

Ageing and Health: The SAGE survey

Nancy Phaswana-Mafuya, (PhD) is a Research Director in the Human Sciences Research Councils HIV/AIDS/STI/TB research programme. She is also an Honorary Professor at the Nelson Mandela Metropolitan University. Areas of interest: HIV/AIDS, Aging and Health, health behavior and health systems. nphaswanamafuya@hsrc.ac.za

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 (1). 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 HIV/AIDS and non-communicable chronic diseases, with as a consequence additional social and economic pressures and responsibilities that have been placed on older people.

Though considerable attention has been paid to the ageing populations around the world, the vast majority of this attention has been focused on higher income countries. Middle and lower income countries, however, are also experiencing rapid growth in their populations of older adults with great variability and diversity between countries. Yet fewer lower income countries have the population based age-specific health and disability data necessary to determine basic levels and distribution of health parameters.

Against this background, the World Health Organization (WHO) initiated the Study on Global Ageing and Adult Health (SAGE) in six countries. The aim was to improve understanding of the health and well-being of adults aged 50 years or older in low- and middle-income countries. The countries studied were China, Ghana, India, Mexico, the Russian Federation and South Africa. The objective of SAGE is to generate data on ageing and on the health and well-being of older adults that is valid and comparable across countries. The study provides information on a wide range of population health, wealth and related indicators. The resulting evidence of SAGE in South Africa will be used to inform policy and planning in the country.

SAGE is a groundbreaking, nationally representative household longitudinal study of the population aged 50 years and above. This survey 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.

In South Africa, SAGE was carried out in partnership with the WHO, the National Department of Health (NDOH) and the HSRC. Funding was provided by these three institutions and the United States National Institute on Aging via the WHO. Technical assistance was provided by the WHO Multi-Country Studies Unit, Geneva. Data collection was undertaken at national level using a population-based representative sample of the population aged 50 years or older, with a smaller sample of adults aged 18–49 years for comparison. The targeted sample of the study was to interview 5000 people 50 years or older, and an additional 1000 people aged 18–49 years. Face-to-face interviews were used to collect self-report data and measurements, including health examination, anthropometric and biomarker data. In South Africa, SAGE used standardized household and individual

questionnaires that were the same as those used in other SAGE countries, with a few country-specific adaptations. Wave 1 Interviews in South Africa were conducted between March 2007 and October 2008.

In addition to the six countries implementing the national level SAGE survey, several countries implemented a short version of the SAGE questionnaire in sub-national areas in health and demographic surveillance system (HDSS) field sites. These field sites are part of INDEPTH – the International Network for the Demographic Evaluation of Populations and Their Health in Developing Countries. In South Africa, the Agincourt Health and Population Unit (AHPU) in rural Mpumalanga (an INDEPTH HDSS) incorporated the short SAGE Wave 1 questionnaire into their annual census round in July 2006 (n=4085) and undertook the full SAGE survey in a small sample (n=426). These two datasets from the AHPU will be compared to the national level SAGE Wave 1 South Africa data at a later stage, and can be used as a field laboratory for the national level SAGE efforts. A Wave 2 is also planned in the AHPU. Cross-site and cross-country analyses are planned for the SAGE data from the eight INDEPTH sites and the six SAGE countries, including South Africa.

This article provides highlights of the findings from the first round of data collection (SAGE Wave 1).

Socio-demographic 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. 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. 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. Dual households in which both spouses were aged 50 years or older were likely to be in higher wealth quintiles. Almost 90% of the population was Black African or coloured. Most respondents were Christian (85%).

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.

Recommendation: Policies should promote healthy eating habits (that is, daily consumption of vegetables and fruits), smoking cessation and reduction of harmful consumption of alcohol, and an increase in physical activity.

Health state

Respondents were asked to rate their general overall health and their level of difficulty with household and work activities. 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.

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: There is 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.

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”.

Recommendation: There is a need to develop health promotion programmes to modify behavioural risk factors for chronic diseases, including promotion of healthy diet and physical activity programmes.

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.

Recommendation: Improving quality of life for all through access to adequate health care is an absolute imperative.

In conclusion, 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. In response to population ageing globally and in the African region, the United Nations Madrid International Plan of Action on Ageing (1) and the 2003 African Union Policy Framework and Plan of Action on Ageing (2) have urged governments to take account of ageing and older populations. South Africa has pledged action to address the needs and well-being of older persons through the African Union Africa Health Strategy 2007–2015 (3). The challenge remains to overcome the policy inaction and research inadequacies.

Note that the views expressed in this article are those of the author(s) and do not necessarily represent the views of PHASA.

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