Current Situation of Older Adults in Sayedpur Union, Sitakund Upazila, Chattogram Division, Bangladesh

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Young Power in Social Action (YPSA)
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"Dear Older ….*Your wisdom, love, and guidance are the foundation of our lives. We deeply respect your sacrifices and cherish the lessons you share with us. Your presence is a blessing, and we are forever grateful for the values you instill in us. So, we should respect you, listen to your wisdom, care for your needs, spend time with you, and make you feel valued and loved. May you always be surrounded by love, care, and happiness. We honor and appreciate you today and always".....****With deep respect***,

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Acknowledgments

This study received ethical approval from the National Research Ethics Committee (Ref: BMRC/NREC12019-202217 9 6) of the Bangladesh Medical Research Council (Registration No: 268 03 12 2019) from the outset.

The data collection, cleaning, and validation processes were conducted by Dr. Shamsun Nahar Chowdhury, Management Adviser, YPSA; Newaz Mahmud, Assistant Director, Economic Development Department, YPSA; Md. Abdus Sabur, Assistant Director, Safeguarding and Youth Focal, YPSA; and Afra Nawar Rahman, Youth Coordinator, YPSA Centre for Youth and Development (CYD), YPSA. Additionally, Dr. Ahbab Mohammad Fazle Rabbi, Assistant Professor, Department of Population Sciences, University of Dhaka, was responsible for data interpretation and drafting the report.

The survey findings were later presented in a day-long workshop on December 23, 2024, at the University of Dhaka, Bangladesh. The event gathered a diverse group of stakeholders, including academics, NGO professionals, volunteers, and students, to discuss key insights on ageing issues. Information about the workshop was published in local daily news outlets and on the YPSA official website: https://ypsa.org/2024/12/research-results-dissemination-workshop-of-the-ypsa-rural-ageing-project/.

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EXECUTIVE SUMMARY

This study focuses on older adults in Sayedpur Union, Sitakund Upazila, Chattogram Division, Bangladesh. The aim is to understand their current situation, living arrangements, health conditions, social engagement, and experiences with abuse, exploitation, and social safety nets. The study will investigate the impact of demographic changes, urbanization, and migration on older adults in this rural setting. By examining these factors, the study seeks to identify the specific needs and challenges older adults face in Sayedpur Union and inform policies and interventions to improve their well-being.

The study primarily employed quantitative data collection techniques. Primary data was collected through door-to-door household surveys using a structured questionnaire, targeting all older adults (aged 60 and above) in Sayedpur Union, Sitakund Upazila, Chattogram. Snowball sampling was used to identify households with older adults/ Data were collected from 866 older adults from June 2023 – April 2024. The questionnaire covered demographic information, health conditions, social engagement, and experiences with abuse and exploitation. This is the first survey/complete enumeration of its kind in Bangladesh to capture a fuller understanding of a specific rural setting about the sustainability of ageing populations.

Ethical approval was obtained from the Bangladesh Medical Research Council (BMRC) in 2020, and informed consent was secured from all participants. The research was funded by a local NGO in Bangladesh called Young Power in Social Action (YPSA). The quantitative data was analyzed using IBM SPSS Statistics, version- 28. A data quality check was done carefully before conducting an exploratory data analysis (EDA) on the socio-economic and health conditions of older adults.

Key findings reveal a complex picture of older adults. Demographically, most older adults fall within the 60-65 age group, with women increasingly represented in older age brackets. Gender disparities are evident in land ownership, education, and income levels, with women facing greater disadvantages. Most older adults reside with their sons, reflecting strong family ties, especially for women.

Regarding social care and support, most older adults receive adequate food and medical care, but support for social activities is limited. Sons are the primary caregivers, providing both financial and emotional support.

Neighborly visits are found to be very strong and play a crucial role in reducing loneliness, particularly for women.

In terms of health and well-being, many older adults rate their health as fair and rely heavily on their sons for financial support. Health perceptions are influenced by factors such as age, gender, housing, and education.

Despite high life satisfaction, there are gender and religious disparities. Social participation and daily activities are limited among older adults.

Only a small percentage engage in domestic, social, and community activities. Participation varies by age, health, education, and economic status. Gender disparities exist in social participation, with men engaging more.

While nearly all respondents are covered by safety net programmes, many are dissatisfied with the amount of financial assistance received. Awareness of and access to pensions and medical allowances are low, highlighting the need for better outreach and accessibility to support programmes.

A significant public health concern is the diagnosis of dementia among 14.6% of older adults. The prevalence is higher among women and the wealthiest group. Access to treatment for dementia is limited, revealing a critical gap in healthcare services.

Overall, the study underscores the need for targeted interventions to address the socio-economic and health challenges faced by older adults in rural Bangladesh. These interventions should focus on expanding social protection programmes, improving healthcare access, promoting social engagement, and raising awareness about dementia. Additionally, addressing gender disparities, empowering older women, and strengthening data collection systems are crucial for effective policymaking.

Key Findings of the Study

Characteristics of the respondents

- Among 866 respondents, the largest age group is 60-65 years, with a notable increase in female representation in older age brackets.
- A significant majority of females (72.4%) do not own land compared to 27.6% of males. Housing conditions reveal that 46.5% of males and 53.5% of females live in pucca or semi-pucca homes.
- There is a marked gender disparity in education, with 72.3% of the illiterate population being female. Additionally, 69.6% of females have no income, while a larger proportion of males fall into higher income brackets.

Social care and support for older adults

- The older adults live with their sons, with significant gender differences; many feel scared to live alone, indicating strong family ties, especially for older women.

- While most receive adequate food (76.1%) and timely medical care (77.8%), only a minority receive their favorite food regularly (32.4%), and support for social activities is limited (34.5%).
- Sons are the primary providers of financial and emotional assistance, while daughters offer less support, particularly to males. Neighbor visits also play a crucial role in reducing loneliness.

Health and well-being of the respondents

- Most older adults in rural Bangladesh rate their health as fair and rely heavily on their sons for financial support (82.8%)
- Health perceptions are significantly affected by age, gender, housing conditions, and education, with better housing and education linked to improved health outcomes.
- Despite high life satisfaction (89.2%), which varies by age, religion, land ownership, and income, there are notable differences by sex and religious affiliation, with Hindus reporting higher satisfaction (98.6%) compared to Muslims (88.3%).

Social Participation and daily activities of older adults

- Only 12.8% of older adults engage in domestic tasks, 19.0% in social work outside the home, and 12.3% in community activities, indicating limited social engagement overall.
- Participation is higher among individuals aged 71-75 and those in better health, with 13.0% of males and 12.6% of females involved in household tasks.
- Educational attainment and economic necessity influence participation levels, with poorer individuals showing greater involvement in activities.
- Participation in social work differs by gender (22.1% of males vs. 16.6% of females).

Social Pension on the well-being of older adults

- While nearly all respondents are covered by safety net programmes, only 74.5% receive financial assistance and 84.8% express dissatisfaction with the amount.
- Awareness and receipt of pensions and medical allowances are low, underscoring the need for better outreach and accessibility to support programmes for older adults in rural Bangladesh.

Prevalence of dementia in rural Bangladesh

- A notable public health concern in rural Bangladesh is the diagnosis of dementia among 14.6% of older adults in this demographic.
- The prevalence of dementia is higher among females (16.6%) compared to males (11.9%), and intriguingly, the wealthiest group also shows a high prevalence (25.3%).
- Despite the diagnosis, only 6.9% of those affected receive treatment, revealing a significant gap in healthcare access, with 93.1% not receiving any form of care.

Contents

Chapter 1: Introduction

1.1 Background to the research

The global population is ageing rapidly, with the proportion of older individuals (aged 60 and above) increasing significantly due to longer life expectancy and declining fertility rates. By 2050, the global older population is expected to double, reaching over 2 billion people (World Health Organization, 2022). This trend is particularly evident in developing countries like Bangladesh, where healthcare systems and social safety nets are often ill-equipped to handle the growing needs of the older population. As of 2022, approximately 8.5% of Bangladesh's population is over the age of 60, and this percentage is expected to increase to nearly 20% by mid-century (Bangladesh Bureau of Statistics, 2022). In rural areas like Sayedpur Union in Sitakund Upazila, Chattogram Division, the challenges faced by the older are especially pronounced, as traditional support systems weaken due to migration and urbanization, and access to healthcare and social services remains limited.

Globally, population ageing presents a critical challenge to governments and societies. Countries worldwide are facing increasing demand for healthcare, pension schemes, and other support services tailored to the older (United Nations, 2023). The burden of non-communicable diseases such as diabetes, hypertension, and arthritis, which disproportionately affect the older, is growing, particularly in low- and middle-income countries. This demographic shift calls for more robust policies to address the specific needs of the ageing population, especially in rural settings where services are less developed (World Health Organization, 2022).

South Asia is one of the fastest-ageing regions in the world, with Bangladesh experiencing a sharp rise in its older population. The region faces a myriad of challenges, including inadequate healthcare infrastructure and social protection systems, particularly in rural areas. Migration has also played a pivotal role in reshaping family structures across South Asia, as younger generations move to urban areas for work, leaving the older in rural regions with less familial support (HelpAge International, 2021). In Bangladesh, unions like Sayedpur in Sitakund Upazila are no exception to these trends, as out-migration further isolates the older population, exacerbating issues related to care and social inclusion.

Bangladesh is experiencing significant demographic shifts as its older population grows. Despite the government's introduction of various social safety nets, including the Old Age Allowance, many older people, particularly in rural areas, are not sufficiently covered by these programmes (Islam et al., 2021). As a largely agrarian society, many older individuals in rural Bangladesh continue to rely on physically demanding agricultural work, despite diminishing capacities with age (Kabir et al., 2023). In Sayedpur Union, these challenges are heightened by limited access to healthcare and specialized services for the older, further complicating their ability to manage chronic health conditions and secure a stable livelihood (Rahman et al., 2021). A 2022 World Health Organization (WHO) report highlights that many rural healthcare centers in Bangladesh are under-resourced, and older individuals often face barriers to accessing consistent and adequate healthcare (WHO, 2022). Despite some governmental efforts, such as the introduction of the National Policy on Older Persons in 2013, the implementation of older-specific programmes

remains inconsistent, especially at the union level (Ministry of Social Welfare, 2022). Social safety nets like the Old Age Allowance cover only a fraction of the older population, leaving many without adequate financial or social support (Islam et al., 2021). Besides, Bangladesh is the seventh largest populated (152.51 million) and most densely populated (1015 people live per square kilometer) country (Population & Housing Census Report 2011) in the world. Furthermore, the nuclear family is increasing in Bangladesh day by day, and older people are left alone living separately from their families and becoming vulnerable. This condition demands more health and welfare services and more provision to the older adults' support system (Islam, et al., 2012; Rahman et al., 2009). Besides, the statistical data of Bangladesh shows that the number of aged populations has increased from 1.38 million to 7.59 million from the year of 1974-2001 (BBS, 2003). Previously the society of Bangladesh took care of the older but now the situation has changed due to changes of social, psychological and economic standpoints. From social, economic and political viewpoints, the older population is now growing rapidly, and it is a big concern for Bangladesh.

The majority of the people over sixty years live in rural areas where there is a lack of proper health care services, economic services, and job opportunities. Consequently, modern society has failed to keep the dignity and honor of the older adults. Although the constitution of Bangladesh mentions the rights of older people. In the Constitution Part II section 15 entitled "Provision of Basic Necessities" describes social security for the older people as the " provision of the basic necessities of life, including food, clothing, shelter, education and medical care; the right to reasonable rest, recreation and leisure; and the right to social security, that is to say, to public assistance in cases of undeserved want arising from unemployment, illness or disablement, or suffered by widows or orphans or in old age, or in other such cases mentioned in the 15 (a) (c) and (d) clause respectively (Bangladesh Parliament, 2019). However, Bangladesh has pension policies to ensure social security on old age for retired government employees only. According to Public Service Retirement Act 1974b now the retirement age of government employee of Bangladesh is 59 years (The public servants retirement act, 1974). Besides, Bangladesh introduced Programme Implementation Plan for protecting old age health and ensures health care. This program aims to provide efficient and sustainable health service delivery and management system with skilled and special emphasis on the development of a sustained health system and improved and responsive efficient human resources [7]. Moreover, recently the Parent Care Act 2013 of Bangladesh tried to ensure that the children have to take necessary steps to look after their parents for three years and provide them with maintenance. But it is not fully function yet (Parent Care Act 2013 of Bangladesh, 2008).

Sayedpur Union, located in the Sitakund Upazila of Chattogram Division, represents a microcosm of the broader challenges faced by rural older populations in Bangladesh. Economic vulnerability, social isolation, and poor access to healthcare services characterize the lives of many older residents in this union. A significant number of the older in Sayedpur continue to work in agriculture despite declining health, while others rely on remittances from family members who have migrated to urban areas (Hossain & Rahman, 2021). The weakening of traditional family care structures, combined with insufficient government support, has left the older population in

Sayedpur increasingly dependent on informal networks and community-based solutions for their daily needs.

