Thesis

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EXPLORATION OF NEEDS, PROBLEMS AND LIVING EXPERIENCES OF OLDER PERSONS IN UGANDA: IMPLICATIONS FOR POLICY AND DECISION MAKING

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MAY 2010

DECLARATION

I, Annet Nankwanga, declare that this is my original work and has never been submitted before to any university for any award of a degree.

Sign.....date……

APPROVAL

This thesis is submitted for examination with our approval as the supervisors.

Supervisors:

Sign..... Date.....

Professor Julie Phillips

Sign..... Date.....

Dr. Stella Neema

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DEDICATION

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ABSTRACT

The purpose of the study was to explore the needs, problems and living experiences of the older persons in Uganda and their implications for decision making and policy. The study was an exploratory descriptive cross-sectional study that involved triangulation of both qualitative and quantitative approaches. It was guided by five objectives, which included: exploring the living experiences of Uganda's older persons living in both rural and urban settings; identifying the barriers to these people's effective participation in society; establishing the mechanisms that they use to cope with the barriers; evaluating the extent to which their needs are addressed by policy; and proposing policy strategies needed to address their plight. The study sample consisted of two purposively selected sub samples of 165 older persons for qualitative data and 50 key informants for quantitative data. The key informants were selected from Ministries of Gender, Labour and Social Development; Urban, Housing and Physical Planning; Agriculture; Health; Education and Sports, Public service, and nongovernmental organizations dealing with the older persons in Uganda. Data were collected using in depth interviews with older persons, self administered questionnaire to key informants and documentary review. The qualitative data was analyzed using content analysis including documentary review, while the quantitative data was analysed using the frequency option of the descriptive method of SPSS, and graphical method of the Excel programme.

Results show that the living experiences of most of Uganda's older persons are characterised by pathetic economic, health, social, housing and accommodation, water supply, and sanitation conditions. The barriers to the effective participation of these people in society take the form of age-related prejudices, problems, and limitations faced at personal, household and community levels. They basically include constraints to the physical fitness, healthcare, economic status, food security and nutrition, and realization of accommodation and housing conditions desired by these people to live a life by which they can effectively participate in society. Other barriers include: large numbers of grandchildren most of whom are orphans left behind by the older person's children claimed by the HIV/AIDS pandemic and community members ignoring them as helpless people who have outlived their usefulness. Accordingly, the coping mechanisms used by these people were established as the psychological, physical, healthcare, and economic ways by which they deal with each of the aforementioned barriers.

A review of development policies such as PEAP, PMA, NAADS, HIV/AIDS policies among others revealed that a number of policies and programs in Uganda exclude the older persons from active participation. Findings show further that though the extent to which the Constitution of Uganda government recognizes the plight of the older persons is appreciable, it is largely insufficiently translated into policy action by which the plight can be effectively addressed. A number of strategies were therefore proposed to help address this insufficiency, thereby solving the needs and attending to the barriers facing these people in an effective policy manner. The strategies focused on improving older persons' physical fitness, access to healthcare, economic capacity, food security and nutrition, and housing and accommodation. Other strategies focused on dealing with the impacts of HIV/AIDS and community prejudices held against older persons.

The study was concluded by observing that although the quality of the living experiences of Uganda's older persons can be improved by dealing with the barriers faced by these people, the mechanisms that they use to do so are not adequate. It was also noted that there was need to translate the constitutionally recognised plight of the older persons into effective policy action. Consequently, it was recommended that the proposed policy strategies should be adopted and translated into the needed policy action. Further research was also recommended into the legal implications and funding implications of the proposed policy strategies.

Key Words: Older persons, needs, problems, living experiences, policies, Uganda

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LIST OF ABBREVIATIONS

AFAD	Automated Flagging Assistance devices
ART	Antiretroviral Therapy
ARV	Antiretroviral
BHF	British Heart Foundation
CBO	Community Based Organisation
CEO	Chief Executive Officer
CVI	Content Validity Index
DANIDA	Danish International Development Agency
DFID	Department for International Development
ECHR	European Convention of Human Rights
EIC	Education, Information and Communication
EU	European Union
HIV/AIDS	Human Immune Virus/ Acquired Immune Deficiency Syndrome
HREA	Human Rights Education Associates
HSSP	Health Sector Strategic Plan
IDA	International Development Association
IDB	International Data Base
IDPs	International Displaced People's Camps
ILO	International Labour Organisation
MAAIF	Ministry of Agriculture, Animal Industry and Fisheries
MDGs	Millennium Development Goals
MFPED	Ministry of Finance Planning and Economic Development
MOH	Ministry of Health
MTCT	Mother- to -child transmission
NAADS	National Agricultural Advisory Services
NGO	Non Governmental Organisation
NIHRC	Northern Ireland Human Rights Commission
NSSF	National Social Security Fund
NUSAF	Northern Uganda Social Action Fund
PACE	Program of All-inclusive Care for the Elderly
PEAP	Poverty Eradication Action Plan

PEP	Post Exposure Prophylaxis
PLHA	People Living with HIV/AIDS
PMA	Programme for Modernisation of Agriculture
PRSP	Poverty Reduction Policy Strategies
ROM	Result Oriented Management
ROTOM	Reach One Touch One Movement
SDA	Seventh Day Adventist
SDIP	Social Development Sector Strategic Investment Plan
SPSS	Software Package for Social Sciences
STD	Sexually Transmitted Diseases
SWAP	State Wide Approach Plan
TAF	The Aged Family
TASO	The Aids Support Organisation
TB	Tuberculosis
UBOS	Uganda Bureau of Statistics
UG X	Uganda Shillings
UN	United Nations
UNESCO	United Nations Educational Scientific and Cultural Organisation
UNICEF	United Nations International Children's Educational Fund
UPE	Universal Primary Education
URAA	Uganda Reach the Aged Association
USD	United States of America Dollar
VCT	Voluntary Counselling and Testing
WHO:	World Health Organisation

CHAPTER ONE
INTRODUCTION

1.1 Background to the Study

The population of older persons has recently increased more than ever before. The latest World Population Census (2002) shows that older persons totalled up to 600 million, 370 million of whom are living in developing countries. The total was projected to double by 2025 and to reach two billion by 2050 (United Nations, 2002a). In 2008, the United States Census Bureau (2008) estimated the population of older persons at 10.1% of the world's 6.76 billion people. In Africa, 5.1 % of the population was estimated to be 60 years or older (Kollapan, 2008). This trend of population increase seems to be cutting across all nations of the world, including Uganda.

The foregoing proportions suggest that older persons form a significant proportion of the world's population, which is rising so fast that it now poses a policy challenge that no country, which respects the life and is concerned about the plight of the older persons can, afford to ignore. In fact, this challenge had already been detected by the United Nations at its Second World Assembly on Ageing held in Madrid, Spain, in 2002. This Assembly's main theme was about 'building a society for all Ages' and its major aim was to find a long-term solution to the above-mentioned challenge. The Assembly attracted 189 Member States, representatives of United Nations (UN) agencies, designated international organizations, and accredited Nongovernmental Organizations, including representatives from Uganda. Delegates adopted a revised version of the 1982 International Plan of Action on Ageing and made a Political Declaration binding all UN member states to implement the plan's long-term strategy on aging. The declaration was therefore made with the optimism that it would translate into improving and maintaining the living conditions of the world's older persons.

Unfortunately, countries especially those in the developing world, have given lip service to older persons. Most of the developing countries have not given adequate attention to understanding or addressing the plight of older persons through scholarship and policy

(Sembajwe, 2004). In Uganda, the plight of older persons has received far less than the scholarly and policy attention it deserves despite the fact that these people form 6.1% of the country's estimated 30 million people (Mugambe, 2006). As a result, little is known about their living experiences, the barriers that these people encounter as they endeavour to effectively participate in society, as well as the coping mechanisms that they use to deal with the barriers.

Such a scenario casts doubts about the circumstances lived by these people, thereby leading to posing a number of questions some of which could be: (a) What are the needs, problems and living experiences of older persons in Uganda? (b) What are the barriers to effective participation of Uganda's older persons in society? (c) What are the mechanisms used by the older persons to cope with the barriers to effective participation in society? (d) To what extent are the needs of the older persons addressed by policy in Uganda? (e) What are the strategies that can be used to address the plight of older persons in Uganda? Finding answers to the above questions formed the motivational basis for this study. Accordingly, the study focused on exploring each of these dimensions of living experiences of Uganda's older persons, with a view of proposing policy strategies that could help deal effectively with the plight of these people.

The concept of old age has always existed since time immemorial. This notion is used in social and natural sciences to describe not only chronological age but also the nature, changes, or characteristics of objects and organisms when they are in the later days of their existence (Moody, 2006). Old age has particularly been considerably pronounced in humankind. Most of the human population censuses, socio-psychological and anthropological studies associate old age with people who have lived for at least sixty years. However, debate still lingers on a universally acceptable definition of an older person (Antonucci, Okorodudu & Akiyama, 2002). The controversy is actually more evident in Uganda.

The Uganda Bureau of Statistics (UBOS) (2007) defines an older person as an individual of at least sixty years. Even the 1995 Constitution of the Republic of Uganda stipulates

that an older person has to be sixty years and above; and the retirement age is sixty years. Ironically, the social protection policy being drafted in Uganda defines an older person as an individual who has at least sixty-five years of age. The policy, therefore, contrasts with the age used by UBOS and defined by Uganda's Constitution. It is, however, presumed that the policy intent of fixing the minimum age of older persons at sixty-five is to minimize the number of older persons who should be entitled to the associated cash transfers. Against this backdrop, the age prescribed by this upcoming policy was disregarded in this study.

For this study, an older person was operationally defined as any male or female individual whose age was at least 55 years. This definition was arrived at following a number of observations. The World Population Census (2002) noted that the onus for survival put people living in most of the poor economies (like Uganda) at a greater disadvantage than those living in rich countries, thereby causing them to age beforehand. Velkof and Kowal (2007) made it clearer by observing that using 60 years of age as a boundary for old age may not be suitable for Sub-Saharan Africa since over 80% of the countries in this region have a life expectancy of less than 55 years of age. In fact, the life expectancy in Uganda is estimated at 50 years (UBOS, 2002). The age limit of 55 was therefore still an exaggeration in statistical terms but it was adopted based on the recommendation that Kanyoni and Phillips (2009) made after an exhaustive literature search on the appropriate cut-off age for older persons in Sub-Saharan Africa. From the search, these scholars recommended 55 years as the age that should define an older person in Sub Saharan Africa. Furthermore, in most African traditions the title "older person" is socially determined by one's role in society.

Evidently, defining an older person as any individual whose chronological age is at least 55 years is more appropriate for a Sub Saharan country like Uganda, particularly for scholarly purposes. This age was further adopted following a tendency in Uganda involving people, especially women, not wanting to reveal their true age. The age that they report is normally less by at least five years, especially when they are in the transition period between adulthood and old age. In Uganda, people have tended to stick

to such a tendency because of lack of records regarding their dates of birth; and this problem is more associated with older persons (UBOS, 2002). Let it be noted that in this study 'older persons' are also referred to as 'elderly people,' elderly respondents' or 'the aged'. These terms are used interchangeably throughout the text but they all carry the same meaning.

Uganda's population is generally young with about 56% below 18 years of age and about 93.9% below 55 years of age; which implies that older persons form the remaining 6.1% of the country's estimated 30 million people (UBOS, 2007). World population predictions indicate that the worldwide proportions of the aged are increasing at a fast rate across all nations (IDB, 2008). Notwithstanding their rapid increase, many older persons in several countries continue to live in apathetic conditions and experiences of life which are characterised by uncertainty, poverty, helplessness and hopelessness (Bagala, 2007; Mugambe, 2006; Ainsworth & Dayton, 2000). In addition, their profile of physical capacity changes with age indicating a threshold for independent life and possible means of reducing the consequences of age related to changes in physical capacity (Ebrahim, 2002). Good healthcare for all ages is likely to play a major role in improving the peak capacity of older people. It is also likely to play a key role in reducing the rate of decline in physical and mental functions that are associated with old age. As a result, good healthcare is likely to ensure that people reach thresholds for maintaining independent life at a much later age.

Effective social policies in conjunction with health policies can play a pivotal role in bringing about such good health. Indeed, these policies are known to be at the core of addressing the needs and problems faced by older persons. Unfortunately, negligible efforts have been made to provide older persons with the deserved care, self-fulfilment, independence, and dignity (Zulema, 2002). Many developing countries in Africa do not have social protection policies for addressing the needs and problems of older persons, thereby helping to reduce their poverty and vulnerability levels. The few African countries that have these policies in place include South Africa, Lesotho, Botswana, and Mauritius among others. There are also a few other African countries like Tanzania

where these policies are still in their pilot stage, implying that there is still time needed to provide evidence for the actual formulation of these policies to take course. In the United Kingdom, there is a national service framework for older people's health services. This framework defines the standard of care to which an older person is entitled (Ebrahim, 2002) but the defined standard is still a dream in most of the African countries; for even the specialised personnel needed to adequately handle the prescribed healthcare for older persons is acutely lacking in these countries.

Uganda has lately realised the gap pertaining to the plight of older persons and is currently undertaking a pilot study as a precursor to formulating the Social Protection Strategic Plan. The pilot study is going on in 14 districts involving providing handouts (cash transfers) to vulnerable older persons and analyzing how the handouts are helping to improve the livelihoods of these people (Devereux, 2010). This cash transfer scheme was proposed after recognising that lack of cash among the chronically poor most of whom are older persons makes it difficult for them to benefit from main stream development programmes. It was realised that households without cash are not able to pay for even transport so as to access health facilities. They are also unable to buy uniforms or scholastic materials needed by children or orphans under their care to go to schools. Currently older persons, just as other chronically poor people, are not benefiting from mainstream development interventions in the country. For instance the poverty reduction programs like UPE, Microfinance Development, Plan for Modernisation of Agriculture, and NAADS only benefit children and people who have cash and are energetically productive. In addition, the current existing traditional safety nets such as 'muno-mukabi' (A friend in need), foot ambulance groups among others only operate negligibly because of their small coverage. These safety nets also exclude older persons because they target only those people who are able to make contributions (Namuddu, 2007). There is thus need for alternatives that can help majority of the older persons and other poor people.

The upcoming cash transfer scheme was proposed to promote escape from chronic poverty by preventing the poor from sinking deeper into poverty. If implemented, the

scheme is likely to support household purchase and to improve human capital: Regular transfers will likely enable households to invest in education and health. However, it is not known whether Uganda shillings 22,000 (equivalent of about 10 USD), which is the amount suggested to be given to each older person per month, will be able to meet these people's requirements given the current state of inflation witnessed in Uganda in form of rapidly escalating fuel and commodity prices.

Furthermore, although most of the aged continue playing important roles through volunteer work, participation in conflict resolution, transmitting experience and knowledge to the youth and adults, grand-parenting, and providing care to members of their households, they get engulfed in pessimism about their present and future life, especially after disengagement from income generating economic activities, and social or public responsibilities (Kollapan, 2008; Anweng-Angura & Anyuru, 1994). Such pessimism has even become more intense today than ever because of the HIV/AIDS pandemic (Mutangadura, 2001). This bubonic plague has tended to increase older people's household responsibilities as a result of causing large numbers of orphans after killing millions and millions of mothers and fathers in their industrious age (Alun, 2003). The worst scenario is that majority of people claimed by the HIV/AIDS pandemic are the very people who are traditionally considered to be the source of support and care for the older persons, especially in developing countries like Tanzania, Zimbabwe, Namibia, and Uganda (Nankwanga, Phillips & Neema, 2009; Sembajwe, 2004; Nayiga-Ssekabira, 2002; Ainsworth & Dayton, 2000; Walugendo, 2000). By killing the industrious stratum of society, HIV/AIDS has greatly weakened the traditional social security or protection maintained by means of family and kinship ties, thereby adversely affecting older people. Kollapan (2008: 1) aptly articulated the impact of HIV/AIDS on older persons as follows:

> In traditional African societies, older persons are generally supported and cared for by their adult children when they are no longer able to take part in economic activity. However, the changing societal dynamics brought about by the HIV/AIDS pandemic have impacted negatively on the cohesion of the family and its ability to create a nurturing and enabling environment for the protection of older persons. Today, older persons are the sources of care for millions of young children orphaned as a result of HIV/AIDS.

According to Mugambe (2006) and the Uganda Bureau of Statistics (2002), orphans left behind as a result of deaths caused by HIV/AIDS-related illnesses, increased from 11% in 1991 to 13% of Uganda's total population in 2002. Out of the thirteen percent, 50% were found to be under the care of older persons. What exacerbates the situation is that as most of the older persons continue to live in uncertainty, the understanding of their living experiences; the barriers that they encounter in daily life, especially in their efforts to participate effectively in society; the coping mechanisms that they use to deal with the barriers, and policy efforts geared towards addressing their plight, have all been given less than the attention they deserve in scholarship and policy formulation and effective implementation. Uganda is one of the candidates as far as this matter is concerned (Ntale-Lwanga, 2003; Najjumba-Mulindwa, 2004; Mugambe, 2006; Bagala, 2007; Kiiza-Wamala, 2008; Nankwanga, Phillips & Neema, 2009; Tavengwa- Nhongo, 2004; Dayton & Ainsworth, 2002).

Where policy efforts have been made to understand and address the plight of older persons, not all of them have been reached and not all dimensions of their conditions of life or living experiences have been dealt with (Nyambedha, Wandibba & Aagaard-Hansen, 2003). In countries like the United States of America, Canada, Great Britain, France, Sweden, Australia, and other European and American nations, policy attention has been largely concentrated on social security programmes that address social welfare challenges of these people (Willis, 2006). Little has been done to understand and deal with their living experiences unrelated to social welfare.

In developing countries, policy attention is given to only the older persons who have retired from public service and a few enterprises in the formal private sector. Attention is demonstrated in form of disengaging older persons with retirement packages and continuing to provide them with monthly pension. Unfortunately, the packages and pensions tend to be not only too difficult to claim but also too inadequate to cause any significant reduction in the pessimism of the older persons about their present and future livelihood (Fentleman, Smith & Peterson, 2000). What is most worrying is that in some countries such as Brazil, laws have even been enacted to prevent the older persons from

accessing bank loan finance (Murray, 2000). Such laws only serve to show how alienated the older persons are in these countries. Moreover, most of the scholarly works that have been directed to understanding the lives of older persons and how these people endeavour to cope with barriers encountered in daily life, tend to be concentrated in other countries other than Uganda (Carmel, Morse, Torres-Gil, Damron-Rodriguez, Feldman & Seedsman, 2008; Cultural Heritage Unit, 2008).

Fortunately, the erudite works have tended to use various theories and perspectives that can readily offer an intellectual framework within which the state of affairs of the older persons in Uganda can be analysed. The theories include not only the biological theories such as telomere, wear-and-tear, ageing-clock and others, but also the socio-psychological theories such as the Disengagement theory, Activity theory, Continuity theory, Selectivity theory, Self-concept theory, and others (Timiras, 2007; Krulwich, 2006; Stuart-Hamilton, 2003). These theories are elaborated in Chapter Two. At this juncture, it suffices to point out that out of all these theories, the self-concept theory was adopted to guide this study reinforced by the selectivity theory.

The self-concept theory was selected because it uses self-perception to describe and analyze life experiences of a person as an individual. It can therefore help explore the living experiences, barriers and coping mechanisms using an individual older person's self perception. It can particularly help explore how an individual older person perceives his/her life from the different perspectives such economic, social and other perspectives to be highlighted shortly hereafter. Self-perception was considered very important for this study because it offers a rich platform for exploring the details of Uganda's older persons' daily lives and associated challenges as individuals. The selectivity theory (explained in chapter two) was adopted to reinforce the self-concept theory because it helps to explore and understand only those activities in which older persons in Uganda participate (Benyamini, Blumstein, Lusky & Modan, 2008).

The various perspectives that have been used in different studies on older persons include the health, economic, psychosocial, food security and nutrition, housing and

accommodation, and sanitation and water supply perspectives (Bagala, 2007; Mugambe, 2006; Kalasa, 2004; Sembajwe, 2004). These perspectives approach living experiences of older persons as conditions, circumstances or states of life that delineate and characterise the livelihoods of these people (WHO, 1999). The perspectives also describe and discuss the barriers to effective participation of older people in society as the problems, challenges, constraints, and individual and societal beliefs as well as behaviours which limit or discourage the functional capacity of aged people to participate in society as efficiently as desired (WHO, 2002a, 2002b).

These perspectives further describe the coping mechanisms of older persons as the dynamic strategies, tactics, or means used by them to physiologically, psychologically, sociologically, and economically deal with the barriers in such a way that they can effectively adapt or adjust to the changing states of life and health conditions (Coulson, Goldstein & Ntuli, 1998). Notwithstanding their common description of each of the dimensions that characterise the life of older persons, each of the perspectives covers different living experiences, barriers and coping mechanisms.

In particular, the health perspective describes the living experiences of the older persons in terms of not only their general self-rated health status in terms of illnesses, sicknesses and diseases from which they are suffering, including HIV/AIDS and its impacts, but also their access to healthcare services needed to deal with these illnesses/diseases (Bekunda et al., 2004; Najjumba-Mulindwa, 2004; Nyambedha et al., 2003; Gorman, 2002; Mutangadura, 2001).

The economic perspective describes the lives of the older persons in terms of livelihood conditions delineated in form of levels of income, education and wealth; occupations or income-generating projects in which older people are involved; their pension status, and the level of economic support and care extended to and received by these people (Bagala, 2007).

The psychosocial perspective defines the psychological and social states, activities and roles associated with the lives of older people (Tavengwa-Nhongo, 2006). The food security and nutrition perspective explains the availability and adequacy of food as well as the frequency of eating and of changing diet by the older persons (Nayiga-Ssekabira, 2002; Sugarman, 2003).

The accommodation and housing perspective focuses on the levels and nature of housing in terms of ownership, wall strength of owned houses if any, their adequacy in terms of room size or spaciousness vis-à-vis the number of accommodated people, state of ventilation, lighting system, and the type and quality of beddings (Duncan, Daly, McDonough & Williams, 2007; Kansakar, 2002).

The sanitation perspective focuses on the hygienic conditions characterising older people's households in terms of toiletry facilities, cleanliness inside the houses and outside, as well as the nature and level of the surrounding environmental health (UNESCO, 2008).

The water supply perspective focuses on the type of water used by the older persons, its sources and distance travelled to reach the sources, and the means used to fetch the water (Mapule-Ramashala, 2008; Kansakar, 2002).

According to Rowe & Kahn (2007), a study based on any of the fore-described theories and perspectives represents the general description of the living conditions of older persons as far as the scope of the theory or perspective is concerned. Some psychosocial theories such as the self-concept and selectivity theories overlap other theories as far as their coverage of older people's living conditions, barriers to participation in society, and coping mechanisms associated with older people, is concerned. Accordingly, these are the theories that were adopted to underpin this study.

As noted earlier, in Uganda, the plight of older persons has also received far less than the scholarly and policy attention it deserves despite the fact that older people form 6.1% of

the country's estimated 30 million people. This population is even predicted to rise to 20% of the total population by 2025(UNHS, 2005/6). This is quite a significant figure that should raise concern to any well-intentioned policy planners and decision makers. Literature points out various problems and needs for older persons in the country which focus around the following areas:

First, the 1995 Constitution of the Republic of Uganda stipulates that older persons are among the marginalised, vulnerable and chronically poor groups of people in the country. This alone makes this group less advantaged in terms of participation in most development programs or political activities, especially because older persons are often undermined as people who cannot afford and whose productivity has waned (Namuddu, 2007). In fact, majority of the older persons in Uganda are non- productive and are thus earning a living (Najjumba-Mulindwa, 2004; Ntale-Lwanga, 2003; Bagala, 2007). Many of them did not attend school, which implies that they did not get an opportunity to work for government and save for old age. It also implies that they were not skilfully empowered so as to work as consultants in the private sector after the setting in of old age. These circumstances imply that most of the older persons in Uganda neither accumulated wealth that could have helped them in old age nor are they in a position to apply skills so as to earn a living during this phase of life. The situation is exacerbated by the current HIV pandemic, which has adversely affected older persons by forcing them to be 'parents or guardians' for the second time in form of looking after increasing numbers of orphans left behind by their adult children claimed by the epidemic. This has imposed an ever increasing burden on the already fragile group of older persons (Uganda Bureau of Statistics, 2002).

At the time of writing this thesis, the government had not put in place any concrete programmes or policies for Social Protection to assist individuals looking after AIDS orphans in the country as well as the older persons (Bird & Shinyekwa, 2005). This is a fact despite the fact that a policy on orphans and vulnerable children was developed in 2009. Its implementation has not yet yielded any impact on the older persons. Many older persons are still grappling with orphans who are not going to school, have nutritional

problems and lack clothing. The current social protection schemes such as NSSF and the contributory pension scheme are just for a few people (less than 10%) who are working in private or public sectors. The majority who work in informal and Agriculture sector are not catered for in the schemes. This makes it necessary for alternatives to be provided so as to enable construction of a 'just and fair' society (Namuddu, 2007).

Most social developmental programmes undertaken by government, the private sector, local Non-Governmental Organizations (NGOs), and international NGOs do not target older persons (Ntale-Lwanga & Kimberley, 2003). It appears that policy makers in all sectors have excluded the older persons from actively participating in decision-making that affects their lives. This exclusion has even been viewed and interpreted as a human rights contradiction, waste of human and social resources (Kalasa, 2004; Mugambe, 2006). This makes older persons feel so left out that their influence over public policies is almost negligible. In fact, most of the Uganda national development policies such as PEAP, NAADS, and PMA among others and the anti-poverty programmes pursued in Uganda have left out older persons. The policies and programmes target the energetic and productive sections of Uganda's population. They often target the so called 'active poor' or 'working poor' who, in turn, are given resources to engage in entrepreneurial activities. The existing social protection interventions such as Universal Primary Education, the School Feeding program, Micro-finance (former Entandikwa), Northern Ugandan Social Action Fund (NUSAF), Community HIV/AIDS Initiative, Early Childhood and Nutrition project, have not helped matters either. This leaves the older persons in a disadvantaged state.

The UPE programme though has very good goals and objectives of improving accessibility to primary education by most of the Ugandan children. Unfortunately, its focus was on children but not on those looking after the children. The programme thus left out older people who shoulder the burden of looking after most of the children. It is therefore not surprising that despite UPE; most of the orphans under the care of older persons are still not attending school regularly. Poverty has added salt to an injury in the sense that although learning under the UPE programme is free, many of the pupils under

the care of older persons cannot afford uniforms, books, meals and other facilities needed to ensure proper schooling. In some older persons' homesteads, especially where the older person is too weak to do income generating activities, children are expected to work and earn for the upkeep of household members. Children work in form of taking care of family businesses like cattle rearing, cultivation, hawking or roadside selling of farm produce and other simple merchandise. There are situation where there are virtually no relative to offer support. In such situations, children have no option but to fend for themselves; thereby not considering education as a priority. Yet education is one of the surest and most powerful ways of promoting economic and social progress as well as responsible and productive children who could in turn help older persons. If proper planning had been done to involve older persons in decision making before implementation of this policy, this scenarios would have been foreseen and addressed.

Uganda has acknowledged the fore-described scenario and has made an effort to start formulating a social protection policy targeting older persons. However, not much has been achieved because of limited knowledge on the plight of these people. The formulation process is therefore still in its early stages and is likely to take some time to be accomplished and to make an impact on this group of people (Civil Society, 2008). This study may help speed up this process when accomplished.

As of now, there is no finished policy in place yet various studies have continued to show that older persons in Uganda continue to lack the capacity needed to sufficiently look after the large number of orphans under their care (Ainsworth & Dayton, 2000; Dayton & Ainsworth, 2002; Ntale-Lwanga & Kimberley, 2003). The same studies indicate, however, that information regarding the plight of these people is still lacking. Indeed, very few studies have been conducted on older persons (Alun, 2003; Najjumba-Mulindwa, 2004; Mugambe, 2006), but not study has particularly targeted the understanding of these people's needs, problems and living experiences, and how each of these aspects can inform policy planning and decision-making in Uganda. This leaves a gap in the data that is required to inform formulation of policies and programmes needed to address the plight of these people. This could be the reason why older persons in Uganda are not given opportunities to enjoy healthy aging through the processes of

accessing effective health care, adequate housing, social protection, employment, re-training, skills acquisition and support of the orphans under their care.

1.2 Statement of the Problem

In Uganda, the percentage for older persons has increased from 4.5% in 2002 to currently 6.1% in 2010 and is expected to rise to 20% by 2025 as discussed earlier (UBOS, 2007). This percentage increase is predicted based on the purported improvement in life expectancy. According to UBOS (2007), people are now living longer than before as a result of urbanisation and globalisation process that have caused improved lifestyles, thereby translating into longevity. These observations suggest that older people form a significant and rapidly increasing proportion of Uganda's population. Unfortunately, studies conducted over the 2000-2009 decade indicate that the plight of older persons is at stake in Uganda (Ntale-Lwanga, 2003; Najjumba-Mulindwa, 2004; Mugambe, 2006; Bagala, 2007; Kiiza-Wamala, 2008; Nankwanga, Phillips & Neema, 2009). Older persons are exposed to a range of increasing risks associated with being disengaged from active employment through retirement and the setting in of old age. Indeed, old age comes with increasing frailty yet disengagement implies reduced of total loss of earning power. Nankwanga, Phillips and Neema (2009) found out that such risks threaten the life of older persons, thereby escalating their vulnerability and eventual death. However, the specific consequences that the risks cause to the older persons before death are not clear in Uganda due to lack of information, especially in terms of the needs, living experiences and problems that they encounter. Furthermore, the barriers encountered by these people as they live a life of old age and as they endeavour to be effective in society and the coping mechanisms they adopt to deal with the barriers are also unclear in Uganda again because of lack of information regarding them.

Such lack of information was first highlighted about ten years ago at 2nd World Assembly on Ageing held in April 2002. The Assembly noted that not much was known about the individual, social, and health needs and experiences as well as policy implications of ageing in the developing countries. The Assembly then recommended scientific research

into these issues as one of the international strategies for Action on Ageing (United Nations, 2002b). However, not much has been done in the particular case of Uganda as noted by the Poverty Eradication Action Plan (PEAP), a key framework guiding all the developmental activities in Uganda. PEAP acknowledges that though necessary for planning, information concerning the needs of older persons in Uganda is still lacking. Similar sentiments are reiterated by the Uganda Reach the Aged Association, the umbrella organisation for older persons in Uganda (URAA, Undated), and by the Ministry of Gender Labour and Social Development, the umbrella ministry for older persons. These two organizations also called for scientific research on ageing. However, no significant strides have taken in response to the call.

Moreover, Uganda is yet to have a clearly formulated policy to address the plight of all older persons. Where attention has been made, focus is on social security fund and pension schemes both of which address older persons retired from the formal private sector and public service, respectively (Nankwanga & Phillips, 2009a). Moreover, not many of the older persons qualifying for these schemes benefit from them because the schemes are ineffectually implemented. The lack policy indicates that older persons are a neglected part of Uganda's population as far as policy is concerned. In addition, lack of information suggests that not much is known about the plight of older persons in Uganda. One is therefore compelled to question what the needs, problems and living experiences of Uganda's older persons are and what policy implications they pose. Responding to this question needs urgent attention. Otherwise, older persons will continue to be a neglected section of Uganda's population, which is unfair given the important role that they play in society as sources of wise counsel and caretakers of increasing orphans, especially in this era of the HIV/AIDS pandemic. This study was therefore timely as it was intended to respond to the question with a view of availing empirical information that policy planners and decision makers in Uganda can use to address the plight of older people. To respond properly to the foregoing broad question, the study was conducted using specific research questions outlined in the next section.

1.3 Research questions

The study was guided by the following research questions:

1. What are the needs, problems and living experiences of older persons in Uganda?
2. What are the barriers to effective participation of Uganda's older persons in society?
3. What are the mechanisms used by the older persons to cope with the barriers to effective participation in society?
4. To what extent are the needs of the older persons addressed by policy in Uganda?
5. What are the strategies that can be used to address the plight of older persons in Uganda?

1.4 Broad Objective of the Study

The purpose of the study was to explore the living experiences, needs, problems, coping mechanisms of Uganda's older persons, and the extent to which these concerns have been addressed by policy with a view of proposing strategies that could help to formulate and implement policies for empowering these people to achieve active and healthy ageing.

1.4.1 Specific Objectives of the Study

The study was guided by the following objectives:

1. To explore the living experiences of the older persons both in the rural and urban settings in Uganda.
2. To identify the barriers to effective participation of Uganda's older persons in society.
3. To establish the mechanisms used by the older persons to cope with the barriers to their effective participation in society.
4. To evaluate the extent to which the needs of the older persons are addressed by policy in Uganda.
5. To propose policy strategies for addressing the plight of the older persons in Uganda.

1.5 Significance of the Study

Despite having a vital role to play in the society, older persons in Uganda are ignored and as a result, information regarding their needs, problems and living experiences is still lacking. This study contributes to making the lacking information available, especially for policy and decision makers in Uganda. The findings and recommendations of study can be used by policy makers to plan and programme for the older persons in Uganda. In particular, departments such as the Ministry of Health; Ministry of Finance, Planning and Economic Development; and the Ministry of Gender, Labour and Social Development (which houses the secretariat for social protection that is currently planning the piloting of the cash transfer for older persons) might use this information to formulate programs and policies addressing the plight of older persons.

The older persons can also use the findings of the study to demand or lobby government for their rights. Finally the study generated new knowledge that enriched the existing body of literature in the area of living experiences of the older persons in the urban and rural context. This can act as a basis for academicians and researchers interested in conducting studies in gerontology.

1.6 Definition of terms

An older person: Any person whose chronological age is at least 55 years. This definition was adopted based on Gerontological considerations explained earlier in the background to the study.

Active Aging: Is a process of optimising opportunities for physical, social, and mental well-being during a lifetime, in order to increase healthy life expectancy, productivity and the quality of life in old age.

Barriers to Participation: Hindrances that prevent or limit older persons from participating in developmental programmes in the society.

Coping Mechanisms: Means that people use to try to maintain their life or livelihoods across different and usually difficult or stressful situations (FitzGibbon & Hennessy, 2003).

Disempowerment: Refers to the inability to affect things around oneself or powerlessness.

Living Experiences: Living experiences refer to states or conditions of life in which people live (Bass, 2006). These conditions may be described in terms of economic, social, recreational, health, housing, accommodation, or sanitation circumstances, or in terms of situations related to food security and nutrition as well as water supply (Moody, 2006). The experiences are also described in terms of the specific diverse life needs of the older people (Bagala, 2007; Teboho-Maitse & Chana-Majake, 2005 Alun, 2003; Mulaudzi-Ntshengedzeni, 2003; Ngatia et al., 2003; Baryayebwa & Barugahare, 2002; Anweng-Angura & Anyuru, 1994; O'Brien, 1994). They may be viewed from a general or an individual person's perspective (Deeg & Bath, 2003; Idler, 2003; Strawbridge et al., 2002).

Mixed method: A research method that combines both qualitative and quantitative data collection and analysis techniques in a single study (Cresswell, Fetters & Ivankova, 2004).

Policy: A government action plan consisting of strategies used to address public issues. According to De Coning (2009), a policy is a statement of intent or a plan of basic principles to be pursued in attaining specific goals.

Social protection: A development discourse that consists of public and private initiatives or measures intended to assist individuals, households, and communities in managing income risks, thereby reducing vulnerability and income fluctuations, improving consumption, smoothing and enhancing equity (Devereux, Ntale-Lwanga, Sabates-Wheeler, 2002).

Social Security: A specific public programme of assistance, insurance, and benefits on which people can rely to maintain a minimum level of income.

Vulnerable people: Persons whose life is open to all forms of risks as a result of not participating in the making of decisions that impact on their welfare. In the Ugandan context, vulnerability is viewed in four aspects: economic/ livelihood risk, political risk, social-cultural risk and physical/health risks (Bird & Shinyekwa, 2005). The World Bank has described the older persons and their dependants as people who are poor and vulnerable (World Bank, 1993:21). According to Alun (2003:196-197), being vulnerable means lack of exposure and defencelessness or lack of means to cope with life. It entails being physically weak, economically impoverished, socially dependent, humiliated or psychologically harmed.

1.7 Outline of the thesis

This study has been presented in nine chapters: the presentations of the chapters are elaborated as follows:

Chapter one gives the background of the study by describing the problems of the older persons globally and in Uganda. It also presents the statement of the problem, research questions, the broad and specific objectives, the significance of the study, and the definition of some terms used in this study.

Chapter two presents a review of the literature on the concept and theories of old age, previous studies related to the variables of the study, the policies that are related to the older persons, and the conceptual framework of the study.

Chapter three describes the research methodology and design used in the study. It also provides a description of the population samples, the instruments and the procedure used to carry out the research.

Chapters four, five, and six contain presentation and discussion of the findings of the study. These chapters are presented according to the objectives of the study.

Finally, chapter seven contains the summary of findings, conclusions and recommendations of the study as well as the identified new knowledge, personal reflections and limitations of the study.

CHAPTER TWO

LITERATURE REVIEW

"No society can enjoy full development without proper consideration of all members and that there is no acceptable future for a society where individuals are excluded and deprived of their rights and dignity" (Mary Roberson, United Nations High Commissioner for Human Rights 1997-2002)

2.0 Overview

This chapter presents the literature relevant to the study. The literature is cited from relevant scholarly works about the definition and theories of old age as a concept, as well as the variables of the study derived directly from its objectives. The chapter is therefore divided into four sections. The first section focuses on the concept of old age. The second section centres on the theories of old age and the choice of a theory that underpins the study. The third section contains literature cited in the context of the study's variables while the fourth section is about the conceptual framework showing how the variables of the study were logically linked. In all the sections, attempts were made to highlight the gaps in the existing body of knowledge which were addressed by the study.

The literature search was carried out to provide evidence for policy makers, to set research agendas (Mulrow, 1994), and also identify knowledge gaps. Data was mainly obtained from archives, internet sources such as Google Scholar, Ebsco, PubMed and Help Age International Websites among others, while some articles were obtained from journals, reports, books and news papers from Makerere University, University of Cape Town and the University of the Western Cape libraries. A thorough search was done of these different data sources to identify the various articles on the concept of old age, theories of ageing and the variables of the study. The criteria for selection of the articles were according to their closeness with the topic of the study. The identified articles were then critically read through and analysed using content analysis. The themes and categories related to the variables and study objectives were identified, coded and finally interpreted. The findings are reported in the next sections.

2.1 Definition of the Concept of Old Age

Old age is a concept that does not seem to have a universally acceptable definition in the existing body of literature. Although this concept focuses on changes experienced by organisms in their later days of life, the different existing schools of thought about it approach it differently (Moody, 2006 & 2000). In human beings, the concept of ageing focuses on a multidimensional process of biological, psychological, social, and chronological changes (Rowe & Kahn, 2007; Schulz & Heckhausen, 1996). Consequently, attempts to define ageing have attracted researchers from the psychological, social, chronological, and biological schools of thought (Masoro & Austad, 2006).

Stuart-Hamilton (2003) examined the psychological school of thought, noting that it views old age as a transformation that sets in after a human organism progresses through the adulthood age, and when the probability of survival decreases accompanied by regular frailty in appearance, behaviour, experience and social roles. This school describes old age as a condition that comes about as a result of the disuse of previously acquired skills; random wear and tear; a decline in the ability to adapt to new environmental variables; or loss of internal and external resources (Strawbridge, Wallhagen & Cohen, 2002).

As discussed by Stuart-Hamilton (2003), the psychological school of thought appears to advance the notion that old age is synonymous with frailty, decline in ability, and decreased chances of survival. This however, defeats common sense because it suggests that even human beings in their early days of life can experience old age as long as the conditions it describes apply to them. This theory does not explain effectively the meaning of old age. Ideally any person born into this world has a probability of decreased survival and is potentially capable of witnessing decreased ability and frailty, especially when the person experiences frequent episodes of disease and illness.

Moody (2006) discussed the social school of thought, observing that this school considers old age as a concept dealing with a society's expectations of how human beings should

act and behave as older people. The school is basically about the expected social roles of the older persons in society (Bisconti, 2006). It considers old age as a stage in life characterised by a wealth of knowledge and wisdom about world events, culture, and social construction (Bisconti, 2006). Important to note about the social school of thought is that it does not consider old age as a condition felt by an individual in advanced age but rather as the social roles expected by the members of society about what the individual should do and how he/she should behave. The social school of thought is therefore inadequate in underpinning what the concept of old age is.

Bengtson & Schaie (2008) pointed out that the chronological school of thought approaches old age from a historical perspective. Accordingly, this school classifies people according to a life span measured in terms of years spent in the world since birth. The school advances the view that the lifespan of human beings starts from zero years at the lower end, and progresses through fractional years (weeks or months) to one, two, three years, onwards to teens, twenties, thirties, and so on up to the over a century years (Saltman, Dubois & Chawla, 2006). Old age occurs when a person enters the upper end of the lifespan (Bengtson & Schaie, 2008).

There is however, still controversy as to when a person enters the upper end of the lifespan (Bowling, 2005). Questions regarding the number of years that one should have in order to enter the upper end of his/her lifetime remain a subject of contention, especially in view of the fact that age intervals developed to define this end vary from culture to culture and from country to country. In China and Japan, for instance, the last menstruation signals the beginning of old age for women but old age for men does not seem to have a standard initial point (Bowling, 2005). In other countries, such as most of the European and American countries, old age is divided in categories such as the young old (65-74 years), the middle old (75-84 years) and the oldest older persons (85 years and above) (Bowling, 2005). In some African countries, old age tend to start at 60 years, while in others it is at 65 years (Bengtson & Schaie, 2008).

Another criticism against the chronological school of thought is that the age it advances does not correlate perfectly with functional old age. Two people may be of the same chronological age but differ in their mental and physical capacities. In addition, even when cultures and countries agree to the years when a person should be considered aged and therefore retired from active public roles, the considered age remains a subject of debate when viewed from the perspective of a person as an individual. Different individuals feel differently about old age. While some may feel older even at 50 or less years, others do not feel that way even when they are 70 or more years. This is why the chronological approach is considered inadequate in underpinning the meaning of old age as a concept. Old age does not seem to focus on merely being advanced in age. It subsumes much more than the growth of people over a time period. This is clearly articulated by the biological school of thought.

According to Meara, Chapin & Cutler (2004), the biological school of thought approaches old age as a concept that focuses on the manifestation of biological changes that occur in the later stages of one's lifetime. It views old age as a condition involving the wear and tear of physical and mental structures, declining cell division, and progressive changes of molecules, cells and organ systems. Important to note about this school of thought is that it considers what happens in old age as the direct opposite of what happens in the early part of one's lifetime. Therefore whereas changes in early life are considered as development, they are regarded as aging in the later lifetime, even when they may be the same. This school of thought thus does not provide a convincing definition of old age as it does not encompass the whole reality about old age. Research indicates that old age is highly associated with an increasing wealth of wisdom and historical experience, and this is not accommodated by the biological school of thought (Krulwich, 2006).

In general, the lack of a universal definition of old age has made the concept somewhat ambiguous. However, distinctions may be made between universal old age (referring to conditions that all people in advanced age share) and probabilistic old age (referring to conditions that may happen to some but not all people in advanced age). There is

chronological old age, which appears to be the most straightforward definition of old age but its functional limitations make it inadequate, too. There is also social old age and biological old age. Some dimensions of old age underpin development while others focus on decline in old age. Involvement in aggressive activities, for example, may slow with age but this may not necessarily mean a decline in the potential for physical, cognitive, and social development in terms of knowledge of world events, wisdom, and purposeful focus on societal development. Thus, being in old age does not mean people have outlived their useful life. It is rather an important part of all human life that is still useful to society and which thus deserves scholarly and policy attention.

2.2 Theoretical Review

A number of theories have been advanced about the concept of old age or ageing in general. The theories have been generally grouped into biological and non-biological theories (Bass, 2006). This section reviews these theories beginning with the biological theories and advancing systematically to the non-biological theories, also known as the psychosocial or social theories. The section is ended with a choice of the theories that underpin the conceptualisation of the study.

2.2.1 Biological Theories of Old Age

Generally, all biological theories focus on the organic, physiochemical and genetic causes of ageing (Carlson & Conboy, 2007); but they do not explain the social, economic, nutritional, health, and other living experiences, problems, needs, and coping strategies associated with the elderly. They therefore cannot be relied upon to underpin a study whose centre of attention is to explore such experiences. The view that biological theories only explain what causes ageing but not the overt experiences associated with older persons is clearly articulated in the notions and ideas advanced by these theories.

In particular, the telomere theory is one of the biological theories (Carlson & Conboy, 2007). This theory states that structures at the ends of chromosomes shorten with each successive cell division, and this activates a mechanism that prevents further cell multiplication (Willis, 2006). As this occurs as a result of time, it leads to ageing in tissues like the bone marrow and the arterial lining where active cell division is necessary

(Diane & Aldwin, 2003). Another biological theory is the reproductive-cell cycle theory. This theory underscores the notion that ageing is regulated by reproductive hormones that act in an antagonistic manner via cell cycle signalling. This occurs at a high rate in the early stages of life because its purpose is to achieve reproduction. It therefore promotes growth and development in early life but as time goes by, the senescence drive or rate slows down and becomes inactive eventually, thereby resulting into a futile attempt to maintain reproduction. The net result is ageing (Diane & Aldwin, 2003).

The wear-and-tear theory is another biological theory of ageing, which advances that changes associated with ageing are the result of chance damage which accumulates over time (Stuart-Hamilton, 2003). The somatic mutation theory, another biological theory, states that old age results from damage to the genetic integrity of the body's cells (Paola, 2003). Another biological theory of old age, the error accumulation theory advances the idea that ageing results from chance events that escape the regulatory mechanism of the body and gradually damage the genetic code of physical growth (Paola, 2003). Other biological theories include the evolutionary theory based on senescence; the accumulative-waste theory that argues that there is a build-up of cells of waste products that presumably interfere with metabolism (Panek & Hayslip, 2003); and the autoimmune theory whose premise is that ageing results from an increase in auto-antibodies that attack the body's tissues among others (Rowe & Kahn, 2007; Schulz, Zarse, Voigt, Urban, Birringer & Ristow, 2007; Panek & Hayslip, 2003).

Generally, the foregoing review indicates clearly that all biological theories are based on the causes of old age and/or how to prevent it but do not explain which circumstances lead to various forms of degeneration. In addition, these theories do not consider the living experiences associated with old age. Therefore, despite explaining the biological roots of the ageing concept, which is very central to this study, these theories cannot underpin its conceptualisation, given its non-biological orientation. The inability of these theories to offer an appropriate notional base implies that the theoretical underpinning of the study should be rooted in other theories.

2.2.2 Psychosocial/Social Theories of Old Age

The available literature highlights a number of social or psychosocial theories of old age (Timiras, 2007). Generally, these theories recognise the role of the fore-cited biological theories as far as explaining the length of human life is concerned; but they also advance that the environment plays an important role in modifying the expected life span (Timiras, 2007). The social theories of old age are therefore primarily characterised by behavioural changes that occur as a person grows older relative to the environment around him/her (Zacks, Hasher & Li, 2000). They focus on the alterations that stem or emanate from environmental influences to contribute to or affect ageing people (Fentleman, Smith & Peterson, 2000). The theories are based on the premise that each older person is an individual whose life experiences are affected by changes in the environment around him/her (Bath, 2003). Therefore as people grow older, their behaviour social interactions as well as the activities in which they engage change (Fentleman, et al., 2000). These theories include: disengagement theory, activity theory, continuity theory, and the self-concept theory (Bengtson & Schaie, 2008; Willis, 2006; Bowling, 2005).

In particular, Stuart-Hamilton (2003) observed that the disengagement theory, pioneered by Cumming and Henry, advances the view that getting older people out of active roles of society is not only normal and appropriate but it also benefits both society and the older individuals themselves. This theory focuses on retiring people from active roles when they get old. The theory has however, been criticised on the basis that it was formulated and universalised using data from a rather small sample of older persons in Kansas City alone (Stuart-Hamilton, 2003). Therefore, the views of the older persons who formed the sample that Cumming and Henry used were likely to have been shaped and guided by similar environmental experiences, pointing to the same activity pattern to which all the sampled older persons were exposed. In fact, subsequent research suggested that the older persons who accept to be detached from active societal roles tend to be individuals who are reclusive initially, which implies that the disengagement theory may not apply to those who are not reclusive (McFadden, 2005; Panek & Hayslip, 2003; Strawbridge, Wallhagen & Cohen, 2002; Mindel & Vaughan, 2001).

Another theory of old age, called the activity theory, was therefore propounded in direct contrast to the disengagement theory (Rowe & Kahn, 2007). This theory advances the view that the more active older persons are, the more likely they are to be satisfied with life (Strawbridge, Wallhagen & Cohen, 2002). The notion that older persons should maintain their well-being by keeping active has had a considerable history since 1972 (Willis, 2006). However, the activity theory may be just as inappropriate for some older persons as the disengagement theory because the current paradigm on the psychology of ageing is that both the disengagement theory and the activity theory may be optimal for certain people in old age, depending on both circumstances and personality traits of the individuals concerned (Stuart-Hamilton, 2003).

Another psychological theory of ageing, the life-course theory, according to Krulwich (2006), was propounded by Erikson in his famous developmental stages. This theory approaches old age as a part of the maturity process (Krulwich, 2006; Zimbardo, 1992). It advances that within each stage, a person faces a crisis or dilemma that he/she must resolve so as to move forward to the next stage, or which he/she fails to resolve resulting into incomplete development. Based on this theory, Hanighurst (2005) observed that progress for older people demands that they must adjust to the following: declining health and physical strength; retirement and reduced income; death of a spouse or family members; living arrangements different from what they are accustomed to; and pleasures of ageing, that is, increased leisure and playing with grandchildren. It is useful to note that this theory provides a theoretical framework that can be used to view ageing as one of the stages that people have to undergo. However, despite highlighting the activities in which people in old age should be involved, it assumes too readily that people in old age must accept reduced activity and all the undesirable and health-threatening experiences as just a part of what ageing brings about, which is not always true.

According to Paola (2003), the continuity theory argues that older persons try to preserve and maintain internal and external structures by using strategies that sustain continuity. Deeg & Bath (2003) noted that the baseline of this theory is that people are inclined to maintaining the same habits, personalities, and styles of life that they have developed in

earlier years as much as they can. It argues that in later life, people make adaptations that enable them to gain a sense of continuity between the past and the present. As older persons pursue such a sense of continuity, they maintain their well-being as desired (Bowling, 2005). The continuity theory has however, also come under attack as a theory that may be a product of its own era, which is not universally applicable to all aged people (Benyamini et al., 2008). It is indeed difficult for all people in advanced age to continue with the same habits, personalities, and styles.

Another theory of old age is the selectivity theory. According to Benyamini et al (2008), this theory mediates between the activity and disengagement theories. The selectivity theory advances a view that it may benefit older people to become more active in some aspects of their lives, but more disengaged in others. This theory suggests that older people are not expected to get involved in all the activities in society. Rather, they should be encouraged to participate in only those societal activities that not only suit the nature of their personalities but also sustain them in good health.

Borozdina & Molchanova (2007) have come up with another theory, the self-concept theory of old age. This theory underscores how people in old age view themselves and/or their life experiences in terms of their health, social, psychological, life conditions and support mechanisms, as well as levels of achievement in life (Bisconti, 2006). The theory is however based on a retrospective direction of self-analysis (Strawbridge, Wallhagen & Cohen, 2002), which may not be applicable to all the people in old age. Some older persons tend to view themselves progressively as opposed to retrospectively. In addition, the self-concept theory tends to over-generalise all old people's self-perception, yet there tend to be wide variations in this perception as a result of individual and gender differences (Benyamini et al., 2003; Deeg & Bath, 2003; Idler, 2003).

In general, the theoretical review above reveals that no single theory of old age is sufficient to account for all the living experiences, barriers witnessed, as well as coping mechanisms used by all older persons. It can also be noted that each theory focuses on changes which are not universal to all the older persons as individuals. Notwithstanding

their general weaknesses, the self-concept and selectivity theories were adopted to underpin this study.

The self-concept theory was adopted because it helps to understand the living experiences of the older persons, encountered barriers, and coping mechanisms from the individual perspective. This theory was particularly helpful to this study because it uses a self-perception approach to establish how the older persons view their own life. This is the approach this study had to use in order to explore and understand the living experiences of the urban and rural older persons in Uganda in terms of their health status, social, nutritional, housing and accommodation, water supply conditions, the barriers encountered in life, and coping mechanisms used to deal with the barriers.

The selectivity theory was adopted because of its mediation between the disengagement and activity theories of ageing. This assisted the study in exploring the activities which the older persons could engage in to maintain their lives in good health and from which, therefore, they should not be disengaged. It also helped to suggest activities which older persons should be encouraged to engage in, in view of their conditions of health.

2.3 Literature Review on Variables of the Study

In this section, an attempt is made to present literature about the variables of the study. The literature is cited and contextualised to suit the objectives of the study.

2.3.1 Living experiences of the older persons

Living experiences refer to states or conditions of life in which people live (Bass, 2006). These conditions may be described in terms of economic, social, recreational, health, housing, accommodation, or sanitation circumstances, or in terms of situations related to food security and nutrition as well as water supply (Moody, 2006). The experiences have also been described in terms of the specific diverse life needs of the older people (Bagala, 2007; Teboho-Maitse & Chana-Majake, 2005; Alun, 2003; Mulaudzi-Ntshengedzeni, 2003; Ngatia et al., 2003; Baryayebwa & Barugahare, 2002; Anweng-Angura & Anyuru, 1994; O'Brien, 1994). They may be viewed from a general or an individual perspective (Deeg & Bath, 2003; Idler, 2003; Strawbridge et al., 2002).

Since this study is more inclined towards the self-concept theory of old age, the literature presented in this section is largely cited from scholarly sources that approach the living conditions of the older persons from an individual perspective. The literature is organised according to the broad perspectives under which the conditions have been described, beginning with the health perspective which includes the general personal health experiences, food security and nutritional conditions, and awareness of and impact of HIV/AIDS as discussed in the subsequent sections.

a) Health experiences of the older persons

Research indicates that the health experiences of the older persons can be described using the dimension of general personal health (Rheinhardt, 2003). According to Diane & Aldwin (2003), general personal health status describes the health conditions of the older persons, which may be established using self-assessment or data from physicians and health workers dealing with the older persons (Strawbridge et al., 2002).

From the physicians' point of view, the health of some older persons is highly associated with a steady decline in many cognitive processes such as some types of memory excluding semantic memory or general knowledge of vocabulary definitions, which typically increases or remains steady (Rowe & Kahn, 2007; Harper,1988). Medical research has also shown that some older persons experience declines in intelligence though the rate varies significantly according to individuals (Stuart-Hamilton, 2003). According to Hanahan & Weinberg (2000), there is evidence that most of the people who suffer from different types of cancer and type II diabetes are older persons. In fact, Paola (2003) observed that it is rare to find type II diabetes in young people.

The observations highlighted above suggest that people suffer from cognitive decline and some biological illnesses as a result of being in old age. The observations are however, based on medical studies conducted in America but not in Uganda. Whether they hold for the case of Uganda or not is therefore necessary to be given attention; hence the need for this study.

In addition to the views of medical research, the illnesses that tend to be associated with the lives of the older persons can be established using the self-assessment approach (Strawbridge, Wallhagen, Cohen, 2002). This approach involves the older persons themselves describing how they feel in terms of physical and psychological states of their life (Strawbridge, Wallhagen, Cohen, 2002). Based on the self-concept theory adopted to underpin this study, this is the approach adopted to establish the health conditions associated with the older people's life in Uganda. It is adopted because it establishes what Deeg & Bath (2003) refer to as self-rated health.

According to Idler (2003), self-ratings are made in terms of scales such as excellent, fair or poor and they describe exactly how older persons feel physically and psychologically. Correlating such ratings with well-being and mortality in the older persons has shown that positive ratings are linked to high well-being while negative ratings are associated with sickness (Deeg & Bath, 2003; Idler, 2003). Various reasons have been proposed for this association; people who are objectively healthy may naturally rate their health better than that of their ill counterparts (Deeg & Bath, 2003), more so in the male rather than the female domain (Benyamini et al., 2003).

According to Strawbridge et al. (2002), self-assessment also establishes the various illnesses suffered by the older persons as individuals. Indeed, older persons tend to explain their exact feelings about their health by naming the diseases from which they suffer. Some of the diseases commonly mentioned by the older persons include diabetes, cancer, high blood pressure, joint pains, backaches, depression, loneliness, HIV/AIDS, malaria, headache, skin diseases, visual and hearing impairments, rheumatism, muscular pains, asthma, crippling arthritis, kidney disease, stroke, cataract, fractures and a host of other biological and psychological illnesses (Silva-Smith, Theune & Spaid, 2007; Oppong, 2006; Leeson, 2005; Benyamini et al., 2003; Deeg & Bath, 2003; Idler, 2003; Livingstone, 2003; Charlton & Rose, 2001; Cumming, undated). Some older persons develop incontinence, instability, dementia, immobility and stomach ulcerations as a result of poor nutritional and dietary tendencies caused by inadequacy or total lack of food (Alun & Tumwekwase, 2001).

