Factors affecting older Ugandan women’s self-perceived health – A qualitative study

Author
Malin Hillblom

Supervisor
Anna Höglund

Examiner
Pranee Lundberg

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ABSTRACT

Background Older people in Uganda suffer from poor health due to a societal marginalization in the form of discrimination and inequitable access to health services. Women’s access to healthcare is also limited and there are different forms of discrimination against women in the Ugandan society which affect their health negatively.

Study objective The objective of this study was to explore in depth the self-perceived health of older women in Uganda, as well as factors that influence their health.

Methods This is an explorative study with a qualitative method and semi-structured interviews were carried out. The data was analyzed using a qualitative content analysis and an intersectional framework was used to discuss the results.

Results The content analysis resulted in seven categories, namely; Self-perceived health; Changes of daily activities related to poor health; Lacking family support; Poor source of income; Accessing healthcare; Cannot afford treatment; and Disrespect and abuse. The women in this study suffered from various illnesses and pain. Family support was important to these women and those who lacked assistance from family members had a difficult time getting by. Some women who lacked assistance had no means to access health care and some women experienced mistreatment and abuse from younger people.

Conclusion For some of the interviewed women, discrimination based on gender and age coupled with low socio-economic status and lack of family support resulted in a very fragile livelihood accompanied by a low quality of life and poor health.

Keywords: health, older, women, Uganda
SAMMANFATTNING

Bakgrund Äldre personer i Uganda lider av dålig hälsa på grund av åldersdiskriminering och de upplever en bristfällig tillgång till hälso- och sjukvård. Även kvinnor utgör en grupp som har sämre tillgång till sjukvård på grund av könsdiskriminering vilket påverkar deras hälsa negativt.

Syfte Syftet med denna studie var att utforska självupplevd hälsa samt faktorer som påverkar hälsan hos äldre kvinnor i Uganda.

Metod Detta är en explorativ studie där en kvalitativ metod användes och semistrukturerade intervjuer genomfördes. En kvalitativ innehållsanalys av datan gjordes och resultatet har diskuterats utifrån ett insektionellt teoretiskt ramverk.

Resultat Innehållsanalysen resulterade i sju kategorier, nämligen; Självupplevd hälsa; Förändringar av dagliga aktiviteter relaterat till dålig hälsa; Brist på familjestöd; Dålig inkomst; Tillgång till sjukvård; Att inte ha råd med behandling; och Respektlöshet och missbruk. Kvinnorna i denna studie led av olika sjukdomar och svårare tillstånd. Familjestöd var en viktig faktor och de som saknade stöd från familjen upplevde svårigheter att klara sig. Vissa kvinnor som inte hade något stöd hade inga möjligheter att söka sjukvård och få behandling. Vissa av de intervjuade kvinnorna upplevde diskriminering och blev missbrukade av yngre personer.

Slutsats Vissa av de intervjuade kvinnorna led mycket av sjukdomar och smärta men levde utan smärtlindring och behandling. För vissa av de intervjuade kvinnorna ledde ålders- och könsdiskriminering kombinerat med låg socio-ekonomisk status och brist på familjestöd till en låg livskvalitet och dålig hälsa.

Nyckelord: hälsa, äldre, kvinnor, Uganda
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BACKGROUND

Ageing has emerged as an important policy issue worldwide because of the large increase in the proportion of older people in the world population. The number of older people in sub-Saharan Africa is expected to grow faster than anywhere else and already make up double the amount of older people in northern Europe. With ageing follows numerous physiological changes and an increase of the risks of chronic diseases. After the age of 60 people to a larger extent suffer from losses in hearing and seeing, as well as Non Communicable Diseases (NCDs) such as heart disease, stroke, cancer and dementia. These health issues are in general even more common in low- and middle income countries (World Health Organization, 2015).

A large barrier towards providing good healthcare to older persons is the fact that there are negative attitudes, misconceptions and assumptions about older people within society at large but also shared by many healthcare professionals. Older people are viewed as frail, burdensome or dependent, despite the fact that these people contribute to society in many ways. Ageism refers to the discrimination of older people perpetuated by prejudice and stereotypes (Butler, 1980). The consequences of ageism are negative both for society at large and for the individual older person by negatively influencing the quality of healthcare as well as creating barriers towards implementation of good policies for sustainable development (WHO, 2015).

The health care gaps which are present in low-and middle income countries have many negative consequences for the health of older people; such as high rates of limitations in functioning as well as negative consequences for their family members. Due to inadequate health care and social care, the poor health of an older person may force a family member to stop working and stay at home as a caregiver (WHO, 2015).

Women’s access to healthcare in Uganda is limited by economical resources and distance to health care facilities among other factors. Women also have a limited control over the decisions which concern safe sex, which makes them more vulnerable to STDs such as HIV. There are different forms of discrimination against women in the Ugandan society which affect their health negatively. These forms of discrimination include discriminating property laws against women and gender based violence. For example 56% of women aged 15 years report having experienced physical violence and 28% of women between the ages of 15 years and 49 years report having experienced sexual violence (Government of Uganda, 2015).
Older women’s health in Uganda

A sense of marginalization is present among older people in Uganda; this societal marginalization exists in the form of discrimination and inequitable access to health services. This is one of the major reasons for the poor health experienced by older people in Uganda (Mulonga et al., 2014) where 62 percent of older Ugandans report bad health (Wandera, Golaz, Kwagala & Ntozi, 2015a). The quality of available healthcare is low and there is shortage of trained personnel, facilities, drugs and rehabilitative care. Older peoples’ needs are neglected by society, the Ugandan state and in particular by the health care system according to Mulumba et al. (2014). When it comes to accessing healthcare, older people in Uganda are more likely to have access to healthcare if the household has a better income. Many old people experience that the quality of care is too low. Mobility also limits older people’s access to healthcare (Wandera, Kwagala & Ntozi, 2015b).

There are only few geriatricians in Africa despite the fact that the number of older people is increasing (Dotchini, Akinyemi, Grey & Walker, 2012). There are also gaps of knowledge about the medical care of older adults with HIV among clinicians in Kampala district of Uganda (Obuku et al., 2013). Traditionally older people in sub-Saharan Africa are cared for by family members of the middle generation. However in East and Southern Africa many members of the middle generation are deceased because of the HIV epidemic. This has resulted in the need for many older people to care for their grandchildren having no one to care for them. The need for care work in East Africa is increasing while there is a growing care deficit (Schatz & Seeley, 2015).

The family caregivers are usually older women who take on the responsibility of caring for their grandchildren whose parents are deceased (Akintola, 2004). The burden on older women when caring for a family member leads to increased risks of poor mental and physical health in the form of stress, depression, fatigue and exhaustion (Oburu & Palmérus, 2005). However Mugisha et al. (2013) found that care giving among older adults in Uganda was actually associated with better health status, greater life satisfaction and better life quality.

