



**Western Cape
Government**

Health

MEDIA UPDATE ON COVID-19 STRATEGY

K Cloete

Premier's digicon

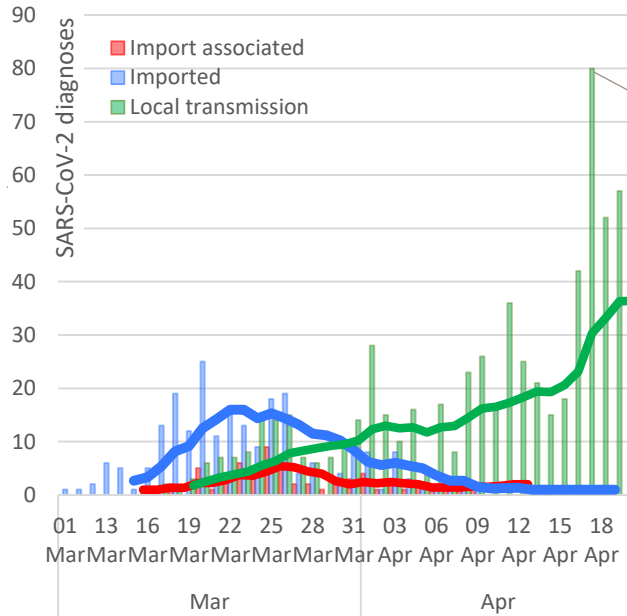
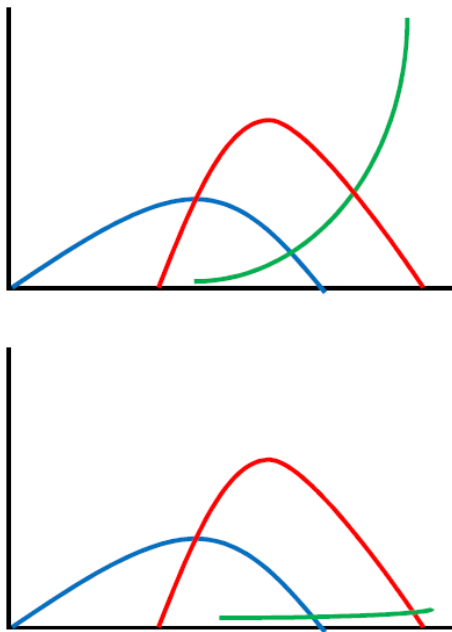
20 May 2020

Overview

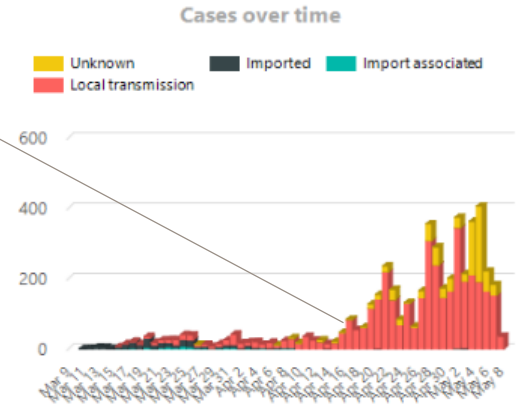
1. Strategy refinement
2. Targeted hotspot plan
3. Providing data at town/suburb level
4. Update on health system preparedness
5. Conclusions

