A National Household Survey of Health Inequalities in South Africa.

Prepared by the Community Agency for Social Enquiry (CASE)
for the Henry J. Kaiser Family Foundation.

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OVERVIEW CHAPTER

OVERVIEW REPORT

The first democratically elected government in South Africa has made improving health and health services for the historically underserved black majority a national prioity. As part of this process, in June 1995, the Minister of Health, Dr. Nkosazana Dlamini Zuma, outlined a plan designed to provide free primary health care to all South Africans. This plan aims to improve the health status of South Africans, as well as the quality of care, through increased emphasis on disease prevention and early intervention.

To establish a baseline from which to measure the impact of these improvements over time, the Henry J. Kaiser Family Foundation, in June 1994, commissioned this national household health survey, the first of its kind in South Africa. The Foundation plans to regularly repeat this survey to provide a reliable monitor of progress.

A nationally representative sample of 4,000 households was drawn and the data weighted to the universe of 7,594,000 households in South Africa and for the universe of each age category, taking into account the distribution of households within provinces, population groups and environment such as metro, urban or rural. The survey was coordinated by the Community Agency for Social Enquiry (CASE) and the questionnaire administered by Market Research Africa.

The questionnaire and data analysis were reviewed by a specially convened panel of reviewers in South Africa and the United States (see Appendix A and B). In addition, the questionnaire was pre-tested in a series of 10 focus groups, representative of different race groups and

population categories, such as the elderly and disabled.

The questionnaire focused on the public health environment; barriers in access to health care; and perceptions of quality and satisfaction with the outcome of health care. In addition, a series of sentinel indicators of health status and health information were identified.

SUMMARY OF KEY SURVEY FINDINGS

The findings of this survey underscore how dramatically worse off the majority African population in South Africa is in almost every aspect of their lives when compared to other race groups. Poverty, combined with poor public health conditions--overcrowded housing, lack of accessible drinking water and sanitation--make Africans most vulnerable to ill health. Yet those who are at greatest risk also have the greatest difficulty accessing health services and are treated the most shabbily when they do.

Although nearly half of all respondents expressed dissatisfaction with the existing health service, predictably dissatisfaction is much higher among Africans. Approximately two thirds of Africans live in rural areas (in the former homelands or on white-owned farms) or in informal squatter settlements abutting urban areas. It is this substantial part of the South African population which must travel furthest to reach a health facility, which must wait the longest to see a health provider and for whom a medical consultation is most likely to last less than five minutes.

The principal findings of the survey are:

Public Health Issues

- Approximately two thirds of the African population is affected by poor public health conditions--overcrowding, lack of electricity, clean water, sanitation.

- Only about 20% of African households have a water tap inside the home compared to nearly 100% of white and Indian households. Sixteen percent of African households have no toilet of any kind and nearly 60% have no electricity.

- Close to two thirds of all African households (more than three quarters in rural areas) have monthly incomes below the minimum living level of R900 whereas nearly two thirds of white households have monthly income in excess of R2,000. Nearly a quarter of all African households have a monthly income below R300.

Access to Care

- Most Africans rely on the public health service, whereas whites and Indians rely almost entirely on private care.
- Cost of health care, distance and the availability and cost of transport are major barriers to care for Africans.
- Most South Africans do not report for their first treatment at a public clinic, but choose either a public hospital or private doctor. This is most likely a function of the inaccesibility and scarcity of clinics, particularly in rural areas, restricted clinic opening times and perceptions that the standard of care in clinics is worse than in public hospitals.

Quality and Satisfaction

- More than 40% of South Africans, across all race groups, think the existing health service serves them badly. African dissatisfaction (46%) is much higher than other race groups.
- Waiting times at public health facilities are excessive and consultation times too short to be effective. This is symptomatic of the extent to which the public health service is oveburdened and under-staffed.
- Health outreach services, including ambulance services, and services for the aged and disabled are poor for all population groups and almost non-existent for Africans.
- A very high proportion (85%) of the population think that community health workers would contribute to the improvement of the health service.
- The majority of respondents (92%) had heard of the government's introduction of free care for children under six and pregnant women. Africans and coloureds reported that this programme had made access easier and improved quality of care, while whites said access and quality had remained the same. However, respondents in urban areas were more likely than those in rural areas to say that services had become worse since the introduction of the programme due to increased congestion at public health facilities.

Child Health

- Seventy percent of African children under five live in rural areas. Of these, 76% live in households with incomes below the minimum living level. Seventy percent live in homes with no electricity, 32% without access to piped water and 22% without a toilet of any sort.
- A high proportion of Africans (23%) said they were too poor to properly feed their pre-school children, but a very low proportion (8%) reported receiving supplemental food from a health facility.

- The government's primary school feeding program is not reaching a substantial proportion of the children from the three quarters of rural African households living below the minimum living level.
- Information regarding the benefits of oral rehydration solution and breast feeding is high among African women.
- Immunization rates among children under five years of age of all races are low.
- Nearly two thirds of African children do not have a birth certificate.

Reproductive Health

- Three percent of respondents had a family member die during pregancy or child birth in the past year. This represents about 626,000 women of whom 574,000 are African.
- Contraceptive usage among Africans remains low and overwhelmingly the responsibility of women.
- Most South Africans (98%) have heard of AIDS, but there is widespread misinformation about the means of transmission of HIV. Nearly half the respondents thought AIDS could be spread by mosquitos, but an average of 90% knew that sex without a condom is high risk for transmission of the disease. Yet only two thirds of respondents said they would use a condom when having sex with a new partner.

PRINCIPAL SURVEY FINDINGS

DEMOGRAPHICS

FIGURE 1. South African Households by Race

70 Percent of households in South Africa are African, 20% white, 7% coloured, and 3% Indian.

TABLE 1. Province/Dwellings

Province	Total	African	Coloured	Indian	White
Western Cape	10.9	2.9	72.7	0	17.7

Northern Cape	1.6	0.9	8.7	0	1.9
Eastern Cape	14.1	16.8	11.7	0	7.4
KwaZulu-Natal	20.7	22.8	-	85.6	12.3
Gauteng	21.9	17.6	6.9	14.4	43.9
Eastern Transvaal	6.9	8.6	-	0	4.3
Northern Province	9.8	13.5	-	0	1.9
Northwest	7.3	9.2	-	0	4.1
Free State	6.7	7.6	-	0	6.6
Total N (000)....	7594	5330	560	196	1508
Type of dwelling	**Total**	**African**	**Coloured**	**Indian**	**White**
House/part of	62.8	60.6	87.5	78	59.1
Flat/townhouse	9.5	0.5	11.4	20.6	39.4
Hotel	0.3	0.1	-	0.3	1.5
Caravan/Zozo	0.1	0.2	0.2	-	-
Shack	9.5	13.4	0.2	-	-
Traditional	15.2	21.7	-	-	-
Hostel	1.6	2.3	-	-	-
Outbuilding	0.9	1.1	0.6	1.1	-
Total N (000)	7594	5330	560	196	1508

54 Percent of Africans live in rural areas--43% in the former homelands and 11% on white-owned farms. The most densely populated provinces are Gauteng (22 % of households) and KwaZulu-Natal (20%). The Northern Cape is the most sparsely populated (2 % of households).

FIGURE 2. Type of Dwelling by Race

11 Percent of African households consist of shacks or informal dwellings in the urban/metropolitan areas. (These are heavily concentrated in the Western Cape and Gauteng.) This percentage would be much higher if the basically informal settlements which have been "formalized" by introduction of "site and service schemes" were to be included.

TABLE 2. Income/Crowding

Average	Total	African	Coloured	Indian	White	African Urban	African Rural	African Urban Formal	African Urban Informal	African Rural Farms	African Rural Homelands	Coloured Urban	Coloured Rural
Income (R)	1359	679	1474	2679	3544	911	481	990	676	350	514	1600	716
HH caretaker school std.	6	5	5	7	9	5	4	6	5	2	4	6	2
People in house	5	5	5	5	3	5	6	5	4	5	6	5	5
Rooms in house	4	4	4	5	6	4	4	4	2	3	4	4	3
People per room	1.25	1.3	1.3	1	0.5	1.3	1.5	1.3	2	1.7	1.5	1.3	1.7

Overcrowding in African and coloured households is much worse than for Indians and whites. 56 Percent of African households and 59% of coloured households consist of five people or more as compared to 11% of white households. 20 Percent of white households consist of only one person.

FIGURE 3. Overcrowding by Race

29 Percent of African homes consist of two rooms or less, as compared to 5% of whites, 2% of Indians and 11% of coloureds.

TABLE 3. Income Distribution

HH Income < R900 per month	Total	African	Coloured	Indian	White	African Urban	African Rural	African Urban Formal	African Urban Informal	African Rural Farms	African Rural Homelands	Coloured Urban	Coloured Rural

Yes	48.9	63.1	32.2	13.4	9.9	51.3	73.1	46.4	65.9	82.5	70.8	26.2	68
No	51.1	36.9	67.8	86.6	90.1	48.7	26.9	53.6	34.1	17.5	29.2	73.8	32
Total N (000)	7594	5330	560	196	1508	2456	2874	1840	616	572	2302	480	80
Monthly HH Income	**Total**	**African**	**Coloured**	**Indian**	**White**	**African Urban**	**African Rural**	**African Urban Formal**	**African Urban Informal**	**African Rural Farms**	**African Rural Homelands**	**Coloured Urban**	**Coloured Rural**
< R300	17	23.3	4.9	1.7	1.1	15.2	30.2	13.3	20.8	43.3	27	4.6	7
R300-R499	15	19.6	8.3	2.5	3.1	12.9	25.3	13	12.7	22.5	26	5	28
R500-R999	20.6	24.1	24.1	10.7	8	29	20	25.2	40.2	18.4	20.4	21.1	42
R1000-R1999	15.5	14.5	27.2	22.9	13.4	21.5	8.6	23	17.1	3.8	9.7	28.7	18
R2000+	20.1	6.8	25.5	54	60.9	11.2	3	14.1	2.5	1.2	3.5	29.4	2
Refused	11.8	11.7	10	8.2	13.5	10.2	12.9	11.4	6.8	10.8	13.5	11.2	3
Total N (000)	7594	5330	560	196	1508	2456	2874	1840	616	572	2302	480	80

Close to two thirds (63.1%) of all African households have monthly incomes below the minimum living level of R900. The number of African households living below the minimum living level increases to 73.1% in rural areas. 23.3 Percent of all African households receive less than R300 per month (30.2% in rural areas).

FIGURE 4. Average Monthly Income by Race

On the other hand, 60.9% of white households and more than half of Indian households (54%) have income in excess of R2,000 per month. Average monthly household income for Africans is R679 compared to R3,544 for whites, R2,679 for Indians and R1,474 for coloureds. Not surprisingly, 55 percent of African households reported difficulty feeding themselves.

TABLE 4. Education of Health Caretaker

Schooling Level	Total	African	Coloured	Indian	White	African Urban	African Rural	African Urban Formal	African Urban Informal	African Rural Farms	African Rural Homelands	Coloured Urban	Coloured Rural
No formal schooling	15.1	20.3	10.2	2.9	0.2	12.2	27.2	12.1	12.4	37.9	24.5	6	35
Up to std. 3	14.6	19.2	13.6	6.4	0.1	14.6	23.1	12.6	20.3	36.8	19.7	11.2	28
Std. 4-5	14.8	17.7	26.1	12.9	0.8	17.8	17.6	15.3	25.2	12.9	18.8	26	27
Std. 6-9	35.2	32.8	39.5	47.4	40.4	41.6	25.3	42.8	38.1	11.2	28.9	44.7	8
Std. 10	11.9	6.4	5.9	19.9	32.3	9.2	4	11.1	3.7	0.6	4.9	6.6	2
Post matric.	8.4	3.6	4.7	10.6	26.2	4.7	2.7	6.2	0.2	0.6	3.2	5.4	0
Total N (000)	7594	5330	560	196	1508	2456	2874	1840	616	572	2302	480	80

20.3 Percent of African caretakers (people responsible for health care in a household) have no formal schooling. 57.7 Percent have less than a standard five education, as compared to 49.9% of coloureds, 22.2% of Indians and only 1.1% of whites. Only 3.6% of Africans have a post-matric education as compared to 26.2% of whites.

PUBLIC HEALTH ENVIRONMENT

TABLE 5. Water Supply

Water for Household	Total	African	Coloured	Indian	White	African Urban	African Rural	African Urban Formal	African Urban Informal	African Rural Farms	African Rural Homelands	Coloured Urban	Coloured Rural
Tap inside	41.9	19.1	83.4	99.2	99.9	39.1	1.9	51.6	1.8	4.4	1.3	87.9	56
Tap outside dwelling	21.2	28.8	13.8	0.8	0.1	44.4	15.4	42.7	49.6	22.8	13.6	11.1	30
Tap outside grounds	17.8	25.2	1.7	-	-	15.9	33.2	5.4	47.4	35.2	32.7	1	6
Tanker	2.2	3.1	0.1	-	-	0.3	5.6	-	1.1	6.9	5.2	-	1

River	12	17.1	0.7	-	-	-	31.7	-	-	21.7	34.1	-	5
Borehole	4	5.6	0.3	-	-	0.2	10.2	0.3	-	7.9	10.8	-	2
Other	0.2	0.3	-	-	-	-	0.6	-	-	-	0.8	-	-
No main source	0.5	0.7	-	-	-	0.1	1.3	0.1	-	1.1	1.3	-	-
Windmill	0	0.1	-	-	-	-	0.1	-	-	-	0.2	-	-
Total N (000)....	7594	5330	560	196	1508	2456	2874	1840	616	572	2302	480	80

Only 19.1% of all African households have a water tap inside the home (1.9% in rural areas), compared to 99.9% of whites, 99.2% of Indians and 83.4% of coloureds. 54 Percent of African households have access to an outside water tap. 31.7 Percent of Africans in rural areas rely on rivers for their household water.

Among households without access to piped water, 89% said they did nothing to treat water from an unpiped source (river or dam) for possible contamination before drinking it.

TABLE 6. Water Retrieval

Water source--outside	Total	African	Coloured	Indian	White	African Urban	African Rural	African Urban Formal	African Urban Informal	African Rural Farms	African Rural Homelands	Coloured Urban	Coloured Rural
More 1/ day	73.5	73.5	74.9	-	-	78.9	72.6	85.5	76.6	82.6	70.5	100	64.3
Once/ day	16.7	16.7	15.1	-	-	15.6	16.8	11.3	17.2	13.2	17.6	-	21.4
Once 2/3 days	7.8	7.8	10	-	-	4.5	8.3	-	6.1	4.2	9.2	-	14.3
Less frequent	2	2	-	-	-	0.9	2.2	3.2	0.1	-	2.7	-	-
Total N (000)	2796	2780	16	-	-	11	405	2376	106	299	416	-	5

Time to fetch water	Total	African	Coloured	Indian	White	African Urban	African Rural	African Urban Formal	African Urban Informal	African Rural Farms	African Rural Homelands	Coloured Urban	Coloured Rural
5 minutes/ less	42.7	42.4	90	-	-	62	39.1	81.9	55	62.4	34.1	100	85.7
5-15 minutes	26.8	27	5	-	-	29.9	26.5	9.6	37.1	20.8	27.6	-	7.1
15-30 minutes	15	15.1	-	-	-	5.7	16.7	2.7	6.8	9.5	18.2	-	-
30-60 minutes	9.9	9.9	-	-	-	1.7	11.3	3.3	1.1	5.9	12.5	-	-
60-90 minutes	4.8	4.9	-	-	-	0.7	5.6	2.6	-	0.7	6.6	-	-
90 min./ longer	0.8	0.8	5	-	-	-	0.9	-	-	0.6	1	-	7.1
Total N (000)	2796	2780	16	-	-	11	405	2376	106	299	416	-	5

Of those households dependent on an outside source of water, 73.5% have to collect water more than once a day. It takes 15.6% of those households more than 30 minutes to collect water from their nearest source.

FIGURE 5. Population Without Toilets by Race

TABLE 7. Toilets

Toilet in house	Total	African	Coloured	Indian	White	African Urban	African Rural	African Urban Formal	African Urban Informal	African Rural Farms	African Rural Homelands	Coloured Urban	Coloured Rural
Yes	88.7	84.3	96.6	99.6	100	98.7	71.9	99.3	96.9	61.6	74.5	99.9	77
No	11.3	15.7	3.4	0.4	-	1.3	28.1	0.7	3.1	38.4	25.5	0.1	23

Total N (000)	7594	5330	560	196	1508	2456	2874	1840	616	572	2302	480	80
Type of toilet	**Total**	**African**	**Coloured**	**Indian**	**White**	**African Urban**	**African Rural**	**African Urban Formal**	**African Urban Informal**	**African Rural Farms**	**African Rural Homelands**	**Coloured Urban**	**Coloured Rural**
Flush: inside	45.2	20.4	82.3	96.5	99.1	36.5	1.5	47.8	1.8	5.1	0.8	86.6	49.4
Flush: outside	15.4	21.8	7.1	3.5	0.9	40.3	-	39.4	43.2	-	-	7	7.8
VIP pit	1.6	2.3	-	-	-	2.5	2.2	1.4	5.7	7.1	1.2	-	-
Pit latrine	34	50.7	2.7	-	-	11.9	96.2	4.4	35.1	87.8	97.9	0.4	20.8
Bucket toilet	3.8	4.8	7.9	-	-	8.8	0.2	7	14.2	-	0.2	6	22.1
Total N (000)	6735	4490	541	196	1508	2424	2067	1827	597	352	1715	479	62

FIGURE 6. Type of Toilet by Race

15.7 Percent of African households have no toilet at all (28.1% in rural areas). In contrast, 99.1% of white households have indoor flush toilets. Of African households with toilets, most (50.7%) rely on pit latrines.

TABLE 8. Electricity

Electricity in house	**Total**	**African**	**Coloured**	**Indian**	**White**	**African Urban**	**African Rural**	**African Urban Formal**	**African Urban Informal**	**African Rural Farms**	**African Rural Homelands**	**Coloured Urban**	**Coloured Rural**
Yes	57.6	40.8	89.2	100	100	70.1	15.8	81.7	35.2	19.2	14.9	96	49
No	42.4	59.2	10.8	-	-	29.9	84.2	18.3	64.8	80.8	85.1	4	51
Total N (000)	7594	5330	560	196	1508	2456	2874	1840	616	572	2302	480	80

Nearly 60% of African households do not have electricity, as compared to 100% of white and Indian homes which do, and 89.2% of coloureds. The number of African households in rural areas with no electricity is 84.2%.

Seventy percent of African children under five live in rural areas. Of these, 76% live in households with incomes below the minimum poverty level. 70 Percent live in homes with no electricity, 32% without access to piped water and 22% without a toilet of any sort. This cohort of children is at particularly high risk for infectious diseases.

SITE OF CARE

TABLE 9. Site of Care/Emergency Services

Where do you go?	Total	African	Coloured	Indian	White	African Urban	African Rural	African Urban Formal	African Urban Informal	African Rural Farms	African Rural Homelands	Coloured Urban	Coloured Rural
Public hospital or clinic	59.5	75.7	44.1	15.6	13.8	67.9	82.4	64.2	79.2	58.4	88.3	43.7	46.5
Private hospital or doctor	39.5	23.6	55.8	84.1	83.9	31.3	17	34.9	20.3	41.6	11	56.2	53.5
Other	1	0.7	0.1	0.3	2.4	0.8	0.6	0.9	0.5	-	0.7	0.1	-
Total N (000)	7545	5293	559	196	1498	2431	2862	1825	606	563	2299	479	79
Emergencies: < than 1 hour	**Total**	**African**	**Coloured**	**Indian**	**White**	**African Urban**	**African Rural**	**African Urban Formal**	**African Urban Informal**	**African Rural Farms**	**African Rural Homelands**	**Coloured Urban**	**Coloured Rural**
Yes	73	64.7	88.1	94.9	93.7	73.9	56.9	75.3	69.5	49.4	58.8	87.8	89.9
No	26.9	35.3	11.9	5.1	5.9	26.1	43.1	24.6	30.5	50.6	41.2	12.2	10.1
Do not know	0.1	0	-	-	0.4	0.1	-	0.1	-	-	-	-	-
Total N (000)	7545	5293	559	196	1498	2431	2862	1825	606	563	2299	479	79

The overwhelming majority (75.7%) of Africans rely on public hospitals or clinics for their health care (82.4% in rural areas), whereas 83.9% of whites and 84.1% of Indians rely on a private hospital or doctor. But more than one third (35.3%) of Africans said they could not get emergency care in less than one hour, as compared to 5.9% of whites and 5.1% of Indians. The situation is even worse among rural Africans with 50.6% on farms and 41.2% in former homelands reporting they could not access emergency care in less than an hour.

FIGURE 7. Percent Without Emergency Care by Race

Only one third of respondents reported receiving their first treatment at a public clinic. Most (34.1%) visited a private doctor first or presented at a public hospital (28.1%).

FIGURE 8. Site of First Contact by Race

TABLE 10. Site of First Contact

First treatment	Total	African	Coloured	Indian	White	African Urban	African Rural	African Urban Formal	African Urban Informal	African Rural Farms	Coloured Rural	Coloured Urban
Public hospital	24.1	28.4	16.4	9.8	9.1	26.9	29.6	27.3	25.7	32.8	16.9	12.7
Private hospital	4.3	4.4	3.4	1.7	5.1	6.4	2.7	6.9	4.8	6.1	3.8	0.5
Public clinic	32.4	40.1	23.6	5.1	3.2	36.5	43.2	32.9	48	19.5	23.8	22.4
Private clinic	1.7	1.4	3	-	2.9	2.2	0.7	2.2	2.1	0.5	2.5	6.2
Private doctor	34.1	22.6	51.1	82	74.3	24.9	20.6	27.2	17.5	36	50.1	50.8
Pharmacist	0.7	0.1	0.3	0.3	4.3	0.1	0.1	0.1	0.1	-	0.3	-
Social Welfare	0	-	-	-	0.3	-	-	-	-	-	-	-
Psych.:Public	0	-	0.1	0.5	0	-	-	-	-	-	0.1	-
Psych.: Private	0	-	-	-	0.1	-	-	-	-	-	-	-
Psych.:Other	0	-	-	0.3	-	-	-	-	-	-	-	-
Trad. healer	0.4	0.5	-	-	-	0.9	0.2	1.2	-	-	-	-
Faith healer	0.5	0.7	-	-	-	0.9	0.6	0.7	1.2	0.3	-	-
Other	0.1	-	0.2	-	0.5	-	-	-	-	-	0.2	-
Place of work	0.3	0.3	-	0.2	0.1	0.6	0.1	0.7	0.5	0.4	-	-

Home remedies	0	-	0.1	-	-	-	-	-	-	-	0.1	-
Never get sick	1.3	1.5	1.9	-	0.1	0.5	2.3	0.6	0.2	4.4	2.2	-
Total N (000)	21805	16237	1818	592	3158	7492	8744	5705	1787	1893	1596	223

BARRIERS TO CARE

The major barriers to accessing health care are the cost of care, distance and the availability and cost of transportation. 73.8 Percent of Africans reported the cost of health services to be the major barrier to care and 11.5% the unavailability or high cost of transport.

FIGURE 9. Reasons for Foregoing Health Care by Race

TABLE 11. Postponed Care

No care past year	**Total**	**African**	**Coloured**	**Indian**	**White**	**African Urban**	**African Rural**	**African Urban Formal**	**African Urban Informal**	**African Rural Farms**	**Coloured Urban**	**Coloured Rural**
Yes	19.5	19.4	28.1	13.6	16	19.9	19	18	26	22.1	27.2	34.3
No	80.5	80.6	71.9	86.4	84	80.1	81	82	74	77.9	72.8	65.7
Total N (000)	21805	16237	1818	592	3158	7492	8744	5705	1787	1893	1596	223
Delayed due to cost	**Total**	**African**	**Coloured**	**Indian**	**White**	**African Urban**	**African Rural**	**African Urban Formal**	**African Urban Informal**	**African Rural Farms**	**Coloured Urban**	**Coloured Rural**
Yes	12.5	14.3	13.3	8.2	3.7	14.5	14.2	13.3	18.3	17.4	12.6	18.4
No	87.5	85.7	86.7	91.8	96.3	85.5	85.8	86.7	81.7	82.6	87.4	81.6
Total N (000)	21805	16237	1818	592	3158	7492	8744	5705	1787	1893	1596	223
Reason for not using care	**Total**	**African**	**Coloured**	**Indian**	**White**	**African Urban**	**African Rural**	**African Urban Formal**	**African Urban Informal**	**African Rural Farms**	**Coloured Urban**	**Coloured Rural**
Not affordable	64.3	73.8	47.4	60.1	23.2	72.9	74.6	74	70.3	78.6	46.3	53.6
Transport not	9.2	11.5	4.8	2	0.5	7.6	15	8.6	5.5	18.5	3.9	10.2

Too busy	4.2	1.5	9.1	6.7	15.4	3.2	-	2.7	4.4	-	10.7	-
No time off	3.5	3.5	6.2	1.1	1.5	1.8	4.9	2.7	-	1.4	3.7	20.5
HH responsible	0.7	0.6	2	2	-	0.7	0.5	0.4	1.5	-	2.3	-
Not now where	0.4	0.6	-	-	-	0.6	0.5	0.9	-	-	-	-
Person very far	0.8	0.3	-	6.2	3.3	0.3	0.3	0.4	-	1.4	-	-
Inconvenient	0.1	-	0.8	-	-	-	-	-	-	-	0.9	-
Afraid/ ashamed	2.4	0.5	8.8	1.4	7.5	0.8	0.3	0.6	1.1	0.2	9.7	3.7
Problem gone	5.6	3.8	7.6	4	15.3	6.5	1.3	4.2	11.6	-	8.2	4
Not serious	5.8	2	7.4	7	27.2	3.2	1	3	3.8	-	7.7	5.8
Intermittent	0.2	-	1	-	0.4	-	-	-	-	-	1.2	-
Other reason	1.5	1.2	3.2	-	1.9	0.8	1.6	0.7	1	-	3.8	-
Social problems	0.2	0.2	0.3	2	-	0.3	-	0.5	-	-	-	2.2
No transport	0.8	0.3	-	7.6	3.3	0.7	-	0.7	0.7	-	-	-
Clinic closed	0.1	0.1	-	-	-	0.3	-	0.4	-	-	-	-
Past experience	0.3	0.1	1.4	-	0.5	0.2	-	0.2	-	-	1.6	-
Total N (000)	4249	3154	510	80	504	1490	1665	1026	464	418	434	76

50.9 Percent of Africans rely on a taxi or public transport (55.5% in rural areas), while 37.4% reported that they must walk to their site of care. In contrast, 81.3% of whites use a private car. An extremely low percentage of all population groups relied on an ambulance, indicative of the poor state of public health outreach services.

TABLE 12. Transportation

How get there	Total	African	Coloured	Indian	White	African Urban	African Rural	African Urban Formal	African Urban Informal	African Rural Farms	African Rural Homelands	Coloured Urban	Coloured Rural

Ambulance	1.4	1.4	2.2	0.2	0.8	1.2	1.6	1.3	1.2	3.4	1.1	1.9	4.7
Taxi/Bus	40.6	50.9	20	10.7	4.7	46.3	55	43.4	55.5	46.5	57.3	20.6	15.3
Private car	21.5	7.5	29.6	63.7	81.3	7.6	7.3	8.6	4.4	22.6	3.1	27.4	45.8
Walk there	33.8	37.4	42.7	25.4	11.8	43.5	32.2	45.3	37.7	16.6	36.5	45.8	20.7
Other	1.4	1.2	3.4	-	1.2	0.8	1.6	0.8	1.1	6.5	0.2	2	13.5
Never get sick	1.3	1.5	1.9	-	0.1	0.5	2.3	0.6	0.2	4.4	1.7	2.2	-
Housecall	0	-	-	-	0.1	-	-	-	-	-	-	-	-
Not use doctor	0	-	0.1	-	-	-	-	-	-	-	-	0.1	-
Total N (000)	21805	16237	1818	592	3158	7492	8744	5705	1787	1893	6852	1596	223

Approximately one third of Africans in rural areas are more than one hour travelling time from the closest health care facility. A total of 24.1% of Africans reported that traveling time to their nearest site of care is one hour or more. Whereas for 84.6% of whites and 81.3% of Indians the nearest point of care is less than 15 minutes traveling time. Distance from a health care facility is greatest for Africans living in Northern Transvaal province, the Eastern Cape and KwaZulu-Natal.

TABLE 13. Travel Time

Travel time	Total	African	Coloured	Indian	White	African Urban	African Rural	African Urban Formal	African Urban Informal	African Rural Farms	African Rural Homelands	Coloured Urban	Coloured Rural
15 mins/ less	46.6	36.3	61.2	81.3	84.6	50.5	24.1	52.9	43.1	21.9	24.7	65.1	33.5
About 30 mins	32.3	37.9	24.5	15.7	11.5	36	39.5	35.3	38.2	46	37.7	22.1	41.5
About 1 hour	13.7	16.8	9.5	2.8	2.2	10.4	22.2	9.5	13.2	16.2	23.9	9.1	12.7
1 hour +	5.9	7.3	2.4	0.3	1.4	2.4	11.6	1.6	5.2	11.3	11.6	1	12.3

Do not know	0.2	0.2	0.4	-	-	0.1	0.3	0.1	0.1	0.3	0.3	0.5	-
Never get sick	1.3	1.5	1.9	-	0.1	0.5	2.3	0.6	0.2	4.4	1.7	2.2	-
Housecall	0	-	-	-	0.1	-	-	-	-	-	-	-	-
Not use doctor	0	-	0.1	-	-	-	-	-	-	-	-	0.1	-
Total N (000)	21805	16237	1818	592	3158	7492	8744	5705	1787	1893	6852	1596	223

FIGURE 10. Travel Time to Care for Rural Africans

QUALITY OF CARE

TABLE 14. Waiting Time

Length waited	Total	African	Coloured	Indian	White	African Urban	African Rural	African Urban Formal	African Urban Informal	African Rural Farms	African Rural Homelands	Coloured Urban	Coloured Rural
15 mins/ less	0	-	-	0.1	-	-	-	-	-	-	-	0.1	-
About 30 mins	31	26.4	41.8	30	53	30.7	22.8	32.3	25.9	18.4	24	31.5	19.8
About 1 hour	24.2	22.1	28.3	27.2	32.5	21.8	22.3	20.6	25.8	27	21	26	36.2
2-3 hours	23.8	27.9	12.9	18.9	8.1	24.4	30.8	24.2	25	27.5	31.7	18.1	24.8
4-5 hours	15.2	17.7	12.8	14.1	3.7	16.6	18.6	16.6	16.7	18.7	18.5	14.5	11.8
Most of day	2.5	2.6	2.6	4.5	0.8	3.3	2.1	3	4.2	2.7	1.9	4.2	6.3
Do not know	1.6	1.5	1.6	2.8	1.7	2.2	0.9	2.3	1.8	1	0.8	3	1

Never get sick	0.3	0.4	-	0.4	-	0.4	0.4	0.4	0.4	0.3	0.4	0.5	-
Housecall	1.3	1.5	-	1.9	0.1	0.5	2.3	0.6	0.2	4.4	1.7	2.2	-
Not use doctor	0	-	-	-	0.1	-	-	-	-	-	-	-	-
Total N (000)	21805	16237	592	1818	3158	7492	8744	5705	1787	1893	6852	1596	223

FIGURE 11. Waiting Time for Rural Africans

70.3 Percent of Africans (73.8% in rural areas) reported waiting one hour or more to see a health provider. 48.2 Percent waited more than two hours and 17.7% waited four to five hours. In contrast, more than 85% of whites reported waiting less than one hour. A higher proportion of coloureds (4.5%) than any other race group reported waiting "most of the day." 51 Percent of respondents in the Western Cape, where the bulk of the coloured population lives, reported waiting four hours or more to see a health provider.

FIGURE 12. Length of Consultation

Half of African respondents reported that their consultation with a health provider customarily lasts five minutes or less. As compared to 20% of coloureds, 16% of whites and 12% of Indians. In the Eastern Cape and KwaZulu-Natal 61% of respondents said their last health consultation lasted five minutes or less.

TABLE 15. Quality of Health Care

Quality of healthcare	Total	African	Coloured	Indian	White	African Urban	African Rural	African Urban Formal	African Urban Informal	African Rural Farms	African Rural Homelands	Coloured Urban	Coloured Rural
Excellent	26	23.2	14.1	31.4	39.9	25.7	21	26.6	23	23	20.6	15.4	6.1
Very good	32.6	31.7	33	33.9	35.7	30	33.1	30.1	29.7	40.6	31.3	34.5	24.2
Good	28.2	30.4	35	29.2	18.2	27.9	32.4	27.1	30.3	30.1	33	31.2	57.6
Fair	8.4	9.3	11.5	3.7	5	10.9	7.9	10.9	11.1	5.1	8.5	11.7	10.1
Poor	4.6	5.5	6.4	1.8	1.3	5.4	5.5	5.3	5.8	1.2	6.6	7.1	2

Total N (000)	7545	5293	559	196	1498	2431	2862	1825	606	563	2299	479	79

Surprisingly, when asked to rate the quality of available health care, more than half of Africans (54.9%) rated it "excellent" or "very good." This contradiction can be attributed to a low level of expectation among African patients of better quality care. Nearly 15% of Africans rated the available quality of care as "fair" or "poor", compared with only 6.3% of whites and 5.5% of Indians. A more accurate indicator of public satisfaction is perceptions of how well the health system as a whole functions.

TABLE 16. Assistance for Elderly People (65 + years)

Received help for condition	**Total**	**African**	**Coloured**	**Indian**	**White**	**African Urban**	**African Rural**	**African Urban Formal**	**African Urban Informal**	**African Rural Farms**	**African Rural Homelands**	**Coloured Urban**	**Coloured Rural**
Yes	40.5	42.9	37.7	34	33.2	43.8	42.5	45.8	26.4	55.8	41.2	34.5	58.5
No	59.5	57.1	62.3	66	66.8	56.2	57.5	54.2	73.6	44.2	58.8	65.5	41.5
Total N (000)	904	657	52	16	180	7	214	443	192	22	38	45	7
Health worker visit	**Total**	**African**	**Coloured**	**Indian**	**White**	**African Urban**	**African Rural**	**African Urban Formal**	**African Urban Informal**	**African Rural Farms**	**African Rural Homelands**	**Coloured Urban**	**Coloured Rural**
Yes	6.5	3.1	9.2	4.9	18.3	5.9	1.7	6.5		0.1	1.9	8	16.9
No	93.5	96.9	90.8	95.1	81.7	94.1	98.3	93.5	100	99.9	98.1	92	83.1
Total N (000)	904	657	52	16	180	7	214	443	192	22	405	45	7
Need medical aids	**Total**	**African**	**Coloured**	**Indian**	**White**	**African Urban**	**African Rural**	**African Urban Formal**	**African Urban Informal**	**African Rural Farms**	**African Rural Homelands**	**Coloured Urban**	**Coloured Rural**
Yes	68.8	80.9	47.6	37.8	18.3	80	81.4	78.6	91	85	80.9	42.9	78.1
No	31.2	19.1	52.4	62.2	81.7	20	18.6	21.4	9	15	19.1	57.1	21.9
Total N (000)	651	504	8	8	101	5	159	345	142	18	306	38	33

Health outreach services	Total	African	Coloured	Indian	White	African Urban	African Rural	African Urban Formal	African Urban Informal	African Rural Farms	African Rural Homelands	Coloured Urban	Coloured Rural
Yes	19.8	9	21	8.9	46.4	14.2	6.1	13.6	18	13.7	5.3	18.8	41.3
No	71.4	87	69.1	88.8	32.6	78.2	92.1	79.1	72.7	86.3	92.7	71.5	46.7
Do not know	8.8	3.9	9.9	2.3	21	7.6	1.8	7.4	9.3	-	2	9.7	12
Total N (000)	1648	1072	100	34	442	391	681	338	53	67	614	90	10

Health outreach services for the elderly population of all race groups are poor. Among elderly respondents (65 years or older) with difficulty walking, seeing or hearing, 93.5% reported never being visited by a health worker, 68.8% (80.9% of Africans) said they needed, but did not have, medical equipment to help them move around.

92 Percent of respondents were aware of the introduction of free health services for children under six and pregnant women. 65 Percent of respondents said that access had become easier as a result of this programme. Nearly three quarters of Africans living in rural areas said access was easier. 54 Percent of respondents said quality had improved, 27% said it had stayed the same, and 17% said it had become worse. Those living in formal housing in metropolitan areas (39%) were more likely to say that quality had deteriorated.

SATISFACTION WITH SERVICES

Although most respondents expressed satisfaction with the quality of the available health care, South Africans across all races are dissatisfied with the public health system.

TABLE 17. Views about the Health System

Health system works	Total	African	Coloured	Indian	White	African Urban	African Rural	African Urban Formal	African Urban Informal	African Rural Farms	African Rural Homelands	Coloured Urban	Coloured Rural
Very well	14.4	13	8.1	13.2	25.1	15.8	10.7	15.7	16	6.8	11.7	8.6	4.6
Fairly well	42.5	40	48	47	51.5	37.3	42.4	37.3	37.5	41	42.7	48.9	41.3

Fairly badly	28.2	31.1	25.4	30.6	14.5	29.7	32.3	29.7	29.9	28.6	33.3	25.1	28.1
Very badly	14.3	15.3	18.5	9.2	8.2	16.5	14.2	16.9	15.4	22.2	12	17.4	26
Do not know	0.5	0.6	-	-	0.8	0.6	0.5	0.4	1.2	1.4	0.3	-	-
Total N (000)	21805	16237	1818	592	3158	7492	8744	5705	1787	1893	6852	1596	223

FIGURE 13. South Africans' View on How Well the Health System Serves Them

More than 40% of all respondents thought that the existing health system serves them badly. Predictably, African dissatisfaction (46.4%) is much higher than other race groups: Whites = 22.7%; coloureds = 43.9%; and Indians = 39.8%. Nonetheless, 53% of Africans expressed satisfaction with the existing system. Given all the other evidence--cost of care, distance to a health facility, waiting time etc.--this result must be interpreted with caution. It is a fact that when respondents do not have an alternative point of reference they can only relate to the reality they know. Most Africans may not have an expectation of a better level of care.

FIGURE 14. Percentage Who Think Health System Serves Them Badly

TABLE 18. Views on Community Health Workers

Training community health workers	Total	African	Coloured	Indian	White	African Urban	African Rural	African Urban Formal	African Urban Informal	African Rural Farms	African Rural Homelands	Coloured Urban	Coloured Rural
Defin. improve	64.7	71.3	67.5	59.4	29.9	68.4	73.9	71.5	58.6	72.8	74.1	66.8	71.9
Prob. improve	20.9	18.5	21	28.2	32	19.6	17.5	17.4	26.6	15.5	18.1	21	21
Unsure	8.9	7.7	8.1	7.3	15.5	8.5	7.1	7.9	10.6	10	6.2	8.5	4.8
Probably not	2.6	1.6	1	3.6	8.4	2.1	1.1	1.9	2.6	1.6	1	1.2	-
Definitely not	3	0.9	2.4	1.5	14.1	1.4	0.5	1.3	1.5	-	0.6	2.5	2.3

Total N (000)	21805	16237	1818	592	3158	7492	8744	5705	1787	1893	6852	1596	223

FIGURE 15. African's Views of Community Health Workers

Almost 90% of African respondents thought that introduction of community health workers would improve the health service.

TABLE 19. Traditional Healers

Visit traditional healer	Total	African	Coloured	Indian	White	African Urban	African Rural	African Urban Formal	African Urban Informal	African Rural Farms	African Rural Homelands	Coloured Urban	Coloured Rural
Yes	24.8	31.9	3	20.9	2.1	33.3	30.7	34.2	30.3	26.8	31.7	3.3	1.2
No	75.2	68.1	97	79.1	97.9	66.7	69.3	65.8	69.7	73.2	68.3	96.7	98.8
Total N (000)	21805	16237	1818	592	3158	7492	8744	5705	1787	1893	6852	1596	223

FIGURE 16. Role of Traditional Healers

31.9% of Africans and 20.9% of Indians reported also regularly consulting a traditional healer.

CHILD HEALTH

TABLE 20. Immunization Records

Possess Road to Health Card	Total	African	Coloured	Indian	White	African Urban	African Rural	African Urban Formal	African Urban Informal	African Rural Farms	African Rural Homelands	Coloured Urban	Coloured Rural
Yes	92.7	92.2	98.6	100	91.9	93.6	91.6	95.5	87.7	90.6	91.8	98.4	100
No	7.3	7.8	1.4	-	8.1	6.4	8.4	4.5	12.3	9.4	8.2	1.6	-

Total N (000)	4248	3626	267	73	282	1031	2595	781	250	419	2176	233	34
RTH card seen	**Total**	**African**	**Coloured**	**Indian**	**White**	**African Urban**	**African Rural**	**African Urban Formal**	**African Urban Informal**	**African Rural Farms**	**African Rural Homelands**	**Coloured Urban**	**Coloured Rural**
Card seen	48.8	48.1	47.1	56.2	56.5	50.2	47.3	48	57.6	48.3	47.1	47.8	42.7
Card not seen	51.2	51.9	52.9	43.8	43.5	49.8	52.7	52	42.4	51.7	52.9	52.2	57.3
Total N (000)	3938	3343	263	73	259	965	2378	746	219	380	1998	230	34

59 Percent of African children do not have a birth certificate. This has obvious implications for the accuracy of data on African births. Of the 92.7% of respondents who said their child had a Road-to-Health card, fewer than half (48.8%) could actually produce the card.

Nearly a quarter (23.3%) of African respondents said that they were too poor to properly feed their child. 13.9 Percent reported having been told by a health provider that their child weighs too little, yet 91.4% said they had never received supplemental food for their child from a health facility.

TABLE 21. Immunization Status of Children 2-5 Years

TB 1 or 2 immunizations	**Total**	**African**	**Coloured**	**Indian**	**White**	**African Urban**	**African Rural**	**African Urban Formal**	**African Urban Informal**	**African Rural Farms**	**African Rural Homelands**	**Coloured Urban**	**Coloured Rural**
Yes	73.9	70.5	95.6	93.6	92	68.9	71.1	66.2	77.3	70	71.3	95.6	95.8
No	8.2	9.5	0.5	-	-	7.6	10.3	8.3	5.5	11	10.1	-	4.2
Do not know	18	20	3.8	6.4	8	23.4	18.7	25.5	17.2	19	18.6	4.4	-
Total N (000)	4248	3626	267	73	282	1031	2595	781	250	419	2176	233	34
Measles 1 or 2 immunizations	**Total**	**African**	**Coloured**	**Indian**	**White**	**African Urban**	**African Rural**	**African Urban Formal**	**African Urban Informal**	**African Rural Farms**	**African Rural Homelands**	**Coloured Urban**	**Coloured Rural**
Yes	73.1	69.6	96.4	90.9	91.8	66	71	64.3	71.2	65.1	72.1	95.9	100
No	9.4	10.9	0.3	2.3	1.1	9.9	11.3	9.1	12.2	13.3	10.9	0.3	-

Do not know	17.5	19.6	3.3	6.9	7.2	24.1	17.7	26.5	16.6	21.6	17	3.7	-
Total N (000)	4248	3626	267	73	282	1031	2595	781	250	419	2176	233	34
Polio full (4) immunizations	**Total**	**African**	**Coloured**	**Indian**	**White**	**African Urban**	**African Rural**	**African Urban Formal**	**African Urban Informal**	**African Rural Farms**	**African Rural Homelands**	**Coloured Urban**	**Coloured Rural**
Yes	30.5	27.5	63.1	13.1	43.8	30.3	26.3	30.1	31.2	28.4	25.9	58.7	93.5
No	49.5	50.5	29.8	76.3	47.8	42.4	53.8	40.8	47.4	49.9	54.5	33.5	4.3
Do not know	20	22	7.1	10.7	8.4	27.3	19.9	29.2	21.4	21.6	19.6	7.8	2.2
Total N (000)	4248	3626	267	73	282	1031	2595	781	250	419	2176	233	34
DWT full (4) immunizations	**Total**	**African**	**Coloured**	**Indian**	**White**	**African Urban**	**African Rural**	**African Urban Formal**	**African Urban Informal**	**African Rural Farms**	**African Rural Homelands**	**Coloured Urban**	**Coloured Rural**
Yes	28.7	25.7	58.6	10.8	44.2	27.7	24.9	28.3	26.1	25.1	24.8	58.2	61.5
No	50.2	51.1	33.2	78.5	47.3	45.9	53.2	43.5	53.7	52.4	53.3	32.7	36.4
Do not know	21	23.2	8.2	10.7	8.4	26.3	21.9	28.3	20.2	22.4	21.9	9	2.2
Total N (000)	4248	3626	267	73	282	1031	2595	781	250	419	2176	233	34
Complete immunizations	**Total**	**African**	**Coloured**	**Indian**	**White**	**African Urban**	**African Rural**	**African Urban Formal**	**African Urban Informal**	**African Rural Farms**	**African Rural Homelands**	**Coloured Urban**	**Coloured Rural**
Yes	24.9	22.2	50.5	8.6	40.2	24.9	21.1	25.6	22.6	21.7	21	48.9	61.5
No	51.3	51.8	39.7	79.7	48.8	46.6	53.8	43.7	55.9	55	53.6	40.2	36.4
Do not know	23.7	26	9.8	11.7	11	28.5	25	30.8	21.4	23.2	25.4	10.9	2.2
Total N (000)	4248	3626	267	73	282	1031	2595	781	250	419	2176	233	34

By two years of age children are expected to have completed a course of immunizations against communicable diseases such as measles, tuberculosis, polio, diphtheria, whooping cough and tetanus. A large percentage (51.3%) of children aged two to five of all race groups do not have complete immunization. A further 23.7% of respondents did not know whether their child's immunizations had been completed. Approximately 73% of children two to five are immunized against tuberculosis and measles, but only 30.5% are immunized against polio.

FIGURE 17. Immunization Status of Children Under 5 Years

TABLE 22. Oral Rehydration Therapy

What to do for diarrhoea	Total	African	Coloured	Indian	White	African Urban	African Rural	African Urban Formal	African Urban Informal	African Rural Farms	African Rural Homelands	Coloured Urban	Coloured Rural
Give ORS	54.6	59.3	34.9	24.7	18	57.5	60.1	56.3	61.1	57.5	60.7	33.3	45.2
Give fluids	3	2.2	8.2	9.8	7.1	3.1	1.9	3	3.4	1.8	1.9	8.6	5.6
Withhold fluids	0.2	0	0.4	1.8	1.9	0.1	-	0.2	-	-	-	-	2.8
Give enema	0.7	0.8	-	-	-	0.5	1	0.4	0.6	1.4	0.9	-	-
Home remedies	2.1	1.5	8.2	1.5	3.5	2	1.4	2	1.9	2.5	1.1	7.3	14
Child vomit	0	0	0.2	-	-	0	-	0.1	-	-	-	0.2	-
Go to doctor	35.8	34.3	44.6	55.1	43.4	34.3	34.2	35.7	30.3	35.1	34.1	46.5	32.4
Chemist	2.9	1.3	2.8	7.2	22.8	2	1.1	1.8	2.4	1.7	1	3.3	-
Other	0.6	0.4	0.7	-	3.3	0.5	0.3	0.6	0.3	-	0.4	0.8	-
Total N (000)	5991	5132	380	100	378	1518	3614	1136	382	617	2998	330	51

Approximately 60% of African respondents with children 0 to 5 years were aware of the use of oral rehydration solution (ORS) to combat the dehydrating effects of gastric ailments in children.

TABLE 23. Infant Nutrition

Not afford food	Total	African	Coloured	Indian	White	African Urban	African Rural	African Urban Formal	African Urban Informal	African Rural Farms	African Rural Homelands	Coloured Urban	Coloured Rural
Yes	20.3	23.3	4.7	1.5	0.6	22.9	23.5	20.3	30.4	19.1	24.4	5.3	1.4

No	79.7	76.7	95.3	98.5	99.4	77.1	76.5	79.7	69.6	80.9	75.6	94.7	98.6
Total N (000)	6014	5147	381	102	384	1518	3629	1136	382	626	3003	330	51
Weighs too little	**Total**	**African**	**Coloured**	**Indian**	**White**	**African Urban**	**African Rural**	**African Urban Formal**	**African Urban Informal**	**African Rural Farms**	**African Rural Homelands**	**Coloured Urban**	**Coloured Rural**
Yes	13.2	13.9	10.4	10.6	6.7	16.9	12.7	15.9	19.7	8	13.7	9.4	17.1
No	86.4	85.6	89.6	88.5	93.3	83.1	86.7	84.1	80.3	90.5	85.9	90.6	82.9
Do not know	0.4	0.4	-	0.8	-	-	0.6	-	-	1.5	0.4	-	-
Total N (000)	6014	5147	381	102	384	1518	3629	1136	382	626	3003	330	51
Extra food	**Total**	**African**	**Coloured**	**Indian**	**White**	**African Urban**	**African Rural**	**African Urban Formal**	**African Urban Informal**	**African Rural Farms**	**African Rural Homelands**	**Coloured Urban**	**Coloured Rural**
Yes	8.4	8.4	13.9	4.6	4.1	9.3	8	8.4	12	11	7.3	14.1	12.7
No	91.4	91.4	86.1	94.6	95.9	90.7	91.7	91.6	88	88.1	92.5	85.9	87.3
Do not know	0.2	0.2	-	0.8	-	-	0.3	-	-	1	0.2	-	-
Total N (000)	6014	5147	381	102	384	1518	3629	1136	382	626	3003	330	51

TABLE 24. School Age Nutrition

Breakfast eaten	**Total**	**African**	**Coloured**	**Indian**	**White**	**African Urban**	**African Rural**	**African Urban Formal**	**African Urban Informal**	**African Rural Farms**	**African Rural Homelands**	**Coloured Urban**	**Coloured Rural**
Yes	90.3	90.2	93	91.5	89.3	87.3	91.4	88.3	82.8	96.3	90.8	92.4	98.3
No	9.7	9.8	7	8.5	10.7	12.7	8.6	11.7	17.2	3.7	9.2	7.6	1.7
Total N (000)	8225	6833	600	168	623	2068	4766	1681	387	555	4211	540	60

Free food at Primary school	Total	African	Coloured	Indian	White	African Urban	African Rural	African Urban Formal	African Urban Informal	African Rural Farms	African Rural Homelands	Coloured Urban	Coloured Rural
Yes	60.1	63.3	68.8	24.1	18.2	53.8	67.3	52.9	57.7	55.9	68.8	67	83
No	39.9	36.7	31.2	75.9	81.8	46.2	32.7	47.1	42.3	44.1	31.2	33	17
Total N (000)	7595	6441	529	134	490	1903	4538	1532	371	533	4005	470	59

African children in Gauteng and Northern Transvaal (16%) were least likely to have breakfast before school. These same children were also least likely to receive free food at school: 30% in Gauteng and 32% in Northern Transvaal.

FIGURE 18. Primary School Feeding Program

63.3 Percent of African children between the age of 6-15 are receiving food at school. This relates almost exactly to the number of African households living below the poverty line. But the percentage of rural coloured children (83%) receiving food is much higher than any other race group. The number of rural African children receiving food is only 67.3%, whereas nearly three quarters of rural African households live below the poverty line.

REPRODUCTIVE HEALTH

TABLE 25. Sexual/Reproductive Health - Women

Sexual partner	Total	African	Coloured	Indian	White	African Urban	African Rural	African Urban Formal	African Urban Informal	African Rural Farms	African Rural Homelands	Coloured Urban	Coloured Rural
Yes	80.9	85.5	59.8	66.6	70	84.6	86.2	83.7	87.2	88.6	85.7	58.1	73
No	19.1	14.5	40.2	33.4	30	15.4	13.8	16.3	12.8	11.4	14.3	41.9	27
Total N (000)	9780	7440	819	255	1266	3207	4233	2326	880	771	3462	725	94
Ask partner to use condom for AIDS	**Total**	**African**	**Coloured**	**Indian**	**White**	**African Urban**	**African Rural**	**African Urban Formal**	**African Urban Informal**	**African Rural Farms**	**African Rural Homelands**	**Coloured Urban**	**Coloured Rural**

Yes	61.3	57.4	69	62.2	78.1	62.1	54	63.5	58	58.2	53.1	69.9	61.5
Unsure	10.7	11.9	9.9	8.7	4.7	10.5	12.9	9.3	13.6	10.2	13.5	8.6	20.5
No	18.3	21.9	9.5	3.5	6.4	18.8	24.2	18.6	19.3	21.1	24.8	8.9	15
Refused	8.7	8.2	10.2	10.4	10.4	8.6	7.9	8.4	9.1	9.6	7.6	11.5	-
No more sex	1	0.6	1.3	15.2	0.4	0.1	1	0.1		0.9	1	1.1	3
Total N (000)	11504	8683	941	301	1578	3635	5047	2673	962	886	4161	839	102
Respondent birth control methods	**Total**	**African**	**Coloured**	**Indian**	**White**	**African Urban**	**African Rural**	**African Urban Formal**	**African Urban Informal**	**African Rural Farms**	**African Rural Homelands**	**Coloured Urban**	**Coloured Rural**
Pill	14.5	11.3	13.4	40.8	32.8	14.4	9	15.4	12.1	3.1	10.4	14.6	5.8
IUD	2	1.5	2.7	5.3	4	3	0.4	2.7	4	0.7	0.3	3.2	-
Diaphragm	0.2	0.3	-	-	-	0.5	0.1	0.3	0.9	0.1	0.1	-	-
Injection	34.4	39.7	29.2	2.4	5.3	41.6	38.3	42.5	39.3	47.5	36.2	29.9	25.1
Sterilized	8.4	4.2	24.7	26.8	26.1	5.2	3.4	6.2	2.6	7.7	2.4	23.2	33.6
Pull out	0.1	0.2	-	0.9	-	0.4	-	0.5	-	-	-	-	-
None sometimes	1.5	1.7	1.3	0.8	-	1.2	2.2	1.4	0.5	-	2.7	1.6	-
Avoid sex	0.4	0.4	1.6	-	-	0.2	0.5	0.3	-	-	0.6	1.8	-
Other methods	0.8	0.8	0.8	-	1.2	1.4	0.4	1.4	1.3	1.5	0.1	0.9	-
Do not use any	36.6	39.1	25.3	23	27.6	31.1	45.1	28.3	38.1	38.2	46.7	23.7	35.5
Refused	1	0.8	1	-	2.9	1	0.6	0.9	1.2	1.1	0.5	1.1	-
Total N (000)	7910	6364	490	170	886	2714	3649	1946	768	683	2966	422	68
Partners birth control methods	**Total**	**African**	**Coloured**	**Indian**	**White**	**African Urban**	**African Rural**	**African Urban Formal**	**African Urban Informal**	**African Rural Farms**	**African Rural Homelands**	**Coloured Urban**	**Coloured Rural**
Condom	5.1	4.5	1.9	5.6	11.3	6	3.4	7.9	1.1	0.9	4	2.3	-

Sterilized	1.3	-	0.7	1.4	10.7	-	-	-	-	-	-	0.8	-
Pull out	0.3	0.2	-	0.9	0.9	0.4	-	0.5	-	-	-	-	-
None sometimes	0.3	0.3	0.3	-	-	0.1	0.5	0.2	-	-	0.6	0.3	-
Avoid sex	0.2	0.1	1.2	-	-	0.1	0.1	0.1	-	-	0.2	1.4	-
Other methods	0.1	-	-	1.5	1	-	-	-	-	-	-	-	-
Do not use any	79.9	79.8	92.4	90.6	71.8	80.7	79.2	77.5	88.7	76.3	79.9	91.2	100
Refused	12.8	15	3.5	-	4.3	12.7	16.7	13.8	10.2	22.8	15.3	4	-
Total N (000)	7910	6364	490	170	886	2714	3649	1946	768	683	2966	422	68

TABLE 26. Sexual/Reproductive Health - Men

Sexual partner	Total	African	Coloured	Indian	White	African Urban	African Rural	African Urban Formal	African Urban Informal	African Rural Farms	African Rural Homelands	Coloured Urban	Coloured Rural
Yes	75.5	78.1	68.1	73.6	67.4	80	76.2	80	79.7	88.7	71.6	64.4	91.2
No	24.5	21.9	31.9	26.4	32.6	20	23.8	20	20.3	11.3	28.4	35.6	8.8
Total N (000)	10302	7554	877	291	1579	3857	3697	3032	825	1006	2691	757	121
Would use condom for AIDS	**Total**	**African**	**Coloured**	**Indian**	**White**	**African Urban**	**African Rural**	**African Urban Formal**	**African Urban Informal**	**African Rural Farms**	**African Rural Homelands**	**Coloured Urban**	**Coloured Rural**
Yes	65.3	60	80.1	78.8	80.1	62.1	57.9	62.9	59.1	44.9	62.7	80.8	75.7
Unsure	8.5	10	8	8.7	1.7	7.3	12.8	7	8.5	17.5	11	8.6	4.6
No	19.3	23.7	7.5	8.4	6.8	26.1	21.1	26.5	24.7	31	17.4	5.9	17.4
Refused	5.7	4.9	3.7	4	11	3.9	5.9	3	7.2	0.4	8	4.3	-
No more sex.	1.2	1.5	0.7	-	0.5	0.6	2.3	0.7	0.5	6.2	0.9	0.4	2.3
Total N (000)	10302	7554	877	291	1579	3857	3697	3032	825	1006	2691	757	121

Respondent birth control methods	Total	African	Coloured	Indian	White	African Urban	African Rural	African Urban Formal	African Urban Informal	African Rural Farms	African Rural Homelands	Coloured Urban	Coloured Rural
Condom	13	11.3	11.6	17.2	22.8	14.7	7.5	17.6	4.3	6.2	8.1	12.1	9.2
Sterilized	2.4	0.4	5.6	1.6	11.8	0.2	0.7	-	0.8	-	1.1	5.8	5
Pull out	0.4	0.1	1.1	-	1.5	0.2	-	0.3	-	-	-	1.3	-
None sometimes	0.8	1	1	-	-	0.8	1.2	1	-	-	1.7	1.2	-
Avoid sex	0.1	0.1	-	-	-	0.2	-	0.3	-	-	-	-	-
Other methods	0.1	-	0.5	-	0.3	-	-	-	-	-	-	0.7	-
Do not use any	80.2	85	77.7	79.4	55.1	82	88.3	79.5	91.2	93.8	85.8	75.9	85.8
Refused	3	2.1	2.4	1.8	8.5	1.9	2.3	1.3	3.8	-	3.3	3	-
Total N (000)	7780	5903	598	214	1065	3084	2819	2427	657	892	1927	488	110
Partners birth control methods	**Total**	**African**	**Coloured**	**Indian**	**White**	**African Urban**	**African Rural**	**African Urban Formal**	**African Urban Informal**	**African Rural Farms**	**African Rural Homelands**	**Coloured Urban**	**Coloured Rural**
Pill	13.9	10	11.2	26.8	34.1	9.1	10.9	10.9	2.6	10.7	11	13.2	2.5
IUD	2.9	2.9	-	3.7	4.7	2.6	3.3	2.6	2.4	-	4.8	-	-
Diaphragm	0.2	0.3	-	-	-	0.5	-	0.3	1.3	-	-	-	-
Injection	21.4	25.6	19.4	1.7	3.1	23.4	28	20.9	32.7	32	26.2	17.9	26.2
Sterilized	5.5	2	14.9	19.7	16.4	1.9	2.2	2.3	0.3	4.7	1.1	14.8	15
Pull out	0.1	-	-	-	0.9	-	-	-	-	-	-	-	-
None sometimes	0.8	0.9	0.5	-	-	0.9	1	0.7	1.7	-	1.4	0.7	-
Other methods	0.4	0.2	1.7	3.3	0.3	0.5	-	0.6	-	-	-	2	-

Do not use any	33.3	33.1	41.4	41.4	28.4	35.3	30.8	34	39.9	39.8	26.6	39.7	49.2
Refused	21.5	24.9	10.9	3.3	12.1	25.9	23.8	27.7	19.1	12.8	28.9	11.7	7.1
Total N (000)	7780	5903	598	214	1065	3084	2819	2427	657	892	1927	488	110

39.1 Percent of African women (45.1% in rural areas) do not use any method of birth control. Among those who do, the largest percentage (39.7%) use depo provera. Nearly 80% of all women said their partners did not take any responsibility for birth control. This was corroborated by male respondents, who also showed a remarkably accurate knowledge of their sexual partner's birth control method.

Most South Africans (98%) have heard of AIDS, but there is widespread misinformation about the means of transmission of HIV. Nearly half the respondents thought AIDS could be spread by mosquitos, but an average of 90% knew that sex without a condom is high risk for transmission of the disease.

TABLE 27. Knowledge of How AIDS is Spread

Mother to unborn Child	**Total Men**	**Total Women**	**African Men**	**African Women**	**Coloured Men**	**Coloured Women**	**Indian Men**	**Indian Women**	**White Men**	**White Women**
TRUE	83	84	79	80	90	91	92	94	97	97
Not Sure	13	14	17	17	8	8	6	5	2	3
FALSE	4	2	4	3	2	1	2	1	1	0
Total	100	100	100	100	100	100	100	100	100	100
Sharing razor blades	**Total Men**	**Total Women**	**African Men**	**African Women**	**Coloured Men**	**Coloured Women**	**Indian Men**	**Indian Women**	**White Men**	**White Women**
TRUE	60	60	60	60	65	65	60	62	55	55
Not Sure	19	23	21	25	15	16	11	15	12	19
FALSE	21	17	19	15	20	19	29	23	34	27
Total	100	100	100	100	100	100	100	100	100	100
Using toilets	**Total Men**	**Total Women**	**African Men**	**African Women**	**Coloured Men**	**Coloured Women**	**Indian Men**	**Indian Women**	**White Men**	**White Women**
TRUE	18	23	21	26	21	22	12	20	4	6
Not Sure	18	23	21	26	9	15	7	8	7	10

FALSE	64	54	58	48	70	63	81	7	89	84
Total	100	100	100	100	100	100	100	100	100	100
Hugging and Kissing	**Total Men**	**Total Women**	**African Men**	**African Women**	**Coloured Men**	**Coloured Women**	**Indian Men**	**Indian Women**	**White Men**	**White Women**
TRUE	23	25	27	27	32	23	16	17	5	14
Not Sure	17	23	18	27	12	13	5	8	12	11
FALSE	60	52	55	46	56	64	79	75	83	76
Total	100	100	100	100	100	100	100	100	100	100
Sharing food	**Total Men**	**Total Women**	**African Men**	**African Women**	**Coloured Men**	**Coloured Women**	**Indian Men**	**Indian Women**	**White Men**	**White Women**
TRUE	19	21	22	25	23	15	11	13	6	8
Not Sure	15	23	17	27	11	14	9	9	11	10
FALSE	66	56	61	48	66	71	81	78	83	82
Total	100	100	100	100	100	100	100	100	100	100
Mosquito bites	**Total Men**	**Total Women**	**African Men**	**African Women**	**Coloured Men**	**Coloured Women**	**Indian Men**	**Indian Women**	**White Men**	**White Women**
TRUE	46	45	49	49	53	43	35	41	28	24
Not Sure	28	31	29	32	22	31	20	23	27	27
FALSE	29	24	22	19	25	26	46	36	46	48
Total	100	100	100	100	100	100	100	100	100	100
Sex without a condom	**Total Men**	**Total Women**	**African Men**	**African Women**	**Coloured Men**	**Coloured Women**	**Indian Men**	**Indian Women**	**White Men**	**White Women**
TRUE	93	90	91	88	96	96	97	95	97	97
Not Sure	6	9	7	11	4	3	2	4	2	1
FALSE	1	1	2	1	0	1	1	1	1	2
Total	100	100	100	100	100	100	100	100	100	100

Even so, only 61% of women said they would ask their new partner to wear a condom during sex to protect against AIDS and 65.3% of men said they would be willing to. Willingness to use condoms to protect against AIDS is highest among whites (about 80% among both men and women) and lowest among Africans (about 60%).

TABLE 28. Pregnancy and Ante-Natal Care

Given birth	Total	African	Coloured	Indian	White	African Urban	African Rural	African Urban Formal	African Urban Informal	African Rural Farms	African Rural Homelands	Coloured Urban	Coloured Rural
Yes	79.5	82.2	74.8	74.4	68.1	80.5	83.4	78.1	87.3	90.6	81.9	73.7	84.4
No	20.5	17.8	25.2	25.6	31.9	19.5	16.6	21.9	12.7	9.4	18.1	26.3	15.6
Total N (000)	11504	8683	941	301	1578	3635	5047	2673	962	886	4161	839	102
Pre/ante-natal care	**Total**	**African**	**Coloured**	**Indian**	**White**	**African Urban**	**African Rural**	**African Urban Formal**	**African Urban Informal**	**African Rural Farms**	**African Rural Homelands**	**Coloured Urban**	**Coloured Rural**
Yes	89.4	90.2	93.8	92	80.6	94.3	87.4	93.9	95.4	83.6	88.3	94.1	91.6
No	10.6	9.8	6.2	8	19.3	5.7	12.6	6.1	4.6	16.4	11.7	5.9	8.4
Refused	0	-	-	-	0.1	-	-	-	-	-	-	-	-
Total N (000)	9141	7137	704	224	1076	2928	4209	2087	840	803	3407	618	86
Where Antenatal Care?	**Total**	**African**	**Coloured**	**Indian**	**White**	**African Urban**	**African Rural**	**African Urban Formal**	**African Urban Informal**	**African Rural Farms**	**African Rural Homelands**	**Coloured Urban**	**Coloured Rural**
Public hospit	23.1	23.7	26	32.5	13.8	30.8	18.5	30.1	32.3	27	16.6	28.3	9.7
Private hosp	2.8	1.7	4.6	14.7	7.2	3	0.6	3.9	0.9	0.6	0.6	5.2	-
Public clinic	60.3	69.3	57.1	16.4	6.3	60.1	76.1	58.1	65.1	64.6	78.7	53.3	85.3
Private clin	1.8	1.7	2	3.6	1.6	1.2	2	1.2	1.4	0.6	2.3	1.8	3.6
Clin Dont know	0	-	-	-	0.1	-	-	-	-	-	-	-	-
Private doctor	11.6	3.5	9.9	32.9	68.6	4.4	2.8	6.2	0.1	7.2	1.8	11	1.4

Pharmacist	0.1	0	-	-	1.2	0	-	-	0.1	-	-	-	-
Social Welfare	0.1	-	-	-	1.1	-	-	-	-	-	-	-	-
Psych.:Priv	0.1	0.1	0.2	-	-	0.3	-	0.4	-	-	-	0.2	-
Other	0.1	0.1	0.2	-	-	0.2	-	0.2	-	-	-	0.2	-
Total N (000)	8173	6439	660	206	867	2761	3678	1959	802	671	3007	581	79
When 1st visit	**Total**	**African**	**Coloured**	**Indian**	**White**	**African Urban**	**African Rural**	**African Urban Formal**	**African Urban Informal**	**African Rural Farms**	**African Rural Homelands**	**Coloured Urban**	**Coloured Rural**
First 3 mths	40.4	30.3	59.9	89.1	88.7	37.6	24.8	39.5	32.9	38.4	21.8	61.8	45.6
4-6 mths	50	58.1	35.3	10.1	9.8	50.6	63.8	49	54.5	52.5	66.4	33.5	48.5
Last 3 mths	9.5	11.6	3.9	0.8	0.8	11.9	11.3	11.5	12.6	9.1	11.8	3.6	5.9
Do not know	0.2	-	1	-	0.7	-	-	-	-	-	-	1.1	-
Total N (000)	8173	6439	660	206	867	2761	3678	1959	802	671	3007	581	79
Who present	**Total**	**African**	**Coloured**	**Indian**	**White**	**African Urban**	**African Rural**	**African Urban Formal**	**African Urban Informal**	**African Rural Farms**	**African Rural Homelands**	**Coloured Urban**	**Coloured Rural**
Doctor	16.3	5.8	35.3	41.6	68	11.8	1.6	13.1	8.4	-	2	38.2	14.8
Nurse/ midwife	40.9	47	38.8	19.8	6	49.4	45.3	49.4	49.3	34.1	48	37.1	50.9
Both	25.1	24.9	23.1	36.8	25.7	28.9	22.1	27.6	32.1	22.5	22	22.7	25.9
Neither	17.7	22.4	2.8	1.7	0.3	9.9	31	9.8	10.1	43.5	28.1	2	8.4
Total N (000)	9141	7137	704	224	1076	2928	4209	2087	840	803	3407	618	86
Traditional birth Attendent	**Total**	**African**	**Coloured**	**Indian**	**White**	**African Urban**	**African Rural**	**African Urban Formal**	**African Urban Informal**	**African Rural Farms**	**African Rural Homelands**	**Coloured Urban**	**Coloured Rural**
Yes	16.1	19.1	5.1	2	6.2	11.4	24.4	10.2	14.3	33.3	4.6	4.6	8.4

No	83.9	80.9	94.9	98	93.8	88.6	75.6	89.8	85.7	66.7	95.4	95.4	91.6
Total N (000)	9141	7137	704	224	1076	2928	4209	2087	840	803	618	618	86

The vast majority of women receive pre and ante natal care in a public health facility, but African women are likely to delay receiving medical care until much later in their pregnancy than white, Indian or coloured women.

CHRONIC HEALTH CONDITIONS

TABLE 29. Chronic Conditions Among Adults 16-64

Most serious condition	Total	African	Coloured	Indian	White	African Urban	African Rural	African Urban Formal	African Urban Informal	African Rural Farms	African Rural Homelands	Coloured Urban	Coloured Rural
Arthritis	20.6	18.5	26.6	32.2	21.5	17.3	19.7	18.6	14.1	24.6	18.3	26.3	28.9
Epilepsy	4.3	5.4	4	2.1	1.4	3.9	6.9	4.1	3.4	0.3	8.7	4.6	-
Hypertension	30.1	33.2	25.5	16	26	28.8	37.8	31.5	22.1	41.8	36.8	26.1	21.6
Cancer	5.2	5.1	-	2.1	9.2	1.4	9	1.9	0.3	-	11.5	-	-
Heart problem	7.9	9.3	10.3	10.6	1.1	14.4	4.1	14.9	13.1	9.5	2.6	8.2	24
Diabetes	5.1	6.1	5.2	8.4	0.9	10.3	1.7	12	6.1	-	2.2	5.9	-
Asthma	11.9	9	14.3	22.2	17.3	10.2	7.8	11.8	6.5	6.1	8.2	14.5	12.6
Other problem	2.5	2.7	2.1	-	2.6	1.6	3.8	2.3	-	17.7	-	1.6	5.3
Skin condition	0.3	-	-	1.2	1.5	-	-	-	-	-	-	-	-
Muscular cond	1	-	-	-	5.1	-	-	-	-	-	-	-	-
Low blood	-	-	-	-	-	-	-	-	-	-	-	-	-
pressure	0.2	-	1.4	1.2	-	-	-	-	-	-	-	1.6	-
Headache	1.6	2.5	-	-	-	0.5	4.6	-	1.7	-	5.8	-	-
Other systemic	5	3.3	4.2	1.8	11.6	3.6	3	2.9	5.2	-	3.8	4.8	-
Gynaecological	0.5	0.4	-	-	0.9	0.9	-	-	3	-	-	-	-
Emotional	2	2.4	1.4	2.2	0.9	4.7	-	-	16.3	-	-	1.6	-

TB	1.4	1.3	5.1	-	-	1	1.5	-	3.4	-	2	4.7	7.7
Stroke	0.5	0.7	-	-	-	1.4	-	-	4.8	-	-	-	-
Total N (000)	1596	1029	178	75	314	523	506	371	151	110	396	154	23
Frequency of check-ups	**Total**	**African**	**Coloured**	**Indian**	**White**	**African Urban**	**African Rural**	**African Urban Formal**	**African Urban Informal**	**African Rural Farms**	**African Rural Homelands**	**Coloured Urban**	**Coloured Rural**
Every month +	27.1	26.5	41.9	53.3	18	28.9	24.4	28.2	30.9	15.6	27.1	42.8	37.3
Every 2-3 mnth	12.8	11.9	13.7	17.5	15.2	12.4	11.5	12.4	12.3	14	10.7	15.4	5.5
Every 4-6 mnth	7.2	3.5	5.8	2.8	22.6	3.7	3.4	3.6	4	0.1	4.4	6.2	3.8
About 1/year	3.9	2.6	2.2	5	9.8	1.9	3.1	2.5	0.5	6.4	2.1	2.7	-
Only when sick	35.9	41.7	27.8	15	21.1	37.5	45.6	37.4	37.7	51.8	43.7	28.3	25.3
Never	13	13.8	8.6	6.4	13.4	15.7	12.1	16	14.6	12	12.1	4.5	28.1
Total N (000)	5387	3772	470	156	990	1791	1981	1327	464	468	1513	389	81

Hypertension is the most common ailment among all population groups, followed by arthritis and asthma. Among those (16-64 years) who had been told they have an on-going health problem, more than half (55.5%) of African respondents reported only having a medical check-up when sick or not at all.

