were the main driver(s) that led to the adoption of HiAP?
    c. Is there an official directive (policy, program) on HiAP?
    d. What factors, structure and processes are in place to support HiAP leadership?
    e. Who are championing HiAP's efforts? What have been the successes?
    f. How have you kept the momentum for HiAP?
    g. What is been the sustainability efforts / strategies?
    h. What funding and/or resources were necessary to start –continue – sustain HiAP?
    i. What has hindered / challenged HiAP processes?
    j. What have been the biggest collaborative (allies and supporters) process?
    k. To date what is HiAP status in Namibia?
    l. What have been the biggest successes since implementation of your HiAP efforts? (Critical success factors)
3. Conclusion –questions and clarity

4. Ending date: Date:

Annexure 18: Equity Analysis guide

1. The Health equity Audit (HEA) adopts the global HEA cyclical standard, illustrated on the next page and the WHO Comparative Evaluation Indicators processes which were slightly amended to fir the Namibian Public Service Employment Context
2. The HEA used Document Review, Focus Groups Discussions and quantitative research results as the unit of analysis to draw health inequalities and highlight most relevant areas for inequities.
3. Following the assessment of the Document Review, Focus Groups Discussions and quantitative research results the SDH are extracted and further and examined and prioritise by level of burden as health inequities.
4. Prioritised health inequities are reflected upon (further reviewed and discussed) using a color coding rating scale '**green**', '**amber**' or '**red**' responses to indicate performance. '**green**' **reflects area for improvement**, '**amber**' **low level of risk** or '**red**' **reflects high risk level**
5. The outcomes of the HEA would influence the pathway for the third study objective –
6. A HEA second level analysis looked as follows:

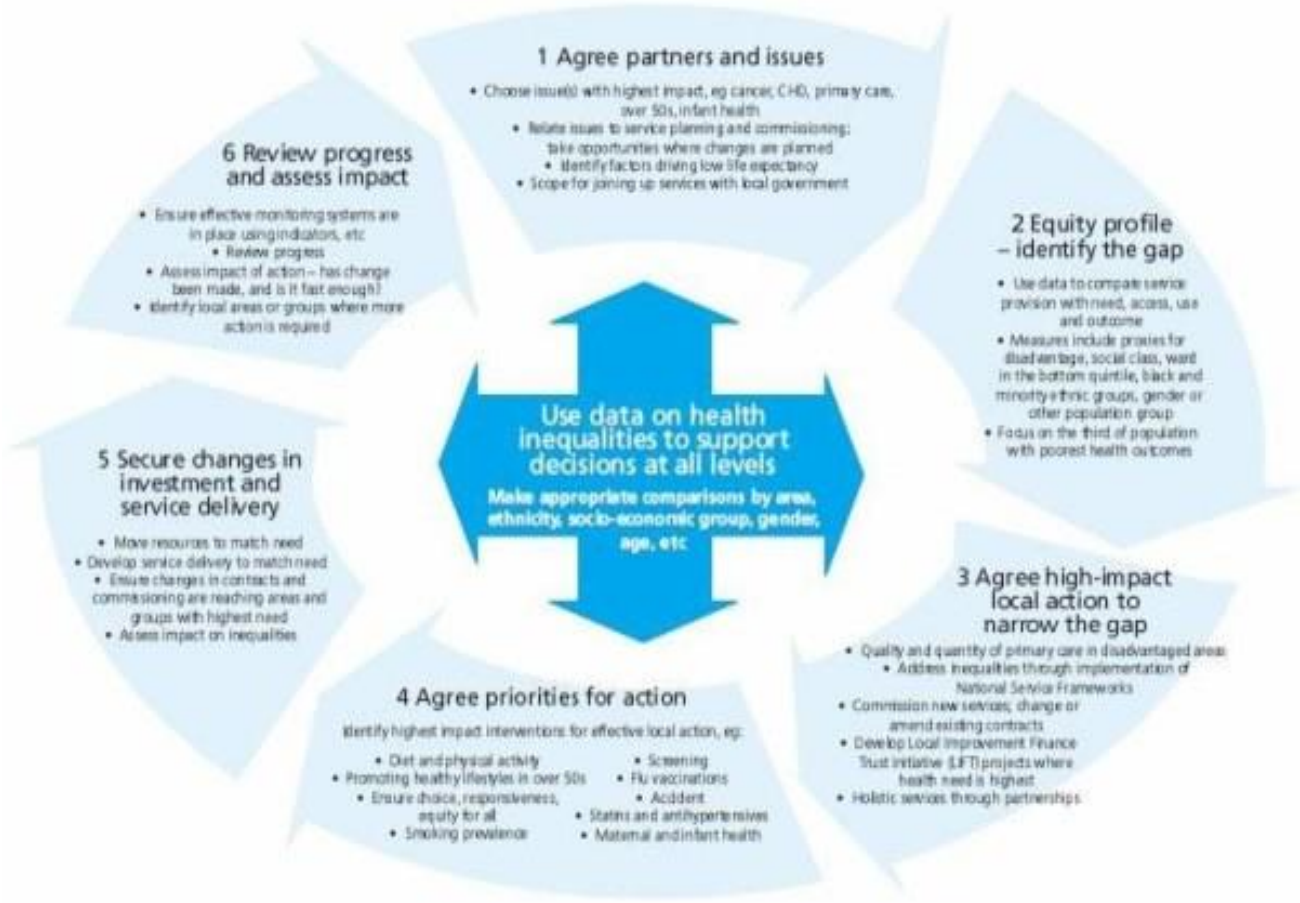
id	ISSUE	Gender	Age	Education Level	Income / Job Grade	Region	Work Type	Q9_GenHealth
1								
1	High Blood Pressure							
2	Lower back pain							
3	Stress/Depression/mental issues							
4	Body Mass Index (BMI							
5	Healthy Eating							
6	Physical Activities							
7	Safety and Hazards							
8	PSEMAS - Deviations							
9	Mortality							
10	Legal status/Policies/Strategies							

