Executive Authority Statement

As we approach the end the 2019/20 financial year and begin a new political term, we look back to what we have achieved amidst the challenges. I am so privileged to be serving a second term at the helm of the biggest and the most resilient Department within the Western Cape Government.

We recently published the Western Cape 2019 Rapid Review Burden of Disease Report, which provides insight into the progress we have made since. The Report is summarized in a variety of reader friendly formats making it more accessible to our health employees and our stakeholders. The report will inform the design of our interventions to ensure that the people of the Western Cape live longer and are healthier, with a particular focus on the health resilience of children and people with long-term conditions.

National Health Insurance was a buzz word this year, in my bid to demystify the NHI Bill, I travelled to all the districts in the Province making presentations in town halls and hospital boardrooms; talking to statutory body representatives and community people about the NHI Bill. On the 24th January 2020, I hosted a Community Engagement Forum, the purpose for this consultative forum was:

- To acknowledge the publication of the National Health Insurance (NHI) Bill in 2019, and the subsequent public consultation hearings that were scheduled to take place in the Western Cape.
- To obtain a better understanding of the difference between Universal Health Care (UHC) and NHI, which was to assist attendees with the necessary information in anticipation of the NHI public hearings.
- To share information about the journey towards Universal Health Coverage in the Western Cape Province.

The South African health system faces many challenges and reform is necessary, however this must be mindfully done so that we do not further compromise the health and well-being of citizens. NHI on its own won’t solve all the problems we face and we must be mindful in the policy decision we make to progressively realise the right to health for all people of the country.

A key development in enhancing our health systems accessibility to hospital services, is the allocation of funds by National Treasury to build the Klipfontein Regional Hospital (replacing GF Jooste that has been decommissioned), and the Tygerberg Regional Hospital.

A major achievement in the last year was receiving a clean audit opinion for the 2018/19 financial year, a first for a provincial health department in the country. Clean and accountable governance is crucial, as it reinforces public trust in the department and the provincial health system.
To all 32 000 employees who are part of the team, I thank you for your bravery in dealing with the pressures you deal with on daily basis.

In closing I would like to welcome and congratulate the new Chief Financial Officer Mr Simon Kaye who took over from Mr van Niekerk who has since retired after serving the department with integrity, I also bid farewell to the retiring Head of Health, Dr Beth Engelbrecht, my heartfelt thanks to her for ensuring that we do not let the people of the Western Cape down. I take this opportunity to welcome and congratulate the new Head of Health, Dr Keith Cloete.

This year has been both challenging and exciting, we have a lot to be grateful for.

Nomafrench Mbombo
Minister of Health

February 2020
Accounting Officer-Statement

In 2018/19 Western Cape Government: Health achieved a clean audit outcome, a first for a provincial health department in the country. Performance achievements in 2018/19 included a 70.3% antenatal visit before 20 weeks of pregnancy, 73.6% contraception prevalence, and measles vaccination coverage of 78.8%. Nearly two thirds of new mothers receive a postnatal visit within 6 days of giving birth.

Deaths in children younger than 5 years has also been decreasing steadily, pointing to better management of childhood illnesses and increased access to health services. Furthermore, the mother-to-child HIV transmission rate in the Western Cape has been reduced to 0.3%, which has also contributed to the reduction in child deaths.

Other notable achievements in HIV treatment are viral suppression rates of 67.1% in children and 91.1% in adults. The treatment success rate of TB of drug-sensitive TB clients was 79.2%, with an 11% loss to follow up rate and a death rate of 3.9%. Client satisfaction was over 80% at all facilities, with the Central hospitals (Groote Schuur Hospital and Tygerberg Hospital) achieving 90% satisfaction rates.

Non-communicable chronic diseases such as diabetes and hypertension continue to place a significant burden on the health system. These conditions are complex in nature to track and measure, however the Department is currently working on formulating appropriate indicators. These will allow us to better understand the underlying aspects which contribute towards reduction in risk factors, incidence, and client- and clinician-management of the condition.

I could not be prouder of what we have been able to achieve as a Department and I want to thank each and every staff member for turning up every day and doing sterling work, often under very trying circumstances. As the exiting HoD I would like to thank my management team who has stood by me over last 5 years, it has been a pleasure to serve with you and I wish you only the best in the coming years. To the new HoD, Dr Cloete, I have no doubt that you will capability lead the Department, I know the provincial health system is in safe hands. These are exciting times to be at the helm of a provincial health department, as the country makes big strides towards achieve universal health coverage, may your journey be as rewarding as mine has been over the last 5 years.

Dr Beth Engelbrecht
Western Cape Head of Health

February 2020
Official Sign-off

It is hereby certified that this Strategic Plan:

- Was developed by the management of Western Cape Government: Health under the guidance of Minister Nomafrench Mbombo.

- Takes into account all the relevant policies, legislation and other mandates for which Western Cape Government: Health is responsible.

- Accurately reflects the strategic outcome-oriented goals and objectives which Western Cape Government: Health will endeavour to achieve over the period 2020 to 2025.

Signature:  
Dr K. Cloete [Chief of Operations]

Signature:  
Mr S. Kaye [Head of Corporate Services]

Signature:  
Dr KN Vallabhjee [Chief Director of the Strategic Cluster]

Signature:  
Dr. BE Engelbrecht [Accounting Officer]

Approved by

Signature:  
Minister Nomafrench Mbombo [MEC for Health]
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Part A: Our mandate

Constitutional mandate

The Constitution of the Republic of South Africa, 1996, obligates the state to respect, protect, promote and fulfill all the rights contained in the bill of rights, which includes the right of access to health care as provided for in sections 27, 28 and 35 of the Constitution. Section 27(1)(a) provides for universal access and stipulates that everyone has the right to access health care services, including reproductive health care. The obligation of the state to take reasonable measures within the available resource to progressively realise the right to health care is contained in section 27(1)(b). While section 27(3) asserts that no one can be denied emergency medical treatment. The right of children to access basic health care services is contained in section 28(1)(c); and section 35(2)(e) provides for the right of detained persons to access adequate medical treatment, at the expense of the state.

Legislative and policy mandates

Legislative Mandates

National

Choice on Termination of Pregnancy Act, 1996 (Act No. 92 of 1996)
Provides a legal framework for the termination of pregnancies based on choice under certain circumstances.

Criminal Procedure Act, 1977 (Act No. 51 of 1977), Sections 212 4(a) and 212 8(a)
Provides for establishing the cause of non-natural deaths.

Mental Health Care Act, 2002 (Act No. 17 of 2002)
Provides a legal framework for mental health in the Republic and in particular the admission and discharge of mental health patients in mental health institutions with an emphasis on human rights for mentally ill patients.

National Health Act, 2003 (Act No. 61 of 2003)
Provides a framework for a structured health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services. The objectives of the National Health Act (NHA) are to:
• unite the various elements of the national health system in a common goal to actively promote and improve the national health system in South Africa;
• provide for a system of co-operative governance and management of health services, within national guidelines, norms and standards, in which each province, municipality and health district must deliver quality health care services;
• establish a health system based on decentralised management, principles of equity, efficiency, sound governance, internationally recognized standards of research and a spirit of enquiry and advocacy which encourage participation;
• promote a spirit of co-operation and shared responsibility among public and private health professionals and providers and other relevant sectors within the context of national, provincial and district health plans; and
• create the foundation of the health care system and understood alongside other laws and policies which relate to health in South Africa.

National Health Act (Act No. 61 of 2003) National Environmental Health Norms and Standards (Notice 1229 of 2015)
Issued in terms of Chapter 3, Section 21(2)(b)(ii) of the National Health Act, 2003, the National Environmental Health Norms and Standards for premises and acceptable Monitoring Standards for Environmental Health Practitioners outlines monitoring standards for the delivery of quality Environmental Health Services, as well as acceptable standards requirements for surveillance of premises, such as business, state-occupied premises, and for prevention of environmental conditions that may constitute a health hazard for protection of public health.

