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Health

BETTER TOGETHER.

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# Population Approaches to Attaining Health Outcomes



## Editorial

By Dr Keith Cloete

Deputy Director General, Chief of Operations,  
Western Cape Government: Health

The theme of this year's departmental research day is "Population Approaches to Improving Health". This is particularly appropriate, given our Department's current context and challenges: for several years now, our services have been asked to "do more with (in real terms) less". Demand often outstrips supply and many frontline service providers describe their daily lived reality as providing health care while standing on a 'burning' platform. Our frontline staff are consumed with the unrelenting task of trying to "mop the floor" and "clear the backlog", all the while striving to render patient-centered, compassionate, empathetic health care. Examples of pressure points in the Department include our Mental Health Services, Obstetric & Neonatal Care, General & Orthopaedic Surgery and our Emergency Centers & Internal Medicine, while the safety of our Emergency Medical Services and Primary Care personnel is threatened in certain geographic areas, due to violence. Our Forensic Pathology Services are facing significant increases in workload due to inter-personal violence.

With the escalating numbers of people choosing to live in the Western Cape, and with an economy which is struggling, resulting in more people using the public rather than private health system, there is little chance that the pressure will relent. We need a different strategy. Instead of just "mopping the floor", we need to "turn off the tap". This involves targeting the so-called "upstream factors" – the "social determinants of health". It involves tackling health at a community and/or population level and not just at an individual level. The articles in this edition of the Research Newsletter address this theme in various ways.

**Kroll** and **Sanders** ("Food environments and the double burden of malnutrition in the Western Cape") remind us of the co-existence of high levels of stunting and obesity in our society, the failure of "highly expensive behaviour change strategies" to make a significant difference and the urgent need for us to better understand and more effectively regulate local food environments. **Weimann** et al ("Health in Urban Housing Policies in the Western Cape: Investigating housing policies to address infectious and non-communicable disease epidemics") highlight the housing problem in the province and its effect on population health. They describe an ongoing collaboration between two provincial departments and a university and stress the need for intersectoral action in addressing this challenge. **Bester** ("Environmental health and healthy communities") focuses on the risks to population health of exposure to toxins and pollutants and gives some current examples. He highlights the valuable contribution that environmental health practitioners can make to primary prevention in this regard. **Sibeko** ("Providing Mental Health Training for Community Health Workers") describes a successful intervention in the province to equip community health workers to correctly identify common mental health problems and to support mental healthcare users. **Mabaso** and colleagues ("HIV prevalence and related factors in the Western Cape Province: profiling the epidemic") present some recent HIV statistics for the province and describe a number of relevant risk factors. They emphasize the need for behavioural change interventions to reduce further transmission of the virus. Lastly, **Matzopoulos** ("The harms and risks of alcohol in Khayelitsha") focuses on the harm that results from high levels of alcohol consumption in Khayelitsha and the need for an evidence-based and whole-of-society approach to the problem.

So what do malnutrition, inadequate housing, pollution, the absence of community mental health support, and the high prevalence of risk behavior for HIV acquisition and alcohol consumption have in common? These are just a few examples of "upstream" factors which impact heavily on the health of our population and influence whether our community members become ill or injured and end up in our facilities or don't. Because they are "upstream", they cannot be addressed by the Health Department on its own, or even by the Health Sector. They need a "whole of society" approach, with collaboration across sectors and departments and meaningful involvement of and partnering with the communities themselves. I hope you enjoy the newsletter.

Sincerely,

Dr Keith Cloete

DDG: Chief of Operations, WCG: Health.  
October 2017

# Food environments and the double burden of malnutrition in the Western Cape

By Florian Kroll and David Sanders

University of the Western Cape

The Western Cape and South Africa, in common with an increasing number of countries in the 'global South', is experiencing a growing 'double burden' of malnutrition – the co-existence of significant rates of undernutrition (protein-energy and micronutrient deficiencies) with overweight and obesity.