Schematic Representation of the European Policy Health Impact Assessment (EPHIA)

Secondly to and lastly to priorities areas for further review. The HEA followed global HEA cyclical standards.

Source: European Policy Health Impact Assessment (EPHIA) – The Guide, ISBN 1-874038-75-9 (2004)

The Health Equity Audit Cycle (DH, 2003b)



Source: Making the case: health equity audit. Health Development Agency, ISBN 1-84279-443-4 (2005) (.pdf)

Annexure 19: Discourse analysis – Data Collection Instrument

Discourse analysis guide:

Step 1: Define the research question and select the content for analysis

Begin with a clearly research question: How and what was Parliament's response to COVID-19 pertaining to public sector work places?

Select a range of materials appropriate to your research question

Step 2: Gather information indicated above and its relevant contextual theories

Establish and discuss the context, social or otherwise, in which the material were produced

Gather factual details of when and where the materials and content were created (the author, publisher, dissemination mode).

Describe the intended purpose and target of the materials

Describe how the materials were intended to be received.

Establish and describe the real-life context of the materials to the discourse – research question using a literature review

Establish and discuss the theoretical underpinnings of the materials

Step 3: Analyse the materials for possible patterns and themes

Examining various parts of the material (concepts, phrases, paragraphs, and overall structure) to relate them to patterns, attributes and or themes relevant to your research question.

Analyse the material for similarities reflective to your key question and phenomenon.

Step 4: Review your results and draw conclusions

Reflect on your discourse outcome in relation to the patterns, attributes and or themes.

Make general conclusions on how you understand the material in relation to the research question and the language used.

Consider how you will conclude your analysis in relation to the research question. Consider how the materials informed current and past events e.g. state of emergency absence of a state of an emergency, dissemination of information, as well as in relation to set theories

Step 5: Write up the process

Produce a write up of this work.

Annexure 20: Key Informants – Data Collection Instrument

Date: **Start time:**

GUIDE:

Introductory statement: In 2016 Cabinet took a resolution to adopt and implement the Health in All Policies (HiAP) Approach as a suitable mechanism to address social determinants of health by non-health sectors. Are you aware of this Resolution?

a. If not aware of the Cabinet resolution proceed to ask: In your opinion how would you define Health in All policies? And go on to (i) under (b)

i. If aware ask; about the status of Cabinet resolution on HiAP in the country? Including the following: (i) (Public servants are the conveyor belt for public service delivery) In general how would you rate the health status of public servants? (ii) (probe) What about in relation to the Public Service Medical Aid Scheme (PSEMAS)? How would you rate the health of public servants? (iii) (probe) Will the adoption and implementation of HiAP benefit public servants? In which ways? What about in relation to workplace wellness programmes in OMAs (iv) (probe) Will the adoption and implementation of HiAP benefit public servants? In which ways? What about in relation to workplace wellness programmes in OMAs

As part of this tool, on the next page, is the reporting format of the Cabinet resolution number 5th/05.04.16/004 for 2016. This will not be given as a handout to avoid bias. It is annexure to this tool for illustration purposes.

Concluding question: Will the Health in All Policies (HiAP) Approach be a suitable mechanism to be enhance workplace wellness policies for public servants in Namibia? Substantiate your answer

Conclusion –questions and clarity

Ending date: Date:

Reporting Format: Cabinet Decisions implementation

Subject	Decision No.	Region/Location of Beneficiaries	Feedback on the extent to which the project/cabinet has reached its objectives/targets	Social/economic impact and benefits to society (output current impact)	Challenges/constraints encountered during the implementation process	Measures taken to overcome challenges/constraints	Target date of implementation
Report on the 138th Meeting of the Executive Board of the World Health Organisation, 25-30 January 2016	5th/05.04.16/004	Nationwide, targeting the general public	The Ministry of Health and Social Services commenced with the process to develop the Strategy to guide implementation of Health in All Polices (HiAP) in other line ministries. A rapid assessment of inter-sectoral actions was recently concluded with technical assistance from World Health Organisation (WHO). Several O/M/A/S were visited during the assessment to identify public health priorities and examine the existing working relationships, activities and challenges and explore the possibilities and opportunities for enhanced inter-sectoral actions for improved health outcomes. The Ministry of Health and Social Services in collaboration with WHO is planning an inter-sectoral workshop to engage stakeholders to further the argument of the agenda in health in all policies. During the NDP5 validation workshop, the Ministry of Health and Social Service briefed the stakeholders on HiAP.	Policies will address social determinants of health that will lead to the increased productive life years and eventually improved health outcome	Thus far, no challenges are being experienced.	-	Ongoing

