

**PRIMARY HEALTH CARE IN LATER LIFE (PHILL):
IMPROVING SERVICES IN BANGLADESH VIETNAM**

Baseline Survey Report 2003

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Table of Contents

- A. *Project Background 3*
 - I. *PHILL Objective*
 - II. *Research hypothesis*
 - III. *Definitions in PHILL*
 - IV. *Framework for quantitative data collection*
 - V. *PHILL study design*
- B. *PHILL quantitative baseline report: BANGLADESH 5*
 - I. *Condition of the elderly in Bangladesh 5*
 - II. *Materials and Methods 7*
 - a. *Baseline survey*
 - b. *Sampling*
 - c. *Field operation*
 - d. *Data collection*
 - III. *Baseline Survey Results: Key findings by domain 9*
 - a. *Socio-economic and demographic characteristics*
 - b. *Health and health-seeking behaviour*
Acute/acute-on-chronic, chronic & tracer conditions
 - c. *Health services*
 - d. *Quality of Life*
 - e. *Life style*
 - f. *Social functioning*
 - g. *Perspective of illness*
 - IV. *Conclusion 30*
 - V. *References 32*
 - VI. *Appendix: Framework of data collection*

A PROJECT BACKGROUND

The Primary Health-Care in Later Life: Improving Service in Bangladesh and Vietnam (PHILL) project seeks to identify the effectiveness of low-cost, preventive and health promotion interventions in improving the primary health care (PHC) of people sixty and over in rural communities in Bangladesh and Vietnam. The three-year project (October 2002—September 2005) is supported by the European Commission (EC) and is being implemented under a four-member partnership. Partner institutions are the Karolinska Institute (KI) in Sweden, the Bangladesh Rural Advancement Committee (BRAC) in Bangladesh, the Health Strategy and Policy Institute (HSPI) in Vietnam and University of East Anglia (UEA) in the UK.

The principal strategy of the project is to integrate existing primary health care infrastructures and promote the active participation of family and community in the health care of the elderly people. The project defines primary health care as including the first level public institutional (government health care system), community level (private and voluntary health services), and self-care at the household and individual levels.

I. PHILL OBJECTIVE

The study will identify the effectiveness of low-cost, preventive and health promotion interventions, involving the primary health-care infrastructures and with active participation of the family and community, in improving primary health care for older persons in rural communities of Bangladesh and Vietnam.

The key project objectives include:

- To develop effective indicators of performance of PHC systems in meeting the needs of older persons;
- To assess the impact of specific PHC interventions for this age group in terms of satisfaction, utilization, and accessibility;
- To improve the health status and quality of life (QoL) of elderly people in targeted locations;
- To develop effective sustainable PHC strategies which can be replicated at the national level and in other countries; and
- To foster research capacity in partner institutions and to develop long-term institutional linkages between all those engaged in the research process.

II. RESEARCH HYPOTHESIS

An appropriate, effective PHC intervention package sensitive to elderly people health needs can have a significant impact on

- Physical functioning
- Mental health (depression, anxiety, stress)
- Morbidity [prevalence (some general indicators of morbidity assessment such as no. of days as sick) and specific health problem e.g. rheumatism)]
- Utilisation of PHC services
- Knowledge, attitudes and practice of health care providers, community members and family members regarding elderly health and elderly care

Within an 18 months' time frame these impacts in turn will have an impact on health-related quality of life of older people.

III. DEFINITIONS IN PHILL

Primary health care (PHC): Includes first level of institutional (health facility within the government health infrastructure) health care, community level health care (private and voluntary health services), self-care at household and individual levels.

Health-related quality of life (HRQOL): HRQOL is defined as quality of life influenced or affected by health status. This project focuses on generic measures of HRQOL.

Health care providers: All health care providers at primary health care level that people use in the area including public, private and voluntary services.

Elderly: Men and women aged 60 years or older.

Main caregiver: Person responsible for looking after the elderly individual. Other household members will identify this person. In case of elderly person living alone, neighbours can be considered to be the source of information.

Community: All village members represent the community/ Community is represented at the village level.

Empowerment: To develop skills and capacity, as well as awareness in dealing with elderly people health and elderly people care.

Socialization: Involving the elderly people in community activities.

IV. FRAMEWORK FOR QUANTITATIVE DATA COLLECTION

This framework (See appendix A) is taken as the main guideline when developing assessment tools. The framework was constructed to address the four major domains of the project. These domains are outlined below:

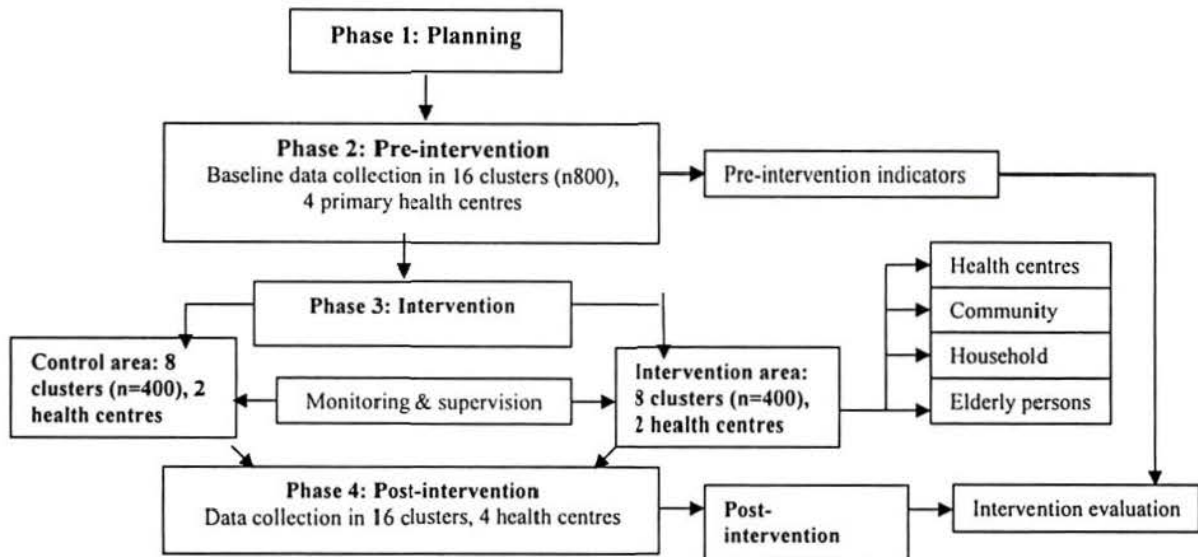
Domains in PHILL project: [Study population: rural men and women aged 60 years and above].

