

Primary Healthcare in Later Life: Improving Services in Bangladesh and Vietnam (PHILL)

Post-intervention Report on Qualitative Data

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BRAC Research Report



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Bangladesh and Vietnam (PHILL)
Post-Intervention Report on Qualitative Data**

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ACRONYMS

ARC-B	Ageing Resource Centre Bangladesh
BRAC	Bangladesh Rural Advancement Committee
CHS	Commune Health Station
CPC	Commune People Committee
EC	European Commission
FGD	Focus Group Discussion
HSPI	Health Strategy and Policy Institute
ICPC	Inter Communal Polyclinic Center
KI	Karolinska Institutet
MBBS	Bachelor of Medicine and Bachelor of Surgery
PHC	Primary Healthcare
PHILL	Primary healthcare in later life
QoL	Quality of Life
TV	Television
UEA	University of East Anglia
UK	United Kingdom
VEC	Village Elderly Club
WHO	World Health Organization

SUMMARY

When thinking of the development of primary healthcare, the position of older people within households and communities should be taken into account. Relationships between primary healthcare and informal support for older people, health education and the promotion of health active life expectancy are of primary importance.

The Primary Healthcare in Later Life: Improving Service in Bangladesh and Vietnam (PHILL) project aimed at developing innovative and policy-relevant primary healthcare delivery strategies for low-income countries targeted for older people. The project was conducted with the aim to identify the effectiveness of low-cost, preventive and health promotion interventions in improving the primary healthcare of people sixty years and older in rural communities in Bangladesh and Vietnam. The three-year project (October 2002—September 2005) was implemented as a collaborative project with four member partnerships including the Karolinska Institutet (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.

Both Bangladesh and Vietnam have placed a strong emphasis on the development of primary healthcare services. Still, the scarcity of resources in the healthcare sector, compounded by inadequate training, have often hindered the delivery of basic health services to vulnerable groups. Although many changes have taken place within the society including the healthcare sector, no study has investigated the impact of these changes on older people, and no specific policies nor interventions have been introduced to improve healthcare for this particular population group in these countries.

The study and its aims

The purpose of the study is to describe perceptive and cognitive aspects relating in health of old people in Bangladesh and Vietnam, including aspects related to quality of life. The study will also examine the healthcare related outcomes of the interventions provided.

The study sites in Bangladesh were located in four villages (Ashikati, Damokergaon, Kumardugi and Mandari), in two unions (Ashikati and Shahmahmudpur), under Chandpur Sadar thana in the Chandpur district. In these areas lived approximately 600 older persons. In Vietnam, the study site was conducted in two communes in Chi Linh district, Hai Duong province. The interventions were directed to older people, family caregivers and formal care providers. All the caregivers came from elderly household. They were provided educational interventions directed formal care providers and family caregivers and for older people themselves. The interventions also had health check-ups and training activities for the older people. Even self-help groups for older people were conducted.

Methods

In both countries the qualitative study was conducted both pre- and post-intervention by focus group and individual interviews with older people themselves, main family caregivers and healthcare providers. The data were obtained from the 60 years old and older people, their caregivers and healthcare providers both before and after the intervention. The participants were purposefully selected.

In Bangladesh, 71 older people, 11 caregivers and 8 healthcare providers were interviewed before, and 60 older people, 20 caregivers and 10 healthcare providers were interviewed after the intervention with in-depth interviews (with 19 persons before and 40 persons after the intervention) and with 12 focus group interviews before and 6 after the intervention. Both before and after the intervention 20 free listing and 20 matrix interviews were also conducted with the older people.

In Vietnam, the data were collected by 10 individual in-depth interviews, where of six with the older people, two with main family caregivers and two with healthcare providers. Additionally, 18 focus group interviews with 5-8 persons in each were conducted. Of the focus group interviews, 12 were conducted with older people, 4 with main family caregivers and 2 with community leaders and social organizations or associations. The focus groups were conducted separately with the older people and the family caregivers both before and after the interventions. However, the selected target groups were different at the two phases of data collection.

All the interviews were tape-recorded. The data was analysed by using qualitative and quantitative content analysis. The pre-intervention and post-intervention material was first analysed separately. The analysis process was conducted in several steps. The results will be presented in descriptive manner.

Findings

Quality in life and health

In Bangladesh, both before and after the interventions, the aspects related to quality of life were about having good health. The older male respondents regarded themselves to have a good quality of life, while the older female respondents had physical illnesses that made their quality of life low. Financial solvency was also regarded to be part of good quality of life. After the intervention, good social relationships, especially among the family members, were added to be important aspect for quality of life. Even in Vietnam, good health and ability to work, financial solvency and happiness were by the older people regarded as aspects affecting their quality of life, although the term 'quality of life' was unknown to them.

Before the intervention, the most commonly mentioned illnesses among the older people in Bangladesh were eye problems, i.e. cataracts, tooth ache, gastric pain, body pain, fever, weakness, uterine problems, loss of appetite and arthritis. Although several older people reported suffering from high blood pressure, diabetes, accidental falls and/or paralysis, they seldom associated these problems with advanced age.

Physical ability and strength, food availability, appetite and medicine, vulnerability to certain illnesses and mental peace and happiness were regarded to influence the health in old age. Before the intervention, the causes and sources of ill-health were commonly reported by the older people to have multifaceted reasons, such as individual lifestyles, environmental aspects (weather conditions), and the impact of social and legal events creating psychological pressure in their lives. Old age in itself was also perceived as being intertwined with ill-health. Even after the intervention, these aspects were mentioned as causes for ill-health. However, even smoking, intake of drugs and alcohol, lack of exercise and lack of prayers, and bad relationships in the family were regarded to cause illnesses.

The older people in Vietnam suffered from joint-pain, backache, headache, hypertension and insomnia. Before the intervention, the older people, their family caregivers and the healthcare providers mentioned strength and mobility, mental pleasure, food availability and

good healthcare service as aspects influencing older people's health. After the intervention, in addition to strength and mobility and mental pleasure and happiness, knowledge on healthcare, good lifestyle and happy family were regarded as important aspects of health in old age.

Social life

Before the intervention, the older people in Bangladesh were mainly involved in maintaining the spiritual well-being: Almost all the older respondents reported that their days were guided by praying five times a day and of reading the Quran. Women prayed mostly at home and men in the mosque, where they also got the opportunity to meet others, and the visit to the mosque also provided an opportunity to have a little walk. The older people also helped with tasks within the household as long as they were physically capable of it. These activities made the older people to feel themselves needed and useful and not being a burden for their families. The intervention increased the older people's domains with training exercises, which they regarded to be good for them in maintaining their health. Some of the women had started to take walks in order to keep their body fit.

Many older people complained that the self-reliance groups ceased to exist when the PHILL-project ended. Now they had no place where they could meet and they could not work together in order to organize any facilities for the old people. Even the caregivers had appreciated these groups.

In Vietnam, the older persons who lived with their children were usually economically dependent on their children. They were too old to do farming work or to earn money. However, they did household work. The old people did not make the decisions in family matters as they were financially dependant on their younger generations, but they were guidance and advices givers for their children. Those old people who live with their spouses were independent of their children. They felt very comfortable as they could live in their own way, they could make their own decisions. However, they had less contacts and communication with their children than those old people who live with their children. The older people were respected in the community due to their contributions, experiences, and prestige. Before the intervention, the old people were seldom involved in decision making on the community issues. The intervention changed their role, and the older people make contributions in social mobilization in the communities. The most common social organization for the older people are the elderly clubs. Although those activities existed in some villages even earlier, few persons had participated in the activities provided by these clubs. After the intervention, these clubs had increased their activities with i.e. morning exercises, poem club and sport activities and most of the older people participated in these.

Caregiving in the family

In Bangladesh, a very strong intergenerational dependency exists. Thus, the older people were both care providers and care receivers. Older women were the main caregivers for their husbands and they also visited and cared for their immobile older relatives and neighbours. They were also caretakers, as they also received care from their family members, close neighbours and friends. The older people also cared for their grandchildren. Similarly, the grandchildren often helped the older people. Some of the family caregivers explained that caring for an older person brings fortune to the family and thus, it is beneficial for the family members to care for the elderly.

The older people in Vietnam received some help from their family members in daily living when they needed help in doing hard work, such as farming, building up or repairing house. In case of illness, they received help in basic daily activities. The older people were not completely satisfied with caring from their family members. Although dissatisfied, they felt

that they have to accept the situation because they understand that their son/daughter were so busy with household work that they have no time to spend for taking care of their parents. However, after the intervention, the older people were more satisfied with the care provided by family members compared to what they had received before.

Healthcare

In Bangladesh, there were three levels of healthcare services available in the study area. The primary healthcare services include health centres and local medicine shops. Besides, the use of different home remedies is common. On the secondary level, there are hospitals and clinics located in the Thana-level town. The tertiary level of healthcare includes the hospitals and clinics at the Comilla district town and in the capital city of Dhaka.

The health-seeking behaviour among older people included a number of options that depended on the perceptions of health and illness, health competencies and the sense of severity of the current illness stage. In case of illness, the individuals dealt with a complex personal, intra-household and inter-household negotiations and the decision-making process over the physical, financial and social aspects.

In the first instance of any illness the older people used a wide range of home remedies for treatment, and hoped that these would cure the health problems they were experiencing. In this stage, the older people themselves were the main source of knowledge. The younger generation sometimes brought medicine from the local providers of traditional medicine or from the medicine shop.

If the illness was not cured, and the discomfort mounted and thus affected the older person in his/her ability to work, the formal medical advice was sought. This help-seeking behaviour was initiated either by the patient, a family member, a relative or by a neighbour. In this stage, there were three decisions to make: to decide the particular healthcare provider among the options, who can accompany – that is, has time – the patient to the healthcare provider, and who will pay the expenses for the healthcare advices and treatment costs. The financial aspect is to be the major constrain for the poorer older people to seek healthcare services. In practice, this usually meant that the older person had to refrain from the care. The older people's health expenses were not regarded as profitable for the families, especially in the poorer households. Even in richer households, the costs could burden a household with loan.

In addition, it was widely believed both among the older people themselves and among the younger generations that illness and suffering are inevitable in old age and part of the ageing process, and therefore, medicine does not work with old people. This results in that the medical care for older people is not sought or given a priority.

Interestingly, before the intervention, the older people were mostly satisfied with the healthcare services they had received. After the intervention, most of the older people were dissatisfied with the availability of the healthcare services. In addition to the financial aspects, they meant that the services needed to be better. There was a lack of access to a number of medicines in the medicine shops in their area and the healthcare services were not situated nearby their homes.

In Vietnam, there are public healthcare providers in the commune health stations or in the villages and operate in the public health facilities. The choice of different sources of healthcare providers depended on the severity of the health problems. The older people used herbal or traditional medicines for treatment of common health problems. If these did not help, they went to private drug sellers or private practitioners to buy medicines. In addition to financial

barriers, barriers related to problems with mobility and geographical distance and healthcare providers' attitudes to the older people and their families as well as lack of healthcare services at home were the main obstacle for using the healthcare services. Transportation was a barrier to access healthcare services, especially hospitals. Thus, going to hospital to seek healthcare was not common among the older people.

