



Correlates of Life Expectancy and HIV/AIDS in South Africa

Abstract

The aim of this paper is to estimate years of sexually active life for older men and women, and examine the association between sexual activity and self-rated health status. Data came from two large scales cross sectional HIV Household Surveys conducted in 2005 and 2012 in South Africa. The main outcomes were sexually active old population life expectancy and sexual activity. The factors of interest were self-rated health and gender. The statistical method was used to estimate sexually active life expectancy, whilst logistic regression was used to assess associations with sexual activity. Wider gender gaps in trends were observed in proportions of remaining life spent sexually active. Self-rated health was significantly associated with sexual activity in men (adjusted odds ratio 1.56; 95% confidence interval 1.11-2.19; $p < 0.001$). HIV infection, moderate exercises were significantly associated with sexual activity among women, whilst presence of chronic conditions was associated with reduced sexual activity among men. HIV among women and chronic conditions among men are areas of intervention to improve sexual activity in old people.

Key words: sexual activity, sexually active life expectancy, older people, South Africa

Introduction

The sexuality of older people is generally neglected [1]. Little is known about the sexual activity of older people, especially in African context where social norms are conservative. Further, data on different sexuality measures including HIV prevalence, which are collected in major surveys such as the Demographic and Health Surveys (DHS) are typically collected only for individuals who are within the reproductive age group i.e. from 15 to 49 years [2]. It is seemingly assumed that people cease to be sexually active or have sexual desires once they go beyond 50 or 60 years of age. However, evidence from five cohorts in South Africa, Uganda, and Zimbabwe revealed that most men and fewer women remained sexually active in their 50s and 60s [3]. Elsewhere, data from the US national social life, health and aging project (NSHAP) also showed that many older men and women were still sexually active even in their 80s [4].

Sexual activity in old age is affected by age-related physiological and psychosocial factors which might alter sexual function [5]. Some of these factors have their antecedents in younger and middle ages, where measures can be taken to prevent or delay onset of sexual dysfunction in the older ages. It is important therefore to study sexual health since it is an important component of overall health and quality of life [6]. As life expectancy increases and older populations grow in developing countries, projecting years of sexual activity is important in informing public health policy and programmes aimed at improving sexual health of older people. Studies have also shown that people are actually growing older with HIV as a result of successful rollout of treatment efforts [7]. Whilst this is welcome news, the paucity of information on sexuality of the older people is worrisome in this context of aging with HIV. Intergenerational sex and age-disparate relationships can be cited as examples of behavioural risks factors involving older people. Therefore, getting an idea of how long older people will be expected to be sexually active is crucial in designing informed prevention programmes targeting various risky behaviours. Further, at an individual level, knowledge of sexual life expectancy can motivate individuals to adopt healthy life styles e.g. healthy diet and regular exercises that can prolong sexually active lifespan.

The objective of this paper is twofold, firstly to estimate sexually active life expectancy, which is the average number of remaining years for an individual to be sexually active. The paper will also examine the association between sexual activity and self-rated health status.

Materials and Methods

The study is based on secondary analysis of the 2005 and 2012 South African National HIV Incidence, Prevalence, Behaviour and Communication Survey (SABSSM) surveys conducted in South Africa by the Human Sciences Research Council. Both surveys targeted all persons above two years of age and residing in community dwellings. The sampling frame for the survey was based on a master sample consisting of 1 000 census enumerator areas (EA) and 15 households were randomly selected per EA. The selection of EAs was stratified by province and locality type (formal urban settlements, informal/ unplanned urban settlements, formal rural settlements, and tribal authority areas) and race (in urban localities). The survey excluded institutionalized individuals (including those in educational institutions, military barracks, old-age homes, or hospitals), and hence were excluded from the study. The surveys include a multistage cluster sample stratified by province, settlement geography (geotype), with the predominant population group in each area used. Further details about the sampling procedures are explained elsewhere 2005 [8] and 2012 [9]. The main sample used in this analysis included the ages 50 years and older. The household response rates were; 84.1 per cent (2005) [8] and 87.2 per cent (2012) [9]. The individual response rates were; 96.0 per cent (2005) [8] and 89.1 per cent (2012) [9]. In both surveys, socio-demographic and behavioural information was collected with participant's consent through face-to-face questionnaires administered by trained fieldworkers.

Sexually active

Sexual activity was assessed by responses to the question asked "Have you had sex during the past 12 months", which was asked with same wording in both surveys. Individuals responding in the affirmative were considered to be "sexually active". This follows other studies [10].



Self-rated health

Self-rated health which was assessed from the question “*In general, would you say that your health is excellent, good, fair or poor?*” The same wording of the question was used in both the 2005 and 2012 surveys. A binary variable was created by categorising; excellent and good as ‘good health’ and fair and poor as ‘poor health’.

Chronic conditions

In the SABSSM surveys a general question was asked on the presence of any chronic condition; “*Do you have any chronic medical condition that is affecting what you do or how you feel?*” This assessment is based on self-reports, and respondents who answered ‘Yes’ were considered to be having a chronic condition.

HIV status

Dried blood spot (DBS) specimens for HIV testing were collected from each participant who assented or consented using finger prick. Samples were tested for HIV using an enzyme immunoassay (EIA) and samples which tested positive were retested using a second EIA. A third EIA was used for any samples with discordant results on the first two EIAs.