DOMAINS				
	PHC	Health	Care	QoL
INDICATORS	<ul style="list-style-type: none"> • Availability • Satisfaction • Barriers to access • Utilization • Quality of service • Health-care seeking behaviour 	<ul style="list-style-type: none"> • Morbidity • Specific problems (e.g. rheumatism) • Nutrition • Function 	<ul style="list-style-type: none"> • Care to the elderly • Care from the elderly (contribution) • Social functioning <ol style="list-style-type: none"> 1. instrumental support 2. emotional support 3. financial support 4. support network 5. Social roles 	<ul style="list-style-type: none"> • Physical • Psychological • Social • Spiritual • Economic • Environmental

V. STUDY DESIGN

The project for each study site, i.e. Bangladesh and Vietnam, is divided into four phases as shown in the figure below (Figure 1):

FIGURE 1. OVERALL DESIGN OF THE RESEARCH PLAN



B PHILL QUANTITATIVE BASELINE REPORT: BANGLADESH

I. CONDITION OF THE ELDERLY IN BANGLADESH

Born in 1971 after a devastating war, Bangladesh is a land of immense beauty and potential. In its short history, Bangladesh has faced a daunting challenge of improving the health of its people with limited resources available and made remarkable progress. Health status in Bangladesh has shown a steady improvement since independence, especially in the last decade. Life expectancy has increased by 15 years, the total fertility rate (TFR) has declined by more than half and the infant mortality rate (IMR) has fallen by almost half. Health indicators now compare favourably with those in the region and with other countries at a similar or higher GNP (Ahmed et al. 2001). This accomplishment of demographic transition (from high fertility and mortality to low fertility and mortality) from the success of the targeted public health interventions such as immunization, family planning, ORS etc. since independence has resulted in gradual ageing of the population in Bangladesh.

Although the elderly make up only a small proportion in Bangladesh's total population, the absolute number of the elderly people aged 60 years and above is quite substantial due to a large population base. Thus, according to 2001 census, 6.2% of the population is ≥ 60 years, the absolute number being above 8.5 million (BBS 2001). Approximately, 80,000 new elderly people are added to this ageing population every year. It is projected that by 2025, the elderly population will exceed 17 million (Warnes 1986). The increase in elderly population in Bangladesh during the period 1990-2025 is projected to be much faster (219%) than that of European countries such as Sweden (33%), UK (45%) or Germany (66%) (Basch 1999). While changing lifestyles, urbanization, and the decline of traditional family support system have

increased the plight of the elderly people, especially the poor, little attention has been given by the policy makers to their health and social needs.

In developing countries older people are often characterised as frail, dependent and unproductive. The vulnerability of the elderly people has other dimensions. Experiences of special events in later life, such as sudden drops in income and reduced socio-economic opportunities increase the probability of economic deprivation and social isolation of elderly people (Leo et al. 1998). The vulnerability of elder people's is also reflected in a higher burden of ill-health and disability. These forms of vulnerability are sometimes compounded by extreme poverty, negative attitudes and gender stereotypes.

Gender inequality and discrimination against women is widespread in Bangladesh. Only 5% of women over the age of 60 are literate compared to 30% of men. Older women also own fewer assets and have less control over family income, and endure more chronic disease and disability than their male counterparts. The majority of older women in Bangladesh are widowed (68%) compared to 7% of men. This issue of widowhood is significant as a woman's marital status is of primary significance to her survival and well-being. Almost all (95%) of female-headed households are estimated to be below the poverty line, with 40% classified as extremely poor. Indeed, the EC CSP (What is EC CSP?) for Bangladesh states that "extreme poverty is still predominately female" (EC). Women are more likely to begin and end life in poverty, have chronic health problems, and face exclusion and low status throughout their life.

Empirical findings from various developing countries show that poor older people experience high levels of sickness, yet their use of health services is below average (Ahmed et al. 2000; Fletcher & Donoghue 1998; Kalache & Sen 1999). There is also disregard for the nutritional needs of older people, as nutritional assessments tend to focus exclusively on the under five-year-olds, without taking representative samples of nutritional status among other age groups. Lack of access to safe water and adequate sanitation facilities contribute to the poor nutrition and health status of older people as well. There are many potential barriers for older persons to access health services in countries such as Bangladesh. These include financial barriers, physical barriers (related to problems of mobility, geographical distance), infrastructure barriers (existence of services specifically targeting the groups), factors relating to social attitudes (on the part of providers, as well as older people themselves and their families), and a lack of information about the existing services (sometimes due to high level of illiteracy among elders).

The available research suggests that well targeted PHC interventions have considerable potential to improve the health and quality of life of older people in any country (Fletcher et al. 1998). However, meeting the specific health needs of this group is not usually a priority for PHC providers in developing countries, and the potential benefits of reorienting priorities have not been studied. As well as improving the well-being of elderly people, effective PHC could reduce the burden of demands for health services at the secondary and tertiary levels. Also, PHC must be understood with reference to the position of elderly people within households and communities. Of particular importance are relationships between PHC and informal support for elderly people, health education and the promotion of healthy active life expectancy. Less than 40% of the population of Bangladesh has access to modern PHC services beyond immunization and family planning (Abedin 1997). The large majority of the health-care seeking population goes to unqualified practitioners providing various kinds of treatments that are frequently sub-standard, ineffective and harmful (Begum 1996). Recent research from Bangladesh indicates that

health services for older persons suffer from a lack of coverage and the inadequacy of existing services to meet older peoples' needs (HelpAge 2000).

