Methamphetamine (MA) use in South Africa (SA), especially in Cape Town and its surrounding areas, has been increasing at alarming rates. Locally known as 'tik' owing to the popping sound made when heated, the inexpensive and easily accessible nature of MA led to a surge in use in the early 2000s, primarily within the Western Cape Province. Recent evidence suggests MA use continues to be prevalent, second only to marijuana as the primary substance use in the Cape Town Metropole in 2005 found 12.6% of Grade 9 learners using MA in their lifetime. Two other school-based surveys were focused on lifetime use, ignoring recency of use. Since 2005, four SA school surveys to monitor prevalence and how use is associated with risk factors have addressed the association between MA use and sexual risk behaviour. Although the proportion of youth seeking treatment primarily for MA use decreased between 2006 and 2011 to 25%, this does not reflect youth seeking treatment primarily for MA use decreased between 2006 and 2011 to 25%, this does not reflect youth seeking treatment primarily for MA use, but range from 2% to 12%. Having an understanding of whether MA use is changing and who is most affected can inform targeted prevention and intervention approaches. In addition, it can inform provision of healthcare and support services such as HIV education, because of the association between MA use and sexual risk behaviour.

Prior research on MA use has suggested the use of large-scale school surveys to monitor prevalence and how use is associated with risk factors. However, few large-scale surveys have addressed youth MA use in detail and those that have collected youth data have focused on lifetime use, ignoring recency of use. Since 2005, four SA school survey studies have collected MA use data. Study details and prevalence findings are reviewed below.

In 2011, Morojele et al. surveyed 20 227 Grade 8 - 10 learners from eight Western Cape districts representing both metro and non-metro areas. Across all districts, 1.4% of Grade 8, 2.1% of Grade 9, and 2.6% of Grade 10 learners reported ever using MA in their lifetime. The 2008 SA Youth Risk Behaviour Survey collected lifetime MA use from 10 270 Grade 8 - 11 learners in nine provinces. Across all provinces, 8.1% of Grade 8 learners reported ever using MA in their lifetime. Prevalence was slightly higher for the Western Cape Province, with 9% of Grade 8 - 11 learners reportedly ever using MA in their lifetime. Two other school-based surveys were collected by Plüddemann et al. Data collected from 4 605 learners in the Cape Town Metropole in 2005 found 12.6% of Grade 9 learners.
had used MA in their lifetime.[9] The second study from 2006 found 8.8% of Grade 8 - 10 learners (n=1 561) in the Cape Town South
demographic education district had ever used MA in their lifetime.[9]

In these school-based surveys, secondary school MA use ranges from
1.4% (Grade 8 data) at the lowest to a high of 12.6% (Grade 9
data). From a chronological perspective, use has gone from 12.6%
(2005 data), 8.8% (2006 data), 8.1% (2008 data), and finally to 1.4%
(2011 data). What is not clear is whether these data are demonstrating
an actual decline in MA use among school-attending SA youth, or
whether variations in samples due to geographical location and grade
representation are driving this trend. Moreover, there is little indication
of recency of MA use and how use may be associated with risk factors,
as these large-scale studies often only address lifetime prevalence.

A systematic review of MA risk factors in North American
youth has identified being male, Caucasian, ever having sex, prior
cigarette and illicit substance use, and reporting being in a homosexual
relationship as associated with greater use.[8] Research on SA youth
MA use suggests these associations may hold cross-culturally. Within
SA, studies have found youth MA use to be associated with poor
mental health including aggression and depression,[9] sexual activity
including vaginal and anal sex,[8] and poor academic attainment or
school dropout.[8]

The current study is one of the few large-scale data collections
from SA school-attending youth to address recency of MA use and
its association with risk factors. Research questions focus on (i) the
prevalence of MA use in the sample including lifetime, past-year,
past-month, and past-week use and (ii) whether known risk factors
for MA use identified by Russell et al.[10] hold cross-culturally when
comparing using and non-using youth.

