COMMUNITY HOUSEHOLD HEALTH & SOCIAL CARE SUPPORT

SUMMARY

- Assessment of 805 households across eight Cape Town areas using surveys, interviews, focus groups, and policy review.
- Evaluates Community-Oriented Primary Care under fiscal pressure, donor withdrawal, and post-pandemic strain.
- Finds high, multi-dimensional need, widespread food insecurity and persistent service access barriers.
- Weak follow-through and feedback systems undermine care outcomes.
- Over a third of households report reduced or lost support between 2024 and 2025.
- Social determinants of health (poverty, safety, distance, infrastructure) continue to drive poor outcomes.
- Recommendations emphasise household-centred, integrated and community-driven approaches with a focus on co-creation, civil society partnerships and whole-of-government coordination.
- Improved financing, governance, and service integration are needed.

Introduction

The Western Cape Department of Health and Wellness commissioned the Household Assessment of Health and Social Care Support in Selected Geographic Areas of the City of Cape Town in the Western Cape Province. A comprehensive, multi-layered research study was undertaken to provide a systematic evidence base and used a triangulation method which included:

- **Household survey** of 805 households across eight geographic sub-structures in the City of Cape Town.
- **Focus group discussions** with community members, community health workers, clinic committee and health forum representatives, and facility level frontline staff.
- **Key informant interviews** with representatives from health facilities and sub-structures management, community health worker supervisors, clinic committee and civil society stakeholders.
- **Desktop review** of Community-Oriented Primary Care (COPC) and related service delivery context, used to broaden the evidence base and support interpretation and recommendations.

The assessment took place within a broader evidence base of studies, research, analyses, evaluations and assessments of COPC in the Western Cape. The assessment (concepts and approach used) and its findings (observations and results) are analysed in tandem with the review of gathered information and knowledge on adopted policies, legislation and implemented programmes. The assessment and the comprehensive review of other evidence provides the platform for the elaboration and synthesis in this policy brief.

Western Cape Government

CITATION

NACOSA with the Western Cape Department of Health & Wellness, 2026. *Community Household Health and Social Care Support Policy Brief.*

Nacosa.org.za
Westerncape.gov.za

ACKNOWLEDGEMENTS

The Community Household Health and Social Care Assessment was commissioned by the Western Cape Department of Health and Welfare and conducted by NACOSA in eight communities in Cape Town.

Key findings were shared with stakeholders in a feedback workshop in February 2026.

This policy brief incorporates the assessment findings, input from the feedback workshop and policy recommendations based on this process.

The policy brief was written by Dr Wiseman Magasela using the assessment conducted by NACOSA with Mitch & Buck Business Solutions and project manager Nathanael van Blydenstein.

Context

Primary Health Care and COPC in South Africa

The concept and strategy of Primary Health Care is one of the pillars of the health care system in the post-1994 period in South Africa. At national, provincial and district levels, the adoption and implementation of primary health care as a rallying, organising principle and goal was adopted with the stated aim of strengthening the health care system and to ensure positive health outcomes for the people of South Africa.

> *"We interviewed a cross-section of government as well as a cross-section of the support systems that poorer households rely on. So it uses the concept of the whole of government and the whole of society approach to understand what's happening in poorer households and how this comprehensive care system can work to support that."*
>
> Mohamed Motala, NACOSA Executive Director at the feedback workshop

Community Oriented Primary Care as formulated by the Western Cape Department of Health is an expression and articulation of primary health care at policy and programme level, with supporting legislated aspects such as clinic committees. In the pursuit of quality health care for all, the three inter-related concepts of Primary Health Care, Community Oriented Primary Care and Universal Health Coverage are central in the formulation of policy, legislation, programmes and the design of the multi-level structures, organisation and functioning of the health system. These three inter-related concepts, enhanced by South Africa's constitutional principles and values, the evidence collected in this brief, offer a basis for re-design, adaptation, modification and change.

Household Assessment

The COPC assessment offers a lens through which to interpret how care is organised, delivered and experienced under conditions of constraint, fragmentation, and change and provides an opportunity to reimagine primary care under new conditions.

Projecting from the assessment, the task is to present an evidence-based, practice and experience-informed analysis to make recommendations on re-design, modifications and change that are aligned to identified policy imperatives of the WCDoHW. The assessment carried out, the multi-faceted analysis of COPC and the synthesis, is within a clear, structured policy and programme (at provincial, district, sub-district, and local site) environment shaping health outcomes at households and community levels.

Strain and pressure

Health and social care systems in South Africa have come under sustained strain as a result of multiple global, national and provincial factors leading to compromises in health and social care system functionality. The manifestation of this pressure on systems is through clinic access barriers, continuity and

Dr Keith Cloete opening the feedback workshop

reliability risk, food vulnerability and follow-through and feedback gaps, and the fragmentation and weakening of enabling community structures and organisations. Key among these 'strain and pressure factors' are:

- The impact of the COVID-19 pandemic
- Donor withdrawals and reduction in donor funding
- Fiscal constraints at national and provincial levels affecting functioning of health districts

The COVID-19 pandemic and responses to it brough about immense disruptions in the provision of health and social care affecting access, continuity and worsening vulnerabilities. The pandemic lockdown increased unemployment, reduced and removed household income and negatively affected the functioning of many community-based organisation that are integral to primary health care. Some of the COPC structures have not recovered from the COVID-19 pandemic impact and the momentum has not been regained.

Developments at the global level, arising mainly from shifts in US government foreign policy and overseas development aid, and relations with South Africa, has seen unplanned for and sudden donor withdrawal and exit. This has had an impact in the health sector, especially community and NGO-led programmes funded through donor aid.

The Provincial Economic Review and Outlook (PERO) 2022/23 documents highlight persistent inequality and rising service demand, while the Overview of Provincial Revenue and Expenditure (2024) highlights budget prioritisation for wellbeing and front-line services under fiscal constraint (Western Cape Provincial Treasury, 2022; Western Cape Provincial Treasury, 2024).

The household assessment and related evidence show that the strain and pressure on COPC and the health and social care systems in general, has led to altered, changed and shifting realities on the ground. The study and analysis spring from these developments and sought to assess household-level shifts in service access, delivery and ongoing health and social care needs.

The South African constitution and the SDGs

In the assessment of COPC and consideration of appropriate responses to address the evident strain and pressure on programming, the central provisions and values in the South African constitution are an important point of reference. The same applies to commitments to the Sustainable Development Goals (SDGs) that national and provincial policies and programmes are directed towards achieving.

Section 27 of the South African constitution states that 'everyone has the right to have access to health care services, including reproductive health care', while Section 28c states that 'every child has the right ¬to basic nutrition, shelter, basic health care services and social services'. The framing in the constitution that brings together health care, food, water and social security for everyone, and ¬basic nutrition, shelter, basic health care services and social services for children is instructive for service delivery strategies based on 'joined up programme design and implementation'.

Human dignity, the achievement of equality and the advancement of human rights and freedoms are the founding values of post-apartheid South African society. Achieving Universal Health Coverage (SDG Target 3.8) is one of the targets the nations of the world, including South Africa, set for themselves when the 2030 Sustainable Development Goals (SDGs) were adopted in 2015.

Social and economic context

Official and published statistics show that South African society, 30 years after the official end of apartheid, continues to display social and economic indicators that have a racial, education and employment, rural-urban, informal settlement-non informal settlement and gender dimension. Poverty is associated with negative health outcomes. In this South African picture, provincial variation is evident.

The Western Cape Province, compared to other provinces in South Africa, performs better on a number of socio-economic indicators. The latest official statistics indicate that in 2025, Quarter 4 unemployment in the Western Cape was at 18.1% (using the narrow definition) which is substantially lower than the national average of 31.4%. The province's labour force participation rate stands at 68.8% – well above the national rate of 59.3%.