Other studies carried out in Africa revealed that non-communicable diseases are on the increase among older persons in East, Central and Southern Africa (Disease Control Priorities Project, 2007; Nankwanga, 2006). Such diseases occur as a result of physical inactivity, unhealthy diet, obesity and smoking (Byarugaba, 2003). These diseases are preventable and can easily be identified and treated in the present health care system through health care programmes (Cumming, undated).

b) Experiences of older persons related to nutrition and food security

Research on the conditions of nutrition and food security indicates that people tend to experience a decline in food security as they grow older (Sugarman, 2003; Abrahams & Pia, 2002). Nutrition also becomes rather difficult to maintain at the desired level as feeding and dietary patterns shift from desirable to undesirable levels. According to Williams (1999), it is not uncommon for older people to miss some of the meals in a day, feeding on the same diet most of the time, or eating inadequate quantities of food.

The situation is worse in African countries where older persons and in fact the bigger proportion of the population feed on monotonous diets consisting of foods such as maize, bananas, millet, beans, groundnuts, cassava, and sweet potatoes (Kanyamurwa, 2008a). It has been observed that these diets tend to be rich only in carbohydrates, water and somewhat in proteins but lack vitamins and fats in a large measure (Shils, Olson & Shike, 2005; Sissel, 2003; Stipanuk, 2000; Summerbell, 1994). Clearly, living conditions associated with such nutrition types and levels are essentially difficult and undesirable. However, it is yet to be established whether they are the same conditions lived by the older persons in Uganda or not.

c) Experiences of older persons related to HIV/AIDS

HIV/AIDS is one of the major challenges of the 21st century. It is still a critical problem facing many countries worldwide. According to Help Age International (2005a; 2005b), more than 39 million adults and children are living with the disease worldwide and of these 22 million are living in Sub-Saharan Africa. The same source indicates that the number of children orphaned by AIDS alone increased from 11.5 million in 2001 to 15

million in 2003; and that it was estimated to increase to 24 million by 2010. HIV/AIDS has not spared elderly people (Knodel, 2008; Best, 2002). They too, have been infected and affected (Abrahams & Pia, 2002).

However, despite the existence of a lot of scholarly work on HIV/AIDS, not much is covered about how the epidemic has affected older people in Uganda let alone how the effects can be curbed (Population Reference Bureau, 2007). This has been caused by the fact that most of the HIV/AIDS statistics are confined to the age of 15- 49 years and it is only of recent that additional data of those people who are 50-59 years was collected (Kiiza-Wamala, 2008). Thus, data of people aged 60 years and above is excluded possibly due to the assumption that HIV/AIDS is a young people's disease. This assumption is however, illusory since there is evidence that the epidemic has infected and affected every member of society, including older people. Studies on the impact of HIV/AIDS indicate that through self-assessments, older people have singled out this epidemic as one of the illnesses that has affected their health and brought them both social and economic costs (Baden & Wach, 1998; Barnett & Whiteside, 2002; Loewenson, 2004; Mall, 2005). Older people have fallen victims to the disease by being infected and at the same time affected by the disease through caring for the sick children (Best, 2002; Fouad, undated). Many of them have lost economic hope as a result of losing their adult children to HIV/AIDS. Consequently the plague has weakened the traditional social security system base on families and kinship ties.

This impact cuts across the rural and urban areas, the different regions and occupational groups. HIV/AIDS especially in resource constrained settings results in physical and psychological sufferings of the infected and eventually the affected older people. Additional the morbidity and mortality of HIV/AIDS also negatively affects the development initiatives at individual and household levels and it eventually affects the development at national levels (Kiwanuka, 2010). Similar findings have been noted by Knodel (2008) who discovered potential pathways through which HIV/AIDS affects the older persons in Thailand and Cambodia. These included emotional distress due to loss of children who are infected by the disease, strain in providing material support during

illness, strain in care giving that requires time and effort which eventually affects even there involvement in income generating activities, adverse community reactions which leads to psychological torture and stigma and financial drain due to expenditures in funeral costs after death. Others included loss of child's support to household, time and costs of orphan care and lose of future support in old age (Knodel, 2008). In my own view, older people who loss children in their early stages of life are likely to suffer during old age as there will be lack of various forms of support that they need at that time.

The epidemic has killed the middle-aged adults and shifted the burden of child caretaking onto the older people; and this burden is burgeoning as the number of children orphaned by the epidemic continues to increase (Knodel, Zachary, Kiry & Sina, 2007; Kakooza, 2004; Ainsworth and Dayton, 2000; Rugalema, 1999). Thus older people are now playing a key though arduous role of bringing up children- the world's future capital. Older people also find themselves providing physical, economic, and social support to their HIV/AIDS sick children; hence having less time to engage in income generating opportunities so as to sustain their livelihoods (Tavengwa-Nhongo, 2004). HIV/AIDS has indirectly changed the role of older people from one of being provided for to one of being providers (Kakooza, 2004). This has particularly been cited among elderly women who in Africa are less likely to have regular income. Indeed, Help Age International (2008a; 2008b; 2008c; 2008d; 2008e) highlighted a gender division in which 80 percent are elderly women caregivers and only 20 percent are elderly men caregivers.

The HIV/AIDS-related Human Rights include the right to freely receive information, social security, and welfare assistance, but older people are unable to realise these rights because they have been excluded from most of the HIV/AIDS programmes (Knodel, 2009; Kyomuhendo, 2003). While promotion and protection of such human rights would have reduced older people's vulnerability to HIV infection, trifling efforts have been spent on ensuring that this happens. Consequently, older people have remained trivially empowered to respond to the epidemic (Kyomuhendo, 2003). Most of the ongoing HIV/AIDS awareness campaigns, treatment programmes, and researches in the world do not target older people (Population Reference Bureau, 2007). Consequently, they end up

catching the disease out of ignorance (Mugenyi & Kanyamurwa, 2004). They also take long to know that they are really suffering from the epidemic because of their tendency to largely believe in and use traditional healing methods (Mukasa-Monico, Otolok-Tanga, Nuwaga, Aggleton & Tyrer, 2001).

In 2001, the United Nations Declaration on HIV/AIDS recognised the role played by older people and committed itself to adjusting and adopting economic and social development policies that address the special needs of these people (United Nations, 2001). Unfortunately, very few and moreover ineffective national policies have been put in place (Help Age International, 2005b). In Uganda, despite considering HIV/AIDS as a developmental issue in the country's 2025 Vision and Poverty Eradication Action Plan (PEAP) (Asingwire & Kyomuhendo, 2003), older people infected and affected by the epidemic have not been included in most of the development programmes. There are no welfare programmes targeting these people; and no special healthcare programmes for them as there are for children and maternal health (Alun, 2003).

Older people are highlighted in Uganda's National HIV/AIDS Policy as one of the groups that should be provided with HIV/AIDS Voluntary Counselling and Testing (VCT) services. However, this policy addresses older people on paper because there is nothing much to show on the ground (Help Age International, 2006). Not even is there data for older people aged 60 years and above that is necessary for policy formulation. Most of the VCT services target youths and adults. There are no identified elderly-people-friendly VCT services provided in the country. Uganda's Policy on Antiretroviral Therapy and National Health Policy have not helped matters either. A review of these policies reveals that none of them gives older people living with HIV/AIDS the attention they deserve. While the policy on antiretroviral therapy gives guidelines to the administration of this therapy and it seeks to promote the provision of information regarding ARVs at community and facility levels, it is silent on older people. Similarly, the various health services highlighted by the National Health Policy, including immunisation, vaccination, medical treatment, antenatal services, and adolescence services, are largely not for older people (Ministry of Health, 2005/06). This scenario is

dangerous to this group of people. It was cited as one of the major causes of HIV/AIDS deaths among elderly females in Zimbabwe (WHO, 2002c; Mutangadura, 2001).

It has also been noted that less priority is given to older people affected and infected by HIV/AIDS in terms of budget allocations both at national and district levels (Kawogo, 2008; Government of Tanzania, 2000). They are also disadvantaged when it comes to national budgetary priorities. The exclusion of HIV/AIDS infected or affected older people from many of HIV/AIDS welfare programmes not only renders these people more vulnerable to the epidemic but also casts doubt as to whether the programmes have effectively achieved their purposes in the context of the Millennium Development Goal of eradicating HIV. In fact, studies on the impact of HIV/AIDS indicate that nothing much has been done to include older people in HIV prevention and treatment programmes (Nankwanga, Phillips & Neema, 2009; Nankwanga, 2009a & 2009b; Hardon 2005; Bekunda, Kibaalya, Rwibasira, Asaba, Haag, Camilo, & Foex, 2004; Alun, 2003; Alun & Tumwekwase, 2001).

The foregoing observations suggest that little is known about the plight of Uganda's older people infected or affected by HIV/AIDS. It is not clear how the disease has affected these people; how they cope with it, and what needs to be done in order to curb the effects. It is in the light of this situation that part of this study was instituted to explore the effects of HIV/AIDS on older people in Uganda; the mechanisms used by these people to cope with the disease; and how the effects can be curbed.

d) Housing and Accommodation Experiences of older persons

A number of studies have been conducted in the area of housing and accommodation conditions describing the health and living experiences of the people both in developed and developing countries (Himanshu-Sekhar, 2008; Duncan, Daly, McDonough & Williams, 2007; Phillips, 1988). These studies indicate that people's housing conditions can be described in terms of their housing preferences, ownership of housing units, types of houses, number of people sharing a house, bedding conditions, and general environmental conditions surrounding their houses. The study conducted by Kansakar

(2002) indicated that increasing proportions of people do not own houses, and most of these are the poor, the homeless and older persons. The study conducted by Phillips (1988) discovered that seventy five percent of older people in Brazil live in housing units characterised by weak wall and roofing structures as well as in-house space, which is below the minimum requirements per person.

e) Experiences of older persons related to water and sanitation

Research on health conditions, in which people live tend to highlight water supply and sanitation as major descriptive indicators of these living conditions (Tenywa, 2010a; Tenywa, 2010b; Mapule-Ramashala, 2008; Kansakar, 2002). As far as water supply is concerned, literature shows that the source of water used in a household, the distance to the source, and means of fetching water are all basic indicators of people's living conditions, especially with regard to the type of water used to support their health and life (Dowd & Kowal, 2000). It has been reported that in Africa generally that most people draw water for domestic use from unprotected spring wells, lakes and rivers (*The New Vision*, 2010). Others fetch it from protected wells, boreholes, and piped water (Tenywa, 2010a). Most of these studies focus on the older persons as either urban or rural dwellers. In Uganda access to safe water is currently at 67%. Although this percentage indicates improvement in access to safe water for the past 10 years, there are still many communities (both rural and urban) that rely on contaminated water sources such as streams and open wells (www.water.org). For instance in unplanned urban settlements that is where older persons live, residents pay three times more for safe water than the residents who live in planned resident areas. This is quite expensive for the older persons especially those who do not even have employment or any income generating activities to have a decent living. Thus as a result these people are forced to collect water from alternative sources that are contaminated sources. Often this causes frequent outbreaks of water borne diseases such as cholera and dysentery (www.water.org).

Studies conducted on the nature of sanitation and hygiene which describe the living conditions of people include that of Malinga (2008), UNESCO (2008), Krieger, Williams & Moss (2007), Kansakar (2002), National Environment Management Authority (2000),

and Morgan (1997). A critical perusal through these studies reveals that such sanitation and hygiene associated with people's living conditions tends to be established and described in terms of the general hygienic conditions inside and outside their houses; the presence, type and cleanliness of the toiletry facilities in a household, as well as the number of people using toiletry facilities. The study of Kansakar (2002) pointed out levels of sanitation that tend to be depicted in the state of surrounding environmental health, drainage facilities and garbage disposal for each housing unit. The studies are however examining people's levels of sanitation and hygiene from a general point of view. They are therefore not helpful in underpinning the sanitation that characterise the living conditions of the older persons, particularly those in Uganda.

f) Experiences of older persons related to the economy

Literature on the economic experiences characterising the living conditions of the older people is richly covered in the scholarly work and writings of Apt and Greico (1994), Kalache (1994 & 1991), Cain (1991), Bond (1990), and MacIntyre (1977). This literature indicates that these experiences tend to take a number of forms, including: people's levels of education, occupations and income-generating activities or roles in which they get involved, and the level of wealth (assets) they possess. According to Zappala (2003) and Human Rights Education Associates (2003), the lower the level of each of these forms the more is the likelihood of an older person to live an uncomfortable life and vice versa. The studies of Brown (1984) pointed out pension status and economic support and care as other indicators that specifically measure the economic experiences of the older persons.

In particular, the Cultural Heritage Unit (2008) dealt with pension status as one of the principal indicators of the experiences characterising the economic lives of older persons. This scholarly source noted that the dilemma that tends to engulf older persons, who get disengaged from active public activities and roles, is the fear of sudden loss of earning capacity because this is effectively viewed as an apparition of incoming poverty. Based on this spectre, governments establish national social security or saving funds, gratuity and pension schemes as well as retirement packages for the older persons, particularly

those disengaged from public service responsibilities, activities and roles (Fentleman, Smith & Peterson, 2000). Retirement packages of some older persons who were public servants place them in relatively secure positions because they include a number of retirement benefits such as gratuity funds, gifts, houses, and pension (Saltman, et al., 2006).

According to Bowling (2005), pension is a postretirement pay extended to the older persons until death. It is such minimal provision meant to support the older persons throughout their old age period. Unfortunately, in addition to being minimum as Bowling (2005) pointed out, Smith & Kington (2006) observe that because pension is determined in accordance with the amount of the highest salary extended to a public servant before disengagement, its value declines as inflation increases. This renders it incapable of enabling the older persons to meet all their needs of life as desired.

According to Kikafunda and Lukwago (2005), the Ugandan government operates pension and national social security programmes for the older persons disengaged from public and formal private service, respectively. However, whether the pension is extended as expected and whether its value enables those entitled to it to meet their needs as desired or not, remains to be established.

The study of Bond (1990) focussed on wealth and income-generating assets, arguing that if a person has property and income-generating projects; she or he is bound to enjoy a sound economic stature even in old age. On the other hand, people without property and projects that generate income are likely to be economically distressed since this adds to their poverty conditions. This argument is made about people as part of the population in general but not about older persons and Uganda in particular. It is therefore still doubtful whether the argument holds in the case of these older persons or not. This study was therefore vital to deal with this doubt in the existing body of literature.

Apart from possession of wealth and income-generating projects, research indicates that the life conditions of the older persons worldwide tend to be highly associated with

economic support and care provided from different sources (Maddison, 2008; Mapule-Ramashala , 2008; Bookman, Harrington, Pass & Reisner, 2007; Saltman, Dubois & Chawla, 2006; Harper, 2006; Bowling, 2005; Fentleman et al., 2000). These studies show that countries worldwide have older persons. In fact the proportion of older persons is growing so fast in countries such as Japan, Brazil, the United States of America, Canada, and Germany that their populations have been referred to as ageing populations (Harper, 2006).

Based on the disengagement theory, all the countries tend to retire older persons from active public roles, but according to Maddison (2008), this has often meant a drastic decline in the earning capacity of those retired. Retiring out of active and earning roles puts the older persons in an economically vulnerable position because they begin to find it difficult to support and maintain their health and life and those under their care (Fentleman et al., 2000). Moreover, all the various needs and requirements of life such as feeding, healthcare, clothing, safety and security, housing and accommodation, recreation, and other needs continue to impose their toll in a normal way (Bookman et al., 2007; Kikafunda & Lukwago, 2005; Alun, 2003; Mulaudzi-Ntshengedzeni, 2003; Ngatia et al., 2003; HelpAge International, 2002; O'Brien, 1994). A number of countries and non-governmental organisations recognise this new dilemma of older persons (Bookman et al., 2007; Kikafunda & Lukwago, 2005; Alun, 2003; Mulaudzi-Ntshengedzeni, 2003; Ngatia et al., 2003; HelpAge International, 2002; O'Brien, 1994)). However, the manner in which they address it varies from country to country (Cain, 1991); and remains a subject of investigation in the case of Uganda.

In most of the European and American countries, governments make efforts to either support and facilitate older persons-based non-governmental organisations or institute or operate special welfare programmes, grant and aid schemes by which they provide older persons with economic support in the form of needy funds and allowances (Bowling, 2005; Cain, 1991; Brown, 1984). Some countries such as Britain, Sweden, and France provide healthcare support in the form of free medical care and accommodation (Strawbridge et al., 2002). They establish special units for the older persons in hospitals

and health centres, train health workers to deal specially with older persons, establish housing units and homes for the older persons; and employ or hire people to take care of the older persons living in the established homes for the old (Harper, 2006).

In addition, non-governmental organisations such as PACE (Program of All-inclusive Care for the Older persons) run programmes through which they provide low-income frail elders with all their health, medical, rehabilitation, social and support services, and health insurance for one monthly fee (Bookman et al., 2007). The programmes enable older persons to remain independent in their community and in their own homes (Bookman et al., 2007). It is however not clear whether such non-governmental organisations exist in Uganda.

In anticipation of an increase in the proportions of older persons in their populations, some countries such as China, Mexico and Malaysia have taken specific interventions to prepare for the increase in demand for long-term care by older persons. The interventions so far taken include: redesigning healthcare delivery systems by introducing special care units for older persons, training health workers in gerontology, and pursuing polices by which funding is extended to facilitate informal caretakers(Saltman et al., 2006). These interventions are clear manifestations of the efforts taken by these countries to provide economic support and care to older persons. However, it remains to be established whether Uganda has taken similar steps so as to be considered as one of the countries providing economic support and care to the older persons.

Research has shown that in most of the countries in the developing world generally and in Africa in particular, providing economic support and care carries with it adverse implications on national budgets (Ablo & Reinikka, 1999). Some countries are so budget-constrained that they cannot afford to provide health support and care to the elderly proportions of their populations (Meara et al., 2004). Spending on free provision of healthcare and other needs of the older persons such as housing and daily bread tends to be costly because it requires equipping health centres with new medical technology for the older persons; training and recruitment of health workers; doing away with

informational asymmetries between healthcare providers and patients; constructions and furnishing of homes for the older persons; and providing them with free homecare services (Rheinhardt, 2003). It is important to note that these observations are made in the context of the entire developing world and Africa in particular. They are therefore too general to be used to infer situations for particular countries like Uganda. It is necessary therefore that the case for Uganda is also given attention in its own right if it is to be clearly understood.

The Cultural Heritage Unit (2008) pointed out that another kind of care that has been extended to the older persons has been in form of children taking care of their aged relatives after being forced by the government law which was enacted by the government of Melbourne, in Australia. This law requires that children should provide the aged with homecare in form of food and housing. As a result, Melbourne maintains the lowest rate of nursing home usage in the whole of Australia. Most of the elderly Melbournians look to young members of their families to help maintain their independence. Similar observations appear in the work of Apt (1992; 1985) and Kendig, Hashimoto and Coppard (1992), although this work uses more of a sociological than a legalistic viewpoint to approach care of older persons from family members.

The Cultural Heritage Unit (2008) went on to observe that the enforcement of such a law could be constrained by urbanisation and the tendency of young members of the family to run away from the burden of looking after their older relatives. The Melbournian government thus supplemented the law by building housing estates as a means of supporting older persons with homes and accommodation. In recognition of their reduced income-earning potential, the government also provided non-means tested Seniors Card, entitling older persons to concessions on public transport and discounts at restaurants, theatres and retail outlets. Whether or not similar arrangements exist in Uganda where the population of the older persons is increasing, is still a matter to be established.

g) Recreational and Social Experiences of the Older persons

The World Health Organisation (2006) emphasised the importance of recreational and social activities in old age, arguing that these activities promote active ageing. By active ageing, the World Health Organisation (2006) meant "the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age."

In support of the above notion, the Cultural Heritage Unit (2008) pointed out that being an older person is more of age than incapacity. The Cultural Heritage Unit (2008) argued that many people gain some new form of freedom once disengaged from active social roles and responsibilities. This source went on to observe that older persons can get involved in travelling or take active participation in family, sporting or community activities. They can also get more involved in domestic activities such as weaving and basketry or embracing a wider range of social activities such as playing music and drama with their children, grandchildren, spouses, or join gender-specific social support groups like the Civilian Widows Association, the War Widows Guild, and the Legacy Laurel Clubs among others (Benyamini et al., 2003; Deeg & Bath, 2003). While the aged are most visible in Older Citizens or Lawn Bowls Clubs, they participate across a much wider range of organisations, volunteering their services to educational, cultural and welfare institutions in their local communities (Harper, 1988). Could this be the case with older persons in Uganda?

According to Bisconti (2006), the older persons are sometimes confronted with increased or decreased social roles at a household and community levels. At household level, they may have a decrease in the role of parenting as a consequence of their children growing up and becoming independent. However, some older persons tend to take up the grand parenting role either out of choice or as a result of inevitable circumstances such as death of their children or sons/daughters-in-law (Satoto & Colletta, 2007; Smith, Kohn, Savage-Stevens, Finch, Ingate & Lim, 2000). This role carries with it the enormous burden of providing for and taking care of the grandchildren, particularly orphans, becoming even more severe and sometimes depressing when the earning capacity of the

older persons wanes out (Windsor, Anstey, Butterworth, Luszcz, Andrews, 2007; Silumesi & Mubu 1999). As a result, most children under the care of older persons are dropping out of school and remaining at home to do house chores for the older people (Ariko, 2009; Nyambedha, Wandibba & Aagaard-Hansen, 2003).

In summary, literature on the living experiences of the older persons indicates that these experiences span over a wide spectrum of needs, conditions, and resources of older people, their patterns of activities, relationships with others, and attachments to their surroundings. The experiences are basically the situations, circumstances and needs encountered by the older persons in their daily health, psychological, economic, and social environments of life. The literature is however comprehensive in other countries but very little is available on the elderly in Uganda, therefore the need for this study.

2.3.2 Barriers to Participation of the older persons in Society

Research has highlighted a number of barriers that older persons encounter not only in their pursuit of health and life conditions which they need so as to be in a position to participate, but also in their efforts to actually participate in society as effectively as desired (Nankwanga & Phillips 2009a; Kalasa, 2004; Diane & Aldwin, 2003; Devereux, et al., 2002; Llyod-Sherlock, 2002; Frisk, 2000; Lloyd-Sherlock, 2000a & 2000b). These barriers are described and discussed as constraints, age prejudices, problems, challenges, and limitations to the active life of older people (Strawbridge et al., 2002). Such barriers tend to occur at personal, household, and community levels (N'nyapule, 2003; MacIntyre, 1977).

a) Barriers at personal level

Barriers at an individual level are the limitations that constrain the older persons from maintaining the health conditions needed to participate in society as effectively as desired (Diane & Aldwin, 2003). They practically occur as impediments to older persons' desired physical fitness, access to healthcare, economic capacity, food security and nutrition, and housing and accommodation. According to Deeg & Bath (2003), barriers to physical fitness include body weaknesses, chronic illnesses, and inadequate feeding. The older persons who suffer from chronic illnesses such as cancer, whooping cough, tuberculosis,

severe disability, impairment of the nervous system, and brain damage, and other forms of physical frailty tend to find it difficult to engage in physical exercises (Nankwanga & Phillips, 2009a, Krulwich, 2006; Schutzer & Graves, 2004; Paola, 2003; Cooper et al., 2001; Hanahan & Weinberg, 2000; Harper, 1988; BHF National Centre, undated). Other barriers according to Schutzer & Graves (2004) include knowledge about the benefits of physical activity, the environment, the physician's advice, and childhood experiences. It is however, not clear yet whether the physical fitness needed by the older persons in Uganda is also constrained by such physical illnesses and weaknesses. This study is therefore vital to establish the situation on the ground.

Barriers encountered by the older persons in their efforts to access healthcare in order to maintain the state of health required to participate effectively in society, have been identified as poverty (lack of financial or economic capacity), illiteracy (lack of reading and writing skills), lack of health information, remoteness, long distances to health centres, disparaging behaviour of health workers, healthcare abuse, ill-equipped/stocked hospitals, and lack of special arrangements for delivering health services to older persons at health centres (Kanyamurwa, 2008a; Nankwanga & Phillips, 2008; Kanyemibwa, 2007; Help Age International, 2001; McGarry, 1996; Coe, 1985). These barriers prevent the older persons from seeking medical treatment, psychological therapy and other forms of curative services needed to sustain themselves in good health (Najjumba-Mulindwa, 2004) so as to participate in society events as effectively as desired.

Other barriers to older people's efforts to seek the needed healthcare include: lagging behind or rigidity to utilisation of modern medical technology (Zappala, 2003). Other researchers reported limited information/lack of awareness, stigma, bureaucratic complexities in the delivery of healthcare, lack of health insurance, traditional beliefs and attitudes against modern medical treatment, lack of transportation facilities such as hospital ambulances or personally owned bicycles, motor cycles, vehicles, and age-related discrimination as barriers to participation into programs (McGarry, 1996; Warlick, 1982).

The foregoing observations indicate that older people meet various limitations in their efforts to seek healthcare needed to maintain them in good health so that they are able to take part in society activities. The observations are however made in the general context, suggesting that they are encountered by all the older persons in all countries. Would these barriers also be encountered by the older persons in Uganda?

b) Economic barriers

The barriers to the economic capacity required by older people to participate effectively in society have been identified as; poverty caused by being disengaged from active earning activities, responsibilities and roles; poor retirement packages; failure of governments to pay their pension; lack of assets and income-generating projects; and lack of special grants and allowances schemes for the older persons, especially in Africa (Bird & Shinyekwa, 2005; Alun, 2003).

Poverty has been singled out as an all encompassing and very undesirable economic condition because it is synonymous with being economically distressed so that a person cannot even meet the basic needs of life (Krieger, Chen & Ebel, 2008; Apt & Grieco 1994). It renders its victims unable to maintain the health conditions desired to participate in society events in an effective manner. In fact, the World Bank (2009) describes poverty very succinctly when they called it another state of illness. According to N'nyapule (2003), poverty is a significant condition that prevents the ability to attain certain minimum standards measured in terms of basic consumption needs or the income that is required to satisfy these needs. Faced with poverty, one cannot even satisfy basic needs, such as food and shelter. N'nyapule (2003) further observes that poverty infiltrates deeper than just lack of financial income to include lack of choices and opportunities, and of assets and endowments. As a barrier, poverty is so comprehensive that it also includes factors such as lack of basic education and lack of access to public and private resources (World Bank, 2009).

N'nyapule (2003) pointed further out that poverty goes beyond the lack of physical necessities, income and material assets. It can also express itself in form of physical

weakness, isolation, powerlessness and low self-esteem, especially in old age. Poverty can also mean failure to access free health care and to claim entitlements due to lack of information or appropriate structures. He concludes that older people are typically the poorest members of the society and live far below the poverty line. These observations were made based on the Tanzanian experience only and it therefore remains to be established whether or not the older persons in Uganda are also limited by poverty which is caused by the factors highlighted in the study by N'nyapule (2003).

Studies which cover barriers to people's food security and nutrition indicate that these barriers are the limitations to production of adequate food and include: lack of land; soil infertility; drought; seasonal floods; armed conflict; utilisation of poor farming technologies; poverty which implies lack of income needed to buy food; frailty leading to weakening labour needed to grow crops or to rear livestock; and the threat of urbanisation which has led to rural urban migration of youthful grandchildren (Kanyamurwa, 2008a, 2008b; Sissel, 2003; Abraham & Pia, 2000; Apt, 1999; Williams, 1999). These studies cite these limitations as general constraints to food security and desired nutrition, but they do not specifically focus on the older persons in Uganda. The validity of the observations is therefore needed in the context of these older persons.

Cited literature indicates that the barriers to the housing and accommodation of people include; poor and weak housing structures which appear to be at the verge of collapsing; inadequate accommodation space, poor and inadequate beddings, poor environmental health; congestion of housing units which develop into slum-like conditions; and lack of land on which to build houses (Apt & Greico, 1994; Bond, 1990; United Nations, 1979). It is worth investigating whether the older persons in Uganda are faced with similar housing and accommodation barriers.

c) Barriers at household level

The barriers at household level are the constraints that prevent older persons from playing their household roles and responsibilities as desired (Kanyamurwa, 2008a). They include economic inability (poverty), unemployment, large numbers of household members,

inadequate accommodation space, death of supportive spouses, and limited food supply (Alun, 2003). Others include ill health conditions of the older person such that they cannot physically participate in household issues, long distances to health centres, high cost of living so that they cannot afford most of the important items that are relevant to maintain a household, adverse effects of HIV/AIDS which result in killing of adult children who are in most cases the bread winners of the home, failure of the government to pay pension in time; and even when it comes it may not be sufficient to cater for all the resources needed in the home due to inflation (Pearson, 2005), and inadequate or lack of agricultural land caused by displacement resulting from armed conflict (Najjumba-Mulindwa, 2004). Furthermore land inadequacy could also be brought about by the selling of land by adult children who prefer relocating to towns in order to carry out businesses.

d) Barriers at community level

Barriers which older persons tend to witness at a community level are problems which tend to emanate from the community and prevent them from active and effective participation in society. Research indicates that these barriers include: social discrimination and segregation which are expressed by; ignoring the older persons as people who have outlived their usefulness, disrespect, and minimisation by adults and youthful community members (Najjumba-Mulindwa, 2004). Older people face barriers to accessing basic health and sanitation facilities, and are often denied appropriate education and information as well as access to bank loans and credit schemes because they are perceived as risks that are not worthy to entrust with funds (Taylor, 2006). This is because they are regarded as people whose age provides minimal or no hope for using the money optimally and profitably to pay back in time (Tayler, 2006). Commercial bank laws restrict credit to the young people arguing that these have all the time to manage borrowed money more carefully and profitably while the older persons do not have such time.

The fore-cited barriers have however, been condemned as unfair forms of violation of the human rights of older people (Murray, 2000). The World Health Organization (1996)

declared that ageing is part and parcel of development because healthy older persons are not a spent force but partners in development since they are a resource for their families, communities, and the economy as a whole. In any case, it has already been observed that the role of older persons in development is critical not only in developing countries but also in developed countries such as Spain where older people play the role of caring for the dependent and sick individuals (of all ages) which is mostly done by older women (Durán & Fundación, 2002). The Help Age International (2007) summarised the barriers that confront the older persons from their respective communities as negative social attitudes, poverty, wars and conflict, and discriminatory laws and practices.

Conclusion

Generally, the literature indicates that the barriers to the effective participation of the older persons in society include not only the state of older people's personal health itself but also poverty and negative and limiting community attitudes, laws and practices. The literature however, paints a picture that all the older persons are confronted with the same barriers irrespective of the countries and settings in which they live, which may not always be the case. This study is therefore needed to not only establish whether the older persons in Uganda face the same barriers but also to clearly specify those encountered in different settings of society.

2.3.3 Coping Mechanisms Used by the older persons

Coping mechanisms are the means which people use to try to maintain their life or livelihoods across different and usually difficult or stressful situations (FitzGibbon & Hennessy, 2003). According to Carmel, Morse, Torres-Gil, Damron-Rodriguez, Feldman & Seedsman (2008), it entails adaptive behaviours in older age that allow for effective and successful engagement with life-related tasks, challenges, and problems. People all over the world develop mechanisms or initiatives by which they endeavour to deal with the problems and challenges that confront them in pursuit of survival and desired participation in society (Juma, Mbanga & Okeyo, 2004).

According to Apt (1996), coping mechanisms span over a wide spectrum; stretching from initiatives and attempts made to overcome barriers confronted at a personal level, through

those encountered at a household level, to those witnessed at community level and in form of limitations and constraints to healthcare, food security and nutrition, housing and accommodation, and other forms of constraints and challenges covered earlier in this chapter. In this study, these mechanisms are considered as the means used by the older persons to overcome the various barriers encountered in their efforts to participate effectively in society.

Carmel et al. (2008) observes that ineffective coping behaviour is often a result of a person feeling powerless, alienated, and obsolete, perhaps due to social structures that often promote a psychological reaction that robs people of vitality. These scholars argue that coping mechanisms that are often used to deal with such a situation, especially in old age involve a positive action at the individual level expressed in form of personal initiatives towards fostering access to support services which protect and empower an older person to achieve and maintain psychological well-being. Carmel et al. (2008) adds that this coping mechanism is about having a sense of being in control of one's life, coupled with a feeling that life is meaningful and full of promises for tomorrow.

Carmel et al. (2008) point out using the social support structures available and providing older people with opportunities to not only learn new responses to life stresses but also address their survival needs as other coping mechanisms. The social support structures that these scholars identified include; voluntary organisations whose missions are to care for the older persons; training professionals in the provision of care to the older persons; and as well as supportive family members. The other mechanisms which these scholars highlight include educational mechanisms which focus on inculcating a belief in older persons that life has meaning even in old age and that an older person is not a spent force but an individual who can have a positive impact on his or her environment, community and society at large.

Carmel et al. (2008) believe that this mechanism works best when the traditional theories of aging are reinforced with a psychological framework which permits older people to adopt a flexible, spontaneous, and creative response to a rapidly changing world. They

conclude by asserting that a psychology of aging which ignores the thoughts, feelings, and capacity for individual actions which surround choices and self-determination, hardly constitutes a valid illustration of life during older age. Their observations were however, based on studies conducted on older persons in Australia, the United States of America, and Israel, but not in Uganda. Moreover, they did not indicate whether there were any differences in the use of the mechanisms by the older persons living in urban and rural settings.

Help Age International (2002) points out creativity in old age is another coping mechanism. This scholarly source indicates that although creativity tends to be viewed as a universal human endowment, it often plays a significant role for older people as far as fostering personal resilience to adversity is concerned. It is a powerful coping mechanism because it involves an older person thinking out creative and realistic ways of survival and advancement to desired success in life. Help Age International (2002) further notes that creativity is more helpful in old age if it is expressed in terms of leisure. It requires older people to use their time selectively by engaging in novel enterprises and creative activities which keep them active and in good health.

Help Age International (2002) concluded by underscoring the proposition that living creatively promotes active aging, which in turn can strengthen internal psychological resources. Creative living has potential to alleviate later life stress by providing a sense of meaning in life resulting from being active and valued for the creative enterprises brought forth. Help Age International (2002) however, made these observations based on the older persons in Kenya and Tanzania but not on those in Uganda. Moreover, despite believing that creativity is a universal human endowment, this may not hold for all the people, particularly the older persons.

According to the Age Concern Report (2006), another mechanism that older persons use to cope with life is utilisation of pension provided by the state. Research has shown however, that many older people feel that their pensions are too small to adequately reflect the contributions that they made during their working lives (Pearson, 2005). It is

therefore argued that unless an increase is made in the pension provided by government, its present value does not seem to offer an effective means of survival to most of the older persons. In fact, Age Concern Report (2006) indicates that the little value of pension has led to a widespread under-claiming with around 30 per cent of older people entitled to pension credit which they are not claiming. The proportion even grows bigger as a result of the process for claiming pension (Leku, 2011). This process tends to be associated with lengthy, difficult, and complicated bureaucracies that discourage many older people who would have used pension as a coping mechanism (Leku, 2011). Due to the above mentioned reason, Pearson (2005) observes that some older people who are relatively wealthy become reluctant to claim their benefits from governments. They tend to believe that it is less involving to be content with the wealth which they have, than having to tussle with claiming such little benefits. This belief is however, criticised as being blinkered since any extra cash makes a lot of difference.

It should be noted that although pension is considered as one of the means used by the older persons to overcome some barriers to their health and participation in society, it is not a universal mechanism because not all the older persons are entitled to pension. In addition, research has shown that giving older people money is sometimes not as helpful as providing other more creative coping mechanisms such as free bus passes, healthcare services, and education for children under their care (Juma et al., 2004). Moreover, the difficulties associated with the process of claiming it do not make it such an effective coping mechanism.

In a study conducted by Apt (1996) in Africa, it was found that it is not only pension that has little value and the associated complex process of claiming it, but also other benefits and grants from government. This study showed that over two million older people entitled to council tax benefits were not claiming it citing similar reasons. Apt (1996) noted that some older people depend on assets and income-generating projects which they established during their golden days or using their retirement packages. Others cope with life using the savings which they made during their working days. In fact, Apt (1996) believes that saving for retirement is much better than waiting for pension because

it offers more reliable support in old age, thereby reducing the need for welfare support and benefits from government. In a study conducted by UNESCO (2008), a number of other coping mechanisms were highlighted, including: buying second hand clothes, buying cheap or bargaining for lower prices of food, and only heating one room at a time in their homes.

The preceding observations were based on studies outside Uganda. In addition, although some observations were made based on samples drawn from Africa, the geographical scopes of the studies were confined to slum areas in mega cities. This implies that coping mechanisms used by the older persons in rural settings were not covered. It therefore remains unclear how the older persons, particularly those in Uganda, cope with life.

Other coping mechanisms used by people to cope with old age appear in the scholarly work of Mall (2005). This work particularly focuses on coping mechanisms used by older people affected by HIV/AIDS, which are outlined as emotional support mechanisms used to cope with the death or grief of their children, or grandchildren; and the day-to-day support to prevent isolation. The other mechanism Mall (2005) points out is HIV/AIDS education so that the older persons not only get to know about how HIV is transmitted and prevented, but also recognise the symptoms of HIV in a family member; how to care for him or her if infected with HIV (including treating common infections); and to access to HIV/AIDS support groups and services.

Mall (2005) also highlights seeking economic support from close kin so as to meet household costs on food and healthcare as well as the education and clothing of grandchildren under the care of the older persons as yet another coping mechanism. He however notes that in many countries, especially in the developing world, some of these coping mechanisms are used informally while in other countries, particularly in the developed world, the mechanisms are given legal support through legislation so as to protect the rights of the older persons.

Juma et al. (2004) had also earlier examined the coping mechanisms used by older people as caregivers of children orphaned or affected by HIV/AIDS. They found that older people had learnt to be parents again and to provide for themselves and the grandchildren left behind by their departed children, or sons/daughters-in-law. The specific mechanisms which these scholars found the older persons use included: farming and small-scale business; providing of manual labour; selling property; leasing land; or begging. Other mechanisms were forcing grandchildren, especially girls, out of school to engage in child labour or prostitution, living with other relatives, friends or their children, while others sent for support from their children. The literature analysed earlier had however showed that using close relatives had waned as a coping mechanism for older people because family bonds and responsibilities over older people had weakened as a result of social changes such as urbanisation, geographic spread, and the trend towards individualism and nuclear families (Chuz-Mba, 2007; Apt & Greico, 1994; Kalache, 1994).

Clearly, there is a contradiction in the existing body of knowledge particularly with regard to whether the older persons look to their families as a means of coping with life. This is further justification for the current study to explore the coping mechanisms of older people in Uganda.

FitzGibbon & Hennessy (2003) outline the following mechanisms which people use to cope with food security and nutrition barriers. Among them is using the existing food resources in a sparing manner so as to save some of the resources for future use; using alternative food sources; and selling cattle or other animals in exchange for food. FitzGibbon & Hennessy (2003) view these mechanisms not as a means of addressing the root causes behind food insecurities, but rather as ways of dealing with these insecurities. In other words, they are mechanisms to cope with food shortages but not to deal with the causes of the shortages. Accordingly, they observe that in a time of food-shortage, people can cope by eating other local foods, which they would not usually consume. Wild fruits and vegetables, water plants, fish and game, are some of the foods which these scholars recommend to eat when the foods that people would normally eat are not adequately available for one reason or another. They continue to note that if the main food is grain

such as corn, and there is a bad harvest, people may eat any of the foods mentioned above which may not regularly be part of their diet.

FitzGibbon & Hennessy (2003) further argue that it sometimes makes sense for people to sell their crops or animals in good seasons and save the proceeds for use in times of poor harvests. It is important to note that FitzGibbon & Hennessy (2003) highlight coping mechanisms used to deal with only food shortages but not all the barriers which characterise the living experiences of people. In addition, these scholars suggest mechanisms that all people could use irrespective of their age.

According to psychologists, older people also use skills to cope with life in old age (Schulz & Heckhausen, 1996). The skills focus on how older people maintain the desired social and spiritual support and are demonstrated in form of active engagement with life as well as having an internal focus of control (Windsor et al., 2007; Diane & Aldwin, 2003). Social support and personal control are possibly the two most important mechanisms that predict well-being, morbidity and mortality in adults (Smith et al., 2000). Other mechanisms include maintaining supportive social relationships by joining sports associations and health clubs (Bowling, 2005) and having control over the surrounding environment (Bisconti, 2006; Diane & Aldwin, 2003; Rodin & Langer 1977; Langer & Rodin, 1976).

Conclusion

The literature thus reveals a number of mechanisms that the older persons can use to cope with the barriers encountered as they get by and as they endeavour to participate in society as effectively as possible. The mechanisms are however identified either in a generalised manner or based on samples of respondents selected outside Uganda. They therefore do not represent the mechanisms specially used by the older persons in Uganda to cope with problems and challenges associated not only with their living experiences, but also with their participation in society. Actually, the mechanisms are so generalised that they paint a picture that older people in rural and urban areas use similar means of coping with life, which may not be always the case in different contexts. Consequently,

this study is needed to understand the coping mechanisms used by the older persons living in the rural and urban settings of Uganda.

2.3.4 Addressing the Plight of Older People by Policy

A policy refers to an action-plan made to guide decisions, procedures and actions which should be taken not only whenever specified conditions prevail but also in a way to achieve a specified purpose (De Coning, 2009; De Clerq, 2004; Smith, 2002). Policies are useful in that they sanction and enable what needs to be done in order to realise intended consequences in the best way possible. They are formulated and implemented as means by which government and other entities transform the intents, aspirations, and mandates of their mission statements, constitutions, and plans into action (Bardil, 2009; Spillane, Reiser, & Reimer, 2002). Policies can be formulated and implemented on virtually everything, including old age. This is because, as Leeson (2005) and the Parliament of Australia (2004) point out, old age has a number of economic and social implications, including changes not only in sources of income support for the extended retirement period and employment status but also in health, consumption, production, structure of the labour market, housing, as well as in needs of transport and expenditure on health and social services, among others. All these changes deserve policy attention, particularly in view of the contributions of the older persons to the development of society (Ministry of Health Uganda, 2004). Accordingly, the Department of Social Development (2001) points out that many countries formulate and implement policies on the plight of older people.

The literature suggests that notwithstanding the fact that these policies are approached using mainly two different perspectives; the human rights perspective and the welfare perspective, their intents and purposes tend to be essentially the same. This is clearly spelt out by a number of scholarly sources that highlight similar policies on older persons using either the human rights perspective or the welfare perspective (Oloka-Onyango, 2009, 2008; Kollapan, 2008; HelpAge International, 2007a, 2001; European Convention on Human Rights (ECHR), 2001; Northern Ireland Human Rights Commission (NIHRC), 2001; Murray, 2000).

In particular, Kollapan (2008) observes that a number of international policy documents have been adopted to strengthen the protection of the rights and social security of older persons. He illustrates his observation by pointing out the 1982 Vienna International Plan of Action on Ageing; the 1991 United Nations Principles for Older Persons that were reinforced in 2002 through the Madrid International Plan of Action on Ageing at the global level; and the African Union Policy Framework and Plan of Action on Ageing at the regional level. He notes that underlying these policies are the five areas of concern for older persons, also expressed in the 1991 UN principles of: independence, participation, care, self-fulfilment and dignity.

Taking a human rights approach, Kollapan (2008) discusses a number of policy instruments that address the plight of older persons and which have been formulated and ratified by a number of African countries. Specifically, Kollapan (2008) analyses the African Charter on Human and Peoples' Rights which came into force in 1986, observing that it has two provisions which are of specific relevance for older persons. Article 18 (4) provides for special measures of protection in keeping with their physical or moral needs for the aged, while Article 29(1) provides that everyone has the duty to respect his parents at all times and to maintain them in case of need. He added that Article 26(c) of the African Youth Charter reiterates this responsibility by stating that 'Youth shall have the duty to have full respect for parents and elders and assist them anytime in cases of need'. He also pointed out that the Protocol to the African Charter on the Rights of Women in Africa in Article 22(b) prohibits discrimination based on age, adding that the Protocol also provides for specific measures to commensurate with the physical, economic and social needs of older women as well as their access to employment and professional training, and that older women shall be guaranteed freedom from violence and the right to be treated with dignity.

Kollapan (2008) further observes that in addition to the older persons-specific rights, the African Charter includes both civil and political and socio-economic rights of relevance to older persons. He notes that for socio-economic rights, the Charter has explicit provisions on the right to work, health and education. Kollapan (2008) concludes his

discussion of the fore-cited policy instruments by expressing concern that a review of reports on policy protection of older persons suggests that African countries do not sufficiently deal with the rights of older persons in their policies. Illustrations cited include Benin, Kenya, Nigeria and the Democratic Republic of the Congo which emphasise that the aged should be protected as senior citizens; against any exploitation whatsoever; and against moral and material neglect. These countries however, do not provide any significant policy steps taken to ensure that this is realised.

The fact that Uganda is not mentioned in the illustrations given by Kollapan (2008), questions about whether policies exist in Uganda for older people remain unanswered, especially in the light of the continued discrimination and state neglect faced by these people as a result of their advanced age. Their rights continue to be abused and violated in both domestic and institutional settings in form of being given 'lip service' in matters affecting their lives, including health care, employment, education, social security, food and adequate nutrition.

According to Yeung-SikYuen (2008), the Poverty Reduction Policy Strategies (PRPS) formulated in many African states provide little in terms of policy prescriptions aimed at the protection of older persons. He illustrates this observation by pointing out the following examples:

- The Mozambique PRPS which provides for the establishment of open community centres; financial and physical assistance to the unsupported older persons; and sensitisation activities with regard to the rights of the older persons.
- The Senegalese PRPS which provides for a minimum allowance for seniors without pensions; specialised geriatric services; and free access to healthcare services for the older persons.
- The Guinean PRPS which provides for the establishment of mechanisms to disseminate and raise public awareness of laws and conventions protecting women, children, disabled persons and older persons.
- The Tanzanian National Strategy for Growth and Reduction of Poverty, which set targets which include ensuring that 40% of older persons are covered by effective

social protection measures as well as ensuring that access to district courts is improved and enhanced in cases involving older people.

- The Algeria programme of action, which provides for the finalisation of the bill on the older persons by 2008.
- The Ghana programme of action that provided that the National Policy on the Aged should be published and implemented by 2006.
- Mauritius adopted The Protection of Older Persons Act in 2005.
- South Africa adopted the Older Persons Act in 2006.
- The Constitution of Ethiopia which declares that, "The state shall, within the available means, allocate resources to provide rehabilitation and assistance to … the aged …' (Yeung-SikYuen , 2008)

Yeung-SikYuen (2008) concludes that in most countries policies dealing specifically with older persons are limited to issues addressing pension funds for retired civil servants or those in other formal employment. National policies on ageing have been adopted in a few African countries but even then, there is little to show as far as effective addressing of the plight of the older persons is concerned. Could this be the case in Uganda?

ECHR (2001) earlier on described the social security policy for older persons using the human rights perspective, advancing a view that every older person has a right to social security. The Help Age International (2007b) discusses the same policy using the welfare perspective and maintains that older persons are entitled to benefits from government in recognition of the contributions that they make to the development of society before their disengagement from active public activities and roles. Both sources indicate that policies on the social security of older persons should focus on and include retirement and gratuity packages, pensions and other forms of benefits provided by government to older persons in order to maintain their social security. The sources showed further that the social security policy should be formulated and effectively implemented by all governments which respect this right and welfare of the older persons. Failure to have this policy effectively implemented not only violates the right of older persons to social

security but also exposes them to living in poor socioeconomic welfare conditions (Murray, 2000).

Indeed, a study conducted by the Department of Social Development (2001) found that 80% of older black people in South Africa were subjected to poor welfare and had their right to social security violated because there was no policy to guarantee them benefits from government in form of pension. Another study conducted in Rajasthan found that the pension policy in India favoured only 6% of older persons entitled to pension. For the majority, the conditions of work and disengagement from active public roles and responsibilities did not meet the policy requirements. In another study conducted by Gravis (2004), it was found that while some countries only operate retirement and pension programmes for the older persons according to the Age Concern Report (2006), some countries set up pension commissions to look at how to provide and improve pensions to the older persons. However, other countries virtually lack policies on the social security of older persons.

Help Age International & HIV/AIDS International Alliance (2006) observe that the failure to have a policy on the social security of older persons is worsened by the tendency to have the right of these people to recognition before the law violated as a result of lack of policy on the enforcement of this right. The violation takes the form of lack of identity documentation, which prevents older people from claiming entitlements, such as pensions or health services that are theirs by right. According to the 2005 survey of nearly 4,000 older people in eight communities in Mozambique, 42% had no identification cards, which they needed to claim free health care; and older women were twice more likely to lack identification cards than older men (MECOVI, 2001). In Bolivia, 16% of older people had no valid documents to prove their right to claim the social pension (Help Age International & Bolivian National Institute of Statistics, 2002). Whether the same holds true for Uganda needs to be investigated.

Arguing that all older people have the right to access healthcare that meets their needs, Help Age International (2005a) asserts that countries should have a policy on the

provision of this healthcare to the older persons in their jurisdictions. The policy should be formulated in such a way that it guarantees older people with access to free healthcare. Help Age International (2005a) however discovered that although such a policy exists in countries like Bolivia, its requirements for hard records and information allowed only 32% of those eligible to the free healthcare scheme to access the services. Many would-be eligible older persons failed to claim their healthcare entitlements due to legal difficulties in accessing the services and lack of documentation, particularly in rural areas.

In an earlier survey conducted in the Nanyuki province of Kenya, Help Age International (2001) found that due to lack of an effective healthcare policy, 30% of the male older persons had their right to healthcare abused by being abandoned at hospitals. This observation suggests that in the absence of an effective healthcare policy for the older persons, there is a high likelihood of denying them a chance to realise their right to deserving healthcare.

In another study conducted in Tanzania, Help Age International (2004a) highlighted that due to lack of a policy on all forms of violence against the older persons, many older persons have had to have their right to freedom from violence and right to life violated. The older persons in Tanzania, especially older women, are subject to violence and abuse. This violates their right to be free from violence as well as their right to life when the abuse results in their death. The study found that 17,220 women were abused between 1998 and 2001 as a result of witchcraft allegations, and 10% of these were killed. Across the nine project districts in Tanzania where Help Age International works, there were 444 killings of people between 1999 and 2004 due to claims that they were involved in witchcraft. Of these, only nine were young or adult people. The rest were older women. Help Age International (2004a) concluded that if there had been an effective policy protecting older persons from such violations, these deaths would have been prevented through legal means.

Ferreira (2001) conducted a survey of people aged 70 and over in rural India and found that 4% had been physically abused. In a survey carried out by Ferreira (2001) in urban India 20% reported physical neglect and abandonment. In a survey of older people's organisations carried out by the South African Government's Department of Social Development (2001), 32% of respondents reported that older people were ill-treated. Fifty five percent of the abusers were grandchildren, 16% were their own children, 20% their spouses and 4% were their caretakers. The studies showed that although policies against violation of the right of the older persons to freedom from violence had been formulated in these countries, insignificant efforts had been made to implement them effectively.

The preceding observations suggest that where there is no policy protecting the older persons from violence and where the policy exists but is not effectively implemented, there is a high likelihood of violating or abusing the rights of the older persons, particularly the right to life. It is not clear whether policies protecting the older persons from having their right to freedom from violence and right to life violated exist in Uganda.

The National Institute of Statistics (2004) indicate that the larger proportion of the current generation of older people in Mozambique have had their right to school education violated and abused. It showed that over 90% of the older persons, especially older women in Mozambique are unlikely to have received any education when they were young; and as a result of lack of policy on adult education, many of the older persons do not have access to education later in life. Not being able to read or write prevents them from accessing entitlements that are theirs by right. The National Institute of Statistics (2004) continues to show that in 2003 in Mozambique, 94% of women over 60 years of age were illiterate (compared to 64% of men over 60). Similar statistics are cited in the case of Bolivia as approximately 8 out of every 10 rural older women do not read or write. This is abuse of the right of the older persons to education as a result of lack of policy to enforce realisation of this right.

In recognition of the right of older persons to work, Second (2006), recommends that countries should have and enforce policies encouraging older people to continue being involved in work. This is because the right to work gives older people the right to freely decide, choose and accept work and the right not to be unfairly deprived of it based on their age. This policy can help countries recognise that even when the older persons are disengaged from active public roles to pave way for the young, they are not supposed to be neglected, especially when their health enables them to continue working normally. This recommendation was made based on a survey that Second (2006) conducted in Moldova and discovered that 77% of older people were denied employment by employers because of old age.

According to N'nyapule (2003), governments especially those in poverty-stricken countries need to formulate and effectively implement policies integrating the plight of the older persons in their strategy frameworks for addressing the challenges of getting out of poverty. This is because such challenges are greater for older people largely because society ignores their needs and fails to recognise their potential. Among (2005) argues that since old age has become a cross-cutting issue of critical significance, poverty alleviation strategies formulated by developing countries must encourage policies that help older people maintain themselves and contribute to their families and communities.

Similar observations were made by the government of Tanzania in its National Poverty Reduction Strategy Paper 2000. The Paper indicates that the government of Tanzania had to incorporate the issue of ageing and appropriate support mechanisms for older people into the mainstream of social and economic planning. It also urged the Tanzanian government to formulate policies for employment, health, transport and social care among others, for older people. Consequently, the National Ageing Policy was formulated identifying areas that needed to be addressed, including health care, income security, education, food security, housing and legal protection. Other areas included the strengthening of household and community support systems and the involvement of NGOs/CBOs and the private sector (Help Age International, 2007b). However, the policy

has not achieved much as far as its implementation is concerned (Help Age International, 2007b).

According to Panek & Hayslip (2003), policies for strengthening the role of civil society in development and taking forward social and economic change should also incorporate issues of older persons. This is because older persons form a significant group within civil society in their own right and are members of many interest groups. There should be policies recognising and encouraging the role of older people in these organisations. Involvement of older people themselves and their families, communities and NGOs/CBOs in research, planning and policy implementation on issues that concern them should be the way forward. It is however still unclear if such policies are in place in Uganda.

In a similar manner, Murray (2000) had earlier recommended that governments should formulate and promote policies that discourage programmes and schemes designed and tailored towards prohibition of inclusion of old people. Murray (2000) pointed out that there should be a policy against the laws and tendencies of commercial banks to deny older people access to credit. Such a policy should be reinforced by one which requires commercial banks to base more on the offered collateral than age when extending credit. This requires that commercial banks get information on the assets of the older persons, their pension status, and employment records rather than mere age (Pearson, 2005). Important to note is that Pearson (2005) and Murray (2000) make these observations in a generalised manner while focussing on the implications of the Human Rights Act on the life of older people.

Najjumba-Mulindwa (2004) observes that countries should formulate and implement policies for promoting older persons' access to resources and to functional literacy programmes that enhance their skills. Ntale-Lwanga & Kimberley (2003) suggest that there should be policies encouraging formation of groups to boost the self-esteem, confidence, and development of friendships and mutual support amongst the older persons. Also suggested are policies that buttress the changing roles of the older persons

(Mugambe, 2006). However, a baseline study conducted earlier on by Anweng-Angura & Anyuru (1994) contends that many of these policies were lacking in Uganda. Nonetheless, the observations of Anweng-Angura & Anyuru (1994) may be obsolete since their study was conducted 15 years back. Times have changed since 1994. A current and empirical situation is thus needed on the matter.

The World Health Organisation (2006) observes that policy principles and recommendations consistent with the Madrid International Plan of Action on Ageing have been pursued globally by Member States and leading academic, professional and nongovernmental organisations. Efforts have been geared towards focusing on ageing at all stages of life rather than compartmentalising older people. Through WHO activities, older persons have been encouraged to join programmes of active ageing and in collaboration, with academic institutions and government agencies from Australia, Brazil, Canada, Costa Rica, Jamaica, Singapore, Spain and Turkey, policies on adult literacy and health care have been implemented. The fact that the World Health Organisation (2006) does not mention Uganda as one of the countries, leads to questioning whether such policies have been implemented in the country as well.

According to Lloyd-Sherlock (2000a; 2000b & 2002), policy concerning the plight of older persons has been pursued in Kenya since 1997. However, little success has been achieved despite some hopes that the policy will eventually be formulated and implemented. Older people continue to benefit from the civil society organisations like NGOs with little help from government. The meeting of their long-term needs either formally or informally is however in suspense as long as the policy is not in place.

MacIntyre (1977) had earlier on advocated policies addressing the plight of the older persons in terms of provision of housing, accommodation and homecare services. He argued that as people grow older, they become frail, weak, sometimes impaired and therefore, need special attention in terms of housing, accommodation and homecare. He further noted that almost everyone in the ageing field is aware of the concept that there is

a continuum of living arrangements, ranging from living independently in one‘s own home to complete institutionalisation.

In support, Bond (1990) observes that in the United States of America, the housing policy provides for accommodation and homecare for frail older persons. This is done in recognition of the fact that meeting the needs of older people is not a short-term obligation but rather a permanent task that grows bigger as the number of older people who experience life conditions in which they live by competing for health care, education, sanitation, nutrition, and so forth, grows. Policy makers responsible for the quality of life had to come up with a housing and accommodation policy for older people so as to help them live a comfortable life.

