A MIXED-METHODS STUDY OF THE NATURE AND EXTENT OF THE ALCOHOL TRADE IN KHAYELITSHA – AND COMMUNITY PERCEPTIONS

Final Report

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EXECUTIVE SUMMARY

Alcohol is one of the key risk factors for the Western Cape's exceptionally high levels of interpersonal violence and several other important contributors to the disease burden, as highlighted by the *Khayelitsha Commission*. The Commission took note of the regulatory challenges posed by unlicensed premises, the potential impact of police raids on traders' livelihoods and that this might also undermine the relationship between police and the community, or at least, it is assumed, those members of the community that frequent alcohol outlets. In order to inform a strategy to alleviate the harm caused by abuse of liquor in Khayelitsha the Commission requested that a provincial task team be convened through the Department of Community Safety and that a survey be undertaken to explore community attitudes to unlicensed liquor outlets to assist policy formulation.

To this end, the University of Cape Town (UCT) conducted a mixed-method study to provide a rapid review of existing knowledge and possible policy options and to identify key areas for further research. The study used data previously collected between 2013 and 2016 as part of research grants provided by the International Development Research Centre (Canada) and the UK's Department for International Development, along with primary data collected specifically for the research commissioned by the Department of Community Safety (DoCS). This is set out in Part 1 of this report.

The study describes the nature and extent of the alcohol trade in Khayelitsha, community perceptions and receptiveness to available interventions, including pricing, enforcement and marketing interventions. It juxtaposes key risk factors and harms drawn from empirical data alongside perceptions of these risks and harms. The study is comprised of the following components:

- Literature review on alcohol trade, alcohol-related harms and community perceptions of alcohol in Khayelitsha (Part 2).
- Household surveys (including 3 411 respondents from Khayelitsha) conducted over three years, questioning alcohol, violence, mental health – and attitudes towards law enforcement and interventions (Part 3).
- Close to 1 500 young adults respond to the same questions as above (Part 4).
- Both legal and illegal outlets are mapped, providing numbers, distribution and
  a baseline with which to assess the impact of enforcement efforts (Part 5).
- Alcohol-related trauma cases presented to the health facilities serving Khayelitsha (Part 6).
- A focus group analysis comprised of eight relevant subgroups (Part 7).

The literature review of alcohol use and alcohol-related harms in Khayelitsha (see Part 2) revealed that alcohol is often conceptualised in relation to criminality, including interpersonal violence, health-related outcomes, economic factors, socio-spatial management, and gender and youthfulness. Most articles explore the effects of the intersections of some of these factors, but few take into account the intersection of all factors, suggesting that scholars rarely see the complete picture when it comes to alcohol-related harms and the prevention of alcohol abuse. This may explain the differences in policy recommendations made by those scholars reading alcohol-related risk through the contextual lens of poverty, compared to those who read the issue through the lens of public health. The literature engages briefly with areas of legislative control, namely drunk-driving policies and policies regulating the availability and marketing of alcohol, pricing policies, and monitoring and surveillance. A small number of studies cover the public-health impact of illicit and informally produced alcohol and community action and the health-services sector, but there is a serious lack of engagement with evidence-based interventions. The literature provides an indication of action in the area of leadership, awareness and commitment, in the form of the Western Cape's legislative reforms, but also reveals a lack of interagency coordination, which is a key requirement in realising the World Health Organisation's 10-point strategy to reduce alcohol harms.

The household survey includes 3 411 adult respondents in Khayelitsha (see Part 3) showed that residents experienced high levels of mild or significant depression. The results showed clear associations between violence (including rape, murder and assault with and without a weapon) and signs of depression. Most respondents were of the belief that alcohol and drugs contributed to violence.

Alcohol was easily available throughout the week and most respondents believed that people in Khayelitsha drank too much. Respondents were overwhelmingly in favour of a range of interventions to reduce alcohol consumption, including restrictions on access and marketing, enforcement and reduced availability.

The survey of 1 466 young adults (see Part 4) included additional questions about the respondents drinking patterns in this high-risk age group. Of the respondents, 62% reported drinking on some occasion; with an average spend of R151 when drinking. Of the drinkers, 42% reported some involvement with the police within the last six months as a result of drinking. This survey also provided further evidence of the inter-relatedness of alcohol, crime and violence. As in the adult survey, respondents who had experience of violence at the household level were more prone to depression, but it was also shown that respondents with signs of depression were more prone to alcohol dependency.

Site B had the highest proportion of respondents whose drinking was cause for concern: almost a third (31%) scoring 3 or more on the reduced Alcohol Use Disorders Identification Test (AUDIT) scale compared to 25% in Lingelethu West

and 16% in the Harare precinct. Site B Sector 2 was particularly problematic with 45% of respondents classified as having potentially problematic drinking patterns. Nevertheless, the results indicated that there were similar levels of support for interventions to reduce alcohol harms among young adults as there were among the older adult respondents in the main household survey.

The mapping of liquor outlets (Part 5) identified 1 045 outlets: 452, 133 and 460 in the Harare, Lingelethu West and Site B policing precincts respectively. This corresponds to ratios of one outlet per 383.5 people, 484.5 people, and 334.1 people in those SAPS station areas. The highest densities of outlets were recorded in Site B sector 2, one outlet to 205.7 people; Harare sector 1, one outlet to 295.1 people; and Site B sector 5, one outlet to 309.6 people. Unlicensed outlets tended to have a smaller capacity for patrons and the vast majority had entertainment equipment. On average, outlets were reported to have been in business for approximately a decade. They primarily served beer and the patrons were mostly male, between 25 and 34 years old. There was significant interest in acquiring formal liquor licenses, and most respondents indicated that they would be interested in a different kind of retail business.

A comparison of outlets reported by fieldworkers to the Western Cape Government's Liquor Authority database of licensed outlets indicates a very high match rate. Of the 103 Liquor Authority records we were able to geolocate (90% of the 114) almost 97 (94%) could be matched to fieldworker-reported outlets within a 150m radius, with the remainder comprising licensed bottle stores that were not part of the survey. The fact that 11 outlets could not be geolocated from the Liquor Authority database is likely to have arisen from local street and site naming conventions in some areas not aligning with formally demarcated addresses. There may be a case to include the geolocation as part of the licensing process.

These data can provide baseline information for identifying hotspots and determining important themes for alcohol-harms-reduction interventions and future comparative studies assessing the impact of such interventions on the density, distribution and characteristics of outlets. This will enable valuable analyses of geospatial relationships between the density, distribution and types of outlets and violence and injury. In addition, these data can act as baseline information for identifying hotspots and determining important themes for alcohol harms reduction interventions and future comparative studies assessing the impact of such interventions on the density, distribution and characteristics of outlets. It is recommended that there be a sustained effort to continually refresh the outlet maps through ongoing systematic data capture processes – perhaps in consort with community agencies (e.g. community safety forums or neighbourhood watch), in a manner that informs community policing.

The descriptive analysis of alcohol-related trauma cases presented to the health facilities serving Khayelitsha (see Part 6) revealed that more than half of the

patients (52%) injured as a result of violence were under the influence of alcohol. The highest percentage of alcohol-related cases (57%) were reported in the Site B police precinct and that the percentage of alcohol-related cases have increased in this precinct, between September 2013 and September 2015.

The focus group included participants from the community policing forum, churches, neighbourhood watches, male and female drinkers, tavern owners and shebeeners (see Part 7) showed that while alcohol use in Khayelitsha was undergirded by complex social, historical and economic dimensions, there was relative consensus on the potential harms implied by the unregulated distribution and consumption of alcohol. This implied at least one entry-point for all stakeholders to mobilise an inclusive containment strategy that is sensitive to the perceptions of the economic consequences of a comprehensive and enforceable alcohol-harms-prevention strategy. The limited community-level perceptions yielded by this study also interestingly show that any tailored intervention aimed at consumption factors should accommodate drivers of female drinking in Khayelitsha. Such interventions should be built on empirical studies of the demonstrable intersections between the socio-economic vulnerabilities of young motherhood and the bi-directional effects on employment opportunities. The study also demonstrated that the community was largely familiar with the DoCS's role as an information gatherer, but a need was identified for such information to be more widely and publically translated into action.

Part 1: Introduction

1.1. BACKGROUND

Alcohol is one of the key risk factors for the Western Cape's exceptionally high levels of interpersonal violence and important contributors to the disease burden. This was highlighted during the *Khayelitsha Commission*, at which the relationship between alcohol and violent contact crime was acknowledged. At the Commission, the CEO of the Western Cape Liquor Authority proffered that more premises should be licensed so as to increase the possibility of effective regulation, but barriers to implementation included zoning restrictions. With many illegal establishments located in residential areas there are limited prospects for successful licensing in accordance with current zoning restrictions unless outlets are relocated to commercial nodes.

The Commission took note of the regulatory challenges posed by unlicensed premises, the potential impact of police raids on traders' livelihoods and that this might also undermine the relationship between police and the community, or at least, it is assumed, those members of the community that frequent alcohol outlets. The Commission called on the Western Cape to take into account the licensing of taverns and the regulation of alcohol. In order to inform a strategy to alleviate the harm caused by abuse of liquor in Khayelitsha. The Commission requested that a provincial task team be convened through the Department of Community Safety (DoCS) and that a survey be undertaken to explore community attitudes to unlicensed liquor outlets to assist policy formulation.

The University of Cape Town (UCT) conducted a mixed-method study using available resources to provide a rapid review of existing knowledge, possible policy options and identified key areas for further research. This study describes the nature and extent of the alcohol trade in Khayelitsha, community perceptions and receptiveness to available interventions, including pricing, enforcement and marketing interventions. It juxtaposes key risk factors and harms drawn from empirical data alongside perceptions of these risks and harms. The study is comprised of the following components:

- A literature review describing the alcohol trade, alcohol-related harms and community perceptions of alcohol in Khayelitsha (see Part 2).
- A descriptive analysis of three household surveys conducted over three years that enrolled 3 411 respondents from Khayelitsha and which included questions pertaining to alcohol, violence, mental health and attitudes towards law enforcement and interventions (see Part 3).
- An analysis of about 1 466 young adult respondents identified from the household surveys described above (see Part 4).
- Mapping of legal and illegal outlets provide an overview of the number of outlets, their distribution and a baseline with which to assess the impact of enforcement efforts (see Part 5).

- A descriptive analysis of alcohol-related trauma cases presented to the health facilities serving Khayelitsha (see Part 6).
- A focus group analysis of purposively sampled sub-groups is comprised of shebeeners, security agencies (including police and community safety groups), and male drinkers (see Part 7).

1.2. RESEARCH PROBLEM AND JUSTIFICATION

South Africa has unusually high levels of interpersonal violence (Norman, Matzopoulos, Groenewald, Bradshawa and Bradshaw, 2007). Alcohol is one of the key risk factors for interpersonal violence that is amenable to intervention in the short-term (Matzopoulos, Bowman, Mathews and Myers, 2010). It is also an important risk factor for a range of other health outcomes, the most important of which are violence, mental health disorders (including alcohol disorders and dependence) and road traffic injuries, which together accounted for more than 70% of the associated disease burden (Schneider, Norman, Parry, Bradshaw and Plüddemann, 2007). There is also emerging evidence of alcohol contributing to infectious diseases, such as HIV and TB (Parry, Rehm and Morojele, 2010) The link between alcohol and non-communicable diseases is also well established (Parry, Patra and Rehm, 2011).

Alcohol has been shown to be the third largest risk factor for the Burden of Disease (BoD) in a comparative risk assessment, nationally, and is bound to play an even larger role in the Western Cape, the province with the highest estimated levels of hazardous and harmful drinking among adults and binge drinking among youth (Reddy et al., 2010; Shisana et al., 2009). Addressing the harmful use of alcohol was one of the key focal areas for prevention arising from the Western Cape Government's BoD Reduction project that was initiated in 2004. This project aimed to identify and prioritise upstream health determinants and appropriate preventive interventions, and which included improvement of surveillance data to facilitate these processes. Surveillance data confirmed that the major drivers of the disease burden are inequitably distributed affecting low-income communities disproportionately, with local level mortality data revealing stark disparities in the different sub-districts of Cape Town (Groenewald et al., 2010).

The sale of alcohol in South Africa's densely populated townships is largely unregulated, mainly from shebeens (unlicensed liquor outlets). Poor zoning and delineation of commercial and residential areas means that there is currently a high density of illegal outlets. Low-income communities, such as Khayelitsha, are most severely impacted by this prolific and unregulated alcohol trade, where large producers knowingly supply larger volumes of alcohol than can be legally sold by licensed operators, which then in effect serve as distribution points for alcohol to reach consumers ultimately through illegal channels. There is increasingly intense activity on the part of local and provincial Government to restrict the number of illegal shebeens and to relocate those that are legal away from deep residential areas to high street zones under the auspices of the

Western Cape Liquor Act, 2008. At the same time it is anticipated that restriction may lead to liquor outlets being moved to informal settlements and adding to an already stressed system there.

1.3. OBJECTIVES

The overarching aim of this research is to inform the allocation of scarce resources to address alcohol, one of the major drivers of the disease burden in the Western Cape.

Objectives include:

- describing the nature and extent of the alcohol trade in Khayelitsha, including empirical data on the number and location of alcohol outlets
- identifying key risk factors and harms drawn from empirical data including trauma facility data
- considering community perceptions of the alcohol trade and receptiveness to available interventions, including pricing, enforcement and marketing interventions
- acknowledging perceptions of these risks and harms

1.4. STUDY SITE

Khayelitsha is home to 391 000 residents. It is a typical mono-functional dormitory township, established in 1983, about 35km outside of Cape Town. *Khayelitsha* is an isiXhosa word, meaning new home. It is one of the city's poorest areas, suffering five-fold exclusion: social, cultural, economic, institutional and spatial; as a result of apartheid planning. Only 60 percent of the population live in formal houses. Violent crimes are a daily reality for residents, the most common being break-ins, robbery and rape. There were 369 murders recorded in 2016, at a rate of 94 per 100 000 population. Gender-based violence is largely underreported, but highly prevalent.

1.5. CONCEPTUAL AND THEORETICAL FRAMEWORK

The project is grounded in the public health approach to violence prevention, which is a variant of an ecologically oriented perspective on human health and development. Violence is thus a fundamental threat to human health and, in accordance with ecological approaches, its causes and consequences are understood as the outcome of complex causal pathways that intersect individual, familial, community and societal systems. Alcohol is considered an important risk factor that impacts across these systems. The consumption of alcohol is a known risk factor for the perpetration of violence by increasing aggressive behaviour and vulnerability among victims, who are more likely to provoke aggression and less able to defend themselves. In addition, alcohol consumption has a deleterious effect on a range of other health outcomes; it undermines the social fabric in communities and relationships.

The range of theoretical and methodological expertise represented in the team has been combined with a participatory research process that includes the

voices of the urban communities in which the interventions are undertaken. This is an exceptionally important methodological imperative because experience in South Africa has shown that infrastructural change interventions are often met with resistance in the absence of community consultations from conception through to evaluation. Thus, in keeping with community empowerment principles and participatory research guidelines (Fawcett, 1991), key informants, local fieldworkers and community leaders were considered both researchers and participants on the initiative.

1.6. METHODS SUMMARY

This mixed-method study comprised six key components that are summarised below. Additional details pertaining to the sub studies are described in Parts 2 to 7.

1.6.1. Literature review

This narrative review describes the alcohol trade, alcohol-related harms and community perceptions of alcohol in Khayelitsha. The literature from medical, psychological and social sciences was reviewed with regards to the role of culture in problem drinking using keywords that included culture, alcohol, alcohol abuse and problem drinking. We also identified and tabulated all studies describing alcohol outlet densities in order to devise an estimate for the total number of shebeens in the Western Cape based on empirical data.

1.6.2. Household survey

A three-phase analysis of 1 200 households in Khayelitsha (i.e. 3 600 respondents) was undertaken, using selected variables, including basic demographic characteristics (age, gender and employment) as well as variables on alcohol policies and interventions. These included proximity to and trading hours of outlets, perceived links between alcohol and violence, perceived enforcement of alcohol laws and attitude towards interventions. We also provide selective results relating to the experience of violent crimes and reporting of these crimes to police to estimate the level of underreporting.

1.6.3. Survey of young adults

A descriptive analysis from a non-representative purposive sample of young adults identified from the main household survey (estimated at between 300 and 400 respondents) provided corresponding information on perceptions relating to alcohol interventions, but also additional information on drinking patterns.

1.6.4. Mapping of legal and illegal outlets

The team geolocated legal and illegal outlets to provide a baseline with which to assess the impact of enforcement and intervention efforts. Geographers based at Simon Fraser University undertook additional analysis of a more comprehensive survey undertaken in Nyanga in 2013 in order to devise a method to calculate potential access to liquor outlets by going beyond the standard distance measures and incorporating trading times and outlet capacity. We considered the development of an android app/tool for data capture by volunteers and CPFs and an accompanying analytic framework to describe the results.[1]

1.6.5. Descriptive analysis of alcohol-related trauma cases

We described the profile of trauma cases presenting to health facilities serving Khayelitsha (Khayelitsha Day Hospital, Site B and Michael Mpongwane Clinic) from five one-week cross-sections collected six months apart between September 2013 and Sept 2015. The data are geocoded to small areas, which allowed for a graphic depiction of injury densities and hotspots. A sub-study will explore the association between alcohol seizures by police on the incidence of alcohol-related violence and injuries.

1.6.6. Focus group analysis

We undertook a qualitative study to examine the cultural correlates of problem drinking through focus groups and in-depth interviews.

1.7. ETHICAL CONSIDERATIONS

The study in its entirety is an observational epidemiological study, and for the most part will rely on secondary data sources, such as those describing area-level socio-demographic data, housing and urban infrastructure information and alcohol outlet locations. Ethical approval for the collection of these data has already been obtained from UCT Health Research Ethics Committee (HRECs 476, 2012, and 245, 2013) and for the health facility data (HRECs 399, 2013), which have also been approved by the Department of Health's Provincial Health Research Committee. As part of the formalisation of this protocol we requested an expedited review for this new use of data, which was granted by UCT's Health Research Ethics Committee. We also obtained permission to conduct additional primary collection, namely the liquor outlet mapping and focus group discussions.

1 The concurrent collection of outlet data from Khayelitsha required that this sub-study utilised previously collected data from Nyanga to demonstrate the concept.

1.8. PROJECT TEAM

This project drew together researchers and representatives from several agencies including tertiary education and research organisations, provincial and local government, non-profit organisations and community structures that share an interest in reducing alcohol-related harm in Khayelitsha. All of these organisations have different mandates, governance structures and funding sources that underpin their roles and their contributions to the research, which can be summarised as follows:

- The University of Cape Town (UCT) was the lead agency through which the research was managed and the funding disbursed. This included peer-review and ethical oversight of the research.
- The Provincial Department of Health, which jointly funds UCT's School of Public Health, provided access to and co-funding for the repeat cross sectional studies of trauma at health facilities serving the Khayelitsha community.
- The Health Systems Trust was sub-contracted by the Health Department to conduct health facilities studies, which was also linked to post-graduate research work at UCT.
- The South African Medical Research Council and Simon Fraser University (SFU) provided expert scientific input in relation to drug and alcohol studies and geoinformatics respectively.
- The University of the Witwatersrand led the qualitative aspects of the work.

Key personnel included the following people:

Richard Matzopoulos (the principal investigator) is a Chief Specialist Scientist at the Medical Research Council's Burden of Disease Research Unit and an Honorary Research Associate at the UCT School of Public Health and Family Medicine, where he co-ordinates its Violence and Injury Research programme, and Visiting Associate Professor at the University of Witwatersrand School of Human and Community Development.

Chris Berens is a Geographic Information Scientist with more than 20 years of experience in spatial data management. He currently works at VPUU where he places special emphasis on the appropriate use of technology so as to embed projects and processes within community and organisational workflows.

Kim Bloch is an MPH graduate and researcher at the UCT School of Public Health and Family Medicine, where she co-ordinated the community surveys that form the basis for this chapter. Since 2015 Kim has worked for Violence Prevention through Urban Upgrading on a part-time basis with a specific focus on enhancing their fieldwork and research methods.

Brett Bowman is an Associate Professor in the School of Human and Community Development at the University of the Witwatersrand, Johannesburg. His primary research focuses on the prevention of crime, violence and injury with an emphasis on identifying the socio-economic and socio-demographic risk factors for vulnerability and resilience to violence and injuries.

Malose Langa is a Senior Lecturer in the School of Community and Human Development at the University of Witwatersrand, South Africa. He is currently the co-ordinator of the MA Programme in Community-based Counselling Psychology. His research interests include risk-taking behaviours amongst the youth and their role in politics, trauma of collective violence and the psychology of men (masculinity) in post-apartheid South Africa.

Sam Lloyd is a researcher based at the Centre for Justice and Crime Prevention and the UCT School of Public Health and Family Medicine, where he is also completing his MPH. His dissertation is based on an analysis of the community participation and mental health outcomes drawn from the survey.

Tatenda Makanga is a Geomatician specializing Geographic Information Systems and its applications to health and urban spaces. He recently completed a Health Geography PhD with SFU in Canada. Prior to starting his PhD, Tatenda worked for the African Centre for Cities (ACC) in Cape Town as a Research Consultant in the Cape Urban Observatory, where he developed methods for spatially representing different composite indicators via a WebGIS platformand in the ACC's the Alcohol Control, Poverty and Development in South Africa Project where he helped develop an injury surveillance tool in Khayelitsha.

Linda Mureithi is a medical doctor with a Diploma in Child Health (MBChB, DCH) interested in using her expertise in strengthening the health systems of Southern Africa. She has knowledge and expertise in clinical infectious diseases particularly HIV, and has a keen interest in adolescent and child health. Linda led a project commissioned by the Western Cape Department of Health to assess the profile of trauma case presenting to facilities in Khayelitsha and several other high-risk communities in the Western Cape for the Health Systems Trust.

Nadine Schuurman is Professor of Geography at SFU with a research interest in trauma care and health geography as a means to understanding the epidemiology of injury and providing and improved response. Nadine's research in support of injury prevention includes spatial analyses of the incidence of injury, and the identification of trends in the spatial distribution of the social determinants of health associated with elevated risk for injury in both urban and low resource settings. Her research work has also focused on exploring barriers and facilitators to access to trauma care, including studies that focus on the particular challenges facing patients in rural and remote communities.

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PART 2: LITERATURE REVIEW - ALCOHOL AND ITS HARMS IN KHAYELITSHA

Compiled by Ella Kotze

2.1. INTRODUCTION

Khayelitsha is a large township in the southeastern part of the Cape Town municipal area, with an estimated 600 000 residents. It has an unemployment rate of 41.7%, and an estimated 54.5% of households living in informal dwellings (City of Cape Town, 2013). As a health district, Khayelitsha has some of the worst indicators in the Cape Town area: mortality rates related to homicide in Khayelitsha are double that of Cape Town; HIV/Aids-related deaths in Khayelitsha is three times that of Cape Town (Groenewald et al., 2010).

Alcohol has been highlighted as one of the most prominent risk factors for health harms in the Western Cape (Myers, 2015), especially health harms related to interpersonal violence, and its effects are amplified through the intersections of poverty, informality of settlements and cultural norms (Makanga, Schuurman and Randall, 2015). Alcohol is also a key indicator in high rates of HIV/Aids-infection (Shapiro and Ray, 2007) and presents as a barrier in the successful treatment of HIV/Aids (Oni et al., 2012). The Western Cape government has made a visibly concerted effort to minimise these risks, in line with the World Health Organisation's *Global strategy to reduce the harmful use of alcohol* (WHO, 2010, Matzopolous and Myers, 2014, Myers, 2015). The strategy proposes 10 areas for action in the sustained reduction of alcohol harms: leadership, awareness and commitment; health services' response; community action; drunk-driving policies and countermeasures; availability of alcohol; marketing of alcoholic beverages; pricing policies; reducing the negative consequences of drinking and alcohol intoxication; reducing the public health impact of illicit alcohol and informally produced alcohol; and, monitoring and surveillance (Myers, 2015). In line with this strategy is the Western Cape Government's adoption of the *Integrated Provincial Violence Prevention Policy Framework* (Matzopoulos and Myers, 2014) in 2013. The *Policy Framework* is informed by the Burden of Disease Reduction Project, initiated in the Western Cape in 2007. It notes the increased risk of becoming both a victim to and perpetrator of violence based on ease of access to alcohol, and it emphasises the need for evidence-based interventions.

As part of a larger project exploring alcohol use and alcohol-related harms in Khayelitsha, this narrative review provides a description of the alcohol trade, problem drinking, and the effects of alcohol use in the area. The review makes use of literature from medical, psychological and social sciences, and reveals very specific focus areas in the research of alcohol use and its related harms in academic literature.

2.2. METHOD

Literature for this study was obtained by conducting searches in six academic databases – PubMed, MedlinePlus, Jstor, EBSCOHost, AfricaPortal and SAGE – using various combinations of the keywords, like culture, alcohol, alcohol abuse, problem drinking, shebeen and Khayelitsha and variations, namely liquor, beer, tavern, Kayalitsha, Khayalitsha and Khayelitsha. The search was repeated on Google Scholar.

Articles were included if the words Khayelitsha (or its variants) and alcohol (or its variants) were found in the main text, and if there was at least one mention of an intervention or research project that was conducted specifically in Khayelitsha or another township in the Cape Town area or Western Cape (articles often referred to unidentified townships in the Cape Town area or the Western Cape), which may have included Khayelitsha itself. The reference lists of the selected articles were scanned for any missing or grey literature.

The selected articles described research on the alcohol trade, alcohol-related harms and community perceptions of alcohol use in Khayelitsha. The texts were labelled according to the main disciplinary frameworks within which they were published, and each text was assigned up to five keywords describing the main themes and concepts. Keywords were grouped into overarching themes to map the main focal areas of articles published in this field. Articles published around specific pieces of legislation were noted, as were articles centring on specific large studies.

2.3. RESULTS

The search identified a total of 365 results of which 56 were included in the study. These studies are arranged by year of publication in Appendix 1, which also describes funding sources where available.

The articles included in this study were published between 1989 and 2016, with the greatest proliferation in the number of articles seen in 2013 (eight articles) and 2014 (14 articles). This proliferation can be attributed to the Western Cape Liquor Act (2008), which came into effect in April 2012 (Faull, 2013), encouraging a slew of research on its positive and negative attributes and the effects of its enforcement.

Table 1: Number of articles published per year

Year	#	Year	#	Year	#
1989	1	2005	0	2011	4
2000	1	2006	2	2012	2
2001	0	2007	3	2013	8
2002	3	2008	2	2014	14
2003	1	2009	4	2015	2
2004	1	2010	4	2016	4

With regards to discipline, most articles were classified as public health articles (30 articles), followed by geography and urban planning (10), economics (eight), sociology and criminology (seven) and other (two). In 2013 and 2014, the majority of articles were published in geography and urban planning (eight) and public health (eight). The disproportionate number of geography and urban planning articles in this period is attributed to a special issue of the South African Geographical Journal, focusing on alcohol, poverty and the South African city (Charman, Petersen and Govender, 2014; Drivdal and Lawhon, 2014; Herrick, 2014; Herrick and Parnell, 2014; Lawhon, Herrick and Daya, 2014; Pirie, 2014; Smit, 2014). Four of the articles (Herrick, 2014; Lawhon, Herrick and Daya, 2014; Pirie, 2014; Smit, 2014) funded by an ESRC-DFID Joint Scheme for Research on International Development (Poverty Alleviation) grant and one other funded by the South African Breweries Foundation (Charman, et al., 2014) position alcohol regulation as a judgmental form of governance that does not take into account the lived experiences of the people it aims to govern.

Seven overarching themes were identified: (1) the nature of drinking in South Africa; (2) HIV/Aids, treatment adherence and other health outcomes; (3) gender factors; (4) invocations of youth; (5) poverty and the informal economy; (6) the alcohol-crime nexus; and (7) spatial management and the socio-spatial contours of alcohol use.

These are discussed in detail in the sections that follow. While gender and age factor into the analysis, only five articles (Myer et al., 2008; Wechsberg et al., 2008; Sawyer-Kurian, Wechsberg and Luseno, 2009; Myers et al., 2013; Peer, Lombard, Steyn and Levitt, 2014) make explicit mention of race. Race is, however, implied in all the other texts under analysis, either through geographical locality (Parry, Louw and Plüddemann, 2000; Du Toit and Neves, 2007; Freeman and McDonald, 2015), economic reality (Townsend et al., 2011; Charman, Herrick and Petersen, 2014; Herrick and Parnell, 2014), or social stratification (Lawhon and Herrick, 2011; Lawhon, 2013; Makanga et al., 2015).

2.3.1. Drinking in Khayelitsha

Peer, Lombard, Steyn, and Levitt (2014) provide a clear view of the nature of alcohol consumption among predominantly black respondents in the Cape

Town areas of Khayelitsha, Nyanga, Langa, Gugulethu and Crossroads. A sample of 1 099 participants (392 men and 707 women) between the ages of 25 and 74 years were surveyed for socio-demographic characteristics, ability to cope with psychosocial stress and adverse life events. The results, obtained in 2008/2009, were then compared with data obtained in 1990 to examine changes in self-reported alcohol consumption. Prevalence of alcohol consumption in 2008/2009 was 68.5% for men and 27.4% for women – significantly higher than the 1990 results of 56.7% for men and 15.1% for women. Problem drinking, defined by Peltzer, Davids, and Njuho (2011) (p. 30) as binge drinking, hazardous drinking "a quantity or pattern of alcohol consumption that places patients at risk for adverse health events" and harmful drinking "alcohol consumption that results in adverse events" was significantly higher in men (50%) compared to women (18%).

According to a report by the Khayelitsha Commission (2014), there were 1 400 unlicenced shebeens and only 35 legal shebeens in Khayelitsha. Puoane, Tsolekile, and Sanders (2013) note concern among residents of Khayelitsha around the easy accessibility of alcohol in the area, as well as the proximity of shebeens to schools.