46 Percent of respondents in the Northern Transvaal and Eastern Cape aged 16-64 (who had previously been diagnosed with a chronic health problem such as tuberculosis) had not gone for health care in the year preceding the study. This compared to the more affluent/urban provinces of Gauteng (32%) and the Western Cape (23%).

MEASURES OF PROGRESS

The principal purpose of this survey is to establish a reliable baseline from which to measure progress in improving South African health and health care. Given that this survey shows nearly two-thirds of African births are unregistered, establishing more precise demographic data and reliable health information systems is essential to accurately monitoring future progress.

The results of this survey suggest some critical measures by which progress could be monitored:

- Public health conditions, particularly for Africans, i.e., availability of formal housing, piped water, toilets and electricity.

- Public satisfaction with the health system.
- Accessibility of public health facilities (closest site of care) including proximity (reduced travel time) and extended opening hours.
- Cost of care, transport, loss of employment as barriers to care.
- Use of public clinics for first treatment.
- Average waiting time at public health facilities.
- Length and quality of consultation with a health provider.
- Availability of emergency and outreach services, particularly for elderly and disabled.
- Nutritional status of children under five years of age.
- Immunization levels for children under five years of age.
- Maternal mortality.
- Contraceptive usage among African women.
- Willingness of males across all races to use condoms for contraception and safe sex.

Chapter 1.
Research Methodology

A National Household Survey of Health Inequalities in South Africa

Ros Hirschowitz and Lebogang Taunyane

CHAPTER ONE.

INTRODUCTION

This chapter describes the research methodology and the research process in some detail. If you are not interested in this fairly detailed technical information, we suggest you skip to Chapter 2.

AIMS OF THE SURVEY

The aims of the survey are:

- To develop health indicators and to gather base-line information which measures perceptions among the general public of:
  - health-status;
  - access to health-care;
  - utilisation of services;
  - quality of care; and
  - outcomes of care, such as improved health knowledge in relation to life circumstances in South Africa.

STEPS IN THE RESEARCH PROCESS

The research involved the following steps:

- Visiting the United States to discuss household-based health surveys with relevant experts and involving eight of them in further questionnaire design.
- Forming and meeting with a South African reference group to discuss the survey design.
- A series of 10 focus-group discussions in different parts of the country.
- Developing indicators.
- Designing a questionnaire for the survey.
- Piloting the questionnaire.
- Drawing a sample of households, and selecting different respondents ithin households, according to each applicable age-category.
- Field-work and back-checks.
- Data analysis and report writing.

Each of these steps is discussed below.

VISIT TO THE UNITED STATES OF AMERICA

The C A S E manager and coordinator of the research project, Dr. Ros Hirschowitz, spent four weeks examining the relevant experience in health-survey research with some of the best experts in this field in the United States.

She also reviewed a wide variety of questionnaires designed for American and international household-based health surveys, conducted by different agencies, including the federal government, USAID, university departments, philanthropic organisations and the private sector. Some questions which are used in this survey were taken directly or adapted from these questionnaires. A list of questionnaires is included as Appendix A.

On the basis of these interviews, eight people were selected to act as an American reference group for the project (see Appendix B). Draft copies of possible South African health indicators and the questionnaire for the present study were distributed to them. Many of these comments were incorporated into the final questionnaire.

THE SOUTH AFRICAN REFERENCE GROUP

A South African reference group consisting of practitioners, researchers and other experts in the field of primary health care was formed. Their names are listed in Appendix C.

This reference group met in a workshop to discuss all aspects of the survey. Members of the group were consulted in the course of the research design and provided valuable input to the draft report. Copies of the following documents were circulated to them for comment:

- The focus-group discussion guides (as discussed below).

- The health indicators.
- The draft questionnaire.
- The draft report.

Their comments and suggestions were valuable and helped shape the survey instrument.

THE FOCUS GROUPS

Ten focus groups formed an essential component of the study. These groups yielded rich descriptions of people's life-circumstances, their coping mechanisms and reactions to these circumstances. The focus groups helped complement and enrich the quantitative information. A record of the focus-group discussions is published as a separate report. We included focus groups in the design of the research with two purposes in mind:

- to enable the researchers to gain an in-depth understanding of the type of problems that people have which make them seek health-care, and their experiences of health-care services when they come for help, and;
- to explore ways of formulating some of the questions to be asked in the household survey so that they could be easily understood by the respondents.

Each group consisted of eight or nine people, recruited according to specified criteria. The first eight groups were made up of "at risk" people, or those who are more likely to require health-care because of their life circumstances. The final two groups were selected to give those who consult traditional healers an opportunity to express their views, since this practice has important implications for South African health-care.

The focus groups were therefore constituted as follows:

- There were two groups consisting of African mothers with at least one child under the age of six years:
  - For the first group urban shack-dwellers in the Western Cape were recruited; and
  - for the second, rural inhabitants of the Northern Transvaal were selected.
- There were also two groups of Africans aged 65 years or older:
  - The first group consisted of males living in rural Northern KwaZulu-Natal,
  - the second consisted of females living in the same area.
- Another group consisted of African physically disabled people of both sexes, excluding those with auditory or visual handicaps, aged between 25 and 49 years, living in Gauteng.
- A further group consisted of Africans of both sexes with chronic illnesses such as diabetes, hypertension and asthma, living in urban sections of the Western Cape.
- A group of African male shack-dwellers living in Gauteng, aged between 16 and 30 years, who had witnessed pre-election violence was also included.
- In addition, a group of Coloured male farm-workers aged between 25 and 49 years living in rural areas in the Western Cape was included.

- Two groups of African people who consult traditional healers were also recruited, consisting of:
  - Women aged between 25 and 45 years living in rural Northern Transvaal Province.
  - Males aged between 25 and 45 years, living in Gauteng.

The groups were selected to introduce as much variety as possible into the qualitative component of the research. The life-circumstances of these participants are indicative of South Africans of different ages, living in shacks or in brick-houses, in both urban and rural areas, with diverse health needs and sources of health-care.

Discussion-guides were developed for the facilitators to use when leading the discussions. Different guides were developed for each group.

The Qualitative Consultancy was subcontracted to recruit people for these groups, according to the above descriptions, to facilitate the discussions and to transcribe them.

DEVELOPING HEALTH INDICATORS

Bearing in mind the aims of the study and the type of focus-group responses, a series of health indicators were developed for the household as a whole and for individuals in each of the four age categories (nought to five, six to 15, 16 to 64 and 65 or more years). These indicators are shown as Appendix D.

They played an extremely important role in the research process since they formed the basis of the questionnaire design, and also the way in which the data were analyzed and written up.

THE QUESTIONNAIRE

The questionnaire consisted of five sections:

- the first section contained questions on household demographics and composition;
- the second had questions relevant to children aged nought to five years;
- for the third section, questions relevant to children aged six to 15 years were included;
- the fourth section contained questions for adults aged between 16 and 64 years; and
- the fifth was for older people, aged 65 years or more.

Questions in each section are briefly summarised below:

Household section

This section of the questionnaire obtained information on:

- Demographics of the household:
  - Province.
  - Type of area (metro - including formal and informal sections,urban - including formal and informal sections, and rural - including those living on white-owned farms and those living in "homelands" or bantustans).
  - Home language.
  - Type of dwelling, including shacks and traditional huts, and number of rooms in the dwelling.
  - Education level of the person responsible for the health-care of the household.
- Living conditions of the household:
  - Description of nearest source of water.
  - Boiling water, among those without access to a piped source.
  - Description of nearest toilet.
  - Access to electricity.
- Description, if applicable, of the usual site of health-care for the household:
  - Days and hours of opening.
  - Quality of care received from this source.
  - Among those households who do not have one, the reason for not having a usual source of care.
- Economic status of the household:
  - Household income.
  - Whether or not people ever go hungry in the household.
  - Membership of medical aid or health insurance.
  - Difficulty in paying for health-care and prescribed medicines.
- Household composition:
  - Number of people in the household, by age and sex, according to the four age categories and in total.

Section for children aged five years or younger

This section of the questionnaire obtained information on:

- Perceived health-status of the randomly selected child (see later discussion regarding the selection procedure).
- Taking this child for check-ups in the first year of life.
- Breast-feeding this child:
  - length of time.
- Immunization status of the child:
  - reading from the "Road to Health" card, or
  - from memory, if "Road to Health" card was absent.

- Childhood nutrition:
  - The health-care person's knowledge regarding oral rehydration solution;
  - Being too poor to adequately feed this child;
  - Being told by health-care professionals that the child weighs too little;
  - Being told that this child is too short for his or her age;
  - Obtaining extra food or milk from a health-care source for the child.
- Satisfaction with health-care services:
  - Perceived attitude of health-care staff towards the child;
  - Attitude towards the new government's policy of free health-care for children.

Section for children aged six to 15 years

In this section, we asked questions to cover:

- Heath-status of the child, including:
  - Subjective assessment by the health-care person;
  - Illnesses in the two weeks prior to the interview;
  - Where this child who was ill was taken for treatment, if anywhere.
- The child's school attendance:
  - Whether or not the child was attending school;
  - Learning problems.
- Nutrition:
  - Eating breakfast before school;
  - Whether the children attending primary school receive free food during school-hours.
- Sex education for children in high school:
  - Attitude of caretaker to sex education at high schools;
  - Whether or not child is receiving this type of education.

Section for adults aged 16 to 64 years

The following issues were covered in this section:

- Biographical description:
  - Marital status;
  - Level of education;
  - Employment status;
  - Health problems in relation to home and work.
- Subjective rating of health status:
  - Physical;
  - Mental;
  - Patterns of cigarette smoking and alcohol consumption.
- Subjective rating of the environment.

- Chronic illnesses:
  - Type of illness;
  - Access to health-care for these illnesses.
- Disabilities:
  - Ability to perform activities of daily living;
  - Type of disability;
  - Access to rehabilitation and health-care.
- Emotional problems:
  - Type of problem;
  - Exposure to traumatic life-events;
  - Effects of this exposure;
  - Access to health-care for emotional problems.
- Access to health-care for physical illnesses and injuries:
  - Barriers to access.
- Description of the last visit to a health-care centre:
  - Time taken to get there, waiting time and treatment time.
- Quality of care:
  - Perceptions of costs of health-care;
  - Perceptions of the attitudes and behaviour of health-care personnel;
  - How well health-care system is working for the respondent.
- Community involvement in health-care:
  - Opinions on the role of community health workers;
  - Having a say in the running of local health-care services.
- Use of traditional healers:
  - Comparison of traditional healing and Western medicine;
  - Use of traditional healers in relation to modern medicine.
- Contraception and family planning:
  - Access to advice on contraception and family planning;
  - Methods of contraception that respondents use;
  - Reasons for not using contraception among those who do not do so.
- Women's health issues:
  - Health-care during pregnancy and child-birth;
  - Awareness of women who have had abortions and who have died as a result of an abortion.
- Knowledge of AIDS.

Section for adults aged 65 years or more

The following issues were covered in this section:

- Subjective rating of physical and emotional health and memory:
  - Overall satisfaction with life.
- Chronic illnesses:
  - Type of illness;
  - Access to health-care for these illnesses.

- Disabilities:
  - Ability to perform activities of daily living;
  - Type of disability;
  - Access to rehabilitation and health-care.
- Social isolation:
  - Amount of time spent alone.
- Main fears and access to social services, such as a state pension and home-help.

PILOTING THE QUESTIONNAIRE

The questionnaire was piloted in two ways:

- Field-workers conducted 100 interviews, based on an area-stratified probability sample, with respondents living in metropolitan, urban and rural areas, throughout the country.
- Before the above step and following it pilot interviews were conducted in a room where the researchers could watch the interview through one-way glass without being seen. Altogether eight such interviews were conducted.

After these pilot-studies, the questionnaire was modified and shortened. It was then translated into seven indigenous languages.

Market Research Africa was subcontracted to draw a sample of households, to conduct the field-work (including the testing), capture the data, and produce the initial set of cross-tabulations.

DRAWING A SAMPLE

Methods used to select households and to select members within households to interview are described below.

Drawing a sample of households

A nationwide probability sample of 4,000 South African households, stratified by race, province and metro, urban rural components was drawn.

- Method of sampling
  - After allocation of the number of households to different areas, a different sampling method was used in those suburbs where there are known addresses (formal housing), compared to those where addresses do not exist, for example shacks in some informal settlements.
  - In suburbs consisting mainly of formal housing, the *Market Research Africa Computerised Dwelling Unit Census* was used. Sampling points were selected using an equi-interval, after a random start. At each point four dwellings were chosen.
  - In metro and urban places without addresses, an estimate was made of the number of households. Sampling points were then chosen using an equi-interval procedure, after a random start. At each point four dwellings were chosen.
  - In rural areas, the selection method for dwellings varied by area. In the RSA, excluding the former homelands, the number of farms to be visited within a given magisterial district was determined. Map references were then randomly selected.
  - In the former homelands republics, the selection of rural dwellings was at the discretion of the leaders of the fieldwork teams, subject to these being within predesignated areas marked on maps.
  - On stands where there was more than one household, a random selection grid was used to select a dwelling.
  - Two visits were made to a sampled household before substitution with an adjacent household.
- Regarding race, Indian (N=352 or 9%), coloured (N=600 or 15%) and white (N=751 or 19%) households were over-sampled, and African households (N=2,300 or 57%) were under-sampled relative to their proportion in the population (Indians 3%, coloureds 9%, whites 13% and Africans 76%). This was done in order to have a sufficiently large sample size to make valid comparisons between and within race groups by gender, province and other appropriate variables. (Refer to Table 1.1 for details of the areas covered for each race).
- As far as province is concerned, we over-sampled households in the provinces with fewer people, for example the Northern Cape and the North West, which are mainly rural, and we under-sampled those with densely populated metropolitan components, such as Gauteng and KwaZulu-Natal. The reason was to have sufficiently large numbers to make comparisons between and within provinces. Table 1.1 also gives a breakdown of sample size by province.
- Regarding rural, urban and metropolitan areas, we tended to under-sample rural households, because they were likely to be more homogeneous and more costly to get to. Table 1.1 also indicates metro, urban and rural sample sizes.

TABLE 1.1. NUMBER OF HOUSEHOLDS IN THE SAMPLE

Area and Province	African	Coloured	Indian	White	Total
METRO	METRO	METRO	METRO	METRO	METRO
W Cape	124	152	0	60	336
N Cape	0	0	0	0	0
Free State	28	0	0	28	56
E Cape	104	60	0	27	191
KwaZulu-Natal	152	0	240	52	444
E Transvaal	0	0	0	0	0
N Transvaal	0	0	0	0	0
Gauteng	284	64	60	144	552
North West	0	0	0	0	0
TOTAL	692	276	300	311	1579
OTHER URBAN	OTHER URBAN	OTHER URBAN	OTHER URBAN	OTHER URBAN	OTHER URBAN
W Cape	28	96	0	52	176
N Cape	100	72	0	52	224
Free State	72	0	0	28	100
E Cape	92	56	0	28	176
KwaZulu-Natal	80	0	52	40	172
E Transvaal	104	0	0	56	160
N Transvaal	116	0	0	52	168
Gauteng	96	0	0	76	172
North West	100	0	0	56	156
TOTAL	788	224	52	440	1504
RURAL	RURAL	RURAL	RURAL	RURAL	RURAL
W Cape	0	100	0	0	28
N Cape	52	0	0	0	100
Free State	68	0	0	0	72
E Cape	168	0	0	0	92
KwaZulu-Natal	160	0	0	0	80
E Transvaal	104	0	0	0	104
N Transvaal	168	0	0	0	116
Gauteng	0	0	0	0	96

North West	100	100	0	0	100
TOTAL	820	600	352	751	920
TOTAL	**2300**	**600**	**352**	**751**	**4003**

Source: Market Research Africa

- Before we analyzed the data, we weighted the sample of households back to the actual number of households in the various provinces, according to the proportions found in metro, urban and rural areas and by race.
  - For each section of the report dealing with a specific age category, the sample was also weighted back to the proportion of individuals in a particular age category, by province, race and metro, urban and rural areas.

Selecting respondents and proxies within households

A main respondent was selected to provide information on the entire household. More detailed information also was obtained on selected individuals in each household. Methods for selecting the main respondents and specific individuals are described below:

- For the section of the questionnaire covering household information, the field-workers were instructed to speak to the person who assumes responsibility for the health of the household (variously referred to as the health-care person or the caretaker in the rest of the report). The following instructions were given to the field-workers to select this person:
  - Speak to the senior woman in the household aged 16 years or older, who assumes responsibility for the health of the household.
  - If there is only one woman in the household, aged 16 years or older, speak to her.
  - If there are no women in the household, speak to the male in the household, aged 16 years or older, who is the main breadwinner.
  - If there is only one male in the household, aged 16 years or older, and *no* women, speak to this male.
- Where applicable, information was gathered on *one* child in the household, aged five years or younger.
  - the health-care person was used to obtain information on this child.
  - Where there was more than one child in the household, a random selection grid was used to select the child about whom information was given.
- Again where applicable, information was collected on *one* child in the household, aged six to 15 years.
  - The health-care person was again used to obtain information on this child.
  - Where there was more than one child in the household in this age group, a further random grid was used to select a child.

- Details of *one* adult in the household, aged between 16 and 64 years were also obtained. In this instance, the person selected answered directly for him- or herself. The relevant adult was chosen using a similar grid to the previous ones.
- Regarding a person in the household aged 65 years or more, *one* person was again selected to answer using a similar grid to select the relevant person when appropriate. This person usually answered for him- or herself, but if there was a problem, for example poor hearing or severe memory loss, the health-care person provided the information.
- Before analyzing the data, each of the above samples of individuals in households was weighted back to the actual number of people in South Africa in that particular age category, according to their proportions found in the various provinces, in metro, urban and rural areas and race. The adults aged 16 to 64 years were also weighted according to their distribution into smaller age categories and their gender distribution in South Africa.
- The population estimates used by Market Research Africa for weighting are based on two sources:
  - the updated version of the 1991 census, using population growth indices supplied by the University of South Africa's Bureau of Market Research and
  - the Development Bank of Southern Africa's estimates of the population size of the former "independent" homelands.

FIELD WORK AND BACK CHECKS

All questionnaires were administered by means of face-to-face interviews lasting approximately one hour.

C A S E researchers designed a training manual and, together with Market Research Africa personnel, conducted training sessions on questionnaire administration for field-workers in Johannesburg, Durban, Port Elizabeth and Cape Town. When in field, these field-workers were supervised by Market Research Africa's area managers.

The field-work was conducted in October, November and early December in 1994, breaking for Christmas holidays. It was resumed in late January and early February, 1995.

Back-checks were done on 25% of the sample by Market Research Africa field-work managers, and a full-time back-check department.

- Of these 25% check-backs, 31% were done by personal interviews, 51% were conducted by telephone, 2% by letter, and 16% were validation checks, to ensure that a particular household had been visited.
- C A S E researchers accompanied the field-work managers on a smaller sub-sample of the face-to-face check-backs, in metro, urban and rural areas in different parts of the country.

DATA ANALYSIS AND REPORT WRITING

Market Research Africa captured the data on computer and supplied the C A S E researchers with cross-tabulations for each section of the questionnaire. In addition, they supplied all data to C A S E on SPSS for further data analysis.

Five C A S E researchers were involved in further data analysis and in writing the report.


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Chapter 2 

Chapter 2.
Household Description

A National Household Survey of Health Inequalities in South Africa

Joan de Castro and Ros Hirschowitz

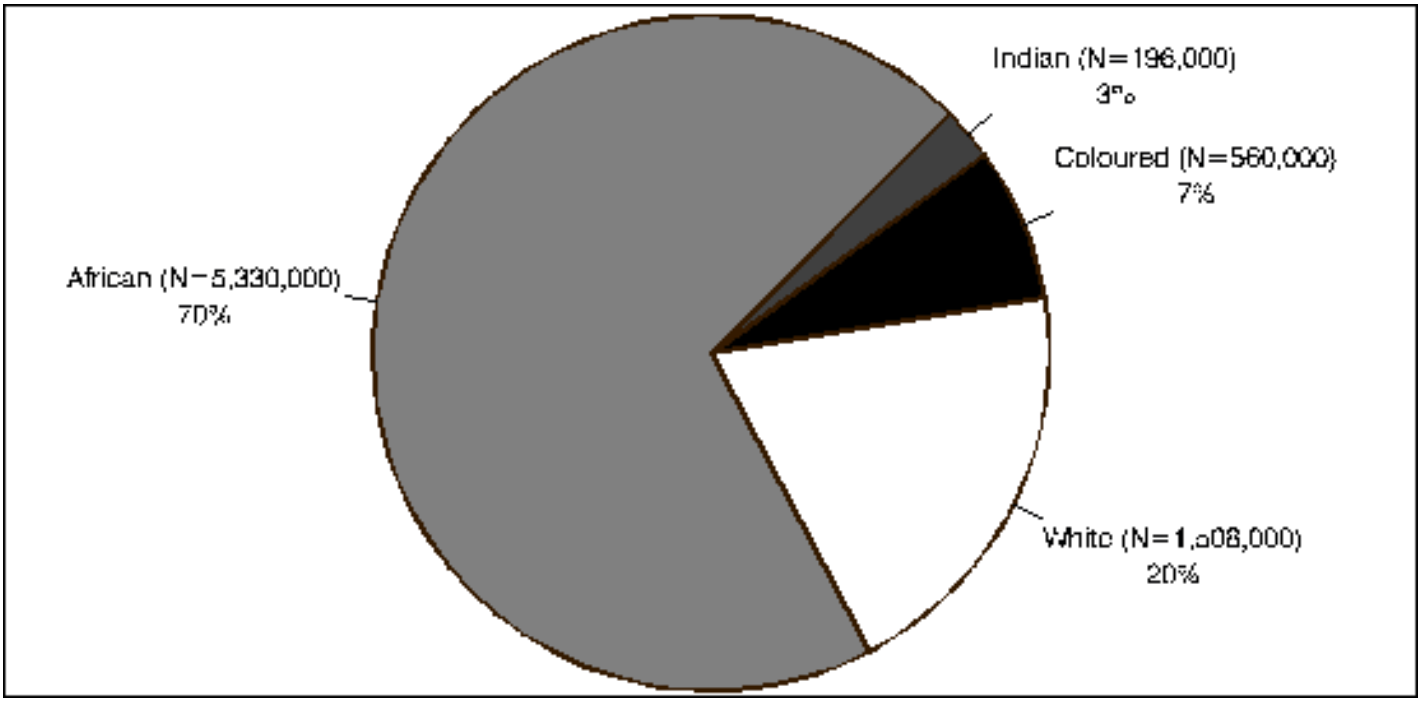
CHAPTER TWO.

Introduction

This chapter presents findings on the 4,000 households constituting the sample*, weighted to represent all households in South Africa (7,594,000).

Figure 2.1 indicates the proportion of households in the country by race.

FIGURE 2.1. Proportion of Households by Race



Total number of households = 7,594,00

C A S E survey for Kaiser Family Foundation

- According to the 1991 census, supplemented by estimates of population size in the former "independent" homelands states, there are approximately 7,6 million households in South Africa.

- The graph shows that more than two thirds (70%) of households are inhabited by African families, as against 20% white, 7% coloured and 3% Indian families**.
  - Although Africans form 76% of the population, they only occupy 70% of households.

  - There are more people per household among Africans and coloureds, compared to Indians and whites: 5,2 people on average for Africans and 5,3 for coloureds, as against 4,5 for Indians and 2,7 for whites.

Indicators that apply to this chapter

The following indicators form the basis of analysis in this chapter:

- Living conditions of the household affecting health:
  - These are examined in terms of the sentinel indicator - access to clean water - and also access to sanitation and levels of overcrowding.

- Socio-economic factors affecting health:
  - These revolve around the sentinel indicator - members of the household who go hungry - and whether or not the income of the household is above or below the minimum living level.

- Access of household members to health-care:
  - Access to health-care is discussed in terms of the sentinel indicator - having a consistent site of health-care, as well as difficulty in paying for medical treatment and prescribed medicine.

Description of person responsible for the health of the household

All information reported in this chapter was obtained from the person responsible for the health and health-care of the members of the household, in almost all cases (92%) a woman.

Table 2.1:
Gender, age and education of household member responsible for health by race

	African	Coloured	Indian	White	Total

Caretaker	%	%	%	%	%
Gender: Male	7	5	10	13	8
Female	93	95	90	87	92
Total	100	100	100	100	100
Age years: 16-24	12	5	9	12	12
25-34	29	23	27	19	26
35-49	31	38	42	27	31
50-64	20	27	19	24	21
65+	8	7	3	18	10
Total	100	100	100	100	100
Education: No formal	20	10	3	0	15
Std 3	19	14	6	0	15
Std 4-5	18	26	13	1	15
Std 6,7,8,9	33	39	47	41	35
Matric	6	6	20	32	12
Higher	4	5	11	26	8
Total	100	100	100	100	100

- Table 2.1 indicates that women between 25 and 34 and between 35 and 49 years of age are most likely to be the caretakers responsible for the health of the household.
  - Almost a fifth (18%) of white households have a health-care person aged 65 years or more, while proportionately fewer African (8%), coloured (7%) and Indian (3%) households are in this situation.

- The table also shows the low level of education of African caretakers. One in five (20%) had received no formal schooling, and a further one in five (19%) had completed five years or less of schooling (up to standard three). This low level of education has an important influence on various health issues, as discussed in subsequent chapters.

- Among African households, with the exception of the Eastern Cape, those provinces that were part of the former homeland system are most likely to have poorly educated caretakers. For example, among households in the Eastern Transvaal, 32% of caretakers had no schooling, compared to 30% in KwaZulu-Natal, 26% in the Northern Cape, 21% in the Northern Transvaal and the North West, 18% in the Free State, 14% in the Eastern Cape , 10% in the Western Cape and 9% in Gauteng***.

Demographic Profile of Households

- In this section we indicate how the households in the sample are distributed by race according to:
  - The nine new provinces.
  - The type of area in which they are situated, including metropolitan areas (large cities) and urban areas (smaller cities and towns), both with formal and informal divisions, and rural areas, including people living on white-owned farms and those living in the former homelands.
  - Type of dwelling, including a brick structure (such as a house, flat, boarding house, hotel, maisonette or townhouse, referred to in this report as a formal dwelling), versus informal dwellings (such as shacks, outbuildings and prefabricated structures or "zozos") and traditional dwellings.

Table 2.2:
Situation of households according to province, area and type of dwelling by race

	African	Coloured	Indian	White	Total
Variables	%	%	%	%	%
Province: Western Cape	3	72	0	18	11
Northern Cape	1	9	0	2	2
Eastern Cape	17	12	0	7	14
KwaZulu-Natal	23	0	86	12	20
Gauteng	18	7	14	44	22
Eastern Transvaal	8	0	0	4	7
Northern Transvaal	13	0	0	2	10
Northwest	9	0	0	4	7
Free State	8	0	0	7	7
Total	100	100	100	100	100
Area: Metro formal	18	51	81	57	30
Metro informal	7	0	1	0	5
Other urban	17	34	18	43	23
Other urban informal	4	1	0	0	3
Rural white farms	11	14	0	0	9
Rural - homeland	43	0	0	0	30
Total	100	100	100	100	100
Type of dwelling:					
House/flat etc.	63	99	99	100	74
Shack/outbuilding/zozo	15	1	1	0	11
Traditional dwelling	22	0	0	0	15
Total	100	100	100	100	100

- Table 2.2 indicates that:
  - The most densely populated provinces are Gauteng (containing 22% of all households) and KwaZulu-Natal (containing 20%).
  - The province containing the lowest proportion of households (2%) is the Northern Cape.

- A large proportion of African (54%) households are found in rural areas, either on white-owned farms (11%), or in the former "homelands" (43%).

- Eleven percent of African households are situated in informal settlements or squatter camps in metropolitan or other urban areas. The proportion would be higher if one allows that many basically informal settlements have been "formalized" with site-and-service schemes.

- The most common type of dwelling in which 74% of households are found is a formal brick structure.

- Almost all the coloured, Indian and white households (99 - 100%) were situated in a formal dwelling, as against African (63%) households. One in six (15%) of African households were found in shacks, outbuildings or "zozos" and one in five (22%) in traditional dwellings.

Table 2.3:
Distribution of households in areas by province

Area	W Cape	N Cape	E Cape	KwaZ-Natal	Gauteng	E Tvl	N Tvl	N West	Free State	Total African
	%	%	%	%	%	%	%	%	%	%
Metro formal	38	0	14	16	57	0	0	0	18	18
Metro inform	48	0	4	7	20	0	0	0	7	7
Urban formal	9	58	15	11	11	27	15	20	17	17
Urban inform	5	15	1	0	12	3	1	6	4	4
Rural home	0	0	62	56	0	43	76	53	43	43
Rural farms	0	28	5	10	0	27	8	21	11	11
Total	100	100	100	100	100	100	100	100	100	100

- Table 2.3 indicates the type of areas in which African households are situated by province.

- The table shows that, in the sample, most provinces contain a large proportion of rural households (for example, Northern Transvaal 76%, Eastern Cape 62%, down to 43% in the Eastern Transvaal and Free State) while two provinces, Gauteng and the Western Cape, contain none. Instead, they have the highest proportion of metro households (formal or informal).

- The distribution of African households on white-owned farms also varies by province. For example, 27% of households in the Eastern Transvaal, compared to 5% in the Eastern Cape, are located on white farms.

HOUSEHOLD COMPOSITION

TABLE 2.4:
Number of people in household by race

	African	Coloured	Indian	White	Total
Household composition	%	%	%	%	%
No. of rooms per household					
1 - 2	29	11	2	5	21
3 - 4	45	51	41	26	42
5 - 6	20	34	41	37	25
7+	6	4	16	32	12
Total	100	100	100	100	100
No. of people in household					
1	9	2	1	20	10
2 - 4	35	39	53	69	43
5 - 7	37	43	42	11	32
8+	19	16	4	0	15
Total	100	100	100	100	100
No. of children in household					
aged 0 - 5 years. 0	42	50	64	82	51
1	31	34	28	14	28
2	19	12	6	3	15
3+	8	4	2	1	6
Total	100	100	100	100	100
No. of children in household					
aged 6 - 15 years 0	35	34	41	74	43
1	26	27	32	15	24
2	21	22	20	8	18
3	12	11	6	2	10
4+	7	6	2	1	5
Total	100	100	100	100	100

No. of adults in household aged 16 - 64 years 0 1 2 3 4 5+ Total	2 21 32 19 12 14 100	2 7 33 23 19 16 100	1 6 38 28 19 10 100	17 16 48 13 4 2 100	5 19 36 18 11 11 100
No. of adults in household aged 65+ years 0 1 2+ Total	80 17 3 100	80 15 5 100	75 17 8 100	75 17 8 100	79 17 4 100
Mean no. of people/room Standard deviation Standard error 95% confidence intervals	1.65 1.15 0.02 ±0.05	1.39 0.78 0.03 ±0.06	0.94 0.42 0.02 ±0.04	0.52 0.27 0.01 ±0.02	1.39 1.09 0.02 ±0.03

- Table 2.4 shows that African and coloured households have proportionately fewer rooms to live in, compared to Indian and white households.
  - Almost three out of every 10 (29%) African households consist of one or two rooms, as compared to 11% of coloured, 5% of white and 2% of Indians.

- African and coloured households tend to contain more people than the other two population groups.
  - About one in five (19%) of African and one in six (16%) coloured households comprise eight or more people.
  - Whites on the other hand have the smallest households with a fifth (20%) having only one person and approximately two thirds (69%) containing two to four people.
  - African and coloured households contain more children than Indian and whites. For example, 42% of African households had no children aged five years or younger, as against 50% of coloured, 64% of Indian and 82% of white households.

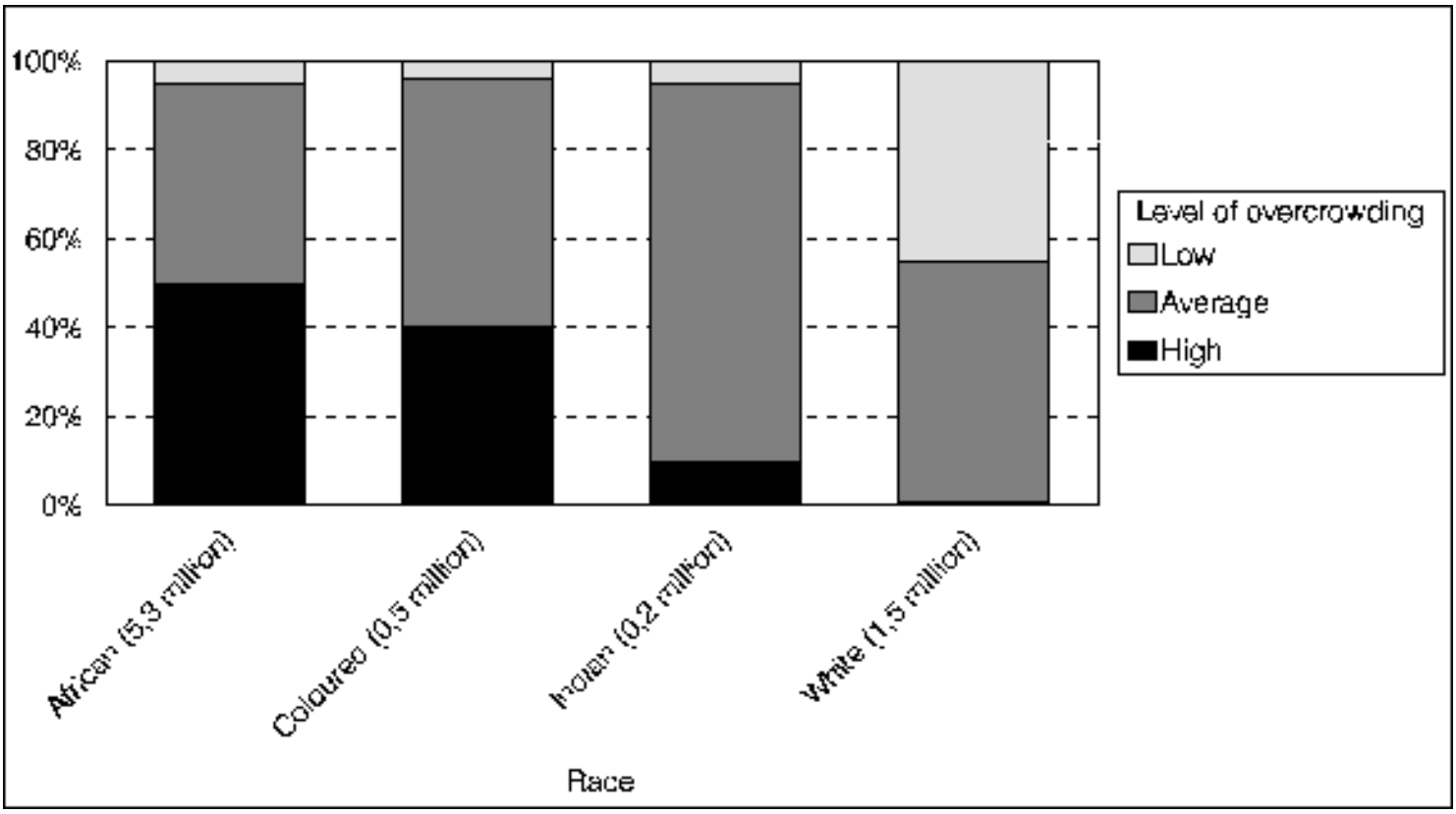
- There are proportionately more Indian and white (25%) households containing at least one person aged 65 years or more, compared to African and coloured households (20%).

- On average, the table also illustrates that there are more people per room in African households (1.65), compared to coloured (1.39), Indian (0.94) and white (0.42).

Living conditions of members of household

Overcrowding

FIGURE 2.2. Level of Overcrowding by Race



- An index of household density was developed for this study consisting of three components: high or overcrowded (three or more people per room), average density (one to two people per room) and low density (fewer than one person per room). As we shall see, overcrowding relates importantly to various health risks.

- Figure 2.2 illustrates that proportionately more African (50%) and coloured (40%) households are overcrowded compared to Indian (10%) and white (1%).

- Regarding African households, when looking at provincial breakdowns, we find that overcrowding is slightly more prevalent in some provinces compared to others. The highest proportions of overcrowded households are situated in the Eastern, Northern, and Western Cape (58% in all three provinces) and in the Northern Transvaal (56%), followed by the North West (49%), the Free State (48%) and KwaZulu-Natal (46%). The lowest proportions are in Gauteng (44%) and the Eastern Transvaal (39%).

- African informal or traditional dwellings are more likely to be overcrowded (67% and 63%) than those made of brick (41%).

- Turning to coloured households, we find that half (50%) in the Northern Cape and just under half (48%) in the Eastern Cape are overcrowded, compared to relatively fewer in the Western Cape (39%) and Gauteng (25%).

TABLE 2.5:
Access to water and toilets by race

	African	Coloured	Indian	White	Total

Facility	%	%	%	%	%
Access to water: Tap in dwelling	19	83	99	100	42
Tap outside house	29	14	1	0	21
Tap outside grounds	25	2	0	0	18
Tanker	3	0	0	0	2
River/stream/dam	17	1	0	0	12
Borehole/protected spring/well	6	0	0	0	4
No main source	1	0	0	0	1
Total	100	100	100	100	100
Access to toilets:					
Flush inside dwelling	17	79	100	100	40
Flush outside dwelling	18	7	0	0	14
Ventilated pit latrine	2	0	0	0	2
Pit latrine	43	3	0	0	30
Bucket	4	8	0	0	3
None	16	3	0	0	11
Total	100	100	100	100	100
Electricity in the household					
Yes	41	89	100	100	58
No	59	11	0	0	42
Total	100	100	100	100	100

- Table 2.5 indicates that most coloured (83%), almost all Indian (99%) and all white (100%) households have a tap inside their dwelling, compared to just under one fifth of African households.

- Among Africans, 17% of household members use a river, stream or dam as their main water source.
  - Use of these sources of water supply varied according to province. In the Eastern Cape, the figure is 47%, decreasing to 31% in KwaZulu-Natal, 12% in the Eastern Transvaal, 8% in the Northern Transvaal and 1% in the Free State. Nobody in the Western or Northern Cape, the North West or Gauteng used these sources.

- In slightly over half (52%) of the African households, someone was required to fetch water for daily use from a source outside the grounds of the dwelling, compared to a small proportion among coloureds (2%) and none among Indians or whites.

- Among those African households where water has to be collected from an outside source, we examine the time that it takes to reach this source.
  - Forty two percent of people from these households could reach this source in five minutes or less and 27% could reach it in more than five minutes and less than a quarter of an hour. A further 15% could reach the source in a quarter of an hour or more, but less than 30 minutes, while 10% took between 30 and 60 minutes. Six percent (members of approximately 157,000 households) took more than an hour to reach this source.
  - Once reaching this source, 60% of people who collect water find that they have to queue. Almost one fifth (19%) spend more than half an hour waiting to collect water at the collection point.

- When asked whether or not there is a toilet inside the dwelling or nearby that members of the household can regularly use, Table 2.5 indicates that 89% of respondents answered positively.

- Eighty four percent of African households have access to a toilet, compared to 97% of coloureds and 100% Indians and whites.

- A large proportion of African households use pit latrines (43%), while 2% use a ventilated pit latrine and 4% a bucket toilet.

- When examining those African households that do not have access to a toilet at all (16% overall), we find that there is a great deal of variation by type of housing and province.
  - A large proportion of members of households living in traditional dwellings (44%) do not have access to a toilet, compared to those living in shacks (8%) or brick houses (8%).
  - Proportionately more members of households in the Eastern Cape (35%), KwaZulu-Natal (19%), the Free State (18%) and the Northern Transvaal (17%) do not have access to a toilet, compared to the Northern Cape (10%), the North West (9%), the Eastern Transvaal (7%),the Western Cape (3%) and Gauteng (1%).

- Proportionately more households where the overall health of members was rated by the health-care person as excellent (63%) or very good (55%) have flush toilets than households where health was seen as poor (45%).

- Table 2.5 further shows that access to electricity is also clearly divided along racial lines. White and Indian households all (100%) have electricity and 86% of coloured households (86%), but over half (59%) of African households are not electrified.

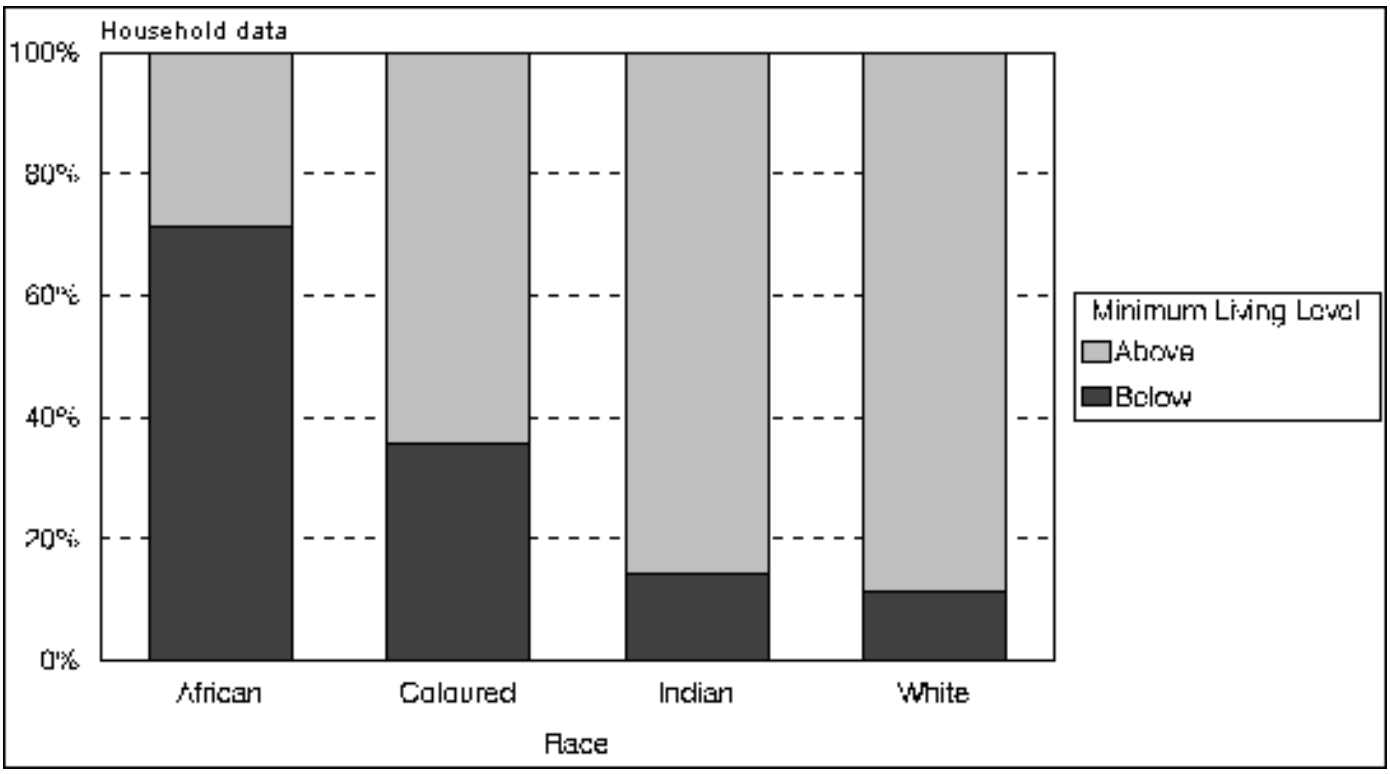
- Respondents in households with flush toilets were more likely to rate their health as excellent (63%) or very good (55%), compared to the 45% who rated their health as poor.

Socio-economic factors relating to health

Income

- Monthly household income was divided into two categories according to the classification of the Bureau of Market Research of the University of South Africa:
  - Those households with a total income of R 900 or more were classified above the minimum living level,
  - those with a total income of up to R 899 were classified as at or below minimum living level.

FIGURE 2.3. Minimum Living Level by Race (Excluding 10% Refusals)



- In this analysis, we only examine cash earnings. We do not take into account the cash value of items such as food obtained from subsistence farming. When we examine hunger in the next section, the importance of subsistence farming becomes apparent.

- Figure 2.3 clearly illustrates that the vast majority of African households (72%) have incomes below the minimum living level. On the other hand, most white (89%) and Indian (86%) households, and a majority of coloured (64%) households have incomes above the minimum living level.

- Among Africans:
  - Altogether, approximately 3,5 million African households of the 4,7 million where the respondent answered this question have incomes below the minimum living level.
  - The only province where slightly more than half of the households have incomes above the minimum living level is Gauteng (51%).
  - In the Western Cape, just under one third of African households (32%) have incomes above this level.
  - In all the other provinces members of three quarters of African households or more were living in poverty at or below this level.
  - Those living on white-owned farms in rural areas are the most impoverished, with only 7% of households having incomes above the minimum level.
  - A high proportion of those living in rural areas that were previously part of the homeland system are also impoverished, with 18% having incomes above this level.
  - Those in informal settlements in metropolitan areas are better off, with 32% having incomes above the minimum living level, while more than half of those households in formal, brick housing in metropolitan areas (54%) have incomes above this level.

- The majority of African (72%) households have only one person earning an income, even though these households often contain extended families.
  - On average, there are 5.2 people per African household, and 18% contain eight or more people.

- Coloured households also often contain extended families. On average, these households contain 5,3 people, while 16% contain eight or more people.
  - Roughly a third (36%) have only one person earning an income.

- Almost half of Indian households (49%) contain only one income earner, but family size tends to be smaller (4.5 people per household, on average, with only 4% containing eight or more people).

- The majority of white households (58%) contain only one income earner, but they tend to consist of small, nuclear families (2.7 people per household, on average, with none containing eight or more people).

Hunger Status

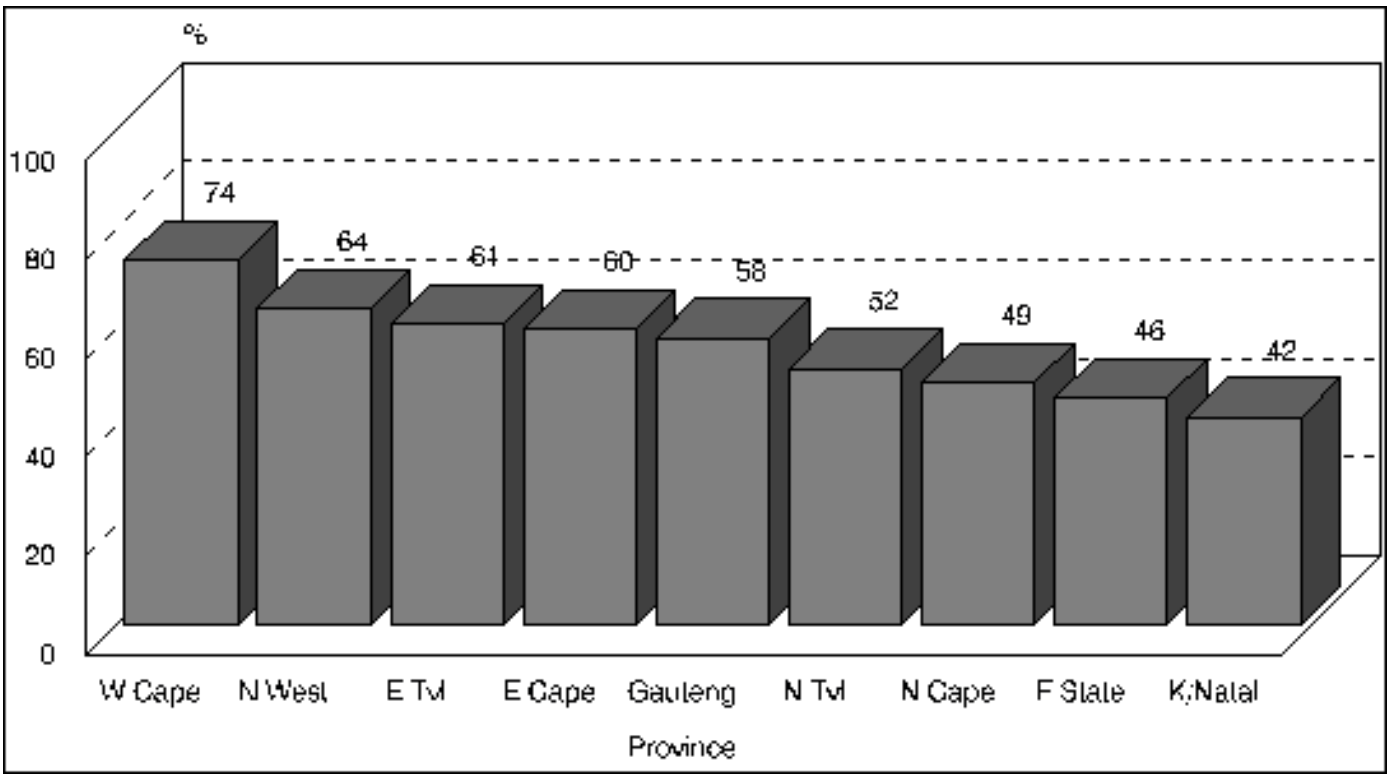
The person in the household responsible for health-care was asked to indicate whether members of the household often, sometimes, occasionally or never go hungry. When interpreting these findings, the reader should bear in mind the possibility of under-reporting. There may be a stigma attached to being unable to feed a family member. Obtaining food through subsistence farming may also account, in part, for these findings.

- Fifty five percent of African households reported difficulty feeding themselves; of these 7% said they often go hungry, 31% sometimes, and 17% occasionally.

- Seventy one percent of coloured households, 97% white and 98% Indian households, said that members of the family never go hungry.

- There is a clear relationship between hunger status and minimum living level. Households whose members often go hungry are more likely (88%) to have incomes below the minimum living level.

Figure 2.4. Africans Who Go Hungry Occasionally by Province

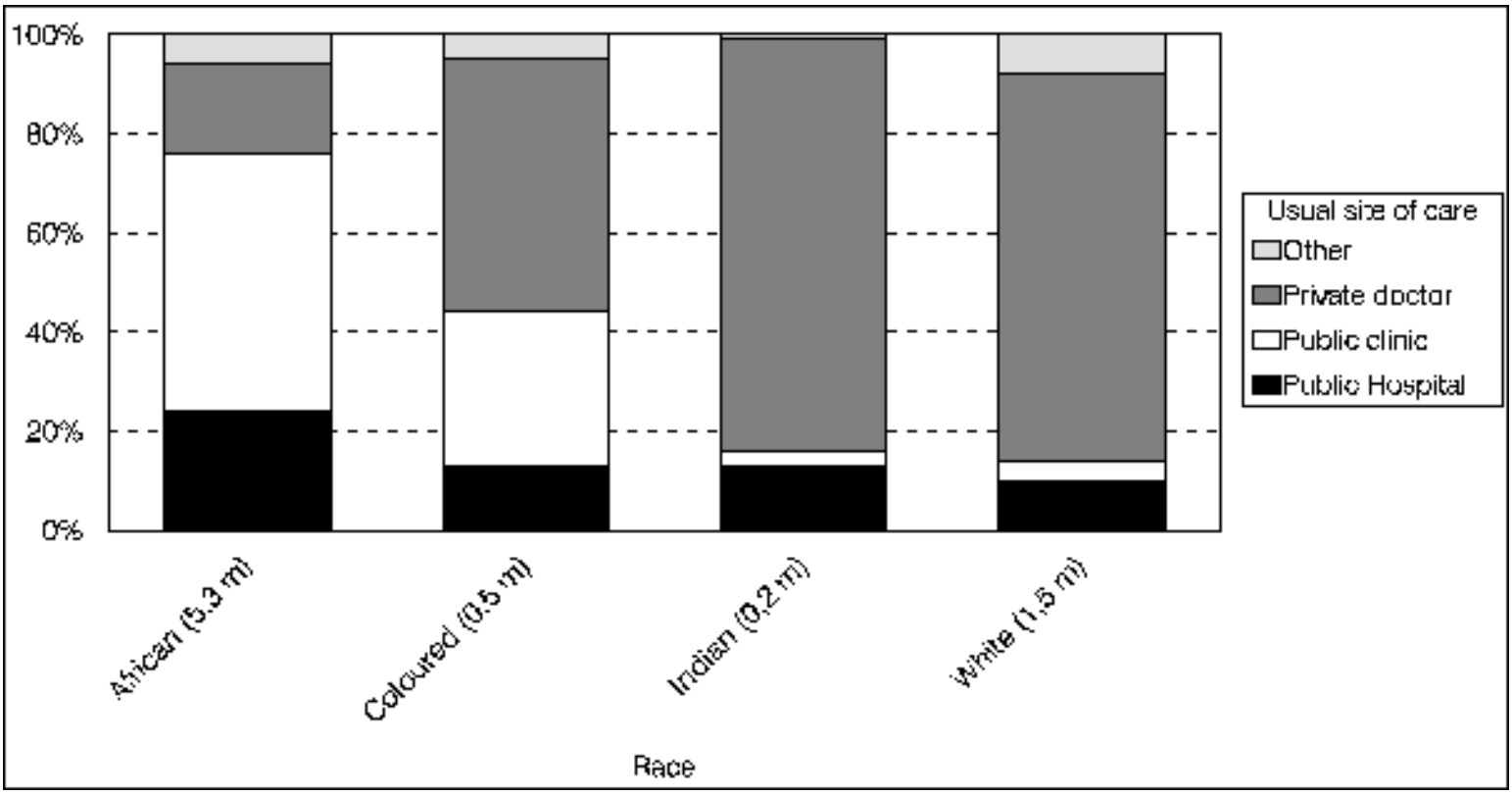


- The benefits of subsistence farming to the relatively large proportion of households classified below the minimum living level but who said they never go hungry (39%) needs further exploration. Among Africans, Figure 2.4 indicates that:
  - In those provinces where subsistence farming is unlikely to occur because they are largely urban, for example the Western Cape (74%) and Gauteng (58%), proportionately more caretakers than average report that members of their households at least occasionally go hungry.
  - In those provinces where subsistence farming is more likely to occur, for example KwaZulu-Natal (42%) and the Northern Transvaal (52%), proportionately fewer caretakers than average report that members of the household at least occasionally go hungry.
  - Subsistence farming may therefore compensate, in part, for extremely low cash incomes.

Having a Usual Site of Health Care

- Almost all respondents (99%) said they were aware of a usual site of health care. This question did not relate to any barriers to access or cost, but merely awareness of the availability of care.

Figure 2.5. Usual Site of Health Care by Race



- Figure 2.5 indicates that the vast majority of Africans (76%) rely on the public sector (clinic or hospital) as their usual site of health-care, while only 44% of coloureds, 16% of Indians and 14% of whites use public health facilities.

- Among Africans, those who live in households in provinces which contain former homelands are more likely to indicate a hospital as their usual site of care, compared to those who live in provinces which are more metropolitan. For example, 38% of African households in the Northern Transvaal use a public hospital, compared to 16% in Gauteng.

Non-Financial Factors Inhibiting Access to a Usual Site

One factor limiting access to a usual site of care is the time taken to reach it. Another is the time spent waiting to be seen. These issues are explored in more depth in a subsequent chapter. In this section, we pay attention to opening times of the usual health-care site.

TABLE 2.6:
Frequency of opening and opening times of usual site of care, and whether there are alternative services for emergencies, by race

	African	Coloured	Indian	White	Total
Opening times of health-care site	%	%	%	%	%

Frequency of opening:					
Every day, incl. w/ends	61	53	78	63	61
Every day, excl. w/ends	32	44	21	33	33
Less frequently	7	3	1	4	6
Total	100	100	100	100	100
Length of time when open:					
24 hours	40	22	14	26	35
Working hrs & extra	12	32	73	43	40
Normal working hrs	44	41	11	30	3
Only a few hrs	4	5	2	1	100
Total	100	100	100	100	
Alternative for emergency:					
Yes	65	88	95	94	73
No	35	12	5	6	27
Total	100	100	100	100	100

- Table 2.6 indicates that a large proportion of Indian (78%) respondents said that the household's usual health-care site was open every day including weekends, while proportionately fewer white (63%) African (61%) and coloured (53%) respondents gave this answer.

- Proportionately more (89%) of those in households whose usual health-care site is a public hospital had access to this site every day including weekends compared to those whose usual health-care site was a private doctor (62%) or a public clinic (46%).
  - Among Africans, as we noticed before, those in remote rural areas tended to mention a hospital as their usual site of care. Therefore it is not surprising that this service is available every day including weekends. What needs to be considered is the time taken to reach this site and the time spent waiting for care, which will be covered in a later chapter.

- Relatively few household members (35%) have access to 24 hour care from their usual site.

- Most households (73%) have an emergency site of health-care if their usual site of health-care is closed. However, 35% of those in African households in contrast to 12% of coloured, 5% of Indian and 6% of white households do not have access to emergency care.

- Proportionately more household members based in provinces which contain metropolitan centres have a site of emergency care (Western Cape 86%, KwaZulu-Natal 77%, Gauteng 78%) than other provinces such as the Eastern Cape (68%) or the Northern Transvaal (61%).

TABLE 2.7:
Affordability of health-care by race

	African	Coloured	Indian	White	Total
Paying for health-care	%	%	%	%	%
Belonging to medical aid/health insurance: Yes	10	36	41	76	26
No	90	64	59	25	74
Total	100	100	100	100	100
Paying for medical treatment:					
Very easy	23	7	8	26	22
Fairly easy	20	25	29	37	24
Fairly difficult	21	24	31	22	22
Very difficult	36	44	32	15	32
Total	100	100	100	100	100
Paying for prescribed medicine:					
Very easy	15	7	7	27	27
Fairly easy	13	25	28	36	36
Fairly difficult	19	17	27	21	21
Very difficult	53	51	38	16	16
Total	100	100	100	100	100

- Table 2.7 indicates that 90% of Africans do not have medical insurance. However 76% of white households, 41% of Indians and 36% of coloureds do indeed have medical insurance.

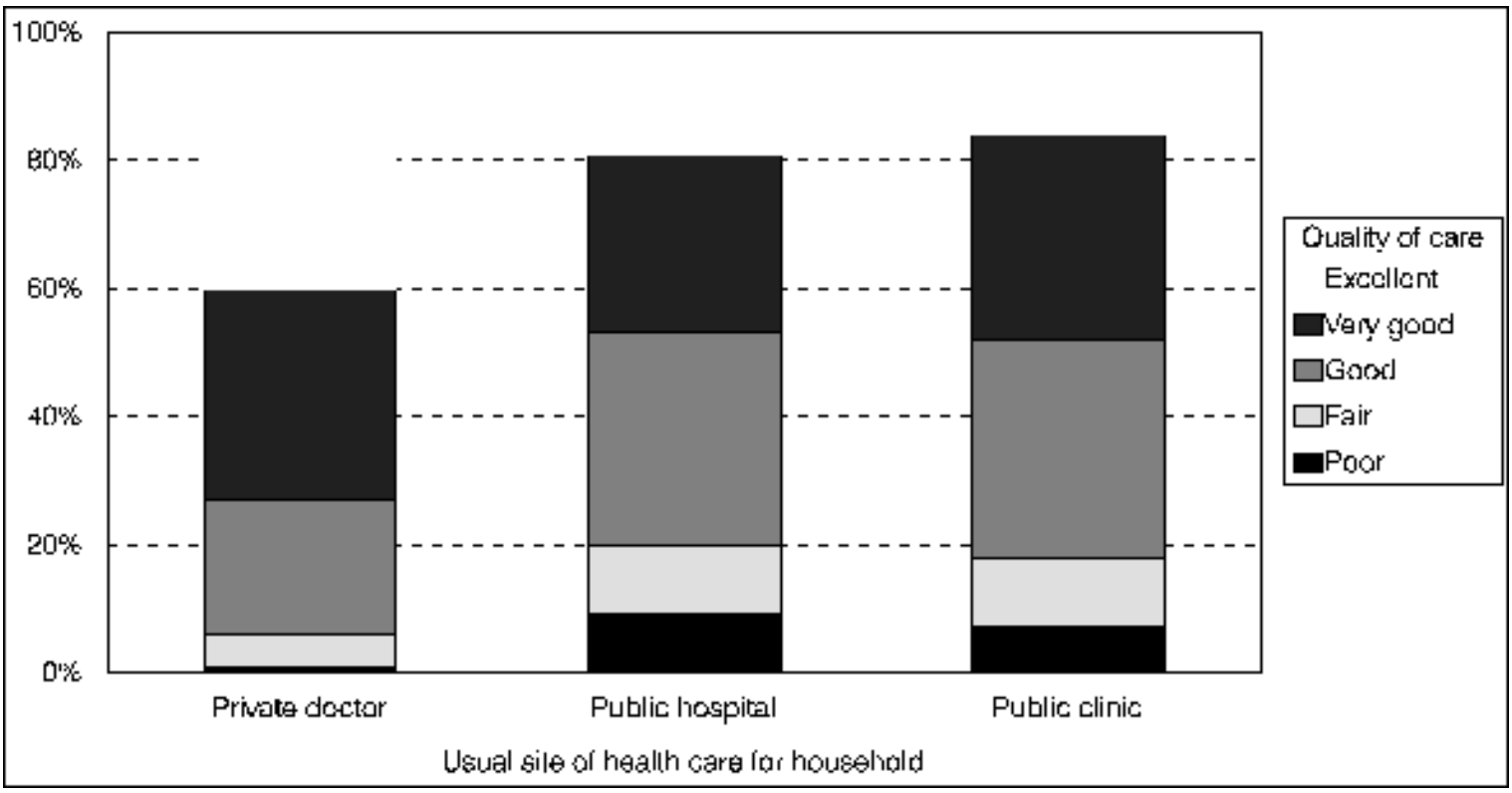
- Among those households where members do have medical aid or other health insurance, 60% of Africans, 75% of coloureds, 94% of Indians and 94% of whites go to a private facility. Those without medical aid tend to use public health facilities.

- Table 2.7 shows that paying for health care is difficult or very difficult for a large proportion of households.

- Over two thirds of African respondents (68%) said that paying for medicine was difficult or very difficult.

Quality of Care

Figure 2.6. Rating of Quality of Health Care Received at Usual Site



- When the caretakers were asked to rate the quality of health-care which the household receives, members of African (55%) and coloured (47%) households are less likely to rate this care as excellent or very good compared to those in Indian (65%) and white (76%) households.

- Figure 2.6 shows that proportionately more of those that use public facilities rate the health-care they receive as fair or poor, compared to those that use private facilities.

- Among Africans, proportionately fewer of those living in traditional dwellings (17%) and shacks (21%) rated the health-care that they received as excellent, compared to those living in formal brick housing in metropolitan areas (30%).

Summary and Conclusions

This chapter clearly shows that African households, which form the vast majority, are more likely to be impoverished and overcrowded, compared to coloured, Indian or white households. They are also less likely to have access to piped water, toilets and electricity. In rural areas, people spend a large proportion of time fetching water. These life circumstances tend to place Africans at greater risk for contracting preventable infectious diseases.

The caretaker in African households is likely to have a lower level of education compared to caretakers in the other race groups. The health risks related to lower levels of education will be explored more fully in subsequent chapters.

Coloured households are more likely to resemble African than Indian or white households. For example, they tend to contain extended families and the caretaker tends to be poorly educated.

Regarding access to health-care, almost all respondents were aware of a site where they could

receive health-care. Among Africans and to a lesser extent among coloureds, this site tended to be a public clinic or hospital, while Indians and whites used a private doctor.

Barriers regarding access to health-care facilities explored in this chapter include costs of care, opening times of services and alternatives for emergencies. Other barriers to access will be explored in later chapters.

Lack of membership of a medical aid or health insurance scheme was associated with utilization of public services rather than private care. Those who used public services were more likely to rate them fair or poor, compared to those who used private doctors.

This description of households forms the background against which the health status and utilization of services by individual members in different age categories, discussed in subsequent chapters, should be viewed.

*** All tables, figures, graphs and other data analysis in this and subsequent chapters are based on weighted data. In this chapter the data have been weighted to the universe of households in South Africa, taking into account the distribution of households within provinces, population groups, and milieux (i.e. metro, urban or rural).**
**** As members of households in this chapter, and as individuals in later chapters, the African population is the primary focus of study, because of its historically disadvantaged position relative to the rest of the population.**
***** In this report, when discussing provinces, the reader should bear in mind that certain of them, for example, the Northern Transvaal, contain large proportions of households that were part of households that were part of the apartheid homeland system, while others, for example, the Western Cape, do not. As we shall see, poverty is more common, and access to toilets, clean water and health care is less common, in those provinces which include former homelands.**

Chapter 1 Back to Contents Chapter 3

Chapter 3.
Research Findings: Children Aged Five Years and Younger

A National Household Survey of Health Inequalities in South Africa

Kim Segel and Ros Hirschowitz

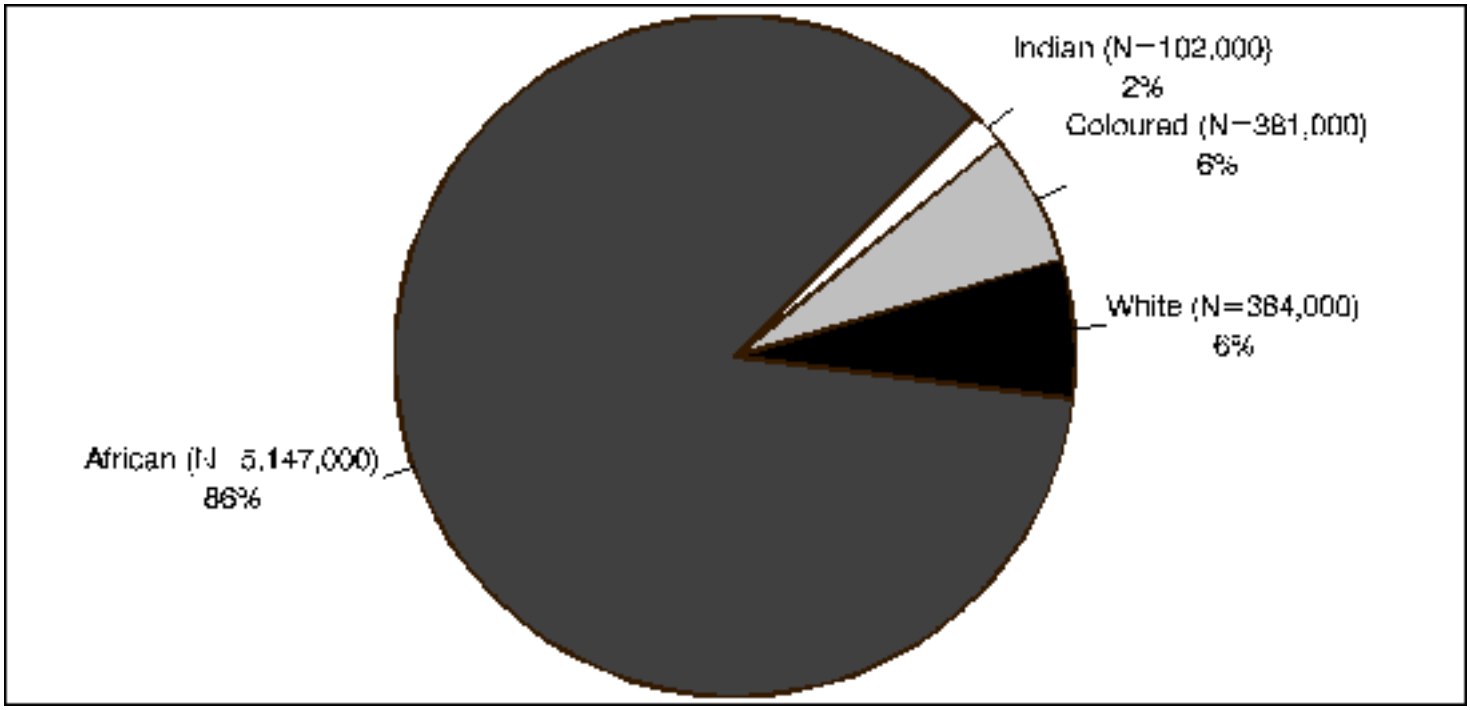
CHAPTER THREE.

Introduction

This chapter looks at the health status and health needs of young children in South Africa*.

Figure 3.1 indicates the proportion of children by race aged nought to five years.

FIGURE 3.1. Proportion of Children Aged Five Years or Younger by Race



Total number of children aged - 5 years = 6,014,000 C A S E survey for Kaiser Family Foundation

- According to the 1991 census, supplemented by estimates of population size in the former "independent" homelands, there are approximately 6 million children aged nought to five years in South Africa. This constitutes 16% of all people in the country. Seventeen percent of Africans fall into this age category, compared to 13% of coloureds, 11% of Indians and 8% of whites.

- Figure 3.1 shows that six out of every seven children (86%) in this age category are African.
  - As we shall see in later chapters, this proportion of Africans in relation to the other race groups gradually decreases as age increases.

Selecting a Child in the Household for the Study

- Nearly half of all households (49%) in the survey have at least one child aged five years or younger.
  - African (59%) and coloured (50%) households are more likely to have at least one child aged five years or younger compared to their Indian (36%) and white (18%) counterparts.

- In all households that contain children aged five years or younger, information was gathered on only one child.
  - Where there was more than one child in the household, a random selection grid was used to select the child about whom information was given.
  - The health-care person was used to obtain information on this child.

Indicators that Apply to this Chapter

Indicators identified for this age category include:

- The immunisation of the child as measured by percentage of children who are fully immunised for age.
- Preventative care as measured by the percentage of children who were breast-fed for at least six months.
- Under-nutrition as measured by:
  - the percentage of children whose caretaker was told by a health professional that they weigh too little, and
  - the percentage of caretakers who say they do not have enough money to feed the child adequately.
- Health care in the first year of life.

TABLE 3.1:
Biographical Description of the Sample

	African	Coloured	Indian	White	Total
Biographical variables	%	%	%	%	%
Age: Up to six months 7 - 12 months 13 - 24 months 3 - 5 years Total	8 10 27 55 100	11 8 27 54 100	8 7 29 56 100	5 11 27 57 100	8 10 27 55 100
Gender: Male Female Total	50 50 100	50 50 100	51 49 100	51 49 100	50 50 100
Birth certificate: Yes*	41	94	96	98	49

*** The balance of this percentage adds up to 100%**

Table 3.1 indicates the age and gender breakdown of the sample of children aged nought to five years.

- As would be expected, the proportion of children in each age category is similar between races and there are equal proportions of male and female children across all race groups

- However, 59% of African children do not have a birth certificate.

- The absence of this certificate makes it difficult to compile national statistics on the health of these children or on other life circumstances affecting them.

Home Circumstances of the Children in the Sample

In this section, we examine the home background of the children aged nought to five years constituting the sample. In particular, we examine demographics, such as province and area in which they live, and socio-economic factors such as type of dwelling, crowding within households and access to electricity, piped water and toilets.

The research findings indicate that:

- The vast majority of African children live in rural areas (70%), including white-owned farms (12%), and former homelands (58%), in contrast to children in the other race groups, where the vast majority are living in urban or metropolitan areas.

- In Chapter 2, we indicated that 43% of households are situated in the rural homelands, and we now find that 58% of infants and pre-school children are living in these households. There are at least two explanations for this finding:
  - Some parents in metro and urban areas send their children to live in extended families in rural areas, while they continue to work in the towns and cities.
  - The birth rate is higher among Africans living in rural homeland areas.

- The distribution of children according to province varies by race, with coloured children largely found in the Western Cape, Indian children in Natal, while white and African children are found in all provinces.

  - A large proportion of African children in the sample live in those provinces in which the former homelands were situated, for example, 24% live in KwaZulu-Natal, 21% in the Eastern Cape and 19% in the Northern Transvaal, while proportionately fewer live in the Western Cape (2%), the Northern Cape (1%) or Gauteng (9%), where there were no homelands.

- Whereas almost all coloured, Indian and white children live in formal brick houses, only 58% of African children do; 31% live in traditional dwellings and 11% live in shacks. This finding can be explained in part by the greater proportion of African children living in rural areas.

- Almost two thirds (66%) of the African, and more than half (57%) of coloured children live in overcrowded households compared to proportionately fewer Indians (17%) and whites (1%). We noted in Chapter 2 that a large proportion of traditional dwellings (63%) are overcrowded.

- Furthermore, 76% of African children live in households subsisting below the minimum living level as against 31% of coloured, 14% of Indian and 3% of white children.

- Seventy percent of African infants and young children live in households which do not have electricity, while 32% live in households where someone fetches water for daily use from a river, stream or borehole, and 22% live in households where there is no toilet facility.

Subjective Perception of Health Status of the Child

The respondents were asked to indicate how healthy they thought the child was compared to other children of that age on a five point scale ranging from excellent, through very good, good and fair to poor.