In the Western Cape, according to the Demographic and Health Survey (DHS) 27% of children under 5 are stunted revealing chronic undernutrition.<sup>1</sup> Undernutrition compromises children's immunity to infectious illnesses, physical growth as well as their cognitive development. This undermines educational attainment and employability, and predisposes individuals to obesity and non-communicable illnesses later in life.<sup>2</sup> The prevalence of obesity in the Western Cape is alarming. About 47% of adult women were obese in 2016, and 26% were overweight. Fewer men were obese (30%) and overweight (16%).<sup>1</sup> Obesity predisposes to non-communicable diseases (NCDs) such as diabetes, hypertension and circulatory illnesses. The DHS findings show just over half (51%) of women and 58% of men in the Western Cape are hypertensive.

NCD-related personal suffering under the 'double burden' is compounded by societal costs of malnutrition attributed to reduced productivity resulting from impaired cognition and educational attainment as well as lower productivity in manual work. These costs are estimated at 12% of GDP in developing countries, and NCD-related costs amount to billions of Rands in South Africa.<sup>3</sup> There is thus a strong moral and economic case for intervention, but this must be informed by an understanding of underlying causes.

The 'double burden' reflects a dietary transition – the increasing consumption of highly-processed foods high in sugars, saturated fats and salt, and low in fibre and micronutrients, particularly in urban settings.<sup>4</sup> Internationally, this transition is explained by a growing urban middle class, but in South Africa it is also linked to poverty. The cost of the basic food basket amounts to R2068.35 for a family of four,<sup>5</sup> but nearly 21% of households in the Western Cape spend less than R2500 in total each month.<sup>6</sup> Therefore, many people struggle to afford enough food to stave off hunger, let alone optimally meet their nutritional needs. The consumption of poor diets is not merely a matter of ignorance or poor motivation. The expansion of 'Big Food' – large food processing and retail corporations, makes ultra-processed foods more available, accessible, easier to store and prepare.<sup>7</sup> Ultra-processed foods are conclusively implicated in the obesity

epidemic.<sup>8</sup> These transitions are accelerated by liberalised trade, which increases imports of all foods, notably processed products, and by foreign direct investment, especially in the fast food industry.

The 'double burden' is therefore linked to social and economic transitions at a national and global scale. It is, however, unclear how these shifts translate into nutrition at the household scale, and what the implications for interventions are at provincial, district and local government level. Current interventions focus primarily on individuals mainly in the health sector. They include promotion of breast and improved complementary feeding, growth monitoring and promotion, micronutrient supplementation as well as treatment of frank undernutrition and diarrhoea among children and management of diabetes and hypertension among adults. Screening for diabetes and counselling are used to promote healthy eating, increased exercise and weight loss.<sup>9</sup> However, costly behaviour-change strategies appear to make little impact on a population level.<sup>10</sup>

While the nutritional transition at the provincial level requires long-term socio-economic transformation, local scale interventions seem more feasible in the short term. Food environments – the physical, social and economic geographies navigated by individuals to acquire food – mediate between macro-scale transitions and micro-scale nutritional shifts in households. Due to high levels of urbanisation and large concentrations of poor people in cities, urban food environments are important settings. It is crucial to emphasise the relationship between supermarkets, which are expanding rapidly into poor areas, and the informal economy which provides affordable and convenient access to food.<sup>11</sup> Understanding these contexts and consequent better regulating local food environments is an important opportunity to promote health.

More detailed research is required to understand how rapidly changing food environments in the Western Cape are related to stunting and promote obesity and related NCDs. In the interim, health departments (provincial and municipal) could promote a 'food environment' approach by nurturing cross-sectoral food governance partnerships especially with planning departments as well as with local civil society organisations. Direct interventions could include: establishing breastfeeding rooms and child care centres at workplaces; optimising the foods provided through the Primary School Nutrition Programme and other public institutions (e.g. prisons, hospitals) by procuring a percentage of nutritious foods from local small producers; developing campaigns to raise public awareness about obesity, its health risks and dietary causes; ensuring that food outlets display appropriate nutritional information; introducing bylaws that limit the presence of fast food outlets or advertising close to schools; promoting sale of affordable, fresh and minimally-processed foods by informal food traders and in supermarkets and appropriately regulating upstream wholesalers supplying food outlets. Starting with these would be a good beginning!

