Community Systems Strengthening for Health

Programme funded by the EUROPEAN UNION

Baseline Assessment of Factors Affecting The Social Determinants of Health in Six Communities in the Western Cape

Baseline Survey Report
July to December 2017

We would like to acknowledge our CSS Project partners:

Women on Farms Project
Training for Transition
Belhar and Gugulethu Health Committees under the Cape Metro Health Forum
Health Monitors in Klapmuts

And Baseline project funders, the South African Medical Research Council.

Thanks to:
The Department of Social Development
The South African Police Service
City of Cape Town Health Department

Special thanks to all of our fieldworkers in Belhar, Bellville South, Lwandle, Gugulethu, Klapmuts, and Montana.

Prepared by:
Janet Austin, MPH, Baseline Project Research Coordinator

Executive Summary

The Community Systems Strengthening Project is a community level intervention aimed at building the capacity of community members to address the social determinants of health regarding child protection, violence reduction, food and nutrition, and chronic illnesses. This involves extensive training and leadership development through health committees in a collaboration between the University of Cape Town, Women on Farms Project, and Training for Transition. Interventions are planned for three, purposively selected residential areas in the Western Cape: Belhar, Gugulethu and Klapmuts, under the guidance of Belhar Health Committee and Gugulethu Health Committee under the Cape Metro Health Forum, and the Health monitors in Klapmuts. Three socioeconomically and culturally equivalent control areas were identified in Bellville South, Lwandle, and Montana (Wolseley). This report describes the baseline assessment of the core social determinants to be targeted for intervention by the CSS project. Findings from the Baseline project will inform CSS Project interventions and serve as the reference for the endline assessment in 2019.

The Baseline Assessment consisted of a household survey, key informant interviews and abstraction of surveillance data recorded by public service organisations. Six hundred households, randomly selected within each of the six clusters, were surveyed by trained local community fieldworkers during the last quarter of 2017. Key informant interviews and routine service data collection took place in this period, with the permission of the Western Cape Departments of Health, and Social Development.

The findings are characterised by high unemployment at all sites, with 69% of Households receiving at least one grant, significant cases of High Blood Pressure and Diabetes across sites, good child clinic attendance yet varying concerns of child neglect, low access to food parcels despite regular daily to monthly hunger, and perceptions of neighbourhoods as fairly unsafe. To embolden communities and respond to overburdened services, training of child protection, food and nutrition peace-building, and chronic illness management trainers can advance community participation in improving the social determinants of health.

Table of Contents

Introduction

The Community Systems Strengthening Project (CSSP) is an intervention designed to strengthen the ability of communities to address the social determinants of health that, if not fostered, give rise to negative outcomes associated with preventable and non-communicable diseases, child abuse, violence, and food insecurity. Through capacity building, training, leadership strengthening and work with local health committees, the project aims to embolden communities to assume ownership of initiatives to tackle food insecurity, violence and neglect, and to hold service-providers accountable for delivering the essential services to which community members are entitled.

The Baseline Assessment forms the foundational part of the information-gathering and monitoring processes through which the CSSP will be evaluated. In partnership with Women on Farms Project and Training for Transition, UCT aims to assess the status of social determinants identified by local health committees, community health workers and activists as target areas for the development, implementation, and strengthening of CSSP intervention work packages. In accordance with the principles of participatory action research, health committee-, health forum- and local community members were consulted at all phases of the process to guide the inception, delivery and assessment of the intervention research.

Methods

Study Design

A cross-sectional study was conducted between September and November 2017 to provide baseline data for the three control and three intervention sites participating in the CSS Project. In order to generate a current and informed overview of conditions in the various locations, a mixed methods approach was employed to generate complementary data from multiple disparate sources for triangulation. Quantitative household data were obtained using a project-specific demographic and health survey instrument, developed by the investigators. Qualitative data were gathered during key informant interviews with health and security officials. Routine monitoring data was sourced from service authorities including the City of Cape Town Health Department (COCT), the South African Police Service (SAPS), and the Department of Social Development (DSD).

Study Sample

Household Survey

Sites with poor health and socio-economic indicators were purposively selected for participation in the CSSP project. An effort was made to 'match' sites assigned to study groups with respect to socioeconomic and demographic indicators, given the relative cultural homogeneity within, and distinction between, residential areas that persists in the Western Cape Province. Ultimately, the suburbs of Belhar, Gugulethu and Klapmuts were selected to receive the Intervention, with Bellville South, Lwandle, and Montana (Wolseley) serving as Control sites (for the CSSP evaluation).

A total sample size of N=600 households was deemed statistically representative, as well as both feasible and affordable, given project resources. To achieve equal weighting between sites and study groups, a sub-sample of 100 Households was planned for each geographical area or *cluster*.

Random Household Selection

All erf (plot) numbers within the target locations constituted the sampling frame. A random number generator was used to produce numbers limited to a range around existing erf numbers within each geographical location (site). To increase the likelihood of meeting enrolment targets, and also to ensure that the probability of household selection within a site was maintained in the event of the chance selection of non-residential properties, vacant homes or plots and refusals, 105 numbers were randomly generated for each site. The precise location of plots represented by the random numbers, was determined with the use of aerial maps supplied by the City of Cape Town Municipality.

Key Informant Interviews

The proposed sample for informant interviews included one representative per topic, i.e., health, security, social development, and food and nutrition, from each site, if available. This would generate an expected 3 – 4 interviews per site for a total of 18 – 24 interviews overall. In some instances, interviews were contingent upon relevant departmental approval and the availability of personnel. Permission was sought from SAPS to interview Station Commanders at each site for information on crime and security, The Department of Social Development to interview social workers about local social development issues, and the City of Cape Town Department of Health in order to interview Clinic Facility Managers or Senior Nurses about disease prevalence and health service utilization. Permission was also sought from local NGOs, Home-Based Care organisations, Community-Based Organisations and Non-Profit Organisations to approach additional key informants in their employ.

Data Collection

CSSP partner organisations operating in the three designated Intervention sites (Belhar, Gugulethu and Klapmuts), and Health Committees or Community Development Organisations in the Control sites were engaged to introduce the baseline project to gatekeepers within their respective communities. These organizations were also invited to assist with the nomination of key informants and the identification of potential fieldworkers.

Household Survey

Participatory Action Research principles were used to identify, train and select local community Fieldworkers who could implement the survey at each of the study sites. Prospective fieldworkers were invited to attend one of two training sessions conducted at a location central to the three Control or three Intervention sites. During training workshops, the overarching goal of the research and specific objectives of the survey were explained, the questionnaire instrument was introduced and the significance of each item explained. Survey administration was practiced using role-play. Upon conclusion of the workshop, 10 fieldworkers were contracted to conduct the household interviews, together with one Supervisor, elected to manage the fieldwork operation on the ground and serve as the liaison with the investigators. While contracted to undertake 10 surveys each, for security reasons, fieldworkers were encouraged to work in pairs to complete 20 household surveys. A stipend was paid, based on the number of completed surveys returned.

The randomly selected households were identified for the fieldworkers on the aerial maps, from which local teams divided up the households at their convenience. Self-identified Heads of Household at the selected plots were informed of the purpose of the study and invited to participate. Sufficient information was supplied to enable willing participants to provide written informed consent. Where the Head of Household was not accessible, or could not be identified, e.g., among young adults sharing accommodation, the oldest available adult in the household was interviewed.

For data quality assurance purposes, 10% of households from each site were contacted by the study coordinators and surveyed a second time.

Key Informant Interviews

The City of Cape Town Health Department granted approval for interviews to take place at St Vincent's Clinic (Belhar), Kasselsvlei Clinic (Bellville South), Gugulethu Clinic (Gugulethu), and Ikwezi Clinic (Lwandle). St Vincent's Clinic, Klapmuts Clinic (Klapmuts) and Wolseley Clinic (Montana) could not be accessed due to staff shortages or unavailability. Home-based carers operating in Belhar, Klapmuts and Lwandle were consulted, as well a nurse in Montana. Twelve semi-structured interviews were conducted with key informants, among whom eight represented the health sector, three were from community development organizations, and one was a food and nutrition advisor.

Some key informants who were active in the local affairs and had assisted in obtaining buy-in from the community, were consented individually, immediately prior to their in-person interviews. Community Development workers were interviewed in Klapmuts, Lwandle and Montana, as well as a Health Promoter specialising in nutrition in Gugulethu.

The Department of Social Development (DSD) granted access to interview social workers operating in each of the sites, however interviews could not begin before January 2018. SAPS representatives were consulted for access to the Station Commanders at each site; this process had not been concluded at the time of writing. The outstanding interviews from DSD and SAPS will form part of a follow-up process in early 2018.

Routine Data

Where available, routine surveillance data on health, social development and security services were obtained from local government services. Monthly and annual crime statistics for the respective geographical areas were drawn from the South African Police Service website at: www.saps.gov.za. Health and Ideal Clinic Measures were derived from the National Department of Health and Early Child Development Centre information was abstracted from records maintained by the Western Cape Department of Health.

Ethical Approval

The study was approved by the Human Research Ethics Committee of the Faculty of Health Sciences at the University of Cape Town (HREC REF 524/2017). The Western Cape Department of Social Development granted written ethical approval for social workers operating in each of the sites to be contacted and recruited, to commence after publishing of this report. City of Cape Town Health approved a request for permission to interview Health Clinic Facility Managers in each of the sites. Permission from SAPS to interview Station Commanders at each of the sites is still pending. Permission to access Ideal Clinic Monitoring records was obtained from the National Department of Health.

Data Analysis

Quantitative household survey data, collected with pencil and paper interviews, were captured in MS Excel 2016 and exported to SPSS Version 24 for statistical analysis. Nominal (e.g. employment status; recent child health service utilisation; exposure to violence) and ordinal (e.g. perceived safety; frequency of violence; food insecurity) variables were tabulated and distributions compared by site, and study group, using Pearson's chi-squared test of homogeneity. Ratio data (e.g. number of crèches in the community; number of household grants received) were averaged and group

means compared using Student's t-tests for Study Groups and ANOVA for Sites. Qualitative data from key informant interviews and open-ended survey questions were manually coded, collated and analysed using acute thematic analysis.