Exercises

Two questions were asked to assess whether the respondent did any form of exercises. The first question was; “*Do you do any vigorous intensity sport, fitness or recreational activities in your leisure or spare time, that cause large increases in breathing or heart rate (like running or strenuous sports, weightlifting) for three times a week at least 30 minutes at a time?*” And the second question was – “*Do you do any moderate-intensity sport, fitness or recreational activities in your leisure or spare time that cause small increases in breathing and heart rate (like brisk walking, cycling or swimming) for three times a week at least 30 minutes at a time?*”

Statistical tools

Sexually active life expectancy was used to estimate the average number of years remaining sexually active. This is a new concept recently introduced by Lindau and GavriloVA [10]. It is an extension of healthy expectancy indicators which have become important measures of summarising population health. The Sullivan method [11] was used to calculate the sexually active life expectancies. This method utilises age-specific prevalence on sexual activity to partition the number of person-years into years with and without sexual activity. The prevalence data was obtained from the 2005 and 2012 national HIV household surveys mentioned above. The purpose of using the two surveys was to establish the trend of sexual activity over time. Life expectancy estimates were obtained from UN Life Tables [12] for 2005–2010 and 2010–2015, i.e. for the corresponding 2005 and 2012 surveys. Standard errors and confidence intervals were calculated from the formulae suggested by the International Network on Health Expectancy [13].

Multiple logistic regression was used to model the likelihood of being sexually active. The main variable of interest was self-rated health which was assessed from the question “*In general, would you say that your health is excellent, good, fair or poor?*” The same wording of the question was used in both the 2005 and 2012 surveys. A binary variable was created by categorising; excellent and good as ‘good health’ and fair and poor as ‘poor health’. Covariates included; age, marital status, exercises (vigorous or moderate intensity) and chronic medical conditions. The data were analysed using STATA 12 [14], incorporating the complex sampling design of the two surveys by using the ‘svy’ commands in obtaining all estimates. The analysis here was restricted to older people aged 50 years and over. The association between the outcome and exposure variables was assessed by the odds ratios (OR) and 95% confidence intervals (95% CI). All variables statistically significant ($p < 0.05$) in univariate analyses were included in the multivariable models. The models were fitted separately for men and women.

Results

Sample characteristics, self-rated health and sexual activity

Table 1 shows the distribution of the sample of older adults (50 years and above) across socio-demographic and behavioural characteristics. In both surveys, the majority of adults were in the younger age group (50–59 years). The majority were still married, although a significant proportion was widowed. Wide gender differentials existed in widowhood i.e. the proportion of adult women who were widowed was four and three times that of adult men who were widowed in the 2005 and 2012 surveys, respectively. Most of the adults had attained primary education, with more men having matric and tertiary education than women. Almost two thirds of the adults across gender were Africans in both surveys. The prevalence of poor and fair health was higher among women, although not much difference is noted, especially among men between the two surveys. Older men were significantly more likely to be sexually active ($p < 0.001$), although the prevalence of sexual activity slightly dropped from 70 (2005) to 68.9 per cent (2012). On the other hand, the prevalence of sexual activity increased from 28.8 (2005) to 33.8 per cent (2012) among older women.

Factors associated with sexual activity

Sexual activity was strongly associated with good health in older men. The same was found in older women, although the association was not significant in adjusted models. As expected, increasing age was strongly associated with reduced odds of being sexually active for both gender groups. Similarly, older people who were single were less likely to be sexually active. Moderate exercise doubled the odds of sexual activity in older women. Non communicable diseases (NCDs) among men significantly reduced sexual activity, whilst HIV almost reduced sexual activity in older women by half **Table 2**.



Figure 1 and table 1 show men to be having consistently higher sexually active life expectancy in both surveys. A 50 year old man would expect to live a sexually active life for another 12.7 years in 2012, whilst a woman of the same age would only expect half of this duration (7.2 years). Similar gender differences persist up to the older ages although the gap widens further, for example at age 70 the estimates are 3.0 years for men and 1.0 for women. In women, the positive change in sexually active life expectancies across the ages between the years of surveys (2005 and 2012) reflects a gain in more years of sexual activity. The gains were all significant in the exception of the last age group. In men, there were losses in years of sexual activity at ages 50 and 70, although not significant. On the other hand, men in good health at age 80 and above had significant gains in sexually active life in the period 2005-2012. **Figure 2** shows the sexually active life expectancy by health status and gender for 2005 and 2012 respectively. In both surveys, men and women in good health had higher sexually active life expectancy compared to those in poor health. The gap between the curves (good and poor health) appears to be much wider in men, especially from the 2012 survey (**Figure 3**). **Table 3** **Error! Reference source not found.** shows that in 2012 men in good health at age 80 years were projected to gain on average 3 years and women in good health were projected to gain on average 1 year of sexually active life.

Table 3 gives a summary of proportion of remaining years spent as sexually active. This was derived as years of sexual activity as a fraction of total remaining years of life. From the 2012 survey, the proportion in men is actually double that of women (65.7 vs. 29.4 per cent) at age 50. **Figure 3 & 4** shows a very huge gap between men and women across all ages in the proportion of remaining life spent sexually active. However, when comparing the two surveys, it can be seen that the proportion dropped among men, whilst some increases can be seen among women, especially at the oldest ages (**figure 4**). **Figure 5 & 6** shows the gender differences in the proportion of remaining life spent sexually active by health status in 2005 and 2012, respectively. In both surveys, it can be seen that the gap in proportions between good and bad health is wider for men than women. The estimates at the oldest ages are less stable and need to be interpreted with caution due to the smaller sample sizes at these ages.

