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Health services — needs of the elderly in two black urban areas of the Cape Peninsula

F. R. PRINSLOO

Summary

The availability and utilisation of essential social and health services were studied in two urban areas, Langa, an established township well within the city boundaries, and Khayelitsha, a newly established and fast-growing township on the margin of the city. They are approximately 10 km and 30 km respectively from the central business district of Cape Town.

Random cluster samples were drawn of 195 residents in Langa and of 170 in Khayelitsha (age range 59 - 89 years). Respondents' knowledge and use of the following services were ascertained: social, shopping, transport, doctors, clinics and services centres for the aged. The questionnaire was adapted from the widely used Duke Older American Resources and Services strategy and Gurland's Comprehensive Assessment and Referral Evaluation.

Most of the elderly in both areas know where to obtain health and social services and transport. Residents of Langa have been in Cape Town much longer and therefore have fewer problems in using the services when needed. The people in Khayelitsha use the social worker services much more than the Langa residents.

S Afr Med J 1991; 79: 485-489.

Black elderly people (65 years and over) in South Africa comprise 3% of the total black population, as opposed to a figure of 8,7% for elderly whites. By the year 2030 the total number of elderly blacks (919 800) is expected to increase and constitute 5,5% of the total black population. Most of these

elderly people will reside in cities, since rapid urbanisation is taking place all over South Africa. Services, in particular health services, will have to be expanded to cope with this growing elderly population.

Aims

The aims of the study were to assess and compare the knowledge of health and other services by black elderly persons in two townships in the Cape Town area, and to assess and compare the health and social needs of the two townships.

This study forms part of a larger study on the effects of urbanisation on health and health service use.

Methods

Site and sample

The respondents were all elderly people (60 years and older) identified in a random cluster sample survey of the two townships (Table I). The older, well-established Langa has brick housing and the recently built Khayelitsha consists mainly of shacks (Table II). Hostels (in which few elderly people live) and open areas were not included in the sampling plan. Town plans for Langa and Khayelitsha were obtained from the relevant authorities and demarcated plots on these plans were counted.

Within each main area, cluster consisting of a fixed number of plots per cluster were marked. A simple random sample without replacement was drawn from the cluster of each area. All eligible elderly people found within a selected cluster were included in the sample¹ (Table I). For further information refer to a complete description in the MRC Technical Report Series on Urbanisation.²

All eligible elderly persons found within a selected cluster were interviewed. In Langa 195 and in Khayelitsha 170 elderly residents were interviewed.

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TABLE I. SAMPLING DETAILS

	Langa	Khayelitsha		
		Site A	Site B	Site C
Number of plots	2 544	5 165	3 864	3 684
Cluster size	20	30	30	20
Total number of clusters	127	172	129	184
Cluster sample size	30	34	28	43
Sampling fraction	0,24	0,20	0,22	0,23

TABLE II. TYPE OF DWELLING

	Langa		Khayelitsha	
	No.	%	No.	%
Brick and mortar	189	96,9	2	1,2
Shack	5	2,6	168	98,8
Old-age home	1	0,5	0	0
Total	195	100,0	170	100,0

Questionnaire

A structured questionnaire was adapted from the widely used Duke Older American Resources and Services (OARS) strategy³ and Gurland's Comprehension Assessment and Referral Evaluation (CARE).⁴ Certain questions were changed and others were added. The questionnaire was translated into Xhosa and modified, after a pilot study had been conducted.

The eight interviewers were black Xhosa-speaking nurses from Groote Schuur and Tygerberg hospitals who were trained in the administration of the questionnaire. They were familiar with the culture and mores of the respondents.

The persons selected by the sampling procedure and their families were visited in advance so that they could be informed of the purpose and nature of the investigation. Collateral information was obtained from family members to validate the data already obtained. Where subjective feelings or personal attitudes were being asked about, only the respondents' responses were taken into account. Interviews were usually completed in one session, which lasted from 1 to 3 hours. It was sometimes necessary to return for a second session if the respondent became too tired or was absent during the first visit.

Results and discussion

Demography

Demographic aspects of the two areas are summarised in Table III.

The male/female ratio was lower (1:1,1) in Langa than in Khayelitsha (1:1,4).

There were nearly twice as many subjects in the age range 80 - 89 years in Langa as in Khayelitsha. More Khayelitsha residents (98%) than Langa residents (64%) had been born in rural areas. Education standards were also lower in Khayelitsha than in Langa.