Methods

Participants and procedures

Data were taken from the HealthWise SA trial testing varying
implementation conditions across 56 high schools in the Metro South
and Metro East Western Cape school districts.[11] To determine which
schools would be recruited, the SA team developed a matrix with
schools’ postal code, assessment of level of safety, assessment of level
of access, total number of students enrolled in Grade 8 and Grade 9,
number of classrooms in the school, school fees, and a poverty index
based on the schools’ locations. This information was used to develop
a principal factor analysis procedure that assisted in the assignment
to condition. Used in the current study, baseline data were collected
in March 2012 from Grade 8 learners in 54 schools (mean standard
deviation (SD) students per school 190.6 (63.8)) prior to curriculum
implementation. Learners with missing data on all variables of
interest (2% of sample) were removed, resulting in a final sample of
10 000 youth. Youth were 14 years old on average (SD 0.99), evenly
split on gender (53% female), with 48% identifying as coloured
(i.e. mixed ancestry), 43% black African, 7% white and 2% other.
For comparison, the 2011 Western Cape census data reported
49% coloured, 33% black African, 16% white and 1% Indian.[12]

Institutional Review Board and Research Ethics Committee approval
for the current study was obtained from study-affiliated universities
and authorised by local education districts.

Measures

Learners were asked about MA use, including one question for
lifetime use: ‘How many times have you used tik in your life?’ and
three separate questions for past year, month and week: ‘How many
times in the past [timeframe] did you use tik?’

Risk factors were modelled after Russell et al.[8] and made
use of available data. These included demographic characteristics,
socioeconomic status (SES), substance use, and sexual activity and
relationship items.

Demographic variables included sex: ‘Are you a boy or a girl?’; race:
‘How do you identify yourself?’ with response options of black, white,
coloured, Indian and other, and who the learner lived with using two
questions of ‘During the last 6 months, has your mother/father lived
with you?’ Response options included ‘no, my mother/father is dead,’
‘no, none of the time,’ ‘yes, some of the time,’ and ‘yes, always or almost
always.’ Responses were dichotomised for parsimony, collapsing
responses of ‘yes, some of the time’ and ‘yes, always or almost always’
and collapsing ‘no, none of the time’ and ‘no, my mother/father is
dead.’

SES was measured dichotomously using home type with the
item ‘Which of the following best describes your home?’ Responses
categories of ‘shack,’ ‘wendy house or backyard building/room,’ ‘tent,’
and ‘other’ were combined to compare with response of ‘brick house,
flat, or apartment’.

Substance use was measured using items of alcohol: ‘How many
drinks of alcohol have you had in the past 30 days (month)’ and
tobacco: ‘During the past month, how many cigarettes have you
smoked?’ Both items were dichotomised to reflect use and non-use
in the past month.

Finally, sexual activity and relationship were measured with two
items. Sexual activity was captured with the question ‘Have you ever
had sex? This means intimate contact with someone during which
the penis enters the other person.’ Relationship was measured from
the item ‘Are you currently in a relationship?’ Same-sex relationship
was calculated as a female learner responding ‘Yes, I have a girlfriend’
or a male learner responding ‘Yes, I have a boyfriend,’ as opposed to
learners reporting being in an opposite-sex relationship or no
relationship.

Analytic plan

Prevalence of MA use was categorised into mutually exclusive groups
of lifetime (i.e. used in their lifetime but not in the past year, month or
week), past year (i.e. used in the past year but not the past month or
week), past month (i.e. used in past month but not in the past week),
and past-week use with dichotomous yes/no responses. Categories
of past month and past week were later collapsed when comparing
past-month users with never users.

Prevalence was descriptively reported while risk factors for past-
month and never use were modelled as outcomes in a hierarchical
logistic regression where model A included demographic and
socioeconomic status predictors and model B added substance use,
sexual activity and relationship predictors to model A. This nested
approach allowed for identification of predictors above and beyond
those in model A using the likelihood ratio test. Differences in the
~2 log-likelihood (~2LL) for model A were compared with model B
using a χ2 test where a significant difference (using difference in
degrees of freedom (df)) would indicate model B is a better fit to the
data.

Results

When examining the prevalence of MA use in the sample, 95.0% of
youth reported no lifetime use, 1.3% used in their lifetime and not in
the past year, 0.4% used in the past year and not in the past month,
1.2% used in the past month and not in the past week, and 2.0% used
in the past week. Demographic characteristics of each user group are
reported in Table 1.

