

Effectiveness and impact of covid-19 response and vaccination challenges in Namibia: A systematic review

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Abstract. Namibia, as with many countries around the world is experiencing devastating impact of Covid-19 disease on the economy, psycho-social interactions, and well-being of the populace. These countries implemented several measures to limit the spread of the virus responsible for the severe acute respiratory syndrome (SARS-CoV-2). Namibia also put measures in place to curtail the spread and fatalities due to the virus. However, the nature and implementation strategies of Public Health regulations seriously have impact on preventing the spread and curtailing fatalities arising from the virus. This article presents a report on the effectiveness and impact of Public Health measures instituted by the Health Authority towards curtailing the scourge of covid-19 on the general populace. Elements of the PRISMA protocol was utilised in the review which enabled the synthesis of data on focused area. Multifaceted databases on covid-19 such as Scopus, Science Direct, Google Scholar, World Health Organisation and the Ministry of Health and Social Services of Namibia (MoHSS) among others was used. A steady increase in covid-19 infection at an average rate of eleven (11) per day was noted in the country up till June 2021. Highest rate was linked to densely populated regions of Erongo and Khomas. Control measures for infection prevention and vaccination drive was ineffective majorly as a result of misinformation. A paradigm shift of enhanced interaction with local populace for effective information dissemination is required towards limiting the scourge of the virus and hence, saving of lives.

Introduction

The Severe Acute Respiratory Syndrome 2 (SARS-CoV-2) is responsible for the Covid-19 or coronavirus disease. Typical

symptoms include high fever, dry cough, continuous headache, and tiredness (1,2). The earliest reported incidence of COVID-19 in Namibia was on 13 March 2020 which led the Ministry of Health and Social Services (MOHSS) declaration of the outbreak on 14 March 2020. This was followed by sporadic increase in infection rate (3). Thereafter, the situation became worse as a result of reported high rate and number (in hundreds) of infection and hospitalisation due to ill-health as a consequence of COVID-19.

Currently, there are no specific and curative medicines for the treatment of COVID-19, however, the eventual development of vaccines provided a glimmer of hope for curtailing the spread and impact of the virus. and Namibia has been administering predominantly Sino Pharm, Astra Zeneca and John and Johnson vaccines. Despite these developments, restrictive public health measures such as stay-at-home, physical distancing, and quarantine where applicable are enforced not only in Namibia, but also in many countries around the world to reduce transmission of the virus. COVID-19 spreads from an infected person to others through respiratory droplets and aerosols (smaller droplets) created when an infected person: talks, sings, shouts, coughs, sneezes etc.

COVID-19 can also spread by touching something that has the virus on it, then touching your mouth, nose, or eyes with unwashed hands. COVID-19 virus can be transmitted before the on-set of symptoms while other people may have been infected but are asymptomatic. In view of little or no research and scientific information on the spread, preventative Public Health measures and hospitalization management procedure in many developing countries especially in Africa, there has been over reliance on WHO directives and information from developed countries such as USA, UK, and France. This situation gross left many developing countries including Namibia in vacuum towards coherent, effective, and decisive approach for the management of the menace of the virus.

Perspectives of Covid-19 management approach: The antecedent

Global perspective. Apt management of the spread of COVID-19 virus across the globe require a multi-faceted approaches. The World Health Organisation has been at the

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forefront of issuing regulations towards preventing the spread of the virus. Such measures include the wearing of facial masks that covers the mouth and nose as part of a comprehensive package of prevention and control measures to limit the spread of SARS-CoV-2, the virus that causes COVID-19 (4). Other measures include hand hygiene through regular washing of hands with soap, observing physical distancing of at least 1.5 metre from the next person, being the average distance, the virus laden aerosol can travel in air, avoidance of touching one's face, respiratory etiquette, adequate ventilation in indoor settings, testing, contact tracing, quarantine and isolation were initiated (5). Together, these measures are critical to prevent human-to-human transmission of SARS-CoV-2.

