TOPIC: The National Health Insurance (NHI) and Women: Making the case for the socialisation of accessing health services a policy perspective

Submitted to

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Declaration of academic integrity

I, the undersigned, hereby declare that the mini-thesis entitled *"The National Health Insurance (NHI) and Women: Making the case for the socialisation of accessing health services a policy perspective"* is my work, that it has not been submitted before for any other degree or examination in any other university, and all sources and references that I have applied or quoted have been acknowledged as references.

- Gabriella Oliver

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List of Abbreviations

AIDS……..…….. Acquired Immunodeficiency Syndrome

ANC……..African National Congress

ART…….……Antiretroviral Therapy

CD ……..Constitutional Development

CHWs…… Community Health Workers

COVID-19……Coronavirus Disease 2019

DRC……...Democratic Republic of Congo

DHA…….…Department of Home Affairs

DHET…… Department of Higher Education and Training

DLR……Doctrinal Legal Research

DoJ……....Department of Justice

DoH……...Department of Health

DSD…….Department of Social Development

DMTs…….……District Management Teams

GDP……...…….Gross Domestic Product

GEMS…….Government Employee Medical Scheme

HPE…….…… Health Professions Education

HIV…… Human Immunodeficiency Virus

HPT……Hypertension

HRFH…… Human Resources for Health

ID…….. Identity Card

IMF…….. International Monetary Fund

NA…….National Assembly

NCOP……...National Council of Province

NDoH…….National Department of Health

NGOs…….. Non-profit Organisations

NHI ……National Health Insurance

NCDs ……....Non-communicable Diseases

OHSC…….Office of Health Standards and Compliance

OTL ……Outreach Team Leader

PPE…….Personal Protective Equipment

RDP…….Reconstruction and Development Programme

PMG…….Parliamentary Monitoring Group

PCD……...People-centred Development

PHC…… Primary Health Care

PMG…….Parliamentary Monitoring Group

PVHI.....……...Private Voluntary Health Insurance

RDP…….Reconstruction and Development Programme

RSA…….….Republic of South Africa

SAPs……..Structural Adjustment Programs

SARS-CoV2……..Severe Acute Respiratory Syndrome

SDGs…….Sustainable Development Goals

SSA……sub-Saharan Africa

STDs……...Sexually Transmitted Diseases

STIs…….Sexually transmitted infections

SSA……sub-Saharan Africa

T2D……....Type II Diabetes

UHC .....Universal Health Coverage

UN……....United Nations

UNHRC……..…….. United Nations Human Rights Council

UNHCR……United Nations High Commission for Refugees

US……United States

UWC……..University of the Western Cape

WHO…… World Health Organization

RSA……Republic of South Africa

List of Tables

Table 1: District Management Team core responsibilities in South Africa ……34

List of Figures

Figure 1: Macro organisation of the National Health System, Republic of South Africa ……18

Figure 2: Private voluntary health insurance (PVHI)…….....22

Figure 3: Levesque conceptual framework for health care access ……..…...……25

Figure 4: WHO's Health System Building Blocks …….……...……33

List of Boxes

Box 1: Fault lines in transforming the health system……27

Contents

1

Declaration of Academic Integrity i

Abstract xiv

CHAPTER ONE: 1

INTRODUCTION 1

1.1 Background, problem statement, contextualization, and the significance of the study 1

1.1.1 Background 1

1.1.2 Problem Statement 3

1.1.3 Contextualisation of the National Health Insurance 4

1.2 Significance of the study 6

1.3 Research Question(s) 6

1.4 Aim of the study 6

1.5 Research objectives 7

1.6 Theoretical and conceptual framework 7

1.6.1 Introduction 7

1.6.2 The doctrinal legal research (DLR) method (also called the black letter method) 7

1.6.3 The complexity theory approach 8

1.6.4 The people-centered approach (PCD) 9

1.7 Research Design 9

1.8 Research Methodology 9

1.8.1 Data collection 9

1.8.2 Data collection techniques 10

1.8.3 Data analysis 10

1.9 Inclusion criteria 11

1.10 Search Strategy for the Identification of Studies 11

1.11 Rigour in research 11

1.12 Limitation of the study 12

1.13 Ethical considerations 12

1.14 Tentative chapter outline 12

1.15 Conclusion 14

CHAPTER TWO: 15

LITERATURE REVIEW 15
2.1 Introduction 15
2.1.1 A brief historical overview of the Apartheid era (1948-1994) 15
2.1.2 Governance of Health Care during Apartheid 16
2.1.3 Access to private medical aid during apartheid 16
2.1.4 An overview of health care in South Africa post-1994 17
2.1.5 Overview of South Africa's health system 17
2.1.6 The public health sector 19
2.1.7 The private health sector 19
2.1.8 Criticisms of private health care 20
2.1.9 Healthcare Financing in South Africa 20
2.1.10 Austerity measures on health care 22
2.1.11 The "quadruple burden of disease" in South Africa 23
2.1.12 Migration and health care 26
2.1.13 Fault lines in transforming the health system in South Africa 27
2.1.14 Government intervention through the National Health Insurance (NHI) 28
2.1.15 Parliament adopts the NHI bill [B 11 - 2019] 29
2.1.16 The possible impact and implication of the National Health Insurance Bill [B 11 - 2019] 30
2.1.17 COVID-19 epidemic impact on South Africa's health system 31
2.1.18 Health System Strengthening 32
2.1.19 District health system (DHS) towards a bottom-up approach to health care 33
2.1.20 The role of community health workers in health care strengthening 35
2.1.21 Invest in health professions education for health system strengthening 36
2.1.22 Health Education Reform 36
2.1.23 Conclusion 38
CHAPTER THREE: 39
THEORETICAL FRAMEWORK 39
3.1 Introduction 39
3.2 Systems theory 39
3.2.1 Background on the systems theory 39
3.2.2 Rationale for rejecting the systems thinking 40
3.3 The people-centered development (PCD) approach 41

3.3.1 Background on the PCD approach 41
3.3.2 Limitations on the people-centered development (PCD) approach 42
3.3.3 Rationale for adopting the PCD approach 42
3.4 The complexity theory 43
3.4.1 Background of the complexity theory 43
3.4.2 Rationale for adopting the complexity theory 45
3.5 Doctrinal legal research (DLR) method (also called black letter method) 45
3.5.1 Background on the doctrinal legal research (DLR) method 45
3.5.2 Limitations of the doctrinal legal research (DLR) method 46
3.5.3 Rationale for employing the doctrinal legal research (DLR) method 47
3.5. The meaning of socialisation in health services 47
3.6 Conclusion 48
CHAPTER FOUR: 49
METHODOLOGY 49
4.1 Introduction 49
4.1.1 What are research methods and methodology 49
4.1.2 Definition of Research 49
4.1.3 Characteristics of Research Design 50
4.1.4 Explorative Study, descriptive study, and causal study 52
4.1.5 Explorative study 52
4.1.6 Descriptive study 52
4.1.7 Causal study 53
4.1.8 Research process 53
4.1.9 Research Strategy 53
4.1.10 Choice of research methodology i.e. qualitative, quantitative mixed methods, etc. 54
4.1.11 Time horizon 54
4.1.12 Population 55
4.1.12.1 Target population sampling population 55
4.1.13 Measuring instrument 55
4.1.14 Secondary research 55
4.1.15 Interviews 55
4.1.16 Questionnaires 56

4.1.17 Validity and Reliability of the measuring instrument 57
4.1.18 Pretesting 58
4.1.19 Pilot study 58
4.1.20 Types of Data Sources 58
4.1.21 Data collection process 58
4.1.22 Ethical consideration 59
4.1.23 Informed consent 60
4.1.24 Anonymity and confidentiality 61
4.1.25 Data Analysis Procedure 61
4.1.26 Statistics 62
4.1.27 Conclusion 62
CHAPTER FIVE: 63
ANALYSIS OF THE STUDY 63
5.1. Introduction 63
CHAPTER SIX: 74
CONCLUSION AND RECOMMENDATIONS 74
6.1 Introduction 74
6.2 Overview of the Study Chapters 74
6.3 Recommendations 75
6.4 Conclusion 78
BIBLIOGRAPHY: 79
ANNEXURE A: CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA BILL OF RIGHTS SECTION 27 (Source: The Constitution of the Republic of South Africa, 1996). 102
ANNEXURE B: NATIONAL HEALTH INSURANCE BILL [B 11 – 2019] PREAMBLE 103
ANNEXURE C: REFUGEES ACT 130 OF 1998 104
ANNEXURE D: NATIONAL HEALTH INSURANCE BILL [B 11 – 2019] SECTION 4 AND 5 105
ANNEXURE E: THE NATIONAL HEALTH INSURANCE BILL [B11 – 2019] 106
ANNEXURE F: NATIONAL DEPARTMENT OF HEALTH REVENUE DIRECTIVE-REFUGEES/ ASYLUM SEEKERS WITH OR WITHOUT A PERMIT (PAGE 1) 107
ANNEXURE G: NATIONAL DEPARTMENT OF HEALTH REVENUE DIRECTIVE-REFUGEES/ ASYLUM SEEKERS WITH OR WITHOUT A PERMIT (PAGE 2) 108

ANNEXURE H: NATIONAL HEALTH ACT (61/2003) OF 2017 DECLARATION OF NOTIFIABLE MEDICAL CONDITIONS (Source: NATIONAL HEALTH ACT (61/2003) OF 2017). 109

ANNEXURE I: NATIONAL HEALTH ACT (61/2003) OF 2017 TABLE 3 AND 4 NOTIFIABLE MEDICAL CONDITIONS Source: NATIONAL HEALTH ACT (61/2003) OF 2017). 110

ANNEXURE J: CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA BILL OF RIGHTS; CHAPTER 2 SECTION 9 27 (Source: The Constitution of the Republic of South Africa, 1996). 111

ANNEXURE K: CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA BILL OF RIGHTS SECTION 10 27 (Source: The Constitution of the Republic of South Africa, 1996). 112

ANNEXURE L: CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA BILL OF RIGHTS SECTION 74 (Source: The Constitution of the Republic of South Africa, 1996). 113

ANNEXURE M: CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA BILL OF RIGHTS SECTION 75 (Source: The Constitution of the Republic of South Africa, 1996). 114

ANNEXURE N: CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA BILL OF RIGHTS SECTION 76 (Source: The Constitution of the Republic of South Africa, 1996). 115

ANNEXURE O: Figure 1 Macro organization of the National Health System, Republic of South Africa (Source: Department of Health, 2006) 116

ANNEXURE P: Figure 2 Private voluntary health insurance (PVHI) represents a proportion of current health spending in countries with populations that exceed six million. (Source: Global Health Expenditure database, 2015) 117

ANNEXURE Q: Figure 3 Levesque conceptual framework for health care access (Source: Cu, Meister, Lefebre and Ridde, 2021) 118

ANNEXURE R: Box 1: Fault lines in transforming the health system (Source: Rispel, 2016). 119

ANNEXURE S: Figure 4 World Health Organization Health (WHO) System Building Blocks (World Health Organization, 2010. *Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies*. World Health Organization. 120

ANNEXURE T: Figure 5 WHO's Health Workforce Education and Production Strategies (Van Staden, D.B., 2021. Investing in health professions education: A national development imperative for South Africa. *South African Journal of Higher Education*, *35*(1), pp.231-245) 121

ANNEXURE U: Table 1 District Management Team core responsibilities in South Africa (South Africa National Department of Health. District Health Planning and Monitoring Framework, 2017; Orgill *et al*., 2021). 122

APPENDIX 1: ETHICAL CLEARANCE LETTER 123

Abstract

The National Health Insurance (NHI) bill [B 11 - 2019], which was approved for adoption by the National Assembly (NA) of South Africa's parliament on June 12, 2023, is the subject of this study, which offers a policy viewpoint. In doing so, the policy perspective attempts to analyse the degree to which the current NHI bill recognizes access to health services for women who are refugees and asylum seekers in particular. This study pays special attention to women who are asylum seekers and refugees because they are adversely affected by poor health outcomes around the world. Women asylum seekers and refugees are one of many variables in the health system in South Africa. The NHI bill and women asylum seekers and refugees are both variables of the same health system and therefore they are interconnected and linked. The linkages and interconnectedness of these variables are non-linear. Nonetheless, given the type of care that is contemplated in the NHI bill, the question that this policy perspective answers are: to what extent does the NHI bill in its current iteration recognize access to health services for women asylum seekers and refugees? And whether the type of care offered in the legislation satisfies constitutional muster.

Keywords: Universal healthcare coverage (UHC); National Health Insurance (NHI); Women; Asylum seekers; Refugees; Access; Health services

CHAPTER ONE:

INTRODUCTION

1.1 Background, problem statement, contextualization, and the significance of the study

1.1.1 Background

Given the gendered nature of this study, it is fundamental to define what the gender construct of 'women' means. Gender identities, defined as 'men' and 'women', are social norms that define appropriate expectations and roles for people based on their sex assigned at birth (Kaufman, Eschliman, and Karver, 2023). Sex refers to the biological characteristics that people are born with (Kaufman *et al*., 2023). The United Nations defines gender as the roles, behaviours, activities, and characteristics that society deems acceptable for men and women and that are socially developed and shaped through socialization methods (Kaufman *et al*., 2023). Another way of defining gender identity is peoples deeply rooted inner sense of self, which does not necessarily correspond to their physiological constitution or sex assigned at birth (Kaufman *et al*., 2023). Gender constructs contribute significantly to people's health outcomes and play a critical role in influencing people's health status (Boateng, 2017).

This study's primary focus is on women who are displaced and categorized as either an 'asylum seeker' or a 'refugee'. However, there are key legal differentiations between a refugee and an asylum seeker and often these two concepts are used interchangeably. Asylum seekers are defined by international refugee law as individuals who applied for refugee status in a country that is not their home, whereas 'refugees' refer to those who have been formally accepted as such by the United Nations High Commission for Refugees (UNHCR) or the government in which they have applied for international protection (Freedman, Cranks haw and Mutambara, 2020). The UNHCR reports that 46.2 million people are displaced worldwide, most of them due to war (UNHCR 2015). There are 4 million asylum seekers and over 20 million refugees worldwide (UNCHR, 2021; Pérez-Vázquez and Bonilla-Campos, 2023). According to Munyaneza and Mhlongo (2019), South Africa hosts more refugees than any other country in the sub-region. South Africa hosts 65,226 out of 449,000 refugees in the sub-region, excluding undocumented and uncounted asylum seekers (Zihindula, Asante, Meyer-Weitz, 2016). The Central African states, including Burundi, Rwanda, and the Democratic Republic of Congo (DRC), are the most affected countries in sub-Saharan Africa (Munyaneza and Mhlongo,

2019). The region in question has been volatile since 1994 due to the numerous conflicts and wars that originated in Rwanda and spilled over into neighbouring countries (Munyaneza and Mhlongo, 2019). According to Flahaux and De Haas (2016), some of the underlying factors that lead many people to relocate elsewhere include different crises such as environmental factors, climate change, violations of basic human rights, access to health services, access to basic and higher educational opportunities, and poverty. These challenges represent some of the push and pull variables that influence people's decision to leave their home country and become refugees in a different country.

In the past, researchers have documented how a range of factors such as experiences of violence in countries of origin and transit, unsafe and traumatic migration journeys, political and legal restrictions on their immigration status and rights, and limited access to social and health services throughout their migration process leads to poor health outcomes for asylum seekers and refugees (Freedman et al., 2020). In the host country, there are often additional challenges that further restrict foreign nationals' access to health services (Freedman et al., 2020). The term "access" refers to an interaction between a person's personality, social and physical environment, and health care and health system characteristics (Levesque, Harris, and Russell, 2013). Heightening racism and xenophobia in the host country, notably discrimination against foreign nationals by health workers, can also make it more difficult for refugees and asylum seekers to access treatment (Crush and Tawodzera, 2014; Palmary, 2016).

Women who are asylum seekers and refugees in South Africa are largely poor and vulnerable and rely on the public health system for health services. According to Kaziboni, Lancaster, Machabaphala, and Mulaudzi, (2022), one of the most popular misconceptions in South Africa is that foreign people such as asylum seekers and refugees have "flooded" and overwhelmed public services (especially hospitals and clinics). Allegations of an influx of migrant people flooding South Africa's public health facilities continue to dominate national discourse and are expressions of "medical xenophobia" (Clifford and Hazvineyi, 2019). However, migrant people make up only about 6.5% of the population (Stats SA, 2021). Consequently, it is statistically impossible to blame people who are asylum seekers and refugees for health system deficits (Kaziboni *et al*., 2022). If anything, the denial of basic health services is an infringement on the rights of asylum seekers and refugees. It is not only politically incorrect but unconstitutional as well.

The widespread belief that foreign nationals do not contribute effectively to the development of communities and global society remains a myth that is often not refuted. Studies have shown otherwise.

1.1.2 Problem statement

A prevailing narrative in South Africa in the migration context is that asylum seekers and refugees adversely affect the socioeconomic conditions, "steal" jobs, and drain public resources such as health services from locals (Kaziboni *et al*., 2022). Such a portrayal of asylum seekers and refugees creates the false impression that they are merely recipients of the social benefits available in South Africa. However, this has not proven to be true. Women asylum seekers and refugees experience adverse challenges to accessing health services (Munyaneza and Mhlongo, 2019). Challenges such as lack of documentation, lack of economic opportunities, and experiences of xenophobia are just some of the wider range of issues asylum seekers and refugees face when attempting to access health services.

Lack of documentation:

Due to a lack of documentation, financial constraints, and xenophobic attitudes among health workers, women asylum seekers and refugees cannot access basic health services (Freedman *et al*., 2020). According to Freedman *et al*. (2020), women asylum seekers and refugees often stay away from hospitals and clinics because they fear being turned away for lack of documentation and also cite financial constraints in accessing medical treatment.

Lack of economic opportunities:

Economic prospects were also among the reasons why the majority of refugees relocated to South Africa (Khanyile, 2017). Asylum seekers face economic fragility and reliance due to a lack of official support and assistance in finding employment (Freedman *et al*., 2020). Thus, lowering their ability to afford quality health services.

Discriminatory xenophobic attitudes:

Freedman *et al*., (2020) further explain that xenophobic sentiments of hospital staff are an added barrier to the provision of adequate health services for women and reflect a larger problem of racism and xenophobia in South Africa. Munyaneza and Mhlongo (2019) found in another study that women refugees also reported receiving poor care from health workers,

particularly nurses. They also stated that they would no longer use public clinics or hospitals if they had the opportunity to do so. Due to the abuse, they experienced in antenatal clinics during labour and after delivery, some survey participants stated that they would probably not have children in South Africa. These attitudes lead to extremely harmful experiences of health care for many women (Freedman *et al*., 2020). These adverse circumstances have demonstrably impacted these women's vulnerability to poor health outcomes. However, not all health workers perform their duties with discriminatory attitudes (Khanyile, 2017). It can be established that women asylum seekers and refugees are vulnerable to worse health outcomes in these intersecting contexts of vulnerability as a result of the combination of lack of documentation, discrimination based on their citizenship, and financial constraints.

To lessen the gap between those who can afford to obtain health services and those who cannot, the South African government plans to integrate the National Health Insurance (NHI) system into the health system. The primary goal of the NHI is to deliver state-funded, quality healthcare services at the point of care (Nkosi, 2020). However, the National Department of Health (NDoH) released an NHI White Paper (2015) that subtly describes how women's primary health needs will be appropriately addressed to their best interest while reducing the inequality in accessing health services. However, the type of health coverage for women's health has not been clearly outlined in the NHI White Paper (2015).

1.1.3 Contextualisation of the National Health Insurance

In August 2011, the South African government took steps to recommit to the ideals of universal health coverage (UHC) for the entire population (Naidoo, 2012), and the National Health Insurance (NHI) financing mechanism is the preferred path to do so. The NHI is a healthcare financing system designed to pool funds for healthcare provision (from taxes, insurance, and other sources) to redistribute them equitably (Department of Health, 2015; Ndebele, 2021). The goal is to provide all South African citizens and non-citizens, regardless of their socioeconomic status, with access to sufficient quality and affordable personal health services according to their health needs (Department of Health, 2015). According to the NHI framework, no fees are charged to healthcare users at the point of care for a defined package of services covered by the NHI Fund (National Department of Health, 2021). The government's efforts to address the inequalities in accessing quality healthcare services were done through issuing official documentation through the Green Paper on the NHI policy and subsequently, published the

NHI White Paper four years later in December 2015 (Passchier, 2017). However, an amended NHI White Paper was released another two years later in June 2017 (Passchier, 2017).

The NHI is founded on the idea that South African residents have an inherent right to have access to health services (Ndebele, 2021). The right to receive healthcare services is outlined in Section 27 of the South African Constitution's Bill of Rights, which serves as the foundation for the NHI's mission (Ngwena, 2003). The National Health Act (2013), states that the pursuit of UHC derives from these sources, the Vision 2030 of the National Development Plan (NDP), the Reconstruction and Development Programme (RDP), and the 1997 White Paper on Health System Transformation.

According to the NHI White paper (2018, UHC is conceptualized as,

"[All] people [shall] have access to promotive, preventative, curative, rehabilitative, all palliative healthcare services that they need, regardless of socioeconomic or healthcare status, where such services are of sufficient quality to be effective, and that people should be financially protected from the costs of using such services (Department of Health: Republic of South Africa, 2018)".

The following contexts inform the NHI framework: a) access, which is also a basic right stipulated in the South African Constitution (The Constitution, 1996); b) social unity, which relates to financial risk protection for the entire population; c) effectiveness, which refers to the use of supported by evidence interventions; d) appropriateness, which refers to the use of new and innovative treatment models; e) equity, which guarantees universal coverage of care that meets needs; and f) cost-effectiveness.

Women asylum seekers and refugees are one of many variables in the health system in South Africa. The NHI bill and women asylum seekers and refugees are both variables of the same health system. Therefore, they are linked. The linkages and interconnectedness of these variables are non-linear. Asylum seekers and refugees in South Africa, of which women make up a sizable share, are part of the legal operations of the health system. However, there is limited scientific data on the extent to which the NHI bill promotes universal health care (UHC) for women asylum seekers and refugees. About half of the world's 20 million refugees are women, and despite their important role in the societies in which they live, their perspectives and needs are often overlooked in research and campaigns targeting this population (Pérez-

Vázquez and Bonilla-Campos, 2023). Subsequently, it is not surprising that this study intentionally seeks to bring attention to women asylum seekers and refugees' health access.

This study aims to examine the extent to which the NHI bill considers the right of refugee or asylum-seeking women in South Africa to access health services, considering the type of care that the bill envisions. In doing so the research project seeks to: (1) delineate the extent to which the current NHI bill recognizes access to health services for women who are asylum seekers and refugees; (2) examine the complex relationship between the private health sector and the public health sector in the context of accessing health services; (3) to make a case for the socialisation of the means of accessing health services.

1.2 Significance of the study

This study bears significance as it can add to the current ongoing debates on the National Health Insurance (NHI) in South Africa. This study extends supportive information to relevant government departments concerned with matters related to public health.

1.3 Research Question(s)

- Central Research Question (CRQ_1)

  To what extent does the current National Health Insurance (NHI) bill recognize access to health services for women who are asylum seekers and refugees?

- Sub-research question (SRQ1)
  To what extent does the complex relationship between the private health sector and the public health sector impact the accessibility of health services?

- Sub-research question (SRQ2)
  To what extent does the term 'socialisation' inform the understanding of accessing health services?

1.4 Aim of the study

Based on the ongoing contentious debates centred on the National Health Insurance (NHI) Bill, this study provides useful insight into the extent to which the NHI bill recognizes access to health services for women who are asylum seekers and refugees.

1.5 Research objectives

1.5.1. To explore the extent to which the current NHI bill recognizes access to health services for women who are asylum seekers and refugees.

1.5.2. To examine the complex relationship between the private health sector and the public health sector in the context of accessing health services.

1.5.3. To theorize what the socialisation of accessing health services would look like from a policy perspective.

1.6 Theoretical and conceptual framework

1.6.1 Introduction

Finding the right theory is a bit more difficult when it comes to gender, health systems, and healthcare legislation. This is because there are not a lot of peer-reviewed articles to inform which theory to apply when, as the topic has not been sufficiently explored in research. Social scientists have debated various public health reforms for years and there is more theory-based literature on the topic, however, NHI is a little different. Some methods and theories were critically evaluated to develop an appropriate theoretical framework for this study.

