PHILL Primary Health-Care in Later Life:
Improving Services in Bangladesh and Vietnam

Project Baseline Report

(Based on Qualitative Data from Bangladesh)

Priti Biswas
ODG, UK

Md. Awlad Hossain
BRAC, Bangladesh

February 2004

BRAC

Primary Health-Care in Later Life: Improving Services in Bangladesh and Vietnam (PHILL)

Project Baseline Report

(Based on Qualitative Data from Bangladesh)

Priti Biswas, ODG, UK

Md. Awlad Hossain, BRAC, Bangladesh

February 2004

The Primary Health Care in later Life—Improving Services in Bangladesh and Vietnam (PHILL) project is funded by the European Commission (EC), ***Project No. ICA4-CT-2002-10035-PHILL****. EC provides fund for the study, but the views and openions expressed in this report are those of the researchers/authors alone*

Acknowledgements

First of all, we would like to thank Dr. Shahaduz Zaman, BRAC and Dr. Peter Lloyd-Sherlock, ODG/UEA, for their comments and advice on the initial outline of this report. Further we would like to thank Dr. Syed Masud Ahmed and Masud Rana, BRAC, for providing their support during the qualitative data coding and Mr. Hasanur Rahman, BRAC, for sharing his experience and expertise. Our thanks also go to Dr. Imran Matin, BRAC, for his interest, suggestions, and kind hospitality. We would also like to thank Ian Nilsson, NEUROTEC, Karolinska Institute, Sweden, for sharing his analysis of the cognitive data with us, which is reflected in the perception of quality of life section of this report. Finally, we would like to thank all the field researchers who have been involved at different times in the qualitative data collection in Bangladesh and, most importantly, the respondents who made their time available and openly shared their invaluable knowledge and experience with the research team. Our heartfelt tribute goes to the departed soul of our dear colleague, Shamima Ara, BRAC, whose invaluable contribution made it possible to produce this report. May her soul rest in peace.

Table of contents

Acronym

BRAC	Bangladesh Rural Advancement Committee
EC	European Commission
E.C.G	Electrocardiogram
FGD	Focus Group Discussion
FWC	Family Welfare Centre
HSPI	Health Strategy and Policy Institute
ICDDRB	International Center for Diarrhoeal Disease Research, Bangladesh
KI	Karolinska Institutet
MBBS	Bachelor of Medicine and Bachelor of Surgery
NGO	Non Government Organisation
ODG	Overseas Development Group
PHC	Primary Health Care
PRA	Participatory Rural Appraisal
QoL	Quality of Life
THC	Thana Health Complex
UEA	University of East Anglia
UHFWC	Union Health and Family Welfare Centre
UK	United Kingdom
WHO	World Health Organisation

Currency rate of Exchange $1=Tk.60 (app.)

Chapter 1: *Introduction*

1.1 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 Overseas Development Group (ODG)/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. 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.

The key project objectives include:

- To develop effective indicators of the 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 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.

The project is comprised of two complementary research components—one quantitative and the other qualitative. This report presents the findings from the qualitative baseline research conducted in Bangladesh.

1.2 Objectives of the qualitative baseline research

The main objective of the PHILL qualitative baseline research is to enhance understanding of the local context and realities in order to develop more appropriate primary health care intervention packages suitable for improving elderly health and quality of life in the study area. The qualitative research themes focus on the organization and functioning of primary health care systems specifically addressing such factors as availability, satisfaction, patterns of utilization, health status and problems, sources of health care for the elderly, and quality of life. More specific issues and themes are discussed in the next chapter.

1.3 Qualitative framework

A qualitative framework in Annex:2 presents a detailed overview of the qualitative research activities in the three key stages. The initial planning stage focused on developing and finalising research tools, such as topic outlines, research/project themes, and the field testing of the set of qualitative research tools. During the second stage, the qualitative data collection activity was carried out. The qualitative data were organised into three categories—a thick description of the study area, cognitive data, and experiential data. The third stage involved the data analysis and was designed to contribute to the development of the quantitative survey tools, to inform the design of appropriate health care interventions, and document a reference set of baseline information. Further data collection activities were conducted to achieve a deeper understanding of specific research issues in Bangladesh.

1.4 Description of the study area

In Bangladesh, the PHILL study sites are located in four villages (Ashikati, Dhamoker Gao, Kumar Duigi and Mandari), in two unions (Ashikati and Shahmahmudpur), under Chandpur Sadar thana in the Chandpur district (Annex:1).

Chandpur district is situated on the large Meghna River about 160 km southeast of Dhaka. Two other rivers, the Dakatia and Gomoty also crosscut the district. Chandpur has one of the country's larges water port and transport point (known as *ghat*) due to its strategic river location between Dhaka and the Southern part of Bangladesh including Barisal, Pirojpur, Jhalokathi and Bhola districts, making it the largest district-level water port in the country and the fourth largest overall.

Agriculture, small business, fishing, and day labour are the most common livelihood occupations of people in the area. Three markets are accessible to the study villages, of which two are located within a mile and have routine market days where outsider traders mix with local merchants. Local producers bring vegetables, fish, handicraft items, and cattle to these markets and sell to large volume buyers who transport to Dhaka and Chittagong, among other places. The wide choice of transport options, either by road or by waterways, provides easy access for local products to local, regional, and national food markets.

Politics and political parties are very active in the area, and several ministers in the last few government administrations have came from Chandpur. According to the local population, these powerful political figures have made substantial contributions in regional infrastructure development, especially the construction of large numbers of culverts, bridges, embankments, and roads. Two important bridges that link Chandpur with Dhaka have stopped and started with the changes in power of political parties, reflecting the importance of politics in the profile of the district.

River erosion is one of the key environmental factors affecting in the area. The confluence of the two gigantic rivers, the Padma and the Meghna, creates one of the worse points of river erosion, which forces residents out of the area every year. The study villages are situated about eight kilometres from the worst erosion point, and the recent expansion of building and infrastructure has moved toward this area of highest vulnerability, thus increasing the risk of serious damage in the future. For example, the Chandpur central jail is under construction in one of the study villages. Although erosion

is an expected phenomenon in the area, an abrupt shift in the rivers about two years ago flooded over an acre of land with shops, part of the market, and railway tracks, raising grave the concern among local residents and authorities. Subsequent measures have been taken to control the erosion process, and some progress has been achieved, according to local citizens.

As one of the busiest points of travel at the confluence of these major rivers, the number of large disasters is very high. Every year, often repeatedly, Chandpur attracts national and international attention because of major fatal accidents with over-crowded boats, particularly during the monsoon months of June and July. Most recently, last year a capsized ferry left 600 people dead.

Over the last 10 years, the availability of health services has increased substantially as new hospitals and health clinics have arisen. In the past, there were only two medicine shops and now there are 25 of them, which not only sell medicine but also see patients and issue prescriptions. There are also three medical diagnostic places (pathologies) in the area which provide a wide range of diagnostic examinations including X-rays, blood tests, E.C.G.'s, etc. Three MBBS doctors attend to patients in Baburhat Bazar. In Chankher Bazar, there are now eight medical shops where once there was only one. On the other hand, the importance of traditional practitioners has diminished. According to local people, the number of kabiraj[1] has decreased significantly due to lack of transmission of this indigenous medical knowledge to new generations.

There are two government hospitals in Paikgacha and Kanyanpur unions, and BRAC hospital, Sushastha, was built five years ago. Every union has a UHFWC (Union Health and Family Welfare Centre) and several private medical centres, and a 250-bed government hospital is currently under construction in Chandpur. In addition, a large number of private hospitals and medical centres offer a range of diagnostic facilities and prescriptions from specialized doctors who come from as far away as Dhaka to visit

[1] Type of health care providers in rural areas uses mainly traditional medicine (i.e. different plants for medicine)

patients on certain days of the week. Local shopkeepers also buy essential medicine from the drugstores for resale in the villages. According to the local people, there has been a dramatic increase in supply of health services and medicine, but the standard is not maintained.

The consultation fees of MBBS doctors are around Tk 200[2] per visit and about Tk 300 for specialist physicians. BRAC hospital charges Tk 20, while government hospitals provide free consultation and prescriptions as long as one pays the appropriate bribe to the slip writers. Local medical shops provide medicine without any consultation fees, as long as they recognize the symptoms to be treated. For the kabiraj, on the other hand, payment arrangements are in kind as well as in money. Commonly, the kabiraj receive will receive as payment a black cock, rice or paddy, coconuts, eggs, oil, fruits and, sometimes, even cloth. Although the number of kabiraj is now highly reduced, these payment practices still exist.

This area has a long history of internal and external migration. In times past, people would sell their lands in the region, then purchase larger amounts in the northern part of the country where land prices were lower. Many people now migrate seasonally, even permanently, to Dhaka and Chittagong, and many people have also sought work in the Middle East, Asia, and America—most frequently to Saudi Arabia, Kuwait, Dubai, Oman, and Malaysia. It is common to sell land in order to finance overseas migration. Some villagers have also migrated to the Chittagong hill tracts as a part of the rehabilitation project implemented in 1980s for landless people. Furthermore, over the last two decades, many women have left their villages to work in the garment factories. Three of the study villages are completely Muslim, and one has a minority population of Hindu residents.

The area has a reputation for violence. In 1981, local villagers killed seven terrorists in full daylight and in public. The terrorists had had a history of crime in the region, killing and torturing local residents and raping local women, and the outraged

[2] $1 = Tk.60

population finally reacted and lynched them. This incident of the "seven murders" was well known throughout the country and served to deter further acts of terror. However, disputes over land among kin are still very common in the area.

Almost every household has a pond, which provides water for cooking, washing, bathing, and sometimes for drinking, too. With a large number of factories located in and around the area, water quality in some of the ponds is not good. According to some local villagers, pond water has caused skin ailments and other diseases. Arsenic is found in village tubewells, but the water is drunk regardless. Sanitation is good in the study villages, and most of the people have and use sanitary latrines.

Chapter 2: *Methodology*

2.1 Methodology of the study

The qualitative component of the PHILL study adopted a methodology designed to be consultative and to engage the participation of all the relevant project stakeholders including elderly individuals (age 60 and above), both male and female, main caregivers and health service providers from the study area. At the beginning of the process, the research team developed the outline of the research plan based upon the outcome of the first partner workshop held in December 2002. There the team developed the set of research tools and field-tested them both in Bangladesh and Vietnam.

The field data collection activity sought to capture two kinds of local realities—the cognitive and the experiential. As its primary focus, the cognitive approach explored respondents' perceptions of health, quality of life, health competence and coping mechanisms. (See Annex:3 for a complete list of cognitive approach checklists). The experiential approach, on the other hand, inquired into such topics as elderly health needs, available health care services, health care practices, patterns of received care, intra-household health care attitudes, and social functioning. It also explored respondents' expectations from the project and elicited their recommendations. (See Annex:4 for a complete list of the experiential approach guidelines).

Following the first round of data analysis, the team realised that certain issues required further inquiry. Thus, later in the research process, additional samples of elderly persons were interviewed in order to document specific elderly illness episodes and particularly the perceived causes, the patterns care seeking, health care decision making in the family, and satisfaction with the available services. A wide range of tools such as free listings, illness-provider matrices, day lines, and illness narratives was used in the second phase of data collection. (See Annex:6 for second round tools). The second round of interviews also explored the routine day activities performed by the elderly in the study area. In some cases, several visits were made to the same respondents in order to discuss the important emergent themes. As stated earlier, the interview approach followed an informal structure, and respondents were provided ample opportunity to talk

about the issues in a flexible, friendly environment. The qualitative data collection took place between February and November 2003.