For application by Provincial Departments of Health in the planning and implementation of public sector health facilities and are applicable to the planning, design and implementation of all new buildings.

National Roads Traffic Act (Act No. 93 of 1996)
Provides for the testing and analysis of drunk drivers.

Occupational Diseases in Mines and Works Act, 1973 (Act No. 78 of 1973)
Provides for medical examinations on persons suspected of having contracted occupational diseases, especially in mines, and for compensation in respect of those diseases.

Sterilisation Act, 1998 (Act No. 44 of 1998)
Provides a legal framework for sterilisations, including for persons with mental health challenges.
The regulations provide for the licensing and accreditation of private health establishments in the Province.

**Regulations Governing the Financial Prescripts in terms of Western Cape Health Facility Boards and Committees Act**, 2016 (Act No. 4 of 2016)
To regulate the management and control of financial matters of the health facility boards and committees in health establishments and primary health care centres in the Province. The regulations focus on the outputs and responsibilities dealing with investment of funds and providing financial and audited statements including asset management.

**Regulations Governing the Procedures for the Nomination of Members for Appointment to Boards and Committees Act**, 2017 (PN 219/2017)
To regulate the manner and the process under which the members of the boards and committees to be nominated and how the Minister must determine how the bodies and organisations representing the communities were invited for nominations.

**Regulations relating to the Criteria and Process for the Clustering of Primary Health Care Facilities**, 2017 in terms of the Western Cape Health Facility Boards and Committees Act, 2016 (Act No. 4 of 2016)
The regulations provide for the process where the Minister determines how the process of clustering of a group of primary health care facilities where a committee is established regarding the geographical distance, between the concerned primary health facilities and the size and distribution of the population in the area.

**Western Cape Ambulance Services Act**, 2010 (Act No. 3 of 2010)
The Act provides for the regulation of the delivery of ambulance services in the province. Further, establishes the Western Cape Ambulance Services Board and further provides for the accreditation, registration and licensing of ambulance services.

**Western Cape District Health Councils Act**, 2010 (Act No. 5 of 2010)
The Act provides for matters relating to district health councils so as to give effect to section 31 of the National Health Act, 2003 (Act 61 of 2003). Further, it establishes district health councils in consultation with the MEC responsible for local government in the province and municipal council of the relevant metropolitan or district municipality.
Western Cape Health Facility Boards and Committees Act, 2016 (Act No. 4 of 2016)
The Act provides for the establishment, functions and procedures of boards established for hospitals and committees established for primary health care facilities and matters incidental thereto.

Western Cape Independent Health Complaints Committee Act, 2014 (Act No. 2 of 2014)
The Act provides that for the establishment of the Independent Health Complaints Committee; provide for a system for referral of complaints to the Committee for consideration and matters incidental thereto.

Western Cape Independent Health Complaints Committee Regulations, 2014 in terms of the Western Cape Health Complaints Committee Act, (Act No. 2 of 2014)
Provides for the referral and consideration of complaints, action plan and period of time for completion of process on complaints referred to the Committee.

Policy Mandates

International

2030 Agenda for Sustainable Development, 2015 (Goal 3)
The Agenda is a shared blueprint for peace and prosperity for people and the planet and consists of 17 Sustainable Development Goals (SDGs). The Department is committed to achieving Goal 3, Good Health and Well-Being, with a particular focus in the next 5 years on:

- Building further on the gains we have made in reducing maternal mortality and preventable deaths under 5 years in the province;
- Further reducing the epidemics of AIDS and TB; and premature deaths as a consequence of NCDs;
- Continue to promote mental health; and ensuring universal access to sexual and reproductive health care;
- Strengthening the provincial health system towards achieving Universal Health Coverage (UHC)

Political declaration of the UN high-level meeting on universal health coverage (UHC), September 2019
The political declaration adopted by the UN General Assembly on UHC reaffirmed that health is a precondition for, and an outcome and indicator of the social, economic and environmental dimensions of sustainable development and strongly recommits to achieving UHC by 2030. Universal health coverage is viewed as fundamental for achieving the sustainable development goals not only for health and wellbeing but also to eradicate poverty, ensuring quality education, achieving gender equality and women’s empowerment, providing decent work and economic growth, reducing inequalities, ensuring just, peaceful and inclusive societies and fostering partnerships. While reaching the SDG goals and targets is considered critical for the attainment of a healthier world for
all, with a focus on health outcomes throughout the life; and stressing the need for a comprehensive, people-centred approach. The Declaration also reaffirmed the assembly’s previous political commitments on ending AIDS, tackling antimicrobial resistance, ending tuberculosis and the prevention and control of non-communicable diseases. The declaration further recognized that UHC implies that all people have access, without discrimination, to nationally determined sets of needed essential promotive, preventive, curative, rehabilitative and palliative services; and safe, affordable, effective and quality medicines and vaccines. This access should not expose people to financial hardship, in particular the poor, vulnerable and marginalized segments of the population.

National

**National Development Plan (NDP), 2012**

The NDP is a broad strategic framework, which sets out a coherent and inclusive approach to the elimination of poverty and reduction of inequality by 2030, based on the following 6 priorities:

- Uniting South African around a common programme
- Citizens active in their own development
- Fast and more inclusive economic growth
- Building capabilities
- A capable and developmental state
- Leadership and responsibility throughout society

Of particular relevance to the Department is the ‘Building capabilities’ priority, as it identifies health as a critical human capability and sets out a vision of a health system capable of providing quality health care for all.

**Medium Term Strategic Framework (MTSF), 2019/24**

The Medium-Term Strategic Framework (MTSF) for period 2019-2024, is aimed at eliminating avoidable and preventable deaths (survive); promoting wellness, preventing and managing illness (thrive); transforming health systems, improving the patient experience, and mitigating social factors determining ill health (transform), aligning with the SDGs for health. UHC is identified as central to progressively realising to the right to health for all South Africans and a priority area of the 2019/24 MTSF. An improved life expectancy of 70 years is the other big priority, specifically the aspiration to reduce maternal and child mortality. Women, the youth and disabled people are identified as cross cutting focus areas, the desired impact being, ‘all women, girls, the youth and people with disabilities enjoy good quality health care and better life opportunities’. The identified outcome for these cross-cutting focus areas is, ‘improved educational and health outcomes and skills development for all women, girls, youth and persons with disabilities’.
Provincial

2019-2024 Provincial Strategic Plan (PSP), 2020

The PSP sets out the provincial medium-term budget policy priorities of the Western Cape Government (WCG), which are aligned with the NDP and its’ implementation plan. The Provincial Government is thus committed to building a values-based competent state that enables opportunity and promotes responsibility in a safer Western Cape and has identified the following 5 vision inspired priorities (VIPs):

1. Safe and cohesive communities
2. Growth and jobs
3. Empowering people
4. Mobility and spatial transformation
5. Innovation and culture

VIP 3 speaks specifically to the mandate of the Department as it seeks to ensure a meaningful and dignified life for residents of the province. Achieving this impact is heavily reliant on the collective efforts of the “whole of society”, being able to collaborate effectively with a broad range of stakeholders is key to success for this VIP. Of particular relevance to the Department are the ‘Children and families’ and the ‘Health and wellness’ focus areas of the priority. The Department is thus committed to the outcomes identified in these two focus areas and has aligned its strategic plan accordingly.

