CHAPTER VII
HEALTHCARE NEEDS OF ELDERLY:
A COMMUNITY PERSPECTIVE

The health of the elderly is one of the important factors that affects their overall wellbeing. This chapter investigates the needs of the elderly population in lower socio-economic community with regards to health. This chapter aim is to understand the perceived health status, illness and wellbeing among these participants. This chapter also looks at perception of elderly population towards health and level of care provided in community.

7.1 Participant Profile

This section provides a brief glimpse of the 18 research participants’ profile who are dwelling in the Sundar Nagari. This community is the resettlement colony of one of the slums in Delhi. They belong to almost same educational(low) and socio-economic (poor) backgrounds, which will be considered while understanding their perceptions. While presenting their profile, identifiers of age and gender have been used in order to maintain the confidentiality of their identity. The brief account of participants presented in this chapter intends to familiarize with their context, individual developments, varying life course and, choices and decisions made on various spheres of needs mostly impacting their overall health and well-being. The chapter covers a wide array of attributes like educational qualifications, age, marital status, living arrangement, nature of dynamics involved in a relationship with spouses and children, and a way of managing their expenses. The importance of understanding these dynamics is to comprehend the ambience around these participants and their acquaintances that could play an important role in shaping their perception and choices.

Participant I

P1 was a male elderly participant of 79 years old, illiterate and widowed for since 12 years. He got married twice, after the death of his first wife, he married again. The second wife died 12 years before. He got son with his second wife, and with the first wife, he had two daughters. Daughters are married. The P1 reported of being homeless and living alone for the last 10 years.
He revealed that his son is being missing for more than eight years and he is not aware where is he how he is doing, whether alive or dead. He was very restless and hopeless while briefing about his life and his missing son. He is managing his life with the help of Prem Chaya and with the community support. For the shelter in the night, he works in one the factory within the community as security where in return he is being allowed to stay and rest at that place. As a family network, he reported that no one is there whom he can call as the family. He added that he only wishes to know exactly where his son is and after that he would like to die.

Participant II

P2 was elderly widow female participant of 84 years old. P2 disclosed that she been staying with her son, daughter in law and grandchildren. She mentioned that she has two granddaughters and one grandson. She revealed that she got married at a very young age of 12 years. She is widowed for more than 17 years. She is illiterate and availing old age pension. She reported that the place she is living with her son was quite small and less spacious. Therefore, she used to come to Prem Chaya where is avail food also and rest for some time. She also revealed that the house she owned, she gave it to her son as she was uncertain about her life.

Participant III

P3 was a female elderly participant. She is the illiterate married housewife of age 62 years with no pension. She relied on her 64 years old husband who is working in some private factory. She is staying in a house which is on her husband name. About her family, she has two sons, both are married and staying in the same house but all the three couples managing their own life. With minimal or no interference. The participant eldest sons have two children (both are girls) where the elder girl was mentally challenged and stays around with the participant only. Whereas her younger son just got baby.

The participants doing fine and no such issues at the family level, though some minor conflicts with the daughter-in-law. P3 revealed her concern and worries for her mentally challenged granddaughter who is almost 14 years’ old. She disclosed her concern for her granddaughter related to marriage and treatment. She reported that she is being the main caretaker for her grand-daughter since she more attached to her.
Participant IV

P4 was a 69 years old female, a widow for last 26 years. She reported her husband died at a very young age due to a sudden heart attack. She was working in private factory until the age of 60. P4 was availing old age pension but just to spend her time and for some extra income, she is into daily wage kind of work in which she needs to make hangings or hanger for the shops. She has one son and three daughters, all were married. The son staying in the same house where the P4 is staying but no communication and interaction with him and his wife. The son is staying on the first floor where the p4 is staying at ground level. P4 disclosed that her son is not in a good term with his wife, they fight a lot and abused too to each other. He is not behaving well and talking to P4 since he got married. P4 is managing alone her day to day life without expecting or asking any favour from her son. However, if fall very sick, she mentioned that she used to ask some nearby children to get her medicine else she avoids taking any sort of medicine until it is very much needed.

Participant V

P5 was 66 years’ illiterate married female living with her husband and one unmarried daughter and one unmarried son. The daughter is working in private firm and managing the expenses of both the parents. P5 was very upset because of the son who got married and not staying with them, neither visiting or taking any responsibility. P5 and her spouse were completely dependent on the daughter who is currently unmarried. P5 discloses that since both of them are really dependent on her, the daughter also mistreating her and her spouse. She added that her spouse mostly stays out of the house and be around of the peers of his age within the community whereas P5 due to her health complication often stays at home and feel very helpless and alone. She also mentioned that she gave birth to 6 children and today's nobody is really concern about her. The house in which the P5 currently staying is on her spouse name. She was very sad and crying throughout the conversation. Even for food, she relied on her daughter and she was unable to stand for long and cook.

Participant VI

P6 was a married elderly male who is 69 years old. He was a motor mechanic in a locally situated garage in the community. He is a chronic smoker (bidi) and reported to consume half
packet of bidi in one day. He further added that that bidi helps in his constipation and keeps him alert. He is getting old age pension, with the help of which he is managing his and his wife expenses. No support from the son, who is working in private factory and staying in the upper portion of the house, whereas the P6 and his wife are managing in the lower portion which consists one small room with an attached very small bathroom with a narrow entry. He was quiet and calm, not shown any interest to express and describe much. He was carrying the give up and let go attitude with the life. He was emphasizing that nothing can be changed now so one should accept and wait for their end.

Participant VII

P7 was 63 years married female staying with her spouse, one married son, his wife and grandson along with one unmarried daughter. She is illiterate. She found in the caregiving role of her husband who is bad ridden for last two years. Also, her youngest daughter is under treatment of having some neurological conditions. She is staying in a house which is on her husband name. She and her spouse were getting old age pension, most of the amount is spent on the treatment of her spouse. She was very hopeless and tired looking at her husband deteriorating condition in spite of so much effort in getting the better treatment. She used to go Prem Chaya to bring food for herself and her husband but stopped as her son did not like her to get food from outside.

Participant VIII

P8 was a 71 years old married man who is educated up to primary level, staying with her two married sons and three grandchildren along with his spouse. He reported staying in a rented house which has only two rooms with common kitchen. His wife reported having some serious heart conditions which need an operation which they cannot afford. He reported a past history of TB for which he already took the treatment and now he is having no health issues. He was reluctant in discussing anything in detail. He was physically mobile but was looking very weak and coughing continuously throughout the interview. When asked, he mentioned that its normal. Whenever he drinks sugarcane juice, which he a few days back, he coughs like this.
Participant IX

P9 was 69 old married males, illiterate, staying with his spouse and children in his own house. He was completely immobile due to the lower body paralysis. He reported that two years back, he managed to walk using a walking stick, but slowly his conditions deteriorated. While reporting his condition, he was blaming all the nearby tertiary hospital for providing him with the poor treatment expressed that he was in need of hospitalization and care within the hospital setting, but no hospital admitted him. He also added that he got exhausted financially as well as energy wise by roaming around to the hospital. Now he is on a bed and completely immobile. He further added that currently, he was taking the treatment from the local practitioner, which is not solving his problem but not deteriorating it either.

Participant X

P10 was a 71 years old female, a widow since last 6 years. She is illiterate and staying in the house owned by her, which she reported that she gave the house papers to his younger son who is mainly offering him the meal. She has two sons staying in the same house, where the elder son is keeping everything separate. She also reported that the younger is keeping her but not at all concern or caring towards her. She said for namesake she is staying with her son but actually going through a loneliness. She was availing old age pension. She reported multiple health issues along with the difficulty in mobility. She reported none of her son or daughter in law is helping her or accompanying her for treatment and managing everything alone. Occasionally her daughter used to come to see her but the poor conduct of her son with her also refrained her to visit her. She was very upset and negative attitude towards her life and showed no willingness to live more.

Participant XI

P11 was a 77 years old male participant, illiterate and currently married. He was staying with his two sons. One of the sons is pulling rickshaw due to losing his job after demonetization from the private factory. He reported managing all his expenses on his own with the help of the pension without any support from the son. But last, 4-5 months, he is not getting the pension amount and sustaining with the help of her spouse pension. P10 mentioned that both he and his wife used to come to Prem Chaya and used to have food and rest, but from last two months, his wife is not
keeping well and currently she is on the bed most of the time. He mentioned that there is support from his son neither they are concern whether the participant and his wife alive or dead. He staying in the house which is the name of his daughter in law. While exploring, the reason, why he made the house on his daughter in law name, he was not comfortable sharing and gave the adhaar card documentation as a reason. He added that due to the indulgence in alcohol drinking and addiction to other forms of substance abuse, he many times behaved and illtreat them as well as use wrong words against them.

Participant XII

P12 was an illiterate married female of 70 years of age. She reported staying with her husband in the community for past 5 years. Currently staying in a rented house. Before that, she was staying with her son, who stays in nearby locality name Bhajnpura with his own family. The main reason reported for staying away from the son was small house space and some differences with the daughter in law. P12 further described that daughter in law not in favour of keeping them. She was availing old age pension. She reported her husband is not mentally sound and keep roaming around the whole day. She availing food from Prem Chaya, whereas her husband manages with his own. She reported difficulty in cooking food at this age.

Participant XIII:

P13 was 72 years old female widow since last 7-8 years. She is staying with her daughter in law and three grandchildren. Her son also died in road traffic accident 5 years back. She was illiterate and availing old-age pension. She is staying in a rented house of one room kitchen. She is not very expressive and did not show interest in talking in details. She was facing difficulty in hearing. She was not expressive and did not talk much about his living arrangement. She was also not comfortable talking about the conduct of the family with her. She said she likes the environment in the Prem Chaya and therefore she likes to come here.

Participant XIV:

P14 was 71 years old female, attended school till 5th standard. She was deserted since last 8 years. She reported staying with her son and daughter in law. She was looking very sick and with the poor hygienic condition. She was not availing any pension neither have any other source of
income. She reported that she was completely relying on her son. She was speaking very slowly and looking very weak and pale. While talking with her she kept asking the details of any place like Prem Chaya which is open always, where she can go and live. She showed her strong desire not to continue staying with her son and his family. She owns nothing to her name and reported that her husband deserted her and marry some other women. She also mentioned that she often forgets things and she is not having money to get her medicine for sugar (diabetes).

Participant XV:

P15 was a 78 years’ illiterate married male elderly participant, staying with a completely bad ridden spouse. He reported that he and his spouse is managing alone and did not give any details about his family and children. He was found walking with the support of wheelchair by holding it. He owned the house. He was availing old age pension and for food, he reported that he is dependent on the Prem Chaya. He reported except for coming out to get his food, he stays mostly with in-house since his wife could not move and afraid of coming and going out without any urgent reason.