2.2 Issues addressed/ themes

Consistent with the data collection framework (used for both the qualitative and quantitative components), the baseline study addressed a number of themes that were identified, discussed and agreed upon during the first partner workshop. This study focused on four key project themes with a number of sub-themes under each one: (1) primary health care (sub-themes—availability, satisfaction, barriers to access, utilization, quality of services and health seeking); (2) health (sub-themes—morbidity, specific problems, nutrition and function); (3) caregiving (sub-themes—care for the elderly and social functioning); and (4) quality of life (sub-themes—physical, social. psychological, spiritual, economic, and environmental dimensions).

2.3 Qualitative tools

The study utilised multiple sources of information to develop the qualitative tools. After a systematic review of available tools and techniques in the field of qualitative research, a multi-method data collection strategy was devised, including such techniques as key informant in-depth interviews and focus group discussions. These techniques were employed with elderly respondents, main caregivers and health care providers in the study area to gather a wide range of perspectives on the relevant issues. In the second round of qualitative data collection, several PRA tools such as those mentioned above were employed. The set of qualitative research tools developed in the project can be found in the report annexes.

2.4 Sampling

The study followed a non-random strategy of sampling that was both purposive and opportunistic. First, researchers purposively sought out sources of maximum variation, such as gender and economic status. The BRAC Survey Register for Nutrition Programme was used to get information about respondents' sex, age, and socio-economic status. The researchers also took advantage of interviewing opportunities which arose in the course of fieldwork. Many of the elderly individuals in the study area could not tell their chronological age because it had never been registered or never celebrated. To be more certain about the elderly respondents' age, events calendar techniques were adapted. In the first round of data collection, in-depth interviews were conducted with a total number of 36 individuals, including 17 elderly, 11 caregivers, and 8 health care providers. Also, thirteen FGDs were conducted with both men and women in the study area, including both elderly and caregivers. In the second round of qualitative data collection, 54 elderly individuals (22 male and 32 female) were further interviewed. Each interview took between 20 to 40 minutes. Both the physical and mental capacities of elderly participants were taken into consideration in the selection of respondents.

2.5 Data analysis

The qualitative data were analyzed by using textual analysis techniques. The transcribed interviews were sorted according to thematic categories in order to be coded. The interview narratives were read thoroughly in order to identify and compare response patterns, to examine the motivations underlying decision making by both the elderly and their households, and to provide a rich description of primary health care situations for the elderly in Bangladesh.

Chapter 3: *Findings*

3.1 Health care services

In Bangladesh, health care provisioning is provided by two main sources—governmental and private sector services. Though not so significant, health care services are also available via non-government organizations in some areas.

There are three levels of health care services available for the inhabitants in the study area—primary, secondary and tertiary. Primary level health care service includes the governmental Family Welfare Centre (FWC), the non-governmental BRAC Health Centre, and private health care services including local medicine shops and home remedies. The secondary level of services is comprised of the governmental Thana Health Complex (THC), the non-governmental ICDDR'B hospital and private clinics located in the thana level town. The tertiary level of health care services includes the government hospitals and private health clinics at the Comilla district town and in the capital city of Dhaka.

According to the baseline data from the study villages, elderly people use the primary level of health care services, i.e., local medical shops and home remedies most commonly for any health problem. However, they also use the secondary level of health care—such as the Chandpur Sadar Hospital at Chandpur Sadar and the ICDDR'B Diarrhoea Hospital at Matlab—when seeking specialized treatment and pathological tests. In the case of severe health problems, they seek services from the tertiary level in Comilla or in Dhaka.

A large number of village doctors (both trained and non-trained), medicine shop owners, kabiraj, and homeopaths is located within easy access of the study villages, and they commonly service the elderly population in the surrounding areas.

3.2 Knowledge and Perception

The qualitative baseline study explored the cognitive perceptions of elderly individuals, their caregivers, and the health service providers in a number of critical health related areas, including the common health problems of elderly population and their causes, the meaning and essential aspects of health, and quality of life. It is evident that both perceptions and knowledge about health significantly influence the health care-seeking decisions of the elderly and their household members. The qualitative baseline data provide the following insights:

3.2.1 Perception of elderly health

The qualitative cognitive interviews explored perceptions of health from the elderly themselves, their caregivers, and local health care providers in the study area. All three categories of respondents mentioned the importance of both physical and psychological aspects in assessing elderly health. The data revealed four key elements of elderly health—(1) reduced physical ability and strength, (2) food availability, appetite, and medicine, (3) increased vulnerability to sudden and certain illnesses, and (4) mental peace and happiness.

Among the elderly respondents, physical ability and strength are reported as an important aspect of elderly health. The ability to move around, walk, and do some housework was perceived as an important indicator of good health. Also, the ability to lift weight was mentioned as an aspect of good health by both male and female respondents. In rural Bangladesh, one of the key tasks of women is to collect water and carry it back to the household on their waist. For men, lifting and carrying heavy weights and bundles might be the job for which they get paid. Thus, elderly respondents commonly associated a reduced ability to lift heavy things with their elderly health status. Others also mentioned that they feel "easily tired" or "feel too weak to work" or "have no strength" as clear signs of elderly health. The respondents expressed their belief that hard demanding work in the fields under a strong sun during their younger years was

responsible for bad health conditions at later stages of life. Although they wish to work hard to maintain their well-being, the combination of hard work and exposure to the sun at an old age is perceived as highly detrimental.

Another important dimension of elderly health emerges around food including adequate supplies of diverse foods, type and quality of food, etc. Several respondents reported that with the old age, food habits gradually change and they tend to have less appetite. Also, the loss of teeth makes it harder to process certain types of food, and the digestive system becomes less efficient. Most of the respondents named foods considered essential for elderly good health—fruits, milk, egg, meat, and fish. Fruit like grapes and bananas and liquids like milk were considered to be good, nutritious foods, perhaps because they are easier to consume. Medicine and vitamin supplements (syrup) were frequently reported as effective to relieve pain and increase appetite. Thus, food occupies an important place in elderly health perceptions, with little difference across the gender and socio-economic class. Respondents from poorer households expressed their ill health to be the result of an insufficient availability of good nutritious food. On the other hand, respondents from the relatively wealthier households reported loss of appetite as the critical factor, even though the food is available. Interestingly, although local seasonal fruits are easily available and relatively cheap in rural Bangladesh, most respondents expressed preference for the expensive imported fruits like grapes.

The third most important characteristic of elderly health is the increased vulnerability to sudden and certain illnesses associated with old age. The baseline qualitative data verified that respondents in the study area perceive elderly health to be highly susceptible to illness, adopting a wear-and-tear theory that human bodily resistance declines with the age. The body shrinks, vision and hearing slowly get worse, problems like rheumatism limit mobility, and illness just becomes more frequent. They "*... fall ill all the time..*", and multiple health problems come "*...one after another...*", or it "*...hurts here, hurts there with a lot of diseases...*", according to respondents. Certain sudden types of disease were perceived to only appear with the old age, such as the heart attack.

The fourth aspect of health is mentioned as happiness and peace. The elderly respondents expressed that happiness is the central contributor to their good health. As one respondent expressed, *"...if the heart and mind are not well, health is not well too..."* Both the caregivers and the health care providers pointed out the importance of peace of mind as an essential criterion for stable health. Talking from his own experience, one health care provider expressed how he found poverty to be directly linked with the mental health of old people and their well-being. Several caregivers reported *"..having a peace of mind"* and an *"..anxiety-free life.."* to be crucial for elderly health.

3.2.2 Causes of common elderly diseases

The respondents reported a number of diseases that were perceived to be common among elderly as well as the perceived causes. The most common illnesses among the elderly included eye problems such as cataracts, toothache, gastric pain, body pain fever, weakness, uterine problems, loss of appetite, and arthritis. Though a number of elderly respondents reported suffering from high blood pressure, diabetes, accidental falling, paralysis—which are widely known as old age health problems—respondents seldom associated these problems with advanced age.

Perceptions about the causes of the more frequent illnesses appears to be multi-faceted—including factors related to individual life histories and lifestyles, environment and seasonal weather, and the impacts of social and legal events that create psychological pressure. Old age itself is perceived as being inter-twined with ill health. When other causes were not clearly identified, illness was sometimes attributed to bad luck or destiny.

An individual's lifestyle at a younger stage was reported to be one of the key reasons for illness in old age and more so among male respondents. Some respondents explained current illnesses in terms of a particularly stressful lifestyle or prior exposure to some sort of disease. For instance, one male respondent who had migrated seasonally to

work in the hill tracts and had suffered from malaria several times during younger age, considered his frequent fever at old age to be a consequence of this history. Another male respondent who had spent much of his life travelling on business to other parts of the country and, as result, did not eat and rest properly during his youth, attributed his stomach problems to this past life style. In respondent's words, *".. I used to run a business, so used to go to Rajshahi... sometimes all day without rest, shower, no food at the due times, like taking lunch in the evening... and that is what caused my current illness... doctor said it is dysentery..."*

Weather and seasonal changes were reported as one of the key causes of elderly illnesses. In the winter and in the rainy season, elderly people reported common bouts with cold, flu, fever, body pain, and arthritis. Several respondents expressed their preferences of the summer days, as they feel less ill in the summer. In one respondent's words, *".. there were clouds at the beginning of Bhadra month, it was raining non-stop, I got soaking wet, and that is why I got fever, waist pain, cough.. and my arthritics got worse with my fever."*

Some elderly respondents directly linked their current illnesses with the mental pressure caused from certain social and legal events. This cause was reported by both male and female respondents. For instance, respondents who had married off their daughter and had to borrow relatively large amounts of money in order to pay the dowry, reported suffering from low blood pressure ever since. In other cases, where families were involved in disputes over land and had to go to the court, the anxieties of losing their land overshadowed their thoughts and they reported general weakness, loss of appetite, and other health problems. In respondent's words, *"I took a loan for my youngest daughter's marriage three months ago, that is not paid yet, also we have promised to give a necklace for my daughter and we have not given yet... I am worried, if my son-in-law hits her for this.. I worry about these a lot and have become ill..."*

Another common response pattern was to link ill health directly with the old age itself. The common perception is as if these two are inseparable and a inevitable fact of

life. Some respondents further reported that old age brought reduced income and drops in the quality and amounts of food, which resulted in vitamin deficiency and a poor appetite. As one of the respondents put it, "*I have nothing in my body, no vitamin, no strength.. it happens with old age...* "

Finally, the baseline qualitative data confirmed that a strong element of fatalism is engraved in the cognition of elderly with regard to the causes of illness. Whenever the reason of the illness is not identified or the health problem is not cured, elderly respondents tend to blame their ill fate. Instead of seeking medical explanations for elderly illnesses, they often simply resign themselves to the inevitable fact that illness and old age are necessary partners.

3.2.2 Perceptions of quality of life

The baseline results demonstrated that the elderly clearly associate health and quality of life. Having good health—both physical and mental—is a central determinant of quality of life. Becoming a burden for the family due to reduced physical abilities is a major source of dread for the elderly. As in most rural settings, the economic well-being of poor people largely depends on their physical abilities to work and earn. In other words, the "body" itself is the main asset which, for many, earns the living. There is no formal retirement as such for old people. Thus, when the body becomes ill and transforms itself into a burden and a source of expense, quality of life is severely compromised. Many respondents voiced their fear of this uncertainty, of becoming ill and able to work, and how it would affect their role in the family as a provider.

It is clear that elderly respondents shared the view that an active role in the family is critical. In the case of men, the role is predominantly economic; for women, it is their household work and caring for other members. These roles bring a sense of self-worth and security. Social functionality in terms of having a good family and strong social networks also helps define for elderly people their sense of quality of life.

3.3 Health seeking behaviour of old people

The qualitative data explored the pattern of elderly health seeking behaviour in the study area. It confirmed that the elderly use the health care services for curative not preventive measures. Interviews suggested that the elderly perception of prevention was to avoid getter seriously ill from a less serious stage of illness.

