

How Iranian Families Response to the Conditions Affecting Elderly Primary Health Care

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Abstract: In response to the need for effective elderly primary health care programs in the Islamic Republic of Iran, the present study sought to determine the nature of family's caring behaviors related to the elderly primary health care in an urban area in Iran. A qualitative research was conducted through 24 in-depth interviews, 4 focus groups (8 participants in each group) and participants observation. The following 2 main categories emerged from the analysis to describe family's caring behaviors: internal responses and external responses. This qualitative study has gathered data that could be used by policy makers and health care providers and researchers concerned with elderly health and their quality of life. Based on these findings, it is recommended that providing primary health care for the elderly should be embedded in a comprehensive approach which aims to change the conditions affecting the elderly primary health care in urban areas.

Key words: Elderly health, primary health care, family caregivers, qualitative research, urban health care centers, Iran

INTRODUCTION

Iran is now grappling with the population ageing phenomenon. Given the scenario that while it has a relatively young population, the proportion of elderly is projected to double in <20 years (Jogataee, 2005). The United Nations statistical projections demonstrate rapid growth of elderly population in Iran. While the proportion of people in the 60 years and above group in Iran was 5.4% in 1975 it will increase to 10.5% in 2025 and 21.7% in 2050 (United Nations, 2007). The Islamic Republic of Iran has to consider ageing issues more seriously now than in the past. The already large number and the projected future of elderly population highlight the need to attend to plan early for the ageing of the population. It is necessary to ensure that the elderly, who are amongst the most vulnerable groups in the population are not increasingly left behind. Thus, it is no longer possible to ignore the ageing phenomenon in Iran and therefore, it is vital to anticipate requirements of this age group in Iran to plan appropriate policies to address their growing needs

and to support their quality of life. Good health is imperative for older people to remain independent and continue to contribute to their families and communities. Whether they make use of traditional knowledge and modern health care services, their aim is to be healthy. However, there always remain a gap between what is actually needed by individuals and what health professionals assume are needed by them. Although health policy makers develop health systems with the goal of providing affordable and quality health care to the older people (Greengross *et al.*, 1997), differing sociopolitical, economic and cultural conditions have not made it possible for the older persons to use health care facilities made available to the population. Changing social, cultural and economic factors in developed countries have led to the emergence of facilities such as day care centers, home health care services, skilled nursing care facilities, nursing homes, congregate housing and hospice care. These serve to provide family-based or community-based health care services to the special care needs of different groups of elders

(Stone *et al.*, 1999). In developing countries such as the Islamic Republic of Iran, access to Primary Health Care (PHC) is prioritized in order to provide care that older people need to prevent or delay the onset of chronic, often disabling diseases. It was in response to the urge by the World Health Organization (WHO), Regional Office for the Eastern Mediterranean (EMRO) in the 1980s for countries to develop suitable programs for their growing elderly population.

The objective is to provide the regular, continuing contact and care needed by the older people through family and social members (WHO, 2006).

Worldwide older people already account for a sizeable proportion of PHC center's patients and as populations age and chronic disease rates climb that proportion will also increase. PHC centers are on the frontline of health care and are thus familiar to older people and their families. They are positioned to provide the regular and extended contacts and ongoing care that older persons need to prevent or delay disabilities resulting from chronic health conditions. Despite the critical role that PHC centers play in older persons' health and well-being, older people encounter many barriers to care. Therefore, there is need for these centers to be accessible and adapted to the needs of older populations has recognized by World Health Organization (WHO, 2004). The urgency of developing a most appropriate health care has to be founded on the felt needs, expectations and perceptions of the group concerned.

In Iran, a national health policy was formed based on PHC as a strategy to attain health for all by the year 2000 in 1978. The government therefore, turned its attention to this approach and improved the health network to implement the PHC principles (Shadpour, 2000). The plan was renewed and reformed in late 1983 and has been improved since then by the Health Ministry of the Islamic Republic of Iran. Today, the Iran PHC network includes the whole country involving both rural and urban areas. The PHC network of the Islamic Republic of Iran covers those activities which include the promotion of proper nutrition, safe water, basic sanitation, maternal and child care, health education, treatment of common diseases and injuries and provision of essential drugs.