Departmental policies & strategies

Healthcare 2030 – The Road to Wellness, 2014

Healthcare 2030 was endorsed by the Provincial Cabinet of the Western Cape Government in 2014, signaling the third wave of health care reform in the Province since 1994. The document outlines the Department’s vision for the health system and directs developments over the next 10 years and is focused on enhancing the health systems responsiveness to people’s needs and expectations; with careful consideration of person-centredness, integrated care provisioning, continuity of care and the life course approach. Healthcare 2030 provides a strong strategic grounding as we move towards achieving universal health coverage (UHC) in fulfilling our constitutional mandate to progressively realise the right health care for the residents of the province.
UHC Strategy 20/25 – Moving towards a healthier province

In line with the Political Declaration of the UN High-Level Meeting on UHC, NDP and MTSF, the Department’s UHC Strategy 20/25 invests in the development of 4 core capabilities of the provincial health system. The enhancement of the system’s service delivery capability, its governance capability, its workforce capability and its learning capability, essential if we are to progressively realise the right to health care for all residents of the province, as the constitution mandates. The Department cannot achieve this on its own, it requires the efforts of the ‘whole of government’ and beyond, thus the Department has embraced the Whole of Society Approach (WoSA). This approach calls for collaborative action across all spheres of government and all sectors, guided by a shared purpose to impact meaningfully on the lives of the people living in the province.

The renewed commitment to the ideals of Healthcare 2030, for the next 5 years, reaffirms the need to place people at the heart of the health system. The Department further grounds its actions, particularly for the service capability area, in the Community Oriented Primary Care (COPC) approach. Both this approach and WoSA necessitate the re-defining of key health actor relationships, consequently UHC 20/25 has become a living strategy, evolving as we adapt and learn, building trusting collaborative relationships as we ‘do’ together. Current emerging priorities of the Strategy includes the re-design of the care continuum focusing on the PHC and general specialist services; the institutionalization of collaborative governance; becoming a learning organization, leveraging maximally off technology; and building a capable workforce with the competence necessary for a high-quality, high performance health system that is resilient, can learn and is ultimately for people.

Relevant court rulings

There are no new court rulings that have a significant, ongoing impact on operations or service delivery obligations of the Department.
PART B
OUR STRATEGIC FOCUS
Vision

Access to person-centred quality care

Mission

We undertake to provide equitable access to quality health services in partnership with the relevant stakeholders within a balanced and well-managed health system to the people of the Western Cape and beyond

Values

Innovation  Caring  Competence  Accountability  Integrity  Responsiveness  Respect

Situational Analysis

Western Cape is the third largest province in South Africa after Gauteng and KwaZulu-Natal, with a population of 6,997,465\(^1\). It is located in the southern tip of the country and comprises of six districts, with 24 local municipalities. Cape Town is the capital of the province and the second most populous city in South Africa behind Johannesburg. The Western Cape is rich in agriculture and fisheries, its climate in the peninsula and the mountainous region beyond it is ideal for grape cultivation, with a number of vineyards producing excellent wines. Other fruit and vegetables are also grown here, and wheat is an important crop to the north and east of Cape Town. Fishing is the most important industry along the west coast and sheep farming is the mainstay of the Karoo. The province has a well-established industrial and business base. Sectors such as finance, real estate, Information and Communications Technology (ICT), retail and tourism have shown substantial growth, and are the main contributors to the regional economy. Many of South Africa’s major insurance companies and

\(^1\) Mid-year population estimates 2019, Statistical Release P0302, Statistics South Africa July 2019
banks are based in the Western Cape. The majority of the country’s petroleum companies and the largest segment of the printing and publishing industry are located in Cape Town.

**External Environment**

**Demographics**

The 2019 mid-year population estimates by Statistics South Africa have projected the population in the Western Cape (WC) to be approximately 6,997,465, an increase of approximately 2.2 per cent per since the last year. It is estimated that 11.7 per cent of South Africa’s population resides in the Western Cape and the province is expected to experience rapid population growth of nearly 20 per cent for the period 2020 – 2030, owing largely to in-migration from other provinces, most notably the Eastern Cape. The Western Cape has been a receiving province for in-migration, due to a range of improved socio-economic opportunities including education, jobs and health. Migration will soon overtake births as the driver of population increase in this Province.

The graphs (Figure B2) below show the population distribution in the province and 51 per cent of the total population are females. About 59 per cent of the population in the Western Cape is below the age of 35, while about 7 per cent of the population is over the age of 65. About 69 per cent of the population are in the economically active age groups 15-64 and about 25 per cent are under the age of 15.

![Figure 1: Western Cape Population by Age](image)

A closer observation of the trends for the period 2020 – 2030 reveals consistent growth of the population older than 65 and a reduction for children under 5, adolescent and youth age categories. These projected changes are concomitant with the general patterns exhibited across...
the country as South Africa is anticipating a surge in the aging population. This will require the health system to pay much more attention to non-communicable diseases as the prevalence of the three major risk factors (hypertension, diabetes, and cardiovascular diseases) increase with age. The change in demographic patterns would also require a significant expansion of rehabilitative and palliative care services in South Africa across the board.

**Fertility Rates**

The Western Cape’s average fertility rate is estimated to decline from 2.22 to 2.0 between the periods 2011-2016 and 2016-2021.

**Life Expectancy**

The Western Cape population has an average life expectancy of 68 years, the highest in South Africa for both males and females. This has increased over the last 18 years (males: 59.6 years in 2001-2006 increasing to 65.7 years 2016-2021; females: 64.5 years 2001-2006 increasing to 71.1 years 2016-2021). Female life expectancy has consistently higher than male life expectancy.

**Social Determinants of Health**

South Africa’s economy has over the past years been operating on low growth, and this trend is expected to persist through 2020, with growth at 1.1 per cent. Low investment, low consumer spending and low export figures are credited for the sluggish growth. The same low growth applied to the global economy which registered 3.2 percent in 2019 and is expected to increase to 3.5 per cent in 2020. The International Monetary Fund (IMF) forecasts average Gross Domestic Product (GDP) growth of 2.4 per cent over the 2021-2023 period.

Household consumption remains under pressure. The high costs of living as a result of increased inflation, 4.5 per cent in 2019 and expected increase to 5.3 per cent in 2020, have reduced the disposable income of consumers. The impact is being felt in the public health sector with an increased demand for services. The demand is also being exacerbated by the high unemployment rate in the Western Cape. In the Western Cape, the official and expanded unemployment rates are estimated at 20.4 per cent and 23.8 per cent, respectively.

The usage of public health services will continue to come under much more pressure as much of the population shifts from private to public health services due to a reduction in disposable income. In

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2 World Economic Outlook, 2019, accessed on 18 October 2019
3 Monetary Policy Review-October 2019, South African Reserve Bank
4 Official unemployment: 15-64 years, actively seeking employment
5 Expanded unemployment: 15-64 years, discouraged work-seekers or other reasons for not searching
the past year, the Department has grappled with the increasing medical inflation on technology, medical equipment and drugs, which tends to reduce the budget in real terms, in turn affecting the health outcomes of the population served.

Globally, it is recognized that health and health outcomes are not only affected by healthcare or access to health services. They result from multidimensional and complex factors linked to the social determinants of health which include a range of social, political, economic, environmental, and cultural factors, including human rights and gender equality. Unemployment, informal housing, lower income levels, lower literacy rates, inadequate sanitation and food insecurity are all associated with poor health status and negative health outcomes and the Department is the universal recipient of these poor socio-economic realities.

The 2018 General Household Survey (GHS)\(^7\) reports that only 1.5 per cent of adults 20 years and older received no schooling, with approximately 30 per cent matriculating, and an adult literacy rate of 98.2 per cent in the Province. The GHS\(^9\) also reflects on inadequate access to funding remaining a hurdle for school attendance across South Africa; in the Western Cape 47.4 per cent of learners attend no-fee schools. In addition, 22.1 per cent of individuals and 36.7 per cent of households in the province were social grant beneficiaries. See Table B1.

Although the Western Cape is considered a relatively wealthy province, Statistics South Africa reports an increase in proportion of individuals below the food poverty line from 2011 to 2015 (37 per cent in 2015\(^8\)). Furthermore, the Western Cape also has high levels of inequality, with a Gini co-efficient\(^9\) greater than 0.5. The Gini co-efficient is high, despite an improvement in the Human Development Index (HDI), which is a measure of the relative development of a population including education, health and living conditions. The difference in trends in the Gini co-efficient and HDI suggest that improvements in development have not been equally distributed, with growing provincial inequity. The spatial distribution of poverty is therefore critical in understanding the provincial burden of disease\(^10\).

