Coronary artery disease (CAD) is the most common cause of death worldwide.

Data from the Global Burden of Disease study suggests that CAD is responsible for an estimated 30% of deaths globally.

The prevalence of CAD varies significantly across different populations and is influenced by factors such as age, gender, and lifestyle.

In some populations, CAD is more common in men, while in others, it is more prevalent in women.

Lifestyle factors such as smoking, physical inactivity, and high blood pressure also contribute to the development of CAD.

The management of CAD often involves a combination of pharmacological treatment, lifestyle modification, and in some cases, invasive procedures.

Early detection and treatment are crucial in managing CAD and reducing the risk of complications and death.
WHAT IS KNOWN

• The burden of noncommunicable diseases, such as cardiovascular disease, has become an increasing challenge for health systems in sub-Saharan Africa.
• For cardiovascular disease in this region, optimal secondary prevention is critical for the reduction of repeated cardiovascular events and the control of cardiovascular risk factors.
• To date, few studies have focused on the management of established cardiovascular disease in sub-Saharan Africa.

WHAT THE STUDY ADDS

• Despite the growing prevalence of cardiovascular disease in sub-Saharan Africa, we found that secondary prevention is currently suboptimal, especially for the outcome of control of all cardiovascular risk factors.
• Fewer than 5% of our study population had all 5 cardiovascular risk factors under control, and the majority of the group had ≤2 risk factors controlled.
• In addition, there were differences in the rates of optimal risk factor management by sex, socioeconomic status, and physical disability, suggesting potential disparities in care.

It is well established that optimal secondary prevention is critical for the reduction of repeated cardiovascular events, and the control of cardiovascular risk factors in this context is essential. Many studies have assessed the prevalence of cardiovascular risk factors and primary prevention strategies, but few have focused on the management of established CVD in the sub-Saharan region.

The lack of information about management of patients with established CVD in SSA prompted us to investigate this topic in an appropriate population: the HAALSI (Health and Aging in Africa: Longitudinal Studies of International Network for the Demographic Evaluation of Populations and Their Health Communities) cohort. One of the main purposes of this cohort is to understand the reasons for changes in the prevalence, incidence, and risk factors for cardiometabolic disease in rural South Africa. To fulfill that purpose, a cohort of 5059 men and women ≥40 years of age was recruited in the Agincourt Health and Demographic Surveillance System (HDSS) site in rural South Africa. The intention of this analysis is to determine CVD prevalence and its management in a rural community in northeast South Africa, focusing on identifying disparities within this population.

Methods

The HAALSI study is based in the Agincourt HDSS site, a subdistrict of the rural Mpumalanga province, South Africa, comprising some 115 000 people living in 21 000 households and 31 villages in an area of ≈450 km². An annual census update, conducted by experienced local field staff, provides up-to-date denominator data on the full population with systematic recording of all vital events (deaths, births, in-/out-migrations).

Eligibility

All adults aged ≥40 years as of July 1, 2014, who had permanently resided in the Agincourt subdistrict for at least 1 year before the 2013 census update were eligible.

Sampling and Sample Size

Participants were selected from an existing framework of the Agincourt HDSS site in Mpumalanga province. Using the full 2013 census data, a sampling frame of adults aged ≥40 years (8974 women and 3901 men) who met the residency criteria were identified. A target sample size, assuming an 80% response rate, was ≥5000 completed interviews. We selected a total of 6281 women and men for the main household study. Among these, 391 had moved outside of the study site or were deceased. Of the remaining 5890 eligible individuals, 5059 (85.9%) participated in the baseline survey.

Ethics Approval

The study received ethical approvals from the Ethics Committees of 3 institutions directly involved in the project (University of the Witwatersrand Human Research Ethics Committee [ref M141159], the Harvard T.H. Chan School of Public Health, Office of Human Research Administration [ref C13-1608-02], and the Mpumalanga Provincial Research and Ethics Committee [approved on 22 October, 2014]).

Recruitment and Follow-Up

Before the survey, the HAALSI study was introduced to community members across the study villages and discussed with a representative Community Advisory Group. This facilitated community review of study objectives and contributed to the effective response achieved.

