BARRIERS TO PHYSICAL FITNESS, HEALTHCARE AND FOOD SECURITY OF OLDER PERSONS AND COPING MECHANISMS TO DEAL WITH THE BARRIERS IN UGANDA

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Abstract

Introduction: This paper explores the barriers to older people's physical fitness,healthcare, food security and nutrition and the coping mechanisms devised to deal with the barriers.

Methods: This was a descriptive cross-sectional survey. The research was based on eight districts, which included: Pallisa, Kampala, Jinja, Lira, Nebbi, Ntungamo, Luwero and Mbarara district. These districts were representative of both the rural and urban areas of the four regions of Uganda, namely: Western, Northern, Eastern and Central region. The sample consisted of 165 older persons and 50 key infromants selected using purposive sampling. Data was collected using focus group discussions and in-depth interviews guided by focus-group discussion guide and interview guide, respectively. Additional data from the key informants was collected through interviews. Analysis was done using the thematic technique and the themes were developed according to the context and variables of the study. The themes were then coded and entered into SPSS software for analysis and frequency and percentage distributions were generated.

Results: Results indicate that bodily weaknesses constituted the barrier to the physical fitness of the majority (75.2%) of the older persons in Uganda. Other barriers included lack of space for physical exercises and money to pay to health clubs. In contrast, suffering from chronic illnesses prevented more (52.5%) of the rural-based older persons than to the urban-based older persons (29.7%). Regarding access to health services the barriers included Health workers' aloofness, lack of respect for older persons, long distances to health centers and unavailability of health workers at health centers. While the barrier to food security and nutrition desired by the overwhelming majority of older persons in both rural and urban areas was economic inability to afford a balanced diet. Concerning coping mechanism, most of the older persons in rural areas (97%) grew food to cope with food security and nutrition barriers, while most of those in urban areas (70.3%) bought the food from markets.

Conclusion: Findings included in this paper indicate that the coping mechanisms devised by older persons in Uganda needed policy action to be effective.

Keywords: Older Persons, Barriers, Coping Mechanisms, Physical Fitness, Food Security, Nutrition, Uganda

Introduction

The vulnerability of older persons has attracted relatively more scholarly attention than the manner in which they cope with it, particularly in Uganda (Najjumba-Mulindwa, 2004; Lwanga-Ntale & Kimberley, 2003). As a result, coping mechanisms used by these persons to deal with the barriers encountered in their daily living conditions have remained largely unexplored (Nankwanga & Phillips, 2009a). A number of national policy frameworks and development programmes pursued in Uganda recognize that information regarding the plight of older persons in Uganda is still lacking. Some of these policy frameworks include: the Poverty Eradication Action Plan (PEAP) (Ministry of Finance, Planning and Economic Development, 2007) developed in 1990; the Uganda Vision 2025 developed in 1999; Plan for Modernization of

Agriculture (PMA) developed in 2000; the National Agricultural Advisory Services (NAADS) formulated in 2001 (Ministry of Agriculture, Animal Industry and Fisheries, 2005); Policy for older persons(Ministry of Gender, Labour and Social Development, 2007). Draft Food and Nutrition Policy formulated in 2003 (MOH), the Health Sector Strategic Plan developed in 2007 (Ministry of Health Uganda, 2007); and the National AIDS Strategic Plan developed in 2008 (Ministry of Health, 2008); to mention but a few.

An older person according to the 1995 Constitution of the Republic of Uganda and the Uganda Bureau of Statistics [UBOS] (2007) is an individual of at least sixty years. For operational purposes, in this paper, an older person is defined as any male or female individual whose age is at least 55 years and this is the definition adopted in this paper. This definition falls short of the constitutional definition but it was arrived at based on a number of observations. For instance, the World Population Census (2002) report noted that the onus for survival put people living in most of the poor economies at a greater disadvantage than those living in rich countries, thereby causing them to age beforehand. This effectively implies that most people in economically disadvantaged countries like Uganda die before they clock the age of sixty years, which the Population Census (2002) report used to define an older person. Velkof and Kowal (2007) clarified it further 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, life expectancy in Uganda is estimated at 50 years (UBOS, 2007), implying that the adopted age limit of 55 is still an exaggeration in statistical terms. This definition was appropriate because Uganda is a Sub Saharan country.