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\(^7\) General Household Survey 2019, Statistical Release P0318, Statistics South Africa May 2019
\(^9\) Gini coefficient - a measure of relative equality or inequality of income distribution. A score of 0 is an absolutely equal society, and a score of 1 is a completely unequal society.
\(^10\) 2019 Burden of Disease rapid review, Health Impact Assessment, Epidemiology & Surveillance
Burden of Disease

Years of Life Lost

Non-Communicable Diseases (NCDs) as a group (cardiovascular diseases, diabetes, cancer, other NCDs) account for half of the premature mortality burden in the province. HIV/AIDS and TB accounted for approximately 19 per cent of premature mortality, while injuries accounted for 22 per cent of premature mortality. When looking at the 8-year premature mortality trend from 2009 – 2016, the Years of Life Lost (YLL)\textsuperscript{11} decreased by 18 per cent from 14 657 in 2009 to a low of 11 999 in 2013 and remained 17 per cent lower than 2009 in 2016 at 12 115, per 100 000 populations. See Figure 2.

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\textsuperscript{11} Years of Life Lost are an estimate of premature mortality based on the age at death and thus highlight the causes of death that should be targeted for mortality prevention.
Age-specific mortality rates decreased by >40 per cent from 2009 to 2016 for all children under 5 years of age. Among females, age-specific mortality rates decreased most markedly between those aged 20 - 34 years of age (>30 per cent). Whereas, among males, age-specific mortality increased by approximately 13 per cent for those aged 15 - 24 years of age between 2009 and 2016.

There have been decreases in the YLL per 100 000 across all districts, ranging from 1.7 per cent in Overberg to 16.4 per cent in Cape Winelands. The largest contributions in decreases to YLL per 100 000 across all districts have been HIV/AIDS & TB (from 34 per cent reduction in the Cape Metro and Central Karoo, to 4 per cent in West Coast), and Communicable/Maternal/Perinatal/Nutritional conditions (46 per cent reduction in Cape Winelands, approximately 35 per cent reduction in the Cape Metro and West Coast, with smaller decreases in the other districts). Injury YLL per 100 000 have increased in the Cape Metro (13 per cent), while decreasing in most other districts. Overall, non-
communicable disease YLL per 100,000 increased in most districts approximately 5 per cent or less), with Overberg increasing by 17 per cent.

**Figure 5: Percentage change 2009 to 2025: YLL per 100,000, by District**

- Cape Metro
- Cape Winelands
- Central Karoo
- Eden
- Overberg
- West Coast
- Western Cape

**Figure 6: YLL per 100,000 populations, by cause 2009 vs 2015**

HIV/AIDS and TB

The Thembisa HIV\(^{12}\) and demographic model estimates that in 2018 there were approximately 450,000 people living with HIV in the Western Cape, including 13,000 children younger than 15 years of age. Among adults 15-49 years, estimated HIV prevalence is 10.3 per cent overall, but nearly twice as high in women (13.4 per cent) compared to men (7.3 per cent). The estimated HIV incidence

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\(^{12}\) Thembisa Model 4.2
among those 15-49 years is 4.7 per 1000, approximately 43 per cent lower than in 2007/08, but remains higher in females than in males (5.9 vs. 3.6 per 1000). Although HIV incidence in the Western Cape is one of the lowest across the provinces, the rate of decline has been relatively slow.

Figure 7: Western cape HIV Prevalence 15-49 and PLHIV

![Graph showing HIV prevalence and number of PLHIV](image)

Figure 8: Western Cape HIV incidence, by sex 15-49 years

![Graph showing HIV incidence by sex](image)

The World Health Organisation’s 90-90-90 strategy has strengthened the focus on HIV testing and treatment. The graph below reflects on these targets for the province for the past decade\(^\text{13}\), with an estimated 66 per cent of those tested for HIV on antiretroviral therapy (ART), and 78 per cent of those on ART confirmed viral suppression (a viral load of less than 1 000 copies per millilitre of blood). A major reason for not achieving the 2nd 90 “90 per cent of all patients diagnosed with HIV being on

\(^{13}\) Provincial Health Data Centre
"ART" is due to non-retention of patients on ART. It is estimated that 40 per cent of patients that have ever started ART are not retained and about one third of those not on ART are patients who have previously started treatment but are no longer on treatment.

Although the number of TB cases diagnosed across the Western Cape has decreased, there is fluctuation over time. In 2018, approximately 83 per cent of TB cases-initiated treatment, with 35 per cent for re-treatment of TB and approximately 12 per cent were cases of extra-pulmonary TB. When looking at sensitivity, in 2018, nearly 60 per cent of TB cases were drug sensitive, 4.8 per cent drug resistant and 36 per cent with unknown sensitivity. Of the drug resistant cases, 2.5 per cent were multi-drug resistant and 0.4 per cent extensively drug resistant (not shown).
Furthermore, in 2018, 40 per cent of those with TB were also HIV+ (trend relatively unchanged) with 82 per cent starting ART, mostly prior to TB diagnosis.

**Infant, Child and Maternal Health**

In 2018/19, of the 103,277 women attending antenatal services at least once, approximately 70 per cent attended within the first 20 weeks of their pregnancies. The Thembisa model estimates that mother-to-child transmission of HIV, including during breastfeeding, has decreased by nearly 75 per cent over the past decade, from 11.8 per cent in 2008 to 3.4 per cent in 2018.
The number of deliveries across the province remain steady at approximately 100 000 per year. The in-facility maternal mortality rate for the 2014-2016 triennium is 68.3 per 100 000 live births\textsuperscript{14}. The main risk for maternal mortality is bleeding during and after delivery, reflecting on surgical and resuscitation skills and emergency transport. There has also been an increase in deaths due to medical disorders, largely cardiac disease and pulmonary embolus.

The trends in the infant and child (under 5) mortality rates are shown below. Rates appear to be plateauing, however data for 2015 and 2016 must be interpreted cautiously as the late registration of births and deaths for these years have not been taken into account\textsuperscript{15}.

\textit{Figure 13: Western Cape under 5 mortality}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure13.png}
\end{figure}

\textit{Non-Communicable Diseases}

The burden of non-communicable diseases (NCDs) remains a concern when considering the high prevalence of risk factors like obesity, smoking and lack of exercise. Various national and provincial surveys indicate wide variation in the prevalence of common NCDs, depending on the source of the estimate and measurement methodology. The ability to estimate the true burden of people living with NCDs in the province is therefore limited. Selected conditions and risk factors as reported in the 2016 South African Demographic and Health Survey (DHS)\textsuperscript{16} for the Western Cape is detailed in the table below.

\textsuperscript{14} Confidential enquiry into maternal deaths
\textsuperscript{15} IMR and U5MR calculated from Statistics South Africa reported live births and deaths for the Western Cape.
\textsuperscript{16} South Africa Demographic and Health Survey 2016, NDOH, Stats SA, SA-MRC and ICF, 2019
The Provincial Health Data Centre has made progress in the use of proxy disease markers, such as dispensing records and laboratory requests to better enumerate disease caseload. The figures below utilise this data to estimate case load and programme performance for diabetes, using diabetic medication as evidence for disease. The graph shows the numbers starting treatment, and those who started treatment and in care at the end of 2018, respectively. Nearly 60 per cent of diabetics are aged 40-65 years, and a further 31 per cent older than 65 years. Testing of glycosylated haemoglobin (HbA1c, a marker of glycaemic control), is variable across the districts, and glycaemic control for those tested is poor with 51 per cent of patients tested having an HbA1c >10 per cent.

