IJAYUSH
International Journal of AYUSH
AYURVEDA, YOGA, UNANI, SIDDHA AND HOMEOPATHY
http://internationaljournal.org.in/journal/index.php/ijayush/

International Journal
Panacea
Research library
ISSN: 2349 7025

Original Research Article | Volume 15 Issue 03 | March 2026

ASSESSMENT OF QUALITY OF LIFE IN ELDERLY PATIENTS SUFFERING FROM DIABETES MELLITUS, HYPERTENSION, COPD, DEMENTIA, BENIGN PROSTATIC HYPERPLASIA, JOINT DISEASES THROUGH PROVED HOMOEOPATHIC MEDICINES

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ABSTRACT

Background: As the global population over 60 years of age is projected to reach 2.1 billion by 2050 , there is an increasing need to evaluate holistic interventions for age-related chronic conditions. This study assesses the impact of individualized & therapeutic homoeopathic treatment on the quality of life (QoL) of elderly patients suffering from various chronic ailments.

Objective: To determine the spectrum of diagnoses and describe the course of illness and quality of life over 12 months in elderly patients receiving homeopathic care.

Materials and Methods: A prospective, multicentre observational study was conducted at the Geriatric & Peripheral OPDs of GHMC, Bhopal, involving 835 participants aged 60 and older. Patients with diagnoses including diabetes mellitus, hypertension, COPD, dementia, benign prostatic hyperplasia, and joint diseases were included. Participants received

individualized & therapeutic homoeopathic medicines in centesimal potencies. Clinical progress was evaluated at baseline and at 3, 6, 9, and 12 months using a Numerical Rating Scale (NRS) (0 = no complaints, 10 = maximum severity) recorded by both patients and physicians. Data were analyzed using repeated measures ANOVA and Bonferroni post-hoc tests.

Results: The most frequent complaint was hypertension (n=613), followed by musculoskeletal disorders (n=536) and diabetes mellitus (n=292). Both patient and physician assessments showed a significant downward trend in NRS scores, indicating improved quality of life ($p < .001$).

- **Patient-reported NRS:** Mean scores decreased from 4.67 (baseline) to 3.36 (12 months), with a large effect size ($\eta^2_p = 0.31$).
- **Physician-reported NRS:** Mean scores decreased from 4.65 (baseline) to 3.22 (12 months), with a slightly higher effect size ($\eta^2_p = 0.35$). The greatest mean reduction occurred between baseline and the 12-month mark.

Conclusion: The findings suggest a highly significant and consistent improvement in the quality of life for elderly patients with chronic illnesses undergoing homoeopathic treatment. While physicians rated improvements slightly more optimistically than patients, the high correlation between both perspectives validates the clinical progress observed over the one-year period.

Keywords: Geriatrics, Homoeopathy, Quality of Life, Chronic Diseases, Numerical Rating Scale (NRS), Observational Study.

INTRODUCTION:

The aim of the present study was to determine the spectrum of diagnoses and treatments, as well as to describe the course of illness over time among older patients who chose to receive homeopathic treatment. To collect data on the use and effects of homoeopathy under conditions of usual care, we investigated 1200 (365 cases were dropped) patients in a prospective observational study. This paper presents the results of our evaluation, focusing on a group of 835 elderly over 60 years of age, who consulted in GHMC, Bhopal Geriatric OPD.

Homoeopathy is increasingly recognized in geriatric medicine as an additional or alternative therapy because of its holistic approach. Elderly folks who commonly struggle with a variety of chronic health concerns will find it to be a good fit. the potential benefits of homoeopathy

in treating age-related illnesses like diabetes mellitus, hypertension, COPD, dementia, benign prostatic hyperplasia, and joint diseases in order to enhance the quality of life for senior citizens.[1] One in six individuals on the planet will be 60 years of age or older by 2030. The number of individuals in the world who are 60 years of age or older will quadruple to 2.1 billion by 2050. Between 2020 and 2050, the number of people 80 years of age or older is predicted to treble, reaching 426 million.[2] In India, there are approximately 104 million senior people, or slightly more than 10% of the population. By 2050, that number is expected to climb to 19.5%.[3]

The ancient "principle of similars" serves as its foundation. Patients who exhibit similar symptoms while ill are treated with highly diluted formulations of substances that elicit symptoms in healthy individuals.[4] A single homeopathic treatment is chosen in classical Homoeopathy based on the patient's entire range of symptoms.[5] Despite the controversy and criticism surrounding the lack of results that have been scientifically validated and the notion that Homoeopathy is based on unsubstantiated findings that are rarely supported by high-quality scientific evidence, Homoeopathy is nevertheless used today.[6]

With more than three lakh registered homoeopathic practitioners offering homoeopathic therapy in both public and private settings, homoeopathy is a recognized and approved alternative medical health care system in India. Osteoarthritis, benign prostate hypertrophy, and multimorbidity are among the elderly illnesses that homoeopathy is known to be helpful in treating.[7] Although the data produced in these individual disease-based studies, which are based on clinical care approaches, varies in quality, it is sufficient to investigate the use of homoeopathy in geriatric populations in public health settings.