Annexure 21: Knowledge, Attitude and Practices Survey instrument

SECTION 1: DEMOGRAPHIC INFORMATION

45. Are you male or female? (please tick where appropriate)

Male		Female	

46. How old are you? (please write the exact age number)

…….. years

47. Do you have a qualification in Workplace Employee Wellness, Occupational Health and Safety? (please tick where appropriate)

YES		NO	

48. What is your educational attainment? (please tick where appropriate)

No Schooling		Secondary Education	
Primary Education		Tertiary Education	

49. What is your current job grading? (please tick where appropriate)

Job Grade	1	2	3	4	5	6	7	8	9	10	11	12

50. Indicate / write your job title, position or portfolio

51. In which government Office, Ministry and or Agencies (OMAs) do you work?

52. In which region do you work? (Please name the region and town where you work)

53. What type of work do you perform? (please tick the appropriate option)

Technical		Managerial		Labourer	
Administrative		Artisan		Others	

54. In general, how would you rate the general health of public servants? (please tick where appropriate)

Excellent	Very good	Good	Fair	Poor	Very Poor

55. Are you a member of the Public Service Medical Aid Scheme? (please tick where appropriate)

YES	NO

56. Please indicate your absenteeism from work as a result of ill health over the last 12 months? (please tick where appropriate)

Approximately …….Days

57. Does your OMA has a designated employee workplace wellness, occupational health and safety Unit/Division? (please tick where appropriate)

YES	NO

58. Does your OMA has a formal Workplace Employee Wellness, Occupational Health and Safety Committee? (please tick where appropriate)

YES	NO

59. Has your OMA offered the following wellness activities in the last 12 months at the workplace?

Activities	**YES**	**NO**	**NEVER**	**NOT SURE**
e) Screening for Blood Pressure and Blood Sugar				
f) World AIDS Day Celebration				
g) Sports and or Wellness Day event				
h) Opportunities for stress management				
i) Opportunities for healthy lifestyle				
j) Others (please specify):				

SECTION 2: KNOWLEDGE ABOUT HEALTH IN ALL POLICIES (HiAP)

60. Have you heard of the concept the Health in All Policies (HiAP) Approach? (tick where appropriate)

YES	NO

61. To your knowledge does anyone in your OMA, in the Wellness Division and or the Wellness Committee, heard of Health in All Policies (HiAP)? (tick where appropriate)

YES	NO

62. If your answer is YES to question 16 and 17, how did you/they become aware of the Health in All Policies Approach? (choose most appropriate)

Ministry of Health and Social Services workshop on Health in All Policies	
WHO workshop on Health in All Policies	
Other: (please specify)	

63. In your own opinion is there (are you aware of) an official policy or directive about HiAP in Namibia?

YES	NO

64. In your own opinion who is responsible for HiAP in Namibia?

65. In your opinion which statements below best describe HiAP?

	Tick most appropriate
Health in All Policies is an approach to public policies across sectors	
Health in All Policies systematically takes into account the health implications of policy actions and decisions	
Health in All Policies seeks synergies to address health implications across sectors	
Health in All Policies seek to improve population health	

66. In your own opinion is the concept HiAP known in Namibia?

YES	NO

67. In your own opinion is the concept HiAP well understood in Namibia?

YES	NO

68. In your own opinion is the concept HiAP accepted in Namibia?

YES	NO

69. Have you or any one in your OMAs receives any information materials related to HiAP in the last 12 months??

YES	**NO**

70. If your answer to Question 24 is YES, please indicate what type of materials on HiAP have you/ or your OMA received?

a)
b)
c)

71. Have you or your OMA read these materials on HiAP? (please list)

YES	**NO**

72. Would you like to receive more information on HiAP?

YES	NO

73. If your answer is YES to Question 28 what type of information on HiAP would you like to receive? Please be specific and precise

a)
b)
c)

74. In your opinion who is responsible for addressing the general health issues of public servants? (please tick where appropriate)

	YES	**NO**
a) Each public servant is responsible for their own health		
b) The Namibian government		
c) Private Health Providers		
d) Other (please specify)		

75. Have you heard of the concept / term the Social Determinants of Health (SDH)? (tick where appropriate)

YES	NO

76. In your opinion which statements below best describe SDH?

	Tick most appropriate
SDH are factors which helps people lead a healthy life	
SDH includes factors such as income, education, access to health care, gender etc.	
SDH are multiple factors which makes people vulnerable to illnesses	
SDH brings about health inequalities and inequities	

77. In your own opinion which of the factors mentioned below are the SDH affecting the workplace?

	YES	**NO**
a) Education levels		
b) Access to basic services (water, electricity, sanitation)		
c) Financial literacy		
d) Mental health		
e) Workplace safety		
f) Gender Based Violence		
g) Others: please specify		

SECTION 3: ATTITUDE INFORMATION

78. In your opinion do you think the HiAP Approach will assist in addressing pertinent public servants general health and health related issues? (please tick where appropriate)

YES	NO

---

79. If your answer is yes to Question 34 which general health and health related issues experienced by public servants will the HiAP approach address? (please tick where most appropriate

	YES	NO
c) Diseases		
d) Lower back pain		
e) Mental health issues (stress, depression, anxiety)		
f) Smoking cessation		
g) Adoption of healthy lifestyle		

80. In your opinion, do you think the HiAP approach will assist in addressing social related issues pertinent to influencing the health of public servants? (please tick where appropriate)

YES	NO

81. If your answer is YES to Question 36 which social issues pertinent to influencing the health of public servants will the HiAP approach address? (please tick where appropriate)?