In conclusion

Good health, financial solvency and good social relationships were the aspects included for the term quality of life or similar in both countries. The older people in Bangladesh and Vietnam considered the old age to be a period in life when they were more vulnerable to diseases due to the ageing process itself. They also considered aspects related to nutrition, mobility and body strength to be risk factors for illness.

The older people's life style was dependent on the family patterns. Most of the older people either managed by themselves or with help of their family members. In Vietnam, there were more old people living alone, making their possibilities to receive help from others more vulnerable. The social life was also largely depending on the nearness to family, but also on the social activities available.

After the interventions, the quality of the encounters with the healthcare providers became one of the most important aspects influencing the choice of healthcare provider in Bangladesh. They had also become more aware of the possibility to counselling about health related aspects. However, the older people became dissatisfied with the availability and quality of the healthcare services provided. They also complained over the scarcity of medicine and that the waiting time had increased. The older people also mentioned the older people's self-help groups as a part of their social life, but many persons were dissatisfied with the continued functioning of these self-help groups.

In Vietnam the interventions increased the older people's knowledge on the needs of healthcare for the older people and the need of self-care in order to have good health in old age. They also increased the older people's knowledge of the importance of the role of self-care related aspects, such as nutritious food, exercise and social aspects in giving strength to resist illnesses and maintain health.

More clearly in Vietnam than in Bangladesh, the intervention helped the older people to realize and provide social activities, which also increased their satisfaction with their life situation. Unfortunately, in Bangladesh only few groups had continued to exist after the intervention period.

In both countries, home remedies were commonly used, mostly different plant products. After the interventions, in Bangladesh, even exercise was mentioned as a common home remedy. Even in Vietnam, the interventions increased understanding of the importance of regular exercise. Financial insolvency and geographical distance were the main obstacles that delayed or hindered the search for professional healthcare providers in both countries. The barriers of accessing healthcare services stayed almost the same after the interventions, as the inconvenience and obstacles for visiting the healthcare services when there was a long distance to these facilities, the older people had economic difficulties and when they did not want or could not bother their children still remained. In Bangladesh, this caused frustration among the older people, when their knowledge about the services increased.

In both countries, the family caregivers increased their understanding of aspects related to older people's health, and more actively promoted their health. In Vietnam, the interventions

also empowered the older people to provide contributions in social mobilization in the whole community.

The study shows that the provided low-cost interventions had a positive effect on the life conditions of the older people both in Bangladesh and in Vietnam, although the changes were small. The study also points out the need of continual information on issues of preventive healthcare in old age. It also shows the need for information about the aspects related in older people's health among the healthcare providers.

Thus, the governments should pay more attention on this older age group in terms of healthcare, in order to improve health status of the elderly in general. Medical check-ups were both wished-for and needed in order to inform the older people of their specific conditions, medical and self-help needs in different illness stages. These medical check-ups also provide the healthcare providers knowledge of the general health patterns in these areas. It is also important to increase the availability and access to these centres. A special attention should be placed on older women's access to healthcare. This places pressure on having the healthcare services available in the villages, or as mobile centres.

The self-help groups showed to have an important place in the older people's life as a social meeting place and thus, increased their quality of life. These self-help groups should be naturalized to the preventive healthcare system.

Decline in fertility and improvement in life expectancy (from 45 years in 1972-73 to 58 years in 1999-2000) have led to rapid increases in the number of older people in Bangladesh to 6% of the current population or 7.2 million, expected to almost double by the year 2020. The health status of older people is poor and they lack access to healthcare and sanitation facilities. Recent research from Bangladesh indicates that health services for older persons suffer from a lack of coverage and the inadequacy of existing services to meet older peoples' needs (HelpAge International 2000). Bangladeshi public health facilities are often under-utilized, and services are perceived to be of low quality (Vaughan *et al.* 2000). In both the public and private sectors the emphasis is heavily geared to maternal and child health, and family planning. Private pharmacies are the main source of acute medical care in the country (Ronsmans *et al.* 1996). Although public health facilities are not supposed to charge any fees for providing services, unofficial fees are reported to be taken (Vaughan *et al.* 2000).

Primary healthcare has been of high priority for the Vietnamese government since the 1970s. Since 1989, health sector reform introduced legal operation of private pharmaceutical and medical practices, and direct hospital user fees. Since then, the private health sector has played an important role in providing healthcare alongside the public sector (Lönnroth *et al.* 1998), giving the population more freedom of choice of health providers (Witter 1996). Although smaller than the public health sector, services of the private sector are widely used by the general population, including older persons, for common health problems (Oanh 2000; Long 2000; Ministry of Health 1999). However, the reform has also led to greater inequalities in terms of access to and utilization of health services, and older people may have lost out. Although the user fee for health services is waived for certain disadvantaged groups, including the poor and single older persons (Ensor & San 1996), health expenditures are still an important constraint for the poor and older people in Vietnam. Although many changes have taken place within the society including the healthcare sector, no study has investigated the impact of these changes on older people, and no specific policies nor interventions have been introduced to improve healthcare for this particular population group in Vietnam.

PERFORMANCE OF PRIMARY HEALTHCARE (PHC) SYSTEMS

Increased attention is now being given to the development of indicators of health system performance (WHO 2000). A recent study in Bangladesh reported provider behaviour, especially respect and politeness as the most powerful predictor of client satisfaction with public health services. The study underscored that client satisfaction was determined by cultural background. They also found out that meeting the psychosocial needs of patients at healthcare centres was as important as meeting their medical needs (Aldana *et al.* 2001). As well as looking at health systems as a whole, it is useful to assess how particular parts of a health system perform in reaching the needs of particular groups. The development of these indicators was the key objective of this project. Given the holistic nature of PHC, it is necessary to go beyond narrow health outcome indicators to include broader quality of life measures.

The concept of quality of life encompasses all aspects of human life, including a person's material, physical, mental, social, emotional, and spiritual well-being (Farquhar 1995). The project is based on an assumption that the use of quality of life-indicators can initiate a more holistic approach to service delivery, and can be used as an outcome measure. It may also encourage healthcare professionals to look beyond ill-health and pay more attention to the positive aspects of people's life and how it can be strengthened (WHOQOL Group 1996). Numerous quality of life indicators have been developed in high-income country settings. The point of departure in this qualitative project is instead to reveal the aspects of quality of life from the older people's and their families' point of view, and thus, to reveal the culturally bound aspects related to the quality of life as they influence the perceptions of health of the older people and their use of healthcare services.

STUDY CONTEXTS

BANGLADESH

In Bangladesh, the PHILL study sites are located in four villages (Ashikati, Damokergaon, Kumardugi and Mandari), in two unions (Ashikati and Shahmahmudpur), under Chandpur Sadar thana in the Chandpur district. In these areas lived approximately 600 older persons.

Chandpur district is situated on the bank of 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 largest water port and transport point (known as *ghat*) due to its strategic river location between Dhaka and the southern part of Bangladesh including Barishal, Pirojpur, Jhalkathi 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 them 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 come 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 the area. The confluence of the two gigantic rivers, the Padma and the Meghna, creates one of the worst 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, and abrupt shift in the rivers, in 2003, they flooded over an acre of land with shops, part of the market, and railway tracks, raising grave concern among the local residents and authorities. Subsequent measures have been taken to control the erosion process, and some progress has been achieved, according to local citizens. - During the intervention period, in June to August 2004, the area experienced a devastating flood. The BRAC Medical Team concentrated on helping and giving treatment for older people during this period.

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.

The 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 1980 for landless people. Furthermore, over the last two decades, many women have left their villages to work in the garments factories. Three of the study villages are completely Muslim, and one has a minority population of Hindu residents.

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 the village tube wells, but the water is drunk regardless. Sanitation is good in the study villages and most of the people have and use sanitary latrines.

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. They sell medicine and 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, ECG's etc. Three medical doctors (MBBS) attend to patients in Baburhat Bazar. In Chandkhar 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 the local people, the number of *kabiraz* (local ayurvedic healthcare providers) has decreased significantly due to lack of transmission of this indigenous medical knowledge to new generations.

There are two government hospitals in Paikasta and Kanyanpur unions. Besides, a BRAC hospital, Sushastha, was built five years ago. Every union has a union health and family welfare centre and several private medical centres, and a 250-bed government hospital and medical centres offer a range of diagnostic facilities and prescriptions from specialized doctors who come from as far as Dhaka to visit patients on certain days of the week. Local shopkeepers also buy essential medicine from the drugstores for re-sale 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 high.

The consultation fees of MBBS doctors are around Tk 200¹ per visit and about Tk 300 for specialist physicians. BRAC hospitals charges Tk 20, while government hospitals provide free consultation and a limited number of medicine. Local medical shops provide medicine without any consultation fees, as long as they recognize the symptoms to be treated. The *kabiraz*, on the other hand, accept payment with a cock, rice or paddy, coconuts, eggs, oils, fruits, clothes as well as money. Although the number of *kabiraz* is now highly reduced, these payment practices still exist.

VIETNAM

Chi Linh is an area of about 300.5 km² in a mountainous district of Haiduong province. The population of Chi Linh is 142 278 inhabitants. The majority of the population in Chi Linh belong to Kinh people, but there lives also people belonging to ethnic groups of Sandiu, Hoa,

¹ US\$= Taka 60 during study period

H'mong, Tay, Khmer and Nung, living in 17 different communes and 3 towns, mostly in mountain areas. This makes the cultural characteristics of the district to be diversified.

Chi Linh is an agricultural district with over 9 000 ha (if this is some sort of unit please give an explanation) of land for growing rice, cereals and vegetables and 14 200 ha of hill-land for growing fruits, whereof litchi and longan are the fruits that are the most income-earners. The growing up of these two fruits has improved the economic status of people in Chi Linh during the last 10 years.

All communes of the Chi Linh district have been supplied with electricity. Most of the people have also access to different media resources such as local speaker, radio, TV with a FM-broadcaster and TV-transfer unit in the centre of the district, which gives good possibilities to access information.

In Chi Linh district the traffic system is generally well-functioning, but there are parts in the mountain areas where the road quality is bad. The central areas with passing highways are more crowded.

Commune People Committee (CPC) is the highest local organization of local authority at the commune level. Under CPC, there are different organizations and associations, such as Women Union, Peasant Association, Red Cross Association, Veteran Association, and the Older People Association. The Older People Association has played an important role in maintaining political and social status of older people, and has given a lot of contributions to different activities in the community.

There are diversified healthcare services in the district that includes both public (district hospital, Inter-communal Polyclinic center and CHSs) and private sectors (private clinic, traditional practitioners...). The public healthcare system includes one district hospital, one inter-communal polyclinic centre and 20 commune health stations (CHS). In these settings, there are 150 staff members, including specialised doctors (2 pediatricians, 1 obstetrician and 2 in public health doctors). Moreover, at the CHS, there are 25 general doctors, 30 administrators, 80 health workers and 224 village health workers.

