The implementation of the National Health Insurance Pilot Program in the Tshwane District: Learning from Stakeholders in the Healthcare Sector

By

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Submitted in accordance with the requirements for the Degree of

Doctor of Philosophy

In the Subject of

Sociology

At the

University of South Africa

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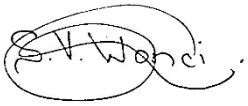
Plagiarism is unacceptable. This doctoral thesis is my own intellectual work. I have cited and referenced the intellectual contribution of other scholars in this work accordingly. I have not given my intellectual work in this doctoral thesis to anyone to present it as my own. There is no conflict of interest associated with this doctoral thesis.

Signature: 

Date: 12 December 2022

Acknowledgements

To my Mother, Mamqocwa, Jojo, Tiyeka, Zikhali, Butsolo bentonga, thank you for your unconditional love and prayers. There are a thousand different ways I could praise you. However, at this moment, I would love to borrow the lyrics of Simphiwe Dana from her song called "Umzali Wam". "Mama ungumnqweno endingayazi ukuba ndowufezekisa, uyinkululeko". The lyrics translate to "Mother, you are a dream; you are what freedom is to me". Thank you for instilling values of hard work, prayer, and kindness in our hearts. I have watched you for years, working hard as a domestic worker and a seamstress. You built our home and family in Pletternberg Bay with a strength of a migrant worker from Ciskei, Eastern Cape. You always taught me that we come from a family of nothing, and it is only through education that our family's dignity will be restored. I pray I have made half of your childhood and adulthood dreams a living reality today. This PhD is for you, Noluthando Mhamhana, Mamqocwa.

To my Father, Babini Belu, Khumalo, Zulu, Mntungwa thank you for leading us and protecting us with grace, kindness and love. You have taught me the values of hard work and consistency in prayer. Thank you for the political education and consciousness of wholeness. You taught us from a young age never to forget where we come from and to treat people with the mercy God bestows on us daily. There are not enough poems to capture how your love has shaped me. However, I always sing your favourite Anglican Hymn 197 to thank and honour you for all the days of my life.

The hymn goes:

Kuzo zonk' ingugungu

Zabo obubomi,

Eyam intliziyo yona

Yozukisa' uThixo.

The hymn translates to throughout life's trials and tribulations, my heart will always praise the Lord.

To my late brother Wonga Belu, thank you for carrying our family emotionally, psychologically, and financially all these years. Thank you for paving the way for your younger siblings to enter higher education and not be in dire need. No words can explain how you have shaped my thinking all these years. I prayed for God's grace to cover and protect your life. On the 15th of

March 2023, at 3 pm, you transitioned to the other side. Your death shattered me. I remember lamenting to God and asking for an alternative to the tragic news of your death. Rest in peace, Buti. Siyabulela ngobomi bakho Zulu, Mntungwa, Khumalo. Usitarhuzisele apho ukhoyo, sophinda sibonane.

To my little sister, Ziphoihle Belu thank you for walking the childhood journey with me. Thank you for loving me unconditionally and always affirming my aspirations and dreams. I love you in ways that I can never articulate in words. To my nieces and nephews Kuhle Belu, Linomtha Belu, Andiphile Belu, Liniko Belu, and Athandwa Belu, thank you for always teaching me basics with grace and love. On days when I want to give up, I always look into your eyes and remember that I must fight to be alive to see your dreams come true. You will always have a calm, weird, loving and affirming Aunt in me.

To my late Father Ntuthuzelo Wonci, you left when I was ten. As the years go by, your memory continues to fade. However, the stories of who you were and how you lived your life fearlessly confirm that I am yours. I feel you in my energy and know you are my one powerful ancestor. As Thandiwa Mazwai sings “andihambi ndedwa, ndikhatshwa ngokhokho bam”. Which translates to "I am never alone; I have an army of my ancestors with me". To my late brother Vuyolwethu Wonci, I was 16 when you tragically lost your life. There is not a single day that I do not grieve your loss. You will always be my Polo, and I am sending you a thousand hugs in heaven. If heaven had visiting hours, I would make you laugh for at least 2 minutes. And share with you that Mom and Dad still lock the gate at 8 pm. Rest in peace.

To my grandmother, Thenjiwe Mhamhana, thank you for loving me loudly. Uyintsika yethu Mazikhali. To my aunts, uncles, and cousins from Wonci and Mhamhana families, thank you for teaching me the values of family, love, and community.

To my community of friends and associates, thank you for holding me and keeping me safe. Samkele Mangxaba, Thulisa Dunga, Sinethemba Chole, Nqabomzi Bikitsha, Esley Philander, Rodney Hammond, Sikhumbuzo Makandula, Professor Phakama Ntshongwana, Professor Sakhumzi Mfecane, Dr Vanessa Brown, Dr Mary Hames, Professor Desiree Lewis, Dr Kola Omowowo, Dr Ashley Sarimana, Dr Hlengiwe Ndlovu, Dr Madalitso Phiri and Dr Lisa Lieberman thank you for your love, protection, and kindness all these years.

To my supervisor, Professor Jimi Adesina, thank you for being a true Mwalimu, 'teacher'. You have shaped, moulded, and believed in this doctoral thesis dream more than I did. I will always

honour and tell the world of your consistency in teaching us about working hard and dreaming the impossible dream.

Funding Acknowledgement

The National Research Foundation fully funded this doctoral thesis under the SARChI Social Policy at the University of South Africa. Thank you to the National Research Foundation and the SARChI in Social Policy under the leadership of Professor Jimi Adesina for making my dream a living reality. Other funding agencies that contributed to the completion of this doctoral thesis are the Woodrow Wilson National Fellowship Foundation, Mellon Mays Undergraduate Fellowship, and the Social Science Research Council

Abstract

The National Health Insurance is a health financing system that aims to redistribute South Africa's financial resources by pooling funds from the public and purchasing healthcare services on behalf of the population from accredited private and public service providers. Part of transitioning from the current healthcare system to the NHI policy involved the implementation of the NHI pilot program in eleven districts across South Africa. The objective of this doctoral thesis was to evaluate the implementation of the NHI pilot in the Tshwane District. This was done by conducted 72 in-depth interviews and three focus group discussions with policymakers, government officials and healthcare workers. Findings from this study show that what was piloted during the NHI pilot program in South Africa is not what was supposed to be piloted. Disagreements between the National Department of Health and Treasury led to a compromised NHI pilot program which implemented the primary healthcare reengineering strategies instead of setting up the NHI Fund and testing how pilot districts would purchase healthcare services on behalf of the population. The results show that PHC strategies that were tested during the NHI pilot program in Tshwane District such as General Practitioner Contracting, District Clinical Specialist Teams, Centralised Chronic Medicines Dispensing and Distribution, Integrated School Health Service, and the Ward-based Outreach Teams improved the delivery of healthcare services in public health facilities and the communities. However, shortages in medical equipment and medication, deteriorating infrastructure, water and electricity cuts, lack of human resources, labour unrest and precarious work contracts made it difficult for these PHC interventions to achieve their intended goals. This thesis locates the NHI pilot program within the politics of evidence-based policy in health policymaking in which government officials, policymakers, and healthcare workers with different pockets of power shape the process of implementation of pilot programs.

Keywords: National Health Insurance Policy, National Health Insurance Pilot Program, Universal Health Coverage, Primary Healthcare, Tshwane District

Contents

List of Acronyms

ANC	African Nation Congress
AIDS	Acquired Immunodeficiency Syndrome
CDC	Centre for Disease Control
CDU	Chronic Dispensing Unit
CEOs	Chief Executive Officers
COSATU	Congress of South African Trade Unions
CCMDD	Centralised Chronic Medicines Dispensing and Distribution
CHWs	Community Health Workers
DA	Democratic Alliance
DSCT	District Clinical Specialist Teams
FPD	Foundation for Professional Development
GPs	General Practitioners
GPs	General Practitioners
GDP	Gross Domestic Product
HIV	*Human Immunodeficiency Virus*
HPV	Human Papillomavirus Infection
ISHP	Integrated School Health Program
MDGs	Millennial Development Goals
INSS	Nicaraguan Social Security Institute
NGOs	Nongovernmental Organizations
NDOH	National Department of Health
NHI	National Health Insurance

PHC	Primary Healthcare
PwC	PricewaterhouseCoopers
RCTs	Randomized Control Trials
SDGs	Sustainable Development Goals
TB	Tuberculosis
UHC	Universal Health Coverage
UNISA	University of South Africa
WHO	World Health Organization
WBOT	Ward-based Outreach Teams

Chapter 1: Introduction

Challenges of the Healthcare System

In South Africa, the healthcare system is characterised by challenges such as the two-tier healthcare system, poor quality of public healthcare services, expensive private healthcare services, fragmentation in funding pools, unequal distribution of healthcare facilities, and maldistribution of healthcare professionals. The history of colonialism and apartheid in South Africa resulted in a racially segregated healthcare system which excludes poor Black working class communities (De Beer 1986; Horwitz 2009; Benatar 1995; van Rensburg 1991; Benatar 1988; Susser & Cherry 1982; Kon & Lackan 2008). The indigenous health systems of the people were eroded by colonialism and replaced with curative and expensive biomedical systems (Pretorius 2004; Coovadia et al 2009; Benatar 1988; van Rensburg 2004; Ritcher 2003; Chersich 2011). The first democratic election in 1994 marked the collapse of the apartheid system, and the efforts to create an equitable healthcare system for all fell short due to the two-tier healthcare system, which consists of the private and public health sectors (Ataguba & Goudge 2012; Alaba & McIntyre 2012; Naidoo 2012). This two-tier healthcare system is primarily based on social income, and it continues to perpetuate health inequalities in South Africa (Ataguba & Goudge 2012; Alaba & McIntyre 2012; Naidoo 2012). The expenditure on healthcare in the private and public health sectors is roughly the same, but inequalities lie in the number of people covered by each health sector (Ataguba & Goudge 2012; Alaba & McIntyre 2012; Naidoo 2012).

In 2019, South Africa spent 9.11% of its Gross Domestic Product (GDP) on healthcare, which amounts to R569.094 billion in monetary terms (National Treasury 2021). This 9.11% GDP was divided between the private health sector, which serves 14.78% of the population, and the public health sector, which serves 85.22% of the population (National Treasury 2021 & Council of Medical Schemes). The Council of Medical Schemes (2021) notes that the percentage of people with medical aid has declined from 16.4% in 2018 to 14.78% in 2021 due to job losses caused by the COVID-19 pandemic. According to Kleintjes (2021), the two-tier healthcare system in South Africa results in health disparities in which 14.7 % of the population covered by medical schemes enjoy the financial and human resources of this country, which are concentrated in the private sector. Then, 85.22% of the population is left to rely on an underfunded public health sector, which carries a tremendous disease burden with insufficient financial and human resources for health (Kleintjes 2021). According to Mayosi & Benatar (2014), the high number

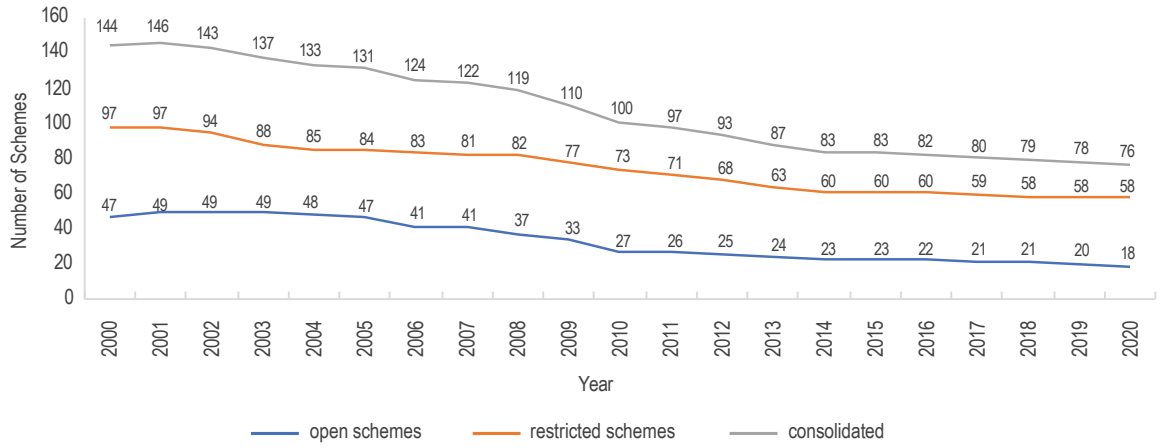
of households covered under medical schemes and have access to private healthcare services are White households, and this still reflects the economic inequalities caused by the history of colonialism and apartheid in South Africa. Private healthcare insurance is 72.9% in White households, 52% in Indian/Asian households, 17.1% in Coloured households and 9.9% in Black households (Council of Medical Schemes 2012). The health expenditure in South Africa is the same as in middle-income countries, but financial resources are not distributed evenly between the private and public sectors, thus deepening health inequalities (McIntyre 2012a; McIntyre 2012b).

The private health sector is expensive and excludes poor working South Africans (Mayosi et al 2009; Mayosi et al 2012; Sekhejane 2013). The private health sector is characterised by a fee-for-service method that over-services patients, resulting in a high cost of medical services (Mayosi et al 2009; Mayosi et al 2012; Sekhejane 2013). People covered by medical schemes are sometimes expected to pay half the cost of medical services (Mills 2012; Rao et al 2014). When medical aid funds are exhausted before the end of the year, people use their disposable income to pay for healthcare services (Mills 2012; Rao et al 2014). The failure of the public health sector to provide quality healthcare services means that people use their disposable income to access healthcare services from the private health sector (Ataguba & Goudge 2012). This out-of-pocket payment for healthcare services exposes people from poor households to financial strains and contributes to the cycle of poverty (Ataguba & Goudge 2012). According to the Council of Medical Schemes (2021), in 2016, the total out-of-pocket expenditure for medical services in South Africa was estimated to be R29.9 billion; in 2020, this amount increased to R32.8 billion.

The fragmentation in funding pools, which limits risk cross-subsidisation, is another challenge in the private sector (McIntyre et al 2012; Mayosi et al 2014). In 2020, there were 76 registered medical schemes in South Africa (Council of Medical Schemes 2021). In 1974, the country had the highest number of medical schemes, sitting at 340, which has declined over the years (Council of Medical Schemes 2021). **Please See Figure 1.** The high number of medical schemes has resulted in fragmented pools of funding in the private health sector, making risk cross-subsidisation between the healthy and sick, the poor and rich impossible (Alaba & McIntyre 2012; Burger et al 2012). According to Burger et al (2012), although the number of medical schemes has declined over the years, and some have consolidated into one big scheme, there is no cross-subsidisation within a single scheme. Medical aid scheme funds and benefits are fragmented, making cross-subsidisation between the rich and poor members of the scheme

impossible (Harris et al 2012; 2014). In a single scheme, people are grouped according to the medical aid plan they can afford (Burger et al 2012). Members with expensive medical aid plans enjoy premium medical benefits (Harris et al 2012; Harris et al 2014). The low-income members of the medical scheme can only afford cheaper plans with fewer medical service benefits such as surgery, expensive medicines and extended hospitalisation stays (Harris et al 2012; 2014).

Figure 1: Number of Medical Schemes in South Africa (2000 - 2020)



Source: Council of Medical Schemes (2021)

The fragmentation in pools of funding in South Africa is also reflected in the public health financing system (McIntyre & Gilson McIntyre 2000; McIntyre 2012; Mills 2012). The global fund for healthcare services is generated from the national revenue annually and divided into three governance streams: national, provincial and district level (van Rensburg 2004). The National Department of Health (NDOH) is responsible for providing provinces with policy guidelines, norms, and standards, and it does not interfere with how much financial resources the provincial government dedicates to health (Mills 2012). The district municipalities are tasked with implementing PHC services, and local government municipalities are responsible for environmental and sanitation services (Mills 2012). This fiscal federalism was adopted in 1997 and resulted in the NDOH having limited powers in deciding how the global fund should be spent by provincial governments (Ataguba & Alaba 2012). Provincial governments can decide how much global fund share should be dedicated to health (Ataguba & Alaba 2012). Different departments at the provincial level, such as education, water and sanitation and health, often compete to get the largest share of the province's global fund (Stuckle 2011). In the 2021/2022

financial year, the national budget for health was R64,5 billion and 86% of this budget R55 billion was transferred to provinces to decide on how they should spend it (National Treasury 2021). Health is one of the sectors that provincial governments do not prioritise, leading to health inequalities within and across provinces (Niekerk (2014).

The National Health Act gives provincial governments the power to purchase healthcare services on behalf of the population (van Niekerk 2014). The power of provincial governments in purchasing healthcare services has resulted in high bloated healthcare costs because no single fund has the buying power nationally to cap the prices (van Niekerk 2014). Each province has its service providers that differ in pricing, and cross-subsidisation between struggling and well-off provinces is difficult (van den Heever 2012). In this fiscal feudalism structure of public financing, provinces like the Eastern Cape, KwaZulu Natal, Limpopo and Mpumalanga, which were underdeveloped during the apartheid era, are not given enough resources to level up the plain field with provinces like Gauteng and the Western Cape, thus health inequalities between rural and urban areas (van den Heever 2012). Giving the power to provincial governments to purchase healthcare services on behalf of the population means that the NDOH has little say on which healthcare services should be prioritised (van den Heever 2012). According to van Rensburg (2014), most health funding is directed to provincial governments, resulting in a lack of coordination in achieving national health goals. In this fragmented structure, it is difficult for national health policies to have the desired impact on the lives of ordinary citizens because of competing interests at the provincial government level (Sussex 2011; van Niekerk 2012; McIntyre et al 2012; Ataguba & Alaba 2012).

The provision of quality healthcare services is a challenge in the public and private sectors in South Africa; however, this is pervasive in the public health sector (Ruiters et al 2012; Mhlanga et al 2020). The public health sector is characterised by long hours of waiting to receive care, lack of proper sanitation, lack of safety and security for healthcare providers and patients, drug stock out, bad attitude of healthcare workers and increasing patient load (Day & Gray 2013; Smith et al 2013). The burden of disease associated with Tuberculosis (TB), HIV/AIDS, maternal and infant mortality, road accidents, interpersonal violence, and chronic illnesses puts a strain on the public health sector, this contributes to poor performance (Ruiters et al 2012; Mhlanga et al 2020; Mayosi et al 2012). The burden of disease in the public health system was worsened by the COVID-19 pandemic in South Africa, which claimed the lives of 102 194 people (Bradshaw et al 2021; Pillay-van Wyk 202; Spaull et al 2020).The shortage and maldistribution of healthcare

professionals have contributed to poor healthcare service delivery, threatening the lives of ordinary South Africans (Rispel & Barron 2012). Healthcare professionals with specialised skills tend to move to the private health sector or migrate to countries like the United Kingdom and Canada for better salaries (National Department of Health 2021; Rispel & Barron 2012). Healthcare professionals and specialists are concentrated in the private sector, leaving the public health sector unable to deliver quality healthcare services (Mndzebele & Matsi 2016). In the public health sector, health professionals feel exhausted, burnt out and disempowered because they are expected to work long hours and attend to a high number of patients per day (Moodley & Ross 2015). In South Africa, healthcare professionals are more likely to work in urban areas than in remote rural areas because of poor infrastructure, lack of good schools for their children, and lack of incentives from the government to work in these remote areas (van Rensburg 2014). People living in rural areas lack access to quality healthcare services because most healthcare facilities and health professionals are concentrated in urban areas (Mhlanga & Garidzirai 2020). Even in urban areas, there is an unequal distribution of health professionals; poor urban areas rely on public health facilities with fewer health professionals with specialised skills (Kon 2008; Kahn 2011; Kim 2015).

In 2019, the number of medical specialists in the private sector was 69 per 100 000, and in the public sector, 7 per 100 000 (National Department of Health 2021). In the public sector, medical specialists are distributed unequally between provinces (National Department of Health 2021). In the Western Cape, the number of medical specialists was 28.5 per 100 000, compared to 1.4 per 100 000 population in Limpopo (National Department of Health 2021). General Practitioners comprise 8.6% of the national health workforce, and most are concentrated in predominantly urban provinces, with the Western Cape recording the highest number of GPs at 14.6% and Gauteng Province at 8.6% (National Department of Health 2021). Predominantly rural provinces have the lowest number of GPs, with Limpopo recording the lowest number at 4.3%, followed by Northern Cape at 6.1%, North West at 6.1%, Mpumalanga at 6.1%, Eastern Cape at 7% (National Department of Health 2021). For most Black South Africans living in rural areas, lack of access to health facilities and health professionals is not the only factor contributing to poor health outcomes (Ataguba & Alaba 2012; Horwitz 2009; Harris et al 2014; Day & Gray 2014). Poverty, poor housing conditions, lack of access to clean water and sanitation, and unemployment have contributed to poor health outcomes and high mortality rates in rural areas (Ataguba & Alaba 2012; Horwitz 2009; Harris et al 2014; Day & Gray 2014).

The National Health Insurance Policy

The persistence of health inequalities and the failure of the healthcare system to promote and provide quality healthcare services undermine Section 27 (a) of the Constitution, which states that "*everyone has a right to access healthcare services, including reproductive health care and the State has a responsibility to meet the healthcare needs of the population progressively within its available resources*" (The Constitution of the Republic of South Africa 1996). To respond to the challenges of the healthcare system, the Ministry of Health introduced the National Health Insurance (NHI) policy through a Green Paper, which was published in 2011 and the National Health Insurance White Paper, which was published on 11 December 2015 (National Department of Health 2011; 2015). The White Paper defines the NHI policy as a health financing system designed to pool funds and purchase healthcare services on behalf of the population (National Department of Health 2015; National Department of Health 2015; Matsoso & Fryatt 2013). The NHI policy promises to promote social solidarity by ensuring that health financial resources in the country are redistributed equally across socioeconomic groups to save lives, improve health indicators, and protect the population from the financial burdens of healthcare costs (Booysen & Hongoro 2018; Naidoo 2012; Setswe et al 2016).

It is estimated that the NHI policy will cost South Africa R256 billion in the year 2025/26 (National Department of Health 2011; 2015). The projected figures of the NHI policy costs have been criticised as optimistic and underestimating the high cost of administration that will come with implementing the NHI policy (Stellenberg 2015; Ruiters et al 2012; van den Heever 2012). However, McIntyre (2012) differs from this criticism and argues that the NHI policy will only cost the government as much as it already spends on financing health care. In 2020, the health expenditure in South Africa doubled the estimates of how much the NHI policy will cost (National Treasury 2021). In 2020, South Africa spent 9. 11% of its GDP on healthcare, which amounts to R569 094 billion in monetary terms, and this doubles the estimate of the implementation of the NHI policy, which is R256 billion (National Treasury 2021). According to McIntyre (2012), judging by how much South Africa spends on healthcare annually, it can afford to fund the NHI policy.

The National Health Insurance Bill

The NHI Bill was published in February 2019 and tabled in Parliament in August 2019 (National Department of Health 2022). In June 2023, the National Assembly passed the NHI Bill in parliament, and it is now sitting with the National Council of Provinces on Health and Social Services for consideration (National Department of Health 2023). The purpose of the NHI Bill is to establish an NHI Fund, which will pool funds and purchase healthcare services on behalf of the population from public and private service providers accredited by the Office of Health Standard Compliance (National Department of Health 2019). The NHI Fund will strategically purchase healthcare services on behalf of the population to protect the people from catastrophic healthcare expenditures (National Department of Health 2019). The NHI Fund is a public entity, and it will be funded through general tax revenue, provincial equitable funds, conditional grants, medical scheme tax credits, mandatory prepayment through a payroll tax and extra charges on personal tax (National Department of Health 2019). In consultation with healthcare service providers, the NHI Fund will determine the appropriate rates for healthcare services (Masuku & Sabela 2020). The NHI Fund will purchase healthcare services on behalf of the population by transferring funds directly to accredited public and private service providers (National Department of Health 2020). Hospital-based services will be purchased from accredited service providers in central, provincial, regional, specialised and district hospitals using the Diagnosis Related Groups global budget (National Department Health 2020). Emergency services will be purchased on behalf of the population using a capped-based fee (National Department of Health 2020).

PHC services will be purchased by transferring funds to Contracting Units of Primary Healthcare (CUP) (National Department of Health 2020). The CUP is an entity that will consist of ward-based outreach teams, clinics, community healthcare centres and district hospitals that will provide healthcare services to the population in a specified sub-district geographical area (Valiani 2020). A registration system will be attached to a CUP, and people will use it to register for the NHI Fund (Valiani 2020). The NHI Fund will be run by the Chief Executive officer and eleven board members who will account to the Minister of Health (Valiani 2020). The Minister of Health will be responsible for the governance and stewardship of the NHI Fund (Solanki et al 2022a). A Risk and Fraud Prevention Investigation Unit will be established to protect the NHI Fund from corruption (Solanki et al 2022a). When the NHI Fund is established, medical schemes will continue functioning and offer people complementary healthcare services not covered under the NHI Fund (National Department of Health 2022). People will be allowed to

keep their medical schemes; however, they will not be exempted from the mandatory prepayment they need to contribute to the NHI Fund (National Department of Health 2022).

Responses to the National Health Insurance Policy

The Portfolio Committee on Health sent the NHI Bill for public participation, and this process started on 25 October 2020 till 24 February 2022 (Solanki et al 2022a). It is estimated that 11 564 people attended the virtual public hearing of the NHI Bill, 100 000 submissions were made, and over 117 oral presentations were heard (Solanki et al 2022a). The people who participated in these public hearings were from 33 district municipalities across nine provinces. Key stakeholders such as medical doctors, specialists, government departments, traditional healers, medical associations, civil society groups, academics, nurses, medical aid schemes, unions, faith-based organisations, and nongovernmental organisations were part of the NHI public hearings(Solanki et al 2022a). The results from public participation show that most people support the government's decision to move South Africa towards UHC through the NHI policy (Tandwa & Dhai 2020). People supporting the NHI Bill commented that the current healthcare system excludes most Black, Coloured, and Indian working communities from accessing quality healthcare services and that the NHI Bill promises to change this (National Department of Health 2022). The people believe the NHI Bill will address healthcare system challenges such as shortage of medical doctors and specialists, deteriorating health infrastructure, long waiting lines and drug stockouts (National Department of Health 2022). Supporters of the NHI Bill expressed that the financial resources of this country are enjoyed by the rich, and the NHI Bill promises to redistribute these health resources between the rich and poor (National Department of Health 2022).

The South African National Health and Nutrition Examination Survey results also show that people support the NHI policy (Booysen & Hongoro 2018). The survey results show that people perceive the NHI policy as a system that will improve the quality of healthcare services in health facilities in South Africa (Booysen & Hongoro 2018). Booysen & Hongoro (2018) note that survey results show that people without medical aid and utilising the public health sector were more likely to support the NHI policy. People with medical aid and utilising the private health sector were less likely to support the NHI policy (Booysen & Hongoro 2018). Another cross-sectional survey conducted in 3 provinces in South Africa found that most public health sector users supported the NHI policy (Setswe et al 2016). Public health sector users expect the NHI policy to improve healthcare services in health facilities by eliminating long waiting lines ensuring availability of medical specialists and essential medicines (Setswet al 2016). Tandwa & Dhai

(2020) warn that there is a great expectation from the public about the NHI policy to work and improve the health needs of the people, and the South African government will have to work hard to ensure that these expectations are met. The Psychological Society of South Africa has come out in full support of the NHI Bill and believes that its implementation will address the gross inequalities that come with accessing mental healthcare services in the country (Kleintjes et al 2021). However, the Psychological Society of South Africa warns that stringent measures must be implemented to prevent corruption and looting of public funds that citizens experienced during the COVID-19 pandemic (Kleintjes et al 2021).

The Congress of South African Trade Unions (COSATU) supports the NHI policy (Dlamini 2016). The former president of COSATU, S'dumo Dlamini, said that the NHI policy will improve the health and well-being of the workers in South Africa (Dlamini 2016). Medical Schemes such as Discovery Health have expressed that they support the NHI policy (Ruiters et al 2012). Scholars such as McIntyre 2012; Naidoo 2012; Mills et al 2012; Filip Meheus 2012; Marten, McIntyre et al 2014 wrote that the NHI policy is an opportunity for the government, healthcare workers and citizens to transform the current healthcare system and eliminate health inequalities. To assess the working population's willingness to contribute part of their income to the NHI policy, Harris et al (2011) conducted a study with civil servants in Johannesburg. The results from this study show that civil servants working in the education and health sector in Johannesburg were willing to contribute part of their income to the NHI Fund (Harris et al 2011). Civil servants expressed that their income contribution to the NHI Fund will ensure that most South Africans access quality healthcare services (Harris et al 2011). Civil servants expressed that contributions to the NHI Fund should be based on the principle of cross-subsidisation to ensure the country's health financial resources are enjoyed by everyone, including the poorest of the poor (Harris et al 2011). Civil servants expressed that contributing to the NHI Fund on one's ability to pay is a way of giving back to society and fostering social cohesion (Harris et al 2011). Civil servants asked the government to administer the NHI Fund effectively and protect it from corrupt officials (Harris et al 2011).

The NHI Bill received critiques from the public and stakeholders within and outside the health sector. According to Solanki et al (2022b), the NHI Bill states that the Minister of Health will control the NHI Fund, and the Minister will appoint the Chief Executive Officer and board members to run the fund. Critiques have come out and said that giving this much power to the Minister of Health will result in the politicisation of the NHI fund and fraud and corruption experienced by citizens with State-Owned Enterprises such as Eskom (Solanki et al 2022b). The

Fraud Prevention Investigation will be an internal unit that will investigate and address corruption and fraud within the NHI Fund (Solanki et al 2021b). Critiques have expressed that it is unethical for the NHI Bill to investigate itself and that an external unit is required to investigate corruption within the NHI Fund. The power given to the NHI Fund to purchase healthcare services on behalf of the population has been criticised for taking away the power and independence of Provincial Governments to secure healthcare services for its population (Masuku & Sabela 2020). Critics argue that the NHI Fund needs to give funds to Provincial Governments to purchase healthcare services on behalf of the population and centralise this role to the NHI Fund (Masuku & Sabela 2020). Critics of the NHI Bill also argue that the government needs to make State-Owned enterprises work, and it cannot be trusted to manage the NHI Fund as this will be a ground for corrupt politicians to milk public funds (Clarke 2022).

The Democratic Alliance (DA)opposed the NHI policy and argued that there is nothing wrong with the healthcare system; the government must build more clinics for the poor (Ruiters et al 2012; Evans 2016). A DA former Member of Parliament, Wilmot James, said that "...the ANC government should forget about the NHI policy and spend the R1 billion set aside for the policy in the 2016 budget to build more clinics for the poor" (Evans 2016: 3). Jason Urbach from the Free-Market Foundation said that the NHI policy is a piped dream that is sold by the government to people of South Africa" (Urbach 2016:). Urbach (2016) argued that South Africa cannot afford the NHI policy because of the low economic growth and high unemployment rate (Urbach 2016). Dr Chris Archer, Chief Executive Officer of the South African Private Practitioners' Forum, stated that universal health coverage is a utopia in South Africa (Acher 2014). Acher (2014) argued that the Minister of Health accuses the private health sector of being dysfunctional in selling this utopia. However, anecdotal accounts and research have shown that private healthcare is effective and efficient (Archer 2014). The former Minister of Health, Dr Aaron Motsoaledi, responded and said, "the NHI policy in South Africa is a revolution, and I am not at war with the private health sector" (Motsoaledi 2014: 1). The former Minister argued that the private health sector is unaffordable to most South Africans (Motsoaledi 2014). In the last ten years, medical schemes have increased premiums above the inflation rate and reduced benefits to their members due to escalating private health sector costs (Motsoaledi 2014). The NHI policy will address health system challenges and ensure that South Africans and legal residents can access quality healthcare services (Motsoaledi 2014).

When the NHI policy is implemented, contributions to medical schemes are expected to drop because people will not be allowed to opt out of the mandatory contributions to the NHI Fund

(National Department of Health 2015; Okorafor 2012). According to Okorafor (2012), the resistance to the NHI policy is because the government will no longer subsidise medical schemes, which are the most significant contributors to private health sector profits in South Africa. According to the National Department of Health (2022), the idea that the NHI Bill will reduce the profits of the private health sector needs to be corrected as the NHI Fund will purchase healthcare services on behalf of the population from accredited public and private health service providers.

Ataguba & Alaba (2012) suggest that if structural inequalities such as poverty and unequal distribution of wealth are not addressed, even the NHI policy, with its aims of moving South Africa towards universal health coverage, will have minimal effect in transforming the lives of the poor in South Africa. The root causes of poverty, unemployment, and economic inequalities, which result from imbalances in power, unequal distribution of resources and neoliberal policies, must be eliminated in South Africa for the NHI policy to work (Ataguba & Alaba 2012). Mukwena & Manyisa (2022) warn that the government must address the rising unemployment rate, currently at 34.5%. If the unemployment crisis is not addressed, it will lead to a few working members of the population bearing the tax increase that will come with the mandatory prepayment contributions to the NHI Fund (Mukwena & Manyisa 2022). However, Adesina suggests (2010:17), "there is a need to move beyond seeing access to universal health coverage as the only project to improve health outcomes of the population". Instead, access to universal health coverage as one of the tools of transformative social policy must be implemented simultaneously with land reform, labour reform, universal education, early development, and pension fund policies (Adesina 2010).

Beyond these varied responses, the NDOH continues to publicly assert that the NHI policy will improve access to quality healthcare services and health outcomes of the population across economic groups (National Department of Health 2022). The NDOH expressed that the NHI policy will assist the country in decreasing infant and maternal mortality and increasing life expectancy (National Department of Health 2015; 2019; 2022). The population will be protected from out-of-pocket health expenditures, which perpetuate the cycle of poverty (National Department of Health 2015). The values of the NHI policy, which are fairness, social justice, and solidarity, will promote social cohesion in a country like South Africa, which is still struggling with racial and economic inequalities (National Department of Health 2015).

Problem Statement

Part of transitioning from the current healthcare system to the NHI policy involved the implementation of the NHI pilot in eleven health districts across South Africa (National Department of Health 2015). The NHI pilot program was implemented for five years, from 2012 to 2017. In the NHI Green Paper, the main objectives of the NHI pilot program were to evaluate:

- The ability of districts to assume greater responsibility for purchasing healthcare services,
- The feasibility, acceptability, effectiveness, and affordability of engaging the private sector,
- Furthermore, the cost of introducing a fully-fledged district health authority and the implications for scaling it up (National Department of Health 2013; MacDonald 2013; Ogunbanjo 2013).

However, in the NHI White Paper, which was published after the NHI Green Paper, the objectives of the NHI pilot program were changed from testing the districts' ability to purchase healthcare services on behalf of the population to implementing PHC reengineering national strategy to improve the delivery of healthcare services in the public health sector. The objectives of the NHI pilot program in the White Paper are recorded as "...the purpose of the NHI pilot program is to improve and strengthen the health system before the introduction of an NHI Fund by implementing specific primary healthcare interventions in selected pilot districts" (National Department of Health, 2015: 27). It is not clear from the two policy documents what led to the objectives of the NHI pilot program of testing districts' ability to purchase healthcare services on behalf of the population to testing the PHC reengineering national strategy to strengthen the delivery of healthcare services in the public health sector. However, key informants who were government officials and policymakers at the NDOH and National Treasury reported that disagreements and tension between the NDOH and National Treasury led to a compromised NHI pilot program. Key informants expressed that what was piloted is not what was supposed to be piloted during the NHI pilot program in South Africa. What was piloted is the PHC reengineering national strategy, which had nothing to do with the NHI policy as a health financing system. Key informants expressed that what was supposed to be piloted is the districts' ability to purchase healthcare services from accredited public and private health service providers using the NHI Fund.

The PHC reengineering interventions that were tested during the NHI pilot program were the District Clinical Health Specialists Teams (DCST), Integrated School Health Program (ISHP), Ward-Based Outreach Teams WBOT, Centralized Chronic Medicines Dispensing and

Distribution (CCMDD) and GP contracting. Eleven health districts across South Africa were selected to be part of the NHI pilot program. The NHI pilot districts were selected based on their health system's capacity, socioeconomic and demographic profiles and disease burden (National Department of Health 2011; 2015). These NHI pilot districts were Eden District in the Western Cape, Pixley ka Seme in the Northern Cape, OR Tambo in the Eastern Cape, Gert Sibande in Mpumalanga, the City of Tshwane in Gauteng, Amajuba, Umzinyathi, uMgungundlovu in KwaZulu Natal, Vhembe in Limpopo, Dr Kenneth Kaunda in North West and Thabo Mafutsanyane in Free State (Ogunbanjo 2013). The Strengthening South Africa's Response to HIV in collaboration with the NDOH, Centre for Disease Control (CDC), Clinton Health Access Initiative and MacDonald Company partnered to monitor and evaluate the implementation of the NHI pilot program (MacDonald 2013; 2014; 2016). Rapid assessment was used to evaluate the NHI pilot program annually and numerically measured the progress made by the eleven NHI pilot districts (MacDonald 2013; 2014; 2016). The MacDonald Company published three reports in 2013, 2014, and 2016 that reflected on the achievements and challenges of the NHI pilot program. In 2019, another monitoring and evaluation report on the NHI pilot program was published by Genesis and PricewaterhouseCoopers (PwC) in partnership with the Centre for Health Policy and Health Systems Research at the University of Witwatersrand.

The evaluation and monitoring work done by MacDonald Company, Genesis, Pwc and the Centre for Health Policy at WITS on the NHI pilot program in South Africa is a valuable contribution to understanding the successes and challenges of the NHI pilot program. However, these evaluation projects provide us with results and recommendations that reduce the successes and challenges of the NHI pilot program in South Africa to mere technical issues that can be addressed through good communication, coordination, planning and collaboration. These evaluation reports fail to capture the in-depth experiences of government stakeholders, healthcare workers, civil servants, administrators, policymakers, and politicians who were at the forefront of implementing the NHI pilot program. The danger in depoliticising the NHI pilot program as reflected in these monitoring evaluation reports is that the process of moving towards the NHI policy in South Africa risks being read as a technocratic project that lives outside the realm of politics, ideology and contested power pockets, which come with the process of health policymaking. To address the shortfall of these monitoring and evaluation reports, this study aimed to investigate the process of implementing the NHI pilot program in the Tshwane District. This was done by engaging with politicians, policymakers, government stakeholders, and

healthcare professionals who were at the forefront of implementing the NHI pilot program in the Tshwane District. These engagements were characterised by in-depth qualitative accounts that captured the technical and political process of implementing the NHI pilot program in the Tshwane District. The interpretation of these different actors draws the researcher to the complex, contested and political nature of making the NHI policy in South Africa.

Objective of the Study

The objective of this study was to investigate the process of implementing the NHI pilot program in the Tshwane District by engaging with healthcare professionals, government officials and policymakers in the health sector.

Research objectives

The research objectives of this study were to:

- Evaluate the goals of the NHI pilot program in Tshwane District and how these goals were related to the broader vision of the NHI policy in South Africa.
- Understand the process of implementing the NHI pilot program in the Tshwane District.
- Assess the opportunities and challenges of implementing the PHC engineering interventions tested during the NHI pilot program in the Tshwane District.
- Understand the roles and influences of key institutions and players in shaping the implementation of the NHI pilot program in the Tshwane District.

Significance of the Study

This study hopes to contribute to the ongoing global debates about the role of pilot programs in the cycle of health policymaking. It hopes to locate the NHI pilot program within the politics of evidence-based policy, where government officials, policymakers, and healthcare professionals with different pockets of power play a role in shaping pilot programs in health policy. This study does this by reflecting on the politics of the NHI pilot program and how it was used to both fast-track and slow the process of moving South Africa towards UHC through the NHI policy.

Methodology

Qualitative research methodology was used in this study to understand the implementation of the NHI pilot program in the Tshwane District. Qualitative research methodology allowed me as a researcher to make sense of and interpret personal and institutional factors that came with implementing the NHI pilot program in the Tshwane District from the perceptions of policymakers, government officials and healthcare professionals. Critical realism as an epistemological standpoint guided the research process, and it allowed me to pay attention to

covert and overt forces that enabled and limited participants' roles and power in implementing the NHI pilot in the Tshwane District. A case study research design was used to narrow the research focus and fully comprehend the implementation of the NHI pilot program in the Tshwane district. Eleven districts were selected to be part of the NHI pilot program in South Africa. For this study, I chose the Tshwane District because it is a geographical area that covers urban, semi-urban and rural parts of Northern Gauteng. The data from the NHI pilot program in the Tshwane District allowed me to capture the complexities of a pilot program in a context with diverse population health needs. Purposive and snowballing sampling were used to recruit participants in this study. Government officials, policymakers and healthcare professionals were recruited to patriciate because of their knowledge, expertise, and experiences with implementing the NHI pilot program in the Tshwane District.

A total of 72 in-depth individual interviews, 3 unexpected focus group discussions and secondary data were used to understand the implementation of the NHI pilot program in the Tshwane District. The data was collected from November 2016 to October 2017. In-depth interviews were conducted in English as participants were healthcare professionals, government officials and policymakers who could converse in English. In-depth interviews were recorded upon gaining consent from the participants. Participants sometimes refused to be recorded, and I would listen and take notes during the interview. Thematic data analysis was used as a method of analysing data. I read transcripts, identified reoccurring themes, and coded them into data sets that assisted me in addressing the research objectives. The ethical clearance to conduct this study was granted by 6 institutions: the Department of Sociology at the University of South, the Department of Health Studies at the University of South Africa, the National Health Research Database Board, the National Treasury, and the Gauteng Department of Education.

Conceptual Framework

Transformative Social Policy defines social policy as a collective commitment of citizens, the State, and public and private institutions to advance the people's human, economic and social welfare within a geographical area (Adesina 2011; Mkandawire 2007). Advancing human development requires collective public interventions to ensure citizens can participate in the economy and secure decent wages (Adesina 2011; Mkandawire 2007; United Nations Research Institute for Social Development 2007). Citizen's full participation in the economy through productive labour means that they can collectively invest in public interventions such as health, education and pension that will protect them from the uncertainty that comes with age,

development, and illnesses (Adesina 2007; 2010; 2011; 2015; Mkandawire 2001; 2007; Tekwa & Adesina 2018; Yi 2013; United Nations Research Institute for Social Development 2007). Collective public savings interventions such as national health insurance, pension funds, and universal education mean that the healthy adult working population protects children, young, elderly and the sick through risk cross-subsidisation (Adesina 2007; 2010; 2011; 2015; 2020; Mkandawire 2001; 2007; Phiri et al 2016; Tekwa & Adesina 2018; Yi 2013; United Nation Research Institute for Social Development 2007). The collective public savings of social policy catalyse economic growth as citizens' participation in the economy becomes more productive when their human development is protected and secured throughout the stages of life (Adesina 2007; Mkandawire 2017). The Transformative Social Policy prescribes five social policy tasks:

- The production function of social policy pays attention to social, political, and economic interventions that provide citizens with universal education and skills development to participate in the economy fully (Adesina 2011; Mkandawire 2007; Yi 2013).
- The reproduction function of social policy is about collective efforts that ensure the continuation of society through family and childcare policies (Adesina 2011; Mkandawire 2007; Tekwa 2020; Tom 2020).
- The protection function is about having collective efforts that protect citizens from the precarity that comes with life, such as childhood, sickness, disability, old age and manufactured or natural disasters (Adesina 2011; 2015).
- The redistributive function of social policy is a political and normative commitment that redistributes essential resources such as land, economy, education, health, and infrastructure fairly across the population to promote equity and social cohesion (Adesina 2020; Phiri et al2016; Tekwa 2020; Tom 2020).

Transformative Social Policy was used as a conceptual framework in this study to show that the NHI policy in South Africa can be used as a tool for Transformative Social Policy by reflecting on the implementation of the NHI pilot in the Tshwane District. The data from this study shows that the NHI policy as an instrument of Transformative Social Policy can play a productive role by increasing human resources through contracting GPs and Pharmacists Assistants to deliver healthcare services closer to where people live. In addition, the NHI policy could ensure South Africa's reproduction through the DCSTs and ISHP, which improved infant and maternal health and children's health in health facilities and schools in the Tshwane District. The data from this study showed that the NHI policy could protect citizens from the precariousness of ill health through the WBOT program, which ensured that community members in the Tshwane District

received essential healthcare services in the comfort of their homes. The redistributive function of the NHI policy was not captured in this study because what was piloted during the NHI pilot program in South Africa is different from what was supposed to be piloted. What was supposed to be piloted is the district's ability to purchase healthcare services from accredited public and private health service providers using the NHI Fund. What should have been piloted could have given us an empirical snapshot of how the NHI Fund will purchase quality healthcare services on behalf of the population. What should have been piloted could have given us a snapshot of how the NHI policy would redistribute the nation's wealth and health resources equally across socioeconomic groups and promote social cohesions in a country riddled with inequalities.

Main Findings

"What was piloted is not what was supposed to be piloted": views of government officials and policymakers about the National Health Insurance pilot program in South Africa

The results from this study show that what was piloted during the NHI pilot program in South Africa is different from what was supposed to be piloted. Policymakers and government officials from the NDOH reported that what was piloted is the PHC reengineering national strategy that aims to improve the delivery of healthcare service in the public sector through community-based interventions such as GP contracting, DCSTs, CCMDD, ISHP and WBOT. What was supposed to be piloted was how the NHI fund would pool funds from the revenue and purchase healthcare services on behalf of the population from accredited private and public sector service providers. Power struggles, disagreements, and political tensions between the National Treasury and NDOH officials led to a compromised NHI pilot program. Government officials and policymakers from the NDOH reported that the NHI pilot program focused on the PHC reengineering national strategy because the National Treasury refused to make the financial commitments required to reform the current health financing system. The NHI pilot program was a strategic political move by the National Treasury to sabotage the NHI policy in South Africa. Officials from the NDOH reported that they opposed the NHI pilot program being turned into a PHC reengineering strategy, as that had nothing to do with the NHI policy as a financing health system.

Policymakers and government officials from the National Treasury responded by claiming that the NDOH does not understand the role of the National Treasury and oversteps boundaries. The NHI policy requires restructuring the financial fiscal system where income tax contributions and medical aid government subsidies are pooled into the NHI Fund. Restructuring the financial fiscal system is the responsibility of the National Treasury, and officials from the NDOH do not

understand this. The NHI policy requires an amendment of the National Health Act Constitution to be amended. The key informants from the National Treasury accused the NDOH of not taking the process required to reform the current healthcare system seriously. The NDOH only delegates one person, the NHI national coordinator, to strategic meetings of the NHI policy, whilst the National Treasury has close to eight people working on the policy reform.

Key informants from the National Treasury reported that the NDOH denies that provincial governments are the biggest threat to the NHI policy. The NHI Fund will remove provincial governments' powers to purchase public health services on behalf of the population. The provincial governments in South Africa receive money from the National Treasury, and each province decides on the percentage it will use to fund healthcare services. The health financing structure in South Africa gives power to provincial governments to decide how much to spend on healthcare services (Burger et al 2012). Each province receives its equitable share from the national government and decides which part of the equitable share will be set aside for health (Burger et al 2012). The national government cannot interfere with how provincial governments divide the funds (Burger et al 2012). When the NHI policy is implemented, the role of provincial governments in purchasing healthcare services will be diminished (McIntyre & Ataguba 2010). Public funds will be centralised to the NHI Fund, which will purchase healthcare services on behalf of the population from accredited private and public health service providers (National Department of Health 2019).

Policymakers and government officials from the NDOH reported that the NHI pilot program was used by a faction of politicians within the African National Congress (ANC) to delay and delegitimise the NHI policy. What was piloted during the NHI pilot program differs from what was supposed to be piloted because a faction of politicians within the ANC is against the NHI policy. The private health sector funds ANC politicians who are against the NHI policy and work collaboratively with the National Treasury to ensure that the policy does not progress. When the data was collected in 2017, South Africa was having its general elections, and government officials from the NDOH warned that if the ANC faction against the NHI policy ascends to power, South Africans must forget about the NHI policy. Key informants from the NDOH and National Treasury agree that even the piloted PHC reengineering national strategy was set up to fail as a political strategy to delay South Africa from moving towards the NHI policy. What was piloted was sabotaged by giving each district R11 million annually to implement the PHC reengineering

national strategy. This R11 million was then decreased to R7 million; no tangible results would be achieved with such little money. In the Tshwane District, government officials reported that the NHI Conditional Grant could not be used to improve infrastructure in public clinics because the pilot district needed delegation powers to procure services and products over R500 000. The procurement structure still needed to be reformed, and the Tshwane District officials could only purchase services below R500 000, as anything above that required the provincial government's approval. Policymakers and government officials interviewed in this study further argued that even what was piloted was underfunded to strategically declare that the NHI policy would not work in South Africa.

Rogers-Dillion (2004) argue that pilot programs can be part of a myriad web of the country's politics. Pilot programs can be used to put the proposed policy agenda on the political table or delay the policy from being implemented (Rogers-Dillion 2004; John 2017; Smith 2013). Findings from key informants from the NDOH and National Treasury in this study show that in South Africa, the NHI pilot program was used to delay the implementation of the NHI policy, which aims to restructure the unequal health financing system. McLeod (2012) states that although improving PHC services is integral to moving toward UHC systems, it tells us little about how the NHI policy as financing health system reform will work in real life. Key informants from the NDOH and National Treasury reported that even what was piloted as PHC reengineering national strategy was set up to fail because it was underfunded. The following chapters reflect on what was piloted during the NHI pilot program in the Tshwane District, which are PHC community-based interventions and draw on some of the opportunities, challenges and lessons learned.

"We bring healthcare services closer to where people live": reflecting on the experiences of General Practitioners during the National Health Pilot Program in the Tshwane District

The NHI policy envisions an equal distribution of healthcare professionals between urban and most rural parts of South Africa (Smith et al 2018). The objective of the GP contracting program during the NHI pilot program was to address the Shortage and maldistribution of GPs, which hinders the delivery of healthcare services (National Department of Health 2018; MacDonald 2016). The NHI pilot program in the Tshwane District is a classic example of how GPs were distributed to impoverished areas to meet the health needs of the people. The Tshwane District was chosen to be part of the NHI pilot program because it consists of areas that are urban, semi-urban and rural (Clinton Health Access Initiative 2016). The rural and township areas of the Tshwane District have a shortage of GPs, and most of the clinics are led by professional nurses

(Clinton Health Access Initiative 2016). During the NHI pilot, 74 GPs were deployed to work in health facilities in disadvantaged communities in the Tshwane District. This chapter aims to provide detailed insight into the experiences of GPs in delivering healthcare services during the NHI pilot program in the Tshwane District.

The results from this study show that GPs contracted to work in the NHI pilot program in the Tshwane District strengthened the provision of healthcare services in public health facilities. GPs managed chronic and acute illnesses and delivered preventative, curative, and emergency care services. GPs in clinics detected health complications earlier and referred people to tertiary levels of care when necessary. Therefore, reducing referrals at the tertiary level of care which results in a high hospital patient load. GPs brought quality healthcare services closer to where people live, building trust between the community and the healthcare system. Community members received the highest level of care within walking distance from where they live, making them believe that the healthcare system was reliable and able to meet their health needs. GPs reported that the model of contracting GPs used during the NHI pilot program in the Tshwane District was ineffective. Two contracting models were used by the NDOH and Foundation for Professional Development (FPD) to contract GPs under the NHI pilot program. The NDOH contracting model paid GPs hourly for sessional work in public health facilities. In The FPD contract, GPs would be on-site 40 hours a week, and the FPD predetermined their salaries. GPs commented that when the NHI policy is implemented, the government should use the risk-adjusted capitation model to contract them. In the risk-adjusted capitation model, a GP would be given a lump sum of money to provide quality healthcare services to a certain number of people within a designated area.

The work of GPs during the NHI pilot program in the Tshwane District and their role in strengthening the delivery of PHC was challenging. Deteriorating public health infrastructure, drug stockout, shortage of health human resources, high patient load, power dynamics between nurses and GPs, delayed payments, and poor communication between GPs and the NDOH were reported as challenges. The challenges GPs experienced in delivering healthcare services in public health facilities were not unique to the NHI pilot program but were challenges of working in the public health sector. GPs in this study expressed that the government needs to implement the NHI policy simultaneously with other policy instruments such as universal education, labour reforms and the provision of quality houses. The NHI policy's success depends on addressing the high unemployment rate in South Africa. When the NHI policy is

implemented, improving health indicators should be a multi-sectoral approach that appreciates that health and illness are a product of our social conditions.

"The worst is when you must review the death of a baby": reflecting on the experiences of the District Clinical Specialists Team during the National Health Insurance Pilot Program in the Tshwane District

The District Clinical Specialist Team (DCST) program was established in September 2012 by a national Ministerial Task Team led by the Former Minister of Health, Dr. Aaron Motsoaledi (Voce et al 2013). The DCST program was introduced concurrently with the WBOT and ISHP as part of the PHC reengineering national strategy to improve the delivery of healthcare services in public health facilities (Voce et al 2013). The objective of the DCST program was to reduce maternal and infant deaths in South Africa as envisioned in Sustainable Development Goals (SDGs) 3 (Chola et al 2015). The goal is to reduce maternal deaths to 70 per 10,000 live births and infant mortality to 12 per 1,000 live births (Chola et al 2015). The objective of the DCST program was to provide clinical training in reproductive health and obstetric care to nurses and doctors in public health facilities to improve maternal and infant health indicators (Nathan et al 2013). The DCST members comprised 7 specialists: an obstetrician-gynaecologist, advanced midwife, paediatrician, paediatric nurse, family physician, PHC nurse and anaesthetist (Nathan et al 2013).

Findings from this study show that DCST members during the NHI pilot program in the Tshwane District provided clinical training to doctors and nurses in public health facilities to improve maternal and infant health. The DCST members collaborated with facility managers and Chief Executive Officers (CEOs) of hospitals to improve the quality of obstetric care services. The DCST members expressed that building relationships with facility managers and healthcare professionals took time. They had to first get buy-in by explaining The DCST members had to explain the program's objectives to get buy-in from health facility managers and healthcare professionals. In some health facilities, DCST members were met with resistance as doctors and nurses thought they were sent by the NDOH to police and audit them. This resistance must be read in a context where accountability is required from healthcare professionals when a baby or a mother dies in a health facility. DCST members reported that sometimes they were perceived as a litigation team that works with families to sue healthcare professionals due to babies dying in health facilities.

DCST members implemented three interventions during the NHI pilot program in the Tshwane District. Two of these interventions were adopted by the NDOH and will be rolled out nationally. The first intervention was a unique health identifier, a digital health system that stored health records of babies across the district. When a baby visits any public health facility within the Tshwane District, health professionals can access their health records and history and treat them accordingly. The second intervention was a morning obstetric drill to train nurses and doctors who work during the night shift about obstetric emergencies. The third intervention was mapping child nutrition, and DCST members recorded cases of child malnutrition in public health facilities and pinned them on the Tshwane District map. This intervention was designed to map cases of malnutrition across the districts and send WBOT members to assess the social conditions that lead to malnutrition and get the necessary government officials and stakeholders to intervene.

The DCST members improved the delivery of reproductive health services during the NHI pilot program in the Tshwane District. The obstetric care training conducted by DSCT members gave doctors and nurses confidence to deal with sick babies at the primary level of care. In the past, healthcare professionals were afraid of attending to minor complications in newborns and referred them to hospitals. DCST members reported that the program improved antenatal care attendance visits before 20 weeks from 45% to 70%. The number of pregnant women enrolled on the HIV Prevention of Mother-to-Child Transmission (PMTC) grew, reducing the number of babies born with HIV. Pap smear screenings, uptake of family planning and exclusive breastfeeding rates increased. DCST members expressed that their work contributed to reducing premature births and stillbirths.

The challenges of DCST members during the NHI pilot program in the Tshwane District were administrative bottlenecks, which caused delays in purchasing medical equipment and essential medicines. Administrators delegated their purchasing powers to managers, and purchasing equipment and medicines took longer because managers had other responsibilities. The DCST program in the Tshwane District filled all 7 posts for specialists. However, DCST members reported that 7 specialists were insufficient to cover all the public health facilities serving more than 3 million people. DCST members complained about being burnt out from travelling long hours to reach all public health facilities in the Tshwane District. Healthcare professionals sometimes abandoned obstetric care lessons, and DCST members had to repeat the clinical training. The high resignation of doctors and nurses in public health facilities meant that DSCT

members must train new staff members in obstetric care. DSCT members reported that the quality of their work was compromised by systematic public health challenges such as shortage of health human resources, lack of equipment, drug stockouts and high patient load. There is no accountability in public health facilities when a baby dies during childbirth. DCST members expressed that it was always someone else's fault: an ambulance that arrived late, a nurse who was on leave or a pharmacist who did not return on lunch on time. DCST members expressed that the worst part of their job is reviewing a baby's death.

"Patients can pick up medication closer to where they live and work": reflecting on the Centralised Chronic Medicines Dispensing and Distribution Program during the National Health Insurance Pilot Program in the Tshwane District

The Central Chronic Medicines Dispensing and Distribution (CCMDD) program was launched in 2014 as part of the NHI pilot program to reduce the patient load in public health facilities (Steel 2014). The objective of the CCMD program is to ensure that stable patients living with chronic illnesses can pick up their medications closer to where they live and work (Steel 2014). Big corporate pharmacies like Clicks, Medirite, Dischem, small-scaled community pharmacies, Nongovernmental Organizations (NGOs) and GPs' private practices were contracted as pickup points (Menold 2019). The CCMD program was implemented in 8 provinces except for the Western Cape, which already has a similar program called the Chronic Dispensing Unit (CDU) (Menold 2019). According to Magadzire et al (2015), the CCMDD program was modelled from the CDU program established in 2005.

The findings from this study show that the CCMDD program during the NHIpilot program in the Tshwane District reduced patient load in public health facilities as stable patients living with chronic illnesses could collect their medication at pickup points. The CCMDD program eased the healthcare professionals' burden of attending to many patients in public health facilities. Healthcare professionals could prioritise attending to sick patients who require their medical attention. Government officials from the NDOH reported that in the beginning, health facility managers in the Tshwane District were uncomfortable with the CCMDD program. Health facility managers thought that when the number of patients decreased in health facilities, the government would reduce their funding. The NDOH government officials informed health facility managers that the funding would remain the same as patients would return to the health facility for check-ups after 6 months.

The CCMDD program, during the NHI pilot program in the Tshwane District, managed to partner with the private sector, civil society organisations and GPs. Big cooperation pharmacies such as Clicks, Dischem and MediRite, small-scaled pharmacies, NGOs and GPs offices were contracted as pickup points. Public health clinics in the Tshwane District signed up for the CCMDD program, and it assisted them in decreasing the patient load. The CCMDD program during the NHI pilot program in the Tshwane District improved treatment adherence among patients living with HIV and hypertension. Government officials from the Tshwane District reported that the CCMDD program encouraged patients to adhere to treatment, and this improved population health indicators. Pharmacists Assistants were employed in the CCMDD program to provide pharmaceutical services such as stock-taking, placing orders, and packaging medication for patients who still pick up medication in public clinics. Pharmacist Assistants improved the delivery of healthcare services by ensuring that there are no drug stockouts in public health facilities. However, Pharmacist Assistants during the NHI pilot program in the Tshwane District complained that the two-year work contract gives them anxiety and makes it harder to make financial commitments. Pharmacist Assistants demanded that the government must employ them permanently with work benefits. Government officials from the NDOH responded and said they never promised Pharmacist Assistants permanent jobs and that the renewal of their work contract depends on funding availability.

The challenges of the CCMDD program during the NHI pilot program in the Tshwane were the reluctance of small-scaled community pharmacies to join the program, struggles with funding, and HIV stigma. Initially, the small-scale community pharmacies were reluctant to partner with the government in implementing the CCMDD program. However, when these small-scaled community pharmacies realised that the big corporate pharmacies were profiting from the CCMDD program, they wanted to be part of it. The CCMDD program did not have enough funds to contract all small-scale community pharmacies. The lack of funding meant that the CCMDD program could only service 60% of the patients in the Tshwane District. Government officials reported that in the beginning, big corporate pharmacies had a separate queue for patients of the CCMDD program. These separate queues made patients uncomfortable as they were associated with HIV medication in communities. Government officials also reported that patients with HIV discarded the empty bottles of ARVs in front of pharmacies because of the HIV stigma they experience in communities. Pharmacies were advised to pack ARVs in boxes that are not identifiable so that patients can feel safe when picking up their medication.

"We are responsible for health needs of learners in public schools": reflecting on the Integrated School Health Program during the National Health Insurance Pilot Program in the Tshwane District

The National Department of Health, Department of Basic Education and Department of Social Department introduced the Integrated School Health Program (ISHP) in 2012 to address the health needs of learners in public schools (De Klerk 2013). The ISHP was implemented as one of the PHC reengineering national strategies during the NHI pilot program in the Tshwane District. The results from this study show that the ISHP improved the delivery of PHC services in public schools during the NHI pilot program in the Tshwane District. Learners in public schools received deworming tablets and Vitamin A supplements, which improved their concentration levels in the classroom. The school nurses conducted eyesight, hearing, and dental assessments and referred learners to specialists. The Tshwane District Department of Education worked with the private sector, NGOs and optometrists to provide learners with free eyeglasses. The HPV vaccine was administered to schoolgirls in Grade 4 to prevent future cases of cervical cancer. Sexual and reproductive health education was incorporated into the Life Orientation curriculum and delivered by teachers. School nurses in the Tshwane District assisted pregnant teenagers and new teenage mothers with reproductive health services.

The challenge of the ISHP program during the NHI pilot program in the Tshwane District was the shortage of human resources to administer deworming tablets to learners. The Department of Basic Education and the South African Democratic Teachers Union (SADTU) banned teachers from assisting government officials with administering deworming tablets. School nurses were burned out and overwhelmed from servicing the health needs of learners in all public schools with fewer human resources. Government officials reported that the parents' informed consent was a significant barrier to learners accessing healthcare services from the ISHP. Parents did not sign the informed consent, and sometimes those who signed it did not sign it correctly. School nurses reported that without the parents' signed informed consent, they could not provide healthcare services to learners.

"We deliver healthcare services to people in the comfort of their homes": reflecting on the Ward-Based Outreach Program during the National Health Insurance Pilot Program in the Tshwane District

Community health work in South Africa is central to reforming the healthcare system through the NHI policy. The WBOT program, through the work of CHWs, delivers healthcare services to people in the comfort of their homes (van de Ruit 2019). Delivering healthcare services to people at home decreases the patient load in public health facilities and eases the pressure on

nurses and doctors (van de Ruit 2019). The results from the study show that the work of CHWs in the WBOT program during the NHI pilot program in the Tshwane District improved the delivery of PHC services in communities. CHWs conducted home visits and recorded the health challenges of the people in households. Recording people's health challenges at home improved the Tshwane District health data system. CHWs conducted free pregnancy tests for women in the households upon request and referred pregnant women to the clinic for antenatal care. This early referral helped to detect early pregnancy complications and possible infections that could result in maternal and infant mortality. CHWs educated new mothers about breastfeeding and caring for the baby after delivery. They tracked children's immunisation progress and brought the nurse to immunise the child at home. CHWs administered Vitamin A to children under the age of 5 years at home.

CHWs conducted health promotions that educated people about communicable and non-communicable diseases. Once CHWs detect that a person suffers from a specific condition, they refer him/her to the nearest clinic for healthcare services. New mothers with children without birth certificates were referred to Home Affairs for birth registration. CHWs worked with the Department of Social Development to register undocumented children of foreign nationals so that they could access the Child Support Grant. Treatment adherence was promoted to patients living with HIV and TB so that they could take treatment and prevent further complications. Treatment adherence support meant that CHWs delivered chronic medication to people in the comfort of their homes. CHWs cared for bedridden people in the community by washing, feeding, dressing wounds and administering medication. The challenges of the WBOT program are that CHWs worked under poor conditions in vulnerable communities riddled with poverty, unemployment and deteriorating infrastructure. CHWs with no physical working space walked long distances to deliver healthcare services in communities. During the NHI pilot program in the Tshwane District, CHWs were the lowest-paid workers with R2500 on a month-to-month contract basis. CHWs were contracted on a multi-system where the NDOH outsourced NGOs and NPOs to employ them. CHWs reported that they were not happy with this multi-system of contracting. They often protested outside the NDOH offices in Pretoria and demanded that the government employ them permanently with benefits.