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# Health in Urban Housing Policies in the Western Cape: Investigating housing policies to address infectious and non-communicable disease epidemics

By Amy Weimann<sup>1</sup>, Warren Smit<sup>2</sup>, Noxolo Kabane<sup>3</sup>, Tracy Jooste<sup>3</sup>, Anthony Hawkrige<sup>4</sup>, and Tolu Oni<sup>1</sup>

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South Africa, like other developing countries, has seen a rise in the number of urban dwellers in major cities. This increase has been attributed to factors including migration, as people have tended to migrate into cities in search of better opportunities. Upon arriving in cities, many find it near impossible to secure affordable housing and are often forced to find accommodation in informal settlements.<sup>1</sup> Consequences of urbanisation and population growth, such as the large numbers of informal settlements, the strain on urban resources and increased growth in the housing backlog, are visible throughout South African cities, suburbs and peri-urban areas. However, the development of informal settlements in South Africa can also be attributed to a history of racial discrimination and segregation, as well as inefficient strategies for urban management, corruption and ineffective policies, among other reasons.<sup>2</sup>

The Western Cape context tells a similar story to the national one. According to Statistics South Africa, the population for the province is increasing over time, at a rate of 2.87% per year.<sup>3</sup> The number of households living in shacks (not in backyards) in the Western Cape increased from 142 706 to 191 668 between 2001 and 2011. This is an increase of 3.4% per year, elevating the demand for adequate housing in the province.<sup>1</sup> The poor housing conditions typical of informal environments are associated with a variety of health issues, including burns and injuries<sup>4</sup> yet preventable health problem globally. This paper describes burns in a cohort of children admitted to the Red Cross Children's Hospital, in Cape Town, South Africa. This six month retrospective case note review looked at

a sample of consecutively admitted patients from the 1 st April 2007 to the 30 th September 2007. Information was collected using a project-specific data capture sheet. Descriptive statistics (percentages, medians, means and standard deviations, mental illness<sup>5</sup> and an increased risk of infectious and chronic respiratory illnesses, including asthma, tuberculosis, and chronic coughs.<sup>6</sup> The current rate of population growth, particularly among the urban poor in informal settlements in the Western Cape, highlights the need for housing interventions that contribute towards the development of healthy communities and living environments.

The social and physical conditions of the environment in which people live, work and play ultimately shape and influence their health. In turn, these conditions or determinants of health are largely influenced by government policies and interventions that lie outside the scope of the health sector.<sup>7</sup> Recently, the World Health Organization<sup>8</sup> and the Commission on Social Determinants of Health<sup>7</sup> issued a global call for all sectors to recognise the downstream impacts that their policies, programmes and interventions have in shaping the health and wellbeing of the population, and to be willing to engage in intersectoral efforts to improve downstream health outcomes, while working towards attaining other social, economic and environmental sustainability goals.

The Western Cape Government Departments of Health and Human Settlements have responded to this call and have partnered together with public health and urban planning academics from the University of Cape Town to undertake a mixed-method, cross-sectional study to investigate how a collaborative partnership might be established to mitigate health risks of inadequate housing, focussing on the physical conditions of the home and neighbourhood environments in the Western Cape informal settlement context.

The study is currently ongoing and incorporates three broad methodological components, specifically:

1. A review of published and grey literature to examine the potential health impact of planned informal settlement service delivery and upgrading; and a policy analysis of key Western Cape Government and City of Cape Town policies and strategies relating to informal settlement development and upgrading, and investigating possible synergies with those of the Health sector.
2. Semi-structured interviews with key planners, technical experts and policy implementers from a range of Western Cape Government and City of Cape Town departments in order to gain insights into perspectives on: i) current conditions in informal settlements and impacts on health; ii) the feasibility of establishing a collaborative partnership between the Human Settlements and Health sectors; iii) the roles that other departments could play to support collaboration to address upstream health determinants.
3. Exploring the availability and range of existing routine administrative quantitative health data that could be used to measure a population's baseline health and their interoperability with human settlement data for an informal settlement area identified for future upgrading.