This study adopts the doctrinal legal research (DLR) method to: (i) delineate the extent to which the current NHI bill recognizes access to health services for women who are asylum seekers and refugees; the complexity theory is used to (ii) examine the complex relationship between the private health sector and public health sector in the context of accessing health services; after that this study uses the people-centred approach to (iii) make a case for the socialisation of the means of accessing health services in a South African context. The following section briefly goes over these approaches and justifies why they apply to this study.

1.6.2 The doctrinal legal research (DLR) method (also called the black letter method)

"Doctrinal or theoretical legal research is commonly referred to as research that explores what the law is in a particular area", according to Ian Dobinson and Francis Johns (Ngwonke *et al*., 2023). It focuses on the evaluation, creation, and application of legal doctrine. Pure theoretical research is another name for this type of study. It is best defined as research that aims to explain in detail the rules, regulations, and concepts that govern a particular area of law or institution and to examine the interactions among those rules, regulations, and concepts to address ambiguities and gaps in existing law (Hutchinson, 2015).

According to Hutchinson (2014), the doctrinal legal approach provides a thorough conceptualization of each major piece of legislation and court decision to find a statement of the law concerning the subject matter under study. The doctrinal approach is essentially the same in all related areas of law (Hutchinson, 2015). Although it was developed for private law, it has since been adopted by researchers working in constitutional, criminal, and other disciplines (Hutchinson, 2015). Moreover, the doctrinal approach is a fundamental prerequisite for conducting any other type of legal study (including economic, comparative, empirical, or behavioural work). All of this helps to define the proper position of legal doctrine in contemporary legal studies.

According to this study, the legal doctrinal approach is a good choice for determining how much the NHI bill recognizes access to health services for women who are refugees and asylum seekers. This study also argues that DLR fulfils three fundamental purposes: The purpose of description, prescription, and justification are interconnected and even mutually helpful. As a result, the NHI bill will be interpreted in line with the existing legislation inside of the South African Constitution.

1.6.3 The complexity theory approach

This study will use complexity theory to examine the complex relationship between the two-tiered health systems in the context of accessing health services in South Africa. The private and public health systems can be described as complex because of their interactions. Many authors argue that complexity theory provides a useful perspective for answering social questions (Sturmberg and Martin, 2013). The motivation for using complexity theory is that it provides a framework that encompasses all elements of the two-tier health system. Thus, complexity theory helps to achieve the goal of this study, which is to examine the complex relationship between the private and public health sectors in the context of access to healthcare services. The analytical approach of dissecting a complex system into smaller, more manageable pieces, studying each one independently, and then reassembling it is challenged by complexity theory. A complex system is defined not by the sum of its parts, but rather by the intricate connections between those parts. Similar to this, South Africa's two-tiered healthcare system is made up of various parts (namely, the private and public health sectors) that interact unequally and disproportionately, resulting in disparities in the use and accessibility of healthcare services for the country's entire population.

1.6.4 The people-centred approach (PCD)

The people-centred approach's (PCD) main tenants include participatory; empowerment; and sustainability which are important elements in theorizing how the term socialisation informs the understanding of the means of accessing health services in the South African context. In essence, PCD places individuals at the centre and enables social development through participation (Jennings, 2000). Additionally, the PCD is seen as a "bottom-up" strategy and is now known as the participatory development approach, in contrast to the classical development theories (Jennings, 2000). Meaning that this strategy promotes and achieves growth as well as sustainability by starting at the local level.

1.7 Research design

This section of the study describes the instruments and sources used to collect data for this study. Any researcher must choose the appropriate instruments for the nature and scope of the objectives and tasks. To use a method effectively, the researcher must first understand what it entails. Data collection refers to the process of obtaining quality evidence and measuring information on selected variables to answer relevant questions. Collecting data is important in many areas of research, including developmental research, the social sciences, and the humanities. Regardless of the different methods used in other disciplines, the common idea of research is to obtain accurate research results and achieve the objectives.

Following a search and collection of relevant literature and evidence on women asylum seekers and refugees' access to health services in South Africa, the data will be "mapped". Data mapping is viewed as a method of synthesizing and analysing data, as well as emphasizing key topics and themes. Mapping the data allows readers and researchers to better comprehend the literature and evidence that informed the literature review study. Mapping the data allows researchers to better comprehend the evidence and literature included in the review. This enables researchers to make an informed decision based on the findings of the study.

1.8 Research methodology

1.8.1 Data collection

This study's main source of information is secondary data. This study recognizes that primary data are still important in research, especially where producing new knowledge to what is already known is concerned. Secondary data, on the other hand, provides much-needed clarification of the topic and is the safest method of investigation because of readily available

literature on the study's theme. In addition, this study's focus on health-related themes including access to health services; legislation on health reform; challenges in the health system; gender constructs and women's health; the social determinants influencing women's access to health services, and the state intervention taken by the South African government to mitigate the iniquitous health system; achieving UHC for all through the adoption of the NHI bill in South Africa.

1.8.2 Data collection techniques

In the analysis and evaluation of the collected data studies, this study uses the method of a literature review study. The literature review is an important consideration in all studies because it is a review that typically involves a framework, a reasoning, and a critical review of previous studies, and problems in recent research, and understands or sets up fresh study problems and supports research questions based on available information (Boell and Cecez-Kecmanovic, 2015). It comprises a compilation of publicly available (published and unpublished) theme materials containing information, ideas, statistics, and data published from a particular point of view to gather or convey those viewpoints on the nature of the subject and how it should be examined, as well as a thorough assessment of the studies and documents engaged (Templier and Paré, 2015).

This study drew on peer-reviewed articles, official government documents, conference papers, and online news reports, data from international organizations including the WHO on health system strengthening and sustainable strategies to improve the health of diverse populations. Other objectives of this study included incorporating previous research and recent studies that are peer-reviewed. Information was gathered from various databases, a Google search was conducted to access journals on PubMed, Google Scholar, ResearchGate, government gazettes, and bills provided by the Parliamentary Monitoring Group (PMG). However, this study also conducted a manual search, which proved effective in collecting data. Most of the literature used for this study was in the English language.

1.8.3 Data analysis

In this study, thematic analysis is used to evaluate the data. It is described as finding, analysing, and interpreting the meaning of trends in qualitative data. Thematic analysis is a commonly used and accessible tool, especially for the analysis of qualitative data (Kiger and Varpio, 2020). This strategy is useful for analysing and understanding people's thoughts, attitudes, and

experiences across a wide range of data. Therefore, this study uses this strategy for data analysis.

1.9 Inclusion criteria

Selected published articles from peer-reviewed journals were screened and reviewed. Articles included were the NHI White Paper; the criticisms and potential implications of NHI; the interaction between the private and public health systems in providing health care to the population; and access to quality health for women. Sources also included information from the Parliamentary Monitoring Group (PMG) including the latest version of the adopted NHI bill [B 11 - 2019]. The review was limited to research that specifically addressed the historical development of South Africa's health system during apartheid and the current struggles facing the country's national health system. Theses and dissertations on public health and health professions education were included. Articles without abstracts or full text were excluded. Research on healthcare financing models was excluded.

1.10 Search Strategy for the Identification of Studies

The initial collection of keywords will include "national health insurance", "universal health coverage", "asylum seekers", "refugees", "access", "women" and "South Africa", as well as synonyms and related themes. An exploratory search was carried out using numerous databases, including PubMed, Scopus, CINAHL (EBSCO), Scopus, Google Scholar, Web of Science, and ResearchGate. The keywords from the titles found in the initial search are utilized to broaden the recommended search strategy, resulting in a more comprehensive search approach. The search algorithm was modified as needed, and the reference lists of articles meeting the inclusion requirements were examined to identify additional studies. Only papers that were published in English were evaluated. All references in the bibliographies of included documents were also systematically searched for relevant documents.

1.11 Rigour in research

This study was the first of its kind at this stage, and some conflicts may have arisen due to the rigor of the study. Due to the use of secondary sources in this study, the research methodology employed by this study is a contextual literature analysis. Contextual analysis can be summarised as follows: Contextual analysis involves the methodical examination of textual data from secondary sources, including peer-reviewed publications and academic journals used in this study.

The collected data for this study were sorted and divided into manageable components throughout the data analysis process. The World Health Organization (WHO) framework for health systems strengthening was used as the conceptual framework for this study and served as the basis for the themes and concepts used to code the data. In this study, secondary studies were compiled from journal articles and peer-reviewed studies after all research studies had been contextualized so that the secondary studies would make sense in their entirety.

Some of the rigor found in this study is its credibility, reliability, and validity, as almost all the secondary studies compiled for this research were recent studies conducted between 2015 and 2023. The study found very similar research findings from global studies, including first-world and developed countries such as America and China, which are consistent with studies in developing third-world African countries with lower socioeconomic societies. In addition, an assessment of the two-tiered health system and women's access to quality health care helped establish the reliability of the findings for this study.

1.12 Limitation of the study

This study has limitations such as including only English-language studies and reviews. Another limitation is that this study concentrates only on women's access to health services. In contrast, men's health access was not considered in this study. This study analysis only focuses on women's access to health services, although transgender, non-binary, and gender non-conforming people are at increased risk of accessing suitable health services.

1.13 Ethical considerations

To conduct this study, formal approval of this research topic was required from the Higher Degrees Committee of the University of the Western Cape (UWC). According to Strydom (1996), ethics is a custom of moral theories established by one person or organization and subsequently accepted by all. In this study, the focus was on adherence to strict ethical principles that preclude the use of information and articles that were not peer-reviewed.

1.14 Tentative chapter outline

This study is divided into six chapters:

Chapter One: An introductory chapter, that explains the background, problem statement, and contextualization of the National Health Insurance (NHI); the significance of the study; the research questions; sub-research questions; aims of the study; research objectives; theoretical

and conceptual framework on the doctrinal legal research (DLR) method; the complexity theory; the people-centred development (PCD) approach; the research design; the research methodology; the data collection; the data techniques; the data analysis; the inclusion criteria; the search strategy for the identification of studies; the rigor in research; the limitations of the study; the ethical considerations; the tentative chapter outline and conclusion of this chapter.

Chapter Two: Will review the literature. This chapter includes a brief historical overview on the apartheid era; governance of the health system during apartheid; access to private medical aid during apartheid; an overview of the health system in South Africa post-apartheid; the two-tier health system; the public health sector; the private health sector; criticisms of private health sector; inequities in health care financing in South Africa; austerity measures on health care; The "quadruple burden of disease" in South Africa; migration and access to health care; fault lines in transforming the health system in South Africa; government intervention through the National Health Insurance (NHI); the adoption of the NHI bill [B 11 - 2019] in the National Assembly; the possible impact and implication of the National Health Insurance (NHI) Bill; COVID-19 pandemic impact on South Africa's health system; health system strengthening; district health system (DHS) towards a bottom-up approach to health care; the role of community health workers in health care strengthening; invest in health professions education for health system strengthening; health education reform and conclusion.

Chapter Three: Will mainly focus on presenting the theoretical framework. This chapter includes an introduction to the chapter and discusses the following; background on the systems theory; rationale for rejecting the systems thinking approach; background on the people-centred development (PCD) approach; main tenants of PCD; limitations of PCD approach; rationale for adopting the PCD approach; background of the complexity theory; the limitations of the complexity theory; rationale for adopting the complexity theory; background of the doctrinal legal research (DLR) method; the limitations of the DLR; the rationale for adopting the DLR; the meaning of socialisation in health services and a conclusion of the chapter.

Chapter Four: Will address the methodology. This chapter discusses the following: What is research methods and methodology; the definition of research; the characteristics of research design; explorative study, descriptive study, and causal study; explorative study; descriptive study; causal study; research process; research strategy; choice of research methodology i.e. quantitative, qualitative, mixed methods; time horizon; population; target population sampling

population; measuring instrument; secondary research; interviews; questionnaires; validity and reliability of the measuring instrument; pretesting; pilot study; types of data sources; data collection process; ethical consideration; informed consent; anonymity and confidentiality; data analysis procedure; statistics and conclusion of this chapter.

Chapter Five: Will provide the results/analysis of the study including making the case for the socialisation of the means of accessing health services of women in the South African context.

Chapter Six: Will provide the researcher's conclusions and recommendations on the topic of the study.

1.15 Conclusion

This chapter explained the background and contextualization of the study; the contextualization of the NHI; the significance of the study; the theoretical and conceptual framework; an introduction to the complexity theory approach; the problem statement, the research questions; the aims and objectives; the research design; the research methodology; the data collection; the data techniques; the data analysis; the inclusion criteria; the search strategy for the identification of studies; the rigor in research; the limitations of the study; the ethical considerations; and the tentative chapter outline.

CHAPTER TWO:

LITERATURE REVIEW

2.1 Introduction

In this chapter, the following sub-headings will be discussed: a brief historical overview on the apartheid era (1948-1994); governance of the health care during apartheid; access to private medical aid during apartheid; an overview of health care South Africa post-1994; an overview of South Africa's health system; the public health sector; the private health sector; criticisms of private healthcare; the inequities in health care financing in South Africa; austerity measures on healthcare services; the "quadruple burden of disease" in South Africa; medical xenophobia in the health system; fault lines in transforming the health system in South Africa; government intervention through the National Health Insurance (NHI); criticism facing the NHI; the NHI bill [B 11 - 2019] passes in parliament; the possible impact and implication of the NHI bill; the COVID-19 epidemic impact on South Africa's health system; health system strengthening; district health system (DHS) towards a bottom-up approach to health care; the role of community health workers (CHWs) in health system strengthening; the investment in health professions education for health system strengthening; updating the health education curriculum and the conclusion of this chapter.

2.1.1 A brief historical overview of the Apartheid era (1948-1994)

This section provides an overview of the South African health system during the apartheid era. The structures created during apartheid affected the distribution of healthcare services to the population and this was done through institutionalized separate development which adversely affected the provision of public health care for the population. In 1948, the National Party (NP) came to power and ruled South Africa from 1948 to 1994 (Coovadia *et al*., 2009). Furthermore, the NP government institutionalized a state policy known as "apartheid" which promoted separate development among different racial groups and perpetuated the political exclusion, social segregation, and economic marginalization of black South Africans, particularly the black African population (Coovadia *et al.*, 2009). According to Brauns and Stanton (2016), apartheid was a race-based system that involved institutionalized racial segregation that favoured white minority South Africans and denied human rights protections to the majority of black South Africans. Schierup (2017) defines the apartheid era as the ideological cornerstone of white supremacy in South Africa. The apartheid system also shaped class

divisions that forcibly removed people from their property and forced blacks to resettle in "homelands" divided by ethnic composition (Braun and Standton, 2016).

2.1.2 Governance of Health Care during Apartheid

Brauns and Stanton (2016) explain that South Africa's history was immersed in unjust laws, social segregation, and racial discrimination that made it inaccessible for black people to access quality public health. A prominent feature of South Africa's health service history was the racial segregation that existed during the apartheid era which adopted fragmenting health policies that ignored black people's health needs, while prioritizing white people's health needs (Coovadia *et al*., 2009). De Beer (1984) makes the case in a thorough analysis of the apartheid health services that they were never intended to address the needs of the black population in South Africa. Instead, their operations gave priority to the discriminatory health policies that compromised the health of millions of black South Africans (Coovadia *et al*., 2009).

The extent of racial discrimination in the healthcare system during apartheid rule included laws such as 1) separate health facilities for different racial groups; 2) unequal health budget spending for the white population compared to the black population; 3) the adoption of public policies that ignored diseases that primarily affected blacks; 4) the disapproval of basic sanitation, the denial of clean water supply to rural and township areas; and 5) people suffering from mental illness and disability were isolated from society and placed in institutions where gross human rights violations were committed against patients (Brauns and Stanton, 2016). Subsequently, it may be arguably correct to suggest that the apartheid state was a failure.

The polarization of South Africa's health system, which was a result of the country's troubled history of racial segregation and discriminatory policies, revealed significant racial and economic disparities, including differences in health outcomes between black and white people and between the rich and the poor. This study therefore contends that black women were among those who were disproportionately harmed by the unequal distribution of health care brought on by discriminatory laws that upheld race-based beliefs.

2.1.3 Access to private medical aid during apartheid

The emergence of private health services in South Africa was at first paid for as an out-of-pocket expense, meaning that patients had to pay for medical costs that were not reimbursed or covered by an insurance program. Studies from Coovadia *et al.*, (2009) state that the introduction of private health insurance programs was called medical schemes. These schemes

were first presented in 1889 to cater to the healthcare needs of white people only, and membership to the private health scheme was based on race and remained restricted to white people until the late 1970s (McIntyre and Dorrington, 1990). Consequently, the provision of private health care for white people only, also meant that the health needs of the black people were ignored and further deepened the health inequalities between different population groups (Brauns and Standton, 2016).

2.1.4 An overview of health care in South Africa post-1994

The African National Congress (ANC) and other political groups that participated in the anti-apartheid mass protests staged a lengthy struggle that ultimately led to the demise of the apartheid system (Schierup, 2017). Eventually, apartheid's demise and the inauguration of South Africa's democracy were caused by political and financial pressure from within and beyond the international community (Schierup, 2017). The primary issue for the elected ANC government in 1994 was to reduce the disarray of the health system. As a result, the health system was eventually merged into a single national health department and nine provincial health departments (Coovadia *et al*., 2009). The introduction of a new health program for post-apartheid South Africa (1994) (African National Congress, 1994) set the groundwork for the implementation of a district-based primary health care (PHC) system in South Africa. Including community members in decision-making, improving local demands, decreasing ineffectiveness in providing healthcare, and shifting the emphasis from controlling health services to enhancing health and quality of care locally are the main goals of the newly created district health system (DHS), which was established (Van Rensburg, 2012).

2.1.5 Overview of South Africa's health system

This section looks at the current health system in South Africa. This is a very important aspect of this research because it explains the interconnectedness of the health system. South Africa's health system is described as a two-tier system divided along socioeconomic lines (Republic of South Africa Health Department, 2015). The two-tier health system is divided into two parts, namely the public health system and the private health system (Republic of South Africa Health Department, 2015). Nkosi (2020) describes this divide as a critical factor in understanding South Africa's health system because of the complex interactions between the two health systems. The two-tier health system's level of treatment quality varies by location (Human, 2010). Numerous studies have argued and shown how there are significant differences between the standard of health care provided by private and public hospitals in South Africa.

Moreover, the two-tier health system includes three hierarchical levels of hospitals: primary, secondary, and tertiary (Young, 2016). Primary-level hospitals generally offer services such as gynaecology, paediatrics, obstetrics, medicines, general surgical practice, and restricted laboratory services (Young, 2016). Hospitals that are considered secondary-level offer a much wider range of services and are much more functional than primary-level hospitals (Young, 2016). Secondary hospitals typically have approximately 200 to 800 available beds and allow patients to be treated by a professional with more specific expertise in attending to whatever health issue the patient may experience (Young, 2016). In comparison, tertiary-level hospitals have a wider range from 300 to 1, 500 available beds which also offer highly specialized expertise and quality equipment to patients including complex treatments such as neurosurgeries, bypass surgery, and severe burn treatments (Jamison, Breman, Measham, Alleyne, Claeson, Evans, Jha, Mills and Musgrove, 2006). Empirical evidence suggests that private hospitals provide higher-quality medical care than public hospitals (Murphy, Bourke, and Turner, 2020).

Delobelle, (2013) presents the macro-organisation of the national health system of South Africa. It includes a clear illustration of the national health system particularly the divide between the two-tiered health system and what each of these two systems represent.

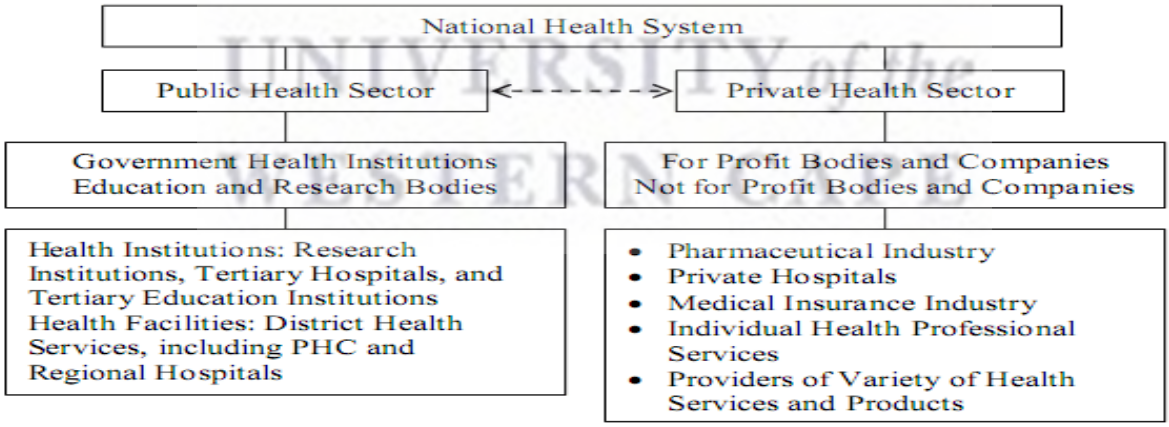


Figure 1: Macro organization of the National Health System, Republic of South Africa (Department of Health, 2006)

In this study, the above framework (see Figure 1) is used to illustrate the gap between the two healthcare sectors and to provide a clear picture of what these two healthcare systems represent. This is important to understand because the relationship between the two health systems leads

to health outcomes that influence the South African government's health reform policies and strategies aimed at achieving better health outcomes for the entire population. This study also asserts that by understanding the national health system, the process of this research will be easier to understand.

2.1.6 The public health sector

Public health services are funded by the South African government through taxation, which has both benefits and drawbacks (Young, 2016). Public healthcare services are funded through government expenditure and are seen as a practical government activity that caters to the healthcare needs of the general population hence, public healthcare services are not charged for (Nkosi, 2020). Public health care benefits include giving all citizens access to free medicines, wheelchairs, crutches, toilet chairs, and house visits (Young, 2016). Given the large percentage of socioeconomic inequities in South Africa, people who otherwise cannot afford private health care, benefit from free health treatment in the public health sector.

Even though South Africa's health system has advanced significantly since 1994, the nation still has trouble providing health services. These include uneven resource distribution (such as access to health care personnel and facilities), insufficient production, and inadequate hiring, specifically in rural locales, for the private and public sectors alike (Maphumulo and Bhengu, 2019), as well as in remote locations (Versteeg, Du Toit, and Couper, 2013; McLaren, Ardington, and Leibbrandt, 2014).

2.1.7 The private health sector

Access to private healthcare and medical aid insurance in South Africa is no longer race-based; instead, it is class-based along the socioeconomic lines of healthcare users (Nkosi, 2020). Health services in the private health system state that people should pay out-of-pocket for quality healthcare services at a price from accredited service providers (Nkosi, 2020). Previous studies by Young (2016) reported that citizens seeking treatment at a private medical facility must purchase their private insurance (medical aid) or pay out of pocket. According to Human (2011), private health insurance/or medical aid is a service that covers members' health care costs such as hospitalization, treatment, and medications. Under private health insurance, there are fewer facilities available, and the cost is higher than in the public market (Young, 2016). The advantages of private health care include short waiting times, better facilities, sufficient resources, easy appointments, and adequate disease control and prevention (Young, 2016).

Disadvantages of private health care include higher costs, fewer facilities, and the requirement that patients pay for doctor visits, medications, and additional aids such as wheelchairs or crutches (Young, 2016). Any person who can afford it uses private health care.

2.1.8 Criticisms of private health care

Criticism against private health care is critical in that its defenders find it difficult to prove how privatization can effectively proliferate economic growth and benefit poor people. The presence of the private health system has had harsh circumstances on poor citizens' health outcomes because the private health system has established a dispassionate reputation for absorbing up to 70% of medical professionals in South Africa much to the demise of the public health service users (Passchier, 2017).

The private health system makes use of the majority of the health specialists, resources, and technology that is available in the country (Human, 2010). Consequently, this leaves the public health sector at a deficit with staff shortages and an under-compensated health workforce. Taking these combined factors into consideration, the public health system cannot provide the same quality of care that is readily available in the private health system. Combating the deep disparity between the public and private health systems remains one of the biggest challenges for the government of South Africa.

2.1.9 Healthcare Financing in South Africa

Another challenge facing the South African health system is the unequal distribution of resources. Michel, Tediosi, Egger, Barnighausen, McIntyre, Tanner, and Evans (2020) and Nkosi (2020), both highlight that government spending on health care is estimated at 8.5% of gross domestic product (GDP), or about R332 billion, and that nearly 50% of total national budgetary spending goes to support 16% of the country's private health care users. The people who make up 84% of public health system users, suffer from more diseases. Nkosi (2020) contends that public health care users are particularly vulnerable to the severe dysfunctions and problems of the public health system due to the inequality of resources.