Discussions

This study was aimed at projecting estimates of sexually active life expectancy, and examining factors associated with sexual activity in older people. The results show that older people are still sexually active, and if anything, they are actually gaining more years of sexual activity over the years. This means that the myth that older people are 'asexual' needs to be dispelled. HIV and AIDS prevention, mitigation and support programmes need to be spilled over beyond the conventional reproductive age group to the old and even oldest ages. Total life expectancy in South Africa has started to steadily rise again after being brought down by AIDS during the last decade 2000-2010. Along with these gains, sexually active life expectancy seems to be increasing as well.

The estimates of sexually active life expectancy found in this study are lower than those found in the national social life, health and aging project (NSHAP) from the USA [10]. Whereas the estimates from the 2012 survey in this study at 55 years were 12.1 (men) and 5.5 (women), the corresponding estimates from the USA study were 14.9 (men) and 10.6 (women). This shows that older people in the USA remain sexually active for a longer time beyond age 55 compared to older people in South Africa. For men, the estimates from the two studies are close, whilst the estimates for USA women are double that of South African women. These differences can be attributed to socio-economic, health and mortality differences between the two countries and other socio-cultural dynamics. Nevertheless, regardless of these differences, the gap in women between the two studies is worth noting.

Similar to other studies [10], this study has shown that poor health status is associated with decreased sexual activity. This further supports other studies which have found that it is poor health, rather than age *per se*, that is associated with decline in active sex life [15]. This is an important finding which goes along with new understanding among demographers and policy makers that aging is not about numbers, but rather more about other dimensions of life such as health, functioning and well-being. In other words, defining aging based on chronological age might be misleading [16, 17]

The study has come up with some findings with significant policy implications. It is interesting to note that HIV reduces sexual activity amongst older women, whilst chronic conditions seem to limit sexual activity among older men. This implies that there is need for gender responsiveness and sensitivity when addressing sexual health among the elderly since the underlying determinants are different. Studies have shown that chronic conditions lead to declines in sexual activity [15]. These include diabetes mellitus which can lead to impotence and osteoarthritis which cause poor mobility and other conditions such as depression which are prevalent at these ages. Further, medications taken for chronic conditions have been known to reduce libido, hence limiting sexual activity [18]. Risk factors for chronic conditions are largely behavioural, and can be mitigated at an earlier age. It is important therefore to ensure prevention programmes for chronic conditions among young men. Based on the results of this study, there is need to raise awareness about the negative effect chronic conditions might have on sexual activity later in life.

Male HIV mortality is higher than that for females [19]. Therefore, it can be insinuated from the results that HIV infected women are less likely to be sexually active because most are likely to be widows who might have lost their husbands to AIDS. On the other hand, HIV does not seem to deter men from sexual activity. Although not significant, HIV infected men are actually more likely to be sexually active. These results have



important implications on public health policies aimed at prevention of HIV infections, especially given the aging of people with HIV. Older men living with HIV may continue engaging in sexual activities, some of which might be risky e.g. age disparate relationships which may continue to put younger people at risk. The erectile dysfunction (ED) among women is poorly understood [15]. Therefore, further research is needed to further understand the sexuality of older women, especially in the context of HIV.

Physical activities need to be promoted in older people. The results give hope in that just moderate exercises are effective in doubling sexual activity in women. Post menopause the sexual activity of women declines, and studies have found that regular exercises can improve sexual activity [20].

The gender differences in sexually active life expectancy found in this study are equally striking. Whilst young girls get sexually active at a younger age than boys [21], this study shows that at the older ages, men are more sexually active than women. Further, the study shows that although women have higher demographic life expectancy than men, they spend fewer years being sexually active than men at the old ages. However, although this is the case, a caution to men is that the results also show that they lose more of their sexually active life expectancy to poor health. This has also been found in other studied [10].

Strengths and limitations

The strength of this study is that it is based on two cross-sectional surveys, with relatively larger sample sizes of older people. This helps to check trends of estimates over the years. The two surveys asked similar question for the outcome and main exposure variables, which strengthens the content validity. Further the Sullivan method used here has been found to give estimates close to those from other methods e.g. multi-state life tables which utilize longitudinal data. However the limits of cross sectional data exist. The SABSSM surveys did not include institutionalized individuals in the sample. The exclusion of older people living in institutions means that the results are not representative of this important segment of the elderly population. Unfortunately, there are no surveys on sexuality of older populations where this information could possibly have been obtained from. Further, although not mentioned anywhere, bias in reporting sexual activity cannot be ruled out. It can be suspected that older women are less likely to report sexual activity especially if they are not married or in union, due to possibilities of being labelled as having 'loose' morals. On the other hand, men can over-report sexual activity because it is associated with manhood, and for covering up sexual dysfunction. However, from the consistence of the results from the two surveys, these shortcomings are unlikely to bias the results

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Table 1 Descriptive characteristics of sample 50 years and older by gender, 2012 and 2005 SABSSM survey