The Namibia perspective. Namibia, just as many of the sub-Saharan and African countries depend mostly on information and directives emanating from the global World Health body, the WHO for guidance towards managing the spread of COVID-19 virus in the country. This reliance can be attributed to paucity of local research drives for effective Public Health control and management measures. The country, as most of the developing countries also instituted preventative directives of wearing of masks, physical distancing, frequent hand washing, and limiting the sizes of gatherings. However, the effectiveness and impact of these control measures towards preventing and curtailing the spread of the virus, especially in low-income suburbs remain the big question. These behavioural management and control elements were largely meant to interrupt the chain of spread of the virus from one person to another especially in open and public places.

However, compliance with these measures are largely ignored by some members of the populace and hence, become ineffective in achieving the intended purpose (6). In developing countries, there is the perception that non-adherence to covid-19 regulations is related to socio-economic status especially among low-income people and within informal settlement communities. This perception may not necessarily be true or generalised. However, several factors such as misinformation may be attributed to the increasing number of cases of new infections. Windhoek, the capital city of Namibia is housed to about 268,132,000 inhabitants, which account for about one-ninth of the total population of 2,603,202 of the country based on projections of the latest United Nations data (7).

In terms of global economic and income status, Namibia has been classified as middle-income country due to the per capital income status (8,9). The country is also regarded as one of the most unequal society in terms of income/wealth distribution (10,11). The distribution of wealth among people sometimes dictates or influences the choice of area in which they live. More often than not, high income earners tend to live in residential areas that are well maintained with sufficient municipal services. Whereas low-income groups are synonymous with areas that are not as aesthetically pristine as those of the high-income groups. Low-income communities, especially in developing countries are generally assumed to be unplanned, crowded and devoid of aesthetic (12,13). The number of inhabitants per square meter and per household in these areas, especially in the informal settlement are quite high and amenable to easy and uncontrolled spread of COVID-19 virus. In addition, it is quite difficult to monitor and enforce

the basic preventative measures such as wearing of mask, safe hygiene practices such as regular washing of hands and safe distance keeping.

A causal relationship between population and the number of COVID-19 infections per local area revealed the disproportionate large number of infections emanating from these low-income suburbs. This trend may also be exacerbated by the increasing rural-urban migration influx of people to the capital city of Windhoek in search of jobs and improved standard of living. With limited resources and inability to secure employment, such local migrants end up living in squatters or informal settlements which may contribute to increase in infection rate within these communities. Namibia recorded 650 deaths that were linked to Covid-19 in the month of May 2021 (14). During this period, the country's daily confirmed Covid-19 cases and deaths per million people has surpassed that of South Africa (SA), India, Brazil, and the United States (15). Namibia recorded 648,87 positive cases per million people, whereas South Africa stands at 254,31 per million people during the month of June 2021. This can be classified as alarming considering a country with a population of about 2.5 million inhabitants (16).

The global drive towards preventing the spread of SARS-CoV-2 virus, hospitalisation and death is the massive vaccination of people. Quite a number of vaccines against the virus have been developed by biotechnology organisations in countries around the world. Some of these include AstraZeneca, Sinopharm, Pfizer, Johnson and Johnson, Sputnik V and Covaxin that has recently been authorised for emergency use in India. With the increased administration of vaccine to people across the world including Namibia, countries have started reducing and, in many cases, lifting restrictions on movements of people. This is expected to open up economies and usher in high level of social interactions with gradual return to pre-pandemic period.

However, this lofty expectation is being hampered by the anti-vaccine denialists and several misinformation about the vaccine across the world that tend to scare people from being vaccinated. This will definitely pose serious problem towards the attainment of 'herd' immunity which many governments are aiming to achieve. In Namibia, there are similar resistance to government efforts to ensuring the vaccination of the populace. One-thirds of survey population in a study revealed unwillingness to be vaccinated due to safety concern (17). Hence, it becomes imperative to elucidate on possible factors that may contribute to low drive towards vaccine uptake in the country.