Khayelitsha is noted to be an impoverished area, shaped by apartheid development policies and migrant labour, with high levels of unemployment and high crime rates (Du Toit and Neves, 2006, 2007; Kane, 2009; Khayelitsha Commission, 2014; Smit et al., 2016). There is a circular causality present in the relationship between alcohol abuse and poverty, as is highlighted by Duncan, Swartz, and Kathard (2011), who attribute rising poverty levels to increased alcohol abuse and addiction – in this case conceptualised as a psychiatric disability. A lack of household income, in turn, increases the negative effects of alcohol abuse, both for the abuser and their families. Hazardous drinking was also linked to the existence of food insecurity and depression in a group of mothers in Khayelitsha (Dewing, Tomlinson, Le Roux, Chopra and Tsaif, 2013).

2.3.2. HIV/Aids, treatment adherence and other health outcomes

The role of alcohol use in the transmission of HIV, the prevention and treatment of HIV/Aids, and its influence on various other health outcomes make up the bulk of articles written from within a public health framework.

Alcohol use, through the resultant loss of self-control, is known to increase the risk of HIV-transmission (Shapiro and Ray, 2007). High-risk sexual behaviour while under the influence of alcohol or drugs was found to be prevalent among coloured women in a Western Cape study (Wechsberg et al., 2008). Peacock, Stemple, Sawires and Coates (2009) link high-risk sexual behaviour by men who are under the influence of alcohol or drugs to harmful masculinity, while black African respondents in a study by Sawyer-Kurian et al. (2009) linked the use of alcohol to the occurrence of rape and high-risk sexual behaviour. Townsend et

al. (2011) found a latent association between alcohol use and transactional sex, which is once again, linked to the effects of harmful masculinity discourses. Wechsberg et al. (2014) found a marginal association between alcohol abuse and HIV risk behaviour among men.

In a rather singular finding from the corpus of texts analysed, Pérez et al. (2016) mentions the role the disinhibiting function of alcohol can play in the reduced perception of stigma with regards to testing for HIV, thereby having a positive effect on the number of HIV-tests conducted in a given area.

Taking into account the structural drivers of HIV-infection, Wechsberg et al. (2013) manage to depict a complex web of driving factors that all contribute to HIV-infection among couples in Cape Town, including alcohol use, poverty and sexual violence. These factors are born out of each other in a continuous cycle, the one increasing the risk of the other occurring. Taking into account this complex web of drivers, Wechsberg et al. (2016) achieved promising results in a couples-based intervention aimed at reducing alcohol use and high-risk sexual behaviour.

In terms of the treatment of HIV/Aids, Oni et al. (2012) note the adverse effects of alcohol use on treatment adherence in recently diagnosed cases, while clinic staff in Khayelitsha identified alcohol abuse as an adherence barrier in patients failing second-line antiretroviral treatment (Barnett et al., 2013).

The influence of ill health on alcohol use has also been noted. HIV-infected individuals have been found to be more at risk for developing alcohol or substance abuse disorders (Myers et al., 2013). Comorbidity of alcohol use and mental disorders among pregnant women are likely to result in various complications in both mothers and infants (Hartley et al., 2011). The effects of food insecurity on pregnant women and mothers of infants were explored by Dewing et al. (2013). Findings included the comorbidity of alcohol abuse, severe depression and suicides. Peer et al. (2014) cite inability to cope with the stresses of a life of poverty and compromised mental health as drivers of problem drinking.

2.3.3. Gender factors

A total of 24 articles mention gender in their analysis of alcohol use and related problems. Masculinity and femininity are taken into account in very specific ways when it comes to alcohol use, raising interesting questions about policy, law enforcement and health provision implications. Men are portrayed as vulnerable (Shapiro and Ray, 2007; Peacock et al., 2009; Peer et al., 2014); as users of alcohol and other harmful substances (Leggett et al., 2002; Sawyer-Kurian et al., 2009; Townsend et al., 2011; Wechsberg et al., 2013; Peer et al., 2014; Seekings and Thaler, 2014; Wechsberg et al., 2014; Makanga et al., 2015; Doherty et al., 2016; Pérez et al., 2016; Wechsberg et al., 2016); and as violent and bound to

harmful masculinity (Gibson, 2003; Wechsberg et al., 2013; Seekings and Thaler, 2014; Makanga et al., 2015; Pérez et al., 2016).

Women, on the other hand, are portrayed as victims (Jewkes and Abrahams, 2002; Gibson, 2003) and as vulnerable (Du Toit and Neves, 2006; Shapiro and Ray, 2007; Wechsberg et al., 2008; Kane, 2009; Hartley et al., 2011; Townsend et al., 2011; Thaler, 2012; Dewing et al., 2013; Myers et al., 2013; Puoane, Tsolekile and Sanders, 2013; Wechsberg et al., 2013; Peer et al., 2014; Wechsberg et al., 2014; Makanga et al., 2015; Doherty et al., 2016; Pérez et al., 2016; Wechsberg et al., 2016). Du Toit and Neves (2007) portray women purely in economic terms, as survivalist entrepreneurs, and Peer et al. (2014) portray women, specifically black women, as users of alcohol and other harmful substances.

Wechsberg et al. (2014), Wechsberg et al. (2016) and Doherty et al. (2016) recruit female participants through their heterosexual male partners. These and other studies in the cohort of texts analysed lay bare the lack of non-heteronormative participants in alcohol studies, at least as it pertains to Khayelitsha and the Western Cape. No studies focused explicitly on queer participants, men who have sex with men, women who have sex with women, non-partnered women or sex workers. This presents an important gap in the current body of research, which is addressed in a separate component of this study (Part 7).

2.3.4. Invocations of youth

Several texts portray South African youth as simultaneously vulnerable and potentially violent (Robins, 2002; Ward, 2007; Seekings and Thaler, 2014; Makanga et al., 2015). The youth's vulnerability, especially through exposure to alcohol use and violence, is further expanded upon by Gibson (2003); Pérez et al. (2016); Puoane et al. (2013); and Shapiro and Ray (2007). Robins (2002) describes the ways in which youth at risk are disciplined through the regulation of space, moving them off the streets and into spaces where they can be appropriately socialised. Gibson (2003) also invokes this tactic when she writes about dangerous township spaces being inhabited by unemployed, destructive youth. Township elders portray the youth as particularly vulnerable to influence, and interventions aimed at youth substance use tend to invoke Gibson's themes.

In a study on youth's perceptions of gang violence in the Cape Town area, Ward (2007) documents substance use and exposure to substances as risk factors for children's involvement in gang activity on the individual, peer/family and social level. In this study, youth were unable to identify any protective factors (on an individual level), while an increase in recreational facilities was the only protective factor identified on a peer/family level. This echoes the previously discussed notion of spatial regulation as the only effective way of disciplining youth and guiding them towards prosocial behaviour.

Seekings and Thaler (2014) in their study with young men from Delft and Khayelitsha, raise employment as a potential protective factor against youth violence and antisocial behaviour, although they quash the notion that unemployment leads directly to violent behaviour. Instead, they cite alcohol abuse or exposure to alcohol abuse, living in squalid conditions and immediate poverty as factors that facilitate interpersonal violence. Their findings are echoed by Makanga et al. (2015) in their study with community members from Khayelitsha and four other townships in the Cape Town area, who directly implicate alcohol as a common factor in more than half of violent deaths recorded among youth. Makanga et al. (2015) point out the risks inherent to a culture of (binge) drinking as it pertains to the youth. Cultural factors, including those regarding masculinity, were also raised by Pérez et al. (2016). In their study, drinking and spending time in shebeens were much more in line with gender norms for young men in Khayelitsha, when compared to health-seeking behaviour like HIV-prevention education and accessing health services.

Puoane et al. (2013) raise the issue of shebeens located near schools in Khayelitsha as potentially encouraging alcohol use among youth. Their study stands out in that it links alcohol use to unhealthy lifestyles and obesity, rather than crime, violence or sexual health.

2.3.5. Poverty and the informal economy

Matzopoulos, Bowman, Mathews, and Myers (2010) recognise the significance of both alcohol and poverty, among other factors, as drivers of interpersonal violence. Their review of potential interventions for interpersonal violence prevention highlights the need for a multi-sectoral approach to preventing interpersonal violence that addresses poverty on a structural level and alcohol use on a behavioural level. The complexity that is required of interventions to be successful is also illustrated by Lawhon et al. (2014); alcohol control strategies rarely take into account the structural drivers of problem drinking, including poverty, and that alcohol policy enforcement needs to go hand-in-hand with poverty alleviation strategies, among other aspects, for it to be successful.

Swart (2006) presents the development of social capital as a strategy to stem poverty in Western Cape communities, eradicating associated social ills such as alcohol and drug abuse in the process. He notes the unique position of religious communities in facilitating such a process.

Pervasive poverty and the unique position of alcohol in township financing (Rogerson and Parnell, 1989, p. 17) features throughout the body of texts under discussion. Several studies suggest that the relaxation of law enforcement around illegal alcohol trade in townships has been driven by the centrality of the alcohol trade to the township economy. Poverty is understood as an enduring legacy of South Africa's apartheid past, fostered by socio-spatial engineering and perpetuated by the country's massive unemployment levels (Robins, 2002).

In addition, poverty is cited as a driver for problem drinking and alcohol abuse (Lawhon, 2013; Seekings and Thaler, 2014; Makanga et al., 2015).

Several studies from the alcohol industry-funded Sustainable Livelihoods Foundation (Charman and Petersen, 2010; Charman, Petersen, et al., 2014; Charman, Petersen, Hartnack and Clark, 2009; Charman, Petersen and Piper, 2013) point to the role of shebeens as so-called incubators of black entrepreneurship, and the importance of shebeens in providing employment. For example, according to Charman et al. (2009), shebeens provide employment to 77 800 people in the Western Cape – employment, they maintain, that is threatened by stricter alcohol law enforcement. This figure is based on an estimate by Charman et al's of 20 500 illegal shebeens in the Western Cape, which is 257% higher than the number of 6 000 to 7 000 estimated by the SAPS, as cited in the same article. These studies also draw only on shebeen owners and other operators in the alcohol industry as key informants and fail to engage with the general population.

The women who participated in Kane's (2009) study described a very specific experience of poverty, informed by a pervasive sense of insecurity, lack of safety and lack of protection for their children, and they made a direct link between their experience of poverty and the alcohol abuse of male partners and neighbours. The flip side of the experience of these women is suggested by Herrick (2014), whose study positions drinking and visiting shebeens as the only rational option for the poverty-stricken populations of Western Cape townships.

Du Toit and Neves (2006, 2007) document the establishment and management of shebeens as a way of surviving outside the formal economy for unemployed residents of Khayelitsha and the Eastern Cape. The illicit sale of alcohol in townships, like Khayelitsha is posited as both a driver of and an alleviator to pervasive conditions of poverty (Herrick, 2014; Herrick and Parnell, 2014), but these authors fail to engage with the majority of the population in each case, with their sampling biased in favour of those who do gain materially from the sale of alcohol.

Industry-funded research instead highlights the potential of shebeens as entrepreneurial enterprises to influence poverty levels in Western Cape townships (Charman and Petersen, 2010) and the unintended effects of the stricter regulations imposed by the Western Cape Liquor Act of 2008 on shebeens, towners and customers (Petersen and Charman 2010). Based on Petersen and Charman's case study, the mass closure of unlicensed shebeens had dire consequences for the livelihoods of shebeen owners and their employees (many of whom have never been employed in the formal economy). The case study draws on their previous work, data from media reports, policy documents and interviews with shebeen operators, as well as a discussion forum with 31 shebeen owners conducted in 2010. Input of members of the broader community is, again, conspicuously absent. According to shebeen owners interviewed by them, the stricter regulation of the flow of alcohol to shebeens has had the

undesirable effect of encouraging the manufacture of illicit alcohol, with deadly consequences for some patrons. The evidence for this is limited to a newspaper report (Mtyala, 2009).

The effects of what is typified as poor law enforcement strategies are expanded upon by Charman, Petersen, and Piper (2013). They maintain that current enforcement strategies are tying shebeen owners to the informal economy, hamstringing efforts to migrate informal businesses into the formal economy. Again, these authors rely on interviews with shebeen owners only, privileging the concerns of those who sell alcohol, whether legally or illegally, over the concerns of the communities at large in which alcohol merchants operate. Of the 117 shebeen operators in their sample, only 41% had actually made some effort to apply for licencing, with new businesses, businesses with low capital and businesses with a low turnover failing to do so; those who had applied for licences were notably well-resourced and had extended business networks that provided them with support. One respondent captures what is possibly at the heart of the lack of formalising:

"*Government expectations are not only stupid but undermine the reasons that people have gone into shebeening [sic] in the first place, to make money.*" (Charman et al., 2013, p. 593)

2.3.6. The alcohol-crime nexus

Criminality, law enforcement and policing are prominent features of the texts under discussion. Alcohol use is viewed as a key driver of crime (Parry et al., 2000; Leggett, Louw, Parry, Pluddemann and Burton, 2002; Robins, 2002; Parry, Plüddemann, Louw and Leggett, 2004; Ward, 2007; Goga, 2014a, 2014b; Freeman and McDonald, 2015), especially violent crime (Ward, 2007; Thaler, 2012; Faull, 2013; Seekings and Thaler, 2014) and sexual crime (Jewkes and Abrahams, 2002; Gibson, 2003; Sawyer-Kurian et al., 2009; Thaler, 2012; Wechsberg et al., 2013). The difficulties of enforcing alcohol policy and policing crimes where alcohol has played a significant role are also well represented (Charman et al., 2013; Faull, 2013; Lawhon, 2013; Charman, Herrick, et al., 2014; Drivdal and Lawhon, 2014; Herrick, 2014; Freeman and McDonald, 2015).

The three-metros study (Parry et al., 2000; Leggett et al., 2002; Parry et al., 2004) presents a large body of work on the relationships between alcohol and substance use and crime in Cape Town, Durban and Johannesburg. When arrestees in these areas were subjected to urinalysis, a significant proportion tested positive for alcohol or other substances. This was especially true for those arrested on housebreaking or alcohol- and drug-related offences, as well as those with previous arrests (Parry et al., 2004). The use of alcohol and other substances as a driver for rape and sexual coercion is noted by Jewkes and Abrahams (2002). While men arrested on rape or attempted rape charges are likely to test positive for alcohol or other substances (Leggett et al., 2002),

women who are inebriated are also more likely to become victims of rape and other sexual crimes (Jewkes and Abrahams, 2002). Gibson (2003) finds the persistence of violent masculinities to be one driver of alcohol abuse in sexual violence and rape.

Crime and alcohol abuse are traced back to the same structural drivers by Robins (2002), and the two are linked inextricably to persistent poverty and inequality between the middle and working classes. This presents significant challenges for the policing of substance-fuelled crimes, as current efforts at law enforcement fail to reflect the complex nature of these combined problems.

It seems as if the policing of crime tends to focus on spatial control and management (Robins, 2002; Ward, 2007; Faull, 2013; Lawhon, 2013; Charman, Herrick, et al., 2014; Charman, Petersen, et al., 2014; Drivdal and Lawhon, 2014; Goga, 2014b; Herrick, 2014; Pirie, 2014; Seekings and Thaler, 2014; Smit, 2014; Smit et al., 2016). This tendency is reflected in the Western Cape Liquor Act (Western Cape Government, 2008), which outlines quite specific ways the geographical bounds of appropriate and inappropriate alcohol use and distribution. This is perhaps also reflective of the persistence of South Africa's apartheid legacy and the socio-spatial engineering that characterised it (Rogerson and Parnell, 1989; Smit et al., 2016).

The Western Cape Liquor Act (Western Cape Government, 2008) is discussed in 14 texts (Charman, Petersen, Hartnack and Clark, 2009; De Vries, 2010; Matzopoulos et al., 2010; Petersen and Charman, 2010; Lawhon and Herrick, 2011; Charman et al., 2013; Faull, 2013; Lawhon, 2013; Charman, Herrick, et al., 2014; Charman, Petersen, et al., 2014; Herrick, 2014; Herrick and Parnell, 2014; Lawhon et al., 2014; Smit, 2014), specifically those written in the context of a geography, economics or criminology framework. The Act provides the State with significant power in the policing of alcohol trade and consumption (Charman et al., 2013) and it is credited with a significant drop in crime in the Western Cape (De Vries, 2010). Faull (2013) sites the 2012/2013 crime statistics presented by the SAPS in September 2013, indicating that more than 1.8 million litres of alcohol had been confiscated in that period, with 74 547 illegal liquor outlets closed. In the previous year, more than 1.1 million litres of alcohol had been confiscated and 92 929 illegal liquor outlets closed.

However, the practical application of the act has come under fire from several corners. In terms of policing, Faull (2013) highlights the impossibility of police officers to enforce alcohol legislation and prevent and prosecute alcohol-related crimes on their own and in ways that are not context-specific. The contextual differences in the policing of alcohol consumption and distribution, between what is said and what is done, are also raised by Herrick (2014). Freeman and McDonald (2015) provides some strategic guidance in this regard by emphasising the utility of cooperative relations between the police's internal structure (the Khayelitsha police station in this case) and external institutional relations, namely police forums, such as cluster offices, specialised units, metro

and traffic police; public services, including health, education and emergency services; justice mechanisms, in the form of courts and prison services; civic and institutional oversight bodies; and community relations.

2.3.7. Spatial management and the socio-spatial contours of alcohol use

The spatial management of alcohol, or what Robins (2002) describes as spatial governmentality, is frequently invoked in the corpus of texts analysed. In the South African context, spatial management is inextricably linked to apartheid segregation policies (Rogerson and Parnell, 1989), and its place in post-apartheid literature provides important contextual information, linking the use of alcohol in townships, like Khayelitsha, to the enduring legacy of apartheid (Robins, 2002; Lawhon, 2013; Charman, Herrick, et al., 2014; Charman, Petersen, et al., 2014; Drivdal and Lawhon, 2014; Goga, 2014b; Herrick, 2014; Smit, 2014; Wechsberg et al., 2014; Smit et al., 2016;).

Scholars consistently point out that alcohol use and abuse and the effects thereof are actualised through socio-spatial management and manipulation (Charman, Herrick, et al., 2014; Charman, Petersen, et al., 2014; Herrick, 2014; Lawhon et al., 2014; Pirie, 2014; Puljević and Learmonth, 2014; Wechsberg et al., 2014; Seekings and Thaler, 2014; Smit, 2014; Smit et al., 2016). This has implications for the ways in which alcohol policy is developed and implemented, suggesting that problem use, whether it pertains to the negative effects of alcohol as outlined in most of the texts in this review, or to problem drinking as defined by Peltzer et al. (2011), is inextricably tied to the socio-spatial context in which it occurs. The insistence by Lawhon (2013) and Charman et al. (2013) that shebeens as counter-hegemonic, albeit illegal, spaces during the apartheid era cannot be separated from current understandings of the concept today, seems to suggest a kind of legacy pass for shebeens, a discursive strategy that overlooks the negative impact of shebeens in the areas in which they operate based on historical and sentimental significance. Furthermore, Charman, Herrick, et al. (2014), Charman, Petersen, et al. (2014), Herrick (2014) and Lawhon et al. (2014) are highly critical of the ways in which alcohol use and abuse have been envisioned as either public health problems or problems of criminality and governance. They invoke the role of socio-spatial context of alcohol use in the South African landscape to argue for a more nuanced and contextually appropriate way of regulating the use of alcohol. They are especially critical of the Western Cape Liquor Act (2008) and how its focus on the shebeen industry further entrenches discourses of township criminality. However, these authors consistently fail to take into account the upstream determinants of health, and the role of alcohol use therein. When one takes into account the work done by Faull (2013) and Freeman and McDonald (2015), it becomes clear that the problem lies not with the alcohol policy, but rather with its application. Effective strategies to address alcohol use needs to be implemented on both the supply and demand sides, and strategies need to be intersectoral and sensitive to

contextual factors (Matzopoulos, Bowman, Mathews and Myers, 2010; Matzopoulos and Myers, 2014).

2.4. CONCLUSION

A review of existing scholarship around alcohol use and alcohol-related harms in Khayelitsha reveals very specific ways in which alcohol and its users are portrayed. Alcohol is often conceptualised in relation to criminality, including interpersonal violence, health-related outcomes, economic factors, socio-spatial management, gender and youthfulness. Although most articles explore the effects of the intersections of some of these factors, none – with the exception of Oni et al. (2012) and Matzopoulos et al. (2010) – take into account the intersection of all factors, suggesting that scholars rarely see the complete picture when it comes to alcohol-related harms and the prevention of alcohol abuse. This might also stand as explanation for the differences in policy recommendations made by those scholars reading alcohol-related risk through the contextual lens of poverty (Charman et al., 2009; Charman and Petersen, 2010; Charman et al., 2013; Charman, Herrick, et al., 2014; Charman, Petersen, et al., 2014), compared to those who read the issue through the lens of public health (Jewkes and Abrahams, 2002; Gibson, 2003; Kane, 2009; Lawhon and Herrick, 2011; Myers et al., 2013).

When compared to the WHO's (2010) *Global Strategy*, the literature provides an indication of action in the area of leadership, awareness and commitment, in the form of the Western Cape's legislative reforms, although there seems to be a lack of interagency coordination, which is seen as a key intervention in this area (Myers, 2015). Related to this area of interest, the literature engages briefly with other areas of legislative control, namely drunk-driving policies and policies regulating the availability and marketing of alcohol, pricing policies, and monitoring and surveillance. The literature also shows significant engagement with the health services sector, while a small number of studies cover the public health impact of illicit and informally produced alcohol and community action. There is a serious lack of engagement with evidence-based interventions.

The lack of literature related to alcohol use and its effects among marginal communities, including queers, the disabled and sex workers, present a gap in the existing research. It is recommended that these communities be included in further engagement on the topic, as their added layers of vulnerability in the context of Khayelitsha might illuminate aspects of vulnerability in the broad population that might have gone unnoticed in previous studies.

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Part 3: Household Survey

Compiled by Sam Lloyd, Kim Bloch and Richard Matzopoulos

3.1. BACKGROUND

This section reports on the preparation, execution and analysis of results of three phases of a community survey in Khayelitsha, Cape Town, South Africa for the Department of Community Safety (DoCS) project: *Research on alcohol use and community perceptions towards unlicensed liquor outlets in Khayelitsha*. These surveys were conducted in 2013, 2014 and 2015 as part of two – International Development Research Centre (Canada) and the Department for International Development (United Kingdom) – funded projects, involving a panel of 1 200 dwellings.

Results presented pertain to the nature and extent of the alcohol trade in Khayelitsha; community perceptions and receptiveness to available interventions; experiences and perceptions of violence, and its association with alcohol use; community participation and mental health outcomes.

3.2. METHODS

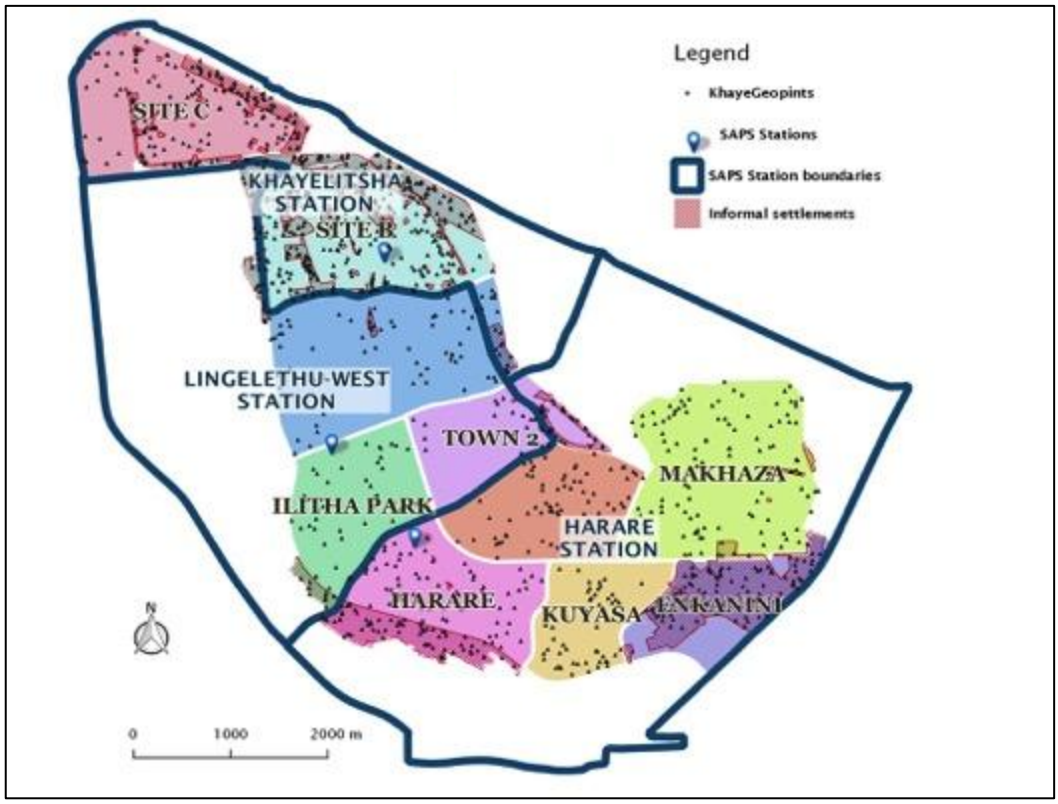
3.2.1. Sampling frame

For the Khayelitsha survey, it was decided that a total of 1 200 dwellings would be visited, given constraints in costs and time. The sample was drawn from GIS data of dwelling units in the designated study area in Khayelitsha.

In 2014 and 2015, the content and fieldwork methodology remained similar with few changes, with fieldworkers initially returning to the same houses that comprised the final sample of the 2013 interviews. The interview was conducted here only if the previous occupants had moved (thus the interviewee was a new person) as it was felt that having been previously interviewed may have affected participants' opinions and awareness of certain programmes, which were part of the outcomes measured by the questionnaire. If the household had previously been interviewed, substitution took place.

A map of sample points can be seen in Figure 1.

Figure 1: Map of survey sample points (2013)



3.2.2. Individual respondent selection

At each dwelling visited, the primary household was first identified. A household member was defined as someone who shares in and/or contributes to a common pool of resources. For example, a household member might be someone who eats with other household members every night and contributes financially to the maintenance of the home. The main household (either owned or occupied) is the largest dwelling at the selected address. If there were other households or individuals living in backyard dwellings or extra rooms these were defined as secondary households.

Main household respondent: The female head of the household, in the primary household, answered the main household questionnaire. This was defined as the oldest female member, where that person was capable of answering the questions. Where there was no female adult in the house, a male adult could be a substitute.

Young adult respondent: The main household questionnaire asked the respondent to list all household members and their dates of birth. This was then used to identify the young adult in the household born closest to June 1990, who answered the young adult questionnaire. If there were any secondary households, the young adult born closest to June 1990 in these households was also approached to complete the questionnaire. If there were multiple secondary households, only one young adult (born closest to June 1990) from

all the secondary households was recruited. It was thus possible that no young adult surveys would be administered at a dwelling, if there were no young adults in any of the households. It was also possible that either one or two young-adult questionnaires would be completed.

3.2.3. Questionnaire

The main household questionnaire was compiled by the research team and included basic demographic information about all household members as well as sections addressing urban upgrading and alcohol policy. The young adult questionnaire centred more on alcohol behaviours and attitudes, but also included some sections from the main household questionnaire.

***Main household questionnaire*:** The main household questionnaire was designed to get an overview of the household as well as solicit opinions and experience of one senior household member. It consisted of eight sections:

1. Household identifiers
2. Household demographics
3. Additional information about the main household
4. Urban upgrading – physical
5. Urban upgrading – social
6. Experience of violence
7. Liquor policy and enforcement
8. Active organisations and programmes

Young Adult Questionnaire: Sections 4, 5, 6 and parts of 8 were adapted and included in the young adult's questionnaire. In addition, a section on alcohol consumption and dependence was included. This section is taken from the International Alcohol Control (IAC) questionnaire, but abridged and modified, including input from partners and specialists. For example, the frequency scale on one question was made less specific, matching other standardised instruments, such as the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST). Some questions were adjusted to include local examples and a few were included to determine illegal access to alcohol. A question on weapon possession was included after suggestion from Gun Free SA to include questions about gun possession. Questions addressing dependence and treatment and were also taken from IAC questionnaire but changed to the frequency scale used on the Alcohol Use Disorders Identification Test (AUDIT).

Piloting: A pilot of the survey was conducted in May 2013. Fieldwork supervisors acted as fieldworkers for two days and visited seven randomly selected points in one small area. Feedback from the pilot was incorporated into the final questionnaire. On the whole, supervisors felt able to read maps and confident that they would be able to execute the survey.

***Finalisation and translation*:** Small changes were incorporated after the pilot in response to ambiguities and other issues raised by fieldworkers.

The entire questionnaire was not translated, and it was required that fieldworkers be able to speak and read both English and isiXhosa, in case they needed to help explain concepts to interviewees. However, for the mental health and wellbeing section some phrases were deemed too subjective to rely on fieldworker translations. For consistency some of these questions were written in both English and isiXhosa.

3.2.4. Fieldwork process

Supervisors: Supervisors were each issued with maps of their designated areas, with points on the dwellings that they were assigned to visit. The supervisor was then responsible for assigning a fieldworker to conduct interviews at the household and manually recording this assignment. The supervisor was also responsible for ensuring the fieldworker correctly recorded the map reference number (written on the map) on all the questionnaires. In 2013, responses were recorded on paper questionnaires and in 2014 and 2015 mobile phones were used to record the data, making use of the Open Data Kit app.[2]

***Fieldworkers*:** Fieldworkers reported to field supervisors and were responsible for the administration of the questionnaire. Fieldworkers were paid per completed household.

