1. **An abstract of 150 words of Prof Nkosi 's lecture.**

Title: **Narrowing the health gap for greater equity in health outcomes: The discourse around the NHI system in South Africa.**

Prior 1994 South Africa had a fragmented health system designed along racial lines. One system was highly resourced and benefitted the few and the other was under-resourced and was for the black majority. Attempts to deal with these disparities did not fully address the inequities.

The objective of the NHI is to address the inequalities by ensuring that all South African have access to affordable, quality healthcare services regardless of their socio-economic status. The majority of the participants do not understand the meaning and the implications of the national health insurance. Among the health professionals that were interviewed, there were no consultations before the implementation of the NHI. The health economists verbalized that it will be too expensive as the majority of citizens do not pay taxes. More roadshows need to be done to make communities aware of the planned strategy which will benefit all.

Narrowing the health gap for greater equity in health outcomes: The discourse around the NHI system in South Africa.

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1. Introduction

In the wake of recent worldwide calls for universal access to health latterly reinforced by our Health Minister Dr Aaron Motsoaleadi in Australia, what readily comes to mind is simple yet elegant definition of peace as the absence of war, poverty and disease. According to the World Health Organization (2007), the enjoyment of the highest attainable standard of health is one of fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. The government has a moral obligation to provide access to health care for all. Under Section 27 (1) and (2) of the South African Constitution of 1996, access to health care is a constitutional recognized right.

Health is a social, economic and political issue and, above all, a fundamental right. Health is a reflection of a society's commitment to equity and justice. Health and human rights should prevail over economic and political concerns. Inequality, poverty, exploitation, violence and injustice are at the root of ill-health and the deaths of poor and marginalized people (PHA, 2013).

2. Issues in the South African context

2.1. Burden of disease –The country is plagued by four health problems which have been dubbed the quadruple diseases. These are HIV/AIDS and TB, maternal, infant and child mortality, non-communicable diseases and injury and violence. It is claimed that the burden of disease in South Africa is, on average, four times larger than that of developed countries, and almost double that of developing countries. Life expectancy in South Africa has dropped from numbers very low due to the emerging burden of diseases (statistic) and there is insufficient progress towards the achievement of Millennium Development Goals (Rispel et al, 2011). A cursory look at the World Health Organization's health indicators

shows that life expectancy should be above 60 years. In South Africa, life expectancy is 56 years for males and 62 for females. In order to measure the success of South Africa, a comparison in terms of Brics and Rwanda gives a clear picture that our health outcomes are not in line with the budget that is allocated towards health. India and China are contributing less GDP towards health yet they are doing so well.The WHO study of 2004 revealed that for every 100,000 of the population, South Africa had 46,237 cases compared to Brazil with 20,112 cases and the United Kingdom with 11,012 cases. According to the WHO, in South Africa, in 2009, the mortality rate was 496 for every 1,000 adults, which a figure much higher than in most countries of the world.

Country	**Population**	**GDP**	**% Health**	**Ranking**	**Life expectancy**
Brazil	199 million	$2 695.9 bn	8.9%	57 **(1)**	76.2
Russia	143 million	$2.021.9 BN	6.2%	130 **(3)**	69.7
India	1.2 billion	$1.824.8 bi	3.9%	128	70
China	1.3 billion	$ 8.227 bn	5.2%	97 **(2)**	74.2
South Africa	**55 million**	**$384.3 bn**	**8.3%**	**159**	**62**
Rwanda	11.45 million	$7.10 billion	10.8%	163	60

Table 1: The WHO ranking according to life expectancy (2013) from www.who.int

2.2. Quality of health care – There are quality problems cited and experienced by the South African public visiting public health care facilities. These include uncleanliness, the lack of safety and security of staff and patients, long duration spent waiting for attention, cavalier attitudes of staff, poor infection control and drug stock shortage. This leads to the public preferring services in the private sector which are funded largely out of pocket and co-payments.