Conclusion

The government introduced the NHI policy to respond to the challenges of the health care system in South Africa. The objective of the NHI policy is to restructure the financial health system by establishing an NHI fund (National Department of Health 2011; 2015; 2019). The

NHI fund will be a single-payer system which will pool public funds and purchase healthcare services on behalf of the population from accredited public and private sector service providers (National Department of Health 2011; 2015; 2019). The NHI Bill was sent out for public participation, and on 13 June 2023, the National Assembly passed it in parliament (National Department of Health 2023). The National Council of Provinces on Health and Social Services is scheduled to sit and consider the NHI Bill (National Department of Health 2023). The NHI Bill received support from public participation, and people expressed that the current healthcare system must be reformed so that the health financial resources of this country can be redistributed equally to the population (Kleintjes et al 2021; Masuku & Sabela 2020). The critics of the bill argued that the NHI Fund cannot be left in the hands of the government as it will be an opportunity for corrupt officials to loot funds (Solanki et al 2020; 2022a; 2022b). Critiques of the NHI Bill expressed that South Africa does not require a publicly managed NHI fund; instead, the government should fix the public health system and build clinics for the poor (Clarke 2022; Solanki et al 2020; 2022a; 2022b).

Part of transitioning from the current healthcare system to the NHI policy involved implementing the NHI pilot program from 2012 to 2017 (National Department of Health 2013). In the Green Paper, the NHI pilot program objectives were to evaluate the ability of districts to purchase healthcare services on behalf of the population from accredited private and public sector providers (National Department of Health 2011). However, in the White paper, the objectives of the NHI pilot program changed to improving the delivery of healthcare service in the public sector by implementing the PHC reengineering national strategy, which tested interventions like GP contracting, DCST, CCMDD, ISHP and the WBOT program (National Department of Health 2015). From these two documents, it is unclear what led to the change of the NHI pilot program from testing the district's ability to purchase healthcare services on behalf of the population to implementing the PHC reengineering national strategy. The objective of this study was to evaluate the implementation of the NHI pilot program in the Tshwane District by paying attention to qualitative accounts of the policymakers, government officials and healthcare professionals who were at the forefront of implementing the program. Previous evaluation studies conducted by MacDonald, the NDOH and PwC about the NHI pilot program focused on rapid assessments that failed to capture the experiences, meaning making and interpretations of stakeholders who were at the front line of implementing the NHI pilot program.

The main finding from this study shows that what was piloted during the NHI pilot program in South Africa is not what was supposed to be piloted. Policymakers and government officials reported that power relations and disagreements between the NDOH and the National Treasury led to a compromised NHI pilot program. The compromised NHI pilot program tested the PHC reengineering national strategy instead of setting up the NHI Fund and testing how districts would purchase healthcare services from accredited public and private service providers on behalf of the population. Policymakers and government officials from the NDOH reported that South Africa ended up with a compromised NHI pilot program because the National Treasury is not supportive of the policy and is doing anything in its financial power to ensure it is stalled. Policymakers and government officials from the National Treasury responded to the allegations by claiming that the NDOH is not committed and proactive in reforming the healthcare system, and it has delegated one person, the NHI coordinator, to be part of the reform processes. Key informants from the National Treasury reported that contrary to popular belief, the resistance to the NHI policy is the provincial governments. The NHI Bill will take away Provincial Governments' powers to purchase healthcare services on behalf of the population (Solanki et al 2021). Policymakers and government officials from the NDOH argued that what was piloted differs from what was supposed to be piloted because a faction of politicians within the ANC is against the NHI policy. These politicians are funded by the private sector, which believes that the NHI policy will take away its profits. However, the policymakers from the NDOH expressed that these politicians and the private sector are misled because the NHI Fund will purchase healthcare services from public and private health service providers.

Government officials from the NDOH and Treasury agree that the implemented NHI pilot program was set up to fail because it was underfunded. The NHI conditional grant gave each pilot district R11 million, which was later reduced to R7 million to implement the PHC reengineering national strategy. Policymakers expressed that underfunding was a political strategy to declare the NHI pilot program as a failure and delay moving South Africa towards the UHC through the NHI policy. What was piloted during the NHI pilot program was captured in this study by engaging with policymakers, government officials and healthcare workers. Findings from this study show that implementing the NHI pilot program in Tshwane District improved the delivery of PHC services. PHC reengineering national strategies such as GP contracting, DCST, CCMDD, ISHP and WBOT were vehicles for delivering healthcare services to the people in health facilities and communities.

The GP contracting program employed more than 70 GPs to ensure that public health facilities in the Tshwane district have a medical doctor. The work of DSCTs improved health indicators such as child and maternal health. The DCST program ensured that public health facilities have rotating specialists who trained healthcare workers to manage obstetric complications and prevent maternal and infant deaths. The CCMDD program reduced the patient load in public health facilities by allowing stable patients with chronic illnesses to collect their medication at convenient pickup points. The ISHP delivered healthcare services to learners in public schools, and this improved their concentration levels in the classroom. The WBOT program, through the work of CHWs, delivered PHC services to people in the comfort of their homes. Although the NHI pilot program in the Tshwane District improved the delivery of PHC services, findings from this study show that the process was challenging. Shortages of medical equipment and essential medicines, deteriorating infrastructure in public health facilities, fewer human resources, high patient load, and water and electricity cuts made delivering PHC services daunting. Poor working conditions, labour unrest and precarious work contracts were reported as challenges during the NHI pilot program in the Tshwane District.

In the politics of evidence-based policy, pilot programs can be used to reform a country's policy and as a catalyst for changing the government's policy priorities (John 2017 & Smith 2013). Pilot programs can also be used to test what works and does not work to fine-tune the proposed health policy before it is implemented nationally (John 2017 & Smith 2013). Rogers-Dillion (2004) argue that pilot programs can also be part of a myriad web of the country's politics. Pilot programs designed by the country's government can put the proposed policy agenda on the political table or delay the policy from being implemented (Rogers-Dillion 2004; John 2017; Smith 2013). Findings from this study show that in South Africa, the NHI pilot program was used to delay the country's progress towards UHC through the NHI policy. The NHI pilot program tested PHC reengineering national strategies programs that had nothing to do with the NHI policy as a health financing system. What was supposed to be piloted is the district's ability to purchase healthcare services on behalf of the population. Political tensions and disagreements between NDOH and the National Treasury led to a compromised NHI pilot program which focused on improving PHC service delivery. What was piloted was underfunded to declare that the NHI pilot program failed and that South Africa is not ready to move towards the NHI policy.

Scholars like Adesina (2017), Smith (2013), and John (2017) argue that the idea of evidence-based policy in policymaking is flawed. Policies do not depend on evidence from pilot programs

to be implemented but on the political commitment and normative values of a desired society (Adesina 2017; Smith 2013; John 2017). The evidence from the NHI pilot program is essential, and it provides us with quantitative and qualitative insights on what works and does not work with the PHC reengineering national strategy, which will be an integral part of the NHI policy. However, findings from the NHI pilot program do not tell us how the NHI Fund will be set up to pool funds and purchase healthcare services from private and public sector providers on behalf of the population. I concur with authors like Adesina (2017), Smith (2013) and John (2017) that political commitment from the government to urgently transform the current unequal healthcare system is what is required to move South Africa towards the NHI policy. Political commitment means deciding that South Africa's healthcare system needs to be transformed because people's lives depend on it. The commitment to move towards the NHI policy in South Africa depends not on the evidence from the NHI pilot program but on the normative values of the desired South Africa. The normative values are enshrined in the founding liberatory documents of this country, such as the Freedom Charter and the Constitution, which states that commitment to transformation and democracy begins with ensuring that people have access to quality healthcare services. The NHI Bill, which aims to move South Africa towards UHC, promises that citizens and permanent residents will have access to quality healthcare services, stands at the giant shoulders of these liberatory documents. These liberatory documents make it clear that universal access to quality healthcare services is about improving people's health conditions and addressing health inequalities that reflect past injustice.

Chapter 2: Literature Review

Evidence-Based Policy

Part of transitioning from the current healthcare system to the NHI policy involved implementing the NHI pilot program in South Africa (National Department of Health 2011; 2015). The NHI pilot program focused on strengthening the provision of healthcare services in public health facilities by implementing the PHC reengineering national strategy (National Department of Health 2011; 15). Pilot programs such as the NHI pilot program have been used to produce knowledge about what works regarding policies (Vreugdenhil & Ker Rault 2010). Pilot programs are implemented within specified geographical locations to test whether the proposed policy will work (Vreugdenhil & Ker Rault 2010). Bennet & Paterson (2003) argue that implementing complex national health policies without testing them is risky and can result in wasteful expenditures (Bennett & Paterson 2003). Pilot programs are defined as "... activities designed to test the feasibility and effectiveness of an intervention" (Lattimer 2013: 9). Pilot programs are demonstration projects that have a clear plan for testing the feasibility of a policy (Lattimer 2013). In policymaking, pilot programs fall under the discourse of evidence-based policy. Evidence-based policy is "...a discourse which informs the policy process, rather than aiming to directly affect the eventual goals of the policy" (Sutcliffe & Court 2005: iii). Evidence-based policy is based on the idea that for policies to be effective, they must be based on systematic scientific evidence (Sutcliffe & Court 2005). The discourse of evidence-based policy promotes a systematic, rational, and rigorous approach to policymaking (Sutcliffe & Court 2005). Creating evidence for policy development is not limited to the boundaries of systematic scientific evidence (Strydom et al 2010). Evidence-based policy is also made up of "....economic, attitudinal, behavioural and anecdotal evidence, together with knowledge and expertise of experts, as well as laypersons, propaganda, judgments, insight, experience, history, analogies, local knowledge and culture" (Strydom et al 2010: 1).

The rise of evidence-based policy became popular in the United Kingdom (UK) in the 20th century (Pawson 2013; Davies et al 2000). When the New Labour Government came into power in 1997, it emphasised modernising and rationalising government policy decisions based on scientific evidence (Pawson 2013; Davies et al 2000). The New Labour Government declared that policy decisions in the United Kingdom would not be informed by ideologies but new scientific evidence (Pawson 2013; Davies et al 2000). The inherent problem of evidence-based policy is its relationship with the history of evidence-based medicine, which is the flawed

assumption that policy decisions are politically neutral and value-free (Smith 2007). The United Nations declared universal health coverage (UHC) as a political commitment by governments to address health inequalities, end child and maternal death, strengthen health systems and improve population health indicators (Ataguba et al 2014). Sustainable Goal 3 states that to achieve UHC by 2030, "countries must ensure financial risk protection, access to quality healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all" (Ataguba et al 2014:3). As part of moving towards UHC pilot programs have found themselves at the centre of health policy experiments that are implemented across developing countries (Ataguba et al 2014). These health policy experiments are implemented to generate evidence about which health financing models are suitable for achieving UHC (Ataguba et al 2014).

Health Policy Experiments

To move towards universal health coverage, Indonesia launched its National Health Insurance policy program called Jaminan Kesehatan Nasional (Banerjee et al 2020). Jaminan Kesehatan Nasional is a mandatory contribution insurance program based on income and employment status (Banerjee et al 2020). Contributions come from people participating in the formal and informal economy (Banerjee et al 2020). The government got mandatory contributions from the formally employed people, which are deducted directly from their income (Banerjee et al 2020). The challenge was getting informal workers, who comprise 30% of the country's population, to enrol on Jaminan Kesehatan Nasional (Banerjee et al 2020). Although the contribution to the National Health Insurance Scheme is mandatory, Indonesia does not have a punitive system to deal with the low enrolment of informal workers (Banerjee et al 2020). The Indonesian government created a subsection within the National Health Insurance Scheme called Jaminan Kesehatan Nasional Mandiri program to increase the membership of informal workers (Banerjee et al 2020).

The Jaminan Kesehatan Nasional Mandiri program was implemented as a Randomised Control Trial (RTC) to test whether providing monetary subsidies, insurance information, and home-assisted online registration would increase the enrolment of informal workers (Banerjee et al 2020). The Indonesian government designed the Jaminan Kesehatan Nasional Mandiri program as a health policy experiment in partnership with SMERU Research Institute in Indonesia, researchers from the Massachusetts Institute of Technology and Harvard University (Banerjee et al 2020). Another key player in the health policy experiment was the National Team for the Acceleration of Poverty Reduction (TNP2K), responsible for developing poverty reduction programs in Indonesia (Banerjee et al 2020). The health experiment was initiated in 2015, and

close to 6000 households nationwide were selected for the experiment (Banerjee et al 2020). Informal worker households were randomised into three treatment groups; the rest formed part of the control group (Banerjee et al 2020). The treatment groups consisted of households that the government offered monetary subsidies to enrol into the Jaminan Kesehatan Nasional Insurance (Banerjee et al 2020). One group of households received the total subsidy amount, and the other group received half the subsidy from the government (Banerjee et al 2020). The second treatment group was households who were provided with information as a motivator to enrol on the national health insurance program (Banerjee et al 2020). The third treatment group were households, where individuals were assisted in registering for national insurance using the online system (Banerjee et al 2020). The remaining households were in the control group and received no treatment (Banerjee et al 2020). The administrative data from the government was used to test the effects of the interventions on the enrolment of informal workers on the Jaminan Kesehatan Nasional Insurance (Banerjee et al 2020).

The results from this health policy experiment show that informal workers from households offered a full subsidy for one year were more likely to enrol on the Jaminan Kesehatan Nasional Insurance than households that did not receive subsidies (Banerjee et al 2020). A total of 30% of households in this treatment group continued being members of the insurance scheme even after the government terminated the full subsidy (Banerjee et al 2020). Informal workers from households who received a total subsidy from the government were reported to be much healthier (Banerjee et al 2020). They visited health facilities often in comparison with those in households who did not receive government subsidies (Banerjee et al 2020). There was no significant difference in enrolment between informal workers from households who were given full and those who were given half subsidies (Banerjee et al 2020). Insurance enrollment did not change in households that received information about the National Health Insurance and in households where people were assisted with online registration (Banerjee et al 2020). This health experiment recommends that temporary monetary subsidies from the Indonesian government can increase the enrolment of informal workers in the Jaminan Kesehatan Nasional Insurance (Banerjee et al 2020).

The Nicaraguan Social Security Institute (INSS) Health Insurance program limits eligibility and access to workers in the formal sector (Thornton et al 2010). The INSS Health Insurance program depends on mandatory contributions from formal workers (Thornton et al2010). In return, formal workers are covered for primary health, secondary and tertiary health care services

in designated INSS clinics and hospitals (Thornton et al 2010). Private healthcare providers are contracted in the INSS Health Insurance program to provide healthcare services to formal workers (Thornton et al 2010). Spouses and children of formal workers are covered as beneficiaries in the INSS Health Insurance Program (Thornton et al 2010). The Nicaraguan government implemented a health policy experiment to test the extension of the INSS Health Insurance Program to informal workers (Thornton et al 2010). The informal workers form part of Nicaragua's economy as vendors, shop owners and traders (Thornton et al 2010). However, informal workers do not have health insurance that protects them from illness and catastrophic health expenditures (Thornton et al 2010). Informal workers utilise the public health system, which is overcrowded, understaffed and with a shortage of equipment and medication (Thornton et al 2010). Informal workers use their disposable income to pay for health care services, increasing out-of-pocket expenditure per household to 48 US dollars per month (Thornton et al 2010).

To address this health disparity, the Nicaraguan government launched a Voluntary Health Insurance pilot program for informal workers (Thornton et al 2010). This Voluntary Health Insurance pilot program was designed as an extension of the INSS Health Insurance Program (Thornton et al 2010). Multiple microfinancing institutions were a central part of the experiment, and their duty was to enrol, collect and purchase healthcare services on behalf of informal workers (Thornton et al 2010). An RCT was implemented to test whether information about the Voluntary Health Insurance or government 6-month monetary subsidy would increase informal workers' enrolment (Thornton et al 2010). Informal workers were randomised into four groups (Thornton et al 2010). The first treatment group received a 6-month monetary subsidy from the government to enrol directly on the INSS Health Insurance Program (Thornton et al 2010). The second treatment group received a 6-month subsidy to enrol in the Voluntary Health Insurance Program using microfinancing institutions (Thornton et al 2010). The third treatment group only received information encouraging them to enrol in the Voluntary Health Insurance program (Thornton et al 2010). The fourth group was a control group, which received no intervention (Thornton et al 2010).

To be eligible for the study, participants had to have a national identity card and be an informal vendor in the market (Thornton et al 2010). Participants were chosen from three large open markets in Managua: Mercado Oriental, Mercadoes Huembers and Ivene Montenegro (Thornton et al 2010). These three open markets are said to be representative of informal

vendors in Nicaragua (Thornton et al 2010). Informal workers were randomly assigned to the INSS Voluntary Health Insurance pilot program interventions using a public lottery system (Thornton et al2010). Each informal vendor was grouped into treatment and control groups based on the ticket they chose from the public lottery hat (Thornton et al 2010). The first ticket was a 6-month subsidy from the government to enrol directly into the INSS Health Insurance program (Thornton et al 2010). The second ticket was a 6-month subsidy from the government to enrol on the INSS Health Insurance program using a designated microfinance institution (Thornton et al 2010). The third ticket was for receiving information to enrol into the program, and the fourth ticket was blank, representing the control group (Thornton et al 2010). A total of 115 informal vendors were enrolled in the study based on the ticket they chose in the public lottery hat (Thornton et al 2010).

The results from this health experiment show that informal vendors who received 6-month government subsidies were more likely to enroll on the INSS Health Insurance program (Thornton et al 2010). Informal vendors who were enrolled directly in the INSS Health Insurance Program were more likely to continue with the insurance even after the government subsidy ended (Thornton et al2010). Those enrolled on the INSS Health Insurance program through microfinance institutions were more likely to fall off the insurance before the 6-month subsidy ended and hardly continued with the scheme after (Thornton et al 2010). These informal vendors were not satisfied with enrolling into the INSS Health Insurance program via microfinance institutions because of the administrative hurdles that came with it (Thornton et al 2010). Informal vendors reported that they trusted INSS's Health Insurance administration with enrolments because it has the expertise in purchasing and providing healthcare services for formal workers (Thornton et al 2010). Informal vendors who only received information did not enroll on the INSS Health Insurance Program (Thornton et al 2010). Informal vendors in the control group receiving no interventions did not enroll in the INSS Health Insurance program (Thornton et al 2010). No significant relationship existed between enrolling in the INSS's Health Insurance Program through government subsidies and healthcare service utilisation (Thornton et al2010). However, healthcare service utilisation increased among informal vendors who received government subsidies and already had underlying conditions such as high blood pressure, diabetes, and physical injuries (Thornton et al 2010). Informal vendors in the 6-month government subsidy group with children under 2 years also visited health facilities more often (Thornton et al 2010). Informal vendors with the 6-month government subsidy utilised designated INSS private health facilities rather than public ones (Thornton et al 2010). Private

health facilities were more efficient than under-resourced public health facilities (Thornton et al 2010). The out-of-pocket payments fell drastically among informal vendors enrolled in the INSS health insurance program through the 6-month government subsidies (Thornton et al 2010). The overall results from the study show that the INSS Health Insurance pilot program did not address the health disparity between formal and informal workers (Thornton et al2010). The INSS Health Insurance pilot program was not a sustainable mechanism to extend the INSS Health Insurance coverage to informal vendors (Thornton et al 2010).

In 2003, the Ghanaian government established the National Health Insurance to improve quality access to healthcare services for citizens (Asuming 2013; 2017). The District Mutual Scheme is part of the National Health Insurance and is highly subsidised by the government to ensure that even the poorest households can access quality healthcare services (Asuming 2013; 2017). The District Mutual Scheme is implemented at the district level, and close to 170 districts in Ghana are under this scheme (Asuming 2013; 2017). Independent cooperative bodies run the District Mutual Schemes under the National Health Insurance Health Regulator (Asuming 2013; 2017). Contributions to the District Mutual Scheme are voluntary; no penalties exist for not enrolling (Asuming 2013; 2017). The challenge with the District Mutual Scheme is that most people who enrol are formal workers concentrated in urban areas (Asuming 2013; 2017). Informal workers and poor households in rural cannot afford to enrol on the scheme (Asuming 2013; 2017). The Ghanaian government designed a program to subsidise enrolment costs for families and informal workers in rural areas (Asuming 2013; 2017). Informal workers receive these government subsidies based on a means-tested model implemented by the National Health Insurance Regulatory bodies (Asuming 2013; 2017). After government subsidies, informal workers contribute 7.20 to 48 Ghanian Cedes (5 - 32 US Dollars) to the District Mutual Scheme (Asuming 2013; 2017). Although there are government subsidies, enrolment of informal workers and poor households in rural areas in the District Mutual Health Insurance remains low (Asuming 2013; 2017).

Patrick Asuming implemented a health policy experiment to test factors behind low enrolment in Wa West District, a rural district located in Northern Ghana. Wa West District's economy is agrarian and home to the Dagaaba, Brefo, Lobi and Wala ethnic groups (Asuming 2013; 2017). Informal workers in this district are farmers who grow their own food and sell it to the market (Asuming 2013; 2017). The key challenges affecting people's lives in Wa West District are the deteriorating infrastructure, such as poor roads, lack of potable water, electricity and shortage of

health facilities (Asuming 2013; 2017). Patrick Asuming's study (2013) tested 3 interventions in Wa West District: an education campaign about the District Health Mutual Scheme, assisted registration and subsidy payment towards premiums and fees. Households were randomly selected and assigned to one of these 3 interventions (Asuming 2013; 2017). The first intervention was the education campaign, and field workers educated people in the community about the importance of enrolling in the District Health Mutual Scheme (Asuming 2013; 2017). Community members were informed about the subsidies they were eligible for to sign up for the scheme (Asuming 2013; 2017). The second intervention was the assisted registration to the scheme, where fieldworkers and government officials went to the homes and the market and assisted people with signing up for the scheme (Asuming 2013; 2017). The third intervention involved three kinds of subsidies to assist households in enrolling on the District Health Mutual Scheme (Asuming 2013; 2017). The households in the first group received a full subsidy of 12.20 Ghana Cedes (8.13 US Dollars) to enrol on the scheme (Asuming 2013; 2017). In the second group, households received three-quarters of the subsidy amounting to 8.10 Ghana Cedes (5.40 US Dollars) (Asuming 2013; 2017). In the third group, households received half the subsidy; the amount was 4 Ghana Cedes (2.6 US Dollars) (Asuming 2013; 2017). All the subsidies offered to households were set to last for two months (Asuming 2013; 2017).

The results from the study show that the education intervention improved people's knowledge about the District Health Mutual Scheme (Asuming 2013; 2017). The education intervention was associated with 7 out of 12 likelihoods of enrolling in the scheme (Asuming 2013; 2017). There was no significant relationship between assisting people with registering in the scheme and enrollment (Asuming 2013; 2017). Only a 1.3% likelihood of enrolment was detected by assisting people in registering for health insurance at home or in the workplace (Asuming 2013; 2017). The subsidy intervention increased enrollment in the scheme, with full subsidy associated with a high number of enrollments (Asuming 2013; 2017). Enrolment from a full subsidy is associated with a 37.4% increase in enrolment; a three-quarter subsidy is associated with 35.6% enrolment; and a half subsidy is associated with 26.2 % (Asuming 2013; 2017). Health facility utilisation increased among households who received full subsidy to enrol in the the District Health Mutual Scheme (Asuming 2013; 2017). Healthcare utilisation increased amongst informal vendors who received the subsidies and already had underlying conditions (Asuming 2013; 2017). Deprivation of healthcare services for a long time can also explain the increase in the usage of health facilities in rural households in Wa West District (Asuming 2013; 2017).

Critique of Health Policy Experiments

The health policy experiments in Indonesia, Nicaragua and Ghana reflect some of the methodological flaws of RCTs. Chance exaggerated statistical significance and confounding factors are fundamental methodological flaws of RCTs that I picked up from these health policy experiments. From the Indonesian study, it is difficult to conclude that all the informal workers enrolled in the Jaminan Kesehatan Nasional Insurance because of the government subsidy alone. Chance as the methodological flaw happens in RCTs when the treatment that is administered is recorded to be effective based on 'chance' alone (Bédécarrats et al 2019). In the case of Indonesia, the government subsidy and education interventions that were used as catalysts for enrolling informal workers into health insurance could have been implemented when some of the informal workers were in dire need of healthcare services. These interventions could have met a crossroads with an Informal worker's ill health, and their recorded impact is based on 'chance' alone.

The efficacy of interventions during RCTs can be statistically exaggerated (Milewa and Barry 2005). The statistical exaggeration of RCTs happens often in a context where there is a lack of healthcare services (Milewa and Barry 2005). The District Health Mutual Insurance pilot program in Ghana exemplifies this. The researcher describes the context of Wa West District as rural, poor and with a lack of infrastructure such as water, electricity, and healthcare facilities (Asuming 2013; 2017). He further explains that the district's economy depends on farming and that the area has the country's lowest health insurance enrolment numbers (Asuming 2013; 2017). The study's objective of testing the relationship between government subsidy, education and people's enrolment into health insurance would yield a significant statistical relationship because there was a lack of health insurance enrolment in Wa West District in the first place. If the same intervention were implemented in urban areas in Ghana, where you have many people already enrolled in the scheme, the interventions' impact would be statically insignificant. According to Newhouse and Normand (2017), health policy experiments often choose contexts with extreme poverty and decaying healthcare systems so that the results of the interventions they test yield statistical power to support that these interventions work. The findings from the Ghanaian experiment show that healthcare utilisation amongst those enrolled in the government subsidy treatment increased (Asuming, 2013 & 2017). Again, the impact of the intervention might be exaggerated as people in that treatment group might not have seen a doctor for an extensive number of years due to a lack of healthcare services.

There are social ties within communities that health policy experiments disrupt. Social policy experiments weaken people's social ties characterised by history, family, blood and communal relations (Adesina 2011). In a social experiment, community members in the treatment group in a policy experiment tend to have familial and communal ties with members in the control group (Adesina 2011). The intervention that the treatment group receives during the experiment, the control group members will be exposed to due to these intimate social ties. In the Nicaragua policy experiment, informal workers were randomised to three treatment groups (Thornton et al 2010). The first group was given full government subsidy, the second group received three-quarters of the subsidy, and the third group was given half the subsidy to enrol into the INSS's Health Insurance Program (Thornton et al 2010). Familial and communal ties between the informal workers could have resulted in those who got the full subsidy lending money to those who got the half subsidy to enrol in the INSS Health Insurance program. These ties could also have led to those in the treatment group lending money to those in the control group so that they could also enrol on the INSS Health Insurance program. The familial ties between informal workers could be a confounding factor where informal workers' relationships with each other were a catalyst for enrolment.

People participating in health policy experiments are often not informed that they are part of an experiment (Hoffmann 2018). According to Hoffmann (2018), health policy experiments in developing countries are carried out without participants' knowledge (Hoffmann 2018). Informed consent is often an agreement between the experimenting organisations and government officials (Hoffmann 2018). In all three health policy trials in Indonesia, Nicaragua, and Ghana, there is no mention of how researchers got informed consent from the participants. According to Bonneuil (2000), Africa is a fertile ground for European and American researchers to test policy experiments without considering participants' humanity and dignity. Bonneuil (2000) further argues that many health policy experiments implemented in developing countries would never pass at the Institutional Review Board of Ethics in the United States. Informed consent in developed countries is not only a matter of convincing participants to be part of the study but also a process of convincing government leaders, civil society and civil servants (Bonneuil 2000).

The dehumanising part of health policy experiments is the randomisation process, which enrols communities and individuals to control and treatment groups (Teele 2014). A public lottery is used to enrol communities in health policy experiments in developing countries (Teele 2014). A brief explanation of the health policy experiment is given to community members at a public

meeting (Teele 2014). On the day of the public lottery ceremony, the names of the communities or individuals are assembled in a lottery basket (Teele 2014). The researcher, accompanied by a local member or an NGO leader, shakes the basket and selects a community or an individual's name (Teele 2014). Communities and individuals deemed 'lucky' become part of the treatment group (Teele 2014). The public lottery is done to ease feelings of favouritism or unfairness that would come about from the randomisation process, which divides the community into treatment and control groups (Calkins & Rottenburg 2016). The public lottery ceremony cements to community members that the treatment and control group selection process was fair (Calkins & Rottenburg 2016). According to Calkins & Rottenburg (2016), experimenters even go as far as telling community members that they will come back and give members of the control group a chance to be part of the treatment group and receive the intervention (Calkins & Rottenburg 2016). Community members in the control group are informed that they will benefit from the health experiment when the government scales it up nationally (Hoffmann 2020). Randomisation in health policy experiments through the public lottery is considered unjust, especially when communities and individuals in treatment and control groups are equally in dire need of life-saving healthcare services (Hoffmann 2018). The question of whose life is worth saving and whose life is not worth saving arises (Hoffmann 2018). According to Haushofer et al (2020), communities in control are often subjected to the false hope that healthcare services enjoyed by the treatment group will be provided to them in the near future, and sometimes this never materialises. For the duration of the experiment, temporary health facilities are often set up (Haushofer et al 2020). Communities receive healthcare services tested in the health policy experiment (Haushofer et al 2020). When the experiment ends, these health services are terminated (Haushofer et al 2020). Communities are left with unanswered questions about the healthcare services the State must address, creating tension between citizens and the State (Haushofer et al 2020).

Policy experiments in Africa have become vital in generating 'knowledge' that will convince political leaders, civil servants and citizens that defunding public goods and leaving them in the hands of the market works (Adesina 2020). According to Adesina (2020 instead of political lobbying, negotiations and collective decision-making, policymaking has become a technocratic process dependent on international expertise from Europe and the United States of America. Generating expert knowledge about policy development in Africa depends on policy experiments, which are vital in depoliticising policymaking in Africa (Adesina 2020). Policy experiments and branded international expertise are used to depoliticise policymaking, which is

marked by asymmetrical power dynamics in which North America and Europe coerce and dictate which policies should be adopted to address social challenges in developing countries (Hoffman 2020; Rottenburg 2009b). When reflecting on making social protection through conditional cash transfers, Ouma & Adesina (2019) argue that the influence of developed nations in policymaking in Africa is not just a top-down relationship. However, it is a complex power-curated process between international organisations, international donors, civil societies, governments, Think Tanks and NGOs (Ouma & Adesina 2019). Ouma & Adesina (2019) refer to these myriad pockets of power as social policy merchandising in Africa.

In this social policy merchandising process, international organisations and donors initiate relationships with a country in Africa through Social Development and the Department of Health (Adesina 2020). The departments are chosen as they deal with what Rutternburg (2009) calls 'declared social emergencies'. Declared social emergencies are classified as poverty, pandemics and civil wars. Public servants in these departments are invited to policy brief meetings, where a specific 'policy' framework to deal with social emergencies in Africa is presented (Rottenburg 2009b). Ouma & Adesina (2019) argue that this presentation of policy frameworks that can solve the declared social emergency is not just a 'meet and greet' process. The interaction involves inviting public servants and government stakeholders to local and international conferences fully funded by international donors and organisations selling the social protection policy framework of conditional cash transfers (Ouma & Adesina, 2019). Ouma (2020) argues that this 'knowledge currency' is used to transfer policy ideas that conditional cash transfers work in eliminating poverty in Africa. Once public servants and government stakeholders buy into this knowledge currency, they are told that pilot programs must be implemented to test how conditional cash transfers will work locally (Ouma & Adesina 2019; Ouma 2020). These pilot programs are then implemented fully paid for by international organisations and their donors (Ouma & Adesina 2019; Ouma 2020). Public servants are encouraged to support the pilot program and assist the international organisation in getting local buy-in to implement it (Ouma & Adesina 2019; Ouma 2020). Adesina (2020) argues that NGOs are quickly set up locally with an international team that will provide technical expertise on implementing the pilot program using RCTs. The pilot program is implemented with international organisations and donors, providing a black-and-white guideline on how it should be done appropriately (Ouma & Adesina 2019; Ouma 2020). Think Tanks and academic departments are sometimes invited to be part of the implementation and assist with research expertise required to conduct RCTs (Ouma & Adesina 2019; Ouma 2020). Once the data is collected and analysed, the results are disseminated to public servants

and government officials initially contacted (Ouma & Adesina 2019; Ouma 2020). The results of the policy experiment are disseminated to other vital actors, such as politicians and critical ministries, such as the Ministry of Finance (Ouma & Adesina 2019; Ouma 2020).

The response from politicians and ministers about the proposed social protection policy program can vary (Adesina 2011). In a case of negative response, NGOs, civil societies, and TinkTanks funded by this international organisation form advocacy alliances and pressure the government to adopt the social protection policy program of conditional cash transfers (Adesina 2011). This advocacy alliance branches out to reach citizens and other stakeholders using mainstream media that conditional cash transfers work and that the government needs to implement it now to end poverty (Adesina, 2011). The time for these advocacy activities is also chosen strategically (Adesina 2020). These advocacy activities for conditional cash transfers are implemented during critical political windows such as national and local government elections (Adesina 2020). This period is also chosen so that the politicians who oppose the current government can use conditional cash transfers as their campaigning tool to gain votes (Adesina 2020). If the resistance to implementing conditional cash transfers continues, senior diplomats are involved and given a directive to influence politicians or specific donor programs in the country will be terminated (Adesina 2020). According to Adesina (2020), this social policy merchandising undermines the collective process of democracy in Africa in which government and citizens independently decide which social policies are appropriate for their social context. This interference with social policymaking in Africa is a new form of brutal neo-colonialism embedded in privatising African public goods (Adesina 2011). It aims to achieve the neoliberal agenda of leaving the well-being and development of Africans to the precarity of the market (Adesina 2011).

In Indonesia, the government initiated the Jaminan Kesehatan Nasional Mandiri's Health Insurance pilot program in partnership with researchers from the Massachusetts Institute of Technology and Harvard University (Banerjee et al 2020). The Indonesian government also partnered with the SMERU Research Institute, an independent research institute for pro-poor public policy (Banerjee et al 2020). Another key player was the National Team for the Acceleration of Poverty Reduction (TNP2K), responsible for developing poverty reduction programs in Indonesia (Banerjee et al 2020). Although the article does not disclose the role of each actor, the multiplicity of partners involved signals there is an intertwined relationship defined by pockets of power between the Indonesian government, independent research institutes and the academic community of Harvard and MIT in the making of Jaminan Kesehatan

Nasional Insurance pilot program. The government initiated and implemented the INSS Health Insurance pilot program in Nicaragua. However, the microfinance institutions that were part of the pilot program signal multiple interests in extending the health insurance program to informal workers. Informal workers enrolled in the INSS health insurance program through microfinance institutions were more likely to fall off the insurance before the 6-month subsidy ended (Thornton et al 2010). Because of the administration hurdles, these informal vendors were not satisfied with enrolling in the INSS Health Insurance using microfinance institutions (Thornton et al 2010). Informal vendors wanted to enrol on the INSS Health Insurance program directly because they trusted its administration with the expertise of purchasing and providing healthcare services (Thornton et al 2010). In the Ghanaian context, the health policy experiment, at the surface, looks like just an academic study. However, when you go to the acknowledgement section of the researcher, the multiple parties involved in the study are revealed. The researcher did this study at Columbia University in New York City under the Department of Economics. Thus cementing Hoffman's (2020) argument that many policy experiments are embedded within the development economics agenda of generating evidence about which policies work in Africa. In the acknowledgement section, the researcher thanks the World Bank. Hoffman (2018) argues that the World Bank funds 76% of policy experiments in developing countries as part of a broader agenda of influencing policy decisions. Another key player in this health policy experiment is SEND Ghana, an NGO that aims to promote the health and well-being of Ghanaians by deepening linkages between research, advocacy and media for policy influence and impact' (Assuming 2013). This confirms Adesina's (2020) argument that NGOs and civil society are part of social policy merchandising in Africa, and their role is to strengthen the transfer of policy ideas from the Global North to the South.

Health policy experiments funded by international donor organisations are an administrative nightmare (Dobrow et al 2004). The ethical process is for these international donor organisations to form relationships with the State, convince civil servants and healthcare workers, and get buy-in from the politicians and community members to implement health policy experiments (Dobrow et al 2004). However, international organisations avoid this ethical route and use NGOs, non-profit organisations, and civil society to implement these health experiments in developing countries (Abiiro et al 2014). Although international organisations bypass the State, they use the same health policy experiment results to lobby and convince the State to implement health policy A instead of B (Abiiro et al 2014). According to Kirkup (2009), health policy experiments funded by international organisations are hardly scaled up nationally. Their

technical design aligns differently from the local administrative structures of government, making it hard to convince politicians and get public servants' buy-in (Kirkup 2009). Health policy experiments undermine the power of sovereignty in policymaking in which politicians, civil servants, healthcare workers, health advisory boards, unions, and legislative bodies are at the centre of the country's health policy decisions (Kirkup 2009). According to Anderson et al (2005), international organisations implement health policy experiments in the country's poorest and rural geographical areas (Anderson et al 2005). The effectiveness of these health policy experiments is exaggerated and would be deemed insignificant if they were implemented in urban of the country (Anderson et al 2005).

On the contrary, health policy experiments funded by the country's government stand a chance of being scaled up nationally (Anderson et al 2005). However, health policy experiments that the country's government initiates are still subject to challenges. The extent to which the healthcare system is centralised or decentralised affects the piloting of health policies (Benet 2004; Díaz et al 2007; McEuen 2007). In countries with decentralised healthcare systems, local authorities and administrators have autonomy on how health policy piloting programs should be implemented (Bennet 2004). However, decentralising pilot programs can be problematic as government officials and administrators against the health policy can easily manipulate the pilot process (Bennet 2004). In countries with centralised healthcare systems, the central government has a lot of power in determining how pilot programs should be implemented (Bennet 2004). When pilot programs are centralised, the disadvantage is that the local realities of different pilot sites tend to be overlooked (Bennet 2004). In this case, local authorities and administrators have no flexibility in adapting the program to the local realities under which they work (Bennet 2004). When pilot programs are centralised, they may not receive the local support they require to succeed, which can hurt the pilot's outcomes (Bennet 2004). Another critique of pilot programs is that they absorb scarce human resources in pilot sites for a prolonged period, leaving other parts of the country suffering (Skibiak et al 2007). In writing about welfare experiments in the United States, Rogers-Dillion (2004) argues that pilot programs are part of a myriad web of the country's politics (John 2017). Governments implement pilot programs to put the policy agenda on the political table or as a catalyst for changing the government's policy priorities (John 2017). Pilot programs can be a political strategy tool to delay policies from being implemented (John 2017). Pilot programs can also be used as a catalyst for changing the government's policy priorities (Smith 2013). Opposition parties utilise pilot programs to delegitimise the ruling party's current policies

(Pawson 2006). The opposition party can run multiple pilot programs on health, education, and public service to state that the ruling government's party's policies are ineffective (Pawson 2006).

The National Health Insurance Pilot Program

The NHI policy is a financing health system that aims to redistribute the country's resources to ensure South African citizens and permanent residents have access to quality healthcare services (National Department of Health 2019). Part of transitioning from the current healthcare system to NHI policy involved the implementation of the NHI pilot in eleven health districts across South Africa (National Department of Health 2015). Eleven health districts across South Africa were selected to be part of the NHI pilot program. These pilot districts were selected based on their health system's capacity, disease burden, and socioeconomic and demographic profiles (National Department of Health 2011; 2015). Eden District in the Western Cape, Pixley ka Seme in the Northern Cape, OR Tambo in the Eastern Cape, Gert Sibande in Mpumalanga, Tshwane District in Gauteng, Amajuba, Umzinyathi, uMgungundlovu in KwaZulu-Natal, Vhembe in Limpopo, Dr Kenneth Kaunda in North West and Thabo Mafutsanyane in Free State were selected as the NHI pilot districts (Ogunbanjo 2013). The NHI pilot program was implemented from 2012 – 2017. In the NHI Green Paper, the objective of the NHI pilot program was to evaluate:

- The ability of districts to assume greater responsibility for purchasing healthcare services,
- The feasibility, acceptability, effectiveness, and affordability of engaging the private sector,
- The cost of introducing a fully-fledged district health authority and the implications of scaling up it nationally (National Department of Health 2013; MacDonald 2013; Ogunbanjo 2013).

However, in the NHI White Paper, which was published after the Green Paper, the objective of the NHI pilot program was changed from testing the district's ability to purchase healthcare services on behalf of the population using the NHI Fund to implementing the PHC reengineering national strategy (National Department of Health 2013; 2015). In the NHI White Paper, the objectives were changed to "...the purpose of the NHI pilot program is to improve and strengthen the health system before the introduction of an NHI Fund by implementing specific PHC reengineering interventions in selected pilot districts" (National Department of Health 2015: 27). It is not clear from both policy documents what lead to the change of the objective of the NHI pilot program from testing the district's ability to purchase healthcare services on behalf of the population to testing the PHC reengineering national strategy. The PHC

reengineering national strategy interventions tested during the NHI pilot program are the General Practitioner Contracting, District Clinical Specialists Team, Integrated School Health Program, Centralized Chronic Medicines Dispensing program and the Ward-based Outreach Team program.

The PHC reengineering national strategy was the NDOH's program to improve the delivery of PHC services in public health facilities across the country (National Department of Health 2019). PHC reengineering national strategies tested during the NHI pilot program were implemented in other districts that were not part of the pilot program (National Department of Health 2019). The Monitoring and Evaluation team from the NDOH, Centre for Disease Control (CDC), Clinton Health Access Initiative, and the MacDonald Monitoring and Evaluation Company evaluated the NHI pilot program (MacDonald 2014). The method of monitoring and evaluating the NHI pilot program was rapid assessment, which numerically measured the progress of pilot districts in implementing PHC national strategies (MacDonald 2014). Three evaluation reports were published, which reflected on the successes and challenges of the NHI pilot program (Macdonald 2013; 2014; 2015). In 2019, another monitoring and evaluation report of the NHI pilot program was published by Genesis, PricewaterhouseCoopers (PwC) in partnership with the Centre for Health Policy and Health Systems Research at the University of Witwatersrand (Genesis, PwC & Centre for Health Policy 2019). This evaluation project employed qualitative and quantitative methods in evaluating the pilot district's performance, progress, and challenges in implementing the NHI pilot program (Genesis, PwC & Centre for Health Policy 2019).

The results from these monitoring and evaluation show that the implementation of the NHI pilot program in South Africa was characterised by success and challenges. All pilot districts have spent 90% of the NHI Conditional Grant they received from the NDOH (MacDonald 2015). The NHI Conditional Grant was spent purchasing medical equipment and renovating public health facilities (MacDonald 2015). Pilot districts differed in their performance regarding public health facilities infrastructure development (MacdDonald 2014). All the public clinics in the NHI pilot districts had referral mechanisms, and patients with severe complications were referred successfully to tertiary levels of care (MacDonald 2014). Pilot districts managed to fill in all 7 posts for the DCST members, and the National Treasury made funds available to help rural districts attract specialists (MacDonald 2013; 2014; 2015). he ISHP ensured that 95% of girls in grade 4 in all NHI pilot districts have been vaccinated for HPV to prevent future occurrences of cervical cancer (MacDonald 2013; 2014; 2015). The GP contracting program increased the

number of GPs in public health facilities by contracting private GPs to do sessional (MacDonald 2013; 2014; 2015). Public clinics in all pilot districts have the National Health Registration Digital System to register people to the NHI Fund (MacDonald 2013; 2014; 2015). The results also show that there was a political commitment from government officials and healthcare workers to implement the NHI pilot program (Genesis, PwC & Centre for Health Policy 2019). District Managers were firmly committed to implementing the NHI pilot program (Genesis, PwC & Centre for Health Policy 2019). Leaders from the provincial departments and pilot districts were champions of the NHI pilot program, encouraging healthcare workers, administrators and civil servants to commit to the pilot program (Genesis, PwC & Centre for Health Policy 2019). The NHI Advisory teams collaborated with provincial governments, improving the implementation of the NHI pilot program (Genesis, PwC & Centre for Health Policy 2019). The availability of human and financial resources for health lead to exceptional performance in NHI pilot districts in urban areas (Genesis, PwC & Centre for Health Policy 2019).

The challenge of the NHI pilot program in South Africa is that the management of the project varied across pilot districts (Genesis, PwC & Centre for Health Policy 2019). Some pilot districts had an NHI coordinator at the district level, and other pilot districts did not have an NHI coordinator (Genesis, PwC & Centre for Health Policy 2019). In pilot districts located in rural areas, the lack of financial and human resources for health prior to the NHI pilot program led to poor performance (Genesis, PwC & Centre for Health Policy 2019). The financial and human resources injected through the NHI Conditional Grant did not make any difference, and NHI pilot districts in rural areas struggled to perform (Macdonald 2015). The lack of institutional relationships between provincial governments and pilot districts made it hard to implement the NHI pilot program (Macdonald 2015). Program managers of PHC interventions worked in silos, which defeated the purpose of implementing a coordinated PHC reengineering national strategy across pilot districts (Macdonald 2015). District Managers and government officials at the provincial government had different opinions on how the NHI Conditional Grant should be utilised and what interventions were worth prioritising (Genesis, PwC & Centre for Health Policy 2019). District managers reported that the NDOH and the National Treasury were deciding how the NHI Conditional Grant should be spent without consulting them (Genesis, PwC & Centre for Health Policy 2019). The NHI Conditional Grant was sometimes misdirected and used for purposes unrelated to the NHI pilot program (Genesis, PwC & Centre for Health Policy 2019). The bureaucratic nature of the supply chain meant that pilot districts required approval from provincial governments to purchase healthcare services (Genesis, PwC & Centre for Health

Policy 2019). Sometimes, the provincial government rejected these requests and concluded they were not compliant with the NHI Conditional Grant (Genesis, PwC & Centre for Health Policy 2019).

There was a contestation between the NDOH and the National Treasury on how the NHI Conditional Grant should be spent (Genesis, PwC & Centre for Health Policy 2019). The NDOH wanted the NHI Conditional Grant to be utilised to test how the NHI Fund will be implemented in real life (Genesis, PwC & Centre for Health Policy 2019). The National Treasury wanted the NHI conditional Grant to be utilised to improve public health facility infrastructure and strengthen the delivery of healthcare services (Genesis, PwC & Centre for Health Policy 2019). The contestation between the NDOH and the National Treasury on how the NHI Conditional Grant should be utilised might have led to the objectives of the NHI pilot program being changed from testing how the districts would purchase healthcare services on behalf of the population using the NHI Fund to implementing the PHC reengineering national strategy. **Figures 1, 2 and 3** below provide a snapshot of how each NHI pilot district implemented the PHC interventions from 2013 – 2015.

NOT APPLICABLE
LESS THAN 50%
50-75%
>75%

Figure 1: NHI Pilot District's Performance

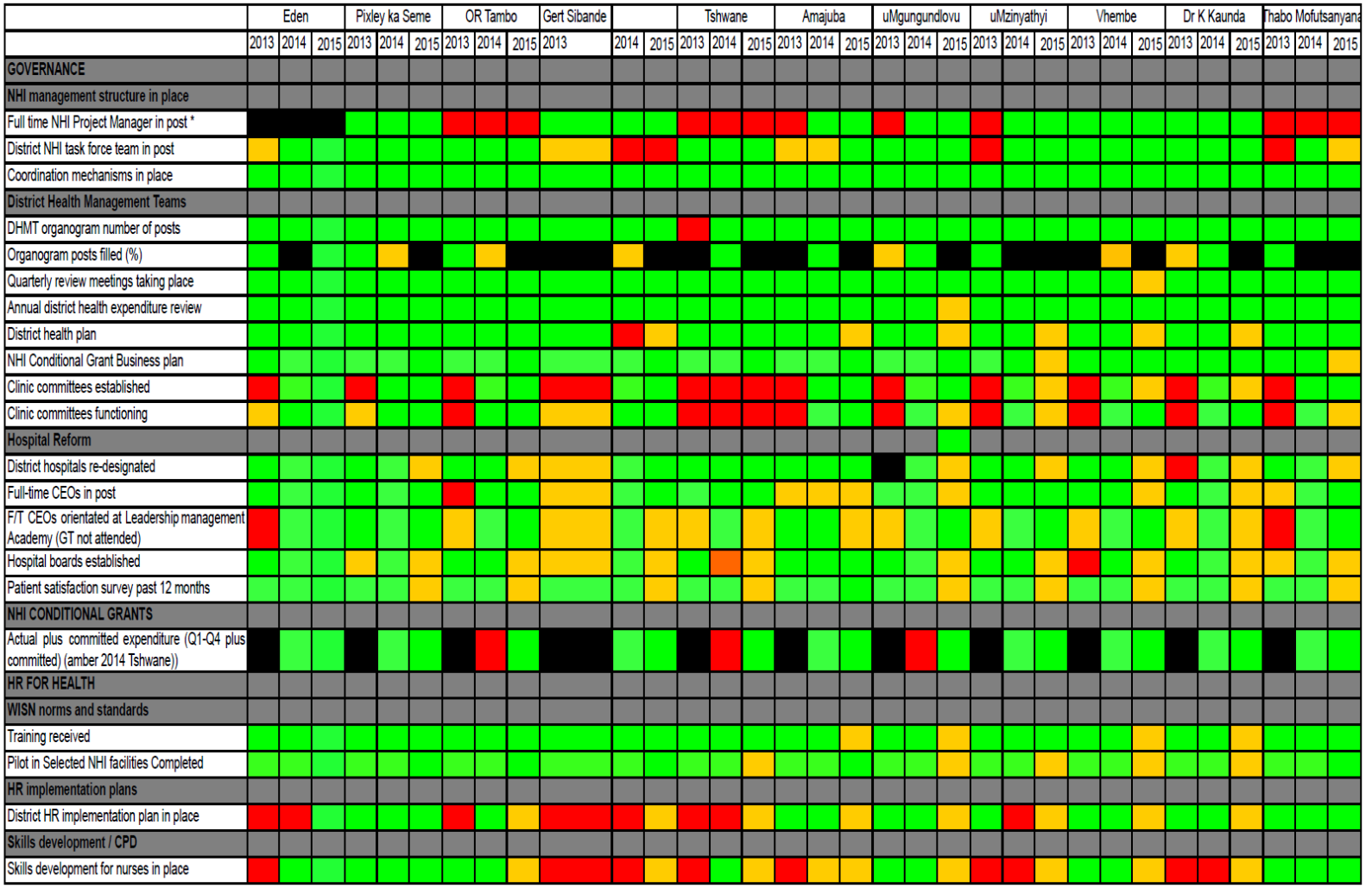
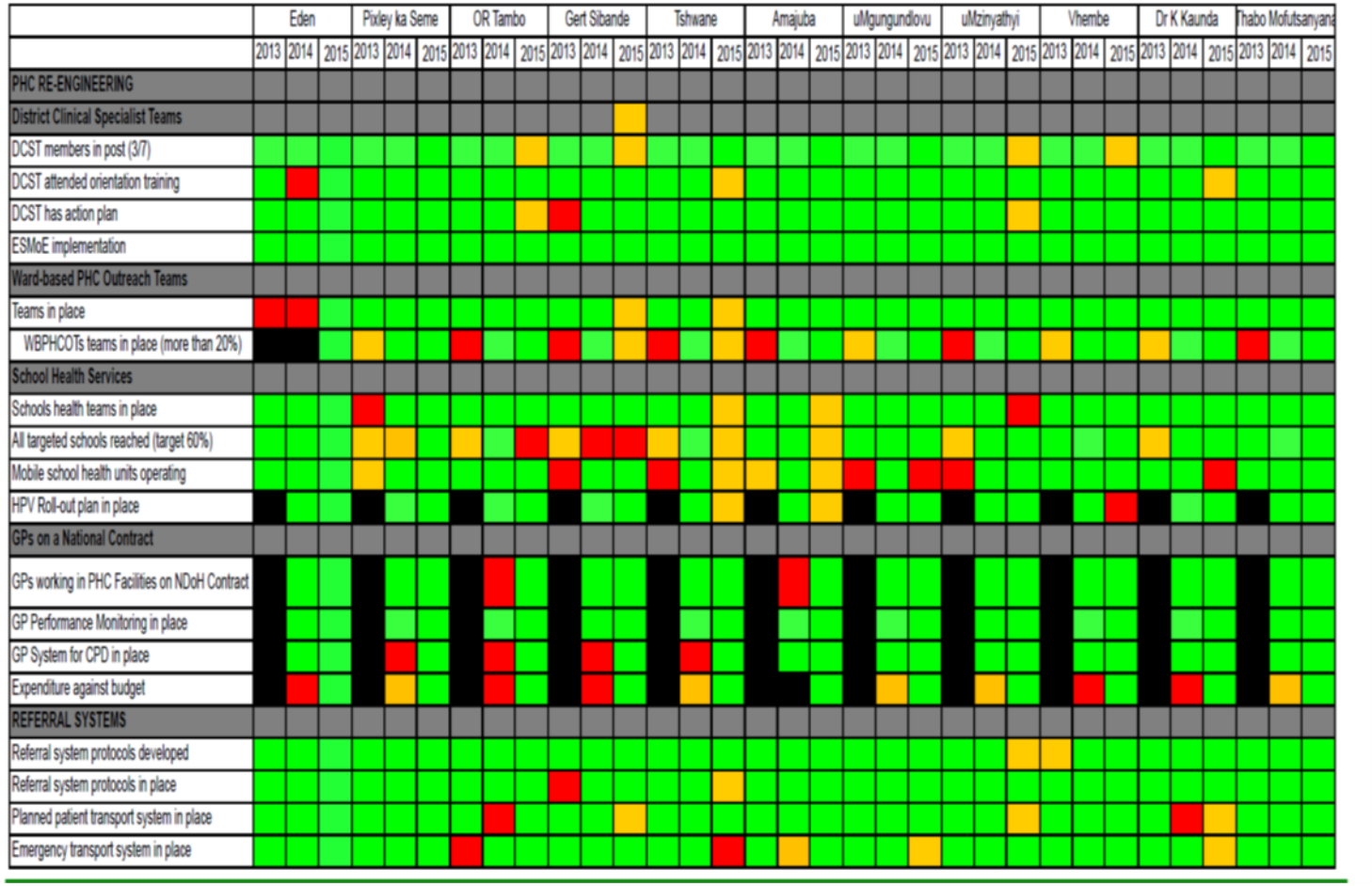
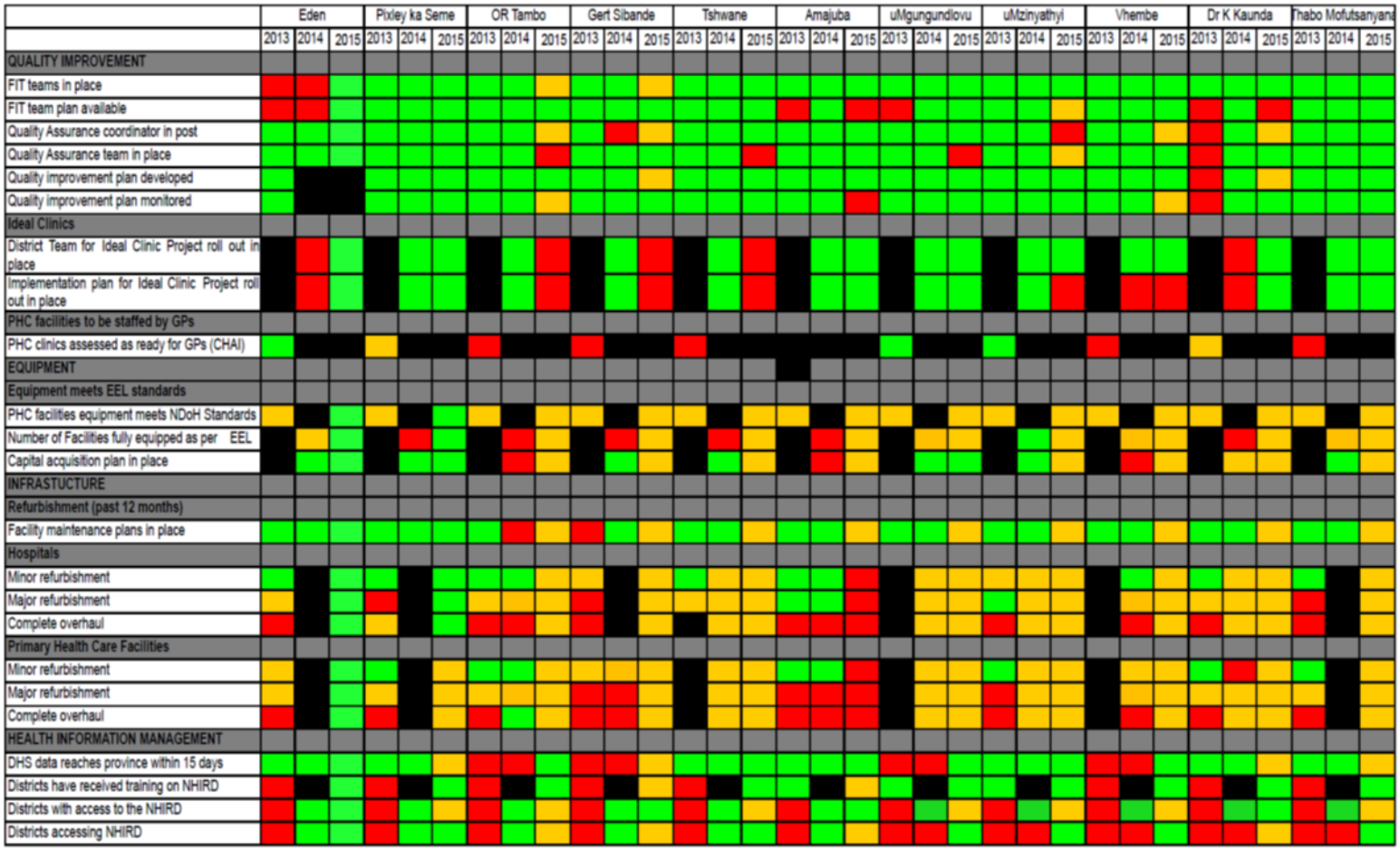


Figure 2: NHI Pilot District's Performance



Source (MacDonald 2013; 2014; 2015)

Figure 3: NHI Pilot District's Performance



Source (MacDonald 2013; 2014; 2015)

Problem Statement

The monitoring and evaluation projects conducted by MacDonald, Genesis, PwC and the Centre for Health Policy at WITS on the NHI pilot program in South Africa are a valuable contribution to understanding the successes and failures of the pilot program. However, these monitoring and evaluation projects provide us with results and recommendations that reduce the successes and failures of the NHI pilot program in South Africa to mere technical issues that can be addressed through good communication, coordination, planning and collaboration. These monitoring and evaluation projects depoliticise the NHI pilot program and fail to capture the in-depth experiences of policymakers, government officials and healthcare workers at the forefront of the pilot program. The danger of depoliticising the NHI pilot program as reflected in these monitoring and evaluation reports is that the move towards UHC through the NHI policy in South Africa risks being read as a mainly technocratic project that lives outside the realm of politics, ideology and contested power pockets which is the crux health policymaking.

The Objectives of the Study

To address this shortfall, this study aimed to investigate the process of implementing the NHI pilot program in the Tshwane District. This was done by engaging policymakers, government stakeholders, and healthcare workers at the forefront of implementing the NHI pilot program in the Tshwane District. The engagements were characterised by in-depth qualitative accounts that captured the technical and political process of implementing the NHI pilot program in the Tshwane District. The interpretation of these different actors and their pockets of power within the healthcare system draws the researcher to the complex, contested and political nature of making the NHI policy in South Africa.

Significance of the Study

This study hopes to contribute to knowledge by showing how health policy experiments like the NHI pilot program are embedded within a flawed epistemology of evidence-based policy. It hopes to show how the NHI pilot program agenda and the actors involved with varied pockets of power played a role in fast-tracking and simultaneously slowing down South Africa's move towards UHC through the NHI policy.

Chapter 3: Methodology

Qualitative research methodology was used in this study to investigate the process of implementing the NHI pilot program in Tshwane District by engaging with policymakers, government officials and healthcare workers. According to Denzin & Lincoln (2003), qualitative research allows the researcher to study a social phenomenon in its natural setting by taking seriously the meaning people attribute to it. Qualitative research methodology offers an in-depth understanding of how health policy systems materialise in real life (Murphy & Dingwall 2003). The methodology brings out the taken-for-granted institutional norms and practices that inform health policy design, implementation, and evaluation (Pope & Mays 2006).

Research Paradigm

Qualitative research methodology is embedded within ontological and epistemological standpoints of what constitutes social knowledge. According to Guba & Lincoln (1994), ontology is concerned with questions about the nature of social reality (Guba & Lincoln 1994). Ontology reflects the researcher's philosophical beliefs about the social world and what is a valid and legitimate source of knowledge (Guba & Lincoln 1994). Epistemology is concerned with questions about our beliefs about knowledge (Adler 2009). Epistemology is about "...the nature of knowledge and how it is derived" (Guba & Lincoln, 1994: 3). Epistemology helps us to analyse the way people understand knowledge or arrive at what they claim to know (Adler 2009). Epistemological questions are about how we come to know what we know (Adler 2009). Epistemology is also concerned with the relationship between the knower and what can be known (Adler 2009).The methodology is about how "...the knower goes about finding that which she believes is worthy of being known" (Guba & Lincoln 1994: 3). The relationship between ontology, epistemology and methodology is a research paradigm that a researcher commits to in making sense of the world (Ormston et al 2014). According to Ormston et al (2014), a research paradigm provides the researcher with theoretical and methodological possibilities and limitations regarding the nature of the social world (Ormston et al 2014). This study used critical realism as a research paradigm to understand and make knowledge claims about implementing the NHI pilot program in the Tshwane District.

Critical realism's ontological standpoint is that the natural world, social world, and human beings exist independently (Bhaskar 2008). However, through experimentation, observation, and everyday practices, these three independent entities can coexist in mutual and conflicting ways (Bhaskar 2008). Knowledge is generated by understanding the contested relationship between

natural objects, the social world and human interaction (Bhaskar 2008). Social sciences, through experimentation, provide us with pathways and language for making meaning of the contested relationship between these three worlds (Bhaskar 2008). Critical realism believes that human behaviour is influenced by hidden natural and social forces (Cruickshank 2003). Humans are aware of forces that influence their behaviours and sometimes are not (Cruickshank 2003). The influence of the natural and social world on human beings is not a determinant but a negotiated one (Cruickshank 2003).

The gift of abstraction that is bestowed on humans allows them to make sense, create meaning and interact with the natural and social world in ways that create new natural objects, social systems and knowledge (Jansen 2020). For critical realism, the role of the researcher is to tap into the language that connects the natural and social world and human beings to make sense of the contested power relations between these three worlds (Cruickshank 2003). Concepts and theories are tools that the researcher can use to generate knowledge about the natural and social world and how it relates to human beings (Cruickshank 2003). Critical realism sees human beings' interpretations of the natural and social world as one contributor amongst others to scientific knowledge (Cruickshank 2003). Researchers need to use human interpretations parallel with other sources of knowledge to make sense of the social phenomenon being studied (Ormston et al 2014). Artefacts, laws, constitutions, the workings of the physical and metaphysical, language, culture, objects, history, and politics are significant contributors to knowledge (Ormston et al 2014). Therefore, multiple methods can be used to uncover knowledge about a social phenomenon that is being studied (Ormston et al 2014).