Of the learners that reported any MA use (n=496), 26.4% (n=131,
95% confidence interval (CI) 22.1 - 29.9%) reported lifetime use and
not past year use, 8.6% (n=43, 95% CI 6.5 - 11.5%) past year use and
not past month use, 24.3% (n=121, 95% CI 20.2 - 27.8%) past-month use and not past-week use, and 40.5% (n=201, 95% CI 36.7 - 45.3%) past-week use.

Table 2 reports results of logistic regression nested models on past-month MA use (including past-month and past-week use, n=322) compared with never users reporting no lifetime use (n=9 504). Results from model A indicate that, compared with youth who have never used MA in their lifetime, past-month users were more likely to be male (OR 2.19); more likely to be black (OR 4.42), white (OR 5.72) or other (OR 3.98) than coloured; less likely to have a present or partially present mother/father than an absent or deceased mother/father (OR 0.37 and 0.77, respectively); and less likely to live in a brick house, apartment or flat (OR 0.46).

Model B demonstrated better fit indicated by significant likelihood ratio test (χ² (4)=43.27, p<0.001). Compared with never users, past-month users were more likely to be male (OR 1.67); more likely to be black (OR 5.49) or white (OR 4.15) than coloured; less likely to have a present or partially present mother than an absent or deceased mother (OR 0.43); less likely to live in a brick house, apartment or flat (OR 0.51); more likely to have used alcohol (OR 4.01) and tobacco (OR 3.73) in the past month; and more likely to report having a same-sex partner (OR 8.82). When compared with model A, the presence of a same-sex partner was significantly associated with past-month MA use (OR 8.82) in model B.

Table 2. Results of fitting hierarchical logistic regression models to MA use data

<table>
<thead>
<tr>
<th>OR (95% CI)</th>
<th>Model A</th>
<th>Model B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>2.19†</td>
<td>1.67‡</td>
</tr>
<tr>
<td>Race (coloured serves as reference group)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black African</td>
<td>4.42†</td>
<td>5.49†</td>
</tr>
<tr>
<td>White</td>
<td>5.72†</td>
<td>4.15†</td>
</tr>
<tr>
<td>Other</td>
<td>3.98†</td>
<td>NS</td>
</tr>
<tr>
<td>Living with mother (None of the time/deceased serves as reference group)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always/some of the time</td>
<td>0.37†</td>
<td>0.43†</td>
</tr>
<tr>
<td>Living with father (None of the time/deceased serves as reference group)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always/some of the time</td>
<td>0.77†</td>
<td>NS</td>
</tr>
<tr>
<td>Home type</td>
<td>0.46†</td>
<td>0.51†</td>
</tr>
<tr>
<td>Past-month alcohol use</td>
<td>4.01†</td>
<td>3.73†</td>
</tr>
<tr>
<td>Past-month tobacco use</td>
<td>0.51†</td>
<td>NS</td>
</tr>
<tr>
<td>Ever had consensual sex</td>
<td>NS</td>
<td>8.82†</td>
</tr>
<tr>
<td>Same-sex relationship</td>
<td>8.82†</td>
<td>43.27† (df=4)</td>
</tr>
</tbody>
</table>

NS = main effect not significant; LR = likelihood ratio; AIC = Akaike information criterion.

Table 1. Sample characteristics by MA use group

<table>
<thead>
<tr>
<th></th>
<th>No lifetime use (n=9 504, 95.0%), %</th>
<th>Used in lifetime and not past year (n=131, 1.3%), %</th>
<th>Used in past year and not in past month (n=43, 0.4%), %</th>
<th>Used in past month and not in past week (n=121, 1.2%), %</th>
<th>Used in past week (n=201, 2.0%), %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>46.2</td>
<td>61.5</td>
<td>60.5</td>
<td>68.6</td>
<td>62.1</td>
</tr>
<tr>
<td>Female</td>
<td>53.8</td>
<td>38.5</td>
<td>39.5</td>
<td>31.4</td>
<td>37.9</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black African</td>
<td>41.0</td>
<td>67.2</td>
<td>72.1</td>
<td>71.1</td>
<td>66.0</td>
</tr>
<tr>
<td>Coloured</td>
<td>49.7</td>
<td>23.7</td>
<td>11.6</td>
<td>14.9</td>
<td>13.2</td>
</tr>
<tr>
<td>White</td>
<td>7.1</td>
<td>6.9</td>
<td>9.3</td>
<td>10.7</td>
<td>17.8</td>
</tr>
<tr>
<td>Other</td>
<td>2.2</td>
<td>2.3</td>
<td>7.0</td>
<td>3.3</td>
<td>3.1</td>
</tr>
<tr>
<td>Age (years), mean (SD)</td>
<td>13.9 (0.95)</td>
<td>14.5 (1.2)</td>
<td>14.8 (1.1)</td>
<td>15.1 (1.2)</td>
<td>14.9 (1.3)</td>
</tr>
</tbody>
</table>

