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# Study On Geriatrics Health Care At Coastal Areas In Bangladesh

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## Abstract

Now a day's people are very much busy for their daily activities. People spent more time to earn money. People don't care their old aged parents. For this reason old people don't get proper care at old age. Old people suffer different complex diseases due to lack of care. However the present study has conducted to explore the geriatrics health care services at coastal areas in Bangladesh and to find out the problems regarding geriatrics health care services at coastal areas in Bangladesh. The study was a cross-sectional study. The study was conducted at Noakhali district in Bangladesh. Total 400 respondents were selected. The respondents were patients. A random sampling technique was used for the study. Patients of Noakhali District were the study respondents. Data were collected from primary sources and secondary sources. A self-administered questionnaire was used for data collection. Data were collected through interview method, i.e. Interviewers collected data from study participants through administered questionnaire by face - to - face interview. Obtained data were checked for error and data will be analyzed by using SPSS software. From the result it was found that older people are subject to multifaceted problems, which are basically physical, psychological, economic and health-related. These problems are inter-linked and mutually reinforcing, and all have implications on the health situations of older people. The study revealed that the problems of older people were given some attention by the government. Though very few NGOs are working on and with older people, their number is nominal as compared to the existing need. Yet, there is clear evidence for the shortcoming in terms of translating the policies into action. From the result it was also found that lack of a unit solely responsible for the planning, coordination and execution of older people-specific interventions is believed to contribute to the implementation problem. Government health recoding system lacks older people-specific health information, mainly because the health management information system (HMIS) is not disaggregated by age. In general, the HMIS is at its nascent stage. In terms of medical treatment, there is lack of drugs and trained personnel. Geriatric training is not given in any of the health training institutions in the country. While older people are vulnerable to various communicable diseases like anybody else, they are peculiarly more susceptible to NCD, especially to the most common ones such as diabetes, hypertension, eye and hearing impairment, cardiac ailments, arthritis and the like. However, getting medical service has never been an easy thing, since the health-care policy focuses on prevention of communicable diseases and also due to the fact that cost for medication and transportation to medical facilities is, nonetheless, unaffordable for most of them. It is also possible to learn from the findings of the survey that the physical setting of health facilities is not at all older people –friendly. Indeed, the very idea of older people-friendly physical structure was alien to many health facility workers, so much so that they showed some kind of bafflement when asked about this issue as if the questions were inappropriate. Many older people, both male and female, and urban and rural residents are visiting traditional healers. But, not all prefer traditional medicine because it is better than the "modern" one, but because it is easily accessible and much cheaper.

**Keywords:** *Geriatric health care, Nurse, Practice, Environment, Behavior, Service duration, Knowledge, Education*

## Introduction

Bangladesh has been experiencing a sharp growth of ageing population, more precisely 4.4% yearly increase. At present, over 60 years old population is around 15 million, which is almost 8% of Bangladesh's population. Projected estimates suggest that by 2025, one in ten persons will be over 60 years in Bangladesh; by 2050, this figure is expected to increase to one in five persons. This rapid growth of the ageing population in Bangladesh has been attributed to factors such as low birth rates, low mortality rates and increasing life expectancy rates. In 2017, the average life expectancy was 72 in Bangladesh, compared to 68 years in 2010. Study suggests that such growth would result in both medical and sociological problems that demand substantial government expenditure on elderly care. However, like many other developing countries, Bangladesh remains far beneath established standards for the provision of elderly care services, especially in regards to health care and home care services. Bangladesh is a poverty-stricken country. Therefore, often policy makers consider economic support in the form of old age allowances

as the prime means of elderly care. In spite of the fact, until 2015, only around 26% of the elderly citizens received pension or old age allowance, which even when available are too small to cover their minimum standard of living costs. The old age allowances are currently equivalent approximately five Euros per month. Although this initiative has been appreciated, the amount is too small to make any significant change in elderly people live. In addition, the remaining 74% were excluded from any form of public support. Thus, this large segment of population have to survive without any public or private organization's support, even if they have no family members capable of helping them. Begging, hard manual jobs for example rikhshaw pulling, selling nuts, and community's informal supports become the only way to survive.

Health care is another dire problem especially for the economically poor people. According to the 2017 National Health Expenditure report, Bangladeshi citizens are among the top highest spenders in regard to health-care costs paid out of their own pocket. The situation has been getting worse as Bangladesh government currently reduced the health budget from 6.2% to 4.3%. Due to the reductions in government budget, citizens need to pay as much as 65% of total health costs from their own pocket. Every year, 6.4 million (4%) of the country's citizens fall into poverty due to excessive healthcare costs. Studies have suggested that due to poverty, a number of elderly people often ignore many diseases, which are preventable by medicine and treatment. Consequently, they fall into deeper health problems. The literature suggest that elderly people in Bangladesh mostly suffer from weakness, failing eyesight, obesity, hearing loss, high blood pressure, obstructive pulmonary symptoms, diabetes, heart diseases and other age-related illnesses, including dementia and Alzheimer diseases.