A study examining gender differences in health among older people in and low- and middle-income countries in Africa and Asia found that the men reported better health than women. The study shows that older women in low resource societies are especially vulnerable when it comes to health issues (Ng et al., 2010). A study on the vulnerability of older adults in Uganda shows that older women constitute a group that is extra vulnerable and they are thus
in greater need of support. The prevalence of vulnerability increases with old age and structural and relational vulnerability are factors that affect women more frequently than men (Golaz and Rutaremwa, 2011). Wandera, Kwagala and Ntozi (2015c) found that in Uganda, self-reported Non Communicable Diseases was associated with advanced age as well as being a woman, they thus conclude that there are social and health inequalities present among older people living in Uganda.

There are gender differences when it comes to self-reported ill health among older people in Uganda. Older women in Uganda report that they are in worse health than older men (Wandera et al., 2015a). This is also supported by the results of Saeed, Xicang, Yawson, Nguah and Nsowah-Nuamah (2015) who found that older women in Ghana experience worse health than older men; women have a higher rate of healthcare utilization and hospitalization.

Gender based violence is a part of many of women’s sexual relationships in Uganda and this is also true for older women. Older women who are victims of gender based violence are at a larger risk of being infected with HIV and they also experience difficulties negotiating access to healthcare system. Women experience very fragile livelihoods in old age and older people with HIV constitute an often neglected group within the health care system (Richards, Zalwango, Seeley, Scholten & Theobald, 2013). However according to Negin, Nyirenda, Seeley and Mutevedzi (2013), research has shown that the investments made to improve HIV health care and services in Uganda have resulted in a situation where older people with HIV have greater access to clinical health care and support than older people who are HIV-negative.

A study determining the prevalence of adult malnutrition and associated risk factors in northern Uganda shows that for women, underweight is associated with older age and widowed and divorced women are more likely to be underweight. Women above the age of 65 were six times more likely to be underweight than women between the ages of 15 and 19 (Schramm, Kaducu, Smedemark, Ovuga & Sodemann, in press). Kikafunda and Lukwago (2005) found that 68% of the older women in the central part of where undernourished whereas the number for the male equivalent was 32,4%. This under-nutrition influences the daily activities of older people – in particular when it comes to mobility and feeding. Sufficient nutrition, especially intake of proteins and micronutrients are essential to the health of older people (Kikafunda & Lukwago, 2005).
Theoretical framework

Intersectionality research is based on the assumption that different forms of discrimination constantly coexist and impact the individual and her place in society. The forms of discrimination that coexist are based on group affiliations, such as gender, class, sexual orientation, ethnicity, nationality and profession. A person can be exposed to discrimination on the basis of being female, bisexual, young and having a low income for example. The concept of intersectionality has been used in the field of research as a tool to understand the individual’s conditions in societies characterized by migration, globalization, altered gender relationships and changed relationship between youths and older people (Lykke, 2003).

Intersectionality has its roots in the American antiracist feminist movement; however, the concept has been welcomed within different areas of research as a theoretical framework. By using this framework the researcher contributes to make visible how power relationships based on race, gender, sexuality, class and age interact and in combination lead to different forms of oppression. Acknowledging the different forms of discrimination and thus the different aspects of a person’s identity contributes to a more complex analysis of the individual and her conditions. A person could for example be superior in one context but inferior in another context (Nationella sekretariatet för genusforskning, 2012).

All of the different power structures that an individual is exposed to, such as discrimination based on gender, age, race or class, interact. However it is up to the researcher to determine which of the grounds for discrimination to stress in the analysis. Intersectionality research does not focus on adding the different forms of discrimination together but rather to describe how these forms of discrimination interact (Jämställ nu, 2013). There are two different ways of using an intersectional framework in research. The first one has its focus on identity and the individual. The aim is to establish what it means for the individual to be exposed to discrimination on the basis of belonging to several categories of minority groups. The second one is useful when it comes to exploring power structures and the systems that they consist of, for example sexism, racism and discrimination based on class (Nationella sekretariatet för genusforskning, 2012). In this study the focus will be on the individual and her identity.

The intersectional perspective has been used within the field of nursing research focusing on inequalities in health and healthcare (Kelly, 2009). It has also been used in other fields of research where the aim is to explore inequalities in health between different groups in society (Hankivsky et al., 2014). Intersectionality research is driven by the pursuit of social justice.
and in the field of health care where the goal is to decrease health disparities. Gaps in the quality of health and healthcare are known as health disparities (Kelly, 2009). From a public health perspective the promise of intersectional research lies in the possibility to explore and address health disparities based on different social categories such as gender, age, ethnicity, sexual orientation and race (Bowleg, 2012).

An intersectional perspective is appropriate for nursing research with focus on health disparities because one of the main responsibilities of nurses is to advocate for health equity and social justice. Nursing education and research needs to address issues concerning human rights, equity, justice and solidarity. According to the International council of Nurses’ Code of Ethics for Nurses there are four fundamental responsibilities for nurses, namely; “to promote health, to prevent illness, to restore health and to alleviate suffering”. The code of ethics also states that nurses have a responsibility to initiate and support action to meet health and social needs of the population – and in particular for vulnerable groups in society (International Council of Nurses, 2012).

A framework of intersectionality with a focus on identity and the individual is useful when exploring the health of a small group of older Ugandan women and the factors which impact their health. Because these women often experience a fragile livelihood in old age and suffer from discrimination based on gender and age, it is interesting to have an intersectional perspective that consider different forms of discrimination and provide a tool for a more complex analysis of the individual and the factors that affect her health. An intersectional framework is also useful in this study because it can be used to highlight health disparities and shed light on the discriminatory power structures that affect older women’s health in Uganda.

**Problem statement**

Despite the fact that older people experience poor health and are in greater need of healthcare compared to young people, there is little research done in the area of access to healthcare when it comes to older people in Uganda (Wandera et al., 2015b). The majority of published research on women’s health in Uganda is focused on gender related violence and women with HIV. There are very few studies done on the subject of older women’s health in Uganda. There is need for research within the field of nursing concentrating on gender and ageing with a focus on social support and health in East and Southern Africa (Schatz & Seeley, 2015). Thus there are strong arguments for doing research focusing on the self-perceived health of older women in Uganda.
Study objective
The objective of this study was to explore in depth the self-perceived health of older women in Uganda, as well as factors that influence their health.

Research questions
- How do the interviewed older Ugandan women perceive their health?
- Which factors affect the health of the interviewed women?