Strategy refinement

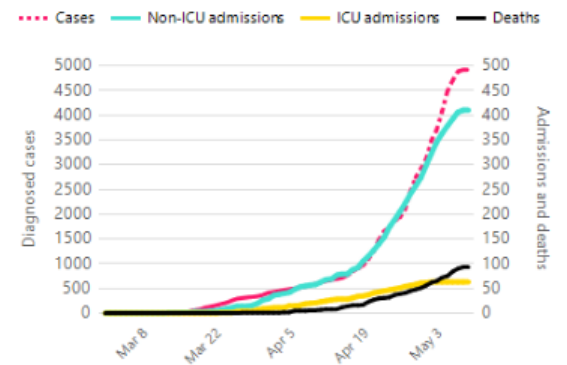
Western Cape experience so far



Based on 973 cases reported by 20 April 2020

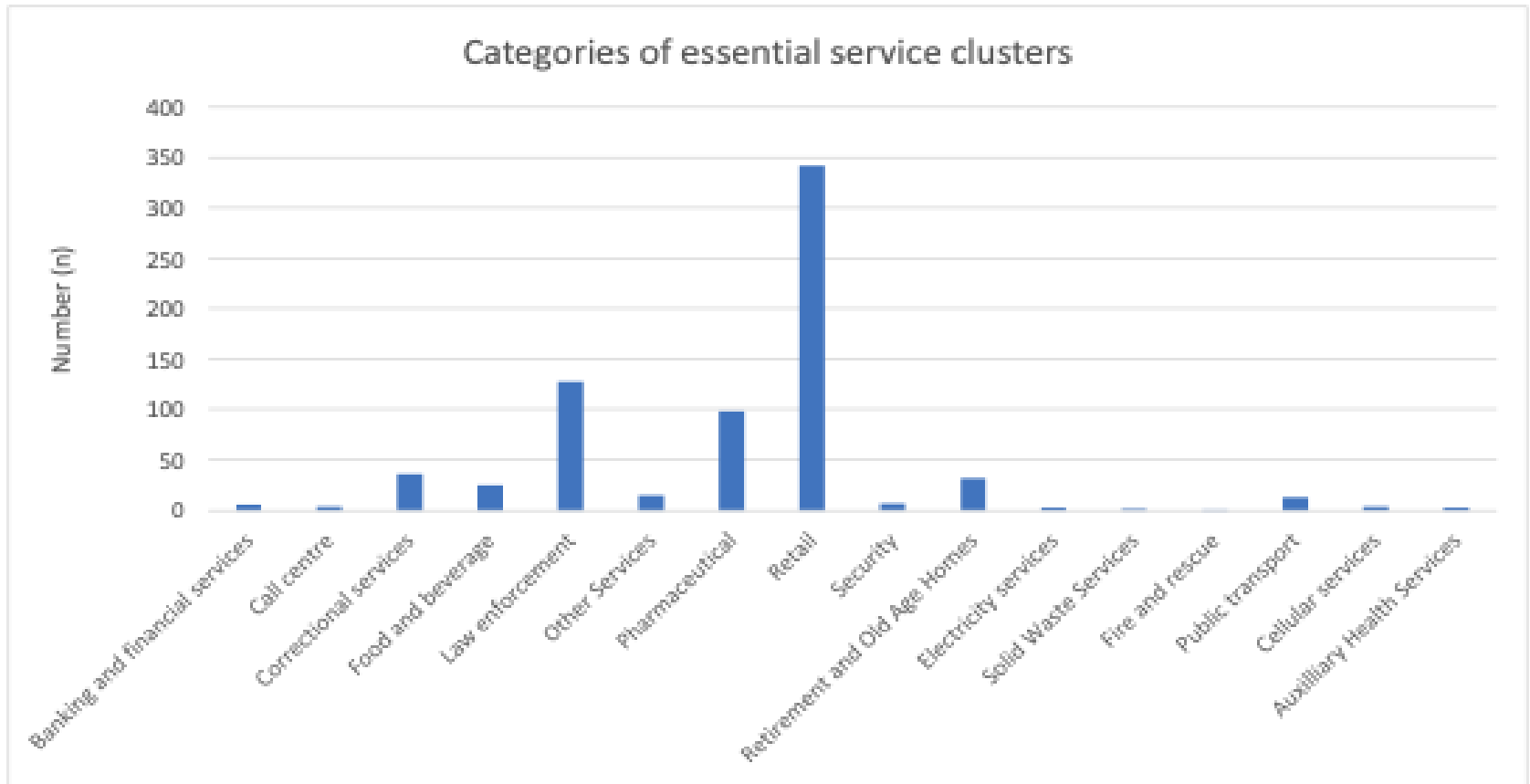


Cumulative cases, admissions and deaths

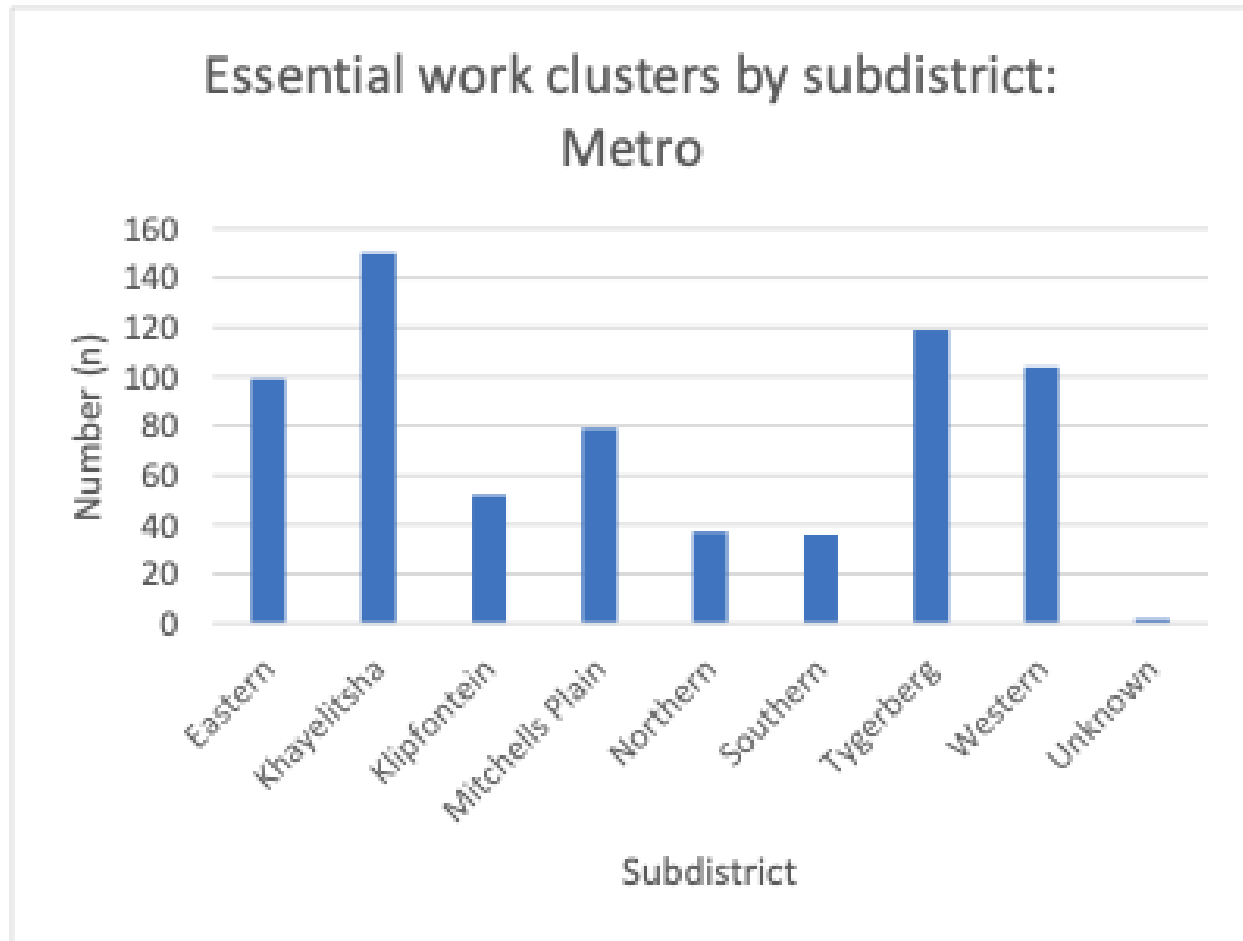


Professor Salim Abdool Karim, address 13 April 2020

Clusters in workplaces...



Transmission in local communities...



Current status of epidemic in the Cape Metro

1. A rapidly increasing epidemic with increases in hospitalisation and deaths – we are on the upward part of the curve, which is the nature of the pandemic.
2. Concentrated in essential services clusters, care homes and in the geographical areas where the workers live, which are mostly in the poorest communities in Cape Town. Hotspot intervention are prioritised in these areas.
3. Testing/ lab capacity is under severe strain.
4. Facilities to isolate and quarantine off-site are being scaled up, but the limits of the available capacity will ultimately be exceeded.
5. There are a large number of undetected cases, which will continue to grow because of the limitations on testing.
6. The ability to continue with individual case detection and contact tracing is being stretched by the sheer number of new positive cases.

Current status of epidemic in the Rural Districts

1. The Cape Winelands District showing evidence of multiple clusters and fast spread, having started in Witzenberg 3 weeks ago, and moving onto Drakenstein, Stellenbosch and Breede Valley, in the past 2 weeks.
2. Emerging early clusters in Overberg (Theewaterskloof and Swellendam), and West Coast (Swartland), during this past week, while there is still many areas with no cases or sporadic cases.
3. Testing/ lab capacity strain is impacting on these Rural areas to detect cases early and move to aggressive isolation and quarantine interventions.
4. Ability to isolate and quarantine off-site will be scaled up rapidly across the Rural areas.
5. Projected to have a smaller number of undetected cases, and aggressive testing is still indicated.
6. Still big value of individual case detection and contact tracing, to contain the spread of virus.

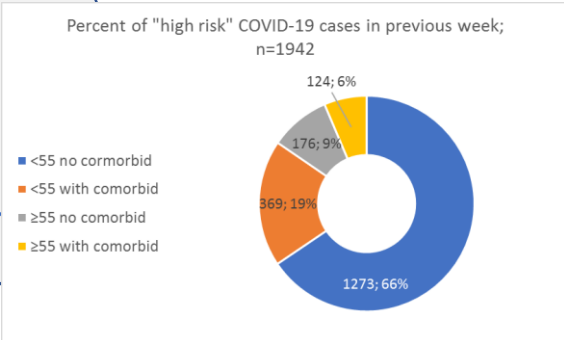
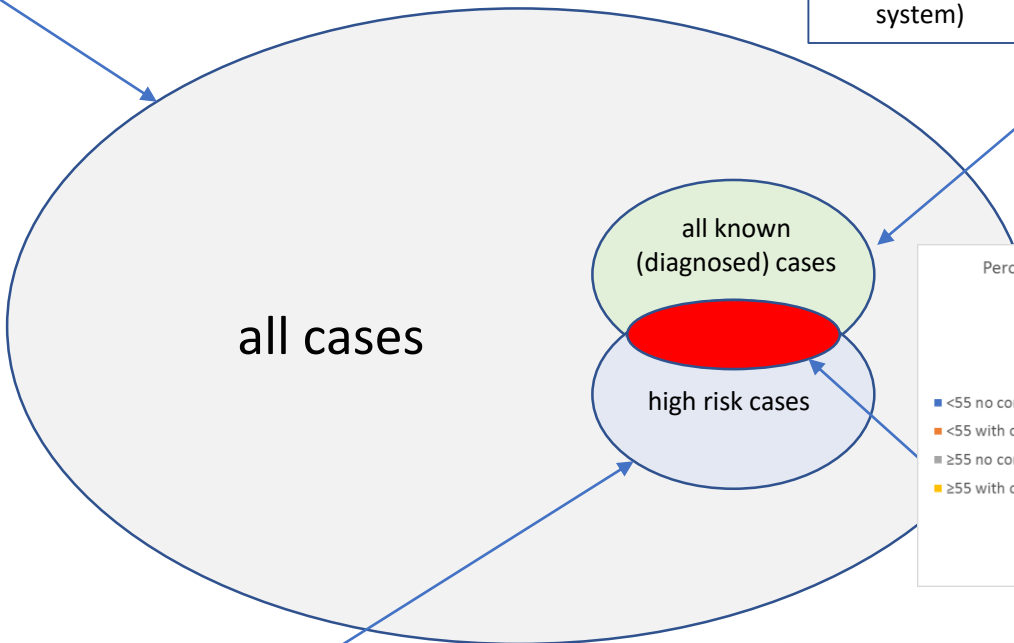
Proposed Risk Stratified Case Management approach, in Cape Metro

Self-management

1. What to do if symptomatic
2. When to seek help

Health system management of known cases, not obviously high risk

3. Impart diagnosis
4. **“passive” follow-up**
5. Impart same advice as per self-management
6. Provide advice re decompensation (?fast track system)