In this context, it becomes essential to analyze the socio-economic and health conditions of the older population in Sayedpur Union, both to inform local policy interventions and to contribute to the broader national discussion on older care. This analysis has examined the current challenges facing the older in Sayedpur within global, regional, national, and local contexts, offering insights into the specific needs of this vulnerable demographic.

1.2 Significance of the Study

The significance of studying the older population in Sayedpur Union, Sitakund Upazila, within the broader contexts of global, regional, national, and local trends is critical for understanding how ageing dynamics impact this specific rural community. As the global population ages, with people aged 60 and above expected to double from 1 billion in 2020 to 2.1 billion by 2050, the implications of this demographic shift are profound, especially for developing countries like Bangladesh (World Health Organization, 2022). The rapid increase in the older population presents social, economic, and healthcare challenges, particularly in rural areas such as Sayedpur Union, where support systems are often weaker.

Globally, population ageing is driven by declining fertility rates and increasing life expectancy. This phenomenon is not only changing the structure of populations but also placing increased pressure on healthcare systems, social services, and economies worldwide. According to the United Nations (2023), the world is experiencing a dramatic increase in the older population, particularly in low- and middle-income countries like Bangladesh, where systems are ill-equipped to handle the demands of an ageing demographic. This global trend necessitates a local response, especially in rural areas like Sayedpur Union, where ageing is often accompanied by poverty, inadequate healthcare, and limited social protection.

Within South Asia, Bangladesh shares demographic characteristics with neighboring countries like India, Nepal, and Sri Lanka, all of which are grappling with similar ageing issues. The region faces significant challenges in addressing the needs of its older population due to widespread poverty, underdeveloped healthcare infrastructure, and limited pension schemes (HelpAge International, 2021). South Asia's ageing population is also affected by migration, as younger generations leave rural areas in search of employment, often leaving behind an older population that relies on traditional family care systems. In Bangladesh, particularly in rural unions like Sayedpur, this migration exacerbates the vulnerability of the older, as they are increasingly isolated from family support systems (Kabir et al., 2023).

At the national level, Bangladesh is undergoing a demographic transition as its older population grows rapidly. The older currently make up approximately 8.5% of the population, but this figure is expected to rise significantly by 2050 (Bangladesh Bureau of Statistics, 2022). Although the government has introduced programmes such as the Old Age Allowance, these initiatives are often insufficient to cover the needs of the older, particularly in rural areas. In regions like Sitakund Upazila, where Sayedpur Union is located, older populations are more likely to suffer from poverty, poor health, and lack of access to social services. A national survey by Rahman et al.

(2021) found that rural older populations in Bangladesh face higher risks of income insecurity and health challenges compared to their urban counterparts.

Economically, the older in rural Bangladesh face significant challenges. Most rely on agriculture as a primary source of livelihood, yet physical limitations due to ageing reduce their capacity to engage in labor-intensive activities (Kabir et al., 2023). With limited access to pension schemes and social safety nets, many older individuals in rural unions live in poverty, unable to meet basic needs such as healthcare and nutrition (Islam et al., 2021). This economic insecurity underscores the importance of expanding social protection programmes, including the Old Age Allowance, to cover more older people in rural areas.

Healthcare is another critical area of concern for the older population. In rural unions, access to healthcare services is often limited by geographical barriers, underfunded healthcare facilities, and a shortage of geriatric care (Rahman et al., 2021). Age-related diseases, including hypertension, diabetes, and arthritis, are prevalent among the older, but the lack of specialized care exacerbates their health issues (World Health Organization, 2022). Improving healthcare accessibility and affordability in rural areas is therefore essential to ensure that the older can maintain a decent quality of life.

This analysis is significant because it highlights the urgent need for targeted interventions to address the socio-economic and health challenges facing the older in rural Bangladesh. By focusing on a specific union, the study offers a localized understanding of these challenges, providing valuable insights for policymakers and social workers aiming to improve the well-being of the older in these communities. The findings will contribute to ongoing discussions about expanding social safety nets, improving healthcare infrastructure, and strengthening community-based care for the ageing population in Bangladesh.

In Sayedpur Union, the challenges faced by the older population are magnified by local economic conditions, family structure changes, and inadequate healthcare services. Most older individuals in this area rely on agricultural work for their livelihood, but declining physical abilities make this increasingly difficult (Hossain & Rahman, 2021). The migration of younger family members to urban centers, particularly Chattogram City, has left many older residents isolated and without adequate familial support, leading to increased social isolation and mental health challenges. Locally, healthcare services are limited, with few facilities offering geriatric care or age-specific services, which leaves older residents struggling to manage chronic illnesses like diabetes and hypertension (Rahman et al., 2021).

The study of Sayedpur Union's older population within these broader contexts is crucial for identifying gaps in local support systems and informing policies that cater to their specific needs. As global and national populations age, understanding the unique challenges faced by rural older communities like those in Sayedpur Union will help shape more inclusive and effective interventions. This analysis, therefore, emphasizes the importance of localized research in informing policy decisions that address the health, social, and economic needs of the older at the union level.

1.3 Aim and Objectives of the Study

The study mainly focused on the current situation of the older population in Sayedpur Union, Sitakund Upazila, Chattogram Division, Bangladesh. It also explored different aspects of older people, namely the demographic conditions of the respondents, living arrangements, care, and support information, physical health condition, mental health condition, family and social engagement, abuse and exploitation, control over life and resources, social safety net, gender perspective, and issues during disasters. The specific objectives of the study are as follows.

- To explore the conditions of older people in the study area.
- To investigate the living arrangements in the family.
- To find out the care and support-related information of their family.
- To know the physical health condition.
- To study their engagement in family and at the social level.
- To observe the exploitation of older people at the family and society level.
- To explore the older issue from a gender perspective.
- To examine 'Dementia' of older people in the study area.

Chapter 2: Methodology

2.1 Study design and participants

The study was cross-sectional descriptive research that employed both quantitative and qualitative methods. The primary focus was on conducting a survey, supplemented by observational techniques. The target population consisted of older individuals (aged 60 and above) residing in a selected union in Bangladesh. A snowball sampling technique was used to identify households surveyed with older members. It is a Census method designed to be conducted uniformly across the entire union. A *"De Jure"* approach was employed, where enumerators visited households multiple times to gather information.

2.2 Census Survey Technique

The study, conducted in Syedpur Union, Sitakund, Chattogram, Bangladesh, employed both quantitative and qualitative methods to analyze the current situation of the older population. Data was collected through door-to-door household surveys and observations, using the "De Jure" method and a structured questionnaire that covered eleven key areas such as demographic conditions, health, social engagement, and experiences of abuse. The census method was designed for uniform implementation across the entire union and was conducted using snowball sampling, including individuals aged 60 and above who could provide informed consent.

Secondary data was derived from literature reviews to contextualize the findings. The study's qualitative data was analyzed using Grounded Theory and Narrative Analysis, while quantitative data was processed using IBM SPSS v-28. Ethical approval was obtained from the Bangladesh Medical Research Council (BMRC), and informed consent was ensured for all participants. The research was funded by Young Power in Social Action (YPSA), providing resources for survey implementation and data collection.

Inclusion Criteria

- Individuals aged 60 and above.
- Households with older members capable of giving informed consent.

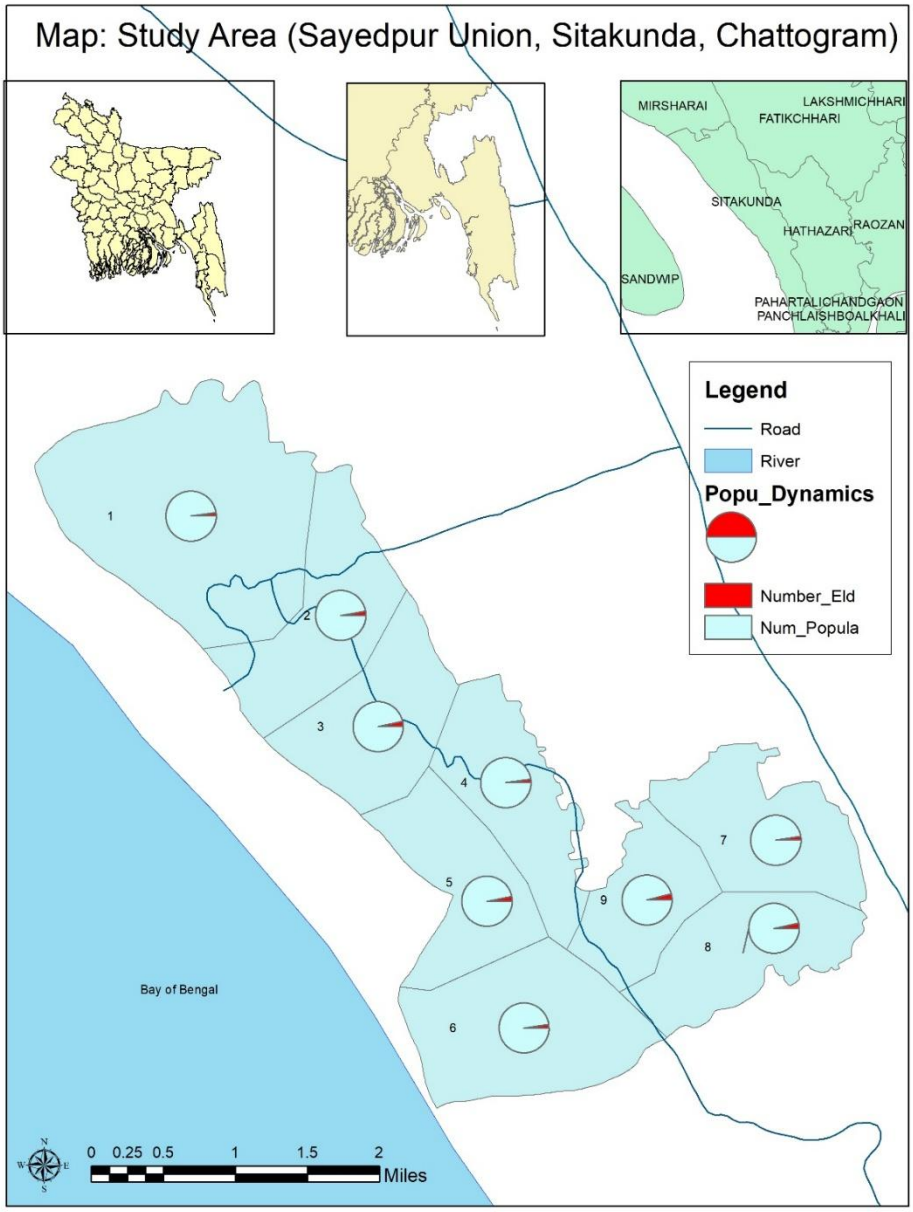
Exclusion Criteria

- Older individuals are unable to provide informed consent due to mental incapacity or other reasons.
- Households without older members.

2.3 Study Area

The research has been conducted at Syedpur Union at Sitakund Upazila in Chattogram district. Geographically, this location bears a big significance as populations are mixed with ethnic

identities (some are native Bengali and some portions have indigenous communities). As well as, a heavy industrial hub, shipbreaking zone, and mostly satellite city in Bangladesh.



Source: Source map collected from Syedpur Union Office, 2025

2.4 Data collection

The study collects both primary and secondary data where primary data was derived from the field through quantitative methods and secondary data comes from literature reviews to provide background and context. The primary data is gathered through:

- Quantitative Data: Acquired using the De Jure Method and Questionnaire Survey. This method involves systematically visiting households and collecting responses from older individuals using a structured questionnaire.

2.5 Questionnaire design

The questionnaire was designed based on the study's objectives and divided into eleven sections:

1. Demographic Conditions
2. Living Arrangements
3. Care and Support Information
4. Physical Health Condition
5. Mental Health Condition
6. Family and Social Engagement
7. Abuse and Exploitation
8. Control over Life and Resources
9. Social Safety Net Programmes
10. Gender Perspective
11. Issues During Disasters

Each section contained relevant questions aimed at capturing the specific needs and experiences of the older population. Both closed-ended and open-ended questions were included to allow for quantitative analysis and qualitative insights.

2.6 Data collection

Primary data was collected through door-to-door household surveys conducted by trained organizational staff who were familiar with the study. These enumerators utilized both overt and covert observation methods alongside the structured questionnaire to collect data. Information was recorded in real-time using either mobile devices or paper forms, depending on the resources available. A pre-test of the survey instrument was conducted with 10-15 respondents in a non-sampling area to ensure the reliability and validity of the questionnaire. Necessary adjustments were made based on the pre-test results before the full-scale data collection began. Secondary Data collection involves reviews of literature, helping to frame the study in the context of existing research on older care, social safety nets, and living conditions.