An independent organization of the Indian government's Ministry of Ayush, the Central Council for Research in Homoeopathy (CCRH) conducts and advances homoeopathic research. Research-based public health care programs are one of CCRH's main initiatives. This entails creating and carrying out public health initiatives aimed at particular demographics. The information produced is documented to determine the program's value and its effects on the nation's public health care system.[13]

In order to evaluate the elderly for unmet psychosocial and medical requirements and record their reaction to homoeopathic treatment, CCRH implemented a public health care program for the geriatric population under the Scheduled Caste Sub Plan (SCSP).[13]

MATERIALS AND METHODS:

Trial design

In a prospective, multicentre cohort study involving geriatric & peripheral OPDs of Govt. Homeopathic Medical College and Hospital, Bhopal. In this group analysis data was analysed from all patients being 60 years or older. Patients were included consecutively at their first consultation and were followed up for a total of 12 months. In order to provide as representative a picture of homeopathic health care as possible, patients were included in the study regardless of their diagnosis.

Ethics approval

The study protocol was accepted by the Institutional Ethics Committee (IEC) (Reference No. College/IEC/24/Certificate/1856-64; dated March 21, 2024).

The protocol conformed to the Declaration of Helsinki and followed the guidelines for Good Clinical Practice.[8] Before recruitment, each patient was provided with a patient information sheet in local vernacular Hindi, and subsequently, written informed consent was obtained from all the participants.

Participants

The inclusion criteria were the aged of patients being 60 years or older, presented with the diabetes mellitus, hypertension, COPD, dementia, benign prostatic hyperplasia, joint diseases, literate with the ability to read English/Hindi, and provided with written informed consent voluntarily to participate in the trial. Exclusion criteria were the patients bellow the age of 60 years, and had a presence of neurological or psychiatric diseases affecting the quality of life, already undergoing homeopathic treatment for any chronic diseases, substance abuse and/or dependence, self-reported immune-compromised state, and the patients willing to take allopathic treatment simultaneously or availing homoeopathic treatment for any chronic disease within the past 3 months.

Interventions

The participants were prescribed according to homeopathic principles in centesimal potencies and individualized & therapeutic dosages. Each dose consisted of six to eight medicated globules (No. 30) of cane sugar. The participants were instructed to take them orally on a clean tongue with an empty stomach. The follow-up period for each participant

was 1 months. All the medicines were procured from a Good Manufacturing Practice-certified firm. Whenever needed individualized & therapeutic prescription was supported by repertorization using repertorization software (Rapid Aid to Drug Aimed Research—RADAR_, version 10.0.028 [ck], Archibel 2009, Belgium) as and when required, consulting Materia Medica, and a consensus among three homeopaths. Medicines, potencies, and dosages were adjusted in subsequent visits whenever required following the classical homeopathic principles.

Most of the homoeopaths possessed a master's degree in Homoeopathy with more than 10 years of experience and practicing classical Homoeopathy. The rest of the homeopaths were postgraduate trainees of the institution. All the homoeopaths involved were affiliated with their respective state councils. Adherence to advice was assured by weekly phone calls and follow-up visits. A drug accountability log was maintained tracking the records for consumed dosage and returned globules.

For physicians, we developed a standardised questionnaire that allowed for continuous documentation during the treatment/follow-up period (12 months), as well as standardised points of assessment at 0, 3, 6, 9 and 12 months. At each follow-up time points the physician saw the patient and estimated the severity of a maximum of all diagnoses from their perspective after they did the case taking with the patient using a numeric rating scale (NRS, 0 = no complaints, 10 = maximum severity of the occurrence of this diagnosis). [9] This information was then forwarded to the study office. The type of homoeopathic treatment, the use of any naturopathy therapy, as well as any referrals to other physicians were recorded on a continuous basis.

Timeline

All the outcomes were measured on monthly intervals, for up to 12 months.

Statistics

We calculated the severity of complaints (patients' assessments) and diagnoses (physicians' assessments), by averaging those all complaints/diagnoses named first for each patient during the baseline examination. At each follow-up (i.e. at 3, 6, 9, and 12 months) the respective severity ratings were ascertained. All results reported here are based on the intention-to-treat approach, i.e. each patient included in the study entered the final analyses. If patients dropped out or withdrew from the study we remove that patient data. For patients

who died during the study, we inserted the Baseline severity rating of all remaining follow-ups. These complete data tables are analysed separately using appropriate statistical models. Afterwards, the results from all statistical analyses are pooled to generate treatment effects and p-values.

Although this study is explanatory by nature confidence intervals and p-values for change scores might be misinterpreted as statistical proof of hypotheses. We thus adjusted the results for all 10 outcomes (1 outcome measures times 5 time points) by applying Bonferroni Post-hoc-Tests.[10]

Standardized mean changes (effect sizes) were calculated by mean changes divided by standard deviation at baseline.

RESULT:

Socio-demographic Details

In the Geriatric OPD, screening was conducted for 1200 participants, and 365 were dropped the treatment. Among the 835 patients, the mean age of the participants was 67 years. The majority of participants were male (55.69%) compared to female (44.31%).