High risk cases not known to the health system

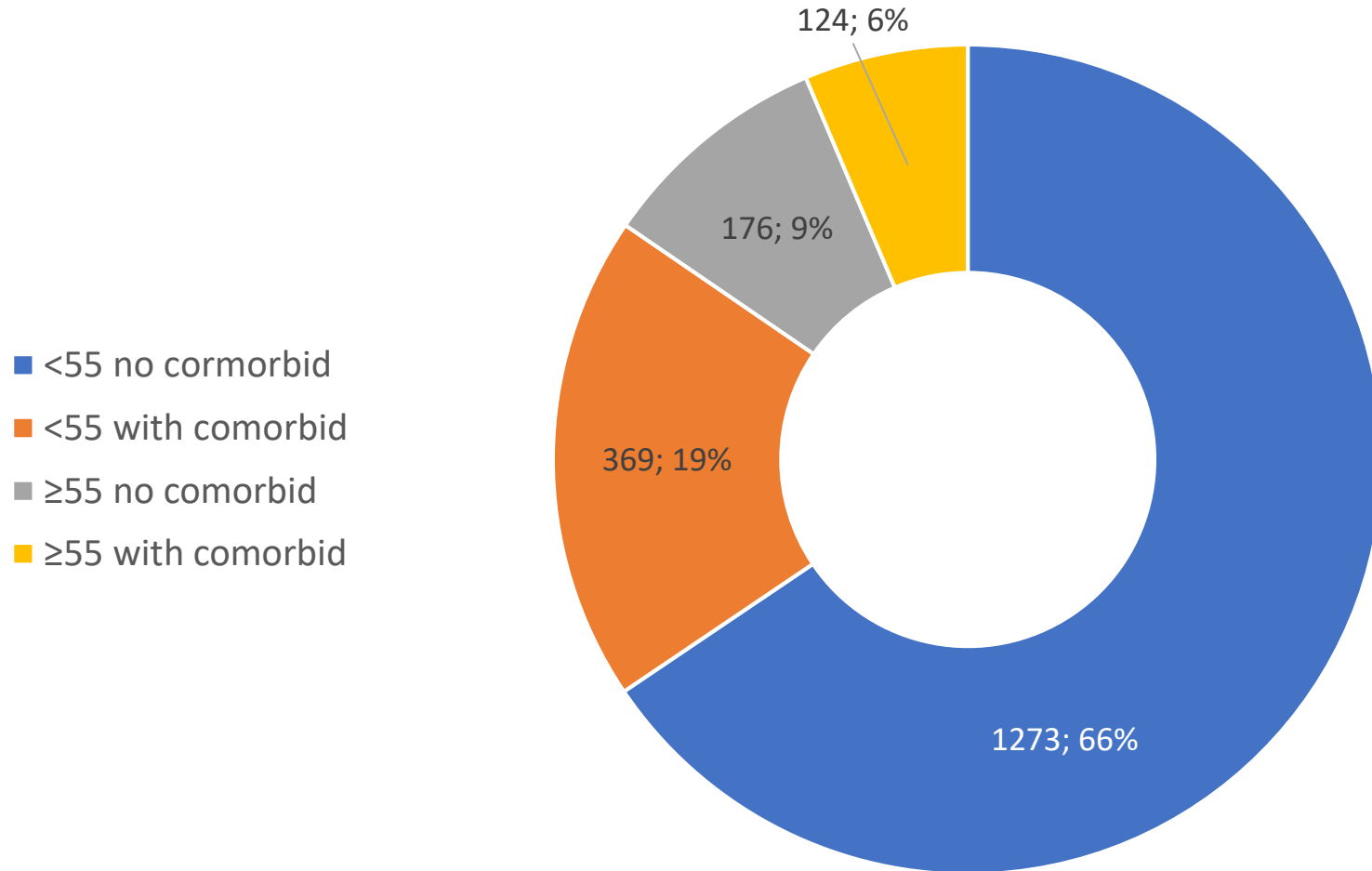
11. Will present to EC/Hospital

Health system management of identified high-risk cases

7. Impart diagnosis
8. **“active” follow-up**
9. Impart same advice as per self-management
10. Advice re decompensation (?fast track system)

~670 cases for past week

Percentage of "high risk" COVID-19 cases in previous week; n=1942



Proposal for strategy alignment in Cape Metro

1. Streamline testing and contact tracing activities to focus on high risk groups such as health workers and vulnerable people.
2. Emphasise case management with a view to early detection of deterioration in health status through risk stratification.
3. Increased focus on mass communication and building agency for behaviour change – individuals and organisations (across sectors).
4. Re-purpose CST and CHWs towards the vulnerable persons and strengthen workplace/ institutional agency with a focus on prevention through inter-sectoral action.
5. CST focuses on reaching high risk groups such as the elderly and those known with co-morbid conditions.
6. Focus on health system preparedness including utilising testing appropriately in the clinical environment.

What does this mean for the Hotspot Strategy?

1. The Health Strategy will be aligned to the risk stratified case management approach, in areas with established community transmission.
2. The identification for appropriate people for admission to designated isolation and quarantine facilities will have to be nuanced, in light of the testing capacity challenges, together with exploration of viable and feasible community-based isolation models (via community initiatives).
3. Behaviour change in terms of social distancing, hand and surface hygiene and universal mask wearing, targeted on all areas of gathering in hotspot areas will be the key drive.
4. Nuanced, agile, pro-active and adaptive responses are required in the local community spaces (in each of the local area).
5. The rate of increase of transmission rates per ward and suburb should be tracked over the next 6-8 weeks.

Targeted hotspot plan

Context: Managing Community Transmission

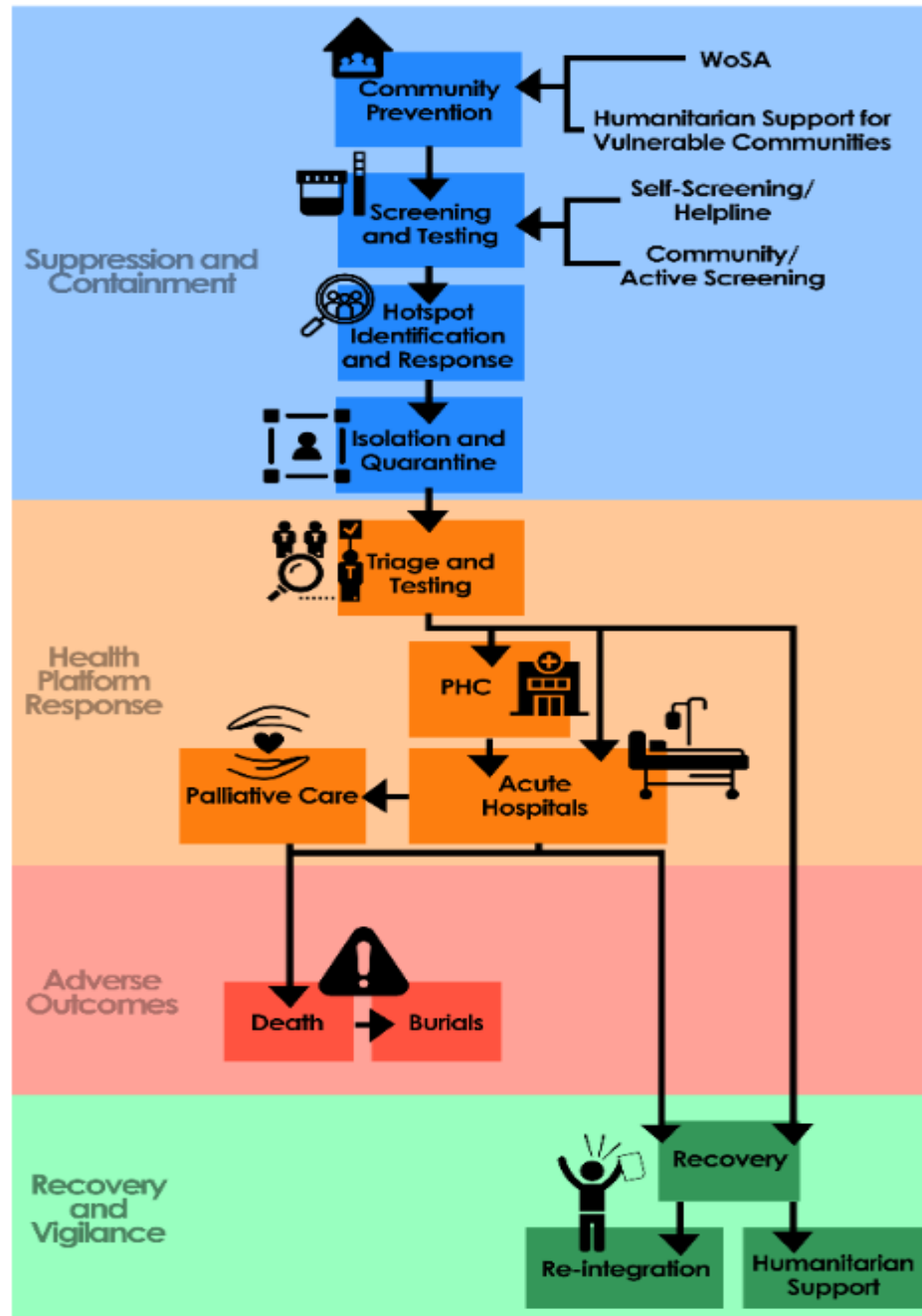
Whole of Government Approach (WoGA) is required:

1. Health Response – risk stratified case management, referral for Q & I
2. Economic – map businesses, protocol management, social distancing and operations, hygiene
3. Safety – SAPS, WCG and CoCT traffic deployment and law enforcement
4. Food security & Humanitarian – Agriculture, DSD & CoCT initiatives
5. Places and Spaces - Human Settlements
6. Transport – EMS, Taxis; CoCT
7. Resource management – finance and human resources

Whole of Society Approach (WoSA) is required:

1. Behaviour Change/ Citizen accountability is required
2. Role of Councilors and Community Leaders
3. FBOs, integration, emotional support & caring
4. Messaging – behavior change

COVID-19 Care Continuum



System Strengthening towards Whole of Society

Framework for the Health Response

What are the hotspots?