METHODOLOGY

Research design
This is an explorative study and a qualitative method was used in order to explore the area of older women’s self-perceived health in Uganda and to gain new knowledge about factors that affect these women’s health. A qualitative method was chosen to have a better chance to do in dept interviews in order to gain new insights into how these women experience their health. Individual semi-structured interviews were performed, using an interview guide with open-ended questions (Polit & Beck, 2010).

Sample
The sample consisted of Ugandan women and the criteria for inclusion were Ugandan women who are; above the age of 60; willing to participate in the study; either English or Luganda speaking. The age criteria of 60 years was inspired by the WHO’s proposed working definition of an older person in Africa which is above 60 years (WHO, 2016).

Informants were found through contacts with a community health worker who also participated in the study; therefore the sampling was done using a snowball technique. Snowball technique means finding one informant who will facilitate contact with other potential informants using her/his own contacts. In order to achieve more transferable results attempts were made to include participants from different socio-economic backgrounds and from different areas, some of the participants were found in small villages and some were found in a small town. Thus the sampling was also strategic (Polit & Beck, 2010).

According to the principle of saturation, when themes and categories in the collected data becomes abundant and repetitive there is no need for doing more interviews because no new information will be gained. If informants have the opportunity to reflect on their experiences and have effective communication with the researcher, saturation may be achieved using only
a small number of participants (Polit & Beck, 2010). In this study language barriers caused communication difficulties, however due to time limitations the number of interviews was somewhat limited. The total amount of participants was 15 and the data did reach a point of saturation.

The participants came from different socio-economic backgrounds where two women ran their own business, seven of the women grew food and sold it or made mats/baskets, six of the interviewed women lacked a source of personal income. The ages of the participants were; 83, 85, 65, 60, 60, 100, 62, 67, 80, 65, 103, 63, 70, 70 and 85.

**Context**

The study was conducted in the Kayunga district in the central part of Uganda. Six of the participants were found in the villages of Namagabi and Kisawo which is part of the Kayunga Town Council which is an urban area. Nine of the participants were found in the villages of Bubajwe and Kisaba which is part of the Kayunga sub county which is rural area.

**Data collection method**

The interviews were conducted using an open ended interview guide which included 7 separate questions (see appendix 1). The interview questions stem from the research objectives and were created to answer the research questions. The interview guide concerned the topics of personal health, changes of health, every day routines and experiences of accessing health care. The interview guide had been translated into Luganda by a teacher at the Nursing department. None of the participants were fluent English speakers and therefore an interpreter/research assistant was also present during the interviews. The interpreter was instructed to ask follow up questions and to use probes in order to get relevant and enough information from the participants. The interpreter was found through contacts at the Nursing department at Makerere University.

The interview guide was tested in a pilot interview after which the informant was given the opportunity to comment and reflect on the interview questions. The pilot interview was carried out on cite in Uganda with one of the participants of the study and it was done in Luganda using an interpreter. The informant did not see any need for changing the interview questions so they were not altered; therefore the pilot interview was included in the results.

**Procedure**

Before starting the interview every participant was informed that the participation was
voluntary and confidential. They were asked to sign or use a thumbprint on a consent form agreeing to participate in an interview (see appendix 2).

The interviews were carried out in Luganda and during the interview an interpreter was translating the main comments from the informants into English to the researcher. The interviews were recorded using a tape recorder and then transcribed manually into a word document by a research assistant. The research assistant was an administrator working at the Nursing department at Makerere University. The research assistant also translated the transcriptions from Luganda to English.

Seven of the interviews were performed in the participants’ homes and eight interviews were performed outside or in the home of a friend or neighbor of the participant. Six of the informants preferred doing the interview in private and nine informants wanted their family members or friends to be present.

The interviews lasted from 7 minutes up to 15 minutes; the majority of the interviews lasted for approximately 10 minutes. The collection of data was done during a four day period between 21st of March and 24th of March 2016.

**Ethical considerations**

The interview questions dealt with sensitive information such as personal health. This required much attention to be paid to ethical aspects during and after the interviews (Polit & Beck, 2010). The informants were asked if they wished to do the interviews in private; however, most of them chose to do it in the presence of family and friends.

Before doing the interviews, an ethical approval from the Ethical Clearance Committee at Makerere University was granted (see appendix 3) and community approvals from the chairmen of the local communities were also needed. The approval from the community leaders was granted on cite before starting the interview process in Kayunga town council and Kayunga sub country, where the respective women chairmen were found in their homes and were informed about the study and an oral approval was given.

In order to make informants feel safe and comfortable during the interview they were informed that their participation was anonymous, voluntary, confidential and that they had the right to end the interview if they did not wish to partake any longer. A document explaining the principles of anonymity and voluntary participation was given to the informants before the interview and they were asked to sign a consent form (see Appendix 2).
Data analysis
Data was first analyzed on the study site where by the interpreter was interpreting on site responses from the local language to English in order for the researcher to know whether she had reached the point of saturation. The data was later analyzed using a qualitative content analysis inspired by the model of Graneheim and Lundman (2004). The transcribed data was sorted into meaning units, which could be described as “words, sentences or paragraphs containing aspects related to each other through their content and context”. These meaning units were condensed into shorter meaning units and coded, and then sorted into categories. A category refers to a descriptive level of content (Graneheim & Lundman, 2004).

RESULTS
The content analysis resulted in seven categories, namely; Self-perceived health; Changes of daily activities related to poor health; Lacking family support; Poor source of income; Accessing healthcare; Cannot afford treatment; and Disrespect and abuse.

Self-perceived health
The women in this study felt that their health had deteriorated with age and they were in general less energetic. The interviewed women suffered from recurring sicknesses, disabilities and weakness. These women also suffered from problems such as poor eye sight, bad hearing, paralysis of legs, tooth loss, hearth problems, high blood pressure and general illness. The most common problem among the older women in the study was that they suffered greatly from leg- and back pain. This caused problems with walking, getting up, sitting and even sleeping.

“Health wise I am not fine, the whole body aches, pain is everywhere and I spend the whole night crying in my bed…I cry because of the pain I feel…”
Informant 15

The interviewed women felt frail and described that different sicknesses emerged frequently. Some women experienced that they were suffering from diseases for which there was no cure, for example heart problems and high blood pressure.

“…if one asks about what is ailing me, I answer that there is nothing because I believe I will remain sick, so I answer that I am alright.” Informant 6
Some women also described psychological problems mainly in the form of worries about their life situation and income. One participant described how she was sick with worry and stress and others felt helpless and useless. Another health related problem for these women was malnutrition; some of the interviewed women could no longer afford to eat what they used to eat when they were younger which resulted in poor feeding which had a negative impact on their health.