Results

1. Demographics

A final sample of 594 households was surveyed; 95 from Montana, 99 from Lwandle and 100 from each of the other four sites. A total of 2674 household members were captured within the sample. Mean household size ranged from <4 (Klapmuts= 3.93) to >5 (Gugulethu= 5.07) giving an overall mean of 4.5 inhabitants per household.

1.1 Gender

With 53.4% of the total, female household members outnumbered males at all sites other than Belhar. The greatest disparity was evident in the Control group where a Female-to-Male ratio of 1:3 was observed at both Lwandle and Montana. Chi-squared testing confirmed that gender distribution of the full sample differed significantly by site (χ^2 =28.491, p=.002) and between study groups (χ^2 =11.323, p=.003).

Table 1.1 Gender Distribution by Study Site: N=2674 Household Members

	Bellville South N (%)	Lwandle N (%)	Montana N (%)	Belhar N (%)	Gugulethu N (%)	Klapmuts N (%)	Total N (%)
Males	188 (44.9)	182 (43.0)	207 (43.6)	232 (50.8)	239 (47.1)	195 (49.6)	1243 (46.5)
Females	231 (55.1)	241 (57.0)	268 (56.4)	225 (49.2)	268 (52.9)	198 (50.4)	1431 (53.5)
Total	419 (100)	423 (100)	475 (100)	457 (100)	507 (100)	393 (100)	2674 (100)

Overall, more households were headed by females (54%), notably in Gugulethu (74%) and Bellville South (62%). Self-identification as Head of Household may have been influenced by the employment status of family members, and the time of day during which the survey was administered. Some respondents interpreted “Head of Household” to be the home owner, whereas others nominated the oldest household member or the chief breadwinner. Single-parent households were commonly headed by a mother.

Table 1.2 Gender Distribution by Study Site: N=594 Heads of Household

		Bellville South	Lwandle	Montana	Belhar	Gugulethu	Klapmuts	Total
Males	N	38	57	43	53	26	54	271 (46%)
Females	N	62	42	52	47	74	46	323 (54%)
Total	N	100	99	95	100	100	100	594 (100%)

N= Number of Households

Despite the unequal distribution across sites (χ^2 =28.592, p<.001), when collapsed into groups, Head of Household gender distribution did not differ significantly (χ^2 =0.406, p=.524).

1.2 Age

Household Members ranged in age from 2 days to 95 years. Student's *t*-tests confirmed that mean age was lower among males (M=29.0 yrs; F= 32.2 yrs; t = -3.279, p=.001) and in the Control group (Control=29.2 yrs; Intervention=32.3 yrs; t = -3.769, p<.001). Significant age differences were evident in joint comparisons by gender and site (ANOVA: F= 9.189, p< .0001). Mean age ranged from just 23.7 years (Lwandle females) to 36.9 years (Bellville South females)

Table 1.3 Mean Age by Study Site and Gender: N=2595* Household Members

Site	Bellville South		Lwandle		Montana		Belhar		Gugulethu		Klapmuts	
Sex	M	F	M	F	M	F	M	F	M	F	M	F
Age	32.3	36.9	25.4	23.9	25.7	30.3	31.6	34.1	28.1	36.0	32.7	31.0
N	185	228	182	241	193	254	214	213	230	264	194	197
SD	21.2	21.8	18.2	16.2	19.4	21.5	21.2	21.3	20.2	22.3	20.6	20.7

*N=79 missing; M= Male; F= Female; Age= Years; N= Number of HH Members; SD= Standard Deviation

About 10% of the sample were of pre-school age, 7% had reached retirement age, and for 3%, age was not reported. Age category distribution differed between study groups (χ^2 =22.370, p=.001). There were more primary school aged children and teenagers in the Control Group versus more adults of employment age in the Intervention Group.

Table 1.4 Age Category by Study Group: N=2674 Household Members

	Control		Intervention		Total	
	N	(%)	N	(%)	N	(%)
0 - 5 years	138	(10.5)	137	(10.1)	275	(10.3)
6-12 years	192	(14.6)	163	(12.0)	355	(13.3)
13-19 years	191	(14.5)	135	(9.9)	326	(12.2)
20-39 years	361	(27.4)	393	(29.0)	754	(28.2)
40-64 years	314	(23.8)	391	(28.8)	705	(26.4)
65+ years	83	(6.3)	97	(7.1)	180	(6.7)
Unknown	38	(2.9)	41	(3.0)	79	(3.0)
Total	1317	(100)	1357	(100)	2674	(100)

N= Number of Household Members; %= within Study Group (column)

Among Heads of Household, mean age was 54.2 years in the Intervention group and 52.0 years in the Control Group. As might be expected, the overwhelming majority of Heads of Household were adults of work-eligible age (65 years or less). Age category distribution was similarly represented in both the Control and Intervention groups (χ^2 =3.569, p=.468).

2. Income

2.1 Employment

A total of N=644 people (Males=323; Females= 321) were reportedly employed, representing 38.2% of the 1685 household members known to be between 16-65 years of age. Gender was equally represented among the employed (+/- 50%), but with more employment-eligible females than males in the sample, the proportion with employment was significantly higher among males (42.3%) than among females (34.9%) (χ^2 =9.48, p=.005).

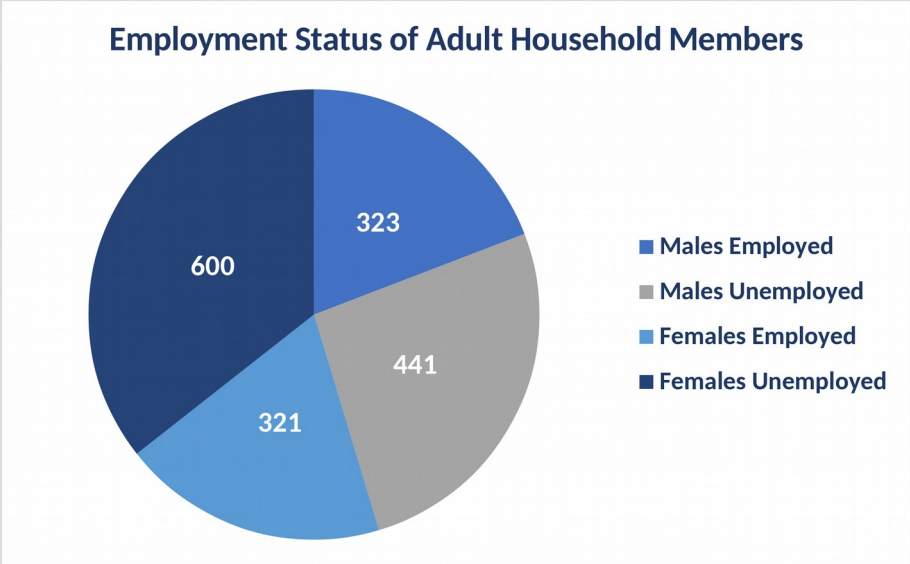

Figure 2.1 Employment by Gender: N=1685 Adult Household Members

Employment status differed significantly by Site (χ^2= 15.496 p=.008). Belhar (44%) and Bellville South (43.9%) had the highest proportion of employed persons among eligible household members. At 68.5%, unemployment was greatest in Gugulethu. When aggregated by Group, no differences in employment status were evident (χ^2= .894 p=.344).

Table 2.1 Employment Status by Study Site: N=1685 Adults

		Bellville South	Lwandle	Montana	Belhar	Gugulethu	Klapmuts	Total
Employed	N	122	100	97	129	102	94	644
	%	43.9	38.8	35.4	44.0	31.5	36.4	38.2
Not Employed	N	156	158	177	164	222	164	1041
	%	56.1	61.2	64.6	56.0	68.5	63.6	61.8
Total	N	278	258	274	293	324	258	1685
	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0

N= Number of Adults; % = within Site (column)

Among all the employed, 90.7% were paid, and only 6.1% were self-employed (3.2% unknown). No group differences were evident among those reporting type of work type.

At least one person was employed in 413 (69.5%) Households, among which 173 had two or more employed adults. Ninety-five percent (567/594) of Heads of Household were within employment age of whom 41.6% (N=236) were employed. There was no association between the gender of the Head of Household and the presence of at least one employed person (not necessarily the Head him/herself) (Male HH = 70.7%; Female HH 68.4%).

2.2 Grants

Two thirds (67.9%) of Households received at least one government grant. Among all Households, 32.2% received a single grant, 17.7% received two grants, 9.8% received three grants, while the remaining 8.2% of all Households received four or more grants. Household grant support (any vs. none) was not equally prevalent across sites, ranging from 87.4% in Montana to 53% in Belhar (χ^2= 29.918 p<.001). Grant support was more likely to be reported by female-headed households (76.3%) than male-headed households (57.6%).

The proportion of Households receiving one or more grant differed by site and grant type. The table below shows the number of Households at each site receiving at least one grant of the specified type[1].

Table 2.2 Household Grant Support by Type and Study Site: N varies by Grant Type

		Control Group			Intervention Group			Total
HH Income via:		Bellville South	Lwandle	Montana	Belhar	Gugulethu	Klapmuts	Households
Child Support	N	24	58	56	21	43	42	244
	% within Type	9.84	23.77	22.95	8.61	17.62	17.21	100.00
Old Age Pension	N	42	11	31	39	41	27	191
	% within Type	21.99	5.76	16.23	20.42	21.47	14.14	100.00
Disability	N	10	5	13	5	11	10	54
	% within Type	18.52	9.26	24.07	9.26	20.37	18.52	100.00
Maintenance	N	0	1	2	0	2	1	6
	% within Type	0.00	16.67	33.33	0.00	33.33	16.67	100.00
Other Grants	N	1	0	2	1	3	3	10
	% within Type	10.00	0.00	20.00	10.00	30.00	30.00	100.00
No Grants	N	39	34	12	47	31	28	191
	% within Type	20.42	17.80	6.28	24.61	16.23	14.66	100.00

N= Number of Households/% within Site; % within Type= % of the awarded Grants of this Type (row);
Note: a) Some Households received >1 Grant Type; b) Some HH received >1 awards of the same Grant Type

[1] Households receiving multiple grants of the same type are reported in Appendix A, Tables A2.3 – A2.7.