All of the 20 commune health stations are supplied with good infrastructure and most of them are located at the centre of the commune, which eases the access to the services of the commune health stations. There is staff available 24 hours a day. The CHSs have health record books of patients. These health record books document information about their health status, diagnosis and treatment regimes. In addition, there is a board to monitor pregnant women and the fetus in every CHS.

The district pharmaceutical agency provides medicine for the CHSs and they reimburse the costs to the district pharmaceutical agency once a month. Most of the CHSs have trained staff responsible for drug management.

Village health workers are mainly responsible for implementing disease prevention activities. They have medicines for treatment of common health problems among the people living in the village. Earlier, these medicines were funded by the public health facilities but nowadays there is no funding for the village health workers' medicinal store.

THE AIMS OF THE STUDY

This study will consider indicators relating to access to primary healthcare of older people, their satisfaction with primary healthcare services (PHC), the range of old age relevant PHC services provided and the relationships between PHC and quality of life. The purpose of the study is to describe perceptive and cognitive aspects relating in health of old people in Bangladesh and Vietnam, including aspects related to quality of life. The study will also examine the healthcare related outcomes of the interventions provided.

Research objectives:

- To identify perceptions of what is regarded as quality of life and the factors that influence older people's quality of life in Bangladesh and Vietnam.
- To explore perceptions of older people's health and risk factors for their health in Bangladesh and Vietnam.
- To explore the life style of older people in Bangladesh and Vietnam.
- To investigate the experiences and attitudes related in caring for the older people within family and the community in Bangladesh and Vietnam.
- To investigate older people's health needs, availability of healthcare services and determinants that influences healthcare seeking behaviours in Bangladesh and Vietnam.
- To explore expectations with regard to healthcare for the older people in Bangladesh and Vietnam.
- To compare results between pre- and post-intervention in order to evaluate intervention outcomes as perceived by the older people in these countries.

INTERVENTIONS

BANGLADESH

A total of 622 older people, 467 caregivers and 53 caregivers were undertaken in the project. All the caregivers were from elderly household.

Educational interventions directed to those providing care for older people

The interventions started in October 2003 after a *training-the-trainees* programme in ageing issues was conducted. The participants were recruited among the resource persons in Ageing Resource Centre Bangladesh (ARC-B). These trainees were then used as *community organizers*. To start with, they made home visits to all the elderly households in the intervention area during one week, discussing aspects related to older people's health and social life both with the older people themselves and their family members. They also did counselling, referred the sick older persons to the healthcare centres and organized training contacts, workshops etc. Thereafter, they regularly visited the elderly households during the intervention period.

PHILL also offered training for healthcare providers in issues related to older people's health, such as knowledge and skills on health, nutrition and emotional needs as well as about the management of common health problems in old age. In total, 65 healthcare providers, including pharmacists, paramedics, MBBS, FWV, FWA, health assistants, Allopathic medicine sellers, homeopathic, *kabiraz* and traditional healers were trained by a resource person from BRAC's health programme. A refresher training group was offered one year later.

Two trained community organizers conducted *training sessions for caregivers and adolescents*. In total 251 adolescents and 273 family caregivers were trained in skills and knowledge in older people's healthcare and in their nutritional and emotional needs.

Training the older people

A *Health Card* was introduced and distributed to 598 older people November 2003. These cards were used to keep record on day-to-day health status. Literate family members, neighbours and sometimes the older people themselves recorded their health status on these cards. Community organizers followed up the documentation during their regular visits at the elderly households. They also advised the family members and the older people in issues of noted illnesses. During the intervention period, in total 10 older persons and 21 adolescents from elderly households were rewarded for the best performance in keeping the health cards up-to-date. In addition, 12 family caregivers were rewarded for looking after their elders properly and regularly.

The Community organizers also launched and held in *Bari meetings*, where older people, their family members and adolescents participated. The aim of these meetings was to build up an awareness about issues concerning older people's health and their health related needs. Each of the community organizer was responsible to conduct three *Bari* meetings a week and they were organized in 105 places.

The Community organizers conducted 53 *group meetings*, where members of the village organizations, and union parishad and other indigenous organizations, as well as students,

adolescents and youths were invited, in order to discuss various issues of ageing and older people.

A total of 22 *self-help groups* were formed to improve self-esteem and the status of the older people within the family and in the community. Each of the self-help groups consisted of 10-25 older people. These groups had meetings every fortnight. Preventive and curative aspects of older people's common health and emotional problems were discussed, the participants shared their experiences and sought solutions to these problems in the group. Occasionally, they organized recreational and social activities and/or entertainment. They also had everyday gatherings in some selected places to read newspapers and other health and developmental magazines provided by the PHILL-project. In addition, 56 volunteers were trained up as peer managers on elderly health issues.

The interventions also included one-day *participatory workshops at the office*, focusing on discussing the preventive and basic curative aspects of older people's health management. These workshops also provided information about the availability, accessibility and affordability of different healthcare providers. The workshops were directed to older people, their caregivers, adolescents and in-laws (what is meant here? Which in-laws?). Thirteen (13) *workshops in the field* were directed to volunteers of the self-help groups. Adolescents and family members were also conducted in order to present various social and health issues of aged people. BRAC provided training exercise for rheumatic and gastric problems (what kind of training programme helps with gastric problems?). The health workers of BRAC facilitated older people to move from their house to the BRAC. They provided teaching and training for older people to ease the movements of old people.

Older people were offered *health check-ups* by the medical officer of BRAC* Health Centre. In total 206 older persons health were examined.

Information *brochures, leaflets* and *posters* were also produced in Bangla. A popular theatre team of BRAC produced 20 stage *shows* on issues regarding older people's health, and these were *videotaped* to be used in information meetings. Even a *documentary* on ageing was produced and shown in villages in order to increase awareness on ageing issues.

VIETNAM

The aim of the intervention activities was to improve the health status of the older people and to improve family members' and community members' awareness of issues related to healthcare for older people, in order to improve the quality of life of the older people. With this aim, different intervention activities were provided for different target groups in the community, including healthcare providers, social organizations, community leaders, household members, and older people themselves.

Educational programs for care providers and family caregivers

Training courses were given to healthcare providers in district health centres and commune health stations. The purpose of this course was to provide knowledge on healthcare for the older people with focus on common health problems and conditions among the older population, i.e. hypertension and joint pain.

Training courses were also organized for family caregivers in order to improve their awareness and knowledge regarding issues on old age health. For community leaders and other social organizations, seminars/meetings were organized to improve awareness on healthcare for the older people in the communities.

Interventions directed for older people

Health check ups for the older people were provided for 423 persons in the study area. In addition, training courses for elderly people were given to the older people in order to provide basic knowledge on healthcare for both common and specific health problems, including how to prevent diseases.

A health monitoring sheet for households about older people was provided. This sheet was developed and introduced to 467 elderly persons in the two intervention communes. Completed sheets were collected monthly. Leaflets with information for preventive care in general were developed and distributed for every older person in the intervention area. Relevant materials related to the older people's health (books, magazines, newspapers) were also provided to strengthen the libraries for the older people in the village elderly clubs.

465 older people were involved in intervention activities that were carried out within a period of 15 months.

METHODS

In both countries the qualitative study was conducted both pre- and post-intervention by focus group and individual interviews with older people themselves, main family caregivers and healthcare providers.

SAMPLING AND DATA COLLECTION IN BANGLADESH

The data were obtained from the 60 years old and older people, their caregivers and healthcare in the study area. The respondents were surveyed before the intervention period and after it.

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 respondent's sex, age and socioeconomic status. The researchers also took advantage of interviewing opportunities that arose in the course of field work.

In the pre-intervention study, data were collected from 71 elderly, 11 caregivers and 8 healthcare providers. In the post-intervention study 60 elderly, 20 caregivers and 10 healthcare providers were interviewed.

A multi-method data collection strategy was devised. Data were collected in order to enlighten both cognitive and experiential aspects of health and old age. The cognitive part investigated perceptions of health and quality of life, health competences and coping strategies and perceived causes of illnesses while the experiential part investigated the older people's use of healthcare services, home remedies, caring patterns, social functioning, intra-household relationships, daily routines and expectations on elderly care.

A free listing technique was carried out to investigate illnesses among older people prevailing in the study area and healthcare providers practicing in the area. A Matrix technique was applied to find out the pathway of choices of healthcare providers and health-seeking behaviour of elderly.

Pre-intervention

In the first round of data collection a total of 19 in-depth interviews and 12 FGDs were conducted. All of the interviews were audiotaped, and transcribed on the same day. In the second round qualitative data collection a total of 40 in-depth interviews with 5-6 persons in each, 20 free listing and 20 matrix interviews were conducted with the elderly people. Each interview took between 20 to 40 minutes. Both the physical and mental capacities of the older participants were taken into consideration in the selection of respondents. Data were collected during February to November 2003.

Post-intervention

The respondents who were earlier interviewed were given priority. Some prior respondents from the pre-intervention period could not be interviewed due to death and migration from the study villages. In that case, new respondents were selected purposively for interview. A total of 40 in-depth interviews and 6 FGD, with 5-6 persons in each, were conducted with older people

and their caregivers. Even 20 free listing and 20 matrix interviews were conducted with the elderly.

Four research assistants (of them 3 graduated in anthropology) who had prior experience on qualitative research were employed to carry out data collection and compiling the data. They were given three days training by senior researchers before working in the field. The checklists of in-depth interview and FGD were also reviewed before finalizing. Field notes were transcribed on the same day. In very few cases (3) research assistants arranged multi-sessions with the respondents to follow-up the interviews. Each interview took 20- 55 minutes to complete. Data were collected during 24 June to 10 July, 2005.

SAMPLING AND DATA COLLECTION IN VIETNAM

In Vietnam, the study was conducted in four communes in Chi Linh district, Hai Duong province. Two communes were selected as intervention communes.

Respondents in the qualitative study were purposively selected. The selection of respondents for FGD was based on a number of identified criteria for different target groups. For the older people, the criteria included sex, age group, economic status, living with family members or without and having good cognitive ability. For caregivers, issues such as sex, occupation, economic status were taken into account when selecting respondents for FGD.

The data was collected by 10 individual in-depth interviews, where of six with the older people, two with main family caregivers and two with healthcare providers. Additionally, 18 focus group interviews with 5-8 persons in each were conducted. Of the focus group interviews, 12 were conducted with older people, 4 with main family caregivers and 2 with community leaders and social organizations/associations. The focus groups were conducted separately with the older people and the family caregivers both before and after the interventions. However, the selected target groups were different at the two phases of data collection..

All the interviews were tape-recorded, and notes were taken down during the interview to supplement the information and in order to collect even the non-verbal information. In addition, ranking techniques were used to identify the most common health problems in the study areas.

The data was collected by four senior researchers of HSPI who were knowledgeable and experienced on qualitative data methods.