	YES	NO
a) Gender Based Violence		
b) Access to basic services (water, electricity, sanitation)		
c) Financial literacy		
d) Housing		
e) Transportation		

82. How concerned are you about the general health of public servants?

Very concern	Moderately concerned	Not concern at all

83. Please substantiate your response to question 38?

1	
2	
3	

84. In your opinion, do you think the following aspects will assist in addressing your concerns for public servant's general health issues?

Activities	YES	NO
a) Screening for Blood Pressure		

b) Screening for Blood Sugar		
c) World AIDS Day Celebration		
d) Sports and or Wellness Day event		
e) Others (please specify):		

85. In your own opinion, what other interventions will assist in addressing the general determinants of health amongst public servants? (please list)

1	
2	
3	

86. In your opinion, which of the following aspects addresses public servants general health?

	YES	**NO**
a) Health education		
b) Visiting a health Practitioner		
c) Others: please specify		

SECTION 3: PRACTICE INFORMATION

87. Have you participated in any HiAP Country processes?

YES	NO

88. Has anyone in your OMA participated in any HiAP Country processes?

YES	NO

---

89. If your answer is YES to question 43 and 44 in which of the following HiAP Country processes has you/they participated in?

	YES	NO
a) HiAP Inception Stakeholder Workshop		
b) HiAP Working Group activities		
c) HiAP Stakeholder Consultation Workshop		
d) Other (please specify) …		

---

90. Can OMAs be helpful in implementing the HiAP Approach response initiatives in Namibia?

YES	NO

---

91. If you answered YES to question 46 propose/suggest ways how OMAs could initiate HiAP response initiatives?

1	

2	
3	

92. What type of capacity building assistance will OMAs require to implement HiAP?

a)
b)
c)

93. If a new approach such as the Health in All Policies approach for workplace promotion of health is made available, will you be willing to implement it?

YES	**NO**

94. The Ministry of Health and Social Service, through Cabinet decided 5th/05.04.16/004 on adopting Health in All Policies (HiAP) in Namibia has develop a HiAP National Strategy. Are you aware of this strategy?

YES	**NO**

95. In your opinion, will your OMA(s) have a role to play in implementing the National Strategy on Health in All Policies mentioned in Question 50?

YES	NO

96. If your response is YES to Question 96 please state the possible role your OMAs could play in implementing the Health in All Policies National Strategy?

1	
2	
3	

97. Do you have any questions or comment(s) about the HiAP approach in Namibia?

Annexure 22: Informed consent form

- **INFORMED CONSENT FORM – Dear Research Participant**

You have been sampled and or selected to participate in this research study titled: *'A Health in All Policies (HiAP) Conceptual Framework Factored around the health status of public servants in Namibia: A case of the Ministry of Works and Transport*. For more information on the research study please peruse the Research Study Information Leaflet.

Your participation in this research is very fundamental and most important. You will be representing the views of others public servants and public service officials, similar to you. Your experiences will add value to the study purpose and objectives. If you consent to participate kindly please complete the following consent form:

CONSENT FORM: STATEMENT OF CONSENT:

I have read and understand the research information provided. My questions and clarity regarding the research and my participation was also provided. I have also consented to have the discussion tape-recorded. I agree to participate in the focus group discussion.

Signature of research participants: ……..

Date: …….

Signature of researcher …….

Date: …….

- **STUDY RESEARCH INFORMATION LEAFLET -**

Dear Research Participant

My name is Kaarina Nduuvunawa Amutenya a student at the University of Namibia pursuing a Doctoral Degree in Public Health. My student number is 9317821. As part of the University's requirements to obtain this qualification I am expected to conduct, complete and submit a Dissertation that includes a research component. The title of my research is: *'A Health in All Policies (HiAP) Conceptual Framework Factored around the health status of public servants in Namibia: A case of the Ministry of Works and Transport*.

The purpose of this study is to develop a HiAP Conceptual Framework, an introductory and implementation guide adjusted to the Namibian public service employment context.

The study objectives are:

1. To assess the health status of public servants in the Ministry of Works and Transport in Namibia.
2. Determine Health in All Policies Knowledge, Attitudes and Practices (KAP) of public service workplace wellness officers, focal person and committee in Namibia.
3. To analyse the health inequities amongst public servants in the Ministry of Works and Transport in Namibia using the research results of objective one.
4. Develop a Health in All Policies (HiAP) Conceptual Framework factored around the health status of public servants in Namibia.
5. Validate the appropriateness of the developed HiAP Conceptual Framework through an Expert Review Panel.

6. Develop a guide for the proper introduction and implementation of the developed Health in All Policies (HiAP) Conceptual framework.