On maternal health, unlike other provinces, the Western Cape achieved the SDG 3.1 target on maternal mortality of 48.3 per 100 000 live births in 2023/24 as Figure 1 illustrates. This reflects a significant improvement from the previous recorded maternal mortality figure of 62 per 100,000 live births.

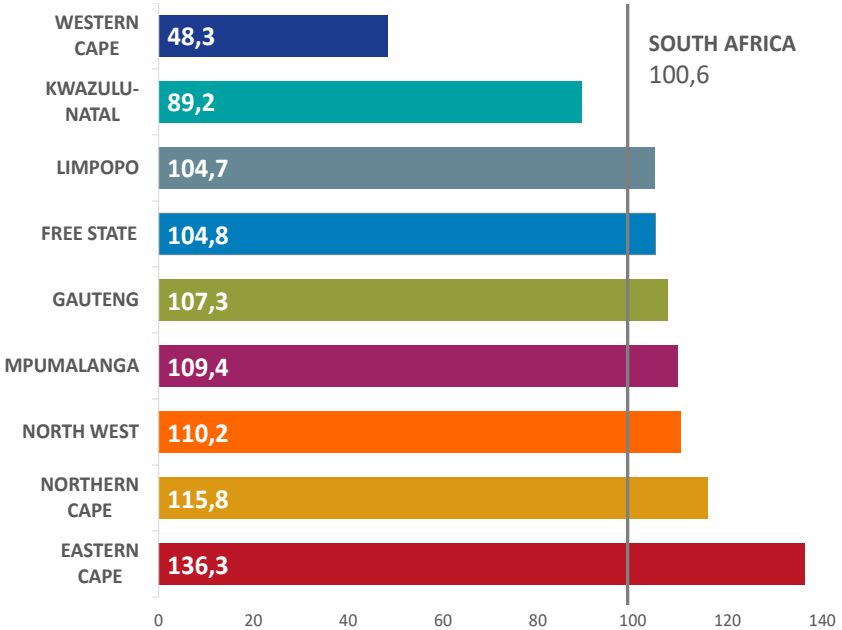
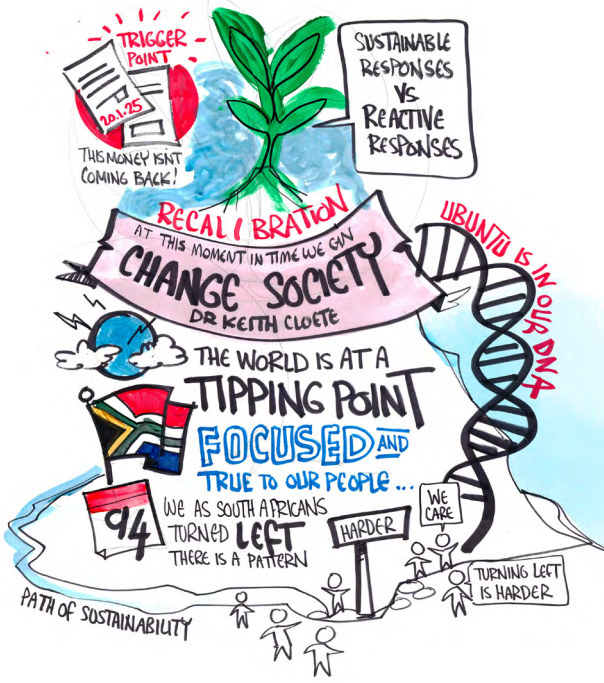


Figure 1 Maternal mortality in facility ratio by province, 2023/24

Live illustrations from the Feedback Session



Official and published statistics show that South African society, 30 years after the official end of apartheid, continues to display social and economic indicators that have a racial, education and employment, rural-urban, informal settlement-non informal settlement and gender dimension.

These positive social and economic development trends in the Western Cape do not mask the stark human development, social and economic indicators that have race, education, income and geographic location as primary determinants of health and wellbeing for the people of the province. Similar to the rest of South Africa, the unemployment rate is highest among black African women. Black African female-headed households have the highest levels of poverty. The Western Cape also faces unacceptably high levels of youth unemployment, despite being comparatively low in comparison to other provinces.

When the notion of multiple deprivation is applied in the Western Cape – income and material, employment, health, education, and living environment deprivation – a pattern emerges that captures significant differences among the Western Cape's health districts and sub-districts. The City of Cape Town Metro performs better than the Central Karoo District and Cape Winelands District when it comes to multiple deprivation. However, within the City of Cape Town itself, there are huge differences in indicators of multiple deprivation, when comparing its 8 health sub-districts of Eastern, Northern, Southern, Western, Khayelitsha, Klipfontein, Mitchell's Plain and Tygerberg.

The Western Cape province contributes disproportionately when it comes to serious crime. Recent crime statistics (October 2025 – December 2025) show that, when 17 selected community-reported serious crimes are considered, the Western Cape (72,056) is second to Gauteng (100,781).

Table 1 Community-reported serious crimes

PROVINCE	EASTERN CAPE	FREE STATE	GAUTENG	KWAZULU-NATAL	LIMPOPO	MPUMA-LANGA	NORTH WEST	NORTHERN CAPE	WESTERN CAPE	SOUTH AFRICA
Oct — Dec 2024	42 107	25 460	109 034	69 712	27 433	23 602	26 999	12 126	75 127	411 600
Oct — Dec 2025	41 128	23 778	100 781	64 479	24 365	21 268	25 889	12 192	72 056	385 936
Count diff	-979	-1 682	-8 253	-5 233	-3 068	-2 334	-1 110	66	-3 071	-25 664
(%) Change	-2,3%	-6,6%	-7,6%	-7,5%	-11,2%	-9,9%	-4,1%	0,5%	-4,1%	-6,2%
Contribution to total	10,7%	6,2%	26,1%	16,7%	6,3%	5,5%	6,7%	3,2%	18,7%	

On levels of contact crime (crimes against the person) the Western Cape features high in provincial rankings. Contact crimes were recorded at 31,399, second to Gauteng at 44,540 cases for the period October 2025 to December 2025.

When assessment of COPC is carried out with the aim of service improvement and impact, indicators such as high burden area, dwelling type, formal or informal settlement, access to water, electricity, sanitation and other necessities, capture the manifest social and environmental challenges that are outside of the strict boundaries of health care. These elements are captured under social determinants of health in this policy brief.

Defining COPC under conditions of strain

The Western Cape Department of Health and Wellness formally adopted Community-Oriented Primary Care (COPC) as its preferred model for translating Universal Health Coverage (UHC) into frontline service delivery. The key reference points for this are *The Metro COPC Framework*, *The COPC Toolkit*, *The Provincial Implementation Plan (PIP) 2023-2028* which embeds COPC within the HIV, TB, and STI agenda and the province's *Position Statement on UHC (2024).*

COPC as a concept, organizing principle, approach, model and reference for practice is placed at the centre in lifting and harnessing the important lessons from current policy implementation, programme design, practice and evident challenges experienced. COPC is further relied upon to inform and provide the framework and rationale for reimagining, redesigning, adaptation and modification of key elements of this approach to realise the objectives of PHC and achieve UHC.

The reimagining and redesign recasts COPC with a decided emphasis on inclusion, engagement, dialogue, co-creation and co-production as some of its central principles.

Community-Oriented Primary Care (COPC) is both a strategic stance and an operational framework for delivering primary health care that integrates clinical services with public health principles, community engagement, and population-level analysis. It is designed to strengthen health systems at the local level by linking facility-based care with household-level outreach, grounded in the lived realities of communities.

The Western Cape Provincial Implementation Plan (PIP) 2023-2028 describes COPC as "a continuous process by which primary health care is provided to a defined community on the basis of its assessed health needs, by the planned integration of primary care practice and public health" (Western Cape Government, 2023, p. 35). This description is situated within a broader conceptual architecture that includes community engagement, multidisciplinary teams, and integration across facility and community platforms.