Participant XVI:

P16 was 75 years old male participant, currently married, ailing old age pension. He reported managing all his expense with the help of this pension amount only. He got 3 daughters and three sons, out of them all the three daughters got married and all the three sons were unmarried. He reported the indulgence of the son into substance abuse and much anti-social activity that’s why no one is giving their daughter to his son for marriage. He reported that he is being verbally and mentally abuse from his sons and wife for not able to manage the girls for their son to marry. He also added his intention of leaving everyone behind and escape to some peaceful and religious place like Haridwar.

Participant XVII:

P17 was 70 years old female, a widow since last 6 years, living alone in a house. She reported having poor vision (not able to see from right eye) and difficulty in walking and moving around. She was not availing or getting any pension and surviving mainly through the support of Prem Chaya. She reported that her daughter in law abandoned her when she went to stay with them.
Now she came back to this place and since then managing all alone. No support or security from her son. She further added that in evening she used to ask for food from the community people, otherwise, no one to look after her once the Prem Chaya closed in the evening.

Participant XVIII:

P18, was a female participant, who is 78 years old, an illiterate widow since more than 12 years. She reported living alone but with further conversation, she reported that she has three sons, one is staying upstairs in the same house where she is staying, but like a stranger. The second one is staying away with his family and the younger one is staying in the same community, who is supporting her for morning breakfast and other tasks. But as per the living arrangement, she is living and managing alone with the support of old age pension. She expressed her intense religious belief and talking about the karma. She was positive towards life in spite of lack of family support and other difficulties. However, complaining, again and again, all the physical issues she was going through.

Participant XIV:

P19 was 76 years old male participant, a widow since last 4 years. He is illiterate. He reported mobility issue due to the rod in one of the legs which he got due to the accident he met 5 years ago. For this accident, he got some compensation amount. He said that he has total 8 children, 3 daughters (all of them married) and 5 sons (2 unmarried, 3 married). Out of the three married sons, two were staying separately. Two unmarried sons were in West Bengal and doing some work there. One of the married sons is staying with him, whose wife left him because of his alcohol and substance abuse. She left behind her three daughters and bring along with her youngest son (P17 grandson). P17 manages to marry his one of the granddaughter with the help of that compensation money. Now he has nothing except the old age pension, which he utilizes for household expenses since his son is not earning and contributing anything for his own children.

Participant XX:

P20 was a disserted female of 70 years old, with disability in one of the hand but managed to do all the basic things except cooking. She has three sons. Two were auto divers and eldest one was
into a severe form of substance abuse. She was availing old age pension and staying in a rented house with her eldest son. She reported the misconduct of his elder son and with her other two sons. She reported that her elder son goes to such extremes to get a physical fight and abuse. She was active and helping some of the Prem Chaya trivial tasks like going to the bank and submitting cheques or bringing some document. She was a bidi smoker and reported that she is consuming that for more than 25 years and it now like a food for her.

7.2 Perceived Health, Health Problems and Wellbeing

In the first section of the chapter measuring the health status of the participants from several perspective including their self-perceived health status, health issues they face and the other dimensions affecting their health. This will help us to indicate various health and related problems among the elderly which often go undetected or under reported as well as to identify a few key interventions or health services that would meet these health needs of the elderly.

Findings:

7.2.1 Various Health Aspects while presenting their health perception:

There were various dimensions of health such as physical, functional limitations, coping strategy, sense of wellbeing, altered life styles which were included by the participants while describing their health.

For the purpose of analysis, the following operationally defined dimensions were considered:

i. Any physical dimension, i.e. any reference to disease, illness or medical treatment.

ii. Any functional limitations i.e. any description of functional inabilities/ limitation in mobility was considered to be an aspect of the functional/mobility dimension.

iii. Any description of an attitude towards a current illness/problems or having adapted to its limitations was considered to be an aspect of the coping dimension.

iv. Any description/reference to happiness, content state, satisfaction and feeling of simply ‘feeling good’, or of the nature of support and caring experiences, or other dimensions of housing food, rest, sleep, respect, care need were considered to be part of the wellbeing dimension. Also, references to emotional (mental health) and social wellbeing were included in the wellbeing dimension.
Perceived Health status:

Most participants understood the concept of health as “being healthy” and “free from discomfort”. Participants were asked about their perception on overall health status and to describe it in terms of how they feel about it. Most participants reported poor to very poor health status of the health. Compared to few who reported their health status as fair or just fair.

“Meri sehat thik nai ha bas aise se hi hai..ye bol lo ki 75% kharab ha and 25% bas chal rahe hain. Bahut buri nai bolunga kyunki kam se kam apne pairon par chal toh raha hun, jaise taise bhi..khat par toh nahin pada na” (PI, Male 79 years reported this he was asked to rate his current health status) [Translation: My health is not fine..it is just like that only. You can say that its 75% bad and 25% is so... so I will not say worst.... because at least I am walking on my feet somehow, not confined to a bed]

Some of the participants reported their self-assessed health as “it is sometimes good and sometimes bad”. They neither report it as good or poor category. As per their descriptions, it revealed that they have associated the poor health condition as a natural thing to be happened during old age.

“sehat ka kya is umar mein... kabh thik toh bigad jati hai... ek si nai rehti ab jo bhi karo kuch na kuch laga hi rahe ha is umar mein toh waise hi sharer toot jaya kare kuch bhi karlo upar se ab kya hi karlenge isko acha bnakar kuch din mein toh humne chale hi jana ha” (Female, 79 years) [Translation: What's about health in this age it is fine sometime and sometime it not. It does not remain same. Inspite of any effort, during this age, the physical strength anyway leaves the body. Apart from this what one can achieve by making helath in this stage, in some time we will leave this world].

While exploring the various dimensions, which the participants have included for measuring and report their conditions, it revealed the following aspects:

Dimension of Physical health

Most of the participants while describing their health, included their physical health problems which caused them discomfort or pain on the very first instance. However, there were some participants who had chronic conditions, but it was not reported as the reason for their poor or bad health status. Only few participants reported chronic health conditions as a reasons for their perceived poor health status. In most of the narrations, it was symptomatic problems, mostly pain and discomforts, lack of mobility or body conditions which hinders or make mobility difficult, like poor vision, need to use a walking stick, pain in knee, breathlessness while walking and weakness (kamjoori), which were the most commonly mentioned reasons for their bad health.
“meri sehat bahut hi gandi ha..itna wazan hogaya thyroid ke karan ki ghutna mein itna dard rehta ha. muje chalna firna bahut pareshani hoti hai..” (Female 66 years while describing her health status where she emphasized more on symptomatic complaints which was held main reason for her current health status.) [Translation: My health is very poor. I have put on so much weight because of thyroid. Due to which I have suffering so much pain in knees. I have difficulty in walking and moving around.]

Beti muje sugar ha..na leti dawa..kaun dilayega..yaha bhi na ate main ro-roz..na aya jata akele bhool jaoo galiya kabhi kabhi..bas abhi uthale muje toh bhagwan (Female, 71 years, ) [Translation: daughter. I have diabetes. Who will get for me and I don’t come here often… while coming alone I used to forgot the ways and streets…just god should carry me up now]

Overall elderly people have different perspective towards their own health. Pain related and discomfort giving problems are major cause of ill health reported by them. This also throw light on the fact that health related quality of life varies for elderly population, which is also true for all age group.

**Well-being and Quality of Life**

To get the insight about the well-being and quality of life, the terms were first explained in the easiest way possible without using heavy technical terms; as concepts describing whether a person feels that his/her life is good/satisfactory and the various ways of interpreting it. Therefore, to get the real essence and retained the subjectivity, the participants were asked to describe what things brings or might bring satisfaction, happiness, how is their life, what things are still missing in their life, when they feel satisfied or content and what makes them to feel sad or pity or dissatisfied about their life or existence.

Results revealed that for most of the elderly participants reported support of spouse, access to food, positive social interaction and peace and rest (sleep) were the factors which were desirable and important things for the elderly life to be comfortable. However; poor conduct from the children usually in the form of fights and conflicts, loss of spouse, being left alone and/or neglect by family or children (son) were the most reported descriptions which they associated with their sadness and helpless situation in their lives which were part of a loss of well-being.

The results show a disconnect between the subjective wellbeing and objective health of the participants. Subjective wellbeing is a cumulative of quality of life factors, (which includes support and life styles) in the absence or presence of ill health or problems.
Few participants with good family support particularly from children reported satisfactory life situation even with the presence of chronic or any health condition. Whereas most of the elderly participants reported poor subjective wellbeing mainly because of the ill-treatment and bad conduct with their own children and who were not getting support from their children.

"Main hu meri biwi ha teen chore hai par main apna yehi akar khata hu or biwi apna kuch bana leti ha ghar par par ladke sahi na ha bahut bigade huye ha ladai jhagde kare ha humse paise ko liye agar ab so ye bhi dedunga toh btaoo main kaise ji". (Male, 77 years) [Translation: Me and my wife is there I have three sons but I used to eat here only and my wife cook something for herselt at home. But my sons are not good in conduct. They fight with me for money. if I will give them this money too than tell me how I will survive]

Some of the participants reported who reported their subjective wellbeing as poor mainly because of the physical health conditions which has the direct implication on their activity of the daily living and causing extreme discomfort and pain.

"Main qa santushth hu qa khusg hu arey is halat mein koi apne jidnagi se khus hosakta ha or na toh bhagwan ne itne diye ki iska ilaj karao or thik karalo” (Male 69 years) [Translation: How ican be satisfied or happy with this physical condition, neither god have given me so much money so that I can treat this condition and feel better]

In this finding, the term health, well-being, and Quality of Life were often connected to the participant’s financial position, family network and their physical health conditions which were seen as a collective phenomenon rather than individual and separate experiences.

**Widowhood**

As per the results, the elderly participants who were widowed and living alone or with their children expressed their overall condition as not good or dissatisfactory and sad life situation, however among them, the male window participants were found dealing with this life situation with more emotional strength as compared to the females who were reported emotionally more vulnerable and weak.

While describing the health status, many of the participants reported widowhood as the main reason for their poor conditions especially among the female’s participant. Out of total 20 participants interviewed,11 elderly participants out of which, nine were widowers and 2 were deserted. Out of these 11 participants, 2 were males and 9 were females. Mostly all these elderly reported their health bad or poor and very negative towards the life situation.
“kuch na ha bas jee rahe ha jab...tak chala raha ha hath paire..kar rahe apna gujara..war na kaun karta ha..kaun khilata ha..sehat kya wo toh jayegi ab..par main inke jane ke bad bahut mushkil jheli..naunki kari..par ab umar hogai..bacho ne bhi palla chada..jab stak kama rahi thi poochte the..ab toh..poochne na ate” (Female, 69 years widowed since 26 years). [Translation: Nothing is there. Just living somehow. Till the time our hand and feet is working, I am sustaining. Otherwise who will feed me. health will detoriate only. After my husband’s death, I faced so many difficulties. I worked also but now I am aged...children also get rid of me. Till the time I was earning they used to ask about me.now they won’t even bother to come and see me]

It was reported that widowhood has a very negative impact on their perceived health or quality of life among the female participants who were very old 70(+) whereas the male was found to be coping with the life situation in much better way as compared to their counterparts. Psychologically, women elderly found more vulnerable while expressing their life situation whereas the men were readily accepted their circumstances and coping with it. Few male participants who were widowed reported the acceptance of the loss of spouse and still managing with their children and able to retain their hold on their personal life without being too dependent on their children.