Barber, Kumar, Roubal, Colombo, and Lorenzoni (2018) claim that South Africa is the only nation in the world where private voluntary health insurance (PVHI) accounts for 43% of government health spending (see Figure 2). This ignores the norms of a significant percentage of society receiving necessary medical care from the private health sector, as seen by the United States (US), the only developed nation with a comparable expenditure pattern (Barber *et al*.,

2018). Instead, it only benefits a small percentage of high-income people who pay PVHI fees to use private health systems and providers (Barber *et al*., 2018). South African history is the source of this particular conundrum.

The Medical Schemes Act of 1988, notably updated by Amendment Act No. 23 of 1993, privatized the sector by introducing risk-based premiums and scrapping guaranteed minimum benefits. Some of these shifts were reversed after 1994. The Medical Schemes Act, No. 131 of 1998 restored regulated minimum benefits and social rating by 1998 (Gray and Vawda, 2017). There were 82 medical schemes in early 2017: 60 employment-based and 22 public membership (Annual Report 2016/17). Among these, the Discovery Health Medical Scheme and the Government Employee Medical Scheme (GEMS) covered a majority of the total beneficiaries (Barber *et al*., 2018).

Health care benefits are promised to government employees as part of negotiated contracts of employment, and subsidies exist today to assist with reducing the financial burden of medical aid membership (Barber *et al*., 2018). As a consequence, the government provided subsidies to employers as a way to get the private healthcare sector to deliver health insurance for their employees (Barber *et al*., 2018) and help deliver healthcare as a government function. According to some studies, these benefits and subsidies might account for up to 30% of overall private health sector profits (National Treasury Budget, 2014).

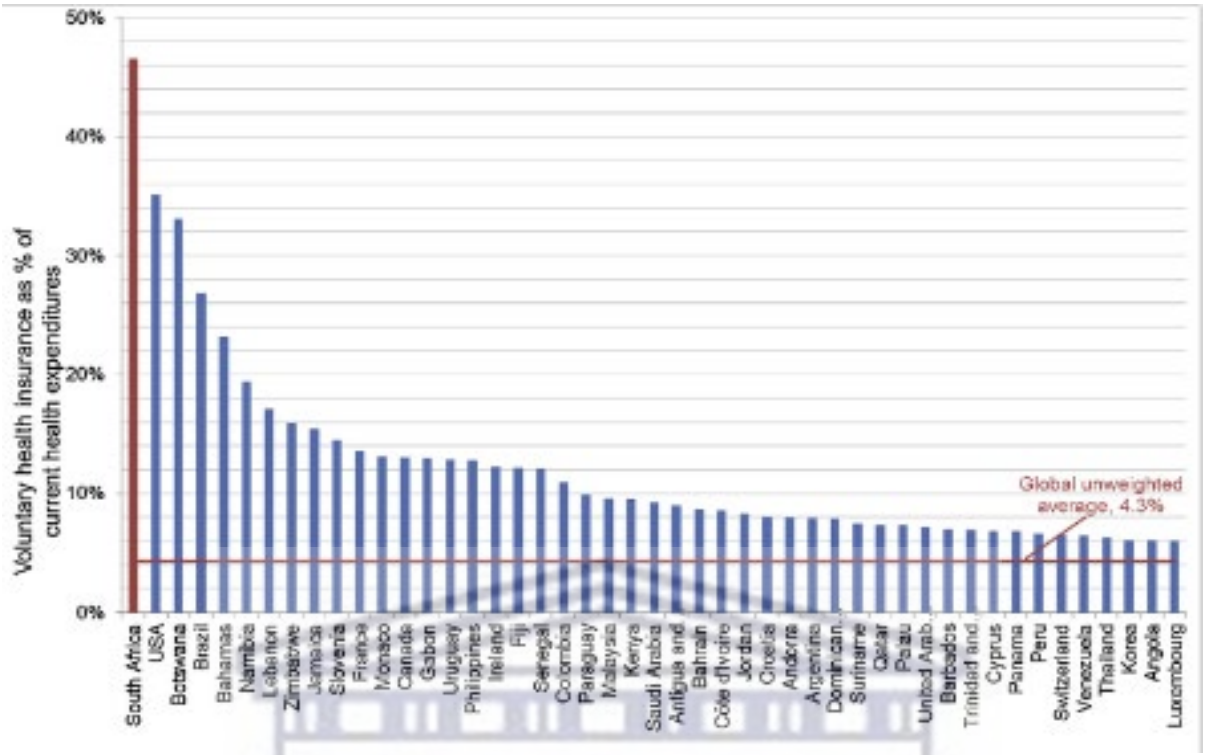


Figure 2: Private voluntary health insurance (PVHI) represents a proportion of current health spending in countries with populations that exceed six million. (Source: World Health Organization, Global Health Expenditure Database, 2015).

2.1.10 Austerity measures on health care

This section considers the impact that austerity measures have on healthcare services in South Africa. The impact that austerity measures have on government expenditure intended for social services has built up a negative reputation for compromising the welfare of public service users. It is therefore necessary to understand the relationship between austerity and its impact on public health care.

Austerity measures are described as formal actions taken by a government to reduce government spending on basic public services through the implementation of regressive economic policies (Sibeko, 2019). In a study of Mali (2022), austerity measures are described as a measure used to justify harsh economic policies that involve cutting government spending that is primarily intended to provide basic public services to the population, including health care, at the detriment of public health users.

According to Sibeko (2019), austerity is a state's fiscal strategy to deal with debt and growth problems during a period of economic stagnation that leads to economic decline. Spending

cuts, regressive tax increases, or a combination of both are examples of austerity measures commonly used by governments to "balance the budget". Austerity measures are used to justify the intention to cut government social spending, deregulate the labour market, emphasize private markets as sources of growth, and promote restructuring in favour of capital, especially the financial sector. As austerity advocates claim, there is no compelling evidence that debt levels above a certain point constrain growth (Sibeko, 2019).

Studies by Gatwiri, Amboko, and Okolla (2020), suggest that the management of public health care in African countries is highly fragmented as a result of austerity measures. The orders of the International Monetary Fund (IMF) and the World Bank to enforce structural adjustment programs (SAPs), which significantly cut social spending on basic public services such as health care and increase general taxation to reduce a country's public debt, are responsible for pressuring most sub-Saharan African governments to enforce austerity measures (Gatwiri *et al*., 2020; Stuckler, Reeves, Loopstra, Karanikolos and McKee, 2017).

The realization of the rights enshrined in the Constitution is hampered by austerity measures. For example, given the rising burden of disease and high price inflation in the health sector, health spending per uninsured person increased by only 1.7% (in real terms) on average from 2014-15 to 2018-19, despite providing care to 83% of the population (Sibeko, 2019). This explains several negative health outcomes. A simple example of the effects that austerity measures had on South Africa's healthcare system was the 2016 Life Esidimeni tragedy. According to Sibeko (2019), the 2016 Life Esidimeni disaster discovered 144 mentally ill people died from starvation and neglect, while 1418 vulnerable patients were exposed to trauma and morbidity after being transferred from a private hospital of which the Gauteng Provincial government had a decades-long contract to several underfunded and poorly resourced non-profit organizations (NGOs). In the arbitration process that followed, it emerged that ministry officials cited the need to cut costs as justification for not taking responsibility for their poor choices (Sibeko, 2016). However, there is no denying that such disasters are more likely to occur in a two-tiered healthcare system with limited resources and tight budgets than in a system where departments have sufficient resources to perform their functions.

2.1.11 The “quadruple burden of disease” in South Africa

While South Africa is respected for having a progressive constitution that safeguards all of its citizens' human rights to access quality health care service delivery (See Annexure A), the

country's public health system continues to face severe challenges that have an impact on the quality of health care service delivery that patients receive. Public health care has some drawbacks, including lengthy wait times, poor treatment compared to private health care, hurried appointments, out-of-date infrastructure, and inadequate disease prevention and management (Young, 2016). These challenges are worsened by the disease burden that plagues the country's fragmented health system (Kahn, 2011).

According to studies, the health system is burdened by four distinct health challenges, dubbed "the quadruple burden of disease" (Amollo, 2012). The prevalence of communicable diseases has been shown to put a strain on the public health system. Communicable diseases as infectious illnesses are triggered by bacteria such as viruses, organisms, and fungi that can be transferred either directly or indirectly from one being to another (Edemekong and Huang, 2022). Some are transmitted through bug bites, others through ingestion of contaminated food or water (WHO, 2021). Sexually transmitted infections (STIs) such as HIV and viral hepatitis are transmitted through contact with infectious body fluids such as blood, vaginal secretions, and semen (WHO, 2021). Illustrations of communicable diseases include Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS), as well as Tuberculosis (TB); maternal and child mortality; an increase in violence and injuries. South Africa is experiencing an increase in noncommunicable diseases (NCDs) (e.g., diabetes, cardiovascular disease, chronic respiratory conditions, and cancer) (Mayosi, Lawn, Van Niekerk, Bradshaw, Karim and Coovadia, 2012; Amollo, 2012; Pillay-van Wyk, Msemburi, Laubscher, Dorrington, Groenewald, Glass, Nojilana, Jobert, Matzopoulos, Prinsloo and Nannan, 2016). Essentially, NCDs as a condition that cannot be transmitted from one person to another and is therefore not contagious and can be long-lasting, slowly worsening conditions, or can lead to fatalities.

The high prevalence of NCDs among women in South Africa is exacerbated by the fact that adult residents of SSA currently have a higher prevalence of obesity than adults worldwide overall (Oladeji *et al*., 2021), with South Africa having the highest incidence of obesity, particularly among women (Puoane, Steyn, Bradshaw, Laubscher, Fourie, Lambert and Mbananga, 2002). In addition, postnatal weight gain and gestational diabetes are widespread in South Africa, increasing women's burden of NCDs and necessitating access to specific services throughout their lives (Nicolaou, Levitt, Huddle, Soepnel and Norris, 2022; Farpour-Lambert, Ells, Martinez de Tejada and Scott, 2018; and Hoffman, Newhouse, Chu, Stringer

and Currier, 2021). There is evidence of substantial inequities in health guides for women based on place of residence (rural/urban), socioeconomic position, and other evidence of unequal access to health care, further increasing the burden of NCDs (Harris, Goudge, Ataguba, McIntyre, Nxumalo, Jikwana and Chersich, 2011; and Lince-Deroche, Berry, Hendrickson, Sineke, Kgowedi and Mulongo, 2019).

According to Gizamba *et al*., (2022), the key to preventing NCDs and the consequences they cause among women is to ensure that they have access to regular, comprehensive NCD-related health maintenance during their lives, especially at critical times such as pregnancy. For this to be efficiently attained, it is first necessary to identify and identify some barriers that prevent women from seeking NCD health care. The term "access" is better defined as the result of the interaction between a person's personality, social and physical environment, and health care and health system characteristics (Levesque, Harris, and Russell, 2013). As outlined in the Levesque dimensions of access to health (See Figure 3), all interventions to encourage health parity in access to NCD-related health care must address both the supply-side elements of the health system and the demand-side elements of the population.

Figure 3: Levesque conceptual framework for healthcare access (Cu, Meister, Lefebvre and Ridde, 2021)

Levesque's theoretical basis for healthcare access (see Figure 3) acknowledges that the accessibility of health services is influenced by socioeconomic status and cultural variables in addition to the availability of services (Bonita and Beaglehole, 2014). Due to the direct impact of these factors on access obstacles, obtaining health services must be assessed from an array of viewpoints and levels, which may necessitate a range of remedial measures.

2.1.12 Migration and health care

The concept of "migration" is suitably contextualized as the movement and relocation of people from their birthplace to another place either to settle temporarily or permanently. It is important to understand that there are different types of migrants in the world and the rationale for migration varies from person to person. But what is very interesting to notice is that the interaction between the influential factors of migration affects how the global community and various governments take decisive action to effectively protect migrants' human rights, govern them accordingly, and cultivate their benefits. This particular action is known as migration governance.

Essentially, migration governance is performed through relevant and internationally recognized structures. The theme around migration governance underpins the movement of migrants from one location to the next, but through orderly, safe, and legal mechanisms (Triandafyllidou, 2022). Migration governance is suitably defined as the standard, relevant, and organizational structures that are responsible for regulating and shaping how states receive and respond to matters related to international migration (Betts, 2011). Similarly, migration governance includes structures that facilitate and ensure orderly, safe, regular, and legally responsible migration and movement of people through organized and effectively managed migration policies. However, the journey of migration is not always orderly, regular, safe, and legal for many migrants who are desperate to cross over to a transit country- a country where migrants stay temporarily to cross over to their final destination- and some migrants are restricted from passing through one country to the next (Triandafyllidou, 2022).

The Department of Home Affairs (DHA) is a department of the South African government that offers a wide range of services to South African citizens, as well as migrants who intend on either visiting, working, or relocating to South Africa (DHA, 2022). The department is an extension within the migration governance discourse because migrants can access services from the DHA, where supporting documents are granted such as admissions of entry into the country also known as permits and status (Kaziboni *et al*., 2022). The mandate of the DHA is two-tiered. Firstly, the DHA is the custodian and status verifier of the citizenship of the population in South Africa (DHA, 2022). Secondly, the DHA is also responsible for administering, controlling, regulating, and facilitating immigration admissions into the country of people via entry ports (DHA, 2022). The department thus plays a significant and contributing role that promotes awareness of national security and healthy international relations as well as

economic development (DHA, 2022). Unfortunately, the quality of governance within the department is inadequate resulting in restrictions on the mobility of migrants. The DHA is plagued with departmental dysfunctions and corrupt activities that cause backlog which ultimately compromises the finalization of permit outcomes for migrants in need of safe, regular, and legal entry into the country (Kaziboni *et al*., 2022).

In addition to the department backlogs, affordability to obtain relevant documentation has become increasingly difficult, further exacerbating restrictions on migrants' mobility. The cost to purchase and renew permits is high thus making it difficult for poor migrants generally, and economic migrants, in particular, to access permits because of the exorbitant costs to access the correct status (Kaziboni *et al*., 2022). In addition to government backlogs, it has become increasingly difficult to obtain the necessary documents, further exacerbating mobility restrictions for migrants. The cost of acquiring and renewing permits is high, making it difficult for poor migrants in general and economic migrants in particular to access permits due to the exorbitant cost of accessing the correct status (Kaziboni *et al*., 2022).

2.1.13 Fault lines in transforming the health system in South Africa

Following Rispel's (2016) box (See box 1), the following illustrates the three main fault lines in health system transformation in the South African context:

Box 1: Fault lines in Transforming the Health System

- Toleration of incompetence, poor management, and poor administration
- Primary health care (PHC) is primarily delivered through the district health system, which is not fully functional
- Inability or unwillingness to address health workforce shortages

This study recognizes the importance of taking into consideration the fault lines in transforming the health system in South Africa because it allows for a more detailed understanding of some of the critical challenges facing the public health system. In doing so, any health reform proposals by the national government will need to take into consideration the gaps in the health system towards strengthening the health system for equitable service delivery.

2.1.14 Government intervention through the National Health Insurance (NHI)

Since apartheid ended, the primary goal of health reform in South Africa has been to reverse its negative effects. Health reform efforts since 1994 also seek to implement the commitment of the constitution to build a "democratic state established on the principles of human dignity, the attainment of parity, and the progression of human rights and freedoms" (Hassim *et al*., 2014). The country's constitution orders the government of the day to work to the recognition that all citizens and non-citizens have the right to access healthcare services (Coovadia *et al*., 2009).

In August 2011, the South African government issued official government documentation through the Green Paper on the National Health Insurance (NHI) policy and subsequently, published the NHI White Paper four years later in December 2015. However, an amended NHI White Paper was released another two years later in June 2017. The NHI refers to a healthcare funding system that aims to pool and distribute healthcare resources (from taxation, insurance, and other streams) equally. The goal is to provide all South Africans, regardless of socioeconomic status, with access to high-quality, cost-effective health services tailored to their specific health needs. For several services covered by the NHI Fund, there is no charge at the point of care (National Department of Health, 2021).

The goal of NHI is essentially to provide free access to quality health services for the entire population. The approach is largely based on the Brazilian experience and focuses on a "revised primary health care system" that will focus primarily on community outreach services using a defined comprehensive package of primary health care (Naidoo, 2012). Primary Health Care (PHC) is provided in three settings, according to the NHI policy document:

Clinical support teams located in districts. These will assist with the implementation of key health programs at the district level, such as reducing rising maternal and child deaths and increasing the general state of health. A senior obstetrician and gynecologist, a senior pediatrician, a senior family physician, a senior anaesthesiologist, a senior midwife, and a senior primary health care nurse will be part of this team. The phrase "principal physician" refers to the most senior positions in healthcare.

School health services are delivered by a group under the direction of a licensed nurse who offers services for promoting healthy living, and treatment to meet the needs of schoolchildren.

Primary Health Care (PHC) agents seek to establish a group of PHC representatives in each district, with each group being directed by a health professional and each team member being given a particular number of families to take care of. These teams' main goal is to support community engagement-based efforts to promote health.

The policy also includes a provision for the provision of primary health care (PHC) services by licensed and contracted private companies operating within districts. An Office of Health Standards and Compliance (OHSC) will be established to assess and accredit health facilities and services, as well as to set norms and standards for these facilities and services and to establish an impartial ombudsman office (Naidoo, 2012).

The NHI White Paper (2015) indicates that primary health care is essential to revitalizing and strengthening the South African health system. However, this is only possible with a strong DHS. Consequently, the National Department of Health (NDoH) needs to develop a detailed implementation strategy for creating an effective DHS. This implementation plan should include a detailed description of the duties of the various levels of government, as well as methods for improving management in all district facilities and at the district level (Naidoo, 2012). It is suggested that the NHI will need to address issues relating to district health departments and the issue of how poor and under-serviced communities in the rural districts will be comprehensively and equitably covered under a district system that is also central in delivering PCH (Amollo, 2012).

2.1.15 Parliament adopts the NHI bill [B 11 - 2019]

On August 8, 2019, the NHI bill was first introduced in the Parliament and submitted to the Portfolio Committee on Health for consideration (The Parliament of the Republic of South Africa, 2023). The Department of Health first briefed the Committee on the bill on August 29, 2019, and on the NHI pilot areas on March 4, 2020, and between October 26, 2019, and February 24, 2020, the Committee held state-wide public hearings in each of the nine provinces to encourage effective public input on the NHI bill (The Parliament of the Republic of South Africa, 2023). Approximately 11,564 members of the public and various stakeholders from 33 county municipalities attended the public hearings, plus the Committee heard a total of 961 oral comments during these proceedings (The Parliament of the Republic of South Africa, 2023).

The National Health Insurance (NHI) Bill [B 11 - 2019] (see Annexure A) was passed by the National Assembly (NA) on Tuesday, June 12, 2023, in Parliament (The Parliament of the Republic of South Africa, 2023). The legislation was passed by the legislative body, and it will now be referred to the National Council of Provinces for consideration before being presented for signature to the President of South Africa (The Parliament of the Republic of South Africa, 2023). As stated in the Bill's preamble (see Annexure B), some would contend that passing the Bill would be a positive step toward achieving universal health care (UHC) for everyone.

2.1.16 The possible impact and implication of the National Health Insurance Bill [B 11 - 2019]

This section focuses on some of the critical concerns against the NHI bill from a wide range of health stakeholders, including medical specialists and scholars in the field of health. This study contends that any major reform can either be considered a progressive policy or a far-reaching policy and therefore assesses the critiques against NHI as a necessary step to examine its potential.

A potential obstacle facing NHI involves medical scheme members' unwillingness to surrender their medical aid in favour of NHI (Booysen and Hongoro, 2018). While previous research has found that the NHI is widely accepted by the general public, medical scheme members are less supportive of the NHI than public health users (Evans and Shisana, 2012). The NHI plans to combine existing medical schemes into a larger universal scheme to cover the entire population. However, resistance from the over 100 medical aid schemes in South Africa exposes the tension between the key private health stakeholders and the government. According to Michel *et al*., (2020), during the year of 2019 the former health minister of health, Dr. Aaron Motsoaledi, on multiple occasions reiterated that the purpose of NHI is not to abolish the private health sector, but to allow wider access for more South Africans to access quality services, and re-emphasized that the private health sector holds much more resources that are not readily available to everyone. Moreover, with the proposed NHI financing reform it is speculated that the medical aid scheme is very likely to experience a decline in membership estimated at 10% of the population, naturally, this is likely to upset those with monopolistic interests (Michel *et al*., 2020).

Another shortfall facing the NHI includes taxpayers as consumers of healthcare. Studies by Ataguba and McIntyre (2018) argue that many medical scheme members are subjected to

annual above-inflation rate increases yet are too afraid to resign from their medical schemes as opposed to relying on public health care. Michel et al., (2020) further contend that if people were to decide to cancel their medical scheme membership due to high costs, it would result in the already overburdened public health system having to take responsibility for the additional intake of patients.

Studies by Fusheini and Eyles (2016) question general taxing as a preferred funding option because South Africa's fiscal policy position has a direct impact on the government's ability to fundraise public revenue which directly affects the level of funding available for health care. Moreover, Michel et al., (2020) note a wide range of structural factors that affect the government's fiscal position including, high poverty levels, stagnant economic growth, and the structure of the South African labor market.

Another obstacle to the implementation of NHI is the threats from health professionals, who fear a shift of public health workers to the private health sector. According to the literature of Nkosi (2020), such a decision is subject to deterministic rules, which promotes the decline of the public health system. Since a large proportion of the population uses public health system services, the consequences of an unprecedented departure of public health professionals could bring about systemic change and have serious implications for the system.

2.1.17 COVID-19 epidemic impact on South Africa's health system

The latest health pandemic known as Coronavirus Disease 2019 (COVID-19) and its impact on the South African health system is an important factor to consider. Health systems around the world have been assessed for their ability to cope with the COVID-19 epidemic. Clinical symptoms of COVID-19 include a sore throat, a high body temperature, tiredness, and shortage of breath (Mokhele *et al*., 2021). Patients with severe cases may develop life-threatening respiratory conditions including asthma or acute respiratory syndrome (ARDS), which may necessitate hospitalization (Zhang, Wang, Zhu, and Wang, 2020). The pandemic of COVID-19 exposed significant flaws in the health system and added further strain on the country's economy.

On March 5, 2020, the first confirmed COVID-19 report in South Africa emerged. Since then, there has been a rapid increase in the amount of confirmed cases in the nation; as of July 7, 2021, 2.09 million instances have been reported (Mokhele *et al*., 2021). The COVID-19 outbreak has brought to light the dire need for a more efficient integrated health system (Nkonki

and Fonn, 2020). Due to the impacts of the confirmed COVID-19 cases, the president of South Africa announced a national state of emergency to decrease the COVID-19 pandemic's possible repercussions (Mokhele *et al*., 2021). In addition to following WHO recommendations, South African authorities and the health system have taken extreme measures in response to rising COVID-19 cases and an absence of licensed vaccines (Ahmad and Amad, 2020). COVID-19 techniques and guidelines to contain the pandemic (Mbunge, 2020).

These measures include the expansion of the testing process and a nationwide total lockdown, travel restrictions both within the country and locally (between provinces), except for employees providing essential services, prohibition of large social gatherings, sale of alcohol and cigarettes, physical disassociation campaigns, implementation of curfews, orders to stay home, the introduction of communiqué protocols for reporting cases and closing departments or units when an employee tests positive (Mbunge, 2020).

The social makeup of the health system and economy of South Africa all suffered greatly as a result of the COVID-19 pandemic. These results show that the COVID-19 pandemic revealed some of the system's flaws and that the South African health sector urgently needs to progress its NHI implementation efforts.

2.1.18 Health System Strengthening

This study asserts that any government that advocates for major health reform policies aimed at achieving UHC for its population must have a national strategy accompanied by a sustainable development strategy. The WHO (2010) Health System Building Blocks framework could serve as a reference point that provides a set of norms and standards for South Africa's health system capacitation towards achieving UHC.

According to the WHO, a health system is made up of six interrelated building parts (see Figure 4). These blocks can be used as a framework for identifying priority areas for future development in a country's health system.

