PREVENTIVE SELF-CARE IN THREE FREE STATE COMMUNITIES

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Abstract

There has been increasing interest in self-care as a potential role-player in health care provision. Existing knowledge about self-care however, is regarded as insufficient, and such knowledge is especially relevant when governments plan to support self-care development programmes. A survey on self-care among whites, blacks and coloureds in the Free State also focused on preventive self-care, and large differences were found between the three groups. Due to several factors, a uniform self-care development programme for all population groups in South Africa, will not be viable.

Opsomming

Daar is toenemende belangstelling in die moontlike rol wat selfsorg in gesondheidsorgvoorsiening kan speel. Bestaande kennis oor selfsorg word egter as ontoereikend beskou, terwyl sodanige kennis juis noodsaaklik is indien regerings selfsorgontwikkeling steun. In 'n opname oor selfsorg onder wittes, swartes en kleurlinge in die Vrystaat, wat deels op voorkomende selfsorg gefokus het, is groot verskille tussen die drie groepe gevind. Die lewensvatbaarheid van 'n eenvormige selfsorgontwikkelingsprogram vir alle bevolkingsgroepe van Suid-Afrika, word deur verskeie faktore geïnhibeer.

Since the mid 1970's the professional health sector began to relinquish its traditional opposition to self-care, due to the realization that self-care in fact may benefit formal health care services. These changes in sentiment were due mainly to two factors:

(a) The dramatic increase in chronic-degenerative diseases with a concomitant decrease in acute-infective conditions. This implied a shift from "cure" to "care" and a much greater extent of patient participation (Dean 1981:673; Levin 1977:116; Pratt 1973:27; Segall & Goldstein 1989:154; Williamson & Danaher 1978:20).

(b) The cost crisis experienced by all formal health care systems. On the side of the consumer, costs may be curtailed by reducing both the demand and the need for professional health care. Seemingly, the demand for care may be scaled down by increasing the financial costs to the consumer (Abel-Smith 1980:26; Maynard 1986:1164) and by developing the self-care skills of patients (Levin et al. 1977:26; Williamson & Danaher 1978:73). The need for care may be reduced by creating "healthier" populations - in this self-care in the form of prevention, health maintenance and healthier life styles may also play a role (Levin et al. 1977:31; Mechanic 1975:242).

Outside the professional and policy sector, dissatisfaction with various characteristics of the professional care system focused additional attention on self-care as a potential contributor in health care. Criticism of formal health care centered on the following:-

* Limited effectiveness and appropriateness of formal care, especially due to its clinical/biomedical orientation. Care furthermore tends to be fragmentary and episodic, rather than comprehensive and continuous (Dean 1986:275; Juffermans 1983:225; Katz & Levin 1980:330; Levin 1976:70).

* The inadequate or differential availability of official care, both in geographic and socio-economic terms (Levin et al. 1977:23; Van der Geest 1987:294).

* The potentially harmful side-effects associated with the professional care-giving process, e.g. unnecessary surgery, over-prescribing of drugs, maximum intervention and the medicalization of society (Juffermans 1983:224; Levin 1977:117; Pratt 1973:23).

* Depersonalization of the patient, overspecialization and technological bias (Field 1980:402; Griffiths & Bankowski 1980:61).

These negative experiences with the formal health care system contributed to a loss of confidence in professional care and a search for alternatives. "The self-care, self-help movements work for less arcane, more humane, less technical and specialized, more decentralized and accountable approaches to medical care delivery" (Katz & Levin, 1980:329). Additionally, the appeal for more self-care has been assisted by rising educational levels among the general population and the increasing availablity of health and self-care information (Levin et al. 1977:22; Pratt 1973:26; Quah 1977:23; Van Wanseele & Branckaerts 1982:19).

With renewed interest in self-care, efforts were made to provide relevant findings for South Africa on the extent of self-care practices. Despite studies already published, existing knowledge of self-care is regarded still as fragmentary and unsatisfactory and particularly so in South Africa.