Poor health need not be inevitable in old age (Kaplan & Haan 1989). Health promotion, a key element of PHC, is an important tool to slow down or even prevent ill-health and consequently, improve quality of life (QoL) of the older people (Fletcher et al. 1998). A positive attitude to ageing should emphasise that much can be done to improve the health status of those who are already elderly, through effective promotion campaigns. In most low-income countries such as Bangladesh services retain a curative bias, and there are few examples of successful nation-wide promotion campaigns for elderly population.

II MATERIALS AND METHODS

a. Baseline Survey

A comprehensive baseline survey was done during last week of April-1st week of June, 2003 (total 6 weeks) in Sadar (the intervention area) and Shahrashiti (comparison area) sub-districts of Chandpur district to record benchmark information at pre-intervention stage. Data were collected on different aspects of the lives of the elderly such as socio-economic and demographic characteristics, Knowledge, Attitude and Practice (*KAP*) on elderly issues, morbidity and health-seeking behaviour, functional ability, social network and social support, and healthcare access and utilization. This report presents key findings from this baseline survey to inform programme design and post-intervention impact evaluation.

b. Sampling

For both the intervention and the comparison areas, four villages with approximately 600 elderly people were selected. The initial sample frame of elderly population (≥ 60 years) was obtained from BRAC local office, which was later verified during survey. These villages were clustered around an NGO health centre and a Government Health centre. Thus, the survey covered about 1640 HHs (Elderly HHs: 519) in four villages in the intervention area and 1391 HHs (Elderly HHs: 491) in four villages in the comparison area (see Table A). Trained interviewers administered structured questionnaires to collect data. All questionnaires were pre-tested in a village outside our sample for ascertaining consistency, appropriateness of languages, sequencing of the questions, and to have an insight into the field operation procedure. These were then modified, rephrased and edited in the light of feedback received. An instruction manual in Bangla for the interviewers backed the easily identifiable colour-coded questionnaires. The full set of instruments was administered to the HHs with elderly individual(s) while only demographic and socio-economic instrument was administered to the rest of the HHs.

Table A: The sampling frame

Name of Village	Total Households	Total population	Number of households with elderly people	Total elderly people
Intervention (Chandpur Sadar)				
Ashikathi	974	5363	293	344
Mandhari	403	2290	144	148
Dhamakergaon	104	538	31	34
Kumerdughi	159	884	51	56
<i>All</i>	<i>1640</i>	<i>9075</i>	<i>519</i>	<i>582</i>
Control (Shahrashthi)				
East Upalata	446	2355	146	159
Waruk	476	2662	181	198
Surshai	169	880	58	73
Sahapur	300	1609	106	121
<i>All</i>	<i>1391</i>	<i>7506</i>	<i>491</i>	<i>551</i>
Grand Total	3031	16581	966	1133

c. Field operation

Prior to the survey, all interviewers (graduates with field experiences) received rigorous training on questionnaire content, probing techniques and strategies to establish rapport and neutrality essential to complete and accurate data collection. Two teams of interviewers comprising 8 each, and led by an experienced supervisor, were deployed in the study villages about a week before beginning of the survey for rapport building activities. The day-to-day field activities of the teams were fine-tuned by two field researchers based in Chandpur PHILL office. The whole survey activity was supervised and managed by the study coordinator who made frequent field visits for spot checking the quality of interviews and providing assistance and guidance when needed. Whenever necessary, re-interview was done by the supervisors for securing reliable and valid data. Households were visited on three repeated occasions at weekly intervals, if the first attempt was not successful due to absence of the respondents. When these repeated attempts failed, the interview was called-off. There was some non-response due to a variety of reasons such as refusal to cooperate, too weak to undergo interview, non-cooperation from household members etc. Thus, out of 1133 elderly individuals targeted, interview was successful done for 1031 individuals i.e., non-response was around 8%.

d. Data collection

The head of the household furnished the general demographic and socio-economic data used in analysis, while the elderly himself/herself or his/her primary caregiver in the family present provided specific information on elderly individuals at the time of survey. *KAP* information was collected from relevant respondents e.g., primary caregiver, healthcare providers etc.

Data on health-seeking behaviour

For each elderly individual of the family, respondents were asked whether that particular member was ill during the reference periods and if so, to describe the symptoms in their own language (lay reporting of symptoms) and recorded as such. Sometimes probing was done to elicit symptoms and exclude 'diagnoses'. When more than one episode of recent illness was reported, data were collected with reference to the major illness, i.e. the one which was longest in duration. Reported symptoms were classified into categories or "types" of illnesses by means of

a pre-tested coding system, and cross-checked by a physician. For example, the reported symptoms of fever and productive cough, and difficulty in breathing were coded as 'pneumonia'. Efforts to improve the reliability and validity of illness reporting included the use of culturally appropriate language, limiting the recall period to 15 days in case of recent illness, intensive field supervision, and on-the-spot checking for inconsistencies.

In cases where a health care provider was consulted, additional information was obtained with respect to the initial choice made about treatment seeking, and associated costs and the source(s) of money spent. These treatments were subsequently grouped into five categories. The category 'self-treatment' comprised of instances in which common home remedies were employed such as ORS. Traditional methods include treatment-seeking within faith healing and traditional systems of medicine such as consultation with *kabiraji/hakimi* and homeopathic practitioners (Ahmed 1993). The category, 'unqualified allopathic' care is mainly made up of untrained pharmacy salesmen, but also includes itinerant drug sellers and roadside "quacks" who provide medical advice and treatment with little or no professional training. The 'Para-professional' category of treatment-seeking consists of consultations with: *palli chikitsoks* (village practitioners who receive a year-long training in diagnosing and treating common rural ailments); medical assistants (who complete a three-year medical programme); and government and non-government community health workers who receive basic preventive and curative health training. Finally, the 'Qualified allopaths' comprising of licensed practitioners who have undergone professional medical training. Together, para-professionals and qualified allopaths represent formal providers of 'medical care'.