Methods

Search strategy and selection criteria. A systematic review of effectiveness and impact of Covid-19 response and challenges with respect to vaccination process in Namibia was carried out. Elements of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) protocol was utilised. This enabled the synthesis of data on the focus of the review with potential areas of further studies and enunciated later in the review. We utilised multifaceted sources of information on Covid-19 that are relevant to the national imperatives and the global discussion. By this, top data bases such as

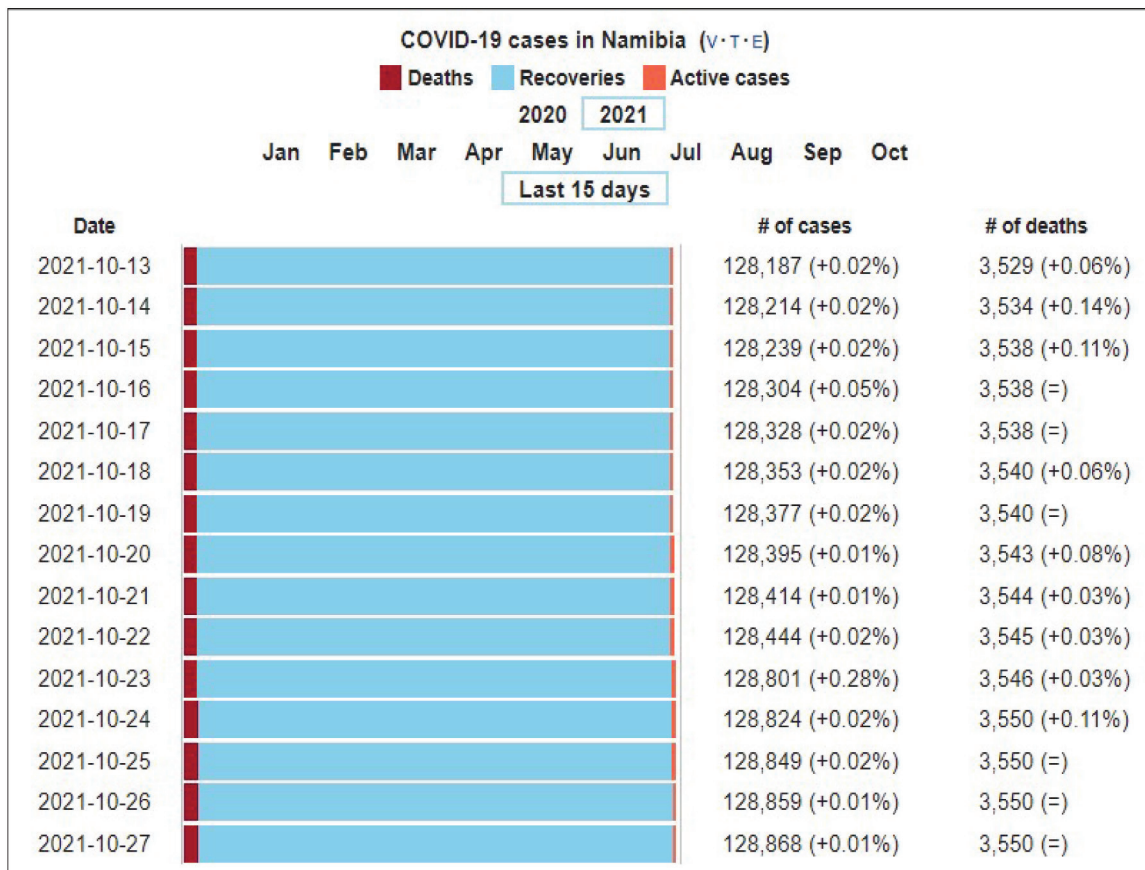


Figure 1. Covid-19 active, recovery and fatality cases in Namibia as of 27 October 2021 (<https://en.wikipedia.org>).

Scopus, Science Direct, Google Scholar, the World Health Organisation (WHO), the Ministry of Health and Social Services of Namibia (MoHSS) among others were searched. Use of data from these sources are vital for reliability and appropriate deductions on discussion. For substantiality of points of discussion, data (Tables and Figures) were directly accessed from these sources and utilised in the analysis and discussion of outcomes. For coherency, the focus of discussion has been structured to reflect relevant points that are aligned to the purpose of the review. Hence, the search terminology used include a mixture of terms such *trends of covid-19 infection in Namibia, covid-19 control measures in Namibia, covid-19 vaccination hesitancy, effectiveness of covid-19 management and covid-19 information dissemination.*

Inclusion and exclusion criteria. Basically, articles that are published in English language in all the above-mentioned searched data bases were included. All articles not published in English language, editorials and letters to editors were excluded.