These activities focus on several vulnerable groups in the community such as children and women (Shadpour, 2000). With regard to the elderly population specific program did not exist till the end of 1990s. It is only in recent years the Islamic Government has begun to give more attention to the health and welfare of the elderly and to seek information about their community health problems. The Ministry of Health presently administers the national policies coordinates committees for the care

of the elderly. A country program for elderly health in Iran was developed with a survey in elderly health status and the elderly health program was started in the Ministry of Health with focus on reducing the burden of diseases among them through delivery of primary and secondary prevention services in health care network. These include health education on healthy lifestyle, screening for early disease detection and treatment. Hence, the PHC centers play a critical role in older persons' health and well-being. While the ultimate goal here is to offer quality accessible care the network system does not have much data to help it make decisions. Without adequate data on the elderly people's needs and existing situations of elderly primary health care, any attempts to improve the system will lead to failure. In the current study, the researcher aimed to redress gap in knowledge by investigating the nature of caring behaviors in elderly family members as one of the components of quality of primary health care.

Family members will likely have a variety of emotions, attitudes and thoughts regarding providing care to their parents. Out of these feelings and attitudes, come a variety of decisions and behaviors regarding care. The examination of family's caring behaviors in this article was part of a larger study on caring behaviors of three groups of people within the health network system, namely the older individuals, their family members and the health care providers in primary health care centers in an urban area in Iran.

MATERIALS AND METHODS

The choice of the research method basically depends on the nature of the problem that is being investigated. Grounded theory is a methodology that allows formulating orderly abstractions from the real life data (De Mello and Erdmann, 2007). The qualitative method of grounded theory was chosen to capture the reality of the nature of caring behaviors among elder families living in Isfahan, Iran. This method allows exploration in terms of the current time, place and culture. Data are interpreted using a systematic set of procedures to explore the phenomenon (Corbin and Strauss, 1998). Following ethical approval, data were collected through tape-recorded, in-depth, open-ended, semi-structured interviews (24 interviews), focus group discussions (4 focus group: 8 participants in each group), participants observation and researcher memos. Each participant was informed of the purpose of the research and a consent form was signed. Some demographic information was also collected. About 12 members of elder families, 12 elderly women and men over 60 years of age that utilize services of health care centers in health care network in urban level (Fig. 1)

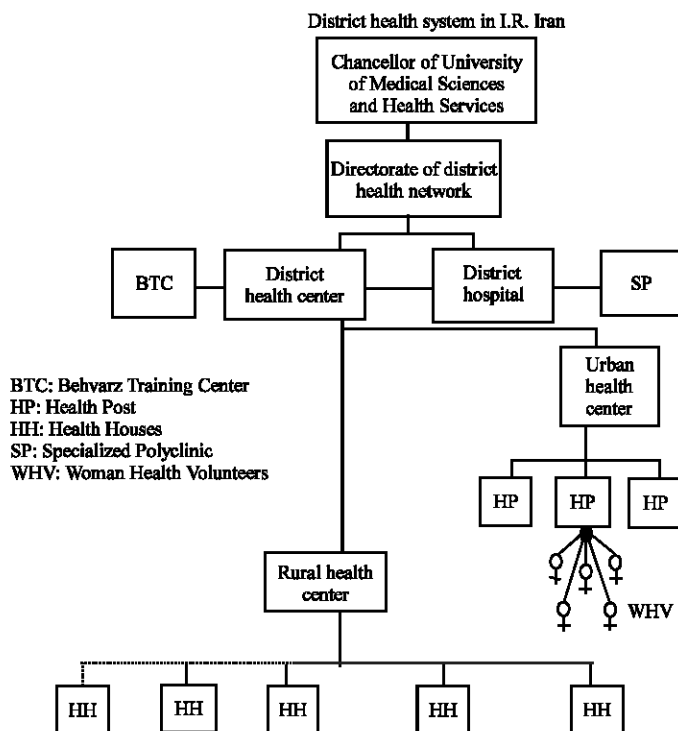


Fig. 1: District health care network in Iran (location of study: Urban health center)

and 8 health care researchers and managers were chosen from two health care centers in Isfahan. The following criteria were used for selecting samples: for the elderly both women and men who were 60 years old and above, able to communicate well, interested to participate in the study and who utilized health care centers services during the last 1 year. As for the sample of family members, children who looked after of their parents were invited to participate in the study. Family members were selected for their experience of caring for aging parents. They were female caregivers living in Isfahan. Caregiving is regarded as women's work in Iran. Aging parents are more likely to receive caregiving assistance from adult daughters.