COPC is based on the perspective and notion that the household, community and social environment contribute in a significant way to people's health and wellbeing. Within this understanding, households, communities and the broader social and economic milieu interface in dynamic ways to either support or negate the goals of PHC.

Current system functionality

Evidence points to the fact that broader social and economic issues are factors, causes and impacts on households and communities that deserve ample attention in redesigning COPC. Multiple sources on this abound such as research analyses, assessments, evaluations, policy and programme documents. There are observations on aspects of COPC that have been made through a range of documented evidence.

Evaluation of the implementation of COPC in the Western Cape informs us that the COPC framework is conceptually sound but that operational challenges persisted across governance, integration, and stakeholder engagement (Goliath, Mash, & Mahomed, 2025, p. 16). The evaluation identified several critical implementation tasks:

- Clarifying macro, meso, and micro-level roles and responsibilities.
- Strengthening integration between facility-based practitioners and community-based teams.
- Specifying service models and governance arrangements tailored to each geographical node.
- Undertaking explicit costing and financing to support delivery. (Goliath et al., 2025, pp. 6-8)

The list of research studies and analysis, followed by the findings of the assessment on system functionality, cover a range of themes and topics that are pertinent in crafting changes and improvements in COPC. Taken together as an evidence-base, these provide a compelling case for the recommendations made – creating a link between what the evidence points to, and what needs to be done differently.

The research studies and analyses cover a wide range of relevant topics on COPC including:

- Community-driven and NGO-partnered studies in Cape Town document **high household food insecurity** in Khayelitsha, Gugulethu, and parts of Mitchells Plain and St Helena Bay, with reliance on low-cost, energy-dense foods that elevate long-term NCD risk (Heinrich Böll Foundation/SLE, 2021; Holliday et al., 2025).
- A mediation analysis in Khayelitsha finds that **food insecurity reduces recovery from postnatal depression**, with perceived social support mediating part of the effect, confirming the relational character of deprivation (Mathew, Lund, & Seward, 2025).
- Sub-district environmental monitoring in Du Noon detected faecal indicator bacteria in the Diep River linked to **settlement sanitation deficits**, demonstrating a settlement-to-environment exposure pathway affecting residents and downstream users (Gqomfa, Maphanga, & Shale, 2022).
- The Western Cape State of the Environment Outlook reports **continuing urbanisation**, household growth, and pressure on drinking water, sanitation, electricity, and mobility systems, with uneven reliability across districts (Western Cape Department of Infrastructure, 2024).

- National analysis demonstrates a **distance-decay effect**: people living farther from facilities are less likely to attend consultations or have attended births, even after adjusting for confounders; poorer quintiles live farther and use services less often (McLaren, Ardington, & Leibbrandt, 2014).
- In Cape Town, peripheral settlements such as Delft and Mfuleni incur **higher transport costs** and time, and residents often avoid movement during unsafe windows, depressing routine care (Western Cape Department of Infrastructure, 2024; City of Cape Town, 2024).
- Cape Town analysis links **neighbourhood socioeconomic conditions** to TB incidence, with spatial dependency indicating that place-based material conditions sustain communicable burden (Molemans et al., 2024).
- The State of the Environment Outlook and the City's SDG Voluntary Local Review highlight **infrastructure backlogs** and uneven progress on adequate housing, underscoring persistent urban inequality in service access (Western Cape Department of Infrastructure, 2024; City of Cape Town, 2024).
- Qualitative work in Cape Town documents **avoidance of clinics across gang boundaries** and periodic disengagement from HIV or TB care among young men because of fear and territoriality (Lima-Chantre, Seeley, & Colvin, 2022).
- In Bo-Kaap, gentrification-linked anxieties and rising costs create **psychological displacement**, weakening social ties and trust, which can reduce help-seeking (Jessa & Rogerson, 2025).
- Cape Flats evidence documents high household food insecurity (meal skipping, diet compromise) with **implications for adherence** and short-term dosing decisions (Heinrich Böll Foundation/SLE, 2021; Holliday et al., 2025).
- In Khayelitsha, food insecurity is associated with **poorer recovery from postnatal depression**, partially mediated by social support, underscoring the relational dimension that can erode the capacity to persist with care (Mathew, Lund & Seward, 2025).

- Emergency centre studies describe weekend trauma peaks and repeat presentations that delay non-urgent care, evidencing how **safety patterns** spill over into routine service access (van Hoving, van Koningsbruggen, de Man, & Hendrikse, 2021; Horn, Bush, & van Hoving, 2024).
- In gang-contested neighbourhoods, **fear and bereavement** contribute to disengagement from HIV/TB care (Lima-Chantre et al., 2022).
- Cape Town emergency centres report heavy **interpersonal violence burden** and repeat trauma presentations with weekend peaks (Horn et al., 2024; van Hoving et al., 2021).

South Africa as a multicrisis society

South Africa is a society that is beset and engulfed by multiple crises, mainly high levels of unemployment, multi-dimensional poverty, gender-based violence and crime. Unemployment and deep levels of poverty affect millions of South Africans. This has seen the proportion of individuals receiving non-contributory, fiscus-based social grants increase from 12,8% in 2003 to 30,9% in 2019, and surging to 40,1% in 2024 due to the introduction of the special COVID-19 Social Relief of Distress (SRD) grant (Stats SA General Household Survey, 2024) Social grants have become the main source of income for millions of people and households living in poverty. In rural areas, social grants have substituted remittances as the primary source of household income.

The COVID-19 pandemic with its economic impact at household level, donor withdrawal and the current environment of fiscal constraints add another layer to the conditions of multiple crises shaping the lives of South Africans. These multiple crises have a direct impact on the nature, extent and magnitude of challenges COPC is designed to address.

Social Determinants of Health and Wellness

In the South African context, social determinants of health (SDoH) are permeated by the enduring legacies of coloniality, apartheid spatial planning, and racialised extractive economies. These historical forces have shaped the structural conditions under which health is produced and reproduced, embedding inequality into the spatial, economic, and social fabric of society. (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009)

STRUCTURAL DETERMINANTS

Structural determinants are the deep-rooted systems of power and resource distribution, such as racialised labour regimes, land dispossession, and spatial apartheid, that have historically stratified South African society. These determinants define the socio-economic positioning of individuals and communities, influencing access to education, employment, healthcare and political agency.

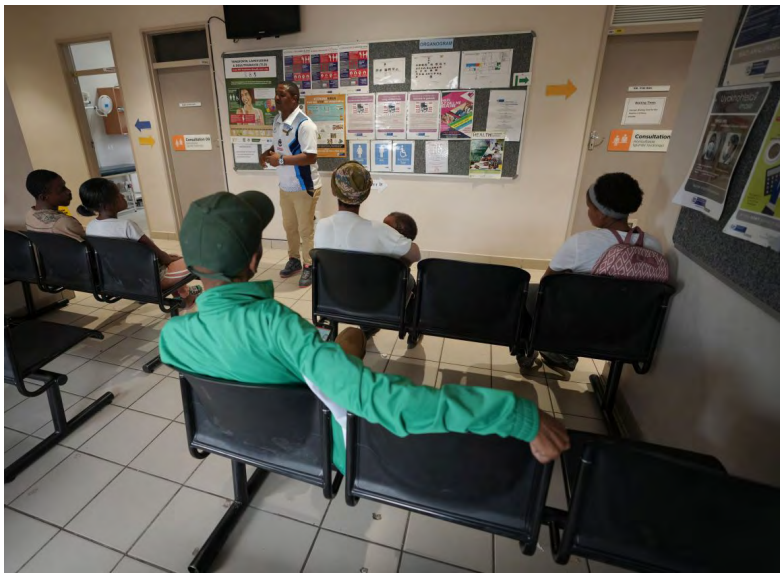
Structural determinants are macro systems that organise exposure by shaping how power, resources, and opportunity are distributed. They are slow to change without multi-sector policy action. Examples include apartheid spatial planning, systemic poverty and unemployment, structural violence and gang power, housing and urban development failures, and governance and health system design. This aligns with WHO's leadership on structural versus intermediary determinants, and with South African analyses of historical roots of inequity. (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009; World Health Organisation, 2025).