Data on Quality of Life (QoL)

III. Baseline Survey Results

SUMMARY OF KEY FINDINGS:

DOMAIN	KEY FINDINGS	COMMENTS
Household level information		
Socio-economic	Socio-economic status shows that average landholding is significantly better in the comparison area. However, no statistically significant difference is found at household level between the two areas in terms of other socio-economic indicators, i.e., household food security and food expenditure during 24 hours prior to the interview. In terms of household size and sex of household head, the two areas are comparable.	Table 1
Individual level information of Elderly		
Socio-demographic	Individual level socio-demographic characteristics of elderly indicate similarity between the intervention and comparison areas of the project.	Table 2

Health Status		
Prevalence of acute illness (and health-seeking behaviour)	Prevalence of acute illness shows that majority of older people got sick in last 15 days. Of them 63% in intervention area and 56% in comparison area. The difference of illness prevalence was statistically significant between the 2 areas ($p < 0.5$). Prevalence of illness was more among women compared to men.	Table 5
	Self-treatment was a major therapeutic activity undertaken in both areas: treatment-seeking from drug retailers and qualified practitioners was more in comparison area while para-professionals were more frequently used in the intervention area	Table 6
Prevalence of chronic illness (and health-seeking behaviour)	Prevalence of chronic illness shows that nearly three-quarters of older people got chronic illness (72%). Women reported more chronic illness compared to men. However, no difference was observed between the intervention and control areas.	Table 7
	Same trend as for acute illnesses noted with respect to health-seeking	Table 8
Prevalence of arthritis (and health-seeking behaviour)	Arthritis was a very common problem in both the areas 76-86%.	Table 9
	Same trend as for acute illnesses noted with respect to health-seeking	Table 10
Perceived health status	Majority of the elderly people perceive their current health status as poor or very poor, greater proportion of women reporting so than men. Less than 10% of elderly people rate their current health status as good or very good.	Table 4
Health Services		
Provision of services	Allopathic type of health service prevails most in both intervention and comparison areas.	Table 20
	Respondent from the comparison area mentioned that more government health facilities are available in the area. About 85% of older people know that medicine shops and pharmacies are available in the nearest place, which is similar for both intervention and control areas.	Table 15 & Table 16
Knowledge of providers	Knowledge on older people health shows that health care provider's thinks health life style, light physical work is good for older people health while unhealthy life style, irregular/poor/inappropriate diet and over exertion is bad for older people health. With regard to illness older people seek treatment for joint pain indigestion and respiratory problems.	Table 21

DOMAIN	PRELIMINARY FINDINGS	COMMENTS
QUALITY OF LIFE	Among the six dimensions of quality of life (QoL) older people were worse in physical, mental, economical and environmental aspects. They are very satisfied with the spiritual dimension while satisfaction of social dimension is also satisfactory.	Table 25
LIFE STYLE	In both areas, one-third of elderly men were current smokers. Chewing of betel leaf/nut was highly prevalent in both areas and among women and men.	Table 12
SOCIAL FUNCTIONING		
Social network	Majority of older people having friends with whom can pass some time irrespective of sex. With regard to member of any association older men were more involved with association than women.	Table 13
Social participation	Participation in voting was high, particularly among men. Visit to places of prayer/worship was high among elderly men. Due to cultural and religious constraints visit to places of prayer are very limited for Muslim women.	Table 13
Social support	Daughter in laws and spouse were the main caregivers of the older people. Sons were the main decision maker of treatment of older people while get sick. About 90% of older people thinks that they need more financial help what is available currently.	Table 14
Perspective of illness	Although emotional problems were identified by primary caregivers and health care providers as one of the health problems of elderly people. The elderly individuals themselves did not report it as a problem. The discrepancy is might due to the difference in the data collection method for this information from elderly people, caregivers and health care providers (HCPs).	Table 24

PHILL BASELINE TABLES: BANGLADESH

Table1: Socio-economic characteristics of households with elderly members by study area at baseline (%).

Characteristics		Intervention area	Comparison area
Landholdings (decimals)			
Mean ± sd	p<. 05	66.5 ± 90.1	76.5 ± 111.5
<50		63.2	55.3
50 – 100		15.6	19.3
100+		21.1	25.3
Major source of income			
Agriculture		16.8	17.6
Wage-labour		15.4	9.0
Service		17.4	21.3
Trade		16.6	21.5
Self-employment		14.8	11.1
Remittance from abroad		12.7	16.3
Others		6.3	3.1
Food security of household			
Always deficit		11.5	12.8
Occasional deficit		29.1	23.0
No deficit		59.4	64.0
Female headed household		12.7	15.1
Household size mean ± sd		6.1 ± 2.7	6.2 ± 2.8
Food expenditure* in last 24 hours mean ± sd		85.8 ± 61.4	89.7 ± 67.6 (ns)
N		488	478

*in Taka

Table 2: Socio-demographic characteristics of the elderly people by study area, PHILL Study 2003 (%)