3.3.1 Use of services

In the study area, elderly people use a range of health care services at one time or the other. It includes medical doctors at the government hospital, village doctors (rural medical practitioners), medicine sellers, kabiraz (ayurvedic), homeopaths, NGO health clinics, religious leaders-spiritual healers, health assistances, and specialists at distant hospitals. An inclusive list of different types of health care providers in the study area presented in Annex:7.

The use of different source of health care depends largely on the type of health problems. For health problems like fever, loss of appetite, and arthritis, the elderly generally utilise home remedies and do not seek any outside health care for first instance. For other health problems, like body pain, asthma, weaknesses, however, both men and women seek out village doctors. In the event of specific eye problems, the elderly seek care from a specialized source and will go to NGO health clinics, travel to a nearby district town hospital or clinic and perhaps go to Dhaka. While the kabiraj is another major source of elderly health care services, data suggest that women seek such services much more frequently than men. A list of health problems specific pathway to choice a health care provider is presented in Annex:8.

3.3.2 Reasons for health provider preferences

Several factors appeared to influence elderly preferences for health care services and choice of provider—reputation, trust and the interpersonal qualities of individual

providers, and financial concerns. Mentioned less frequently though regarded as important were factors such as the geographical location of the service and the provider's sex (in the case of female respondents).

3.3.2.1 Reputation, trust, and the interpersonal qualities of the individual providers

Respondents reported that a major criterion in selecting the source of health care providers was the doctor's training and experience and reputation in the area. When a provider is known by the user and is widely considered to be good, then he is sought out by the elderly. In some cases, the ties between the provider and the user cross generational lines—several generations of users will seek the stay with several generations of providers. Male respondents appear to put more emphasis on the providers' training than female respondents, the latter showing more preferences for providers who have been known for long time regardless their formal training. The service provider's behaviour also influences female preferences.

Where the source of services are being used for the first time by an elderly user, the key factor is the behaviour of the provider, in the sense of showing respect and care for the patient. Even when the treatment was not successful, the patient will still demonstrate satisfaction with the services, if they feel respected by the provider. This appears to be especially true of doctors and nurses in government health services.

Trust and distrust of the service providers also determines the choice of health care service. Distrust of certain types of providers, such as kabiraj, are equally prominent among the female and male respondents. However, the trust factor is more common among the male respondents, and they tend to stay with the same provider even though the problem might require specialized treatment.

3.3.2.2 Financial factor

Financial concerns also determine the choice of health provider. Since elderly incomes are often low, flexibility in payment and credit purchases of either medicine or services are very attractive. One reason that medicine shops are frequently used is that these shops often sell medicine on credit. This appears to be equally important among the male and female respondents.

The other important factor is user fees. The elderly show preference to sources where user fees are either relatively cheap or negotiable. Preferred service providers also show flexibility by reducing the amount of user fees and by not putting pressure on the recipients or, in some cases, by just charging for the medicine. A list of some key preference indicators are presented in the Annex :9.

3.3.2.3 Others factors

Geographical distance can also affect user preference. The elderly prefer providers who are closely located and can be called easily in case of emergencies. Such providers are often neighbours or live nearby friends or relatives of the users.

Among the female respondents, the sex of the service provider is an important factor. Female respondents expressed their preference for the female doctors and even kabiraj. The data revealed a tendency among the elderly health service users is to stick to the one known source for all type of problems. This patterns holds true even when family members take an elderly patient to visit a specialist in Dhaka or Comilla; preference is given to the provider who is known and trusted. Bangladesh has no patient record keeping system that can give providers a clear idea about earlier health problems and prior treatments of their patients. So once a trusted doctor is gone, the patients feel lost and have to build the relationship once again with a new provider.

There is also a tendency to not seek any treatment at the beginning of a health problem and wait until it gets to a point of serious illness.

3.3.3 Sense of severity and use of services

The study revels a general pattern that elderly people in the study area do not seek any formal health care until the illness is severe by their own definition. Very often people simply live with the health problem until sudden deterioration of the condition. Until such time, they self-medicate, using some form of home remedy to see if it gets better.

> *"I had been feeling unwell for a month, but when only I had a fall, and became senseless, immediately after that I was taken to a doctor..." – 60 year old woman*

Sometimes this waiting time is prolonged because of the dilemma of making a choice between extended suffering and the possibility of asset loss as is often the case for poor families.

> *"I was suffering for some time, very, very weak, lost appetite, hardly could get about...I thought I might have 'holda palong' (jaundice)...I waited and finally I was too ill to do anything, so I sold my chicken and went to see a doctor..."*

Case—1: Sense of severity and health seeking behaviour

Asura is 65, lives with 5 other family members including husband and son. In the early June, last year, she became ill. She had a large painful spot near her waist on the spine. It was very painful and had several mouths and she was suffering from a lot of pain. People in the neighbourhood said, she had a *'pistok'* . She thought she had that, too. Though she was not entirely sure about the reason of the problem, she thinks it was due to fate or bad luck. Within 4-5 days, the spot became too painful and needed to be dealt with.

First, she went to her sister-in-law who is a kabiraj in her neighbourhood. The kabiraj cut the spot open using a blade and squeezed out the bad blood, then put some plant paste on the spot.

After another 4/5 days that became much worse, totally unbearable and too painful to live with. The kabiraj suggested that she go to the doctor and he took her there. The doctor who was well-known to them cleaned the infectious spot with warm water and treated it with an injection and medicine. He also suggested that she return every other day and get the wound dressed and cleaned. She continued to visit him for about two weeks and then when the pain got better, she stopped.

The infection was not totally cleared but the pain got better. And that is when she stopped visiting the doctor and started to put plant paste on the spot again. After two weeks of using these, she got well again. In her wards, *"The kabiraj is good but it was my fate that I did not get well. The doctor was good too, I was half-cured with his medicine, perhaps if I continued it might have been cured quicker, but I did not have much money to continue that treatment. It might have taken longer to cure but with God's blessing, I got well at last...."*

3.3.4 Elderly health seeking decisions

The baseline data revealed that the decision to seek health care for the elderly can be made by a wide range of people, including nearest family members, close or distant relatives, neighbours, and friends. Commonly, male respondents who have greater mobility can make their own health care decisions. In contrast, women almost always rely on a male member of the family or even a neighbour for care-seeking decisions. The fact that women are unable to travel on their own and have to be accompanied by a male member influences elderly health seeking. Sometimes, male members bring medicine home after explaining the condition to a provider. In general, it is common for key male members of the family to decide about elderly treatment and health care seeking. When male household members are temporarily absent in the family and severe illness arises, the women in the family along with a male neighbour resolve where to take elderly members.

3.3.5 Barriers to health care access

The elderly in the study area do not always seek out health care even though they might suffer from health problems that affect their quality of life and a significant number of private and public health care services and institutions exist in the study area. The survey data identified two key factors that constrain elderly respondents from seeking health care in the study area.

The first reason is financial. When the elderly member of the household is not an income-earner, his or her health expenses are simply not so important. It is clear from the baseline data that elderly health care costs in poor households are often considered exorbitant and may result in the loss of assets including livestock and poultry. Alternatively, the cost of health care may burden a household with a formal (from in institution) or informal (from a friend or relative) loan which will have to be paid off over a period of time.

The second reason is related to cultural attitudes towards elderly health. The common perception about the ineffectiveness of the medicine and treatment at an old age is vital. It is widely believed among the elderly themselves and their household members that illness and suffering at an old age are inevitable, and medicine does not work with old people. These cultural notions severely constrain the access of old people to the health care services in the study area. While certain problem can be dealt with when still at a less serious stage, such care is not given priority. Consequently, it gets much worse, increases both the elderly suffering and elevates the cost of illness to a much higher level.

3.4 Utilization experience and satisfaction

It is known in the health care sector that the sense of satisfaction influences the utilization of the services. In the developed world, user satisfaction in the health care sector has been given much importance and in the developing world it is increasingly becoming important as well. The qualitative baseline data explored the determinants of elderly satisfaction that affects their utilization. It is important to note that most of the respondents expressed themselves to be satisfied with their sources of health care services.

The baseline data presents a complex scenario and combination of determinants of elderly satisfaction based on their health care utilization experiences which includes both the private and public health care services. There are three key determinants—cost and payment flexibility, access and mobility, and the perception factor of medical outcome.

3.4.1 Cost factor and payment flexibility

Cost of treatment appears to significantly influence the level of satisfaction of elderly people the health care utilized in the study area. Since certain financial flexibility is provided in private health care services such as the medicine shops in and around the study villages, they were reported to be the most utilized sources. The elderly

respondents stated their satisfaction because these sources offer credit purchases of medicine and flexible payment options. As the availability of cash money varies widely throughout the year for most rural families, flexibility of payment is often very attractive. The respondents reported that they prefer to go to these sources and expressed their satisfaction with them, because they are known to each other, can get medicine on credit, and the providers do not put pressure on the users. Moreover, user fees are flexible and can be negotiated.

3.4.2 Mobility and access

Old age always limits human mobility and makes physical access much harder than with other age groups. The necessity of travel to a health care service facility often causes a substantial burden for the elderly individuals and their families, and sometimes it is simply too difficult or even impossible to take elderly person to a health care facility using public transports. Such lack of mobility affects both the utilization of the service and the satisfaction of the elderly. When, however, the providers offer home visits and are likely to be available at any time during day or night, the elderly feel a certain peace of mind. And even when the elderly patient is not cured with this local treatment, he or she remains satisfied at least with the access to the health care.

3.4.3 Medical outcomes and cultural perception

> *"Of course I am satisfied, my fever was well after 4 days with the medicine" – 64 year old male,*
>
> *"No, I am not satisfied, been to many doctors, but my health did not get any better, how can I be satisfied!" – 60 year old paralyzed male (post stroke)*

The medical outcome was seen as a key aspect of satisfaction among the respondents. If patients get well with the treatment, they are satisfied and when they do not, they are unsatisfied users. However, in some cases, cultural perceptions introduced an element of fatalism. It was very common for the elderly to have a cultural perception

about the ineffectiveness of treatment and medicine in later life. Often the elderly showed appreciation and satisfaction with the efforts of providers even though they remain unwell because they maintain the view that medicine just does not work with old age. There is also a certain belief that some elderly health problems, like arthritis, can not be treated. In the cases where elderly patients were better for a short while and simply did not continue the treatment, they tended to remain satisfied with the temporary betterment and effort of the providers.

In some cases, when the medical outcomes of certain treatment were successful at all, the elderly users remained deeply satisfied because they thought they were treated with respect, dignity and care and the service providers made every effort to make them well. This result was more apparent in the case of government health services.

Satisfaction and dissatisfaction indicators for government and private services (perception of respondents):		
Services	Satisfaction indicators	Dissatisfaction indicators
Govt. services	• Health service providers' behaviour, politeness, showing respect to the patients • Medical outcome	• Difficulties to access the service, including payment of bribe to the middle man to access free service
Private services	• Flexible payment options and small discount • Easy accessibility and providers' availability for home visits • Medical outcome	• Late referral to other specialized services when necessary • Pressure for payment

3.5 Elderly health and coping mechanisms

The qualitative data suggests a pattern of coping mechanisms, which includes a number of options depending on the perception of illness and health, health competencies, and sense of severity of certain illness. The data give the idea of a general pattern that is followed among the elderly in the study area. The elderly coping mechanisms to deal with health problems presents a complex individual, intra-household and inter-household negotiation and decision making process over the physical, financial, and social aspects.