Looking at systemic determinants of health is apt in the Western Cape context. Apartheid spatial planning placed Black and Coloured communities on the urban periphery, entrenched under-investment in local infrastructure, and fixed longer and costlier trips to services and employment. These spatial arrangements continue to organise health opportunity, exposure, and utilisation in the Cape Metro (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009).

Empirical work shows service use declines as distance to facilities increases. A national panel analysis identified a distance-decay gradient for consultations and attended births even after adjusting for confounders, with poorer quintiles living farther from clinics and using care less often (McLaren, Ardington, & Leibbrandt, 2014). Cape Town spatial analysis links neighbourhood socioeconomic conditions to tuberculosis incidence and finds spatial dependency in these associations, confirming that place continues to shape communicable disease burden (Molemans et al, 2024).

INTERMEDIATE DETERMINANTS

Intermediate determinants encompass the lived realities that mediate structural conditions. These include housing quality, food security, access to basic services, and psychosocial stressors. In South Africa, these are often shaped by historical patterns of urban planning, service exclusion, deep inequality and community dislocation. Examples include food affordability, WASH reliability, transport time and cost, housing quality, and local amenity functioning. The World Health Organisation's framework treats these as intermediary conditions that mediate social stratification into daily health experiences (World Health Organisation, 2025; Coovadia et al., 2009).

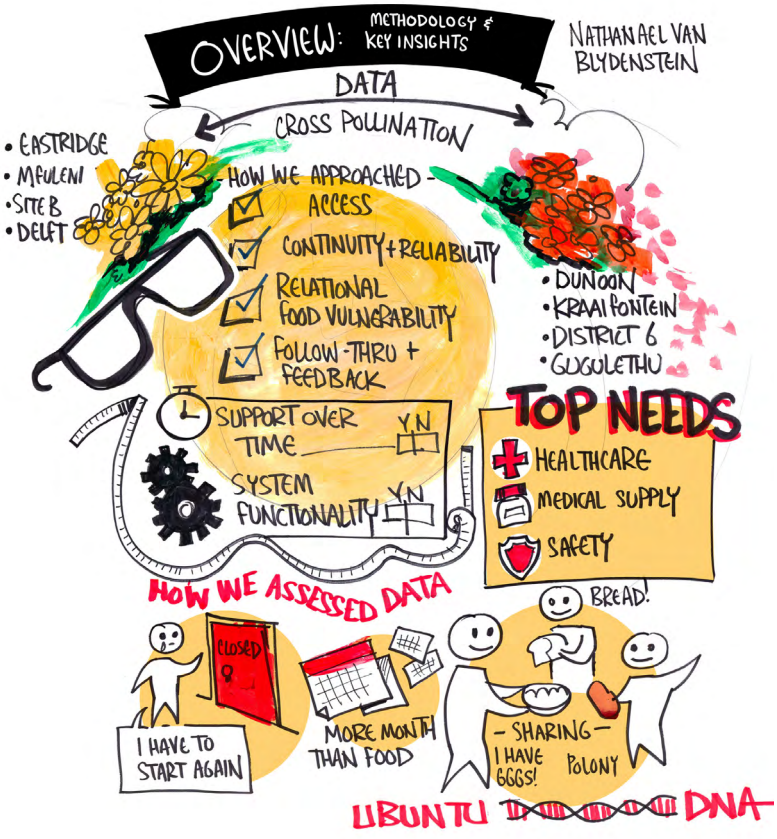


PROXIMAL DETERMINANTS

Proximal determinants are the immediate factors affecting individual health, such as access to healthcare, health behaviours, and environmental exposures. These are the most visible expressions of deeper systemic inequities and are often the focus of clinical interventions, though they cannot be fully addressed without engaging upstream determinants.

Proximal determinants are immediate exposures and behaviours that interrupt care today. Examples include hunger in the present period, skipped or delayed care because of safety threats, interpersonal violence, and acute mental health stressors. These sit closest to clinical interfaces and are where COPC teams act with brief screens and rapid linkages.

Data from the 2025 Planet Youth survey in the Western Cape show that nearly half of adolescents (47%) reported not having enough to eat for breakfast or lunch at least once in the past seven days, and about 30% reported missing dinner. These shortfalls co-occur with indicators of psychosocial stress and risk behaviours, including substance use and disrupted sleep patterns. (Planet Youth Western Cape Report, 2025). While food insecurity is conventionally treated as an intermediate determinant, these associations suggest it may also operate as a proximal signal of vulnerability, influencing mental health and care continuity. This nuance does not alter the structural-intermediate-proximal scaffold but highlights the need for interpretive flexibility when designing assessment tools.



Live illustration from the Feedback Session

Community Household Assessment Findings

Methodology and indicator construction

The assessment looked at how support availability, continuity, and experience may be shifting under fiscal constraints and reductions in external funding. The findings of the assessment describe what households reported they had in 2024, what they still had in 2025, what reduced during 2025, and what they expect to need and prioritise in 2026, using four system functionality lenses.

The aim was to identify which forms of household support appear to be most relied on, where households report reductions or interruptions, what households expect to need in 2026, and what COPC-aligned service design and operational changes could stabilise access, continuity, and follow-through.

The evidence base for the assessment integrates four evidence sources:

- **Household survey** (N = 805 households) across eight geographic sub-structures
- **Focus group discussions** (FGDs) with community members, community health workers (community health worker's), clinic committee and health forum representatives, and facility level frontline staff, providing verbatim excerpts linked to evidence IDs
- **Key informant interviews** (KIIs) with representatives from health facilities and sub-structures management, community health worker Supervisors, clinic committee and civil society stakeholders, providing system-level and operational perspectives.
- **Desktop review** of Community-Oriented Primary Care (COPC) and related service delivery context, used to broaden the evidence base and support interpretation and recommendations.

The assessment used **four system functionality indicators.** Each indicator is a binary construct derived from related survey items.

1. **Clinic access barriers**
2. **Continuity and reliability risk**
3. **Food vulnerability**
4. **Follow-through and feedback gaps**

A further indicator of '**breadth of need** and **overall level of need**' made up of 21 support types was constructed to identify areas where households face both high breadth of need and high system functionality pressures.

The overall design of the assessment, the indicators used and sources for the data and evidence, was intended to be comprehensive and to cover the range of key and critical elements of COPC. The evidence gathered, taken together with other studies and analyses, and input from stakeholders in a feedback workshop in February 2026, provides a sound evidence-base for redesign and changes to increase the impact of COPC.

Key findings

Need is high and multi-dimensional: median breadth of need is 8 support types; 55.8% of households have very high overall needs (8+ supports needed).

Food insecurity is widespread: 50.9% report at least one marker; 18.0% report severe food insecurity (2 markers).

Access barriers persist: 21.5% report difficulty accessing care when needed; 27.6% meet the clinic's access barriers indicator.

Continuity risks are common: 28.4% meet the continuity and reliability risk indicator, with highest levels in Khayelitsha and Kraaifontein.

Follow-through gaps are concentrated: 15.7% meet the follow-through and feedback gaps indicator, peaking in Mitchells Plain and Khayelitsha.

Support instability is frequent: 35.0% report at least one support type lost and/or reduced between 2024 and 2025 (loss and/or reduction).

Food support is a critical gap: 38.1% say they will need food support in 2026, while only 8.6% report having received any kind of food support in 2025.

Top priorities for 2026 cluster around health access and continuity: Clinic or healthcare when needed: 83.7%; Regular medication supply (incl. chronic medications and ARVs): 51.8%; Safety or security mediation such as neighbourhood watch, CPF, violence de-escalation: 47.6%; Clinic admin help (queue support, appointment booking): 46.7%; Water, sanitation or hygiene improvements: 37.3%; Help from neighbours or informal networks: 35.0%.

