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Post Covid-19 conversations on health care provision, pandemic preparedness and responsiveness for rural communities and townships

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Abstract
The COVID-19 pandemic severely exposed and exacerbated pre-existing structural health vulnerabilities and service inequalities within South Africa's healthcare system, particularly in high-density urban townships and geographically isolated rural communities. These areas faced critical challenges in accessing essential services, including testing, vaccination, and consistent medical support. This paper conducts a qualitative, exploratory study to synthesize the lessons learned regarding routine healthcare provision, system preparedness, and emergency responsiveness through the perspectives of those most affected. The study employed a qualitative research design, utilizing in-depth interviews to capture the nuanced, lived experiences of participants. Purposive sampling was used to engage a diverse cohort of community members and local leaders residing in marginalized geographical contexts. This methodological approach allowed for a granular exploration of the socio-spatial barriers to healthcare and the subjective meanings attributed to state interventions during the crisis. Key findings consistently demonstrate that the reliance on centralized, top-down response models proved inadequate. These models failed to account for the unique logistical hurdles in rural settings and the high social density and resource scarcity prevalent in townships. Participants emphasized that this gap resulted in delayed care, poor service uptake, and a significant breakdown in trust between healthcare authorities and local populations. The study concludes that future pandemic preparedness must prioritize

decentralized, community-led frameworks that are sensitive to the socio-economic realities of marginalized South African landscapes.

Keywords: Covid 19, public health, accessibility, township, healthcare

Introduction

Service delivery in terms of the Constitution of South Africa Act 106 of (1996) is defined as the municipal responsibility for the rendering of basic services to the citizens; services such as water, sanitation, electricity, refuse collection, municipal roads, and primary health care in safe and conducive environments. The Constitution lays down values and principles to guide administration in all the spheres of government this then provides the structure of public service. Service delivery remain one of the main challenges for most developing states (Kyle and Resnick, 2019). This can be seen in South Africa through the distress in the provision of public infrastructure, public primary health care, and basic services. The White Paper on Transforming Public Service Delivery of South Africa published in 1997 brings forth the eight principles of Batho Pele, which reiterate that "All citizens should have equal access to the services to which they are entitled". Townships in South Africa tend to fall through the cracks when it comes to service delivery.; This can be seen in townships that do not have adequate health care facilities, where mobile clinics and standing clinics run out of medication, clinics being understaffed or the nearest clinic and hospital being several kilometres away from residents. The study sought to investigate the importance of accessing public health care facilities and how the lack thereof can place certain individuals and communities at a disadvantage, this being evident during the Covid19 outbreak. The study acknowledges certain policies such as Spatial Planning brought about by the Apartheid government which have led to certain areas being underdeveloped and isolated. The study further breaks down the expectations residents of various communities have with regards to public health care and uses.

South African history places a huge emphasis on colonization as well as the dawn of the apartheid era that was the result of the National Party resuming power in 1948. During this period, the then South African government enforced laws of segregation in residences, development, and races. These laws, policies and acts played a pivotal role in ensuring that apartheid prevailed as did institutionalized racial discrimination (Reddy, 2006). The Group Areas Act of 1950 and similar Acts that were imposed between 1950 and 1985 can be noted as legislations that further instilled segregation within the then Spatial Planning Laws.

According to (Du Plessis, 2014) the drafting and the implementation of the Group Areas Act specified separate residential and business areas amongst the various racial groups. The scholar further argues that this law was effective in removing non-whites from areas that were deemed as most developed (Du Plessis, 2014). The above-mentioned era is of great importance when trying to understand the history of South Africa as well as its current social and political standings. The 1994 government had to propose drastic policies that would redress the inequalities due to laws imposed by the apartheid government.

Alongside the Group Areas Act was the Urban Areas Act of 1923, these legislations resulted in the outward displacement of African people to townships in the peripheries of cities.