Since the review entirely make use data and information from online literatures and do not involve human or animal participants, it is the opinion of authors that ethical consideration is not applicable.

Results

Trend of Covid-19 virus infection and vaccination drive in the country. As earlier mentioned, the first case coronavirus

infection in Namibia was reported on 14 March 2020. This was followed by sporadic increase in cases at key hotspots such as borders and coastal areas. In spite of immediate preventative measures that were put in place by the health authority, the rate and hence, number of infections increased drastically. By the end of July 2020, about 2052 cases of coronavirus infections had been recorded in Namibia (18). Lately however, the country has been reported to be recording an average of eleven (11) new Covid-19 virus infections per day with a peak of 1% being the highest reported daily average by June 29, 2021. Recent record revealed about 128, 907 infections and 3,554 corona virus-related deaths (Fig. 1) in Namibia (15).

With the availability of vaccines, the expectation was that there will be gradual decrease in the rate of infection, hospitalisation, and fatalities. This was not the case as the 15-day record in the month of October 2021 revealed otherwise as shown in Fig. 1.

Covid-19 surveillance and information dissemination pathways. The Centre for Disease Control of Namibia (CDC) under the MoHSS established a communication hotline on 15 March 2020. This was meant to provide assistance and responses to enquiries from the general public including symptomatic individuals (3). The government also utilised State-Owned broadcasting platform such as the Namibia Broadcasting Corporation and other MoHSS social media platforms (19). This was followed by the establishment of multi-disciplinary emergency response team for testing, surveillance, and monitoring of covid-19 issues in the country

Table I. Distribution of confirmed covid-19 cases by region in Namibia as of 13 August 2021.

| Region | Total No. of cases | Active cases | Recoveries | Cumulative deaths | Cumulative deaths with co-morbidity | Non-covid deaths | Health workers |
|--------------|--------------------|--------------|------------|-------------------|-------------------------------------|------------------|----------------|
| Erongo | 17,903 | 678 | 16,826 | 394 | 327 | 5 | 405 |
| Hardap | 7,336 | 83 | 6,999 | 254 | 158 | 0 | 122 |
| Kharas | 7,443 | 59 | 7,243 | 141 | 124 | 0 | 225 |
| Kavango East | 5,391 | 30 | 5,186 | 175 | 112 | 0 | 244 |
| Kavango West | 578 | 32 | 532 | 14 | 11 | 0 | 38 |
| Khomas | 41,134 | 1,181 | 39,117 | 835 | 653 | 1 | 1,480 |
| Kunene | 3,378 | 82 | 3,226 | 70 | 58 | 0 | 90 |
| Ohangwena | 3,927 | 267 | 3,537 | 121 | 78 | 2 | 138 |
| Omaheke | 3,642 | 27 | 3,370 | 245 | 170 | 0 | 119 |
| Omusati | 4,874 | 269 | 4,414 | 191 | 118 | 0 | 171 |
| Oshana | 8,564 | 178 | 8,076 | 309 | 184 | 1 | 509 |
| Oshikoto | 6,382 | 175 | 6,049 | 156 | 124 | 2 | 312 |
| Otjozondjupa | 9,085 | 86 | 8,730 | 269 | 184 | 0 | 254 |
| Zambezi | 2,832 | 647 | 2,082 | 103 | 59 | 0 | 103 |
| Total | 122,469 | 3,794 | 115,387 | 3,277 | 2,360 | 11 | 4,210 |

Adapted from: WHO Namibia Covid-19 Situation Report No. 513 (30).

including border posts. The declaration of emergency enabled the government to all levels of educational institutions with gradual phased-in reopening plans. Several covid-19 virus testing centres were set up within governmental and private hospitals for handling the increasing rate of infection. The lockdown regulation was initially applied to the two main economic hub regions of Khomas and Erongo in view of the high rate of infection for about twenty-one (21) days. By May 04, 2020, the lockdown was applicable to all regions. Despite these measures, the cases of covid-19 in terms of infections and fatalities continue to increase across all regions but majorly in the two economic hubs of the country as revealed in Table I.