“One of them (the problems) is that you can wish you eat meat but you are unable, you may desire for dried fish but you cannot afford it...” Informant 3

Changes of daily activities related to poor health

The general body and joint pains described by the informants seems to be the major health issue which stopped them from carrying out their daily household tasks like cleaning, washing, cooking, and fetching water as well as working in the garden digging or performing other types of work.

“I am no longer able to walk a long distance even walking around the compound, my legs pain me. I just force myself to walk because my body aches all over...” Informant 8

Some of the interviewed women could no longer support themselves and felt that they were unable to do anything. They were not able to walk to town or even go to church. The feeling of uselessness caused by not being able to take care of the household and provide for oneself and ones’ family, in combination with constant pain, caused some women to feel hopeless about their life situation.

“I wish to die because I am no longer useful.” Informant 11

Lacking family support

The women in this study who received support from their families considered themselves lucky. Children and grandchildren looked after their health, assisted them in accessing healthcare, did household chores and even brought them food and money for upkeep.

“...I am grateful to the grandchild who agreed to stay with me ...she refused to abandon me even if I am old...” Informant 11
Some if the interviewed women received financial support from their children and grandchildren however the family members did not always have the means to help their parents or grandparents out. And often times the support was not enough to cover the daily expenses. The interviewed women who had lost their husbands also found themselves in a situation where the person who used to provide for them had passed away and often times they were not able to find another source of income. This inflicted a sense of hopelessness for some women due to the fact that they were being left behind and they had lost their income. They were no longer able to afford medical care or even to buy good food.

The interviewed women who had lost their children experienced fragile livelihoods because they could not depend on their children for any assistance. Sometimes the children had moved away and they stopped providing assistance to their older parents. Some of the women in the study experienced a lack of family support in old age because their grandchildren stopped giving them support when they grew up. The lack of support from grandchildren was problematic when their children had passed away or moved away.

“My health changed when my children who were looking after me died... Then I remain like that unable to do anything for myself...” Informant 1

Some of the interviewed women were forced to care for their sick children or grandchildren even though they themselves were sick and in need of care. This could result in an extra burden being put on these women which affected their health negatively. Others got assistance from their grandchildren or their children when caring for the grandchildren.

“You start all over again even carrying the child on your back – a back which is old and painful...we are also happy to have them if at all they can bring support and sustain it...” Informant 7

The women in this study who had not given birth to any children experienced a double grief; they did not have the support of children or grandchildren and they suffered from the stigma of being a woman unable to produce children.

**Poor source of income**

Failing to get assistance was also a challenge; some women even went without food the whole day and the constant worry about money for upkeep was something that took up a lot of time and energy for some. Another issue was that even if the women were not in shape to do hard work they could be forced to because of lack of other incomes.
“Secondly we tend to engage in strenuous work forgetting that we are now old, the doctor can advise you to get rest but because you want to get something to eat you disregard what the doctor said…” Informant 12

The interviewed women who lacked family support were more fragile and depended on assistance from others or were forced to find some other source of income. Sometimes the women were too sick or lacked the resources to support themselves.

“We often get sick and when it is coupled with failure to have someone to look after you; you can die alone in your house…” Informant 2

Some of the older women who could not work and who did not get any family support depended on well wishers to give them food and money to buy that they needed. However the women in this study who were able tried to provide for themselves, some made mats and sold them and others made baskets. Those who were healthy enough also grew crops and sold food. Some of the interviewed women expressed wishes to expand their businesses but they lacked the capital. They had clear views on how to increase their income however they lacked the means to put their plans into action.

**Accessing healthcare**

A challenge to accessing health care at health care centers was the system of line up, where patients need to stand up in line waiting for their turn. This could be very challenging for some of the interviewed women who suffered from weak and aching legs and back. Another difficulty was managing to find a means of transportation to the health center. Some were lucky and had friends or family who helped them with transport to the hospital. Others were forced to walk there despite aching legs.

“Health care is not easy because in my old age you cannot go to the hospital and line up or even moving on those benches …” Informant 8

Using herbal medicine seemed to be an established method for treatment of illness among the interviewed women. Herbal medicine was used as a substitute for drugs when the person could not afford drugs or when she felt that the drugs were not effective. Some also used herbal medicine as complementary treatment. Using herbal medicine was deeply rooted in the culture and it was tradition to treat illness with herbal medicine in the societies where the
interviewed women stayed. Some women were skeptical of modern medicine like drugs and injections.

“I do (use herbal medicine) because we have been using herbal medicine since our youth...We grew up being told that medicines like for example injections are not good for the body...” Informant 12

**Cannot afford treatment**
A problem the interviewed women had when it comes to health care was being able to afford treatment. When they went to a health center or hospital only some of the drugs were given to patients. If they needed a drug which was not available they needed to buy it themselves from the pharmacy.

“The drugs are prescribed and I am told to go and buy them...Most times I find myself without money to buy the drugs...I stay with my pain without medication.” Informant 5

Because of the poor incomes of these women and the high prices of drugs, it happened that they were not able to complete their treatment. Treatments such as surgery are not free and therefore it happened that someone needed surgery but they simply could not afford it. This resulted in suffering, poor health and a feeling of hopelessness.

“All this time I have been sick and having pain...and I was told I needed surgery but I did not have any penny to do surgery....” Informant 2

**Disrespect and abuse**
Some of the women in this study felt disrespected by the youth; they experienced a breakdown in communication and a change in the way people treated them. Some felt forgotten and neglected by people who had previously been associating with them and assisting them. Some of the interviewed women also felt that younger people disrespected them and some had experiences of being abused by youths. There was also a lack of understanding and empathy for older women who suffered from sickness. The interviewed women were also disrespected by young children who for example picked the fruits from their garden before they were ripe which stopped them from selling the fruit and getting an income.
“People mistreat me saying that I am old and I am dirty because I do not wash...it is that dozing that stops me from carrying out household tasks.”
Informant 14

There was disappointment with the government of Uganda among the interviewed women because some of the women felt that the government was not providing old people the assistance that they needed. One woman said that if the government could just assist them with a small sum of money they could have used that money and set up a stall of tomatoes and made a small profit to use for upkeep.

“We hear in other countries that their government helps old people. Here in Uganda the government is not helping old people as they should.” Informant 8

**DISCUSSION**

The results from this study shows that the interviewed women were suffering from various illnesses and pain in legs and back turned out to be a major issue affecting their life and their health. They also felt less energetic compared to before and some felt useless because they could no longer provide for themselves. Family support was important to the women in this study and those who lacked assistance from family members had a difficult time getting by. When it came to health care some of the interviewed women who lacked assistance had no means to even reach the health center or to afford treatment. Some of the interviewed women experienced mistreatment and abuse from younger people who did not respect older people.