For the managers and health care providers, a 3 years working experience was required as basis for including them in the sample. They would then have ample experience and perceptions related to primary health care for the elderly. Another criterion was their willingness to share their experiences and submit related information. They were female and male who were responsible of providing primary health care to all of the clients of health care centers as well as elderly. All of them had graduated from medical schools in Iran, five health care providers had GP degree and three of them had bachelor's degree in public health.

Two health care centers from different parts of the city were chosen to cover different level of socio-

economic status of participants. Initially, participants were selected using a purposive sampling technique. Theoretical sampling guided the selection of further participants. Interviews and observations have done in health care centers, in some cases in the elderly homes and focus groups carried out in faculty of health in Isfahan University of Medical Sciences. Data collection was carried out by the same interviewer and focus groups were led by one experienced moderator. During the interviews and focus groups, notes were made about the situation of the interviews and non-verbal signals from participants and the topics they raised in focus groups. These helped researchers to develop the interview guide over time. The duration of interviews and focus groups was between 1, 2 and ½ h.

Each interview and focus group were transcribed verbatim and then managed for analysis. The constant comparative method of data analysis was used, whereby collection, coding and analysis occur simultaneously. The analysis techniques suggested by Corbin and Strauss (1998) were followed closely in this respect. Each transcript was hand-coded from repeated examinations of the text. Every sentence in the transcript was analyzed to identify descriptive categories. Data from the interviews, focus groups and observations were analyzed concurrently using the constant comparative method. Open, axial and selective coding was applied to the data

(Corbin and Strauss, 1998). Following reading and re-reading of the transcripts, subcategories emerged and were then categorized, labelled and were clustered into categories. This process progressed to a more detailed indexing. The process of continual checking and questioning of emerging categories was continued until the same categories with those of repeated reading and analysis emerged (Priest *et al.*, 2002). Finally, data were categorized into categories and subcategories. Data collection continued until all categories were saturated and no new data emerged. Rigour in qualitative designs can be measured in terms of credibility, dependability, transferability, auditability and confirmability (Streubert and Carpenter, 2002). In this study, Credibility was established through prolonged engagement with participants through participants' interviews and observations and extensive immersion in the data.

The data, categories and interpretations were reviewed with 5 participants. These refer to member checks. To establish auditability, a second review was conducted by faculty members. Triangulation of sources was achieved here through ensuring maximum variation in the sampling of interviewees and types of data sources (Patton, 2002; Hammersley and Altkinson, 2007). This also improved the credibility of the study.

Transferability was achieved through thick descriptions of process for analysis. This will allow others to make accurate and informed judgments if the findings of this study are applicable to their contexts. Dependability was established through use of an interview schedule for each participants and focus group discussion and by keeping an audit trail outlining the process and used by researcher through the research and analysis.

Confirmability has been enhanced by keeping an audit trail that included all the raw data such as recorded interviews, transcribed interviews, field notes, memos and interview schedule.

As the values, experiences, interests and epistemological and methodological beliefs of the researcher can affect the construction of meaning in the data a researcher can improve confirmability of a study by being reflexive reflexivity is a process of conscious self awareness where a researcher continually appraises the subjective responses and intersubjective relationships within the data in relation to his/her values, experiences, interests and beliefs (Finlay, 2002).

Ethical approval was obtained from ethical approval committee of Isfahan University of Medical Sciences and University Putra Malaysia. Permission for interviews, focus groups discussions, observations and recordings was gained from Deputy of Health of Isfahan University

of Medical Sciences and chief executive of health care centers when required. Furthermore, ethical issues in this study involved the assurance of confidentiality and autonomy for the participants. All participants were informed of the purpose and design of the study and their voluntary participation. Verbal consent was sought from the participants for the audiotaped interviews and videotaped focus groups.

RESULTS

Two main categories delineated from the data to explain nature of caring behaviors in family members: family internal responses and family external responses. Figure 2 shows the major categories and their subcategories.

Family internal responses: It seemed that the internal response of family members resulted from their negative evaluation about inhibiting factors such as economical problems, lack of family support, families' unawareness about elderly issues and caring methods, cultural changes in the new generation and inattention to the importance of family role in elderly health care planning.

These factors acted to increase the despair of the families and they were not effective at engaging with parents' health care. Sub-categories of this response included considering the elderly as children, emotional escape and feeling of inability to care.