Covid-19 control measures instituted by the Government of Namibia. One of the foremost control measures instituted by the government after confirmation of the first case on 14 March 2020 in Namibia was the suspension of air flights. A state of emergency was declared by the country's president on 17 March 2020 as a legal means of avoiding public reactions to limitation of citizens basic rights as enshrined in the constitution. This was later followed by the closure of all ports on entry on 18 March 2020. In order to further curtail the spread of the virus, all public and private schools were closed for about a month including prohibition of large gatherings that was reduced to not more than fifty (50) people at that time. Many developing countries such as China, Indonesia, Philippines, South Africa, Kenya including Namibia also implemented limits on social gatherings and internal travel restrictions spanning a week to couple of months (20). Some closure measures that was implemented by Government of the Republic of Namibia include the closure of schools, workplaces and stay-at-home as presented in Fig. 2A to C. In addition, several health and safety protocols were provided

by the Namibia Minister of Health and Social Services as part of the Public Health Covid-19 General Regulations under the Public and Environmental Health Act of 2015. These regulations include those involving the wearing of masks, public gatherings, restriction of movement (curfew), restriction on sale of liquor, resumption of business operations and activities, provisions relating to workplace, restrictions relating to certain activities, restrictions related to Entry into Namibia, restrictions on quarantine and COVID-19 testing, on public transport and regulation and that of Covid-19 deaths and burials (21).

Possible militating factors against effective Public Health COVID-19 Virus control measures. In Namibia, the main channel of information dissemination on infectious diseases including COVID-19 virus is the Ministry of Health and Social Services (MoHSS). Apart from access to information through the website of the Ministry, information dissemination channel from the national health management level to regional and local health authorities is mainly through the relevant district health commissioners to local health authorities. However, compliance to health directives and regulations at low-income and informal settlement are influenced by certain factors. Several factors such as educational level, socio-economic, cultural and behavioural/attitude of people among others have been reported to exert high influence on compliance with governmental directives and regulations (22,23).

Behavioural change theories and management of Covid-19. The use of behavioural theories for assessing the factors responsible for non-adherence to public health regulations and guidelines was encouraged (24). Such procedures provide pathways for enquiries on pre-assessment strategies, measuring and monitoring parameters and subsequent evaluation. Among often used behavioural theories are the social cognitive theory



Figure 2. (A) Lockdown policy implemented for schools in Namibia. Source (15). (B) Lockdown policy implemented for workplaces in Namibia. Source (15). (C) Stay-at-home policy implemented for in Namibia. Source (15).

(SCT), the transtheoretical model (TTM) of change, the health belief model (HBM), and the theory of planned behaviour (TPB) (25). However, behavioural changes are modulated by four (4) components which include biological, emotional, cognitive, and environmental functioning. Hence, behavioural changes may be influenced by either or a combination of these

components (26). In spite of these, social behaviour can be said to characterize the interactions that occur among individuals. It was however, pointed out that intentional non-adherence to public health regulations is strongly associated with anti-social psychological factors which has been linked to people living in high-risk, low-income, unplanned, and informal settlement