One major factor behind this apparent negligence might be the existence of traditional informal care support provided by family and relatives in kind, which is free of costs. However, a number of factors, including the prevalence of poverty, demographic changes and globalization have lessened the traditional care function of family and neighbors. Rather, older people in many cases have been treated as a burden and suffer neglect by their families and society, primarily due to poverty. In addition, evidence suggests that, although a number of elderly people struggle with poverty, income is not the only indicator for their elderly care deprivation. Negligence and oppression by family members for diverse reasons, home care and social care deprivation have been increasing in Bangladesh significantly. Along with old age allowances, the government of Bangladesh has recently initiated Parents Care Act (PCA) in 2013 following National Policy on Ageing (NPA) in 2007. However, evidence suggests that while undertaking elderly care initiatives, significant elderly care needs remain unaddressed or overlooked. For example, health care and long-term care is not yet provided. In addition, old age pension coverage is still very limited in terms of quality and quantity. Considering the above-mentioned conditions, the state and development agencies need to reassess the policies and build capacities to ensure sustainable care provision for elderly people in Bangladesh. In doing so, extensive research from different perspective is equally important.

## OBJECTIVES OF THE STUDY

The objectives of the study are as follows:

1. To explore the geriatrics health care services at coastal areas in Bangladesh.
2. To find out the problems regarding geriatrics health care services at coastal areas in Bangladesh.

## JUSTIFICATION OF THE STUDY

This is the era of science and technology. People are busy for their career. For this reason single families are occurring more in recent years. People don't care their old aged parents. For this reason old people don't get proper care at old age. Old people suffer different complex diseases due to lack of care. According to UNFPA survey 2019, 13 million people are suffering from elderly physical and mental health problems. If they are not properly cared this number will be reached 20 million in 2025. In some cases the sons or daughters just admit their parents to a government hospital and don't go to the hospital. The doctors and nurses face very critical situation due to lack of patients attendance. To face this type of challenges doctors and nurses' knowledge and attitude towards geriatrics should be up to date. For the reason this type of research is essential.

## OPERATIONAL DEFINITION

### 1. Geriatrics

The term geriatrics comes from the Greek word geron meaning "old man", and iatros meaning "healer". However, geriatrics is sometimes called medical gerontology. Geriatrics, is a specialty that focuses on health care of elderly people. Rather, this decision is determined by the individual patient's needs, and the availability of a specialist. It is important to note the difference between geriatrics, the care of aged people, and gerontology, which is the study of the aging process itself.

### 2. Geriatric health care

Geriatric health care is the health care of elderly people.

It aims to promote health by preventing and treating diseases and disabilities in older adults. There is no set age at which patients may be under the care of a geriatrician, or geriatric physician, a physician who specializes in the care of elderly people.

**3. Nurse**

The term nurse originates from the Latin word nutire, which means to suckle. This is because it referred primarily to a wet-nurse in the early days and only evolved into a person who cares for the sick in the late 16th century. In other words a nurse is a caregiver for patients and helps to manage physical needs, prevent illness, and treat health conditions.
(Source: https://www.news-medical.net health Roles-of-a-Nurse)

**4. Registered nurse**

A registered nurse is a person who has passed General nursing and Midwifery examination after training in a recognized school of nursing and has been granted a license to practice nursing profession.

**5. Nursing**

Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well, and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles. (Source: International Council of Nurses 2002)

**6. Geriatric nurses**

Geriatric nurses are registered nurses (RNs) who are educated and trained to care for elderly patients and understand their specific health needs. They are also called "gerontology or gerontological nurses." Geriatric nurses provide patient-focused care to a vulnerable population with the ability to greatly improve their patients' quality of life. They understand that conditions regarded as minor in a younger adult can quickly become serious or even life-threatening for an elderly person.

**METHODOLOGY OF THE STUDY**

**1. Research Design:** A cross-sectional study was conducted with nurses at Governmental and Non-Governmental hospitals.

**2. Study Area**: The study was conducted at Noakhali district in Bangladesh.

**3. Sample size:** Total 400 respondents were selected. The respondents were geriatric patients.

**4. Sampling Technique:** A random sampling technique was used for the study.

**5. Study Respondents:** Patients of Noakhali district in Bangladesh were the study respondents

**6. Study Period:** The study duration about 2 years (July 2020 to July 2021)

**7. Sources of data:** Data were collected from primary sources and secondary sources.

**8. Data Collection Tools/Instrument:** A self-administered questionnaire was used for data collection.

**9. Methods of data collection:** Data were collected through interview method, i.e. Interviewers collected data from study participants through administered questionnaire by face - to - face interview.