1. Clusters:

- a) Linked cases in specific settings of gathering, e.g. workplaces or events of gathering

2. Hotspots:

- a) Geographic areas with many linked cases through local community transmission
- b) Prioritised Cape Metro hotspot areas:
 - Tygerberg
 - Khayelitsha
 - Klipfontein
 - Western – Du Noon
 - Southern – Hout Bay
- c) Prioritised Rural hotspot areas:
 - Cape Winelands – Witzenberg, Drakenstein

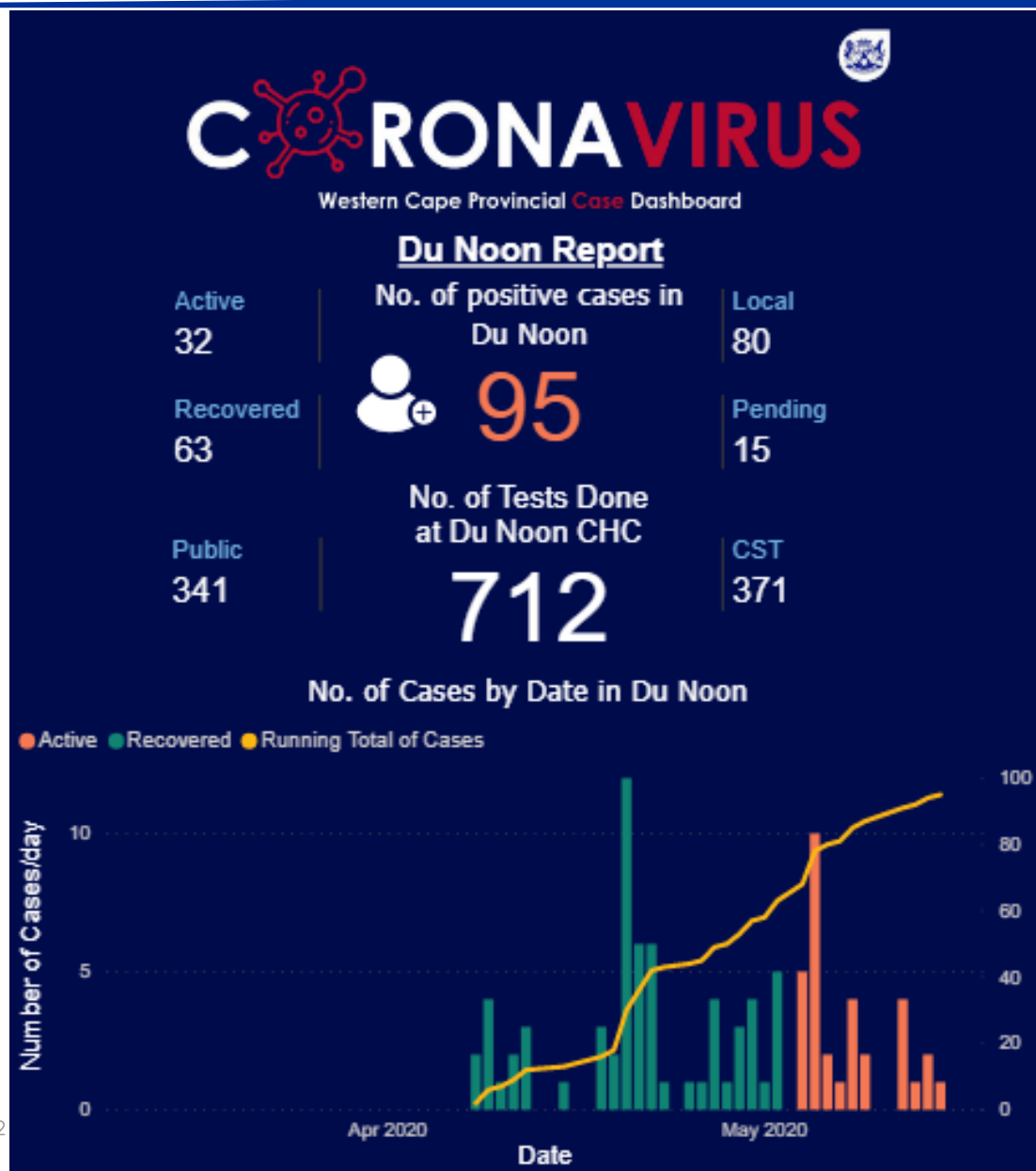
Du Noon Heatmap - 18 May 2020



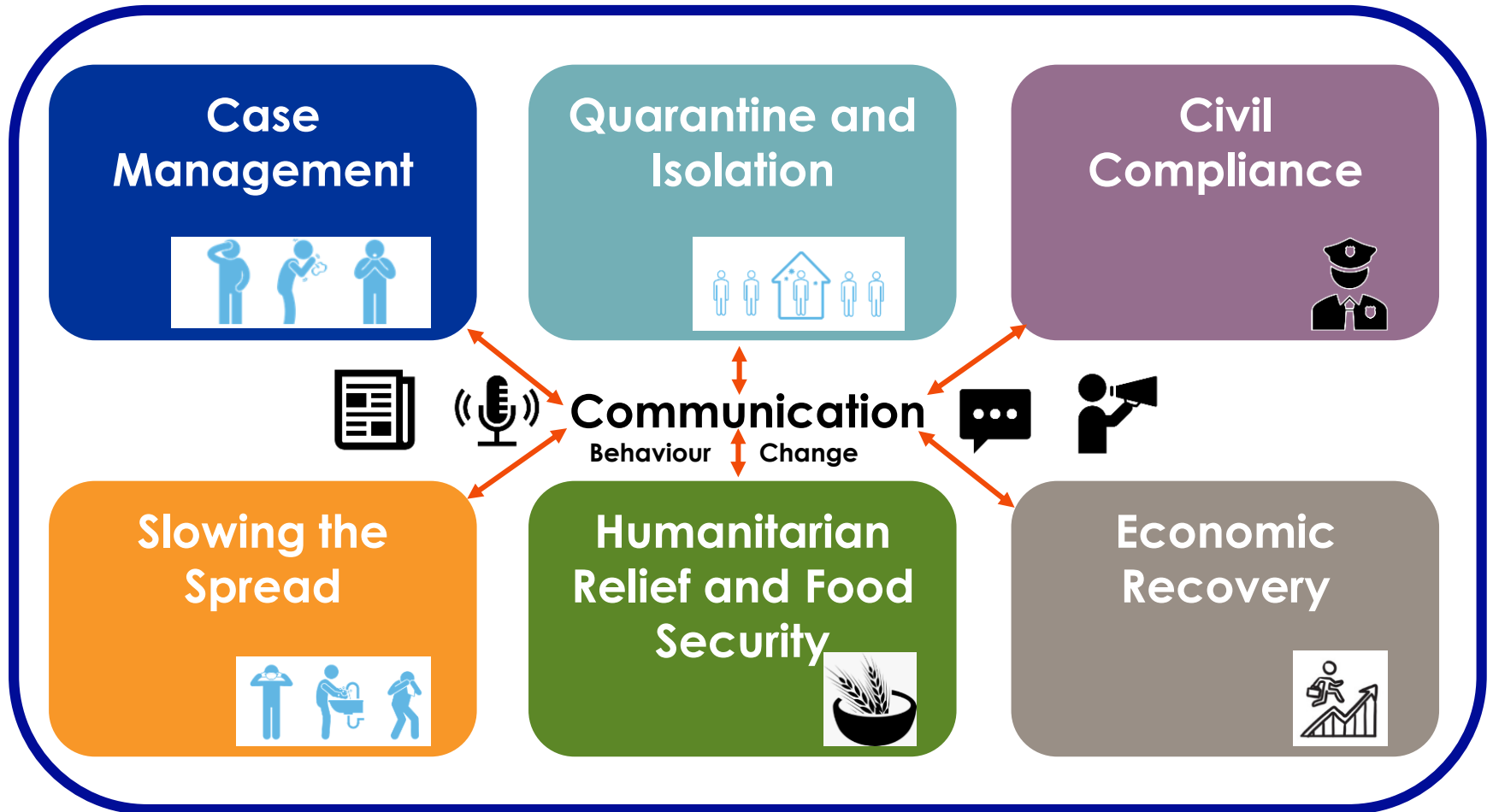
COVID-19 Health strategy for Du Noon

Health strategy encompasses the following:

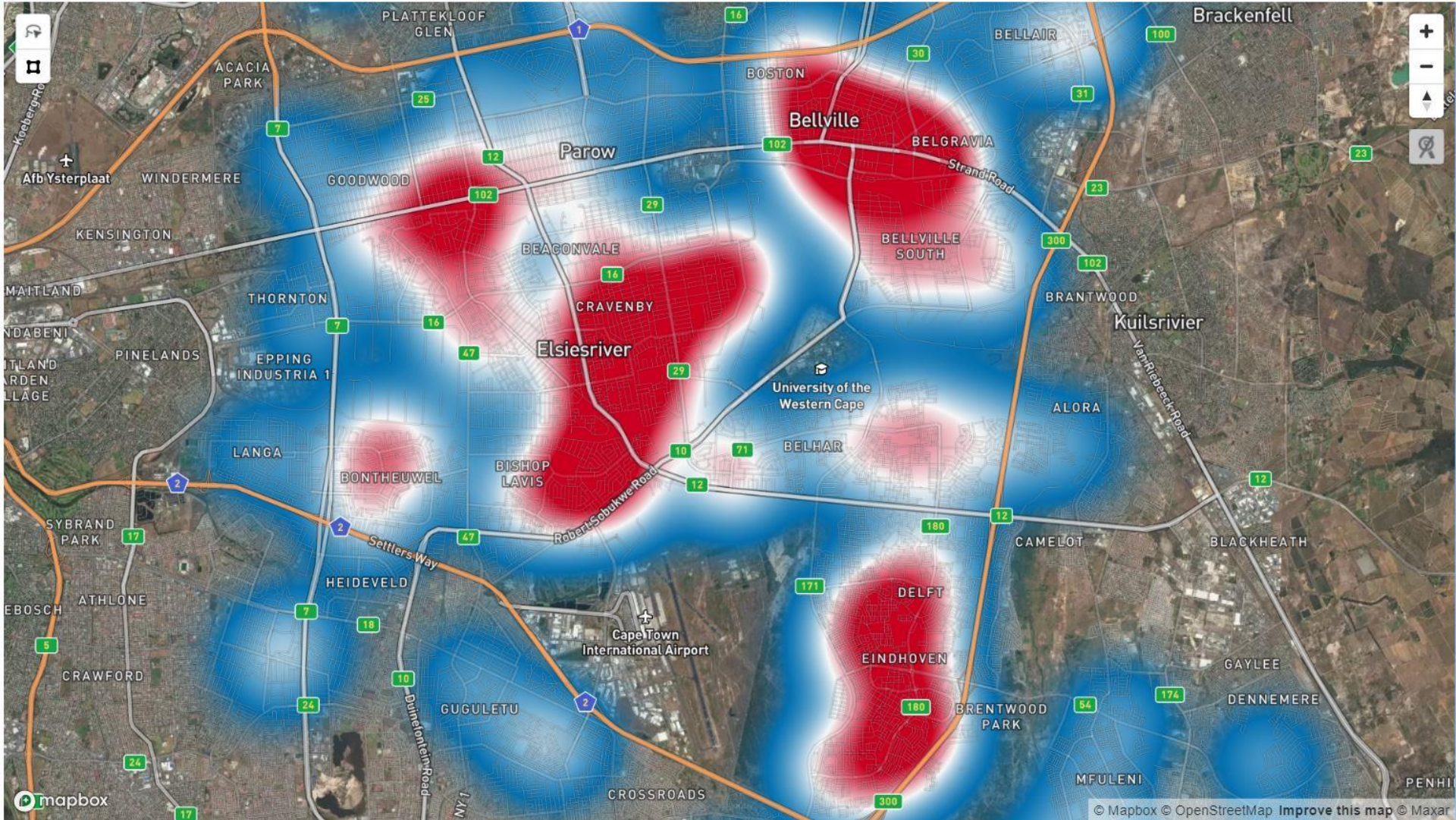
1. COVID-19 case detection and management
2. Community Screening and Testing
3. Referral for isolation and quarantine
4. Risk stratified case management



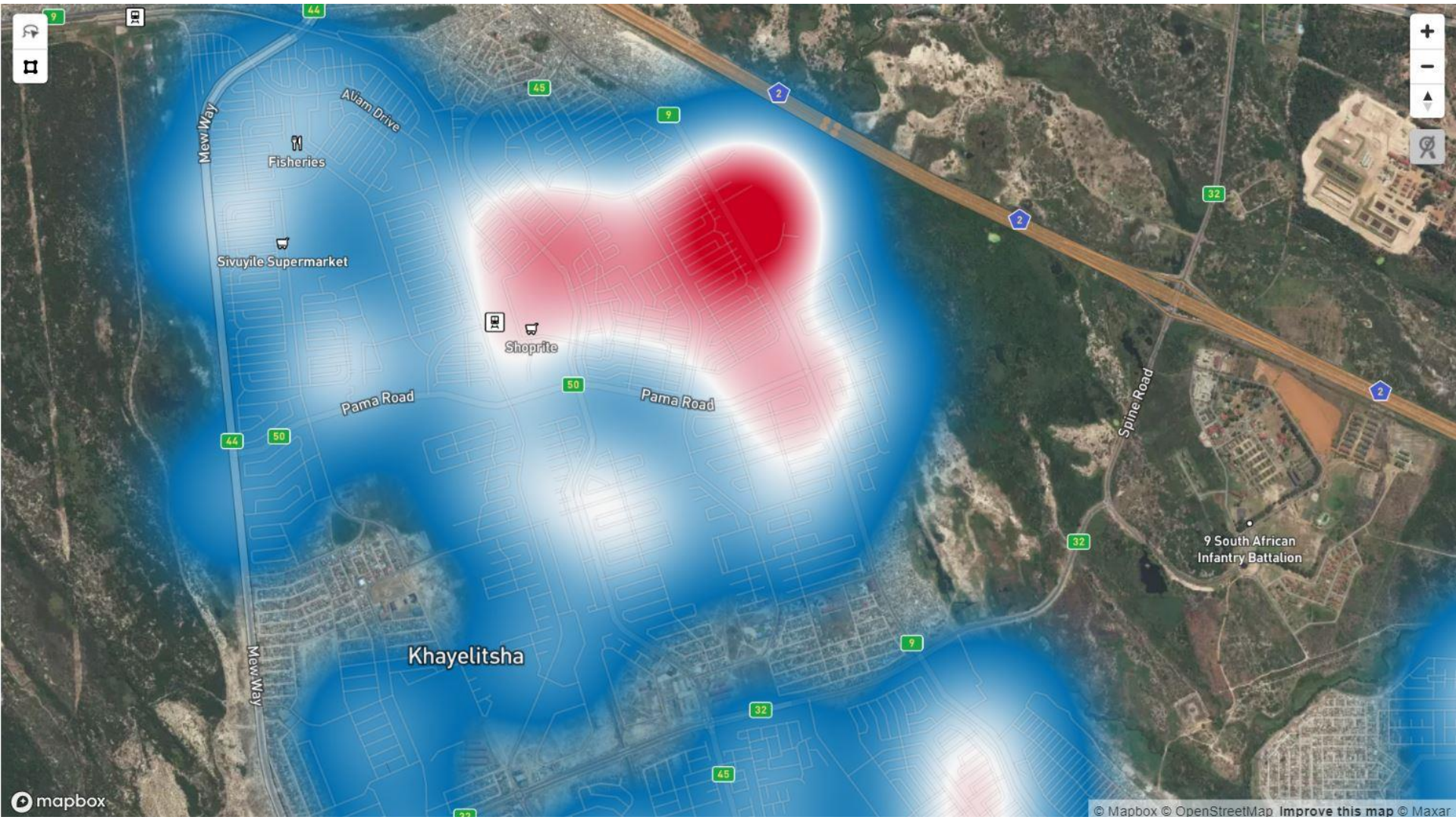
Thematic areas for intervention – Du Noon hotspot