Your participation in this research is very important. You were sampled and or selected amongst many other participants to respond and represent the views of the public service. Your health experiences will represent that of many other public official and public servants in your Ministry and Namibia overall.

If you grant me your consent you will be required to complete a questionnaire and or participate in a Focus Group Discussions containing various questions and statement on yours and the health of public servants overall as well as on workplace programmes on wellness in your Ministry and the public service. The questionnaire will take approximately 30 minutes to complete whereas the Focus Groups Discussion will take about 45 minutes to 2hrs.

This research is non-invasive. It does not involve any physical harm or conduct.

Your professional career will not be harm as the researcher will use a code to identify you. Your identity will thus be kept confidential. Only the researcher will have access to your information. All research materials, including data collected from you will be stored in lockable cabinets and on the computer and password protected files.

There are no rewards for participating in this research, but research findings might be beneficial for policy making in relation to workplace health promotion programming now and in future. Your participation in this study is totally voluntary and you may refuse to respond to specific questions if you feel uncomfortable. You are also free to withdraw from this research at any given time without fear of prejudice. Your responses will not be

linked to you personally in anyway. Your responses will be combined with those of all research participants to provide an overall view for this study.

For further clarity please contact me at cell number 081 2575 914 or per email kaarina@pkinnas.com or my research supervisors: Dr. Hermine Iita at 081 231 8751 email: hitta@unam.edu.na or Dr. Lucia Nelumbu at email address lnelumbu@unam.edu.na .

Annexure 23: Subject Expert Evaluation Tool

EVALUATION CRITERIA – CHAPTER 5 & 6: DEVELOPED HiAP-BASED CONCEPTUAL FRAMEWORK

Subject Expert name:

General comments:

Evaluation criterion	Remarks
1. Clarity of the HiAP based framework and its guide	
2. Simplicity: Do you think the HiAP-based framework and its guide are easy to understand?	
3. Scope and goal of the framework: Are the HiAP-based framework and its guide objectives implementable/achievable?	
4. Is the suggested guide for the HiAP-based framework practical	
5. The generality of guide for the HiAP-based framework (Can the proposed strategies be applied in other situation?	
6. Accessibility of suggested guide for HiAP-based framework	
7. Importance: Do you think the suggested guide for HiAP-based framework is important and significant for public health?	
8. Service significance and usefulness of the suggested guide for HiAP-based framework	
9. How relevant are the different aspects of the suggested guide for HiAP-based framework?	

EVALUATION CRITERIA – CHAPTER 5 & 6: DEVELOPED HiAP-BASED CONCEPTUAL FRAMEWORK

Subject Expert name: Ms. Julia Ndinelago Malule (Shipena)

General comments:

- I must say you have done a great job. This is very inspiring. Your study will really give direction on what could be done to ensure the realization of HiAP in Namibia. With your amount of experience that you have gained during this period, I am sure that you are now one of the few Namibians who can immensely contribute to the successful implementation of HiAP in the country.
- I am of the idea that somehow there is a need **to make reference to the Public and Environmental health Act 2015.** taking into consideration that it forms part of the legal framework/or tools through which the HiAP could be traced back. Specifically on Chapter 5, on the conceptual framework and verification, I am of the opinion that **it may be useful to maximize on what is currently happening with regards to the implementation of HiAP in Namibia.** I have gathered some ideas under the HiAP conceptual framework for your perusal and approval. You may twist them to suit your context.
- I might be wrong on this, but I would like to highlight this. **I am aware that the concept framework being developed is for the Namibian Public service. however, i wanted to ask if it is not possible to have some linkages with other stakeholders?** so as to demonstrate the relations to outside environment other that the GRN? just thinking aloud.

Evaluation criterion	Remarks
1. Clarity of the HiAP based framework and its guide	The HiAP framework is clear so as the guidelines for its implementation.
2. Simplicity: Do you think the HiAP-based framework and its guide are easy to understand?	Yes. The HiAP framework is easy to understand. What made it easier to understand is the fact that it is developed in line with the OSH/OHS strategies that are currently in use.
3. Scope and goal of the framework: Are the HiAP-based framework and its guide objectives implementable/achievable?	Scope is clearly defined. The two set objectives are achievable as they are implementable within the existing structures. The advantage is that the data sources are also identified. Once the HiAP national strategy is developed, it will also add value to the implementation of the framework.
4. Is the suggested guide for the HiAP-based framework practical	
5. The generality of guide for the HiAP-based framework (Can the proposed strategies be applied in other situation?	The application of the HiAP framework can be applied in different settings other than the public workspace.
6. Accessibility of suggested guide for HiAP-based framework	
7. Importance: Do you think the suggested guide for HiAP-based framework is important and significant for public health?	The proposed HiAP framework is important for public health. This is because the implementation of it will allow prioritizing health issues to be dealt with in non-health settings.
8. Service significance and usefulness of the suggested guide for HiAP-based framework	
9. How relevant are the different aspects of the suggested guide for HiAP-based framework?	