According to Bhaskar (2008), critical realism's ability to move beyond human interpretation of the social world and connect it sophistically to what exists within and outside human control is critical for health policy research. Gilson (2013) argues that knowledge about health policy can be derived from actors' interpretations. However, this falls short if it is not done in collaboration with the socioeconomic, political, epidemiological, and institutional context in which the health policy is designed (Gilson 2013). Critical realism is fitting as a research paradigm in this study because it will allowed me to read and interpret the meanings policymakers, government officials, and healthcare professionals attach to implementing the NHI pilot in the Tshwane District. Critical realism will allowed me to tap into the institutional arrangements, practices and forces that influence how the NHI Pilot program was implemented in the Tshwane District. Critical realism will allowed me to pay attention to covert and overt forces that enable and limit

policymakers, government officials and healthcare workers in implementing the NHI pilot in the Tshwane District. Critical realism allowed me to gain insight into how policymakers, government officials and healthcare workers negotiate with social forces and use their pockets of power to influence the implementation of the NHI pilot program. Critical realism assisted me in locating the implementation of the NHI pilot program in the Tshwane District within the broader conversation of the NHI policy, which aims to move South Africa towards UHC. Critical realism further assisted me in locating the NHI pilot program within scholarly conversations about the contested roles of pilot programs in health policymaking in developing countries.

Research Design

A case study research design was used to investigate the implementation of the NHI pilot program in the Tshwane District. A case study allows the researcher to study a social phenomenon within its context using various sources and methods (Yin 2003). This research design is interested in making sense of the complexity of institutions, organisations, interventions and policies within a geographical era (Yin 2003). The case study research design allowed me to focus solely on the NHI pilot program in Tshwane District to gain insight into its complex implementation processes. A case study research design allowed me to narrow down the focus of my study by reflecting on the experiences and interpretations of policymakers, government officials and healthcare workers about the implementation of the NHI pilot program in the Tshwane District.

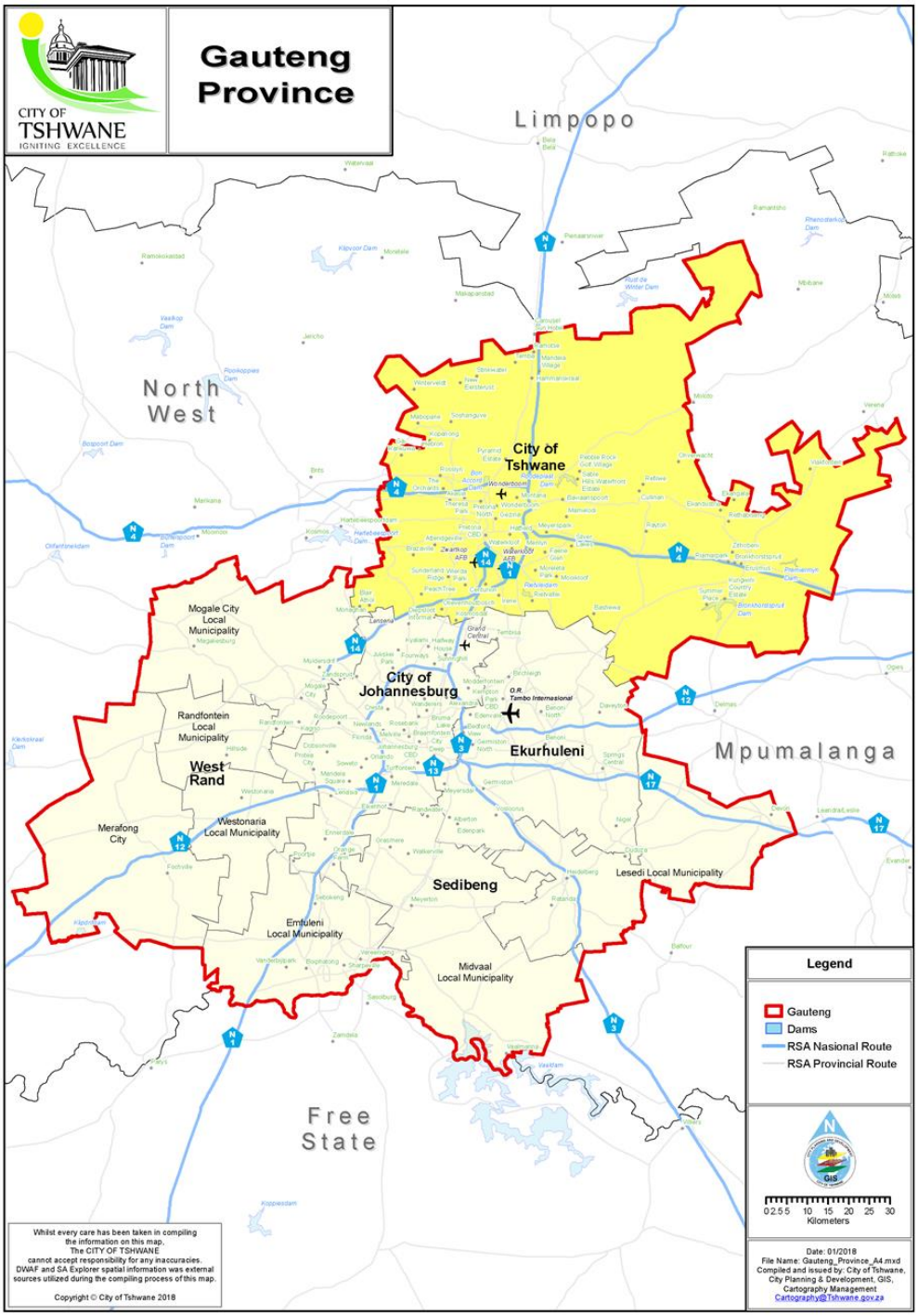
Eleven districts were chosen to be part of the NHI pilot program in South Africa. These districts include Eden District in the Western Cape, Pixley ka Seme in the Northern Cape, OR Tambo in the Eastern Cape, Gert Sibande in Mpumalanga, the City of Tshwane in Gauteng, Amajuba, Umzinyathi, uMgungundlovu in KwaZulu-Natal, Vhembe in Limpopo, Dr Kenneth Kaunda in Northwest and Thabo Mafutsanyane in Free State (Ogunbanjo, 2013). For this study, the Tshwane District was chosen as a case study to understand the implementation of the NHI pilot program by engaging with policymakers, government officials and healthcare workers. The Tshwane District was chosen because its geographical area covers urban, semi-urban and rural parts of Northern Gauteng. The data emanating from the Tshwane District can capture the complexities of implementing the NHI pilot program in a geographical context with varied population health needs. When launching the NHI pilot project in 2012, the former Minister of Health, Dr Aaron Motsoaledi, emphasised that the Tshwane District was chosen as one of the NHI pilot sites because it covers both urban and rural areas (Mail & Guardian 2012).

The Tshwane District is divided into seven regions: urban areas, semi-urban areas, farming and rural communities (Maitland & Ritchie 2009). Region 1 comprises townships like Mabopane, Winterveld, Soshanguve and Garankuwa (Maitland & Ritchie 2009). Located in the western part of the district, these areas used to be labour reserves during the apartheid era for the City's manufacturing hub area called Rosslyn (Maitland & Ritchie 2009). Region 2 is where the Wonderboom Airport is located, and it covers township areas such as Sinkwater and Hammanskraal (Maitland & Ritchie 2009). This region is famous for its small agricultural activities and is located in the northern part of the district (Maitland & Ritchie 2009). Region 3 is where the district's central businesses are located, famously known as Pretoria Central Business District (Maitland & Ritchie 2009). Institutions of higher learning, such as the University of Pretoria, Tshwane University of Technology and the University of South Africa, are situated in this region surrounded by suburbs such as Brooklyn and Waterkloof (Maitland & Ritchie 2009). Region 4 connects the City of Tshwane Metropolitan Municipality to the City of Johannesburg (Maitland & Ritchie 2009). Residential areas such as Centurion and newly established townships such as Olievenhoutbosch are situated in this region. This area also has suburbs such as Cornwall, Midstream and Kosmosdal (Maitland & Ritchie 2009). Region 5 comprises farming and mining activities with surrounding townships such as Refilwe and Cullinan (Maitland & Ritchie 2009). Region 6 is dominated by high and middle-income households with suburbs such as Mooi Kloof, Moreleta Park and Silver Lakes (Maitland & Ritchie 2009). Region 7 connects the district to Mpumalanga Province, and it is characterised by housing farmland in Bronkhorspruit town (Maitland & Ritchie 2009). Please refer to **Figures 1, 2 and 3** for the geographical layout of the Tshwane District.

Figure 1: City of Tshwane in South Africa

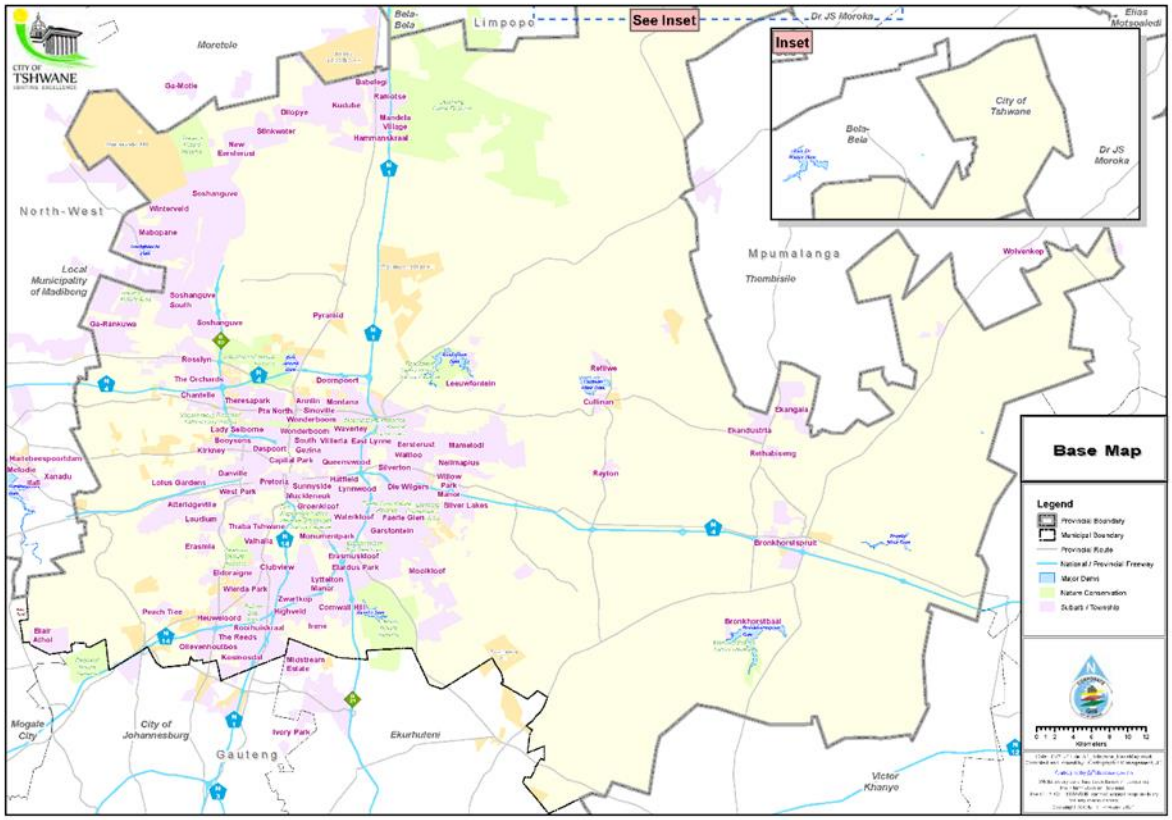
Source: City of Tshwane 2022

Figure 2: Tshwane District in Gauteng Province



Source: City of Tshwane (2022)

Figure 3: Tshwane District



Source: City of Tshwane (2020)

In 2019, it was estimated that the Tshwane District is home to 3,555 741 million people (Department of Cooperative Governance and Traditional Affairs 2020). Sixty-three per cent of the district's population is below the age of 35 years (Department of Cooperative Governance and Traditional Affairs 2020). People 65 years old and above comprise 8% of the population (Department of Cooperative Governance and Traditional Affairs 2020). The demographics of the Tshwane District can be understood within the context of South African migration labour, where young bodies from rural parts of the country move to the City to study, work and return to rural areas closer to retirement (Department of Cooperative Governance and Traditional Affairs 2020). The Tshwane District has 1 136,876 households, and 16.4% are located within the informal sector with no electricity and running water (Department of Cooperative Governance and Traditional Affairs 2020). The unemployment rate is 16%, and 31% of the population lives below the poverty line of R1 077 per month (Department of Cooperative Governance and Traditional Affairs 2020). The leading causes of death in the Tshwane District are HIV/AIDS, road injuries, Tuberculosis, interpersonal violence, diarrhoeal diseases, diabetes, and lower respiratory infections (Health System Trust 2020). The Tshwane District was also hit hard by the

COVID-19 pandemic. Since May 2020, the Tshwane District has recorded "...241,794 cases of COVID-19, 35 090 hospital admissions and 7,086 deaths" (Abdullah 2022: 38).

Sampling and Recruitment

Purposive and snowballing sampling, which are non-randomised sampling techniques, were used in this study. According to Ritchie & Lewis (2003), purposive sampling is when a researcher selects participants based on attributes that will assist the researcher in understanding the social phenomenon being studied (Ritchie & Lewis 2003). Before selecting participants, the researcher reads about the subject to determine which participants will be suitable to answer research questions (Ritchie & Lewis 2003). Policymakers, government officials and healthcare workers were recruited to understand the implementation of the NHI pilot program in the Tshwane District. Before selecting participants for this study, I read widely about the NHI policy in South Africa using peer-reviewed articles, books, policy documents and newspaper articles. The critical document which helped select my participants was the monitoring and evaluation reports on the NHI pilot program in South Africa published by MacDonald in collaboration with the NDOH and Clinton Health Initiative. The monitoring and evaluation report gave me insight into the PHC reengineering programs tested during the NHI pilot program. These programs were GP Contracting, DCST, CCMDD, ISHP and WBOT program (MacDonald 2015).

Healthcare workers recruited to be part of the study were 5 GPs whom the NDOH contracted to work under the NHI pilot program in the Tshwane District. Another set of 5 GPs recruited for this study was contracted by the Foundation for Professional Development (FPD). FPD is a Private Higher Education Institution which was central in partnering with the NDOH to recruit and contract GPs to work under the NHI pilot program in the Tshwane District. Two participants from FPD responsible for contacting GPs for the NHI pilot program were also recruited to participate in this study. GPs in the private sector who owned their practice were recruited to get their perspectives on the NHI policy. Five DCST members, including an Obstetrician/Gynaecologist, Paediatrician, Advanced Midwife, PHC Nurse and Aesthetician, were recruited to participate in this study. A total of 7 CHWs from the WBOT program were recruited to participate in this study through individual interviews. However, during the fieldwork, I found out that CHWs do not have an office space where I could interview them individually. Therefore, three unexpected focus group discussions were conducted with CHWs ranging from 6 to 8 members. A total of 6 PHC Nurses who were team leaders of the WBOT program in different were also recruited to participate. Four PHC Nurses who are managers of the WBOT program in different regions of the Tshwane District were recruited. A total of 10

Pharmacists Assistants who were involved in the CCMDD program were recruited to participate in this study. The Tshwane District Department of Education ran the ISHP, and I managed to recruit 4 government officials responsible for implementing it. Two School Nurses responsible for implementing the ISHP during the NHI pilot program in the Tshwane District were recruited to participate. Government officials involved in implementing the NHI pilot program in the Tshwane District were recruited to participate in this study. Five Tshwane District Department of Health government officials were recruited to participate in this study. These government officials included the Acting Director, NHI Conditional Grant Coordinator, WBOT District and Supply Chain Manager. The government officials from the Gauteng Department of Health refused to participate in the study and expressed that the NHI pilot program is in the jurisdiction of the Tshwane District.

Figure 6: Study Participants

	Program and institution	Role	Number of participants
Healthcare workers	General Practitioner Contracting	General Practitioners contracted by the National Department of Health	10
		General Practitioner owning private medical practice	5
		Foundation for Professional Development Representatives tasked to contract GPs for the NHI pilot program	2
	District Clinical Specialist Teams	Gynaecologist	1
		Paediatrician	1
		Advanced Midwife	1
		PHC nurse	1
		Aesthetician	1
	Ward-based Outreach Teams	Community Health Workers	7

		individual interviews	
		Community Health Workers focus group discussions	3
		WBOT Team Leaders – PHC Nurses	6
		WBOT Mangers – PHC Nurses	4
	Central Chronic Medicines Dispensing and Distribution	Pharmacist Assistants	10
Government officials	Integrated School Health Program	Tshwane Department Education Representatives	4
	Tshwane District Department of Health	Acting Director	1
		NHI conditional grant coordinator	1
		WBOT District Manager	1
		GP Contracting District manager	1
		Supply Chain Manager	1
	National Department of Health	CCCMDD National Representative	3

		WBOT National Representative	3
Policy makers	National Department of Health	NHI National Coordinators	2
	National Department of Health	Director General Representatives	2
	National Department of Health	PHC Reengineering National Strategy Representatives	1
	National Treasury	Representatives working on the NHI policy	3
Total number of participants			72

In non-random sampling, purposive sampling is used simultaneously with snowballing sampling (Ritchie & Lewis 2003). Once a researcher purposively selects the participants with knowledge of the social phenomenon being studied, she can ask these participants to refer them to other participants who are knowledgeable on the matter (Ritchie & Lewis 2003). My recruitment journey started by visiting the NDOH in the City of Tshwane. I was asked if I had an appointment when I got to the reception. My response was that I did not have an appointment. However, I would love to make one with government officials and policymakers working on the NHI policy. The receptionist responded, 'Ms Wonci, many people are involved, but I can make an appointment with the government official responsible for GP contracting'. Luckily, the government official was available that day to meet me at 3 pm, so I had to return in the afternoon. The government official's first question was, 'Ms Wonci, are you a journalist?' I said no, I am a PhD student from UNISA researching the NHI pilot program. The government official's question needs to be contextualised in an era between 2016 and 2017 when many newshouses published articles about the proposed NHI policy in South Africa. The newspapers were also publishing articles and critiquing the then Mister of Health, Dr Motswaledi, about the NHI policy. I presented my student card and all the ethical clearance documents I had received from UNISA and various ethical review boards in the province to conduct the study. With ease, the government official said, 'Ms Wonci I will not have an interview with you'. However, I will give you all the contact details of the GPs we have contracted to work under the NHI pilot program. All the best with your research. The contacts were in a spreadsheet with names, phone numbers, and emails of GPS contracted to work on the NIH pilot program in the Tshwane District.

I sent official emails to GPS, inviting them to participate in this study. I attached the ethical clearance certificate and the information sheet that explains the study's objective in the email. Two days after sending the email to GPs, I called them using the numbers on the spreadsheet. Ten GPs in different public clinics in the Tshwane District agreed to participate in the study. The GPs who refused to participate in the study explained to me that the NHI policy is a sensitive topic and that for the sake of keeping their jobs, they prefer not to participate. During my recruitment, one call with a GP made me realise that whilst we are consumed with the research process, the people we are interested in studying are going through tribulations of life. I called a GP, and the phone was answered. I introduced myself and the reasons why I was calling. There was a big sigh on the other side of the

phone. *'I am sorry I cannot participate in your study; my husband lost his battle with cancer this morning.* The phone dropped. That evening, I was overwhelmed with sadness. I went back and forth with what-ifs: what if I had called another time? I asked myself how we can humanise research subjects not only when we meet, interview, and write about them but also during the recruitment process.

Recruiting private GPs who owned a private practice and were not part of the NHI pilot program in the Tshwane District was easier. I walked into the GPs' offices, most of which were in Pretoria CBD, Sunnyside, Hatfield and Brooklyn. I would explain my intentions to the receptionist and book an appointment to meet and interview the GP. A total of 5 GPs who owned their private practice agreed to participate and shared their views about the NHI policy in South Africa. The GP Contracting Program Manager referred me to two representatives from the FPD who contracted GPs to work under the NHI pilot program. I invited these two representatives to the study, and they agreed to participate. Recruitment of government officials from the Tshwane District Department of Health was made possible by the Acting Director at the time. After I managed to recruit and interview the Acting Director, she gave me the names and contact details of all the people involved in the different portfolios of the NHI pilot program. The Acting Director then emailed all these government officials, encouraging them to participate in this study. In the email, the Acting Director also expressed her excitement that someone is taking the evaluation task of the NHI pilot program in the Tshwane District. The Acting Director's buy-in of the study motivated the government officials in the Tshwane District to agree to participate.

The DCST members, including a Gynaecologist, Paediatrician, Advanced Midwife, PHC Nurse and Aesthetician, were pleased to participate in the study. The WBOT Manager referred me to all the PHC Nurses who were WBOT Managers and WBOT Team leaders in the Tshwane District. The WBOT Manager told me that the Team Leaders would refer me to the CHWs working in different communities. The WBOT Team Leaders then invited me to their communities to meet and recruit CHWs to be part of the study. The Tshwane District Department of Health administrator gave me a list of the contacts of Pharmacist Assistants working under the CCMDD program. The list had their names, emails, and contact numbers, and I used this information to recruit Pharmacist Assistants to participate in the study.

The most difficult participants to recruit for the study were government officials and policymakers at the NDOH. After the government official who gave me a list of GPs' contacts, I was not lucky in securing an interview with anyone at the NDOH for months. I continued calling, emailing, and sometimes visiting the NDOH. The reply I got from the receptionist was that 'the NHI national coordinator will get back to you soon. However, this changed when I was invited to a Fulbright Alumni breakfast in May 2017. I met an old acquaintance who was also a Fulbright Alumni, and we talked about our Cape Town days and what we are doing with our lives. I told her that I am conducting research on the NHI policy and the NHI pilot program. I am at a frustrating stage of my fieldwork where I need help securing interviews with key NDOH stakeholders. Her response was, 'wow, I am doing consultancy work for the NHI policy with the World Health Organization*'. Work Stream 3, which focuses on the NHI policy financing models, is looking for a consultant. Would you be interested in that kind of work?*' I agreed immediately and told her I had to inform my supervisor. She shared with me the contacts of the WHO representative who is looking for a consultant and sent an introduction email to both of us. I was asked to submit my resume and writing samples, and a week later, I was informed that I got the consultancy job. I had two supervisors in this new job, one from the World Health Organization and another from the NDOH. At the NDOH, my supervisor was the then Director General.

At our first meeting, the Director General told me about my role and what was expected of me. I used this opportunity to tell the Director General about my PhD project and how I have been struggling to secure interviews with government officials and policymakers at the NDOH. He responded that I would kindly email everyone who can assist you and ask that they meet with you for an interview. I was grateful. The Director General asked if I wanted to interview him about the NHI policy. I said yes. We arranged to meet, and I interviewed him about the NHI policy and the NHI pilot program. With the assistance of the Director General, 2 NHI national representatives, 2 PHC reengineering national representatives, WBOT program national director, CCMDD program national coordinator, and two NHI policymakers agreed to participate in this study. The Director General also referred me to 3 National Treasury policymakers working on developing the NHI Fund. The consultation job at the WHO gave me access to key policymakers and government officials at the national level who were at the forefront of the NHI policy. I will forever be grateful

to the Fulbright Alumni acquaintance who introduced me to the WHO consultancy job opportunity.

Methods of Data Collection

A total of 72 In-depth interviews, 3 impromptu focus group discussions and secondary data were used to understand the implementation of the NHI pilot program in the Tshwane District. According to Pope & Mays (2006), in-depth interviews provide the researcher insight into how institutions work for members within and outside (Pope & Mays 2006). In-depth interviews allow the researcher to tap into how members and non-members of the institution make meaning, interpret and experience the social institution being studied (Pope & Mays 2006). In this study, in-depth interviews allowed the healthcare workers, government officials and policymakers to provide me with insight into the implementation of the NHI pilot program. In-depth interviews helped me to understand the meanings, interpretations and experiences healthcare workers, government officials, and policymakers attached to the process. The in-depth interviews were semi-structured, allowing me to use interview guides to make sense of the process while simultaneously allowing participants to express how it has been for them (Pope & Mays 2006).

The fieldwork was 12 months, and in-depth interviews were conducted between November 2016 and October 2017. Most in-depth interviews were conducted in English as participants were healthcare workers, government officials and policymakers who were professionals who could converse using the language. Only one participant who was a CHW asked to be interviewed in Isitswana. I told the participant I was not from the Tshwane District and that my first language was Isixhosa. Unfortunately, I cannot speak IsiTswana. The participant replied, if you are Xhosa, you can speak a bit of IsiZulu. If you can speak a bit of IsiZulu, you can speak Isipitoli'. I said yes, I can converse with a Zulu person, and I can try harder with Isipitoli. The participant said, let us have the interview in Isipitoli'. Isipitoli is a dialect spoken in the City of Tshwane, which was formerly referred to as Pretoria. This dialect is a mixture of Isitswana, Isipedi and IsiZulu that the migrant labourers from different parts of the country use in this area to communicate.

This in-depth interview was the longest and the most insightful I had with a CHW. It lasted for two hours and 30 minutes. The participant had been working as a CHW since 1998. She had historical

and current knowledge of community healthcare work in the Tshwane District. The participant told me she had worked for different NGOs implementing the WBOT program in the Tshwane District. Now in her late 50s, she is starting to work on a government contract under the NHI pilot program. This interview brought me to the attention of multiple parties such as NGOs, NPOs and the government institutions involved in the implementation of the WBOT program in the Tshwane District. I imagined what other forms of institutional knowledge I would have gained from the participant about the WBOT program if I was fluent in her first language, Isitswana. In-depth interviews in this study were recorded upon gaining informed consent from the participants. There were cases where participants refused to be recorded. In such cases, I would listen and take notes of the key messages from the interview. There were also moments when participants asked me to turn off the recorder when they were relaying certain information to me. Participants would say, please turn off the recorder. This should be between you and me and not part of the research findings". I would turn off the recorder as instructed. The GPs expressed that too many journalists call us to comment on the NHI policy, and we do not want to be recorded in these studies. Each in-depth interview lasted from 40 minutes to 1 hour and 30 minutes. The longest interview was 2 hours and 30 minutes with the CHW described above.

Cock (1989), in her book, *Maids and Madams*, writes about 'moments in the field' that a researcher encounters which disrupt her preconceived notion of a social phenomenon. At the beginning of her research journey for the *Maids and Madams* research project, Cock (1989) details that her primary interest was to understand the experiences of domestic workers under apartheid in South Africa. However, accessing domestic workers who were predominantly Black in Grahamstown meant that she had to go through the Madams who were White (Cock 1989). Cock's research journey begins during a highly contested racialised era of apartheid where Black and Whites lived apart and connected intimately through labour (Cock 1989). When Cock knocked at the houses of the Madams where the Maids worked, she explained to the Madams that she was interested in studying the experiences of domestic workers (Cock 1989). The first few houses she visited, the Madams quickly opened their doors for Cock as she was also a White woman (Cock 1989). When Cock explained the objective of her study, White women refused to let her in their houses (Cock 1989). Cock (1989) documents that she then had to go back to the drawing board and change what she presented as research objectives at the door of these white women's houses. The research objectives

were changed to 'investigating how White women were running their households' (Cock 1989). Cock (1989) argues that this new research objective allowed White women who were Madams to open their doors for her. Integral to the household management of white women's houses were the Black Maids employed for duties such as cleaning, ironing and child rearing (Cock 1989). The change in research strategy allowed Cock to gain access not only to the daily household running of White Madams but also to the Black Maids who were an integral part of the household duties through their domestic labour (Cock 1989).

During my research in the Tshwane District, I had my share of what Cock (1989) terms 'moments in the field'. I had scheduled individual in-depth interviews with CHWs from Mamelodi Township. When I got to the venue, it was a room inside the high school premises. Close to 20 CHWs were there, including the WBOT Team leader. The team leader welcomed me and introduced me to all the CHWs. I told the team leader that I am interested in having individual in-depth interviews with CHWs about their experiences in the WBOT program. The team leader said, 'Ms Wonci, we will have a problem. We are all using this room, and we do not have a physical office space that you can use to meet us one by one. So individual interviews with them in this venue will not work'. For a moment I felt lost. I told the Team Leader to give me a second, and I need to call my supervisor. I called my supervisor and explained the situation. His response was, 'Sivuyisiwe please conduct focus group discussions'. I informed the team leader that I will conduct a focus group discussion with the CHWs. I asked for volunteers amongst the 20 CHWs to participate in the focus group discussion. Eight CHWs agreed to participate, and we held the focus group discussion outside their rented classroom. I visited Hamanskraal and Garankuwa and experienced the same situation where CHWs did not even have a rented classroom office like in Mamelodi. CHWs in Hamanskraal and Garankuwa worked outside public health clinics. For these reasons, three unexpected focus group discussions were conducted with CHWs.

In-depth interviews and focus group discussions were used simultaneously with secondary data. Secondary data included policy documents on the NHI policy, evaluation reports on the NHI pilot program, peer-reviewed articles, books, and newspaper articles on the NHI policy in South Africa. Peer-reviewed articles, books, and newspapers gave me insight into the NHI policy and local debates of moving South Africa towards UHC. Articles, books, and newspaper articles gave me insight into

the location of the NHI policy within local and global debates of moving South Africa towards UHC. The policy documents helped to understand the objectives of the NHI pilot program and how these objectives were in the NHI Green Paper and the White Paper. The evaluation reports gave me insight into the achievements, opportunities and challenges of the NHI pilot program across pilot districts.

Methods of Data Analysis

The 72 in-depth interviews and 3 focus group discussions used to understand the process of the NHI pilot program in the Tshwane District were transcribed, read, and analysed using thematic data analysis. According to Adler (2009), thematic data analysis allows the researcher to do intensive reading, identify reoccurring information and code them into themes that assist in addressing the research objectives. After transcribing, I read each in-depth interview and focus group discussion. Using an Excel Spreadsheet, I identified a set of reoccurring themes and grouped them accordingly. I uploaded the same individual interviews and focus group discussion data to Atlas.ti, a qualitative data analysis software. I analysed the data by reading each interview and focus group discussion to detect reoccurring themes. I compared reoccurring themes from Atlas.ti with themes from the Excel Spreadsheet. In Atlas.ti I detected a few new themes that I did not detect when using the Excel Spreadsheet.

Ethical Procedure

The ethical clearance for this study went through 6 institutions of ethical review boards. My intellectual department, the Department of Sociology at the University of South Africa, was the first institution to approve this study. The second ethical review board was the Department of Health Studies at the University of South Africa. This ethical review board is responsible for processing and approving health research conducted by staff and students at the university. The third institution that approved the research proposal was the National Health Research Database Board. To conduct research with healthcare workers in South Africa, the National Health Research Database Board must process and approve the research. The fourth review board to process and approve my research proposal was the Tshwane District Department of Health because I was conducting the research in their district. The National Treasury was the fifth institution to grant me ethical clearance because I was interested in engaging with government officials and policymakers responsible for financing the NHI policy. The 6th review board to process my research request was the Gauteng

Department of Education because the Integrated School Health program formed part of the NHI pilot program. Conducting research with learners, teachers, and government officials in education, the Gauteng Department of Education needs to process and approve your research. It took 3 months for all these institutions to grant me ethical clearance to conduct my research on the NHI pilot in the Tshwane District. Please refer to **Appendix 1 - 4** for all the ethical clearance certificates.

Social scientists are responsible for engaging with human subjects within the parameters of respect, accountability, and dignity (Guillemin & Gillam 2004). The researcher must ensure that participants are adequately informed about the research (Guillemin & Gillam 2004). The researcher must take accountability for minor and significant risks that might expose participants to discomfort and hurt during and after the research process (Guillemin & Gillam 2004). Confidentiality ensures that the information participants share with the researcher will not be tied to their identity and pose personal and professional risks (Rossman & Rallis 2010). Anonymity means that the researcher must present and write the research findings in ways that protect the identity of participants (Rossman & Rallis 2010). The purpose of anonymity and confidentiality is to protect the dignity of participants from any immediate or future harm that might result from what is written by the researcher (Guillemin & Gillam 2004).

An information sheet was used to explain the objectives of the study to possible participants in this study. I explained to participants that the objective of this study was to evaluate the implementation of the NHI pilot program in the Tshwane District. I informed participants that this doctoral degree is under the Social Policy SARChI Chair at the University of South Africa. Participants were informed that the research data will be used to complete the doctoral degree and contribute to knowledge through peer-reviewed articles, books, and book chapters. Once a participant agreed to participate in the study, I provided him/her with an informed consent form which articulated their rights within the research process. I explained to participants that partaking in this study is voluntary and that the information they shared will be used for this doctoral study. Participants were informed that they did not have to answer uncomfortable questions. I encouraged participants to withdraw from participating in the study at any given moment. I informed participants that information such as names, surnames, and home physical addresses will not be tied to this research's findings and

future publications. Please see **Annexure 1 – 7** for an information sheet and informed consent form.

The researcher has an ethical accountability to return to the participants and present the research findings (Tolich & Tumilty 2020). Due to the high number (72) of participants interviewed in this study, I could only return to some individually to report research findings. After analysing my data and sharing my key findings with government officials and stakeholders, I returned to the Tshwane District Department of Health. Government officials commented on the findings and provided clarity on matters that were not clear with the NHI pilot program. After my presentation, the government officials thanked me for conducting this insightful evaluation work, and they said that once I pass my doctoral thesis, they will archive it in their library. One government official said, 'Ms Wonci, we appreciate the work that you have done, and we will reflect more on it. You must also write in your findings that what was piloted during the NHI pilot program in South Africa is not what was supposed to be piloted. However, we cannot discuss what was supposed to be piloted in today's meeting as we have external stakeholders.

Institutional Reflexivity

Feminist scholars argue that researchers must constantly interrogate how their class, race, gender and sexuality identities affect the research process (Wasserfall 1993; Hemmings 2012; Hesse-Biber & Piatelli 2012). Bourdieu (2004) dismantles identity politics as the main factor in one's positionality and power during the research process. Identity politics minimises the power of disciplines in shaping a researcher's perceptions and methods to investigate a social phenomenon (Bourdieu 1992). Disciplines such as Anthropology and Sociology influence the researcher's positionality, methodology and language during research (Bourdieu 1992). These disciplines open the researcher to specific knowledge and experiences in the field (Bourdieu 1992). Disciplines can also blind the researcher from paying attention to specific knowledge and experiences in the field (Bourdieu & Wacquant 1990). Researchers go into the field with prior knowledge from these respective disciplines and engage with subjects in the field with preconceived knowledge prescribed by the discipline (Bourdieu & Wacquant 1990). For Bourdieu (1992), researchers need to pay attention to how institutions of knowledge open their eyes and simultaneously shut them, resulting in blind spots that are not easily identifiable during fieldwork.

It was in April 2017 when a GP from Hamanskraal at Jubilee Hospital agreed to meet with me to discuss the NHI pilot program. The appointment was at 1 pm, and I got there on time. At the hospital gate, I asked security about the GP's station. The security accompanied me, and we walked for 15 minutes to a stand-alone house. I entered the stand-alone house, and two nurses were at the front desk. I explained the purpose of my visit, and the nurse asked me to sit down and wait. On my far right was an older woman who was in her 70s. On my far left was a teenage girl. I waited, and after 60 minutes, two policemen walked in. The police officers greeted the nurse, picked up a file and left. I started observing the surroundings and realised that the older woman was peeing on herself. I reported the matter to the nurse, who said, Please do not worry. We will take care of it. I asked to use the bathroom. I was directed to a passage and entered a room with a full bedroom suite with a shower and toilet seat. I asked myself, who sleeps in a clinic?

After 3 hours of waiting, the GP came in with a woman carrying a baby screaming hysterically. They went into the GP's room, and the consultation lasted 45 minutes. The GP attended to the older woman was attended to the older woman and the teenage girl. The GP came out of his consultation room and said, Ms Wonci, it is already 5 pm and thank you for your patience. Unfortunately, we cannot have the interview here as the shifts are changing. The GP working the night shift is going to require the consultation room. Where do you stay? I replied I live in Pretoria CBD. The GP said that is great. I do not live far from Hatfield, and I know a quiet coffee shop where we can have the interview. I agreed, and we drove to Hatfield. In the car, I asked the question that had been bothering me for hours. Doctor, what kind of clinic is that? The GP looked at me surprised and said, Ms Wonci, you have never been to a rape clinic? That is a rape clinic, and I am one of the GPs who must examine rape victims and send specimens to the lab so that the rapists can be prosecuted. I was shocked, and the images of the older woman, the teenage girl and the crying baby could not leave my head. The GP told me that the older woman was gang-raped last night, and they took her pension money. A neighbour raped a teenage girl. A relative raped the 3-month-year-old baby. That is the Jubilee Hospital rape clinic, and it operates 24 hours. Sometimes rape victims come to the emergency ward in the middle of the night, and we keep them in that clinic for debriefing and specimen collection. I work with another male doctor, and the courts depend on us to do our work accurately, so the rapists are charged.

I was numb, and the interview with the GP about the NHI pilot program felt long. When I entered my apartment, I broke down mentally. I remember calling my supervisor, saying, '*I was in a rape clinic, and I did not know. I* had just experienced what Bourdieu (1992) describes as blind spots in the field. I sat in a rape clinic for hours and did not know what was happening. I regard myself as a feminist and an activist for women's struggles. I have attended South African protests to end gender-based violence, rape, and femicide against women. However, I did not even know what a rape clinic looked like. I majored in Women and Gender Studies and Sociology of Health in my undergraduate studies, and I did not know what a rape clinic looked like. I did my Masters in Public Health in New Jersey, where we tackled policy issues of sexual and reproductive health in the United States, and I did not know what a rape clinic looked like. I was a PhD candidate in Sociology at the University of South Africa under the SARChI Chair in Social Policy, and I did not know what a rape clinic looked like. My institutional knowledge of public health, women's rights and sexual reproductive health and my disciplinary home of Sociology could not help me identify a rape clinic in a country like South Africa, where women are raped daily.

Chapter 4: The National Health Insurance policy as a possible tool for Transformative Social Policy in South Africa

Transformative Social Policy Analytical Framework

Transformative Social Policy is an analytical framework that defines social policy as a collective commitment of citizens, the State, and public and private institutions to advance the people's human, economic and social welfare within a geographical area (Adesina 2011 & Mkandawire 2007). This analytical framework believes that Africa needs to return to the broader political commitment of social policy in which economic development is intrinsically embedded within social development (Adesina 2015). Mkandawire (2001) asserts that the role of social policy in developing countries is to advance human development and economic growth simultaneously. The commitment to a broader social policy project in Africa is committing to collective public and private interventions that advance human development and protect and secure livelihoods whilst paying attention to economic growth (Adesina 2007 & Adesina 2011). The Transformative Social Policy Analytical Framework believes that a commitment to a broader social policy vision has multiple economic gains for developing nations (Mkandawire 2004).

Advancing human development and protecting livelihoods means implementing collective public interventions that ensure that citizens have access to the economy through participating in decent work to secure fair wages and dignity (Adesina 2011; Mkandawire 2007; United Nations Research Institute for Social Development 2007). Citizen's full participation in the economy through productive labour means that they can collectively invest in public interventions such as health, education, and pension funds that will protect them from the uncertainty that comes with age, development and illnesses (Adesina 2007; 2010; 2011; 2015; Mkandawire 2001, 2007; Tekwa & Adesina 2018; Yi 2013; United Nations Research Institute for Social Development 2007). Public savings interventions such as national health insurance, pension funds and investment in universal education mean that the healthy adult working population protects children, the young, the elderly and the sick through risk cross-subsidisation (Adesina 2007; 2010; 2011; 2015; 2020; Mkandawire 2001; 2007; Phiri et al 2016; Tekwa & Adesina 2018; Yi 2013 & United Nations Research Institute for Social Development 2007). The collective public savings of social policy become a catalyst for economic growth as citizen's participation in the economy becomes more productive when their

human development is protected and secured throughout the stages of life (Adesina 2007, 2010, 2011, 2015; Mkandawire 2001, 2007; Phiri et al 2016; Tekwa & Adesina 2018; Yi 2013; United Nations Research Institute for Social Development 2007). The Social Transformative Policy Analytical Framework sees social policy as a collective public intervention that is not an afterthought for economic development (Mkandawire 2001; 2007). Mkandawire (2007) argues that countries must not wait for the economy to develop before committing to collective social policy interventions.

The Transformative Social Policy Analytical Framework recognises that policy architecture of targeting is often used to address human development vulnerabilities (Mkandawire 2005). Targeting policy architecture rests on the reactionary neoliberalist role of social policy, which is about protecting individuals from the failure of the market (Mkandawire 2005). Mkandawire (2005: 1) defines the policy architecture of targeting as "eligibility to social benefits based on means-testing to determine the truly deserving". The targeting policy architecture requires citizens to go through income, behavioural and status screenings to decide whether or not they should be beneficiaries of welfare policies (Mkandawire 2005). This means-testing approach minimises the number of people who will benefit from welfare policies (Mkandawire 2005). This policy architecture is embedded in the idea that the State has limited resources and cannot socially protect everyone (Mkandawire 2005). Targeting as a policy architecture promotes the idea of social policy as an emergency tool or a safety net to address the failures of the neoliberal markets (Mkandawire 2005). Social services such as education, housing, water, energy and healthcare are privatised (Mkandawire 2005). In targeting social policy architecture, social welfare benefits are a project to cater for the poor (Mkandawire 2005). This policy architecture has been criticised for leaving the development and welfare of citizens to unstable markets (Adesina 2011). It assumes that income based on remuneration is enough and sustainable to address the well-being and development of citizens (Adesina 2011). Targeting creates social divisions among citizens as beneficiaries and non-beneficiaries of State programs (Adesina 2011). Social policies targeting the poor are often poorly administered, creating social stigmas for beneficiaries and entrenching social division (Adesina 2011).

An alternative to targeting policy architecture is universalism (Mkandawire 2005). In the policy architecture of universalism, welfare benefits are seen as a fundamental human right that should be

afforded equally to all citizens (Mkandawire 2005). The State secures funds through public funds and taxation and purchases social services on behalf of the population (Jorg Michael 2010). The State becomes the machinery for providing social services such as health, education and housing (Jorg Michael 2010). Universalism has been praised for redistributing the country's wealth through social benefits that contribute to citizens' well-being and development (Jorg Michael 2010). It has also been seen as a solid social policy tie that unites citizens as equal contributors and beneficiaries of welfare services, thus strengthening social cohesion (Jorg Michael 2010). Critics of universalism policy architecture argue that the State becomes too involved and often controls the intimate parts of citizens' development and well-being (Jorg Michael 2010; Mkandawire 2005). Universalism has been criticised for letting the State make decisions for citizens concerning welfare (Jorg Michael 2010; Mkandawire 2005). It has also been criticised for silencing historical and continuing inequalities that benefit only privileged groups in society (Jorg Michael 2010; Mkandawire 2005). Mkandawire (2005) argues that social policies are never just targeted or universal. Social policies are often a mixture of targeting and universalism instruments to safeguard the historically marginalised, redistribute the country's wealth, achieve equity and foster social cohesion (Mkandawire 2005).

Five Functions of Transformative Social Policy

The Transformative Social Policy Analytical Framework prescribes five social policy tasks: production, protection, reproduction, redistribution and social cohesion (Adesina 2011; Mkandawire 2007; Tekwa 2020; Tom 2020). The first function of social policy is production in which citizens can contribute to society using their skills, labour and wisdom (Adesina 2011; Mkandawire 2007; Tekwa 2020; Yi 2013). The production function of the social policy pays attention to social, political, and economic interventions that provide citizens with universal quality education and skills development so that they can participate fully in the economy (Adesina 2011; Mkandawire 2007; Yi 2013). The production function of social policy is not about exploitative labour markets that rely on precarious cheap labour (Adesina 2011; Mkandawire 2007; Yi 2013). Instead, the production function of social policy is about developing skills and resources to advance human development through labour markets that provide decent wages and work benefits (Adesina 2011; Mkandawire 2007; Yi 2013). In addition, this function pays attention to the value of collective savings through health insurance, pension funds and progressive taxation that ensures risk cross-subsidisation (Adesina 2011; Mkandawire 2007; Yi 2013). According to Mkandawire (2007),

focusing on production as a function of social policy means paying attention to reproduction, protection, redistribution and social cohesion simultaneously. Once countries only obsess about production without paying attention to other functions of social policy, they are read as using human capital only for economic profits through labour exploitation (Yi 2013).

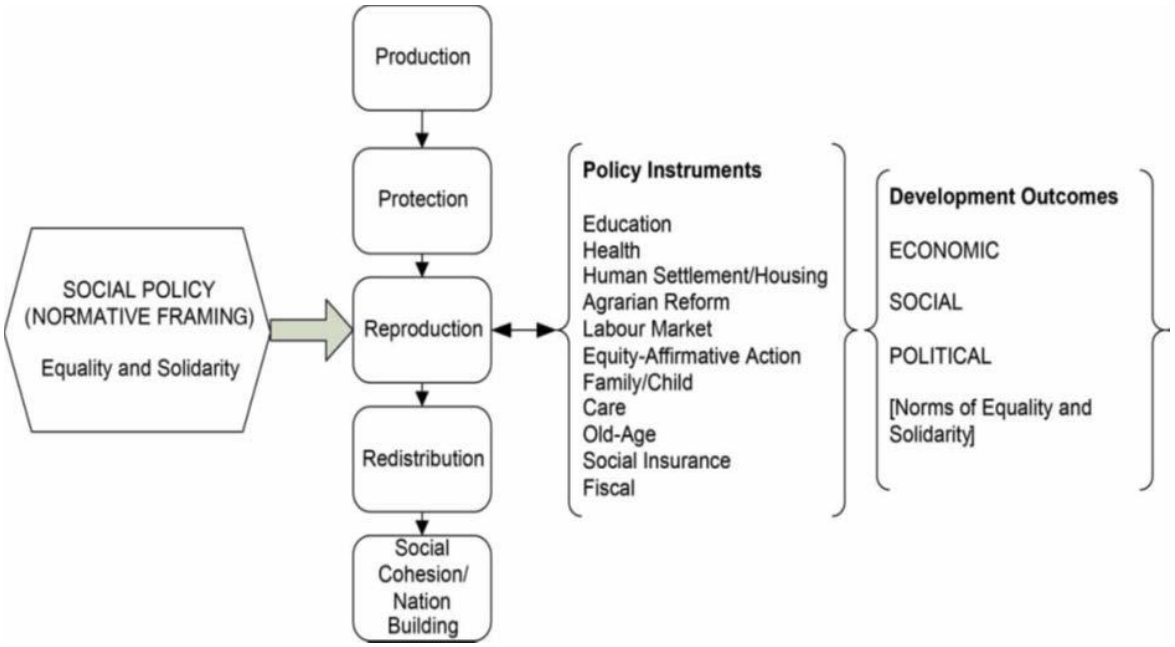
The reproduction function of social policy is about collective efforts that ensure the continuation of society through family and childcare policies. Reproduction as a social policy function must take seriously the burden of unpaid caregiving often bestowed on women in patriarchal societies (Tekwa & Adesina 2018). Therefore, reproduction as a function of social policy needs to ensure that collective efforts of family and childcare rearing consider women's livelihoods through programs such as universal early childhood development, universal healthcare, universal education and gender-sensitive labour laws (Tekwa & Adesina 2018). This ensures that women have the freedom to participate freely in society and the labour market without feeling that their reproductive choice of having a child is a burden (Tekwa & Adesina 2018; Tekwa 2020). According to Hassim & Razavi (2006), a commitment to reproduction as a function of social policy means letting go of patriarchal ideologies through gender-sensitive policies that alleviate the burden of unpaid caregiving for women.

The third function of social policy is protection, and this means that collective efforts have to be in place to protect citizens from the precarity that comes with life, such as childhood, sickness, disability, manufactured or natural disasters and old age (Adesina 2011, 2015). The protection function of social policy is about something other than the neoliberal prescription of protecting the population from market failures (Adesina 2011, 2015). Protection is about establishing universal early development programs, universal health coverage systems, universal education, redistributive land reforms, labour markets with decent wages and progressive pension funds that will advance human development and protect people from the precarity of life (Adesina 2011; 2015).

All the functions of social policy mentioned above can only come to fruition when there is a collective commitment to redistribute the income and wealth of a given territory across generations, races, genders and socioeconomic backgrounds (Fine 2017). The history of colonialism in Africa dispossessed people and alienated them from essential resources such as water, land, and the

mainstream economy (Fine 2017). The redistributive function of social policy is an urgent political program that can restore equity and peace in colonised nations (Tekwa 2020). The redistributive function of social policy is a political and normative commitment that redistributes essential resources such as land, economy, education, health, and infrastructure fairly across the population to ensure that equity and social cohesion is achieved (Adesina 2020; Phiri et al 2016; Tekwa 2020; Tom 2020). This function focuses on economic structures such as collective savings through taxation, universal health coverage, pension funds, universal education, land redistribution and non-exploitative labour markets (Adesina 2015). The redistributive function of social policy addresses the past's racial, class, gendered and socio-political injustices by redistributing resources fairly to the whole population to achieve equity (Mkandawire 2007). This function is also critical to the economic development and success of the country as collective savings such as pensions and progressive taxation are used to invest in business and infrastructure that advances human, social and economic development (Mkandawire 2001; 2007). The redistributive function of social policy is a political and normative function of sharing resources and wealth of the country fairly so that citizens are protected and afforded equity, thus strengthening the fifth social policy function, social cohesion (Adesina 2007, 2011, 2015). The fifth function of social policy can only be achieved when the country's essential resources, such as land, water, economy, educational opportunities, and health and welfare benefits, are redistributed fairly (Adesina 2007, 2011, 2015). Social cohesion as a function of social policy gives citizens the confidence and commitment to building and strengthening their collective effort to make the other 4 functions of social policy work effectively (Adesina 2007, 2011, 2015). Please refer to **Figure 1** for the Social Transformative Policy Analytical Framework diagram.

Figure 1 Transformative Social Policy Analytical Framework



Source: (Adesina 2011: 463)

The Transformative Social Policy Analytical Framework recognises education, health, human settlement, agrarian reform, labour market, affirmative action, family and childcare, old age and social insurance as key social policy instruments for human, economic, and social development (Adesina 2011; Mkandawire 2007; Tekwa 2020; Yi 2013). Each policy instrument has the potential to achieve goals associated with production, reproduction, protection, and social cohesion, especially when they are implemented concurrently (Adesina 2011; Mkandawire 2007; Tekwa 2020; Yi 2013). For example, to achieve maximum health indicators such as longevity, child and maternal health and low mortality rates, social policy instruments such as universal health coverage must be implemented simultaneously with agrarian reforms, decent housing, and progressive labour markets (Adesina 2011; Mackintosh 2005). A commitment to implementing social policy instruments simultaneously takes seriously that the health and well-being of the population are directly influenced by social determinants of health such as poverty, homelessness, unemployment, and economic inequalities (Mackintosh 2005).

Universal Health Coverage as a tool for Transformative Social Policy

Universal Health Coverage is a political and economic commitment to protect the population from health uncertainties and the financial burden of disabilities and illness (Yi et al. 2017). According to Somkotra & Lagrada (2008: 207), UHC policies in developing countries are "... a valuable social protection strategy that contributes to the prevention of financial catastrophe and impoverishment due to ill health". Beyond protecting people from the financial costs of ill health, the UHC agenda promotes primary healthcare, decreases child and maternal deaths, and improves population health (MacGregor 2017). In developing countries, the UHC agenda is about creating health financing systems where citizens and permanent residents contribute to collective savings that will aid in redistributing healthcare resources equally (MacGregor 2017). The individual and collective benefits of UHC policies are recorded widely in developing countries (Kuhonta 2017).

In Thailand, within five years of implementing the 30 Baht "Cure All Disease" UHC program, there was a decline in maternal and infant deaths, and poor households were protected from the financial burden of ill health (Mongkhonvanit & Hanvoravongchai 2017). According to Mongkhonvanit & Hanvoravongchai (2017), the 30 Baht program in Thailand reduced the number of uninsured people from 17 million in 2001 to 46 million in 2002 (Mongkhonvanit & Hanvoravongchai 2017). In 2013, the number of uninsured people in Thailand was less than 82,000 (Mongkhonvanit & Hanvoravongchai 2017). Thailand is a classic case of how political commitment and civil servants' support are essential in achieving UHC goals. In January 2001, a new political party called the Thai Rak Thai (TRT) Party was elected into power. In April 2001, the 30 Baht Program aimed to move Thailand toward UHC was implemented nationwide (Kuhonta 2017 & Sen 2015). The Thai Rak Thai political manifesto promoted economic reforms that would alleviate poverty and improve the population's health indicators through UHC reforms (Kuhonta 2017 & Sen 2015). The promotion of the UHC reform in Thailand was also spearheaded by doctors and physicians who worked in rural areas where people did not have access to quality healthcare services (Kuhonta 2017 & Sen 2015). When these doctors and physicians moved higher up to the Ministry of Health, they advocated for the country to move toward UHC (Kuhonta 2017 & Sen 2015). Medical doctors and physicians lobbied political parties such as Thai Rak Thai to prioritise UHC reforms (Kuhonta 2017 & Sen 2015). Political lobbying from civil servants paid off, and within 3 months of being in power, the Thai Rak Thai government implemented the 30 Baht program throughout Thailand (Sen 2015).

The 30 Baht program reached vulnerable populations in rural who did not have access to quality healthcare services and were not protected from the financial catastrophe that comes with ill health (Kuhonta 2017 & Sen 2015).

The National Health Insurance Policy as a Tool for Transformative Social Policy

The NHI policy in South Africa can be a tool for Transformative Social Policy because it aims to improve population health by redistributing the country's financial resources to ensure people have access to quality healthcare services (National Department of Health 2011; 15; 17). The NHI is a financing system designed to pool funds and provide quality and affordable health services to all based on their health needs and not income (National Department of Health 2015). The goals of the NHI policy will be achieved by establishing an NHI Fund, which will poool public funds from collective contributions of income tax, pre-mandatory payments, public revenue and medical aid tax contributions (National Department of Health 2018). The NHI Fund will then purchase healthcare services on behalf of the population from accredited public and private service providers (National Department of Health 2015). The NHI Fund will promote citizen equity and social solidarity through risk cross-subsidisation, where the healthy working population subsidises the ill and the elderly (National Department of Health 2017).

Empirical evidence on how the NHI policy can be used for Transformative Social Policy exists in policy documents, peer-reviewed articles, books, policy briefs and newspapers. This is because the NHI policy in South Africa is yet to be implemented nationally. The only empirical evidence on how the NHI policy can be used as a tool for Transformative Social Policy is reflected in the NHI pilot program implemented between 2012 and 2017 across eleven districts in South Africa. One of the key objectives of the NHI pilot program was to test PHC reengineering national strategy innovations that will improve healthcare service delivery in public health facilities (National Department 2011; 2015; 2017). The tested PHC innovations were GP Contracting, DCST, CCMDD, ISHP and WBOT programs. In this chapter, I reflect on the possibilities of the NHI policy in achieving health equity, improving population health and encouraging social cohesion by examining what was piloted and not piloted during the NHI pilot program. I do this by critically analysing how functions of Transformative Social Policy such as production, reproduction,

protection, and redistribution were reflected in the PHC innovations tested during the NHI pilot program in the Tshwane District.

The productive function of Transformative Social Policy: reflecting on the National Health Insurance Pilot program in the Tshwane District

Transformative Social Policy's productive function is developing skills and resources to advance human development through labour markets that provide decent wages and work benefits (Adesina 2011; Mkandawire 2007; Yi 2013). The productive function of Transformative Social Policy was reflected in the GP Contracting and CCMDD program during the NHI pilot in the Tshwane District. The GP Contracting and CCMDD program increased human resources by employing GPs and Pharmacist Assistants to improve the delivery of healthcare services in public health facilities. The GP contracting program employed 74 to work in public health facilities in disadvantaged communities. The work of GPs strengthened the provision of healthcare services in public health facilities. From the NHI pilot program in the Tshwane District, we learned that the presence of GPs in public clinics meant that people's health conditions were at the appropriate level of care. The presence of GPs in public clinics reduced unnecessary referrals at the tertiary level, resulting in overcrowded hospitals. GPs brought quality healthcare services closer to where people lived, building trust between the community and the health system. Community members received the highest level of care within walking distance of where they lived, making them believe that the healthcare system is reliable and able to meet their needs.

The work of GPs as the productive function of Transformative Social Policy was not without challenges. Medical doctors rendered the model of contracting GPs during the NHI pilot program in the Tshwane District ineffective. Two contracting models were used to contract GPs under the NHI pilot program in the Tshwane District. In the first model, the NDOH contracted GPs to do sessional work in public health facilities. The NDOH paid GPs based on hourly rate. In the second model, GPs were contracted by FPD and expected to be onsite for 40 hours a week. In the FPD contracting model, the organisation predetermined GPs' salaries. GPs were unhappy with both models and suggested that the risk-adjusted capitation model should be used as a contracting system when the NHI policy is implemented. The deteriorating public health facility infrastructure, shortage of medical equipment and essential medicines, patient overload, power dynamics between nurses and GPs and delayed payments were reported as challenges. GPs reported that the challenges

they experienced in delivering healthcare services are not unique to the NHI pilot program but the challenges of working in public health facilities.

The CCMDD program during the NHI pilot program in the Tshwane District allowed stable patients with chronic illnesses to collect medication at convenient pick-up points. The CCMDD program reduced the patient load in public health facilities and allowed healthcare professionals to focus on patients who require medical attention. The CCMDD program improved the health indicators of patients as they were adhering to taking their medication regularly. The CCMDD employed more than 145 Pharmacists Assistants in the Tshwane District. The CCMDD program in public health facilities was run by Pharmacist Assistants responsible for placing orders, stock-taking, pre-packing and dispensing medication. The challenge of the CCMDD program is that Pharmacist Assistants were employed on a two-year-based contract and have asked the NDOH to employ them permanently. The government officials running the CCMDD program at the national level reported that Pharmacist Assistants had created their expectations about full-time employment. Government officials reported that they never made promises of full-time employment to Pharmacists Assistants because the CCMDD program relies on donor t funding that is not sustainable. In the beginning, small-scale community pharmacies were reluctant to join the CCMDD. Big corporate companies such as Clicks and Dischem joined the program and reaped the profits that could have benefited small-scale community pharmacies. Pharmacies have separate queues for patients who are in the CCMDD program. Patients complained that this separate queue makes people in the community think that they are collecting medication for HIV. Pharmacies worked on integrating the queues of the CCMDD program with other patients. Pharmacies worked in packaging ARVs in generic bottles to reduce the HIV stigma in waiting lines.

The results from the GP Contracting program and CCMDD program during the NHI pilot program in the Tshwane District show us that increasing human health resources is critical for improving the delivery of quality healthcare services. The presence of GPs in public clinics meant that people could access quality healthcare services closer to where they live. GPs' work in public clinics ensures that medical conditions are treated appropriately, reducing unnecessary referrals that overburden hospitals with patients. During the NHI pilot program in the Tshwane District, the GP contracting program taught us that redistributing human resources to communities is essential in improving

healthcare service delivery. Contracting Pharmacist Assistant in the CCMDD program showed us that investing in human resources can reduce long waiting lines and patient load in public health facilities. The work of Pharmacist Assistants prevented drug stockouts, a common challenge amongst public health facilities in South Africa. These two programs show us that a commitment to the productive function of Transformative Social Policy, which is to invest in human resources for health, is lifesaving. These programs also showed us the possibilities of the NHI policy in redistributing human resources in disadvantaged communities to improve the health indicators of the population. The NHI pilot program in the Tshwane District showed us that UHC policies, such as the NHI policy, have a productive role in increasing human resources to improve the delivery of healthcare services and the population's health indicators.

The productive function of Transformative Social Policy must pay attention to labour markets, labour laws and a decent living wage (Mkandawire 2007). The contracts of GPs and Pharmacist Assistants during the NHI pilot program in the Tshwane District GP reflect labour challenges in South Africa, where unemployment is high and precarious work contracts are rife. GPs complained that the contracts used to employ them were ineffective and preferred the risk-adjusted capitation model as a system of contracting when the NHI policy is implemented. GPs complained that the NDOH did not pay them on time and sometimes were unpaid for months. Pharmacist Assistants were employed on a 2-year contract and had no job security and benefits. The NDOH denied making promises of full-time employment to Pharmacist Assistants because the CCMDD program relied on external donor funding. Findings from the NHI pilot program in the Tshwane District caution us that for the NHI policy to achieve the productive role of Transformative Social Policy, labour reforms that guarantee healthcare workers sustainable work contracts and decent wages must be implemented to ensure delivery of quality healthcare services that will save lives.

The reproductive function of Transformative Policy: reflecting on the National Health Insurance Pilot Program in the Tshwane District

The Transformative Social Policy Analytical Framework views reproduction as a social policy function responsible for the safe continuation of life in society (Tekwa & Adesina 2018; Tekwa 2020; Tom 2020). Safe continuation of life needs to be protected by collective reproductive services that protect women, children, and families from the uncertainty of human development (Tekwa & Adesina 2018; Tekwa 2020; Tom 2020; Phiri et al. 2016). During the NHI pilot program in the

Tshwane District, the DSCT program and ISHP reflected some aspects of the reproductive function of Transformative Social Policy social policy. Both programs were responsible for the continuity of life in society. The DCST program was responsible for improving maternal and child health in public health facilities, whilst the ISHP was responsible for improving children's health in schools.

The DCST program was responsible for training doctors and nurses on reproductive health and obstetric care in public health facilities to improve maternal and infant health indicators. DCST members reported that their work improved the delivery of reproductive health services, and healthcare professionals were confident about treating newborn babies with minor complications at the primary level of care. The DCST members expressed that their work increased antenatal bookings, uptake of family planning, pap smear screening, breastfeeding rates and reduced premature births and stillbirths. The challenges of DCST members during the NHI pilot program in the Tshwane District were administration bottlenecks, which delayed the purchase of medical equipment and essential medicines. DCST members complained that they are overworked and burnt out as the team of 7 specialists is insufficient to cover all public health facilities in the Tshwane District. High turnover and staff resignation in public health facilities meant that DCST members should start clinical training from scratch. DCST members reported that reviewing the death of a baby is the worst part of their job, and they never get used to it.

The ISHP delivered healthcare services to learners in public schools. Health screenings such as assessment of learners' eyesight, hearing and dental conditions were conducted. Once a learner was identified to have a complication, they were sent to higher levels of care to consult. Deworming tablets and Vitamin A were administered to improve the learner's classroom concentration. With parents' approval, the school nurses administered HPV vaccines to girls in Grade 4 to prevent the future occurrence of cervical cancer. The challenge of the ISHP during the NHI pilot program in the Tshwane District was the shortage of human resources. School nurses and government officials complained that the workload of the ISHP was too much, and teachers were not allowed to assist them. The Department of Basic Education and the teachers' union SADTU banned teachers from participating in the ISHP. Government officials and school nurses reported that parents did not sign the consent form permitting them to provide learners with medical services. HIV, teenage pregnancy, and drug abuse in high schools were reported as challenges the ISHP must address in

the Tshwane District. The DCST program and ISHP show that the NHI policy has the potential of fulfilling the reproductive role of Transformative Social Policy by protecting women, families and children from the precarity that comes with pregnancy, childcare and educational development. However, the number of specialists on the team must be increased for the DCST program to reduce maternal and infant deaths in South Africa. Each community must have 7 DCST members to attend to maternal and child health needs in that area. The ISHP must employ more school nurses, and each school must have one school nurse responsible for learners' health needs.

The protective function of Transformative Social Policy: reflecting on the National Health Insurance Pilot program in the Tshwane District

The protective function of Transformative Social Policy means that collective efforts have to be in place to protect citizens from the precarity that comes with life, childhood, sickness, disability, manufactured or natural disasters and old age (Adesina 2011, 2015). The protective function of Transformative Social Policy was reflected in the WBOT program during the NHI pilot program in the Tshwane District. The objective of the WBOT program is to deliver PHC services to people in the comfort of their homes. The findings from this study show that the WBOT program, through the work of CHWs, delivered PHC services in poor communities with no access to healthcare services. CHWs worked in communities riddled with poverty, unemployment, and crime. In these communities, people lived in squatter camps without electricity, sanitation, and health facilities. People told CHWs they do not want healthcare services alone but jobs so that they put food on the table. CHWs delivered reproductive health services to women at home by offering free pregnancy tests. Once CHWs discovered that a woman was pregnant, they sent her to the nearest health facility for antenatal care. Accompanied by professional nurses, CWHs administered immunisation and Vitamin A to improve children's health. Health promotion interventions such as screening people for HIV, TB and hypertension were implemented by CHWs during the NHI pilot program in the Tshwane District. To improve treatment adherence, CHWs delivered chronic medication to people in the comfort of their homes. Bedridden patients were washed, fed, and comforted by CHWs.