**Results discussion**

*Self-perceived health*

The interviewed women suffered from physiological changes, various chronic diseases and they often fell sick. Some suffered from NCDs such as heart disease, high blood pressure and cancer. Health issues like these are common on low income countries (WHO, 2015), thus it is not surprising to find these types of diseases among older women in Uganda. Wandera et al. (2015c) also found that in Uganda, self-reported NCDs was associated with advanced age as well as being a woman which is supported by the results from this study.

The women participating in this study perceived their health as deteriorating with age, they suffered from different illnesses and they experienced a loss of energy and felt weak. Among
the interviewed women, poor health sometimes lead to a feeling of hopelessness because they had no relief for their pain and they could not afford treatment for the diseases they suffered from. Baiyewu, Yusuf, and Ogundele (2015) found that the high prevalence of late-life depression in developing countries results from interactions between the factors; social network, poverty and physical health. Their results could be applied to the context of this study where some of the interviewed women experienced hopelessness due to poor self-perceived health and financial constraints.

Some of the women in this study described being sick with worry, worrying about their own income and how to provide for family members who depended on them. According to a study examining the role of family support among widowed older people in China, older people who worried about not having a care giver experienced higher levels of depressive symptoms. The authors of this article found that worrying about not having a care giver could have detrimental effects on the psychological health of widowed older adults (Xu, Li, Min & Chi, in press). Whether the widowed interviewed women worried more about having a care giver is hard to say, however according to the findings of this study some of the women who were not widowed did worry about having a care giver or a steady source of income.

Another health related problem experienced by the women in this study was malnutrition and undernutrition caused by poor feeding. Some of the women could not afford to buy nutritious food and lived mainly of vegetables and carbohydrates, lacking important micro nutrients and proteins, which are essential parts of the diet for older people (Kikafunda & Lukwago, 2005). According to the findings of Schramm et al. (in press) the prevalence of underweight among women in Uganda is associated with older age, and widowed women are more likely to be underweight. This finding is supported by the prevalence of poor feeding and malnutrition found among the interviewed women.

Changes of daily activities related to poor health
Among the interviewed women a feeling of uselessness was described by some who felt that the inability to provide for themselves and do their daily household tasks made them useless to themselves and their families. Being dependent on someone else for things like fetching water, cleaning or cooking was difficult for some women and some felt useless because they were no longer able to take care of themselves. Some felt sad about no longer being able to do activities like going to town or going to church to meet friends, this finding is in line with
results of Baiyewu et al. (2015) who found that social network, together with poverty and physical health, are important determinants of the prevalence of late-life depression in developing countries.

A reason for the changes of daily activities related to poor health among the interviewed women could be, as before mentioned, poor feeding and undernutrition. According to Kikafunda and Lukwago (2005) undernutrition influences the daily activities of people and in particular when it comes to mobility. They found that improving the nutritional status of older people may improve their functional ability and increase their independence which will improve their quality of life. They can thus be able to keep an active role within the household and in their community (Kikafunda & Lukwago, 2005). This result could be applied to the women in this study who felt that they missed performing their daily activities in their homes and in the communities.

*Lacking family support*

Family support was essential to the interviewed women and those who lacked the support of a family could experience a hard time finding an income. Sometimes family members stayed at home with the older women to help them; this means that a grandchild may have been forced to stay at home caring for her grandmother. This is something which is mentioned in the WHO report on health and ageing, where they found that due to inadequate health care and social care, the poor health of an older person may force a family member to stop working and stay at home as a caregiver (WHO, 2015).

Some of the interviewed women were left with the responsibility of caring for their grandchildren and these results are in line with Schatz and Seeley’s study who found that in East and Southern Africa many members of the middle generation are deceased due to the HIV epidemic, which has resulted in the need for many older people to care for their grandchildren having no one to care for them (Schatz & Seeley, 2015).

Some of the interviewed women described how caring for grandchildren could be a burden when it was not accompanied by assistance. Caring for a grandchild could require a greater income in order to provide for their upkeep and schooling, as well as a physical burden carrying around small children on their backs. The burden of caring for a grandchild leads to increased risks of poor mental and physical health in the form of stress, depression, fatigue
and exhaustion according to Oburu and Palmérus (2005). This is evident for some of the women in this study who described worrying and feeling stress about being able to provide for their grandchildren.

However Mugisha et. al (2013) found that care giving was actually associated with better health status, greater life satisfaction and better life quality among older adults in Uganda. These findings are also supported by results from this study where some of the interviewed women reported that they were happy to care for their grand children as long as they were getting some assistance.

**Poor source of income**

The interviewed women who lacked family support and were unable to find an income from doing business depended entirely on the charity of others; these women experienced very fragile livelihoods and could go a whole day without any food. This finding is supported by the study made by Golaz and Rutaremwa (2011) who found that older women in Uganda constitute a group that is extra vulnerable and they are in need of greater support; the prevalence of vulnerability increase with older age and structural and relational vulnerability are factors that affect women more frequently than men. This is seen in this study where the interviewed women who lack family support and a source of income seem to be more vulnerable. Golaz and Rutaremwa (2011) also question the capacity of family support systems in Uganda which seem to fail to care for their family members. This failure is also seen in this study; some of the interviewed women who did receive family support did not get enough assistance and were still lacking a steady source of income.

**Accessing healthcare**

When it comes to health care some women who lacked assistance had no means to even reach the health center or pay for the treatment. Some did not have the money to afford transport and some were not be able to get there because of disabilities or inability to walk far distances. This is confirmed by Wandera et al. (2015b) who found that when it comes to accessing healthcare, older people in Uganda are more likely to have access to healthcare if the household has a better income and that mobility also limits older people’s access to healthcare. Mulumba et al. (2014) found that there is a shortage of drugs at the health centers which also is one of the major issues that older women face when seeking health care.

However it also became clear from the results of this study that standing in line or even sitting
on the benches at the health centers was a challenge for some of the interviewed women when accessing healthcare.

*Cannot afford treatment*

Among the interviewed women a problem was being unable to pay for treatment and medication. According to Wandera et al. (2015c) it is the Ugandan ministry of health that should improve the supply of essential drugs for treatment of NCDs among older people, and Mulumi et al. (2014) write that there is a shortage of drugs and the Ugandan state and health care system are neglecting older people’s needs. According to these researchers, the solution to the problem of not being able to afford health care is that the state should take their responsibility and provide older women with the drugs and treatment that they need.