As there is little research available that seeks to assess the health impact of informal settlement upgrading in the Western Cape and South Africa, we envisage that these findings will draw attention to the impact that the informal settlement environment has on health outcomes. It should identify opportunities for data sharing between the health and human settlements sectors to assist in targeting of housing interventions, inform an intersectoral collaboration model and contribute to an alignment of health and housing policy interventions towards improving overall population health and wellbeing for the urban poor in the Western Cape and South Africa.

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# Environmental health and healthy communities

By Dirk J Bester

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While healthy communities need healthcare interventions, factors such as their demographics, genetics, socio-economic status and environmental conditions all play a role in community's health status. It is, however, often the most vulnerable communities who have the least control over their environment. Consequently, most environmental health research focusses on minors, the working class and informal settlements. In addition, crime and politics was shown in a recent study by Smit and co-workers to impact on non-communicable disease patterns within communities.<sup>1</sup>

Environmental pollutants associated with agriculture is a major current area of research in the Western Cape. There are several areas of concern associated with this sector, including potential anti-androgenic<sup>2</sup> and neurotoxic<sup>3</sup> effects of pesticides as well as heavy metal toxicity in water, soil and crops.<sup>4</sup> It is commonly accepted that pesticides have health effects, but we know very little about their specific effects. A study by Archer and Van Wyk<sup>2</sup> aimed to provide more information on the mechanism by which pesticides exert their anti-androgenic effects, and whether mixing different pesticides increases these effects. These chemicals interfere with the binding of dihydrotestosterone to androgen receptors. The research found that mixing common pesticides did not necessarily lead to additive effects. Anti-androgenic effects of pesticides result in disorders such as early, late or abnormal sexual development in children.<sup>5</sup>

Recent information provided by Motsoeneng and Dalvie,<sup>3</sup> suggests that neurological side effects may arise from frequent contact with pesticides. People residing on farms studied were more likely to exhibit neurological symptoms than those from rural towns. These findings, however, showed only a low association between pesticides and the neurologic symptoms. A recent study revealed higher than permitted limits of heavy metal levels in water, soil and vegetables in the Philippi region.<sup>4</sup>

A review by Sibanda et al.<sup>6</sup> suggests that these conditions and pollution could be due to increased discharge of waste water effluent in South Africa. It describes how this water pollution also leads to mutations in water-born pathogens, antibiotic resistance, reduced fertility and increased risk of cancer, in addition to more direct environmental impacts.

These studies all seek to improve health outcomes in those working on farms and in rural communities, by providing essential information as to the extent of risk in the Western Cape. This approach allows government, farmers,

workers and consumers to make informed choices about pesticide use, waste management and where to source food. With sufficient uptake of this information there could be a significant reduction in the health burden, through preventing debilitating toxic conditions. This information also serves to set standards and make recommendations for monitoring maximum allowable levels of pollutants and toxins in human environments.

Standards are currently being revised for measures to regulate, or protect workers against, noise pollution in the workplace (SANS10083). Changes will incorporate findings of a masters' study of a CPUT student, Johan Bronkhorst. It proposes a baseline hearing test for workers entering employment. This test together with current legislation will allow for earlier intervention for hearing loss. Similarly, studies are ongoing to investigate antibiotic use in food-animals, microbial safety in ready-to-eat chicken products and food safety practices in restaurants.

By investigating the current effects of pollution or toxins within our communities, environmental health practitioners are making valuable recommendations and developing standards to prevent disease. By doing so, they are uplifting community health through prevention rather than treatment. This should contribute greatly to reducing the burden of disease with its associated costs.