Across the four system functionality lenses, the areas most exposed on combined indicators are: **Khayelitsha, Mitchells Plain and Delft**.

Key quantitative observations and patterns

Across all areas combined, the survey indicates a **high-burden, high-complexity needs environment**:

Overall needs are concentrated at the high end: 449 (55.8%) of households fall in the "very high" category (8+ support types needed in 2026).

Food insecurity affects 410 households (50.9%), with 145 households (18.0%) reporting severe food insecurity (2 markers).

173 households (21.5%) report **difficulty accessing care** when needed.

80 households (9.9%) report **any community health worker home visit**, with large variation by area.

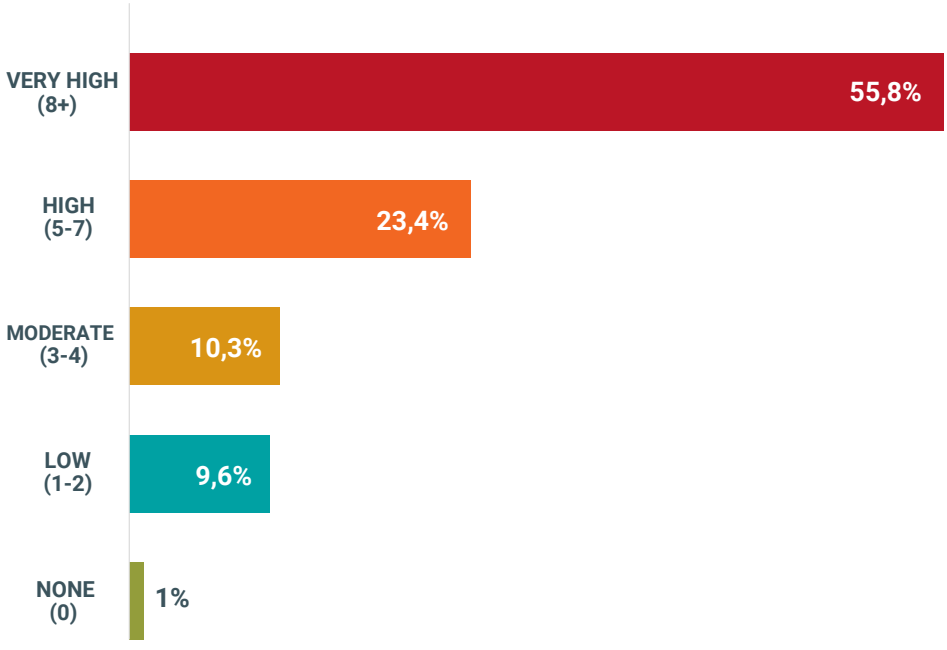
System functionality indicators show **concurrent challenges**: clinic access barriers (27.6%), continuity and reliability risks (28.4%), food vulnerability (37.4%), and follow-through and feedback gaps (15.7%).

Support instability is substantial: 282 households (35.0%) report at least one support type that was lost and/or reduced between 2024 and 2025.

> *There used to be a time when they would ask for the children's clinic cards because they used to send nurses to the creches to do immunisations. They no longer do such stuff now."*
>
> Community member, Delft

Overall level of need is based on the count of support types marked as "needed in 2026" (21 support types).

Overall level of household need (based on supports needed in 2026)



21 SUPPORT TYPES

- Clinic or healthcare
- Regular medication supply
- HIV or TB services
- Mental health or psychosocial
- Substance use
- Disability and rehab
- Community health worker visits
- Social worker
- Food parcels
- Childcare, after-school or grant
- School-based health or psychosocial
- Youth-friendly reproductive health
- Transport
- Safety or security mediation
- Water, sanitation and waste improvements (WASH)
- Clinic admin help
- Documentation help
- Income or work support
- Community or soup kitchen
- Church or faith group
- Neighbours or informal networks

Community voices: what the numbers feel like

Across FGDs and KIIs, participants described the lived experience behind the quantitative patterns: long queues and service delays, constrained staffing, fragile continuity for chronic care, food insecurity shaping whether medication can be taken, and weak closure where referrals or requests for help do not reliably translate into action or feedback.

"I got in there; I was attacked by a pain so badly. … I was crying but doctors could not attend to me because there are not enough doctors. I was given a date for another day."

Community members, Kraaifontein

"Patients will complain and say, "We have been waiting too long." … [they are told] "Unfortunately, we can't see you right now. You need to come back tomorrow."

Facility Manager / Facility leadership, Mfuleni

"Some of the NGOs that are doing soup kitchens are not looking after TB patients… The new patient will struggle. … They say, "We don't have food in the house."

Community health workers, Khayelitsha Site B

"There were instances where the facility will engage with the staff member and not engage with the patient… the patient will just see when they visit the next time that the person is still there; nothing has happened and they haven't gotten feedback."

Health forum / health committee and community stakeholders, Gugulethu

"When Anova was there, we had extra pharmacists, nurses, and data capturers … Suddenly, all the staff members were withdrawn."

Facility Manager/Facility leadership, Kraaifontein

These accounts illustrate how queues and capacity constraints, food-related vulnerability, and weak referral closure loops can shape whether households experience care as reachable and continuous. Taken together, these accounts point to a central operational insight: when **the "cost" of engagement (time, transport, safety, paperwork, stigma) is high** and **continuity systems are brittle**, households disengage and later re-enter through crisis or escalation. The result is repeated, high-effort contact with the system without durable resolution — increasing the burden on both households and facilities.

Key observations and evidence

The assessment and other research analysed capture the evidence of strain and pressure in high burden areas exacerbated by donor withdrawals and fiscal constraints and other aspects that compromise COPC system functionality. The evidence synthesis draws attention to multiple, multi-sectoral, inter-connected factors, as illustrated in structural determinants of health that cut across individual, household, community and societal dimensions.

The assessment highlights the various parts of the system that are characterised by fragmentation, dysfunction and operating in silos which worsens conditions in high burden areas. In many areas, clinic committees are not established and functioning. Community Development Workers – who are the primary frontline staff for home visits and are the anchor for COPC – show low household-reported contact with large area variation.

Stakeholders unpacked the findings in groups at the Feedback Workshop

Re-imagining, redesign & driving change

The evidence from the assessment and other research points to the need for redesign, adaptation and modification of the implementation of COPC. The guiding principles and values that inform COPC have to be re-stated and emphasised as appropriate policy, legislation, programme (structure, governance, agents, key actors, stakeholders, etc) and practice are considered.

All the constitutive elements that are within the sphere of government, and those in the sphere of households and communities, should be considered to realign a COPC approach, system and model that achieves its desired impact at service interface. This is about identifying what is happening in government, in communities, and at health centres and linking and connecting the various actors in a holistic manner.

Community and social environments, particularly service sites and open access to households in communities, do not adhere to the 'one size fits all' strategy. A deliberate effort has to be made to identify all key actors and stakeholders without upfront exclusion. The role, function, contribution, value of local actors and stakeholders for programme strengthening is crucial.

Civil society and the principles of co-creation and co-production

South Africa has a rich history of active civil society. The country has also witnessed community-level, organic initiatives and creative energy of CBOs in the responses to the HIV and AIDS and COVID-19 pandemics and in the present environment of donor withdrawal and constraints. Civil society (CBOs, churches, soup kitchens, support groups etc) play a critical role in community programmes: organising, building trust, mediating citizenship and increasing impact. Civil society in its various forms, has played a central role in South Africa's health system.

Embedded in many communities in South Africa is a tradition of community level organising that, if harnessed and directed through negotiation, stands to make significant contribution to COPC success and Community Health System Strengthening. The 'community oriented' in COPC, directs that the role and contribution of civil society and CBOs is taken into consideration. This, in nearly all cases, is a critical success factor for non-health centre interventions.