Considering the elderly as children: Most of the participating family members assumed that their parents are similar to children and they believed that they should

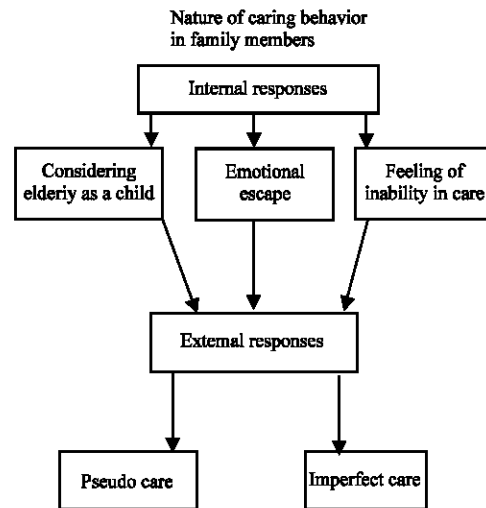


Fig. 2: Emerged categories and sub-categories

act with them as children. This inner attitude did not have positive outcome such as more attention or more care as a child rather, its outcome was inattention to the elderly in family intercommunications and decision making. In the process of childcare, most of the families consider physical needs. Hence, their child-caring behaviors were applied for the elderly and consequently the needs of the elderly in other domains such as mental, emotional and social domains are not met. Accordingly, this outcome conducted to mental health damages for the elderly.

This category is exemplified by the participants' remarks: as much as we take care of her (his mother) she is never satisfied. By God, I prepare lunch, dinner, fruit for her and take her to the bath. But she has too much expectations and nags all the time. She wants to interfere in everything. There is no one to tell here that she should not do this in such age and you should thank God for every thing they prepare for you. So it's better not to interfere in other' issues. For example, she says why do not you ask my opinion about that issue? Why do not you take me to that place? Why do not you tell me where you go? (family member).

My children behave as if I'm a child. It's true that we say an old person is like a child but not to this extent. They do not accept me at all and don't think that at least, I have had long life. If they want to do something and I state my opinion they do not accept that and tell me: you do not know what is going on (elderly woman).

One of the family members who have participated in this study, said that old people are like children. They always nag. I always try to treat my parents like children. The researcher has written in her observation field note from the house of one of the elderly; the old woman was confined to bed because she had fallen. Her daughter brought food and she made her cloth dirty while she was eating food. The old woman was criticized for such behavior. Her daughter said her to be careful and not made her clothes dirty. She looked at me and told: you see that they become like children when they got old. We are having a baby again at this age.

Emotional escape: Emotional escape was defined as not to get involve in elderly issues, lack of sympathy for elderly problems and disinterest in communicating with the elderly. Some of the children did not respond positively to elderly desires, sadness and problems. Emotional escape was toned down based on individual characteristics of family members such as beliefs and conscience. This is typified by one of the participants who said that I like so much to do something for my parents, even for God's sake. But I am unable to do so, not only from financial aspects but also from physical aspects. So, I try to not to

think of them. One of the family members said! I have so many problems in my life that I cannot come and visit her (her mother) regularly and help her, I try not to think about my mother's needs but I am not pleased I have no alternative.

The researcher has written in her observation note; when his father was talking to her about his painful knees, she did not answer. I thought she did not hear. So I told her, he was with you. She answered; I heard but if I listened to him, he would groan until tomorrow. I had so much to do and I cannot sit and listen to him.

My mother is very bad-tempered and she grumbles. I try to see her every now and then. The more attention we pay to her, the more she groans. Whenever I come to see her, she asks me to take her somewhere (family member).

Feeling of inability to care: Most of the family members believed that in most cases they are unable and desolate in offering elderly health care. Lack of appropriate information and knowledge about elderly health care and its issues, lack of economical supports and weaknesses of social supports were stated as the most important factors that caused feeling of inability and desolation. Some phrases used by family members for stating this were I do not have ability, I cannot do anything and I do not know what should I do. My mother has fallen some time ago and now she is confined to bed. They have told that it's too bad for to develop bed sore but we do not know what to do to prevent it. One of the relatives asked us to take a nurse to look after her or someone who tells us what to do but whom we should ask to look after her. It needs too much money and we do not have any. I'm worried very much. I'm not in a condition to do anything for her. I have so many problems that I leave home in the morning and do not come back until night.