In the first instance of any illness, from cold and flu to cataract, the elderly negotiate their physical discomfort and sufferings. Very seldom are health services sought at this stage. Elderly people often use a wide range of home remedies for treating health problems at this stage in the hopes that they might cure the problem. The elderly themselves are the key source of knowledge about home remedies and sometimes use this knowledge on the younger members in the family. Although they take such home remedies, family members sometimes bring medicine from a local store, a kabiraj or a medicine shop. The elderly in general suffer at this stage and often wait to see if the illness gets cured.

In the second instance, when the discomfort mounts as a result of the illness and consequently affects the ability to work or care oneself, formal medical advice is sought for the elderly, initiated either by the patient, a family member, a relative or even a neighbour. At this stage, there are three key decisions to be made: first, where to take the patient, i.e., decide the particular health service provider among all available options; second, who can accompany the elderly, i.e., who is willing and can make time to take the elderly to the health care service provider; and, third, who will pay the expenses and how the health care advice and treatment cost will be handled. While the first and second decisions are made, the financial aspect constitutes a major constraint for the poorer elderly to seek health care. A number of elderly reported that they sold their poultry, which is a main source of animal protein. At a critical point, close kin, such as a son or

daughter, may offer support or in the case that cash is not available, money may be borrowed from a neighbour or relative. Since there is no direct NGO credit as such for elderly, female relatives may be asked to take out formal loans. In one reported case, a young female relative had borrowed from her NGO and the patient was making the repayment, but with great difficulty.

In the third instance, when the elderly person recovers from the health problem, he or she gradually attempts to recover from the financial effect of illness. When the illness is not cured and it is necessary to seek services of a specialized health source in a district town or in the capital, another level of negotiation occurs. The rich families with better social connections and children living in the towns are less vulnerable and can seek the treatment. However, for the poorer segments of the population, such events bring the potential for capital asset loss including agricultural land. At this stage, the poor elderly simply resign to their fate and accept suffering as a way of life.

3.6 Functions of elderly people

By taking stock of routine day activities that are performed by the elderly in the study area, the baseline study explored patterns of daily functioning. The data confirmed that the elderly are involved in a range of spiritual, economic, and social functions. The dominant activity for many is maintaining spiritual well-being, and almost all respondents reported that their days are guided by praying five times a day, saying special prayers in the morning, and reading the holy Koran. While women pray at home, men often go to mosque, which provides an opportunity for walking a bit and meeting others.

It is common for both elderly men and women to continue their respective roles within the household as long as they are physically able to perform them. Women are involved in washing, cleaning, cooking, and looking after children. Even when they are not totally able to do the cooking, they help preparing the vegetables and other tasks which do not require much physical movement. On the other hand, men remain busy with

their income-earning roles as businessmen, shopkeepers, farmers, etc. They do the food shopping for the family, work in the fields, and in the homestead—preparing ground, planting, weeding and caring for the livestock. It was clear from the data that as long the elderly are encouraged to work, they feel positive as a useful part of the family and not a burden.

Another important aspect is the social contact among the elderly people in the study area. It was clear from the data that elderly people maintain much contact with their neighbours, relatives, and friends. Family members visit their elderly relatives frequently and the elderly also visit their neighbours to the extent that their physical strength allows it. Some meeting places are common used by the elderly for chatting. In the case of women, it is the pond, where they go often for washing to pray and take a bath; for men, the common meeting places are the shops where people come and gather and at the mosque, before or after prayer. The elderly also spend time looking after and playing with their grandchildren. Several elderly respondents reported that they watch evening television programs either at their own house or at their neighbour's. A Page: 35 number of respondents also expressed their feeling of abandonment and expressed their felt-desire for companionship of family members and neighbors.

3.7 Elderly people and care in the family

The data suggests, the elderly themselves provide care within the household as well as receive it. Elderly women in the family are the main caregivers for their husbands. Several elderly respondents reported that they visit their immobile elderly relatives and neighbours, and several said that they had received care from several family members including daughter-in-laws, sons, grandchildren, nephews, and sometimes a close neighbour or friend of similar age.

It appears to be the case that the living arrangements of elderly people affect their care-receiving pattern. When the elderly live with a house surrounded by several family members in different households, there is always someone to talk to and look after them.

Often the grandchildren sleep with them and help with things like getting water during night. Religious education plays an important role in caregiving. Some caregivers expressed their belief that caring for an elderly person brings fortune so the younger members of the family, including young males, do it without objection.

Care for elderly also has its connection with cultural perception. The respondents mentioned that the daughter-in-laws who take good care of their elderly family members are the ones who come from good families and respected parents. So the upbringing and family culture reflects the behavioural pattern of the daughter-in-laws. Younger individuals who provide such care gain respect by doing so among the elderly community as a whole.

On the other hand, elderly themselves also care for their grandchildren not only when living within the same households but also while living in the same compound. Several elderly respondents reported to sleep together with their grandchildren and care for each other during nights. For instance, grandchildren carry water to grandparents for prayer washing, while grandparents accompany grandchildren going outside during the night. Where an elderly couple lives together, the wife cares for her elderly husband. Very strong intergenerational dependency exists in the study area.

3.8 Traditional Medicine and Home Remedies

3.8.1 Defining traditional medicine

Traditional medicine is a comprehensive term used to refer both to various traditional medicine systems such as Chinese medicine, Indian Ayurvedic and Arabic Unani medicine and to other forms of indigenous medicine. Traditional medicine practices include medication therapies if they use herbal medicines, animal parts, or minerals and non-medication therapies if they are practiced primarily without the use of medication, as in the case of acupuncture, manual therapies and spiritual therapies (WHO

2002[3]). In the WHO traditional medicine strategy 2002-2005, the World Health Organization defines traditional medicine as "*including diverse health practices, approaches, knowledge and beliefs incorporating plant, animal, and/or mineral based medicines, spiritual therapies manual techniques and exercises applied singularly or in combination to maintain well-being, as well as to treat, diagnose or to prevent illness*" (WHO 2001/2002).

Traditional medicine is alternatively termed "complementary", "alternative" or "non-conventional" where it is incorporated into a country's national health care system (WHO 2002). In Bangladesh, the use of traditional medicine is neither incorporated nor inclusive within the primary health services system; however, it is well known, tolerated, and widely practiced in rural areas along side the national primary health care system based on allopathic medicine. Although the working definition of traditional medicine within the PHILL project is consistent with this WHO definition, it focuses on the health care practices used by the elderly based on their own knowledge or by a local provider (kabiraj) to treat and cure their most common perceived health problems and illnesses. In this sense, the term "traditional medicine" is often used synonymously with the term "home remedies".

3.8.2 Policy and regulatory background

The Unani and Ayurvedic forms of traditional medicine have been regulated in Bangladesh for a long time. The Pakistani Board of Unani and Ayurvadic Systems of Medicine provided such regulation while Bangladesh constituted the eastern part of Pakistan. Then, after Independence, the Bangladesh Unani and Ayurvadic Practitioners Ordinance of 1972 restructured this body as the Board of Unani and Ayurvadic Systems of Medicine, (Bangladesh 184 cited in WHO 2001[4]). This board is currently responsible for maintaining educational standards at teaching institutions, arranging for the registration of duly qualified persons, and standardizing the Unani and Ayurvadic

[3] WHO (2002), WHO Traditional Medicine Strategy 2002-2005, Geneva

systems of medicine. The Bangladesh Unani and Ayurvadic Practitioners Ordinance of 1983 (185) further prohibits the practice of Unani and Ayurvadic medicine by unregistered persons; however, a significant feature of the 1983 Ordinance is the deliberate omission of a provision contained in preceding legislation that made it an offence for an Ayurvedic or Unani practitioner to sign birth, medical and physical-fitness certificates (WHO 2001).

3.8.3 Use of home remedies to treat common health problems among the elderly

The use of home remedies and herbal medicine plays an essential part of the health seeking practices of all people in Bangladesh. Gani (2002)[5] claims that eighty percent of Bangladeshis still rely totally on herbal medicine and home remedies, and it is difficult to imagine a range of health care options and choices without taking into account herbal treatments and home remedies. The qualitative interviews in the PHILL baseline study were designed to explore and assess the extent of usage of such herbal and home remedies among the elderly population in rural Bangladesh. The data identified a wide range of home remedies and treatment practices commonly employed by the elderly in the project study villages. It emerged that not only do people use these home remedies in the case of a single source of treatment but also combine it with other forms of formal treatment. The wide range of such practices can be put into four main categories.

3.8.3.1 Use of Herbal Plants

Different species of plants are the most common products used widely among the elderly in the study villages. For the most part, these plants are locally available and often used in conjunction with other forms of allopathic medicine. In some cases, the medicinal plants are cultivated as garden herbs and used for cooking. A list of a range of common medicinal plant species, their botanical names, and their modes of application presented in Annex:10.

---

[4] WHO (2001), Legal Status of Traditional Medicine and Complementary/ Alternative Medicine: A Worldwide Review, Geneva

[5] Gani. A., (2002) *Bheshaja Oshudh* (Herbal Medicine), bangle Academy, Dhaka

Plant remedies themselves are prepared from a variety of plant parts including roots, bark, leafs, flowers, and fruits—either fresh or dried. Herbal medicine is often applied both internally and externally. Thus, the most common forms of preparation are the plant juice which is taken orally and extracts derived from boiling parts of the plants over a long period of time. Some plants are also cooked and served with meals. For most external uses, pastes are prepared from diverse plant parts.

While some species have very specific applications as a home remedy, others are used commonly to treat an array of health problems. For example, the plant known botanically as *Coccinea cordifolia* (locally known as *kalakachu or telakachu*) is used for general body pain, arthritis, and gastric problems, but is also applied to treat eye problems, such as cataracts. For arthritis and body pain relief, this plant is either consumed in a cooked or raw spinach form or it is taken orally as a liquid plant juice. For gastric pains, the plant juice is taken orally; however, to treat cataracts, the juice is used as an eye drop. Thus, the same plant can be processed differently for different problems and even differently for the same problem.

There are plants that are also used as normal home condiments for cooking and are easily available. For example, turmeric, ginger, garlic, etc., are part of daily domestic cooking, thus found at home in every household in Bangladesh. Dried plant parts that are used as herbal medicine are also available in the local markets or kept in the house, including such plants as dried which are locally known *horitoki (terinalia chebula), bohera (terinalia bellirica), amloki (phyllanthus emblica), chirata (Swearia Hami)*, *isopguler bhushi*, etc.

3..8.3.2 Use of oils

The elderly in the study villages commonly employ massage oils as home remedy treatments for muscular pain, arthritis, and sometimes for asthma. The most prevalent product is mustard oil, used either in its own form or as a base to which one can add other

plant pastes or spices. Kerosene oil is also applied as a massage oil in case of body pain. These massage oils are heated before use.

3.8.3.3 Use of animal products

Despite many food restrictions among the Bangladeshi, certain meats not regarded as part of the normal diet—such as frog meat, fox meat, and some birds—are consumed as part of treatment. For instance, fox meat is commonly used to treat arthritis, either as cooked meat, dried meat inserted into a banana, or as fox oil (meat fried in mustard oil). It is further believed that meat from the male fox (locally known as *sabani*) is more effective then the female fox meat for curing arthritis. Earthworms are also consumed to relieve arthritic conditions. Frog meat is either fried or curried and consumed to treat tuberculosis. Meat from a yellow coloured bird is taken to treat jaundice (locally known as *holda palong*).

3.8.3.4 Use of chemical agents

Bicarbonate of soda is used to reduce severe gastric pain, and salt and lime are also used as either a co-product with other plants or oil or on its own for different problems.

3.8.3.5 Spiritual techniques

The study has identified two levels of spiritual technique used either in combination or alone.

