Western Cape Government
Health

Office of the Head: Health

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Enquiries: Dr K Cloete

TO ALL

SMS MEMBERS

HEADS OF FACILITIES

CIRCULAR H 68 OF 2020: HEALTH SYSTEM STRATEGY TOWARDS COVID-19

COVID 19 is the biggest acute threat at this point in time to our population, locally, nationally and globally. It therefore rightly justifies a whole of society focused approach of the highest priority with unity of purpose to defeat this pandemic and mitigate its risks.

The Health Department has been given the responsibility of not only driving the health system response but also critically informing the Whole of Government response within the province.

The Western Cape Health Strategy towards COVID-19 aligns with the National strategy.

Please note that implementation has already commenced.

Any further enquiries may be directed to Dr Krish Vallabhjee at Krish.Vallabhjee@westerncape.gov.za or 021- 483 6865

Yours sincerely

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Date: 14th May 2020

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Western Cape Government

Health

Strategy towards COVID 19

May 2020

HEALTH SYSTEM STRATEGY

TOWARDS COVID 19

Contents

Strategy towards COVID 19

Executive Summary

COVID 19 is the biggest acute threat at this point in time to our population, locally, nationally and globally. It therefore rightly justifies a whole of society focussed approach of the highest priority with unity of purpose to defeat this pandemic and mitigate its risks.

The Health Department has been given the responsibility of not only driving the health system response but also critically informing the Whole of Government response within the province.

The Health System Response is underpinned by the following imperatives:

1. *The Premier and the Provincial Cabinet has taken ownership and accountability to drive the provincial strategy on COVID 19.*
2. *The strategy requires a Whole of Government approach (WoGA) and Whole of Society Approach (WoSA).* While the pandemic is a major threat, it also poses significant opportunities to strengthen social solidarity, relationships at multiple levels including within communities, between sectors and between government, civil society and business.
3. *COVID 19 is of the highest priority within the province and requires a single - minded focus of the whole of government. Agile decisiveness is required and governance arrangements will be re-organised accordingly.*
4. *Courageous and decisive leadership is required at all levels of the system with efficient and effective communication both internally to our staff and externally to the public and our partners.*
5. *Health has been mandated to provide the technical leadership to WCG to inform their strategic response, as well as support other sectors.*
6. *Scenario planning and modelling will be used to forecast the demand of COVID 19 on the care continuum and inform the health system and WCG response. The modelling numbers quoted are being revised on an ongoing basis as we receive better intelligence. Management will use its collective wisdom, the best data and health intelligence available to make pragmatic judgements around the health system response and resource planning requirements.*
7. *Health Intelligence, including scientific evidence, global and local experience, data and information as well as rapid learnings will inform the constant re-shaping of our response and strategy to changing conditions during this outbreak.*
8. *The Health System strategy must align with the national strategic approach, while it can be customised to local context*

The overall strategy towards COVID 19 is divided into three phases which is aligned to the care continuum (See Figure 1):

1) Suppression and Containment

2) Mitigation

3) Recovery

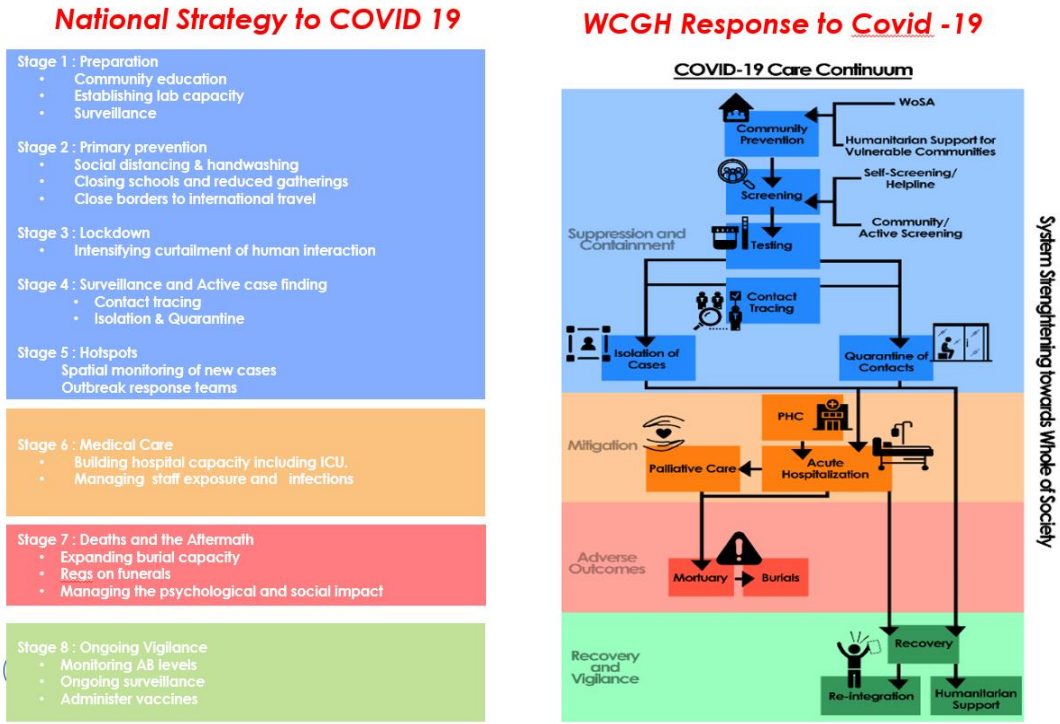
It also important to recognise that strategies in one part of the care continuum has knock on effects on every other part. Thus, the importance of seeing the continuum as one system with inter-related parts. Each of the care continuum components are assessed from a WHY, WHO and HOW perspective and strategic considerations or questions are surfaced.