N=10 000. MA use groups are mutually exclusive.
Discussion

This study is one of the few large-scale secondary school datasets capturing past year, month, and week MA use in Western Cape Province, SA. Results indicate that 4.9% of youth report lifetime MA use while 3.2% report past-month use. Given that youth and young adults comprised one-third of the population in the 2011 Cape Town census, current study results have the potential to translate into a large number of MA-using youth. In comparing with prior learners reporting lifetime prevalence use, the current study is the most recent data collection (compared with 2011[13]) and falls somewhere in the middle of previously reported youth lifetime MA prevalence, which ranged from 1.4% to 12.6%. The most similar sample can be taken from the study conducted by Morojele et al.,[28] which found that the Western Cape Metro South and Metro East education districts (the same districts used in the current study) on average reported 2.1% lifetime use. However, the data provided spanned Grades 8 through to 10, making direct comparisons difficult. Across all eight education districts in Western Cape Province, 1.4% of Grade 8 learners used MA in their lifetime.[30] However, these eight school districts included both rural and urban settings while the current study was focused within the Metro, or urban, area only. Overall, when comparing current study results with available data, it remains challenging to address the inconsistencies in measurement and sampling to obtain accurate estimates of MA use. This suggests youth MA use remains a high priority within Western Cape Province. Going further, the current study finds a more concerning subgroup of past month and week users, making up 65% of learners who report using.

Analyses support prior SA work indicating MA risk factors are generally consistent with Western samples[19] suggesting that although the context across North American countries and SA differs, risk factors for youth MA use may not. One notable exception is that the current results did not find that having consensual sex was associated with MA use. This finding is inconsistent with prior studies from the Cape Town area[50] and may be due to the low rate of sexual activity for youth at this age (7.6% in the sample). Despite this, the urgency of addressing youth MA use may be especially important within Western Cape Province. For example, the SA context poses additional risks given the young age of users (14 years old on average), the prevalence of HIV risk in the area, and the fact that MA is inexpensive and easily accessible.

Demographic risk factor results also supported prior research finding individuals not consistently living with mother and father and with lower SES (as evidenced by home type and/or educational attainment as proxies) are more likely to use MA. Current results indicated that compared with coloured youth, black and white youth are more likely to use MA. This finding is inconsistent with prior community-based studies finding higher rates of MA use in coloured individuals.[11] However, most of the school-based results have not reported MA use by race and greater integration is occurring within Western Cape secondary schools, representing more black and coloured, but also white, learners.

The logistic regression results highlight the continued need to address MA use in policy and broad prevention initiatives to address risk factors which are difficult to change such as gender, race, SES and household composition. Policy changes such as keeping schools open as recreation hubs in the afternoons and evenings would allow for the provision of supervised programming in low-income areas for youth who may have absent parents at home. In addition, community centres could be used for skill development programmes to promote youth development within a safe environment. Access to leisure and recreation opportunities is especially important for youth and is associated with delayed substance use initiation in Cape Town females.[20]

In addition, results suggest avenues for targeted approaches where youth could be screened for the presence of known predictors and recent (e.g. past month/week) use and then be provided with additional services. Implementing approaches such as SBIRT (screening, brief intervention and referral to treatment), which has been used in hospital settings,[41] may be effective to quickly identify youth and direct them to existing services within the educational system to address modifiable risk factors.

Although the current study provides insights into SA youth MA use and associated risk factors that have not previously been identified, limitations exist. Firstly, due to the school-based sample, high-risk youth who have dropped out of school would not be captured within the current data, resulting in conservative estimates of use. However, all school-based studies experience this same issue. Secondly, the current study makes use of youth self-report data which are prone to self-report bias. Finally, results from the current study of Western Cape youth many not be generalisable to more rural areas. Even with these limitations, the current study provides important detail on the recency of Western Cape youth MA use and informs public policy and prevention approaches to address use.

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