Study of Global Ageing and Adult Health (SAGE)

South Africa 2007–2008

Phaswana-Mafuya N, Peltzer, K, Schneider M, Makiwane M, Zuma K, Ramlagan S, Tabane C, Davids A, Mbelle N, Matseke G & Phaweni K (2011). Study of Global Ageing and Adult Health (SAGE), South Africa 2007–2008. Geneva, World Health Organization. 2012.

Executive Summary

1 Background

The phenomenon of population ageing has become more significant in South African society during recent decades, with the cohort aged 50 years or older increasing noticeably in both percentage and number. The social, economic and political consequences of population ageing have thus become a significant factor to be taken into account in all planning aspects of policies and programmes. This is particularly the case with regard to the care of older people, including sustainability of social assistance and services in light of the growing epidemic of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and noncommunicable chronic diseases, with the consequent additional social and economic pressures and responsibilities that have been placed on older people.

In South Africa, Wave 1 of the Study of Global Ageing and Adult Health (SAGE) collected data on South Africans aged 50 years or older over the period 2007–2008.

2 Methods

SAGE is a national population-based longitudinal survey that will have three or four data collection rounds of the same cohort of people as they age over a period of 5–10 years, with replacements for attrition. This paper represents the first round of data collection (SAGE Wave 1) involving a sample of 3840 South Africans aged 50+ years. Face-to-face interviews were used to collect self-report data and measurements.

3 Sociodemographic characteristics

The overall proportion of male and female household members in the sample was 38% and 60%, respectively. The proportion of male and female household members living in urban and rural areas was the same, with 62% in urban areas and 38% in rural areas. Most respondents (83%) did not have health insurance (the same proportion for males and females). The mean household size was two people, and did not differ between urban and rural areas. Rural households were slightly larger than urban households – 28% and 20%, respectively, had six or more household members. Men and women were heads in 40% (rural) and 42% (urban) of households. In rural areas, older women were more likely to be head of households than in urban areas. Households with only one member, households headed by older women and households where the woman was the main income earner were clustered in the lower wealth quintiles. Almost one third of the households had two generations in both urban and rural areas). Dual households in which both spouses were aged 50 years or older were likely to be in higher wealth quintiles. The major difference between the sexes was that a larger proportion of women aged 70–79 years were head of household. Another difference between the sexes was that men who were head of households were more likely to have received higher education than women, and to live in a household with higher wealth status. Almost 90% of the population was Black African or coloured. Most respondents were Christian (85%).

3 Current and past employment, income, transfers of assistance and health expenditures

About 15% of respondents had never worked for pay; of those, 55% were not working at the time of the survey. More females than males had never worked (18% and 10%, respectively); of those who had ever worked, more males than females were still working (39% and 23%, respectively). With regard to residence, 24% in rural areas had never worked, compared to 10% in urban areas. Among

those who had ever worked, about half in both urban and rural areas were still working. The most common reason for discontinuing work was health or age related. These reasons were slightly more common among women (77%) than men (72%). As expected, stopping work due to health-related reasons or retirement increased with age, reaching 97% among those aged 80 years or older. Slightly more people in urban areas stopped working due to health-related reasons than those in rural areas. Those aged 50–69 years were about half as likely to be employed in the public sectors as those aged 70–79 years. There was a trend towards more professional, sales and services occupations in the younger age group. Households represented by higher status occupations tended to fall into the higher quintiles. The largest number of households received transfers from the government in monetary form, and these transfers were most commonly made to other family members (83%). For transfers in terms of actual monetary assistance (in Rand) into the household, government generally provided the most assistance (an average of R7128.60). In terms of out-of-household transfers, the family transferred the most out (R4381.40) and the community gave the most in terms of hours per week (15 hours).

Among those who had suffered a catastrophic event in the past 30 days, mean household expenditure was less, and they were more likely to be poor (54.7%) or impoverished (15.3%), to have higher out-of-pocket expenditure as a percentage of all expenditures (27.8%) and higher out-of-pocket expenditure as a percentage of non-subsistence spending (60.3%). The poor also had less mean household expenditure (R694), yet spent a lot more on insurance (R5569). At R3607, urban expenditure was more than twice as high as rural expenditure, with 57% of people residing in rural areas. In terms of expenditure quintiles, all people in the lowest quintal were poor and, as expenditure increased, so too did out-of-pocket expenditure as a percentage of all expenditures, and out-of-pocket expenditure as a percentage of non-subsistence spending. In the past 30 days, outpatient health payments held the overall majority of out-of-pocket health payments in all categories. The overall majority used their current income as the payment source for health services.

4 Risk factors and health behaviours

Tobacco use: About 68% of adults had never used tobacco, 19.4% were current daily tobacco users, 3.4% not daily tobacco users and 9.5% not current tobacco users. The mean daily tobacco consumption was 16 tobacco products. More men than women were current daily tobacco users, but the mean daily tobacco consumption was higher for women.

Alcohol consumption: Most adults – across age, gender, type of locality and marital status – were lifetime abstainers from alcohol (76–85%); 11.5% were non-heavy drinkers, 3% were infrequent heavy drinkers and 1% were frequent heavy drinkers.

Physical inactivity: Overall, 60.1% did not undertake sufficient daily physical activity. More women than men, those in a younger age group, adults in lower wealth quintiles and urban residents did not undertake sufficient daily physical activity.

Fruit and vegetable consumption: Overall, 68.5% did not consume sufficient fruits and vegetables. More women, rural residents, adults with less than primary school education and those in lower wealth quintiles did not consume sufficient fruits and vegetables.