Characteristic	2005		p-value	2012		p value
	Men (n=1291) N (%)	Women (n=2504) N (%)		Men (n=3096) N (%)	Women (n=4751) N (%)	
<i>Age (year)</i>			p=0.001			p<0.001
50-59yrs	653 (46.1)	1222 (44.0)		1480 (54.7)	2202 (46.9)	
60-69yrs	438 (38.3)	783 (33.0)		1003 (29.7)	1481 (31.2)	
70-79yrs	154 (12.3)	385 (17.0)		466 (12.6)	755 (17.0)	
80+	46 (3.4)	114 (6.0)		144 (3.0)	310 (4.9)	
<i>Marital status</i>			p<0.001			p<0.001
Single	70 (4.6)	237 (10.6)		176 (5.4)	496 (10.8)	
Married	919 (74.7)	1141 (43.2)		2155 (68.8)	2092 (43.9)	
Cohabiting	43 (3.2)	40 (1.6)		253 (9.7)	212 (5.1)	
Separated	93 (8.1)	187 (6.6)		136 (4.8)	300 (7.6)	
Widow	141 (9.4)	864 (38.0)		321 (11.3)	1569 (32.6)	
<i>Education</i>			p=0.001			p=0.001
Primary	610 (55.5)	1403 (63.6)		770 (36.6)	1328 (38.6)	
Secondary	330 (18.2)	637 (20.9)		795 (28.0)	1277 (32.8)	
Matric	182 (13.4)	275 (9.6)		546 (20.2)	594 (17.6)	
Tertiary	160 (12.9)	170 (5.9)		332 (15.5)	323 (10.9)	
<i>Race</i>			p<0.001			p=0.027
African	606 (63.2)	1335 (74.9)		1390 (64.5)	2407 (68.6)	
White	281 (24.4)	457 (15.7)		621 (21.5)	710 (18.8)	
Coloured	216 (8.8)	402 (6.7)		550 (10.2)	866 (9.4)	
Indian	186 (3.6)	304 (2.7)		528 (3.8)	764 (3.3)	
<i>Self-rated health</i>			p<0.001			p<0.001
Excellent	117 (7.9)	168 (6.2)		483 (16.1)	535 (11.1)	
Good	716 (60.9)	1223 (48.5)		1594 (53.1)	2428 (52.3)	
fair	370 (26.3)	935 (38.9)		824 (26.4)	1490 (31.2)	
Poor	66 (4.9)	130 (6.4)		144 (4.4)	231 (5.4)	
<i>Sexual activity</i>			p<0.001			p<0.001
Not active	404 (30.0)	1569 (71.2)		1007 (31.1)	2852 (66.2)	
Active	814 (70.0)	745 (28.8)		1835 (68.9)	1494 (33.8)	

Table 2 Factors associated with sexual activity among older adults (50 years and older), 2012 SABSSM survey



	Males		Females	
	UOR (95% CI)	AOR (95% CI)	UOR (95% CI)	AOR (95% CI)
<i>Self-rated health</i>				
Poor	1	1	1	1
Good	1.86 (1.41-2.47)***	1.56 (1.11-2.19)**	1.63 (1.31-2.03)***	1.01 (0.75-1.37)
<i>Age</i>				
50-59	1	1	1	1
60-69	0.53 (0.39-0.74)***	0.43 (0.30-0.62)***	0.44 (0.33-0.58)***	0.43 (0.30-0.62)***
70-79	0.14 (0.06-0.21)***	0.11 (0.07-0.17)***	0.94 (0.06-0.15)***	0.11 (0.06-0.19)***
80 +	0.13 (0.06-0.26)***	0.06 (0.03-0.13)***	0.04 (0.02-0.10)***	0.05 (0.01-0.17)***
<i>Marital status</i>				
Married	1	1	1	1
Single	0.09 (0.06-0.13)***	0.06 (0.04-0.10)***	0.03 (0.02-0.05)***	0.04 (0.03-0.06)***
<i>Vigorous Exercises</i>				
No	1	1	1	1
Yes	1.83 (1.21-3.00)*	1.34 (0.78-2.31)	1.61 (1.13-2.28)**	1.00 (0.60-1.53)
<i>Moderate Exercises</i>				
No	1	1	1	1
Yes	1.26 (0.89-1.78)	0.95 (0.54-1.69)	1.89 (1.41-2.53)***	1.99 (1.32-3.00)**
<i>Chronic Conditions</i>				
None	1	1	1	1
At least one	0.67 (0.50-0.86)**	0.64 (0.46-0.91)*	0.79 (0.62-1.00)*	0.91 (0.62-1.32)
<i>HIV status</i>				
Negative	1	1	1	1
Positive	1.42 (0.88-2.29)	1.78 (0.98-3.24)	0.62 (0.39-0.98)*	0.52 (0.27-0.98)*

UOR – Unadjusted Odds Ratio;
 AOR – Adjusted Odds Ratio;
 CI – Confidence Interval;
 ***P<.001; **P<.01; *P<0.5

Table 3 Gender differences in proportion (%) of remaining sexually active life by health status at ages 50, 60, 70 and 80, based on the 2005 and 2012 SABSSM surveys

Age	Expectation of life	Men			Women		
		2005	2012	change 2005-2012	2005	2012	change 2005-2012
	All	69.0	65.7	-3.3	25.8	29.4	3.5
50-59	Self-rated health						
	Bad Health	57.2	58.0	0.8	20.5	24.8	4.3
	Good Health	74.6	69.6	-4.9	30.1	32.0	1.8
60-69	All	54.3	54.2	-0.1	11.7	17.8	6.1
	Self-rated health						
	Bad Health	41.6	43.9	2.4	9.4	13.8	4.4
	Good Health	61.1	59.9	-1.3	14.0	20.3	6.3
70-79	All	39.8	34.5	-5.3	3.2	6.7	3.4
	Self-rated health						
	Bad Health	26.5	22.0	-4.5	1.6	3.0	1.4



	Good Health	48.0	43.3	-4.7	5.1	8.9	3.8
	All	14.8	32.7	17.8	1.1	3.7	2.6
80+	Self-rated health						
	Bad Health	13.8	11.0	-2.8	0.0	2.2	2.2
	Good Health	16.4	48.2	31.8	3.1	3.3	0.1