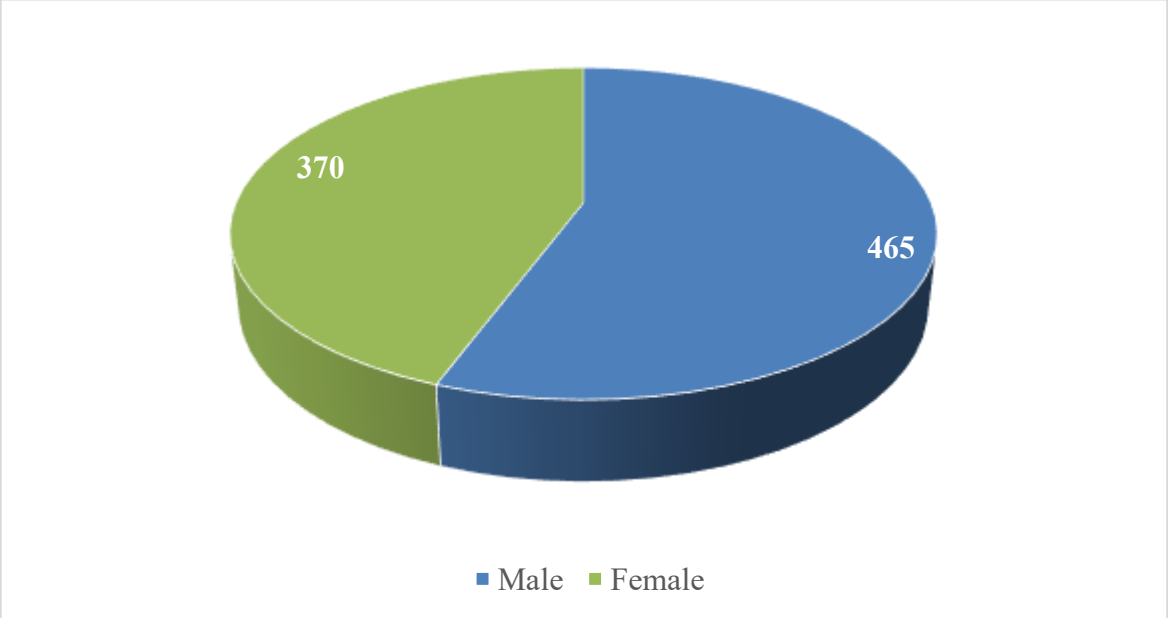

Figure 1: Socio-demographic Details

System Affected

The most frequently reported complaints were Hypertension, followed musculoskeletal disorders, particularly joint pain, diabetes mellitus, benign prostatic hyperplasia, dementia

and COPD. The highest affected system is the Hypertension (613). Musculoskeletal system follow closely with 536 cases, diabetes mellitus (292 cases), benign prostatic hyperplasia (119 cases), Dementia (78 cases), COPD conditions (37 cases). This distribution highlights the diverse health challenges faced by the elderly population. These findings highlight the importance of integrating cognitive and psychological support into geriatric care. Overall, the study demonstrates the multi-faceted health challenges faced by older adults, necessitating comprehensive and multi-disciplinary approaches to ensure effective management and improved quality of life.

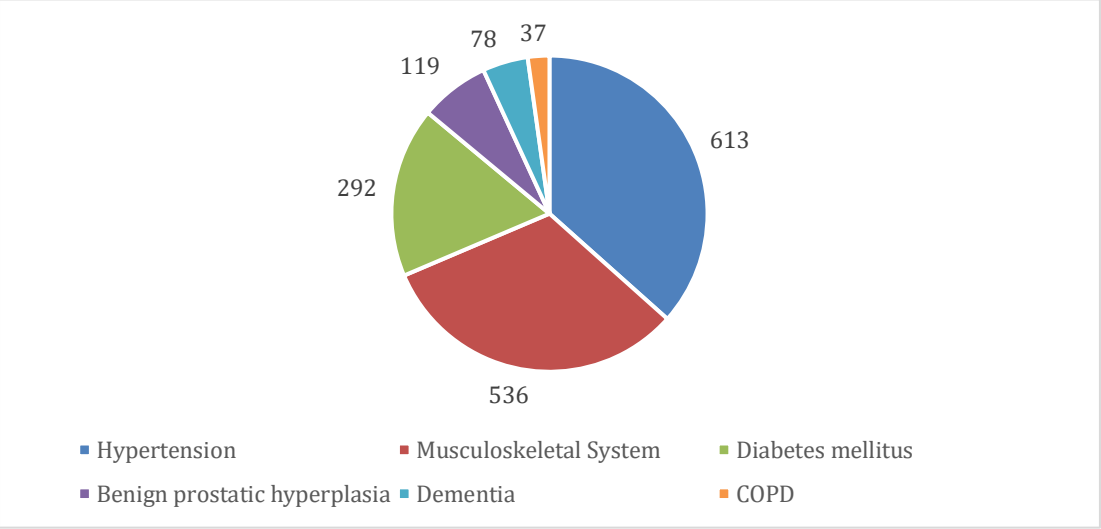

Figure 2: System Affected

All patients underwent an initial homeopathic consultation, lasting during for 12-month observation period following the initial interview, patients consulted their physicians an average of 12 times. The average period of treatment lasted 12 months. 365 patients dropped during follow-up.

NRS by Patients:

Hypotheses

Null hypothesis: There is no difference between the dependent variables Baseline, 3rd Month, 6th Month, 9th Month and 12th Month.

Alternative hypothesis: There is a difference between the dependent variables Baseline, 3rd Month, 6th Month, 9th Month and 12th Month.