DATA ANALYSIS

The analysis was conducted in a similar way in both countries. The data was analysed by using qualitative and quantitative content analysis (Morgan 1993; Sandelowski 2001). The pre-intervention and post-intervention material was first analyzed separately. The analysis process was conducted in several steps: 1) The transcripts were coded according to the areas in the research questions; 2) Each question area was coded and then categorized separately and the occurrence of different codes and categories were counted in order to explore the commonness of each code; 3) The post-intervention categories were thereafter compared with pre-intervention data, in order to explore similarities and differences in the experiences.

The results are presented in descriptive manner and quotes are used to illuminate the respondents' own descriptions and even to verify the findings.

FINDINGS

PERCEPTIONS AND EXPERIENCES OF QUALITY OF LIFE AND FACTORS AFFECTING IT

Bangladesh context

In Bangladesh, and in many other developed countries, the 'body' is the main asset for most of the older people for the possibilities for earning for their living, thus leading even to the financial solvency. Thus, good health is the central determinant of the quality of life. Both before and after the interventions, the aspects related to quality of life were about having good health: "If one is free from diseases, then he can maintain a good quality of life". One family caregiver said:

Quality of life becomes enriched through financial solvency. There would be no happiness, no well-being when there is no income and therefore everything would look dreary.

Financial solvency was, in fact, the most commonly mentioned aspect of quality of life after the intervention, especially among older men, but also among the family caregivers and the healthcare providers. Even the intake of nourishing food was commonly mentioned by older people as one aspect of quality of life:

Good quality of life depends on good intake of food. For this, intake of milk is essential, as it keeps your brain cool all day long. One reason for rheumatics is the inadequate intake of food.

Good social relationships, especially among the family members, were also important for quality of life. The good relationships were expressed among older woman in terms of sharing and caring for each other and not having any squabbles in the family. The good social relationships included also an active role in the family. This meant for the older women doing their share of household work and taking care of other family members, especially grandchildren, and for men the role was predominantly economical.

Most of the older men regarded their life to go on in a comfortable manner, as their economic situation was rather stable, through their own property and the other family members' income. The males also considered that their family provided service to them and there had not been any family disturbances. The older men also considered their health to be good, although they had some diseases. But these were not bothering them too much and they had no problems related to medications. They kept themselves healthy by regular jogging and sufficient food intake:

"I am keeping myself quite well. It is Allah who keeps me happy. Out of my five sons, three are living overseas and the rest of them are here in Bangladesh. Out of the two sons living here, one is a chef, working in a hotel and the other one is a farmer. Together with my daughter-in-laws, we are all living in a mixture of grief and happiness. But in accordance to the relationships amongst the family members, we do not have any problems and therefore I am very pleased with my situation. /--/ Everything is available in the market, there are no clashes or disturbances among the family members. I am quite happy, In sha Allah."

Those few men who had low quality of life had either financial or family problems or they were severely ill: "I am passing my days very well. Whenever my pressure goes up, I feel very nervous. As I have become old, I don't have any income. How can one expect one to be happy without any income".

However, most of the older women were dissatisfied with their quality of life. Reasons for the low quality were mostly family disturbances, sicknesses, lack of attention by their sons and financial solvency. They were unable to eat proper food and could not fulfil their desires because the shortage of resources. As the women participating in the study were mainly from the lower middle class, they were dependant on their sons for the financial support:

My eldest son lives in Saudi Arab. He sends all his money to his father-in-law's house. His wife spends that money. She gives me only 2000 taka. I can't support the family with this amount. It is very difficult to survive without money. I find during my cooking that there is no salt, no oil. Then, naturally I feel depressed. In these circumstances, how can I express that I am well. We (my husband and I) need medicines and for this my second son then has to send us money.

The physical illnesses also caused low quality of life for the older women:

I can't do anything during the long day. My body doesn't permit to do what I used to do before. I move around to my neighbours all day long and then come back to my house and keep lying on the bed.

When the older women were paid attention by their family members, especially by sons, and if they had financial support, then their quality of life was high:

Whenever my son has not seen me (for a while) he eagerly asks me 'Mother, how are you? What was the menu today?' He also asks people to bring mangos to me. In spite of my unwillingness, he still brings mangos for me. I am quite happy with this situation.

Both before and after the intervention, the family caregivers regarded the quality of life to depend on maintaining good mental health and having subsequent medication for various diseases. They regarded the older people's quality of life to be depending on their financial solvency (through the older people's own incomes or support from the family members), establishment of children, maintaining peaceful co-existence and sharing and caring tendency among the family, maintaining a good health and on the insurance of good healthcare services, providing primary healthcare at home through different home remedies, and, if necessary, by the local medical centre facility. Even adequate food intake provides quality of life, according to the family caregivers. The family caregivers also thought that the possibility to religious facilities, such as prayers, was part of the quality of life of older people.

Not surprising, the healthcare providers regarded the quality of life to be dependent on good physical health. Therefore, they thought that the older people should be cared for so that they would not fall sick, and if they became ill, they should be given proper treatments, by regular food intake, regular movements and adequate sleep. The healthcare providers regarded a good diet to be the basis of the good quality of life, but in old age, as the old people are unable to digest proteins, they should avoid them. Food rich with vitamins was regarded to be good for the health of the older people.

The healthcare providers also regarded entertainments and activities to be part of the quality of life in old age, as they were regarded as necessary for the good mental health: "Sources of entertainment could come from the family or outside. If all members of the family could share their feelings with each other, then the family could live peacefully and calm. Even

to join other occasions outside the home can please one.” (I don’t understand what this means. The last part of the previous sentence is not complete and does not make any sense. I suppose BD needs to revise this) Family relationships were regarded to have a great influence on the quality of life, too: “If an old person is in tension, then it can easily be said that he is passing his life in misery. There are a number of old people who always stress about their family. Diseases spread due to the tension. Gradually they lose their desire to eat. Therefore, it is necessary to look after them so that they don’t worry.” The older people were considered to lead of loneliness to great extension, and therefore depressions were regarded to be common.

Even the healthcare providers regarded the financial conditions to have a great impact on the quality of life of the old people.

The Vietnamese context

The concept of quality of life was not familiar for Vietnamese rural older people. Many of the older people reported that so far they had never heard the term ‘quality of life’. One man said:

What is quality of life? The word ‘quality’ is not associated with rural life. We are farmers, which mean we are vulnerable people. Vulnerable people should not talk about quality of life. That belongs to higher social classes.

To overcome this problem, the question was to be re-formulated to be about ‘happiness in life’, as this was what the older people referred to: “I am not sure if I can understand what quality of life is. As for me, quality of life means happy life”.

Good health, ability to work, sleep, worries, happiness, sadness, family, respectfulness, relationships, going to pagoda, economic status and accommodation were by the older people regarded as aspects affecting the happiness in life.

Good health was a major constituent of quality of life. It included both mental and physical well-being and functional ability: “Health is the most important. Physical factor is not as important as health. If we have good health, we can do everything and we can have many things. They all will make us have good quality of life.”

Quality of life and health have a close relationship. If we are ill, our quality of life will be decreased. Even though we have good food to eat, but we don’t want to eat if we are ill. Therefore, good health will bring good quality of life for us.

Mental health was regarded as an important aspect of happy life: “Good quality of life means that we do not have to worry about anything”. Loss of health was equivalent to bad quality of life.

Good living condition and economic status were also mentioned as an influencing factor of quality of life. Good living conditions meant having enough money to pay for daily living, not having to worry about money, having money for saving, enough food to eat and good accommodation. One older man stated:

I think economic is very important factor which influences on the quality of life. If we are very poor, we do not have enough food to eat, that’s why we cannot say that we have good quality of life. If there’s not enough food to maintain our life, how we can think about our quality of life.

Even accommodation was mentioned as a factor influencing possibilities for good quality of life:

Having good living conditions, which means good house, good economic status, enough food to eat; good mental health and happy life, are three things that have positive influences on the quality of life.

Relationship with family members was considered to be very important factor that have influence on the elderly quality of life. All of respondents appreciated the company and emotional support, which their children provided. Good children will make the elderly happier and have better quality of life. Some people mentioned the importance of knowing that there is someone to call on if they have a problem, particularly if their children were living nearby.

Even though we are rich, but if our children are not good, they fight or argue with each other, we cannot have a good quality of life.

I think if children are not good, they will make us unhappy and upset. In that case, we cannot have a good quality of life.

Social participation also influenced the quality of life of the older people. Engagement in activities, which were mentally stimulating, was regarded to be important for the older people's mental health.

When we participate in social activities such as Festival for the Elderly Day, Elderly club... we feel our life is not boring and we are very excited to participate. When I stay at home a whole day, I don't know how to spend the time and I find the day is too long.

Self-confidence with life was indicated by some respondents as a factor that influenced quality of life. For them, the most important aspect leading to good quality of life was that they know how to adapt and cope with different situations. One man explained:

Compared to what was before, there's a big difference in our quality of life and much in it has improved. We feel confident with our life. We know what we should do if we have diseases. We know how to treat light illness and we know when we should go to health facilities to seek treatment. We don't worry about our health because we have better knowledge on how to prevent diseases. We develop strategies how to reach the age of 100 years. So far, we have thought that we can live only to the age of 60 years.

HEALTH IN OLD AGE

Bangladesh

Before the intervention, four aspects were regarded to influence the health in old age: physical ability and strength, food availability, appetite and medicine, vulnerability to certain illnesses and mental peace and happiness.

Ability to walk, move around, lift heavy weights and to do household work was perceived as important aspects of good health in old age by older people. Similarly, the reduced capacity, getting easily tired and feeling too weak to do these things were associated among the older people as aspects of being old. The older people mentioned good physical capacity as an important element of health also after the intervention: "A healthy body means a strong and good-looking body". After the intervention, many of the older people regarded doing a proper work being an aspect both to maintain health and to be part of a healthy lifestyle:

If one is able to work, then he can maintain a healthy life. To engage in proper work means that you have a secure source of income, then you have good food as well.

Food was regarded by the older people to have an important role in improving or reducing health, and was mentioned both before and after the intervention. Adequate supplies of different foods and the quality of the food were seen as determinants of good health. After the intervention, the older people meant that the intake of food is adequate if it is the food the body wants, and adequate food is health:

Whenever people have to work they get hungry and then they have to take food that eventually makes them healthy. This is called health.

However, many of the older people reported losing their appetite, due to loss of teeth or deteriorated digestive system, and thus, their health had reduced due ageing. In this, medicine and vitamin supplements were used to improve appetite, and to improve health in old age. Even different kind of fruits, milk, egg, meat and fish were mentioned to be the basis of a healthy diet.

The older people regarded fruits (i.e. mango, jackfruit, lemon and pineapple), vegetables (i.e. okra and kidney beans) and fish as favourite food, while milk, fruits and vegetables were regarded as nutritious food for old people. They considered that it is important to eat all kinds of food in small amounts. Duck meat, beef, milk, egg and fish with lots of bones and green leaves were avoided when having physical problems, such as falling tooth, high blood pressure, rheumatics, diarrhea and other gastric problems.

Ramadan caused problems for women, as they felt that they could not fast anymore, while men did not feel any problems for fasting: One older woman complained:

This year I couldn't fast. It's very hard to fast, I feel very tired. Gastric problems increase. But, earlier I could fast for the whole period.