Annexure 24: Key Informant Report

TRANSCRIPTION OF A KEY INFORMANT INTERVIEW

Ms. Naomi Shoopala: Director of Primary Health Care MoHSS Virtual interview

Date: 3 December 2020 – introductory session conducted on the 1 December 2020

Interviewer: **In 2016 Cabinet took a resolution to adopt and implement the Health in** All Policies (HiAP) approach as a suitable mechanism to address social determinants of health by non-health sectors. Are you aware of this Resolution? And what is the current status?

Interviewee: First of all let me clarify the scope and proper placing of HiAP in the Ministry. The HiAP program is under the Policy Planning Unit and Mr. Charles and his supervisor Mr. Nghipundjwa are the people and the Directorate directly responsible for HiAP. This program is not in the Primary Health Care (PHC) Directorate. I have learnt however that a Stakeholder meeting was conducted at some point and Management were briefed. Thus I cannot same much regarding the Cabinet resolution at this point. I am not that familiar with the Cabinet resolution the Policy Directorate will have much more information on this.

Interviewer: **(If not aware of the Cabinet resolution) proceed to ask In your opinion how would you define HiAP?**

Interviewee: In general, HiAP is the presence of health in all public policies irrespective of what sector deals with non-health issues. Each sector should address health in some way. Not necessary provide health – clinical services, but e.g Agriculture in terms of food services should address the quality of food, issues around access to water. Trade should address issues about alcohol trading and the health elements in the use of alcohol

In relation to HiAP public service Public Service Staff Rules offers numerous things to be adhere to including remuneration, safety in public building (work spaces), wellness services, healthy food, exercise platforms. Implementation of the rule will result into cascading

Interviewer: **Public servants are the conveyor belt for public service delivery. In** general, how would you rate the health status of public servants?

Interviewee: Health status of public servants is Namibia I can say its good, but when quantified does not conform to numerous health issues or categorisation that can be related to issues such as mental health, chronic diseases, abuse both at work and home, ART uptake.

Public servants are members of the society, so much so, that their health is impacted and negatively affected by social issues (food quality, access to water). Various aspects can have minimal and or

maximum health impact. Literary their working conditions might affect their health both medically – the place of work can pose a threat to their health and that is why there are wellness programmes in the workplaces. Wellness programmes needs to be strengthened to ensure that the work places provide access to health nutritional food, provide healthy lunch places and sitting arrangements, some might opt or seek t provide gym hours and before its dark might provide exercise. The work need to promote health

Interviewer: **What about in relation to the Public Service Medical Aid Scheme** (PSEMAS)? How would you rate the health of public servants?

Interviewee: Sure, PSEMAS data on health status can be extracted from PSEMAS as long as its not personally identified with individual public servants. Data on dispensations, habitual stress and average ages can be used to determine the health status. Other sources of health status data can be available NSI statistics on employment regarding occupations (jus not sure if includes public service data) or the DHS. Public servants's personal files also contains health information, other is sick leave form may be the OPM can have access to this

Interviewer: Will the adoption and implementation of HiAP benefit public servants?

Interviewee: I believe yes, the framework allows for the implementation of numerous aspect and not specifically for a given sectors of the public. For the public service the framework need to have an implementation and M&E modality – component and make approapriate recommendation. Regulalry tracking of those activities

Interviewer: What about in relation to workplace wellness programmes in OMAs

Interviewee:

Interviewer: Will the adoption and implementation of HiAP benefit public servants?

Interviewee: as I indicated the introduction of HIS in HiAP

Interviewer: Final words?

Interviewee:

Annexure 25: HiAP-based Conceptual Framework Evaluation report

A REPORT ON EVALUATION OF A CONCEPTUAL FRAMEWORK (HiAP FRAMEWORK) AND GUIDE

Date: 06 October 2021

To: Dr. Iita Hermine, School of Nursing and Public Health: Oshakati Campus, University of Namibia

From Evaluator: Dr. Harriet Rachel Kagoya

Scope of work reviewed: Chapters 5 and 6

Introduction:

Thank you for the opportunity given me to evaluate the HiAP framework for the PhD candidate.

The following criteria, as suggested in the request to review, guided the evaluation:

1. Clarity of the HiAP-based framework and its guide
2. Do you think the HiAP-based framework and its guide are easy to understand?
3. Are the HiAP-based framework and its guide objectives implementable/achievable?
4. Is the suggested guide for HiAP-based framework practical?
5. The generality of the guide for HiAP-based framework
6. Can this guide for HiAP-based framework be applied in other situations?
7. Accessibility of suggested guide for HiAP-based framework
8. Do you think the suggested guide for HiAP-based framework is important and significant for public health?
9. Service significance and usefulness of the suggested guide for HiAP-based framework
10. How relevant are the different aspects of the suggested guide for HiAP-based framework?