The health system response must be agile, responsive (decisive) and adaptive to changing material conditions on the ground and be governed accordingly. It must be adequately enabled and supported by health intelligence, communication (messaging), people management, supply chain and infrastructure (See Figure 2). Strategic considerations for each of these support pillars are also summarised.

The investments and strategic decisions we make must also be considered from a health system strengthening perspective towards UHC. This should be achieved within a whole system strengthening perspective towards the whole of society and a sustainable future dispensation.

The provincial strategy should be aligned with the national approach and customised for local context where appropriate. The stages or sections in the care continuum should not be mechanistically seen as sequential as many of the interventions need to happen in parallel.

Figure 1: The COVID -19 Care Continuum aligned with the national strategy



Strategic risks have to be closely assessed with changing conditions and new information emerging. The strategic risk questions at this point in time include:

1. Are we under-planning and under-preparing for this pandemic and its impact?
2. Will there be a resurgence after the Lockdown is lifted and how do we prepare to mitigate this?

3. How do we align our efforts between scaled up community screening, testing, isolation and quarantine capacity in this containment phase?
4. What surveillance mechanisms do we put in place over and above the CST to be vigilant about transmission of this pandemic.
5. How do we manage when the created capacity is overwhelmed by demand.
6. How do we cope with a significant proportion of staff becoming ill which reduces capacity to respond?
7. What are the complications of the coincidence of the annual Infuenza season and how do we mitigate this?
8. How do we share health intelligence and actual data in the public domain without creating alarm and panic and compromising patient confidentiality?

Some of the mitigation strategies are described in detail.

Post COVID, the Health system will need to recover from this shock. The leadership must recognise the staff especially at the frontline for their heroic efforts way beyond the call of duty. Processes to undertake significant reflection and learn the lessons at all levels of the system will need to be undertaken. The positive ways of working differently, being responsive and agile must be institutionalised to be sustained. Relationships must be harnessed towards UHC and the whole of society approach.

The Strategic Governance Executive, on behalf of Top Management, will oversee, review and govern the implementation of the strategy at a provincial level. Management at operational levels need to develop a consolidated Covid Plan for their facility or geographic area i.e. sub district or district using the broad parameters outlined within this strategy. These plans should include a health system strengthening approach while addressing the specific approach towards the COVID 19 pandemic, assessing risks with appropriate risk mitigation strategies, working with other sectors, community involvement, collaboration with the NPO and private sector to strengthen the WoSA, as well as work preparedness plans based on risk assessments to protect staff as outlined in the OHS policy. The plans need to be agile and adapted with changing conditions, evidence and policies.

Appropriate governance mechanisms to provide oversight, collaboration and coordination of effort, monitoring of progress and review of local strategies and plans need to be in place. This could be built into existing mechanisms and structures where appropriate.

Data and information to monitor progress is critical. Systems are being developed to assess progress in each aspect of the health system response to the care continuum. While the focus is on Covid - 19, important aspects of health system strengthening also need to be monitored to ensure we are making sustainable gains for the medium to long term.

In this period, transparent sharing of information is important to build public confidence. A public dashboard has been launched in this regard that is updated daily.

Over and above the monitoring of progress, the culture, systems, processes of rapid learning has to be embedded so that we can constantly adapt and sharpen our responses to emerging evidence and changing conditions. Bottom up learning circles will be encouraged where staff from similar settings can share experiences and lessons. The learning from implementation will also inform policy review processes at a macro level.

Our strategy towards Covid 19 needs to be agile and rapidly adjusted as conditions change. This document covers our strategic considerations at this conjecture.

A. Introduction

COVID 19 is the biggest acute threat at this point in time to our population, locally, nationally and globally. It therefore rightly justifies a whole of society focussed approach of the highest priority with unity of purpose to defeat this pandemic and mitigate its risks.

The Health Department has been given the responsibility of not only driving the health system response but also critically informing the Whole of Government response within the province.

While the pandemic is a major threat, it also poses significant opportunities to overcome the multiple fault lines that fracture us as a society generally and government more specifically. It's an opportunity to build social solidarity and social capital, strengthen relationships at many levels including between government and communities, civil society and business. Within the health sector, it demands as a necessity that we have a single health system response between the public, private and NPO sectors.

The Health System Response is underpinned by the following imperatives:

1. *The Premier and the Provincial Cabinet has taken ownership and accountability to drive the provincial strategy on COVID 19.*
2. *The strategy requires a Whole of Government approach (WOGA) and Whole of Society Approach (WoSA). While the pandemic is a major threat, it also poses significant opportunities to strengthen social solidarity, relationships at multiple levels including within communities, between sectors and between government, civil society and business.*
3. *COVID 19 is of the highest priority within the province and requires a single - minded focus of the whole of government. Agile decisiveness is required and governance arrangements will be re-organised accordingly.*
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5. *Health has been mandated to provide the technical leadership to WCG to inform their strategic response, as well as support other sectors.*
6. *Scenario planning and modelling will be used to forecast the demand of COVID 19 on the care continuum and inform the health system and WCG response. The modelling numbers quoted are being revised on an ongoing basis as we receive better intelligence. Management will use its collective wisdom, the best data and health intelligence available to make pragmatic judgements around the health system response and resource planning requirements.*
7. *Health Intelligence, including scientific evidence, global and local experience, data and information as well as rapid learnings will inform the constant re-shaping of our response and strategy to changing conditions during this outbreak.*
8. *The Health System strategy must align with the national strategic approach, while it can be customised to local context.*