**Selected conditions**

<table>
<thead>
<tr>
<th></th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>51.6%</td>
<td>58.7%</td>
</tr>
<tr>
<td>HbA1C ≥6.5% (adjusted)</td>
<td>12.2%</td>
<td>13.3%</td>
</tr>
</tbody>
</table>

**Risk Factors**

<table>
<thead>
<tr>
<th></th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overweight or obesity (BMI ≥25)</td>
<td>73.3%</td>
<td>43.7%</td>
</tr>
<tr>
<td>Smoking</td>
<td>26.4%</td>
<td>43.2%</td>
</tr>
<tr>
<td>Risky drinking*</td>
<td>9.0%</td>
<td>22.8%</td>
</tr>
</tbody>
</table>

*5 or more drinks on a single occasion

The Provincial Health Data Centre has made progress in the use of proxy disease markers, such as dispensing records and laboratory requests to better enumerate disease caseload. The figures below utilise this data to estimate case load and programme performance for diabetes, using diabetic medication as evidence for disease. The graph shows the numbers starting treatment, and those who started treatment and in care at the end of 2018, respectively. Nearly 60 per cent of diabetics are aged 40-65 years, and a further 31 per cent older than 65 years. Testing of glycosylated haemoglobin (HbA1c, a marker of glycaemic control), is variable across the districts, and glycaemic control for those tested is poor with 51 per cent of patients tested having an HbA1c >10 per cent.

**Figure 15: Western Cape: Number of Diabetics**
The figure above illustrates the total number of diabetics that have at some point been diagnosed in our system but are not in active care, juxtaposed against the diabetics who have been diagnosed, and are still receiving healthcare—this is done at a sub-district level. These figures are concerning as it shows the percentage of diabetics who have touched our services but are no longer in our care. These patients are at high risk for the negative sequelae of untreated diabetes, including end organ damage and microvascular disease. If we are able to retain diabetics in care, we could improve diabetes control in the population.
Mental Health

Quantifying the burden of mental illness is challenging both because of limited epidemiological studies and because mental illness is associated with morbidity rather than mortality. The burden of mental illness cannot be approximated from mortality surveillance data. Disability-Adjusted Life Years (DALYs) are more appropriate than mortality data to quantify the burden of mental illness as DALYs combine morbidity (years life with disability) with premature mortality (YLL). In 2000, in South Africa, neuropsychiatric disorders were the third leading cause of DALYs, however no data are available for the Western Cape. The 2004 South African Stress and Health Survey (SASHS) remains the main source of mental health prevalence data for South Africa. The SASH reported a lifetime prevalence of 39.4 per cent of any mental disorders in the Western Cape. The prevalence of anxiety disorder was 19 per cent, mood disorder 14 per cent and substance use disorders 21 per cent.

Injuries

Injuries accounted for 14 per cent of all deaths in the Western Cape in 2016, while homicides accounted for 51 per cent of all injury deaths, and 38 per cent were unintentional (accidental). Suicides were 11 per cent of all injury deaths. Mostly males (80 per cent of injury deaths), particularly between the ages of 20 - 39 years, died from injuries.

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19 Western Cape Injury Mortality Profile 2010-2016, Evans et al 2018
Intentional injuries

There has been a year-on-year increase in the annual number of homicides in the province from 2010 to 2018, with the major increase being homicide due to firearms (age-standardised rate doubled from 17 to 35 per 100 000 population from 2010 to 2016).

Most of the increase in homicides in the province came from the Cape Metro, specifically Mitchells Plain, Klipfontein, Tygerberg and Khayelitsha. The last three sub-districts had the highest age-standardised homicide rate among males in 2016. Furthermore, 50 per cent of homicide deaths tested positive for alcohol, with 45 per cent having a blood alcohol concentration greater than the legal driving limit in South Africa (>0.05g/100ml)20.

Unintentional injuries

Road traffic injuries were the leading cause of unintentional injuries (35 per cent motor vehicle, 25 per cent pedestrian fatalities), followed by fires (14 per cent) and drowning (approximately 9 per cent) in 2016. The absolute number of road injury deaths increased slightly between 2012 and 2019, due to population growth, the age-standardized road injury mortality rates have remained relatively

20 Western Cape Injury Mortality Profile 2010-2016, Evans et al 2018
constant. Central Karoo had the highest motor vehicle age-standardized rate, mainly due to the high number of fatal accidents (residents and non-residents) occurring along the N1 national road, although it declined substantially between 2010 and 2016.

Figure 19: Western Cape road traffic injuries age-standardised rates trend, 2010-16

![Graph showing trend of road traffic injuries age-standardised rates](image)

Figure 20: Western cape road traffic injuries age standardised rates, 2016

![Map showing distribution of road traffic injuries age-standardised rates](image)
Climate Change

The Western Cape is one of the most vulnerable regions in Africa and the reality of this has become more evident with extreme weather events such as the recent drought. The Department has in the past few years been actively developing and implementing mitigation and adaptation strategies to ensure business continuity. Carbon footprint drives climate change. The Department is committed to reducing its carbon footprint on the environment and is implementing a number of energy efficient initiatives.

Internal Environment

The built environment

There are 457 primary health care service points and 33 district, 5 regional, 6 tuberculosis, 4 psychiatric, 2 central and 1 tertiary hospital. Furthermore, there is also a rehabilitation centre and 459 ambulance stations with 254 licensed ambulances. One hundred and ninety (190) of the primary health care facilities and all of the hospitals are connected to broadband connectivity, either via fibre, radio frequency or wirelessly, with a minimum of 10mb and a maximum of 1gb. The Department, via its strategic partner CEI, will increase bandwidth by 10gb for large facilities and 100mb for all the rest.

Infrastructure

The Department considers accessibility to healthcare facilities as extremely important. Based on the Social Facility Provision Toolkit, developed by the Department of Rural Development and Land Reform (in association with the CSIR), rural health facilities should be within a radius of 5 km from a dependent population of 3,000 or more. Using this as baseline, the Department’s coverage within rural areas is above average based on the number of Primary Healthcare facilities. With respect to metro facilities, due to the higher population density, a 2.5 km radius was used as baseline. The travel distance of 2.5 km, based on the 2011 population, indicated good (90%) access and good concentration of facilities in high density areas. This exercise was undertaken in 2014 and will be updated in 2020.

Ageing infrastructure, as well as the impact of population growth and the burden of disease on the need for infrastructure, remains a reality for the Department. Currently, the infrastructure backlog is estimated at R32.4 billion. In addition, the difference between maintenance funding required and that allocated per annum is approximately R1.359 billion. The situation is further exacerbated by the huge increase in project cost in the last two years, which is due to escalation, regulation requirements and increased safety measures.

The major disaster events that the Department experienced in recent years, ranging from the fires that destroyed the Swartland Hospital main building, the Mitchell’s Plain Hospital Emergency Centre and the theatre at Mitchell’s Plain CHC, as well as the destruction of the Diazville Clinic due to civil
unrest have a prolonged effect on infrastructure and service delivery. These disasters, together with the ill-effects of climate change on water resources and energy required the prioritization of various capital infrastructure and maintenance projects to reinstate or replace facilities affected by the disasters and the development of mitigation and adaptation strategies to address the demands of climate change. Some projects have already been undertaken, with others either in planning or underway.

**IT Innovations**

ICT processes have been systematically integrated into the business process of the department, along with the development of an IT vision that is coherent and aligned with the service and support priorities of the Department. All core and support functions that are currently on paper are sought to be digitized, and ICT has been identified as a key lever for efficiency gains. Therefore, our Health IT solutions should follow the business logic to facilitate seamless continuity of patient information across an integrated service delivery platform and ultimately support patient agency.

The electronic Continuity of Care Record (eCCR) is an innovation aimed at improving the continuity of care between hospitals and primary health care. It is a collaborative project by the Department and Health System Technologies with an initial focus of establishing a web-based electronic Discharge Summary. The enhancement of the patient-centred experience necessitates the continuity of care for patients who require multiple packages of care to achieve desired health outcomes in inpatient-, ambulatory-, and community settings. It has been implemented at 99 per cent of the fixed health facilities (Hospitals and PHC facilities) in the Province.