“Humare bache kab ke bhagg gay chod Gaye pta nai bhi na ha kaha ha kaha reh rahe kya kar rahe. par main or wo jab tak the ek dusre ko karte theomain khoob kara apne pati ko fir uski halat bahut bigad .bahut dikhaya fir bhi nai thik hua ,unko gaye aj 6 saal chal raha aur ab mere dhore koi na ha”(Female, 70 years)[Translation: Our children ran away... left us alone don’t know where they are, where they are living, what they are doing.... but till the time I and my husband were there, we used to take care of each other. I did a lot for my husband, then his condition detoriated very much.... consulted at so many places but then his condition not improved. He left me thirteen years ago and now I have no one]

Furthermore, some of the participants seemed to emphasize on the dimensions of ‘having children and spouse’ as one of the most crucial elements that would influence their health positively especially in the phase of old age. However, while expressing their thoughts it was found that they assume the spouse presence as obligatory to retain the health and position of the female elderly. Though they mentioned the expectations from the children(son), they identified the changing family structure and changes in the society as leading to children becoming insensitive towards their parents.

“jab mera pati jinda the. mera bahut khayal rakh.aj main bistar par hu koi poch nai raha..ek aurat ka jindage mein pati ke jane ke bad kuch thik nai rahta..bache bhi nai pochte” (Female, 78 years). [Translation: When my husband was alive he took care of me very well, today I am on bed, nobody is asking me. In women life after husband nothing left as her existence even children wont ask about]
It was found that the adverse impact of widowhood was more among the female participants than the males in this community.

**Functional Limitation and Mobility**

Mostly all the participants reported difficulty in physical mobility but managing their activities by their own. However, some of the participant reported the high degree of physical mobility issue and depending on others for their basic needs as the main reason of their poor health, sadness and dissatisfaction with their life. These were the ones who were completely physically immobile, whereas there were some participants who had partial forms of immobility who were either walking with stick or by holding wheelchair. The ones who were with partial mobility reported that they often slip or lose their balance or hit themselves which often results in minor injury.

“Main bas yehi at hu centre (Premchaya) par mera or mere biwi ke liye khana lene who bhi ye wheelchair ko pakad kar, wo bistar par ha pichle do saalo se pehle ate jab uska sharer thik tha ate thi par ab bilkul bistar par padi ha toh main at ahu mere bhi dekho paire mein ghaav ha par qa karu khana lene at ahu ghar par nai bnapate,baki iske alawa kahi nai nikalna hota itne halat kharab ha gailo ki upar se koi gari se lag wag gai bas main yehi at ahu” (Male, 78 years) [Translation: I only used to come here for taking food for me and my wife. I used till here holding this wheelchair. We both used to come here only when she was able to walk, now she is paralysed for last two years. I don’t come out until its very important. Look at the condition of the road and you know never know any vehicle might hit then]

Also, while expressing the impact of their mobility issues, it was mentioned by few of the participants that they avoid going far until unless it is very urgent for them due to the fear of falling down or being hit by some vehicle. Further description of some of the participants also revealed that the necessity of family support with poor mobility. They expressed that since they have poor family support and care from family, difficulty in mobility adding further challenge for them to sustain their activities in normal manner.

**Financial Hardship**

This was a poor socio-economic community and all the participants had never been into any form of formal job or occupation. Before, all of them were either managed with daily wages or worked into informal sector. The female elderly had been working in informal sectors like domestic worker, in factories etc. Not a single participant reported any source of income they
were having as either interest or savings, rent from assets, or pensions. However, the participants coming in contact with SSCHC, were able to get some old-age entitlements in the form of old-age pensions from the government.

Some of the participants who were availing old age pensions perceived it as a power which provided them with a sense of independence. Most of the participants mentioned that the pensions they are availing is the only source of their own livelihood even if they are staying with their son/family. Among the participants, who were staying with their children, mostly sons, most are managing the expenses of their food on their own or giving some part of their pension to their children for this purpose.

Participants who were having some form of income showed great relief that they were capable of managing their basic needs, even if not completely. At least they perceived themselves as better off compared to those participants who were not having any source of income nor having a family support. The latter were uncertain about the fulfillment of their daily basic needs as well as their health.

"Aisa ha jo meri vridha ki pension ati hai main apna sara khracha utati hun...dava khana pina sab..bahu ko jo ha 500-1000 pakada deti hun ki bhai usko bhi bolne na ho ki mera khana chala raha.." (Female, 72 years) [Translation: It like this I used to manage all my expenses including food medicines everything with my old age pension. And used to hand over 500-1000 to my daughter in law so that he should not say that he is bearing me or keeping me]

**Expectations for dignity, respect and care**

The participants who reported currently staying with children (son) had expectations to be taken care of by them, whereas the care from the spouse is found obligatory. Most of the elderly participants expected their spouse as their primary support and care giver. Due to the increased life expectancy, women were found more vulnerable to lead lives after widowhood than the male elderly. Almost all these participants reported their situation as bad. Either they were alone or they who were living with their children (Son) with whom they felt less cared for and respected. They reported that it was difficult for them to manage everything alone at this age but the children were nowadays insensitive and least bothered.

"kya hogi sehat bas aise hi ha ...kitna karenge is umar mein bache karte hain mar mar kar par wo bhi aise hi horaha ha jab tak unka kaam nikalta ha pooch lete par ek bar sab kuch hone ke bad juthe muth dekhti bhi maru ya jio unhe kuch nai pada..koi rakhna chahta rakhe toh aise kare
It was reported that after spouse, most of the participants have higher expectation with their son. Even though they do have daughters but no one mentioned or described any desired to be taken care by their daughter, nor they considered as it as the daughter’s responsibility. Whereas the participants perceive that the responsibility of care of elderly patents lies on the son, they also perceive that this is changing and the current generation does not treat the parents the way the participants themselves took care of their parents. While presenting their thoughts some of the elderly were comparing their current situation with their parents and relating the same to their own children and commenting on the changing times and culture impacting the conduct of the children towards their parents especially in their old-age.

“Kuch nai ha mera pati toh khud hi pada ha din bhar khaste rehta ha wo kitna karega ab jo ha beta tha achi naukari pakadi thi socha wo karega hum budha budhi ke liye par wo toh alag hogaya ab apne sasural meinrehta ha ab upar se lad ta ghar ke liye ab ye bhi usko dedenge toh qa road par rahenge ladki ha wo kamaraha ha thoda khracha chalrahe ha par wo bhi toh shadi karke chali jayegi fir kya karunge itna sharer kharab ki bache ke liye or wo hi nai kar raha ha, humne bhi kara ha beiti jab main shadi karke aye toh maine kabhi apne saas sasur ko aise na choda..na hi apne ma baap ko humne khoob sewa kari or dekho hume (Female, 66 years)]Translation: My husband himself is in bad condition, all day he used to cough, how much he can do, my son he got a decent job but he left us now staying in his in laws place. Now he used fight with us for this house, If we will give this to him than where we should go and live. On road? My youngest daughter is now managing our expenses but she will also go after marriage. I spoiled my body for the children and see my son left us like this, when I got married I served my in laws with full dedication, even when I was at my house, I did for my own parents and now look at my condition]

Most of the participants reported experienced bad support, poor treatment or bad conduct from their children but had expectations to be cared and respected by their children (son).
Ill-treatment and bad conduct

Abuse or ill treatment seemed to be as a taboo in the community and most of the time its either under reported or there is no report about the abuses or ill treatment in general even though it is alarming situation within the elderly people. But, in this community, participant was vocal about the misconduct and the ill treatment they were confronting or facing. In this study, on asking the question on ill-treatment or day to day discrimination or any other form of mistreatment, some of the participants responded.

“Main rehta hu mera pura pariwar ha biwi ha teen ladke ha bin biyaha hain.par koi kaam ke na bas rikhsha kheechte ha fir jiina kamate ha daru sharab mein uda dete ha.fir mere ko gali bakte ha pasie ke liy..” (Male, 75 years) [Translation: I live with my family, wife, three unmarried son, but it is of no use, my son is pulling rickshaw in day time and whatever he earns, he used that money in drinking alcohol, then daily abusing me for more money] 

Mere ko koi jagah bta de beti jaha par main jakar reh lu mera ghar par na lagta thik na man karta waha rehne ka koi dekh rekh bhi na karta na koi bolne wala mujse ab na kiya jata kuch, or ab meri yaadaash bhi thik nai uspar bhi bahut dikkat karte ha”(Female, 71 years, disserted since 8 years, staying with son and daughter-in law)[Translation: Tell me some place where I can go and live peacefully, I don’t feel like staying with my son, no body actually cares or bother, nobody talks with me, and I am unable to do things for myself. I also have memory issue, because of that also they treating me bad] 

The ill-treatment was reported in various forms by these participants. One of the most common forms was emotional one, materialized either by blackmail or the emotional pressure from the son or daughter in law. There was no physical abuse reported but verbal abuse was reported mostly.

Few of them reported financial abuse from the children with whom they were staying with. It was revealed that they contribute their share in monetary terms in exchange for staying with them. The reasons stated to live in such compromised situation was just to maintain peace and security, or else they feared that it would lead to more fights and conflict between them. Also, it was reported that to live with family even in such conditions were better than living alone in old age.

“Mere bete ke biwi chod gai usko. piche teen ladkiya chod gai chote bache ko sathe legai ha..main jaise taise accident wali paise jo mile the uske badi beti ke shadi karai..bahut kariya..ab bhi kuch kare bas mujse karwaye ye toh sahi baat na ha mere bhi umar ho li ab bhat bari jab pee kar ghar ate hain lada ha chilaye hain buri buri bake hain main na jawab deta na padta usse muh ab mere natin dekhti ha unklo bhi toh delhna ha ” (Male, 76 years)[Translation:
My sons wife left him along with his three daughters. She took his youngest son along with him. I am somehow managed to marry my eldest daughter in law with the compensation I got when I met with an accident. I have done enough for them. My son still expects me to take all his responsibility and spend and he will do nothing. Now I am getting older how much should I do. Many a times he tried to fight with me when he drunk use slangs and abuse but I prefer to ignore rather giving him response, I have to see my grandchildren also.

Few of the participants did not report this situation as negative or as ill-treatment to them. Rather they describe such circumstances as the obvious thing to be faced or suffered when one is old or widowed or alone and you do not own any power or asset.