Child Support Grants were the most commonly reported (41.1% of all Households), with 24% of all Households (58% of child grant recipients) receiving multiple grants for infants and young children. While Control Group Households were more likely to receive child support grants overall (χ^2= 8.263, p=.004), this study group difference was exacerbated in male-headed Households (χ^2= 10.24 p=.001). Old Age Pensions were reportedly received in almost one third of Households (32.2%), 23% of which received more than one such grant. Disability grants were rare; less than 10% (N=54) of Households reported receiving these grants, of which only two received more than one. (See Tables 2.3– 2.7 in Appendix A)

Almost all (92.8%) Households declared a formal income source, where at least one member was employed, or, at least one grant received. Some 44.3% of Households derived income from both employment and grants. The proportion of Households without any declared income source was significantly greater in the Intervention group than in the Control group, and also among Male-headed Households. Female-headed Households were significantly more likely to derive income from grants alone, or both grants and employment, whereas male-headed Households were more likely to rely on employment alone, or to have no income source (χ^2= 24.477, p<.0001).

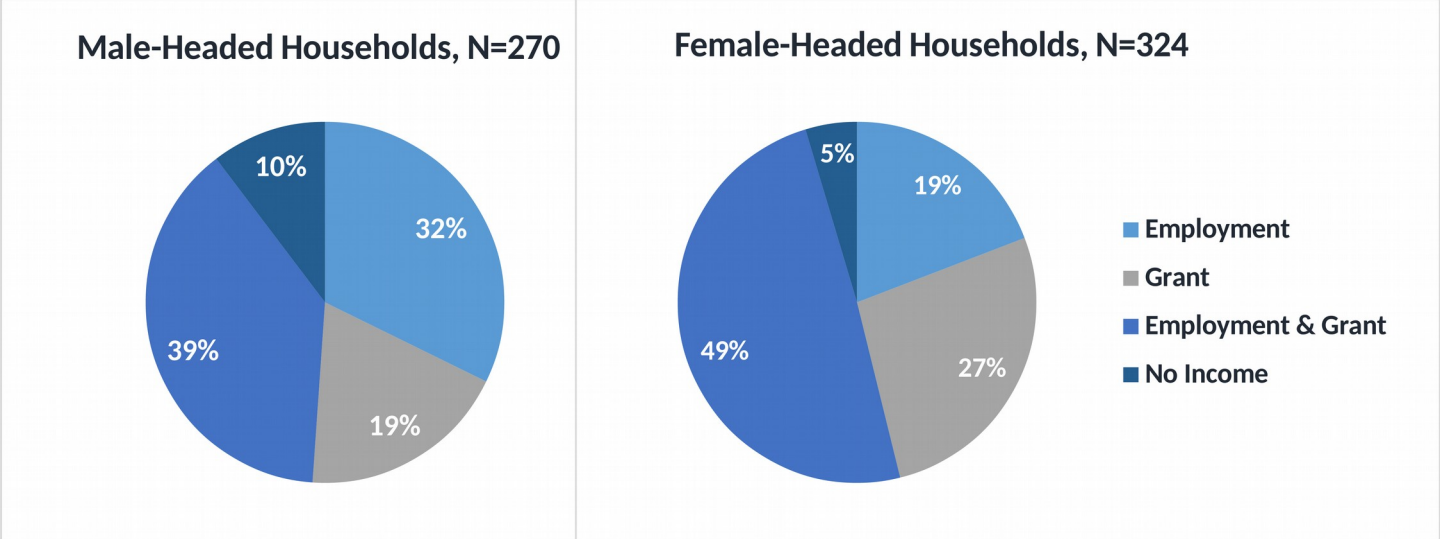

Figure 2.2 Sources of Household Income, by Head-of-Household Gender: N=594 Households

3. Child Protection

3.1 Crèche Attendance and Availability

Crèche attendance among the N=275 Children aged 5 years or younger varied little between groups (Control= 32.6%, Intervention=35.0%, *p*=.868) however there was a considerable difference between study sites with almost 60% attendance in Lwandle and Gugulethu, versus just 14% in Montana and Belhar (*p*<.0001).

Table 3.1 Crèche Attendance by Study Site: N=275 Children Aged <6 years

		Bellville South	Lwandle	Montana	Belhar	Gugulethu	Klapmuts	Total
Yes	N	6	32	7	7	29	12	93
	%	18.2	59.3	13.7	14.0	59.2	31.6	33.8
No	N	21	12	11	19	5	16	84
	%	63.6	22.2	21.6	38.0	10.2	42.1	30.5
Unknown	N	6	10	33	24	15	10	98
	%	18.2	18.5	64.7	48.0	30.6	26.3	35.6
Total	N	33	54	51	50	49	38	275
	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0

N= Number of Children; % = within Site (column)

When asked about the availability of neighbourhood day-care facilities for preschool children, 86% of household heads (N=513) were able to provide an estimate of the number of crèches in their communities. Mean estimates were highly consistent for the two study groups (Control=2.96, Intervention = 3.03), but site-specific differences were apparent. Belhar (mean= 2.14) and Gugulethu (mean=2.22) offered the lowest estimates of available neighbourhood crèches, while Klapmuts (mean = 4.14) reported the most.

The box and whisker plot in Figure 3.1a (below) reveals Klapmuts to be an outlier. Compared with the other sites, Klapmuts and Montana, which had the second highest estimates of crèches in the community, had the lowest mean age for the full sample, suggesting the presence of a greater proportion of young children in these communities. This may have translated into a greater awareness of relevant facilities – rather than, necessarily, an actual difference in available facilities.

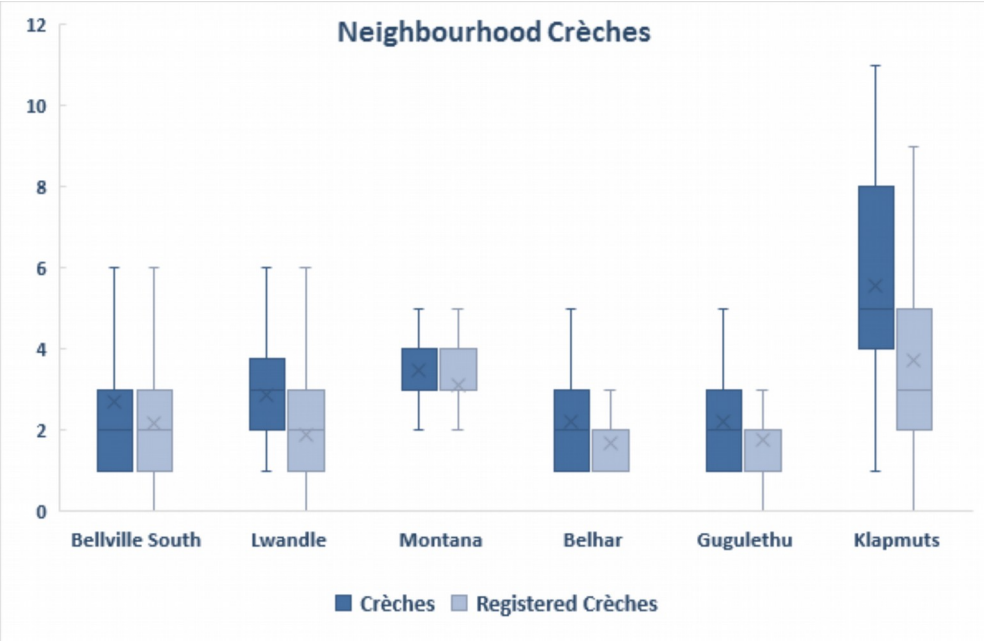

Figure 3.1a Estimated Number of Total vs. Registered Crèches, by Site

Not all of the neighbourhood crèches were believed to be formally registered with the Department of Social Development. Relative estimates were proportional to those for total known crèches, but reduced by a factor of about 20%. According to the Western Cape Government[2] the number of registered (Early Child Development (ECD) centres in each site is as follows:

- Bellville South: 2 (+5)
- Lwandle: 15
- Montana: 4
- Belhar: 9
- Gugulethu: 22
- Klapmuts: 4

The disparity between available (known) and registered crèches, as seen in Klapmuts, for example, reflects the proportion of unregistered and hence *unregulated* crèches.

[2] Available at: www.westerncape.gov.za

The mean number of registered crèches was very similar in the intervention and control groups (Control=2.40; Intervention=2.33; *t*=.497, *p*=.619). However, a histogram of estimates by group revealed somewhat skew distributions with mode= 3 in the Control Group vs. mode=1 in the Intervention Group.