Between November 2014 and November 2015, all identified individuals were visited at home by a supervised local field worker who briefly described the study in the local language (Shangaan) and requested permission to read and explain the relevant informed consent forms. Those who agreed to participate signed a consent form or, if not able to sign their name, were asked to have a literate witness sign and date the informed consent on their behalf. Field workers also signed and dated the informed consent form.

Study Procedures

Interviews lasting 2 to 3 hours were conducted in participants’ homes. The visit included a questionnaire in 2 parts: household and socioeconomic data then individual interview data; followed by anthropometric, physical, and cognitive functioning assessments plus blood sample collection in the form of capillary blood sample and dried blood spots. Data were captured on laptop computers using a Computer-Assisted Personal Interview program.

Data collected included blood pressure (Omron M6W automated cuff; Omron, Kyoto, Japan), weight (Genesis Growth Management Electronic Scale; Johannesburg, South Africa), height using a sensor with infrared measurement, and waist and hip circumferences with a flexible tape measure (SECA, Hamburg, Germany). Blood drops were used to measure glucose (CareSens N Monitor, Seoul, Korea) and individual lipid levels (Cardiocheck PA Silver version; Indianapolis, IN) in point-of-care machines. The dried blood spots were collected via finger prick on Whatman 903 paper (Whatman, Buckinghamshire, UK) and used to measure human immunodeficiency virus (HIV) status and high-sensitivity C-reactive protein. Three blood pressure readings (systolic and diastolic) were obtained with 2 minutes between each reading, and the mean blood pressure was calculated using the average between the second and third reading.

Definition of Cardiovascular Disease

Cardiovascular disease was defined by self-report of stroke and myocardial infarction or a diagnosis of angina by Rose criteria (World Health Organization Rose questionnaire is widely used in epidemiological studies and is a validated and standardized method for defining angina pectoris).
Control of Cardiovascular Risk Factors

Smoking status was defined by self-report of current smoking status, and the nonsmokers were considered as having this risk factor controlled. Low-density lipoprotein cholesterol was considered controlled with a value <1.8 mmol/L, according to the South African Dyslipidaemia Guidelines. Body mass index in kg/m² was categorized using World Health Organization cutoffs, and values lower than 25 kg/m² were considered controlled. Waist-to-hip ratios were considered controlled if ≤0.90 for men and ≤0.85 for women. Hypertension was considered controlled if systolic blood pressure <140 mmHg and diastolic blood pressure <90 mmHg.

Other Covariates

Treatment of stroke, angina, and myocardial infarction was assessed by self-report. Clinical determination of HIV status was made by first using the Vironostika Uniform 11 (BioMerieux, France) screening assay. Negative results were assigned an HIV-negative status while positive results triggered a second (confirmatory) test using the Roche Elecsy (Indianapolis, IN) assay to determine the viral load. If both screening and confirmatory tests were positive, a final status of HIV positive was assigned. If the screening and confirmatory tests yielded opposing results, a third assay was run on the Siemens Centaur XP (Erlangen, Germany) immunoassay. This third test served as the tie-breaker to determine a final HIV-positive or -negative status, in accordance with World Health Organization guidelines. HIV-positive status was defined as a self-report of being informed of the condition by a health professional or a positive result from blood analysis. Physical disability (PD) was assessed by self-reported presence or absence of limitations in activities of daily living (excluding difficulty in dressing as an activities of daily living). Socioeconomic status (SES) was measured using the wealth asset index that is a quintile ranking of scores constructed following the Demographic Health Surveys methodology to create a composite indicator of living standards using data on household ownership of assets. This index includes information on durables, such as televisions and refrigerators, as well as housing conditions. Immigrants were defined as the subjects who were born outside South Africa. Illiteracy was assessed separately from education; respondents were asked whether they could read or write.

Analyses

All analyses were conducted using STATA V14 software (StataCorp. 2015. Stata Statistical Software: Release 14. College Station, TX). Continuous variables were compared using t-test (expressed in mean values and SDs because they were normally distributed) and categorical variables using χ² test (expressed in absolute numbers and percentiles). The distribution of modifiable risk factors under control was assessed by HIV and immigration status because these 2 conditions were highly prevalent in this cohort, have been shown to impact on noncommunicable diseases management in the region, and yet need to be better studied. A linear regression model was built to identify factors associated with the number of cardiovascular risk factors controlled. The predictors included in this model were sex, PD, age, SES, HIV status, immigration status, and illiteracy. These variables were included because they were previously reported as possible factors interfering with health management in this setting. The results are presented using β coefficients and 95% confidence intervals; level of significance was set as 5%.