***Quality control*:** Supervisors were responsible for looking over each fieldworker's questionnaires before handing them over to the fieldwork coordinator.

On a weekly basis, the fieldwork coordinator chose five respondents (one from each supervisor's list of reported visits) to call and verify. This call involved checking that the fieldworker had been to the interview at the reported time, behaved appropriately and completed the questionnaire. In addition, the fieldwork coordinator would verify that the number of reported household members was correct and that all appropriate interviews had been completed.

3.2.5. Data capture

In 2013 data capturing was handled by the in-house data capturers at the Medical Research Council (MRC), who provided the data on an excel spread sheet. In 2014 and 2015, fieldworkers captured data onto mobile phones.

[2] Open Data Kit is an open source mobile data-gathering tool, operating on android devices (s. See opendatakit.org).

3.2.6. Ethics approval

A revised ethics approval for the full questionnaire was granted by the Research Ethics Committee of the Health Sciences Faculty of the University of Cape Town.

3.3. RESULTS

The results presented below represent only those from the main household questionnaire. The young adult survey will be reported in Part 4. All results and percentages are reported for only those who answered the question.

At times results are discussed in terms of differences between police precincts and police precinct sectors (see Figure 2).

3.3.1. Description of households

Data was available for 3 411 households, 2 968 (87%) reported to have a formal electrical connection, while 289 reported an informal connection and 154 reported having no electrical connection. 1 400 out of 3 410 households (41%) have a floor level above ground level, while 300 had a floor below ground level, and 1 710 were level with the ground. 355 out of 3 410 dwellings (10%) have gardens. 47% of households were located in an informal area.

The table below indicates the most commonly used materials in walls of selected dwellings.

Table 1. Wall material of main dwelling

	Frequency	%
Bricks	630	18
Blocks	1 046	29
Corrugated iron	1 586	44
Wood	315	9

3.3.2. Perceptions of neighbourhood, facilities and services

3.3.2.1. Tenure

Table 3 outlines the respondents' reported housing situations. 88% and 68% say their homes are theirs and affordable, respectively. Most people say their neighbourhoods are good, safe and clean (72%, 46% and 57% respectively).

Many respondents (79%) say they will still be in their current dwelling in five years' time, while 15% say they will not. Of the 548 people reporting that they would not still be in the same dwelling, 5% reported that they would be moving closer to work and 15% reported moving for family reasons. 70% reported planning to move to a better/formal neighbourhood and 2% stated they had no choice but to move, as they would be evicted.

Figure 2: SAPS Khayelitsha police precincts and sectors

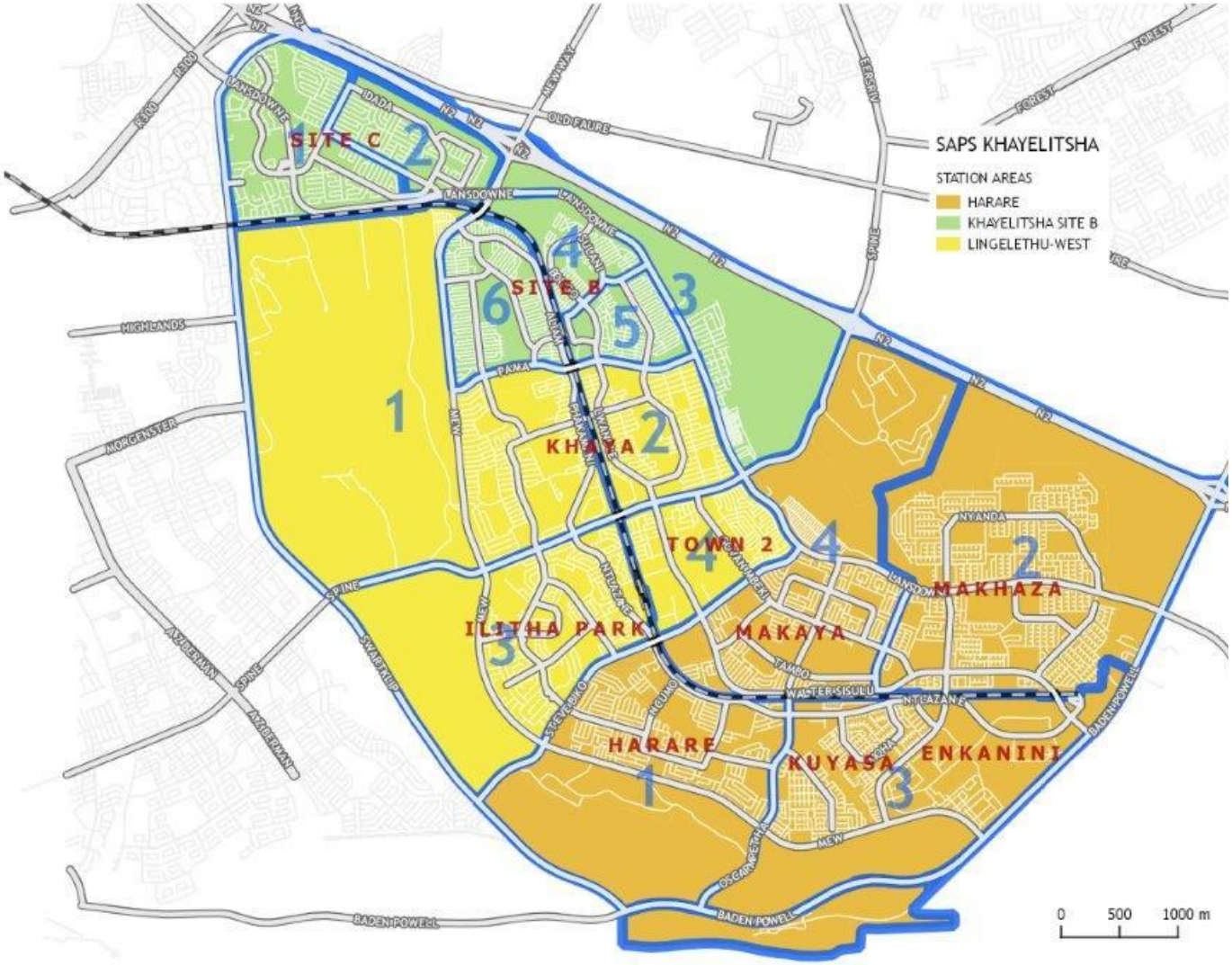


Table 3: Summary description of housing situation

Ownership	88%
Affordable	68%
Close to amenities	63%
Home is large and spacious	44%
Adequate services	52%
Neighbourhood is good	72%
Neighbourhood is safe	46%
Neighbourhood is clean	57%
Neighbourhood is private	42%
Housing needs maintenance	70%
Housing situation: bad landlord	31%

3.3.2.2. Opinions of infrastructure and services

Table 4 gives people's opinions about various infrastructure and services. Most people were satisfied with basic services, such as water, electricity and refuse removal (74%, 66% and 79% respectively). Only a minority of people were happy with the condition of green areas (20%) and open spaces (26%).

Table 4. Satisfaction with condition and maintenance of neighbourhood infrastructure?

	Yes	No	Unsure	Non-existent
Roads	54%	37%	2%	8%
Storm water drainage	47%	40%	2%	10%
Streetlights	35%	41%	5%	19%
High-mast lights	62%	24%	3%	11%
Electricity	66%	30%	1%	3%
Refuse removal	79%	18%	1%	2%
Green areas	20%	53%	6%	20%
Open spaces	26%	49%	5%	19%
Sport facilities	30%	44%	9%	18%
Water taps	74%	21%	2%	3%
Toilets	50%	37%	2%	10%

3.3.3. Wellbeing, social cohesion and participation

3.3.3.1. Mental health

The shortened 10-item version of Centre for Epidemiological Studies Depression (CESD-10) scale, which contains 10 questions relating to respondents' experiences over the previous week of different

symptoms of depression, was administered to all main household respondents. With potential scores ranging between 0 and 30, a score of 11 or more usually reflects mild or significant symptoms of depression. The median score of respondents was seven, with the middle 50% of respondents falling between scores of four and 10. High levels of depression in the community were identified, with 769 people (22% of respondents) scored 11 or higher.

Table 5 below describes the proportion of respondents with a CESD score of 11 or more, broken down by experience of different forms of crime over the past year. The results strongly suggest that being affected by crime is associated with a higher likelihood of depression. For example, 47% of those who had experienced some form of violence within their household reached the cut-off for likely depression, compared to 21% of those who had not.

Table 5: Experience of likely depression by crime experience in the last year

Crime experienced	Likely depression (CESD ≥ 11)	
	Yes	No
Property taken with actual or threatened violence	31%	20%
Anyone close to you murdered	31%	21%
Injured with a weapon on purpose	35%	21%
Injured without a weapon	27%	22%
Violence within the household	47%	21%
Rape or the fear of rape	35%	22%

3.3.3.2. Community participation

Of 3 606 respondents, 1 363 or 38% had attended a community meeting to discuss urban upgrading, safety, facilities, services or any other neighbourhood problems in the past year. Out of these 1 363 people, 839 (57%) reported having found this meeting useful. Table 6 shows a more detailed breakdown of reported community involvement.

These results indicate a relatively high level of community involvement, though the high proportion of respondents attending public meetings and over one in five being actively involved in a group discussing local problems or taking part in a public demonstration may be indicative of the high levels of community problems that exist.

Table 6. Community participation in the past 12 months

	Yes	No
Attended a public meeting or rally	70%	30%
Taken part in public demonstration	21%	78%
Signed a petition	21%	78%
Completed a questionnaire about local services or problems	22%	77%
Been actively involved in a group discussing problems	27%	72%
Been involved in social/religious/hobby group	36%	64%
Been involved in a voluntary security-related org	10%	90%
Been involved in another voluntary org	9%	91%

3.3.4. Perceptions and experiences of violence

3.3.4.1. Personal experience of the past year

Table 7 shows reported personal experiences of crime over the past year. The most common forms of violent crime affecting respondents were petty theft (14%) and robbery/home invasion (12%), while 8% had been affected by a murder. The incidences for other forms of crime over the previous year were reported to be relatively low.

Table 7. Personal experiences of crime in the last year (no.=3 606)

Robbery/home invasion	12%
Petty theft	14%
Murder	8%
Assault with a weapon	3%
Assault with no weapon	4%
Domestic violence	3%
Rape	1%
Car hijacking	1%
Arson	2%
Crimes targeting minorities	4%
Drug trafficking	0%
Community justice	3%

Table 8 shows where criminals in the area are thought to come from. The majority of respondents thought that most acts of violence were committed by people from their area, or in collaboration with people living outside the area.

Table 8. Perceptions on the origin of perpetrators

The person/people committing violence are:	
Living within the neighbourhood	53%
From outside sub-area but same large area	15%
From outside Khayelitsha	2%
From outside area, but in collaboration with locals	30%

3.3.4.2. Household members' involved in violence

5% reported a household member being involved in violence between family members in the past year and 7% reported a household member involved in violence between strangers. Of the incidents between family members, 68% reported alcohol involvement and 20%

reported drug involvement.[3] 51% of victims went to hospital and 58% reported the incident to the police. Of the incidents between strangers, 43% were reported to involve alcohol involvement and 27% had reported drug involvement. 38% of victims went to hospital and 47% reported the incident to the police.

The high proportion of violent incidents (both between family members and strangers) where alcohol involvement was reported provides further evidence of the link between alcohol consumption and violence in Khayelitsha, and thus the need to address alcohol use as a risk factor for violence.

3.3.4.3. The role alcohol and drugs play in violence

Similar findings to the above can be found in Table 9, which shows the perceived involvement of alcohol in neighbourhood violence. Alcohol and drugs are perceived, by more than half of the respondents, to be commonly involved in violence in their neighbourhood, with a third of people thinking that alcohol and drugs are involved some of the time.

Table 9. Perceived contribution of alcohol and drugs to violence

	Most of the time	Sometimes	Hardly ever
Does alcohol contribute to violence in this neighbourhood?	49%	40%	11%
Do drugs contribute to violence in this neighbourhood?	60%	32%	8%

In a similar vein, Table 10 shows the perceived substance use of both victims and perpetrators of crime. Perpetrators are most commonly perceived to be drunk or high on hard drugs, while about a quarter of the people say that victims are mostly drunk.

Table 10. Perceived sobriety of victims and perpetrators of crime

	Drunk	High (cannabis)	High (hard drugs)	Drunk and high	Sober	Unsure
Perpetrators (no.=3 615)	32%	7%	34%	16%	4%	8%
Victims (no.=3 583)	24%	2%	11%	6%	44%	13%

[3] It was not specified whether this was alcohol/drug use on the part of the perpetrator, or the victim.

3.3.4.4. Weapons

Respondents were also asked what weapons were carried and when household members carried them. 5% of people reported that a member of their household carried a weapon for self-defence. Of these 180 people, 62 reported guns and 106 reported knives. 30 reported carrying them all the time, 79 reported carrying them some of the time and 45 reported carrying them at night only.

3.3.5. Liquor policy and enforcement

3.3.5.1. Alcohol access

Respondents were asked which type of alcohol outlet is closest to their home. As shown in Figure 3 below the most common answer provided, in both formal and informal areas, was a shebeen, indicating the limited number of formal regulated establishments in the study area. As expected, residents of formal areas were more likely to have a licensed establishment nearby compared to residents of informal areas.

In all three police precincts respondents were much more likely to report that the type of outlet nearest to their home is a shebeen. This pattern was much less pronounced in Lingelethu West however, where only 59% reported this, compared to 83% in Harare and 84% in Site B. This difference is largely due to a higher proportion of respondents in Lingelethu West reporting that licensed taverns are the closest to their home (37% in Lingelethu West, compared to 15% and 11% in Harare and Site B respectively). (See Appendices Table 1.)[4]

[4] Due to differences in the way answers were recorded in 2015 compared to 2013/14 only results relating to the 2013/14 surveys are included here.

Figure 3. Type of outlets reported near dwellings

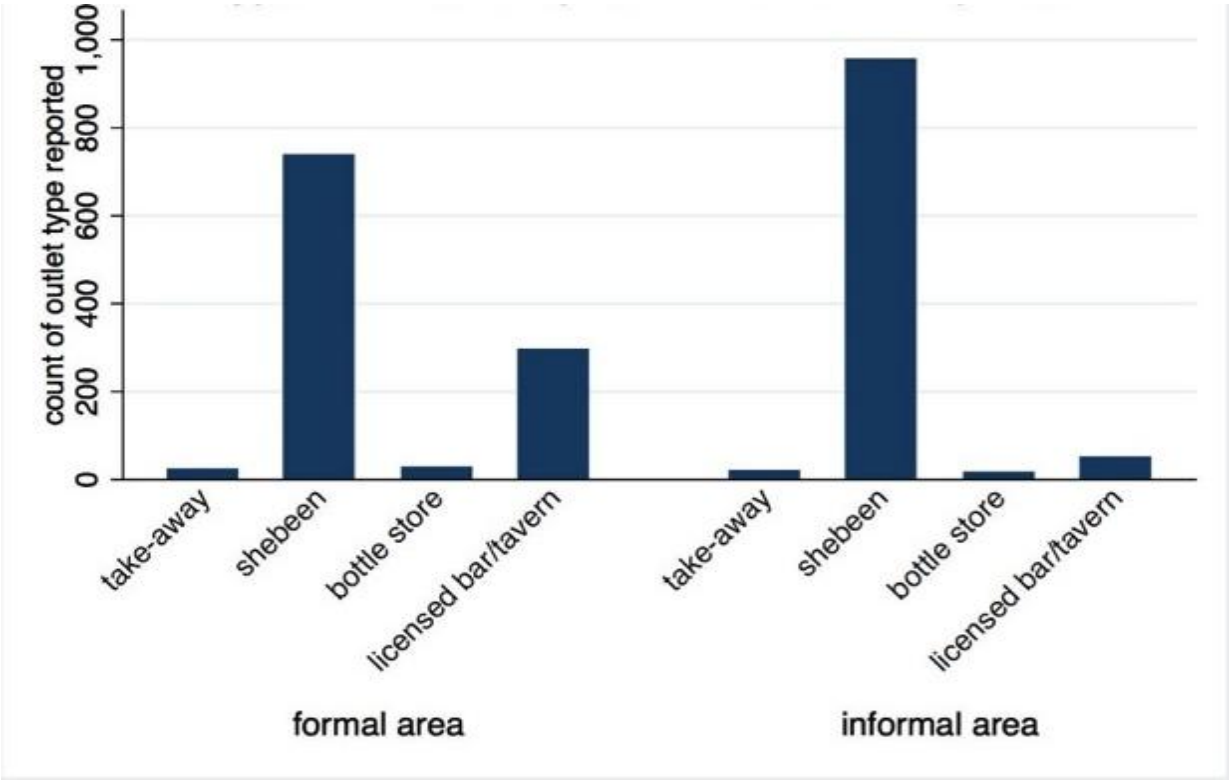


Table 11 shows the time taken to get from respondents' homes to the nearest alcohol outlet, broken down by the time of week and the type of outlet. Respondents reported the nearest alcohol outlet to them to be a median three minutes from their dwelling during a weekday, five minutes on a week evening, five on a weekend day, and five on a weekend evening.[5] This implies easy access to alcohol for a great majority of community members.

Table 11. Minutes to nearest outlet

Minutes to nearest outlet	no.	Median	Inter-quartile range
Weekday			
Shebeen	1 348	5	2 – 10
Take away	31	10	4 – 15
Licensed tavern	299	5	3 – 10
Bottle store	28	5	5 – 10

[5] Results are from 2013 and 2014 only.

Weekday evening

Shebeen	1 336	5	2 – 10
Take away	31	10	4 – 15
Licensed tavern	293	5	4 – 10
Bottle store	27	5	5 – 10
Weekend			
Shebeen	1 347	5	2 – 10
Take away	31	10	4 – 15
Licensed tavern	298	5	4 – 10
Bottle store	27	5	5 – 10
Weekend evening			
Shebeen	1 327	5	2 – 10
Take away	30	8	4 – 15
Licensed tavern	291	5	4 – 10
Bottle store	25	5	5 – 10

The only clear difference between police precincts appears to be the average time taken to go to a licensed tavern, which is roughly twice as long in Lingelethu West (median 10) compared to in Harare (five) and Site B (five) (see Appendices Table 2).

3.3.5.2. Opinions on alcohol and drug consumption in neighbourhoods

The need to address unlicensed alcohol outlets is highlighted again by the fact that 42% of 3 611 respondents think that shebeens have more violence than licensed outlets. (27% disagreed and 31% did not know.)

Table 12 shows peoples' experience of drinkers in their neighbourhoods. Demonstrating the potentially antisocial aspects of liquor outlets, about a third of respondents had had an unpleasant incident, such as a drinker urinating or vomiting near their property, and about a third had been concerned about noise from a nearby outlet.

Table 12. Experience of drinkers in neighbourhood

Felt threatened by drinkers	22%
Been concerned by noise from nearby outlet	34%
Called police for alcohol-related disturbance	14%
Had someone urinate or vomit near their property	33%

Tables 13 to 16 reflect peoples' perceptions of others' drinking and drug use patterns. Most people think that half or more of the people in their area drink alcohol, drink until drunk and drink too much. The most common perception of hard drug use is that only a minority of people do this.

As such, it appears that alcohol use is considered by community members to be more of a problem than the use of hard drugs, such as *tik* or mandrax, and thus should be given greater weight in the development of policy and interventions.

Table 3 in the Appendices provides a stratification of these results by police precinct. These results indicate that in the opinion of respondents, levels of alcohol use and excessive alcohol use are higher in Harare than in Lingelthu-West or Site B.

Table 13: Opinions on drinking too much

How many people here drink too much?	Frequency	%
Almost all	1 244	34.4
About half	1 530	42.4
Not many	838	23.2

Table 14: Opinions on drunkenness

How many people here drink alcohol until drunk?	Frequency	%
Almost all	1 560	43.5
About half	1 193	33.3
Not many	832	23.2

Table 15: Opinions on alcohol consumption

How many people here drink alcohol?	Frequency	%
Almost all	1 403	38.8
About half	1 468	40.6
Not many	744	20.6

Table 16: Opinions on drug use

How many people here use tik or mandrax?	Frequency	%
Almost all	676	19.1
About half	1 023	28.9
Minority	1 574	44.5
No-one	263	7.4

3.3.5.3. Observed interventions in neighbourhoods over the past year

Table 17 shows interventions, which the respondents reported having observed over the previous 12 months. Respondents seem to indicate that outlet regulation or self-policing has increased, but 16% more people also indicated that they had observed more liquor industry activities supporting community events over the past year.

Table 17: Observed alcohol-related activities

In the past year have you noticed:	
Shebeens closing earlier	43%
Fewer shebeens/more closed down	30%
Improved shebeen facilities	22%
Better security and management	23%
More liquor industry activities supporting comm events	16%

Table 4 in the Appendices shows that a higher proportions of respondents in Site B report that they have observed changes across the range of variables.

3.3.5.4. Alcohol policy support

Support for a variety of alcohol-targeted interventions is high, as depicted in Table 18. Interventions that do not receive as much support (though still over 50%) however, are those relating to restrictions on liquor industry marketing activities. Little difference is seen between police precincts, aside from slightly higher levels of support in Lingelethu West (see Appendices Table 5)

Overall, the high levels of support for most interventions should be seen as indicative of community members' perceptions that alcohol use in their communities is a problem that must be addressed.

Table 18. Alcohol intervention support (no. = 3 616)

Respondents support:	%
Purchase age of 21	80
Restricting number of outlets	75
Earlier closing hours for onsite licenses	93
Earlier closing hours for off-site licenses	92
Increase prices	87
Random breath testing	93
Taxes to pay for alcohol treatment	86
Taxes to lower other taxes	85
Taxes for any other Government purpose	89
Taxes for other harms	84
More police raids	92
Restrictions on TV/radio marketing	63
Restrictions on billboard marketing	63
Restrictions on sponsorship	63
Restrictions on alcohol promotions	60

3.3.6. Active organisations and programmes

Table 19 reflects awareness of various initiatives over the past year.
The types of initiatives respondents were most aware of were social development initiatives, youth development programmes (50%) and early childhood development programmes (45%). This is followed by reduced closing times for outlets in collaboration with neighbourhood watches (NHWs) (38%).

Table 19. Knowledge of initiatives in area (no.=3 658)

Are you familiar with any of the following programmes?	%
Reduced closing times for outlets in collaboration with neighbourhood watch	41
The development of a high street or clustering of liquor outlets	17
A safe-shebeen pilot project	17
Initiatives to diversify trade and retailing in your area	19
Provision of recreational activities	22
Provision of mental health programmes	19
Skills development programmes	38
Measures to improve access to police and justice services	25
Measures to improve access to social welfare services	26
Urban upgrading	38
Media campaign about alcohol or violence	22

Treatment programmes for alcoholics and substance abusers	20
Employment programmes	34
Training of liquor outlet staff in the responsible serving of alcohol	13
Services for victims of violence	21
Provision of transport alternatives for drunk drivers and walkers	10
School based alcohol and substance abuse education programme	26
Early childhood development programmes	47
Family or parenting programmes	37
Programmes trying to challenge gender norms	28
Youth development programmes	53

PART 4: KHAYELITSHA HOUSEHOLD SURVEY REPORT: YOUNG ADULTS

Compiled by Sam Lloyd, Kim Bloch and Richard Matzopoulos

4.1. BACKGROUND

This section presents a basic summary of results of three phases of a community survey of young adults in Khayelitsha, Cape Town, South Africa for the Department of Community Safety (DoCS) project: *Research on alcohol use and community perceptions towards unlicensed liquor outlets in Khayelitsha* instituted in response to the request of the Commission. The surveys were administered in addition to a broader but overlapping household survey, administered to the head of household. These surveys are three annual surveys conducted between 2013 and 2015 as part of two, International Development Research Centre (IDRC) and Department for International Development (DfID), funded projects, involving a panel of 1 200 dwellings.

Results presented pertain to the nature and extent of the alcohol trade in Khayelitsha; community perceptions and receptiveness to available interventions; drinking patterns and alcohol-related problems among young people; experiences of violence; and mental health outcomes.

4.2. METHODS

More detailed methods can be found in Part 3 of this report, which describes the main household survey.

4.2.1. Sampling frame

For the entire survey, it was decided that a total of 1 200 dwellings would be visited, given constraints in costs and time. The sample of 1 200 dwellings was drawn from Geographic Informal System (GIS) data of dwelling units in the designated study area in Khayelitsha.

4.2.2. Individual respondent selection

First the primary household was identified, then the secondary dwellings (backyard and extra rooms). The main member was the owner or the person financially contributing to common resources and maintenance of the largest home at the selected address.

Main household respondent: The female head (usually the oldest woman) of the household, in the primary household, answered the household questionnaire.
A male substituted only when there was no female present or capable of answering the questions.

Young adult respondent: The main household questionnaire required a list
of all household members and their dates of birth. This was used to identify young adults born closest to June 1990, who then answered the young-adult questionnaire. This also occurred in secondary households, but no more than two young adults were chosen from each selected address.

4.3. RESULTS

Unless otherwise stated, all results and percentages are reported for only those who answered the question.

4.3.1. Description of interviews and households

In 2013 a total of 513 young adult interviews were completed. Of these, 446 young adult questionnaires were completed where the young adult was part of a selected main household. In addition, nine young-adult questionnaires were completed in a secondary household, usually a backyard dweller or renter. 58 young-adult questionnaires were matched to a household but it was unclear whether they were members of the main or secondary household.

In 2014, a total of 671 young-adult interviews were completed. Of these, 659 young-adult questionnaires were completed where the young adult was part of a selected main household. In addition, 12 young-adult questionnaires were completed in a secondary household, usually a backyard dweller or renter.

In 2015, a total of 870 young adult interviews were completed. Of these, 828 young-adult questionnaires were completed where the young adult was part of a selected main household. In addition, 42 young-adult questionnaires were completed in a secondary household, usually a backyard dweller or renter.

4.3.1.1. Interviews

Interviewees were alone 60% of the time.

4.3.1.2. Education and employment.

334 young adults, or 16% of those interviewed reported being enrolled in a tertiary institute. 17% of the young adults reported being employed. Table 1 breaks this down by type of institute.

Table 1: Types of tertiary institutes attended

	no.	%
Enrolled in university	20	6
Enrolled in False Bay College	64	19
Enrolled in other technical training	55	16
Enrolled in other tertiary	111	33

Table 2 lists the reasons for not studying. 16% chose not to study, 51% state that they cannot afford it, while 12% say they did not meet the entrance requirements.

Table 2: Reasons for not studying

	no.	%
Chose not to	273	16
Can't afford it	880	51
Did not meet entrance requirements	208	12
Other	214	12

4.3.2. Wellbeing, social cohesion and participation

4.3.2.1. Mental health

As described in Part 3, the CESD-10 depression scale is used to measure the level of depression symptoms, contains 10 questions relating to respondents' experiences over the previous week of different symptoms of depression. With potential scores ranging between 0 and 30, a score of 11 or more usually reflects mild or significant symptoms of depression. The median score of respondents was six, with the middle 50% of respondents falling between scores of three and eight. 221 people (16% of respondents) scored 11 or higher, meaning that over one in six young adults in the sample demonstrated likely mild or significant symptoms of depression over the previous week.

Table 3 below describes the proportion of respondents with a CESD score of 11 or more, broken down by experience of different forms of crime over the past year. As with the main household survey respondents, the results strongly suggest that being affected by crime is associated with a higher likelihood of depression. For example, 42% of those who had been raped or were really frightened they could be raped reached the cut-off for likely depression, compared to 15% of those who had not.

Table 3: Experience of likely depression, by crime experience

Crime experienced	Likely depression (CESD ≥ 11)	
	Yes	No
Property taken with actual or threat of violence	25%	14%
Anyone close to you murdered	23%	15%
Injured with a weapon on purpose	25%	15%
Injured without a weapon	29%	15%
Violence within the household	33%	15%
Rape or fear of rape	42%	15%

4.3.2.2. Community participation

Of 1 446 who responded to this question, 232 or 16% had attended a community meeting to discuss urban upgrading, safety, facilities, services or any other neighbourhood problems in the past year. Out of these 232 people, 151 (65%) reported having found this meeting useful. Table 4 shows a more detailed breakdown of reported community involvement.

Table 4: Community participation in the past 12 months

	no.	%
Attended public meeting or rally	408	28
Took part in public demonstration	140	10
Signed a petition	142	10
Completed a questionnaire about local services or problems	160	11
Been actively involved in a group discussing problems	192	13
Been involved in a social/religious/hobby group	383	26
Been involved in a voluntary security-related org	107	7
Been involved in another voluntary org	112	8
Attended a community meeting	232	16

4.3.3. Perceptions and experiences of violence

4.3.3.1. Personal experience of the past year

Table 5 shows reported personal experiences of crime over the past year. 12% of respondents had been affected by a robbery or home invasion, while 11% were victims of petty theft. 8% of young adults had had someone close to them murdered, and 9% had been assaulted with or without a weapon.

Table 5: Personal experiences of crime in the past year (no. = 2 054)

	%
Robbery/home invasion	12
Petty theft	11
Murder	8
Assault with weapon	4
Assault with no weapon	5
Domestic violence	3
Rape	1
Car hijacking	1
Arson	1
Crimes targeting minorities	5
Drug trafficking	1
Community justice	3

4.3.3.2. Weapons

Respondents were also asked what weapons were carried and when household members carried them. 3% people reported that they carried a weapon for self-defence. Of these 63 people, 7 reported guns and 52 reported knives. 6 reported carrying them all the time, 22 reported carrying them some of the time and 28 reported carrying them at night only.

4.3.4. Alcohol consumption and access

As has been observed before, a significant proportion of respondents (74%) report not drinking at all, although this result may be subject to a certain degree of social desirability bias (i.e. respondents answer in the way they think is most socially acceptable). Where this was the case, or where people refused to even discuss alcohol, fieldworkers would skip the section in the survey about drinking habits. Therefore, where

specified below, data on drinking habits is sometimes presented for only drinkers, as this is the relevant population.