The reference of these legislations is important when wanting to track the lack of provision of adequate service delivery for non-whites. An example of this lack of provision in services, can be noted with the lack of adequate housing and infrastructure that resulted in squatter settlements known as townships mushrooming on the peripheries of major cities. Townships were mainly perceived as predominantly residential areas for non-white residents, which had matchbox houses with similar designs, gravel roads and located on the urban peripheries (Maluleke, 1995). These legislations assist in creating a better understanding of how townships were developed, and evidence that services rendered were not equal, especially when it came to issues such as health care services. The unequal delivery and distribution of health care services prior to 1994 is echoed in the Reconstruction and Development Programme (2003) as well as the White Paper on the Transformation of the Public Service (1995). The dawn of democracy in South Africa was left burdened with apartheid legacies such as spatial inequalities especially land tenure, poor integration, access to basic services as well as infrastructure (Huchzermeyer, 1999).

The health care system is one of the many areas impacted and affected by the apartheid era in South Africa. After 1994 the health care system had to undergo substantial transformation for issues pertaining to access to services for all and the quality of services provided (Maphumulo and Bhengu, 2019). Maphumulo and Bhengu (2019) emphasise that the main goal amongst others was to shift the distribution of health resources, from tertiary and secondary health care to primary health care services and this was done to do away with health care systems that perpetuated racial segregation. The White Paper on the Transformation of the Health System in South Africa (1997) emphasizes that the transition to a decentralized system introduced the District Health Systems (DHS) which was deemed as the most appropriate vehicle for the delivery of primary health care services. The decentralization implied that there would be a shift of power, authority as well as the functioning of the health care system.

Access to health care

A health care system is noted as being the organization of people, an institution and resources that delivers health care services to meet the health needs of a targeted population (White, 2015). The right to have access to health care services is a basic human right that is guaranteed by the Constitution of South Africa. Section 27 of the Constitution of South Africa states that everyone has the right to have access to health care services, including reproductive health care services and no one may be denied access to emergency medical treatment (Constitution of the Republic of South Africa, 1996). Access to healthcare services is important for improving good health however rural areas face a variety of access barriers. People should have access to health care services for the prevention of diseases, treatment of illness and to prevent the rate of death. The right to health care can however be limited in certain instances, depending on the availability of resources. Rural residents often experience barriers to healthcare that limit their ability to obtain the care they need. Some of the challenges experienced in

respect of access to health care services are recorded in the reports by the South African Human Rights Commission (SAHRC) arising from its investigations into Access to Healthcare Services and into access to emergency medical services in the Eastern Cape respectively (McDonald, 1993). The SAHRC found that public health care services are largely under-resourced in terms of personnel, availability of suitable medication and infrastructure, conditions which are unfavourably impacting the ability to deliver adequate care to poor people, especially to those in rural areas. According to McDonald (1993), the reports noted a serious shortages of emergency transport, long waiting times, and over-crowding and under-staffing. Most of residents do not have access to quality health care due to financial constraints and they cannot afford to go to private hospitals to access good medical care. The Constitution and the National Health Act 61 of 2003 envisage a single health system for South Africa. However, in addition to public health care several private health care service providers exist in country. Everyone can access both public and private health services, with access to private health services depending on an individual's ability to pay (World Health Organization 2010).

Healthcare systems are continuously changing and re-modelling in both developed and developing countries due to many reasons such demographic changes, unemployment and increasing economic instability (Tarimo and Webster 1994). The healthcare systems in developed nations are more advanced than developing countries. This is due to the availability of funding, which allows for higher standard healthcare facilities and services. The South African health system has been described as a two-tiered system divided along socioeconomic lines" (Republic of South Africa Health Department, 2015, p.1). This socio-economic divide extends to the healthcare sector in many ways. The government does, now, provide free and equal healthcare to all South Africans while those with deeper pockets have the opportunity to receive private healthcare (Ruff et al, 2011). Klinton (2020) defines the private healthcare sector as "individuals and organizations that are neither owned nor directly controlled by governments and are involved in provision of health services". The private sector ranges from non-profit to for-profit organisations, drug stores, traditional healers, to even major healthcare centres. Young (2016) argues that private healthcare seems to be viewed as being superior from the public healthcare system, as it is associated with efficiency and delegate practice such as cleanliness, shorter waiting times, quality care and facilities, abundance of resources.