Missing Data

Several categories had varying levels of missing data. No imputation was performed for missing height (5%), weight (7%), waist circumference (6%), glucose (9%), total cholesterol (16%), high-density lipoprotein cholesterol (16%), triglycerides (16%), and high-sensitivity C-reactive protein (15%). Descriptive statistics in Table 1 reflect the results for all people who had values for the respective variable. For the wealth index, 231 individuals were missing data, and for these individuals, the mean value for their village was imputed for this variable. In the subset of individuals with CVD, the analysis excluded subjects with missing key variables: blood pressure (3%), body mass index (7%), waist-to-hip ratio (7%), and low-density lipoprotein cholesterol (16%).

Table 1. Overall and CVD Population Characteristics, Agincourt Subdistrict, South Africa, 2015 (n=5059*)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Overall</th>
<th>Non-CVD</th>
<th>CVD</th>
<th>P Value†</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>5059</td>
<td>4467</td>
<td>592</td>
<td></td>
</tr>
<tr>
<td>Male sex</td>
<td>2345</td>
<td>2121</td>
<td>224</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Age, y</td>
<td>61.74</td>
<td>61.34</td>
<td>64.71</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Weight, kg</td>
<td>71.87</td>
<td>71.80</td>
<td>72.43</td>
<td>0.430</td>
</tr>
<tr>
<td>Height, m</td>
<td>1.63</td>
<td>1.63</td>
<td>1.61</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Body mass index, kg/m²</td>
<td>27.25</td>
<td>27.16</td>
<td>27.98</td>
<td>0.009</td>
</tr>
<tr>
<td>Waist circumference, cm</td>
<td>92.39</td>
<td>92.18</td>
<td>93.95</td>
<td>0.009</td>
</tr>
<tr>
<td>Waist-to-hip ratio</td>
<td>0.91</td>
<td>0.91</td>
<td>0.91</td>
<td>0.070</td>
</tr>
<tr>
<td>Average SBP, mm Hg</td>
<td>137.99</td>
<td>137.88</td>
<td>138.79</td>
<td>0.380</td>
</tr>
<tr>
<td>Average DBP, mm Hg</td>
<td>82.14</td>
<td>82.15</td>
<td>82.04</td>
<td>0.840</td>
</tr>
<tr>
<td>Glucose, mmol/L</td>
<td>6.67</td>
<td>6.65</td>
<td>6.81</td>
<td>0.270</td>
</tr>
<tr>
<td>Total cholesterol, mmol/L</td>
<td>4.24</td>
<td>4.22</td>
<td>4.38</td>
<td>0.006</td>
</tr>
<tr>
<td>High-density lipoprotein, mmol/L</td>
<td>1.57</td>
<td>1.57</td>
<td>1.58</td>
<td>0.830</td>
</tr>
<tr>
<td>Triglycerides, mmol/L</td>
<td>1.76</td>
<td>1.77</td>
<td>1.67</td>
<td>0.170</td>
</tr>
<tr>
<td>Low-density lipoprotein, mmol/L</td>
<td>2.12</td>
<td>2.11</td>
<td>2.19</td>
<td>0.240</td>
</tr>
<tr>
<td>hs C-reactive protein, mg/L</td>
<td>3.26</td>
<td>3.24</td>
<td>3.42</td>
<td>0.210</td>
</tr>
<tr>
<td>Current smokers</td>
<td>460</td>
<td>418</td>
<td>42</td>
<td>0.072</td>
</tr>
<tr>
<td>HIV positive</td>
<td>1134</td>
<td>1028</td>
<td>106</td>
<td>0.005</td>
</tr>
<tr>
<td>Illiterate</td>
<td>2108</td>
<td>1831</td>
<td>277</td>
<td>0.007</td>
</tr>
</tbody>
</table>

Statistically significant at α<0.05; Data given as mean±SD or n (%). CVD indicates cardiovascular disease (self-report of stroke/myocardial infarction or angina by Rose criteria); DBP, diastolic blood pressure; HIV, human immunodeficiency virus; hs, high-sensitivity; and SBP, systolic blood pressure.