Personal health

Self-perceived health status is shown in Table IV. There are small differences between men and women in most variables assessed. These are not statistically significant.

TABLE III. DEMOGRAPHY

	Langa		Khayelitsha	
	No.	%	No.	%
Gender				
Male	94	48,2	71	41,8
Female	101	51,8	99	58,2
Total	195	100,0	170	100,0
Age (yrs)				
59 - 69	113	58,0	102	60,0
70 - 79	71	36,4	63	37,1
80 - 89	11	5,6	5	2,9
Total	195	100,0	170	100,0
Language use				
Xhosa	187	95,9	164	96,5
English	79	40,5	36	21,2
Afrikaans	36	18,5	38	22,4
Other	8	4,1	6	3,5
Birthplace				
Rural	124	63,6	166	97,7
Urban	71	36,4	4	2,3
Total	195	100,0	170	100,0
First came to Cape Town				
< 1 yr	3	1,5	30	17,7
1 - 10 yrs	8	4,2	40	23,5
> 10 yrs	182	94,3	100	58,8
Total	193	100,0	170	100,0
How long living in Langa/Khayelitsha				
< 1 yr	3	1,6	76	44,7
1 - 10 yrs	18	9,3	92	54,1
> 10 yrs	173	89,1	2	1,2
Total	194	100,0	170	100,0
Schooling				
None	33	16,9	83	48,8
Primary	112	57,4	80	47,1
Higher	50	25,6	7	4,1
Total	195	100,0	170	100,0

TABLE IV. PERCEIVED IDEA OF PERSONAL HEALTH

	Langa		Khayelitsha	
	No.	%	No.	%
Good	69	35,4	18	10,6
Variable	116	59,5	78	45,9
Poor	7	3,6	73	42,9
Bedridden	3	1,5	1	0,6
Total	195	100,0	170	100,0
Admission to hospital in last 2 years	58	29,7	37	21,8
Someone to help after discharge from hospital	57	98,3	34	91,9

Only 11% of elderly Khayelitsha respondents described their health as good, and 43% said that they were in poor health, yet only 49% made use of available health services (clinics) (Table V). Eighty-three per cent had knowledge of their existence of the clinics and only 10% had transport problems (Table VI).

TABLE V. UTILISATION OF SERVICES IN THE LAST 2 YEARS

	Langa		Khayelitsha	
	No.	%	No.	%
Doctor	96	49,2	81	47,4
Clinic	99	50,8	83	48,8
Social worker	3	1,5	35	20,6
Dentist	2	1,0	17	10,0
Traditional healer	10	5,1	15	8,8

TABLE VI. KNOWLEDGE OF AND ACCESS TO SERVICES

	Langa		Khayelitsha	
	No.	%	No.	%
Knowledge of where to find				
Doctor	187	95,9	125	73,5
Clinic	191	98,0	141	82,9
Dentist	154	80,1	72	42,4
Social worker/ service centre	169	86,7	93	54,7
Transport	189	96,9	132	77,7
Traditional healers	168	86,2	54	31,8
Grocery shops	191	98,0	140	82,4
Reporting difficulty in access to services				
Doctor	18	9,2	35	20,6
Clinic	17	8,7	39	22,9
Dentist	15	7,7	12	7,1
Social worker/ service centre	16	8,2	18	10,6
Transport	16	8,2	17	10,0
Traditional healer	14	7,2	5	2,0
Shops	16	8,2	17	10,0

TABLE VII. EMPLOYMENT AND PENSION

	Langa		Khayelitsha	
	No.	%	No.	%
Employed	23	11,8	25	14,7
Pension	146	74,9	81	47,7
Applied for pension	20	10,3	45	26,5
Without job or pension	6	3,0	19	11,1
Total	195	100,0	170	100,0

More Langa residents (30%) than Khayelitsha residents (22%) reported hospital admissions in the previous 2 years (Table IV). In the same table, help to residents after discharge is also shown; in this instance Langa is slightly better off (98%) than Khayelitsha (92%). It would appear that after discharge from hospital to the home, help with household chores is nearly always available. Only 2% of Langa respondents had no one available when help was needed. In Khayelitsha 8% were without such help (Table IV).

Income

Over 74% of the elderly respondents in Langa were receiving a pension, while the figure for Khayelitsha was much lower (48%). Slightly more Khayelitsha respondents (15%) than Langa respondents (12%) were in employment. Nearly four times as many elderly respondents in Khayelitsha were without an income (Table VI).