*Disrespect and abuse*

Some of the women in this study experienced mistreatment and abuse from younger people who did not respect older people. Butler (1980) found that a barrier towards providing good healthcare to older persons is the fact that there are negative attitudes, misconceptions and assumptions about older people within society. Older people are viewed as frail, burdensome or dependent, despite the fact that these people contribute to society in many ways (Butler, 1980). This fits the description which some women gave of their relationship to young people; they experienced that they were not being respected and people had stopped associating with them and stopped giving them assistance.

The main reasons for the poor health experienced by older people in Uganda are inequitable access to health care and discrimination. Older people constitute a marginalized group in society which has a negative impact on their health (Mulumi et al., 2014). The results from this study are in line with this statement because some of the interviewed women felt that the abuse by the youth was a major challenge in their lives. Discrimination, negative attitudes and disrespect of older people were factors that affected the health of the women in this study.

Older peoples’ needs are being neglected by society, the Ugandan state and in particular by the health care system according to Mulumi et al. (2014), they argue that the right to health is not being fulfilled in Uganda, which is a statement that is supported by the results of this study.
**Intersectional discussion**

Viewing the results from an intersectional perspective it is seems evident that for some of the women in this study, discrimination based on gender and age coupled with low socio-economic status and a lack of family support resulted in a very fragile livelihood accompanied by a low quality of life and poor health.

The women in this study who had not given birth to any children experienced discrimination on the basis of this because they were not viewed by society as “real women”. Others felt discriminated by young people because of their age; this gave them a feeling of no longer being part of society. Some experienced age discrimination from society and even from their own family. These forms of discrimination coexist and interact, which for some of these women lead to a life situation that was difficult to manage because of lack of support from their family and from society. Intersectionality research is based on the assumption that different forms of discrimination constantly coexist and impact the individual and her place in society (Lykke, 2003). This coexistence of different forms of discrimination is clearly observed from the results of this study where discriminatory practices lead to a low quality of life and poor health for some of the interviewed women.

The widowed women also were also experiencing more fragile livelihoods than the married women, they lived in a situation where their main care giver was gone and sometimes the late husband’s family even tried to take possession of the women’s homes. Golaz and Rutaremwa (2011) found that belonging to the group of widowed women means having an extra vulnerable existence. This seems to be the case for the women of this study due to discriminatory cultural practices against women which become even more evident late in life and affect women more in an economical way after their husbands have passed on. This is also evident in the study made by Ng et al. (2010) who found that women in low resource societies are very vulnerable when it comes to their health and they experience poorer health than men living in the same areas.

From the results of this study it could be argued that being female, older, widowed and in poor health resulted in a situation where some of the interviewed women suffered from poor health due to being exposed to discrimination on the basis of belonging to several categories of minority groups (Nationella sekretariatet för genusforskning, 2012).
The purpose of this paper is not to generalize to the population of Uganda but to shed light on the situation and life conditions which some older women face and thus contribute to improving the understanding of their challenges, and promoting the health of this vulnerable group. Gender sensitive health interventions are needed to address the problem of poor health among older women in Uganda (Ng et al., 2010) and research on the health of older women in Uganda also needs to have a gender perspective as well as considering the ageist practices that exist in this area. In this context intersectionality is a good method for doing further research on this topic since intersectionality research is driven by the pursuit of social justice and in the field of health care the goal is to decrease health disparities (Kelly, 2009).

**Methodological discussion**

A pilot interview was performed on cite in the study area with one of the older women participating in the study in order to find out whether the interview questions were appropriate to get the right and enough information to answer the research questions. The informant participating in the pilot interview did not see any cause for changing the questions, however it turned out that many of the participants had difficulties understanding the interview questions. This is something that could influence the dependability of the results (Polit & Beck, 2010).

The interpreter was encouraged to ask follow up questions and use probes to get relevant information from the informants; however, the research assistant changed some of the questions and added some new ones. He also focused much on background information, rather than putting most of the time on health related issues. This would imply that the researcher did not sufficiently prepare the interpreter for the interviews which may have an impact on the results. However, the interpreter’s knowledge of local culture probably also benefited the research; changes made to the interview questions may have been done in order to adapt them to the local context. Unfortunately the results will not be shared with informants due to language barriers and time limitations which is something that could negatively affect the trustworthiness of the results (Polit & Beck, 2010).

In order to avoid research bias due to cultural differences and prejudice the researcher tried to be aware of her preconceptions and to remain objective and open minded throughout the
study. Despite the rather small sample size and the limited time span, a point of saturation was reached which strengthens the credibility of the results (Polit & Beck, 2010).

All interviews were not performed in private, which is something that may have affected the credibility of the results; the participants may have shared other thoughts during the interviews if their family members or friends had not been around. However, the presence of close ones may also have given the participants a sense of security that made them comfortable to talk about health related issues. An established method for analyzing data, qualitative content analysis using the model of Graneheim and Lundman (2004) and a well established research method; semi structured interviews was used in this study which strengthens the credibility of the results (Polit & Beck, 2010).

Using a health care worker, who worked at the local public hospital, as an interpreter may have benefited the research and the credibility of the results because Ugandans in general have a lot of confidence in health care personnel and this may have made the participants feel free to open up and share their thoughts with us. However the presence of the health care worker may have hindered the participants from expressing negative views on public health care thus affecting the results. The interpreter was also a man which also could have played a role in skewing the results affecting the credibility of this study negatively, because the women may have felt more comfortable talking about the challenges they have as older women with another woman (Polit & Beck, 2010).

Language barriers may have affected the credibility of the results because neither researcher, nor interpreter or informant, had English as their mother tongue, and some information may have been misinterpreted or got lost in translation. The use of an interpreter during the interviews may have contributed to lower dependability of the results because there is an increased risk of misinterpretations between the interpreter and the researcher (Polit & Beck, 2010). However since the participants did not speak English using an interpreter was the only possible way to carry out this study.

The informants came from different backgrounds; some from rural areas and some from urban areas which strengthens the transferability. There was also a large age-span within the group of participants, where the youngest was 60 years old and the oldest was over 100 years old; this could also increase the transferability of the results because the results could be applied to
a large part of the Ugandan population of older women. The results from this study could have applicability to areas that share the same socio-economic and demographic context as rural and urban Uganda, which include many areas of Africa (Polit & Beck, 2010).

Ethical approval was granted from Makerere University (see appendix 3) as well as from the chairpersons of the communities where the interviews were performed. The research focus was in the area of personal health and therefore it was important to make sure that the participants had full protection from coming to any harm. In order to keep them from harm several steps were taken; the participants were informed thoroughly about what it meant to participate in the study, what the topic of the interview was and that participation was completely voluntary and confidential. They were also informed that their name would not be found anywhere in the research and that their interview statements would be given a number which could not be traced back to the individual. They were then asked to sign a consent form and given a copy of the form with written information about the purpose of the study and contact information to the researcher and local contacts in case they had any questions.