The older people told about the increased vulnerability to certain diseases associated with old age. They perceived health in old age to be influenced of declined bodily resistance through the wear-and-tear of the body. They regarded the body to shrink, vision and hearing to degenerate, and thus, the body to be in increased risk for being subjected to rheumatism that limits the mobility, and to other sudden and age-related illnesses that give an increased 'entry' to the weakened body. Besides, certain types of diseases as heart attacks were regarded to be apparent only in old age.

The older people expressed happiness and peace to be the main contributor to good health in old age. They talked about "anxiety-free life" and "having a peace of mind" as important aspects of health.

After the intervention, proper movements, strength of the body, looking fresh and the ability to do one's work were regarded as determinants of good health. The caregivers regarded aspects such as to get up early in the morning, to keep oneself clean and tidy, to engage themselves in light work and to have regular meals and to take medications as crucial in maintaining health among the older people, as regarded by the caregivers. Different kind of addictions, such as chewing tobacco leaves and smoking were regarded as dangerous for the old people's health.

Compared to adult age, the care providers, the family caregivers and the older people themselves regarded the difference in old age health to be the diminishing capacity to prevent diseases. This was regarded to be due to diminishing strength, energy and the capacity of

digesting food. Even memory loss, malfunction of the medicines and lack of cognitive ability were regarded as causes for the worse health in old age, compared to the adult years.

The older people thought that they had suffered less during their adulthood than they did now in their old days. Problems related to urine, stools and eyes were something they had not suffered during the adulthood, but did now.

Before the intervention, the most commonly mentioned illnesses among the older people were eye problems, i.e. cataracts, tooth ache, gastric pain, body pain, fever, weakness, uterine problems, loss of appetite and arthritis. Although several older people reported suffering from high blood pressure, diabetes, accidental falls and/or paralysis, they seldom associated these problems with advanced age.

After the intervention, most of the respondents talked about rheumatism-related diseases, such as rheumatic pain in the joints, body ache, burning sensations and cramps in hands and legs as the common illnesses they suffered from. Another commonly mentioned illness was dizziness, caused by high blood pressure. They also mentioned eye problems, such as watering eyes, deterioration of vision and cataract. Even gastric problems, such as stomach ache or indigestion, belch or eructation and stomach movements after eating were commonly mentioned. They also mentioned fever (or: high body temperature), catching cold, asthma and skin diseases (i.e. ringworm, itching and scabies) being common diseases in the area. Several old people also suffered from insomnia and tiredness and weakness, loss of appetite and feeling bitter tastes. Diabetes, backache, heart problems, diarrhea and dysentery, dental problems and hearing problems were also mentioned. Older women also mentioned uterus problems. The female respondents mentioned gastric problems far more often than male respondents. On the other hand, male respondents suffered more often from loss of appetite, insomnia, diabetes and constipation than the female respondents.

Before the intervention, the causes and sources of ill-health were commonly reported by the older people to have multifaceted reasons, such as individual lifestyles, environmental aspects (weather conditions), and the impact of social and legal events creating psychological pressure in their lives. Old age in itself was also perceived as being intertwined with ill-health. Even the role of destiny was expressed.

The individual lifestyle in younger stages of life was reported being one of the main causes for illnesses in old age, especially among males. Stressful lifestyle in the past, such as travelling much on business and thus not having time to eat and rest properly were attributed to gastric problems in old age:

I used to run a business and I used to travel to X, sometimes all day without rest shower, no food at due times, like taking lunch in the evening... and that is what caused my current illness, doctor said it was dysentery.

Weather and seasonal changes were commonly reported as causing illnesses in old age. The hard and demanding work in the fields under a strong sun was regarded as a cause for many illnesses. In the winter and in the rainy season, the common diseases were cold, flu, fever, body pain and arthritis.

Even mental pressure due to social and legal events, especially the financial problems, was linked with getting ill-health.

There was also a strong emphasis on fatalism. When the reason for illness was not identified, or the health problem was not curable, the older people blamed it to be caused by ill fate. They regarded illness and old age to be necessary partners, nothing to do to avoid.

After the intervention, inadequate (especially fried food) and irregular food intake, lack of rest (especially among women), hard workload, weather, and financial problems were still mentioned as causes for ill-health. However, they also mentioned smoking, intake of drugs and alcohol, lack of exercise and lack of prayers, and bad relationships in the family as causes for illnesses. The family caregivers and the healthcare providers considered the regular intake of food and exercises as the source of health. Some of the healthcare providers thought that if the older people were free from any addictions then they would have better health: "There are a number of older people who are addicted to cigarettes and so on. One should make sure that they no longer smoke." They also regarded the capacity of going to the healthcare providers and thus, getting regular medication, would lead to good health. Even regular sleep, less work burden and less stress were regarded to lead to better health among older people.

Vietnam

Before the intervention, the older people, their family caregivers and the healthcare providers mentioned four key aspects influencing older people's health. They were strength and mobility, mental pleasure, food availability and good healthcare services. After the intervention, five aspects were mentioned. In addition to strength and mobility and mental pleasure and happiness, knowledge on healthcare, good lifestyle and happy family were regarded as important aspects of health in old age.

Strength and mobility were important indicators to assess older people's health. The respondents regarded independence in activities of daily living and being able to do housework as aspects of health in old age. The older people themselves also considered mental pleasure and happiness as important elements. For them, mental pleasure and happiness were elements that referred both to the health in old age and to factors that influence on the old age health. The older people were healthy people if they were happy people: "Pleasure has a positive influence on our health".

Before the intervention, both the elderly and their caregivers reported food availability as an element that influences the health in old age. They regarded the older people to be healthier if they have enough with nutritious food to eat. After the intervention, food availability was no more mentioned by caregivers nor healthcare providers. The older people regarded healthy food to be an important factor influencing health, but:

We now understand that even if we have enough food to eat we may not have a good health because we do not know how to eat healthy food.

For the older people, good healthcare service meant good access to, availability and quality of healthcare service. They meant that for those who have mobility problems, the healthcare should be provided at home. One older man said:

I think availability of healthcare service is not in the health facilities only. I think it should also be available for those who cannot go to health facilities because they cannot move. If healthcare service is available in the health facilities only, I think that is not enough. I do not say this for my own sake, I say this for the sake of the weak older people in my village.

After the intervention, the older people also regarded the knowledge on self-care to be an important factor in having a good health in old age. Several old people mentioned that they did not know what is good for their health, what they should avoid and how they can prevent diseases. They wanted to learn basic knowledge on healthcare for older people.

We can have better health if we have knowledge on healthcare. It is very necessary for us who are farmers and who know nothing about healthcare.

You provide knowledge on how to improve health; we do following what you show us. When we have headache, we take massage and we feel better. After having more knowledge and know how to protect our health, we are not sick very often. We are healthier.

The good lifestyle included regular morning exercise and appropriate regimen of food intake.

The factors that were considered to influence the older people's health were i.e mental pleasure, family, economic status, hard work, the physical environment and lifestyle. However, most of respondents mentioned mental pleasure as the most important factor in avoiding illness:

I think we can have good health if we have good mental health. If children are good, our mental health will be good. If they drink too much and they have bad behaviour with us, we cannot have good health.

You encourage us to be good parents and encourage our children to be good children, all of our family members feel very happy and try to behave to each other in the good way. We feel healthier when we have happy family.

Health needs of aged persons could be different from those of middle-aged persons, because the physiological, functional, structural, mental, emotional characteristics of aged persons were considered to be different from those of middle-aged adults. Being old was not regarded as an illness or disease itself, but as a risk for the occurrence and development chronic and degenerative conditions, as a result of the ageing process. The older people reported several differences between the old age and adult age health. Firstly, the older people were regarded to be in higher risk of getting diseases, especially chronic diseases, compared to the younger age. They also often suffer from several diseases due to weak health status. The duration of suffering from diseases among older people was also regarded to be much longer compared to when they were adult. Besides, the treatment effects were considered to be slower, compared with when they were younger. All of these elements will make the older people more vulnerable to suffer from diseases. The older people also shared a view of the negative circle of getting a disease leading to weaker resistance leading to new disease etc.

The common chronic health problems among the older people were joint-pain, backache, headache, hypertension and insomnia. However, there were gender differences. Backache was more common among the older women than men: "I have terrible backache and I think there are many older women have backache as me. I think it is due to the fact that we all are farmers; we had to work very hard". In contrast, hypertension was a disease, which the older men suffered more often than women.

SOCIAL LIFE AND LIFESTYLE

Bangladesh

Before the intervention, the data reveals that the older people in the study area were involved in a range of spiritual, economy and social functions. The main activity for many older people concerned about maintaining the spiritual well-being. Almost all the older respondents reported that their days were guided by praying five times a day and of reading the Quran. Women

prayed mostly at home and men in the mosque, where they also got the opportunity to meet others, and the visit to the mosque also provided an opportunity to have a little walk.

The older people continued to perform the respective tasks within the household as long as they were physically capable of it. Women did the laundry, cooked and looked after the younger children. When they did not manage the cooking anymore, they still helped by preparing the vegetables and other less physically demanding activities. Men went on with their roles as businessmen, shopkeepers, farmers etc. They did the shopping for the family, worked on the fields and in the homestead by preparing ground, planting, weeding and caring for the livestock. These activities made the older people to feel themselves needed and useful and not being a burden for their families. One older woman said:

Daughters-in-law are doing the main tasks in the family. I just try to help them a little bit, such as when the daily shopping comes, and the daughters-in-law are cutting the fish, I clean them for cooking, or after the dinner, I wash the dishes etc.

After the intervention, this kind of tasks were still the activities the older people were engaged in.

Most of the old people and their family caregivers mentioned religious and social festivals taking place in the villages. Among the religious festivals, there were both Hindu (i.e. *kirtan*, Hindu religious songs, and *Rath Jatra*, chariot journey of a Hindu God) and Islamic (*Quran Khatam*, rituals for the completion reading of the holy Quran and *jamayet*, gathering) festivals. The social festivals were rituals as marriage, *musalmanni* (circumcision of boys), namegiving rituals and familial and social judicial (juries of respected older persons).

The older people said that they liked attending these kinds of gatherings as they are able to meet people and spend time with their relatives and friends. Religious programmes gave them peace in mind and a feeling of rewarding of virtue.

The older people had also large social contacts with their neighbours, relatives and friends. They received frequent visits and made themselves visits to their relatives and neighbours in the extent their physical strength allowed. Women had as their common meeting place the pond, which they used for laundry, prayers, baths and chats. Men had their social forum in shops and at the mosque after the prayers. However, half of the older persons expressed feelings of abandonment and missed the companionship with their family members and neighbours.

Watching TV was also a common activity in the evenings. This was done either at their own homes or at their neighbour's.

After the intervention, the caregivers wished for the training with BRAC to continue as they regarded it to be good for the older people in order to train and maintain this healthy life style. Even religious habits and occasions, such as prayers and fasting, were regarded to increase the quality of life of the old people. Some of the older women said that they took walks in order to keep their body fit.

