



Social cohesion and self-rated health among adults in South Africa: The moderating role of race



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ABSTRACT

In African countries including South Africa, the nexus between social cohesion and health remains under-researched. Using data from the 2012 South African social attitudes survey with a sample of 1988 adults in South Africa aged 18 years or older, we used the collective efficacy theory by Sampson and colleagues to examine the relationship between social cohesion and self-rated health in an African sample. We also examined how this relationship differed by race. Results from the multivariate analysis after adjusting for covariates suggested that adults in the highest tertile of social cohesion were more likely to report moderate or good health compared to those in the lowest tertile. Sub-group analysis provided no evidence that the relationship was moderated by race. These findings corroborate prior evidence that social cohesion is important for improving the health of adults.

1. Introduction

South Africa (RSA) confronts a relentless burden of infectious and non-infectious diseases. Coupled with these are high levels of HIV, injuries, maternal and child health issues (WHO, 2010; Norman et al., 2006). Although life expectancy has increased from 52 years in 2005–61 years, the health status is poor compared with other middle-income countries (Benatar, 2013). Persisting social disparities and inadequate resources to provide for the growing population are known to be a contributing factor (Mayosi et al., 2012; Whiteside and Sunter, 2000).

An appropriate response to the South Africa healthcare challenges is perceived to be by addressing the social determinants of health (SDH) which lie outside of the health system while also strengthening the health care system and facilitating the universal coverage for (Krech, 2011).

Social cohesion which in various operationalizations encompasses trust, social support, tolerance and quality and quantity of social connections is becoming one of the neighbourhood attributes that are becoming relevant internationally (Gilbert et al., 2013; Kawachi et al., 1997; Pearce and Davey, 2003). Research has also shown that how one perceives their local environment regarding neighbourhood quality may be substantial for health (Sooman and Macintyre, 1995). It has also been documented in previous studies that cohesive neighbour-

hoods are likely to foster healthy lifestyle behaviours such as safe public spaces for activity, clean and safe housing, and availability of nutritional foods (Rios et al., 2011). It may also be beneficial for self-rated physical and mental health as it is likely to foster a sense of community, which is considered to be an affective component of social cohesion (Rios et al., 2011).

However, South Africa in recent times has shown evidence of weak social cohesion in terms of high racial and gender discrimination, vast income inequalities, extreme violence, and criminal victimisation (Coovadia et al., 2009; National Planning Commission, 2012). For instance, the most recent estimate of South Africa's Gini coefficient of income inequality is 63.4, which is about the highest in the world (World Bank, 2011). There are also issues of declining public confidence in South Africa political institutions coupled with low levels of interpersonal trust, xenophobic attacks on migrants and the straining of community safety (Presidency, 2008).

While major efforts have been made by researchers in developed countries to examine the connection between social cohesion and health, African researchers has been silent over years in part because of the unavailability of data from which to measure social cohesion (Gordeev and Egan, 2015; Macintyre and Ellaway, 2000; Mair et al., 2009; Martin et al., 2010; Mulvaney-Day et al., 2007; Rios et al., 2011; Robinette et al., 2013).

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However, more scholarship is needed to better illuminate the relationship between social cohesion and health, particularly in an African sample. To the best of our knowledge, the only available evidence on the relationship between social cohesion and health in Africa including South Africa has been restricted to older adults aged 50 years or older (Peltzer, 2012; Peltzer and Phaswana-Mafuya, 2013). Moreover, the construct of social cohesion used in these studies measured participation in social activities which closely approximates social capital than social cohesion and are likely to have not taken place within the neighbourhood leading to the possibility of bias.

1.1. Moderating role of race

South Africa has a historical legacy of deeply entrenched racial discrimination resulting from apartheid policies and has persisted to date (Franchi and Swart, 2003; James and Lever, 2000). Yawning divides in resource allocation characterised by inadequate water supply and sanitation in black African communities were notable features of the apartheid era (Walker et al., 2004; Whiteside and Sunter, 2000). Hospitals and clinics in the African communities during this era were also under-resourced, and understaffed unlike white communities (Walker et al., 2004).

Yet more than two decades after democracy (post-apartheid), the country is still grappling with massive racial health inequalities evidenced in marked differences in rates of disease and mortality among South African racial groups (Burgard, 2002; Moller, 1998). For example, after adjusting for demographics and other socio-economic characteristics, a study found that black Africans reported higher levels of ill health and psychological distress than Whites (Williams et al., 2008). National prevalence estimates for HIV have also shown that white and Indians have a very low prevalence of the disease compared to black Africans (Shisana et al., 2005). In 2002, infant mortality rates varied between 7 per 1000 among whites compared to 67 per 1000 among black Africans. Life expectancy was also about 50% higher for white adult women compared to black African women (Bradshaw and Nannan, 2004).