It is emphasized that a descriptive date base on self-care is required (Dean 1981:686). Such a data base is above all essential when governments have made policy decisions regarding the promotion of self-care. This is the case in South Africa, as evidenced by the pronouncement of the Minister of Health and Population Development on 14 May 1990: "The health service should be preventive and promotive and stimulate self-care in the community, which has to take responsibility for its own health." As part of a broader project of the HSRC on affordable social security, a study was consequently undertaken during 1989 to establish the nature and extent of existing self-care patterns in three Free State communities (Van Zyl-Schalekamp 1990). (The complete research report on self-care is available from the HSRC).

SUBJECTS AND METHODS

A questionnaire was designed and administered to three multi-phase random cluster samples of respondents: (1) 149 white households in Bloemfontein; (2) 150 black households in Mangaung (the black township adjacent to Bloemfontein); and (3) 137 coloured households in Heidedal (the coloured township adjacent to Bloemfontein). A total of 45 interviewers, mostly students, were recruited to

conduct interviews in their own communities. Interviews had to be conducted with "the woman of the house". The questionnaire covered the following aspects: (1) socio-demographic particulars of respondents (e.g. age, level of education); (2) other correlates of self-care, such as health knowledge; (3) the differential availability and accessibility of professional health care; (4) the perceived health status of the respondent and her (nuclear) family; and (5) the nature and extent of different self-care modalities, e.g. preventive care and self-medication. In addition, in-depth interviews were conducted with black and coloured community leaders in order to gain feedback on some of the survey findings. This was considered necessary as the researcher, being white herself, lacked in-depth knowledge of black and coloured communities and wished to avoid unwarranted conclusions.

FINDINGS

The different forms of prevention/health maintenance studied, were (1) the most important activities undertaken by respondents to protect their health; (2) regular physical, dental and cervical (Papanicolaou) examinations: (3) the inclusion or avoidance of certain types of food in the diet; (4) immunization and (5) exercise.

1. Health protective activities

In response to the question about the most important action that respondents take to protect their health, a healthy diet was emphasized by all three groups, while sufficient rest was stressed expecially by the coloured respondents as shown in Table 1.

The category healthy/clean living included responses such as the following: fresh air, warm clothes and hygiene.

Incidentally, the black group reported the highest extent of medicine use during the two weeks preceding the interview, which is confirmed by their "consult/medicate" response in this instance.

Table 1
Most Important Health Protective Activity for whites, blacks and coloureds, in percentages

	White (149)	Black (150)	Coloured (137)
Healthy diet	53,0	24,7	32,1
Healthy/ clean living	12,1	17,4	10,2
Consult/ medicate	2,0	20,6	13,1
Exercise	13,4	8,7	13,9
Sufficient rest	12,8	8,0	21,9
Work	2,7	5,3	4,4
Nothing	4,0	15,3	4,4
TOTAL	100,0	100,0	100,0

TABLE 2
Routine Medical and Dental Examinations and Cervical (PAP) smears for whites, blacks and coloureds, in percentages

	White	Black	Coloured
Regular Physical Examination			
All family members	23,5	15,3	42,3
Some members	20,8	18,0	14,6
Uncertain	1,3	5,4	4,4
No regular physical examination	54,4	61,3	38,7
	100,0	100,0	100,0
	(N=148)	(N=149)	(N=136)
Regular Dental Examination			
All family members	67,8	7,3	32,8
Some members	11,4	3,9	27,7
Not applicable	3,4	0,0	2,3
No regular dental examination	17,4	88,8	37,2
	100,0	100,0	100,0
	(N=144)	(N=149)	(N=134)
Cervical Smear			
Semi-/annually	67,5	10,4	46,9
Every 2-5 years	12,7	0,0	3,6
Seldom	13,5	11,4	10,8
Never	6,3	8,3	28,8
Ignorant	0,0	69,8	9,9
	100,0	99,9	100,0
	(N=126)[1]	(N=96)[1]	(N=111)[1]

[1] Only the responses of females under 55 years of age were taken into consideration.

2. Regular physical, dental and cervical (Pap) examinations

The responses regarding routine medical, dental and cervical examinations are presented in Table 2.