*Not shown, missing: height (5%), weight (7%), body mass index (7%), waist circumference (6%), waist-to-hip ratio (7%), blood pressure (3%), glucose (9%), total cholesterol (16%), high-density lipoprotein cholesterol (16%), triglycerides (16%), low-density lipoprotein cholesterol (16%), C-reactive protein (15%).

†P value for comparison between non-CVD and CVD individuals.

Results

Of the 5890 eligible people, 85.9% (5059) agreed to be interviewed, 7.3% refused to participate, 6.0% could not be located, and 0.8% were unable to participate. The number of subjects
living with self-reported CVD was 592, which was 11.7% of the overall population. In this subset of CVD patients, angina was reported in 77.0% of the subjects, stroke in 25.2%, and myocardial infarction in 3.7%. The population of patients with CVD was more likely to be female, older, with higher body mass index, larger waist circumference, higher total cholesterol, and less likely to be smokers when compared with the non-CVD population. The overall population characteristics, as well as results of those with CVD compared with the non-CVD population, are summarized in Table 1.

Among the subjects with angina, 6.1% (28 of 456) were receiving treatment. In the group with stroke, 65.8% (98 of 149) were being treated and in the subset with previous myocardial infarction 86.4% (19 of 22) reported treatment of their disease. Collectively, 24% (142 of 592) of those with CVD were being treated.

To understand the impact of HIV on CVD in the community, we compared the proportion of individuals with angina, myocardial infarction, and stroke based on their HIV status. We found that 18.6% (85 of 456) of those who were HIV positive had angina compared with 22.9% (1048 of 4576) among those who were HIV negative, and this difference was statistically significant \(P=0.036\). The prevalence of stroke and myocardial infarction for HIV-positive people was 16.3% (24 of 147) and 9.1% (2 of 22), respectively, compared with 22.7% (1110 of 4894) and 22.5% (1132 of 5020) for HIV-negative people. These differences were not statistically significant \(P=0.068; \) myocardial infarction: \(P=0.132\).

The percentage of those with CVD who attained control for each of 5 modifiable risk factors was assessed, and the results are presented in Table 2. Higher proportions of control were attained for smoking, with 92.9% of the patients with history of CVD reported to be nonsmokers. Lower levels of control were attained for adiposity, as indicated by 29.7% of patients with waist-to-hip ratio below the cutoff values (0.90 for males and 0.85 for women). When these rates of modifiable risk factors were compared according to HIV and immigration status, higher numbers of patients with controlled blood pressure were found in the HIV-positive patients, and fewer smokers were observed in the immigrant population (Table 2).

Figure 1 shows the cumulative number of risk factors under control in this secondary prevention population. More than 57% of the patients with CVD had only \(\leq 2\) risk factors controlled and \(<5\%\) had all 5 risk factors under control. When the number of risk factors controlled was assessed by sex, 55.8% of the male subjects had \(\geq 3\) risk factors controlled compared with 34.2% of the females \((P<0.001)\). In contrast, 28.3% of the females had only 1 risk factor controlled compared with 13.0% of the males \((P<0.001)\).

An additional analysis was conducted to address the individual impact of each of the 5 risk factors on angina, myocardial infarction, and stroke. The only statistically significant difference we found was a higher percentage of waist-to-hip ratio in the ideal range among those with angina when compared with those with stroke (31.4% versus 22.8%; \(P=0.045\)). All other comparisons for the remaining risk factors were not statistically significantly different (Figure 2).

A multivariable linear regression model was developed to identify factors independently associated with the number of cardiovascular risk factors controlled, as shown in Table 3. Better management of CVD in this context was associated with male sex, absence of PD, and higher SES.