Figure 4: WHO's Health System Building Blocks (WHO, 2010)

According to WHO, health systems improvement is based on six building blocks: service delivery, health workforce, information, medical supplies, vaccines and technology, financing, leadership/governance, and finally the six building blocks listed in Figure 4.

The framework has been shown to help assess the effectiveness of domestic health care (Mounier-Jack, Griffiths, Closser, Burchett and Marchal, 2014), the links between health reforms and national health systems (Senkubuge *et al*., 2014), the impact of changes in the health sector (Obermann *et al*., 2016), the state of health facilities (Mutale, Bord, Mwanamwenge, Mlewa, Balabanova, Spicer and Ayles, 2013), and specific health problems (Fisher and Cabral, 2011). Any division of a complicated construct such as the health system inevitably leads to complications (Bhatia, 2015). This is also true of frameworks that focus on efforts in the health sector and downplay the value of interventions in other sectors (Bhatia, 2015). This study suggests that South Africa needs an effective approach to health system strengthening.

2.1.19 District health system (DHS) towards a bottom-up approach to health care

This section discusses the critical role of health districts in healthcare delivery and how the decentralized bottom-up approach to healthcare delivery must complement the top-down approach to healthcare delivery as part of strengthening the health system in South Africa to achieve UHC through the implementation of the NHI.

The DHS is recognized as a critical decentralized foundation for a well-functioning system focused on PCH (WHO, 1978; WHO, 1987). Reasons for decentralizing decision-making include better coordination of different interventions, increased use of local expertise, and more accountability, all to improve equity, responsiveness, efficiency, and quality of health care (Bossert, 1998). According to Orgill, Gilson, Chitha, Michel, Erasmus, Marchal, and Harris, (2019), the DHS encompasses a wide range of interrelated components that promote health in homes, schools, and workplaces. To bring all these elements and institutions together into a comprehensive set of health promotion, prevention, curative, and rehabilitative interventions, the individual elements must be well coordinated by a commissioner charged with this task (WHO, 1988). The DHS was created with the main objectives of involving community members in decision-making, addressing local needs, reducing inefficiencies in service delivery, and shifting the focus from managing health services to improving health and quality of care at the local level (Van Rensburg, 2012).

According to Orgill *et al*., (2021), it is often noted that the administrative capacity for DHS is inadequate and needs to be strengthened across the board. There are currently 53 health districts in South Africa, spread across its provinces, and each district is headed by a district manager who is supported by a district management team (Orgill *et al*., 2021).) The duties of district management teams in South Africa are listed in Table 1.

Table 1 District Management Team core responsibilities in South Africa

- Identification of client and stakeholder needs
- Identification of critical health and systemic challenges and understand source of the challenges
- Take decisions and set priorities (public health interventions)
- Balance competing demands by taking decisions on key District Actions, which respond to key priorities, client and stakeholder needs and challenges
- Allocate resources (time from personnel, goods and services and capital costs). Ensure that capacities are matched with planned Actions. Refine the Actions until the allocated resources meet the Actions
- Monitor and reflect on progress against plans
- Strengthen processes where necessary (to implement the plan)

Table 1: District Management Team core responsibilities in South Africa (South Africa National Department of Health. District Health Planning and Monitoring Framework, 2017; Orgill *et al*., 2021).

Under the health system strengthening in South Africa, the responsibilities of a district management team must be outlined and conceptualized in alignment with the bottom-up policy implementation.

2.1.20 The role of community health workers in health care strengthening

This section examines the role of community health workers (CHWs) in strengthening the health system toward delivering healthcare services to local communities. South Africa needs to achieve its Sustainable Development Goals (SDGs) and, like other countries around the world, is working to modernize its healthcare system to achieve UHC (Kieny, Bekedam, Dovlo, Fitzgerald, Habicht, Harrison, Kluge, Lin, Menabde, Mirza and Siddiqi, 2017). The NHI is one way to achieve this (Department of Health White Paper, 2015). Reorganizing and refocusing primary health care and health services in the nation's districts with an emphasis on illness prevention, management, and health promotion is one way to strengthen the health system. A multifaceted strategy including teams of CHWs, coordinated school health services, clinical specialist teams at the district level, and the hiring of private service providers like general practitioners would be used to achieve this. The strategy to reinvent primary health care in South Africa is based on this.

According to Olaniran, Smith, Unkels, Bar-Zeev, and van den Broek (2017), CHWs are people who have a general understanding of the dialects and customs of their local communities, can deliver culturally appropriate health services to the community, and need less training than health professionals. Depending on the needs of the household, a CHW would offer an array of broad health and psychosocial services, with an emphasis on detection, prevention of illness, and health knowledge for children and mothers, individuals affected by HIV/AIDS, tuberculosis, chronic illnesses like high blood pressure or diabetes, and orphaned households. They locate defaulters and return them to the clinic so that they can resume their therapy (Thomas et al., 2021). In this sense, CHWs are "game changers" in the broadest sense (Barlow, 2016). Depending on the population size in a municipal district, each clinic had a certain number of PHC teams (Thomas, Buch, and Pillay, 2021). A municipal district is the lowest political geographic subdivision of the country's 52 districts (Thomas et al., 2021). Community

access and participation are supported by the local political representative of the district (Thomas et al., 2021). According to Schneider, Besada, Daviaud, Sanders, and Rohde (2018) each PHC team, which preferably consisted of six CHWs, was responsible for 1500 to 2000 houses (about 6000 people) in a district, with each CHW serving about 250 households. Therefore, it is arguably correct to suggest that CHWs play a critical role in improving community-based health care, as well as school-based health care, environmental health care, and health promotion.

2.1.21 Invest in health professions education for health system strengthening

Any healthcare system must have human resources for health (HRFH) to deliver efficient and effective medical services (Van Staden, 2021). Global programs focusing on transforming medical education to build health systems are being led by high-income societies, and interest in health professions education has increased substantially over the past ten years (Van Staden, 2021). Africa still struggles with a lack of HRFH, which hurts the delivery of health services and is dependent on the degree of development of individual nations including South Africa, which is one of the continent's most developed nations (Van Staden, 2021).

According to Van Staden (2021) in Africa, the field of HPE is anticipated to expand as the discipline matures and the industry receives more funding for capacity building and research. Investments in HRFH are therefore essential for low- and middle-income nations like South Africa that seek to raise the standard of health care and increase access to it (Cometto and Campbell, 2016). These investments also have an opportunity to make a difference in broader development outcomes.

2.1.22 Health Education Reform

Walsh (2014) pointed out that there is not enough money spent on health professional's education. On the other hand, investments in education are commitments toward health care (Barnes *et al*., 2015). It is important to note that national governments, through their ministries of education, subsidize the majority of undergraduate education (Walsh 2014). Therefore, medical and educational institutions are essential for the growth of communities and nations, yet public funding is frequently insufficient (Van Staden, 2021).

According to Shay (2017), South Africa's higher education system will not be able to meet its policy goals of equity of access and equity of outcomes if it continues to grow without concurrent investments in teaching and learning. Similarly, South Africa will also fail to meet

WHO's Health Workforce Education and production goals of improved relevance, quality, and capacity of health professions training programs to produce appropriately skilled professionals who can build the health system (See Figure 5).

Figure 5: WHO's Health Workforce Education and Production Strategies (Van Staden, 2021)

In addition, the creation of blended learning access mechanisms has become necessary due to the COVID-19 pandemic and the need for distance learning, placing additional strain on already limited institutional resources. Training of health professionals in line with transformation goals is also required. In addition, HPE programs are expected to meet the needs of the national healthcare system through their education and training activities. Looking at health workforce education and training strategies (WHO) (see Figure 5), investment in infrastructure is the only gap that has not yet been addressed, at least not in a sustainable way.

This chapter performed extensive work explaining the different complex themes around healthcare services in South Africa. The chapter provided a brief historical overview on the apartheid era (1948-1994); governance of the health care during apartheid; access to private medical aid during apartheid; an overview of health care South Africa post-1994; an overview of South Africa's health system; the public health sector; the private health sector; criticisms of private health care; the inequities in health care financing in South Africa; austerity measures on healthcare services; the "quadruple burden of disease" in South Africa; gender constructs effects on women's health outcomes; women's accessibility to quality health services in South Africa; medical xenophobia in the health system; fault lines in transforming the health system in South Africa; government intervention through the National Health Insurance (NHI);

criticism facing the NHI; the NHI bill [B 11 - 2019] passes in parliament; the possible impact and implication of the NHI bill; the COVID-19 epidemic impact on South Africa's health system; health system strengthening; district health system (DHS) towards a bottom-up approach to health care; the role of community health workers (CHWs) in health system strengthening; the investment in health professions education for health system strengthening; health education reform and the conclusion of this chapter.

2.1.23 Conclusion

This chapter performed extensive work explaining the different complex themes around healthcare services in South Africa. The chapter provided a brief historical overview on the apartheid era (1948-1994); governance of the health care during apartheid; access to private medical aid during apartheid; an overview of health care South Africa post-1994; an overview of South Africa's health system; the public health sector; the private health sector; criticisms of private health care; the inequities in health care financing in South Africa; austerity measures on healthcare services; the "quadruple burden of disease" in South Africa; gender constructs effects on women's health outcomes; women's accessibility to health services in South Africa; medical xenophobia in the health system; faultlines in transforming the health system in South Africa; government intervention through the National Health Insurance (NHI); criticism facing the NHI; the NHI bill [B 11 - 2019] passes in parliament; the possible impact and implication of the NHI bill; the COVID-19 epidemic impact on South Africa's health system; health system strengthening; district health system (DHS) towards a bottom-up approach to health care; the role of community health workers (CHWs) in health system strengthening; the investment in health professions education for health system strengthening; health education reform and the conclusion of this chapter.

CHAPTER THREE:

THEORETICAL FRAMEWORK

3.1 Introduction

This chapter outlines the theoretical framework that will deal with the research question/s and examine the key issues of this study. Additionally, the theoretical framework will be used to analyse the National Health Insurance (NHI) bill and its relation to women who are asylum seekers and refugees' access to health services in South Africa. This chapter outlines and discusses (i) systems theory; (ii) people-centred development approach (PCD); (iii) complexity theory and (iv) doctrinal legal research (DLR) method. Furthermore, this section essentially identifies and explains the reason behind the four different theoretical approaches that will be used in analysing the study's aims and objectives. Fundamentally, a comparative assessment of the different approaches will be made in this chapter. This section is divided into three main sections: (1) a historical classification of the four approaches is provided; (2) the reasons for rejecting or adopting the theoretical approaches for this study are explained and; (3) the limitations of our approaches.

3.2 Systems theory

3.2.1 Background on the systems theory

According to Beasley (2012), systems thinking involves the functions of the human brain and our ability to think - hence systems thinking. According to Richmond (1994), the phrase systems thinking was defined as the art and science of developing well-grounded hypotheses about behaviour through developing a broader understanding of the causal structure. In simpler terms, Richmond's interpretation of the systems thinking approach expects that researchers must develop reliable theorizing about what influences people's behaviour by first understanding the basis of the system. Similarly, systems thinking can also be defined as an intellectual framework that may be applicable across a wider range of disciplines to describe, organize, and address the connecting behaviorbehaviour of social and economic systems (Clark *et al*., 2017). Clark and Hoffman (2019) suggest that Richmond understood that the dynamics of a system are regularly composed of interconnectedness relations.

Many scholars have used the systems thinking approach in the public health field. Research by Peters (2014) discusses more directly systems thinking in health care and its evolution during the 20th century. He explains that in systems thinking the variations on a study and what it means, essentially rely on the discipline that the approach is being applied to. Clark and Hoffman (2019) explain that in healthcare, systems thinking is developed to address the numerous complex issues and how that complexity intersects with each other. However, numerous studies are available that explain how systems thinking is one of the most challenging theoretical frameworks to develop and apply.

Limitations of systems thinking

Theoretically, "systems thinking" presents an incredibly enticing solution to the problems that preventive public health continues to face (Boswell, Baird, and Taheem, 2020). According to this view, public health initiatives shouldn't be conceived, created, and implemented as stand-alone ventures. Systems thinking, on the other hand, encourages public health scholars and practitioners to think about how their initiatives, programs, and policies relate to those in other fields (Greenhalgh and Papoutsi, 2018; Rutter, Savona, Glonti, Bibby, Cummins, Finegood, Greaves, Harper, Hawe, Moore and Petticrew, 2017). The goal is to implement coordinated interventions that better anticipate administrative and political obstacles and barriers to success and take advantage of opportunities to amplify feedback from other initiatives (Boswell et al., 2020). In reality, however, the impact of systems thinking has yet to be felt by many public health decision-makers and practitioners (Boswell et al., 2020). Additionally, many people are still confused by the implications, or sceptical about their usefulness in the chaotic 'real world' where people must implement these theories.

3.2.2 Rationale for rejecting the systems thinking

This study notes that the systems thinking approach is not the appropriate approach to examine the complex relationship between the private and public health sectors in South Africa because it focuses mostly on the behaviours of social and economic systems instead of the asymmetrical relationship between the private and public sectors. In examining the complex relationship between the private and public health sectors, a theoretical approach can assist in examining the systemic conditions in which the private and public health sectors function in South Africa. Therefore, it would not be appropriate to apply the systems thinking approach.

3.3 The people-centred development (PCD) approach

3.3.1 Background on the PCD approach

According to Jennings (2000), the people-centred development (PCD) approach is a "ground-up development" and humanistic strategy that strengthens local communities, starting in the late 1970s and early 1980s. In essence, PCD places individuals at the centre and enables social development through participation (Jennings, 2000). Additionally, the PCD is seen as a "bottom-up" strategy and is now known as the participatory development approach, in contrast to the classical development theories (Jennings, 2000). Meaning that this strategy promotes and achieves growth as well as sustainability by starting at the local level.

Furthermore, PCD implies freedom and democracy, which guarantees that people can pursue their agendas, according to Yoms (2013). According to Etana (2014), modernization and dependency did not add to the "desired development", which is why the PCD approach was developed. According to Frank and Smith (1999), growth results in change. Working with others, gaining new skills and knowledge, and actively taking part in a society's economic, political, and social growth are all ways that people can develop. Participation is necessary for development to take place, which is why the strategy is also known as participatory development theory.

The main tenets of the PCD approach:

Participatory Decision-Making: Participatory decision-making is a humanistic theory that places people first, PCD is based on it. As a result, they are involved in the decision-making procedures. People are included in all broad, significant choices that have a bearing on their lives. According to the People and Planet organization, participatory decision-making is a creative process that empowers individuals to take charge of and make choices. It is also stated that involvement promotes responsibility, self-assurance, and human growth (Yoms, 2013).

Empowerment: Participation and the empowerment of individuals and groups are essential components of people-centred development (PCD). Possessing skills and abilities promotes good human development for each person. Following Yoms (2013), empowerment is a "process that is concerned with equipping people to decide and take action within the context of their own development needs." People and groups can be empowered without necessarily

needing financial resources, and by this, this study means that communities can be empowered without necessarily needing financial resources.

Sustainability: Human growth must be sustained. Future and current growth depend on sustainable development. According to Yoms (2013), sustainable development includes four facets: environmental sustainability, economic sustainability, societal sustainability, and institutional sustainability. It facilitates the process of sustainability by establishing the aforementioned principles. Non-economic elements of development are one of the central tenets or characteristics of PCD. It is important to acknowledge that PCD advocates for changes in social, political, and environmental values and practices because it does not take economic growth into account, which means it does not add to human development (Yoms, 2013).

3.3.2 Limitations on the people-centred development (PCD) approach

While these approaches promise to change, they can also obscure the application of traditional top-down development methods (Thecla, 2011). Makuwira (2004) notes that the notion of participation differs from "superficial display" to "transformative participation" Thecla (2011) noted that participation can be used to marginalize people who lack decision-making capacity. Participatory development is an evolving mix of context-specific qualitative methods and practices that change according to local conditions Thecla (2011).

3.3.3 Rationale for adopting the PCD approach

The people-centred approach's (PCD) main tenants include participatory; empowerment; and sustainability which are important elements in theorizing how the term socialisation informs the understanding of the means of accessing health services in the South African context. The study therefore suggests that the PCD approach is an appropriate approach to examine the extent to which the term socialisation informs the understanding of accessing health services.

This study further argues that the PCD approach creates an opportunity for active citizenry through participation. In the context of accessing health services, members of the public are essentially variables of the health system either as patients or health workers and therefore, play a critical role in health care delivery. Participation in health care delivery can occur through participating as a community health worker (CHW). Studies have explained how important community health workers (CHWs) are in ensuring members of the local community are up to date with their doctor's appointments with the local clinic. The CHWs also ensure that elderly patients are reminded to take their prescriptions for any medical conditions. In

addition, the PCD approach promotes empowerment which is also critical in the advancement of society, and in this context accessing health services in the health system. The health system cannot function without any support from various stakeholders involved in health care delivery. Therefore, the empowerment of the health workforce towards health care delivery for the population must derive from an empowered health system that can function effectively. Lastly, the PCD approach promotes sustainability which is key in maintaining a health system for long periods. Without any sustainability, access to health services may stagnate and potentially lead to cases of medical negligence.

3.4 The complexity theory

3.4.1 Background of the complexity theory

There is no consensus on what complexity theory is or how complicated something must be to fall under the term complexity theory, making definitions of the field difficult (Nunn, 2007). The conceptual ambiguity surrounding complexity theory may be caused by its debatable validity, its transdisciplinary (Wallis, 2008), and/or researchers' ignorance of its methodological issues. Nevertheless, the lack of a universally accepted definition does not mean that anything is invalid. Since "any definition of complexity depends on the perspective from which it is viewed" (Manson, 2001), the transdisciplinary nature of complexity theory is a viable explanation for an elusive definition.

There are calls for more frequent use of theory in the preparation and conduct of health services research. Such calls are made in the areas of knowledge translation and interdisciplinary collaboration in health services research. The best way to ensure that stakeholders are aware of research evidence and use it in decision-making is to conduct knowledge translation research (Lapaige, 2010). Research on interprofessional collaboration examines how best to help professionals create and maintain the best working relationships (Thistlethwaite, 2012). Research on inter-professional collaboration and knowledge translation has the potential to improve healthcare practices and outcomes (Zwarenstein and Reeves, 2006).

Following the examples of Cilliers (2012) and Strumberg and Martin (2013), this study presents some complexity theory theses. First, complexity theory provides a framework for studying complex systems without reducing them to individual components. According to complexity theory, the interactions between the components of a system are important to the study of a system (Thompson, Fazio, Kustra, Patrick, and Stanley, 2016). Second, the

interactions of the system components determine the overall behaviour of the system (Thompson *et al*., 2016). Complexity theory recognizes that such behaviour is caused by the interaction of actors within a system. In terms of complexity, self-organization refers to interactions between actors, while emergence refers to system-level changes. Third, there is no central control over the interactions of agents (Thompson *et al*., 2016). Individual agents interact by following simple rules and responding to changes in the environment - control is decentralized. Fourth, the system is open to the outside world (Thompson *et al*., 2016). Agents' interactions with their environment result in the exchange of information and people (Thompson *et al*., 2016). These interactions affect how the agents interact. Finally, agents have little influence on how system-level changes occur. As a result, new system behaviour is often unpredictable and difficult to attribute to a specific cause (Thompson *et al*., 2016).

Many authors agree that complexity theory provides a useful perspective for answering social questions (Sturmberg and Martin, 2013). Similarly, Rangachari (2008) and Ruhe, Weyer, Zronek, Wilkinson, Wilkinson, and Stange (2005) agree that descriptions of complexity theory vary and are influenced by the particular discipline and phenomena of interest.

Since the application of complexity theory in health services research is still in its infancy compared to other fields, health services researchers have a unique opportunity to develop the basic conceptual perspectives that complexity theory offers for health services research. According to Davis, Sumara, and Luce-Kapler (2007), complexity theory is a perspective or a way of thinking about certain phenomena rather than a theory.

There are reviews of complexity theory in organizational science (Wallis, 2009) and health care (Sturmberg, Martin, and Katerndahl, 2014). Sturmberg *et al*., al (2014) found that researchers use complexity theory more frequently than they did a few decades ago. Despite ongoing debate about how best to apply complexity theory in health services research, researchers are increasingly incorporating it (Greenhalgh, Plesek, Wilson, Fraser, and Holt, 2010). There are no reviews that address how complexity theory has been integrated into the larger body of health services research literature in nursing, medicine, and related fields. Given the broad range of ways complexity theory can be conceptualized and ultimately integrated into health services research, a review of complexity theory in health services research is needed. The goal of this review is to examine how complexity theory has been applied in health systems research.

Limitations of complexity theory

Stacey (1996) concludes that short-term behaviour can be predicted, but that participants in a group, no matter how knowledgeable and influential, are unlikely to anticipate the precise future consequences of their actions. How long does the long run last? Many discussions of complexity point out this important point. In the case of weather conditions, it is obvious that a forecast for more than 5 days is long-term. The time scale for systems to evolve could be thousands of years. The link between unpredictability and time is less obvious for companies and industries; companies have historically developed goals for 3 or 5 years, but many companies are also trying to predict major technology changes beyond 10- and 20-year time frames.

3.4.2 Rationale for adopting the complexity theory

This study will use complexity theory as a theoretical framework. South Africa's two-tier health system can be described as complex because of its interactions. The motivation for using complexity theory is that it provides a framework that encompasses all the elements of the two-tier health system. Complexity theory attempts to overcome the analytical method where a complex system is divided into manageable units, analysed separately, and then put together again. However, a complex system is not characterized by the sum of its components, but instead by the complex relationships between these components. Similarly, the two-tiered health system in South Africa is made up of different components (namely, the private health industry and public health industry) which interact asymmetrically and disproportionately producing inequalities in the utilization and accessibility of health services for the entire population. Thus, complexity theory helps achieve the objectives of this study, namely to examine the complex relationship between the private and the public health sectors in the context of accessing health services.

3.5 Doctrinal legal research (DLR) method (also called black letter method)

3.5.1 Background on the doctrinal legal research (DLR) method

The word "doctrinal" is a derivative of the Latin noun "doctrine", which means knowledge, instruction, principle, or gain of knowledge. A detailed and critical study of legal principles, doctrines, and concepts is referred to as doctrinal legal research methodology. It involves rigorous methodological explanation, investigation, and critical analysis of legal norms, ideas, and philosophies, as well as their interrelationships (Myneni, 2006). It involves a critical

examination of laws, decision-making procedures, and underlying principles (Ngwonke *et al*., 2023). The traditional legal approach to law, or the study of law as it is, is also known as doctrinal legal research methodology (Kornhauser, 1992). It is an investigation of the black letters of the law (Ngwonke *et al*., 2023). It is best defined as research that aims to explain in detail the rules, regulations, and concepts that govern a particular area of law or institution and to examine the interactions among those rules, regulations, and concepts to address ambiguities and gaps in existing law (Hutchinson, 2015).

The doctrinal approach is essentially the same in all related areas of law (Hutchinson, 2015). Although it was developed for private law, it has since been adopted by researchers working in constitutional, criminal, and other disciplines (Hutchinson, 2015). Legal doctrine, black letter law, formalism, doctrinarism, and legal dogmatic research are all terms used to denote (the result of) a similar approach to law, although with certain geographical differences (Hutchinson, 2015). Initially, doctrinal analysis was the preferred legal method in the traditional legal space, although other categories of research such as reform-oriented, theoretical, and basic research were considered crucial, and doctrinal research always involved a multidisciplinary aspect (Hutchinson, 2015). Despite this, legal learning has been evaluated within a doctrinal methodological approach that includes the tracing of precedent and the interpretation of legislation (Hutchinson, 2015). According to Hutchinson (2014), the doctrinal legal approach provides a thorough conceptualization of each major piece of legislation and court decision to find a statement of the law about the subject matter under study.

The methodology has also been defined by eminent legal experts. For example, doctrinal research includes the analysis of jurisprudence, the organization, classification, and systematization of legal concepts, and the study of legal organizations through legal analysis and logical reasoning (Jain, 1982). It is "the exploration of one or more legal propositions carried out through the analysis of pre-existing laws and judgments using reasoning power" (Myneni, 2012).

3.5.2 Limitations of the doctrinal legal research (DLR) method

i) This research method has been criticized for being too hypothetical, technical, uncritical, and rigid without giving due attention and consideration to the social, economic, and political significance of the legal system (Ali, Mohamed, and Ayub, 2017).

ii) It is biased because it is the result of a researcher's analysis. However, the methodology of doctrinal legal research must take these elements into account.