Young (2016) argues that public healthcare system in South Africa is of paramount as it caters to the disadvantaged citizens allowing them access to have free healthcare services such as pharmaceutical care. The scholar further argues that public healthcare does however face many challenges such as patient, staff ratio. Sambo and World Health Organization (2014) indicated that over 60% of South African hospital vacancies are not filled. This shortage of staff puts a strain on the healthcare workers who must work long hours catering to the large number of South African dwellers. This thus leads to unsatisfactory quality of healthcare, longer waiting times etc. According to World Health Organisation (2014), a clinic ought to service a maximum of 10 000 patients however many clinics in South Africa

services over 13 000 people. What the afore mentioned leads to is a decline in quality-of-service delivery and extended waiting times.

Due to the South African public healthcare system being riddled with mismanagement and unsatisfying service delivery, a growing number of affording South African citizens are shifting towards the private healthcare sector (Econex, 2013). When considering people utilizing private medical facilities including general practitioners and pharmacies, South Africans who benefit from private health are estimated between 28% and 38% (Econex, 2013). Thus, the need for South Africans to have better healthcare services. Mayosi and Benatar (2014) suggested a merger between public and private healthcare sectors. To bridge the gap in quality and provision of healthcare in South Africa proposing for an inclusive health system that would deal with the inequalities encountered in the public health sector. In 2017, discussions emanated proposing for the National Health Insurance scheme which aims to provide universal health care to all south Africans thus doing away with the public and private health care systems (Ngqolowa, 2017). This proposed NHI scheme will thus provide the same quality of healthcare to all South Africans, no matter the socio-economic status or class. The NHI proposed scheme aimed to improve service delivery, resources in the healthcare sector for all South Africans and legal permanent residents, it also emphasises the pertinence of adequate staff (Venturini, 2018). Several discussions have emanated on the proposed NHI health scheme issues of funding that is cost funding of the program together with management of the scheme have been in the forefront. Lack of faith in the program have been highlighted as many argue that the NHI scheme if facilitated and managed by the government is doomed for failure just like the many different program initiated in the past, these are programs such as RDP, GEAR, ASGISA etc. (Ngqolowa, 2017).

Covid 19

The COVID-19 pandemic, also known as the coronavirus pandemic, is an active pandemic of coronavirus disease 2019 caused by extreme acute respiratory syndrome coronavirus 2 (SARS-CoV-2). The covid 19 pandemic created havoc especially in the health sector, raising issues of adequate healthcare provision. Provision of adequate health care service especially in African countries has been questioned mainly for the disadvantaged poor rural communities and townships. In a country such as South Africa with majority of its people residing in rural and township engulfed by lack of basic service needs such as healthcare and adequate water. The outbreak of Covid 19 in such areas was detrimental and with high impact. Several strategies had been employed by many countries as means to curb the spread and severity of the corona virus. Ranging from awareness campaigns aimed at educating people about covid 19, its dangers, and prevention methods to socio-economic strategies that is food parcels, social relief grants, UIF to health precaution measure such as PPEs, masks, vaccines, and indigenous medicines. The question however was this enough, did the government provide enough strategies and facilitates for rural and township dwellers to have a fighting chance against the Covid19 pandemic.

Theoretical Framework

The study is grounded and guided by the Relative deprivation theory. This theory suggests that people who feel they are deprived or perceive that there is a lack of essential resources that are not rendered to maintain the standard quality of life (for example, basic rights, access to resources, political voice, material possession). They will then organize or initiate a movement that will be dedicated to trying to ensure that the services due to them are rendered (Townsend, 1979). Guided by this theory, the study sought to address the impact of unequal service delivery, access to resources among township communities, as well as how the perceived lack of these resources can impact a community.