### Discussion

Many different aspects of CVD have been studied in SSA, particularly the prevalence of cardiovascular risk factors and primary prevention strategies.\(^{1,6-9,12,30}\) However, to our knowledge, no publications have assessed the management of patients with established CVD focusing on individuals’ disparities related to cardiovascular risk factors control. Even though CVD prevalence is increasing in SSA, our results suggest that the secondary prevention of the disease is currently not being optimally managed, especially considering the need to have all cardiovascular risk factors controlled. Less than 5% of our study population had all 5 risk factors that were assessed under control, and the majority of the group had \(\leq 2\) risk factors controlled. In addition to that, sex, SES, and PD were identified as associated with CVD management in this setting.

### Table 2. Distribution of Modifiable Risk Factors Under Control Among the Subjects With CVD by HIV and Migration Status, Agincourt Subdistrict, South Africa, 2015

<table>
<thead>
<tr>
<th></th>
<th>Overall (%)</th>
<th>HIV Positive (%)</th>
<th>HIV Negative (%)</th>
<th>(P) Value</th>
<th>Immigrant (%)</th>
<th>Nonimmigrant (%)</th>
<th>(P) Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waist-to-hip ratio*</td>
<td>29.7</td>
<td>34.9</td>
<td>28.7</td>
<td>0.207</td>
<td>29.1</td>
<td>30.1</td>
<td>0.809</td>
</tr>
<tr>
<td>LDL cholesterol†</td>
<td>31.4</td>
<td>36.8</td>
<td>30.4</td>
<td>0.197</td>
<td>28.5</td>
<td>32.7</td>
<td>0.317</td>
</tr>
<tr>
<td>Body mass index‡</td>
<td>33.8</td>
<td>41.5</td>
<td>32.2</td>
<td>0.068</td>
<td>33.1</td>
<td>34.1</td>
<td>0.817</td>
</tr>
<tr>
<td>Blood pressure§</td>
<td>51.2</td>
<td>61.3</td>
<td>48.8</td>
<td>0.019‖</td>
<td>48.8</td>
<td>52.0</td>
<td>0.480</td>
</tr>
<tr>
<td>Not smoking</td>
<td>92.9</td>
<td>88.7</td>
<td>93.8</td>
<td>0.063</td>
<td>96.5</td>
<td>91.4</td>
<td>0.028‖</td>
</tr>
</tbody>
</table>

CVD indicates cardiovascular disease (self-report of Stroke/Myocardial Infarction or Angina by Rose criteria); HIV, human immunodeficiency virus; and LDL, low-density lipoprotein.

*Waist-to-hip ratio: \(\leq 0.90\) (men) or \(\leq 0.85\) (women).
†LDL cholesterol <1.8 mmol/L.
‡Body mass index <25 kg/m².
§Blood pressure <140×90 mm Hg.
‖Statistically significant at \(\alpha=0.05\).
The prevalence of CVD in our population was 13% and is similar to the 10% for combined angina, stroke, and myocardial infarction reported in the adult US population from the 2010 American Heart Association estimates. According to SANHANES, the South African National Health and Nutrition Examination Survey from 2013, the self-reported prevalence of heart disease (2.2%) and stroke (1.8%) was lower than was found in our cohort (10.7% and 3%, respectively). However, it should be noted that in both the American Heart Association and SANHANES studies, the CVD prevalence was estimated for the adult population (>18 years) while for HAALSI, only subjects >40 years were included so we would anticipate higher prevalence rates in our older population.

The overall prevalence of self-reported angina in our study was 2.35%, similar to previous findings reported for the same Agincourt population (4.02%) while the prevalence of angina as determined using the Rose criteria is 9.04%. It is likely that relying only on self-report underestimates the true prevalence of angina.

It is well established that HIV-infected individuals are at increased risk for CVD because of, among other factors, the high prevalence of cardiovascular risk factors in HIV-infected individuals. Despite the fact that prevalence of HIV positivity...
Disease)37 that included 33
which ultimately can lead to fewer cardiovascular events.

on secondary prevention had all risk factors controlled, as well
differences noted across subgroups defined by race–ethnicity)
from the National Health and Nutrition Examination Survey
2 risk factors under control. A similar analysis
(57.6%) had
all risk factors controlled, and the majority of the subjects
pared with the CVD population (18%) of our study, we strati-
was higher in the non-CVD population (23.1%) when com-
pared with those without angina (22.9%). These findings might be
explained by previous findings from the same cohort that