Based on the operational definition, the proportion of older persons was adjusted from 6.1% to 7.1% of Uganda's estimated 30 million people (UBOS, 2007). This implies that older persons are about 2.13 million in Uganda. Out of these 2.13 million older persons, 88.5% live in rural areas and only 11.5% live in urban areas (UBOS, 2007). According to UBOS (2002), older persons' population is growing at an annual rate of 3.2%, which implies that their number is likely to double in the next 25 years. The statistics suggest that older people constitute a significant proportion of Uganda's population, which is rising so fast that it can no longer be ignored, especially in terms of policies required to deal with their plight. This paper is therefore important in that it provides a basis for formulating and implementing some of the required policies.

The social protection policy intended to alleviate the economic distress faced by older persons in Uganda should it come into force after its ongoing piloting is inadequate to address the needs of older persons (Nankwanga, 2011). The review of this draft policy reveals that it is intended to guide only cash transfers to these people. The draft therefore addresses a narrow scope of these persons' plight. One of the explanations for the narrowness is that the formulation of the draft did not pay attention to the analysis of the barriers encountered by Uganda's older persons in their living conditions and the coping mechanisms they use to deal with the barriers (Nankwanga & Phillips, 2009b). This would have provided a good basis for understanding and developing a course of action that would have facilitated the mechanisms, thereby making them effective in dealing with the barriers (Nankwanga, 2011). Accordingly, exploring and analyzing the coping mechanisms used by older persons in Uganda to deal with barriers encountered in their daily life is still needed so as to determine the policy implications of these mechanisms and the way forward.

According to literature, barriers have been described as 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 (Diane & Aldwin, 2003). This paper, however, focuses on those that hamper older persons' realization of desired physical fitness, healthcare, food security and nutrition. According to Deeg and Bath (2003), barriers to personal health include all hindrances to a person's physical fitness and access to healthcare needed to maintain personal health as desired. The barriers tend to include body weaknesses that set in as described by the wear-and-tear biological theory of old age explained by Stuart-Hamilton (2003), chronic illnesses, and poor and inadequate feeding.

Pertaining to healthcare, the barriers encountered by older persons in their efforts to access needed healthcare have been identified as poverty, illiteracy, lack of health information, and long distances to health centres. Others include 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).

On the other hand, coping mechanisms have been defined as the means which people use to try to maintain their life across different and usually difficult or stressful situations (FitzGibbon & Hennessy, 2003). According to Carmel et al. (2008), coping mechanisms entail adaptive behaviours in old age that allow for effective and successful engagement with life-related tasks, challenges, and problems. In this paper however, only coping mechanisms used by older persons to deal with barriers to their personal health, food security and nutrition are considered.

The preceding observations were based on studies outside Uganda. 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 was therefore unclear how the older persons, particularly those in Uganda, cope with life. This explains why a study was conducted based on which this paper is developed. The study was conducted using the methodology discussed in the next section.

Methodology

This was a descriptive cross-sectional survey. The study's setting covered the rural and urban areas of eight districts selected randomly from each of the four regions of Uganda, namely: Central, Eastern, Northern and Western region. The selected districts included: Pallisa, Kampala, Jinja, Lira, Nebbi, Ntungamo, Luwero and Mbarara district. The population of the study consisted of rural and urban older persons of Uganda. These persons were targeted to provide primary data about barriers to physical fitness, needed healthcare services, food security and nutrition and coping mechanisms. There were other categories of respondents who were included to act as key informants providing complementary data about the fore-mentioned themes. These included goverment policy makers and implementers in the Ministries of Gender, Labour and Social Development; 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. Policy makers and implementers were targeted as key informants.

The sample drawn from the above population consisted of 165 older persons and 50 key infromants. The 165 older persons were selected using purposive sampling from the eight above named districts in the four regions of the country. The female older respondents (54%) were proportionally more than their male counterparts (46%), but 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.

While the fifty key informants were purposively selected from each district to participate in the study. 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.

Data was collected from the selected older persons using focus group discussions and in-depth interviews guided by focus-group discussion guide and interview guide, respectively. Data from the key informants was collected by administering an interview schedule. The collected data focused on all the themes of the study but this paper focuses on only barriers to Uganda's older persons' physical fitness, access to healthcare, food security and nutrition, and coping mechanisms used to deal with the barriers. Data was analysed using the thematic technique of the content method of qualitative analysis. The themes were developed according to the context and variables of the study. The themes were then coded and entered into the SPSS

software for analysis. Frequency and percentage distributions were generated and the results are presented in the next section.