3.5.3 Rationale for employing the doctrinal legal research (DLR) method

Most doctrinal legal research (DLR) is less strenuous compared to more complicated methods. Since it does not use field studies or other types of empirical methods, it saves the researcher the trouble of obtaining first-hand data through field research. Instead, it examines readily available data from reliable sources that have already been collected and analysed by others. In addition, it provides judges, lawyers, and researchers with readily available, quick, and accessible tools to reach a legal conclusion.

This study therefore suggests that the DLR method is well suited to determine the extent to which the NHI bill recognises access to health services for women asylum seekers and refugees. A bill is a draft version of the law/Act but the DLR method can examine a bill because it is subject to the legislature (Parliament). Moreover, this study maintains that doctrinal legal research (DLR) meets three basic goals: Description, Prescription, and Justification and that these goals are closely related and even mutually supportive. As a result, the NHI bill is subject to existing laws for interpretation based on the Constitution of South Africa. Legal doctrine represents the basis of the legal system in this regard.

3.5. The meaning of socialisation in health services

Scholars have proposed several definitions of the socialisation of the means of accessing health services (Ashoorkhani, Rajabi, and Majdzadeh, 2019). The definition of the term varies in global literature. However, there is no single, coherent, and comprehensive definition of socialisation-especially about health services for developing countries such as South Africa - and there are varying definitions and opinions of the term. And because there is no single, unambiguous definition of health care socialisation, different agencies and sectors have different ideas about it and end up tailoring their operational steps to their agendas. This study therefore chooses to theorize its interpretation of the meaning of the socialisation of health care. For this analysis, it is defined as the realization of access for all to free, promotive, preventative, curative, rehabilitative, and all palliative health services paid for by the government. This theorized definition subscribes to the philosophical values of universal health coverage (UHC).

3.6 Conclusion

This chapter outlined the theoretical framework that will deal with the research question/s and examine the key issues of this study. This chapter outlined and discussed (i) systems theory; (ii) people-centred development approach (PCD); (iii) complexity theory and (iv) doctrinal legal research (DLR) method. Furthermore, this section essentially identified and explained the reason behind the four different theoretical approaches that will be used to analyse the study's aims and objectives. Fundamentally, a comparative assessment of the different approaches was made in this chapter which was divided into three main sections: (1) a historical classification of the four approaches was provided; (2) the reasons for rejecting or adopting the theoretical approaches were explained and; (3) the limitations of four approaches and (4) the meaning of term 'socialisation' for this study.

CHAPTER FOUR:

METHODOLOGY

4.1 Introduction

This chapter discusses the various themes based on research methods and research methodology. In addition, this chapter details the approach that was used to create this thesis. This chapter discusses the following: What is research methods and methodology; the definition of research; the characteristics of research design; explorative study, descriptive study, and causal study; explorative study; descriptive study; causal study; research process; research strategy; choice of research methodology i.e. quantitative, qualitative, mixed methods; time horizon; population; target population sampling population; measuring instrument; secondary research; interviews; questionnaires; validity and reliability of the measuring instrument; pretesting; pilot study; types of data sources; data collection process; ethical consideration; informed consent; anonymity and confidentiality; data analysis procedure; statistics and conclusion of this chapter. The chapter serves as an example of how the researcher intends to conduct the study, as well as the factors that motivated and encouraged him or her to make these decisions while carefully considering what scientific research means and represents in social science.

4.1.1 What are research methods and methodology

According to Goundar (2012), research methods and research methodology are two different terms that are often used interchangeably. Technically, they are not, and there are differences between them. One of the most important distinctions between research methods is the procedures used to explore a topic or question, while research methodology describes how to proceed with your research (Goundar, 2012). Experiments, tests, and questionnaires are part of the research methodology. Research methodology, on the other hand, includes the study of all methods that can be used in conducting research, as well as tests, experiments, surveys, and critical studies (Goundar, 2012). This is the difference between research methods and research methodology.

4.1.2 Definition of Research

Ngwonke, Mbano, and Heylynn (2023) define research as the application of scientific techniques to find solutions to questions. In common usage, research refers to the pursuit of knowledge. It can be further defined as a thorough scientific investigation of a topic to find

new information or gain a new perspective (Kirk and Mueller, 1986). Kerlinger and Lee (2000) define research as the systematic, controlled, empirical, and critical study of social phenomena, guided by the theory of hypotheses about the presumed relationships among such phenomena. According to Saunders, Lewis, and Thornhill (2003), research is simply "a search for knowledge". Research, as Rajasekar, Philominathan, and Chinnathambi (2006) put it, is an orderly search for fresh and useful information on a given topic. The objective of a research study is to investigate the solutions that can be found in favour of science and societal problems, using an analysis carried out objectively and systematically (Goundar, 2012). It's an investigation of knowledge, or at least the discovery of a secret fact. In this context, knowledge means information about things. Information can be obtained from different sources, like experience, humans, books, journals, nature, and so on (Goundar, 2012).

When you say you are conducting a research study to find answers to a question, you are suggesting that the process: 1.) Be conducted within the framework of a set of philosophies (research approaches); 2.) Uses procedures, methods, methods, and techniques that have been tested for validity and reliability; 3.) It is designed to be unbiased and objective. The word "research" consists of two syllables: "re" and "search". According to Goundar (2012), "re" is a preface prefix meaning "again", "new" or "to seek once more, anew or search more" and is a verb referring to "examine closely and carefully, to test carefully", "test and try".

4.1.3 Characteristics of Research Design

A research design is a comprehensive formulation of a research problem (Kabir, 2016). It is the general method you use to integrate the many components of the study consistently and logically (Kabir, 2016). It serves as a foundation or template for conducting the research. Simply put, it is your overall strategy for conducting your study. Smith (1976) defines a design as "a carefully planned scheme for experimenting". The design of a study specifies the study type (descriptive, correlational, semi-experimental, experimental, review, and meta-analysis) and subtype (e.g., descriptive - longitudinal case study), the research question, hypotheses, independent and dependent variables, experimental design, and, if necessary, data collection techniques and a strategy for statistical analysis (Kabir, 2016). A research design usually describes how the data will be collected, what instruments will be used, how they will be applied, and how the data will be analysed (Kabir, 2016). The research project is held together by its research design (Kabir, 2016). A research design is used to organize the research and show how all the key components of the project-including samples or groups, measures,

treatments or programs, and allocation methods together to answer the main research question (Kabir, 2016).

Effective research design usually reduces bias and increases the reliability of the data collected and processed. According to Fielding (2000) and Kabir (2016), the following four criteria- objectivity, reliability, validity, and generalizability of results should be met by a sound research design.

Objectivity: This term refers to the conclusions drawn from the data collection and response analysis procedures (Kabir, 2016). The research design should allow for exactly objective measurement instruments, meaning that any judge or observer evaluating performance will provide the same feedback. In other words, the degree of agreement between the final ratings received by different individuals from a set of independent observers can be used to assess the impartiality of the process. This guarantees the objectivity of the data that is collected and can be analysed to draw generalizations.

Reliability: According to Kabir (2016), reliability is the consistency of a set of measures. When a respondent answers a particular question, he or she is expected to give the same answer when asked further. Consistency is lost if they answer differently to the same item. Therefore, the researcher should design the questionnaires to ensure consistency or reliability. When a researcher researches regularly, he or she expects consistent results. Your approach should show how you create research questions to ensure the quality of your results. Your objectives can only be achieved with a sound design (Fielding, 2000).

Validity: Any measuring instrument is considered legitimate if it measures the things that are expected of it (Kabir, 2016). For example, an intelligence test to determine the intelligence quotient (IQ) should only measure intelligence and nothing else, and the questionnaire should be designed accordingly.

Generalizability: Refers to the extent to which generalizations can be made from the data obtained from the samples to a larger group from which the sample was selected (Kabir, 2016). Thus, if a researcher has paid attention to identifying the population, selecting the sample, and determining the relevant statistical analysis, then the research design will help the researcher generalize his or her findings (Kabir, 2016).

4.1.4 Explorative Study, descriptive study, and causal study

4.1.5 Explorative study

According to Singh (2021), exploratory research seeks to provide an answer or address a specific question. A more exploratory approach to the subject is effective when the nature of the object being studied prevents the researcher from changing an element, when it cannot be conducted in a controlled environment, or when the researcher is unable to determine each of the effects on the entity. This type of research, commonly referred to as the inductive method, aims to find general principles that can be used to explain facts and observations.

An exploratory study aims to better understand a particular phenomenon. Its goal is to find out as much as possible about the relationship between the dependent and independent variables (Singh, 2021). Since the exact nature of the dependent variable may not be understood or known before the experiment, it will be observed and documented more fully. The relationship between the two variables will be described once an exploratory research study is completed (Singh, 2021). Since the relationship between the variables has been established, it is conceivable that an experimental study will be conducted following an exploratory research study.

The data collected for exploratory research will likely be similar to that of an experimental study. Nevertheless, exploratory research differs from experimental because the data are either collected "in the field" or already exist and must be structured in new ways. It is important to remember that just because a study involves the collection of field data does not necessarily mean it is exploratory. Depending on the goals of the study, data may also be collected through surveys or interviews.

4.1.6 Descriptive study

According to Manjunatha (2019), descriptive research is a type of analysis that focuses on outlining the characteristics of the population or subject being studied. This methodology emphasizes the "what" of the study topic more than the "why" of the topic. Descriptive research, then, focuses largely on identifying the characteristics of a particular demographic group without addressing the "why" of a particular phenomenon (Manjunatha, 2019). In other words, it "describes" the research subject without explaining "why" it occurs. Since they have no control over the variables, descriptive studies can be described as an assessment of the current state of affairs (Manjunatha, 2019). The definition of descriptive research is a statement

of the current state of affairs without the researcher having control over the variables (Manjunatha, 2019). In addition, descriptive research can also be characterized by an attempt to determine, describe, or delineate something, while an analytic study attempts to find out why it is so or how it came to be so. Descriptive studies are essentially used to characterize different facets of the phenomenon.

4.1.7 Causal study

Strydom (2013) explains that explanatory research aims to understand and explain the origins of social conditions by establishing causality between various factors, determining the effects on behaviour, and predicting how these factors will change or vary over time. This should lead to developing, expanding, testing, or modifying a theory and explaining why events occur (Strydom, 2013).

4.1.8 Research process

According to Singh (2021), the research process involves a series of steps or actions necessary to effectively conduct research. This includes formulating the research problem, conducting a comprehensive literature review, developing hypotheses, creating the research design, determining the sample, collecting data, conducting the project, analysing the data, testing the hypotheses, generalizing and analysing, and writing the report or presenting the results (Singh, 2021). Overall, the research process includes a collection of scientific steps used to conduct the research. Each step is linked to the previous ones. The process begins with the research problem. Then it proceeds in sequence to the next steps. A researcher usually conducts his/her research in seven steps. A research proposal is primarily required for the research work. This is because the proposal supports the research project, whether or not you become competent to conduct research (Singh, 2021). So, when a researcher writes a research proposal, he/she must make sure to state the exact strategies and explicit goals of your research.

4.1.9 Research Strategy

According to Kapur (2018), the research process is often referred to as the general framework for conducting research. When conducting a qualitative or interpretive study, the method is well understood, and one does not usually adhere to the procedural process by phases, but rather moves back and forth between components or performs multiple tasks simultaneously (Kapur, 2018).

4.1.10 Choice of research methodology i.e. qualitative, quantitative mixed methods, etc.

Qualitative and quantitative research methodologies are widely used in various educational areas, including sociology, psychology, and historiography (Rahman, 2020). Qualitative research examines the nature of phenomena, including their quality, manifestations, context, and perspectives, without focusing on their scope, frequency, or causal chain (Chinyere and Val, 2023). The formal definition can be complemented by a more practical guide. According to Punch (2013), qualitative research often uses textual data rather than numerical data. Whereas, quantitative research involves the calculation and evaluation of variables to obtain research results. It also involves the use and analysis of statistical information to examine statistical trends and attempt to answer questions such as who, how much, why, where, how, the number, etc (Apuke, 2017).

A mixed-methods approach represents an independent research methodology (Dawadi, Shrestha, and Giri, 2021). A mixed-methodologies research design, as defined by Creswell and Plano Clark (2011), is a research design with philosophical presumptions and methods of investigation. It uses philosophical presumptions as a technique to give instructions for the gathering and interpretation of information from multiple sources in one investigation. Tashakkori and Creswell (2007) describe mixed-methods research as research in which the researcher collects and analyses data, integrates the results, and derives interpretations using a combination of quantitative and qualitative techniques or approaches in a single study. The use of traditional methods to collect data does not limit the research but rather is guided by a basis of inquiry that underpins the research activity (Creswell, 1994). A mixed methods study includes both a qualitative and quantitative component, but difficulties can arise when the researcher attempts to describe how the two aspects are interrelated. (Tashakkori and Creswell, 2007).

4.1.11 Time horizon

The time horizon is referred to as the preparation or planning that takes place in research and typically uses time-based periods to examine a variety of research periods and usually has a specific time goal for completion (Melnikovas, 2018).

4.1.12 Population

4.1.12.1 Target population sampling population

Any researcher who wants to know or understand human behaviour must study people. Select a number or small group of people who better reflect what you want to ask (Kerlinger and Lee, 2000). In research, the general population is the largest group of people who may participate in a qualitative study (Chaudhury, 2010). Although the general population is what is commonly known and stated by researchers, it makes little sense unless it is specified with target and accessible populations (Asiamah, Mensah, and Oteng-Abayie, 2017).

The well-defined group of units of interest (systems) for which evaluation is required is called the target population or simply the population (da Silva, 2022). The size of the population is measured by the number of units. The units that make up the target population, or the requirements for the units to be part of the population, are specified (da Silva, 2022). The research objectives specify the population and its units, and these specifications must be made when formulating the research problem.

4.1.13 Measuring instrument

A measuring instrument serves as a tool for collecting, measuring, and analysing data relating to your study interests (Trigueros, Juan, and Sandoval, 2017). Interviews, examinations, surveys, and checklists are some of the most popular methods used in health and social sciences (Trigueros *et al*., 2017). A Research Instrument is typically chosen by the researcher and is linked to the study approach (Trigueros *et al*., 2017).

4.1.14 Secondary research

In simpler terms, secondary data is any collection of information that was not collected by the researcher, or more specifically, the analysis of information collected by someone else (Boslaugh, 2007). Data that have already been collected and are to be reused for new questions for which the collected data were not originally intended can be considered secondary data (Vartanian, 2010).

4.1.15 Interviews

The interview process is a dialogue designed to gather information (Easwaramoorthy and Zarinpoush, 2006). An interviewer coordinates the course of the dialogue and asks questions during a research interview while the interviewee responds to those questions. Interviews are often conducted in person or by telephone and the Internet is also becoming more popular as a

tool for conducting interviews (Easwaramoorthy and Zarinpoush, 2006). Interviewing, according to Trigueros *et al*., (2017), means asking study participants questions and getting their answers. There are many different types of interviews, including group and individual interviews.

Interviews are an effective strategy for gathering in-depth information about people's opinions, beliefs, experiences, and feelings. Interviews are effective whenever the subject matter requires complicated questioning and in-depth follow-up (Easwaramoorthy and Zarinpoush, 2006). Face-to-face interviews are suitable when the target group is better able to communicate in person than in writing or by telephone (e.g., young people, the elderly, or people with disabilities). Interviews can be structured, semi-structured, or unstructured, and asking and receiving questions can be done over the telephone or other electronic devices (such as laptops) (Trigueros *et al*., 2017).

Structured interviews: In a structured interview, the interviewer asks a series of conventional, predefined questions on specific topics in a specific order. Respondents must choose their answers from a set of choices. Structured interviews are often used in surveys. Semi-structured interviews: In a semi-structured interview, the interviewer uses a set of predetermined questions, and respondents respond according to their ideas (Easwaramoorthy and Zarinpoush, 2006). To ensure that all respondents provide data on the same topics, some interviewers use a topic guide that also serves as a checklist. When detailed information needs to be collected systematically from a variety of participants or respondents (e.g., religious leaders or community leaders), semi-structured interviews can be helpful.

Unstructured Interviews: In an unstructured interview, there are no set rules, restrictions, planned questions, or options available to the interviewer (Easwaramoorthy and Zarinpoush, 2006). The interviewer asks some general questions to allow for a free, unstructured conversation with the person.

4.1.16 Questionnaires

According to to Roopa and Rani, (2012), questionnaires are often used in quantitative economic research and social science research. A questionnaire consists of a list of questions asked of individuals to collect statistical data on a particular topic. Questionnaires can be an important tool for making statements about specific individuals, groups, or entire populations if they are well-designed and implemented. They are an effective way to collect a variety of data from a

large group of people, often referred to as respondents. The success of a survey depends on the questionnaires being properly designed. The survey can be worthwhile if the questions are appropriate, the questions are arranged correctly, the scaling is appropriate, or the questionnaire is well designed and reflects the thoughts and opinions of the participants.

4.1.17 Validity and Reliability of the measuring instrument

Thatcher (2010) defines validity in quantitative research as the degree to whereby any measuring instrument evaluates what it is designed to measure. However, qualitative research is when a researcher employs specific methodologies for validating the research data (Creswell, 2014). According to Kapur (2018), validity and reliability are the degree to which a test measures what it purports to measure. The test must be valid so that the results can be applied and interpreted correctly. The reliability and validity of a test are determined by a collection of studies that establish the relationship between the test and the actions it is intended to assess (Kapur, 2018). It is the most important criterion because it reflects the extent to which an instrument measures what it is intended to measure. The repeatability of the results is referred to as reliability. Assuming that the data are accurate, repeating the study would yield similar results (Kapur, 2018).

According to Mohajan (2017), reliability and validity must be presented concisely but precisely in the chapter on research methods. They are appropriate to create an exceptional environment for the study (Mohajan, 2017). The stability of the results is called reliability, while the reliability of the results is represented by validity (Altheide and Johnson, 1994). In qualitative research, validity and reliability promote transparency while reducing the risk of researcher bias (Singh, 2014).

A complete examination of reliability and validity for all secondary data includes an assessment of data collection procedures (Saunders, Lewis, and Thornhill, 2009). These provide a good basis for interpreting the results of psychometric instruments used in clinical practice, research, education, and administration (e.g., symptom scales, surveys, educational tests, and observational assessments) (Cook and Beckman, 2006). These concepts are important in current research because they are used to improve the accuracy of assessment and evaluation of a student's work (Tavakol and Dennick, 2011). It is not possible to discuss the impact of measurement flaws on theoretical relationships being measured without first examining the reliability and validity of the research (Forza, 2002).

4.1.18 Pretesting

According to Bowden, Fox-Rushby, Nyandieka, and Wanjau, (2002), pretesting is the most important opportunity for researchers to assess the importance of survey questions before it is too late, i.e., before an enormous amount of money is invested in questions that are not correct or in topics where the researcher is not sure what is being asked. Since researchers know the purpose of the study, they must conduct these interviews rather than delegating this task to research assistants. Pre-testing included the following steps: - determining the intended reference and contextual meaning of each question; - confirming a set of requirements for evaluating the appropriateness of survey questions; - selecting methods for evaluating the appropriateness and conduct of the research; and - reading questions for inclusion, revision (of the question or intended meaning), or exclusion.

4.1.19 Pilot study

Lowe (2019) defines a pilot study as a preliminary feasibility investigation to test strategies for a bigger, more comprehensive, or definitive research. A pilot study aims to prevent time-consuming and costly errors in large-scale research, rather than answering specific research questions (Lowe, 2019).

4.1.20 Types of Data Sources

After the study question has been specified and the research strategy has been properly formulated, the work of data collection begins (Kapur, 2018). There are two types of research data: Primary and secondary data. Primary data are information collected by the researcher for the study and are characterized by a particular style and were collected for the first time for the intended study (Kapur, 2018). Secondary data are data that have already been obtained by someone else; they are not new and can be obtained from both published and unpublished sources (Kapur, 2018).

4.1.21 Data collection process

Collecting data is the systematic process of collecting and analysing data concerning variables of interest to answer specific inquiries, investigate hypotheses, and evaluate results. Data collection is a component of research that occurs in all fields of study, including the social and natural sciences, business, and the humanities. While procedures vary by field of study, the emphasis on accurate and truthful collection remains constant (Kabir, 2016). The goal of any data collection is to capture high-quality evidence that leads to a rich analysis of the data and allows for the construction of a compelling and credible solution to the issues being addressed

(Kabir, 2016). Accurate data collection is critical to maintaining the integrity of the research, regardless of the research topic or the preferred method for defining the data (qualitative, quantitative). The risk of error is reduced by selecting appropriate data collection instruments (common, modified, or newly invented) and providing clear instructions on their proper use.

One of the most important phases in conducting a study is data collection. Even with the best study design in the world, your project will not be successful if you are unable to collect the necessary data. Data collection is an extremely difficult task that requires careful planning, diligence, persistence, patience, and a variety of other skills to complete the task.

4.1.22 Ethical consideration

The quality of research techniques is called ethical if they comply with their professional, legal, and social obligations to research participants. According to Polit and Beck (2004), this is the area of philosophy that deals with morality. The following ethical guidelines must be followed when using human subjects:

Right to self-determination: the ethical imperative of respect for the person serves as the basis for the right to self-determination, as asserted by Burns and Grove (2001). This requires that participants be adequately informed about the research, that they be able to understand the material, and that they have the freedom to accept or decline participation in the research as they see fit.

Participants must be informed of the objectives of the study and their informed consent must be obtained. Participants must be informed of their right to leave a research project at any time. Participants must be repeatedly told that they have the right to review the original agreement (informed consent). The research must be discussed and it must be made clear to participants what they understand. After the pre-interview meeting, during which interview times and written consent are agreed upon, informants are briefed on the goals and purpose of the investigation.

Right to Confidentiality: consistent with Burns and Grove (2001), confidentiality refers to the researcher's handling of personal information provided by participants, which may not be disclosed to third parties without participant consent. The researcher has taken precautions to prevent unauthorized use of the data and has ensured that only the project sponsor and the researcher have access to the data.

Anonymity: According to Burns and Grove (2001), anonymity is the inability of the researcher to associate a participant with his or her data. Although anonymity cannot be fully guaranteed in qualitative research (Streubert and Carpenter 1999), the researcher must try to ensure that no one can access the data without their consent. The information is also kept secure by locking it in a cabinet and deleting it after the study is completed. Disclosure of information, such as participants' names, must be withheld during data collection.

The right to privacy: The researcher maintains confidentiality in all personal matters, including information obtained from participants. This could take the form of feelings, attitudes, and beliefs. Unprocessed information will be protected from unauthorized individuals, kept private, and not linked to names. In addition, records are destroyed after the study is completed and data are kept in a locked cabinet (Burns and Grove 2001).

4.1.23 Informed consent

Before deciding to participate in a study, one must first obtain informed consent. This is a process by which one receives important information about a clinical trial, including potential risks and benefits (Nnebue, 2010). At any point, the study is conducted with informed consent. A legal method known as informed consent is used to ensure that a participant or client is aware of all risks and costs associated with a study or surgery (Nnebue, 2010). The client must be of legal age and consent must be given voluntarily for informed consent to be considered legal (Nnebue, 2010). Informing the participant or client about the nature of the procedure or research, possible alternatives, and the potential risks and benefits of the procedure or study are some of the components of informed consent.

Ethical issues arise frequently in research. One of the most important ethical rules for research involving human subjects is that subjects must give informed consent before participating in a study. Consequently, informed consent is a critical component of the research process. Informed consent consists of three components: Information, Understanding, and Voluntariness. Informed consent is a process, not a form. The information must be given understandably. This is to allow people to decide for themselves whether or not they want to participate as subjects. It is a fundamental tool to ensure respect for human beings by allowing informed consent to be an act of assent.

Informed consent is based on the principle that participation in research must not have negative consequences for the subjects, that the fundamental rights of the individual must be respected,

and that commitments, agreements, and promises must be honoured. Several requirements and procedures have been established to ensure the protection of study participants. These procedures take the form of a written agreement with an active, informed participant who agrees to the terms.

4.1.24 Anonymity and confidentiality

Although anonymity and confidentiality are connected, they nevertheless have some key differences. The extent to whereby the source of a message may be recognized can be used to define anonymity (Scott 1995). It might be very high (the source is almost impossible to find) or it can be zero (the source is obvious or has already been found). Anonymity seems to be a more reliable guarantee than confidentiality for reaching this goal because researchers need to safeguard the participant from unintended consequences. An anonymous researcher does not keep track of any identifying information. However, if secrecy is promised, identifying information is recorded but will not be shared with anyone else.