- Overall, 29% of respondents think that the child's health is excellent, 33% think it is very good, 26% said it was good, 10% fair and 3% poor.
  - These ratings are similar across race groups. Reasons for this may be that subjective perceptions are based on different reference groups, when comparing the child to others, diverse life experiences and different expectations regarding what health means. In the focus groups of African mothers, we found that health meant absence of disease, rather than general well-being.

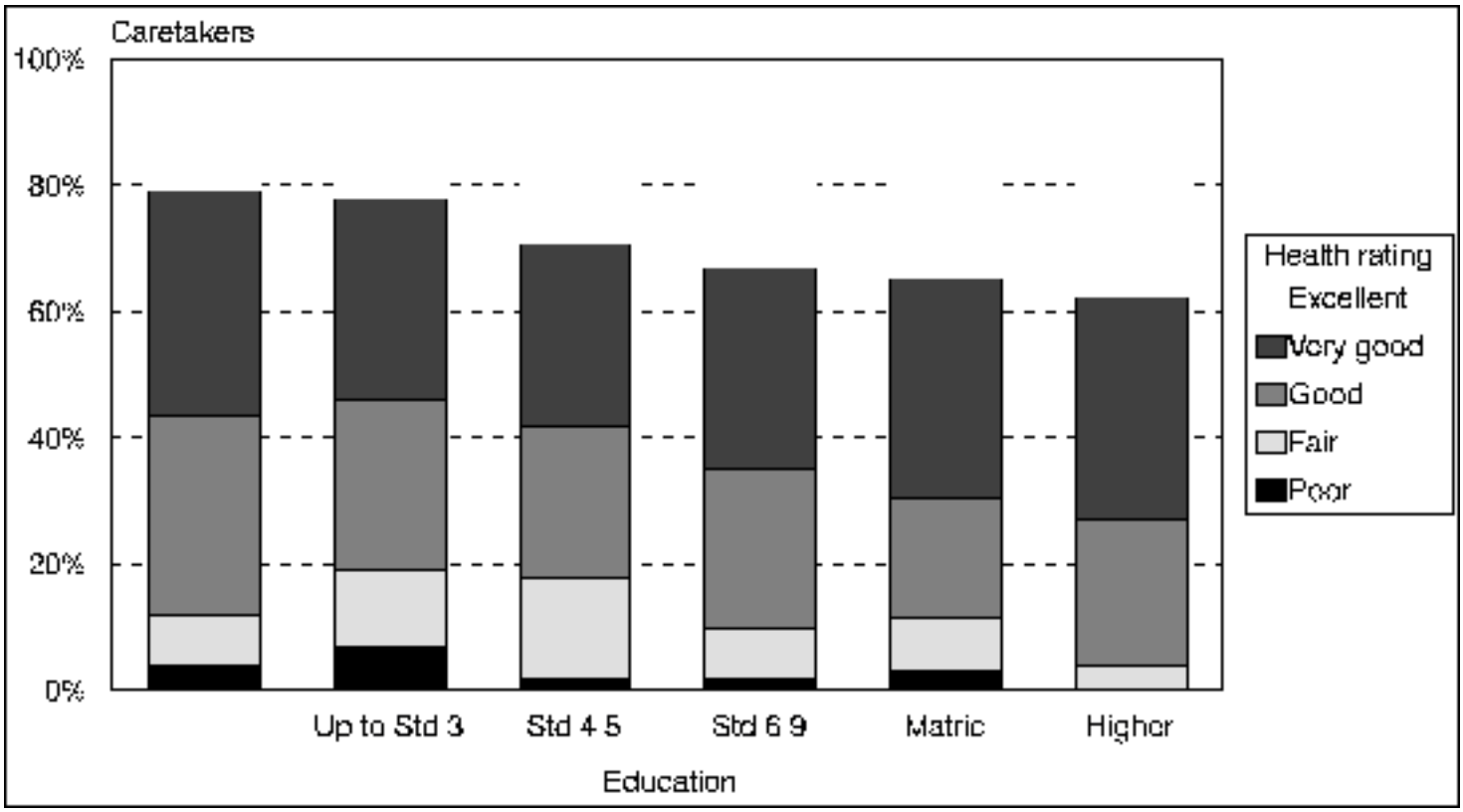
- However, caretakers who were told by a health care professional that the child weighs too little are more likely to think that the child's health is fair or poor (29%), compared to those who were never told this (11%).

- Those who report being too poor to feed the child adequately are more likely to rate the child's health as fair or poor (24%) than those who did not report this type of poverty (10%).

- Among Africans, socio-economic circumstances influence this health status rating.
  - Proportionately more caretakers living in overcrowded households (15%) or below the minimum living level rate the child's health as fair or poor (15%) compared to those living above it (10%).
  - Proportionately more living in metropolitan informal areas (22%) and on white-owned farms (16%) said that the child's health was fair or poor, compared to those living in metropolitan formal areas (11%).
  - Caretakers of children living in provinces which are more rural are less likely to characterise their child's health as excellent. For example, 13% of those in the Northern Cape and 16% in the North-West believed that the child's health was excellent, compared to 37% in Gauteng and 33% in the Western Cape.

- Another important variable influencing perceptions of the child's health is level of education of the caretaker. Figure 3.2 shows that, among Africans, the higher the level of education the more likely the caretaker is to report the health of the child as very good or excellent.

FIGURE 3.2. Africans Rating of Child's Health Status by Caretaker's Level of Education



Children 5 years and younger C A S E survey for Kaiser Family Foundation

Immunisation Status

The spread of communicable diseases such as measles and tuberculosis can be can be effectively controlled through immunisation. We therefore examine the extent to which infants and pre-school children are immunised.

- The following is an example, given by the Johannesburg City Council, regarding when immunisations are usually given in the first two years of life. There may be some slight variation in other provinces, districts or areas regarding times when these are given, depending on the health authority concerned.
  - Coverage against tuberculosis (BCG) is given at birth, and if there is no scar, it is repeated at three months. At two years, the child should have received at least one inoculation.
  - Polio is also usually given at birth and then again at three months, four and a half months, six months and 15 to 18 months. At two years, the child should have received at least four doses.
  - Immunisation against diphtheria, whooping cough and tetanus (DWT) is given at three months, four and a half months, six months and then again at 15 to 18 months. At two years, the child should have received four DWT injections.
  - Measles is given at nine months and is usually repeated at 15 to 18 months. At two years of age, the child should have received at least one measles vaccine.

- To assess the immunisation status of children aged five years and younger, the field-workers asked the respondents to show them a "Road to Health" or similar card, completed by private doctors or staff in clinics and hospitals each time the child receives a vaccination. If such a card was produced, the immunisation status of the child was read directly from it, but if not, we relied on the memory of the caretaker.

"Road to Health" Cards

- Of the 94% of caretakers who claimed that the child had a "Road to Health" card, only 56% were able to produce it.
  - A similar proportion of respondents in all race groups produced this card.
  - Respondents living in informal metropolitan areas (67%) were most likely to produce these cards, followed by those living in formal metropolitan areas, and in both formal and informal urban areas, and on white-owned farms (all 59%) as compared to those living in rural homeland areas (54%).

- Female caretakers (57%) were more likely to produce cards than were male caretakers (35%).

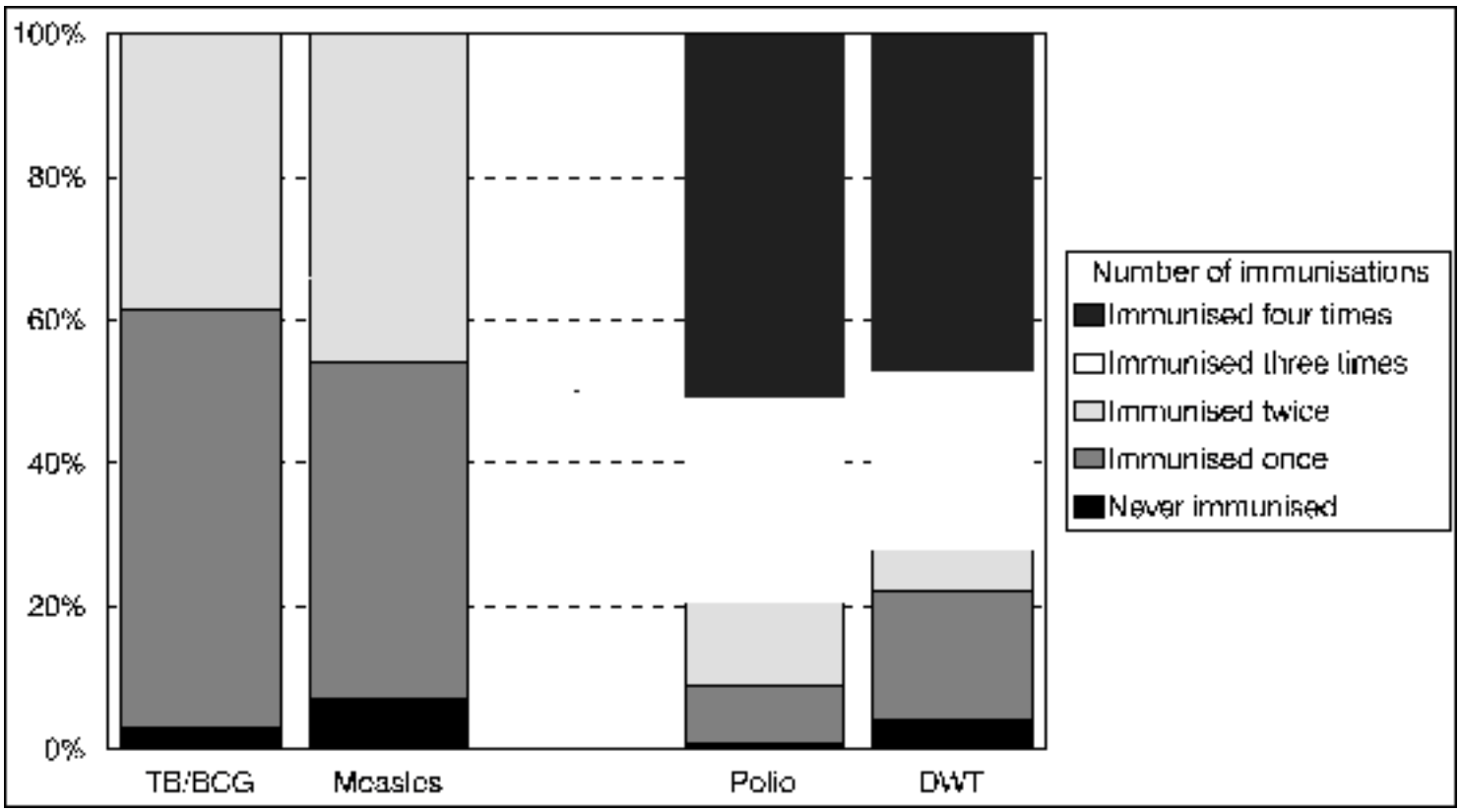
Using Two Year Olds to Assess Immunisation Status

- In this section, we examine the immunisation status of the two year olds in the sample. We chose this age group because by this age the first round of inoculations and boosters, including tuberculosis (BCG), diphtheria, pertussis and tetanus (DWT), polio and measles, should be complete.

- We discuss the immunisation status of those whose caretakers had produced cards, and those who had not, separately.

- Figure 3.3 indicates that the vast majority of children at age two years whose caretaker could produce a "Road to Health" card had been immunised at least once against tuberculosis (97%) and measles (93%). But relatively few had received four polio (51%) or four DWT (47%) immunisations.

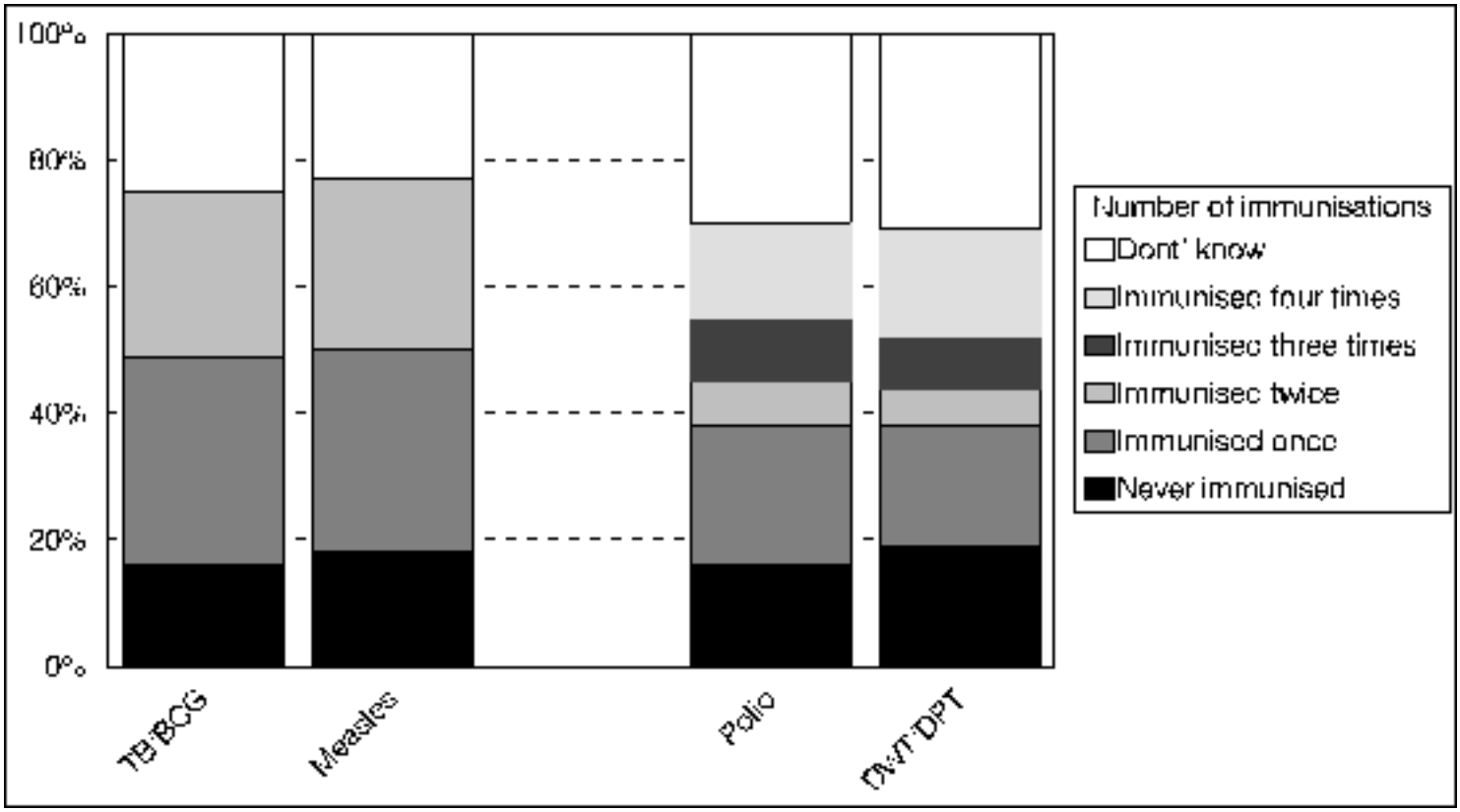
FIGURE 3.3. Immunisation Status of Two Year Olds Whose Card Was Seen by the Fieldworker



Children 5 years and younger C A S E survey for Kaiser Family Foundation

- Figure 3.4 shows that a relatively larger proportion of caretakers who did not produce a "Road to Heath" card, compared to those who did, said that their child aged two years had not received any BCG (16%), measles (18%), DWT (19%) or polio (17%) vaccines.

FIGURE 3.4. Immunisation Status of Two Year Olds Whose Cards Were Not Seen



Children 5 years and younger C A S E survey for Kaiser Family Foundation

- In addition, the graph indicates that there are relatively large proportions of respondents who indicated that they do not know the immunisation status of the child. (BCG %, Measles %, DWT % Polio %).
  - The "don't knows" include those who do not know whether or not a child has received a specific vaccine and those who do not know how many of each kind the child may have received.

Findings Related to the BCG Vaccine

- BCG is generally given at birth, therefore it is possible to compare vaccination status across all ages among infants and pre-school children.

- Among those who produced a "Road to Health" card, 97% of children had received this vaccine, and there was very little variation by race, province, area in which they lived, type of housing, overcrowding or household income.

- Among those who did not produce a card, relatively fewer (86%) said that their child had received this vaccine.
  - There was some variation between races (83% of Africans, 98% of coloureds, and 100% of Indians and whites) and provinces (lowest in the Eastern Transvaal at 66% and the Free State at 72%) regarding the proportion who had received this vaccine.
  - Respondents with no formal schooling (76%), those living on white-owned farms (77%), those with incomes below the minimum living level (81%) and those in homes without electricity (82%) were less likely than average to say that their child had received this vaccine.
- Socio-economic status is therefore directly linked to BCG immunisation status. Improvement in the education level of caretakers, together with the improvement of living conditions, should in future contribute to better immunisation status.

Under-Nutrition

A major health risk to infants and young children is under-nutrition, because it directly affects normal growth and development. In addition, communicable diseases and deficient nutrition are closely interrelated. For example, severely undernourished children experience four times the number of attacks of diarrhoea per year than adequately nourished children. Under-nutrition also makes any infection more severe, which in turn influences the extent of malnutrition as a result of loss of appetite (Sanders and Carver, 1985).

- To examine under-nutrition in the sample, caretakers were asked to indicate whether or not:
  - a health professional had ever told them that the child weighs too little for his or her age and
  - whether they had ever been too poor to give the child for whom they were responsible enough food to eat.

Children who were Underweight for their Age

- The caretakers of 14% of African children had been told by health care professionals that the child weighs too little as compared with 11% of Indians, 10% of coloureds and 7% of whites.

- More caretakers of children who were told that the child was underweight lived in metro informal areas (23%) than any other area.

- Female caretakers (13%) were more likely to be told by health care professionals that the child weighed too little than male caretakers (7%).

- Caretakers with a higher level of education, for example matriculation (8%), were less likely to be told that the child for whom they cared was underweight as against caretakers with no formal schooling (16%).

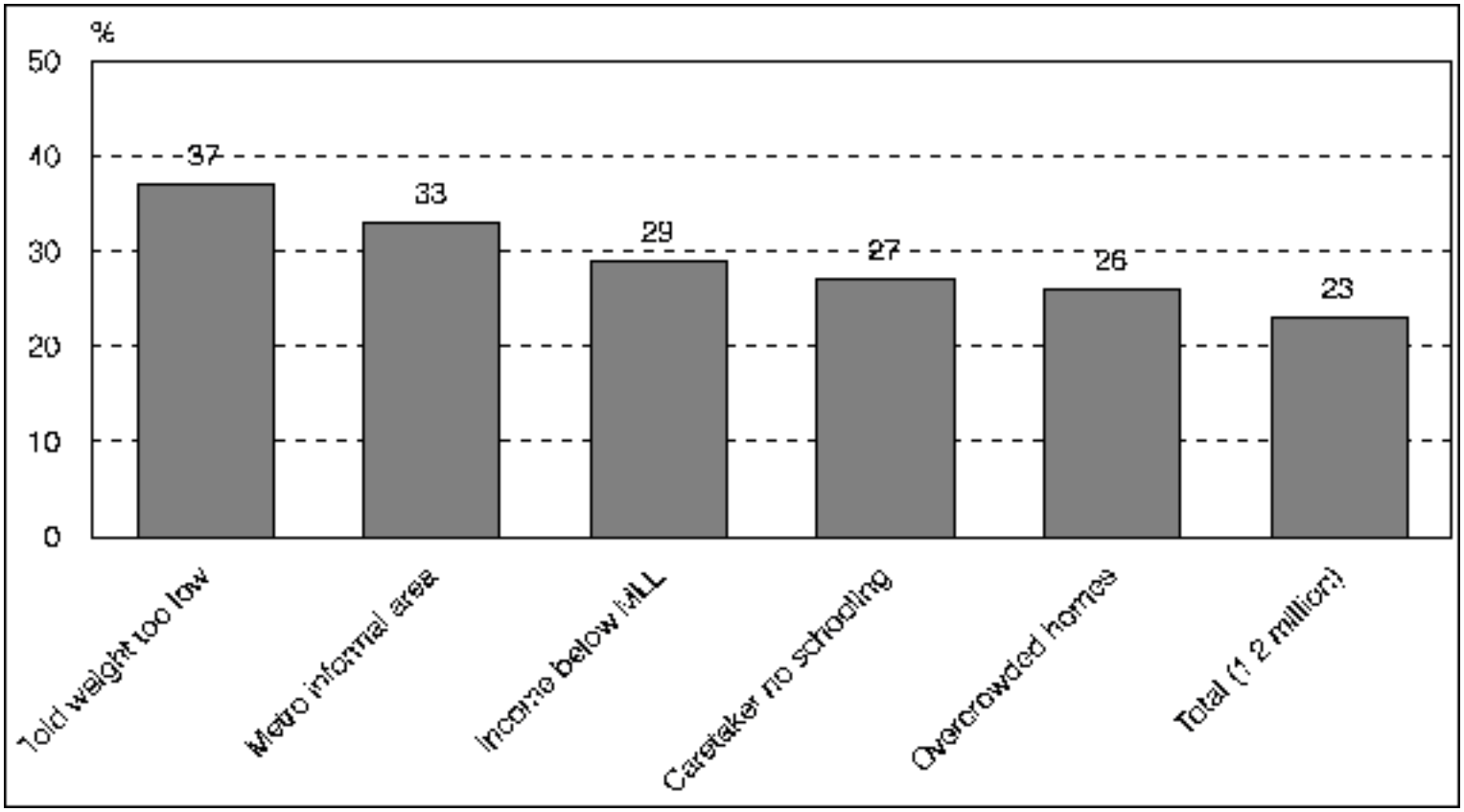
- Thirty one percent of those caretakers who characterised the child's health as poor as against 11% of those who characterised the child's health as excellent said that they had been told by a health care professional that the child weighed too little for its age.

Caretakers who Said They had been too Poor to Feed the Child Adequately

- Almost a quarter of African caretakers (23%), as against 5% of coloureds, 2% of Indians and 1% of whites said that they had been too poor to feed the child adequately.

- As Figure 3.5 indicates, among African caretakers, those who had been told by a health professional that the child weighs too little (37%), those with no schooling (27%) and those living in adverse socio-economic conditions (income at or below the minimum living level, 29%; overcrowded homes, 26%) were more likely than the total group of respondents (23%) to indicate that they had been too poor to feed the child adequately.

FIGURE 3.5. Africans Who Said Caretakers Were too Poor to Feed the Child Adequately



Children 5 years and younger C A S E survey for Kaiser Family Foundation

- Proportionately more Africans living in metropolitan and urban informal areas and in rural homelands (33%, 28% and 24% respectively) said that they had been too poor to feed the child, compared to those living in metropolitan and urban formal areas (9% and 16% respectively) and white-owned farms (18%).

- A third (33%) of Africans living in the Eastern Transvaal, and over a quarter of those living in the Western Cape, the Eastern Cape, the Northern Transvaal (28% in all three cases) and Gauteng (26%) said they had been in a position where they could not afford to feed the child aged five years and younger compared to proportionately fewer among those in the Free State and North West (19%), the Northern Cape (15%) and KwaZulu-Natal (14%).
    - Obtaining food through subsistence farming may account in part for this finding.

Food obtained from clinic, doctor or hospital

- Caretakers were asked whether they had ever obtained extra food or milk for the child from a clinic, doctor or hospital. In total, 8% obtained food from one of these sources.

- Coloureds (14%) were more likely to obtain extra food or milk for the child as against Africans (8%), Indians (5%) and whites (4%).

- Children who were given extra food and milk were more likely to live in the Western Cape (12%), the Northern Cape (12%), and the Eastern Cape (12%) than any other provinces.

- Relatively more African children living in metro informal areas had received extra food or milk (14%) as compared with those living in rural homelands (7%).

- Almost a quarter (24%) of those children whose caretakers were told by health professionals that they weighed too little were given extra food or milk as compared to 6% who were not told this.

Breast-Feeding

Poor nutrition is less likely to occur, at least in the first two years of life, among those who are breast-fed during this period. We therefore asked a series of questions about breast-feeding.

TABLE 3.2:
Extent and duration of breast feeding among children in the sample

	African	Coloured	Indian	White	Total
Breast feeding	%	%	%	%	%
Whether child was breast-fed: Yes	86	77	72	63	84
No	14	23	28	37	16
Total	100	100	100	100	100
Among those who had been breast-fed:					
Whether still being breast-fed: Yes	25	23	17	2	24
No	75	77	83	98	76
Total	100	100	100	100	100
Among those who had been breast-fed, but breast-feeding had stopped:					
Number of months child was breast-fed					
1-6 months	20	53	53	69	27
7-12 months	21	18	17	22	20
13-18 months	19	7	12	3	17
19-24 months	33	14	10	3	30
25+ months	7	8	8	3	6
Total	100	100	100	100	100
Among those who had been breast-fed, and were still being breast-fed:					
Number of months plans to continue					
1-6 months	2	9	22*	100*	3
7-12 months	9	33	25	0	11
13-18 months	10	3	14	0	10
19-24 months	61	24	25	0	58
25+ months	15	24	14	0	15
Don't know	4	8	0	0	4
Total	100	100	100	100	100

*** Number of respondents in this category less than 33, therefore % should be interpreted with caution.**

Table 3.2 indicates that five out of every six children aged five years or less (84%) in the sample have been breast-fed.

- Proportionately more Africans (86%) breast-feed their children. They also continue to do so or plan to carry on doing so for longer time periods compared to those in other race groups.

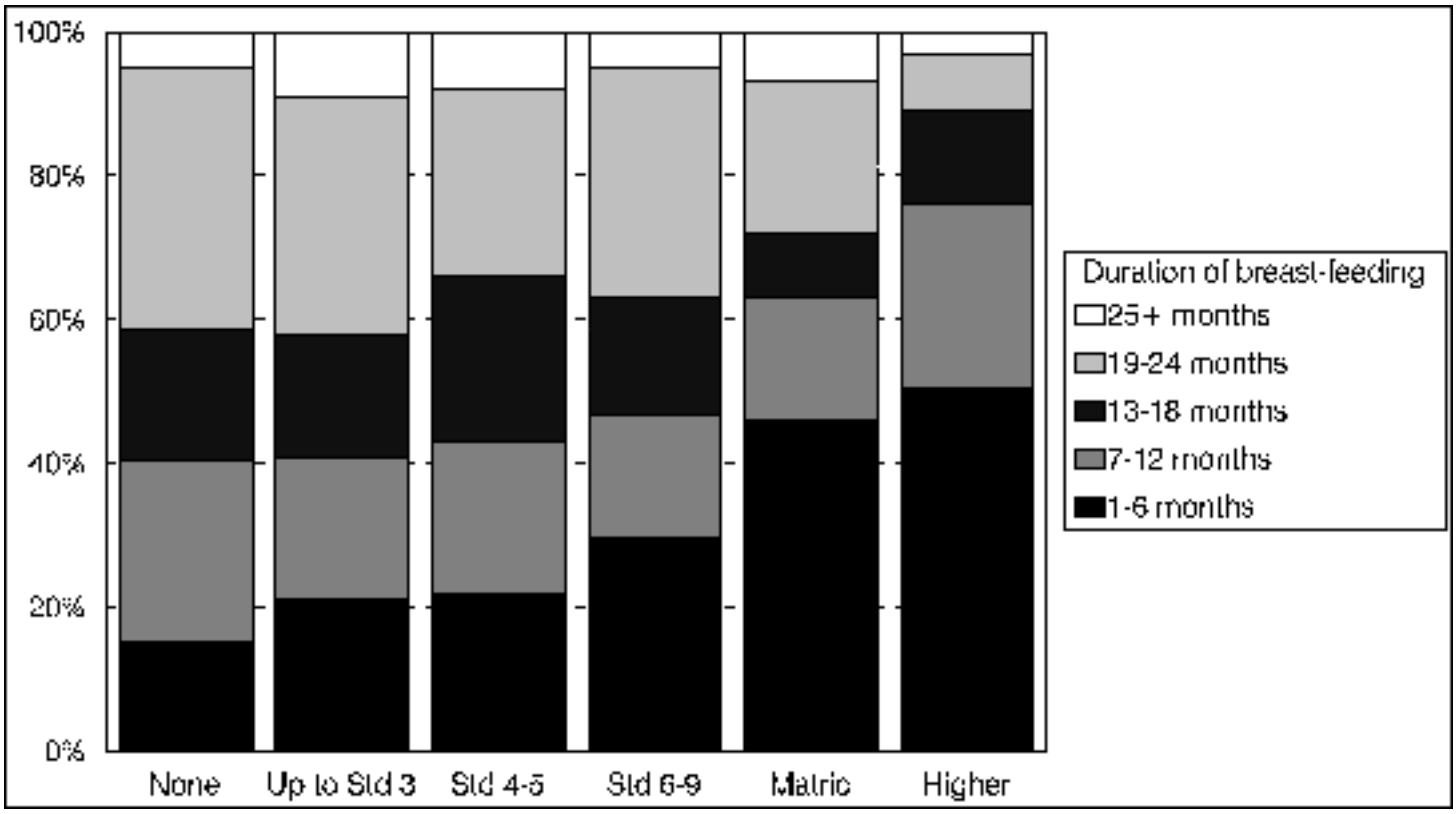
- In addition the findings show that children living in provinces which are largely rural such as the Northern Transvaal (94%), the Eastern Transvaal (88%) and KwaZulu-Natal (87%) are more likely to have been breast-fed than those living in mainly metropolitan areas such as the Western Cape (74%) and Gauteng (76%).

- Those in poorer socio-economic circumstances are more likely to have been breast-fed.
  - Children living in households subsisting below the minimum living level (86%) were more likely to have been breast-fed compared to those living above it (79%).
  - Fewer children living in households which were uncrowded (68%) were reported to have been breast-fed as against those living in overcrowded households (86%).

- The lower the education level of the caretaker the more likely the child was to have been breast-fed. For example, those children whose caretakers had post-matric qualifications (79%) were less likely to have been breast-fed than those children whose caretakers had no education or else a formal education up to Standard 3 (89%).

- Figure 3.6 indicates that level of education of the caretaker is inversely related to the length of time that the child is breast-fed.

FIGURE 3.6. Duration of Breast Feeding by Education Level of the Caretaker



- A large proportion (36%) of weaned children whose caretakers had no formal schooling were breast-fed for 19- 24 months as against proportionately fewer (8%) of those with post-matriculation qualifications.

TABLE 3.3:
Among weaned children, duration of breast-feeding by household income

	Above minimum level	Below minimum level	Total
Duration of breast-feeding	%	%	%
1-6 months	38	20	26
7-12 months	21	21	20
13-18 months	13	18	17
19-24 months	23	34	30
25+ months	5	7	6
Total	100	100	100

- Table 3.3 indicates the inverse relationship between length of breast-feeding and household income. Those living at or below the minimum living level tend to breast-feed for longer, compared to those living above it.

Health Care During First Year of Life

A further health indicator is the percentage of children aged five years and younger who went for check-ups at a doctor, clinic or hospital at least once every second month during their first year of life.

- Generally, more than three quarters of the respondents(78%) said that the child was taken for check-ups every second month or more frequently.
  - This finding is probably a result of over-reporting. When looking at vaccination status, the rate of visits seems much lower, and it is highly likely that a "Road to Health" card would have been examined and vaccination backlogs updated at each visit.
  - Only 8% said that the child was taken every third or fourth month, while 10% of the sample were taken for visits to the doctor or clinic less frequently than this and 4% were never taken.

- Whites (72%) were less likely, and Indians (87%) were more likely than average, to take their children for check-ups every two months or more frequently.

- Approximately one in eight children (12%) who were rated by their caretakers as in fair or poor health had never been taken for medical check-ups.

- The most common reason (57%) given for taking a child for check-ups less frequently than once every two months is that the caretaker did not think that it was necessary.
  - Proportionately fewer Africans (54%) gave this reason, compared to whites (77%) or coloureds (83%).

- Africans tended to give more diverse reasons, including being instructed by the health-care personnel to come less frequently (17%), long distances to travel (10%), lack of time or inability to get time off work (9%), expense of transport or of visits (8%), and problems related to the facility, including rudeness of staff (2%).

- Amongst Africans taking the child less frequently than every alternate month, 18% of those with no formal education and 17% of those with formal education up to Standard 3, as compared with 6% of those with matriculation, said that transport was too expensive.

- Proportionately more of those with no or some primary school education (8%) were likely to say that visits were too expensive, as against those with at least some secondary education (2%).

- Among those caretakers living in rural homelands who did not take their child for frequent medical check-ups, 13% said the clinic was too far as compared with 3% of urban formal dwellers and 1% of those living in metro formal areas.

- A larger proportion of those living in traditional dwellings (24%) or shacks, outbuildings and zozos (20%) said the clinic was too far to take the child more frequently for medical check-ups as against those living in formal brick dwellings (3%).

Summary and Conclusions

Of the approximately six million children in the country aged nought to five years, six out of every seven (86%) is African.

These African children are highly likely to be found in rural areas, either in former homelands (58%) or on white-owned farms (12%). They are also likely to be living in impoverished circumstances (76%), without electricity (70%) or without access to piped water (32%) or toilets (22%).

In spite of these impoverished circumstances, a similar proportion of African caretakers rated their child's health as excellent or very good compared to the children in the same age category in other race groups. Subjective perceptions may however be influenced by a variety of factors, including the other children in the environment with whom comparisons

are being made, diverse life experiences and different expectations. Caretakers in deprived circumstances may use different criteria to judge health status, compared to those in more affluent circumstances.

Immunisation status was generally difficult to assess, because more than half the sample could not produce a "Road to Health" card. Among those who could produce one, the main problem seems to be follow-up vaccinations. Among those who could not produce "Road to Health" cards, almost a third did not know the immunisation status of the child.

A major health problem is under-nutrition, and as many as 14% of African caretakers had been told by a health-care professional that the child weighs too little. Almost a quarter of respondents said that they had been too poor to feed the child adequately.

Breast-feeding during the first two years of life can, to some extent, help to overcome under-nutrition, and the vast majority of African children (86%) had been breast-fed, the majority for more than one year.

We shall examine outcomes of health measures, for example, knowledge of oral rehydration therapy, in a later chapter.

*** In this chapter the data on 1,815 children aged five years or younger have been weighted to the universe of children in this age group in South Africa, taking into account their distribution within provinces, population groups, gender and milieux (i.e. metro, urban or rural).**

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Chapter 4.
Research Findings: Children Aged Six to Fifteen Years

A National Household Survey of Health Inequalities in South Africa

Steven Hirschowitz

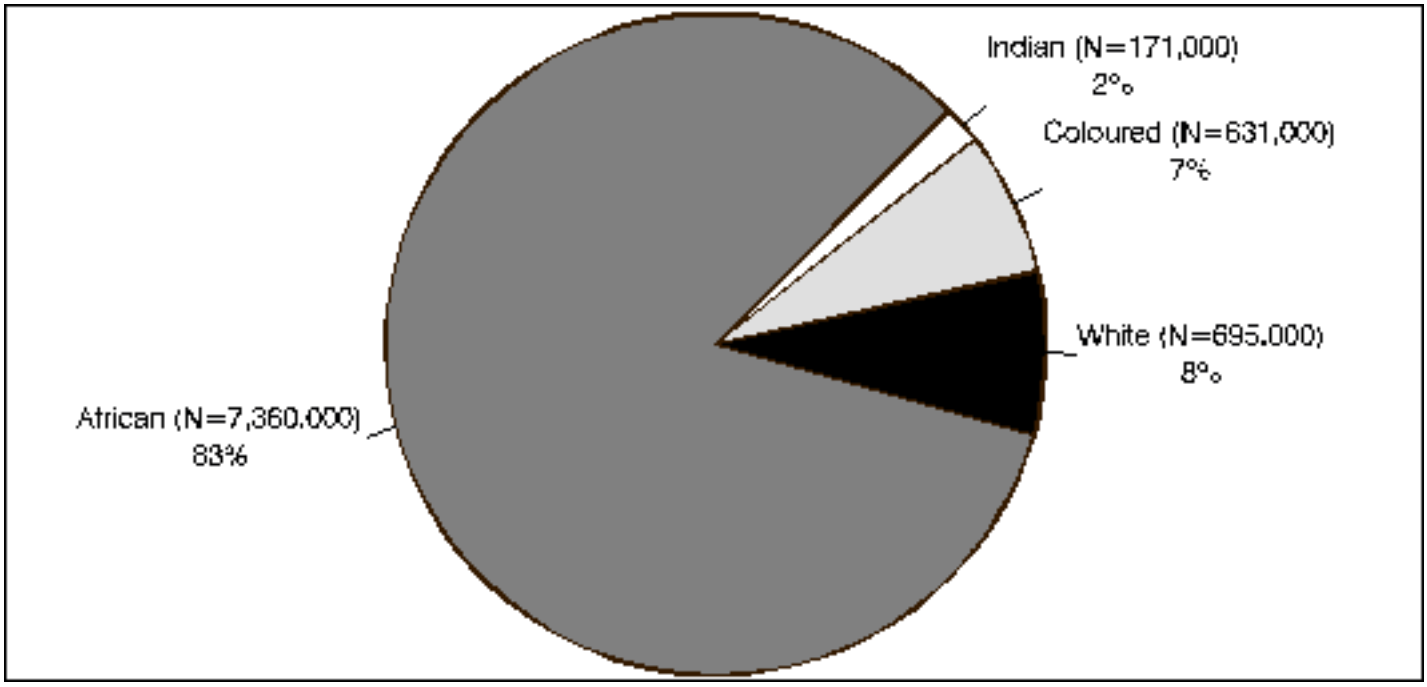
CHAPTER FOUR.

Introduction

This part of the survey investigates the health status of the 8,856,000 children and teenagers aged between six and 15 years, the variables affecting this status and their access to health care*.

- Figure 4.1 indicates that there are 8,9 million children in this age group.

FIGURE 4.1. Children Aged Between Six and Fifteen Years by Race



Total number of children aged 6 - 15 years = 8,856,000
C A S E survey for Kaiser Family Foundation

- This total is based on the 1991 census, supplemented by estimates of population size in the former "independent" homelands.

- Figure 4.1 also shows that five children and teenagers (hereafter referred to as "children") out of every six (83%) in this age category are African.
  - This proportion represents a slight decrease, compared to the proportion of those aged nought to five years (86%), but African children remain the vast majority.
  - African children in this age category constitute 25% of all Africans, compared to 22% of coloureds, 19% of Indians and 15% of whites.

Selecting an Appropriate Child in the Household

- More than half of all households in the survey (57%) contain at least one child aged between six and 15 years.
  - African (65%), coloured (66%) and Indian (59%) households are more likely to have at least one child in this age category, compared to whites (26%).

- In all households that contain children aged between six and 15 years, information was collected on one child.
  - Where there was more than one child in the household in this age group, a random grid was used to select a child.
  - The health-care person was again used to obtain information on this child.

- The sample consisted of 2,264 children, each from a different household, of which 1,461 were African, 396 coloured, 204 Indian and 203 white.

Indicators that Apply to this Chapter

In addition to health status and access to health care, this chapter examines access to improved nutrition through school feeding, remedial or special education for children with learning problems and sex education.

It is important to emphasize that the sentinel indicator of health - asking the person responsible for health care of the household to classify the child into the health categories excellent, very good, good, fair or poor - is subjective. The other possible measure - whether the child has missed school or been in bed for at least one day in the two weeks prior to the interview due to sickness or injury -is more objective. Both of these measures have been widely used in previous health surveys in other countries (for example the American National Health Interview Survey).

The research shows that children in this age category are generally healthy. Comparisons between different categorical variables, for example gender, race, province or access to electricity will therefore involve small numbers in poor health.

Table 4.1. indicates that:

TABLE 4.1: Biographical description of the sample

	African	Coloured	Indian	White	Total
Biographical variables	%	%	%	%	%
Age: 6-11 years 12-15 years Total	67 33 100	65 35 100	63 37 100	62 38 100	67 33 100
Gender: Male Female Total	50 50 100	50 50 100	50 50 100	50 50 100	50 50 100
Of those at school: Primary High Nursery/special Total	94 6 0 100	87 12 1 100	79 21 0 100	77 22 1 100	92 8 0 100
Birth certificate: Yes*	61	96	99	99	67

***The balance of this percentage adds up to 100%**

- Of those children at school, a relatively small proportion (6%) of Africans were in high school compared to coloureds (12%), Indians (21%) and whites (22%).

- A smaller proportion of African children (61%) compared to almost all coloured (96%), Indian (99%) and white (99%) children had a birth certificate.

Further findings not shown in the table are :

- Almost all children in this age group (at least 90% across all race groups) were at school.
  - Those living in shacks, outbuildings or zozos were more than twice as likely not to be at school as those in other dwellings (15% compared to 6%). Children in households where the person responsible for health care was a male were more than twice as likely not to be at school than those where the health care person was a female (15% compared to 7%).
  - The percentage of children not at school decreased steadily with the increasing educational level of the health care person in the household from 10% for no education to 5% for further than matric.

- A low proportion (4%) of schoolchildren in the Eastern Cape and Northern Transvaal in contrast to Gauteng, North West, Northern Cape and Western Cape (12% in all cases) were in high school.

- A far higher percentage of those in formal dwellings than those in informal dwellings had a birth certificate (for example 92% for metro formal as against 50% for metro informal).

Home Circumstances of Children in the Sample

When we examine the life circumstances of children aged six to 15 years, we find that African children, compared to the other race groups, are highly likely to be living in rural areas, many without access to piped water or to toilets in their households. Since these African children form the vast majority of those of school-going age, the health risks that they face demand attention.

The research findings show that:

- A relatively small proportion of African children live in Gauteng (9% in contrast to 42% of white children) and the Western Cape (2% compared to 7% of all other races in this age group).
  - In Chapter 2 we saw that 18% of all African households are situated in Gauteng. This suggests that in this province members of at least some African households send their children to rural areas for schooling.

- A large proportion (70%) of African children live in rural areas (60% in rural homelands and 10% on white-owned farms) compared to children in other race groups.

  - A large proportion (29%) of African children live in traditional dwellings.

- African (61%) and coloured (51%) children were more likely to live in overcrowded homes, compared to Indians (11%) and whites (1%).

- Seventy-four percent of African children live in households with incomes below the minimum living level compared to 32% of coloured, 13% of Indian and 4% of white children.

- Relatively few African children (67%) had electricity in their homes, while 33% lived in households where water was obtained from a river, stream or borehole and 20% lived in households without toilets.

- A relatively large proportion of the caretakers of African (23%) and coloured (9%) children had never attended school.

- Relatively few African caretakers (5%) compared to white (30%) had completed matric, and even fewer had higher academic qualifications.

- This picture of deprivation and impoverishment is very similar to the one which was drawn in the previous chapter, among African children aged five years or younger. These children frequently continue to live in remote rural areas with very few, if any modern amenities.

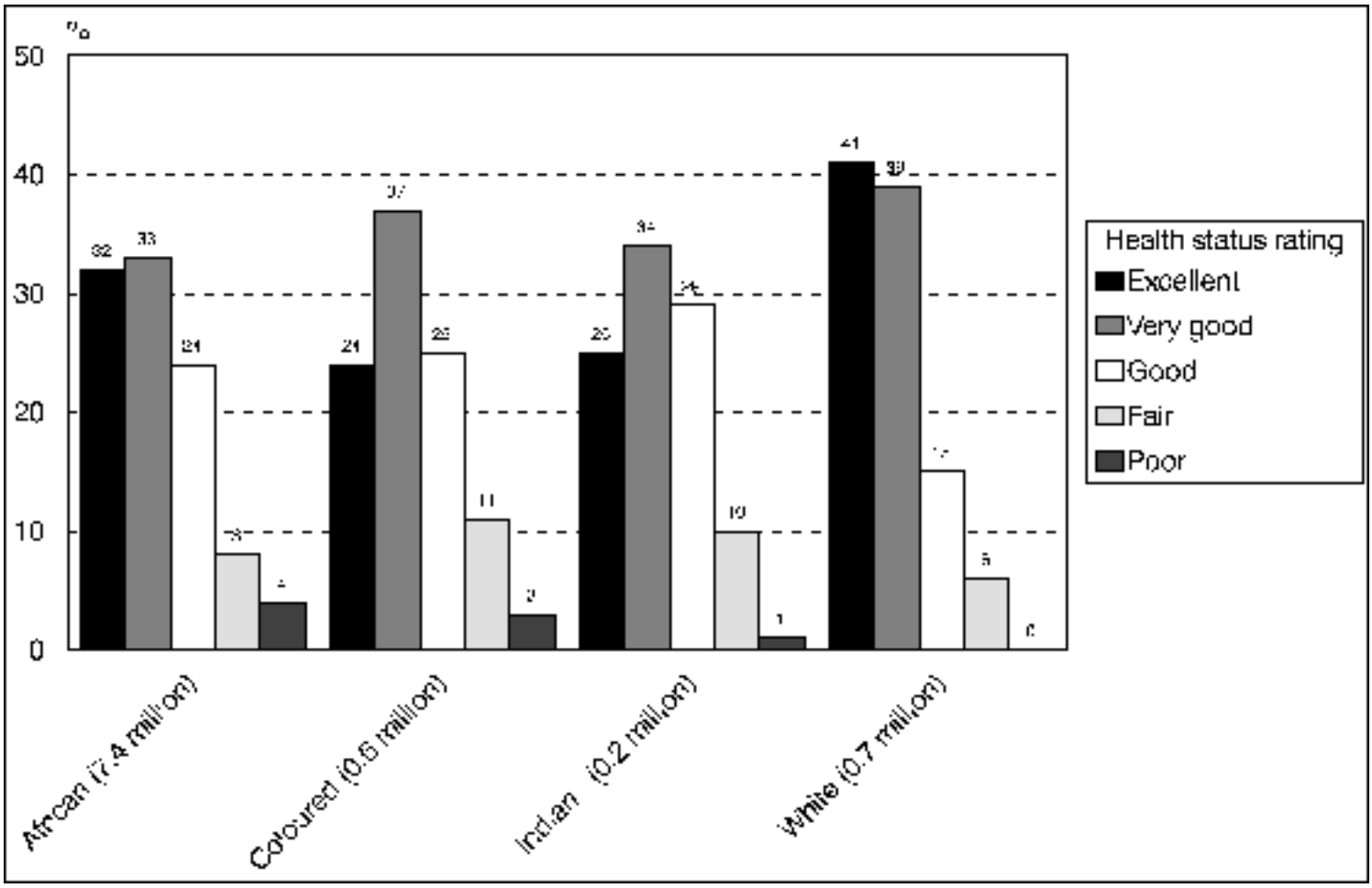
- There is relatively little change in the life circumstances of children as they progress from pre-school to school-going age and from primary school into high school.

Caretakers' Perceptions of the Health Status of Children Aged Six to 15 Years

- The caretaker was asked to rate the child's health as either excellent, very good, good, fair or poor relative to other children of the same age.

- Figure 4.2 shows that, in general, the health status of children aged between six and 15 years is regarded as good. Relatively few caretakers rated their child's health as fair or poor. However, more white caretakers rated the child's health as excellent (41%) or very good (39%) compared to those in the other population groups.

FIGURE 4.2. Perceived Health Status of Children by Race



Children 6-15 years
C A S E survey for Kaiser Family Foundation

- It therefore seems as if, having survived the health risks that infants and pre-school children in impoverished circumstances face, the health of school-going children is unlikely to be rated as poor. Nevertheless, if we translate the percentages of those estimated to be in poor health into numbers, we have a total of 302, 000, of whom 278, 000 (92%) are African.

- When singling out those judged to be in poor health by their caretakers, the graph also indicates that no whites were seen to be in poor health compared to 1% of Indians, 3% of coloureds and 4% of Africans.

Demographic Variables and Perceived Health Status

- Overall, the caretakers' health ratings did not vary much between groups. For example, rural - urban differences tended to be small. However, there were some differences found.
  - The percentage of children judged to be in poor health was lower for KwaZulu-Natal (1%), Gauteng (1%) and the Western Cape (2%) - more urban provinces - and higher for the North West (8%) and Free State (7%) -more rural provinces.

- Gender of child had no effect on perceived health status.

- Surprisingly, children living in traditional dwellings were judged by the caretaker to be healthier, compared to those living in other types of housing. Thus, 6% of children in traditional dwellings were judged to be in fair or poor health compared to 13% of those living in both formal brick houses and informal housing units such as a shack, outbuilding or zozo.

- Thirteen percent of children in the six to 11 year age group were assessed as in fair or poor health as against 9% in the 12 to 15 year age group.

Socio-Economic Variables and Perceived Health Status

- The socio-economic circumstances of the children also had very little effect on their health ratings, as assessed by the caretakers.
  - Household income had no effect on perceived health status of the child. Twelve percent of those children whose household income was above the minimum living level were assessed as in fair or poor health as against 13% of those with household income below the minimum level.
  - Extent of crowding also had no effect on perceived health status of the child.

- The education level of the caretaker also had no effect on perceived health status of the child. One feature stands out: only 1% of children whose parents had passed matriculation were assessed as in poor health.

- Those children from households that found great difficulty in paying for health services were more likely to be assessed as in poor health than those for whom payment was easy.

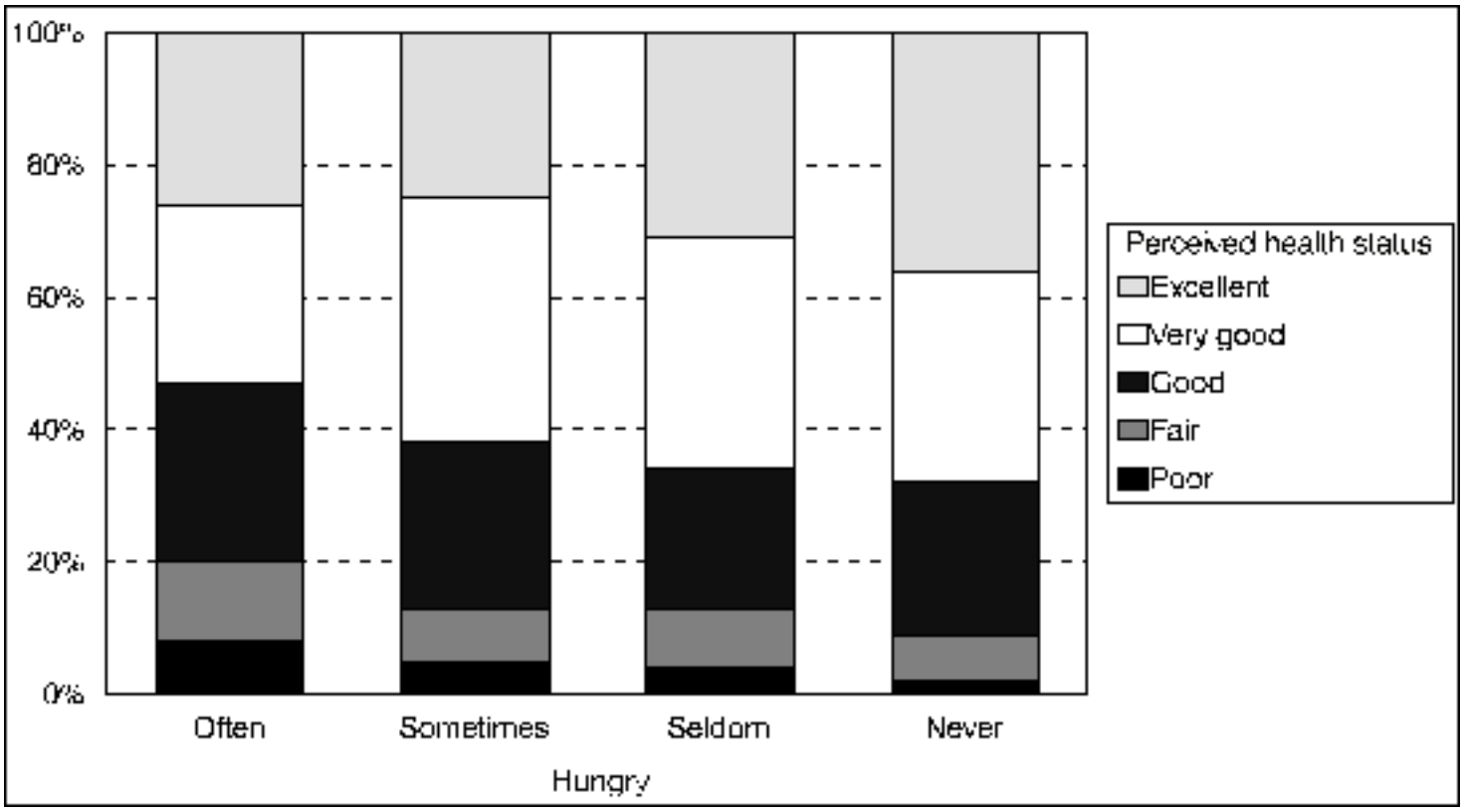
- Among Africans, 3% of those children with household incomes below the minimum living level as against 7% of those with incomes above it were seen to be in poor health.

Health Rating of Child by Frequency of Hunger in Household

Figure 4.3, shows that:

- As frequency of hunger in the child's household increases, the percentage of children estimated by the caretaker to be in poor or fair health increases, and the percentage in excellent health decreases. Two percent of those children from households that never went hungry were judged to be in poor health compared to 8% of those from households that frequently went hungry.

FIGURE 4.3. Health Rating of Child by How Often People in the Child's Household Went Hungry



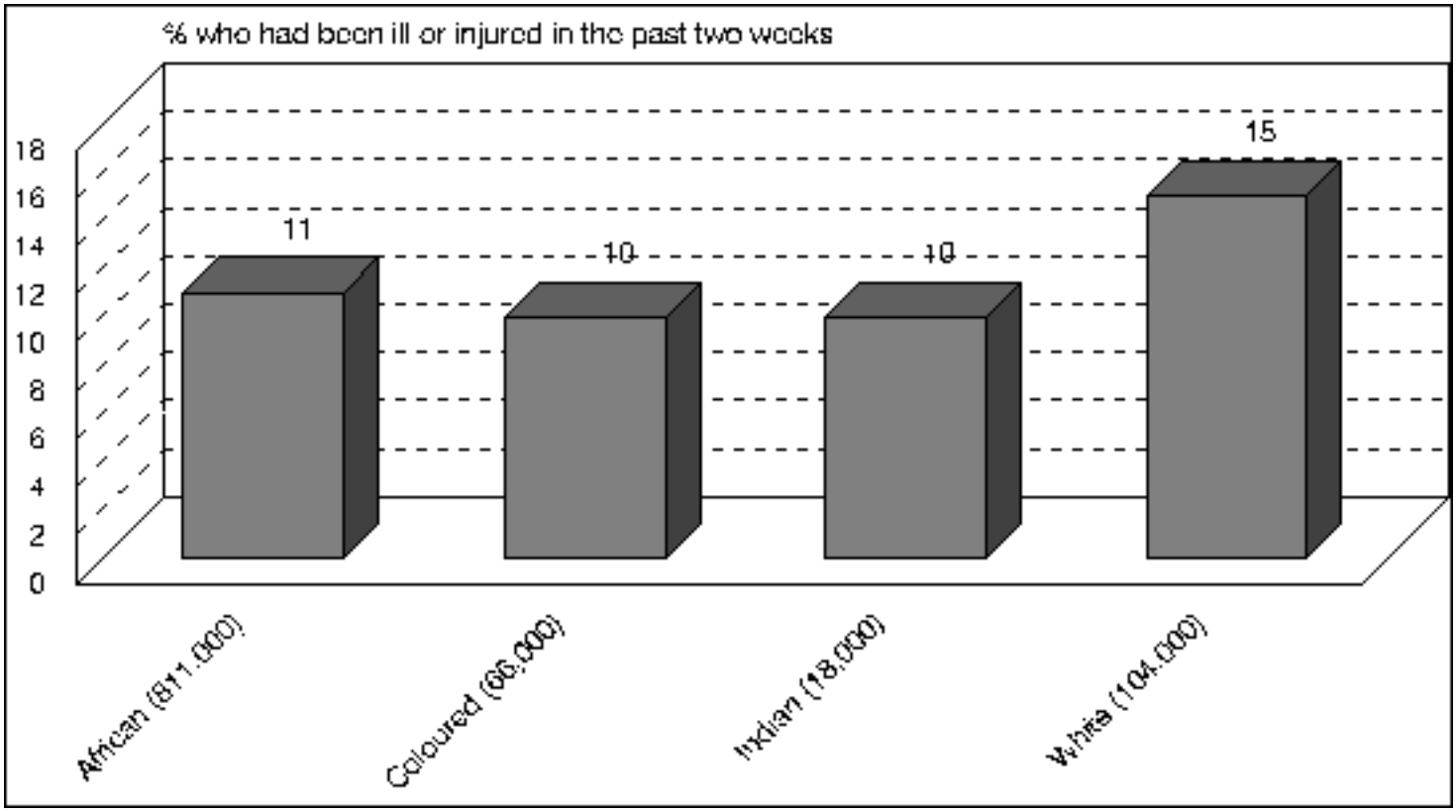
Children 6-15 years
C A S E survey for Kaiser Family Foundation

Whether Child had been ill or Injured in the Prior Two Weeks

The caretaker was also asked to indicate whether the child had been so sick or injured in the two weeks prior to the interview that he or she had to stay in bed, or miss school for at least one day.

Figure 4.4. shows that:

FIGURE 4.4. Percentage of Children that had been Sick in the Past Two Weeks by Race



Children 6-15 years
C A S E survey for Kaiser Family Foundation

- The percentage of whites (15%) that had been sick or injured for at least one day in the two weeks prior to the interview was higher than Africans (11%) coloureds (10%) and Indians (10%).

- The incidence of illness or injury was unlikely to change significantly in relation to demographic or socio-economic variables.
  - Being sick was not related to sex of child, area, type of dwelling, household income or education level of health care person.
  - Access to electricity and services also had no effect on the percentage of children that had been sick or injured.
  - Frequency of hunger in the household also had no effect on the percentage of children who had been sick or injured.

- A surprising finding was that 20% of those living in conditions of low crowding had been sick, as against 13% of those in high crowding. One interpretation is that those living in relatively better circumstances are more readily inclined to say they are sick.

- Younger children (age 6 to 11) were more likely (13%) to have been sick than older children (age 12 to 15).

- Seventeen percent of children in Free State had been sick compared to 8% for the Eastern Cape and between 10 and 13% for the other provinces.

TABLE 4.2:
Duration of sickness or injury by race

	African %	Coloured %	*Indian/ White %	Total %
Duration: 1 day	14	19	26	15
2 days	27	24	39	28
3 days	20	16	9	18
4 or more days	39	41	26	39
Total	100	100	100	100

*** Combined due to smaller sample size**

- Table 4.2 shows that among those who had been sick or injured in the two weeks prior to the interview, the duration of this illness or injury tended to be shorter for Indians and whites than for Africans and coloureds.

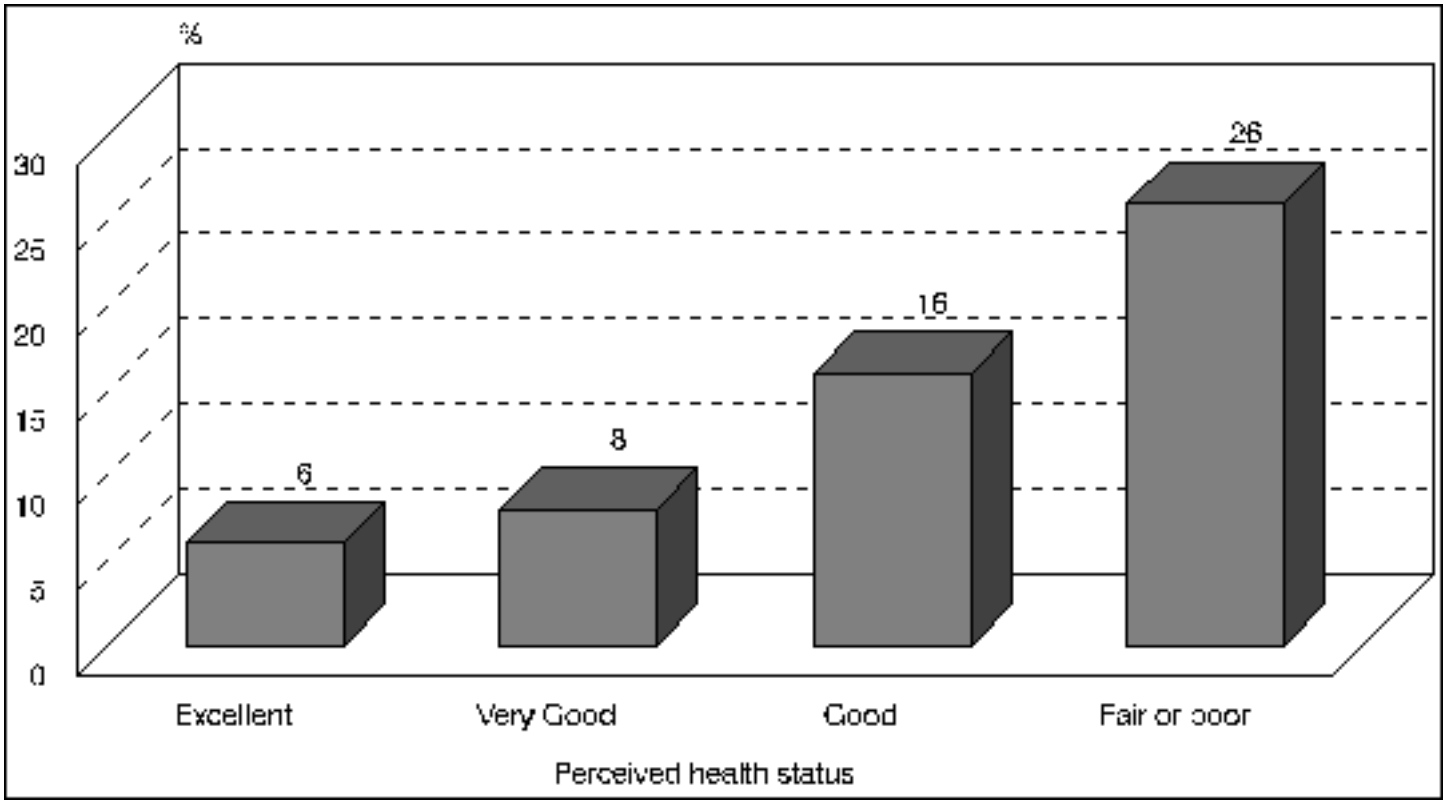
Further findings not shown in the table are:

- Duration of illness or injury tended to be shorter for children from households whose income is above the minimum living level (MLL).
- Older children (12 to 15 years) tended to be sick for longer periods than younger children (6 to 11 years).
- From these findings, one may conclude that those in more affluent circumstances tend to take more frequent but shorter periods of time off school, possibly for less serious illnesses or injuries, compared to those in more impoverished households.

Comparison of Measures of Health

- Figure 4.5 shows that proportionately more children who were perceived by the caretaker to be in fair or poor health had been sick or injured in the two weeks prior to the interview than those perceived to be in good, very good or excellent health.

FIGURE 4.5. Percentage of Children Who had beenIll or Injured in the Past Two Weeks



Children 6-15 years
C A S E survey for Kaiser Family Foundation

- The two measures - caretakers' rating of health status of the child and missing school as a result of illness or injury in the past two weeks - were found to be interrelated ($r=0.1924$; $p<0.001$). A subjective rating of health status could therefore be a useful predictor of actual illness or injury.

Access to and Quality of Health Care

- Of the 242 children that had been sick or injured in the prior two weeks, 69% had received treatment.
  - However, more Indians and whites (78%) than coloureds (70%) and Africans (68%) had received treatment.

- The sick or injured children from households with incomes above minimum living level more commonly (81%) received treatment than those from poor households, but even those from households with incomes below the minimum living level received treatment in nearly two thirds (64%) of cases.

- The most common place of treatment for Africans was a public clinic (47%) or a public hospital (24%), and a private doctor for other race groups (65%).

- Since there were only 180 respondents in the sample who had taken a child for treatment, cell sizes were too small for further analyses of where they were taken by province, type of housing or extent of crowding in the household for example.

Issues Related to Nutrition

Malnutrition is also a health risk for children aged six to 15 years. One way of overcoming this is to provide food to children at school. We therefore examine the extent to which the recently introduced government school-feeding programme has reached those in primary school who can benefit.

In addition, we examine whether or not children in the sample have breakfast before going to school, since not having breakfast can affect a child's health, but also the ability to concentrate at school. We examine this issue first before turning to school-feeding.

Having Breakfast before School

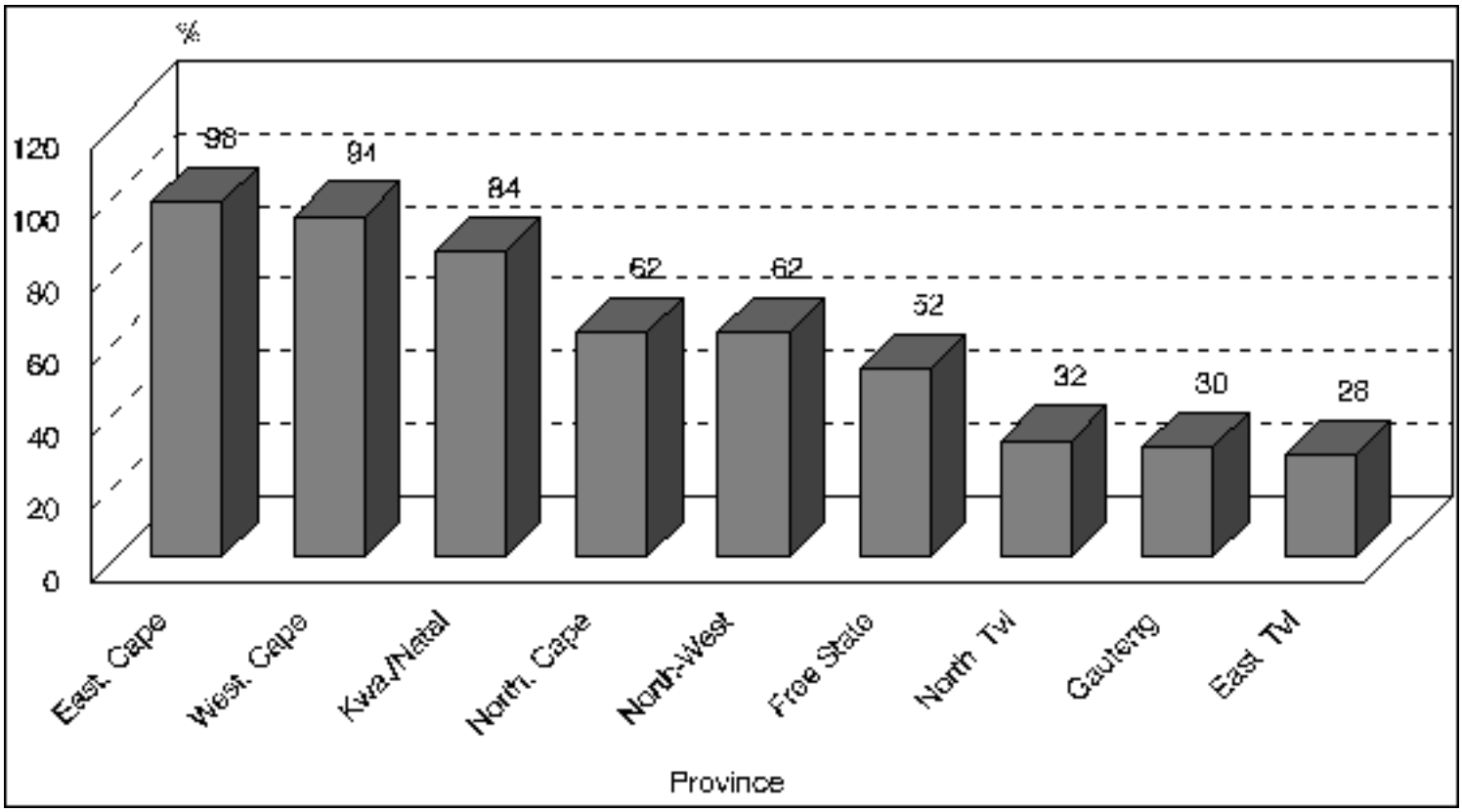
- Ninety percent of those who were at school had breakfast , and this proportion was approximately constant across all race groups.
- Those living in conditions where crowding was low were more likely (21%) to miss breakfast than those living in conditions of average to high crowding (9%).
- Those living in traditional huts were more likely to have breakfast (95%) than those living in other dwellings (89%).
- Female children were less likely to have breakfast (87%) than male children (94%).
- Children from households with a male caretaker were more likely to have breakfast (94%) than those with a female caretaker (90%).
- There was no relationship between household income or education level of the caretaker and whether or not the child had breakfast before school.
- More than three times as many children (10%) who did not have breakfast before school were estimated to be in poor health than those who had breakfast (3%).

School Feeding Scheme for Primary Schools

- Free food was provided at school to the majority of African (63%) and coloured (69%) schoolchildren but only to a small proportion of white (18%) and Indian (24%) schoolchildren.

- Figure 4.6 shows that almost all African children in the Western Cape (98%) and Eastern Cape (94%) and KwaZulu-Natal (84%) receive free food at school compared to relatively few in the Northern Transvaal (32%), Gauteng (30%) and the Eastern Transvaal (28%). Therefore some, but not all, provinces in which poverty predominates provide free food for those who may need it.

FIGURE 4.6. African Children in Primary School Who Received Free Food at School



Primary, special and nursery schoolchildren 6-15 years
C A S E survey for Kaiser Family Foundation

Further findings (not shown in the graph) are:

- Those children living in traditional huts were more likely (78%) to receive free food at school than those in other dwellings (54%).

- Those children living in conditions of high crowding were more likely (66%) to receive free food than those in low or average crowding (52%).

Learning Problems and Remedial Education

The health caretakers of those children at school were asked: "Does s/he have any problems with learning e.g. hyperactivity, poor concentration, difficulty understanding, learns slowly?".

- The caretakers of 24% of whites compared to 11% of Indians, 18% of coloureds and 10% of Africans reported their children to have learning problems. This obviously also reflects relative awareness of a child's learning difficulties among different race groups -- whites are more likely to be aware.

- Thirteen percent of those from households with income above the minimum living level were reported to have learning problems compared to 10% from households with income below it.

- Fifteen percent of male children were reported with learning problems as against 9% of females.

- Those children perceived as in excellent (10%), very good (9%) or good health (11%) were far less likely to be reported to have learning problems than those fair or poor health (26%).

- Of those children with learning problems:
  - Fifty-three percent of whites as opposed to 16% of Africans and 25% of coloureds received remedial education.

Sex Education

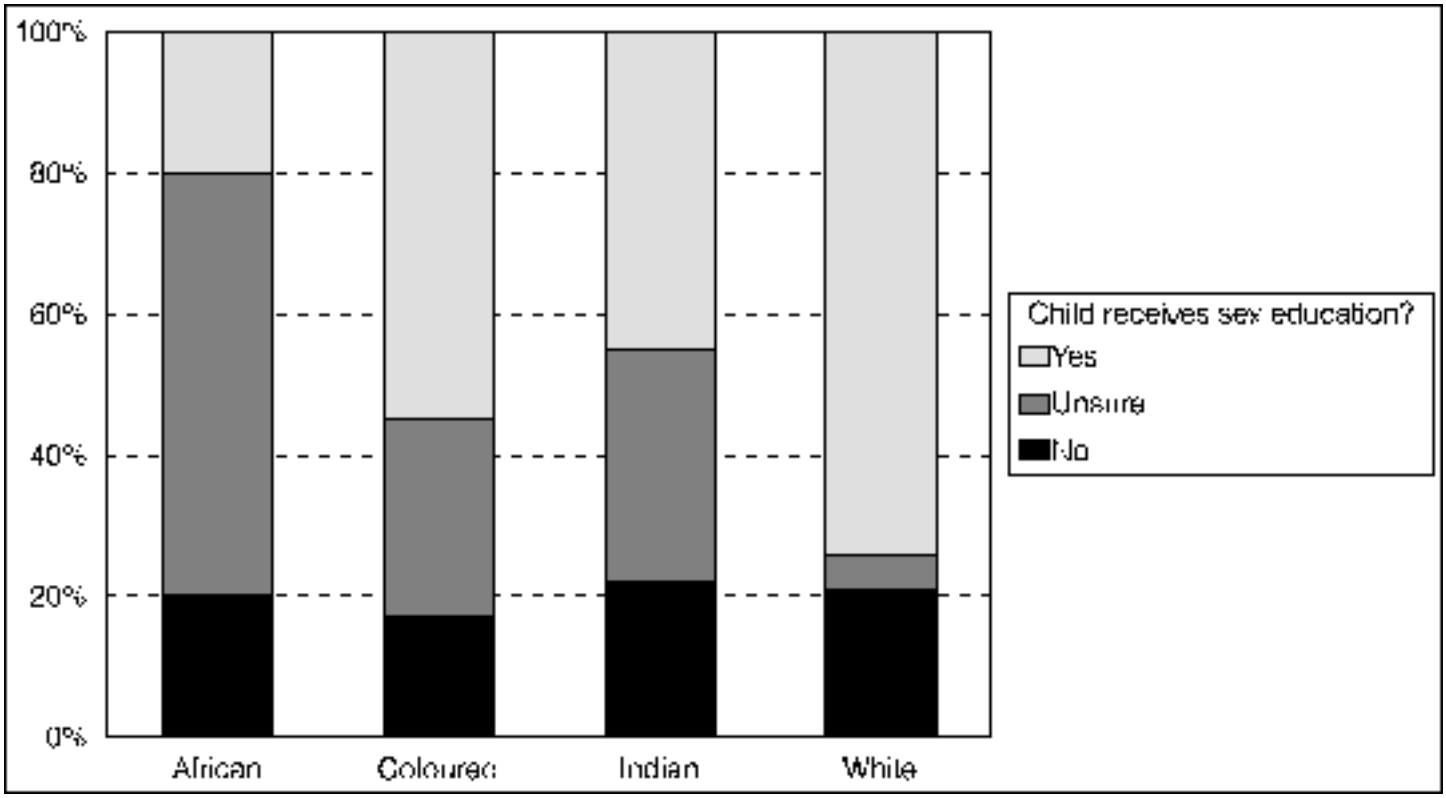
Teenage pregnancies can disrupt the lives of those affected, and sexually transmitted diseases are a severe health risk among young people. Preventive programmes such as sex education at school are vital. We therefore asked the caretakers of those children who were at secondary school to indicate whether or not these children had received any sex education at school.