B. Overall Health System Strategy towards COVID 19

The overall strategy towards COVID 19 is divided into four phases which is aligned to the care continuum (See Figure 1):

1) Suppression and Containment

2) Mitigation

3) Recovery & Vigilance

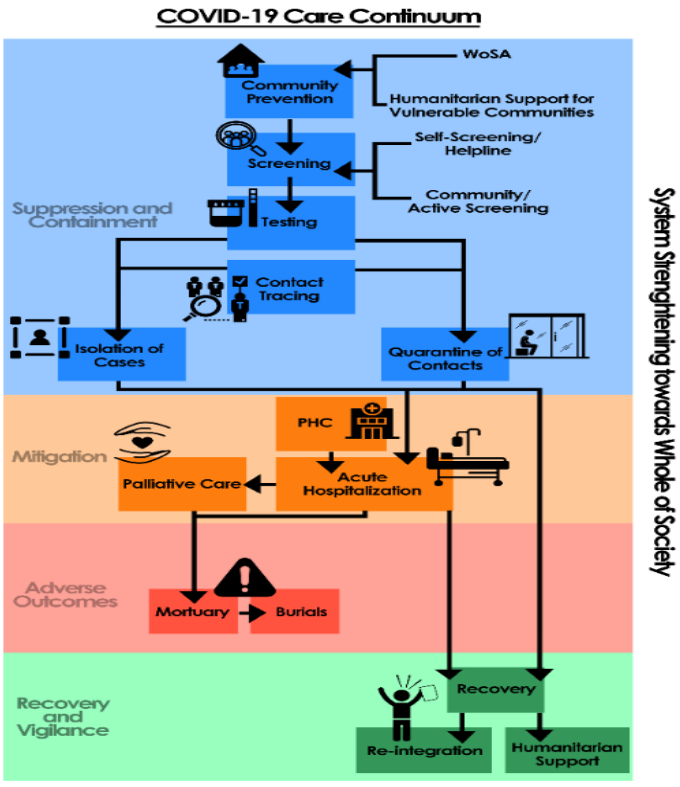
4) Adverse Outcomes

The health system response must be agile, responsive (decisive) and adaptive to changing material conditions on the ground and be governed accordingly. It must be adequately enabled and supported by health intelligence, communications (messaging), people management, supply chain management and facilities and infrastructure management (See Figure 2 below).

It also important to recognise that strategies in one part of the care continuum has knock on effects on every other part and thus the importance of the need to see the continuum as one system and with inter-related parts. They should also not be seen as mechanistically sequenced steps, as many of the interventions need to happen in parallel.

The investments and strategic decisions we make must also be considered from a health system strengthening perspective towards UHC and a sustainable future dispensation.

Figure 1: The COVID Care Continuum



B.1 SUPPRESSION AND CONTAINMENT:

This is the most critical phase of the pandemic and needs a highly focussed approach by the Whole of Government and Whole of Society.

The strategy in this phase is to prevent transmission, early identification and isolation of cases, tracing and quarantining of contacts. The effectiveness of the strategy in this phase will determine impact on the rest of the health system, the lives that we lose through COVID 19 and its negative ripple effects through society. Thus, suppression and containment is the key to limiting this threat.

Key elements of the Strategy in this phase :

B.1.1 Community prevention

WHY: Community prevention is about preventing and protecting people from the contracting COVID 19 in the first place.

WHO: This requires a united whole of society response, strong social solidarity and a humanitarian response to especially vulnerable communities and sections of our population. This is an opportunity to mobilise all the forces and structures within communities to join hands to unite against COVID 19 and to support especially the most vulnerable sections of our population. Each of the other sectors in society need to play their role in ensuring prevention of transmission of this infection.

HOW:

1. Social distancing: The National Government has implemented a ***lockdown*** which has included airports, sea and land to reduce persons who have been infected in other countries from entering and this has seen the slowing down of "import cases". The lockdown within the country has minimised the gathering and movement of people locally and further reduced the risk of transmission. A range of other measures included loads on taxis and buses and encouraging people to stay 1,5 m apart and stay home/ work from home in non-essential and other services.

When the lockdown is eased, there is a need for targetted interventions to manage high risk areas as well as populations. This will include, amongst others, public gatherings, public transport, other areas of concentrated populations such as big work-places, supermarkets, prisons and old age homes. Social distancing in informal settlements is particularly challenging and requires innovative thinking.

2. Health Education and awareness through strong messaging that focusses on ***universal hygiene measures*** such as hand washing, cough etiquette, use of masks and PPE where appropriate must continue.

3. The Health Department has been playing an active role in **supporting a range of other sectors** through the provision of guidelines, clarifying roles and responsibilities and enabling implementation where feasible. However, each sector takes responsibility for implementation in its space.