More recently, Bookman et al. (2007) observes that many countries have made attempts to formulate policies addressing the problems of older people’s economic security, dependency and isolation as a means of improving the quality of life of these people. A specific policy has been designed focusing on improving the inadequate housing conditions particularly of the impaired, handicapped or disabled older persons. In the United States of America, such a policy has helped reduce the unnecessary admission of older dependent people in homes for senior citizens (Bookman et al., 2007). This policy has been operating in such a way that it helps older people to remain in their own homes more satisfactorily, through the work of voluntary non-governmental organisations, societies, and local authorities, rather than central or national governments (Apt & Greico, 1994).

Another justification for a housing policy for the older persons is given by Streib (1982) when he argues that older people are heterogeneous in terms of income, family backgrounds, and level of health, mobility, attitudes, and personalities. Providing supportive housing services that permit them to remain in their homes is therefore the best option by many persons who are witnessing old age. Apt (1999) suggests that this policy is even the best for countries in Africa because, being poor developing countries, they may find it expensive to offer institutional care for the older persons.

2.4 International Policy Instruments that Protect the Rights of Older Persons

A number of international policy instruments have been taken on to protect the rights of older people globally. As revealed earlier in this chapter, these include the 1982 Vienna International Plan of Action on Ageing and the 1991 United Nations Principles for older persons which were supported in 2002 through the Madrid International Plan of Action on Ageing at a global level (United Nations, 2002). In the African region, the African Union policy framework and Plan of Action on Ageing was put in place in 2002 to address the needs of the older persons in Africa. The framework calls on African states to ensure that the specific needs of older persons are taken into account in the national development plans (African Union, 2008a; 2008b). As mentioned earlier, all the above mentioned policy plans are related to five areas of concern for older persons. These include Independence, Participation, Care, Self-fulfilment and Dignity (Kollapan, 2008). Furthermore, other policy instruments include the Universal Declaration of Human Rights (1948) of which Article 25, paragraph 1, states that: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, medical care and necessary social services, as well as the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control" (Human Rights Education Associates (HREA), 2003).

The International Covenant on Economic, Social, and Cultural rights (1966) Article 9, 11 and 12 reiterates the right of everyone to social security. All people are entitled to an adequate standard of living, including food, clothing and housing. Going further than the Universal Declaration of Human Rights, the International Covenant also guarantees everyone the right to continuous improvement of living conditions. This elucidates that governments should continuously work in the direction of improving the living conditions of all people, including those under the care of the state, such as older persons (HREA, 2003).

The Charter of the United Nations (1945) Article 55 guarantees member states of the United Nations to promote higher standards of living for all people, social and economic progress, and international cooperation on social issues including health and education,

and universal respect for human rights regardless of individual backgrounds or characteristics.

Furthermore, The ILO Recommendation 162, regarding older workers (1980) (section II paragraph 5) recommends that older workers should enjoy equality of opportunity and treatment with other workers without age discrimination, including access to housing, social services and health institutions, particularly when this access is related to occupational activity or employment (HREA, 2003).

Another instrument that had been pointed out earlier is the Declaration on the Elimination of Violence against Women (1993). This declaration centres on violence against women as both a violation of their rights and as an obstacle to achieving equality. It draws round the types of violence often committed against women and brings special attention to groups of women that are particularly vulnerable, including older women (HREA, 2003).

The Declaration on the Rights of Disabled Persons (1975) Articles 5,9,10 and 12 defines the status of disabled persons to include some of the older persons as well. As some of the older persons often suffer from various types of disabilities, the rules established in this declaration are also applicable to them. Disabled people are entitled to all measures designed to assist them in becoming as self-reliant as possible. If a disabled person must stay in an institution for assistance, that individual is entitled to living conditions that come as close as possible to those of other people of the same age. Disabled persons should be protected from exploitation and abuse.

In the same milieu, in the African Charter on Human and Peoples' Rights (1981) article 18 as pointed out earlier by Kollapan (2008) deals with human rights and acknowledges the basic, specific right of the aged and/or disabled persons to special measures of protection and security according to their needs, both physical and moral. In 2007, the African Commission on Human Rights and People's Rights (African Charter) also established a Focal point on the Rights of older persons in Africa with a notion of developing a declaration to be followed by an agreement dealing with the rights and welfare of older persons in Africa. So far this commission commenced with holding a

consultative meeting on the rights of older persons in October, 2008 in Mauritius (Kollapan, 2008).

In the face of having all the above international policy instruments in place, Kollapan's (2008) findings as seen earlier on indicate that the elderly in Africa are still in a marginalised situation. This coincides with Oloka-Onyango's (2008) findings in Uganda that the older persons are still discriminated and their rights are abused. They are always the most exposed to a whole range of risks such as illnesses, unemployment, effect of old age among others and at the same time they have less access to appropriate risk management instruments. Kollapan (2008) recommends that domestic legislation and policies of relevance to the rights of older persons should be systematically collected and analysed. In addition, the rights of older persons should be included in the guidelines on state reporting under the African charter and in the African peer review mechanism questionnaire. The literature shows that there has been no reporting by most of the African states to the African Charter about their implementation on the rights of older persons except for only a few countries in Africa. Uganda is one of those countries which did not include any implementation activity on the older persons in her report to the African charter (Republic of Uganda's Report, 2008). Does this mean there are no programmes for the elderly in Uganda?

Regarding social protection framework, it generally involves public measures to income security for individuals in virtue of reducing transitory poverty, prevent the poor from falling deeper into poverty, and provide an avenue out of poverty. The measures include social insurance, social safety nets and local lobar market interventions. These measures came as a result of the recent financial crisis that intensified up in almost every country thus causing an increase in their level of poverty. Those who were mainly at risk included the older persons, the unemployed, those with health risks and those affected by war amidst others. This prompted the World Bank to formulate social principles and good practices of social policy to guide policy makers in the various countries to attempt to improve the minimum social conditions of individuals which included social protection provision in normal times and in episodes of crisis and stress (Holzimann & Jorgensen,

2000; World Bank 1999). However, majority of the African countries including Uganda have embraced the framework but unfortunately the policy is still in the offing.

2.5 Summary of Literature

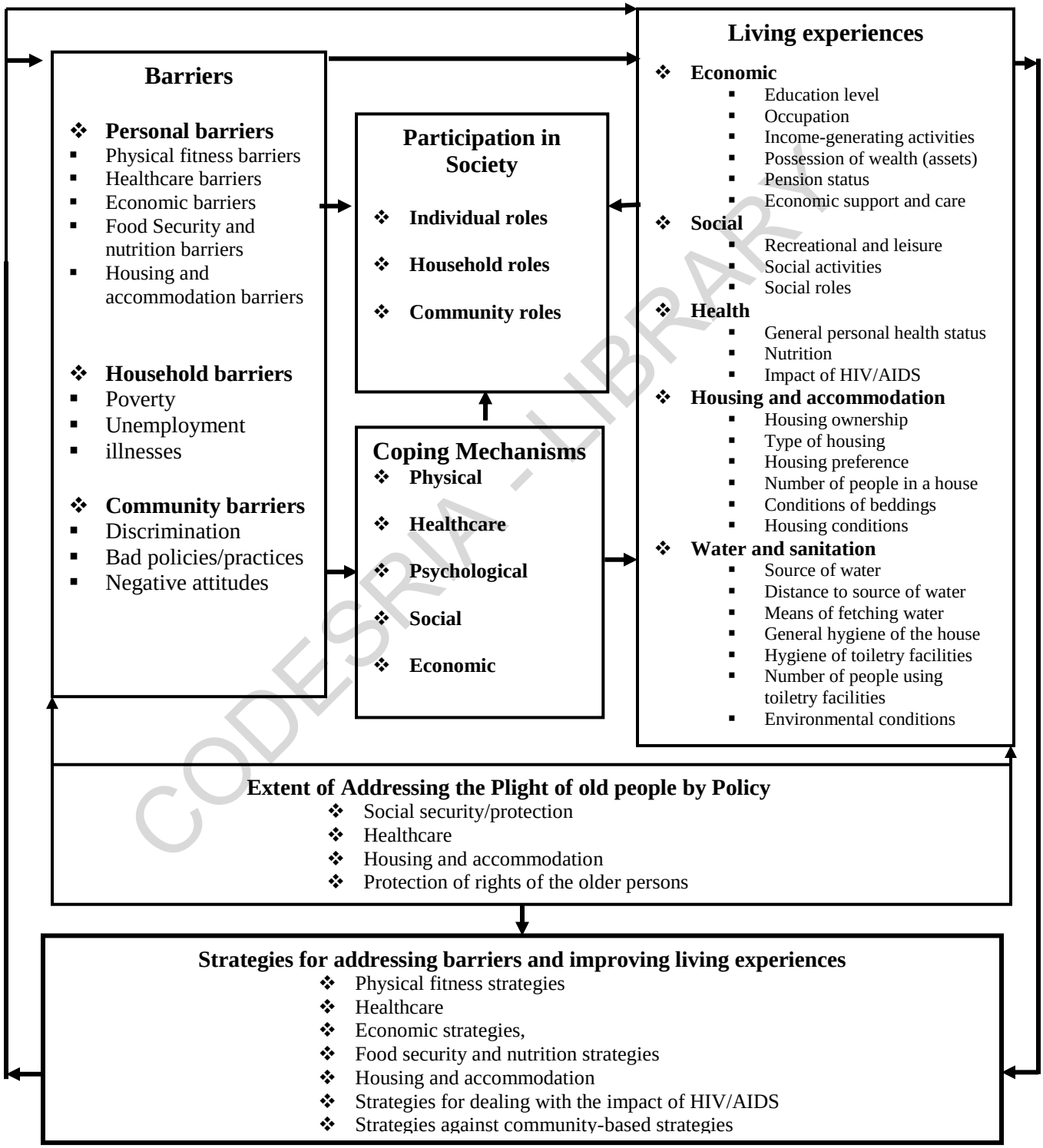
The literature cited in the various sections of this chapter reveals that the living experiences of older people are characterised and described by various dimensions of life, spanning over health, economic, social, recreational, sanitation, housing and accommodation, food security and nutrition, and water supply conditions. The literature also shows that in their efforts to live and to participate in society as desired, the older persons encounter a number of barriers in form of constraints, age prejudices, problems, challenges, and limitations to active life. The barriers occur at personal, household and community levels.

The cited literature further shows that older persons develop or devise a number of mechanisms to cope with these barriers, including: personal initiatives towards fostering access to support services that protect and empower an older person to achieve and maintain psychological well-being; using the social support structures available and willing to provide them with opportunities to not only learn new responses to life stresses but also address their survival needs; creative response to the rapidly changing world; utilisation of pension provided by governments; emotional support mechanisms; engaging in farming and small-scale businesses; provision of manual labour; selling property; leasing land; begging; using skills that focus on maintaining the desired social and spiritual support in form of active engagement with life, and having an internal focus of control. The literature further indicates that a number of countries have formulated and implemented policies addressing the plight of older people as far as their social security, healthcare, housing and accommodation, and protection of their rights are all concerned. The literature however highlights the gaps that must be addressed regarding the older persons in Uganda. These are the gaps which this study attempted to bridge following the conceptual model presented in the next section.

2.6 Conceptual Framework

Following the self-concept and selectivity theories of old age, the study was conceptualised as shown in the following conceptual model.

Figure 2.1: Conceptual Model



The above conceptual model summarises the manner in which the study was conceptualised. The model not only identifies the variables of the study, but also shows how they were logically linked. The variables included the following:

- Barriers
- Participation in society
- Coping mechanisms
- Living experiences
- Policy extent of addressing the plight of old people
- Strategies for dealing with the barriers

In particular, the model indicates that the barriers were conceived as variables which affect the participation of the older persons and their living experiences; they can be personal, or household and community barriers (N'nyapule, 2003; MacIntyre, 1977). Personal barriers are the problems or limitations that an individual old person faces as a result of his/her poor conditions of health, thereby preventing his/her effective participation in society or constraining the realisation of the living conditions he/she would have desired to experience. They manifest themselves in various forms such as barriers to desired physical fitness, healthcare, economic status, food Security and nutrition, and housing and accommodation (Diane & Aldwin, 2003; Llyod-Sherlck, 2000a; Frisk, 2000). Household barriers are the problems that limit the older persons from participating in society by way of playing their household roles such as grand parenting or taking care of their grand children and other members of their households (Kanyamurwa, 2008a; Alun, 2003). Community barriers are the problems that originate from communities within which the older persons live to prevent or constrain their effective participation and desired living experiences (Taylor, 2006; Najjumba-Mulindwa, 2004).

Participation in society was conceived of as the process by which old people get actively involved in their communities by playing their personal, household and community roles. For instance, if an older person is engaged in cultivation of food, this may be carried out as a personal role since it may be regarded as an activity carried out to ensure that the

older person gets food to eat. It can however, also be considered as a household role if the older person is cultivating to get food for his/her household members. At the same time, it can be a community role if the older person is growing food for sell or to supply to other members of the community. Clearly, participation in the society is a dimension that delineates living experiences of the older persons in its own right. This explains why barriers to participation in society are also barriers to the living experiences of the older persons.

The living experiences of the older persons were considered as the conditions or circumstances that characterise their lives as individuals. They were classified and approached using different categories, namely:

- Economic category: This category was considered as one defining the living experiences of individual older persons in terms of their education levels, occupations, income-generating activities, possessed wealth (assets), pension status, and provided economic support and care.
- Social category: This category was regarded as one focusing on the leisure, recreational, and social activities and the roles that characterised the lives of older persons as individuals.
- Health category: This was a category conceived as delineating the older person's general personal health status, nutrition, and impact of HIV/AIDS.
- Housing and accommodation: The living experiences under this category were described in terms of ownership of a house, type of housing, housing preference, number of people in a house, conditions of beddings, and general housing conditions.
- Water and sanitation: This was a category of living experiences that focused on the source of water, distance to the source of water, means of the fetching water, general hygiene of the house, type and cleanliness of toiletry facilities, the number of people using the toiletry facilities, and the environmental conditions associated with the places where the older persons lived.

The model indicates that there were mechanisms that the older persons used to deal with barriers to their participation in society and to their desired living experiences. These

mechanisms are categorised as: healthcare, psychological, social, and economic mechanisms. Healthcare mechanisms were considered as the means used by the older persons to deal with their physical illnesses; psychological and social mechanisms were regarded as skills used by the older persons to seek emotional and social support for overcoming emotional and social problems; while economic mechanisms were viewed as means used to deal with economic poverty.

The extent of addressing the plight of old people by policy was considered as a measure of how far the concerns of these people are addressed by policy in Uganda. The conceptual model indicates that the concerns dealt with include the quality of the living experiences as well as the barriers encountered by these people in their attempt to participate in society (Nankwanga & Phillips, 2009a; Kalasa, 2004; Diane & Aldwin, 2003; Llyod-Sherlck, 2000a & 2000b; Frisk, 2000). They can be addressed through a number of policies related to the social security/welfare, healthcare, housing and accommodation, and protection of rights of the older people's perspective (Kollapan, 2008; Help Age International, 2007a, 2007b, 2001; European Convention on Human Rights (ECHR), 2001; Northern Ireland Human Rights Commission (NIHRC), 2001; Murray, 2000).

The model finally indicates that the study was also conceptualised to focus on strategies that can be adopted to address the barriers and improve the living experiences of the older persons. Accordingly the strategies were conceptualised as variables that can be informed by the existing quality of such experiences and barriers so that they can effectively deal with them to achieve the desired quality improvement. Since both the living experiences and barriers were grouped in a number of dimensions, including: the physical fitness, healthcare, economic, food security and nutrition, housing and accommodation, household, and community dimensions, the strategies for dealing with them were also categorised following the same dimensions. Consequently, they included: physical fitness, healthcare, economic, food security and nutrition, housing and accommodation, household, and community strategies.

In general, the conceptual model indicates that a barrier that an old person encounters in life affects not only his/her effectiveness in participating in society but also the living experiences characterising his/her life. Conversely, these living experiences determine the degree to which the person participates in society. The model indicates further that there are coping mechanisms that an older person can use to deal with the barriers to his/her participation in society and to his/her living experiences. It also shows that the plight of the older persons can be addressed by policy based on the barriers to their participation in society and the nature of the living experiences characterising their lives. It finally indicates that there are strategies that can be adopted to address the barriers and improve the living experiences of these people. This explains why the study explored each of these variables in detail.

CHAPTER THREE
METHODOLOGY

3.0 Overview

In this chapter the methods utilised in the study are outlined. The research setting, population and sample used in the study are described. Furthermore, the research design, methods of data collection and analysis are also explained. Finally the issues of ethical considerations of the study are reported.

3.1 Elaborating research Questions

As stated earlier in section 1.4, the purpose of the study was to explore the living experiences, needs, problems, coping mechanisms of Uganda's older persons, and the extent to which these concerns have been addressed by policy with a view of proposing strategies that could help to formulate and implement policies for empowering these people to achieve active and healthy ageing. The study sought to answer the following five questions:

1. What are needs, problems and living experiences of older persons in Uganda?
2. What are the barriers to effective participation of Uganda's older persons in society?
3. What are the mechanisms used by the older persons to cope with the barriers to effective participation in society?
4. To what extent are the needs of the older persons addressed by policy in Uganda?
5. What are the strategies that can be used to address the plight of older persons in Uganda?

3.2 Research Setting

The research setting of the study refers to the geographical area where the study is carried out. It may be described in terms of geopolitical location, population size, socio-economic activity patterns, and the extent of rural or urban development, settlement patterns, or any other features that characterize the area and are relevant to the study (Sekaran, 2001). Based on this understanding, the study was carried out in two Ugandan settings: the rural and urban. These settings were intended to establish whether or not there were any significant differences in the living experiences of the older persons

brought about by the setting in which the older persons lived. These settings were determined basing on the geopolitical divisions of Uganda. According to the Uganda Bureau of Statistics (2008), at the time of writing, Uganda had 81 districts. The districts are distributed in four regions in which the country is divided. The regions include Central, Eastern, Northern and Western regions. Each of these regions has both rural and urban districts. The districts that constituted the research setting are shown in diagram 3.1.

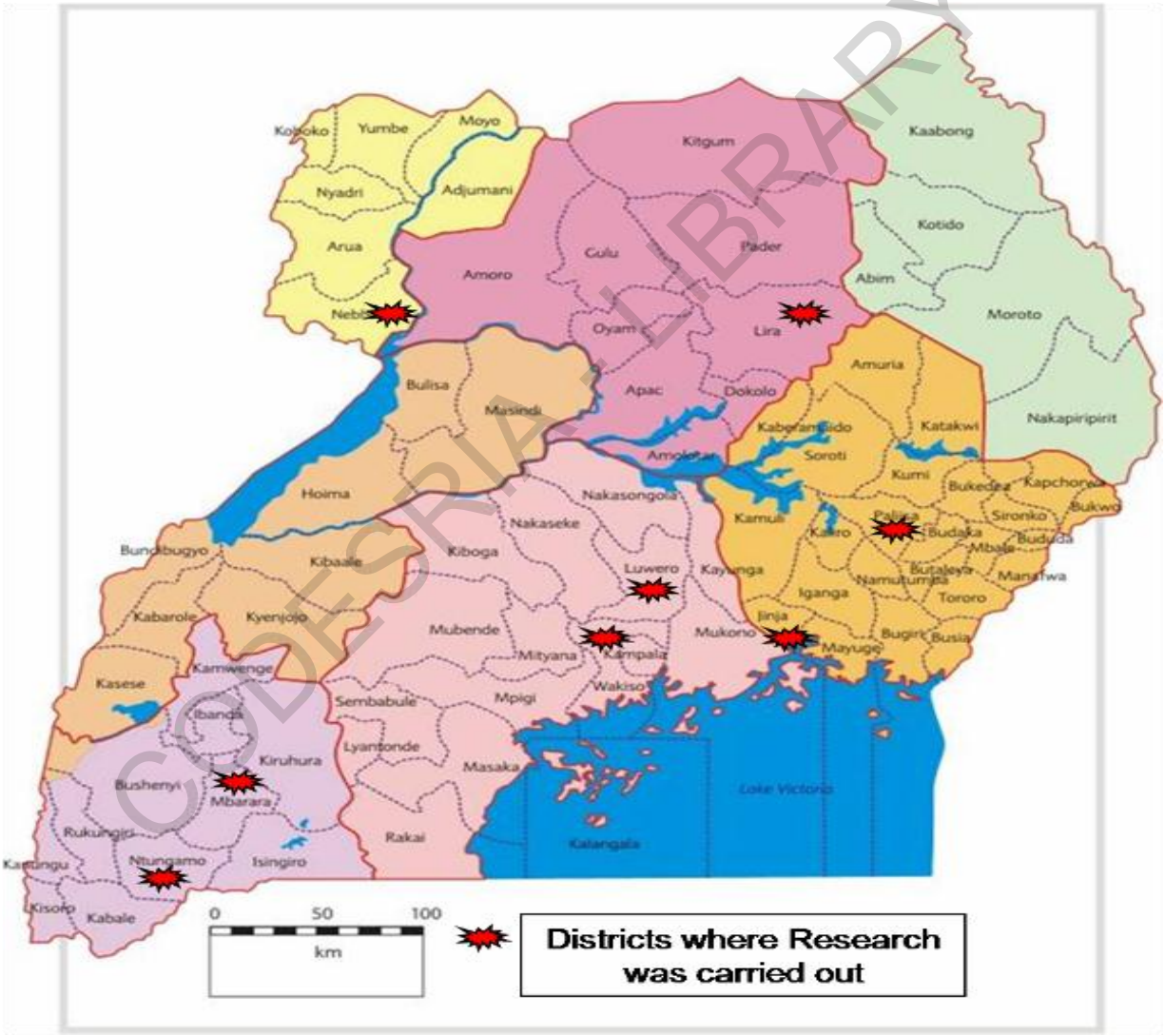


Diagram 3.1: Map of Uganda illustrating the Research Setting

(Source: http://www.reliefweb.int/mapc/afr_east/cnt/uga/ugaad2.html).

As shown in Figure 3.1, Lira, Nebbi, Kampala, Luwero, Pallisa, Jinja, Mbarara, and Ntungamo were the districts that constituted the setting of the study. This implies that the study's setting consisted of eight districts. These were regionally distributed as shown in Table 3.1.

Table 3.1: Regional Distribution of the Districts by Settings

	Districts by Settings	
Region	**Urban**	**Rural**
Central	Kampala	Luwero
Eastern	Jinja	Pallisa
Northern	Lira	Nebbi
Western	Mbarara	Ntungamo

Table 3.1 summarises the regional distribution of the districts that constituted the setting of the study. The table indicates that Kampala district represented the urban setting while Luwero district represented the rural setting of the central region of Uganda. The explanation is the same for the remaining regions. The districts in Table 3.1 constituted the setting of the study because their residential and economic activity patterns fitted the fore-described criteria.

In summary, the fore-described setting consisted of rural and urban districts of the four regions of Uganda. In each district four sub counties were visited to purposively select older persons who participated in the study. Majority of the selected older persons did not attend school and many of them did not have any occupation. The setting was deemed suitable for the study whose main aim was to explore the living experiences of the older persons in Uganda with a view of proposing policy strategies for improving these experiences. The study was conducted based on this setting following the research design explained in the next section.

3.3 Research Design

The study was conducted as an exploratory cross-sectional survey involving a triangulation of both qualitative and quantitative research approaches. The study was intended to inform formulation of policies pertaining to the plight of older persons in Uganda by fully explaining their needs, problems, living experiences and encountered barriers using first-hand and textual data collected from different categories of respondents elaborated shortly under Section 3.5. According to Amin (2005), an exploratory cross-section survey was appropriate to realizing such study intention. The qualitative methods used in the study included: in-depth interviews and focus-group discussions with older persons, observation and document review. While in-depth interviews and focus-group discussions were used to identify the needs, problems, living experiences, and barriers faced by older persons, document review was applied to identify areas in Uganda's development policies in which older persons could fit but were excluded. The used quantitative method included administration of a questionnaire to key informants for purposes of enriching data obtained from older persons. The intention was to enrich a basis for identifying policy strategies that could be used to address the needs, problems and barriers faced by older persons in Uganda, thereby improving their living experiences. As Neuman (2000) aptly observed, the combination of these methods helped to make the study's findings more informative and comprehensive, and this enriched it as basis for a deeper understanding needed in Uganda in order to address the needs, problems, living experiences, and barriers of the country's older persons from an informed point of view.

In fact, the fore-described research design is not unique to this study. It has been applied to successfully conduct a number of studies such as that of Kawogo (2008), Kiiza-Wamala (2008), Kanyamurwa (2008a, 2008b), Kanyemibwa (2007), and Kikafunda & Lukwago (2005). Moreover, all these studies were conducted in different areas of gerontology, vulnerable families, and other social groups that were typically similar to the older persons. In addition, Borkan (2004) endorsed the use of this approach when a study is intended to inform policy. In addition, as Borkan (2004) observed, such a design is also appropriate to studies seeking to address practical and policy issues from the point

of view of documentary review, numbers and narratives. The design was therefore appropriate since this study was partly intended to provide information needed to formulate policies needed to address the plight of older persons in Uganda.

3.4 Study Population

A study population refers to the total number of people from whom subjects who participate in a study as respondents are selected (Amin, 2005). The population of this study consisted of rural and urban older persons of Uganda, policy makers and implementers in government ministries and departments that were in charge of services for the older persons. Specifically, it included policy makers and implementers in the Ministries of Gender, Labour and Social Development; Urban, Housing and Physical Planning; Agriculture; Health; Education and Public service. The study population also included the administrators, managers, and officials of NGOs and religious organisations linked to the older persons in Uganda. Key informants were selected from all the regions of the country particularly in the study districts.

The older persons were included in the study population as a primary source of data. They were included to provide data regarding their living experiences, problems, needs, coping strategies, and recommendations for improving their conditions of life. Other categories of respondents were included to act as key informants providing complementary data about the fore-mentioned themes of the study as well as about policy strategies needed to be adopted in order to improve the life conditions of older persons in Uganda.

According to Mugambe (2006), the older persons constitute 6.1% of Uganda's population estimated at 30 million people, which implies that the total number of these respondents was 1,830,000. Government officials in the departments dealing with the older persons were, according to the Personnel records of 2006, seventy eight (78) in total and these included those in the pensions department and the older persons department of the Ministries of Gender, Labour and Social Development. The managers, administrators and officials in the NGOs and religious organisations dealing with the older persons were 65

in total (Survey Report of NGOs in Uganda, 2006). However, the total number of the older persons who were living in the districts that made up the study's setting was 2.925% (computed as the average of the proportions of the older persons in the districts described under the study's settings) of the total Ugandan population.

In each of the urban and rural districts, respondents were targeted to provide data needed to accomplish the study. In particular, Kampala district had a total resident (not transient) population of 1,189,142, at that time of which 21,066 (1.8 percent) were older persons aged between 60 years and above (Uganda Bureau of Statistics, 2002). In addition, Kampala district had 94% of the respondents who were identified as key informants; for it housed the headquarters of policy makers and implementers, government departments, and most of the head offices of NGOs dealing with the older persons. It is also the most urbanised district in Uganda (Uganda Bureau of Statistics, 2002).

Jinja district was considered because 2.1% of its resident population of 1,006, 171 people consisted of persons aged 60 years and above (Uganda Bureau of Statistics, 2002). Lira district had 2.3% of its total resident population of 607,555 people aged 60 years and above (Uganda, Bureau of Statistics, 2002). Mbarara district had 2.4% of its total resident population of 799, 987 made up of people aged 60 years and above (Uganda Bureau of statistics, 2002).

In the rural setting, Luwero district was considered because 3.3% of its population of 874,089 people consisted of people aged 60 years and above (Uganda Bureau of Statistics, 2002). Pallisa district was considered because its population of 520,578 people had 30,247 (5.8%) persons aged 60 and above (Uganda Bureau of statistics, 2002). Nebbi district had a total population of 456,778 out of whom 3.6% were aged 60 years and above. Lastly, Ntungamo district was considered as part of the study's setting because 3.5% of its population of 899,809 consisted of persons of 60 years and above. In addition, each of these districts had at least one office of one of the categories of the key informants targeted for the study for instance a community based officer, social worker, head of an NGO among others. The Table 3.2 summarises the study population in the

setting including sub-counties visited. In each district four sub-counties were randomly selected as research sites.

Table 3.2 Population of older persons per targeted district and sub-county

District	District Population	Population of older persons	Percentage of older persons	Counties/Sub-counties Visited
Kampala	1,189142	21,066	1.8%	Kawempe Rubaga Nakawa Kampala central
Luwero	874,089	28845	3.3%	Bamunanika Zirobwe Kasangombe Makulubita
Ntungamo	899,809	31493	3.5%	Ntungamo T/C Kibatsi Ngoma Itojo
Mbarara	799,987	199199	2.4%	Mbarara municipality Kamukuzi Biharwe Nyakayojo
Jinja	1,006,171	21129	2.1%	Jinja municipality Budondo Busedde Kakira
Pallisa	520,578	30,247	5.8%	Pallisa T/C Kabwangasi Butebo Kakoro
Nebbi	456,778	16444	3.6%	Atego Paidha Parombo Akworo
Lira	607,555	139737	2.3%	Lira municipality Adekokwok Barr Omoro
Total	**6354109**	**488,160**		

Source: UBOS, 2002

3.5 Sampling procedure

The sample was selected after selection of the districts and sub counties shown in Table 3.2. The selection procedure applied in each case is explained in the following sections.

3.5.1 Sampling of districts and sub counties

Initially the country was stratified geographically into its four regions (strata) of North, East, West and Central Uganda, following Saunders, Lewis and Thornhill's (2000)

observation that stratified sampling is used to divide the study population into homogeneous sub categories, also called strata. This sampling technique was intended to ease selection of respondents from each of the created strata (regions). The technique was also used because according to Amin (2005), it makes sample selection cheaper. Instead of covering all the study area, it permits dividing it up to create a few manageable strata. Based on the same reason, stratified sampling was further applied to divide each region into districts. Thereafter, two districts were selected from each region using judgemental random sampling. Judgmental random sampling was applied to select the district because, according to Seigle (2004), it helps to select subjects at random but prudently so that only those judged to be in a position to provide required data are selected. It is carried out more or less like purposive sampling because it is based on judgment that creates bias in selection; but it is different in the sense that any subject can be selected (randomness) as long as the subject qualifies on the considered judgment or criterion. The criteria used for selecting a district included the following:

- A district's general residential pattern
- A district's general economic activity pattern
- Number of older persons as a proportion of a district's total population

A district was regarded as urban not only because its general residential pattern was such that the households were close to each other, but also if most of its economic activities were in form of public, formal private or informal economic and largely non-agricultural but business-oriented activities. Such activities could be retailing, wholesale trade, or any other earning but non-agricultural activity. A district was considered rural if its general residential pattern was such that households were remotely distributed from each other and if most of its economic activities were largely agricultural or in form of subsistence farming. The proportion of older persons relative to the district population was considered to ensure that districts with the highest number of older persons were selected from both the rural and urban areas of Uganda. On the basis of these criteria, two districts, one rural and the other urban, were selected to represent each region in the study. In this case, a total of eight districts were selected to provide the setting of the study. Subsequent to selecting the eight districts, the researcher continued to randomly

select four sub-counties from each selected district. This was carried out by getting a list of all the sub-counties of each district from the District Administration Office and randomly selecting four sub-counties from each district. The names of the selected sub counties appear in Table 3.2. After selection of the sub counties, older persons were selected as explained in the next section.

3.5.2 Sampling of Older Persons

Purposive sampling was used to select older persons because only those who qualified on the inclusion criteria were targeted. The inclusion criteria included age (at least 55 years), experience of the old age phenomenon, and willingness to share the experience with the researcher. The exclusion criteria focused on older persons who were frustrated, naïve, hostile or attention-seeking, and those who held negative perceptions of the ageing process. In one situation, for instance, the community leader and the researcher came across an old lady who was suspected to be in the age range of 60 to 65. When she was approached and asked to take part in the study, she refuted saying that she did not know anything concerning ageing. She was accordingly left out; for as Patton (1990) and Bowling (2002) observed, with purposive sampling, a deliberate decision can be made to select only 'information rich cases'. Following the above inclusion criteria, the number of older persons selected to participate in the study appears in Table 3.3 below.

Table 3.3: Selected Older Persons by Districts and Settings

Region	District	Older people Respondents					
		Urban		Rural		Total	
		Freq	%	Freq	%	Freq	%
Central	Kampala	25	15.2	0	0.0	25	15.2
	Luwero	4	2.4	16	9.7	20	12.1
Eastern	Jinja	13	7.9	6	3.6	19	11.5
	Palisa	6	3.6	15	9.1	21	12.7
Northern	Lira	3	1.8	17	10.3	20	12.1
	Nebbi	3	1.8	17	10.3	20	12.1
Western	Mbarara	6	3.6	14	8.5	20	12.1
	Ntungamo	4	2.4	16	9.7	20	12.1
	Total	64	38.8	101	61.2	165	100.0

Table 3.3 also shows that 165 older persons were selected to take part in the study. Of these, 64 were selected from urban while 101 were selected from rural settings. Each older person was selected by seeking guidance from sub county leaders. These leaders were asked to direct the researcher (or her field assistants) to the lower community leaders (called Local Council One (LC1) Leaders) under his or her jurisdiction. The LC1 leaders were then requested to help identify the older persons residing in their respective jurisdictions. Accordingly, the LC1 leaders helped identify and select four to seven older persons. As Table 3.3 indicates, the highest number of older persons was selected from Kampala district because they were easily accessed as a result of the district's relatively close residential pattern. The higher number was intended to generate data that needed to reach the point of saturation during data collection. It is imperative to note that although the 165 selected older persons constitute a relatively large number for a qualitative study, it was necessary because the study covered different sub counties in the different districts and regions of Uganda. Besides, this number helped to attain the saturation point, thereby collecting sufficient data.

3.5.3 Characteristics of the Selected Older Persons

The main demographic characteristics that were considered relevant for this study included age and sex of the older persons. As far as age was concerned, the selected older persons were at least 55 years of age. This was in line with the operational definition of an older person, which was adopted for this study as explained in the Background Section of Chapter One as well as in the inclusion criteria. Important to note is that even when the operational definition set the age of older persons at 55 years, attempts were made to select as many older persons as possible. Subsequently, the selected older persons who were less than 60 years of age consisted of only six percent of the sample. The majority (94%) were over 60 years of age. This implies that most of those selected were older persons even by Ugandan Constitutional standards.

The sex of older persons was considered as a way of ensuring that the living experiences, problems, needs and coping strategies used by the older persons in Uganda were free of gender biases. Therefore, both the male and female older persons were selected to

participate in the study. Figure 3.2 shows the gender distribution of those selected to participate in the study.

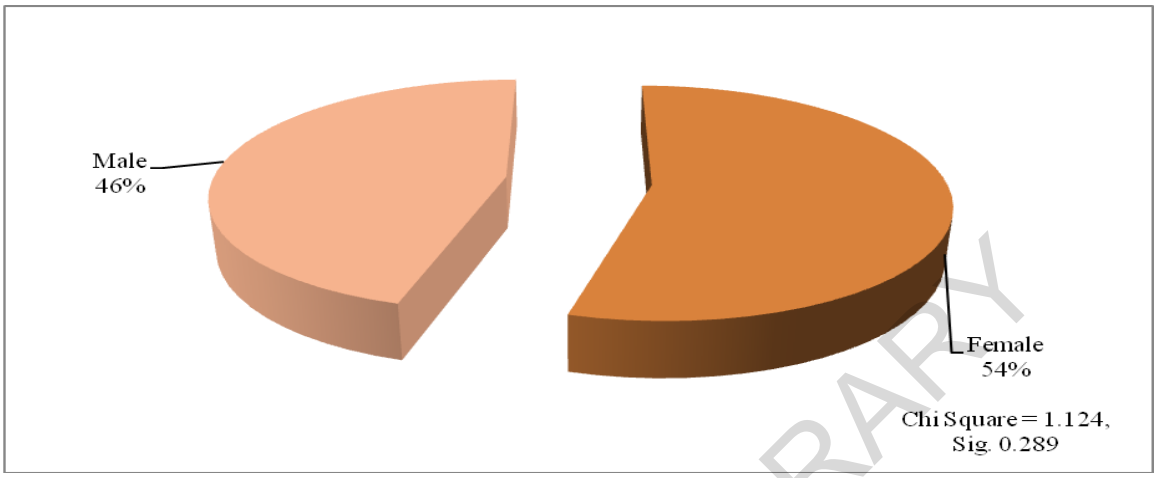


Figure 3.2: Selected Older Persons by Gender

Figure 3.2 indicates that although the female aged (54%) were proportionally more than their male counterparts, there was no significant difference resulting from numbers (Chi square = 1.124, Sig. = 0.289). This implies that the data obtained from these respondents did not significantly differ as a result of the proportional difference in their gender.

In summary qualitative data was collected from 165 elderly respondents. These were purposively selected to provide data that was needed to get an in-depth understanding and insight about the variables of the study. This number was relatively big for a qualitative sample but it was necessary for purposes of covering all the regions and targeted districts and sub counties of Uganda. It enabled collection of data to the point of saturation, thereby enriching the understanding of the living experiences, needs, and barriers faced by these people, as well as the coping mechanisms they used to deal with the barriers.

3.6.4 Selection and Size of Key Informants

Key informants were also selected using purposive sampling because only those working with government departments, NGOs and religious organizations dealing with older persons were targeted to participate in the study. Fifty (50) out of Fifty two (52) expected

key informants were selected to participate in the study. The fact that these respondents were selected to provide quantitative data meant that their sample had to be statistically determined. Consequently, as summarised in Table 3.4 below, their expected number was determined according to Krejcie and Morgan's 1970 Sample Determination Table cited in Amin (2005: 454).

Table 3.4 Determination of the Sample for Quantitative Data

Respondents	Population size	Expected sample	Actual sample size
Members of Parliament dealing with the elderly	2	2	2
Officials from Agencies and Organisations dealing with the plight of elderly people in Uganda	34	32	31
Government Officials from the Department of Elderly People in the Ministry of Gender, Labour and Social Development	11	10	10
Officials from the Ministry of Public Service (Pensions Department) dealing with the elderly	3	3	3
Officials from other Relevant Government Ministries	5	5	4
Total	55	52	50

Note: Expected sample was drawn directly from Krejcie and Morgan's (1970) Sample Determination Table

The key informants were selected to provide data explaining the overall picture of the variables of the study as it applied to Uganda. This was the reason why they were considered as key informants and subsequently selected using purposive sampling following Sekaran's (2001) observation. Their total number was smaller than that of older persons (who provided qualitative data) because people dealing with issues of older persons were generally very few in Uganda. Notwithstanding their relatively smaller number, key informants provided adequate data. This was in line with Strydom and Venter's (2002) recommendation that a sample of 30 to 100 participants should be sufficient to conduct basic statistical analysis. This study was exploratory, implying that 50 respondents were statistically acceptable for quantitative data.

The selected key informants were distributed regionally and in terms of settings as summarised in Table 3.5.

Table 3.5: Key Informants by Districts and Settings

Region	District	Older people Respondents					
		Urban		Rural		Total	
		Freq	%	Freq	%	Freq	%
Central	Kampala	24	48.0	.00	.00	24	48.0
	Luwero	2	4.0	4	8.0	6	12
Eastern	Jinja	1	2.0	2	4.0	3	6.0
	Palisa	0	0.0	4	8.0	4	8.0
Northern	Lira	1	2.0	2	4.0	3	6.0
	Nebbi	0	0.0	4	8.0	4	8.0
Western	Mbarara	2	4.0	0	0.0	2	4.0
	Ntungamo	2	4.0	2	4.0	4	8.0
	Total	32	64.0	18	36.0	50	100.0

From Table 3.5, the largest proportion of key informants (48%) was selected from Kampala district. This was because the offices of these respondents were mostly located in this district. They were therefore more easily accessible in this district. However, for purposes of collecting representative data, at least one key informant was selected from the rest of the remaining seven districts. Those selected were distributed according to the departments for which they worked as summarised in Figure 3.3

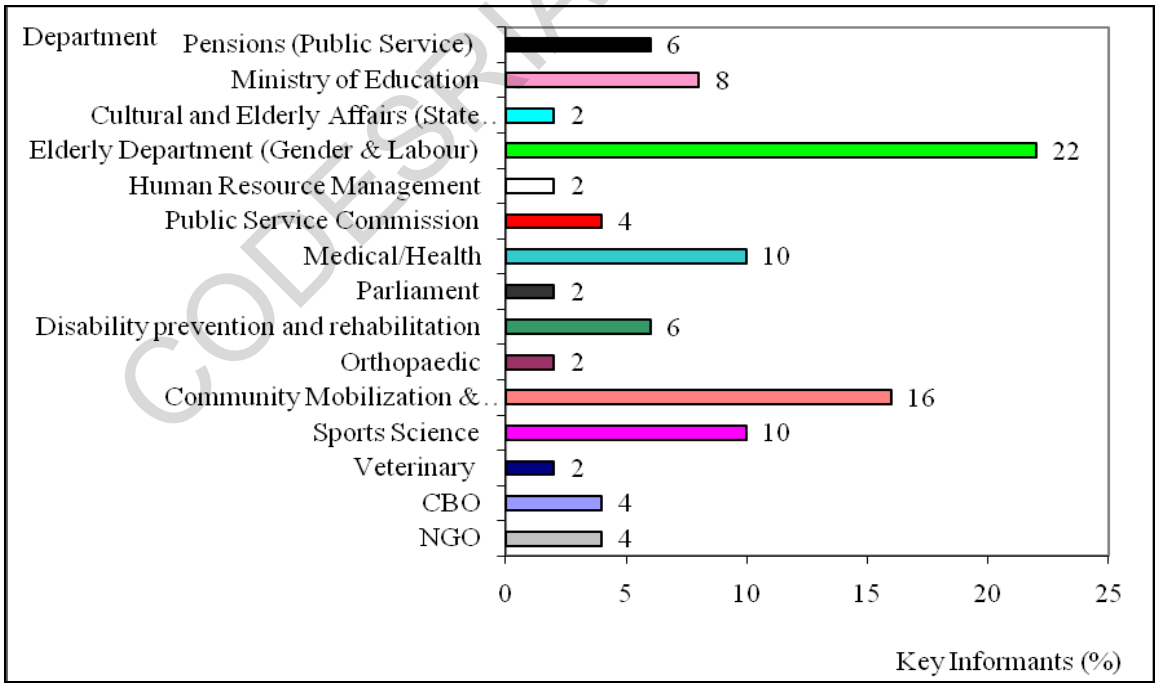


Figure 3.3: Key Informants by Departments (N = 50)

Figure 3.3 summarises the various departments from which key respondents were selected. It indicates that the key informants were selected from most of Uganda's departments that deal with the older persons in one way or the other. This implies that the selected key respondents were in a position to provide the data needed about the older persons in Uganda. in fact, most of these respondents (22%) were selected from the department of older persons in the Ministry of Gender, Labour and Social Development and from social workers (16%) dealing with community mobilisation and development.

Regarding the positions held in the departments from which they were selected, the key informants were distributed as indicated in Figure 3.4

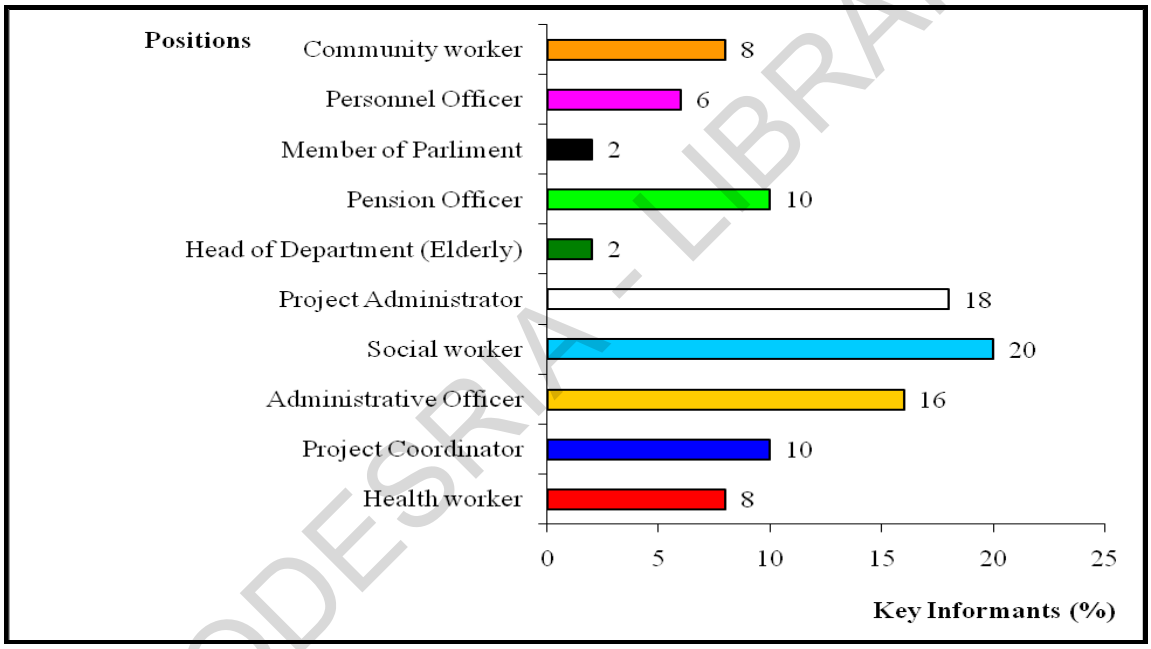


Figure 3.4 Key Informants by Position Held in Department

Figure 3.4 indicates that most of the key informants worked as social workers (20%), project administrators (18%), and administrative officers (16%). Others were pension officers (10%) and project coordinators (10%). In addition, two members of parliament (the former minister and current minister for disability and the older persons) who were directly concerned with issues of the older persons were included in the study. This suggests that most of the key informants targeted to provide data about policy issues addressed in the study were selected. Therefore, data obtained from them was largely

informative of what needs to be done in order to have policies that address the plight of the older persons in Uganda. The selected key informants were further distributed according to gender as shown in Figure 3.5.

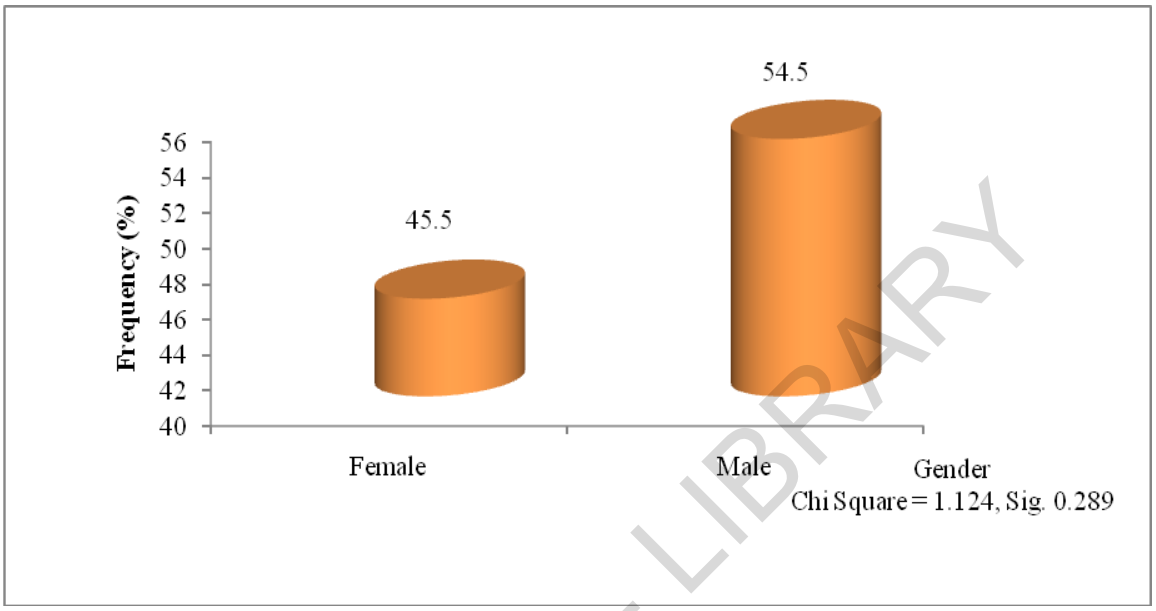


Figure 3.5 Key Informants by Gender (N = 50)

Figure 3.5 indicates that although the male key informants (54%) were proportionally more than their female counterparts, there was no significant difference between the two groups (Chi square = 1.124, Sig. = 0.289). As such, the data obtained from these respondents did not significantly differ as a result of their gender.

3.7 Data collection methods and instruments

Qualitative data were collected using interviews and focus group discussions. These were guided by use of an interview schedule and focus group interview guide designed according to the objectives of the study. Quantitative data were collected using a self administered structured questionnaire also designed according to the objectives of the study. Document review of polices relevant to the study was also carried out. As to how each of these methods and instruments was used is explained further in the subsequent sections.

3.7.1 Qualitative data collection methods and instruments

The following were the methods and instruments used to collect qualitative data.

a) Interview (face-to-face individual)

This method was used to gather primary data in forms of detailed views and opinions on the living experiences, needs, problems and barriers faced by elderly people in Uganda. Due to its flexibility as pointed out by Rubin and Rubin (2005), this method helped collect more complete data about each of these variables because it allowed the selected older persons to express themselves in their own language. As Sekaran (2001) observed, such flexibility also permitted rephrasing, translating or interpreting the questions to the older persons who could not understand English because of illiteracy (see Table 3.4). Translation was carried out using professional translators hired from Makerere Institute of Languages, depending on the dialect used in a particular region. It is important to note that during translation, interpretation and paraphrasing of questions, care was taken not to influence the respondents' answers. The interview method also helped the researcher to conduct immediate follow-ups and clarifications.

All the interviews held with the individual older persons were aided by an interview guide. This guide was used because according to Sekaran (2001), it ensures not only that the interview is progressing systematically according to the main themes of the study; but also that the researcher covers all the questions needed to exhaust all issues on which data is needed. The administered interview guide appears in Appendix A. It contained questions under the main headings as summarised in Figure 3.6. The themes included socio-demographic information, health care issues, economic, housing, water and sanitation, leisure and recreation and organisations for the aged. There was a range of about five to ten questions per theme.

Accordingly, administering the interviews was quite involving. In fact, some of the older persons even refused to continue with the interview after answering the preliminary questions. They became uncomfortable to share their personal experiences. This was particularly the case with older persons who were infected with HIV/AIDS. They felt it was shameful to reveal that they suffered from this disease at their age. However, effort

was made to counsel and comfort them and this produced positive results as some of them changed their minds and continued with the interviews.

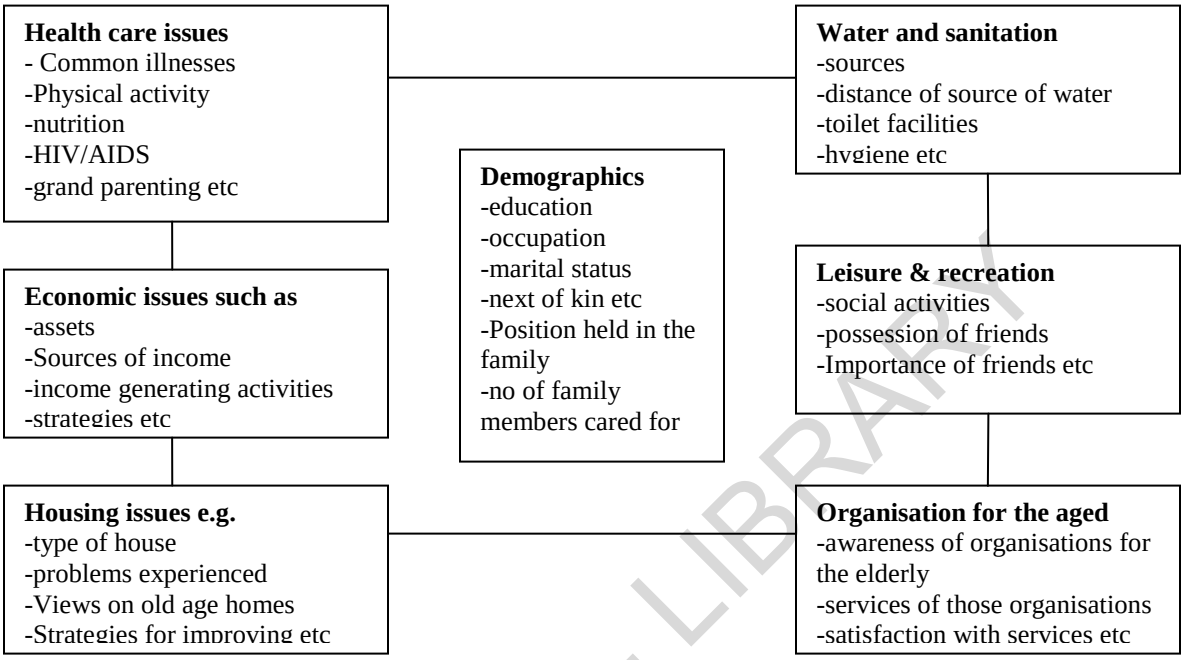


Figure: 3.6: Themes covered in the older people's interview guide

b) Focus group discussions

Focus group discussions were used as a second qualitative data collection method. They were used to get a general in-depth understanding of the variables of the study. Four focus group discussions were organized and each involved eight respondents. The number of eight respondents was determined following a scholarly observation that a focus group discussion can involve six to twelve people, (Krueger & Casey, 2000; Kitzinger, 1994; Marshall & Rossman, 1994). Although organizing each session was quite involving, the discussions helped save time because they facilitated data collection from eight older persons at once. As Marshall and Rossman (1994) observed, they also eased data collection because they permitted free interaction that allowed free exchange and building on each other's ideas and comments, thereby providing an in-depth insight regarding the variables of the study.

The discussions were held with the aid of a focus group interview guide which consisted of nine questions designed according to the themes derived from the objectives of the study. A copy of this guide appears in Appendix B. The themes included the main problems experienced by older persons in terms of health, economic, psychological, and nutrition; possible solutions to the previous problems; accessibility to resources; factors for lack of participation in developmental activities, effect of HIV/AIDS to the community; challenges in parenting; and strategies for improvement. This guide helped to conduct the discussions in a systematic manner as it allowed asking the questions following the themes of the study.

3.7.2 Quantitative data collection method and instrument

Quantitative data were collected by administering a self administered semi-structured questionnaire to the selected key informants. This questionnaire was designed according to the main objectives of the study. It was divided into two sections. Section A consisted of socio-demographic characteristics that were considered relevant to the study while section B was about problems, care and support for the older persons, as well as policy matters regarding the living conditions of the older persons in Uganda.

A questionnaire was used because all the key informants were literate, given the positions they occupied in their respective departments and organisations. They were in a position to read the questions and write their responses accordingly. The open-ended items were included because according to Meyer (2003) and Bless and Higson-Smith (1995), they give respondents (key informants in this case) freedom to divulge some not-easy-to-predetermine data in details. Some of the questions were selected from a validated structured self-administered questionnaire that was used by Baryayebwa and Barugahare (2002) in Kamuli and Wakiso districts to assess the health needs of older persons. Others were adapted from another validated questionnaire cited in Ngatia et al. (2003), having been used by Help Age International in a baseline survey in Kenya on the situation of the older persons. The questions were however, modified to suit the context of this study. A copy of the administered questionnaire appears in Appendix C.

3.8 Reliability and validity in quantitative research

3.8.1 Validity

There are various methods that can be used to establish the validity of a research instrument (Mason, 1996; Carmines & Zeller, 1979) but the method used in this study was the content validity method as described by Nunnally (1978). This method involved asking graduate student colleagues in the physiotherapy and social science departments to critique each item in the designed research instruments. Based on the generated critique, the items were revised and improved. After making the recommended adjustments, a thorough content validity test was conducted. The process involved item analysis and assessment, which was carried out with the help of a PhD colleague who was knowledgeable about the themes of the study, and the supervisor. These two persons critically examined each item in the questionnaire by establishing whether or not it was measuring what it was expected to. They carried out item evaluation by rating each as either relevant (R) or irrelevant (IR) to the study. From their rating, a Content Validity Index (CVI) was computed using the formula adopted from Amin (2005). The computed CVI was 0.868 and was greater than 0.7 (Appendix D). This meant that most of the items in the questionnaire were valid. The invalid items were eliminated from the questionnaire before administering it to the selected key informants.

3.8.2 Reliability

The reliability of the questionnaire designed to collect quantitative data was established using Cronbach's Alpha coefficient method of internal consistency as explained by Kothari (2005). Ten questionnaires were administered to ten key informants in the pilot study and used to establish this reliability. The Alpha coefficient computed using the SPSS programme was 0.875. This coefficient was greater than 0.7, which implies that the questionnaire was highly reliable and therefore ready for data collection.