2.7 Analysis of data

- Quantitative data were processed using IBM SPSS Statistics v-28, a statistical software, to run various types of analyses, likely including descriptive statistics and inferential tests.

2.8 Ethics approval

Before conducting the survey, the research protocol, including the questionnaire, was submitted to the Bangladesh Medical Research Council (BMRC) for ethical approval. Informed consent was

obtained from all participants, ensuring their voluntary participation and the confidentiality of their information. Participants were fully informed about the purpose, procedures, and any potential risks associated with the study.

2.9 Source of funding for the research

The research was funded by Young Power in Social Action (YPSA), which provided the necessary financial support for survey implementation, data collection tools, and enumerator training.

Chapters 3 to 8: Results

Chapter 3: Background characteristics of the respondents

3.0 Introduction

This chapter comprises findings regarding the respondents' background characteristics. Respondents are first classified according to the location of their residence. Their socioeconomic status and demographic characteristics are presented by their sex.

3.1 Background characteristics of the respondents

The distribution of the study population by sex is presented in Table 3.1. The data comes from nine wards of Syedpur Union in Sitakund, Chattogram, Bangladesh. The table presents population data for these nine wards, detailing the distribution of males and females out of a total of 866 individuals. Among them, there are 385 males, which account for 44.4% of the total population, and 501 females, making up 57.7%. Ward No 7 has the highest total population (209), while Ward No 8 has the lowest (26). Females outnumber males in most wards, with Ward No 6 showing the highest female percentage at 62.5%.

Table 3.1. Distribution of study population across wards in Syedpur union, Sitakund.

Ward	Males (385)	Females (501)	Total (n=866)
Ward No 1 (Uttor Boga Chator)	50 (45.9%)	59 (54.1%)	109
Ward No 2 (Dokhin Boga Chator)	38 (44.7%)	47 (55.3%)	85
Ward No 3 (Mohanagar)	23 (45.1%)	28 (54.9%)	51
Ward No 4 (Shakher Hat)	20 (55.6%)	16 (44.4%)	36
Ward No 5 (Bakk Khali)	74 (46.3%)	86 (53.8%)	160
Ward No 6 (Possim Sayed Pur)	66 (37.5%)	110 (62.5%)	176
Ward No 7 (Purbo Syed Pur)	91 (43.5%)	118 (56.5%)	209
Ward No 8 (Uttor Kather Khil)	7 (26.9%)	19 (73.1%)	26
Ward No 9 (Dakkhin Kader Khil)	16 (47.1%)	18 (52.9%)	34

3.2 Background characteristics of the respondents

Table 3.2 presents the background characteristics of respondents, categorized by sex, with a total of 866 individuals—385 males and 501 females. In terms of age, the largest group falls within the 60-65-year range, comprising 48.4% males and 51.6% females. The distribution shows a trend of increasing female representation in older age brackets, particularly among those aged 66-70 and beyond. Regarding religion, many respondents identify as Muslim (815 total), with 43.1% males and 56.9% females, while Hindu respondents account for a smaller portion. The data on land ownership indicates that a significant number of females (72.4%) do not own land, compared to 27.6% of males. Housing conditions reveal that 46.5% of males and 53.5% of females live in pucca or semi-pucca homes, while a larger proportion reside in other types of housing. Education levels show a notable gender disparity, particularly among the illiterate population, where 72.3% are female. In terms of marital status, a majority are currently married, but there is a stark contrast in

the "Others" category, where 96.6% are female, indicating a higher prevalence of divorce or widowhood among females. Occupation data highlights that a vast majority of males (96.1%) are engaged in agriculture, while females predominantly fall into the retired/unemployed category (92.1%). Monthly income analysis reveals that a significant number of females (69.6%) have no income, while males show higher representation in the income brackets above 500 TK. Lastly, the wealth index indicates a slightly higher percentage of females in the poorer categories compared to males, suggesting economic disparities between genders.

Table 3.2 Background characteristics of the respondents.

Variables	Males (385)	Females (501)	Total (866)
Age (in years)			
60-65	181 (48.4%)	193 (51.6%)	374
66-70	73 (34.1%)	141 (65.9%)	214
71-75	61 (43.0%)	81 (57.0%)	142
76-80	45 (46.9%)	51 (53.1%)	96
More than 80	25 (41.7%)	35 (58.3%)	60
Religion			
Islam	351 (43.1%)	464 (56.9%)	815
Hinduism	34 (47.9%)	37 (52.1%)	71
Land property			
No lands	42 (27.6%)	110 (72.4%)	152
Has some lands	343 (46.7%)	391 (53.3%)	734
Housing conditions			
Pucca/semi pucca	93 (46.5%)	107 (53.5%)	200
Others	292 (42.6%)	394 (57.4%)	686
Education level			
Illiterate	100 (27.7%)	261 (72.3%)	361
Can sign only	165 (45.7%)	196 (54.3%)	361
Primary (incomplete)	53 (63.1%)	31 (36.9%)	84
Primary or higher	67 (83.8%)	13 (16.3%)	80
Marital status			
Currently Married	380 (51.4%)	360 (48.6%)	740
Others (divorced/widow/widower)	5 (3.4%)	141 (96.6%)	146
Occupation			
Agriculture	198 (96.1%)	8 (3.9%)	206
Others	158 (50.5%)	155 (49.5%)	313
Retired/Unemployed	29 (7.9%)	338 (92.1%)	367
Monthly income			
No Income	140 (30.4%)	321 (69.6%)	461
Up to 500 TK	72 (37.1%)	122 (62.9%)	194
501-1500 TK	42 (71.2%)	17 (28.8%)	59
1501-5000 TK	62 (74.7%)	21 (25.3%)	83
More than 5000 TK	69 (77.5%)	20 (22.5%)	89
Wealth index			

Poorest	88 (49.4%)	90 (50.6%)	178
Poorer	82 (45.6%)	98 (54.4%)	180
Middle	70 (39.5%)	107 (60.5%)	177
Richer	72 (41.6%)	101 (58.4%)	173
Richest	73 (41.0%)	105 (59.0%)	178

Chapter 4: Social care and support for the older adults in rural Bangladesh

4.0 Introduction

This chapter presents the findings regarding social care and available support from family members or society for older adults. The findings also include the living arrangements and sources of support.

4.1 Living arrangement of older adults in Rural Bangladesh

Figure 4.1 illustrates the living arrangements of older adults in rural Bangladesh, categorized by the sex of the respondents. In terms of living arrangements, a majority of both sexes live with their sons, with 43.2% of males and 56.8% of females in this situation. Notably, 71.4% of males live with their spouses, while only 28.6% of females share this arrangement. Additionally, 57 females live with daughters or others, with a striking 86% being female.

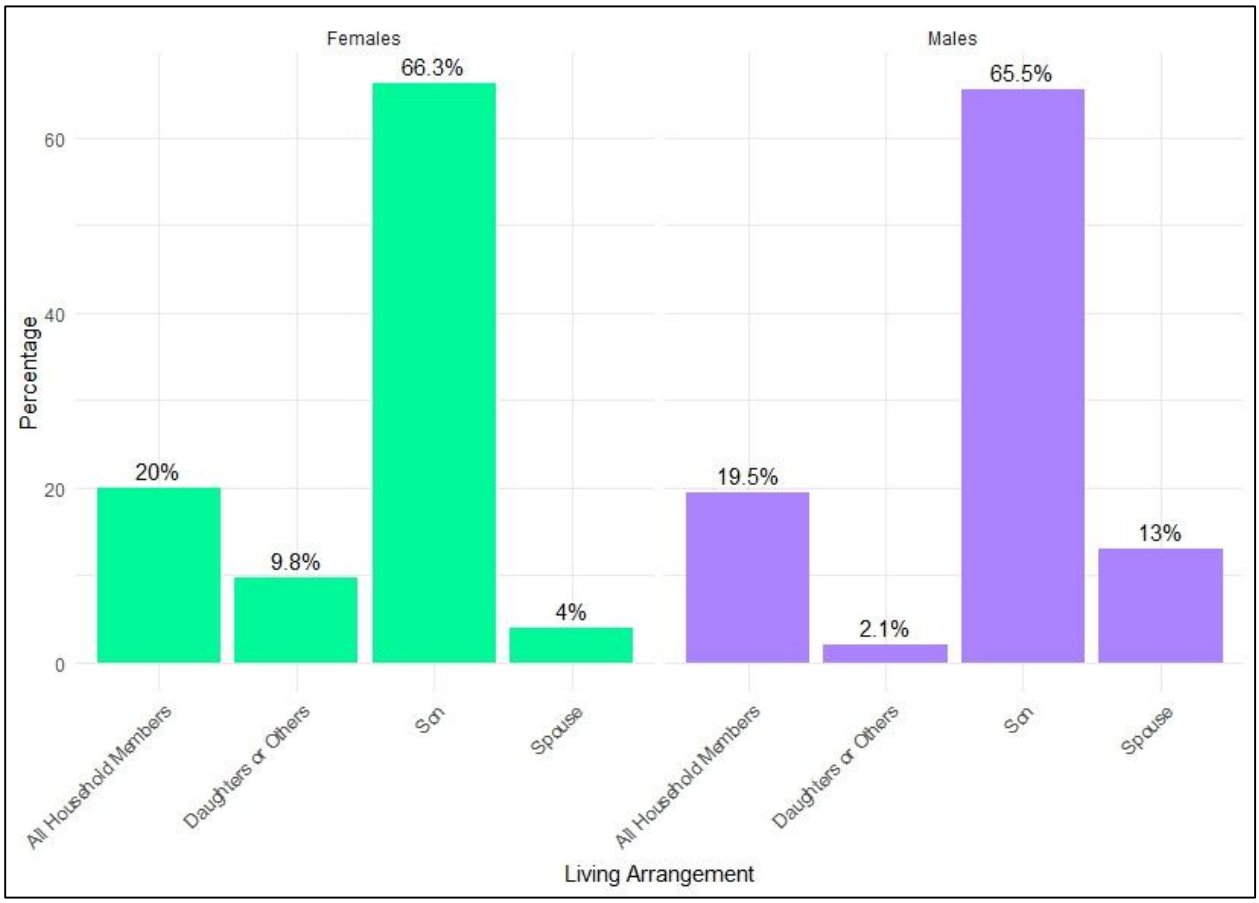


Figure 4.1 Living arrangement by sexes of older adults in rural Bangladesh.

Table 4.1 illustrates the living arrangements of older adults in rural Bangladesh, categorized by the sex of the respondents. Regarding normal sleeping places, most respondents sleep in the living room (43.5% males, and 56.5% females). A few individuals report sleeping in the corridor or kitchen. When it comes to sharing a bed or room, 43.8% of males and 56.3% of females share their sleeping space with others. Feeling comfortable sharing a bed reflects a similar pattern, with 44.0% of males and 56.0% of females expressing comfort. However, a significant number of respondents feel scared to live alone, with 40.4% of males and 59.6% of females reporting this fear. The frequency of visits from offspring shows that 45.8% of males and 54.2% of females have daily visits, while a smaller number see their children once a month or rarely. This suggests a strong support system among family members, particularly for older females.

Table 4.1 Living arrangement by sexes of older adults in rural Bangladesh.

Living arrangement	Males (385)	Females (501)	Total (886)
Normal place of sleeping			
Living Room	384 (43.5%)	498 (56.5%)	882
Corridor/kitchen	1 (25.0.0%)	3 (75.0%)	4
Sharing bed/room with others			
Yes	161 (43.8%)	207 (56.3%)	368
No	224 (43.2%)	294 (56.8%)	518
Feeling comfortable sharing a bed with others			
Yes	155 (44.0%)	197 (56.0%)	352
No	230 (43.1%)	304 (56.9%)	534
Feel scared to live alone			
Yes	110 (40.4%)	162 (59.6%)	272
No	275 (44.8%)	339 (55.2%)	614
Frequency of visits of the offspring			
Always (Daily)	237 (45.8%)	280 (54.2%)	517
More Than Once a Week	35 (50.0%)	35 (50.0%)	70
Once a Week	59 (39.9%)	89 (60.1%)	148
Once a Month	13 (32.5%)	27 (67.5%)	40
Rare or never	41 (36.9%)	70 (63.1%)	111

4.2 Indicators of social care and support for older adults

Table 4.2 presents various indicators of social care and support for older adults in rural Bangladesh, focusing on the frequency with which these individuals receive care. Overall, the table highlights a generally positive outlook on social care for older adults, particularly in terms of food and medical support, while indicating areas for improvement in social engagement and leisure activities. In terms of basic needs, a significant majority (76.1%) receive adequate food consistently, while 23.9% receive it sometimes. However, only 32.4% report getting their favorite food regularly, with 67.3% receiving it sometimes. For suitable food, 66.1% of respondents receive it always, while 33.9% receive it sometimes. Regarding clothing, 59.8% receive necessary clothes

in a timely manner, with 37.5% sometimes receiving them. When it comes to medical needs, a high percentage (77.8%) receive their medicine on time, while 19.6% receive it sometimes. Support for mobility is also noteworthy, as 73.7% receive help to walk, and 66.4% get assistance to visit health centers. However, only 43.9% receive pocket money when needed, with 51.1% getting it sometimes. For social interactions, 41.2% receive money for visits to friends or relatives, while 51.4% receive this support sometimes. Lastly, support for leisure activities such as going to parks or cinemas is lower, with 34.5% receiving help regularly and 22.3% never receiving such support.