Methodology

Sampling

This study adopted a qualitative research approach, specifically utilizing a phenomenological design. This approach was selected as it allows for a detailed description of participants' lived experiences, opinions, and the subjective meanings they attach to social actions. As noted by Leach (2020), a qualitative framework is pivotal in gaining a deeper understanding of healthcare challenges and the socio-economic impact of the COVID-19 pandemic within South African rural townships, particularly for vulnerable populations. The study employed a non-probability, purposive sampling technique to ensure the selection of participants who possessed rich, relevant information regarding the phenomenon under study. The sample consisted of fifteen (n=15) participants, comprising one local official, ten community members, and four members of the community forum.

Data collection

Data was collected through two primary qualitative methods: semi-structured, in-depth face-to-face interviews and a focus group discussion. In-depth face-to-face interviews were conducted with the community members and the local official to capture nuanced personal narratives, while the community forum members participated in a focus group discussion to explore collective community perspectives. All participants were aged 18 years or older, meeting the legal age of consent in South Africa. Ethical rigor was maintained throughout the research process; participants were provided with informed consent forms outlining their rights to privacy, anonymity, and voluntary participation. The study received formal ethical clearance from the University of Fort Hare. The primary objective was to explore the lived experiences of township dwellers regarding government interventions and the impact of the pandemic both during and after the crisis.

Discussion

Access to/ provision of healthcare facilities

Findings revealed that there were no healthcare facilities in the area or in proximity. As such the community of Unit P depended on a mobile clinic that offer services once a week, while somedays it was not available. In such cases, the community members therefore express that they had travel long distances to access any medical services. As per the section 27 of the Constitution, lack of healthcare

facilities in the area is an infringement of the Unit P people right.

‘‘We *get medical help from mobile clinics, sometimes it does not arrive when it has problem, so people have to get treatment from another place which is Unit.17 or Unit.13 (sic)". Respondent 11(In-depth Interview), replied at Unit P.*

"We were struggled to test for Corona virus during the time due to the unavailability of testing tools (sic)", Respondent 12 (In-depth Interview), replied at Unit P.

The findings indicate that residents struggled during the pandemic because of the availability of health facilities for testing the virus and antibiotics. White (2015), argues that access to healthcare services is important for good health, which suggests that the Unit P community was not privy to good health. Although the post democratic government has tried to re-address all these issues as per the country's constitution which states that provision of basic needs is a human right. Spatial and geographic location inequality still persists. Townships and rural communities are engulfed by the lack of basic services such as clinics, hospitals, schools etc. while urban areas have vast accessibility to these services. Thus, issues of healthcare provisions for the township did not emanate from Covid however they have been long pressing issues. Covid 19 however exposed such issues. The findings align with the Relative Deprivation theory, in arguing that when people or communities feel they are deprived or note inequalities in the provision of services, they tend to mobilize and address the issues with officials through movements and protests. This, in Unit P, can be seen through the formation of the Community Forum where members mobilize for inclusion.

Lack of Covid-19 testing facilities

Respondents stated that there were no testing facilities in the area, if someone were showing symptoms, they would have to go to a clinic that is far from Unit P and get a letter so that they could go to the Makhiwane hospital for testing. As such many people were untested as they complained of the administration duty to acquire an approval letter from the clinic. This contributed to the high contamination/ spread of the covid 19 virus. Obunkalo, et. al., (2022) states that disadvantaged communities faced major challenges in getting mobile testing facilities given by the South African government. The major challenges included limited access to these areas due to poor road networks, shortage of healthcare workforce and limited access to Covid19 services.

"There were no testing facilities in the area, some people would be showing symptoms they then go to Nontyatyambo clinic so that they could get referral to Makhiwane hospital so that they could get tested. Our area is dominated by low-income residents, it is not easy for them to go to town to special doctors for testing (sic)". Respondent 14 (In-depth Interview), replied at Unit P.

Lack of awareness campaigns about Covid-19

Majority of the respondents stated that no one from the department of health or from the local government had came to educate the residents of Unit P about Covid-19. Participants indicated that

only a few participants learnt about Covid-19 through radio, television, and social media platforms. From there word of mouth was the tool of awareness, however the challenge with this was the issue of misconception. Many people therefore made up stories about what the virus was resulting in moral panic amongst the community. This in return contributed to mental health issue such anxiety, fear of the unknown.