- Of those respondents that had a child in high school, 36% said that their child received sex education, 20% said that their child did not receive sex education and 44% were unsure.

Figure 4.7 shows that far more Africans (61%) than whites (5%) were in the "unsure" category.

A further result (not shown in Figure 3.12) is that less educated and lower-income respondents were more likely than others to be unsure whether their child received sex education.

FIGURE 4.7. Caretaker's Knowledge of Whether Child Receives Sex Education by Race



Children attending high school
C A S E survey for Kaiser Family Foundation

Caretakers' Attitudes to Sex Education

- Overall, 83% of caretakers thought that sex education at school was a good idea, while 14% said it was a bad idea and 3% were undecided.
- A far higher proportion of African caretakers (20%) than of other race groups thought that sex education was a bad thing.
- Ninety-six percent of caretakers with household income above the minimum living level compared to 69% of those with income below the minimum living level had positive views on sex education.

Summary and Conclusions

The research shows that children and teenagers in this age category are usually seen as healthy. Only 3% of children were perceived by their caretakers to be in poor health.

One effect of this is that the number of children in poor health for practically any combinations of variables was small. This makes it difficult to determine which variables have the greatest effect on the health status of this group.

The proportion of children considered to be in poor health was highest for Africans, followed by coloureds, Indians and whites. Socioeconomic variables such as household income,

education level of the caretaker and access to electricity were found to have little effect on perceived health status of the child. The exception to this is frequency of hunger in the household which was found to be positively related to a rating of poor health by the caretaker.

A larger proportion of white children had been sick or injured for at least one day in the two weeks prior to the interview than was the case for other race groups. However, the duration of sickness tended to be shorter for white children, possibly indicating that white children tend to miss school or stay in bed for more minor illnesses or injuries, compared to those of other race groups.

A high proportion of children that had been sick or injured had received treatment. This proportion was higher for whites and Indians than for Africans and coloureds. For Africans treatment tended to be in a public clinic or hospital, and for other race groups with a private doctor.

Whether or not the child had breakfast before going to school seems to be a good indicator of nutrition, as those that did not have breakfast were more likely to be judged to be in poor health. However, children from higher socioeconomic classes were no more likely than those from lower classes to have breakfast before school.

A considerably higher proportion of white children than children of other race groups were reported to have learning problems. This is probably due to the greater awareness of the problem among whites. There was a strong positive correlation between worsening perceived health status of the child and being reported to have learning problems.

White children with reported learning problems were far more likely than others to receive remedial education or special schooling.

It is difficult to assess how widespread sex education for those in high school is, as a large proportion of African caretakers were unsure whether or not the child received sex education at school. African caretakers were more likely than those of other race groups to oppose sex education at school.

It therefore seems as if, having survived infancy and early childhood, poverty has a less noticeable effect on the health status on children of school-going age.

*** In this chapter, the data have been weighted to the universe of children aged six to fifteen years in South Africa, taking into account their distribution, population groups, gender and milieux (metro, urban or rural).**

Chapter 5.
Background Information:
Adults Aged 16 to 64 Years

A National Household Survey of Health Inequalities in South Africa

Ros Hirschowitz and Joan de Castro

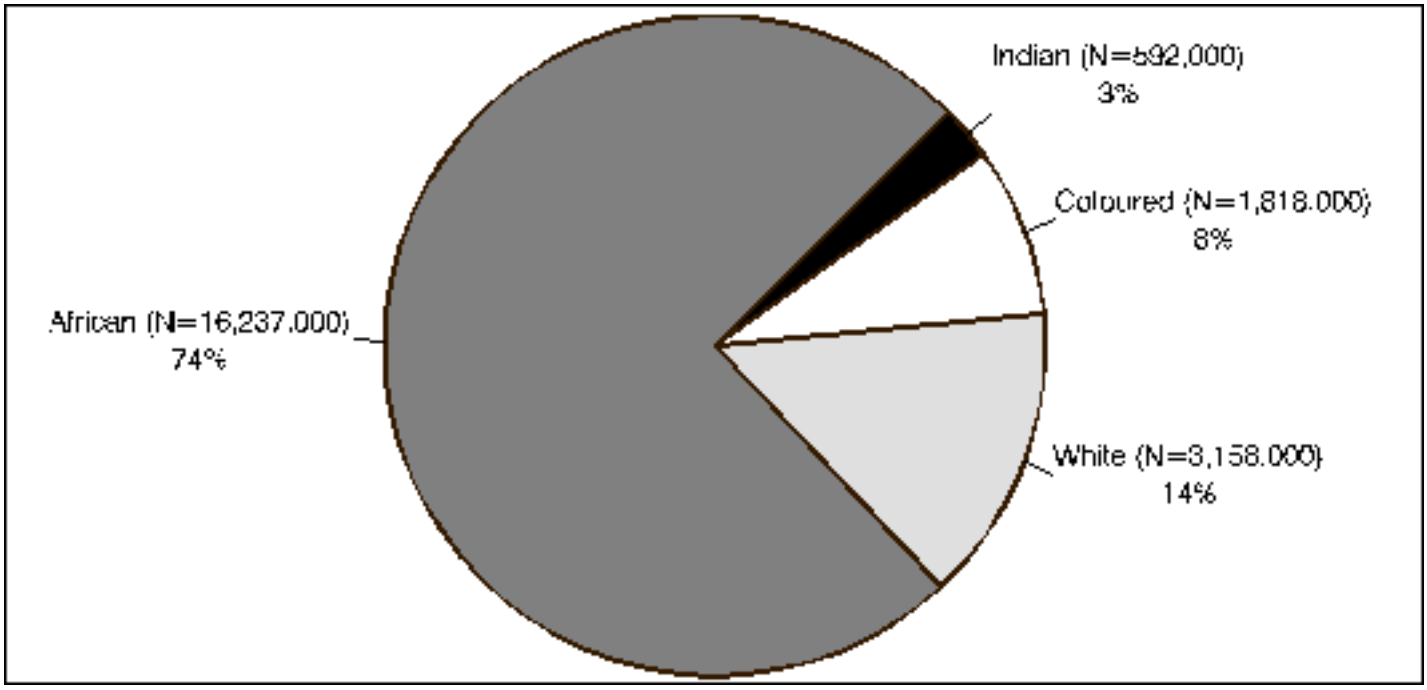
CHAPTER FIVE.

Introduction

In this and the following chapters we provide information on the 3,796 respondents aged between 16 and 64 years representing all adults in South Africa of this age*.

Figure 5.1 indicates that there are 21,8 million people in South Africa aged between 16 and 64 years.

FIGURE 5.1.Proportion of Adults Aged Between 16 and 64 Years by Race



Total number of adults aged 16 - 64 years = 21,805,000
C A S E survey for Kaiser Family Foundation

- This total is based on the 1991 census, supplemented by estimates of the population size in the former "independent" homelands.

- Figure 5.1 also shows that three quarters (75%) of all South Africans in this age category are Africans, while 15% are white, 8% are coloured and 3% are Indian.
  - This represents a further decrease in the proportion of Africans, compared to their proportions as infants and pre-school children (86%), and as children of school-going age (83%).
  - The pyramidal age structure typical of developing countries is becoming clearly apparent among the African population, compared to the age structure of the other race groups. Fifty five percent of all Africans fall into this age category, compared to 62% of coloureds, 66% of Indians and 67% of whites.

Selecting an Appropriate Adult in the Household as a Respondent

- The vast majority of households in the sample (95%) had one or more adults in the age category 16 to 64 years.

- Information was obtained on only one adult in each of these households.
  - If there was more than one adult in this age-category, the relevant adult was chosen using a random grid.
  - In this instance, the person selected answered directly for him- or herself. Unless the health-care person was selected on the grid as the respondent, he or she did not answer this section.

Indicators that Apply to this Chapter

In this chapter, we give a biographical description of the respondents. We then discuss their life circumstances and their health status, including health problems or handicaps that prevent full participation in a variety of activities.

The indicators that apply to this chapter are the following:

- The subjective assessment of both the physical health of the respondents and the state of the environment in which they live.

- Loss of productive activity due to illness.

Biographical Description of Respondents Aged 16 to 64 Years

Table 5.1 indicates that:

- The white adult population is relatively older, compared to Africans.
  - There are proportionately more Africans in the age category 16 to 24 years (32%), compared to whites in this age-category (23%).
  - There are also proportionately fewer Africans aged 50 to 64 years (14%), compared to whites in the same age-category (21%).

- Africans and to a lesser extent coloureds have lower levels of education than Indians and particularly whites.
  - Over one in 10 Africans (12%) had no formal schooling, and one in six (17%) had received a standard three education or lower. Education and health status, as we shall see, are inter-linked.

- The unemployment rate, although relatively high among all race groups, is extremely high among Africans. As we shall see, unemployment is an important variable, influencing health status.
  - The table shows that of all Africans available to the labour market, just over half (51%) are unemployed, compared to whites (13%).
  - Among Africans, the unemployment rate is high in all provinces, but it is particularly high in those provinces affected by the recent drought (Northern Transvaal 55% and the Eastern Transvaal 51%). It is also high in those provinces with large manufacturing components, where the recent recession has had a major impact (Eastern Cape 63%, Western Cape 55%, Gauteng and KwaZulu-Natal both 50%) It is lowest in those provinces where there is a preponderance of white -owned farms (Free State 38% and Northern Cape 28%).

- When examining unemployment in relation to type of area in which the African respondents lived, the above analysis is confirmed. Those living on white-owned farms are least likely to be unemployed (28%), followed by those living in formal (43%) and informal dwellings (45%) in urban areas, then those living in informal (47%) and formal dwellings (50%) in metropolitan areas, while more than two thirds of those living in rural areas in the former homelands (69%) are unemployed.

Table 5.1: Biographical description of the sample

	African (N = 16,2 million)	Coloured (N = 1,8 million)	Indian (N = 0,6 million)	White (N = 3,2 million)	Total (N = 21,8 million)
Biographical variables	%	%	%	%	%
Gender: Male	47	48	49	50	47
Female	53	52	51	50	53
Total	100	100	100	100	100
Age: 16-24	32	31	27	23	31
25-34	28	29	26	24	27
35-49	26	27	30	32	27
50-64	14	13	17	21	15
Total	100	100	100	100	100
Marital status:					
Never married	48	42	27	28	44
Married	38	44	65	57	42
Separated	2	2	2	2	2
Widowed	4	4	4	3	4
Divorced	2	4	2	7	3
Living together	6	4	0	3	5
Total	100	100	100	100	100
Education level:					
No formal schooling	12	3	2	0	9
Up to Std 3	17	9	3	1	14
Std 4 or 5	18	19	7	0	15
Std 6 to 9	40	51	50	34	40
Matric	10	13	25	31	14
Higher	3	5	13	34	8
Total	100	100	100	100	100

Employment status:					
Student/scholar	19	15	12	12	18
Housewife	11	18	28	17	13
Retired	4	3	4	6	4
Disabled	3	6	2	5	3
Unemployed-want work	32	16	8	8	27
Working for employer	28	40	40	46	32
Working in own/fam. bus	3	2	6	6	3
Total	100	100	100	100	100
Among those working:					
Blue collar	82	69	43	27	68
White collar	18	31	57	73	32
Total	100	100	100	100	100
Unemployment rate *	51	27	14	13	43

*** The unemployment rate is calculated by determining the number of people who are unemployed / number of people who are available in the labour market x 100. To obtain this percentage the following steps are taken:**
- The exclusion of all those in the population who are outside the labour market (scholars, students, housewives, disabled, retired and those who want to study).
- Among the remainder (those who are available for work, including those who are unemployed, those who work for an employer and those who work for themselves or else in a family business), the determination of the percentage who are unemployed.

- Among those who are employed, the majority of Africans (82%) and coloureds (69%) are in blue collar jobs, whereas most whites are in white collar jobs (73%). Indians are found in roughly equal proportions in white (57%) and blue collar (43%) jobs.

- Both the high rate of unemployment among Africans as well as the low level blue collar work in which most of them are engaged may explain in part their living conditions and the extent of poverty they experience, as discussed in the following section.

Living Conditions of the Respondents

Living conditions of the respondents in the sample aged between 16 and 64 years are now examined, including demographic variables such as the province and type of area in which they live, and socio-economic variables such as type of dwelling, overcrowding in the dwelling, access to water, electricity and toilets.

- We have seen in a previous chapter that many of these factors pose a particular threat to the health of infants and pre-school children aged five years or younger. Among adults, we shall indicate in this and later chapters, how these living conditions influence both mental and physical health.

- Among Africans:
  - There is a smaller proportion of adults (42%) living in rural homeland areas, compared to the children of pre-school (58%) and school-going age (60%), as indicated in the previous two chapters.
  - Proportionately more females (48%) than males (36%) live in rural areas in the former homelands.
  - Proportionately fewer adults (50%) live in overcrowded households, compared to children of pre-school (66%) and school-going (61%) age.
  - A larger percentage of adults aged 16 to 64 years have access to piped water (taps and tankers; 76%) and toilets (86%) compared to the children discussed previously, partly because fewer adults live in rural homeland areas.

Perceived Health Status and Quality of the Environment

We now turn to the respondents' perceptions regarding their physical health and the quality of the environment in which they live.

Physical Health

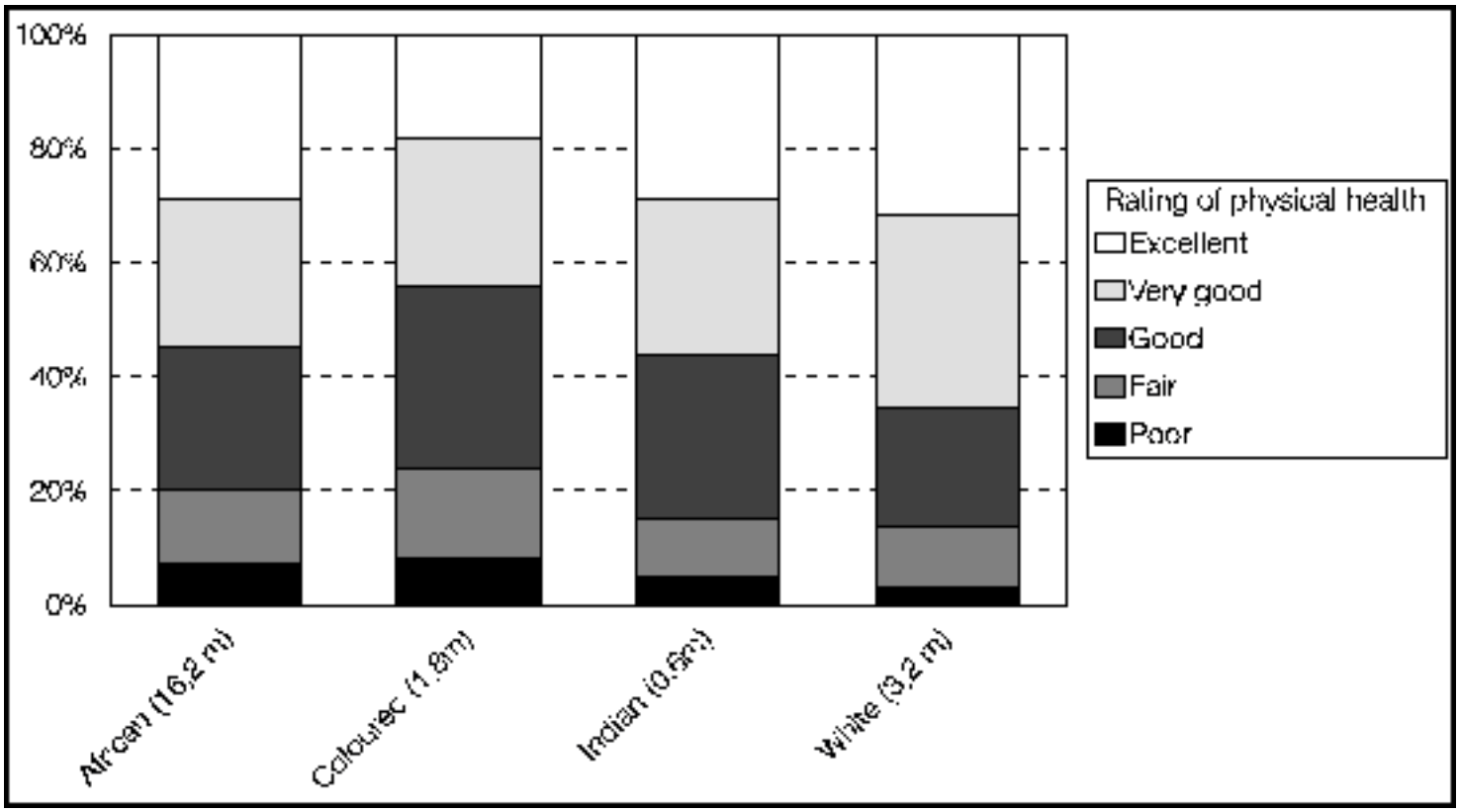
Respondents were asked how they would rate their physical health in relation to other people of their age on a five-point scale ranging from excellent, through very good, good and fair, to poor.

- Overall, a large proportion of respondents perceived their health to be excellent (28%), very good (27%) or good (25%) in comparison to others who are the same age. Proportionately fewer rated their health as fair (13%) or poor (6%).

- Figure 5.2 shows that coloured respondents are likely to give lower ratings regarding their physical health, compared to respondents in the other race groups, followed by Africans, Indians and whites.
  - As we have noted previously, these types of perceptions are subjective and may be influenced by a number of variables, including the people with whom the respondents compare themselves, their expectations in relation to their life-style and their definitions of health.

- Among coloureds, socio-economic conditions are closely linked with health rating:
  - In the Eastern Cape, where unemployment tends to be highest for coloureds, a larger proportion (14%) rate their physical health as poor compared to those living in other provinces (Gauteng 8%, Western and Northern Cape 7% each).
  - Among coloureds living in rural areas, proportionately more (14%) rate their physical health as poor than those in metro areas (7%).
  - Proportionately more of those living in households without electricity (19%) rated their health as poor, compared to those with electricity (7%).
  - Thirty one percent of those with no formal schooling rated their health as poor, compared to less than 5% of those with high school or higher qualifications.

FIGURE 5.2. Preceived Health Status in Comparison to Others of the Same Age by Race



Adult aged 16-64 years
C A S E survey for Kaiser Family Foundation

- Among Africans, a similar pattern of relationships between a poor health rating and poor socio-economic conditions emerges:
  - Adults with no schooling or some primary school education (12% in both cases), those living in the Eastern Cape (11%) where unemployment is particularly high, those living in informal metropolitan areas (11%), or below the minimum living level (8%) are more likely to perceive their health status as fair to poor, compared to the average (7%).

- Among Indians:
  - A higher proportion of females (7%) reported their health to be poor compared to males (3%).

- Among whites:
  - Afrikaans-speakers (5%) are more likely to rate their health as poor than English-speakers (2%).

- As expected, those aged from 50 to 64 years are more likely (18%) to rate their physical health as poor compared to those aged 16 to 24 (3%), 25 to 34 (3%), and 35 to (8%) years.

Table 5.2: The percentage of respondents who rated their health as poor by age and race

	African	Coloured	Indian	White	Total
Age categories	%*	%*	%*	%*	%*
Age: 16 - 24 years	3	1	1	1	3
25 - 34 years	3	5	2	0	3
35 - 49 years	8	13	8	4	8
50 - 64 years	21	20	11	8	18
All ages	7	8	5	3	6

*** The balance of each percentage shown in the table adds up to 100%**

- What is noteworthy, however, are the differences in health ratings between race groups as people age. For example, Table 5.2 shows that in the age category 50 to 64 years there is a higher frequency of people reporting to be in poor health among both Africans (21%) and coloureds (20%), compared to Indians (11%) and whites (8%).

- House et al. (1990) point to the additive effects of socio-economic variables such as sex, race, education and income on health, as people age. They suggest that the reduction of socio-economic differentials in middle and early old age can contribute towards postponing morbidity, disability and mortality.

- The effects of better socio-economic conditions, as experienced from birth by Indians and whites, on the postponement of reports of poor health are evident in this study.

Perceptions of the Quality of the Environment

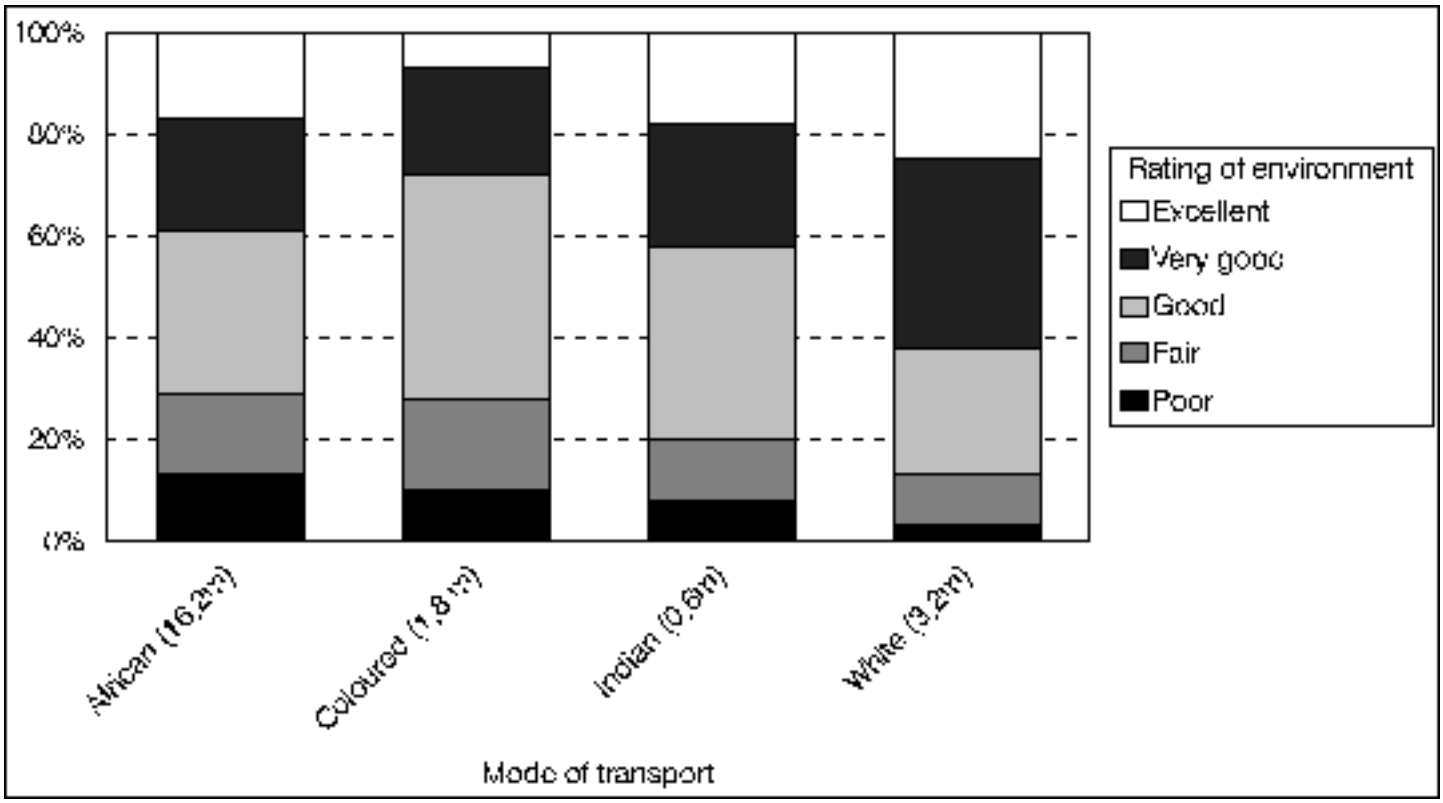
- A previous study (Hirschowitz and Orkin, 1994) indicated that race classification influences the type of problems in the environment that people perceive as affecting their health. Africans more frequently mention unsafe or dirty water, dirty streets and pavements and inadequate toilet facilities, while coloureds tend to identify inadequate housing and overcrowding. These are problems associated with under-development. Indians and whites, on the other hand, tend to identify air pollution as the major problem. This issue is generally associated with industrialisation.

- In this survey, we examine the issue from a different perspective. We first ask the respondents aged 16 to 64 years to rate the environment in which they lived on a five point scale ranging from poor to excellent, and then we relate these findings to socio-economic and other health variables.

- Overall, relatively few respondents view the state of the environment in which they live as excellent (17%) or very good (25%), while approximately one third rate it as good (32%). One in six described it as fair (15%) and one in 10 as poor (11%).

- Figure 5.3 indicates that, overall, white respondents tend to rate the state the environment in which they live higher than the other groups, while proportionately fewer coloureds rate their environments as excellent (7%) or very good (21%).

FIGURE 5.3. Perceptions of the Quality of the Environment by Race



Adult aged 16-64 years
C A S E survey for Kaiser Family Foundation

- Personal life circumstances, illnesses and disabilities influence this rating.
  - Thus those who rated their emotional (51%) or physical (29%) health as poor, disabled persons (18%), the chronically ill (17%) and those who had experienced a psychologically disturbing event (17%) are more likely to rate their environment as poor compared to the average for the total sample (11%).

- Socio-economic variables also had an influence, but this time the emphasis falls on urban rather than rural under-development.
  - Those living in informal metro (30%) or urban areas (27%) and those living in shacks (28%) are more likely to rate these environments as poor, compared to the average (11%).

Cigarette Smoking and Alcohol Consumption

The cigarette smoking and drinking habits of the respondents are probed as examples of life-styles which place health at risk.

Cigarette Smoking

Respondents were asked if they smoke cigarettes and if so how many, on average, per day.

- Three people in 10 in the sample (29%) claimed to smoke cigarettes at the time of the survey.

- Over half the coloured (55%) and over a third of the white (37%) sample smoke, compared to approximately a quarter of the Indian (28%) and African (25%) sample.

- Among the total sample:
  - Males are almost four times as likely to smoke (47%) than females (13%).
  - A higher proportion of those aged 35 to 49 years (40%) are smokers compared to younger respondents aged 16 to 24 (20%) or 25 to 34 (31%) years, and older ones aged 50 to 64 years (24%) .
  - A higher proportion of those who rated their physical (37%) and emotional health (35%) as poor or who had experienced a psychologically disturbing event (40%) are smokers than the total sample (29%).
  - Moderate to heavy drinkers (66%) are more commonly smokers than light (47%) or non-drinkers (15%).

- Among coloureds:
  - While two thirds of males (63%) smoke, a large proportion of females (49%) also do, compared to relatively few female African smokers (6%).
  - Rural dwellers on white-owned farms (76%) are more likely to smoke than metro dwellers (52%).

- Among whites:
  - Forty percent of males smoke, compared to 34% of females.
  - A higher proportion of the unemployed smoke (48%) compared to those who are working (40%); this trend was not found for other race groups.

- Among Indians:
  - Males (48%) are more likely to smoke, compared to females (8%).
  - More than two thirds of those who consume any alcohol (69%) also smoke, compared to those who do not drink (19%).

- Among Africans:
  - A relatively small proportion of those living in the rural homelands (16%) smoke.
  - There is an inverse relationship between education and the likelihood of smoking cigarettes.
  - Whereas 46% of males smoke only 6% of females did so.

Number of cigarettes smoked per day

Those who smoke are asked to indicate how many cigarettes they smoke, on average, per day.

- On average, among those who smoke, whites tend to smoke more cigarettes per day (mean = 20) than Indians (mean = 12), coloureds (mean = 9) and Africans (mean = 8).
  - Twenty three percent of white smokers smoke 30 or more cigarettes per day on average, compared to 1% of coloured and Indian and less than 1% of African smokers.

- Higher, rather than lower socio-economic status, was linked with heavier smoking.
  - Proportionately more smokers living in formal housing (33%) smoke an average of 11 or more cigarettes per day, compared to those living in shacks (19%) or traditional dwellings (12%).
  - Fifty five percent of smokers living in uncrowded households smoke an average of 11 or more cigarettes per day, compared to 32% in households of average density, and 20% in high density households.
  - Thirty eight percent of smokers with electricity in their homes smoke 11 or more cigarettes per day, compared to 13% without electricity.

Alcohol Consumption

Respondents are asked to classify their consumption of alcohol into one of the following categories: non-drinker, light drinker, moderate drinker, fairly heavy drinker and heavy drinker.

Table 5.3: Alcohol consumption among males and females by race

	African		Coloured		Indian		White		Total	
Alcohol consumption	M %	F %	M %	F %	M %	F %	M %	F %	M %	F %
Type of drinker:										
Non-drinker	54	87	44	73	68	97	23	42	49	80
Light	24	8	31	21	18	3	54	48	29	14
Moderate	17	4	19	5	14	0	19	9	17	5
Heavier	5	1	6	1	0	0	4	0	5	1
Total	100	100	100	100	100	100	100	100	100	100
Among drinkers:										
% who drink *										
Beer	62	40	52	46	**	**	59	20	60	33
Sorghum beer	14	18	1	1	0	0	0	0	10	9
Homebrew beer	18	29	0	2	0	0	0	0	12	15
Wine	4	7	26	21	**	**	24	41	11	22
Spirits	9	4	19	5	**	**	38	22	17	11
Average amount consumed a week:										
Beer-cans	10	7	10	4	**	**	6	3	9	5
Sorghum-cartons	10	6	**	**	NA	NA	NA	NA	10	6
Homebrew-scoops	7	5	NA	**	NA	NA	NA	NA	7	5
Wine-glasses	12	5	24	13	**	**	5	3	11	4
Spirits-tots	15	6	16	4	**	**	9	5	11	5

*** The balance of these percentages add up to 100%**
**** The number of respondents are too few for percentage breakdowns**
NA There are no respondents in these categories, therefore average quantities consumed do not apply

Table 5.3.: Alcohol consumption among males and females by race

- Almost two thirds (65%) of the sample claimed to be teetotallers, but there are significant differences in alcohol consumption patterns between race groups.
  - A large proportion of white respondents (67%) claim to drink alcohol, compared to relatively fewer coloured (41%), African (28%) and Indian (17%) respondents.

- Even more significant than these race differences are the gender differences.

- Table 5.3 shows that women are less likely to drink, and if they do, they consume far less than their male counterparts.

- Smoking and drinking heavily are directly linked; those who are smokers are far more likely (31%) to drink moderately to heavily than those who are not (6%).

- As education increases, coloureds and Africans are less likely to drink alcohol. However for whites the pattern reverses: the higher the education the more likely they are to consume alcohol.

Health Problems Influencing Home and Work Activities

In this section, we probe health status in more detail by examining its influence on productive activity in a home or work situation. In this regard, we ask the following questions:

- Amongst housewives we ask whether any health problem or handicap limits the housework activities they can do.

- Amongst those who are unemployed, we ask whether or not a health problem or handicap prevents them from finding work.

- Amongst those who are employed, we ask for an indication regarding:
  - whether a health problem or handicap restricts the activities they can perform at work;
  - whether or not, in the two weeks prior to the interview, they had taken at least one day off work due to illness or injury; and if so
  - whether they had visited a doctor, nurse or other health professional for treatment.

Health Problems Preventing Housewives from Doing their Housework

Amongst housewives:

- Twenty three percent of coloureds, 21% of Indians and 19% of Africans, as against 9% of whites said that they have a health problem or handicap which limits the type of housework they can do.

- Clear differences are found between race groups as far as age and ability to perform all housework tasks are concerned.
  - For example, among Africans, 3% of those aged 16 to 24 years have a health problem or handicap which prevents them from performing all housework tasks, increasing to 13% of those aged 25 to 34, to 19% of those aged 35 to 49 and to 41% of those aged 50 to 64 years. Among whites however, this percentage remains constant at approximately 7% across all age categories.

- Among Africans, poverty, increasing age, and impaired ability to carry out household tasks are related:
  - Twenty four percent of those living in shacks, compared to 18% of those living in brick houses, have a health problem or handicap preventing them from performing all housework tasks.
  - Twenty five percent of those who say that members of the family often or sometimes go hungry as a result of poverty have problems in performing housework tasks, compared to 11% of those where household members never go hungry.
  - Thirty four percent of those with no schooling have health problems or handicaps affecting the ability to perform all household tasks, compared to no-one with matriculation or higher qualifications.

- The contention of House et al. (1990) that onset of disability and morbidity is delayed in those who enjoy better socio-economic circumstances is again supported by these findings.

Health Problems Preventing the Unemployed from Finding Work

Among the unemployed:

- Eight percent of adults aged 16-64 years who are unemployed but looking for work claim that a health problem or handicap prevents them finding a job.
  - There are proportionately fewer Africans (8%) compared to coloureds (12%) who make this claim. (The sample size of Indians and whites who are unemployed is too small for further analysis).

- The lower the level of education amongst both Africans and coloureds, the more likely they are to claim that a health problem prevents them from finding work. For example, 15% of those with no schooling, compared to 8% with matriculation made this claim.

- The proportion of those who are prevented from finding work due to a health problem is similar (approximately 8%) across other socio-economic variables, for example, type of dwelling, crowding and family income.
  - Therefore it seems as if poor health preventing employment and socio-economic circumstances are not directly related.
  - On the basis of these findings one can argue that the race classification on which apartheid was based is the common denominator preventing people from finding work. Inability to find work, impoverished life circumstances and poor health are all, at least in part, consequences of this classification.

Amongst the Employed, Health Problems Influencing Type of Work

Those who worked for an employer or in their own or family business were asked whether any health problem or handicap restricted the type of work they could do.

- Overall, 9% of employed people claim that they are hampered in the type of work they can do by a health problem or handicap. There are no significant differences in this proportion across races.

- Health problems or handicaps which restrict the type of work that people can do are more likely to be a feature of urban impoverishment and squalor than rural life.
  - Shack dwellers generally (13%), and those living in metropolitan informal areas in particular (17%) are more likely than those living in formal brick housing in metropolitan areas (5%) to say that a health problem or handicap restricts the type of work they can do.
  - More than double the proportion (12%) of those whose household incomes were below the minimum living level are restricted in the type of work they can do as a result of health problems or handicaps, compared to those living above it (5%).
  - Those living in overcrowded households (12%) were also more likely than average (9%) to say that a health problem restricts the type of work they can do.

- The lower the level of education, the more likely the respondents were to say that a health problem or handicap limits the type of work they can do.
  - For example, 14% of those with no education, as against 6% with post-school qualifications, gave this response.

- Moderate to heavy drinkers (13%) were more likely than smokers (10%) to say that a health problem or handicap affects the type of work they can do.

Amongst the Employed, Missing a Day of Work in the Prior Two Weeks

The research findings show that, overall, 11% of employed respondents had missed at least one day of work in the two weeks prior to the interview as a result of sickness or injury. This

proportion is similar to the schoolchildren who had missed a day of school for these reasons as discussed in the previous chapter.

- There were some differences in these proportions between race groups, but these were rather slight: 14% of coloureds, 13% of whites, 11% of Indians and 10% of Africans gave this response.

- The research showed that missing a day of work in a two week period is more common amongst those living in conditions of urban poverty and squalor, rather than amongst those living in rural environments or amongst those living in more affluent urban conditions.
  - For example, 16% of those living in metropolitan informal areas, and 12% in overcrowded households had missed a day of work, compared to those living in rural areas (10%).

- Females (13%) were more likely than males (10%) to have taken time off work.

- Proportionately more of those aged between 35 and 49 years (15%) had taken a day off work for heath reasons, compared to both younger (9%) and older respondents (10%).

- Those who rate their health as poor (35%), fair (18%) or good (15%) were more likely to take a day off work as a result of illness or injury in the two weeks prior to the interview, compared to those who rate their health as very good (9%) or excellent (3%).

Going for Treatment, amongst Those who had Missed a Day of Work in the Two Weeks Prior to the Interview

- The vast majority (85%) of those who had taken a day or more off work because of illness or injury in the two week interval prior to the interview had sought medical treatment.

- Socio-economic conditions had a significant impact on seeking medical treatment.
  - A relatively large proportion of those living in households with incomes below the minimum living level did not seek medical treatment (29%), compared to those living above it (11%).
  - Those living in overcrowded homes were less likely to have sought treatment (80%), compared to those living in uncrowded ones (92%).

- Moderate to heavy drinkers are less likely to have gone for treatment (76%) than light (85%) or non drinkers (88%).

- Proportionately fewer of those whose usual site of health care is a public clinic (77%) went for treatment, compared to those whose usual source is a private doctor (92%). Although the actual number of respondents in the "clinic" category is small and this outcome should be treated with caution, this is an important trend, indicating that clinic services in the public sector are less easily available to workers than private services.

Summary and Conclusions

Of the 21,8 million adults aged between 16 and 64 years in the population, three quarters are African. Although this percentage constitutes the vast majority, there are proportionately fewer African adults, compared to infants and children, indicative of a pyramidal age structure typical of developing countries.

Pyramidal age structures go together with poverty and squalid life circumstances. The picture of Africans continuing to live in poverty and squalor as a direct result of apartheid is highlighted in this study.

Compared to children, where the majority live in rural areas, more African adults, particularly males, live in urban or metropolitan milieux. We interpret this finding to mean that children are likely to be sent to rural areas for nurturing and schooling, while parents work in urban areas to support them.

The high rate of unemployment among Africans and the low level work that the employed were doing was noted. Unemployment was found to have a negative impact on health status.

In general, coloured and African respondents tended to rate their health status more negatively than whites. However, socio-economic conditions had a direct influence on this rating, with those living in conditions of impoverishment rating their health status as worse than those living in more affluent circumstances.

Relatively few African and coloured respondents aged 16 to 24 years rated their health as poor, but this proportion steadily increased with an increase in age, compared to the relatively small increase with age found among whites. These results support previous research which demonstrates that the onset of morbidity can be delayed by improving socio-economic circumstances.

Coloured and African respondents were more likely to rate the state of the environment in which they live as poor, compared to whites, but in this case, urban under-development, for example living in shacks, rather than rural poverty, influenced this perception.

Habits affecting health, for example cigarette smoking and alcohol consumption, were explored in this chapter. We found that whites and coloureds were more likely to smoke than Indians and Africans, and that men were more likely to smoke than women. White

smokers were likely to smoke more cigarettes per day than those smokers in the other population groups.

Women were far less likely to consume alcohol than men, and were highly unlikely to see themselves as moderate to heavy drinkers. Smoking and drinking patterns affected health status ratings.

We now turn to the examination of health problems in different occupational groups - housewives, the unemployed and the gainfully employed.

Amongst housewives, proportionately more coloured and African respondents complained of a health problem or handicap limiting the type of housework they can do. Clear age differences in the ability to perform these tasks were found between races. For example, proportionately more African women aged between 50 to 64 years complained of a health problem affecting their housework, compared to younger African women, as well as to white women in the same age category.

Amongst the unemployed 8% complained of a health problem or handicap which prevented them from finding work. This proportion did not differ significantly across a variety of socio-economic variables.

Ten percent of those who were employed said that they were limited in the type of activity they could do at work as a result of a handicap or health problem. Urban living conditions, for example living in shacks, rather than rural poverty, was associated with being restricted in the type of work one can perform.

Just over one in 10 of the respondents had missed at least one day of work due to illness or injury in the two weeks prior to the interview. Poor urban conditions, for example living in shacks and in informal settlements was most likely to be associated with missing work for this reason.

While the vast majority had sought treatment for illnesses and injuries that had caused them to miss a day of work in the two weeks prior to the interview, those who usually went to public clinics for health-care were less likely to seek treatment when sick, compared to those who usually went to private doctors.

The research findings clearly show that poor health and poverty are closely interlinked. There is also an indication that the poor, who use public facilities have less access to health-care, compared to the more affluent. This theme will be explored further among respondents in this age category in the following chapters.

*** In this and the following chapters dealing with adults aged 16 to 64 years, the data have been weighted to the universe of these South Africans, taking into account their distribution**

by race, gender, age, provinces and milieux (metro, urban or rural).

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Chapter 6.
Access to Health-Care:
Adults Aged 16 to 64 Years

A National Household Survey of Health Inequalities in South Africa

Ros Hirschowitz and Joan de Castro

CHAPTER SIX.

Introduction

In this chapter, the access that the respondents aged between 16 and 64 years have to health-care is examined, and the extent to which they utilise these services.

In this regard, we determine how frequently in the last year they went for health-care and where they went. We also probe whether they had decided against going or delayed going for treatment when they felt they needed it, and if so, why. Respondents were then asked to recall the last time they went for treatment and to describe how long it took to get there, how long they waited to be seen and what happened at the visit. We also examine overall satisfaction with health-care and the use made of alternative services, for example, traditional healing.

Indicators that Apply to this Chapter

Relevant indicators regarding access to care and utilisation of health-care services are the following:

- Financial barriers to access, for example, not going for treatment or delaying seeking health-care when it is needed for financial reasons.

- Other barriers to access, for example travelling long distances and waiting in long queues for health-care.

- Extent to which clinics and private practitioners, rather than public hospitals, are used as the first point of contact with health services.

- Satisfaction with health-care services, for example, understanding explanations of illnesses and feeling that the present health-care system works well.

- Alternatives to western medicine, for example, the extent to which the services of traditional healers are used.

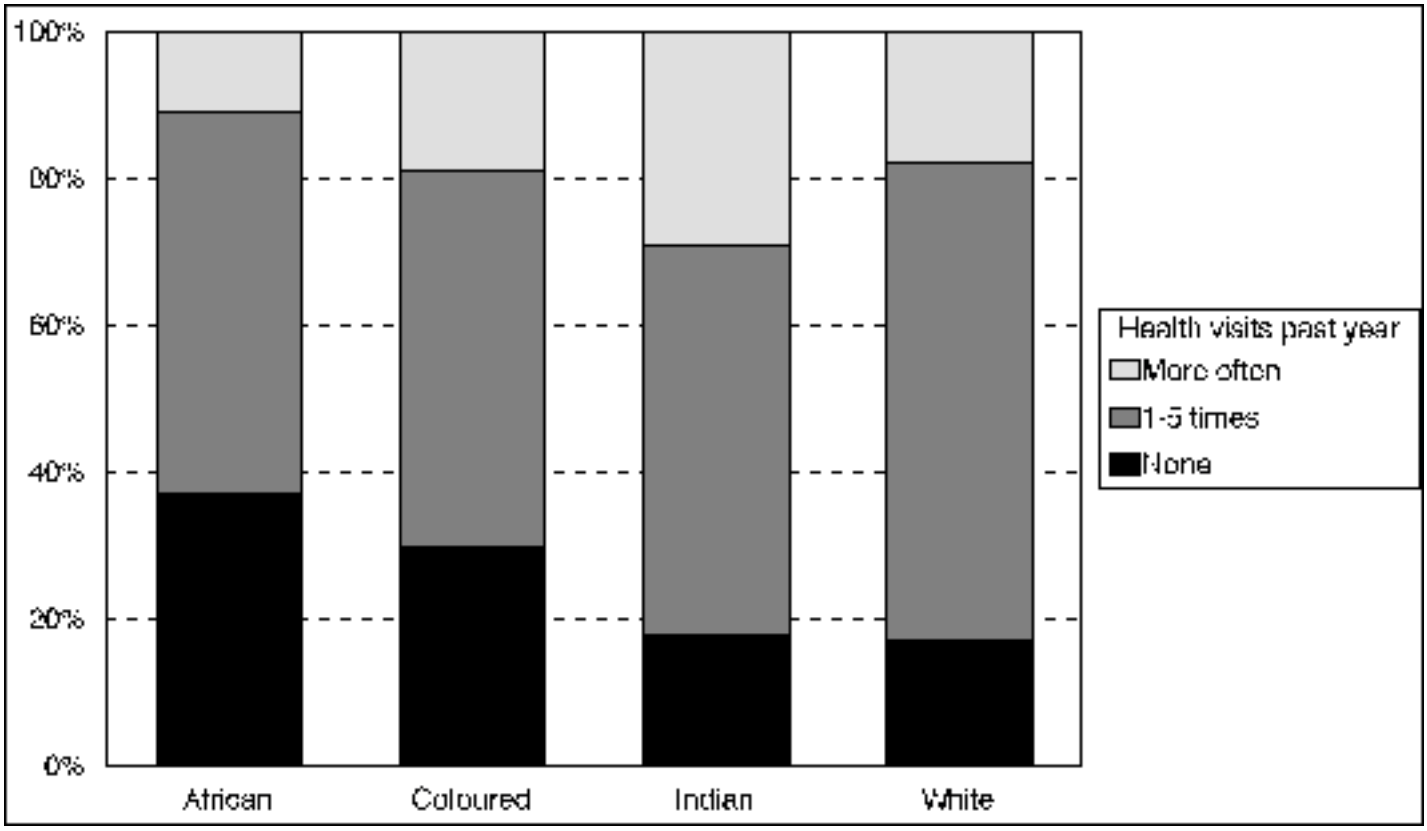
Utilisation of Health-care Services in the Past Year

The respondents were asked to indicate how many times in the year prior to the interview they had consulted a doctor, nurse or other health professional about an illness or health problem.

- Proportionately fewer males (63%) had consulted a health professional at least once in the past year, compared to females (71%).

- Relatively more older rather than younger respondents had consulted a health professional during the past year, irrespective of race.
  - For example, 62% of those aged between 16 to 24 years, 67% of those aged between 25 and 34 years, and 68% of those aged between 35 to 49 years had consulted a health professional, compared to 78% of those aged between 50 and 64 years.
- Figure 6.1 indicates that a larger proportion of Africans (37%) and coloureds (30%) had not received health-care in the past year, compared to whites (17%) and Indians (18%).

FIGURE 6.1. Number of Times in the Past Year South Africans Consulted a Health Professional by Race



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- This finding adds support to the emerging theme of this report that those who are most in need of health-care do not necessarily receive it.
- The reader will recall that proportionately more coloureds and Africans rated their health as poor or fair, compared to Indians and whites, and that these ratings were associated with conditions of poverty and overcrowding.
- We also showed that relatively few African (10%) and coloured (36%) families belong to a medical aid or health insurance scheme and consequently find it difficult to pay for treatment or for prescribed medicines.

Table 6.1 indicates that, in general, poverty, overcrowding and unemployment are associated with lack of health-care, and that this applies particularly among Africans and coloureds.

- For example, 41% of Africans who were living below the minimum living level had not received health-care in the year prior to the study, compared to 22% of whites in this income category.

- The higher the health status rating among the respondents, the less likely they were to receive health care in the year prior to the interview.
  - But proportionately fewer Africans and coloureds who rate their health as fair or poor had received health-care in the year prior to the survey, compared to Indians and whites. For example, 15% of Africans who rate their health status as poor had not consulted a health professional in the past year, while all Indians and whites who rated their health as poor had consulted a health professional at least once in that time.

- While those with chronic illness and disabilities were generally more likely than average to have received health-care in the year prior to the study, Africans with chronic illness (19%) or disabilities (23%) were less likely to have received care compared to whites with similar illnesses (5%) or disabilities (14%).

- Among Africans, the type of facility that is the usual site of care is associated with how often, if at all, health-care services are used.

Table 6.1: Proportion of respondents who had not received health-care in the past year by life circumstances and by race

Percentage who have not received health-care in the past year	African (N=16,2m)	Coloured (N=1,8m)	Indian (N=0,6m)	White (N=3,2m)	Total (N=21,8m)
	%*	%*	%*	%*	%*
Crowding in household					
Low	31	10	3	20	24
Average	34	28	20	15	30
High	39	33	12**	20	39
Income of household:					
Below minimum living level	41	37	18**	22**	40
Above minimum living level	24	27	19	19	23
Employment status:					
Unemployed	41	45	18**	40**	41
Employed	32	25	18	18	28

Health status:					
Excellent	50	40	28	21	44
Very good	40	30	24	20	35
Good	33	27	11	13	29
Fair	22	31	6*	7	21
Poor	15	9	0*	0	4
Chronic illness/disability:					
Chronic illness	19	6	4*	5	15
Disability	23	24	10*	14	22
Usual source of care					
Public hospital	36	34	14	24	35
Public clinic	41	29	10	10	40
Private doctor	27	27	20	15	23
Total	37	30	18	17	33

*** The balance of all percentages indicated in the table add up to 100%**
**** The percentages should be interpreted with caution as they are based on small numbers**

- Proportionately more of those respondents who use public clinics (41%) and hospitals (36%) as their usual site of care have not received health-care in the year prior to the interview, compared to those who use private doctors (27%).

- We also found that proportionately more Africans who live in rural areas in the former homelands (41%), on white owned farms (39%), in traditional dwellings (43%) and in shacks (37%) had not received health-care in the past year, as against those in formal brick housing (34%).

Avoiding or Delaying Seeking Treatment when it was Needed in the Past Year

To explore utilisation of health services further, the respondents were asked to indicate:

- Whether there was a time during the past year when they wanted to seek health-care or treatment, but they decided against going, and if so, they were requested to state the main reason for this decision.

- They were also asked to say whether they had delayed seeking treatment in the past year because they were worried about the cost.

Table 6.2: Failing to or delaying seeking treatment in the past year by race

Failing or delaying seeking treatment in the past year	African	Coloured	Indian	White	Total
	%	%	%	%	%
Needed care but failed to go	19*	28*	14*	16*	20*
Among those who failed to go - Main reason:					
Could not afford it	74	47	60	23	64
Could not afford transport	12	5	2	1	9
No time (work and home)	6	17	10	17	8
Problem not serious	6	16	11	43	12
Inconvenient	1	2	14	6	3
Embarrassment	0	9	1	8	2
Other	1	4	2	2	2
Total	100	100	100	100	100
Delaying treatment because costs too high	17*	19*	14*	11*	16*

*** The balance of this percentage adds up to 100**

- Table 6.2 indicates that 19% of Africans and 28% of coloureds decided against going for health-care in the past year when they wanted to go.
  - Almost three quarters of Africans (74%) and six out of every 10 Indians (60%) who did not go for health-care when they wanted to during the past year said they could not afford the costs, compared to proportionately fewer coloureds (47%) and even fewer whites (23%).
  - In contrast, a large proportion of white respondents (43%) did not go for care in the past year when they wanted to, because they did not consider their illness to be serious enough to warrant a visit to a health professional.

- In addition to costs, dissatisfaction with health-care received at the past visit was found to be related to failing to go for treatment.
  - For example, among those who felt that the staff did not listen to them the last time they went for treatment, 32% of respondents decided against going when they wanted to during the last year, compared to 19% amongst those who felt that the staff did listen.

- One in every six (16%) respondents said they had delayed going for health-care in the past year when it was required because of the costs.
  - Proportionately more coloureds (19%) and Africans (17%) delayed seeking care because of costs, compared to Indians (14%) and whites (11%).

- Those who were most in need of care, for example, the chronically ill (30%), the disabled (29%), those who rated their health status as fair (27%) or poor (45%) were more likely than average (16%) to delay seeking care when they needed it because of high costs.

- Those living in poor socio-economic conditions, for example shack-dwellers (22%), the unemployed (22%) and those living in households with incomes below the minimum living level (22%) were also more likely than average (16%) to delay seeking treatment because of cost.

Experiences During the Last Visit to a Health-Care Site

- We requested the respondents to think of the most recent time they went somewhere for health-care for any problem. They were asked to indicate:
  - where they went (or where they went first, if they were referred elsewhere),
  - how they got there,
  - how long it took to get there,
  - how much time they spent waiting before being seen and
  - how long the doctor, nurse or other health-professional spent talking to them and examining them.

Table 6.3: Where respondents went for health care, how they got there and how long it took by race

At last visit, where respondents went for care, how they got there and how long it took	African	Coloured	Indian	White	Total
	%	%	%	%	%
Site of health-care: Public hospital	28	16	10	9	24
Public clinic	40	24	5	3	32
Private practice	28	57	84	82	40
Other	4	3	1	6	4
Total	100	100	100	100	100

Transport to get there:					
Taxi/bus/public transport	51	20	11	5	41
Walking	37	43	25	12	43
Private car	7	30	64	81	22
Ambulance	1	2	0	1	1
Other	4	5	0	1	2
Total	100	100	100	100	100
Duration of trip: 1/4 hr. or less	36	61	81	85	47
About 1/2 hr.	38	25	16	12	32
About one hour	17	10	3	2	14
More than one hour	7	2	0	1	6
Other	2	2	0	0	1
Total	100	100	100	100	100

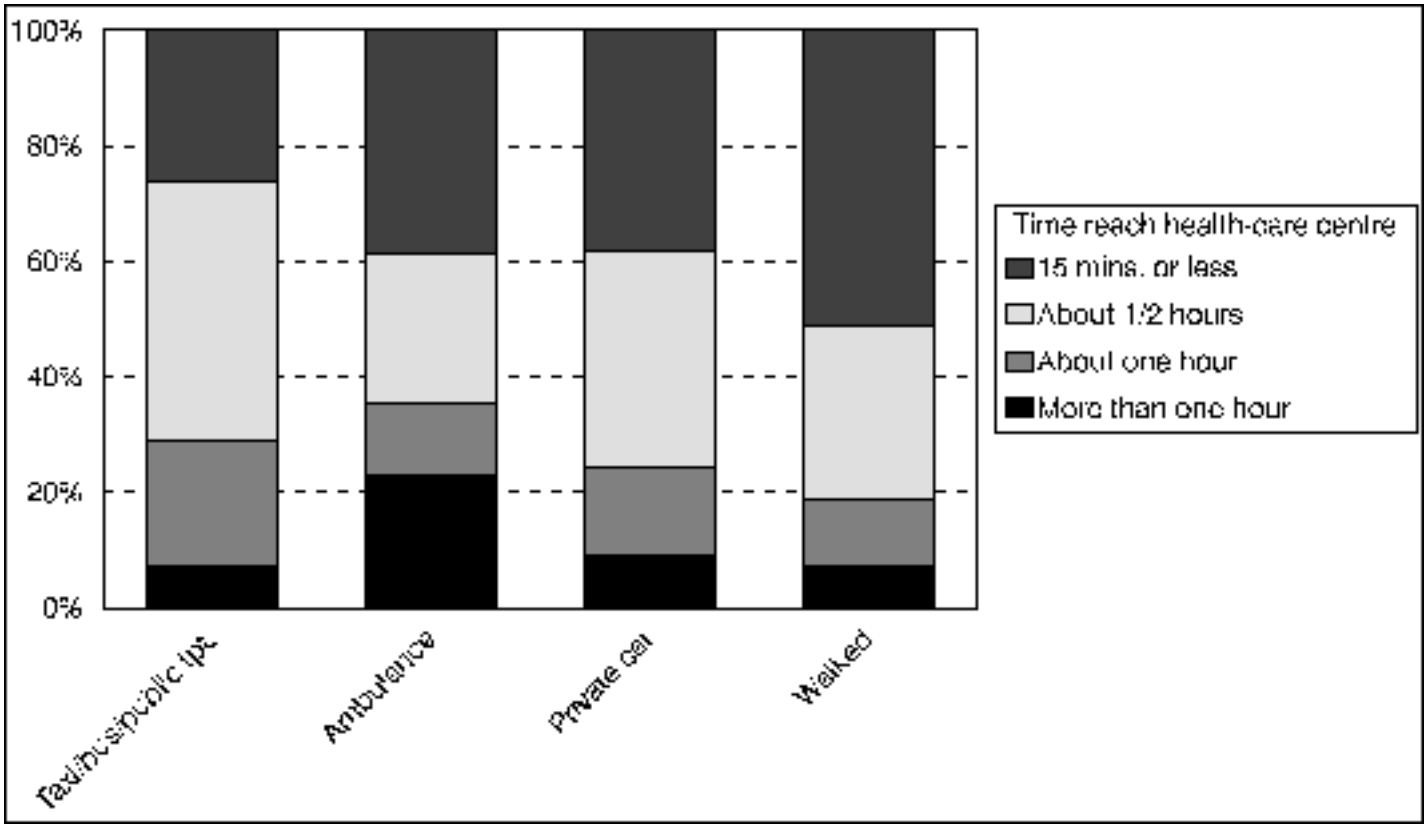
- Table 6.3 shows that more than two thirds of African adults (68%)used public health-care centres the last time they went for care, while more than half of the coloureds (57%), and the vast majority of whites (82%) and Indians (84%) made use of private facilities.

- Africans were likely to use taxis, buses or other forms of public transport (51%) or else to walk (37%) to reach the health-care facility, while whites tended to use private cars (81%).

- Africans generally took longer to reach the health care facility than the others.

- Among Africans, Figure 6.2 indicates that 75% of respondents who used private cars and 71% who used taxis, buses or other forms of public transport had reached their health-care facility within a half an hour, while a large proportion who had travelled by ambulance (36%) had taken about an hour or even longer to get there.

FIGURE 6.2. Time to Reach Health Care Facility by Mode of Transport



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- Among those who walked, just over half (51%) reached the health facility within 15 minutes, but one in five (19%) took about an hour or even longer to get there. This applied particularly to those in rural areas.

- A large proportion of Africans living in rural areas which were previously part of the homelands (36%) generally, or more specifically those in traditional dwellings (40%), took about an hour or even longer to reach their health-care facility, compared to relatively few metropolitan dwellers living in formal brick housing (11%) or even those in informal settlements in metropolitan areas (14%).
  - The time that it takes Africans in rural areas to reach a health centre clearly is a barrier to utilisation of health-care facilities.

Table 6.4: Time spent waiting to be seen at health-care facility by race

Time spent waiting for treatment	African	Coloured	Indian	White	Total
	%	%	%	%	%

1/2 hour or less	26	30	42	53	31
About 1 hour	22	27	28	33	24
2 - 3 hours	28	19	13	8	24
4 - 5 hours	18	14	13	4	15
Most of the day	4	7	4	2	3
Do not know	2	3	0	0	3
Total	100	100	100	100	100

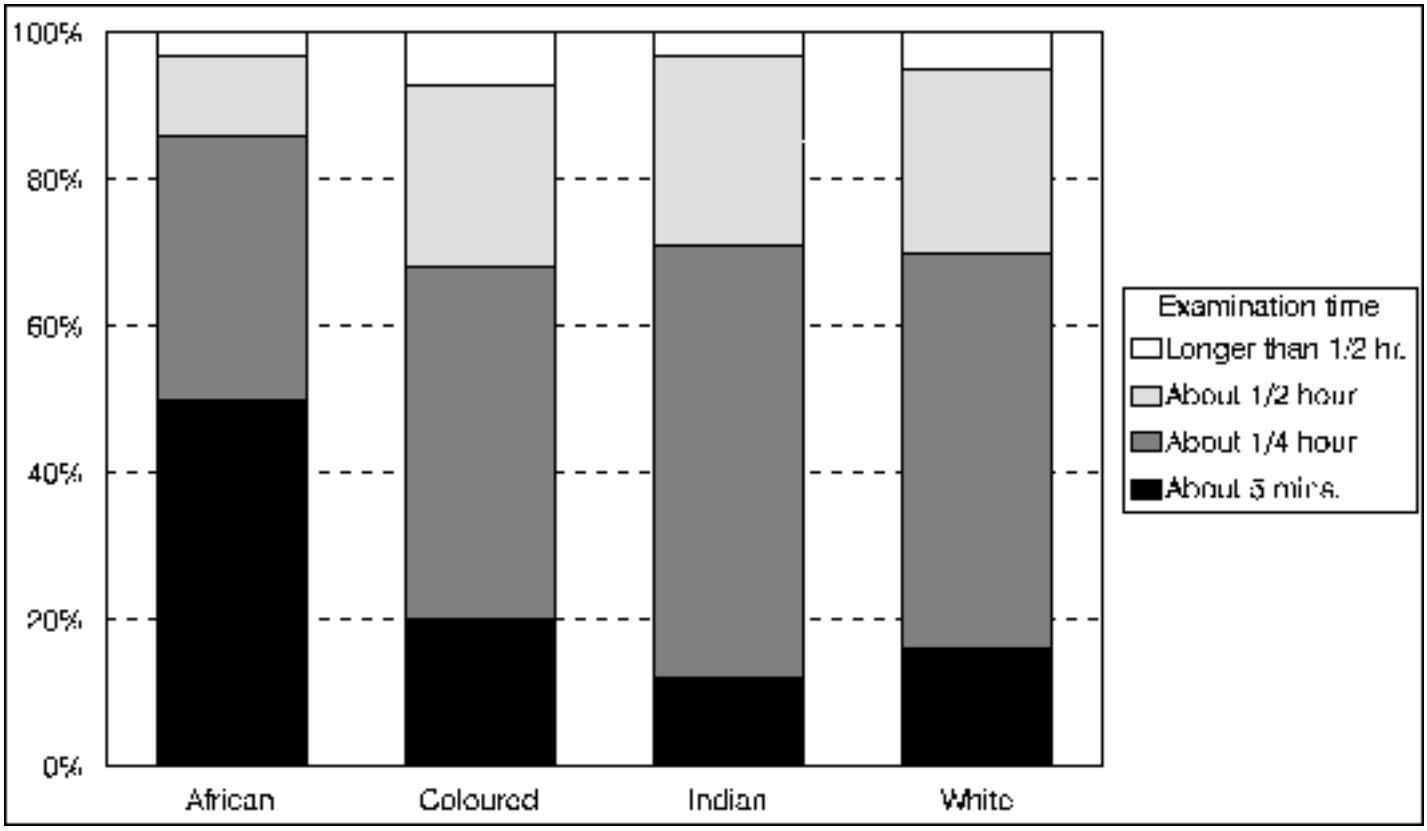
- Another non-financial barrier to health-care is the amount of time people are kept waiting before they are seen by a health-care professional. Table 6.4 shows that Africans in particular, but also coloureds, are likely to be kept waiting for long periods of time before they are seen.
  - Half the African sample (50%) waited for a minimum of two hours before being seen by a health-care professional compared to 14% of whites.

- Among Africans, the amount of time one was kept waiting before a consultation was largely influenced by whether one went to a public hospital, a public clinic or private source of health-care.
  - Among those who went to a public hospital, 63% spent at least two hours waiting to be seen, compared to 51% who went to a clinic and 40% who went to a private doctor.
  - There were also some slight differences regarding the amount of time one was kept waiting in rural, urban or metropolitan areas. For example, 54% of those who lived in rural areas were kept waiting for at least two hours before being seen, compared to 48% of those living in both formal and informal metropolitan areas.
  - The chronically ill (57%) and the disabled (56%) were more likely than average (50%) to be kept waiting for at least two hours before being seen by a health-care professional.

The Amount of Time that the Consultation Lasted

- Figure 6.3 indicates that half the Africans (50%) were seen for approximately five minutes, compared to relatively fewer coloureds (20%), whites (16%) and Indians (12%).

FIGURE 6.3. Time Taken by Health Care Professional for Examination and Consultation by Race



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- Among Africans, the length of the consultation and examination did not depend on how long one had been kept waiting. Approximately half the respondents were seen for about five minutes, even if they had waited for more than two hours.
  - But there was one exception; only 34% of those who had waited for most of the day to see a health professional, said that they had been seen for five minutes, compared to 51% of those who had waited about an hour.
  - The site of care made a slight difference. Proportionately fewer Africans who went to private doctors (46%) were seen for about five minutes, compared to those who went to public hospitals (50%) or public clinics (58%).
  - Those living in rural homeland areas were more likely to be seen for only five minutes (56%) compared to those living in metropolitan formal dwellings (41%).
  - Proportionately more of those living in households earning below the minimum living level (53%) were seen for about five minutes by a health-care professional, compared to those in households earning more than this (43%).

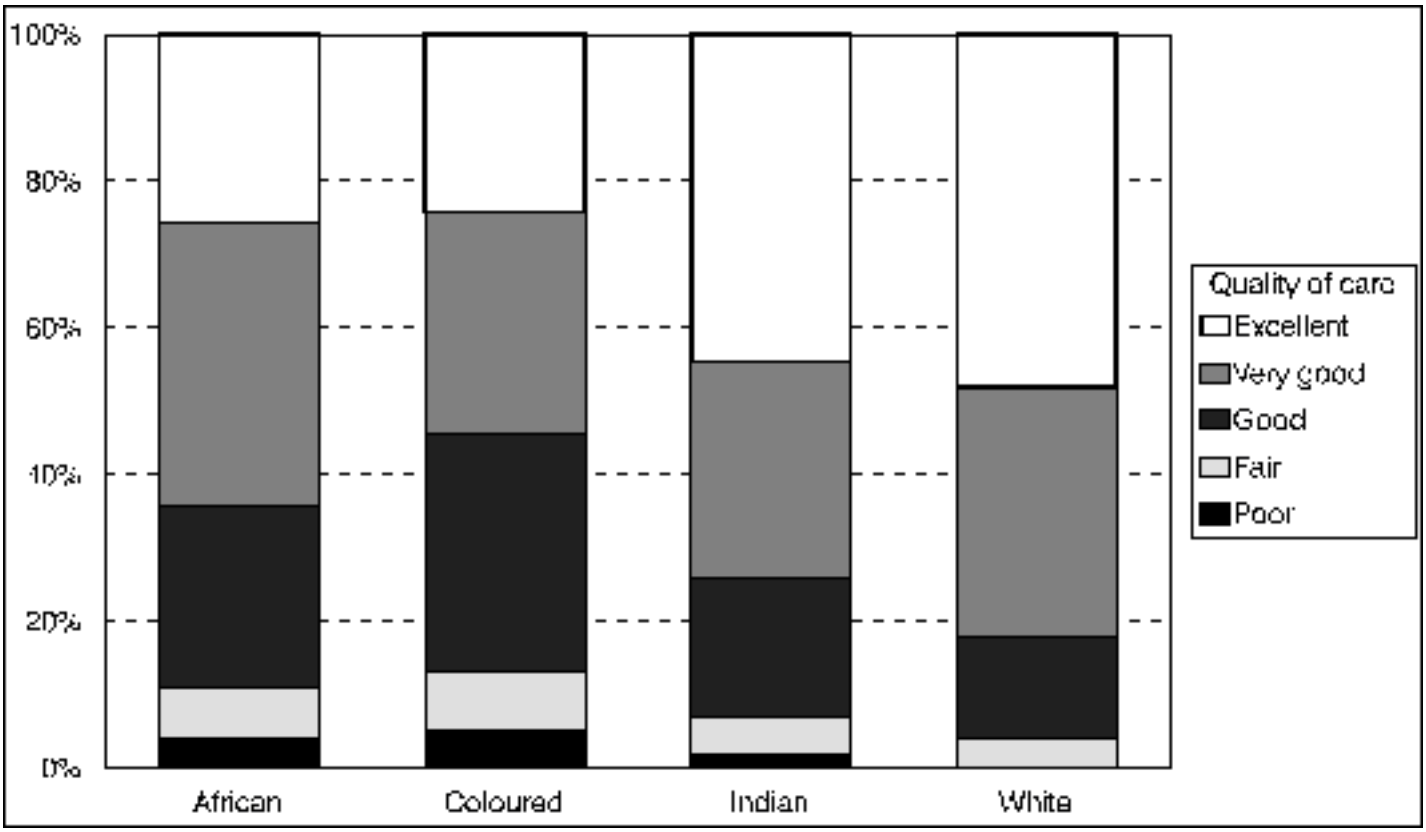
- These findings clearly point to the fact that perceptions do exist among the recipients that little has been done to ensure that health-care is accessible, and of an acceptable standard to everyone. Waiting times are long, and consultations are short.

Satisfaction with Health Services

- Figure 6.4 indicates that coloureds and Africans tended to rate the health care they had received at the last visit lower than Indians or whites.
  - Almost half the white respondents (48%) rated this care as excellent, compared to approximately a quarter of Africans (26%) and coloureds (24%).

- Among Africans, differences in ratings were found between those who used public versus private facilities, between rural versus urban dwellers, between poorer versus more affluent people and between those in poorer versus those in better health:
  - A large proportion of those who had gone to a private doctor (42%) rated the health-care they had received as excellent, compared to relatively few who gave this rating among those who had gone to a public hospital (21%) or clinic (16%).

FIGURE 6.4. Quality of Care by Race



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- Relatively few of those living in rural homelands (19%), or those living in traditional dwellings (14%) in particular, and those living on white-owned farms (24%) rated the health-care they had received as excellent, compared to those living in formal brick housing in urban (35%) or metropolitan areas (32%), while shack dwellers were close to the average (27%).
- The poorer respondents were likely to rate the health-care they received lower than average. For example, only 22% of those in households with incomes below the minimum living level rated the health-care they had received as excellent, compared to 35% living in households above this level. Twenty two percent of those living in highly crowded homes rated the health-care they had received as excellent, compared to 38% in uncrowded ones.
- Proportionately fewer of those who judged their physical health-status as poor (24%) rated the health-care they had received at the last visit as excellent, compared to those who rated their health-status as excellent (46%).
- Relatively few of those with chronic illnesses (20%) rated the health-care they had received at the last visit to a health facility as excellent, compared to the average (26%).

Table 6.5: Specific experiences when using health-services by race

Specific experiences at last visit to health-care facility	African	Coloured	Indian	White	Total
	%*	%*	%*	%*	%*
Rudeness or impatience	7	5	2	2	6
Kindness and helpfulness	93	93	99	96	93
Rough handling	8	5	1	3	7
Careful listening	94	94	97	95	94
Good explanations of what was wrong	89	91	97	91	89

*** The balance of each percentage shown in the table adds up to 100.**

- Table 6.5 indicates that, contrary to the impression created in the focus-group discussions, from which some of the questions in this survey were derived, relatively few respondents complained of rudeness (6%) or rough handling (7%) by health-care personnel. Instead, the vast majority (93%) said that the staff were kind and helpful.
  - In the focus groups, a recurring complaint was staff rudeness and shouting. Perhaps a more qualitative method than a survey is required to bring these dissatisfactions to the fore. Another explanation for this contradiction is the low level of expectations among Africans that they might be treated better.

- Nevertheless, certain groups were more likely to say that they had been treated badly during their last visit to a health-care facility:
  - One in 10 (11%) of those living in shacks or in informal settlements complained of rudeness, compared to one in 20 (5%) in formal brick dwellings. One in six (15%) shack dwellers said that the staff were unkind or unhelpful, compared to one in 20 (5%) of those in formal brick dwellings.
  - Almost one in every 10 respondents using a public clinic (9%) said that they were treated rudely or roughly, compared to only one in every 33 respondents using a private doctor (3%).

- A surprising finding was that among Africans, level of education, poor socio-economic conditions or even a rural place of residence did not influence whether the respondent felt he or she had been given a good explanation of the illness or problem. Approximately 10% of respondents across all variables were not satisfied with the explanations they were given, while 90% were satisfied. This is obviously a subjective finding because the less educated the respondent, the less of an explanation they are likely to expect or understand.

Rating of the Existing Health System

As a further measure of satisfaction with health-care in South Africa, the respondents were asked to indicate how well the existing health system works for them and how much it should change.