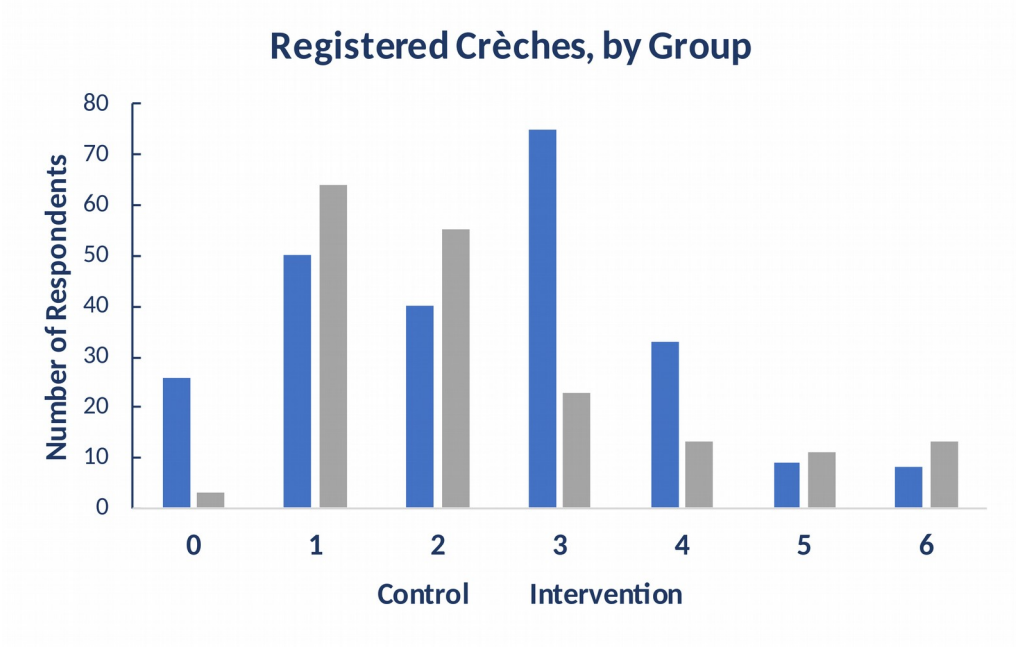

Figure 3.1b Estimate of Registered Crèches, by Group

3.2. Child Health-Care Utilisation

For the N=914 children, aged between 2 days and 18 years in the sample, clinic attendance within or beyond the past 4 weeks was assessed, together with precipitating indications and outcomes. A little over one quarter (N=248; 27%) of the children had visited a clinic/health facility within the 4 weeks prior to the survey, N=149 (60%) of whom were 5 years of age or younger. Among those with a recent clinic/provider visit, 28% (N=69) had returned for a follow-up visit, the majority of whom (N=53; 77%) were infants or pre-schoolers.

For N=190 (76.6%) of these cases, Heads of Households indicated that a satisfactory outcome had been achieved. In just N=7 (2.8%) cases, the treatment provided by the clinic was not considered successful, and in less than 1% (N=2 cases), additional care was sought from a different facility.

At all sites, recent health facility attendance was highest among children in the birth to 5-year age category. A high proportion of these visits were routine baby clinic visits for immunization, growth monitoring and general early infant care services. Aside from these, across all three age categories, the most common reasons for clinic attendance in descending order were diarrhoea; colds, flu, fever, coughing or bronchitis; asthma; and skin rashes or eczema.

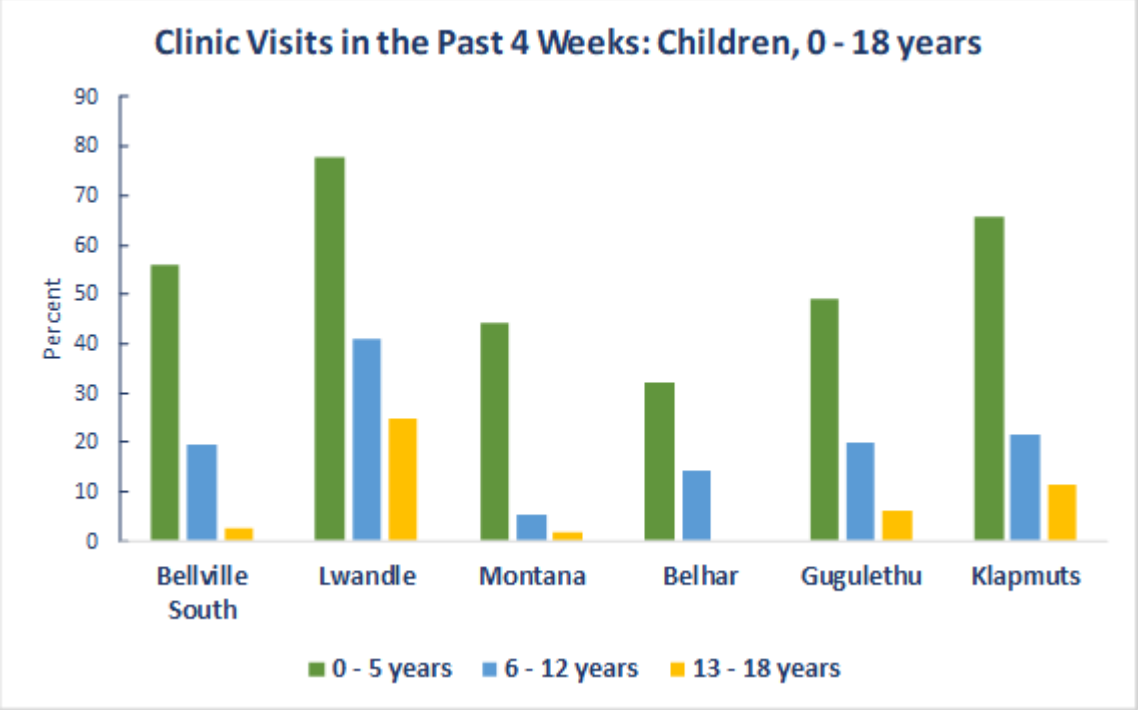

Figure 3.2 Percentage of Children with a recent Clinic Visit, by Site and Age Category

For the N=666 (73%) children in the sample who had *not* visited a health facility or provider within the prior 4 weeks, an estimate of the time since their last visit was obtained. For N=68 children (7.4% of total) a visit within the preceding year (>1 to ≤ 12 months prior) was reported. The most common reasons for seeking care were infant immunization and check-ups, fever and respiratory conditions, and skin irritations. Six cases of measles were reported in Klapmuts. A further N=43 (4.7% of total) had last been seen by a health practitioner more than a year prior to the survey. Heads of Household did not recall formal healthcare visits for the remaining N=555 (61%) children, suggesting that, for 65% of children aged 18 years or younger, more than a year had passed since their last contact with a health provider.

3.3 Neighbourhood Safety for Children

The majority (N=348; 58.6%) of Heads of Household viewed their residential neighbourhood as unsafe or very unsafe for children. Almost 75% reported that assaults and violence were a problem, particularly among adolescents. While many (N=290; 49%) were aware of services in the community to combat violence, few knew of school programs for this purpose (N=124 21%). Perceived neighbourhood safety differed significantly by site (χ^2= 59.823, p<.0001).

Table 3.3 Child and Adolescent Neighbourhood Safety

	Bellville South N	Lwandle N	Montana N	Belhar N	Gugulethu N	Klapmuts N	Total N (%)
Safety for Children							
Very Safe	5	10	2	7	12	2	38 (6.4)
Safe	41	46	23	41	32	25	208 (35.0)
Unsafe	31	38	52	27	28	50	226 (38.1)
Very Unsafe	23	5	18	25	28	23	122 (20.5)
Total	100	99	95	100	100	100	594 (100)
Assaults/Violence							
Not a problem	8	18	1	15	25	11	78 (13.1)
A small problem	10	12	11	18	21	7	79 (13.3)
A problem	35	23	19	16	8	15	116 (19.5)
A big problem	22	26	26	22	8	32	136 (22.9)
A very big problem	25	20	38	29	38	35	185 (31.2)
Total	100	99	95	100	100	100	594 (100)
Adolescents Fighting Violently							
Not a problem	21	24	1	30	33	14	123 (20.7)
A small problem	14	12	9	12	6	6	59 (9.9)
A problem	23	19	19	9	6	13	89 (15.0)
A big problem	18	19	26	15	10	36	124 (20.9)
A very big problem	24	25	40	34	45	31	199 (33.5)
Total	100	99	95	100	100	100	594 (100)
Services to Address Violence							
Yes	62	67	40	25	64	32	290 (48.8)
No	38	32	55	75	36	68	304 (51.2)
Total	100	99	95	100	100	100	594 (100)
School Programmes to Address Violence							
Yes	20	10	32	14	24	24	124 (20.9)
No	78	84	62	81	74	72	451 (75.9)
Unsure	2	5	1	5	2	4	19 (3.2)
Total	100	99	95	100	100	100	594 (100)

3.4 Measures to Improve Neighbourhood Safety for Children

Increased police visibility and patrols such as a Neighbourhood Watch were the most frequent suggestions for improving neighbourhood safety offered by survey respondents, supported by health and social development interviewees. The only site at which a Neighbourhood Watch was currently active was Bellville South; activity in other sites was either too small, infrequent, or had been abandoned.

Development of parks, and youth centres with recreational programmes was the chief suggestion from health and social development respondents to alleviate issues of child neglect. A need for enrichment activities for children whose parents were working and possibly leaving children unsupervised was identified. Children seeking engagement and recreation on public streets were seen as susceptible to gang involvement, with health and social development informants in Klapmuts, Montana, and Belhar stating that gangs provide social capital and material rewards even as little as R50 ($4). Afterschool sports clubs and other occasional community activities had been well received in Montana and Klapmuts, but all sites reported a shortage of stable alternative recreation facilities for children.

In addition to motivating for youth centres, the poor condition of roads was cited with respect to Gugulethu, Lwandle and Klapmuts, while speeding drivers were identified as a problem in all areas. Respondents from all sites indicated that speedbumps, fencing and other safety infrastructure were needed in public spaces and roads.

4 Violence Reduction

4.1 Personal Experience of Crime/ Safety

Heads of Household were asked about their own exposure to and direct experience as victims of crime and violence over the prior 12 months. Specifically, they were asked to indicate whether they had a) been mugged or had property taken from them with actual or threatened violence in their home or on the street (violent robbery), b) had their homes broken into but not come into contact with the perpetrator (home burglary), c) lost someone close to them as a result of murder (murder of friend/ relative), d) been purposefully injured with a weapon such as a gun or knife (injury with weapon), e) experienced any form of violence in their home (domestic violence), and f) been the victim of violence on the basis of their gender, sexual orientation, race or nationality (bigotry).