3. 9 Reliability and validity in qualitative research

The reliability and validity of the designed interview guide and focus group discussion guide were established by investigating the dependability, credibility, transferability and confirmability of the data obtained using each tool. This exercise was carried out

following the rationale of the observations made by a number of scholars (Babbie & Mouton, 2001; Silverman, 2001; Lincoln & Guba, 1985; Denzin & Lincoln, 1994). In particular, the credibility of these instruments was established using the critique of colleagues and the supervisor to improve integrity of the items administered to the selected older persons. Transferability was ensured by describing the collected data within the perspective of the research setting, participants and contextual factors. Dependability was guaranteed by putting emphasis on accurate reporting of the findings generated from the interviews and focus group discussions. Confirmability was ensured by validating responses obtained from one respondents with those obtained from another respondent selected from the same setting.

Finally in addition to the above four constructs that were observed, reflexivity was also observed by the researcher's acknowledging her role and influence on the research project, and minimizing it by avoiding to interpret the data according to her philosophical assumptions, values or ideology but rather as it was.

3.10 Pilot study

A pilot study is conducted prior to the main study for purposes of determining whether the methodology, sampling, instruments and analysis are adequate and appropriate (Bless & Higson-Smith, 2000). As pointed out earlier, a pilot study was carried out prior to commencing the main study. The pilot study involved administering the designed instruments to ten people (who were in a position to qualify as key informants but who were not included in the sample of the study). The purpose of the pilot study was to determine the clarity of the questions and the instructions of the research instruments, to try the research procedure and to test if the instruments could yield the needed data. The pilot study was also conducted to test the workability of the research design in the field setting and also to identify design problems and weaknesses so as to rectify them through applying necessary corrective measures before the main study. Thereafter, items in each instrument were reviewed and adjusted in accordance with the insights got from the pilot study. The necessary adjustments were made in form of removing some items that had been discovered as irrelevant and adding others that had been omitted. For instance, the

questions concerning 'parenting' and 'nutritional' issues in the older persons came as a result of suggestions from some participants who participated in the pilot study. Following discussions with the supervisor about the same, it was agreed that these important questions that had been suggested be added.

3.11 Data collection process

The process of data collection was done in three phases. The first phase involved collection of qualitative data; the second phase was collection of quantitative data and the third phase was carrying out a critical review of a range of relevant documents. In a broad view, the data collection process involved a series of activities aimed at collecting good information to answer the research questions (Creswell, 1998:110). The series of activities included; locating sites/individuals; gaining access and making rapport; purposeful sampling; and actual data collection; recording information; resolving field issues and storing data.

a) Procedure for collecting qualitative data

The first phase of the study commenced by seeking permission from the University of the Western Cape Higher Degrees Committee and then from the Uganda National Research Council of Science and Technology. Furthermore, ethical clearance was obtained from the Senate Research Grant and Study Leave Committee in the University of the Western Cape. An introductory letter was then secured from the Uganda National Research Council of Science and Technology. A copy of this letter appears in Appendix G. It was obtained for purposes of aiding the principal researcher's self-introduction to the study district head officials, community leaders and selected older persons and key informants.

Other permissions were sought from the various authorities in the ministries (Appendix H) and districts (Appendix I) where data was collected. In addition, permission was also sought from administrators in the ministries in order to have access to records and documents.

This was followed by locating the study sites. The process preceded by gaining access to those study sites prior to collecting data. During this process frequent field visits were made by the researcher herself in order to start establishing rapport with the participants prior to the main study. The participants were accessed by direct personal contact with the help of gatekeepers. The gate keepers included people like community leaders and project coordinators among others because they are the ones who knew the older people in the communities. The older persons were then purposively chosen according to their willingness to participate, experience with and knowledge about the phenomenon. Finally an explanation regarding the purpose of the study was provided and a consent form was given to each participant to fill in first as a way of accepting to participate in the study. This was followed by further arrangements for when the interviews would be conducted. The appointments were made according to the participants' convenient day, time and place for when to conduct the individual interviews. However, most interviews were carried out at the respondents' homes as that is what was preferred.

During the days of carrying out interviews with the respective selected respondents, the initial process involved assuring them that their responses were to be treated confidentially and that they were free to withdraw from the study at any time if they so wished (subject information sheet, Appendix G). Finally the permission for using a tape recorder during the process of interview was obtained from each respondent initially as a way of observing ethical principles of research.

On average about three to five in-depth interviews were conducted each day. Each interview session was conducted in a highly informal, conversational and face-to-face style at the respondent's home. The researcher would first ask the older person whether to use English or the local language. If the older person agreed to be interviewed in English, the researcher would immediately begin by asking the prepared questions in a systematic, humane and prudent manner. Care was taken not to ask the questions in an embarrassing or humiliating manner and probing was done where need arose. The interview began by asking about the socio-demographic characteristics of the older persons and progressed on to the main themes of the study. Given the large number of questions that were asked,

each individual interview was punctuated with short breaks to allow recuperation over a drink. Otherwise each interview process lasted for one and half hours.

Whenever a question was asked, the response from the older person was recorded using the shorthand writing style. This ensured that the detailed views, opinions, perceptions and suggestions about the living experiences, problems, needs and concerns of every older person respondent were hand and tape recorded. For some respondents who did not properly understand the questions at once, attempts were made to rephrase the questions in order to make them comprehensible to them.

If the selected older person was not in a position to answer the questions in English, the principal researcher would switch to the local language. This meant translating the questions in the local language of the older person. In case the principal researcher was not in a position to translate the questions in the local language of the older persons like areas in the north and west (Lira and Nebbi; Mbarara and Ntungamo), efforts were made to hire a trained research assistant to help out. However in such circumstances the interviews were conducted in the presence of the researcher to ensure that the right procedure was followed. In addition, where the principal researcher was incapable of accessing the older respondents, attempts were made to identify a research assistant who would help out. These were first trained so as to ensure accuracy in the procedure of data collection.

Regarding the procedure of movement in the collection of qualitative data, the researcher first began collecting data from Kampala district in the earlier named divisions, then moved on to Jinja district in the named sub-counties, then to Pallisa district, to Mbarara district and then to Ntungamo and finally collected from the northern part of the country in Lira and Nebbi districts. The whole process lasted for six months.

Accordingly during the process of data collection, observations were made to supplement on the data from the interviews and a review of the qualitative data was continuously done in order to identify areas of clarification or further probing. Therefore this helped to

collect data to the point of data saturation. At the same time data were continuously summarised, and the validity of the contents confirmed with the respondents periodically. In addition, the use of a tape recorder also helped in recording all the interviews besides note taking. Therefore, all the amount of data that was necessary to answer the research questions in a credible and scientific way was collected.

b) Focus group discussion

Following individual interviews, focus group discussions where conducted with the older persons who were considered more resourceful to the study in order to get a general picture of the living experiences as mentioned earlier.

One focus group discussion consisting of eight respondents in each group was conducted in each region of Uganda, implying that four such discussions were held. Of these, two were held with the older persons selected from urban settings and the other two were carried out with the older persons selected from rural settings. The two came as a result of isolating the women from men so as to be able to capture issues in relation to gender differences. The interviews were held in convenient places at the community leaders' offices or in cool quiet places under trees in cases were a room was not available. The duration of sessions lasted between one and a half to two hours.

The themes that were discussed included; main problems affecting older persons; how these problems are dealt with at the community level; problems experienced with accessibility to resources and services; factors that have led to their lack of participation in developmental activities; effect of HIV/AIDS pandemic to older persons; the role of parenting by older persons and its challenges; possible strategies that could help improve the older people's livelihoods and who should be the implementers of the proposed strategies.

During interviewing process, the participants' responses were recorded and audio-taped on permission and transcribed in verbatim by an independent person with experience in transcription. This was done after seeking for their consent to do so. The discussions

began with simple introductions and then talking about the general issues of ageing. Following creation of rapport, then the detailed discussions relating to the themes of the study proceeded with the guidance of an interview guide. The interviews were highly interactive and stimulative. 'Probes' and 'paraphrasing' techniques were made use of for purposes of having detailed data. At the end of the discussions debriefing sessions were held immediately and notes were compared and discussed for accuracy during these sessions. In this way all the data needed to accomplish the qualitative part of the study was collected from the older persons. However even after this phase, the data collection was still ongoing because whenever there were issues to be clarified in the field the researcher would go back for clarifications.

c) Procedure for collection of quantitative data

After collection of qualitative data, the second phase of quantitative data collection proceeded by collecting data from 50 key informants using a self administered structured questionnaire.

Permissions to collect data from key informants in the different ministries and organisations were sought beforehand. Appointments to meet these people to carry out the research were made during the process of seeking permission. The questionnaires were then administered to key informants by the researcher and a trained research assistant on the days of the appointment that had been made earlier with each one of them. During the process of administering the questionnaires, some of the key informants who could not fill in at that particular time asked for time to be able to fill in the questionnaires properly latter. This was allowed but they were requested to spend at most two days with the instruments.

In the case were the questionnaires were administered by the trained research assistant, a copy of the principal researcher's introductory letter was appended (together with a letter written by the principal researcher introducing the research assistants to the respondents) to each questionnaire to ease the research assistants' self-introduction process to the key informants. The research assistant was encouraged to convince

respondents to use at most two days to fill in the questionnaires. The questionnaires were then collected from the key informants, organised, cleaned and prepared for analysis.

This intensive and systematic data collection process began in April 2008 and ended in December of the same year.

d) Procedure for Documentary Review

The third phase of the data collection was document review. It was done after collection of quantitative data. The process began by seeking permission from the different ministries and archives in order to have access to the documents (appendix J). The documents were then searched, collected, sorted, grouped according to themes and filed in preparation for review and analysis. Wide selections of programme and policy documents and various articles were reviewed to establish the extent to which the issues and rights of the older persons were addressed in Uganda's development policies. During this review articles or policies were read and re-read in order to be able to articulate what the documents were all about. As the review process was ongoing, gaps were identified where older persons could fit and yet were not included in such policies. And those that had addressed issues of older persons were also noted.

This was done through identifying who the stakeholders were in those documents, the objectives of the programmes, the policy formulation process that is if it was consultative, research based or for political reasons/interests. The vision of the policy, the outcomes and challenges, funding and monitoring and evaluation were also among the things considered in the review. Regarding articles, the review involved quoting the articles that are relevant to the study and identifying gaps were older people could fit in. Finally comparisons were made with other related policies elsewhere to make out the differences and similarities.

Some of the relevant policy documents reviewed included the 1995 Constitution of Uganda; the Local Government Act; HIV/AIDS and Antiretroviral therapy policies; Poverty Eradication Action Plan policy; Home Based Care policy, the Nutrition Policy; the NAADS Policy; Plan for Modernisation of Agriculture; the Pensions Act; the

Housing and Planning Act; and the National Social Security Fund (NSSF) Policy among others.

Marshall and Rossman (1995) point out that document review is one of the methods of data collection in qualitative research. Wazakili (2007: 87) adds that "the review of documents [can be] is an obtrusive method [that is] rich in portraying the values and beliefs of participants in the setting because researchers gather and analyse documents produced in the course of every day events". However the documents can include policies, minutes of meetings, records, logs, and letters among others which may be useful in helping to develop an understanding of a phenomenon or a group under study. Archival data may also be used to supplement such qualitative methods.

Additionally, the strength of document reviews is that many documents are easily accessible; they are free and contain information that would take an investigator enormous time and effort to gather otherwise. Documents are also a good source of data as they are often used when it is hoped that they will yield better or more data (Merriam, 1998). The researcher determines where the greatest emphasis lies after the data have been gathered (Marshall & Rossman, 1995). However, their limitation is that most documents are not produced for research purposes; therefore, the information they present may not be in a form that is useful or understandable to the investigator (Bailey, 1994). Furthermore, such data may not even fit in the present context or definitions of the concepts under inquiry (Merriam, 1998). Besides the method of analysis of documents relates only to the content and does not relate to the process by which the document was produced. Thus with all this in mind the researcher carried out the document review with conscientiousness and only recent and relevant documents closely related to the research topic were reviewed.

3.12 Data Processing and Analysis

This section provides the procedure for data analysis of the qualitative, quantitative and the reviewed data.

a) Analysis of qualitative data

Analysis is the breaking up, sorting or disassembling of research materials into pieces, parts or units (Seidel, 1998). This ends up with facts broken down into manageable pieces of information materials (Jorgensen, 1989). According to Jorgensen , in qualitative research, the researcher sorts, and filters the material, searching for types, classes, sequences, processes, patterns, or wholes. The aim of this process therefore is to assemble or reconstruct the data in a meaningful or comprehensive style (Jorgensen, 1989). Seidel (1998) compares qualitative data analysis to a simple process that involves noticing, collecting and thinking processes. According to Seidel this process is not a linear one. It does not simply involve noticing, collecting and then thinking, and then writing a report. According to the author the process has the following characteristics as well:

- **Iterative and progressive:** The process is iterative and progressive because it is a cycle that keeps repeating. For example when you are thinking about things you also start noticing new things in the data. You then collect and think about these new things. In principle the process is an infinite spiral similar to what is explained by Creswell (1998).
- **Recursive:** The process is recursive because one part can call you back to a previous part. For instance while you are busy collecting things you might simultaneously start noting new things to collect.
- **Holographic:** The process is holographic in that each step in the process contains the entire process. For example when you first notice things you are already mentally collecting and thinking about those things (Seidel, 1998: 2).

This scenario is similar to the experience the researchers underwent during data processing and analysis in this study. Qualitative analysis was applied to data obtained in form of interviews, focus group or open-ended questionnaire-responses. The process involved iterative, progressive, recursive and holographic processes as explained above. Content and thematic approach was particularly applied according to the context of the study. Where data had been collected in local dialects; professional translators were hired

from Makerere Institute of Languages to help translate it into English. This was done to ensure that there was accuracy in translation so as not to loose meaning.

The analysis involved reading the written scripts, one by one, and in a repeated manner so as to develop meaning out of them. There was also repeated listening and re-listening to recorded audiotapes, so as to make comparisons while reflecting on the data and making notes and memos. This was followed by grouping of the themes into broader categories in order to develop fewer categories that were manageable. This was done by combining related themes and renaming them as one theme. The interpretative technique was particularly used to develop the categories. The developed thematic categories were then re-categorised according to the relevant variables of the study. Sub-themes were also developed under each of the major themes.

The major themes (high level categories) on the living experiences of the older persons included: socio-economic issues, health, accessibility to health services, housing and accommodation, water and sanitation among others. Information under each theme was then coded into different smaller categories or sub-themes (lower level categories) for instance pension, economic activities, education, occupation were categorized under a major theme of: "Socio-economic issues" This was followed by identification of overlapping codes which were placed into segments where they fitted while the un-coded text that was not relevant to the research objectives was left out. In addition, field notes were used to corroborate themes and to assist in the interpretation of findings, and where possible thick descriptions using actual words of the respondents were used for verification.

The process was repeated continuously to make necessary refinements of categorising the themes, searching for subtopics and selection of appropriate quotes that convey the real meaning of the categories. It is vital to note that some of these interview and focus group responses or quotes obtained from the older persons were incorporated verbatim in the text of the study with minor editing, where need arose. They were incorporated according

to the different categories of themes in order to avoid losing the original meaning of the participants' ideas.

When the analysis process was finalised, an independent researcher was used to re-read through the transcripts to generate sub themes again in order to enhance the validity and reliability of the categorized findings. The developed thematic categories were then compared to identify what the researcher might have left out during the first analysis. When the analysis of independent researcher was scrutinized, it was discovered that there were no new sub themes identified. This confirmed that the first analysis was adequately exhaustive. Further checking of the analysed findings was carried out involving asking colleagues who were experts of qualitative research to read through the draft and make critical contributions. The draft was finally submitted to the supervisors who made further improvements in the results. Thereafter, the final report was written. During the reporting of the results in the final report, names of the respondents were left out in order to comply with the ethical principles of anonymity and confidentiality.

It is important to note that the writing of the final report involved careful triangulation of the qualitative and quantitative findings following the objectives of the study. The triangulated quantitative data was analysed as explained in the next section.

b) Analysis of quantitative data

Quantitative data was captured on a spreadsheet using the Word Excel programme in preparation for analysis. It was then imported to the Statistical Package for the Social Sciences (SPSS) version 12. Quantitative techniques used to analyse the quantitative data included the Excel technique and the frequency techniques of the descriptive method of the SPSS soft ware. Coding was a very important pre-requisite to the use of these techniques because the SPSS programme accepts data entered using mainly numerical values called codes. Coding was thus used to transform the close-ended responses and some of the themes developed during qualitative analysis into numerical values.

After data entry, data editing followed after which data analysis commenced using the techniques outlined above. Specifically, the frequency option of the descriptive method

of SPSS was used to generate tabulated and standardised frequency distributions from data obtained from key informants. For purposes of improving the quality of data presentation, other descriptively generated results were transferred to the Excel computer programme, which transformed them into graphs and pie charts. The differences in counts were tested for significance using Chi-square test as recommended by Pretorius (1995). Alpha level was set at $p<0.05$. All the results obtained from the analysis are presented in the next chapters and the chapters are presented according to the objectives of the study.

c) Document Analysis

Qualitative type of analysis (using review of textual content) was applied to the government legal and policy documents that were identified as relevant to the issues affecting older persons in Uganda. The process of analysis began by identifying the appropriate policy documents and other legal instruments that were closely related to the research; this was followed by a careful and critical review of each identified document with the intent to establish whether the issues of the older people were addressed and to what extent their needs and problems were addressed by these documents.

This review process involved first reading through the preamble of the documents to identify the vision and mission, the objectives of the instruments and the target group of the instrument. This was followed by critically reading and re-reading through each section by section of the entire document to critically identify gaps in these instruments or policies where the older persons could have fitted in. Findings about the policy outcomes, challenges, how the policies clearly addressed problems; the current trends and opinions in this area of study were noted and recorded. In addition records were made on whether such policies were based on evidence during there formulation process or not and how the formulation process was done. The funding sources were identified including challenges in the running of the programs. The monitoring and evaluation process and procedures of these programmes were also recorded. Other things that were noted were comments made on the policies by other people or researchers. And finally comparisons with other policies elsewhere were done in order to identify the similarities and differences. The details of the findings are presented in chapter seven.

The analysed documents included the Constitution of the Republic of Uganda (1995), Health policy, HIV/AIDS and Antiretroviral Therapy policies, Poverty Eradication Action Plan (PEAP), SDIP and other relevant policies and legal instruments.

The objectivity of the analysis of documents was enhanced through ensuring that the coding was done according to the explicit set of exclusion and inclusion criteria that had been set. For instance only recent documents that met the selection criteria were reviewed and analysed like the current policies that are being used by the government and private sector. These were accessed from libraries of the line ministries after seeking permission from the relevant authorities.

3.13 Ethical Considerations

"In every research process ethical issues and considerations must be made, addressed and adhered to" (Opolot-Okurut, 2004). According to Strydom (2001), ethics is

> A set of widely accepted moral principles that offer rules for, and behavioural expectations of, the most correct conduct towards… respondents…researchers, assistants (Strydom, 2001:75).

A number of authors have discussed ethical issues and considerations in literature (Bless & Higson-Smith, 2000; Strydom 2001; Mason 1996). There are similarities in all what these authors mention about ethical issues. According to Mason (1996) the usually discussed ethical issues include; the rights to privacy and voluntary participation; anonymity and confidentiality; high quality practice; and the responsibility to produce good quality research. On the other hand, according to Strydom (2001) while some authors mostly discuss similar things on ethical issues, some authors discuss different classifications of ethical issues. Some authors generally categorise and discuss only few issues, while others do in detail the analysis of some issues. Therefore the discussions of ethical issues semantically vary and depend on the degrees of emphasis that the different researchers become accustomed (Opolot-Okurut, 2004).

For instance, contrasting between what Bless and Higson-Smith (2000) bring up and what is raised by Strydom (2001), the significant issues discussed relate to paying due attention to care against harm to respondents or subjects, obtaining informed consent, taking care against deception of respondents or subjects, avoiding the violation of privacy or anonymity or confidentiality, taking care about the actions and competence of the researcher, cooperation with contributors, release or publication of the findings, and debriefing of the subjects or respondents. Decisively one could articulate that ethical principles form the researcher's constitutional working document consisting of the laws that guide, protect and inform the researcher and others in implementing the research plan (Opolot-Okurut, 2004).

Thus, in this study, ethical considerations of access, informed consent, attention to anonymity, confidentiality and debriefing were observed as explained henceforth:
Permission was first sought from the University of the Western Cape Higher Degrees Committee and ethical clearance was obtained from the Senate Research Grant and Study Leave Committee of the same university. Further permission was sought from the Uganda National Council of Science and Technology to allow the researcher carry out the study in Uganda. An introductory letter was secured from the Uganda National Research Council of Science and Technology to permit the researcher to access the study districts. A copy of this letter appears in Appendix G. Finally written consent was obtained from the respondents prior to carrying out the research and for tape recording (Appendix F).

Confidentiality was observed by safely keeping the information that was obtained from the respondents away from people who were not part of the study until the information was used to write a research report. No identification names were used for purposes of observing anonymity of the respondents.

The respondents were also told that participation was voluntary and that they were free to withdraw from the study at any time if they so wished. The researcher also guaranteed support counselling for any of the participants who could have been negatively impacted

by the research especially concerning HIV/AIDS issues. To ensure this, social workers from nearby clinics were consulted (see Appendix K) for assistance in case of any emergencies prior to the study; fortunately none of the respondents was affected during the study process.

The respondents were assured that the study data are only being used for research purposes. No unauthorised persons will have access to the data and there is no intention to have the data known or revealed to any person who is not part of the study for purposes of conforming to confidentiality of the information.

The respondents were assured that no names will appear in the final report for purses of ensuring anonymity of the respondents.

Debriefing was done at the end of the qualitative data collection and the rest of the research process.

Finally the results of the study have been disseminated to those respondents who were interested in knowing what came out of the research and part of the findings have been published in a peer reviewed Journal of Community Health and Sciences in form of research articles, and the findings have also been presented at two International Scientific Conferences of the World Configuration of Physical Therapists- Africa in Ghana and Kenya and at national level at three consultative meetings of policy makers and stakeholders during the formulation of the older persons policy.

3.14 Conclusions

This chapter presented an outline of the methodology used in the current study. The research setting, sampling technique, methods of data collection and analysis followed in the qualitative and quantitative data were described. Lastly the chapter concluded with an outline of ethical issues. The results of the study are presented in the subsequent chapters.

CHAPTER FOUR

LIVING EXPERIENCES OF UGANDA'S OLDER PERSONS AND THEIR BARRIERS TO EFFECTIVE PARTICIPATION IN SOCIETY

4.0 Overview

The first objective of the study was to explore the living experiences of the older persons both in the rural and urban settings in Uganda. The second objective was to identify the barriers to effective participation of these persons in society. In other words, while the first objective focused on finding out the conditions of life that older persons in Uganda lived, the second objective centred to specifying the barriers hindering these persons from living a life that they have wanted to live. The purpose of this chapter is to present, interpret and discuss the findings obtained in response to these two objectives. The chapter is organized using the following perspectives: economic, social, health, housing, and water and sanitation perspectives. For each perspective, findings on barriers are presented after explaining the lived experiences. The findings are presented in a triangulated manner following the fact that they were obtained from interviews and focus group discussions held with older persons as well as questionnaires administered to the key informants.

4.1 Economic Perspective of the Living Experiences of the Older Persons

In this perspective, focus was on establishing the economic means used by the older persons in the rural and urban settings of Uganda to sustain their livelihoods. The specific forms of the means explored included: an older person's education level, main occupation, other income-generating activities or roles, wealth (mental and physical assets), pension status, and economic support or care and marital status. The latter two forms were intended to establish whether older persons had breadwinners, caretakers, assistance providers, and if they did, who the Samaritans were. Also explored were the barriers to the economic capacity of these people.

Education was considered because it is widely believed that the more education a person attains the more likely it is for him/her to maintain his/her livelihood. To establish the level of education of the older persons, they were first asked whether they had ever

attended any school or not. Those who had attended school were further asked about their highest level of education attained. Qualitative analysis of the responses led to findings summarised in the Matrix 1.

Matrix 1: Selected Older Persons by School Attendance and Level of Education attained

Question	Responses	Setting	Older Persons by Gender and Regions in Uganda							
			Central		East		West		North	
			Male	Female	Male	Female	Male	Female	Male	Female
Ever attended school?	Yes	Rural	1	3	2	2	3	1	3	1
		Urban	6	3	5	3	8	3	3	1
	No	Rural	1	11	4	7	3	10	6	15
		Urban	5	15	9	4	7	5	5	6
Level of Education attained by those who attended school	Primary	Urban	1	2	3	3	5	2	2	1
		Rural	1	3	1	None	None	None	None	None
	Post-primary	Urban	1	1	1	2	2	2	2	1
		Rural	1	1	None	None	None	None	None	None
	Secondary	Urban	1	None	1	None	2	None	1	None
		Rural	None	None	None	None	None	None	None	None
	Post secondary	Urban	1	None	1	None	1	None	None	None
		Rural	None	None	None	None	None	None	None	None
	University	Urban	1	None	None	None	1	None	1	None
		Rural	None	None	None	None	None	None	None	None

In total, Matrix 1 indicates 63 out of 165 interviewed older persons answered in affirmative across all regions of Uganda. This implies that older persons who attended school constituted a relatively small proportion of the sample, and by extension, of Uganda's population. The matrix shows further that the few older persons who had attended school consisted of very few female older persons in the central and western regions, and very, very few female older persons in the eastern and northern regions of Uganda. This is also reflected by the fact that in all the regions, older persons who had not attended school consisted of relatively more males and much more females; moreover, this distribution did not differ much across the urban and rural settings of Uganda. Matrix 1 shows further that many of the older persons who had attended school attained primary education; and these were mostly males in urban settings of the central and western regions of Uganda. The matrix indicates further that older persons became fewer as the level of education increased. They reduced so much that none of the female older persons reached secondary school and very few male older persons who, moreover were in urban settings, attained university education. Asked why most of them had not

gone to school, thematic analysis of their responses revealed the reasons summarised in flow Chart 1 below:

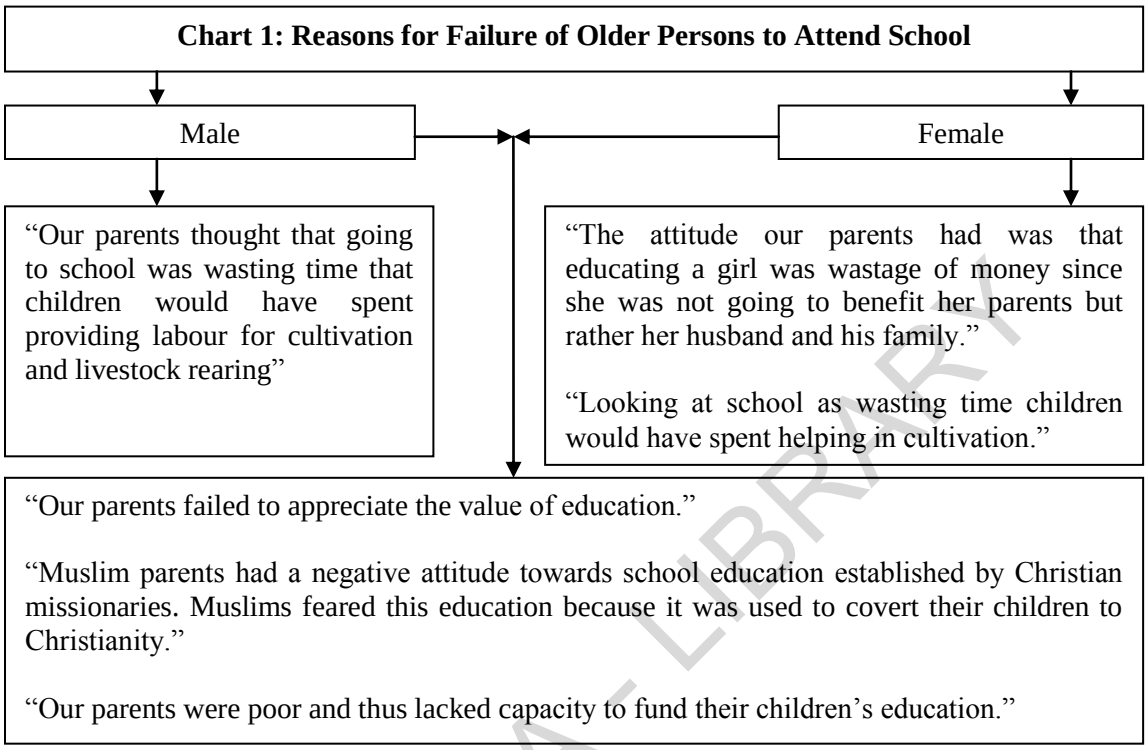


Chart 1 above shows that although some reasons why most of the older persons failed to attend school applied to females only and others to males only, there were those that applied to both sexes. Generally, the reasons suggest that many older persons failed to attend school not only because their parents held negative cultural and religious attitudes against formal education but also because the parents considered their children as a source of labour for subsistence production in addition to having a wrong perception that educating girls was like investing a project whose returns would not benefit them.

It is important to recall that among the few older persons who had attended school, the majority did not go beyond the primary level. Why this was the case, especially for the female older persons was candidly substantiated by one female older person as follows:

> During our school going-age time, the highest level a girl would attain was primary. The time when a girl completed primary school coincided with the time when her parents decided that she was woman enough to be sent off into marriage. For me I was lucky because my parents waited until I reached junior one, maybe because I delayed to

become a 'woman' and that I was very tiny by the time I completed primary (Female, 72 years, Nebbi district) .

In general, findings show that most of the older persons did not have formal education. The findings also show that among the few older persons who had attended school, majority most of who were females, did not go beyond the primary level of education. This implies that the level of education that the few older persons had attained was also not enough to translate into capacity which could enable most of them to join formal employment or do skilled work, thereby earning and living a good life in old age. It is not surprising that most of the older persons in Uganda live in daunting conditions, even when some of them had chance to attend school. In fact, lack or inadequate education contributes to the pathetic conditions lived by most of the older persons in Uganda. This was clearly revealed when older persons were interviewed about how failure to go to school had affected their livelihood. Thematic analysis of their interview responses revealed that some of them suffered with "Lack of qualifications needed to work in government" while others had to contend with "Failure to get into gainful employment." Other older persons witnessed "Constant struggling to get what to eat instead of enjoying retirement as those who had gone to school." Others faced the consequences of "Bringing up jobless children because of lack of capacity to educate them" while others could not raise "Enough resources to even build a good house and put in good accommodation facilities. Other older persons faced the problem of "Living in abject poverty characterized by large numbers of grandchildren accommodated in small, weak and leaking grass thatched and wattle huts without energy and money to repair them.

The effects outlined above cut across the different forms of sexes, settings and regions of Uganda. They basically show that failure to attend school denied older persons in Uganda skill acquisition and access to gainful employment opportunities out of which they would have earned, built good residences, educated their children and lived a comfortable life in old age. In fact, observation revealed that most of the older persons who had missed going to school lived in pathetic housing conditions characterised by grass thatched huts that looked so weak that it was as if they were at the verge of collapsing. It also observed that such housing conditions contrasted very sharply with the residential conditions lived by the older persons who had received education up to the post-secondary and university

levels. The housing conditions of these older persons were much better characterised by iron-roofed and brick-walled houses with well-planned and large compounds. In essence thus, findings suggest that failure to go to school is one of the factors that explain why many older persons in Uganda live in pessimism punctuated by undesirable housing conditions. The findings are thus in line with the observation made by Zappala (2003) and Human Rights Education Associates (2003) that the lower the level of education attained, the higher is the likelihood of an older person to live in sore conditions and vice-versa.

Apart from education, the occupation in which a person is engaged is considered to be one of the economic means that can enable him or her to live a comfortable life in old age. Based on this observation, effort was made to explore the occupations in which Uganda's older persons were engaged. This involved asking them about how they earned their living. Thematic analysis of the responses led to findings shown in Matrix 2.

Matrix 2: Selected Older Persons by their Earning Occupations

Occupations	Setting	Older Persons by Gender and Regions in Uganda							
		Central		East		West		North	
		Male	Female	Male	Female	Male	Female	Male	Female
Manual and pure subsistence cultivation	Rural	1	None	None	None	None	None	None	None
	Urban	None	None	1	1	None	None	None	None
Manual Cultivation, small livestock rearing	Urban	None	1	None	None	1	None	None	None
	Rural	1	None	None	None	None	1	None	None
Manual Cultivation, small, large livestock rearing	Urban	None	None	None	None	None	None	None	None
	Rural	None	None	None	None	1	None	None	None
Tailoring	Urban	None	1	None	None	None	None	None	None
	Rural	None	None	None	None	None	None	None	None
Shoe shining and repair	Urban	None	None	None	None	None	None	None	None
	Rural	1	None	None	None	None	None	None	None
Manual Cultivation Informal roadside selling	Urban	None	None	None	1	None	None	None	None
	Rural	None	1	None	None	None	1	None	None
Food vending	Urban	None	None	None	None	None	None	None	None
	Rural	None	None	None	None	None	None	None	None
Manual Cultivation, rearing and Traditional healing	Urban	None	1	None	None	None	None	None	None
	Rural	1	None	None	None	None	1	None	None
Manual Cultivation, Traditional birth attendance	Urban	1	None	None	None	None	None	None	None
	Rural	None	None	None	None	None	None	None	None
Butchery	Urban	1	None	None	None	None	None	None	None
	Rural	None	None	None	None	None	None	None	None
Real estate	Urban	1	None	None	None	None	None	None	None
	Rural	None	None	None	None	None	None	None	None
Cultivation and Teaching	Urban	1	None	1	None	None	None	None	None
	Rural	None	None	None	None	None	None	None	None
None	Urban	8	11	10	9	8	7	6	7
	Rural	16	10	9	10	13	8	8	5

Matrix 2 displays how selected older persons were distributed according to the occupations from which they earned a living. The bottom row of the matrix indicates that most (145) of the older persons, especially those in urban areas were not involved in any occupation. In addition, the two columns on the extreme right hand side of the matrix show that none of the older persons in northern Uganda was involved in any occupation. Not being involved in any earning activity implies that most of the older persons depended for their survival on the mercy of other people. This means that they were highly pessimistic about their livelihood and therefore lived a life of vulnerability. If no Samaritan came to their rescue by way of providing some means of livelihood, most of the older persons remained unsure of their living. The findings thus concur with the observations made by Bird and Shinyekwa (2005), Devereux et al. (2002), Najjumba-Mulindwa (2004), Ntale-Lwanga (2003) and Bagala (2007) that most of the older persons in African countries are exposed to pessimism and a high level of vulnerability.

Further probing revealed that most of the older persons in northern Uganda were rendered inactive by the Kony insurgence that had ravaged this region for over 20 years. The insurgence forced many people, including older persons, to abandon their land and all the income-generating projects, thereby settling in Internally Displaced Peoples' Camps (IDPs) where they were kept redundant. Other older persons were displaced to other regions of the country where they continued to be redundant because they had left all their assets behind. This displacement added to the already problematic situation that had been created by the 1980-1985 guerrilla war that took place in Luwero triangle. The guerrilla war had already forced many people, including older people to flee to other regions where they remained redundant because they, too, had left all their assets behind. This redundancy, however, has adverse affects on the concept of active ageing because it borders on inactivity, which, according to World Health Organisation (2006), is one of the ways that deteriorates older persons' health.

Although most of the older persons were inactive in respect of earning occupations, Matrix 2 indicates that there were a few who were engaged in various occupations. Of these few, the majority were involved in cultivation across all settings and regions of

Uganda. The exception was in the western region where many of the active older persons were involved in a combination of cultivation and small and large scale livestock rearing. Other occupations that older persons conducted in addition to cultivation included: informal roadside selling, food vending, traditional healing, traditional birth attendance, and teaching. Note that some older persons who were involved in tailoring, shoe shining and repair, butchery, and real estate were the only ones who did not combine their occupations with cultivation, the explanation being that all these older persons were in urban settings were there they had no land to cultivate. To understand more about the occupations that older persons carried out, they were asked about the animals that they reared and the crops that they cultivated. Qualitative analysis of their responses led to findings summarised in Chart 2.

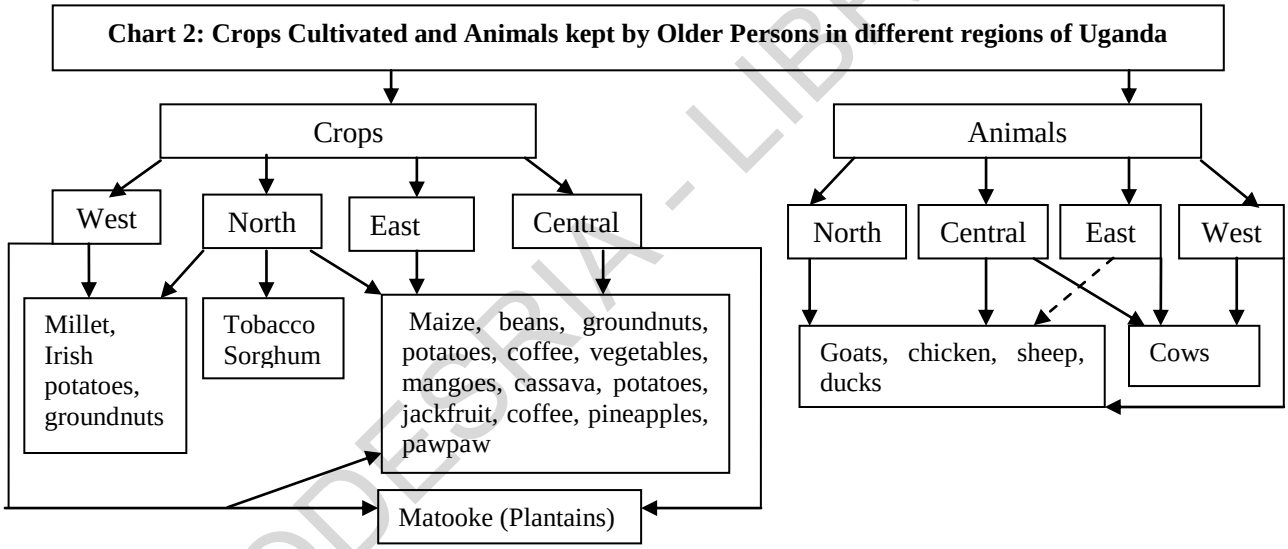


Chart 2 above shows various crops cultivated and animals kept by the few older persons who were engaged in cultivation and animal rearing in the different regions of Uganda. Following the arrows, the chart indicates that as far as crops were concerned, all older persons in all regions of Uganda cultivated maize, beans, groundnuts, potatoes, coffee, vegetables, mangoes, cassava, potatoes, jackfruit, coffee, pineapples, pawpaw. In addition, those in northern region cultivated tobacco and sorghum as well as millet, Irish potatoes, and groundnuts. Regarding animals, all older persons reared goats, chicken, sheep, ducks. In addition, those in the central, east and west reared cows. Other findings

in Chart 2 are similarly interpreted. Generally, the findings indicate that most of the older persons earned their living from subsistence production.

In fact, even the older persons who were engaged in roadside selling revealed that the stocks that they put on the market consisted of mostly animal products (eggs, chickens, ducks, goats, beef), farm produce (potatoes, cassava, matooke, maize, beans, and others shown in Chart 2) plus firewood that they fetched from nearby forests and thorny bushes. Unfortunately, observation revealed that the stocks were very small consisting of very few items that could not even raise a total sales value of $2 US dollars as capital. Accordingly, even roadside selling could not translate into economic means that could guarantee meaningful livelihood for older persons.

Apart from occupations, further efforts were made to understand the economic conditions of the aged people in Uganda by interviewing them on whether they had other income-generating activities that they carried out in order to support their livelihoods. It was discovered that the overwhelming majority replied negatively, implying that they did not have other income-generating activities. This concurred with the observation made by Kollapan (2008) and Anweng-Angura and Anyuru (1994) that most of the older persons in Africa are not involved in income-generating activities. The very few who indicated that they were involved in other income-generating activities were asked to mention the activities. Content analysis of the responses revealed the following as the activities: producing and selling potent gin (waragi) or local brew, running transport businesses, selling tap water, and running a school project. The analysis of the responses according to settings and regions showed that the older persons who carried out the above activities were mostly in urban settings of the central and eastern regions of Uganda. There was virtually no older person carrying out these activities in northern Uganda for reasons cited earlier.

It was also found that some elderly people were involved in more than one income-generating activity. Indeed, a 76-year older person from western Uganda indicated that in addition to earning as a teacher, he also generated income as a cattle keeper and a

producer of coffee, matooke and maize. Another 78-year older person from eastern Uganda indicated that apart from being a real estate investor, he also earned his living by carrying out retail trade with the aid of his wife and hardware trade aided by his children. In fact, observation revealed that the two aged persons together with their families enjoyed better living conditions. They had well-planned and clean homesteads, suggesting that earning was very central to ensuring comfortable living conditions in old age. This supported Bond's (1990) observation that old persons who run income-generating activities tend to enjoy a sound economic stature while those who do not get involved in the activities live a life which is economically distressed.

In addition to income-generating activities, the economic conditions of older persons were further explored by asking about whether they had any assets from which they earned a living. It was established that many older persons considered their children as their assets. A few of them pointed out land while one 80-year older person considered his two equally frail wives his assets. Similar view was expressed by a 76 old year widow by asserting that all that she considers as her asset in the world was her 89 old-year husband. While those who pointed out children and spouses argued that they could not live without these human assets, those who pointed out land argued that they used it as the main source of livelihood; that land enabled them to grow food and rear animals from which they earned their living. The value that older persons attached to land as a valuable asset came out clearly through a widow from the rural setting of eastern Uganda as summarised in following caption:

> "My husband died in 2005 and left six children all whom are feeding and going to school because of the land he left behind. All the food we eat and sell is cultivated from the land. In fact, when my husband's relatives grabbed the land from us, we were left to the mercy of God until I struggled to regain it..,"

Female, 64 years, Kakoro SDA, Pallisa district

Analytically speaking, the foregoing findings imply that most of the older persons in Uganda consider their children, spouses and land as valuable assets from which they

expect to earn a living. This suggests that older persons who do not have children, spouses or land consider themselves 'asset-less'. In fact, many older persons went on to show that failure to have such assets was one of the main barriers that prevented them from enjoying desired economic living conditions. This supported Bird and Shinyekwa (2005), and Alun (2003) who identified lack of economic assets as one of the major barriers experienced by older persons in their attempts to participate and live comfortably in society. The findings also give credence to Kollapan's (2008) argument that older persons in Africa depend on the traditional social security system by which children are expected to support their parents in old age although this is also changing because of the current resource constraints and the impact of HIV/AIDS (Kawuma, 2011). The fact that 85 out of the selected 165 older persons indicated that they did not have assets suggests that they did not have children, spouses or land. According to Bond (1990), such conditions imply that most of the older persons in Uganda experienced economic distress and thus, did not enjoy sound economic stature.

Generally, not being involved in any occupation or income-generating activity and not having economic assets implies that many older persons did not have any source of earning. This explains why one of the barriers to that prevented them from living an enjoyable old age life by which they could effectively participate in society was lack of financial earnings. Without any financial earnings, it is difficult to contribute to society in a meaningful way. There is therefore need to economically empower older persons by creating income-generating opportunities for them and encouraging them to get involved in the opportunities. Unfortunately most of the Ugandan development programs do not target them (Kibuka, 2011).

In addition, getting assistance or care was another economic area explored to establish whether older persons in Uganda used it as a means of livelihood. Attention was focused on establishing the marital status of these persons, who their breadwinners were, and whether they received any assistance. Each of these had been earmarked as a source of economic survival. Indeed, marital status is highly associated with caring and sharing. It is therefore a means of livelihood for many people. Accordingly, when the older persons

were asked about their marital status, it was discovered that the majority (154) of them did not have spouses. In fact, 99 of them described themselves as widowed, 33 as separated, and 14 as divorced. Eight of them indicated that they had been single throughout their life. This implies that the economic life of the overwhelming majority of the older persons did not depend on their marital status. In fact, content analysis of the responses obtained when older persons were asked who their breadwinners/caretakers were revealed that most of them fended for themselves. Further analysis indicated that those who fended for themselves were mostly in rural settings of the central, eastern and western regions of Uganda. Only 11 of the interviewed older persons relied on their marital status as a source of their economic survival. Of these few older persons, the majority were women. Indeed, asked who their breadwinners were, one of the older married women articulated it clearly when she replied:

> "I entirely depend on my husband. He looks after this whole family of 17 grandchildren and me. But he is getting too old. I sometimes I feel that he should rest but as a man, his God given role is to look after us. He tries his best though the family is too big for him to support adequately"

Female, 66 years, Kiwoko, Luweero district, Central Uganda

There were a few older persons who indicated that they derived their economic survival from their children, brothers, sisters, and friends or well-wishers. These older persons were mostly those selected from urban settings. They emphasized that much of the support was provided by their children and it was in form of received food and medicine. The very few who were rural-based indicated that the support they received, still from children mainly, consisted of clothing, beddings, and financial support. These findings give more credence to confirm Kollapan's (2008) argument that older persons in Africa depend on the traditional family social security system involving adult children supporting their old parents. This however raises a policy question that should the economic life of older persons in Uganda continue in this fashion, especially in the light of the fact that community ties are fading as more and more adult children are succumbing to HIV/AIDS and as the European and American spirit of individualism

gains ground in Uganda? Clearly, the answer is a big 'No'. As people who actively contribute to Uganda's economy before the setting in of old age, older persons cannot be left to continue depending on the fading family social security system. Efforts need to be made by government to protect the economic life of these people by as shall be recommended later.

Apart from family means of economic support, effort was also made to explore whether older persons obtained any assistance from any privately founded organisation. This involved asking them to mention any organisation that had been formed in their respective communities as a means of supporting them economically. Only 8 of the interviewed older persons were able to identify the organisations, which included *Munnomukabi* (A Friend in Need is a Friend Indeed) established at Makindye in Kampala district in the central Uganda; *'Zarimpeke'*, an Older Persons Women Association in Kawempe II Zone; AIDS association of Kampala City Council; *Agalyawamu Gegaluma Enyamma* (Unity is Strength) which was also established at Makindye, Kampala district in central Uganda and Uganda reach the Aged Association which is also located in central Uganda. Evidently, these findings show that very few older persons obtained economic assistance from organizations. Moreover, they were only older women from only one division of Kampala located in the urban setting of central Uganda. However Uganda Reach the Aged Association which is the umbrella organisation for older persons has projects targeting older persons but it targets only few districts of Kasese, Iganga, Kampala and a few others thus the impact of this organisation has not yet been yielded at a larger level in relation to income generating activities. However interaction with two of the beneficiaries from URAA provides evidence of improvement in lifestyle as shown:

> I was bone in 1958, tested for HIV/AIDS in 1995 and found that I was positive. My husband died in 1995 and I am now a widow. I fell sick and got skin rashes, vomiting and diarrhoea. I started getting treatment and I am now better. I suffered emotionally, I was being referred to as a person who did not have any use in the world, I felt hungry there was no food. Then I came across this organisation called URAA which taught me prevention, treatment and nutrition and how to live positively. They also trained me to help others who are living with HIV. And how to do income generating activities and gave me some money to start. Now I live very well and I am okay. I thank URAA for all the help they gave me (65 year old female who had come to visit in Kampala but lives in Kasese).

> …you would not have seen me here if it was not for this NGO because I can now eat and drink because of URAA. I also look after so many orphans (80 years old Male, central region, Kampala).

Evidence above indicates that support from organisations can help improve the life of older persons unfortunately there are only a handful of such organisations. But apart from this support provision, URAA has also spearheaded advocacy activities to help change discriminative policies to include older persons as a target group too.

It is imperative to note that the names of the above mentioned organizations carry a lot of economic sense. Not only do they suggest that group members help each other. They also show that combining efforts produces greater returns than working alone. This is in line with the principle of Gestalt Psychologists which states that the whole is bigger than the sum of its parts. In fact, when asked about how they benefited from the groups, the responses obtained from the member older persons revealed that the groups helped them to get involved in programmes and activities contributing materials and making handcrafts such as mats, baskets, and sweaters, which they would sell and earn income. It was however discovered that the members were yet to be fully satisfied with the benefits of the groups. These findings give an impression that encouraging older persons to form groups and associations can help improve their economic livelihoods. They also show that enhancing the ability of the already existing groups or associations can help improve the satisfaction that members derive from them. Groups when used properly could also yield positive results in terms of advocating for their rights.

In addition to privately formed organizations, document review revealed that there were a few non-governmental organisations that had been established in Uganda to help older persons. These included: Uganda Reach the Aged Association (URAA), Reach one Touch One Movement (ROTOM), The Aged Family (TAF) and Hoima Voice of Older Persons. These were discovered to be the largest organisations which help to advocate for the older persons in Uganda. URAA was the supreme umbrella organisation as indicated earlier. An interview with the Chief Executive Officer (CEO) of URAA revealed that the organisation was involved in advocacy work for the older persons in

Uganda at national level. It was also involved in networking and lobbying, policy formulation, and giving support to a few poor older persons through providing loans and/or funding their income generating activities.

Other activities in which URAA was involved included: health education on care and HIV/AIDS, capacity building and promoting the formation of small group associations of the older persons at district level. Other organized units for older persons in Uganda were homes, which included: Bakateyemba Home of the Destitute, Nalukolongo, Nakanyonyi Day Care centre for the older persons, Mbarara Home of the Older Persons and Nsambya Home of Retired Priests. These homes were owned and funded by churches. It is worthy noting that these homes were found to have been all established in central and western Uganda, implying that the eastern and northern region did not have any such organizations and homes. It is also important to note that from interviews held with older persons in northern Uganda, it was established that the livelihood of the overwhelming majority of them was much dependant on aid donated by well-wishers and international donors like the United Nations, and World food programme. This was the case because the family social security system in this region had been destroyed by the Kony war that lingered on for over 20 years.

What worsened the situation was that older persons in this region continued preferring living with their family members to living in homes for the elderly. In fact, this was the same reason why no effort had been made to form homes for older persons in eastern region of Uganda. It was, however, not clear why no older persons-based NGOs had been established in the northern and eastern regions of Uganda. Even where such NGOs had been established, interviews held with older persons revealed that most of these people had not been heard of, let alone felt their impact. This raises a policy question as to whether the economic life of old persons in Uganda should be left to continue in such a state. As argued before, the answer is still a big 'No'; more so in the light of the findings obtained from key informants about the adequacy of the welfare support extended by the NGOs to older persons as shown in the next section.

4.1.1 Level of Welfare Support to Uganda's Older Persons from NGOs

The question of whether older persons were really supported by the NGOs that had been established to assist these people in Uganda was also posed to the key informants. Out of the 50 selected key informants, 56% responded positively while 44% replied negatively. These findings suggest that slightly over a half of the NGOs supported older persons in Uganda. The forms of support that key informants mentioned to have been extended by the NGOs to older persons are shown in Figure 4.1.

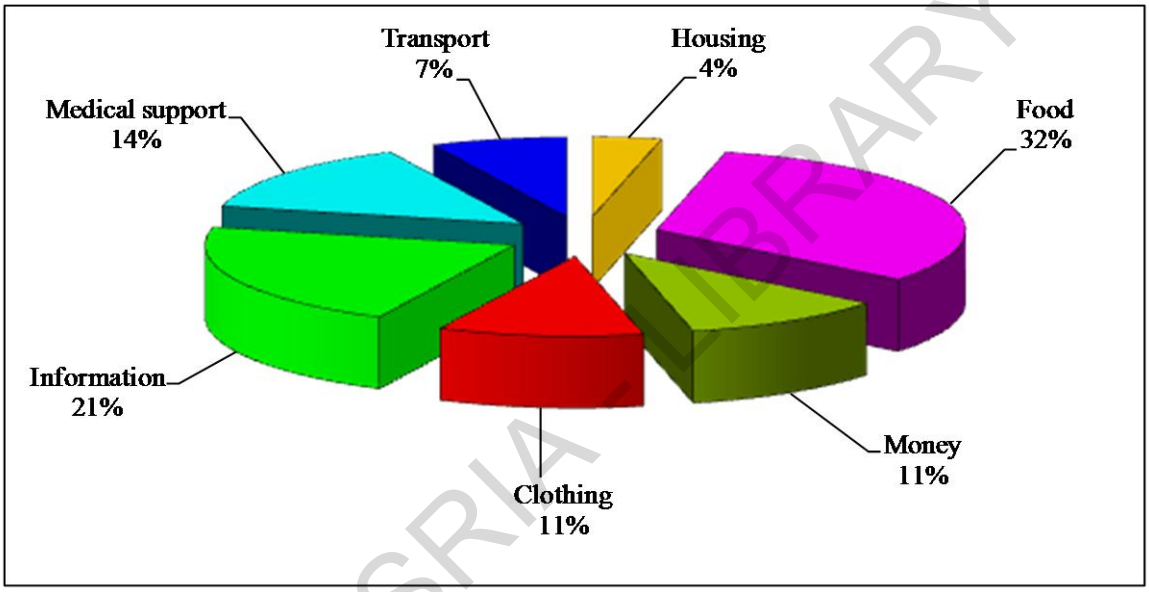


Figure 4.1: Support Extended to the Older persons by the Key Informants' Organisations (N = 28)

A comparative analysis of the proportions of key informants that reported the forms of support in Figure 4.1 reveals that fewer NGOs provided each form of support. Accordingly, these findings suggest that not many NGOs supported the economic life of older persons in Uganda in its entirety. No wonder that most of the older persons did not get, let alone feel the impact of the support from the NGOs. In fact, even the support that the NGOs extended to a few older persons was judged by the majority (85.7%) of the key informants as inadequate as shown in Table 4.1 below.

Table 4.1: Adequacy of the Support NGOs Extend to Older persons in Uganda

	Is support provided to the elderly by the organization enough?[1]					
	Yes		No		Total	
Support	Count	%	Count	%	Count	%
Housing	.00	.00	1	100.0	1	100.0
Food	2	22.2	7	77.8	9	100.0
Money	.00	.00	3	100.0	3	100.0
Clothing	.00	.00	3	100.0	3	100.0
Information	2	33.3	4	66.7	6	100.0
Medical support	.00	.00	4	100.0	4	100.0
Transport	.00	.00	2	100.0	2	100.0
Total	4	14.3	24	85.7	28	100.0

1. Chi Square = 4.407, df = 6, Sig. = 0.622

From Table 4.1, 85.7% of the key informants dissented to the adequacy of the support, which their respective organisations provided to the older persons in form of food, money, clothing, information, medical support, and transport, housing-which was reportedly provided at homes that the key informants mentioned as Nalukolongo, Nakanyonyi, and Mbarara Home of the Elderly. The reasons why organisations provided inadequate support to older persons in Uganda is illustrated in Figure 4.2.

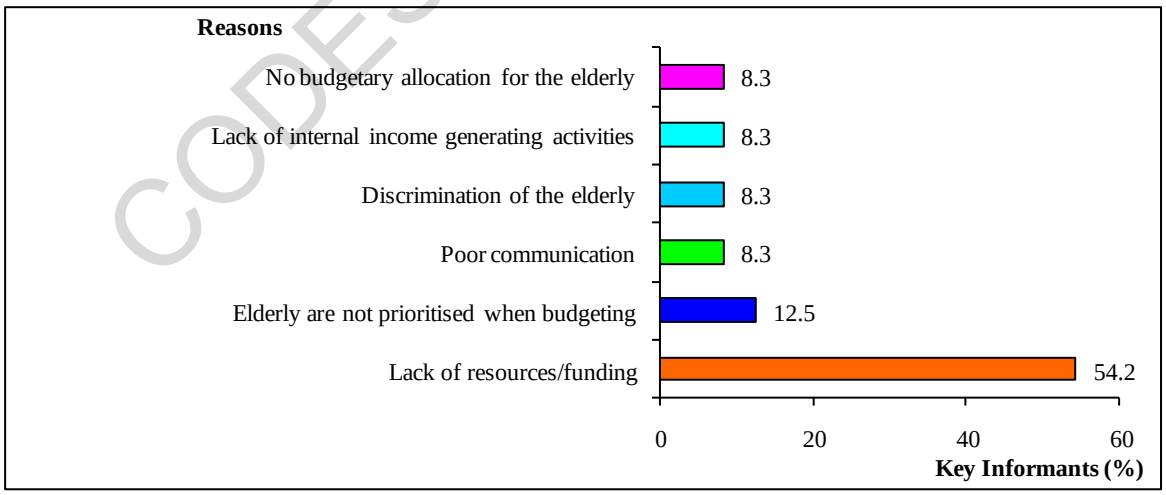


Figure 4.2: Reasons why Organisations Provide Inadequate Support to the older persons in Uganda, as given by Key Informants

From Figure 4.2, slightly over half of the key informants (54.2%) indicated that lack of resources was the reason why their NGOs provided inadequate support to older persons in Uganda. The government of Uganda was even in a worse position as far as supporting the economic life of older persons was concerned. Findings to this effect are presented in the next section.

4.1.2 Level of Government Welfare Support to the older persons in Uganda

When older persons were asked whether they received any support from government or not, it was discovered that government efforts supported a negligible portion of them. This implies that a large majority of the older persons was not supported. Government was particularly doing nothing for most of the older persons as far as their healthcare, housing, and food security were concerned.