Another innovation, the Provincial Health Data Centre (PHDC), currently loads data from around 20 different provincial source systems, processing in excess of a million rows of data daily. Processes in the PHDC include ETL and data harmonisation, data curation (including mapping of clinical concepts to standard code-lists and patient identity mapping), data beneficiation through a multi-evidence inference engine, and pre-processing of data for reporting through the building of disease cascades.

Running off the PHDC is the Single Patient Viewer (SPV) as a prototype consolidated visualisation tool for clinicians to ensure continuity of care. It serves as a portal to other systems, actionable line listing reports and associated aggregate reports delivered via SSRS and Sharepoint. Other functions include email alerts on occurrence of certain health conditions, and data extracts and analysis for internal and external data queries, in accordance with data governance prescripts of the Department. SPV has 250 registered users and 50 regular users.
The workforce

The World Health Organization standard doctor to patient ratio is 1:1 000. The ratio in the Western Cape is 0.32 doctors for every 1000 people, and 0.43 for every 1 000 uninsured people. Whilst this is just under half of the ideal staffing norm for doctors, the vacancy rate is low, at 3.21%. Increasing the number of posts available is a challenge given the shrinking fiscal envelop. The ratio of professional nurse to patient is 0.9 for every 1 000 people in the province. This can be improved if the vacancy rate of 9.71% decreases. Furthermore, if we consolidate the various nursing categories, the nurse to patient ration is 1.9.

Table 1: Table showing number of public health personnel and staff and staff-to-population ratios

<table>
<thead>
<tr>
<th>Category</th>
<th>No. Employed</th>
<th>% Of Total Employed</th>
<th>No. / 100 000 People</th>
<th>No. / 100 000 Uninsured People</th>
<th>Vacancy Rate</th>
<th>% Of Total Personnel</th>
<th>Annual Cost / Staff Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Officers</td>
<td>2 265</td>
<td>7.10%</td>
<td>32</td>
<td>43</td>
<td>3.21%</td>
<td>16.6%</td>
<td>763 665</td>
</tr>
<tr>
<td>Medical Specialists</td>
<td>716</td>
<td>2.24%</td>
<td>10</td>
<td>14</td>
<td>3.89%</td>
<td>9.8%</td>
<td>1 317 362</td>
</tr>
<tr>
<td>Professional Nurse</td>
<td>6 275</td>
<td>19.66%</td>
<td>90</td>
<td>119</td>
<td>9.71%</td>
<td>23.0%</td>
<td>441 920</td>
</tr>
<tr>
<td>Staff Nurses</td>
<td>2 642</td>
<td>8.28%</td>
<td>38</td>
<td>50</td>
<td>4.24%</td>
<td>5.4%</td>
<td>258 015</td>
</tr>
<tr>
<td>Nursing Assistant</td>
<td>4201</td>
<td>13.16%</td>
<td>60</td>
<td>80</td>
<td>2.03%</td>
<td>7.3%</td>
<td>221 603</td>
</tr>
</tbody>
</table>

Organizational design

The Department is currently engaged in a process to improve efficiencies and alignment of the management structures, functions and processes, referred to as the Management Efficiency and Alignment Project (MEAP). This intervention will address duplication of functions, the appropriate delegation of authority, the imbalance between centralisation and decentralisation and the reduction of administrative burden. It will include a new model for the Department’s macro- and micro-structures.

MEAP has been focussed on designing and implementing an organisational realignment toward a people-centred learning organisation. The management functions have been grouped into the following three broad categories: Service functions, Strategic Cluster functions and Corporate functions. The manner in which these functions are executed have been streamlined, with a focus on changing the organizational culture and the way the Department does business.

Health system governance

The key governance imperative is for the Department to actively engage in a series of meaningful collaborative governance arrangements with key stakeholders in other government departments,
community and civil society formations and other partners, such as private providers, higher education institutions, etc.

This will require highly streamlined and inter-connected internal Departmental governance arrangements across the macro, meso and micro-levels, to create seamless alignment between the Service, Strategic and Corporate functions. This will call on every official to embrace a culture that promotes active collaboration, intentional learning and adaptive approaches to finding solutions to challenges, within clear enabling policy parameters and controls.
PART C
MEASURING OUR PERFORMANCE
In 2025 Western Cape residents will live a longer and healthier life than they did in 2019.

### Measuring our outcomes

<table>
<thead>
<tr>
<th>MTSF PRIORITY 3</th>
<th>Education, skills and health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome 1</strong></td>
<td>A provincial health system that by design supports wellness</td>
</tr>
<tr>
<td>INDICATOR</td>
<td>BASELINE</td>
</tr>
<tr>
<td>Life expectancy at birth</td>
<td>68 years</td>
</tr>
<tr>
<td><strong>Outcome 2</strong></td>
<td>The children of the province have the health resilience to flourish</td>
</tr>
<tr>
<td>INDICATOR</td>
<td>BASELINE</td>
</tr>
<tr>
<td>Maternal Mortality Ratio</td>
<td>68.3 / 100 000</td>
</tr>
<tr>
<td>Under 5 mortality Rate</td>
<td>23.3 / 1000</td>
</tr>
<tr>
<td><strong>Outcome 3</strong></td>
<td>People with long-term conditions are well managed</td>
</tr>
<tr>
<td>INDICATOR</td>
<td>BASELINE</td>
</tr>
<tr>
<td>Viral load suppression</td>
<td>82%</td>
</tr>
<tr>
<td>Non-communicable diseases (NCDs)</td>
<td>Metrics for an NCD outcome are currently being developed, as the Department refines the design of its NCD interventions.</td>
</tr>
<tr>
<td><strong>Outcome 4</strong></td>
<td>A high-performance provincial health system for people</td>
</tr>
<tr>
<td>INDICATOR</td>
<td>BASELINE</td>
</tr>
<tr>
<td>Unqualified audit opinion</td>
<td>100%</td>
</tr>
<tr>
<td>Entropy</td>
<td>17.9%</td>
</tr>
<tr>
<td>Access</td>
<td>Metrics for an access outcome is currently being developed as the Department refines its UHC Strategy 2025.</td>
</tr>
</tbody>
</table>
Explanation of planned performance over the next 5 years

In seeking to ensure that Western Cape residents live longer and are healthier by 2025 the Department has identified four core outcomes as detailed below; in line with the service and system priorities over the next 5 years. The service priorities focus on drives of the disease burden for children and residents with a long-term health condition. While the system priorities focus on the redesign of the PHC services to support wellness and then in preparing for UHC, the focus is on enhancing technical efficiencies, ensuring a capable workforce and improved access to care. Diagram 21 illustrates how the Department’s plans align with NDoH identified MTSF impacts and outcomes, captured in green and the province in blue.

A provincial health system that by design supports wellness

The social dimensions of disease highlight the need for integration and continuity of care coupled with more comprehensive and person-centred approaches to service delivery. This necessitates a re-think of ‘what’ and ‘how’ services are provided as care systems would need to:

- Span a range of risks and illnesses
- Recognize people as partners in managing their own health and that of the broader community
- Re-orientate care around people’s needs and expectations, making them more socially relevant to produce better health outcomes.

In the next 5 years the Department will focus on making health services more people-centric with greater capability for prevention and health promotion; delivered by close-to-user interdisciplinary teams, responsible for a defined geographical area. Figure 21 illustrates how this outcome connects with the National Department of Health’s (NDoH) plans over the next 5 years, specifically their outcome ‘Co-coordinating health services across the care continuum, re-orienting the health system towards primary health’.