Figure 1 Sexually active life expectancy in South African men and women, based on 2005 and 2012 SABSSM surveys

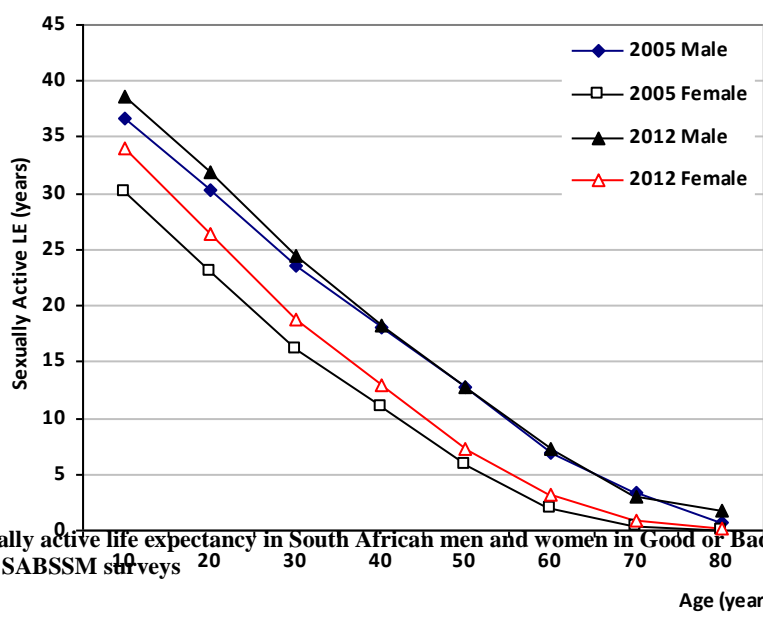


Figure 2 Sexually active life expectancy in South African men and women in Good or Bad Health, based on 2005 SABSSM surveys

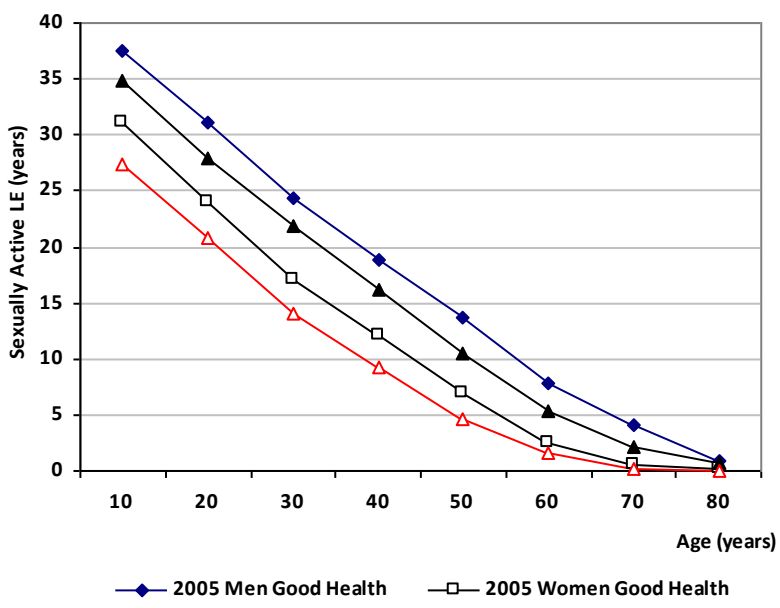


Figure 3 Sexually active life expectancy in South African men and women in Good or Bad Health, based on 2012 SABSSM surveys

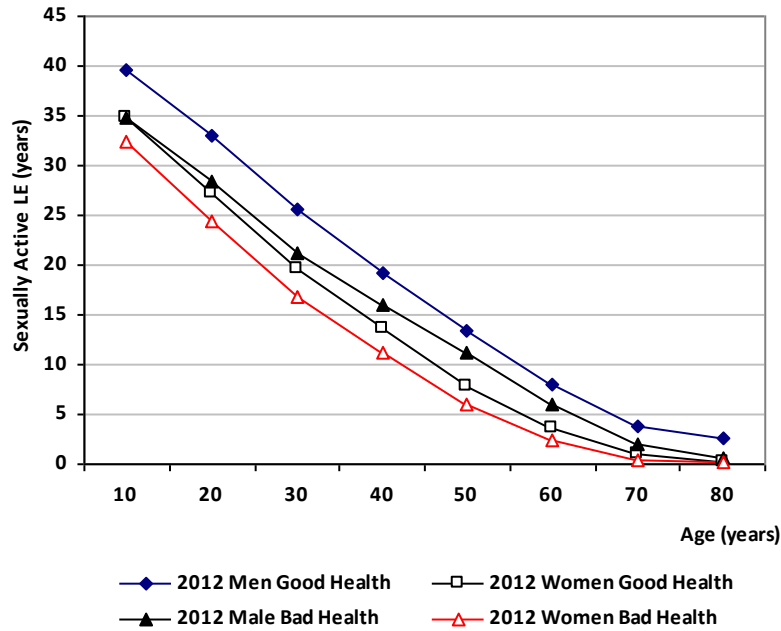


Figure 4 Proportion of remaining sexually active life for men and women, 2005 and 2012

