Aging and the Meaning of Health in South Africa  
UMSAEP Partnerships Program 2008 Report  
Enid Schatz

Principal Investigator:  
Dr. Enid Schatz, University of Missouri, Columbia  
Assistant Professor, Department of Occupational Therapy

South African Co-PIs:  
Dr. Diana Gibson, University of Western Cape  
Professor Stephen Tollman, University of the Witwatersrand

The aim of this project was to conduct a pilot project exploring older persons’ perceptions of their health and build collaborations with two South African institutions (University of the Witwatersrand and University of Western Cape). The pilot project laid the groundwork for an a larger external grant application on older persons well-being in the HIV/AIDS era in South Africa collaborating with local scientists in two sites in South Africa, one rural and one urban. The pilot research was conducted in a rural site where I have previously worked, the Agincourt Health and Demographic Surveillance System study site (a research site affiliated with the School of Public Health at the University of the Witwatersrand) located in the northeastern border with Mozambique. The urban site was selected in collaboration with colleagues from University of Western Cape, the respondents were residents in Langa, a township on the outskirts of Cape Town. This pilot project entailed in depth interviews with approximately 12-15 (half male/half female, over the age of 50) respondents in each of the sites in order to understand the types of questions and topics that will be worthwhile to explore in the larger study. While the rural data collection went smoothly and was quite successful, the urban data collection was more difficult to set up and has yet to be completed. Four interviews have been received from the interviewer via email, and an additional 4 have been completed but not yet translated/transcribed. Ideally the 12 interviews for which the interviewer was contracted will be completed, translated, transcribed and emailed.

**Intended outcomes**

The intended outcomes of this project include:

1. Conducting a small qualitative pilot study on aging and the meaning of health in one rural and one urban area in South Africa.
2. Building a research collaboration with UWC, which includes both faculty and graduate student participation.
3. Further strengthening my research linkages with the Agincourt Health and Population Unit/Rural Health and Health Transitions Unit at the University of the Witwatersrand (Wits).
4. Collecting sufficient data on the meaning of health among the elderly in rural and urban South Africa, and building strong enough collaborative relationships, to write an external proposal in collaboration with UWC and Wits.
This proposal requested funding to conduct a pilot project focusing on the meaning of health for aging individuals and build collaborations with two South African institutions through this project. While not all of the intended outcomes were accomplished, the trip was productive and worthwhile. The project primarily focused on building collaborations necessary to write a joint external proposal for a larger project on the meaning of health to elderly in South Africa. The trip strengthened ties with Wits, and provided an opportunity to expand my networks and relationships with academics in Cape Town. However, it is unlikely that I will conduct future work with my UWC collaborator since her interests are moving in different directions from my project.

The pilot examined the health and meaning of health among older South African adults (ages 50+). In order to fully understand the topic area and possible directions a future external grant application may take, we conducted a qualitative pilot study in two sites in South Africa, one rural and one urban. In each site we intended to conduct a limited number of in-depth interviews with older men and women (over the age of 50). The interviews lasted about an hour each. I trained local staff in qualitative interviewing techniques, as well as the aims of the project. The interviews were conducted in the local language of the area by the local staff, and were recorded and fully translated and transcribed into English. We completed all the intended interviews in the rural area, but the urban interviews are still under way. The completed interviews are currently being analyzed for emergent themes in order to understand what physical, emotional and psychological factors contribute to the way in which the elderly assess their own health. These interviews will serve as a foundation for writing a more in-depth external grant application in which we will request funds to complete a larger project in the two sites to better understand the factors contributing to self-assessment of health in each rural and urban areas of a developing country setting.

Timeline of trip
The seed money funded a two-month exploratory trip to South Africa in June-July 2008. I spent a few days with colleagues at the University of the Witwatersrand (Johannesburg) who manage the Agincourt Health and Population Unit Study site in South Africa’s rural northeast to prepare for fieldwork. Then I spent three weeks in the Agincourt research site conducting 16 in-depth interviews with men and women over the age of 50. The interviews focused on their perceptions of their own health and the meanings they attach to the notion of health. In the second half of the trip, I attempted to will meet with colleagues at the University of Western Cape to establish a similar fieldwork schedule. I had some difficulties making contact with my UWC colleague, and once contact was established, she provided a research assistant, who then decided not to participate in the project. That student did suggest another student, who I eventually trained to be the project interviewer, but due to the delays she was not able to start data collected before I had to leave the country. Over the course of the Fall semester she has emailed a total of 4 interviews, and has conducted several additional interviews that she has yet to transcribe and email. I am still waiting for the remaining interviews in order to enter them in the software program to facilitate an urban/rural comparison.

