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INTRODUCTION:

Predicting the household's ability to cope with adult illness and death can be complicated in low-income countries with high HIV prevalence and multiple other stressors and shocks. This study explored the link between stage of the household in the life cycle and the household's capacity to cope with illness and death of adults in rural Uganda.

METHODS:

Interviews focusing on life histories were combined with observations during monthly visits to 22 households throughout 2009, and recorded livelihood activities and responses to illness and death events. For the analysis, households were categorised into three life cycle stages ('Young', 'Middle-aged' and 'Old') and the ability to cope and adapt to recorded events of prolonged illness or death was assessed.

RESULTS:

In 16 of the 26 recorded events, a coping or struggling outcome was found to be related to household life cycle stage. 'Young' households usually had many dependants too young to contribute significantly to livelihoods, so were vulnerable to illness or death of the household head specifically. 'Middle-aged' households had adult children who participated in activities that contributed to livelihoods at home or sent remittances. More household members meant livelihood diversification, so these households usually coped best. Worst off were 'Old' households, where members were unable to work hard and often supported young grandchildren, while their adult children had stopped sending remittances as they had established households of their own.

CONCLUSIONS:

While households may adopt diverse coping mechanisms, the stage in the household life cycle when stressful events occur is important for coping outcomes. Households of the elderly and households with many young dependents are clearly vulnerable. These results demonstrate that household life cycle analysis can be useful in assessing ability to respond to stressors and shocks, including AIDS-related illness and death.

OBJECTIVE:

Community based evidence on pregnancy outcomes in rural Africa is lacking yet it is needed to guide maternal and child health interventions. We estimated and compared adverse pregnancy outcomes and associated factors in rural south-western Uganda using two survey methods.

METHODS:

Within a general population cohort, between 1996 and 2013, women aged 15-49 years were interviewed on their pregnancy outcome in the past 12 months (method 1). During 2012-13, women in the same cohort were interviewed on their lifetime experience of pregnancy outcomes (method 2). Adverse pregnancy outcome was defined as abortions or stillbirths. We used random effects logistic regression for method 1 and negative binomial regression with robust clustered standard errors for method 2 to explore factors associated with adverse outcome.

RESULTS:

One third of women reported an adverse pregnancy outcome; 10.8 % (abortion = 8.4 %, stillbirth = 2.4 %) by method 1 and 8.5 % (abortion = 7.2 %, stillbirth = 1.3 %) by method 2. Abortion rates were similar (10.8 vs 10.5) per 1000 women and stillbirth rates differed (26.2 vs 13.8) per 1000 births by methods 1 and 2 respectively. Abortion risk increased with age of mother, non-attendance of antenatal care and proximity to the road. Lifetime stillbirth risk increased with age. Abortion and stillbirth risk reduced with increasing parity.

DISCUSSION:

Both methods had a high level of agreement in estimating abortion rate but were markedly below national estimates. Stillbirth rate estimated by method 1 was double that estimated by method 2 but method 1 estimate was more consistent with the national estimates.

CONCLUSION:

Strategies to improve prospective community level data collection to reduce reporting biases are needed to guide maternal health interventions.