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# Providing Mental Health Training for Community Health Workers

By **Goodman Sibeko**  
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Community health workers (CHWs) are a valuable resource in primary health care, providing home-based adherence and social support services to those in need.<sup>1,2</sup> In the Western Cape, training programmes prepare CHWs to provide care for chronic diseases such as hypertension, diabetes, tuberculosis and HIV. The same, however, cannot be said for mental disorders. CHWs manage a range of common mental disorders in their daily work but have not been trained and appropriate standardized training is important.<sup>3,4</sup>

With the guidance and assistance of Western Cape Department of Health, Dr. Peter Milligan and I, initially worked with Dr. Tracey Naledi and Ms. Tobeka Qukula to conceptualize a structured training manual to fill this gap. Based on previous mental health training developed by 'New Beginnings', conducted at Koinonia by Mrs. Lezel Molefe, I worked closely with Mrs Marinda Roelofse (Deputy Director: Mental Health and Substance abuse, Health programmes), to develop, finalize and pilot the new training manual. The manual was presented to the Khayelitsha and Mitchell's Plain health sub-structures for input and feedback. Suggestions were incorporated and the updated training programme was initially piloted with the CHWs working for not-for profit organisations (NPOs) in Khayelitsha, Mitchells Plain and Strand.<sup>5</sup>

We conducted 3-hour training sessions at the employing NPOs. The programme discusses culture, and how cultural constructs overlap with and relate to mental disorders. Specific mental disorders are covered: depression, bipolar mood disorder, anxiety disorders, psychotic disorders, suicide, aggression, and finally mental disorders affecting the elderly. Issues affecting people with intellectual disability are briefly discussed. We then discuss the range of mental health care role players, focussing on the role of CHWs and processes involved in psychiatric assessment and admission.

The training programme was well received, with CHWs expressing gratitude for and excitement at encountering mental health training content for the first time. Their enthusiasm was matched by the outcomes. In the field, CHWs are not expected to make diagnostic decisions independently. However the trained cohort demonstrated a significant improvement in knowledge and skill, with 63% improving in their ability to correctly identify a diagnosis when presented with a case vignette. We used validated measures to further assess knowledge, as well as to assess change in confidence in their ability to deliver mental health support, and attitudes towards mental illness. There

was a significant improvement in all outcomes, with CHWs being more confident than at the start of training, and displaying an improvement in attitudes towards mental illness.

The structured training approach succeeded in improving the capability of these CHWs to provide support for mental health care users. Future work should focus on expanding the footprint of this training more widely amongst the CHW workforce. Indeed it would be of benefit for this training to be periodically repeated to maximize learning. It is crucial to incorporate plans to reliably evaluate and monitor the resulting impact on home-based mental health support, with a view to making the necessary modifications and policy adjustments to ensure that the value of these important cadres is fully realized. This evaluation plan must include an approach to measure the quality of mental health supervision received by CHWs, the service delivered, and the relationships with mental health service users receiving the support.

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# HIV prevalence and related factors in the Western Cape Province: profiling the epidemic

By **Mabaso M, Moyo S and Naidoo P**  
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## Background

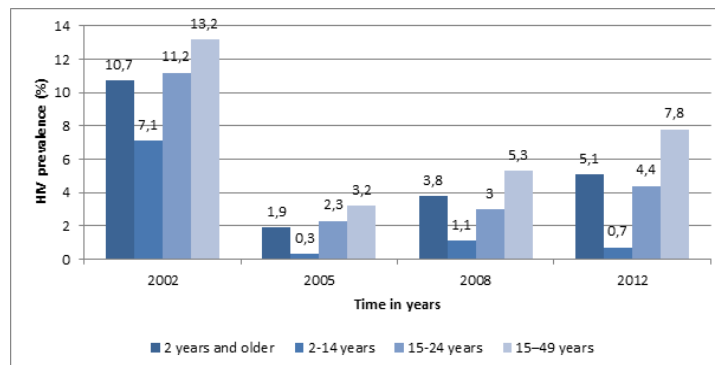
In South Africa, the Fourth Population-Based household survey conducted by the Human Sciences Research Council (HSRC) in 2012 to assess the HIV epidemic in South Africa confirmed that HIV prevalence remains high (12%) in the general population, and that it varies significantly between provinces.<sup>1</sup> Overall the Western Cape Province had the lowest HIV prevalence (5%).<sup>1</sup> Despite this low estimate, there are variations at district and sub-district level, and the prevalence is higher in the Metro.<sup>1,2</sup> Furthermore, according to the Western Cape 2015/2017 HIV and TB report, HIV still accounts for 8.7% of all deaths in the province and remains the single leading cause of premature deaths.<sup>3</sup>