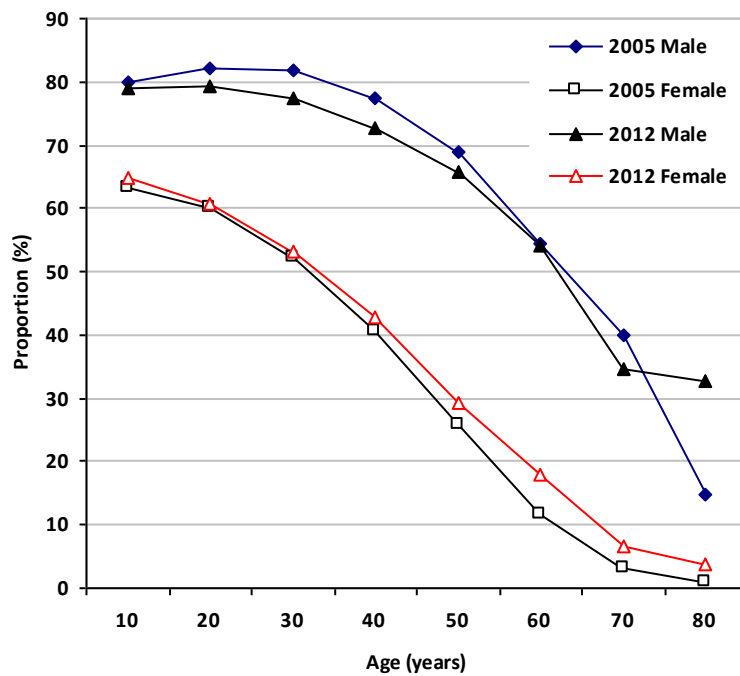


Figure 5 Proportion of remaining sexually active life for men and women by health status, 2005

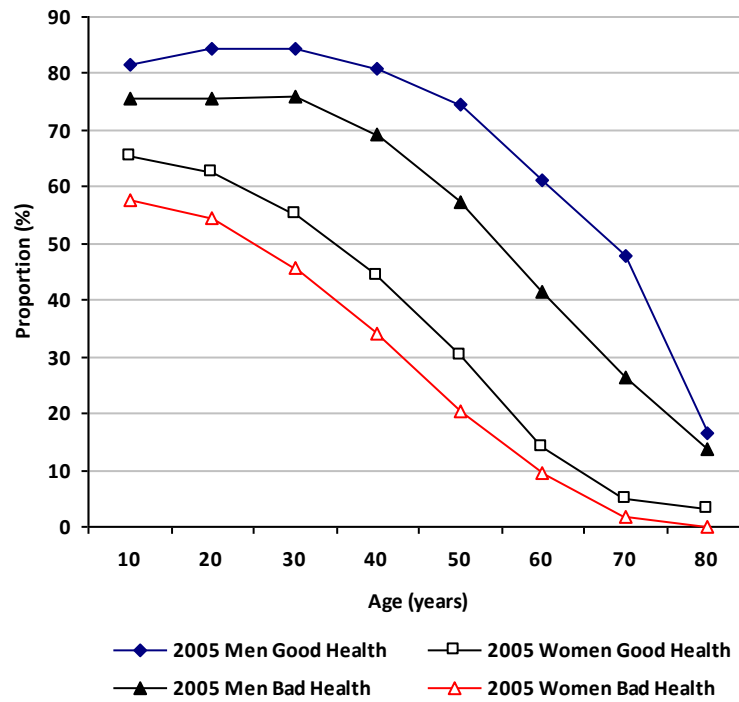


Figure 6 Proportion of remaining sexually active life for men and women by health status, 20012

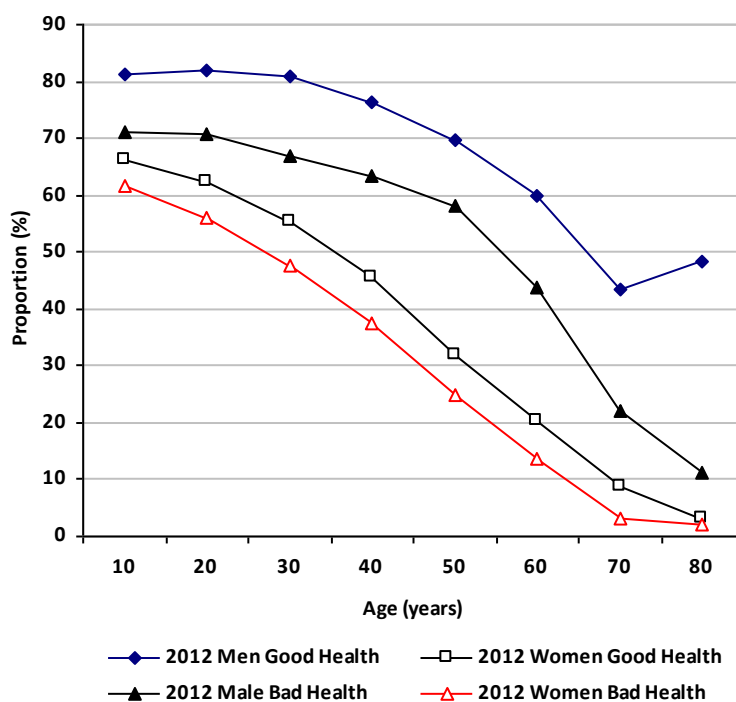


Table 4 Gender differences in proportion (%) of remaining sexually active life by health status at ages 50, 60, 70 and 80, based on the 2005 and 2012 SABSSM surveys