B.1.2 Screening

WHY: Screening is a well established public health intervention for the early detection of cases. As the pattern of the pandemic has shifted to increased local transmission, and given the fertile ground that

poverty, overcrowded living conditions, lack of water and sanitation and a range of other factors creates for the rapid spread of this disease, we have to focus on vulnerable communities and screen as many people as possible to identify infected persons and isolate them from spreading the disease. The purpose of the screening is to identify and isolate COVID-19 cases early, trace contacts and contain the epidemic from being transmitted locally. The presence of significant levels of asymptomatic infections does raise a challenge for screening, early detection and testing that must be addressed.

WHO: The case definition is the net that needs to be defined to determine how wide or narrow we make it. The definition has been widened to factor in local transmission in vulnerable communities. Tools have been created to enable screening. These tools are available on the department website and private institutions like Nedbank, Vodacom, Discovery have also created online access for screening. People should be encouraged to use these tools should they have any symptoms.

The Department, working with partners and Community Health Workers (CHWS) have started to undertake household screening and this has been scaled up in recent weeks.

HOW:

The community screening programme aims to identify positive cases. The NDOH has identified vulnerable wards, ranked by a socio-economic vulnerability index, for mass based door-to-door screening. In this province, we have taken a more targeted approach to concentrate our efforts around identified cases from vulnerable communities and to screen households in the immediate geographic vicinity of cases. We are engaging the laboratories to provide test results by geographic area so as to connect with focussed screening strategies.

We have agreed to learn as we progress. There will be a scale up of the screening over the next few weeks to increase our coverage. There are key rate limiting factors that need to be addressed which include human capacity, sampling capacity, lab testing and the rapid provision of results. The Department will recruit more volunteers from local communities to join our CHWs in this screening effort. The Department is addressing the need for PPE. NHLS has been engaged to ramp up testing capacity in the province from the current 2000 tests per week. We eagerly await the approval of a rapid test nationally. These factors will significantly change the ability of the department to scale up community based screening.

It is important that we rapidly learn lessons from each area based screening intervention on a daily basis, as we titrate and scale up our system response to this outbreak. We have already identified cases in supermarkets, prisons, certain large workplaces, police stations and health facilities as “bushfires” that are being targeted for CST and isolation and quarantine.

B.1.3. Testing

Why: The symptoms and signs of Covid 19 are non–specific and therefore the cases are confirmed through laboratory testing.

WHO: The swab samples are undertaken by Health Workers, mainly nurses, wearing the appropriate PPE. These swabs are then transported under optimal conditions to the nearest laboratory for testing. The public sector laboratories are managed by NHLS. They also provide the swab kits.

How: Sampling (taking of swabs) will happen in multiple places. These will include specifically set up field stations, mobile vehicles, PHC facilities and our hospital ECs or triage and testing sites on Hospital premises. Testing is undertaken by NHLS. There are also private laboraties doing testing.

The current testing methodology with its average of 69 hours turnaround time for lab results is a major constraint and rate limiting step in the campaign and has implications for transporting specimens, persons under investigation (PUI) having to be quarantined if they cannot self quarantine at home with personal and family disruption and implications for contact tracing.

NHLS will be making gene expert testing more available at a decentralised level by mid-April which will also help in obtaining the test results in 90 minutes. But its unlikely to be available at every field station and so delays while reduced will still hamper the rapid processing of clients.

Rapid test kits are being explored by NHLS. SAHPRA has recently made recommendations to NHLS in this regard.

B.1.4 Contact Tracing

Why: To contain the spread of infection, contacts need to be traced, screened for symptoms, quarantined within facilities if not able to be seperated at home. It is important to recognise that by the time a case is identified, the infected person would have been contagious for several days before and the immediate family and others would have been exposed to the infection.

When symptomatic, they need to be tested. While they are awaiting results, they are deemed a person under investigation (PUI) and need to be isolated. Once their results are obtained, if positive and well they need to be self-isolated at home or group isolated in a facility or if ill, hospitalised. If they are negative, they can be re-integrated at home.

Contact tracing will be reviewed as the size of the epidemic grows and the capacity to trace the number of contacts is outstripped.

Who: The Department is responsible for contact tracing. Contact tracing teams have been set up centrally and locally at the initial stages of the epidemic. Contact tracing within health facilities of health workers will be undertaken by the in-house facility teams and the family, friends and other contacts based within communities will be followed up be the local contact tracing teams in the community. Contact tracing within workplaces or institutions such as prisons will be be jointly managed with the resident health service capacity. Collaboration with Envionrmental Health practitioners from Local Government is also being strengthened in the management of workplace clusters.

How: The contact tracing model has migrated from a centralised approach at the beginning of this outbreak locally when the majority of cases were imported to a decentralised approach as we have seen the escalation of local transmission. The public health expertise has been distributed to work with local structures and support local responsiveness during the community screening, testing, contact tracing aspects of the campaign. Contact tracing in workplace clusters have become a sinificant part of the workload. The contact tracing team is being strengthened by the redeployment of staff and other strategies are being explored. A separate stream for workplaces is also being explored.

B.1.5 Isolation and Quarantine (I&Q)

Why: To contain the spread of infection, both cases and contacts need to be seperated for the duration of their infective period, from the surrounding people be it at work, home or in the community. This process of seperation is called isolation for confirmed cases and quarantine for contacts or persons under investigation. Separating cases and contacts who cannot self isolate/ quarantine is a key part of this phase to contain transmision. However, the cost effectiveness of this

strategy as the numbers escalate and identifying triggers to reconsider this strategy at various points in the epidemic are being discussed.