Services

The questions in this section were phrased as follows: 'Do you know where to find', followed by 'Do you have difficulty in getting to', various services (Table VI). For both these groups of questions transport services (bus, train, taxi) were included in the questionnaire.

The elderly Khayelitsha respondents were less aware of and less able to find services such as social workers/service centres (55%) and dentists (42%). Knowledge of the location of traditional healers (32%) indicates that elderly respondents in Khayelitsha are generally less well informed on these matters than those in Langa (Table VI).

Almost all Langa respondents (98%) knew where to find the local shops (98%), whereas in Khayelitsha 18% did not know this.

Some Khayelitsha respondents had difficulty in getting to a doctor (21%), the clinic (23%), the social worker/service centre (11%), transport (10%) and shops (10%). Langa respondents found it less difficult than Khayelitsha respondents to locate a doctor (10%), but where access to traditional healers was concerned the situation was reversed, difficulty being reported by 2% of Khayelitsha respondents and 7% of those from Langa (Table VI).

In Khayelitsha 21% of the respondents reported using the services of social workers. About 2% of Langa elderly residents reported such use (Table V).

Commonly used aids

The questions were phrased as follows: 'Do you use or require any or more of the following items.' In Langa 18% of respondents wore spectacles, but in Khayelitsha only about 6% did so (Table VIII). False teeth were used by a fairly high proportion of Langa respondents (about 9%) but only by just over 1% in Khayelitsha.

TABLE VIII. MOST COMMONLY USED AIDS

	Langa		Khayelitsha	
	No.	%	No.	%
Spectacles	36	18,5	10	5,9
False teeth	17	8,7	2	1,2
Walking stick	14	7,2	11	6,5

About 7% of respondents in both areas reported using walking sticks. These three aids (spectacles, false teeth and walking stick) seem to be those most commonly used by the elderly respondents of both townships.

Place of residence

Respondents were asked how many of these children were alive, the extent of contact with the children, and where the respondent lived now. Very few elderly people in Khayelitsha lived alone (3%), although in Langa 10% did so (Table IX).

TABLE IX. PLACE OF RESIDENCE

	Langa		Khayelitsha	
	No.	%	No.	%
Live alone	19	9,7	5	2,9
Males	14	14,9	2	2,8
Females	5	5,0	3	3,0
Live with family/ friends	169	86,7	164	96,5
Live in own home	6	3,1	0	0
Board and old-age home	1	0,5	1	0,6
Total	195	100,0	170	100,0

Discussion

Overall trends

In general it appears that the elderly are fairly well catered for as far as most services are concerned.

The relative lack of awareness of available essential services amongst elderly women in Khayelitsha can probably be accounted for by the fact that 98% of them have lived there for less than 4 years. Although their knowledge of the health and social services seems to be good, few actually used these services. About half of the elderly respondents in both townships reported using doctor and clinic services (Table V).

Although family and friends appear most helpful and supportive of the elderly residents of both Langa and Khayelitsha, and most residents of both communities know the location of essential services, there appears to be some problem concerning transport services, particularly among elderly women in Khayelitsha. Difficulty in access to transport could account for failure to use this service, but this is doubtful, bearing in mind the explosive development of the fast, comfortable and relatively cheap black mini-taxi service — poverty is probably the main problem. This observation was also reported by Wicht *et al.*⁵

As far as the use of aids is concerned, it is known that among the aged use of false teeth is both erratic and low, particularly if some time has elapsed since extraction of the teeth.⁶ We are aware of the excellent mobile dental units that visit the Khayelitsha area regularly.

Among the Khayelitsha respondents 10% use dental services. Slightly more Khayelitsha respondents (9%) Langa residents (5%) use traditional healers (Table V). Khayelitsha respondents used social worker services much more than the Langa residents, which is to be expected, because Khayelitsha is still a recently established town in comparison with Langa.

The social support system is a very important factor in lower socio-economic communities in the cities. This was borne out by Chinkanda¹ in his study, where 'all the needs of the aged [black] — economic, social or biological' were met within the extended family. In describing one of the most deprived areas of New York City, Marjorie Cantor⁸ identified about 7% of elderly poor as living alone; in Langa (Table IX) twice as many elderly respondents lived alone, but they were not necessarily lacking in social support. When discharged from hospital, for example, help was made available to most of the Langa elderly (98%) (Table IV). A study done by E. M. P. Wolff and E. Sophangisa in Langa and Guguletu (unpublished, 1979) found that 88% of the males and 83,9% of the females surveyed were completely independent in attending to their own needs. This help in all probability came mostly from friends.