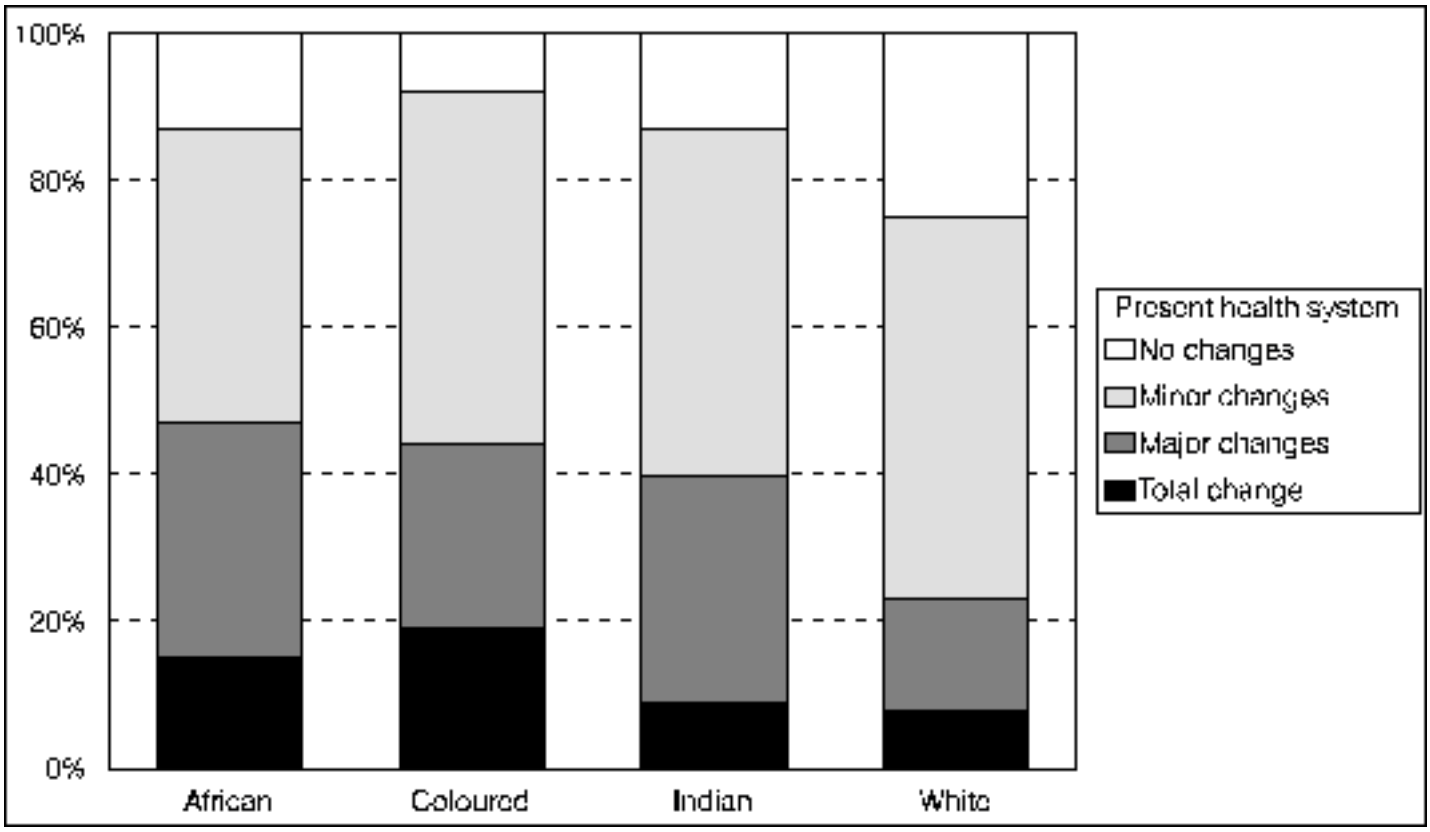
- In this regard, they were requested to choose one of the following four options:
  - It works very well; no changes are required.
  - It works fairly well; only minor changes are required.
  - It works fairly badly; major changes are needed.
  - It works very badly; a totally different system is needed.

- Overall, one in every seven respondents (14%) believed that the present health system works very well, and a further one in every seven (14%) believed that it works so badly that an entirely new health system is required.

- Figure 6.5 indicates that almost half the African (47%) and coloured (44%) respondents thought that the present health system works either fairly badly or very badly and major changes, if not entirely new systems, are needed.
  - Whites are generally satisfied with the present system with 25% saying that it works very well, and that no changes are needed,and 52% saying that only slight changes are required.

- Among Africans,
  - Proportionately more of those living in either formal (24%) or informal (26%) areas in smaller urban cities and towns and those living on white-owned farms (22%) said that the present health system works very badly for them, and a totally new system is needed, compared to those living in either rural homelands (12%) or in metropolitan areas (10%).
  - The more educated respondents, particularly those with post-school education (21%) were more likely to say the system works very badly compared to those with no education (10%).

FIGURE 6.5 . Evaluations of the Existing Health Care System by Race



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- Dissatisfaction with the way in which one had been treated was related to negative feelings about the health system in general. Three out of every 10 respondents (30%) who felt that the staff did not listen to them sufficiently at the last visit said that the present system works very badly, compared to 14% who said the staff did listen.

Community Participation in Health Care

- We examined two issues in relation to community participation in health services:
  - using community health workers for certain tasks and
  - giving people more say in the way in which their health-care centres are run.

The responses to these issues are discussed below.

The Use of Community Health Workers

Community health workers are used extensively in other countries as part of primary health-care services. In South Africa, however, there are relatively few of these workers at present.

- To probe the respondents' attitudes to community health workers, we first explained their role as follows:
  - Some people are talking about training ordinary people in our communities to help the professionals, for example training them to do home visits among the aged, to help the disabled and to give health education.
  - We then asked the respondents to indicate whether or not these people would improve health services for them personally.

Table 6.6: The extent to which community health workers would improve services by race

Trained community health workers would:	African	Coloured	Indian	White	Total
	%	%	%	%	%
Definitely improve health services	71	68	59	30	65
Probably improve health services	19	21	28	32	21
Unsure	8	8	7	16	9
Probably not improve health services	2	1	4	8	3
Definitely not improve health services	1	2	2	14	3
Total	100	100	100	100	100

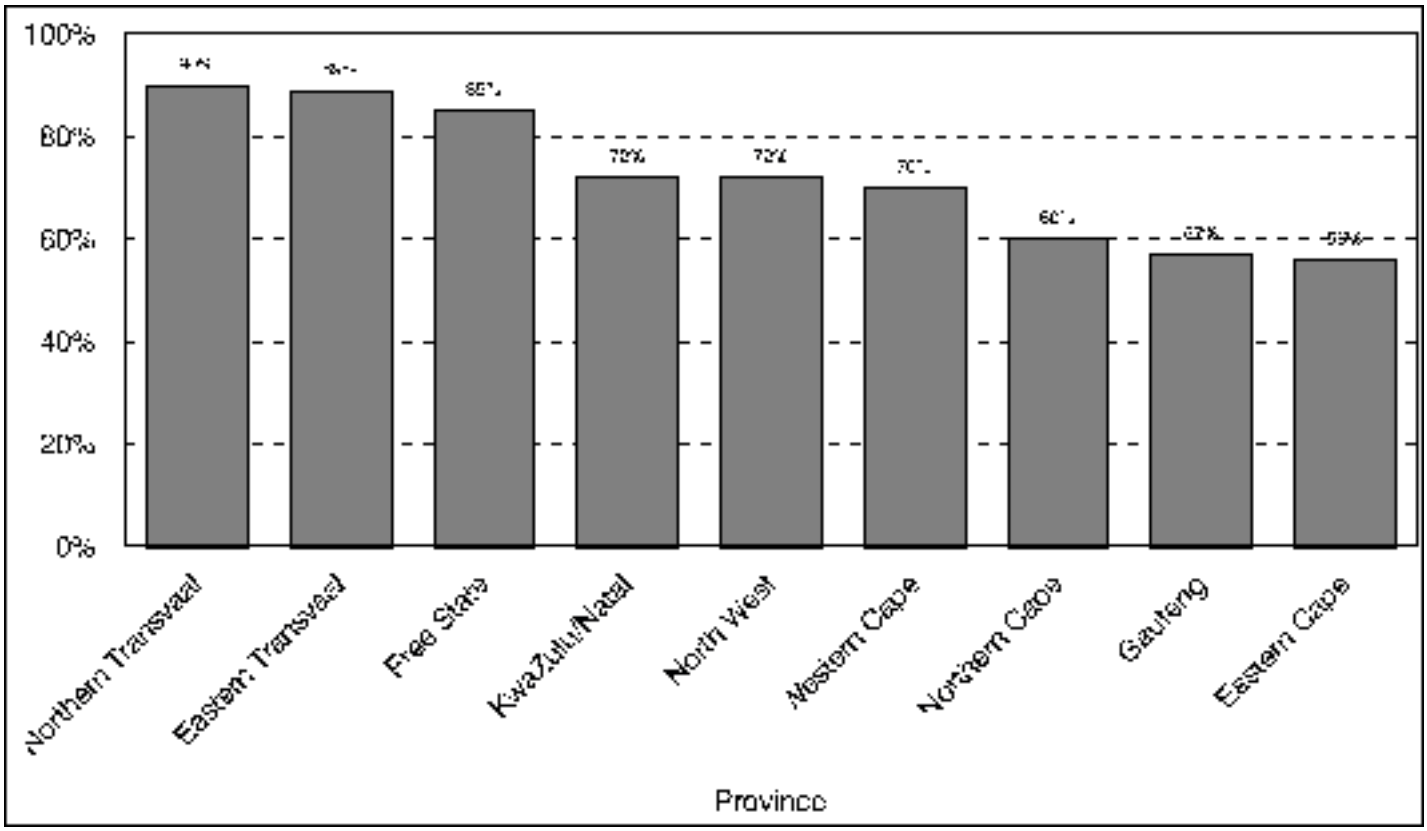
- Table 6.6 shows that the vast majority of Africans (71%) and coloureds (68%) and the majority of Indians (59%) thought that community health workers would definitely improve health services for them, but relatively few whites (30%) felt this way, probably because they have grown accustomed to the general practitioner playing this role.

- In general, proportionately more of those living in rural areas (74%) were likely to favour community health workers, rather than those in formal (58%) or informal areas (59%).

- Among Africans, while there was general acceptance of the need for community health workers to improve health services, the more educated respondents (77% of those with matriculation and 81% with post-school qualifications as against 67% with no formal schooling) were more likely to approve of this idea.

- Figure 6.6 indicates that, among Africans, the vast majority of respondents living in the largely rural provinces where health-care centres are remote (for example, 90% in the Northern Transvaal and 89% in the Eastern Transvaal) think that community health workers would definitely improve health services, compared to those living in provinces which are largely metropolitan (for example 57% in Gauteng).

FIGURE 6.6. Africans Who Think Community Health Workers Would Improve Health Care



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Having a Say in Running Local Clinics

Democratisation of health-care means involving people in decision-making in issues that affect them.

- We asked the respondents to indicate whether or not they think that members of the community should be involved in:
  - Deciding on times when local clinics should be open or closed.
  - How staff deal with patients.
  - What people should pay for services.
  - The appointment of staff members.

Table 6.7: Percentage of respondents who think that community members should have a say in aspects of running a local clinic by race

Community members should have a say:	African	Coloured	Indian	White	Total
	%*	%*	%*	%*	%*
Deciding on times when clinics open	83	84	96	79	82
How staff deal with patients	70	81	94	71	72
What people should pay for services	66	74	90	69	67
Appointing staff members	48	57	71	38	48

*** The balance of each percentage shown in the table adds up to 100.**

- Table 6.7 indicates that the vast majority of respondents would like to have a say in the way in which their local clinics are run.
  - This applies particularly to opening times of clinics (82%), but it also applies to staff dealings with patients (72%) and what people should pay for services (67%).
  - Relatively fewer respondents (48%), but close to half, felt that community members should have a say in staff appointments.

- While there was generally wide support for community participation in the running of clinics, almost all the Indian respondents (96%) were in favour of this process.

The Use of Traditional Healers

The traditional healer, as an integral part of African culture, offers a service which fulfils functions far beyond those of the western health professional. Because of their standing in the community, they could be valuable partners in the delivery of health-care. (Abdool Karim et al., 1994).

- The analysis of this section applies only to the African respondents. We explored the extent to which they utilise the services of these healers as follows:

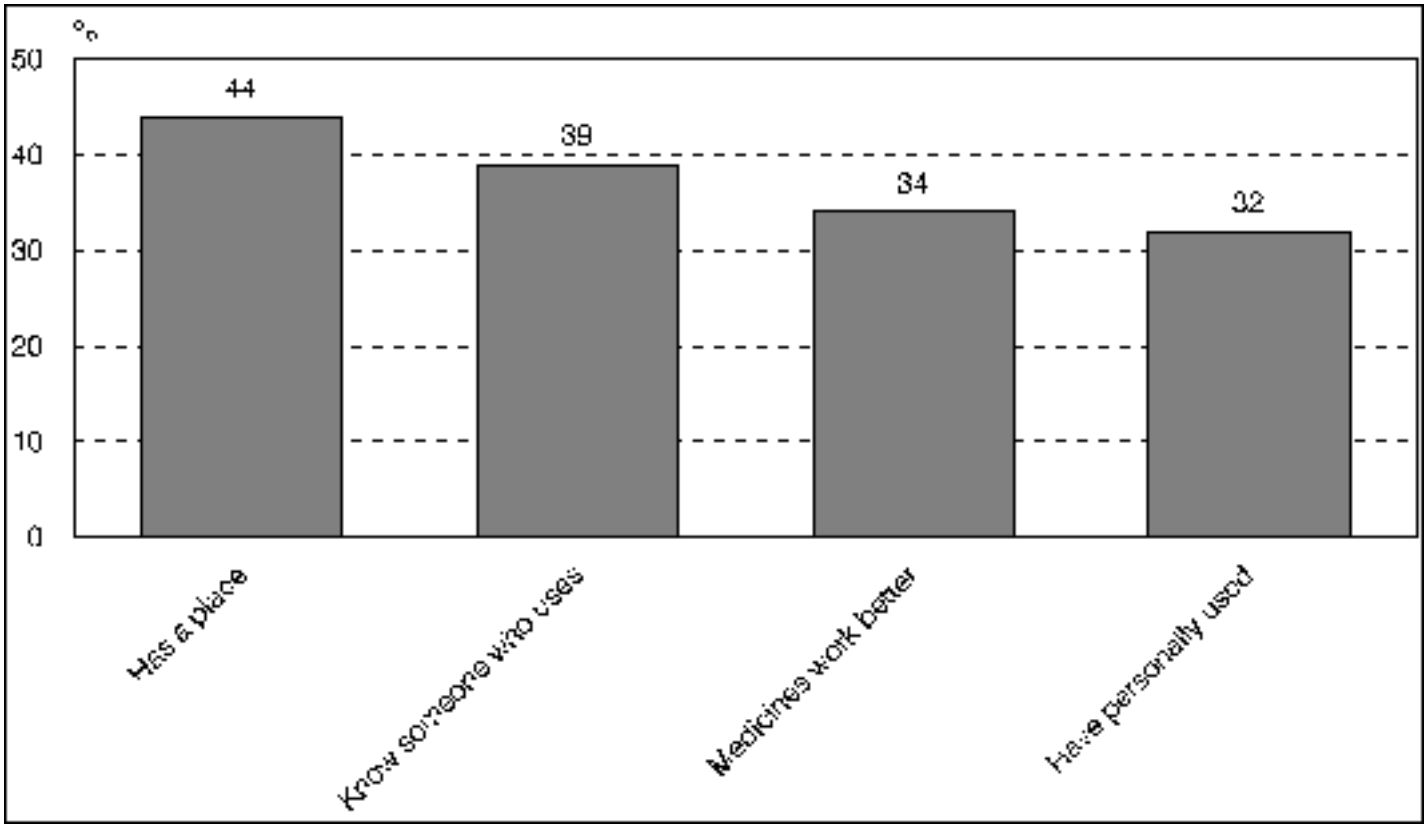
- We initially introduced the subject by saying: "Let us talk about traditional healing by considering the way in which some people compare it to western medicine." We requested the respondents to make two comparisons:
  - Sipho says that traditional medicine no longer has a place in modern society. Thabo says that traditional medicine has a definite place in modern society. Who do you agree with most, Sipho or Thabo?
  - Khetso says that western medicines work better because they are based on science. Farouk says that traditional medicines work better because they have been handed down from generation to generation. Who do you agree with most, Khetso or Farouk?

- Respondents were asked whether a good friend or family member had ever told the respondent they had visited a traditional healer, and whether the respondent had ever done so.
  - Among those who said they had personally visited a traditional healer, we examined how many times, if any, they had gone in the past year and whether they had used these healers instead of or in addition to western health-practitioners.

The results of the study show that traditional healing continues to play an important role in health-care.

- Figure 6.7 indicates that almost half of the African respondents (44%) believe that traditional healing has a definite place in society, while almost one in four (39%) knew a relative or friend who had visited one. One in three respondents (34%) believe that traditional medicines work better because they have been handed down from generation to generation.

FIGURE 6.7. Africans Who Expressed Positive Attitudes About Traditional Healers



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- One in every three respondents (32%) indicated that they had personally consulted a traditional healer.

- Males (35%) were more likely than females to say that they personally had visited a traditional healer.

- Respondents with some primary school education (40%) were more likely to say that they had visited a traditional healer, compared to those who had not gone to school (32%), or those with a high school (29%) or post-school (27%) education.

- Poverty and overcrowded circumstances did not have an influence on the proportion of people using traditional healers.

- Using traditional healers is not a rural phenomenon. Metropolitan inhabitants of formal dwellings (38%) were more likely to say that they personally had used the services of traditional healers, compared to those living in rural areas (32%), in metropolitan informal areas (30%), in urban areas (31%) or on white-owned farms (27%).

- Regarding age, 22% of those aged between 16 and 24 years had consulted a traditional healer, increasing to 36% of those aged between 25 and 49 years and 38% of those aged between 50 and 64 years.

- The same proportions of the chronically ill and the disabled (35%) had visited a traditional healer.

Visits in the Past Year

The services of traditional healers are relatively frequently utilised, but these visits take place in addition to, rather than instead of, consultations with western health-care personnel.

- Among those who had visited traditional healers, 23% said that had not gone at all in the year prior to the interview, while 66% had visited one between one and five times and 11% had gone to see one six or more times.

- Among those who use the services of traditional healers, 78% said that they went to them in addition to going to western health-professionals, while 22% said that they use them instead of western practitioners, for different purposes.

Summary and Conclusions

This chapter examined the extent to which individuals aged between 16 and 64 years utilise health services, and their perceptions of the quality of the available care.

The findings indicate that there are both financial and other barriers preventing people in this age category from seeking health-care, or delaying seeking it, when they need it. Africans in particular are likely to avoid seeking health-care when they need it for financial reasons. In general, we found that the poor, rural inhabitants and those living in overcrowded conditions have less access to care, compared to other respondents.

The time that it takes to reach the health care centre and the costs of travelling also act as barriers to health-care utilisation. The long waiting times for Africans once they reach the centre, particularly those using the public sector, act as further disincentives. Many people, having waited for at least two hours for a consultation find that the actual visit lasts five minutes or shorter. This applies particularly in the public sector.

Relatively few respondents reported experiencing rudeness or impatience at the last visit to a health-care facility. However shack dwellers and those using public clinics and hospitals were more likely to complain of staff rudeness, compared to the other respondents.

Dissatisfaction with the present system of health care was more likely to be expressed by Africans, coloureds and Indians, rather than whites. In general, whites reached their health-care centre quicker, waited for shorter times to be seen and were given attention for longer periods of time, therefore it is hardly surprising that they tend to want only slight modifications, if any to the present system.

Having community health workers offer services such as home visits and health education

was strongly supported, but white respondents were less likely to support this suggestion, compared to Africans. Those living in remote rural areas were highly likely to want community health workers to be introduced.

The idea of community members having a say in the running of local clinics was strongly supported, particularly the idea of giving people a say in the opening times of the clinic.

One in every three African respondents indicated that they made use of the services of traditional healers. The vast majority of those using them said that they consulted both western practitioners and traditional healers when they become ill.

 Chapter 5


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Chapter 7 

Chapter 7.
Chronic Illnesses and Disabilities: Adults aged 16 to 64 Years

A National Household Survey of Health Inequalities in South Africa

Ros Hirschowitz and Lebogang Taunyane

CHAPTER SEVEN.

Introduction

This chapter focuses on adults aged 16 to 64 with chronic diseases, difficulties in carrying out activities of daily living and disabilities.

We determine the proportion of respondents who have at least one chronic disease or ongoing health condition, the proportion of those with functional impairments, for example, difficulty in washing or bathing, and those who have at least one disability. We examine the impact of socio-economic factors on their health.

We also look at the health-care services which are available to these respondents, and the extent to which they utilize them.

Indicators that Apply to this Chapter

The following health indicators apply to this chapter:

- Management of chronic diseases, measured by:
  - The percentage of those with a chronic illness who go for regular check-ups (at least every two to three months)

- Management of disability, measured by:
  - The percentage of disabled people who have had therapy or rehabilitation assistance

Chronic or Ongoing Illnesses

Respondents were asked whether or not they had ever been told by a doctor, nurse or other health-professional that they have chronic or ongoing health problems, such as diabetes, high blood pressure, a heart condition, epilepsy or arthritis.

- Overall, 25% of respondents reported that they had at least one chronic or ongoing illness.

- Females (30%) were more likely to report having at least one chronic illness diagnosed by a health-professional compared to males (19%).

- The prevalence of chronic diseases increases with age. Thus 12% of those aged between 16 and 24 years mentioned at least one chronic disease from which they suffered, increasing to 18% amongst those aged between 25 and 34 years, 28% of those aged between 35 and 49 years and 56% of those aged 50 and 64 years.

Table 7.1: Proportion of respondents with chronic illnesses by province, area and type of dwelling and by race

	African (N=16,2m)	Coloured (N=1,8m)	Indian (N=0,6m)	White (N=3,2m)	Total (N=21,8m)
Percentage who have a chronic disease	%*	%*	%*	%*	%*
Province: Western Cape	28	26	26	28	27
Northern Cape	40	18	27	29	29
Eastern Cape	24	33	NA	42	26
KwaZulu-Natal	22	NA	NA	28	23
Gauteng	23	23	NA	31	26
Eastern Transvaal	17	NA	NA	37	19
Northern Transvaal	17	NA	NA	33	17
Northwest	32	NA	NA	38	33
Free State	30	NA	NA	29	30

Area: Metro formal	20	23	24	32	25
Metro informal	25	**	**	NA	25
Other urban	26	26	37	30	28
Other urban informal	27	**	NA	NA	27
Rural white farms	25	36	NA	NA	26
Rural - homeland	22	NA	NA	NA	22
Type of dwelling:					
House/flat etc.	22	26	26	31	24
Shack/outbuilding/zozo	27	**	**	NA	27
Traditional dwelling	25	NA	NA	NA	25
Total with at least one chronic disease	23	26	26	31	25

*** The balance of all percentages indicated in the table add up to 100%**
**** Numbers too small for reporting percentages**
NA This category is not applicable as there were no respondents

- White respondents (31%) were more likely to say that they had this type of health problem, followed by Indians and coloureds (26% in both cases), and then Africans (23%).
  - This finding may be due, in part, to the better access among whites to health-care, compared to other race groups generally, and Africans in particular. Chronic illnesses may be diagnosed more frequently among those with better access to care.
  - On the other hand, this finding of lower rates of chronic illness among Africans compared to whites also may be due, at least in part, to differences in life-styles, for example, diverse diets in rural and urban areas.
- We explore this hypothesis of under-diagnosis as a result of poorer access to health services further by examining differences in the reporting of chronic diseases between provinces, rural-urban environments and type of housing by race.

- Table 7.1 indicates that the proportion of people who claim to have chronic diseases differs by province, rather than by area or type of dwelling.
  - Among Africans living in poorer provinces, where rural areas in the former homelands are remote from towns and cities, and where health services are often far away, for example, the Northern or Eastern Transvaal (17%), proportionately fewer people say they have a chronic illness diagnosed by a health professional, compared to the average for Africans (23%).
  - A similar picture emerges regarding coloureds. Among those living mainly in rural areas in the sparsely populated Northern Cape (18%), proportionately fewer people report having chronic illnesses compared to the average for coloureds (26%).

- It therefore seems as if access to health-care facilities is related to the extent of diagnosis of chronic diseases.

- In certain provinces, however, a larger proportion of respondents than average (for example 40% of Africans in the Northern Cape, 42% of whites in the Eastern Cape) report that they have a chronic illness. To explain these findings we need to look more closely at type of illness, as discussed below.

Table 7.2: Percentage of those with a particular chronic illness by race

	African	Coloured	Indian	White	Total
Type of illness	%*	%*	%*	%*	%*
Hypertension	9	11	11	11	9
Arthritis	7	9	15	9	8
Asthma/breathing problem	5	6	7	8	5
Heart problem	4	3	4	3	4
Diabetes	2	3	7	2	2
Epilepsy	1	1	1	2	1
Cancer	0	0	1	2	1
Total with at least one chronic disease	23	26	26	31	25

*** The balance of all percentages indicated in the table add up to 100%**

Table 7.2 indicates the proportion of respondents with a specific type of chronic illness. Diseases that were reported by fewer than 1% of respondents overall, for example, chronic skin conditions, migraine and ulcers, are not shown.

- The table shows that hypertension tends to be more frequently diagnosed among coloureds, Indians and whites (11%), than Africans (9%).
  - Among Africans, hypertension is less frequently reported among those living in informal settlements (7%), on rural white-owned farms (7%) and in rural homeland areas (8%), compared to those living in urban formal areas (12%). This finding may be due to altered life-styles and diets associated with urbanisation.

- Diseases which were not listed in the questionnaire, but which respondents selectively mentioned, for example, having had a stroke, water retention and swollen legs, account, at least in part, for the higher than average prevalence of overall chronic conditions in some provinces. Those in metropolitan areas were more likely to mention these problems.
  - White respondents were more likely than those in the other race groups to mention a variety of chronic ailments, each one of which constituted fewer than 1% of the total sample.

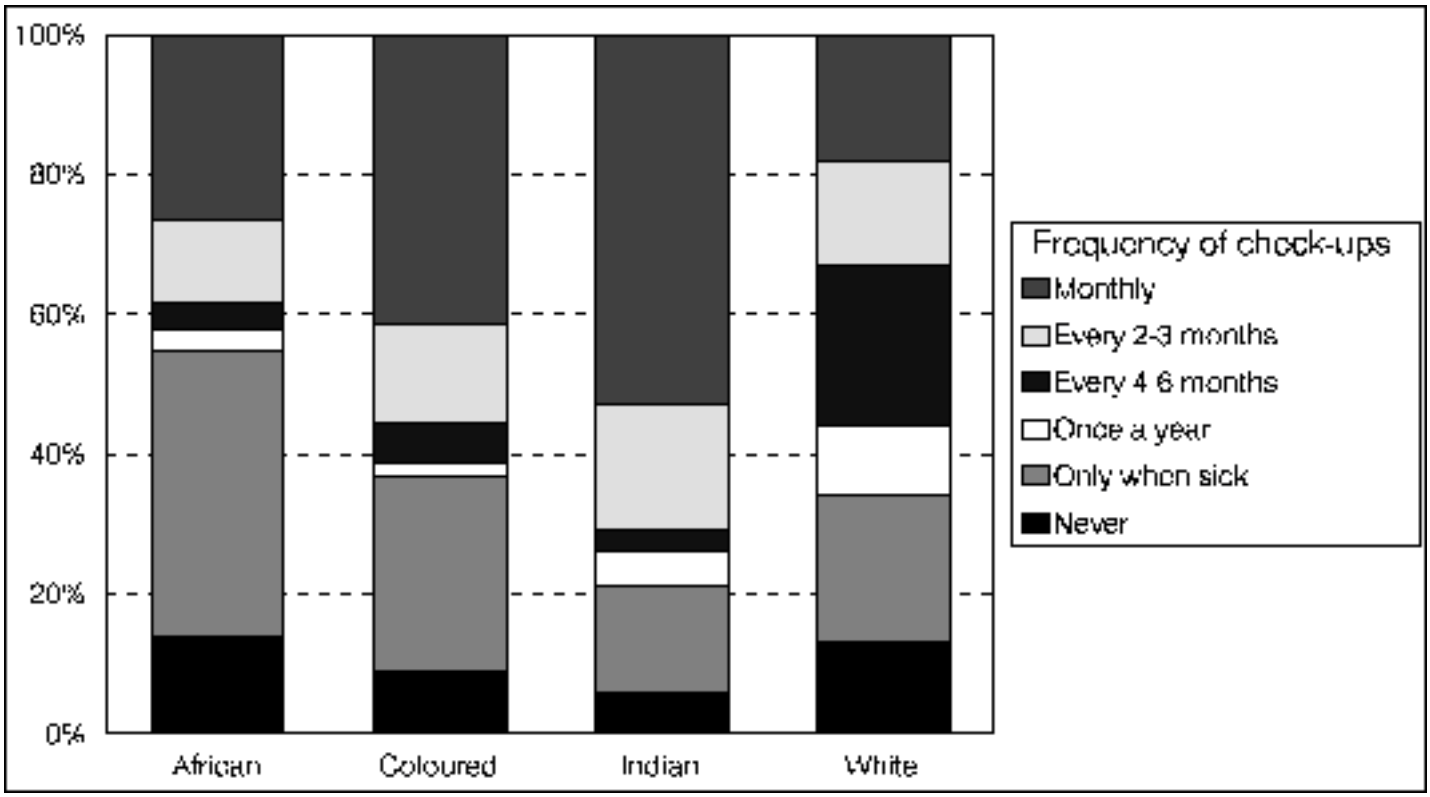
- Tuberculosis, although it was not listed as a chronic disease in the questionnaire, was reported as an ongoing health problem by 2% of African respondents in the Northern Cape, the North West and the Western Cape, two provinces with higher than average rates of reporting of chronic diseases for Africans, compared to the other provinces.
  - This disease was also reported as a chronic health problem among 2% of coloureds generally, but particularly those in the Eastern Cape (3%).
  - There were no whites or Indians who mentioned tuberculosis.
  - The literature clearly indicates that tuberculosis is associated with poverty and overcrowding (see for example the report of the Office of Technology Assessment, United States Congress, 1993). In addition this reference indicates that AIDS is associated with an increased incidence and severe manifestations of tuberculosis.

- There was an increase in the rate of reporting of specific chronic illnesses as age increased; for example:
  - 3% of those aged 16 to 24 years reported having hypertension, as against 29% of those aged 50 to 64 years.
  - 3% of those aged 16 to 24 years reported having arthritis, as against 24% of those aged 50 to 64 years.
  - 3% of those aged between 50 and 64 years reported a chronic heart condition, compared to 5% of those aged between 35 and 49 years, and 2% of those aged 34 years or younger.
  - Fewer than 1% of respondents in the age categories 16 to 24 years and 25 to 34 years had diabetes, compared to those in the categories 35 to 49 years (3%) and 50 to 64 years (8%).

- When we compare differences in age categories regarding prevalence in reporting specific chronic disease among African and white respondents, we find that Africans tend to develop chronic conditions earlier than whites. This supports the hypothesis that onset of certain diseases can be delayed by improved living conditions. Africans, as we have seen, live in far worse socio-economic conditions than whites.
  - Among Africans 11% of those aged between 35 and 49 years and 29% of those aged between 50 and 64 years complained of hypertension, compared to 8% of whites aged between 35 and 49 years and 25% of those aged between 50 to 64 years.
  - Eight percent of Africans aged between 50 and 64 years said that they had diabetes, compared to 5% of whites in this age category.

When looking at how often respondents go for check-ups for a chronic illness, or the most serious illness if they listed more than one, Figure 7.1 shows that:

FIGURE 7.1. Frequency of Check-ups for a Chronic Illness by Race



Adults aged 16 - 64 years
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- Indians and coloureds tend to go more frequently for check-ups for a chronic illness, compared to Africans and whites even though a large proportion of coloured respondents said that they only go when they feel sick (28%).
  - A large proportion of Africans (42%) go for check-ups only when they feel sick, and a relatively large proportion (14%) never go.
  - White respondents tend to spread more evenly across the entire range of options, with 18% going every month and 13% never going.

- Poverty and frequency of check-ups were found to be closely associated.
  - For example, among respondents with a chronic illness living in households with an income below the minimum living level, 16% said that they never went for check-ups and 40% went only when they felt ill, compared to those living above the poverty line, where 9% said that they never went, and 33% went only when they felt ill.

Where Those with Chronic Illnesses Usually Go for Check-Ups

- A similar pattern to the one already described in Chapter 6 for general health-care emerges, when we examine the facility that those with chronic diseases use for check-ups: Africans, and to a lesser extent coloureds, tend to use the public sector (36% of Africans go to public clinics and 34% to public hospitals; 32% of coloureds use clinics and 21% use hospitals), while Indians (45%) and whites (75%) tend to use private doctors.

- The use of private doctors for check-ups was highest among respondents living in metropolitan areas (50%) and urban areas (52%), as against those living in rural areas (30%).

- The lower the household income of the respondents, the more likely they were to go to the public clinics than to private sources for check-ups. Thus 38% of those living in households with an income below the minimum living level go to public clinics for check-ups, in contrast to only 18% of those living in households with an income above the minimum living level.

- Proportionately more respondents with a chronic disease who were unemployed (41%), retired or disabled (41%) went to public clinics for check-ups.

Access to Health Care for Those with Specific Chronic Illnesses

In this section we examine in more detail the health-care received by those with hypertension and diabetes. These two illnesses were selected for further exploration because, in both instances, careful monitoring through regular check-ups is necessary for adequate control.

Table 7.3: Among those with hypertension, frequency of visits and health care facility by race

	African	Coloured	Indian	White	Total
Among those with hypertension	%	%	%	%	%
Frequency of check-ups					
Every month or more often	33	57	66*	23	35
Every 2-3 months	9	10	19*	23	11
Every 4-6 months	5	5	0	30	9
About once a year	2	2	0	5	2
Only when ill	43	19	13*	13	34
Never	9	7	2*	7	8
Total	100	100	100	100	100
Health-care facility					
Public hospital	27	17	31*	7	23
Public clinic	36	31	30*	9	31
Private doctor	21	32	37*	70	31
Other	6	13	0	7	7
None	9	7	2*	7	8
Total	100	100	100	100	100

*** These percentages should be interpreted with caution, since they represent a small number of respondents**

Table 7.3 indicates that among those with hypertension:

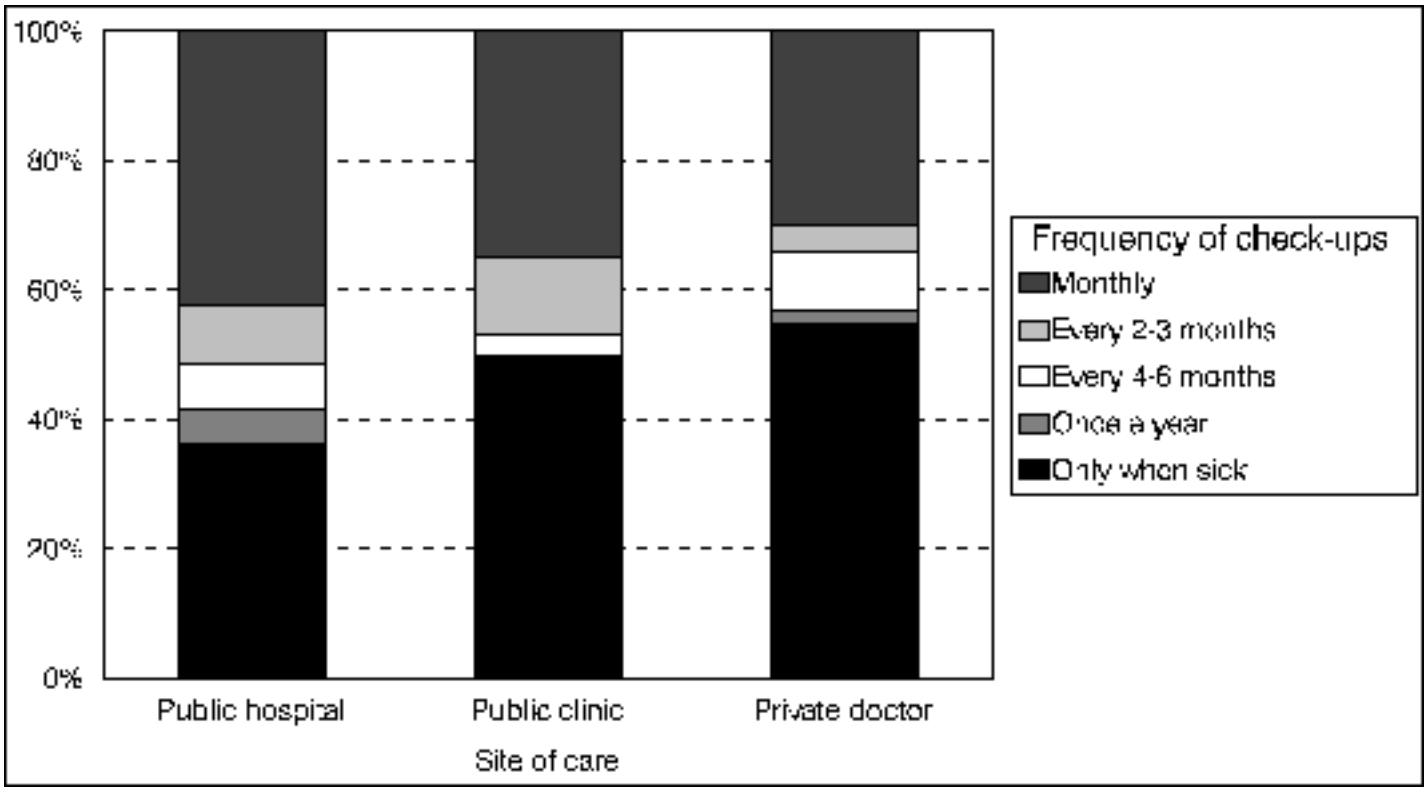
- Indians and coloureds tend to go more frequently for check-ups, compared to whites and Africans.
  - A large proportion of Africans (43%), compared to those in the other race groups (19% of coloureds, and 13% each of Indians and whites), only go for check-ups when they feel ill.

- Africans (63%) and coloureds (48%) tend to go to the public sector for check-ups, while whites (70%) tend to go to private doctors.

- Among Africans with hypertension, we examined the frequency of visits by the type of facility they use.

- Figure 7.2 below indicates that Africans with hypertension who use private facilities are likely to go for check-ups less frequently than those who use public facilities. However, even among those using the public sector, hospital facilities are likely to be more frequently utilised than clinics.
  - For example, proportionately more of those who use private doctors (55%) and public clinics (50%) only go for check-ups when they feel ill compared to those who use public hospitals (38%).
  - Those who said they never go for check-ups are excluded from the graph, because they did not answer this section.

FIGURE 7.2. Frequencey of Check-ups Among Africans with Hypertension



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- Among those with diabetes, a similar picture emerges compared to the one for hypertension. While the actual numbers of respondents in these categories are small, since, as Table 7.2 indicates, only 2% of the entire sample had this chronic condition, the emerging pattern is important, because it indicates that there are striking differences in the utilisation of health-care services, depending on type of facility used.
  - Africans tend to use public hospitals (32%) or clinics (43%) for check-ups, while whites tend to use private doctors (85%), with coloureds and Indians falling in between these extremes, tending to use either public or private facilities (for example, 40% of coloureds use private doctors).

- Among Africans with diabetes who use private doctors for check-ups, more than half (53%) go only when they feel sick, as against proportionately fewer who do so when they use public clinics (39%), while relatively few who go to public hospitals (6%) do so only when they feel sick.

- Thus, for two types of chronic conditions which require careful monitoring - hypertension and diabetes - public facilities are likely to be better utilised than private services, probably because they are more affordable.

Having Difficulty in Carrying Out Activities of Daily Living

In this section, we examine impairments preventing respondents from carrying out their normal daily living activities, for example getting in and out of bed, washing themselves or bathing and using the toilet.

Table 7.4: Difficulty in carrying out various activities of daily living by age and race

Having difficulty in performing activities of daily living	African	Coloured	Indian	White	Total
Age category	%*	%*	%*	%*	%*
All those aged 16-64 years:					
Getting in and out of bed	4	6	4	1	4
Bathing/showering/cleaning	1	2	1	1	1
Eating/feeding oneself	1	1	0	0	1
Using the toilet	1	1	1	0	1
Getting around outside the home	1	2	2	1	1
Shopping	2	3	2	2	2
Age 16-24 years:					
Getting in and out of bed	3	2	2	1	2
Bathing/showering/cleaning	0	0	0	0	0
Eating/feeding oneself	1	0	0	0	1
Using the toilet	0	0	0	0	0
Getting around outside the home	0	0	0	0	0
Shopping	0	2	0	0	0
Age 25-34 years:					
Getting in and out of bed	2	4	0	1	2
Bathing/showering/cleaning	1	1	0	0	0
Eating/feeding oneself	0	0	0	0	0
Using the toilet	1	1	0	0	0
Getting around outside the home	1	0	2	1	1
Shopping	1	0	2	1	2

Age 35-49 years:					
Getting in and out of bed	4	10	3	1	4
Bathing/showering/cleaning	1	5	0	0	1
Eating/feeding oneself	1	2	0	0	1
Using the toilet	1	4	0	0	1
Getting around outside the home	2	6	1	1	2
Shopping	3	5	2	2	3
Age 50-64 years:					
Getting in and out of bed	10	11	16	2	8
Bathing/showering/cleaning	1	2	3	5	2
Eating/feeding oneself	3	1	2	0	2
Using the toilet	1	1	3	1	3
Getting around outside the home	3	5	5	3	1
Shopping	5	10	5	5	6

*** The balance of all percentages indicated in this table add up to 100**

- Table 7.4 shows that, overall, relatively few people in the survey had difficulties in carrying out activities of daily living, for example getting in and out of bed, having a bath or shower or getting around outside the home. This result is to be expected. These difficulties are likely to be associated with people older than 64 years. As we shall see in a later chapter, the proportion of those with difficulty in performing activities of daily living increases substantially for those aged 65 years or more.
  - However, even though the percentages are low, proportionately more coloureds, rather than Africans, Indians or whites, experienced these problems.

- There is also a clear association shown in the table between these difficulties and the age of the respondents. But again, the proportion of those who experience these difficulties tends to increase unevenly across races as age increases, with whites having the slowest increment.
  - For example, as far as difficulty in getting in and out of bed is concerned, among Africans, fewer than 0,5% of respondents in the age category 16 to 24 years experienced this problem, increasing to 2% in the 25 to 34 year category and then to 4% in the category 35 to 49 years and then finally increasing substantially to 10% for those aged 50 to 64 years.
  - Among coloureds the age at which an increase is noticed is even earlier. Two percent of those aged between 16 to 24 years, 4% of those between 25 to 34 years, 10% of those aged between 35 to 49 years and 11% of those aged between 50 to 64 said they had this problem.
  - Among Indians, a relatively large proportion (16%) of those in the age category 50 to 64 years had this problem, compared to relatively fewer in the other categories.

- Among white respondents, the proportion stayed constant at 1% for the age categories 16 to 24, 25 to 34 and 35 to 49 years, increasing to 2% of those in the age category 50 to 64 years.

- Difficulty in shopping is also found to be correlated with aging.
  - In similar vein to the previous findings, delayed increase in the onset of this problem also varies by race, and hence socio-economic conditions.

- Overall, when examining the effects of varying socio-economic conditions on impaired functioning, without taking age into account, the relationship between poor socio-economic conditions and impairment is less noticeable.
  - Those in overcrowded households and those living below the minimum living level were only slightly more likely to experience problems in carrying out activities of daily living, compared to the average.
- In general, both those with chronic illnesses and the disabled were more likely than average to experience difficulties with activities of daily living.

Disabilities or Handicaps

The respondents were asked to indicate whether or not they had difficulty in seeing even with glasses, in hearing, speaking, moving or walking, and in learning or understanding.

Table 7.5: Those with disabilities by race

	African	Coloured	Indian	White	Total
Type of disability	%*	%*	%*	%*	%*
Difficulty in seeing	12	13	4	6	11
Difficulty in hearing	4	3	3	3	4
Difficulty with speech	1	1	0	1	1
Difficulty walking or moving	3	4	2	4	3
Difficulty learning or understanding	2	2	1	1	2
Those with at least one disability	18	17	7	12	17

*** The balance of all percentages indicated in this table add up to 100**

- Table 7.5 indicates the extent of disability in the sample: 18% of the African respondents and 17% of coloureds, as compared to 12% of whites and 7% of Indians, indicated that they had at least one disability.

- Visual impairments (11% of the total sample) were more common than other handicaps. This finding may be due, in part, to inadequate access to optical health-services among coloureds and Africans.

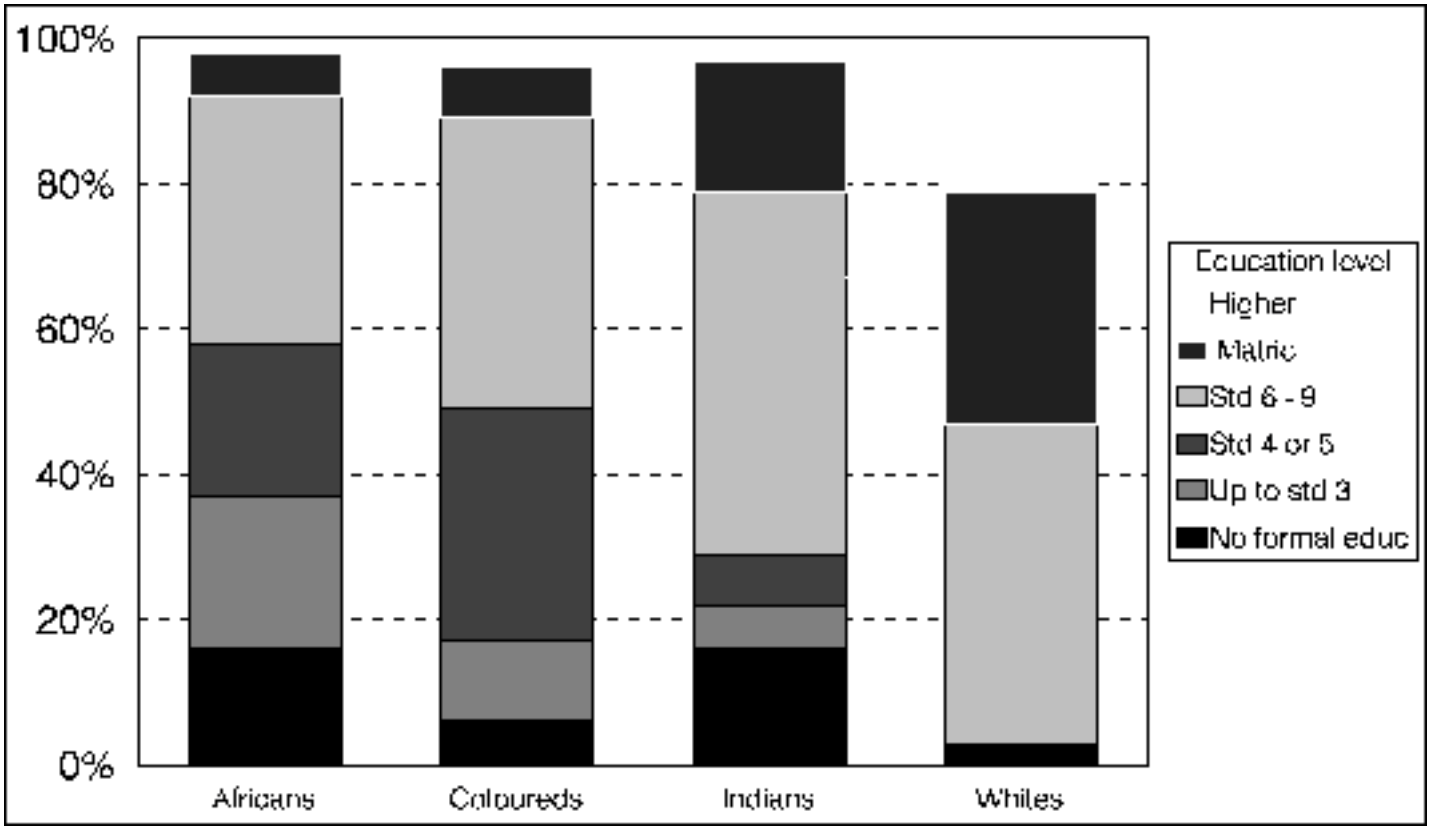
- There was very little variation between race groups with regard to the proportion of those with hearing, speech, walking or learning disabilities. The only disability where variation between race groups was found was difficulty in seeing even with glasses.
  - This disability was most prevalent among coloureds (13%) and Africans (12%), followed by whites (6%) and lastly Indians (4%).
- Proportionately more females (19%) said they were disabled, compared to males (15%).

- As expected, the prevalence of disability increased with age. Thus 13% of those aged 16 to 24 years and 11% of those aged 25 to 34 years had at least one type of disability, increasing to 18% among those aged 35 to 49 years and to as much as 34% among those aged 50 to 64 years.
  - Although the differences were proportionately smaller, a similar pattern of increase in prevalence of disabilities by age according to race emerged, as previously discussed for chronic diseases.

- Thirty two percent of those with at least one chronic illness also had at least one disability, indicating that a person with a chronic condition is more likely than average to be disabled.

- Whether or not a respondent had a disability was associated with perceptions of health-status. Thus 9% of those who rated their health as excellent, 10% who rated it as very good and 16% who rated it as good said they had at least one disability, as against 30% who rated their health as fair and 50% who rated it as poor.

FIGURE 7.3. Education Level of Disabled or Handicapped Respondents by Race



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- Educational attainments of the disabled were generally lower than those of the total sample.
  - At primary school level, we find proportionately more disabled people with no education or else with some primary school compared to the total sample. Thus 14% of the disabled sample, compared to 9% of the total sample, had no education, 18% of the disabled, compared to 14% of the total sample had some primary school education, and 19% of the disabled, compared to 16% overall, had completed primary school.
  - At secondary school level and higher, we find proportionately fewer disabled. Thus for example, 9% of the disabled had completed matriculation compared to 14% of the total sample.
  - We did not ask the age of onset of the disability. Therefore it is difficult to tell whether a lower level of education increases the chances of becoming disabled as one ages, or whether being disabled negatively influences access to educational opportunities.
  - It is likely however that in some cases, being disabled influenced access to education, while in others, a lower education level increased the risk of becoming disabled later, as a result of occupational and poverty-associated hazards that those with a low level of education face.

- However, Figure 7.3 clearly shows that racial differences in access to education continue to persist, even amongst the disabled. We have seen in previous chapters that lower levels of education, poverty and poor health are associated. We now find that this relationship persists, in spite of disability.
  - Among disabled Africans, 16% had never received any education (compared to 12% of all Africans in the sample), 41% had received some or a complete primary education (compared to 35% overall) and only 43% had gone further than primary school (compared to 53% overall).
  - Among disabled whites, 3% of respondents had received no formal education (compared to fewer than 0,5% of all whites in the sample), while 44% had completed some secondary school (compared to 34% overall), and proportionately fewer (21%) had received tertiary education (compared to 34% overall).

Requirements among the Disabled Regarding Devices or Equipment

Disabled respondents were asked to indicate whether or not they require any devices or equipment to assist them in coping more adequately with their disability, and if so whether they have the equipment they need.

- Table 7.6 below indicates that a large proportion of disabled people generally (36%), but whites in particular (72%) say that they do not need any devices or equipment to assist them.

- More than half of the disabled Africans (55%) indicated that they do not have the devices or equipment that they require, compared to relatively few coloureds (24%) and even fewer whites (8%).

- In general, coloured respondents who are disabled tend to have the devices and equipment they require.

- When we examine the need for devices for three specific disabilities - visual, auditory and ambulatory - Table 7.6 further indicates that a large proportion of Africans across all categories (51% with visual, 41% with auditory and 49% with ambulatory handicaps) say they require devices to help them cope better which they cannot get.

Table 7.6: The need for devices for various disabilities by race

	African	Coloured	Indian	White	Total
Devices	%	%	%*	%	%

All disabilities:					
Do not need devices	29	50	39*	72	36
Have necessary devices	16	26	20*	20	17
Still require devices	55	24	41*	8	47
Total	100	100	100	100	100
Visual disabilities:					
Do not need devices	22	44	48*	78	28
Have necessary devices	19	27	25*	16	20
Still require devices	51	28	48*	6	52
Total	100	100	100	100	100
Auditory disabilities:					
Do not need devices	51	52*	37*	66*	53
Have necessary devices	8	26*	0*	25*	11
Still require devices	41	22*	63*	9*	36
Total	100	100	100	100	100
Ambulatory disabilities:					
Do not need devices	33	66*	52*	62*	42
Have necessary devices	18	29*	23*	29*	21
Still require devices	49	6*	25*	9*	37
Total	100	100	100	100	100

*** These percentages should be interpreted with caution, since they represent a small number of respondents**

We now exclude from the discussion those who do have devices or equipment to assist them, and examine the extent of need among those who do not.

- Poverty and the need for devices among the disabled are closely interlinked.
  - Proportionately more of those living in overcrowded conditions (66%), compared to those living in conditions of low crowding (35%) said that they require devices or equipment but cannot obtain them.
  - Those living below the minimum living level (67%) were also more likely to say that they required equipment compared to those living above it (34%).

- Proportionately fewer people living in metropolitan areas, either in formal housing (33%) or even in informal settlements (31%) were likely to say that they needed equipment to assist them to cope with their disability, compared to those living on white-owned farms (63%) or in rural areas in former homelands (74%).

- A striking finding was the variation according to province in need for equipment among the disabled.
  - People living in provinces which are predominantly metropolitan, for example, Gauteng (24%) and the Western Cape (32%) were less likely to say that they required equipment compared to those living in provinces which contained former homelands, for example KwaZulu-Natal (77%), the North West (75%) and the Eastern Cape (71%).

Table 7.7: Access to rehabilitation services for disability by race

	African	Coloured	Indian	White	Total
Received professional help to manage disability better	%	%	%*	%	%
All disabilities:					
Yes	41	65	50	49	44
No	59	35	50	51	56
Total	100	100	100	100	100
Visual disabilities:					
Yes	44	66	42*	52	46
No	56	34	57*	49	54
Total	100	100	100	100	100
Ambulatory disabilities:					
Yes	54	71*	58*	68*	59
No	46	29*	42*	32*	41
Total	100	100	100	100	100

*** These percentages should be interpreted with caution, since they represent a small number of respondents**

- Table 7.7 indicates that only 44% of the handicapped or disabled respondents had received professional help, for example physiotherapy or occupational therapy, to learn how to cope with the disability.
- Coloureds (65%), who tend to use public services, were more likely than those in the other groups to have received this type of assistance, while Africans (41%) were least likely.
- A surprising finding was the relatively few white (49%) and Indian (50%) disabled respondents who had received rehabilitation care, probably because medical aid schemes do not always pay for it and doctors in the private sector do not always advocate this type of assistance.

- A similar picture to the general one emerges when two specific types of disability - visual and ambulatory impairments - are examined. Coloureds tend to have more access to rehabilitation services for both of these handicaps, with whites and Indians having surprisingly little access. Relatively few Africans who are disabled receive rehabilitation assistance.

Home Visits by Health-Care Personnel for the Disabled

The disabled respondents were asked to indicate whether or not any health worker had ever come to visit them at home since they became disabled to assist them to cope better.

- An extremely small proportion of disabled people across all race groups (5%) had received professional assistance at home to enable them to cope better.
  - Coloureds (11%) were more likely to receive this type of assistance, compared to the other respondents.
  - Only 2% of those living in rural areas in the former homelands had received this type of assistance, compared to 11% in formal metropolitan areas.

Summary and Conclusions

This chapter examined the extent of chronic illness, functional impairments and disabilities in the sample of those aged 16 to 64 years.

We found that a quarter of the sample had at least one chronic illness, for example hypertension, arthritis, heart conditions and diabetes. Hypertension and arthritis were the most commonly reported chronic illnesses.

There were proportionately fewer Africans in particular, but also coloureds and Indians, who reported having chronic illnesses compared to whites. We suggested that among Africans this was due at least in part to under-diagnosis. We based this contention on the finding that in certain provinces where the majority of people live in rural areas and where access to health-care is difficult, there are proportionately fewer respondents who report having this type of illness.

We found support for the contention of House et al. (1994) that an impoverished life-style is related to an earlier onset of this type of disease. We showed that the prevalence of certain chronic illnesses, for example hypertension and diabetes, increases with age. However, this increase tends to occur at an earlier age among Africans than whites.

When examining frequency of check-ups for chronic illnesses generally, and for hypertension and diabetes in particular, we find a pattern of irregular attendance. For example, approximately four out of every 10 Africans with a chronic illness only go when they feel sick, and one in seven never go. Africans and coloureds who go for check-ups tend to use public facilities, while whites tend to use private doctors.

Functional impairments, for example difficulty in getting in and out of bed, in using the toilet and getting around outside the home were relatively rare, but these problems tended to increase with age. However a delayed increase in the onset of these problems was found among whites who live in better socio-economic conditions compared to coloureds and Africans.

The most common disability reported in this survey was visual impairment. Approximately one out of every eight respondents said that they had difficulty in seeing, even with glasses. This disability was reported by proportionately more Africans and coloureds than whites, probably because, among other reasons, they have poorer access to optical services.

The disabled in the sample were likely to have lower educational attainments compared to the total sample, both in general and within race categories, making it more difficult for them to afford health care.

More than half the African disabled respondents did not have the appliances they require to enable them to cope better with their disability. Poverty and the need for devices to assist with managing a disability were found to be interlinked.

Fewer than half of the respondents with a disability had benefited from the services of a therapist.

An extremely small proportion (5%) had received professional help at home to enable them to cope better with their disabilities.

 Chapter 6


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Chapter 8 

Chapter 8.
Mental Health:
Adults Aged 16 to 64 Years

A National Household Survey of Health Inequalities in South Africa

Steven and Ros Hirschowitz

CHAPTER EIGHT.

Introduction

In this chapter the mental health of adults aged between 16 and 64 years is investigated. More specifically, we examine the following issues related to mental health.

- Firstly, the way in which the respondents rate their mental health.
- Secondly, the extent to which they feel powerful and in control of their own lives.
  - We contend that apartheid undermined people's self-confidence and the belief that they can control the events that shape their lives. The effects of this policy on mental well-being are however largely unknown at present.
- We continue by probing the experiences of anxiety and depression among the respondents.
  - Symptoms of these illnesses may be related to past experiences of apartheid.

- Finally, we examine the extent of post-traumatic stress disorder (PTSD) in our respondents.
  - The recent history of political violence in South Africa and the effect of exposure to violence on psychological well-being are presently unknown.
  - In the 1980s resistance to apartheid claimed many lives and subjected thousands to police brutality and murder.
  - In the early 1990s, up to the time of the April 1994 election, orchestrated political violence affected the lives of many people. For example train violence in which commuters were brutally assassinated, the burning of homes and shacks, attacks by hostel dwellers on township residents, shootings of taxi-passengers, shootings of marchers and demonstrators were commonplace events. Previous C A S E research shows that, in the Witwatersrand area alone, from July 1990 to February 1994, there were 8,312 people killed and over 13,000 people injured as a result of political violence (Everatt, Jennings and Orkin, 1994).
  - We investigate the extent of exposure to these events.
  - We examine the possible impact of exposure to these and other traumatic events on mental health, including such manifestations as unwanted recollections of these disturbing events at inappropriate times, nightmares and loss of the ability to feel warmth towards others.

- The effects of living conditions (for example overcrowding) and poverty on mental health are also examined.

- Access to health care for those mental health problems is then investigated.

Ratings of Emotional State

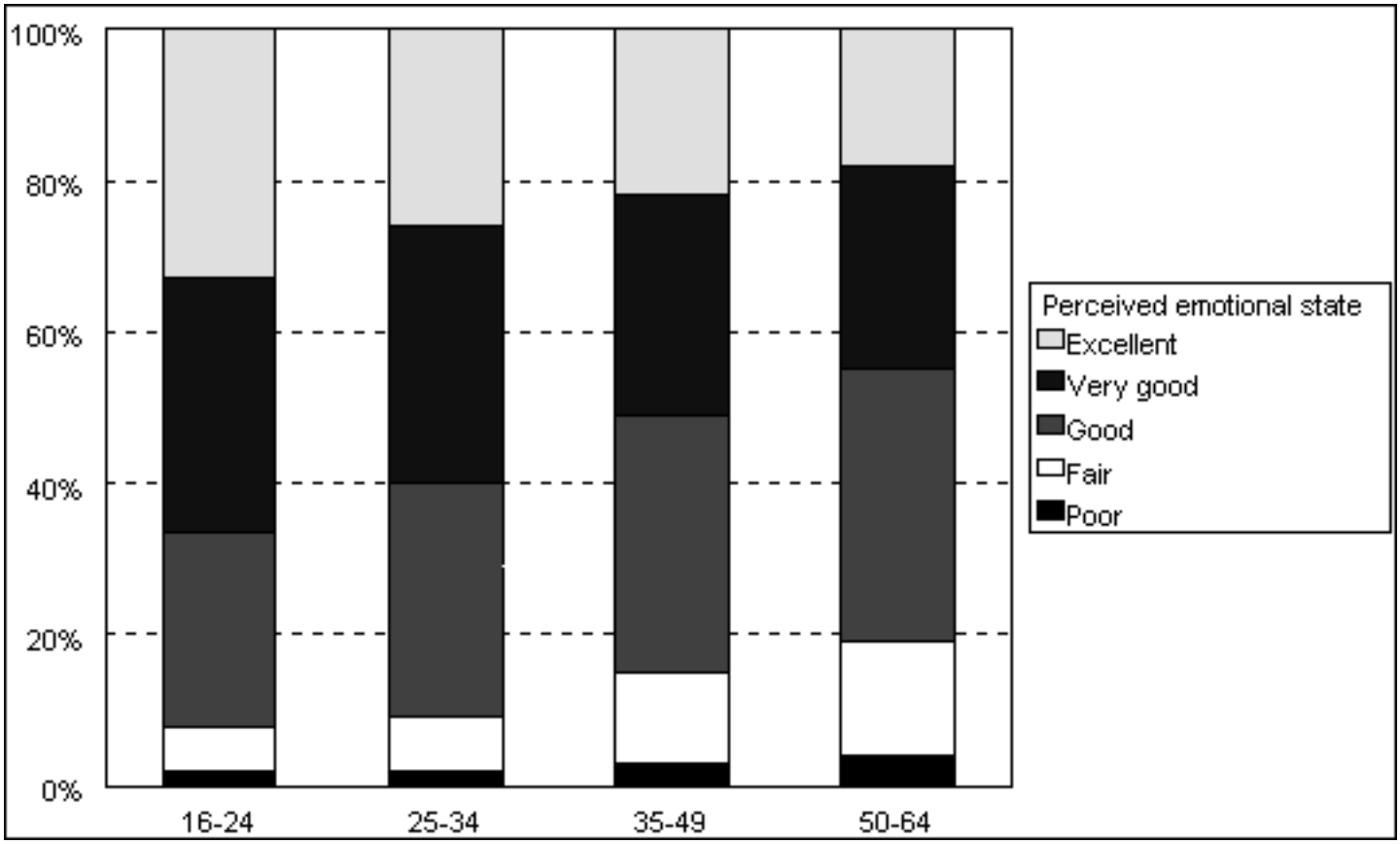
Respondents were asked to rate their perceived state of mind or emotional state on a five point scale - excellent, very good, good, fair or poor - compared to other people of the same age.

- Overall, 26% of respondents considered their state of mind to be excellent, 32% very good, 31% good, 9% fair and 2% poor.

- Sixteen percent of coloureds described their emotional state as fair or poor compared to 12% of whites, 11% of Africans and 9% of Indians.
  - Previous C A S E research (Everatt and Orkin, 1993) has shown that coloureds tend to feel more alienated and threatened by political change than those in other race groups. This may partially explain their lower than average rating of mental health.

- Figure 8.1 shows that, in common with other perceptions of health status, the perceived emotional status of respondents deteriorates with age.

FIGURE 8.1. South Africans' Perceived Emotional State by Age



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- However, the pattern found previously in physical health measures - a steeper decline in health ratings as age increases among Africans and coloureds, compared to whites - was not found for this particular mental health measure. Perceived emotional status declines with age irrespective of race.
- Emotional health is therefore less likely to be related to circumstances of impoverishment.

- Those respondents who were retired or unable to work due to illness or disability (10%) were more likely than average (2%) to describe their emotional state as poor.

- Respondents with a lower level of education were more likely to rate their emotional state as fair or poor than those who had attained a higher educational level (16% of those with less than standard three compared to 9% of those with matric or higher).

- Fifteen percent of those living in a shack, outbuilding or zozo described their emotional state as fair or poor compared to 12% of those in a house or flat and 8% of those in a traditional hut.
  - A possible explanation for this is that those in housing which is more permanent, whether in a rural or urban setting, tend to feel more secure.

- Moderate to heavy drinkers were more likely (5%) to describe their emotional state as poor than non- or light drinkers (2%).

- Those respondents who lived in what were previously the most politically oppressed environments in the country were likely to rate their emotional health lower than average.
  - For example, 24% of those living in the North West province described their emotional state as fair or poor compared to 11% overall.

- Proportionately more of those in households with incomes below the minimum living level (13%) and those in households with incomes above it (10%) rated their health as fair or poor.

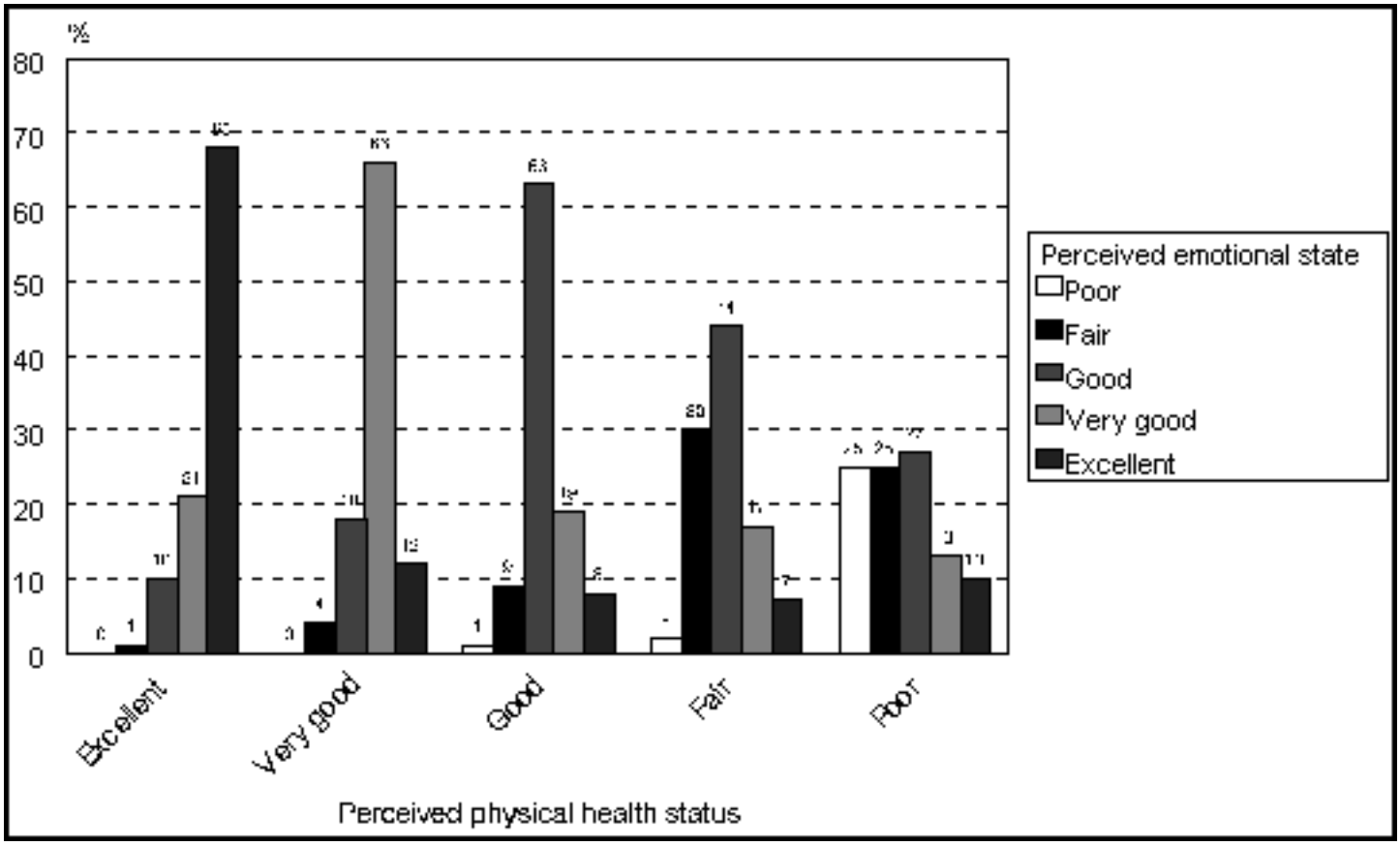
- Those living in overcrowded conditions (11%) were almost equally as likely as those living in conditions of low crowding (10%) to rate their emotional health as fair or poor.

- Extreme poverty and perceived mental health status were related.
  - Eleven percent of adults living in households in which the occupants frequently went hungry rated their emotional state as poor compared to 2% of those from households which sometimes, seldom or never went hungry.

When we examine the relationships between physical and mental health ratings, we find that, in general, emotional health and physical health are closely interlinked.

- Figure 8.2 shows that there is a strong relationship between perceived physical health and perceived emotional state, but this relationship is stronger at the upper (excellent, very good or good) rather than the lower (fair or poor) end of the scale.

FIGURE 8.2 . Perceived Emotional State by Perceived Physical State



Adults 16-64 years
C A S E survey for Kaiser Family Foundation

- Twenty-five percent of those whose perceived physical state was poor described their emotional state as poor.
- Thirty-five percent of those who perceived their physical health to be fair or poor rated their emotional state as fair or poor compared to 5% of those who perceived their physical health to be good, very good or excellent.

- A relatively large proportion of respondents (16%) with chronic illnesses described their emotional state as fair or poor compared to 11% overall.

- Those who were disabled or handicapped were more likely (24%) to describe their emotional state as fair or poor.

- Those who had experienced a disturbing or traumatic event (see below) were more likely (17%) to describe their emotional state as fair or poor.

Feeling in Control of One's Life

To assess the extent to which respondents feel powerful and in control of their lives we asked the following two questions.

- "Do you have any major worries in your life that you feel powerless to solve?".

- "Thinking of major events that affect or disturb your life, do you find it difficult to understand why they are happening?"

Table 8.1: Feelings of alienation by race

Feelings of alienation	African	Coloured	Indian	White	Total
	%	%	%	%	%
Powerless to solve major worries:					
Yes	30	19	12	21	27
No	70	81	88	79	73
Total	100	100	100	100	100
Difficulty understanding why major events happen: Yes	22	22	13	19	21
No	78	78	87	81	79
Total	100	100	100	100	100

- Table 8.1 indicates that overall, just over one quarter (27%) of adult respondents said that they were experiencing major worries in their lives which they felt powerless to solve.
  - Thirty percent of Africans compared to 21% of whites, 19% of coloureds and 12% of Indians said that they had these unsolvable major worries.

- Those living in informal settlements were more likely to feel powerless to solve major worries than those in formal areas (for example 37% of those in metro informal dwellings compared to 24% of those in metro formal dwellings feel powerless to solve major problems).
  - This indicates that having a more permanent place in which to live contributes to feelings of control over events affecting ones life.

- Forty one percent of those living in shacks, outbuildings or zozos as against 27% of those living in a house, flat or back of a house and 20% of those living in traditional huts experience these feelings of powerlessness.