In particular, the overwhelming majority (145) of older people indicated that they were not entitled to pension, implying that those that government supported through pension constituted a minute proportion (< 10%) of the total number of older persons in Uganda (UBOS, 2002). Further probing revealed that most of the elderly people were not entitled to pension because they had not worked for government. A quick reflection would refer to findings obtained about the level of education to explain this situation; for these findings revealed that most of the older persons could not work for government because they either lacked or had inadequate education.

According to Cultural Heritage Unit (2008), Bagala (2007), Bowling (2005), Najjumba-Mulindwa (2004); and Ntale-Lwanga (2003) pension is worldwide regarded as a means of livelihood for older persons. Therefore, having the majority of older persons not entitled to pension implies that they lose out on this means of earning. This was aggravated by the facts that even the very few (20) older persons who were entitled to pension some of them indicated that they, too, did not receive it. Some of the interview responses are summarised in Chart 3 below, which were obtained when these older persons were asked why they did not get their pension, provide scenarios that substantiate this observation.

Chart 3: Scenarios Explaining Failure of Older Persons Entitled to Pension to Get It

"When I sent my children to the Pensions Department in the Ministry of Public Service, they were rudely told that according to the records in the department, I was already dead. I went there myself but still they did not respect and give me my pension. Nothing comes from government apart from the problems of putting off power and water" (Female, 95 years, Rubaga, Kampala, central Uganda)	"I worked in Uganda Railways until I was retired but I have never received my pension much as I tried to follow it up. Even my wife who worked for Public Service for 26 years did not receive her little pension until she died. We have tried with the children to no avail" (Male, 72 years, Kawempe, Kampala district, central region).	"I am entitled to pension from government because I worked for it in various capacities. When I retired I was a Senior Inspector of Schools. But I don't get any pension from the government. I tried to process it, walked and walked to the pensions department but I gave up. Nothing was coming up" (Male, 75 years, Mbarara district, Western Uganda).	"Pension is not enough given the needs of my family, inflation and high cost of living. I get about UGX 330,000 but it is peanuts compared to the cost of living in Uganda. What is UGX 330,000 when the school fees I have to pay for my grandchildren total to over three million shillings? Besides, that it is not the only expenditure I incur. There are all sorts of expenses on family needs: treatment bills, buying food and sauce, and clothing for my family members. No one can say that pension is enough and even getting it is another battle" (Male, 80 years, Pallisa district, Eastern Uganda).

Generally, the findings suggest the number of older persons earning a living based on pension is negligible in Uganda. A critical analysis of the findings in Chart 3 reveals that older persons who were entitled to pension failed to get it because of a number of barriers that they encountered in their efforts to access it. These barriers are reflected in the Chart 3 and they include the following:

- Deliberate long delays in the Pensions Department which frustrate pensioners
- Deliberate loss of files/records in the pensions department
- Corrupt pension officers swindling pension by declaring those entitled to it dead
- Rudeness and lack of respect for the older persons by pension officers.
- Inadequacy of pension whose value is eroded by rising inflation and high cost of living

The above findings where in line with what Leku (2011) pointed out as challenges in the pension reforms. Evidently, even the older persons who were entitled to pension lived more or less like those who were not entitled to it. This defeats the purpose of pension, which, according to Saltman et al. (2006), is to place older persons in a relatively secure position until death. Bowling (2005) put it clearly by observing that pension is such a minimal provision meant to support the older persons throughout their old age period.

Denying the entitled older persons a chance to get pension was therefore tantamount to exposing them to insecure living conditions. Something therefore, needs to be done. Looking at the barriers, it is clear that the pension was being ruthlessly swindled by the very officials who were supposed to process its payment to the entitled older persons. There is thus need to salvage the Pensions Department from the hands of the unscrupulous and disrespectful officials if Uganda's older people entitled to pension are to receive it. The barriers also indicate that controlling inflation can help maintain the value of the pension. There is also need to reduce on the time of processing the pension as according Leku (2011) the process involved 38 business steps that one goes through before he/she is given the pension. This however, has implications of transport costs of moving to and fro as one makes a follow up from one step to the other. Some times files get lost and one is forced to start the process afresh.

Regarding healthcare, key informants were asked to indicate whether government extended any assistance to older persons in form of free medical services, assistive devices, information about their health, and cataract treatment and free checkups on cancer and other chronic diseases. The results obtained are shown in Table 4.2.

Table 4.2 Key Informants' Responses on Government Health Support to the older persons in Uganda

Questions on Forms of Health Support	Responses							
	Yes		No		None response		Total	
	Count	%	Count	%	Count	%	Count	%
Does government give free medical services to older persons	14	28.0	29	58.0	7	14.0	50	100
Does government give free assistive services	4	8.0	37	74.0	9	18.0	50	100
Does government give free health information to older persons	12	24.0	28	56.0	10	20.0	50	100
Does government give older persons free cataract treatment and check-ups on cancer and other chronic diseases	9	18.0	32	64.0	9	18.0	50	100
Average	**5**	**10.0**	**31**	**62.0**	**14**	**28.0**	**50**	**100**

On average, 10% of the key informants responded positively, 62% negatively and 28% did not respond. These results indicate that the majority of the key informants dissented

to government provision of health support to the older persons, implying that government did not support the majority of these people as far as their health conditions were concerned. Illustrations given by the key informants to explain government's lack of support are outlined in table 4.3.

Table 4.3: Illustrations against Government Support to older persons in Uganda

Illustration	Count	%
Government does not provide special grants to the elderly as it is in other countries	10	32.3
Failure to control inflation erodes value of the little pension given to some elderly	5	16.1
Government does not make budgetary allocation for the Elderly	4	12.9
Government does not have a policy for the elderly	3	9.7
The elderly are not given priority in government planning	3	9.7
Presence of an increasing number of destitute elderly	2	6.5
Government does not give enough money at retirement	2	6.5
Government does not have any mechanism of interaction with the elderly	2	6.5
Total	**31**	**100.0**

As illustrated in Table 4.3, the largest proportion (32.3%) of the key informants showed that government did not provide special grants to older persons as the case is in other countries. Other key informants pointed out the presence of an increasing number of destitute older persons yet others argued that government did not: give enough money at retirement; have a particular policy on the older persons (this was at the time of the study but however there is now a policy for older persons that was launched in 2009); make budgetary allocation for the older persons; and give priority to the older persons in its planning. Other key informants felt that government neither controlled inflation, thereby leading to erosion of the value of the little pension given to a few older persons, nor had any mechanism for interacting with the older persons.

As a result, most of the older persons encountered many barriers in their efforts to live in society. Indeed, in the group discussions held with the selected older persons, they were asked to describe the problems that constrained their effective participation in society. The qualitative analysis of their responses revealed that all (165) of them were constrained by "Lack of financial income" and subsequent "Lack of material resources or assets". In addition, some (19) older persons faced the problem of "Unabated land

grabbing and illegal evictions" while others (39) were hindered by "Lack of income generating activities", while others were hampered by "High crime", "High taxes", and "High and increasing cost of living."

The important point to note about the foregoing economic barriers is that some of them-lack of financial income and high cost of living-constrained was reported by almost all older persons irrespective of the regions and settings in which they lived. The barriers suggest that there is need to come to the economic rescue of older persons in Uganda. A critical eye on these barriers reveals that they all reflect lack of income occasioned poverty caused either by lack of income-generating activities, assets or pensions. This implies that most of the older persons in Uganda find it difficult to realize the economic capacity that they need to meet their economic needs and those of their household members. This explains why most of Uganda's older persons find it difficult to adequately meet their economic needs. There is therefore need address the economic barriers facing older persons in Uganda. This will help improve the income situation of these persons, thereby putting them in a position to adequately meet their economic needs.

Overall, findings show that the living experiences of older persons in Uganda were such that the overwhelming majority of these people were the breadwinners of all the members of their households. The findings therefore concur with the observation made by Kollapan (2008) that today older persons are the sources of care for millions of the young who would traditionally have been the ones looking after them. Being breadwinners implies that older persons in Uganda fully shoulder the economic responsibility of fending for all members of their households. This is a no mean obligation because its effective execution implies that the concerned older person has to have the capacity required to fend for all members of his/her household as satisfactorily as expected. This capacity can be generated in three principle ways. It can be generated when the older person concerned has knowledge and skills that can help him or her earn a living formally. It can also be realized when the older person is involved in earning activities and occupations, or when

adequate support is extended to him or her. These three ways are reflected in the scholarly work of Apt & Greico (1994), Kalache (1994, 1991), Cain (1991), and Bond (1990).

Unfortunately, findings showed that the overwhelming majority of older persons in Uganda are uneducated, implying that they lack the knowledge and skills from which they can formally earn a living. Most of these people are also neither involved in gainful occupations nor income-generating activities. This implies that they lack the capacity needed to be able to look after their households in a satisfactory manner. Even when a large number of Uganda's older persons, especially those in the rural areas are engaged in manual subsistence cultivation as a means of fending for their household members, the level of cultivation is too subsistence and low to cause any meaningful impact on the desired quality of their living conditions. This is in line with the argument raised by Stuart-Hamilton (2003) that as old people experience increasing physical frailty, their ability to carry out and sustain activities that require spending a lot of energy decreases. Since manual cultivation involves spending a lot of physical energy, it is one of the activities that the older persons cannot sustain for long. Therefore, manual cultivation alone is not an adequate economic base which older persons in Uganda can use to earn and be able to create a satisfactory quality of life for their households.

Findings revealed that very few older persons supplemented manual cultivation with livestock rearing, production and selling of local brew, and informal roadside selling of various items of agricultural produce. However, the value of the sale proceeds was reportedly too meagre to make any meaningful economic effect on their households and themselves. Consequently, supplementing cultivation with other income-generating activities does not translate into adequate capacity for older persons in Uganda to be in a position to shoulder the responsibility of breadwinning for their households and themselves in a satisfying manner. If a breadwinner cannot raise adequate economic capacity, it follows that he/she cannot meet the economic needs of his/her household in an effective manner. Thus the orphans and children under their care will continue to suffer in terms of meeting there essential needs such as school, food security, clothing and treatment among others.

The situation could have been salvaged if older persons were economically supported and cared for by government, NGOs established to address their plight, and/or other sources. Indeed, economic support to older persons could have enabled them to meet their breadwinning obligation. Unlike adults who are not expected to be assisted to meet their breadwinning responsibility (because they are expected to be industrious enough to earn a living for their households and themselves), it is natural and normal in all societies for older persons to be supported in their efforts to meet this responsibility. In fact, ensuring that older persons meet the obligation effectively is, according to Brown (1984), Fentleman et al. (2000), Bowling (2005), Saltman, et al. (2006) and the Cultural Heritage Unit (2008), the very essence of retirement packages, pension or, generally, social security and welfare programmes run by governments for older persons in society.

Citing the psychological theory of old age, Stuart-Hamilton (2003) justified economic support to older persons by arguing that as people grow old, they experience declining health and physical strength as well as reduced income; their capacity to handle active and earning roles wanes, thereby putting them in an economically vulnerable position. As a result, they find it difficult to support and maintain their households and themselves economically. Maddison (2008) and Fentleman et al (2000) justified it further by arguing that people experience a continuing decline in the earning capacity as they grow old. Further justification is derived from the selectivity theory whose rationale is, according to Benyamini et al. (2008), to disengage people from some rigorous activities as they grow old, even when the activities are earning activities. After disengagement from earning activities, it is only fair that older people are economically supported.

Unfortunately, findings indicate that the overwhelming majority of the older persons in Uganda do not receive any economic support from government. The social security programmes in Uganda focus on very few older persons. Indeed, the Pension Scheme focuses on older persons retired civil servants yet the National Social Security Fund focuses on workers retired from formal employment, including those retired from registered formal private companies. As indicated earlier, the older persons belonging to

these two categories form a minute proportion of Uganda's population for older persons. Moreover, most of these older persons showed that they did not receive the economic assistance to which they were entitled due to the unscrupulous behaviour of the officials handling the processing of this assistance. This supports the observations made by Bagala (2007) and Kalasa (2004) that neither pension nor national social security fund is available as a means that most of Uganda's older persons can use to support themselves economically.

In fact, even the very few older persons who struggled to access such economic entitlement through thick and thin showed that it was too inadequate to support a satisfying livelihood. This implies that the government of Uganda does not extend adequate economic support to the very few older persons entitled to it. Findings obtained from key informants indicated further that the government of Uganda is also not fulfilling its constitutional obligation of extending welfare that its older citizens deserve in order or live in satisfying economic conditions. This explains why pensioners in Uganda are also living in pathetic conditions.

What aggravates the economic situation of older persons in Uganda is that even the NGOs established to address their plight are not playing their role effectively. Indeed, the overwhelming majority of older persons indicated that they do not get any economic support and care from the organizations. The same view was implied by the overwhelming majority of the key informants who showed that the economic and health support that their NGOs extended to older persons was inadequate mainly because of lack of funding. The situation is worsened by the fact that the support and care that the older persons receive from their children was reported as being too inadequate to help them support their households, which, moreover, consisted of over six members many of whom being orphans.

To recap, the economic perspective of the living experiences of the older persons in Uganda was explored in terms of level of education, occupation, income-generating activities, possessed assets, pension status, and support and care which characterised

these experiences. Findings show that the overwhelming majority of older persons had no education and no occupations from which they could earn a meaningful living. They were not pensioners; had neither assets nor income-generating activities; yet they were the breadwinners of their households. The very few older persons who were entitled to pension indicated that in addition to it being too inadequate to make a satisfying living, they failed to get it because unscrupulous officials in the Pensions Department swindled it. A large number of the older persons were involved in manual subsistence farming. Very few rural-based older persons supplemented cultivation with livestock rearing, production and selling of local brew, and informal roadside selling of various items of agricultural produce. A few older persons showed that they received some inadequate support and care mostly from their adult children. Not many older persons received support from older persons-based NGOs. The very few older persons who received this support and the majority of the key informants who extended it showed that it was very inadequate.

In the final analysis therefore, findings reveal that the living experiences of the older persons in Uganda leave a lot to be desired. The majority of them are still finding it difficult to live a sufficiently satisfying economic life. The findings therefore point to the need to improvise strategic ways by which the economic life of older persons in Uganda can be improved using the Ugandan economy to which they contribute before old age sets. This points to the need for the government of Uganda to formulate and implement effectively a social protection policy that addresses the economic life of all older persons irrespective of whether they worked in the civil service or not. However, at the time of writing, the government was in the process of formulating the social protection policy to address issues of the majority poor older persons who had missed out on pension because they were not employed by government or the private sector. But this is just at the initial phase hence it may take quite a number of years for the program to start.

4.2 Social Perspective of Living Experiences of Uganda's Older Persons

This perspective focused on exploring the recreational and leisure activities as well as social activities and roles that typified the lives of the older persons in the rural and urban

settings of Uganda. Also explored were the barriers to these people's social life. The social activities and roles were ascertained from interviews and group discussions held with the older persons. Emphasis was on establishing how these persons spent their free time, the social activities in which they participated, and the roles that they played in their communities. Results obtained are presented henceforth.

a) Leisure Activities Characterising the Lives of the older persons in Uganda

The leisure activities that characterise the living experiences of older persons in Uganda were established by asking them to describe how they spent their free time. Thematic analysis of their responses revealed that the various leisure activities in which most (137) of these persons were involved included; weaving mats, and baskets, conversing with grandchildren, visiting relatives and neighbours, walking around/going out, checking on the cattle on the farm, going to gardens to look at crops, protecting crops against rodents, going to church for choir practice, reading the Bible, going to church for prayers and choir practice, reading books about great men, and listening to radio announcements. Other activities included playing Mweso (Local game), drinking Ajono (local brew) with friends, writing story books and poems, writing autobiographies and conversing with spouses. These activities are consistent with those identified by Deeg and Bath (2003), Cooper et al. (2001), and Hanahan and Weinberg (2000), Harper (1988). They suggest that most of the older persons in Uganda spend their leisure doing at least some activity.

The analysis of the leisure activities according to gender and settings revealed that while older women in rural areas spent much of leisure weaving mats and baskets, listening to radio announcements; conversing with grandchildren; and visiting relatives and neighbours, most of the older men spent much of this time going to gardens to look at crops, protecting crops against rodents, and drinking *mwengebigere* or *Ajono* (called local brew in English) with friends. A few of the rural-based older men who reared livestock spent their leisure checking on the animals. Most of the older men in urban areas spent their leisure by reading the Bible, playing Mweso (Local game), conversing with spouses, and walking around while older women spent most of their leisure doing church activities

and fellowships. A few educated older men in urban areas of central Uganda spent their leisure in fellowships of the Rotary Club of Ggaba and the Rotary Club of Lubaga.

Despite the fact that most of the older persons were involved in leisure activities, there were a few (28) of them who were not involved in any leisure activity. Asked why they were not involved, some of the older persons cited "Bodily weaknesses due to ill-health" as the cause. Others cited "Lack of leisure time due to demanding occupations, too much house work load" while others pointed out "Lack of money to pay to health clubs". Other interviewed older persons noted that they were hindered by the fact that they had to "Give constant attention and care to spouses bedridden with paralysis and/or stroke" while others were hampered by "Inadequate feeding" and "Loss of hope". Some of the older persons were not involved in leisure activities due to the "Misconception that leisure exercises belong to only youthful people". Other older persons cited "Remoteness (lack of access to leisure facilities)" and the main barrier while others showed that they "Lacked space where to carry out leisure activities."

Many of the barriers specified above are consistent with those identified in the work of Nankwanga and Phillips (2009a), Krulwich (2006), Schutzer and Graves (2004), Paola (2003). As this work indicated, the barriers show that some older persons were barred by the ailing state of their health while others were inhibited by poor feeding and inevitable responsibilities that pre-occupied them all the time. The analysis of the barriers according to settings revealed that while most of the older persons in rural settings were barred by ill-health and remoteness, most of those in urban areas were barred by lack of space, lack of time due to demanding jobs, and lack of money to pay for the activities at health clubs. Some of the above mentioned barriers were however, not obstacles especially when viewed in the light of some leisure activities in which some older persons were involved. In particular, remoteness, lack of space and lack of money could not prevent any older person from getting involved in leisure activities such as walking around or going to church. Therefore, older persons who pointed out these barriers need to be helped to appreciate that they can participate in leisure activities which do not depend on having money, space, or living in a remote area. Leisure does not need to be sophisticated. It is as simple as having an evening walk or socially interacting with household members or

friends by telling conversations and sharing words of wisdom amongst each or with the younger generation, amongst others.

However, addressing other barriers such as inadequate feeding, bodily weaknesses, and loss of hope can help improve the social life of older persons in Uganda. This boils down to the need to address the physical and psychological weaknesses of these people, which can be realised through provision of the necessary therapeutic services such as medical care, physiotherapy and counselling to restore their hope in life and to sensitise them out of the misconception that leisure activities are for youths only.

b) Social Activities Characterising the Lives of the older persons in Uganda

The social activities that characterised the living experiences of the older persons were explored by asking these people to mention the shared activities in which they participated in their respective communities. Content analysis of their responses indicated that going to church for prayers and choir practice; going to their clubs to discuss issues as members; attending weddings and graduation parties; meeting with friends over a drink; and going for last funeral rites were the social activities in which these people were involved.

Qualitative analysis according to settings indicated that while most of the urban-based older persons were involved in church-related social activities, weddings, graduation parties, and meetings with friends over drinks, most of the rural older persons were involved in activities related to last funeral rites. Analysis according to gender indicated that while older women were more involved in church-related social activities and funeral rites, older men were more involved in meetings with friends over drinks. Generally, the identified social activities indicate consistency with those specified by the Cultural Heritage Unit (2008), Benyamini et al. (2003) and Deeg and Bath (2003). As these scholars argued, older persons who got involved in such activities avoided isolation and loneliness that could have adversely affected their life.

Unfortunately, relative to the total number of the older persons interviewed, only few (71) of them participated in the social activities identified above, and only when their health permitted them to do so. Moreover, their participation was mostly limited to interacting mostly with grandchildren, and with neighbours and church goers but to a less extent. In both settings, the social interactions expressed themselves in a number of forms, including praising and praying to God; guiding grandchildren about hardworking, instilling good behaviour and discipline; as well as discussing economic issues and work experiences as well as problems of old age and widowhood.

The above findings suggest that in addition to the fact that older persons who interacted socially were relatively few, the pattern of their participation was irregular and confined to a few categories of people. According to the active ageing concept explained by the World Health Organisation (2006), this pattern of participation is not satisfactory, especially in the light of the fact that many older persons identified social interaction as one of the main aspects that they needed in order to live a comfortable life. It was identified when these people were asked to describe the value of keeping friends. Indeed, most of the older persons indicated that keeping friends (social interaction) enabled them to derive comfort and care in time of grief and sorrow. It also helped them get assistance whenever they were faced with economic crises or problems. It furthermore enabled them to share resources, experiences and ideas, and to get socio-psychological support. One older person put it clearly that, "Good friendship is wealth because you can get from friends a lot of things such as knowledge, physical items and mental support, and valuable connections (networking)." Evidently, these findings indicate that most of the older persons perceived social interaction as an important means of improving their socio-psychological and economic lives.

Accordingly, the irregular and narrow pattern of older persons' social interaction needs to be improved so that it can produce a more positive impact on the life of more and more of these people in Uganda. In addition, the modes of social interactions in which older persons participated suggest that these people are a resourceful source of wisdom, good counsel and discipline. Promoting the regularity and expanding the span of their

social participation in society is therefore necessary. It is bound to help more and more of the younger generation.

c) Social Roles Characterising the Lives of the older persons in Uganda

Social roles are the functions that people are expected to play in their relative positions in society. They therefore constitute one of the main characteristics of people's living experiences. Against this backdrop, it was necessary to explore the social roles that characterised the living experiences of the older persons in Uganda. The roles explored included those a person is expected to perform at household and community levels.

i) Social Roles at Household Level

One of the social roles that any adult person is expected to play in society is to be a head of a household. With intent to establish whether this was one of the roles that characterised the living experiences of the older persons in Uganda, they were asked to divulge who the heads of the households in which they lived were. Thematic analysis of the responses revealed that most of these people were the very heads of their households, especially in the rural settings across all regions of Uganda. Other household heads, especially in urban areas included sons, brothers and husbands, especially for female older persons. The latter heads were however, generally few. The findings indicate thus that majority of the older persons in Uganda play a social role of being heads of households. The findings are therefore consistent with the observations made by Pearson (2005) and Najjumba-Mulindwa (2004) that in Africa, older persons continue to play a significant role as heads of households.

Another social role that was explored at the household level focused on parenting. The majority (155) of the participants confirmed their roles as grandparents and not parents. Asked about the number of children (referred to as grandchildren henceforth in recognition of what the overwhelming majority of the older persons accentuated) who were under their care, findings from the thematic analysis of the given responses showed that most of the older persons looked after 11-15 grandchildren. However, those in rural areas looked after between 6-22 children while those in urban areas cared for between 7-

15 grandchildren. Asked about the circumstances under which they came to look after such a big number of grandchildren, all the older persons cited wars or insurgencies, HIV/AIDS and other diseases that killed their adult children, thereby forcing them back into parenting the orphans left behind.

The above findings support the observations made by Satoto and Colletta (2007) and Smith et al. (2000) that older persons tend to take up the grand parenting role as a result of inevitable circumstances such as death of their children or sons/daughters-in-law. The findings suggest, too, that although older persons in either setting had many grandchildren under their care, those in rural areas looked after more grandchildren than their counterparts in urban areas. In either case, the findings suggest that older persons had a very big role to play. Parenting at least six orphans was no mean feat in any way. The findings therefore, concur with the observations made by Windsor et al. (2007) and Silumesi and Mubu (1999) that the parenting role taken up by older persons carries with it the enormous burden of providing for and taking care of many grandchildren, particularly orphans, becoming even more severe and sometimes depressing when the earning capacity wanes out. This was particularly articulated by the interviewed older persons when they were asked about the barriers that they encountered in the performance of this role.

Indeed, content analysis of their responses revealed that almost all (160) the interviewed older persons were barred by "Poverty leading to inability to meet the needs of large numbers of their household members most of whom were orphans". In addition, 109 of these people were limited by "Inadequate food to provide for the orphans' yet 99 showed that they were hampered by "Lack of school fees and scholastic requirements. Furthermore, 77 of these people showed that "Lack of medical care" hindered them from effective playing of their grand-parenting role while 55 noted that the problem was "Lack of clothing and beddings". Fifty older persons showed that "Inadequate physical strength to bring up the orphans in a well behaved manner" was the hindrance while 30 noted that their problem was "Lack of accommodation space". In addition, 9 older persons showed that "Government indifference to the plight of orphans" was also a hindrance while 19 noted that the barrier that they also faced was "Stress from the loud

noise constantly made by the large numbers of grandchildren". Similarly, some of the older persons showed that "Disrespectful/undisciplined grandchildren", "Small-size houses", "Ill heath of grandchildren and spouses", and "Death of spouses" constituted other problems that hampered them from playing their grand-parenting role.

Generally, findings on social roles at household level indicate that most of the older persons in Uganda are heads of households and are mainly playing the grand-parenting role by looking after at least six grandchildren most of whom are orphans left behind by their parents who died in wars, insurgencies, and of diseases such as HIV/AIDS. The findings indicate however, that most of the older persons are prevented from playing the role effectively by various barriers the most critical of which constitutes poverty. They therefore suggest that most of these persons have no economic capacity required to effectively play their social roles at household level. Consequently, the need to improve such capacity cannot be overemphasized, especially in the light of the many orphans under the care of older persons. A careful look at barriers above suggests that the need can be addressed through government abandoning its aloofness and making interventions in form of extending economic, health and housing support needed by these persons to adequately look after the orphans. And this can be achieved through introducing social security programs.

4.3 Social Roles Played by Uganda's older persons at Community Level

The community social roles that characterised the living experiences of the older persons in Uganda were established by asking key informants whether these people got involved either in any community activities or in decision-making positions in their respective communities. Findings appear in Figure 4.3.

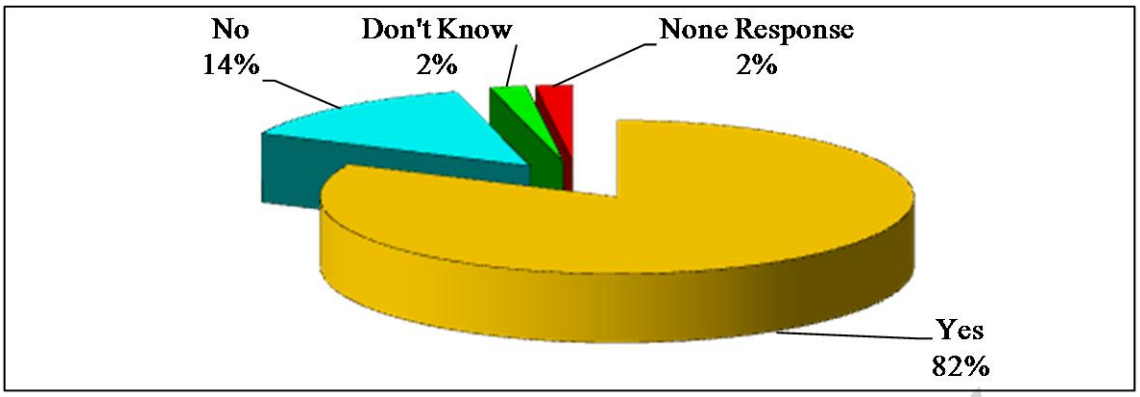


Figure 4.3: Responses of Key Informants on Uganda's Older persons Playing Social Roles at a Community Level (N = 41)

Figure 4.3 summarises the responses of the key informants on whether the older persons were involved in playing social roles, including decision-making in their respective communities/area. It indicates that while 82% of the key informants responded affirmatively, 14% replied negatively and 2% were either not sure or did not respond at all. These findings show that the majority of the key informants reported that the older persons participated in social roles at community level. To explore these roles, key informants were further asked to mention them. Findings are as shown in Figure 4.4.

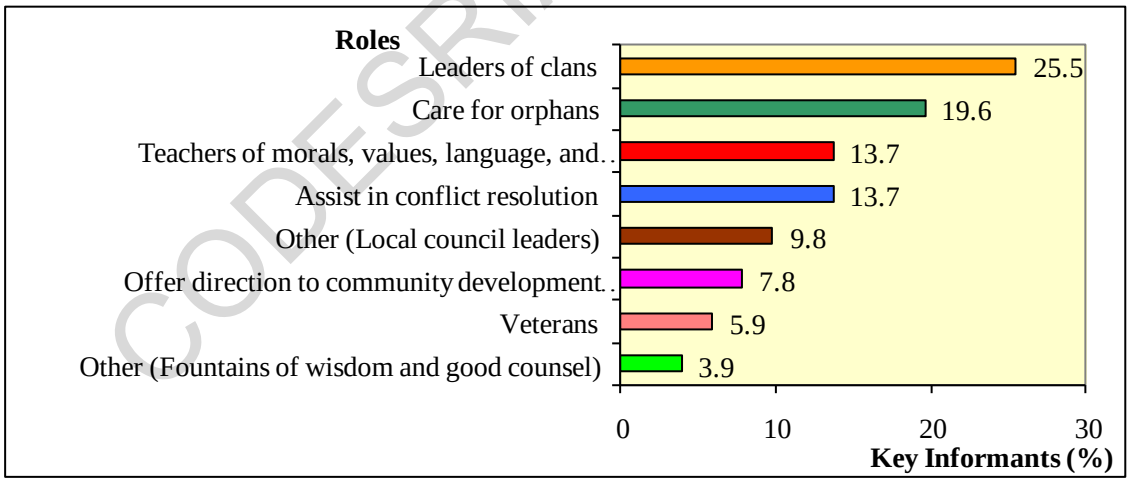


Figure 4.4 Community Roles Played by the older persons in Uganda as Reported by Key Informants (N = 41)

Note: N is 41 because nine key informants said no, did not know, or did not respond (see Figure 4.3)

Figure 4.4 represents a summary of the community roles that, according to key informants, characterised the living experiences of the older persons in Uganda. The

largest proportion of the key informants (25.5%) showed that older persons played a community role of being clan leaders while 19.6% indicated that these people cared for orphans. In addition, 13.7% showed that older persons served as teachers of morals, values, language and culture. The same proportion showed that older persons assisted in conflict resolution while 9.8% noted that they participated in community leadership as local council leaders. Other reported roles included: offering direction to community development initiatives (7.8%), serving as veterans (5.9%), and as fountains of wisdom and good counsel (3.9%).

Generally, the findings in Figure 4.4 show that to majority (82%) of the key informants, older persons in Uganda play various community roles, the most predominant of which involve clan leadership and caring for orphans. The latter role confirms what the older persons reported earlier on, only that they regarded it as a household role yet key informants perceived it as a community role. It is important to point out that older persons did not play these roles smoothly. They encountered a number of barriers along the way. This was established when key informants were asked to agree or disagree to a number of problems that tend to constrain older persons' participation in societal development activities. Findings are summarised in Table 4.4.

Table 4.4 Responses of Key Informants on Community Barriers to Older Persons' Participation in Development Activities in Uganda

	Responses					
	Agree		Disagree		Total	
Barriers	Count	%	Count	%	Count	%
Lack of technological skills	44	88.0	6	12.0	50	100.0
Perceived as big risks for the feasibility of credit (financial) programmes	46	92.0	4	8.0	50	100.0
Lack of access to education programmes	40	80.0	10	20.0	50	100.0
Regarded as the poorest in the society	26	52.0	24	48.0	50	100.0
Regarded as vulnerable to physical and psychological violence	25	50.0	25	50.0	50	100.0
Regarded as helpless and unproductive members of society	50	100.0	0	0.0	50	100.0
Lack of organised associations of the older persons	47	94.0	3	6.0	50	100.0
Lack of communication	33	66.0	17	34.0	50	100.0
Age discrimination	44	88.0	6	12.0	50	100.0
Average	**40**	**80.0**	**10**	**20.0**	**50**	**100.0**

On average, majority (80%) of the key informants agreed, thereby showing that all the community-based problems in Table 4.4 were barriers to the effective participation of Uganda's older persons in societal development activities. Note that the barrier to which all the key informants (100%) agreed was older persons being regarded as helpless and unproductive members of society. Other community-based barriers facing these persons were established when the key informants were asked to mention any other problems that these people faced in their respective communities. Results are shown in Figure 4.5.

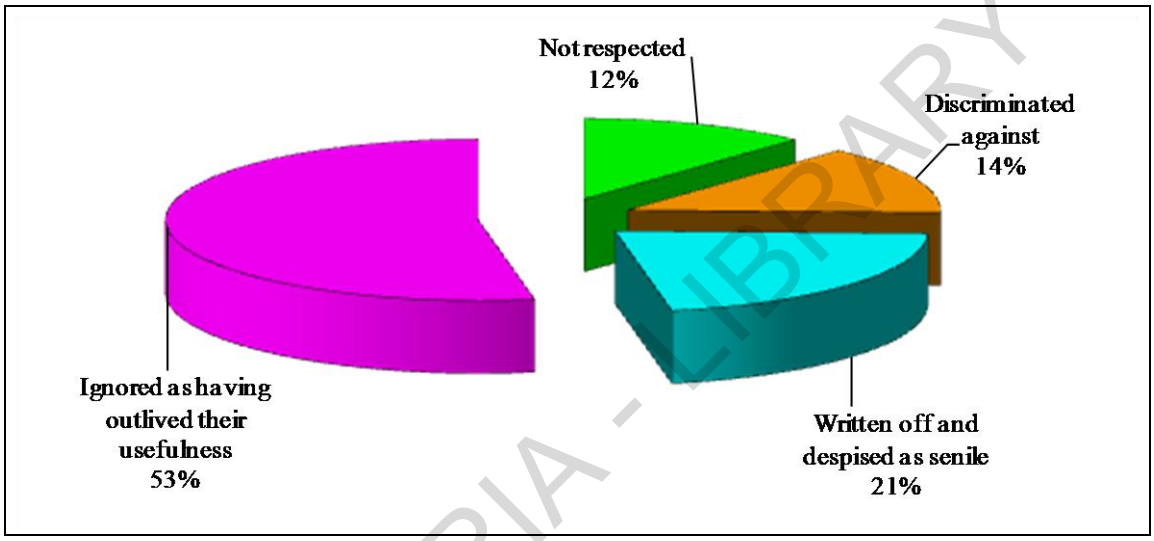


Figure 4.5: Community Barriers to Participation of the older persons in Society, as reported by key Informants

Figure 4.5 indicates that 53% of the key informants showed that the barrier that the older persons in Uganda faced constituted other community members ignoring them as people who had outlived their usefulness, 21% showed that the older persons were written off and despised as senile, 14% pointed out that the older persons were discriminated against, and 12% noted that other community members did not respect the older persons. These findings show that to most of the key informants, the main barrier that the older persons faced from their communities was to be ignored as people who had outlived their usefulness. To explore more about barriers to the participation of the older persons at community level, key informants were asked to describe the problems that the older persons faced in accessing community resources. Thematic and frequency analysis of the responses revealed that 84% of the key informants pointed out lack of education and

skills, 70% cited lack of access to finance, 68% cited lack of clothing, and 90% zeroed in on poverty as the main economic barriers facing the older persons.

Overall, findings indicate that the living experiences of most of the older persons in Uganda are largely characterised by playing household and community social roles. The experiences are however typified by low participation in leisure and social activities. The findings are therefore depicting two fold implications. In the first place, they indicate that most of the older persons in Uganda are very active in the area of executing social obligations of society, particularly at household and community levels. They participate in conflict resolution, transmitting experience and knowledge to the youths and adults; grand-parenting; and provision of care to members of their households. The findings are therefore consistent with the observations made by Kollapan (2008) and Anweng-Angura & Anyuru (1994) about the roles played by older persons in society. Playing these roles casts these people as a still very useful section of Uganda's society. This concurs with Kollapan's (2008) observation that older persons continue to play important roles in society in their advanced age notwithstanding.

Indeed, grand-parenting involves guiding grandchildren about how to be hardworking and instilling in them good behaviour and discipline. This is an important social role since it effectively means that the older persons in Uganda continue being resourceful participants in the process of maintaining a society of good citizens. In addition, serving as clan leaders and teachers of morals, values, language and culture, implies that these people participate in the transmission of cultural heritage, which is an important role as far as societal civilization is concerned. These people were also reported to be playing the roles of assisting in conflict resolution and community leadership as local council leaders. This implies that they are important in ensuring peace and harmony in society. Other identified community roles included offering direction to community development initiatives, serving as veterans as well as fountains of wisdom and good counsel. These roles imply that older persons are partners in the socioeconomic development process of Uganda. Consequently, the roles suggest that the older persons in Uganda are a still resourceful force that propels community development initiatives through provision of guidance and

direction to community leaders. Older persons therefore have to be respected and recognised as useful citizens. This boils down to the need to take community initiatives focusing on changing the perception that older people are a spent force that has outlived its usefulness.

It should be recalled from findings that the lives of most of Uganda's older persons are characterised more by execution of social roles than by active involvement in leisure and social activities. Therefore, the second implication of the findings is that the majority of older persons in Uganda carry out social obligations at the expense of their social leisure. In other words, most of the older persons in Uganda do not get enough time for leisure. Although conducting one's social roles is not bad in itself, doing so at the expense of one's time for leisure is not good, given its health implications. The World Health Organisation (2006) argued that older persons need to have enough time for recreational and social activities because these activities promote active ageing by optimising opportunities for health and enhancing the quality of life of older people.

Findings show that there are very few older persons who get such opportunities through participating in such leisure and social activities as conversing with grandchildren and spouses, visiting relatives and neighbours, going to church for prayers and choir practice, playing Omweso (local game), and drinking Ajono (local brew) with friends. Unfortunately, even these few older persons do not harness the opportunities efficiently. Their pattern of participation is irregular, low and limited to very few people. In general thus, findings point to the need to encourage more of the older persons in Uganda to appreciate the contribution of social leisure to maintaining a health and active life so that they can create time for it instead of spending all the time executing obligatory social roles.

By and large, the social perspective explored the living experiences of older persons in Uganda in terms of leisure and social activities as well as household and community social roles characterising these experiences. Findings indicate that most of the older persons play the role of heading households predominated by grand-parenting to the

extent that these people do not get time for leisure. The few older persons who create leisure time spend it walking around, checking on their crops, weaving mats and baskets, and reading the Bible among others. A few older persons who participate in social activities do so by conversing with grandchildren or spouses, guiding grandchildren about how to be hard-workers and instilling good behaviour and discipline in them. They also interact by visiting relatives and neighbours, going to church for prayers and choir practice, playing *omweso* (local bead game), and drinking *Ajono* (local brew) with friends. Findings indicate however, that older persons do not spend their leisure efficiently and the pattern of their social interaction is very irregular and therefore at a low level, especially in rural areas. They therefore do not optimise the benefits of active ageing. Effective execution of the grand-parenting role is critically constrained by poverty and therefore lack of resources. The findings therefore suggest that there is need to improve active ageing of Uganda's older persons by improving their participation in leisure and social activities, and empowering them economically so that they can get resources needed to care for their grand orphans.

4.4 Health Perspective of the Living Experiences of the older persons

The health perspective explored health conditions that characterised the living experiences of older persons in Uganda. In this perspective, the main concern was on understanding the health state of affairs that characterised the lives of the older persons in both rural and urban settings of Uganda in terms of the following dimensions: personal health status, nutrition, and knowledge and the impact of HIV/AIDS on the older persons. This was intended to provide policy designers with an empirical basis for formulating policies by which the lives of the older persons in Uganda could be improved. These dimensions are explained in the next sections.

a) Personal Health status of the older persons in Uganda

The general personal health status of Uganda's older persons was established through the interviews and focus group discussions held with them. Specifically, older persons were asked to describe their general health status in terms of how they felt at the time when they were being interviewed. Content analysis of their responses revealed that

their descriptions of how they felt formed a continuum ranging from 'well' through to 'not so well', 'sick,' to 'very sick'. The 'not so well' feeling described the general person health of almost all (144) of the older male and female persons interviewed in both rural and urban areas and across all regions of Uganda. This implies that the overwhelming majority of these persons were essentially not in good health.

Efforts made to establish the specific sickness that affected the health of individual older persons revealed that the following were the ailments: malaria, high blood pressure, joint pains, dental defects, loss of sight, short-sightedness, long-sightedness, paralysis of the limbs, diabetes, stomach pains, headache, cataracts, finger abscess, intestinal obstruction, heart problems, skin disease, asthma, tumours, chest pain, cough and flu, and HIV/AIDS. It was established that diabetes and ulcers affected mostly urban-based older persons while malaria and joint pains affected mainly those in rural areas. Other diseases affected older persons irrespective of where they lived. Thematic analysis revealed that the leading diseases were malaria, diabetes, joint pains and dental defects. Some of the older persons were affected by multiple illnesses as summarised in Chart 4:

Chart 4: Descriptions Showing Multiple Illnesses suffered by Older Persons in Uganda

"I worked for a long time as a farmer in Kawolo; so now whenever I sit down, I feel I don't want to stand up again. I have constant joint pains, I cannot hear very well, and my sight is not very clear, especially when the things are about five metres away" (Female, 100 years, Lira district).	"My major sicknesses include malaria and ulcers. Ulcers have disturbed me for years" (Female, 70 year, Kasana, Luweero district, central region).	"My sicknesses are many. I have joint and back pains, pressure, diabetes, and I often get malaria. A disease often attacks me and I fall unconscious on the ground, thereby losing my memory" (Male, 74 years, Nakawa, Kampala, central region).	"I have been suffering from the HIV/AIDS epidemic for over 8 years now since my husband died. This has worsened the high blood pressure and joint pains that I already had" (Female, 69 years, Jinja).

Key informants were also asked to describe the illnesses that they knew affected older persons in Uganda. Findings are reported in Table 4.5.

Table 4.5: Personal Illnesses of the older persons in Uganda as Reported by Key Informants

Illness	Count	%
Malaria	16	32.0
Chronic illnesses	6	12.0
Inadequate and poor feeding	6	12.0
HIV/AIDS	6	12.0
Old age	5	10.0
General body weakness	5	10.0
Depression	3	6.0
Sciatica/backaches	3	6.0
Total	50	100.0

Table 4.5 summarises the personal illnesses of the older persons in Uganda as reported by the key informants. The table indicates that of the various illnesses that affected the health of the older persons, malaria was reported by the largest proportion (32%), followed by HIV/AIDS, chronic illnesses and inadequate and poor feeding each of which was reported by 12% of the key informants. these findings confirm those obtained from older persons, which showed that malaria was the leading illness affecting their health.

The foregoing findings indicate that the older persons in Uganda suffer from various curable and chronic illnesses. The findings are therefore consistent with the observations made by Krulwich (2006), Deeg & Bath (2003), Paola (2003), and Hanahan & Weinberg (2000). Each of these scholars had discovered that most of the older persons tend to suffer from a number of diseases most of which tend to be chronic. A close comparison of the findings obtained from older persons and key informants revealed that the illness from which most of the older persons in Uganda suffered was malaria. This suggests that most of the older persons in Uganda suffer from preventable and curable diseases. Indeed, malaria is not only preventable but also curable.

Accordingly, the findings suggest that the quality of health of most of the older persons in Uganda can be easily improved by preventing, curing or eliminating malaria. This calls for developing health programmes which can be used to prevent, cure or eradicate malaria among Uganda's older persons. The programmes may include one focusing on

prevention of malaria by maintaining a clean environment, which is free of breeding grounds for plasmodium-carrying mosquitoes, bushes and stagnant water, and provision of mosquito nets to the older persons. Other programmes may include: promotion of health insurance and free access to screening, diagnosis and treatment of malaria. These programmes are particularly needed in the light of the barriers that prevented older persons from accessing healthcare.

Indeed, qualitative analysis of the interview responses obtained from older persons on whether they encountered any barriers in their attempts to seek treatment of the sicknesses that affected their health revealed a number of barriers. Eighty older persons showed that the "Long distances to that they had to walk to the health centres" constituted a major hindrance. Fifty noted that the problem that faced was about "Inadequacy or absence of health workers at the health centres when needed"; yet 55 of these persons showed that "Health workers' aloofness and lack of respect for the older persons" was a major problem to accessing healthcare services. In addition, 35 of the older persons showed that "Bribery and corruption at health centres" hindered their access to the needed healthcare services. In the way same, 33 of the older persons showed that "Inadequate diagnosis from health workers" and "Lack of medicine and drugs at health centres" hampered their access to the health services. Twenty four older persons showed that the problem was "Inadequate hospital beds" while sixty of them cited "Over-waiting in long patient queues" as the main problem. Furthermore, 89 elderly persons indicated that they failed to access the services because of "Unaffordable medical costs" while 18 pointed out "Inadequate space for inpatients admitted at health centres/hospitals" the hindrance.

The barriers identified by the older persons are consistent with those appearing in the scholarly work of Kanyamurwa (2008a), Kanyemibwa (2007), Najjumba-Mulindwa (2004), HelpAge International (2001), McGarry (1996), and Coe (1985). Qualitative analysis of the barriers according to settings revealed that aloofness and rudeness of health workers, lack of drugs, and lack of money prevented older persons across the rural and urban areas in all the regions of Uganda from accessing healthcare. However, other barriers such as lack of medicine and drugs at the health centres featured more

prominently in urban areas while others like long distances to health centres were more outstanding in rural areas.

Generally, as Kanyamurwa (2008a) and Kanyemibwa (2007) observed, the barriers suggest that the provision of health services needed by older persons has largely gone to the dogs in Uganda. The lack or inadequacy of all the healthcare resources mentioned above implies that the older persons cannot receive the medical treatment, physiotherapy, psychological therapy and other forms of curative and preventive services needed to sustain themselves in good health. The situation is worsened by the fact that some older persons fail to access the healthcare services due to long distances while those who manage to access the services find it difficult to pay for the services due to the high cost of the services. There is therefore need for government to fulfil its obligation of providing free healthcare services and bringing them nearer to the older persons.

Another implication of the barriers is that the rights of the older persons are infringed upon by health workers. According to Kollapan (2008), the older persons are entitled to being respected and cared for by other members of society. This is also recognised in many international conventions and national constitutions, including the Constitution of Uganda (1995); the 1982 Vienna International Plan of Action on Ageing; the 1991 United Nations Principles for Older Persons that were reinforced in 2002 through the Madrid International Plan of Action on Ageing at the global level; and the African Union Policy Framework; and Plan of Action on Ageing at the regional level. By not respecting the older persons; remaining aloof to them when they come to health centres; and keeping them waiting in long patient queues, the health workers are in effect violating the rights of these people in Uganda. Therefore, there is need to make health workers appreciate that they need to respect and care for the older persons whenever they come for health services.

Another implication of the barriers is that health workers demonstrate the highest level of lack of commitment to their work. This is evidenced in their unavailability at health centres whenever the older persons need them. It is also reflected in the fact that when the

older persons manage to get these workers, they either administer inadequate diagnosis or demonstrate corruption and bribery tendencies in form of demanding for money before attending to them. Administering inadequate diagnosis implies that health workers do not identify the exact diseases affecting the health of older persons. This exposes the older persons to far reaching risks, including wrong diagnosis and therefore prescription and administration of wrong medical care. This leads to deteriorating the already fragile health situation of older persons. On the other hand even the essential drugs that are needed most by the older persons are missing in most of the health centres and hospitals hence most of them do not get the required right drugs for their health conditions and it is often substituted by simple pain killers such as paracetamol which may be inadequate in curing their diseases.

Consequently, the healthcare programmes older persons need have to focus on dealing with the barriers to these peoples healthcare. A critical look at these barriers suggests that the content and purpose of the needed healthcare programmes should focus on specialised training of health personnel in the management and treatment of older persons (Geriatrics and gerontology) so that they can adequately take care of older person's healthcare needs just as paediatricians handle children. Health workers also need to be trained in ethics and integrity in how to relate with older persons and to pay them a living wage which will motivate them to work better. This can help to eliminate the arrogance, aloofness and corrupt tendencies of these workers. In fact, demanding bribes from the already economically distressed older persons is like denying them access to healthcare. The programmes need to also focus on establishing more health centres in rural areas so as to reduce the distances walked by these people; and equipping all health centres with adequate essential medicines and healthcare equipment required to treat malaria and other diseases affecting the health of older persons in Uganda. Previously the essential drugs for older persons were not even included on the essential drug list that is provided by the minimum healthcare package that is provided by government until when advocacy was done to include such drugs on the list so that these drugs could be sent to health centres at village level so that they could be given to older persons. Unfortunately this is still in paper form and it is yet to be implemented.

b) Nutrition and Food Security

Exploring the kind of nutrition that characterised the living conditions of the older persons in Uganda focused on establishing the varieties of food on which these people fed, the number of meals eaten per day, the means used to get food, and the adequacy of food available to these people throughout the year. Regarding the varieties of food, older persons were asked about the various types of foods on which they fed. Thematic analysis of the responses revealed the following as the food varieties: matooke (plantains), maize (posho and porridge), potatoes, Irish potatoes, cassava, beans, rice, groundnuts, yams, and dodo and ntula (greens). Further analysis revealed that while the food varieties on which most of the urban-based older persons fed included maize, cassava and beans, those on which most of the rural-based older persons fed consisted of millet and plantains and groundnuts. Very few older persons indicated that they fed on many food varieties. In particular, one of these persons had this to say:

> "The type of food is entirely dependent on the area where one lives, but in this area the most common food is Matooke (plantain). I then add fruits like pumpkin, pawpaw, orange, etc"
>
> Female, 70 years, Nakawa, Kampala, central region.

Generally, these findings suggest that the nutrition of most of the older persons in Uganda is dominated by foods largely rich in starch, water and proteins. This supports the findings of Shils et al. (2005, 1999) and Help Age International (2004b) that show that most people tend to take diets that are rich only in carbohydrates, water and proteins. Although such food intake is necessary for keeping the body in good health, it is not sufficient enough given that it does not represent a balanced diet. A close scrutiny reveals that most of the older persons miss out on vitamins, minerals, and fats, which according to Sissel (2003), Stipanuk (2000) and Summerbell (1994), are also part and parcel of a recommended balanced diet. It is therefore not surprising that the health experiences of some of Uganda's older persons are characteristic of suffering from diseases such as cough and flu which can be curtailed by taking vitamin-rich foods. It is also not surprising that some of these people suffer from joint pains since they do not take fats (or oil-rich foods) from which body lubricants are generated.

Asked about the number of meals that they ate per day, most of the urban older persons showed that they ate at most two meals per day with some eating only one meal. However, most of the rural older persons ate at least two meals per day. Therefore, the number of meals taken by the majority of the older persons in urban areas was far less than the expected minimum of three meals per day, that is, breakfast, lunch and supper.

Further attempts were made to explore what the older persons ate at breakfast, lunch, dinner or supper. This involved asking them about what they normally ate at each of these meals. Content analysis of their responses revealed that for breakfast, the older persons had dry or milk tea, coffee, bread, cassava, porridge, millet porridge, yams, or maize porridge. A close analysis showed that the food contents of breakfast for most of the older persons did not differ across settings. Most of them had breakfast made up of maize/millet porridge. Very few older persons took milk at breakfast, implying that breakfast for all the older persons in either setting was mainly composed of starch foods and water.

Regarding lunch, the contents of food that the older persons reportedly ate in either settings included peas, plantain, cassava, millet, milk, ghee, posho, beans, groundnuts, and fish. As far as supper was concerned, the older persons indicated that the contents of food eaten consisted of peas, plantain, cassava, millet, milk, ghee, posho, beans, groundnuts, and a few of them had fish. A comparative analytical look at the food contents that made up the lunch and supper of the older persons reveals that they were the same consisting mostly of posho, plantain, millet, and beans. This confirms the earlier findings, which revealed that maize, millet, plantain, and beans were the leading food contents in the nutrition of the older persons in Uganda.

The foregoing findings indicate that the food and nutrition conditions of older persons in Uganda are characterized by taking less than the standard number of meals per day. Most of these people eat two meals per day, with some, especially those in urban settings eating only one meal. This is inline with findings reported by Bagala (2007). Moreover,

the meals are made up of the same food varieties; for findings show that the food varieties eaten at lunch are the same varieties eaten at supper. This indicates that the diets observed by most of Uganda's older persons are unbalanced and monotonous. Such a situation depicts a high level of poor nutrition, which increases the vulnerability of these people to disease.

To establish their food security, the older persons were asked whether food available to them throughout the year was adequate. While most of the older persons in rural areas responded affirmatively, the majority of the urban-based older persons responded negatively. This implies that most of the urban-based older persons did not have adequate food security. It was further discovered that although most of the rural-based elderly people responded affirmatively, those in northern and eastern Uganda responded in much the same way as the urban-based elder persons. Accordingly, the findings give an impression that most of the older persons did not have enough food throughout the year. The findings suggest therefore that older persons did not have enough food security. The findings are thus consistent with the study of Kanyamurwa (2008a) that showed that there is food insecurity in Uganda.

Inadequate food security implies that older persons do not have enough food to eat, let alone balance their diets. No wonder most of them eat less than the standard number of meals per day. It is also not surprising that they feed on monotonous diets, thereby exposing themselves to all the negative health consequences of poor nutrition. There is therefore need to ensure that the older persons in Uganda have enough food security. The desired improvements can be realised by addressing the barriers encountered by these people in their efforts to ensure adequate food and nutrition.

When older persons were asked why they did not have enough food throughout the year, 19 of them cited "Loss of gardens due to illegal land evictions by people who buy land from landlords without informing squatters." 15 of them showed that the problem was "Lack of land on which to grow food while seven older persons cited "Land conflicts by family members discourage cultivation". In addition, 55 older persons noted that they were hampered by the

"Declining soil fertility leading to inadequate food output" while 16 of them faced the problem of "Pests". Sixty of these people were constrained by "Rudimentary farming methods" while 56 of them cited "Wars, insurgencies, and drought, especially in northern and eastern Uganda. furthermore, "Environmental degradation" was another problem that hampered these people from growing enough food. Other cited limitations included: Floods (11), Lack of storage facilities (15), Poverty (66), and lack of seeds (19).

The qualitative analysis of the above barriers according to settings revealed that the barrier that most of the urban-based older persons pointed out was poverty yet the barriers pointed out by most of the rural-based older persons included environmental degradation and insurgencies. Generally, while some of the identified barriers such as floods are natural disasters which may not be easy to control, others can be controlled, thereby helping to improve the food and nutrition security of older persons in Uganda. Indeed, landlessness can be controlled through legislation and government resettling of evicted people on public land. Peace can be restored through round table discussions and negotiations between government and warring factions. The failure to store food can be addressed either by building stores and granaries for the older farmers; encouraging food processing industries; or expanding food markets as means of converting the would-be wasted food during harvests to liquidity which can be kept and used to buy food during other seasons. While, others did not even have seeds to plant these could be given to them directly to plant so that they could have food.

To recap, the food and nutrition conditions characterising the living experiences of the older persons in Uganda include feeding on food varieties spanning over bananas, maize, potatoes, cassava, beans, rice, groundnuts, yams, and greens. However, most of the older persons eat maize, beans, millet, and bananas. They therefore feed on unbalanced and monotonous food varieties that are rich in starch, water and proteins but deficient in vitamins, minerals and fats. The number of meals that older persons eat per day is less than the three standard meals. Most of older persons eat at most two meals per day with some, especially in urban settings eating only one meal. Breakfast of most of the older persons consisted largely of maize and millet porridge. Most of these people

especially those in urban areas do not have adequate food security throughout the year due to poverty and environmental degradation.

c) Knowledge and Impact of HIV/AIDS

Given the prevalence of HIV/AIDS in the world today and the fact that it affects all members of society irrespective of their chronological age, it was deemed appropriate to explore the living experiences of the older persons. This involved probing into these people's knowledge about HIV/AIDS and the impact that it had inflicted on their lives.

To establish the knowledge that older persons in Uganda had about HIV/AIDS, they were asked about whether they had heard about this disease. Their responses indicated that all of them had heard about the epidemic. They were then asked how they got the information about the disease. Their responses indicated that they got the information through the following means and channels: radio, television, the press (newspapers, magazines and tabloids), teachers, friends/colleagues, books on HIV/AIDS, health workers, personal initiatives, and the grapevine. The analysis revealed that most of the older persons in all regions of Uganda and across the rural and urban settings got the knowledge about HIV/AIDS over the radio and from health workers. This supports the study of Kanyemibwa (2007) that showed that most people in Uganda get HIV/AIDS-related information by listening to radio stations. It also suggests that although there are many sources of HIV/AIDS knowledge, radio stations are the commonest source used by older persons in Uganda.

To establish the impact of HIV/AIDS on the older persons, they were asked to describe how the pandemic had affected them and their families. The most revealing verbatim responses are summarised in Chart 5:

Chart 5: Descriptions of the Impact of HIV/AIDS on Older Persons in Uganda

"I have orphaned grandchildren whose parents died from AIDS. One was taken away and I have remained with one who now has dropped out of school in senior four due to lack of money to support her" (Female, 60 years, Nakawa, Kampala).	"AIDS has greatly affected my home because the father of my children, plus some children died. I am also infected and on ARVs. I still have to work for my children, educate and feed them" (Male, 61 years, Pallisa, Eastern Uganda).	"AIDS has affected my family because I lost one child and I have orphans. Because of AIDS, my grandchildren and I are suffering. I cannot provide the optimum support for them. I used to stay with them but when I could not manage to provide food, relatives from their father's family took them away." (Female, 60 years, Kawempe, Kampala).	"AIDS has greatly affected my home because all the children I had died. In fact the last daughter has just been buried four months ago; including my brother's children and now I am on my own. Sometimes I go to bed and I can't help it but to wonder how HIV/AIDS came to take away my children and leave me for nothing in life. I get traumatized sometimes" (Female, 69 years, Nebbi, Northern Uganda).