WHO: Wherever feasible, cases or contacts or PUIs that can seperate themselves at home, this is encouraged. This responsibility has been allocated to the Department of Transport and Public Works and Municipalities to set up isolation and quarantine facilities, with proper infection control measures, and organizational arrangements to manage the use of these lodging arrangements, transport, meals and other humanitarin support, etc. and have a clear interface with the health system for referrals and case management.

HOW: The epidemic commenced with imported cases who could largely self-quarantine and self-isolate. Thus isolation facilities for cases and quarantine facilities for contacts and PUIs are for clients who are well, but just could not be isolated at home. Thus they do not require medical care unless they deteriorate, yet daily communication is needed.

Health must advise the responsible sectors on the policy parameters for the identification, activation, and running of these facilities from a health perspective, as well as the interface governance with the health system. A range of isolation and quarrantine facilities have already been organised and range from public facilities to private guest lodges and hotels. Clients may stay up to 14 days in these facilities. DEA&DP will engage municipalities for the waste management requirements of the quarantine and isolation facilities. The policy does not require that clients need to test negative before they are discharged.

At a point in time of this pandemic, when the numbers are outstripping the capacity we have and when turnaround times for lab results are not enabling efficient use of these facilities, we will need to consider alternative options of isolation and quarantine within communities.

B.2. MITIGATION

B. 2.1 PHC

WHY: It is estimated that only 10% of infected patients will be severely ill to require hospital admission. The majority of infected people will manage themselves at home or require PHC services. Thus the ability of PHC services to cope must be strengthened.

WHO: The WCG together with the City Health (in the City of Cape Town) will be the main providers of PHC services in the public sector. General practice and smaller innovative models of PHC by NPO and retail pharmacies will also provide PHC in the private sector.

HOW: Supporting self-management will become important by empowering patients with helplines for advice, information and easily accessible medicines for symptomatic reflief. Collaborative models of care between WCG, COCT and the private sector need to be rapidly developed to enable optimal coverage and access to services without necessarily congesting PHC facilities. PHC facilities have the largest footprint in the health sector must provide easy access for sampling and testing, clinical assessment and management and referral to hospitals where appropriate. Staff must be adequately protected with PPE and other measures. Local plans for good occupational health and IPC practice will be developed.

Health must play a leadership role in strengtening relationships and mobilising the range of forces across sectors and civil society within local communities around a common goal of defeating COVID-19 through community prevention, screening, supporting self-management and providing humanitairian aid to vulnerable families and individuals in communities.

B2.2 Acute Hospitalisation

WHY: a small proportion of the clients who become infected will become seriously ill to require admission to hospitals and more intensive medical care. Global evidence shows that certain categories of the population are at higher risk including the elderly and those with reduced immunity such as cancer and HIV, as well as other co-morbities such as Hypertension, diabetes and heart disease.

WHO: The WCGH has engaged with the private sector and other partners to develop a united, single health platform response.

How: The approach to acute hospitalisation will be characterised by the following:

a) The clinicians have agreed that there are three levels of acuity to be planned for:

1) Intermediate care – mild to moderate patients

2) Acute care - moderate

3) Critical Care – severe, requiring intensive care and/or ventilation.

b) The approach of the Department has been to first try to accommodate as many of above 3 categories within our established hospitals (public and private) by both de-escalation of our services and then optimising any space to add additional capacity. The remaining gap should be filled by creating further off-site facilities, which should primarily be used for intermediate care i.e patients with the lowest acuity requiring admission.

c) While beds are being used as a unit for hospital planning, it is recognised that this requires an ecosystem to function that includes staffing, equipment, PPE and consummables, etc. Hospitals will also have to create COVID Zones and Non COVID Zones to manage infection control appropriately.

d) It has been agreed that the transport of infected patients should be minimised across the service platform. Thus some palliative care beds will also be created in our acute hospital settings.

e) It has been agreed that critical care patients will be mainly accomodated within Central and Regional Hospitals and private hospitals that have exisiting experience and capacity.

f) The clinicians are developing clinical guidelines to support the appropriate management and rationing of care especially to the limited intensive care beds that will be available, at the peak of the pandemic.

g) Detailed planning around the provision of acute hospital and critical care is being undertaken and each hospital is expected to plan for a quantum of Covid patients accordingly.

B.2.3 Palliative Care

WHY: Given the limited resources we have and the projected demand that Covid 19 will place on the health service, it is clear that not everyone will receive the full spectrum of medical care especially critical care, which is a very limited resource. Thus provision has to be made for a quantum of patients who will be given palliative care that includes pain relief and other forms of less intensive care to be made comfortable. A significant proportion will pass on and must do so with dignity, respect and empathy to the patient and the family.

WHO: The Department of Health will take responsibility for palliative care, in partnership with its long-standing NPO partners.

HOW: Scenario planning and a service delivery model will be developed to quantify the need for palliative care beds. A proportion of these deaths will occur at home and a proportion will die while in acute care or intensive care. Clinical criteria and guidelines developed by clinicians will be used to estimate the proportion that may not be admitted to ICU/ High Care and that will require palliative care.

B.3 RECOVERY & VIGILANCE

B.3.1 Recovery

WHY: The majority of patients with COVID 19 will recover. However, early experience has shown the impact of stigmatisation and challenges with returning to their communities. There are clients and patients exiting/ recovering from isolation, quarantine and hospitals that need support to safely return to their communities. The overwhelming majority of patients in isolation and quarantine will come from vulnerable families and the capacity to povide humanitarian support including food security in real time must be significantly strengthened.