Descriptive Statistics of Patient's NRS

	Baseline	3rd Month	6th Month	9th Month	12th Month
Mean	4.67	4.47	4.36	3.98	3.36
Std. Deviation	1.53	1.43	1.42	1.51	1.42
Minimum	1	1	1	0	0
Maximum	9	8	8	9	9

Table 1: Descriptive Statistics of Patient's NRS

Tests for normal distribution of Baseline of Patient's NRS

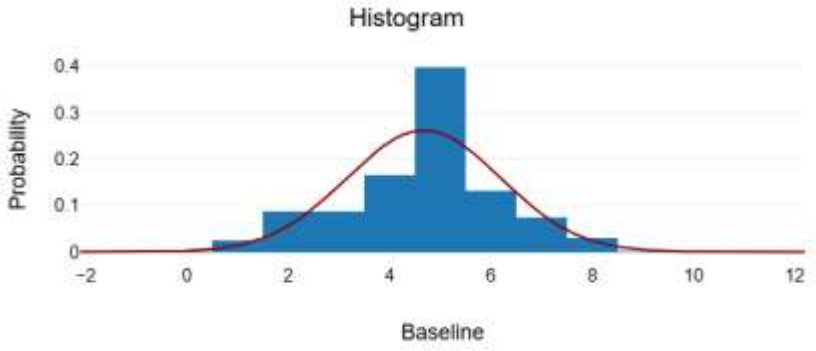

Figure 3: Distribution of Baseline of Patient's NRS

Tests for normal distribution of 3rd Month of Patient's NRS

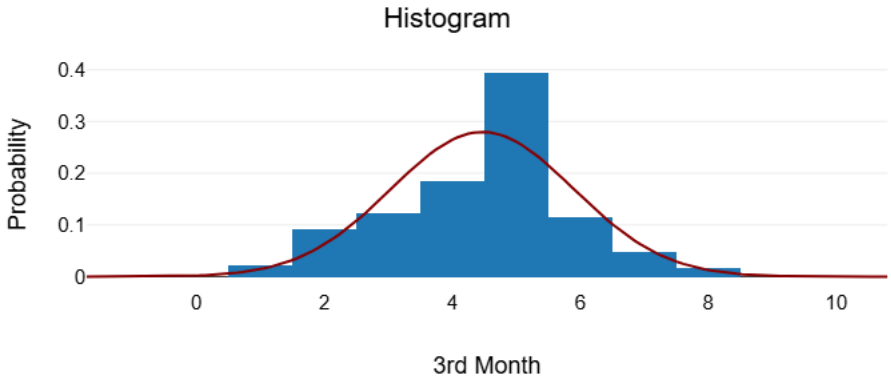

Figure 4: Distribution of 3rd Month of Patient's NRS

Tests for normal distribution of 6th Month of Patient's NRS

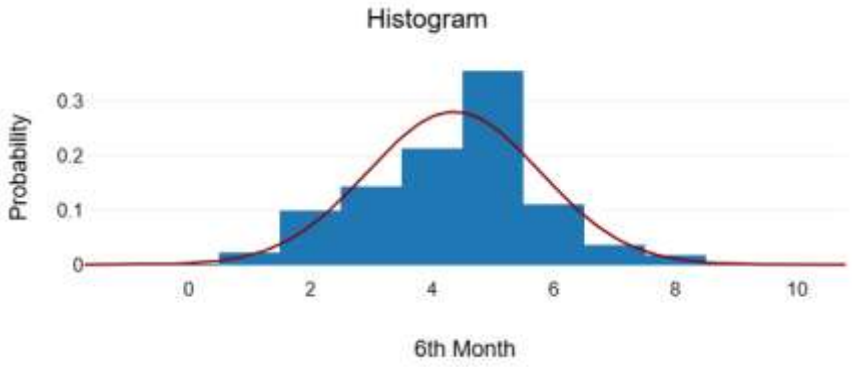

Figure 5: Distribution of 6th Month of Patient's NRS

Tests for normal distribution of 9th Month of Patient's NRS

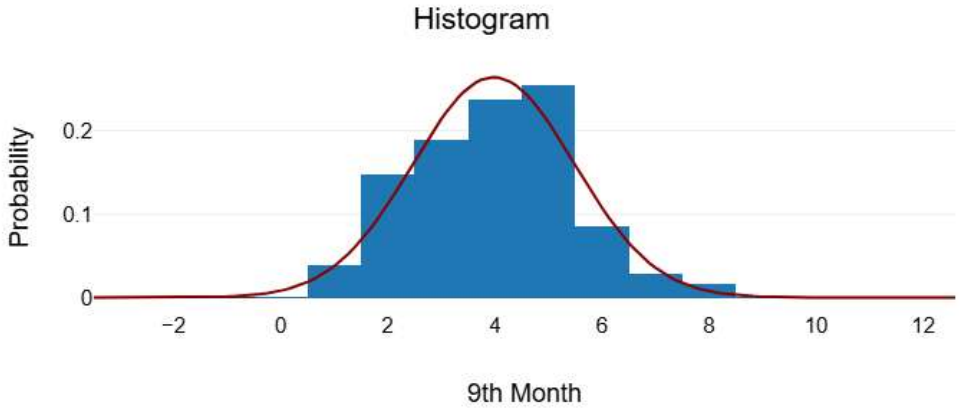

Figure 6: Distribution of 9th Month of Patient's NRS

Tests for normal distribution of 12th Month of Patient's NRS

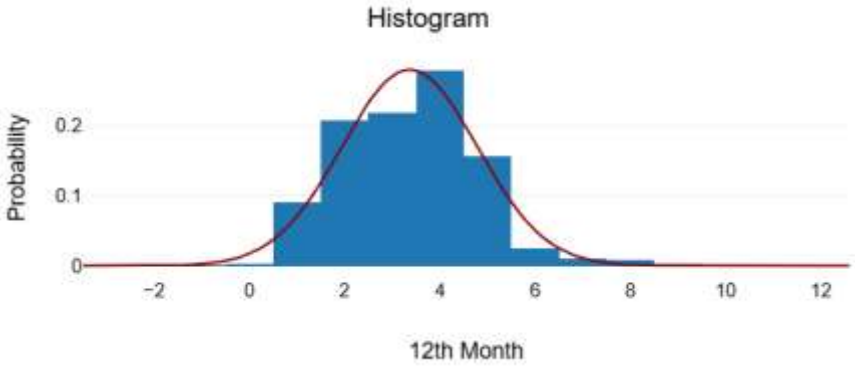

Figure 7: Distribution of 12th Month of Patient's NRS

Repeated measures ANOVA of Patient's NRS

	Type III Sum of Squares	df	Mean Squares	F	p	η^2
Treatment	890.1	4	222.52	377.99	<.001	0.31
Residual	1963.9	3336	0.59			

Table 2: Repeated measures ANOVA of Patient's NRS

A one-factor analysis of variance with repeated measures showed that there was a significant difference between the variables, F = 377.99, p = <.001. Thus, the null hypothesis was rejected.