2.3. Distribution of financial and human resources - The mal-distribution of health care resources in the public and private sectors leads to the skewed redistribution of health care professionals in favour of the private sector. The average doctor-to-population ratio in the private and public sector is 55 doctors per 100,000. This average in developed countries is 280:100,000. South Africa lags behind other middle-income countries like Brazil, where the ratio is 185:100,000. The World Health Organization (2010) aggregates for 230:100,000. To illustrate this point, two provinces in South Africa, namely Gauteng and Limpopo provinces, provide a true reflection of mal-distribution, one being an urban setting and the other rural. The ratio in Gauteng is 102:100,000 while in Limpopo it is 17: 100,000. The ratio of patients to health professionals is lower in the private than in the public sector. The amount of money spent in the private health sector—all in the name of quality—in relation to the number of people covered defeats the principles of social justice and equity. Simply put, however much quality could be touted in the private sector, the profit-driven imperatives of that health provision environment will priotize shareholders above patients—contrary to the principles of justice and equity.

2.4. High cost of health care –The high cost of private health care is forever spiralling out of control, and is at the expense of medical aid members in the first and last instance. The cost of public health care is escalating at the expense of the fiscus; this means that health care is unaffordable for the poor (Government Gazette, 12 August 2011). In 1910 the government of the day decided to have separate developments which resulted in Group Areas Act and Homelands. Inherited inequalities due to the Apartheid system led to fragmentation of services, high health expenditure and poor health outcomes. Furthermore, an additional challenge lies in the fact that the roots of health inequalities are embedded in social conditions outside the health system's control. These inequalities have to be addressed through cross-government action. A fundamental step that a country can take to promote health equity is to move towards universal coverage. This means universal access to the full

range of personal and non-personal health services required with social health protection (World Health Report, 2008).

The Millennium Development Goals (MDGs)- The global health community has recognized that public spending on health in developing countries is essential in meeting the MDGs (Lu et al, 2010). The achievement of the MDG is a global indicator that the country is moving towards the positive direction in achieving the health outcomes. In South Africa, more work needs to be done as we are lagging behind in achieving our MDGs.

3. Tried and tested solutions in the South African context

The Primary Health Care approach was adopted by the ANC government from the onset of the democratic dispensation. Van Rensburg (2010) stated that the comprehensive health care system advocated an equity-oriented approach to health care and preventive and promotive health.

There are policies and programs that were implemented to improve the lives of all South Africans, namely, RDP, GEAR, ASGISA and now the National Development Plan (NDP).

Reconstruction and Development Programme (RDP)

The RDP is a socio-economic policy framework implemented by ANC government in the interest of intersectoral collaboration, aimed at addressing the many social and economic problems facing the country. A key aspect of the RDP was that it linked reconstruction to development.

In respect of Health care, the State was obligated to give free medical care to children under 6 years and to homeless children; improve maternity care for women; organize programs to prevent and treat major diseases like TB and AIDS. Unfortunately, this policy yielded less success because, due to privatisation without proper restructuring,structures were not in place to deal with such an overhaul of the health system.

Growth, Employment and Redistribution (GEAR)

It is an economic policy aimed at promoting growth through exports and investments and to promote redistribution through the creation of jobs and reallocation of resources (ANC, 1997). While significant progress has been made in education, health care, housing and providing basic services, poverty continues to be widespread, income disparities remain, unemployment is still high and many people lack basic necessities (Knight, 2001).

AsgiSA

Accelerated and Shared Growth Initiative for South Africa (**AsgiSA**) was launched by President Thabo Mbeki in 2006 with the aim to guide and improve on South Africa's economic growth. The initiative was intended to boost the economy to at least 4.5% and halve levels of poverty and unemployment by 2014. As much as there were positive outcomes, the distribution outcomes were skewed towards the few at the expense of the majority (Kearney& Odusola, 2011).

4. Definition of NHI

According to the Farlex Medical Dictionary (2012), the NHI is a health insurance program financed by taxes and administered by the government to provide comprehensive health care that is accessible to all citizens of the nation. The South African Department of Health defines the NHI as a financing system that will make sure that all citizens of SA and legal long-term residents are provided with essential health care, regardless of their employment status and ability to make monitory contributions to the NHI fund (DOH, 2012).Amod (2012) argued that for equitable redistribution to occur, those with higher incomes are expected to incur costs and those with low incomes should receive net benefit. That is the spirit of Ubuntu.