4.3.4.1. Drinking habits

Table 6 shows young adults' reported drinking frequency.

Table 6. Reported alcohol consumption

How often do you drink?	Frequency	%
Every day	4	0
Almost daily	5	0
Weekly	168	8
Monthly	157	8
Less than monthly	165	8
Never	1 431	74
Refused	23	1
Don't know	12	1

Among those who do drink, very few young adults report that they drink either every day or almost every day (just nine respondents in total). Little difference is seen between police precincts in terms of frequency of drinking, with only a slightly higher prevalence of more frequent drinking habits in Site B. Levels of drinking frequency appear to be particularly high in Site B Sector 2 however, with only 61% of young adult respondents reporting that they never drink, significantly less than the overall 74% average (see Appendices Table 1).

Table 7 shows young adults' reported preferred drinks. Given differences in survey methods between 2013 and 2014/15 (where respondents were able to select more than one option) just results for these latter years are reported. Out of a total of 331 respondents, 269 reported drinking cider (the most popular alcoholic beverage), 248 reported drinking commercially produced beer (the second most popular alcoholic beverage). Wine is the third most popular drink (42), followed by mixed cocktails (38), and then home-brewed beer (22).

Table 7: Usual drinks – in order of popularity

	Frequency
Cider	269
Beer	248
Wine	42
Mixed cocktail	38
Home-brewed beer	22

Spirits (neat)/shooters	21
Ready-to-drinks	5
Liqueurs	4
Fortified wines	2
Other	1

All respondents were asked how many drinks of various types they would drink during an average drinking session. Amongst those who reported how much they drink (471), the mean units of alcohol drunk per session was 13, with the middle 50% of respondents falling between scores of five and 15. 359 people (76% of respondents) drink five or more drinks in an average session, indicating a high level of binge drinking[6] among these respondents.

Table 8 reflects alcohol dependency-related questions. Alcohol dependency was assessed using four of the ten questions on the AUDIT questionnaire, with answers coded on a scale of 0 to 4 (Never = 0; Less than monthly = 1; Monthly = 2; Weekly = 3; Almost daily = 4) the summed together to create a composite score ranging from 0 to 16. A score of three or higher is considered a cause for concern in terms of the likely presence of alcohol dependency issues. 141 respondents (7%) had a score of three or higher.

Table 8. Alcohol dependency scores from the last 6 months

Score*	n/a	0	1	2	3	4
Felt guilt/remorse after drinking	10%	82%	5%	2%	1%	1%
Not remembered things you did/said while drinking	10%	83%	4%	1%	1%	1%
Failed to do what was normally expected because of drinking	10%	83%	4%	1%	1%	1%
Taken a drink when first waking up in the morning	10%	84%	4%	1%	1%	0%

* n/a: missing; 0: Never; 1: < monthly; 2: monthly; 3: weekly; 4: almost daily

With regards to differences between areas in the level of alcohol dependency and problematic drinking among those who drink, Site B has the highest proportion of respondents whose drinking is cause for concern (almost one in three (31%) scoring three or more on the reduced AUDIT scale), followed by Lingelethu West (25%), then Harare (16%). As with other variables, Site B Sector 2 is particularly problematic, with 45% of respondents classed as having potentially problematic drinking (see Appendices Table 2).

As shown in Table 9, higher alcohol dependency scores (i.e. higher AUDIT scores) are also correlated with higher depression scores (CESD

[6] The consumption of five or more drinks in one session.

scores), although the samples are small. For example, for those with an AUDIT score less than the cut-off for likely alcohol dependency of three, only 15% scored higher than the cut-off for likely depression, compared to 21% of those with an AUDIT score of three to five, and 40% of those with an AUDIT score of nine or more.

These results demonstrate the clear relationship between problematic or excessive drinking patterns and negative mental health experiences. While the direction of causality cannot be determined from this data (whether those with pre-existing mental health issues are prone to drink more frequently, poor mental health is caused by excessive drinking or, most likely, a mix of the two), these results strongly suggest the need to treat alcohol use disorders alongside other common mental disorders, such as anxiety and depression, and vice versa.

Table 9: Mental health by alcohol dependency

AUDIT Score	Proportion with likely depression (CESD ≥ 11)
0 to 2	15%
3 to 5	21%
6 to 8	38%
9+	40%

4.3.4.2. Purchasing alcohol

Amongst the 510 young adults who reported how much they spent on an average drinking session, the average amount spent was R151 with the middle 50% of respondents spending between R90 and R200 per session. Alcohol consumption must therefore be seen as contributing to the financial burden among young people, which is of particular importance in a multiple deprived community, such as Khayelitsha.

Eating food alongside the consumption of alcohol is recommended, due to the reduced rate at which alcohol enters the bloodstream. Encouragingly, of 522 respondents 79% say they usually eat when they drink alcohol, 11% say they do not, and 10% say that they sometimes do.

Respondents were asked the latest and earliest times that they had bought alcohol over the past three months. Of those 479 and 435 who reported latest and earliest times respectively, 14% had made the purchase after midnight and 41% had purchased before 10am,

indicating that a number of outlets are likely to contravene legal hours of sales. Of the entire sample of 2 054 young adults, 275 (13%) reported having bought alcohol on a Sunday.

Table 10 shows young adults' reported venues of drinking. 683 (33%) of the total young adults reported a normal drinking venue. Of these, 148 (22%) reported drinking at home, 189 (28%) reported drinking at friends' houses and 136 (20%) and 165 (24%) reported drinking at shebeens and taverns respectively. 41 (6%) reported drinking at street bashes. With one in five young drinkers choosing to drink in shebeens, the need to bring these establishments inside the regulatory framework is clear.

Table 10: Place of alcohol consumption

	Frequency	%
At home	148	22
Friends' homes	189	28
Shebeens	136	20
Taverns	165	24
Street bash	41	6
Other	4	1

Table 11 below provides results on the relationship between alcohol dependency and normal place of drinking. The proportion of young people with AUDIT scores of 3 or more (indicating probable alcohol abuse issues) was examined according to whether they normally drink at their own or a friend's home, at legal taverns, or at shebeens. From this, it appears that drinking at a shebeen is associated with a higher proportion of alcohol abuse issues (38% scoring 3 or more), followed by drinking at a tavern (28%), with drinking at home showing the lowest level of problematic drinking behaviours (20%).

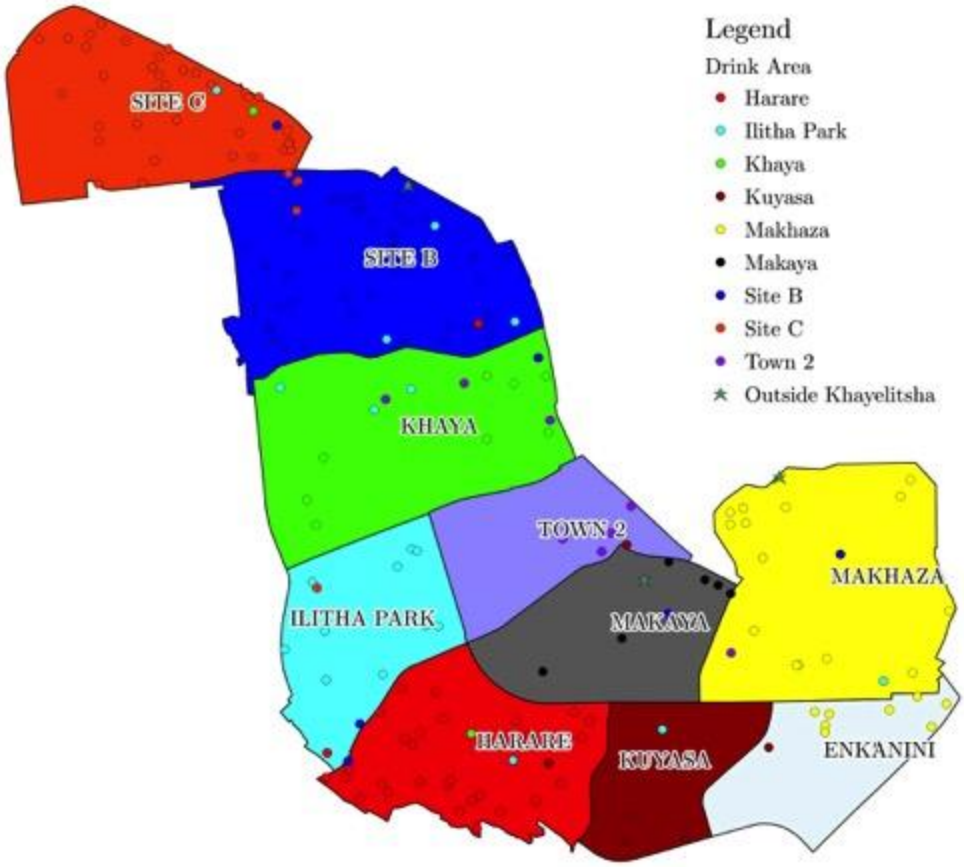
Table 11: AUDIT score of three or more, by normal drinking venue

	Frequency	%
Home or friend's home	55	20
Taverns	46	28
Shebeens	51	38

As shown in Figure 1, most young adults reported drinking drink in their area of residence. The points on the map represent the geo-location of the household, colour-coded by area of alcohol consumption. Where the area of alcohol consumption does not match the area of residence, it is usually a closely neighbouring area.

The average time travelled to get to their normal place of alcohol consumption is 12 minutes. Half of respondents take between five and 15 minutes to travel to their drinking establishment. Of the 454 people that reported their travelling methods to a venue to drink alcohol, 85% walked and 11% took taxis. 0% cycled and 0% took trains. 0% travelled by car as a driver and 3% as passengers. This reflects that most people, of the minority that drink regularly, walk to alcohol outlets that are near to their homes.

Figure 1: Place of drinking (2013 survey)



4.3.4.3. Alcohol and safety

Table 12 shows reported incidents observed by young adults over the preceding six months, suggesting that drinking is often observed to be involved with being threatened or vulnerable.

Table 12. Safety while consuming alcohol

In the past six months have you:	%
Had any involvement with police?	3
Had any involvement with police because of drinking?	3
Observed others involved with police because of drinking?	11
Felt unsafe while drinking?	8
Been threatened while drinking?	6
Seen someone else's safety threatened while drinking?	11

Looking at differences between police precincts (see Appendices Table 3), across most variables Harare has the lowest level of problems, apart from involvement with the police because of drinking, where

Lingelethu West performs best, followed by Site B (19% in Harare; 10% in Lingelethu West; 15% Site B). For all other variables Site B reports the highest level of problems. In terms of police precinct subsectors, Harare Sector 1 stands out as one of the Sectors with the lowest level of problems overall, while Site B Sector 2 is the worst.

4.3.4.4. Liquor policy and enforcement

As depicted in Table 13, support for a variety of alcohol-targeted interventions is high, which should be seen as indicative of young peoples' perceptions that alcohol use in their communities is a problem that must be addressed. Interventions that do not receive as much support (though still supported by almost 60% of young people) are those relating to restrictions on the liquor industry's marketing activities. Little difference is seen between police precincts, apart from somewhat less support for interventions in Site B overall (see Appendix Table 4).

Table 13: Alcohol intervention support (no.=1 468)

Increase of purchase age to 21	75%
Restricting number of outlets	74%
Earlier closing hours for onsite licenses	86%
Earlier closing hours for off-site licenses	84%
Increase prices	78%
Random breath testing	90%
Taxes to pay for alcohol treatment	79%
Taxes to lower other taxes	78%
Taxes for any other Government purpose	82%
Taxes for other harms	79%
More police raids	89%
Restrictions on TV/radio marketing	59%
Restrictions on billboard marketing	59%
Restrictions on sponsorship	59%
Restrictions on alcohol promotions	57%

4.3.4.5. Observed alcohol-related activities in the neighbourhood over the past year

Table 14 shows alcohol-related interventions and other activities, which the respondents reported having observed over the previous 12 months. Respondents seem to indicate that outlet regulation or self-policing has increased, but also that more raids on shebeens have

been conducted. In contrast to these activities geared towards the regulation of alcohol consumption, 25% of respondents indicated that they had observed more liquor industry activities supporting community events over the past year. Respondents in Site B were more likely to have observed all forms of activity (see Appendices Table 5).

Table 14: Observed alcohol-related activities

More raids	61%
Shebeens closing earlier	56%
Fewer shebeens/more closed down	43%
Improved shebeen facilities	37%
Better security and management	36%
More liquor industry activities supporting community events	25%

PART 5: ALCOHOL OUTLET MAPPING: DENSITY, SPATIAL DISTRIBUTION AND CHARACTERISTICS OF ALCOHOL OUTLETS

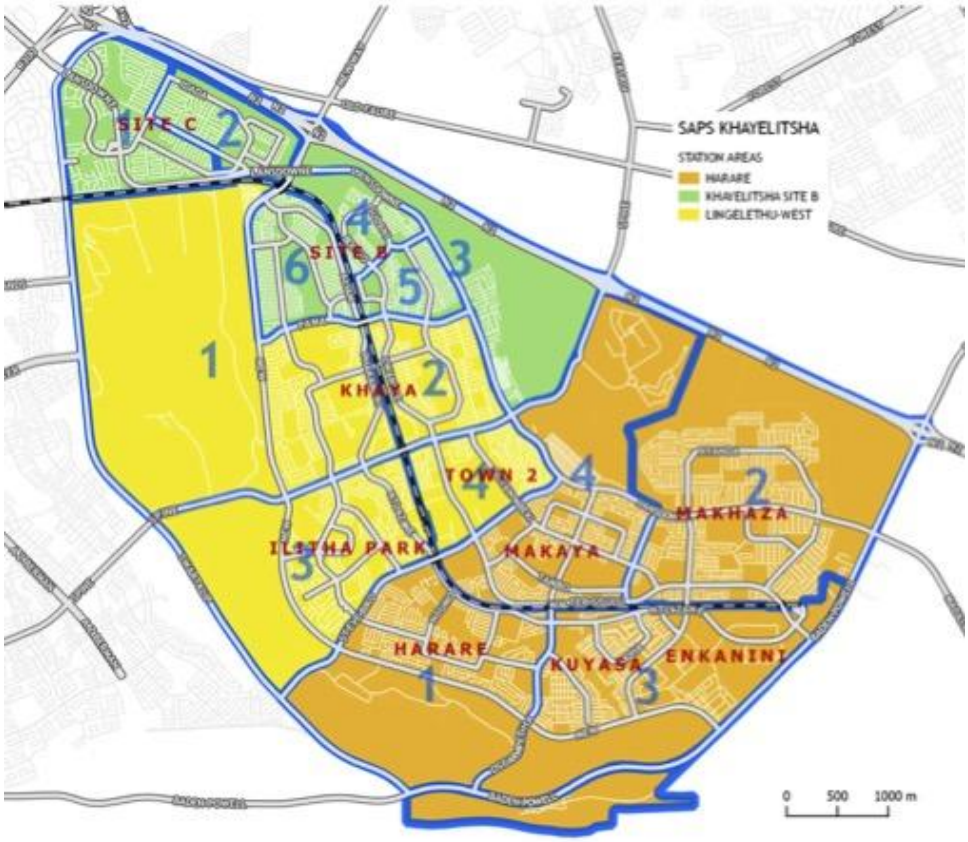
Compiled by Kim Bloch

5.1. PURPOSE

The purpose of the alcohol outlet mapping exercise was to determine the locations and types of licensed and unlicensed alcohol outlets in Khayelitsha. The mapping was carried out in cooperation with the Violence Prevention through Urban Upgrading (VPUU). This is an extension of the IDRC-funded research project: *Evaluating the effectiveness of the Western Cape Liquor Act in Khayelitsha, a large low-income community in Cape Town, South Africa* (HREC ref: 476/2012).

This sub-project is funded by the Western Cape Department of Community Safety as part of the research work assigned to them by the Commission of Inquiry into policing in Khayelitsha. The purpose of the outlet mapping is to provide an overview of the number of outlets, their basic characteristics, and spatial distribution within Khayelitsha's three policing precincts (Figure 1 shows SAPS boundaries) and a baseline with which to assess the impact of enforcement efforts over time. The data will also enable analyses to understand the spatial relationships between violence, drinking patterns and access to alcohol.

Figure 1. SAPS boundaries

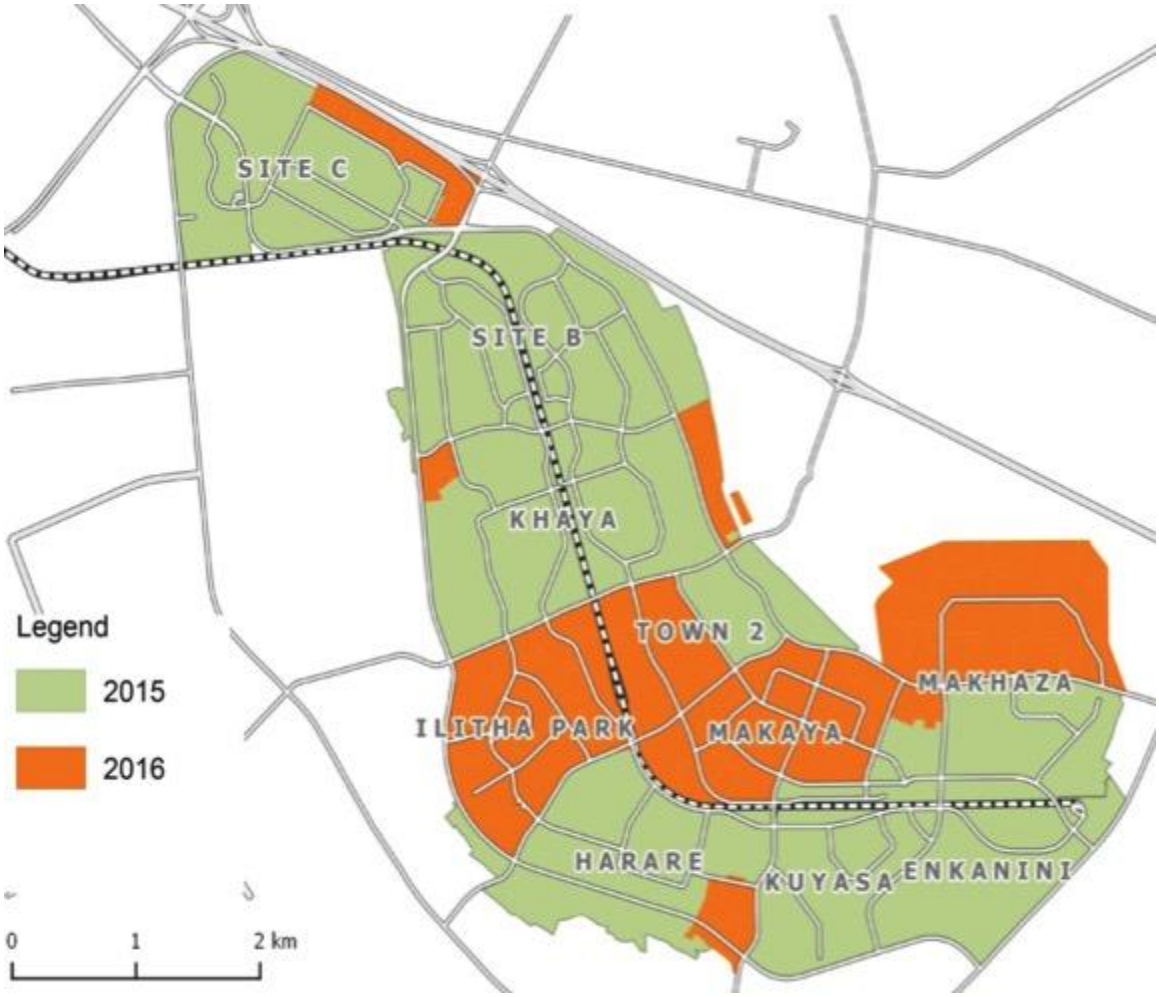


5.2. METHODOLOGY

5.2.1. Mapping phases

Mapping was conducted in two phases: 1.) April to May 2015 and 2.) August 2016. Phase one covered 70% of Khayelitsha and phase two covered the remaining 30% (see Figure 2).

Figure 2: Target areas



5.2.2. Data collection tools

The mapping was done using Samsung Galaxy Pocket mobile phones. Basic information and geolocations were captured in real-time using the open-source software, ODK (open data kit) Collect application.

In 2015, the data tool consisted of only observational questions; therefore, no written informed consent was required. The data tool in

2016 included observational questions as well as business-related questions for an outlet staff member. This tool was modular and was constructed in the following way:

- Module 1: geographic information (fieldworker observations)
- Module 2: basic characteristics inside outlet (verbal consent to enter establishment but observations recorded by fieldworker)
- Module 3: specific questions related to business and operations (written informed consent and fieldworker administered interview)

Table 1: Survey content

Question	Year	Question type
Module 1		
Date of interview	2015/16	Auto
Start time	2015/16	Auto
End time	2015/16	Auto
Fieldworker name	2015/16	Fieldworker
Outlet ID number	2015/16	Fieldworker
Is the outlet open?	2015/16	Observational
Was the Informational letter given?	2016	Fieldworker
Does owner agrees to observational data being recorded?	2016	Fieldworker
Area where outlet is located	2015/16	Observational
Sub-area where outlet is located	2015/16	Observational
GPS location of the outlet	2015/16	Observational
Module 2		
Type of outlet	2015/16	Observational
Capacity of outlet*	2015/16	Observational
Presence of: television, pool table, jukebox/stereo*	2015/16	Observational
Visible alcohol-related advertising/branding*	2016	Observational
Module 3		
Was the Informed consent given?	2016	Fieldworker
Did the outlet owner sign the informed consent?*	2016	Fieldworker
When (which year) did you start your business?*	2016	Interview
Do you sell: beer, wine, spirits, umqombothi?*	2016	Interview
Who do you sell your alcohol to?*	2016	Interview
What is the most popular type of alcohol sold?*	2016	Interview
What is the cheapest type of alcohol sold?*	2016	Interview
How much do you sell this cheapest drink for?*	2016	Interview
Do you get support from alcohol manufacturers?*	2016	Interview
Do you sell food for on-site consumption?*	2016	Interview
What time do you open, Monday to Thursday?*	2016	Interview
What time do you close, Monday to Thursday?*	2016	Interview

What time do you open, Friday to Sunday? *	2016	Interview
What time do you close, Friday to Sunday? *	2016	Interview
What gender are most of your customers? *	2016	Interview
What age are most customers? *	2016	Interview
Do you have a liquor license? *	2016	Interview
Have you applied for a liquor license before? *	2016	Interview
Would you want to obtain a liquor license? *	2016	Interview
If not alcohol, what other business interests you? *	2016	Interview

* Required consent

5.2.3. Stakeholder engagement

Prior to and during the mapping process, relevant police and community stakeholders were consulted. We collaborated with leadership from Lingelethu West South African Police Service (SAPS) and local Khayelitsha CPFs working in conjunction with Lingelethu West, Harare and Site B SAPS jurisdictions.

5.2.4. Fieldwork

Mapping was done by trained community members who reside in and are familiar with the specific target neighbourhoods in Khayelitsha. Fieldworkers walked systematically area by area, street by street, looking for and identifying alcohol outlets of any kind.

Fieldworkers with previous mobile data collection skills as well as unskilled local community members recommended by local stakeholders were recruited as an effort to build local capacity. They were given a daily transport stipend and remunerated according to a locally acceptable daily rate.

Fieldworkers received a two-day training in the use of cellphones; data collection using the ODK app; map reading comprehension; fieldwork methodology; administrative tasks; and safety.

5.2.5. Data management and confidentiality

Data collected using ODK was uploaded and stored in a secure, online database called ODK Aggregate. These data were exported from the cloud database on a daily basis, saved on a secure computer, and quality control was conducted regularly. Data was analysed using Excel and STATA.

5.2.6. Ethics

This study was approved by the University of Cape Town Health Research Ethics Committee (HREC). All individuals who participated in the one-on-one business interviews provided written informed consent. No personal identifiers of staff or names of outlets were captured. A unique identifier was assigned per outlet. Furthermore, the cell phone GPS units lead to five to 25m degree of systematic inaccuracy due to atmospheric variation and structural barriers, such as corrugated iron shacks. This provides an additional layer of confidentiality and anonymity, as one is unable to determine the exact location of the outlet per the captured GPS coordinates.

5.3. RESULTS

5.3.1. Outlets and accessibility

A total of 1 076 outlets were identified in Khayelitsha: 873 in 2015 and 203 in 2016. Of the outlets identified in 2015, 31 were excluded due to data collection errors arising from either the mobile devices or fieldworker input. Therefore a total of 1 045 outlets were included in this analysis. Complete information was obtained for 915 accessible outlets (87.6%) but 130 outlets were inaccessible and only partial information was obtained. Of the 203 outlets identified in the 2016 target areas (Figure 2), 87 outlets agreed to participate in one-on-one interviews about their businesses.

5.3.2. Outlet density

Table 2 and Figures 3 to 5 indicate outlet density by SAPS precinct, SAPS sector, and corresponding ratios of populations to outlets. These data showed that there were 452, 133 and 460 outlets in Harare, Lingelethu West, and Site B precincts respectively.

Figure 3: Outlets and population density

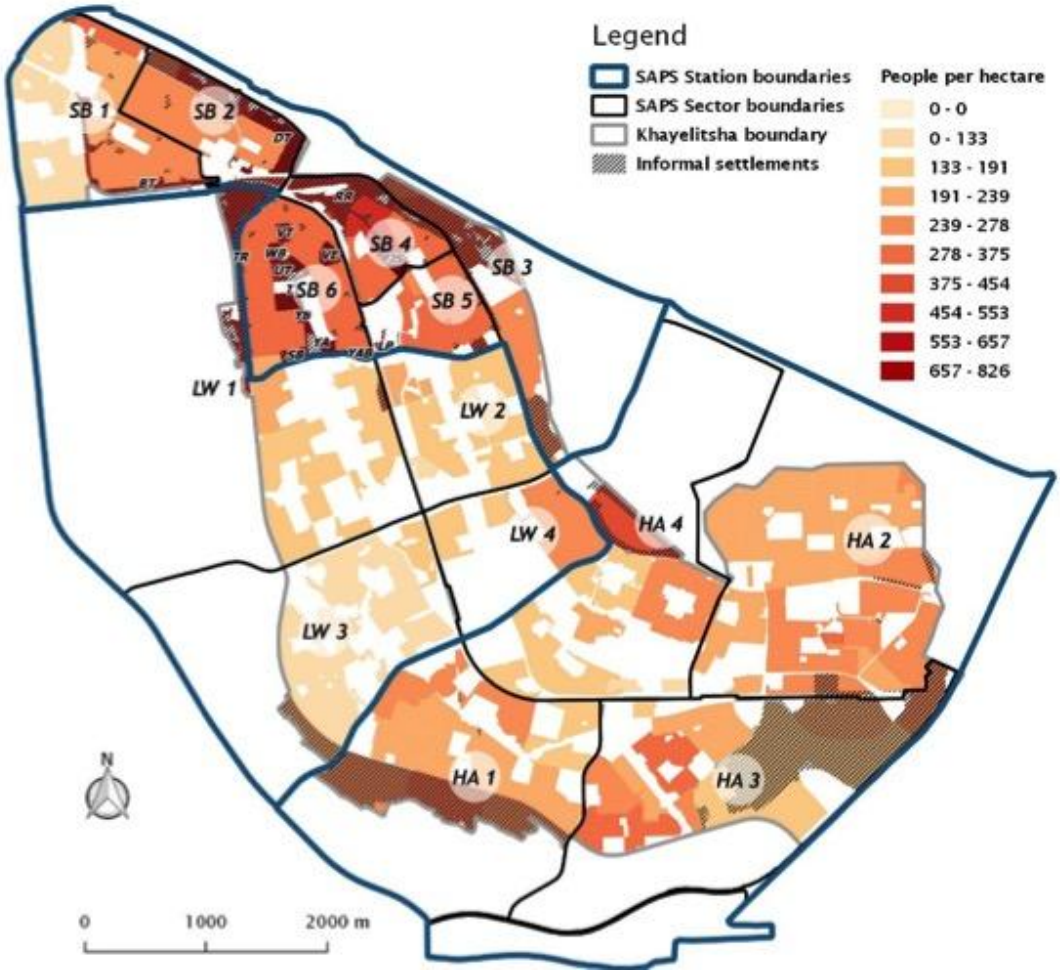


Table 2: Ratio of outlets to population by SAPS station and sector (no.=1 045)

Precinct	Outlets (no.)	Population (no.)	Ratio	Ranking
Harare	452	173 348	383.5	
Sector 1	144	42 495	295.1	2
Sector 2	120	56 501	470.8	12
Sector 3	128	46 929	366.6	4
Sector 4	60	27 423	457.1	11
Lingelethu West	133	64 441	484.5	
Sector 1	56	23 471	419.1	10
Sector 2	22	12 875	585.2	13
Sector 3	41	17 011	414.9	8
Sector 4	14	11 084	791.7	14
Site B	460	153 676	334.1	
Sector 1	67	27 376	408.6	7
Sector 2	128	26 331	205.7	1

Sector 3	47	18 755	399.0	6
Sector 4	64	26 644	416.3	9
Sector 5	48	14 861	309.6	3
Sector 6	106	39 709	374.6	5
Total	**1 045**	**391 465**	**374.6**	

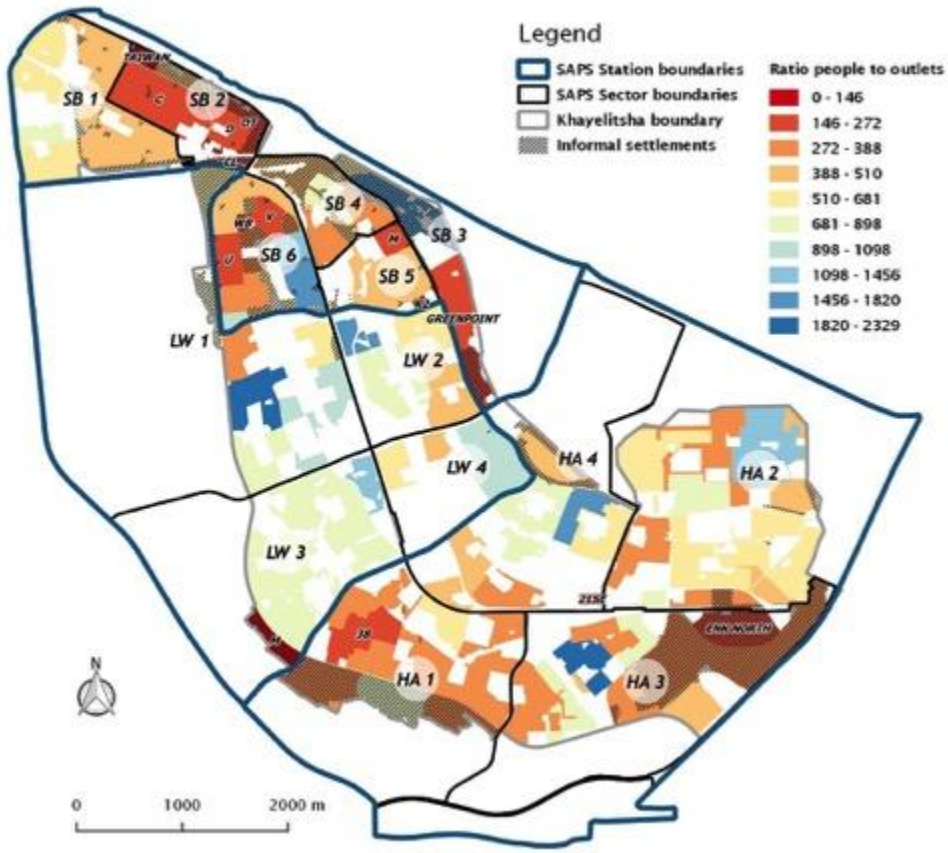
This corresponds to ratios of one outlet per 383.5 people, 484.5 people, and 334.1 people in those SAPS station areas. The variability in the density of outlets across precincts can be seen when the data is stratified by SAPS sector or at section level (such as in Figure 4).