"No one came to inform us about Covid-19, but the community members did call a meeting where people exchanged information about Covid-19 awareness, symptoms, medication and remedies that people could use so that they could combat the spread of Covid-19 (sic)" Respondent 11 (In-depth Interview), replied at Unit P.

Most people found it hard to access the correct information about covid-19 and preventive measures (Haffejee and Levine, 2020). According to Mutanga and Abayomi (2020), people's resistance to measures that threaten their economic activities had been fueled by false news spread by social media sites about Covid19. The spread of Covid-19 had been followed by a flood of false news, making it difficult for people to locate credible sources and advice when they need it. (Scerri and Grech: 2020). Poor information access and poor health literacy was a challenge in disadvantaged communities. People from disadvantaged backgrounds relied on social media and social platforms, which however fueled incorrect information about the pandemic (Ogunkola et al., 2020).

Distribution of Covid-19 Personal Protective Equipment

Social distancing, Personal Protective Equipment, strict washing of hands, isolation, all of these are terms that we had to not only get accustomed to but also closely follow to improve our survival chances during the Covid-19 pandemic. Personal Protective Equipment play a major role in curbing the infections of Covid-19, as it protects people from getting the virus which spreads by respiratory mainly through the air when people are near each other and spread via contaminated surfaces. The PPE were believed to protect individuals. Many of the respondents in Unit P were of the view that the increasing number of Covid-19 infections in the country is caused by unequal access to PPE. Lack of monitoring of the distribution of PPE had resulted in disadvantaged communities not getting the required services to help control the spread of Covid-19. Mbunge (2022) argues that community members from disadvantaged backgrounds were among the most hit by the pandemic due to lack of PPE supply. He further argues that there were major contributors to disadvantaged.

"*We did not get the PPE which were to be delivered by our Ward councilLor and health workers, we bought them because we wanted to be protected from the deadly virus. Those who could afford bought them and we share with one another. We also had to improvise by making our own PPE such as masks using materials such as our t-shirt etc.(sic)". Respondent 5 (Focus Group Discussion), replied at Unit P.*

Delay in admission to hospitals.

Majority of the respondents asserted that there were delays in hospital admissions. Participants stated

that one needed to first travel to Nontyatyambo clinic which was afar, where they would receive a referral letter in order to be admitted at Cecilia Makhiwane Hospital. Most residents mentioned the financial constraint that comes with travelling to Nontyatyambo, whereas the process would have been less costly had the letter been accessible if they had a clinic. Young (2016) argues that there are advantages and disadvantages to government funded/public healthcare. The advantage of government public healthcare systems being free pharmaceuticals, surgeries, and general healthcare extending to wheelchairs and home care visits. While disadvantages include long waiting times and overcrowding, poor quality of facilities and care (Kautzkyi and Tollman 2008).

"You cannot just go to Makhiwane hospital even during an emergency without being referred by the nurses at Nontyatyambo clinic (sic)." Respondent 13 (In-depth Interview), replied at Unit P.

Absence of quarantine sites

The majority of the participants recognized the government's failure in providing the disadvantaged communities with quarantine sites. Residents of Unit P had no knowledge about sites made available for quarantine. This made people to be anxious of getting the virus when Covid-19 symptomatic people are not being isolated in quarantine sites. Absence of campaigns and means of distributing the information about quarantine sites also had an impact in rising Covid-19 cases, as symptomatic people were more to risk their family members in getting infected too because they use their houses to quarantine (Haffejee and Levine, 2020). Participants indicated that they had to stay with their sick people in the same house. For those who did not have adequate space this meant they had to share the same room with those infected.

"Clearly our government does not care about remote areas, these quarantine sites are possibly provided to urban areas only, as we were not given any information about available quarantine sites (sic)." Respondent 1 (In-depth Interview), replied at Unit P.