Quite a big proportion of the coloured respondents reported undergoing regular physical examinations, due to the widespread availability of clinic and school clinic facilities in the coloured residential area. Relative to population size the coloured population is better served by clinics than blacks and this was commented on during the in-depth interviews. Both in the black and white groups regular physical examinations were found to be associated with perceived poor family health, and in the black group a high family income was found to be positively associated with regular physical examinations.

The biggest extent of regular dental examinations was reported by the white respondents. In all three groups regular dental checks were associated with high levels of education and health knowledge, as well as with high family income and the availability of medical insurance. The differential availability of medical insurance was marked by the fact that 95% of the white, 27% of the coloured but only 12% of the black respondents claimed to have medical insurance.

The extent of reported regular cervical (Pap) tests was distressingly low, especially among the black respondents. Two remarks regarding this are pertinent:- (1) Due to the sensitivity of the topic and cultural taboos, black women may have been unwilling to discuss this subject with young, generally male interviewers; (2) During the in-depth interviews it was alleged that cervical smears are mostly carried out on females who visit family planning clinics and often only on those women who use IUDs. In both the white and black groups, regular Pap tests were strongly associated with a high level

of education, and in the coloured group with a high family income.

3. The inclusion or avoidance of certain types of food in the diet.

The highest extent of food inclusion as well as food avoidance was reported by the white respondents; 75,8% of those respondents indicated that they tried to include specific foods in the diet, especially vegetables, protein and fibrous food. The most important motivation given was the perceived need for a healthy or balanced diet. Efforts at specific food inclusion occurred especially among those with higher levels of education and health knowledge, and with the lowest frequency among the youngest and oldest age groups. Food avoidance, especially of foods containing cholesterol, fat or oil, was reported by 43,6% of the white respondents, largely due to health concerns. Apart from high education and good health knowledge, food avoidance in this group was also associated with high perceived family morbidity.

[illegible] percent of the black respondents reported efforts at specific food inclusion, mainly vegetables and protein, for purposes of a healthy or balanced diet. In both the black and coloured groups, food inclusion was associated with high levels of education and health knowledge, but showed a decrease with increasing age. About a third of respondents in the black group indicated avoidance of certain foods in the family diet; oily or fatty foods, owing to health considerations, and pork, due to religious convictions were avoided. Personal distaste and allergies also were advanced as reasons for food avoidance. As in the white group, food avoidance in the black group was associated with high levels of education and health knowledge and perceived high family morbidity.

The coloured group presented the lowest levels of both specific food inclusion (44,5%) and avoidance (20,4%) and followed the same patterns as in the black group.

4. Immunization

Questions about immunization against poliomyelitis, diphtheria, whooping cough, tetanus, measles and tuberculosis produced disturbing figures for the black population. Table 3 presents the responses received regarding some components of immunisation.

The respondents in the in-depth interview attributed the low reported immunization figures in the black community to an earlier resistance to immunization. In addition, large-scale immunization campaigns are a fairly recent phenomenon, which implies that older people often have not been reached. The high incidence of tuberculosis among blacks has probably provided for a better immunization coverage for this condition. Among the black respondents a high "do not know" response was encountered, which is in itself significant. No associations were found between variables such as education, income or immunization in any of the three groups.