Site B sector 2 had the lowest ratio of outlets to people (1 outlet: 205.7 people), followed by Harare sector 1 (1:295.1) and Site B sector 5 (1:309.6). The highest ratios (least outlet-dense areas per population) were Harare sector 2, Lingelethu West sector 2, and Lingelethu West sector 4.

Figure 4 also indicates certain small section areas with exceptionally high outlet density per population (ratio of 1: ≤272.5) including:

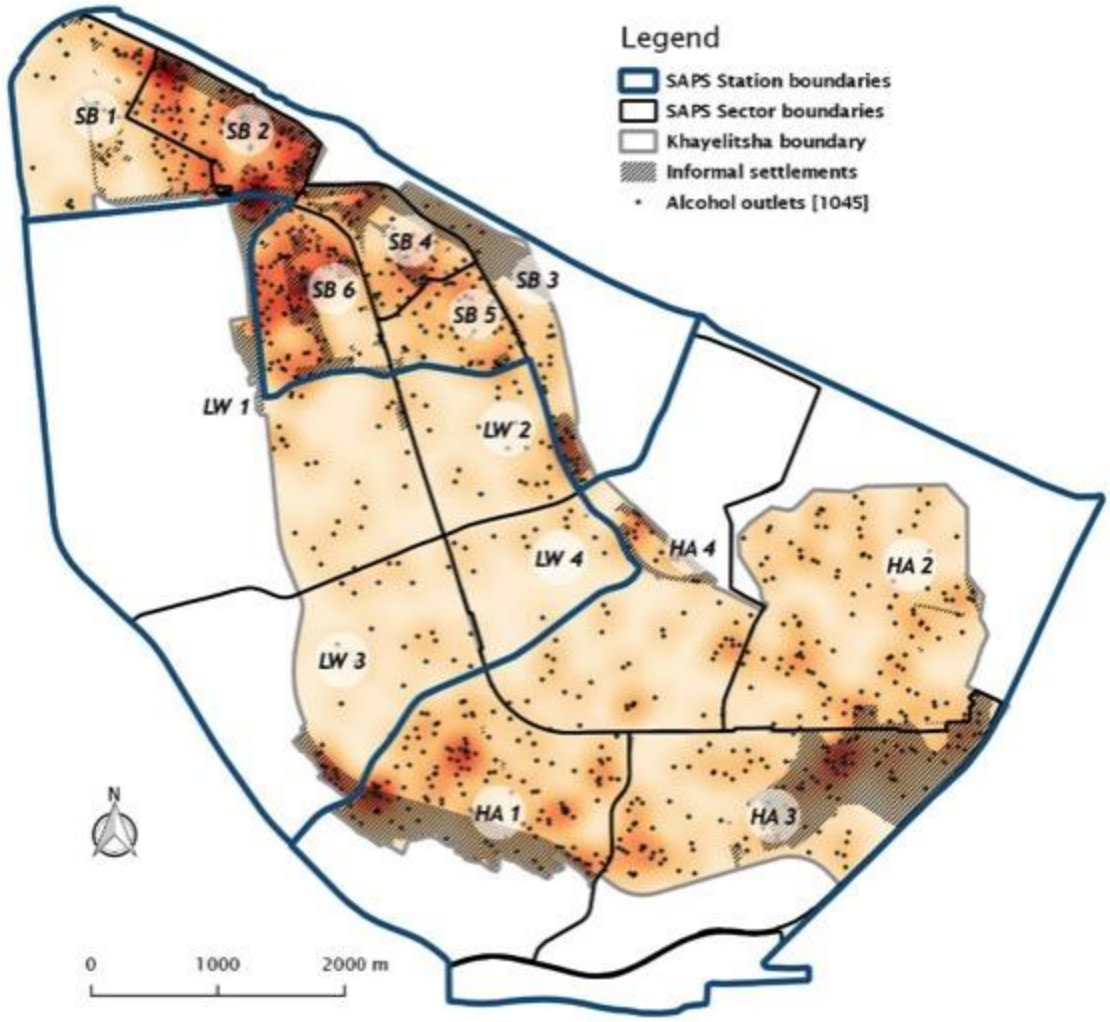
- Site B, sector 2: Taiwan, C, D, DT, CL sections
- Site B, sector 6: U, WB, V sections
- Site B, sector 5: M, K2 sections
- Site B, sector 3: Greenpoint
- Lingelethu West, sector 3: M section
- Harare, sector 1: 38 section
- Harare, sector 4: 21SE section
- Harare, sector 3: Enkanini North

Figure 4: Ratio of outlets to population



The heatmap in Figure 5 clearly indicates that Site B, Site C, and to a lesser extent Harare and Enkanini were the most outlet-dense areas, irrespective of population estimates.

Figure 5: Outlet density



5.3.3. Outlet type

Outlets were classified into four groups:

- shebeen: unlicensed, drinking on site
- take-away: unlicensed, sells alcohol on site, no consumption on site
- umqombothi: unlicensed, traditional beer sold, drinking on site
- tavern: licensed, drinking on site

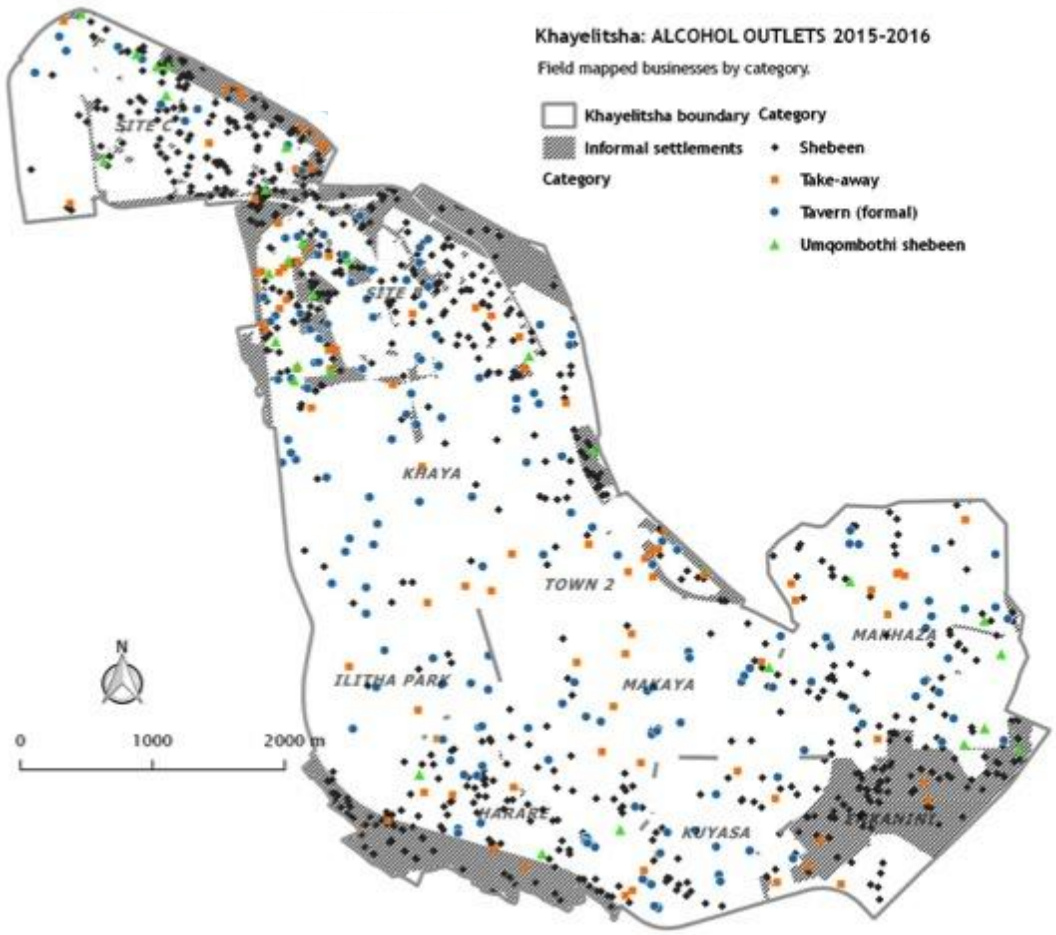
Classification was based on fieldworker observations and perceptions of the establishment. In addition for looking for the presence or absence of a liquor license, they spoke to the community and used the aid of visual cues such as branding and structure type.

Table 3 reports that of the 1 044 classified outlets, the vast majority (71.8%) were shebeens, 16.3% were taverns, 9% were take-aways and 2.9% were umqombothis. Across SAPS precincts, Site B had the most informal outlets (89.3%), while Lingelethu West had the most reported taverns (30.8%). Figure 6 shows the spatial diversity of outlets across Khayelitsha. For data further broken down by sector, refer to Appendix A.

Table 3: Outlet type by SAPS station (no.=1 044)

Outlet type	Harare	Lingelethu West	Site B	Total
	no. (%)	no. (%)	no. (%)	no. (%)
Shebeen	319 (71)	72 (54)	359 (78)	750 (72)
Take-away	41 (9.)	20 (15)	33 (7)	94 (9)
Tavern	80 (18)	41 (31)	49 (11)	170 (16)
Umqombothi	11 (2)	0 (0)	19 (4)	30 (3)
Total	451	133	460	1044

Figure 6: Outlets by type



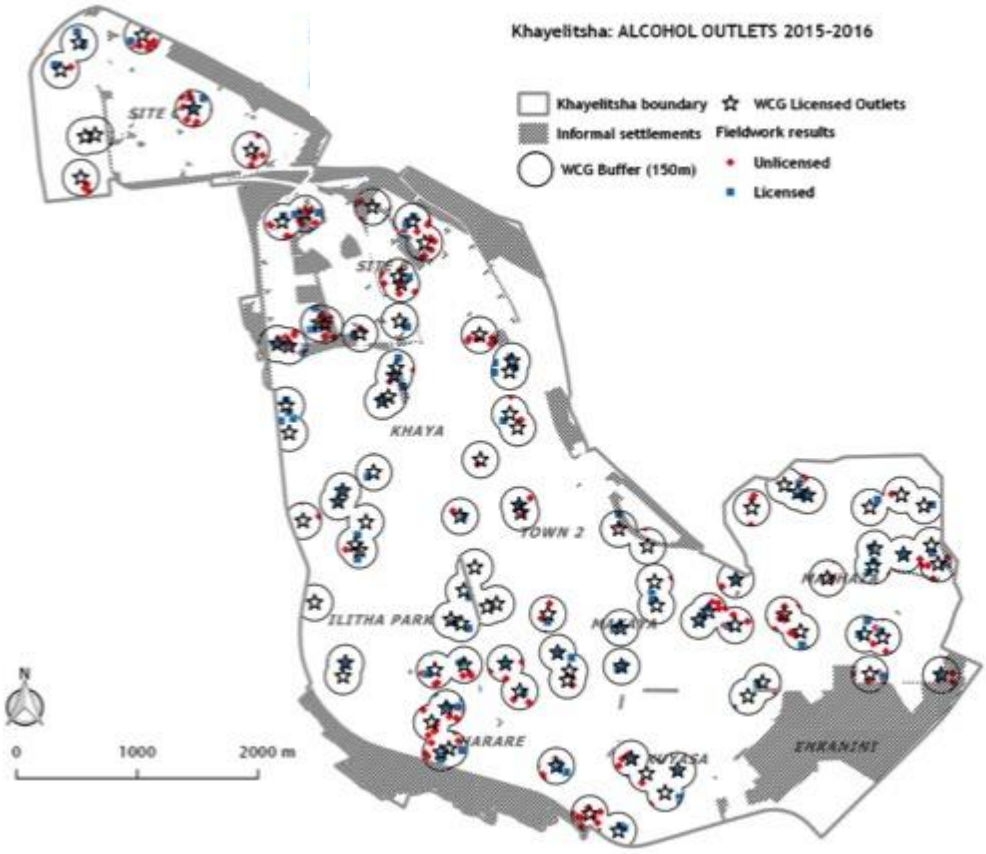
Fieldworker-reported outlets were compared to Western Cape Government (WGC)'s Liquor Authority official records of licensed outlets in the area. Of the 114 WCG registered outlets, we were able to geolocate 103 (90.3%). The remaining 11 outlets could not be geolocated because the listed addresses were not consistent with the mapping software.

Figure 7 illustrates fieldworker outlets located, found within a 150-metre radius buffer, and matched the WCG registered outlets. These data show a very high match rate; however, not all outlets identified by fieldworkers were categorised as taverns. Of the total 103 WCG outlets, 97 outlets (94.2%) matched to at least one fieldworker-reported outlet within a 150m radius. The unmatched 6 outlets (Africa Discount Liquors 1, Africa Discount Liquours 2, Uncle's Liquors, Picardi Rebel, Duma's Place, and Ammies Place) may be due to the fact that fieldworkers did not survey licensed bottle stores.

In total, 293 fieldworker-reported outlets matched, with an average of 3.1 per WCG outlet. The closest outlet was on average 49.7 metres away from the WCG target outlets (range two to 147 metres) and more than half (53%) were classified as a tavern. This is most likely primarily due to the high density of shebeens in close proximity to formal outlets, although misclassification may be a minor factor.

When excluding all outlets reported by fieldworkers as unlicensed, a total of 80 WCG outlets (77.7%) matched with fieldworker-reported taverns. There was an average of 1.6 taverns per WCG outlet and the closest outlet was on average 54 metres away from the target WCG outlet (range two to 147 metres).

Figure 7: Comparison of WCG and fieldworker outlets



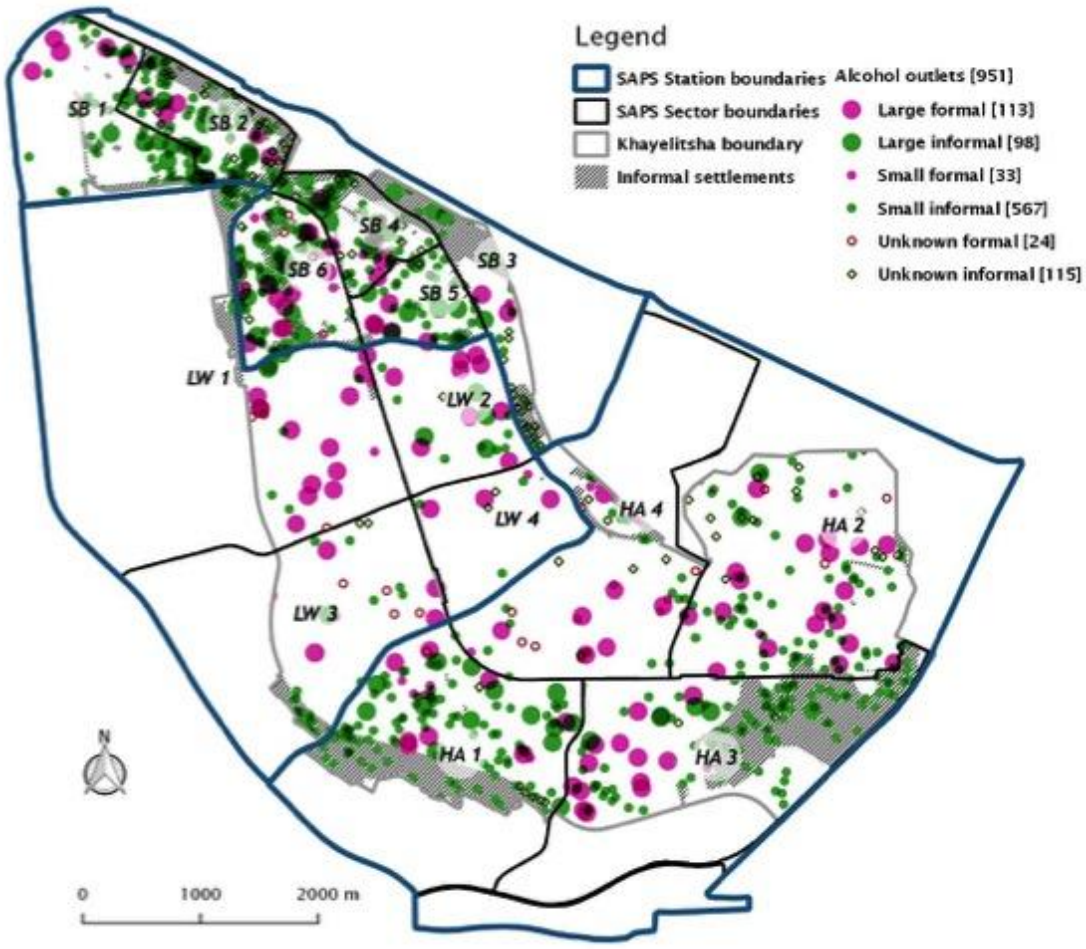
5.3.4. Outlet capacity

Table 4 and Figure 8 indicate capacity of outlets by outlet type. Capacity was defined as small if the outlet could accommodate approximately 0 to 39 people or large if the outlet could accommodate 40 or more people. Take-away outlets were excluded from this analysis, as this type of outlet does not cater to on-site drinking. Unknown capacity size was reported if fieldworkers were unable to accurately determine the size of the outlet due to the outlet being closed or owner/staff being unwilling to let them enter the premises. Overall, 63.2% of outlets were small, 22.2% were large, and 14.6% were unknown. There was a significant difference in capacity by outlet type ($p<0.001$). Nearly two-thirds (72.1%) of shebeens and 86.7% of umqombothis were small, while 66.5% of taverns were large.

Table 4: Capacity by outlet type and SAPS station (no.=950)

Capacity by outlet type	Harare	Lingelethu West	Site B	Total
	no. (%)	no. (%)	no. (%)	no. (%)
Shebeen	319	72	359	750
large	21 (7)	11 (15.3)	64 (18)	96 (13)
small	272 (85)	56 (78)	213 (59)	541 (72)
unknown	26 (8)	5 (7)	82 (23)	113 (15)
Tavern	80	41	49	170
large	48 (60)	30 (73)	35 (71)	113 (67)
small	20 (25)	4 (10)	9 (18)	33 (19)
unknown	12 (15)	7 (17)	5 (10)	24 (14)
Umqombothi	11	0	19	30
large	1 (9)	0	1 (5)	2 (7)
small	10 (91)	0	16 (84)	26 (87)
unknown	0	0	2 (11)	2 (7)
All outlets	410	113	427	950
large	70 (17)	41 (36)	100 (23)	211 (22)
small	302 (74)	60 (53)	238 (56)	600 (63)
unknown	38 (9)	12 (11)	89 (21)	139 (15)

Figure 8: Outlet capacity



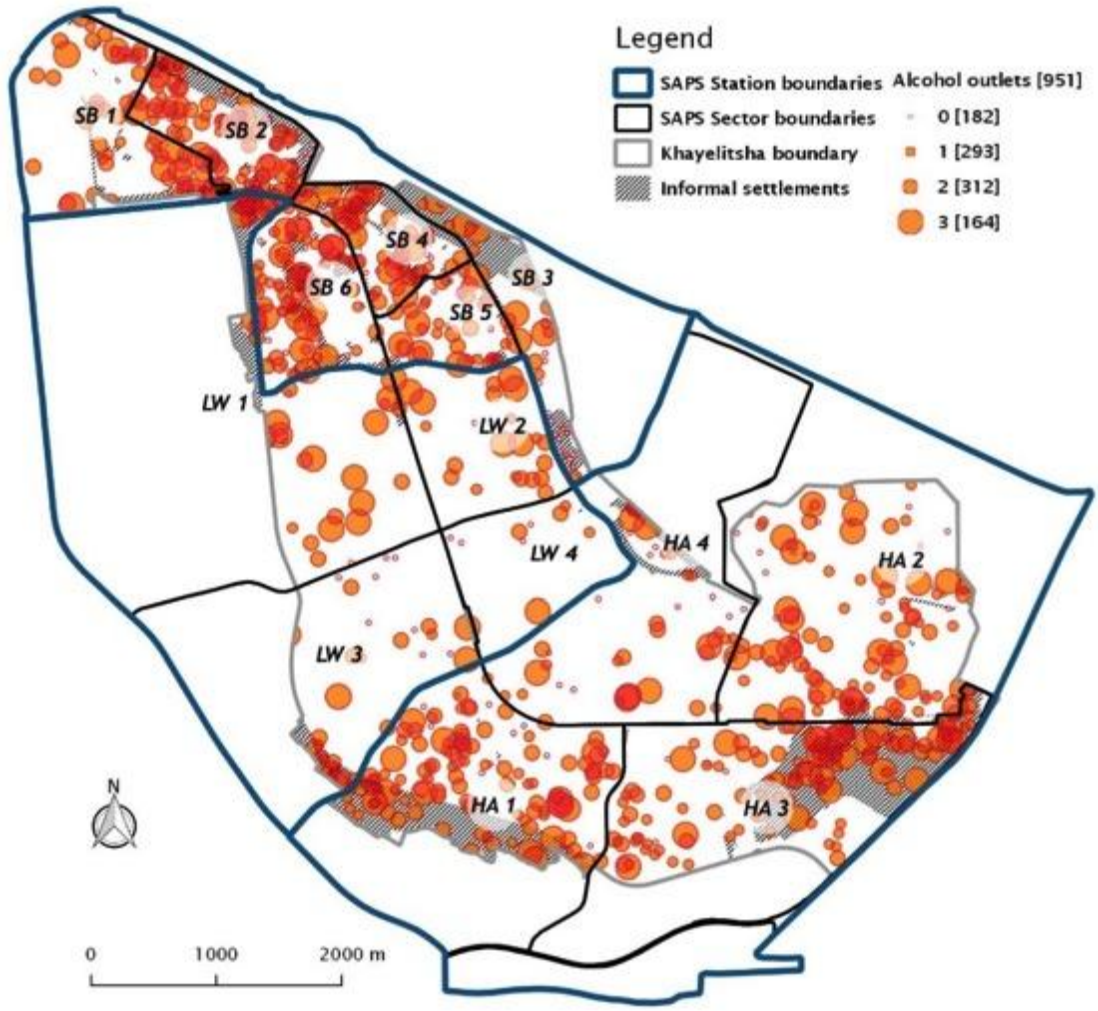
5.3.5. Presence of entertainment equipment

The presence of entertainment equipment in the form of TV, music player and pool table were reported according to fieldworker observations. This data may be considered a proxy for economic resources and may provide insight into the type of clientele an outlet caters to. According to Table 5 approximately two-thirds (71.9%) of outlets had a TV, 32% had a pool table and 44.4% had some sort of music player. The map in Figure 9 shows wide diversity in the number of entertainment items across geographic areas – 19.1% had no equipment, 30.8% had one type, 32.8% had two types and 17.3% had three types. Formal outlets are significantly more likely to have equipment (TV, music and pool tables) than informal outlets ($p<0.001$), but TVs were widely available across all outlets.

Table 5: Presence of entertainment equipment by outlet type and SAPS station (no.=950)

Equipment by outlet type	Harare no. (%)	Lingelethu West no. (%)	Site B no. (%)	Total no. (%)
Shebeen	319	72	359	750
TV	249 (78)	56 (78)	224 (62)	529 (71)
Music	111 (35)	30 (45)	170 (47)	311 (42)
Pool	115 (36)	25 (35)	70 (20)	210 (28)
Tavern	80	41	49	170
TV	60 (75)	33 (81)	38 (78)	131 (77)
Music	47 (59)	25 (61)	35 (71)	107 (63)
Pool	45 (56)	22 (54)	27 (55)	94 (55)
Umqombothi	11	0	19	30
TV	11 (100)	0	12 (63)	23 (77)
Music	1 (9)	0	3 (16)	4 (13)
Pool	0	0	0	0
All outlets	410	113	427	950
TV	320 (78)	89 (79)	274 (64)	683 (72)
Music	159 (39)	55 (49)	208 (49)	422 (45)
Pool	160 (39)	47 (42)	97 (23)	304 (32)

Figure 9: Entertainment equipment



5.3.6. Years in operation

Table 6 shows that on average, outlets surveyed in 2016 have been open since 2005 (11 years in operation). The one umqombothi interviewed in Harare has been open the longest – since 1994. Taverns have been open for an average of16 years. Shebeens and take-aways have been open for an average of eight to 10 years respectively. These data show that Harare has the oldest informal outlets (average year of opening 2003) and Lingelethu West not only has the youngest informal outlets (average year of opening 2011 to 2013) but also the oldest taverns (average year of opening 1996).

Table 6: Average year of opening business by outlet type and SAPS station (no.=87)(Standard deviation [SD])

	Harare (no.=45)			Lingelethu West (no.=19)			Site B (no.=23)			Total		
Outlet type	no.	Mean	SD	no.	Mean	SD	no.	Mean	SD	no.	Mean	SD
Shebeen	22	2 003.4	8.0	9	2 011.9	4.9	15	2 007.7	6.8	46	2 006.5	7.7
Take-away	6	2 006.8	9.2	2	2 013.5	3.5	8	2 007.9	10.6	16	2 008.2	9.3
Tavern	16	2 003.1	5.5	8	1 996.6	12.4	0	n/a	n/a	24	2 000.9	8.7
Umqombothi	1	1 994.0	n/a	0	n/a	n/a	0	n/a	n/a	1	1 994	n/a
Total	45	2 003.5	7.4	19	2 005.6	11.6	23	2 007.7	8.1	87	2 005.1	8.7

Outlets surveyed in 2016 reported very long operating hours. The earliest opening time was 5am and the latest closing time appeared to be 7am the following morning. The average operating hours during the weekdays and weekends were similar, between 14.7 and 15.5 hours, respectively. 25 of the outlets (29%) (all informal except one) reported that they were open for business all hours during the week. Figures 10 and 11 show the total number of daily operating hours of formal and informal outlets. These data show that the majority of formal outlets worked on 12-hour daily shifts, whereas informal outlets had variable and longer operating hours.