Simple spiritual mode

The simple spiritual mode employs a set of holy actions and items including holy water, *mantra, doa-durud, tabij, jhar fuk,*etc. In the simple process, healer or practitioner reads or quietly chants sacred or holy verse from a religious book or some similar source. This practice requires strong faith in the healer's abilities.

Sometimes, the practitioner massages the ill person with oil while chanting mantras. It was also reported that wearing a *tabij* or hanging a piece of shell is used to treat cataract ailments. In the simple approach, the particular time of the day and day of the week are important factors when scheduling the treatment, and respondents stated that Saturday and Tuesday are the two most important days.

Dramatic spiritual mode

Another spiritual mode includes a rather dramatic approach. While similar to the simple approach above, the difference lies in the importance placed on the timing of the treatment, including phase of the moon and the day of the week. For the dramatic treatment, the healer seeks to create a rather supernatural environment and may employ a form of surgery. Here is an example provided by one respondent:

"... arthritis is caused from bad blood in the body. So to treat it, first tie up the patient's feet very tightly with jute ropes to stop the blood flowing. After that the healer chants the mantra, massages and blows holy breath. S/He starts from the feet and slowly moves higher up the body, up to the head. The process continues until the healer feels that all the bad blood has been gathered in the feet. Then s/he cuts the toe open and lets the bad blood flow out..."

3.8.4 Place of home remedies in health care services

The place and importance of traditional herbal treatments and home remedies within the range of health care services and practices are very high. Almost all the elderly respondents reported that they use such options at one time or another. The common patterns appears to be that, in case of any illness, some kind of home remedy is the first option used by elderly. When the problem is perceived as more serious, the suffering gets extreme, and the severity of the illness becomes evident, the formal allopathic option is exercised. When, however, the severity of the problem retreats, the people commonly return to the traditional remedies until another severe episode appears. It is also apparent among the respondents that they continue using traditional medicine while taking the other medication and the allopathic treatment is an addition to the usual remedies.

Case–2: "Wearing different hats" – elderly respondent who is a recipient and a provider of rural health care services:

Begam is a 64 year-old woman in one of the study villages. She lives with her husband and four other family members in the family house. Two of her sons are working in Saudi Arabia, but she does not receive help from them. Another son lives in the village but is poor and unable to help his parents financially. Begam's husband is frail and ill so he can't work.. Begam is known as a kabiraj in the village. She treats an array of health problems for different age groups—problems ranging from cataracts in old people to uterus problems of young women. She also treats such things as fever, arthritis, body pain, and toothache. She uses diverse plants and other materials and also uses *jhar-fuk*, and *mantra*. During the interview, she insisted on maintaining the confidentiality of the plants that she uses for treatment.

Recently, Begam began suffering from a kind of arthritis (*aguinya bat).* Her fingertips were swollen and very painful, some type of infection was visible. She also complained of body pain. Begam had been suffering from high blood pressure for 30 years. She thought that the cause of this recent problem was linked to the other one, i.e., high blood pressure. In her words: *"I have high blood pressure, and I get headache, my arm and leg muscles ache. About 15 days ago I found a spot on my thigh (fora bat) and from that the poison spread all over the body making these fingertips very painful".*
Although Begam is a kabiraj herself, she did not treat her own health problem. She went to a homeopathic doctor whom she has known for long time and had visited for a similar problem before. She reported that she did not get well last time from his medicine; however, she prefers to go there as she can acquire medicine on credit and she believes that he is a good doctor for younger patients. She thinks the reason that his medicine did not work for her illness is simply because she is too old. She has also been treating her high blood pressure with another allopathic doctor for years.

For the most recent illness, Begam had borrowed Tk.100 from a relative who lives nearby and Tk.10 from a neighbour. Begam reported that this year alone she paid about Tk. 5000 for different health treatments. She also added, *"whatever I earn from my kabiraji, goes to doctors for my own treatment."*

Chapter 4. *Conclusion*

This report presents a number of the key findings of the analysis of the qualitative data from the study villages in Bangladesh. It presents a complex reality and multi-dimensional nature of older peoples' health and well-being in rural Bangladesh. It also presents the evidence of deep-rooted cultural dimension of older peoples' health and well being in the context of rural Bangladesh.

The report recorded the four key elements of elderly health—reduced physical ability and strength; food, appetite and medicine; increased vulnerability to sudden and certain illnesses; and mental peace and happiness. Old age is perceived as being inter-twined with ill health. Perceptions about causes of frequent illnesses are multi-faceted—including factors related to individual life histories and lifestyles, environment and seasonal weather changes, and the impacts of social and legal events that create psychological pressure. When the causes of illness are not clearly identified, it is attributed to bad luck or destiny. It is widely believed among the elderly themselves and their household members that illness and suffering at an old age are inevitable, and medicine does not work with old people.

The common practice is that elderly people in the study area do not seek any formal health care until the illness is severe by their own definition. Very often people simply live with the health problem until a sudden deterioration of the condition. Until such time they self-medicate, using some form of home remedy to see if it gets better. The use of traditional herbal treatments and home remedies by the elderly people is also very high. Almost all the elderly respondents reported that they use such options at one time or another, sometimes on its own and at other times with other types of medicine. However, when they do go to seek formal healthcare, there are some key factors that influence elderly preferences for health care services and choice of provider—reputation, trust and interpersonal aspect of individual providers; and financial concerns. Geographical location of the service and the provider's sex (in case of women respondents) also were regarded as important factors.

The costs of elderly health care in poor households are often considered exorbitant and may result in the loss of assets including livestock and poultry. Alternatively, the cost of health care may burden a household with a formal loan (from in institution) or informal (from a friend or relative) loan which will have to be paid off over a period of time. The decisions about elderly health care are made by a wide range of people, including nearest family members, close or distant relatives, neighbours, and friends. Commonly, male respondents who have greater mobility may decide on their own health care. In contrast, women almost always rely on a male member of the family or even a neighbour for care-seeking decisions. The fact that women are unable to travel on their own and have to be accompanied by a man influences their health seeking behaviour.

The elderly women in the family are the main caregivers for their husbands. Elderly themselves also visit their immobile elderly relatives and neighbours. The living arrangement of elderly people affects their care-receiving pattern. When the elderly live in a house surrounded by several family members in different households, there is always someone to look after them. The ability to perform roles in the family brings a sense of self-worth and security for elderly people. Being socially functional by having a good family and social network plays a very important role in elderly peoples' quality of life.

Finally, the existing qualitative data set will be further analyzed to explore certain issues related to primary health care for the elderly to improve their quality of life. Thus, this report does not represent the end of the analysis, but rather identifies future pathways that future inquiry would usefully pursue.