"One of the unique histories of our country is that civil society is an intricate fabric of our community serving in the darkest days of South Africa. And if we don't leverage on that rich fabric of that civil society, we will lose an important part of what we need to build a sustainable future." – Dr Keith Cloete, Head of Western Cape Department of Health and Wellness, at the Feedback Workshop

It should, however, be noted that the South African civil society context is unequal; operating on different levels and these stages of development of organisations vary considerably. This climate attracts skewed levels of skills, resources, influence and the ability to grow in many organisations. Organisations with better skills attract better resources and will have more influence on the public and government. Organisations with more influence also have an added advantage in that they are most likely to be sustainable, innovative and attract skilled people. The organisations that are struggling, newly formed and most likely operating in remote areas, remain marginalised and disenfranchised (National Development Agency, Enhancing Civil Society Participation in the South African Development Agenda: The Role of Civil Society Organisations, 2016).

The International Classification of Non-profit Organisations (ICNPO) identifies groups or sectors and associated activities in each group. Of relevance to civil society in the Western Cape and COPC are:

- Group 3: **Health** including crisis intervention, public health and wellness education as well as health treatment, primary outpatient.
- Group 4: **Social services** including child welfare, child services, and day care; youth services and youth welfare; facility services such as parent education, family violence centres etc.; services for the handicapped; services for the elderly; self-help and other personal social services; disaster /emergency prevention and control; temporary shelters; refugee assistance; income support and maintenance; material assistance i.e. food, clothing etc.
- Group 6: **Development and housing**
- Group 10: **Religion**

In relation to COPC, it is crucial that the principles of co-creation and co-production are thoroughly considered and embedded in practice. This requires, at times, a shift in thinking for state actors in particular. Co-creation and co-production methodologies emphasise meaningful (not token) engagement, partnership, collaborations between state and non-state actors, primarily CBOs to develop co-owned solutions. Co-production is enacted and becomes evident in planning, design and implementation and feedback into the policy and programme evidence loop. Co-creation and co-production methodologies have been proven to improve results in community-based health programme and allow a genuine focus on the needs of communities as they participate in the development of solutions.

Illustrator Robert Dersley documented the Feedback Workshop

Community Health Systems Strengthening

COPC is part of community health systems which are the people, organisations, relationships, and local mechanisms that help a community prevent illness, promote health, detect problems early (including pandemic preparedness), and connect people to care, especially outside hospitals and clinics. They are anchored by healthy community assets.

Community health systems sit at the 'community level' of the wider health system and usually include both formal (government-linked) and informal (community-led) parts. They promote health (education, prevention, behaviour change); prevent and manage disease (screening, adherence support, tracing, home-based care); reduce barriers to care (stigma reduction, navigation, transport, language/culture mediation); strengthen trust and responsiveness between communities and facilities; coordinate multi-sector support (health + social services + protection + livelihoods).

Community health systems are increasingly recognized as being foundational to health systems, serving as critical bedrocks and conduits for improving access to primary health care and advancing the goal of universal health coverage (Sacks et al. 2020). These systems are rooted in the community and built on foundations of trust, participation, and local engagement. Their primary function is to extend the reach of primary health care by providing culturally appropriate, accessible, and continuous care at the community level. In doing so, community health systems significantly contribute to the realisation of universal health coverage, ensuring that all individuals and communities receive the health services they need without suffering financial hardship (Mupara et al. 2023).

Community health systems foster greater ownership, accountability, and responsiveness to local health challenges (Sacks et al. 2020). This context-sensitive approach is particularly vital for reaching marginalized, rural, and underserved populations, who often face significant barriers to accessing facility-based care due to distance, cost, or cultural factors.

Community health systems include:

Community health workers (community health workers): outreach, adherence support, household visits, basic screening, referrals.

Networks of peer supporters: adherence clubs, mentor mothers, youth peer educators, key population peer navigators.

Community-based organisations (CBOs) and NGOs: prevention programmes, psychosocial support, service delivery, advocacy.

Local leadership and governance: ward committees, traditional leaders, community health committees, clinic committees.

Community-led monitoring and accountability: tracking service quality, stock-outs, waiting times, stigma/discrimination, and escalating issues.

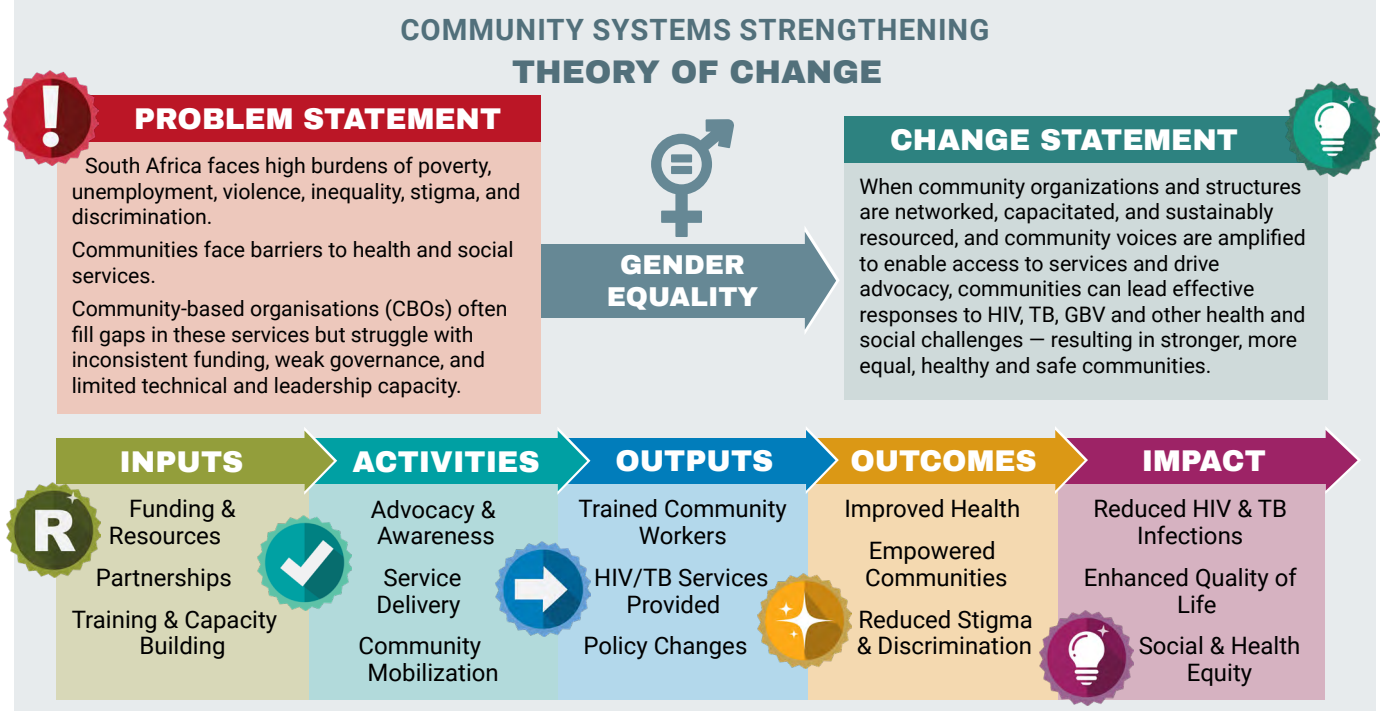
Health information and referral linkages: systems that help people move between community support and facilities (and back), including follow-up.

Social support and enabling services: transport support, food/nutrition support, legal aid, GBV response pathways, harm reduction linkages.

Resources and financing at community level: small grants, community funds, stipends, supplies, supervision structures.

Theory of Change for Community Health Systems Strengthening

NACOSA's theory of change for community systems strengthening has been developed over 20 years' of working with and within community health and social care systems.