Effect size

Calculation of the effect size partial Eta squared: η^2_p= 0.31

According to Cohen (1988), the limits for the size of the effect are 0.01 (small effect), 0.06 (medium effect), and 0.14 (large effect).

Bonferroni Post-hoc-Tests on Patient's NRS

		Mean diff.	Std. Error	p	95% CI lower limit	95% CI upper limit	
Baseline	3rd Month	0.2	0.032	6.497	<.001	0.14	0.27
Baseline	6th Month	0.31	0.039	8.088	<.001	0.24	0.39
Baseline	9th Month	0.7	0.046	14.979	<.001	0.6	0.79
Baseline	12th Month	1.31	0.046	28.647	<.001	1.22	1.4
3rd Month	6th Month	0.11	0.027	4.025	.001	0.06	0.16

		Mean diff.	Std. Error	p	95% CI lower limit	95% CI upper limit	
3rd Month	9th Month	0.49	0.038	12.813	<.001	0.42	0.57
3rd Month	12th Month	1.11	0.04	27.432	<.001	1.03	1.18
6th Month	9th Month	0.38	0.032	11.853	<.001	0.32	0.44
6th Month	12th Month	1	0.038	26.211	<.001	0.92	1.07
9th Month	12th Month	0.61	0.032	19.189	<.001	0.55	0.68

Table 3: Bonferroni Post-hoc-Tests on Patient's NRS

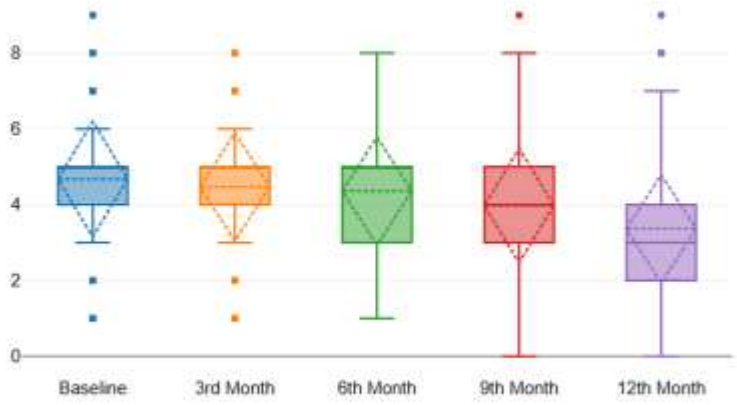

Figure 8: Distribution of Patient's NRS Mean

NRS by Physician:

Hypotheses

Null hypothesis: There is no difference between the dependent variables Baseline, 3rd Month, 6th Month, 9th Month and 12th Month.

Alternative hypothesis: There is a difference between the dependent variables Baseline, 3rd Month, 6th Month, 9th Month and 12th Month.