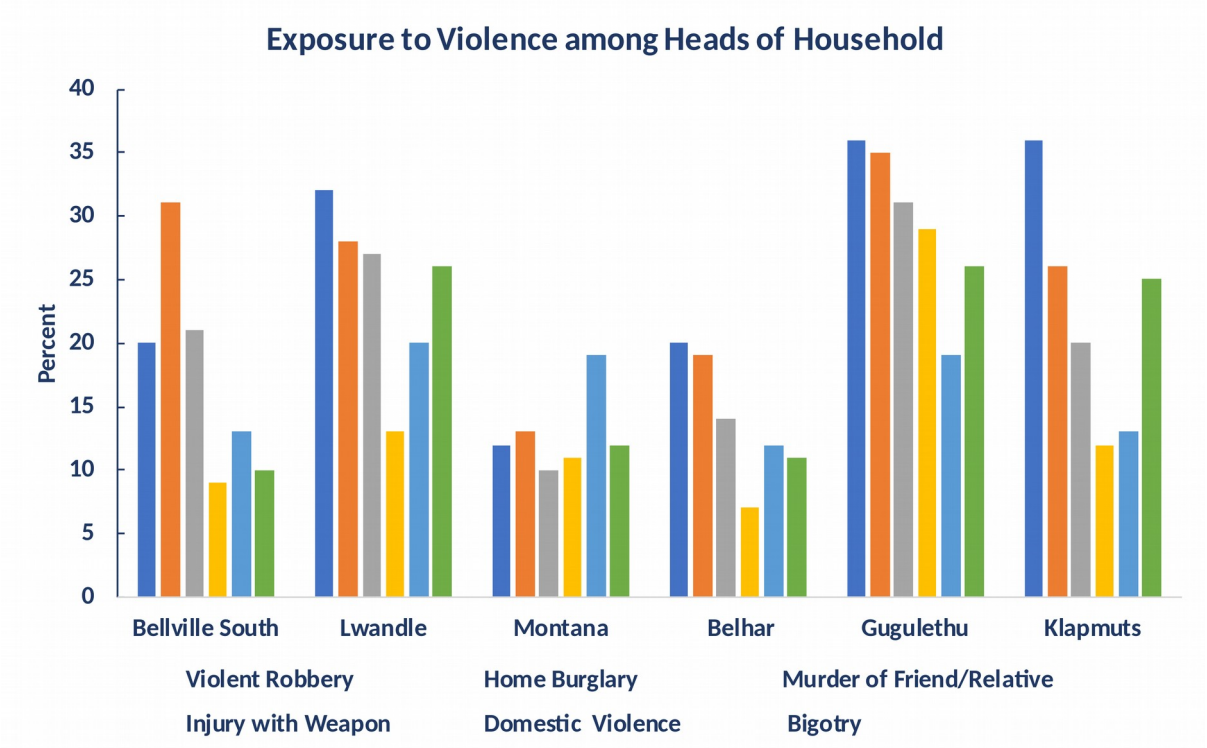

Figure 4.1 Percent of Heads of Household with Exposure to Violence, by Site and Category

While there was an alarmingly high prevalence of violence of all types, the distribution varied by site. With the exception of home burglary (Bellville South, 31%), Heads of Household in Gugulethu, Lwandle and Klapmuts consistently reported more violence than the other three sites. These differences were significant with respect to violent robbery (χ^2= 28.34 p=.002), murder of a relative or close friend (χ^2= 19.05 p=.04), injury with a weapon (χ^2= 33.31 p<.0001), and bigotry (χ^2= 28.92 p=.001).

4.2 Neighbourhood Crime

Frequent violent crime and abuse was reported for all sites. More than 40% of respondents in Montana and 35% in Klapmuts reported child-abuse on a daily basis. Weekly occurrences of gang violence were reported from more than one third of Households. Thirteen percent of Heads of Household in Gugulethu believed rape to be a daily occurrence.

Table 4.2 Neighbourhood Crime and Violence: N=594 Heads of Household

	Bellville S.	Lwandle	Montana	Belhar	Gugulethu	Klapmuts	Total
	N	N	N	N	N	N	N
Violence Between Family/Friends							
Every Day	5	2	21	5	9	12	54
Every Week	4	6	15	6	10	20	61
Every Month	14	5	17	7	14	15	72
Once or Twice a Year	17	15	24	19	15	14	104
Never	59	70	16	61	50	39	295
No Response	1	1	2	2	2	0	8
Total	100	99	95	100	100	100	594
Gang Violence							
Every Day	6	22	23	14	20	21	106
Every Week	9	26	10	15	12	24	96
Every Month	16	16	16	9	23	19	99
Once or Twice a Year	19	17	39	11	12	9	107
Never	49	15	5	50	31	27	177
No Response	1	3	2	1	2	0	9
Total	100	99	95	100	100	100	594
Child Abuse/Neglect							
Every Day	15	15	42	14	18	35	139
Every Week	6	15	13	2	11	8	55
Every Month	2	17	19	4	10	9	61
Once or Twice a Year	5	16	10	5	10	8	54
Never	71	36	9	74	49	40	279
No Response	1	0	2	1	2	0	6
Total	100	99	95	100	100	100	594
Rape/Sexual Assault							
Every Day	2	4	6	2	13	11	38
Every Week	1	11	8	0	8	8	36
Every Month	4	24	27	1	7	10	73
Once or Twice a Year	8	11	33	6	10	18	86
Never	84	49	19	88	60	53	353
No Response	1	0	2	3	2	0	8
Total	100	99	95	100	100	100	594

SAPS crime statistics for April 2016 to March 2017 showed a drop in overall contact crimes (assault, murder, sexual offences, robbery with aggravating circumstances) compared with the preceding year in all sites except Lwandle, varying between 12.1% (Belhar) and 9.6% (Bellville South). However large increases in sexual offences specifically as high as 57% in Lwandle, 47.8% in Montana, and 28.6% in Belhar were also reported, at odds with the 59% of Heads of Household who perceived a total absence of these crimes. Key informants seldom if ever reported cases of violent child abuse; malnutrition, accidents due to poor supervision or other instances of neglect were more commonly cited. Survey respondents and key informants emphasised an awareness of robbery and burglary, which have seen increases in Belhar, Lwandle, and Montana.

4.3 Awareness of Violence Reduction Services

The most frequently cited violence reduction service was SAPS, routinely accompanied with the comment that they were often unresponsive. Neighbourhood Watches and street committees were commonly cited next, especially in Bellville South and Gugulethu respectively. A Taxi Association was the most frequently reported organisation in Lwandle, above SAPS. A fair number of respondents (51.2%) in all areas reported knowing of no services to address violence.

4.4 Measures to Reduce Crime

Substance abuse due to poverty and unemployment was the most cited reason for high incidence of violence in communities by both survey and interview respondents. Drugs and alcohol are widely available and inexpensive, and their addictive properties cause the procurement of substances to be prioritised over food. Respondents communicated a need for employment opportunities, education for parents, and emphasised a need for activities to protect and occupy the youth in order to prevent future substance abuse.

Increased visibility and responsiveness of the police was the most common measure reported to address crime. Tougher sentencing for criminal activity was reported as a necessary deterrent. Klapmuts respondents reported success with community engagements and eagerness for similar activities in future to provide children with potential upward mobility and alternatives to criminal activity.

5. Food and Nutrition

Thirty percent of Households reported that members had insufficient food at some time during every month. Eight percent of Households reported a food shortage every day. As with crime, hunger was most prevalent in Gugulethu, where 14% of Households reported experiencing hunger on a daily basis.

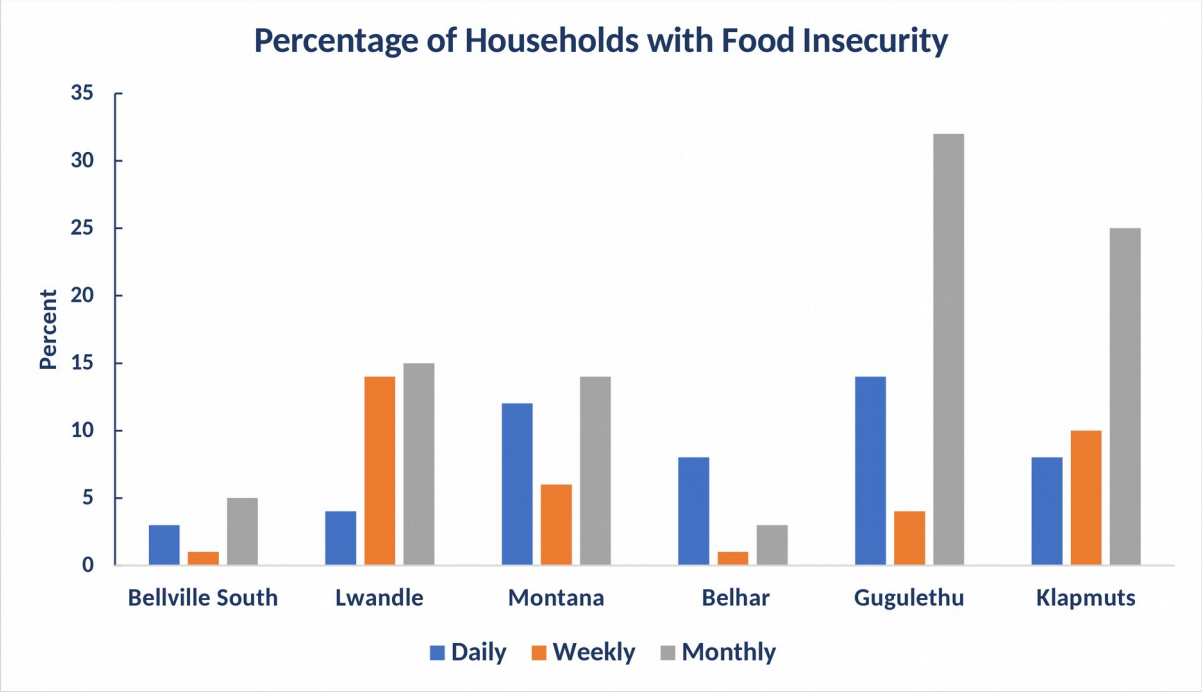

Figure 5.1 Percent of Households with Food Shortages, by Site and Rate of Occurrence

Just 5% of Households had a member who was a food parcel recipient. Parcels were provided on an irregular basis, typically by churches or other private organizations, i.e., not social welfare services. Even among the few who did receive food parcels, Heads of Household did not know how to access these services.