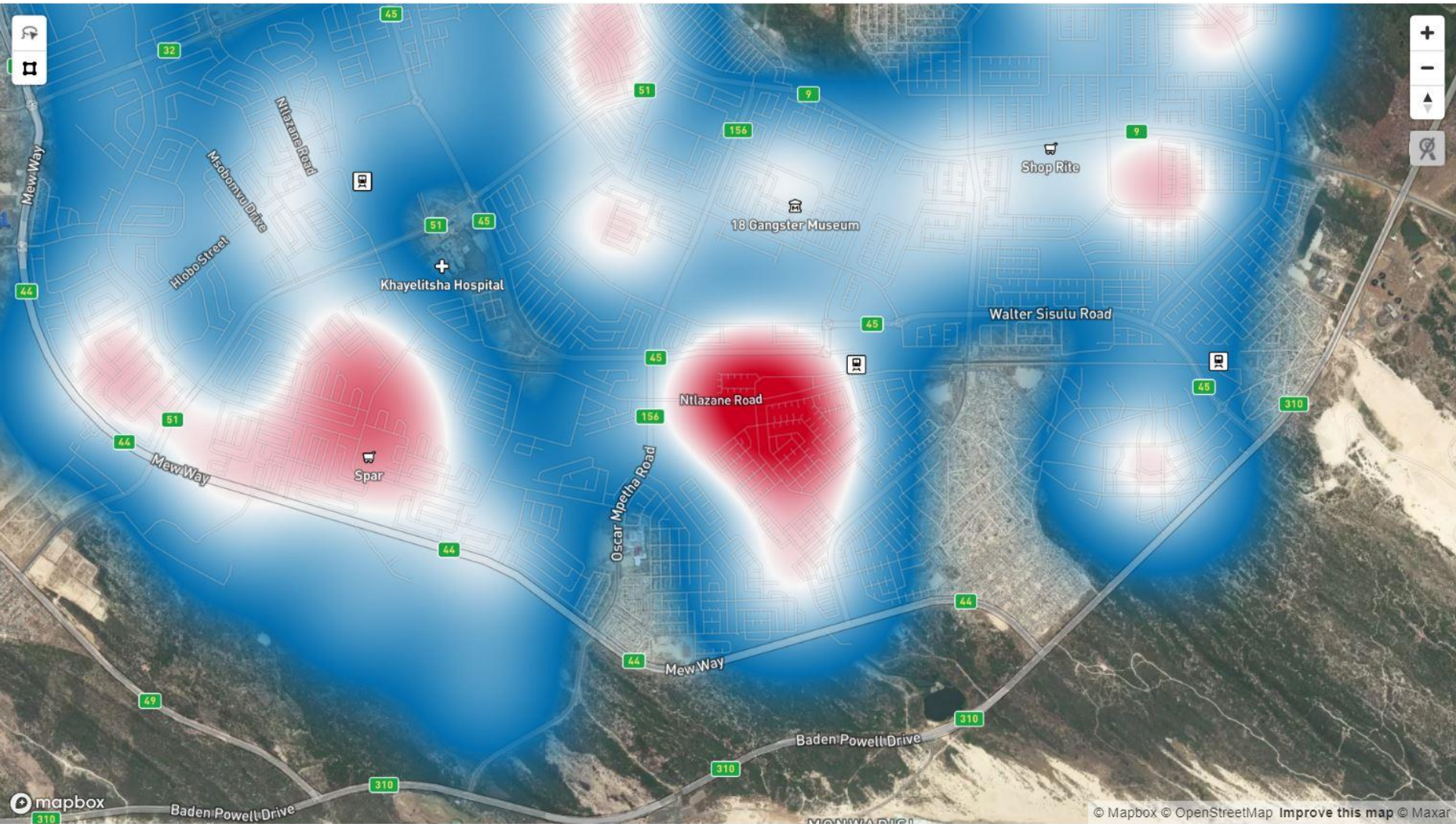
COVID-19: Tygerberg hotspots



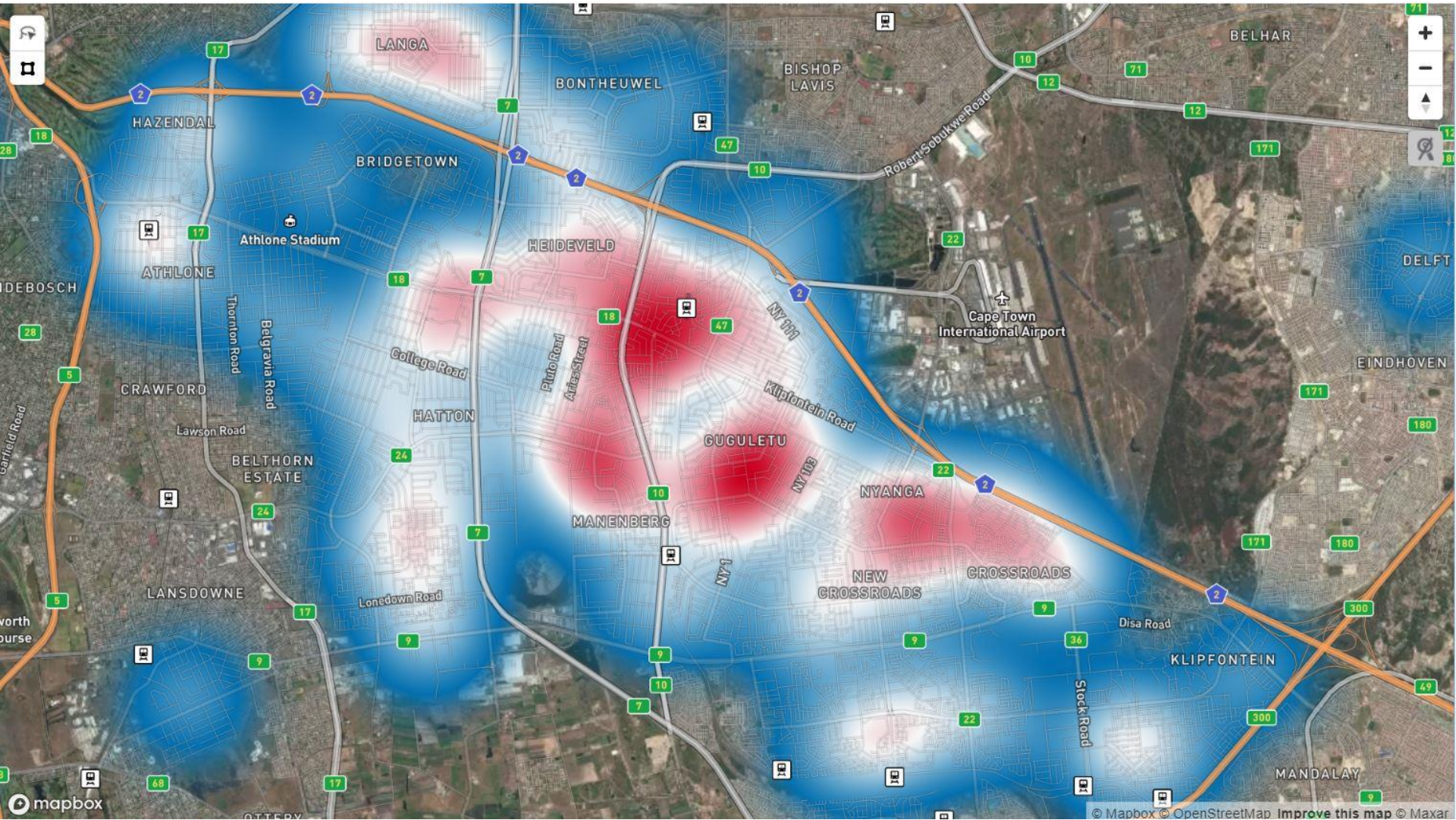
COVID-19: Khayelitsha hotspots



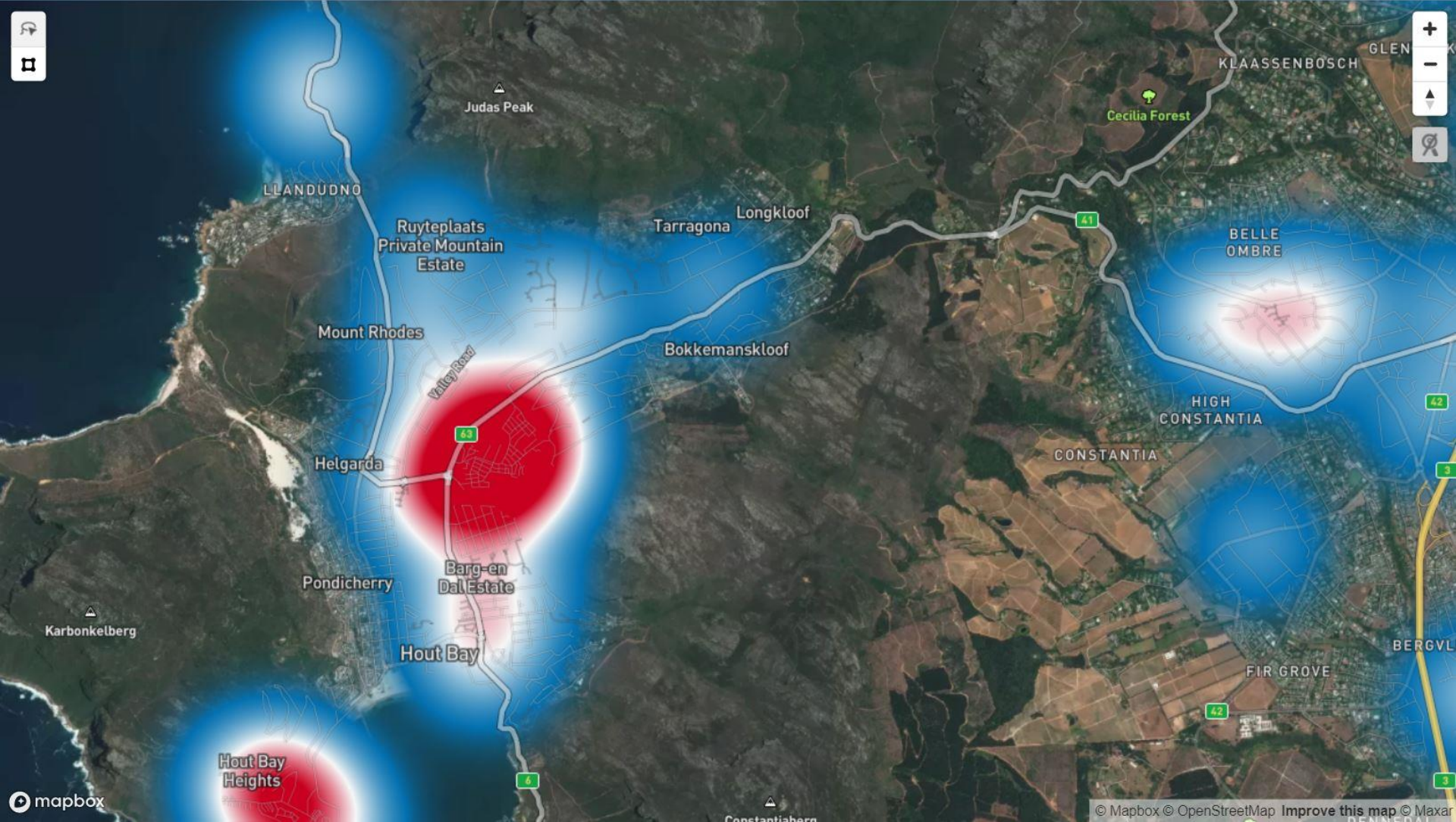
COVID-19: Khayelitsha hotspots



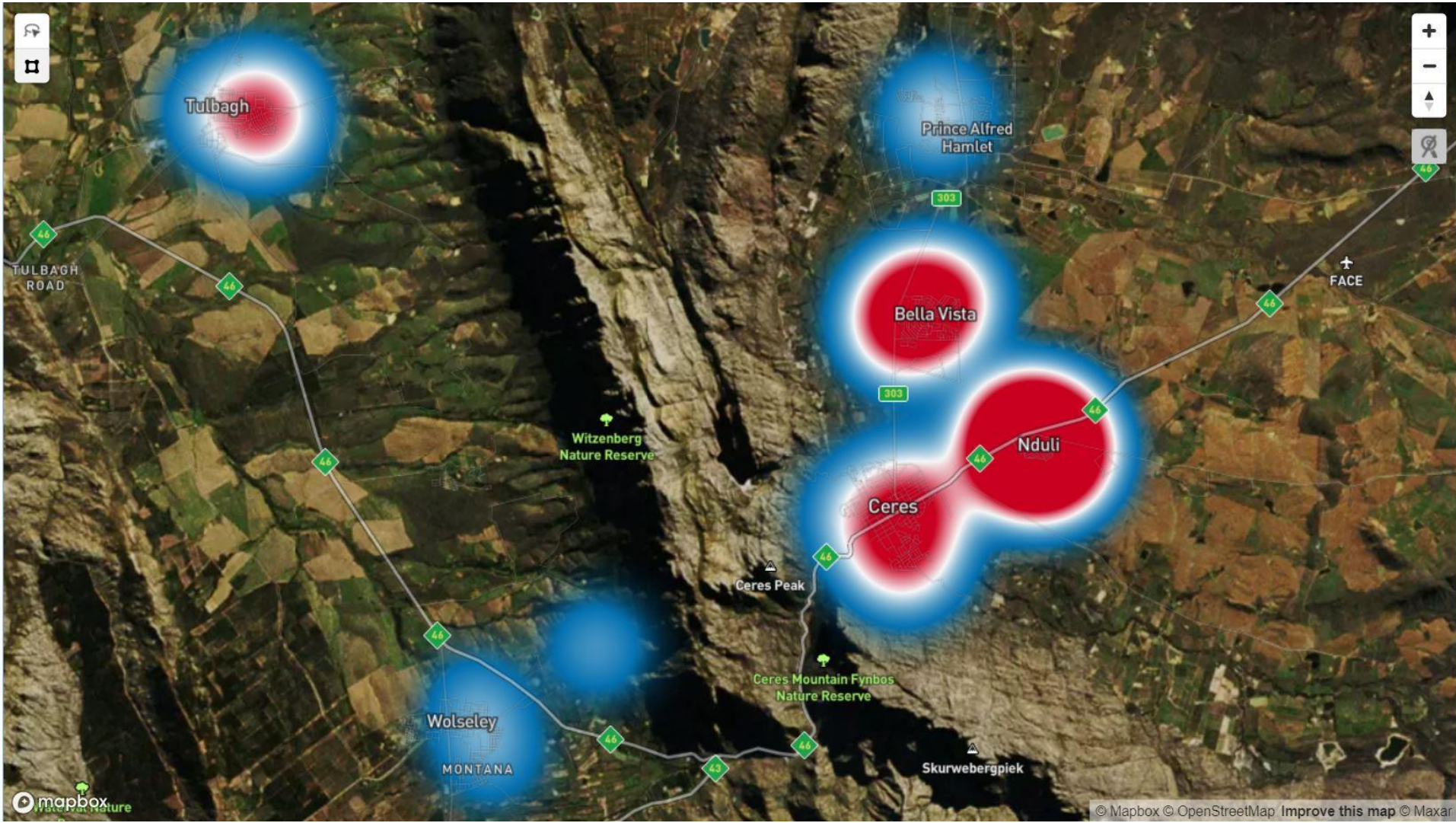
COVID-19: Klipfontein hotspots



Southern hotspots – Hout Bay

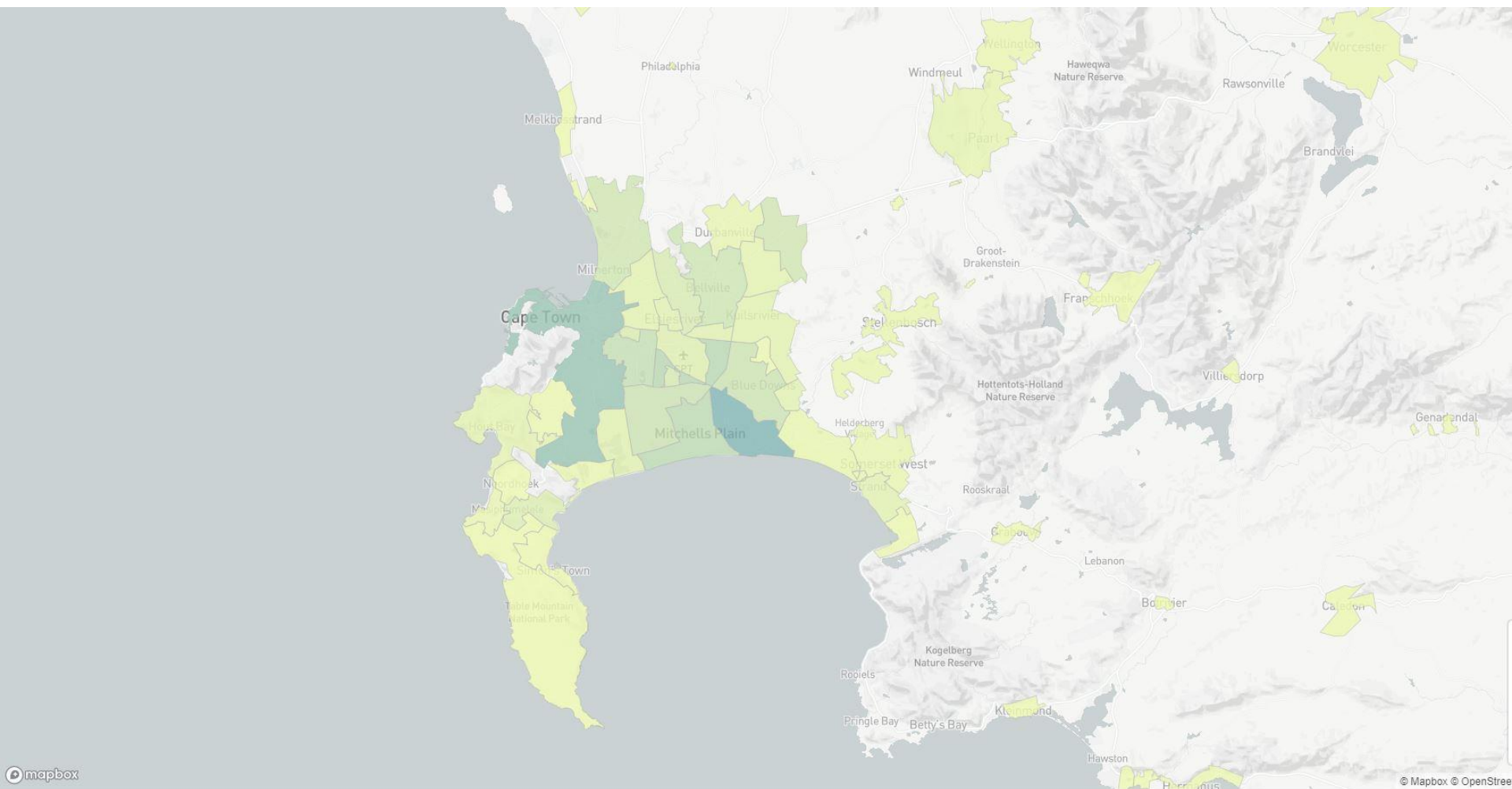


Witzenberg: COVID-19 hotspots

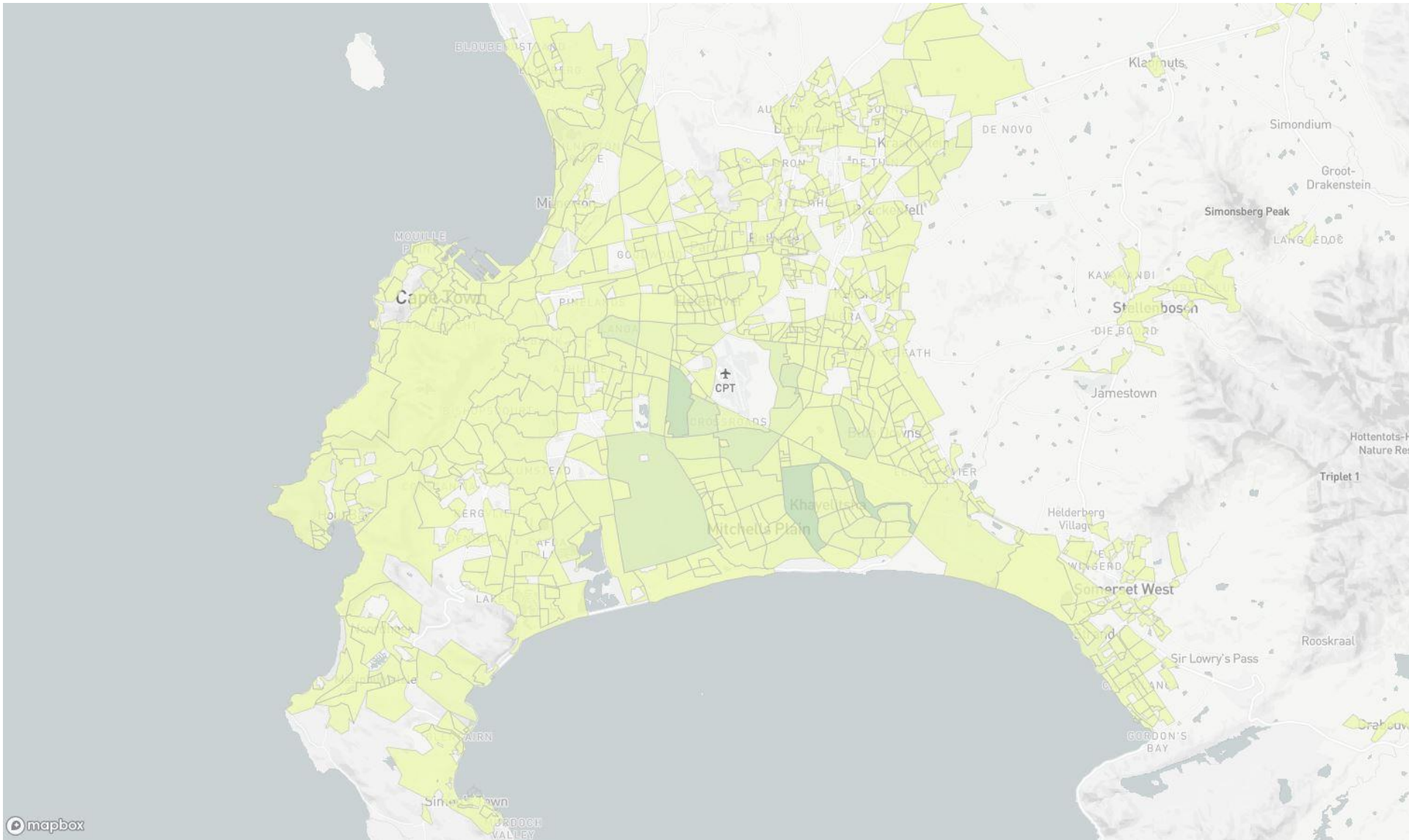


Providing data at town/suburb level

COVID-19 cases by town - 20 May 2020



COVID-19 cases by suburb - 20 May 2020



Update on health system preparedness

Primary Health Care Preparedness

PRINCIPLES THAT UNDERPIN PHC RESPONSE:

1. Leverage this as an opportunity for PHC system strengthening
2. 90% of cases will be relatively well or managed via the PHC platform, therefore we have to be COVID-19 responsive, whilst maintaining certain essential services:
 - a) Immunisations (opportunistic & routine),
 - b) Management of Chronic Diseases,
 - c) Continued management of HIV and TB,
 - d) Appropriate Maternal & Child health services, etc.
3. Preparedness plans consider system inputs e.g. people management, SCM, infrastructural readiness, health intelligence, communications

PHC system inputs for COVID-19

1. **People management:**

- a) Staff trained in IPC and appropriate use of PPE (provincial guidelines)
- b) Staff screened at facility levels
- c) Staff support

2. **Supply chain management:**

- a) Ensure enough PPE stocks, medication, etc.
- b) Ensure oxygen supply
- c) System for collection of contaminated waste, etc.

3. **Infrastructure issues:**

- a) Re-organisation of the facilities into COVID and non-COVID areas
- b) Facilities prioritised according to greatest need

4. **Health intelligence** - ensure continued data collection, reporting, etc.

5. **Communication** - collaborate with UCT's Knowledge Translation Unit

Acute care, critical care and palliative care

1. Acute Hospitalisation:

a) Intermediate care beds ('Field Hospitals') for mild cases – **1428 beds being planned:**