Many older people complained that the self-reliance groups ceased to exist when the PHILL-project ended. Now they had no place where they could meet and they could not work together in order to organize any facilities for the old people. Where the self-reliance groups continued to exist, and had existed, the older people told that they had learned about the primary health, to exercise for rheumatics and they had practiced exercises and got benefits from the training. Even the economical system of the self-reliance groups' funds had been

beneficial during i.e. the wedding arrangements. Even the caregivers had appreciated these groups:

Since they (the old people) can talk to each other there they feel good. They get enjoyment by chatting during the leisure time. The doctors, medicine and service won't work alone, this is mental feeding. When the old people come home, then you understand this. Both the mind and the body need to be kept well. So, it helps the old people to get better.

Only few older people, mostly male, attended in self-reliant groups after the intervention. Those who did it, made it to learn things and get help to solve problems, and got funding for i.e. daughter's wedding. They also appreciated the exercise as it reduced the rheumatics. These groups for men usually met in the mosque, while the women's groups met at home or in front of the sitting room. The self-reliant groups were regarded by the majority of the old people as non-existing, or that the finances were badly organized:

There are many women who are involved with cooperatives (self-reliance groups), but I am not. Because, those who used to deposit money there to get interest, those also take money and also those who write, they are all sinful. I will live without food but I won't take money from other people.

Vietnam

In the family where the older persons lived with their children, they were usually economically dependent on their children. They were too old to do farming work or to earn money. However, they did household work, such as cooking, cleaning, gardening and were looking after grandchildren. In general, all family members respected the older people. The old people did not make the decisions in family matters as they were financially dependant on their younger generations, but they were guidance and advices givers for their children. Children often consulted their parent's opinion in making decision on important issues. In most cases, they respect their parents' opinions. They had officially the highest position in the family, but in reality this did not always work. Sometimes, children followed their parent's opinions just to please them.

Those old people who live with their spouses were independent of their children. They felt very comfortable as they could live in their own way, they could make their own decisions. However, they had less contacts and communication with their children than those old people who live with their children.

In the community, the elderly are always highly appreciated and respected due to their contributions, experiences, and prestige. The older people often participated in common social events in community such as weddings, funerals and festivals. Before the intervention, the old people were however seldom involved in decision making decision on the community issues. The intervention has changed their role, and now the older people make great contributions in social mobilization in the communities.

Before the intervention, healthcare for the older people came mainly from family members, not from community. In community, activities oriented to older people were quite rare and formalistic. The most common social organization for the elderly was the elderly clubs, but there were few activities. After implementing the intervention, there was a large supply of activities and diversity of the social activities in the community. The activities for the older people that were commonly mentioned were morning exercises, poem club and sport activities. Although those activities existed in some villages even earlier, the number of older

people participated in the Village Elderly Club (VEC) was very limited before the intervention. Only the healthy old people and who had free time were able to participate.

Number of elderly people who participate in VEC has dramatically increased after the intervention. This depends on the older people's increased understanding of the usefulness of participating in social activities on their health. Besides, activities of the VEC are now more diversified for different target groups. Even those who do not have any special capacity can still participate. The VEC also works now in trying to motivate as many older people as possible to participate.

Even family members' awareness on the meaning of activities in old age has improved. They convince their parents and give chance for the elderly to participate in the different social activities in the community. The local authorities also pay more attention on healthcare prevention on older people in terms of providing concrete supports to the VEC:

We feel healthier when we do regular morning exercise; therefore, my children usually encourage me to do that. Earlier, we didn't participate in any social activities such as dancing, singing. We were afraid that our children might think we are not good parents and that they won't support us to participate in such kind of activities. We ourselves also thought that we were too old to join in such kind of activities. Now, our children understand its usefulness and they encourage us to participate since it is good for our health. We feel very confident to participate and we enjoy very much. We actually feel healthier.

CAREGIVING IN FAMILY

Bangladesh

A very strong intergenerational dependency exists in the study area. Thus, the older people were both care providers and care receivers. Older women were the main caregivers for their husbands and they also visited and cared for their immobile older relatives and neighbours. They were also caretakers, as they also received care from their family members, including daughters-in-laws, sons, grandchildren, nephews and close neighbours and friends in the same age as themselves.

The older people, mainly women, took also care of their grandchildren both when they were living in the same household and while living in the same compound. Similarly, the grandchildren often slept with them and helped the older people by i.e. getting water to them during the night. The older people also gave religious education for their grandchildren.

Some of the family caregivers explained that caring for an older person brings fortune to the family and thus, it is beneficial for the family members to care for the elderly. There was also a commonly held perception that the good and respectful behaviour of daughter-in-laws also reflected their original family's reputation in the community.

The family caregivers mentioned preparing and giving food, even feeding, as one of the forms of support they provided for the older people in their family. They also helped the older people with bath, and toilette visits when needed. They could also provide the older people with medicine, and sometimes with massage. The reason for caregiving for older people was the family members' responsibility to care for each other. It is a way of showing respect for the old person. As the old people have declining strength, they need to be provided with adequate food, such as fruits and meat in order to fill "the strength gap", to get more energy. They should also be provided with medical care when they are in need of it.

In one sense to look after the older people is an easy job and in another sense it is a bit hard. We get accustomed with it in our childhood. But whenever I feel tired, it is hard when my grandfather asks me to do a favour by doing his work. Then I feel bored.

The caregiving was learned in the childhood family, by taking care and helping the older members of the family, mostly by their mothers. After the intervention, even the information and training interventions were mentioned as a source for know-how.

Since my childhood I have noticed that the older people used to care and respect the old people in the family. Through observations I have learned the process of giving service. I have gathered experience from the BRAC training, they used to teach about protection and service for the old people's health.

The care giving activity can be difficult as the caregivers felt that they could not do what they felt was needed due to the financial resources available or due to the lack of their own energy and time. There was also wishes of good elderly care services:

If I had the capacity, then I would establish a hospital for the old people where they are free services. Besides, I have the desire to provide the stipend for the older people. As I do not have the financial resources needed I cannot bring my desire to the becoming.

According to the older people, the family caregivers helped them with waking them up for breakfast, lunch and dinner. They received company and got medicines. The family members washed their clothes and bed covers and helped them to dress up after the bath: "My granddaughter changes my clothes. When I could not do the prayer, my daughter-in-law and my granddaughter used to hold me, they also corrected the recitation of the prayer when I could not recite it correctly." Most of the older people were satisfied with the care they received from their family members:

I am very happy for her (wife) performance. I cannot think of life without her. She helps me during my shower. She accompanies me during my visits to the doctors. I do not want anything except the presence of her in my entire life.

Vietnam

A Vietnamese proverb says: "Each tree has its own flower, each family has its own circumstances". There were three different living patterns among the older people in rural Vietnam. Depending on the living pattern, the level and type of care varied from one the elderly to the other.

When the older persons lived with their spouses, the caregiver was usually the spouse. However, for the women, in addition to their husband, even their daughter or daughter-in-law provided them with care, especially in cooking. When living with their children, the main caregiver was usually daughter-in-law or their son. It was commonly reported by the older people that daughter-in-law takes better care of them than a daughter does, because they live close. In contrast, the male caregivers regarded the sons (themselves) to be better caregivers than their wives as they were next-of-kin. Those older people who live alone have usually no caregiver. In case of illness, they received care from their neighbours or relatives.

The older people received some help from their family members in daily living when they needed help in doing hard work, such as farming, building up or repairing house. In case of illness, they received help in basic daily activities, such as bathing, dressing, eating, and toileting. When sick, the older people needed physical care, such as being provided with food and medicine, help in seeking healthcare, and emotional care:

Our parents-in-law live separate from us, but we live very close to each other. When our parents are still healthy, we do not have to take care of them. They can take care of each other. We only take care of them when they are ill. For mild illness, we come and talk to them and bring fruits or some foods for them. If they suffer from severe diseases, we invite doctor to come to give examination and medicines for my parents at home or we take them to hospital in the case if necessary.

The older people complained that they received poor emotional support from their family caregivers. They wanted to have someone to talk with, to share with. The caregivers themselves regarded the provision of physical and medical care as the primary task. However, many caregivers also realized the importance of providing emotional care for the elderly.

Every older person wants their children and grandchildren to be very close to them. They want to receive regular emotional care from their family members. Sometimes we take our mother to go to the pagoda or to go to see her relatives. She is very happy when we do that."

The older people were not completely satisfied with caring from their family members. Although dissatisfied, they felt that they have to accept the situation because they understand that their son/daughter were so busy with household work that they have no time to spend for taking care of their parents. However, after the intervention, the older people were more satisfied with the care provided by family members compared to what they had received before.

With your support in terms of talking with our children about how to take care of us and about our roles in the family and society, our children spend more time in taking care of us, both mentally and physically. We are very happy. Children in the community respect us as well.

HEALTHCARE SERVICES

Bangladesh

Available healthcare services

In Bangladesh, healthcare is mainly provided by governmental and private sector services. In some areas there is also availability to healthcare from non-government organizations.

There are three levels of healthcare services available in the study area. The primary healthcare services include the governmental Family Welfare Centres (FWC), the non-government BRAC health Centre and private healthcare services, including local medicine shops. Besides, the use of different home remedies is common.

On the secondary level, there are governmental the Thana Health Complex, the non-governmental ICDDR'B hospital and private clinics located in the Thana-level town. The tertiary level of healthcare includes the governmental hospitals and private healthcare clinics at the Comilla district town and in the capital city of Dhaka.

In the study area, all the village doctors are RMP trained and there are only a few of the allopathic drug sellers were not trained. The availability of private practitioners is easy, but only few of them have specialised. In the district hospital, there are specialised doctors, apart from the MBBS doctors. All MBBS and specialised doctors are found in the government and private hospitals in Comilla and Dhaka.

Healthcare-seeking behaviours

The health-seeking behaviour among older people included a number of options that depended on the perceptions of health and illness, health competencies and the sense of severity of the current illness stage. In case of illness, the individuals dealt with a complex personal, intra-household and inter-household negotiations and the decision-making process over the physical, financial and social aspects.

In the first instance of any illness the older people, as in any known culture, relied on the layman sector (Helman 1994), where they started to negotiate their physical discomfort and sufferings. They used a wide range of home remedies for treatment, and hoped that these would cure the health problems they were experiencing. In this stage, the older people themselves were the main source of knowledge, and sometimes they even intermediated this knowledge to the younger generations. The younger generation sometimes brought medicine from the local *kabiraj* (local providers of traditional medicine) or from the medicine shop.

If the illness was not cured, and the discomfort mounted and thus affected the older person in his/her ability to work, the formal medical advice was sought. This help-seeking behaviour was initiated either by the patient, a family member, a relative or by a neighbour. In this stage, there were three decisions to make: to decide the particular healthcare provider among the options, who can accompany – that is, has time – the patient to the healthcare provider, and who will pay the expenses for the healthcare advices and treatment costs. The financial aspect is to be the major constrain for the poorer older people to seek healthcare services. There were narratives of how the older people had been forced to sell their poultry, which was their main income, in order to finance their healthcare. A next-of-kin may also offer financial support if the older people themselves did not have cash, or they borrowed money from a neighbour or a relative. This means that in many cases, after the recovery of the illness, the older people have also to recover from the financial effects of the illness.