4.1National Health Insurance as a solution for South Africa

The South African Government thus needs to adopt an approach or strategy that will ensure universal access to healthcare. National Health Insurance is acknowledged as a Universal Coverage model by the World Health Organization. Universal health coverage (UHC) is defined as access to key, affordable, preventable, curative and rehabilitative health interventions for all (Shisana et al, 2006). A government that claims to provide UHC needs to establish that access to health services is available to the whole population for the full spectrum of services without risk of undue financial hardship (Allotey et al, 2012). The World Health Organization (WHO) considers health insurance a promising means for achieving universal health coverage (Spaan et al 2012).

The ANC-led government thus proposed National Health Insurance for South Africa (ANC National Polokwane Conference, 2007). The arrangements for universal coverage can be tax-based or organised through social health insurance. The idea is to pool pre-paid contributions which are collected on the basis of a person's ability to pay, and to use the funds to ensure that services are available, accessible and produce quality care for those in need, without exposing them to the risk of additional expenditure. The starting point should be to create or strengthen networks of accessible quality primary care services that rely on pooled pre-payment for their funding (World Health Report, 2008).

In South Africa, National Health Insurance (NHI) is intended to ensure that all citizens and legal residents will benefit from healthcare financing on an equitable and sustainable basis. It aims to provide coverage to the whole population and minimise the burden carried by individuals of paying directly out of their pockets for health care services (Government Gazette, 12 August 2011).

Four key interventions needed to take place simultaneously, in order to successfully implement a healthcare financing mechanism that covers the whole South African population and legal residents as the NHI, are as follows:

- A complete transformation of healthcare service provision and delivery
- The total overhaul of the entire healthcare system
- The radical change of administration and management

- The provision of a comprehensive package of care underpinned by a re-engineered Primary Health Care plan (Government Gazette, 12, August 2011).

4.2. Purpose for NHI: It is to improve and promote people's health, to protect them against the financial costs of illness by reducing out of pocket spending and to achieve some form of universal coverage (Shisana et al 2006). **The principles that will guide the National Health Insurance are:**

- The right of access to health care services.
- Social solidarity – the creation of financial risk protection for all, and subsidization between rich and poor, healthy and sick.
- Effectiveness - better performance of the health care system, contributing to positive health outcomes and value for money.
- Appropriateness - new and innovative health service delivery models tailored to respond to local needs.
- Equity - those with the greatest health needs are provided with access to services without barriers, and inequalities are minimized.
- Affordability - services will be procured at reasonable costs.
- Efficiency of administrative structures to minimise or eliminate duplication across all spheres. Minimal resources to be spent on the administrative structures of the NHI and value for money achieved (Government Gazette, 12 August 2011).

4.3. Objectives of NHI

- To improve access to quality health services for all South Africans, irrespective of whether they are employed or not
- To pool risks and funds so that equity and social solidarity will be achieved through the creation of a single fund
- To procure services on behalf of the entire population and effectively mobilise and control key financial resources

- To strengthen the under-resources and strained public sector so as to improve health systems performance

According to Amado et al, (2012), the implementation of NHI in South Africa is a noble attempt to address the inequities and scarcity of healthcare in the country. Its success is threatened by mismanagement of resources, corruption and poor quality institutions. Inequalities in the health system go well beyond the health sector usage burden to sector related challenges that prevent access to health service delivery. In this instance equity is compromised and the provision of health care is limited, having implications on access needed (Mack, 2011). The outcome of inequity in access to care is that there are many missed opportunities for early prevention and care, hence the NHI is designed to offer social protection in health so that no one will suffer financial burden because of illness (Shisana et al, 2006).

NHI is a financing system that will ensure that all citizens of South Africa and legal residents are provided with essential health care regardless of their employment status and ability to make a direct monetary contribution to the NHI fund (Ogunbanjo, 2013).