The challenge of the WBOT program during the NHI pilot program in the Tshwane District was the exploitative work contracts of CHWs. CHWs were employed on monthly contracts by NGOs and NPOs that the NDOH outsourced. Under this precarious work contract, CHWs were paid R2500 with no work benefits such as medical aid and maternity leave. CHWs protested before the

NDOH offices in Pretoria and demanded that the government employ them permanently. CHWs also worked under poor conditions without physical office spaces, medical equipment, digital gadgets, uniforms, and transportation. The protective function of Transformative Social Policy was evident in the WBOT program during the NHI pilot program in the Tshwane District. The WBOT program, through the work of CHWs in the Tshwane District, protected communities from the burden of ill health by delivering healthcare services to people in the comfort of their homes. However, when the NHI policy is implemented, CHWs must be employed permanently with decent wages and improved working conditions. If the working conditions of the CHWs are not reformed, the NHI policy will burden CHWs, who are primarily poor Black working-class women, with unpaid caregiving.

The redistributive function of Transformative Social Policy: reflecting on the National Health Insurance Pilot program in the Tshwane District

The redistributive function of Transformative Social Policy is a political commitment to redistribute the country's resources, such as land, economy, education, health, and infrastructure, across the population to ensure equity and social cohesion. The redistributive function of Transformative Social Policy was not reflected during the NHI pilot program in the Tshwane District. This is because what was piloted during the NHI pilot program in South Africa is not what was supposed to be piloted. What was supposed to be piloted was how districts would purchase healthcare services from public and private healthcare providers using the NHI Fund. The NHI Fund will collect public funds through general tax, pre-mandatory contributions, and public revenue and purchase healthcare services on behalf of the population from accredited public and private service providers (National Department of Health 2018). The health financial resources of the NHI Fund will then be used to purchase quality healthcare services from accredited public and private healthcare services providers on behalf of the population (National Department of Health 2018). Findings from this study show that disagreements between NDOH and the National Treasury led to the NHI pilot program being turned into PHC reengineering national strategy that had nothing to do with the NHI policy as a health financing system. What was not piloted could have given us an empirical snapshot of how the NHI fund, as a single purchaser of healthcare services, has the possibility of redistributing South Africa's financial health resources between the rich and the poor. In order to strengthen social cohesion in a country riddled with inequalities due to colonialism and apartheid, which left most Black South Africans poor and unprotected.

Chapter 5: "What was piloted is not what was supposed to be piloted": views of policymakers and government officials about the National Health Insurance Pilot Program in South Africa

Background

South Africa has responded to the call to move toward UHC by introducing the NHI policy (National Department of Health 2015; Matsoso & Fryatt 2013). The objectives of the NHI policy are to restructure the unequal healthcare system in South Africa and ensure that citizens and permanent residents have access to quality healthcare services based on need and not income (National Department of Health 2015; Matsoso & Fryatt 2013). This will be achieved by creating a single NIH fund, which will pool public funds to the NHI Fund and purchase healthcare services on behalf of the population (National Department of Health 2015). The NHI Fund is created as a public entity and will be funded through general tax, provincial equitable funds, conditional grants and medical scheme tax credits (National Department of Health 2019). The personal income tax contribution to the NHI Fund will be mandatory, and people's contributions will be based on their income bracket (Gani 2015). According to Gani (2015), the personal income tax contributions to the NHI Fund will be progressive and ensure social solidarity through cross-subsidization. The cross-subsidization principle of the NHI policy means that people will contribute to the NHI Fund based on their ability to pay and receive healthcare services based on their health needs (Douwes & Stuttaford 2018). The principle of cross-subsidizing in health financing guarantees social solidarity as the health financial resources of the nation are redistributed between the sick and the healthy, wealthy and the poor, and employed and unemployed (Douwes & Stuttaford 2018).

In consultation with healthcare service providers, the NHI Fund will determine the appropriate rates for healthcare services (Masuku & Sabela 2020). The NHI Fund will purchase healthcare services on behalf of the population by transferring funds directly to accredited private and public service providers contracted at the central, provincial, regional and district levels (National Department Health 2020: 35). The Diagnosis Related Groups (DRGs) will be used to reimburse hospital care services (National Health Insurance 2015; 2018). The DRG reimbursement system categorizes patients with similar clinical diagnoses to determine hospital costs (World Health Organization 2007). Emergency services will be purchased on behalf of the population using a capped-based fee (National Department of Health 2020). PHC services will be purchased by

transferring funds to Contracting Units of Primary Health Care (CUP) (National Department of Health 2020). The CUP is a sub-district geographical area consisting of ward-based outreach teams, clinics, community healthcare centres and district hospitals to provide healthcare services to the population (Valiani 2020). People will register for the NHI fund using the NHI registration system, which will be attached to a CUP (Valiani 2020).

Part of transitioning from the current healthcare system to the NHI policy involved the implementation of the NHI pilot in eleven health districts across South Africa (National Department of Health 2015). The NHI pilot program was implemented from 2012 to 2017. In the NHI Green Paper, the objectives of the NHI pilot program were to evaluate the ability of districts to assume greater responsibility for purchasing healthcare services, the feasibility, acceptability, effectiveness, and affordability of engaging the private sector, and the costs of introducing a fully-fledged district health authority and the implications for scaling up (National Department of Health 2013; MacDonald 2013 & Ogunbanjo 2013). However, in the NHI White Paper, which was published after the Green Paper, the objectives of the NHI pilot program "is to improve and strengthen the health system before the introduction of an NHI Fund by implementing specific primary healthcare interventions in selected pilot districts" (National Department of Health, 2015: 27). It is not clear from both policy documents as to what lead to the change of the NHI pilot program from testing how pilot districts will purchase healthcare service on behalf of the population using the NHI Fund to testing the PHC reengineering national strategies to improve the delivery of healthcare services in public health facilities. This chapter aims to show that what was piloted during the NHI pilot program in South Africa is not what was supposed to be piloted.

Findings

The objective of the National Health Insurance Pilot Program

When asked about the objective of the NHI pilot program in South Africa, government officials and healthcare workers in this study responded that it was to test PHC interventions such as the GP Contracting, DCST, CCMDD, ISHP and the WBOT program. These PHC reengineering interventions were implemented to improve healthcare service delivery in public health facilities, increase human resources for Health and improve health indicators of the population. The NHI Conditional Grant given to pilot districts was to improve infrastructure in public clinics. However,

General Practitioners expressed that the NHI pilot program failed because the public clinics did not have the basics such as essential medicines, equipment, and adequate health human resources.

> *"The NHI pilot program was designed to test health systems. They wanted to see what works before the NHI policy is implemented". – NHI General Practitioner*

> *"The pilot program through the NHI conditional grant was set up to improve clinic infrastructure to meet the ideal clinic standards. We also tested the national PHC reengineering strategy and selected programs such as GP contracting, District Clinical Specialist Teams, Integrated School Health Program, and Ward-based Outreach Program that we could evaluate for tangible outcomes. When we see that these PHC reengineering programs are working, that is when we rolled them out to other Districts. So, the NHI Pilot program focused on PHC reengineering". –Government official, National Department of Health*

> *"So how do you now say you are piloting the NHI when the clinics do not provide basic services? There are no medications here, and we do not have enough nurses and doctors. This whole NHI pilot program is a failure" –NHI General Practitioner*

What was piloted is not what was supposed to be piloted

Government officials and policymakers from the NDOH reported that what was piloted during the NHI pilot program in South Africa is not what was supposed to be piloted. These key informants reported that what was piloted has nothing to do with the NHI policy as a financing system. Government officials and policymakers from the NDOH reported that what was piloted during the NHI pilot program in South Africa differs from the initial agreements. The agreement was that the NHI pilot program would test how the NHI Fund would pool funds from the public and purchase health services on behalf of the population from accredited private and public service providers as envisioned in the White Paper. The NHI pilot program was also supposed to test how reimbursement systems like the capitation payment model and DRGs will be used to purchase

health services. The disagreements between the NDOH and Treasury led to the NHI pilot program focusing on testing PHC interventions to improve healthcare service delivery in public health facilities.

> *"We often requested to put the money into testing the NHI policy as a financing system, but that did not happen in practice. We wanted to test how the NHI Fund would work in real life, but the Treasury rejected that call. - Policymaker, National Department of Health*

> *"The whole NHI pilot program is a joke. What does PHC reengineering tell you about financing the healthcare system differently? Nothing!" – Government Official, National Department of Health*

> *"From my understanding, what was piloted focused on PHC reengineering. So, how did we move from testing purchaser-provider reimbursement mechanisms such as the capitation payment model to PHC reengineering? How did that happen?" –Government official, National Department of Health*

Government officials and policymakers from the NDOH reported that the NHI policy does not have the necessary support from the National Treasury. These key informants further commented that the NHI pilot program was a strategic political move to sabotage the NHI policy. Government officials and policymakers from the NDOH reported that the NHI pilot program was underfunded and designed to fail because the private sector is against the NHI policy. The private sector was accused of not wanting to see poor Black people having medical aid as guaranteed by the NHI policy. These key informants expressed that senior government officials are against the NHI policy because there is no money to finance it and that the NHI pilot program is a political strategy to stall it.

> *"We wanted to test how the NHI Fund will purchase healthcare services on behalf of the population from public and private service providers, which the Treasury rejected. If the Treasury does not support your policy in South*

Africa, it will never be implemented. It is sad to say that the NHI policy is one of those policies". -Policymaker, National Department of Health

"What was piloted is not what was supposed to be piloted. The initial agreement was to set up the NHI Fund and test reimbursement mechanisms such as the risk-adjusted capitation model and Diagnosis-Related Groups. Supply chain management reforms were supposed to be implemented. None of that happened. Instead, we were told to implement the PHC reengineering national plan as the NHI pilot program. Even that was underfunded. How do you expect a reform when you gave each District 11 million a year for such a huge project? The truth is that no one wants the NHI policy to be implemented. This compromised NHI pilot program was set up to delay our objective of moving towards UHC". -Government Official, National Department of Health

"I do not think they are winning with the NHI pilot program. I do not think they are winning. There is a lot of resistance from the private sector. To tell you the truth, the NHI pilot program is underfunded because the private healthcare sector does not want to see poor people having medical aid. To them, most black people do not deserve medical aid. So, this NHI pilot program was designed to fail". – Policymaker, National Department of Health

"That is why the NHI pilot policy has remained in the pilot phase because there is no money to fund it. Even senior government officials are stalling the process because there is serious opposition to implementing the NHI pilot program from the top. No one wants this policy, so we will keep on piloting and piloting". -Policymaker, National Department of Health

The contestations between the Treasury and NDOH meant that the PHC national reengineering strategy was turned into the NHI pilot program, which had nothing to do with the NHI policy as a financing mechanism. Government officials and policymakers from the National Treasury reported that they fought with the NDOH officials because they did not respect the role of the National Treasury. Policymakers from the National Treasury reported that the NDOH is trying to take over public finance decisions about the NIH policy that are supposed to be made by the National Treasury. The pooling of resources like public revenue, income tax, and medical aid government subsidies into the NHI Fund is the National Treasury's responsibility. The NDOH was accused of not wanting to take responsibility for the NHI policy. The NDOH only sends one person, the NHI National Coordinator, to be part of these financial reform engagements. Whilst the National Treasury has close to ten people working on redesigning financial policies to enable NHI policy reform.

> *"The NHI policy is a difficult issue. Certain rules fall under Treasury, and certain rules fall under NDOH. We have noticed that NDOH is trying to make Treasury decisions. For example, the Treasury is responsible for reducing medical tax credits, pooling income tax into the NHI fund, and redirecting medical aid government subsidies to the NHI fund. That financing system is the Treasury's mandate and not an NDOH one. So, we are having difficulty managing these two different roles. The struggle is what NDOH is and what is Treasury. As the Treasury, we are willing to engage with the NDOH on the financing aspect of the NHI policy. However, the NDOH sees the NHI policy as a healthcare reform matter, not a financing reform issue. And there is only so much that NDOH can do in the absence of the Treasury in the room. Whether it is changing the legislation or increasing funding for health, it needs to be done in consultation with Treasury. So, we had a tough time engaging with the NDOH. Although we have made ourselves available to them". -Government Official, National Treasury*

"From our perspective, we need to implement the financing recommendations around the NHI policy. However, the NDOH is holding onto that power and not engaging with us on how to move forward. It is a difficult one. This NHI policy has to do with old power dynamics and politics between the Treasury and NDOH. We as Treasury have been trying to engage, but the NDOH is not coming to the party" – Policy Maker, National Treasury

"And when it is such a major reform, you cannot have one person representing the NDOH in our engagements. One person cannot have all the necessary information that we need as Treasury to take the NHI policy forward. One person might have information on this, and another might have information on that. However, they are not talking to one another at the NDOH or even to us. They only send the NHI national coordinator, who does not have all the information, and this is a massive reform. There has to be a team for the NHI policy reform. Otherwise, it will not work". -Government Official, National Treasury

"We have a group of colleagues working on tax policy reforms to enable the NHI policy to work. Some of my colleagues are working on redesigning the financial fiscal policy and the medical scheme's financial reform. We have a group of 8 to 10 people in the Treasury who are working and thinking about the NHI policy. However, the NDOH only sends one person, the NHI National Coordinator. How is that possible? How can you make decisions when you only have one person? The NDOH is not serious about the NHI policy. If they were serious, they would have a dedicated team working with us". – Policymaker, National Treasury

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Government officials and policymakers from the National Treasury shared that contrary to popular belief that the Treasury does not want to fast-track the implementation of the NHI policy, the Provincial Governments are against the NHI policy. The National Health Act and the Constitution give power to provincial governments to purchase healthcare services on behalf of the population.

The National Treasury gives billions of rands to Provincial Governments annually, and they decide which percentage of those funds should allocated to health. The Provincial Governments' power in deciding how much money to allocate to health is why they are not supporting the NHI policy. Provincial Governments fear that the NHI policy will take away their financial power to purchase healthcare services on behalf of the population. The NDOH was accused of being scared to address the resistance from Provincial Governments and blamed the National Treasury and the private sector for stalling the NHI policy.

> *"People think the Treasury and the private sector are against the NHI policy. No! The Provincial Governments are the ones who do not want the NHI policy. This reform means that Provincial Governments will no longer have the power to purchase healthcare services on behalf of the population. Provincial Governments have the power to decide which money goes to funding health. With the NHI policy, you take the Provincial Government's power away, and that is where the resistance comes from. The NDOH has failed to address the resistance from Provincial Governments". – Policymaker, National Treasury*

> *We give Provincial Governments billions of rands each year, and they can decide how much of that money goes to funding health. For the Provincial Government's powers to change, we must change the National Health Act and possibly the Constitution, and this is where the big fight is. Provincial Governments hate the word NHI and do not want to engage with us about this reform. Now that is where the political contestation is". -Government Official, National Treasury*

> *"Provinces now have the power and the authority over health. Provinces feel that with the NHI policy, their power will diminish significantly. The NDOH needs to buy in from the Province to move forward with the NHI policy and trust me, they will not get it". -Government Official, National Treasury*

Government officials and policymakers from NDOH reported that the National Treasury is the stumbling block to moving toward the NHI policy in South Africa. The NHI policy is taking much longer than anticipated because the NDOH and National Treasury have differing views on how to implement the reform. The National Treasury wants the government to subsidize medical aid schemes even when the NHI policy is implemented, and the NDOH disagrees. Government officials and policymakers from the NDOH reported that if the government continues to subsidize the medical aid scheme, this defeats the purpose of reforming the health system through the NHI policy. A faction of politicians within the ruling party the ANC, are funded by the private sector to oppose the NHI policy. When these interviews were conducted in 2017, South Africa was heading to the general elections. Government officials and policymakers from the NDOH expressed that South Africa must forget about the NHI policy if the political faction against the NHI policy ascends to power. Politicians who work with the private sector to oppose the NHI policy are misled, as the private sector will benefit from the policy as service providers.

> *"The Treasury does not want to change the fiscal financial policy and stop subsidizing medical aid schemes. For the NHI policy to work, one needs to stop subsiding medical aid schemes and redirect those funds to the NHI policy. The Treasury disagrees with us on the matter. The Treasury must implement these financial policy changes, and they are resistant to do it". – Policymaker, National Department of Health*

> *"The management of politics is very difficult. That is one big thing. How do you manage politics? Because politics is driving the formulation of the NHI policy. So, now we are going to the election season, which will change how the NHI policy progresses. Politicians within the ANC do not want the NHI policy. They believe that the government should fix the public health system. Now, if those politicians ascend to power this year, forget about the NHI policy in South Africa". -Government Official, National Department of Health*

"I think the NHI policy requires a strong political persuasion. We are going to general elections, and if the ANC politicians against the NHI policy win, forget about the policy. Within the ANC, politicians are funded by the private health sector to be against the NHI policy". – Policy Maker, National Department of Health

"The idea that the NHI policy will bankrupt the private health sector is wrong. The NHI policy will purchase healthcare services from both the private and public sectors. We need the politicians to know that the private sector will get a lot of business from the NHI policy". – Government Official, National Department of Health

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Michel et al (2020) concur with the findings of this study that what was piloted during the NHI pilot program in South Africa is not what was supposed to be piloted. The NHI pilot program in South Africa tested PHC reengineering national strategies, which had nothing to do with the NHI policy as a health financing system (Michel et al 2020). The PHC reengineering national strategy features in the NHI White Paper as key to transforming the healthcare system that negates primary healthcare and focuses on curing diseases in South Africa (Michel et al 2020). Although strengthening PHC systems is essential for healthcare system reforms, the NHI pilot program in South Africa was supposed to the NHI fund was going to reform the health financing system in South Africa (Michel et al 2020). The PHC community-based interventions tested during the NHI pilot program have nothing to do with setting up the NHI fund and testing districts' ability to purchase healthcare services on behalf of the population.

The tension between the National Treasury and NDOH was also observed by Murphy & Moosa (2021) in a study which investigated public service managers' perceptions of the NHI policy in Gauteng Province. Public service managers from this study reported that the National Treasury and the NDOH are operating in silos regarding the NHI policy (Murphy & Moosa 2021). The National Treasury and the NDOH disagree about how the NHI policy should be financed in South Africa (Murphy & Moosa 2021). Public service managers from this study also noted that even within the

NDOH there is no consensus around the NHI policy (Murphy & Moosa 2021). The NDOH is imposing its ways on how the NHI policy should be implemented without consulting government officials from the province and district levels (Murphy & Moosa 2021). Public service managers at the district level in Gauteng reported that they felt excluded from the policy process, and their contributions were not considered when the NHI Bill was formulated (Murphy & Moosa 2021). According to Rangasamy (2021), resistance to the NHI policy from Provincial Governments is to be expected. Provincial Governments have the power to decide which healthcare services should be purchased on behalf of the population in that specific province (Rangasamy 2021). According to van Niekerk (2012), disagreements about the future and the financing of the NHI policy in South Africa are taking place at multiple levels of government. These policy disagreements at the national level are between the National Treasury and the NDOH, the NDOH and Provincial Governments and district municipalities (van Niekerk 2012). Inter-governmental disagreements about the NHI policy reflect the challenges of healthcare governance inherited from apartheid and continue to be fragmented (van Niekerk 2012).

The National Health Insurance Conditional Grant

The National Treasury generated the NHI Conditional Grant from the existing national health budget. The National Treasury gave the grant to the NDOH to decide how it will be split across provinces. Government officials and policymakers from the Tshwane District Department of Health reported that the NDOH, in collaboration with the Provincial Treasury, allocated R11 million to each pilot district annually. Government officials from the Tshwane District Department of Health reported that the NHI pilot districts received a financial framework from the NDOH on how to spend the NHI Conditional Grant. Once the District completed its financial framework, it was sent to the NDOH for approval. In the beginning, the total amount of the NHI conditional grant was R11 million. However, over the years, it decreased to R7 million. Government officials for the Tshwane District Department of Health expressed that even what was piloted was underfunded and set up to fail. A Professor from the University of Pretoria shared the same sentiments and claimed that the PHC reengineering national strategies tested during the NHI pilot program were underfunded through the NHI Conditional Grant. The underfunding of the NHI pilot program resulted in various stakeholders and the public declaring that the NHI pilot program in South Africa was a total failure.

"The NHI Conditional Grant funds were from the existing health budget. The Treasury determined the allocation for the NHI conditional grant, and the NDOH decided on how much to give each district". –Government official, Tshwane District Department of Health

"The whole NHI pilot program was set out to fail and delay the actual implementation of the NHI policy. If you give people R7 million to implement the so-called NHI pilot program, you want it to fail. The NHI Conditional Grant could not have any noticeable impact even on reengineering PHC services". – Government Official, Tshwane District Department of Health

"I think it was split evenly and across all 9 provinces. Each pilot district was given R11 million initially, which decreased to R7 million. The NHI Conditional Grant is a small amount, and there is no way that such an amount would make a difference even with reengineering PHC services. These people do not want the NHI policy and even managed to defund what was not supposed to be piloted". -Professor, University of Pretoria

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The NHI Conditional Grant was used to purchase three mobile clinics in the Tshwane District. The NHI Conditional Grant in the Tshwane District purchased maternity delivery beds for public health facilities. A queue management system to improve filling, reduce long waiting times, and improve patient experience in public health facilities was paid for using the NHI pilot program. The Tshwane district used the grant to buy CHWs uniforms to be identifiable in the community during household visits. HIV testing kits, BP machines, diabetes testing machines and electronic gadgets to register people in households and gather health information were bought using the NHI Conditional Grant. Government officials working in the supply chain of the Tshwane District Department of Health reported that the NHI Conditional Grant could only purchase items approved in the District's business plan by the NDOH. The NHI Conditional Grant was too small to fund big projects such as building clinics and improving health infrastructure in public health facilities.

"We bought three clinic mobiles that can reach farfetched areas. You know the Tshwane District has new informal settlements, so we use the mobile clinics to cover those areas". –Government official, Tshwane District Department of Health

"We also bought uniforms for our community healthcare workers in the WBOT program. Because we felt that when they visit the households, there must be an identity that says these people are from the Department of Health. We also used the NHI Conditional Grant to buy BP machines and HIV rapid testing kits". –WBOT Manager, Tshwane District Department of Health

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Delegation

Government officials from the Tshwane District Department of Health reported that the NHI pilot program was set out to fail because the delegation's powers of procuring services were not amended. The procurement system needed to be amended to allow the pilot districts to spend the NHI conditional grant efficiently. Government officials working in the procurement section of the Tshwane District Department of Health reported that the District's delegation powers in procuring services and products remained the same. The Tshwane District was only allowed to procure services for R500 000. If the District wanted to purchase services or above R500 000, it required approval from the Provincial Government. Government officials from the Tshwane District Department of Health reported that they struggled to purchase the mobile clinics and pay for the queue management system because these services were above R500 000. Getting approval from the Provincial Government took longer, delaying purchasing essential services that could have improved service delivery. Government officials from the Tshwane District Department of Health reported that with R500 000 purchasing powers, it was difficult to commit to more significant projects, such as refurbishing public health facilities during the NHI pilot program. Provincial Government delays in approving purchase services meant that Tshwane District had to return money to the Province. Once the money is sent back to Provincial Governments, Tshwane District had to apply for a rollover. The rollover application means applying for the money you did not spend in the previous financial year. Government officials from the Tshwane District Department of Health reported that districts can only apply for a rollover once. Therefore, if you do not utilise the money within that

financial year, it returns to the system. Participants felt that when the NHI policy is implemented, the delegation powers of Provincial Governments must be decentralised so that it is easier to purchase services that will improve the delivery of healthcare services.

> *"I can only spend R500 000 in the NHI Conditional Grant. I have to apply for a rollover because we could not utilise the money on time because of the delegation delays. And when they approve the rollover, we must buy services quicker without even comparing service providers' prices. The procurement system must change, and the District must be given more delegation powers". – Government Official, Tshwane District Department of Health*

> *"For the NHI policy to work, the delegation powers to purchase healthcare services must be given to districts. The relationship between the Province and Districts in the procurement system is not working and is delaying service delivery. And then people from the national government blame the District for the failure of the NHI pilot program. No, the NHI pilot program failed because we did not have the powers to procure the necessary services". - Government Official, Tshwane District Department of Health*

Discussion

Pilot programs can be used as a catalyst for changing the government's policy priorities (John 2017; Smith 2013). Rogers-Dillion (2004) argue that pilot programs designed by the country's government can be a tool for fast-tracking or delaying the proposed policy. The NHI pilot program in South Africa was used to delay the implementation of the NHI policy because what was piloted is not what was supposed to be piloted. What was piloted is the PHC reengineering national strategy that aims to improve healthcare service delivery in the public sector through community-based interventions such as GP contracting, DCST, CCMDD, ISHP and the WBOT program. Government officials and policymakers in this study reported that what was supposed to be piloted was the districts' ability to purchase healthcare services on behalf of the population from accredited public and private providers using the NHI fund. According to McLeod (2012), although improving PHC services is integral to moving toward UHC, it does not tell us much about how the NHI policy as financing health system reform will work in real life.

The results from this study show that what was piloted is not what was supposed to be piloted during the NHI pilot in South Africa because of power struggles and disagreements between the National Treasury and NDOH. Government officials and policymakers from the NDOH reported that the NHI pilot program focused on implementing the PHC reengineering national strategy because the National Treasury refused to make the financial commitments required to reform the current health financing system. The NHI pilot program was a strategic political move by the National Treasury to sabotage the NHI policy in South Africa. Government officials and policymakers argued that the NDOH was against the NHI pilot program being turned into a PHC reengineering national strategy as that had nothing to do with the NHI policy as a financing health system. Government officials and policymakers from the National Treasury responded and said that the NDOH does not understand the role of the National Treasury and oversteps its boundaries. The NHI policy requires restructuring the financial fiscal system where public revenue, income tax contributions and medical aid government subsidies are pooled into the NHI fund. Restructuring the financial fiscal system is the responsibility of the National Treasury, and officials from the NDOH do not understand this. Government officials and policymakers from the National Treasury accused the NDOH of not taking seriously the process of reforming the current healthcare system to the NHI policy. The NDOH was accused of sending only the NHI National Coordinator to strategic meetings of the NHI policy, whilst the National Treasury has eight people working on the policy reform.

Government officials and policymakers from the National Treasury reported that the biggest threat to the NHI policy in South Africa is Provincial Governments, and the NDOH is in denial about this dynamic. The NHI policy will remove Provincial Governments' powers to purchase public health services on behalf of the population. Provincial Governments in South Africa receive money from the National Treasury, and each province decides how much it will allocate to healthcare services. Burger et al (2012) agree with this finding and claim that the health financing structure in South Africa gives power to Provincial Governments to decide how much to spend on healthcare services (Burger et al 2012). Each Province receives its equitable share from the National Government and decides which parts of the equitable share will be set aside for Health (Burger et al 2012). The National Government does not interfere with how Provincial Governments allocate these public funds (Burger et al 2012). The NHI policy will remove the Provincial Governments'

power to purchase healthcare services on behalf of the population and ensure that people have access to healthcare services based on need and not income (McIntyre & Ataguba 2012). Pubic funds will be centralised to the NHI Fund, which will be responsible for purchasing healthcare services from accredited private and public health service providers on behalf of the population.

Government officials and policymakers from the NDOH reported that what was piloted during the NHI pilot program is not what was supposed to be piloted because there is a faction of politicians within the ANC that is against the NHI policy. When I collected data for this study in 2017, South Africa had its general elections. Government officials and policymakers from the NDOH warned that South Africa must forget about policy if the ANC faction against the NHI policy ascends into power. Government officials from the Tshwane District Department of Health reported that even what was piloted, the PHC reengineering national strategy was set up to fail to declare that the NHI pilot program was a failure in South Africa. A Professor from the University of Pretoria reported that even what was piloted was sabotaged by giving each District R11 million per year to implement the PHC community-based strategies. This R11 million was then decreased to R7 million; no tangible results would be achieved with that amount. Government officials in the Tshwane District reported that the procurement structure was not reformed and required approval from the province to purchase services above R500 000. Provincial government officials delayed the approval process, which meant that essential services required to improve service delivery during the NHI pilot program were not purchased on time. Government officials from the Tshwane District Department of Health expressed that even what was piloted was compromised by procurement structures that were not reformed for the NHI Conditional Grant to be utilised efficiently.

Conclusion

The objective of the NHI policy is to restructure the unequal healthcare system in South Africa by ensuring that citizens and legal residents have access based on need and not income (National Department of Health 2015). This will be achieved by creating a single NIH Fund, which will pool funds from the public and purchase quality healthcare services on behalf of the population from accredited private and public sector service providers (National Department of Health 2015). Part of transitioning from the current healthcare system into the NHI policy was implementing the NHI pilot program in eleven districts across South Africa. Studies conducted by Korafor (2012),

Ogunbanjo (2014), Sekhejane (2013), Passchier (2017), Mukwena & Manyisa (2022)suggest that the NHI pilot program was a failure. These scholars have claimed that the NHI pilot program is a reflection of how the NHI policy will not work in South Africa (Korafor 2012; Ogunbanjo 2014; Sekhejane 2013; Passchier 2017; Mukwena & Manyisa 2022). The findings from this study show that the NHI pilot program cannot be used as a benchmark to make claims about the possible success or failure of the NHI policy. This is because what was piloted during the NHI pilot program is not what was supposed to be piloted.

The findings from this study show that power dynamics and tensions between the National Treasury and the NDOH resulted in a compromised NHI pilot program which tested PHC reengineering national strategy. What was supposed to be piloted was the districts' ability to purchase healthcare services on behalf of the population from accredited private and public health service providers using the NHI fund. Government officials and policymakers from the NDOH reported that the NHI pilot program was compromised because the National Treasury is against the NHI policy and is doing everything it can to stall it. However, government officials and policymakers from the National Treasury responded that the NDOH oversteps its boundary and needs to understand NHI policy as financial health reform is the responsibility of the Treasury. The NDOH was accused of not taking the reform seriously and delegating only the NHI coordinator to serious engagements about the NHI policy. Government officials and policymakers from the National Treasury reported that contrary to population belief, the resistance to the NHI policy in South Africa is from Provincial Governments. Provincial Governments have the power to decide how much of their equitable share will be allocated to health. Government officials and policymakers from the National Treasury reported that the NHI policy will diminish Provincial Governments' powers to purchase healthcare services on behalf of the population.

Government officials and policymakers from the NDOH reported that what was piloted is not what was supposed to be piloted because political leaders within the ANC are against the NHI policy. Pilot programs are often used to stall and delay the implementation of a proposed policy (Rogers-Dillion 2004; John 2017; Smith2 013). The views of government officials and policymakers from this study tell us that the NHI pilot program was used to delay moving South Africa towards UHC through the NHI policy. The PHC reengineering national strategy that was piloted had nothing to

do with the NHI policy as a financing health system that aims to redistribute the country's health resources equally. What was supposed to be piloted, which is the district's ability to purchase healthcare services on behalf of the population, could have given us a snapshot of how the NHI fund would operate in real life. The NHI pilot does not tell us how the NHI policy as a financing health system will operate in real life. Therefore, South Africa must adopt a big-bang approach to implementing the NHI policy. However, a bing-bang approach to implementing the NHI policy will require multisector collaboration between the National Treasury, the NDOH, Provincial Governments and districts. The NHI policy will require strong political will from political leaders of the ANC, the current ruling party. The following findings chapters will reflect on what was piloted during the NHI pilot program in the Tshwane District, which is the PHC reengineering community-based interventions and draws on some of the opportunities, challenges and lessons learned.

Chapter 6: "We bring healthcare services closer to where people live": the experiences of General Practitioners during the National Health Pilot Program in the Tshwane District

Background

The delivery of a comprehensive primary healthcare (PHC) strategy depends on human resources for health (Fusheini & Eyles 2016). The healthcare system requires a knowledgeable workforce committed to the ideals of a comprehensive PHC strategy (Fusheini & Eyles 2016). A shortage of human resources for health hinders the delivery of PHC services, putting the population at risk of life-threatening health conditions (Fusheini & Eyles 2016). In South Africa, the shortage and maldistribution of healthcare workers threaten PHC service delivery (National Department of Health 2011). The South African healthcare system is divided into two, consisting of the public and private health sectors. Healthcare professionals with specialised skills, such as GPs and specialists, are concentrated in the private health sector, and others migrate to countries like the United Kingdom and Canada for better salaries (National Department of Health 2011; 2015; Rispel & Barron 2012). Medical doctors and specialists in the private sector only serve 14% of the population who are members of medical aid schemes (Coovadia et al 2009). The public health sector serves 86% of the population with limited medical doctors and specialists (Rispel & Barron 2012; Naidoo 2012). The concentration of healthcare workers in the private sector has resulted in the public health sector being unable to deliver quality healthcare services (National Department of Health 2011).

In 2019, medical specialists were recorded at 69 per 100 000 in the private sector and 7 specialists per 100 000 in the public sector (National Department of Health 2021). In the public sector, medical specialists were distributed unequally between rural and urban areas (National Department of Health 2021). Medical doctors are more likely to work in urban areas than remote rural areas (McIntyre & Ataguba 2014). This is because of poor infrastructure, shortage of good schools for children and lack of incentives from the government to work in these remote areas (Engelbrecht & Rensburg 2012). Within urban areas, inequalities also exist with access to medical doctors (George et al 2012). In poor urban areas such as townships, people struggle to access healthcare services because of the shortage of medical doctors in public health facilities (George et al 2012). Most public health facilities in the township areas are operated by professional nurses (Human Sciences Research Council 2007). Health conditions that medical doctors can treat at a primary level of care are referred unnecessarily to hospitals (Human Sciences Research Council

2007). Even when medical doctors are on-site, they are overburdened with a high patient load (Human Sciences Research Council 2007). One medical doctor in a public health facility is estimated to see 40 to 50 patients daily (Human Sciences Research Council 2007).

Primary healthcare services will be central to reforming the South African health system through the NHI policy (National Department of Health 2018). Part of transitioning from the current healthcare system to the NHI policy involved implementing the NHI pilot program from 2012 to 2017 across eleven districts in South Africa. One of the key objectives of the NHI pilot program was to test PHC innovations that would improve healthcare service delivery in public health facilities (National Department 2011; 2015; 2018). The PHC national strategies tested during the NHI pilot program were General Practitioner Contracting (GP Contracting), District Clinical Specialist Teams (DCST), Central Chronic Medicines Dispensing and Distribution (CCMDD), Integrated School Health Program (ISHP) and the Ward-based Outreach Team (WBOT) program (National Department; 2011; 2015; 2018).

The GP Contracting program is an old initiative of the NDOH which aims to address the shortage of GPs in public health facilities (Hongoro et al 2015). The GP contracting program contracts GPs from both the public sector and private sector to do sessional work in public health facilities (Hongoro et al 2015). GPs are placed in public clinics and hospitals and paid hourly for their service (Rispel et al 2018). The NDOH also contracts GPs in the private sector who own their medical practice to work in public hospitals (Rispel et al 2018). In the early 2000s, the GP Contracting program was adapted to be part of the PHC reengineering national strategy to improve the delivery of healthcare services in public health facilities (Mureithi et al 2018). GPs were contracted to work in public clinics because, for a long time, these clinics were run by professional nurses (Mureithi et al 2018). The aim of the GP Contracting program during the NHI pilot program was to improve human resources for health by addressing the shortage of medical doctors in the public sector (National Department; 2011; 2015; 2018).In the NHI pilot program, GPs were contracted to treat people's conditions at the primary level of care and reduce unnecessary referrals to hospitals (Moosa 2014). This chapter aims to analyse the experiences of GPs in the GP contracting program during the NHI pilot program in the Tshwane District.

Views of General Practitioners about the National Health Insurance Policy

When asked about their opinions about the NHI policy, GPs in this study expressed that it is a significant reform that will address the unequal distribution of healthcare resources in South Africa. GPs expressed that most South Africans living in rural and poor urban areas do not have access to quality healthcare services. The NHI policy promises that people will have access to quality healthcare services based on health needs and not income. The current healthcare system in South Africa favours people with money and excludes the poor. GPs reported that everyone in South Africa deserves access to quality healthcare services as enshrined in the Constitution. The NHI policy will merge the public and private health sectors and ensure that human resources for health are redistributed equally amongst the population. GPs perceive the NHI policy as a strategy for strengthening the delivery of healthcare services and ensuring that people are treated at the appropriate level of care. The NHI policy was perceived as a political commitment by the government to address health inequalities in the country. GPs reported that the NHI policy will help South Africa improve health indicators and prolong the population's lifespan.

> *"The NHI policy is an equitable way for everyone to have access to healthcare as promised by the Constitution". -Private General Practitioner*

> *"My understanding of the NHI policy is that it is about solidarity regarding access to healthcare services. It is about ensuring that those who need healthcare services and cannot afford them are not deprived of the opportunity. It seeks to remove the inability to pay as a hindrance to accessing quality healthcare services". -NHI General Practitioner*

> *Is the NHI policy a good initiative? Yes, it is! Not because I am Black, but it is necessary to deal with the healthcare needs of our people". -NHI General Practitioner.*

> *"Honestly, it is a good system because we live in a society with great inequalities. Just because people are poor does not mean that they do not have the right to life or to prolong life. The health system is about prolonging people's lifespans. So, the NHI policy is one of the tools that will help us to get a better life expectancy. I support the NHI policy. It will cost money, but the right to life should not be determined by how much money you have. Medical services should be provided equally to all". -Private General Practitioner*

In this study, GPs expressed that they would become part of the NHI policy when it is implemented. GPs expressed that they would become part of the NHI policy because it is their moral commitment to provide quality healthcare services to the people. The NHI policy seeks to address health inequalities in South Africa. GPs perceived their willingness to be involved in the NHI policy as a way of giving back to the country. Public savings of South Africans fund medical school through taxation, and GPs expressed their moral obligation is to give back to society by getting involved in the NHI policy and delivering quality healthcare services to the people. GPs in the private sector expressed that they are already preparing their practices to be accredited by the Office of Health Standard Compliance to be contracted to provide healthcare services to the population under NHI policy. However, GPs in this study reported that their involvement in the NHI policy comes with conditions. These conditions are that the government needs to fund the NHI policy appropriately. GPs expressed that they want an NHI policy run differently from the current public health sector, with drug stock-outs, staff shortages and poor infrastructure. The NHI policy cannot operate like the private health sector, where prices are not regulated; patients are overly charged for services and billed for medical tests they do not need.

> *"I think every doctor who is trained in South Africa must help. So, the government must provide resources for the NHI policy and capacitate doctors. There are various models they can adapt from other countries on how the policy should work. We are willing to work under the NHI policy if we are paid decently. For us doctors, the bottom line is patriotism. We want to see our people getting quality healthcare services. As long as we are paid and given the right environment to work under". -Private General Practitioner*

> *"The NHI policy must not be run like the private healthcare system that is expensive and wasteful. I run a department where the cost of blood tests in one month will be two million. In other months, the cost of blood tests will be R600 000, R800 000 or R3 million. The work and number of patients receiving the blood tests are the same. Then you ask yourself, what is happening with these private health sector numbers? Doctors in the private sector are wasteful because they can order as much as they want. For most people on medical aid, come August or September, their medical aid money is finished. This is because 100% of that money was not spent appropriately and covered what the patient needs. If I am doing an operation on the tummy, I submit that I did something to your liver,*

I did something to your kidney, your bowel. There was something wrong there, and I fixed it. I prepare an itemised bill and submit it to the medical aid. An operation that is supposed to cost R20 000 I write that it cost R200 000. I submit that bloated bill to the medical aid, and medical aid will pay. Anybody who says the NHI policy will not be affordable is lying. It will be affordable if the prices are regulated, and doctors are ethical and follow proper prescribed guidelines to treat conditions". -Private General Practitioner

"You see all the doctors, specialists and nurses got their degrees by studying or training on poor people. My greatest motivation is to say that the people who gave me my degree, the poorest of the poor, must get equal treatment in the country. So, I would not hesitate to participate in the NHI policy. Let everybody get equal treatment". -NHI General Practitioner

"I am preparing for my department to be part of the NHI policy. When the NHI policy is implemented, facilities will be accredited to provide healthcare services. I am preparing all my departments to be accredited. I want us to be amongst the best in providing services such as brain injury operations and rehabilitation. Imagine a big hospital like this, which cannot provide brain operations. I am working hard to ensure we are ready for accreditation". -Private General Practitioner

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GPs expressed that the government must consult GPs, specialists, the public and medical associations about how the NHI policy should be run. Public and medical professionals' participation is critical to the success of the NHI policy. The human resource challenge was flagged as an issue that could make the NHI policy not to function optimally. GPs expressed that the South African government needs to build more medical schools and reopen nursing colleges to increase the human resources for health. The government must incentivise GPs to move to rural areas so that people in remote areas can enjoy the benefits of the NHI policy. GPs expressed that the NHI policy is ambitious and worried about where the government will get the money to fund it with the country's high unemployment rate. For the NHI policy to work, the government must create jobs so that people can contribute to the public taxation that will fund the NHI policy. Creating jobs means the government must provide inclusive quality education and training to people in townships and rural areas. Universal access to quality education and

secure employment with decent wages were seen as policy instruments that should be implemented simultaneously with the NHI policy.

> *"For the NHI policy to work, you need the government's institutional, political will and money. With the country's high unemployment rate, who is going to fund the NHI policy?" -NHI General Practitioner*

> *"For the NHI policy to work, build more medical schools. We do not have enough medical schools. Reopen the nursing colleges that the ANC shut down post-1994. Shutting down nursing colleges and merging them with universities was a bad move that is costing us to this day." – NHI General Practitioner*

> *"For the NHI to work, please improve the economic conditions of Black people from the ground. And the only way to do that is to improve the educational system. So, the solution is good education, better jobs, and better remuneration money to fund the NHI policy. If you give people good education that reaches people from the lower economic backgrounds, it gives them a better chance in life and contributes to the economy". - Private General Practitioner*

These findings are similar to those of a study conducted by Gaqavu & Mash (2019) at Chris Hani District in the Eastern Cape. GPs in Chris Hani District expressed that the NHI policy will ensure that the healthcare system in South Africa is equal (Gaqavu & Mash 2019). According to Gaqavu & Mash (2019), GPs said they would become part of the NHI policy if remunerated appropriately. Located in the rural parts of the Eastern Cape, the GPs in Chris Hani District also expressed that for the NHI policy to work, the government must invest in building clinics and hospitals in rural areas (Gaqavu & Mash 2019). The building of clinics and hospitals in rural areas must be accompanied by installing water and electricity and building roads and good schools (Gaqavu & Mash 2019). From the findings of this study and that of GPs from Chris Hani District in the Eastern Cape, it is evident that GPs who work in the public and private health sectors support the NHI policy. However, a study conducted by Mathew & Mash (2019) in Cape Town in the private sector found that GPs are reluctant to become part of the NHI policy (Mathew & Mash (2019). GPs from this study reported that they do not trust that the South

African government will run the NHI policy efficiently because they have failed to run the public health sector. These GPs expressed that they fear the NHI policy will be used to shut down their private practice and take away their independence (Mathew & Mash 2019).

Another study conducted by Blecher et al in 1995 in Cape Town showed that private GPs supported and endorsed South Africa's plans to move towards UHC. GPs in that era expressed that the ANC government needed to redress the injustices of the apartheid and ensure that people have access to quality healthcare services (Blecher et al 1995). GPs expressed that the government must merge the private and public health sectors into a single National Health System (NHS) that would provide quality healthcare services to the people (Blecher et al 1995). The NHS in South Africa must focus on PHC to improve population health and reduce infant and maternal mortality by 2005 (Blecher et al 1995). GPs reported that the NHS system should be funded through a public taxation system so that people would not pay user fees at the point of consuming healthcare services (Blecher et al 1995). Interestingly, in Cape Town, GPs in the private sector in 1995 endorsed the UHC system through the NHS. Fast-forward to 2019, a generation of new GPS in the private sector in the same city is rejecting the NHI policy. An intergenerational comparison of the views of GPs who practised early in the 1990s and those currently practising about the UHC system can help us answer some of these questions.

Views of General Practitioners about the National Health Insurance Pilot Program

GPs expressed that the NHI program was an initiative by the government to test how the NHI policy would work in real life. The NHI pilot program is a system set up by the government to transition from the current health system to the NHI policy. It aimed to address the shortage of human resources for health by employing GPs to work in the public health sector. The NHI pilot program was seen as a strategy for improving healthcare services in rural and semi-urban areas. GPs from the private sector complained that the government did not inform them about the NHI pilot program. This resulted in GPs in the private sector missing the opportunity of contracting with the NDOH to do sessional work in public health facilities. The government was accused of not knowing what it was doing with the NHI pilot program because the public health facilities do not have proper infrastructure, human resources, equipment and essential medicines. GPs also expressed that there was no need for the NHI pilot program. The South African government could have adopted a big-bang approach in implementing the NHI policy and using best practices from other countries.

"The objective of the NHI pilot program, as stated in the White Paper, is to see how the NHI policy will work in real life". -NHI General Practitioner

"The NHI pilot program seeks to determine what is possible going forward. Currently, there are ten districts for the pilot program. Some of them are quite rural and semi-rural and have challenges with service delivery. These districts are resource-constrained, and the NHI pilot program will offer healthcare services in these areas". -Private General Practitioner

"We still do not know what we are doing. We do not have enough staff to offer healthcare services to the people. We run out of medication, and Black people must queue from 6 am to 7 pm. This is what I call sub-standard treatment in these NHI pilot sites. It is unacceptable. -NHI General Practitioner

"The way I understood the NHI pilot program is to get private healthcare professionals to do sessions at public clinics. And this is how I got involved". -Private General Practitioner

"So, I am saying when we are doing something that has been done somewhere, we can copy from other countries. If you go to the UK, for example, they have patient care pathways. And they have norms and standards for healthcare service delivery. So, if a patient is coming and a child has diarrhoea, they will have a patient care pathway for diarrhoea. We could have gone to the UK and copied how they run the NHS for the NHI policy. This pilot, pilot, the pilot is a waste of money and delays the urgent healthcare reform we need in South Africa". -NHI General Practitioner

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Contracting Models for General Practitioners

The recruitment of GPs for the NHI pilot program in the Tshwane District happened in three waves. The prominent institutions responsible for the recruitment of GPs were the NDOH, the Tshwane District Department of Health, the Foundation for Professional Development and Africa Health Placement. The NDOH gave the Tshwane District Department of Health a mandate to recruit and appoint GPs. The Tshwane District was responsible for advertising posts

and recruitment. After shortlisting candidates, the list was sent to the NDOH for interviews and appointments. The NDOH issued a tender for service providers to recruit and contract GPs for the NHI pilot program. The FPD won the tender and worked with the Africa Health Placement agency to recruit and contract GPs. Africa Health Placement Agency posted job advertisements and recruited and appointed GPs. Once Africa Health Placement Agency found a suitable candidate, FPD would communicate with the Tshwane District Department of Health and say we have found a GP. Word of mouth and connections were used to recruit GPs to work under the NHI pilot program in the Tshwane District. This recruitment process was informal, and sometimes no interviews were conducted. GPs reported that they probably would not have known about these vacant positions without their contacts. It was suggested that the NDOH should use media platforms such as radio, newspapers, and the internent to advertise job opportunities for medical doctors. GPs contracted to work under the NHI pilot program in the Tshwane District were recent graduates and those currently serving in the public and private sectors.

> *"When we started, we only recruited through the National Department of Health. However, we changed this and gave the district the go-ahead to recruit and contract doctors. Doctors signed an agreement with the district and the National Department of Health". –Government official, Tshwane District Department of Health*

> *"All the CVs go to Africa Health Placement, and they are responsible for appointing GPs. Once they appoint a GP, they call us. As FPD, we communicate this with the district and say we have this doctor who needs to be placed in a clinic". –Foundation for Professional Development Representative*

> *"I heard about the program through a colleague. He referred me to relevant people at the National Department of Health. I submitted my documents. The recruitment process was not formal, and no interviews were done." – General Practitioner*

The Tshwane District recruited 74 GPs to work in the NHI pilot program. A study conducted by Surender et al (2016) found that GPs who worked in the NHI pilot program in the Tshwane District were recruited from the private and public health sectors (Surender et al 2016). Surender et al (2016) highlight that most GPs contracted under the NHI pilot program in the Tshwane District were in a transitional phase of their lives. These GPs had just graduated from medical school, and others were starting to establish their private practice and needed more flexible hours (Surrender et al). Other GPs were new mothers who wanted the benefits of shifting around their working hours, and the NHI contract offered this flexibility (Surender et al 2016). Some GPs were close to retirement and had free time to commit to doing sessional work in public health facilities (Surender et al 2016). According to Surender et al (2016), the geographical area of the Tshwane District, with 3 medical schools, contributed to the high number of GPs contracted under the NHI pilot program.

Two models were used to contract GPs during the NHI pilot program in the Tshwane District. In the NDOH model, GPs were contracted to do sessional work in public clinics and were paid hourly. In the FPD model, GPs were contracted full-time and expected to work 8 hours daily. The challenge with the NDOH contracting model, which offered flexible working hours, is that some GPS did not show up for work. Patients were stranded in public clinics with no GP to meet their health needs. The FPD model was perceived as rigid as GPs were expected to be on-site for 8 hours daily. In both contracting models, GPs were expected to write reports about the quality improvement in delivering healthcare services in public clinics. GPs complained that they never get the opportunity to write these reports because of the high patient load in public clinics. The two contracting models were seen as a challenge, and GPs recommended that there should be one contracting model for all.

> *"In the National Department of Health contract, doctors are paid hourly to do sessional work in public clinics. I would not call them full-time doctors because they are paid per hour. So, if a doctor is contracted for 8 hours and they work for 7 hours, they will be paid for those hours" –National Department of Health Government Official*

> *"The FPD contract is much stricter. GPs are expected to be on-site from 8 till 4 pm. I hear they do not like this contract arrangement". – National Department of Health Government Official*

"Some of the NHI doctors contracted by the National Department of Health do not show up for work. Patients are left in public clinics with no doctor to attend to them. We fired some of these doctors". –Tshwane District Department of Health Government Official

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GPs recommended that when the NHI policy is implemented, the government can explore contracting models such as fee-for-service, group practice and risk-adjusted capitation models. The government can learn from the medical scheme and contract GPs based on the fee-for-service. In the fee-for-service method, GPs will be paid based on the services that they have provided to the patient. In the risk-adjusted capitation model, a fixed amount of money is paid to GPs to provide healthcare services to patients within a defined geographical area. The GP will be remunerated quarterly for the health needs of the population registered in that area. In the risk-adjusted capitation model, the cost is determined by the nature of the service, the number of patients and the time it took to render the service. The GP is incentivised for improving the health indicators of the population in a geographical area. GPs expressed that group practice would work well with the risk-adjusted capitation model. A team of GPs, nurses, allied health and specialists will deliver healthcare services to people within a specific area.

"We should adopt the system medical aid use to contract GPs. You pay the doctor based on the services they provide". – Private General Practitioner

In the network system, GPs work with a team of medical specialists. The money is paid into that network, and they collectively provide services to the people. Group practice is effective for referrals. Complicated conditions that a GP cannot treat are referred to specialists in the network. - NHI General Practitioner

"The model is called the risk-adjusted capitation model. The doctor will be given a lump sum for the community they will treat. We give you so much money, and you ensure that people in that community are healthy". –NHI General Practitioner

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The NHI White Paper states that the risk-adjusted capitation model will be used to contract GPs under the NHI policy. A GP will be assigned to 10,000 people within a catchment area (National Department of Health 2015). A lump sum from the NHI fund will be paid to the GP to deliver healthcare services to the people in that catchment area (National Department of Health 2015). The catchment area will be served by a multidisciplinary team of GPs, community health workers, district clinical specialists team, professional nurses and specialists (National Department of Health 2015). GPs will treat medical conditions at the primary level of care and only refer patients with complications to specialists within the multidisciplinary team (National Department of Health 2015). Health indicators such as infant and maternal mortality, chronic illnesses, infectious disease, and overall population health will be used to assess GPs' performance (Moosa et al 2012). Incentives will be provided to GPs who improve health indicators of the population within that catchment area (Moosa et al 2012).

A study conducted by Hongoro et al (2015) in the OR Tambo pilot district in the Eastern Cape found that GPs preferred the risk-adjusted capitation model as a contractual agreement under the NHI policy (Hongoro et al 2015). GPs saw the risk-adjusted capitation model as a better contractual arrangement between them and the State (Hongoro et al 2015). The only concern of GPs was whether the State would pay them on time (Hongoro et al 2015). The NHI Bill that was published after the NHI White Paper does not mention the risk-adjusted capitation model contracting model for GPs (National Department of Health 2018). It only states that a lump sum will be paid directly to accredited public and private sector service providers within a sub-district area (National Department of Health 2018).

The role of General Practitioners during the NHI Pilot Program

The role of GPs during the NHI pilot program in the Tshwane District was to provide healthcare services in public health facilities. The role included patient care, infectious disease treatment, and chronic and acute illnesses management. GPs provided emergency healthcare services, stabilised patients, and referred them to specialists. They also took on the role of prescribing medications, administering contraceptives and immunisations. GPs were responsible for training and mentoring nurses and writing reports about improving healthcare services in public health facilities.

> *"I manage patients. I must get involved if the sister does not know what to do with the patient. If there is an emergency, I must attend to it. I prescribe*

treatment medications. Chronic and TB patients come to me. I must review the X-ray results. I mostly see acute patients because that is where we get a lot of problems". –NHI General practitioner

"I provide healthcare services, and I manage all kinds of diseases. I provide training to nurses, and I am responsible for the clinical development of nurses". –NHI General Practitioner

"I write monthly reports about the quality of healthcare services in the clinic and how they can be improved. I sent these reports to the District". -NHI General Practitioner

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General Practitioners and Health Care Service Delivery

The contracting of GPs in the NHI pilot program in the Tshwane District improved the delivery of healthcare services in communities. In the past, professional nurses ran clinics, and people could only access a GP when they went to the hospital. The contracting of GPs in the NHI pilot program in the Tshwane District brought healthcare services closer to where people live. GPs expressed that their presence in public clinics ensured people had access to high medical care within walking distance. This saved patients from spending money travelling to hospitals for health conditions that can be treated at the primary level of care. GPs reported that when people know a doctor is in the clinic, this strengthens the relationship between the people and the healthcare system. It builds trust between the community and the State because people know they can rely on the healthcare system.

"We bring healthcare services closer to where people live. In the past, people could only access a GP when they went to the hospital". -NHI General Practitioner

"The community has confidence that will get the best possible care within walking distance. That strengthens the trust between community members and the healthcare system". –NHI General Practitioner

"When there is a doctor at the clinic, people trust that the government is working for them and that it cares". -Private General Practitioner

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The presence of GPs during the NHI pilot program in the Tshwane District improved the running of public clinics and patient care. When patients come to the clinic, they receive quality healthcare services. GPs reported that with the help of nurses, they are responsible for overseeing health promotion, health education, prevention of diseases and immunisation of children. The presence of GPs in the clinic reduced the waiting time to receive care and eliminated long queues. People's health conditions were treated at the appropriate level of care, thus reducing unnecessary referrals to hospitals. GPs expressed that when there is a smaller number of people that are referred to the hospital, it reduces the healthcare costs of the country.

"I see many patients with diabetes and lifestyle diseases such as hypertension. For the past two years I have been here, I can confidently say that patients' health conditions are controlled. We are preventing complications". –NHI General Practitioner

"We provide immunisations to a high number of children in this community. The more children you immunise in the community, the better the health of all. The spin-offs are amazing. There was a child who was deaf. We arranged for the child to be assessed and treated". – NHI General Practitioner

"Me being at the clinic assures people in the community that they can get the necessary healthcare services. It alleviates the burden of people being referred to hospitals and prevents the challenge of resource constraints at the tertiary level of care". -NHI General Practitioner

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The findings from this study are similar to those of a study conducted by Moosa (2021) in the Chiawelo Community in Soweto, Johannesburg. GPs in the Chiawelo mobile clinics improved patient care, TB infections were controlled, children received immunisations, and the number of people enrolled on antiretroviral treatment increased (Moosa 2021). The study also found that GPs' presence in mobile clinics reduced waiting time to receive care and reduced the number

of hospital referrals (Moosa 2021). The number of women who received reproductive healthcare services such as family planning and antenatal and postnatal care in the Chiawelo Community also increased (Moosa 2021). Moosa (2021) warns that the achievement of the GP contracting in the Chiawelo community should not be read in isolation from the other PHC interventions implemented concurrently, such as WBOT, DCST and the ISHP.

The training of General Practitioners

The Tshwane District Department of Health and FPD provided training to GPs during the NHI pilot program. The training focused on infectious diseases, chronic illnesses, maternal and child care, and healthcare service improvement. GPs expressed that they have received more training in the NHI pilot program compared to other working environments. However, not all GPs contracted to work under the NHI pilot program in the Tshwane District shared this sentiment. Other GPs expressed that they did not receive any training. These GPs expressed that when they paid for the training they attended. Other GPs expressed that training was frequent when they started working in the NHI pilot program, and now they no longer receive it. The lack of training was seen as a barrier to skills development and providing quality healthcare services in public clinics.

> *"We provide GPs with training in diabetic and hypertension management. We send the invite to the facility manager, who decides which doctor to send to the training. If FPD is having training, we also invite the doctors to that training. We had an HIV management course for 3 days. So those who do not have the HIV management skills, they register and attend the course". –Tshwane District Department of Health Government Official*

> *"I was in casualty for the Department of Health for 3 years. I did not attend any courses. However, within two months of the NHI pilot program, I attended a lot of training. They always take us to courses". –NHI General Practitioner*

> *"I have to pay for courses to improve my skills. When I raise this issue with management, they say the NDOH does not have money. You do what you are expected to do; if there is a limitation, you can only report to them. Is it enough? No. If no courses are rendered to healthcare service providers, then healthcare quality is compromised". –NHI General Practitioner*

Challenges for General Practitioners

GPs reported that the challenges of working in the NHI pilot program in the Tshwane District were inherent to the public health system in South Africa. Deteriorating infrastructure, lack of human resources, high patient load, and shortage of essential medicines and equipment hindered GPs' ability to provide quality healthcare services in public clinics. Public clinics ran out of medication, and patients were sent home without essential medicines. High patient load meant that GPs had to attend to 40 to 50 patients daily. GPs expressed that the shortage of nurses and medical doctors hinders the management of high patient load in public clinics. The NDOH and FPD were accused of not having functioning communication systems where GPs could lay their grievances about the NHI pilot program. GPs expressed that the NHI pilot program is coming to an end in two years, and they were unsure about their employment future with the NHI policy.

> *"Challenges we face are not about the NHI program but structural issues of the public health system. The simplest thing that has been a challenge in the public health sector is the shortage of medicine and lack of human resources". –NHI General Practitioner*

> *"Sometimes there are no lights. Imagine examining a rape survivor, a female rape survivor, and there are no lights in the facility. It makes life difficult. This past Sunday, there was no water. How do you practice when there is no water? To maintain professional cleanliness, I need water. Unfortunately, from the office I work in, you find that the infrastructure is in a state of decay. The water comes in when it rains and stuff like that". – NHI General Practitioner*

Tensions between nurses and GPs were signalled as a challenge during the NHI pilot program in the Tshwane District. Nurses referred minor medical cases to GPs, inhibiting them from attending to patients with severe complications. In public clinics, facility managers are professional nurses. GPs resented being managed by professional nurses and felt superior to them regarding clinical experience. Facility managers were accused of using their administrative power to hinder GPs from improving the quality of healthcare services. The NDOH did not pay the salaries of GPs on time. GPs complained that they would go on for months without being paid.

"In our clinics, a professional nurse is the facility manager. Most doctors do not want to be managed by a nurse. If you work in the clinic, the professional nurse deals with all administrative issues. It is challenging because the facility manager will say, Doctor, you are late for work. The response is that you cannot tell me that I am late. I am a doctor". –NHI General Practitioner

"The NDOH or people who work for the NHI policy do not take doctors seriously. There are times when doctors are not paid for two or three months. Crazy situation. I have been in meetings with the Director-General about such issues. Imagine working and not being paid for two or three months, and you are not given any reasons. Maybe those are some of the issues that make doctors feel that I should not be in this place. For me, not being paid for two months is unacceptable". -NHI General Practitioner

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Hongoro et al (2015) found that GPs who worked in the NHI pilot program at OR Tambo District in Eastern Cape experienced similar challenges. GPs in the NHI pilot program in OR Tambo District expressed that challenges such as power outages, lack of running water, drug stock-out and unavailability of medical equipment were not the challenges of the NHI pilot program (Hongoro et al 2015). However, these challenges were that of the public health system in South Africa. GPs in the NHI pilot program in OR Tambo District complained about not being paid on time (Hongoro et al 2015). These GPs expressed that the NDOH does not incentivise them to travel to far-fetched places to deliver healthcare services in rural areas (Hongoro et al 2015).

Discussion

The NHI policy envisions an equal distribution of healthcare professionals between urban and most rural parts of South Africa (Smith et al 2018). Part of the objective of GP contracting was to address the shortage and mal-distribution of GPs, which hinders the delivery of healthcare services in public facilities (National Department of Health 2018; MacDonald 2016). The Tshwane District was chosen to be part of the NHI pilot program because it consists of areas that are urban, semi-urban and rural (Clinton Health Access Initiative 2016). The rural and

township areas of the Tshwane District had a shortage of GPs, and most of the clinics were led by professional nurses (Clinton Health Access Initiative 2016). During the NHI pilot, 74 GPs were contracted to work in health facilities in disadvantaged communities in the Tshwane District. The results from this study show that GPs contracted to work in the NHI pilot program in the Tshwane District strengthened the provision of healthcare services in public health facilities. GPs managed communicable and non-communicable diseases, attended to emergency cases and improved the quality of healthcare services.

The GPs' presence meant that health conditions were treated at the primary care level, reducing hospital patient load. One of the goals of the NHI policy is to strengthen PHC systems in South Africa so that health conditions are treated at the appropriate level of care (National Department of Health 2018). PHC facilities will be the first entry point into the healthcare system, and GPs will make clinical decisions about which cases to refer to tertiary levels of care (National Department of Health 2018). This will save healthcare system costs, which are bloated by treating minor conditions at the tertiary level of care (Fryatt et al 2014). Community involvement and participation are essential in building an effective NHI in South Africa (Schneider et al 2018). To get people involved in developing and strengthening the health system, they need to trust that it works for them (Schneider et al 2018). People must believe that the health system will meet their needs at the right time (Schneider et al 2018). The results from this study show that GPs brought quality healthcare services closer to where people live, building trust between the community and the health system. Community members received the highest level of care within walking distance, making them believe that the healthcare system is reliable and able to meet their needs.

Two models were used to contract GPs to work under the NHI pilot program in the Tshwane District. In the NDOH contracting model, GPs were contracted to do sessional work in public health facilities and were paid hourly. In The FPD contracting model, GPs were expected to be on-site for 8 hours a day. These two contracting models were ineffective, and GPs preferred to be contracted under the NHI policy through risk-adjusted capitation, fee for service and group network. Deteriorating infrastructure, shortage of essential medicines, and high patient load hindered GPs from delivering quality healthcare services. This study's findings indicate that difficulties experienced by GPs in delivering healthcare services were not that of the NHI pilot program but of the public health system in South Africa. The NHI policy plans to accredit public

and private sector service providers to provide quality healthcare services to the people. For public health facilities to be accredited under the NHI policy, urgent reforms are required to improve the public health system.