The children of the province have the health resilience to flourish

While the province has achieved the SDG targets for maternal mortality and the under 5 mortality rate, children remain a major focus for the province and the Department. Investing in the first 1000 days of life allows for a shift in the trajectory of a child’s life, which if sustained, ultimately narrows inequality and supports human development potential across the life course. The focus on the health resilience of children, aligns with the National focus on child survival. Intergenerational interventions are required to interrupt continuous cycles of ill-health and violence, necessitating a shift in focus from interventions aimed at only the infant and child from after birth to that of both the mother-baby dyad starting before conception, in the context of family, community and environment. From a public health perspective, it requires a further shift from a disease-orientated approach towards a more holistic recognition of the role of social determinants and the adoption of an intersectoral approach to well-being. It calls on the health care system to engage with other sectors in
transversally redesigning care services for pregnant women and children as well as for supportive relationships by health workers towards families to model and promote the essential nurturing care on which the infant brain depends for its optimal development.

**Figure 21: Mapping the journey to a healthier Western Cape and ultimately a healthier South Africa in 2025**

**OUTCOMES**

- The children of the province have the health resilience to flourish
- People with long-term conditions are well managed
- Maternal, Neonatal, Infant and Child Mortality reduced
- Mortality and premature mortality due to Communicable diseases (HIV, TB and Malaria) reduced
- Mortality and Premature mortality due to Non-Communicable Diseases (NCDs) reduced by 10%

**IMPACTS**

- Universal Health Coverage for all South Africans achieved, and all citizens protected from the catastrophic financial impact of seeking health care by 2030
- In 2025 Western Cape residents will live a longer and healthier life than they did in 2019
- Leadership and governance in the health sector enhanced to improve quality of care
- Management of patient safety incidents improved
- Contingent liability of medico-legal cases reduced by 80%
- Quality of health services in public health facilities improved
- Robust and effective health information systems to automate business processes and improve evidence-based decision making
- Package of services available to the population is expanded with priority given to equity and most cost-effective services
- Infrastructure maintained and backlog reduced

**OUTPUTS**

- Child Health
- Women’s Health
- HIV/AIDS, STI & TB Services
- Improved financial management
- Technically efficient provincial health system
- Capable Workforce
- Accessible Health Services

**People with long-term conditions are well managed**

Producing better health outcomes is premised on the development of a set of well-defined context-sensitive co-created service interventions capable of meeting population health needs. HIV/AIDs and NCDs remain a significant part of the burden of disease and thus interventions in this area would need to ensure people with these conditions are well manage. This requires taking into consideration
the environmental and personal factors which impacts on peoples’ capability for self-management, when designing models of care for people with long-term conditions.

A high-performance provincial health system for people

Strengthening the capacity of the health system to manage resilience is paramount to creating a high performance, high quality health system for people. The health system’s ability to absorb, adapt and transform in the face of adversity is contingent on its ability to anticipate and cope with uncertainty; to manage interdependence in engaging effectively with multiple and cross-scale dynamics and feedback; and to build legitimate institutions that are socially acceptable and contextually adaptable. Good governance is thus a powerful resilience advantage as it shapes the ability of the health system to cope with the everyday challenges of providing health services. It requires health governance actors to exercise ethical and effective leadership, to achieve the governance outcomes of an ethical culture, good performance, effective organisational control and legitimacy. Key areas of intervention of the next 5 years include enhancing the technical efficiency of the health system; building a capable workforce and enhancing the accessibility of the health system so that no one is left behind. See Figure 21 for alignment with NDoH identified outcomes.
## Key risks & mitigations

<table>
<thead>
<tr>
<th>Outcome 1</th>
<th>A provincial health system that by design supports wellness</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk</strong></td>
<td>Inability to mobilise the necessary financial, human and other resources</td>
</tr>
<tr>
<td><strong>Mitigation</strong></td>
<td></td>
</tr>
</tbody>
</table>
  - Clearly defined principles and process for re-prioritisation of resources  
  - Establish alternate funding sources  
  - Change management strategy  
  - Build relationships of trust with key stakeholders |

<table>
<thead>
<tr>
<th>Outcome 2</th>
<th>Children have the health resilience to flourish</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk</strong></td>
<td>The fragmented PHC services in the City of Cape Town district</td>
</tr>
<tr>
<td><strong>Mitigation</strong></td>
<td></td>
</tr>
</tbody>
</table>
  - Have measures in place to minimize the impact on service users to ensure a seamless transition between care settings  
  - Advocate for provincialization of PHC services to align with rural districts |

<table>
<thead>
<tr>
<th>Outcome 3</th>
<th>People with long-term conditions are well managed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk</strong></td>
<td>Medicine supply interruptions</td>
</tr>
<tr>
<td><strong>Mitigation</strong></td>
<td></td>
</tr>
</tbody>
</table>
  - Monitor stock levels and timeously order new stock  
  - Provide alternatives to the essential medicines, where possible  
  - Tight contract management with suppliers  
  - Create provincial contracts for items that have been excluded from the revised national tenders, where possible  
  - Optimal functioning of ICT system for stock management |

<table>
<thead>
<tr>
<th>Risk</th>
<th>Inadequate models of care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mitigation</strong></td>
<td></td>
</tr>
</tbody>
</table>
  - Re-defining what the health system must do  
  - Re-design of the health systems care continuum  
  - Change management strategy to enable the transition to a person-centres clinical practice culture |
### Outcome 4  A high-performance provincial health system for people

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
</table>
| Load shedding | • Strategies to become more energy efficiency  
• Business continuity plans are in place |
| Water restrictions | • Reduce water consumption and supply of potable water by means of behaviour change (surgical scrubs, alcohol hand sanitizers, reduced utilisation of laundry services, etc.)  
• Engineering interventions (elimination of leaks, installation of low flow sanitary fixtures, waterless urinals, re-use of treated water etc.)  
• Continue with roll-out of boreholes programme and installation of storage tanks  
• Investigate and implement feasible water treatment technologies  
• Implementation and monitoring of Water Preparedness Plan |
| Built environment does not enable high performance | • Planning and prioritisation of maintenance and renewals  
• Ongoing monitoring of infrastructure expenditure  
• Develop a capacity building and retention strategy for both Engineering and Health Technology to help ensure support sustainability  
• Implement alternative contracting strategies to streamline service delivery  
• Monitor compliance with the Service Delivery Agreement between WCGH and WCGTPW  
• Develop improved asset and maintenance management system for Health Technology and Engineering assets  
• Identify and implement Health Technology strategies, options and interventions related to funding and service delivery impact scenarios for medical equipment  
• Review policies for emergency maintenance and repairs  
• Utilise Facility Condition Assessments to prioritise facility maintenance  
• Implement the Hub and Spoke Maintenance Blueprints for both Engineering and Health Technology |
| Workforce safety compromises the responsiveness of the health system and the morale of employees | • Safety guidelines and protocols that empower staff to make decisions around their own safety  
• Raise employee awareness on safety in the workplace  
• Ensuring optimal security measures are in place at health facilities  
• Engage the SAPS and community safety stakeholders on ways in which closer collaboration and interagency partnerships could assist in securing the physical safety of staff |
Public entities

Not Applicable
PART D
TECHNICAL INDICATOR DESCRIPTIONS
### Life expectancy at birth

**Definition**
Life expectancy at birth is the average number of years that a cohort of people would live, based on age-specific mortality rates. It is a summary of the mortality pattern across all age groups for a given year and reflects the overall mortality level of a population.

**Source of data**
Statistics South Africa

**Method of calculation / assessed**
Modelled data, based on a set of assumptions

**Means of verification**
Modelled data

**Assumptions**
Based on age-specific mortality rates of the geographic area

**Disaggregation of beneficiaries**
N/A

**Spatial transformation**
N/A

**Desired Performance**
Life expectancy would increase

**Indicator responsibility**
HIA

**Notes**

### Maternal Mortality Ratio

**Definition**
Maternal death is death occurring during pregnancy, childbirth and the puerperium of a woman while pregnant or with 42 days of birth or termination of pregnancy, irrespective of the duration and site of pregnancy and irrespective of cause of death (obstetric and non-obstetric) per 100 000 live births in public and private facilities.