If the illness was not cured and it became necessary to seek services from the specialised healthcare in a district town or in the capital, new negotiations occurred. For the richer families with better social connections and children living in the towns, the financial and other problems connected to the illness were solvable, but for the poorer people, the costs of medical treatment and hospital stay may lead to capital asset loss, even of agricultural land. In practice, this usually meant that the older person had to refrain from the care.

After the intervention, the older people reported use of all the available service types. Apart from the home remedies, they had contacts with ayurvedic physicians, village doctors, MBBS doctors, NGOs hospital, family healthcare clinics and specialised doctors. They also bought drugs from the local pharmacy.

Home remedies

So called traditional medicine is not incorporated into nor is inclusive within the national healthcare system. However, it is well-known, tolerated and widely practiced, especially in the rural areas along side with the national primary healthcare system based on the allopathic medicine. Here, the term will be used to describe healthcare practices used by the older people, based on their own knowledge or that of the local provider, *kabiraj*, to treat and cure their most common perceived health problems and illnesses. Thus, the term 'traditional medicine' is used synonymously with the term 'home remedies'.

The general pattern was that the older people did not seek formal healthcare services until the illness was severe according to their own definition. Often, the older people just lived with the health problem until a sudden deterioration of the condition occurred:

I had been feeling unwell for a month, but only when I fell and became senseless, then I immediately was taken to the doctor.

The traditional herbal treatments and other home remedies had an important part in the healthcare practices in the villages of this study. Almost all the older respondents used them, as they were the first option in case of illness. First when the suffering got worse or the illness turned out to be a very serious one, the formal allopathic medicine was used. Even then, if and when the severe symptoms vanished or became manageable, the older people returned to this medication. They might even use both the home remedies and allopathic treatments at the same time.

Different species of plants were the most common products used as home remedies. For the most part, these plants were locally available and they were often used alone or in conjunction with allopathic medicine. Some of the medicinal plants were cultivated as garden herbs and used even for cooking. Plant remedies were prepared from a variety of plant parts, from roots, barks, leaves, flowers and fruits, either fresh or dried. Herbal medicine was often applied both internally and externally. Plant juice was drunk and extracts from the boiled parts were derived for use over a longer period:

I do not have a severe rheumatic problem. Once I was suffering from it. Already in my childhood and then later on, I have been able to observe how the use of herbal medicine benefits everybody. My pain is cured whenever I take the juice of the Tek leaf.

Even pastes were prepared from diverse plant parts for external use. Some plants and plant parts were used for specific health problems, while others were more used more generally, i.e. *kalakachu* and *telakachu* (*coccinea cordifolia*) were used for general body pain and arthritis as cooked or as a raw spinach form orally as a plant juice, for cataracts the juice was used as an eye drop and for gastric problems as an orally taken plant juice.

For muscular pain, arthritis and asthma the older people commonly employed massage oils, especially the mustard oil and kerosene oil, which was used either in its own form or as a base to which other plant pastes or spices were added.

Even certain meats that were not regarded as a part of the normal diet, such as frogs, fox and some birds, were consumed as part of treatments. E.g. (male) fox meat was used to treat arthritis either cooked or dried inserted into a banana or in oil. Chemical agents, such as bicarbonate of soda, was used to reduce severe gastric pain, salt and lime as co-products with plants or oils for different kind of problems.

Even water therapies were used, alone or combined with oil therapies. Water therapies were used to cure insomnia, fever, pressure, eye problems, weakness, dysentery and other problems. Cold water was used, i.e. in case of fever: "I used to suffer from fever regularly. Then I used to pour cold water over my head". Warm/hot water was used e.g. for rheumatic.

In addition to the medical/herbal remedies, spiritual techniques were used among the older people. In the simpler form, healer or practitioner read or quietly chanted sacred and holy verse from a religious books and employed even use of holy water, *mantras*, *doda-durud*, *tabij* and *jhar phuk*. Sometimes the healer massaged the ill person with oil while chanting mantras. The particular time of the day and the day of the week are important factors in order to have the best effect of the treatment. In the more complicated forms, the healer sought to create an environmental effect, and even the timing of the treatment became more important. The healer might even provide some form of surgery:

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 the body and blows holy breath. She/he starts from the feet and slowly moves higher up the body, then up to the head. The process continues until the healer feels that all the bad blood has been gathered in the feet. Then she/he cuts the toe open and lets the bad food flow out.

Even after the intervention, the older people still used the home remedies commonly. These were used for primary treatment for i.e. general rheumatic, insomnia, lack of appetite, cold and flu, asthma, constipation, diarrhea, physical weaknesses, waist pain and dysentery. The older people also used resting as a treatment for their illnesses, especially with high blood pressure and weakness.

However, after the intervention, exercise was mentioned as an important home treatment. The older people regarded exercise to help in cases like rheumatic and constipation, in gastric and waist pains. Most of the interviewed older people had participated on the training exercises provided by BRAC:

The lady instructors of BRAC provided us teaching. Now we are doing this exercise in the morning and in the evening. I am now quite fit.

Another woman said:

The female instructor of BRAC advised us to walk in a straight posture. They advised us to walk for our rheumatic disease. They also advised us to wake up early in the morning and to go swimming.

Use of formal healthcare

Respondents reported that the major criterion for choosing the doctor was his/her reputation, especially among males. In this reputation, the doctor's medical training was the key aspect. Besides, after choosing a healthcare provider, the older people preferred to continue to keep this contact, as this healthcare provider then had knowledge about this patient. For women, the doctor's way of encountering the patients was more important, especially if this was the first encounter with the doctor. Even though the treatment was unsuccessful, the patients were satisfied with their doctor if they had shown respect for the patients.

However, the financial concerns played an important role in the choice of the healthcare provider. Flexibility in payment and credit purchases of medicine and services were appreciated. This was one of the reasons why the medicine shops were frequently used, as they sell medicine on credit. The older people also preferred healthcare services with low fees, negotiable fees and the providers who did not press the patients with payment. Even the geographical distance affected the choice of the healthcare provider. The older people preferred healthcare providers closely located and who easily could be called in case of emergencies.

There was also a gender difference in the healthcare seeking decisions. The older men, who had greater possibilities to be mobile by their own, made their healthcare decisions more often by themselves. Women relied on the head of the family or other male members in the family, sometimes even a male neighbour, for their healthcare seeking decisions, as they were dependant on having some male member to accompany them to the healthcare providers. For women, the gender of the service provider was also an important aspect to take into account. Before the intervention, the women preferred female doctors. After the intervention, they did not mention the gender of the healthcare provider anymore. Instead, the healthcare providers reputation increased in importance in choosing the healthcare provider.

The older people expected their sons to transfer them into the specialised doctors and to buy them medicines whenever their health conditions deteriorated. There was also an expectation from the old people that their sons, daughters and daughters-in-law would care for them as they had cared for their children during their childhood.

The interventions did not change the choice of healthcare providers. For problems like body pain, asthma and weaknesses, the village doctors were sought by both men and women, while *kabiraj* (Ayuurvedic physicians) was more often sought by women, especially for the gynelogical problems. However, the use of *kabirajs* was diminishing, because they were not trusted as much as in earlier times.

Eye problems and diabetics often caused a visit to the MBBS doctors or NGO clinics, and to the specialised doctors. These diseases were considered by the older people to be so complex in their nature that they needed a 'proper' treatment, and they were seldom cured by the village doctors:

At first I went to Dr X (the village doctor) for my diabetics. Then, after consultation with my daughter, I have visited Dr. X's chamber, a specialist doctor. Now I am following his advice.

For my high blood pressure, I went to Dr. X at the district hospital. But I was not cured, so, following my children's advice, I went to Dhaka to obtain better treatment from specialised doctors.

If the older people suffered from dysentery, they bought dysentery medicine from the local allopathic drug centres. In case of diarrhea, they could go to the ICDDR in Matlab centre, which was the only hospital they preferred to visit.

The interventions increased the older people's use of the village doctors in case they had problems like high blood pressure, asthma, diabetics or gastric problems. These village doctors were visited because they were often geographically near, they were often relatives, and moreover, their treatments were often cost effective. Village doctors were visited for the illnesses that were not cured by the home remedies:

If the in-house treatment does not fulfil the requirements, then I use to go to Mr. X, the village doctor. He is my childhood friend. That's why I visit him.

Healthcare access

The most severe obstacle for seeking healthcare was financial. As the older member of the household were not income-earners, their health expenses were not regarded as profitable. This was especially true for the poorer households, where the costs for healthcare for older people were often considered exorbitant and could result in the loss of assets, including livestock and poultry. Even in richer households, the costs could burden a household with formal (from a loan institution) or informal (from a friend or relative) loan that has to be paid off over a period of time and thus burdens the household economy.

In addition to this, there was a common perception of the ineffectiveness of medical treatments in older people. It was widely believed both among the older people themselves and among the younger generations that illness and suffering are inevitable in old age and part of the ageing process, and therefore, medicine does not work with old people. This results in that the medical care for older people is not sought or given a priority. Consequently, the older people sought healthcare only in severe stages of the illness.

After the intervention, the older people still regarded the village doctors to have the easiest accessibility, because they did home visits.

Financial problems were still the most commonly mentioned obstacles for the older people for using other healthcare services than the *kabiraj*, local village doctors and medicine shops:

It is very easy to get treatments as a good number of doctors are available at B, but it is difficult to me as I have scarcity of money. My youngest son works in a steel factory and my other son has a grocery shop. Besides, I have problems to move. For all these reasons, I am not able to go to the hospital.

The need of someone to accompany the older women to the services further away from the village, remained to be an obstacle for the older women:

I cannot move far away from my house. As all my sons are busy with their work, they do not have the time to take me to the hospital. Moreover, in consideration to my present financial situation I do not dare to go to the doctors.

These obstacles were pointed out even after the interventions.

Satisfaction with the existing healthcare services

Before the intervention, the older people in this study were mostly satisfied with the healthcare services they had received. After the intervention, most of the older people were dissatisfied with the availability of the healthcare services. In addition to the financial aspects, they meant that the services needed to be better. There was a lack of access to a number of medicines in the medicine shops in their area and the healthcare services were not situated nearby their homes:

Money is needed in all places (clinics, in doctors' chambers and in hospitals). I have the scarcity of money, what can I then do with these available sources of healthcare services? We do not have any hospital nearby our village. Many kinds of medicine are not available to the nearest medicine centre. Moreover, their treatment is not up to the mark.

The older people even complained that the waiting times at the hospitals were long and that the FWC hospitals provided only prescriptions of medicine but not medicines itself.

Most of the interviewed persons expressed their satisfaction regarding the activities provided in the PHILL project. The older people were pleased about the possibility to train and exercise:

The BRAC programme for the old people is a very good initiative. All the components of their training are also very good. They advised us to walk in the straight posture. They emphasised on regular swimming and getting up early in the morning. For the treatment of the waist pain, they suggested special exercise. They also suggested carrying the same weight in both hands whenever the older people are carrying anything from the market. Therefore, more training programme should be introduced, like the BRAC programme.