The provision of comprehensive PHC services under NHI policy requires political commitment (Ataguba & Alaba 2012). A comprehensive PHC strategy takes seriously the economic, social, political and environmental factors that affect people's health (Ataguba & Alaba 2012). A political commitment to PHC means addressing the social determinants of health, such as poverty, crime, unemployment, deteriorating public infrastructure and violence (Ataguba & Alaba 2012). GPs in this study expressed that the government must implement the NHI policy simultaneously with other instruments such as universal education, labour reforms, and human settlement. GPs also expressed that when the NHI policy is implemented, the strengthening of healthcare services should not only be about the work of GPs in health facilities. However, it should be a commitment to a multi-sectoral approach to health that appreciates that health and illness are a product of our social conditions.

Conclusion

Strengthening primary healthcare services is an integral part of the proposed NHI policy in South Africa. GP contracting is part of the PHC reengineering national strategies tested during the NHI pilot program in the Tshwane District. The objective of GP contracting was to employ GPs to improve the delivery of healthcare services in public health facilities. Findings from this study show that the presence of GPs in public clinics brought healthcare services closer to where people live. GPs in public clinics improved patient care by managing communicable and non-communicable diseases, treating health conditions at appropriate levels of care and chronic and acute illnesses, and reducing unnecessary referrals to tertiary levels of care. The challenges of GPs during the NHI pilot program in the Tshwane District were power dynamics between nurses and GPs, delayed payments, deteriorating infrastructure, high patient load, and shortage of equipment and essential medicines. However, GPs warned that these challenges are not that of the NHI pilot program but that of the public health system in South Africa. GPs in this study expressed that as South Africa moves towards the NHI policy, the provision of comprehensive PHC services must not only be limited to the corridors of health facilities. PHC interventions such as GP contracting should be implemented concurrently with policy instruments that will address poverty, poor housing, education, and unemployment.

Chapter 7: "The worst is when you have to review the death of a baby": the experiences of the District Clinical Specialist Team during the National Health Insurance Pilot Program in the Tshwane District

Background

Maternal and infant mortality remains a global public health concern (Goga et al 2019). Sustainable Development Goal (SDG) 3.1 aims to reduce maternal mortality to less than 70 per 100,000 live births by 2030 (Goga et al 2019). In the same breath, SDG 3.2 aims to reduce infant mortality to less than 12 per 1,000 live births (Goga et al 2019). Countries are encouraged to implement reproductive health policies and interventions to prevent maternal and children's deaths (Goga et 2019). South Africa has witnessed a steady decline in maternal and infant mortality rates over the years (Mabaso et al 2014; Moodley et al 2018). Although this is the case, scholars have shared concerns that South Africa's current maternal and infant mortality rates are too high for a middle-income country (Mabaso et al 2014; Moodley et al 2018). In 2019/2020, it was estimated that the maternal mortality rate was 88.0 per 100,000 live births, meaning that 1 065 maternal deaths occurred at the facility level (McKerrow 2020). In the same year, 2019/202O, the neonatal death rate was 11.9 per 1,000 live births (McKerrow 2020). According to the National Department of Health (2022), although maternal and infant mortality rates have declined over the years, reproductive health systems need to be improved in South Africa.

The leading causes of maternal deaths are non-pregnancy-related infections, obstetric haemorrhage, hypertensive disorders during pregnancy, medical and surgical disorders, and pregnancy-related sepsis (National Department of Health 2021). The leading causes of neonatal deaths are prematurity and related complications, intrauterine hypoxia, and sepsis (Rhoda et al 2018). According to Chola et al (2015), another leading cause of maternal mortality in South Africa "... is the length of time it takes to arrive at a facility where a birth attendant has the right skill to deal with an emergency". Deteriorating infrastructure, shortage of equipment and essential medicines, and human resources with specialised obstetric skills have been flagged as the leading causes of maternal and infant mortality in public health facilities (Mabaso et al 2014). According to Moodley et al (2015), the plight of maternal and infant mortality rate in South Africa requires medical interventions and health system reforms.

A national Ministerial Task Team led by the then Minister of Health, Dr Aron Motsoaledi, was formed in September 2012, and it launched the District Clinical Specialist Team program (Feucht et al 2013). The objective of the DCST program is to provide clinical training to health professionals in obstetric units in public health facilities (Feucht et al 2016). The clinical training was designed to improve the skills of nurses and medical doctors so that they can deal with obstetric complications and save mothers and babies(Feucht et al 2016). The DCST program was expected to put clinical governance and accountability systems to prevent maternal and infant deaths in public health facilities (Feucht et al 2016). The DCST program comprises 7 specialists: an obstetrician-gynaecologist, advanced midwife, paediatrician, paediatric nurse, family physician, PHC nurse and anaesthetist (Nathan & Rautenbach 2013).

The NDOH established a conditional grant to fund the establishment of the DCST program. In 2012, it was estimated that more than R396 million was spent to fund the salaries of 7 specialists per district (Nathan & Rautenbach 2013). However, filling the posts of DCST members in all districts has been a challenge (Nathan et al 2013). When the program was launched, 364 posts were created, and only 206 appointments were made (Oboirien et al 2014). According to Oboirien et al (2014), only two districts managed to attract and fill all the posts, and these districts are Eden District in the Western Cape and the Tshwane District in Gauteng Province. Rural districts such as the Eastern Cape, KwaZulu-Natal and the Western Cape Province have struggled to attract specialists (Oboirien et al 2018). Central Karoo District and Overberg District have no DCST members, followed by Cacadu in the Eastern with only two members and Amajuba District in KwaZulu-Natal with two members (Oboirien et al 2018). The DCST program in these areas relies on professional nurses and midwives (Oboirien et al 2018). **Please see Figure 1 below, which reflects the number of DCST members per district.**

Figure 1 National District Clinical Specialist Team Overview

Province	District	Anaesthetist	Obstetrician	Paediatrician	Family Physician	Advanced Midwife	Paediatric Nurse	PHC Nurse	Total
EC	Alfred Nzo DM				1	1	1	1	4
	Amathole DM		1	1		1		1	4
	Buffalo City MM			1		1	1		3
	Cacadu DM					1		1	2
	Chris Hani DM					1	1	1	3
	Joe Gqabi DM					1	1	1	3
	Nelson Mandela Bay MM			1		1	1	1	4
	OR Tambo DM			1		1	1	1	4
FS	Fezile Dabi DM		1			1	1	1	4
	Lejweleputswa DM		1		1	1	1	1	5
	Mangaung MM				1	1	1	1	4
	Thabo Mofutsanyana DM				1	1	1	1	4
	Xhariep DM		1		1	1	1	1	5
GP	Ekurhuleni MM		1	1	1	1	1	1	6
	City of Johannesburg MM		1	1	1	1	1	1	6
	Sedibeng DM		1		1	1	1	1	5
	City of Tshwane MM	1	1	1	1	1	1	1	7
	West Rand DM		1	1	1	1	1	1	6

Province	District	Anaesthetist	Obstetrician	Paediatrician	Family Physician	Advanced Midwife	Paediatric Nurse	PHC Nurse	Total
KZN	Amajuba DM					1		1	2
	eThekwini MM		1	1		1	1	1	5
	iLembe DM			1	1	1	1	1	5
	Harry Gwala DM			1	1	1	1	1	5
	Ugu DM				1	1	1	1	4
	uMgungundlovu DM				1	1	1	1	4
	uMkhanyakude DM				1	1	1	1	4
	uMzinyathi DM					1	1	1	3
	uThukela DM		1			1	1	1	4
	uThungulu DM		1		1	1	1	1	5
	Zululand DM					1	1	1	3
LP	Capricorn DM				1	1	1	1	4
	Mopani DM			1	1	1	1	1	5
	Vhembe DM				1	1	1	1	4
	Waterberg DM			1	1	1	1		4
	Greater Sekhukhune DM				1	1	1		3
MP	Ehlanzeni DM	1	1	1		1	1	1	6
	Gert Sibande DM		1				1	1	3
	Nkangala DM					1	1	1	3
NC	Frances Baard DM				1	1	1		3
	John Taolo Gaetsewe DM			1	1	1		1	4
	Namakwa DM				1	1			2
	Pixley Ka Seme DM	1		1	1	1			4
	Zwelentlanga Fatman Mgcawu DM		1		1	1			3
NW	Bojanala DM		1	1	1	1		1	5
	Dr Kenneth Kaunda DM		1	1	1	1	1	1	6
	Dr Ruth Segomotsi Mompati DM			1	1	1	1	1	5
	Ngaka Modiri Molema DM		1		1	1	1	1	5
WC	City of Cape Town MM	1	1	1					3
	Cape Winelands DM	1	1	1	1				4
	Central Karoo DM								0
	Eden DM	1	1	1	1	1	1	1	7
	Overberg DM								0
	West Coast DM								0
Total		6	21	22	32	46	39	40	206

Source: National Department of Health District Clinical Specialist Team Database (2015)

The specialists that were difficult to attract to the DCST program were gynaecologists, paediatricians, and anaesthetists (Oboirien et al 2019). There is a shortage of these specialists in the country; most of them work for the private sector or move overseas for better opportunities (Oboirien et al 2019). According to Voce et al (2013), when these specialists are appointed, they quickly resign due to unbearable working conditions in public health facilities. The resignation of DCST members is associated with a high patient load, lack of human resources, lack of

support from the provincial government, poor roads and deteriorating health infrastructures in public health facilities (Feucht et al 2019; Oboirien 2019; Nathan et al 2013). In the NHI pilot program, the DCST program was implemented concurrently with GP Contracting, CCMDD, ISHP and WBOT programs to improve the delivery of healthcare service in public health facilities (Feucht et al 2014, 2018, 2019). This chapter aims to evaluate the experiences of DCST members during the NHI pilot program in the Tshwane District.

Findings

The Objectives of the District Clinical Specialist Team Program

The objective of the DCST program was to improve maternal and infant health indicators during the NHI pilot program in the Tshwane District. DCST members reported that they were responsible for the clinical training of nurses and medical doctors to ensure healthy deliveries in public health facilities. The DCST members were responsible for clinical governance and quality improvement of reproductive and obstetric health services. The Tshwane District managed to fill all the posts of specialists for the DCST program. DCST members expressed that the post that was difficult to fill was that of an anaesthetist. There was a concern that some specialists were close to retirement, and the Tshwane District Department of Health would have to fill these posts. However, human resource dynamics, departmental politics and administrative bottlenecks hindered recruiting and appointing specialists who would replace the retiring DCST members.

> *"The DCST program aims to improve child and maternal health. It is also responsible for clinical governance, training and research. In clinical governance, we develop skills of doctors and nurses for obstetric care service delivery" -District Clinical Specialist Member*

> *"We are responsible for the women's pregnancies and the health of the newborn baby. Our focus is prenatal, antenatal, and postnatal to improve reproductive health services in public health facilities". -District Clinical Specialist Member*

> *We struggle to fill posts such as anaesthetists. Some of our members are going to retire soon. This will make our job difficult as there is a shortage of these specialists in the country. HR delays and departmental politics make the recruitment process challenging. We lose specialists because HR takes*

too long to appoint them after the initial interviews. Next year, our team will be short of members" -District Clinical Specialist Team

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Studies conducted by Feucht et al (2014; 2018,2019) also found that the objective of the DCST program is to reduce maternal and infant mortality. The DCST program was adopted as part of the PHC national strategies tested during the NHI pilot program in South Africa. According to Feucht et al (2019), the Tshwane District in Gauteng Province and Eden District in the Western Cape are the only two districts with a complete team of DSCT members. The two medical schools gave the Tshwane District an advantage in filling the DCST members' posts (Feucht et al 2019). However, findings from this study show that the DCST program is under threat as some specialists will retire.

The role of the District Clinical Specialist Team Members

During the NHI pilot program in the Tshwane District, DCST members were responsible for training nurses and doctors on obstetric care to improve maternal and infant health indicators in public health facilities. DCST members expressed that they were responsible for strengthening reproductive health services. DCST members travelled across the Tshwane District and trained nurses and medical doctors to deal with obstetric emergencies. DCST members said they conducted unannounced visits to evaluate if doctors and nurses in public health facilities followed clinical training guidelines.

"We provide intensive clinical training. We mentor nurses and medical doctors on obstetric emergency care so that no child or mother dies at the hands of a healthcare professional". -District Clinical Specialist Member

"I am responsible for paediatric care training. I train and mentor healthcare professionals on breastfeeding and child malnutrition. I rotate across the Tshwane District and attend to children and mothers in public health facilities. After hours, I visit public hospitals' paediatric units to assist with complicated children's cases". -District Clinical Specialist Member

"We evaluate emergency cases that lead to children's death. It is not about whether this baby could have died or not. Was the service good? Was there a delay on the side of the parent who did not bring their child? Was

there a delay at the casualty? Was there a delay at the clinic? Did the nurses not realise that the child was sick? Was there access to emergency transportation? We evaluate case studies and engage with clinicians and facility managers on how we can prevent a baby from dying in the system". - District Clinical Specialist Member

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Buy-in for the District Clinical Specialist Team Program

The DCST members had to get buy-in from nurses, doctors, and facility managers in public health facilities. In the beginning, healthcare professionals were sceptical about the presence of DCST members. DCST members were perceived as auditors the NDOH sends to police healthcare professionals. DCST members had to introduce themselves to facility managers, doctors and nurses. They ensured healthcare professionals that their role was to assist them in improving maternal and child health services. DCST members also had to convince facility managers that maternal and infant health services are the clinic's responsibility. In the past, facility managers would refer minor cases of babies to the hospital. This flooded the hospital with babies that could have been treated at the primary level of care. A few public health facilities in the Tshwane District were still hesitant about the DCST program. Facility managers felt that the DCST members were interfering with the clinical system they had built for years. In these public health facilities, nurses and medical doctors refused to implement the clinical guidelines to improve obstetric care from DCST members.

"We struggled to get buy-in from healthcare professionals. They did not see us as part of the furniture. Facility managers used to chase us out of the clinics. I do not blame them; they did not know who we were. We worked hard in getting consent to work in public health facilities. When people do not know who you are, they become sceptical. They often have questions such as who are you? Why are you here? Are you going to police us? We had to assure them that we are not auditors but a team sent to support them". –District Clinical Specialist Team Member

"Some public health facilities did not even have neonatal care services. We had to get buy-in from facility managers to prioritise maternal and infant health services. Babies with minor conditions that could be treated at a

clinic level were passed to tertiary hospitals. We had to provide intensive training to healthcare professionals so that the health facility managers could have confidence in their ability to treat babies. Healthcare professionals do not want to deal with sick babies because they must account if a baby dies at the facility. Babies were overcrowding hospitals, and we changed this". -District Clinical Specialist Member

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According to Voce et al (2013), when the DCST program was introduced nationally, one of the challenges was getting buy-in from health facility managers. A study conducted by Nathan et al (2013) found that the government had to invest money in roadshows nationally to promote the DCST program. Support from district health managers helped DCST members to be accepted in public health facilities (Voce et al 2013; Nathan et al 2013). In other districts, a directive had to be sent by the Provincial Department of Health that the DCST program would be implemented, and facility managers had to comply (Voce et al 2013; Nathan et al 2013). According to Voce et al (2013), the DCST interventions had to be integrated into key performance indicators of facility managers for them to accept the program. In some districts, DCST members were perceived as a police force that the NDOH delegates to record clinical errors that will be used to punish facility managers (Nathan et al 2013). In a study conducted by Oboirien et al (2014), DCST members were perceived as a police force that wants healthcare professionals to account for a baby's death in public health facilities. Facility managers feared that DCST members were part of the litigation team that sues public health facilities for maternal and infant deaths (Oboirien et al 2014).

Interventions of the District Clinical Specialist Team Program

DCST members, during the NHI pilot program in the Tshwane District, implemented three interventions to improve child and maternal health indicators. The first intervention was a unique health identifier, a health information system that stored baby's health records in public health facilities in the Tshwane District. Healthcare professionals could access baby's records from all public health facilities to improve the continuity of paediatric care. The NDOH adapted the unique health identifier, which will be rolled out in all districts in South Africa. The second intervention was the morning obstetric drills, which aimed to improve healthcare professionals' skills so they could deal with obstetric emergencies. DCST members visited health facilities at 5 am and conducted obstetric morning drills for nurses and doctors who work night shifts. The

third intervention was mapping child malnutrition, which uses a geographical information system to trace cases of children's malnutrition in the Tshwane District. DCST members reported that sometimes cases of malnutrition occur more than once in an area. The ward-based outreach teams will be sent to assess the socio-economic conditions of communities with the highest number of children with malnutrition. The NDOH has also adopted the mapping of the child nutrition program, and it will be scaled up nationally.

> *"And I can just show you one of these copies. This is one of the Tshwane District's inventions and will now be implemented nationwide. It is a unique health identifier digital system that helps us store babies' health records. Nurses in our different health facilities can access the unique health identifier to understand the history of the baby's health. It even stores blood results of babies across the district". -District Clinical Specialist Member*

> *"Remember, nurses and doctors work at night, which means they are not part of the in-service training during the day. We conduct morning obstetric drills at 5 am so these nurses and doctors are not left behind. If there are clinical skills gaps, they can do wrong things and may not be equipped to deal with life-threatening obstetric emergencies". - District Clinical Specialist Member*

> *"We trace cases of child malnutrition by recording them on the district's map. When we are presented with a case of malnutrition in hospitals, we record it on the map. The Ward-based Outreach Teams are sent out to go and check the situation and see what is going on in that community. Sometimes it is not a family situation but the whole community that cannot survive due to poverty". -District Clinical Specialist Member*

District Clinical Specialist Team Program and Reproductive Health Services

The DCST program during the NHI pilot program in the Tshwane District strengthened the delivery of reproductive health services. DCST members reported that the clinical training they provided to healthcare professionals improved obstetric care delivery in public health facilities. In the past, healthcare professionals were afraid to deal with minor complications of newborns and referred them to hospitals. This led to babies with minor complications overcrowding

hospitals. However, since the clinical training, nurses and doctors are confident about treating babies with minor complications in clinics. The quality improvement clinical guidelines provided by DCST members increased pap smear visits, family planning uptake, antenatal visits, and exclusive breastfeeding rates. DCST members in the Tshwane District reported that their work reduced maternal and infant mortality rates.

> *"Healthcare professionals are now confident with treating neonates. This was a challenge in our district. All newborns were referred to hospitals for minor issues. Nurses and doctors were sacred to dealing with a baby with a problem. We trained them, and now they are confident with treating babies". -District Clinical Specialist Team Member*
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> *"We can show that the maternal and infant mortality rate went down in the Tshwane District. The quality of antenatal clinics has improved. Our breastfeeding rates went up. Our family planning rate also went up. Women come early to the clinic for antenatal care, and we test them for HIV to prevent babies from contracting the virus". -District Clinical Specialist Team Member*
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> *"When we started, the antenatal care bookings before 20 weeks was 45%. Today, I can confidently say we are at 70%. Our target is to reach 80% by 2020. We will get there eventually". -District Clinical Specialist Team Member*
>
> *"We significantly reduced stillbirths in public health midwife obstetric units. And that stillbirth reduction intervention package will be published soon, and it will also be rolled nationally". -District Clinical Specialist Team Member*

A study conducted by Feucht et al (2018) also found that the DCST program improved reproductive health services in South Africa (Feucht et al 2018). The DCST program equipped doctors and nurses with skills to deal with obstetric emergencies (Feucht et al 2018). The work of DCST members increased antenatal care visits and reduced cases of HIV mother-to-child transmission (Feucht et al 2018). Another study by Oboirien et al (2019) also found that preterm

and, low-birth and stillbirth cases decreased in districts where the DCST program was implemented. The clinical training provided to nurses and doctors helped to detect life-threatening pregnancy complications and women who require emergency C-sections (Oboirien et al 2019). However, the authors of this study warn us that the achievements of the DCST program should be linked to the implementation of other PHC interventions, such as the WBOT and ISHP (Oboirien et al 2019). The South African government abolition of user fees for pregnant women in public health facilities is also associated with the reduction of maternal and infant mortality (Silal et al 2012). According to Udjo et al (2014), the success of the DCST program should be read with the success of HIV Prevention of Mother-to-Child Transmission, which reduced the number of babies born with HIV in South Africa. Therefore, the impact of the DCST program in the Tshwane District should not be read in isolation from these national reproductive health interventions.

The Challenges of the District Clinical Specialist Team Program

The challenges of the DCST members during the NHI pilot program in the Tshwane District were the bottlenecks that came with administration. DCST members reported that ordering medical equipment and essential medicine for obstetric care takes ages. Administrators allegedly caused these delays by not taking responsibility and accountability. Medical equipment and essential medicine purchases were delegated to managers. However, managers have other responsibilities and doing a simple task like actioning purchase is not their priority. DCST members reported that delayed the implementation of interventions that can improve obstetric care services. The lack of accountability also presents itself in health facilities when a baby dies. No one wants to take accountability when a baby dies. It is always somebody else's fault: a nurse who did not come to work last week, a doctor who was late, an ambulance that did arrive on time. DCST members complained that they are constantly burnt out because a team of 7 specialists is too small to cover the Tshwane District with more than 3 million residents. The facility managers of clinics and chief executive officers of hospitals have autonomy over the quality improvement of healthcare services. DCST members expressed that managers and CEOs were reluctant to implement the suggested quality improvements in some public health facilities. DCST members reported that they provide clinical training to the staff, and three months later, the staff has abandoned all they have learned. High staff resignations in public health facilities meant that DCST members must constantly retrain. Lack of human resources, shortage of equipment and essential medicine hindered the delivery of reproductive health services. DCST

members reported that the worst part of the job is reviewing the death of a baby. DCST members reported that nothing prepares them for the death of a baby.

> *"It takes ages to purchase health equipment and essential medicines because people do not want to take administrative accountability if anything goes wrong in the supply chain. So, they pass the purchasing powers to their bosses who do not have time. This slows down the implementation of clinical training. Most of our clinical initiatives are stuck because you need a signature on a piece of paper, which you never get". –District Clinical Specialist Team Member*
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> *"It is tough to get around the place; 3 million people stay in this district. It is a big place geographically, so we struggle to drive around everywhere. We are on the road every day. So, 7 specialists for this team are insufficient for the Tshwane District". –District Clinical Specialist Team*
>
> *"What is frustrating is you go to a public health facility to train the staff and mentor them. However, when you return a month later, they have abandoned everything you taught them. Nurses and doctors are resigning, and three months later, you are back to square one". –District Clinical Specialist Team Member*
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> *"If a baby dies, it is always somebody else's fault. It is the nurse who was there last week but is now on leave, who we cannot speak to. Delays at the pharmacy or the ambulance arrived late". –District Clinical Specialist Team Member*
>
> *"The worst is when you have to review the death of a baby. Reviewing the death of a baby is the most difficult part of the job". –District Clinical Specialist Team Member*

The results from a study conducted by Feucht et al (2013; 2016; 2018) also found that challenges of the DCST program nationally are administration bottlenecks, lack of accountability when the baby dies, and shortage of essential medicines and equipment (Feucht et al 2013, 2016, 2018).

According to Feucht et al (2013), the challenges of the DCST program in South Africa are embedded in the broader challenges of the public health system. A study conducted by Oboirien et al (2014; 2018; 2019) also found that filling specialist posts is the main challenge of the DCST program in South Africa. Some districts only have two professional nurses to lead the team, and this defeats the goal of the program (Oboirien et al 2014; 2018; 2019). The Tshwane District is one of the districts that managed to fill the 7 specialists' vacant posts. Although this is the case, the results from this study show that the DCST members during the NHI pilot program in the Tshwane District were burnt out and overworked. Seven specialists were insufficient to cover the Tshwane District, with a population of more than 3 million people. The NDOH must review the number of specialists in the DCST program based on the size of the district and the population. The one finding that was not reflected in other studies is the reflection of the DCST members about how the death of a baby makes them feel. These specialists, who have more than 20 years of working in obstetric care, reported that they never get used to reviewing the death of a baby.

Discussion

The DCST program was established in September 2012 by a national Ministerial Task Team led by the then Minister of Health, Dr Aaron Motsoaledi (Voce et al 2013). The DCST program was introduced concurrently with the WBOT and ISHP as part of the PHC reengineering national strategy (Voce et al 2013). The objective of the DCST program was to provide clinical training on reproductive health and obstetric care to nurses and doctors in public health facilities (Nathan et al 2013). DCST members comprised 7 specialists: obstetrician-gynaecologist, advanced midwife, paediatrician, paediatric nurse, family physician, PHC nurse and anaesthetist (Nathan et al 2013). In the same year the DCST program was introduced, it was integrated into the NHI pilot program, which began in 2012 and ended in 2017 (National Department of Health 2021). The NHI pilot program implemented the DCST program concurrently with other PHC interventions such as GP Contracting WBOT, ISHP and CCMDD programs (National Department of Health 2021). The objective of this chapter was to evaluate the experiences of DCST members during the NHI pilot program in the Tshwane District.

Findings from this study show that the role of DCST members during the NHI pilot program in the Tshwane District was to provide clinical training for doctors and nurses to improve maternal health indicators in public health facilities. DCST members expressed that they had to get buy-

in from facility managers and healthcare professionals. In some public health facilities, DCST members were met with resistance as healthcare professionals thought they were auditors sent by the NDOH. This is in a context where accountability is required from healthcare professionals when a baby dies in a health facility. DCST members were also perceived as a litigation team that works with families to sue healthcare professionals for babies dying in public health facilities. The DCST members, during the NHI pilot program in the Tshwane District, managed to improve the delivery of reproductive health services. The clinical training provided by DCST members empowered doctors and nurses with the confidence to deal with sick babies at the primary level of care. In the past, healthcare professionals were afraid of treating babies with minors and referred them to hospitals. The DCST program increased antenatal care visits, pap smear rates, uptake of family planning and exclusive breastfeeding rates. DCST members also expressed that since the program has been implemented, they have witnessed a decrease in premature births and stillbirths.

The challenges of the DCST program during the NHI pilot program in the Tshwane District were administrative bottlenecks that caused delays in purchasing medical equipment and essential medicines. The DCST program in the Tshwane District was lucky to have filled all 7 posts for specialists. However, the 7 specialists were insufficient to cover all the public health facilities serving more than 3 million people in the Tshwane District. DCST members were burnt out from travelling long hours to reach all public health facilities. DCST members reported having to retrain healthcare professionals because they abandoned their teachings. The high resignation of doctors and nurses in public health facilities meant that DCST members had to start clinical training from scratch. Lack of human resources, shortage of equipment and essential medicines hindered the delivery of reproductive health services. DCST members reported that reviewing the death of a baby is, thus far, the worst part of their job.

Conclusion

DCST members provided clinical training to healthcare professionals to improve obstetric care in public health facilities. These clinical trainings empowered doctors and nurses to treat babies with minor complications at the primary level of care. The DCST members expressed that their work improved antenatal bookings, uptake of family planning, pap smear screening, increased breastfeeding rates and reduced premature births and stillbirths. The challenges of DCST members during the NHI pilot program were administration bottlenecks that delayed purchasing

medical equipment and essential medicines. DCST members were burnt out because a team of 7 specialists was insufficient to cover all public health facilities in a district with more than 3 million people. Reviewing the death of a baby was the worst experience for DCST members. DCST members reported that after years of working in obstetric care, they still do not get used to reviewing the death of a baby. The DCST program will be an integral part of the NHI policy and can improve the country's maternal and infant health indicators. However, the number of specialists in the team must be adjusted to the size and population of the district.

Chapter 8: "Patients can pick up medication closer to where they live and work": reflecting on the Centralised Chronic Medicines Dispensing and Distribution program during the National Health Insurance Pilot Program in the Tshwane District

Background

The South African healthcare system is overburdened with a high number of patients living with chronic illnesses such as HIV, hypertension, and diabetes. In 2021, it was estimated that 8.2 million people were living with HIV, and 4.8 million were receiving antiretroviral treatment (Statistics South Africa 2021). In the same year, it was estimated that 8.22 million people were with hypertension, and only 4.3 million were receiving treatment (Statistics South Africa 2021). People living with diabetes were estimated to be 4.58 million in 2020, and only 1.6 million were receiving treatment (Statistics South Africa 2021). According to Grundlingh et al (2022), HIV, hypertension, diabetes, personal injury, maternal and infant mortality, and cardiovascular disease are the leading causes of death in South Africa (Grundlingh et al 2022). Most people with HIV, hypertension and diabetes rely on public health facilities for treatment (Grundlingh et al 2022). This has led to the congestion of public health facilities with patients who are stable on chronic medication (Kandala et al 2021). Healthcare professionals feel the heavy burden of attending to a high number of stable chronic patients daily and not delegating enough time to patients who are sick and in need of urgent medical care (Samodien et al 2021).

To address this public health system challenges, in 2014, the NDOH introduced the Centralised Chronic Medicines Dispensing and Distribution (CCMDD) program (National Department of Health 2021; Steel 2014). The CCMDD program was implemented simultaneously with other PHC reengineering national strategies such as GPD Contracting, DCST, ISHP and the WBOT programs during the NHI pilot program in South Africa. The objective of the CCMDD program is to ensure that stable patients with chronic illnesses can pick up their medication closer to where they live and work (National Department of Health 2021; Steel 2014). To be eligible for the CCMDD program, a patient must be 18 years old and live with a chronic condition such as HIV, hypertension and diabetes (Magadzire et al 2017). Patients are given a six-month script that they can use to collect medication at convenient pickup points (Magadzire et al 2017). After six months, patients were expected to return to the public health facility for blood and physical checkups (Magadzire et al 2017). Patients in the CCMDD program are encouraged to return to the health facility should they encounter a health problem, even if the six-month period has not

elapsed (Magadzire et al 2017). The CCMDD program contracted big corporate pharmacies such as Medi-Rite, Dischem and Clicks as pickup points for medication (Menold 2019). Small-scale community pharmacies, non-governmental organisations, and General Practitioners' offices were also contracted as pickup points (Menold 2019). Patients had the liberty of choosing a convenient pickup point to collect their chronic medication (Du Toit 2017). The CCMDD program was implemented in 8 provinces in South Africa except for the Western Cape, which already had a similar intervention called the Chronic Dispensing Unit (CDU) (Du Toit 2017).

Since its inception, the CCMDD program has grown and serves many patients across South Africa. In 2017, it was recorded that 401 pharmacies, community pharmacies, NGOs and adherence clubs registered as pickup points for the CCMDD program (Maharaj 2018). In 2019, pickup points increased to 2037, covering 46 districts (Dorward et al 2020). The number of patients who registered for CCMDD grew from 1300 000 in 2017 to 2069 039 in 2019 (Dorward et al 2020). The CCMDD program has reduced the high number of stable patients overcrowding public health facilities (Dorward et al 2020). This has helped healthcare professionals attend to patients requiring serious medical care (Maharaj 2018). According to Dorward et al (2020), patients living with HIV found the CCMDD program to be convenient, and it reduced the community stigma that came with picking up medication in clinics. The CCMDD program improved medication adherence among patients living with HV (Dorward et al 2020). In the past, these patients were discouraged from picking up their medication in clinics because of the long waiting lines (Dorward et al 2020).

The challenge of the CCMDD program in South Africa is the difficulty of tracing patients who moved cities and changed their physical address (Steel 2014). When a patient is no longer picking up their medication, a nurse in the public health facility is informed (Steel 2014). The nurse sends the WBOT to trace the patient in the community (Steel 2014). In some circumstances, the patient would have moved to a different city and changed location, making it hard to know if they are still taking the treatment (Du Toit 2017). In the beginning, the 6-month script led to patients thinking they were not supposed to go to the clinic when sick before the 6 months elapsed (National Department of Health 2021). Nurses had to educate patients that they could come to the clinic for consultation anytime they feel sick (National Department of Health 2021). Patients complained that some pharmacies had a different line for them, thus exposing them to the same community HIV stigma they were running from in public clinics (Maharaj 2018;

Magadzire 2017; Dorward 2020). Errors in scripts, drug stock out in small-scaled community pharmacies and adverse reactions to medication were reported as challenges in the CCMDD program (Magadzire 2017; Menold 2019). This chapter aims to reflect on the successes and challenges of the CCMDD program during the NHI pilot program in the Tshwane District.

Findings

The objective of the Centralised Chronic Medicines Dispensing and Distribution Program

The objective of the CCMDD program during the NHI pilot program in the Tshwane District was to ensure that stable patients with chronic illnesses could collect their medication closer to where they live and work. The clinician gave patients a six-month prescription to present at their preferred pickup point. After six months, the patient returned to the clinic for physical checkups. Sick patients were still expected to come to the clinic for monthly checkups, and once they stabilised, the clinician would send them back to the CCMDD program. Pickup points for the CCMDD were big commercial pharmacies such as Clicks, Dischem and Medi Rite. Independent small-scaled community pharmacies, NGOs, and GPs' private practice were also contracted under the CCMDD program.

> *"We work with patients who take chronic medication for HIV, Diabetes and Hypertension. We only enrol stable patients who do not have to see the doctor regularly. Patients can collect medications closer to where they live and work. Patients are expected to return to the clinic after six months for a checkup. We screen patients by conducting blood tests and physical checkups. If the patient is unstable, we take them off the CCMDD program, monitor them in the clinic and refer them back to the program once they are stable". –Pharmacist Assistant*

The CCMDD program was launched to reduce the high number of patients in public clinics. In the past, public clinics were filled with a mixture of patients who were stable and seriously ill. This patient load meant doctors and nurses had insufficient time to attend to patients requiring urgent medical care. Patients were also subjected to long waiting lines when picking up medication in public clinics. The CCMDD program during the NHI pilot program in the Tshwane District addressed these challenges by taking stable patients out of the public health

facilities to convenient pickup points where they spent less than 5 minutes picking up medication.

> *"The CCMDD program was designed to create accessibility to medication. We know that most public health desperately need upgrades and maintenance. They are too small to cater to many patients. We also do not have human resources for health. Most of the patients that come to our public health facilities are stable, and there is no need for them to come to public health facilities and wait in long lines". –Policymaker, National Department of Health*

A study conducted by Otwombe et al (2022) also found that the objective of the CCMDD program was to reduce the high number of stable patients in public health facilities. Steel (2014) notes that the CCMDD program was introduced during the NHI pilot program as part of the NDOH national plan for reengineering PHC services in public health facilities. The objective of the CCMDD program was to alleviate the high patient load and long waiting lines in public health facilities (Steel 2014). According to Maharaj (2018), the CCMDD program contracted a mixture of big corporate pharmacies, small-scaled community pharmacies and NGOs. What is unique about the Tshwane District is that GPs' private practices were also contracted as chronic medication pickup points. In a study conducted by Dorward et al (2020), adherence clubs that were designed for patients living with HIV were also contracted as pickup points.

Origins of the Centralised Chronic Medicines Dispensing and Distribution Program

Policymakers from the NDOH reported that the CCMDD program was inspired by the Bayview Community Outreach program in Cape Town, Western Cape Province. The Bayview Community Outreach program prepacked chronic medication for patients and sent them text messages to fetch their medication parcels. When patients could not fetch the medication, it was delivered to their houses. Medication adherence amongst patients in this area improved because of the convenience of the Bayview Community Outreach program. The Western Cape Department of Health recognised the Bayview Community Outreach program's success in dispensing medication to more than 300 patients within 5 hours.

"The CCMDD program was inspired by the Bayview Community Outreach program in Cape Town. Stable patients were encouraged to pick up their medication at the Bayview Community Outreach Centre. The staff would pre-pack the medication, and patients would come to pick up the parcel. When patients could not afford to pick up the parcel, the medication was delivered directly to their houses. We conceptualised the CCMDD from this program. The difference with the CCMDD program is that we got the private sector to be involved." -Policymaker, National Department of Health

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Authors such as Magadzire et al (2015) and Steel (2014) trace the inspiration for the CCMDD program from the CDU program in the Western Cape Province. The CDU program was established in 2005 to centralise the dispensing of chronic medication (Munyikwa 2010). The CDU program contractor collects scripts of stable patients on chronic medication from public clinics (Munyikwa 2010). The scripts of stable patients are captured in the CDU system (Magadzire et al 2015). The CDU contractor then orders this medication from the Cape Town Medical Depot (Du Toit et al 2008). Once the medication is received, a process of double-checking accuracy and errors takes place (Du Toit et al 2008). The medication is pre-packaged, and patients are sent text messages to come and collect at public health facility pickup points (Du Toit et al 2008).

The Centralised Chronic Medicines Dispensing and Distribution Program and Service Providers

In the Tshwane District, big corporate pharmacies, small-scaled community pharmacies, NGOs and GPs' private practices were contracted as service provers in the CCMDD program. The service providers received scripts from public health facilities and estimated the quantity of medication they needed to order. The orders would be sent to the provincial government, and it forwarded the order to the manufacturer. The manufacturer would then deliver medications directly to CCMDD service providers. The benefit of centralising the medication orders to the provincial government is eliminating drug stockouts. The CCMDD program has also implemented the same approach to medication that is required in public health facilities. The health facilities place medication orders on the provincial government. The order is sent straight

to manufacturers, which directly deliver the medication to health facilities without the interference of medical depots.

> *"By centralising medication orders to the provincial government, we have cut out the struggles of the medical depot middleman. The provincial government places an order directly to the manufacturer. The manufacturer delivers the order to health facilities and CCMDD service providers. The manufacturer delivers the medication on time, and we no longer have a situation of drug stockouts". – Policymaker, National Department of Health*

The CCMDD program in the Tshwane District contracted big commercial pharmacies such as Clicks, Dischem and MediRite. These big cooperative pharmacies made it easier for patients to have options regarding pickup points. Small-scale community pharmacies were also contracted, which was an advantage for people in small towns or rural areas with only one reliable community pharmacy. NGOs and GPs' private practices were also contracted as pickup points in the Tshwane District. Policymakers in this study reported that it was necessary to diversify CCMDD service providers so that people could have options regarding pickup points. Small-scale community pharmacies, NGOs and GPs' private practices were contracted as part of the strategy to empower small businesses and community-based organisations.

> *"Our service providers are diverse. We work with Clicks, Dischem, MediRite, small companies and NGOs. We wanted our people to have options regarding where they can pick up medications". Government Official, National Department of Health*

> *"We allowed small-scaled community pharmacies, NGOs and GPs' private practices to be part of the CCMDD program. We did this to empower small businesses and to create jobs at a community level. These small businesses employed people in the community to pre-pack and deliver the medication. This program uplifts small businesses and creates jobs that were not there before. So, the CCMDD program is a win-win situation for patients, small businesses, the healthcare system and the community". - Government Official, Tshwane District Department of Health*

Partners of the Centralised Chronic Medicines Dispensing and Distribution Program

The CCMDD program receives funding from the National Treasury, Global Funds, Centres for Disease Control and Prevention (CDC) and the United States President's Emergency Plan for AIDS Relief (PEPFAR). The CCMDD program has partnered with organisations such as the National HIV Unit, Health Systems Trust, and NGOs such as Kheth' Impilo and Match. The Foundation for Professional Development was another critical partner of the CCMD program and provided training to healthcare professionals about the program's administration. The CCMDD program partnered with big corporate pharmacies, small-scale pharmacies, NGOs, and the private health sector in the Tshwane District. It also collaborated with the WBOT teams, which delivered chronic medication to houses of bedridden patients and older people.

"We looked for funding, and thank God the Treasury, CDC, and Global Funds gave us money to implement the CCMDD program. We are still working with these funders to improve the program". – Government Official, National Department of Health

> *"Our external pickup points are big corporate pharmacies like MediRite, Dischem and Clicks. We work with NGOs like Progressive Societies and Lazer. We have doctors who have converted their houses into pickup points. If they meet the criteria of a pickup point, we contract them". – Government official, National Department of Health*
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> *"PEPFAR supported the implementation of the CCMDD program. We partnered with Health System Trust, Kheth' impilo and Match. They assisted with the implementation. So, we work very closely with the National HIV Unit". – Policymaker, National Department of Health*
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> *"We partnered with the WBOT team to deliver chronic medication to older people. The sister will pre-pack medication parcels and give them to the WBOT team. They would hop onto the bicycle and deliver the medication parcel to patients at home. They deliver medication to the granny caring for the kids and cannot come to the clinic". –Government official*

The Centralised Chronic Medicines Dispensing and Distribution Program and Primary Healthcare

The CCMDD program during the NHI pilot program in the Tshwane District improved the delivery of PHC services by making it possible for stable patients to collect chronic medication at a convenient pickup point. Patients have the liberty of choosing a pickup point that is closer to where they live and work. In these selected pickup points, patients only wait 5 minutes to receive medication. Patients did not take time off work to wait at the clinic for the whole day to receive medication. The CCMDD program reduced the high number of patients in public health facilities. A public health facility that used to serve 200 people daily now attends to 50 patients in serious need of medical care. Convenient pickup points for medication improved treatment adherence among people living with HIV, hypertension, and diabetes.

> *"Patients used to wait 4 hours to 5 hours at the facility. Now, with the CCMDD program, they collect their medication at a pickup point, and the waiting time is 3 to 5 minutes. So, the program greatly benefits the patient in terms of convenience. Patients have a choice as to where they collect their medication. Before, patients had no choice and had to go to a health facility to collect medication". – Pharmacist Assistant, Clicks Pharmacy*

> *"Patients are happy with the CCMDD program. The HIV patients we refer to the CCMDD program are doing much better. Their viral loads are suppressed and undetected. We do not send patients with a high viral load to the CCMDD program. Those patients we manage them here at the clinic." –Pharmacist Assistant, Public Health Facility*

> *"Public health facilities do not have to attend to 200 patients daily. Attention is given to the 50 patients who need medical attention. Patients do not want to go to a public health facility that is always full. Patients are encouraged to seek medical care if the health facility does not have long lines". – Policymaker, National Department of Health*

> *"Sometimes, when patients wait for hours, they get tired and leave the public health facility without medication. They would stop taking their medication. The CCMDD program has encouraged patients to take their treatment. Patients know that they will be deregistered from the program*

and sent back to the clinics if they do not take their treatment. They take their treatment because they do not want to go back to the waiting lines"- Government official, National Department of Health

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In a study conducted in Namakwa Northern Cape by Smith & Nicol (2020), the CCMDD reduced the high number of patients in public clinics and healthcare professionals could attend to sick patients. According to Ramphal (2018), in uMzinyathi KwaZulu-Natal, the CCMDD program improved treatment adherence among people living with HIV. A study conducted by Piotie et al (2021) in the Tshwane District also found that the CCMDD program made it easier for patients with diabetes to access their medication at convenient pickup points. However, there was no relationship between being enrolled in the CCMDD program and the improvement of diabetes among patients (Piotie et al 2021). This means that although patients were enrolled in the CCMDD program, this did not improve their diabetes (Piotie et al 2021). Kok et al (2021) suggest that, unlike HIV, diabetes is a more complex disease, requiring treatment and a significant lifestyle change. Piotie et al (2021) concluded that the CCMDD program alone was insufficient to make significant changes in diabetes management.

Achievements of the Centralised Chronic Medicines Dispensing and Distribution Program

The demand for the CCMDD program grew drastically during the NHI pilot program in the Tshwane District. The CCMDD program was initially implemented as part of the NHI pilot program in the Tshwane District, and other districts in Gauteng Province applied to be part of the program. Within 3 months of the CCMDD program, districts nationwide demanded the NDOH to implement the program nationally. The CDC in the United States funded the NDOH to roll out the program in all districts in South Africa. Policymakers reported that there was not enough time to test whether the CCMDD program works or not. The CCMDD program was implemented with a big-bang approach, and policymakers had to learn and adjust as the program developed. The national demand for the CCMDD program and its benefits to the people and the healthcare system could not be ignored.

"We did not expect the CCMDD program to grow so quickly. Initially, we started with the NHI pilot sites. We thought we would pilot, see how it works, and later move to other districts. Whilst we were busy piloting, officials from other districts wanted to come on board. Then, CDC said

okay, we are going to give you X amount of money, and you need to roll out the CCMDD program nationally". -Government Official, National Department of Health

"And then boom, it was a big bang approach. Whatever challenges came, we fixed them along the way. Government officials saw the benefits and said I want the CCMDD program to be rolled out in my province". And we had to give people what they want". -Policymaker

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According to Otwombe et al (2022), in 2016, the CCDMM program was only implemented in 16 districts. This coverage grew; by January 2018, 46 out of the 52 districts in South Africa were part of the CCMDD program. The number of public health facilities in the CCMDD program grew from 972 in 2015 to 3436 in 2019 (National Department of Health 2021; Otwombe et al 2022). The number of contracted pickup points also grew from 164 in 2015 to 2037 in 2019 (Department of Health 2021; Otwombe et al 2022). In 2019 it was recorded that the CCMDD program has "...2993 044 registered patients and 206 9039" active patients (Otwombe et al 2022: 10).

The Role of Pharmacist Assistants

The CCMDD program during the NHI pilot program in the Tshwane District recognised that not all patients want to pick up their medication outside public health facilities. Public health facilities also needed human resources to take stock, place orders, and dispense medication. Pharmacist Assistants were contracted under the CCMDD program to work in public health facilities. The role of Pharmacist Assistants was to control stock, place orders, and pre-pack medication for collection. Pharmacist Assistants were responsible for monitoring and evaluating medication in public health facilities to prevent drug stockouts.

"We prepare medication and dispense it to patients. We minimise the waiting time patients spend in clinics when collecting medication" – Pharmacist Assistant, Public Health Facility

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The Contracting of Pharmacist Assistants

The Primary Healthcare Unit at the NDOH recruited and contracted Pharmacist Assistants. was responsible for recruiting and contracting Pharmacist Assistants. Pharmacist Assistants signed a contract with the NDOH to work in public health facilities for two years. A total number of 150 Pharmacist Assistants were contracted during the NHI pilot program in the Tshwane District. Pharmacist Assistants expressed that they are constantly in a state of anxiety because they do not know if their contracts will be renewed after 2 years. Pharmacist Assistants reported that they hope that the NDOH employ them permanently.

> *"I am not sure about the future of the NHI policy and where this program is going. We pray they can extend our contracts and hire people permanently. We cannot make any financial commitments. There is no job security. -Pharmacist Assistant, Public Health Facility*

> *I would like to know if they will extend the contracts. Will the contracts be renewed or not? Now, the Tshwane Department of Health is promising three permanent vacant posts, but 100 of us are on contract. We are panicking because we do not know if the contracts will be renewed. Now we need to prepare ourselves in case our contracts are not renewed. The future is uncertain". –Pharmacist Assistant, Public Health Facility*

Government officials at the NDOH expressed that Pharmacist Assistants create their expectations about permanent employment. The NDOH is not obliged to renew the contract for Pharmacist Assistants. The renewal of contracts for Pharmacist Assistants depends on the availability of funding.

> *"Pharmacist Assistants create their expectations. They expect to be employed permanently, but their contract is for 2 years. They get despondent when you tell them your contract is only for 2 years and you must leave. They tell you that I am doing a good job. It is not about doing a good job, but the availability of funding for the CCMDD program". - Government official, National Department of Health*

The history of Pharmacists Assistants in South Africa can be traced back to 1928, to the middle-worker pharmacy workers' program (Gray 2005). The training of pharmacists in those days was solely based on apprenticeship for two years at the College of Pharmacy (Gray 2005). In 1960, the Apartheid Government declared the middle-workers pharmacy program essential in delivering pharmaceutical services in homelands where the majority of Black South Africans reside (Gray 2005). The Pharmacy Act of 1970 continued the tradition of unqualified pharmacists receiving training for two years and providing pharmaceutical services in homelands (Gray 2005). The homelands struggled to attract qualified pharmacists, and most qualified pharmacists at the time were White people who were not allowed to work in homelands due to the racial segregation of apartheid policies (Gray 2005).

In 1995, Pharmacist Assistants found themselves at the centre of Pharmacy Act legislation that was set to transform the racialised pharmacy services in South Africa (Boschmans et al 2015). Pharmacist Assistants were categorised to work in the public sector, private sector and manufacturing industry (Boschmans et al 2015). The basic and post-basic levels were adopted as levels of qualifications for pharmacists. Please refer to Figure 1. In 2013, the NDOH adopted the Pharmacist Assistant program as part of the national project of improving health human resources in the healthcare system (National Department of Health 2021). The CCMDD program employed Pharmacist Assistants on a contract basis to provide pharmaceutical services in public health facilities (National Department of Health 2021). Pharmacist Assistants reduced the workload of pharmacists in the public health sector (Boschmans et al 2015). Pharmacists can now focus on complicated tasks in the pharmacy and delegate responsibilities such as stock taking, placing orders, and packing medication to Pharmacist Assistants (Boschmans et al 2015).

Figure 1: Pharmacist Assistants' level and roles

Pharmacist Assistant (Basic)	Pharmacist Assistant (Post-basic)
The following, under the personal supervision of a pharmacist: ✧the sale of Schedule 1 medicines or scheduled substances ✧ assist with the compounding, manipulation or preparation of a non-sterile medicine or scheduled substance according to a formula and standard operating procedures approved by the responsible pharmacist ✧ assist with the manufacturing of a non-sterile medicine or scheduled substance according to a formula and standard operating procedures approved by the responsible pharmacist ✧ the re-packaging of medicine ✧ the distribution and control of stock of Schedule 1 to Schedule 6 medicines or scheduled substances	The following, under the personal supervision of a pharmacist: ✧ the sale of Schedule 1 and Schedule 2 medicines or scheduled substances ✧ assist with the compounding, manipulation or preparation of a non-sterile or sterile medicine or scheduled substance according to a formula and standard operating procedures approved by the responsible pharmacist ✧ assist with the manufacturing of a non-sterile or sterile medicine or scheduled substance according to a formula and standard operating procedures approved by the responsible pharmacist ✧ the re-packaging of medicine ✧ the distribution and control of stock of Schedule 1 to Schedule 7 medicines or scheduled substances ✧ the ordering of medicine and

✧ the provision of information to individuals in order to promote health	scheduled substances up to and including Schedule 7 according to an instruction of a person authorised in terms of the Medicines Act to purchase or obtain such medicine or scheduled substance ✧ the reading and preparation of a prescription, the selection, manipulation or compounding of the medicine, the labelling and supply of the medicine in an appropriate container following the interpretation and evaluation of the prescription by a pharmacist ✧ the provision of instructions regarding the correct use of medicine supplied ✧ the provision of information to individuals in order to promote health.

Source: (Gray 2005)

Challenges of the Centralised Chronic Medicines Dispensing and Distribution Program

At the beginning of the CCMDD program in the Tshwane District, there was resistance from facility managers. Facility managers thought that the CCMDD program would decrease the number of people that come to the facility, which would mean less funding for the facility. Government officials had to inform facility managers that patients would return to the facility after 6 months for a checkup. Facility managers were informed that the CCMDD program is designed to reduce the number of stable patients in public health facilities so that healthcare professionals can attend to sick patients who require medical care. Another challenge was that public health facilities ordered large amounts of medication, although stable patients were transferred into the CCMDD program. When public health facilities order medication as if they

are dispensing medication to 500 patients a day, this results in excessive drugs that are unused and expire in the system.

> *"Facility managers did not want to enrol patients in the CCMDD program as they feared it would decrease the number of patients in public health facilities. The decrease in number of patients means less funding for the health facility. So, we informed facility managers that resources will not be cut because patients will return to the facility after 6 months for regular checkups". –Policymaker, National Department of Health*

> *"Public clinics still order medications as they dispense medication to more than 500 patients. This leads to medication expiring in the system. Pharmacist Assistant, Public Health Facility*

When the CCMDD program was launched in the Tshwane District, independent small-scaled community pharmacies did not want to be part of the program. The CCMDD program only contracted commercial pharmacies such as Clicks, MediRite and Dischem as pickup points. However, when small-scaled community pharmacies saw that the commercial pharmacies were making profits, they wanted to be part of the CCMDD program. However, the CCMDD program had reached its quota regarding service providers it could contract as pickup points. All the patients in public health facilities wanted to be part of the CCMDD program and to pick up their medication at convenient pickup points. However, the program could not absorb all the patients due to eligibility criteria, which required patients to be stable and on chronic medication. Struggles with funding meant that the CCMDD program could only service only 60% of stable patients in public health facilities.

> *"Then suddenly, all of these independent pharmacies wanted to be part of the CCMDD program. They were now seeing the value in monetary terms that big corporate pharmacies gained. In the beginning, independent pharmacies did not take the CCMDD program seriously. When the CCMDD program was seen as a way of making a profit, independent companies wanted to come on board". –Government official, Tshwane District Department of Health*

HIV stigma in the community made patients to be reluctant to pick up medication at the pharmacy as the CCMDD was associated with HIV. Patients did not want to go to the pharmacies to pick up the medication because the program was associated with HIV. This challenge was solved by including other chronic illnesses in the program, such as diabetes and hypertension. Service providers were also instructed to package the ARVs in small boxes so that people would not see the type of medication collected at the pharmacy.

> *"When the CCMDD program started, it was only serving patients with HIV. Patients complained that when they went to the pickup points, people knew they were collecting ARVs. We then diversified the recipients and included patients living with hypertension and diabetes. We asked service providers to package the medication after we saw that patients throw away the ARVs bottles outside the pickup points" -Government Official, National Department of Health*

In Umzinyathi KwaZulu-Natal, patients complained that pharmacies had separate lines for the CCMDD program (Ramphal 2018). When patients were seen in separate lines, they were stigmatised as living with HIV in communities (Ramphal 2018). The NDOH instructed pharmacies to have one line for all patients to destigmatise the program (Dorward et 2020; Ramphal 2018). In Namakwa North West Province, patients complained that the small-scaled community pharmacies were not properly packaging the medication (Smith et al 2020). Patients living with HIV felt that their status was exposed to other community members (Smith et al 2020). These small-scaled pharmacies were encouraged to pack the medication in appropriate boxes (Smith et al 2020).

Discussion

The findings from this chapter show that the CCMDD program during the NHI pilot in the Tshwane District ensured that stable patients living with chronic illnesses could collect their medication closer to where they live and work. Patient load in public health facilities decreased due to stable patients no longer going to the clinic to pick up medication. Healthcare professionals could now attend to sick patients who required their medical care. The CCMDD program in the Tshwane District improved treatment adherence rates in patients living with HIV

and hypertension. The CCMDD program, during the NHI pilot program in the Tshwane District, managed to partner with the private sector, civil society organisations and GPs. The big corporate pharmacies such as Clicks, Dischem and MediRite, small-scaled pharmacies, NGOs and private GPs' offices were contracted as pickup points.The CCMDD program contracted Pharmacists Assistants to work in public health facilities. Pharmacist Assistants were responsible for placing orders, stock-taking and pre-packing medication in public clinics. The work of Pharmacist Assistants ensured that there were no drug stockouts in public health facilities. Pharmacist Assistants in the Tshwane District complained that the contract of 2 years puts them in a state of anxiety and makes it harder for them to make financial commitments. Government officials from the NDOH replied that they never made promises of permanent employment to Pharmacist Assistants. They expressed that the renewal of their contract depends on the availability of funding.

In the beginning, health facility managers in the Tshwane District were not comfortable with the CCMDD program. Facility managers thought that when the number of patients decreased in health facilities, their funding would be reduced by the government. Government officials informed facility managers that the patients would always return to the clinic after 6 months for regular checkups. Small-scale community pharmacies were reluctant to join the CCMDD program. However, when these small-scale community companies realised that big corporate pharmacies were making profits, they wanted to join the program. However, the CCMDD program needed more funds to contract more small-scale community pharmacies. The lack of funding also meant that the program could only service 60% of the patients in the Tshwane District. Pharmacies had a separate queue for patients of the CCMDD program. In the community, these separate queues were associated with people living with HIV. Government officials then told pharmacies to dismantle separate queues to destigmatise the program. Pharmacies were now advised to pack ARVs in boxes that are not identifiable to community members.

Conclusion

The objective of this chapter was to evaluate the CCMDD program during the NHI pilot program in the Tshwane District. The results from this chapter show that the CCMDD program allowed stable patients living with chronic illnesses to pick up their medication closer to where they live and work. The CCMDD program improved the delivery of PHC services by ensuring that the patient load in public health facilities is reduced as stable patients no longer come to the

health facilities to pick up medication. Healthcare professionals were now able to focus on patients who are sick and who require their attention. The CCMDD program has improved the health indicators of patients as they are now taking their medication regularly. The CCMDD program in public health facilities is run by Pharmacist Assistants responsible for stock taking, placing an order, pre-packing and dispensing medication. However, Pharmacist Assistants complained that the 2 year work contract gives them anxiety, and they have asked the government for permanent employment. The government officials reported that Pharmacist Assistants created their expectations about permanent employment. The officials reported that renewal of contracts or permanent employment of Pharmacist Assistants depends on the availability of funding. In the beginning, small-scaled community pharmacies were reluctant to join the CCMDD program employment. Big corporate companies now took the CCMDD program business that could have benefited small-scaled pharmacies. Pharmacies had different queues for patients living with HIV, and this heightened HIV stigma in the community. Government officials from the NDOH instructed pharmacies to have one worked queue at the pharmacy to destigmatise the program. When the NHI policy is implemented, the CCMDD program must prioritise small-scaled community pharmacies when contracting service providers. This will ensure that small-scaled community pharmacies benefit from the profits of the CCMDD program that big corporate pharmacies now enjoy. Pharmacist Assistants must be employed on long-term sustainable contracts with benefits.

Chapter 9: "We are responsible for the healthcare needs of learners in public schools": reflecting on the Integrated School Health Program during the National Health Insurance Pilot Program in the Tshwane District

Background

The history of school health services in South Africa can be traced to 1920, when the government adopted the School Health Service Policy to respond to the challenge of poor Whites (Shung-King et al 2014). The School Health Services were only reserved for White learners, and it excluded Black, Coloured and Indian learners (Shung-King et al 2014). In the early 1960s, the apartheid government extended School Health Services to Indian and Coloured schools (Shung-King et al 2016). However, to cement the racial segregation of the time, Black schools were still excluded from the program (Shung-King et al 2016). In 2003, the South African government introduced the National School Health Policy to address the injustices of racial segregation created by the apartheid system (Shung-King et al 2016). The objective of the National School Health Policy is to implement comprehensive school health services to learners in public schools (National Department of Health 2012 & Department of Basic Education 2012). However, the National School Health School Health Policy was criticised for only focusing on feeding scheme programs and failing to deliver healthcare services in public schools (National Department of Health & Department of Basic Education 2012).

In 2010, former President Jacob Zuma introduced the Integrated School Health Policy to address the healthcare needs of learners in public schools (National Department of Health & Department of Basic Education 2012). The objective of the Integrated School Health Policy was to provide comprehensive healthcare services in public schools so that children from vulnerable communities could achieve their educational goals (National Department of Health & Department of Basic Education 2012). The Integrated School Health Policy was designed as a multisector approach between the Department of Basic Education, the National Department of Health, and the Department of Social Development (National Department of Health & Department of Basic Education 2012). This multisector collaboration was adapted to address the educational, health and social needs to prevent morbidity and mortality of learners (National Department of Health & Department of Basic Education 2012). The policy recognised that schools are the safest and most convenient spaces for implementing comprehensive interventions

that address the physical, psychological, educational and material needs of children (Ramukumba et al 2019). In 2012, the Integrated School Program (ISHP) was introduced as a vehicle for implementing the Integrated School Health Policy (Ramukumba et al 2019).

The objective of the ISHP was to provide health promotion, health screenings, immunisations and medical treatment to learners in public schools (Mojapelo 2019). The health promotion of the ISHP was embedded in the curriculum of Life Orientation, and it was going to be delivered by health promoters and teachers (Mojapelo 2019). Nurses conducted health screenings in schools, and learners were screened for eyesight challenges, dental infections, malnutrition and infectious diseases (Mojapelo 2019). School nurses rotated across districts to conduct health screenings and refer learners with complications to clinics and hospitals (Ramukumba et al 2019). School nurses administered immunisations and traced children who never received essential immunisations (Ramukumba et al 2019). The ISHP team administered vitamin A and deworming tablets to learners in primary schools to improve their concentration in the classroom (Ramukumba et al 2019). The ISHP collaborated with the National School Nutrition Program and the National Scholar Transport Program (Shuro & Waggie 2021). The National School Nutrition Program provides universal breakfast and lunch to learners to prevent and treat child malnutrition (Shuro & Waggie 2021). The National Scholar Transport ensures that children who live far away are transported to school daily. The National Scholar Transport provides safe, convenient transportation to learners who live in rural areas and often have to walk a long distance to school (Shuro & Waggie 2021).

South African public schools are divided into quintiles 1, 2, 3, 4 and 5, with quintiles 1 and 2 located in socioeconomically vulnerable communities (Lenkokile 2016). When the ISHP began, it concentrated in quintiles 1 and 2 with the assumption that the parents of learners in quintiles 3, 4 and 5 schools could afford the health needs of their children (Lenkokile 2016). Government officials, trade unions and teachers challenged the decision of the ISHP to focus on quintiles 1 and 2 schools in court (Lenkokile 2016). Government officials, trade unions and teachers demanded that the ISHP be extended to quintiles 3 and 4 (Lenkokile 2016). The argument in court was that the quintile school system in South Africa is not a true reflection of the socioeconomic status of the most vulnerable learners in the public health school system (Lenkokile 2016). The court ruled that the ISHP must be implemented in public schools from quintile 1 to 4 (Ramukumba 2019). In 2012, the ISHP formed part of the PHC national

reengineering strategy, and it was implemented simultaneously with the DCST, CCMDD, ISHP, and WBOT programs during the NHI pilot program in South Africa (Ramukumba et al 2019). The objective of this chapter is to evaluate the implementation of the ISHP during the NHI pilot program in the Tshwane District.

Findings

The Objectives of the Integrated School Health Program

The objective of the ISHP during the NHI pilot program in the Tshwane District was to attend to the health needs of learners in public schools. The PHC interventions of the ISHP were health promotion, administration of immunisations and Vitamin A, prevention of infectious diseases and referral of complicated cases of learners to higher levels of care. The ISHP in the Tshwane District was a result of collaboration between the National Department of Health, the Department of Basic Education and the Department of Social Development. This multisector collaboration appreciated that the health needs of learners are a result of political, social and economic conditions. In South Africa, public schools are categorised from quintiles 1 to 5. The ISHP, during the NHI pilot program in the Tshwane District, only provided healthcare services to public schools that fell under quintiles 1, 2 and 3. Government officials reported that public schools falling under 4 and 5 were excluded. The assumption was that the parents in these schools could afford to pay for healthcare services for their children.

> *"We are responsible for the healthcare needs of learners in public schools. We use a holistic approach and pay attention to the physical, emotional, social, and environmental factors that affect our learners. We work collaboratively with the National Department of Health and the Department of Social Development". –Government official, Gauteng Department of Education*

> *"Our schools are divided into 5 quintiles. The Department of Basic Education funds quintiles 1, 2, and 3 schools in poor communities. We decided that quintiles 1, 2, and 3 should be the focus of the ISHP in the Tshwane District. Learners from quintiles 4 and 5 have parents who can afford to take them to the doctor". –Government official, Tshwane District Department of Education*

According to Ramukumba et al (2019), the eligibility of public schools to form part of the ISHP using the quintile system has been challenged in court. When the Department of Basic Education announced that the ISHP would only be implemented in schools that fall under quintiles 1, 2 and 3, government officials, trade unions and teachers challenged this decision (Ramukumba et al 2019). The Department of Basic Education was accused of being in denial that schools in quintiles 4 and 5 have learners who come from poor communities (Ramukumba et al 2019). The quintile school system was declared ineffective as criteria for excluding learners in quintiles 4 and 5 schools from the ISHP (Ramukumba et al 2019). According to Mojapelo (2019), school districts submitted to the court that schools which fall under quintiles 4 and 5 have children who live in extreme poverty. Some parents of learners in quintiles 4 and 5 are unemployed and cannot afford to pay for private healthcare services (Mojapelo (2019). The ISHP was ordered by the courts to extend its services to public schools that fall under quintile 4 (Mojapelo 2019). In 2017, during my fieldwork, government officials from the Tshwane District Department of Education reported that ISHP is only implemented in public schools that fall under quintiles 1, 2, and 3. However, a study conducted by Ramalepa et al (2022) shows that in the Tshwane District, the ISHP is implemented in public schools under 1, 2, 3 and 4. This means that the Tshwane District was also ordered by the courts to implement the ISHP in public schools that fall under quintiles 4 and 5.