**10. Data Processing and Analysis:** Obtained data were checked for error and data will be analyzed by using SPSS software.

**RESULTS AND DISCUSSION**

**Table 1: Age of the Respondents**

| | Frequency | Percent | Cumulative Percent |
|---|---|---|---|
| 31-40 Years | 73 | 18.2 | 18.2 |
| 41-50 Years | 183 | 45.8 | 64.0 |
| 51Years and Above | 144 | 36.0 | 100.0 |
| Total | 400 | 100.0 | |

Source: Field survey, 2022

Figure 1: Age of the Respondents

Source: Field survey, 2022

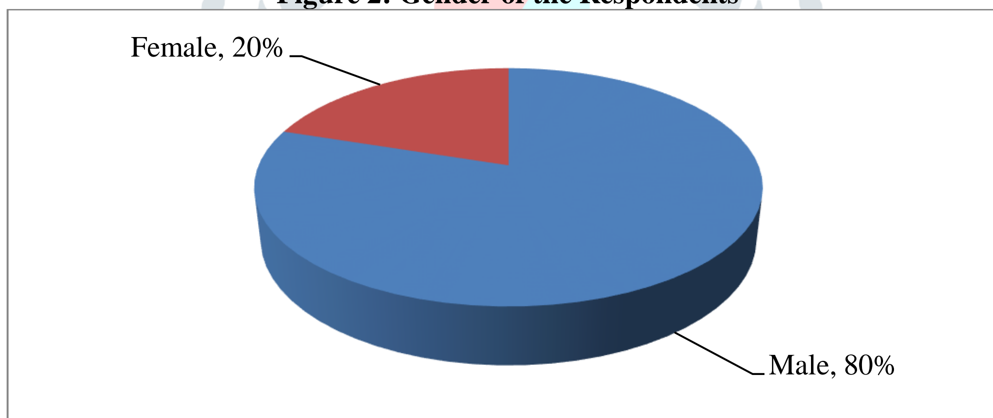
Age of the Respondents has shown in the above table and graph. From the result it was found that 45.8% respondents were age group41-50 Years which was maximum but 18.2% respondents were age group 31-40 Years which was minimum. On the other hand 36.0% respondents were age group 51years and above.

Table 2: Gender of the Respondents

| Gender | Percentage |
|---|---|
| Male | 80% |
| Female | 20% |
| Total | 100% |

Source: Field survey, 2022

**Figure 2: Gender of the Respondents**




Source: Field survey, 2022

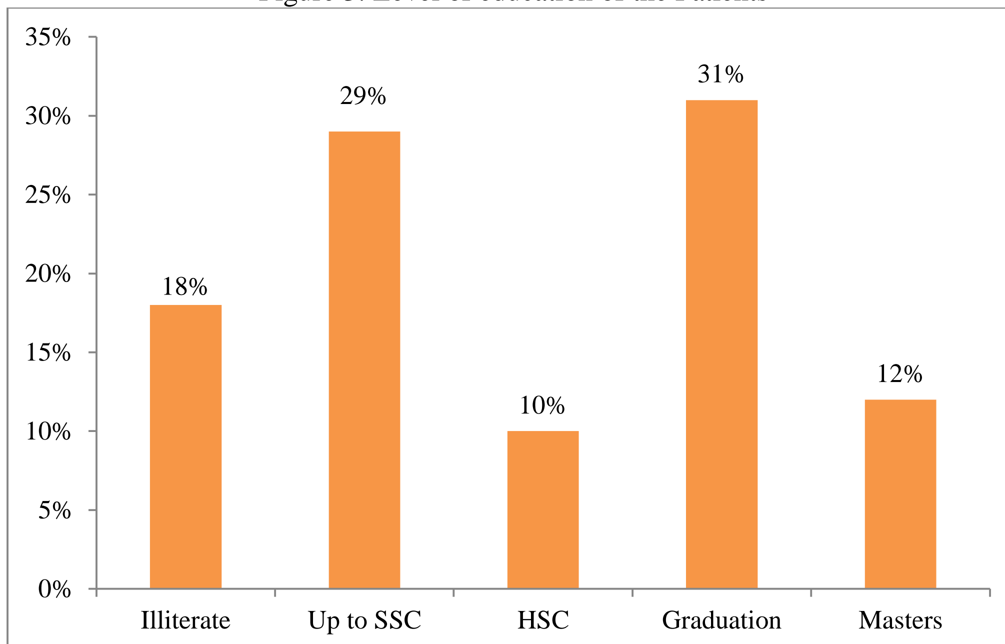
Gender of the Respondents has shown in the above figure. From the result it was found that out of 50 respondents 80% respondents were male and 20% respondents were male.