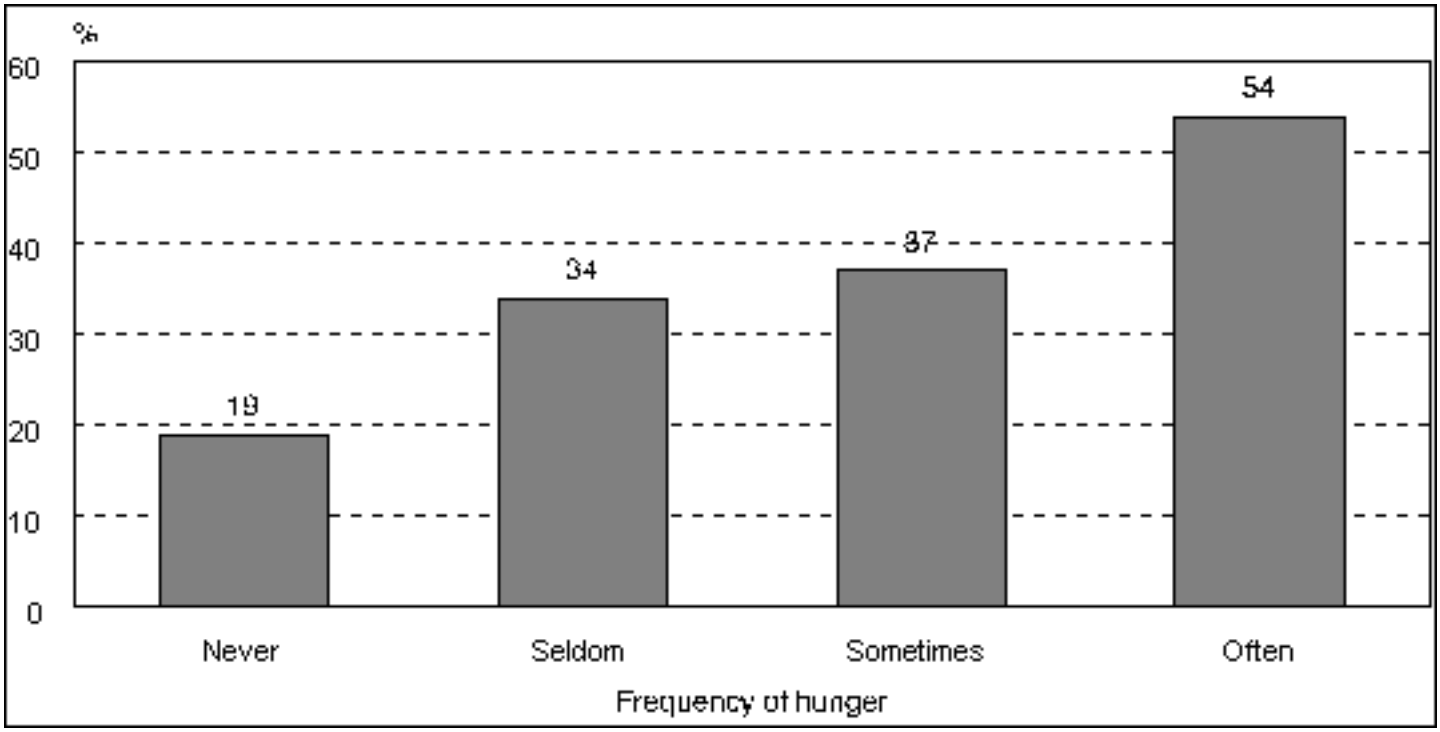
- The proportion of adults feeling powerless in the face of major worries increased with age from 17% of those aged 16 to 24 years to 34% of those aged 35 to 64 years.

- Those retired or disabled were more likely (42%) and students or scholars less likely (12%) to be experiencing major worries which they could not solve.

- Males and females were approximately equally likely to be feeling this way.

- One in five (20%) adults whose perceived state of physical health was excellent or very good experienced unsolvable major worries increasing to nearly three in five (57%) of those whose perceived physical state was poor.

FIGURE 8.3. Adults Who Feel Powerless to Solve Major Worries by How Often People in the Adult's Household Went Hungry



Adults 16-64 years
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- Those adults who rated their emotional state as poorer were more likely to have experienced major worries which they felt powerless to solve than those who thought that their emotional state was better.
  - For example, 72% of those who rated their emotional state as poor said they were experiencing unsolvable major worries as against 19% of those who rated their emotional state as excellent or very good.

- Poverty and feelings of powerlessness are closely related. Figure 8.3 shows that the percentage of adults who said that they had major worries which they felt powerless to solve increased steadily from 19% of those from households that never went hungry to 54% of those from households that often went hungry.

- The percentage of adults feeling powerless to solve major worries also increased with increasing difficulty in paying for the household members' medical treatment.

- Just over one third (34%) of those adults from households with incomes below the minimum living level experienced major worries which they felt powerless to solve, as against just over one fifth (21%) of those with household income above this level.

Difficulty in Understanding Why Major Events are Happening

- Table 8.1 indicates that the proportion of Africans (22%), coloureds (22%) and whites (19%) who felt bewildered by major events which influenced their lives were approximately equal, while Indians were less likely to feel this way (12%).

- The two alienation measures - difficulty in understanding why major events affecting one's life are happening and feeling powerless to solve major worries -are highly correlated ($r = 0.60$; $p < 0.001$).
  - Therefore it is not surprising to find similar patterns of relationships between these two variables and other variables, for example, lower education, increasing age and shack dwelling were related to larger proportions of respondents having difficulty in understanding why major events affecting their lives happen as well as feeling powerless in the face of major worries.
  - For example, the percentage of adults who found it difficult to understand why major events affecting their lives were happening increased steadily from 16% of those from households that never went hungry to 46% of those from households that often went hungry.

Symptoms of Anxiety and Depression (Mood Disturbances)

To examine the extent of symptoms of anxiety and depression, the respondents were asked: "In the last few months or so, have you found that:

- You frequently feel isolated
- There is little point in thinking about the future
- You lose interest in doing things
- You have trouble concentrating
- You are unusually irritable
- You have trouble sleeping
- You sweat or tremble or your heart beats fast?"

- Female respondents were slightly more likely (36%) to display one or more disturbed moods than males (32%).

Table 8.2: Mood disturbances by race

Symptom	African	Coloured	Indian	White	Total
	%*	%*	%*	%*	%*
Feeling isolated	13	17	13	12	13
Hopeless future	11	8	10	10	11
Lose Interest	15	14	12	12	14
Poor concentration	8	11	10	14	9
Feel irritable	9	18	19	19	12
Trouble sleeping	11	14	12	19	12
Sweating etc	10	17	12	9	10
Any of the above	32	41	30	43	34

*** The balance of each percent in the table adds up to 100**

- Table 8.2 shows that fewer Africans (32%) and Indians (30%) than coloureds (41%) and whites (43%) had symptoms of anxiety and depression.
  - Each symptom was approximately equally likely to have been experienced.
  - Coloureds (18%), Indians(19%) and whites(19%) were relatively likely to have been unusually irritable in the few months prior to the interview compared to Africans (9%).

- For the African, coloured and Indian population groups, the proportion of adults who had experienced disturbed moods increases steadily with age. Among white adults, however, this proportion drops from 48% for the 16 to 24 year age group to 31% for the 25 to 34 year age group, then rises to 53% for the 35 to 49 year age group and drops to 38% for the 50 to 64 year age group.

- Gender was related to the age at which symptoms of anxiety and depression manifest.
  - Among females, the proportion that had experienced disturbed moods increases steadily from 31% for ages 16 to 24 years to 44% for ages 50 to 64 years, perhaps because women may be required to redefine their roles at this older age as their children become adults and leave home.
  - Among males, however, this proportion drops from 38% for ages 35 to 49 years to 35% for ages 50 to 64 years, perhaps because this time period is one of consolidation, particularly in relation to work achievements, rather than redefining one's roles.

- Those retired or disabled were more likely (54%) and students or scholars less likely (27%) to have experienced disturbed moods.

- It is noteworthy that symptoms of anxiety and depression are more likely to be found among those in metropolitan, rather than more rural environments. For example, 40% of people living in formal housing in metropolitan areas had experienced these symptoms, compared to 26% in rural homelands.

- In support of the finding that isolation is a key predictor of symptoms of anxiety and depression, we found that those who live in conditions of low crowding were more likely to experience symptoms of anxiety and depression (41%), compared to those in average (34%) or overcrowded conditions (33%).

Health Care for Symptoms of Anxiety and Depression

- Overall, only one in five (20%) of those that had experienced at least one of these mood disturbances sought professional treatment.

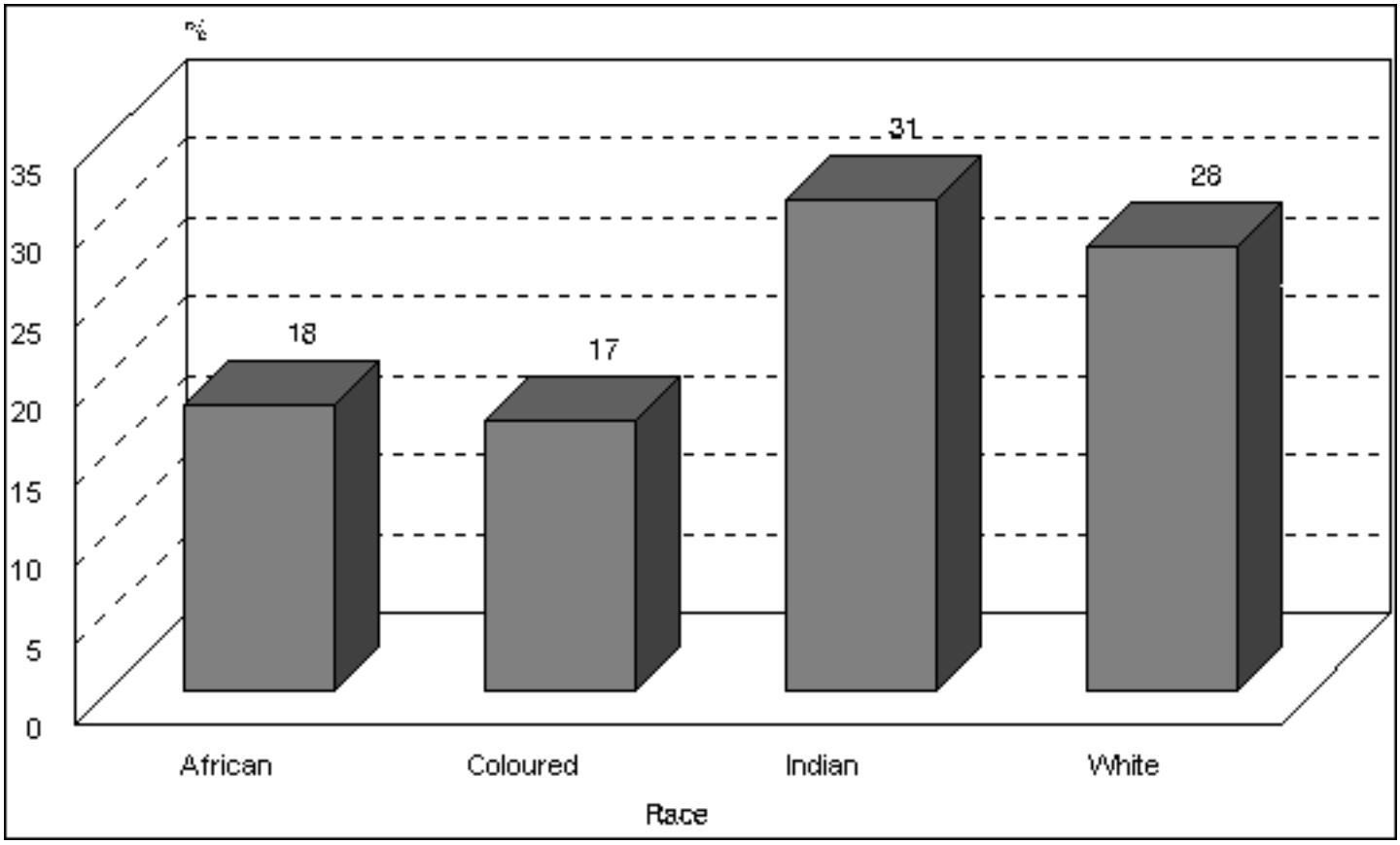
- Figure 8.4 shows that, while in general, proportionately few people seek health-care for symptoms of anxiety and depression, Indians (31%) and whites (28%) were considerably more likely to have sought professional help than Africans (18%) and coloureds (17%).
  - The need for mental health services for African and coloured people in particular therefore demands attention.

- Females were more likely (23%) to have sought professional help than males (15%).

- Older respondents were more likely to have sought treatment for mood disturbances than younger respondents (43% of those aged 50 to 64 as against 11% of those aged 16 to 24).

- The percentage seeking treatment increased with worsening perceived emotional state. Thirteen percent of those rating their emotional state as excellent had sought help increasing to 24% of those rating their emotional state as poor).

FIGURE 8.4. Percentage of Adults Who Have Experienced One or More Symptoms of Anxiety and Depression



Adults 16-64 years
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Traumatic Events and their Effect on Mental Health

As we indicated at the beginning of this chapter, the recent history of political violence in South Africa and the effect of exposure to violence on psychological well-being is presently unknown. We investigated the extent of exposure to these events by asking the respondents whether they had experienced one or more of the following:

- Fighting in a war (Namibia, Angola, Mozambique, South Africa).
- An accident or incident, flood or fire that threatened his/her life.
- Witnessing an attack or life threatening incident.
- Participating in actions that resulted in someone being injured or killed.
- Being raped or sexually abused.
- Being physically attacked with a gun, knife or other weapon.
- Being kept in solitary confinement or being beaten or tortured by the police or people in authority.
- Witnessing shacks or houses being burnt down.
- Being evicted out of his/her home.
- Any other such event.

Table 8.3 Percentage that had experienced a traumatic event by gender and race

Event	Male				Female				Total
	Afric. %*	Col. %*	Indian %*	White %*	Afric. %*	Col. %*	Indian %*	White %*	%*
Fighting a war	2	2	1	11	1	2	0	0	2
Life threatening incident	7	13	9	17	5	7	5	12	7
Witnessing attack	7	19	12	14	4	8	6	8	7
Participating in violence	4	2	8	9	1	2	1	4	3
Being raped	0	0	0	0	1	0	1	4	1
Being attacked	12	24	15	12	4	5	4	4	8
Being tortured	4	3	0	2	1	0	0	1	2
Witness home burning	7	10	3	9	8	7	3	3	7
Evicted from home	1	3	3	1	2	2	2	2	1
Other event	0	0	0	1	0	0	0	2	1
Any of above	24	41	24	41	18	25	13	24	23

*** The balance of each percent in the table adds up to 100**

Table 8.3 shows that:

- Nearly one quarter of respondents (23%) had experienced one or more disturbing events.
- Males were more likely (28%) to have experienced at least one disturbing event than females (19%).
- Proportionately more coloureds (33%) and whites (32%) had experienced at least one disturbing event than Africans (20%) and Indians (19%).
  - However, in actual numbers the picture looks different: approximately five million adults - 3,3 million Africans, 0,6 million coloureds, 0,1 million Indians and 1,0 million whites - had these negative experiences.

Among males:

- More than two in five (41%) whites and coloureds had experienced a disturbing event. This compares with just less than one in four (24%) Africans and Indians.
  - A possible partial explanation for the high proportion of coloured males is that they are more likely to be part of gangs during their youth. The results showed that younger, rather than older coloured respondents have witnessed these traumatic events.
  - Among whites, compulsory conscription into the army or police until 1994, seen together with the role that the apartheid government played in the wars in the region and in intimidation in the townships, may in part explain these findings, particularly as proportionately more respondents aged 25 to 34 years were exposed to these events, compared to older and younger respondents.
  - Among African males, although the proportion is lower than coloureds or whites, the actual number is large - approximately 2.2 million out of 10.3 million males have experienced at least one traumatic event.

- Being physically attacked with a gun, knife or other weapon was the most common disturbing event experienced by African, coloured and Indian males and was also one of the most common among whites.

- Other events relatively commonly experienced by all race groups were witnessing an attack or life threatening incident and being involved in an accident, life threatening incident, flood or fire (particularly amongst whites).
  - The percentage of coloureds that had been physically attacked (24%) or witnessed an attack or life threatening incident (19%) was particularly high.

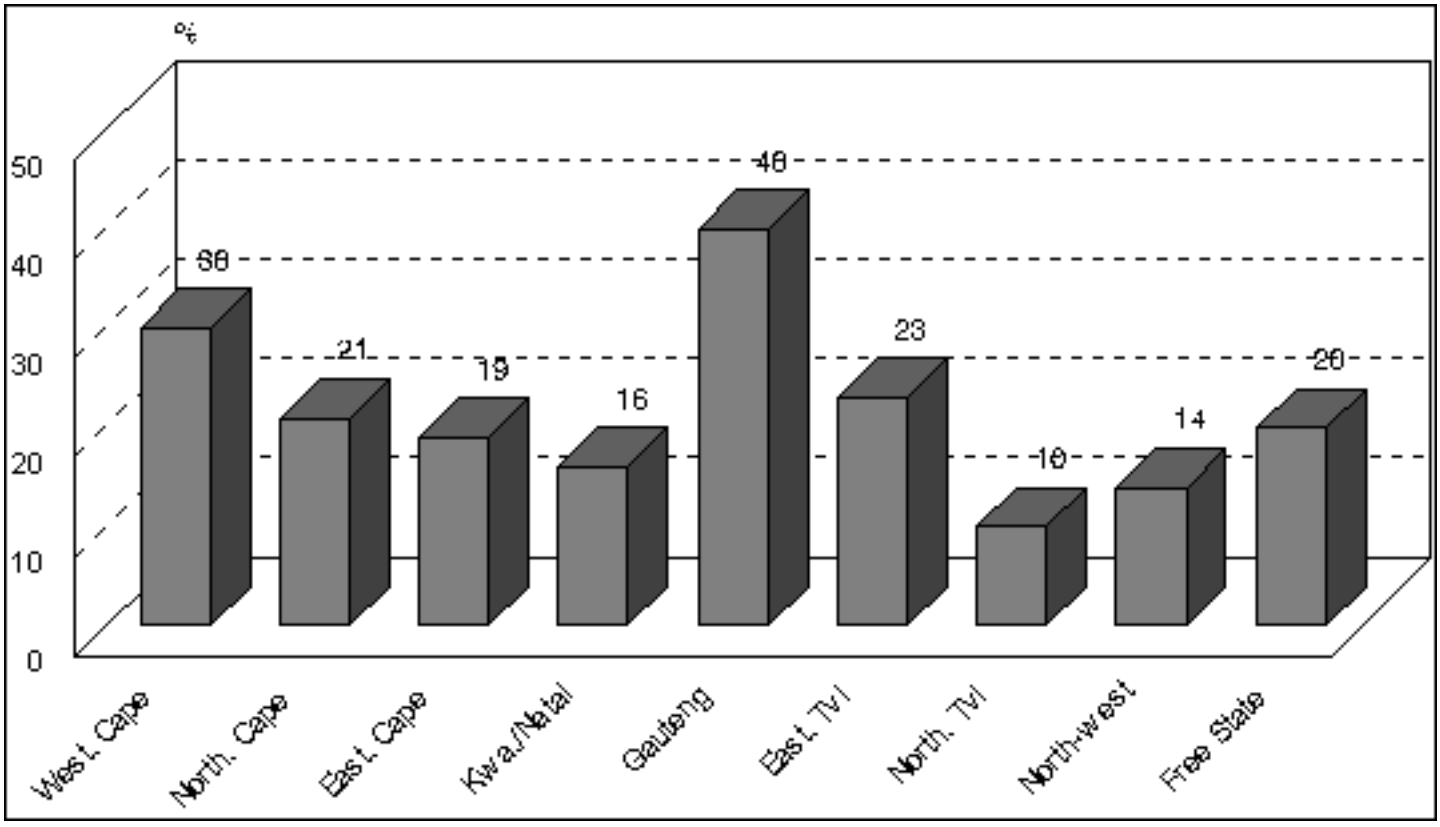
Among females:

- The most commonly experienced event amongst Africans (8%) was witnessing shacks or houses being burnt down, while amongst whites it was an accident, incident, flood or fire (12%), and amongst Indians (6%) and coloureds (8%) it was witnessing an attack or life-threatening incident.

- Four percent of whites as opposed to 1% or less of the other race groups admitted they had been raped or sexually abused.

- A picture therefore emerges in which large numbers of people across all race groups have experienced extreme forms of violence over an extended period of time.
  - This can be interpreted to mean that the undeclared war that was being waged to prevent political change, and ways in which people fought back, had a severely negative psychological impact on the population.

FIGURE 8.5. Adults Who Have Experience of at Least One Disturbing Event by Province



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- Figure 8.5 indicates that those living in urbanised provinces (Gauteng, Western Cape) were more likely to have experienced a disturbing event than those living in more rural provinces (Northern Transvaal, North West).

- This is confirmed by the fact that more than one third (35%) of those living in metro areas as opposed to about one quarter (26%) of those in non-metro urban areas and 12% of those in rural areas had experienced a disturbing event.

Psychological Effects of a Traumatic Experience

- Table 8.4 indicates that nearly four-fifths (78%) of those that had experienced a traumatic event were experiencing one or more of the following effects:
  - ongoing remembrance of the event even when this is not wanted
  - ongoing dreams or nightmares about it
  - suddenly acting or feeling that the event was happening all over again
  - becoming extremely upset in a similar situation
  - having lost the ability to feel love and warmth towards anyone
  - going out of his/her way to avoid situations that remind him/her of the event
  - forgetting certain details of the incident.

Table 8.4: Effects of witnessing traumatic events

Symptom of post-traumatic stress	African	Coloured	Indian	White	Total
	%*	%*	%*	%*	%*
Unwanted memory of event	66	43	41	32	56
Recurring nightmares	23	23	27	16	22
Sudden actions	26	29	29	16	24
Extreme upset-similar situation	46	43	52	31	42
Lost feelings of warmth	14	10	12	11	13
Avoid similar situations	37	53	51	34	39
Block out details	16	31	23	20	19
Any of the above	85	74	71	60	78

*** The balance of each percent in the table adds up to 100**

- Africans in particular (85%) and fewer whites (60%) were affected by experiencing traumatic events.
- The most common effect, a persistent recall of the event, was experienced by more than half (56%) of those who had gone through at least one such disturbing event.
- Other commonly experienced effects were becoming extremely upset in a similar situation (42% of those who had suffered a disturbing event) and going out of one's way to avoid situations that remind one of that event (39%).
- The proportion of people experiencing one or more effects of traumatic events decreases as perceived state of physical health increases from 86% of those who perceived themselves to be in fair or poor health to 69% of those seen to be in excellent health.
- Three fifths (60%) of those that had experienced at least one disturbing event had also experienced symptoms of anxiety and depression (see above section) as against just over one quarter (26%) of those that had not experienced a disturbing event. This pattern was similar across all race groups.

Treatment of Post-Traumatic Stress

- The proportion of people affected that had sought professional help in dealing with the effects of a traumatic event (18%) was relatively low.

- It is similar to the proportion that had sought professional help in dealing anxiety and depression (20%).
  - However, more Indians (38% as against 31%) and fewer whites (17% as against 28%) had sought help for post-traumatic effects than for anxiety and depression.

- Nearly two fifths (38%) of Indians had sought professional help for post-traumatic stress compared to less than one fifth (17%) of those from other race groups.

- Relatively few post-traumatic stress sufferers in the Northern Transvaal (5%) and the Northern Cape (7%) and relatively more in KwaZulu-Natal (27%) and Free State (24%) sought professional help.

Place of Help for Those Seeking Help

- This section applies to those seeking treatment for either anxiety and depression or the effects of a traumatic event.

- Those from households with total income above the minimum living level were more likely (48%) to go to a family doctor or a specialist in consulting rooms, while those with household incomes below it were more likely to go to a public hospital or nursing home (38%) or a public clinic or day hospital (30%).

- A relatively high proportion of white help-seekers (29%) went to a psychiatrist, psychologist, social worker or counsellor compared to fewer than 3% for other race groups.

- Amongst Africans, the most common place of treatment was a public hospital or nursing home (35%) and public clinic or day hospital (31%).
  - Amongst coloureds they were public clinic or day hospital (30%), private doctor or specialist (27%) and public hospital or nursing home (24%). On the other hand, half of Indian (50%) and three fifths (60%) of white help-seekers went to a private consultant.

- Those respondents with higher levels of education were more likely to go to a private consultant than those with lower levels of education.

- Only 3% of African help-seekers gave a traditional healer as their source of treatment.

Summary and Conclusion

Just over a quarter (26%) of adults between the ages of 16 and 64 years described their emotional state as excellent, while one in every 10 (11%) described it as fair or poor.

Thirty-four percent of respondents experienced one or more symptoms of anxiety and depression (recent mood changes).

More than a quarter (27%) of respondents said that they have major worries in their lives which they felt powerless to solve.

Nearly one quarter of respondents (23%) had experienced one or more disturbing events, of whom nearly four fifths (78%) were showing after-effects.

Males were more likely than females, and whites and coloureds more likely than Africans and Indians to have experienced a traumatic event. Experience of traumatic events was particularly high in Gauteng (40% of respondents).

The research shows that as age increases, the proportion of those in poor mental health, as measured by perceived emotional state, experiencing major worries that one feels powerless to solve and symptoms of anxiety and depression, increases.

Poor physical health is associated with poor mental health. Those retired or disabled were likely to be in a poorer and students or scholars in a better mental state.

Living conditions had very little bearing on mental health. However, poverty had a definite negative effect.

Less than one in five people (about 19%) experiencing a mood disturbance or after-effects of a traumatic event sought professional help for the problem. Whites and Indians were more likely to go to a private consultant and Africans and coloureds more likely to go to a public facility (although more than a quarter (27%) of coloureds went to a private consultant).

Chapter 9. Reproductive and Sexual Health

A National Household Survey of Health Inequalities in South Africa

Ros Hirschowitz and Kim Segel

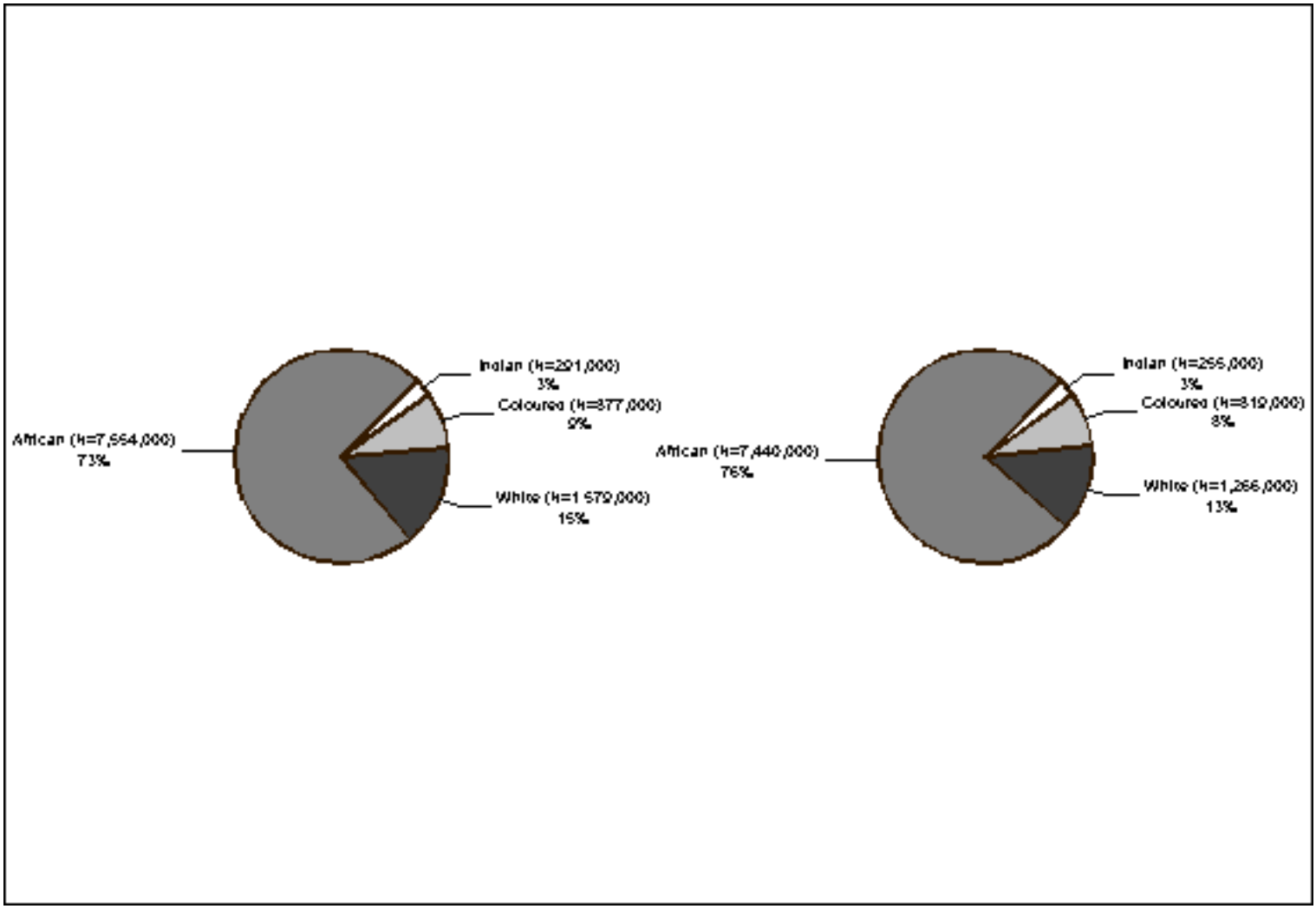
CHAPTER NINE.

Introduction

In this chapter we consider the sexual health of male respondents aged between 16 and 64 years and females aged between 16 and 50 years. We exclude women above the age of 50 years, because they are likely to have gone through menopause once they have reached this age. The sample size of 3,391 represents 20,082,000 people in these age categories.

- Figure 9.1 indicates that Africans constitute the vast majority of both males (73%) and females (76%) in the relevant age categories. Therefore we shall continue to focus on Africans as the target group in relation to sexual health practices and requirements. The other race groups will be used for comparative purposes.

FIGURE 9.1. Proportion of Males and Females by Race



Total number of respondents = 20,082,000
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Indicator that Applies to this Chapter

The indicator that has been identified for assessing sexual health is the following:

- The percentage women aged 50 years or younger and men aged 16 to 64 years who use or else whose partners use recognised contraceptive measures for family planning

Contraception

We first determine whether or not the respondents had a sexual partner at the time of the interview, before asking the questions on contraception.

Having a Sexual Partner

We give an indication of the proportion of respondents who have sexual partners according to marital status and age. We do so because those who do have a sexual partner, but who

are not married or in a permanent relationship with these partners, may be at greater risk for contracting sexually transmitted diseases (STDs) or AIDS.

Table 9.1 Proportion of males and females who had a sexual partner at the time of the study by race

Percentage of respondents who had a sexual partner	Male				Female				Total
	Afric. %*	Col. %*	Indian %*	White %*	Afric. %*	Col. %*	Indian %*	White %*	%*
Marital status									
Never married	67	35	29**	40	78	35	4**	27	71
Married/part	96	100	98	90	97	97	98	99	96
Sep/wid/div**	60	21	0**	30	63	22	6**	15	51
Age									
16-24	59	38	26**	37	78	35	30**	53	62
25-34	88	85	85**	85	93	75	87**	81	89
35-49	90	79	99**	77	88	71	81**	73	86
50-64	83	84	88**	66	NA	NA	NA	NA	78
Total	78	68	73	64	86	60	67	70	78

*** The balance of each percent in the table adds up to 100**
**** These percentages are based on small numbers, therefore they should be interpreted with caution.**
Married/part = married or living together with a partner in a permanent relationship.
Sep/wid/div = separated, widowed or divorced.

- Table 9.1 indicates that 78% of respondents reported that they had a sexual partner at the time of the interview. The questions about contraception therefore apply to these respondents, who represent 7,780,000 males and 7,910,000 females.

- When looking at the marital status of the respondents with a sexual partner, we found that a large proportion of African females and males who had never married (78% of females and 68% of males), or who were separated, widowed or divorced (63% of females and 60% of males), and who were not in a permanent relationship, said they had a sexual partner.

- Regarding age, the proportion of people with sexual partners increases from 62% of those aged 16 to 24 years to 89% of those aged 25 to 34 years, but then starts decreasing to 86% of those between 35 and 49 years and to 78% of those aged between 50 and 64 years.

- Respondents living in overcrowded households (81%) were more likely to have a sexual partner than those living in uncrowded households (70%).

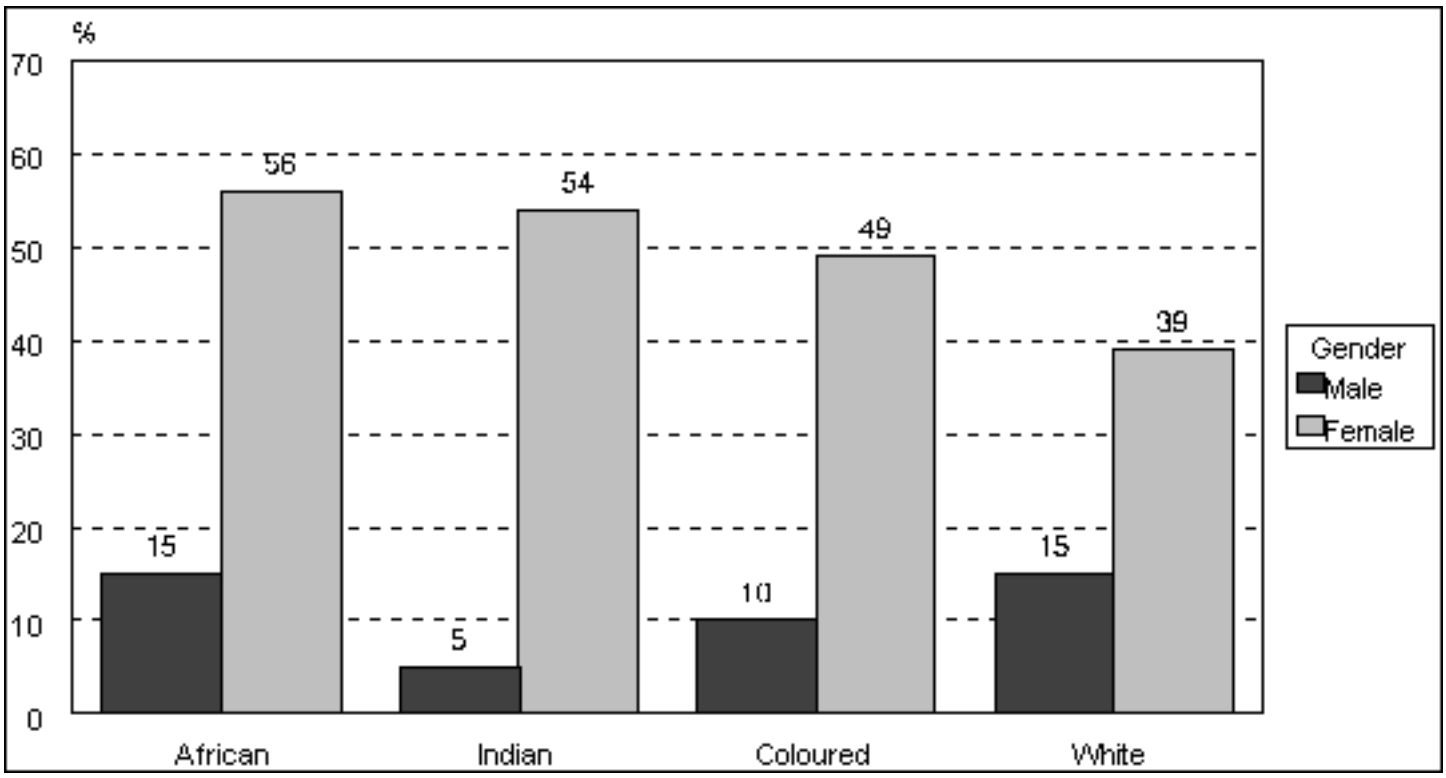
Receiving Advice on Contraception

Respondents who had sexual partners were asked whether or not they go anywhere to obtain advice on contraception or family planning. In total, only a third (34%) went anywhere to obtain advice on contraception.

- Just over half (53%) of females aged between 16 and 50 years said that they went somewhere to obtain contraceptive advice as compared to only one in every seven (14%) men aged between 16 and 64 years.

- Figure 9.2 indicates that within the small percentage of males who seek to obtain contraceptive advice, there are differences between races.

FIGURE 9.2. Adults Who Received Contraceptive Advice by Race and Gender



Adults 16-64 years
C A S E survey for Kaiser Family Foundation

- Among the male respondents, 15% of Africans and whites and 10% of coloureds, but only 5% of Indian men, go to a family planning clinic or other type of health centre to obtain contraceptive advice.
- Amongst women, 56% of Africans said that they went to a family planning clinic or other health centre for contraceptive advice, compared to 39% of whites.

Regarding age, the younger the respondents, the more likely they were to go for family planning advice.

- Among men, those aged 16 to 24 and 25 to 34 years (both 20%) were more likely to obtain contraceptive advice from a health-care centre than those aged 35 to 50 (10%) or 50 to 64 years (3%).
- Women aged between 16 and 24 and 25 to 34 years (both 63%) were more likely than those aged 35 to 50 years (35%) to go somewhere to obtain advice regarding family planning.

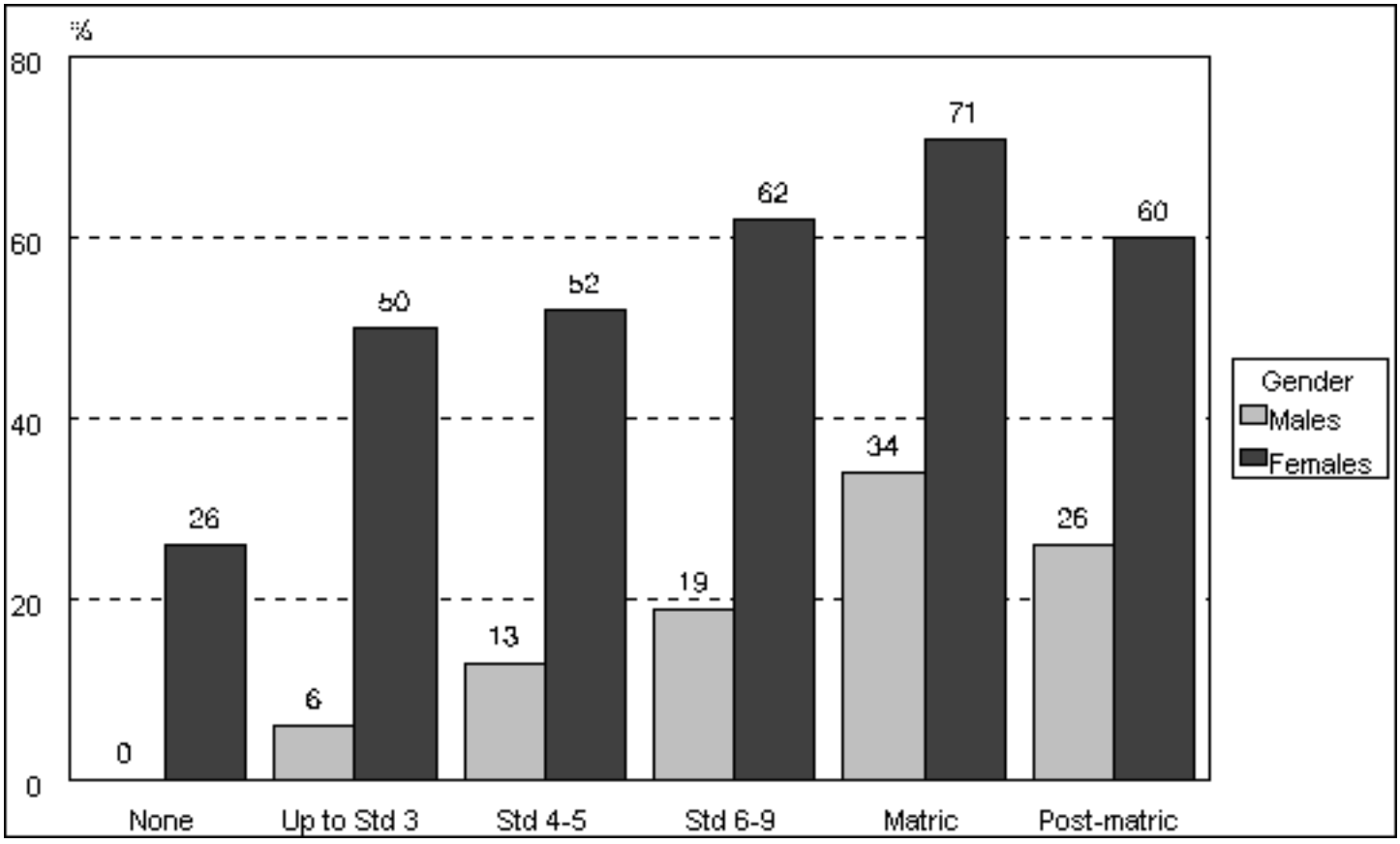
Rural Africans are less likely to seek advice on contraception, compared to those living in urban or metropolitan areas.

- Among African males, proportionately fewer (4%) of those living on white-owned farms went to obtain contraceptive advice, compared to those living in informal settlements in urban areas (11%), in rural homelands (17%), in both formal and informal metropolitan areas (18% in both cases) and in urban formal areas (18%).
- Among African females, while 50% of those living in a rural homeland area went somewhere to obtain contraceptive advice this proportion increased to 54% of those living in metropolitan informal areas, 57% on white-owned farms, 60% in urban informal areas, 64% in urban formal areas and 66% in urban metropolitan areas.

As far as the relationship between education and seeking contraceptive advice among Africans is concerned, Figure 9.3 shows that there is a steady increase in seeking this type of advice among both males and females as level of education increases, but it then decreases for those with post-school education. However, the small proportions of males requesting this advice remain evident.

- For example, less than 1% of African males with no formal schooling went somewhere to obtain contraceptive advice compared to 25% of those with matriculation.
- Among African females, approximately a quarter of those with no formal schooling (26%) went for contraceptive advice compared to almost three quarters (71%) of those with matriculation.

FIGURE 9.3. Africans Seeking Contraceptive Advice by Gender and Level of Education



Adults 16-64 years
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Source of Contraceptive Advice

Those respondents with a sexual partner who went for contraceptive advice were asked where they actually went.

- More than two thirds (69%) of respondents went to a family planning clinic to seek contraceptive advice, while one in 10 (11%) went to a public clinic, a further one in 10 (11%) went to a private doctor, and relatively few (7%) went to a public hospital or pharmacist (1%).

- Table 9.2 shows that a large proportion of women (69%) who went for contraceptive advice, particularly coloureds (80%) and Africans (70%), went to a family planning clinic, while men, with the exception of Africans (where 73% went to a family planning clinic), were more likely to go to a private doctor.

Table 9.2: Source of contraceptive advice by gender and race

Source of contraceptive advice	Male	Female	Total %

	Afric. %	Col. %*	Indian %*	White %*	Afric. %	Col. %	Indian %	White %	
Fam. planning clinic	73	24	17	19	70	80	58	57	68
Other clinic	7	8	0	3	14	8	0	1	11
Pubic hospital	7	11	83	14	7	4	4	6	7
Private doctor	12	48	0	57	8	8	33	34	13
Pharm./other	1	9	0	6	1	0	5	2	1
Total	100	100	100	100	100	100	100	100	100

*** These percentages are based on small numbers, therefore they should be interpreted with caution.**

Using Contraception

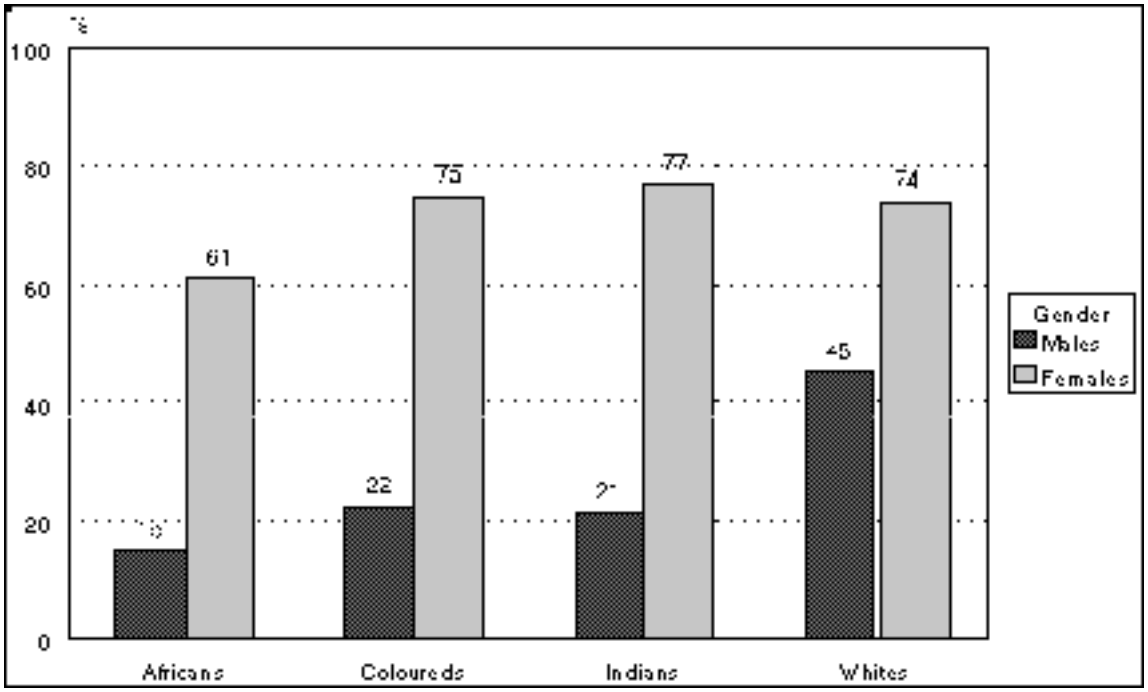
Respondents with sexual partners were asked what method of contraception, if any, they mainly used. We first examine the proportion of those who use contraceptives, and then we look at the different methods among those who use them.

- Overall, relatively few men (20%) use contraceptive methods, and Figure 9.4 indicates that proportionately fewer African (15%) than white (45%) males do so.

- Women (63%) are far more likely to use contraceptive methods compared to men. However, African females (61%) are less likely to do so, compared to whites (74%), coloureds (75%) or Indians (77%).

- Regarding rural-urban differences in contraceptive use among Africans:
  - Proportionately more African males living in formal dwellings in metropolitan or urban areas (21%) use a contraceptive method, compared to those living in rural homeland areas (14%), in metropolitan informal areas (13%), on white-owned farms (6%) or urban informal areas (3%). This means that almost all males living in urban informal areas (97%) and on rural white-owned farms (93%) do not use any form of contraception.
  - Among females, although contraceptive use is much higher, a similar pattern of urban-rural differences emerges. Thus 75% of those living in metropolitan formal areas use some form of contraception, decreasing to 70% in urban formal areas, 63% in urban informal areas, 62% in urban, 61% in metropolitan informal areas, and 54% in rural homeland areas.

FIGURE 9.4. Adults Who Use Contraceptives by Gender and Race



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- Regarding education level and contraceptive use among Africans, we find a similar pattern to the one described for seeking advice on family planning.
  - Among males, 4% of those with no education used some form of contraception, increasing to 9% of those with some primary school, 16% of those with some secondary school and 41% of those with matriculation, but then decreasing to 18% of those with post-school qualifications.
  - Among females, 32% of those with no schooling used some form of contraception, increasing to 56% of those with some primary school, 65% of those with some high school and 82% of those with matriculation, but then decreasing to 72% among those with post-school qualifications.

Methods of Contraception

- Among those who use contraceptives, Table 9.3 shows that, within both groups of men and women, there are variations between races regarding choice of method:
  - While the majority of men who practice contraception use condoms, Indian men (91%) were most likely and coloured men (58%) were least likely to do so. White (33%) and coloured (28%) men were more likely to be sterilised than Indian (9%) or African (3%) males.
  - Among women who practice family planning, injections, for example Depo Provera and Nur Isterate, were most likely to be used by Africans (40%), followed by coloureds (30%), while relatively few whites (5%) or Indians (3%) used injections.
  - Indian (54%) and white women (48%) are more likely to use oral contraception or sterilisation/hysterectomy (38% of white women and 34% of Indian women) as primary methods of avoiding pregnancy.

Table 9.3: Among those who use contraception, method that is used

Type of contraceptive used	Male				Female				Total
	Afric. %	Col. %*	Indian %*	White %	Afric. %	Col. %	Indian %*	White	
Pill	NA	NA	NA	NA	19	18	54	48	18
IUD	NA	NA	NA	NA	3	4	7	5	2
Diaph/foam/jelly	NA	NA	NA	NA	1	0	0	0	0
Condom	87	58	91	63	0	0	0	0	16
Injection	NA	NA	NA	NA	66	40	3	8	44
Sterilised/hyst	3	28	9	33	7	33	34	38	14
Pulling out	1	5	0	4	NA	NA	NA	NA	1
Rhythm method	8	5	0	0	3	2	1	0	3
Abst. till child	1	0	0	0	1	2	1	0	1
Other	0	3	0	1	1	1	0	2	1
Total	100	100	100	100	100	100	100	100	100

These percentages are based on small numbers, therefore they should be interpreted with caution.
Due to rounding off some of the individual percentages add up to slightly more or less than 100%, but are reflected here as 100%.
NA = Not applicable >BR> IUD = Inter-uterine device
Sterilised/hys = sterilised or had a hysterectomy
Diaph/foam/jelly = diaphragm, foam or jelly
Abst. till child = abstinence until a child is wanted

Reasons for Not Practising Contraception

- Those respondents who had a sexual partner but did not use any method of contraception were asked the main reason why they did not do so.

- Amongst males:
  - Table 9.4 indicates that the most common reason given amongst males (48% of Africans, 49% of Indians, 53% of coloureds and 56% of whites) for not using contraceptives was that they relied on their partner to take protective measures.
  - Among African males a lack of knowledge about contraception (15%) and a desire for their partners to conceive (13%) were also mentioned relatively frequently. Among Indian (32%) and white (28%) infertility, of either the respondent himself or else of his partner, was also commonly mentioned.

Table 9.4: Reasons for not using contraceptives by gender and race

Reasons for not using contraception	Male				Female				Total
	Afric. %	Col. %	Indian %	White %	Afric. %	Col. %	Indian %	White %	%
Pregnancy desired	13	11	5	2	27	33	13	19	16
Rely on partner	48	53	49	56	11	5	18	39	38
Religious reasons	4	3	3	0	5	3	0	0	4
Fear	4	1	0	0	10	0	0	0	5
Lack knowledge	15	1	0	0	14	7	3	3	12
Infertility	4	12	32	28	13	17	28	29	11
Already pregnant	1	0	2	0	3	9	5	4	1
Partner refuses	1	2	0	0	1	0	7	0	1
Medical reasons	0	1	0	8	8	15	9	5	6
Distrust contra.	1	1	0	0	1	0	7	0	1
Other	5	15	7	2	5	9	6	1	3
No reason given	4	0	3	4	2	3	4	0	2
Total	100	100	100	100	100	100	100	100	100

- Amongst females:
  - The desire to be pregnant was the most common reason given by coloured (33%) and African (27%) women for not using contraception, while a large proportion of Indian (28%) and white (29%) women tended to cite infertility of themselves or their partners as the reason.
  - In contrast to the other races (18% of Indians, 11% of Africans and 5% of coloureds), four out of every 10 white women (39%) relied on their partner to use contraceptive methods.

Whether Partners Use Contraception

- Respondents were asked what method of contraception, if any, their partner mainly used.

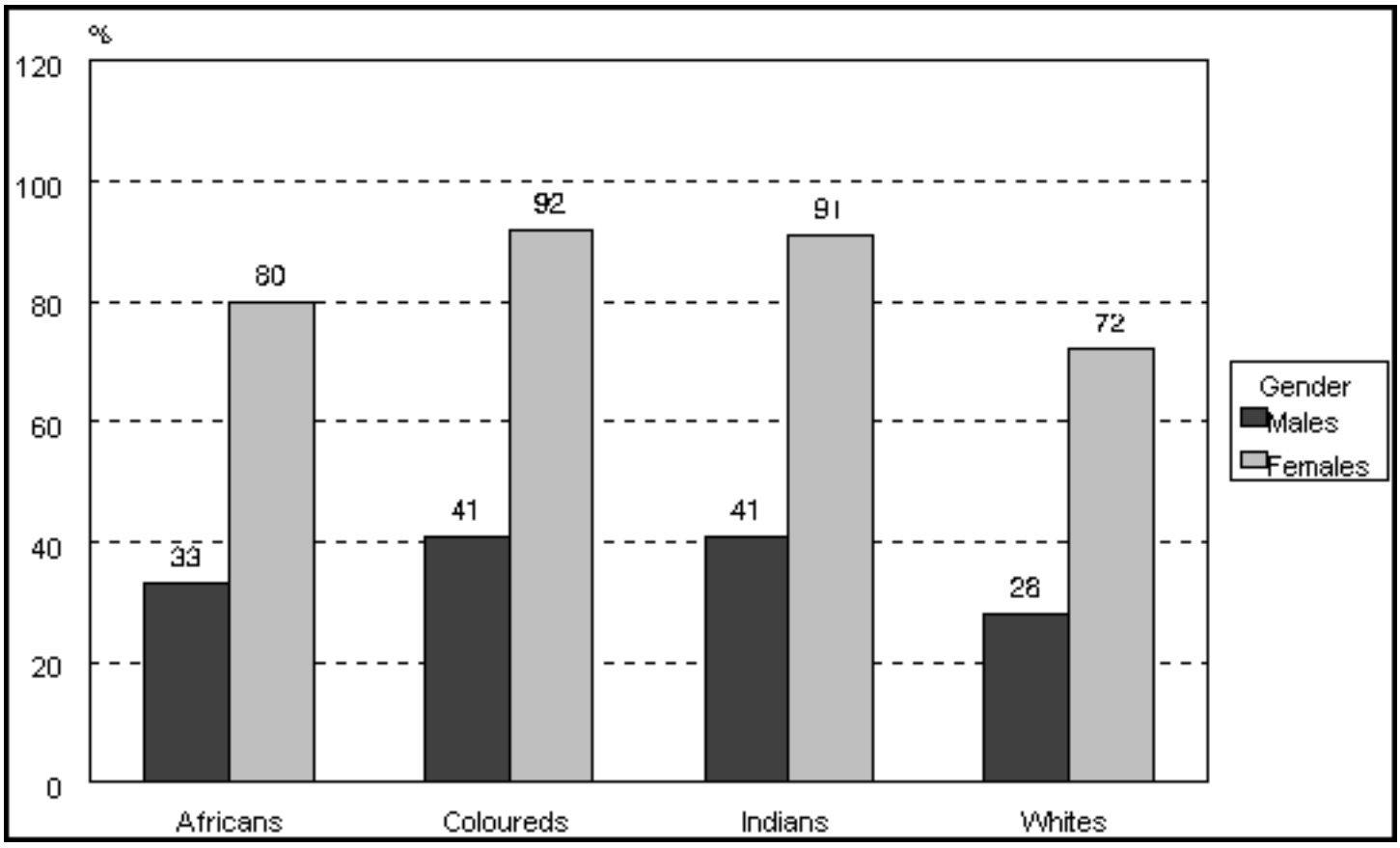
- Eight out of every 10 women (79%) and one out of every three men (19%) reported that their partner did not use contraception.

- Figure 9.5 shows that more than nine out of every 10 coloured (92%) and Indian (91%) female respondents reported that their partners did not use any method of contraception, compared to eight in 10 African (80%) and seven in 10 white (72%) women.

- A relatively large proportion of coloured (41%) and Indian (41%) men said that their partners did not use any form of contraception, compared to Africans (33%) and whites (28%).

- Bearing in mind that this is a probability sample, it should be possible to compare the proportion of respondents who said that they themselves use contraceptives with the proportion who say that their partners use them, even though, obviously, we are not talking about the same partners.

FIGURE 9.5. Adults Who Say Their Partner Does Not Use Any Form of Contraception by Race



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- If we compare the data in Figures 9.4 and 9.5, we see that people generally, but particularly coloureds and Indians, tend to underestimate the extent to which their partners say they use contraceptive methods.
  - For example 92% of coloured females say that their partners do not use any form of contraception, while 78% of coloured male respondents say that they personally do not do so.
  - Among Indians, 41% of males say that their partners do not use any form of contraception. However, only 23% of females say that they personally do not take any protective measures.
  - Among white males, a more accurate picture emerges. While 28% of these respondents (white men) say that their partners do not use any form of contraception, this proportion compares well with the 26% of white female respondents who say they do not practice contraception.

Summary and Conclusions

In this chapter we examined the sexual health of those males aged between 16 and 64 years and those females aged between 16 and 50 years who had a sexual partner. Altogether, 78% of respondents in these age categories had sexual partners.

Among Africans, we noted that 67% of males and 78% of females who had never married, and 60% of males and 63% of females who were separated, widowed or divorced, claimed to have a sexual partner. These individuals may be at greater risk regarding contracting sexually transmitted diseases and AIDS, particularly in the absence of contraceptive measures such as condom use.

Among those who had a sexual partner, only a third of respondents sought professional advice on contraception, but just over half of the females had done so, compared to only one in every seven males.

Younger, urbanised, more educated respondents are more likely to seek contraceptive advice, compared to older, less educated rural ones. When advice is sought, the majority of respondents tend to go to family planning clinics, but white, coloured and Indian males tend to go to private doctors.

Regarding contraceptive use, we found that the vast majority of men with a sexual partner (80%) do not use any form of contraception. However, younger men living in metropolitan formal areas with higher levels of education are more likely than others to use contraception.

A far larger proportion of women with sexual partners (63%) use contraceptives, compared to men. Indian and white women are more likely to take oral contraceptives while African and coloured women are more likely to receive contraceptive injections.

The most common reason given by men for failing to use contraceptives is that they rely on

their partners to do so. The responsibility for family planning therefore tends to be delegated to women. Men generally tend to underestimate the extent to which their partners use contraception.

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Chapter 10.
Women's Health

A National Household Survey of Health Inequalities in South Africa

Joan de Castro and Ros Hirschowitz

CHAPTER NINE.

Introduction

In this chapter we probe the experiences of pregnancy and childbirth, and the health-care received during these periods, among the sample of 2,653 female respondents representing all 11,504 000 women aged between 16 and 64 years. Of these women, 8,683,000 or three quarters (75%) are African, while 941,000 (8%) are coloured, 301,000 (3%) are Indian and 1,578,000 (14%) are white.

- The first part of this chapter is concerned with access to ante-natal care while the second part examines professional assistance during child-birth.

Indicators that Apply to this Chapter

The following indicators form the basis of analysis of this chapter:

- The percentage of women who have given birth who went for ante-natal care in the first trimester the last time they were pregnant.
- The proportion of women who had a health-care professional present at the birth of their last child

Pregnancy

We now examine the health care received during pregnancy among those respondents who have given birth at least once.

- The vast majority of women in the sample (81% in total; 83% of Africans, 76% of coloureds, 76% of Indians and 70% of whites) had been pregnant at least once during their life, and 80% (82% of Africans, 75% of coloureds, 74% of Indians and 68% of whites) had given birth at least once.

Ante-Natal Care

All women who had given birth were asked whether they had been for ante-natal care during their last pregnancy.

- The vast majority of women (89%) who had given birth had received ante-natal care.
- In general, proportionately fewer older respondents had received ante-natal care, compared to younger respondents. For example 73% of those aged between 50 and 64 years had this care, increasing to 90% in the 35 to 49 year and then to 95% in the 25 to 34 and 96% in the 16 to 24 years age categories.
- Among African women, 90% overall had gone for ante-natal care at least once during their last pregnancy.
  - Rural-urban differences in access to ante-natal care are clearly evident. For example, 84% of those Africans living on white-owned farms received ante-natal care, increasing to 86% of those living in rural homeland areas, and then to 90% in urban formal and informal areas and to 95% in metropolitan areas.
  - Poverty and failing to go for ante-natal care are also found to be linked. For example, one in seven of those African women living below the minimum living level (14%) did not go for ante-natal care, compared to one in 20 (5%) of those living above it.
  - Education had a significant impact on African respondents regarding whether or not they received ante-natal care. For example, one in three of those with no schooling (31%) failed to go for ante-natal care, decreasing to one in eight amongst those with some primary school (12%), and one in 20 amongst those with some high school (4%), while all respondents with post-school qualifications had received ante-natal care.
  - Disabled and chronically ill Africans had less access to ante-natal care than average. Thus, one in every six (17%) disabled and one every seven (15%) of the chronically ill did not go for ante-natal care, compared to the average of one in 10 (10%).

Table 10.1: Source of ante-natal care by race (Females who received ante-natal care)

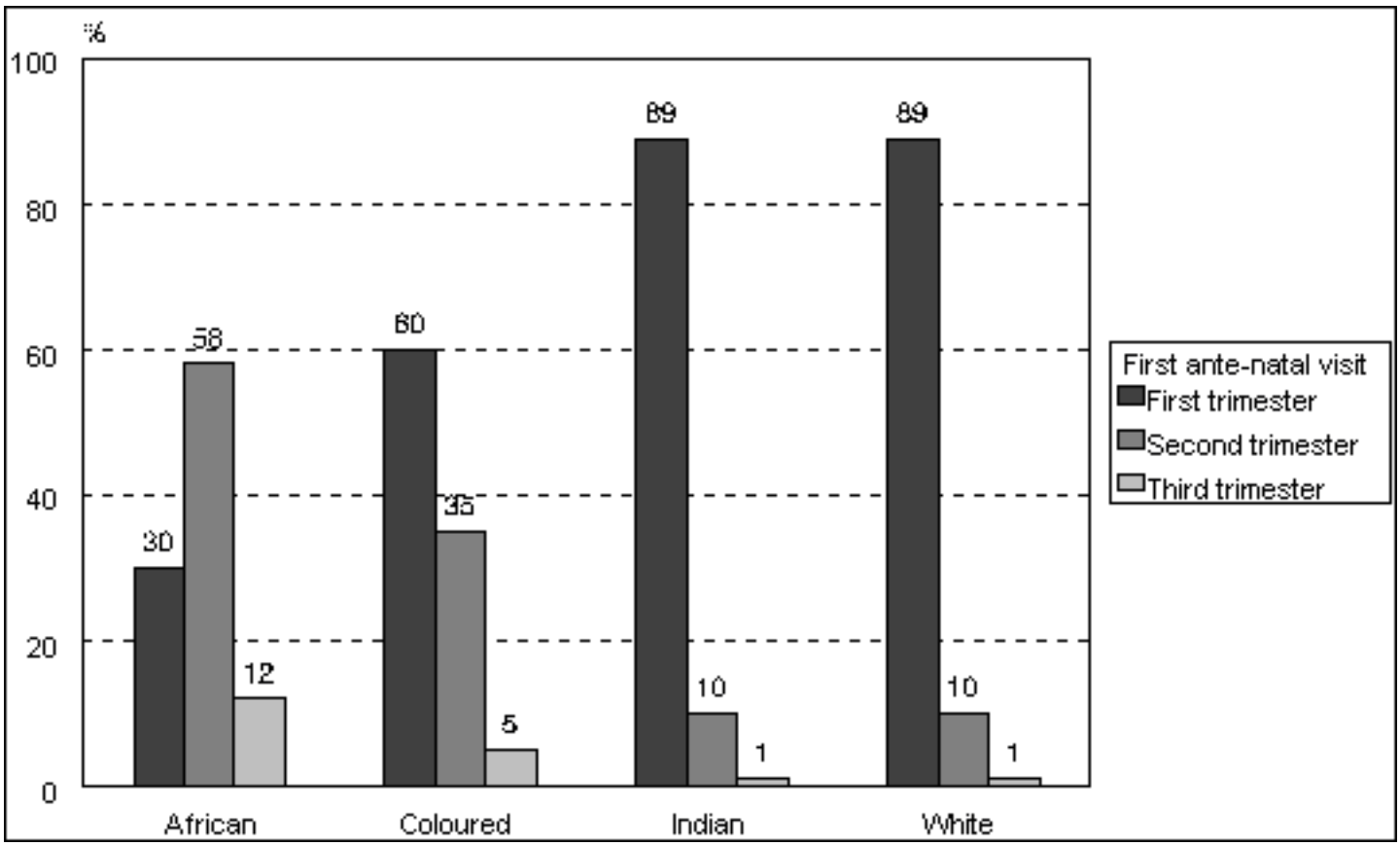
Where respondents received ante-natal care	African	Coloured	Indian	White	Total
	%	%	%	%	%

Public hospital	24	26	33	14	23
Public clinic	69	57	16	6	60
Private doctor	6	17	52	79	17
Other	1	0	0	1	1
Total	100	100	100	100	100

- As with the other findings in this survey, Table 10.1 shows that, among those who went for ante-natal care, almost all African (92%) and coloured (83%) women received ante-natal care from public facilities, compared to Indian (48%) and white (20%) women.

Going for Ante-Natal Care in the First Trimester of Pregnancy

FIGURE 10.1. When Respondents Went for Ante-Natal Care by Race



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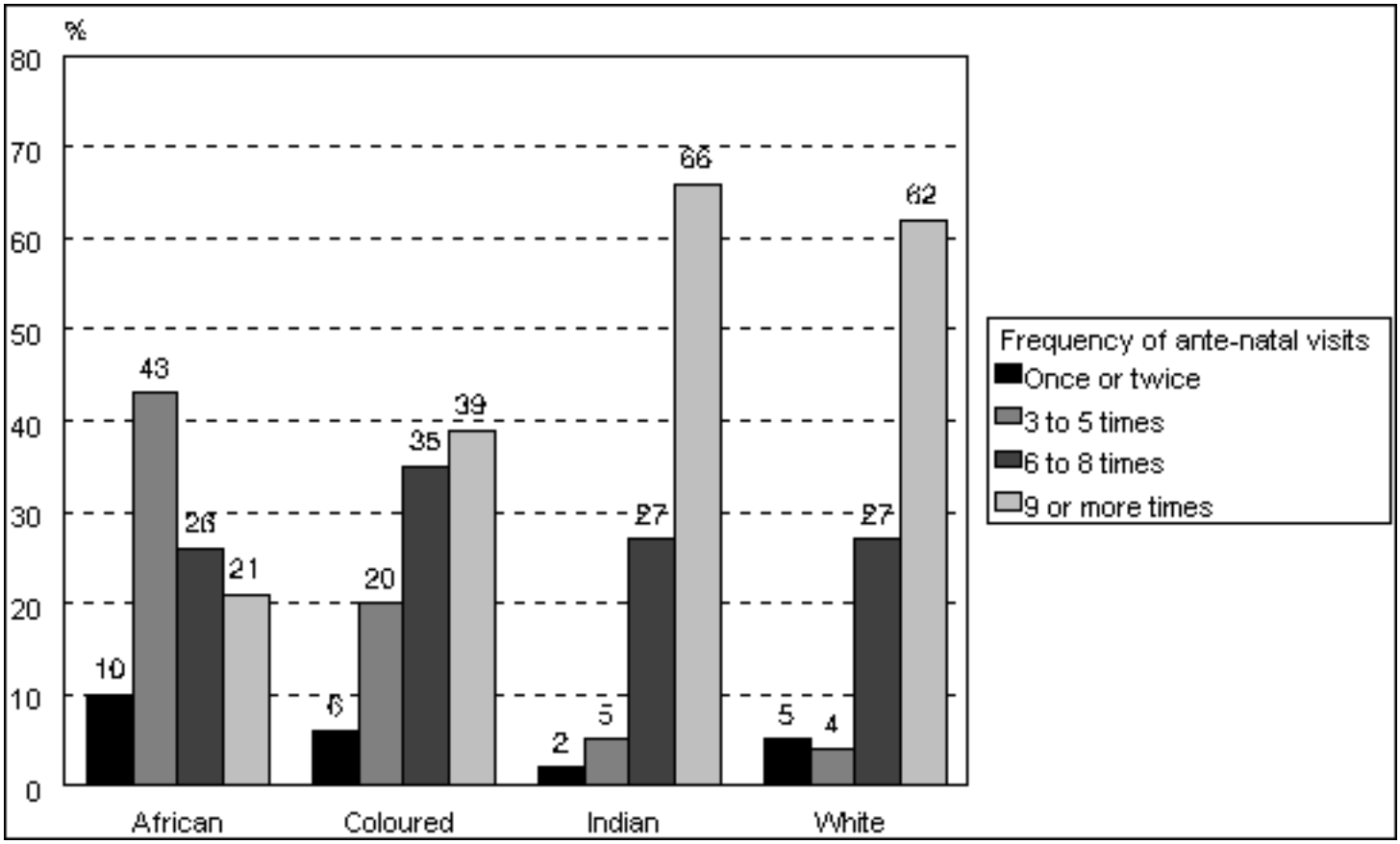
To enable careful monitoring of both the mother's health and the development of the foetus during pregnancy, going for the first ante-natal visit during the first trimester is an important preventive health-care measure.

- Figure 10.1 indicates that, among those respondents who went for ante-natal care, the vast majority of Indian (89%) and white (89%) women did so during their first trimester, but this percentage dropped to six in every 10 (60%) among coloured women and only three in every 10 (30%) among African women.
    - Over half of the African women (58%) and over a third (36%) of coloured women went for their first ante-natal visit between the fourth and sixth month of their last pregnancy. One in eight African women (12%) went for their first ante-natal visit only in the third trimester of their pregnancy, placing both mother and baby at risk.
- Among African women, we find a familiar pattern, where socio-economic circumstances and going for ante-natal visits in the first trimester of pregnancy are directly related:
    - Proportionately more of those living in formal housing in metropolitan areas (46%) went for ante-natal care in their first trimester, compared to those living in informal housing in metropolitan areas (30%) or in rural homeland households (22%).
    - Proportionately fewer of those living in overcrowded homes (29%) went for ante-natal care in their first trimester of pregnancy, compared to those living in uncrowded homes (41%).
    - A smaller proportion of those living in households with incomes below the minimum living level (27%) went for ante-natal care in the first trimester, compared to those in households with incomes above this level (37%).
    - Relatively few of those with no schooling (28%) went for ante-natal care in their first trimester, as against those with post-school qualifications (56%).

Frequency of Ante-Natal Visits during the Last Pregnancy

- Figure 10.2 shows that, among those who went for care, relatively few African women (21%) went for nine or more ante-natal care visits during their last pregnancy, compared to whites (62%) and Indians (66%). One in 10 (10%) African women went only once or twice.

FIGURE 10.2 . Frequency of Ante-Natal Visits by Race



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- Among Africans, socio-economic circumstances are again found to be directly related to frequency of ante-natal visits during the last pregnancy. Only one example will be cited.
  - While 26% of Africans living in formal brick housing went at least nine times for ante-natal care during their last pregnancy, only 17% of those living in shacks and 9% of those living in traditional dwellings did so.

Childbirth

We now examine where the respondents gave birth to their last child, and whether or not there was a health professional present.

Place at which Child was Born

- Almost all white (98%) and Indian (96%) women gave birth in a hospital, clinic or medical centre. However, almost a quarter of Africans (24%) and just under one in six coloureds (16%) gave birth in their homes.
- There is an inverse relationship between the education of the respondents and the likelihood of a home birth. Thus 58% of those with no education, gave birth in their homes, decreasing to 30% amongst those with some primary school education, and even more to 4% amongst those with matriculation and then to 2% amongst those with post-school qualifications.

- Proportionately more older respondents gave birth at home, compared to younger respondents.
  - For example, among Africans, 14% of those aged between 16 and 24 years gave birth at home, increasing to 17% of those aged 25 to 34 years and then to 23% amongst those aged between 35 and 49 years and to 52% amongst those aged between 50 and 64 years.
- A far greater proportion of those who did not have ante-natal care during pregnancy (58%) gave birth at home compared with those who did (16%).
- Among African women:
  - Those living in provinces which had large metropolitan centres such as the Western Cape and Gauteng were less likely to have given birth at home (4% and 10% respectively), compared to the other provinces (for example, Eastern Transvaal 34%, Free State 32%, Eastern Cape 28%, KwaZulu-Natal 26%).
  - Women living on rural white farms were more likely (43%) to have given birth at home than those living in rural homelands (30%) or metropolitan informal areas (12%).

Health Personnel Present at Birth

- Table 10.2 shows that almost a quarter of the African respondents (22%) did not have a health professional present at their last birth, compared to 3% of coloureds, 2% of Indians and fewer than 1% of whites.
- Among Africans:
  - More than four out of every 10 women living on white-owned farms (44%) did not have a professional health worker present at the birth of their last child, decreasing to 28% of those living in rural homelands, and even further to 15% of those living in urban formal and then to 11% in urban and 10% in metropolitan informal areas and then even further to 5% in metropolitan formal areas.
  - Whereas over three quarters (76%) of those who did not receive ante-natal care during their last pregnancy did not have a health-care professional when their last child was being born, only one in six (17%) who obtained ante-natal care were in these circumstances.

