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Factors associated with self-reported ill health among older Ugandans: A cross sectional study

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ABSTRACT

Introduction: There is limited research on the prevalence and factors associated with self-reported ill health among older people in Uganda.
Objective: Therefore, the aim of this paper was to estimate the prevalence of self-reported ill health and to identify associated risk factors among older people (age 50+) in Uganda.
Materials and methods: We conducted secondary analysis of a cross sectional survey data from a weighted sample of 2382 older persons from the 2010 Uganda National Household survey. We used frequency distributions for descriptive statistics, chi-square tests (significance set at 95%) to identify initial associations and multivariable logistic regressions reporting odds ratios to examine observed associations with self-reported ill health.
Results: Over half (62%) of the older people reported ill health in the 30 days preceding the survey. Self-reported ill health was positively associated with being a woman, being among the oldest old, living in the eastern region, being a household head, being Catholic, self-reported non-communicable diseases (NCDs) and being disabled.
Conclusion: Gender differentials exist in self-reported ill health among older persons in Uganda.
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1. Introduction

Population aging is a global concern in the World today. Two thirds of older people (age 60+) live in developing countries including sub-Saharan Africa (UNFPA & HAI, 2012). In Uganda, the population of persons age 60 and older increased from 1.1 million in 2002 to 1.3 million in 2010 (UBOS, 2010) and is expected to increase from 1.6 million in 2014 to 5.5 million by 2050 (UN, 2013). In Uganda, the retirement age of 60 years is used to define older persons (MoGLSD, 2009). In this paper however, we defined older persons as those aged 50 years and above, as recommended by the World Health Organization (WHO) and the INDEPTH network data for African contexts (Gómez-Olivé, Thorogood, Clark, Kahn, & Tollman, 2013; Hirve, Juvekar, Lele, & Agarwal, 2010; Kyobutungi, Egondi, & Ezeh, 2010; Mwanyangala et al., 2010a; WHO, 2015).

One of the growing concerns related to population aging and health in SSA is the "vulnerability of older persons to poor health outcomes" (Aboderin, 2010) such as non-communicable diseases (NCDs), disabilities or functional limitations; and the lack of access to healthcare or age-related exclusion in access to healthcare (Aboderin, 2010; Aboderin & Ferreira, 2008; UN, 2002).

To address the health needs of older persons, international, regional, and national institutions enacted several policy frameworks. These include the 2002 Madrid International Plan of Action on Aging abbreviated as the MIPAA (UN, 2002), the African health strategy (AU, 2007) and in Uganda, the policy on older persons (MoGLSD, 2009). As result of the policy, Uganda is piloting a non-contributory scheme for older persons called social assistance grants for empowerment (SAGE) in 14 out of 112 districts. In this scheme, older persons age 65 years or 60 years in Karamoja region, receive 25,000 Uganda shillings monthly, an equivalent of $10 (MoGLSD, 2011). The Ugandan policy for older persons also recommended

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research on the health of older persons because of the poorly developed medical records. So far, self-reported health has been a key source of data on health needs.

Although self-rated health or self-reported health (SRH) is primarily subjective, it is useful for assessing the health of a population for which objective measures are scarce. SRH focuses on one's health status – whether it is excellent, very good, good, fair or poor (Phaswana-Mafuya, Peltzer, Chirinda, Kose, et al., 2013). SRH has also been measured using self-reports on physical functioning or disability, morbidity (including non-communicable disease) and hospitalization (Bodde, Seo, & Frey, 2009; Lee, Huang, Lee, Chen, & Lin, 2012; Phaswana-Mafuya, Peltzer, Chirinda, Kose, et al., 2013). In addition, SRH can be measured by self-reporting on the incidence of ill health or illness (Drum, Horner-Johnson, & Krahn, 2008; Kabir et al., 2003a; UBOS, 2010) in national surveys. In this paper, we used the incidence of being sick or ill during the past 30 days preceding the survey (UBOS, 2010) to measure ill health among older people.

Factors associated with SRH range from demographic to socio-economic. Advanced age was associated with poor physical health (Phaswana-Mafuya, Peltzer, Chirinda, Kose, et al., 2013; Tomás, Gutiérrez, Sancho, & Galiana, 2012; Wasiak et al., 2014) for instance in Angola (Tomás et al., 2012), self-reported NCDs in South Africa (Phaswana-Mafuya, Peltzer, Chirinda, Musekiwa, et al., 2013; Ward & Schiller, 2013), multi-morbidity in Ghana (Nimako, Baiden, Sackey, & Binka, 2013). Advanced age leads to reduced immune response against illnesses, increased mobility limitations, and NCDs (Phaswana-Mafuya, Peltzer, Chirinda, Musekiwa, et al., 2013; Ward & Schiller, 2013). However, the Ghanaian study was hospital-based and did not predict the community level prevalence. In developed countries like Sweden, the pattern is similar (Marengoni, Winblad, Karp, & Fratiglioni, 2008).