The single biggest risk factor for HIV is concurrent TB infection together with poor levels of education and the socio-economic clustering of poverty, unemployment, overcrowding and migration. The risk of acquiring HIV also involves mainly the practice of unsafe sex, which is worsened by patterns of high partner turnover and partner concurrency.<sup>4</sup> This highlights that the Western Cape cannot be overlooked in projects that evaluate behaviour change designed to prevent HIV infection in the country.

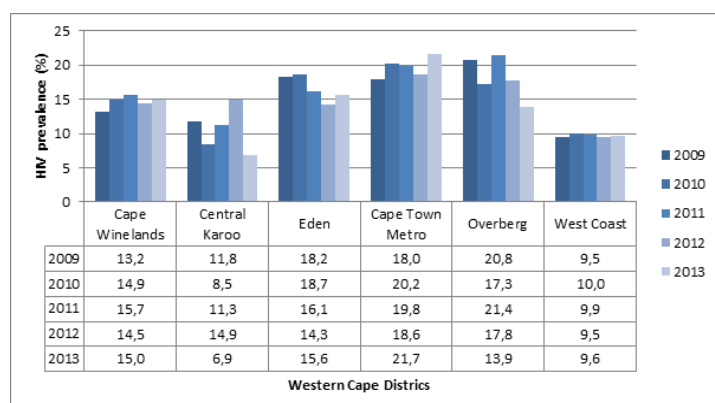
This article profiles the HIV epidemic in the province and factors that may have an impact on the transmission and prevention of HIV, using data from the 2012 national household based population HIV survey,<sup>1</sup> and the 2013 National Antenatal Sentinel HIV prevalence Survey.<sup>2</sup>

## Trend in HIV prevalence

The Western Cape has had the lowest HIV prevalence among the nine provinces since 2002 (Figure 1). While the prevalence remained low among children aged 2-14 years from 2005 to 2012, this increased in the general population during the same period. In fact, the Western Cape was the only province where HIV prevalence increased among young people (15-24 years) between 2005 and 2012. Nevertheless, the province had the lowest HIV prevalence nationwide among people of reproductive age 15-49 years.<sup>1</sup>



**Figure 1:** Western Cape HIV prevalence, from the 2002, 2005, 2008 and 2012 surveys<sup>1</sup>

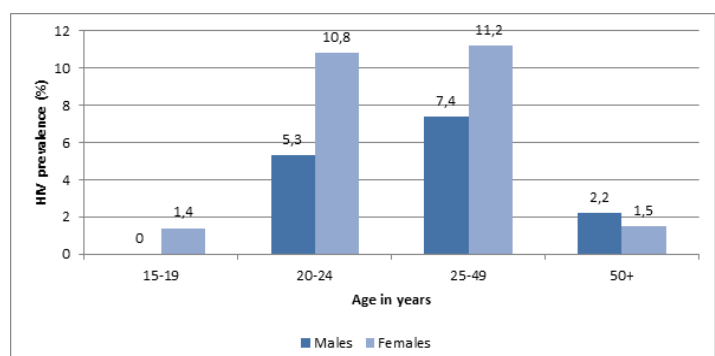


**Figure 2:** Western Cape Antenatal HIV Prevalence per district from 2009-2013<sup>2</sup>

Findings from the Antenatal Survey (Figure 2) indicate that there are major differences between districts in HIV prevalence.<sup>2</sup> The HIV prevalence also varied over time with some districts recording a major decrease while others recorded moderate increases between 2009 and 2013. The Cape Metro continued to carry the heaviest burden of HIV in the province. In the Metro, HIV prevalence increased from 18.0% in 2009 to 21.7% in 2013.