Age	Expectation of life	Men			Women		
		2005	2012	change 2005-2012	2005	2012	change 2005-2012
	All	69.0	65.7	-3.3	25.8	29.4	3.5
50-59	Self-rated health						
	Bad Health	57.2	58.0	0.8	20.5	24.8	4.3
	Good Health	74.6	69.6	-4.9	30.1	32.0	1.8
	All	54.3	54.2	-0.1	11.7	17.8	6.1
60-69	Self-rated health						
	Bad Health	41.6	43.9	2.4	9.4	13.8	4.4
	Good Health	61.1	59.9	-1.3	14.0	20.3	6.3
	All	39.8	34.5	-5.3	3.2	6.7	3.4
70-79	Self-rated health						
	Bad Health	26.5	22.0	-4.5	1.6	3.0	1.4
	Good Health	48.0	43.3	-4.7	5.1	8.9	3.8
	All	14.8	32.7	17.8	1.1	3.7	2.6
80+	Self-rated health						
	Bad Health	13.8	11.0	-2.8	0.0	2.2	2.2
	Good Health	16.4	48.2	31.8	3.1	3.3	0.1



Figure 1 Sexually active life expectancy in South African men and women, based on 2005 and 2012 SABSSM surveys

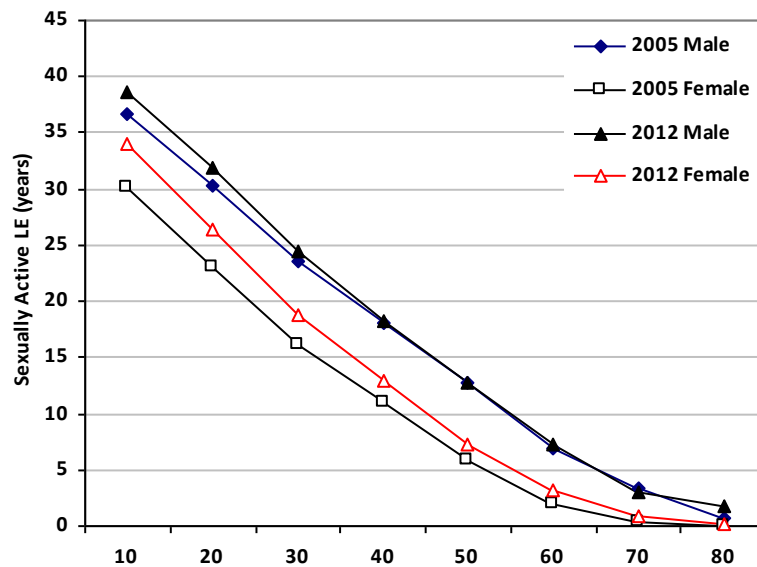


Figure 2 Sexually active life expectancy in South African men and women in Good or Bad Health, based on 2005 SABSSM surveys

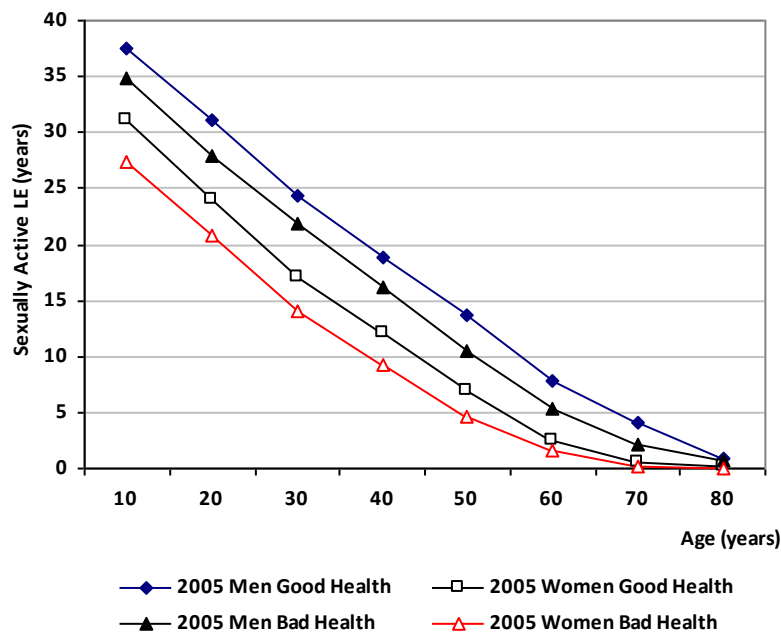


Figure 3 Sexually active life expectancy in South African men and women in Good or Bad Health, based on 2012 SABSSM surveys

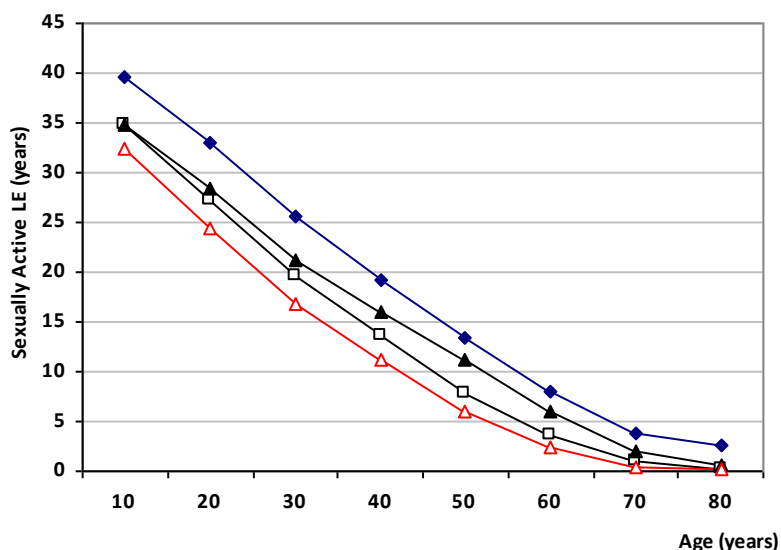


Figure 4 Proportion of remaining sexually active life for men and women, 2005 and 2012