Results

Barriers to Physical fitness, Food Security and Nutrition

The barriers to Uganda's older persons' physical fitness were established by asking these people to give factors that prevented them from participating in physical exercises by which they would keep physically fit. Results are shown in Table 1.

Table 1: Percentage Distribution of Barriers to Physical Fitness of Older Persons in Uganda

Preventive factor (Barriers)	Frequency by settings					
	Urban (N = 64)		Rural (N = 101)		Total percent (N = 165)	
	f	%	f	%	f	%
Bodily weaknesses	35	54.7	89	88.1	124	75.2
Suffering from chronic illnesses	19	29.7	53	52.5	72	43.6
Loss of hope, just waiting to die	11	17.2	22	21.8	33	20.0
Social life is the youth not us the elderly	15	23.4	33	32.7	48	29.0
Remoteness (lack of access to leisure facilities)	0	0.0	76	75.2	76	46.1
Tension and fear of rebel attacks	0	0.0	55	54.5	55	33.3
Housework	9	14.1	19	18.8	28	16.9
Lack of space for doing physical exercises	15	23.4	0	0.0	15	9.0
Lack of money to pay to health clubs	19	29.7	0	0.0	19	11.5
Lack of time due to a demanding job	9	14.1	12	11.9	21	12.7

***Note**: Respondents were not restricted to one reason; each respondent was thus free to give as many reasons as he/she could.*

From Table 1, bodily weaknesses constituted the barrier to the physical fitness of the majority (75.2%) of the older persons in Uganda. Remoteness, tension and fear of rebel attacks hampered the physical fitness of 75.2% and 54.5% of rural-based older persons but did not prevent any urban-based older persons' physical fitness. The reverse was true of urban-based older persons in the case of lack of space for physical exercises and money to pay to health clubs. Even suffering from chronic illnesses prevented more (52.5%) of the rural-based older persons than to the urban-based older persons (29.7%). These results suggest that older persons whose physical fitness was hampered by the barriers were more rural than urban based. It is important to note that some of the cited barriers were not hindrances in practice as shall be discussed later.

Barriers to older persons' access to healthcare were established by asking these people to point out problems that they encountered in accessing healthcare services. Findings appear in Table 2.

Table 2: Percentage Distribution of Barriers to Uganda's Older Persons Access to Needed Healthcare Services

Barriers	Frequency by settings					
	Urban (N = 64)		Rural (N = 101)		Total (N = 165)	
	f	%	f	%	f	%
Health workers' aloofness and lack of respect for older persons	36	55.4	55	54.5	91	55.2
Lack of medicine and drugs at health centres	35	54.7	89	88.1	124	75.2
Inadequate hospital beds	36	55.4	55	54.5	91	55.2
Bribery/corruption	50	78.1	67	66.3	117	70.9
Over waiting in long lines	44	68.8	76	75.2	120	72.3
Unconvincing diagnosis from health workers	35	54.7	55	54.5	90	54.5
Unaffordable medical costs	59	92.2	99	98.0	158	95.8
Long distances to health centres	0	0.0	78	77.2	78	47.3
Unavailability of health workers at health centres	50	78.1	69	68.3	119	72.1
Inadequate health workers at health centres	35	54.7	89	88.1	124	75.2
Inadequate space for inpatients	36	55.4	55	54.5	91	55.2

Table 2 reveals that all the barriers hindered most of Uganda's older persons from accessing healthcare services that they needed to maintain their personal health as desired. The only exception was the long distances that impeded 77.2% of older persons in rural areas but none in urban areas of Uganda.

Barriers to older persons' food security and nutrition were ascertained by asking these people to mention factors that hindered them from having enough food for feeding. Results appear in Table 3.