- CTICC = 850 beds
- Brakengate R300 = 330 beds
- Thusong Centre, Khayelitsha = 68 beds
- Cape Winelands, Sonstraal Hospital = 150 beds
- Tygerberg Hospital = 30 additional beds

b) Acute care beds for moderate cases – capacity created in existing public sector – **2 162 beds**, of which **658 beds are additional beds, through expansion.**

c) Critical care (ICU and HC) beds for severe cases –

- | | |
|---|----------|
| ▪ Existing critical care capacity within public sector | 150 beds |
| ▪ Additional critical care to be created within public sector [requires additional resources] | 100 beds |
| ▪ Public sector to purchase from private sector | 300 beds |
| ▪ Private sector (own beds) | 300 beds |

2. Palliative Care:

a) In-patient care and community service delivery model finalised

b) 795 beds planned for peak, includes additional Palliative Care overflow of 75 stand-alone palliative care.

Status: Triage & Testing temporary structures

Temporary Structures have been designed for Triage & Testing at facilities as prioritised by the Rural and Metro Service. These structures are designed in response to IPC strategies for COVID19. The progress of these projects are as follows:

Operational Facilities: Tygerberg, Victoria, Khayelitsha, Karl Bremer, Mitchells Plain, Paarl, New Somerset, George, Wesfleur, Eerste River, Worcester, False Bay, Helderberg Hospitals. Kraaifontein CHC and Heideveld EC,

Construction Completed: Red Cross [minor adjustments being made], Ceres Hospital

Projects in Construction: Groote Schuur Hospital (completion date 2 June)
Mowbray Maternity Hospital (waiting area complete, to be completed by 25 May)

Phase 2: Additional facilities planned



Status: Intermediate Care facilities

Intermediate Care Facilities have been identified for the treatment of mild to moderately ill, COVID positive patients. The status is as follows:

Project in Construction: Thusong Centre, Khayelisha

Donated and implemented by Doctors Without Borders (MSF) - a temporary intermediate care centre within an existing sports centre.