Table 4.2 Different indicators of social care and support for older adults in rural Bangladesh.

Indicators	**Frequency of receiving care**		
	Always	**Sometimes**	**Never**
Getting Adequate Food	674 (76.1%)	211 (23.9%)	-
Getting My Favorite Food	287 (32.4%)	596 (67.3%)	2 (0.2%)
Getting Suitable Food	586 (66.1%)	295 (33.9%)	3 (0.3%)
Getting Necessary Clothes Timely	530 (59.8%)	332 (37.5%)	21 (2.4%)
Getting Medicine in Time	689 (77.8%)	174 (19.6%)	21 (2.4%)
Getting Help to Walk	653 (73.7%)	194 (21.9%)	23 (2.6%)
Getting Help to Go to Health Center	588 (66.4%)	293 (33.6%)	2 (0.2%)
Getting Pocket Money (if needed)	389 (43.9%)	453 (51.1%)	41 (4.6%)
Getting Care Due to Sickness	529 (59.7%)	327 (36.9%)	28 (3.2%)
Getting Money for Visits (friends/relatives)	365 (41.2%)	455 (51.4%)	59 (6.7%)
Getting Help for Refreshment (park, cinema, etc.)	306 (34.5%)	359 (40.5%)	198 (22.3%)

Table 4.3 outlines the distribution of supporting sources for older adults in rural Bangladesh, categorized by gender, with a total of 886 individuals. In summary, sons serve as the main source of both financial and emotional support for older adults, revealing notable gender differences in dependence on daughters and neighbours. The data highlights a robust family support system, especially from sons, while also pointing out opportunities for improved community engagement. In terms of financial support, the primary source for both males and females are their sons, with 44.0% of males and 56.0% of females relying on them. Self-funding is less common, with 50.8% of males and 49.2% of females indicating this source. Daughters and others provide financial support to a smaller extent, with 32.9% of males and 67.1% of females receiving assistance. For mental support, again, sons are the most significant source, providing support to 45.1% of males and 54.9% of females. Spouses offer mental support to a similar percentage of both genders, with 51.4% of males and 48.6% of females indicating this source. However, daughters and others provide less mental support, with only 27.4% of males and 72.6% of females relying on them.

The visits of neighbors play a crucial role in the lives of older adults, offering both emotional and practical support. These visits can significantly enhance the well-being of seniors by providing social interaction, which helps combat loneliness and isolation often experienced in later life. Regarding neighbor visits, a substantial majority report having neighbors visit, with 43.6% of males and 56.4% of females indicating this support. Only a small number reported no neighbor visits, comprising 33.3% of males and 66.7% of females. Overall, the table illustrates that sons are the primary source of both financial and mental support for older adults, highlighting gender differences in reliance on daughters and neighbors. The data suggests a strong familial support system, particularly from sons, while indicating areas where community engagement could be enhanced.

Table 4.3 Distribution of supporting sources by sexes of older adults in rural Bangladesh.

Supporting source	**Males (385)**	**Females (501)**	**Total (886)**
Financial source			
Self-funded	32 (50.8%)	31 (49.2%)	63
Son	323 (44.0%)	411 (56.0%)	734
Daughter or Others	28 (32.9%)	57 (67.1%)	85
Mental support			
Spouse	37 (51.4%)	35 (48.6%)	72
Son	319 (45.1%)	389 (54.9%)	708
Daughter or Others	29 (27.4%)	77 (72.6%)	106
Status of neighbor's visit			
Yes	381 (43.6%)	493 (56.4%)	874
No	4 (33.3%)	8 (66.7%)	12

Chapter 5: Health and wellbeing of older adults in rural Bangladesh

5.0 Introduction

This chapter comprises findings regarding the health and well-being of older adults. Here, we consider both the physical and mental health of the older adults.

5.1. Indicators of physical health and wellbeing in older adults

Physical well-being among older adults in rural Bangladesh is plotted in Figure 5.1 which categorizes health status into three levels: bad or worse, fair, and good or better. The results are shown for males and females separately. A small portion of females (13.2%) and males (13.8%) reported to have bad or worse health condition. Overall, a majority (80.2%) report their condition as fair, while 13.4% indicate it is bad or worse, and only 6.3% describe it as good or better.

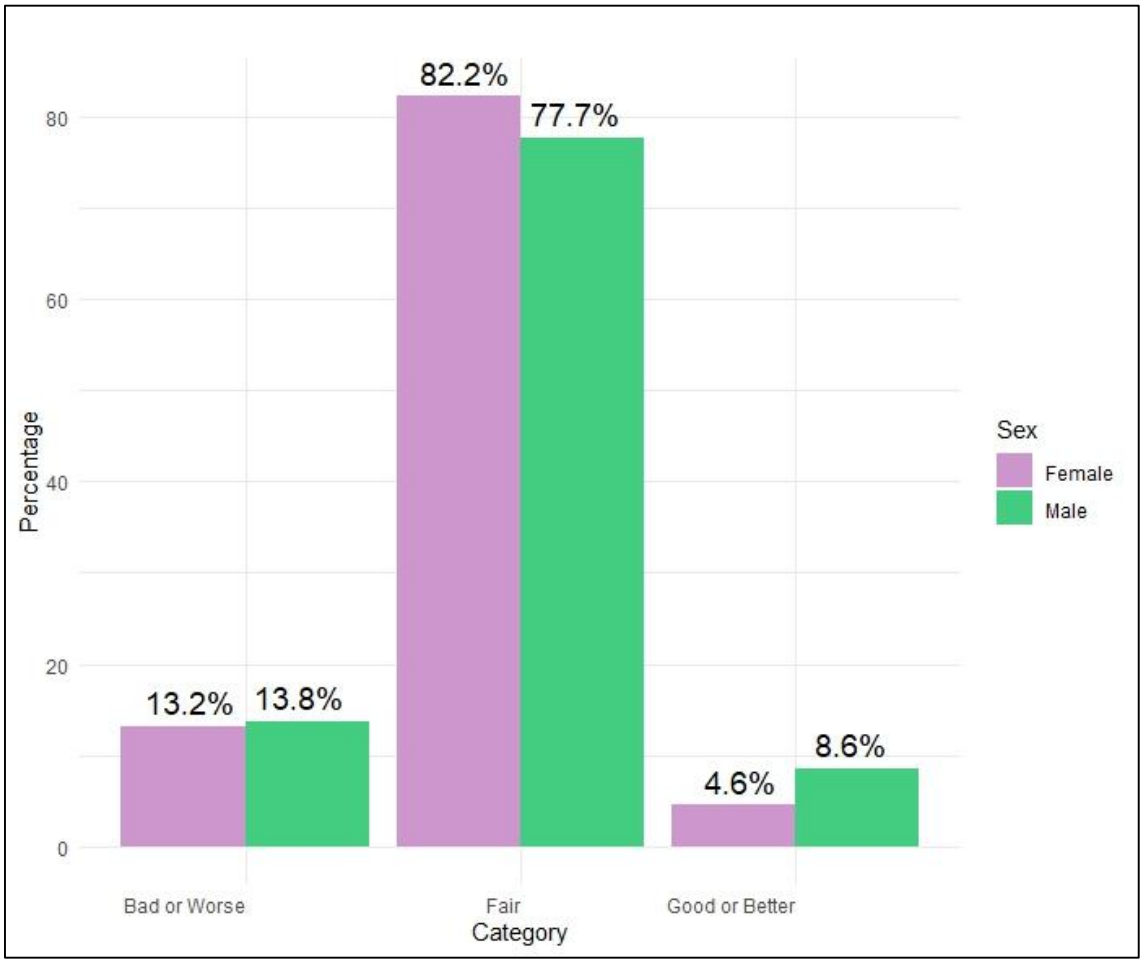


Figure 5.1. Health condition of the older adults in rural Bangladesh.

Table 5.1 presents various well-being indicators for older adults in rural Bangladesh, focusing on their health conditions and support systems. The table highlights the health status, communication practices, and financial support systems of older adults, indicating a reliance on family, particularly sons, for treatment and care. Older adults (75.7%) communicate their health issues to family members, while 24.3% do not. When addressing health problems, a significant portion (84.4%) prefer to try to solve their issues independently. However, some express challenges, with 8.1% stating that their family does not respond when they are sick and 9.0% feeling that their family lacks the ability to help. In terms of financial support for treatment, the primary source is overwhelmingly from sons, accounting for 82.8% of respondents. Self-funding is minimal, with only 7.1%, and spouses contribute 2.3%. Additionally, 9.8% rely on other sources for financial assistance.

Table 5.1. Wellbeing indicators of the older adults in rural Bangladesh.

Indicator	Frequency (n)	Percent (%)
Inform family about sickness		
Yes	671	75.7
No	215	24.3
Solving sickness through		
Try to Solve on My Own	612	84.4
They Do Not Respond When I Am Sick	58	8.1
They Have Not the Ability to Help Me	65	9.0
Financial sources for treatment		
Self-funded	63	7.1
Spouse	20	2.3
Son	734	82.8
Others	69	9.8

The determinants of physical well-being among older adults in rural Bangladesh are examined in Table 5.2, which categorizes health status into three levels: bad or worse, fair, and good or better. Table 5.2 highlights the complex interplay of demographic, social, and economic factors that determine the physical well-being of older adults in this rural setting. The table reveals that most respondents report their health as fair, with 80.2% overall, while 13.4% indicate bad or worse health and 6.3% describe their health as good or better. Gender differences show that slightly more females report fair health compared to males.

Age appears to influence health perceptions, with older age groups exhibiting a higher percentage of bad or worse health. For instance, those over 80 years old have the highest percentage (18.3%) in this category. Religion also plays a role as Hindu respondents show a lower percentage of bad health compared to Muslims. Housing conditions and education level correlate with health status as well. Those living in pucca or semi-pucca houses report better health outcomes than those in other types of housing. Illiterate individuals also tend to report poorer health compared to those with higher education levels. Marital status, occupation, and income are additional factors

affecting physical well-being. Currently married individuals and those with higher incomes generally report better health. Notably, the wealth index indicates that the poorest individuals have a higher percentage of bad health. The frequency of neighbor visits and family interactions significantly influences well-being. Older adults who receive regular visits from neighbors report better health outcomes, and those living with sons have a lower percentage of bad health compared to those living with daughters or alone.

Table 5.2. Determinants of physical wellbeing of the older adults in rural Bangladesh

Variables	Bad or Worse	Fair	Good or better	Total
Age (in years)				
60-65	45 (12.0%)	307 (82.1%)	22 (5.9%)	374
66-70	26 (12.1%)	176 (82.2%)	12 (5.6%)	214
71-75	23 (16.2%)	105 (73.9%)	14 (9.9%)	142
76-80	14 (14.6%)	76 (79.2%)	6 (6.3%)	96
More than 80	11 (18.3%)	47 (78.3%)	2 (3.3%)	60
Religion				
Islam	116 (14.2%)	647 (79.4%)	52 (6.4%)	815
Hinduism	3 (4.2%)	64 (90.1%)	4 (5.6%)	71
Land property				
.No Lands	20 (13.2%)	126 (82.9%)	6 (3.9%)	152
Has Some Lands	99 (13.5%)	585 (79.7%)	50 (6.8%)	734
Housing conditions				
Pucca/semi pucca	15 (7.5%)	167 (83.5%)	18 (9.0%)	200
Others	104 (15.2%)	544 (79.3%)	38 (5.5%)	686
Education level				
Illiterate	53 (14.7%)	293 (81.2%)	15 (4.2%)	361
Can Sign Only	46 (12.7%)	290 (80.3%)	25 (6.9%)	361
Primary (Incomplete)	10 (11.9%)	63 (75.0%)	11 (13.1%)	84
Primary or Higher	10 (12.5%)	65 (81.3%)	5 (6.3%)	80
Marital status				
Currently Married	104 (14.1%)	587 (79.3%)	49 (6.6%)	740
Others (Divorced/Widow/Widower)	15 (10.3%)	124 (84.9%)	7 (4.8%)	146
Occupation				
Agriculture	29 (14.1%)	160 (77.7%)	17 (8.3%)	206
Others	43 (13.7%)	254 (81.2%)	16 (5.1%)	313
Retired/Unemployed	47 (12.8%)	297 (80.9%)	23 (6.3%)	367
Monthly income				
No Income	56 (12.1%)	382 (82.9%)	23 (5.0%)	461
Up to 500 TK	28 (14.4%)	157 (80.9%)	9 (4.6%)	194
501-1500 TK	10 (16.9%)	42 (71.2%)	7 (11.9%)	59
1501-5000 TK	13 (15.7%)	62 (74.7%)	8 (9.6%)	83
More than 5000 TK	12 (13.5%)	68 (76.4%)	9 (10.1%)	89