Table 3: Percentage Distribution of Barriers to Uganda's Older Persons' Food Security and Nutrition

Barriers	Frequency by settings					
	Urban (N = 64)		Rural (N = 101)		Total (N = 165)	
	f	%	f	%	f	%
Loss of gardens due to illegal eviction from land	11	17.2	20	19.8	31	18.8
Lack of land for cultivation	55	85.9	12	11.9	67	40.6
Destruction of crops by pests	13	20.3	56	55.4	89	53.9
Prevention of food production by the war/rebellion	19	29.7	39	38.6	58	35.2
Economic inability to afford a balanced diet	60	93.8	99	98.0	159	96.4
Destruction of crops by floods	18	28.1	62	61.4	80	48.5

Table 3 shows that the barrier to food security and nutrition desired by the overwhelming majority of older persons (96.4%) in both rural and urban areas was economic inability to afford a balanced diet. Regarding other barriers, while most (85.9%) of the older persons in urban areas were constrained by food due to lack of land for cultivation (85.9%) and food shortages (57.8%), most of those in rural areas were hampered by destruction of crops by floods (61.4%) and pests (55.4%).

Coping Mechanisms used by Older Persons in Uganda

The coping mechanisms in this section include those used by older persons in Uganda to deal with barriers to physical fitness and those used to deal with barriers to accessing needed healthcare services. Mechanisms used to deal with barriers to physical fitness are summarized in Table 4.

Table 4: Mechanisms used by Uganda's Older Persons to Cope with Barriers to Physical Fitness

Mechanisms	Frequency by settings					
	Urban (N = 64)		Rural (N = 101)		Total (N = 165)	
	f	%	f	%	f	%
Digging	15	23.4	30	29.7	45	27.7
Walking around	30	46.9	17	16.8	47	28.5
Cleaning the house	10	15.6	11	10.9	21	12.7
Cleaning the compound	14	21.9	15	14.9	29	17.6
Dancing	9	14.1	8	7.9	17	10.3
Running/jogging	5	7.8	0	0.0	5	3.0
Playing with grandchildren	6	9.4	18	17.8	24	14.5
Moving with cattle uphill every morning	0	0.0	19	18.8	19	11.5
Drumming	3	4.7	5	4.9	8	4.8
Playing guitar	2	3.1	7	6.9	9	5.4
Riding a bicycle	3	4.7	11	10.9	14	8.4
Going to health clubs	2	3.1	0	0.0	2	1.2
Picking food from the garden	3	4.7	17	16.8	20	12.1
Fetching water	6	9.4	15	14.9	21	12.7

Results in Table 4 indicate that relatively few older persons applied the coping mechanisms to deal with barriers to their physical fitness.

The mechanisms used by older persons to cope with healthcare barriers were established as shown in Table 5.

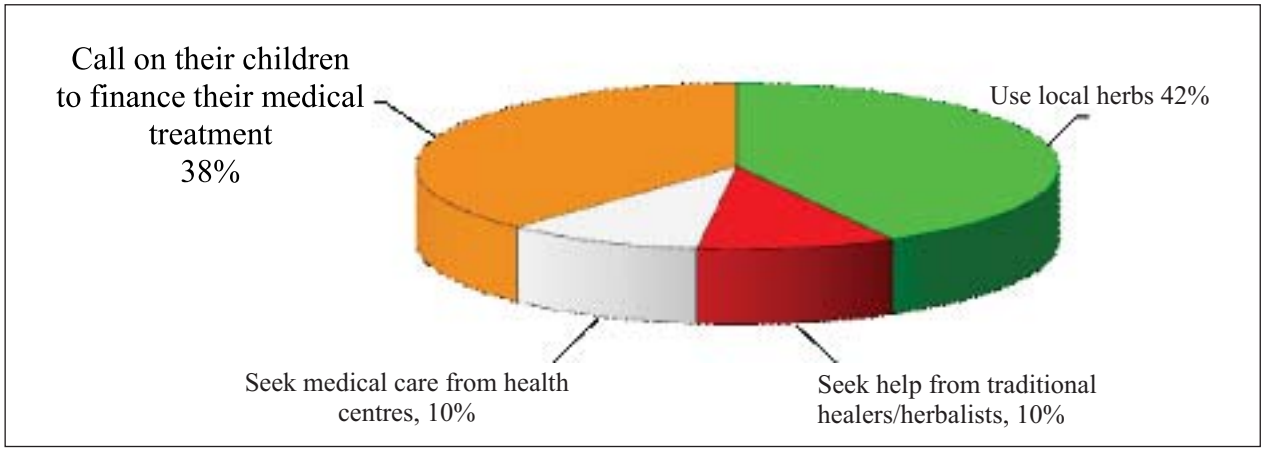
Table 5: Mechanisms Used by Older Persons in Uganda to Cope with Barriers to Personal Health care