The Integrated School Health Program and Primary Healthcare

The ISHP was responsible for deworming learners, administering Vitamin A tablets, immunising learners, administering HPV vaccines, screening learners for complications and referring them to higher levels of care. A team of government officials were responsible for administering deworming tablets to learners in primary schools. The deworming intervention improved the concentration of learners in the classroom. School nurses were responsible for administering immunisation to primary school learners as part of the Road to Health Program. School nurses required learners to bring their Road to Health card so that they could assess which immunisation the child missed and administer it to them in school. School nurses administered the HPV vaccine to girls in grade 4 to prevent the future occurrence of cervical cancer. The ISHP conducted health screenings to detect dental infections, eyesight and hearing problems. In the Tshwane District, the ISHP collaborated with the private sector and NGOs to provide learners with glasses and hearing aids for free. Health promotion was incorporated into the Life Orientation curriculum, and learners were taught about HIV and AIDS, teenage pregnancy, nutrition, drugs and substance abuse. A sexual and reproductive health program was

implemented to prevent teenage pregnancy and sexually infectious diseases and support learners who have kids in schools. The ISHP worked with health facilities and the National Department of Health to manage disease outbreaks such as tuberculosis and measles in schools.

> *"If a kid has worms, he will not concentrate in the classroom. He will be hungry the whole time. If he cannot see the board, he will not be able to write. If he cannot hear the teacher, that will influence his performance in school. We have to address all these health needs within the school premises". -School Nurse*

> *"We have partnerships with optometrists' companies, and we have a mobile eye clinic. We screen and refer learners who cannot see to the optometrist. Optometrists come to the school and screen learners who cannot see. After two weeks, optometrists return to the school with eyeglasses for learners. The National Department of Health partnered with NGOs to provide eyeglasses to learners for free". –Government official, Gauteng Department of Health*

> *"There was a TB outbreak in one of the schools in Soshanguve. The child went to the clinic because he was not feeling well. At the clinic, they checked and discovered that he had TB. Immediately, we arranged with that school to make sure everybody was tested and received a vaccination for TB. The National Department of Health came and tested and vaccinated all the learners". –Government official, Tshwane District Department of Education*

> *"We do not only focus on learners who are pregnant. We also focus on learners who are mothers already. We teach them about postnatal care because their bodies change after giving birth. We teach them how to take care of the little ones. We teach learners how to avoid pregnancy and what alternatives they have if they find themselves pregnant". –School nurse*

A study conducted by Khoza (2017) in Mgugundlovu KwaZulu-Natal found that the ISHP improved the delivery of healthcare services by providing deworming tablets, Vitamin A and

immunisations to learners who come from poor communities. According to Lenkokile (2016), in Region C Gauteng Province, the ISHP provided eyeglasses for free to learners with eyesight challenges in public schools. In the Tshwane District, a group of dental specialists and dental hygienists provides dental care to learners who suffer from tooth decay and dental infections Molete (2020). According to Tatiah (2014), the HPV vaccination intervention under the ISHP managed to reach 90% of school girls in Grade 4 nationally. The sexual and reproductive health program was the most difficult to implement in schools (Ramalepa et al 2022). There was no consensus between parents, the National Department of Health and the Department of Basic Education on what should be included and excluded in the sexual and reproductive health program (Ramalepa et al 2022). Religious leaders and School Governing Bodies (SGBs) complained that the sexual reproductive program was introducing learners to sexual practices (Ramalepa et al 2022). According to Ramalepa et al (2022), in 2018, the National Department of Health and the Department of Basic Education published a policy which provided guidelines on the content of sexual and reproductive health interventions that should be implemented in public schools.

The Actors of the Integrated School Health Program

The key actors of the ISHP in the Tshwane District were government officials, teachers, school nurses, SGB and parents. In a few schools, SGB and parents assisted with implementing the ISHP. In schools where the SGB and parents were involved, the ISHP managed to deworm most learners. However, in schools where the SGB and parents were not involved, there was a backlog in deworming learners. The government officials from the Tshwane District Department of Education were responsible for administering deworming tablets and Vitamin A to learners in primary schools. School nurses were responsible for eye, hearing and dental assessments of learners. School nurses administered the HPV vaccine to school girls in Grade 4 and immunised learners in primary school . Life Orientation teachers were responsible for health promotion and sexual reproductive health education of learners. Teachers identified learners in the classroom who were struggling to concentrate due to worms, malnutrition, eyesight, hearing and dental problems and referred them to school nurses. When the ISHP began, teachers used to assist government officials with administering deworming tablets to learners. However, teachers are no longer allowed to dispense deworming tablets to learners because of the mandate from teachers' unions. The teachers' union has banned teachers from administering any drug to learners, including deworming tables. The teachers' union argued that teachers are not medically trained

to dispense medication. Teachers will be forced to account if a learner develops complications due to the medication.

> *"In some schools, the SGB is active, and in others, they are not. We do not have enough staff for deworm learners. The SGB schools assist us with deworming. Especially in a context where teachers are no longer assisting us because of the directive from the unions. We rely on the help of the SGB to assist us with deworming. In my team, it is only 2 of us who are responsible for deworming 1,500 learners per day. We seldom achieve this target without the help of the SGB. We appreciate the help of the SGB". – Government official, Tshwane District Department of Education*
>
> *"When there is a learner at school with a health problem, I have to assess them. I refer them to the clinic and hospital when there are complications. My responsibility is to take care of the health of learners. I have to make the learners and teachers aware if there is a disease outbreak in the school". -School nurse*
>
> *"I had 78 schools that I had to deworm. I think it was in 38 schools where the teachers said we cannot help you. Our unions said we are not allowed to be involved in deworming and that we should not touch any child. When you do not have the assistance of teachers, it makes the work difficult". -Government official, Tshwane District Department of Education*
>
> *"The school nurses are responsible for health screenings. They conduct eye and hearing tests. They have all the equipment you need to use for a hearing test. We are not qualified to do the screenings. –Government official, Gauteng Department of Education*

A decision between the Department of Education and the South African Democratic Teachers Union (SADTU) prohibited teachers from deworming learners (Shuro & Waggie 2021). SADTU instructed that the ISHP needs to employ more school nurses to deworm learners and not use teachers (Shuro & Waggie 2021). Teachers were instructed not to administer medication to learners and only identify and refer learners with complications to school nurses (Shuro &

Waggie 2021). According to Shung-King et al (2016), the ISHP nationally has not reached its target of improving the health needs of learners because of a shortage of school nurses. The Integrated School Health Policy states that there should be one school nurse for 2000 learners (Shung-King et al 2016). However, this target has not been reached, and principals complain that school nurses come to do health screenings and never return to the school (Shung-King et al 2016). In the Tshwane District, school nurses complained that they could not finish health screening and provide healthcare services to learners because they are understaffed (Peu et al 2015). The school environment is not conducive for the ISHP as there is no extra physical space for nurses to conduct health screenings (Peu et al 2015). In some districts, school nurses must assist public clinics as they are always understaffed (Peu et al 2015). School nurses reported that the ISHP does not provide sufficient medical equipment and essential medicines to attend to the needs of sick learners in public schools (Peu et al 2015).

Integrated School Health Program and the Consent Form

Parents had to complete the consent form for learners to receive school healthcare services. Government officials in the Tshwane District reported that the parents did not sign the consent form. Without the signed consent form from parents, the ISHP health team could not offer healthcare services to learners. **Please see Figure 1 for the consent form.** School nurses highlighted that even when the parent manages to complete the informed consent form, they do not fill it correctly. The consent form has different services, and the parent must tick next to all the healthcare services a learner must receive. If the parent only ticks 2 health interventions, the learner will only receive those 2 interventions. School nurses also complained that the consent form requires parents to make a right tick, and parents put a cross instead of the right tick. In this case, the school nurses are unable to help the learner as it is not clear if the parent is agreeing to the healthcare services or not. Learners who live with grandmothers who cannot read and write were left behind and did not receive healthcare services. This is because grandmothers could not sign the informed consent form. Teachers held school meetings and explained to parents the significance of signing the consent form for learners to receive healthcare services. Government officials contacted grandmothers who could not write and received verbal consent so that learners would receive healthcare services.

> *"Nothing can be done without the signed consent form from parents. That learner will not receive the HPV vaccine and deworming tablets. Health*

screening screening, such as eye tests and urine tests, will not be done without the signed consent form. The parents must be specific on the informed consent form about healthcare services that the learner must receive. The parent must tick next to the HPV vaccine, eye test or deworming. If no tick is next to healthcare service, the learner will not receive that specific treatment". –Government official, Tshwane District Department of Education

"The challenge is that some learners live with grandmothers who cannot read or write. The grandmother cannot sign the consent form, and unfortunately, we cannot administer any health intervention to that learner". -School Nurse

"In high school, we are happy because most learners are above the age of 14 years. This means that these learners can assent to healthcare services, and we do not need the parent's signature". –School Nurse

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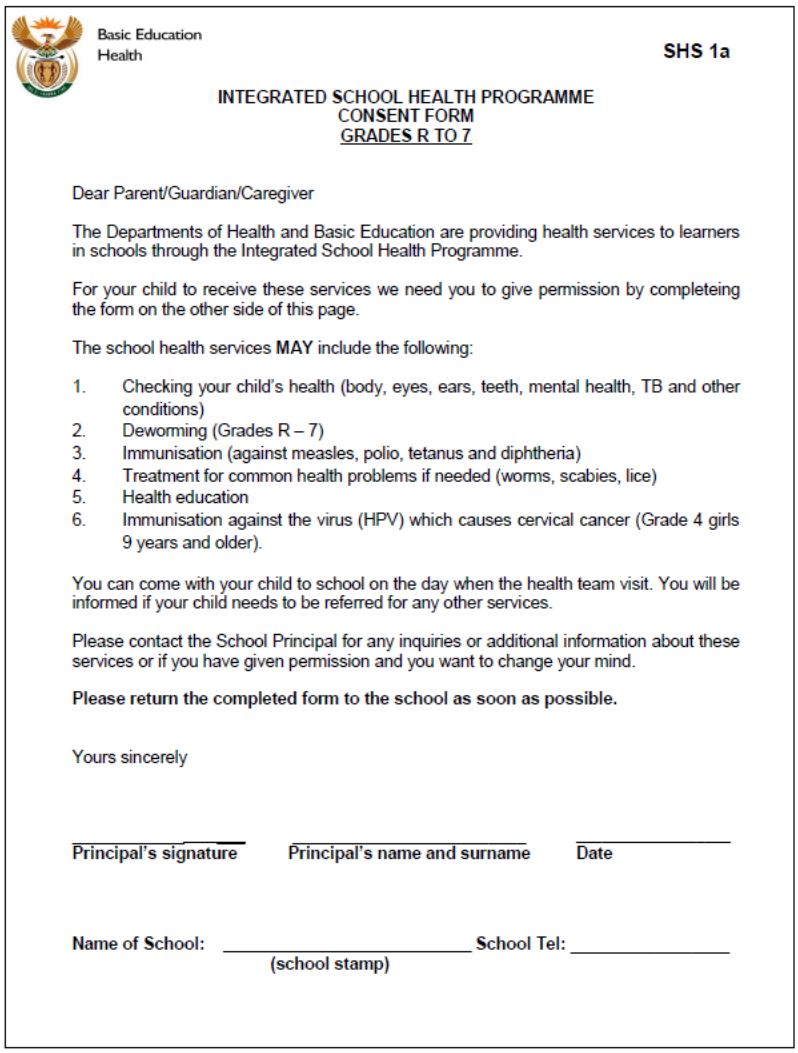
The challenge of the consent form was also noted by Mojapelo (2019) in a study conducted in Ekurhuleni, Gauteng. The results from this study show that learners without an informed consent form from their parents did not receive healthcare services from the ISHP (Mojapelo 2019). The law and the Integrated School Health Policy only allow school nurses to treat learners with the informed consent form from parents (Mojapelo (2019). School nurses reported that they could not take the chance and offer a health intervention to a learner without a signed consent form from parents (Mojapelo (2019).

Figure 1: Consent Form



Basic Education
Health

SHS 1a

INTEGRATED SCHOOL HEALTH PROGRAMME
CONSENT FORM
GRADES R TO 7

Dear Parent/Guardian/Caregiver

The Departments of Health and Basic Education are providing health services to learners in schools through the Integrated School Health Programme.

For your child to receive these services we need you to give permission by completeing the form on the other side of this page.

The school health services **MAY** include the following:

1. Checking your child's health (body, eyes, ears, teeth, mental health, TB and other conditions)
2. Deworming (Grades R – 7)
3. Immunisation (against measles, polio, tetanus and diphtheria)
4. Treatment for common health problems if needed (worms, scabies, lice)
5. Health education
6. Immunisation against the virus (HPV) which causes cervical cancer (Grade 4 girls 9 years and older).

You can come with your child to school on the day when the health team visit. You will be informed if your child needs to be referred for any other services.

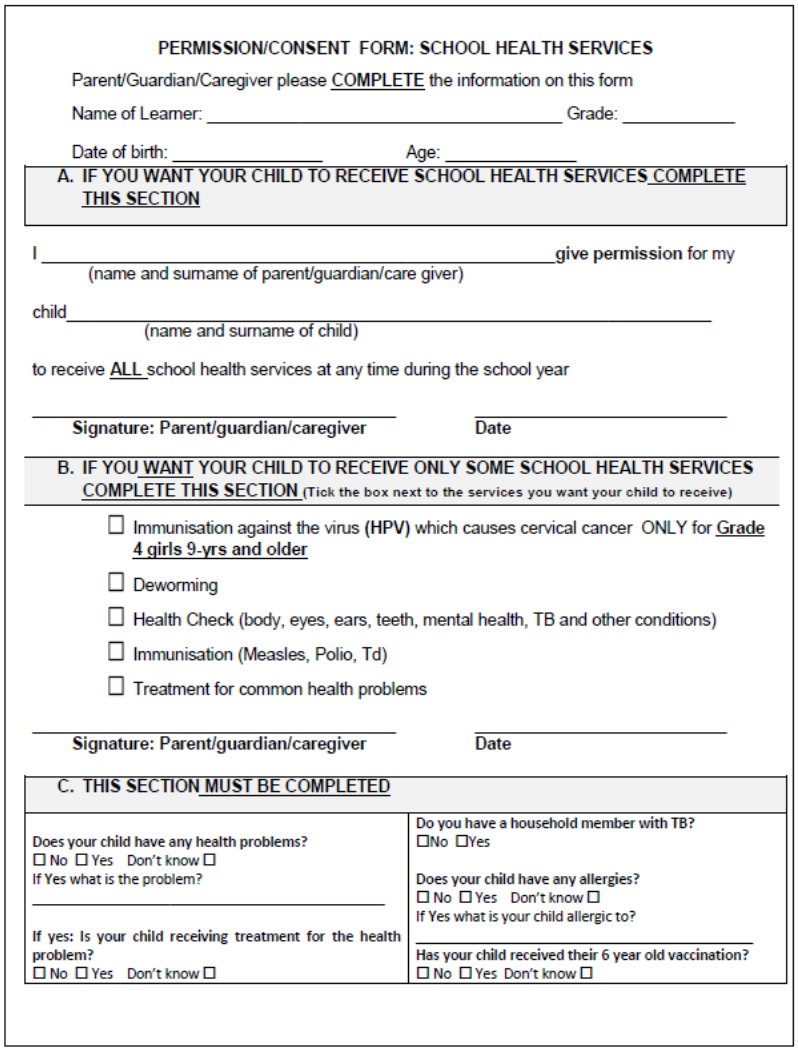
Please contact the School Principal for any inquiries or additional information about these services or if you have given permission and you want to change your mind.

Please return the completed form to the school as soon as possible.

Yours sincerely

Principal's signature **Principal's name and surname** **Date**

Name of School: _____ **School Tel:** _____
(school stamp)



PERMISSION/CONSENT FORM: SCHOOL HEALTH SERVICES

Parent/Guardian/Caregiver please COMPLETE the information on this form

Name of Learner: _____ Grade: _____

Date of birth: _____ Age: _____

A. IF YOU WANT YOUR CHILD TO RECEIVE SCHOOL HEALTH SERVICES COMPLETE THIS SECTION

I _____ **give permission** for my
(name and surname of parent/guardian/care giver)

child _____
(name and surname of child)

to receive ALL school health services at any time during the school year

_____ _____
Signature: Parent/guardian/caregiver **Date**

B. IF YOU WANT YOUR CHILD TO RECEIVE ONLY SOME SCHOOL HEALTH SERVICES COMPLETE THIS SECTION (Tick the box next to the services you want your child to receive)

- ☐ Immunisation against the virus **(HPV)** which causes cervical cancer ONLY for Grade 4 girls 9-yrs and older
- ☐ Deworming
- ☐ Health Check (body, eyes, ears, teeth, mental health, TB and other conditions)
- ☐ Immunisation (Measles, Polio, Td)
- ☐ Treatment for common health problems

_____ _____
Signature: Parent/guardian/caregiver **Date**

C. THIS SECTION MUST BE COMPLETED

Does your child have any health problems? ☐ No ☐ Yes Don't know ☐ If Yes what is the problem? _____ If yes: Is your child receiving treatment for the health problem? ☐ No ☐ Yes Don't know ☐	Do you have a household member with TB? ☐No ☐Yes Does your child have any allergies? ☐ No ☐ Yes Don't know ☐ If Yes what is your child allergic to? _____ Has your child received their 6 year old vaccination? ☐ No ☐ Yes Don't know ☐

The Challenges of the Integrated School Health Program

The challenges of the ISHP during the NHI pilot program in the Tshwane district were the shortage of human resources, the inability of teachers to assist, the participation of SGB and parents, informed consent forms from parents and buy-in from the principal. Government officials reported that they only have a team of 5 people responsible for deworming learners in all public schools in the Tshwane District. Teachers could not assist government officials in deworming the learners because they are inhibited by the Department of Education teachers union from administering deworming tablets to learners. The Department of Basic Education and SADTU claim that teachers are not medically trained to administer medication to learners. The ISHP in the Tshwane District only had 2 school nurses, and they were constantly complaining about being burnt out and overworked. In schools where the SGB was involved, parents were not active in implementing the ISHP. Parents were not signing informed consent forms so that learners could receive healthcare services. Principals in some schools complained

that the ISHP was interrupting the teaching and learning program. The high rate of HIV infections, teenage pregnancy and drug abuse among learners were reported as critical challenges that the ISHP needs to address in the Tshwane District.

> *"The challenge is the distribution of deworming tablets. If we had the human resources, it would help. At this point, I have 78 schools where I need to administer deworming tablets. Covering 78 schools alone is impossible. Some schools have more than 1800 learners, which is too much of a burden for one person". –Government official, Tshwane District Department of Education*
>
> *"The unions say teachers are not qualified to administer medication to learners. The unions are protecting teachers. If the teacher administers medication to a learner and something happens, the teacher will be liable". –Government official, Gauteng Department of Education*
>
> *"The Bluetooth is the way these young ones are taking drugs. They are no longer snorting. One person will take the drug, and they will get high. They will draw the blood from the high one and inject it into another learner. The method is called Bluetooth, and it makes them high quickly. Can you see how amused you are? We were also surprised. And there is HIV infections and teenage pregnancy challenge in high schools. We are not winning the war on teenage pregnancy". -School nurse*

According to Shung-King et al (2016), the ISHP is performing poorly nationwide because there are no sufficient resources delegated to the program. The South African government has not prioritised the ISHP, and this has led to its poor performance (Shung-King et al 2016). The ISHP has been highly criticised for not employing enough school nurses to attend to the healthcare needs of learners (Dibakwane et al 2018). In the Tshwane District, school nurses designated for the ISHP are moved to public clinics, thus neglecting school healthcare services (Dibakwane et al 2018). In the Tshwane District, dental hygienists complained that public schools were not a conducive environment to offer dental services (Molete et al 2020). Dental hygienists complained that there was no physical space in schools to assess the dental health of learners

(Molete et al (2020). The high rate of HIV infections and teenage pregnancy in high schools has been associated with a lack of consensus on the content of sexual and reproductive health programs in public schools (Shaikh et al 2021). According to Shaikh et al (2021), the Department of Basic Education only published a sexual and reproductive health policy in 2018, after a long battle with religious communities and parents.

Discussion

The history of school health services can be traced to the 1920s in South Africa (Shung-King 2013). To respond to the challenges of the poor whites, the government of the time introduced the School Health Service Policy (Shung-King 2013). The School Health Service Policy was designed to address the needs of poor white kids in schools (Shung-King 2013). However, the School Health Service Policy was not implemented in townships and homelands where the Black majority lived (Shung-King 2013). In the 1960s, the School Health Service Policy was extended to Indian and Coloured schools, thus neglecting Black schools (Shung-King 2013). It was in 2003 when the ANC-led government introduced the National School Health Policy as a national project to deliver healthcare services in public schools (National Department of Health and Department of Basic Education 2012). However, this National School Health Policy only focused on school feeding schemes and neglected essential healthcare services for learners (National Department of Health and Department of Basic Education 2012). In 2010, Former President Jacob Zuma introduced the Integrated School Health Policy, which aimed to promote health, conduct essential health screenings, administer immunisation, prevent infections, and refer learners to higher levels of care (National Department of Health and Department of Basic Education 2012). This policy was then transformed into the ISHP, which was integrated into the PHC reengineering national program, which became the core of the NHI pilot program in South Africa. The objective of this chapter was to evaluate the implementation of the ISHP during the NHI pilot program in the Tshwane District.

The results from this chapter show that the ISHP improved the delivery of PHC services in public schools in the Tshwane District. Learners in primary schools received deworming tablets and Vitamin A supplements, which improved their concentration in class. School nurses conducted eyesight, hearing and dental assessments and referred learners to specialists. The Tshwane District Department of Education worked with optometrists from the private sector and NGOs to provide free eyeglasses to learners. The HPV vaccine was administered to schoolgirls in Grade 4 to prevent future cases of cervical cancer. Sexual and reproductive health

education was incorporated into the Life Orientation curriculum and delivered in classrooms. School nurses in the Tshwane District assisted learners who were pregnant and those who were mothers with antenatal and postnatal care. The challenge of the ISHP program in the Tshwane District was the shortage of human resources to administer deworming tablets. The Department of Basic Education and the teacher's union banned teachers from assisting government officials with administering deworming tablets. School nurses were overwhelmed and burnt out as they were expected to attend all the public schools in the Tshwane District. Parents did not sign the informed consent so that learners could receive healthcare services. School nurses reported that without the informed consent form from parents, they could not offer healthcare services to learners.

Conclusion

The objective of this chapter was to evaluate the implementation of the ISHP during the NHI pilot program in the Tshwane District. The results show that the ISHP improved the delivery of PHC services in public schools in the Tshwane District. School nurses conducted health screenings such as eyesight, hearing and dental assessments. Learners with complications were referred to medical doctors and specialists in hospitals. The ISHP administered deworming tablets and Vitamin A to learners to improve their concentration in the classroom. HPV vaccines were administered to girls in Grade 4 to prevent future occurrences of cervical cancer. The ISHP in the Tshwane District had a shortage of human resources, which inhibited the program from delivering quality healthcare services to learners. School nurses and government officials complained that the burden of the ISHP was too much, and teachers were not allowed to assist. The Department of Basic Education and the teacher's union SADTU banned teachers from administering medication to learners. Parents did not sign the informed consent form, and this inhibited learners that allows them from receiving healthcare services. The Tshwane District Department of Education held school meetings to explain to parents the importance of signing the informed consent form. HIV infections, teenage pregnancy, and drug abuse in high schools were reported as challenges that the ISHP needs to address in the Tshwane District. When the NHI is implemented, the ISHP needs to be equipped with enough human resources to deliver healthcare services to learners effectively. For the ISHP to reach its desired goal, there must be 1 school nurse per public school responsible for the health needs of learners.

Chapter 10: "We provide healthcare services to people in the comfort of their homes": reflecting on the Ward-Based Outreach Program during the National Health Insurance Pilot Program in the Tshwane District

Background

There is a long history of the Ward-based Outreach Team Program (WBOT) in South Africa. In 1920, G.A Park Ross, a senior health officer in Natal and Zululand, established a community healthcare work program (van Ginneken et al 2010). This community healthcare work program was designed to respond to the challenges of Malaria in the area (van Ginneken et al 2010). The program was run by Community Health Care Workers (CHWs) who were sent to communities to track cases of Malaria (van Ginneken et al 2010). These CHWs were referred to as the Malaria Assistants (van Ginneken et al 2010). According to Philips (2014), Community healthcare work programs in South Africa emerged as the vehicle of the oppressive Apartheid State to offer cheap healthcare services to Black people in Bantustans (Phillips 2014). In 1939, to respond to the burden of infectious disease amongst Black people, the Secretary of Public Health, Eustace H. Cluver, gave a directive that cheap clinics should be built in Bantustans (Phillips 2014). These cheap clinics would be the State's response to the decaying health conditions of Black people in rural areas without incurring any costs (Phillips 2014).

In the early 1940s, Sidney and Emily Clark experimented with a healthcare centre that focused on Community Orientated Primary Care (COPC) in Pholela, a rural area in KwaZulu-Natal (Kautzky & Tollman 2008). Kark's COPC model studied the social and epidemiological profiles of individuals and families to improve health indicators (Kautzky & Tollman 2008; Howe et al 2013). In Kark's COPC model, CHWs were the backbone of delivering healthcare services in communities (Kautzky & Tollman 2008; Kinkel et al 2013). CHWs were part of the community and understood people's beliefs and experiences with health and illness (Kautzky & Tollman 2008; Kinkel et al 2013). These CHWs were mainly Black women who were part of the community, unemployed, and worked as volunteers (Phillips 2014). In Kark's COPC model, CHWs were trained in health promotion, taking health records, and identifying symptoms to prevent the spread of diseases (Kautzky & Tollman 2008; Kinkel et al 2013). The plight of healthcare services in the Bantustans also caught the attention of churches and non-governmental organisations (NGOs) (Phillips 2014). Beyond building clinics and hospitals, missionary organisations implemented community healthcare work programs to deliver healthcare services

in rural areas and townships where Black people lived (Phillips 2014). These community healthcare work programs included but were not limited to the South African Christian Leadership Assembly Health Project, Health Care Trust, Brown's Farm Project, Chalumna and Newlands Village Health Worker Project, Mamre Community Health Project, The Elim Care Group Project (van Ginneken et al 2010). Today, only a few of these community healthcare programs are functioning, as most have shut down due to a lack of funding (van Ginneken et al 2010).

In the 1980s, with the political movement to liberate South Africa from apartheid, there was support for Universal Health Coverage (UHC) (Kinkel et al 2013). Centring PHC services was seen as essential in achieving UHC (Kinkel et al 2013). Community health care work programs were endorsed as an integral part of delivering PHC services into people's homes (Kinkel et al 2013). However, when the African National Congress (ANC) came to power in 1994, it adopted the District Health System in which PHC services could only be accessed in designated public health facilities (Kinkel et al 2013). The HIV and AIDS pandemic challenged the District Health System model, which was curative, expensive and relied on people going to public health facilities to receive healthcare services (Hunter 2012). Clinics and hospitals were not coping with the high numbers of bedridden sick patients with AIDS (Hunter 2012). At the time, antiretroviral treatment was not universally accessible to people in South Africa (Hunter 2012). The home-based care policy was introduced, and AIDS care was moved out of public health facilities into homes (Hunter 2012). Patients who were sick with AIDS were sent home to be treated by predominantly women family members (Hunter 2012). The home-based care work also attracted existing and new NGOs to take on AIDS care by employing CHWs (Uys 2002). The South African government contracted NGOs and NPOs to provide home-based care to bedridden patients with AIDs (Uys 2002).

The WBOT program, a community healthcare work program that aims to deliver PHC services in communities, is at the centre of the proposed National Health Insurance (NHI) policy, which aims to move South Africa towards UHC. The WBOT program was implemented simultaneously with GP Contracting, DCST, CCMDD and ISHP as part of the NHI pilot program in eleven districts across South Africa (National Department of Health 2018). The objective of the WBOT program is to deliver "comprehensive community-based PHC services that will contribute to the improvement of health and well-being of individuals, households and

communities being served" (National Department of Health 2018: 9). The WBOT program during the NHI pilot program in South Africa was run CHWs. CHWs delivered reproductive and child healthcare services into people's homes (Marcus et al 2017). CHWs recorded people's health conditions, delivered medication, and washed and fed bedridden sick patients (Marcus et al 2017). According to Marcus et al (2017), CHWs employed in the WBOT program across NHI pilot districts were the lowest paid, taking home R2500 and contracted on a monthly basis with no work benefits (Marcus et al 2017). CHWs lived and worked in communities riddled with poverty, unemployment and deteriorating infrastructure. CHWs did not have physical office space, no uniforms and walked long distances to deliver healthcare services to people in communities (van de Ruit 2019). The objective of this chapter is to evaluate the implementation of the WBOT program during the NHI pilot program in the Tshwane District.

Findings

The objective of the Ward-based Outreach Team Program

The objective of the WBOT program during the NHI pilot in the Tshwane District was to bring healthcare services to people in the comfort of their homes. In the past, people could only access healthcare services when they went to public health facilities. The WBOT program reached people who could not attend the clinic, such as pregnant women, elders and bedridden patients. The WBOT team was tasked with the responsibility of understanding social conditions that contribute to ill health in communities. In the Tshwane District, the WBOT team worked collaboratively with stakeholders from the National Department of Health, Department of Basic Education and Department of Social Development. The backbone of the WBOT program was CHWs who went into communities to provide healthcare services to the people in the comfort of their homes. CHWs were supported by a professional nurse, WBOT team leaders, subdistrict managers, and the WBOT district manager.

> *In the past, people could only access healthcare services when they visited a public clinic. We used to address patients' health problems in clinics. We never had the opportunity to see where the patient stays so that we can help them better. With the WBOT program, we can assess the home environment and determine the contributory factor to the patient's ill health. –Professional Nurse, Subdistrict Manager*

"We provide healthcare services to people in the comfort of their homes". - Professional Nurse, WBOT Team Leader

"With the help of our CHWs, we reach patients who do not have the strength to come to the clinic. Sometimes, the patient is so sick that they have no means to come to the clinic. With the WBOT program, we get to see the social challenges that our people are living under". –Professional Nurse, WBOT District Manager

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The context of the Ward-based Outreach Team Program

The WBOT program during the NHI pilot in the Tshwane District reached people who lived in squatter camps with no electricity and running water. In these squatter camps, environmental health services such as sanitation, clean water and garbage collection were not provided by the City of Tshwane. The WBOT program collaborated with the Department of Social Development to ensure that children of foreign nationals are registered at Home Affairs so that they can receive the Child Support Grant. CHWs reported that some foreign nationals are scared to go to Home Affairs and register their newborn babies because they fear deportation. When a child is not registered at Home Affairs, they cannot receive the Child Support Grant and attend school. The burden of disease in the Tshwane District was TB, HIV and AIDS, hypertension and diabetes. Poverty and unemployment were challenges that contributed to people's chronic stress and poor health. CHWs reported that when they visit households, people tell them that health is not their primary concern; they need jobs so that they can put food on the table.

"In this community, people are not working. People have no place to stay. Some foreigners do not have a passport. It is hard for the kids of foreign nationals to go to school because they do not have the necessary documents. Some people who live here do not have food. There is an NGO that gives people bread, but bread alone is not enough". – Community Health Worker

"In one squatter camp, there is still a bucket system and sewerage flow in the streets". -Professional Nurse, WBOT Team Leader

"People are suffering here. People have no homes. They live in squatter camps that are built on cardboard. People do not care about their health anymore. Many people have given up. They do not want to get help, especially when they are sick. People tell us that they need jobs to put bread on the table and not the clinic. –Community Healthcare Worker

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Three studies conducted by Kinkel et al (2013), Masango et al (2019) and Ndimande et al (2019) in the Tshwane District on the work of the WBOT program also found that poverty and unemployment in townships contributed to people's ill health. The burden of diseases in the Tshwane District, such as HIV and AIDS, TB, hypertension, and diabetes, reflects the nation's burden of disease (Kinkel 2013). The work of CHWs reached people in squatter camps who could not afford to travel and seek help in the clinic.

Partners of the Ward-based Outreach Team Program

During the NHI pilot program in the Tshwane District, the WBOT program partnered with NDOH, public clinics, the University of Pretoria, the Foundation for Professional Development, and local NGOs. All the WBOT teams in the Tshwane District were attached to a public clinic. The teams worked with nurses, social workers, and doctors in public clinics to deliver healthcare services to people. The NDOH provided guidelines on how the WBOT program should be implemented in communities. The Tshwane District Department of Health was responsible for overseeing the implementation of the WBOT program. The Department of Family Medicine at the University of Pretoria monitored and evaluated the successes and challenges of the WBOT program. The University of Pretoria also provided training to CHWS on how to deliver healthcare services appropriately and ethically to people in their homes. The Foundation for Professional Development provided training and technical assistance to professional nurses managing the WBOT program. Local NGOs around the Tshwane District worked with CHWs to provide food to households that were in need.

"The WBOT teams work with clinics. We do not have a WBOT team working in isolation. If a clinic has a challenge tracing a sick patient, they go to the WBOT team for assistance". – Professional Nurse, Team leader

"We work with doctors, nurses, NGOs, social workers and occupational therapists". –Community Healthcare Worker

"The role of the National Department of Health is to provide us with guidelines and policy documents to implement the WBOT program successfully. We also work with the Foundation for Professional Development and the University of Pretoria". –Professional Nurse, WBOT District Manager

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Buy-in for the Ward-based Outreach Team Program

The WBOT program during the NHI pilot in the Tshwane District required the community's buy-in. Political leaders, community stakeholders and ward councillors were contacted before implementing the WBOT program. The WBOT team representatives attended community meetings to explain the objectives of the WBOT program. The implementation of the WBOT program was approved in the City of Tshwane Council Meeting. The WBOT team consulted with facility managers to get approval to work with public clinics. The CHWs visited households and introduced the program to people in communities. The uniforms that CHWs wore when visiting households helped them to be accepted and trusted by people in the Tshwane District.

"The political leaders' buy-in is essential for the WBOT program. We introduced ourselves to the ward councillor and the ward committee. We briefed them about the WBOT program. When there is a community meeting, we must attend so that people know us when we visit their homes". – Community Health Worker

"Without the buy-in from Ward Councillors, you cannot implement the WBOT program in the Tshwane District" –Government official, National Department of Health

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The Ward-based Outreach Team Program and Primary Health Care

The WBOT program strengthened the delivery of PHC services during the NHI pilot program in the Tshwane District. The WBOT program, through the work of CHWs, conducted home

visits and registered people into the program. CHWs documented people's health conditions, and this information improved the Tshwane District health system date. Home visits and data collection informed health authorities about the health conditions of the people's communities. The WBOT program improved infant and maternal health indicators in the Tshwane District. CHWs provided pregnancy tests to women upon request. Once the results were positive, CHWs referred pregnant women to the nearest clinic for antenatal care. Antenatal care visits assisted healthcare professionals in detecting and treating pregnancy-related complications. CHWs encouraged pregnant women to attend clinics so that they could be screened for HIV to prevent Mother-to-Child Transmission. During home visits, CHWs provided health education and training to new mothers on how to breastfeed and take care of babies. CWHs administered Vitamin A to children under the age of 5 years in households. Professional nurses accompanied CHWs during home visits and administered necessary immunisation to children. Working collaboratively with the Department of Social Development and Home Affairs, CHWs referred parents of children who need to be registered to Home Affairs.

The WBOT team, during the NHI pilot program in the Tshwane District, screened people for TB, HIV, diabetes and hypertension in the comfort of their homes. Once it was detected that a person was suffering from any of these health conditions, they were referred to the nearest public clinic to receive treatment. CHWs assisted people who were defaulting on HIV and TB treatment to take their medication regularly. Part of helping patients to adhere to treatment, CHWs delivered medication to elders and sick bedridden patients in their homes. CHWs implemented health promotion programs, taught people about Sexually Transmitted Infections (STIs) and HIV and distributed condoms to the people in communities. CHWs identified people who were sick in households and referred them to public clinics and hospitals. When CHWs refer patients to higher levels of care, the WBOT team requires a back referral form. This back referral form must be signed by a healthcare professional who attends to the patient. CHWs used the back referral form to track if the patient attended the clinic and received the necessary medical care. The challenge was that nurses and doctors did not sign the back referral form. CHWs educated communities about appropriate levels of access to care. They informed community members that their first point of entry into the healthcare system was the clinic. The hospital should be utilised in serious medical emergencies and health complications.

"It is like Home-Based Care; we register people in households, and we refer them to the clinic when they are sick. People default on their treatment, and we encourage them to visit the clinic. Some foreigners in the community do not have papers, so we refer them to Home Affairs so that they can get their documents. The people we refer to Home Affairs are those without the birth certificate and passports". -Community Health Worker

"We do health talks with people about TB, HIV, and STIs. We also distribute condoms. We screen people for HIV and TB". -Community Healthcare Worker

"We help people who are suffering at home. People are suffering here. There is a lot of suffering. We refer people who are sick to the clinic, and sometimes we call the ambulance for them". –Community Healthcare Worker

"We check if there is a pregnant woman within the household and encourage them to go to the clinic. Culturally, we do not want to talk about or show our pregnancy up until a certain period. We try and encourage pregnant women to go to the clinic. We encourage pregnant women to go to the clinic and test for HIV so that we can prevent mother-to-child HIV transmission". CHWs teach new mothers how to breastfeed and take care of their newborn babies. -Professional Nurse, WBOT Team Leader

"We work with environmental officers. In one squatter camp, there is still a bucket system and sewerage flow in the streets. The WBOT program is for poor people who cannot afford healthcare services". –Community Healthcare Worker

"Families rely on the WBOT program for the delivery of medication. We deliver medications to the elderly in their homes". -Community Healthcare Worker

"We need to prove that the patient received medical care. However, the nurses and doctors at the clinic do not sign the back referral letter and give it back to the patient. –Community Healthcare Worker

Studies conducted by Ndimande et al (2019), Jobson et al (2020) & Marcus et al (2017) also found that the WBOT program improved the delivery of PHC services such as infant and maternal care, health education, delivery of medication and immunisations. A study conducted at the Emfuleni Sub-district, Gauteng Province, found that diabetes and hypertension were much controlled among patients whose medication was delivered at home by CHWs, compared to patients who had to go to public clinics to collect them (Ndou et al 2013). Patients who had to go to the public clinic to collect medication defaulted in taking their diabetes and hypertension medication (Ndou et al 2013). Patients forgot their clinic appointment dates and were discouraged by the long waiting time to receive medication in public clinics (Ndou et al 2013). When CHWs delivered the medication at home, it freed the patients from the burden of waiting in long lines and improved treatment adherence (Ndou et al 2013). A study conducted by Masango et al (2019) in the Tshwane District found that community members were satisfied with PHC services offered by CHWs. Community members reported that their family members who were gravely sick with AIDS and TB recovered because CHWs administered treatment, fed, washed and monitored their recovery during household visits (Masango et al 2019).

The impact of the WBOT program in improving the provision of PHC services in communities across South Africa has not gone unnoticed. According to Doherty et al (2016), the WBOT program has played a critical role in preventing Mother-to-Child HIV transmission. The results from this study show that CHWs identified women who were pregnant and referred them to the clinic to get tested for HIV to prevent Mother-to-Child transmission (Doherty et al 2016). Doherty et al (2016) recommend that CHWs must be trained to assess and treat childhood illnesses such as pneumonia and diarrhoea to prevent child death in households. This is in a context where pneumonia and diarrhoea still contribute significantly to the cause of preventable child deaths in South Africa (Doherty et al 2016). According to Wadler et al (2011), CHWs in South Africa, can prevent and detect early development of breast cancer among women in communities. According to Loeliger (2016), in rural areas in KwaZulu-Natal, where health

facilities are far away from where people live, CHWs used wheelbarrows to transport sick patients and prayed that they get to the hospital on time before the person died.

The work of the WBOT program in improving the delivery of PHC services in communities was also recorded during the COVID-19 pandemic. When COVID-19 hit South Africa in March 2020, it was estimated that 28,000 CHWs were deployed nationwide (Abdool Karim 2020). The role of CHWs was to implement community-based screening and testing to curb the spread of COVID-19 (David & Mash 2020). CHWs screened door-to-door for possible COVID-19 symptoms (David & Mash 2020). Once a family or an individual was suspected of having or reported signs of COVID-19, CHWs referred them to clinics and testing stations (David & Mash 2020). When the person tested positive for COVID-19, CHWs went back to the household to evaluate living conditions and the possibility of isolation (David & Mash 2020). In Cape Town, it is reported that when the household setting was not conducive for isolation, CHWs referred the person to health facilities designated for isolation (Van Dyk 2021). Community members reached out to CHWs when a person suffered from severe COVID-19 complications (Van Dyk 2021). CHWs would call an ambulance and refer the person to the hospital (Van Dyk 2021). Even post-hospitalisation, CHWs kept track of people's recovery (Van Dyk 2021).

CHWs were tasked with mapping out hotspot areas and communities with the highest number of new COVID-19 infections (D'Ambruoso et al 2021). CHWs updated communities about COVID-19 and encouraged people to practise hand washing, sanitising and social distancing (D'Ambruoso et al 2021). In South Africa, the public healthcare system serves the majority of the population, and clinics and hospitals became sites of COVID-19 infection and death (Brey et al 2020). People who live with chronic conditions such as HIV, hypertension and diabetes were hesitant to go to the clinic for regular check-ups and collect medication (Brey et al 2020). This population group already has an immune system that is compromised, and contracting the COVID-19 virus could be deadly (Brey et al 2020). CHWs delivered chronic medication to people's homes, preventing overcrowding in clinics and protecting people with chronic conditions from contracting the virus (Brey et al 2020).

Contracting of Community Healthcare Workers

The recruitment and contracting of CHWs in the WBOT program during the NHI pilot program in the Tshwane district involved multiple parties, which was a source of frustration for CHWs. CHWs reported that they were recruited into the program by word of mouth, NDOH and local NGOs. The recruitment process was confusing because it was unclear who the employer was. Some CHWs reported that they were already working for local NGOs, which the NDOH contracted to implement the WBOT program. In some communities in the Tshwane District, CHWs expressed that they thought the NDOH directly contracted them, as the contract they signed had a letterhead of the NDOH. Once they started working, they discovered they were contracted by multiple organisations such as local NGOs, Health Systems Trust and Foundation for Professional Development. This led to confusion and frustration as they were unsure who was responsible for addressing their needs and complaints. CHWs also expressed that they were frustrated with the Smart Purse company responsible for paying them. The NDOH contracted Smart Purse to pay CHWs. Smart Purse required new CHWs to be under the age of 35 years and have matric, and CHWs were not happy about these new requirements.

CHWs were frustrated with the duration of the contract and the stipend they received during the NHI pilot program in the Tshwane District. CHWs reported that their work contract is for one year, and they are not employed permanently. The stipend that they receive a month is R2500, which is too low for the cost of living in South Africa. CHWs did not have work benefits such as medical aid, pension funds, and maternity benefits. CHWs were only given 2 months of maternity leave, and if they wanted to take 4 months of maternity leave, it was unpaid. They had to leave the baby behind and return to work early. Due to uncertainty, confusion, and frustration about the nature of their work contracts, CHWs reported that they would go on stay-away strikes and protest in front of the NDOH offices in Pretoria.

> *"In the Tshwane District, the contracting of CHWs is complex. The National Department of Health contracts organisations like Health Systems Trust, Foundation for Professional Development, and local NGOs to employ CHWs. It is like a labourer broker system. Now, as the NDOH, we do not have control over how these organisations treat CHWs. We can see that the relationship is not good because CHWs are always protesting in front of the NDOH offices". -Government Official, National Department of Health*

"The old CWHS were taken from NGOs and home-based care organisations. In the past, you only needed grade 9 to qualify to be a CHW. Now, they want CHWS to have matric with math, science, and biology. The age limit is demoralising. Smart Purse wants CHWS who are under the age of 35 years, and this was the cause of the strike". – Professional Nurse, Subdistrict Manager

"The challenge is the stipend we are getting. We are getting R2500. We are not permanently employed. They are renewing our contracts every year. We are not too happy with the stipends. So, we go on strike every week so that they can hear our demands". –Community Healthcare Worker

"Also, for maternity leave, they only pay you two months. If you go on maternity leave for four months, you will not get paid". -Community Health Worker

"We want the government to employ us permanently, we do not want Smart Purse, and we do not want contracts". -Community Health Worker

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The challenge of CHWs with precarious month-to-month contracts was also documented during the COVID-19 outbreak in South Africa. CHWs complained that they were contracted on a monthly basis with a stipend of R3500 (Thomas et al 2021). At times, this low stipend was not paid on time, and this led to some of the CHWs resigning from work and losing work morale (Thomas et al 2021). According to Brey et al (2020), there are close to 3,000 NGOs, NPOs and faith-based organisations that contract CHWs. Some of these organisations are outsourced by the National Department of Health and Provincial Department of Health to run community healthcare programs (Brey et al 2020). In Gauteng Province, CHWs have been staging protests and often giving up on the program because they feel that their demands for permanent employment, with a minimum living wage and benefits, fall on deaf ears (Van Dyk 2021). The Gauteng Department of Health has initiated a policy of employing CHWs under level 2 of public service (Van Dyk 2021). The Gauteng Department of Health has promised to absorb 8500 CHWs and employ them permanently (Van Dyk 2021). This plan was said to be implemented in September 2020, but it has not materialised (Van Dyk 2021).

According to Van Dyk (2021), in Western Cape Province, the Department of Health has not given a clear direction on the permanent employment of CHWs. In Cape Town, when CHWs went to the NGOs to complain about low stipends, precarious contracts and poor working conditions, which exposed them to COVID-19, NGOs sent them to the Western Cape Department of Health (David & Mash 2020). When CHWs went to the Western Cape Department of Health to lay grievances, they were sent back to NGOs (David & Mash 2020). The irony of CHWs in South Africa is that they brought healthcare services to the people in the comfort of their homes during the COVID-19 pandemic. However, they did not have an institutional home of their own. The current framework for the WBOT program in South Africa still adopts a multiple-party approach in contracting CHWs (National Health Department of Health 2018). This document states that when the NHI policy is implemented, CBOs, NGOs, and NPOs running community healthcare projects will be contracted by the State to provide PHC services in communities (National Health Department of Health 2018).

These community healthcare service providers will be attached to a multidisciplinary team of health professionals responsible for delivering healthcare services to the community (National Health Department of Health 2018).

The Challenges of the Ward-based Outreach Team Program

The challenges of CHWs during the NHI pilot program in the Tshwane District were a lack of office space, uniforms, and health equipment and rejection by health facilities and community members. CHWs did not have offices, worked from outside and were subjected to extreme weather conditions. CHWs rented rooms in schools, churches, and NGOs, and they took out rent money from their low stipends. The lack of office space made it difficult for CHWs to complete administrative work and capture the health data from household visits. CHWs reported that they did not have enough electronic gadgets to collect household data. The WBOT team leaders did not have laptops to capture the household health required by the NDOH. CHWs complained that they did not have health equipment, such as BP machines, to monitor hypertension at home. On a few occasions, people did not allow CHWs to come into their homes. These community members told CHWs they have medical aid and do not need their assistance. People chased CHWs away because they said they associated the WBOT program with people with AIDS. There was no mutual relationship between CHWs and some public clinics in the Tshwane District. In some squatter camps, there were no clinics, and this made it harder for CHWs to refer people who needed healthcare services.

"We do not have a space to work under. We sit outside, sometimes in this cold and rainy weather. It is frustrating". -Community Health Worker

"I did not mention this, but one of the challenges is that we are collecting data manually. If you do not have space to sit in, what will happen to the very papers you are using to collect data? They are stuck somewhere, and we cannot even track and analyse these papers. As a district, we were privileged to have a partner that gave us electronic gadgets. However, due to financial constraints, we could not continue maintaining them. Now we are back to collecting data using paper". –Government official, Tshwane District Department of Health

"They do not have an area to come together like a room like this. Clinics are not seeing CHWs as part of them. They see them as separate entities. But when they need to trace sick patients, they use CHWs" -Professional Nurse, WBOT Team Leader

"The clinic is far. We want to have a clinic here in the community. Even if it is a mobile clinic, it is okay". -Community Healthcare Worker

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The challenges of CHWs in the WBOT program were also documented during the COVID-19 outbreak in South Africa. According to Thomas et al (2021), it is estimated that +-50 CHWs in South Africa contracted COVID-19 in the line of duty and shortly succumbed to its severe complications. Tasked with screening and testing COVID-19 in communities, CHWs did not have adequate Personal Protective Equipment (PPE) such as masks and sanitisers (Thomas et al 2021). In Ekurhuleni, Gauteng Province, CHWs reported that they conducted door-to-door without PPEs and risked their lives and that of their families (Thomas et al 2021). According to Van Dyk (2020), CHWs reported that people knocked at their doors at odd hours of the night because a family member was suffering from severe COVID-19 complications. This meant attending the call in the middle of the night with no PPEs to ensure the person was referred to a hospital (David & Mash 2020). CHWs were in contact with individuals who were sick with

COVID-19 and ended up contracting the virus (David & Mash 2020). CHWs also used their own money at times to buy PPEs so that they could protect themselves in the line of duty (Van Dyk 2020). Due to a lack of transportation, CHWs had to walk long distances to do door-to-door screenings in households (Thomas et al 2021). The National Laboratory Services had a backlog in releasing COVID-19 test results (Thomas et al 2021).CHWs had to deal with community members who were waiting anxiously and panicking about their test results (Thomas et al 2021).

Discussion

The WBOT program was implemented as part of the PHC reengineering national strategy in eleven districts during the NHI pilot program. To respond to the challenge of unequal distribution of human resources in the healthcare system, the WBOT program delivered healthcare services to people in the comfort of their homes (van de Ruit 2019). The WBOT program helped to decrease the patient load in public health facilities and eased the pressure on nurses and doctors who were already understaffed (van de Ruit 2019). The objective of this chapter was to evaluate the implementation of the WBOT program during the NHI pilot program in the Tshwane District. The results show that the WBOT program improved the delivery of PHC services in communities. CHWs conducted home visits and registered people in the program. CHWs recorded the health conditions of people in households and referred them to health facilities and social services. Registering people in the program and recording their health conditions improved the Tshwane District health system data. Free pregnancy tests were offered to women upon request. After confirming that the woman was pregnant, CHWs referred her to the clinic for antenatal care. Early referral helped to detect pregnancy complications and prevented Mother-to-Child HIV transmission. CHWs educated new mothers about breastfeeding and taking care of the baby after delivery. They tracked children's immunisation progress and brought the nurse to immunise the child at home. CHWs also administered Vitamin A to children under the age of 5 years at home.

CHWs conducted health promotion programs to educate and screen people for TB, HIV and hypertension in the comfort of their homes. Once they detected that the patient suffered from a specific condition, they referred her to the nearest clinic for medical care. CHWs worked with Social Development to register undocumented children of foreign nationals so that they could access the Child Support Grant. CHWs from this study worked with elders and patients who were defaulting on HIV and TB treatment. Treatment adherence support was offered to

community members so that they could take their chronic medication regularly and prevent complications. Results from this study also show that CHWs cared for bedridden patients by washing, feeding, administering medication and dressing their wounds.

During the NHI pilot program in the Tshwane District, CHWs worked in vulnerable communities riddled with poverty, unemployment and deteriorating infrastructure. CHWs had no working space, equipment and walked long distances to deliver healthcare services. In Tshwane District, CHWs were paid R2500 on a one-month contract and with no work benefits. A multi-system approach was used to contract CHWs during the NHI pilot program in the Tshwane District. In this multi-system approach, NGOs and NPOs were outsourced by the NDOH to employ CHWs. CHWs were unhappy with this contracting approach and protested outside the NDOH offices and demanded permanent employment with benefits. In a context where communities relied on the failing public health system, the State burdened CHWs with unpaid community health caregiving. When the NHI policy is rolled out nationally, the government must abolish the multi-party system of contracting CHWs. A unit must be established in each district that will be responsible for contracting CHWs. Alternatively, the government must have a contractual agreement with NGOs and NPOs on how much to pay CHWs. If an organisation does not pay CHWs a decent wage stipulated by the government guidelines, they must be reported, and their contract as service providers must be terminated. The government must also purchase community healthcare services from accredited organisations to ensure CHWs have a safe physical working space, health equipment, transportation and proper uniforms.

Conclusion

The objective of the WBOT program was to deliver healthcare services to people in the comfort of their homes. The objective of this chapter was to evaluate the implementation of the WBOT in the Tshwane District. The findings show that the WBOT team delivered PHC services in vulnerable communities with poverty and unemployment. In these communities, people lived in squatter without clean water, sanitation and electricity. CHWs reported that people told them that they did not want healthcare services but wanted jobs so they could put food on the table. CHWs provided reproductive health care services to pregnant women and immunised children. They screened people for HIV, TB and hypertension, delivered medication and took care of bedridden patients in the comfort of their homes. CHWs were employed using a multi-system approach during the NHI pilot program in the Tshwane District. The NDOH contracted NGOs

NPOs to employ CHWs into the WBOT program. In this multi-system approach, CHWs were subjected to precarious work contracts, a low stipend of R2500 and no work benefits. CHWs protested in front of the NDOH offices in Pretoria and demanded that the government employ them permanently. CHWs also worked under poor conditions without physical offices, medical equipment, computers and digital gadgets, uniforms and transportation.

When the NHI policy is rolled out nationally, the WBOT program will heavily rely on CHWs to deliver healthcare services to people in the comfort of their homes. The multi-party system that is used to employ CHWs through NGOs and NPOs must be abolished. A unit in each district must be established, and the government must purchase community healthcare services from accredited service providers at a reasonable price. NPOs and NGOs must be accredited as service providers of community healthcare services and be monitored as to whether they pay CHWs a decent living wage. The government must penalise and ban NPOs and NGOs if they underpay and exploit CHWs. The accreditation requirements should ensure these organisations provide CHWs with adequate working spaces, medical equipment, and uniforms. If these proposed conditions are not met, the NHI policy, with its ideal of UHC, will be institutionalising underpaid community health caregiving and exploiting CHWs.

Chapter 11: Conclusion

The National Health Insurance Program

The NHI policy aims to redistribute South Africa's financial resources equally across socioeconomic groups to ensure that people have universal access to quality healthcare services based on need and not income (Booysen & Hongoro 2018; National Department 2011; 2015; 2019; Naidoo 2012; Setswe et al 2016). This will be achieved by creating a single NIH Fund, which will be responsible for pooling public funds from and purchasing healthcare services on behalf of the population from accredited private and public service providers (National Department of Health 2015; 2019). Part of transitioning from the current healthcare system to the NHI policy involved implementing the NHI pilot program in eleven districts across South Africa. Eleven districts were selected for the NHI pilot program based on their health system's capacity, demographic and socioeconomic profiles (National Department of Health 2011; 2015). The districts that were selected are Eden District in the Western Cape, Pixley ka Seme in the Northern Cape, OR Tambo in the Eastern Cape, Gert Sibande in Mpumalanga, the City of Tshwane in Gauteng, Amajuba, Umzinyathi, uMgungundlovu in KwaZulu Natal, Vhembe in Limpopo, Dr Kenneth Kaunda in North West and Thabo Mafutsanyane in Free State (Ogunbanjo 2013). The NHI pilot program was implemented for five years, from 2012 to 2017. The initial objective of the NHI pilot program in the NHI Green Paper was to test the district's ability to purchase healthcare services on behalf of the population, the feasibility of engaging the private sector to purchase healthcare services, and the cost of introducing a fully-fledged District Health Authority (National Department of Health 2015). However, in the NHI White Paper, the objective of the NHI pilot program was changed to implementing the PHC reengineering national strategy to improve the delivery of healthcare services in the public sector (National Department of Health 2015: 27). Findings from this study show disagreement and tension between the NDOH and National Treasury resulted in the NHI pilot program being about implementing the PHC reengineering national strategy instead of testing the district's ability to purchase healthcare services on behalf of the population.

The PHC interventions tested as part of the NHI pilot program were GP contracting, CCMDD, ISHP, and WBOT programs. The South African government funded the NHI pilot program through NHI Conditional Grants (Genesis, PwC & Centre for Health Policy 2019). Each pilot district received R11 million, which was later reduced to R7 million annually (Genesis, PwC &

Centre for Health Policy 2019). The objective of this study was to investigate the process of implementing the NHI pilot program in the Tshwane District. This was done by engaging with politicians, policymakers, government stakeholders, and healthcare professionals responsible for the NHI pilot program in the Tshwane District. These engagements were characterised by in-depth qualitative accounts that captured the technical and political process of implementing the NHI pilot program in the Tshwane District. Seventy-two in-depth individual interviews and 3 unexpected focus group discussions were conducted with policymakers, government officials and healthcare professionals. The significance of this study is to contribute to the ongoing global debates about the role of pilot programs in the cycle of health policymaking. It hopes to locate the NHI pilot program within the politics of evidence-based policy in which government officials, policymakers, and healthcare professionals with different pockets of power play a role in shaping the implementation of pilot programs.

Contributions to evidence-based policy

The NHI pilot program in South Africa forms part of the global discourse known as an evidence-based policy. Evidence-based policy is the idea that for policies to be effective, they must be based on systematic scientific evidence (Sutcliffe & Court 2005). This systematic scientific evidence must be generated through pilot programs which test how the proposed policy will work in real life (Sutcliffe & Court 2005). Pilot programs are often implemented within specified geographical locations to test how the proposed policy will work when scaled up nationally (Vreugdenhil & Ker Rault 2010). As part of moving towards UHC to achieve Sustainable Development Goal 3, pilot programs have been at the centre of health policy experiments implemented across developing countries (Ataguba et al 2014). These health policy experiments are implemented to generate evidence about which health financing models are suitable for achieving UHC within a country (Ataguba et al 2014). Health policy experiments often use RCTs to assess the efficacy of a policy intervention in communities (Bhide et al 2018). Communities are assigned to treatment groups which receive the policy intervention and control groups which do not receive the policy intervention (Bhide et al 2018). The results of control and treatment groups are compared to determine the efficacy of the policy intervention (Rayzberg 2019).

The use of RCTs in health policy experiments has been criticised as methodologically flawed, unethical and weakening social ties. The methodological assumption of causal effect in RCTs has been highly criticised (Black 2001). The causal effect in RCTs assumes that policy

intervention A implemented in a community causes outcome B (Black 2001). However, the assumption that policy intervention A causes outcome B is often met with multiple confounding factors (Black 2001). There could have been other social, economic and political interventions implemented concurrently with policy intervention A that could have contributed to outcome B (Black 2001). Chance as a methodological flaw in RCTs happens when the treatment is recorded as effective based on 'chance' alone (Bédécarrats et al 2019). Health policy experiments could have been implemented when a community is in dire need of healthcare services (Bédécarrats et al 2019). The policy intervention's recorded impact could be based on 'chance' alone (Bédécarrats et al 2019). The efficacy of policy interventions in health policy experiments can be statistically exaggerated (Milewa and Barry, 2005). The statistical exaggeration of a policy intervention during RCTs happens in a context where there is a lack of healthcare services (Milewa and Barry 2005). If the same policy intervention could be implemented in an area where people have access to quality healthcare services, the interventions' impact would be statistically insignificant. According to Newhouse & Normand (2017), organisers of health policy experiments often choose contexts where there is extreme poverty and deteriorating healthcare infrastructure so that the results of the policy interventions yield statistical power to make claims that the proposed policy will work.

The method of RCTs, where communities are divided into treatment groups and control groups, did not happen during the NHI pilot program in South Africa. PHC interventions that were tested during the NHI program were implemented in all 52 districts in South Africa to improve the delivery of healthcare services in public health facilities. Although RCTs were not used, the recorded impact of the PHC reengineering interventions during the NHI pilot program in the Tshwane District can be scrutinised. The results from this study show that PHC reengineering programs implemented during the NHI pilot program in the Tshwane District improved the delivery of healthcare services in public health facilities. The PHC reengineering programs like GP contracting, DCST, CCMDD, ISHP and WBOT were vehicles for delivering healthcare services in public health facilities and the community. These PHC reengineering interventions managed to deliver healthcare services to far-fetched disadvantaged communities in the Tshwane District. The GP contracting program employed more than 70 GPs who improved the delivery of healthcare services in public health facilities. The work of DSCT members during the NHI pilot program in the Tshwane District improved infant and maternal health indicators. The DCST program ensured that public health facilities have rotating specialists who trained

healthcare professionals to deal with obstetric complications. The CCMDD programs ensured that stable patients collected their chronic medication at convenient pick-up points. The CCMDD program reduced patient load in public health facilities so that healthcare professionals could attend to patients who require medical care. The ISHP delivered healthcare services to learners in public schools. The WBOT delivered healthcare services to people in the comfort of their homes.

The impact of PHC reengineering interventions implemented during the NHI pilot program in the Tshwane District cannot be read in isolation from other social, political and economic interventions. For example, the impact of the DSCT in improving infant and maternal health indicators must be read with other reproductive health interventions. The building of clinics and day hospitals that focus on infant and maternal health could be another contributing factor that reduced maternal and child deaths in the Tshwane District. The employment of gynaecologists and midwives outside the DCST members in public health facilities could be another contributing factor to the reduction of infant and maternal deaths. The DCST program could not have reduced the rates of maternal and child deaths in the Tshwane District alone. Other social, economic, political, medical and reproductive health interventions that were implemented simultaneously with the DCST program could have contributed to the reduction of infant and maternal deaths. This applies to all other PHC reengineering interventions; their recorded impact on improving the delivery of healthcare services in public facilities in the Tshwane District must be read with other social, economic, political and medical interventions.

RCTs in health policy experiments have been criticised for being unethical, preying on vulnerable populations, unjust and dehumanising
(Anderson et al 2005). The most dehumanising part of health policy experiments is the randomisation process, which enrols communities and individuals to control and treatment groups (Teele 2014). The public lottery is used as a system of enrolling communities to control and treatment groups in health policy experiments in developing countries (Teele 2014). A brief explanation of what the health policy experiment is about is given to community members at a public meeting (Teele 2014). On the day of the public lottery ceremony, the names of communities or individuals are assembled in a lottery basket (Teele 2014). The NGO leader, government official and researcher in the health policy experiment shakes the basket and selects a community or an individual's name (Teele 2014). These communities and individuals who are

deemed 'lucky' become part of the treatment group, and those who are deemed unlucky are assigned to the control group (Teele 2014). The public lottery is done to ease feelings of favouritism and unfairness that come with the randomisation process (Calkins & Rottenburg 2016).

The NHI pilot program in South Africa did not subject people to randomisation and the dehumanising process of a public lottery. The PHC reengineering interventions implemented in 11 pilot districts during the NHI pilot program were simultaneously implemented in 41 other non-pilot districts in South Africa. The PHC reengineering interventions, such as the ISHP and the WBOT program, have a long history in South Africa and have been part of the healthcare system. The history of ISHP can be traced to the 1920s when the oppressive colonial government adopted the School Health Service Policy to respond to the challenge of poor Whites (Shung-Kingt al 2014). The history of the WBOT program can be traced back to the 1920s when G.A Park Ross established a community healthcare work program in Natal and Zululand to respond to the challenges of Malaria (Phillips 2014). The contracting of GPs to do sessional work in public health facilities has a long history in South Africa (Geiger 1993). The history of the CCMDD program can be traced back to 2005 with the establishment of the Baywest Outreach Program and Chronic Dispensing Unit (CDU) in the Western Cape (Du Toit 2017). The DCST was introduced by the NDOH in 2012 as part of the national strategy to end maternal and child mortality deaths in South Africa (Feucht et al 2018). All the PHC interventions that were tested continued to be implemented even after the NHI pilot program ended because they are part of a national strategy to improve the delivery of healthcare services in public health facilities. The PHC reengineering national strategy became part of the NHI pilot program due to disagreements between the National Treasury and the NDOH. What was supposed to be piloted during the NHI pilot program was how the districts would purchase healthcare services on behalf of the population from accredited public and private service providers.