WHO: The Department of Social Development (DSD) has been mandated to assist in this regard. However, many social workers and other allied staff across Departments, civil society and NPOs structures, as well as volunteers, will need to be mobilised. This will be coordinated by DSD.

HOW: We need strong messaging from both the national, provincial and local leadership to de-stigmatise COVID 19. DSD officials charged with this responsbility need to be closely connected with facilities for isolation, quarantine and hospitals to faciliate efficient and safe return to patient homes or find alternatives. Delays cannot be afforded as this will block beds in overstretched facilities.

Humanitarian support is going to be required in significant quantities not only for patients and their familiies, but also given the high levels of poverty and further negative socio-economic implications, to cope with the wide ranging consequences of COVID 19 in vulnerable communities.

B.3.2 Vigilance

Why: Given the negative public health and broader impact this virus has had on society, it would be important we remain vigilant, and track through regular surveillance any potential infections being transmitted in our various settings.

WHO: The Department will undertake this surveillance within health facilities and in other high risk settings, such as prisons, public transport, schools and large workplaces/ factories, etc.

HOW: This aligns with the stage 8 focus on vigilance and surveillance identified in the national strategy. Over and above the CST, regular testing of samples of staff within health facilities and other high-risk areas such as schools, prisons, large workplaces will be conducted to closely monitor any potential transmission that may be occurring. Also when a vaccine against COVID 19 is available, we need to ensure optimal population coverage.

B. 4: ADVERSE OUTCOMES

B.4.1 Death management: Mortuary and Burials

WHY: Noting the global experience, there are a significant number of deaths expected especially given our limited resources and levels of vulnerability of our patient population. We will plan for an efficient service delivery model for death management that prevents health facility mortuaries from being over-whelmed, as well as a process that is managed with dignity, respect and empathy to completion.

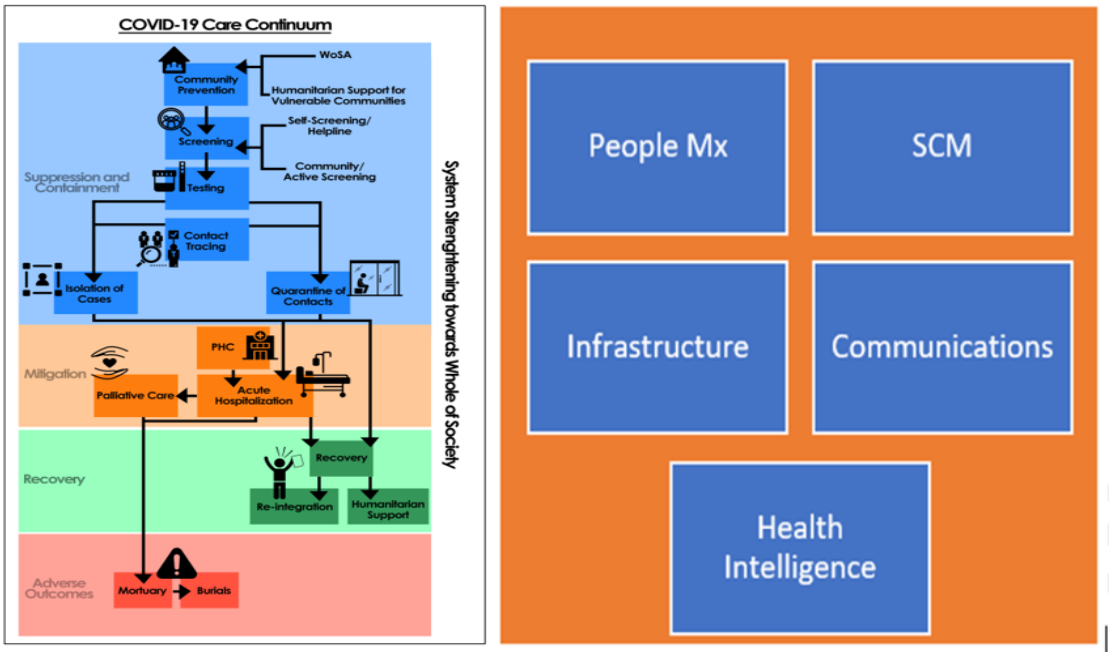
WHO: Given that most of the deaths will happen within our health facilities, the mortuary capacity will be overwhelmed and this requires the Local Government in partnership with the undertaker fraternity to manage a service delivery model that enables the rapid transit of bodies out of health facilities. It has been agreed that deaths from COVID 19 are not regarded as unnatural deaths and therefore not fall within the remit of FPS.

HOW: Patients that pass on and their family members must be managed with utmost dignity, respect and empathy at all times. Local Government has been mandated to engage with the undertaker fraternity to develop plans for each local area, protocols for managing dead bodies of COVID patients and their transport, and ensure adequate burial capacity within the different localities.

C. Enabling Support key to the Health Systems Response

The main pillars of enabling support are shown in Figure 2 below.

Figure 2: Key enabling support areas to the whole care continuum



Strategic Considerations

1. Communications:

The overall goals and objectives of the Communication strategy is to build trust and inspire confidence in the health system and its ability and readiness to respond to the COVID19 threat.

While the overall provincial strategy is directed via the Department of Premier (Stop the Spread) the Health Communications strategy complements and supports the campaign by providing the basic messages, information, stats and facts that drive a large part of the credibility of all the communication.