According to Bos (2020), confidential information is any information concerning a person's private life that he or she does not want others to know. Distinguished from this is 'public information,' to which everyone has a right of access. The right of study participants to maintain their privacy and withhold certain information has become increasingly accepted within and outside of academia and is now governed by a variety of laws.

The fundamental ethical principle of confidentiality in research requires that the researcher take care to ensure that any use of data collected from or shared with human participants respects the autonomy and dignity of the participants and is not contrary to the interests of the people or their communities.

4.1.25 Data Analysis Procedure

According to Taherdoost (2020), data analysis is only the process that transforms the obtained data into useful knowledge. In this process, numerous tools, such as modelling, are used to identify trends and correlations and ultimately draw conclusions for the decision-making process (Start, 2006). Before data can be used in data analysis, it must first be prepared. According to Taherdoost (2020), data preparation is the process of converting data into a machine-readable numerical format for use in specific analysis programs.

4.1.26 Statistics

Statistics is a scientific discipline that deals with the collection, organization, and analysis of data, as well as concluding samples of the entire population (Winters, Winters, and Amedee, 2010). This requires proper study design, appropriate sample selection, and selection of an appropriate statistical test (Ali and Bhaskar, 2016). Proper design of an epidemiologic investigation or clinical trial requires an adequate understanding of statistics. Inappropriate statistical approaches can lead to erroneous results and unethical behaviour (Sprent, 2003).

4.1.27 Conclusion

This chapter discussed the various themes based on research methods and research methodology. This chapter also explained the approach that was used to create this thesis. Essentially, this chapter discussed the definition of research; research methods; research methodology; research design; explorative study; descriptive study; causal study; research process; research strategy; choice of research methodology; time horizon; techniques and procedures; target population, and sampling population; measuring instrument; interviews; questionnaires; validity and reliability of the measuring instrument; pretesting; pilot study; types of data services; data collection process; ethical consideration; informed consent; anonymity and confidentiality; data analysis procedure and statistics. The chapter serves as an example of how the researcher conducts the study, as well as the factors that motivated and encouraged the researcher to make these decisions while carefully considering what scientific research means and represents in social science.

CHAPTER FIVE:

ANALYSIS OF THE STUDY

5.1. Introduction

This chapter will analyse the study by employing the complexity theory to examine the study's objectives which are: (a) to delineate the extent to which the current NHI bill [B 11 - 2019] recognizes access to health services for women who are asylum seekers and refugees; (b) to examine the tensions between the private and public health sector in the context of accessing health services for women. The people-centred-development (PCD) approach is employed to (c) make a case for the socialisation of accessing health services. The chapter concludes with an analysis of the study.

The following analysis employs complexity theory to examine the study's objectives.

(a) To delineate the extent to which the current NHI bill [B 11 - 2019] recognizes access to health services for women who are asylum seekers and refugees

Women asylum seekers and refugees are one of the many variables in the health system. The NHI bill and women are elements of the same health system, thus they are interconnected and interlinked. The linkages and interconnectedness of these variables are non-linear. In South Africa asylum seekers and refugees, of whom women make up a large proportion, are part of the legal operations in the health system, for example, through various international conventions and treaties granting asylum seekers and refugees the right to basic health services. An example of such laws is the Refugees Act 130 of 1998 section 27 (g) (see Annexure C). However, this finding has implications for the current NHI bill.

According to section 4 (2) of the current NHI bill (see Annexure D), states that "an asylum seeker or illegal foreigner is only entitled to —

(a) emergency medical services; and

(b) services for notifiable conditions of public health concern."

The definition of "emergency medical services" used in the bill means "services provided by a private or public entity dedicated to the acute medical treatment and transportation of the sick or injured and having appropriate personnel and equipment" (see Annexure E). The meaning of "notifiable conditions of public health concern" is derived from the latest version of the National Health Act (61/2003) of 2017 (see Annexure H) and describes notifiable conditions as medical conditions, illnesses, or infections of public health concern that are classified as

notifiable under Regulation 12 (see Annexure H) of which the NHI bill adopted this definition. However, sections 4 (2) (a) and (b) of the NHI bill (see Annexure D) restrict asylum seekers and refugees from accessing basic and comprehensive health services. The NHI bill consists of variables that can be considered unconstitutional and violates section 27 (2) (a) of the Constitution (see Annexure A) and the Refugee Act 130 of 1998 (see Annexure C) section 27 (g) (see Annexure A). This is even though the South African Constitution declares in section 27 (1) (a) that everyone has the right to healthcare services (see Annexure A). The term "everyone" in the context of the Bill of Rights was interpreted by the Constitutional Court to mean basically every single person and necessarily includes asylum seekers and refugees (Moyo, Botha, and Govindjee, 2022). The restriction of refugees' right to health care contravenes the Refugees Act 130 of 1998 (see Annexure C) which states that refugees are entitled to the same basic health services as the citizens of South Africa (Constitution, 1996). Therefore, the failure of the NHI bill to cover basic health services for everyone violates this specific provision of the Constitution. The best way out of this exclusivity is for the state to progressively realize the right to health care in section 27(1) (a) of the Constitution (see Annexure A), the right to equality section 9 (1) (2) of the Constitution (see Annexure J) and the right to human dignity in section 10 of the Constitution (see Annexure K). In addition, the state must also recognize that asylum seekers and refugees in South Africa are human beings who are part of the legal operations of the country and deserve access to health services when in need.

The findings of the study found that women asylum seekers and refugees will be adversely affected. Therefore, the NHI bill should be amended to include asylum seekers and refugees, of whom women constitute a large proportion. It may be the case that restricting asylum seekers and refugees to emergency medical care could have financial implications for the state. For example, when medical conditions become emergencies, the state bears a much greater financial burden for treatment. It would make better financial sense to treat illnesses while they are less severe by permitting access to basic health services. Another important issue emerging from these findings is if asylum seekers and refugees are refused access to health services unlawfully, it may lead to a civil claim against the state. This could potentially hurt the state coffers by introducing a bill of this nature because it opens up state liability where medical negligence cases are concerned.

According to section 4 (2) (b) of the NHI bill asylum seekers and illegal foreigners (whether undocumented or whether in possession of an expired permit) are entitled to services for

notifiable conditions of public health concern (see Annexure D). This analysis notes that category 4: notifiable medical conditions (see Annexure I) only focuses on multi-drug resistant organisms of public health concern. Interestingly, HIV/AIDs are not recognized as a notifiable condition under the latest version of the National Health Act (61/2003) of 2017, which means that this type of coverage was excluded from the bill. The NHI bill therefore needs to make provision to include HIV/AIDS as a notifiable medical condition because it is a prevalent medical condition. Another limitation of the analysis is that it did not describe the various limitations in accessing health services under the approved NHI bill.

Given the nature of coverage provided under the NHI bill, it is interesting to understand the extent to which the bill will promote UHC if access to antiretroviral therapy (ART) for HIV/AIDS-affected refugees is excluded under the NHI bill. If access to ART is excluded under NHI, it is reasonable to assume that women asylum seekers and refugees affected by HIV/AIDS will have to pay upfront for ART services in South Africa. This finding suggests that HIV-positive women refugees are at risk of having to pay out of pocket for a service that is already provided free of charge in public health facilities in South Africa. If they cannot afford to pay upfront, they could be denied health services and, as a result, their health could deteriorate and possibly lead to mortalities.

Another important point arising from these findings that could have implications for women asylum seekers and refugees is section 5 (a) (b) and (c) of the NHI bill (see Annexure D), which states that users of the NHI Fund must prove their identity to register. This includes an identity card (ID), original birth certificate, or refugee identification card. It may be the case that producing any form of ID may result in denied access to much-needed health services. This finding is inconsistent with the 2007 National Department of Health (NDoH) Refugee Assessment directive (see Annexure F) which recognizes the right of asylum seekers and refugees to receive medical care with or without permits. Systematic problems and backlogs in the issuance of permits by the Department of Home Affairs (DHA) often make it difficult for people to obtain their permits. The rising cost of obtaining and renewing permits also makes it difficult for financially vulnerable women who need legal protection to obtain the appropriate documents. Effective mechanisms may need to be created to allow undocumented persons to access supporting documents for registration under the NHI. To put this into practice, asylum seekers and undocumented foreigners must be able to register as users under the NHI bill. However, the bill needs to be amended to expand the universality in sections 5 (a) (b) and (c)

of the bill (see Annexure D) to allow asylum seekers and refugees to exercise their right to access health coverage.

After the NHI bill is passed in the National Assembly (NA), it will be referred to the National Council of Provinces (NCOP) under Section 75 (1) (a) of the Constitution (see Annexure M) which states that once a bill is passed in the NA it must be subjected to the NCOP. The committee of the NCOP is responsible for the bill and then conducts deliberations and public hearings. However, it is linked to the proceedings in the provincial legislatures, since the NCOP is composed of delegates from the nine provincial legislatures and must make its decisions based on the documents submitted by those delegates. After the provincial parliaments have given negotiating mandates to the NCOP to either approve, reject, or amend the bill, the mandates are passed on to the delegates, who return to the NCOP, which then holds a meeting on the negotiating mandates. In principle, the NCOP cannot pass a bill if fewer than six of the nine provincial legislatures in South Africa reject the bill under section 74 (1) (a) (b) of the Constitution (see Annexure L). However, if the bill is passed by the NCOP it must return to the National Assembly (NA) for finalization under section 76 (1) (a) (see Annexure N). Furthermore, if the NCOP rejects a bill that has been passed by the NA, the bill is subject to a mediation phase under section 76 (1) (d) of the Constitution (see Annexure N).

The findings suggest that the introduction of NHI in the health system should be intended to protect people from social determinants, gender constructs, and financial costs that determine their access to health services. Based on this reason this study endorses the introduction of NHI into the health system for wider access to a fundamental human right. Future research should therefore focus on the interpretation of the entire NHI bill and make recommendations for changes before presidential approval. The bill will be submitted to the President of South Africa for approval once it has passed both the National Assembly (NA) and the National Council of Province (NCOP). It becomes law when signed by the President and constitutes an Act of Parliament. The analysis therefore argues that the NHI bill, as currently drafted, needs to be amended to ensure that asylum seekers and refugees are recognised as human beings deserving of access to comprehensive health services. In this way, UHC can be achieved for asylum seekers and refugees who require health services that meet their needs.

(b.) To examine the tensions between the private health sector and the public health sector in the context of accessing health services.

The health system in South Africa is complex. Therefore, complexity theory is applied to examine the tensions between the private and public health sectors in the context of access to health services. Both the private and public health sectors are variables of the complex health system. A complex system is divided into manageable units, analysed separately, and then reassembled. However, a complex system is not characterized by the sum of its components, but by the complex relationships between those components. Similarly, the two-tier health system in South Africa consists of different components (namely, the private health sector and public health sector) that interact asymmetrically and disproportionately, leading to inequities in healthcare utilization and accessibility.

The complexity method helps this study examine the link between the public and private health sectors, which function unequally and lead to inequities in access to care. The South African government relies on the private health sector to subsidize services for government employees. One of the main reasons that the government subsidizes the private health sector to provide health services to government employees as an employee benefit is to avoid placing an extra burden on the already strained public health system. Government employees are critical to the economy, so subsidizing the private health sector to support this government function is justified for the health and productivity of government workers. However, if the government redirects the health expenditure budget to strengthen the public health system, there may be no need to subsidize the private health sector because the public health system could deliver a similar quality of care that is available in the private health sector.

Based on the contextualization above, this study can be understood through the complexity approach that the contradictions between the private and public health sectors divide health users' experiences in accessing health care. On the one hand, middle- and upper-class people may be able to afford to keep up with increases in private health insurance or pay out-of-pocket for health services, and thus are more likely to have improved health when they need treatment. The irregular distribution of health expenditure and resources shows the private health sector enjoys 'privileges' that are not found in the public health sector. On the other hand, complexity theory reveals to us that the 'success' of the private health sector is at the detriment of the public health sector. South Africa allocates about 8.5% of its gross domestic product (GDP) into health care, but the country has two very different healthcare delivery systems with very different levels of funding (Nkosi, 2020). The 16% of the population that can afford to access private providers under the private voluntary health insurance (PVHI) scheme (frequently

referred to as “medical aid”) receive just under 50% of total health spending from the government (Barber *et al*., 2018).

South Africa is battling to find ways to achieve universal health coverage (UHC) for all in a country that started with a health system largely dominated by the private sector. The country’s position as a middle-income country, inadequate tax base, slow economic development, and high inequality make it difficult for the state to achieve UHC. It is arguably correct to state that the relationship between the private health sector and the public health sector is fuelled by tensions and awkwardness around healthcare budget allocation. The government must therefore take a position to firmly straighten out the fault lines in the health system and capacitate the public health sector to lessen any reliance on the private health sector to help with this government function in delivering health services to the population.

(c.) *Making the case for the socialisation of the means of accessing health services*

Making the case for the socialisation of accessing health services

However, this study proposes that by applying the main tenets of the people-centered development (PCD) approach, particularly participatory decision-making, empowerment, and sustainability, as well as its theoretical meaning of the concept of socialisation of the means of accessing health services, the following variables within the health system must be fully empowered and functional before NHI is implemented in South Africa: (1) community health workers (CHWs); (2) district health systems (DHSs); (3) health workers; (4) strengthened health worker training; (5) policy-making; and (6) good governance and effective management.

Participatory decision-making:

The National Health Insurance (NHI) appears to encourage the citizenry to serve as implementers of the country’s constitution towards the re-engineering of the primary health system. The citizenry is another important variable within the health system. Citizens, non-citizens, and women in general should actively participate as community health workers (CHWs) in their jurisdiction. Not because they are women, but because they are adversely affected by poor health outcomes. The most prominent approach in this area is to promote public participation in achieving health goals. Participation can occur at various levels, such as needs assessment, planning, mobilization, training, implementation, monitoring, and evaluation. Therefore, this study argues that CHWs are an essential component of the

successful implementation and maintenance of the NHI system towards improving the health system.

Concerns around how health services will be equitably and adequately delivered through the NHI while the district health system (DHS) in some parts of the country are faced with gross challenges. There are currently 53 health districts in South Africa, spread across its provinces (Orgill, Marchal, Shung-King, Sikuza and Gilson, 2021). According to Orgill *et al*., (2021), it is often noted that the administrative capacity for DHS is inadequate and needs to be strengthened across the board. The DHS is recognized as a critical decentralized foundation for a well-functioning system focused on PCH (Orgill *et al*., 2021). Reasons for decentralizing decision-making include better coordination of different interventions, increased use of local expertise, and more accountability, all to improve equity, responsiveness, efficiency, and quality of health care (Orgill *et al*., 2021).

Notably, change on the health front lines cannot be brought about by only writing legislation, nor will it solve the deep-seated flaws in the health system. This analysis supports the argument that a top-down approach from the government must complement the bottom-up approach (Schneider, van der Merwe, Marutla, Cupido, and Kauchali, 2019). In this way, the involvement of all key stakeholders in a well-coordinated environment can enable more effective collaboration in improving population health outcomes. This can also be achieved through the co-production of appropriate recommendations for health care service delivery. Meaningful change requires systematic approaches that can directly affect change at the core of the health system (Schneider *et al*., 2019). Top-down reforms, such as those proposed in the NHI bill, must be accompanied by a bottom-up process to strengthen health systems (Schneider *et al*., 2019). This requires a focus on the most decentralized level of the health system, the DHS.

Studies by Schneider *et al*., (2019) suggest that coordinated action by CHWs, and other local, provincial, and government representatives with available resources, could lead to rapid improvements in health district performance, resulting in lowered mortality rates in acute child malnutrition. The government can learn much from the Gert Sibande health district case study in the Mpumalanga province in South Africa (Schneider *et al*., 2019). This may be relevant as the findings in reducing acute child malnutrition in the Gert Sibande district were a result of coordination, communication, and accountability without any substantive budget allocation to affect change in the district. This means that a rapid change in the way DHS operates may not require a large appropriation of funds from state coffers. It is often the simplest tasks, such as

coordination, transparent communication, and collaboration, that can make a big difference in health service delivery, even in the most challenging environments. The DHS was fundamentally created with the main objectives of involving community members in decision-making, addressing local needs, reducing inefficiencies in service delivery, and shifting the focus from managing health services to improving health and care at the local level.

Table 1 District Management Team core responsibilities in South Africa

- Identification of client and stakeholder needs
- Identification of critical health and systemic challenges and understand source of the challenges
- Take decisions and set priorities (public health interventions)
- Balance competing demands by taking decisions on key District Actions, which respond to key priorities, client and stakeholder needs and challenges
- Allocate resources (time from personnel, goods and services and capital costs). Ensure that capacities are matched with planned Actions. Refine the Actions until the allocated resources meet the Actions
- Monitor and reflect on progress against plans
- Strengthen processes where necessary (to implement the plan)

Table 1: District Management Team core responsibilities in South Africa (South Africa National Department of Health. District Health Planning and Monitoring Framework, 2017; Orgill *et al*., 2021)

Table 1 is by the responsibilities of a district management team and may assist in the conceptualized alignment with the bottom-up approach for the implementation of the NHI bill. This study recognizes that change on the health front lines cannot be brought about by only drafting legislation, nor will it solve the deep-seated flaws in the system. Meaningful change requires systematic approaches that can directly affect change at the core of the health system. Top-down reforms, such as those proposed in the NHI bill, must be accompanied by a bottom-up process to strengthen health systems (Schneider *et al.,* 2019. This requires a focus on the most decentralized level of the health system, the DHS. Studies conducted by Schneider *et al.,* (2019) have shown how coordinated action by local, provincial, and government representatives with available resources can lead to relatively rapid improvement in health district performance. The government can learn much from the case study as South Africa prepares to implement NHI.

Sustainability:

This analysis also points out that the success of NHI is highly dependent on qualified health workers. Without a highly motivated health workforce with recognized qualifications to deliver

health services, the overall quality of care could be compromised. Therefore, while the NHI is seen as a matter for the Department of Health (DoH), much of the successful implementation of the NHI may depend on other departments such as the Department of Social Development (DSD) and the Department of Higher Education and Training (DHET). Against this background, this analysis argues that the NHI represents an opportunity to increase the number of medical schools in the country. Normally, matters related to higher education and training, such as medical schools and public universities, fall under the jurisdiction of the DHET, not the DoH. Similar to how the DSD has its set of objectives, its developmental goals are consistent with those of health and higher education because its primary objective is to develop society. Notably, these other variables are external to the health system. A complex system is an open system. As a result, complex systems are influenced by external variables. Policies, guidelines, and actions of other sectors such as agriculture, food, housing, communications, and transportation all have a direct impact on health service outcomes and therefore create an atmosphere for collaboration between the various departments towards service delivery in health.

Empowerment:

This analysis also suggests the need for updates in the education curriculum to meet the health needs of the country. According to Shay (2017), South Africa's higher education system will not be able to achieve its policy goals of equity in access and outcomes if it continues to grow without concurrent investments in teaching and learning. In the same way, South Africa will also fail to meet the WHO's Health Workforce Education and Production goals, which envision improved relevance, quality, and capacity of health professions training programs to produce appropriately skilled professionals who can build the health system (see figure 4).

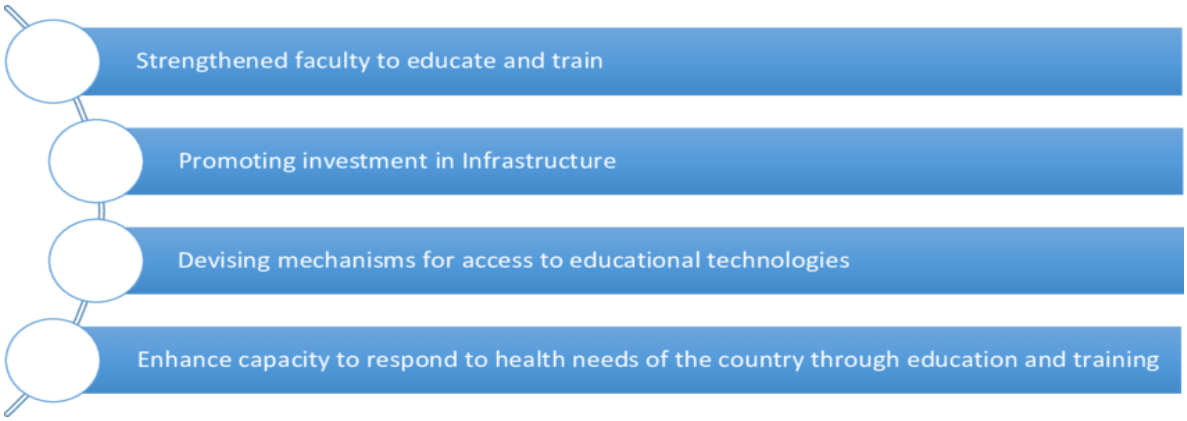


Figure 4: WHO's Health Workforce Education and Production Strategies (Van Staden, 2021)

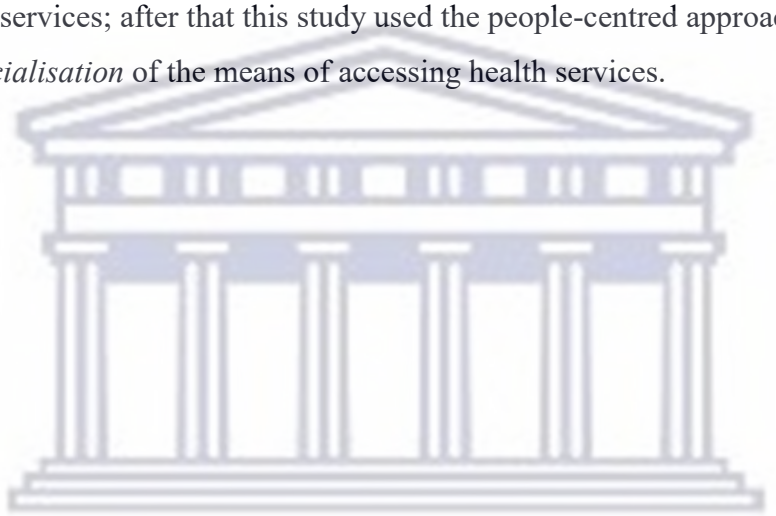
Figure 4 presents goals that are essential for health service delivery and highlights the need to enhance capacity to respond to the health needs of the country through education and training. Studies argue that medical student education should be tailored to the changing needs of the health system (Frenk, *et al*., 2010). These findings also suggest the qualities of medical school graduates must match the competencies and attitudes needed to address priority health needs (Frenk *et al*., 2010) including the needs and rights of vulnerable groups such as women asylum seekers and refugees.

In a South African context, updated research should be conducted on the fault lines in the health system, social determinants of health for women, and the quadruple burden of diseases to equip future health graduates. In this way, the health graduates are skilled and prepared to accurately address the health concerns that are influenced by the complexities of the environment. In addition, the creation of blended learning access mechanisms has become necessary due to the COVID-19 pandemic and the need for distance learning.

This analysis further emphasizes the need to include women's social determinants of health in policymaking, because many factors that affect health and disease exist outside the health domain. Public health professionals must be aware of the consequences of societal variables that affect women's health or that restrict access to health-promoting services for women. To better understand how humans live it is important to consider their environment. Living conditions, nutrition, education, employment, income, and social class are just a few examples of the factors that influence health in society, its distribution, and the emergence of inequalities. The role and importance of good governance are particularly relevant to any healthcare reform bill. This analysis argues that addressing leadership, management, and administrative deficiencies requires political will; meritocratic appointment of public service leaders with the requisite skills, competencies, ethics, and value systems; effective administration at all levels of the health system to enforce laws; appropriate management systems; and citizen involvement and advocacy to hold public officials accountable. Good governance could benefit not only women's health but also the health of the population as a whole. According to this view, poor governance and corruption deny healthcare users access to quality healthcare, further compromising them.

5.2 Conclusion of the analysis

In favour of achieving Universal Health Coverage (UHC) for all through the introduction of the NHI system, this study explored to what extent the current NHI bill recognizes access to health services for women who are asylum seekers and refugees. Furthermore, this study made a case for the *socialisation* of the means of accessing health services in a South African context. This study employed the doctrinal legal research (DLR) method to: (i) delineate the extent to which the current NHI bill recognizes access to health services for women who are asylum seekers and refugees; the complexity theory was used to (ii) examine the complex relationship between the private health sector and public health sector in the context of accessing health services; after that this study used the people-centred approach to (iii) make a case for the *socialisation* of the means of accessing health services.