Table 5.1 Household Food Sources, by Site and Type

	Bellville S.	Lwandle	Montana	Belhar	Gugulethu	Klapmuts	Total
	N	N	N	N	N	N	N (%)
Any Food Parcels							
Yes	8	0	4	8	2	9	31 (5.2)
No	87	95	86	86	97	91	542 (91.3)
Unsure	5	4	5	6	1	0	21 (3.5)
Total	100	99	95	100	100	100	594 (100)
Food Parcel Recipient							
Father	0	0	0	2	1	0	3 (9.7)
Mother	2	0	1	0	0	1	4 (12.9)
Son	1	0	0	0	0	0	1 (3.2)
Other	5	0	3	6	1	8	23 (74.2)
Total	8	0	4	8	2	9	31 (100)
Food Parcel Frequency							
Every Day	0	0	0	0	0	2	2 (6.4)
Every Week	2	0	0	3	1	1	7 (22.6)
Every Month	1	0	1	1	0	1	4 (12.9)
Unknown	5	0	3	4	1	5	18 (58.1)
Total	8	0	4	8	2	9	31 (100)
Current Food Garden Participation							
Yes	10	4	10	11	14	18	67 (11.3)
No	90	95	85	89	86	82	517(88.7)
Total	100	99	95	100	100	100	594 (100)
Future Food Garden Participation							
Definitely	38	38	59	34	35	53	257 (43.3)
Perhaps	29	21	23	29	14	24	140 (23.5)
Unlikely	6	9	4	10	21	4	54 (9.1)
Not at all likely	27	31	9	27	30	19	143 (24.1)
Total	100	99	95	100	100	100	594 (100)

As with food parcels, knowledge of food gardens was low across survey respondents and key informants. Previous efforts to cultivate food gardens were reported to have been short-lived or vulnerable to ownership issues and nepotism with respect to potential beneficiaries. Many informants believed that untapped resources existed within the community – in the form of agricultural know-how acquired while growing up in a rural area – that could be transferable to such initiatives.

6. Chronic Illness and Adult Health Service Utilisation

6.1 Prevalence of Chronic Illnesses

The study focused on High Blood Pressure, Diabetes, Epilepsy, Heart Failure plus 'other' chronic illnesses. More than half (56%) of all Households reported at least one member living with a chronic condition. Prevalence in Lwandle was significantly lower than elsewhere, a finding consistent with the younger mean age of the Household members at that site.

Table 6.1 Any Chronic Disease: N= 594 Households

	Control Sites			Intervention Sites			
	Bellville S.	Lwandle	Montana	Belhar	Gugulethu	Klapmuts	Total
Yes	67	24	59	65	55	61	331
No	33	75	36	35	45	39	263
Total	100	99	95	100	100	100	594

High Blood Pressure was the most prevalent chronic disease across all sites at 264 cases (some Households had more than one case), followed by diabetes with 89 cases overall. This was always ascribed to poor diet and lifestyle factors. Some respondents reported challenges to treatment adherence such as an inability to travel to clinics, schedule clashes with work obligations, or simply insufficient food to accompany medication.

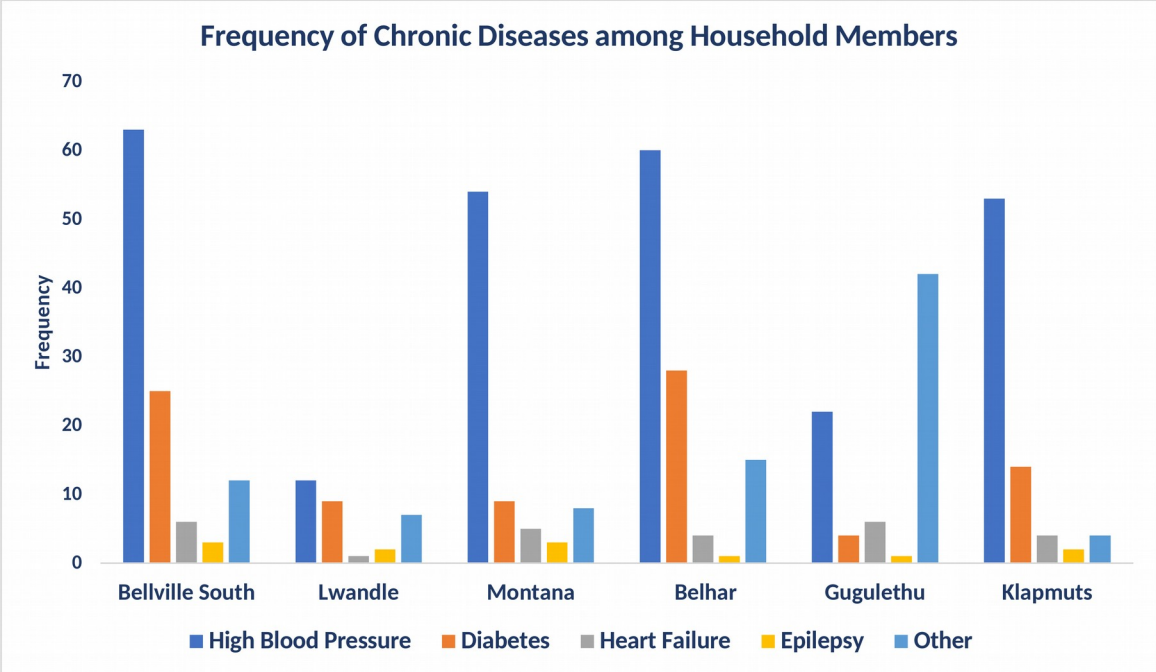

Figure 6.1 Number of Household Members with Chronic Disease, by Site and Type

The ‘other’ category consisted predominantly of cases of HIV/AIDs, tuberculosis (TB), and mental illness, when these conditions were disclosed. Although not the focus of this assessment, health care informants reported seeing significantly more cases of HIV/AIDs and TB than any other chronic illness.

	Control Group			Intervention Group			
	Bellville S.	Lwandle	Montana	Belhar	Gugulethu	Klapmuts	Total
High BP: Total Patients	63	12	54	60	22	53	264
Currently in care	49	12	50	40	22	47	220
Attendance in past	49	12	47	40	22	49	219
Care club member	4	7	2	3	19	5	40
HBC Visit in past 4 weeks	15	1	1	9	1	4	31
Diabetes: Total Patients	25	9	9	28	4	14	89
Currently in care	20	7	9	20	4	14	74
Attendance in past	18	8	9	14	4	14	67
Care club member	3	2	0	2	3	1	11
CCW Visit in past 4 weeks	9	1	0	2	0	4	16
Heart Failure: Patients	6	1	5	4	6	4	26
Currently in care	6	1	5	4	5	3	24
Attendance in past	5	1	5	2	6	3	22
Care club member	0	0	1	1	5	0	7
CCW Visit in past 4 weeks	3	0	0	1	0	0	4
Epilepsy: Total Patients	3	2	3	1	1	2	12
Currently in care	3	2	3	1	1	2	12
Attendance in past	3	2	3	1	1	2	12
Care club member	0	0	0	0	0	0	0
CCW Visit in past 4 weeks	1	1	0	1	0	0	3
Other: Total Patients	12	7	8	15	42	4	88
Currently in care	10	6	8	11	40	4	79
Attendance in past	10	6	8	5	40	4	73
Care club member	3	4	0	0	30	0	37
CCW Visit in past 4 weeks	6	1	1	1	2	1	12

* Includes facility attendance within past week
Note: Some Household members had more than one disease.

Quality of care available to chronic disease patients was perceived to be ‘good’ by 47.8% of Households. Participants in Bellville South (57%) and Lwandle (56%) were more likely to report good care than those from Montana (42.1%) or Klapmuts (42%). Respondents in Klapmuts, Gugulethu, and Belhar reported sufficient medical supplies yet staff shortages and limited access to allied health professionals, echoing 2016 Ideal Clinic Monitoring records.

6.2 Measures to Assist Chronic Illness Patients

Overall, respondents reported a need for greater awareness regarding chronic illnesses to motivate communities to implement changes such as healthy diet, exercise and other lifestyle habit improvements. This was supported by all health informants who claimed that clinics are overburdened by curative services, therefore having to neglect prevention and health promotion. Clinic staff also report having too little time with patients to provide holistic health awareness in all cases due to high workload.

Chronic illness is compounded in many cases by patients not having sufficient food to take with their medications. It was suggested that food supplements, food parcels or food garden initiatives could provide options for chronic illnesses suffers attempting to follow a healthier lifestyle. Adherence to treatment is also a challenge for those unable to travel to clinics due to ability or financial constraints. It was commonly suggested that a health delivery service or the aid of community care workers could improve adherence. Chronic care clubs have been successful in Bellville South, as a means of social support, knowledge transfer, and as link to further services.

Discussion

Youth Protection and Development

Child protection and development is fundamental to early prevention of and resilience against ill-health, becoming at-risk of violence as victims or perpetrators, substance abuse, and chronic unemployment. Parents and caregivers affected by these social factors struggle to mitigate the risks for their children, with little or sporadic social support in communities. Social, educational and health services are often under-resourced or present many barriers to entry such as transport costs, long waiting times, or even social discrimination. Service providers are bound by time and resource constraints, and limited reach to ensure that parents adhere to the treatments, strategies, or education provided.

In this study, early child development facilities are well represented and attended despite varying knowledge of their particulars such as registration. There is however a gap for after school activities for children of all ages. All of the sites reported a need for more active youth centres and enrichment programmes, safety features in their community environments, and prevention campaigns to ward against substance abuse, gangsterism, and crime. Child abuse, most commonly in the form of neglect, is rampant as parents are away from the home due to work, may struggle with substance addiction, or be unable to afford adequate nutrition, health care and other childcare.

Peace-Building

Community perception of crime has a major role to play in the responses, attitudes, and resilience demonstrated by communities and the support available for victims. There is a significant disconnect between awareness of the frequency of rape and sexual assault and the high rates of a generally under-reported crime. This can largely be attributed to the prevalence of myths and stereotypes surrounding what constitutes rape, and barriers to reporting such as stigma and fear of retribution by the accused or other community members, and lacking sexual offences justice proceedings. The resulting trauma and bodily harm pose a great threat to personal safety and well-being, as well as an increased risk of transmission of HIV/AIDs and other communicable diseases. Unlike other crimes, rape and sexual assault are shrouded in shame and secrecy, and are therefore difficult for communities to confront without being provided spaces to do so with support and without judgement.