Chart 5 shows that HIV/AIDS affected older persons in Uganda by killing their adult children, thereby creating a burden of looking after an enormous number of orphaned grandchildren. These findings indicate twofold implications. First of all, the loss of a child is a big blow not only because most parents naturally find it difficult to come to terms with it but also because they look to their children as sources of support and care when they enter advanced age. Losing children thus comes with adverse effects on the survival of the older persons, especially in Africa where, according to Kollapan (2008); Knodel, Saengtienchai, Wassana and Vanlandingham (2007) and WHO, (2002c) most of them depend on their children. By killing some or all the children of some older persons in Uganda, HIV/AIDS effectively renders these people hopeless as they remain with no one to turn to for care and support. This explains why some of the older persons reached the extent of perceiving themselves as living by the grace of God.

Secondly, HIV/AIDS alarmed older persons in Uganda by creating an enormous burden of looking after a big number of orphans left behind by those it killed. The thought of having an enormous burden of looking after a large number of orphans when the older persons cannot even fend for themselves is not only overwhelming but also humbling at the same time. It shows the highest level of helplessness and despair, which, if not

urgently addressed, can easily plunge the older persons into trauma, depression or any other forms of extreme psychological stress. In spite of that, the young people are not willing to take care for HIV/AIDS relatives (Atekyereza & Kirumira, 2004). This explains why key informants showed that some older persons in Uganda suffer from depression.

Other impacts identified by other older persons included HIV/AIDS claiming the life of their spouses, killing their grandchildren, infecting the older persons themselves, bringing many sicknesses to the older persons, thereby weakening them, and increasing their faith in God. These findings are consistent with the studies of Knodel et al. (2007), Mall (2005), Kakooza (2004), Loewenson (2004), Barnett and Whiteside (2002), Best (2002), Ainsworth and Dayton (2000), Rugalema (1999) and Baden and Wach (1998). Indeed, many of these impacts appear in the findings of each of these studies. As Knodel et al. (2007), these impacts suggest that not only has the personal health of many older people been adversely affected. HIV/AIDS has also brought these people both social and economic costs.

The situation becomes worse when the older persons are the ones who are infected. They get traumatized and feel out of place, especially when there are no special HIV/AIDS programmes for them. And this was the case. Indeed, when older persons were asked about any other challenges they are facing as a result of HIV/AIDS, a number of them noted that they lacked programmes addressing their HIV/AIDS-related problems in an age-friendly manner and this stigmatised some of them. Stigma according to (Goffman, 1996) is defined as an undesirable or discrediting attribute that an individual possesses that reduces that individual's status in the society. It is also a common human reaction to disease. Throughout history many diseases have carried considerable stigma, including leprosy, tuberculosis, cancer, mental illness, and many STDs. HIV/AIDS is only the latest disease to be stigmatized. It presents in two forms Internal (self) e.g. blaming oneself, not associating with others, self neglect etc. and External stigma e.g. other people not wanting to associate with the person. Stigma and discrimination relating to HIV/AIDS (AIDS stigma) undermines public health efforts to combat the epidemic. AIDS stigma

negatively affects preventive behaviors such as condom use, HIV test-seeking behavior, and care-seeking behavior upon diagnosis, quality of care given to HIV-positive patients, and perception and treatment of PLHA by communities, families, and partners. Atekyereza & Kirumira (2004) advised that controlling stigma is very critical in controlling HIV/AIDS infection, which implies that if the trauma felt by the infected older persons is not addressed through administering proper treatment, they are likely to get worse. There is therefore need to develop healthcare programmes that give older persons priority when they go for treatment as pointed out in the Declaration on commitment on HIV/AIDS (United Nations, 2001).

Generally, the foregoing results suggest that HIV/AIDS killed some or all of the children of most the older persons and their spouses, thereby leaving most of them with the burden to care for orphans. Further analysis revealed that the intensity of the impact differed across settings. While impact of HIV/AIDS on most of the urban-based older persons was to kill their children, that on most of the rural-based older persons was to leave them with the burden of orphans, while others lacked even what to eat as they could not access food easily.

4.5 The Housing Perspective

People's housing conditions reveal a lot about their living experiences. The housing conditions of the older persons in Uganda were thus explored based on this premise. Most of the rural-based older persons owned the houses in which they lived while most of the urban-based older persons did not. When older persons were asked to describe the houses that they occupied, the thematic analysis of their responses showed that these people lived in various types of houses. Most of the rural-based older persons lived in small grass thatched, mud and wattle huts or houses. Most of those in urban areas lived in small mud houses roofed with old and leaking iron sheets. Very few older persons lived in small concrete houses roofed with iron sheets and very few older persons lived in concrete bungalow houses roofed with tiles/iron sheets. These findings suggest that the housing conditions of most of the older persons in Uganda were generally poor characterised by weak and small housing structures.

With the intention of exploring the in-space of older persons' houses, they were asked about the number of people with whom they shared their respective houses. Findings indicated that while the number of the people ranged between one and twenty one, many of the older persons lived with between 11 and 15 people (grandchildren). These findings suggest that most of the older persons shared a house with at least eleven people. Given the small-size huts and houses that they had, this was a big number that points to squeezed accommodation space within the houses. The findings therefore support the study of Phillips (1988) that indicated that most of the older people in Brazil live in housing units characterised by weak wall and roofing structures as well as in-house space, which is below the minimum requirements per person. As Phillips (1988) observed, such housing conditions are below the minimum requirements and therefore need to be improved.

Being perceived as small implies that most of them do not have enough space. This explains why they were said to offer poor and substandard accommodation conditions. This is even worsened by the fact that the houses were reported to be accommodating large numbers of people who mostly include grandchildren ranging from 11 to 20. They therefore are able to offer much squeezed accommodation space. Coupled with poor ventilation, such accommodation cannot escape conditions of poor aeration and therefore suffocation of those dwelling in the houses. To make matters worse, most of the older persons showed that they do not have the desired beddings. This implies that the beds, mattresses, blankets, bed sheets and general sleeping conditions of the older persons were below their expectations. The results further indicate that the fore-discussed substandard housing and accommodation conditions were more pronounced in urban than rural areas of Uganda, implying that the urban older persons were more exposed to poor housing and accommodation than their rural counterparts. This could probably be due to resource constraints since majority of them could only afford to rent cheaper houses which are even in poor locations in terms of security, access to safe water and good sanitation.

In addition to exploring the housing conditions of older persons, attempts were made to find out whether these people would have wished to be accommodated in homes for the

aged. The attempts involved asking these people whether they preferred to live alone, with a relative, or in an old age home. The majority (125) of the older persons, particularly those in rural areas preferred to live with their relatives. Very few (14) of those in urban areas did not mind living in homes for the older persons. This implies that they are attitudinally not ready to live in old age homes. Instead, they prefer living in their own houses with their kin who may include mostly their grandchildren, relatives, in-laws, tenants, spouses, or friends. These findings suggest that building old age homes may not be one of the solutions to the poor housing conditions in which most of the older persons in Uganda live. However there are few who are homeless and the destitute who may not mind living in old age homes.

Further efforts were made to explore the barriers to proper housing of older persons in Uganda. The efforts involved asking these people whether they had any constraints as far as their accommodation was concerned. The majority (124) responded affirmatively, implying that most of the older persons witnessed housing and accommodation problems. When the older persons were asked to describe the barriers they faced regarding accommodation, the content analysis of their responses led to identification of the following as the barriers: poverty, poor surrounding environmental health, land evictions, and lack of electricity. Accordingly, any improvements in the housing and accommodation of older persons in Uganda need to focus on finding solutions to these barriers.

Generally, findings indicate that most of the older persons in Uganda own and live in poor housing and accommodation conditions characterised by small weak-walled grass thatched mud huts or leaking iron-roofed houses occupied by large numbers of people who mostly include grandchildren. Most of the older persons prefer to live with their relatives to living in old age homes. Findings indicate that the housing conditions of these people are constrained by a number of barriers, which include: poverty, poor surrounding environmental health, land evictions, and lack of electricity. The findings suggest therefore that any improvements in the housing and accommodation of older persons in Uganda need to focus on finding solutions to these barriers.

4.6 The Water Supply and Sanitation Perspective

In this perspective, the focus was on exploring and ascertaining the water supply and sanitation conditions that characterised the living experiences of the older persons.

a) Water Supply

As far as water supply was concerned, the older persons were asked to describe the sources of the water that they used in their households. The analysis of the responses revealed that these sources included unprotected and protected springs, permanent rivers, temporary streams, boreholes, dams or ponds and piped tap water. However, the majority (109) of older persons indicated that they drew water from unprotected springs and wells. However, while most of the urban older persons drew their water from protected springs, the majority of the rural older persons fetched it from unprotected springs. These findings suggest that the urban older persons used relatively better water than their rural counterparts. Notwithstanding the relative difference, the findings indicate that in general the water supply conditions of most of Uganda's older persons are substandard and generally poor. Results therefore support the findings of Kanyamurwa (2008a; 2008b) and Cox and Mberia (1977) that most of the people living in Africa, especially in rural areas, contend with substandard water supply conditions.

The substandard water supply conditions are mostly witnessed by rural older persons because unprotected springs are exposed to all sorts of contamination ranging from human, animal and bird waste products and droplets as well as decomposing matter. Water from these springs is therefore basically contaminated and not good for human consumption. It only serves to expose those who use it to water borne diseases. It is even unfortunate that most of these people consume it when it is not boiled; for this exposes them to a high risk of catching these diseases. It is therefore important that the condition of water supply available to most of the older persons is improved so as to avoid such likely adverse health consequences.

For purposes of establishing the barriers to water supply for the older persons, these people were asked to describe how far the nearest source of water was from their households. Content analysis of the responses indicated that majority (61) of the urban-

based older persons covered a distance of less than one kilometre to fetch their water. However, most (104) of the older persons of whom the majority are rural-based older persons covered a distance of between one and three kilometres. This shows that the rural older persons had to cover far longer distances to fetch water compared to their urban counterparts. Although covering such distances may carry with it some advantages in terms of enhancing physical fitness, it tends to be straining, especially when it comes to people in advanced age. Besides, the intention of covering the distances is essentially not to become physically fit.

It is therefore not the suitable form of keeping physical fitness for the older persons. Fetching water was therefore relatively burdensome to the rural older persons. It is thus important that the distances covered by these people to fetch water are reduced by bringing the water supply sources nearer either through digging more boreholes or extending piped water supply lines to rural areas. In any case, the PEAP (2004) policy indicates that it is a goal of government to allocate water to every district so as to reach the same level of coverage in both rural and urban in 2015. Right now the water coverage in urban areas is 60-65% but it is still far less in rural areas. Achieving this target in rural areas requires more government effort.

b) Sanitation

The sanitation conditions that characterised the living experiences of older persons were explored at two levels: the household and the general environment level. As far as the household level sanitation was concerned, older persons were asked to describe the hygienic conditions of their homesteads. The thematic analysis of their responses showed that the majority (139) of them, especially those based in urban areas lived in unhygienic housing conditions characterised by poor toiletry facilities and dirty inside and outside walls. Very few (5) older people, especially those in urban areas had flash toilets but the majority had pit latrines. There were even older persons who did not have toilets, especially in the rural areas of northern and eastern Uganda. Those who had toilets or pit latrines were asked to describe the general cleanliness of these facilities. Only a few (72), most of whom were rural-based, showed that their toilets were clean. The other older persons (93), most of whom were urban-based, were either uncertain

about the cleanliness of their toilets or frantically showed that the facilities were dirty. This implies that most of the older persons' toilets were dirty. A similar response pattern was obtained when the older persons were asked to describe the cleanliness of the bathrooms in their households.

To establish why toilet and bathroom facilities were generally dirty for most of the older persons, they were asked whether they shared the facilities or not. Most of them, the majority being urban-based, responded affirmatively. Asked about the number of households with whom they shared the facilities, many older persons (107) showed that the number was at least four households. This explains why most of the older persons had dirty toiletry facilities. If these facilities are shared amongst many households, they tend to be difficult to maintain as clean as desired.

Regarding the general environment level, the focus was on ascertaining the nature of the environmental health which characterised the surroundings of the older persons' homesteads. The older persons were asked to describe the hygienic conditions surrounding their houses. Only a few older persons (74) most of whom were rural-based described these conditions as hygienically good. Others, mainly from urban areas, showed that the conditions were below the desired hygienic levels. In fact, most of the urban-based described their sanitation conditions as dirty, stuffy and heavily polluted with noise and pungent atmosphere. Observation revealed that most of the urban-based older persons were surrounded by filthy and smelly neighbourhoods typified by poor and heavily polluted drainage systems. They lived in slum-like conditions.

These findings show that most of the older persons in Uganda, especially those in urban areas live in poor homestead conditions. These conditions expose older persons to various air and water borne diseases as well as STDs. These diseases can only be prevented by improving the hygiene of the toiletry facilities and their surroundings. The findings also show that the sanitation experiences of the older persons, particularly those living in urban areas characterised by poor and slummy environmental health conditions. They imply that little attention is given to waste management and drainage maintenance. In

fact, only eight percent of the population in urban areas can access piped sewerage (PEAP, 2004). The rest of the population uses inbuilt system or uses latrines and some dispose off the refuse carelessly in polythene bags in compounds, roads or bush. Such sanitation conditions are a recipe for disaster because they are fertile grounds for various diseases such as flu, cough, cholera and others associated with dirty and filthy environmental health. There is therefore need to improve the environmental health surrounding the households of most of the older persons, especially those living in urban areas of Uganda.

CHAPTER FIVE

COPING MECHANISMS USED BY UGANDA'S OLDER PERSONS TO DEAL WITH ENCOUNTERED BARRIERS

5.0 Overview

The third objective of the study was to explore the coping mechanisms used by older persons in Uganda to cope with the barriers hindering their effective participation in society. This chapter is to present, interpret and discuss the findings obtained in response to this objective. The presented mechanisms were established by administering interviews and focus group discussions to the older persons as well as questionnaires to the key informants. They were identified at personal, household and community levels.

5.1 Mechanisms to Cope with Barriers Encountered at Personal Level

The content analysis of the data collected from the interviews and focus group discussions held with the older persons indicated that these persons dealt with barriers which they encountered at individual level using a number of coping mechanisms summarised in Chart 6.

Chart 6: Mechanisms used by Older Persons in Uganda to Cope with Barriers Faced at Personal Level

Mechanisms to Cope with Physical Fitness Barriers

- Digging
- Walking around
- Cleaning house
- Cleaning compound
- Dancing
- Running or jogging
- Playing with grandchildren
- Moving with cattle uphill every morning
- Riding a bicycle
- Picking food from the farm
- Fetching water
- Going to health clubs for physical exercises

Mechanisms to cope with healthcare barriers

- Going to health centres
- Going to nearest private clinics or dispensaries
- Visiting traditional healers/herbalists
- Getting herbs from wilderness/garden
- self medication (using herbs or medicine bought from pharmacies)
- Praying to God for healing,
- Sending for personal doctors to come home and provide the necessary treatment.

Mechanisms to cope with HIV/AIDS Impacts

- Growing much food to feed orphans
- Using ARVs
- Joining HIV/AIDS associations/clubs
- Surrendering to Jesus
- Appealing to good Samaritans for help
- Telling children to send assistance
- Going for counselling to avert the trauma
- Advising the children and grandchildren on how to prevent HIV/AIDS

Mechanisms to cope with economic barriers

- Persistence and patience with pension officials
- Appealing to churches, pastors and good Samaritans
- Digging/cultivation
- Assistance from children
- Engaging in roadside selling of farm produce
- Operating a small retail shop
- Selling land
- Selling livestock products (milk)
- Collecting rent from commercial houses
- Cleaning roads/markets at a fee
- Selling self-written poems and story books
- Making and selling local brew
- Making and selling mats and baskets
- Rearing and selling poultry.

Chart 6 summarises the various mechanisms used by older persons in Uganda to deal with the barriers that they encountered at a personal level. The analysis of the mechanisms according to settings revealed that most of the older persons in rural areas coped with physical fitness and economic barriers as well as the impacts of HIV/AIDS through cultivation. Most of them dealt with the health barriers by looking for local herbs from bushes or sending children to get the herbs or going to traditional healers or herbalists. However, older persons in urban areas coped with economic barriers and impacts of HIV/AIDS by appealing to churches, pastors and good Samaritans such as PLAN International that helps educate many orphans from primary to senior four. They also coped with health barriers through self medication and with physical fitness barriers through walking around. Relatively few older persons sought healthcare services from government health centres/hospitals and most of those who went to these centres did not get deserved treatment from health workers as a result they proposed government/non-governmental organisations to provide older people friendly services.

It is imperative to note that the coping mechanisms for physical fitness were sometimes carried out for purposes of improving the health of older persons. Similarly, some of the healthcare and economic mechanisms helped some older persons to deal with the impacts of HIV/AIDS. The coping mechanism that most of the older persons opted for to deal with the impact of HIV/AIDS was to grow as much food as they could so as to feed the orphans left behind by the people killed by HIV/AIDS.

To establish whether the older persons knew that the physical activities in which they were involved were coping mechanisms used to deal with barriers to their physical health, they were asked to mention the physical health-related benefits that they derived from the activities. The thematic analysis of their responses led to identifying; keeping the body healthy, gaining energy and strength, getting to feel good, keeping good memory, maintaining body resistance or immunity, avoiding costs on diseases that attack weak bodies, and getting food, as the benefits of physical activity.

However, most of the rural and urban older persons showed that the benefit of digging was more about getting food than physical fitness. This suggests that physical fitness was an indirect benefit to all the older persons who carried out cultivation. In fact, whereas there were some urban older persons who carried out physical activities for purposes of purely keeping physically fit and healthy, all the rural-based older persons realised this benefit in a rather indirect way. Incidentally, all older persons were aware that physical fitness was a way of keeping strong so as to avoid the costs of treating diseases that attack weak bodies. This was properly articulated by one of them as shown below.

> "I dig not so much because I want to keep physically healthy. This comes as a secondary benefit. My digging is mainly intended to help produce food we need to survive as a family. It is however a form of hard work which helps me to avoid sicknesses and body weaknesses by keeping my body strong" (Female, 62 years, Kibaare, Ntugamo district, western Uganda).

Female, 62 years, Kibaare, Ntugamo district, western Uganda

Most of the older persons were also aware that doing physical activities enabled them to improve their memory and to control the effects of diabetes. Notwithstanding their awareness of the benefits of physical exercises, it was ascertained that older persons in the urban areas depicted a very irregular pattern of getting involved in these activities. Those in the rural registered a regular pattern because they often went for cultivation. The content analysis of their responses revealed that the older persons were not regularly involved in the activities as they only carried them out sometimes. Generally therefore, although many older people were involved in various physical activities, their irregular involvement in the activities partly explains why many of them suffered from at least an illness.

When the older persons were asked to mention the source from which they got to know about the coping mechanisms that they used to deal with barriers to their physical fitness, the content analysis of their responses led to identification of the following as the sources: personal initiative, radio stations, television stations, the press, the grapevine through friends or colleagues, teachers, health workers, personal experience accumulated since childhood. A comparative content analysis of the responses showed that most of the older

persons, especially those in rural areas, got the information from their personal childhood experiences.

To understand more about the coping mechanisms used by the older persons in Uganda, key informants were also asked about how these people coped with health barriers to their effective participation in society. In particular, key informants were asked to describe the mechanisms that the older persons employed to address their illnesses. The results are shown in Figure 5.1.

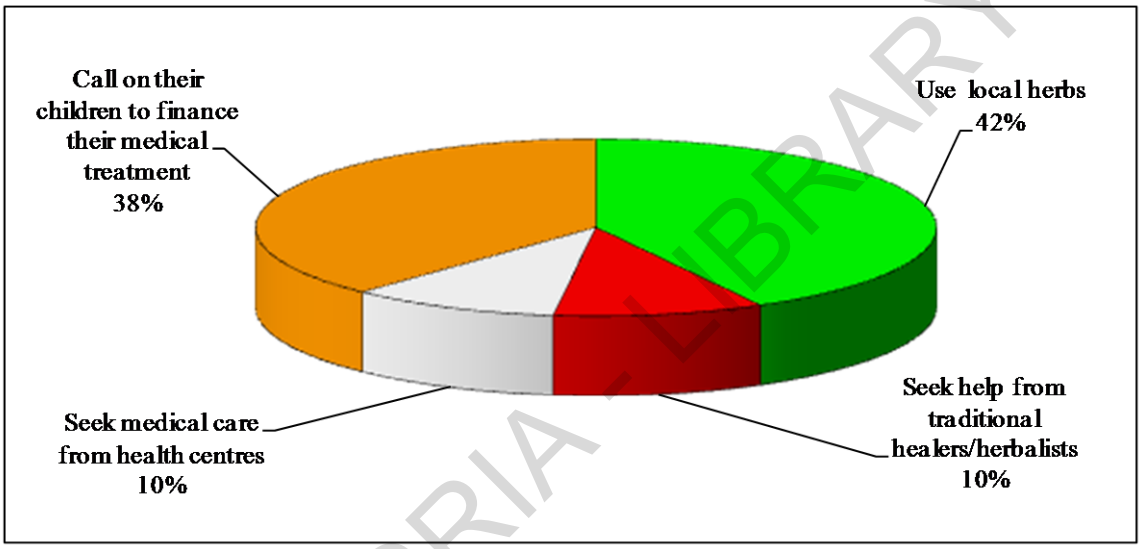


Figure 5.1 Mechanisms used by the older persons to cope with illnesses, as reported by key informants

Figure 5.1 illustrates the mechanisms used by the older persons to cope with illnesses as reported by key informants. The results show that the largest proportion of key informants (42%) reported that the older persons used local herbs. This confirms the results obtained earlier from most of the older persons.

With intent to establish whether the older persons did not find difficulties accessing healthcare services at health centres/hospitals to which they went to seek the services, they were further asked to describe any special treatment that was offered to them while at the centre/hospital. Special treatment here meant health workers giving an older person deserved priority, attention, care or medical treatment whenever he/she showed up at the

health centre. Only a few older persons described this special treatment as summarised below:

> As an older person, sometimes even if I find about three people they allow me to see the doctor and 1 am attended to faster. This has happened to me twice in Mulago hospital but it is not easy lining up with young people" (Male, 81 years, Rubaga, Kampala, central region).

> I get special help but only when I have money to give to the doctor and that is only when my son comes along to the hospital with me, otherwise when I go alone I find it difficult to get the services" (Male, 61 years, Nakawa, Kampala, central region).

> When I was receiving drugs from Mulago Hospital, I used not to get special attention from nurses. The sick people were many and sometimes you could come out without receiving anything but now I receive special medical help ever since I shifted from TASO(Non-government organisation) Mulago to TASO Kanyanya , because the place has enough space for patients, enough and caring health workers and counsellors and we get every medicine we need. The only problem is that we line up with those young people who normally laugh at us old people who are infected (stigmatisation)" (HIV positive, widow of 60 years, Kawempe, Kampala, central region).

> It takes luck for an older person to get special treatment in government hospitals unless those people who are seen to have money but private health centres do care for us" (Female, 80 years, Lira, Northern Uganda).

The above results indicate that occasionally a few elderly patients received special treatment through being given priority over young patients whenever they (the older persons) showed up at health centres. However, some older persons received special treatment after paying for it. It was noticed that only five older persons showed that they received special treatment. This implies that the overwhelming majority did not get such treatment at all. The other issue that came out of the results outstandingly was "stigmatisation" that some older persons felt as they accessed healthcare services related to HIV/AIDS. Many of those who had an HIV/AIDS-related illness felt ashamed and uneasy lining up with young people to receive healthcare services. As two of the older persons noted below, this experience was particularly felt during voluntary counselling and administration of treatment to HIV/AIDS related illnesses.

"When we stand in the same line with these young people for ARVs they normally laugh at us and we feel bad about it."

(Male, 60 years, Kampala district)

"You can stand for a long time in the long queue and no nurse will even look at you and sympathise with you to call you out of the queue even if you are very sick."

(Female, 70 years, Jinja district)

Even the older persons who coped by giving their children and grandchildren advice articulated how they did so as summarised:

> Ever since I heard of and experienced the wrath of HIV/AIDS, I started emphasising to my children and grandchildren to be extra careful. I take the time and talk to my remaining children about AIDS. I advise the grandchildren to be careful when choosing partners and not to play around with girls or boys, or to use condoms just in case... Although I get little money through selling food, I ensure that I provide for them educationally for their future self-sustenance while am still with them (Male, 60 years, Kawempe, Kampala, central region).

> I always tell my grandchildren to use condoms when they find themselves in the situation that can lead to getting infected by HIV/AIDS (Male, 72 years, Nakaseke, Luwero, central region).

The results indicate that some older persons coped with the impact of HIV/AIDS by advising their children and grandchildren to be extra careful when choosing partners, not to carelessly play around with girls or boys, or to use condoms for purposes of ensuring their safety. Some older persons provided the orphans with education for future self-sustenance.

5.2 Mechanisms to Cope with Barriers Encountered at Household Level

The mechanisms investigated at household level included those that the older persons used to cope with the barriers faced when playing their household roles of general grand parenting as well as food and water provision.

a) Mechanisms to Cope with Barriers to Grand Parenting

Regarding the general grand parenting, the mechanisms used by the older persons were investigated by asking them how they managed to look after all the grandchildren, especially the orphans. The thematic analysis of their responses revealed the following as the mechanisms: food cultivation; mobilising food from good Samaritans; using the little money realised from milk, land, mats, baskets, self-written poems and story books, brew/potent gin, poultry and roadside sales; appealing to churches/pastors to assist in educating the orphans, getting assistance from children, using rent obtained from commercial houses; pension; revenue collected from owned public taxis or school projects.

The responses also revealed that there were a few older persons who reported that they depended on the mercy of God and others who survived because of charitable

organisations such as the Red Cross and UNICEF. It is important to note that most of the older persons who lived by the mercy of God were urban-based. Some of the mechanisms were substantiated as shown:

> I have a retail shop from which I get some money that helps me meet some of my grandchildren's needs like school requirements, clothing, food and medication" (Male, 77 years, Kawempe, Kampala, central region).
>
> I use my little income I get from selling fried cassava and it helps in feeding and meeting the medical care cost just in case one of my grandchildren falls sick (Male, 70 years, Kasana, Luweero, Central region).
>
> We have a garden where we cultivate crops from which we get food some of which is sold to get some income that could help us meet other costs of living (Male, 75 years, Pallisa district, Eastern region).
>
> I have many grandchildren whose parents died but the situation is worsening because even those who have been assisting me are also dying as a result of HIV/AIDS. Many of my children have succumbed to the disease and the two remaining children who have been helping out are also bedridden now. We are now surviving on the mercy of God (Female, Mbarara district, Western Uganda).

Results indicate that while some older persons depended purely on the mercy of God, some had means of looking after their grandchildren. With intent to establish the extent to which the mechanisms helped the older persons to cope with the barriers to playing their household headship and grand parenting roles, they were asked to rate the care that they were able to provide the grandchildren with. Their ratings revealed that the care was generally inadequate and therefore unsatisfactory. This implies that the coping mechanisms did not help the older persons to sufficiently overcome the economic barriers to their grand parenting role.

b) Mechanisms used by the older persons to cope with Barriers to Food Security and Nutrition

To ascertain the mechanisms that the older persons used to cope with the barriers to their households' food security and nutrition, they were asked about how they managed to get food. The content analysis of their responses revealed buying food from markets and the grandchildren carrying it home; buying food from markets and carrying it home by bicycle; buying food from markets and carrying it home by themselves; growing food and grandchildren carrying it home from the gardens, growing food from gardens and

carrying it home from the garden by themselves, and sending grandchildren to get food from gardens or markets as the coping means used.

A further comparative analysis of the responses showed that while most of the rural older persons grew the food, most of the urban older persons bought the food from the market. Although most of the older persons carried the food home using grandchildren irrespective of their settings, there were a few of them who carried the food home by themselves. To establish the distance that these older persons had to cover in order to the get the food from the market or garden, they were asked how far their gardens or markets were from their homes. Most of them (115) showed that the distance was at least one kilometre. Only a few elderly respondents (50) of whom, most of them were in urban areas got the food from a distance of less than a kilometre. This implies that the older persons in rural areas had to cover longer distances in order to deal with the food security and nutrition of their households.

For purposes of understanding why the older persons were personally involved in growing or buying and carrying the food home despite having grandchildren, they were asked to explain why they did so. Their responses led to identification of grandchildren being sickly, being too young to dig or buy and carry the food home, granddaughters spending almost all the time away looking for money to support household members, grandchildren keeping away loitering around the village or simply being big-headed as the reasons. The reason cited by most of the rural older persons related to their granddaughters spending most of the time looking for money to support other members of the household, while that reported by most of the urban older persons was that their grandchildren were bigheaded as expressed by one of the respondents:

> Children of these days, you cannot even send them for anything. They spend most of their time loitering other than helping with house chores. They are even spoilt further by the law that protects them from being disciplined properly because they can report you to police the moment you beat them (Male, 78 years, Kampala district)

c) Mechanisms to cope with water supply barriers

To establish the mechanisms used by the older persons to cope with the distance-related barriers encountered in accessing water, they were asked about the means that they used to fetch water. Most of them showed that they were using human means such as carrying the water on their heads. However, there were a few older persons who used bicycles or oxen.

In general, results indicate that various means were used by the older persons to cope with the barriers that they encountered in daily life. The mechanisms were however, not so effective as to help most of the older persons to play their grand parenting role as satisfactorily as desired. In particular, most of the older persons grew or bought the food and carried it home with the help of their grandchildren. Some carried the food by themselves, thereby covering a distance of at least one kilometre. Most of those who carried the food did so either because their granddaughters kept most of the time away looking for money to support household members or because of the bigheadedness of their grandchildren. Most of the older persons coped with barriers related to distance to water sources by using human means to fetch water as reported by one of the respondents:

> I normally send my grand children to fetch for me water because it is collected from very far, but if they are not around then I will have to stay without water because my legs cannot allow me to move for a long distance (Female, 78 years, Pallisa district).

5.3 Mechanisms Used by the Older Persons to Cope with Barriers at Community Level

These mechanisms were explored and established by asking the older persons respondents to describe how they dealt with the barriers they encountered from their communities. Content analysis of their responses showed; reminding the young people that elderliness does not mean inability or senility, giving words of good counsel to overcome disrespectfulness, reminding the young people that older persons have a right to be part of society, and talking productively so as not to be despised as a spent force, were used as mechanisms. The analysis also revealed that while most of the urban older persons coped by reminding the young that elderliness did not mean inability or senility,

most of the rural older persons overcame disrespect from community members by giving words of good counsel.

Generally, qualitative results indicate that the older persons deal with the barriers to their effective participation in society by applying psychological, social, healthcare, and economic coping mechanisms.

In line with the coping mechanisms to cope with community based barriers, the Key Informants were also asked to describe how the older persons coped with these barriers at community level. The results obtained are shown in Table 5.1.

Table 5.1: Mechanisms used by the older persons to cope with community-based barriers, as reported by key informants

Mechanisms	Count	%
Advise young people to behave responsibly regarding HIV/AIDS as we lost most of our children because of the epidemic	22	44.0
Participate in community religious services	13	26.0
Participate in community cultural activities	6	12.0
Self Respect	5	10.0
Participate as advisers to community leaders	4	8.0
Total	**50**	**100.0**

Results in Table 5.1 indicate that to the largest proportion of key informants (44%), the mechanism that the older persons used to overcome community-based barriers to their participation in society was to advise the young people to behave responsibly. As a way of understanding whether any efforts had been made to help the older persons in Uganda cope with barriers to their participation in society, key informants were further given a list of strategies and asked to indicate whether the strategies had been used in Uganda. The results obtained from the analysis of their responses are shown in Table 5.2.

Table 5.2: Responses of Key Informants on Mechanisms Used to Eliminate Barriers to the Participation of Uganda's Older persons in Society

Mechanisms	Responses					
	Agree		Disagree		Total	
	Count	%	Count	%	Count	%
Raising awareness of the older persons Through provision of information	12	24.0	38	76.0	50	100
Providing the older persons with resources	6	12.0	44	88.0	50	100
Developing policies that integrate the older Persons into programmes	5	10.0	45	90.0	50	100
Giving the older persons lifelong skills	3	6.0	47	94.0	50	100
Average	**8**	**16.0**	**42**	**84.0**	**50**	**100**

Findings in Table 5.2 indicate that on average 16% of the key informants agreed while 84% disagreed. This implies that to the majority of the key informants, the mechanisms shown in the table were not used to help the older persons cope with barriers to their effective participation in society.

Generally, findings indicate that the mechanisms take physical, psychological, healthcare, and economic forms and that they are used by Uganda's older persons to cope with barriers encountered at personal, household and community levels in form of not only constraints to their physical fitness, healthcare, food security and nutrition, economic capacity, grand parenting, and water supply, but also the impact of HIV/AIDS and community hindrances. The findings are therefore largely in line with the observation made by Apt (1996) that coping mechanisms used by the older persons tend to span over a wide spectrum stretching from initiatives and attempts made to overcome barriers confronted at personal, household and community levels and in form of constraints to healthcare, food security and nutrition, housing and accommodation, and other forms of limitations. A close eye on the established mechanisms reveals that although most of the older persons make attempts to overcome the barriers encountered in their efforts to participate in the society, the attempts do not result into effective participation in society. This concurs with the observations made by Carmel et al. (2008), UNESCO (2008), Age Concern Report (2006), Mall (2005), Juma et al. (2004), FitzGibbon & Hennessy (2003)

Help Age International (2002), Apt (1996) that although older persons made attempts to overcome the problems that they encounter in their daily life, they do not do so effectively.

Specifically, results show that Uganda's aged people endeavour to deal with barriers to their physical fitness by getting involved in various physical activities, which include: walking around, cleaning houses and compounds, dancing, running or jogging, playing with grandchildren, moving with cattle uphill every morning, drumming, playing the guitar, riding a bicycle, going to health clubs for physical exercises, picking food from the farm, fetching water, and most of all, digging. It is a fact that all these mechanisms can help a great deal in ensuring that the older persons keep physically fit. A close look at all the mechanisms reveals that they actually help older people to carry out body exercises which help to effectively deal with and overcome the bodily weaknesses. In most cases, overcoming bodily weaknesses carries with it indirect health advantages such as enhancing the immunity of the body against diseases and illnesses; keeping the body healthy, gaining energy and strength, feeling good, keeping good memory, and avoiding costs on diseases that attack weak bodies.

Thus, the older people's adoption of the fore-mentioned coping mechanisms helps them to keep their bodies physically fit, thereby placing them (the bodies) in a stronger position to resist diseases and realise the rest of the benefits that come as a result. The mechanisms, particularly digging, can also help the older persons to overcome the barrier of inadequate feeding since, in effect, it helps not only to exercise physically but also grow food as well. As one digs, he/she is expected to be growing more and more food provided other factors such as soil fertility and rain are in adequate supply.

The reported mechanisms, however, cannot help much when it comes to dealing with other barriers that were reported to constrain the physical fitness that Uganda's older persons need to participate effectively in society. In particular, the mechanisms cannot help to overcome physical illnesses, loss of hope, the misconception of some older persons that leisure exercises belong to only youthful people, and remoteness. When a

person is ill, doing physical exercises may not help much to overcome the illness. An illness tends to represent a disease that requires medical or psychological attention but not physical exercises only.

In addition, no amount of physical exercises can help the older persons who have lost hope in the exercises and those who misconceive them (the exercises) as activities for the youths only to overcome these barriers. As noted earlier, overcoming such barriers requires psychological therapy in form of counselling to help the older persons with such a state of mind to appreciate the fact that they, too, can get involved in physical exercises as a means of keeping physically fit. Further, none of the reported mechanisms for keeping physically fit could help the older persons to overcome the barrier of remoteness. This barrier requires government action involving taking recreational packages and social amenities to rural areas and empowering the older persons to access them. However there is also need for health workers to involve physical activity in the health package they give to the older persons as they visit hospitals.

Apart from mechanisms for coping with barriers to the physical fitness that the older persons need to participate effectively in society, the results show that these people developed other mechanisms in order to deal with barriers to accessing the healthcare services that they need to enhance this participation. These mechanisms were established from the key informants and the older persons themselves to include: calling children to provide finance medical treatment; going to government hospitals/health centres or nearest private clinics or dispensaries; visiting and seeking treatment from traditional healers/herbalists; and buying medicine from pharmacies for personal treatment. Others were: getting herbs from bushes or gardens or sending grandchildren to collect them; praying to God for healing; and sending for personal doctors to come to the homes of the older persons and provide them with the necessary treatment.

A plain look at these mechanisms gives an impression that the older persons in Uganda have all the ways through which they deal with and effectively overcome the barriers to accessing healthcare needed to maintain a personal health status required to effectively

participate in society. Indeed, the mechanisms exhaust all the means that any person can use to access the needed healthcare services. This impression may be practically true with some of the mechanisms such as getting herbs from bushes or gardens, or sending grandchildren to do so, sending for personal doctors, and miraculously true when it comes to praying to God for healing.

The impression is however, not entirely true when it comes to some of the mechanisms such as going to government hospitals/health centres and visiting traditional healers/herbalists. As far as going to government hospitals/health centres or private clinics/dispensaries is concerned, the falseness of the impression comes out clearly viewed from the perspective of the reported barriers to Uganda's older persons' access to the needed healthcare services. It is worth noting that these barriers were reported as: health workers' aloofness and lack of respect for the older persons; lack of medicine and drugs at health centres; inadequate hospital beds; bribery and corruption; over-waiting in long patient queues; inadequate diagnosis from health workers; unaffordable medical costs; long distances to health centres; unavailability of health workers at the health centres when needed; inadequate health workers; and inadequate space for inpatients admitted at health centres/hospitals.

Clearly, going to a hospital, health centre, clinic or dispensary as a means of dealing with barriers to accessing healthcare services cannot be considered as an effective mechanism. There is no way a person can access needed healthcare services from a hospital or health centre characterised by the fore-mentioned barriers. Accordingly, the older persons who reported use of this mechanism indicated in effect that they had not effectively overcome barriers to their access to the needed healthcare services. In fact, results obtained from some of these older persons serve to support this argument. The results showed that when these older persons reach the hospitals/health centres, they were inadequately diagnosed and told to buy the medicine from drug shops and pharmacies. What kind of healthcare service is this? Something therefore needs to be done in order to ensure that the effectiveness of the coping mechanism by which the older persons use government

hospitals/health centres to overcome barriers to their healthcare is improved. What needs to be done will be suggested in due course.

In addition, the coping mechanism involving visiting traditional healers or herbalists has its own loopholes. Many traditional healers or herbalists tend to be quacks who cannot administer effective medication. They only work through manipulation and duping of innocent patients. This is actually echoed in the work of Kanyemibwa (2007). Consequently, visiting them as a means of accessing the needed healthcare may not be as effective as expected.

The results indicate further that Uganda's older persons had also developed mechanisms to deal with the impact of HIV/AIDS. These included: using ARVs, joining HIV/AIDS associations/clubs, surrendering life to Jesus, appealing to good Samaritans for help, telling children to send assistance, going for counselling to avert the trauma, advising grandchildren and other young people to be careful about HIV/AIDS, and most of all, growing as much food as possible. When these mechanisms are compared with the problems caused to the older persons by HIV/AIDS, they indicate that these people have gone a long way in their efforts to deal with the problems. In the first place, using ARVs indicates that the older persons infected with HIV/AIDS are making attempts to prolong their lives through using the drugs.

Secondly, joining HIV/AIDS clubs or associations indicates that the infected older persons are making efforts to reap the benefits of these clubs and/or associations, which tend to include: getting economic, social, and psychological support. The net effect of these two mechanisms is to overcome the adverse health, economic, social and psychological effects caused by HIV/AIDS. The mechanisms such as going for counselling and surrendering life to Jesus indicate that the older persons enhance the psychological support realised from HIV/AIDS clubs or associations with professional therapeutic and spiritual support. This ensures that they are fully relieved of the trauma caused by HIV/AIDS.

The mechanisms such as appealing to good Samaritans for help, telling children to send assistance, and growing as much food as possible suggest that Uganda's older persons make attempts to overcome the barriers related to looking after the large numbers of grandchildren orphaned by HIV/AIDS. In fact, the mechanisms help the older persons to mobilise economic support and food that they need to feed these children and themselves. It is crucial to point out that although growing food may help to overcome such barriers, the extent to which it does so tends to decline as food growers grow old amidst growing numbers of people for whom the food is grown. Accordingly, the efforts that the older persons in Uganda spend in growing the food are not enough when viewed from the perspective of the large numbers of grandchildren who they look after. The efforts therefore need to be enhanced by government as a matter of fulfilling its obligation to these people. What the government can do in order to achieve this, will be recommended later.

The mechanisms involving advising grandchildren and other young people to be careful about HIV/AIDS suggest that the older persons in Uganda attempt to deal with the effects of this plague through preventive means. Indeed, advising people against something effectively means helping them to avoid it. The limitation with this mechanism is that it tends to be effective only when those being advised are listening and changing their behaviour as advised. When this is not the case, the mechanism cannot achieve much.

As far as dealing with economic and grand parenting barriers is concerned, results show that the following were the mechanisms devised by Uganda's older persons: appealing to churches, pastors and good Samaritans, getting assistance from children, cultivation of food, engaging in roadside selling of farm produce, operating small retail shops, selling land or livestock products, especially milk, collecting rent from commercial houses, cleaning the roads/markets at a fee, selling self-written poems and story books, making and selling local brew/potent gin, making and selling mats and baskets, pension, rearing and selling poultry, and revenue collected from owned public taxis or school projects. These mechanisms indicate that the older persons in Uganda attempt to cope with economic barriers either by getting aid, cultivating food, or selling their assets. Although

these mechanisms have potential to help deal with and overcome the economic barriers, some of them do not seem to be sustainable in the long run.

In particular, as has already been shown, cultivation becomes less and less of an effective coping mechanism as frailty sets in. Secondly, appealing to churches, pastors and good Samaritans, getting assistance from children can only work for a time. Churches, pastors and good Samaritans are likely not to be in a position to provide for a person all the time, more so when the person has many dependents. The children may also be hard to rely on, especially in this era of increasing infestation of HIV/AIDS, declining life expectancy, and the rapid growth of the spirit of individualism caused by the emerging notion of capitalism. Selling land is perhaps the most dangerous mechanism because although it may yield a lot of financial inflows in the short run, it effectively implies that the person selling it makes him/herself landless in the long run, thereby lacking where to grow food or even to stay and look after the people under his/her care. It is therefore important that government comes to the rescue of the older persons who overcome economic barriers by selling land or through aid from churches and individual Samaritans.

Turning to coping with the food security and nutrition barriers, the results indicate that while most of the rural older persons use the mechanism of growing food, their counterparts in urban areas buy the food from markets. In other cases, the food is carried home either with the help of the grandchildren, bicycles or by the older persons themselves. These coping mechanisms suggest that while overcoming the food security and nutrition barriers largely depends on the ability to cultivate enough food for the older persons in rural areas, it largely depends on financial ability for the older persons in urban areas. Given the limitations of declining physical energy due to frailty and the fact that the overwhelming majority of Uganda's older persons are economically distressed, it goes without saying that in either case, the used mechanisms cannot help to fully overcome the food security and nutrition barriers faced by these people.

There is therefore need for government to assist these people as far as realisation of the desired food security and nutrition is concerned. This is necessary because the results

indicate that it is largely the older persons who largely carry out the cultivation. The people under their care who would have helped to boost the capacity to cultivate are not effectively participating due to the fact that some are sickly, others are too young to dig, others spend almost all the time away looking for money to support household members, while others keep away loitering around the villages or just being just big-headed.

As far as overcoming the barriers to water supply were concerned, the mechanisms which the older persons reportedly used included using bicycles and oxen but the overwhelming majority used human or manual means. These mechanisms have two implications. Firstly, they show that the only barrier that older persons attempted to deal with was the long distances. Moreover, the human means that the majority reported using to overcome this barrier suggest that water is fetched by carrying its container on one's head, shoulder or lifting the container in the hands. This implies that the older persons use a lot of physical energy to overcome the long distances. This is likely to expose them to physical fatigue given their frailty. It is therefore important that the sources of water supply are brought nearer to these people. How government can achieve this is recommended later.

Secondly, the fore-mentioned mechanisms imply that the older persons in Uganda have no means of dealing with other barriers to the supply of their water. It should be recalled that the water supply conditions that characterised the living conditions of the older persons showed that those in rural areas draw water from unprotected springs. As discussed earlier, this indicated that these people use largely contaminated water; and there is no mechanism by which they deal with such water. The results do not indicate whether the older persons boil or treat the water before use. There is therefore need for encouraging the adoption of these mechanisms among Uganda's older persons, especially those in rural areas.

It should be noted that while the older persons indicated that they live in poor housing and accommodation conditions characterised by poor sanitary conditions, unhygienic latrine and bathroom facilities, and poor environmental health, results do not indicate any mechanisms that they use to overcome these problems. This suggests that if the housing

and accommodation conditions are to be improved, mechanisms for dealing with these conditions need to be put in place. These mechanisms will be recommended later.

Last but not least, the mechanisms used by the older persons in Uganda to cope with community barriers to their effective participation in society were established as: reminding young people that elderliness does not mean inability or senility; giving words of good counsel and advice to the young who disrespect them; reminding the young people that older persons have a right to be part of society; and talking productively so as not to be despised as a spent force. Other reported mechanisms include: participating in religious and cultural affairs through giving guidance to the young; and giving direction to community leaders to behave responsibly.

The foregoing mechanisms suggest that the older persons use wise and assertive means of dealing with barriers that they experience from their communities. Indeed, making it clear that elderliness does not mean inability or senility shows that these people use self-confidence to ensure that they are not ignored in society. In addition, giving words of good counsel, guidance and direction to the young and community leaders indicates that these people overcome community prejudices by showing the young that they are wise and therefore resourceful advisors who can guide the young and leaders towards being productive in society. In a nutshell, the results show that the older persons in Uganda ensure that their position is felt in society.

What needs to be noted, however, is that the results reflect only the point of view of the older persons. They do not show the side of the young people. This notwithstanding, the results indicate that the older persons can be useful to the young if they are not ignored as people who have outlived their usefulness. There is therefore need to sensitise the young people to appreciate the fact that the older persons are still useful in society so that they (the young) can stop ignoring them (the older persons).

It must be noted that all the mechanisms identified and discussed so far were devised by the older persons themselves. This is supported by the overwhelming majority of the key

informants who showed that older persons in Uganda are not helped in any way to deal with barriers to their effective participation in society. They are not provided with information so as to raise their awareness of what is going on in the communities as far as technological changes and developmental activities are concerned. The older persons are not provided with resources to enhance their capacity to participate in society. They are neither given lifelong skills nor integrated in developing policies and programmes.

On the whole, the results indicate that Uganda's older persons use a number of psychological, physical, healthcare, and economic mechanisms to cope with the various personal, household and community barriers to their effective participation in society. The mechanisms range from involvement in physical activities so as to keep physically fit through means for seeking healthcare services; cultivation and sale of assets to create the economic capacity required to deal with food security and nutrition barriers as well as grand parenting needs; to human ways of dealing with long distances covered to fetch water. The mechanisms are however, inadequate not only in themselves since they only provide short term solutions but also because they do not help the older persons to overcome all the barriers to their effective participation in society. There is therefore need to address the plight of the older persons in Uganda through improving the mechanisms which they use to deal with the barriers to such participation.

CHAPTER SIX

ADDRESSING ISSUES OF OLDER PERSONS BY POLICY AND STRATEGIES THAT CAN BE ADOPTED TO ADDRESS THEIR CONCERNS

"Older people contribute so much…its time to invest in them"

(Douglas Lackey, Africa's Regional Advocacy & communication Manager-Help Age International)

6.0 Overview

The theme of this chapter is about presentation and discussion of findings responding to the fourth and fifth objectives of the study. The fourth objective was to evaluate the degree to which the concerns of the older persons were addressed by relevant policies in Uganda, thereby identifying gaps therein, while the fifth objective comprised of suggestions of strategies which ought to be adopted in order to address the concerns effectively. The evaluation was carried out through document review and administration of a questionnaire to key informants. The reviewed documents and how they were evaluated were discussed in Section 3.11.4 of Chapter Three. The findings are presented forthwith.

6.1 Effectiveness of Uganda's Policies in Addressing Older Persons' Concerns

This effectiveness was explored by asking Key informants to indicate whether or not the following government policy instruments had effectively addressed the needs of the older persons in Uganda: Poverty Eradication Action Plan (PEAP), Vision 2025, Contributory Pension Scheme, the Uganda Constitution, the Social Development Sector Strategic Investment Plan (SDIP), and the Local Government Act. Findings are shown in Table 6.1.

Table 6.1: Responses of Key Informants on Effectiveness of Government Policies in Addressing Concerns of the older persons in Uganda

	Responses					
	Yes		No		Total	
Legal government instrument	count	%	Count	%	count	%
Poverty Eradication Action Plan	16	32.0	34	68.0	50	100.0
Vision 2025	6	12.0	44	88.0	50	100.0
Contributory Pension Scheme	15	30.0	35	70.0	50	100.0
Uganda Constitution	28	56.0	22	44.0	50	100.0
Social Development Sector Strategic Investment Plan (SDIP)	7	14.0	43	86.0	50	100.0
Local Government	26	52.0	24	48.0	50	100.0
Average	**16**	**32.0**	**34**	**68.0**	**50**	**100.0**

Table 6.1 indicates that on average, while 32% of the key informants assented, 68% dissented to the effectiveness of government policies in addressing concerns of the older persons in Uganda. This implies that the majority of the key informants felt that the policies were not effective in addressing the concerns of the older persons in Uganda. Indeed, as shown in Table 6.2 below, when the key informants were asked to describe how government had achieved its goals regarding the policy instruments shown in Table 6.1, half (50%) of them replied that there was nothing to show on ground in relation to the concerns of the older persons.

Table 6.2: Achieving Goals of Policy Instruments in Relation to the Concerns of the older persons in Uganda, as described by Key Informants

Description	**Count**	**%**
Nothing much to show	25	50.0
The elderly are mentioned in some instruments like the Local government Act but there are no enabling policies	14	28.0
Mentioning the elderly in instruments is more of paper work than action	11	22.0
Total	**50**	**100.0**

From further probing, key informants revealed that there was only one department of the older persons in the Ministry of Labour and Gender Affairs, which was moreover highly ill-funded. This was aptly summarised by one of the key informants are shown below:

> We have the department of the older persons here but it is just that. It is not facilitated. There are no funds released to it. In most cases, the department has no budget of its own…. However even when there is money in the ministry, always the priority is put on young children or the youth, but not elderly people because they are regarded as non productive …nobody wants to invest in older people.

Key Informant, Ministry of Gender, Labour and Social Development

Another Key Informant pointed out a government department established to address the economic concerns of the older persons. The respondent called this department as the Pensions Department in the Ministry of Public Service. This was in line with the observations made by Namuddu (2007) and Bird and Shinyekwa (2005) that Uganda has a pension scheme for older persons. However, these scholars noted, the above mentioned respondent noted that this scheme targets very few older persons who were retired from civil service and that even then, there are difficulties that prevent many of these people from getting the pension. These difficulties were highlighted by another key informant from the Ministry of Public Service as including: the pension scheme being poorly financed, pensioners being generally desperate and impatient; the inadequate customer relationship management; and lengthy process of pension bureaucracy that involves 38 business steps which a retiring officer must undergo before receipt of pension. These difficulties had also been mentioned by the findings obtained from older respondents who were pensioners. All these findings point to one thing: that the policies in Uganda have negligibly addressed the plight of older persons.

This was further corroborated by a critical review of various policy documents that were deemed relevant to addressing the plight of these people. Findings are presented in the sections that follow.

a) The Constitution of the Republic of Uganda (1995)

The preamble of the 1995 Constitution of the Republic of Uganda (hereafter referred to as Constitution) was formulated by the Constituent Assembly (CA) elected through adult suffrage that took place in 1994. The CA formulated the Constitution based on the Odoki Report that contained all the wishes and aspirations of all the people of Uganda. The

stakeholders of the Constitution were therefore all the people of Uganda. The Constitution was formulated and promulgated to address all the wishes and aspirations of all Ugandans. Accordingly, the preamble of the Constitution declares that this constitution consists of the supreme laws and principles that prescribe and determine the fundamental political and administrative direction of Uganda. This implies that this constitution is the overall source of policies that should guide the conduct of public affairs in Uganda. As such, whatever the constitution does not provide for either by omission or commission cannot have any policy formulated and implemented about it unless constitutional amendments are carried out first.

A careful review of this Constitution reveals that fortunately, its prescribed national objectives provide for government to address the welfare of older persons in Uganda. Specifically, one of the objectives prescribed under the National Objectives and Directive Principles of State Policy proclaims that, "The state shall make reasonable provision for the welfare and maintenance of the aged." This implies that the Constitution commits the State of Uganda to ensuring that older persons are provided for and maintained in terms of welfare. This objective is reinforced by a number of constitutional articles that provide a basis for enactment of laws and formulation of policies that can serve to address the welfare concerns, needs and interests of older persons in Uganda.

Among the articles, one that is most articulate about older persons is Article 32 (1) that declares that, "Notwithstanding anything in this Constitution, the State shall take affirmative action in favour of groups marginalized on the basis of gender, age, disability or any other reason created by history, tradition or custom, for the purpose of redressing imbalances which exist against them". This Article commits the State of Uganda to taking up affirmative action in favour of older persons as one of the groups marginalised.

Other constitutional articles that provide a basis for formulating and implementing policies addressing the plight of older people in Uganda include the following:

- Article 21 (1) which states that, "All persons are equal before and under the law in all spheres of political, economic, social and cultural life and in every other respect and shall enjoy equal protection of the law." This article prohibits discrimination but earlier findings reveal that older persons are still being discriminated as far as participation in developmental programs is concerned. In fact, not much has been done even when Article 21 (4) of the Constitution commits Parliament to formulating the enabling laws and policies when it declares that, "Nothing… shall prevent parliament from enacting laws necessary for implementing policies and programmes aimed at redressing social, economic, educational or other imbalances in society."

- Article 26 (1). This article is about protection from deprivation by poverty. It is relevant since it categorically states that, "every person has a right to own property either individually or in association with others." This article sets grounds for formulating policies for ensuring that this right is protected and realised by all the people including the older persons. However, findings revealed that the majority of the older persons in Uganda do not have enough assets to help them out of the chronic poverty that they were faced with.

- Article 30 is relevant in that it underscores the right of all people to education. It states that, "All persons have a right to education." Unfortunately, findings presented earlier indicated that most of the older persons in Uganda were not educated. Even when there is adult education, many older persons are still uneducated, suggesting that they are not benefiting from this education.

- Article 36 article states that, "Minorities have a right to participate in decision-making processes, and their views and interests shall be taken into account in the making of national plans and programmes." This article is relevant to older persons since, by virtue of being only 6.1% of Uganda's population they qualify to be among the minorities. Even when a policy on development was formulated, older persons were not catered for. They, for instance, are still not represented in parliament where

major decisions regarding their lives are made; there is also no council for older persons as there is for women and youth who, moreover, are not in minority by population size (Oloka-Onyango, 2008). Older persons are only provided for at local government but even then, their representation is thin on the ground.

- Article 39: This article articulates the right of all Ugandans to a clean and healthy environment. It is therefore relevant in that it serves as a basis for formulation and implementation of policies for protection of people against an unhygienic and unhealthy environment. Despite this protective article in relation to hygiene being in existence, majority of older people especially those living in urban areas are still living in filthy conditions where there is poor drainage system, no toilets, and in places where garbage is just disposed off any how. This is evidenced in the responses provided during the interviews.

Generally, the review of the Constitution reveals that there are a number of articles that provide a basis for formulating and implementing policies for addressing the plight of older persons. Unfortunately, very little has been done to address the plight of older persons by policy. As shall be elaborated shortly, a number of policies and developmental programs have been formulated. Although most of these policies and plans address the plight of children, youths, and women, they conspicuously live out older persons either by omission or commission. This concurs very well with the argument raised by Nayiga-Ssekabira (2002) that constitutional objectives and articles only serve to indicate intents and aspirations but not action.