The various aspects of ill-treatment reported by these participant due to their children indulgence in the various form of substance abuse and poor education and economic condition which causes the situation even worst among the elderly in this community. Both male and females are facing ill-treatment and bad conduct.

7.2.2 Self-reported health problems

The study explored the perceived health problems among elderly in this community. All the participants were asked whether they had any health problems both chronic and acute/symptomatic. If they had any health problems, then they were asked to state the nature of the health problem. Almost every participant reported some health problem or issue. But while reporting the problems (if they are facing more than one), they first reported those conditions which were causing the immediate discomfort to them.

For probing the cause of illness we developed a list with category of disease (chronic) and others health conditions. The interviewer read these out one by one to the participant and they self-reported the ones which they perceived as health problems.

It was noted that until unless the chronic conditions was causing any discomfort or difficulty to the respondent, it was not self-reported. But on asking from the list they would report it.

Overall, it was noted that the Hypertension, Asthma and Diabetes were the chronic conditions which are prevalent and reported by about a one third of the participants. participant reported hypertension (2 males and 4 females), 4 reported Diabetes (Females) and 3 reported Asthma (Females). Among them, only one women reported having heart related condition, for which she
was not sure but mentioned doctor suggested some machine needs to be inserted. The findings indicated that females were reported more chronic conditions than the male participants. It could be due to the reason that male elderly was not very concern to revealed their health problem during the interview and reported fairly well overall situation than the females.

Reported pain mostly in knee and back, and vision problems were most prevalent and reported by almost all the participants. Cough, cold and fever were also reported by some of them, but they have a perception that this will be a routine or seasonal problem and therefore not unusual. Most of the elderly female participants reported weakness and lack of energy as one of the main health concern.

It was also observed that they were well versed with the regular health issues they were facing and the most common chronic illnesses like BP and diabetes, but not beyond this.

There were two elderly female participants and one male participant who reported urinary incontinence or problem in passing urine, but this was not viewed as a health concern. Rather it was again perceived as ‘normal’ or usual thing during ageing or with increased age. The data also revealed that pain, vision disabilities and difficulty in mobility due to pain in knee were the most discussed concerns revealed.

“R: Koi pisab se jodi paresani ya dikat? (Any urine related issues)
P: Na..Na..Koi bimari nai ha waise (No, NO, no such disease)
R: Kabhi khaste cheekte pisaab niklta ho? (Do you pass urine while sneezing and coughing)
P: ha,wo toh hoti ha par maine na lerahi uski koi dawa..wo bache paida karien to bachedani kamjore hojaye kare usi se koi paresani dard nai ha (Yes, it happens but I am not taking any medicine for it, due to delivery, uterus gets weak that’s why it happen, it’s not giving any pain or problem)"

While exploring the health conditions, some of the male elderly reported history of tuberculosis, for which they undergone to treatment and it is recovered. TB reported cases were prevalent in this community and could be highly related with the overcrowded and congested condition of the dwelling area.

As per the discussion with the participant, it was observed that they have their own understanding about some of the health issues. Also it was found that on describing about urinary incontinence, few of the female participants were listening very carefully and raised their queries like whether it is a severe problem, what medication is available for this etc. Though they did not report this as a problem their curiosity about any treatment or medicine for this makes it possible
that some of them had, or it was a problem in peers, but they were embarrassed to revealed such problem.

**Lack of sensitization to mental health problems:**

Out of total participants, 5 participants found reported symptoms of depression. However, none of them had reported depression in response to the list of various chronic health issues that were read to them. It clearly indicated the lack of sensitization and awareness about this issue among the participants.

“Kuch na ha jindagi mein main nai chahta aise jindagi...Na uth pata hu ...khud se na chal pata hu ...nahane laterine sab kuch ki liye apahij hogaya hu ab nai chahta aise rehna bas uthaye bhagwan mujе” (male, 69 years) [Translation: Life is nothing to me now, I don’t want such life ever. I am unable to stand, sit or walk. even not for toilet bathroom. I am handicapped for everything. I don’t want this life anymore god should end my life soon]

“mera koi ghar nai ha..adhe din yaha pada rehta hu yaha logo se has bol lete hu..par cente band hone k bad meri halat kharab hojati ha..bas ek bar bete ka muh dekh tu fir uthale bhahwan mujе” (male , 79 years)[Translation: I am homeless, half day I spend here in the daycare centre after this in the evening my condition worse where to go what to do..just I want to see my son for last time than I would like to die]

“Kaha se khao dawa beti..koi jagah ha kya jaha par muje rakh le..main na rehna chati udhar bete bahu k sath pati bhi chod gaya itne bimariya lag gai or ilaj ke paise nai kabhi kabhi samj hi nai ata kya horaha ha mere sath upar se kisi ko padi nai yaha agai toh kah liya thoda in logo se baat karli warna ghar par lash ki trah padi rehti hu..” (Female, 71 years) [Translation: From where I should take medicine for this, I don’t want to stay with my son and his wife at all, my husband also left me and ran away. I have so many problems but I don’t have money sometime I don’t understand what is happening with me. If I manage to come here, I used to eat little bit, talk to all of them otherwise there keep lying on bed like died body]

“bahut dikkat ha..shareer bhi jawab deraha ha..main padi rehti hu koi pochta nai aakar baihtna nai mere pas dekho main khud aye na tumhare pass chalkar mere ko koi baat nai karne wala main kuch bhi karo bas rona ata ha or kuch jee nai karta aise bahar khat bichaye huyi ha ate jate bhi koi nai baithta akar thoda der.wo toh chale gaye muj bhi uthaye bhagwan” (female, 71 years)[Translation: I lots of problem, now my body is also giving up, no body ask me how m feeling or going through. When I saw, I came to you no body is there to talk or listen to me whatever I am doing I just feel like crying see now also. I used to lie down at the entrance of my house than also nobody asked or come and sit with me for a while. He passed away, god should call me soon as well]

“Mera koi karne wala nai..ha mera beta bhi chod gaya..ek bar nai dekhne aya..aakh se nai dikhta..ne meri pension bandhi..muje bilkul acha nai lagta bilkul nai beti bas ab bhagwan ke bulane ko intezar karrahi hu...” (Female 74 years)[Translation: I don’t have anyone who will do for me, my son also left me.Not a single time he came back to see my situation. I cannot see
properly. And I am not getting the pension also there is some issue in the papers. I not at all feel good, I am just waiting for my end]

Also found that there was a participant who was not coming to the center regularly. The care taker informed that the participant used to forget the way to the center and might have cognition or memory related problem. Also the participant reported diabetes for which she could not afford the medicine and staying with son and daughter-in-law. On exploring more, it was reported by the participant as:

"main bhool jate hu. kabhi lagta ha mera dimag ruk gaya. Agar jo yaha aqi toh ye log kuch baat cheet karlete hain warna toh ghar par kone par padi rahi koi dekhne tak nai ata baat kit oh chod hi or mere se jada baat bhi nai hoti par jo ha ruk sa jata ha dimag kabhi kabhi pehle kam hua karti thi ab jada bholne lage hu main (Female, 71 years)."[Translation: I used to forget, sometime it feel like my brain has stopped working. If I used to come here (Prem Chaya), I talk with these people, otherwise at home I stayed on my bed in the corner and nobody bother to talk or ask me. Anyways I could not able to talk much but sometimes I feel my brain has stopped working. Previously it happens very rarely, but now I used to forget things very often]  

She was continuously asking me about the place where she can go and live and was giving obvious expression that she was not at all comfortable and feeling ignored and left out where she was currently staying. There were no direct complaints of ill-treatment with her but looking at her condition, it looked like she has not changed her dress for long time and not even combed her hair. Her lips were scaly and she was looking all pale and weak. She was very sad and sounded hopeless throughout the interview. There were some bruises noticed in her hands and forehead. When asked about that she said nothing and did not comment on why and how it happened. She was repeatedly asking about the place where she can go and stay.

More than half of the participants reported being very lonely mainly due to the loss of spouse and due to living alone without any family support or network. There were different reasons quoted by the elderly for their loneliness feelings such as not living with children or death of spouses or single because of desertion and neglect, or insensitive behavior of the children. The participants reported that the social interaction of the day care center was the only way to deal with loneliness, at least for some time and they prefer to be around with people rather being alone.

Ghar par pade pade kya karunge toh yaha ajati hukam se kam yahan par hum umar log hain ...kuch batein karte hathoda aram karte ha.man halka hojaye. warna toh akele main kat ta ha (Female, 78 years)[Translation: What I will do at my home, so I used to come here, at least here I meet and all these my age people and rest for some time , I feel stress free otherwise alone at home is so bad feeling]
7.2.3 Coping strategy to deal health conditions

Acceptance as natural process
The results revealed that, in general, the elderly respondents from this community who were interviewed, consider that the optimal coping strategy is that they adapt to or accept the conditions or situation as it appears. It was expressed in their interviews that any type of vulnerability is obvious at this age. This outlook persisted for both the physical health and other problems they were facing or encountering. Most of the elderly participants express that since they are ageing, some or the other form of illness or problem can catch up with them at any time. Also, some of them stated that they lose all the power and authority they had on their children and physical aging old makes their situation more vulnerable.

“budhape mein jada dawa shawa ke chakkar mein nai padna..budhape ki dikat mein koi dawa kaam nai ate” (Male, 69 years, with chronic coughing). [Translation: In old age, one should have too much medication, I don’t start taking medicines for such problem happening to me I have realized, no medicines will work in old age]

“Budhape mein kuch na kuch laga hi rahta ha bache bhi nai karte ab [ female, 70 years) [In old age, some or the other things will keep on happening, children are also not doing

Comparing their condition with others
Comparisons of their health with other peers was very prevalent among the participants. While reporting their health or other life situations, they keep referring to the health condition of the other peers in the community. The comparison was mostly on the “not so good condition like other” direction and very few for “better than others”

“aise hi sabke halat. unka bhi nai ha koi..akele rehti ha muj oro wali dikat na ha pariwar ki mje..main yaha aoo kyunki meri juggi choti ha is wajah se. or inki dekho bichare ka beta bhi na milrahe biwi bhi na rahet bahut pareshani ha inko..(Female, 84 years)[No, no I am in better position, My son, daughter in law all are good, I don’t have problem like others are facing with their son and daughter in law, I used to come here because my house is very small. Otherwise look at him he neither his son nor wife, he is much bigger problem and issues]

Most of the participants were having almost similar life situations in this community. They rationalizing their situations which helps them to get adjusted with the existing situation
7.2.4 Summary

The understanding of health among the participants provides the insight how they describe and understand their health state. Most of the elderly reported their overall health status as bad or poor and some of them reported it fair. While further exploration to understand the dynamics how the participants were reporting their health as fair or poor, the findings indicated various important dimensions, related to both physical and other life situations they were living with.