**Clinical significance of the results**

Results that stem from this study could possibly open the eyes of policy makers and health care workers to better understand the situation of older women and thus provide them with more appropriate assistance and healthcare. For example, some may need health care in their homes because of difficulties getting to a health center, some cannot stand in line or sit on the benches at the clinic and they need to be taken care of at once and not kept waiting for hours. The results also show that some older women feel skeptic towards modern medicine and in this situation more information and patient education is required to get better adherence to treatment. The fact that some older people feel discriminated and mistreated by young people is also important for a nurse to know because in that situation it is perhaps even more important that he/she gives good care and shows a lot of respect and empathy. Some older women live with constant pain and health care practitioners need to be aware of this suffering in order to give patients advice on how to reduce or live with the pain. It is also vital that nurses do not simply see an old woman but that he/she sees the patient as an individual with her own thoughts and needs.
Researchers Mulumba et al. (2014), Kikafunda and Lukwago (2005) and Wandera et al. (2015c) and some of the interviewed women believe that the government of Uganda is not doing enough to assist older people in Uganda. From the results it is also clear that society does not always favor old women, some suffer from discrimination and mistreatment and feel alienated from their communities and society. Young people and society at large needs to show older people respect – not because they are older but because all people have the same value. Many older people also contribute a lot to society; providing for their families, running businesses and acting as caregivers for children and grandchildren.

For nurses it is important to understand the health issues that affect different patient categories in order to provide good health care. The ultimate goal of this research is to contribute to improving the health of older women which is in line with nurses’ fundamental responsibilities of promoting health (International Council of Nurses, 2012). The code of ethics of the International Council of Nurses states that nurses have a responsibility to initiate and support action to meet health and social needs of the population – and in particular for vulnerable groups in society. This means that it is in particular nurses’ responsibilities to work towards ending the discrimination of older people that exists within the Ugandan society and even within the health care system.

There is a gap in the research about older women’s health in Africa in general, and to really understand the factors affecting their health and the challenges they face there is need for more research in this area. Older women constitute a fragile group of the Ugandan society and their need for assistance is great (Golaz and Rutaremwa, 2011). Thus more research is needed in order to find out how to improve the health of these women and what role health care practitioners can play in accomplishing this.

Conclusion
The women in this study experienced poor health and suffered from disease and pain. Some found that their income was insufficient and they depended on family support or charity. The interviewed women who lacked a source of income had no means of accessing health care or getting treatment, and even those who did have a source of income experienced difficulties paying for treatment. This affected their health negatively and some suffered greatly without any relief. For some of these women, discrimination based on gender and age coupled with low socio-economic status and lack of family support resulted in a very fragile livelihood accompanied by a low quality of life and poor health. The results of this study will hopefully
contribute to a better understanding of the factors that affect the health of older women in Uganda, which is important to researchers in the field of health care, to health care practitioners as well as to policymakers.

Acknowledgments

I would like to thank the women who agreed to participate in this study and made this research possible.

I would also like to extend a special thank you to Lydia Kabiri from the Nursing Department at Makerere University for all her practical help in coordinating and conducting this study.

This project would not have been possible without the support of the Linnaeus-Palme scholarship from Universitets- och Högskolerådet (UHR).
REFERENCES


Appendix 1. Interview guide

1. Would you tell me little bit about your background? How old are you? What is your occupation? From where do you get your income?
2. Would you like to tell me about what you do on a typical day?
3. How do you perceive your own health?
4. In what way has your health changed as you have become older?
5. Could you tell me about your life situation and factors that affect your health today?
6. What are your experiences of accessing healthcare?
7. What do you think are the major issues that affect the health of older women (60+) in Uganda today?

Interview guide in Luganda

1. Mbulirakubikukwatako, n’geemyakagyo, Omulimugwokola, kyokolaokufunaensimbi?
2. Mbulirangabwotambuza mulunakulwo?
3. Ebikwatakunsonga yobulamubwo, obilowozakokyobaobilabaotya?
4. Mukukulaemyakan’ ofuka omukade, ensongobulamubwozikyusemuzitya?
5. Mbulirakumberayon’ eokusomozemwakunsonga yobulamubwo?
6. Mbulirakubo zeoyi tamumukufuna obujanjabi obabyo zeoyitamumunsongazebyobulam?
7. Nsonga Kyi ezikosa obulamubwabakyalaa bakade abali mumyakagy omunsiyafeYuganda?
Appendix 2. Information letter and consent form

Title of study: A qualitative study exploring factors that affect older women’s self-perceived health in Uganda.

Investigators: Malin Hillblom

Background and rationale for the study
My name is Malin Hillbom and I am doing a study on the health of older (+60) women in Uganda. This study is part of my bachelor thesis in the area of Nursing at Uppsala University in Sweden. The reason I wish to study the health of older women is Uganda is because it is a group who often suffer from poor health and in order to improve older women’s health it is important to know what factors affect their health.

Purpose
The purpose of the interview is to explore factors affecting older women’s health in Uganda. The topic for the interview is personal health experiences and factors that influence personal health. You are being invited to take part in this research because I feel that your personal experience as a woman living in Uganda can contribute much to our understanding and knowledge of local health practices.

Procedures
During the interview, I and an interpreter will sit down with you in a comfortable place outside or if it is better for you, the interview can take place in your home. This interview will take about 30 minutes, perhaps longer. The interview will be recorded on a tape-recorder and later be written into text documents.

Who will participate in the study?
The participants in this study are Ugandan women above the age of 60.

Risks/discomforts
There is no risk or harm coming to participants who choose to partake in this study.

Benefits
There are no direct benefits for participants. The benefits of the study will be seen in the future and the results of this study will generate new knowledge about the health of older women in Uganda which can benefit the health of older women in the future.

Alternatives
Participation in this study is not mandatory. If you do not wish to participate you may say so without any penalties. The participant is allowed to withdraw at any point of the study.

Cost
There are no costs attached to participation.

Compensation for participation in the study
There is no compensation because there is no risk of injury or harm to participants.

Reimbursements
If the interview is performed in the home of participant there are no costs for transport. If the interview takes place in another location participants will be reimbursed for the travel costs at a public transport rate up to 10,000 UGX.
Questions
Participants are free to ask any questions during interview and anything that is not clear will be explained. If participants have questions after the interview they can use the contact information below.

Questions about participants’ rights
If participants have questions about their rights they may ask the researcher at any time.

Statement of voluntariness
Participation in the study is voluntary and participants may join on their own free will. Participants also have a right to withdraw from the study at any time without penalty.