	Intervention area			Comparison area		
	Male	Female	All	Male	Female	All
Age (years)						
60 - 64	28.3	28.9	28.5	22.9	26.1	23.8
65 – 69	22.8	29.2	25.6	30.6	31.0	27.2
70 – 74	23.1	20.6	22.0	21.2	21.9	21.4
≥ 75	25.8	21.3	23.9	26.1	25.3	25.3
Mean age	70.0	69.2	69.6	70.4	70.1	70.3
Formal schooling (years)						
None	47.7	79.1	61.3	45.3	82.5	62.5
1-5	23.7	19.4	21.8	22.0	15.2	18.8
5+	28.6	1.6	16.8	32.8	2.3	18.7
Current occupation						
Agriculture	50.8	0.0	28.6	45.3	0.0	22.0
Wage-labour	13.6	2.6	8.8	8.8	1.0	4.8
Service/Trade	25.6	0.0	14.4	25.9	0.5	12.8
Self-employment	7.5	0.0	4.2	8.8	0.0	4.3
Domestic chores	2.5	97.4	43.3	11.0	98.5	56.0
Marital status						
Currently married	90.9	34.4	66.3	88.6	25.7	59.4
Widow/ Widower	8.9	64.7	33.7	11.4	74.3	40.6
N	329	253	582	296	257	553

Table 3: Physical disability status of the elderly people, PHILL Study 2003 (%)

	Intervention area			Comparison area		
	Male n=289	Female n=225	All n=514	Male n=276	Female n=241	All n=517
Physical disability	60.9	67.1	63.6	59.4	63.1	61.1
Types of disability						
Blind	1.1	1.3	1.2	0.6	3.3	1.9
Dimness of vision	86.9	84.8	85.9	87.2	84.9	86.1
Deaf	---	2.0	0.9	1.8	3.9	2.8
Can't walk	3.4	5.3	4.3	6.1	2.6	4.4
Can't move upper limb(s)	2.8	2.0	2.4	2.4	3.9	3.2
Hearing problem	5.7	4.6	5.2	1.8	1.3	1.6
N	176	151	327	164	152	316

Table 4: Perceived current health status of the elderly people, PHILL Study 2003 (%)

	Intervention area			Comparison area		
	Male	Female	All	Male	Female	All
Perceived current health status						
Good/Very good	13.1	5.3	9.7	9.0	4.1	6.8
In-between	41.9	34.7	38.7	40.2	40.7	40.4
Bad/Very bad	45.0	60.0	51.6	50.8	55.2	52.8
N	289	225	514	276	241	517

Table 5: Recent illness (15 days recall) and morbidity profile of the elderly people, PHILL Study 2003 (%)

	Intervention area			Comparison area		
	Male n=329	Female n=253	All n=582	Male n=296	Female n=257	All n=553
Prevalence of illness in last 15 days	61.7	65.6	63.4	56.4	58.8	57.5
			p<0.5			
Morbidity profile						
Bodily pain	17.8	19.4	18.5	29.4	30.5	29.9
Fever (Uncomplicated)	15.1	13.7	14.5	14.7	11.0	13.0
Respiratory illnesses	16.4	13.7	15.2	13.0	11.7	12.4
Gastrointestinal illnesses	18.7	16.6	17.8	6.2	9.1	7.6
Skin/Eye/ENT illnesses	9.1	10.9	9.9	4.5	8.4	6.3
Hypertension and Cardio-vascular illnesses	3.2	5.1	4.1	5.6	2.6	4.2
Weakness/paralysis of limbs	1.8	3.4	2.5	4.0	1.9	3.0
Generalized weakness	6.8	8.0	7.4	9.0	9.1	9.1
Others	11.0	9.1	10.2	13.6	15.6	14.5
N	219	175	394	177	154	331

Table 6: Health-seeking behaviour of the elderly people for recent illness (15 days-recall), PHILL Study 2003 (%)

	Intervention area			Comparison area		
	Male	Female	All	Male	Female	All
Self-treatment	24.2	32.6	27.9	21.5	22.1	21.8
No medicine taken	7.8	10.3	8.9	4.5	5.8	5.1
Traditional medicine*	5.0	4.6	4.8	1.1	2.6	1.8
Unqualified practitioners of allopathic medicine	15.1	10.9	13.2	21.5	23.4	22.4
Para-professionals**	35.6	22.3	29.7	19.8	19.5	19.6
Qualified allopathic practitioners (MBBS)	12.3	19.4	15.5	31.6	26.6	29.3
N	219	175	394	177	154	331

*Kabirai, Faith-healer, Herbalists etc. including homeopath, **PCs, MAs, CHWs of GO/NGO etc. who have some formal training in allopathic medicine

Table 7: Chronic illness (>1 year duration) and morbidity profile of the elderly people, PHILL Study 2003 (%)

	Intervention area			Comparison area		
	Male	Female	All	Male	Female	All
Chronic Illness in last 1 year	68.5	76.9	72.2	69.9	73.9	71.8
N	289	225	514	276	241	517
Morbidity profile						
Bodily pain/Joint pain	10.2	10.7	10.4	11.7	11.0	11.4
GI Illnesses	23.1	18.7	21.1	16.6	15.5	16.1
Respiratory Illnesses	13.4	10.2	11.9	8.8	8.8	8.8
Cardiovascular Illnesses	11.1	13.4	12.2	9.3	5.5	7.5
Generalized weakness	4.6	9.1	6.7	5.9	8.3	7.0
Eye problems	14.8	25.7	19.9	35.6	38.7	37.0
Urinary problems	12.5	5.9	9.4	5.4	1.7	3.6
Others	10.2	6.4	8.4	6.8	10.5	8.5
N	216	187	403	204	181	385

Table 8: Health-seeking behaviour of the elderly people in last one month for chronic illnesses, PHILL Study 2003 (%)

	Intervention area			Comparison area		
	Male	Female	All	Male	Female	All
Health-seeking behaviour						
Self-treatment	12.1	10.7	11.5	8.8	7.2	8.1
No medicine taken	25.2	22.5	23.9	27.0	30.9	28.8
Traditional medicine*	4.7	3.2	4.0	3.4	1.7	2.6
Unqualified practitioners of allopathic medicine	7.9	10.2	9.0	16.7	20.4	18.4
Para-professionals**	27.1	28.3	27.7	13.7	14.9	14.3
Qualified allopathic practitioners (MBBS)	22.9	25.1	23.9	30.4	24.9	27.8
N	216	187	403	204	181	385