The physical dimension of health has, traditionally, been viewed as being the core of self-assessed health, and in this study too this dimension proved to be a central factor in the self-assessment of the health among the elderly participants. Nevertheless, when assessing their own health in totality, the participants considered various dimension to describe their health. It included emotional and social wellbeing and quality of life related factors- such as family and social support, subjective satisfaction, happiness, loneliness, ill-treatment along with the physical dimension of their health.

The findings indicated the disconnected between the subjective wellbeing and objective state of health. Few of the participate with better family support revealed better state of wellbeing in spite of suffering from any health conditions, where among most of the participants who were suffering with health conditions but mainly reported their poor life situation as the main reason of the poor state of wellbeing and quality of life.

All these reporting clearly indicated health is not just a matter of physical ailments but a multidimensional concept and in such marginalized community, the social aspect of health need takes precedent over the medical aspect of health needs.

While reporting their health problems, on the very first instance, participants were reporting the conditions and problems which were causing them discomfort and troubling in their basic activity. Generalized body pain, pain in back and knees and vision related problems were the most reported conditions among these participants, followed by vision related problems and cough cold and fever which they considered as the effect of seasonal change. Apart from the, among female participants, most of them reported weakness and lack of energy as one of their main concern of their health.

One third of the elderly reported having chronic health condition. Female participant reported more chronic conditions as compared to male. Chronic conditions were reported as primary
causes of ill-health only when they were facing discomfort due to the chronic problem at that point of time. Otherwise it required probing with specific questions related to each chronic illness. Also, some of the age related health conditions like urinary incontinence were not considered as health problem, being perceived as part of the natural process of ageing.

Most importantly, in this community, it was found that there was a lack of sensitivity and awareness about the various mental health conditions like depression. No respondent had self-reported depression, but probing with specific questions using the depression scale uncovers it in 5 of the participants. Out of this, 2 were males and 3 were female’s elderly.

The findings of the ill-treatment suggested that the elderly in the community were facing the bad conduct and ill-treatment from their own children. There was no physical abuse reported, but other forms like verbal abuse, emotional abuse as well as financial abuse were reported. The intensity of the ill-treatment gets worsen due to the indulgence of the elderly children in various form of substance abuse and no secure income source. This further worsen the overall wellbeing the elderly in this community.

Among these partipnats for rationalizing their situation, they reported some of the coping strategies which mainly included acceptance of their situation as natural and obvious during old age and second by comparing their conditions or situation with the other member within the community who were more worsen and marginalized condition than them.
7.3 Perceived Needs for Care among Elderly

In the second section, exploring and identifying their perceived care needs based on their personal circumstances as well as their community setting. The third section will cover the dimension of the healthcare seeking and various perceived potential barriers to access care by these participants.

Findings

7.3.1 Need of Comforts and Convenience:

Most participants reported that the locale based and distributed health services implemented in the community through this health centre make it easy to avail care which is now within their reach. They reported that for their day to day health problems, they are getting treatment without travelling long distances which is very difficult at this age.

Out of the total participants, some (7/20) who were having chronic diseases reported difficulty in reaching the healthcare point to avail the free medicine. It was mainly due to the fact that medicines for chronic conditions was not available, free of cost at the centre itself and therefore they need to travel to the nearby tertiary care hospital to avail medicine.

The elderly faced many difficulties in accessing care at the tertiary care centre. The most reported reasons were a complex set of processes that involved more expenses, long waiting times and difficulty in travelling alone to the health facility.

"Us parche se (referal letter) se koi koi saholiate na hoti..waha jakar fir line mein logo fir ve log idhar udir bhagate hain..aise toh budha insan mar na jaye..na hosakta akele jane par..ye kisi ko sath nai bheje..or humare koi ha nai..qa kare..toh bas apne private se leaye karein dava"

"(Female, 65 years. Window, astham and Diabetes) [This referral letter is actually of no help, after reaching there again they make us stand in queue, make us run here and there.... like this older person will die only. Its impossible when you are alone.... they don’t send anyone with us, nor I have anyone what to do so I avail care from locally available private centre only]

Also, they reported that though, in these hospitals, there was separate queue for senior citizens, this was only for registration and that too was crowded. For other procedures or processes- at the doctors’ consultation room, at the diagnostics station, for collecting drugs etc., there is no privilege or ease provided to the elderly. Understanding the instructions and moving from one room to the other is quite difficult and tiring for them. It would be way too difficult for the elder
person to seek care or treatment in these hospitals if he/she is alone and has no one to accompany them. It was mentioned very often that if they would have had some person to accompany him/her, it would make the process a bit convenient for them.

“We log dete ha likh kar kagaj mein dikhane ko GTB or general hospital par qa hai ki wahan bhi jane ke bad wo log dus baat bolte hain..jo ki bahut takleef ka kaam ha..ha koi ho humare sath kisi ko toh kuch ho paye warana kaha hum akle dehade bhage waha waha us bheed hbad mein” [female, 78 years] [Translation: These people gave in writing for the referral to GTB or general hospital but even on going there the staffs there say ten different things…. that is very painful. if somebody is there with us that’s a different thing otherwise how we can run here and there alone in such crowded place]

They also mentioned that most of them who have to manage alone due to lack of accompanying person face such a lot of delays and difficulties that they withdraw from care altogether. Also, few of the participants who were in the 70+ cohort added that they are even afraid to take a few steps. This fear is mostly related to falling or slipping due to body imbalance and the weakness associated with ageing,. It is way too difficult for them to travel alone to such hospitals.

“Mere ankh ka operation karana tha main mere do chorehain par samajlo akeli hu main jaise taise pahuchi gtb par waha par bhi ine bheed main akle hu upar se ine bheed mein log kaise bhi chalte ha kaun kab dhakka marde fir toh or lene ke deene..chod diye ab aise hi kaam chala rahe hu main na jati akele” [Female, 70 years, widow since 6 years] [Translation: I need to get my eye surgery done, I have two son but you consider me alone only, somehow I reached gtb hospital but after reaching there I found so much crowd….I was alone…. above that in such a crowded place, people walk careless in hurry. anyone can be hit by any chance; it could have increased my problem further. I have therefore given up the idea, somehow managing things; do not go alone…]

“Aise hi buri halat hoti ha hospital mano pure dilshad garden sema puri..or as pass ke ilake mein log yehi jaya karain waha jakar toh acha khassa jawan admi ki bhi halat kharab hojaye fir toh hum qa hi ha is umar mein toh khoshish yehi rehte ki bina jada janjhath ke agar ilaj horaha ho toh karalo warma toh in asptalo mein jana bahut hi jada dikat ki baat ha ha wo alag baat ha ki koi jan pehachan ho in jagah par warna toh apne ghar baitho or jada takleef na lo nai toh ilaj toh chodo or kuch takleef miljati ha” [Male, 71 years] [Translation: Its already worst condition of these hospitals, entire Dilshad garden and Seema puri and people from other nearby areas go to these two hospitals only….after going there for the treatment, even a young person gets tired ...then how we can expect ease at such place, in this age. Mostly we try to seek care without such difficulties... otherwise going to such hospitals is extremely difficult for us.... that’s a different matter if you have some contacts... otherwise be at home; better be at your place and forget about your treatment, you will land up with more problems]

Easy reach and the convenient process was the main desired reported by these elderly participants in the health care setting.
7.3.2 Age-Friendly Healthcare Provision:

The participants who were visiting the Prem Chaya and availing basic medical care at the SSCHC appreciate not only how competent the health-care personnel were but also how kind and hospitable they were. Answering the probing question regarding the attitude of the staff, most of the participants appreciated the health-care personnel, said similar statements including: good person (bhale)," “examines carefully (ache se dekhte ha),” “talks pleasantly and with respect (has kar baat karte ha ijjat dete hai),” “professional—does his work with sincerity/integrity, (apna kaam imandari se karete hain)” “communicative and listens to us (baat karte ha humari sunte ha),”

However, among these participants, some reported to have chronic conditions for which to avail medicines, they need to visit the nearest tertiary care centre. They report that they never get the entire medicine in one visit. Also, reported the attitude of the staff who distributes medicine often behave rudely and do not provide the clear information on when the medicine will become available. This makes them travelling more than the required.

“Mere BP aur sugar dono dikkat ha..dawai lene ke liya gtb jao nai toh general jao..ek toh itne mushkil ke bad pahucha jata ha waha fir jakar pta chalta ha ye dawa ha ye nai ha..fir bolte bhi nai ache se kab ayegi kab wapas aye bas bol kar bhej dete ha gale saptah pta karo arey bahut lafde ha ab kya pta dava hoti na ha ki dete na ha bhagwan hi jane”[67 years, Male] [Translation: I have BP and sugar, for medicine I either go to GTB or General hospital… it is often very difficult to reach the hospital first, and then I came to know that some medicine is there and some is not there. Nor the staff there talk properly neither inform when we should come when will be the medicine available, they simply say you go and check next week. Its too complex we don’t know what the reality whether medicine actually not there or they did not give us… god knows only]

Also, few of the participants reported an experience of being served unfriendly at the health-care who were community dwellers and once or twice visited the SSCHC. Also, they added that getting services in the SSCHC with rest of the people that includes children, young women, men would make them invest longer time and even tiring process to get the service.

“ye centre mein sabhi jate hain.. koi aisa toh nai hai ki bas budhon ke liye khola ho… ab jo hai woh jawan log hai… ho sake khade ab hume toh takleef hone lage …isse badiya main apna bahar se lun dava ...jab ho dikat mere bas ki na ha ki ghante lagakar dikhaao for dava lo” (Male, 65 years) [Translation: This centre is accessed by all the people in this community it’s not specifically for older people like us, The younger people can wait for longer time but I can’t wait
"I start some uncomfortable, its better I take treatment from outside whenever need, for getting my medicines I can’t bear so much problems and time]"

“Jab Prem Chaya centre shuru kari thi main jaya karte thi...inka khana bhi lekar ate thi fir mere shauhar ko aise lakwa mara toh main unhe dispensay lekar gai..par unne na beji humko 30 hazari..bas idhar GTB ka jake dikhne bola or koi bhi madat na kari” (Female 68 years) [Translation: When just recently this daycare centre was started, I used to go there, I used to bring food for him as well (Spouse). My husband got paralysed and I went to this dispensary along with him to show him to the doctor there but rather sending us to tees hazari (St. Stephen hospital), they simply refer us to GTB, we did not get any sort of help]"

While discussing the needs for care, the most important aspect that was mentioned by almost all the participants was the easy access and empathetic conduct with them by the staff and service providers. Where participants experienced no empathetic conduct and extreme difficulty to access care, it resulted either in irregular treatment or complete withdrawal from the treatment.