Figure 10: Total operating hours during the week (formal vs informal outlets)

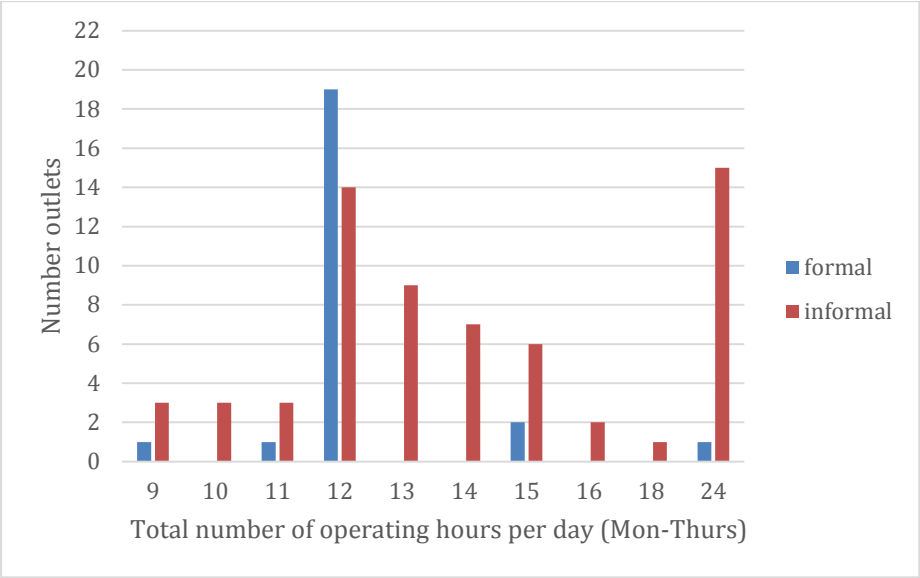
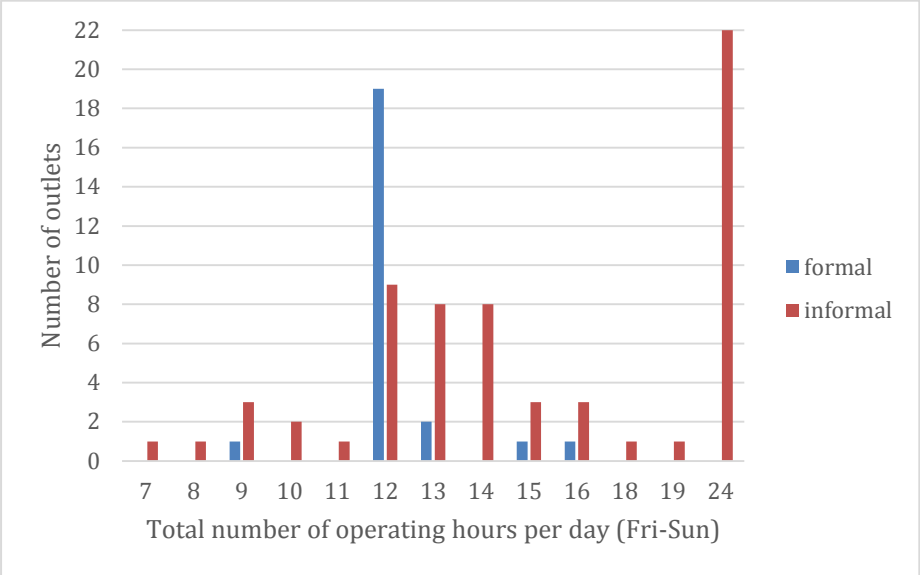


Figure 11: Total operating hours on the weekend (formal vs informal outlets)



5.3.7. Alcohol and food availability

Table 7 describes the types of alcohol available at outlets surveyed in 2016. Nearly all outlets served beer (97.7%). Beer was not only reported as the most popular type of alcohol by 92% of respondents but also the cheapest by 88.5% of respondents (mean price R14.90). More than half (55.2%) also served wine, 62.1% served spirits, and 2.3% served umqombothi. A small proportion (16.1%) of outlets sold food on the premises: nine in Harare, one in Lingelethu West, and four in Site B.

In comparing types of alcohol by type of outlet, it is clear that more formal than informal outlets serve a wider range of alcohol beyond beer. In Harare and Lingelethu West, a larger proportion of take-aways sold wine and spirits as compared to take-aways in Site B.

Table 7: Type of alcohol available by outlet type and SAPS station

Alcohol type by outlet type	Harare (no.=45) no. (%)	Lingelethu West (no.=19) no. (%)	Site B (no.=23) no. (%)	Total (no.=87) no. (%)
Shebeen	22	9	15	46
Beer	22 (100)	9 (100)	14 (93)	45 (98)
Wine	8 (36)	4 (44)	4 (27)	16 (35)
Spirits	9 (41)	5 (56)	8 (53)	22 (48)
Umqombothi	0	0	0	0
Take-away	6	2	8	16
Beer	6 (100)	2 (100)	7 (88)	15 (94)
Wine	5 (83)	1 (50)	2 (25)	8 (50)
Spirits	5 (83)	1 (50)	3 (38)	9 (56)
Umqombothi	1 (17)	0	0	1 (6)
Tavern	16	8	0	24
Beer	16 (100)	8 (100)	0	24 (100)
Wine	15 (94)	8 (100)	0	23 (96)
Spirits	14 (88)	8 (100)	0	22 (92)
Umqombothi	0	0	0	0
Umqombothi	1	0	0	1
Beer	1 (100)	0	0	1 (100)
Wine	1 (100)	0	0	1 (100)
Spirits	1 (100)	0	0	1 (100)
Umqombothi	1 (100)	0	0	1 (100)
All outlets	45	19	23	87
Beer	45 (100)	19 (100)	21 (91)	85 (98)
Wine	29 (64)	13 (68)	6 (26)	48 (55)
Spirits	29 (64)	14 (74)	11 (48)	54 (62)
Umqombothi	2 (4)	0	0	2 (2)

5.3.8. Demographics of patrons

All outlets surveyed in 2016 reported that they sell exclusively to community members, not other businesses. According to Table 8, the majority of outlet owners (62.1%) reported their patrons were primarily male. Two-thirds (23%) reported that they served an even distribution of males and females. Few outlets had mostly female (10.3%) or male only (4.6%) patrons.

Table 8: Gender distribution by outlet type and SAPS station

Gender distribution by outlet type	Harare (no.=45)	Lingelethu West (no.=19)	Site B (no.=23)	Total (no.=87)
	no. (%)	no. (%)	no. (%)	no. (%)
Shebeen	22	9	15	46
equal M/F	6 (27)	1 (11)	3 (20)	10 (22)
mostly F	4 (18)	3 (33)	1 (7)	8 (17)
mostly M	11 (50)	4 (44)	11 (73)	26 (57)
Only M	1 (5)	1 (11)	0	2 (4)
Take-away	6	2	8	16
equal M/F	3 (50)	0	2 (25)	5 (31)
mostly F	0	0	1 (13)	1 (6)
mostly M	2 (33)	1 (50)	5 (63)	8 (50)
Only M	1 (17)	1 (50)	0	2 (13)
Tavern	16	8	0	24
equal M/F	3 (19)	2 (25)	0	5 (21)
mostly F	0	0	0	0
mostly M	13 (81)	6 (75)	0	19 (79)
Only M	0	0	0	0
Umqombothi	1	0	0	1
equal M/F	0	0	0	0
mostly F	0	0	0	0
mostly M	1 (100)	0	0	1 (100)
Only M	0	0	0	0
All outlets	45	19	23	87
equal M/F	12 (27)	3 (16)	5 (22)	20 (23)
mostly F	4 (9)	3 (16)	2 (9)	9 (10)
mostly M	27 (60)	11 (58)	16 (70)	54 (62)
Only M	2 (4)	2 (11)	0	4 (5)

According to Table 9, approximately half (50.6%) of outlets primarily served 25 to 34 year olds, 27.6% primarily served a slightly older crowd (35 to 45 year olds), and a small proportion (approx. 10%) primarily served the youngest or the oldest age strata.

Table 9: Age distribution by outlet type and SAPS station

Age distribution by outlet type	Harare (no.=45) no. (%)	Lingelethu West (no.=19) no. (%)	Site B (no.=23) no. (%)	Total (no.=87) no. (%)
Shebeen	22	9	15	46
<25 yrs	6 (27)	0	0	6 (13)
25-34 yrs	5 (23)	7 (78)	7 (47)	19 (41)
35-45 yrs	7 (32)	1 (11)	5 (33)	13 (28)
>45 yrs	4 (18)	1 (11)	3 (20)	8 (17)
Take-away	6	2	8	16
<25 yrs	1 (17)	0	0	1 (6)
25-34 yrs	3 (50)	0	4 (50)	7 (44)
35-45 yrs	2 (33)	2 (100)	4 (50)	8 (50)
>45 yrs	0	0	0	0
Tavern	16	8	0	24
<25 yrs	2 (13)	0	0	2 (8)
25-34 yrs	12 (75)	6 (75)	0	18 (75)
35-45 yrs	2 (13)	1 (13)	0	3 (13)
>45 yrs	0	1 (13)	0	1 (4)
Umqombothi	1	0	0	1
<25 yrs	1 (100)	0	0	1(100)
25-34 yrs	0	0	0	0
35-45 yrs	0	0	0	0
>45 yrs	0	0	0	0
All outlets	45	19	23	87
<25 yrs	10 (22)	0	0	10 (12)
25-34 yrs	20 (44)	13 (68)	11 (48)	44 (51)
35-45 yrs	11 (24)	4 (21)	9 (39)	24 (28)
>45 yrs	4 (9)	2 (11)	3 (13)	9 (10)

5.3.9. Liquor licensing

Table 10 indicates that among the outlets surveyed in 2016, 29.9% were licensed and 70.1% were unlicensed. Table 11 shows that of those who were unlicensed, 16.4% had applied for a license or attempted to apply for a license. Nearly all (93.4%) of those without licenses reported that they would like one. There was a high level of agreement between fieldworker-appointed classification of outlets and owner's self-reported licensing status – only one shebeen was reportedly licensed and one tavern unlicensed according to owner-input. This reinforces the fieldworker's strong classification skills based on external observations.

Table 10: Liquor licensing by outlet type and SAPS station

License by outlet type	Harare (no.=45)	Lingelethu West (no.=19)	Site B (no.=23)	Total (no.=87)
	no. (%)	no. (%)	no. (%)	no. (%)
Shebeen	22	9	15	46
No	21 (96)	9 (100)	15 (100)	45 (98)
Yes	1 (5)	0	0	1 (2)
Take-away	6	2	8	16
No	4 (67)	2 (100)	8 (100)	14 (88)
Yes	2 (33)	0	0	2 (13)
Tavern	16	8	0	24
No	1 (6)	0	0	1 (4)
Yes	15 (94)	8 (100)	0	23 (96)
Umqombothi	1	0	0	1
No	1 (100)	0	0	1 (100)
Yes	0	0	0	0
All outlets	45	19	23	87
No	27 (60)	11 (58)	23 (100)	61 (70)
Yes	18 (40)	8 (42)	0	26 (30)

Table 11: Applications for liquor licenses by outlet type and SAPS station

Application by outlet type	Harare (no.=45)	Lingelethu West (no.=19)	Site B (no.=23)	Total (no.=87)
	no. (%)	no. (%)	no. (%)	no. (%)
Shebeen	21	9	15	45
No	19(91)	6(67)	13(87)	38(84)
Yes	2(10)	3(33)	2(13)	7(16)
Take-away	4	2	8	14
No	2(50)	1(50)	8(100)	11(79)
Yes	2(50)	1(50)	0	3(21)
Tavern	1	0	0	1
No	1(100)	0	0	1(100)
Yes	0	0	0	0
Umqombothi	1	0	0	1
No	1(100)	0	0	1(100)
Yes	0	0	0	0
All outlets	27	11	23	61
No	23(85)	7(64)	21(91)	51(834)
Yes	4(15)	4(36)	2(9)	10(16)

Overall, a small proportion of outlets (34.8%) had any sort of visible branding (Table 12; Figure 12). There was a significant association between licensing and branding ($p<0.001$). Most unlicensed outlets (88.5%) did not have visible branding while nearly all licensed outlets (92.3%) did have branding.

The vast majority of outlets (85.1%) reported receiving no support from alcohol manufacturers. Of the 15% who received support, 10 out of the 13 outlets were taverns.

Figure 12: Branding visibility (formal vs informal outlets)

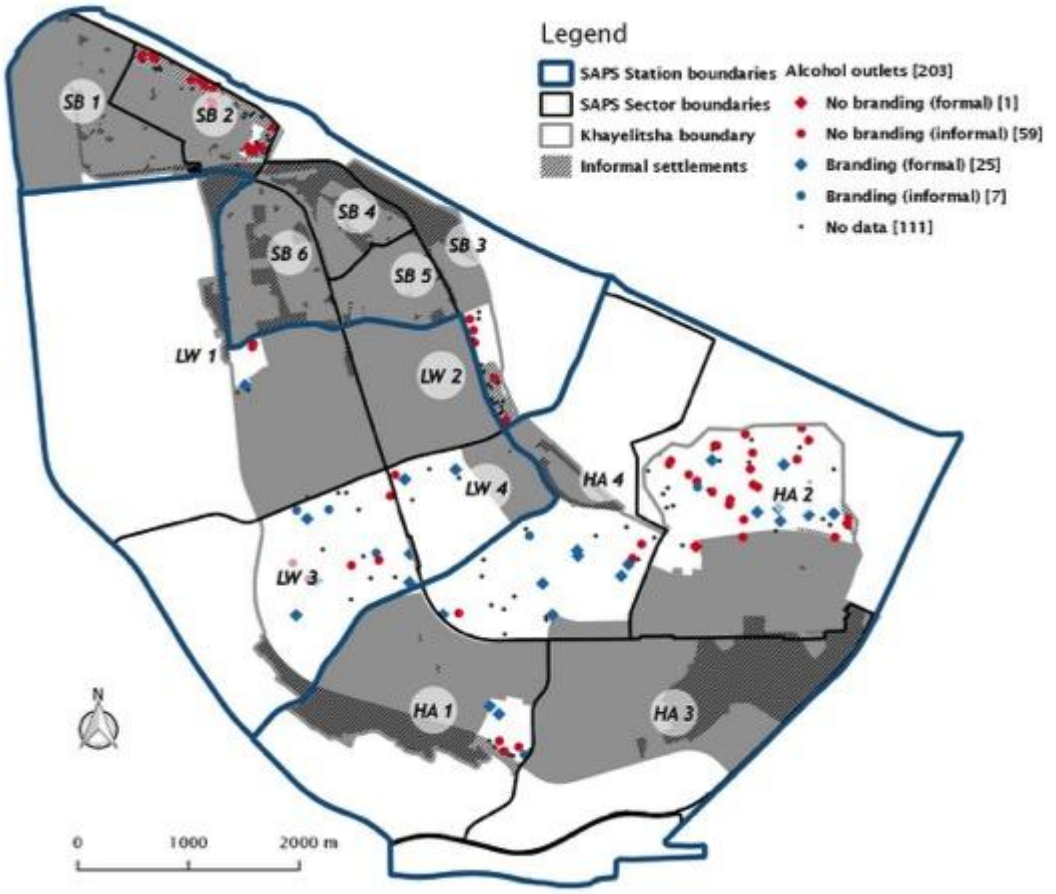


Table 12: Presence of visible alcohol branding by outlet type and SAPS station (no.=92)

Visible branding by outlet type	Harare (no.=45)	Lingelethu West (no.=19)	Site B (no.=23)	Total (no.=87)
	no. (%)	no. (%)	no. (%)	no. (%)
Shebeen	24	9	15	48
No	23(96)	6(67)	14(93)	43(90)
Yes	1(4)	3(33)	1(7)	5(10)
Take-away	7	2	8	17
No	5(71)	2(100)	8(100)	15(89)
Yes	2(29)	0	0	2(12)
Tavern	17	9	0	26
No	1(6)	0	0	1(4)
Yes	16(94)	9(100)	0	25(96)
Umqombothi	1	0	0	1
No	1(100)	0	0	1(100)
Yes	0	0	0	0

All outlets	49	20	23	92
No	30(61)	8(40)	22(96)	60(65)
Yes	19(39)	12(60)	1(4)	32(35)

5.3.10. Alternative business interests

All outlets surveyed in 2016 were asked what kind of alternative business they would be interested in opening up in lieu of an alcohol business. There were four categories:

- manufacturing (e.g. building, welding, making clothes and making crafts)
- retail (e.g. food, clothes, technology and hardware)
- services (e.g. training, education, hair salon and household repairs)
- extractive (e.g. agriculture)

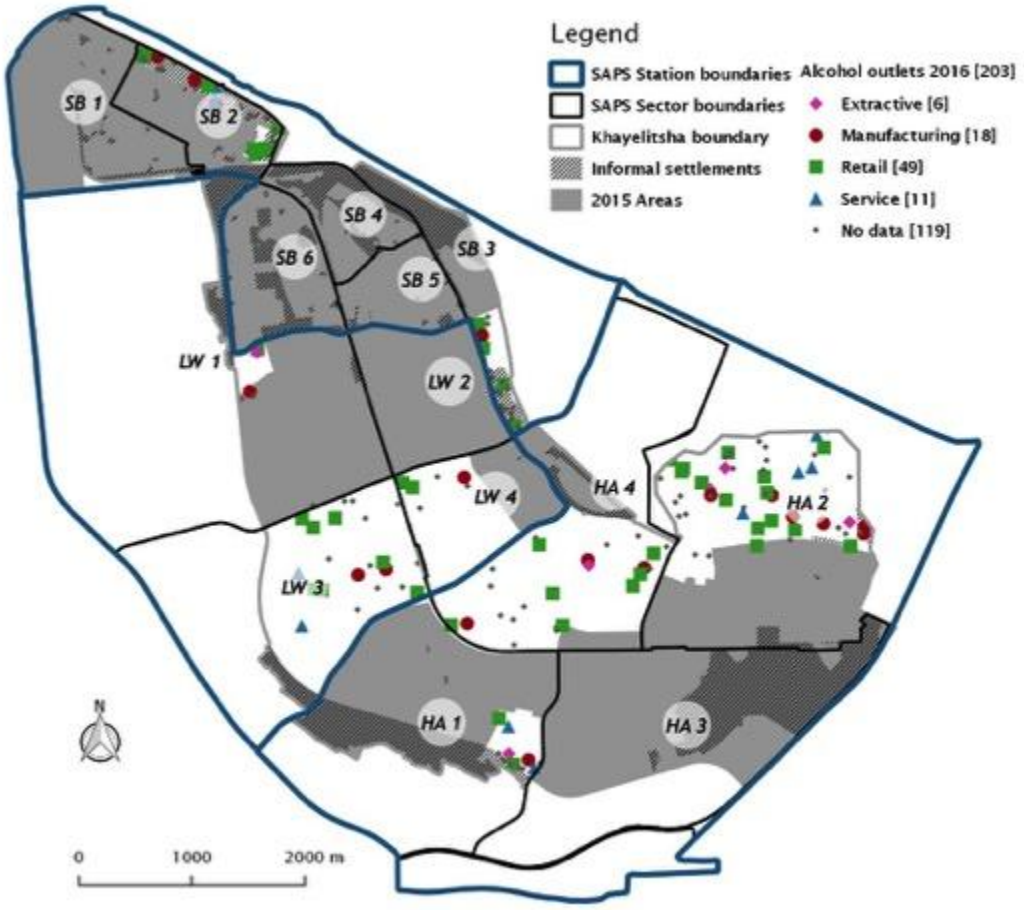
Most outlets would be interested in pursuing retail (59.8%) or manufacturing (24.1%) (see Table 13). The map in Figure 13 provides valuable information beneficial for developing targeted business development interventions, such as developing a potential urban, business corridor or business education courses in Harare sector 2, which would cater to alternative businesses outside of the alcohol industry, based on outlet owners' desired alternatives.

Table 13: Alternative business interests by outlet type and SAPS station

Business alternatives by outlet type	**Harare (no.=45)**	**Lingelethu West (no.=19)**	**Site B (no.=23)**	**Total (no.=87)**
	no. (%)	**no. (%)**	**no. (%)**	**no. (%)**
Shebeen	22	9	15	46
Manufacturing	7(32)	2(22)	4(27)	13(28)
Retail	11(50.)	6(67)	10(67)	27(59)
Services	3(14)	0	2(13)	5(11)
Extractive	2(9.)	1(11)	0	3(7)
Take-away	6	2	8	16
Manufacturing	1(17)	1(50)	1(13)	3(19)
Retail	4(67)	1(50)	6(75)	11(69)
Services	1(17)	1(50)	1(13)	3(19)
Extractive	0	0	0(	0
Tavern	16	8	0	24
Manufacturing	3(19)	2(25)	0	5(21)
Retail	8(50)	5(63)	0	13(54)
Services	2(13)	1(13)	0	3(13)
Extractive	3(19)	0	0	3(13)
Umqombothi	1	0	0	1
Manufacturing	0	0	0	0

Retail	1(100)	0	0	1(100)
Services	0	0	0	0
Extractive	0	0	0	0
All outlets	45	19	23	87
Manufacturing	11(24)	5(26)	5(22)	21(24)
Retail	24(53)	12(63)	16(70)	52(60)
Services	6(13)	2(11)	3(13)	11(13)
Extractive	5(11)	1(5)	0	6(7)

Figure 13: Alternative business interests (formal vs informal outlets)



5.4. LIMITATIONS

This study included several limitations:

- The second phase of the study commenced a year after the first, which may have affected comparability of data due to changes in the alcohol trade environment over time.

- Interviews were conducted with a small sample size, which may limit the generalizability of the findings.

- Fieldworkers used observational techniques to classify outlets, due to the sensitive nature of informal outlets, which may have led to a degree of misclassification. However, self-reported licensing information corroborated fieldworker-reported classifications of outlets, which provides an indication of high-quality classification.

- Due to the transient and clandestine nature of unlicensed alcohol outlets, it is possible that these data are an under-estimation of how many unlicensed outlets are truly operating.

- Some fieldworkers were confused using 24-hour military time when reporting operating hours. For example, certain outlets opened at 23:00 and closed at 23:00 or opened at 9:00 and closed at 11:00. An assumption was made that fieldworkers had confused daytime versus night time hours and the data was carefully cleaned accordingly. Due to the uncertainty of these data, the results should be interpreted with caution.

- Comparison of outlets identified as licensed during the fieldwork and the database of officially licensed outlets obtained from the Liquor Authority was instructive for several reasons:

    - Several outlets could not be geolocated from the database provided by the Liquor Authority, which may have arisen from local street and site naming conventions in some areas not aligning with formally demarcated addresses. There may be a case to include the geolocation as part of the licensing process.

    - The high rate of matching for geolocated outlets indicated that global positioning errors on phones might have been up to 50 metres. To deal with this issue, whenever there was a discrepancy between the fieldworker-reported location of an outlet and the fieldworker's GPS coordinates within 50m of an area boundary, the outlet was categorised to the fieldworker-reported location. Even so, this may have led to a minor misallocation of outlets to suburbs, sectors or precincts.

5.5. CONCLUSIONS

These data provide a wealth of insight into the density, spatial distribution and characteristics of alcohol outlets in Khayelitsha. This is the first time that such a comprehensive dataset has been available to interrogate. In summary, these data indicate pervasive access to alcohol, particularly in Site B and Site C, and primarily from unlicensed outlets. Overall, one outlet in Khayelitsha serves approximately 375 people, but there is a wide variation in accessibility per population across sectors. Site B sector 2, Harare sector 1 and Site B sector 5 had the highest number of outlets relative to the population in those areas. Harare sector 2, Lingelethu West sector 2 and Lingelethu West sector 4 had the lowest number of outlets per population.

Unlicensed outlets tended to have a smaller capacity for patrons, the vast majority had entertainment equipment, the average outlet had been in business for approximately a decade, they primarily served beer, their patrons were mostly male, between 25 and 34 years old, there was high interest in obtaining liquor licenses, and most would switch to a different kind of retail business. In regards to outlet characteristics, there were many interesting differences in outlets between SAPS precincts and sectors.

These data will enable valuable analyses of geospatial relationships between the density, distribution and types of outlets and violence and injury, as well as how urban upgrading has affected where and how outlets operate. In addition, these data can act as baseline information for identifying hotspots and determining important themes for alcohol harms reduction interventions and future comparative studies assessing the impact of such interventions on the density, distribution and characteristics of outlets.

To demonstrate this utility we provide an example from earlier work in Nyanga, led by Dr Tatenda Makanga. Figure 14 provides a graphical representation of the availability of alcohol in Nyanga at different times of the day taking into account the capacity of each outlet. We have also included an appendix (Part 5, Appendix 2) summarising the requirements for a sustained effort to continually refresh the outlet maps through ongoing systematic data capture processes, perhaps in consort with community agencies (e.g. Community Safety Forums or neighbourhood watch), in a manner that informs community policing. Specifically, we describe our idea for 1) a mobile app to facilitate liquor outlet data capture and use of these data for community

policing and 2) an ArcGIS server based platform for processing the outlet data, providing real time PLOCT data to field officers.

Figure 14: Spatio-temporal patterns of access to liquor outlets

PART 6: ALCOHOL-RELATED VIOLENT INJURIES IN KHAYELITSHA (2013-2015)

Compiled by Sam Lloyd, Kim Bloch and Richard Matzopoulos, based on research conducted by Health Systems Trust and led by Linda Mureithi

6.1. INTRODUCTION

This document reports on the results of a descriptive analysis for the Western Cape Department of Community Safety (DoCS) of data collected as part of the Injury Morbidity Surveillance study conducted by the Health Systems Trust (HST), with funding from the International Development Research Centre (IDRC), Canada. This project involved a series of repeat cross-sectional surveys of trauma cases seen at health facilities in Khayelitsha and Nyanga, and aimed to identify population sub-groups and areas at high risk of injury and to monitor trends over time.

The analysis presented in this report pertains to a subset of injuries caused by violence that were reported to have occurred within Khayelitsha. Through providing a profile of non-fatal injuries caused by violence between 2013 and 2015 in Khayelitsha, and the involvement of alcohol in such injuries, our analysis serves to highlight the linkage between alcohol-related violence and interpersonal injuries.

6.2. METHODOLOGY

Repeat cross-sectional surveys were conducted every six months, the first in September 2013 and the final round in September 2015, with five phases in total. For each survey, data was collected over a one-week period, 24 hours a day, on all trauma injury cases at six selected health facilities located in Khayelitsha, Gugulethu, and Nyanga. The facilities serving Khayelitsha, where the majority of violent injuries occur were visited, including Khayelitsha District Hospital (KDH), Khayelitsha Site B Community Health Centre (CHC) and Michael Mapongwana Community Day Centre (CDC). Seven cases seen at Gugulethu CHC were reported to have occurred in Khayelitsha.

Data collected on trauma cases by study staff via patient interviews and folder reviews included basic demographic data, such as age

and gender, the cause of injury, location and time of injury, and the involvement of alcohol or other drug use.

6.3. RESULTS

Overall, 945 violent injuries occurred in Khayelitsha over the five surveys. Alcohol use by patients was reported or suspected in over half (52%) of these injuries and in 11% the use of alcohol was unknown. Meaning, only 36% of injuries reported indicated alcohol was not involved.

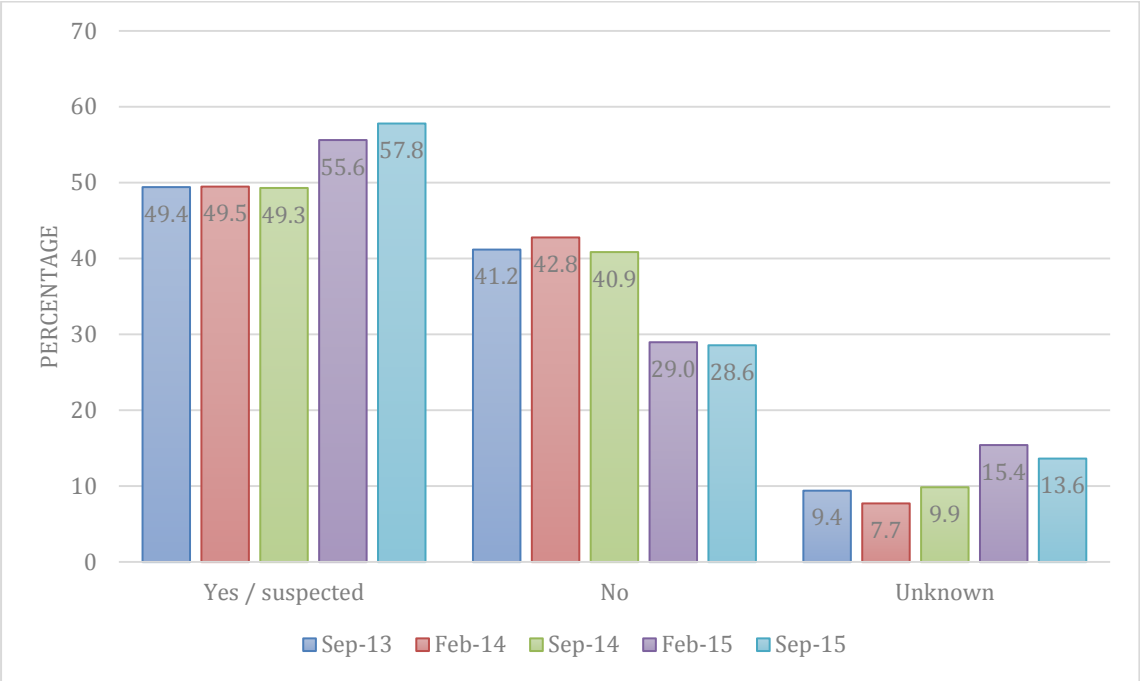
6.3.1. Trends in alcohol-related violence over time

Table 1 and Figure 1 below present data on changes over time in the involvement of alcohol in violent injuries. Similar proportions were found between September 2013 and September 2014, followed by a rise in the proportion of violent injuries that involved alcohol in February 2015 to 56%, to a high of 58% in the September 2015 survey.

Table 1: Alcohol use in violent injuries by survey

Alcohol-relatedness of injury		Survey					
		Sept 2013	**Feb 2014**	**Sept 2014**	**Feb 2015**	**Sept 2015**	**Total**
Yes / suspected	no.	84	96	105	119	89	493
	%	49	50	49	56	58	52
No	no.	70	83	87	62	44	346
	%	41	43	41	29	29	37
Unknown	no.	16	15	21	33	21	106
	%	9	8	10	15	14	11
Total	no.	170	194	213	214	154	945

Figure 1: Alcohol use in violent injuries by survey



6.3.2. Alcohol-related violence by police precinct

In terms of differences in the proportion of violent injuries involving alcohol use by police precinct, the proportion is highest in Site B (57%) followed by Lingelethu West (54%), with Harare having the lowest with 46%. Variation is seen across precinct sectors also: particularly high proportions are found in Site B sectors 5 and 6 (61% and 64% respectively), and Lingelethu West sectors 1 and 2 (61% and 62%). Sectors with the lowest proportions of alcohol involvement in violent injuries were Harare sectors 1 and 4 (41% and 29%) and Lingelethu West sector 3 (41%) (see Table 2 and Figure 2 below).

With regard to the absolute number of violent injuries that involved alcohol use, again Site B is ranked first with 15.1 injuries involving alcohol per 10 000 people[7], followed by Lingelethu West (9 per 10 000), then Harare (8.54 per10 000) (see Table 3 and Figure 3).

[7] Population figures from Census 2011.