Descriptive Statistics of Physician's NRS

	Baseline	3rd Month	6th Month	9th Month	12th Month
Mean	4.65	4.44	4.34	3.87	3.22
Std. Deviation	1.36	1.34	1.41	1.52	1.45
Minimum	1	1	1	0	0
Maximum	8	8	8	9	9

Table 4: Descriptive Statistics of Physician's NRS

Tests for normal distribution of Baseline of Physician's NRS

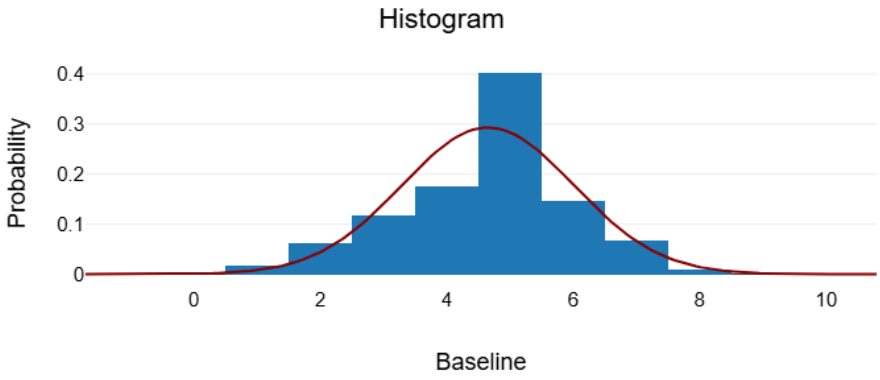

Figure 9: Distribution of Baseline of Physician's NRS

Tests for normal distribution of 3rd Month of Physician's NRS

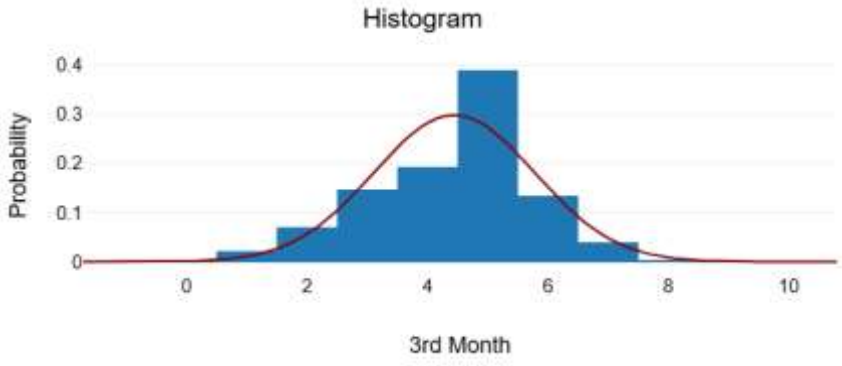

Figure 10: Distribution of 3rd Month of Physician's NRS

Tests for normal distribution of 6th Month of Physician's NRS

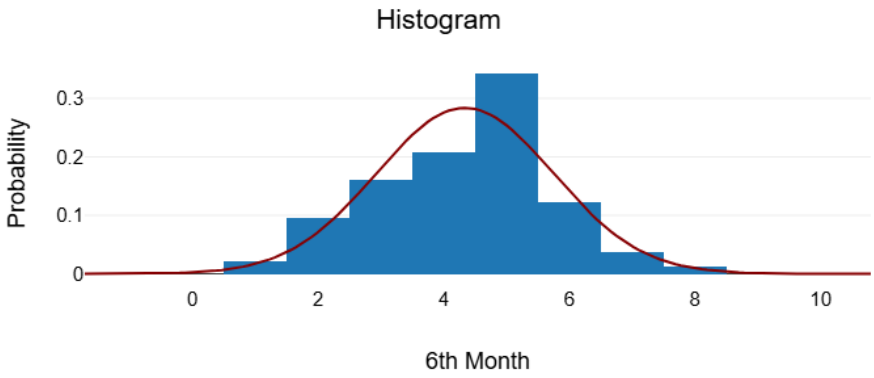

Figure 11: Distribution of 6thMonth of Physician's NRS

Tests for normal distribution of 9th Month of Physician's NRS

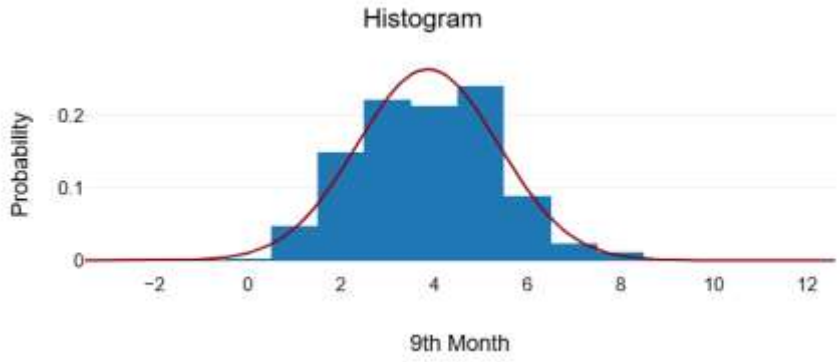

Figure 12: Distribution of 9th Month of Physician's NRS

Tests for normal distribution of 12th Month of Physician's NRS

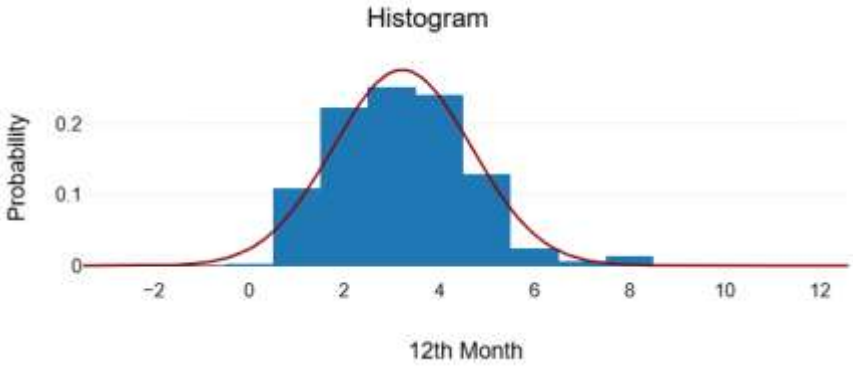

Figure 13: Distribution of 12th Month of Physician's NRS

Repeated measures ANOVA of Physician's NRS

	Type III Sum of Squares	df	Mean Squares	F	p	η^2
Treatment	1089.03	4	272.26	440.52	<.001	0.35
Residual	2061.77	3336	0.62			