However, given the importance of older persons in society as earlier findings revealed and the fact that the Constitution provides for them, continuing to ignore them is an unfair error which calls for the attention of policy initiatives and designers in Uganda. There is therefore a critical need to formulate policies needed to operationalize Article 32 (1) of the 1995 Constitution of the Republic of Uganda. In fact, Article 32 (2) of this Constitution assigns this responsibility to the Parliament of Uganda; for it pronounces that, "Parliament shall make relevant laws (and policies) including Equal Opportunities

Commission for the purpose of giving full effect to clause (1) of Article 32 of the Constitution." Accordingly, Uganda's Parliament is the first State Organ that needs to ensure that it formulates policies relevant to operationalizing and realizing this article. This is needed particularly in the light of the fact that Equal Opportunities Commission has long been established and nothing much has been done for older persons. The only effort is still in offing and requires a lot of empirical information to take off in a meaningful manner.

b) Poverty Eradication and Action Plan (PEAP) (2004)

This policy was formulated through consultative process between central & local governments, parliament, donors, civil society and holding series of workshops. Formulation was also based on statistical evidence of changes in poverty levels from 34% in 2000 to 38% in 2003 and also changes in inequality which had risen from a Gin coefficient of 0.35 in 1997/8 to 0.43 in 2003 (PEAP, 2004). Qualitative data was provided by the 2nd participatory poverty assessment process conducted in 12 districts in Uganda which showed some of the perceptions of older persons regarding poverty (PEAP, 2004). In short, it is an all-embracing five year policy framework that is guiding the socio-economic development of Uganda.

The formulation of PEAP was funded by donors, government and different private companies. Like most policies in Africa, PEAP was formulated basing on consultations with consultants but on using research and open debates that help to get all views and opinions of stakeholders, including target beneficiaries. It was based on extensive consultations with experts, various ministries and civil society organizations. Procedures such as capacity building for M&E; increased quality in decision making, budgeting and operational management; and development of 33 indicators were used. In addition the MDG indicators were adopted for the M&E process. For qualitative data, the instrument on Uganda Participatory Poverty Assessment process was used. However, stakeholders at the grassroots were left out despite the fact that PEAP was envisaged to act as guide to development in Uganda.

Indeed, the introduction section of PEAP indicates that this plan was adopted in Uganda in 1997 as a national strategic policy framework for guiding government developmental and poverty eradication initiatives, programmes and activities (Ministry of Finance, Planning and Economic Development (MFPED), 2004). It has since served as a multi-sectoral policy intended to foster socio-economic development and in the process, fight and eliminate poverty. PEAP seeks to improve the quality of life of the people of Uganda through promoting agriculture, food security and nutrition, education, health, water supply, and use of information and computer technology. It also seeks to achieve its purpose by promoting transportation and communication networks, rural electrification, and democracy and good governance.

According to MFPED (2004), PEAP is anchored on five pillars, namely: 1) economic management, 2) production, competitiveness and incomes, 3) security, con ict resolution, 4) disaster management and 5) human development. All these pillars seem to focus on achieving economic development of the people of Uganda. One of the objectives of the policy is to increase the ability of the poorer households to participate in economic growth through self employment inside and outside agriculture and wage employment. However, though this policy has targeted poor people for the past years, the older persons have not gained much because till now they are still grouped under the most vulnerable and poorest of the poor.

The PEAP policy mentions briefly about the older persons and recognises that older persons are a potential target group for social protection. It also acknowledges the important role of older persons in caring for people living with HIV/AIDS and orphans. It however provides no prescriptions for improving the quality of life of these people despite recognizing on their protection. The lack of detailed coverage of the plight of older persons in PEAP can be explained by its acknowledgement of the knowledge gap regarding the needs of these people. Thus, notwithstanding its provision of the overall framework for pursuing the achievement of the Millennium Development Goals and transformation of Uganda, and despite its well intentioned developmental scope and principal aim of helping vulnerable groups to improve their quality of life, PEAP does

not cover much about the plight of older people, especially as far as its prescribed development programmes and activities. Like most policies, PEAP suffers from the weaknesses of generalising its target group.

It should be remarked that if the PEAP had adequately addressed older persons as a specific group, something should maybe have been in place for them by now. The neglecting of these people was therefore a big blow to their life. No wonder that they are still living in pathetic conditions as earlier findings revealed. In fact, the ministry of Gender, Labour and Social Development recognised these conditions and is currently in the process of developing older persons' bill while piloting on how to formulate a policy but little has been achieved due, still, to lack of data about these people.

Although scholars have commented on the impact of PEAP on poverty reduction (Kamanyi, 2003; MFPED, 2007), they have not covered its impact on older persons; but as findings presented earlier revealed, the quality of life of the majority of older persons in Uganda is still wanting despite the existence of these programs. There is therefore need to develop policies by which the life of older persons can be improved.

c) Uganda Vision 2025: Prosperous People, Harmonious Nation, Beautiful Country

Review of the Ugandan vision 2025 policy reveals that it is a strategic policy framework that was developed in 1999 to guide Uganda's national long term development initiatives. The policy was developed to steer economic, social and political destiny in the next century. The policy entails Uganda citizens' long-term aspirations such as job creation, productive employment, sustainable livelihood, poverty eradication and combating HIV/AIDS. Uganda Vision 2025 recognises older persons as a traditionally and culturally respectable group of people, who have made various contributions to society throughout their youthful and adult life. It also underpins their role of continuing to serve as a source of valuable knowledge, thereby underscoring their importance to the rest of the Ugandans and advising them to respect and care for these people as a way of valuing and recognising their important contributions. Unfortunately, findings on the social perspective of the living conditions of these people indicate that this is not the case at the grassroots level (The Republic of Uganda, 1999).

Uganda Vision 2025 acknowledges older persons as one of the vulnerable groups that face: problems related to inadequate food and nutrition, the burden of caring for the increasing numbers of orphaned children, and erosion of respect among the youth who perceive them as a burden to society. It therefore concludes by underscoring the protection and provision of social services to the older persons. However, effect of Uganda Vision 2025 appears to be negligible because the implementation of its recommendations, especially those concerned with the older persons, has not received the attention it deserves. It appears to be more at the stage of formulation than at implementation. The older persons continue to suffer with the problems of poor nutrition, ill health, and poor social welfare and poor accessibility to social services, suggesting that efforts to formulate a social protection policy on their plight need to be accelerated.

d) Programme for Modernisation of Agriculture (PMA)

PMA came up in 2000 as a key policy initiative aimed at reducing poverty to a level below 28% by 2014 and to less than 10% by 2017 (MAAIF, 2005; NAADS, 2011). Its overall objective is to enhance production, competitiveness and increase smaller holder farmers' incomes. It provides a framework for coordinated implementation of Agriculture sector reforms aimed at the transformation of smaller holder agriculture from subsistence farming to commercial oriented production. It has an agenda of policy and institutional reforms across seven pillars. PMA policy is very important because it targets the main economic activity and source of livelihood of farmers who constitute over 90% of the people in Uganda, especially in rural areas.

The policy recognises the role of older persons and brings them on board when it states that, focusing on the aged will help tap their experience, target resources to them and give them a sense of hope as an important group of society. This would suggest that Uganda has a policy for helping the older persons engaged in agriculture to improve their livelihood. However, a review of studies conducted by Alun (2003), Ntale-Lwanga and Kimberley (2003), Najjumba-Mulindwa (2004), Kalasa (2004) and Mugambe (2006),

indicate that the situation of older persons on the ground is far different from what the PMA policy indicates. Older persons whose livelihood is dependent on agriculture continue to suffer with food insecurity, poor nutrition and biting poverty. The quality of life of most of them is still pathetic (Alun 2003; Ntale-Lwanga and Kimberley 2003; Najjumba-Mulindwa 2004; Kalasa 2004; Mugambe 2006). This review suggests that the Programme for Modernisation of Agriculture has not yielded the benefits anticipated to trickle down to older farmers in Uganda. In fact, most of the older persons are still hopeless. Uganda's current level of poverty is purported to be at 38% but the majority of older persons are still deep seated in chronic poverty (See findings on the economic perspective of the living conditions of these people in chapter four).

The lack of improvement in older farmers' quality of life seems to be explained by the fact that PMA targets only those it refers to as "economically active and able to use modern technology and make profits from Agriculture." This is unfair because it makes PMA implementers ignore older persons when extending PMA services, such as those provided under the National Agricultural Advisory Services (NAADS) program.

e) National Agricultural Advisory Services (NAADS)

NAADS program became operational initially in 2001 in six districts, but now it has spread in over 79 districts and 710 sub-counties in the country (NAADS, 2011). It is a 25 year program that uses an innovative public-private extension service delivery approach. The policy was initiated in line with the pursuit of the National Development framework of PEAP agenda. It works through farmers forums based on specific profitable enterprises (Benin et al., 2007). The aim of the program is to redress past shortcomings in the provision of the agricultural extension services through far reaching reforms and innovation approaches in service delivery and enhance rural livelihood by increasing agricultural productivity and profitability in a sustainable manner.

The budgeting of NAADS is decentralised to local government level so that it can reach people at the grassroots (Sub-counties). The sponsors of the program include: the government of Uganda plus co-operating partners such as DFID, AFAD, IDA, EU, Irish AID, and DANIDA among others. In addition, the participating local government and

participating farmers also contribute to the budget. Accordingly, despite its good goals of fighting poverty, NAADS eliminates people whom it would have helped. In particular, it excludes most of the older persons because they cannot meet the requirement of participation based on sound contribution. Given the high poverty level witnessed by most of these people, they cannot meet the costs involved.

The program achieves its aim through promoting development of farmers' organisations by empowering them to procure advisory services, manage linkage with marketing partners and conduct demand-driven monitoring and evaluation of the advisory services and their impacts. While the roles of the NAADS secretariat include; national coordination and supervision, district coordination, quality assurance, contracting service providers, technology development, capacity building and monitoring and evaluation. It is run at local government level and monitored by national NAADS secretariat, community and district leadership.

A review of an article on NAADS (Benin, et al., 2007) reveals that the program is guided by five objectives. These include; 1) increasing effective, efficient and sustainable extension delivery services, 2) increasing farmers' access to and sustaining knowledge, information and communication to the farmers, 3) increasing access to and sustaining effective and efficient productivity enhancing technologies to farmers, 4) creating and strengthening linkages and co-ordination within the overall extension services, and 5) aligning extension to government policy, particularly privatisation, liberalisation, decentralisation and democratisation. If used appropriately, these objectives are geared towards improving the farmers' economic achievements in farming and hence improve on quality of life.

While the key defining principles of NAADS are empowering farmers, targeting the poor, mainstreaming gender issues and deepening decentralisation, the programme targets the 'economically energetic and active poor', that is, those who have demonstrated modern forms of farming (NAADS, 2011). Most of these people tend to be youths or adults, implying that older persons are excluded. This, however, defeats the aim of NAADS, which is to alleviate poverty. Excluding older persons most of whom

are poor is therefore unfair and needs to be addressed by eliminating such excluding conditions. This should be one of the recommendations NAADS program implementers should consider in order to ensure that the programme achieves its aims without being discriminating against Ugandan farmers generally and older farmers in particular.

f) The Decentralisation Policy

Decentralisation policy was initiated way back in the late 1980s as a number one issue of the ten point programme brought by the National Resistance Movement (Italy & Mugabi, 2004). The return of the rule to the people was a main agenda for the NRM government in 1986. The formulation process of decentralisation policy was preceded by an unofficial pilot case of the Bush Resistance Councils as well as the official pilot study that involved three districts of Mukono, Mubende and Masaka. Consultations and inquiries began thereafter in order to gather enough information about local government systems. These were followed with phases of technical analyses and discussion papers until when the policy was approved at cabinet and parliamentary level, leading to its adoption in 1992.

The 1992/1993 national budget was formulated following this policy because it was envisaged to improve social services provision in Uganda (Mutabwire, undated). The objectives of the policy were to contribute to the development of Uganda by empowering the people and institutions at every level of society including public, private and civil institutions, improving access to basic services, increasing people's participation in decision making, assisting in developing people's capacity and enhancing government's responsiveness, transparency, accountability and representation in the management of public affairs. All these objectives were intended to democratise society, bring good governance, improve service delivery and bring sustainable development.

The policy also provided a framework within which Uganda government implements its Poverty Eradication Action Plan (PEAP). It provided a legal and institutional framework for achieving international and national commitments including the millennium development goals. It has been used as a vehicle for implementing major government policies and programmes. The implementation is carried out by democratically elected representatives who are closer to the people and have a clear mandate to initiate and implement local development plans that reflect local priorities which are arrived at

through active participation by local population (World Bank, 2003). The powers that have been decentralised include political, financial, administration, planning, legislation, and judicial powers. And this is where older person's issues have to be addressed but unfortunately nothing much has been done to make an impact on lives of older persons.

The benefits of the policy were envisaged to include transfer of power to local governments and thus reduce the workload of remote under-resourced central officials and bring political and administrative control over services to the point where they are actually delivered. This policy is implemented through the Local Government Act. This Act provides a legal framework that guides local administration and participation of the various groups of people in decision-making pertaining to public service delivery at District (Local Council V), Sub-county (Local Council III) and Local Council One levels. The 1997 Local Government Act excludes older persons over seventy five years from participation in local governance as district or city leaders. This is articulated in Article X, section 111 (c). This article states that, "a person shall not qualify for election as chairperson of a district or city unless that person is at least thirty five years and not exceeding seventy five years" (Local Government Act, 1997).

On realising how important older persons are good in playing leadership roles, the 1997 Local Government Act was later amended to provide for representation of older persons. The amended Act became the 2006 Local Government Act. The 2006 Local Government Act mentions the groups as including women, the youths and older persons. In particular, older persons are mentioned in Article 10 that focuses on the composition of district councils. Indeed, Article 10 (f) states that district councils shall consist of "Two older persons, a male and female, above the age of sixty years and elected by the executive committees of the respective associations of the older persons" (Local Government Act, 2006). This was intended to achieve representation of decisions of older persons to the council.

A review of the progress of implementing the decentralization policy revealed that it has been accepted by almost all the ministries as a means of service provision; it has also led

to poverty reduction from 56% in 1991 to 35% in 2003 (Italy & Mugabi, 2004) but met amidst challenges that need to be addressed. One of the challenges was identified as failure to enable older people to participate in decision-making and access social services such as healthcare, particularly at the district (Local Council V) and Sub County (Local Council III) level. With a view of solving this and other challenges, the policy has been refocused in order to enhance people's incomes and expand the tax base for local governments (Mutabwire, undated). A bill is also being formulated to increase the representation of older persons at local council five and parliament. However, no tangible benefits have trickled down to older persons. The proportion of older person living in abject poverty is still high, suggesting that more improvements are still needed to make the decentralization policy more beneficial to these people.

g) Pensions Policy

The pension policy focuses on provision of retirement benefits, gratuity and pension for the older persons disengaged from active service. It was formulated to operate more or less like a source of social security for people retired due to age or health problems. It was established by government to cater for employees in the Ugandan protectorate. The provision is guided by Article 254 of the constitution. The scheme is funded by the Ugandan government out of government tax revenue. On retirement, a public servant gets a lump some payment basing on his last pay and the number of years worked for. Thereafter a monthly payment is made until he dies, thereby leaving the payment to his/her family members to continue getting it for about 15 years thereafter. In spite of the smallness of the amount given, it is found to be a valued transfer scheme for those benefiting from it.

The pension policy targets former civil servants such as teachers, soldiers, widows, and former public servants who retired at age of 60, the police and army who retire at 55 years and the judges who retire at 65 years. This implies that all older persons who have never worked for government or in formal private employment because of lack of education and who, moreover, are the majority in Uganda, are not catered for by this policy. In fact, the policy is currently catering for only 40,000 older persons out of all the

older persons who consist of 6.1% (1.2 million) of Uganda's 30 million people. Alternatives to the Pensions Policy are therefore needed to cater for the social protection of the majority of the older persons in Uganda.

In addition, the pension policy also needs amelioration, particularly in the light of the various challenges faced in its implementation. Firstly, the processing of the pension takes a long time because of the bureaucratic nature of the required documentation and verification, which, moreover, makes it costly in terms of transport. All the offices are located in Kampala yet most pensioners are in the rural areas that are far from Kampala. Thirdly the pensioners at the district level face even harder challenges as they are often denied the pension because of constraints in the resources at district levels. The lack of resources sometimes also affects the timely payment system. And in most cases the pension is too small to meet the basic needs of the pensioners as majority have a number of dependants such as orphans and grandchildren who are under their care.

In addition some pensioners miss out on the pension because they are not aware of the procedures involved. This is because the process itself is initiated by the pensioners themselves and not the government. It is even worse when the pensioner dies earlier and the members of the family are ignorant about the system. The other challenge is about the tedious process of registration that requires a lot of documentations, the lack of customer care at the pension offices, the unfriendly services and corruption, among others. As a result, majority of the retired older persons in Uganda do not benefit from the NSSF and pension schemes (Ntale-Lwanga & Kimberley, 2003). Most of these people find it so hard to access their retirement benefits let alone pensions that they end up giving up, thus suffering as though they are not entitled to the pensions (Najjumba-Mulindwa, 2004; Mugambe, 2006; Bagala. 2007). There is therefore need to address these policy challenges so that 2% of older persons supposed to benefit from it are enabled to do so in a simple manner.

h) The National Social Security Fund (NSSF)

The National Social Security Fund (NSSF) is part of the public service pension scheme which is a provident fund to which all private sector employers with five or more staff

and their employees must make mandatory monthly contributions. The scheme was initiated in 1967 as a provident fund on government's realisation that there was an influx of people from the villages who were in formal employment but who when they retired in later years had no fall back position in terms of gratuity or pension. In 1985 the scheme gained autonomy from the Ministry of Gender Labour and Social Development and became the National Social Security Fund.

Under the scheme, the employer is required to contribute 10% and the employee 5% to make a total of 15%. The funds are then invested and interest is paid every year to individual members. The objective of the scheme is to provide a comfortable fallback position on retirement and permanent injury. The target group include employers and employees in formal employment. NSSF has sub-schemes which include survivors' benefit which caters for the families of members that have passed away; invalid benefit for those that have been permanently injured or disabled; and old age benefit for those who retire.

The terms of payment are such that each member has an account to which his/her contributions and interests are credited. The scheme specifies the retirement age and the sustenance of permanent injury. The benefits are paid in lump sum using standard criteria for members to obtain benefits. This enables the beneficiaries to plan and also execute investments. The challenges are that sometimes the beneficiaries misuse the money when it is paid to them at once in lump sum. The other challenge is that the funds do not provide protection to members who have not been in employment for a long time. Finally the scheme does not benefit families of contributing members who either die young or fail to make a claim due to various reasons. The NSSF policy suffers shortcomings similar to those of the pension scheme, implying that improvements are also needed in the policy, especially in its implementation.

i) Functional Adult Literacy Programme

The functional adult literacy programme was formulated to provide functional skills, knowledge and attitudes necessary for effective participation in development and advancement of concerns of the adults and older persons in the national agenda (Help

Age International, 2006; Odurkene & Okello, 1985). The program was formulated way back in 1992 and it was embedded within the policy on education and other policies. It was formulated as a result of evidence from several studies about the low level of education attainment that had led to low productivity and technological uptake of Uganda's labour force. This was a challenge to national development. The programme promotes social functioning and is targeting mainly the adults and older persons who did not get an opportunity to acquire formal education. It is through this programme that the Uganda government committed itself to supporting functional adult literacy activities, promotion of older people's access to information through public library networks, and contracting some of the activities to community-based organisations that have easy access to older persons.

The vision of Adult learning and education as spelt out in the draft policy is "a literate, well informed transformed and prosperous society" while, the goal of the policy is to promote non-formal adult learning programs for equitable and sustainable development. The objectives of the program aim at providing: 1) basic fundamental education so as to attain good deficiencies many people experience because of curtailed education or non-existence period of formal education; 2) opportunities for further or continued education in order to update professional competencies required by the world work; 3) vocational and technical education necessary for the acquisition of certain specific skills needed for the improvement of job performance; 4) education for building social, political and civic competencies including instructions on national and international issues; 5) education for leisure and relaxation; 6) education on health, welfare and family life including guidance on physical and mental health, family problems and parenthood.

The draft policy defines adult education as all learning processes, activities or programs intended to meet the needs of various individuals considered by society as adults and youths forced out of school by circumstances so that they can play roles normally played by educated people (Ministry of Gender, Labour & Social Development, 2008). Adult education is one of the means through which a second chance is given to those who have been and continue to be marginalised (Ordukene & Okello, 1985). Adult Literacy enables people to access information from both print and electronic media. As the saying goes

that "information is power", access to information is vital for participating in the development processes. People need information concerning production mechanisms such as adopting new technologies in modern methods of farming, marketing of products, availability of jobs and all the existing development programmes in the community. Reading skills enable people to read posts, posters and all the information on developments taking place in their localities. Adult Literacy is a key component in empowering the individual/communities to be self-confident and participate in development opportunities/activities (Ministry of Gender, Labour & Social Development, 2008).

Adult Literacy programme increases awareness among the individual participants/learners and their communities. They therefore become conscious of whom they are and the potentials they have within themselves. This increased self-consciousness results into individuals and communities tending to develop positive attitudes towards work, innovation, optimal use of resources, participating in community work, harmony and behavioural change. Adult Literacy equips participants with appropriate life skills which are necessary for employment and increased household incomes and standards of living thus creating wealth (Ministry of Gender, Labour and Social Development, 2010a). It was therefore important that measures are put in place to promote literacy especially adult literacy because of the immense benefits it has across the sectors of development such as health, agriculture, water, environmental management, good governance, hygiene and sanitation, nutrition as well as influencing the learning outcomes of children (Ministry of Gender Labour & Social Development, 2008).

The implementation of the program is a responsibility of the local governments while the central government does the policy formulation, standard setting monitoring and evaluation and support supervision of the program. The challenges are that currently there is no comprehensive policy on adult education but an attempt has been made to formulate one which is still in the process of formulation. But however policies such as Vision 2025, the PEAP, the Uganda 1995 constitution, the National Health policy, the

education policy, the national adult literacy strategic investment plan, the national equal opportunities policy, PMA, the rural development strategy, the social development sector strategic investment plan and the national gender policy all have activities related to literacy such as health education, community development among others (Ministry of Gender Labour and Social Development, 2008). For instance the Constitution of the Republic of Uganda under Objective XVIII, directs the State to promote free and compulsory basic education. It also enjoins the State to take appropriate measures to afford every citizen equal opportunity to attain the highest educational standard possible. Further more, Article 30 of the Constitution states that all persons have a right to education (The Republic of Uganda constitution, 1995).

The above measures have been implemented in the country and are ongoing though facing some challenges. According to the Ministry of Gender Labour and Social Development (2008) Adult Education programs in Uganda have inherent weaknesses and face many challenges as they work towards the empowerment of marginalized groups. The author indicates that majority of marginalized groups do not enrol in adult education. Those who enrol exhibit high levels of irregular attendance, absenteeism and drop out yet these are the same groups that have been left out of formal education. For example a study carried by Rogers (2008) in Kalangala and Buvuma islands found out that the older persons were shy of coming to classes; they believed there are standards of dress for class membership which they do not meet. Some of them were found to be too busy earning enough to keep their families rather than taking time off for what they see as irrelevant learning, literacy. In addition functionalities on economic activities were taught but unfortunately the chosen economic activities did not bond with the district development plans. While in the northern region adult learning was affected by wars (Cula, 2000) so most adults including older persons had no chance to enrol.

Concerning monitoring and evaluation, the Ministry of Gender, Labour and Social Development put in place a national curriculum and the implementation guide together with an assessment guide that is used in the implementation, monitoring and evaluation of the program (Ministry of Gender, Labour and Social development, 2004). Funding was

provided by local and central government, local non profit organizations, foreign/international organisations and NGOs, commercial enterprises, and individuals who sponsor themselves for further education and membership fee.

However, the programme faces challenges like poor incentives for the educators which compromised the quality of their work, the training is scattered and not coordinated which leads to duplication and wastage of resources. There is no unified curriculum for adult educators given the diversity of the programs. This diversity makes it even difficult to bring the practitioners together. While the other challenge is the job market that has not yet acknowledged professionals in the field of adult learning hence, there is lack of employment of the graduates of adult learning (Ministry of Gender Labour and Social Development, 2008). Probably if this is rectified, there could be an increase in the enrolment.

j) Food and Nutrition Policy (Draft)

This initial formulation process began in 2003 based on the framework of the 1995 constitution of Uganda which stipulates that the state is required to fulfil the fundamental rights of all Ugandans to social justice and economic development, and to ensure that all Ugandans enjoy the rights and opportunities and access to education, health services, clean and safe water, work, decent shelter, adequate clothing, food security, pension and retirement benefits. It was based on evidence that about 38% of the population live in absolute poverty due to low productivity of crops, livestock and fish. There was indication of in adequate intake of foods containing micronutrients, protein and energy (MOH, 2004). As a result, there were increasing diseases such as protein deficiency malnutrition, vitamin A deficiency, iodine deficiency, malaria and HIV/AIDS. The policy was also based on international frameworks such as the Declaration of Human Rights among others (Ministry of Agriculture, Animal Industry and Fisheries & Ministry of Health, 2004). The formulation of the policy was further occasioned by the fact that in past, emphasis was placed on curative rather than nutrition driven or disease preventing practices. There were inadequate nutrition educations related to non-communicable diseases which are suffered by older persons. There were no programs to increase public awareness about food security and preparations. There was limited information,

education and communication packages to effect wholesome behavioural changes in nutrition awareness and healthcare practices. And finally there was limited research done in the area of nutrition to provide evidence for policy formulation.

Based on the above evidence Ministry of Health and the Ministry of Agriculture, Animals Industry and Fisheries and other relevant stakeholders were authorised to promote household food security and healthier eating habits with special attention to children, pregnant women and lactating mothers. Unfortunately the older persons are not emphasised in this policy as target group yet they too do face food insecurity and malnutrition as a result of lack of awareness on the right foods to eat as well as lack of affordability due to high levels of poverty. According to the policy document the national targets include reduction in stunting in the under 5 years old children from 38% to 28% ; reduction in under weight in the under 5 years old from 26% to 20%; increase and sustainable Vitamin A supplementation coverage for children 6-59 months from 80% to 95%; increase public awareness on appropriate nutritional practices to 95% and increase on exclusive breastfeeding at 6 months from 68% to 75% (Ministry of Agriculture, Animal Industry and Fisheries & Ministry of Health , 2004). However the policy talks more on children and adults leaving out older persons.

The overall goal of this policy was to ensure food security and adequate nutrition for all people of Uganda. While the overall objective of the policy is to promote the nutritional status of the people of Uganda through multicultural and coordinated interventions that focus on food security, improved nutrition and increased incomes. However the policy does not mention the vision and mission. Probably this is because of the tendency to develop policy within the framework of MDGs and International Declarations and therefore the vision of the policy is overlooked and the focus is geared towards the goals of the framework in which the policy is developed. Discussing a vision of a policy in the context of the vision of MDGs creates an impression that the goals are more important than the vision. Most policies in Africa including Uganda fall prey to this trap. If they succeed good lack but most cases they don't because the whole conceptualisation right from the word go is faulty. This has always been a problem in this country. Thus the

visions of most of the policies you need to look for them in the objectives and aims because they are not always mentioned in majority of the policies.

The main areas of focus of the food and nutrition policy include food supply and accessibility; food processing and preservation; food storage, marketing and distribution; external food trade; food aid; food standard and quality control; nutrition; health; information education and communication; gender food and nutrition; food nutrition and surveillance; and research.

Unfortunately, despite the tremendous focus of the policy with very good objectives, it is still in draft form, has not been implemented and has therefore not made any impact generally and with regard to older persons in particular. Accordingly, older persons, especially those in northern Uganda are still faced with food insecurity. Many of them are malnourished because of lack of nutritious foods. There have been a lot of food shortages and monotonous diets in Uganda but very minimal efforts have been put in to rescue the situation. Good nutrition is a pre-requisite for adequate growth and development, health, learning capacity, work performance and good quality of life; it is an indicator of economic well being but unfortunately majority of Ugandans, particularly older persons are facing the challenge of good nutrition.

k) Home-Based Care policy (HBC) - 2010

A review of the HBC policy revealed that this policy was intended to promote the quality of life of all people suffering from chronic conditions and long-term illnesses. The policy is in line with the National Decentralisation Policy, the National AIDS Strategic Plan and the Health Sector Strategic Plan. It deals with the provision of psychological, medical, social, material, and spiritual support to the clients and their families. The policy is not particularly about older persons but as people who are susceptible to chronic diseases, they, too, are its direct beneficiaries. The formulation of this policy used multiple ministerial expert consultative workshops but not empirical prior research and open debates to look for people's opinions. This implies that it did not cover all the issues that would have been generated by research and public debates. This is why it fails to specify older persons who tend to be vulnerable to chronic diseases, putting a lot of emphasis on

children, mothers and women, and HIV/AIDS as if it is the only chronic illness. It is also silent on specification on home based care provisions for older persons but some clauses articulating issues of older persons were included and there are no specific guidelines on home based care for older persons (The Republic of Uganda, 2010). There is therefore need to expand the scope of this policy in terms of specific target groups and specified chronic diseases. This will ensure that older persons are brought into the picture.

l) National Health Policy I

This policy was intended to guide delivery and improvement in the delivery of health services in Uganda (Ministry of Health, 2007). It was developed as a result of the country experiencing various problems in health service provision. The problems included: under serving of some areas of the country, scarcity of hospital infrastructure in regions, long distances to access health services, and health was under prioritised compared to social sector (Ministry of Health, 2007). This policy started to be developed in 2000. The aim was to decentralise government health services to district and lower levels. The government further introduced a Minimum Healthcare Package in order to be able to meet its budgetary allocations adequately. A health policy was formed and derived its guidance from the Alma-Ata Declaration of "Health for All" strategy (Ministry of health, 2007). The policy focuses on provision of primary healthcare services on major burdens of disease including preventive and curative services. The burden of disease that are focused on include malaria, HIV/AIDS, TB, diarrhoeal diseases, respiratory tract infections, prenatal and maternal conditions, vaccination of preventable childhood diseases, malnutrition, injuries, adolescent services and physical and mental disabilities. This constitutes the minimum healthcare package that was to be reviewed regularly. Many illnesses relating to older persons were however excluded and this makes it difficult to plan for their treatments and even include the drugs that treat older persons' illnesses on the essential drug list.

The implementation of the policy is guided by the Health Sector Strategic Plan which stipulates the delivery process of health services at different levels of each health care system. It also underscores the importance of partnering with the private sector in delivering improved healthcare services to the people of Uganda and this has been taken

care of in the reviewed draft Health policy 11 (Ministry of Health, 2005/06). Great emphasis has been put on the poor, adolescents, women and children and less attention was put on non-communicable diseases. As a result, research indicates that the Health Policy 1 in Uganda largely ignored the health needs of older people (Lloyd-Sherlock, 2000b; 2002). Research also shows that 80% of type II diabetes and premature heart diseases and stroke, and 40% of cancers that could be avoidable remain high in Uganda (Okiror, 2007) probably because of the less attention given to such diseases. In addition, the percentage of disabilities among the older persons in Uganda is currently 18 percent (Uganda Bureau of Statistics, 2002). This could have been avoided had the Health Policy 1 in Uganda included active ageing programmes in the health service delivery system in the country (Nusbaum, 2007; Knickman and Snell, 2002).

Literature indicates that there were various constraints in the implementation of the National Health Policy I (Omaswa, 2007). The constraints included under funding of the provision of the Minimum Healthcare Package which is anticipated to be much lower (9.6%) than the 15% percentage that was recommended by the Abuja Declaration, there is still poor access to health services that is caused by long distance, poor quality of services, inefficient allocation of resources, poor distribution of human resource, low staff morale due to poor remuneration, over dependence on untrained staff in primary healthcare facilities, weak management and supervision system and inefficient collaboration with private sector that has resulted in poor outcomes (Jeppsson, 2004; Omaswa, 2007). Some of these challenges are similar to Garshong et al. (2001) findings in their study on factors influencing implementation of the health policy in Ghana. However what came out of this study that is related to these findings was the rudeness and negative attitudes of health personnel as they treated older persons. As a result this affected the older persons' accessibility to health services.

The above mentioned variations in the implementation of the Minimum Healthcare Package led to the introduction of Health Sector Reforms such as 2000/1-2004/5, Health Sector Strategic Plan (HSSP) that was made in line with the PEAP and the decentralisation policy, State Wide Approach Plan (SWAP) to provide guiding principles

in health planning and resource mobilisation in line with the decentralisation policy. Other strategies included partnership with private sector in the provision of health services, and introduction of result oriented management (ROM) across public service to help in the supervision, monitoring and evaluation processes.

Opinion from Omaswa (2007) indicated the need to develop Quality Assurance programs which are designed exclusively for ensuring continuous performance improvement in the sector. And use of existing management structures to promote and consolidate a culture of openness and trust in order to make members of the sector to believe that they are valued and respected. The other strategy that was proposed by this author was continuous monitoring and evaluation which involves monitoring the effectiveness and consequences of the policy so as to find out if it is achieving the desired results. Monitoring and Evaluation of a policy seeks to relate and assess the connections between actual policies and changes in the areas they are supposed to be influencing. It is intended to find out the policy outcomes and suggest changes/adjustments where possible (Barkenbus, 1998). Evaluation is also necessary because policies become outdated, unclear or contrary in their implementation after sometime. When these occur the policy may need modification or elimination. It was therefore necessary to review this policy on a regular basis because this helps to keep track of the progress of the policy. Even the revisions being made to come up with what has been referred to as draft Health Policy II do not seem to have given older persons priority. They are covered as part of the general public, which should not have been the case. Older persons suffer the illnesses that face any other persons but there are diseases (such as Diabetes II, hypertension, arthritis, etc) that are common among them and which, therefore, need special policy attention.

m) National HIV/AIDS Policy (2008 Draft)

This policy provides broad intervention guidelines for HIV/AIDS, counselling and testing and addressing stigma and discrimination. Its aim is to promote and make Voluntary Counselling and Testing (VCT) services user friendly particularly to the youths, sex workers, and older people. Though the policy mentions the older persons as one of the target group, the programs designed to deal with the epidemic and mitigate its consequences rarely take into account the older persons. However it does acknowledge

the impact of HIV/AIDS on older persons. It also defines no specific or explicit strategies to promote access to HIV/AIDS services by older persons.

Another reviewed policy document was the National HIV/AIDS Strategic Plan (NSP). The NSP operationalises the National HIV/AIDS policy. It recognises that HIV/AIDS epidemic has geographic, socio-demographic and socio-economic heterogeneity. And it also acknowledges that as the epidemic matures, the population groups most severely affected have shifted from young unmarried individuals to older and married or formerly married individuals. It also continues to acknowledge the roles of older person populations in caring for orphans. Older persons are identified as a target group for social support. NSP provides an opportunity for developing interventions and allocating resources to address older persons' HIV and AIDS concerns and interventions unfortunately this has not yet translated into actions that can be noticed. The gaps in this policy are that NSP does not specifically spell out prevention, care and treatment, social support and home based care services for older people. No specific guidelines on HIV/AIDS services have been pointed out for older persons and not even its performance indicators are specific to the older persons.

As a result, while there have been attempts to set up youth friendly VCT services, older persons friendly services have not been taken into consideration. Even the community education channels such as mass media, community events, bars, dances, STD clinics, music, drama, and antenatal clinics that are used to sensitise the public about these services, leave out older persons (Help Age International, 2006). Even when posters are made most of them indicate images of young people which reveals a picture that HIV/ AIDS is a young people's disease. Many of the older persons cannot read yet much of the HIV/AIDS messages are in written form. This implies that much more policy action is needed in Uganda in order to bring the older persons on board. That is there is need to take into consideration the older persons' needs in relation to HIV/AIDS because they are also affected and infected by the disease.

n) National Antiretroviral Treatment (ART) policy and the ART Guidelines for Adults, Adolescents and Children

The ART Policy for Uganda misses out on the Older People. The policy spells out the recommendation for treatment of HIV-infected patients and prevention of HIV transmission such as: those who meet clinical eligibility criteria; post-exposure prophylaxis; HIV-infected mothers; children and infants infected by HIV through mother-to-child transmission (MTCT), blood transfusion, sexual abuse and infected needles among others. However, the policy does not specifically provide for treatment of older people. While a review of the policy guidelines on antiretroviral therapy revealed that the guidelines were formulated as a result of the statistical evidence of the increasing burden of HIV care since an estimated 2.6 million people have been infected with HIV while 1.6 million of the infected people have died and this number is expected to increase rapidly (Ministry of Health, 2009; Kawuma, 2011). In addition there were major challenges in delivery of care and treatment in terms of limited infrastructure, human resource and supplies. The document consists of guidelines for the administration of Antiretroviral Therapy in Uganda. The objectives of the guideline are; (1) to provide a standardized and simplified guide to use of antiretroviral drugs in a comprehensive HIV/AIDS service delivery setting, (2) to maintain a standard delivery of ART with evidence-based, safe and rational use of antiretroviral drugs and finally (3) to serve as a training tool and reference material for health service providers, program managers and people living with HIV.

The policy provides details of how ARVs should be administered to people infected with HIV/AIDS (MOH, 2003). It also seeks to promote provision of information regarding ARVs at community and facility levels in order to increase people's access to this information. However the main target groups of the guideline are adults in the productive age, adolescents and children. The guideline is, silent on older persons yet they too are affected and infected by HIV/AIDS (MOH, 2009). The ART guidelines are intended for all health providers who work with HIV/AIDS positive patients but do not recognise that older persons with HIV may have their unique medical, social and emotional tensions, which should be addressed to aid decision making in ART. A family

based approach as the best strategy for addressing issues of disclosure and partner testing can be particularly difficult for older persons. Review of the Uganda National Policy guidelines for HIV, VCT, for instance VCT I, the major lynchpin in HIV and AIDS prevention and care strategies was not specific on access for older persons yet it is known that there is stigma associated with HIV and more so among older persons. The policy also indicated that PEP should be given to those exposed to HIV. However it does not indicate that the older persons should also get PEP yet it is known that some times they get exposed to HIV through caring for OVCS and other relatives living with HIV/AIDS.

o) Draft National Policy for Older Persons (Ministry of Gender, Labour, and Social Development, 2007)

At the time of writing this policy was still in the pilot stage of its formulation. It is aimed at forming a basis for programme planning and implementation of issues pertaining to older persons. According to Help Age International (2006), this draft document recognises the social security challenges facing the older persons. It also highlights HIV/AIDS as a challenge to older persons since many of them remain sexually active. It also recognises the role of the older persons in taking care of the orphans left behind by adults. Consequently, it seeks to mainstream the challenges of older persons into sectoral programmes and plans that can help promote the welfare of these people. However, the extent to which this draft has been put into action remains dismal probably because of the lack of policy guidelines that would help in the implementation process.

At the same time, the National Council for Older People Bill, 2010 is also in the making. The Bill intends to provide for the establishment of a National Council for Older persons to coordinate various stakeholders involved in the implementation program for older people in accordance with the constitution; to promote participation and influence of older people to ensure that the wide range of experience that older people have represent an important resource that will be utilized in all planning processes and development activities at all levels. The specific objectives of the council are to promote the implementation and equalization of opportunities for older persons, to monitor and

evaluate the impact of policies and programmes designed for equality and full participation of older persons, and to advocate for and promote effective service delivery and collaboration between service providers and older persons. The other objective is to advocate for the enactment of laws and reviewing of existing laws with a view to complying with the constitution, other laws and international legal instruments. It was referred to a Committee on Gender for Consideration (Kibuuka, 2011).

The functions of the council include the following: 1) to act as a body at a national level through which the needs, problems, concerns, potentials and abilities of older persons can be communicated to government and its agencies for action; 2) to monitor and evaluate the extent to which government, NGOs, and the private sector include and meet the needs of older persons in their service delivery; 3) to act as a coordinating body between government departments, other service providers and older persons; 4) to solicit for and acquire funds and other resources from government and development partners for use in the performance of the council's functions; 5) to advocate for the promotion of and encourage activities undertaken by institutions, organisations and individuals for the promotion and development of programmes and projects designed to improve the lives and situation of older persons; 6) to carry out or commission surveys and investigations in matters or incidents related to older persons; 7) to hold annual general meetings of representatives from councils for older persons or the purposes of reviewing the councils performance and also plan for the subsequent year; 8) to assist the electrical commission to ensure the conducting of free and fair elections of representatives of older persons to local government councils and parliament; and 9) to perform any other functions relating to the above as the minister may determine. At the time of writing the bill had been tabled in parliament for the first reading (MGLSD, 2010b). The Department is also in the process of working on the National Programme Plan of Action for older persons 2011/2012-2015/2016 (Baryayebwa, 2011).

Overall, findings obtained from key informants and document review suggest that while Uganda's Constitution provides a clear basis for formulating policies on the plight of the older persons, the policies that have so far been developed are still lacking in one way or another as far as effective addressing of this plight is concerned. Document review

revealed that various policies have been formulated to address public needs and are relevant to addressing the plight of older persons. However, the target beneficiaries of most of these policies exclude or pay negligible attention to older people, thereby denying them a chance to participate in, let alone benefit from the mainstreamed development programmes implemented in Uganda.

In particular, despite PEAP's targeting of the poor and although it recognises older persons, its implementation through the policies formulated subsequently from it does not pay recognisable attention to the concerns of older persons (simply because of lack of information on these concerns). Not having information on older persons implies that PEAP failed to specify and address the needs of these people. However, as a framework guiding national development, PEAP needed to ensure that this information is collected so as to appreciate and integrate the needs of these people because they, too, are part and parcel of society. Their concerns needed to be included in the overall development framework. Secondly, both the contributions that the NAADS programme requires of people before bringing them into the fold and the focus on the PMA on only energetic farmers serve to eliminate older persons. Setting conditions means that older persons most of whom cannot afford the requisite assets because of poverty are eliminated from participating in the NAADS programme. In fact, earlier findings indicate that many of these did not even have land, the asset that one must have in order to satisfy some of the conditions of the NAADS programme.

Participation of older persons in the NAADS programme is further undermined by their limited ability to organize themselves in pre-requisite groups. Moreover, many groups require membership fees, which older people can not afford due to poverty as found out earlier. Besides, the co-financing element required of some groups to benefit from development programmes excludes older persons who can not afford counter-funding (Kibuuka, 2011). Older people lack access to information on the available development programmes and how they can benefit. Information Education and Communication (IEC) strategies do not have an explicit strategy to reach out to the older people since in the majority of cases they are considered as "unproductive" by the policy makers and

implementers. At the same time, targeting the economically energetic farmers excluded older persons because they are expected to be weak and frail, at least according to the psychological theories of old age. These three policies are significant to the development of agriculture in Uganda. Therefore, anyone they excluded is denied effective access to and control of productive agriculture.

The review also revealed that policies on decision-making do not articulated the role of older persons except at Local Government Councils. This implies that the policies do not adequately empower older persons to influence development issues through decision-making. From earlier findings, it was established that these people are a fountain of wisdom and have the capacity to give guidance and direction to community development initiatives. Their policy exclusion from playing this role is therefore unfair and needs to be addressed as shall be elaborated latter. The review revealed further that some of the policies acknowledge older persons as a special category that requires attention to solve their problems. There was lack of coherency in policy with no specific policy for older persons until 2009 when one was launched. The policies cited above are scattered across various sectors and are not formulated to explicitly address the issues of older persons. In fact some of these policies do not even categorize their activities as activities for older persons. There is scattered implementation by the various sectors and institutions without reference to each other and with no coordination. There was also lack of discussion of older person's specific risks and vulnerabilities within the policies reviewed. HIV/AIDS related policies were not explicit about HIV/AIDS services targeting older people despite the fact that older persons have their own unique challenges. For instance the ART guidelines do not provide directions to health workers on how to respond to older persons, provide counselling and follow up. The National HIV/AIDS policy guidelines do not specify older people as a risk and special group which require special attention in the fight against HIV/AIDS.

At the time of writing, the lack of data on the needs of older persons which was acknowledged by the PEAP policy at that time seemed to have been the major barrier to policy formulation as far as issues of older people are concerned. At the same time, at

the time of writing the older persons policy was still under preparation and review of this policy was out of the scope of this study as it was still in the making. However though there were identified gaps in policies previously, current evidence shows that there is tremendous effort made by the Ministry of Gender, Labour and Social Development in changing the situation of older people in Uganda.

A careful scrutiny of the results reveals that the Uganda government has made some positive strides towards looking into the concerns of the older persons. Specifically, the government recognises these concerns as reflected in a number of national legal instruments that it has enacted and a number of international conventions relevant to the plight of the older persons, which it has ratified. The results are therefore in agreement with the observations made by Kollapan (2008), Help Age International (2007b, 2001), the Department of Social Development (2001), the European Convention on Human Rights (2001), the Northern Ireland Human Rights Commission (2001) and Murray (2000) that various countries the world over recognise the concerns of the older persons through national legislation and ratification of international conventions regarding the plight and place of these people in society.

The extent to which the Uganda government recognises the concerns of the older persons is reflected in a number of articles or sections of such enacted legal documents as: the 1995 Constitution, the supreme law of the land, the 2006 Local Government Act, National Social Security Fund (NSSF), the Pensions Policy, and other instruments, Uganda Vision 2025, Programme for Modernisation of Agriculture, Functional Adult Literacy Programme, Home Based Care, and the Draft National Policy for Older Persons. It is also evidenced in the international conventions that the Uganda government has ratified, including: the 1982 Vienna International Plan of Action on Ageing; the 1991 United Nations Principles for Older Persons, the 2002 Madrid International Plan of Action on Ageing, and the African Union Policy Framework and Plan of Action on Ageing.

The enactment of the aforementioned instruments and ratification of the aforesaid international conventions gives an impression that the government of Uganda has registered a considerable extent in the direction of addressing the plight of her older persons. This impression is, however, false to large extent. Further scrutiny of the findings reveals that the extent is greatly low as it is largely confined at only recognising the plight of these people. Recognising one's plight is far different from addressing it. To recognise a person's plight is to appreciate the fact that the person faces a problem or a challenge and that is it. It does not involve taking action intended to address the problem or challenge. Therefore, the Uganda government's efforts to recognise the plight of the older persons at a level of constitutional enactment and ratification of international conventions do not amount to addressing this plight as desired. Though such recognition is necessary, it is not sufficient. The enacted constitutional articles and ratified conventions have to be translated into appropriate action by legislating and implementing enabling policies. In Uganda, however, results indicate that when it comes to addressing the plight of the older persons through policy action, the success that government has achieved is far too low.

Government established a department of the older persons in the Ministry of Labour and Gender Affairs; has been implementing the National Social Security Fund (NSSF) and the Pensions Policy; and has drafted the National Policy for Older Persons which was inaugurated on 1st October 2009 in Namutumba. This partly supports the observation made by Yeung-SikYuen's (2008), the Age Concern Report (2006) and Gravis (2004), that in most countries, policies dealing specifically with older persons are limited to issues addressing pension funds for retired civil servants or those in other formal employment. However, success achieved in Uganda as far as each of these policy actions is concerned is unfortunately very minimal. As one key informant lamented, the department established has no budget, is not funded at all and is therefore very ineffectual. It just exists for the sake of it.

The success of these policies is even made more negligible given that the operational NSSF and Pensions Policies cater for only those older persons retired from formal

employment. These people constitute a very small proportion of the older people's population in Uganda, implying that the two policies address the plight of a handful of the older people in the country. Moreover, quoting the welfare perspective, the Help Age International (2007a) argues that this is unfair to the majority of older persons all of whom are, according to the 1986 African Charter on Human and Peoples' Rights, entitled to benefits from government in recognition of the contributions that they make to the development of society before their disengagement from active public activities and roles. Moreover, the implementation of the NSSF and Pensions Policy is reportedly marred with problems such as swindling of pension/NSSF money by officials through losing, misplacing or hiding their records, or declaring some of the pensioners dead, even when they are still alive as some of the respondents reported. This concurs with the observation made by Help Age International & HIV/AIDS International Alliance (2006) that older persons tend to have their right to social security violated by lack of proper identity caused by loss of documentation. This is because such loss prevents them from claiming their entitlements. Such problems coupled with delays in the release of pension/NSSF funds make success registered by Uganda government in addressing the plight of the older persons retired from formal employment largely negligible. There is need to have paralegals who could be helping out in such situations of the older persons so that their rights are fulfilled.

The situation is worsened by the fact that the National Policy addressing the plight of all older persons irrespective of their past employment status was only in a draft form at the time of writing. It had neither been debated and passed in Parliament nor implemented during the time of the study. Other acts such as the 2006 Local Government Act and programmes such as Uganda Vision 2025, Programme for Modernisation of Agriculture, Functional Adult Literacy Programme, Home Based Care, which address some concerns of the older persons are also hampered by ill-funding and lack of clear guidelines for addressing the concerns. Even the ratified international conventions are largely not backed by enabling local policies. This supports Yeung-SikYuen's (2008) who contends that although some African countries have policies on ageing, there is little to show as far as effective addressing of the plight of the older persons is concerned.

The foregoing arguments are clearly backed in the results obtained from the key informants. The majority of these respondents showed that Uganda government legal instruments are not effective in addressing the concerns of the older persons in Uganda, adding that there is nothing much to show on the ground. Even the few key informants who showed that the older persons are catered for in some articles of some government legal instruments were quick to add that there are no policies by which the articles can be implemented. This was further endorsed by the view expressed by other key informants who showed that the extent of addressing the plight of the older persons by policy in Uganda is more of paperwork than an action-oriented matter. Further confirmation of the arguments was discovered from the documentary review of the policies in Uganda. It was discovered at the time of writing that there was virtually no specific policy in Uganda addressing the housing and accommodation, healthcare and protection of the rights for the older persons neither was there a national council for older persons that can represent their views in parliament.

The findings are therefore consistent with the observations made by Oloka-Onyango, (2008, 2009), Mugambe (2006), Kalasa (2004), Najjumba-Mulindwa (2004), Alun (2003), and Ntale-Lwanga and Kimberley (2003), that although a number of legal instruments happen to recognise the plight of the older persons in Uganda, the situation on the ground is far different. The plight of older persons continues to be ignored in policy circles.

To recap, findings from key informants and document review suggest that Uganda's Constitution provides a clear basis for formulating policies on the plight of the older persons. However, the basis is insufficiently translated into policy actions for addressing this plight. The net effect has been that older persons are still faced with severe poverty, are abused, and suffer from social and health problems. This situation cannot be left unattended to because the older persons are also citizens who deserve to benefit from government programmes and policies in much the same way as other members of society.

There is therefore need to translate enacted constitutional articles and international conventions pertaining to the plight of the older persons and ratified in Uganda by formulating and implementing a comprehensive and effective policy on the plight of older persons in the country. This will require reviewing most of the development policies and programmes so as to ensure that older persons are explicitly targeted just like the other marginalised groups such as children, women, youth and the disabled. It will also need the use of advocacy strategies to involve older persons in the design, implementation and monitoring of poverty reduction development programmes. It will further need to remove the barriers to participation in development programmes such as membership fees and co-financing conditionality for their groups that hinder them to benefit effectively from such development programmes. The manner in which all these issues can be addressed was also explored by respondents to suggest strategies for the way forward. Findings are presented and discussed in the next section.

6.2 Strategies for Addressing the Plight of the Older Persons in Uganda

The fifth and last objective of the study was to propose strategies for addressing the plight of the older persons in Uganda. This objective was approached by administering interviews and focus group discussions to the older persons as well as questionnaires to the key informants. During the interviews and focus group discussions, older persons were asked to recommend what they thought government would do in order to help them overcome the barriers to their living experiences. Thematic analysis of their responses led to findings summarised in Chart 7.

Chart 7: Strategies for Addressing the Plight of the Older Persons in Uganda

Strategies against Physical Fitness barriers

- Local Councils encouraging the older persons to do physical activities
- Initiation of mass media programmes educating and encouraging the older persons to do physical exercises
- Initiation of projects involving older persons in physical activities
- Opening up health clubs for the older persons

Strategies against Healthcare barriers

- Setting up special care units in hospitals that can offer older people friendly services to the elderly.
- Introducing health insurance as part of the retirement benefits.
- Setting up more hospitals near people to reduce distance costs.
- Revitalising ambulance services for the older persons.
- Recruiting adequate health personnel in public health centres.
- Stocking public health centres with enough medicines.
- Weeding corruption out of hospitals.
- Subsidising healthcare costs for the poor older persons.
- Introducing mobile clinics.
- Providing the disabled older persons with assistive devices such as wheel chairs, spectacles, hearing aids or as required.
- Recruiting geriatricians and gerontologists.
- Improving of the existing curricula of health institutions such nurses, paramedics and doctors to include issues of older persons.

Strategies against HIV/AIDS Impacts

- Initiating a special fund for HIV/AIDS orphans
- Funding or soliciting donor funding of HIV/AIDS orphanages
- Educating HIV/AIDS orphans free of charge
- Distributing free condoms to the grandchildren.
- Providing free VCT services, ARVs and food to HIV positive older persons
- Sensitising grandchildren about HIV/AIDS
- Initiating programmes that target the older persons
- Encouraging existing NGO and Government programmes to include the older persons.

Strategies against economic barriers

- Increasing and paying pension in time
- Introducing a special fund for non-pensioners (non contributory pension)
- Training pension officials in customer care and integrity
- Weeding corrupt officials out of the pensions department
- Stopping to promise hot air
- Paying property losers in wars
- Removing law hindering the older persons from accessing loans from commercial banks
- Initiating a pool to serve as collateral for older persons.

Strategies against Food Security barriers

- Providing the older persons with seeds for food production
- Initiating food production programmes for the older persons
- Providing fertilisers, pesticides, food storage facilities
- Provision of handouts to especially those who are frail and cannot help themselves
- Restoration of hope among the people living in the war ravaged north
- Stopping illegal land evictions.

Strategies against household barriers

- Providing feeding and educational support for the orphans
- Providing school fees and requirements to these children
- Providing better housing units for older persons
- Supporting the older persons with better beddings
- Improving environmental health
- Providing clothing for the older persons and grandchildren
- Encouraging older persons to engage in handcraft making
- Improving discipline in schools regarding HIV/AIDS

Strategies against housing barriers

- Setting up special homes for the destitute and lonely older persons
- Building better housing units for the older persons to live in with their kin
- Initiating a fund for renovating housing units for the older persons
- Encouraging building societies among the older persons.

Chart 7 summarises the various strategies that older persons suggested to help improve their plight of the older persons in Uganda. The analysis of the strategies according to settings revealed that there was no much difference in strategies suggested against the barriers to physical fitness. Most of the older persons in either setting felt that initiation of projects involving them in physical activities and exercises was the best strategy against barriers to their physical fitness.

Regarding strategies against healthcare barriers, while most of the urban older persons recommended setting up special care units in hospitals for the older persons, most of the rural older persons recommended setting up more health centres near people to reduce distance costs, and stocking the centres with enough medicines. However, most of the elder people in either setting emphasized of training of geriatricians and gerontologists as these professionals were lacking in Uganda.

Regarding strategies against food insecurity, most of the older persons in rural areas advised government to provide seeds and other inputs for food production, while those in urban areas recommended initiating food production programmes for the older persons. Weeding corrupt officials out of the pensions department was proposed by most of the pensioners as a good strategy against economic barriers while introducing a special fund for non pensionable older persons was the strategy suggested by most of the elderly respondents in this category. Most of the older persons in either setting advised government to build better housing units for them to live with their kin, especially the grandchildren.

As far as the impacts of HIV/AIDS were concerned, comparative analysis revealed that whereas most of the urban older persons recommended initiation of a special fund for HIV/AIDS orphans and provision of free ARVs and Voluntary Counselling and Testing (VCT), most of the rural older persons recommended provision of food, sensitisation of grandchildren against catching HIV/AIDS and where need arises, provision of free condoms, and provision of free education to grandchildren, particularly orphans.

In addition to older persons, key informants were also asked to suggest plans that could be put in place to help solve the problems of HIV/AIDS that faced older persons in Uganda. The thematic analysis of their responses led to results presented in Table 6.3.

Table 6.3: Strategies suggested by Key Informants for Addressing the Impact of HIV/AIDS on the older persons

Strategy	Count	%
Intensify mobilisation, sensitisation and awareness of HIV/AIDS and its impact	23	46.0
Create HIV/AIDS centres providing free VCT, ARVs, and foods for the older persons found to be HIV positive	16	32.0
Government should provide support to the orphans left with the older persons by their children who died of HIV/AIDS	8	16.0
Mobilise resources and funds for facilitating HIV positive older Persons	6	12.0
Introduce gerontology courses in Uganda's institutions of higher of learning	2	4.0
Create NGOs for the older persons living with HIV/AIDS	2	4.0
Form support groups or associations for the older persons living with or having grandchildren living with HIV/AIDS	2	4.0
Create/Encourage outreach programmes	2	4.0

Findings in Table 6.3 indicate that the strategies that most of the key informants suggested included: intensifying the mobilisation, sensitisation and awareness of HIV/AIDS and its impact among older persons (46%) and creation of HIV/AIDS centres providing free VCT, ARVs, and food to the HIV positive older persons (32%). Analytically speaking, these two strategies suggest that fighting the impacts of HIV/AIDS on older persons requires adoption of both preventive and curative means. Therefore, adoption of these two strategies implies that older persons infected and/or affected by the pandemic will be helped to overcome the impacts.

Key informants were further asked to suggest strategies that could help improve on the living conditions of the elderly people. This involved administering a list of strategies and requesting key informants to show by agreeing or disagreeing whether the strategies could be adopted by government to improve the living conditions of the older persons. The results obtained appear in Table 6.4.