*Kabirai, Faith-healer, Herbalists etc. including homeopath, **PCs, MAs, CHWs of GO/NGO etc. who have some formal training in allopathic medicine

Table 9: Arthritic morbidity among elderly people, PHILL Study 2003

	Intervention area			Comparison area		
	Male	Female	All	Male	Female	All
Have arthritic problems	75.4	77.8	76.5	81.2	92.1	86.3
N	289	225	514	276	241	517
Symptom profile						
Pain in the joints	64.2	60.8	62.7	99.6	99.6	99.6
Others						
N	240	194	434	236	230	466

Table 10: Health-seeking behaviour of the elderly people in last one month with respect to arthritic illnesses, PHILL Study 2003 (%)

	Intervention area			Comparison area		
	Male	Female	All	Male	Female	All
Health-seeking behaviour						
Self-treatment	18.0	14.0	16.2	13.2	10.9	12.0
No medicine taken	23.4	18.7	21.3	17.0	22.6	19.8
Traditional medicine*	3.3	3.1	3.2	2.1	0.9	1.5
Unqualified practitioners of allopathic medicine	11.7	15.5	13.4	30.6	29.6	30.1
Para-professionals**	33.9	34.2	34.0	16.6	20.9	18.7
Qualified allopathic practitioners (MBBS)	9.6	14.5	11.8	20.4	20.9	17.8
N	240	194	434	236	230	466

Table 11: Activities of daily living by the elderly people, PHILL Study 2003 (%)

	Intervention area			Comparison area		
	Male	Female	All	Male	Female	All
Have difficulty in:						
Getting from bed	---	1.3	0.6	0.4	0.8	0.6
Going to toilet	0.3	2.7	1.4	1.4	1.2	1.4
Taking bath	2.4	3.6	2.9	2.5	1.7	2.1
Getting dressed	1.4	4.4	2.7	1.1	1.2	1.1
Taking food	---	0.9	0.4	1.4	0.4	1.0
Moving in-door	5.5	3.6	4.7	3.6	4.1	3.9
Completely bed ridden	0.3	2.7	1.4	1.4	1.2	1.4
Needs help for moving out-door	6.9	5.8	6.4	6.2	6.2	6.2
N	289	225	514	276	241	517

Table 12: Life-style of the elderly people, PHILL Study 2003 (%)

	Intervention area			Comparison area		
	Male	Female	All	Male	Female	All
Current smoker	30.1	0.4	17.1	29.0	1.2	16.1
Chew betel leaf/nut	87.2	84.9	86.2	85.1	90.9	87.8
Takes raw tobacco with betel leaf	68.3	75.9	71.6	67.7	80.4	73.8
Gets up from bed at morning prayer	87.9	94.7	90.9	76.4	72.2	74.5
Goes to bed after night prayer	41.2	66.2	52.1	40.6	44.8	42.6
Takes three meals a day	66.4	74.2	69.8	79.3	81.7	80.4
N	289	225	514	276	241	517

Table 13: Social network of the elderly people, PHILL Study 2003 (%).

	Intervention area			Comparison area		
	Male	Female	All	Male	Female	All
Member of any association	20.4	7.1	14.6	19.9	1.7	11.4
Having friend (s) with whom can pass some time	76.1	76.0	76.1	74.6	62.7	69.1
Goes to visit neighbour at leisure	66.8	75.6	70.6	81.2	80.9	81.0
Voted in the last local election	89.6	68.0	80.2	95.3	82.2	89.2
Visit places of prayer/worship	97.6	4.9	57.0	99.6	25.7	65.2
Consulted during important family decision making	91.3	95.1	93.0	86.2	94.6	90.1
N	289	225	514	276	241	517

Table 14: Social support network of the elderly people, PHILL Study 2003 (%)

	Intervention area	Comparison area	All
Primary caregiver of the elderly people			
Daughter in law	50.6	50.4	50.5
Spouse	32.7	39.0	35.9
Offspring	13.4	5.3	9.3
Others*	3.3	5.3	4.3
Person deciding for treatment of elderly people			
Son	60.9	64.6	62.8
Spouse/self	23.5	18.3	20.8
Daughter in law	10.9	12.8	11.9
Daughter	4.1	3.3	3.6
Others	0.6	1.0	0.9
Recipient of			
Old age pension	3.2	2.4	2.8
Occasional relief	0.6	1.2	0.9
Thinks that			
Need more financial help than what is available currently	89.8	90.7	90.2
Current assets are sufficient to meet health emergencies	23.2	15.8	19.6
N	468	492	960

* Grand-children/ neighbour/ servants

Table 15: Health facilities available in the neighbourhood of the elderly people's households PHILL Study 2003 (%)

	Intervention area	Comparison area
Health Facilities in the neighbourhood*		
Govt. health centre	40.5	92.7
BRAC health centre	47.3	36.3
NGO health centre	1.3	9.4
Private Clinic/Hospital	5.0	50.6
Medicine shop/Pharmacy	85.2	84.7
Average time to reach nearest health facility (minutes)	15.0 ± 7.8	20.8 ± 9.4

*Multiple responses

Table 16: Health care providers available in the PHILL study areas, 2003

	Intervention	Comparison	Total
Health Care Providers			
Qualified allopathic	1	9	10
Paramedics	33	29	62
Herbalists	3	4	7
Spiritual healers	1	0	1
Homeopathic	4	10	14
Pharmacy salesmen	4	31	35
Total	46	83	129

Table 17: Primary care-giver's knowledge on elderly people care and elderly people health problems, PHILL Study 2003 (%)