Heads of Household and key informants in each area described being wary of gang activity to different degrees. The dynamics of local gang geopolitics affect community movement to such a degree that residents in Klapmuts and Belhar have learned not to travel between sides of the suburbs if possible, or to do so with extreme caution. This was described to be particularly the case in Klapmuts, where school children from one school are informally prohibited from approaching another school. The high percentage of respondents having no awareness of services to address violence suggests limited experience of, or confidence in, violence reduction services. Communities are willing however to take ownership of these issues and work together with these and other services to stem crime and promote local safety. Peace-building trainers can hold community dialogues and sessions to invite community members to participate in neighbourhood safety planning, crime protection forums, and peace-talk sessions to promote unity in fractured neighbourhoods.

Food and Nutrition Services

Both knowledge and uptake of food supplementation services for families such as food gardens were extremely low at all sites. Some health-care personnel informally provided patients with food out of pocket, which has become an unexpected norm and strain on their personal resources. Others do so in order to bribe patients to take their medication regularly. Many community members follow an insufficient and nutrient-poor diet due to price and convenience. Nutritional needs are neglected through a lack of awareness or as a result of substance dependency. Some scepticism for food gardens arose as a result of previously unsustainable attempts, or lack of skill or motivation to devote time and labour in addition to other daily obligations. Without sustainable management, such projects can become silos and regressively competitive. Food garden initiatives need to be anchored by ensuring adequate skill-sharing and effective management of resource input and outcomes. Food and nutrition trainers in communities can co-create feeding and gardening schemes where differing skills of community members are effectively channelled into group owned results.

Community Chronic Illness Support

To respond to the burden of diseases such as HIV/AIDs, tuberculosis (TB), hypertension, diabetes, and others, clinics and primary health facilities have been relegated to placing emphasis on curative and chronic healthcare management services, to support and reduce the load on secondary facilities. This is at the expense of prevention and health awareness activities, including open days, distribution of materials, and sufficient time spent educating each patient. A lack of attention to preventative services and health promotion increases infection rates, reduces treatment adherence and brings additional pressure onto under-resourced health services. Clinic staff are not able to stretch themselves further to cover all levels of healthcare and extend these services outside of the clinic.

Many chronic illness patients are prevented from accessing treatment regularly due to working hours or transport costs. However, follow-up is improved where food is supplied to accompany medication – without which, patients may experience unpleasant side-effects. Some elderly patients may drop out due to poor mobility and lack of transportation. Trained members of the community, Community care workers and home-based carers can assist with these issues, by bringing services to these patients in their homes.

Communities can play an active role in chronic illness prevention, management, and support. Many community members from non-medical backgrounds are invested in social and community well-being, and are receptive to training on healthcare topics. There is also a need for health activists, to spearhead community health discussions, scale up complaints, and organise lobbying and responses to local public health policy. Interested community members could be joined by Facility staff, home-based carers, and other health personnel who may not always have the capacity to promote such causes. This would provide a response to the common survey appeal for more chronic care clubs, transfer between facilities and homes, and health awareness generally.

Further Issues

Poverty and unemployment were routinely cited above any others as the root causes of crime, violence, hunger, and ill health in all communities by all key informants. A lack of upward mobility though incomplete education or insufficient skills development, poor job opportunities, and other barriers such as transport costs or weak social support are compounded and promoted by poor health and unsafe home environments. The challenge of attempting to improve health-seeking behaviours imposes great cost to low-resource communities when public health care systems are not responding adequately, and thus poor health outcomes accumulate. Upskilling and income generation training could follow the establishment of social and health support mechanisms in communities to provide healthier and safer foundations for social advancement.
Key informants described substance abuse as the next major cause of assaults, child abuse and neglect, and as a primary incentive for criminal activity. Low cost drugs such as “tik”

(methamphetamine) are easily available and those with addictions may often purchase these substances instead of providing food for their homes and families. Alcohol abuse is particularly high in communities with high proportions of seasonal workers in more rural areas such as Montana and Klapmuts, with weekends bringing high levels of fighting, assault, and domestic violence as alcohol abuse activity increases. Many informants cited a lack of substance abuse rehabilitation services or centres accessible for their communities. Schools and health activists can promote awareness of the dangers of substance abuse and support child protection activities to promote healthy recreation for the youth. Community peace-building efforts, including neighbourhood watches, could collaborate with police to tighten security that could stem the influx of illegal substances.

Knowledge and perceptions of the frequency of rape and sexual assault are highly disproportionate to reported realities of sexual offences. Across all sites, 59% of respondents reported the belief that rape and sexual assault "never" happen in their communities. While sexual offence statistics for the last reported period (April 2016 – March 2017) have seen some improvement in the intervention group, increases of such crimes stand at 37% (Bellville South), 51% (Lwandle) and 47.8% (Montana) in the control sites. Informants in Bellville South stated that domestic violence is the second largest cause of death in the area. A need was identified by informants for shelters for survivors of abuse and sexual assault in the control sites as well as Belhar and Klapmuts. Discrepancies between perception and reality regarding gender-based violence and sexual offences may be entrenched in myths and stereotypes that persist around gender relations and sexuality, which may be unchallenged by religious and cultural norms. Awareness programmes and other health activism are vital for prevention, support of survivors, and seeking justice proceedings.

Limitations of the Study

A number of challenges were encountered, some of which may have impacted the findings.

Language

The Supervisors and Fieldworkers were comprised of English, Afrikaans and Xhosa speakers, and the survey materials were made available in all three languages. The training on the Baseline project process, how to conduct the survey, and interview skills was however only conducted in English, with some support in Afrikaans. Study sites tended to have a dominant language, with a probability of all three in languages to varying degrees. Study participation was contingent upon fluency in one of these three languages by at least one adult Household member. Being randomly assigned HHs meant that Fieldworkers would need to be able to accommodate willing respondents in any of the three preferred languages. This language limitation may have been compounded by the varying education and literacy levels of the Fieldworkers. In an attempt to mitigate this, Fieldworkers conducted the surveys in pairs with fluency in three or at least two of the selected languages.

Transport costs

Due to the varying sizes of the six study locations and availability of public transport, Fieldworkers in some areas faced challenges accessing their assigned Households. In rural and smaller sites, Fieldworkers travelled on foot, while in urban areas the cost of public transport due to the need for repeated attempts to make contact with Household members who were not home proved to be a challenge. Fieldworkers were given a standard transport stipend at the commencement of fieldwork which was not always sufficient.

Dual Roles

Many of the Fieldworkers had other roles connected to community health as members of Health Committees, the Neighbourhood Watch, or other health forums. While this was advantageous in areas where these public bodies are well known and regarded and therefore improved access to homes for fieldworkers, this also challenged the survey process. Some Fieldworkers found that their dual roles inadvertently created false expectations in survey respondents, who in some cases only granted access to their homes and agreed to participate under the impression that they would receive some kind of immediate reward. In their other capacities these Fieldworkers would have previously brought food or housing supplies, helped secure funds from varying sources, or tended to have provided tangible support to families in the community. It became difficult to communicate that the survey was purely for research purposes with ultimate community upliftment goals, yet no immediate compensation due to ethical issues stemming from a similar scenario to be avoided.

This challenge was primarily seen in Gugulethu, where highly dedicated Health Forum and Health Committee members play a vital role in health activism. Fieldworkers in these dual roles then had to navigate these dynamics sensitively and ensure that all respondents were provided adequate information on the survey purpose and process. Elsewhere, such as Bellville South, these Fieldworkers were able to cohere the survey process and their interests as Health Committee members in gathering community feedback seamlessly.

Feedback and Dissemination

As health ambassadors and health care service users, a feedback presentation for the survey Fieldworkers was held in December 2017. Site specific pamphlets or results files will be compiled for each study site to accompany consultations on how best to respond to the needs highlighted and plan relevant activities.

Conclusion

Child neglect was highly prevalent due to the lack of supervision options for working parents, or their struggles with substance abuse. Recreational and youth activity programmes are sporadic and there is a real need for activities to keep children off the street and protected from abuse and gang recruitment. Community members and key informants believe that increased patrols and policing, coupled with investment in youth development centres and programmes such as sport, art, educational outings and other activities would promote child

Although SAPS statistics show a decline in various crime rates, communities perceive their environments to be unsafe to very unsafe. Infrastructure is lacking for safe public spaces for children and to ensure neighbourhood safety. Police resources may be insufficient to respond to social instability and escalating violence brought on by gangsterism, substance abuse, and lacking access to basic needs. Peace-building community actors can open spaces for acknowledging social problems, promoting crime prevention and civil vigilance, and exploring rehabilitation and restorative justice proceedings.

Daily and monthly hunger were reported to be higher in the Control group, with knowledge and uptake of food parcel services to be low and irregular across all sites. Access to healthy food options are challenged by affordability, poverty, and substance abuse. Nutritional supplementation for undernourished children is well adhered to once children enter the program at clinics, however no stable food parcel programs for adults and families were found. Current or previous food gardens are few and far between and can be susceptible to poor management. This shortcoming can be dealt with by training community members in nutrition and harnessing agricultural skills to establish well located community food gardens, with the view to create a legacy for future gardens and beneficiaries.

Chronic illnesses are highly prevalent with at least one case of high blood pressure, diabetes, heart failure, or epilepsy in the majority of Households. This can be attributed to lifestyle factors such as diet, stress, smoking and substance abuse, poor health service attendance, amongst other factors.

Recommendations

- Train cadres of community members in child protection, peace building, food and nutrition, and chronic illnesses. These groups would in turn train others to increase their reach and to facilitate wider scale programmes in their communities.

- The Training Model developed by the CSSP can be scaled up on a national level to assess community needs for capacity building in other provinces.