General comments:

- This, HiAP framework, is a very important piece of work essential for promoting public health. It is a great initiative to evaluate current public policies and recommend changes for HiAP in Namibia. Great initiative!
- It is assumed that the framework was that illustrated in "*Figure 5.1 Researcher's conceptual reasoning and understanding*". The candidate needs to update the caption for figure 5.1 for accurate reference.
- The candidate made significant effort to describe and present the framework. There is however need to improve the framework and guidelines for its implementation. See example of HiAP framework by WHO - Health in All Policies (HiAP) Framework for Country Action. January 2014. Accessible at https://www.who.int/healthpromotion/hiapframework.pdf
- The scope of implementation, implied in the reviewed draft, needs review considering feasibility. Suggestions for improvement are included in the reviewed document i.e. chapters 5 & 6
- It was a bit hard to understand HiAP framework, the conceptual framework by virtue of limited introduction and acronyms not written in full or explained. The candidate may consider writing the acronyms in full at first occurrence in the chapter, given its importance and the fact that some readers may dive straight into the chapter without reading earlier sections.
- Consistency of citation format within text: some are with page numbers and others are without. Update to one consistent style.

- There seems to be a lack of connection between some sections. See details within the document
- It was difficult to comprehend section 5.4 in relation to the framework. It seems to be a standalone section, unrelated to the framework described in earlier sections. The candidate needs to relate sections to each other.
- Summaries should draw from content within the text and not bring out new aspects.
- Comments to enhance clarity, feasibility and implementation of the HiAP-based framework and its guide are given in the table below, and in the reviewed document

Specific findings, comments and recommendations by evaluation criterion Evaluation criterion	Remarks
1. Clarity of the HiAP-based framework and its guide	• The major concepts i.e. agents, recipients, context, procedure, dynamics and terminus are not defined at first introduction in chap 5. Effort is made much later to define them, but description is limited. See related comments in the reviewed doc. • Some concepts are not used in a manner consistent with their definitions, and relating to the scope of the study; need review. • Some arrows in diagrams are misleading; need review • The student made reference to objectives and earlier studies that the reviewer did not have access to; re-stating them and linking them to the chapter's content will be helpful for the audience. • See specific comments on concepts in figure 5.1 and their descriptions in text. Insights are provided in the comments on how to improve content to that expected in the sections • See detailed comments on the guide as well in the reviewed document
2. Simplicity: Do you think the HiAP-based framework and its guide are easy to understand?	The framework and guide need improvement for easier understanding and possibility of successful implementation. Description of activities and how they are to be undertaken to achieve the goal, etc. need enhancement. See suggestions in the reviewed document.
3. Scope and goal of the framework: Are the HiAP-based framework and its guide objectives implementable/achievable?	• The scope – targeting all public servants, government offices, ministries and agencies nationally seems quite a huge undertaking, unless procedurally the framework proposes phased implementation, and considering other factors like resources and multi-sectoral approach for input and implementation. The candidate may consider focusing on a few selected policies and ministries to start with. • The ultimate goal/terminus is not clear i.e. whether it is a Healthy workforce as shown in fig 5.1, or health status profiling, or healthier and capable public servants resulting from informed workplace health promoting wellness programme fostering improved performance (section 5.2.1.4), or workplace health promotion programmes aimed to improve performance subsequently public service delivery (5.2.1.2.1) … Candidate should refine the goal and state the same consistently in the document. • HiAP in itself may not lead to a healthy(ier) workforce but contribute. Several factors impact on health. • The guide needs enhancement as indicated in comments within the text. It should describe implementation of the framework; rather than development of the guide. Content is expected to describe the agents, recipients, procedures, dynamics, interlinkages, resources and goal for the framework. How will the framework be implemented (detailed plan of how, where, at what level, by whom, when, through which forums, etc) leading to achievement of the goal/terminus. This was not clear/sufficient in the draft.

EVALUATION CRITERIA – CHAPTER 5 & 6: DEVELOPED HiAP-BASED CONCEPTUAL FRAMEWORK

Subject Expert name: Ms. Julia Ndinelago Malule (Shipena)

General comments:

- I must say you have done a great job. This is very inspiring. Your study will really give direction on what could be done to ensure the realization of HiAP in Namibia. With your amount of experience that you have gained during this period, I am sure that you are now one of the few Namibians who can immensely contribute to the successful implementation of HiAP in the country.
- I am of the idea that somehow there is a need **to make reference to the Public and Environmental health Act 2015.** taking into consideration that it forms part of the legal framework/or tools through which the HiAP could be traced back.
- Specifically on Chapter 5, on the conceptual framework and verification, I am of the opinion that **it may be useful to maximize on what is currently happening with regards to the implementation of HiAP in Namibia.** I have gathered some ideas under the HiAP conceptual framework for your perusal and approval. You may twist them to suit your context.
- I might be wrong on this, but i would like to highlight this. **I am aware that the concept framework being developed is for the Namibian Public service. however, i wanted to ask if it is not possible to have some linkages with other stakeholders?** so as to demonstrate the relations to outside environment other that the GRN? just thinking aloud.

Evaluation criterion	Remarks
1. Clarity of the HiAP based framework and its guide	The HiAP framework is clear so as the guidelines for its implementation.
2. Simplicity: Do you think the HiAP-based framework and its guide are easy to understand?	Yes. The HiAP framework is easy to understand. What made it easier to understand is the fact that it is developed in line with the OSH/OHS strategies that are currently in use.
3. Scope and goal of the framework: Are the HiAP-based framework and its guide objectives implementable/achievable?	Scope is clearly defined. The two set objectives are achievable as they are implementable within the existing structures. The advantage is that the data sources are also identified. Once the HiAP national strategy is developed, it will also add value to the implementation of the framework.
4. Is the suggested guide for the HiAP-based framework practical	
5. The generality of guide for the HiAP-based framework (Can the proposed strategies be applied in other situation?	The application of the HiAP framework can be applied in different settings other than the public workspace.
6. Accessibility of suggested guide for HiAP-based framework	
7. Importance: Do you think the suggested guide for HiAP-based framework is important and significant for public health?	The proposed HiAP framework is important for public health. This is because the implementation of it will allow prioritizing health issues to be dealt with in non-health settings.
8. Service significance and usefulness of the suggested guide for HiAP-based framework	
9. How relevant are the different aspects of the suggested guide for HiAP-based framework?	