**Table 3: Level of education of the Patients**

| Educational qualification | Percent |
|---|---|
| Illiterate | 18% |
| Up to SSC | 29% |
| HSC | 10% |
| Graduation | 31% |
| Masters | 12% |
| Total | 100.0 |

Source: Field Survey, 2022

Figure 3: Level of education of the Patients




Source: Field survey, 2022

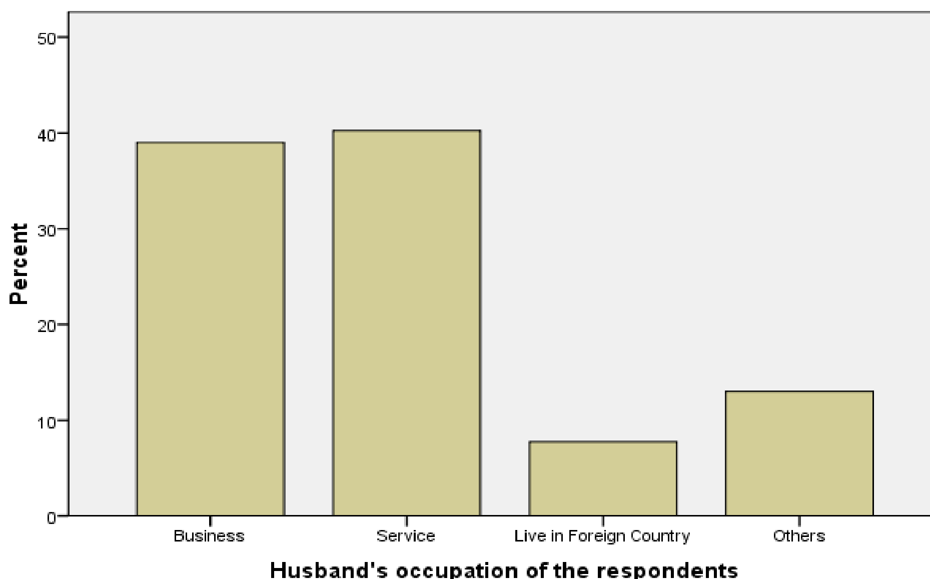
Level of education of the Patients has shown in the above table and graph. From the result it was found that 31% patients were graduate which was maximum but only 10% patients completed HSC which was minimum.

**Table 4: Distribution of patients by occupation**

| | Percent |
|---|---|
| Business | 39.0 |
| Service | 40.2 |
| Live in Foreign Country | 7.8 |
| Others | 13.0 |
| Total | 100.0 |

Source: Field Survey, 2022

Figure 4: Distribution of patients by occupation




Source: Field Survey, 2022

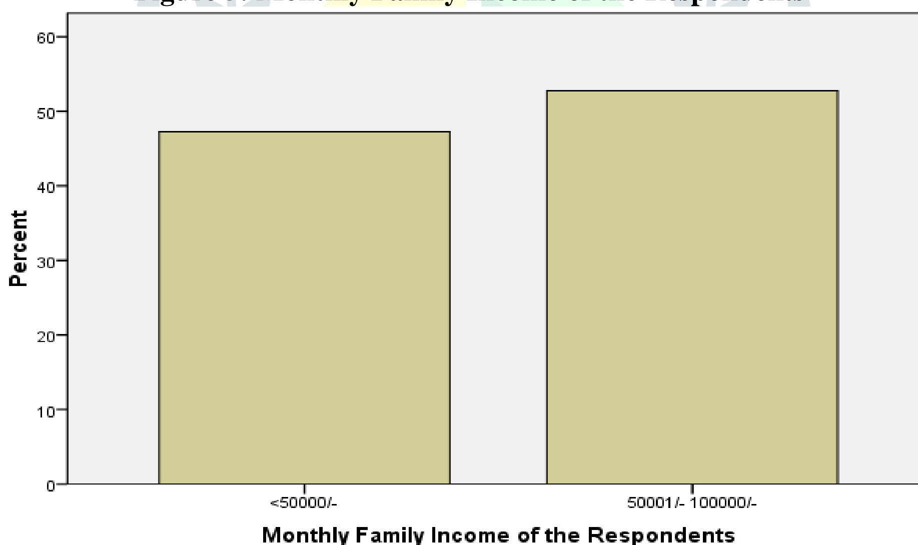
Distributions of patients by occupation have shown in the above table and graph. From the result it was found that 40.2% respondents were service which was maximum but only 7.8% respondents husband live in foreign which was minimum.