Mechanisms	Frequency by settings					
	Urban (N = 64)		Rural (N = 101)		Total (N = 165)	
	f	%	f	%	f	%
Go to government hospital/health centre	13	20.3	14	13.8	27	16.4
Go to the nearest clinic/dispensary	60	93.8	0	0.0	60	36.4
Visit a traditional healer/herbalist	44	68.8	78	77.2	122	73.9
Buy medicine from pharmacy to treat myself	60	93.8	0	0.0	60	36.4
Look for herbs from bush or send a child to get them	60	93.8	98	97.0	158	95.8
I pray to God to heal me	60	93.8	33	32.7	93	56.4
Send for my doctor to come and treat me at home	2	3.1	0	0.0	2	1.2
Do physical exercises	13	20.3	14	13.8	27	16.4

Results in Table 5 indicate that the coping mechanisms that most of the older persons used to deal with barriers to their personal healthcare included: looking for herbs from bush or sending children to get the herbs (95.8%); visiting traditional healers (73.9%); and praying to God (56.4%). Key informants were also asked to describe the mechanisms that the elderly employed to deal with their personal health problems

Results are shown in Figure 1.

Figure 1: Mechanisms Used by Older Persons to Cope with Personal Health Problems, as Reported by Key Informants



From Figure1, most of the key informants (42%) reported that older persons in Uganda used local herbs to attend to their personal health problems. These results corroborate with the results obtained from older persons as shown in Table 5.

Mechanisms Used by older persons to cope with barriers to food security and nutrition were established as shown in Figure 2.

Figure 2: Mechanisms Used by Older Persons to Cope with Food security and Nutrition Barriers

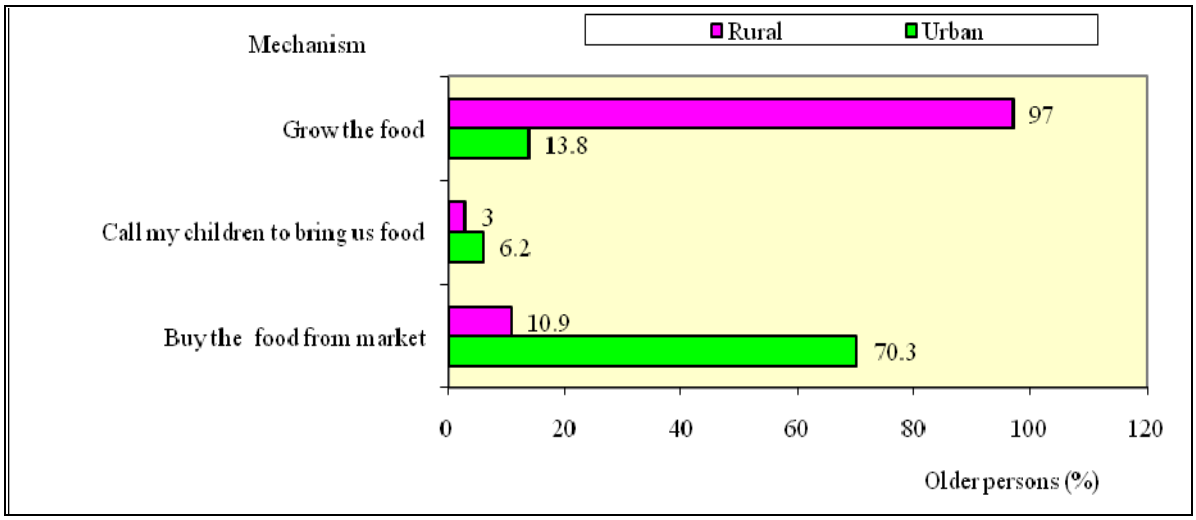


Figure 2 indicates that while most of the older persons in rural areas (97%) grew food to cope with food security and nutrition barriers, most of those in urban areas (70.3%) bought the food from markets.