Distribution of food parcels

The Covid-19 pandemic came with a nationwide and mandatory lock-down. This meant very limited movement for South African citizens, only allowing essential workers, and individuals going to purchase essential goods such as medicine or food to be allowed in the streets (Paul et al, 2022.). With the history and current situation of socio-economic disadvantage in South Africa this restriction to movement meant hunger for some people. As such form of intervention were implemented by the South African government-initiated provision of social relief such as food parcels to the disadvantage individuals and communities. However, issues of corruption dominated this process. Mdantsane Unit P participants indicate that issues of favouritism, nepotism and affiliation dominated the process of food parcel distribution as those in power structures distributed the food parcels to their friends and those affiliated to the same organisations with.

My name was written on the list of people that will receive the food parcels, but I only heard that members of community forums were only distributing the food parcels to their friends only and they were selling the remaining parcels at night. I had no interest in asking about the list where my name was written, because corrupt acts are popular in this community (sic)." Respondent 9 (Focus Group Discussion), replied at Unit P.

Lessons learnt from the pandemic.

The aim of the study is to present lessons that can be learnt from the pandemic in relation to the challenges experienced by rural township dwellers. These lessons are essential in planning for future disasters and pandemics ensuring that government in better ready and prepared. Understanding that the covid-19 pandemic caught countries and having learnt the impact of such pandemics it is essential that we are prepared for future occurrences. As such government needs to have a preparedness and responsive plan especially for rural communities and townships. This is to ensure that different strategies are in place tailor made for rural communities/ townships considering the needs and intervention strategies for such communities. Thus, ensuring that the impact of such pandemics are not a server and dire as was the covid-19 impact. Dudley et al, (2023) advocates for an improved vertical coordination across national, regional, and local levels of government, these scholars argue will ensure that government is better prepared and responsive in rural areas thus allowing for optimal adaptation and tailoring for rural townships/ communities.

Media is a create tool when used well as it ensures better communication addressing all communities and ensuring that it addresses misconceptions. Use of media coupled with rural community stakeholders' engagement is helpful platform in ensuring community participation and addressing barriers and misconceptions. This is essential in understanding rural township/ communities' health challenges and lack of resources. In the case of Unit P health facilities were located far from the community which required community members to travel long distances. This is a challenges as rural townships are engulfed with higher unemployment with many people living below the poverty line. Lack of service delivery facilities is rural communities is a major challenge which has grossly contributed to the many challenges experience with the covid-19 pandemic. There is a need to strengthen health facility provision systems in rural and remote areas. Government alone however is unable to address this shortage thus this effectiveness the call for partnership with stakeholders such as the business sectors and NGO's etc. In addressing this shortage. Support for rural development needs all stakeholders especially policy makers in ensuring integrated rural development and pandemic preparedness and readiness.

Conclusion

The residents of Unit P were severely disadvantaged in terms of public healthcare infrastructure. The participants highlighted that there were no permanent clinics, proper roads, community halls, and schools. There is a lot that needs change and improvement to be made by local governmental structures including visibility and taking residents' concerns. For any community to be cohesive and functional,

every part of the community needs to serve the interests of the whole community and avoid acting against the interests of the community. This means that the government, local official and other community gatekeepers need to take it upon themselves to serve in the best interest of the people at large. Poor spatial planning made room for areas like Unit P to exist, have still not been corrected to this day. Poor service delivery in townships and rural areas is a prevailing factor that affects residents daily, and the breakout of the Covid-19 pandemic only highlighted issues that have existed long before pandemic and exist years after the initial outbreak. Therefore, there is a need to correct and address all the service delivery shortage ensuring that we are better prepared for future pandemics. Government needs to fully understand rural communities, understanding their difference from urban areas thus require a planned strategies of address rural communities, their challenges, stakeholders in its preparedness and responsiveness to disasters and pandemics.

References

Bialek, S., Boundy, E., Bowen, V., Chow, N., Cohn, A., Dowling, N., Ellington, S., & Gierke, R. (2020). Severe outcomes among patients with coronavirus disease 2019 (COVID-19)—United States, February 12–March 16, 2020. *Morbidity and Mortality Weekly Report*, *69*(12), 343–346.