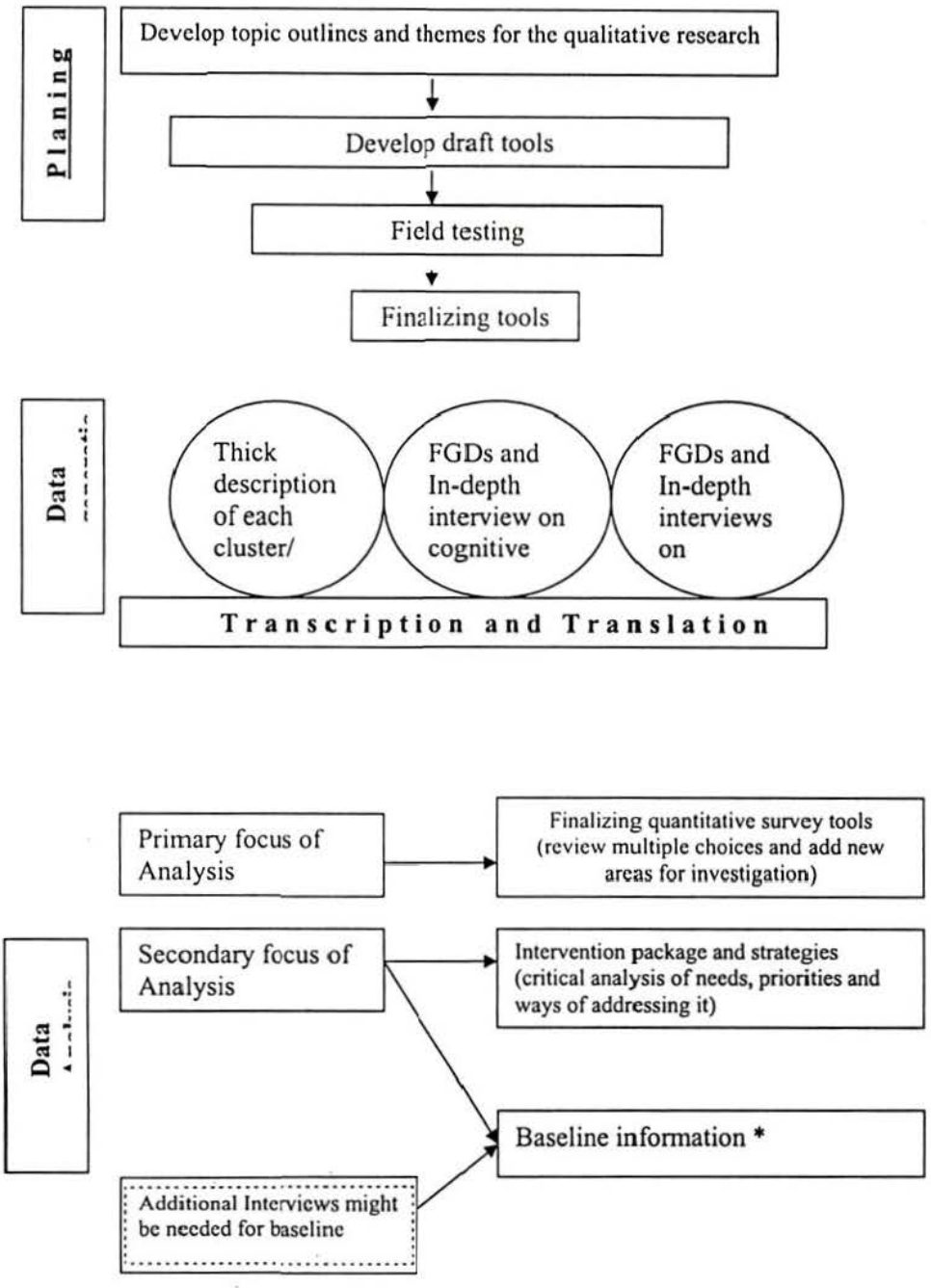
Appendices

Annex: 1

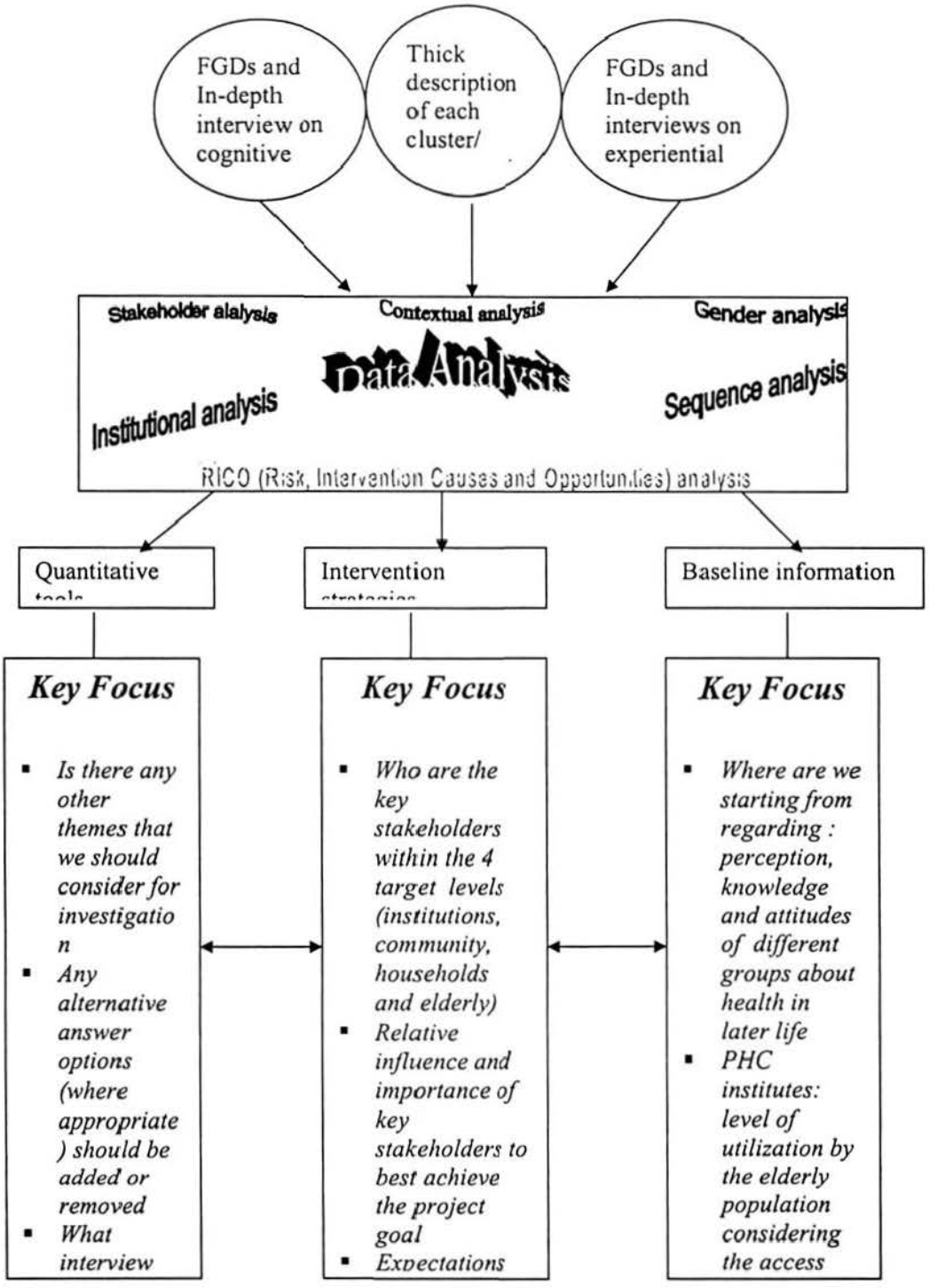
A map of Bangladesh and the study area:

Annex:2

Detail Overview of Qualitative Activities in PHILL



Overview of data analysis outline



Annex:3

Qualitative Checklists—Cognitive Approach

Primary Health Care in Later Life (PHILL) – Bangladesh

Checklist for in-depth interviews with elderly people
(n=6-8, M & W, frail & healthy, poor)

Village Name:

Bari Name:

Household Number:

Name of Elderly Respondent:

Name of HH Head:

Sex of Elderly Respondent:

Marital Status:

Literacy Status:

Date of Interview:

Interviewed by:

Notes taken by:

Length of Interview:

Primary Health Care in Later Life (PHILL) – Bangladesh
Checklist for in-depth interviews with elderly people

- Could you please tell me what you normally do a whole day?

Theme Health

- What does health means to you? / What do you understand by health?
- What are the factors that contribute to good health?
- What are the factors that contribute to bad health?
- What is specific to older people's health in comparison to other adult's health?
- What is it like for you to have good health?
- Can you tell me about a certain occasion when you as an elderly felt healthy?
- What is it like for you to have bad health?
- Can you tell me about a certain occasion when you as elderly felt unhealthy/ill?

Health problem

- What are common health problems among elderly in this area?
- How does it vary in different seasons/month of the year?
- What kind of health problem do you face as elderly compared to when you were younger?

Theme Quality of Life

- What do you understand by quality of life?
- What factors contribute to a good quality of life?
- What factors contribute to a bad quality of life?
- Can you tell me about a phase of your life when you as elderly felt that you had a good quality of life?
- Can you tell me about a phase of your life when you as elderly felt that you had a bad quality of life?

Theme Health Competence (instruction to interviewer, focus on "old age experience")

- Can you tell me about a concrete situation when you helped another person with a health problem?
- How did it start?
- What did you do?
- How did it end?
- What did you learn?

Theme Coping Strategies

- Can you describe a concrete situation when you or someone in your family had a severe problem (any)?
- How did it start/what was the problem?
- What did you do?
- Why did you do what you did?
- (Why didn't you do so?)
- What did you think?
- What did you feel?
- How did it end?
- What did you learn?
- Were you satisfied with this outcome?

Primary Health Care in Later Life (PHILL) – Bangladesh

Checklist for in-depth interviews with care giver

n= female care giver to elderly healthy and unhealthy (poor, not poor)

Village Name:

Bari Name:

Household Number:

Name of Care giver:

Care Giver to:

Relation to Elderly:

Marital Status:

Literacy Status:

Date of Interview:

Interviewed by:

Notes taken by:

Length of Interview:

Primary Health Care in Later Life (PHILL) – Bangladesh

Checklist for in-depth interviews with Care Givers

- Could you please tell me what you normally do for a whole day?

Theme Health

- What does health means to you? / What do you understand by health?
- What factors contribute to good health in general?
- What factors contribute to bad health in general?
- What do you think is specific for elderly people health in comparison to adult health?
- What factors influence elderly people health?
- What factors contribute to good health for elderly people?
- What factors contribute to bad health for elderly people?
- Can you tell me about an elderly person who is/was healthy?
- Can you tell me about an elderly person who is/was unhealthy?

Health problem

- What are common health problems among elderly in this area?
- How does it vary in different seasons/month of the year?
- What kind of health problem do you face as elderly compared to when you were younger?

Theme Quality of Life

- What do you understand by quality of life?
- What factors contribute to a good quality of life?
- What factors contribute to a bad quality of life?
- What do you think is specific for elderly people's quality of life?
- What factors contribute to good quality of life for elderly people?
- What factors contribute to bad quality of life for elderly people?
- Can you tell me about an elderly person who is having/had a good quality of life?
- Can you tell me about an elderly person who is having/had a bad quality of life?

Theme Health Competence

- Can you tell me about a situation when you have been able to use the experience/knowledge of an elderly person to deal with a health problem (any)?
- How did it start?
- What was the problem?
- What did he/she do?
- What happened then?
- How did it end?
- What did you learn?

Primary Health Care in Later Life (PHlLL) – Bangladesh

Checklist for in-depth interviews with health care providers

n=2 of each kind available provider on the basis of used and not so much used.

Village Name:

Kind of Health Care Provider::

Name of Health Care Provider:

Sex of Health Care Provider:

Date of Interview:

Interviewed by:

Notes taken by:

Length of Interview:

Primary Health Care in Later Life (PHILL) – Bangladesh

Checklist for in-depth interviews with Health Care Provider

- Could you please tell me what you normally do for a whole day?

Theme Health

- What does health means to you? / What do you understand by health?
- What factors contribute to good health in general?
- What factors contribute to bad health in general?
- What do you think is specific for elderly people health in comparison to adult health?
- What factors influence elderly people health?
- What factors contribute to good health for elderly people?
- What factors contribute to bad health for elderly people?
- Can you give an example an elderly person who is/was healthy?
- Can you give an example an elderly person who is/was unhealthy?

Health problem

- What are common health problems among elderly in this area?
- How does it vary in different seasons/month of the year?
- What kind of health problem do you face as elderly compared to when you were younger?

Theme Quality of Life

- What do you understand by quality of life?
- What factors contribute to a good quality of life?
- What factors contribute to a bad quality of life?
- What do you think is specific for elderly people's quality of life?
- What factors contribute to good quality of life for elderly people?
- What factors contribute to bad quality of life for elderly people?
- Can you give an example on an elderly person who is having/had a good quality of life?
- Can you give an example on an elderly person who is having/had a bad quality of life?

Theme Health Competence

- Do you think that elderly peoples experience/knowledge can be used as a resource in dealing with basic health problems within their families/communities?
- Do you know about such a situation?
- How did it start?
- What was the health problem?
- What did he/she do?
- How did it end?

Annex:4

Qualitative guidelines—Experiential approach

Primary Health Care in Later Life (PHILL) – Bangladesh

Guideline for FGD with elderly persons – Experiential Approach

n=12-15

Location of FGD:

Date:

Group of: Men / Women / Mix

Respondent's brief profile:

Opening discussion: Clearly explain the objectives of your meeting with the participants.

Theme Health Care Service

Availability

- What kind of services are available in this area (define) in general?
- What kind of service can you get there?
- What kind of health service do you seek when you have a simple health problem (self-perceived)?
- What kind of health service do you seek when you have a severe health problem (self-perceived)?

Accessibility

- How easy/difficult is it for elderly people to seek health care?
- What are the problem elderly people face when they seek health care?
- How do you deal and cope wit them?

Satisfaction and expectation

- Are you satisfied with existing health care service (health staff, health facilities, treatment received, availability of drugs)?
- What do you expect from the service providers?

Theme Care

Receiver and provider

- Who are the main caregivers for elderly people in your community?
- Who do you think provide best care for elderly?
- Who do think get best care among elderly?
- What do you expect from your families?
- What kind of care do elderly people provide to their families?
- What do elderly people expect from the community?
- What do elderly people expect from the government?

Theme Social Functioning

Social participation

- What kind of social event takes place in your community?
- How common / important is it for elderly people to participate in these events?
- Is there any clubs that elderly people can join?
- Are you a member of any group/club?
- Do you get any benefit from being a member?
- Do you think getting older affects on participation in any way?
- What kind of activities do you want to join?

Social network

- Can you tell me what kind of support elderly people seek from outside their families?
- Where do they go for what kind of support?
- How do you feel about that?
- What do you expect from your community?
- What do you expect from your government?

Expectations and recommendations

Primary Health Care in Later Life (PHILL) – Bangladesh

Guideline for in-depth interview with elderly persons– Experiential Approach
n=10-12
Location of interview:

Date:

Respondent's brief profile:

Name: Age: Sex: Religion:

Living with: /Alone

Number of people living together:

Education:

Employment/occupation:

Opening discussion: Clearly explain the objectives of your meeting with the participant. Start with a general discussion about how a normal day look like for you? What do you do?

Theme Health Care Service

Availability

- What kind of services are available in this area (define) in general?
- What kind of service can you get there?
- What kind of health service do you seek when you have a simple health problem (self-perceived)?
- What kind of health service do you seek when you have a severe health problem (self-perceived)?

Utilization

- Could you please tell us about one specific incident when you seeked healthcare?
- How did it start, where did you go first, why, what happened then?
- Where did you go after that, what happened there?
- How did it get better?

Accessibility

- How easy/difficult is it for you to seek health care?
- What are the problems you face when they seek health care?
- How do you deal and cope wit them?

Satisfaction and expectation

- Are you satisfied with existing health care service (health staff, health facilities, treatment received, availability of drugs)?
- What do you expect from the service providers?

Theme Care

Receiver and provider

- What kind of help do you need from your family members?
- Who do you get care from?
- What kind of care do you get?
- How do you feel about the care you receive?
- What kind of care can you get if you have some problems?
- Who will take care of you in that case?
- What do you expect from your family?
- What kind of care do you provide to your families?

Theme Social Functioning

Social participation

- How often do you participate in any social events?
- What kind of events do you go to?
- What kind of social activities/events do you want to go to?
- Are you a member of any group/club?
- Do you get any benefit from being a member?
- Do you think getting older affects on participation in any way?