COMMUNITY-LED MONITORING

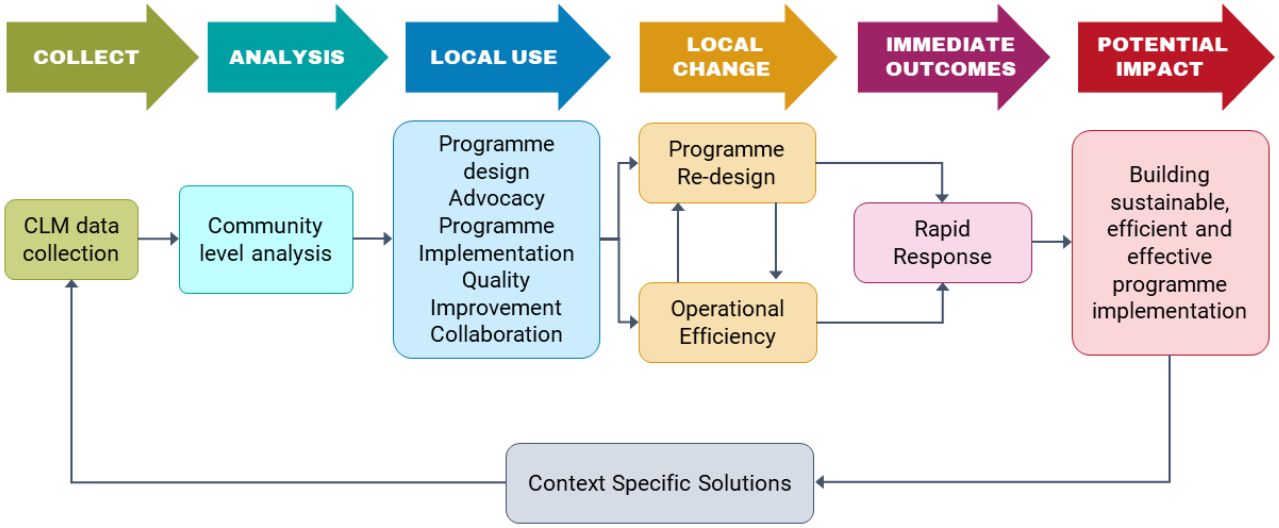
CLM is part of community health systems strengthening approach formulated and implemented by community-led groups. The model uses collection of data, analyses, interpretation of data, and dissemination of information to advocate for solutions and monitor change. Community-led monitoring (CLM) is an emerging approach that empowers local communities to actively participate in data collection and decision-making processes within the health system' (Tshuma N et al, 2024. *The Transformative Impact of Community-Led Monitoring in the South African Health System*).

The CLM model originated during the COVID-19 pandemic and it was formulated as a response to the impact on health care and the strain it placed on public health systems.

When the COVID-19 pandemic began, many predicted a looming catastrophe for HIV and TB responses. In high-burden settings, it was estimated that HIV- and TB-related deaths over five years may be increased by up to 10% and 20%, respectively. Major multi-lateral organisations recommended community-led monitoring in the context of COVID-19 to help report service disruptions, commodity stock-outs, and human rights violations (ITPC, 2022. *Citizen Science, Addressing the Impact of COVID-19 on HIV and TB Services*).

Analyses of the approach see CLM as 'a powerful tool for improving program implementation, quality, and advocacy in South African healthcare' as 'it strengthens accountability, trust, and transparency by involving local communities in data-driven decision-making'. (Tshuma, et al. 2024)

Community-led monitoring value chain (West Rand, South Africa, 2023)



Community Health Workers

Community Health Workers are the foundation of community health systems and are crucial in achieving sustainable and equitable access to healthcare. In the Western Cape's health provision systems, community health workers play a central role covering preventive, promotional, curative, nutritional, and rehabilitative services. In South Africa, community health workers are established frontline workers facilitating access to health and social care.

Within the COPC framework, community health workers operate as extensions of the health system in geographically defined catchments. They act as relational agents of care, knowledge, and connectedness, supporting the delivery of comprehensive services that are systematically embedded in community contexts. Community Health Workers remain the most credible bridge between households and facilities. They support first contact, re-engagement, and case finding. However, their impact is limited by fragmented employment, supervision load, and slow professionalisation.

Integration challenges faced by Community Health Workers have been identified. There is the emotional and moral toll of frontline care, the precarious nature of community health worker employment, and systemic gaps in professional development and career pathways. These vulnerabilities, such as fragmented supervision, low recognition, and limited career mobility are likely constraints on the effectiveness and sustainability of community health worker-led care.

A number of critical issues affecting community health worker require urgent attention:

Organisation of labour within COPC teams, including the disease burdens they are working with, mental health and rehabilitation roles, and institutional innovations.

Community health worker **retention, recognition, and rewards**, highlighting working conditions, supervision gaps, and pathways to professionalisation.

Clinic Committees vs Health Committees

Clinic Committees are statutory bodies mandated by the Western Cape Health Facility Boards and Committees Act (Act 4 of 2016) to facilitate community participation in primary health care governance. Clinic committees and district councils formalise voice and problem-solving. When they function, they support trust, agenda-setting, and closure of issues. When they are weak, grievance cycles persist and households carry more of the burden (Western Cape Provincial Parliament, 2016; Western Cape Provincial Parliament, 2010).

Local governance capacity has declined in several sub-structures. Fewer clinic committees are properly constituted than in 2023. This reduces problem solving, weakens accountability, and slows response times when services fail.

Clinic Committees are embedded in fragmented systems that are characterised by unclear governance arrangements, strained relationships, and dispersed accountability. They are unlikely to be able to effectively perform the mediated citizenship role that would support cooperation and collaboration between facility-based teams, community health workers and households. Their diminished legitimacy and influence thus indirectly constrain the participatory structures needed to strengthen household-level health and social care.

On the other hand, Health Committees have emerged as organic, community-led responses to health and social care challenges – stepping in where government failure is evident. The COVID-19 pandemic exposed both the limitations and latent capacities of participatory governance in the Western Cape health system. In economically marginalised areas such as Gugulethu and Mannenberg, Health Committees responded to urgent community needs by stepping into roles that the Western Cape Department of Health was unable to fulfil. These included enforcing infection prevention measures outside clinics, assisting with vaccine registration, and conducting door-to-door outreach to counter vaccine hesitancy. (Kannemeyer, Colvin, & Haricharan, 2022, pp. 3- 4).

Health Committees began creating spaces – community-led forums for planning, coordination, and mutual support. These spaces allowed them to exercise agency, build solidarity, and develop their own strategies for community health.

Whole of Society Approach

The UNESCO perspective on whole of society approach is instructive and carriers close link to the objectives of COPC in Western Cape Province environment. According to UNESCO:

'Governance' – beyond 'government' – involves not only relevant government departments and agencies, but also the private sector and civil society. This chapter explains how a 'whole-of-society' approach – involving civil society as well as the public and private sectors in the joint pursuit of common solutions to complex problems – contributes to building effective partnerships and cooperation. A whole-of-society approach embraces both formal and informal institutions in seeking a generalized agreement across society about policy goals and the means to achieve them (UNESCO, The United Nations World Water Development Report 2023).

Whole Society Approach frames health as a shared societal responsibility, requiring intersectoral collaboration and community-led responses. In the Western Cape, this approach has been adopted as a strategic orientation to support Universal Health Coverage and the operationalisation of Community-Oriented Primary Care (COPC). It emphasizes collaborative governance, intersectoral action, and community-led responses. Rather than viewing health outcomes as the sole domain of clinical services, the Whole of Society Approach frames them as emergent properties of broader social systems, including education, housing, safety, and economic development (Western Cape Government, 2014). The Western Cape's adoption of Community-Oriented Primary Care (COPC) and the Whole of Society Approach represents a deliberate shift from fragmented, programme-based service delivery to integrated, place-based health system transformation.