Wealth index				
Poorest	10 (5.6%)	153 (86.0%)	15 (8.4%)	178
Poorer	17 (9.4%)	148 (82.2%)	15 (8.3%)	180
Middle	23 (13.0%)	148 (83.6%)	6 (3.4%)	177
Richer	31 (17.9%)	130 (75.1%)	12 (6.9%)	173
Richest	38 (21.3%)	132 (74.2%)	8 (4.5%)	178
Neighbors come to visit				
Yes	116 (13.3%)	704 (80.5%)	54 (6.2%)	874
No	3 (25.0%)	7 (58.3%)	2 (16.7%)	12
Currently living with				
Son	81 (13.9%)	469 (80.3%)	34 (5.8%)	584
Spouse	8 (11.4%)	52 (74.3%)	10 (14.3%)	70
With All Household Members	16 (9.1%)	148 (84.6%)	11 (6.3%)	175
Daughters or Others	14 (24.6%)	42 (73.7%)	1 (1.8%)	57
Frequency of visits of the offspring				
Always (Daily)	49 (9.5%)	429 (83.0%)	39 (7.5%)	517
More than Once a Week	13 (18.6%)	50 (71.4%)	7 (10.0%)	70
Once a Week	30 (20.3%)	115 (77.7%)	3 (2.0%)	148
Once a Month	18 (45.0%)	21 (52.5%)	1 (2.5%)	40
Rare or Never	9 (8.1%)	96 (86.5%)	6 (5.4%)	111

5.3. Indicators of mental health and wellbeing in older adults

The following plot presents data on the life satisfaction of older adults in rural Bangladesh (Figure 5.2). Most older adults in rural Bangladesh report high levels of life satisfaction, with 89.2% indicating they are satisfied. This reflects a generally positive outlook on life among this demographic.

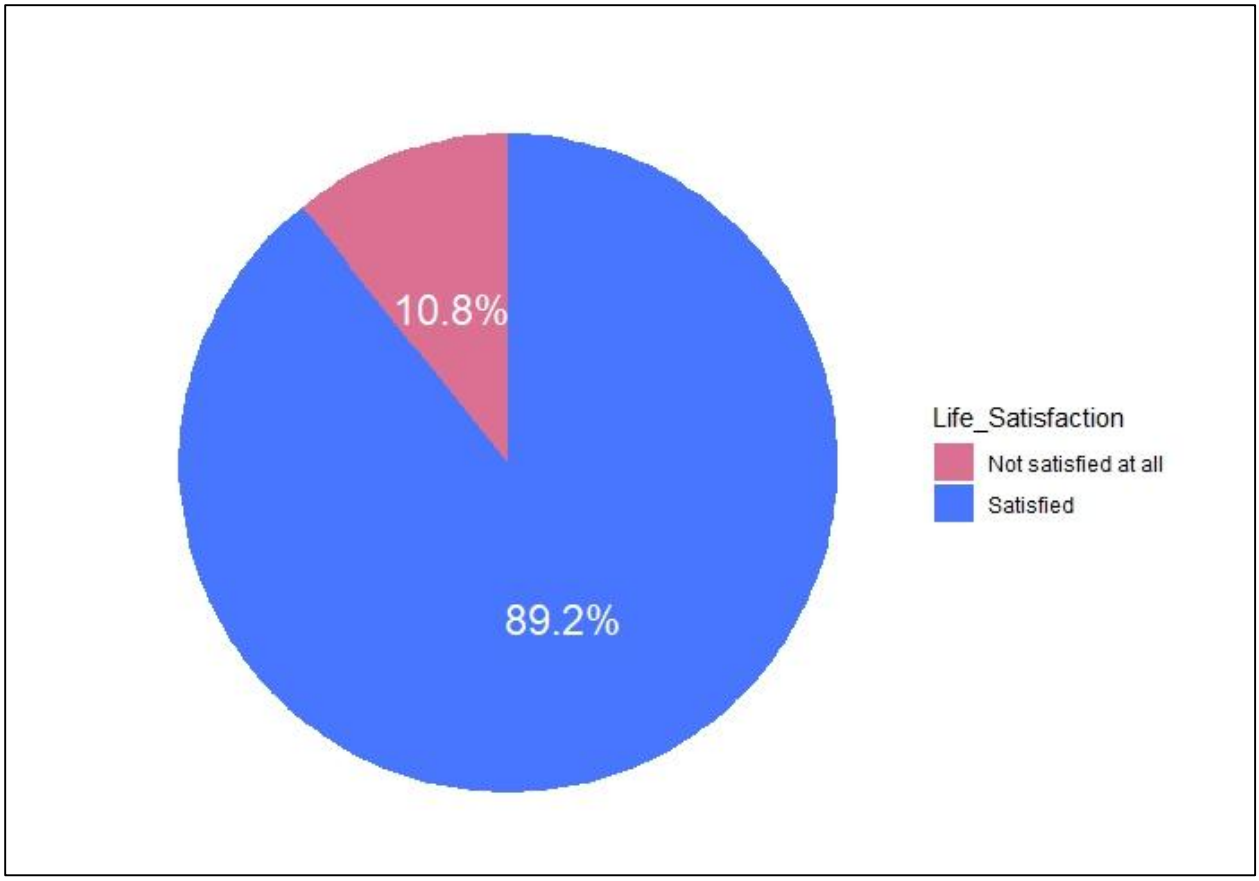


Figure 5.2. Life satisfaction of the older adults in rural Bangladesh.

Table 5.3 presents life satisfaction indicators for older adults in rural Bangladesh, with data categorized by gender. Among the 866 individuals surveyed, a majority expressed feeling satisfied in life, with 47.6% of males and 52.4% of females reporting satisfaction. Additionally, 44.9% of males and 55.1% of females indicated feelings of happiness. When it comes to energy levels, 46.1% of males and 53.9% of females reported feeling full of energy. Conversely, a significant portion experienced anxiety, with 43.4% of males and 56.6% of females reporting thoughts that make them anxious. Feelings of meaninglessness were also notable, as 40.6% of males and 59.4% of females expressed that life has no meaning. Lastly, feelings of rejection were reported by 39.5% of males and 60.5% of females. Overall, the data highlight notable gender differences in life satisfaction and emotional well-being among older adults in this rural setting.

Table 5.3. Different indicators of life satisfaction by different background characteristics of the older adults in rural Bangladesh.

Indicators	Male (385)	Female (501)	Total (866)
Feeling satisfied in life	242 (47.6%)	266 (52.4%)	508
Feeling happy	114 (44.9%)	140 (55.1%)	254
Feeling full of energy	107 (46.1%)	125 (53.9%)	232
Thoughts that make anxious	293 (43.4%)	382 (56.6%)	675
Life has no meaning	119 (40.6%)	174 (59.4%)	293

Feeling rejected	135 (39.5%)	207 (60.5%)	342

Table 5.4 examines life satisfaction among 866 older adults in rural Bangladesh. Unlike the specific indicators presented in Table 5.4, this table focuses on the overall life satisfaction of older adults. Sex differences are notable, with 90.1% of males and 88.4% of females indicating satisfaction. Age also influences satisfaction; 88.8% of those aged 60-65 are satisfied, compared to 83.3% of those over 80. Satisfaction rates vary by religion, with 98.6% of Hindus satisfied, while 88.3% of Muslims report the same. Land ownership correlates with higher satisfaction (91.1% for landowners vs. 79.6% for non-landowners). Housing conditions affect satisfaction, as 90.0% of those in pucca/semi-pucca homes are satisfied. Educational attainment also plays a role, with 91.1% of individuals who can sign reporting satisfaction compared to 86.4% of illiterate individuals. Marital status impacts satisfaction, with 90.1% of married individuals satisfied, compared to 84.2% of those who are divorced or widowed. Income is a significant factor as well; only 81.4% of those earning 501-1500 TK are satisfied, while 92.1% of individuals earning more than 5000 TK express satisfaction. Overall, the data underscores the influence of socioeconomic factors on life satisfaction among older adults.

Table 5.4. Life satisfaction by different background characteristics of the older adults in rural Bangladesh.

Variables	**Not satisfied at all (96)**	**Satisfied (790)**	**Total (866)**
Sex			
Male	38 (9.9%)	347 (90.1%)	385
Female	58 (11.6%)	443 (88.4%)	501
Age (in years)			
60-65	42 (11.2%)	332 (88.8%)	374
66-70	20 (9.3%)	194 (90.7%)	214
71-75	13 (9.2%)	129 (90.8%)	142
76-80	11 (11.5%)	85 (88.5%)	96
More than 80	10 (16.7%)	50 (83.3%)	60
Religion			
Islam	95 (11.7%)	720 (88.3%)	815
Hinduism	1 (1.4%)	70 (98.6%)	71
Land property			
No lands	31 (20.4%)	121 (79.6%)	152
Has some lands	65 (8.9%)	669 (91.1%)	734
Housing conditions			
Pucca/semi pucca	20 (10.0%)	180 (90.0%)	200
Others	76 (11.1%)	610 (88.9%)	686
Education level			
Illiterate	49 (13.6%)	312 (86.4%)	361
Can sign only	32 (8.9%)	329 (91.1%)	361
Primary (incomplete)	7 (8.3%)	77 (91.7%)	84

Primary or higher	8 (10.0%)	72 (90.0%)	80
Marital status			
Currently married	73 (9.9%)	667 (90.1%)	740
Others (divorced/widow/widower)	23 (15.8%)	123 (84.2%)	146
Occupation			
Agriculture	25 (12.1%)	181 (87.9%)	206
Others	30 (9.6%)	283 (90.4%)	313
Retired/unemployed	41 (11.2%)	326 (88.8%)	367
Monthly income			
No income	62 (13.4%)	399 (86.6%)	461
Up to 500 TK	11 (5.7%)	183 (94.3%)	194
501-1500 TK	11 (18.6%)	48 (81.4%)	59
1501-5000 TK	5 (6.0%)	78 (94.0%)	83
More than 5000 TK	7 (7.9%)	82 (92.1%)	89
Wealth index			
Poorest	21 (11.8%)	157 (88.2%)	178
Poorer	19 (10.6%)	161 (89.4%)	180
Middle	22 (12.4%)	155 (87.6%)	177
Richer	31 (17.9%)	142 (82.1%)	173
Richest	3 (1.7%)	175 (98.3%)	178

Chapter 6: Social Participation and daily activities of older adults in rural Bangladesh

6.0 Introduction

In previous chapters, we explored the health and wellbeing of older adults in rural Bangladesh. Physical and mental well-being has a strong association with recreational activities like social participation; with home/family members and involvement with community work. This chapter compiles the social participation and daily activities of older adults in rural Bangladesh.

6.1 Involvedness in other social activities of the older adults

Figure 6.1 presents the distribution of involvement in various social activities among older adults in rural Bangladesh, focusing on their participation in activities beyond daily household chores. It highlights three key dimensions of social engagement: other work inside the house, social work outside the home, and community works outside the home. The data indicates that a small percentage of older adults engage in activities beyond their regular household responsibilities. Specifically, only 12.8% report involvement in other work inside the house, while participation in social work outside the home stands at 19.0%. Additionally, 12.3% are involved in community work outside the home. This suggests that a significant majority—ranging from 81.0% to 87.7%—do not engage in these types of activities, pointing to a limited level of social participation and community involvement among older adults in this rural context.