4.4. Challenges with empirical evidence for implementing NHI

1. Health economists anticipate that the NHI will be very expensive.
   "The NHI is expected to cost R128 billion in its first year and will increase to R 376 billion by 2025.Taxpayers will have to pay an extra R244 billion for NHI to work"
   "The funding required to fund the NHI at Basic Benefit Package (BBP) levels is a full R176 bn, a massive amount compared with budget income tax revenue of R206 bn"
   "The government will have to come up with an extra R165 bn-R244 bn a year, over and above the money it already spends on public health

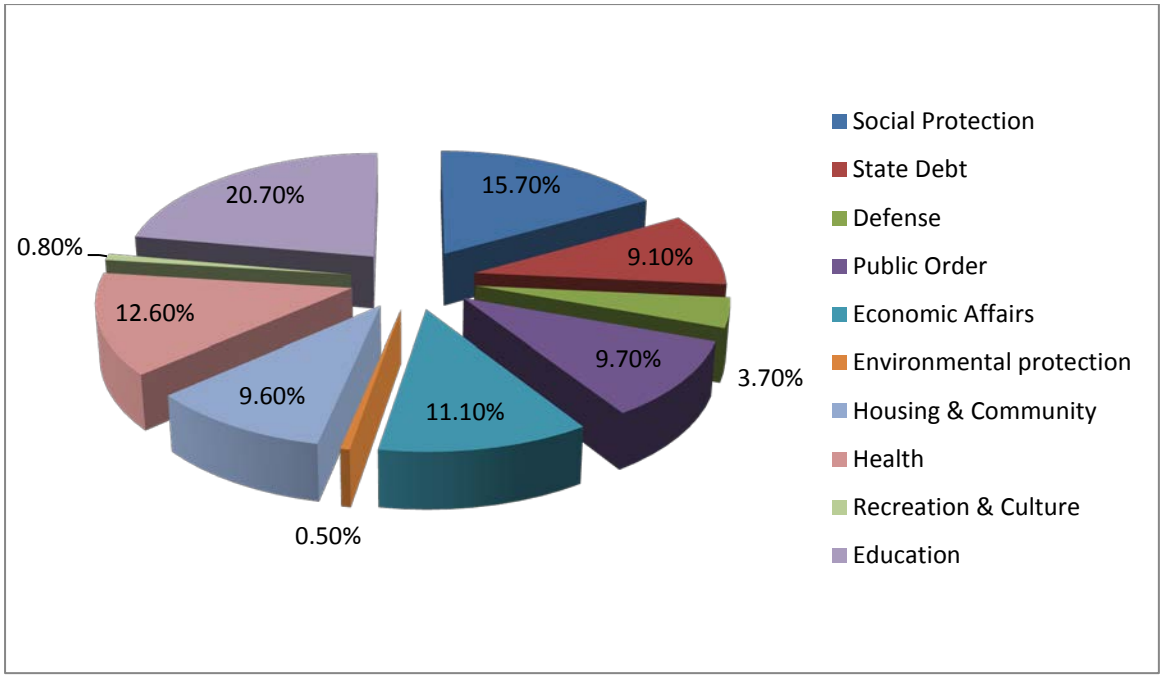

Figure 1: Budget allocation 2013/2014

There has been great improvement in allocation of budget on health as it is rated number 3. Education got a bigger slice (20.7%), followed by social protection (15.7%) and then health (12.6%) . In terms of monetary value R42 billion was allocated on HIV and AIDS and R145.7 billion allocated for health in the country. According to Shisana (2012), NHI would cost R128 billion by 2012 and R375 billion by 2025

2. Participants verbalized that there is mismanagement of resources as procurement policies are not adhered to

Procurement policies

One study participant said that*"… the delivery of care of health care system is not equal for example if I may quote. Here there are certain drugs that we do not receive, not any of them, and when we enquire they say it is because we are not at primary health level… When we*

are doing procurement we are told that we cannot have this one, we can have this one because I do not know if it is known by our department

- **High staff turnover**

"Although the government had tried with rural allowance, people keep moving in spite of that". This statement amplified the problem, identified by the participants, of staff moving away from rural hospitals and the hospitals' failure to retain its human resources. According to the World Health Organization and International Council of Nurse's norms, there must be 200 number of nurses per 100 000 population. In South Africa we are still way beyond the required number. There is a great need for the country to produce more nurses so as to meet the health demands of the country (See table2).

Community health workers (CHW)are the foundation of successful PHC systems; the proposed system in South Africa is to have 1 CHW for every 270 households which are extremely unlikely as we are having a high burden of disease and a large percentage of people requiring time consuming home care (PHM, 2013). We need at least 500, 000 CHW which will be translated to 500.000. X 270 so that 13 million people's lives can be saved.