**Table 5: Monthly Family Income of the Respondents**

| | Frequency | Percent | Cumulative Percent |
|---|---|---|---|
| <50000/- | 189 | 47.2 | 47.2 |
| 50001/- 100000/- | 211 | 52.8 | 100.0 |
| Total | 400 | 100.0 | |

Source: Field Survey, 2022

**Figure 5: Monthly Family Income of the Respondents**




Source: Field Survey, 2022

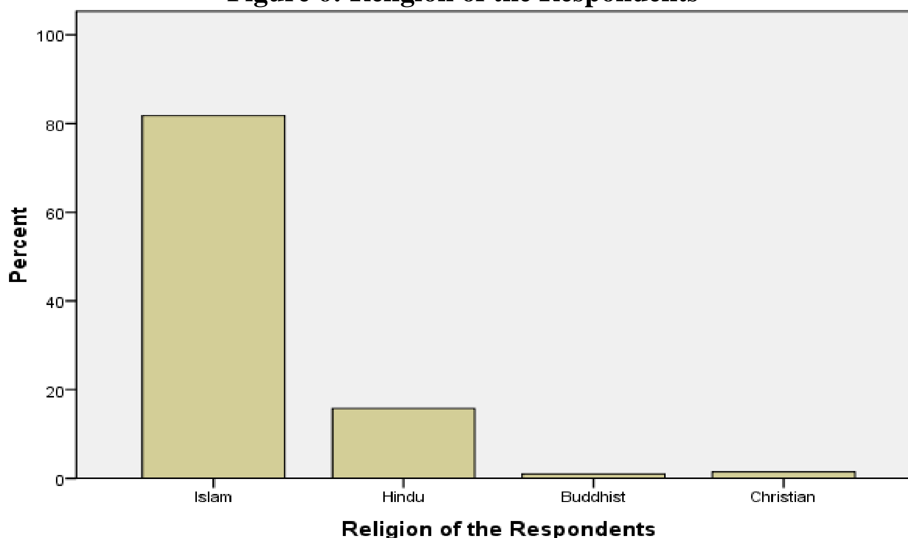
Monthly Family Income of the Respondents has shown in the above table and graph. From the result it was found that52.8% respondents had monthly family income 50001-100000 Taka and 47.2% respondents had monthly family income less than (<) 50000 Taka.

**Table 6: Religion of the Respondents**

| Name of Religion | Percent |
|---|---|
| Islam | 81.8 |
| Hindu | 15.8 |
| Buddhist | 1.0 |
| Christian | 1.5 |
| Total | 100.0 |

Source: Field Survey, 2022

**Figure 6: Religion of the Respondents**




Source: Field survey, 2022

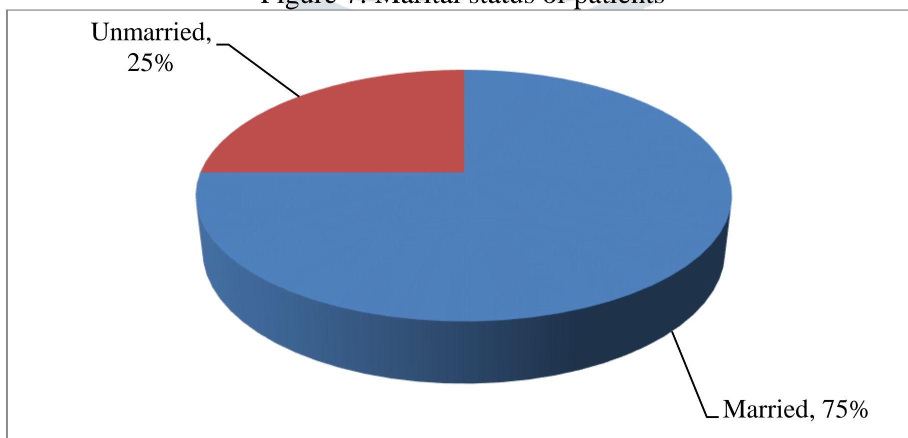
Religion of the Respondents has shown in the above table and graph. From the result it was found that 81.8% respondents' religion were Islam which was maximum but 1% respondents were Buddhist which was minimum. On the other hand 15% respondents were Hindu and 1.5% respondents were Christian.

**Table 7: Marital status of patients**

| Marital status | Percentage |
|---|---|
| Married | 75% |
| Unmarried | 25% |
| Total | 100% |