Table 2: Alcohol use in violent injuries by police precinct

Alcohol-relatedness of injury (%)		Police precinct (Sector number) HARARE					LINGELETHU WEST					SITE B						
		1	**2**	**3**	**4**	**Total**	**1**	**2**	**3**	**4**	**Total**	**1**	**2**	**3**	**4**	**5**	**6**	**Total**
Yes / suspected	no.	38	54	41	15	**148**	14	8	13	23	**58**	35	24	31	31	43	56	**232**
	%	41	57	51	29	**46**	61	62	41	58	**54**	52	44	57	52	61	64	**57**
No	no.	42	32	29	29	**132**	6	3	12	14	**35**	27	27	17	27	22	28	**151**
	%	45	34	36	57	**41**	26	23	38	35	**33**	40	49	32	45	31	32	**37**
Unknown	no.	13	9	11	7	**40**	3	2	7	3	**15**	5	4	6	2	5	4	**27**
	%	14	10	14	14	**13**	13	15	22	8	**14**	8	7	11	3	7	5	**7**
Total	no.	93	95	81	51	**320**	23	13	32	40	**108**	67	55	54	60	70	88	**410**

Figure 2: Alcohol use in violent injuries, by police precinct

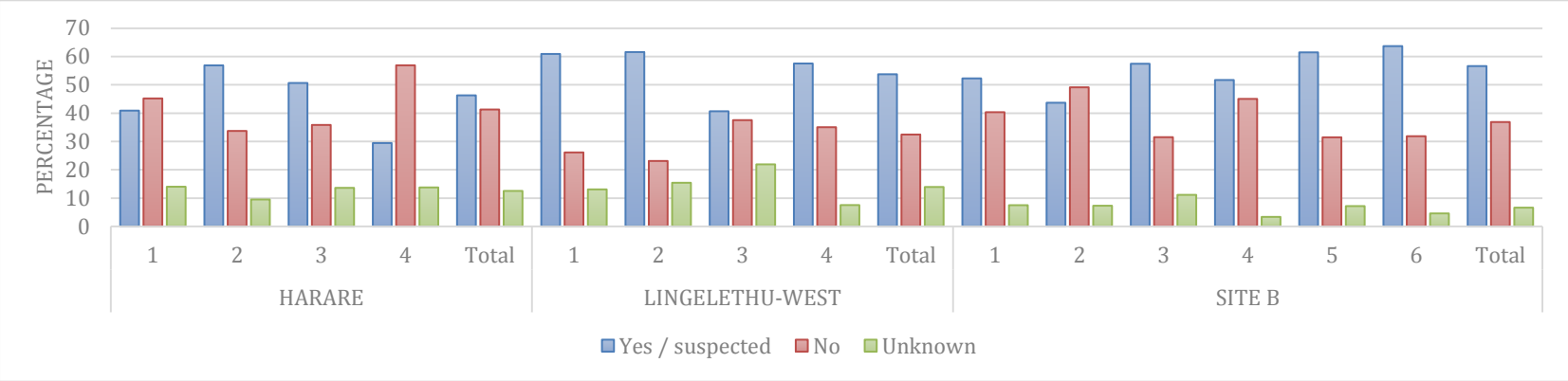
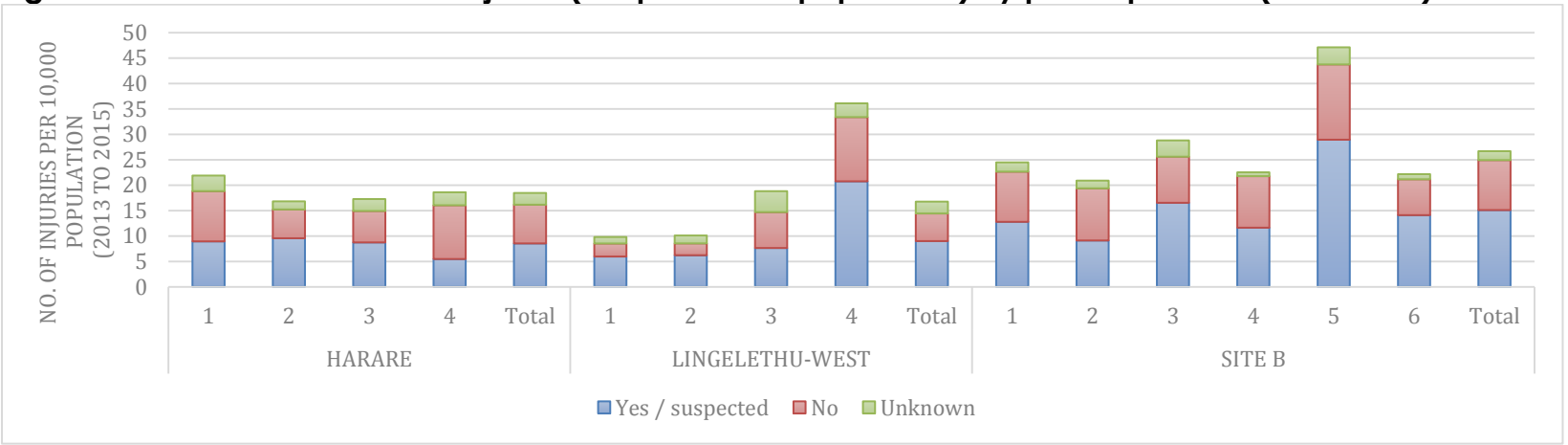


Table 3: Alcohol use in violent injuries (no. per 10 000 population) by police precinct (2013-2015)

Alcohol-relatedness of injury (%)	Police Precinct (Sector number)																
	HARARE					LINGELETHU WEST					SITE B						
	1	**2**	**3**	**4**	**Total**	**1**	**2**	**3**	**4**	**Total**	**1**	**2**	**3**	**4**	**5**	**6**	**Total**
Yes / suspected	9	10	9	6	**9**	6	6	8	21	**9**	13	9	17	12	29	14	**15**
No	10	6	6	11	**8**	3	2	7	13	**5**	10	10	9	10	15	7	**10**
Unknown	3	2	2	3	**2**	1	2	4	2	**2**	2	2	3	1	3	1	**2**
Total	22	17	17	19	**19**	10	10	19	36	**17**	25	21	29	23	47	22	**27**

Figure 3: Alcohol use in violent injuries (no. per 10 000 population) by police precinct (2013-2015)



6.3.3. Alcohol-related violence over time by police precinct

Trends in alcohol-related violent injuries can be seen in Tables and Figures 4 and 5 below. The level of violent injuries involving alcohol has stayed relatively steady over time, while in Lingelethu West it appears to have fallen sharply between the September 2013 and February 2014 surveys, before rising again, followed by another sharp fall between the last two surveys. Site B, on the other hand, saw a relatively fast rise in alcohol-related violent injuries up to February 2015, before a sharp decline to September 2015, though not to as low as September 2013 levels.

Table 4: Alcohol use in violent injuries over time by survey and police precinct

		no. and % of violent injuries involving alcohol		
Survey		Police Precinct		
		HARARE	LINGELETHU WEST	SITE B
Sep-13	no.	27	19	33
	%	53	73	44
Feb-14	no.	32	9	38
	%	49	64	46
Sep-14	no.	27	12	56
	%	38	43	62
Feb-15	no.	33	12	63
	%	45	46	65
Sep-15	no.	29	6	42
	%	49	43	64

Figure 4: Alcohol use in violent injuries over time by survey and Police precinct

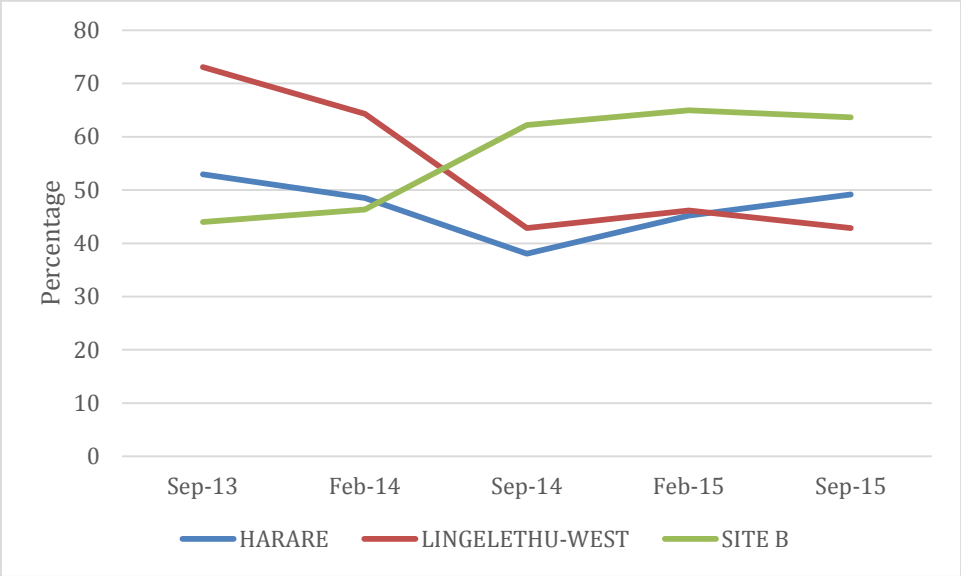
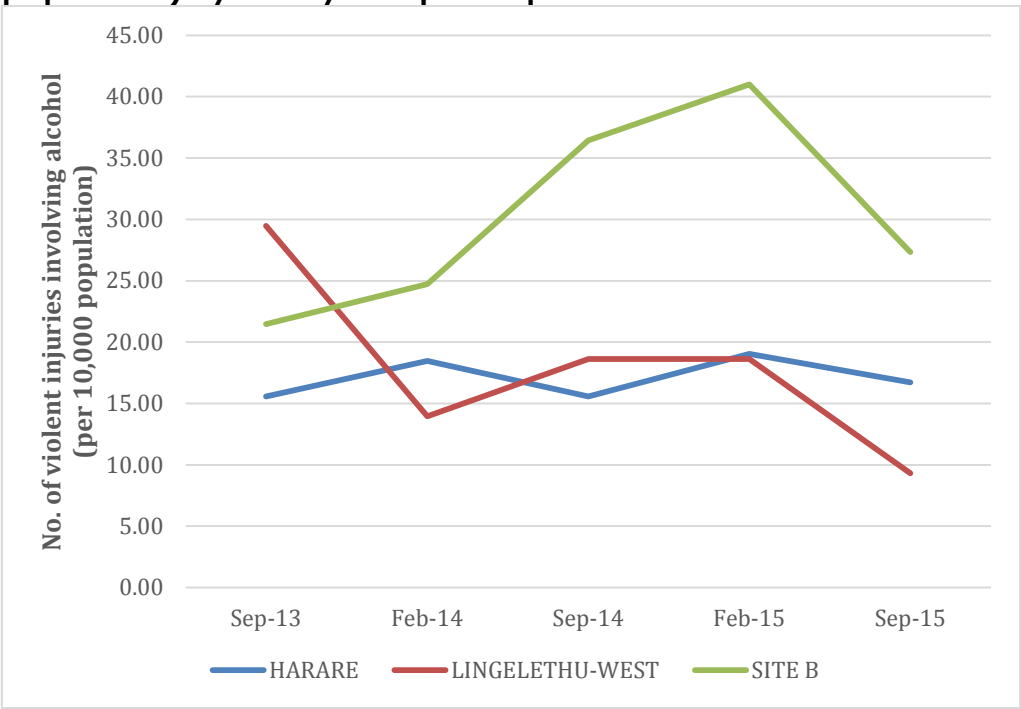


Table 5: Alcohol use in violent injuries over time (no. per 100 000 population) by survey and police precinct

Survey	Violent injuries per 100 000 population Police precinct		
	HARARE	LINGELETHU WEST	SITE B
Sep-13	16	30	22
Feb-14	19	14	25
Sep-14	16	19	36
Feb-15	19	19	41
Sep-15	17	9	27

Figure 5: Alcohol use in violent injuries over time (no. per 100 000 population) by survey and police precinct



6.4. LIMITATIONS

Limitations to the analysis presented above including the issue of missing information regarding specific sub-areas of Khayelitsha for a relatively high number of cases, and the fact that denominators used for calculating the number of injuries (per 10 000 and 100 000 people) are based on 2011 figures derived from the Census 2011, with population changes likely to have occurred since that time.

6.5. CONCLUSION

The data presented in this report highlights the serious implications of alcohol use for the health and safety of the Khayelitsha community, with over half of all sufferers of violent injuries having reported or suspected alcohol use – a proportion that has grown since the end of the September 2014 survey. The relationship between alcohol use and experiencing an injury as a result of violence is of particular concern in Site B police precinct, with both the absolute number of injuries and percentage of violent injuries that involved alcohol appearing to have grown significantly over time, although the most recent survey conducted in September 2015, which saw a reduction in the absolute number of alcohol-related injuries, is somewhat encouraging.

PART 7: FOCUS GROUP ANALYSIS: A QUALITATIVE STUDY OF THE PERCEPTIONS OF ALCOHOL, ALCOHOL HARMS AND REGULATION POSSIBILITIES IN KHAYELITSHA

Compiled by: Brett Bowman and Malose Langa

7.1. BACKGROUND

Alcohol use and abuse remains a serious global problem. In South Africa, the type, frequency and volume of alcohol consumed is directly and indirectly related to a range of harms that exert a significant burden on the health, development and economy of the country (Matzopoulos et al., 2014). Although dangerous drinking patterns are widespread throughout the country, the prevalence and frequency of risky drinking significantly compounds the already-pronounced risk profile for communicable diseases, violence and injuries in the country's low-income contexts. One such context is Khayelitsha, the Western Cape's largest township where the alcohol trade is largely unregulated. Home to more than 400 000 people there are 114 licensed alcohol-serving or selling establishments and, more than 900 illegal establishments. Existing studies have shown that this mix of population density and unregulated distribution of alcohol is associated with a range of alcohol-related harms (Peer, Lombard, Steyn and Levitt, 2014). In recognition of the potential role of alcohol in exacerbating extant risk for poor health outcomes in contexts such as Khayelitsha, the Western Cape Province's Department of Community Safety commissioned a high-level study, which aimed to inform the allocation of scarce resources to address alcohol, one of the major drivers of the disease burden in the Western Cape Province. In response a mixed-methods, multi-armed study was undertaken by the Universities of Cape Town and the Witwatersrand. This report outlines the aims, objectives, methods and results of the qualitative arm of the overarching study. It should thus be read as part of the integrated report on the overarching project titled: *A mixed-methods study of the nature and extent of the alcohol trade in Khayelitsha – and community perceptions*.

7.2. AIM AND OBJECTIVES

The preceding sections of the report used survey and surveillance data to outline current international and local knowledge on alcohol harms, consumption patterns, attitudes to alcohol, alcohol regulation and the injury burden attributable to alcohol. In order to further enhance the overall picture provided by this quantitative data, the specific aim of this qualitative arm of the study was to provide a more fine-grained, rich exploration of community perceptions of the nature and extent of, and interventions aimed at, alcohol trading and consumption in Khayelitsha.

The specific objectives of this arm of the study are to describe community perceptions of the alcohol trade, with an emphasis on:

- exploring the risks and harms associated with alcohol
- describing community receptiveness to available interventions, including pricing, enforcement and marketing

7.3. METHODS

7.3.1. Design

The qualitative study used both semi-structured interviews and focus group discussions (FGDs) to collect data on the perceptions of the distribution, consumption and regulation of alcohol and its related harms across the township, from targeted key informants and stakeholders. As the qualitative component of a concurrent, nested mixed-methods design; the data was collected independently of other information gathering strategies of the study. The resultant qualitative data was used to supplement the existing quantitative data, and elaborate and advance the findings of the prospective quantitative arms of the study.

7.3.2. Procedure

Following ethics clearance from the University of Cape Town Human Research Ethics Committee, the two authors and a trained fieldworker began recruiting participants for the interviews and FGDs. Recruitment took two primary forms. Firstly, the fieldworker arranged meetings with

representatives from key formal organisations. This strategy resulted in FGDs with the community-policing forum (CPF), church and neighbourhood watch. The second form of recruitment involved haphazard on-site sampling across the various targeted geographical boundaries in Khayelitsha. In cases where more than one group of particular types of informants were required, additional participants were recruited using snowball-sampling techniques. This second approach yielded FGDs with male and female drinkers, tavern owners and shebeeners. In each case, consent for participation in the FGDs and the recording and transcription thereof was secured.

7.3.3. Participants

Community perceptions were operationalized as those perceptions reported by five key collective stakeholders. The first group, shebeeners, has obvious vested interests in the regulation of alcohol, and is an important participatory partner in considering possible changes to the alcohol environment. Tavern owners constituted the second important group of stakeholders implicated in better understanding the distribution and regulation of alcohol. The third group of participants are young male drinkers. Survey data shows that this group of residents are most at risk for the harms associated with alcohol as a result of frequent consumption by volume.

The fourth group is made up of non-drinkers. This often-neglected group in alcohol-related research provides an important vantage point from which to understand the role of alcohol in the communities from those that do not consume it, but are nonetheless subject to its community-level effects. Female drinkers are only recently emerging as an important group of high-risk consumers. In line with Peer, Lombard, Steyn and Levitt (2014), female drinkers were included as the fifth stakeholder group in this study. The sixth group is the Community Policing Forum (CPF). The seventh group is the neighbourhood watch. Given its co-ordinating role in government, the eighth collective of key informants represented the South African National Civic Organisation (SANCO). Lastly, a church leader was interviewed in order to provide some insight on the perceptions of alcohol consumption and regulation by the dominant religious grouping in Khayelitsha. The sampling strategy resulted in the recruitment of 30 male and 22 female participants into

the study. Data collection from these informants took the form of 10 focus groups and five interviews as described in table below.

Table 1: Data collection instrument by number and type of participants

Instrument	Participant type	Area	Females	Males	Code
SSI	Shebeen owner	Site C		1	SSHB00
SSI	Shebeen owner	Harare		1	SSHB01
SSI	Tavern owner	Town 2	1	1	SSHB02
SSI	Tavern owner	Makhaza	1		SSHB03
SSI	Church leader	C Section	1		SSHB04
FGD	Non-drinkers (Group 1)	Town 2	2	3	FND01
FGD	Non-drinkers (Group 2)	C Section	3	3	FND02
FGD	Neighbourhood watch	Site B	3	3	FNW01
FGD	CPF	Site B	4	2	FGDC01
FGD	Drinkers (Group 1)	Makhaza	3	2	FGDD01
FGD	Drinkers (Group 2)	C Section	1	3	FGDD02
FGD	Male drinkers	Harare		5	FGDD03
FGD	Male drinkers	C section		4	FGDMD02
FGD	SANCO	Site B		2	FGDSNC01

7.3.4. Data collection

Each of the prospective group discussions (FGDs), consisting of at least two but no more than six participants, were facilitated by trained fieldworkers and/or one of the two dedicated researchers on the project. The discussions were guided by the semi-structured interview schedules (attached as appendices).

The schedule was designed to facilitate discussions on risks and harms associated with alcohol in Khayelitsha and the receptiveness to available interventions, including pricing, enforcement and marketing within each of eight homogenous groups outlined above. In cases where more in-depth information was required from a single participant, the participant was invited to a semi-structured interview. Once consent had been obtained, fieldworkers conducted the

interviews in a quiet place. The discussions and interviews were audio recorded and transcribed verbatim.

7.3.5. Data analysis

The analysis distilled the main themes and patterns that characterised the FGDs and interviews both within and across groups. This analysis was guided by several of the methodological sequences advanced by Braun and Clarke (2006). Essentially, these involved the immersion of each facilitator in the full dataset, followed by the extraction of codes or patterned uses of terms, phrases and other units of meaning. The codes were then further clustered into themes. The themes were described within and then across groups. A diagrammatic representation of the relationships between themes used to describe the dataset was then compiled (see Appendix 2). Finally, this map is written up to account for the evidence-based decisions underpinning its organisation.

7.4. RESULTS AND DISCUSSION

A diagrammatic representation of the data analysis and discussion is provided in Appendix 2. In line with any self-report study these themes represent reported perceptions of the topic discussed.

7.4.1. Drinking trends and hotspots

7.4.1.1. Alcohol abuse is a major problem in Khayelitsha

Without exception and echoing a number of other recent studies (Peer, Lombard and Levitt, 2014; Peltzer, Davids and Njuho, 2011) and the findings in all the preceeding sections of this report, all of the participants asserted that alcohol abuse is a major problem in Khayelitsha.

Respondent (R): There is a lot of alcohol abuse in our areas. There is no difference between weekends, holidays or weekdays. They drink all the time. You would see a person in the street drunk and still carrying some.

(FGDC01)

It was asserted in all the interviews that people in Khayelitsha drank too much. As reflected in the earlier household survey, binge drinking (which is defined as drinking five or more drinks at one occasion) appears to be a common feature across Khayelitsha. In line with the findings in the preceding outlet mapping section, it was reported that people drank daily, although their drinking increased marginally on weekends, perhaps reflecting the slight increases in operating hours. These fluctuations in the volumes and types of alcohol consumed could also be influenced by wage earning patterns, by both the formally employed and the self-employed. Based on the views of both male and female drinkers, volumes of consumption are mostly low on Tuesdays and Wednesdays, when the money has run out.

R: Alcohol abuse is rife.
R: We drink a lot.
R: On Thursday, Friday, Saturday, Sunday and Monday. Sometimes when you have money you can drink on a Wednesday.
R: We cleanse the wallets on Thursday then Friday, Saturday, Sunday – and then on Monday we finish off.
Interviewer (I): Do you rest for a few days?
R: On Tuesday and Wednesday.
R: If you drank on Monday you will also drink on Tuesday. If you drink on Tuesday then you will drink on Wednesday as well. People drink every day. Sometimes people may drink over a weekend or when there is something to celebrate but here they drink all the time.

(FDGFD01)

Despite the reports in the household survey in which the majority of respondents indicated rarely drinking. The majority of the respondents in the qualitative arm of this study reported that drinking in Khayelitsha occurs every day; it's almost a defining feature of life. It was evident in the interviews that taverns and shebeens are popular places that young and old people visit regularly in Khayelitsha. The main aim in visiting these places is to drink, to get drunk and socialise. Many participants spoke about drinking to dangerous levels of intoxication as the norm in the community. This supports the findings of several studies reviewed in

this report: drinking appears to be high in Khayelitsha (Reddy et al., 2010; Shisana, Rehle, Simbayi, Zuma, Jooste, Pillay-Van Wyk, Mbelle, Van Zyl, Parker, Zungu, and Pezi, 2009). The results highlighted some very critical trends: drinkers are getting younger and female drinkers are greater in number, compared to previous studies.

7.4.1.2. Drinkers are getting younger

Although past studies have found that underage drinking and drunkenness is common in South Africa (Parry, 2012), most participants in this study reported drinkers in Khayelitsha to be very young. These reports find resonance with Morojele et al.'s (2006) study of drinking behaviour and risky sex in shebeens in Gauteng. However, the Khayelitsha focus group reported having seen children as young as 13 drinking excessively at various shebeens and taverns.

I: What age are the underage drinkers in your estimation?

Female respondent (F): They are very young.

F : Thirteen.

F : They've just started high school.

F : They've just started high school. Some are in Grade 8. That child is 13.

(FDGFD01)

The numbers of school-going youth frequenting shebeens and drinking excessively is perceived to increase when children celebrate the end of term. Anecdotal accounts are important as they provide context for the increases in episodic drinking and gaining access to alcohol among adolescents in different socioeconomic strata (Morojele and Ramsoomar, 2014).

F: They are too many. Just yesterday we were bumping into some young ones at the shebeen. They said they were celebrating pens down.

F: They said they were celebrating pens down. We were sitting with children this small.

I: What do they say pens down is?

F: They've just finished writing, so its pens down.

F: They 'cleanse the question paper'.
I: They cleanse it by going to the shebeen?
F: Yes.

(FDGFD01)

Shebeens provide easy access to alcohol – and as they are unregulated they provide meeting points for school going youth during school hours. Thus, shebeens act as a resource or additional enabler for truancy in many of the sites in the township. In some instances children are sold alcohol for immediate consumption, in other cases children are sold alcohol that they claim is intended for adults. However, in both cases, the law and/or common conventions, which prohibit selling liquor to underage children, are clearly flouted.

R: And what makes it worse is that you'd find that there are underage or younger children frequenting the ismokolo *(shebeen). Around 12am in the morning you will find young boys and girls sitting at the* ismokolo.
R: The other thing is that there are regulations that alcohol should not be sold to people under 18. But I do not think that is observed at many of these shebeens. Even if they see it written, many people still send children to buy alcohol. School are closed and you'd see many children carrying plastics with alcohol. At least they still use plastics to carry it. But the problem is that they send children. Whereas the law says no under 18s are allowed to buy alcohol.
I: I was still going to raise it in your conversation if you've ever witnessed children under 18 drinking alcohol. But then you are raising it already. Are the tavern and shebeen owners playing any role against that? Or do they observe any restrictions when it comes to the children who are under 18? Or do they just ignore it? It's just anything goes?
R: They just ignore it. Anything just goes. And when we ask them they would say it's their work, what do we think they must do to survive if we don't allow them to sell alcohol. So whether a child is under 18 or not, they don't care.

(FGDC01)

Clearly the minority of tavern owners reported children were not permitted to buy alcohol from nor drink within their taverns. However, even these owners conceded to the fact that despite their sanctions, alcohol was widely available to children in Khayelitsha. Most tavern owners did not enforce policy regulations to deny young children access to alcohol.

I: Children are not allowed to drink?
R: We do not sit and drink with younger people here.
I: In this particular tavern?
R: In this place.
I: But generally, is alcohol consumption rife in the community?
R: In the community, I can say there are younger people who drink and we see them.

(FGDMD01)

7.4.1.3. Young people prefer shebeens to taverns

One key sub-theme that emerged in the contexts of reports on drinking trends was the widely held perception that children prefer shebeens to taverns because they are less likely to be policed by patrons or owners when purchasing alcohol from or drinking at the former. In addition, shebeen culture is marked by more youthful music and the ambience is seen as attracting underage children, as evidenced in the extracts from multiple sources below.

R: The underage children do not go to the taverns. They go to the shebeens because the shebeens do not have age restriction.
R: Shebeens do not have age restriction and it is not licensed. They just sell illegally, they want money. They do not care what age the children are. They just sell alcohol to anyone.

(FGDC01)

R: Yes. The youth would prefer a certain place, and others would prefer a certain place. What happens then is that a place would close and then the people would go to the yizo-yizo's.[8]

[8] Shebeens characterised by lawlessness and violence.

R: The places frequented by older people, are normally frequented by married people. And the music is not loud. They just play jazz and they would be chatting to each other. You would never find people fighting there, or get people engaged in arguments. They just sit and chat to each other.

(FND01)

Both taverns and shebeens are places of entertainment for the youth in Khayelitsha. These are places where the youth meet, especially during school holidays or weekends to drink alcohol. It is normal to see young people on the street corners drinking alcohol. The young adults in this report also indicated that young people also drink at home with friends. It is possible that young people drink in the presence of their parents, confirming our view earlier that drinking alcohol is a key feature of life in this community. The earlier survey's finding that alcohol consumption amongst females in Khayelitsha is increasing was also confirmed by the reports in a number of the focus groups discussions.

7.4.1.4. Female drinkers, gender, children and violence

Despite the prevalent preconception of men as key actors in alcohol consumption and distribution, women were frequently reported to be highly visible in both areas of interest in the study. Moreover, these reports pointed to the fact that women of all ages drink frequently in shebeens, including young females and young mothers that are accompanied by children. A group of male drinkers linked underage drinking amongst females with unplanned pregnancies.

I: Is there anyone else who'd like to say how he feels about it? Is there a problem when you see children under 14 drink alcohol? And the way they behave as a result?

Male respondent (M): Drinking is a huge problem when minors drink because at the end they cause problems. For example, girls under 18 drink and they end up falling pregnant. They behave as if they have been drinking for a long time, but they are just overwhelmed.

(FGDMD01)

I: What is the reason for you as ladies to drink? Is there any reason that makes you spend time at the shebeen?

F: It's just to relax. Because when you are drunk everything becomes easy.

F: It becomes easy.

F: Yes.

F: You do not think about anything. You just relax and enjoy yourself.

I: When you have a small child?

F: Yes. Sometimes I would take my child to the shebeen – so other shebeen owners would order you out, but others would just leave you and drink in the presence of your child.

(FDGFD01)

These findings lend support to several studies that have recently shown that female participation in a culture of drinking appears to be on the increase (Peer, Lombard, Steyn and Levitt, 2015; Wilsnack, Wilsnack and Kristjanson, 2009). Another major theme related to female drinking trends involved exchanging alcohol for sex. This is a well-documented transaction (Townsend et al., 2010; Simbayi, et al., 2006), which was confirmed by several female drinkers who reported active courting of men who would buy them alcohol on the promise of sex. Female unemployment was cited as a major factor driving this practice.

I: So then you think you should just go and relax at the shebeen?

F: Yes.

F: Even during the day, you'd find that there are only four men at the shebeen and the rest are women. We would then depend on those nguthus *(men who buy women alcohol).*

I: So there would only be four nguthus*, what are you going to do as you would be in majority? How do you handle such a thing?*

F: Each nguthus *knows his lady.*

F: Even when he could be sitting with someone, when you arrive he comes to you.

I: So then won't you fight with the lady you found him with?

F: We do not fight.

F: He is not your boyfriend, he is just an inguthu *[long bottle of beer]*.

I: So the other lady has the same understanding?

F: Yes, you just get him to spend his money on you.

(FDGFD01)

While many of the female drinkers insisted that they actively pursue alcohol for sex, they also reported the implicit risk for violence this behaviour carries, especially rape in cases where women change their mind after being bought drinks. In these cases of sexual violence, men enforce masculine entitlements in the face of their loss of money and a broken promise. This is exacerbated by alcohol consumption.