With respect to gender and aging, older women report poorer health outcomes than the men. Paradoxically, older men experience higher mortality than older women (Kakoli & Anoshua, 2008). Being a woman was associated with depression in South Africa (Nyirenda, Chatterji, Rochat, Mutevedzi, & Newell, 2013; Phaswana-Mafuya, Peltzer, Chirinda, Kose, et al., 2013) and non-communicable diseases (Khanam et al., 2011a; Marengoni et al., 2008; Phaswana-Mafuya, Peltzer, Chirinda, Musekiwa, et al., 2013; Stelmach, Kaczmarczyk-Chałas, Bielecki, Stelmach, & Drygas, 2004; Ward & Schiller, 2013), poor physical health (Phaswana-Mafuya, Peltzer, Chirinda, Kose, et al., 2013; Wasiak et al., 2014), multi-morbidity in Ghana (Nimako et al., 2013) and Bangladesh (Khanam et al., 2011b) and hospitalization. The possible explanations are that women live in unfavorable socio-economic conditions (Nimako et al., 2013). The female gender disadvantage prevails even in developed countries (Marengoni et al., 2008) except in an Australian study (Britt, Harrison, Miller, & Knox, 2008). In addition, women easily report their health challenges more than the men, because the latter are not expected to acknowledge illness as readily as women do (Kabir et al., 2003a). Women are more sensitive to their health conditions than men due to their frequent interface with the health care system earlier in life (Kakoli & Anoshua, 2008; Razzaque, Nahar, Khanam, & Streatfield, 2010).

Residing in urban areas is associated with poor SRH including NCDs in South Africa (Phaswana-Mafuya, Peltzer, Chirinda, Musekiwa, et al., 2013). Urban areas are associated with sedentary lifestyles and poor dietary habits (Hosseinpoor et al., 2012). Rural residents engage in active lifestyles which increases their physical activity, lowers the risk of obesity and hypertension and therefore improves their survival rates (Fantahun, Berhane, Hogberg, Wall, & Byass, 2009). Being not married (never married, separated and or divorced) is associated with poor health (Agrawal & Keshri, 2014; Gómez-Olivé, Thorogood, Clark, Kahn, & Tollman, 2010; Khanam et al., 2011a; Phaswana-Mafuya, Peltzer, Chirinda, Kose, et al., 2013; Razzaque et al., 2010).

Low levels of education are associated with poor health (Phaswana-Mafuya, Peltzer, Chirinda, Kose, et al., 2013), depression in Amsterdam, Netherlands (Koster et al., 2006; Stelmach et al., 2004) and NCDs in South Africa (Phaswana-Mafuya, Peltzer, Chirinda, Musekiwa, et al., 2013) and Sweden (Marengoni et al., 2008). Low education limits access to health services especially for older persons (Phaswana-Mafuya, Peltzer, Chirinda, Kose, et al., 2013). On the other hand, better education is associated with a lower prevalence of NCDs in South Africa because the more educated utilize health education or information better than the less educated (Alaba & Chola, 2013).

Low income is associated with depression among older persons in Amsterdam, Netherlands (Koster et al., 2006). High income is associated with self-reported non-communicable diseases in South Africa (Alaba & Chola, 2013; Phaswana-Mafuya, Peltzer, Chirinda, Musekiwa, et al., 2013) and Bangladesh (Khanam et al., 2011b). Affluent households in developing countries, including South Africa, are more likely to adopt a western lifestyle and diets (Alaba & Chola, 2013; Hosseinpoor et al., 2012). Disability or functional limitations have been associated with poor health in Angola (Tomás et al., 2012) and South Africa (Phaswana-Mafuya, Peltzer, Chirinda, Kose, et al., 2013).

In Uganda, studies on the health of older persons have explored disability (Wandera, Ntozi, & Kwagala, 2014), and HIV and AIDS (MRC & UVRI, 2011; Nankwanga, Phillips, & Neema, 2009). However, investigating self-reported ill health and associated factors among older people, preferably using a nationally representative sample, has received limited attention. Despite the available evidence about ill health in other developing countries, there is limited evidence on the risk factors for ill health among older persons in Uganda. Therefore, the objective of this paper was to estimate the prevalence of ill health and identify the associated risk factors, among older people in Uganda.

2. Materials and methods

2.1. Data

The study used the 2010 Uganda National Household Survey (UNHS) data. The UNHS was a cross-sectional design, which used a two-stage stratified sampling. At the first stage, 712 enumeration areas were drawn using probability proportional to size. At the second stage, households were drawn using systematic sampling. A total of 6800 households were interviewed in the survey (UBOS, 2010).

Using the variable age, we selected older persons (50+) from the sample for further analysis. We obtained unweighted and weighted samples of 2628 and 2382 older persons respectively. We applied individual weights using the survey command (svy) in STATA 13 to account for the survey design including clustering and stratification. In the results, we reported weighted analyses. The decision to select persons aged 50 years and above was based on the fact that several studies using WHO and INDEPTH network data define older persons starting at age 50 for African contexts (Gómez-Olivé et al., 2013; Hirve et al., 2010; Kyobutungi et al., 2010; Mwanyangala et al., 2010a).

2.2. Explanatory variables

The UNHS data covered individual and household characteristics - demographic and socio-economic characteristics, disability, health, and housing conditions. Demographic factors included: gender (male or female), age group, region, place of residence (rural or urban), living arrangement, relationship to household head, and marital status. Age was recoded into four age categories: 50–59, 60–69, 70–79 and 80+. Region was recoded into four categories (1 = central, 2 = eastern, 3 = northern and 4 = western).

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