I'm very tired and I have to do house works, too. I have no energy and time to visit my parents and have no power at all. Even if I wanted, I can not. I have a bad sense. My father wants to be looked after because of his prostate and other problems. I was looking for some one whom we could confide but I could not find an experienced and trustable person. There is no good place in this big city. If you find someone with a trustworthy and good personality, he may be able to look after him. I myself can not do it and I do not know what to do.

Family external responses: External responses in the families of the elderly were created pursuant to internal responses and they referred to objective behaviors of the families that categorized to pseudo care and imperfect care.

Pseudo care: Pseudo care refers to the care that is not genuine but has the appearance of care. This kind of care was one of the common obvious caring behaviors in the families. This behavior has its roots in cultural background. Based on the dominant Iranian culture in the society, the families accentuate the opinion of people who observe them as that of their relatives. As a result, some of them have been doing their caring behaviors to avoid others' accusation. Having different behavior in presence of others and perpetual worryment for others' judgments were the common indicators of pseudo care.

This is typified in comments by participants: I asked my brother and sisters to visit and help to my father and told them that all relatives seek to know how we behave with him.

If we don't do anything for him they would tell that his children do not pay attention to him. They make an excuse every day and do not heed at all. I'm sick and have a lot of difficulties. If I had not to do my task in front of every one, I could not even come to see her but I come anyhow. Of course, I do not do anything for her but she flatters herself that I call on her.

The researcher has written in her observation note; while her daughter went into the kitchen to bring tea, the old woman put her head beside my ear and said that among her children just she calls on me in a standing on ceremony for her aunt and uncle. But she made a show and made me clean whenever they wanted to visit me. Sometimes my body smelled awfully but no one paid any attention to me. She asked me not to complain about my children in front of others.

Imperfect care: Imperfect care was the other obvious behavior of the families pursuant to their internal responses as a result of various inhibiting factors. It refers to care that is characterized by defects or weaknesses. This category manifested as three sub-categories including not giving priority to elderly care, inattention to a holistic care of the elderly and insufficient visiting. Not giving priority to elderly health care issues was one of the most important behaviors at the family level.

The families' desperate need for other issues, especially the youth and the presence of some attitude and beliefs about aging and the elderly, led to considering elderly health care as a side issue (secondary). In some cases, elderly participants looked at themselves as lost. One of the participants commented; It's true that we should take care of the parents but they have lived a long time. I have two young children who have no job and no bright future. How can I think about my parents? They should think about us, since they have had a bright past. We have lived a long life. Attention should be focused on

the youth and their problems. We do not expect from the government to do any thing for us. The government should take action for the youth as much as possible, for problems such as addiction, unemployment and so on (elderly woman).

One of the elderly woman said that my children have forgotten me. If I say a word they say that they have a lot of difficulties in life. They say that they can not come to take me to the doctor; they would come if it is possible and they have more necessary things to do. To sum up they do not pay attention to me.

Unawareness and lack of appropriate knowledge about different domains of health and the need to pay attention to elderly health with this perspective, led to imperfect attention to elderly health care in families. Even in the families that as a result of intervening factors, despair was reduced or modified, most of focus was on the physical domain of health and they did not pay attention to other aspects of elderly health care although in a majority of elderly participants the necessity of attention to social, mental and emotional needs was more predominant. Such issue is captured in the following comments: I do not know what I should do for her (my mother).

Her food and clothing are provided. My brother sends money to her but he can not visit her himself. So, my mother is not satisfied and all the time complains about her loneliness and impatience. I do not know what does she want? I do not expect them (her children) too much. I just expect them to talk to me properly and call on me. If they want to go somewhere I expect them to ask me whether I want to come or not. I do not go with them, just telling me is enough. They think that by providing my expenses they do a Herculean task (elderly man).

The researcher has written in her memos; altogether, families and the society neglected the real needs of old people. They consider the elderly as machines. And they think providing the fuel will suffice. Most of the children of the elderly accepted that they have not paid attention to visitation of their parents and meeting their need for communication. However, most of them accounted for their actions by mentioning some reasons. Elderly participants talked about their loneliness and their need for attention often times. This situation affected different domains of elderly health, especially their mental health and led to despair in the elderly. My children do not pay attention to me they often pass in front of my room (we live in the same house) but they do not even look at me. Previously, I told I do not allow any one to give me even a glass of water but now, I'm helpless and no one helps me. It's too difficult (elderly man). I have not seen one of my daughters for 2 months and every time she makes a

pretext. Some time ago she asked me to give her some money which I had not (she did not believe). Because of this she does not call on men (elderly woman). I'm always afraid of being humiliated by my children. It's difficult for me to do my own affairs, for instance going to a doctor, I can not go alone, I want to but I can not. I have to ask my children to take me but they do not pay attention. I hope my condition would not become worse than it is. There is nothing, I can do for myself.