CHAPTER SIX:

CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

The main research question of this chapter, which was to determine whether the current National Health Insurance (NHI) bill recognizes access to health services for women who are refugees and asylum seekers, is answered based on the results of the study. Conclusions were drawn from the study's objectives, research questions, and findings. The implications of these findings and the resulting recommendations are also explained. The results of the study formed the basis for the recommendations.

6.2 Overview of the Study Chapters

This study was divided into six chapters:

Chapter One: An introductory chapter, explaining the background and contextualization of the study; the contextualization of the NHI; the significance of the study; the theoretical and conceptual framework; an introduction to the complexity theory approach; the problem statement, the research questions; the aims and objectives; the research design; the research methodology; the data collection; the data techniques; the data analysis; the inclusion criteria; the search strategy for the identification of studies; the rigor in research; the limitations of the study; the ethical considerations; the tentative chapter outline and conclusion of the chapter.

Chapter Two: Discussed a review of the literature. Chapter two included a brief historical overview on the apartheid era; governance of the health system during apartheid; access to private medical aid during apartheid; an overview of the health system in South Africa post-apartheid; the two-tier health system; the public health sector; the private health sector; criticisms of private health sector; inequities in health care financing in South Africa; austerity measures on health care; The "quadruple burden of disease" in South Africa; migration and health care; fault lines in transforming the health system in South Africa; government intervention through the National Health Insurance (NHI); the adoption of the NHI bill [B 11 - 2019] in the National Assembly; the possible impact and implication of the National Health Insurance (NHI) bill; COVID-19 pandemic impact on South Africa's health system; health system strengthening; district health system (DHS) towards a bottom-up approach to health care; the role of community health workers in health care strengthening; invest in health professions education for health system strengthening; health education reform and conclusion.

Chapter three: Mainly focused on presenting the theoretical framework. This chapter included an introduction to the chapter and discussed the following; background on the systems thinking; rationale for rejecting the systems thinking approach; the limitations of systems thinking; a background on the people-centred development (PCD) approach including its main tenants; the limitations of PCD; the rationale for adopting the PCD approach; a background of the complexity theory; the limitations of complexity theory; the rationale for adopting the complexity theory; a background on the doctrinal legal research (DLR) method; the limitations of the DLR method; the rationale for adopting the DLR method and the meaning of socialisation in health services.

Chapter Four: This chapter addressed the methodology. This chapter discussed the following: What is research methods and methodology; the definition of research; the characteristics of research design; explorative study, descriptive study, and causal study; explorative study; descriptive study; causal study; research process; research strategy; choice of research methodology i.e. quantitative, qualitative, mixed methods; time horizon; population; target population sampling population; measuring instrument; secondary research; interviews; questionnaires; validity and reliability of the measuring instrument; pretesting; pilot study; types of data sources; data collection process; ethical consideration; informed consent; anonymity and confidentiality; data analysis procedure; statistics and conclusion of the chapter.

Chapter Five: This chapter provided the results/analysis of the study's aims and objectives which was (i) To explore the extent to which the current NHI bill recognizes access to health services for women who are asylum seekers and refugees; (ii) To examine the complex relationship between the private health sector and the public health sector in the context of accessing health services and; (iii) To theorize what the *socialisation* of accessing health services would look like from a policy perspective.

Chapter Six: The sixth and final chapter of the study provided the researcher's conclusions and recommendations on the research topic of the study.

6.3 Recommendations

The Department of Health (DoH) should consider the following recommendations based on the findings of this study to achieve Universal Health Coverage (UHC) for all, including asylum seekers and refugees, through the implementation of the National Health Insurance

(NHI) in line with the National Development Plan 2030. The main recommendations of this study are as follows:

Recommendation 1

It is recommended that section 4 of the current NHI bill be amended through the legislative authority of the National Council of Provinces (NCOP) to expand universality and ensure that women who are asylum seekers and refugees are included and recognized as persons who are deserving of health benefits under the NHI system. This can be achieved if six of the nine provincial legislatures decide not to pass the NHI bill in its current iteration, and instead amend the bill for further consultation and public hearings. This study therefore recommends that the current NHI bill be amended to allow broader access to NHI services, including access to basic health services and any health services that asylum seekers and refugees may need. This is because the right to health care for asylum seekers and refugees is protected and legally binding under the South African Constitution and through South Africa's membership in the United Nations Human Rights Council (UNHRC).

Recommendation 2

This study also recommends that section 5 of the NHI bill needs to change the requirements for registration as a user of the NHI Fund. The NHI bill must allow users to register for NHI membership including refugees and asylum seekers. Financially challenged women who require legal protection find it difficult to secure the necessary documentation due to the increased expense of getting and renewing permits. Therefore, efficient processes might need to be developed. Efficient processes may include registering for NHI membership at the nearest health facilities in South Africa or using mobile trucks to assist in reaching out to people in remote areas to capture asylum seekers' and refugees' details.

Recommendation 3

The NHI bill must make provision to include HIV/AIDS as a notifiable medical condition because of its prevalence as a medical condition as well as provide access to antiretroviral therapy (ART) for HIV-positive persons. If ART is not covered by NHI, it is logical to expect that HIV-positive women who are asylum seekers or refugees will have to pay for ART in South Africa upfront. This study explained in its findings that HIV-positive women may have to pay for a service and treatment (ART) that is already available for free inside public health facilities. If they cannot afford to pay in advance, they may be refused health service, and their health may deteriorate, leading to mortality.

Recommendation 4

The Department of Justice and Constitutional Development (DoJ and CD) and the Department of Health (DoH) need to work with other departments and civil society groups to gather accurate information to dispel misconceptions and disinformation about asylum seekers and refugees that are aimed at promoting medical xenophobia in South Africa. This is because the promotion of medical xenophobia is not only politically incorrect and illegal in South Africa, but also a traumatic experience for the victims of such discrimination and extremely destructive as it creates a sense of fear among South Africans towards people from other countries. This study, therefore, recommends that all relevant stakeholders, including community members, health workers, government agencies, migration authorities, researchers, civil society groups, and international organizations such as the UNHR, need to develop a holistic approach to co-producing solutions to eliminate medical xenophobia. Active citizenry and participation through co-production in resolving medical xenophobia allow for productive human relations to lay down a foundation for long-term systemic change. An example of how this can be done is through shaping nation-building initiatives and programs that promote inclusivity, diversity, and human rights. This can be done through public campaigns centred on not only citizen's rights but the rights of asylum seekers and refugees.

Recommendation 5

This study recommends that the public health system must be strengthened by directing additional expenditure of South Africa's GDP for health to the public health sector instead. Therefore, this study supports the introduction of the NHI into the health system as a way to strengthen the public health sector. By building capacity and an efficient health system, the realization of the right to health services could create an environment where the government no longer needs to heavily subsidize the private health sector to fulfil this government function. One of the main reasons that the government subsidizes the private health sector is to provide health services to government employees as an employee benefit and to avoid placing an extra burden on the already strained public health system. Government employees are critical to the delivery of goods and services, so subsidizing the private health sector to support this government function is justified for the health and productivity of government workers. However, if the government redirects the majority of the health expenditure budget to fund the public health system, there may be no need to subsidize the private health sector to service government employees because the public health system could deliver similar quality of health care that is available in the private health sector.

Recommendation 6

This study recommends that the public health system must be strengthened by directing an increased percentage of South Africa's Gross Domestic Product (GDP) for health to the public sector instead of subsidizing the private health sector to provide health services to less than 19% of the population that uses the private health services. Therefore, this study supports the introduction of the NHI into the health system as a way to strengthen the health system. Through building capacity and an efficient public health system, the government would no longer rely heavily on the private health sector to fulfil this government function.

6.4 Conclusion

This study found that the NHI bill in its current iteration undermines universal health coverage (UHC) for women asylum seekers and refugees. The findings of the study show that women asylum seekers and refugees will be affected. Therefore, the NHI bill should be amended to include this vulnerable group, of which women constitute a large proportion, to realize UHC for all. The NHI bill also needs to include HIV/AIDS as a notifiable medical condition because it is a widespread disease. Another limitation of the analysis is that the various restrictions on access to health services for other vulnerable groups under the current NHI bill were not described.

Thus, the findings argue that the introduction of NHI in the health system should aim to protect people from social determinants, gender constructs, and the financial costs that determine their access to health services. For this reason, the study advocates for the introduction of NHI into the health system to provide broader access to a basic human right. The study also found that the NHI bill needs to be amended before presidential enactment to ensure universal health coverage (UHC) for women who are asylum seekers and refugees. Going forward, the bill will be submitted to the South African President for approval once it has passed both the National Assembly (NA) and the National Council of Provinces (NCOP). It becomes official law when signed by the President and constitutes an Act of Parliament.

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ANNEXURE A: CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA BILL OF RIGHTS SECTION 27 (Source: The Constitution of the Republic of South Africa, 1996).

of past racial discrimination, provided that any departure from the provisions of this section is in accordance with the provisions of section 36(1).

(9) Parliament must enact the legislation referred to in subsection (6).

Housing

26. (1) Everyone has the right to have access to adequate housing.

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right.

(3) No one may be evicted from their home, or have their home demolished, without an order of court made after considering all the relevant circumstances. No legislation may permit arbitrary evictions.

Health care, food, water and social security

27. (1) Everyone has the right to have access to—

(a) health care services, including reproductive health care;

(b) sufficient food and water; and

(c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

(3) No one may be refused emergency medical treatment.

Children

28. (1) Every child has the right—

(a) to a name and a nationality from birth;

(b) to family care or parental care, or to appropriate alternative care when removed from the family environment;

(c) to basic nutrition, shelter, basic health care services and social services;

(d) to be protected from maltreatment, neglect, abuse or degradation;

(e) to be protected from exploitative labour practices;

(f) not to be required or permitted to perform work or provide services that—

(i) are inappropriate for a person of that child's age; or

(ii) place at risk the child's well-being, education, physical or mental health or spiritual, moral or social development;

ANNEXURE B: NATIONAL HEALTH INSURANCE BILL [B 11 – 2019] PREAMBLE

- in terms of section 27(2) of the Constitution the State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the right of access to health care services;
- in terms of section 27(3) of the Constitution no one may be refused emergency medical treatment; and
- section 28(1)(c) of the Constitution provides that every child has the right to basic health care services;

AND IN ORDER TO—

- achieve the progressive realisation of the right of access to quality personal health care services;
- make progress towards achieving Universal Health Coverage;
- ensure financial protection from the costs of health care and provide access to quality health care services by pooling public revenue in order to actively and strategically purchase health care services based on the principles of universality and social solidarity;
- create a single framework throughout the Republic for the public funding and public purchasing of health care services, medicines, health goods and health related products, and to eliminate the fragmentation of health care funding in the Republic;
- promote sustainable, equitable, appropriate, efficient and effective public funding for the purchasing of health care services and the procurement of medicines, health goods and health related products from service providers within the context of the national health system; and
- ensure continuity and portability of financing and services throughout the Republic,

BE IT THEREFORE ENACTED by the Parliament of the Republic of South Africa, as follows:—

Sections

ARRANGEMENT OF ACT

1. Definitions

Chapter 1

PURPOSE AND APPLICATION OF ACT

2. Purpose of Act
3. Application of Act

Chapter 2

ACCESS TO HEALTH CARE SERVICES

4. Population coverage
5. Registration as users
6. Rights of users
7. Health care services coverage
8. Cost coverage

Chapter 3

NATIONAL HEALTH INSURANCE FUND

9. Establishment of Fund
10. Functions of Fund
11. Powers of Fund

ANNEXURE C: REFUGEES ACT 130 OF 1998

(a) invite the UNHCR representative to make oral or written representations;
(b) request the attendance of any person who is in a position to provide it with information relevant to the matter being dealt with;
(c) on its own accord make such further enquiry and investigation into the matter being dealt with as it may deem appropriate; and
(d) request the applicant to appear before it and to provide such other information as it may deem necessary.

(3) The Standing Committee—
(a) may confirm or set aside a decision made in terms of section 24(3)(b); and
(b) must decide on a question of law referred to it in terms of section 24(3)(d).

(4) The Standing Committee must inform the Refugee Status Determination Officer concerned of its decision in the prescribed manner and within the prescribed time.

(5) After the Standing Committee has decided a question of law referred to it in terms of section 24(3)(d), the Standing Committee must refer the application back to the Refugee Status Determination Officer with such directives as are necessary and the Refugee Status Determination Officer must decide the application in terms of the directives.

Appeals to Appeal Board

26. (1) Any asylum seeker may lodge an appeal with the Appeal Board in the manner and within the period provided for in the rules if the Refugee Status Determination Officer has rejected the application in terms of section 24(3)(c).

(2) The Appeal Board may after hearing an appeal confirm, set aside or substitute any decision taken by a Refugee Status Determination Officer in terms of section 24(3).

(3) Before reaching a decision, the Appeal Board may—
(a) invite the UNHCR representative to make oral or written representations;
(b) refer the matter back to the Standing Committee for further inquiry and investigation;
(c) request the attendance of any person who, in its opinion, is in a position to provide the Appeal Board with relevant information;
(d) of its own accord make further inquiry or investigation;
(e) request the applicant to appear before it and to provide any such other information as it may deem necessary.

(4) The Appeal Board must allow legal representation upon the request of the applicant.

CHAPTER 5

RIGHTS AND OBLIGATIONS OF REFUGEES

Protection and general rights of refugees

27. A refugee—
(a) is entitled to a formal written recognition of refugee status in the prescribed form;
(b) enjoys full legal protection, which includes the rights set out in Chapter 2 of the Constitution and the right to remain in the Republic in accordance with the provisions of this Act;
(c) is entitled to apply for an immigration permit in terms of the Aliens Control Act, 1991, after five years' continuous residence in the Republic from the date on which he or she was granted asylum, if the Standing Committee certifies that he or she will remain a refugee indefinitely;
(d) is entitled to an identity document referred to in section 30;
(e) is entitled to a South African travel document on application as contemplated in section 31;

(f) is entitled to seek employment; and
(g) is entitled to the same basic health services and basic primary education which the inhabitants of the Republic receive from time to time.

ANNEXURE D: NATIONAL HEALTH INSURANCE BILL [B 11 – 2019] SECTION 4 AND 5

(5) The Competition Act, 1998 (Act No. 89 of 1998), is not applicable to any transactions concluded in terms of this Act.

Chapter 2

ACCESS TO HEALTH CARE SERVICES

Population coverage

4. (1) The Fund, in consultation with the Minister, must purchase health care services, determined by the Benefits Advisory Committee, on behalf of—

(a) South African citizens;
(b) permanent residents;
(c) refugees;
(d) inmates as provided for in section 12 of the Correctional Services Act, 1998 (Act No. 111 of 1998); and
(e) certain categories or individual foreigners determined by the Minister of Home Affairs, after consultation with the Minister and the Minister of Finance, by notice in the *Gazette*.

(2) An asylum seeker or illegal foreigner is only entitled to—

(a) emergency medical services; and
(b) services for notifiable conditions of public health concern.

(3) All children, including children of asylum seekers or illegal migrants, are entitled to basic health care services as provided for in section 28(1)*(c)* of the Constitution.

(4) A person seeking health care services from an accredited health care service provider or health establishment must be registered as a user of the Fund as provided for in section 5, and must present proof of such registration to the health care service provider or health establishment in order to secure the health care service benefits to which he or she is entitled.

(5) A foreigner visiting the Republic for any purpose—

(a) must have travel insurance to receive health care services under their relevant travel insurance contract or policy; and
(b) who does not have travel insurance contract or policy referred to in paragraph *(a)*, has the right to health care services as contemplated in subsection (2).

Registration as users

5. (1) A person who is eligible to receive health care services in accordance with section 4 must register as a user with the Fund at an accredited health care service provider or health establishment.

(2) *(a)* A person as contemplated in subsection (1), must register his or her child as a user with the Fund at an accredited health care service provider or health establishment.

(b) A child born to a user must be regarded as having been registered automatically at birth.

(3) A person between 12 and 18 years of age may apply for registration as a user if he or she is not registered as a user in terms of subsection (2).

(4) *(a)* A supervising adult as contemplated in section 137(3) of the Children's Act, 2005 (Act No. 38 of 2005), must register a child in the child-headed household concerned.

(b) If no adult has been designated in terms of section 137(2) of the Children's Act, 2005 (Act No. 38 of 2005), any employee of an accredited health care service provider or health establishment must assist the child to be so registered.

(5) When applying for registration as a user, the person concerned must provide his or her biometrics and such other information as may be prescribed, including fingerprints, photographs, proof of habitual place of residence and—

(a) an identity card as defined in the Identification Act, 1997 (Act No. 68 of 1997);
(b) an original birth certificate; or
(c) a refugee identity card issued in terms of the Refugees Act.

(6) The Minister, in consultation with the Minister of Home Affairs, may prescribe any further requirements for registration of foreign nationals contemplated in section 4(1)*(e)*.

"emergency medical services" means services provided by any private or public entity dedicated, staffed and equipped to offer pre-hospital acute medical treatment and transport of the ill or injured;

"financial year" means a financial year as defined in section 1 of the Public Finance Management Act;

"Formulary" means the Formulary and its composition referred to in section 38(4);

"Fund" means the National Health Insurance Fund established by section 9;

"health care service" means—

(a) health care services, including reproductive health care and emergency medical treatment, contemplated in section 27 of the Constitution;

(b) basic nutrition and basic health care services contemplated in section 28(1)*(c)* of the Constitution;

(c) medical treatment contemplated in section 35(2)*(e)* of the Constitution; and

(d) where applicable, provincial, district and municipal health care services;

"health care service provider" means a natural or juristic person in the public or private sector providing health care services in terms of any law;

"health establishment" means a health establishment as defined in section 1 of the National Health Act;

"health goods", in respect of the delivery of health care services, includes medical equipment, medical devices and supplies, health technology or health research intended for use or consumption by, application to, or for the promotion, preservation, diagnosis or improvement of, the health status of a human being;

"health related product" means any commodity other than orthodox medicine, complementary medicine, veterinary medicine, medical device or scheduled substance which is produced by human effort or some mechanical, chemical, electrical or other human engineering process for medicinal purposes or other preventive, curative, therapeutic or diagnostic purposes in connection with human health;

"health research" means health research as defined in section 1 of the National Health Act;

"hospital" means a health establishment which is classified as a hospital by the Minister in terms of section 35 of the National Health Act;

"Immigration Act" means the Immigration Act, 2002 (Act No. 13 of 2002);

"mandatory prepayment" means compulsory payment for health services before they are needed in accordance with income levels;

"medical scheme" means a medical scheme as defined in the Medical Schemes Act;

"Medical Schemes Act" means the Medical Schemes Act, 1998 (Act No. 131 of 1998);

"medicine" means medicine as defined in section 1 of the Medicines and Related Substances Act, 1965 (Act No. 101 of 1965);

"Minister" means the Cabinet member responsible for health;

"National Health Act" means the National Health Act, 2003 (Act No. 61 of 2003);

"national health system" has the meaning ascribed to it in section 1 of the National Health Act;

"Office of Health Standards Compliance" means the Office of Health Standards Compliance established by section 77 of the National Health Act;

ANNEXURE F: NATIONAL DEPARTMENT OF HEALTH REVENUE DIRECTIVE- REFUGEES/ ASYLUM SEEKERS WITH OR WITHOUT A PERMIT (PAGE 1)

DEPARTMENT OF HEALTH
DEPARTEMENT VAN GESONDHEID
Private Bag X828
PRETORIA, 0001

Republic of South Africa

UMNYANGO WEZEMPILO
LEFAPHA LA MAPHELO
Privaatsak X828
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Faks/Fax : (012) 312-0759
Telefoon/Telephone : (012) 312-0550
Navrae/Enquiry : Ms. U Le Roux/ x0550
Verw/Reference : BI 4/29 REFUG/ASYL 8 2007

REVENUE DIRECTIVE- REFUGEES/ ASYLUM SEEKERS WITH OR WITHOUT A PERMIT

To: PROVINCIAL HEALTH REVENUE MANAGERS
HIV/AIDS DIRECTORATES

19TH SEPTEMBER 2007

Dear All

HOSPITAL FEES: ASSESSMENT OF REFUGEE / ASYLUM-SEEKERS (with or without a permit)

Preamble

REFUGEE ACT, Act No. 130 of 1998 (Chapter 5; Section27, (g))

RIGHTS AND OBLIGATIONS OF REFUGEES (Protection and general rights of refugees)
27. A refugee-
(g) Is entitled to the same basic health services and basic primary education which the inhabitants of the Republic receive from time to time.

To avoid contravening patients rights, as precepts to the Constitution (section 27 (3)) and the Refugee Act: **Act No. 130 of 1998 (Chapter 5; Section27, (g))**

1. **Where refugee status have been determined or asylum seekers with or without a permit:**

1.1. Basic Health Care:

1.1.1 Refugees / asylum seekers **with or without a** permit that do access public health care shall be assessed according to the current MEANS test. (as specified in the Annexure H).

ANNEXURE G: NATIONAL DEPARTMENT OF HEALTH REVENUE DIRECTIVE- REFUGEES/ ASYLUM SEEKERS WITH OR WITHOUT A PERMIT (PAGE 2)

1.2. Anti-retroviral treatment (ART)

1.2.1 Refugees / asylum seekers **with or without a** permit that do access public health care, shall be exempted from paying for ART services irrespective of the site or level of institution where these services are rendered. ***(Please refer to the ART directive: BI/429/ART dated the 20th April 2007).***

2. Full paying patients:

2.1 The following full-paying patients **are excluded** from free services (basic Health Care and ART) irrespective of the level of care where the service is being rendered:

2.1.1. Refugees / asylum seekers whose income **exceeds** the prevailing means test shall be levied at the full paying UPFS.

2.1.2. Externally funded patients, including members of medical schemes registered in terms of the Medical Schemes Act, 1998 (ACT No. 131 of 1998).

2.1.3. Externally funded patients whose medical schemes **are not recognised** within the RSA scheme pool shall be charged as full paying patients (Self Funded), unless prior arrangements have been made.

2.1.4. Patients treated on account of other state departments, e.g. Compensation Commissioner (COID), SA Police Services, Department of Correctional Services.

2.1.5. Patients treated in state facilities by their **private medical practitioner.**

NB: The execution of this directive is with immediate effect.

Your co-operation would be appreciated.

MR. FG MULLER

CHIEF FINANCIAL OFFICER (CFO) (NDOH)

ANNEXURE H: NATIONAL HEALTH ACT (61/2003) OF 2017 DECLARATION OF NOTIFIABLE MEDICAL CONDITIONS (Source: NATIONAL HEALTH ACT (61/2003) OF 2017).

CHAPTER 2

Declaration of notifiable medical conditions

12. (1) The medical conditions listed in Annexure A, Tables 1, 2, 3 and 4 are herby declared to be notifiable medical conditions.

(2) The Minister, may declare, by Notice in the Government Gazette, a medical condition not listed in Annexure A, as notifiable if in his or her opinion the medical condition–

(a) poses a public health risk to a population of a particular community, district, municipality, province or the country;

(b) may be regarded as a public health risk or has a potential for regional or international spread; and

(c) may require immediate, appropriate and specific action to be taken by the national department, one or more provincial departments or one or more municipalities.

(3) The Minister may determine, by Notice in the Government Gazette, that–

(a) certain diseases or medical conditions be notifiable in certain provinces, districts or municipalities, for a period specified in the Notice or until the Notice is withdrawn;

(b) certain diseases or medical conditions be notifiable by certain categories of health care providers, pathologist or laboratory personnel; and

(c) specific diagnostic or laboratory criteria apply to specific diseases or medical conditions.

Notification and reporting process

13 (1) (a) A health care provider who diagnoses a patient with a notifiable medical condition listed in Annexure A, Table 1, must report the medical condition to the focal person at the health sub-district level by the most rapid means available upon diagnosis, even before the case is laboratory confirmed in order to facilitate the implementation of public health measures and response;

ANNEXURE I: NATIONAL HEALTH ACT (61/2003) OF 2017 TABLE 3 AND 4 NOTIFIABLE MEDICAL CONDITIONS Source: NATIONAL HEALTH ACT (61/2003) OF 2017).