## HIV prevalence by socio-demographic profile

As was found nationally, young males in the Western Cape had a lower HIV prevalence than their female counterparts. Males, 50 years and older, had a higher HIV prevalence than their female counterparts. These differences are given in Figure 3 below.<sup>1</sup>



**Figure 3:** HIV prevalence by sex and age in the Western Cape, 2012 survey<sup>1</sup>

In addition, HIV prevalence was higher among 'black Africans', those with no education, the unemployed, those from poor or low socio-economic status (SES) households and those residing in urban informal areas (Table 1). These findings may be attributed to a range of historic, social, economic and political factors.

**Table 1:** HIV prevalence by socio-demographic profile in the Western Cape in 2012<sup>1</sup>

Factor	Total	HIV prevalence (%)
<b>Race</b>		
African	499	17.5
Other	2143	1.9
<b>Education level</b>		
No education/Primary	428	8.6
Secondary	1901	6.2
Tertiary	144	2.0
<b>Employment status</b>		
Unemployed	1182	7.8
Employed	1172	5.7
<b>Asset based socio-economic-status</b>		
Low	277	17.1
Middle	1023	9.4
High	1164	1.5
<b>Locality type</b>		
Urban formal	2070	4.4
Urban informal	227	29.7
Rural formal	353	5.1

### Other HIV related factors

In the 2012 survey, the Western Cape was one of three provinces with high levels of accurate knowledge of both HIV transmission and its prevention (29.5%). In line with the lowest levels of HIV prevalence, the province had the lowest number of orphans.<sup>1</sup> On the other hand, despite the relatively small HIV burden, the Western Cape has high rates of HIV counselling and testing (HCT). In addition, Western Cape ranked highest in proportion of people who believed that they would definitely not get infected with HIV (55.6%).<sup>1</sup>

Data on risk factors implicated in HIV transmission such as circumcision status, postponing sexual debut, condom use and alcohol use were illuminating. Demand for male circumcision among those aged 15 years and older not circumcised was lowest in the Western Cape (27%), highlighting the need for sustained campaigns to increase demand. Of concern, the province has the highest rates of early sexual debut among 15-24 years olds (14.2%). It also has the lowest rates of condom use at last sex (24.3%), and consistent condom use (every time) – 8.4% – among those 15 years and older. A high prevalence of negative attitudes towards people living with HIV (PLHIV) was found in the province.<sup>1</sup> Alcohol abuse has been shown

to increase HIV related risky sexual behaviour, including unprotected sex and sex with multiple partners.<sup>5</sup> In this context, it is alarming that the prevalence of lifetime alcohol use in the Western Cape ranges from 39% to 64%.<sup>6</sup> Other drivers of the HIV epidemic include, transactional sex, gender inequalities and the coercive nature of some sexual transactions.<sup>4</sup>

In conclusion, although the Western Cape has the lowest HIV prevalence nationwide, the province is characterised by great unevenness and heterogeneity in HIV prevalence at the district level.<sup>1,2</sup> In order to prevent further spread of HIV in the province, there is a need to map 'hot spots' for targeting the most vulnerable population groups such as women, poor households and urban informal settings. These areas are also characterized by risk behaviours such as early sexual debut, inconsistent condom use, alcohol abuse and poor attitudes towards PLHIV. This highlights the need for behavioural change interventions to prevent and reduce HIV transmission.

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# The harms and risks of alcohol in Khayelitsha

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**A**lcohol is a key risk factor for the Western Cape's exceptionally high levels of interpersonal violence. It is a key risk factor for interpersonal violence that is amenable to intervention in the short-term.<sup>1</sup> It is also an important risk factor for a range of other health outcomes, such as mental health disorders (including alcohol disorders and dependence) and road traffic injuries, which together accounted for more than 70% of the associated disease burden.<sup>2</sup> There is emerging evidence that alcohol contributes to infectious diseases, such as HIV and TB.<sup>3</sup> The link between alcohol and non-communicable diseases is well established.<sup>4</sup>

The University of Cape Town recently completed a mixed method study on the nature and extent of the alcohol trade in Khayelitsha in collaboration with University of the Witwatersrand, the Health Systems Trust, Violence Prevention through Urban Upgrading and Simon Fraser University (Canada). The study was funded by Department of Community Safety (Western Cape) on the recommendation of the Commission of Inquiry into policing in Khayelitsha and included the following components:

- a literature review on the alcohol trade, alcohol-related harms and community perceptions of alcohol;
- descriptive analyses from household surveys conducted from 2013 to 2015 of more than 3400 adult and 400 young adult respondents;
- mapping legal and illegal liquor outlets;
- a descriptive analysis of alcohol-related trauma cases presenting to health facilities serving Khayelitsha; and
- focus group discussions with a range of stakeholders including 'shebeeners', security agencies (including police and community safety groups), and drinkers.