- The Model can be replicated and expanded to cover other areas of need, such as substance abuse, addressing gangsterism, economic upliftment, and gender-based violence. The results of the current training will strengthen future community responses to these issues.

References

https://www.saps.gov.za/resource_centre/publications/statistics/crimestats/2014/crime_stats.php

https://www.westerncape.gov.za/directories/facilities/669

Appendix

Supplementary Tables and Figures

Section A2.1 Employment

Table A2.1 Employment Status by Gender: N=1685 Adults

		Gender		
		Males	Females	Total
Employed	N	323	321	644
	% within Employment	50.2	49.8	100.0
	% within Gender	42.3	34.9	38.2
Not Employed	N	441	600	1041
	% within Employment	42.4	57.6	100.0
	% within Gender	57.7	65.1	61.8
Total	N	764	921	1685
	% within Employment	45.3	54.7	100.0
	% within Gender	100.0	100.0	100.0

N= Number of Adults; % within Employment (row %); % within Gender (column %)

Table A2.2. Type of Work, by Site: N=644 Employed Adults

		Study Site						
		Bellville South	Lwandle	Montana	Belhar	Gugulethu	Klapmuts	Total
Q2. Type of work	Paid	115	98	90	102	92	87	584
	Self-employed	6	2	5	11	9	6	39
	Unknown	1	0	2	16	1	1	21
	Total	122	100	97	129	102	94	644

Section A2.2 Grants

Table A2.3 Number of Child Support Grants received per Household

		Households	Percent	Valid Percent	Cumulative Percent
Number of Child Support Grants	1 Grant	102	17.2	41.8	41.8
	2 Grants	73	12.3	29.9	71.7
	3 Grants	41	6.9	16.8	88.5
	4 Grants	14	2.4	5.7	94.3
	5 Grants	10	1.7	4.1	98.4
	6 Grants	3	0.5	1.2	99.6
	7 Grants	1	0.2	0.4	100.0
	Total	244	41.1	100.0	
	None	350	58.9		
	Total	594	100.0		

Table A2.4 Number of Old Age Pensions received per Household

		Households	Percent	Valid Percent	Cumulative Percent
Number of Old Age Pensions	1 Pension	147	24.7	77.0	77.0
	2 Pensions	41	6.9	21.5	98.4
	3 Pensions	3	0.5	1.6	100.0
	Total	191	32.2	100.0	
	None	403	67.8		
	Total	594	100.0		

Table A2.5 Number of Disability Grants received per Household

		Households	Percent	Valid Percent	Cumulative Percent
Number of Disability Grants	1 Grant	52	8.8	96.3	96.3
	2 Grants	2	0.3	3.7	100.0
	Total	54	9.1	100.0	
	None	540	90.9		
	Total	594	100.0		

Table A2.6 Number of Maintenance Grants received per Household

		Households	Percent	Valid Percent	Cumulative Percent
Number of Maintenance Grants	1 Grant	4	0.7	66.7	66.7
	2 Grants	2	0.3	33.3	100.0
	Total	6	1.0	100.0	
	None	588	99.0		
	Total	594	100.0		

Table A2.7 Number of Other Grants received per Household

		Households	Percent	Valid Percent	Cumulative Percent
Number of Other Grants	1 Grant	8	1.3	80.0	80.0
	2 Grants	2	.3	20.0	100.0
	Total	10	1.7	100.0	
	None	584	98.3		
	Total	594	594	100.0	

Table A2.7 Grant Receipt by Employment Status: N=594 Households

			Employment		
			Yes	No	Total
Grant Receipt	Yes	N	263	139	402
		% of Total	44.3	23.4	67.7
	No	N	149	43	192
		% of Total	25.1	7.2	32.3
	Total	Count	412	182	594
		% of Total	69.4	30.6	100.0

N= Number of Households; % of Total = % of table Grand Total
Employment: One or more adult Household Members has employment
Grant: One or more Household Members receives a social welfare grant

Section A3. Child Health

Table A3.1 Recent Clinic Visits by Site and Age Category: N=914 Children aged 0-18 yrs

		Clinic Visit within past 4 Weeks					
		Yes		No		Total	
Site	Age Category	N	%	N	%	N	%
Bellville South	0 - 5 years	19	55.9	15	44.1	34	100
	6 - 12 years	9	19.6	37	80.4	46	100
	13-18 years	1	2.4	41	97.6	42	100
	Total	29	23.8	93	76.2	122	100
Lwandle	0 - 5 years	42	77.8	12	22.2	54	100
	6 - 12 years	30	41.1	43	58.9	73	100
	13-18 years	16	25.0	48	75.0	64	100
	Total	88	46.1	103	53.9	191	100
Montana	0 - 5 years	23	44.2	29	55.8	52	100
	6 - 12 years	4	5.5	69	94.5	73	100
	13-18 years	1	1.7	57	98.3	58	100
	Total	28	15.3	155	84.7	183	100
Belhar	0 - 5 years	16	32.0	34	68.0	50	100
	6 - 12 years	6	14.3	36	85.7	42	100
	13-18 years	0	0.0	35	100.0	35	100
	Total	22	17.3	105	82.7	127	100
Gugulethu	0 - 5 years	24	49.0	25	51.0	49	100
	6 - 12 years	14	20.0	56	80.0	70	100
	13-18 years	3	6.3	45	93.8	48	100
	Total	41	24.6	126	75.4	167	100
Klapmuts	0 - 5 years	25	65.8	13	34.2	38	100
	6 - 12 years	11	21.6	40	78.4	51	100
	13-18 years	4	11.4	31	88.6	35	100
	Total	40	32.3	84	67.7	124	100

N= Number of Children; %= within Age Category (row)

Section A4. Exposure to Violence

Table 4.1 Personal Exposure to Crime, Violence and Bigotry: N=594 Heads of Household

	Bellville S.	Lwandle	Montana	Belhar	Gugulethu	Klapmuts	Total
	N	N	N	N	N	N	N
Robbed/Violence							
Yes	20	32	12	20	36	36	156
No	79	64	82	78	63	61	427
No Response	1	3	1	2	1	3	11
Total	100	99	95	100	100	100	594
Home Broken Into							
Yes	31	28	13	19	35	26	152
No	68	70	80	80	65	73	436
No Response	1	1	2	1	0	1	6
Total	100	99	95	100	100	100	594
Know Person Murdered							
Yes	21	27	10	14	31	20	123
No	77	70	84	85	68	79	463
No Response	2	2	1	1	1	1	8
Total	100	99	95	100	100	100	594
Injured with Weapon							
Yes	9	13	11	7	29	12	81
No	89	85	81	88	71	87	501
No Response	2	1	3	5	0	1	12
Total	100	99	95	100	100	100	594
Domestic Violence							
Yes	13	20	19	12	19	13	96
No	86	76	75	86	80	87	490
No Response	1	3	1	2	1	0	8
Total	100	99	95	100	100	100	594
Experienced Bigotry							
Yes	10	26	12	11	26	25	110
No	88	68	81	88	72	75	472
No Response	2	5	2	1	2	0	12
Total	100	99	95	100	100	100	594

Section A5. Food Security & Nutrition

Table A5.1 Frequency of Hunger: N=594 Household Members

	Bellville S.	Lwandle	Montana	Belhar	Gugulethu	Klapmuts	Total
	N	N	N	N	N	N	N (%)
Every Day	3	4	12	8	14	8	49 (8.2)
Every Week	1	14	6	1	4	10	36 (6.1)
Every Month	5	15	14	3	32	25	94 (15.8)
Never	89	65	61	78	48	57	398 (67.0)
No Response	2	1	2	10	2	0	17 (2.9)
Total	100	99	95	100	100	100	594 (100)

Section A6. Chronic Disease

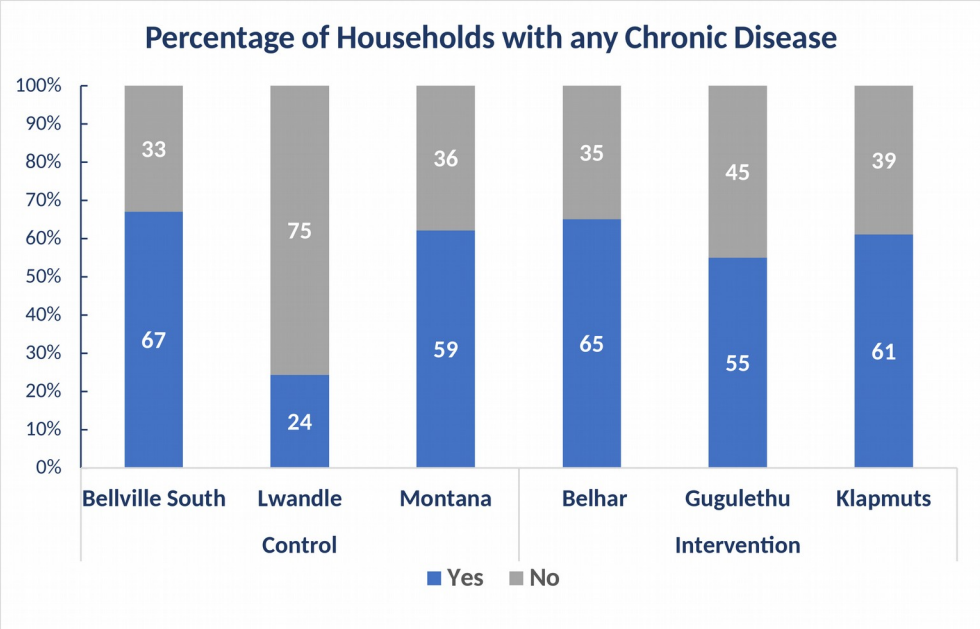

Figure A6.1 Household Presence vs. Absence of Chronic Disease, by Site

Table A6.1. Do people with chronic health problems have good access to care?

	Households	Percent	Valid Percent	Cumulative Per-cent
No Response	63	10.6	10.6	10.6
No	244	41.1	41.1	51.7
Unsure	2	.3	.3	52.0
Yes	285	48.0	48.0	100.0
Total	594	100.0	100.0	