Table 3: Category 3 notifiable medical conditions to be notified through a written or electronic notification to the Department of Health within 7 days of diagnosis by private and public health laboratories

	Notifiable medical condition	Pathogen/s to notify
1.	Gonorrhoea	Ceftriaxone-resistant Neisseria gonorrhoea
2.	Endemic arboviral diseases	West Nile virus, Sindbis virus, Chikungunya virus
3.	Non-endemic arboviral diseases	Dengue fever virus, other imported arboviruses of medical importance
4.	Non-typhoidal Salmonellosis	*Salmonella* spp. other than *S.* Typhi and *S.* Paratyphi
5.	Rubella	Rubella virus
6.	Shiga toxin-producing *Escherichia coli*	Shiga toxin-producing *Escherichia coli*
7.	Shigellosis	*Shigella* spp.

Table 4: Category 4 notifiable medical conditions to be notified through a written or electronic notification to the Department of Health within 1 month of diagnosis by private and public health laboratories

	Notifiable medical condition	Pathogen/s to notify
1	Health care-associated infections or multi drug-resistant organisms of public health importance*	• Carbapenemase-producing Enterobacteriaceae • Vancomycin-resistant enterococci • Staphylococcus aureus: hGISA and GISA • Colistin-resistant *Pseudomonas aeruginosa* • Colistin-resistant *Acinetobacter baumanii* • *Clostridium difficile*

*Health care-associated infection means an infection occurring in a patient during the process of care in a health establishment which was not present or incubating at the time of admission.

ANNEXURE J: CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA BILL OF RIGHTS; CHAPTER 2 SECTION 9 27 (Source: The Constitution of the Republic of South Africa, 1996).

CHAPTER 2
BILL OF RIGHTS

Rights

7. (1) This Bill of Rights is a cornerstone of democracy in South Africa. It enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom.
   (2) The state must respect, protect, promote and fulfil the rights in the Bill of Rights.
   (3) The rights in the Bill of Rights are subject to the limitations contained or referred to in section 36, or elsewhere in the Bill.

Application

8. (1) The Bill of Rights applies to all law, and binds the legislature, the executive, the judiciary and all organs of state.
   (2) A provision of the Bill of Rights binds a natural or a juristic person if, and to the extent that, it is applicable, taking into account the nature of the right and the nature of any duty imposed by the right.
   (3) When applying a provision of the Bill of Rights to a natural or juristic person in terms of subsection (2), a court—
      (a) in order to give effect to a right in the Bill, must apply, or if necessary develop, the common law to the extent that legislation does not give effect to that right; and
      (b) may develop rules of the common law to limit the right, provided that the limitation is in accordance with section 36(1).
   (4) A juristic person is entitled to the rights in the Bill of Rights to the extent required by the nature of the rights and the nature of that juristic person.

Equality

9. (1) Everyone is equal before the law and has the right to equal protection and benefit of the law.
   (2) Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed

ANNEXURE K: CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA BILL OF RIGHTS SECTION 10 27 (Source: The Constitution of the Republic of South Africa, 1996).

to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination may be taken.

(3) The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.

(4) No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3). National legislation must be enacted to prevent or prohibit unfair discrimination.

(5) Discrimination on one or more of the grounds listed in subsection (3) is unfair unless it is established that the discrimination is fair.

Human dignity

10. Everyone has inherent dignity and the right to have their dignity respected and protected.

Life

11. Everyone has the right to life.

Freedom and security of the person

12. (1) Everyone has the right to freedom and security of the person, which includes the right—
    (a) not to be deprived of freedom arbitrarily or without just cause;
    (b) not to be detained without trial;
    (c) to be free from all forms of violence from either public or private sources;
    (d) not to be tortured in any way; and
    (e) not to be treated or punished in a cruel, inhuman or degrading way.

(2) Everyone has the right to bodily and psychological integrity, which includes the right—
    (a) to make decisions concerning reproduction;
    (b) to security in and control over their body; and
    (c) not to be subjected to medical or scientific experiments without their informed consent.

ANNEXURE L: CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA BILL OF RIGHTS SECTION 74 (Source: The Constitution of the Republic of South Africa, 1996).

(4) Only a member or committee of the National Council of Provinces may introduce a Bill in the Council.

(5) A Bill passed by the National Assembly must be referred to the National Council of Provinces if it must be considered by the Council. A Bill passed by the Council must be referred to the Assembly.

Bills amending the Constitution

74. (1) Section 1 and this subsection may be amended by a Bill passed by—
- (a) the National Assembly, with a supporting vote of at least 75 per cent of its members; and
- (b) the National Council of Provinces, with a supporting vote of at least six provinces.

(2) Chapter 2 may be amended by a Bill passed by—
- (a) the National Assembly, with a supporting vote of at least two thirds of its members; and
- (b) the National Council of Provinces, with a supporting vote of at least six provinces.

(3) Any other provision of the Constitution may be amended by a Bill passed—
- (a) by the National Assembly, with a supporting vote of at least two thirds of its members; and
- (b) also by the National Council of Provinces, with a supporting vote of at least six provinces, if the amendment—
  - (i) relates to a matter that affects the Council;
  - (ii) alters provincial boundaries, powers, functions or institutions; or
  - (iii) amends a provision that deals specifically with a provincial matter.

(4) A Bill amending the Constitution may not include provisions other than constitutional amendments and matters connected with the amendments.

(5) At least 30 days before a Bill amending the Constitution is introduced in terms of section 73(2), the person or committee intending to introduce the Bill must—
- (a) publish in the national Government Gazette, and in accordance with the rules and orders of the National Assembly, particulars of the proposed amendment for public comment;
- (b) submit, in accordance with the rules and orders of the Assembly, those particulars to the provincial legislatures for their views; and

ANNEXURE M: CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA BILL OF RIGHTS SECTION 75 (Source: The Constitution of the Republic of South Africa, 1996).

(c) submit, in accordance with the rules and orders of the National Council of Provinces, those particulars to the Council for a public debate, if the proposed amendment is not an amendment that is required to be passed by the Council.

(6) When a Bill amending the Constitution is introduced, the person or committee introducing the Bill must submit any written comments received from the public and the provincial legislatures—
(a) to the Speaker for tabling in the National Assembly; and
(b) in respect of amendments referred to in subsection (1), (2) or (3)(b), to the Chairperson of the National Council of Provinces for tabling in the Council.

(7) A Bill amending the Constitution may not be put to the vote in the National Assembly within 30 days of—
(a) its introduction, if the Assembly is sitting when the Bill is introduced; or
(b) its tabling in the Assembly, if the Assembly is in recess when the Bill is introduced.

(8) If a Bill referred to in subsection (3)(b), or any part of the Bill, concerns only a specific province or provinces, the National Council of Provinces may not pass the Bill or the relevant part unless it has been approved by the legislature or legislatures of the province or provinces concerned.

(9) A Bill amending the Constitution that has been passed by the National Assembly and, where applicable, by the National Council of Provinces, must be referred to the President for assent.

Ordinary Bills not affecting provinces

75. (1) When the National Assembly passes a Bill other than a Bill to which the procedure set out in section 74 or 76 applies, the Bill must be referred to the National Council of Provinces and dealt with in accordance with the following procedure:
(a) The Council must—
(i) pass the Bill;
(ii) pass the Bill subject to amendments proposed by it; or
(iii) reject the Bill.
(b) If the Council passes the Bill without proposing amendments, the Bill must be submitted to the President for assent.

ANNEXURE N: CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA BILL OF RIGHTS SECTION 76 (Source: The Constitution of the Republic of South Africa, 1996).

(c) If the Council rejects the Bill or passes it subject to amendments, the Assembly must reconsider the Bill, taking into account any amendment proposed by the Council, and may—
  (i) pass the Bill again, either with or without amendments; or
  (ii) decide not to proceed with the Bill.

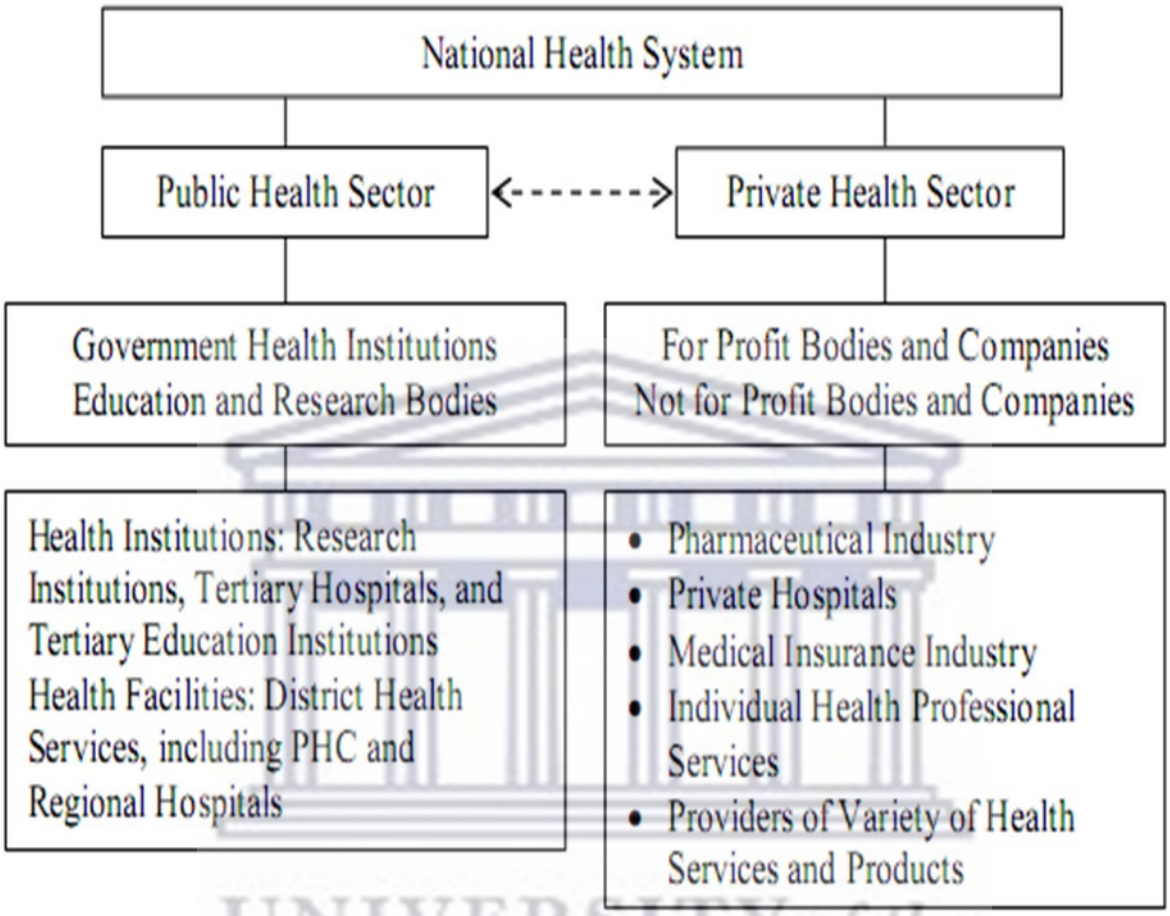
(d) A Bill passed by the Assembly in terms of paragraph (c) must be submitted to the President for assent.

(2) When the National Council of Provinces votes on a question in terms of this section, section 65 does not apply; instead—
(a) each delegate in a provincial delegation has one vote;
(b) at least one third of the delegates must be present before a vote may be taken on the question; and
(c) the question is decided by a majority of the votes cast, but if there is an equal number of votes on each side of the question, the delegate presiding must cast a deciding vote.

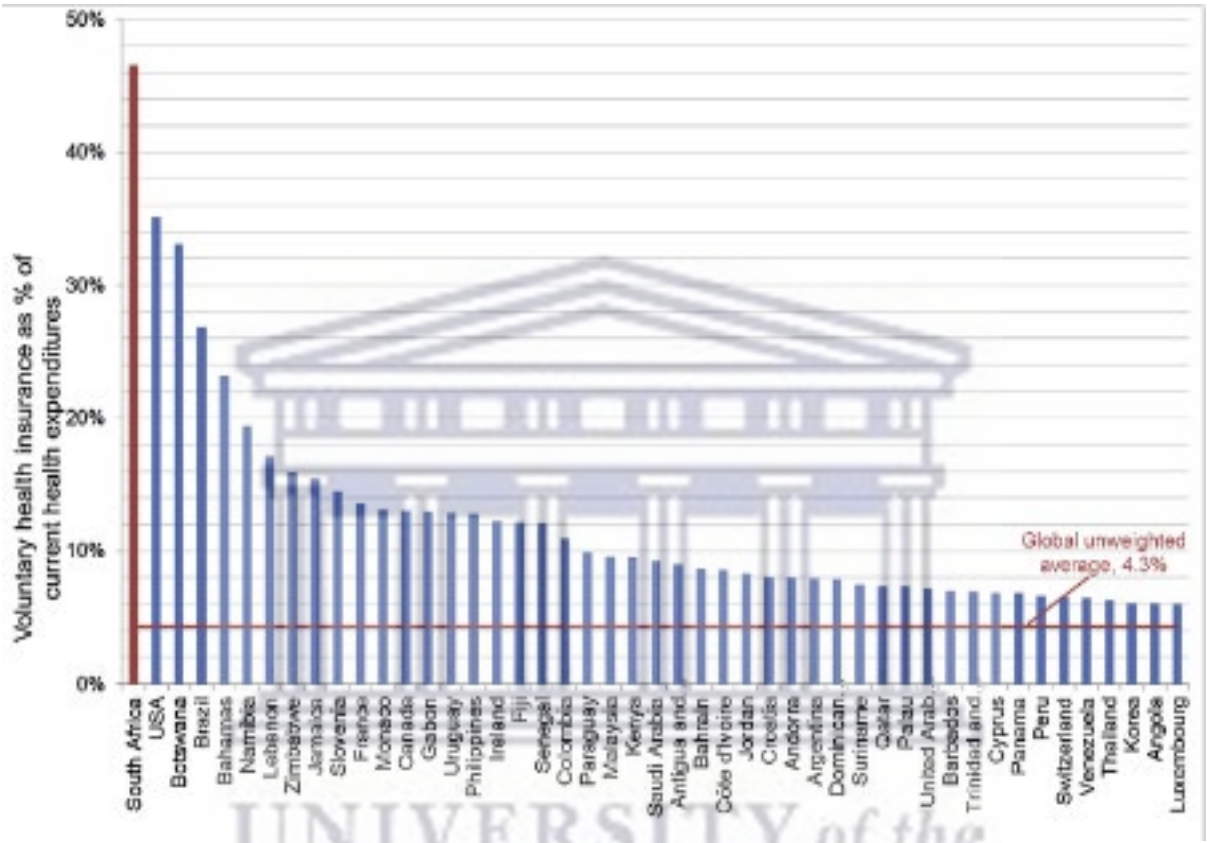
Ordinary Bills affecting provinces

76. (1) When the National Assembly passes a Bill referred to in subsection (3), (4) or (5), the Bill must be referred to the National Council of Provinces and dealt with in accordance with the following procedure:
(a) The Council must—
  (i) pass the Bill;
  (ii) pass an amended Bill; or
  (iii) reject the Bill.
(b) If the Council passes the Bill without amendment, the Bill must be submitted to the President for assent.
(c) If the Council passes an amended Bill, the amended Bill must be referred to the Assembly, and if the Assembly passes the amended Bill, it must be submitted to the President for assent.
(d) If the Council rejects the Bill, or if the Assembly refuses to pass an amended Bill referred to it in terms of paragraph (c), the Bill and, where applicable, also the amended Bill, must be referred to the Mediation Committee, which may agree on—

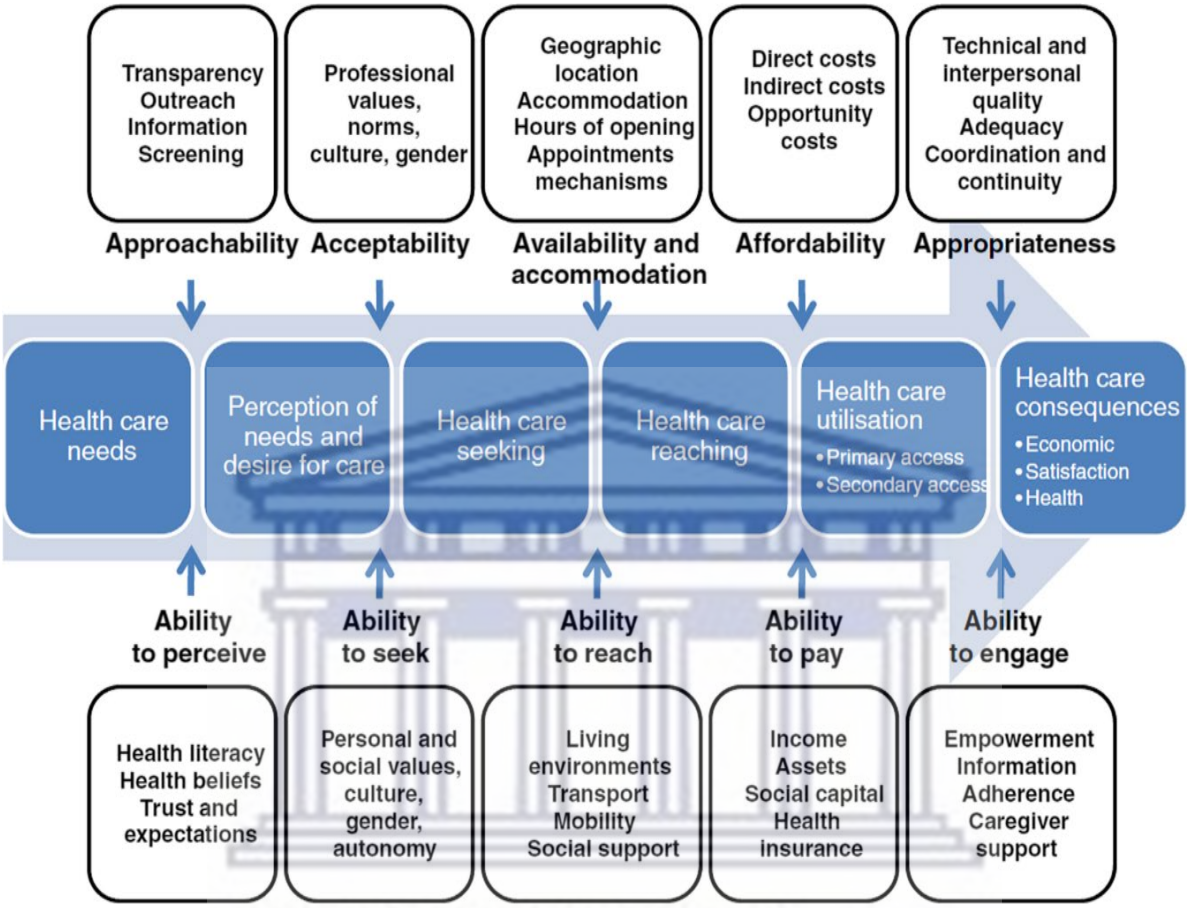
ANNEXURE O: Figure 1 Macro organization of the National Health System, Republic of South Africa (Source: Department of Health, 2006)



ANNEXURE P: Figure 2 Private voluntary health insurance (PVHI) represents a proportion of current health spending in countries with populations that exceed six million. (Source: Global Health Expenditure database, 2015)



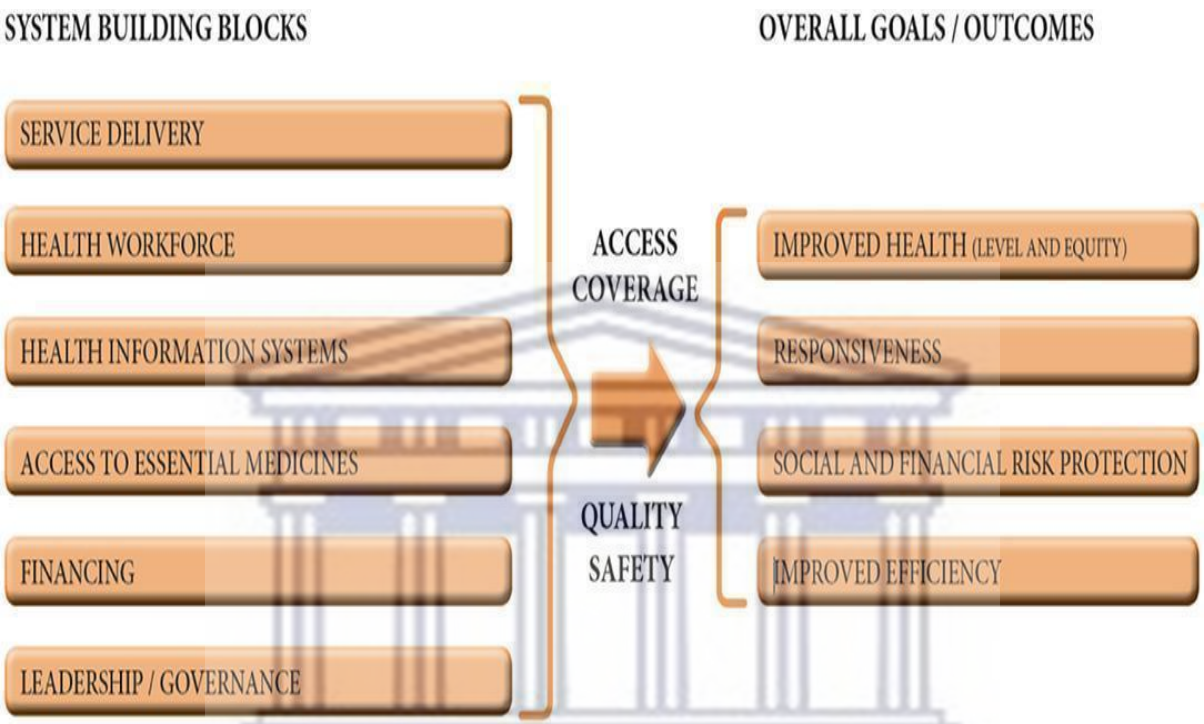
ANNEXURE Q: Figure 3 Levesque conceptual framework for health care access (Source: Cu, Meister, Lefebre and Ridde, 2021)



ANNEXURE R: Box 1: Fault lines in transforming the health system (Source: Rispel, 2016).

- Toleration of incompetence, poor management, and poor administration
- Primary health care (PHC) is primarily delivered through the district health system, which is not fully functional
- Inability or unwillingness to address health workforce shortages

ANNEXURE S: Figure 4 World Health Organization Health (WHO) System Building Blocks (World Health Organization, 2010. *Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies*. World Health Organization.



ANNEXURE T: Figure 5 WHO's Health Workforce Education and Production Strategies (Van Staden, D.B., 2021. Investing in health professions education: A national development imperative for South Africa. *South African Journal of Higher Education*, *35*(1), pp.231-245)

ANNEXURE U: Table 1 District Management Team core responsibilities in South Africa (South Africa National Department of Health. District Health Planning and Monitoring Framework, 2017; Orgill *et al*., 2021).

Table 1 District Management Team core responsibilities in South Africa

- Identification of client and stakeholder needs
- Identification of critical health and systemic challenges and understand source of the challenges
- Take decisions and set priorities (public health interventions)
- Balance competing demands by taking decisions on key District Actions, which respond to key priorities, client and stakeholder needs and challenges
- Allocate resources (time from personnel, goods and services and capital costs). Ensure that capacities are matched with planned Actions. Refine the Actions until the allocated resources meet the Actions
- Monitor and reflect on progress against plans
- Strengthen processes where necessary (to implement the plan)

APPENDIX 1: ETHICAL CLEARANCE LETTER

UNIVERSITY of the WESTERN CAPE

50 YEARS of hope, action & knowledge

28 September 2022

Ms G Oliver
Institute for Social Development
Faculty of Economics and Management Science

HSSREC Reference Number:	HS22/7/9
Project Title:	The National Health Insurance (NHI) and women: making the case for the socialisation of the means of accessing health services a policy perspective.
Approval Period:	**28 September 2022 – 27 September 2025**

I hereby certify that the Humanities and Social Science Research Ethics Committee of the University of the Western Cape approved the methodology, and amendments to the ethics of the above-mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

Please remember to submit a progress report by 30 November each year for the duration of the project.

For permission to conduct research using student and/or staff data or to distribute research surveys/questionnaires please apply via:
https://sites.google.com/uwc.ac.za/permissionresearch/home

The permission letter must then be submitted to HSSREC for record keeping purposes.

The Committee must be informed of any serious adverse events and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

NHREC Registration Number: HSSREC-130416-049

FROM HOPE TO ACTION THROUGH KNOWLEDGE.