In the Wolff⁹ study, only 1% of elderly coloured and white respondents said that they had experienced problems in obtaining medical services after discharge from Groote Schuur

Hospital. The percentage in the present study is much higher, and since we are dealing with another population group (black) the reason for this needs further investigation.

In the unpublished study by Wolff and Sophangisa, 54% and 69,8% of elderly black males and females respectively in Langa and Guguletu consulted a medical facility. A decline seems to have taken place 10 years later, as the present study indicates, possibly owing to an improvement in general health, services or other factors.

However, in planning for services for the black aged, not just present problems but also those of the future must be considered. By the year 2020 blacks will cease to be described as a young population, with some 5% of this group being 65 years and older.

Owing to the already overcrowded conditions and the prevailing economic problems, and with very little hope of immediate major improvement, families and friends will find it increasingly difficult to provide for the needs of their old folk, in particular their frail aged. It is therefore important that provision in the form of institutional and community care facilities (outpatient treatment and home visiting by community health workers) must be made available.

The number of old-age homes for blacks is completely inadequate (at present catering for only 0,05% of the elderly black population); 5% of any elderly population can be expected to need accommodation in homes for the aged, and by 2030 the number of frail aged black people needing institutional care has been projected as 188 655.¹ If each home houses 100 persons, 1 886 homes country-wide would be needed. During the next 40 years it would therefore be necessary to erect about 45 old-age homes per year, i.e. a new home every 8 days.¹⁰ In the interim, as an urgent priority, existing homes will have to be extended and adapted, while community services should be improved and expanded.

Conclusions and recommendations

Health and nutrition

The elderly have a right to health care services which will enable them to maintain and regain their maximum functional capacity.

Improving the health of the elderly will help reduce their admission to hospitals and their consumption of medicines and other health products; this is undoubtedly the most cost-effective way of reducing health care spending.

In Langa use of the health services by the elderly is more in line with their perceived ideas of the state of their health. However, there is a definite need for a community health nurse or worker to identify the people in need of health care and to assist them in obtaining this care.

Housing and the environment

Housing has a great influence on quality of life, and suitable housing for the elderly is important. Here again, apart from the very frail aged, elderly people should remain part of the community, and it is important to perceive the concept of the extended family, since it provides not only the biological needs of the elderly but also their social, financial and emotional needs. The traditional values, which are so important in keeping peace and order in a community, can then be preserved.

Although new houses are being built every day, particular emphasis should be on extra rooms to house elderly parents. Overcrowding is a major problem today and will get worse in future as the population increases. Old-age homes for the very frail aged (at least 2% of the elderly population) should be built to accommodate those people who are in need of constant care.

Income security

Income security for the majority of black people depends primarily on the availability of pensions, state or private. This is the single most important aspect that affects most of the old people today.

There is a limit beyond which the resources of the families in these areas cannot be stretched, and the 'unrealistic expectations' of increased responsibility that we in the health service have of them must be re-evaluated. The present welfare pension will have to continue, keep pace with inflation, and even increase relative to inflation in order to ensure a minimum dignified subsistence level for all those who qualify.

Elderly people who qualify for financial support must be identified so that a social pension can be applied for timeously, to enable waiting periods to be as short as possible or even eliminated. An active search for elderly people without pensions or incomes should be part of the services rendered by the social workers.

Education and training

We are dealing here with people with a very low level of education, and some form of informal community-based and recreation orientation programmes for the aged should be instigated to help them develop a sense of self-reliance and community responsibility.

In order for future generations of elderly people to be better prepared for their later years, the general public, starting at an early age, needs to be educated about the process of ageing. Appropriate opportunities should be provided for older people, for instance job training and retraining. Learning opportunities should be available to meet their needs and interest.

Transportation

The elderly need access to transportation to enable them to participate fully in community life and to obtain needed services and goods. Adequate public transport is available in both areas, but again the problem of finances crops up.

Research

Ongoing interdisciplinary co-ordinated research on the specific but changing needs of the aged should be undertaken, in order to assist with planning and determining policy on a

national scale. Health and social services should be made more accessible by bringing the services to the people and thereby reducing their travelling costs. Improving their health may well reduce admissions to hospitals, cutting consumption of medicine and other health resources. We suggest further support to aged service centres and community health workers.

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