Messaging:

a) Messaging needs to remain focussed, fresh, creative and well attuned to strategies at every stage of the campaign – both to the public and internally to staff using both printed and digital mediums
b) The messages should follow the various phases and touch points of the care continuum
c) Should remain agile and able to identify risks quickly and respond fast
d) Internal Communication should function as a support to the Corporate response to enable staff to feel connected, included and informed
e) Work with various teams (e.g. health promotion) to ensure messages are a catalyst for behaviour change in public
f) Ensure that messages are inclusive (language) enough and penetrate the right audiences and communities.
g) Provide trusted official announcements on the status of the outbreak in South Africa and Western Cape
h) Communications forms an important network to connect and streamline various aspects of the response and ensure coherence of messages.

2. **Integrated Health Intelligence:**

Integrated Health Intelligence must be available daily in user friendly bytes to inform decision making:

a) An information system to track the cohorts of cases and contacts in the province is being developed. The main challenge is to access information from the private sector which is being addressed.
b) A dashboard has been created that captures daily new cases, number of negative tests, both within the country and the province. The cases within the province have been geo-located to suburb level and are aggregated to a sub-district level.
c) The WCGH needs to keep abreast of developments and experiences globally to inform our strategies.
d) Epidemiological and health evidence and intelligence is critical to re-shaping our interventions thro this epidemic.

3**. People management**:

The following people management interventions are required:

a) Our staff members need to be protected and kept safe and provided with the necessary PPE to conduct their duties. A PPE policy and a provincial occupational health policy has been finalised.
b) Employee wellness capacity to provide emotional support to staff
c) A database of volunteers has been established and a call for volunteers widely advertised.
d) A people management policy has been issued that covers amongst others, flexible working arrangements, leave, travel, employee support, and most importantly staff safety. While the policy cannot cover every eventuality, it is broad enough to allow for local discretion and customisation.

e) COVID-19 is rapidly evolving and our people management response will have to adapt accordingly. These are very challenging circumstances and calls for business unusual. It is therefore imperative for each staff member to be mindful, flexible and supportive of the health system response to this crisis. This may require staff to be re-deployed owing to operational requirements. It calls on each staff member to take primary responsibility for their own safety and to raise and address concerns with their immediate supervisors.
f) Accommodation and transport needs of staff are being addressed in partnership with the Department of Transport and Public Works.
g) A People Management desk has been established to assist and support staff
h) Organized labour are recognized as essential stakeholders and partners.

4**. SCM**:

The following key interventions are required:

a) The supplies especially of PPE is critical for the protection of staff and all means possible will be deployed to secure adequate stocks.
b) A dashboard of stock on hand is being created for the identified items provided per facility in near real-time with Geographic Information System (GIS) mapping capabilities. Stock on hand will be closely monitored daily via the appropriate electronic systems e.g. LOGIS, SYSPRO and MEDSAS. The centrally appointed team will proactively supply stock once levels reach minimum acceptable levels.
c) A central store is being created for bulk supplies which will be distributed based on the evolution of the pandemic.
d) Donations are being coordinated through the Department of Social Development, via the JOC.
e) Local manufacturing opportunities are being coordinated with the Department of Economic Development and Tourism to secure local supplies for PPE.

5. **Infrastructure and Health Technology**:

The following key actions are required:

a) The capacity to rapidly build, equip and commission temporary structures or redesign existing spaces to accommodate service needs including triage and testing or acutely ill patients or palliative care needs to be available in partnership with DTPW.
b) Multi - disciplinary commissioning teams are required to commission the additional acute bed facilities.
c) Procurement of beds, ventilators and oxygen supplies are being coordinated.
d) Flexible and emergency delegations are critical in these unusual times.
e) Negotiations are ongoing with the private hospital sector to secure additional acute and critical care beds.

D. Risks and Risk Mitigation Strategies

1. Are we under-planning and under-preparing for this pandemic and its impact?

We are using emerging health intelligence globally and locally, closely monitoring actual data from local reality to calibrate our health system response. Modelling and scenario planning is being used to forecast demand options. Management will use its collective wisdom, the best data and health intelligence available to make pragmatic judgements around the health system

response and resource planning requirements. We also recognise the need for agility to modify our responses. Resources are finite and we also need to prioritise the most cost effective interventions in keeping with the departmental pledge.

2. **Will there be a resurgence after the Lockdown is eased and how do we prepare to mitigate this?**

   There is a recognition that the decision to ease the lockdown must consider a range of public health and other socio-economic considerations. As the lockdown is eased, there is a need for targetted interventions to manage high risk areas as well as populations. This will include, amongst others, public gatherings, public transport, other areas of concentrated populations such as supermarkets, prisons and old age homes. Also measures such as social distancing, universal hygiene measures like hand washing, cough etiquette, the use of cloth masks must be continued. Social distancing in informal settlements is particularly challenging and will require more innovative thinking.

3. **How do we align our efforts between scaled up community screening, testing, isolation and quarantine capacity in this containment phase?**

   This requires integrated resource planning on the supply side as each component of the care continuum is inter-related and has knock effects on the others. We are in close engagement with NHLS regarding the expansion of testing capability and this is being addressed. We are in engagement with Public Works regarding the capacity for Isolation and Quarantine and revised estimates have been tabled. The impact of all of these interventions must also be reviewed in the light of emerging evidence and adjusted accordingly.