M: Rapes are also the result of that. A man would want to sleep with her because she spent all his money promising that she will have sex with him. But she then refuses because the money is finished.

(FNW01)

R: *Loss of dignity amongst women mainly. When a woman is drunk she does not care, she can even wet herself. She does not care who is watching her.*

I: Is there another thing?

R: People get raped. There are some men who take advantage.

I: Because she is drunk. But generally is alcohol a problem? Generally, in your opinion?

R: And rape happens easily. A lady would get misled and then accept drinks from a man. And the man thinks he is going to get rewarded. So when he is supposed to leave with her as expected, she thinks of running away. But then the guy beats her up and she finally gives in. So then that is rape.

(FND01)

Alcohol consumption is a risk factor for violence and gender-based violence (Jewkes, 2003), in Cape Town taverns and shebeens specifically (Pitipan et al., 2013). The participants provided several interesting insights into the pathways for violence through alcohol

consumed at shebeens and taverns. Both involve the re-assertion of hegemonic masculinity in the face of entitlement to sex by women for whom drinks have been bought. The other is domestic violence, coaxed by the humiliation of having no more money.

F: *Women always come to the police station to report being beaten up by their husbands who've been drinking. They want money.*

I: *So alcohol contributes to violence in relationships and in homes?*

M: *The money is all spent at the shebeen.*

(FNW01)

I: *So alcohol contributes to violence in relationships and in homes?*

M: *The money is all spent at the shebeen.*

I: *Just expand on that brother?*

M: *When he has money he does not go home. He sees a beautiful girl at the shebeen and he joins her, but then she just tricks him all of his money. He buys lots of alcohol until early in the morning. He forgets his wife and children. He has fun there and when morning comes all his money would be gone. There is no food in the house. The money is taken by that girl.*

(FNW01)

Another perception that linked gender to violence is that women are the principal reason over which men fight. Again, such accounts implicate masculine ideals, and patriarchal competition of women as resources in an environment where excessive liquor consumption approves violence.

M: *You would find that there are more males drinking than women. So some men might approach a lady. They end up fighting. Maybe a lady is with someone and you don't know. So you would think of approaching her.*

M: *It leads to fighting.*

I: *Do you think it is the result of drinking?*

M: *Yes.*

M: *I think if men and women could drink at different places. I think there would be fewer conflicts. Many people are being attacked because of girls. A person gets drunk and then he thinks of approaching a girl.*

I: *So the fact that men and women drink at the same shebeen leads to problems?*

M: *It is a huge problem.*

I: *So in your opinion they need to be separated? There should be taverns for women and for men specifically?*

M: *Yes.*

(FGDMD01)

7.4.2. Differences in the dynamics of distribution and consumption

7.4.2.1. Taverns and shebeens are vastly different entities

All of the participants agreed that taverns and shebeens were the main source of alcohol across Khayelitsha, however they were consistently differentiated by the levels of formality and licensing. Taverns were regarded as formal, licensed liquor outlets frequented by adults, while shebeens were seen as any alcohol serving or distributing structure that was informal, unlicensed and easily accessible. Shebeens were considered more prominent in the informal settlements than were taverns.

R: *Where I come from in Site M there is no tavern. And there are over 300 houses. There are about 40 shebeens, and no tavern. But when you go to another area like K, there is a tavern, but here there are just shebeens.*

(FNW01)

Many of the participants insisted that it was impossible to even estimate the number of shebeens or taverns operating in Khayelitsha. The outlet mapping of liquor outlets (see Part 5) identified 1 045 outlets: 452, 133 and 460 in the Harare, Lingelethu West, and Site B policing precincts respectively. This corresponds to ratios of one outlet per 383.5 people, 484.5 people, and 334.1 people in those SAPS station areas. The highest densities of outlets were recorded in Site B sector 2 (1 outlet: 205.7 people), Harare sector 1 (1:295.1) and Site B sector 5 (1:309.6). There

was overwhelming consensus that the only objective pattern in the organisation of taverns and shebeens was that there were many more shebeens than taverns in Khayelitsha, and that these were mainly found in the informal settlements. Significantly, several participants reported that shebeens were so densely dotted within informal living that they had become more than businesses in the community. Integrated into the daily culture of informal living in Khayelitsha, shebeens were regarded as more popular because they were easily accessible within a short walking distance.

P: In each and every street. Shebeens are no longer businesses, they are a culture now.
R: What do you mean when you say it's not a business, it's a culture?
P: They are just too many. You'd even find that in one street there is more than one shebeen.

(FND01)

R: In your comparisons, between shebeens and taverns, which ones experience more alcohol drinking?
F: It's the shebeens.
F: It's the shebeens. And the music they play is very loud.
R: What makes them stand out?
F: They are not regulated.
F: They are not regulated and there is no age restriction.
F: There is no age limit.
F: And each and every one is allowed access to the shebeen. But at the taverns if they are aware that you rob people they refuse you access. And at the taverns they have a dress code. At the shebeens you dress as you wish.

(FGDC01)

The lack of any adherence to the stipulations of the Liquor Act was seen as driving the popularity of shebeens over taverns. These included unregulated trading hours, inattention to underage drinking and no dress code. Tavern owners insisted that it was precisely this lack of compliance to regulations that made it difficult to compete with the consumption at shebeens.

I: In your opinion, are there differences between shebeens and taverns?

R: There is a huge difference, because I am also a tavern owner. The tavern closes at 11pm and then open again at 11am. The shebeens open at 6am in the morning, or at 4am and then close at 3am.

I: So what do you think about the regulations by the Government with regards to alcohol trading and the prices? How do you feel about it?

R: I feel bad because as a tavern owner I pay R3 000 monthly tax. But the shebeen owners are allowed to operate unregulated. We have to close at 11pm. The people then go to the shebeens to drink, and when we wake up in the morning we would hear that someone has been assaulted or killed.

(SSHB03)

The tavern owners interviewed in the study consistently reported being frustrated because shebeens operated beyond any form of regulation. An often-cited example was the perception that shebeens do not regulate closing hours, while its expected to comply with this aspect of the Liquor Act. This is one of the tensions that cause conflict between these two important distribution stakeholders. These differences undermine attempts to foster co-operation in the sector through group meetings and discussions.

I: Do you sit together as tavern and shebeen owners in meetings and discuss the problems in the community, as to how you can address the situation?

R: We used to have such meetings before we got licenses. But right now they do not have licenses, they do not know the regulations. We have been given regulations as the taverners. We follow those regulations. As such there is nothing that brings us together. They just do things their own way. They then say we think we are smart because we are registered.

I: Okay. So you no longer have a relationship with them?

R: We do not have a relationship anymore because they have no licences. What are we going to talk about with them?

(SSHB02)

On the other hand, shebeen owners asserted that it was unfair for their businesses to be targeted by law enforcement officials because they do not have licences. Despite operating illegally, they asserted that their businesses are legitimate in the community and as such, should not be subjected to unfair police harassment. They believed they are unduly targeted by the police and other law enforcement officials. This was attributed to the tavern owners' attempts to eliminate competition from shebeens.

R: The problem is that people undermine each other. Those who have licences, the tavern owners would not have meetings with someone like me who has no licence and discuss issues around alcohol.
I: So you do not see things the same way?
R: Those who have licences want to be the only ones trading.
I: So there is such discrimination?
R: There is such discrimination. So we've never had a meeting to discuss issues.

(SSHB01)

Shebeen owners asserted as it was found in Faull's (2013) study that the problem is not with the illegality of the businesses but with the haphazard and inconsistent regulations these outlets uphold. Tavern and shebeen owners had different views on themes raised in the study. Each has vested interests in generating revenue in a relatively competitive environment. The tensions between these two key players in alcohol distribution in Khayelitsha are markedly hostile.

R: *They [tavern and shebeen owners] are not in good terms. I do not want to lie; they are not in good terms. What causes the tension is that taverns pay licenses, but the shebeens do not pay licences. They sell for free. Their liquor never gets confiscated. Even if they can get closed, when you go back within an hour, they would be opened.*

(FGDC01)

Despite the shared threats to business and community life, such as crime and violence (identified by both sets of stakeholders), these two groups still find it difficult to cooperate with each other to regulate risky behaviours associated with alcohol consumption

I: And how do the tavern owners and shebeen owners cooperate amongst each other? Are there ways you cooperate or there is none?
R: There is no relationship.
I: Everyone just operates in isolation?
R: You just operate on your own.
I: Don't you ever have meetings, as you have indicated people get shot at times? Don't the tavern and shebeen owners meet and discuss the role they can play with regards to crime?
R: No.

(SSHB04)

I: So the tavern owners would have their meetings alone, and the shebeen owners would have their own meetings.
R: We've never had a meeting in this area.
I: You've never had a meeting in your area. So everyone just trade for himself or herself?
R: Yes, you just run your own business.

(SSHB03)

Territorial competition, over the selling of alcohol, is a potential driver of crime and violence – and the lack of co-operation between sellers sustains high-levels of tension in the area. This impacts the way that alcohol harms are thought to affect the community and the self-interest in protecting the selling area of the shebeener or taverner. This fundamental tension must therefore be considered a constant in making sense of the reported barriers to alcohol harm interventions and recommendations for overcoming them, both of which are discussed later in this report.

7.4.2.2. Both taverns and shebeens are violent places but regulation enables safety

Another central finding of this study was that taverns were perceived to be far safer than shebeens. Taverns were mainly described as safe spaces for people to drink. Underage drinking was taken seriously to protect that formal image of the tavern. An investment in regulating the tavern space and complying with the liquor act translated into a perceived easiness in controlling and patrolling the areas surrounding them. This was especially emphasised by members of the neighbourhood watch (NW).

> *R: I mean the places that do not have licences to trade are the most dangerous. We are able to enforce control over taverns because they have opening and closing times.*
> *R: Is there a difference? Can you just explain if there are differences between taverns and shebeens, for you as the neighbourhood watch?*
> *R: There is a difference because customers at the tavern drink in a controlled way, they sit inside the establishment. They do not display/expose themselves outside. But shebeen patrons sit outside, and some of them would be drinking out of the bottle even if there are glasses. They carry it walking in the street.*
>
> (FNW01)

However, this view was rejected by shebeeners who insisted that not all shebeens were unsafe and that many taverns were also dangerous. Shebeen owners argued that both shebeens and taverns were dangerous especially if they are not strictly regulated. Furthermore, they perceived that levels of safety are determined by the involvement of the owner in his/her business rather than merely the type of outlet. Some of the rules identified as most important in ensuring safety were enforcing specific dress codes, and policing underage drinking, both of which were considered to result in a larger base of older patrons who are less likely to drink excessively or get into fights.

> *I: The law targets the shebeens more often? The shebeens are regulated?*

R: The shebeens are not operating legally, but they can be controlled.

I: Shebeens must not be the only ones targeted?

R: They must not only target the shebeens. There is a tavern just nearby where a certain guy was shot as he was walking from the tavern. He was robbed.

(SSHB01)

I: Are there structures like NW or CPF that do patrols? As you have said, in other areas where there are youths drinking, there would be violence and crime?

R: We do not have those problems, especially at the places which close early. But at the places which remain open throughout the night that is where you would get the violence I was talking about.

(SSHB01)

The safety of liquor outlets depends entirely on its ability to regulate its patrons, prevent underage drinking and adhere to trading hours. Having security officials at entry points to search for weapons was considered to be one of the safety measures. However, this was not a common practice at many liquor outlets. The distribution of drugs at some of the drinking places was found to be one of the drivers of violence amongst drinkers and in the immediate surroundings. This 'tik'-alcohol nexus has been clearly demonstrated in earlier studies (Watt et al., 2013). The combination of alcohol and drugs that were available to both adults and underage children was perceived to drive up risks for violence. The presence of weapons within these environments compounds the risk of serious violence.

I: Is tik sold in the shebeens and the taverns?

R: Tik traders sell tik only. But there is a house on that other side which
sells tik and alcohol throughout the night.

I: So they trade both in alcohol and drugs?

R: They trade in drugs and alcohol.

I: Does anything ever get done about such a shebeen?

R: People in the community tried to have a meeting about it, but their efforts were unsuccessful because that person stood his ground that he was surviving by selling tik.

(SSHB03)

7.4.3. Policing and enforcement of rules and regulations of Liquor Act

As it was highlighted in Faull's (2013) work, police attempt to enforce the rules and regulations of the Liquor Act to ensure adherence of trading hours, prevent underage drinking and confiscate alcohol sold at illegal outlets through routine patrols. In keeping with the household survey, 42% of drinkers reported some alcohol-related involvement with the police within the last six months. Many of the male focus groups reported that the police do patrol but were often regarded an ineffective because they are corruptible. The police work with members of Community Policing Forum (CPF) and NW to patrol the streets of Khayelitsha to ensure that both taverns and shebeens close on time and adhere to other rules as prescribed in the Liquor Act. However, the primary responsibility for the safety of patrons at both shebeens and taverns was perceived to lie with SAPS.

R: The patrols are needed in the community. We need patrols 99.9% of the time.
R: By the police.
R: By the police and the community.
R: It should not be done mainly by the community members. The community would only be there just for providing [strength], they are not obliged. But then the police are supposed to do it because they are employed to do so. And secondly, they are protected. For us, it is just a risk. You put your life at risk. At the end of the day you will not benefit anything. Sometimes people see that you were amongst a group of people with the police and then they target you.
R: Patrol is needed.
R: With the police, if the government feels it does not have manpower, it must hire more police to do patrols.

(FGDD03)

By and large when the police were considered to be operating optimally, the shebeeners, tavern owners and drinkers believed that they were important players in keeping Khayelitsha safe. Those who are found with weapons are arrested and taken to the police stations. Those patrons who are too drunk on the streets are commonly arrested for public drinking and pay a fine before being released. NHW members asserted that all these activities contribute to the overall safety and reduction of alcohol harms in Khayelitsha.

I: Would the police be available when you do the patrols?
F: They would be there.
I: When you apprehend a person?
F: Yes.
I: Okay. Is there someone else who would also like to add?
M: A person gets apprehended and then locked up in the police station. He would then be released on payment of a R50 in the morning. He would be charged for drinking in the street.
I: He gets released the next day?
M: He gets released the next day to sober up, and for his safety. Sometimes they could come across criminals who'd kill them. So we keep them safe in the police station, and then the next day the family would pay R50 for his release.
I: Do you keep track of the R50s paid to the police?
R: We do not keep track of it.

(FNW01)

While all of the stakeholders believe the police are ultimately responsible for enforcing the Liquor Act, there was a sizeable consensus that the CPF and NHW have important supporting roles to play. Without the police, both the NHW and CPF groups could not effectively regulate alcohol nor its harms; these groups need police assistance as situations can become life-threatening, some owners and patrons become extremely unhappy when they are forced to close their businesses during certain hours. However both the CPF and NHW feel able to identify taverns and shebeens that do not comply with rules and regulations. Such lists are then given to the police to conduct operations at those places.

F: The police are helpful. Because we would inform them that such and such a shebeen never closes, the music plays till early in the morning. And there are complaints with a particular shebeen. So we would like you to take the alcohol so they can close. There are times where we would identify all the shebeens during the patrols. We would then make a list and give it to the police to conduct operations at those shebeens.

(FGDC01)

Once the CPF and NHW have briefed the police, operations are initiated. However, police corruption was flagged as a significant barrier to regulating alcohol and its harms by all of the stakeholders in this study. Such corruption is considered a fundamental challenge to regulating alcohol as discussed in the section below.

7.4.4. Barriers to intervention and their effects

7.4.4.1. Police corruption

Many participants (especially those in the CPF and NHW) asserted that police corruption is a major stumbling block in dealing with the many harms associated with drinking alcohol at taverns and shebeens.

F: The CPF tries and works hard. But then the problem is that the shebeens are hard to control. The CPF orders them to close, but then they reopen.
R: And they bribe the police.
I: Who bribes the police? Is it the shebeen owners?
R: Yes.
R: Yes. They bribe the police.
R: They would pay R500 to the police.
I: Then what follow up gets done when you as the CPF finds out that there are police officers who get bribed by the shebeen owners? What do you do as the CPF?
R: We do report to the police, but those police officers denied accepting bribe because there was no proof.

(FGDC01)

For many participants, the police were not perceived to be wholly invested in enforcing alcohol regulations nor diffusing the tensions between shebeen and tavern owners. Corruption of the police in Khayelitsha, mainly through soliciting bribes was reported to be a key challenge to addressing the harms associated with alcohol distribution and consumption in the area. Very specific signals of the amenability of police to bribery were cited by the CPF.

I: What do you say about the fact that the police do not wear badges
at night?
R: We have always emphasised that the police should wear badges when they patrol at night. But then they put them on when they leave the police station, but when they get outside they remove them.
I: So you would not be around when the police patrol at night, as the CPF? Do they patrol on their own? So you cannot see if they put their badges on. The badges are important because it is a form of identification.
R: When we patrol with them, they do put them on. And there is no bribery because they enter in company of CPF or neighbourhood members.
So they cannot take bribes. They only get bribed when they are patrolling alone.

(FGDC01)

Both tavern and shebeen owners also pointed to the corruptibility of the police. They agreed that tavern and shebeen owners who broke the law are often able to bribe police who then did not return to enforce it. The police themselves also initiate bribery by demanding bribes. The corruptibility was also bi-directional with police threatening to close down shebeens if they were not paid accordingly.

I: But then you said already that there are rules only at the taverns.
R: The police are corrupt.
R: They are dishonest.
I: How?

R: As a police officer I'd have to go and close up such and such a shebeen, but when I get there they give me a bottle of Bell's and then I leave.

R: You no longer order them to close.

I: So they get bribed?

R: I know that on a weekend, from such and such a shebeen I get R1 000, I will get so much from such and such a shebeen.

R: Most of the time, shebeens have to close because they are not allowed to sell as they do not have licences.

I: Is there a law they need to follow? But they disregard it?

R: There is. They just disregard it. When the police arrive to close the shebeen, they get bribed and then do not close the shebeen. But you will see other shebeens have been closed. So you wonder what's going on. On a Friday, the police would go to a shebeen to close it, and if they do not get bribed they would tell everyone to leave at that very moment. They avoid being exposed that they went to so-and-so's place and were not given anything. They would tell everyone to leave.

(FGDFD01)

Although, police inefficiency and corruptibility was reported by the overwhelming majority of participants, selected shebeen and tavern owners reported that policing was sometimes effective in addressing alcohol related harms. However, in such cases patrons would find alternative places to drink alcohol.

I: So what do you do when the police come and order the shebeen to close? What role do you play?

R: We look for other places.

I: You go elsewhere?

R: The police are helpful. Because we would inform them that such and such a shebeen never closes, the music plays till in the morning. And there are complaints with a particular shebeen. So we would like you to take the alcohol so they can close. There are times where we would identify all the shebeens during the patrols. We would then make a list and give it to the police to conduct operations at those shebeens.

(FGDFD01)

7.4.4.2. Failure to follow trading hours

Non-compliance with trading hours was the most frequently identified barrier to curbing alcohol harms. A steady and accessible supply of alcohol was perceived as a defining feature of living in Khayelitsha. Regulating the operating hours for selling alcohol has proven to be a generally effective strategy for preventing its associated harms (Parry, 2005; Matzopoulos et al., 2008). Given the density and unregulated nature of the majority of the shebeens in the area, attempting to monitor and enforce operating hours was considered a difficult task by many of the participants. There was however general consensus that doing so would require different approaches for taverns and shebeens respectively.

> *R: People still drink alcohol at 2am in the morning. They would have been drinking from the previous day until the following day. That is madness.*
> *R: If they are supposed to operate until 9pm, let it be 9pm for everybody. They must be closed at 9pm, there shouldn't be anyone walking around at that time.*
> *I: But you need the law to play its role in terms of trading hours?*
> *R: Trading hours, yes.*
>
> (SSHB01)

The challenge in monitoring operating hours in shebeens was directly linked to the high-levels of violence associated with drinking in shebeens in Khayelitsha (described in 4.1.1. and 4.1.2.2. above) by many of the participants.

7.4.5. Recommendations for regulation, policing and harm reduction

7.4.5.1. Develop and enforce a stricter licencing process

Many participants insisted that new stricter licensing processes to regulate taverns and shebeens should be developed and enforced. These should involve broad-based community consultation and use participatory methods to reach some degree of consensus amongst the most significant stakeholders. However, existing licensing conditions

must be enforced and that the Western Cape must be strict on issuing licenses.

> *R: Of importance is that the government should be strict on issuing of the licences. You'd now find that a tavern is next to a school, a church or pre-school. So when a child is at school he does not concentrate because he can see people drinking. When classes end he then goes to the tavern.*
>
> *(FDGC01)*

> *I: So the community is not involved during the licence application process?*
> *F: The community is not involved, they are not consulted. You just see a person having a licence. And most of the time this thing results in many divorces because the husbands spend most of their time at the taverns after a fight. He goes there and then comes back in the morning. So then there are tensions in marriages, children have no food. You see such things? He says he uses his own money.*
> *I: The neighbourhood watch is also not consulted when licences are applied for?*
> *R: No.*
> *F: They don't involve the neighbourhood watch and the CPF. A person goes and applies for a licence. You'd just see him building a huge structure that will be used as a tavern.*
> *I: So the community is not involved at all, or the neighbourhood watch, or CPF or the police in that instance?*
>
> (FNW01)

Another important recommendation involved regulating all parties in the alcohol distribution transaction. Regulation and enforcement should not just be prioritised on outlets themselves, all points in the distribution chain should be tackled so that enforcement is not haphazard.

7.4.5.2. Enforce strict trading hours

The other key recommendation was that strict trading hours must be enforced. The lack of enforcement of opening and closing times was

seen as harmful in two primary ways. The first concerned the accompanying noise and other disruptions associated with drinking late at night and into the early mornings. This was seen as fundamentally disturbing because sleeping was compromised, which has run on effects into daily functioning. The second objection to unenforced closing times was based on the fact that early morning drinking implied greater risk for violence, especially robbery and rape. The enforcement was considered the responsibility of the police because "… [if] the police could put pressure on the shebeens. Shebeens are not regulated; they operate till early in the morning. People who get murdered would be from the shebeens. The tavern would have long been closed by then. But you'd find people saying someone was murdered on his way from the tavern." (FGDMD02)

> *R: The operating times must be reduced. They must close at around 12pm, they must not close at 1am or 3am those who have licences. With regards to licences, those who issue licences must try to be strict; they must not just issue licences to everyone who needs it. They must regulate the numbers so that the number of taverns and shebeens could be few.*
>
> (FGDMD02)

7.4.5.3. Increase the age limit for drinking alcohol

Some respondents felt that the minimum legal drinking age should be increased, citing the fact that even at 18, children cannot be considered mature enough to make informed choices about alcohol. Many participants linked under-age drinking with teenage pregnancy and the risk for rape.

> *R: And the traders must stick to the regulations. The drinking age limit must also be increased, because at 18, most of the youth are still immature and young. Even the* phara-pharas *(school dropouts) are still young children. They look older than their age – a 17 year old would look like an 18 year old. And in the location, alcohol sellers do not ask for an ID just like in town. Just to confirm the age.*
> *I: So what age should be set as a drinking age?*
> *R: If they could set it at 21.*

I: *They should do away with 18?*
R: *They should do away with 18 and set it at 21.*

(FND01)

7.4.5.4. Support for neighbourhood watches and CPF

CPF and NHW members feel that they need support in making their work more effective. One of the recommendations was that CPF and NHW members must be financially supported for their work in providing policing in Khayelitsha.

R: *Our aspiration as the CPF is if there could [payment] because as the neighbourhood watch members and CPF, we are not paid, we volunteer. If there could be some people who are employed. Just like in the past there was Bambanani which then changed to a neighbourhood watch. If there could be some money put aside by the Government for the neighbourhood watches. Where members could get paid. Because if as the neighbourhood watch we patrol the streets in our communities, instruct the shebeens to close down at certain times, without waiting for the police, then there would be a difference. But at the moment people are getting threatened in their communities. The DoCS must get involved. We did ask them.*

(FGDC01)

R: *Our Government in the Western Cape, as in the past, should meet with the national Government and put some money aside with the relevant departments to support the neighbourhood watches so the work could be done without hassles.*
R: *The other thing is; since it has been said that most people in the neighbourhood watch are not working, the Government must look after them. Because there are organisations that they say they fight crime and they get paid, but we have never seen them walk the streets like we do. But there is no one who cares for the CPF and NHW. We are not getting anything. You leave your husband alone and you do not know where you are going.*

(FNW01)

While some members of the CPF and NHW suggested that payment of a stipend would be an important resource to enable a more systematic and sustained support for regulating alcohol and its harms, others insisted that expecting payment was unrealistic. Both groups were however divided on the nature of the support that was needed to incentivise their on-going commitment to supporting the fight against crime as they were almost all unemployed. The CPF members acknowledged their uniforms and other equipment as a form of support, but the NHW group argued: "In schools where the neighbourhood watch is guarding, crime went down because the school is paying the neighbourhood watch members" (FNW01). The precise nature of support required by both groups by the DoCS should therefore be negotiated by both parties directly.

7.4.5.5. DoCS involvement

There were a number of recommendations for enhancing the visibility and role of the Department of Community Safety. Some participants suggested that the DoCS needs to be actively involved in engaging with the people of Khayelitsha on the ground, rather than asking researchers to come and ask them questions because they do not see the benefits of such research projects. One of the key ways that several participants suggested that DoCS could be involved was as a direct mediator between the police and the community itself.

> *I: So DoCS should intervene with regards to the police?*
> *F: They should intervene; we should not get beaten up. We spent money to buy the alcohol, so they should spill our alcohol. We'd like them to search for guns from the patrons at the drinking places. If the tavern closes at 11pm, they would come at 9pm.*
>
> (FGDSNC01)

One group of male drinkers believed that the DoCS should facilitate more visible enforcement, mainly in the form of negotiating increases in the number of patrols across the community. They suggested that this would require greater coordination between the police, CPF and NHW.

However, the net effect would be a greater sense of safety through routinized, visible patrols.

I: So how do you think the government and the DoCS could get involved? What role can the DoCS play in that situation? What can it do to help the community and the tavern owners?
M: If there could be patrols.
I: There should be patrolling. The police should be visible?
R: Yes.
I: So you'd like the Government to intervene?
M: Yes, it should intervene and do patrols.

(FGDMD02)

When asked about the suggested role of DoCS in regulating the number of shebeens and taverns in the area, several participants identified two key types of interventions that could be mobilised to effect a safer drinking environment. The first involved strong enforcement of the geography of the distribution of alcohol. According to this perspective: "Government should be strict on issuing of the licences. You'd now find that a tavern is next to a school, a church or pre-school. So when a child is at school he does not concentrate because he can see people drinking. When classes end he then goes to the tavern" (FGDC01). However, other participants insisted that stricter enforcement of licensing would not have a significant impact on unlicensed venues. The ultimate problem for this group was relatively free access to high volumes of alcohol that could move between taverns and shebeens. This group of drinkers was of the opinion that the solution is systemic. As one male drinker put it: "The policies must change from the top. The SAB must also be regulated in terms of the amount of stock it distributes to Khayelitsha outlets. That way we could minimise [harm] because we'd know how many cases are being distributed." (FGDD03). Tackling the distribution system would however require community buy-in.

I: So what do you think about the DoCS, or what could be done to control the liquor trading industry?
R: It could be controlled by making sure that younger children are not sold alcohol. But then the problem is that the older

ones are buying for the younger ones. They drink from home. It can be controlled. We cannot say SAB [South African Breweries] must not come to Khayelitsha. SAB must come to Khayelitsha, but then the parents and the community must be involved in reprimanding the children.

(SSHB02)

One innovative suggestion for DoCS involvement was that it should invest in technologies that are better able to disrupt the flow of alcohol from licensed to unlicensed distribution points. This male drinker suggested that the licensed people are assisting those who are unlicensed to buy more. But they would pay them. The one who does not have a license would bribe the one who has a license. (FGDMD02). A viable technology suggested was that licenced vendors be issued with an identification sensitive smartcard for all purchases. This would undermine the potential for corruption amongst distributors and stop the illegal flows of high volumes of alcohol into Khayelitsha.

7.5. CONCLUSION

The results of this small-scale, qualitative study shows that while the use of alcohol in Khayelitsha is undergirded by complex social, historical and economic dimensions, there is relative consensus on the potential harms implied by the unregulated distribution and consumption of alcohol. This implies at least one entry-point for all stakeholders to mobilise around an inclusive containment strategy that is sensitive to the perceptions of the economic consequences of a comprehensive and enforceable alcohol harms prevention strategy (Matzopoulos and Myers, 2014). Such sensitivity should however be informed by the available evidence on the costs of these harms (Matzopoulos, Truen, Bowman and Corrigall, 2014). The limited community-level perception yielded by this study also interestingly shows that any tailored intervention aimed at consumption-side factors should accommodate drivers of female drinking in Khayelitsha. Such interventions should be built on empirical studies of the demonstrable intersections between the socio-economic vulnerabilities of young motherhood and their bi-directional effects on employment opportunities (Peltzer, David and Njuho, 2011). Our results show that key stakeholders in the community

require a far more co-ordinated approach to enforcement that hold the police accountable and facilitates a stronger contribution from the CPF and NHW, in Khayelitsha. Lastly, the findings of the study show that there is generally strong support for two important regulatory strategies. The first involves endorsement of enforcement approaches focused on the protection of children from easy access to alcohol. The second concerns conceptualising systematic interventions that disrupt the flow of high volumes of alcohol from licensed to unlicensed distribution points in the community. Although, such regulations could be actively resisted by unlicensed stakeholders whose livelihoods depend on this illegal access, the evidence suggests that the net effect of strong alcohol regulation are positive for health overall. To catalyse these benefits DoCS should consider mobilising harm reduction strategies, including increasing visible policing and directing significant resources towards enabling healthier recreational alternatives to drinking alcohol.

7.6. REFERENCES

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