Whole-of-Society Approach for Community Health Systems

Whole of Government Approach

Whole of Government is considered central to promote and achieve policy coherence and effectiveness. Whole of Government is defined as an approach 'in which public service agencies work across portfolio boundaries' to develop integrated policies and programmes towards the achievement of shared or complementary, interdependent goals' (WHO, 2016. Whole- of- government, whole- of- Society, health in all policies, and multisectoral).

In the Western Cape Government, there are identifiable 'systems' that function across government, being the custodians of policy, legislation, programme, implementation and the measurement of results and impact. These systems are the social care system, safety system, economic system and spatial system. Whole of Government Approach is about how these systems are made to function together to achieve set, specific goals and outcomes.

The Whole of Government Approach is particularly relevant in high burden areas. Aligned, coordinated, synergistic and supportive, jointly planned operations on the ground bring about great benefits to the local populace.

Hybridised governance and resilience

Hybridised governance and resilience places emphasis on co-governance between statutory and civic actors, and the system's capacity to adapt under strain.

Hybridised governance refers to the blending of formal state structures with informal, community-based, and non-governmental actors to address complex service delivery challenges. In the South African health system, this model has emerged as a pragmatic response to historical governance deficits, fragmented accountability, and the need for more inclusive and adaptive decision-making processes (ASSAf, 2024).

Resilience, in this context, is the capacity of health systems to absorb shocks, adapt to changing conditions, and maintain core functions. It is not only technical but relational, depending on trust, collaboration, and the ability to learn and reorganize in the face of uncertainty (Muller, 2014). In the Western Cape, resilience-thinking has increasingly informed collaborative governance models, especially in the integration of Community-Oriented Primary Care and the Whole Society Approach.

Hybridized governance describes the blended, negotiated space where statutory actors (DoH, facilities, sub-structures) and civic actors (clinic/ health committees, CBOs, faith groups, neighbourhood networks) co-produce decisions and accountability. Resilience is treated as the system's capacity to maintain and adapt care functions under fiscal and social stress, tested through concrete practices such as community health worker coverage and referral closure, committee mediation/agenda-setting, and the everyday use of relational infrastructures (community kitchens, churches, neighbour care, WhatsApp groups).

Community members interrogated findings with researchers at the Feedback Workshop

Together, hybridized governance, constituency connectedness and resilience offer a framework for navigating the tensions between centralised authority and local responsiveness. They support the co-production of health solutions, enable flexible partnerships, and foster system learning. This conceptual pairing is essential for understanding how health systems can remain responsive and equitable in contexts marked by structural inequality and social complexity.

Recommendations for local government

Household-centred approach

The Western Cape Department of Health uses the human life cycle / life course approach as the scaffold for its policy and programme integration. A life course approach involves policy and programmes that follow the different stages in the life of an individual from conception, birth, infancy, childhood, adolescence, transition to adulthood, adulthood and old age – from 'cradle to grave'.

COPC as part of primary health care and UHC, brings together various components – individual, household, community, health centre, etc. Members of households (as family) play a central and critical role in the life and development of members of society. The household is the first line of support and defence. Household dynamics such as income, education, wellness and, on the opposite end, unemployment, poverty, gender-based violence, substance abuse, have a direct impact on prospects and opportunities for individual household members.

This is the compelling reason for an approach that is household-centric, as the household and family become the first line of intervention and defence. The household is the entry point.

The household-centred health services model fully acknowledges that households are part of communities and exist and live within community environments. Household are impacted upon by the communities they are part of. Issues on safety, water, sanitation, electricity, health and education facilities are provided

at community level. This making the immediate environment to be of consequence for Households as part of communities. There is an important role for communities even in a household-centred COPC.

Principles and values inform programmes

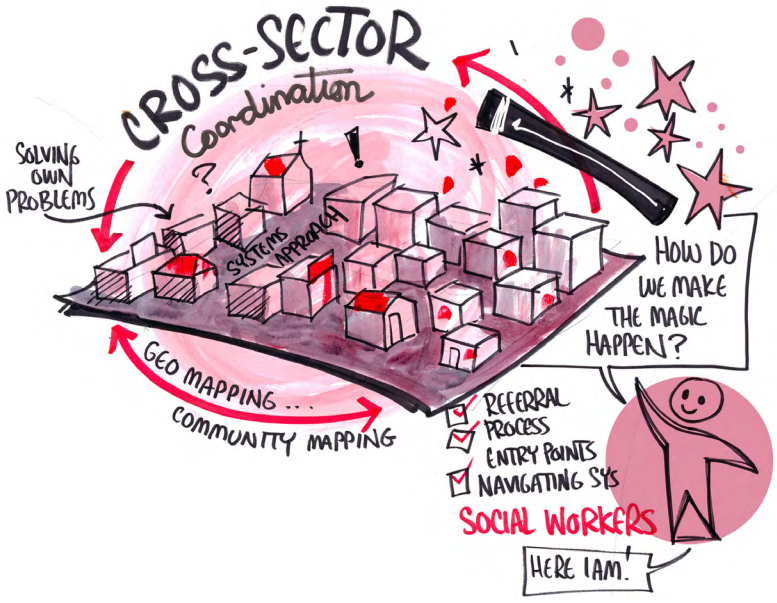
It is imperative that principles and values that guide and shape programme design, approach, implementation and operations are declared as programmes are reviewed in the context of constraints and pressure.

There is the human rights-based approach to development, commonly accepted as:

- The formulation of goals and implementation process in human rights terms.
- An agreement by all stakeholders on the appropriate performance indicators.
- An evaluation of the outcomes based on human rights and participation.

Principles and values such as respect, dignity, accountability, consultation, engagement, trust, partnership, and others that are relevant should be written into policies and the design of programmes. The issue of principles and values is foundational for programme success and particularly crucial in high burden areas.

Live illustration from the feedback workshop



Coordination beyond the tick box

In systems of government, there are various forms of coordination, from minimal to maximum, passive compliance and tick box exercise to a dedicated focus on measurable results, ongoing review and impact. The type of coordination that is envisaged is one in which the overriding goal is coordination that breaks silos, permeates the thinking of the coordinating government partners at all levels, and shapes how programmes are implemented and operate on the ground. This type of coordination is directly led, institutionalised, results-focused and impact-oriented. This type of coordination is not only an idea in government documents, realised through meetings and workshops among officials, it extends to observed changes on the ground that comes out of, primarily, government departments breaking operational barriers.

Government working together to bring services to a single point

Attempts at making government departments work together have revolved around co-location, the physical occupation of the same space, like a building. Government working together to bring services to a single point is about joint planning (drawing common plans), joint operations at service sites. This is of great benefit as it reduces time and travel costs for recipients and beneficiaries (Integrated Community Registration Outreach Programme (ICROP) is a model of the South African Social Security Agency).

Aligning service registers

Departments of government hold information of beneficiaries and recipients of different services that is utilised in access to, and distribution of, services. Departments and agencies such as SASSA, local government, local health own these registries. Alignment of these for joint programme operations is necessary to achieve the goals of COPC.

Exploring this notion, Melis Guven (May 2024) of the World Bank speaks of 'dynamic registries' that 'are interoperable' with people being able to:

'… apply for multiple benefits and services through a common application' and 'administrators and government agencies can pool resources on the front lines through common intake and registration … and in the back-end social registry systems can integrate information for better quality; accuracy; efficiency, and savings in administrative cost (Melis Guven, 2024, *Rethinking Social Registries in the face of multiple crises*).

Costing and financing to support delivery

Government departmental budgets are based on prioritisation, determining what gets done and when and what is postponed and left out. Cost benefit analyses of COPC and other related approaches and systems have been undertaken in high burden areas and communities.

The benefits of COPC are well established and costing and budgeting should form part of the reimagining and redesign.

> *"This process gives me a power of going back and saying to my people, this is the process and give them the hope that I also got to trust to our government, to our stakeholders, that there will be a change to the gaps that we have."*
>
> Fanelwa Gwashu, Community Activist, at the Feedback Workshop 2026