“bangali doctor ghar par ajata ha dekhne kabhi bhi bolo usko or achi dawa deta ha sab ache se sunta ha takleef fir dawa likhta ha. udhar toh bas sunte bhi naif fat se ikh dete ha koi bhi dawa..aise thodi hota ha” (Female, 64 years) [Translation: Bangali doctor used to come home if we call him and he used to give good medicine , he listens carefully about the problem, carefully examines and then writes the medicine. There they hardly bother to listen to us ...they were in a hurry for writing some medicine]"

While exploring the participants experience about taking treatment from the centre or facility most participant’s responses were based on the way doctor treated them individually. The descriptions were mostly about their personal interactions, the time they spend, whether they listen to all their issues, and most importantly if they offer any kind of assistance to them in availing the treatment.

Patient Hearing, Attention and period of time given to the elderly patient while consulting is thus considered as important attribute of the quality of care by these participants.

Few of the participants described how not providing much time for the elderly, disrupts the care. Firstly, the doctor remains unaware about the problem or the disease or the discomfort and often provides ineffective medicines. Secondly, the problems of old age are much more complex and thus require more time and listening from the doctor.

“Beta kya hi chahenge ab jo ha doctor ko jo ha humare dhayn se takleef sunni chahiye par jo wo bhi kya kare itne bheed hojati ha ki wo bhi jaldi jaldi niptaye ha mareez par wo jo ha humare
7.3.3 Need of Assistance or Accompanying Person

As discussed in the earlier results the participants stated consequences of being alone and availing the care. More than half of the participants were widowed/deserted and almost all reported very weak family support system except two participants who have fair to good support from their children. The perceived vulnerability of the participants included the consideration of being physically weak and unable to walk or stand by their own, not having children (son) or family support, or living alone or having problems in physical mobility.

“Mera shareer nai chalta ab ye bhi budhi ha koi jawan toh ha nai kaha utati fire mujhe bahut khoshish kari..kisi ne bharti nai karke ilaj nai kiya bas idhar udhar bhagate rahe ab bas main jan nai sakta kime gadiya karu paisa bhi toh hone chaiye ab chod diya main apna bansal ki goliya leraha hu ab bas” (Male 68 years) [Translation: My body is paralysed, and she (spouse) is also old now not a young person, how she will manage me all alone, but she tried as much as possible for her, we went to get admitted for better care for me but no one admitted me rather we roamed from one hospital to another spending so much money on renting cars... I could not travel in bus... after get tired now, I left going to all these hospitals. Now taking medicines from Bansal only]

7.3.4 Need for Free Chronic Medicine at the Nearest Centre

One third of the participants reported one or more chronic condition(s) they were currently suffering from. Most elderly who are dwelling in this community have a poor financial condition and are most often without support. Due to which even if the medicines are available at subsidized rates or available free of cost at the public tertiary hospitals, they are unable to meet this need. The scenario of discontinuation of the medication or irregular compliance was prominently found among these participants. One of the reasons reported was that at the centre (SSCHC), the chronic medicines for B.P and Sugar which was previously available for free were now available at a subsided rate, if they needed it free they had to go to some tertiary government hospitals where these medicines are available for free, but given all the constraints discussed this results in the irregular course of medication.
Among the participants, who reported having more than two ailments, some were prioritising one of the two for buying medicines. It was stated that affording medicines for all the health conditions could be very challenging.

“Muje sugar ha dama ha bp bhi ha. mera wazan bhi itna bad gaya ki chula firna nai jata. mera jo dawa chalaraha ha gb pant se par koi nai ha lane wala..der mahine se nai lerahe hu dawa..dekho meri halat..ab dekho kab jaunge kab dawa milega abhi filhal mein abhi thyroid k hi lerahe hu kitne dawa kharyu kharred kaar main bahut dikat hoti ha” (female, 68 years) [Translation: I have sugar, asthma and BP also,... I put on so much weight because of this I have so much difficulty in moving around. I used to take my medicines from Pant but from last one and a half months, I am not taking medicines, since no one is there, let’s see]

7.3.5 Need of Assistive/Supportive Device

Almost all the participants have vision-related issues not necessarily associated with any disease; rather a result of the ageing process (macular degeneration and cataracts). Some of the participants reported that they have undergone the cataract surgery and also got the glasses. Whereas some reported they were facing difficulty getting the procedure done and could not afford private treatment. While exploring the participants perceived needs for care, most of the participants expressed the needs for aids such as spectacles/eyeglasses and walking sticks. There were few who expressed the need for aids such as dentures and hearing devices.

Ye meri annkh par chilli chad gaye. unne dekhi bole ab operation na hopayega..iss wali se bhi na dikhta bas kaam chalata hu,ab jo hain chasma bhi na dete bole paise lagte hain “(Male, 73 years) [Translation: I have got this coating on my eye, they said now operation is not possible now managing with this other eye only but with this also I cannot see properly. Now they are not even providing eyeglasses, it will cost me only]

7.3.6 Other Perceived Needs:

Food Provision

More than half of these participants are availing services from the Prem Chaya and almost everyone was receiving a daily lunch and tea and snacks during morning and evening. Most participants when asked about their perceived need for care, particularly in context to health care, expressed the importance of food, rest and sleep and comfortable residence. Some of the participants even relate the importance of food and sleep for the good effect of the medicines they are taking. This is not surprising given the socio-economic condition of this community and
their reported poor financial conditions and poor family support systems. But except a few, no other participant explicitly mentioned the crisis of food they are suffering or facing at home, but was very appreciative of the provision of food at this centre. They commented that the food is basically suitable for their health and digestion.

“yaha jo khana hota ha wo kam mirch masala dale hain bilkul sahi banate ha jo humare pachane mein sahi rahta ha or fir wo kahan khakar jada jalan bhi nai hoti pate mein na pate kharab hota asani se pach jaya lare ha” [Male, 75 years] [Translation: The food from here is less spicy that is too good for our digestion and it does not irritates the stomach and digest easily]

They reported no concerns about the quality of nutrition or the balanced diet. Rather they were more appreciative about this provisioning of food, more so in those who were without a spouse and / or living alone. From the responses, it was clear that the elderly perceived food as the cornerstone for not feeling weak and for feeling ‘energy’. They were reported food rationing in terms of the quantity and quality of food available and accessible to them at home and this supplementation was needed.

“Is umar mein khana bahut jaruari ha..isse he shareer chalega or bimariya nai lagengi” [Female, 75 years] [Translation: At this age, food is very important otherwise body will not work and we can catch illness]

Though there was explicit acceptance of the importance of food, they nevertheless provided various reasons of not having food at home and having it here, without directly stating the lack or difficulty of accessing food at their home. Most were not forthcoming on the rationing and lack of access to the home initially and were sensitive to questioning on this- more so in women elderly. Apart from household and economic factors, there were beliefs about the food intake and living alone that determined intake.

There were many coping mechanisms reported - reducing the portion or size of the food or the number of meals etc. Perceived health related issues - like poor digestion and edentulousness (partial or full also limited their food intake.

One elderly couple, who used to come to the centre just to take the food for himself and for his spouse, reported difficulty in making and arranging food at home.

“Na main bas jo yaha khakar jata hu bas wahi fir nai khata ghar jakar..pate ka kya ha jitna doaloge lelega..par is umar mein or hi dikat hojati ha hajma nai le pata’(Male 75 years)
[Translation: No I don’t eat once I eat from her. Stomach will take whatever you put into it but in this age, it creates problem]

“Pehle jati thi centre apna or inka khane lekar ate thi rukti na thi kyu ki ye bistar par ha chal fir nai sakte..fir bacho ko sahi laga bole ki sab bolengi hum na dete khane ko toh for chod di main” (female 68 years) [Translation: I used to go to centre to bring food for myself and for my husband because he was bed ridden. Then my children did not like this and said the rest of the community will think that they are not giving them food…. that’s why I have stop going there]

**Better Housing and Social-gathering Places**

While exploring the healthcare needs, many of these perceived needs that was not directly influential or need for health care rather it is an enabling factor perceived by the elderly people for maintaining good health state. Different aspects such as small space or lack of comfortable housing arrangements were revealed as one of the reasons for coming to this Prem Chaya.

“Main aya aye hu..thoda aram karlu so lo..meri juggi choti or bete bahu bacha rahe ha..toh main aram karan ko yaah ajaya karu” (Male Widower, 75 years) [Translation: I used to come here only, my house is very small, now son and daughter in law is their, their children is also there that’s why I used to come her and rest]

The participants who reported living with their family (spouse and children) expressed that due to very small housing infrastructure and availability or space, they prefer to come the this centre for rest and sleep, however no single participant reported the need for privacy of their married son or daughter in law.

“.ab akele pade pade kya karu..yaha ajatt hu..yehi kha bhi lete hu man kia toh thoda aram kar liya warna insab se baat chit karti par jab fir ghar jati hu wapis bas bekar lagta ha akele pade pade dimag sa dukhi hojata ha..main toh bolu aise jagah or banana chaiye sarkar ko taki hum jaise budhe budhi akar rahe baat karein unko acha lagta ye sab” [female, 75 years] [Transaltion: What should I do being alone at home, I used to come here, I usually eat here only if want I used to rest else I used to talk with the fellow people here but when I use to retun home I feel bad being alone at home, what I suggest government should make more place like this centre for an older people like us so that they come and interact, they feel better]

Some of the participants, who were living alone and living with poor family network expressed the importance of places like day care centre. Most of them reported mental distress as in the form of loneliness and boredom is very common to them but they expressed how coming to such place and social interaction makes them feel better at least for some time
7.3.7 Summary

The perceived need for health care in context to health services are emphasized from the perspective of the elderly themselves. One of the major problems is regular medication for chronic illness. Free drugs were available at the tertiary care centre, but there was such difficulty and risk in accessing drugs in the crowded tertiary care centre for the elderly, that most dropped out. The referral to the higher centres did not gain any advantage for them. Easy access to continued medication through a nearby centre was their most important need. Support and assistance for even such local access was important- but without an escort regular access of care/medicines at the tertiary care hospital was impossible.

Additionally, the participants showed the need for accompanying to reaching the health facility and assistance within the healthcare facility.

Dissatisfaction in health care at the tertiary care site related to many factors. These include provider’s conduct and behaviour, time spent per patient, and the lack of availability of free medicines for chronic conditions.

Apart from the healthcare needs, food, better housing and more social gathering opportunities were emphasised by the participants who were either living alone or with poor family support and network.
7.4 Health Seeking Behaviour

This section presents the results of the health care seeking behaviour of the elderly participants in this community. It begins by asking them about their practices of seeking care when they are ill, place of a health check-up, how managing health expenditure, their own understanding about the illness, preference for taking treatment and how these influence the process of decision making to seek care.