4. **What surveillance mechanisms do we put in place over and above the CST to be vigilant about transmission of this pandemic?**

   This aligns with stage 8 focus on vigilance and surveillance identified in the national strategy. Over and above the CST, regular testing of samples of staff within health facilities and other high- risk areas such as schools, prisons, large workplaces will be conducted to closely monitor any potential transmission that may be occurring.

5. **How do we manage when the created capacity is overwhelmed by demand?**

   This risk is mitigated by a three-pronged approach:

   a) Firstly, capacity will be ramped up to provide a system response through all components of the care continuum. This will include, amongst others:
      - Community screening, testing, I &Q (see (3) above)
      - Combining resources optimally from the private and public sectors in a single health system response who will also de-escalate non-emergency services, add additional capacity where feasible and create additional off site facilities that can be equipped and staffed appropriately.
      - Volunteers, including health professional, and students are being called for to assist.
      - Extra-ordinary measures to secure additional supplies including re-purposing local industry and robustly exploring alternative, innovative options to developing PPEs
      - Tight controls over the supplies and appropriate utilisation of PPE

   b) Secondly, rationing of care will have to be implemented using ethical principles and developing of clinical guidelines in this regard including which patients will be admitted to the limited intensive care beds available. Clinicians working in both public and private sector from the critical care society are addressing this matter.

c) Thirdly, public messaging to manage expectations and create a good understanding of the challenges to be faced will be important.

6. **How do we cope with a significant proportion of health staff becoming ill which reduces capacity to provide a health service?**
The protection of staff is a critical imperative. Numerous related policies have been developed including on the appropriate use of PPEs, staff safety framework, vulnerable staff and an overarching Occupational Health Policy. The frontline staff are going to be working under difficult circumstances and need to be physically and emotionally supported. Risk assessments and workplace preparedness plans including the streaming of COVID and Non - Covid patients will be developed. When cases are identified in health facilities, rapid responses to identify and manage contacts and cases will be implemented. Volunteer staff, staff from the private sector, agency staff and bursars who are not employed will be hired or approached to assist.

7. **What are the complications of the coincidence of the Flu season and how do we mitigate?**
Many of the symptoms of Flu and COVID overlap and this complicates the clinical identification of COVID cases. It will also mean that many patients with flu may be anxious and present themselves at health facilities for testing and management. Enhanced public education and messaging, supporting self-management and developing clinical guidelines to better manage this situation will be implemented. The Department has prioritised staff and vulnerable groups to be immunised with the flu vaccine as a preventative measure.

8. **How do we share health intelligence and actual data in the public domain without creating alarm and panic and compromising patient confidentiality.**
The Department has recommended and the provincial cabinet has endorsed greater sharing of information in the public domain. Identifiable patient level data will be confidentially managed and only shared for the clinical management of patients and a health service response such as contact tracing. A public facing dashboard has been launched that shows the metrics per sub-district in the province.

E. Post COVID Health System Recovery and Adaptation

The Health system will also need to recover from this shock. The leadership will need to recognise the staff especially at the frontline for their heroic efforts way beyond the call of duty. Processes to undertake significant reflection and learn the lessons at all levels of the system will need to be undertaken. Processes to reflect and learn are ongoing through this period. The positive ways of working differently, being responsive and agile must be institutionalised to be sustained.

F. Implementation and Governance

The Strategic Governance Executive (SGE), on behalf of TEXCO, will provide oversight, monitor, review and govern this strategy at a provincial level.

Management at operational levels need to develop a consolidated Covid-19 Plan for their facility or geographic area i.e. sub district or district using the parameters outlined within this strategy. These plans should include a health system strengthening approach while addressing the specific approach towards the COVID - 19 pandemic, assessing risks with appropriate risk mitigation strategies, working with other sectors, community involvement, collaboration with the NPO and

private sector to strengthen the WoSA, as well as work preparedness plans based on risk assessments to protect staff as outlined in the OHS policy. The plans need to be agile and adapted with changing conditions, evidence and policies.

Appropriate governance mechanisms to provide oversight, collaboration and coordination of effort, monitoring of progress and review of local strategies and plans need to be in place. This could be built into existing mechanisms and structures where appropriate.

G. Monitoring, Evaluation and Learning

Data and information to monitor progress is critical. Systems are being developed to assess progress in each aspect of the health system response to the care continuum. Alignment is being sought with national requirements for reporting. While the focus is on Covid - 19, important aspects of health system strengthening also need to be monitored to ensure we are making sustainable gains for the medium to long term.

In this period, transparent sharing of information is important to build public confidence. A public dashboard has been launched in this regard that is updated daily.

Over and above the monitoring of progress, the culture, systems, processes of rapid learning has to be embedded so that we can constantly adapt and sharpen our responses to emerging evidence and changing conditions. Bottom up learning circles will be encouraged where staff from similar settings can share experiences and lessons. The learning from implementation will also inform policy review processes at a macro level. The pace at which we need to respond to Covid - 19 demands rapid learning processes. Our academic colleagues within HEIs, MRC and organizations such as Institute of Health Improvement will be engaged to provide expertise as well strengthening learning in the Department.

H: Conclusion

Our strategy towards Covid-19 needs to be agile and rapidly adjusted as conditions change. This document covers our strategic considerations at this point in time. This requires unity of purpose and strong partnerships – the Health Department cannot do this alone. There needs to be good alignment with the WCG strategy for a whole of society response. It is also a major opportunity to fast-track health system strengthening, and building towards UHC and WoSA. This calls for business unusual, sense of urgency and courageous leadership from all of us.