Table 3. Linear Regression Coefficients for the Number of
Risk Factors Controlled Among Subjects With CVD, Agincourt
Subdistrict, South Africa, 2015

<table>
<thead>
<tr>
<th>Variables</th>
<th>β-Coefficient</th>
<th>95% CI</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male sex</td>
<td>0.44</td>
<td>0.25 to 0.63</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>Absence of PD</td>
<td>0.40</td>
<td>0.16 to 0.65</td>
<td>0.001*</td>
</tr>
<tr>
<td>SES</td>
<td>0.10</td>
<td>0.01 to 0.19</td>
<td>0.035*</td>
</tr>
<tr>
<td>Age</td>
<td>0.00</td>
<td>-0.01 to 0.00</td>
<td>0.687</td>
</tr>
<tr>
<td>HIV positive</td>
<td>0.20</td>
<td>-0.04 to 0.44</td>
<td>0.106</td>
</tr>
<tr>
<td>Immigrant</td>
<td>-0.05</td>
<td>-0.26 to 0.15</td>
<td>0.582</td>
</tr>
<tr>
<td>Illiterate</td>
<td>-0.04</td>
<td>-0.24 to 0.16</td>
<td>0.675</td>
</tr>
</tbody>
</table>

CI indicates confidence interval; CVD, cardiovascular disease (self-report
of stroke/myocardial infarction or angina by Rose criteria); HIV, human
immunodeficiency virus; PD, physical disability—self-reported presence or
absence of limitations in activities of daily living; and SES, socioeconomic status
(measured using the wealth asset index).

*Statistically significant at α=0.05.

was higher in the non-CVD population (23.1%) when com-
pared with the CVD population (18%) of our study, we strati-
ified our analysis of angina, myocardial infarction, and stroke
by HIV status. This approach addresses the important inter-
action between stroke and HIV.38 Our results showed similar
HIV infection numbers in individuals with and without myo-
cardial infarction and stroke and an even lower percentage
of HIV-infected subjects with angina (18.6%) when compared
with those without angina (22.9%). These findings might be
explained by previous findings from the same cohort that
showed that HIV-positive patients are more likely to receive
healthcare services for diabetes mellitus and hypertension,36
which ultimately can lead to fewer cardiovascular events.

In the CLARIFY registry (Prospective Observational
Longitudinal Registry of Patients with Stable Coronary Artery
Disease)37 that included 33 283 outpatients (77% male, mean
age: 64 years) with proven stable coronary artery disease from
45 countries, 12% of patients smoked. 78% were overweight,
71% of patients had hypertension, and the control rates ranged
from 47% to 66%. Dyslipidemia was reported in 75% of
patients, and low-density lipoprotein cholesterol control was
between 35% and 76%. The HAALSI cohort is notably differ-
ent from this study that assessed patients with CVD in its lower
smoking rate (7.1%). Because we only investigated currently
smoking, this lower smoking rates in the CVD group may be
attributable to smoking cessation after a cardiovascular event.38

Within the current study, only 4.4% of the population had
all risk factors controlled, and the majority of the subjects
(57.6%) had ≤2 risk factors under control. A similar analysis
from the National Health and Nutrition Examination Survey
showed that 10.6% of the US population (with no significant
differences noted across subgroups defined by race–ethnicity)
on secondary prevention had all risk factors controlled, as well
as an increasing temporal trend in this result.39 Considering
that having all risk factors under control is the most effective
action in secondary prevention of CVD,5,40 we can conclude
that the management of CVD in the region is far from optim.
Even more concerning is the poor level of CVD control
found in women especially considering the greater effects of
cardiovascular risk factors on women when compared with men.5,42

Because each risk factor assessed in this population has a
different impact as a secondary prevention strategy on angina,
myocardial infarction, and stroke,5,44 we assessed the propor-
tion of control for each the 5 risk factors individually. Once
again, this stratification is of particular interest when dealing
with stroke because it is already known that hypertension is
the most dominant risk factor for cerebrovascular events,44 and
additionally a focus on blood pressure and excess weight con-
trol would yield best preventive results for stroke in this popu-
lation.44 Our results show that across all 3 CVD groups, blood
pressure is better controlled than lipids, and this is consistent for
what has been observed with stroke prevention in the Agincourt
population.44 However, still only 50% of stroke sufferers have
controlled blood pressure and this need to be improved.