Table 5: Repeated measures ANOVA of Physician's NRS

A one-factor analysis of variance with repeated measures showed that there was a significant difference between the variables, F = 440.52, p = <.001. Thus, the null hypothesis was rejected.

Effect size

Calculation of the effect size partial Eta squared: η^2_p= 0.35

According to Cohen (1988), the limits for the size of the effect are .01 (small effect), .06 (medium effect), and .14 (large effect).

Bonferroni Post-hoc-Tests of Physician's NRS

		Mean diff.	Std. Error	p	95% CI lower limit	95% CI upper limit	
Baseline	3rd Month	0.21	0.03	6.963	<.001	0.15	0.27
Baseline	6th Month	0.31	0.038	8.289	<.001	0.24	0.39
Baseline	9th Month	0.78	0.046	16.873	<.001	0.69	0.88
Baseline	12th Month	1.43	0.045	31.548	<.001	1.34	1.52
3rd Month	6th Month	0.11	0.029	3.582	.004	0.05	0.16

		Mean diff.	Std. Error	p	95% CI lower limit	95% CI upper limit	
3rd Month	9th Month	0.58	0.041	14.139	<.001	0.5	0.66
3rd Month	12th Month	1.22	0.043	28.294	<.001	1.14	1.31
6th Month	9th Month	0.47	0.034	13.682	<.001	0.4	0.54
6th Month	12th Month	1.12	0.04	28.113	<.001	1.04	1.19
9th Month	12th Month	0.65	0.033	19.374	<.001	0.58	0.71

Table 6: Bonferroni Post-hoc-Tests on Physician's NRS

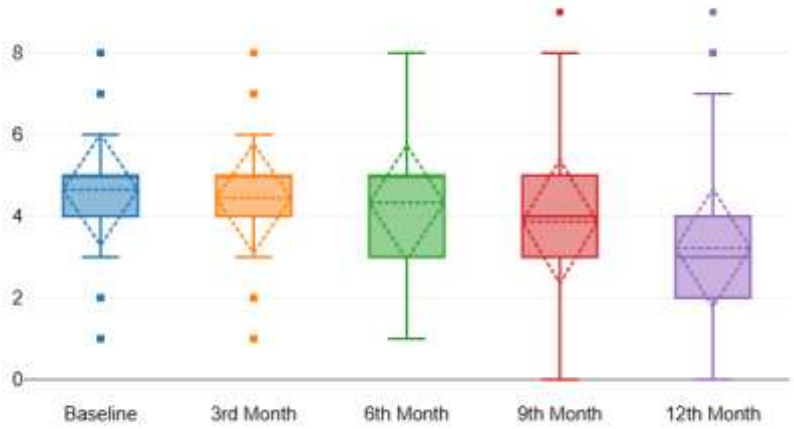

Figure 14: Distribution of Physician's NRS Mean

Descriptive Statistics (Mean NRS Scores)

Both group show a consistent downward trend in Numerical Rating Scale (NRS) scores from baseline to 12 months, though physician-reported scores generally trended slightly lower than patient-reported scores.

Time Point	NRS by Patient (Mean)	NRS by Physician (Mean)
Baseline	4.67 (1.53)	4.65 (1.36)
3rd Month	4.47 (1.43)	4.44 (1.34)
6th Month	4.36 (1.42)	4.34 (1.41)
9th Month	3.98 (1.51)	3.87 (1.52)
12th Month	3.36 (1.42)	3.22 (1.45)

Table 7: Descriptive Statistics (Mean NRS Scores) Comparison

Statistical Significance and Effect Size

The repeated measures ANOVA confirmed that the differences across time points were highly significant for both groups ($p < .001$). However, the physician-reported data demonstrated a stronger effect size compared to the patient-reported data.

- Patient-Reported: $F = 377.99$; Partial Eta Squared $\eta_p^2 = 0.31$.
- Physician-Reported: $F = 440.52$; Partial Eta Squared $\eta_p^2 = 0.35$.

According to Cohen (1988)[11], both values represent a **large effect size** (threshold ≥0.14), though the physician ratings captured a slightly higher proportion of variance.

Post-hoc Comparisons (Bonferroni)

Bonferroni post-hoc tests revealed that every time-point comparison was statistically significant ($p \leq .001$) for both patients and physicians.

- **Greatest Improvement:** The largest mean difference occurred between Baseline and 12 Months. Patients reported a mean reduction of 1.31 , while physicians recorded a slightly higher mean reduction of 1.43.
- **Short-term Change:** The smallest significant difference was observed between the 3rd and 6th Month for both groups (Mean Diff: 0.11).