South African researchers have long described the multiple ways in which the deeply unequal allocation of material and socio-political privileges based on race could have pervasive adverse consequences on the health of Black adults (Williams et al., 2008). One of the most common reasons cited has been challenges in accessing quality healthcare services. For instance, some studies have shown that black Africans experience the greatest barrier to quality health care services as a result of unaffordability and other reasons (Harris et al., 2011; Myburgh et al., 2005; Omotoso and Koch, 2017). About 15% of the population has access to private healthcare while the remainder, majority of whom are blacks depend on the already overstretched public health system (Ijumba et al., 2003). Black Africans' coverage for medical aid in accessing private health facilities were also about 50% lower than those of whites (Omotoso and Koch, 2017).

1.2. Our study

We used the collective efficacy theory by Sampson and colleagues to assess the association between social cohesion and health status of adults in South Africa. The collective efficacy theory highlights the impact of neighbourhood structural factors in the form of social cohesion and informal social control on resident's quality of life and health status (Sampson et al., 1999, 1997). It argues that collective efficacy contributes to the ability of communities to regulate their members according to desired principles (Sampson et al., 1997). In line with this theory, we hypothesise that the social cohesion dimension of collective efficacy may predict the health status of adults in South Africa. The mechanisms through which this may contribute to health include the social control of health-related behaviours, access to health care services and amenities, the management of neighbourhood

physical hazards, and psychosocial processes all of which may generate a protective effect for health (Kawachi and Berkman, 2000).

Given the disadvantages that racial inequalities pose for improvements in the health of adults and the potential benefit of social cohesion, we also examine how race interact with social cohesion to affect the health of adults in South Africa. We suspect that social cohesion could serve as a buffer among black Africans adults such that they could improve their health by residing in highly cohesive neighbourhoods characterised by trust, sense of belonging and shared values. An awareness of this relationship may contribute towards addressing a crucial social determinant of health while also increasing the possibility of achieving the country's health goals particularly the sustainable development goal 3. Achieving this goal would imply that by 2030, South Africa would have been able to improve the overall health of all persons in the country.

2. Data and methods

2.1. Data source

We used data from the 2012 South African Social Attitudes Survey (SASAS), questionnaire 3, version 3 implemented annually by the Human Sciences Research Council. The SASAS dataset is a nationally representative sample of individuals aged 16 years and older in South Africa irrespective of their nationality or citizenship in households geographically spread across the nine provinces of the country (Roberts and Struwig, 2012). This survey used a multi-stage sampling technique encompassing proportional to size sampling (first stage), a simple random selection of individual dwelling units (second stage). In the final stage, interviewers visited each visiting point drawn in the EA (PSU) and listed all eligible persons for inclusion in the sample, that is, aged 16 years or over and resident at the selected visiting point. A random sampling of 16 years and older in the drawn dwelling units based on a Kish grid (Roberts and Struwig, 2012). The dataset contains a standard 'core' set of demographic, behavioural and attitudinal variables, which are repeated each round, with the aim of monitoring change and continuity in a variety of social, economic and political values (Roberts and Struwig, 2012). Details of the sampling procedure and design are published elsewhere (Roberts and Struwig, 2012).

2.2. Study population and sample

The population of interest for this study are adults aged 18 years or older in the nine provinces of South Africa and are usual residents in the selected households. The sample for this study was a weighted distribution of 27,239,194 (1988 unweighted) adults who are 18 years or older at the time of the survey. The mean age of adults in this study is about 37.6 years (Table 1). More than half of the sample are females (54%) and the majority are black Africans (75%) while whites and coloureds each constitute about one-tenth of the population. The majority of the adults (57%) were also never married and close to one-tenth were formerly married. Almost three-quarter of the adults had attained the secondary level education while about 14% had less than secondary education. Only about one-third of the adults are currently employed while another 28% reported to have never been employed. About 45% also reported that their family is rich while only 21% are residing in poor households. The average number of years spent in the neighbourhood among the adults is 17.7 years while almost two-thirds of the adults feel unsafe in the same neighbourhood. Only about one-third of the adults are residing in the rural place of residence, and about 85% are affiliated with a religious group. The majority of the adults also reported having never been a member of trade union groups while about one-tenth are current members.

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