Using the HAALSI data, we developed a multivariable lin-
ear regression model to identify the factors associated with the
number of CVD risk factors controlled. Included in this model
were variables previously reported as possible factors inter-
fering with health management in this setting,25–29 including
illiteracy, immigration status, PD, and SES. Male sex, absence
of PD, and SES were positively associated with the number
of risk factors controlled. Higher SES has been consistently
associated with better risk factor control45 in secondary
prevention of CVD, and even within the HAALSI cohort, hyper-
tension was better managed in those individuals from higher
SES.24 A possible explanation for the male sex and absence
of PD results might be related to a better adherence to treatment
in these 2 groups when compared with females and individu-
als with comorbidities.46,47

A potential limitation of this particular study is the fact
that the subdistrict from which the cohort was recruited has
been part of an HDSS since 1992. This may create a specific
environment of improved healthcare surveillance that might
increase the level of risk factor control among patients with
CVD when compared with subjects with CVD living in other
parts of South Africa, as we previously showed in a study
addressing hypertension management.25 The low control rates
of CVD risk factors, observed in this particular area under sur-
veillance, suggest that levels of risk factor’s control may be
even worse at sites not covered by a HDSS.

Another limitation is the absence of data about specific
drugs/strategies for secondary prevention. Information about
antiplatelet drugs, β-blockers, blockers of the renin–angioten-
sin system, and statins was not obtained, limiting these specific
comparisons with other epidemiological studies.48 However,
we were able to make comparisons with another study for the
number of individuals with established CVD not taking any
appropriate medication. In this scenario, our results (24% not
being treated) are better than the mean level observed in South
Africa and other upper middle-income countries (Argentina,
Brazil, Chile, Malaysia, Poland, and Turkey; 48.4%),49 rein-
fơcing the hypothesis of better healthcare associated with
HDSS coverage.25

The strengths of this study include the investigation of
variables, such as immigration and HIV status, which have
not previously been assessed for their effects on CVD risk
factor management. In these analyses, fewer immigrants with
CVD were found to be smokers when compared with non-immigrants. This suppression of smoking in the immigrant population was previously shown in the literature, although not in individuals with known CVD, and may reflect more general social sanctions against personal consumption among immigrants who have taken on the responsibility of leaving home to earn money and build savings for their households.\textsuperscript{50} The better blood pressure control in HIV-positive subjects is aligned with the results of a recent meta-analysis that assessed the association between HIV and cardiometabolic diseases in SSA.\textsuperscript{51} Their results suggested that HIV-positive patients have, on average, lower blood pressure than their HIV-negative counterparts. An additional strength is the fact that this study provides relevant information on disparities in CVD management, which ultimately can be used to develop more equitable health models in a setting with limited resources.

Mortality from CVD has increased globally, particularly in the developing world from 1990 to 2013. Overall mortality from these conditions in SSA is low (ischemic heart disease 4.7%, stroke 5.0%) but South Africa’s are slightly higher (7.6% and 6.3%, respectively).\textsuperscript{52,53} Our data show that one of the reasons for these high levels of mortality from cardiovascular events may be because of the poor control of CVD risk factors. This suggests that mortality may be decreased through improvement in treatment of these risk factors coupled with greater community education on the importance of lifestyle modification. Initiatives to achieve these goals, such as population-wide screening for hypertension and diabetes mellitus, engagement of community resources and governance structures, geographic decentralization of care services, and group medical visits alone or integrated into microfinance groups, have been previously proposed in SSA,\textsuperscript{54} and some of these interventions are currently under investigation.\textsuperscript{55}

In conclusion, this analysis of the HAALSI study demonstrates that CVD is currently not being optimally managed in this rural area of South Africa and that there are significant opportunities to improve secondary prevention in this population. A particular focus should be placed on females, subjects from lower SES, and those with PD.

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Disclosures

None.

References


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Disparities in Management of Cardiovascular Disease in Rural South Africa: Data From the HAALSI Study (Health and Aging in Africa: Longitudinal Studies of International Network for the Demographic Evaluation of Populations and Their Health Communities)
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