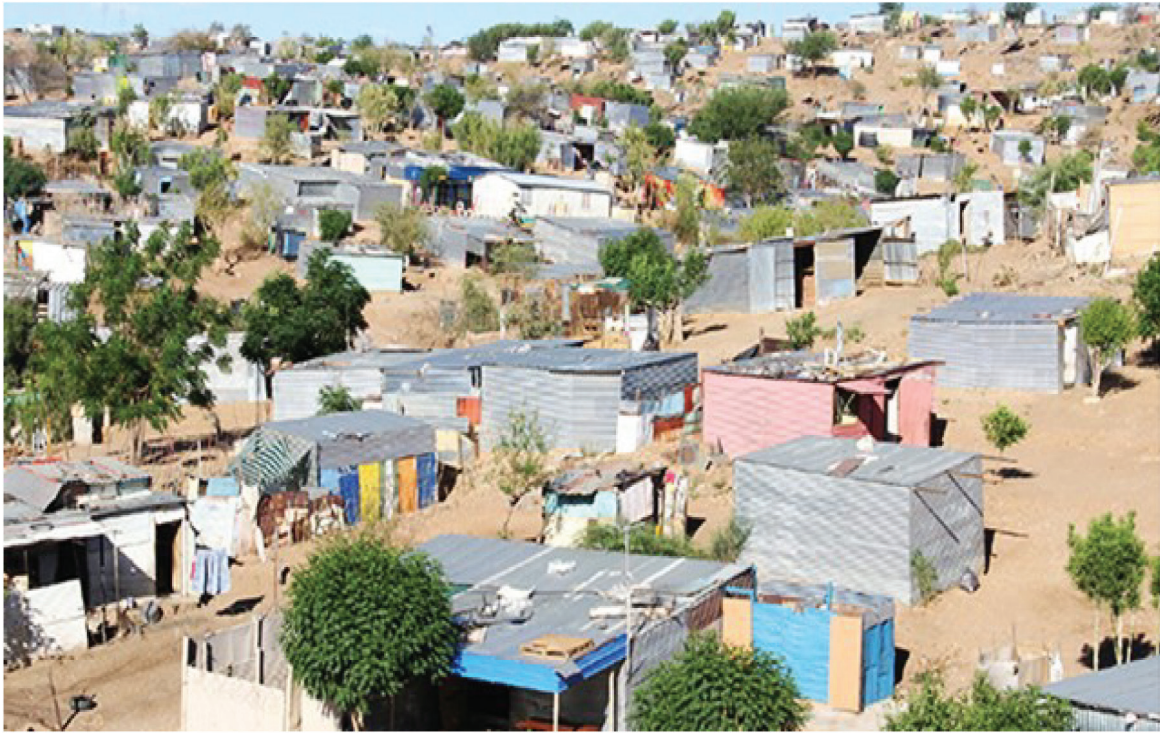


Figure 3. One of several unplanned and high-risk informal settlements in Windhoek, Namibia. Source (33).

environment (27). A typical example of such informal settlement is as shown in Fig. 3 (28).

In order to ensure adherence to public health regulations and guidelines, it is important that these social factors are taken into consideration and public health information should reiterate collective responsibility for the benefit of the whole populace. Incidences of non-adherence to the basic covid-19 regulations of social distance maintenance, staying at home and wearing of masks that covers the mouth and nose have been reported (29). Similar incidences were also noted and reported in Namibia (30). This anti-social non-adherence to public health safety and regulations in relation to prevention of the spread of covid-19 virus was characterised by overcrowding of Police holding cells by defaulters (31).

However, arrest and detention of defaulters cannot be said to be the solution, rather it is the use of effective communication strategies that low-income, uneducated, unemployed members of the populace will relate to. Many of this group of people as earlier mentioned live in un-serviced and impoverished informal settlements.

Similar deduction can be made with respect to unwillingness and hesitancy to be vaccinated. Several individuals or groups of people have expressed unwillingness to receive the covid-19 vaccine across the world. The hesitancy or refusal to receive the vaccination have been reported to be associated with factors such as misinformation, educational level, low-income or poverty level and in some cases, ethnicity (32-36). Namibia has not been spared on the issue of covid-19 vaccination hesitancy as a result of misinformation. For example, in early April of 2020, a report on the social media claimed that the 5G network that was launched by the Namibia's largest telecommunication operator is linked to covid-19. The operator, MTC denied the claim and clarified that Namibia does not even have 5G installed yet (37).

Discussion

Following the detection and reporting of the first case of coronavirus infection in Namibia, several measures involving restricting the movement and activities of people was implemented by the Government of Namibia. These measures are similar to those that were applied by other countries across the world. These include closure of schools, stay at home, restricting the number of people that can interact or gather together, including family members, local and regions restrictions of movement, closure of borders among other were implemented. Due to the cosmopolitan nature of regional capital cities in some regions, the rate and number of SARS-CoV-2 virus had been higher in these cities. These include the capital city of Windhoek (41, 134) in the Khomas region and Walvis Bay (17, 903) in the Erongo region of Namibia as shown Table I. These places were among the earlier cities where lockdown/restriction on movements of people was implemented as a strategy of curtailing the spread of the virus.