Table 2: Future supply of nurses 2009-2015 (ECONEX reform note 2010)

Category	**2009**	**2010**	**2012**	**2015**
Projected output	**15,910**	**16,674**	**18,313**	**21,078**
Total registered with SANC	**221,817**	**231,363**	**251,852**	**286,422**
Total nurses actively working in SA	**181,890**	**189,718**	**206,518**	**234,866**
Nurses per 100000 population	**369**	**383**	**413**	**462**

- **Nurses and policy process**

Another participant clearly stated that *"we were not involved in the development of the policy but we were only told what to implement"*

> *"…anyway I do not know what the strategy...but I thought before they could start (with the NHI) they could visit a hospital"*. One participant confessed that she did not

know what the NHI policy contained but knew that it was good for the people as it was going to do away with inequality caused by classifying hospitals.

3. The Unemployment rate in South Africa increased to 25.2% from 24.10 % leading to a limited tax base. Only 3.3. million people pay 99% of all income tax in South Africa (Le Roux, 2013). This has led to a high demand for social grants. Out of 55 million people , 16 million are dependent on social grants (Statistics SA , 2013)
   What we should be asking is why, when we have 25% unemployment, fantasies like these are even on the drawing board?

   South Africa's small tax base can't bear the increased responsibility of meeting the health care needs of the entire nation.
4. Lack of leadership was identified as a challenge as health care workers were not involved in policy formulation and are thus uninformed aboutthe implementation of policy. Participants demonstrated that they have a limited understanding of NHI whereas NHI is nurse led.
   I am not sure about NHI because we are not involved as nurses
   Things are still the same; I do not see any difference
   I heard from the television that our district is one of the pilot sites and after that nothing from management
   I do not know that there are policy implementations in our institution. Things are still the same

5. The country is faced by the high level of corruption which is also evidenced in our health care service delivery. Drugs, equipment and other material resources are stolen from health service facilities. Supply chain management for procurement is poor, as a result of which tender systems are flawed. At the end of the day it is the ordinary citizen who suffers.
   A huge amount of money will be involved, how long before somebody starts putting their fingers in the till?

6. Lack of stakeholder engagement--this is meant to be a patient-centred, nurse driven policy. The community was not aware of the NHI at all.

   To be honest with you, I have no idea what NHI means----------I saw the information from television but I do not know how health service will be delivered (Participant1, teacher, male, 40 years)

   I have no clue at all (Participant 2, administrator, female, 30 years)

   What I know is that the government is trying to pull public and private health together so that the haves and the have nots will have equal access to health care services in the country (Participant 3, university student, female, 23 years)

   I do not understand what you are talking about (Participant 4, unemployed young adult, male, 35 years)

   I have never heard of the word, it's the first time I hear it and I do not know what it means (Participant 5, student, male, 21 years)

7. Litigation. The government is experiencing a high rate of litigations due to medical negligence. Medical negligence claims may threaten the viability of the NHI scheme due to high legal costs. All DOH are affected but KZN and Gauteng top the list as each have claims against them worth billions.

   Some of the claims by patients

   Hospital X in KZN: 1 million rand, post brain tumor surgery the drip was not monitored and he developed gangrene which led to the amputation of the thumb and index finger

   Hospital X IN Gauteng: 1million rand – HIV woman was sterilized against her will

   Mpumalanga: R5.8 million for loss of sight after childbirth

4.5. Lessons learned from other countries

GHANA

- The government is the main financier of health
- Abolish out of pocket payments

- Stronger political willingness
- All stakeholders were involved in the process of policy making

UK

- More money is allocated to health
- Eligibility is based on having permanent residence
- Payment of practitioners is done via capitation system (weakness)

THAILAND

- Financing for the health system is through general taxation
- UC entitles the population for a comprehensive package of outpatient, inpatient, EDL, ART & zero copayments
- Compulsory community service

KOREA

- Decentralization of the health care insurance
- Passed a law that mandated medical insurance in large firms
- Ensure balance of power between the state and civil society

4.6. NATIONAL DEVELOPMENT PLAN

Despite all the opponents, proponents and outcomes from the pilot sites, the national development plan is the latest policy that was implemented in 2013 to deal with some of the identified problems in the country. Only two topics that are relevant to NHI and delivery of health in the country will be discussed.