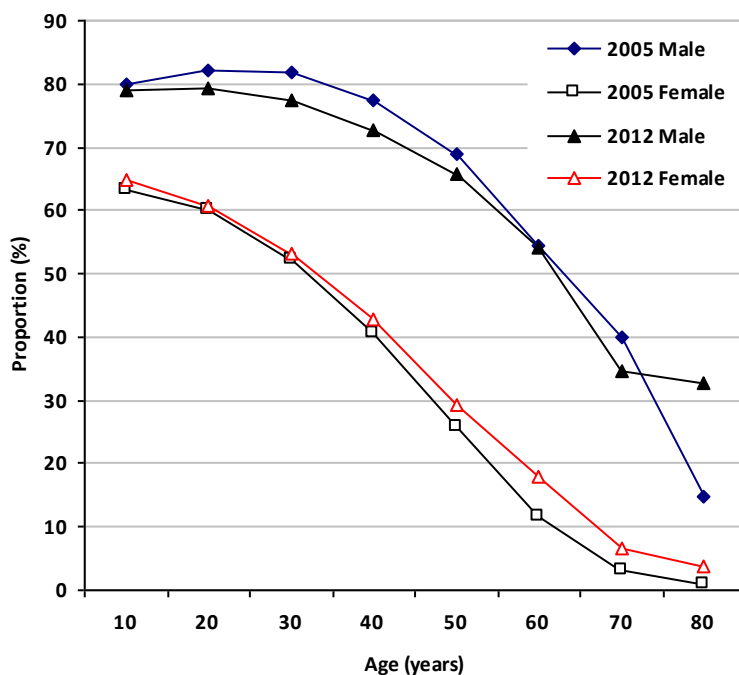


Figure 5 Proportion of remaining sexually active life for men and women by health status, 2005

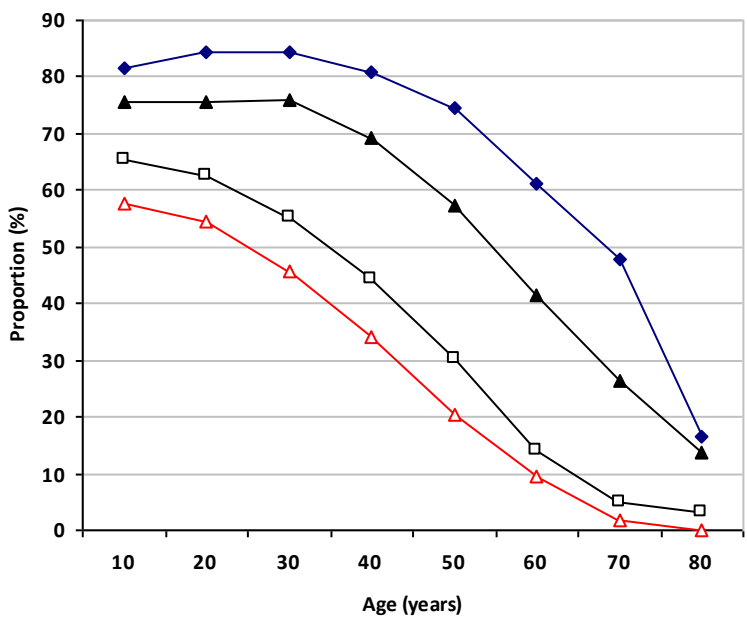
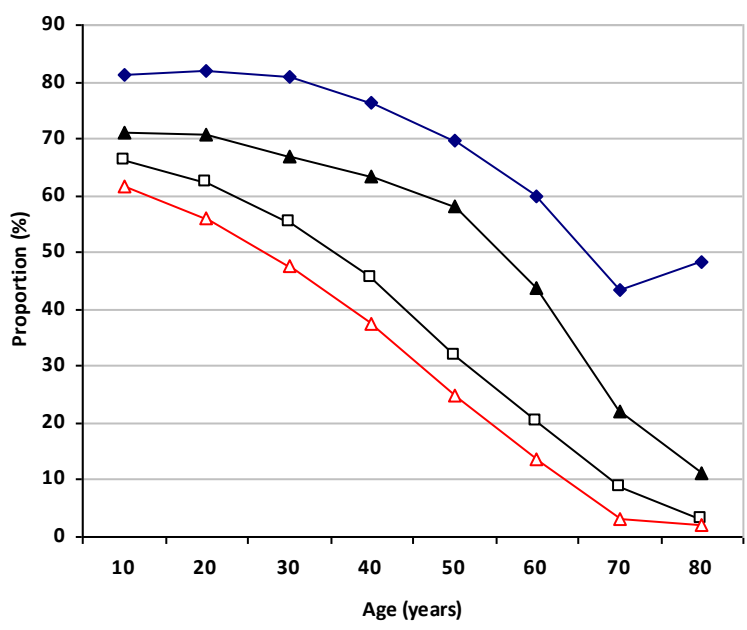


Figure 6 Proportion of remaining sexually active life for men and women by health status, 20012

◆ 2005 Men Good Health □ 2005 Women Good Health
▲ 2005 Men Bad Health △ 2005 Women Bad Health



◆ 2012 Men Good Health □ 2012 Women Good Health
▲ 2012 Male Bad Health △ 2012 Women Bad Health