The lockdown of these two populated major 'hotspots' was seen as a strategic attempt to prevent the spread of the virus to other less populated regions and the rural areas especially in the northern part of the country. This was an attempt to prevent this category of people from being infected since they are seen as more vulnerable to the impact of the virus. This strategy was evident from the statement made by a top government official who stated that 'limited interaction between rural and urban dwellers is one of the factors designed to protect rural communities, against the full impact of the third wave of Covid-19 due to limited interaction between urban and rural dwellers'.

In terms of the effectiveness of communication for improved testing for the SARS-CoV-2 virus and vaccination

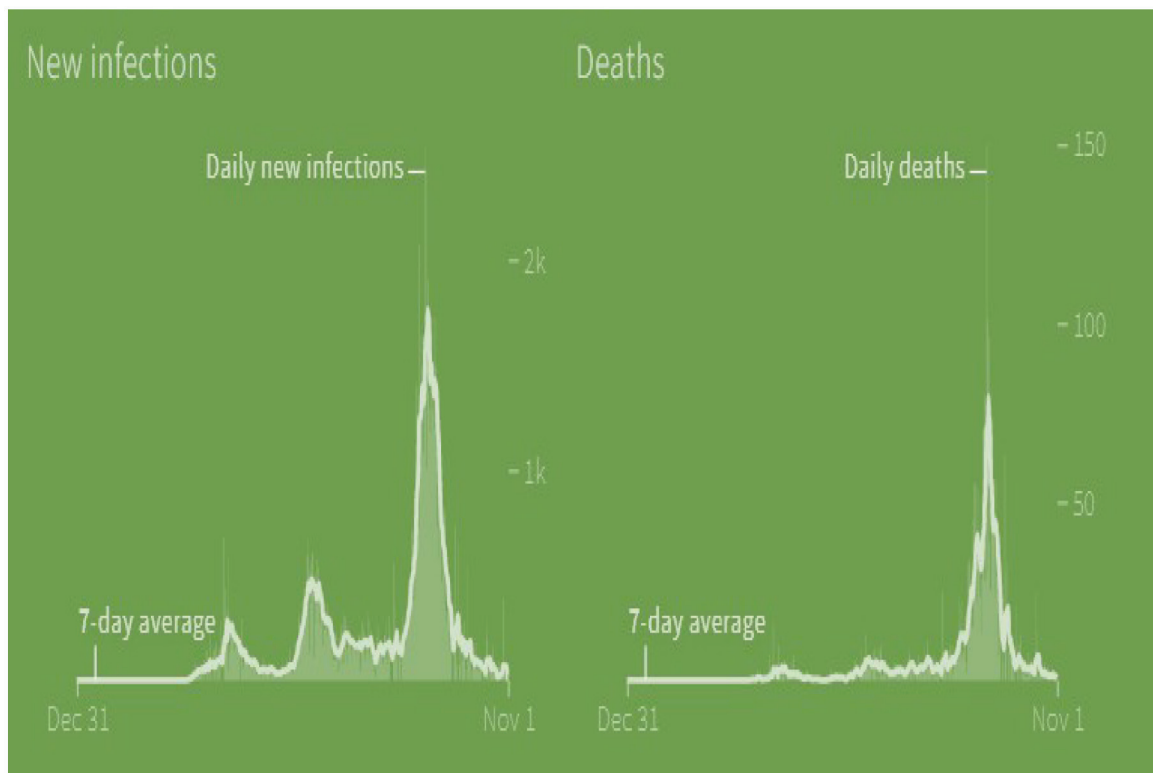


Figure 4. Trend of reported new infections and death in Namibia. Source (15).

against the disease, many challenges were encountered by the government and health authorities. The challenges centred mostly on misinformation on the use and safety of the vaccine. The outcome of a survey in Namibia revealed that one-third of respondents were not willing to be vaccinated due to safety concerns (30). Although, there was a period of unavailability of vaccines in the country, this unwillingness to receive the vaccine is contributing to low rate of vaccination with about 6.3% of the population having received the first dose and only 1.6% are fully vaccinated as of July 2021 (30). Some of the factors responsible for the unwillingness to be vaccinated may be attributed to a reported case in the (social) media that the death of an individual was linked to or was due to the vaccine (38).