Topic 1 deals with the reduction of the burden of disease and deploying PHC teams to provide care to families and communities as everyone must have access to an equal standard of care regardless their income

Topic 2 deals with fighting corruption as a corruption –free society, a high adherence to ethics throughout society and government that is accountable to its people.

5. Way forward

South Africa's choice of health financing should be guided by how best it can achieve universal coverage given the current reality. Government has an important stewardship role in the major transformation process.

- The auditing of health facilities and reliable information will be the key to implementation of the NHI systems which aim to give everyone access to a minimum level of care (Abdool-Carim, 2014).
- Monitoring and evaluation using core standards. There should be clear distinction of Implementation vs outcomes
- Capacity building in leadership for nurses who are going to lead the implementation because NHI is patient-centred and nurse- driven
- Information , education and communication to enable the broadening of public discourse on critical policy issues
- Allocate more money for health so as to cover the NHI initiative. South Africa requires diverse revenue sources which will be robust enough to ensure medium to long-term sustainability e.g. PAYE, mandatory and voluntary prepayments, sin tax, a special levy on large and profitable companies. Avoid increases in VAT as it will further marginalize the poor.
- Re-engineering PHC which will help promote efficiency and sustainability of the NHI
- Increase the pool of skilled health workers who will deliver health services on an equitable level hence transformation and mainstreaming of nursing education
- Harmonise the relationship between public and private sector so as to allow more willingness , commitment and corporation
- There must be a policy champion with sufficient political power to sustain political reform process.

- The involvement of the grassroots organisations will help to create a needed civic movement that could prove pivotal in the progress towards implementation of the NHI
- There must be clear health care frameworks that define responsibilities, targets, modes of provision of care, financing and benefit packages.
- Regulate private sector pricing as the matter of urgency

6. IMPLICATIONS FOR NURSING EDUCATION IN THE COUNTRY

Preparation of students for training- post graduate diplomas- a highly skilled nurse who will be able to function in all spheres without compromising quality. The implementation of post graduate diplomas is introduced in line for the production of highly qualified nurses who will respond to the needs of the country. Health service delivery should ensure value for money by improving efficiency which is more important than generating resources.

7. In conclusion

The current health system in South Africa is unconstitutional, inefficient, not accessible and unequal and it undermines human dignity. The NHI policy is about building a social institution and healing a fragmented nation for a united country post-1994. Health services users need to be involved in processes and activities around planning, implementation, and accountability and performance improvement. The government should ensure that the principle of social solidarity prevails over market principles, that is, where the rich will contribute a percentage of their income to fund health services for the poor.

As President John F. Kennedy stated , " There are risks and costs to a program of action , but they are far less than the long –term risks and costs of comfortable inaction "

Phambili with Universal Health Coverage ----------Phambili

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1. **Two pages, biographical info about who I am?**

Zethu is the youngest daughter of the late Mr. John Nkosi & Mrs. Thandiwe MaShakhane Nkosi. She was born in Durban, KwaZulu –Natal and comes from a family of six. She was born, bred and brewed in Kwamashu Township. Zethu received all her basic education in KwaMashu Township and tertiary education at King Edward Nursing College, Iris Marwick College, University of South Africa and University of KwaZulu- Natal.

Prof Zethu Nkosi obtained her PHD in Nursing Management from the University of KwaZulu-Natal in 2009. Besides her nursing qualifications, she obtained a distinction in project management and Higher Education in South Africa certificate, through the University of Witwatersrand. She is more passionate about leadership and management issues in the workplace. Her research centers on health issues and staffing in the workplace.

Prof Zethu regards herself as hardworking as her Master's degree was sponsored by Kellogg's Foundation, her PHD by NRF, and Higher Education certificate by HESA and recently she will be off to the headquarters of ICN in Geneva, Switzerland for a Global Nurse Leadership Course sponsored by Burdett Trust.