This article reports on the various arms of this study. The literature on alcohol use in Khayelitsha focuses on its relationship with criminality, including interpersonal violence, health-related outcomes, economic factors, socio-spatial management, gender and youthfulness. There are clear differences in the policy recommendations of scholars who read alcohol-related risk through the contextual lens of poverty. This lens highlights the unique position of alcohol in township financing and even suggests the relaxation of law enforcement around illegal alcohol trade. By comparison, those that apply a public health lens adopt a more intervention-focused approach.

The 2013-15 household surveys demonstrate clear associations between alcohol use and violence (including rape, murder and assault with and without a weapon) and signs of depression. Respondents believed that violence could be attributed to the use of alcohol and drugs, and the easy availability of alcohol throughout the week enabled people in Khayelitsha to drink too much. There was support for a wide range of interventions to reduce alcohol consumption, restrict access and marketing of alcohol and to increase law enforcement.

Our survey of young adults found that 62% were drinkers and spent an average of R150 per drinking session. Of the drinkers almost half (42%) reported involvement with police within the last 6 months due to drinking. Site B had the highest proportion of respondents whose drinking was cause for concern - almost a third (31%). In Site B Sector 2, 45% of respondents had potentially problematic drinking patterns.

We located 1045 alcohol outlets in Khayelitsha, of which 460 were in the Site B policing precinct, 452 were in Harare and 133 in Lingeletu West. Site B Sector 2 had the highest outlet density of 1 outlet for every 206 people. In Harare sector 1, this was 1 for 295 people, and in Site B sector 5, this was 1 for 310. Patrons were mostly male aged 25-34 years and beer was the most common drink of choice. Unlicensed outlets had smaller capacities, but most had entertainment equipment and were open longer hours. Most outlet owners wanted to acquire formal liquor licenses.

Of the people presenting to health facilities for violence-related injuries, more than half were under the influence of alcohol. The highest percentage of alcohol-related cases (57%) were from Site B precinct.

Focus groups, which included 'shebeeners', tavern owners, security agencies (including Community Policing Forums and neighbourhood watch groups) churches and community safety groups (such as the South African National Civic Organisation), young male drinkers and female drinkers, as well as non-drinkers, acknowledged the potential harms of unregulated distribution and consumption of alcohol. Young mothers were considered as being particularly vulnerable due to their socio-economic circumstances and limited employment opportunities. However, they recognised that the alcohol trade was a key part of the Khayelitsha economy and that strategies to reduce harms should mitigate economic impacts.

The study confirmed the considerable harm that high levels of alcohol consumption, resulting from unhindered access, imposes on residents of Khayelitsha. Broad agreement with interventions to reduce harm should be harnessed to support the Alcohol Harm Reduction policy process being led by the Department of the Premier that follows an evidence-based and whole-of-society approach.

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## THE VALUES:



### **Innovation**

To be open to new ideas and develop creative solutions to challenges in a resourceful way



### **Caring**

To care for those we serve and work with.



### **Competence**

The ability and capacity to do the job we were employed to do.



### **Accountability**

We take responsibility.



### **Integrity**

To be honest and do the right thing.



### **Responsiveness**

To serve the needs of our citizens and employees.



### **Respect**

To be respectful to those we serve and work with.

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## THE VISION:



### **Internal Vision**

We are committed to the provision of "Access to Person-Centred Quality Care"



### **External Vision**

Open opportunity for all.



### **Better Together**

The Western Cape Government has a duty to provide opportunities. Citizens have the responsibility to make use of them.



Western Cape  
Government

Health

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