Creswell, J. W. (2014). *Research designs: Qualitative, quantitative, and mixed methods approach* (4th ed.). SAGE Publications.

Du Plessis, D. J. (2014). A critical reflection on urban spatial planning practices and outcomes in post-apartheid South Africa. *Urban Forum*, *25*(1), 69–88.

Econex. (2013). *The South African private healthcare sector: Role and contribution to the economy*. South African Private Practitioners Forum (SAPPF) and Health Man (Pty) Ltd.

Haffejee, S., & Levine, D. T. (2020). 'When will I be free': Lessons from COVID-19 for child protection in South Africa. *Child Abuse & Neglect*, *110*, Article 104715.

Huchzermeyer, M. (1999). *Current informal settlement intervention in South Africa: Four case studies of people-driven initiative*. CSIR Boutek, University of Cape Town.

Kanu, I. A. (2020). COVID-19 and the economy: An African perspective. *Journal of African Studies and Sustainable Development*, *3*(2).

Kautzky, K., & Tollman, S. M. (2008). A perspective on primary health care in South Africa. In P. Barron & J. Roma-Reardon (Eds.), *South African Health Review*. Health Systems Trust. http://www.hst.org.za/publications/841

Kyle, J., & Resnick, D. (2019). Delivering more with less: Subnational service provision in low capacity states. *Studies in Comparative International Development*, *54*, 133–163.

Leach, M. (2020). *Covid-19—A social phenomenon requiring diverse expertise.*

Maluleke, T. S. (n.d.). *Urban black townships: A challenge to Christian mission*.

Maphumulo, W. T., & Bhengu, B. R. (2019). Challenges of quality improvement in the healthcare of South Africa post-apartheid: A critical review. *Curationis*, *42*(1), 1–9.

Mayosi, B. M., & Benatar, S. R. (2014). Health and health care in South Africa 20 years after Mandela. *The New England Journal of Medicine*, *371*(14), 1344–1353.

Mbunge, E. (2021). Effects of Covid-19 in South African health system and society: An explanatory study. *Diabetes & Metabolic Syndrome: Clinical Research & Reviews*, *14*(6), 1809–1814.

McDonald, J. (1993). *Primary health care: Medicine in its place*. University of Bristol.

Ogbolosingha, A. J., & Singh, A. (2020). Covid-19 pandemic: Review of impediments to public health measures in Sub-Saharan Africa. *American Journal of Preventative Medicine and Public Health*, *6*(3), 68–75.

Ouma, S. (2013). *M-Health user experience framework for the public healthcare sector* (Doctoral thesis, Nelson Mandela Metropolitan University).

Paul, C., Ikwegbue, A. O., Enaifoghe, H. M., & Leonard, U. A. (2021). The challenges of Covid-19 pandemic and South Africa's response. *Sabinet African Journals*.

Reddy, T. (2006). Higher education and social transformation in South Africa since the fall of apartheid. *Cahiers de la recherche sur l'éducation et les savoirs*, *5*, 121–145.

Republic of South Africa Department of Health. (2015). *National health insurance for South Africa: Towards universal health coverage*. Department of Health.

Tarimo, E., & Webster, E. G. (1994). *Primary health care concepts and challenges in a changing world: Alma-Ata revisited* (WHO SHC Paper No. 7). World Health Organization.

Townsend, P. (1979). *Poverty in the United Kingdom: A survey of household resources and standards of living*. Penguin Books.

Turner, J. H., & Maryanski, A. (1979). *Functionalism*. Benjamin/Cummings Publishing Company.

Van Der Byl, C. (2014). *Twenty-year review: South Africa 1994 - 2014*. Presidency of South Africa.

Venturini, R. R. (2018). *A framework to address the shortage of registered nurses in South Africa in alignment with the National Health Insurance requirement* (master's thesis, Nelson Mandela University).

Young, M. (2016). *Private vs. public healthcare in South Africa* (Honors thesis, Western Michigan University).