**Source of data**
Confidential inquiry into maternal deaths

**Method of calculation / assessed**

<table>
<thead>
<tr>
<th>NUMERATOR</th>
<th>Maternal deaths in public</th>
</tr>
</thead>
<tbody>
<tr>
<td>DENOMINATOR</td>
<td>Live births in facility</td>
</tr>
</tbody>
</table>

**Means of verification**
Maternal death registers

**Assumptions**
Reporting from all public and private facilities is complete

**Disaggregation of beneficiaries**
N/A

**Spatial transformation**
N/A

**Desired Performance**
Lower maternal mortality ratio in public and private facilities indicate better obstetric management practices and antenatal care.

**Indicator responsibility**
HIA

**Notes**
This indicator includes both public and private facilities
### Under 5 mortality Rate

<table>
<thead>
<tr>
<th><strong>INDICTOR TITLE</strong></th>
<th><strong>Definition</strong></th>
<th><strong>Source of data</strong></th>
<th><strong>Method of calculation / assessed</strong></th>
<th><strong>Means of verification</strong></th>
<th><strong>Assumptions</strong></th>
<th><strong>Disaggregation of beneficiaries</strong></th>
<th><strong>Spatial transformation</strong></th>
<th><strong>Desired Performance</strong></th>
<th><strong>Indicator responsibility</strong></th>
<th><strong>Notes</strong></th>
</tr>
</thead>
</table>
| **Definition**    | Children who die under the age of 5 per 100 live births in public and private facilities | Mortality reports | **NUMERATOR** Total deaths in children under 5  
**DENOMINATOR** Live births in public and private facilities | Mortality reports | Accurate reporting of death data | N/A | N/A | Lower death rates in children under 5 indicate better IMCI, better EPI and better treatment of injuries. | HIA | |
| **Source of data** | | | | | | | | | |
| **Method of calculation / assessed** | | | | | | | | | |
| **Means of verification** | | | | | | | | | |
| **Assumptions** | | | | | | | | | |
| **Disaggregation of beneficiaries** | | | | | | | | | |
| **Spatial transformation** | | | | | | | | | |
| **Desired Performance** | | | | | | | | | |
| **Indicator responsibility** | | | | | | | | | |
| **Notes** | | | | | | | | | |

### Viral load suppression

<table>
<thead>
<tr>
<th><strong>INDICTOR TITLE</strong></th>
<th><strong>Definition</strong></th>
<th><strong>Source of data</strong></th>
<th><strong>Method of calculation / assessed</strong></th>
<th><strong>Means of verification</strong></th>
<th><strong>Assumptions</strong></th>
<th><strong>Disaggregation of beneficiaries</strong></th>
<th><strong>Spatial transformation</strong></th>
<th><strong>Desired Performance</strong></th>
<th><strong>Indicator responsibility</strong></th>
<th><strong>Notes</strong></th>
</tr>
</thead>
</table>
| **Definition**    | Art viral load under 400 as a proportion of all viral loads done in adults and children | Sinjani | **NUMERATOR** Viral load under 400 in adults and children  
**DENOMINATOR** Viral load done in adults and children | ART paper register | Accurate reporting of data from reporting facilities | N/A | N/A | Higher proportion indicates more HIV clients on ART are achieving viral suppression | Programme Manager | |
| **Source of data** | | | | | | | | | |
| **Method of calculation / assessed** | | | | | | | | | |
| **Means of verification** | | | | | | | | | |
| **Assumptions** | | | | | | | | | |
| **Disaggregation of beneficiaries** | | | | | | | | | |
| **Spatial transformation** | | | | | | | | | |
| **Desired Performance** | | | | | | | | | |
| **Indicator responsibility** | | | | | | | | | |
| **Notes** | | | | | | | | | |
### Unqualified audit opinion

<table>
<thead>
<tr>
<th>Indicator Title</th>
<th>Definition</th>
<th>Source of data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Outcome of the audit conducted by the Auditor-General of South Africa (AGSA).</td>
<td>Audit Report of AGSA</td>
</tr>
<tr>
<td>Method of calculation / assessed</td>
<td>NUMERATOR Number of unqualified audit opinions</td>
<td>DENOMINATOR Total number of audits conducted</td>
</tr>
<tr>
<td>Means of verification</td>
<td>Audit Report of AGSA</td>
<td></td>
</tr>
<tr>
<td>Assumptions</td>
<td>Accurate reporting</td>
<td></td>
</tr>
<tr>
<td>Disaggregation of beneficiaries</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Spatial transformation</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Desired Performance</td>
<td>Unqualified or clean audit i.e. no matters of emphasis</td>
<td></td>
</tr>
<tr>
<td>Indicator responsibility</td>
<td>DDG: Corporate Services</td>
<td></td>
</tr>
<tr>
<td>Notes</td>
<td>• For the purposes of this indicator ‘clean audit opinions’ will be counted as an “unqualified audit opinion” • The audit opinion expressed during the current financial year will relate to the audit outcome of the previous financial year (e.g. the audit opinion expressed during 2015/16 will relate to the audit outcome of 2014/15).</td>
<td></td>
</tr>
</tbody>
</table>

### Cultural Entropy

<table>
<thead>
<tr>
<th>Indicator Title</th>
<th>Definition</th>
<th>Source of data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cultural entropy provides an indication of organisational culture and is the amount of energy in an organisation that is consumed in unproductive work. It is a measure of the conflict, friction and frustration that exists within an organisation. Cultural entropy is calculated as the proportion of votes for limiting values that participants in the Barrett values survey pick to describe the current culture of the organisation. Entropy risk bands: • Less than 10%: healthy functioning • 10% - 19%: problems requiring attention and careful monitoring • 20% - 29%: significant problems requiring immediate attention • 30% - 39%: crisis situation requiring immediate change • Above 40%: impending risk of implosion, bankruptcy, or failure</td>
<td>Barrett Values Survey</td>
</tr>
<tr>
<td>Method of calculation / assessed</td>
<td>NUMERATOR Votes for potentially limiting values (PL) in current culture</td>
<td>DENOMINATOR Participants in the survey x 10 possible values</td>
</tr>
<tr>
<td>Means of verification</td>
<td>Cultural Values Assessment Report</td>
<td></td>
</tr>
<tr>
<td>Assumptions</td>
<td>Accurate reporting</td>
<td></td>
</tr>
<tr>
<td>Disaggregation of beneficiaries</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Spatial transformation</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Desired Performance</td>
<td>A reduction in cultural entropy enables a more optimal work environment that improves organisational performance, increases employee engagement as well as reduces employee turnover</td>
<td></td>
</tr>
<tr>
<td>Indicator responsibility</td>
<td>CD: People Management</td>
<td></td>
</tr>
<tr>
<td>Notes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ANNEXURES
Annexures

Annexure A: District Development Model

In Western Cape, the District Development Model is implemented using the Joint Metro and District Approach (JMDA). This is a geographical, team-based, citizen-centric approach to integrated service delivery. There is a single support plan per district with various levels of engagement by interface teams. This allows for strategic alignment of all platforms at the various spheres of government, as the interface team has representation from each local municipality, the district municipality, all provincial departments and any relevant national departments. Thus the interface is both horizontal (between provincial departments) and vertical (between national and provincial departments and municipalities).

In order to strengthen the capacity of municipalities, key projects and support initiatives are identified, with specific departments assuming various levels of responsibility to drive the projects. Key to the JMDA is the culture of data-driven and evidence-based decision making. This in turn will drive a culture of accountability, which ultimately results in improvement in service delivery that have a meaningful positive impact on the lives of citizens. Furthermore, the JDMA is premised on developmental local government, sustainable service delivery and good governance.

At the time of publishing the SP, the JDMA models had not yet been finalised