Discussion

The results reveal a number of barriers that prevent older persons in Uganda from realizing desired physical fitness. Of all the barriers, one that prevents most of the older persons in Uganda face from realizing desired physical fitness was reported as bodily weaknesses. This barrier points to physical frailty that naturally sets in as a person grows old; and it is supported by the wear-and-tear theory of old age explained by Stuart-Hamilton (2003). It however, implies that most of the older persons in Uganda do not get involved in physical activity. Indeed, bodily weaknesses tend to be barriers when older persons are not involved in active ageing programs as Schutzer & Graves (2004) and Cooper, Bilbrew, Dubbert, Kerri, & Kirchner, (2001) point out. According to Help Age International (2002) and World Heath Organization (2002), being involved in physical activity regularly keeps the body muscles strong, with stable joints, improves cardiovascular and respiratory functioning, and strengthens the skeletal system thereby delaying the effects of frailty, falls and becoming tired all the time (Kanyoni & Phillips, 2009). Regular physical activity can also improve health and reduce the risk of premature death in many ways. For instance it can reduce the risk of heart disease, developing high blood pressure and developing type II diabetes and obesity. According to literature regular physical activity reduces the risk of developing colon cancer and possibly other cancers and lowers the blood cholesterol level and triglycerides which could harm the body when in high levels(Centre for Disease Control and Prevention, 2012).

The fact that most of the older persons were not involved in physical activity is clearly confirmed that it was a few of them who reported that they conducted physical exercises to cope with barriers to their physical fitness. Moreover, even the few who carried out the exercises did not do so regularly. Thus could not have some of the benefits that emanate from doing regular physical activity. Most of the older persons showed that they got involved in physical activities sometimes and sometimes not. This suggests that active ageing programs are inadequate in Uganda yet formulation of active ageing programmes was recommended in the WHO (2002) policy framework to all nations. Accordingly, the policy action implied by this suggestion involves promotion of active ageing in Uganda. This is particularly needed in the light of other factors such as nutrition and healthy behaviors.

Some of the reported barriers were actually not obstacles when viewed from the perspective of physical activity. In particular, remoteness, lack of space and lack of money were some of the reported barriers but each of these factors cannot prevent an individual from getting involved in regular physical activity. Physical activity involves activities such as walking, running, cycling or jogging around, doing domestic work like washing clothes, moping or indoor physical exercises with simple tools such as stools, stones, and objects with some weight. Clearly, any older person can carry out any of these physical exercises irrespective of whether he/she lives in a remote area, has money or space or not. Referring to each of these factors as barriers implies, however, that most of the older persons in Uganda are not aware of the many physical exercises that they can do in order to delay frailty. The policy issue implied by the findings is therefore about provision of information and promoting awareness of the benefits of physical activity, so that older persons can do in order to delay the onset of bodily weaknesses.

Results indicate further that most of the older persons were constrained from realizing desired personal healthcare by such barriers as health workers' aloofness and lack of respect for older persons. Unavailability of health workers and lack of drugs at health centres made the older people have a negative attitude towards accessing healthcare. As a result, most of them did not feel like going back for the services. Other barriers included bribery/corruption; over waiting in long lines; unconvincing diagnosis from health workers; unaffordable medical costs; and long distances to health centres. These barriers are consistent with those identified in the work of Kanyamurwa (2008a; 2008b), Nankwanga and Phillips (2008), and Kanyemibwa (2007). The barriers suggest that most of the older persons find it difficult to access desired healthcare services from government health centres.

This implication is reinforced by the mechanisms that older persons in Uganda reportedly used to cope with their personal health problems. Indeed, the overwhelming majority of these people resorted to looking for herbs from the bush or sending children

to get the herbs; visiting traditional healers; and praying to God. Evidently, these coping mechanisms imply that most of the older persons did not look to the formal healthcare sector for solutions to their personal health problems yet use of herbs without prescription could have its own negative effect on the body. Besides these herbs do not usually have a specific known dosage and some are not even based on research. Hence older people end up wasting their money on herbs that may not even heal them. The results suggest therefore that there is need for policy action for encouraging older persons in Uganda to seek solutions to their personal health problems from the formal health sector as most of the traditional healers are not trained in what they do. The needed policy action can be derived from the barriers.

The results also suggest that most of the older persons avoided government health centres as a result of the centres' poor customer care, corruption, inaccessibility, and lack of healthcare facilities by which the needed healthcare services could be provided. The results suggest therefore that the needed policy action should focus on training health workers in gerontology and geriatrics to attain this speciality. There is need for government to weed out corruption from government health centres and hospitals, raise the commitment of health workers to their work; build accessible health centres and stock adequate healthcare facilities and drugs.