EVALUATION CRITERIA – CHAPTER 5 & 6: DEVELOPED HiAP-BASED CONCEPTUAL FRAMEWORK

Subject Expert name: Ms. Celia Kaunatjike

General comments:

- HIAP is meant to address health equity and social determinants of health through an all-government approach involving and holding to account multiple stakeholders on how their policies and strategies affects health of the population.
- The application of the approach to the public servants in a workplace context is an innovation and worthy of commendation.
- It uses the existing policy and legal framework to enhance the health and wellbeing of civil servant through a systemic approach which allows for easy coordination and monitoring.
- With time, it will allow for government to see if all benefit equally from health promotion activities and health services available irrespective of position or location ensuring that all have equal and quality access to health information and health promotion activities thereby reducing ill-health and allowing for a healthier workforce in the public sector.
- It will be interesting to see over time how the prevalence rates of certain diseases are changing over time, how sick leave is affected, and if the public servant are adapting new behavior in relation to physical activities, health diets, alcohol consumptions and smoking.

Evaluation criterion	Remarks
1. Clarity of the HiAP based framework and its guide	Yes, the framework implies that there is need for a catalyst to facilitate its implementation. Human resource officers and wellness focal person would then be the catalyst to ensure that the framework is implemented
2. Simplicity: Do you think the HiAP-based framework and its guide are easy to understand?	Yes, it is. It may require additional guide of key actions to support the Human Resource Officers and Wellness focal persons.
3. Scope and goal of the framework: Are the HiAP-based framework and its guide objectives implementable/achievable?	Its achievable. In my understanding the goal is to strengthen the current wellness programme of civil servants by introducing a systematic way of providing health information and services and health promotion activities. This will then be reflected in the wellness policies of different government ministries guided by the Public Servants Act and its regulations. The Human Resources Officers and wellness officer will then be the advocates of this approach and ensure that their respective ministries implement framework.
4. Is the suggested guide for the HiAP-based framework practical	Yes it is. It a matter of re-orgnizing the current wellness programme using the proposed HiAP-Based framework. This would require investment in training and orientation of the key implementers and as proposed earlier, some key guiding actions that informs the workplans of the different government entities.
5. The generality of guide for the HiAP-based framework (Can the proposed strategies be applied in other situation?	The general premise of HiAP of influencing policies for a healthier population with equitable access to resources can be applied in any situation. However, the difference would be in the nature of the issue. In a workplace, the catalyst of the framework are the Human resource officers and wellness focal persons whereas for a cross sectoral issues the catalysts/advocate for implementation could a taskforce or working group with a common goal.
6. Accessibility of suggested guide for HiAP-based framework	Accessibility is key and since this will essentially by through existing ministerial wellness programs, it is most likely to be accessed by all in the public service. The framework should consider strengthening these services where they maybe weak or non-existent.
7. Importance: Do you think the suggested guide for HiAP-based framework is important and significant for public health?	Yes, it is. Public sector is one of the biggest employers and if its workforce through this framework can improve their health and well being it will be significant. The lessons drawn from the public sector in the workplace could be applied to other situations.
8. Service significance and usefulness of the suggested guide for HiAP-based framework	The overall aim is to ensure a healthy and productive workforce. This is most certainly significant and needed.
9. How relevant are the different aspects of the suggested guide for HiAP-based framework?	The different aspects are suggested to support the implementation of the framework and are relevant.

Annexure 26: Editing Certificate

EXPRESS LANGUAGE EDITING

CERTIFICATE OF EDITING

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25-11-2021

To whom it may concern

This is to certify that a master's thesis titled '**A HEALTH IN ALL POLICIES (HIAP) CONCEPTUAL FRAMEWORK TO FACILITATE THE PROFILING OF PUBLIC SERVANTS' HEALTH STATUS IN NAMIBIA: A CASE STUDY OF THE MINISTRY OF WORKS AND TRANSPORT**', commissioned to us by **Ms KAARINA NDUUVUNAWA AMUTENYA** has been edited for English language, proofreading, technical, grammar, punctuation, and spelling by Express Language Editing.

Yours sincerely

Lazarus Gawazah

Professional English Language Editor

Master of English and Applied Linguistics
(NUST) Namibia

Disclaimer: Please note that the author of the document should notify us if there are any changes made to the document after our editing. We will revise the document and gladly resend it to you.

Annexure 27: Submission of final submitted Dissertation

Annexure 27 acknowledgement s

Annexure 28: Permission to public article from the Dissertation

Annexure 28
permission to public

Annexure 29: Editing Certificate – Final Dissertation