The caregivers were also satisfied with the training programme. Through the programme they had learned about nutritional values of different food items, how to better serve the older people and a number of suitable exercises for older people.

I like the BRAC programme for older people. They said to introduce water therapy during the fever, to have regular normal food when gastric and not to think while they are taking their meal. They further suggested sleeping in the normal bed because it is a kind of exercise. My Mother-in-law greatly benefited from the training. This training should continue in the future.

Even the healthcare providers regarded this kind of training programme to be good for the older people's health, and wished for the government to introduce the programme.

The initiative that has been taken is a good one and also adequate in its nature. /--/ We are quite happy now that we have been able to get proper health related knowledge, which we lacked previously.

Only few persons expressed negative attitudes against the training programme. Some of the older people complained about the costs for treatments and medicine. There were also healthcare providers who meant that the programme was only a waste of time, as the doctors are not in place all the time and when available, they only give advice, not treatments. Besides, they complained about the outcomes only to be short-time effects:

The initiative that has been taken is a good one, and also adequate in its nature. I think that older people should follow the instructions. But in practice, only 30 percent of them are following the instructions properly and the rest of them are not.

One of the family caregivers said:

"BRAC has suggested a number of things for several times but nothing was improved in our lives. BRAC promised us to do something better for us, but they were unable to keep that promise and therefore our fate is unchanged."

However, most of the respondents meant that it would be good if there were other health service programmes like the BRAC's. There were also wishes about free medicine. The older people also emphasised the need to introduce separate seats for them in the bus and separate lines in the banks and hospitals.

The older women did not expect any help or support outside the family. Men expected to get formal information and social company even outside their family and relatives. It is typical that there were no expectations from the government, as they felt that they did not get any support from others than their close ones:

We don't have any demand or expectation from the government. They don't inquire about us at all. So, we don't want anything new anymore.

However, especially men wished that the societal level would help during sickness, that rich people should arrange some service oriented to older people. Low costs for treatments and financial help with illnesses were wished for:

The government could do something to us. For example, there could be reserved seats in the bus for old people. In hospital there could be separate arrangements for old people. These are the things we want from the government.

Vietnam

Available services

In Vietnam, there are different types of healthcare providers. Public healthcare providers include those who work in the commune health stations or in the villages and operate in the public health facilities. Private healthcare providers include those who work in the CHS but provide healthcare services at home after working hours and as private drug sellers.

Health-seeking behaviours

The choice of different sources of healthcare providers depended on the severity of the health problems. A large number of the respondents indicated that they use herbal or traditional medicines for treatment of common health problems: "We often go to CHS, but firstly, we use some herbal or traditional medicines" or "we often use traditional medicine at home for ailments". These health problems were such as cough, flu, headache, and fever:

We usually buy medicines at private drug sellers to treat common diseases, such as flu, cough. It is more convenient for us because we are too old to walk.

If these did not help, they went to private drug sellers or private practitioners to buy medicines.

There were many potential barriers for older persons to access healthcare services. These included financial barriers, physical barriers (related to problems with mobility and geographical distance), factors related to social attitudes (attitudes of the healthcare providers, to the older people and their families). The lack of possibility to receive healthcare services at home was the main obstacle for making people to use the healthcare services more. Due to this, in the villages where there was a Commune Health Station (CHS), the older people often sought healthcare services at the CHS or invited commune health staff to come to home. In the village far from CHS, people usually went to private practitioners or drug sellers to buy medicines.

Most respondents complained over the distance from home to healthcare facilities. Transportation was a barrier to access healthcare services, especially hospitals. Thus, going to hospital to seek healthcare was not common among the older people.

We have children but they live very far from us. When we are ill and we need to go to health facilities, in fact we cannot go because no one can take us there. There are many people who cannot go to health facilities to seek healthcare because they are too old to walk.

It is very difficult for us to go to hospital because we live very far from hospital and our children cannot drive us there because they are very busy. We also don't want to bother them.

Financial problems were another barrier in access to healthcare services. The rural older people had their income only from agricultural products and thus, they seldom can save money. Without money they could not seek healthcare:

For us, the factor that has much influence on accessibility to healthcare services is lack of money. Sometime we cannot go to hospital because we cannot afford to pay there.

One poor woman said:

*Sometime I wish I would die soon. I often get ill but I have no money to buy drugs.
Nobody looks after me. My life depends on the God. I am very miserable.*

The older people's expectations of the healthcare

The older people and their family members wished for more knowledge of healthcare for the old people so that they themselves had knowledge how to prevent diseases and could realize onset of the diseases. They expected diversified information that was appropriate for different groups of old people, e.g. organizing training courses or getting information through mass media or visual leaflets or by providing information at home for those who cannot participate in groups.

The older people also wished for an implementation of healthcare insurance scheme for old people. They considered it to be necessary to set up routine health check-ups and health monitoring systems for old people. Besides, they meant that the healthcare providers should be regularly trained to improve their knowledge about the issues of older people's health.

The older people wanted also to receive more attention and support from the community and they wanted their family to show them respect and to provide them with good care.

Outcomes of the interventions

Aspects that influenced the quality of life remained almost the same in Bangladesh even after the intervention. A new aspect was added to quality of life: the importance of functioning social relationships. Many of the perceptions of diseases and illnesses, as well as the causes, were mentioned both before and after the intervention, but the old people's perception of ill-health being a fate of old people and that the medicine and treatment does not help older people vanished. The use of home remedies continued to be the main source of healthcare among the older people, but they started to regard even exercise and training as part of the home remedies. They had, however, become more aware of the possibility to counselling about health related aspects and the gender of the healthcare providers was not anymore regarded as an important aspect influencing the choice of the healthcare provider.

After the interventions, the quality of the encounters with the healthcare providers became one of the most important aspects influencing the choice of healthcare provider. In simple health problems, the knowledge about FWC and BRAC hospitals was the main change in the knowledge about available healthcare services. However, the older people became dissatisfied with the availability and quality of the healthcare services provided. They also complained over the scarcity of medicine and that the waiting time had increased. The older people also mentioned the older people's self-help groups as a part of their social life, but many persons were dissatisfied with the continued functioning of these self-help groups.

In a same way, the most aspects relating to health and quality of life stayed the same in Vietnam after the intervention. The interventions increased the older people's knowledge on the needs of healthcare for the older people and the need of self-care in order to have good health in old age. They also increased the older people's knowledge of the importance of the role of self-care related aspects, such as nutritious food, exercise and social aspects in giving strength to resist illnesses and maintain health.

More clearly in Vietnam than in Bangladesh, the intervention has helped the older people to realize and provide social activities, which also increased their satisfaction with their life situation. Even in Bangladesh, those who still attended in self-help groups were satisfied with

these groups and the social and physical activities that were provided. However, only few groups had continued to exist after the intervention period.

In both countries, the barriers of accessing healthcare services stayed almost the same after the interventions, as the inconvenience and obstacles for visiting the healthcare services when there was a long distance to these facilities, the older people had economic difficulties and when they did not want or could not bother their children still remained. In Bangladesh, this caused frustration among the older people, when their knowledge about the services increased.

In both countries, the family caregivers increased their understanding of aspects related to older people's health, and more actively promoted their health. In Vietnam, the interventions also empowered the older people to provide contributions in social mobilization in the whole community.

CONCLUSIONS

Good health, financial solvency and good social relationships were the aspects included for the term quality of life or similar in both countries, although the term 'quality of life' was unfamiliar to the older people in rural Vietnam. In both countries the current quality of life was relatively good, although women in Bangladesh and those in Vietnam who had family problems had a low quality of life.

The older people in Bangladesh and Vietnam considered the old age to be a period in life when they were more vulnerable to diseases due to the ageing process itself. They also considered aspects related to nutrition, mobility and body strength to be risk factors for illness.

The older people's life style was dependent on the family patterns. Most of the older people either managed by themselves or with help of their family members. In Vietnam, there were more old people living alone, making their possibilities to receive help from others more vulnerable. The social life was also largely depending on the nearness to family, but also on the social activities available.

In Bangladesh, there were no changes in old people's experiences and perceptions of family care giving. In Vietnam, the older people were more satisfied with the care received from their family members after the intervention. The children were regarded to spend more time with the older people and showing more respect for them.

In both countries, home remedies were commonly used, mostly different plant products. After the interventions, in Bangladesh, even exercise was mentioned as a common home remedy. Even in Vietnam, the interventions increased understanding of the importance of regular exercise. Financial insolvency and geographical distance were the main obstacles that delayed or hindered the search for professional healthcare providers in both countries.

The study gives new learnings of the health related aspects and living conditions of the older people in rural areas in Bangladesh and in Vietnam. This knowledge hopefully increases the possibility to provide relevant and accessible healthcare for the older people in these, and other similar, areas. The study also points out the need of understanding about the old people's and their family members' perceptions of health related aspects when providing healthcare for these groups. Without an understanding of these aspects from the old people's perspective, the healthcare provision may fail, if it does not start from the experienced needs of the target population.

The study also shows that the provided low-cost interventions had a positive effect on the life conditions of the older people both in Bangladesh and in Vietnam, although the changes were small. The older people and their family members received increased knowledge of self-care activities that were health promoting and maintaining, such as exercise and nutritional aspects, which changed some of their lifestyles in a positive way. The older people also received increased knowledge of the healthcare services available. However, especially in Bangladesh, this resulted in greater dissatisfaction with the existing healthcare services as they were regarded as insufficient.

The study points out the need of continual information on issues of preventive healthcare in old age. It also shows the need for information about the aspects related in older people's health among the healthcare providers.

To conclude, the study shows that the governments should pay more attention on this older age group in terms of healthcare, in order to improve health status of the elderly in general. Medical check-ups were both wished-for and needed in order to inform the older people of their specific conditions, medical and self-help needs in different illness stages. These medical check-ups also provide the healthcare providers knowledge of the general health patterns in these areas. These medical check-ups could be organized by mobile healthcare centres. As the awareness of the PHC increased, the older people became more dissatisfied with the PHCs, probably because the expectations did not correspond to the recourses available for the PHCs. Thus, it is important to increase the availability and access to these centres. A special attention should be placed on older women's access to healthcare. In Bangladesh, the older women were especially vulnerable in their access to healthcare centres, as they also need a male follow them when they visit healthcare centres and hospitals further away from the village. This places pressure on having the healthcare services available in the villages, or as mobile centres.

The self-help groups showed to have an important place in the older people's life as a social meeting place and thus, increased their quality of life. However, the self-help groups showed to be vulnerable for lack of support. In Bangladesh, after the finished support from the PHILL-project, there was seldom a natural continuation of the self-help groups. In Vietnam, where there was already before the intervention organized social clubs for the older people, the support during the PHILL-project helped the older people to 'naturalize' these groups as a part of the village life, and showed to work well even after the intervention. These self-help groups should be naturalized to the preventive healthcare system.

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