Optimal nutritional status is another important component of good health and requires particular attention (Kanyamurwa, 2008a; 2008b; Lee & Frongillo, 2001). Regarding food security and nutrition, results show that barriers included: loss of gardens due to illegal eviction from land; lack of land for cultivation; destruction of crops by pests and floods; prevention of food production by the war/rebellion; economic inability to afford a balanced diet due to high prices of food as a result they buy less and lack of capacity to grow food crops since most older people are weak and frail. These barriers suggest that most of the older persons in Uganda face food shortages as a result of natural disasters and lack of resources needed to acquire food. Certainly, food shortages imply that there is no adequate food security for older persons in Uganda. They also imply that older persons do not have enough food by which they can realise the desired nutrition levels and hence are forced to go through chronic hunger as many of them eat one meal instead of two meals a day. Food insecurity is a risk factor associated with poor nutritional and health status among older persons. Besides malnutrition can result in increased costs of care and also inflates national healthcare costs due to increased complication rates. Thus given the increasing ageing population in Uganda, if not addressed, demand for healthcare and social services by older persons will increase the national healthcare costs. Healthcare costs could be greatly reduced by improving the well being of older persons.

The barriers therefore, point to policy action that needs to focus on improving the food security and nutrition of older persons in Uganda. This action is particularly needed in view of the mechanisms that older persons used to deal with the barriers to their food security and nutrition. Indeed, the coping mechanisms showed that the overwhelming majority of older persons in rural areas were digging yet those in urban areas were buying the food from markets. These mechanisms are inadequate. Digging can only produce for subsistence. Secondly, buying the food is also difficult in view of the high poverty levels in Uganda. Coping mechanisms therefore need to be enhanced by better options such as encouraging large scale food production and improving the food storage facilities and provision of adequate information regarding food security and nutrition. While those who are very frail could be given handouts so as to boost their nutritional status and also in addition be encouraged to do physical activity alongside practicing healthy behaviours.

Conclusions

1. The coping mechanisms used by older persons to deal with barriers to their physical fitness are inadequate and point to the fact that physical activity programs are inadequate in Uganda. There is therefore need for policy action involving promotion of active ageing in the country.

2. The coping mechanisms used by most of the older persons suggest that these people do not look to the formal health sector for solutions to their personal health problems. There is need for policy action for encouraging older persons in Uganda to

seek solutions to their personal health problems from the formal health sector. The needed policy action needs to focus on training health workers in gerontology, weeding corruption out of government health workers, raising the commitment of health workers to their work; building easily accessible health centres and adequately stocking them with adequate healthcare facilities and drugs.

3. The coping mechanisms used by older persons to deal with barriers to their food security and nutrition are inadequate and the food security and nutrition barriers faced by older persons in Uganda imply that these people are faced with food shortages. This is aggravated by the fact that the mechanisms used to deal with the barriers are inadequate and therefore need to be enhanced by better options such as encouraging large scale food production and improving the food storage facilities.

In Summary, with an increasing population, ensuring that the older persons in Uganda have enough food to eat in order to meet their nutritional needs may be one important aspect to help our older people enjoy a healthy, active and successful quality of life. As Lee & Frongillo (2001) point out food insecure older persons require more attention because food insecurity is an unwanted occurrence, not only because of its relationship to poorer nutritional and health status, but it is also ethically unacceptable. In addition older persons need to be encouraged to do physical activity to remain physically active and fit for the proper functioning of their body. This could be enhanced through provision of the right information by physicians or medical personnel who regularly see them as they come to hospitals to seek for health care.

Recommendations

1. The government of Uganda, nongovernmental organizations, and agencies dealing with older persons should formulate a policy for promoting active ageing in Uganda through dissemination of information and rising the awareness of older persons of the physical fitness exercises that they can freely and easily conduct. Such policy strategies should include physical activity, health promotion of healthy lifestyles and nutritional programs

2. Institutions for training health workers should be encouraged to train health workers in gerontology and geriatrics and commitment of health workers to their work. The government of Uganda should also weed corruption out of health centres; build more health centres to improve accessibility; and adequately stock the centres with adequate healthcare facilities and medicines especially the essential drugs required by older people.

3. The government of Uganda should take a policy action for encouraging large scale food production and improvement in food storage facilities in Uganda and also provide information regarding nutrition to the elderly.

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