Water and sanitation: Access to water: Most households had access to a safe drinking water source (93.3%). More households from urban (97.7%) had a safe drinking water source than rural areas (84.6%). The prevalence of access to an improved water source increased with wealth. Few people had water on their premises (7.4%). More people in urban areas (12.6) than in rural areas (5.0) has water on their premises. Even in households in the highest wealth quintile, only about one fifth had water on their premises.

Improved sanitation: The prevalence of improved sanitation was higher in urban (67.5%) than in rural areas (50.3%), and increased dramatically with wealth.

Air pollution: More than three quarters of households used clean fuel for cooking purposes. Only 13% overall used solid fuels; however, 33% of households in rural areas depended on these fuels for cooking, compared to only 2% in urban areas. The use of solid fuel and paraffin fuel decreased with increased wealth: 25% of households in the lowest wealth quintile used solid fuels, compared to only 1% in the highest wealth quintile. There was no difference in the use of paraffin between urban and rural residence.

Recommendation

In line with the results of the study and the United Nations Madrid International Plan of Action on Ageing (UN 2002), policies should promote healthy eating habits (that is, daily consumption of vegetables and fruits), smoking cessation and reduction of harmful consumption of alcohol, an increase in physical activity, better access to improved drinking-water and sanitation, and reduced air pollution.

5 Health state

Respondents were asked to rate their general overall health and their level of difficulty with household and work activities. They were then asked a series of more detailed questions covering multiple dimensions of their health and functioning. The results were consistent for all three types of questions. Women rated their health worse than men, and younger adults (50–59 years) reported better health and functioning than older people, with few reported health differences between urban and rural residents. One difference between urban and rural dwellers was noted: those living in rural areas had more difficulties in doing household or work activities than their urban counterparts (42 % of urban dwellers had no difficulties compared to 33% of rural dwellers; 6% of urban dwellers had severe difficulties compared to 15.6% of rural dwellers). This last result needs further examination to understand its causes.

Recommendation

Self-reported health is a strong predictor of health and mortality, so maintaining and enhancing health status should be a policy and programmatic priority. This requires a broad range of actions that affect individual health, including improvements in the economic and social situation of older people.

6 Morbidity and interventions

Eighteen per cent of men and 29% of women self-reported a diagnosis of arthritis; 3–4% of men and women had had a stroke; 5–6% had had angina; and 6% of men and 11% of women had been diagnosed with diabetes. In addition, men and women, respectively, self-reported the following diagnoses: 2% and 3% chronic lung disease; 4% asthma (both sexes); 3% depression (both sexes); 23% and 33% hypertension; 7% and 10% edentulism (loss of all teeth); and 4% and 5% cataracts. In the past year, 1–2% of adults had been injured in a traffic accident, from which more than one out of three sustained a disability.

Overall, 32% of women had ever undergone cervical cancer screening during a pelvic exam, and 16% had ever had breast cancer screening. The proportion of both breast cancer and cervical cancer screening was higher in urban areas than in rural areas. In urban areas, the proportion that had ever been screened was 29.9% for breast cancer and 41.9% for cervical cancer; in rural areas, it was 6% and 14% for breast and cervical cancer screening, respectively. The higher screening proportions in

urban areas than in rural areas might be attributed to availability and accessibility of health facilities and services in urban areas.

Recommendation

The results of this study indicate a need to develop health promotion programmes directed at promoting prevention of chronic diseases, including periodic health examinations and better access for disadvantaged communities to preventive health examinations.

7 Health examination and biomarkers

About three quarters of respondents were either obese (45%) or overweight (27%). The prevalence of obesity among men and women was high: 38% and 51%. Obesity was highest among those aged 60–69 years (50%) and among urban dwellers (47%). Among women, 70.7% had a waist–hip ratio (WHR) indicating central obesity (>0.85); among men, 53.7% had a WHR ratio higher than the standard average for males (>0.90). Based on waist circumference, overall, 22.1% of men and 63.1% of women had central obesity. The mean systolic blood pressure was 146.2 mm Hg among women and 144.3 mm Hg among men, indicating a high prevalence of hypertension. The overall mean diastolic blood pressure was 96 mmHg; again these findings clearly put this population in the category of "high blood pressure". A high proportion (71.4%) had systolic or diastolic hypertension. Regarding lung function, 8.2% had severe or very servere chronic obstructive pulmonary disease (COPD), with the highest in the 80+ age group, and 14.% had severe asthma. Low near visual acuity (35.6%) was more common among older people than low distant vision (11.3%). High risk glycosylated haemoglobin levels were found among older men (69.3%) and older women (66.8%). Finally, the HIV prevalence among the older population was 4.9% among men and 7.5% among women, with 3.3% among those 70 years and above.

Recommendation

The results indicate a need to develop health promotion programmes to modify behavioural risk factors for chronic diseases, including promotion of healthy diet and physical activity programmes.

8 Well-being and quality of life

Subjective well-being and quality of life was assessed using the WHO Quality of Life (WHOQoL) index, which ranges from 0 to 100. The mean WHOQoL score for females (51.5) was comparable to that of males (49.1) and implied that quality of life was moderate. The results of the WHOQoL questions showed that men and women rated their quality of life similarly, with women rating quality of life slightly better than men.

Recommendation

Improving quality of life for all through access to adequate health care is an absolute imperative. This study raises important long-term policy issues about health status and the determinants of healthy ageing. There is a need to develop sustainable policies for healthy ageing at the local and national levels, to integrate health and older people in all policy areas, and to tackle health inequities at the core of South African policies.