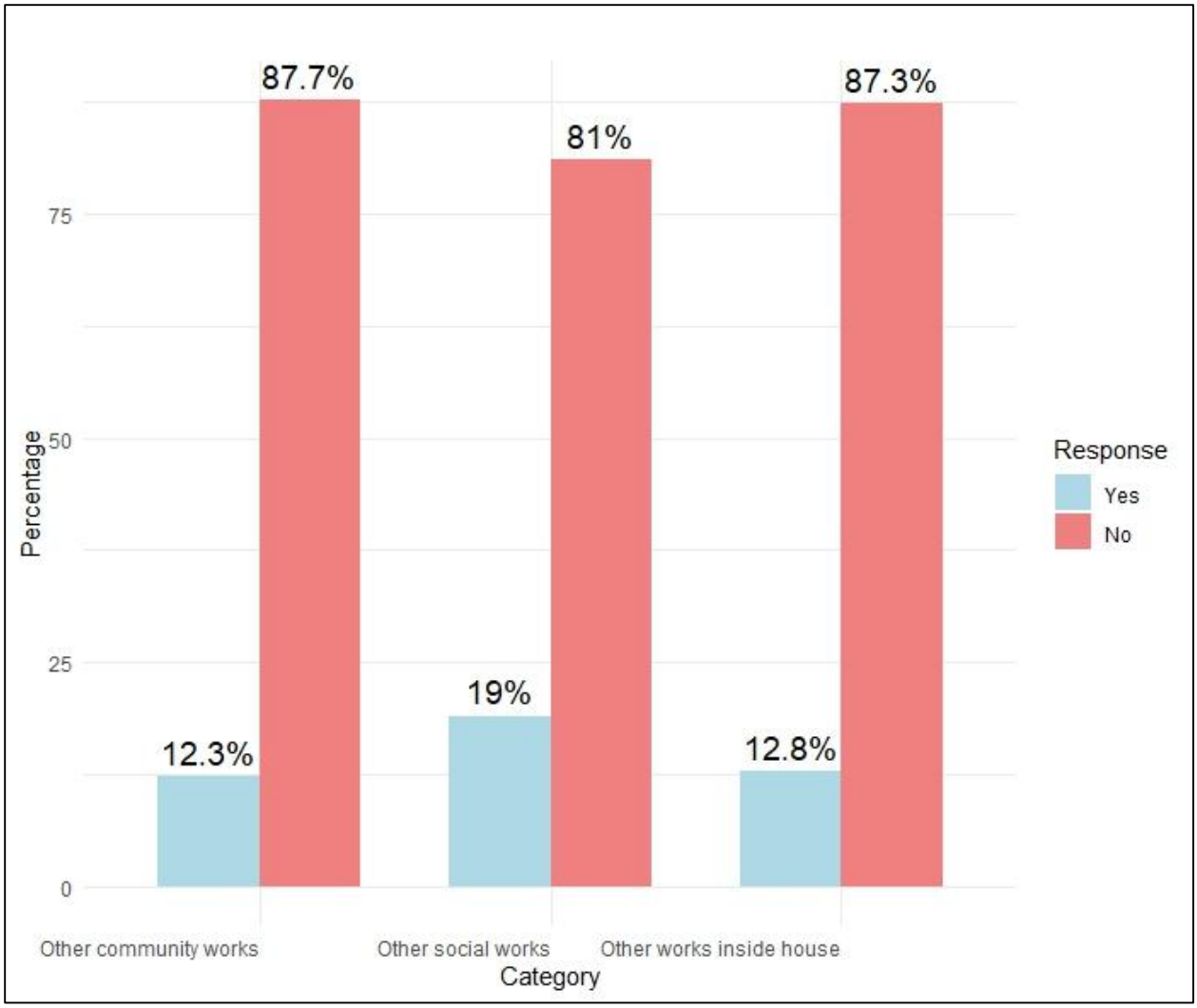


Figure 6.1. Distribution of involvedness in other social activities of the older adults in rural Bangladesh.

6.2 Determinants of involvedness in other works of older adults

Table 6.2 presents a comprehensive analysis of the involvement of older adults in rural Bangladesh in various types of activities beyond their daily household responsibilities. Specifically, it categorizes their participation into three distinct types of work: other work inside the house, other social work outside the home, and other community work outside the home. The table disaggregates participation rates based on several background characteristics, including sex, age, health condition, religion, land property, housing conditions, education level, marital status, occupation, monthly income, and wealth index. This detailed breakdown provides valuable insights into the factors influencing the engagement of older adults in these activities, highlighting the social dynamics and challenges faced by this demographic in rural settings. Understanding these trends is crucial for designing effective policies and interventions aimed at enhancing the well-being and active participation of older adults in their communities. In summary, the data reveals nuanced patterns of involvement in various types of work among older adults in rural Bangladesh, influenced by factors such as age, health condition, education, religion, land ownership, and socioeconomic

status. Understanding these dynamics is crucial for developing targeted interventions that support the active participation of older adults in their households and communities.

Table 6.2. Involvedness in other works (rather than daily household work) by different background characteristics of the older adults in rural Bangladesh.

Variables	Different types of involvedness in other social activities		
	Other works inside house (113)	Other social work outside home (168)	other community works outside home (109)
Sex			
Male	50 (13.0%)	85 (22.1%)	56 (14.5%)
Female	63 (12.6%)	83 (16.6%)	53 (10.6%)
Age (in years)			
60-65	48 (12.8%)	77 (20.6%)	46 (12.3%)
66-70	20 (9.3%)	31 (14.5%)	29 (13.6%)
71-75	23 (16.2%)	29 (20.4%)	14 (9.9%)
76-80	17 (17.7%)	21 (21.9%)	14 (14.6%)
More than 80	5 (8.3%)	10 (16.7%)	6 (10.0%)
Health condition			
Bad or Worse	5 (4.2%)	12 (10.1%)	9 (7.6%)
Fair	94 (13.2%)	145 (20.4%)	91 (12.8%)
Good or Better	14 (25.0%)	11 (19.6%)	9 (16.1%)
Religion			
Islam	99 (12.1%)	145 (17.8%)	89 (10.9%)
Hinduism	14 (19.7%)	23 (32.4%)	20 (28.2%)
Land property			
No lands	15 (9.9%)	19 (12.5%)	7 (4.6%)
Has some lands	98 (13.4%)	149 (20.3%)	102 (13.9%)
Housing conditions			
Pucca/semi pucca	26 (13.0%)	39 (19.5%)	27 (13.5%)
Others	87 (12.7%)	129 (18.8%)	82 (12.0%)
Education level			
Illiterate	36 (10.0%)	65 (18.0%)	41 (11.4%)
Can sign only	56 (15.5%)	66 (18.3%)	38 (10.5%)
Primary (incomplete)	7 (8.3%)	13 (15.5%)	14 (16.7%)
Primary or higher	14 (17.5%)	24 (30.0%)	16 (20.0%)
Marital status			
Currently married	99 (13.4%)	154 (20.8%)	103 (13.9%)
Others (divorced/widow/widower)	14 (9.6%)	14 (9.6%)	6 (4.1%)
Occupation			
Agriculture	25 (12.1%)	39 (18.9%)	28 (13.6%)
Others	42 (13.4%)	65 (20.8%)	39 (12.5%)
Retired/unemployed	46 (12.5%)	64 (17.4%)	42 (11.4%)

Monthly income			
No income	54 (11.7%)	81 (17.6%)	45 (9.8%)
Up to 500 TK	25 (12.9%)	40 (20.6%)	33 (17.0%)
501-1500 TK	5 (8.5%)	10 (16.9%)	6 (10.2%)
1501-5000 TK	13 (15.7%)	17 (20.5%)	11 (13.3%)
More than 5000 TK	16 (18.0%)	20 (22.5%)	14 (15.7%)
Wealth index			
Poorest	42 (23.6%)	57 (32.0%)	34 (19.1%)
Poorer	12 (6.7%)	32 (17.8%)	29 (16.1%)
Middle	10 (5.6%)	31 (17.5%)	28 (15.8%)
Richer	10 (5.8%)	19 (11.0%)	14 (8.1%)
Richest	39 (21.9%)	29 (16.3%)	4 (2.2%)

Among the older adults engaged in other works inside the house, a total of 113 individuals participated, comprising 50 males (13.0%) and 63 females (12.6%). This slight gender disparity indicates a marginally higher involvement among females in domestic tasks. Age also plays a significant role in determining participation levels. The highest involvement was noted among the 71-75 age group, where 23 individuals (16.2%) actively engaged in these activities. This trend may suggest that this age group, while perhaps less mobile, still contributes significantly to household responsibilities. Health status is another critical factor influencing participation. Individuals who rated their health as "Good or Better" exhibited the highest engagement, with a notable participation rate of 25.0%. This underscores the importance of physical well-being in enabling older adults to contribute to household tasks. Conversely, those classified as having "Bad or Worse" health showed the least involvement, with only 4.2% participating. Educational attainment also affects involvement levels, with illiterate individuals showing a lower participation rate of 10.0%. This finding could reflect barriers related to education and awareness regarding household responsibilities. In contrast, older adults who achieved primary education or higher displayed improved involvement rates. Interestingly, the wealth index highlights that the poorest segment of older adults had a notable participation rate of 23.6%, suggesting that economic necessity may drive greater involvement in household tasks.

When examining involvement in other social work outside the home, 168 individuals were reported to participate, with 85 males (22.1%) and 83 females (16.6%). This data reveals a more pronounced gender disparity in favor of males, indicating that men may be more engaged in social activities beyond household responsibilities. Age significantly influenced participation, with the 60-65 age group demonstrating the highest involvement at 20.6%. Additionally, the 76-80 age bracket also showed a substantial participation rate of 21.9%, suggesting that older adults in these groups are likely to be more active in their communities. Health conditions play a pivotal role in social involvement as well. Among those with a fair health rating, 20.4% participated in social work, highlighting that better health correlates with higher social engagement. In contrast, only 10.1% of those with "Bad or Worse" health conditions were involved, indicating that physical limitations can hinder participation in social activities. The religious affiliation of participants also sheds light on involvement patterns, as Hindu respondents exhibited a higher engagement rate of

32.4% compared to their Muslim counterparts at 17.8%. This disparity suggests that cultural and religious factors might influence the willingness and ability to engage in social work. Furthermore, land ownership emerged as a significant factor influencing participation in social work. Older adults with some land demonstrated a higher inclination to engage, with 20.3% involved, compared to 12.5% among those with no land. This may indicate that land ownership provides both economic stability and a sense of community responsibility, motivating participation in social endeavors.

Lastly, the participation in other community works outside the home involved 109 individuals, with 56 males (14.5%) and 53 females (10.6%). This data reflects a similar gender pattern, where males showed slightly higher involvement in community work compared to females. Age once again played a significant role in influencing participation rates. The 66-70 age group had a noteworthy participation rate of 13.6%, while the 71-75 age group experienced a decline in participation to 9.9%. This pattern might suggest that younger older adults are more inclined to engage in community activities compared to their older peers. Health status is particularly significant in determining community involvement. Among those rated as "Good or Better," the participation rate was 16.1%, indicating that better health correlates with increased community engagement. In contrast, those with poorer health conditions showed lower levels of involvement, reinforcing the idea that health limitations can impede social participation. The wealth index further illustrates the socioeconomic disparities in community involvement. Surprisingly, the richest group displayed the lowest participation rate at just 2.2%, which might suggest that wealthier individuals may have different priorities or opportunities that reduce their involvement in community activities. In contrast, older adults from poorer segments demonstrated relatively higher involvement rates, with the poorest group at 19.1%. This finding may indicate that economic challenges could motivate greater participation in community work as a means of seeking support and connection.

Chapter 7: Social Pension on the well-being of the older in rural Bangladesh

7.0 Introduction

This chapter briefly discusses the status of social pensions among older adults in rural Bangladesh. Social pensions and safety nets are essential for older adults as they provide financial security, enhance well-being, and enable active participation in their families and communities, mitigating the risks of poverty and social isolation. Different types of available sources are also shown in this chapter.

7.1 Different social safety nets for older adults

Table 7.1 presents the distribution of social safety net access among older adults in rural Bangladesh. The findings reveal a high prevalence of support, with an overwhelming 99.7% of respondents indicating that government or private organizations are working for older people in their locality. Additionally, 96.7% of older adults reported being eligible to receive some form of allowance, highlighting the widespread recognition of their needs within social safety net programmes. However, when it comes to actual financial assistance, only 74.5% stated that they had received any allowance recently, indicating a gap between eligibility and actual receipt of benefits. This suggests that while the framework for support is largely in place, there may be challenges in the implementation or distribution of these resources.

Table 7.1. Distribution of social safety net for the older adults in rural Bangladesh.

Social safety net	Yes	No
Any government/private organization working for older people in locality	883 (99.7%)	3 (0.3%)
Eligible to receive any allowances	857 (96.7%)	29 (3.3%)
Received any allowance recently	660 (74.5%)	226 (25.5%)

Table 7.2 presents the distribution of various aspects of social safety nets among older adults in rural Bangladesh. The data indicates that a significant portion of the older population, 51.5%, do not receive any allowance, while 40.7% receive an allowance of 500 BDT. Only a small fraction, 4.4%, receive more than 500 BDT. In terms of satisfaction with the amount received, a striking 84.8% of the respondent's expressed dissatisfaction, highlighting concerns over the adequacy of support. Additionally, the table reveals that 67.7% of respondents do not have the freedom to spend their received allowance as they wish, indicating potential restrictions on how financial assistance is utilized. The satisfaction of the respondents regarding the money received as allowance is plotted in Figure 7.1. In terms of satisfaction with the amount received, a striking 84.8% of the respondent's expressed dissatisfaction, highlighting concerns over the adequacy of support. This data underscores the challenges faced by older adults in accessing sufficient and flexible financial support through social safety nets.

Table 7.2. Distribution of different types of social safety nets for older adults in rural Bangladesh.