Social network

- Can you tell me what kind of support you seek from outside their families?
- What kind of support do you get?
- How do you feel about that?
- What do you expect from your community?
- What do you expect from your government?

Theme Intra Household Relation

Decision making

- Who makes decisions in your family?
- Who is the main decision maker for your health care?
- How do you take part in any family decision?
- Has it always been like this?
- Has it changed over time?

Food behavior and nutrition

- What do you like to eat?
- What kind of food is good for elderly people?
- Do you fast?
- Is there times when you don't take any food?
- Does it affect your health in any way?

Primary Health Care in Later Life (PHILL) – Bangladesh

Guideline for FGD with caregiver's– Experiential Approach
n=4
Location of FGD:

Date:

Group of: Men / Women / Mix

Respondent's brief profile:

Opening discussion: Clearly explain the objectives of your meeting with the participants.

Theme Care

- We understand that you are the main caregiver for elderly members of your family.
- What kind of care do you provide?
- How have you learnt about caring for elderly?
- Is it easy or difficult to care for elderly?
- What kind of care is important for elderly people?
- How much care do you think elderly people get?

Theme Health Care Service

Availability

- What kind of services are available in this area (define) in general?
- What kind of service do you use for elderly people?
- What kind of health service do you seek when your elderly relatives have got a simple health problem (self-perceived)?
- What kind of health service do you seek when your elderly relatives have got a severe health problem (self-perceived)?
- How do you understand if a health problem is serious or not?

Accessibility

- How easy/difficult is it for elderly people to seek health care?
- What are the problem elderly people face when they seek health care?
- How do you deal and cope wit them?

Satisfaction and expectation

- Are you satisfied with existing health care service provided for elderly people (health staff, health facilities, treatment received, availability of drugs)?
- What do you expect from the service providers?

Theme Social Functioning

Social participation

- What kind of social event takes place in your community?
- How common / important is it for elderly people to participate in these events?
- Is there any clubs that elderly people can join?
- Do you think getting older affects on participation in any way?
- What kind of social events do people enjoy most?
- Who do they go with?
- Do you think it is important for older people to participate in social events?

Expectations and recommendations

- Do you experience any problem to provide care?
- What do you expect from your family/community/state to overcome these?
- What do you think can be done to improve elderly peoples health?
- How will it make a difference?

Primary Health Care in Later Life (PHILL) – Bangladesh

Guideline for in-depth interview with caregiver's – Experiential Approach
n=8
Location of interview:

Date:

Name of Respondent: Age: Sex: Religion:

Education:

Employment/Occupation:

Caring for: How long:

Number of people living together:

Opening discussion: Clearly explain the objectives of your meeting with the participants. Can you tell us how a normal day looks like for you. What are the main work you are doing?

Theme Care

- We understand that you are the main caregiver for your ..... .
- What kind of care do you provide to him/her?
- How have you learnt about caring for elderly?
- Is it easy or difficult is it for you to provide care?
- Does anyone else help you?
- How do you feel about the care he/she gets?
- Is there anything you wish to do for him/her that you cant manage?

Theme Intra/household health seeking behavior

- What are the health services available in this area for elderly people?
- Where do you take your ..... in case of a serious problem?
- How do you understand if it is a serious problem or not?
- How is the decision made? Who decide? When?
- What kind of healthy/unhealthy habits do you think the elderly person has got?

Theme Health Care Service

Accessibility

- How easy/difficult is it for you to seek health care?
- What are the problem you face to seek health care for elderly people?

- How do you deal and cope wit them?

Satisfaction and expectation

- Are you satisfied with existing health care service provided for elderly people (health staff, health facilities, treatment received, availability of drugs)?
- What do you expect from the service providers?

Theme Social Functioning

Social participation

- Does your ..... participate in any social events ?
- What kind of events?
- Who does he/she goes with?
- What kind of social events does he/shc want to go to?
- How does it affect his/her life?
- How important do you think it is for him/her to participate in such events?

Expectations and recommendations

- Do you experience any problem to provide care to the elderly in your household?
- What do you expect from your family/community/state to overcome these?
- What do you think can be done to improve elderly peoples health in general?
- How will it make a difference?

Primary Health Care in Later Life (PHILL) – Bangladesh

Guideline for in-depth interview with health care provider – Experiential Approach
n=6-10
Location of interview:

Date:

Name of Respondent: Age: Sex:

Education:

Kind of institution:

Year of experience: Years in current location:

Lives in the area/village: Y/N

Opening discussion: Clearly explain the objectives of your meeting with the participants. Can you tell us something about how you have become a health care provider.

Theme Health Care Service

Availability and Accessibility

- When do elderly people come to you?
- Where do they come from? How far do they travel?
- Do you know any reason that stops old people to come to you?
- How often do you go to house calls for elderly people?
- What types of problems needs house visits?
- What type of preventive/curative measures do you offer?
- How do you treat them?
- What do you about previous treatment before they are coming to you?

What is the best treatment you can offer for elderly people? For which specific health problem?

Theme training and retraining

- Could you tell us about your training /education regarding elderly health?
- What do you easily treat?
- What health problems do you find difficult to deal with?
- What do you do if you find the health problem of the elderly beyond your area of knowledge?
- How easy/difficult is it for you to deal with elderly people / patients?

- Could you think about any specific health training that you think you might help you to be able to give better treatment to elderly people?

Theme health service providing institute

- What are the major problems your institute have that prevents better health care for elderly people?
- What are the opportunities your institute have that can be used?
- What do you think health professionals/providers can offer?
- What role can community play?
- What can the government do?
- What changes would you recommend for your institute and for providers like you to offer elderly people better and appropriate health care?

Annex:5

Thick descriptive information outline:

Aim: to give a brief contextual picture of the studied country and the study areas. Information sources for some items will differ between local and national levels. It would be useful to know how "typical" the study areas are of wider regions or the country as a whole (e.g. do they have above average fertility or do cultural attitudes to gender vary from the national norm?).

Key areas	Few Details	Sources
Demography	▪ Demographic pattern and population aging ▪ Any demographic changes over last few years ▪ Mortality and fertility rates and patterns	
Economic environment	▪ Per capita income ▪ Economic growth ▪ Main economic sectors ▪ Economic migration ▪ Patterns of land-holding	
Cultural environment	▪ Main religions and relations in general ▪ Languages ▪ Cultural attitudes to gender	
Political environment	▪ Main political forces (formal and informal; locally and nationally) ▪ Degree of local participation in policy-making	
Policies	▪ Any policy interventions for elderly (for or against) -change over time ▪ PHC policies, locally and nationally -change over time ▪ Presence of NGO programmes or other external initiatives (eg donor-funded projects)	
Natural resources and location	▪ Location of the study areas ▪ Brief description of natural resources ▪ Any major changes over last few years ▪ Changing climate, perception, adaptation ▪ Crops	
Institutions	▪ Key institutions in the area (i.e. educational institutes, religious institutes, NGOs, community based organizations, youth clubs etc,) ▪ Major health care institutions	
Infrastructure	▪ Brief description of infrastructure of the area (for example road communication, market place etc.)	
Historical information	▪ Any disaster either natural or man made that well remembered (i.e. war, floods etc.) ▪ Its implications on people in general and especially on elderly	
Epidemiological	▪ main causes of mortality for general population ▪ main causes of morbidity for general population ▪ main causes of mortality for elderly population ▪ main causes of morbidity for elderly population	
ANY OTHER	▪	

Annex:6

Qualitative guidelines for second round interviews

Exercise 1:

A. Free listing of illnesses

Illness (Local Term)	Sign and Symptom	English Equivalent

B. Free listing of practitioners

Name of practitioner and Institute	Type	Location

Exercise 2:

Matrix of most frequently mentioned Illnesses and Providers (Based on the free listing)

	Practitioners			
Illnesses				

Finding out the preferred practitioners for specific illness. Grading the practitioners as 1, 2, 3 according to the sequence of preference.
Also to find out the answer, 'WHY' certain practitioner was selected for certain illness.

Exercise 3:

A. Illness episode:
Detail narrative of a illness that the respondent suffered within last three months covering the following issues:

1. When the episode occurred
2. What were the sign symptoms
3. What the respondent thought s/he had?
4. Perceived cause
5. Home care practices prior to seeking care(any change in food intake, who suggested /prepared)
6. Duration of signs and symptoms prior to seeking care, signs and symptoms that triggered seeking of care from provider
7. Name and location of the first health care facility visited during the episode.
8. Who made the decision to see provider? Who went?
9. Were any special financial arrangements necessary? Were there any other constrains to care seeking?
10. Was there a sequence of provider? Did family go to another provider? Why?
11. Were there any changes in signs and symptoms (improvement or worsening) after first treatment?
12. What treatments were given by the provider? Were there also any use of home remedies concurrently ?
13. What was the level of satisfaction with care?

B. Narrative of Self care regarding the most frequently mentioned illnesses.

Exercise 4:

Time line:
Detail narrative of a day's activity of the respondent (day before the interview)

Dividing the day according to hour by hour or 'Namaz wakts'.

Detail of the activity

Eating (Who is served, when, how much, place)

Sleeping(Place, material)

Seasonality

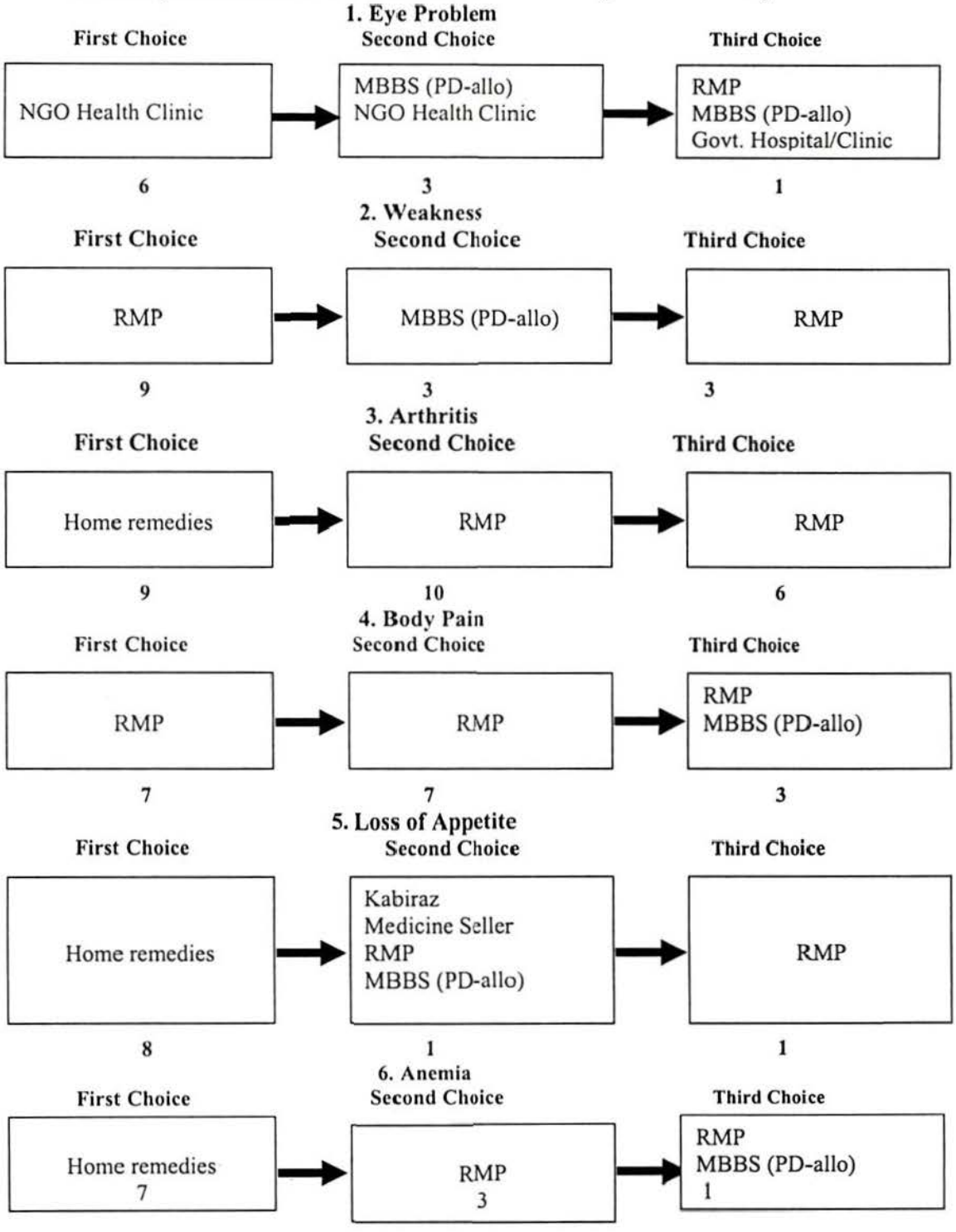
Annex:7

Type of health care service providers in the study area:

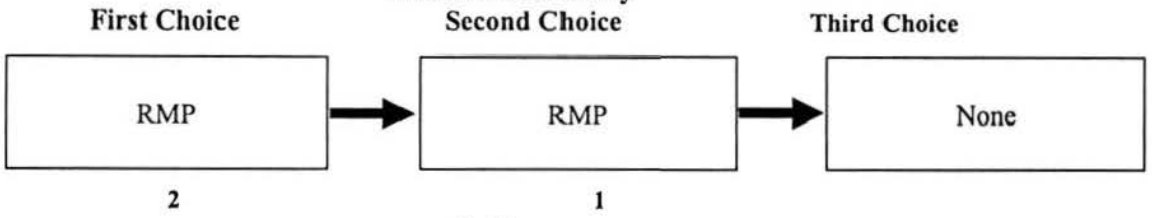
Sl. no	Type	Description
1	Home Remedies/ Self-Care	People use self-made remedies and also are provided care by family members, neighbours and relatives for common illness.
2	Kabiraz (Ayurvedic)	They use various plants as medicine.
3	Medicine seller	They have Medicine Shop. Patients come to their shops to buy medicine. Generally patients are not given consultation here.
4	Pharmacist	Have training (1-3 months) organized by local druggist samity (organization). Some pharmacists also visit the patient's house to provide treatment. They also have medicine shops.
5	Rural Medicine Practitioner (RMP)	Have 3-6 months training. They have medicine shops. Patients come to their chamber to consult with them for illness and buy drugs from them. They go to the patient's house as well.
6	Sub Assistant Community Medical Officer (SACMO)/ Medical Assistant(MA)	Have 3 years training and worked in Family Welfare Centre (FWC). Now they are retired from the service and practicing in the locality. They also visit the patient's house.
7	Homeopathy	They have degree on homeopathy. They also have homeopathy medicine shop. Patients consult with them and buy drugs from them.
8	MBBS (Private Doctor allopathic)	They Practice from private clinic in the district sadar. People also visit Dhaka to consult with MBBS doctors. People go to their clinic to consult with them.
9	NGO Health Clinic	MBBS doctors are available here. There are three NGO Health Clinics where people go for treatment. They are BRAC Health Centre in the study village, Eye hospital in district sadar & ICCDDR'B in Matlab thana sadar.
10	Government Hospital/Clinic	Government hospital/clinic includes Thana Sadar Hospital (THC), Family Welfare Centre (FWC). There are MBBS Doctors in Sadar Hospital and SACMO, FWV, HA in FWC.
11	Religious Leader/Spiritual Leader	People go to some religious leader like Maoulovi, Imam of Mosque for treatment. Tabiz, Panipara, Mantra are used as remedies.
12	Health Assistant	They are working in Government hospital/clinic. They also have medicine shop. Sometimes they visits the patients house.

Annex:8

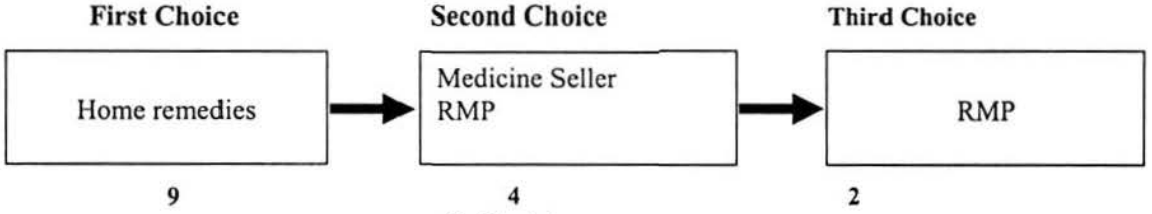
Pathway to Choice of Health Care Providers (From Matrix)



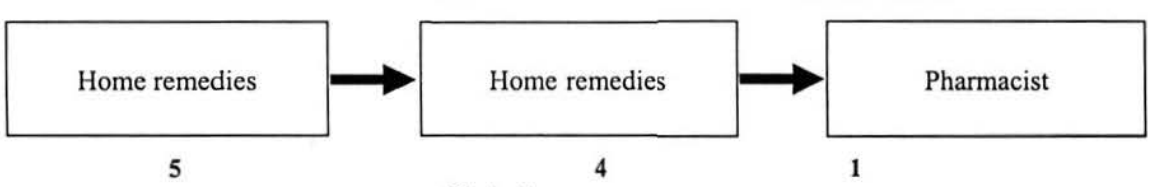
7. Deficit of Memory



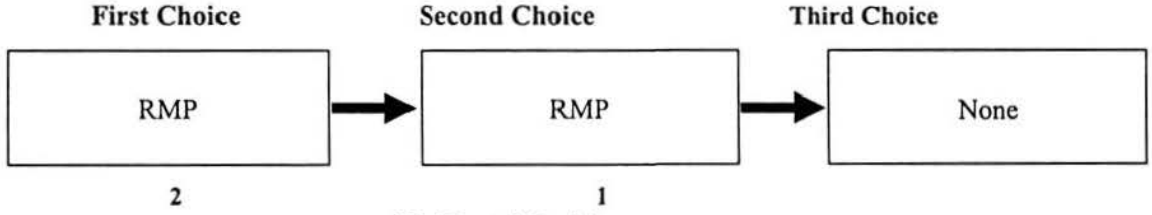
8. Fever



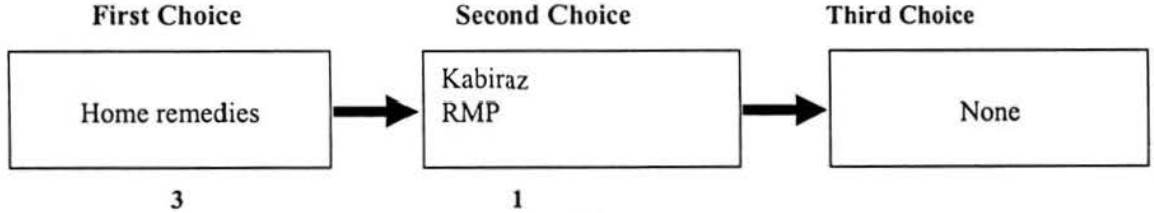
9. Gastric



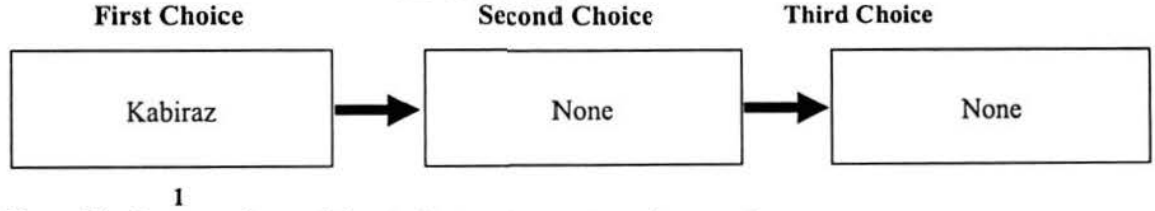
10. Asthma



11. Dental Problem



12. Uterus Problem



Note: The figure under each box indicates the number of respondents.

Annex:9

Some key preference indicators of elderly choosing and using certain health care services: [from illness episode, total respondents 20 (Female 10 + Male 10)] :

Some key preference indicators	Respondents		
	Female	Male	Total
• Doctor in known to us • S/he is our regular doctor • Doctor is known for several generations	4	7	11
• Doctor will visit our home at any time of day and night if necessary		2	2
• Doctor is trained/ passed MBBS • Doctor has training and experience • Specialist doctor • Doctor has good reputation	3	13	16
• Have faith on the person and treatment • Have trust / have not got trust	1	10	11
• Satisfied with the treatment	2	1	3
• Doctors' good behavior	-	3	3
• Buy medicine on credit	4	4	8
• Doctor is a relative/ neighbor	2	3	5
• Cheaper fees • Kabiraj is cheaper	3	3	6
• Female doctor	1	0	1
• Close relative took to an specialist	3	1	4
• Referred by a known doctor	2	2	4
• Faith on Allah and not seeking any service	1	0	1

Annex:10

Uses of some home remedies among elderly:

Local name	Other name/ Botanical name	Used for
Plants:		
Kalakachu/ Telakachu	Cucurbitaceae/ (*Coccinea cordifolia* Cogn).	Eye problem/ cataracts, body pain, gastric, tummy pain, arthritics
Lozzaboti /Gorjoboti	Mimosaceae (*Mimosa pudica* Linn.)	Dental problems
Guava		Dental problems, gastric, tummy pain
Chalta	Dilleniaceae/ (*Dillenia indica* Linn.)	Fever
Tulshi	Labiatae/ (*Ocimum sanctum* Linn.)	Fever
Chirata	*(Swearia Hami)*	Fever, loose of appetite, *Pittashul/ Pittarog*
Boira	Combretaceae / (*Terminalia bellerica* Roxb.)	Loose of appetite
Horitoki	Combretaceae/ (*Terminalia chebula* Retz.)	Loose of appetite
Amloki	*(Phyllanthus emblica)*	Loose of appetite
Anarash (pineapple)	*Ananas sativus* Sch.	Body pain
Ada (Ginger)	Zingiberaceae/ (*Zingiber officinale* Rosc.)	Body pain, asthma, jaundice, arthritics
Halud (Tumaric)	Zingiberaceae / (*Curcuma laoga* Linn.)	Body pain
Rasun (garlic)	*Allium sativum* Linn.	Body pain, asthma
Muster oil		Body pain, asthma, arthritics
Arjun	Combretaceae/ (*Terminalia arjuna* W.&A.)	Weakness
Neem	Meliaceae/ (*Azadirachta indica* A. Juss.)	Weakness
Olot kambal	Sterculiaceae/ (*Abroma augusta* Linn.)	Weakness
Haori		Weakness
Sadzna	Moringaceae/ (*Moringa oleifera* Lamk..)	Weakness
Kafila		Loose of appetite
Basak	Acanthaceae/ (*Adhatoda zelanica* Nees.)	Fever, cough
Meats:		
Frog meats	Weakness, tuberculosis	
Fox meats	Arthritics, body pain,	
Bird meats	Jaundice	
Others:		
Tabij	Gastric/ tummy pain, fever, asthma, uterus problem	
Holy water	Gastric/ tummy pain, fever, uterus problem	
Mantra	Gastric/ tummy pain, fever, uterus problem	

[Botanical name source: Gani A. 2002, *Bheshaja Oshudh,*(Herbal Medicine*)*, Bangla Academy, Dhaka]