Source: Field survey, 2022

Figure 7: Marital status of patients




Source: Field survey, 2022

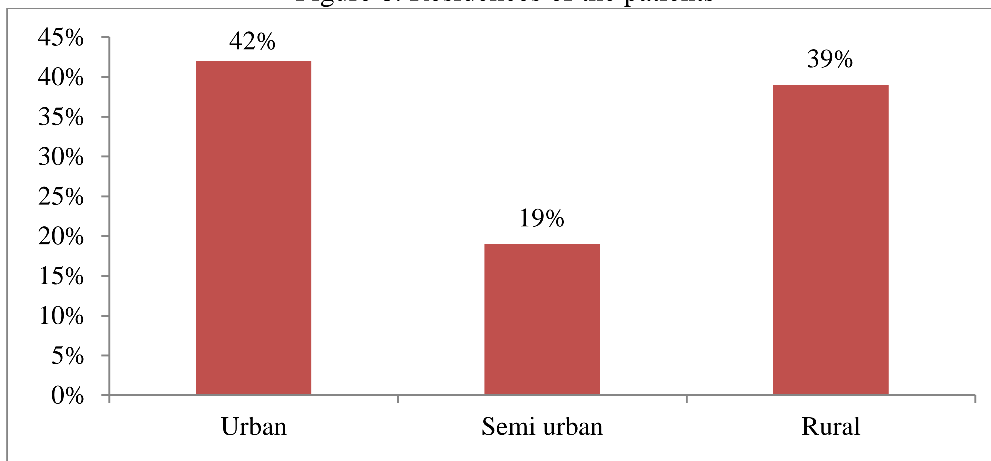
Marital status of patients has shown in the above table and graph. From the result it was found that 75% patients were married and 25% patients were unmarried.

Table 8: Residences of the patients

| Location | Percent |
|---|---|
| Urban | 42% |
| Semi urban | 19% |
| Rural | 39% |

Source: Field survey, 2022

Figure 8: Residences of the patients




Source: Field survey, 2022

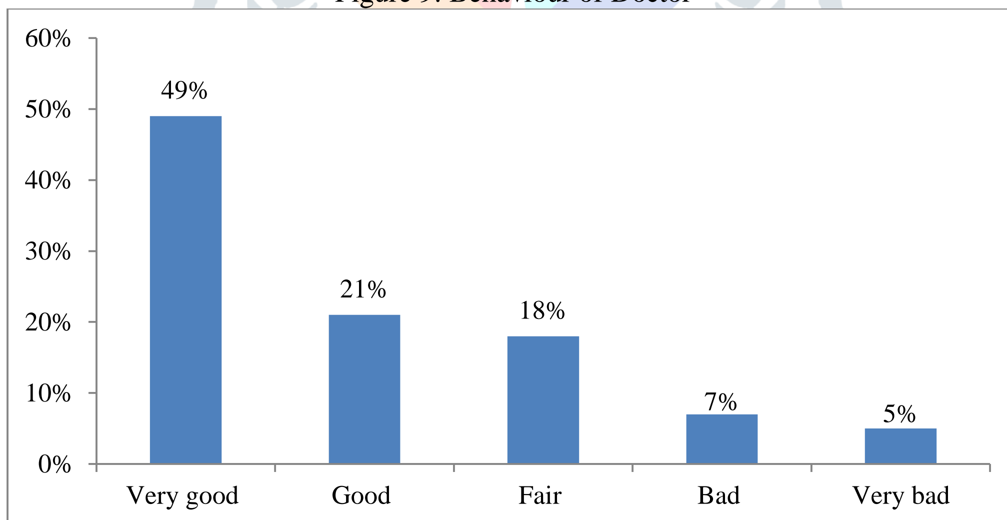
Residences of the patients have shown in the above table and graph. From the result it was found that 42% patients were from urban area, 19 patients were from semi urban area and 39% patients were from rural area.

Table 9: Behaviour of Doctor

| Behaviour | Percentage |
|---|---|
| Very good | 49% |
| Good | 21% |
| Fair | 18% |
| Bad | 7% |
| Very bad | 5% |

Source: Field survey, 2022

Figure 9: Behaviour of Doctor




Source: Field survey, 2022

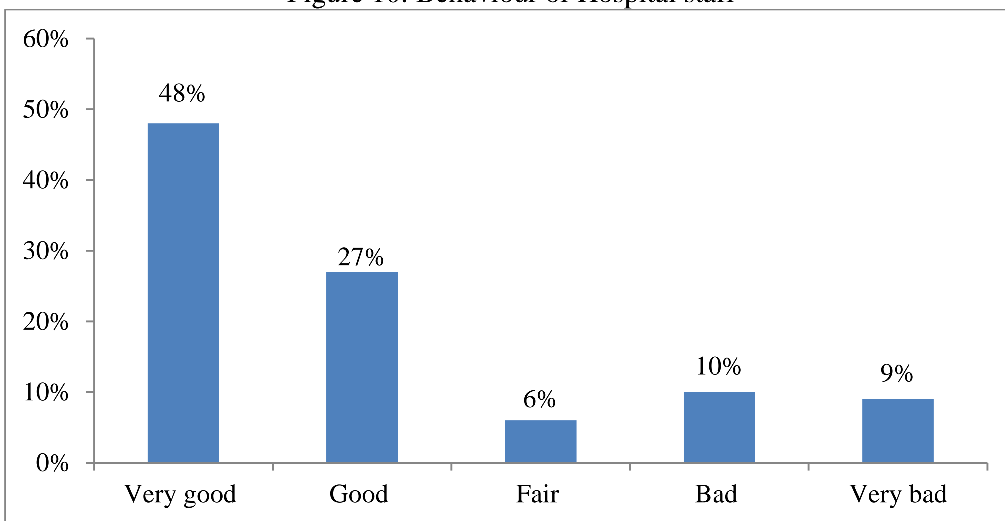
Behaviour of Doctor has shown in the above table and graph. From the result it was found that 49% patients replied that the Behaviour of Doctor was very good which was maximum but only 5% patients replied that the Behaviour of Doctor was very bad which was minimum. On the other hand 21% patients replied that the Behaviour of Doctor was good, 18% patients replied fair and 7% patients replied bad.