DISCUSSION

The study provided information on the course of disease in elderly patients receiving homoeopathic treatment, as assessed by both patients and physicians. We recorded the homoeopathic treatment and its results in 835 elderly patients over a 12-month period in a prospective multicentric observational study with qualified homoeopathic physicians in everyday practice. Following homeopathic treatment, patient and physician evaluations of the severity of the complaints consistently showed significant improvements that persisted throughout a 12-month follow-up period. Overall, for the course of the 12-month monitoring period, both the quality of life and the quantity of medications taken stayed constant.

To the best of our knowledge, this study is the first to thoroughly assess the variety of diagnoses and treatments available in traditional homeopathic medical practices for patients over 60 at GHMC, Bhopal. There isn't any widely used measurement tool to determine the severity of various medical issues. Rather, numerical rating scales[12] were used, which would provide a diagnosis-independent assessment of the complaint's intensity. Nonetheless, the design of additional Homoeopathy research, such as randomized clinical trials on the efficacy of customized homeopathic treatments, may benefit from our results. However, these trials ought to use customized tools that evaluate treatment effects more precisely than the very general metrics we used in our investigation.

Since the purpose of our study was not to evaluate the efficacy of homeopathic medicines, a control group, randomization, or blinding were not included in the technique, and patients were free to use additional conventional treatments. Because it is known for complex interventions, the observed improvement can be ascribed to a variety of potential causes. The long-term care of older persons with chronic illnesses may benefit from homeopathic medical therapy, according to our findings. Further research on comparative effectiveness is required to test this theory.

Because the homeopaths are part of a group that only uses classical & therapeutic Homoeopathy, there may be some selection bias. Clinical Homoeopathy, for instance, treats acute illnesses more frequently, focuses more on the symptoms of the core disease, takes fewer cases, and uses a narrower selection of homeopathic medications. The fact that the majority of our elderly patients strongly believed in homoeopathy may be another drawback of our study.

High therapeutic expectations may have set off the therapeutic outcome.

The analysis of the Numerical Rating Scale (NRS) scores reveals a significant and consistent improvement in quality of life over the 12-month study period, as reported by both patients and physicians. While both datasets follow a nearly identical downward trajectory, subtle differences in the descriptive and inferential statistics provide a nuanced view of quality of life perception versus clinical observation.

Comparative Trends in improvement in quality of life

Both groups started at a similar baseline, with patients reporting a mean of 4.67 and physicians a mean of 4.65. By the 12th month, the mean scores dropped to 3.36 for patients and 3.22 for physicians.

- **Physician vs. Patient Perception**: Physicians consistently recorded slightly lower mean scores than patients at every follow-up interval.
- **Magnitude of Change**: The total mean reduction from Baseline to 12 months was 1.31 for patients and 1.43 for physicians.
- **Clinical Significance**: This suggests that while both groups recognize substantial improvement, physicians may perceive the treatment effect as slightly more pronounced than the patients experiencing the quality of life.

Statistical Robustness and Effect Size

The results of the repeated measures ANOVA confirm that the improvement in quality of life was not due to chance ($p < .001$ for both).

- **Effect Size**: The partial Eta squared (η_p^2) for physician reports was 0.35, compared to 0.31 for patient reports.
- **Cohen's Standards**: Both values far exceed the threshold of 0.14 for a "large effect," indicating that the passage of time (and the associated treatment) accounts for a substantial portion of the variance in NRS scores.
- **Consistency**: The Bonferroni post-hoc tests showed that the most significant drop for both groups occurred between the 6th and 12th months, with a mean difference of 1.0 for patients and 1.12 for physicians.

The high degree of alignment between patient and physician NRS scores validates the reliability of the quality of life assessment in this study. The slightly more optimistic ratings

by physicians, paired with a higher effect size, may reflect a "clinical observer bias" or simply the difference between subjective internal experience and objective external assessment. Overall the large effect sizes provide strong evidence for the efficacy of the intervention over a one-year period.

CONCLUSION

The results indicate a highly significant and consistent clinical improvement in quality of life levels over 12 months, regardless of whether the NRS was recorded by the patient or the physician. Physicians tended to rate the improvement slightly more optimistically than patients, as evidenced by a higher effect size (0.35 vs. 0.31) and a larger total mean reduction in scores. Nevertheless, the high degree of correlation between the two perspectives validates the efficacy of the treatment under study.

Our study's results show that the majority of elderly people seeking homeopathic treatment have chronic illnesses that have been present for a long time. Studies on comparative efficacy are required to assess the idea that homeopathic medical therapy may be helpful in the long-term care of older persons with chronic illnesses, as suggested by our data.

ACKNOWLEDGEMENTS

Authors would like to thank Dr. Ritu Mishra, Casualty Registrar, Government Homoeopathic Medical College and Hospital, Bhopal, India and Mr. Durgesh Koghare, Computer Operator, Government Homoeopathic Medical College and Hospital, Bhopal, India. Also thankful to Dr. Roza Varanasi (RO, CCRH) and Dr. Swati Juneja (Ministry of AYUSH).

FUNDING

The study was funded by PHI-Ministry of AYUSH (Govt. of India)

CONFLICT OF INTEREST

None declared

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