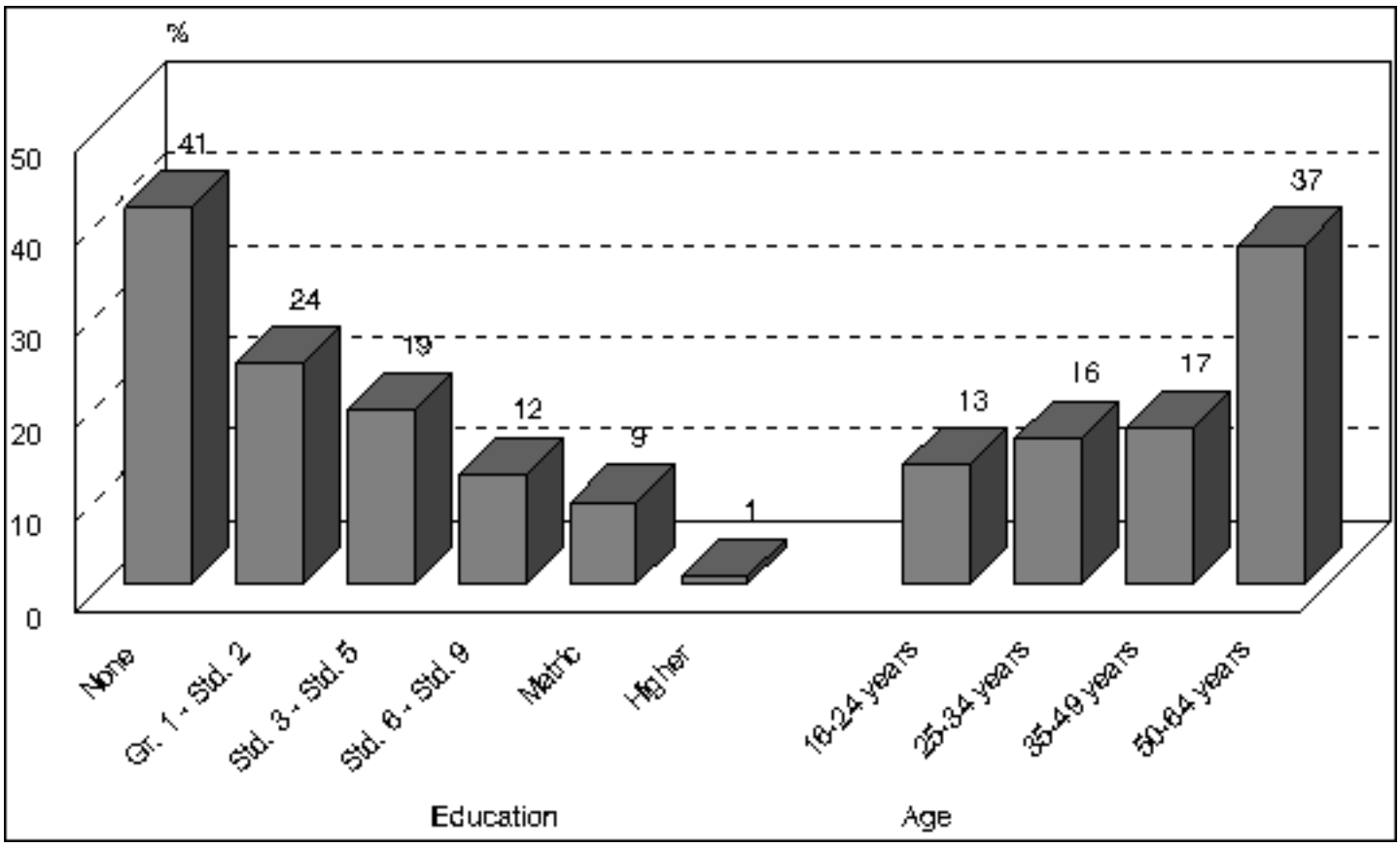
Table 10.2: Health personnel present at birth of last child by race

Type of health professional present at birth of last child	African	Coloured	Indian	White	Total
	%	%	%	%	%
Doctor	6	35	42	68	16
Nurse/midwife	47	39	20	6	41
Both doctor and nurse	25	23	36	26	25
No health professional	22	3	2	0	18
Total	100	100	100	100	100

Presence of Traditional Birth Attendant

- Almost a fifth of Africans (19%) had a traditional birth attendant present at the birth of their last child.
- Among African women:
  - Having a traditional attendant present at the birth of the last child was more common among those in rural areas, those with a lower level of education, older women and those living in poorer socio-economic circumstances.

FIGURE 10.3. Africans Who had a Traditional Birth Attendant By Education and Age



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- Figure 10.3 shows that 41% of those with no schooling had a traditional attendant present at the birth of their last child, compared to 1% of those with post-school qualifications.
- A larger proportion of those aged between 50 and 64 (37%) years had a traditional attendant present at the birth of their last child, compared to those aged between 16 and 24 years (13%).

Additional Women's Health Issues

Women's health and freedom of choice are closely interlinked. In this section we examine death in the family during pregnancy and childbirth in the year prior to the interview. Such deaths during pregnancy and childbirth are recognised worldwide as indicative of poverty, underdevelopment and poor access to care.

We then examine whether or not the respondents knew of anyone who had an abortion in the year prior to the interview, and whether or not they know of anyone who has died of an abortion during this period.

Deaths during Pregnancy and Childbirth

- Altogether 3% of respondents had a family member who had died during pregnancy or childbirth in the year prior to the study. This translates into approximately 626,000 people of which 574,000 are African.
- Three percent of African and coloured respondents indicated that a female in the family had died during pregnancy or childbirth in the year prior to the study, while only 1% of Indian women and less than 1% of white women indicated that this had happened.
- Among Africans, those living in informal settlements in urban areas (7%) were more likely to report a death in the family in the past year during pregnancy or childbirth, compared to those in formal housing in metropolitan areas (3%) or in rural areas (3%).

Incidence of Abortions in the Past Year amongst Friends and Relatives

- Respondents were asked whether they knew a friend or relative who had an abortion in the year prior to the survey.
- Four percent of African, coloured and white respondents and relatively few Indians (1%) knew a friend or relative who had an abortion in the previous year.
- Among Africans, those who were in more affluent socio-economic circumstances were more likely to admit that they knew someone who had an abortion in the year prior to the interview, compared to those in poorer circumstances.
    - For example, African women living in uncrowded dwellings were twice as likely (6%) to know a friend or relative who had an abortion than those in crowded dwellings (3%).
    - Proportionately more of those who had completed matriculation (6%) said that they knew someone who had an abortion in the year prior to the study, compared to those with a primary school education (2%).
- Among coloureds the opposite pattern emerges: as socio-economic status increases, the probability of knowing a friend or family member who had an abortion in the year prior to the survey decreases.
    - For example, 7% of those with no formal schooling compared to 3% of those with matric or higher are aware of someone who had their pregnancy terminated.

Death as a Result of an Abortion

- Four percent of African, 3% of coloured, 1% of Indian and fewer than 1% of white respondents knew someone who had died as a result of an abortion in the past year.

- Among Africans, those in better socio-economic circumstances were more likely to admit knowing someone who had died in the past year as a result of an abortion, compared to those in worse circumstances.
  - For example, 5% of those living in formal, brick homes knew of someone who had died after an abortion in the past year, decreasing to 3% of those living in shacks and 2% in traditional dwellings.
  - Seven percent of those with a matriculation said that they knew someone who had died, compared with 2% of those with primary school education.
  - Younger African respondents were more likely to say they knew someone who had died as a result of an abortion in the past year compared to older respondents. Thus 5% of those aged 16 to 24 years knew of someone, compared to 1% of those aged 50 to 64 years.

Summary and Conclusions

This chapter examined access to health-care during pregnancy and childbirth. The vast majority of women in the sample (81%) had given birth to at least one child.

Among those who had given birth, nine out of every 10 (89%) had received ante-natal care. However, among Africans, those living in a rural environment, those who had received little, if any, education, and those who were poor were less likely to receive ante-natal care.

It is therefore essential for health personnel to reach out to the poorest women in the most remote rural areas to ensure that maternal and child health is accessible to all.

Regular monitoring throughout pregnancy was less likely to occur among Africans, where a large proportion (70%) went for their first ante-natal visit in the second or third, rather than in the first trimester of pregnancy.

Advocacy among women regarding early and regular attendance at ante-natal clinics is therefore an important preventive primary health-care measure. This applies particularly to those living in informal settlements and in rural areas.

The research showed that a relatively large proportion of African women (22%) did not have a health professional present at the birth of their last child. This applied particularly to those in rural areas. Access to health services during childbirth in rural areas is therefore an essential component of future planning for primary health-care services.

The use of traditional birth attendants was however more widely practised in rural than in urban areas. It is important for health professionals involved in maternal and child health to find ways of working together with traditional birth attendants. This cooperation could mean that fewer mothers and babies, particularly in rural areas, are at risk during birth.

Three in every 100 Africans had a family member who had died in pregnancy or childbirth compared to fewer than one in every 100 whites.

Chapter 11.
Research Findings:
Adults Aged 65 Years or More

A National Household Survey of Health Inequalities in South Africa

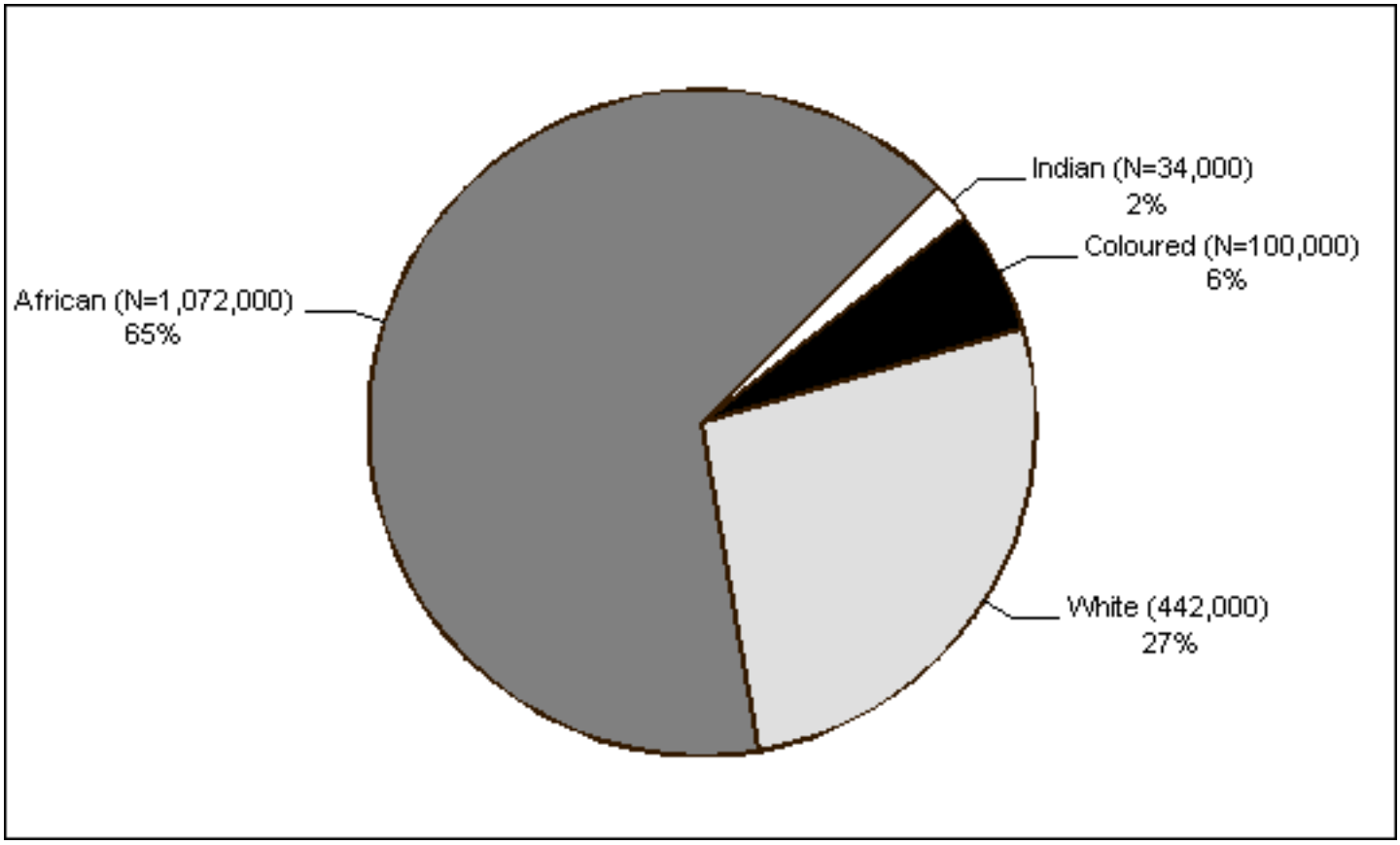
Lebogang Taunyane and Ros Hirschowitz

CHAPTER ELEVEN.

Introduction

This chapter considers the research findings regarding the health status and health requirements of the 830 respondents aged 65 years or more who answered this section of the questionnaire, and who represent the entire South African population of 1,648,000 people in this age category*.

FIGURE 11.1. Proportion of Adults Aged 65 Years or Older by Race



Total number of adults aged 65 years or more = 1,648,000
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- Figure 11.1 indicates that 65% of people aged 65 years or more are African, while 27% are white, 6% are coloured and 2% are Indian.
  - Three percent of all Africans and coloureds and 4% of Indians are in this age category, compared to 10% of whites.
- We now compare the above proportions with those cited in previous chapters. In Chapter 3 we showed that 86% of children aged nought to five years are African, and 6% are white.
  - Among children aged six to 15 years however, 83% are African and 8% are white, as indicated in Chapter 1.
  - Among adults aged 16 to 64 years we showed in Chapter 5 that 75% are African and 15% are white.
  - In the oldest age group, among those aged 65 years or more, we now find that 65% are African and 27% are white.
- There is therefore a significant decrease in the proportion of Africans (from 86% to 65%), and an increase in the proportion of whites (from 6% to 27%) in the population, as one moves from the youngest to the oldest age category.
  - This profile of an aging population among whites has implications for future health-care priorities. In the past, as we have indicated a large proportion of the health budget was spent on expensive, curative care involving high-level technology. Whites in this age group were the main beneficiaries of this type of care.

Selecting an Appropriate Adult in the Household Aged 65 years or More

- One in five households (21%) contained one or more adults aged 65 years or more. White households (25%), as can be expected from the above discussion, were most likely to contain at least one person in this age category.
- Information was obtained on only one person in each of these households.
  - If there was more than one adult in this age category, the relevant adult was chosen using a random grid.
  - This person usually answered for him- or herself, but if there was a problem, for example, poor hearing or severe memory loss, the health-care person provided the information.

Indicators that Apply to This Chapter

The following health indicators apply to this chapter:

- Perceived quality of both physical and mental health.
- Prevalence and management of chronic illnesses.
- Prevalence and management of disabilities.
- Prevalence of loneliness, as measured by the percentage of people who spent all of the week prior to the interview alone.

Biographical Description of the Sample

- Table 11.1 indicates that more than half (60%) of the respondents were females as against 40% males.
- Overall, the largest proportion of respondents (46%) were in the age category 65 to 70 years.
  - However, among whites, the largest proportion of respondents were in the age category 76 years or more, indicating that whites are living longer than those in the other population groups.
- The level of education among Africans was particularly low, with 29% having not gone to school at all, 22% with only a basic primary education up to standard three, and 16% with a standard four or five.
- Among Africans:
  - More than half of the respondents lived in rural homelands (57%), while relatively fewer lived in formal metropolitan (17%), urban (16%) or informal (5%) areas or on rural white-owned farms (5%).
  - The majority (66%) of the respondents lived in formal, brick accommodation. However, a quarter (26%) lived in traditional dwellings and one in 20 (5%) lived in shacks.

Table 11.1: Biographical description of the sample by race

Biographical description	African (N = 1,1m)	Coloured (N = 0,1m)	Indian (N = 0,03 m)	White (N = 0,4m)	Total (N = 1,6m)

	%	%	%	%	%
Age years: 65-70	51	57	51	31	46
71-75	22	20	23	24	22
76+	27	23	27	45	32
Total	100	100	100	100	100
Gender: Male	40	39	43	40	40
Female	60	61	57	60	60
Total	100	100	100	100	100
Education None	29	11	2	0	20
Gr. 1 - Std 3	22	19	13	0	16
Std. 4 - 5	16	34	16	3	14
Std. 6 - 9	26	25	42	52	34
Matric.	4	7	16	24	10
Higher	3	4	10	21	7
Total	100	100	100	100	100
Respondent: Self	69	66	44	80	71
Proxy	31	33	56	20	29
Total	100	100	100	100	100
Province: W Cape	1	68	0	23	11
N Cape	1	13	0	2	2
E Cape	24	13	0	9	19
KwaZulu-Natal	22	0	85	15	20
Gauteng	12	6	15	36	18
E Tvl	7	0	0	3	6
N Tvl	16	0	0	2	11
N West	10	0	0	4	7
Free State	7	0	0	6	6
Total	100	100	100	100	100
Area: Metro-formal	16	50	84	57	0
Metro-informal	3	0	0	0	2
Urban-formal	16	39	16	43	25
Urban-informal	2	1	0	0	1
Rural-white farms	6	10	0	0	5
Rural-homeland	57	0	0	0	37
Total	100	100	100	100	100
Type of dwelling: House/flat/boarding house	67	99	100	100	78
Shack/outbuilding/zozo	7	1	0	0	5
Traditional dwelling	26	0	0	0	17
Total	100	100	100	100	100

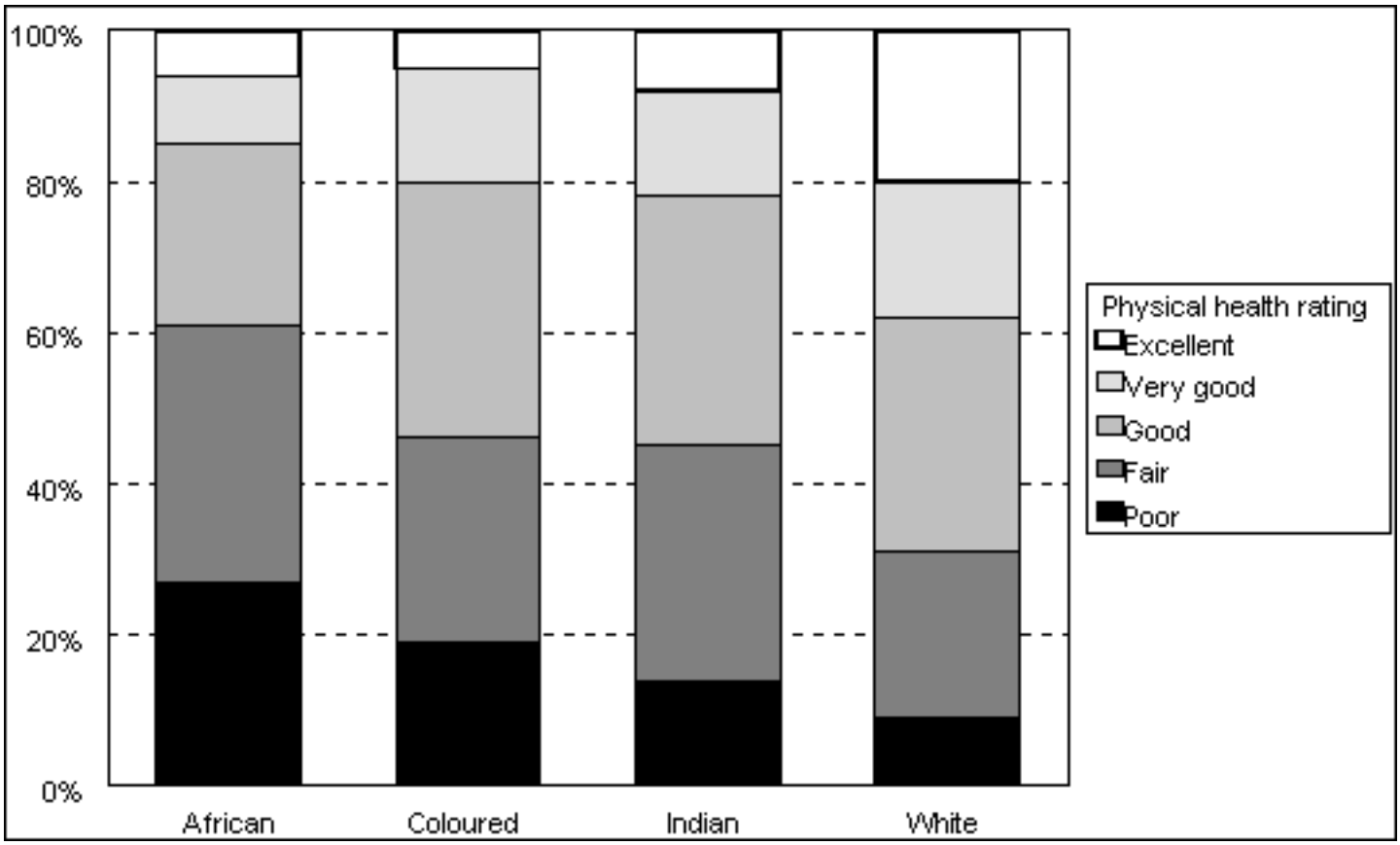
Ratings of Health Status

We now examine the ratings that the respondents aged 65 years or more gave to their physical health and their mental health as well as their overall satisfaction with life.

Perceived Physical Health Status

- When asked to describe their physical health compared to other people of their age, 10% of the total sample described their health as excellent and 12% as very good, while 27% described it as good, 30% as fair and 22% as poor.
  - Thus more than half of all respondents aged 65 years or more (52%) perceived their health status as fair or poor, compared to others of their age.
- If we compare this rating with that of people aged 16 to 64 years, we see a significant rise in the proportion of older people who rate their health status as fair or poor, and a significant drop in those who rate their health status very good or excellent. This result is to be expected.

FIGURE 11.2. Perception of Physical Health Status by Race



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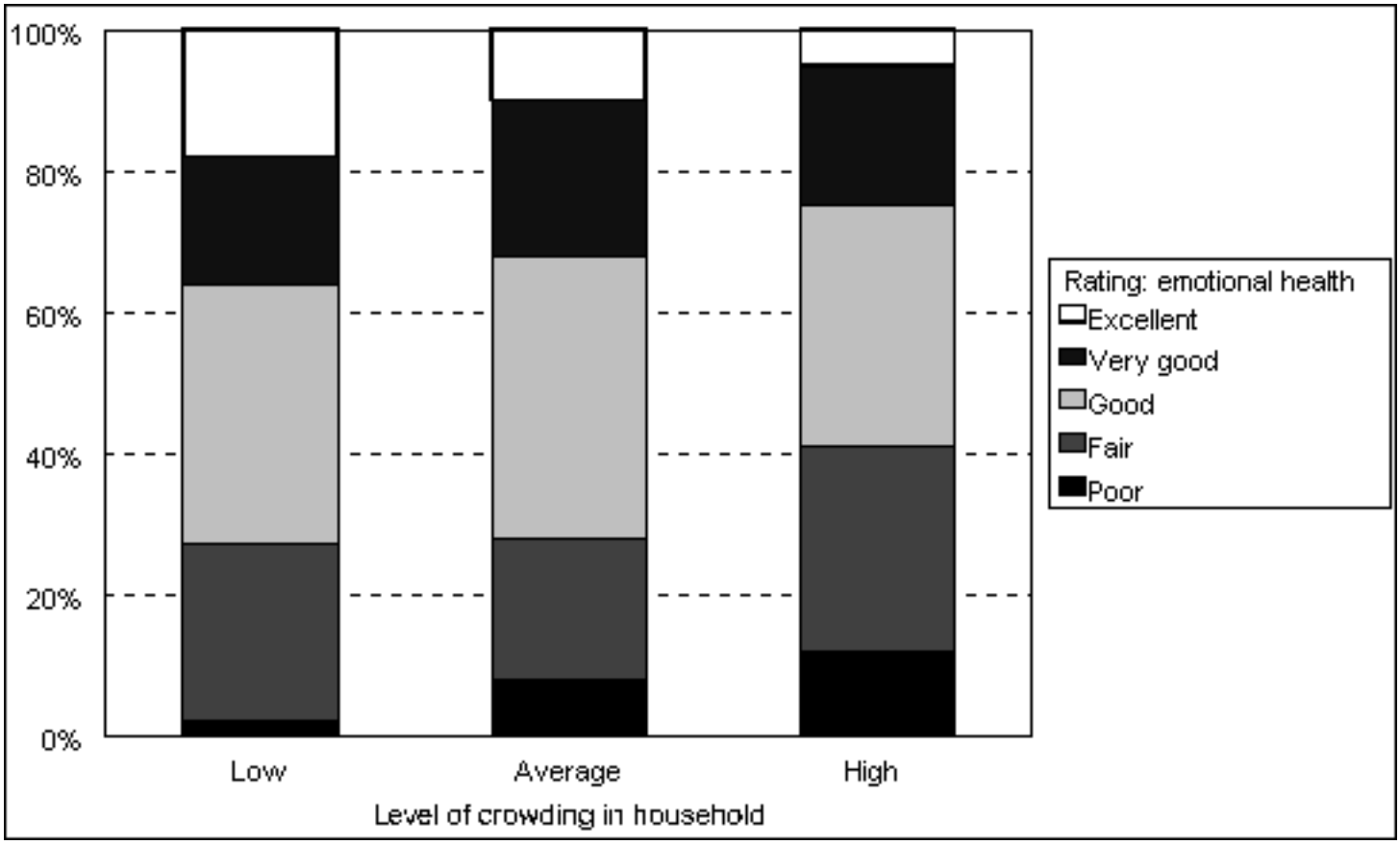
- However, race disparities in health status ratings persist, even among those aged 65 years or more. Fig. 11.2 shows that proportionately more Africans (27%) believe that their health status is poor in contrast to coloureds (19%), Indians (14%) and whites (9%).
- In general, almost equal proportions of males (23%) and females (21%) perceived their health-status as poor.

- Sixty three percent of respondents in this age category with any form of disability perceived their health status to be fair or poor compared to 52% in the total sample.
- Among Africans, socio-economic circumstances were directly linked to perceptions of poor physical health.
  - Proportionately fewer of those living in formal metropolitan areas believe that their state of health is poor (22%) compared to those living in rural areas (30%) or in informal settlements (36%).
  - One in three of those (32%) living in over-crowded conditions perceived their health status to be poor in contrast to those living in conditions of average (23%) or low crowding (19%).
  - Thirty percent of those living with no electricity believed that their health was poor, compared to 21% of those with electricity in their homes.

Perceived Emotional Health Status

When asked to describe their emotional health status compared to other people of their age, 10% of the respondents described it as excellent, 21% as very good, 39% as good, 22% as fair and 8% as poor. We therefore see that the elderly respondents in the survey tend to rate their physical health lower than their emotional health.

Figure 11.3 Rating of Emotional Health by Crowded Living Conditions Among Africans

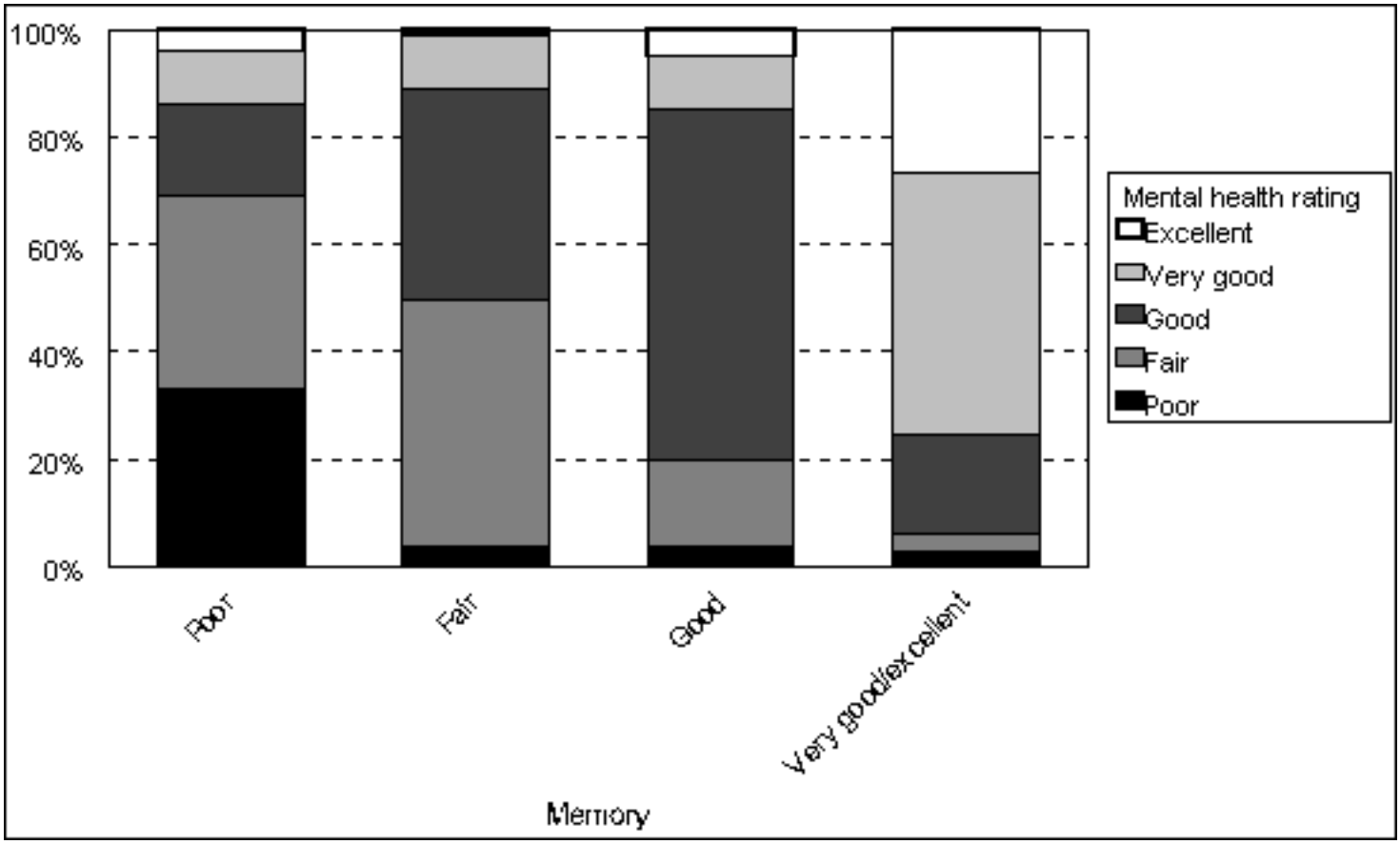


- Proportionately more African respondents (35%) described their emotional health as either fair or poor, followed by coloureds (32%), Indians (28%) and whites (19%).
- Living conditions influenced mental health ratings. Figure 11.3 shows that 41% of the elderly living in over-crowded conditions thought that their emotional state was fair or poor in contrast to 27% of those living in conditions of low crowding.
- Loneliness was related to perceived fair or poor emotional state. Those who had spent every day in company in the week prior to the study (29%) were less likely to perceive their emotional state as fair or poor as against those who spent their time alone (35%).
- Proportionately more of those with one or more disabilities (40%), compared to the total sample (30%), perceived their emotional state as either fair or poor.

Memory When asked to compare the state of their memory to that of other people of their age, 11% said it was excellent, 17% said it was very good, 34% good, 22% fair and 16% poor.

- Poor living conditions were found to be related to the respondents' perceptions of the quality of their memory, probably because these conditions place undue stimulation and strain on elderly people.
  - Twenty two percent of those living in over-crowded conditions thought that their memory was poor, compared to 17% of those living in conditions of average crowding and 4% of those living in conditions of low crowding.
  - Twenty two percent of those living in households which had no access to electricity said that their memory was poor, compared to only 11% of those who had access to electricity.
- Figure 11.4 indicates that there is a strong positive relationship between perceptions of failing memory and ratings of mental health. Among those who said that their memory was poor, 33% described their mental health as poor while among those who described their memory as excellent or very good, only 3% said that their mental health was poor.

FIGURE 11.4. Rating of Mental Health by Rating of Memory



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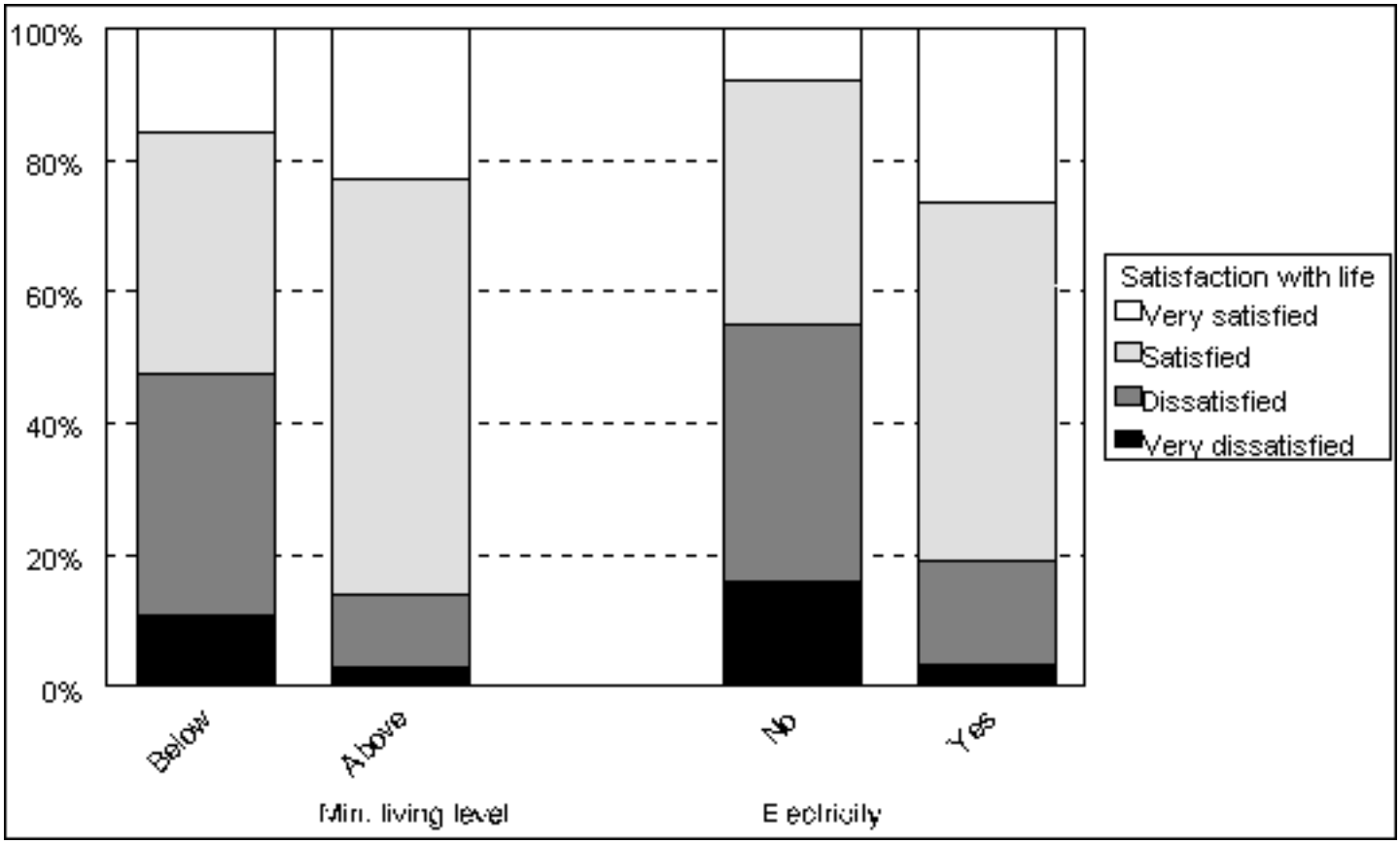
Satisfaction with Life

When asked to rate their overall satisfaction with their lives, 18% said they were very satisfied, 47% were satisfied, while 27% were dissatisfied and 9% were very dissatisfied.

- The research showed that life satisfaction, feeling physically and mentally healthy and believing that one is capable of remembering recent events are closely correlated, and elderly people who believe that their physical or mental health or memory are poor, are more likely to say they are dissatisfied with their lives.
  - Almost seven in every 10 respondents (69%) who said that their memory was poor were either dissatisfied or very dissatisfied with their lives, compared to only a quarter (24%) of those who rated their memory as very good or excellent.
  - Almost three quarters (72%) of those who rated their physical health as poor said that they were either dissatisfied or very dissatisfied with their lives, compared to only one in 10 (10%) who rated their physical health as very good or excellent.
  - An even higher proportion (87%) of those who rated their mental health as poor said that they were dissatisfied with their lives, compared to fewer than a quarter (22%) who rated their mental health as very good or excellent.
- The majority of the elderly respondents living in over-crowded conditions (55%) were either dissatisfied or very dissatisfied with life, compared to those living in conditions of average crowding (38%) and low crowding (8%).

- Fifty five percent of those living in shacks or outbuildings and 50% of those living in traditional dwellings were either dissatisfied or very dissatisfied with life, as against those living in formal dwellings (31%).
- Proportionately more elderly Africans (52%) were either dissatisfied or very dissatisfied with life, compared to relatively few Indians (13%), whites (8%) or coloureds (3%).

FIGURE 11.5. Africans Satisfaction with Life by Household Income and Access to Electricity



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- Among Africans, Figure 11.5 shows that socio-economic circumstances and life satisfaction are closely interlinked.
  - Elderly Africans living in households with an income below the minimum living level (55%) were more likely to be dissatisfied or very dissatisfied with life than those living in households with an income above the minimum living level (37%).
  - Seventeen percent of those who had no electricity, were very dissatisfied with life, compared to only 6% of those who had electricity.

Chronic or ongoing illnesses

Seven in every 10 (70%) elderly respondents indicated that they had at least one chronic condition or ongoing health problem.

Table 11.2: Proportion of respondents with chronic illnesses by gender, area and type of dwelling and by race

Percentage with chronicdisease	African (N=16,2m)	Coloured (N=1,8m)	Indian (N=0,6m)	White (N=3,2m)	Total (N=21,8m)
	%*	%*	%*	%*	%*
Gender: Male	61	70	56**	67	63
Female	73	80	85**	76	74
Age: 65 - 74 years	69	78	73	71	70
75 years +	66	71**	72**	73	69
Area: Metro formal	80	78	73	72	75
Metro informal	47**	NA	NA	NA	47**
Other urban	62	75	71**	73	68
Other urban informal	88**	NA	NA	NA	89**
Rural white farms	57	71**	NA	NA	59
Rural - homeland	68	NA	NA	NA	68
Type of dwelling:					
House/flat etc.	70	76	72	72	71
Shack/outbuilding/zozo	61	NA	NA	NA	62
Traditional dwelling	66	NA	NA	NA	66
Total with at least one chronic disease	68	76	72	72	70

*** The balance of all percentages indicated in the table add up to 100%**
**** Percentages should be interpreted with caution because they are based on small numbers**
NA This category is not applicable as there were no respondents

- Table 11.2 indicates that a smaller percentage of elderly Africans (68%) had at least one chronic illness, compared to coloureds (76%), Indians (72%) and whites (72%). This finding may be due in part to under-reporting, as a result of possible under-diagnosis. As we have seen, Africans tend to be examined for shorter time periods when they go for health-care compared to those in other population groups. Therefore it may be more easy among Africans for chronic illnesses to be overlooked.
- Proportionately fewer males (63%) than females (74%) across all races reported that they had at least one chronic illness.
- The proportions of those with chronic illnesses aged 65 to 74 years (70%) and those aged 75 years or more (69%) are very similar.
  - The effects of age on the prevalence of at least one chronic illness among the elderly are therefore not clear-cut, perhaps because mortality according to age cannot be taken into account in a household survey of this nature.

- Among Africans:
  - Those living in shacks (61%) were least likely to report having a chronic illness, followed by those living in traditional dwellings (66%) and then those living in formal brick housing (70%).
  - Those living in informal metropolitan areas (47%) were least likely to report having a chronic illness, followed by those living on white-owned farms (58%), compared to a higher proportion of those living in metropolitan formal areas (80%).
  - These findings may be due to under-reporting as a result of under-diagnosis.

Type of Illness

Table 11.3: Percentage of those with a particular chronic illness by race

	African	Coloured	Indian	White	Total
Type of illness	%*	%*	%*	%*	%*
Hypertension	34	34	29	40	36
Arthritis	33	48	48	35	35
Asthma/breathing problem	10	13	6	8	10
Heart problem	16	16	19	19	17
Diabetes	11	11	17	10	11
Epilepsy	1	1	4	0	1
Cancer	2	1	4	7	3
Total with at least one chronic disease	68	76	72	72	70

*** The balance of each percentage indicated in the table adds up to 100%**

- Table 11.3 indicates that hypertension (36%) and arthritis (35%) are the most common chronic illnesses affecting elderly respondents.
- Proportionately, more white elderly people (40%) suffer from hypertension, compared to Africans (34%), coloureds (34%) and Indians (29%).
- Proportionately more females reported having these two diseases, in comparison to males.
  - Forty four percent of females had hypertension, compared to 23% males.
  - Forty percent of females had arthritis, in comparison to 27% males.
- Proportionately more Indians (17%) reported having diabetes than whites (10%), coloureds (11%) and Africans (11%).

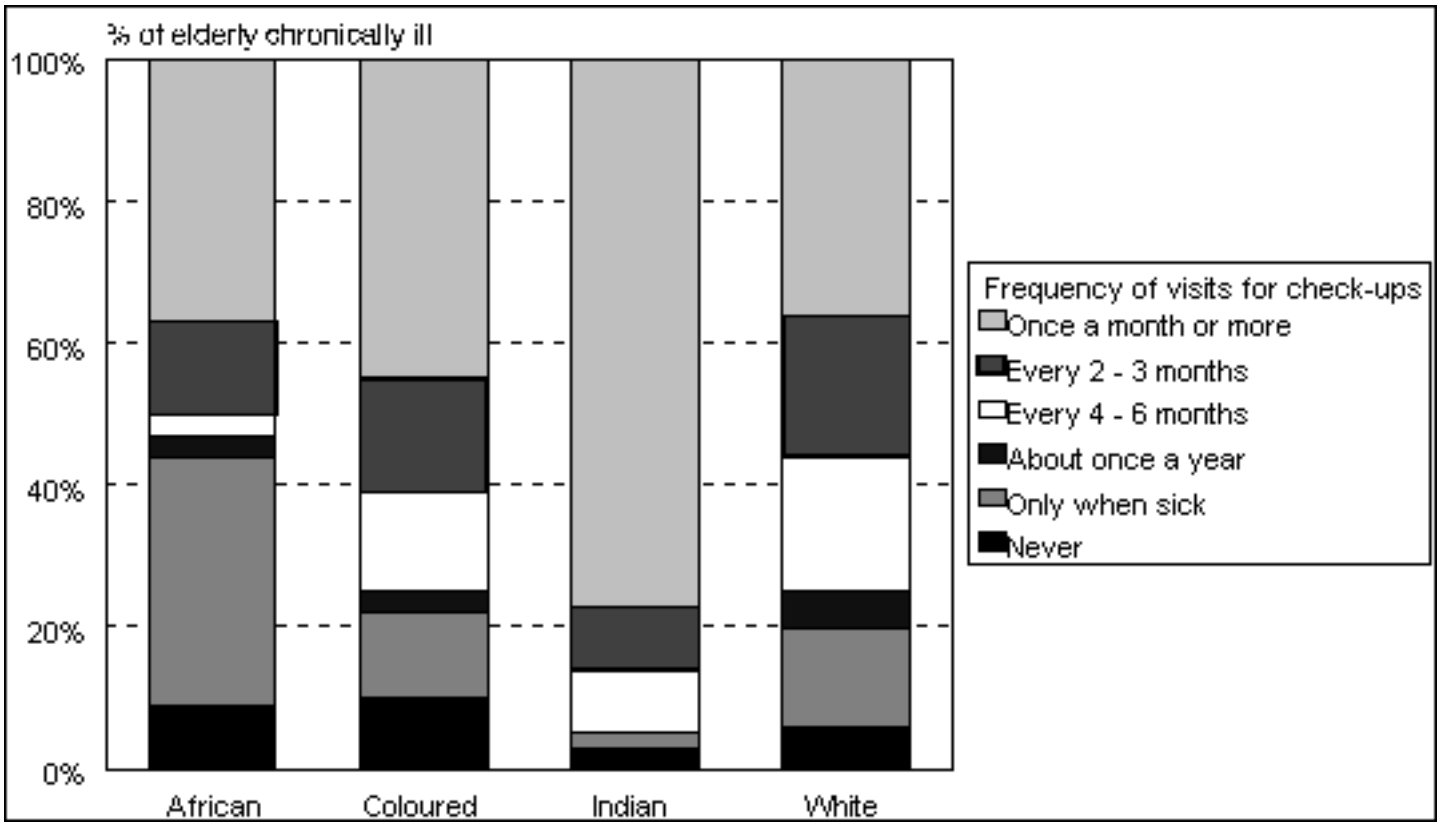
Most Serious Chronic or Ongoing Illnesses

- Among those who had more than one chronic or ongoing illness, hypertension (34%) was thought to be the most serious, followed by arthritis (22%), heart problems (15%), asthma (11%) and diabetes (9%).
- Relatively more elderly females with more than one chronic illness regarded arthritis (24%) and hypertension (37%) as their most serious illness.

- Conversely, proportionately more elderly males with more than one chronic illness perceived that heart problems (24%) and asthma or breathing difficulties (18%) were their most serious chronic or ongoing illnesses.

Going for Check-Ups for Chronic Illnesses

FIGURE 11.6. Frequency of Check-ups for Most Serious Chronic Illness by Race



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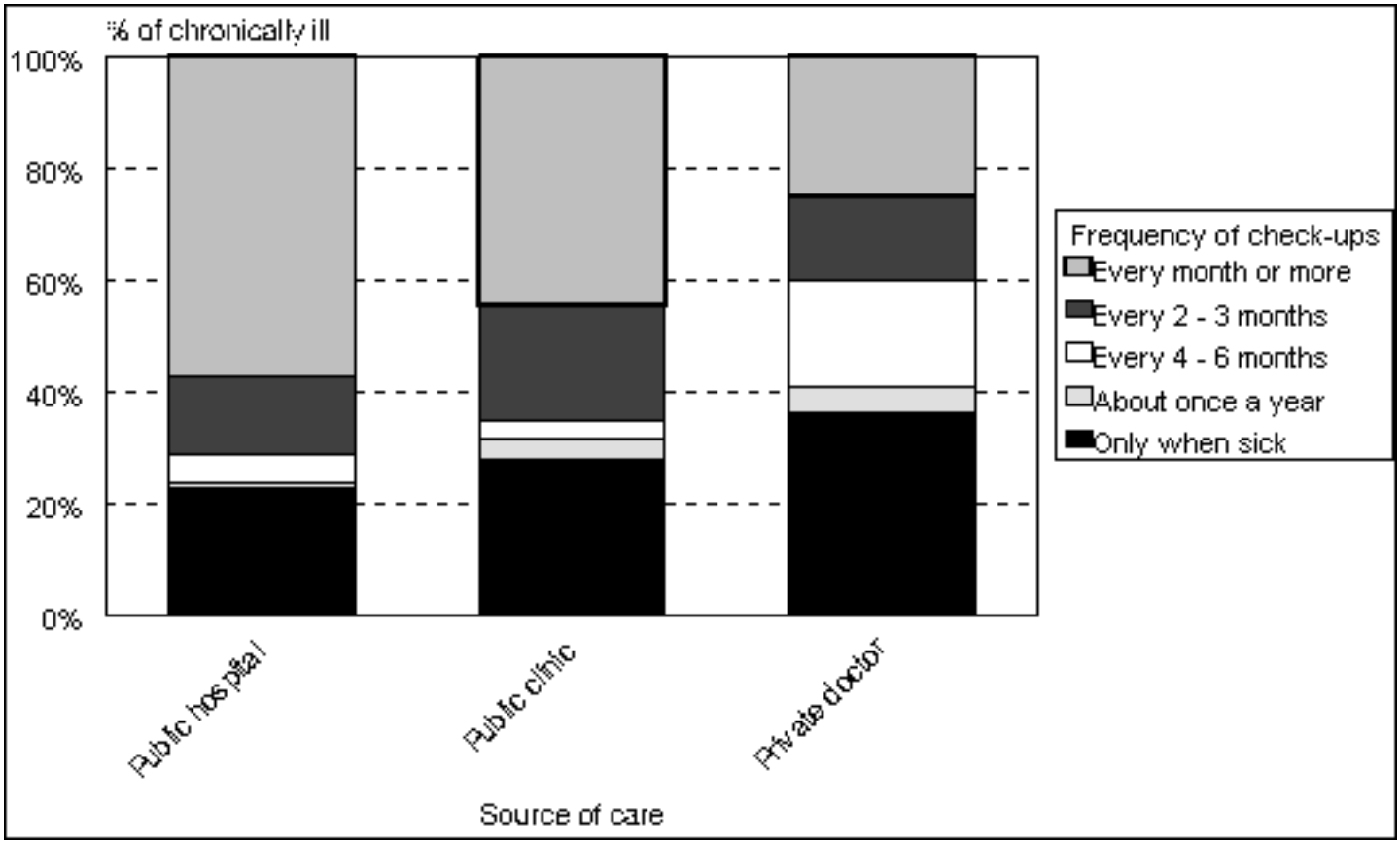
- Figure 11.6 indicates that elderly Indian respondents with chronic illnesses tend to go most frequently for check-ups (77% went once a month or more frequently), compared to those in the other race groups. A relatively large group of Africans (35%) go for check-ups only when they feel sick.
- A third (33%) of those elderly people living in households with an income below the minimum living level go for check-ups only when they feel sick, in contrast to one in five (20%) of those living in households with an income above the minimum living level.
- Among Africans with chronic illnesses, health care is least accessible for those living on white-owned farms.
    - More than half (54%) of those living on white-owned farms tend to go for check-ups only when they feel ill, compared to one third (35%) living in rural homelands and a quarter (25%) of those living in formal metropolitan areas.

Site of Health Care for Chronic Illnesses

FIGURE 11.7. South Africans with a Chronic Illness, Frequency of Visits by Site of Care



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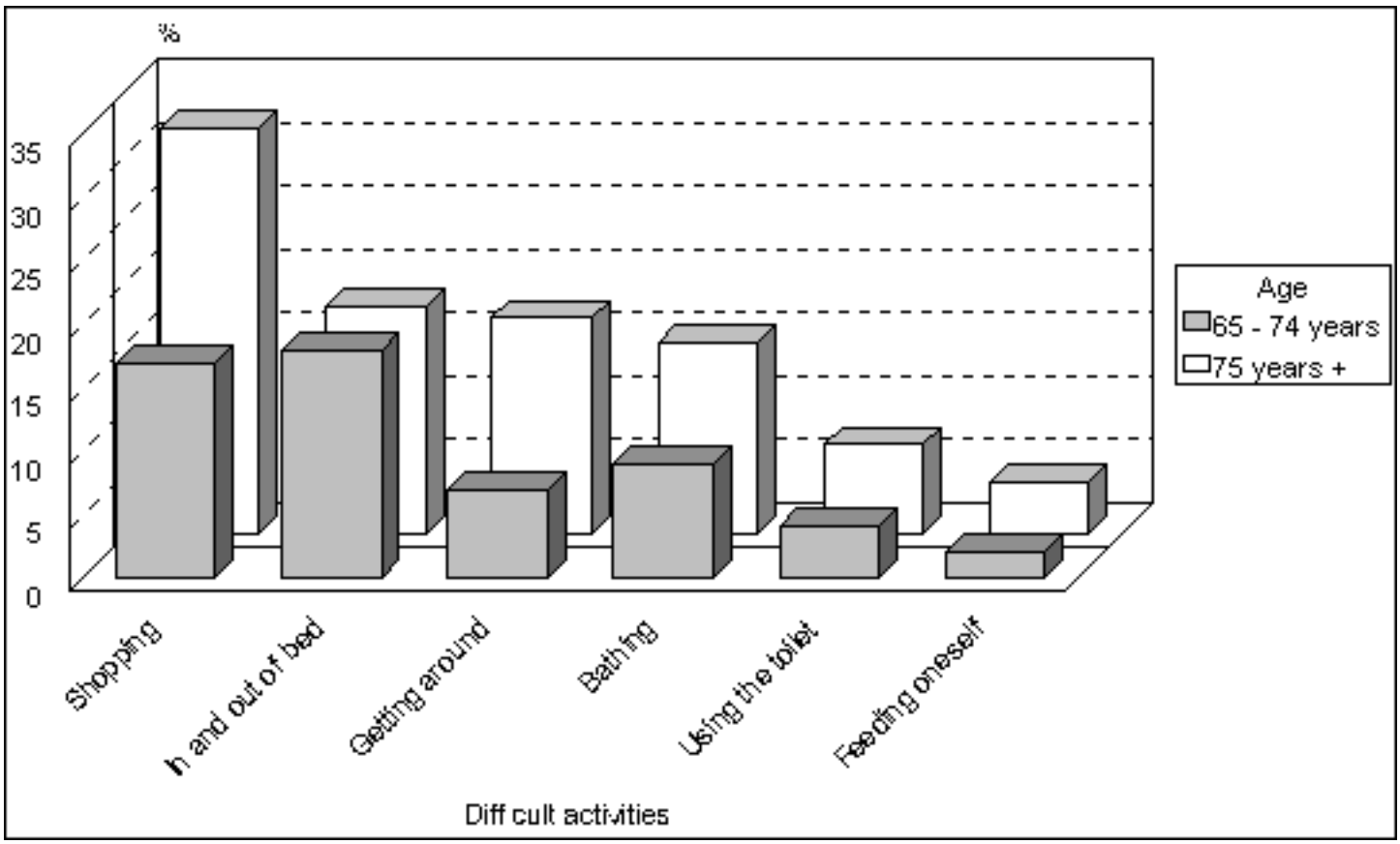
- When respondents with chronic illnesses were asked to indicate the place that they go to for check-ups, 27% said they went to a public hospital, 32% to a public clinic and 39% to a private doctor, while 2% went elsewhere, for example a pharmacist or homeopath.
- Figure 11.7 shows that, among respondents with chronic illnesses, those who go to a public facility for check-ups tend to go more frequently than those who go to a private doctor.
  - For example, 58% of those who go to a public hospital tend to go for check-ups every month or more frequently, compared to 25% of those who go to a private doctor.
- Africans (71%) and coloureds (60%) with chronic illnesses tend to use public facilities for check-ups, while Indians (54%) and whites (64%) tend to use private services.
  - For example, 40% of Africans use public clinics for check-ups, and 31% use public hospitals, while 28% use private doctors.
  - Among whites, however, 61% use private doctors for check-ups, while 20% go to public hospitals and 16% go to public clinics and 3% go to other sites such as pharmacists or homeopaths.
- Africans who use private doctors for check-ups tend to go less frequently than those who use public facilities, because costs are prohibitive.

Having Difficulty in Carrying out Activities of Daily Living

We now examine the proportion of respondent who had difficulty in performing activities of daily living, for example getting in and out of bed, using the toilet and going shopping.

- The main difficulty experienced by the respondents was going shopping, affecting 23% of them, while 18% had difficulty getting in and out of bed, 11% had difficulty washing, bathing or showering, 11% had difficulty in getting round outside the home, 5% had difficulty using the toilet, and 3% had difficulty feeding themselves or eating.
- Old age implies becoming more frail. Figure 11.8 shows that, with the exception of getting in and out of bed, as age increases, so does the proportion of those finding difficulty in performing activities of daily living.
- Poor living conditions and difficulty in performing activities of daily living were found to be related. Thus, proportionately more of those living in overcrowded conditions (23%) had difficulty in getting in and out of bed, compared to those living in conditions of average (16%) or low crowding (11%).

FIGURE 11.8. Difficulties in Conducting Activities of Daily Living by Age



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- Among Africans, even at this age, rural versus urban life circumstances were found to be related to difficulty in performing activities of daily living.
  - Proportionately more of those living on white-owned farms (28%) and in rural areas that were previously part of the homeland system (27%) had difficulty in going shopping, compared to those living in urban formal areas (18%).
  - Proportionately more of those living in traditional dwellings (11%) experienced difficulty in getting around outside the home, compared to those living in formal brick structures (8%) or in shacks (4%).

Disabilities or Handicaps

The respondents were asked to indicate whether or not they had difficulty in seeing, even with glasses, in hearing, with speech, walking or moving about and with learning or understanding.

Table 11.4: Those aged 65 years or more with disabilities by race

Type of disability	African	Coloured	Indian	White	Total
	%*	%*	%*	%*	%*
Difficulty in seeing	45	32	31	14	36
Difficulty in hearing	22	12	22	17	20
Difficulty with speech	2	5	8	3	3
Difficulty walking or moving	18	27	29	21	20
Difficulty learning or understanding	16	8	14	3	12
Those with at least one disability	61	52	46	41	55

*** The balance of all percentages indicated in this table add up to 100**

- Table 11.4 indicates that, overall, 55% of respondents aged 65 years or more said that they suffered from at least one type of disability or handicap. This is a significant increase, by age, compared to 17% of those aged between 16 and 64 years as discussed in Chapter 7.
- Africans (61%) were most likely to have at least one handicap or disability followed by coloureds (52%), Indians (46%) and lastly whites (41%).
- The most prevalent problem, found among 36% of respondents, is difficulty in seeing, even with glasses.
  - Among Africans, 45% experienced this problem, compared to 14% of whites. Lack of access to optical health-care may in part explain this large discrepancy.
- Difficulty in hearing also tends to be a problem amongst 20% of respondents, compared to 4% of those aged between 16 and 64 years.
  - Proportionately more African (22%) and Indian (22%) respondents complained of this problem, compared to whites (17%) and coloureds (12%).

- The proportion of people finding difficulty in walking or moving about also increases with age from 3% among those aged between 16 and 64 years to 20% of respondents, overall, but particularly among Indians (29%) and coloureds (27%).
- As to be expected, difficulty in learning or understanding also increases with age from 2% among those aged 16 to 64 years to 12% among those aged 65 years or more.
- Females aged 65 years or more were more likely than males in the same age category to complain of certain handicaps, for example, difficulty in hearing (22%, compared to 17% of males), difficulty in walking or moving about (22% compared to 17% of males), and difficulty in learning or understanding (14% compared to 9% of males).
- Among the elderly, perceptions of poor physical and mental health and disability are directly correlated.
  - Of those who rated their physical health as poor, 72% had a disability, compared to 37% of those who rated their physical health as excellent.
  - Of those who rated their mental health as poor, 72% had a disability, compared to 47% who described their mental heath status as excellent.
- Elderly people living in rural areas (66%) were more likely to have at least one disability, compared to those living in metropolitan (48%) or urban (47%) areas.
- As one would expect, among those aged 65 years or more, the prevalence of having at least one disability increases with age.
  - Among those respondents aged between 65 and 74 years, a smaller percentage (49%) suffered from at least one disability, compared to those aged 75 years or more (65%).

FIGURE 11.9. Type of Disability by Age

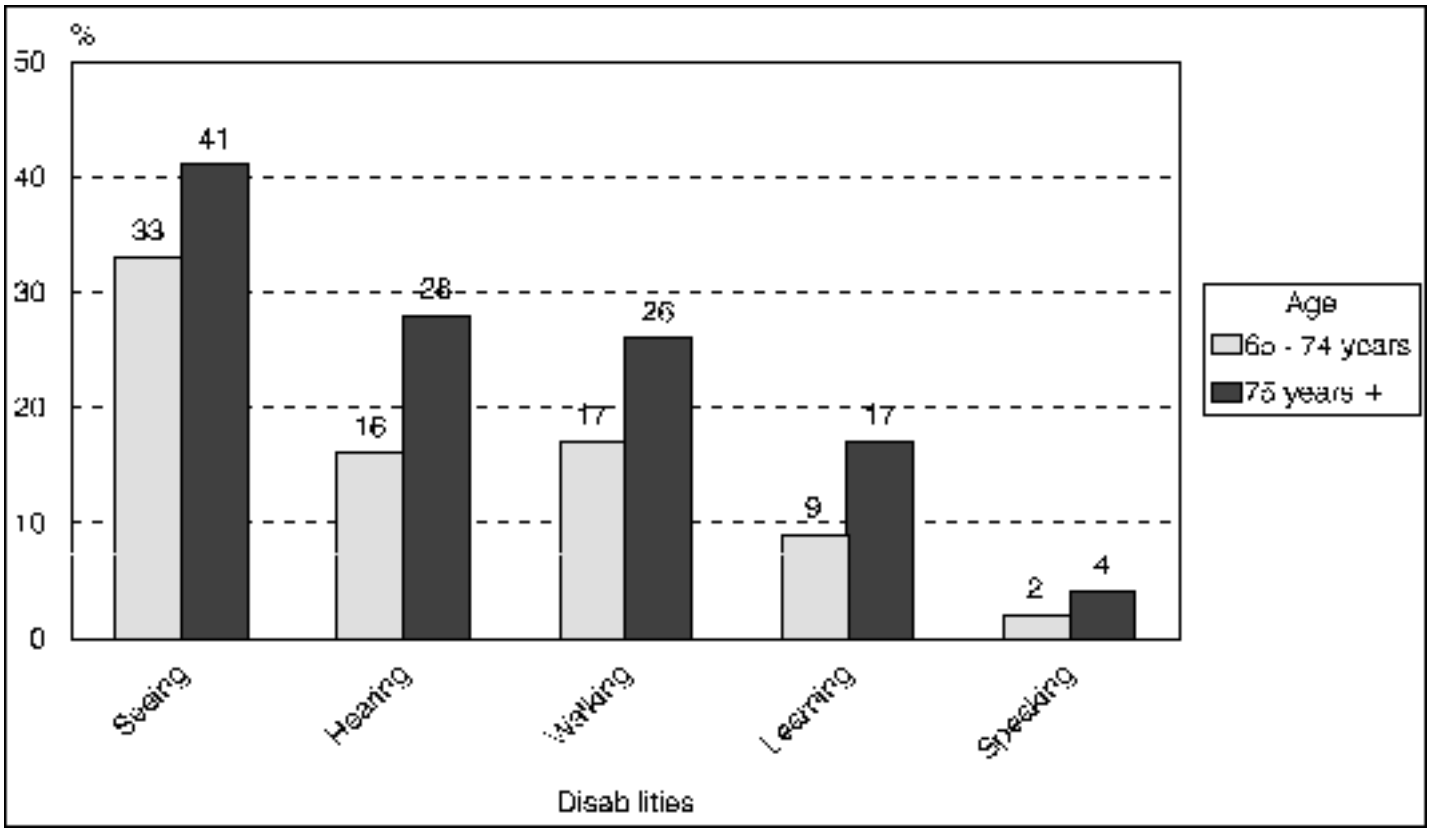


Figure 11.9 indicates that the prevalence of all types of disabilities increases with increasing age.

Requirements among the Disabled for Devices or Equipment

The disabled respondents aged 65 years or more were asked to indicate whether or not they require any devices or equipment to assist them in coping more adequately with their disability, and if so, whether they have the equipment they need.

Table 11.5: The need for devices to help cope with disabilities by race

Devices	African	Coloured	Indian	White	Total
	%	%	%*	%	%
All disabilities:					
Do not need devices	15	39	19*	46	22
Have necessary devices	23	25	50*	44	28
Still require devices	62	35	31*	10	49
Total	100	100	100	100	100

*** These percentages should be interpreted with caution, since they represent a small number of respondents**

- Table 11.5 indicates that one in five disabled people (22%), but particularly whites (46%) say they do not require any devices or equipment to assist them.
- More than six out of every 10 disabled Africans (62%) indicated that they do not have the devices or equipment that they require, compared to relatively fewer coloureds (35%), Indians (31%) and whites (10%).

We now exclude from the discussion those who do have devices or equipment to assist them, and examine the extent of need among those who require them but who do not have them.

- We find that poverty and the need for equipment or devices among the disabled who do not have them are closely interlinked.
  - Proportionately more of those living in overcrowded conditions (82%), compared to those living in conditions of low crowding (35%) said that they require devices or equipment to help them cope better with their disabilities, but cannot obtain them.
  - Those living below the minimum living level (79%) were also more likely to say that they required equipment or aids, but could not get them, compared to those living above it (47%).

- Proportionately fewer people living in formal housing in metropolitan (53%) or urban (51%) areas said that they needed equipment or aids to assist them to cope with their disability but did not have them, compared to the vast majority of the disabled living on white-owned farms (84%) or in rural areas in the former homelands (81%).

Receiving Professional Help to Assist in Coping with a Disability

Table 11.6: Access to rehabilitation services for disability by race

	African	Coloured	Indian	White	Total
Received professional help to manage disability better	%	%	%*		%
All disabilities:					
Yes	43	38	34	33	41
No	57	62	66	67	59
Total	100	100	100	100	100
Visual disabilities:					
Yes	46	41*	32*	28	43
No	54	59*	68*	72	57
Total	100	100	100	100	100
Ambulatory disabilities:					
Yes	45	32*	16*	37	41
No	55	68*	84*	63	59
Total	100	100	100	100	100

*** These percentages should be interpreted with caution, since they represent a small number of respondents**

- Table 11.6 indicates that only 41% of the handicapped or disabled respondents had received professional help, for example physiotherapy or occupational therapy, to learn how to cope with their disabilities.
  - Relatively few white (33%) and Indian (34%) disabled respondents had received rehabilitation care, probably because medical aid schemes do not always pay for it and doctors in the private sector do not always advocate this type of assistance.
- A similar picture to the general one emerges when two specific types of disability - visual and ambulatory impairments - are examined. The elderly disabled in all race groups, but particularly Indians (but these results should be interpreted with caution, because the actual numbers of disabled Indians are small), have surprisingly little access to rehabilitation assistance.

Visits to the Disabled in their Homes by Health Workers

Outreach services for the disabled are an important component of both preventive primary

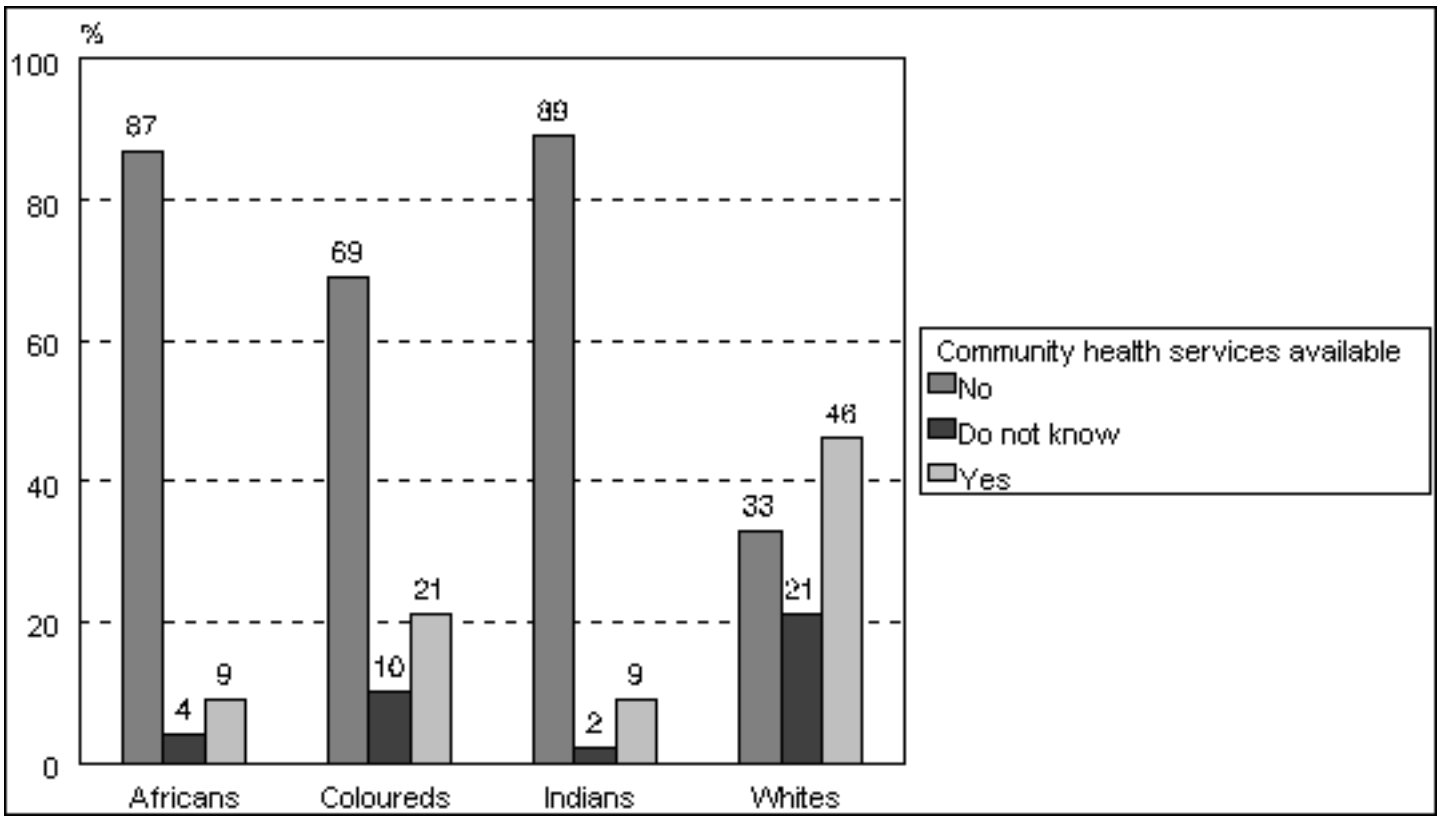
health care and rehabilitation. The disabled respondents were therefore asked to indicate whether or not any health worker had ever visited them at home to help them cope better with their disabilities.

- Overall, only 7% of disabled elderly respondents (18% of whites, 9% of coloureds, 5% of Indians and 3% of Africans) indicated that a health worker had visited them at home.

Health Outreach Services in the Community

Health services that extend out into the community are vital, not only for the disabled, but also for all other elderly people who may wish to use them. Thus all the elderly respondents were asked to indicate whether or not there are any health outreach services such as mobile clinics or meals on wheels for older people in their particular communities.

FIGURE 11.10. Availability of Health Outreach Services by Race



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- When asked whether there were any health outreach services such as mobile clinics, meals on wheels for elderly people in their communities, Figure 11.10 indicates that:
  - Almost all Africans (87%) and Indians (89%), seven in every 10 coloureds (69%), but less than half the whites (33%) said there were no health outreach services in their community for elderly people.
  - A relatively large groups of whites (21%) did not know whether or not these services are available.

- More than half (54%) of those who lived in rural, compared to 24% in the metropolitan and 22% in urban areas, said that there were no outreach services in their community.

Contact among the Elderly with Other People

Loneliness among the elderly may increase the likelihood of forgetfulness and poor mental health. We therefore asked the respondents to indicate how many days in the week prior to the interview they had spent entirely alone.

Number of Days in the Previous Week Spent Entirely Alone

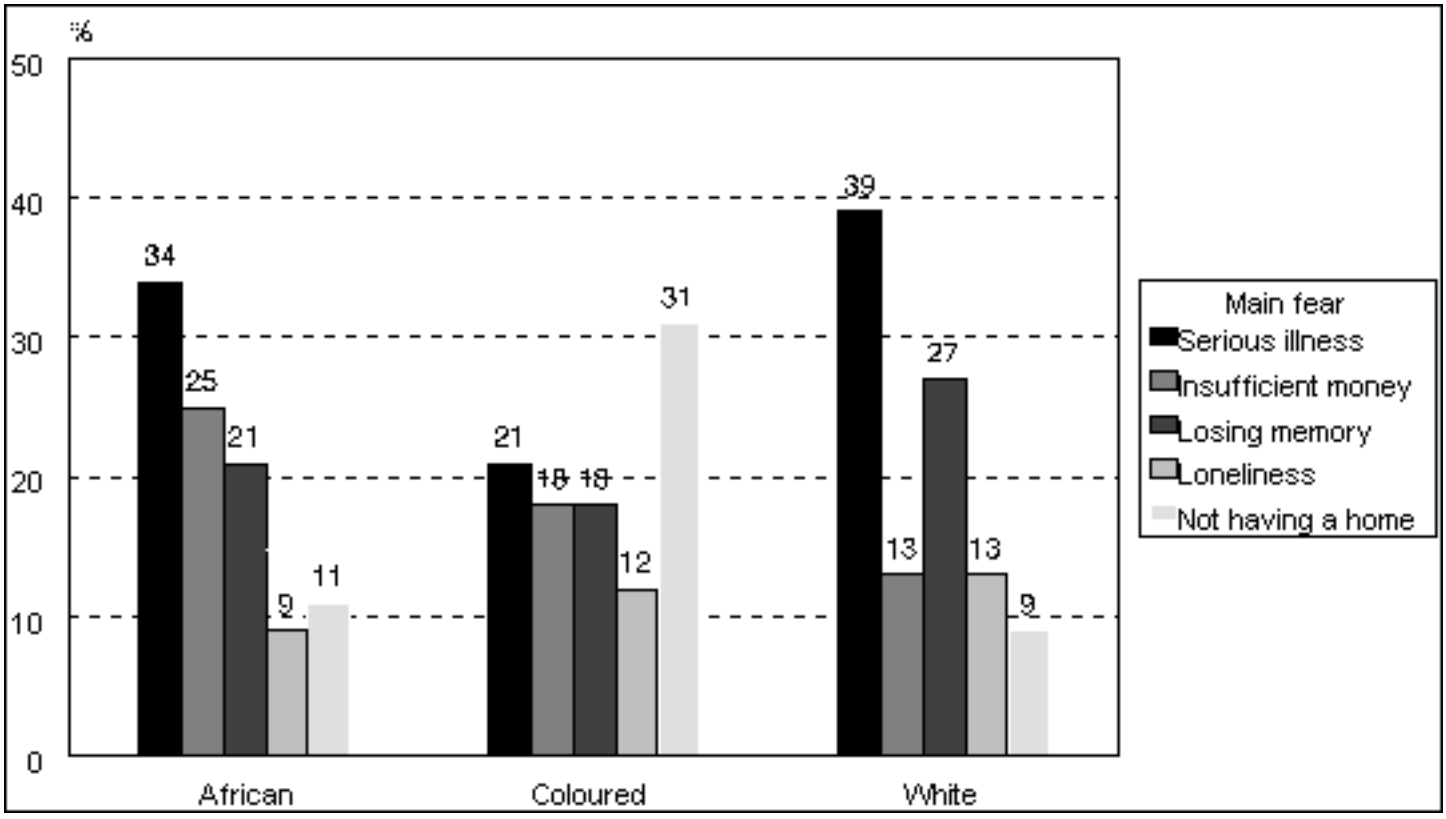
- While nine out of every 10 elderly people (91%) said that there had been no days in the week prior to the interview that they had spent entirely alone, 5% of whites, compared to 2% of Africans and Indians and 1% of coloureds, had spent all seven days entirely alone.
  - The proportion of respondents who had spent all seven days without any human contacts in the week prior to the research (3%) translates into 40,000 people in the population, countrywide.
- Although the differences in proportions are small since there were not more than 5% of respondents in any particular category, a clear pattern emerges, regarding a profile of someone who spent all seven days in the week prior to the interview entirely alone.
  - The more affluent respondents living in uncrowded dwellings, who rate their emotional health and their memory as poor and who tend to go for health care at least once a month are more likely than average to have spent all seven days prior to the interview entirely alone.