Table 10: Behaviour of Hospital staff

| Behaviour | Percentage |
|---|---|
| Very good | 48% |
| Good | 27% |
| Fair | 6% |
| Bad | 10% |
| Very bad | 9% |
| Total | 100% |

Source: Field survey, 2022

Figure 10: Behaviour of Hospital staff



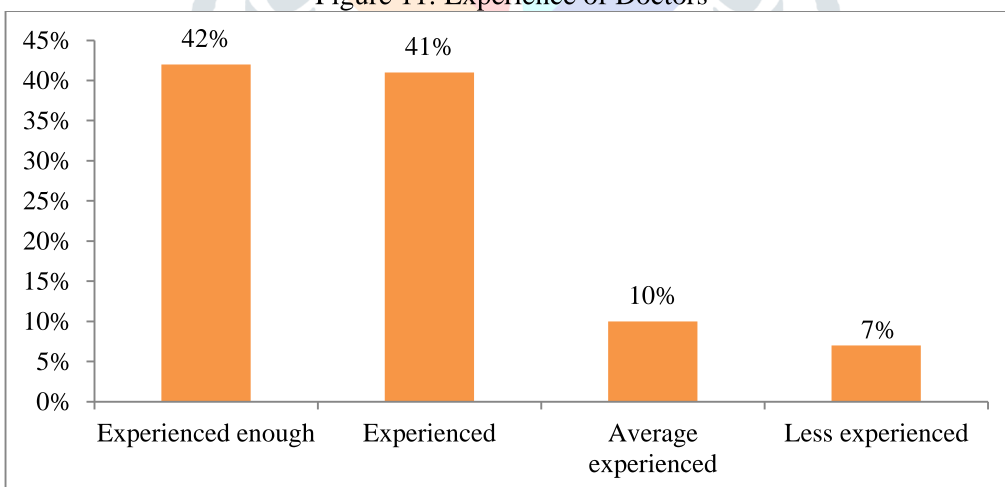

Behaviour of Hospital staff has shown in the above table and graph. From the result it was found that 48% patients replied that the Behaviour of Hospital staff was very good which was maximum but only 6% patients replied that the Behaviour of Hospital staff was very bad which was minimum. On the other hand 27% patients replied that the Behaviour of Hospital staff was good, 18% patients replied bad and 9% patients replied very bad.

Table 11: Experience of Doctors

| Experience | Percentage |
|---|---|
| Experienced enough | 42% |
| Experienced | 41% |
| Average experienced | 10% |
| Less experienced | 7% |
| Total | 100% |

Source: Field survey, 2022

Figure 11: Experience of Doctors




Source: Field survey, 2022

Experience of Doctors has shown in the above table and graph. From the result it was found that 42% patients replied that the Doctors of selected hospitals were experienced enough which was maximum but only 7% patients replied that the Doctors of selected hospitals were experienced enough which was minimum. On the other hand 41% patients replied that the Doctors of selected hospitals were experienced and 10% patients replied that the Doctors of selected hospitals were average experienced.

## CONCLUSION

The result of the survey, in a nutshell, disclosed that older people are subject to multifaceted problems, which are basically physical, psychological, economic and health-related. These problems are inter-linked and mutually reinforcing, and all have implications on the health situations of older people. The problems of older people were given some attention by the government. Though very few NGOs are working on and with older people, their number is nominal as compared to the existing need. Nonetheless, as of recent times the problems seem to be getting relatively better attention as various policies and strategies are being issued. Yet, there is clear evidence for the shortcoming in terms of translating the policies into action. The latest policy document, the National social security policy, has several articles that aim to tackle the health and non-health problems. The document recognizes the significance of appropriate planning and implementation of cash transfer in positively affecting the lives of poor older people,

especially in a situation where a very small proportion of the population has pension entitlement. Lack of a unit solely responsible for the planning, coordination and execution of older people-specific interventions is believed to contribute to the implementation problem. Government health recoding system lacks older people-specific health information, mainly because the health management information system (HMIS) is not disaggregated by age. In general, the HMIS is at its nascent stage. In terms of medical treatment, there is lack of drugs and trained personnel. Geriatric training is not given in any of the health training institutions in the country. While older people are vulnerable to various communicable diseases like anybody else, they are peculiarly more susceptible to NCD, especially to the most common ones such as diabetes, hypertension, eye and hearing impairment, cardiac ailments, arthritis and the like. However, getting medical service has never been an easy thing, since the health-care policy focuses on prevention of communicable diseases and also due to the fact that cost for medication and transportation to medical facilities is, nonetheless, unaffordable for most of them. Although the Bangladeshi government has no system in which the poor get free medical services. In government hospitals or health facilities systems old aged people almost always have to spend more money to get medical facilities from private hospitals/clinics.