According to Calkins & Rottenburg (2016), agents of health experiments promise communities that they will come back and roll out the interventions to members in the control group (Calkins & Rottenburg 2016). Community members are told they will benefit from the health policy experiment when the government scales up nationally (Hoffmann 2020). Randomisation in health policy experiments is considered unjust, where communities and individuals in treatment and control groups are in dire need of lifesaving healthcare services (Hoffmann 2018). The

question of whose life is worth saving and whose life is not worth saving arises (Hoffmann 2018). The PHC reengineering interventions that were tested during the NHI pilot program were already implemented at a national scale across 52 districts to improve the delivery of healthcare services in public health facilities. The only difference is that the 11 pilot districts were given R11 million annually, which was later reduced to R7 million. When locating the NHI pilot program into the politics of evidence-based policy, one can critique it based on fairness. The 41 health districts that were not part of the NHI pilot program also deserved the NHI Conditional Grant, which helped to improve the delivery of healthcare services in public health facilities in pilot districts.

Communities are hardly informed that they are part of a health policy experiment (Haushofer et al 2020). According to (Hoffmann) 2018, most health policy experiments in developing countries are carried out without the participants' knowledge (Haushofer et al 2020). The sampling method of cluster randomisation means that researchers choose certain areas to implement health policy experiments (Hoffmann, 2018). Informed consent is often an agreement between the experimenting organisations and government officials (Hoffmann 2018). According to Bonneuil (2000), Africa is a fertile ground for European and American researchers to test health policy experiments without taking into account the humanity and dignity of participants. Bonneuil (2000), further argues that many health policy experiments implemented in developing countries would never pass at the Institutional Review Board of Ethics in the United States. Informed consent in these developed countries is not only a matter of convincing participants to be part of the study, but it is a process of convincing government leaders, civil society and civil servants (Bonneuil 2000). Policymakers, government officials, and healthcare professionals did not grant informed consent to be part of the NHI pilot program in the Tshwane District. Government officials in the Tshwane District Department of Health knew that the district was part of the NHI pilot program. Healthcare professionals such as GPs, specialists managers of the WBOT program, ISHP and the CCMDD program were aware that their work is part of the NHI pilot program. However, community health workers in the WBOT program were unaware they were part of the NHI pilot program. CHWs knew that they were working for the WBOT program in the Tshwane District and could not make a connection between their work and the NHI pilot program.

In health experiments, communities are often subjected to the false hope that healthcare services enjoyed by the treatment group will be provided in the near future (Haushofer et al 2020). For the duration of the health policy experiment, temporary health facilities are set up (Haushofer et al 2020). Communities receive healthcare services that are tested as part of the health policy experiment (Haushofer et al 2020). When the experiment ends, these healthcare services are terminated, leaving communities with unanswered questions which the State must address (Haushofer et al 2020). Temporary healthcare services of experiments create tension between citizens and the State (Haushofer et al 2020). Health policy experiments weaken and disrupt social ties characterised by history, family, blood and communal relations (Adesina 2011). In a health policy experiment, community members in treatment groups tend to have familial and communal ties with members in the control group (Adesina 2011). Intimate social ties mean that the control group will be exposed to the interventions that the treatment group receives (Adesina 2011).

The communities in pilot districts during the NHI pilot program were not subjected to the false hope that the PHC reengineering national strategies will be implemented in the near future. These PHC reengineering national strategies were part of the healthcare system and implemented nationally. These interventions continued to be implemented in pilot and non-pilot districts even when the NHI pilot program ended. There are no community social ties that were disrupted during the NHI pilot program in South Africa because all the PHC reengineering national strategies were implemented across 52 districts. However, the challenges of the NHI pilot program caused discomfort among healthcare professionals. For example, during the NHI pilot program in the Tshwane District, deteriorating infrastructure in public health facilities made it difficult for healthcare professionals to deliver quality healthcare services. Shortages of medical equipment, drug stock-outs, high patient load, and water and electricity cuts compromised the quality of healthcare services in public health facilities. Precarious work, labour contracts, low wages, and delayed payments were a source of frustration for healthcare who were at the forefront of implementing the NHI pilot program in the Tshwane District.

Pilot programs in Africa have become vital in generating knowledge that will convince political leaders, civil servants and citizens to defund public goods and leave them in the hands of the private market (Adesina 2020). According to Adesina (2020), instead of political lobbying, negotiations and collective decision-making, policymaking in Africa has become a technocratic

process dependent on international expertise from Europe and the United States of America. Pilot programs generate this international expertise to depoliticise policymaking in Africa (Adesina 2020). The process of generating expert knowledge using pilot programs reflects the power dynamics in which North America and Europe coerce and dictate which policies should be adopted to address social challenges in developing countries (Hoffman 2020; Rottenburg 2009b). When reflecting on the making of social protection through conditional cash transfers, Ouma & Adesina (2019) argue that the influence of developed nations on policymaking in Africa is more than just a top-down approach. It is a complex power-curated process between international organisations, international donors, civil societies, governments, Think Tanks and NGOs (Ouma & Adesina 2019). Ouma & Adesina (2019) refer to these myriad power pockets as social policy merchandising in Africa.

In this social policy merchandising process, international organisations and donors initiate relationships with a country in Africa through Social Development and the Department of Health (Adesina 2020). The departments are chosen because they are responsible for what Rutternburg (2009) calls 'declared social emergencies' such as poverty, pandemics, and civil wars. Public servants in these departments are invited to policy brief meetings, where a certain 'policy' framework to deal with social emergencies in Africa is presented (Rottenburg 2009b). Public servants and government stakeholders are invited to local and international conferences, fully paid for by international donors selling the social protection policy framework of conditional cash transfers (Ouma & Adesina 2019). Ouma (2020) argues that this 'knowledge currency' is used to transfer policy ideas that conditional cash transfers work to eliminate poverty in Africa. Once public servants and government stakeholders buy into this knowledge currency, they are told that policy pilots must be set up to test how conditional cash transfers will work locally (Ouma & Adesina 2019; Ouma 2020). These pilot programs are then implemented fully paid for by international organisations and their donors (Ouma & Adesina 2019; Ouma 2020). Public servants are encouraged to support the pilot programs and assist the international organisation in getting buy-in from the locals to implement them (Ouma & Adesina 2019; Ouma 2020). Adesina (2020) argues that NGOs are quickly established at the local level with an international team that will provide technical expertise on how to implement pilot programs. The pilot program is implemented using the black-and-white guidelines provided by international organisations (Ouma & Adesina 2019; Ouma 2020). Think Tanks and academic departments are invited to be part of the pilot program and assist with the research expertise required to conduct RCTs

(Ouma & Adesina 2019; Ouma 2020). Once the data is collected and analysed, the results are disseminated to public servants and government officials who were initially contacted (Ouma & Adesina 2019; Ouma 2020). The audience of the results of the pilot programs moves from the initial public servants to politicians and senior government in different ministries (Ouma & Adesina 2019; Ouma 2020).

The response from politicians and ministers about the proposed social protection policy program can vary (Adesina 2011). In a case of negative response, NGOs, civil societies, and Think Tanks funded by international organisations form advocacy alliances that pressure the government to adopt the social protection policy (Adesina 2011). This advocacy alliance branches out to reach citizens and other stakeholders using mainstream media that conditional cash transfers work and the government must implement them now to end poverty (Adesina 2011). Again, the declaration of a state of emergency tactic is used, and the time for these advocacy activities is also chosen strategically (Adesina 2020). These advocacy activities for conditional cash transfers are implemented during political window periods such as national and local government elections (Adesina 2020). This period is chosen so that opposition political parties can use conditional cash transfers as their campaigning tool to gain votes (Adesina 2020). If the resistance to implementing conditional cash transfers continues, senior diplomats are involved and given a directive to influence politicians or specific donor programs in the country will be terminated (Adesina 2020). According to Adesina (2020), this social policy merchandising undermines the collective process of democracy in Africa in which government and citizens independently decide which social policies are appropriate for their social context. This interference with social policymaking in Africa is a new form of brutal neo-colonialism that is embedded in privatising public goods in Africa (Adesina 2011). It aims to achieve the neoliberal agenda of leaving the well-being and development of Africans to the precarity of the private market (Adesina 2011). Policy trials undermine the power of sovereignty in policymaking in which politicians, civil servants, healthcare workers, health advisory boards, unions and the legislation are at the centre of the country's policy decisions (Kirkup 2009).

In South Africa, the NHI pilot program was initially designed to test the district's ability to purchase healthcare services on behalf of the population from accredited private and public service providers. However, findings from this study show that contestations between the NDOH and the National Treasury led to the NHI pilot program testing the PHC reengineering national

strategies to strengthen the delivery of healthcare services in public health facilities. The NHI pilot program does not tell us anything about the NHI policy as a financing system that will collect financial resources from the public and purchase healthcare services on behalf of the population. States Rogers-Dillion (2004) argue that pilot programs are part of a myriad web of the country's politics. Pilot programs can serve as a tool for fast-tracking or delaying the implementation of a proposed policy (Rogers-Dillion 2004). The NHI pilot program was designed, endorsed and funded by the South African government. The influence of external agencies, as observed in other health policy experiments, was minimal during the NHI pilot program in South Africa. External agencies such as the Clinton Health Access Initiative and CDC partnered with NDOH in monitoring and evaluating the implementation of the NHI pilot program. Macdonald, PwC, and the Centre for Health Policy at Wits University were contracted by the NDOH to provide technical monitoring and evaluation reports on the progress of the NHI pilot program.

The NHI pilot program in South Africa challenged the idea of evidence-based policy, where pilot programs are implemented to test whether a proposed policy will work. The findings from this study show us that what was piloted during the NHI pilot program is not what was supposed to be piloted. Disagreements and tensions between the NDOH and the National Treasury led to a compromised NHI pilot in South Africa. Key informants from the NDOH reported that what was piloted as a PHC reengineering national strategy was a deliberate act by the Treasury and some politicians from the ANC to stall the NHI policy in South Africa. The PHC reengineering national strategy tested during the NHI pilot program does not tell us how the NHI policy as a financing health system will work in real life. The findings from the study also show that even what was piloted as the PHC reengineering national strategy was underfunded to claim that the NHI pilot program did not work and, therefore, the NHI policy will fail.

The NHI pilot program was not a determining factor as to whether South Africa will move towards the NHI policy. The NHI pilot program formed part of multiple interventions that were put in place to prepare South Africa for the NHI policy. Multiple government strategies were implemented simultaneously with the NHI pilot program to accelerate the process of moving the country towards the NHI policy (National Department of Health). The NHI Bill was introduced in 2019, and it has gone through public participation (National Department of Health 2022). In June 2023, the National Assembly passed the NHI Bill in parliament, and it is now sitting with the National Council of Provinces on Health and Social Services for consideration (National

Department of Health 2023). The work of reforming the National Health Act and the Constitution to set up the NHI Fund is underway (National Department of Health 2022). The setting up of the NHI population registration system is ongoing, and certain public clinics have been equipped with a digital health system to start the registration process (National Department of Health 2022). Refurbishments of public health facilities so that they can be accredited service providers under the NHI Fund have started in the Western Cape and Gauteng Province (National Department of Health 2022). Several work streams have been set up to determine the reimbursement models the NHI Fund will use to purchase healthcare services from service providers (National Department of Health 2022). The findings from this study confirm the declaration of scholars like Adesina (2017), Smith (2013) and John (2017) that evidence-based policy discourse in policymaking is flawed. Policymaking does not depend on evidence from pilot programs but rather on the political commitment of governments and citizens to achieve the normative values of the desired society.

Contribution to Transformative Social Policy

Transformative Social Policy is an analytical framework that defines social policy as a collective commitment of citizens, the State, and public and private institutions to advance the human, economic and social welfare of the people within a geographical area (Adesina 2011; Mkhandawire 2007). This analytical framework believes that Africa must return to the broader political commitment of social policy in which economic development is intrinsically embedded within social development (Adesina 2015). Mkandawire (2001) asserts that the role of social policy in developing countries is to advance human development and economic growth simultaneously. The commitment to a broader social policy project in Africa is a collective effort to advance human development and protect and secure livelihoods whilst paying attention to economic growth (Adesina 2007; Adesina 2011).

Advancing human development and protecting livelihoods means implementing public interventions to ensure citizens have access to the economy by participating in labour and securing decent wages (Adesina 2011; Mkandawire 2007; United Nations Research Institute for Social Development 2007). Citizen's full participation in the economy through productive labour means that they can collectively invest in public interventions such as health, education, and pension that will protect them from the precarity of development (Adesina 2007; 2010; 2011; 2015; Mkandawire 2001; 2007; Tekwa & Adesina 2018; Yi 2013; United Nations Research Institute for Social Development 2007). Public interventions such as national health insurance,

pension funds and investment in universal education mean that the healthy adult working population protects children, young, elderly and the sick through risk cross-subsidisation (Adesina 2007; 2010; 2011; 2015; 2020 Mkandawire 2001; 2007; Phiri et al 2016; Tekwa & Adesina 2018; Yi 2013 & United Nations Research Institute for Social Development 2007). The collective public savings of social policy become a catalyst for economic growth as citizen's participation in the economy becomes more productive when their human development is protected and secured throughout the stages of life (Adesina 2007; 2010; 2011; 2015; Mkandawire 2001; 2007; Phiri et al 2016; Tekwa & Adesina 2018; Yi 2013 & United Nations Research Institute for Social Development 2007).

The Transformative Social Policy Analytical Framework prescribes five functions of social policy, and these are production, protection, reproduction, redistribution and social cohesion (Adesina 2011; Mkandawire 2007; Tekwa 2020 & Tom 2020). To contribute to the ongoing intellectual debates about the role of the Transformative Social Policy Framework, I reflect on the possibilities of the NHI policy in achieving health equity, improving the population's health and encouraging social cohesion by examining the NHI pilot program. I analyse how key functions of Transformative Social Policy, such as production, reproduction, and protection, were achieved at the primary healthcare level during the NHI pilot program. What was not piloted during the NHI pilot program could have given us a snapshot of how the NHI policy as a financing health system would work in real life.

The first function of social policy is production in which citizens can contribute to society using their skills, labour and wisdom (Adesina 2011; Mkandawire 2007; Tekwa 2020; Yi 2013). The production function of the social policy pays attention to social, political, and economic interventions that provide citizens with universal education so that they can participate fully in the economy (Adesina 2011; Mkandawire 2007; Yi 2013). The production function of social policy is not about exploitative labour markets that rely on precarious, unprotected cheap labour (Adesina 2011; Mkandawire 2007; Yi 2013). This function pays attention to the value of collective savings through health insurance, pension funds and progressive taxation to ensure risk cross-subsidisation between children, healthy adults, sick and older people (Adesina 2011; Mkandawire 2007; Yi 2013). The productive role of the NHI pilot program in the Tshwane District was to increase health and human resources by implementing the GP, Contracting and CCMDD programs. The GP contracting and the CCMDD programs increased human

resources for health by employing GPs and Pharmacist Assistants in public health facilities. The GP contracting program employed 74 GPs to deliver quality healthcare services in public clinics. The program had two models of contracting GPs. In the first model, GPs were contracted by the NDOH to do sessional work at the clinic, and they would be paid based on an hourly rate. The Foundation for Professional Development ran the second contracting model, and GPs were employed full-time. In this contracting model, GPs were expected to work 8 hours a day, amounting to 40 hours a week.

The role of GPs during the NHI pilot program in the Tshwane District was to provide PHC services to the people. GPs were responsible for patient care, managing and treating communicable and noncommunicable diseases. GPs provided emergency care, stabilised patients and referred them to hospitals. Besides clinical work and managing patients, GPs were responsible for training and mentoring nurses. They wrote reports on how to improve the quality of healthcare services in public health facilities. The work of GPs during the NHI pilot program in the Tshwane District reduced unnecessary referrals to hospitals. When few people are referred to higher levels of care, this reduces overcrowding in hospitals and healthcare costs in the country. Having GPs in the clinic ensured that people could receive quality healthcare services within walking distance. GPs' presence reduced waiting times to receive care in public health facilities. From the GP contracting program, we learned that redistributing health human resources to communities in the Tshwane District was essential in improving the quality of healthcare services and health indicators.

Contracting Pharmacist Assistants in the CCMDD program showed that investing in health human resources alleviates the burden of the high number of patients in public health facilities. The work of Pharmacist Assistants ensured that patients did not default from taking their medication because of waiting in long lines at public health facilities. Pharmacist Assistants prevented drug stock-outs, which is a common complaint amongst public health facilities across the country. Contracting of GPs and Pharmacist Assistants during the NHI pilot program showed that a commitment to the productive role of Transformative Social Policy, which is to invest in human resources for health, is lifesaving. These programs show us that there is a possibility that comes with the NHI policy in redistributing health human resources in disadvantaged communities to achieve health equity amongst the population. UHC policies such as the NHI

policy have a productive function of increasing health human resources to improve the quality of healthcare services and health indicators of the population.

The Transformative Social Policy Framework views reproduction as a function responsible for the safe continuation of life in society (Tekwa & Adesina 2018; Tekwa 2020; Tom 2020). This safe continuation of life needs to be protected by collective reproductive services that protect women, children and families from the uncertainty of pregnancy, birth and human development (Tekwa & Adesina 2018; Tekwa 2020; Tom 2020; Phiri et al 2016). The reproduction function of social policy is about collective efforts that ensure the continuation of society through family and childcare policies (Mkandawire (2007). Reproduction as a social policy function must take seriously the burden of unpaid caregiving often bestowed on women in patriarchal societies (Tekwa & Adesina 2018; 2020). Therefore, reproduction as a function of social policy needs to ensure that collective efforts of family and childcare rearing consider women's livelihoods through programs such as universal early childhood development, universal health coverage, universal education and gender-sensitive labour laws (Tekwa & Adesina 2018). This is to ensure that women have the freedom to participate freely in society and the labour market without feeling that their reproductive choices are a burden (Tekwa & Adesina 2018; Tekwa 2020). According to Hassim & Razavi (2006), a commitment to reproduction as a function of social policy means letting go of patriarchal ideologies through gender-sensitive policies that alleviate the burden of unpaid caregiving on women.

The DSCT program portrayed some elements of the reproductive function of Transformative Social Policy. The objective of the DSCT program was to improve child and maternal health indicators by training nurses and doctors on obstetric care. The DSCT program comprised the Obstetrician-Gynaecologist, Advanced Midwife, Paediatrician, Paediatric nurse, Family Physician, PHC nurse and Anaesthetist. The DCST members reported that the program's objective aligns with Sustainable Development Goal 3, which aims to decrease child and maternal deaths. This study showed that the DCST program improved the delivery of reproductive health services during the NHI pilot program in the Tshwane District. In the past, healthcare professionals would refer babies with minor complications to hospitals. Hospitals were overcrowded with babies that could have been treated at the primary level of care. The clinical training by DCST members empowered medical doctors and nurses to treat babies with minor complications in clinics. The DCST program increased the rates of family planning and pap

smears in public health facilities. The bookings of antenatal and postnatal care increased, as well as breastfeeding rates. The number of babies infected with HIV through the implementation of the Prevention of Mother-to-Child-Transmission HIV program. The DCST program strengthened the delivery of reproductive health services, thus decreasing the number of preterm labour, low-birth and stillbirths in the Tshwane District.

The ISHP reflected some elements of the reproductive function of Transformative Social Policy by delivering healthcare services in public schools. The objective of the ISHP was to promote health by preventing and treating health complications of learners in public schools. Learners received deworming tablets and Vitamin A supplements, which improved their concentration in class. School nurses conducted eyesight, hearing, and dental assessments and referred learners to specialists. The Tshwane District Department of Education worked with optometrists from the private sector and NGOs to provide eyeglasses for free. Upon parental consent, the HPV vaccine was administered to schoolgirls in Grade 4 to prevent future cases of cervical cancer. Sexual and reproductive health education was incorporated into the Life Orientation curriculum and delivered by teachers. School nurses provided antenatal and postnatal care to learners who were pregnant and new mothers.

The third function of Transformative Social Policy is protection, in which collective efforts are in place to protect citizens from the precarity that comes with life, childhood, sickness, disability, old age and disasters (Adesina 2011; 2015). The protection function of Transformative Social Policy is about designing public interventions such as early childhood development programs, universal health insurance, universal education, redistributive land reforms, pension funds and progressive taxation systems (Adesina 2011; 2015). The WBOT program during the NHI pilot program in the Tshwane District reflects some elements of the protective function of social policy. The objective of the WBOT program was to deliver healthcare services to people in the comfort of their homes. CHWs documented the health conditions of people in households, and the information was used to improve the Tshwane District health system data. The WBOT program promoted reproductive health services by providing free pregnancy tests to women at home. Once the results were positive, pregnant women were encouraged to attend antenatal care so that pregnancy complications were treated early. CHWs improved children's well-being by administering Vitamin A and ensuring they get all the necessary immunisations. CHWs delivered medication to people living with HIV and TB to improve treatment adherence in communities.

CHWs cared for bedridden patients in households by washing, feeding and administering medication.

The redistributive function of Transformative Social Policy is a political commitment to redistributing resources such as land and economy fairly across the population to promote equity and social cohesion (Adesina 2020; Phiri et al 2016; Tekwa 2020; Tom 2020). This function focuses on economic structures such as collective savings through taxation, health insurance, pension funds, universal education, and land redistribution (Adesina 2020; Phiri et al 2016; Tekwa 2020; Tom 2020). The redistributive function of social policy addresses the racial, class, gendered and socio-political injustices of the past by redistributing resources fairly to the whole population (Mkandawire 2007). Is a political commitment of sharing resources of the country to protect citizens from the uncertainty of development and to foster equity and social cohesion (Adesina 2007; 2011; 2015). The redistributive role of the NHI policy could not be captured from this study because what was piloted during the NHI pilot program is not what was supposed to be piloted. The findings from this study show that disagreements between the NDOH and the National Treasury led to a compromised NHI pilot program in South Africa. What was piloted was the PHC reengineering national strategies, which had nothing to do with the NHI policy as a health financing system. What was supposed to be piloted was the district's ability to purchase healthcare services on behalf of the population from accredited private and public service providers. What was not piloted could have given us an empirical snapshot of how the NHI Fund will collect financial resources from the public and purchase quality healthcare services on behalf of the population from accredited private and public service providers. This was the empirical evidence from the NHI pilot program that could have given us a picture of how the NHI policy would redistribute the country's financial health resources equally across the population. In order to strengthen social cohesion in a country that is riddled with inequalities due to colonialism and apartheid, which left the majority of Black people poor and unprotected.

Contributions to Critical Realism

When I started reading about the NHI pilot program from the reports published by MacDonald (2013; 2014; 2015), I struggled to understand why I was reading about PHC reengineering national strategies. I knew improving PHC service is an integral part of NHI policy to reform the current healthcare system, which is disease-driven, curative and expensive. I moved between reading peer-reviewed articles about the NHI policy as a health financing system and evaluation reports about the NHI pilot program as a PHC national strategy to improve the delivery of

healthcare services in public health facilities. Public debates about the NHI policy were about whether the South African government could afford the policy. Questions were raised about the mandatory income tax contribution, the future of medical schemes and management of the NIH Fund. None of these public debates focus on improving PHC services in public health facilities, as this was the focus of the NHI pilot program. It was clear that there was a disjuncture between the NHI policy and the NHI pilot program. I stayed with this confusion, and at the beginning of my fieldwork, I focused on evaluating the PHC reengineering strategies tested during the NHI pilot program.

Critical realism encourages researchers to use human interpretations parallel with other sources of knowledge to make sense of the social phenomenon world (Ormston et al 2014). Artefacts, laws, constitutions, the workings of the physical and metaphysical, language, culture, objects, history, and politics are significant contributors to knowledge (Ormston et al 2014). Multiple methods can be used to uncover knowledge about a social phenomenon that is being studied (Ormston et al 20). My confusion about why the NHI pilot program tested PHC reengineering national strategies, which had nothing to do with the NHI policy as a financing health system, was clarified by policymakers and government officials from the NDOH and National Treasury. These key informants informed me that what was piloted during the NHI pilot program is not what was supposed to be piloted. What was supposed to be piloted is the district's ability to purchase healthcare services on behalf of the population from accredited public and private service providers. However, disagreement between the NDOH and the National Treasury led to a compromised NHI pilot program which focused on testing PHC national reengineering strategies. Policymakers from the National Treasury went as far as to say that the NHI pilot had nothing to do with the NHI policy as a health financing system.

Critical realism's use of multiple methods to make sense of the dynamics of the social world assisted me in uncovering that what was piloted during the NHI pilot program is not what was supposed to be piloted. When I told my supervisor about these key informant interviews, he said, 'go and read the NHI Green Paper and the White Paper to see if there was a change in the objectives of the NHI pilot program'. I re-read the two documents, and I found that in the NHI Green Paper, the objectives of the NHI pilot program were to test the district's ability to purchase healthcare services from public and private sector providers using the NHI Fund. However, in the NHI White Paper, the objectives of the NHI pilot program were to test the PHC national

strategies to improve the delivery of healthcare services in public health facilities. These documents confirmed what key informants from the NDOH and National Treasury reported that what was piloted during the NHI pilot program is not what was supposed to be piloted. Government officials and policymakers from the NDOH reported that the change in the objectives of the NHI pilot program was a strategic move by the National Treasury to delay the NHI policy. Government officials and policymakers from the National Treasury responded to these claims and said the opposition to the NDOH is in denial that the opposition to the NHI policy comes from Provincial Governments. When the NHI policy is implemented, Provincial Governments will be stripped of their power to purchase healthcare services on behalf of the population.

Critical realism argues that human beings' interpretation of the social world is one contributor, amongst others, to scientific knowledge (Cruickshank 2003). It was the triangulation of key informant interviews with government and policymakers and revisiting the NHI Green Paper and White Paper that cracked my thesis open that what was piloted during the NHI pilot program is not what was supposed to be piloted. If I did not appreciate the methodological rigour that comes with using multiple sources of knowledge as proposed by critical realism, my PhD thesis would have focused on the NHI pilot program as a system for improving PHC services in public health facilities. This would have depoliticised the NHI pilot program rather than situate it within the politics of evidence-based policy, where pilot programs are used as tools for either delaying of fast-tracking a proposed policy reform. However, I caution the reader that using multiple sources of information to understand a social phenomenon is about timing and seeking guidance.

The NHI Green Paper and White Paper were published before I started my fieldwork, and it was clear from both documents that the objectives of the NHI pilot program had changed. When I first read these policy documents, I did not recognise this change. It was when I went to the field and conducted interviews with key informants from NDOH and the National Treasury that I learned that what was piloted is not what was supposed to be piloted in South Africa. A conversation with my supervisor after these interviews led me to re-read the NHI Green Paper and White Paper to confirm that the South African government implemented a compromised NHI pilot program. Interacting with multiple sources of knowledge to uncover the truth about

the social world requires time and guidance from those who are knowledgeable about the field of study.

Recommendations for the Primary Healthcare Reengineering National Strategy

Primary healthcare will be central to delivering healthcare services under the NHI policy. The PHC reengineering national strategies, such as GP contracting, DCST, CCMDD, ISHP and the WBOT programs, will form part of the NHI policy's mandate to improve health indicators of the population. These PHC interventions function under a multidisciplinary called the Contracting Unit for Primary Healthcare Services (CUP). The CUP is a contracting unit that the NHI Fund will use to purchase healthcare services on behalf of the population (National Department of Health 2015). The CUP will operate in a sub-district geographical area with community healthcare centres that will provide healthcare services to the population (Valiani 2020). The CUP will be attached to a district hospital that will function 24 hours a day to attend to complicated cases (National Department of Health 2015).

Recommendations for General Practitioner Contracting

The GP contracting program during the NHI pilot program in the Tshwane District contracted 74 GPs to work in public health facilities. The work of GPs strengthened the provision of healthcare services in public health facilities. GPs reported that they managed communicable and noncommunicable diseases. The presence of GPs in public clinics meant that people's health conditions were at the appropriate level of care. This reduced unnecessary referrals to hospitals, which inflates healthcare costs. GPs brought quality healthcare services closer to where people live, building trust between the community and the health system. The work of GPs in the NHI pilot program in the Tshwane District was challenging. GPs reported that they were dissatisfied with the models used to contact them in the NHI pilot program. The NDOH model contracted GPs to do sessional work in public health facilities, and they were paid based on an hourly rate. The FPD model contracted GPs to work 40 hours a week in a public clinic. In this contracting model, the salaries were of GPs predetermined by FPD.

GPs commented that when the NHI is implemented, the government should use the risk-adjusted capitation model to contract them. Deteriorating infrastructure, drug stock-out, high patient load, power dynamics between nurses and GPs, delayed payments, and lack of communication between GPs and the NDOH were reported as challenges. GPs from this study reported that the challenges they experienced in delivering healthcare services in public health facilities are not unique to the NHI pilot program. However, they are challenges of the public

health system in South Africa. When the NHI policy is implemented, the government should use a risk-adjusted capitation model to contract and reimburse GPs. Interventions such as GP contracting should be implemented simultaneously with DCST, WBOT, CCMDD and ISHP, which take healthcare services outside the health facilities to communities. Strengthening PHC services should include more than just the work of GPs in health facilities. However, it should be a commitment to a multi-sectoral approach to health that appreciates that health and illness are a product of our social conditions.

Recommendation for the District Clinical Specialist Team Program

The objective of the DCST program during the NHI pilot program in the Tshwane District was to provide clinical training to doctors and nurses in public health facilities to improve maternal and infant health indicators. Clinical training empowered healthcare professionals to treat babies with minor complications at the primary level of care. DCST members expressed that their work improved antenatal bookings, uptake of family planning, pap smear screenings and breastfeeding rates. The DSCT also contributed to the reduction of low birth weight, preterm labour and stillbirths in the Tshwane District.

The challenges of DCST members during the NHI pilot program in the Tshwane District were administration bottlenecks, which delayed the purchase of medical equipment and essential medicines. DCST were constantly burned out as the team of 7 specialists was insufficient to cover the whole district. DCST members reported that they had to start their clinical training from scratch due to high staff turnover and resignations in public health facilities. Reviewing the death of a baby was the worst experience for DCST members during the NHI pilot program. DCST members reported that after years of working in obstetric care, they still do not get used to reviewing the death of a baby. As South Africa moves towards UHC through the NHI policy, the number of specialists within a DCST team must be reviewed and adjusted to the size and population of the district. Districts with high population density, like the Tshwane District, must have 3 or 4 teams to deliver reproductive and obstetric care effectively.

Recommendation for the Central Chronic Medicines Dispensing and Distribution Program

The objective of the CCMDD program during the NHI pilot program in the Tshwane District was to allow stable patients with chronic illnesses to pick up their medication closer to where they live and work. The CCMDD program improved the delivery of PHC services by ensuring that the patient load in public health facilities was reduced. Healthcare professionals could now focus on patients who were sick and in dire need of medical care. The CCMDD program improved

the health indicators of patients as they were adhering to treatment. Pharmacist Assistants in the CCMDD program were responsible for stock-taking, placing orders, pre-packing and dispensing medication in public health facilities. However, Pharmacist Assistants complained that the two-year contract gives them anxiety, and they asked the NDOH for permanent employment. Government officials reported that Pharmacist Assistants have created their expectations about permanent employment, and renewal of their contract depends on the availability of funding.

The challenge of the CCMDD program in the Tshwane District was that the small-scale community pharmacies were reluctant to join the program. Big corporate companies now took the CCMDD business that could have benefited small-scaled pharmacies. Patients complained that pharmacies had separate queues for them, and people in the community associated those queues with living with HIV. Queues at the pharmacy were integrated to destigmatise the CCMDD program. When the NHI policy is implemented, the CCMDD program must prioritise small-scaled community pharmacies. This will ensure that small-scaled community pharmacies benefit from the profits of the CCMDD program that big corporate pharmacies now enjoy. Pharmacist Assistants' work contracts must be longer than 2 years to offer them job security and stability.

Recommendation for the Integrated School Health Program

The objective of the ISHP during the NHI pilot program in the Tshwane District was to deliver healthcare services to learners in public schools. School nurses conducted health screenings such as eyesight, hearing and dental assessments. Once a learner was identified to have a complication, they were referred to higher levels of care to receive treatment. Learners received deworming and Vitamin A tablets to improve their concentration in the classroom. The ISHP administered HPV vaccines to girls in Grade 4 to prevent the future occurrence of cervical cancer. School nurses and government officials complained that the burden of the ISHP was too much, and teachers were not allowed to assist them.

The Department of Basic Education and the teachers' union SADTU banned teachers from participating in the ISHP. Government officials and school nurses also reported that parents did not sign the consent form that allows them to deliver healthcare services to learners. HIV, teenage pregnancy, and drug abuse in high schools were reported as challenges that the ISHP had to address in the Tshwane District. When the NHI policy is implemented nationally, the ISHP must have enough human resources to carry out its mandate fully. For the ISHP to reach its

desired goal, there must be 1 school nurse per public school responsible for the health needs of the learners.

Recommendations for the Ward-based Outreach Team Program

The objective of the WBOT program during the NHI pilot program in the Tshwane District was to deliver healthcare services to people in the comfort of their homes. CHWs worked in communities that were riddled with poverty and unemployment. People lived in squatter camps without running water, sanitation and electricity. People informed CHWs that they do not want healthcare services alone but jobs so that they put food on the table. CHWs delivered reproductive healthcare services to pregnant women, immunised children, screened people for HIV, TB and hypertension, delivered medication, and took care of bedridden patients in the comfort of their homes.

The challenge of the WBOT program is that CHWs were employed on a month-to-month basis by NGOs and NPOs that the NDOH outsourced. Under this precarious work contract, CHWs were paid R2500 with no work benefits such as medical aid and maternity leave. CHWs protested in front of the NDOH offices in Pretoria and demanded that the government employ them permanently. CHWs also worked under poor conditions with no physical offices, medical equipment, computers and digital gadgets, uniforms or transportation. When the NHI policy is rolled out nationally, the WBOT program will heavily rely on CHWs to deliver healthcare services to people in the comfort of their homes. The multi-party system that is used to employ CHWs through NGOs and NPOs must be abolished. A unit in each district must be established, and the government must purchase community healthcare services from accredited service providers at a reasonable price. Alternatively, NPOs and NGOs must be accredited as service providers of community healthcare services and be monitored as to whether they pay CHWs a decent living wage. Part of accrediting requirements should ensure that these organisations provide CHWs with adequate working spaces, medical equipment, and uniforms and pay them decent wages. If these proposed conditions are not met, then the NHI policy, with its ideal of UHC, will be exploiting CHWs by institutionalising underpaid community health caregiving.

Recommendations for the National Health Insurance Policy

The findings from this study show that what was piloted during the NHI pilot program is not what was supposed to be piloted. The power dynamics of the National Treasury and the NDOH resulted in the NHI pilot in a compromised NHI pilot program. What was supposed to be piloted was the districts' ability to purchase healthcare services on behalf of the population from

accredited public and private service providers. Government officials and policymakers from the NDOH reported that the NHI pilot program was turned into the PHC reengineering national strategy by the National Treasury to delay the implementation of the NHI policy in South Africa. Key informants from the National Treasury responded and said the biggest threat to the NHI policy are Provincial Governments, who will be stripped of their power to purchase healthcare services on behalf of the population, and the NDOH is in denial of this.

The South African government must adopt a big-bang approach to implementing the NHI policy. The commitment to moving South Africa towards UHC through the NHI policy will require multisector collaboration between the National Treasury, the NDOH and the Provincial governments. The South African government must make a political commitment to transforming the country's healthcare system through the NHI policy. The findings from this study showed us that what was piloted during the NHI pilot program tells us nothing about the NHI policy, a financing system that will redistribute the country's health financial resources across socioeconomic groups. The political commitment to move towards the NHI policy in South Africa is not dependent on the evidence from the NHI pilot program. However, it depends on the normative values of the desired South Africa, which are enshrined in the founding documents of this country, such as the Freedom Charter and the Constitution. These founding documents state that the commitment to transformation and democracy begins with ensuring people have access to quality healthcare services.

Annexure 1 -7

UNISA university of south africa

RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES
REC-012714-039 (NHERC)

15 February 2017

HSHDC/617/2017
MS SV Wonci
Student: 5765-425-5

Supervisor: Prof JM Adesina
(Sociology)
Qualification: PhD
Joint Supervisor: -

Dear MS SV Wonci

Decision: Ethics Approval

Name: MS SV Wonci

Proposal: Implementation of National Health Insurance Pilot Program in Eden and Tshwane Districts: Learning from Stakeholders in the Healthcare Sector.

Qualification: DPHLSOC

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted for the duration of the research period as indicated in your application.

The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on 15 February 2017.

The proposed research may now commence with the proviso that:

1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*

2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*

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3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

4) *[Stipulate any reporting requirements if applicable].*

Note:
The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.

Kind regards,

Prof L Roets
CHAIRPERSON
roetsl@unisa.ac.za

Prof MM Moleki
ACADEMIC CHAIRPERSON
molekmm@unisa.ac.za

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HEALTH
REPUBLIC OF SOUTH AFRICA

427 Hilda Street, 4th floor, The Fields Building, Hatfield Pretoria 0001 South Africa. Tel: +27 12 451 9036
Enquiries: Dr. Lufuno Razwiedani
e-mail: lufuno.razwiedani@gauteng.gov.za

TSHWANE RESEARCH COMMITTEE

CLEARANCE CERTIFICATE

Meeting: N/A

PROJECT NUMBER: 23/2017

Title: IMPLEMENTATION OF THE NATIONAL HEALTH INSURANCE PILOT PROJECT IN EDEN AND TSHWANE DISTRICT.

Researcher: Ms Sivuyisiwe Veronica Wonci

Supervisor: Prof Jimi O Adesina

Department: Health Sciences

DECISION OF THE COMMITTEE
Approved

NB: THIS OFFICE REQUESTED A FULL REPORT ON THE OUTCOME OF THE RESEARCH DONE

Date: 31 March 2017

.....

Dr. Lufuno Razwiedani
Chairperson: Tshwane Research Committee
Tshwane Health District

.....

Ms. M Lerutla
Acting Chief Director: Tshwane District Health
Tshwane District

NOTE: Resubmission of the protocol by researcher(s) is required if there is departure from the protocol procedures as approved by the committee.

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Enquiries: Dr L Razwiedani
Cell: 0609879564
Tel: (012) 451 9036
e-mail:Lufuno.Razwiedani@gauteng.gov.za

TO : TSHWANE RESEARCH ETHICS COMMITTEE

FROM : CHIEF DIRECTOR'S OFFICE

DATE : 28 MARCH 2017

SUBJECT : DECLARATION OF INTENT (ANNEXTURE 1)

This serves to give permission to Ms Veronica Wonci to conduct her research on **Implementation of the National Health Insurance Pilot Project in Eden and Tshwane District.**

The Tshwane Research Ethics Committee reviewed the protocol and recommended it will add value to the district.

The final clearance certificate will be from the Tshwane Research Ethics Committee and that is only to indicate that the researcher can have access to district management staff.

MS M LERUTLA
ACTING CHIEF DIRECTOR: TSHWANE DISTRICT HEALTH
DATE: 31/3/2017

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HEALTH
REPUBLIC OF SOUTH AFRICA

Annexure 1: Declaration of intent from the clinic manager or hospital CEO

I give preliminary permission to **Ms. Veronica Wonci** to conduct her research

Research **on Implementation of the National Health Insurance Pilot Project in Eden and Tshwane District**

The final approval will be from the Tshwane Research Ethics Committee and that this is only to indicate that the clinic/hospital is willing to assist.

Other comments or conditions prescribed by the clinic or CHC manager or hospital CEO:

Signature
WBOT Manager

GAUTENG PROVINCE
Department: Education
REPUBLIC OF SOUTH AFRICA

8/4/4/1/2

GDE RESEARCH APPROVAL LETTER

Date:	07 March 2017
Validity of Research Approval:	06 February 2017 – 29 September 2017 2017/23
Name of Researcher:	Wonci S.V
Address of Researcher:	Room 417 Lisa's Place
	Visagie Street, Pretoria Central
	Pretoria, 0002
Telephone Number:	078 922 3897
Email address:	ntombi.wonci234@gmail.com or 57654255@mylife.unisa.ac.za
Research Topic:	Implementation of the National Health Insurance Pilot Project in Eden and Tshwane Districts: Learning from Stakeholders in the Healthcare Sector
Number and type of schools:	N/A
District/s/HO	Tshwane North, Tshwane South and Tshwane West

Re: Approval in Respect of Request to Conduct Research

This letter serves to indicate that approval is hereby granted to the above-mentioned researcher to proceed with research in respect of the study indicated above. The onus rests with the researcher to negotiate appropriate and relevant time schedules with the school/s and/or offices involved to conduct the research. A separate copy of this letter must be presented to both the School (both Principal and SGB) and the District/Head Office Senior Manager confirming that permission has been granted for the research to be conducted.

08/03/2017

Making education a societal priority

Office of the Director: Education Research and Knowledge Management
7th Floor, 17 Simmonds Street, Johannesburg, 2001
Tel: (011) 355 0488
Email: Faith.Tshabalala@gauteng.gov.za
Website: www.education.gpg.gov.za

1. *The District/Head Office Senior Manager/s concerned must be presented with a copy of this letter that would indicate that the said researcher/s has/have been granted permission from the Gauteng Department of Education to conduct the research study.*
2. *The District/Head Office Senior Manager/s must be approached separately, and in writing, for permission to involve District/Head Office Officials in the project.*
3. *A copy of this letter must be forwarded to the school principal and the chairperson of the School Governing Body (SGB) that would indicate that the researcher/s have been granted permission from the Gauteng Department of Education to conduct the research study.*
4. *A letter / document that outlines the purpose of the research and the anticipated outcomes of such research must be made available to the principals, SGBs and District/Head Office Senior Managers of the schools and districts/offices concerned, respectively.*
5. *The Researcher will make every effort obtain the goodwill and co-operation of all the GDE officials, principals, and chairpersons of the SGBs, teachers and learners involved. Persons who offer their co-operation will not receive additional remuneration from the Department while those that opt not to participate will not be penalised in any way.*
6. *Research may only be conducted after school hours so that the normal school programme is not interrupted. The Principal (if at a school) and/or Director (if at a district/head office) must be consulted about an appropriate time when the researcher/s may carry out their research at the sites that they manage.*
7. *Research may only commence from the second week of February and must be concluded before the beginning of the last quarter of the academic year. If incomplete, an amended Research Approval letter may be requested to conduct research in the following year.*
8. *Items 6 and 7 will not apply to any research effort being undertaken on behalf of the GDE. Such research will have been commissioned and be paid for by the Gauteng Department of Education.*
9. *It is the researcher's responsibility to obtain written parental consent of all learners that are expected to participate in the study.*
10. *The researcher is responsible for supplying and utilising his/her own research resources, such as stationery, photocopies, transport, faxes and telephones and should not depend on the goodwill of the institutions and/or the offices visited for supplying such resources.*
11. *The names of the GDE officials, schools, principals, parents, teachers and learners that participate in the study may not appear in the research report without the written consent of each of these individuals and/or organisations.*
12. *On completion of the study the researcher/s must supply the Director: Knowledge Management & Research with one Hard Cover bound and an electronic copy of the research.*
13. *The researcher may be expected to provide short presentations on the purpose, findings and recommendations of his/her research to both GDE officials and the schools concerned.*
14. *Should the researcher have been involved with research at a school and/or a district/head office level, the Director concerned must also be supplied with a brief summary of the purpose, findings and recommendations of the research study.*

The Gauteng Department of Education wishes you well in this important undertaking and looks forward to examining the findings of your research study.

Kind regards

.....

Ms Faith Tshabalala
CES: Education Research and Knowledge Management

DATE: 08/03/2017

Office of the Director: Education Research and Knowledge Management
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national treasury

Department:
National Treasury
REPUBLIC OF SOUTH AFRICA

Enquiries: Alfred Tau
Telephone: (012) 315-5455
Email: alfred.tau@treasury.gov.za

Ms Sivuyisiwe Veronica Wonci
Room 417, Lisa's Place
180 Visagie Street
PRETORIA
0002

Dear Ms Wonci

PERMISSION TO CONDUCT A RESEARCH WITHIN NATIONAL TREASURY

The National Treasury acknowledges your letter dated 21 February 2017 and we are pleased to confirm that your request to conduct research at the National Treasury has been granted. Ms Aparna Kollipara has been recommended as the official you will be conducting the research with.

While undertaking research at the National Treasury, the following terms and conditions apply:

- You are expected to follow reasonable instructions in relation to the terms of the right of access;
- You are required to co-operate with the National Treasury in discharging its duties under the Health and Safety Act and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on the National Treasury premises;
- You must observe the same standards of care and propriety in dealing with staff, visitors, equipment and you must act appropriately, responsibly and professionally at all times;
- Ensure all information you have gathered remains secure and *strictly confidential* at all times;
- Ensure that you understand and comply with the requirements of the National Treasury Code of Practice and the Data Protection Act; and

- Furthermore, you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

The department may terminate your right to conduct a research with us at any time either by giving a written notice to you or immediately without any notice if you are in breach of any of the terms and conditions described in this letter, or if you commit any act that we reasonably consider to amount to serious misconduct, or to be disruptive and / or prejudicial to the interests and / or business of the National Treasury.

Please contact Ms Aparna Kollipara for further arrangements. Her contact details are: 012 315-5386 or aparna.kollipara@treasury.gov.za.

Yours sincerely

DONDO MOGAJANE
ACTING DIRECTOR-GENERAL
DATE: 22/05/2017.

Participant Information Sheet

Title: Implementation of the National Health Insurance Pilot Project in Eden and Tshwane Districts: Learning from Stakeholders in the Healthcare Sector.

Dear Prospective Participant

My name is Sivuyisiwe Veronica Wonci and I am doing research with Professor *Jimí* O. *Adésínà*, a Professor and DST/NRF SARChI Chair in Applied Social Policy in the College of Graduate Studies, Archie Mafeje Research Institute (AMRI) towards a Doctoral Degree in Sociology at the University of South Africa. We have funding from National Research Fund (NRF) and the University of South Africa. We are inviting you to participate in a study entitled Implementation of the National Health Insurance Pilot Project in South Africa: Issues, Challenges and Opportunities.

What is the purpose of the study?

I am conducting this research to find out about the process of implementing the NHI pilot program in Eden District in the Western Cape and Tshwane District in Gauteng. This will be done by engaging policy makers, different stakeholders from government, and healthcare workers about their perceptions, experiences and interpretations of the process. This study is expected to collect important information that could contribute to knowledge about some of the issues, opportunities and challenges that need to be addressed in order to fine-tune the process of scaling up the NHI in South Africa.

Why am I being invited to participate?

You have been invited to participate in this study because of your involvement in NHI pilot program in Eden and Tshwane Districts. Your perception, knowledge, experience and interpretation of the process of implementing the NHI pilot project in these two districts and in South Africa will inform the researcher about some of the challenges, opportunities and issues that need to be addressed in order to fine-tune the roll out of the NHI in South Africa.

This study will involve policy makers and stakeholders from the National Department of Health, Gauteng Department of Health and Western Cape Department of Health who are involved in the process of implementing the NHI pilot program in Eden and Tshwane Districts. District managers

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in Eden and Tshwane Districts who are responsible for the implementation of NHI pilot program will be interviewed in this study in order to understand how the districts are working towards achieving goals of NHI pilot program.

Medical doctors who are part of the NHI pilot program in Eden and Tshwane Districts will be interviewed so that they can share their perceptions, knowledge and experiences about their involvement in the NHI pilot program. Medical Doctors who are part of NHI pilot program in Eden and Tshwane Districts but are not contracted by the National Department of Health to work in the NHI pilot program will be interviewed to find out why they are not contracted by National Department of Health. Medical doctors who are not part of the NHI pilot program in Eden and Tshwane Districts will be interviewed in order to understand their perceptions and knowledge about the NHI pilot program and NHI as a whole.

Nurses who are leading the Ward-based Outreach Teams (WBOTs) in Tshwane District will be interviewed in order to find out about some the of issues, challenges and opportunities that come with implementing the WBOTs in this District. Nurses who are leading the Integrated School Health Program (ISHP) will also be interviewed in order to understand some of the challenges and opportunities in promoting primary healthcare in schools at Tshwane and Eden Districts.

The Department of Basic Education is working with the NHI pilot districts to implement the ISHP. Therefore stakeholders from the Department of Basic Education at national, provincial and at district level will be interviewed about their perceptions, experiences and interpretations of working on the ISHP. The Treasury works with the National Department of Health in distributing the NHI conditional grant to pilot districts. In this study the Treasury at national level will be engaged about some of the issues, opportunities and challenges it has experienced in working with the National Department of Health in the NHI pilot program.

The estimated total number of participants in this study are +- 50. The information of the participants in this study have been obtained from different organizations and sources, such as the National Department of Health, Treasury, National Department of Basic Education, Gauteng Department of Health, Western Cape Department of Health, various government and company websites, Eden and Tshwane Districts medical practitioners information directory.

What is the nature of my participation in this study?

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If you agree to take part in this study, you will participate in an in-depth interview which will last for one hour and thirty minutes. All interviews will be conducted in English. If you agree, I would like to audio record the interview using a tape recorder so that I do not lose any information that you will provide. You are free to refuse being recorded during the interview. The questions that will be asked in the interview are related to the process of implementing the NHI pilot program in Tshwane and Eden Districts. In the interview you will be asked to share your perceptions, experiences and interpretation about the NHI pilot program. You will also be asked to talk about some of the lessons you have learned about implementing the NHI pilot program and how these lessons can be used to fine-tune the roll out of the NHI in South Africa. When necessary you will be asked to share documents and reports of your specified organization about the process of implementing the NHI pilot project.

Can I withdraw from this study even after having agreed to participate?

Participating in this study is voluntary and you are under no obligation to consent to participation. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form. You are free to withdraw from the study at any time and without giving a reason. You are also free to change your mind about participating in the study, even after you have agreed that you will participate. When you withdraw in the middle of the study you can also make a choice as to whether the researcher can use the information you have provided or discard it. You will not experience any coercion or discrimination once you have withdrawn from participating in the study at any given time.

What are the potential benefits of taking part in this study?

There are no direct personal benefits from participating in this study. You might not benefit from this study directly as an individual. But the information you provide can help the public, communities, governments and academic institutions to have a better understanding about the process of implementing the NHI pilot project in Eden and Tshwane Districts and possibly in South Africa as a whole. The information you provide can also help to make recommendations about what needs to be done in order to fine-tune the roll out of the NHI nationally.

Are there any negative consequences for me if I participate in the research project?

The risks of participating in this study are minimal. You may feel some inconvenience because of the time it takes to complete the interview. Some of the questions asked about the process of

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implementing the NHI pilot program might make you feel uncomfortable. You are encouraged not to answer any question that you do not feel comfortable with. You can also ask me to not include an answer that you have changed your mind about.

Will the information that I convey to the researcher and my identity be kept confidential?

All the information you will provide in this study will be treated with confidentiality. No personal identifiers such as your name will be attached to the information you provide. All identifiable information will be removed from the study and only pseudo name will be used. The information collected in this study will only be used for the purpose of this Doctoral Research Thesis, academic journals and conferences. Even when the information collected for this research is used for these purposes your identity will be kept confidential and only pseudo names will be used to refer to participants.

How will the researcher (s) protect the security of data?

Hard copies of your answers will be stored by the researcher for a period of five years in a locked cupboard/filing cabinet at the Archie Mafeje Research Institute, College of Graduate Studies in the University of South Africa. For future research or academic purposes; electronic information will be stored on a password protected computer. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable. When the research information is no longer useful, hard copies will be shredded and electronic copies will be permanently deleted from the hard drive.

Will I receive payment or any incentives for participating in this study?

There are no monetary or gift incentives that will be provided as a result of you participating in this study. Your participation is voluntary and no incentives will be given to participants. Although this is the case, sharing your opinions and experiences in relation to the implementation of the NHI pilot program may be satisfactory as this will inform researchers, institutions of higher learning and government departments about what needs to be done in order to fine-tune the process of rolling out the NHI in South Africa.

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Has the study received ethics approval?

This study has received a written approval from the Research Ethics Review Committee: Department of Health Studies of the University of South Africa. A copy of the approval letter can be obtained from the researcher if you so wish.

How will I be informed of the findings/results of the research?

If you would like to be informed of the final research findings, please contact Sivuyisiwe Veronica Wonci at E-mail: ntombi.wonci234@gmail.com or 57654255@mylife.unisa.ac.za Cellphone number: 0789223897. Should you require any further information or want to contact the researcher about any aspect of this study, please contact E-mail: ntombi.wonci234@gmail.com or 57654255@mylife.unisa.ac.za Cellphone number: 0789223897 .

Should you have concerns about the way in which the research has been conducted, you may contact Professor *Jimí* O. *Adésínà* Email: adesij@unisa.ac.za Office number: +27 12 337 6002.

Thank you for taking time to read this information sheet and for participating in this study.

Thank you.

Signature

Name of the Researcher

Sivuyisiwe Veronica Wonci

Date

21 February 2017

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CONSENT TO PARTICIPATE IN THIS STUDY

I, _____ (participant name), confirm that the person asking my consent to take part in this research has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty (if applicable).

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I agree to the recording of the In-depth Interview.

I have received a signed copy of the informed consent agreement.

Participant Name & Surname…… (please print)

Participant Signature……Date……

Researcher's Name & Surname……(please print)

Researcher's signature……Date……

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Potential risks

The risks of participating in this study are minimal. You may feel some inconvenience because of the time it takes to complete the interview. Some of the questions asked about the process of implementing the NHI pilot program might make you feel uncomfortable. You and your institution are encouraged not to answer any question that you do not feel comfortable with. You can also ask me to not include an answer that you have changed your mind about.

Feedback procedure

If you would like to be informed of the final research findings, please contact Sivuyisiwe Veronica Wonci at E-mail: ntombi.wonci234@gmail.com or 57654255@mylife.unisa.ac.za Cellphone number: 0789223897. Should you require any further information or want to contact the researcher about any aspect of this study, please contact E-mail: ntombi.wonci234@gmail.com or 57654255@mylife.unisa.ac.za Cellphone number: 0789223897.

Should you have concerns about the way in which the research has been conducted, you may contact Professor *Jimí* O. *Adésínà* Email: adesij@unisa.ac.za Office number: +27 12 337 6002.

Yours sincerely

Signature of researcher

Name of the above signatory

Sivuyisiwe Veronica Wonci

Insert above signatory's position

Doctoral Candidate University of South Africa

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Organisation Permission Letter

Request for permission to conduct research at ……

(Name of Organisation or Institution)

Title: Implementation of the National Health Insurance Pilot Project in Eden and Tshwane Districts: Learning from Stakeholders in the Healthcare Sector.

Date……

Contact person's name……

Contact person's building no. or room no……

Contact person's Department……

Contact person's telephone number and email address……

Dear Prospective Institution

My name is Sivuyisiwe Veronica Wonci and I am doing research with Professor *Jìmí* O. *Adésínà*, a Professor and DST/NRF SARChI Chair in Applied Social Policy in the College of Graduate Studies, Archie Mafeje Research Institute (AMRI) towards a Doctoral Degree in Sociology at the University of South Africa. We have funding from National Research Fund (NRF) and University of South Africa. We are inviting you to participate in a study entitled Implementation of the National Health Insurance Pilot Project in Eden and Tshwane Districts: Learning from Stakeholders in the Healthcare Sector.

Objectives of the Study

The aim of the study is to find out about the process of implementing the NHI pilot program in Eden District in the Western Cape and Tshwane District in Gauteng. This will be done by engaging policy makers, different stakeholders from government, and healthcare workers about

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their perceptions, experiences and interpretations of the process. This study is expected to collect important information that could contribute to knowledge about some of the issues, opportunities and challenges that need to be addressed in order to fine-tune the process of scaling up the NHI in South Africa.

Why is your institution selected to participate in this study?

Your institution has been selected because its involvement in the NHI pilot program in Eden and Tshwane Districts and in South Africa as a whole. Your institution's involvement in the process of implementing the NHI pilot project in Tshwane and Eden Districts will help inform the researcher about some of the challenges, opportunities and issues that need to be addressed in order to fine-tune the roll out of the NHI in South Africa.

Procedure

The study will entail an in-depth interview which will last for one hour and thirty minutes. All the interviews will be conducted in English. If you agree, I would like to audio record the interview using a tape recorder so that I do not lose any information that you will provide. You are free to refuse being recorded in this interview. The questions that will be asked in the interview are related to the process of implementing the NHI pilot program in Tshwane and Eden Districts. In the interview you will be asked to share your perceptions, experiences and interpretations about the NHI pilot program. You will also be asked to talk about some of the lessons your institution have learned about implementing the NHI pilot program and how these lessons can help to fine-tune the roll out of the NHI in South Africa. When necessary you will be asked to share documents and reports your institution has about the process of implementing the NHI pilot project.

The benefits of this study

There are no direct benefits in participating in this study. Your institution might not benefit from this study directly. But the information you and your institution provide can help the public, communities, governments and academic institutions to have a better understanding about the process of implementing the NHI pilot project in Eden and Tshwane Districts and possibly in South Africa as a whole. The information you and your institution provide can also help to make recommendations about what needs to be done in order to fine-tune the roll out of the NHI nationally.

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References

Adesina, J.O., 2020. Policy Merchandising and Social Assistance in Africa: Don't Call Dog Monkey for Me. *Development and Change*, *51*(2), pp.561-582.

Adesina, J.O., 2009. Social policy in sub-Saharan Africa: A glance in the rear-view mirror. *International Journal of Social Welfare*, *18*, pp.S37-S51.

Adesina, J.O., 2001. NEPAD and the challenge of Africa's development: Towards the political economy of a discourse. *African Journal of International Affairs*, *4*(1-2).

Adesina, J.O., 2007. Social Policy in sub-saharan Africa: in search of an inclusive development: Introduction. *Social policy in sub-Saharan African context: In search of inclusive development*, pp.1-53.

Anderson, L.M., Brownson, R.C., Fullilove, M.T., Teutsch, S.M., Novick, L.F., Fielding, J., Land, G.H., 2005. Evidence-Based Public Health Policy and Practice: Promises and Limits. *American Journal of Preventive Medicine*, 28, pp.226–230.

Abdool Karim, S.S., 2020. The South African response to the pandemic. *New England Journal of Medicine*, *382*(24), p.e95.

Akintola, O. (2015). Public works programme and primary health care in South Africa: Creating jobs for health systems strengthening? *Development Southern Africa*, 32(5), 623-638. doi: 10.1080/0376835x.2015.1044073

Abdullah, F., Myers, J., Basu, D., Tintinger, G., Ueckermann, V., Mathebula, M., Ramlall, R., Spoor, S., de Villiers, T., Van der Walt, Z. and Cloete, J., 2022. Decreased severity of disease during the first global omicron variant covid-19 outbreak in a large hospital in Tshwane, South Africa. *International Journal of Infectious Diseases*, *116*, pp.38-42.

Adler, P.S. ed., 2009. *The Oxford handbook of sociology and organization studies: Classical foundations*. Oxford University Press, United Kingdom.

Abiiro, G.A., Torbica, A., Kwalamasa, K. and De Allegri, M., 2014. Eliciting community preferences for complementary micro health insurance: a discrete choice experiment in rural Malawi. *Social science & medicine*, *120*, pp.160-168.

Asuming, P., 2013. Getting the poor to enrol in health Insurance and its effects on their Health. *Evidence from a field experiment in Ghana.* Columbia University, New York.

Archer, C., 2014. NHI: Let's talk about this revolution. *Mail & Guardian.* [online] Available at: http://mg.co.za/article/2014-02-06-lets-talk-about-this-revolution [Accessed 8 Mar. 2016].

Ataguba, J.E.O. and Goudge, J., 2012. The impact of health insurance on health-care utilisation and out-of-pocket payments in South Africa. *The Geneva Papers on Risk and Insurance-Issues and Practice*, *37*(4), pp.633-654.

Ataguba, J.E., Day, C., McIntyre, D., 2014. Monitoring and Evaluating Progress towards Universal Health Coverage in South Africa. PLoS Med 11, e1001686. https://doi.org/10.1371/journal.pmed.1001686.

Alaba, O.A. and McIntyre, D., 2012. What do we know about health service utilisation in South Africa? *Development Southern Africa*, *29*(5), pp.704-724.

Ataguba, J.E.O. and Alaba, O., 2012. Explaining health inequalities in South Africa: A political economy perspective. *Development Southern Africa*, *29*(5), pp.756-764.

Ataguba, J.E., Day, C., McIntyre, D., 2014. Monitoring and Evaluating Progress towards Universal Health Coverage in South Africa. *PLoS Med* 11, e1001686.

Ataguba, J., & Alaba, O. 2012. Explaining health inequalities in South Africa: A political economy perspective. *Development Southern Africa*, *29*(5), 756-764.

Banerjee, A., Finkelstein, A., Hanna, R., Olken, B.A., Ornaghi, A. and Sumarto, S., 2021. The challenges of universal health insurance in developing countries: Experimental evidence from Indonesia's national health insurance. *American Economic Review*, *111*(9), pp.3035-63.

Bédécarrats, F., Guérin, I. and Roubaud, F., 2019. All that glitters is not gold. The political economy of randomized evaluations in development. *Development and Change*, *50*(3), pp.735-762.

Bhide, A., Shah, P.S. and Acharya, G., 2018. A simplified guide to randomized controlled trials. *Acta obstetricia et gynecologica Scandinavica*, *97*(4), pp.380-387.

Black, N., 2001. Evidence-based policy: proceed with Care. *British Medical Journal*, 323, pp. 275–278.

Bamford, L., (2018). School Health. *District Health Barometer*. District Health Systems Trust.

Bonneuil, C., 2000. Development as experiment: Science and state building in late colonial and postcolonial Africa, 1930-1970. *Osiris, 15*, pp.258-281.

Booysen, F. and Hongoro, C., 2018. Perceptions of and support for national health insurance in South Africa's public and private healthcare sectors. *The Pan African Medical Journal, 30*.

Brey, Z., Mash, R., Goliath, C. and Roman, D., 2020. Home delivery of medication during coronavirus disease 2019, Cape Town, South Africa. *African Journal of Primary Health Care* and Family Medicine, 12(1), pp.1-4.

Boschmans, S.A., Fogarty, T.L., Schafermeyer, K.W. and Mallinson, R.K., 2015. Practice analysis for mid-level pharmacy workers in South Africa. *Pharmacy Education, 15.*

Blecher, M.S., Jacobs, T. and Mclntyre, D., 1999. General practitioners and national health insurance results of a national survey. *South African Medical Journal, 89*(5).

Blecher, M.S., Bachmann, M.O. and McIntyre, D., 1995. Acceptability to general practitioners of national health insurance and capitation as a reimbursement mechanism. *South African Medical Journal, 85*(9).

Bhaskar, R., 2008. *A realist theory of science, classical texts in critical realism*. Routledge, London.

Bourdieu, P., 2004. *Science of science and reflexivity*. University of Chicago, Chicago.

Bourdieu, P., 1990. *In other words: essays towards a reflexive sociology*. Stanford University Press, California.

Bourdieu, P. and Wacquant, L.J., 1992. *An invitation to reflexive sociology*. University of Chicago press, Chicago.

Bédécarrats, F., Guérin, I. and Roubaud, F., 2019. All that glitters is not gold. The political economy of randomized evaluations in development. *Development and Change*, *50*(3), pp.735-762.

Bonneuil, C., 2000. Development as experiment: Science and state building in late colonial and postcolonial Africa, 1930-1970. *Osiris*, *15*, pp.258-281.

Bhaskar, R., 2008. *A realist theory of science, Classical texts in critical realism*. Routledge, London; New York.

Booysen, F. and Hongoro, C., 2018. Perceptions of and support for national health insurance in South Africa's public and private healthcare sectors. *The Pan African Medical Journal*, *30*.

Bamford, L., 2020. Death in facility under 5 years rate. In Massyn, N., Day, C., Ndlovu, N., & Padayachee, T., eds. *District Health Barometer 2019/20*. Health Systems Trust: Durban.