	Intervention area	Comparison area
Perceived needs for elderly people care		
Elderly can't take care of themselves due		
to: physical weakness	75.3	60.3
mental weakness	22.7	39.7
Other(s)	2.0	0.0
Kinds of illnesses elderly people suffer from		
Bodily pain/aches/joint pain	16.4	22.7
Problems of indigestion/defecation	16.4	21.2
Problems of respiratory system	13.0	7.5
Emotional problems	10.1	12.1
ENT problems	17.1	19.5
Other(s)	27.0	17.0
Kind of elderly care needed		
Physical	34.7	33.2
Emotional	20.9	24.5
Nutritional	28.7	21.4
Spiritual	5.7	9.1
Financial	8.2	11.7
Other(s)	1.8	0.2
Person(s) to provide elderly care		
Spouse	20.6	24.5
Son	9.1	14.2
Daughter	20.8	8.2
Daughter-in-law	43.3	49.6
Grand children	6.0	31.5
N	616	812

Table 18: Primary care-giver's elderly people related practice, PHILL Study 2003 (%)

	Intervention area	Comparison area
Providing help to elderly for		
Taking bath	30.8	29.5
Taking food	30.4	32.3
Daily supervisory activities	26.2	32.8
Going to toilet	10.5	5.4
Others	2.1	0.0
Average time spent on these activities* (mean ± sd)	2.84 ± 1.81	3.85 ± 2.41
	p<.001	
Perceived ways to improve elderly care		
Provide specialized care	33.7	33.1
Provide medicine free of cost	21.8	14.2
Provide medicine at low cost	15.0	11.1
Better geographical access to primary healthcare centres	18.8	24.9
Improved behaviour of the healthcare providers	6.6	10.2
Others	0.6	4.4
N	438	477

*p<0.001

Table 19: Primary care-giver's and elderly people related practice, PHILL Study 2003 (%)

	Intervention area	Comparison area
Providing help to elderly for		
Taking bath	29.2	29.3
Taking food	28.9	32.0
Daily supervisory activities	25.3	32.1
Going to toilet	9.8	5.3
Others	6.8	1.3
Average time spent on these activities* (Mean ± sd)	2.81 ± 1.79	3.94 ± 2.72
Perceived ways to improve elderly people care		
Provide specialized care	33.7	33.0
Provide medicine free of cost	21.5	14.2
Provide medicine at low cost	15.5	11.0
Better geographical access to primary healthcare centres	18.7	25.0
Improved behaviour of the healthcare providers	6.6	10.2
Others	4.0	6.6
N	438	477

*p<0.001

Table 20: Characteristics of healthcare providers, PHILL Study 2003 (%)

	Intervention area	Comparison area
Stated type of services provided by HCPs		
Allopathic	65.6	80.2
Homeopathic	4.9	13.6
Traditional/Herbal	6.6	6.2
Ayurvedic/Unani	1.6	0.0
Faith-healing	6.6	0.0
Other(s)	14.8	0.0
Place of practice		
Union H & FWC	0.0	3.8
BRAC Health centre	3.4	7.6
Pharmacy/medicine vendor	37.9	72.2
Village market	0.0	1.3
Own Household	10.3	7.6
Travelling through village to village	48.3	1.3
Other (s)	0.0	6.3
Process of becoming healthcare provider		
Formal training	30.2	76.6
Informal apprenticeship	18.9	1.3
Selling medicine	9.4	10.4
Working in a health facility	20.8	1.3
Hereditary	20.8	9.1
Other(s)	---	1.3
Received formal training on elderly people health problem	1.9	3.9
	N=53	N=77

Table 21: Healthcare provider's knowledge on elderly people health, and common illnesses of the elderly people, PHILL Study 2003 (%)

	Intervention area	Comparison area
Thinks good for elderly people health		
Healthy lifestyle	43.4	42.0
Regular, nutritious diet	13.3	8.6
Light physical exercise	21.9	23.5
Preventive health practices	10.2	11.1
Mental peace	11.2	12.8
Social interaction	0.0	2.1
Thinks bad for elderly people health		
Unhealthy lifestyle	38.9	25.1
Irregular/poor/inappropriate diet	16.2	26.6
Reluctance to physical movement	7.2	5.8
Emotional stress	9.0	11.6
Poor attention to self-health	3.0	5.3
Over exertion	25.7	25.6
Common illnesses of the elderly people		
Bodily pain/aches/joint pain	18.8	18.0
Problems of indigestion/ defecation	22.7	17.2
Problems of respiratory system	17.7	16.5
Emotional problems	6.3	12.3
ENT problems	11.8	12.2
Hypertension	2.9	3.0
Other(s)	19.8	20.8
N	53	77

Table 22: Healthcare provider's expectations about PHC for the elderly people, PHILL Study 2003 (%)

	Intervention area	Comparison area
<i>PHC for elderly people should cover</i>		
Health and nutrition education	25.0	23.5
Establishment of health facilities etc.	24.0	7.4
Health check-up/specialised treatment	18.0	16.2
Treatment/medicine at low /free of cost	11.0	5.9
Financial assistance for self-reliance	11.0	8.8
Emotional well-being	2.0	9.6
Social inclusion	1.0	14.7
Others	8.0	14.0
<i>Ways to improve elderly people healthcare</i>		
Specialised care	24.2	23.3
Free medicine	18.5	16.0
Health centre near residence	19.1	24.9
Good behaviour of providers	20.4	17.1
Medicine at low cost	14.6	12.5
Don't know/Others	3.2	6.2
N	53	77

Table 23: Healthcare provider's elderly people health related practices, PHILL Study 2003 (%)

	Intervention	Comparison
No. of elderly patients seen last month	118 ± 89	48 ± 61
Separate by type of providers		
Drug sellers	18	86
Para-professionals	146	60
Qualified allopathic practitioners	120	27
Type of services provided to the elderly people		
Consultation only	13.7	7.0
Provide medicine	9.5	3.5
Provide both consultation and medicine	40.0	31.6
No specific service(s)	36.8	57.9
Gives written prescription to the elderly people	39.6	55.8
Keeps record of the patient	26.4	28.6
Thinks specific training needed for healthcare of the elderly people	81.1	79.2
Received training for elderly people healthcare	1.9	3.9
N	53	77