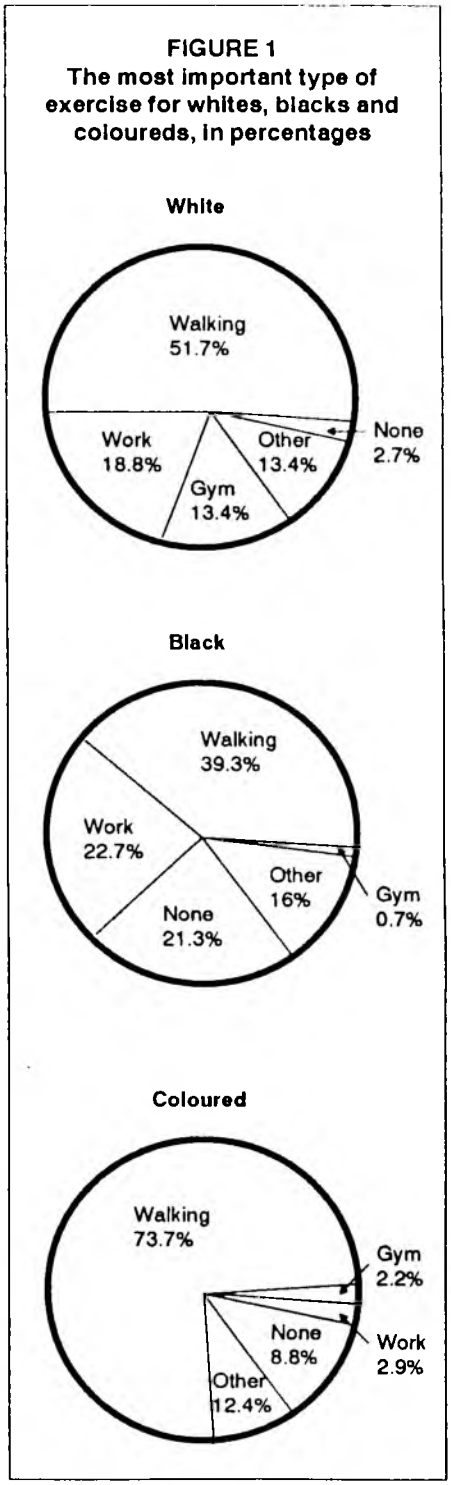
5. Exercise

The three groups differed regarding the most common types of exercise reported as shown in Figure 1. The whites clearly can avail themselves of more varied types of exercise, while the black group performs more physical labour than do members of the other two groups.

TABLE 3
Immunization against Polio, Diphtheria, Whooping Cough and Tuberculosis for whites, blacks and coloureds, in percentages

	White (149)	Black (150)	Coloured (137)
Polio			
[illegible]amily members	94,0	37,3	84,7
Did not know	2,7	15,3	5,1
Diphtheria			
All family members	91,3	21,3	81,8
Did not know	2,7	25,3	7,3
Whooping Cough			
All family members	88,6	24,0	80,3
Did not know	4,0	16,0	8,0
Tuberculosis			
All family members	85,9	41,3	83,9
Did not know	2,7	2,7	5,8

FIGURE 1
The most important type of exercise for whites, blacks and coloureds, in percentages



DISCUSSION

Any effort towards self-care development must take cognisance of South Africa's population composition. Different ethnic groups often are characterized by distinctive cultural values and beliefs, which are among other things, reflected in their health and illness behaviour. The perception and definition of health and illness, disease explanations and acceptable forms of care therefore are influenced by group traditions, religious convictions, family organization, childrearing patterns, etc. (Litman 1974:504; Quah 1985:353; Suchman 1964:319).

In comparison with the whites and urban coloureds in South Africa who have a bio-medical approach to health and disease, the black group, to a large extent, has an unique view of health, which is seen as expression of a cosmic equilibrium; serious illness may be ascribed to an imbalance of cosmic powers (Manganyi 1974:922). Regarding disease causation, black South Africans distinguish between diseases with natural or clear causes, and diseases which can only be explained by magic (Murdock 1980:8; Pretorius 1990:104; Read 1966:24). The particular theory of disease causation determines its treatment - by implication this includes self-care activities, both preventive and therapeutic. The differences in the preventive self-care practices of the three groups identified in this study obviously can not be only ascribed to cultural differences, but it will be short-sighted to neglect cultural factors in efforts to develop self-care skills.

Furthermore, a uniform self-care development programme for all groups will not be viable, due to differences regarding educational, income, health knowledge and morbidity levels, morbidity patterns, and important sources of information regarding health, disease and medicines. Very important too, are the inequalities in the availability and accessibility of formal health care to the different population groups. Not only the contents of self-care development programmes will have to be group-specific, but also the methods of

education. The results of the study show that the mass media would be very effective for the black community, interpersonal sources of information in the coloured community, while medical sources and the mass media are most relevant for the white community. However, care should be taken that differential self-care development programmes do not perpetuate or even enhance current structural inequalities in health care provision.

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