Prof Nkosi's first teaching experience was in the United Arab Emirates, Middle East where she experimented practically about cultural diversity and how to be culturally competent. In 2004, 2006 and 2008 she was an exchange lecturer at the Hochschule Bremen, in Germany. She was also the coordinator for the UKZN-Bremen exchange programme for students and academics from both institutions. The international experience and exposure led her to be able to converse in Arabic and German.

Prof Zethu Nkosi has presented numerous academic papers in local and international conferences and has published 21 scientific papers in local and international peer- reviewed journals. Two doctoral and fifteen Masters and MPH students graduated under her supervision. Zethu's academic journey has led her to Australia, Botswana, Canada, Dubai, Germany, Ireland, Japan, Rwanda Singapore, Thailand, Turkey, United Kingdom and United States of America.

Prof Nkosi has written four chapters in three books. She is the reviewer for several local and international scientific journals. In 2011 she was invited by NRF to be a panelist in the final review of the NRF/DST projects. In 2012 she was invited by SAVIC **(S**outh **A**frican **V**accine **I**mmunization **C**entre) based at Medunsa to revamp the Extended Programme on Immunization (EPI) curriculum. In

2013 she participated in the development and validation of the prototype curriculum for the World Health Organization in the Africa region.

As South Africa is embarking on the new postgraduate diplomas for nurses, she was part of the team that was responsible for drafting the nursing management competences in the South African context and has also contributed a chapter in the book titled: "A new specialized nurse in South Africa"

As a health activist, she is an active member of People Health Movement, which is an organization that promotes and work towards the achievement of health for all through the process of awareness raising, capacity building and partnerships with other organisations.

Currently she is actively involved in two community projects, the innovative church leadership project and Thandolwethu peer based empowerment project.

An abbreviated CV of 2 double spaced typed pages

EDUCATIONAL QUALIFICATIONS

2009: Doctoral Degree (University of KwaZulu-Natal)

Title: Analysis of the relationship of leadership styles and organizational factors towards staff retention of professional nurses in public health facilities in KwaZulu-Natal

1998: Master's Degree in Nursing (University of KwaZulu- Natal)

Thesis: The Comparative study of professional competence of nurses who completed different bridging programmes

1998: Nursing Administration (UNISA)

1995: Bachelor's Degree (B CUR, majors Nursing Education and Community Health) University of South Africa

1992: Diploma in Psychiatric Nursing (Iris Marwick College)

1988: Diploma in General Nursing and Midwifery (King Edward College of Nursing)

WORK EXPERIENCE

January 2014 to date: Full Professor

February 2011 – December 2013: Associate Professor (UNISA)

2011: Senior Lecturer (UKZN)

2003 -2010: Lecturer and Academic Coordinator (UKZN)

2002- March 2003: Lecturer: Netcare Training Academy

1998 to 2001: **Lecturer**: United Arab Emirates

Nursing experience: Academic hospitals (King Edward V111 Hospital & Groote Schuur Hospital)

PUBLICATIONS x 21 accredited journals

Graduated Doctoral (2) and Masters (15) students

Contributed 4 chapters in 3 books

Presently involved with writing a finance book for nurse managers in South Africa

AWARDS

Scholarship to attend the Global Nurse Leadership Institute in Geneva , September 2014 sponsored by Burdett Trust (UK) for the International Council of Nurses

Scholarship by South African University of the people (2013) to attend a conference in Cape Town (December 2013)

Best Researcher in a lecturer category (2009) - College of Health Sciences (UKZN)

Best Journal article in ALASA (African Language Association of Southern Africa).**Nursing students' use of language in communicating with isiZulu speaking clients in clinical settings in KwaZulu-Natal** which appeared in SAJAL 28(2) of 2008.

Scholarship to attend the Higher Education certificate on Leadership& Governance by Higher Education in South Africa (HESA)

NRF recipient for PHD studies (2006-2009)

Master's degree UKZN funded by Kellogg's foundation (1997)

Involved in two Community Engagement Projects

2014: **Nkosi, ZZ. Thandolwethu,** Peer based empowerment project among the Orphaned Vulnerable Children in Durban (**R80 000.00**)

2013 -2014: **Nkosi, Z.Z**. & Mphuthi, D.D. Innovative church leadership. (Funded by the Community Engagement Office, CHS; **R80 000.00 + R70 000.00**)