Deepest Fears

The respondents were asked to indicate which of the following they feared most: being seriously physically ill, not having enough money, being lonely, losing one's memory and becoming senile or not having a home to live in.

- The main fear of elderly respondents was being seriously physically ill (35%), followed by losing one's memory and becoming senile (23%), and not having enough money (21%).
- Figure 11.11 (which excludes Indians, since very few respondents answered this question) indicates that the main fear among Africans was having a serious illness (34%), followed by having insufficient money (25%) and then senility and loss of memory. Among whites, however, relatively few (13%) feared not having sufficient money. Among coloureds, a large proportion (31%) feared losing their home and not having somewhere to stay.

FIGURE 11.11. Main Fears of Elderly People by Race



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Summary and Conclusions

Of the approximately 1,6 million people aged 65 years or more, 65% are African, while 27% are white.

We noticed that the proportion of Africans has been steadily decreasing, from 86% of those aged nought to five years to the above-mentioned figure of 65% of those aged 65 years or more, while the proportion of whites has been increasing from 6% in the youngest group to 27% in the oldest group. We also noticed that among whites 45% were aged 76 years or more compared to Africans (27%).

The aging white population has, in the past, absorbed a disproportionate amount of the health budget. But we found that white elderly people did not have access to comprehensive health services, for example rehabilitation and preventive care.

The African elderly people are the most disempowered group. The majority of them are living in rural areas remote from health care and other services, while those in the other race groups are likely to be found in metropolitan or urban areas. A large proportion of the African elderly (29%) had never been to school and a further 22% had only had a minimum primary school education up to standard three.

More than half of the respondents rated their physical health as fair or poor, compared to others of their age, with proportionately more Africans believing that their physical health

status is poor, compared to those in the other race groups.

Among Africans, socio-economic circumstances, for example overcrowded living conditions, were directly linked to lower physical health ratings.

A low rating regarding mental health and memory was also found to be linked to poor socio-economic circumstances. There was a strong positive correlation between believing one's memory was poor and believing that one's mental health was poor or fair.

More than one third of respondents were either dissatisfied or very dissatisfied with their life, but this applied particularly to those who rated their physical or mental health or their memory as poor.

Among Africans, socio-economic circumstances and dissatisfaction with life were closely interlinked.

As many as seven out of every 10 respondents indicated that they had a chronic illness or ongoing health problem. Proportionately fewer males than females reported having a chronic illness. Hypertension and arthritis were the most commonly reported chronic illnesses, particularly among females.

Among those with more than one chronic illness, females tended to regard hypertension and arthritis as the most serious, while males regarded heart problems and asthma or other breathing difficulties at the most serious.

Indians tended to go most frequently, and Africans least frequently, for check-ups for chronic illness. Those who went to a private doctor were likely to go less frequently for check-ups, compared to those who went to public clinics and hospitals. Private health services therefore cater less well for preventive care, compared to the public sector.

A large proportion of respondents had difficulty in carrying out everyday activities, for example getting in and out of bed, getting around outside the home and shopping. These difficulties increased with age.

More than half the respondents reported having a disability, the most common being difficulty in seeing, even with glasses.

Relatively few of those with a disability had access to devices, aids or equipment that they felt could help them to manage better and proportionately even fewer had received professional help, for example physiotherapy or occupational therapy, as part of a rehabilitation programme. This applied particularly to whites.

Loneliness was not a problem for the vast majority of elderly respondents, but it was more likely to be an issue among more affluent whites.

Outreach services for the elderly were largely absent. This applied not only to the disabled, but also to the others who may require assistance or preventive care.

The main fears among the elderly were developing serious physical illnesses, becoming senile or losing ones memory and having insufficient money to cope.

*** In this chapter the data have been weighted to the universe of adults aged 65 years or more in South Africa, taking into account their distribution within provinces, population groups, gender and milieux (i.e. metro, urban or rural).**

Chapter 10 Back to Contents Chapter 12

Chapter 12.
Health Knowledge

A National Household Survey of Health Inequalities in South Africa

Ros Hirschowitz

CHAPTER TWELVE.

Introduction

In this chapter we focus on some possible future outcome measures of a comprehensive approach to health care. With the development of such measures in mind, we give an indication of beliefs, knowledge and practices among different groups of respondents with regard to the following health issues:

- Knowledge about what to do to make water that is not piped safe to drink.
- Awareness of how to treat diarrhoea among infants and pre-school children.
- Knowledge about free health-care for children aged five years or younger.
- Beliefs about the effects of smoking.
- Knowledge of AIDS.

We have singled out these issues because they show the extent to which education campaigns are needed in the country, and where they are most needed.

This survey provides new base-line information. The data can be used at a later stage to measure outcomes of health programmes, for example the success of an AIDS or an oral rehydration solution (ORS) education campaign.

Treating Water before Drinking it

In those households where there was no access to piped water, we asked the senior person in the household responsible for health care the following question: "what, if anything, do you do to the water before you use it for drinking?"

Households without Access to Piped Water

- The analysis of the data for this question only applies to Africans. The reader will recall that all whites and Indians, and 99% of coloureds had access to piped water.
- Almost a quarter of African households in the sample (23%) did not have access to piped water.
  - This means that members of approximately 1,2 million of the 5,3 million African households do not have access to piped water.
- A large proportion of households situated on white-owned farms (31%) and in rural "homeland" areas (46%) did not have access to piped water.
- Therefore it is not surprising to find that in households situated in provinces which contain rural areas that were part of the former homeland system there was less access to piped water.
  - Members of all households in the Western Cape, 99% in Gauteng and the Northern Cape, and 94% in the North West and the Free State had access to piped water, compared to 83% in the Eastern Transvaal, 77% in the Northern Transvaal, 57% in KwaZulu-Natal and 49% in the Eastern Cape.

Treating Un-Piped Water

- Among those households where there was no access to piped water, almost nine out of every 10 senior members responsible for health care (89%) said that they did nothing to water from un-piped sources, such as a river, stream or dam, before drinking it. A small proportion (5%) said that they boil it, while proportionately even fewer said that they sift it through a cloth (3%), add chlorine (1%) or treat it in some other way, for example, they add herbal medicines (2%).
- A larger proportion of those living on white-owned farms said that they boil the water (11%) compared to those living in rural areas (4%).
- Only 3% of those with no education said that they boil the water, increasing to 7% among those with some high school.
- Among those households without access to piped water and containing at least one child under the age of six years, 88% of caretakers said that they did nothing to the water before using it for drinking, while 6% said they boil it, 4% said that they sift it through a cloth, and 1% said that they added chlorine.
- Members of households in rural areas generally, and children under the age of six years in particular, are therefore at risk regarding contracting preventable, water-borne diseases.

Treating Diarrhoea

- The above discussion indicates the extent to which infants and young children under the age of six years in rural areas are a high-risk group regarding contracting diarrhoeal diseases. But children in all socio-economic circumstances can, for a variety of other reasons unrelated to the consumption of unsafe water, experience attacks of diarrhoea.
  - Dehydration as a result of diarrhoea is preventable through the administration of oral rehydration solution.
- We asked all caretakers of a randomly selected child aged between nought to five years in a household: "What would you do as a first step if this child gets diarrhoea (frequent, runny stools)?" We allowed each respondent to give a spontaneous answer, which was then recorded.

Table 12.1: First step that would be taken to treat diarrhoea by race

First step taken if child gets diarrhoea	African	Coloured	Indian	White	Total
	%	%	%	%	%
Give ORS*	59	35	24	18	54
Give other fluids	2	8	10	7	3
Withhold fluids	0	1	2	2	0
Take child to doctor/clinic	35	45	54	43	36
Ask a chemist	1	3	7	23	3
Other**	3	9	4	8	4
Total	100	100	100	100	100

*** Any mention of a solution of water, salt and sugar.**
**** This category includes, herbal and home remedies, enemas, encouraging vomiting, giving yoghurt and solids.**

- Table 12.1 shows that, among Africans, almost six out of every 10 respondents (59%) spontaneously mentioned giving a solution of water, salt and sugar (ORS), while proportionately fewer coloureds (35%), Indians (24%) and whites (18%) did so. Instead, they were more likely to say that they would take their child to a health professional.
- Relatively few male caretakers (28%) spontaneously mentioned ORS, compared to females (55%).
- Among Africans, a familiar pattern emerges. Socio-economic circumstances are directly related to awareness of ORS.
  - Those living in traditional dwellings were least likely (54%), and those living in shacks were most likely (67%), to be aware of ORS, compared to those living in formal brick structures (61%).
  - Those living in overcrowded households were least likely (58%), and those in uncrowded ones were most likely (70%), to be aware of ORS, compared to those living in households which are average in terms of crowding (61%).
  - Those living in households with incomes below the minimum living level (58%) were less likely to spontaneously mention ORS, compared to those in households with incomes above this level (65%).
  - Fewer than half of those with no formal schooling (46%) mentioned ORS, compared to 76% of those with matriculation.
- Awareness among Africans, regarding ORS is therefore relatively widespread. But we did not test the extent to which they could actually prepare the solution, using the correct amounts of water, sugar and salt.
- It seems as if knowledge about important health matters is more likely to spread among those with better education and in more affluent circumstances.

Awareness of Policy of Free Health Care for Pre-School Children

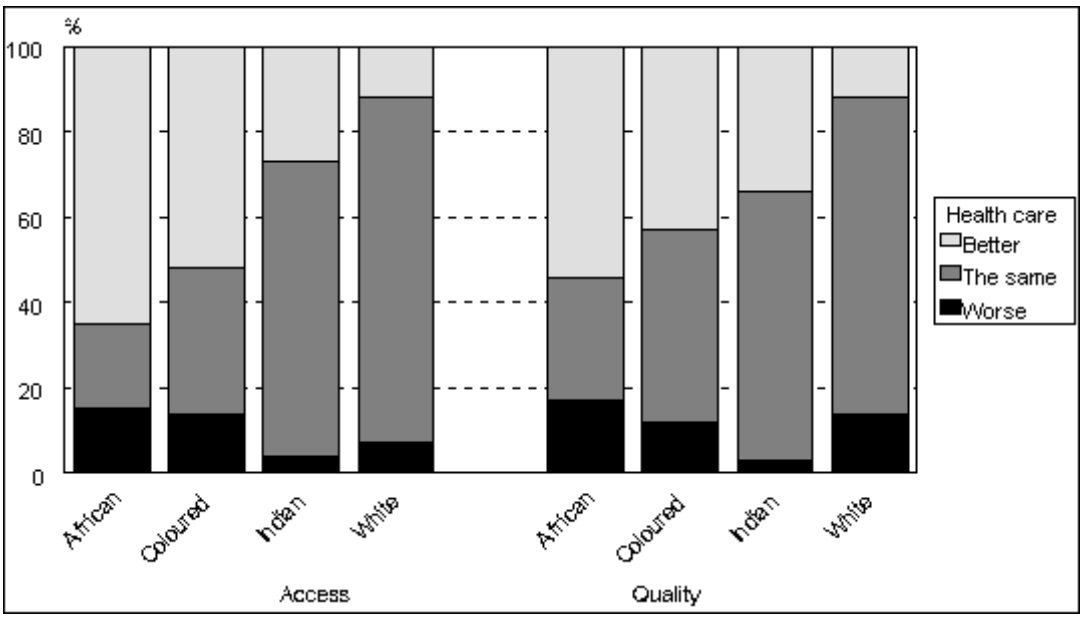
Some health messages can however be effective, even among the poorest members of society, as seen from the next example.

- Respondents who are responsible for the health care of a child aged five years or younger were asked the following question: "Some people are talking about the new government's policy of free health care for children aged five years or younger. Have you yet heard of this policy?"
- More than nine out of every 10 respondents (92%) had heard of it, indicating that important health messages can be rapidly transmitted to everyone.
- Relatively more Africans (92%) than Coloureds (88%), Indians and whites (86% in both cases) had heard of this policy.
- Within the African group, this high level of awareness could be found amongst both well-off and poor, both the well educated and those who had never gone to school. Those living in traditional homes and shacks were equally likely to have heard of the policy, compared to those living in formal brick housing. But those living on white-owned farms (83%) were least likely to have heard of it.

Quality of Free Health Care

- Those respondents who were aware of the new policy of free health care for infants and pre-school children were asked to indicate:
  - whether access to health care for their child had become easier, the same or more difficult, and
  - whether the quality of care had improved, stayed the same or become worse since its introduction.

FIGURE 12.1. Access to Health Care and Perceptions of Quality Since the New Policy has been Introduced by Race



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- Altogether 65% of respondents said that access to care had become easier, while 21% said that it had remained the same, and 14 % said it had become worse.
- When it came to quality, 54% said it had improved, 27% said it had stayed the same, and 17% said it had become worse.
- Figure 12.1 indicates that most Africans and coloureds tended to find access to health care easier and the quality of care better since the introduction of the new policy, while for most Indians and whites both access and quality have stayed the same.
- Among Africans, while access was now generally easier for 65% of respondents, this applied particularly to those living in traditional dwellings (74%), in informal settlements in urban areas (72%), and on white farms (71%).
  - It was less likely to apply to those with matriculation (52%) or a post-school education (47%), compared to those with no schooling (69%) or with some primary school up to standard three (71%).

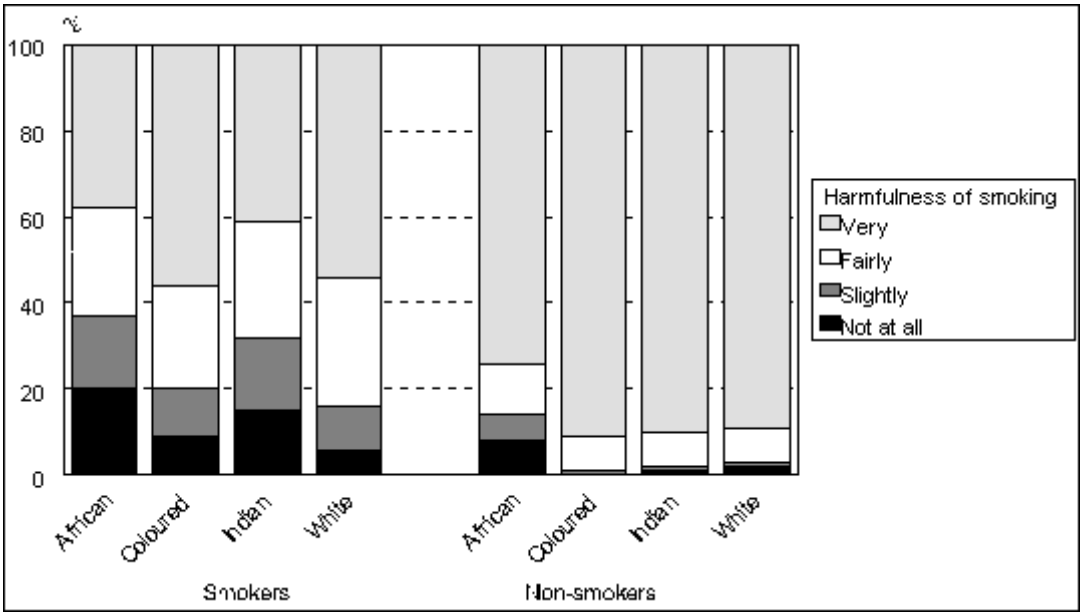
- As far as quality of care is concerned, among Africans:
  - Those who were living in formal housing in metropolitan areas (39%) were more likely than average (17%) to say that services have become worse since the introduction of free health care for all pre-school children, probably because of overcrowded health-care facilities.
  - Proportionately more of those with incomes above the minimum living level (24%) said that services had become worse, compared to those with incomes below it (14%).
- Therefore the poorest children now have better access to health-care than previously, and the caretakers of these children believe that they are receiving better treatment than before.

Beliefs among Adults regarding the Effects of Smoking

From children, we now turn to the adults in the sample aged between 16 and 64 years. We focus on the issue of cigarette smoking and the respondents' beliefs about its effects.

- This could be an important outcome measure for future monitoring, after health messages on cigarette packages are introduced.
- In Chapter 5 we indicated that, overall, 29% of respondents said that they smoked. A larger percentage of coloureds (55%) were smokers, compared to those in the other race groups, and relatively few women (13%) smoked.
- When asked to indicate how harmful they thought cigarette smoking was, just over two thirds of respondents (68%) thought it was very harmful, while relatively few said that it was fairly harmful (15%) or slightly harmful (8%) and approximately one in 10 (9%) said it was not at all harmful.
- Proportionately fewer Africans (66%) thought that cigarette smoking was very harmful, compared to coloureds (72%), whites (76%) and Indians (77%).
- Females (73%) were more likely to think that cigarette smoking is very harmful, compared to males (62%).
- The age of the respondent is related to his or her beliefs about cigarette smoking. Thus 72% of those aged 16 to 24 years and 71% of those aged 25 to 34 years thought that cigarette smoking was very harmful, as against 61% of those aged 35 to 49 years and 65% of those aged 50 to 64 years.

FIGURE 12.2. Harmfulness of Cigarette Smoking Among Smokers and Non-smokers by Race



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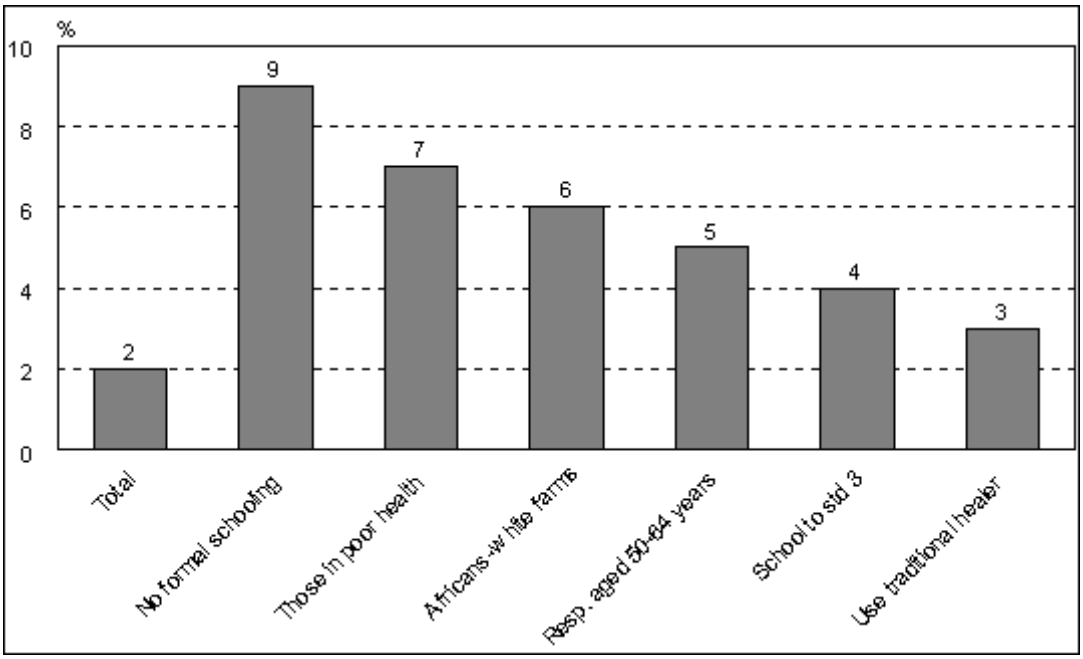
- In general, non-smokers were more likely to describe the habit as very harmful (78%) compared to smokers (44%).
- Figure 12.2 indicates that, while the vast majority of non-smokers across all races thought that smoking is very harmful, proportionately fewer African non-smokers (74%) than those in other race groups (89% of whites, 90% of Indians and 91% of coloureds) felt this way.
- Among smokers, 38% of Africans, 41% of Indians, 54% of whites and 57% of coloureds said that cigarette smoking was very harmful. A further 24% of coloured, 25% of African, 27% of Indian and 30% of white smokers said that this habit was fairly harmful.
  - Therefore there is a realisation among the majority of smokers that this habit is at least fairly harmful.

- Regarding alcohol consumption we found that the more alcohol a respondent consumed, the less likely he or she was to believe that cigarette smoking was harmful. Thus, while 74% of non-drinkers thought that cigarette smoking was harmful, 64% of those who classified themselves as light drinkers and 43% who classified themselves as moderate to heavy drinkers felt this way.
- Relatively few respondents, whether smokers (15%) or non-smokers (9%), believed that smoking is not at all harmful.
- These research findings illustrate a well-known phenomenon. Awareness that something is harmful does not necessarily change behaviour.

Knowledge of AIDS

In addition to measuring beliefs about the harmfulness of smoking among adults aged between 16 and 64 years, we also asked a series of questions about AIDS.

FIGURE 12.3. Respondents Who Had Never Heard of AIDS



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- Awareness of AIDS is widespread. When asked whether or not they had ever heard of AIDS, only 2% of respondents had never heard of it.
- Figure 12.3 indicates that respondents who had never been to school (9%), who rated their physical health as poor (7%), aged between 50 and 64 years (5%), as well as Africans living on white-owned farms (6%) were more likely than average (2%) to say that they had never heard of AIDS.
  - People in these categories can therefore be regarded as at a higher than average risk regarding contracting the disease.

Table 12.2: Knowledge regarding the transmission of AIDS by gender and race

AIDS can be passed on from:	African		Coloured		Indian		White		Total	
	M%	F%	M%	F%	M %	F%	M%	F%	M%	F%
A mother to her unborn child:										
True	79	80	90	91	92	94	97	97	83	84
Not sure	17	17	8	8	6	5	2	3	13	14
False	4	3	2	1	2	1	1	0	4	2
Total	100	100	100	100	100	100	100	100	100	100
Sharing razor blades:										
True	60	60	65	65	60	62	55	55	60	60
Not sure	21	25	15	16	11	15	12	19	19	23
False	19	15	20	19	29	23	34	27	21	17
Total	100	100	100	100	100	100	100	100	100	100

Using toilets:										
True	21	26	21	22	12	20	4	6	18	23
Not sure	21	26	9	15	7	8	7	10	18	23
False	58	48	70	63	81	72	89	84	64	54
Total	100	100	100	100	100	100	100	100	100	100
Hugging and kissing:										
True	27	27	32	23	16	17	5	14	23	25
Not sure	18	27	12	13	5	8	12	11	17	23
False	55	46	56	64	79	75	83	76	60	52
Total	100	100	100	100	100	100	100	100	100	100
Sharing food: True	22	25	23	15	11	13	6	8	19	21
Not sure	17	27	11	14	9	9	11	10	15	23
False	61	48	66	71	81	78	83	82	66	56
Total	100	100	100	100	100	100	100	100	100	100
Mosquito bites:										
True	49	49	53	43	35	41	28	24	46	45
Not sure	29	32	22	31	20	23	27	27	28	31
False	22	19	25	26	46	36	46	48	29	24
Total	100	100	100	100	100	100	100	100	100	100
Sex without a condom: True	91	88	96	96	97	95	97	97	93	90
Not sure	7	11	4	3	2	4	2	1	6	9
False	2	1	0	1	1	1	1	2	1	1
Total	100	100	100	100	100	100	100	100	100	100

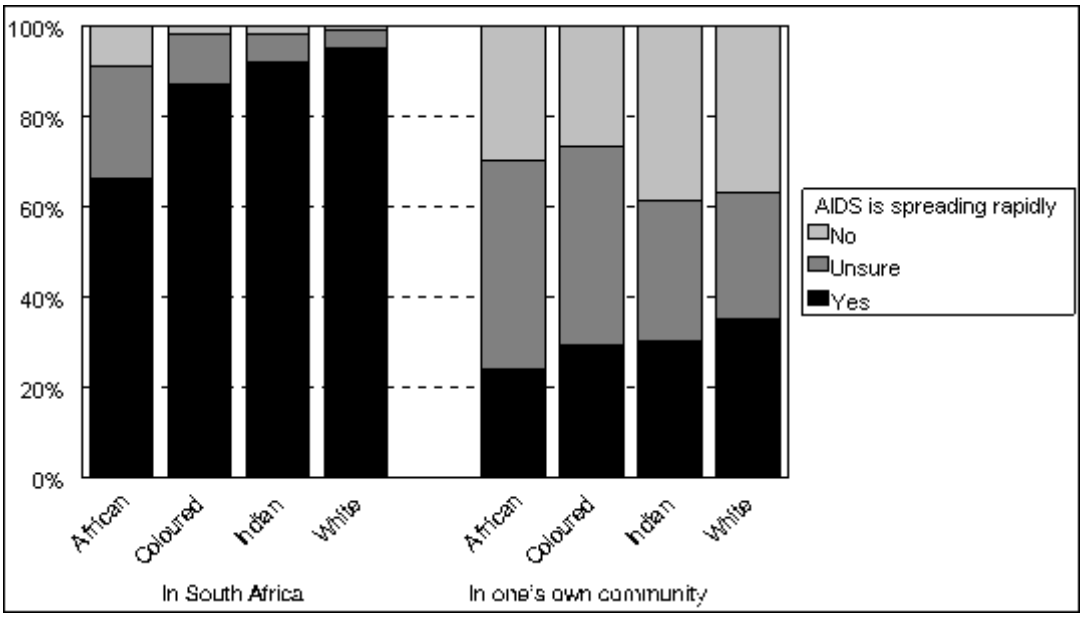
- While almost everyone had heard about AIDS, a large proportion of people answered incorrectly when they were asked specific questions about the transmission of AIDS.
- Table 12.2 indicates that the vast majority of respondents knew that AIDS can be passed on through unprotected sexual intercourse (sex without a condom).
- However, as many as 46% of males and 45% of females believed that AIDS could be transmitted via mosquito bites, 23% of males and 25% of females thought that it could be transmitted through hugging and kissing, while 18% of males and 23% of females thought that it could be transmitted through the toilet. On the other hand, only 60% of respondents knew that AIDS could be passed on through using contaminated razor blades, and only 83% of males and 84% of females knew that it could be passed on from a mother to her unborn child.
- The lower the level of education among the respondents, the more likely they were to say they were unsure how AIDS was transmitted. For example, 47% of those with no schooling said they were unsure whether AIDS could be transmitted by sharing food with someone who has AIDs, compared to 6% of those with post-school qualifications; 57% of those with no schooling said they did not know whether AIDS could be passed on through mosquito bites, compared to 18% of those with a matriculation.
  - Only 74% of those who had not gone to school and 84% of those with primary schooling up to standard three knew that AIDS could be transmitted through having sexual intercourse without using a condom.
- Africans living in rural areas which were formerly part of the homeland system (86%) were least likely, and those living in formal housing in metropolitan areas (94%) were most likely, to know that AIDS is transmitted by having sex with someone with AIDS without using a condom.
- There is a clear need for more information, particularly among the less educated and the rural people in the country, regarding the ways in which AIDS is transmitted.

Attitudes to AIDS

To measure attitudes towards AIDS the respondents were asked to indicate whether or not they thought that the AIDS epidemic was spreading rapidly, firstly through South Africa, and secondly through their particular communities. We also asked them whether or not they thought that people in their community use condoms to avoid AIDS.

- Altogether, almost three quarters of respondents (73%) believed that the AIDS epidemic was spreading rapidly throughout South Africa.

FIGURE 12.4. Beliefs About the Spread of AIDS



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- Figure 12.4 clearly indicates that people in all race categories are more likely to believe that AIDS is spreading rapidly throughout South Africa, but they are less likely to believe that it is spreading rapidly through their own particular communities.
- However, a large proportion of respondents (43%) were unsure whether or not it was spreading rapidly through their particular communities, This applied particularly to Africans (46%) and coloureds (44%).
- Proportionately fewer Africans (66%) believed that AIDS was spreading rapidly throughout South Africa, compared to coloureds (87%), Indians (92%), and whites (95%).
- Among Africans, socio-economic circumstances and beliefs are again found to be inter-related:
  - Compared to those living in formal brick structures (70%), proportionately fewer of those living in shacks (62%) or in traditional huts (59%) believed that an AIDS epidemic is spreading rapidly throughout South Africa.
  - Those living on white-owned farms (58%) or in rural areas that were formerly part of the homelands (60%) were less likely to believe that an AIDS epidemic was spreading rapidly throughout the country.
  - Those with household incomes below the minimum living level (63%) were less likely to believe this than those with incomes above this level (73%).
  - The lower the level of education of the respondent, the less likely they were to believe that an AIDS epidemic is spreading rapidly throughout South Africa. Thus 46% of those with no education believed this, compared to 71% with some high school and 84% of those with a post-school education.

Beliefs about condom use in the community

- Regarding beliefs about people in the community using condoms to avoid AIDS, 35% of respondents indicated that they did believe that this was true, while 45% were unsure and 20% said that they did not think that people in their community were using condoms to avoid AIDS.
- Africans (28%) were less likely to think that people in their community use condoms to avoid AIDS, compared to Indians (41%), coloureds (52%) and whites (57%).

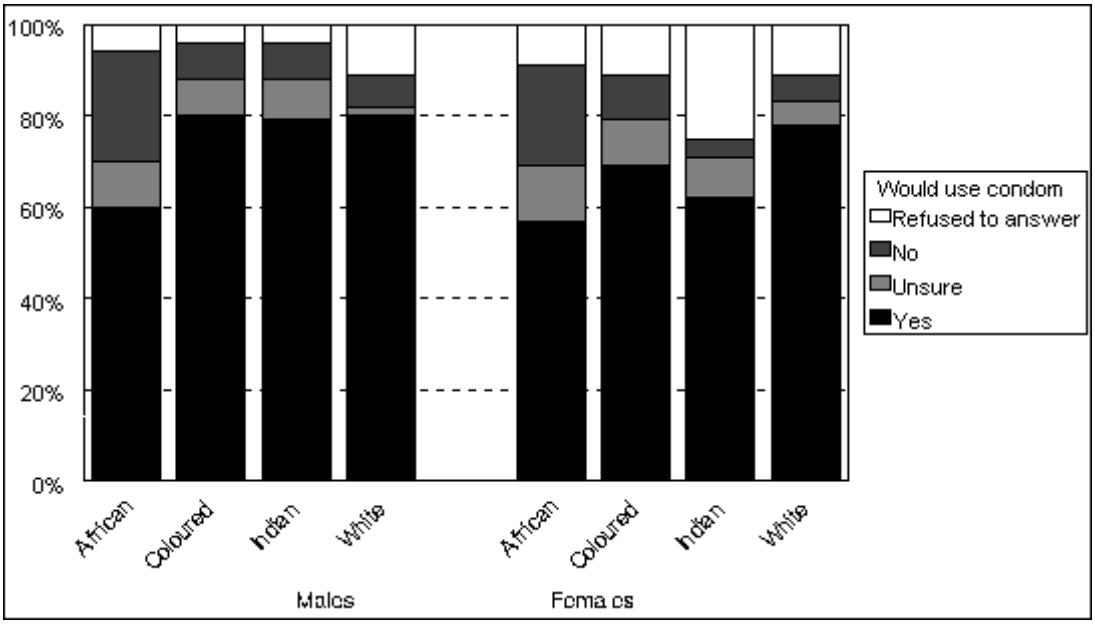
Behavioural Intentions

To assess behavioural intentions, the males were asked to indicate whether or not they personally would use a condom to avoid getting AIDS, while the females were asked to indicate whether they would ask a new partner to use one, to avoid getting AIDS.

- Figure 12.5 indicates that the majority of respondents said that they would use a condom, or else ask a new partner to use one, to avoid getting AIDS.
- Africans males (60%) and females (57%) were least likely to say they would have protected sex with a new partner.

- Among Africans:
  - Males living in informal settlements in metropolitan areas (46%) or on white-owned farms (45%) were least likely to say they would use a condom to avoid getting AIDS. Relatively few of those males with no schooling (28%) said they would do so, compared to 76% of those with matriculation.
  - Among females, a similar pattern regarding education is found. Twenty three percent of those with no schooling said they would ask a new partner to use a condom increasing steadily to 77% among those with post-school qualifications.

FIGURE 12.5. Using Condoms with New Partners by Gender and Race



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Summary and Conclusions

In this chapter, we looked at knowledge, attitudes and practices in relation to certain important health issues where health education can make an impact. The information given here can be used as base-line data against which the success of future campaigns and programmes can be measured nationwide.

Firstly, we examined the extent to which people in households without access to piped water treat the water that they use before drinking it. We found that a very small percentage treat the water in any way, for example boiling it (5%), sifting it through a cloth (3%) or adding chlorine (1%). We concluded that a large proportion of rural people in South Africa are at risk, regarding contracting waterborne diseases, for example cholera and typhoid.

Secondly, we turned our attention to infants and pre-school children. We examined what the respondents responsible for the health of a child aged nought to five years would do as a first step if this child gets diarrhoea, and knowledge of oral rehydration solution (ORS). Almost six out of every 10 African caretakers (59%) spontaneously said that they would give ORS.

Thirdly we looked at the extent to which people had heard of the new government's policy of free health care for infants and pre-school children. Almost everyone (92%) had heard of it, indicating that important messages can indeed spread rapidly through all parts of the country.

Most Africans (65%), particularly those living in traditional dwellings (74%), felt that services had improved for children since its introduction. It is only in metro areas, where overcrowding may be a problem, that a relatively large proportion (39%) said that services had deteriorated since the introduction of this free service.

It therefore seems as if measures to improve access to health care taken by the government are widely appreciated by the recipients.

The next issue that we examined concerned smoking among adults. We asked all respondents aged between six and 16 years to indicate how harmful they thought smoking was for one's health. We found that more than three quarters (78%) of non-smokers thought that this practice was very harmful, compared to smokers (44%). However, relatively few respondents,

whether smokers (15%) or non-smokers (9%) thought that it is not at all harmful.

These findings support a well known fact - knowledge, on its own, does not change behaviour. A complex process is at work, including altered attitudes, beliefs, social norms and mores and expectations regarding the outcomes of this change.

Finally we examined knowledge, attitudes and behavioural intentions in relation to the AIDS epidemic. We found that almost everyone (98%) had heard of AIDS. Nevertheless, certain groups of people were less likely than others to have never heard of this disease. For example, almost one in 10 (9%) of those with no schooling had not heard of it.

Even though almost everyone knew about the disease, knowledge regarding ways in which it is or is not transmitted was less common. For example, 45% of respondents thought that it could be spread through mosquito bites, and 24% through hugging and kissing.

 Chapter 11


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Chapter 13 

Chapter 13.
Provincial Comparisons

A National Household Survey of Health Inequalities in South Africa

Ros Hirschowitz

CHAPTER THIRTEEN.

Introduction

This chapter examines comparative data for each of South Africa's nine provinces. Household differences between provinces are discussed, followed by an analysis of how health issues vary by province and by individuals in each age category (0 to 5, 6 to 15, 16 to 64 and 65 or more years).

Focus on Africans

This chapter focuses only on Africans for the following reasons:

- Among whites there is very little variation in access to health care, or patterns of use, by province. Four in every 10 whites (41%) live in Gauteng. The sample size tends to be too small in the other provinces for further provincial analyses.
- Coloureds live mainly in the Western Cape (61%), and Indians in KwaZulu-Natal (77%). The sample size in other areas therefore also tends to be too small for further provincial analyses.

The Former "Homelands"

A clear indication will be given regarding which provinces contain former "homelands",

"independent states" or "self-governing territories" created by the apartheid regime. Poverty is more acute and health care is less accessible in these areas than in the rest of the country.

Background Information on the Provinces

The Western Cape

The Western Cape is one of only two provinces in which Africans constitute a minority (the other province is the Northern Cape). Of approximately 3,6 million people living in this province, 640,000 (18%) are Africans, most of whom are relatively recent arrivals living in informal settlements. Under apartheid, Africans were prevented from coming into this province, since it was defined as a "coloured preference area" for employment purposes.

The province is largely urbanised, with 86% of people living in urban, and 14% in non-urban areas. It contains an average of 33 people per square kilometre. The province occupies 11% of the land mass of South Africa. It is relatively wealthy, since its average per capita annual gross geographic product of R 7,326 in 1993 was the second highest in the country.

The Northern Cape

The Northern Cape, is vast in size. It occupies 30% of the land mass of the country. But it is also the most sparsely populated province containing an average of two people per square kilometre. Africans are in a minority in this province constituting 221,000 (30%) of the 737,000 people living there. The province consists mainly of small towns, with 73% of the population living in urban and 27% in non-urban areas. In 1993 it had an average per capita annual gross geographic product of R 5,890 which is the fourth highest in the country.

The Eastern Cape

The Eastern Cape is situated on 14% of the country's land mass. The province as a whole is relatively densely populated containing an average of 38 people per square kilometre. However, approximately two thirds of its population (67%) are living in non-urban areas, many without basic infra-structure such as tarred roads, electricity and running water.

Two former "independent states", the Transkei and Ciskei, are found within the geographical boundaries of the province. With a population of 6,4 million people, it is the third largest in terms of population size. The vast majority (5,6 million or 87%) are African. It is the second poorest region with an average annual per capita gross geographic product in 1993 of only R 2,317.

KwaZulu-Natal

While KwaZulu-Natal occupies only 8% of South Africa's land mass, it is its most populous province, containing approximately 8,5 million people of whom 7,0 million (82%) are African.

The previous "self-governing territory" of KwaZulu is situated within its boundaries. It has an average of 92 people per square kilometre. In spite of this relatively high population density, more than six out of every 10 people (62%) are living in a non-urban environment, many of whom lack access to basic infra-structure such as tarred roads, piped water and electricity. It is the third poorest region in the country with an average annual per capita gross geographic product of R 3,573 in 1993.

Gauteng

As far as land mass is concerned, Gauteng is the smallest province in the country, containing less than 2% of the territory. But it is the second largest region in terms of the size of its population, since it contains 6,9 million people, of whom 4,3 million (62%) are African. It is the most densely populated province, containing, on average, 366 people per square kilometre. It is almost entirely urbanised, with only 4% of people living in non-urban environments. It is the industrial and commercial heart of the country, and in 1993 its annual average per capita gross geographic product of R 10, 949 was the highest in the country.

Eastern Transvaal

The Eastern Transvaal constitutes 6% of the country's land mass. It contains 2,9 million people of whom 2,6 million (90%) are African. The former homelands KwaNdebele and Kanguane, and parts of Lebowa and Gazankulu, are found within its borders. On average, there are 37 people per square kilometre in the province. More than two thirds of the people (68%) are rural dwellers.

In spite of its rural character, its per capita average annual geographic product of R 6,064 was third highest in the country in 1993.

Northern Transvaal

The Northern Transvaal contains the former "independent state" of Venda as well as large parts of Lebowa and Gazankulu. It occupies 10% of the land mass and has 5,2 million people living in it, of whom 5,0 million (96%) are African. The area is largely rural, with as many as 91% of the inhabitants living in non-urban areas. In spite of its largely rural character, it contains, on average, 42 people per square kilometre. It is the most impoverished area in the country, with an average gross geographic annual per capita product of only R 1,266 in 1993.

The North West

This province is also largely rural, with 68% of the population living in non-urban areas. Its average annual per capita gross geographic product is relatively low at R 4,092 in 1993. It occupies 10% of the land, and there are 3,5 million people living in the North West, of whom 2,9 million (83%) are African. Most of the former "independent state" of Bophuthatswana is found within its boundaries. There are, on average, 28 people per square kilometre.

The Free State

The Free State occupies 11% of the land and contains 2,7 million inhabitants, of whom 2,3 million (85%) are African. Over half of the population (54%) lives in urban areas. It has a population density of 21 people per square kilometre and had an average annual per capita gross geographic product of R 5,180 in 1993. It contains the relatively small former homeland of QwaQwa.

Household Data by Province

Against this description of each province, we now turn to the research findings of the survey. We first discuss the households and how they differ across provinces. Then we focus on individuals within each household.

Description of Living Conditions in African Households by Province*

Table 13.1 Indicates that there are large differences in living conditions according to province

Living conditions	West Cape	North Cape	East Cape	KwaZNatal	Gauteng	East Tvl	North Tvl	North West	Free State	Total
	%	%	%	%	%	%	%	%	%	%
Type of housing										
House	39	81	50	51	61	71	69	73	75	61
Flat	3	1	1	1	1	0	0	0	0	1
Shack	52	14	4	7	29	6	8	21	15	13
Traditional dwelling	0	4	43	38	0	22	20	6	9	22
Hostel	5	0	1	3	7	0	0	0	1	2
Other	1	0	1	0	3	1	2	1	0	1
Total	100	100	100	100	100	100	100	100	100	100
Number of rooms										
1	12	6	10	8	17	10	13	10	15	12
2	23	33	17	14	18	9	17	16	20	16
3	17	8	22	16	8	11	24	11	13	16
4	35	40	30	31	37	30	20	32	22	30
5+	13	13	22	31	21	40	26	31	30	26
Total	100	100	100	100	100	100	100	100	100	100
Crowding										
Low	4	6	5	5	6	7	5	5	4	5
Medium	39	36	37	49	50	54	39	47	48	45
High	58	58	58	46	44	39	56	48	48	50
Total	100	100	100	100	100	100	100	100	100	100

Water source										
Tap inside dwelling	37	31	15	12	40	18	10	11	23	19
Tap in grounds	56	41	14	22	47	37	26	29	26	29
Tap out of grounds	8	26	18	19	13	27	36	48	45	25
Tanker	0	1	3	4	1	2	6	7	1	3
River	0	0	47	31	0	12	8	0	1	17
Borehole	0	1	3	12	0	1	13	2	5	6
None	0	0	1	0	0	4	2	4	0	1
Total	100	100	100	100	100	100	100	100	100	100
Toilets										
Flush inside	26	23	15	15	32	16	8	7	23	17
Flush outside	66	25	10	13	48	7	4	13	9	18
VIP pit latrine	0	0	1	5	3	2	0	1	2	2
Pit latrine	0	17	33	48	14	67	70	65	33	43
Bucket	6	23	7	1	4	2	1	5	15	4
None	3	11	35	19	0	7	17	9	18	16
Total	100	100	100	100	100	100	100	100	100	100
Electricity										
Yes	75	51	22	45	79	35	16	24	39	41
No	25	49	78	55	21	65	84	76	61	59
Total	100	100	100	100	100	100	100	100	100	100

- Traditional dwellings, while generally characteristic of a rural life-style, are more commonly found in those provinces that contain former homelands, for example, the Eastern Cape (43% of all housing in this province) and KwaZulu-Natal (38%).
- Shacks are most frequently found in the more urbanised provinces where people hope to find more work opportunities.
  - For example, in the Western Cape, 52% of all Africans in this province live in shacks.
  - Shacks are also relatively common in Gauteng, constituting 29% of all housing for Africans in that province.
- In general, rural dwellings tend to contain more rooms than urban ones. Therefore those provinces which are largely rural have fewer homes with one or two rooms in them, compared to provinces which are largely urban.
  - For example, in Gauteng, 35% of homes consist of one or two rooms, compared to 19% in the Eastern Transvaal.
- Rural dwellings tend to house extended families, including the young children of people working in the towns and cities. Overcrowding is therefore a feature of both urban and rural households.
  - For example, more than half of all African households (58%) in the Western, Northern and Eastern Cape were classified as densely crowded, even though the Western Cape is largely metropolitan in character, while the Northern Cape is more urban, with people tending to live in small towns, and the Eastern Cape is largely rural.

- As to be expected, households in provinces which are largely rural, particularly those that contain former homelands, are less likely to have access to piped water, either inside the dwelling, or in the grounds, or even outside the grounds, compared to the households in more urban provinces.
  - For example, 47% of households in the Eastern Cape obtain water directly from rivers and streams, compared to less than 1% in the Western Cape.
- Toilet facilities are less accessible in provinces which are largely rural, particularly those which contain former homelands.
  - For example, 35% of households in the Eastern Cape have no toilets at all, compared to only 3% in the Western Cape.
- Electricity is rare in rural areas. For example, in the Northern Transvaal 84% of households have no electricity, compared to only 21% in Gauteng.
- Living conditions have a direct impact on health. For example, diarrhoea is more common among infants and young children when there is no clean water.

Socio-Economic Circumstances in African Households by Province

Table 13.2: Socio-economic conditions of African households by province

Economic conditions	West Cape	North Cape	East Cape	KwaNatal	Gauteng	East Tvl	North Tvl	North West	Free State	Total
	%	%	%	%	%	%	%	%	%	%
Household income										
Above MLL	32	21	24	25	51	19	21	22	22	29
Below MLL	68	79	76	75	49	81	79	78	78	71
Total	100	100	100	100	100	100	100	100	100	100
Household hungry										
Often	4	7	4	3	5	9	15	14	4	7
Sometimes	57	26	45	22	32	25	25	34	27	31
Occasionally	14	16	12	18	21	27	13	16	16	17
Never	26	51	40	58	43	39	48	36	54	46
Total	100	100	100	100	100	100	100	100	100	100
Medical aid										
Yes	7	11	8	5	19	12	8	9	17	10
No	93	89	92	95	81	88	92	91	83	90
Total	100	100	100	100	100	100	100	100	100	100

In addition to variation in living conditions, there are also vast differences in socio-economic conditions between provinces.

- Table 13.2 indicates that there are proportionately more people living below the minimum living level in provinces which are largely rural, but particularly in those provinces that contain former homelands.
  - For example, in the Northern Transvaal, 79% of households have incomes which are below the minimum living level, compared to 49% of households in Gauteng.
- Hunger is a common feature in all provinces, but it is not necessarily more common in the poorer, more rural provinces.
  - For example, a smaller proportion of caretakers in Gauteng (43%) said that members of the household never go hungry, compared to a larger proportion in KwaZulu-Natal (58%).
  - This probably occurs because subsistence farming can more easily be practised by those in rural areas who have access to some land.
  - As we have already seen, hunger, poverty and poorer ratings of health status are clearly related.
- For African households in all provinces, membership of a medical aid or health insurance scheme is rare, but it is least common in KwaZulu-Natal (5%).
  - Therefore, as we have clearly seen in previous chapters, large numbers of household members in all provinces rely on the public, rather than the private sector, for health care.

Biographical Details

Table 13.3: Education level of caretaker and household language by province

Biographical details	West Cape	North Cape	East Cape	KwaNatal	Gauteng	East Tvl	North Tvl	North West	Free State	Total
	%	%	%	%	%	%	%	%	%	%
Education caretaker										
None	10	26	14	30	9	33	21	21	18	20
Gr 1 - Std 3	18	17	20	21	11	21	16	28	26	19
Std 4 - 5	17	22	20	19	19	13	16	15	20	19
Std 6 - 9	50	27	34	24	48	26	33	32	27	32
Matric	3	3	8	4	10	7	7	4	7	6
Higher	2	5	5	3	3	1	7	1	2	4
Total	100	100	100	100	100	100	100	100	100	100

Household language										
Zulu	1	0	2	97	35	30	3	1	4	32
Xhosa	96	24	98	3	11	1	0	4	8	23
N Sotho	0	0	0	0	13	13	58	4	1	12
S Sotho	2	2	0	0	18	0	1	3	80	10
Tswana	1	68	0	0	17	1	4	82	7	12
Swazi	0	0	0	0	1	36	0	0	0	43
Tsonga/Shangaan	0	0	0	0	3	7	19	5	0	2
Venda	0	0	0	0	1	0	14	1	0	2
Ndebele	0	1	0	0	1	12	2	0	0	0
Other	0	5	0	0	0	0	0	0	0	100
Total	100	100	100	100	100	100	100	100	100	

Table 13.3 shows educational and language differences between provinces.

- Caretakers of households in the largely urban provinces have received a better education than those in the largely rural provinces.
  - For example, in Gauteng, a smaller proportion of caretakers have never gone to school (9%), compared to KwaZulu-Natal (30%).
  - We have already seen how a lower education level of the caretaker is related to poorer ratings of health status and access to health care.
- As far as the main language spoken in a household is concerned, there are vast differences between provinces, reflecting possible cultural differences.
  - For example, African households in the Eastern (98%) and Western Cape (96%) are almost all Xhosa speaking, and those in KwaZulu-Natal (97%) are almost all Zulu speaking.
  - On the other hand, a variety of languages is spoken in households in Gauteng, the Eastern and Northern Transvaal, indicating a high degree of cultural diversity.
  - The implication for health care is that culturally-based requirements should be taken into account in service delivery.

Provincial Comparisons: Health Indicators for Children Aged Nought to Five Years

When examining the health indicators relevant to children aged nought to five years, the research findings indicate that there are large differences between provinces.

Table 13.4: Health indicators for children aged 0 - 5 years by province

Indicators: Children aged 0 - 5 years	West Cape	North Cape	East Cape	KwaNatal	Gau-teng	East Tvl	North Tvl	North West	Free State	Total
	%*	%*	%*	%*	%*	%*	%*	%*	%*	%*

Absence of birth certificate	43	27	74	63	34	55	71	41	35	59
Visits to clinic every 2 - 3 months	76	80	74	73	56	84	84	84	83	77
Child was not/is not breast-fed	34	13	22	11	17	12	6	13	11	14
Spontaneous mention of ORS	52	45	48	58	58	71	67	62	64	59
Heard of free health care	86	95	89	96	93	93	95	87	89	92
Access to care easier since free	44	58	76	63	42	70	63	64	76	65
TB immunization	95	91	93	96	95	76	85	93	85	90
Too poor to feed child	28	15	28	14	26	33	28	19	19	23
Health professional says child weighs too little	16	16	17	8	21	13	14	14	19	14

*** The balance of all percentages in this table add up to 100%**

- Table 13.4 shows that children in provinces that are largely rural, or that consist of small towns, are less likely to have a birth certificate, compared to those in provinces that are largely metropolitan.
  - For example, 74% of children in the Northern Cape, and 71% in the Northern Transvaal did not have a birth certificate, compared to 34% in Gauteng.
  - The absence of a substantial number of birth certificates makes it difficult to monitor the mortality and morbidity rates of children in this age category, particularly in rural provinces.
- As far as utilisation of health-care facilities are concerned, caretakers in the metropolitan province of Gauteng (56%) are least likely, while those in the more rural provinces of the Northern and Eastern Transvaal and the North West (84%) are most likely, to take a child for care every two months or more frequently.
  - The nuclear family structure in urban areas, and the work commitments of caretakers outside the home, may explain in part why children in urban provinces are less frequently taken for check-ups than those in rural provinces.
- Awareness of the existence of free health care services for infants and young children was wide-spread, but it was lowest in the Western Cape (86%).
  - In those provinces which are largely rural, for example the Eastern Cape and the Free State (76%), caretakers were more likely to say that health care had improved since the introduction of free services for infants and young children, compared to those in the urbanised provinces, for example Gauteng (42%) and the Western Cape (44%).

- Preventive health measures, for example breast feeding and immunisation, are generally widespread in all provinces. But there are some exceptions.
  - In the Western Cape, which is characterised by the fact that more than half the African population live in informal settlements, breast-feeding is least commonly practised, since 34% of children were never breast-fed. This compares poorly to only 6% who were never breast-fed in the Northern Transvaal.
  - TB immunization, which is generally given at birth, was lowest in the Eastern Transvaal (76%), probably because more children were born at home in this province.
- Surprisingly, awareness of oral rehydration solution as a treatment for diarrhoea was highest in the Eastern Transvaal, in spite of this province having the lowest TB immunization rate.
  - Awareness of ORS tended to be lowest in the Northern and Eastern Cape.
- Poverty, measured by the proportion of respondents who said that they were too poor to feed their child aged nought to five years was particularly widespread in the Eastern Transvaal (33%), but it was also relatively common in the Western and Northern Cape, the Northern Transvaal (28% in all three instances) and Gauteng (26%).
  - Poverty affecting health is therefore common in even the richest provinces. The distribution of incomes within a province, rather than the average per capita gross geographic product is at issue.
  - A relatively large proportion of all caretakers in all provinces, but particularly in Gauteng (21%), had been told by a health professional that the child weighs too little.

Provincial Comparisons: Health Indicators for Children Aged Six to 15 Years

When turning to the health indicators among children aged six to 15 years, the research again shows that there are clear differences between provinces.

Table 13.5: Health indicators for children aged 6 - 15 years by province

Indicators: Children aged 6 - 15 years	West Cape	North Cape	East Cape	KwaNatal	Gau-teng	East Tvl	North Tvl	North West	Free State	Total
	%*	%*	%*	%*	%*	%*	%*	%*	%*	%*

Absence of birth certificate	44	13	52	40	17	32	48	34	17	39
Child is not attending school	17	9	6	4	8	11	6	11	11	7
Child missed school in last two weeks	10	13	8	13	9	9	13	10	16	11
No breakfast in the morning	12	4	7	5	16	9	16	13	9	10
Child receives free food at school	94	62	98	84	30	28	32	62	52	63

*** The balance of all percentages in this table add up to 100%**

- Table 13.5 shows that whether or not a child had a birth certificate varied by province.
  - For example, 48% children of school-going age in the Northern Transvaal, characterised by its remote rural nature, did not have a birth certificate, compared to 17% in largely metropolitan Gauteng.
- While relatively few children aged six to 15 years were not attending school, as many as 17% in the Western Cape were not attending school.
- The proportion of children who missed at least one day of school in the two weeks prior to the interview was generally lower in the more rural provinces, ranging from 8% in the Eastern Cape to 16% in the Free State. The reason for this high incidence in the Free State is not clear.
- Good nutrition at school-going age is an important preventive health measure, contributing to the ability to learn.
  - Children in both the richest province of Gauteng and the poorest province of the Northern Transvaal (16% in both instances) were least likely to have breakfast before going to school.
  - Not only the average per capita income, but also the distribution of income among households within a province, are important considerations when examining nutrition-related matters. The research findings show that missing breakfast in the morning in Gauteng occurs mainly in those households living below the minimum living level.
  - Children in these two above-mentioned provinces (30% in Gauteng, 32% in the Northern Transvaal) were also least likely to receive free food at school.
  - Under-nutrition can therefore be a problem for children in both highly urbanised as well as remote rural provinces.

Provincial Comparisons: Health Indicators for Adults Aged 16 - 64 Years

Table 13.6: Health indicators for adults aged 16 - 64 years by province

Indicators: Adults aged 16 - 64 years	West Cape	North Cape	East Cape	KwaNatal	Gau-teng	East Tvl	North Tvl	North West	Free State	Total
	%*	%*	%*	%*	%*	%*	%*	%*	%*	%*
No formal schooling	5	15	12	15	7	15	15	14	7	12
Chronic illness	28	40	24	22	23	17	17	32	30	23
Difficulty seeing	5	23	17	9	8	14	15	14	14	12
Disability	12	34	23	14	13	17	22	21	22	18
Did not receive care in the past year	23	29	46	30	32	38	46	37	36	37
More than one hour to reach care site	17	23	28	32	14	22	27	23	20	24
Waiting for care four or more hours	51	32	26	23	13	12	25	21	26	22
Received care for five minutes or less	21	50	62	62	37	32	54	47	50	50
Used traditional healer	42	17	31	37	32	34	22	28	34	32
Want community health workers	70	60	56	72	57	89	90	72	85	71

*** The balance of all percentages in this table add up to 100%**

- Among adults aged 16 to 64 years, when examining biographical variables, Table 13.6 shows that the level of education of adults differs by province.
  - There are proportionately fewer people who never went to school in the urban provinces, for example, the Western Cape (5%), the Free State (7%) and Gauteng (7%), compared to the rural provinces, for example Eastern and Northern Transvaal (15%).
  - Level of education, health knowledge and access to health care, as we have seen, go hand in hand.
- When examining the health status of adults, chronic illness tends to be more frequently reported in the Northern Cape (40%), the North West (32%) and the Free State (30%).
  - This finding is probably a reflection of differences in access to health-care facilities between provinces, which in turn influences the extent to which chronic diseases are diagnosed.
- Regarding disabilities, the prevalence was generally higher in the rural and the sparsely populated provinces, compared to the urban provinces. There could be a number of reasons for this. For example, extended families in rural areas may be more able to care for a disabled person, rather than nuclear families in urban areas.

- For example, difficulty in seeing, even with glasses, was the most frequently reported disability (12% of all African respondents). However, there was wide variation in the frequency of reporting this problem between provinces.
  - In rural areas generally, a relatively high proportion of respondents reported having visual difficulties. However, proportionately more people in the sparsely populated province of the Northern Cape (23%) reported that they had visual difficulties, compared to the more densely populated provinces, for example the Western Cape (5%).
  - One can conclude that gaining access to ophthalmic services may therefore be more difficult in remote rural areas and in areas of sparse population density, which would account, at least in part, for the high prevalence of reported visual disabilities in certain provinces.
- A lack of access to health care in rural provinces generally, and in the most impoverished provinces in particular, becomes clear when we examine whether or not all African respondents aged between 16 and 64 years went for care in the year prior to the survey.
  - Proportionately more people living in the poorest, largely rural provinces of the Northern Transvaal (46%) and the Eastern Cape (46%) had not gone for health care in the year prior to the study, compared to the more affluent, more urban provinces of Gauteng (32%) and the Western Cape (23%).
- The remoteness of rural areas from health-care facilities is evident in this study. People in largely rural areas tend to take longer to reach their health-care site, compared to people living in urban areas.
  - For example, 32% of respondents in KwaZulu-Natal, 28% in the Eastern Cape and 27% in the Northern Transvaal took longer than an hour to reach their health-care site, compared to 14% in Gauteng.
- Non financial barriers to health care include waiting in long queues to be seen. While waiting for long periods of time to receive professional attention was a general problem in all provinces, this problem was worst in the Western Cape where more than half of the respondents (51%) said that they waited four hours or longer before receiving attention.
- Another general problem acting as a barrier to care was the short time that the health-care professionals spent on examining and speaking to the respondents.
  - This problem was most acute in the Eastern Cape and KwaZulu-Natal, where 62% of respondents said that they were seen for five minutes or less the last time they went for care.
- The idea of training community health workers to help professionals was generally favoured. But this applied particularly in certain rural provinces.
  - For example, 90% of respondents in the Northern Transvaal and 89% in the Eastern Transvaal favoured the introduction of community health workers, as against 57% in Gauteng.
- More than one in every three respondents used traditional healers, usually in addition to western medicine.
  - Respondents living in the Western Cape (42%) were more likely to report that they used traditional respondents than respondents living in the other provinces.

Provincial Comparisons: Health Indicators for Adults Aged 65 Years or More

In this section the extent to which chronic illnesses and disabilities are experienced by respondents aged 65 years or more by province is examined. Among those with these problems, access to care by province is also discussed.

Table 13.7: Health indicators for adults aged 65 years or more by province

Indicators: Adults aged 65 years or more	West Cape	North Cape	East Cape	KwaNatal	Gau-teng	East Tvl	North Tvl	North West	Free State	Total
	%*	%*	%*	%*	%*	%*	%*	%*	%*	%*
Proportion with chronic illness	64	97	78	64	72	42	64	85	50	68
Among those with a chronic illness, going for check-ups only when ill or never	50	45	60	28	41	38	43	45	32	44
Proportion with disability	63	67	68	53	57	62	61	71	56	61
Among disabled, having received professional help	49	39	46	39	44	38	41	51	35	43

*** The balance of all percentages in this table add up to 100%**

- Chronic illnesses for example, arthritis, hypertension, diabetes and asthma tend to be far more common among the elderly, compared to younger adults. Indeed, Table 13.7 indicates that chronic illness affects two thirds of elderly respondents.
  - These illnesses are most common in the Northern Cape, where 97% of respondents indicated that they had been told by a doctor or other health care professional that they had at least one such illness. They are least common in the Eastern Transvaal, where 42% reported that they had been told by a doctor or other health professional that they had at least one chronic illness.
  - This diversity is surprising. It may be that in those provinces with better health-care facilities for the aged, or where attention is focused specifically on diagnosis of illnesses among the aged, chronic illnesses are more frequently reported.

- A large proportion (44%) of those with at least one chronic illness said that they either never go for check-ups, or else they go for check-ups only when they feel sick.
  - This applied particularly in the Eastern Cape, where 60% of elderly respondents said that they go only when they feel ill or else they never go.
- Disabilities among the elderly also tended to be relatively common, with approximately six out of every 10 respondents (61%) reporting that they had at least one of the following: difficulty in seeing, even with glasses, difficulty in hearing, difficulty in walking or moving about and difficulty in learning or understanding.
  - While there is variation between provinces regarding the proportion of people who have a disability, the reasons why there should be 63% of disabled elderly respondents in the Western Cape, 68% in the Eastern Cape and 53% in KwaZulu-Natal, for example, are not clear. There is no clear pattern based on rural/urban differences between provinces.
- Professional help for the disabled is more likely to be available in the North West (51%) and the Western Cape (49%). It is least likely to be available in the Free State (33%).

Summary and Conclusions

This chapter shows that there are vast differences between provinces regarding living conditions, access to health care and utilisation of services.

The rural provinces generally, and the poorest provinces in particular, are most likely to have worse access to health care, compared to the more affluent provinces. Those provinces which contain former apartheid-based homelands are the most underserved. Nevertheless, even in those provinces where the average annual gross geographic product is comparatively high, inequalities in living standards, in health and access to health care persist.

*** Based on Central Statistical Service and COSATU data.**

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Appendices
A-D

APPENDIX A.

Louis Harris and Associates:
Various health-status, health-insurance and contraceptive use questionnaires

Harvard trauma questionnaire:
Lao version

Harvard School of Public Health:
Questionnaire on health-care issues

Harvard School of Public Health:
Mexican health issues questionnaire

Indonesian Family Life Survey:
Questionnaire

Robert Wood Johnson Foundation:
Behavioral risk factor questionnaire

Robert Wood Johnson Foundation:
Questionnaire for survey of access to health-care

Kaiser/Commonwealth Fund:
Questionnaire for the health insurance survey

Medicare Beneficiary Health Status Registry:
Questionnaires

National Health and Nutrition Examination Survey:
Questionnaire

National Health Interview Survey:
Questionnaires

National Medical Expenditure Survey:
Questionnaires

National Survey of Family Growth:
Questionnaire

Barbara Starfield, Johns Hopkins University:
Primary care survey for the development of a comprehensive primary care system for all children questionnaire

University of Michigan, Health and retirement Survey:
Questionnaire

University of Michigan, Aging and Health in America:
Questionnaire

University of Michigan: National survey of health and stress:
Questionnaire

World Bank:
Human resource development survey for Tanzania

USAID, Demographic and Health Surveys:
Questionnaires for high and low contraceptive prevalence countries.

APPENDIX B.

American Reference Group

Robert Blendon
Harvard School of Public Health

Gerry Hendershot
Division for Health Interview Statistics, Center for Disease Control

James House
Institute of Social Research, University of Michigan

Judith Kasper
School of Hygine and Public Health, Johns Hopkins University

Dorothy Rice
Institute of Health and Aging, University of California

Barbara Starfield

School of Hygine and Public Health, Johns Hopkins University

Dan Walden
Agency for Health Care Policy and Research, Department of Health and Human Services

APPENDIX C.

South African Reference Group

Peter Barron
Health Systems Trust

Debbie Bradshaw
Centre for Epidemiological Research in Southern Africa, Medical Research Council

Eric Buch
Health Department, Gauteng Provincial Government

Irwin Friedman
National Progressive Primary Health Care Network

David Harrison
Health Systems Trust

Daniel Jacobs
Department of Health

Rose Mazibuko
Hlatlolanang Health and Nutrition Centre

Ralph Mgijima
Health Department, Gauteng Provincial Government

Shirley Ngwenya
Health Services Development Unit, University of the Witwatersrand

David Power
Department of Paediatrics, University of Cape Town

Helen Rees
Reproductive Health Unit, Johannesburg Metropolitan Government

Welile Shasha
Department of Community Health, University of Transkei

Thabo Sibeko
National Progressive Primary Health Care Network

Steve Tollman
Health Services Development Unit, University of the Witwatersrand

Hennie van Rensburg

Department Health

APPENDIX D

Household Indicators

Living Conditions of Household

Aim:

Improvement of living conditions that directly influence the incidence of preventable diseases such as diarrhoea, respiratory diseases

Sentinel indicator: Access to piped water

Measured by:

- % of households with access to piped water. (Other important considerations: length of time spent fetching water for household use).

Other indicators for total sample:

Access to sanitation measured by:

- % of households with flush toilets or VIP pit latrines

Overcrowding measured by:

Number of people per household by number of rooms in household

Poverty Affecting Health

Aim:

Improving health through reducing poverty.

Sentinel indicator: Members of the household going hungry

Measured by:

- % of households who say that people in them often or sometimes go hungry

Other indicators for the total sample

Difficulty in paying for medical treatment and for prescribed medicines measured by:

- % of households who find it very difficult or fairly difficult to pay for medical treatment and prescribed medicines

Difficulty in surviving measured by:

- % of households with a disposable incomes below the estimated Minimal Living Level

Access of Household Members to Health-Care

Aim:

To improve access to primary sources health-care of household members

Sentinel indicator: Having a consistent source of health-care

Measured by:

- % of households who have a usual person or place (other than a hospital) where they go to when they need health-care or treatment

Other indicators for a subset of the sample:

Access to emergency services measured by:

- % of households who have a usual health care source and have access to health care 24 hours a day every day

Access to high quality care measured by:

- % of households who have a usual health care source and who claim that most members of their household receive excellent or very good care

Indicators for Individuals Aged 16-64 Years

Health Status of Individuals Aged 16-64 Years

Aim:

To improve the health status of adults

Sentinel indicator: Subjective perception of health status

Measured by:

(a) % of people who say their physical health is excellent or very good, compared to others of their age
(b) % of people who say their mental health is excellent or very good, compared to others of their age
(c) % of people who say their living environment is excellent or very good for their health

Indicators for a subset of the sample:

Management of chronic diseases measured by:

- % of those with a chronic illness who go for regular check-ups (at least every two to three months)

Management of disability measured by:

- % of disabled people who have had therapy or rehabilitation assistance

Management of post-traumatic distress syndrome measured by:

- % of people with symptoms of post-traumatic distress who have received professional help

Loss of productivity due to illness measured by:

- % of people who work for an employer/self/family business who
(a) lost work days in the two weeks prior to the interview, and
(b) are restricted in the type of work they do because of health problems
- % of people who are unemployed due to a health problem/handicap
- % of people who are housewives/disabled or retired and are limited in the activities they can do by a health problem

Access to Health Care of Individuals Aged 16-64 Years

Aim:

To improve access to primary sources of health-care of individuals aged between 16 and 64 years

Sentinel indicator: Having an affordable source of health-care

Financial barriers to access measured by:

(a) In the last year, % of people who did not go for treatment when they thought they needed it because they could not afford to go .
(b) In the last year, % of people who delayed going for treatment when they thought they needed it because they could not afford it
(c) In the last year, % of people who were refused treatment when they sought it because they could not pay

Other barriers to access measured by:

Time taken for a visit to health-care provider
(a) time taken to get there
(b) time taken waiting
(c) examination time

Appropriate Utilisation of Health-Services among Individuals Aged 16-64 Years

Aim:

To increase utilisation of sources of primary care and to decrease need for secondary or tertiary care

Sentinel indicator: Utilisation of clinics and general practitioners measured by:

(a) % of people who have visited a public clinic as their first contact on their most recent visit to a health care source
(b) % of people who have visited a general practitioner as their first contact on their most recent visit to a health care source

Other indicators for the total sample

Attitude towards community health services measured by:

- % of people who feel that community health workers would definitely or probably improve

health services

Alternatives to western medicine measured by:

- % of people who have ever used traditional healers who utilised them at least once in the last year

Satisfaction with Health-Care among Individuals Aged 16-64 Years

Aim:

To improve the perceived quality of delivery of health-care services

Sentinel indicator: Satisfaction with health-care services

Measured by:

% of people who think that the present health-care system works very well for them

Other indicators for the total sample:

Perceived attitude of health professionals measured by:

- % of people who experienced rudeness, shouting or rough handling by health professionals at their last visit to a health-care facility

Perceived quality of attention measured by:

- % of people who understood explanations given to them about their illness at their last visit to a health-care facility

Outcomes of Health-Care among Individuals Aged 16-64 Years

Aim:

To improve knowledge of health, thus enabling people to make informed choices with regard to health practices

Sentinel indicator: Knowledge of AIDS

Measured by:

- % of people who have heard about AIDS and answer all AIDS questions correctly

Other indicators for the total sample

Knowledge of harmful effects of smoking Measured by:

- % of people who strongly believe that smoking is harmful to their health

Indicators for a sub-set of the sample

Family planning measured by:

- % of fertile people (women aged 50 years or younger, men of all ages) who use/whose partners use recognised contraceptive measures for family planning

Knowledge of oral rehydration solution measured by:

- % of mothers who know about oral rehydration solution

Coping with environmental problems measured by:

- % of households who boil drinking water among those who do not have piped water

Women's Health Issues

Aim:

To improve women's health status through preventive measures

Sentinel indicator: Ante-natal care (Applies to a sub-set of the sample)

Measured by:

% of women who went for ante-natal care the last time they were pregnant in the first trimester among those who have given birth

Indicator for a sub-set of the sample:

Health-care during child-birth measured by:

- % of women who had a health-care professional present at the birth of their last child

Health Indicators for Children Aged Five Years or Younger

Aim:

To improve health of infants and pre-school children through preventive measures

Sentinel indicator: Immunisation status measured by:

- % of children who are fully immunised at two years of age

Other indicators for the total sample:

Health-care during first year of life measured by:

- % of children who went for check-ups at least once every second month during their first year of life

Preventive care measured by:

- % of children who were breast-fed for at least six months

Under-nutrition measured by

: - (a) % of children whose caretaker was told by a health professional that they weigh too little
- (b) % of mothers who say they do not have enough money to feed the child adequately

Health Indicators for Children Aged Six to 15 Years

Aim:

To improve health of children and teenagers of school-going age through preventive measures

Sentinel indicator: Subjective perception of health status

Measured by:

(a) % of people who say their child's physical health is excellent or very good, compared to other children of that age
(b) % of children who stayed in bed for at least one day in the two weeks prior to the survey due to ill health or injury

Indicators for a sub-set of the sample:

Poor nutrition measured by:

- % of children who do not have breakfast before going to school

School feeding measured by:

- % of children at primary school whose school provides free food

Remedial care measured by:

- % of children who have received remedial teaching or special education, among those who have had learning problems

Sex education measured by:

- % of children at high school who receive sex education at school

Health Indicators for Those Aged 65 Years or More

Aim:

To improve the health-care of the elderly

Sentinel indicator:Perceived quality of life

Measured by:

(a) % of people who say their physical health is excellent or very good, compared to other people of their age
(b) % of people who say their mental health is excellent or very good, compared to others of their age
(c) % of people who say their memory is excellent or very good, compared to other people of their age
(d) % of people who say they are satisfied with their life

Other indicators for total sample:

Mental health measured by:

- % of people who spent all of the previous week entirely alone

Chronic illnesses: measured by:

- % of people who have at least one chronic illness

Disability: measured by:

- % of people who have at least one disability

Indicators for a subset of the sample:

Management of chronic diseases measured by:

- % of those with a chronic illness who go for regular check-ups (at least every two to three months)

Management of disability measured by:

- % of disabled people who have had therapy or rehabilitation assistance

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