Table 24: Perspective of health care providers and primary care givers related to Common illnesses of the elderly people

	Intervention	Comparison
<i>Health care providers perspective</i>		
Bodily pain/aches/joint pain	18.8	18.0
Problems of indigestion/ defecation	22.7	17.2
Problems of respiratory system	17.7	16.5
Emotional problems	6.3	12.3
ENT problems	11.8	12.2
Hypertension	2.9	3.0
Other(s)	19.8	20.8
<i>Primary caregivers' perspective</i>		
Bodily pain/aches/joint pain	16.4	22.7
Problems of indigestion/defecation	16.4	21.2
Problems of respiratory system	13.0	7.5
Emotional problems	10.1	12.1
ENT problems	17.1	19.5
Other(s)	27.0	17.0

Table 25: Status of six dimensions of quality of life of older people by study area

Status of different dimension of (QoL)	Intervention	Comparison
<i>Physical dimension</i>		
Worse	88.5	79.7
Better	11.5	20.3
<i>Mental Health</i>		
Worse	85.0	75.6
Better	15.0	24.4
<i>Social dimension</i>		
Worse	6.2	2.9
Better	93.8	97.1
<i>Spiritual dimension</i>		
Not satisfied	1.2	1.4
Satisfied	98.8	98.6
<i>Environmental dimension</i>		
Not satisfied	86.2	65.6
Satisfied	13.8	34.4
<i>Economic dimension</i>		
Worse	90.3	87.0
Better	10.7	13.0
N	514	517

Conclusion

Findings reveal that majority of older people suffer from different types of chronic and acute illnesses. About three-fourth of older people suffered from arthritis related problems. Health-seeking behaviours show that substantial numbers of older people do not seek treatment during illness and self-care is largely prevalent for managing illnesses. Health-seeking behaviour also shows that during illness older people seek allopathic treatment, mostly from the local health care providers. Findings from the quality of life of older people show that among its six dimensions, older people are satisfied with respect to spiritual and social dimensions while they were worse off in physical, economic, mental and environmental dimensions. In order to improve quality of life of older people, physical, economical, mental and environment aspects need to be addressed in the intervention activities.

Since local health care providers are the key persons for health care, and very often they are not adequately trained to take manage older people's health needs, it is crucial that their health-management capacity is improved through basic geriatric health training. Health care management issues may be considered while awareness education is provided to the household members including primary care-givers.

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Appendix A: Framework for quantitative data collection of PHILL *(areas requiring qualitative also specified)*

Domain	Topic	Type of information	BD	VN	Sources	Methods
1. PHC						
	- Availability	- Types of PHC services - Distance to PHC for the elderly - Availability of drugs	+	+	Health care provider The elderly	Quantitative Qualitative
	- Use of services	- Number of elderly patients	+	+	Health care provider	Quantitative
	- Barriers to access	Cost, payment mechanism, distance	+	+	Health care provider The elderly	Quantitative Qualitative
	- Quality	- Human resource (e.g. training on elderly health) - Infrastructure (e.g. facility, equipment available for assessing elderly health) - Knowledge about drug use for treating certain common elderly health conditions	?	+	Health care provider	Quantitative
	- Health seeking behaviour	- Choices of providers - Use of type of drugs	+	+	The elderly	Quantitative
	- Satisfaction	- Level of overall satisfaction - Aspects of satisfaction: health staff, health facilities, drug, treatment received	+	+	The elderly	Quantitative Qualitative

2. Health						
	- Morbidity	- No of sick days, prevalence, type of morbidity	+	+	The elderly	Quantitative
	- Physical disability	- Prevalence, type of disability	+	+	The elderly	Quantitative
	- Specific tracer health problems	- Types and prevalence of specific health problems (rheumatism,)	+	+	The elderly	Quantitative
	- Nutritional status	- BMI or something else? (Zarina to provide info)	+	+	The elderly	Quantitative
		- Intra-household food distribution and allocation	+	+	Proxy/observation	Qualitative
	- Functioning	- ADL , performance measures	+	+	The elderly/proxy (not performance measures)	Quantitative
	- Life style	- Eating habit (dietary habit), smoking, drinking, betel leaf, physical activity (exercise)	+	+	The elderly/ proxy	Quantitative Qualitative

Domain	Topic	Type of information	BD	VN	Sources	Methods
3. Care						
	- Care to the elderly	- Knowledge, perception about health of the elderly - Skills for caring the elderly	+	+	The elderly Main caregiver	Quantitative Qualitative
	- Self-care	Knowledge, perception of the elderly on health care	+	+	The elderly	Quantitative Qualitative
	- Social support	- Types of supports: emotional, financial, instrumental supports - Sources of support (institutional, family)	+	+	The elderly (Community and social organizations)	Quantitative Qualitative
	- Social network	- Contact with children and other family members, frequency with contact, satisfaction with contact, distance from family, membership in organizations, attendance of social events	+	+	The elderly	Quantitative and qualitative
	- Social functioning	- Elderly's contributions	+	+	The elderly; HH members; community	Quantitative Qualitative

4. Quality of life						
	- Physical dimension	- Physical functioning (ADL), functional health, pain	+	+	The elderly	Quantitative Qualitative
	- Psychological	- Anxiety, energy, sleep, self-esteem, memory, orientation	+	+	The elderly	Quantitative Qualitative
	- Social	- Support, relation, decision making, contacts, respect	+	+	The elderly	Quantitative Qualitative
	- Economic	- Needs, worry, cash	+	+	The elderly	Quantitative Qualitative
	- Environmental	- Accommodation, physical environment (hygiene, pollution, noise,...) , seasonal/climate	+	+	The elderly	Quantitative Qualitative
	- Spiritual	- Belief, pray	+	+	The elderly	Quantitative Qualitative

Red crosses (+) indicate commonality of item between Bangladesh and Vietnam. Black crosses (+) indicate that the item is country specific.

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from Bangladesh)

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February 2004



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