In this exploration, the study focused on the general conceptualization of ill-health and management of disease among these elderly group through identification of common themes. The identified underlying themes were directed towards how elderly in this communities perceive ill-health and attempt to manage it. The following research questions were considered here:

1. What factors influence the decision to choose health care for availing care?
2. Which are the preferred treatment-seeking approaches for these elderly participants?
3. What Attitudes, beliefs and knowledge does these elderly carry to access care?

Findings:

7.4.1 Health problem identification and ways of managing

The data revealed that the health-seeking behaviour among most of these participants depends on their own understanding of health problems leading to priority setting among the many problems which require care, the ease of access to such care and the resource constraints. Perceived severity in terms of discomfort and pain was the priority for accessing care.

Ye jo dard ha mera ..idhahr dekho gaath se ban rahe ha bahut dard uthe tha bahut dino se pard aap hi chale jaye tha..par pichle do roz se aise dukh raha ha mano koi ghav sa ban raha ho ab bilkul bardsah na horahe to main parle jake lekar aye dava dispensary gait hi par wo dava na kara asar inma  (Female, 75 years) [Translation: this pain of mine see here forming like some lump, it was paining a lot since many days but subsides itself but from last two days the pain is very much like some wound, now not at all able to tolerate that’s why I went nearby and brought medicines, I went to dispensary also but that medicine was not effective enough]

Muje bahut khasi uth ti ha kabhi kabhi dikhaya kuch na nikla sare dava khali cough syrup piye kuch na hua ab chod diya bekar ki goliya or dava khane iske piche khud uth ti ha or khud hi ruk
The data also suggested that most of these participants have their own attribution of priority for an illness and decide for what problems they should seek treatment and for what problems they should not. For example, certain conditions like urinary incontinence were not considered as serious problems to be discussed with the doctors, rather it was labelled by them as the conditions often normal in old age.

The elderly was de-medicalizing many of their health problems and associating it with the normal ageing process. Discussing with them further revealed that it is both due to the perceived difficulties and complexities of accessing appropriate care as well as the various constraints such as financial lacking, lack of persons to accompany and fear in travelling alone. This all resulted in low expectations in terms of taking care.

“Dekho main to manta hu ki hum jaise bane hain waise hi khatam honge hadiya kamjor hongi, daanth jhadenge, ankhe kamjor honge, kam sunega, bhoomkh pyass kam hajeyega. ab qa hi bhagenge in sab ke liye ye toh hoga hi na ab or ima kuch ha bhi na humare pass na ime paise na koi sath lejaye. ab jada akele fira nai jata toh jab bhi kuch jada hi takleef hui lele jakar dava ya toh malik nai toh centre se or apna shanti se time kato” [Male, 75 years] [Translation: See, I believe that they way we developed, same way we will vanish, bones will become weak, denture will go away, eyesight will be low, hearing issues will develop, the hunger will reduce. Now why we will run for all these issues, in this stage, it all will keep on happening. And neither I have so much money nor anyone who can accompany me. Now I can’t travel alone so whenever if I suffer with any problem which is troubling me much, I used to take medicine either from malik or from the centre and leave here peacefully]
treatment based on their previous medical prescription of the same symptoms or following the care is given earlier or suggested to other family members or person in the community.

“Mere is pare mein bahut dard rehta ha puri nase phool jati ha dard hota ye dekh ahu dikhaliya bola operation karna padega ab main kaha jaunge is umar mein ched fad karane. Main lassoon or tail khoob jadkar lagta hu jab bhi jada takleef hone lagte ha aur ye hmaesha badh kar rakhta hu” [Male, 72 years] [Translation: I have severe pain in this leg all the nerves get swollen look at this I have been suggested for operation now why will I go for surgery I used to apply garlic and oil paste on this whenever discomfort is more and I always tied this on my leg]

“muje kuch nai khaya jata man hi nai karte..mere bache bhi bolte ha itne pareshan rehta ha ki main q aise suhti jarahe hu khoon ki jaanch karai fir ladke ne toh private se ne bola ki khoon ki kami ha or dil ki bhi kuch toh dikkat boli aise ha kabhi bhi paseene choote lagte ha ghanrahate hoti bp bad jata ha ye hi sab ha ab inka chal raha bangali se tilai fir main bhi pahuch jaao fir ghar kaun mein kaun karega inko ye bhi bistar par hain..fir main ladki ki jo khurakh di thi wahi maaine leli wo bhi bahut najuk marne se hogayi thi tab likhi thi wo doctor ne” [Female 64 years] [Translation: I am not able to eat anything neither I feel like eating anything, my children are also worried looking at my condition that why I am losing so much weight then my elder son got my blood text examined privately and I have some problem with my heart also sometimes I started sweating purfusely restless and BP rises all these things are there, my husband is getting his treatment from bangali doctor and if I will also go to hospital who will take care my house my husband he is also on bed....then I took syrup which was given to my daughter, she also became very weak and pale then doctor gave her]

7.4.2 Other Options for Care

In this community, there were various unregistered medical practitioners (UMP) practising. Among the participants who were registered member at Prem Chaya daycare centre, they were mainly utilizing the SSCHC centre to seek basic medical care. Among them, there were some female participants who were approaching, both the SSCHC centre as well as the local private practitioners. The main reason reported was their beliefs that the medicines prescribed by these UMPs for some of the ailments like gastric and weakness are more effective than what they received from the SSCHC centre and there were some conditions for which they only approach SSCHC centre for eg. Pain oil.

Among the male’s participants, it was mentioned that they only prefer to seek care from the SSCHC centre and approach over the counter only when the centre is not functioning and they were in urgent need of some drugs. Also, some participants reported they only prefer going to the local practitioners mainly due to the availability of the care without much waiting and
convenience. Also, reported that in minimal cost implication, they were getting treatment which included consultancy and medication both.

“Main centre par jati hu ye jo ghutna ka dard ha na uska tail lene ko par inne jo muje pate ke liye goli di wo na kaam kari toh main roshan ke kakar lekar aye uski goliyo ne kiya kaam toh ab main uske liye wahi se larahe hu dawa” [Female, 75 years] [Translation: I go centre to take the pain relief oil for my knee pain, however, the medicine they gave me for my stomach issue could not helped me then I went to roshan, his medicine is effective now I am taking medicine for this problem from him only]

“Mere bahut chaakr se uth rahe hain or bahut kamjori lag rahi ha..idhar (dispansary) gayi dawai ko..inne teen goli dii..par kuch na hua..ab jo ha main bansal ke jake lekar aye goli uune das goli di muje 75 ki main wahi lerahe hu thodi kamjori kam lagrha ga” (Female, 64 years) [Translation: I am getting feeling faintness, feeling very weak, went to dispensary, they gave me three tablets, but it did not work, now I took medicine from bansal, they gave me 10 tablets in 75 rupees, I am taking that medicine, now feeling less weak]

Further exploration revealed that the state of relieving from the existing health complains mostly symptomatic also influence them to approach the other local practitioners either who is very commonly talked about in the community or suggested by some other peer member. Almost all the participants reported seeking treatment from the private local practitioners mostly for acute or symptomatic conditions not for any chronic conditions, except one participant who reported that she is availing her medication and treatment from the local private clinic available within the community.

“Ye banagli doctor acha bole ha sab kahe hain ki achi dwa diya kare.ghar bhi aajya kare..toh iske bhi dawa ab wahi karai humne kyuki kahi kuch or kaam karahe..ye pure badan par ye chati par khaj khaj si horahi or nisan sa banraha ha” (Male, 68 years) [Translation: This banglai doctor is refered by people here, everyone used to say he is good and give good medicine, then we approached him also since no other thing was helping, see all the patches see here on my chest]

Among the participants, who reported chronic conditions, their main concern was the medication. They did not consider the necessity of regular follow-up, which will have an impact on their variation in their dose prescribed. The participants who reported chronic conditions, it was observed that their main concern is the availability of the free source drugs within the community, earlier which used to be available at the SSCHC centre, which is now available at
the subsidized rates. However, the provision of free chronic medications is available at the nearby tertiary care hospital (GTB or General hospital), but reported difficulties in accessing and the main reasons reported difficulty in reaching, overcrowded, long waiting time even for accessing the drugs and uncertainty involved whether they will get drugs even if they reach there. This lead to either the discontinuation of the medicine or very irregular compliance among these participants. Currently, most of them were taking the medication for their chronic problems (BP and Diabetes) either over the counter or getting it from SSCHC centre as and when they feel discomfort due to the condition.

“muje thi BP..pehle leti thi jab cnetre par milti thi us waqat main kayede se roz leti hu par ab nai milte kuch paise lete hain uske liye toh ab band kari maine ab jo ha mere ek takleef koi ha mere isse jada takleef toh mere dard se or ye jo ha kabhi kabhi pareshan karta ha sar ghumne lage uliti se man hoye toh main chup chap cheeni namak ka khol le liya karo or thodi der late jaya karo toh app hi thik hojata ha” [Female, 76 years] [Translation: I was having BP, I used to take medication when it is available at the centre itself, now they take some money for this medication, so my problem is not only, I am in suffering due to my pain. This is not anyway not causing any severe problem to me now, once in a while, I feel headache/ vomiting tendency so I used to have mixture of sugar and salt and lie down for some time then it normalizes]

Some of the participants also mentioned that if they were having more than one ailment, they decide which one is causing the most discomfort and take treatment for that particular condition either by over the counter or by local private clinics and ignore the other co-morbidities.

7.4.3 Convenience within the Affordability

Affordability for the care is the serious concern among this elderly participant since most of the participant reported that they were managing everything by their own without any other significant support system either from the family or at the community level. Continuity of care among them depends upon these two determinants i.e, convenience and easy reach to care.

Some elderly participants were not opting care from the SSCHC centre due to long waiting hours which led them to seek care either from the local private facility or over the counter. The main reason to visit locally available clinics or practitioners was the immediate treatment of their illness with charging modest service fees which included their medication as well. Some participants who were availing services at the Prem Chaya daycare centre claimed that they used
to go only to SSCHC centre because they have developed a good interpersonal relation the staff and health care providers and were aware of the process to seek care in this centre.

“Ye bangali doctor ko pehchan ha bimari ki..acha dekhta ha or dawa bhi dedeta ha..60 rupaye leta ha dekhne ke.(Female, 70 years)[Translation: this Bengali doctor know about the disease conditions he examined well and provides medicine accordingly.. charged only rs.60 for the consultation]

7.4.4 Perceived Efficacy of the Treatment

While exploring the health seeking behaviour of these elderly participant, some of them talked about their perceived efficacy about the treatment they were availing. The main reason for not going to the SSCHC health centre was firstly the long waiting time and secondly their perception about the efficacy of the treatment provided at the centre.

Some of the participants mentioned that usually seek from the local practitioners(UMPs) mainly because of the convenience and effective treatment by charging minimal fees. They also reported their trust on the medicines they availing from the private facility as compared to the SSCHC health centre. On the other hand, the elderly participants at the Prem Chaya daycare centre, most of them reported availing care only from the SSCHC centre and do not visit any other facility as it incurred, but among them some of the female elderly participants reported they seek treatment for some of the ailments from the local private practitioners as they don’t find the medicines provided from the SSCHC health centre work well for that problem.