The vaccination hesitancy also extend to members of the armed forces, some of whom refused to be vaccinated compulsorily where in a petition, immediate stop to the mandatory vaccination of members of the Namibian Defence Force (NDF) was demanded (39). Most worrying however, on the issue of unwillingness was the refusal by some health workers to also be vaccinated (40). The implication of this to the general public, especially the less educated members are of great concern. The drive towards achieving 60% vaccination of the population by the government may not be achieved.

Namibia recorded a daily vaccination of between 3,000-4,000 people with over 20,000 people per week across the country between the months of July and September 2021. This figure has declined to less than 1,900 per day and less than 10,000 per week across the country. The WHO attributed this low vaccination rate to the spread of misinformation, and concern over safety and efficacy of the vaccine (41). The impact of misinformation on the spread of covid-19 and the

resultant fatalities is not peculiar to Namibia but across the globe (42-44).

From the above, it is apparent that drastic and effective measures are required to be implemented in order to dissuade the false and misinformation that are propagated by few uninformed and denials of numerous scientific evidence that are available on the safety of the vaccines. Some control and mitigating measures that can be put in place and implemented for improved number and rate of vaccination include rigorous and effective community education and awareness drive. This can be in the form of organising community-wide information and awareness sessions with the purpose of convincing them of the safety of the vaccines, hence resolving the misinformation and scare that was created through individuals and the media. By this, evidence can be presented to community members. These sessions can also be used as vaccination campaign towards achieving the intended 60% vaccination of the population.

In order to influence the behaviour of people, especially those that are highly prone to misinformation, certain interventions are required. Although, there is currently no data in the country that link or elucidate on the demographic suburb-based model of non-adherence to covid-19 regulations and unwillingness to be vaccinated, extrapolation is always based on educational and socio-economic strata of the society. If this assumption is to be considered, the focus of such assessment will be on section of the population that live in low-income, unplanned, and informal settlement as depicted in Fig. 3.

Inexplicitly however, the uneducated and poor people living in poverty in the informal settlements seems to display nonchalant attitude towards being infected by the virus. This attitude might have been influenced by community in which

they live. These are usually 'shacks' built with rusted corrugated sheet, woods, and plastics. The unplanned environment, which are mostly crowded foster closer social interactions among the informal settlers. It was noted that at the on-set of the pandemic in Namibia in March 2020, the government of Namibia paid special preventative Public Health attention to people in the informal settlements who constitute about 40% of the country's population (45-48). However, their attitudes, perception and social interaction dynamics are not in tandem with governmental covid-19 Regulations. These are people that share same glass and cigarette when consuming alcoholic beverages. General expectations are high cases in number of infections, hospitalisation, and fatalities among this group of people. On the contrary, informal settlers believe that those that are infected and hospitalised by the virus are people from protected, affluent, and covid-19 Regulations intensive areas. These perceptions may be contributing to the apathy among people in these communities to adhere to the rules of Covid 19. This extrapolation will be the focus on the next investigation.

Conclusion

Effective communication of healthcare issues especially those involving covid-19 pandemic is essential for the general well-being of the society. Health communication strategies could be verbal or written with the purpose of empowering individuals, community members and the general populace in order to make informed decision. It is important that the government, through the Ministry of Health and Social Services of Namibia implement information dissemination strategy that are localised. This entails community-based information diffusion at the community level in addition to the use of radio broadcast, distribution of information pamphlets in local languages. Through this, dispelling of wrong information leading to improved adherence of health regulations and rate of vaccination will be achieved.

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None.

Contributions

AN conceptualised the manuscript, prepared the layout, and draft concept of the study. Further data search, collection, assessment, vetting and general writing of the manuscript was carried out by OA. Overall correction, review and inclusion of additional literature was done by AN.

Conflict of interest

The authors hereby declare no conflict of interest.

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