Confidentiality
The results of this study will be kept strictly confidential, and used only for research purposes. My identity will be concealed in as far as the law allows. My name will not appear anywhere on the coded forms with the information. Paper and computer records will be kept under lock and key and with password protection respectively. The interviewer has discussed this information with me and offered to answer my questions. For any further questions, I may contact Malin Hillblom Tel: (+256) 790 271724 or Lydia Kabiri Tel: (+256) 0779429986. Or the Chairperson, School of Health Sciences Institutional Review Board (MakSHS-IRB) or Uganda National Council of Sciences and Technology. Tel (+256)772-404970/ (+256)200903786 or (+256)-41-250431.

STATEMENT OF CONSENT/ASSENT
..............................................has described to me what is going to be done, the risks, the benefits involved and my rights regarding this study. I understand that my decision to participate in this study will not alter my usual medical care. In the use of this information, my identity will be concealed. I am aware that I may withdraw at anytime. I understand that by signing this form, I do not waive any of my legal rights but merely indicate that I have been informed about the research study in which I am voluntarily agreeing to participate. A copy of this form will be provided to me.

Name:..................................Signature of participant...........................................Age....
Date.........................................

Or thumb print.......................................................... ..................................................

Name:..................................Signature of research assistant...............................
Date..........................................................

Name:..................................Signature of interviewer...........................................
Date..........................................................


Information letter and consent form in Luganda

EKIWANDIiko Ekiraga Okukkiriza Okwetaba Mu Kunoonyereza (Ekyo Luganda).

Abakyala Abakadde Abali Mumyaka Enkaga Nokuyitim, Ensonga Zebayitim Kubikwata Ku Bulamu Bwabwe

Okweyanjula

NzeMalin Hillblom, ndimuyiziwabusawokutendekelolya Uppsala University, mu Sweden.

Esimu- +256 785 300 956

Ekigendelerwaekyokunonyereza.

AmanyanzeMalinHillbomonnyerezakunsongaezikwatakubulumubwabakyalaabalimumyaka 60 nokugendawagulu Mu Yuganda.


Ebigobelerwa.


Ani atekedwaokwetabamukunonyerezakuno?

Atekedwaokwetabamukunonyerezakuno, yemukyalaomunaugandaalimumyakaenkaganokusukamu

Obulabe.

Tewalibulabebwojjakufuna mu kunonyerezakuno.

Emiganyulo.

Tewali emigaso egyamanggu mukunonyerezakuno, biyiteeyenfuna oba ebilala. No’lwekyo ebivamukunonyereza bigyakubabyamugaso mu Kufunaamagezi amapya Kunsonga ezikwatakulumu bwapakyalaakadebaganyulwemu mu maaso.

Ebisale
Tewalibisalebyona mukukiriza okwetabamukunonyerezakuno

**Okusasulwa**

Mukunonyerezakunotetusubiraokukosebwamungeliyona. Nolwekyotewalisa
tezingendaokusulibwamungeliyakukosebw.

**Ebibizo**

Oliwaddembeokubuzaebibuzobyobatotegeddemukonnyerezakuno. Oba
osobalakubzaebibuzokusimawamaga.

**Okukumaebyekyama**

Ebinavamukunonyerezakunobigyakukumibwangabyamangabwebabilambikidwamumatek
a. Ebikukwakatobjiakuwebwaenambatebijjakubelanakakwatekubifulumizibwa mu’ aripota.

Wobbanebibuzobyona, oliwaddembeokukubakusimuyya’Malin Hillblom Tel: (+256) 790
271724 oba Lydia Kabiri Tel: (+256) 0779429986. Oba akulira School of Health Sciences
Institutional Review Board (MakSHS-IRB) Oba Uganda National Council of Sciences and
Technology. Tel (+256)772-404970/ (+256)200903786 or (+256)-41-250431

**OkukirizangaTokakidwa**

___________________________ebyawaggulubyonaabinyonyoden’ekigendererwaekyoku
nonyereza.,ebigobelerwa, obulabe, omuganyulo
,edembelyangeabuuzibwanokukwataedozi
tukatambi. Era
ng’aebibuzobyangebyakakatibizidwamu.
Kimpadeamanyiokukirizan’okusaomukonokulupapulunongerasikakidwaokwetabamukuno
nyerezakuno.

Omukonogw’abuuzibwa_________________________enakuzomwezi_________________Emyaka__

Oba

EkinkumuKyoyoabuuzibwa_____________________________enakuzomwezi________

Omukono g’omunonyereza_____________________________enakuzomwezi______
Appendix 3. Copy of ethical approval

March 03\textsuperscript{rd} 2016

Ms. Malin Hillblom
Uppsala University
Sweden

Category of review

[X] Initial review
[ ] Continuing review
[ ] Amendment
[ ] Termination of study
[ ] SAEs

Dear Ms. Malin,

Re: Approval of Proposal #SHSREC REF: 2016-004
“A qualitative study exploring factors that affect older women’s self perceived health in Uganda”

Thank you for submitting an application for ethical review of the above — referenced. The committee reviewed it and granted approval for one (1) year, effective March 03\textsuperscript{rd}, 2016. Approval is valid until March 02\textsuperscript{nd}, 2017.

Continuing Review
In order to continue work on this study (including data analysis) beyond the expiration date, the School of Health Sciences Research and Ethics Committee must reapprove the protocol after conducting a substantive, meaningful, continuing review. This means that you must submit a continuing report form as a request for continuing review. To avoid a lapse, you should submit the request six (6) to eight (8) weeks before the lapse date. Please use the forms supplied by our office.

Amendments
During the approval period, if you propose any change to the protocol such as its funding source, recruiting materials, or consent documents, you must seek School of Health Sciences Research and Ethics Committee approval before implementing it.

Please summarize the proposed change and the rationale for it in a letter to the School of Health Sciences Research and Ethics Committee. In addition, submit two (2) copies of an
updated version of your original protocol application- one showing all proposed changes in bold or 'track changes,' and the other without bold or track changes.

**Reporting**
Other events which must be reported promptly in writing to the School of Health Sciences Research and Ethics Committee include:
Suspension or termination of the protocol by you or the grantor
Unexpected problems involving risk to participants or others

Adverse events, including unanticipated or anticipated but severe physical harm to participants.

Do not hesitate to contact us if you have any questions. Thank you for your cooperation and commitment to the protection of human subjects in research.

Final approval is to be granted by Uganda National Council for Science and Technology.

Documents approved for use along with protocol include:
- English Informed consent form
- Translated informed consent (Luganda)
- Interview guide
- Translated interview guide

Yours sincerely,

Mr. Paul Kutyabami
Chairperson, School of Health Sciences Research and Ethics Committee