Variables	Frequency (n)	Percentage (%)
Received allowance		
Don't receive any allowance	456	51.5
500 BD Taka	361	40.7
More than 500 BD Taka	39	4.4
Satisfied with the amount of received allowance		
Yes	135	15.2
No	751	84.8
Respondent can spend the allowance received in their wish		
Yes	286	32.3
No	600	67.7

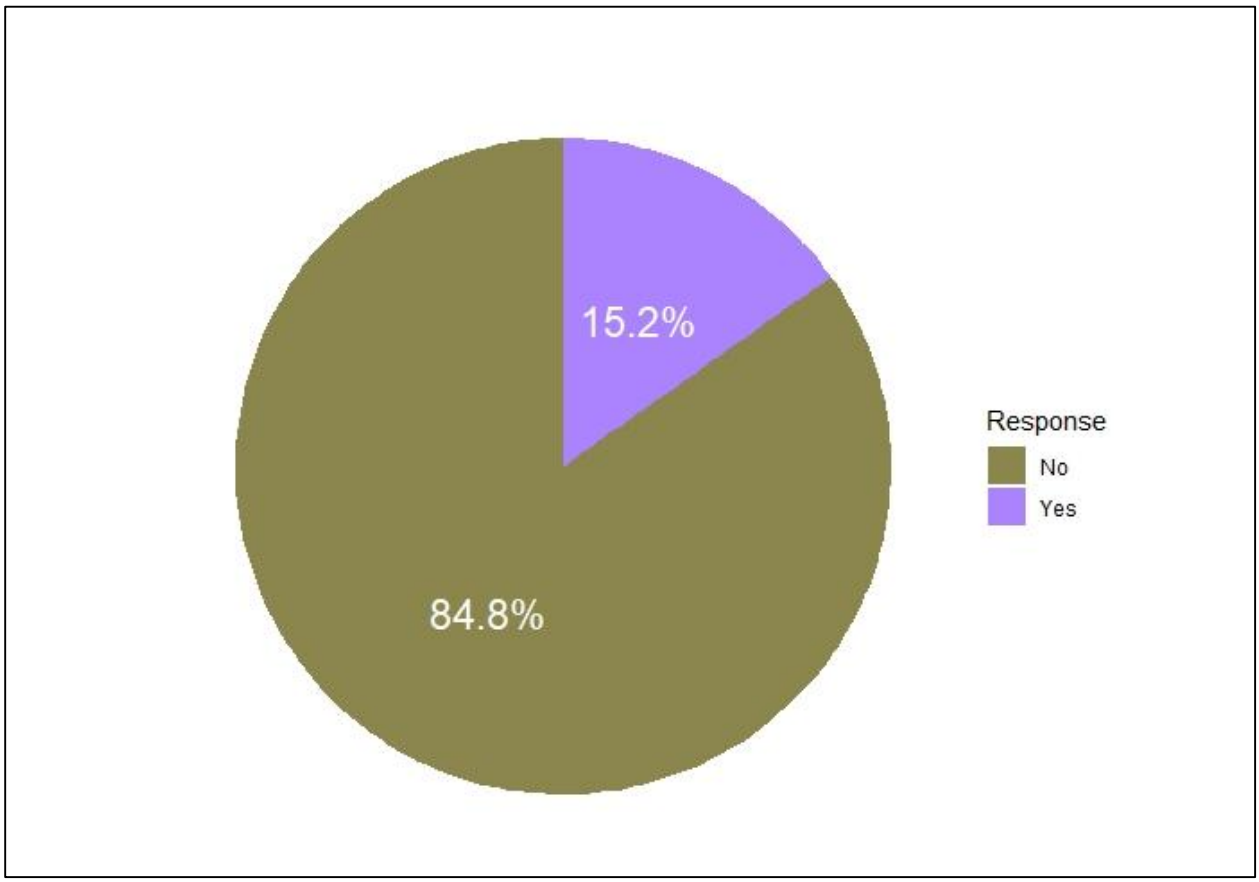


Figure 7.1. Satisfaction with the amount of received allowance the older adults in rural Bangladesh.

The levels of awareness and receipt of various social safety net allowances among older adults in rural Bangladesh are outlined in Table 7.3. The data indicates that a significant portion of older

adults are familiar with the "Allowance for the older," with 42.8% indicating awareness and 37.1% confirming receipt. Other forms of financial support, such as pensions, medical allowances, and honorariums for freedom fighters, show lower levels of both familiarity and receipt, with pension awareness at 5.6% and receipt at 3.3%, and medical allowances at 2.7% familiar and just 0.2% received. Overall, the table highlights the varying levels of awareness and actual benefits received from different social safety net programmes, underscoring the need for broader outreach and accessibility for older adults in rural communities.

Table 7.3. Received allowance and its use among the older adults in rural Bangladesh.

Social safety net	**Familiar (%)**	**Receiving (%)**
Allowance for the older	379 (42.8%)	329 (37.1%)
Pension	50 (5.6%)	29 (3.3%)
Medical allowance	24 (2.7%)	2 (0.2%)
Honorarium for freedom fighters	38 (4.3%)	20 (2.3%)
Allowance for disabled persons	17 (1.9%)	4 (0.5%)
VGD/VGF	57 (6.4%)	40 (4.5%)
Widow allowance	11 (1.2%)	8 (0.9%)

Chapter 8: Prevalence of dementia in rural Bangladesh

8.0 Introduction

This chapter briefly discusses the status of social pensions among older adults in rural Bangladesh. Social pensions and safety nets are essential for older adults as they provide financial security, enhance wellbeing, and enable active participation in their families and communities, mitigating the risks of poverty and social isolation. Different types of available sources are also shown in this chapter.

8.1 Prevalence of dementia and its indicators

Table 8.1 presents data on various indicators of dementia among older adults in rural Bangladesh. This table highlights the prevalence of specific behavioral and cognitive signs associated with dementia, providing insights into how these indicators manifest in this population. The percentages of respondents reporting "yes" or "no" for each indicator illustrate the extent of these issues within the community. Notably, a significant proportion of respondents reported losing interest in activities even after physical recovery (30.8%) and keeping themselves aloof (44.4%). Participation in family or social activities was low, with only 12.6% indicating disengagement. Difficulties with daily personal tasks were also reported by 31.2% of respondents. Cognitive challenges were evident, with 28.0% hesitating to answer questions and 26.9% unable to find the right answer. Avoidance of questions was rare (5.8%), and feelings of regret over inadequate responses were minimal (1.9%). Lastly, only 1.6% reported forgetting familial relationships, highlighting the varied impact of dementia indicators among the older population.

Table 8.1. Distribution of related indicators of dementia among older adults in rural Bangladesh

Indicators of Dementia	Yes (%)	No (%)
Losing interest in everything even after being healed physically	273 (30.8%)	613 (69.2%)
Keeping yourself aloof from everything	393 (44.4%)	493 (55.6%)
Not participating in family or social activities	112 (12.6%)	774 (87.4%)
Not being able to do daily personal tasks	276 (31.2%)	610 (68.8%)
If asked something, hesitates to answer	248 (28.0%)	638 (72.0%)
If asked something, fails to find the right answer	238 (26.9%)	648 (73.1%)
If asked something, trying to avoid it	51 (5.8%)	835 (94.2%)
Feeling sorry for not being able to answer properly	17 (1.9%)	869 (98.1%)
Forgetting relationships; ex: calling parents or offspring as ‘bhai’ (brother)	14 (1.6%)	872 (98.4%)

Figure 8.1 provides an overview of the prevalence of dementia and the treatment status among older adults in rural Bangladesh. This plot focuses on two critical indicators: the proportion of individuals diagnosed with dementia and the percentage of those receiving treatment for the condition. The findings shed light on the challenges faced by this demographic regarding dementia

awareness and access to care. The data indicates that a notable minority of older adults in rural Bangladesh are affected by dementia, with 14.6% of respondents reporting a diagnosis. However, treatment for dementia remains severely limited, as only 6.9% of those diagnosed are receiving any form of treatment. In contrast, a significant majority (about 85.4%) do not have dementia, and an overwhelming 93.1% of respondents are not receiving treatment, highlighting a critical gap in healthcare access for this vulnerable population.

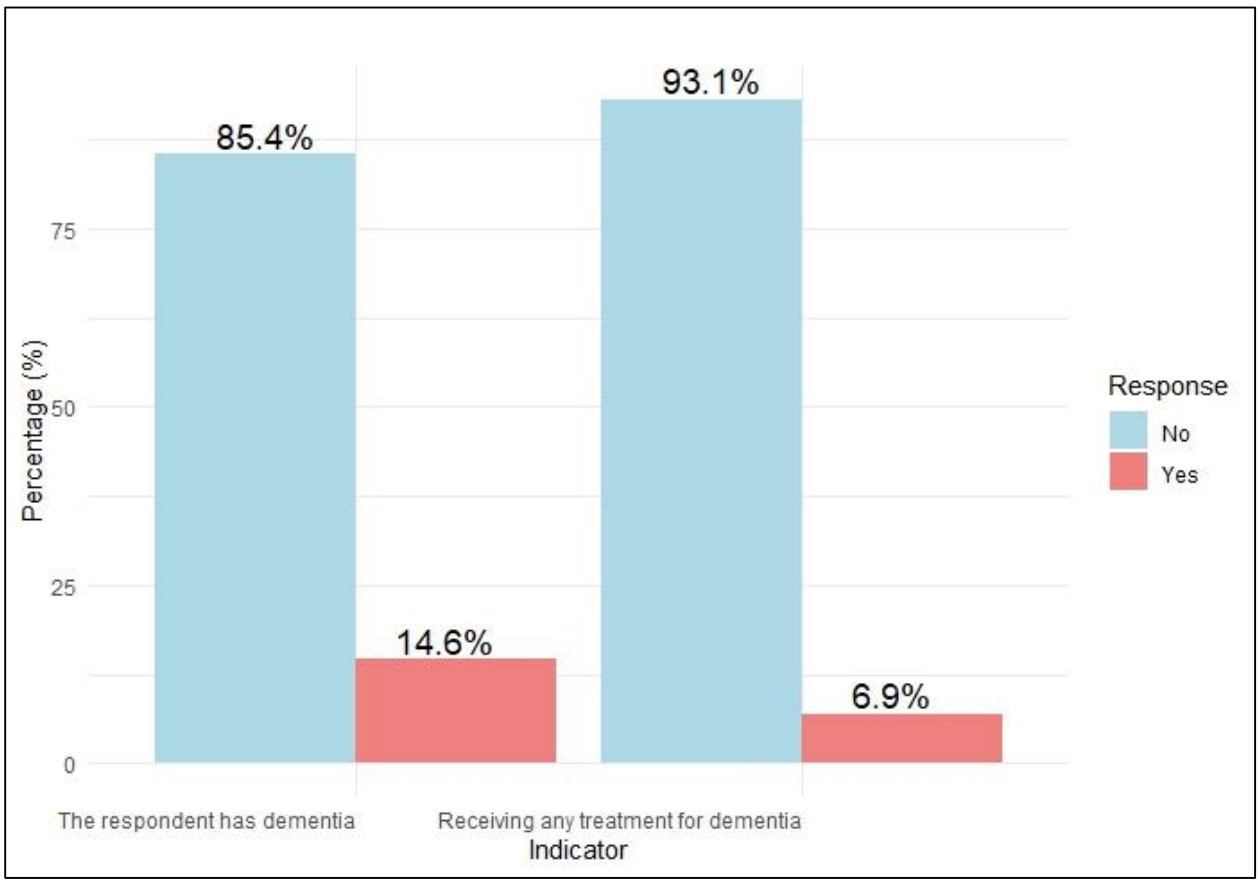


Figure 8.1. Prevalence of dementia and receiving treatment among older adults in rural Bangladesh

8.2 Prevalence of dementia by different background characteristics of the respondents

The prevalence of dementia among older adults in rural Bangladesh, categorized by various demographic and socioeconomic background characteristics is summarized in Table 8.3. This table provides valuable insights into how factors such as sex, age, religion, land ownership, housing conditions, education level, marital status, occupation, monthly income, and wealth index correlate with the likelihood of having dementia. Table 8.3 reveals a dementia prevalence of 14.6% among older adults in rural Bangladesh, with notable differences across various demographic and socioeconomic factors. Females exhibit a higher prevalence (16.6%) compared to males (11.9%), and the age group of 76-80 years has the highest rate at 17.7%. Additionally, individuals without

land ownership report a significantly elevated prevalence (26.3%) compared to those with some land (12.1%). Education level also plays a role; as illiterate individuals show a higher prevalence (16.6%). Among occupations, retirees and the unemployed have a notable rate of 17.2%, while the married population has a lower prevalence (14.3%). Interestingly, despite having better resources, the wealthiest group shows a high dementia prevalence at 25.3%. Overall, these findings underscore the complex interplay of socioeconomic and demographic factors in dementia prevalence among older adults in this rural setting.