Table 6.4 Responses of Key Informants on Strategies for Improving the Living Conditions of Older Persons in Uganda

Strategies	Responses					
	Agree		Disagree		Total	
	Count	%	Count	%	Count	%
Improve access of older persons to resources	44	88.0	6	12.0	50	100
Promote activities that integrate both the youth and older persons	26	52.0	24	48.0	50	100
Open up consultancies where older persons can be employed to keep active, based on their expertise.	38	76.0	12	24.0	50	100
Set up adult literacy programmes to enhance older persons' skill development	46	92.0	4	8.0	50	100
Build day/residential care centres at local levels for destitute older persons	26	52.0	24	48.0	50	100
Start income generating activities for older persons	37	74.0	13	26.0	50	100
Encourage formation and promotion of older persons' groups to develop friendship and mutual support strategies	26	52.0	24	48.0	50	100
Provide free health and welfare services to incapacitated older persons	46	92.0	4	8.0	50	100
Government should share in responsibility of caring for orphans	47	94.0	3	6.0	50	100
Average	**37**	**74.0**	**13**	**26.0**	**50**	**100**

Table 6.4 presents responses of Key Informants on strategies that could be adopted to improve the living conditions of the older persons. The key informants who agreed showed that the strategies could be adopted yet those who disagreed indicated the contrary. On average, 74% of the key informants agreed while 26% disagreed to the adoption of the strategies the strategies by government to help the plight of older persons. Accordingly, majority of the key informants showed that government needed to adopt all the strategies in the table to help improve the living conditions of the older persons.

Key informants were further asked to divulge other strategies that could be used to promote active ageing in Uganda. The results obtained from the thematic analysis of their responses are shown in Table 6.5.

Table 6.5: Strategies for Improving the Livelihood of the older persons

Strategies	Count	%
Formulate and implement policies for the elderly	25	50
Advocate and lobby government for support of the elderly	5	10
Encourage collaboration and networking between NGOs for the elderly	5	10
Train gerontologists and geriatricians	3	6.0
Conduct awareness and sensitisation programmes for the elderly	2	4.0
Include the elderly in decision making	2	4.0
Establish and fully fund fitness centres for the elderly	2	4.0
Encourage early planning for old age	2	4.0
Integrate the elderly in the Poverty Eradication Action Programmes	2	4.0
Create and sponsor associations for the elderly	1	2.0
Create a universal social security scheme	1	2.0
Total	**50**	**100.0**

From Table 6.5, the majority of the Key Informants (50%) suggested formulation and implementation of policies for the older persons.

Overall, the strategies suggested by the older persons focused on government helping them in setting up special care units for them in the hospitals; giving all retired public servants their pension benefits so that they can use it to maintain their livelihoods during retirement; initiating special fund for the older persons who do not have any care takers or who lack families or homes; giving free healthcare to the HIV positive older persons; supporting the orphans left behind by people killed by HIV/AIDS in terms of free education, feeding, and accommodation; and encouraging food production through promoting use of modern agricultural practices. Regarding housing and accommodation, the proposed strategy focused on building better housing facilities for older persons and improving the surrounding environmental health by working on the drainage systems and managing waste.

Strategies for improving older persons' healthcare focused on building more and health centres to improve accessibility and stocking them with necessary medicines, drugs and

healthcare equipment as well as health workers with a professional touch in handling sick older persons. Other suggested strategies included: improving access of the older persons to resources such as finances and food; promotion of activities that integrate both the youth and the older persons as a means of promoting intergenerational interaction. Another strategy focused on opening up consultancies where the older persons can be employed to keep active and also continue using their skills; setting up adult literacy programmes to enhance skills development; and building day or residential care centres at local levels for the older persons among which will be the incapacitated and the lonely older persons. These centres were proposed to include a number of services such as social services, physiotherapy, psychotherapy, nutritional therapy and occupational therapy among others which would benefit the elderly in terms of their health and consequently longevity. The strategies proposed against economic barriers focus on the need to put a special fund put in place for older persons to enable them access and control productive assets.

When the strategies are carefully scrutinised, one gets the impression that they demand that such a programme or policy be designed in such a manner that it involves local council or community leaders, use of mass media houses such as radio and television stations, and establishment of community projects and centres focusing on encouraging the older persons to participate in physical exercises. Local Councils and mass media houses need to be involved for purposes of mobilising, sensitising and educating the older persons about the importance of physical exercises to their health. As observed by World Health Organisation (2006), Krulwich (2006), Paola (2003), and Hanahan & Weinberg (2000), the projects need to be tailored to the establishment and facilitation of community recreational centres and leisure programmes that encourage the older persons to carry out physical exercises intended to improve their physical fitness. An example of where such programmes have worked very well and improved the lives of the older persons is South Africa (Kadalie, 2005). These centres consist of a physiotherapist, an occupational therapist, a gerontologist, a geriatrician, a psychologist, a social worker and nurses to take care of the different aspects of their health needs.

A quick glance at the strategies by which the older persons in Uganda could be helped to overcome the barriers to their access to healthcare services need to improve their personal health and therefore participate effectively in society reveals that the manner in which healthcare services are delivered to the older persons in Uganda is so substandard that it calls for improvement. Since no one is obliged to provide citizens (the older persons inclusive) with healthcare services but government, it goes without saying that the strategies boil down to one thing: that government needs to improve healthcare service delivery to the older persons in Uganda. From the strategies, the suggested improvements focus on introduction of health insurance in the retirement benefits. This can help a great deal in subsidising the healthcare costs incurred by older persons.

What should be noted is that health insurance need not be introduced as part of only retirement benefits. It has to cut across the board, implying that it should instead be introduced as a policy covering even the older persons who do not fall under the category of retirees. Other suggested improvements focused on stocking already existing health centres with adequate drugs and other medical facilities; recruiting more health workers; paying them adequately so that they are not vulnerable to bribery and corruption; and sensitising them about how to respect and care for the older persons. Other needed improvements in the delivery of healthcare services focus on bringing the delivery of these services nearer to the older persons by setting up more health centres. This will help to reduce distance costs.

The Government was also urged not only to introduce older people friendly special care units and services in hospitals, home based care and to revitalise ambulance services for the older persons but also to provide wheel chairs and other assistive aids for disabled older persons. All these could help a great deal in dealing with a blow to the barriers to the older persons' access to healthcare services needed to maintain themselves in good health and therefore participate effectively in society. It is important to point out that the nongovernmental organisations and international agencies dealing with the older persons can also help to enhance the realisation of some of the suggested improvements. In particular, they can help in the provision of wheel chairs and other assistive aids to the

disabled older persons, donation of equipment needed to establish special care units in hospitals and of mobile clinics and ambulances needed to provide healthcare required by the older persons.

As far as dealing with the impact of HIV/AIDS was concerned, the suggested strategies focused on initiating a special fund for HIV/AIDS orphans; funding or soliciting donor funding of HIV/AIDS orphanages; educating HIV/AIDS orphans free of charge; providing free VCT services free ARVs and food to HIV positive older persons; sensitising grandchildren about HIV/AIDS; and distributing free condoms to them. These strategies suggest that what the government has so far done through the existing Uganda AIDS Commission and other agencies as well as the various HIV/AIDS related non-governmental organisations, has not delivered much to the older persons as far as dealing with the impacts of this pandemic is concerned. This implies that government needs to do more for the older persons infected or affected by HIV/AIDS by introducing specific programmes for the older persons or mainstream age friendly programmes.

Specific emphasis needs to be put on helping these older persons by supporting the large number of orphans left in their care by the children claimed by the plague. The critically needed support is in terms of meeting the orphans' cost of education and feeding. Strategies such as providing free VCT services and ARVs, free food to HIV positive older persons, and distributing free condoms to grandchildren call for the need to provide not only free healthcare services but also enough food security to the older persons and children infected and affected by HIV/AIDS. Strategies regarding sensitisation of grandchildren about HIV/AIDS point to the need to intensify HIV/AIDS awareness campaigns among both the young and old generation.

Strategies for dealing with the food insecurity and inadequate nutrition witnessed by the older persons focused on government initiating food production programmes for the older persons involving provision of seeds, fertilisers, pesticides, food storage facilities. Other strategies included appealing to government to stop the rampant illegal land evictions and restoration of hope among the people living in the war ravaged north. These strategies

indicate that the older persons look to cultivation as the only means of overcoming the barriers to their food security and nutrition. Whereas this may be necessary, it is not sufficient. Government needs to do more than improving cultivation conditions as shall be recommended later.

In addition to the fore-discussed strategies, more others were suggested to help deal with the economic barriers faced by the older persons. These strategies included: increasing and paying pension in time, introducing a special fund for the non-pensioners; training pension officials in customer care and integrity; weeding corrupt officials out of the pensions department; stopping to promise hot air and paying those who lost property during wars; removing the law hindering the older persons from accessing loans from commercial banks; and initiating a pool in which the older persons can present assets that can serve as collateral. In effect, these strategies indicate that government provides inadequate and delayed pension and that it does not provide any funds to non-pensioners. This needs to be dealt with by increasing and paying pension promptly and providing non-pensioners with a special fund or cash transfer.

The strategies suggest further that there is need to deal with corrupt pension officials through training them in the area of ethics and integrity. There is also need to abolish commercial bank policies that bar the older persons from accessing loans, especially when these people can afford the required collateral. Government is also advised to stop making empty promises to older persons who lost their property during wars. This implies that government needs to ensure that these people are compensated. This definitely can help the concerned older persons to deal with their economic hardships to a considerable extent.

As far as dealing with housing and accommodation barriers was concerned, the suggested strategies included: setting up special homes for the destitute and homeless older persons; building better housing units where they could live with their kin; initiating a fund for renovating their housing units; and encouraging building societies among the older persons. These strategies suggest that most of the older persons felt that their housing and

accommodation conditions were substandard. They therefore want to improve these conditions. The strategies also show that if government does not build special homes for the older persons, it can build quality housing units for them or renovate those in which they currently live. This requires having in place a policy on the housing and accommodation of the older persons in Uganda.

It is important to note that although the option of building homes for the older persons is more financially efficient and viable compared to the one of building or renovating housing units, it does not seem to have the support of the older persons. Earlier findings indicate that most of these people do not want to live in old age homes. They prefer living in their housing units with their kin apart from a few who are destitute or homeless. Therefore, if government is to take up the option of building old age homes, this has to be accompanied with changing such attitude.

Other strategies that were suggested to help improve the participation of the older persons in society point to government providing better beddings and adequate clothing for the older persons and their grandchildren; and exempting the older persons from paying taxes while encouraging them to get involved in income-generating activities such as handcraft making and animal rearing. Others focused on introducing gerontology courses in Uganda's institutions of higher institutions of learning or including gerontology issues in training curricula; encouraging outreach programs; and opening up consultancies where older persons can be employed to keep active, and share there experiences based on their expertise so that the public does not loose such significant experiences especially for people like professors in the different specialities. Other strategies point to setting up adult literacy programs to enhance skills development among the older persons; and provision of free services to the incapacitated older persons.

To recap, results indicate that the strategies needed to deal with the barriers constraining the living conditions of the older persons in Uganda as well as their effective participation in society focused on the different ways that government can adopt as policy actions or service delivery measures for purposes of improving older persons' physical fitness,

access to healthcare and other social services, economic capacity, food security and nutrition, and housing and accommodation; or deal with the impact of HIV/AIDS. In a large measure therefore, the strategies point to the need for government to make policy interventions against the barriers. The interventions may be executed either through improving and implementing the Draft National Policy for Older Persons in a manner that ensures delivery of public services and utilities by which older persons' pathetic living conditions are improved comprehensively and effectively.

CHAPTER SEVEN

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

7.0 Overview

This chapter contains the summary of findings as well as the conclusions and recommendations drawn from the discussion. It also highlights the new knowledge that came out of the study.

7.1 Summary of Findings

The economic perspective of the living experiences of the older persons in Uganda was explored in terms of level of education, occupation, income-generating activities, possessed assets, pension status, and support and care which characterised these experiences. Findings show that the overwhelming majority of older persons had no education and no occupations from which they could earn a meaningful living. They were not pensioners; had neither assets nor income-generating activities. Yet they were the breadwinners of their households. The very few older persons who were entitled to pension indicated that in addition to its inadequacy, they failed to get it because unscrupulous officials in the Pensions Department swindled it. A large number of the older persons were involved in manual subsistence farming. Very few rural-based older persons supplemented cultivation with livestock rearing, production and selling of local brew, and informal roadside selling of various items of agricultural produce. A few older persons showed that they received some inadequate support and care mostly from their adult children. Not many older persons received support from older persons-based NGOs such as URAA, ROTOM and others. The very few older persons who received this support and the majority of the key informants who extended it showed that it was very inadequate. Accordingly, the majority of Uganda's older persons are still finding it difficult to live a sufficiently satisfying economic life. The findings therefore point to the need for policy designers to improvise ways by which the economic life of older persons in Uganda can be improved.

The social perspective explored the living experiences of older persons in Uganda in terms of leisure and social activities as well as household and community social roles characterising these experiences. Findings indicate that most of the older persons play the role of heading households predominated by grand-parenting to the extent that these people do not get time for leisure. The few older persons who create leisure time spend it walking around, checking on their crops, weaving mats and baskets, and reading the Bible among others. A few older persons who participate in social activities do so by conversing with grandchildren or spouses, guiding grandchildren about how to be hard-workers and instilling good behaviour and discipline in them. They also interact by visiting relatives and neighbours, going to church for prayers and choir practice, playing omweso, and drinking Ajono with friends. Findings indicate however, that older persons do not spend their leisure efficiently and the pattern of their social interaction is very irregular and therefore at a low level, especially in rural areas. They therefore do not optimise the benefits of active ageing. Effective execution of the grand-parenting role is critically constrained by poverty and therefore lack of resources. The findings therefore suggest that there is need for policy planners to design ways for improving the social life of Uganda's older persons by empowering them economically and improving their active ageing through promoting their participation in leisure and social activities.

The food and nutrition perspective revealed that the food and nutrition conditions characterising the living experiences of the older persons in Uganda include feeding on a food varieties spanning over bananas, maize, potatoes, cassava, beans, rice, groundnuts, yams, and greens. However, most of the older persons eat maize, beans, millet, and bananas. They therefore feed on unbalanced and monotonous food varieties that are rich in starch, water and proteins but deficient in vitamins, minerals and fats. The number of meals that older persons eat per day is less than the three standard meals. Most of older persons eat at most two meals per day with some, especially in urban settings eating only one meal. Breakfast of most of the older persons consisted largely of maize and millet porridge. Most of these people especially those in urban areas do not have adequate food security throughout the year due to poverty and environmental degradation.

The health perspective explored that health conditions that characterise the living experiences of older persons in Uganda. Findings indicate that these conditions are generally poor characterised by various illnesses many of which like malaria are preventable and curable. The conditions are also characterised by unbalanced, monotonous and poor nutrition as well as food insecurity; and unnerving effects of HIV/AIDS. Generally, these health conditions call for the attention of the government and non-governmental organisations to put in place older-people-friendly programmes that could help improve and ameliorate the general living experiences of the older persons.

The housing perspective focused on understanding the housing and accommodation conditions that characterised the living experiences of older persons in Uganda. Findings indicate that most of the older persons in Uganda own and live in dilapidated, structurally weak and therefore substandard housing and accommodation conditions characterised by small grass thatched mud huts or iron-roofed houses occupied by large numbers of people who mostly include grandchildren. Most of the older persons prefer to live with their relatives to living in old age homes. Findings indicate that the housing conditions of these people are constrained by a number of barriers, which include: poverty, poor surrounding environmental health, land evictions, and lack of electricity. The findings suggest therefore that any improvements in the housing and accommodation of older persons in Uganda need to focus on finding solutions to these barriers.

Findings regarding the coping mechanisms indicate that Uganda's older persons use a number of psychological, physical, healthcare, and economic mechanisms to cope with the various personal, household and community barriers to their effective participation in society. The mechanisms range from involvement in physical activities so as to keep physically fit through means for seeking healthcare services; cultivation and sale of assets to create the economic capacity required to deal with food security and nutrition barriers as well as grand parenting needs; to human ways of dealing with long distances covered to fetch water. The mechanisms are however, inadequate not only in themselves since they only provide short term solutions but also because they do not help the older persons

to overcome all the barriers to their effective participation in society. There is therefore need to address the plight of the older persons in Uganda through improving the mechanisms which they use to deal with the barriers to such participation.

Findings in response to the extent to which the needs of older persons in Uganda are addressed by policy indicate that Uganda's Constitution provides a clear basis for formulating policies on the plight of the older persons. However, the basis is insufficiently translated into policy actions. The net effect has been that older persons are still faced with severe poverty, are abused, and suffer from social and health problems. This situation cannot be left unattended to because the older persons are also citizens who deserve to benefit from government programmes and policies in much the same way as other members of society. There is therefore need to translate enacted constitutional articles and international conventions pertaining to the plight of the older persons and ratified in Uganda by formulating and implementing a comprehensive and effective policy on the plight of older persons in the country. This will require reviewing most of the development policies and programmes so as to ensure that older persons are explicitly targeted just like the other marginalised groups such as children, women, youth and the disabled. It will also need the use of advocacy strategies involving older persons in the design, implementation and monitoring of poverty reduction development programmes. It will further need to remove the barriers to participation in development programmes such as membership fees and co-financing conditionality for their groups that hinder them to benefit effectively from such development programmes.

Findings indicate that the strategies needed to deal with the barriers constraining the living conditions of the older persons in Uganda as well as their effective participation in society focused on the different ways that government can adopt as policy actions or service delivery measures for purposes of improving older persons' physical fitness, access to healthcare and other social services, economic capacity, food security and nutrition, and housing and accommodation; or deal with the impact of HIV/AIDS. In a large measure therefore, the strategies point to the need for government to make policy interventions against the barriers. The interventions may be executed either through

improving and implementing the Draft National Policy for Older Persons in a manner that ensures delivery of public services and utilities by which older persons' pathetic living conditions are improved comprehensively and effectively.

7.2 Conclusions

The following conclusions are drawn from the findings as discussed in the previous sections of the chapter. They are made following the objectives of the study.

1) The results obtained in response to the first objective of the study indicate that:-

- The overwhelming majority of the aged in Uganda continue to execute household economic responsibility.
- The older people play a community role of looking after large numbers of grandchildren the majority of whom are orphans whose living experiences are marred by economic distress.
- Most of older people are inactive in pure social leisure activities
- Older people suffer from at least an illness
- The older people are exposed to poor nutrition and food insecurity.
- Many of the older people live in substandard housing and accommodation.
- The water supply and sanitation conditions leave a lot to be desired.

Generally, the living experiences of most of Uganda's older persons are characteristic of pathetic economic, health, social, and housing, accommodation, water supply, and sanitation conditions. They therefore need to be addressed so as to improve the quality of life of the older persons in Uganda.

2) The results obtained in response to the second objective of the study indicate that:-

- The effective participation of Uganda's older persons in society is hampered by personal problems that are basically caused by poverty.
- The hindrances take the form of impediments to the health, economic, food security and nutrition, housing and accommodation conditions of these people.

- This participation is hindered by household problems the most biting of which constitutes the large numbers of grandchildren that the older persons have to look after.
- At the community level, the barrier is essentially to contend with the age-related prejudice and tendency of perceiving the older persons as people who have outlived their usefulness.
- Most of the barriers can be addressed by policy so as to improve the quality of life of these people.

3) The results obtained in response to the third objective of the study indicate that: -

- Uganda's older persons use a number of mechanisms to cope with the various personal, household and community barriers to their effective participation in society.
- The mechanisms span over a spectrum ranging from involvement in physical activities so as to keep physically fit, through seeking healthcare services to treat illnesses; cultivation and sale of assets to create economic capacity required to deal with barriers to food security, nutrition and grand parenting.
- The older people use manual means to deal with long distances which constrain easy access to water supply sources.
- The mechanisms older people use are inadequate not only in themselves since they only provide short term solutions, but also because they do not help the older persons to overcome all the barriers to their effective participation in society.
- There is need to improve the participation of Uganda's older persons in society through improving the mechanisms that they use to cope with the barriers to such participation.

4) The findings obtained in response to the forth objective of the study indicate that:-

- Uganda government recognises the plight of the older persons through the enacted Constitutional articles or sections, and has ratified to international conventions.

- The extent to which the elderly are addressed by the above instruments is largely insufficient because it has not translated into policy actions by which this plight can be effectively addressed.
- There is need to translate enacted constitutional articles and international conventions pertaining to the plight of the older persons by formulating and implementing a comprehensive and effective policy on the plight of older persons in the country.

5) The results obtained in response to the fifth objective of the study indicate that:-

- The strategies needed to deal with the barriers constraining the living conditions of the older persons in Uganda as well as their effective participation in society are included in different ways that government can adopt as policy or service delivery measures.
- This can help older people either to improve their physical fitness, access to healthcare and other social services, economic capacity, food security and nutrition, and housing and accommodation; or deal with the impacts of HIV/AIDS.
- In a large measure, the strategies point to the need for government to make policy interventions against the barriers.
- The interventions should be executed through improving and implementing the National Policy for Older Persons in a manner that ensures that all improvements required in their pathetic living conditions are addressed comprehensively and effectively
- The elderly can be helped through improving and mainstreaming older persons' needs in the delivery of public services and utilities that support the lives of the older persons.

7.3 Implications of the study

1. Information got from this study is important in the review of the existing policies
2. The information got is important in advancing more policies relating to the elderly
3. The information got can go along way to address the gaps in the policy on the elderly.

7.4 Recommendations

The following recommendations are made in light of the conclusions reached in the foregoing section. They are also made in view of how they can help deal with the barriers faced by the older persons and improve the quality of their living experiences.

1) As far as eliminating the barriers to the physical fitness needed by Uganda's older persons to participate in society in a manner that will help improve their quality of life, it is recommended that:

- The Uganda government should develop a national policy for dealing with the promotion and maintenance of the physical fitness of the older persons. The policy should be designed in such a way that it involves local council or community leaders, setting up of community centres, use of mass media houses such as radio and television stations in the sensitisation and mobilisation of the older persons for participating in physical exercises.
- Government and the international agencies concerned with the plight of the older persons should establish, equip and facilitate recreational centres and educational programs by which Uganda's older persons can be sensitised, counselled and encouraged to appreciate the value of social leisure to the realisation and maintenance of the physical fitness that they need to ensure active and productive ageing. The programmes should be designed in such a way that they encourage the older persons to take an active part in physical exercises and recreational activities.
- As recommended by Schutzer & Gravis (2004), physicians and other medical personnel should take up the responsibility of advising older persons to do physical

activity since they are in regular contact with them because of their increased likelihood of falling sick as their chronological age increases.

2) Regarding the elimination of the economic barriers faced by the older persons with a view of empowering them to be in a position to support and improve their quality of life as desired, it is recommended that:

- Government should increase the pension provided to the older persons disengaged from public service.
- Government should train pension officials in customer care and integrity.
- Government should abolish the law hindering the older persons from accessing loans from commercial banks.
- Government should put in place welfare programmes that cater for the economic well being of the older persons not retired from public services. The programmes should be tailored towards improving the economic and financial situation of the older persons so that they are in a position to adequately provide for the grandchildren and orphans under their care. This can be achieved when the government initiates a social grant by which it can extend adequate funding to the older persons, especially in view of helping them to play their household economic responsibility effectively. It will empower and help to rescue those older persons who deal with their economic distress by selling land or begging from churches and individual Samaritans to stop it.
- Non-governmental organisations like Uganda Reach the Aged Association that are concerned with the older persons should ensure that they play their roles of empowering these people economically by equipping them with productive skills and income generating activities throughout the country.

3) With respect to removing the barriers hindering the older persons from accessing the healthcare services needed to prevent or cure the illnesses that constrain their effective participation in society as well as realisation of the desired quality of life, it is recommended that:

- Government should promote older people friendly health programmes which can be used to prevent, cure or eradicate the causes of the illnesses with particular emphasis on those which bring about malaria, diabetes or joint pains among others.
- The programmes should focus on:
  - Subsidising healthcare costs for the poor older persons and introducing and providing these people with health insurance.
  - Promoting free access to treatment of malaria, diabetes and joint pains and others.
  - Maintaining a clean environment by making it free from breeding grounds for plasmodium-carrying mosquitoes as well as bushes and stagnant water.
  - Improving the entire healthcare delivery system through equipping and stocking health centres with the necessary medicine, drugs and recruiting adequate health workers.
  - Bringing the healthcare delivery centres nearer to the people, especially the older persons.
  - Sensitising and/or training health workers to appreciate and observe the rights of the older persons by respecting and providing them deserving care that is age sensitive.
  - Improving the commitment of health workers so as to prevent them from making inadequate diagnosis, which may result into fatal risks instead of helping to enhance the participation of the older persons in society. This can be achieved by improving such motivational aspects related to work of health workers as salaries and other allowances.
  - Setting up special care units in hospitals that provide specifically for the older persons and even ease their access to such services by serving them early to avoid standing in long queues.
  - Revitalising ambulance services for the older persons.
  - Introducing mobile clinics and enhancing community based care programmes.
  - Providing the disabled older persons with assistive devices such as walking frames, spectacles, hearing aids as their health need arises.
  - Improving existing curricula for health workers so that they learn how to provide deserving care to elderly patients.

- Training geriatricians and gerontologists who are specialists in managing older person's health needs.

4) With regard to dealing with the adverse effects caused to the older persons by the HIV/AIDS pandemic, it is recommended that:

- Government should improve, promote and adequately facilitate programmess that offer VCT services to all those traumatised by the effects of HIV/AIDS including the older persons. These programmes should be older-people-friendly so as to minimise the stigma they face while getting services together with the young people.
- Government should also provide, establish and fund programmess which provide assistance towards the welfare of grandchildren orphaned by HIV/AIDS and are under the care of economically distressed older persons.
- Government should also fund or solicit donor funding for HIV/AIDS orphans.
- Government should educate HIV/AIDS orphans free of charge.
- Government should promote and support the distribution of free condoms to the grandchildren and the older persons because they are also sexually active.
- Government should be more vigilant about sensitisation of grandchildren and the older persons about HIV/AIDS since most of them are looking after sick people.

5) Regarding ensuring that there is enough food security and balanced nutrition for the older persons in Uganda, it is recommended that government should:

- Address the landlessness of the older persons evicted from their arable land through legislation and resettling of those evicted on public land.
- Restore peace and give hope to the older persons especially in northern Uganda, through round table negotiations with insurgents who threaten these people's plans to grow enough food.
- Build food stores for older farmers because there is increase in theft of food from granaries especially in the rural areas which calls for building permanent stores at community levels to store excess food.
- Encourage food processing industries.

- Expand food markets as means of converting the would-be wasted food during harvests to liquidity which can be kept and used to buy food during other seasons.
- Encouraging the older persons to sell extra food during good harvests and save the money to buy food during low seasons.
- Provide food packages to the older persons who are frail and helpless as a means of encouraging them to take balanced diets.
- Provide the older persons in rural areas with seeds and encourage them to grow more food varieties
- Encourage and facilitate the older persons through health education programmes to supplement their starch, water and protein rich food varieties with local foods rich in vitamin, fats and minerals.
- Improve cultivation conditions faced by the older persons by initiating food production programmes involving provision of seeds, fertilisers and pesticides.
- Encourage mechanised agriculture to supplement the manual labour of older farmers since most of them are weak.

6) As far as elimination of the barriers to the housing of the older persons and improving the accommodation conditions of these people are both concerned, it is recommended that:

- Government should establish programmes by which it can:
    - Rehabilitate and ameliorate most of the houses occupied by the old people as most of them are in bad conditions.
    - Build homes for the homeless and destitute older persons and encourage them to join the homes by counselling them out of resentment of living in old age homes and permitting those who join the homes to live with their kin.

7) Regarding elimination of the barriers to the water supply with intent to improve the conditions of this supply for the older persons, it is recommended that:

- Government should ensure that all unprotected springs are protected. This will help to avoid the adverse health consequences to the older persons, which are caused by using unclean and unsafe water.

- Government should also work at reducing the distance that the older persons, especially those in rural areas, have to cover in order to access the nearest water supply sources. This distance should be reduced to at least less than one kilometre from the home of each older person. This can be achieved by:
  - Establishing more boreholes
  - Extending water supply lines to rural areas

- The older persons, particularly those in rural areas, should also be encouraged to improve the quality of the water drawn from unprotected springs before using it. This can be achieved by encouraging them to boil or treat this water before use. Alternatively, clean water should be provided to these people either by taking treated piped water nearer to them or digging more boreholes.

8) As far as improving the hygienic conditions hindering the older persons from living in better quality conditions of life is concerned, it is recommended that:

- Local authorities should enforce and ensure that each older person has a well-maintained toilet and bathroom in each respective homestead. This will help to avoid all illnesses or diseases that tend to be caused by poor toiletry facilities.
- Local authorities, especially urban authorities, should improve environmental health by clearing bushes, improve on the drainage systems, spray harmful pests and parasites such as bed bugs, fleas, jiggers, mosquitoes, and ensure cleanliness in the premises of older persons including working on filthy drainage systems.

9) To eliminate community barriers to older people's effective participation in society and realisation of desired quality of life, government together with concerned civil society organisations and NGOs should discourage the tendency of regarding the older persons as people who have outlived their usefulness. This can be achieved through organising community sensitisation programmes and activities discouraging this tendency over the radio, television, and the press and through community workshops, seminars and conferences. The programmes should focus mainly on sensitising young people to appreciate the fact that the older persons are still useful in society.

10) Finally as Oloka-Onyango (2009) recommended, in addition to putting in place an Act for the older persons that would help in implementation of the older people's policy, the government should put in place a National Council for the older persons so as to improve on their participation in public decision making and also to be able to voice their needs in parliament just like the other marginalised groups do.

7.5 Recommendations for Further Research

A number of policy strategies are recommended to be adopted by government so as to address the barriers encountered by Uganda's older persons and therefore improve the quality of the living conditions of these people. However, the legal and funding implications of these strategies have not been addressed in the study. Further research is therefore recommended into these implications.

7.6 New Knowledge that came out of the study

This study has provided a detailed documentation of the needs, problems and living experiences of older persons in Uganda that had not been documented before in detail. It also identified the barriers to participation of older persons in the society and provided some of the coping mechanisms the older persons use in order to earn a living during old age. One of the coping mechanisms that were revealed by the majority of older persons was turning to God as a means to survive in old age which according to the researcher was something new that had been discovered. The study also found out the challenges of HIV/AIDS among the older persons. The issue that predominantly came out was that older persons in Uganda look after HIV/AIDS patients and orphans yet the majority of them were found to be poor and complained of the inability to look after these people.

Another issue that was identified was that older persons were infected and affected by HIV/AIDS and they reported having no HIV/AIDS related programmes in the country that specifically addressed their needs as old people. Most HIV/AIDS programmes in the country target people who are in their reproductive age (15-49 years) which excludes older people. As a result the older people get services together with the young people. However during the interviews of this study it was discovered that the older people felt

stigmatised when receiving HIV/AIDS services together with the young people yet these services are not even age sensitive. This was noticed especially in counselling sessions where young people counselled the older persons or treated them. Some of the older persons even reported failure to open up for the young doctors or having the guts of undressing in front of them when told to do so due to the age gap which existed. In addition they also experienced internal stigma as they felt ashamed and blamed for acquiring HIV/AIDS despite their age. This was more felt in the long queues as they lined up with young energetic people to get ARV drugs. However in line with this, the older people proposed a necessity for their own specific programmes which are older-people-friendly which could cater for their HIV/AIDS and Health needs or modification of existing programmes to ensure that they are age friendly to accommodate older persons' needs.

Another finding was noted in most hospital set-ups in Uganda, where the elderly where not given priority of being served first despite their unbearable state of condition due to old age. They were left to stand in long queues with young people yet the majority had painful diseases such as hypertension, diabetes, osteoporosis, backache which conditions make one feel uncomfortable following standing for a long period of time. However this also led to a recommendation of having their own departments in hospitals and specialised health personnel who could handle them in a way that is age friendly.

It was also noted that there are no nutritional programmes or policies that are related to the elderly in the country specifically in the ministry of health. As a result the elderly in Uganda feed poorly with the majority mainly feeding on carbohydrate foods as their main food intake and having very little or no vitamins, calcium and minerals among others which are very essential for their body. This also calls for formulation of nutritional policies and programmes which could help address the situation so as to improve on the quality of life of the elderly as well as promote active ageing.

This research was motivated by my personal and professional experiences with older persons as a Senior Physiotherapist. During practice of physiotherapy, many older

persons revealed their health challenges to me and this inspired me to get more involved in old age issues.

In line with this situation, I observed that my dad's life situation following his retirement from civil service gradually deteriorated to the level that made me feel concerned about the way he was living. Just a year after his retirement, his wife died and the situation even worsened more because he still had young children to look after and pay school fees for yet his pension was not enough. I really felt anxious to know whether other older persons were going through similar situations and hence developed the idea of carrying out a study in the area of gerontology particularly on the exploration of their living experiences.

I also began teaching gerontology at university level in the Department of Sports Science at Makerere University. The teaching at the university gave me a challenge to search for more information in order to be able to execute my duties appropriately.

With this background I developed interest in advancing my studies in the area of gerontology since I had already got a background of it when I did a module in gerontology at Master's level in the University of Western Cape in South Africa.

Following the results of the study I have realised that there is a lot that is needed to be done (as suggested in the recommendations) in order to help the older persons live an improved quality of life. This study has contributed and enriched my understanding of issues pertaining to the theories, concepts, practices and living experiences of old age there by raising my standard of appreciation of the policy issues involved.

7.7 Limitations of the Study

The first limitation of the study involved funding constraints. The administration of questionnaires to the key informants, and of the interviews and group discussions to the older persons throughout Uganda was more costly than had been budgeted. Facilitating the movement of research assistants, making reminder calls, and motivating some of the resourceful elderly respondents overstretched the budget beyond expectations. Many of the elderly respondents demanded for money before accepting to participate in the study.

In some cases, getting access to the appropriate respondents, especially the older persons involved incurring extra transport costs. However this was soled by outsourcing for more funds.

In addition, some of the research assistants delayed so much that they needed phone call reminders to be prompted to access the respondents specified for them. Others lost copies of the research instruments first given to them to administer to key informants and the older persons. Others did not report back and had to be replaced by other research assistants. All these problems placed time and huge financial costs and stress on the researcher. However, patience was exercised until enough data was collected for the study.

The minimum age internationally recognised to qualify as an older person was itself a limitation to the study. Many of the people who had been identified as elderly persons turned out to be much younger than they appeared. This was discovered when the selected elderly persons were asked about their age. Many of them revealed ages that were much below 60 years that by international standards had been considered as the minimum age that any person had to have before his/her selection to participate in the study. The situation was only improved when the minimum age was lowered to 55 years. In fact, it was discovered that many people in Uganda, especially in rural areas, look much older than their actual age. As noted earlier, the cause of this scenario was related to the health and nutrition problems faced by most of the people in Uganda.

Further, elderly respondents were difficult to identify not only because of their relatively small proportion in the Ugandan population but also because those in the rural districts were living very remotely from each other. Accessing them involved moving long distances. In some cases, this implied traversing the whole district, which was largely unviable in terms of time and financial costs.

Furthermore, some of the research assistants did not reach out to all the places where the older persons were living. They only accessed the older persons within a small radius of their assigned districts.

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APPENDIX A

INTERVIEW QUESTIONS FOR PARTICIPANTS

(A) Interview questions for the older persons

Interview number……..……..

Code of interviewee…….……

Sex……..…… ……..…

Date of interview……..……..……

Location……..……..

[A] Interview on Socio- Demographic Information

1. If I may humbly ask, Please how old are you?
2. What is the number of people who live with you?
3. Who is the head of the household you live in?
4. Sex of the head of household
5. What is your occupation?
6. Did you attend any school?
7. If yes, what was your highest level of education?
8. If no, why?
9. How does the attaining of education help you to earn a living?
10. What is your marital status?
11. Do you have children? (Probe- how many?)
12. Who looks after you?
13. What problems are you facing as a member of this household?

[B] Interview on Health care issues

14. How would you describe your health at the moment? (e.g., Generally well, Not so well, Sick, Very Sick)

15. What are the main health problems that affect you?
16. When you have those problems (the problems mentioned) where do you seek for healthcare/help? (probe traditional, home remedies, medical care)
17. What problems do you encounter when accessing health services?
18. What special services are offered to you as an older person at the hospitals?
19. What don't you like about the services?
20. What recommendations do you suggest government/community should do to improve on the healthcare services provided to the older persons?

Physical activities

21. Do you do any physical activities to improve on your health? (For instance walking around, jogging, dancing, visiting health clubs, garden work, picking food from the farm etc)
22. If yes, how did you get to know about the physical activities?
23. How often do you do the activities?
24. What do you think are the benefits of doing physical activities?
25. If no, what could be the possible reasons for not engaging in physical activities? (Is it because of health problems, you don't know its use, or pre-occupied by other things that you see important?) probe- for more information
26. What would you recommend the government to do regarding physical activities for the older persons (probe- what about local government ……..and the community)

Nutrition

27. What foods do you normally eat?
28. How many meals do you normally have in a day?
29. What do you normally eat during breakfast, lunch, dinner and supper?
30. How do you acquire food?
31. How far is your home from the garden or market from which you get the food?
32. If you carry the food yourself, why do you do so when your grandchildren can help you?
33. Do you have enough food throughout the year?

34. If no, why don't you have enough food?
35. What would you recommend (government - local/ central) to do regarding food security?

HIV/AIDS

36. Have you had about HIV?
37. If yes, how did you get the information?
38. How has HIV/AIDS pandemic affected you and your family?
39. How have you managed to solve the problems HIV/AIDS has caused you?
40. How can government help you to solve the problems of HIV/AIDS?
41. What would you like the government to help in eliminating the impact of HIV/AIDS on the older persons?

Parenting

42. Do you have any children you are looking after?
43. If yes, how many children are under your care?
44. Do have any orphans among the children you are looking after?
45. If yes, how many orphans are among the children?
46. Why do you have grandchildren, including the orphans under your care?
47. How do you manage to look after the children, especially the orphans?
48. How do you view the care you give to the children?
49. What problems do you encounter in looking after grandchildren, especially orphans?
39. What strategies do you suggest would help to improve on your livelihood?

[C] Interview on economic concerns

40. How do you earn a living?
41. Are there any income generating activities that you do? If so what are they?
42. Who is the breadwinner in your household?
43. What assets do you own? (For instance land, radio, TV, domestic animals/poultry)
44. What assistance do you get from elsewhere (e.g. your children or relatives or friends)
45. Do you receive any pension from government?

46. If yes, is the pension enough to meet your needs?
47. What difficulties do you encounter when accessing your pension?
48. If you don't get any pension at all, how do you cope with life?
49. What would you like the government to do for you regarding your economic needs?

[D] Interview on housing

50. Do you have any constraints with accommodation? What constraints?
51. What problems do you experience with the house you are living in?
52. Is it your own accommodation? If not whose is it?
53. What type of house is it?
54. How has government helped you in terms of accommodation?
55. With whom do you live with in the house?
56. Do you prefer living alone or with a relative or in an old age home?
57. What are your opinions regarding options of living in old age homes?
58. How would you like government to help you regarding your accommodation?

[E] Water and Sanitation

59. What is your main source of water for household use?
60. How far in kilometres is the source of water from your house?
61. How far in minutes is the source of water from your house?
62. How do you fetch the water?
63. Which type of toilet facility does your household use?
64. Do you share the toilet facility with other households?
65. How would you describe the general cleanliness of the toilet facilities you use?
66. How would you describe the cleanliness of the bathrooms you use?
67. Do you share toiletry facilities with other households?
68. If yes, how many households do you share the toilet facilities with?
69. How would you describe the general hygiene conditions of your household?
70. How would you describe the hygienic conditions of the surroundings?

[F] Interview on leisure and recreation (Psycho-social concerns)

71. What do you normally do in your free time?
72. How often do you engage in social activities during your free time? (such as visiting friends, attending meetings/ cultural programs/functions)
73. What social activities do you take part in your community?
74. If no, why don't you participate?
75. What problems do you experience when accessing social services? (such as recreation centres etc)
76. Who are the people you normally relate with in times of happiness/ unhappiness?
77. What do you normally talk about?
78. What is the importance of having friends?

[G] Organizations for the Aged

79. Which organisations of the aged do you know of in your community?
80. What programmes and activities of these organizations are you involved in?
81. Are you satisfied with the services they provide.
82. If not, what suggestions would you recommend to help bring desired change?
83. Are there any views you would like to share concerning the services provided, problems and needs faced by the older persons.

Thank you for your time!

APPENDIX B

FOCUS GROUP INTERVIEW GUIDE FOR THE OLDER PERSONS

Location & Venue……..…….

Sex/gender of group……..……..…….

1. What are the main problems affecting the older persons in this community? For example….
   a) Health
   b) Economic
   c) Psycho-social
   d) Nutrition
2. Regarding the problems that you have mentioned, how do the older persons deal with these problems? For instance

   Problem **solution**

   Health…….

   Economic……..….

   Psycho-social……..…….

   Nutrition……
3. What problems do the older persons face when accessing resources? (such as land, health facilities, money, food, water, market of products, etc)
4. In your view, what are the factors that have led to the exclusion of the older persons from participating in development programs and public activities?
5. **HIV/AIDS**- How has HIV/AIDS pandemic affected the older persons in this community?
6. **Parenting**-How are they caring for the orphans?
7. What problems do they encounter in looking after the orphans?
8. What strategies do you suggest would help to improve on the livelihood of the older persons
9. Who should do it? (gov't/NGOs, CBOs/ the community)

APPENDIX C

QUESTIONNAIRE FOR KEY INFORMANTS: POLITICIANS, ADMINISTRATORS OF NGOS AND MINISTRIES, ACADEMICIANS AND RELIGIOUS LEADERS

Title: Exploration of Needs, Problems and Experiences of the Older persons in Uganda: Implication for Policy and Decision Makers

Questionnaire Number……..…
Interviewee Name……..……..……..
Interview Number……..……...
Date of Interview……..……
Date checked……..…….…….
Name of Ministry/ code……..…….…….
Location……

This questionnaire aims at obtaining information about the strategies and recommendations for improving on the quality of life for the older persons. The information obtained will only be used for the purpose of this study and will be held confidential.

Instructions: Use the space provided against the question for recording answers. Tick the number corresponding to the right answer.

Answer all questions for all the sections.

Section A: Demographic information

1. Respondent's sex Male=1 Female=2

2. Which Department are you from?

.....

3. What position are you in this department?

.....

4. What is your occupation?

.....

Section B: Problems, Support and Care of the older persons

5. At what age are people considered older persons in Uganda?

6. (a) What could be the problems faced by the older persons in your community? (**Tick more than one**)

Problem	**Yes**	**No**	**Problem**	**Yes**	**No**
1=Loneliness			7= lack of access to finance		
2=depression			8=lack of respect		
3=poverty			9=chronic illnesses		
4=poor housing			10=lack of education & skills		
5=lack of clothing					
6=lack of food			Other specify……		

(b) Mention any other problems facing the older persons from the communities in which they live

……

……

……

……

c) Describe how the older persons attempt to overcome the problems endorsed above

……

……

……

7. Do you know any organisations of the older persons in Uganda?

1= Yes 2 =No

b) If yes, specify

……

……

……

8. What kind of support do these organisations give? (**Tick more than one**)

Support	**Yes**	**No**
Food		
Money		
Clothes		
Information/communications		
Housing		
Medical		
Transport		
Other specify……		

If your answer was on housing yes, state any homes accommodating the older persons you know

……

……

……

9 a). Are the older persons people involved in any activities or decision-making positions in your

community/area?……

1= Yes 2=No 3-Don't Know

b). Mention any of the roles played by the older persons (**Tick more than one**)

Roles of the older persons	**Yes**	**No**
Leaders of clans		
Teachers of morals, values, language, and culture		
Assist in conflict resolution		
Care for orphans		
Veterans		
Other specify……..		

10. Is your ministry or organisation involved in supporting the older persons?

1=yes 2=No 3=don't know

11. If yes, what kind of support does it give? (**Tick more than one**)

Support	**Yes**	**No**
Food		
Money		
Information/communications		
Clothes		
Housing		
Medical		
Transport		
Other specify……		

12. If the answer is yes to any of the above, is what you provide enough for them?

Support	**Yes**	**No**
Food		
Money		
Information/communications		
Clothes		
Housing		
Medical		
Other specify……		

13. If any of the answers is no in number 12, why?

.....

.....

.....

.....

14 a). Do you believe that any of the following government policy instruments have effectively addressed the needs of the older persons in Uganda?

Policy instruments	**Yes**	**No**
Poverty Eradication Action Plan (PEAP)		
Vision 2025		
Contributory Pension scheme		
The constitution		
Social Development Sector Strategic Investment Plan (SDIP)		
Local Government Act		
Other specify……		

c) Describe how has government achieved its goal regarding these instruments?

.....

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.....

15. Give examples where government has provided support to the older persons as far as health is concerned

……

……

……

……

……

……

16. Has government provided any of the following to the older persons? (**Tick more than one answer**)

Health support	**Yes**	**No**
Free medical services		
Free assistive devices		
Provision of information about their health		
Free cataract treatment		
Free check ups on cancer and other chronic diseases		
Other specify……		

17. a) Do you know of any physical activity policies in the country that promote active ageing?

1=Yes 2=No

b) If yes, please mention any

……..……

……

……

……..……

c) What strategies do you know that can be used for promoting active ageing in the country?

.....

.....

.....

.....

d) Have any of the following strategies for promoting active ageing been applied in your community? (**You can tick more than one answer)**

Strategies for promoting active ageing	**Yes**	**No**
Creating awareness		
promoting accessibility to physical activity programs		
promote self-directed physical activity opportunities for the older persons		
Provide voluntary activities for the older persons		
provide a wider range of opportunities for employment		
Other specify……		

18. What strategies have been used to improve on the livelihood of the older persons in your community?

.....

.....

.....

.....

.....

19 Do you agree that the older persons have been excluded from participating in development activities?

1= Yes 2= No

b) If your answer in number 19 is yes, could you please mention some of the development programs where the older persons are most likely to be excluded from participation.

Program	**Yes**	**No**
Educational programs		
Technological development		
Social programs (entertainment)		
Affordable health care		
Financial (credit) services		
Other specify……		

19. The following views have been identified as some of the reasons preventing participation of the older persons in development activities. Do you agree or disagree

Barriers	**Agree**	**Disagree**	**Barriers preventing participation**	**Agree**	**Disagree**
Lack of technological skills			Inadequate qualification and skills		
Perceived as big risks for the feasibilit credit (financial) programs			Belief of eligibility		
Lack of access to education programme					
Regarded as poorest in the society					
Regarded as vulnerable to physical and psychological violence					
Regarded as helpless and unproductive members of society					
Lack organised Associations of the older persons					
Lack of communication					
Age discrimination					
Other……..					

20. How do the older persons cope with the barriers to their effective participation in society?

.....

.....

.....

.....

21. What are some of the measures that have been used to eliminate the barriers faced by the older persons in their communities?

Measures to eliminate the barriers	**Agree**	**Disagree**
Raise awareness/provide information		
Provide them with resources		
Provide them with resources		
Develop policies that integrate the older persons into programs		
Lifelong learning		
Other specify……		

22. Which of the following strategies should government do to improve on the livelihood of the older persons? (**Tick more than one**)

Strategies to be done by government to improve on livelihood of The older persons	**Agree**	**Disagree**
There is a need to improve accessibility to resources e.g. financial, human, social etc.		
Need to promote activities that integrate both the youth and the older persons		
Open up consultancies where older persons people can be employed basing on their expertise to keep active.		
Set up adult literacy programs to enhance skills development of the older persons.		
Need to build day/residential care centres at local levels for the incapacitated/ lonely older persons.		

Need to facilitate income generating activities of the older people in the community.		
Encourage formation and promotion of groups of the older persons to develop friendship and mutual support strategies.		
Provide free services for the older persons		
There is a need to take over the responsibility of looking after the orphans.		
Other specify……		

23. HIV/AIDS is a serious problem among the older persons in Uganda (they are looking after AIDS orphans; they are affected by HIV/AIDS themselves and lack access to drugs and update information.) As a government official what plan would you put in place to help solve the problems of HIV/AIDS facing the older persons in your community?

……

……

……

24. Anything else that concerns the older persons that I did not ask and it concerns their well-being?

THANK YOU FOR YOUR TIME

APPENDIX D

COMPUTATION OF THE CONTENT VALIDITY INDICES

The content validity indices for the administered instruments were computed using the following formula (Amin, 2005):

CVI = R/

The indices were computed as shown in the Table below:

Table Computation of content validity Indices for the administered instruments

Instrument	**Rating of questions**			**Computation**
	Relevant (R)	Irrelevant (IR)	Total (N = R + IR	CVR = R/N
Questionnaire	36	5	41	0.878
Interview Guide	92	14	106	0.868

APPENDIX E

SUBJECT INFORMATION SHEET

INFORMATION SHEET

Project Title: Exploration of Needs, Problems and Experiences of the Older persons in Uganda: Implication for Policy and Decision Makers

This is a research project being conducted by Nankwanga Annet at the University of the Western Cape. We are inviting you to participate in this research project because you are an older persons person and knowledgeable about the issues of the older persons that are required for this study. The purpose of this research project is to explore the needs, problems and experiences of the older persons and propose strategies that might help to empower the older persons in Uganda so as to achieve Active and Healthy ageing. Information about living experiences will also assist in informing policy makers about the relevance of planning for the older persons through developing policies that can suit the needs of the older persons so as to help improve on their quality of life.

You will be asked to participate in an interview or discussion. Here you will be required to explain your experiences regarding old age. For instance questions such as "what problems are you facing in your day to day life?" will be asked. You will also be asked what the government should do for you in order to improve on your livelihood and other questions. The study will be conducted in Uganda in eight districts at the participants' homes or at a convenient venue as may be required by the participant. The interviews will last for 1 to1 and half hours.

We will do our best to keep your personal information confidential. To help protect your confidentiality, we will ensure that the thesis does not compromise the position of the participants, government officials and other key informants or any material made available during the study. And if there is any identifying information, we assure you that such information will not be made available to anyone who is not directly involved in the study. In addition, your names will not be recorded on the tape instead we shall use pseudonyms for anonymity purposes. A code will be used in circumstances were questionnaires will be used to collect data.

If we write a report or article about this research project, your identity will be protected to the maximum extent possible. This research project involves making audiotapes, photographs of you. This will be done for purposes of not loosing important information. The audio tapes will be kept in locked cabinets for safety purposes. On the other hand, safety of the data entered into the computer will also be ensured by not releasing it to others.

___ I agree to be audio taped/ photographed during my participation in this study.

___ I do not agree to be audio taped/photographed during my participation in this study.

However, in accordance with legal requirements and/or professional standards, we will disclose to the appropriate individuals and/or authorities information that comes to our attention concerning your vulnerability.

There may be some risks from participating in this research study such as emotional or psychological risks such as depression. In case these occur a social worker will be contacted to handle the situation or in case any disease crops up during the interviews, the participant will be referred to nearby clinics for treatment.

The benefits to you include: firstly, it will provide concrete evidence to policy makers the need to address 'Active and Healthy Ageing' in Uganda which will directly benefit you.

Secondly, the results of the study will empower the older persons in Uganda to lobby for their rights from the Government. In addition, at the end of the interview you will also be told information about active and healthy ageing.

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify. For example if you fall sick and feel like not continuing to participate you will be free to do so without any objection from us. In case you are negatively affected by participating in the study, you will be referred to a social worker for counselling.

This research is being conducted by Nankwanga Annet, Department of Physiotherapy, at the University of the Western Cape. If you have any questions about the research study itself, please contact _**Nankwanga Annet** at: nankwangaa@yahoo.com

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:
Head of Department:
Dean of the Faculty of Community and Health Sciences:
University of the Western Cape
Private Bag X17
Bellville 7535

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee and the Uganda National Research Council of Science and Technology.

APPENDIX F

CONSENT FORM

Title of Research Project: Exploration of Needs, Problems and Experiences of the Older persons in Uganda: Implication for Policy and Decision Makers

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

Participant's name……..

Participant's signature…….

Date……

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Study Coordinator's Name: Nankwanga Annet

University of the Western Cape

Private Bag X17, Belville 7535

Telephone: (021)959-2542

Fax: (021)959-1217

Email: nankwangaa@yahoo.com

APPENDIX G

ETHICAL CLEARANCE REQUEST - UGANDA

University of Western Cape
Department of Physiotherapy
Faculty of Community & Health Sciences

The Research Ethics Committee
Uganda National Research Council of Science and Technology
Kampala

RE: Request to carry out a Research study in Uganda

I am Nankwanga Annet, a PhD student at the University of Western Cape, South Africa. I intend to carry out a research study with an ultimate aim of finding out needs, problems and experiences of the older persons in relation to strategies that could help to improve on their livelihood. This study is a requirement for a PhD degree award in Physiotherapy.

The purpose of this letter is to request for permission to carry out a study in Uganda. Part of this study will also be looking at experiences of the older persons in the rural and urban areas. Details of the study are contained in the attached proposal.

It is hoped that the findings of the study will be useful in the planning for the older persons in Uganda.

I remain awaiting for the reply

Yours faithfully

…….
Nankwanga Annet
(PhD student)

APPENDIX H

LETTER FOR PERMISSION TO CONDUCT RESEARCH IN MINISTRIES

University of Western Cape
Department of Physiotherapy
Faculty of Community & Health Sciences

The Administrator
Ministry of ……
Kampala

Dear Sir/Madam,

RE: Request to conduct research in the ministry

I am Nankwanga Annet, a PhD student at the University of Western Cape, South Africa. I intend to carry out a research study with an ultimate aim of finding out needs, problems and experiences of the older persons in relation to strategies that could help to improve on their livelihood. This study is a requirement for a PhD degree award in Physiotherapy.

The purpose of this letter is to request for permission to conduct interviews in your ministry for research purposes. Part of this study will also be looking at experiences of the older persons in the rural and urban areas. Details of the study are contained in the attached abstract of the proposal.

It is hoped that the findings of the study will be useful in the planning for the older persons in Uganda.
I remain awaiting for the reply

Yours faithfully

……
Nankwanga Annet
(PhD student)

APPENDIX I

LETTER FOR PERMISSION TO CONDUCT RESEARCH STUDY IN YOUR DISTRICT

University of Western Cape
Department of Physiotherapy
Faculty of Community & Health Sciences

The Chief Administrator
……District
Uganda

Dear Sir/Madam,

RE: Request to carry out a Research Study in your District

I am Nankwanga Annet, a PhD student at the University of Western Cape, South Africa. I intend to carry out a research study with an ultimate aim of finding out the needs, problems and experiences of the older persons in relation to strategies that could help to improve on their livelihood. This study is a requirement for a PhD degree award in Physiotherapy.

The purpose of this letter is to request for permission to carry out the study in your district. Part of this study will also be looking at experiences of the older persons in the rural and urban areas. Details of the study are contained in the attached abstract of the proposal.

It is hoped that the findings of the study will be useful in the planning for the older persons in Uganda.
I remain awaiting for the reply

Yours faithfully

……
Nankwanga Annet
(PhD student)

APPENDIX J

LETTER SEEKING PERMISSION TO ACCESS OFFICIAL DOCUMENTS

University of Western Cape
Department of Physiotherapy
Faculty of Community & Health Sciences

The Administrator
Ministry of ……

Dear Sir/Madam,

RE: Request to access official documents for Research purposes

I am Nankwanga Annet, a PhD student at the University of Western Cape, South Africa. I intend to carry out a research study with an ultimate aim of finding out the needs, problems and experiences of the older persons in relation to strategies that could help to improve on their livelihood. This study is a requirement for a PhD degree award in Physiotherapy.

The purpose of this letter is to request for permission to access documents in your ministry for purposes of the study. Part of this study will also be looking at the experiences of the older persons in the rural and urban areas. Details of the study are contained in the attached abstract of the proposal.

It is hoped that the findings of the study will be useful in the planning for the older persons in Uganda.
I remain awaiting for the reply

Yours faithfully

…….
Nankwanga Annet
(PhD student)

APPENDIX K

LETTER REQUESTING FOR SOCIAL SERVICES DURING THE RESEARCH PROCESS

University of Western Cape
Department of Physiotherapy
Faculty of Community &Health Sciences

The social worker
……..
Dear Sir/Madam,

RE: Request for assistance with social services during a Research process

I am Nankwanga Annet, a PhD student at the University of Western Cape, South Africa. I intend to carry out a research study with an ultimate aim of finding out the needs, problems and experiences of the older persons in relation to strategies that could help to improve on their livelihood. This study is a requirement for a PhD degree award in Physiotherapy.

The purpose of this letter is to request for assistance with social services such as counselling and medical treatment amongst others during the research process in case of any emergencies. Part of this study will also be looking at experiences of the older persons in the rural and urban areas. Details of the study are contained in the attached proposal.

It is hoped that the findings of the study will be useful in the planning for the older persons in Uganda.

I remain awaiting for your reply

Yours faithfully

…….
Nankwanga Annet
(PhD student)