SELF-ASSESSED HEALTH AS PREDICTOR OF OBJECTIVE HEALTH STATUS AMONG RURAL AGED IN NIGERIA

ABSTRACT. Structured interviews of 112 old males and females in three rural locations in Nigeria examine the relationship between self-assessed health and four objective health indicators. Results show that although almost all of the respondents describe their health as 'better' or 'much better' than that of their peers, other health indicators reveal evidence of a generally poor health status. There was no significant association between self-assessed health and three out of the four objective health indicators. The best predictor of both objective and subjective health status was the degree of stress experienced by the respondents in the six months preceding the survey. Discussions examine possible reasons for the finding and pay particular attention to those factors which may encourage the overestimation of good health and underestimation of objective health failings among rural elderly in Nigeria.

Key Words: functional health status; poverty, stress, culture, Yoruba, Nigeria

INTRODUCTION

Studies conducted in the Western world have led to an increasing recognition of the diverse ways in which self perception of health affects the life of the elderly. Cockerham and his associates argue that subjective health feeling is a very important indicator of the ways in which aged persons relate to their social world (Cockerham, Sharp, and Wilcox 1983). Others report that the aged's self-assessment of health is a strong predictor of general life satisfaction (Larson 1978; Palmore and Luikart 1972). Of particular relevance to this paper is the finding by some researchers that self-assessment of health is an important predictor of objective health status among old people (Fillenbaum 1979; Linn and Linn 1980; Maddox 1973; Suchman, Phillips, and Streib 1958). This study aims at examining the applicability of this proposition to the rural elderly in Nigeria. The rationale for this examination are both theoretical and practical.

Theoretically, the validity of this proposition appears to have been affirmed in countries where the overall health status of the populace is high, where health facilities are plentiful and where institutional arrangements exist to ensure the aged's access to medical care. In Nigeria, the general health status is very low; life expectancy at birth for males is 45.9 years and for females, 49.2 years (United Nations 1979). The estimated crude death rate is 18.9 and only 35% of the population is covered by any form of modern health care service (Federal Republic of Nigeria 1980). Sixty percent of the population live more than ten kilometers from the nearest hospital and 45% live more than 20 kilometers away from the
nearest hospital (Egunjobi 1983). The conditions are worse in the rural areas, where the available health facilities are usually ill equipped, poorly staffed and ineffectively run dispensaries (Adejuyigbe 1977). The general living conditions are so poor that some have characterized rural dwellers in Nigeria as the silent but oppressed majority.

Furthermore, because of the demographic features of Nigerian society — a high birth rate, a very young population and the associated high infant and childhood mortality and morbidity — government health policies and programs focus almost exclusively on the prevention and treatment of childhood diseases such as measles, whooping cough, diptheria, etc. There are, as of this writing, no policies or programs or any institutional arrangements which aim at facilitating the aged’s access to health care services. Thus, the poorer overall health status and the limited access of the elderly to health enhancing services in effect means that this study is testing the proposition about the relationship between subjective and objective health status in a setting very different from that in which the proposition emerged. Theoretically, this may prove helpful in efforts to check the cross-cultural applicability of the proposition and thereby separate the universal elements of the proposition from some of its particular and culturally unique elements.

The practical benefit of examining the applicability of this proposition lies in its potential as a heuristic device for planning and location of health facilities. To date, epidemiological surveys in Nigeria are not sufficiently widespread and comprehensive to place the incidence of diseases on a fully quantifiable level and if, as Maddox and Douglas (1973) suggest, subjective health feeling could serve in the place of a more elaborate assessment where a general health measure was needed, then measurement of subjective health feeling may be an inexpensive method to identify needy catchment areas for the provision of essential health services for the rural aged.

This paper therefore examines the question: What, if any, is the relationship between self-assessed health and objective measures of health among rural elderly? Is self-assessed health a good predictor of objective health status among them?

METHOD

The study was conducted in three villages in Oyo State — Ascjire, Ajeigbe and Ikoji-Ile. The selected villages were visited by the author and a research assistant, and with the assistance of a community member an attempt was made to compile a list of aged individuals. An aged individual was defined as 55 years of age and above. We chose age 55 years and above out of the recognition that we are dealing with a population in