DISCUSSION

In regard to increasing population aging families are increasingly confront the care giving needs of their older parents when an older adult's health slowly or rapidly declines and frailty threatens independence, a family member is often the primary provider of care. In addition, the current trend toward a community-based health care system means that when an older adult requires care, much of it will be provided by family and at home. Although, based on religious and eastern culture, it is expected that the elderly receive high quality care and respect in Iran; however, as a result of several conditions such as economic problems, lack of family support, families' unawareness about elderly issues and caring methods, cultural changes in the new generation and inattention to the importance of family role in elderly health care planning family members were walking a line towards the despair in providing care for their old parents.

Consistent with this study's results, Sajadian (2009)'s study indicated reduction in family function regarding elderly support in Iran and Naji (2006) found that the families paid partial attention to take care of their elderly in Isfahan Province in Iran and their caring behaviors was not at favorable level. Also similarly according to Martin (1990) in China, Japan and south Korea intergenerational family relations are changing and the expected declining role of the family in elderly' care are causing growing concern among policymakers. According to Cooney and Juxin (1999) child generation in China who had less traditional cultural orientation and greater economic resources to pay for services express the greatest need for formal service support to care of parents. In contrary with this study, Subgranon (2000) found that culture, tradition and religion dominated throughout caregiving process of Thai caregivers for their elderly stroke relatives.

Family internal responses to conditions were at first manifested as considering the elderly as children in this study. Caregivers' attitudes about elderly can determine their caring behavior as Yonge and Molzahn (2002) found that health care providers looked at the elderly as a school kid and they believed that they were expert who should be

listened to. In this study, families looked at their parents as children and this attitude did not have positive outcome such as more attention or more care as a child, rather its outcome was inattention to the elderly in family intercommunications and decision making and inattention to elderly real needs. Caring for old parents is a challenging and difficult task for family caregivers especially who bears major responsibility for the older person's welfare (Braithwaite, 1992). It requires great investment of time, as well as physical and emotional energy and may become a burden (Greenberger and Litwin, 2003). Burden is liable to diminish the caregiver's ability to provide quality care (Braithwaite, 1992). Caregiver stress or burden level has been found to be a predictor of caregiving outcomes (Rosalie, 1994; Hills, 1998).

Some researchers have documented the positive consequences of caregiving for caregivers. Greenberger and Litwin (2003) and Lawton *et al.* (1991) also argued that one can be a burdened caregiver and yet a confident and successful one and satisfaction with and success in caregiving on the one hand and burden on the other are not mutually exclusive but can indeed coexist. However, much of the caregiving literature published during the past two decades has focused on the negative effects that such caregiving has on caregivers. In particular, these studies have focused on the burden and the stress generated by caregiving (Pearlin *et al.*, 1990). Considering that interventions and health care policies are aimed at enhancing caregivers' well-being and adaptation to their caregiving role, it is understandable that research in this area has focused primarily on understanding the negative consequences at the expense of the more positive consequences of the experience of caregiving (Kramer, 1997).

In a qualitative research Mohammadi *et al.* (2008) found that Iranian family caregivers who took care from their parents experienced different negative effects of being caregivers such as stress, burden of care and physical and mental problems. Elderly participants in Mohammadi *et al.* (2008) looked for balance between their different roles. It seemed that in this study, family caregivers tried to emotionally escape from involving in their parents' care by not getting involved in their parents' issues and reduced their communication with them to reduce burden resulted from elderly care.

This result was supported by Lazarus and Folkman (1984)'s theory. According to the theory, escape is one of the strategies that may be utilized by individuals or groups for avoiding the problem or its sources. According to Pearlin *et al.* (1990) and Braithwaite (2000) social support has been shown to counteract stress and to

bolster caregivers in their role performance. In this study, lack of social support led to increased burden and stress resulted from elderly care and consequently family emotional escape as internal responses to conditions. On the contrary, in a study of adult children and their view of problems with aging parents, Simos (1973) found that the children could cope with the physical problems of their parents, even though they required considerable time and attention. Silverstone and Hyman (1976) indicated that children of aging parents respond with feelings of guilt, helplessness and resentment when they perceive loneliness, depression and dissatisfaction in their elderly parents.