Table 8.3. Prevalence of dementia by different background characteristics of the older adults in rural Bangladesh.

Variables	Have dementia (129)	No dementia (757)	Total (866)
Sex			
Male	46 (11.9%)	339 (88.1%)	385
Female	83 (16.6%)	418 (83.4%)	501
Age (in years)			
60-65	60 (16.0%)	314 (84.0%)	374
66-70	33 (15.4%)	181 (84.6%)	214
71-75	13 (9.2%)	129 (90.8%)	142
76-80	17 (17.7%)	79 (82.3%)	96
More than 80	6 (10.0%)	54 (90.0%)	60
Religion			
Islam	123 (15.1%)	692 (84.9%)	815
Hinduism	6 (8.5%)	65 (91.5%)	71
Land property			
No Lands	40 (26.3%)	112 (73.7%)	152
Has Some Lands	89 (12.1%)	645 (87.9%)	734
Housing conditions			
Pucca/semi pucca	26 (13.0%)	174 (87.0%)	200
Others	103 (15.0%)	583 (85.0%)	686
Education level			
Illiterate	60 (16.6%)	301 (83.4%)	361
Can Sign Only	53 (14.7%)	308 (85.3%)	361
Primary (Incomplete)	8 (9.5%)	76 (90.5%)	84
Primary or Higher	8 (10.0%)	72 (90.0%)	80
Marital status			
Currently Married	106 (14.3%)	634 (85.7%)	740
Others (Divorced/Widowed)	23 (15.8%)	123 (84.2%)	146
Occupation			
Agriculture	23 (11.2%)	183 (88.8%)	206
Others	43 (13.7%)	270 (86.3%)	313
Retired/Unemployed	63 (17.2%)	304 (82.8%)	367
Monthly income			

No Income	76 (16.5%)	385 (83.5%)	461
Up to 500 TK	22 (11.3%)	172 (88.7%)	194
501-1500 TK	9 (15.3%)	50 (84.7%)	59
1501-5000 TK	10 (12.0%)	73 (88.0%)	83
More than 5000 TK	12 (13.5%)	77 (86.5%)	89
Wealth index			
Poorest	23 (12.9%)	155 (87.1%)	178
Poorer	22 (12.2%)	158 (87.8%)	180
Middle	20 (11.3%)	157 (88.7%)	177
Richer	19 (11.0%)	154 (89.0%)	173
Richest	45 (25.3%)	133 (74.7%)	178

Chapter 9: Overall Discussion of Results

The study reveals that most of the respondents live with their sons, with notable differences between sexes: 43.2% of males and 56.8% of females. A significant portion of males (71.4%) live with their spouses, while 28.6% of females do the same. Many respondents sleep in living rooms, and a large percentage share sleeping spaces, with 40.4% of males and 59.6% of females feeling scared to live alone. Daily visits from offspring are common, highlighting strong family support, particularly for older women.

Most older adults (76.1%) receive adequate food, though only 32.4% get their favorite food regularly. Medical assistance is high, with 77.8% receiving timely medicine. However, support for social engagement and leisure activities is limited, with only 34.5% receiving help for day out. Sons are the primary providers of financial and emotional assistance. Daughters provide less support, particularly for males (32.9%) compared to females (67.1%). Neighbor visits play a crucial role in combating loneliness, with 43.6% of males and 56.4% of females reporting these interactions. Overall, the data highlights a robust family support system, especially from sons, while suggesting opportunities for enhanced community engagement. Besides, most of the older adults in rural Bangladesh rate their health as fair, with a strong reliance on sons for financial support (82.8%). This is mainly due to the cultural aspects of the country.

Many prefer to address health issues independently, although some feel unacknowledged by their families during sickness. Factors like age, gender, housing, and education significantly influence health perceptions, with better housing and education correlating with improved health outcomes. As an indicator of mental health, 89.2% of older adults report high life satisfaction, reflecting a positive outlook, however, a sex differential is present there. Moreover, our findings suggest that life satisfaction varies by age, religion, land ownership, and income, with Hindus (98.6%) showing higher satisfaction than Muslims (88.3%). These findings highlight the influence of socio-economic factors on the well-being of older adults in rural Bangladesh.

Moreover, low participation rates are observed for the older adults for daily activities: only 12.8% engage in other domestic tasks, 19.0% in social work outside the home, and 12.3% in community activities, indicating limited social engagement. A detailed analysis of these activities reveals that 13.0% of males and 12.6% of females participate in household tasks, with higher engagement among those aged 71-75 and those in better health. Educational attainment and economic necessity also influence participation levels, with poorer individuals showing greater involvement. Social work outside the home has different driving factors, say, 22.1% of males and 16.6% of females participate in such work, particularly among those aged 60-65. Health status significantly affects engagement, as those in fair health are more active, and Hindus demonstrate higher participation rates than Muslims. Land ownership is also a key factor, with those owning land showing greater community involvement.

Overall, the challenges faced by older adults in engaging in social and community activities are influenced by health, education, and socioeconomic factors. The data suggests a need for targeted interventions to enhance social participation among this demographic.

Furthermore, almost all the respondents are found to be covered by at least one safety net programme. However, only 74.5% report receiving financial assistance, indicating a gap between eligibility and actual benefits. A significant 84.8% express dissatisfaction with the amount received, and 67.7% lack the freedom to spend their allowances as they wish, highlighting issues with the adequacy and flexibility of support. Awareness and receipt of pensions and medical allowances are much lower, indicating the need for improved outreach and accessibility to these programmes for older adults in rural areas.

Our findings suggest that 14.6% of older adults in the study population are diagnosed with dementia, yet only 6.9% receive treatment. This indicates a significant gap in healthcare access, as 93.1% of respondents are not receiving any form of treatment. However, the prevalence could be underestimated as the indicators showed higher prevalence. Females have a higher prevalence (16.6%) than males (11.9%). Interestingly, the wealthiest group has a high prevalence (25.3%), highlighting the complex interplay of various factors affecting dementia in this population. On the other hand, the relevant research findings explored different issues, for instance, research by Help Age International (2021) has highlighted the gender disparities in ageing, with women often facing greater challenges in terms of health, economic security, and social support compared to men. This is evident in the findings of the current study, which show that a larger proportion of older women live alone and feel scared to do so.

While most older adults in this study receive adequate food and medical care, there is a need for more comprehensive support, including mental health services and social activities. This is consistent with the findings of the World Health Organization (WHO, 2022), which emphasizes the importance of addressing the social and psychological needs of older adults. Also, Chowdhury et al. (2015) found that older people in rural Bangladesh have a strong preference for self-management of health problems, with traditional remedies being the primary choice, indicating a strong cultural belief in traditional remedies. Besides, Ahmed et al. (2018) reported that older adults in rural Bangladesh experience a high rate of mental health issues, with depression being the most common condition, often due to factors like poverty, isolation, and chronic illnesses. Additionally, Huda et al. (2019) found that older individuals in rural Bangladesh have limited social engagement, with women being particularly disadvantaged. The study also highlights that education and economic resources are major determinants of social participation, as those with higher education and income levels are more likely to engage in community activities. As well, Rahman et al. (2020) found that while most older adults in rural Bangladesh are covered by at least one safety net programme, many do not receive the full benefits due to a lack of information or administrative inefficiencies. This highlights the importance of improving awareness and targeting social protection schemes for this population. In Addition, Roy et al. (2021) reported that dementia is a highly underdiagnosed condition in rural Bangladesh, with only a small proportion of individuals receiving treatment. The study also highlights those social and cultural factors, such as the stigma associated with mental health issues, contributing to the under diagnosis and under treatment of dementia in the region.

Chapter 10: Limitations of the Study

Based on the key findings, the following limitations can be identified:

- **Limited Generalizability:** The study focused on a specific union in Bangladesh. While it provides valuable insights into the situation of the older in that particular area, it may not be representative of the entire country.
- **Self-Reported Data:** The study relied on self-reported data, which can be subject to recall bias and social desirability bias.
- **Cross-Sectional Design:** The cross-sectional design limits the ability to establish causal relationships between variables. Longitudinal studies would be needed to track changes over time.
- **Potential Bias in Sampling:** The snowball sampling technique may introduce bias, as it relies on participants to identify other potential participants, potentially leading to a non-representative sample.
- **Limited Exploration of Mental Health:** While the study touched on mental health issues like dementia, a more in-depth exploration of other mental health conditions, such as depression and anxiety, would be beneficial.
- **Lack of In-Depth Qualitative Analysis:** While qualitative data was collected, the extent of its analysis and the depth of insights gained from it may be limited.
- **Cultural and Contextual Nuances:** The study may not fully capture the cultural and contextual nuances that influence the experiences of the older, particularly in rural areas.

Chapter 11: Policy Recommendations Based on Key Findings

1. Strengthening Social Safety Nets

- Expand Coverage: Increase the coverage of social safety net programmes like the Old Age Allowance to reach a larger proportion of the older population, especially in rural areas.
- Enhance Financial Assistance: Increase the amount of financial assistance provided through social safety net programmes to adequately meet the basic needs of the older.
- Improve Accessibility: Simplify the application process and streamline the disbursement of benefits to ensure that the older can easily access social safety net programmes.

2. Promoting Health and Well-being

- Enhance Healthcare Access: Improve access to quality healthcare services, particularly in rural areas, by establishing more healthcare facilities and increasing the number of healthcare providers.
- Promote Preventive Healthcare: Implement programmes to promote preventive healthcare, such as regular health check-ups, vaccinations, and health education campaigns.
- Address Mental Health: Increase awareness about mental health issues among the older and provide access to mental health services, including counseling and therapy.
- Support Dementia Care: Develop comprehensive dementia care plans that include early diagnosis, treatment, and support services for both patients and caregivers.

3. Empowering the Older

- Promote Financial Literacy: Provide financial literacy training to empower the older to make informed decisions about their finances.
- Encourage Social Engagement: Organize social activities and community programmes to reduce social isolation and promote active ageing.
- Support Skill Development: Offer vocational training and skill development programmes to enable the older to contribute to the economy and maintain their independence.

4. Gender-Sensitive Policies

- Address Gender Disparities: Implement policies to address gender disparities in health, education, and economic opportunities for older women.
- Promote Women's Empowerment: Empower older women by providing them with access to resources, information, and decision-making opportunities.

5. Data-Driven Policymaking

- Strengthen Data Collection: Improve data collection systems to monitor the needs and well-being of the older population.

- Utilize Data for Policy Formulation: Use data to inform evidence-based policymaking and program implementation.

6. Public Awareness Campaigns

- Raise awareness about the socio-economic and health challenges faced by the older, particularly concerning mental health issues like dementia. Engage in community education campaigns to reduce stigma and promote early diagnosis and intervention.

7. **Improve Housing Conditions**

- Develop affordable housing solutions for the older that are conducive to their health and well-being. This includes promoting housing designs that accommodate the needs of older adults and providing subsidies for housing improvements.

Chapter 12: Conclusions

This study provides a comprehensive overview of the living conditions, health status, and social engagement of older adults in rural Bangladesh, with a focus on Sayedpur Union, Sitakund Upazila. The findings highlight the crucial role of family, particularly sons, in providing financial, emotional, and social support to older adults. While family support is a major strength, gender disparities and cultural factors contribute to differences in living arrangements, access to resources, and health outcomes. The study reveals that while most older adults report adequate food and medical care, there are significant gaps in mental health support, social participation, and the personalization of care. The high reliance on sons for financial assistance and the limited involvement of daughters, especially for males, emphasize the need to strengthen support from female family members and the broader community. Social isolation and limited social engagement are prominent issues, with low participation in household tasks, social work, and community activities. These challenges are influenced by health, education, and socio-economic factors, highlighting the need for targeted interventions to enhance social inclusion and community involvement for older adults, particularly women and those in poorer health. Additionally, the findings indicate substantial gaps in the provision of social safety nets, with many older adults not receiving the full benefits of government programmes. Dissatisfaction with financial support and lack of flexibility in spending are critical concerns that need to be addressed through improved outreach and program design. A particularly concerning finding is the underdiagnoses and under treatment of dementia, which affects a significant portion of the older population. The stigma surrounding mental health issues, combined with limited access to healthcare, particularly in rural areas, calls for more robust healthcare systems, including mental health services and dementia care. In conclusion, while family structures provide a strong foundation of support for older adults in rural Bangladesh, there are several areas requiring urgent attention. Enhancing social engagement, improving healthcare access, and addressing the gaps in social protection programmes are essential to ensuring the well-being of this vulnerable demographic. Policy initiatives should focus on increasing the accessibility and flexibility of social support programmes, reducing gender disparities in caregiving, and ensuring that mental health and dementia care are integrated into healthcare services for older adults. By addressing these issues, we can improve the quality of life and promote the overall well-being of older adults in rural Bangladesh.

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