It is also possible to learn from the findings of the survey that the physical setting of health facilities is not at all older people –friendly. Indeed, the very idea of older people-friendly physical structure was alien to many health facility workers, so much so that they showed some kind of bafflement when asked about this issue as if the questions were inappropriate. The traditional system of community mutual support is reported to be increasingly being eroded. It might, however, be poverty rather than the erosion of the culture that incapacitated communities to support older people. This implies that concerned organizations should work on the revitalization of the culture, while exerting every effort on poverty eradication/reduction. Many older people, both male and female, and urban and rural residents are visiting traditional healers. But, not all prefer traditional medicine because it is better than the “modern” one, but because it is easily accessible and much cheaper. Nursing is a noble profession. Nurses can serve a lot to the old age people in Bangladesh. For this reason the nurses should get modern knowledge, skill, attitude and training related to the geriatric health care. Governments should take necessary steps regarding this matter.

## RECOMMENDATIONS

Based on the survey findings presented above and the suggestions made by older people, community members, appropriate institutions and other stakeholders in response to the study tools, as well as the experiences of other countries reviewed the following recommendations are forwarded.

### 1. Strengthening government and community support

a) The government should establish or reinstate an authority or a unit that would be solely responsible for planning and executing activities concerning older people, which will also be in charge of networking and mobilization of stakeholders at both federal and regional levels.
b) The government needs to strengthen the health management information system in a way it captures data on older people. International NGOs and multi-and bilateral organizations could provide technical and financial support to this end.
c) The traditional extended family and mutual-help system should be revitalized by extensive promotional work, using all available media, and public for such as community conversations.
d) Continuous and integrated effort shall be made to re-orient traditional social institutions and religious associations so that they could support older people whenever they fall sick or needed support.

### 2. Concerning health problems

The ministry of health and family welfare should outline how older people would best access healthcare services, including protocol and reception, such as giving them priority at all service points, assigning support staff to help their movement within the facilities, assigning ambulance service for at least emergency cases and appointment dates, allocating waiting places particularly for them within the facilities, and so on. Treatment for non communicable diseases should be given proper attention, and the proper implementation of policies and strategies regarding non communicable diseases should be ensured. To this end, the following points should be considered.

a) Establish mechanisms to enhance the capacity of health personnel. Ensure that basic drugs and medical equipment for non communicable diseases are available in all health facilitates.
b) Establish a mechanism to facilitate referrals from health centers to specialized care facilities initiate an introduction of geriatric training into the curriculum of the institutions of higher learning.
c) Accelerate the process of the introduction of the health insurance system and give equal attention to the community health insurance initiative.
d) Strengthen the database on the health and other problems of older people.

Moreover, the ministry of health and family welfare should do the following:

a) Provide communities with continued health education on ageing-related health problems.
b) Put in place a mechanism of follow-up on client complaints and ethical standards of the activities of health professionals, which is being partially implemented in some health facilities as a result of the Business Process

Reengineering (BPR) and Hospital Management Reform, in order to enhance the quality of services provided to customers regardless of their ages.

c) Physical structures of health facilities should be made older people-friendly (the laboratory, cash office and pharmacy should be easily accessible and located adjacently, the different rooms should be accessible by wheelchair, there should be older people specific waiting rooms, and the like).

d) NGOs, especially those working on health, should incorporate or mainstream issues of older people into all their health programmes.

e) Some older people may need palliative care services at home (including washing their clothes, fetching water, do shopping, etc.). This could be done by mobilizing young people and providing them with the necessary training. NGOs and CBOs could play significant roles in this regard.

**3. Concerning Economic Problems**

a) Addressing the economic problems of older people mean partially addressing their health problems. In this regard, schemes of income-generating activities (IGA) should be encouraged by the government. Indeed, the government has to be engaged in, and guide, NSAs in providing IGA opportunities to the healthy capable older people.

b) NGOs need to make the problems of older among the focus areas of their intervention. It would be critical to encourage, support, and scale-up best practices of CBOs already working on and with older people.

**4. Advocacy**

a) Advocating the health service need of older people is vital to get decision makers recognize the health problems and health service needs of older people and respond appropriately. International NGOs should take initiatives in designing advocacy work projects, create forums, and seek the collaboration efforts of stakeholders.

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