“mere damma bhi ha par mein uska pump nai leti yehi par jati hu bangali ke pass wo sahi dawa deta ha toh main jo ha apne sugar ki or thyorid ki goli jo hain pant se leti hu par ab toh kharred kar khati hu baki dame ki main usse lerahe hu” (Female, 62 years) [Translation: I have asthama too but I am not taking pump inhaler, I used to go to bangali doctor, he used to provide effective medicine for it, so I am taking my Diabetes and thyroid mediciens from pant, that too nowadays I am buying rest for Asthama I am taking bangali doctors prescribed medicine]

7.4.5 Gender role in Seeking Care

Less than half of the elderly participants were currently married. Among the male elderly participants, it was found that the spouses were playing the significant role in their access to care and process of care. For the married elderly males, the spouses were assisting them as an escort to the health facility and being the primary caregiver.
Whereas among married female’s elderly participants, observed the compromised or passive healthcare seeking in terms of taking medicine and consulting doctors. It was mentioned that until unless they have suffered any critical problem which needs an urgent treatment, they don’t go for the treatment. They reported either taking the medications which used to be prescribed either to her spouse or any other member in the family without consulting, they prefer to visit the local private practitioner if an encounter with some health issues if not get better after self-medication. However, among the female elderly participants who were the widow or alone were found more active in seeking and consulting care, whereas the male widow found restricted in their health-seeking behaviour.

7.4.6 Self-treatment:

The self-treatment was mostly reported among the female elderly participants compare to only one elderly male (self-treatment for his chronic coughing). The female participant either living alone or in the caring role of her spouse reported self-treatment either followed by home remedies or through over the counter drugs by referring old prescriptions or prescriptions given to their spouse or children.

“Mere beech main bahut kamjori hui thi. kuch khane ka dil na karte ye bolte hain khane ko par nai khayajata. or muje na bhari dava na jhjeli jatii.toh main jab kuch aisa ho jaise khasi bhukhar ke liye gharelu nukse hi karu..pas jo is bari khasi hui toh ruki na rahe thi tab maine cough syrup liya pichle bari jab inko asptal lekar gaye thi tab doctor ne inko likhi thi maine wahi li..” (female, 68 years) [Translation: I had weakness sometime before and don’t feel like eating anything, he (husband) used to say to eat but I am unable to eat and I can eat heavy doses of medicine, my body could not resist, so whenever I catch these minor fever, coughing or cold I follow some home remedies only, but this time I got coughing which was persistent, not ready to stop only then I took cough syrup which was prescribed to him last time when I took her to the hospital]

There resource setting and the elderly surrounding along with their perceived understanding and beliefs shapes the health seeking behaviour among them.

7.4.7 Summary

The findings presented the findings on the health seeking behaviour of the elderly in this community. The overall findings suggested that the participants have their own priority setting of the health problem that will require care. Their perceived understanding and severity of the problem were one of the main drivers among these participant’s health-seeking behaviours.
The healthcare seeking behaviour was influenced by the ease in accessing care and self-perceived efficacy of the treatment. Also, gender differential is evident in seeking health care. Among the elderly married female’s health seeking found to be a very passive affair whereas among the elderly female who were widow found to be very active in health seeking. However, the male elderly, their spouses were the main escort for them to access care and main caregiver. The self-treatment mostly reported by the elderly females as compared to only one elderly male. There were options of care available within community mainly in the form of unregistered medical practitioners have found to approached to seek care mostly by the females mainly due to the convenience, affordability and their own beliefs system.
7.5 Barriers to Access Care

While discussing the difficulties or issues in accessing care among these elderly participants, various categories of barriers which comprise of both individual as well as healthcare system level factors emerged from the response and descriptions provided.

Findings

7.5.1 Double Financial Burden

Financial constraints pose considerable barriers to accessing needed health care among these elderly people in this community. Most of them were illiterate and never had a chance to be formally employed and had very poor socio-economic status. More than half of the participants reported that their only source of income was old age pension. They were self-managing and support their livelihoods. Few of them who reported staying with their children (mostly with married or unmarried son) contributing the part of the pension to the children as well as managing their own health expenses within that. This double financial burden actually putting them in a condition of prioritizing the needs between shelter, food, clothing and health.

“The people (SSCHC) helped in making my documents then only my pension started, now with this, my all the expenses being managed, but I used to give some portion to him (son) to avoid his taunts and conflicts, else I used to come here in the morning only, used to have my food (lunch) and tea here itself. Then I spent some more time here and there in the evening when this centre closed down. I only take one-time meal that includes two chapatis and for sleep in the night.”

The irregularity in getting the pension makes the situation worsen particularly who were living alone and self-dependent for health as well as other basic needs like food, housing etc. Some of the participants, who reported staying with their family, they contribute some portion of their pension money to help their children (son) and grandchildren, which did not reflect any forceful act on them rather sounds a liability, they feel on them. This was mainly because of the indulgence of their children (son) into forms of reported substance abuses, due to which they were not having any income source or very less income.

“Mere teen bete hain, ek toh dimag se thik naa or do ha chota alag hi rehta ha bhajanpura mein kyu ki yaha jagah hi na hoti ha, or jo beech ka ha bahut nasha karta ha uske biwi bhi chod
gai, uske teen bache, apne sath bas chote wale bache ko legayi, piche do aur bache ha uske wo yehi ha ek ladki ha 13 ki or ek ladka wo bhi hoga 10-11 saal ka. Ab jo ha ye ladka kuch na karta riksha kheetchta ha par uski bhi peejata ha pade rahe idhar udhar ab main karu, mere jab accident hui tab jo paise mile maine apne ladki mein dedi ab jo thodi bahut pension milti ha usse hi jo ha chal raha..uske bache bhi toh ha btao is umar mein main kya karu main kab nai kaun karga ab meri bhi toh umar horae ha ki nai” [Male, 75 years] [Translation: I have three sons, one is having some mental problem, the youngest one lives in Bhajan Pura since this place is very small, and the middle one is into sever substance abuse, his wife left him . she took along her younger child, other two are here, one girl who is around 13 and son who is 10-11 years old. Now this son does nothing, pulls rikshaw and whatever he earns he drank from that money, what should I do. When I got some amount of money after my accident, that money I used for my own daughter; now getting some small pension that helping us in sustaining, my son children are there, you tell me in this age what should I do, my life is also uncertain know can’t say tomorrow I will be there or not, I am also old enough now say yes or no]

7.5.2 Mismatch in Subjective Preference for Care

It was clearly stated by the participants that the ease of accessing care in terms of reaching to the health facility as well as within the health facility is one of the important factor given consideration for availing care. Similarly, while exploring the referral care among these elderly participants, it was revealed that the elderly participants have their subjective preference for the referral unit and the main reason was their perceived comfort in terms of knowing the staffs and trust on the care which will be provided at the main base o centre that is St. Stephen hospital irrespective of the fact that this referral unit is situated approximately 15-16 kms away from this community. Whereas there were 2-3 referral units for this centre which are less than 4-5 km away, the participants were reluctant to go in these referral unit mainly due to the long waiting time and exhaustion involved in taking care or treatment in that facility

“ 30 hazari mein ache suna kare or waha par ye jo bachiya ate ha yaha par waha jane par mila karein fir we bahut ache se sab kara diya kare humre, yaha toh GTB ya General subah se sham hojaye karee kuch bhi karane mein, main na jati waha ke alawa kahi”[72 years, Female] [Translation: At St.Stephen hospital, they listen to us properly and the nursing girls who used to come in the community, I meet them there, they help in entire process there, but here at GTB or General it took morning to evening for any simple thing to be done]

7.5.3 Individual level Barriers

Issue of physical mobility

The self-reported mobility issues were reported by almost all the participant. They reported difficulty in walking and climbing stairs, both within their dwelling places as well as outside
even with the supportive device. They even recognized this issues as age-related which further exaggerated by the diminishing eyesight and hearing capabilities. Mobility among the participants was found as major barriers between health and health seeking... However, it is not cleared whether the participants were perceiving their environment as problematic because of their mobility limitations or whether the environmental conditions precede incident mobility limitation and consequently contribute to the progression of mobility decline among the participant. But, in their description, both the reasons were incorporated.

**Lack of accompanying person**

Living alone, lack of accompanying person, fear of travelling alone, poor conditions of public transport were most prominent factors emerged as the barriers among the elderly to access healthcare beyond the community. They reported for the minor illness or for the symptomatic condition, they usually avail care within the community or nearby, but when referred to other, facility, they could not meet the ends mainly because of the lack of some accompanying person.

**Conduct and behavior of the health providers**

While discussing the various challenges the participants face in accessing care, one of the reason reported as the conduct and behavior of the health providers at the SSCHC centre or any facility they were availing care. The elderly participants at the Prem Chaya daycare were very appreciative about the conduct and behavior of the staff with them, however they reported time spent was not enough to listen their problems by the doctor, whereas among the the participants, who were not enrolled at the daycare centre was not appreciative about the centre staff behavior and conduct. Due to this, they do not prefer to avail care from the SSCHC centre, and go to the local practitioners who reportedly listens to them carefully by giving enough time and hence offering them the effective medication.

**Attitude and lack of awareness**

As understood while exploring the health seeking and decision making for seeking care, there were reported delayed in seeking care for some of the health problems until the time it was realized or perceived serious. This delayed often results either in more complicated conditions and complexed intervention, which might have dealt more efficiently if it would have consulted
without delay. Apart from this, declining health and health problems were considered as the part of ageing itself. Also, the lack of knowledge for many of the conditions revealed among the participants.

7.5.4 Summary

The reasons behind the lower accessibility are perceived were included financial reasons (not having the financial ability to visit a doctor especially due to poor financial condition, poor family support, disability or mobility issues, difficulty in understanding (process barriers) etc. Apart from this, various individual-level factors such as the participants own beliefs and understanding about the ailments/health problem, severity or priority and lack of awareness about the existing facility were some of the barriers in accessing care. Long waiting times, inconvenience and lack of availability and provisioning of drugs for chronic diseases within community centres and uncertainty in the availability at tertiary facility were the system level barriers reported by some of the participants who were either availing care from the private local facility and over the counter drugs. Few participants reported the unfriendly conduct and behaviour as the reason for not availing care from the available SSCHC.

To great extent these elderly participants found were trying to manage their health requirement within their community but when it comes to accessing care at a tertiary hospital or for referral care, due to lack of accompanying person and fear of travelling alone in the public transport resulting in discontinue or irregular care among them. Due to poor financial condition and family network, they need to prioritise all their needs including food, shelter and health, as most of them were managing their livelihood by their own with the support of the old age pension, that is too irregular.