The facility can accommodate 68 beds; MSF medical staff will be used and nursing staff are being recruited via agencies
Anticipated completion is 30 May 2020

Cape Town International Convention Centre (CTICC)

The facility can accommodate 850 beds
Construction commenced on 10 May 2020 and progressing well
The planned 'first patient admission date' is 8 June 2020

Projects in Procurement: Brackengate

Existing Warehouse, design for the facility has been completed.
The lease agreement awaiting Provincial Treasury approval
The facility can accommodate 330 beds; pods will be released as these are completed
The planned 'first patient admission date' is 7 July 2020

Status: Intermediate Care facilities

Projects in Design:

Tygerberg Hospital

The current temporary structure is already being used for Testing & Triage; will now also be converted into an additional Intermediate care facility

The facility can accommodate 30 intermediate care beds.

The planned 'first patient date' is 1 July 2020

Sonstraal Hospital

Master planning is complete

The facility will accommodate approx. 150 beds

The design is underway.

Implementation will be undertaken in phases.

In the first phase, 63 beds will become available at the beginning of June and the balance to follow in phases by mid August 2020

Conclusions

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1. Refined strategy is required to deal with different realities in Cape Metro and Rural Districts.
2. The risk stratified case management approach is an important strategy refinement to adopt in areas of established community transmission.
3. Local health teams in areas of established community transmission should focus on reducing morbidity and mortality, by focusing on the most vulnerable.
4. Behaviour Change through WoGA and WoSA should be nuanced, agile, pro-active and adaptive.
5. The health system should focus on health system preparedness including utilising testing appropriately in the clinical environment.

Thank you