Bradshaw, D., Dorrington, R.E., Laubscher, R., Moultrie, T.A. and Groenewald, P., 2021. Tracking mortality in near to real time provides essential information about the impact of the COVID-19 pandemic in South Africa in 2020. *South African Medical Journal*, *111*(8), pp.732-740.

Burger, R., Bredenkamp, C., Grobler, C. and van der Berg, S., 2012. Have public health spending and access in South Africa become more equitable since the end of apartheid? *Development Southern Africa*, *29*(5), pp.681-703.

Calkins, S. and Rottenburg, R., 2016. Evidence, infrastructure and worth. In *Infrastructures and social complexity* (pp. 271-284). Routledge.

Chola, L., Pillay, Y., Barron, P., Tugendhaft, A., Kerber, K. and Hofman, K., 2015. Cost and impact of scaling up interventions to save lives of mothers and children: taking South Africa closer to MDGs 4 and 5. *Global health action*, *8*(1), p.27265.

Clinton Health Access Initiative. 2016. *Status of NHI Pilot Districts: Progress Report.* Pretoria: Clinton Health Access Initiative. Retrieved from http://www.health.gov.za/.../383-national-health-insurance?...nhi-pilot-districts-progress-report .

Coovadia, H., Jewkes, R., Barron, P., Sanders, D., & McIntyre, D. 2009. The health and health system of South Africa: historical roots of current public health challenges. *The Lancet*, *374*(9692), 817-834.

Cock, J., 1989. *Maids and madams: Domestic workers under apartheid*. Women's Press Ltd, London.

Cruickshank, J. ed., 2003. *Critical realism: The difference it makes* (Vol. 6). Routledge, London.

Calkins, S. and Rottenburg, R., 2016. Evidence, infrastructure and worth. In *Infrastructures and social complexity* (pp. 271-284). Routledge.

Clarke, M., 2022. South Africa: ANC Continues with unconstitutional NHI Bill. Democratic Alliance Press Release. https://allafrica.com/stories/202208230532.html.

Collinson, M.A., Tollman, S.M. and Kahn, K., 2007. Migration, settlement change and health in post-apartheid South Africa: Triangulating health and demographic surveillance with national census data1. *Scandinavian journal of public health*, *35*(69_suppl), pp.77-84.

Council of Medical of Medical Scheme., 2021. *Industry Report 2020: Regulating through the Pandemic*. Pretoria. Council of Medical Scheme.

Cruickshank (2014). *Critical Realism: The Difference it Makes.* 259.

Dobrow, M.J., Goel, V. and Upshur, R.E.G., 2004. Evidence-based health policy: context and utilisation. *Social science & medicine*, *58*(1), pp.207-217.

Du Toit, J., Dames, S. and Boshoff, R., 2008. Centralised dispensing-an affordable solution. *SA Pharmaceutical Journal*, *75*(10), pp.18-20.

David, N. and Mash, R., 2020. Community-based screening and testing for Coronavirus in Cape Town, South Africa. *African Journal of Primary Health Care and Family Medicine*, 12(1), pp.1-3.

Dageid, W., Akintola, O., & Saeberg, T. (2016). Sustaining motivation among community health workers in AIDS care in KwaZulu-Natal, South Africa: challenges and

prospects. *Journal of Community Psychology*, 44(5), 569–585. https://doi.org/10.1002/jcop.21787

Doherty, T., Kroon, M., Rhoda, N., & Sanders, D. (2016). Ending preventable child deaths in South Africa: What role can ward-based outreach teams play? *South African Medical Journal*, 106(7), 672. https://doi.org/10.7196/SAMJ.2016.v106i7.10790

De Klerk, E.P.J., 2013. *Comprehensive school–health services in selected secondary schools in the North West province* (Doctoral dissertation).

Dibakwane, S.T. and Peu, M.D., 2018. Experiences of school health nurses regarding the provision of the school health service delivery in the Tshwane district. *African Journal of Primary Health Care & Family Medicine*, *10*(1), pp.1-8.

Dorward, J., Msimango, L., Gibbs, A., Shozi, H., Tonkin-Crine, S., Hayward, G., Butler, C.C., Ngobese, H., Drain, P.K. and Garrett, N., 2020. Understanding how community antiretroviral delivery influences engagement in HIV care: a qualitative assessment of the Centralised Chronic Medication Dispensing and Distribution programme in South Africa. *BMJ open*, *10*(5), p.e035412.

Du Toit, J., 2017. Alternative models for delivery of medication to stable patients on long term therapy. *SA Pharmaceutical Journal*, *84*(3), pp.56-57.

Du Toit, J., Dames, S. and Boshoff, R., 2008. Centralised dispensing-an affordable solution. *SA Pharmaceutical Journal*, *75*(10), pp.18-20.

Denzin, N., & Lincoln, Y. 2013. *Strategies of qualitative inquiry*. Sage Publications, Carlifornia.

Department of Cooperative Governance and Traditional Affairs., 2020. *City of Tshwane Profile.*

https://www.cogta.gov.za/ddm/wp-content/uploads/2020/11/Tshwane-October-2020.pdf

Davies, H., Nutley, S. and Smith, P., 2000. Introducing evidence-based policy and practice in public services. *What works*, pp.1-12.

Day, C. & Gray, A, A., 2014. Health and related indicators. In A. Padarath & R. English, eds. *South African Health Review 2013/14* . Durban, KwaZulu-Natal: Health Systems

Trust, pp. 202–350. Available at: http://www.hst.org.za/publications/south-african-health-review-2013/14 [Accessed September 1, 2015].

De Beer, C. 1986. *The South African Disease: Apartheid Health and Health Services*. Nottingham United Kingdom: Russell Press.

Department of Cooperative Governance and Traditional Affairs., 2020. *City of Tshwane Profile*. https://www.cogta.gov.za/ddm/wp-content/uploads/2020/11/Tshwane-October-2020.pdf.

Dlamini, S., 2016. COSATU is very much alive - Sidumo Dlamini. *Politics Web*. [online] Available at: http://www.politicsweb.co.za/politics/cosatu-is-very-much-alive--sidumo-dlamini [Accessed 20 Mar. 2016].

Engelbrecht, M., & Rensburg, H. 2012. Primary Healthcare: Nature and state in South Africa. In *Health and health care in South Africa* (2nd ed., pp. 51–108). Pretoria: Van Schaik Publishers.

Evans, J., 2016. Forget NHI, use the money for new clinics: DA MP. *Times Live*. [online] Available at: http://www.timeslive.co.za/politics/2016/02/17/Forget-NHI-use-the-money-for-new-clinics-DA-MP [Accessed 1 Apr. 2016].

Feucht, U.D., 2013. Keeping children alive and healthy in South Africa-how do we reach this goal? Perspectives from a paediatrician in a District Clinical Specialist Team s. *South African Journal of Child Health*, *7*(4), pp.124-126.

Feucht, U., Marshall, C., Kauchali, S., Barron, P., Slavin, L., Bhardwaj, S. and Pillay, Y., 2018. Innovations in the clinical care of mothers and children in South Africa: The contribution of district clinical specialist teams. *South African Medical Journal*, *108*(3 Supplement 1), pp. S38-S43.

Feucht, U., Van Rooyen, E., Bergh, A.M. and Skhosana, R., 2016. Taking kangaroo mother care forward in South Africa: the role of district clinical specialist teams: healthcare delivery. *South African Medical Journal*, *106*(1), pp.49-52.

Goga, A.E., Feucht, U.D., Zar, H.J., Vanker, A., Wiysonge, C.S., McKerrow, N., Wright, C.Y., Loveday, M., Odendaal, W., Ramokolo, V. and Ramraj, T., 2019. Neonatal, infant and child health in South Africa: Reflecting on the past towards a better future.

Freund, B., 2012. The South African developmental state and the first attempt to create a national health system: Another look at the Gluckman Commission of 1942–1944. *South African Historical Journal*, *64*(2), pp.170-186.

Fine, B., 2017. The continuing enigmas of social policy. In towards universal health care in emerging economies (pp. 29-59). Palgrave Macmillan, London.

Fryatt, R., Hunter, J., & Matsoso, P. 2014. Innovations in primary health care: considerations for National Health Insurance. In L. Rispel & Padarath, *South African Health Review*. Health Systems Trust, Durban.

Fusheini A, Eyles J. 2018. Achieving universal health coverage in South Africa through a district health system approach: conflicting ideologies of health care provision. *BMC Health Services Research*, 16(1):1-11.

Hassim, S. and Razavi, S., 2006. Gender and social policy in a global context: Uncovering the gendered structure of 'the social'. In *Gender and social policy in a global context* (pp. 1-39). Palgrave Macmillan, London.

Haddad, D.N., Makin, J.D., Pattinson, R.C. and Forsyth, B.W., 2016. Barriers to early prenatal care in South Africa. *International Journal of Gynecology & Obstetrics*, *132*(1), pp.64-67.

Guba, E.G. and Lincoln, Y.S., 1994. Competing paradigms in qualitative research. *Handbook of qualitative research*, *2*(163-194), p.105.

Guillemin, M. and Gillam, L., 2004. Ethics, reflexivity, and "ethically important moments" in research. *Qualitative inquiry*, *10*(2), pp.261-280.

Gaqavu, M.M. and Mash, R., 2019. The perceptions of general practitioners on National Health Insurance in Chris Hani district, Eastern Cape, South Africa. *South African Family Practice*, *61*(3), pp.102-108.

George, G., Quinlan, T., Reardon, C., & Aguilera, J. 2012. Where are we short and who are we short of? A review of the human resources for health in South Africa. *Health SA Gesondheid*, *17*(1).

Goldkuhl, G. 2012. Pragmatism vs interpretivism in qualitative information systems research. *European Journal of Information Systems*, *21*(2), 135-146.

Genesis., PwC., & Centre for Health Policy., 2019. Evaluation of phase 1 implementation of interventions in the National Health Insurance pilot districts in South Africa. NDOH10/2017-2018.

Geiger, H.J., 1993. Community-oriented primary care: the legacy of Sidney Kark. *American journal of public health*, 83(7), pp.946-947.

George, A. (2008). Nurses, community health workers, and home carers: Gendered human resources compensating for skewed health systems. *Global Public Health*, 3(sup1), 75–89. https://doi.org/10.1080/17441690801892240

Geiger, H.J., 1993. Community-oriented primary care: the legacy of Sidney Kark. *American journal of public health*, 83(7), pp.946-947.

Gray, A., Gengiah, T. and Naidoo, P., 2005. The pharmacist's assistant: a case study of a mid-level worker option: human resources. *South African Health Review*, *2005*(1), pp.162-173.

Grundlingh, N., Zewotir, T.T., Roberts, D.J. and Manda, S., 2022. Assessment of prevalence and risk factors of diabetes and pre-diabetes in South Africa. *Journal of Health, Population and Nutrition*, *41*(1), pp.1-12.

Genesis., PwC., & Centre for Health Policy., 2019. Evaluation of phase 1 implementation of interventions in the National Health Insurance pilot districts in South Africa. NDOH10/2017-2018.

Harris, B., Eyles, J., Penn-Kekana, L., Thomas, L. and Goudge, J., 2014. Adverse or acceptable: negotiating access to a post-apartheid health care contract. *Globalization and Health*, *10*(1), pp.1-14.

Harris, B., Goudge, J., Ataguba, J.E., McIntyre, D., Nxumalo, N., Jikwana, S. and Chersich, M., 2011. Inequities in access to health care in South Africa. *Journal of public health policy*, *32*(1), pp.S102-S123.

Harris, B., Eyles, J., Penn-Kekana, L., Thomas, L. and Goudge, J., 2014. Adverse or acceptable: negotiating access to a post-apartheid health care contract. *Globalization and Health*, *10*(1), pp.1-14.

Hardcastle, T.C., Samuels, C. and Muckart, D.J., 2013. An assessment of the hospital disease burden and the facilities for the in-hospital care of trauma in KwaZulu-Natal, South Africa. *World journal of surgery*, *37*(7), pp.1550-1561.

Horwitz, S., 2009. *Health and health care under apartheid*. Adler Museum of Medicine, University of the Witwatersrand.

Hassim, S. and Razavi, S., 2006. Gender and social policy in a global context: Uncovering the gendered structure of 'the social'. In *Gender and social policy in a global context* (pp. 1-39). Palgrave Macmillan, London.

Hoffmann, N., 2020. Involuntary experiments in former colonies: The case for a moratorium. *World development*, *127*, p.104805.

Hoffmann, N., 2018. When are experiments corrupt? *Journal of Contemporary African Studies*, *36*(4), pp.532-552.

Howe, A. C., Mash, R. J., & Hugo, J. F. M. (2013). Developing generalism in the South African context. *South African Medical Journal*, 103(12), 899. https://doi.org/10.7196/SAMJ.7509

Hongoro, C., Funani, I.I.N., Chitha, W. and Godlimpi, L., 2015. An assessment of private General Practitioners contracting for public health services delivery in OR Tambo District, South Africa. *Journal of Public Health in Africa*, *6*(2).

Hemmings, C., 2012. Affective solidarity: Feminist reflexivity and political transformation. *Feminist theory*, *13*(2), pp.147-161.

Hesse-Biber, S.N. and Piatelli, D., 2012. The feminist practice of holistic reflexivity. *Handbook of feminist research: Theory and praxis*, *2*, pp.557-582.

Haushofer, J., Chemin, M., Jang, C. and Abraham, J., 2020. Economic and psychological effects of health insurance and cash transfers: Evidence from a randomized experiment in Kenya. *Journal of Development Economics*, *144*, p.102416.Hoffmann, N., 2020. Involuntary experiments in former colonies: The case for a moratorium. *World development*, *127*, p.104805.

Hoffmann, N., 2018. When are experiments corrupt? *Journal of Contemporary African Studies*, *36*(4), pp.532-552.

Jobson, G., Naidoo, N., Matlakala, N., Marincowitz, G., Railton, J., McIntyre, J. A., Struthers, H. E., & Peters, R. P. H. (2020). Contextual factors affecting the integration of community health workers into the health system in Limpopo Province, South Africa. *International Health*, 12(4), 281–286. https://doi.org/10.1093/inthealth/ihz082

Jansen, F., 2020. *Explaining society: critical realism in the social sciences*. 308-310.

Jorg Michael, D. (2010). The Developmental Welfare State and Social Policy: Shifting From Basic to Universal Social Protection. *The Korean Journal of Policy Studies*, *25*(3), 147–172. https://doi.org/10.52372/kjps25308.

Jansen, F., 2020. *Explaining society: critical realism in the social sciences*. Routledge: Abingdon.

Kuhonta, E.M., 2017. The politics of health care reform in Thailand. In *towards universal health care in emerging economies* (pp. 91-118). Palgrave Macmillan, London.Mkandawire, T., 2001. Thinking about developmental states in Africa. *Cambridge journal of economics*, *25*(3), pp.289-314.

Kahn, T., 2015. Why the NHI pilot programme is failing. *Rand Daily Mail*. [online] Available at: http://www.rdm.co.za/business/2015/03/26/why-the-nhi-pilot-programme-is-failing [Accessed 1 Apr. 2016].

Khumalo, G., 2012. South Africa Pilots National Health. *SouthAfrica.info*. [online] Available at: http://www.southafrica.info/about/health/nhi-230312.htm#.VxdfzUfz7Vv [Accessed 8 Apr. 2016].

Kon, Z.R. & Lackan, N., 2008. Ethnic disparities in access to care in post-apartheid South Africa. *American Journal of Public Health*, 98(12), p.2272.

Kale, R., 1995. South Africa's Health: Restructuring South Africa's health care: dilemmas for planners. *BMj*, *310*(6991), pp.1397-1399.

Kahn, K., 2011. Population health in South Africa: dynamics over the past two decades. *Journal of public health policy*, *32*(1), pp. S30-S36.

Keeton, C., 2010. Bridging the gap in South Africa: the South African government's proposed national insurance scheme aims to tackle the stark divide in health care between rich and poor. *Bulletin of the World Health Organization*, *88*(11), pp.803-805.

Kim, Y.S., 2015. Obstacles to the response to HIV/AIDS in South Africa: Historical legacies in perception and policy environment in 1994–2006. *International Area Studies Review*, *18*(2), pp.199-215.

Kleintjes, S., Den Hollander, D.H., Pillay, S.R. and Kramers-Olen, A., 2021. Strengthening the National Health Insurance Bill for mental health needs: response from the Psychological Society of South Africa. *South African Journal of Psychology*, *51*(1), pp.134-146.

Kirkup, B., 2009. Scaling up Health Service Delivery – From pilot innovations to policies and programmes. Public Health 123, 638–639.

Kinkel, H.-F., Marcus, T., Memon, S., Bam, N., & Hugo, J. (2013). Community oriented primary care in Tshwane District, South Africa: Assessing the first phase of implementation. *African Journal of Primary Healthcare and Family Medicine*, *5*(1).

Khoza, T.R., 2017. *An exploration of the learners' perceptions, awareness and satisfaction regarding the implementation of Integrated School Health Programme (ISHP) in selected secondary schools in uMgungundlovu district, Kwazulu-Natal, South Africa* (Doctoral dissertation).

Kandala, N.B., Nnanatu, C.C., Dukhi, N., Sewpaul, R., Davids, A. and Reddy, S.P., 2021. Mapping the burden of hypertension in south africa: A comparative analysis of the national 2012 sanhanes and the 2016 demographic and health survey. *International Journal of Environmental Research and Public Health*, *18*(10), p.5445.

Kohli-Lynch, C.N., Erzse, A., Rayner, B. and Hofman, K.J., 2022. Hypertension in the South African public healthcare system: a cost-of-illness and burden of disease study. *BMJ open*, *12*(2), p.e055621.

Kok, A., Hariram, A., Webb, D. and Amod, A., 2021. Patterns of diabetes management in South Africa: baseline and 24-month data from the South African cohort of the DISCOVER study. *Journal of Endocrinology, Metabolism and Diabetes in South Africa*, *26*(2), pp.60-65.

Loeliger, K. B., Niccolai, L. M., Mtungwa, L. N., Moll, A., & Shenoi, S. V. (2016). "I Have to Push Him with a Wheelbarrow to the Clinic": Community Health Workers' Roles, Needs, and Strategies to Improve HIV Care in Rural South Africa. *AIDS Patient Care and STDs*, 30(8), 385–394. https://doi.org/10.1089/apc.2016.0096.

Lenkokile, M.R., 2016. *The implementation of the integrated school health policy in primary schools of region C in the Gauteng province* (Doctoral dissertation).

London, L., 2004. Health and human rights: What can ten years of democracy in South Africa tell us?. *Health and Human Rights*, pp.1-25.

MacDonald, M., 2012. *Status of NHI Pilot districts: 12-month progress report*. Strengthening South Africa's response to HIV and Health. Pretoria.

MacDonald, M., 2014. *Status of NHI Pilot districts: 12-month progress report*. Strengthening South Africa's response to HIV and Health. Pretoria.

MacDonald, M., 2015. *Status of NHI Pilot districts: 12-month progress report*. Strengthening

South Africa's response to HIV and Health. Pretoria.

Mail & Gaurdian., 2012. Motsoaledi launches NHI pilot programme. [online] Available at: http://mg.co.za/article/2012-03-22-national-health-insurance-coming-to-a-district-near-you [Accessed 9 Mar. 2016].

Marten, R., McIntyre, D., Travassos, C., Shishkin, S., Longde, W., Reddy, S. and Vega, J., 2014. An assessment of progress towards universal health coverage in Brazil, Russia, India, China, and South Africa (BRICS). *The Lancet*, *384*(9960), pp.2164-2171.

Maimela, E., Van Geertruyden, J.P., Alberts, M., Modjadji, S.E., Meulemans, H., Fraeyman, J. and Bastiaens, H., 2015. The perceptions and perspectives of patients and health care providers on chronic diseases management in rural South Africa: a qualitative study. *BMC health services research*, *15*(1), pp.1-12.

Marks, S. and Andersson, N., 1987. Issues in the political economy of health in Southern Africa. *Journal of Southern African Studies*, *13*(2), pp.177-186.

Masuku, M.M. and Sabela, T.P., 2020. The National Health Insurance Bill: a critical review within the South African development context. *the rest: journal of politics and development*.

Mayosi, B.M., Lawn, J.E., Van Niekerk, A., Bradshaw, D., Karim, S.S.A., Coovadia, H.M. and Lancet South Africa team, 2012. Health in South Africa: changes and challenges since 2009. *The lancet*, *380*(9858), pp.2029-2043.

Mayosi, B.M. & Benatar, S.R., 2014. Health and Health Care in South Africa—20 Years after Mandela. *New England Journal of Medicine*, 371(14), pp.1344–1353.

Mayosi, B. M., Lawn, J. E., van Niekerk, A., Bradshaw, D., Karim, S. S. A., Coovadia, H. M., & Lancet South Africa team., 2012. Health in South Africa: changes and challenges since 2009. *The Lancet*, 380(9858), pp. 2029-2043.

McCoy, D., Harrison, D., Bamford, L., Donohue, S., Nxumalo, Z. and Radebe, G., 1998. *The Development of the District Health System in South Africa: Lessons Learnt from the Experience of ISDS*. [online] Durban: Health Systems Trust. Available at: http://www.hst.org.za/sites/default/files/techrep5.pdf [Accessed 16 Mar. 2016].

McIntyre, D., 2012. The political economy of the health industry and the private health funding crisis. In G. Ruiters & R. van Niekerk , eds. *Universal Health Care in Southern Africa: Policy contestation in health system reform in South Africa and Zimbabwe* . Durban, KwaZulu-Natal: University of KwaZulu-Natal Press, pp. 136–161.

McIntyre, D., 2012. Proposal and prospects for national health insurance in South Africa. In G. Ruiters & R. van Niekerk , eds. *Universal Health Care in Southern Africa: Policy contestation in health system reform in South Africa and Zimbabwe* . Durban, KwaZulu-Natal: University of KwaZulu-Natal Press, pp. 165-185.

McIntyre, D.I. and Gilson, L., 2000. Redressing dis-advantage: promoting vertical equity within South Africa. *Health care analysis*, *8*(3), pp.235-258.

McIntyre, D., Gilson, L., Wadee, H., Thiede, M. and Okarafor, O., 2006. Commercialisation and extreme inequality in health: the policy challenges in South Africa. *Journal of International Development*, *18*(3), pp.435-446.

McIntyre, D., Doherty, J.E., & Ataguba, J.E., 2012. Healthcare financing and expenditure: Post-1994 progress and remaining challenges. In H. J. C. van Rensburg, ed. *Health and health care in South Africa*. Pretoria, Gauteng: Van Schaik Publishers, pp. 443 – 482.

Mills, A., Ataguba, J.E., Akazili, J., Borghi, J., Garshong, B., Makawia, S., Mtei, G., Harris, B., Macha, J., Meheus, F. and McIntyre, D., 2012. Equity in financing and use of health care in Ghana, South Africa, and Tanzania: implications for paths to universal coverage. *The Lancet*, *380*(9837), pp.126-133.

Mhlanga, D. and Garidzirai, R., 2020. The influence of racial differences in the demand for healthcare in South Africa: A case of public healthcare. *International journal of environmental research and public health*, *17*(14), p.5043.

Mndzebele, S. and Matsi, M., 2016. Perspectives and experiences of healthcare workers on the National Health Insurance at tertiary hospitals in the Limpopo Province, South Africa. *PULA: Botswana J Afr Stud*, *30*(1), pp.123-30.

Moodley, J. and Ross, E., 2015. Inequities in health outcomes and access to health care in South Africa: a comparison between persons with and without disabilities. *Disability & Society*, *30*(4), pp.630-644.

Mkandawire, T., 2001. Thinking about developmental states in Africa. *Cambridge journal of economics*, *25*(3), pp.289-314.

Mkandawire, T., 2005. Targeting and universalism in poverty reduction. Geneva: World Health Organization.

Mkandawire, T., 2004. Social policy in a development context: Introduction. In *Social policy in a development context* (pp. 1-33). Palgrave Macmillan, London.

Mkandawire, T., 2007. Transformative social policy and innovation in developing countries. *The European Journal of Development Research*, *19*(1), pp.13-29.

Mkandawire, T., 2012. Transformative social policy and the developmental state. *London School of Economics and Political Science*.

Mkandawire, T., 2010. How the new poverty agenda neglected social and employment policies in Africa. *Journal of Human Development and Capabilities*, *11*(1), pp.37-55.

Mkhwanazi, A. & Nkosi, S., 2014. NHI pilot district "shows signs of collapse". *The South African Health News Service*. [online] Available at: http://www.health-e.org.za/2014/08/22/nhi-pilot-district-also-shows-signs-collapse/ [Accessed 1 Apr. 2016].

Motsoaledi, A., 2014. Physician don't fool yourself - Motsoaledi replies to NHI criticism. *Mail&Gaurdian*. [online] Available at: http://mg.co.za/article/2014-02-06-physician-dont-fool-yourself [Accessed 4 Mar. 2016].

MacPhail, C., Venables, E., Rees, H. and Delany-Moretlwe, S., 2013. Using HPV vaccination for promotion of an adolescent package of care: opportunity and perspectives. *BMC Public Health*, *13*(1), pp.1-11.

Mojapelo, N., 2019. *Integrated school health implementation constraints: an inquiry into the Ekurhuleni Health and Education system* (Doctoral dissertation)

Mohlabi, D.R., Van Aswegen, E.J. and Mokoena, J.D., 2010. Barriers to the successful implementation of school health services in the Mpumalanga and Gauteng provinces. *South African Family Practice*, *52*(3).

Molete, M., Stewart, A., Bosire, E. and Igumbor, J., 2020. The policy implementation gap of school oral health programmes in Tshwane, South Africa: a qualitative case study. *BMC health services research, 20*(1), pp.1-11.

Masango Makgobela, A., Ndimande, J., Ogunbanjo, G., Bongongo, T., & Nyalunga, S. (2019). Households' satisfaction with the healthcare services rendered by a ward-based outreach team in Tshwane district, Pretoria, South Africa. *South African Family Practice*, 61(3), 75–78. https://doi.org/10.1080/20786190.2018.1524552

Magadzire, B.P., Marchal, B., Mathys, T., Laing, R.O. and Ward, K., 2017. Analyzing implementation dynamics using theory-driven evaluation principles: lessons learnt from a South African centralized chronic dispensing model. *BMC health services research, 17*(2), pp.15-23.

Magadzire, B.P., Marchal, B. and Ward, K., 2015. Improving access to medicines through centralised dispensing in the public sector: a case study of the Chronic Dispensing Unit in the Western Cape Province, South Africa. *BMC health services research*, *15*(1), pp.1-8.

Maharaj, L., 2018. *Assessment of factors affecting healthcare workers involved in the Centralised Chronic Medicines Dispensing and Distribution (CCMDD) Programme: the case of eThekwini Metropolitan Health district, South Africa* (Doctoral dissertation).

Menold, F., 2019. Centralised Chronic Medicines Dispensing & Distribution (CCMDD) supporting National Health Insurance (NHI) objectives to improve the supply of chronic medication to patients in the public sector. *SAPICS Conference*. Cape Town.

Munyikwa, E.N., 2010. *Implications of the centralised chronic dispensing unit in the Western Cape Province, South Africa* (Master's thesis, University of Cape Town).

Lloyd, Lizel G., and T. W. De Witt. "Neonatal mortality in South Africa: How are we doing and can we do better?." *South African medical journal* 103, no. 8 (2013): 518-519

Lumadi, T.G. and Matlala, M.S., 2019. Perceptions of midwives on shortage and retention of staff at a public hospital in Tshwane District. *Curationis*, *42*(1), pp.1-10.

Makua, M., & Naomi Massyn., 2020. Maternal and neonatal health. In Massyn, N., Day, C., Ndlovu, N., & Padayachee, T., eds. *District Health Barometer 2019/20*. Health Systems Trust: Durban.

Makua, M., & Naomi Massyn., 2020. Antenatal 1st visit coverage. In Massyn, N., Day, C., Ndlovu, N., & Padayachee, T., eds. *District Health Barometer 2019/20*. Health Systems Trust: Durban.

McKerrow, N., 2020. Maternal mortality in facility ratio. In Massyn, N., Day, C., Ndlovu, N., & Padayachee, T., eds. *District Health Barometer 2019/20*. Health Systems Trust: Durban.

McKerrow, N., 2020. Neonatal death in facility rate. In Massyn, N., Day, C., Ndlovu, N., & Padayachee, T., eds. *District Health Barometer 2019/20*. Health Systems Trust: Durban.

Mabaso, M.H., Ndaba, T. and Mkhize-Kwitshana, Z.L., 2014. Overview of maternal, neonatal and child deaths in South Africa: challenges, opportunities, progress and future prospects. *International Journal of MCH and AIDS*, *2*(2), p.182.

Moodley, J., Fawcus, S. and Pattinson, R., 2018. Improvements in maternal mortality in South Africa. *South African Medical Journal*, *108*(3), pp.4-8.

Macdonald. 2015. *Status of NHI Pilot districts: 12-month progress report*. Pretoria: National Department of Health. Pretoria.

Macdonald. 2014. *Status of NHI Pilot districts: 12-month progress report*. Pretoria: National Department of Health. Pretoria.

Maitland, R. 2010. *City tourism: national capital perspectives. Cambridge, Massachusetts.*

Mathew, S. and Mash, R., 2019. Exploring the beliefs and attitudes of private general practitioners towards national health insurance in Cape Town, South Africa. *African journal of primary health care & family medicine*, *11*(1), pp.1-10.

McIntyre, D., & Ataguba, J. 2014. *Access to quality health care in South Africa: Is the health sector contributing to addressing the inequality challenge?* (pp. 1-86). Cape Town: Health Economics Unit, University of Cape Town.

Mureithi, L., Burnett, J., Bertscher, A., & English, R. 2018. Emergence of three general practitioner contracting-in models in South Africa: a qualitative multi-case study. *International Journal for Equity in Health*, *17*(1), 1-18.

Moosa, S., Carmichael, T., Luiz, J., Peersman, W. and Derese, A., 2016. Insights of private general practitioners in group practice on the introduction of National Health Insurance in South Africa. *African Journal of Primary Health Care and Family Medicine*, *8*(1), pp.1-6.

Moosa, S., Peersman, W., Derese, A., Kidd, M., Pettigrew, L.M., Howe, A., Martinez-Bianchi, V. and De Maeseneer, J., 2018. Emerging role of family medicine in South Africa. *BMJ global health*, *3*(Suppl 3),

Moosa, S., 2022. Community-oriented primary care for National Health Insurance in South Africa. *African Journal of Primary Health Care & Family Medicine*, *14*(1), pp.1-4.

Moosa, S., Carmichael, T. and Luiz, J.M., 2012. Introducing a National Health Insurance system in South Africa: a general practitioner's bottom-up approach to costing. *South African Medical Journal*, *102*(10), pp.794-797.

Moosa, S., 2014. A path to full-service contracting with general practitioners under National Health Insurance: correspondence. *South African Medical Journal*, *104*(3), pp.155-156.

Musonda, J.M. and Moosa, S., Private General Practitioners' Agreement on Skills and Competencies for Universal Health Coverage in Urban South Africa-A Descriptive Cross-Sectional Survey.

Mukudu, H., Otwombe, K., Fusheini, A. and Igumbor, J., 2020. Contracting of private medical practitioners in a National Health Insurance pilot district: What has been the effect on primary healthcare utilisation indicators? *African Journal of Primary Health Care and Family Medicine*, *12*(1), pp.1-10.

Mkandawire, T., 2005. Targeting and universalism in poverty reduction. Geneva: World Health Organization.

Mkandawire, T., 2004. Social policy in a development context: Introduction. In *Social policy in a development context* (pp. 1-33). Palgrave Macmillan, London.

Mkandawire, T., 2007. Transformative social policy and innovation in developing countries. *The European Journal of Development Research*, *19*(1), pp.13-29.

Mkandawire, T., 2012. Transformative social policy and the developmental state. *London School of Economics and Political Science*.

Mkandawire, T., 2010. How the new poverty agenda neglected social and employment policies in Africa. *Journal of Human Development and Capabilities*, *11*(1), pp.37-55.

MacGregor, S., 2017. Universalism and Health: The Battle of Ideas. In *towards universal health care in emerging economies* (pp. 61-88). Palgrave Macmillan, London.

Mackintosh, M., 2005. Commercialization of health care: global and local dynamics and policy responses: Introduction. *In Commercialization of health care: global and local dynamics and policy responses* (pp. 5-20) Palgrave Macmillan, London.

Mongkhonvanit, P.T. and Hanvoravongchai, P., 2017. The impacts of universalization: A case study on Thailand's social protection and universal health coverage. In *towards universal health care in emerging economies* (pp. 119-154). Palgrave Macmillan, London.

Murphy, E. and Dingwall, R., 2017. *Qualitative methods and health policy research*. Routledge, New York.

Milewa, T. and Barry, C., 2005. Health policy and the politics of evidence. *Social Policy & Administration*, *39*(5), pp.498-512.

Naidoo, S., 2012. The South African national health insurance: a revolution in health-care delivery! *Journal of Public Health*, 34(1), pp. 149-150.

National Department of Health. 2011. *National Health Insurance in South Africa: Policy paper*. Green Paper (pp. 1-35). Pretoria: National Department of Health.

National Department of Health. 2015. *National Health Insurance for South Africa: Towards Universal Health Care.* White Paper (pp. 1-40). National Department of Health, Pretoria.

National Department of Health., 2022. *National Health Insurance Bill*. Parliament of the Republic of South Africa. https://www.parliament.gov.za/project-event-details/54

National Department of Health., 2019. *National Health Insurance*. National Health Insurance Bill. National Department of Health Pretoria.

National Department of Health & Department of Basic Education., (2012). Integrated School Health Policy. https://serve.mg.co.za/content/documents/2017/06/14/integratedschoolhealthpolicydbeanddoh.pdf

National Department of Health., 2021. *Annual Report 2020/2021*. ISBN: 978-0-621-49712-0 Pretoria.

National Department of Health., 2021*. South African maternal, prenatal and neonatal health policy*. Pretoria. https://www.knowledgehub.org.za/elibrary/south-african-maternal-perinatal-and-neonatal-health-policy.

National Department of Health., 2022. Annual performance plan 2021/22. Pretoria.

https://www.health.gov.za/wp-content/uploads/2021/10/Annual-Performance-Plan-2021-2022-1.pdf.

Ndimande, J., Ogunbanjo, G., Nyalunga, S., Masango-Makgobela, A., & Bongongo, T. (2019). Community healthcare workers' satisfaction with ward-based outreach team

services in Tshwane district, South Africa. *South African Family Practice*, 61(5), 172–176.

Ndou, T., van Zyl, G., Hlahane, S., & Goudge, J. (2013). A rapid assessment of a community health worker pilot programme to improve the management of hypertension and diabetes in Emfuleni sub-district of Gauteng Province, South Africa. *Global Health Action*, 6(1), 19228. https://doi.org/10.3402/gha.v6i0.19228

Ngcobo, S., & Rossouw, T. (2020). "They come and knock at the gate until the neighbours see". Perceived barriers and benefits of implementing HIV care at the community level in Tshwane district: A qualitative study. *PLOS ONE*, 15(10).

Nathan, R. and Rautenbach, P., 2013. Risks identified in implementation of district clinical specialist teams. *SAMJ: South African Medical Journal*, *103*(3), pp.144-146.

Naidoo, S. 2012. The South African national health insurance: a revolution in health-care delivery!. *Journal of Public Health*, *34*(1), 149-150.

National Department of Health. 2018. *National Health Insurance Bill* (pp. 1-31). National Department of Health, Pretoria.

National Department of Health. 2019. *Evaluation of Phase 1 implementation of interventions in the National Health Insurance (Nhi) pilot districts in South Africa. Evaluation of Phase 1 implementation of interventions in the National Health Insurance (NHI) pilot districts in South Africa.* National Department of Health. Pretoria.

Norman N & Lincoln, Y. 2003. *Introduction: The Discipline and Practice of Qualitative*. Sage Publications. London.

South African Government. 1994. *The Reconstruction and Development Programme*. National Government, Pretoria.

National Department of Health., 2011. *National Health Insurance in South Africa: Policy paper*. Pretoria: Department of Health. Available at: http://www.gov.za/sites/www.gov.za/files/nationalhealthinsurance.pdf [Accessed July 29, 2015].

National Department of Health., (2015). *National Health Insurance For South Africa: Towards Universal Health care*. White Paper, (2015). [online] Available at:

http://www.gov.za/sites/www.gov.za/files/39506_gon1230.pdf [Accessed 15 Dec. 2015].

National Department of Health., (2017). *National Health Insurance*. National Health Insurance Bill. National Department of Health Pretoria.

National Department of Health., 2011. National Health Insurance in South Africa: Green Paper. Policy. Pretoria: National Department of Health Department.

National Department of Health., 2015. National Health Insurance for South Africa: towards Universal Health care. *White Paper*. National Department of Health. Pretoria.

National Department of Health., 2021. *2030 Human Resources for Health Strategy: Investing in the Health Workforce for Universal Health Coverage*. National Department of Health. Pretoria.

National Treasury., 2022. *Provincial budget and expenditure review*. Pretoria. National Treasury. 2015/16 – 2022/23.

National Treasury., 2021. *Adjusted Estimates of National Expenditure 2021.* Pretoria. National Treasury. ISBN: 978-0-621-49626-2.

National Treasury., 2021. *Budget Review 2021*. Pretoria. National Treasury. ISBN: 978-0-621-49079-4.

Naidoo, S., 2012. The South African national health insurance: a revolution in health-care delivery! *Journal of Public Health*, 34(1), pp. 149-150.

Ogunbanjo, G., 2013. What is the status quo of South Africa's National Health Insurance pilot project? *South African Family Practice*, 55(4), pp. 301–301.

Ouma, M., 2020. Social protection policymaking in Kenya. *Africa Development/Afrique et Développement*, *45*(2), pp.125-142.

Ouma, M. and Adésínà, J., 2019. Solutions, exclusion and influence: exploring power relations in the adoption of social protection policies in Kenya. *Critical Social Policy*, *39*(3), pp.376-395.

O'Donovan, J., Hamala, R., Nalubwama, M., Ameniko, M., Govina, G., Gray, N., Panjabi, R., Palazuelos, D. and Namanda, A.S., 2021. Roles for mHealth to support Community Health Workers addressing COVID-19. *Global Health Promotion*, 28(1), pp.60-64.

Oboirien, K.O., Harris, B., Eyles, J., Goudge, J., Orgill, M., McIntyre, D. and Chimbindi, N., 2014. Understanding roles, enablers and challenges of District Clinical Specialist Teams in strengthening primary health care in South Africa. *South African health review*, *2014*(1), pp.45-55.

Oboirien, K., Harris, B., Goudge, J. and Eyles, J., 2018. Implementation of district-based clinical specialist teams in South Africa: Analysing a new role in a transforming system. *BMC health services research*, *18*(1), pp.1-14.

Oboirien, K., Goudge, J., Harris, B. and Eyles, J., 2019. Can institutional entrepreneurship strengthen clinical governance and quality improvement: a case study of a district-based clinical specialist team in South Africa. *Health Policy and Planning*, *34*(Supplement_2), pp.ii121-ii134.

Ouma, M., 2020. Social protection policymaking in Kenya. *Africa Development/Afrique et Développement*, *45*(2), pp.125-142.

Ouma, M. and Adésínà, J., 2019. Solutions, exclusion and influence: Exploring power relations

in the adoption of social protection policies in Kenya. Critical Social Policy, 39(3),

pp.376-395.

Ormston, R., Spencer, L., Barnard, M. and Snape, D., 2014. The foundations of qualitative research. *Qualitative research practice: A guide for social science students and researchers*, *2*(7), pp.52-55.

Ogunbanjo, G., 2013. What is the status quo of South Africa's National Health Insurance pilot project? *South African Family Practice*, 55(4), pp. 301–301.

Ouma, M., 2020. Social protection policymaking in Kenya. *Africa Development* *45*(2), pp.125-142.

Ouma, M. and Adésínà, J., 2019. Solutions, exclusion and influence: exploring power relations in the adoption of social protection policies in Kenya. *Critical Social Policy*, *39*(3), pp.376-395.

Ogunbanjo, G., 2013. What is the status quo of South Africa's National Health Insurance pilot project? *South African Family Practice*, *55*(4), pp. 301–301.

Otwombe, K., Munsamy, M., Dheda, M., Ramdas, N., Herbst, C., Pillay, M., van Tonder, T., Serenata, C. and Lalla-Edward, S., 2022. Tracking adverse drug reactions and medication errors in the Central Chronic Medicine Dispensing and Distribution (CCMDD) programme in South Africa. *Southern African Journal of HIV Medicine*, *23*(1), p.8.

Pawson, R., 2006. *Evidence-based policy: a realist perspective*. SAGE, London ; Thousand Oaks, California.

Phiri, M.Z., Molotja, N., Makelane, H., Kupamupindi, T. and Ndinda, C., 2016. Inclusive innovation and inequality in South Africa: a case for transformative social policy. *Innovation and Development*, *6*(1), pp.123-139.

Phillips, H. (2014). The Return of the Pholela Experiment: Medical History and Primary Health Care in Post-Apartheid South Africa. *American Journal of Public Health*, 104(10), 1872–1876. https://doi.org/10.2105/AJPH.2014.302136

Peu, M.P., Mataboge, S., Ngunyulu, R., Mulaudzi, F.M. and Moloko Phiri, S.S., 2015. Challenges experienced by healthcare providers with regard to the provision of school healthcare services in Tshwane sub-district, Gauteng province. *Africa Journal of nursing and Midwifery*, *17*(sup-1), pp.201-221.

Phiri, M.Z., Molotja, N., Makelane, H., Kupamupindi, T. and Ndinda, C., 2016. Inclusive innovation and inequality in South Africa: a case for transformative social policy. *Innovation and Development*, *6*(1), pp.123-139.

Pope, C. and Mays, N. eds., 2020. *Qualitative research in health care*. Wiley Blackwell, Oxford.

Pawson, R., 2006. *Evidence-based policy: a realist perspective*. SAGE, London ; Thousand Oaks, California.

Petryna, A., 2009. *When experiments travel: clinical trials and the global search for human subjects*. Princeton University Press, Princeton.

Petryna, A., 2007. Experimentality: On the Global Mobility and Regulation of Human Subjects Research. *Political and Legal Anthropology Review*, 30, pp. 288–304

Pillay-van Wyk, V., Bradshaw, D., Groenewald, P., Seocharan, I., Manda, S., Roomaney, R.A., Awotiwon, O., Nkwenika, T., Gray, G., Buthelezi, S.S. and Mkhize, Z.L., 2020. COVID-19 deaths in South Africa: 99 days since South Africa's first death. *SAMJ: South African Medical Journal*, *110*(11), pp.1093-1099.

Pretorious, E., 2004. Complementary/ Alternative and Traditional Health Care in South Africa. In H. J. C. van Rensburg, ed. *Health and health care in South Africa* . Pretoria, Gauteng: Van Schaik Publishers, pp. 506–559.

Rayzberg, M.S., 2019. Fairness in the field: The ethics of resource allocation in randomized controlled field experiments. *Science, Technology, & Human Values*, *44*(3), pp.371-398.

Razavi S, Hassim S. (2006). Gender and Social Policy in a Global Context: Uncovering the Gendered Structure of 'the Social'. In: Razavi S, Hassim S, ed. by. Gender and Social Policy in a Global Context Uncovering the Gendered Structure of 'the Social'. 1st ed. Geneva: Palgrave Macmillan; 2006. p. 1 - 42.

Roggers-Dillion, R., 2004. *The Welfare experiments: politics and policy Evaluation*. 1st ed. California: Stanford University Press.

Rottenburg, R., 2014. Experimental engagements and metacodes. *Common Knowledge*, *20*(3), pp.540-548.

Rottenburg, R., 2009. *Far-fetched facts: A parable of development aid*. MIT Press.

Rottenburg, R., 2009. Social and public experiments and new figurations of science and politics in postcolonial Africa. *Postcolonial Studies*, *12*(4), pp.423-440.

Rottenburg, R., Merry, S.E., 2015. A world of indicators: The making of governmental knowledge through quantification, in Rottenburg, R., Merry, S.E., Park, S.-J.,

Mugler, J. (Eds.), *The World of Indicators*. Cambridge University Press, Cambridge, pp. 1–33.

Ruiters, G., Shamu, S., van Niekerk, R & McIntyre, D., 2012. Competing policy choices and the debate on national health insurance in South Africa. In G. Ruiters & R. van Niekerk , eds. *Universal Health Care in Southern Africa: Policy contestation in health system reform in South Africa and Zimbabwe* . Durban, KwaZulu-Natal: University of KwaZulu-Natal Press, pp. 21-40.

Ramalepa, T.N., Matshoge, G.P. and Ramukumba, T.S., 2022. Challenges to ethical integration of reproductive health education in schools of Tshwane District, South Africa. *African Journal of Reproductive Health*, *26*(4), pp.75-81.

Ramukumba, T.S., Rasesemola, R.M. and Matshoge, G.P., 2019. Compliance to the integrated school health policy: Intersectoral and multisectoral collaboration. *Curationis*, *42*(1), pp.1-8.

Rhoda, N.R., Velaphi, S., Gebhardt, G.S., Kauchali, S. and Barron, P., 2018. Reducing neonatal deaths in South Africa: Progress and challenges. *South African Medical Journal*, *108*(3), pp.9-16.

Rispel, L., & Barron, P. 2012. Valuing human resources: Key to the success of a national health insurance system. *Development Southern Africa*, *29*(5), 616-635.

Rispel, L., Blaauw, D., & Ditlopo, J. 2018. Human resources for health and universal health coverage: progress, complexities and contestations. In L. Rispel & A. Padarath, *South African Health Review*. Durban: Health Systems Trust. Retrieved from http://www.hst.org.za/publications/Pages/SAHR2018

Ritchie, J., & Lewis, J. 2003. *Qualitative research practice: a guide for social science students and researchers.* (1st ed.). London: Sage Publications.

Razavi S, Hassim S. (2006). Gender and Social Policy in a Global Context: Uncovering the Gendered Structure of 'the Social'. In: Razavi S, Hassim S, ed. by. Gender and Social Policy in a Global Context Uncovering the Gendered Structure of 'the Social'. 1st ed. Geneva: Palgrave Macmillan; 2006. p. 1 - 42.

Rossman, G.B. and Rallis, S.F., 2010. Everyday ethics: Reflections on practice. *International Journal of Qualitative Studies in Education*, *23*(4), pp.379-391.

Ritchie, J., Lewis, J., Nicholls, C.M. and Ormston, R. eds., 2013. *Qualitative research practice: A guide for social science students and researchers*. Sage Publications, Los Angels.

Ruiters, G., Shamu, S., van Niekerk, R & McIntyre, D., 2012. Competing policy choices and the debate on national health insurance in South Africa. In G. Ruiters & R. van Niekerk , eds. *Universal Health Care in Southern Africa: Policy contestation in health system reform in South Africa and Zimbabwe*. Durban, KwaZulu-Natal: University of KwaZulu-Natal Press, pp. 21-40.

Rajagopalan, R., Deodurg, P.M. and Badgal, S., 2013. Overview of randomized controlled trials. *Asian J Pharm Clin Res*, *6*(3), pp.32-33.

Rayzberg, M.S., 2019. Fairness in the field: The ethics of resource allocation in randomized controlled field experiments. *Science, Technology, & Human Values*, *44*(3), pp.371-398.

Roggers-Dillion, R., 2004. *The Welfare experiments: politics and policy Evaluation*. 1st ed. California: Stanford University Press.

Rottenburg, R., 2014. Experimental engagements and metacodes. *Common Knowledge*, *20*(3), pp.540-548.

Rottenburg, R., 2009. *Far-fetched facts: A parable of development aid*. MIT Press.

Rottenburg, R., 2009. Social and public experiments and new figurations of science and politics in postcolonial Africa. *Postcolonial Studies*, *12*(4), pp.423-440.

Rottenburg, R., Merry, S.E., 2015. A world of indicators: The making of governmental knowledge through quantification, in Rottenburg, R., Merry, S.E., Park, S.-J., Mugler, J. (Eds.), *The World of Indicators*. Cambridge University Press, Cambridge, pp. 1–33.

Rao, K. D., Petrosyan, V., Araujoc, E. C., & McIntyre, D., 2014. Progress towards universal health coverage in BRICS: translating economic growth into better health. *Policy & Practice*, 92, pp. 429-435.

Republic of South Africa., 1996. Constitution of the Republic of South Africa, Section 27 (a) of 1996. *Government Gazette*, 378. Available at: http://inkomaticma.co.za/images/Constitution_of_the_Republic_of_South_Africa_1996.pdf [Accessed August 9, 2015].

Roggers-Dillion, R., 2004. *The Welfare Experiments: Politics and Policy Evaluation*. 1st ed. California: Standford University Press.

Ruiters, G., Shamu, S., van Niekerk, R & McIntyre, D., 2012. Competing policy choices and the debate on national health insurance in South Africa. In G. Ruiters & R. van Niekerk , eds. *Universal Health Care in Southern Africa: Policy contestation in health system reform in South Africa and Zimbabwe* . Durban, KwaZulu-Natal: University of KwaZulu-Natal Press, pp. 21-40.

Setswe, G., Witthuhn, J., Muyanga, S. and Nyasulu, P., 2016. The new national health insurance policy in South Africa: public perceptions and expectations. *International Journal of Healthcare Management*, *9*(2), pp.77-82.

Smith, K., 2013. *Beyond Evidence-Based Policy in Public Health*. Palgrave Macmillan, London.

Simmons, R. and Shiffman, J., 2007. Scaling up health service innovations: a framework for action. *Scaling up health service delivery: from pilot innovations to policies and programmes. Geneva: World Health Organization*, pp.1-30.

Solanki, G.C., Myburgh, G., Wild, S., Cornell, J.E. and Brijlal, V., 2022. Thematic analysis of the challenges and options for the Portfolio Committee on Health in reviewing the National Health Insurance Bill. *South African Medical Journal*, *112*(7), pp.456-464.

Solanki, G.C., Cornell, J.E., Wild, S., Morar, R.L. and Brijlal, V., 2022. The role of the Minister of Health in the National Health Insurance Bill: Challenges and options for

the Portfolio Committee on Health. *SAMJ: South African Medical Journal*, *112*(5), pp.317-320.

Solanki, G.C., Cornell, J.E., Morar, R.L. and Brijlal, V., 2021. The National Health Insurance Bill: Responses and options for the Portfolio Committee on Health. *South African Medical Journal*, *111*(9), pp.812-813.

Sutcliffe, S. and Court, J., 2005. *Evidence-Based Policymaking: What is it? How does it work? What relevance for developing countries*. Overseas Development Institute.

Strydom, W.F., Funke, N., Nienaber, S., Nortje, K. and Steyn, M., 2010. Evidence-based policymaking: a review. *South African Journal of Science*, *106*(5), pp.1-8.

Schatz, E. J. (2007). ``Taking care of my own blood'': Older women's relationships to their households in rural South Africa. *Scandinavian Journal of Public Healt*h, 35(69_suppl), 147–154. https://doi.org/10.1080/14034950701355676

Shaikh, N., Grimwood, A., Eley, B., Fatti, G., Mathews, C., Lombard, C. and Galea, S., 2021. Delivering an integrated sexual reproductive health and rights and HIV programme to high-school adolescents in a resource-constrained setting. *Health Education Research*, *36*(3), pp.349-361.

Shung-King, M., Orgil, M., & Slemming., W., (2014). School Health in South Africa: reflections on the past and prospects for the future. *South African Health Review 2013/14*. Health Systems Trust.

Shung-King, M., 2013. From'stepchild of primary healthcare'to priority programme: Lessons for the implementation of the National Integrated School Health Policy in South Africa. *South African Medical Journal*, *103*(12), pp.895-898.

Shung-King, M., Zuhlke, L., Engel, M.E. and Mayosi, B.M., 2016. Asymptomatic rheumatic heart disease in South African schoolchildren: implications for addressing chronic health conditions through a school health service: in practice. *South African Medical Journal*, *106*(8), pp.761-762.

Shuro, L. and Waggie, F., 2021. A vibrant reflection of the revised integrated school health policy with a lens on substance use. *African Journal of Primary Health Care & Family Medicine*, *13*(1), p.3082.

Smith, K.G. and Nicol, E., 2020. Process evaluation of the central chronic medicines dispensing and distribution programme in Namakwa district, Northern Cape province protocol: a multimethod approach. *BMJ open*, *10*(2), p.e032530.

Piotie, P.N., Webb, E.M. and Rheeder, P., 2021. Suboptimal control for patients with type 2 diabetes in the Central Chronic Medicine Dispensing programme in South Africa. *African Journal of Primary Health Care & Family Medicine*, *13*(1), pp.1-7.

Samodien, E., Abrahams, Y., Muller, C., Louw, J. and Chellan, N., 2021. Non-communicable diseases-a catastrophe for South Africa. *South African Journal of Science*, *117*(5-6), pp.1-6.

Statistics South Africa., 2021. *Mid-year population estimates 2020*. Statistical Release P0302. Pretoria.

Steel, G., 2014. Alternative Chronic Medicine Access Programme for Public Sector Patients. *National Department of Health*. Pretoria.

Silal, S.P., Penn-Kekana, L., Harris, B., Birch, S. and McIntyre, D., 2012. Exploring inequalities in access to and use of maternal health services in South Africa. *BMC health services research*, *12*(1), pp.1-12.

Smith, A., Ranchod, S., Strugnell, S., & Wishnia, J. 2018. Human resources for health planning and National Health Insurance: the urgency and the opportunity. In R. L & P. A, *South African Health Review*. Durban: Health Systems Trust.

Surender, R., Van Niekerk, R. and Alfers, L., 2016. Is South Africa advancing towards National Health Insurance? The perspectives of general practitioners in one pilot site. *South African Medical Journal*, *106*(11), pp.1092-1095.

Surender, R., Van Niekerk, R., Hannah, B., Allan, L. and Shung-King, M., 2015. The drive for universal healthcare in South Africa: views from private general practitioners. *Health Policy and planning*, *30*(6), pp.759-767

Sen, A., 2015. Universal Health Care. *Harvard Public Health Review*, *5*, pp.1-8.

Somkotra, Tewarit, and Leizel P. Lagrada. 2008. Payments for health care and its effect on catastrophe and impoverishment: Experience from the transition to universal coverage in Thailand. *Social Science & Medicine* 67: 2027–2035.

Smith, K., 2013. *Beyond Evidence-Based Policy in Public Health*. Palgrave Macmillan, London.

Simmons, R. and Shiffman, J., 2007. Scaling up health service innovations: a framework for action. *Scaling up health service delivery: from pilot innovations to policies and programmes. Geneva: World Health Organization*, pp.1-30.

Sutcliffe, S. and Court, J., 2005. *Evidence-Based Policymaking: What is it? How does it work? What relevance for developing countries*. Overseas Development Institute.

Strydom, W.F., Funke, N., Nienaber, S., Nortje, K. and Steyn, M., 2010. Evidence-based policymaking: a review. *South African Journal of Science*, *106*(5), pp.1-8.

Sekhejane, P. R., 2013. South African National Health Insurance (NHI) Policy. *Africa Institute of South Africa Policy brief*, 102, pp.1-4.

Setswe, G., Witthuhn, J., Muyanga, S. and Nyasulu, P., 2016. The new national health insurance policy in South Africa: public perceptions and expectations. *International Journal of Healthcare Management*, *9*(2), pp.77-82.

Smith, K., 2013. Beyond Evidence-Based Policy in Public Health. Palgrave Macmillan UK, London. https://doi.org/10.1057/9781137026583.

Stellenberg, E.L., 2015. Accessibility, affordability and use of health services in an urban area in South Africa. *Curationis*, *38*(1), pp.1-7.

Spaull, N. and Van der Berg, S., 2020. Counting the cost: COVID-19 school closures in South Africa and its impact on children. *South African Journal of Childhood Education*, *10*(1), pp.1-13.

Schierenbeck, I., Johansson, P., Andersson, L. and van Rooyen, D., 2013. Barriers to accessing and receiving mental health care in Eastern Cape, South Africa. *Health & Hum. Rts.*, *15*, p.110.

Solanki, G.C., Myburgh, G., Wild, S., Cornell, J.E. and Brijlal, V., 2022. Thematic analysis of the challenges and options for the Portfolio Committee on Health in reviewing the National Health Insurance Bill. *South African Medical Journal*, *112*(7), pp.456-464.

Solanki, G.C., Cornell, J.E., Wild, S., Morar, R.L. and Brijlal, V., 2022. The role of the Minister of Health in the National Health Insurance Bill: Challenges and options for the Portfolio Committee on Health. *SAMJ: South African Medical Journal*, *112*(5), pp.317-320.

Solanki, G.C., Cornell, J.E., Morar, R.L. and Brijlal, V., 2021. The National Health Insurance Bill: Responses and options for the Portfolio Committee on Health. *South African Medical Journal*, *111*(9), pp.812-813.

Stuckler, D., Basu, S. and McKee, M., 2011. Health care capacity and allocations among South Africa's provinces: infrastructure–inequality traps after the end of apartheid. *American journal of public health*, *101*(1), pp.165-172.

Susser, M. and Cherry, V.P., 1982. Health and health care under apartheid. *Journal of Public Health Policy*, *3*(4), pp.455-475.

Teele, D.L. (Ed.), 2014. *Field experiments and their critics: essays on the uses and abuses of experimentation in the social sciences*, The Yale ISPS series. Yale University Press, New Haven.

Tilley, H., 2011. *Africa as a living laboratory: empire, development, and the problem of scientific knowledge*, 1870-1950. University of Chicago Press, Chicago.

Tekwa., 2020. *Gender, land reform and welfare outcomes: a case study of Chiredzi District, Zimbabwe.* PhD Thesis. University of South Africa.

Tom T., 2020. *The wider vision of social policy: an analysis of the transformative role of the fast track land reform programme in Zimba District (Zimbabwe).* PhD Thesis. University of South Africa.

Thomas, L.S., Buch, E. and Pillay, Y., 2021. An analysis of the services provided by community health workers within an urban district in South Africa: a key contribution towards universal access to care. *Human resources for health*, 19(1), pp.1-11.

Tatiah, N., Moodley, I., Denny, L., Moodley, J., & Waasila, J., (2014). Cervical cancer in South Africa: challenges and opportunities. South African Health Review 2013/14. Health Systems Trust.

Tshotetsi, L., Dzikiti, L., Hajison, P. and Feresu, S., 2019. Maternal factors contributing to low birth weight deliveries in Tshwane District, South Africa. *PloS one*, *14*(3), p.e0213058.

Tongco, M. 2007. Purposive Sampling as a Tool for Informant Selection. *Ethnobotany Research and Applications*, *5*, 147.

Tekwa, N. and Adesina, J., 2018. Gender, poverty and inequality in the aftermath of Zimbabwe's land reform: A transformative social policy perspective. *Journal of International Women's Studies*, *19*(5), pp.45-62.

Tekwa., 2020. *Gender, land reform and welfare outcomes: a case study of Chiredzi District, Zimbabwe.* PhD Thesis. University of South Africa.

Tom T., 2020. *The wider vision of social policy: an analysis of the transformative role of the fast track land reform programme in Zimba District (Zimbabwe).* PhD Thesis. University of South Africa.

Teele, D.L. (Ed.), 2014. *Field experiments and their critics: essays on the uses and abuses of experimentation in the social sciences*, The Yale ISPS series. Yale University Press, New Haven.

Thornton, R.L., Hatt, L.E., Field, E.M., Islam, M., Solís Diaz, F. and González, M.A., 2010. Social security health insurance for the informal sector in Nicaragua: a randomized evaluation. *Health economics*, *19*(S1), pp.181-206.

Tilley, H., 2011. *Africa as a living laboratory: empire, development, and the problem of scientific knowledge, 1870-1950.* University of Chicago Press, Chicago.

Tandwa, L.A. and Dhai, A., 2020. Public engagement in the development of the National Health Insurance: a study involving patients from a central hospital in South Africa. *BMC public health*, *20*(1), pp.1-9.

United Nations Research Institute for Social Development., 2006. Transformative Social Policy: lessons from UNRISD Research. *Policy Brief UNRISD/RPB5e/06/4.* Switzerland. United Nations Research Institute for Social Development.

Uys, L. R. (2002a). The practice of community caregivers in a home-based HIV/AIDS project in South Africa. *Journal of Clinical Nursing*, 11(1), 99–108. https://doi.org/10.1046/j.1365-2702.2002.00566.x

Udjo, E.O. and Lalthapersad-Pillay, P., 2014. Estimating maternal mortality and causes in South Africa: national and provincial levels. *Midwifery*, *30*(5), pp.512-518.

Vreugdenhil, H. and Rault, P.K., 2010. Pilot Projects for evidence-based policy-making: three pilot projects in the Rhine Basin. *German Policy Studies*, *6*(2), pp.115-151.

van Niekerk, R., 2003. The evolution of health and welfare policies in South Africa: inherited institutions, fiscal restraint, and the deracialization of social policy in the post-apartheid era. *The Journal of African American History*, *88*(4), pp.361-376.

van Niekerk, R., 2012. Revisiting history: the creation of provinces and the politics of social policy in a democratic South Africa. *Social Policy & Administration*, *46*(6), pp.619-635.

van den Heever, A.M., 2012, June. The role of insurance in the achievement of universal coverage within a developing country context: South Africa as a case study. In *BMC public health* (Vol. 12, No. 1, pp. 1-13). BioMed Central.

van Rensburg, H.C.J., 2004. History of Health Care in South Africa. In H. J. C. van Rensburg, ed. *Health and health care in South Africa*. Pretoria, Gauteng: Van Schaik Publishers, pp. 51-108.

van Rensburg, H. C., 2014. South Africa's protracted struggle for equal distribution and equitable access–still not there. *Human Resources for Health*, 12(26), pp. 1-16.

van Rensburg, H.C.J., 1991. South African health care in change. *South African Journal of Sociology*, 22(1), pp.1–10.

van de Ruit, C. (2019). Unintended Consequences of Community Health Worker Programs in South Africa. *Qualitative Health Research*, 29(11), 1535–1548.

van Ginneken, N., Lewin, S., & Berridge, V. (2010). The emergence of community health worker programmes in the late apartheid era in South Africa: An historical analysis. *Social Science & Medicine*, 71(6), 1110–1118.

Voce, A., Bhana, R., Monticelli, F., Makua, M., Pillay, Y., Ngubane, G. and Kauchali, S., 2013. District clinical specialist teams. *South African health review*, *2013*(1), pp.45-58.

Wabiri, N., Chersich, M., Shisana, O., Blaauw, D., Rees, H. and Dwane, N., 2016. Growing inequities in maternal health in South Africa: a comparison of serial national household surveys. *BMC pregnancy and childbirth*, *16*(1), pp.1-12.

World Health Organization & United Nations Children's Fund. 1978. Alma-Ata 1978 Primary Health Care. World Health Organization, Geneva.

Wasserfall, R., 1993. Reflexivity, feminism and difference. *Qualitative Sociology*, *16*(1), pp.23-41.

Webber GC, Chirangi BM. In support of community-based primary health care: coping with the COVID-19 crisis. *African Journal of Reproductive Health*. 2020 Aug 26;24(2):64-5.

Wells, K.J., Dwyer, A.J., Calhoun, E. and Valverde, P.A., 2021. Community health workers and non-clinical patient navigators: A critical COVID-19 pandemic workforce. *Preventive Medicine*, 146, p.106464.

Yin, R.K., 2003. *Case Study Research: Design and Methods*, SAGE Publications.

Yi, I., 2013. Universalism from Transformative Social Policy Perspective. *Combating poverty and inequality*. United Nations Institute for Social Development.

Yi, I. and Kim, T., 2015. Post 2015 Development Goals (SDGs) and transformative social policy. *Oughtopia*, *30*(1), pp.307-335.

Yi, I., 2014. How Could the Enhancement of Education and Health Contribute to Economic Growth in South Korea?. In *Learning from the South Korean Developmental Success* (pp. 172-194). Palgrave Macmillan, London.