In this study, although some of the family' caregivers talked about some similar feeling, their responses showed emotional escape. Feeling of inability to provide care as a result of lack of appropriate knowledge about elderly health care and lack of social and economic support was another internal response of family caregivers in this study. Having knowledge and skills to take care of elderly is so important and influences quality of provided care by family caregivers. Especial situations of elderly care require knowledge and skills in the use of resources, devices and positioning an old person for comfort. Lack of sufficient knowledge in family caregivers was reported in previous studies.

According to NAC and AARP (1997) and Schumacher *et al.* (2006), only 41% of caregivers reported that someone had instructed them in how to perform at least one caregiving activity. Percentages of family caregivers who knew nothing about symptoms as well as risk factors of hypertension and arthritis prevention respectively was 80 and 76% in Vietnam (Oanh and Kiet, 2005).

Lack of knowledge and appropriate knowledge in addition to weaknesses of social and economic support affected family caregivers' feelings and behavior in this study. Consistent with this study, Hosseini *et al.* (2009) found a significant relationship between elderly' economic status and elderly position in family in Iranian elderly in Bandar Abbas province.

Namely, they found that families' behaviors regarding the elderly are changed based on economic status of their parents. Iranian families' participants in Iranpoor *et al.* (2009) study also talked about economic problems as one of the most important issues influenced providing care for their parents. Also Naji (2006) found a significant relationship between contribution of Isfahanian families for caring their elderly and family income.

The role of family caregivers' social support also has been emphasized by Baillie *et al.* (1988). According to Baillie *et al.* (1988) caregivers who are caring for an elderly

for an extended time and who have low social support are at risk of distress or depression. In this study, family members had a variety of emotions, attitudes and thoughts concerning provide care for their parents. Common feelings included emotional escape, inability in providing care, considering elderly as a child and worry for others' judgments. Out of these feelings and attitudes, came a variety of behaviors regarding care.

More commonly families caring behaviors have been motivated by a combination of that feeling and socio-economic conditions that influenced their behaviors. As a result, family caring behavior in this study manifested as pseudo care and imperfect care. Pseudo care has its roots in cultural background. Based on the dominant Iranian culture in the society, the families accentuate the opinion of people who observe them as that of their relatives. As a result, some of them have been doing their caring behaviors to avoid others' accusation by different behavior in presence of others. Forces resulting from cultural context led to external responses of family as pseudo care in this study. On the contrary, according to Lee (2001) qualitative analysis supported the value of the concept of the ethic of care in understanding the social and individual forces that propel older women into providing family care despite its demonstrably negative effects on their wellbeing.

Imperfect care was other external responses of the families' participants in this study. As a result of conditions especially extent of youth issues and economic problems and other factors, families did not give priority to elderly health care. WHO defined health as a state of complete physical, mental and social well-being and not merely the absence of disease and more recently, achieving health for all (WHO, 1986) defined health in terms of quality of life and included in the definition the opportunity to make choices and to gain satisfaction from living despite functional limitations. Family participants in this study did not attention to this concept in health care providing for their old people. All of the families commonly considered physical domain of elderly health and this behavior defined as imperfect care in this study. This finding was consistent with other researches' findings.

As Salemeleh *et al.* (2007) found most of the elderly families in Mazandaran Province in Iran paid attention to their parents in case of ill health and also their nutrition and individual hygiene during their illness. They did not pay attention to other domains of their needs such as respect to their views, their need to participate in family issues and so on.

Almost 50% of families relegated caring of their parents to others when they were going on a trip.

Consistently, according to Oanh and Kiet (2005) caring for the elderly was not provided comprehensively and physical care and medical care were considered as important issues of providing care among family caregivers in Vietnam.

CONCLUSION

The family has a fundamental role to play in elderly health. This study emphasized two main categories associated with the nature of caring behaviors in family caregivers in an urban area in Iran: internal and external responses.

Having these data would provide the basis for improving the activities engaged by the groups concerned and would lead toward promoting the quality of life for the elderly as they make use of the services offered and the family members better understand their role to offer more appropriate and justified quality services.

So, providing quality elderly primary health care in urban health care centers need to be comprehensive and to involve other aspects of the community with focus on family empowerment as well as fostering change in socio-economic and cultural environment.

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