I took advantage of being in South Africa to participate in and contribute to a number of things that would not have been possible otherwise. During this trip I was also able to contribute to a 2-
week course on Longitudinal Data Management and Analysis presented by the University of Colorado and the University of the Witwatersrand (Wits) in Johannesburg that included approximately 30 students from Wits, the African Population and Health Research Center in Nairobi, Kenya, the University of Colorado, Boulder, and Brown University. I gave a lecture introducing the students to the Agincourt Health and Demographic Surveillance System Database and site (the rural site where the pilot was conducted), the data on which the course is based. My colleague Sangeetha Madhavan also presented our co-authored paper, HIV/AIDS Mortality and Household Dependency Ratios in Agincourt. I also participated in the 6th Annual Wits-Brown-Colorado-APHRC Colloquium held at Wits. I presented initial impressions from the pilot in the rural area, and co-presented on older headship in Agincourt with Sangeetha Madhavan. While in Cape Town, I gave two lectures at the University of Cape Town, one to the Demography Program (titled, HIV/AIDS-mortality and household dependency ratios in rural South Africa) and one for Institute of Ageing in Africa (titled, Coexisting discourses: how rural older women in South Africa make sense of the AIDS epidemic).

**Background & Significance of project**

Despite the aging of developing countries, little is know about the aging process and health of the elderly in developing countries compared to those in developed countries. Valid, reliable and comparable information on health, morbidity and mortality from developing country settings is crucial to creating effecting public health programs (Murry et al 2002). Due to demographic and epidemiological changes in the developing world, understanding the health of older adults is becoming even more important. One relatively low-cost way to begin to capture adult health in the developing world is through self-rated health, which has been shown in many developed country settings to be correlated with mortality outcomes. Self-rated health is often measured with a simple single item that asks respondents to assess their current health on a scale with ordered response categories (for example, excellent, very good, good, fair or poor). Variations of this self-rated health question have appeared on the World Values Survey conducted in 80 countries including 10 African countries (see [www.WorldValuesSurvey.org](http://www.WorldValuesSurvey.org)), the World Health Survey in 69 countries, including 11 African countries (Üstün et al 2003), and a number of other developing country survey programs, for example the Indonesia Family Life Survey (Frankenberg & Jones 2004), and the Matlab Health and Socioeconomic Survey (Rahman et al 1999). However, the analyses and cross-country comparisons of the outcomes of these studies are only beginning to emerge (Yu et al 1998; Rahman & Barsky 2003; Frankenberg & Jones 2004; Szwarcwald et al 2005).

The importance of this pilot project and future external grant derive from the importance of self-rated health as a predictor of mortality. Although the correlation is not as strong in developing countries as has been found in developed countries (Idler & Benyamini 1997; see Benyamini & Idler 1999 for thorough reviews of developed country research), Frankenberg and Jones (2004) find that even in Indonesia, a low-income setting, self-rated health is a significant predictor of mortality. This is true of both men and women, and even while controlling for anthropomorphic measures and indicators of physical functioning and illness. Self-rated health measures are a first step in understanding perceptions of health, but in order to understand what a person means when s/he says s/he feels very good versus when s/he says s/he feels poor, we need qualitative work to unpack the meaning of health.
In developed countries, researchers have used in-depth interviews and qualitative data analyses to evaluate the range of meanings that different respondents attach to questions on self-rated health (Groves et al 1992; Jylha 1994; Borawski et al 1996; Manderbacka 1998; Idler, Hudson & Leventhal 1999; Kaplan & Baron-Epel 2003; Simon et al 2005). The methods ranged from open-ended probes following a self-rated health question (a method similar to that we plan to use in the R02) to rating the influence of a list of predetermined factors to in-depth interviews (the method similar to what we plan to use in the pilot and R03 application). The aim of qualitative research on the meaning of health in these studies is to explore the reasoning behind self-rated health assessments. Some researchers found responses were driven mainly by current illnesses, health behaviors and physical functioning (Grove et al 1992). Others found variation in health-frame-of-reference by age, race and education-level (Krause & Jay 1994), with older respondents less likely to focus on physical health than younger respondents (Borawski et al 1996). Kaplan and Baron-Epel (2003) found that key factors influencing self-rated health varied over age and self-rated health levels, with older people more likely to compare their health to people of the same age, and respondents with low self-rated health more likely to report that their ratings were influenced by pain and tiredness. These studies help us to understand the variety of considerations that might influence self-rated health assessments. None of these studies, however, were conducted outside of high-income settings. The pilot project and R03 application will take this notion of using qualitative data to explore meanings of self-rated health a step further by collecting open-ended in-depth interviews as the first step to understandings the meanings of health to the elderly.

South Africa is a special case, and an important context, or several reasons. First, compared to many developing countries, South Africa has a fairly advanced and decentralized public health system. Second, women over the age of 60 and men over the age of 65 receive a non-contributory state pension, giving them more access to a healthy lifestyle and health care services. Despite these facts, however, the HIV/AIDS epidemic that is ravaging South Africa means that the elderly, particularly elderly women, are increasingly taking on burdens (financial, physical and emotional) related to caregiving for sick adult children and fostered and orphaned children (Ainsworth & Dayton 2003; Baylies 2002; Dayton & Ainsworth 2002; Ferreira 2004; Schatz 2006). In addition, despite the pensions, many rural and urban households live below the poverty line and struggle to make ends meet, making elders’ health care needs perhaps not as immediate as other needs in multi-generational households. As a double burden of disease emerges in South Africa, HIV/AIDS among prime-aged adults and non-communicable disease in older age groups, these realities combine to make South Africa a crucial arena for understanding older people’s understanding of health and being healthy.
Works Cited


