

## Family behavior with elderly people and their care seeking pattern in rural Bangladesh

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### ABSTRACT

This descriptive cross sectional study was conducted on purposively selected 400 elderly (235 male and 165 female with the age of 60 years and above) people, from four randomly selected rural areas in four divisions of Bangladesh with the aim to determine family behaviors with elderly people, health status and their care seeking patterns. Relevant information was collected by face to face interview using a pre-tested structured questionnaire. Average age of the respondents was 72.6 years for males and 70.1 years for females. About two-fifths of them were illiterate. Among the participants, 66% of males were farmers and 84.2% of females were housewives. At the time of interview 85.2% of males and 63.1% of females suffered from some kind of disability and 68.5 % of males and 66.7 % of females were found to suffer from some sorts of illness. Main type of disabilities was difficulty in walking, visual disturbance, uncontrolled urine and eating disability. Among the chronic illness; gastritis, diabetes and hypertension were most prevalent. Greater percentage (82.1%) of male respondents had their wives still alive; contrary to only 40.6 % of females had their husbands still alive. Regarding participant satisfaction of the nursing care by their family members, significant differences were noted between the literate and illiterate group. In literate group, 93.5% of literate males and 83.3% of literate females were satisfied with the family members' nursing care. Whereas among the illiterate group, 86.6 % of illiterate males and 65.8 % of illiterate females were satisfied with the family members' nursing care. Additionally, significant statistical association was found with the monthly family income and acute illness of any sort at the time of interview. **Conclusion:** The social wellbeing of the rural elderly in Bangladesh is not strong. Care and engagement of the female elderly especially were far from satisfactory, including their experience of family support. Targeted programs are needed to meet their needs. **Implication:** This analysis is helpful to policy makers and program planners to create sustainable aging policies.

### Introduction

Globally, the elderly peoples are growing faster. This change in demographics is one of the greatest concerns in the 21<sup>st</sup> century throughout the world (Baral & Sapkota, 2018). It is felt this is due to ongoing decline of global fertility and mortality at older ages. (UN- DESA, 2015). Worldwide, 901 million people over the age of 60 years or above in 2015, an increase of 48% over the 607 million older persons globally in 2000. By 2030, it is projected to grow by 56%, to 1.4 billion, and by 2050, it is more than double its size in 2015, reaching nearly 2.1 billion. Among the "oldest-old" (over 80 years old) category is growing even faster than the number of older persons overall. Since then, the number of oldest-old grew by 77% to 125 million in 2015. Projections indicate that in 2030, it will be reach nearly 202 million and by 2050 the oldest-old will be 434 million globally, having more than tripled in number since 2015 (UN, 2015).

Older persons get sick more frequently than younger ones (Kirkwood *et al.*, 1996). They also encounter non-communicable diseases such as cardiovascular diseases, chronic respiratory diseases, renal disease, cancers and diabetes as well as other chronic diseases (Rowshon, 2012; Kabir *et al.*, 2013). Several reports have referred to

the socio-economic and health-related challenges of aging societies (Jin *et al.*, 2015) and warns that health systems around the world are falling short with respect to meeting the needs of older persons (WHO, 2015).

Bangladesh is a lower middle income country, according to the National census 1974 to 2011 the growth of elderly people is gradually increasing. Report shows that elderly people were 5.7% of the population in 1974, in 2001 they were 6.38%, and by 2011 they were 7.48% (BBS, 2011). This growth is a big concern and quite alarming for Bangladesh. From the demographic point of view, elderly persons will face the problem of financial and nursing support due ongoing process of forming nuclear family and lack of economic solvency of the society (Islam & Nath, 2012). Inadequate social support is associated not only with an increase in mortality, morbidity and psychological distress but a decrease in overall general health and wellbeing (Barikdar *et al.*, 2016).

### Materials and Methods

This descriptive cross sectional study was conducted on purposively selected 400 elderly people (aged 60 years and above; 235 male and 165 female) from randomly selected four rural areas

of four divisions (Dhaka, Rajshahi, Chittagong, and Khulna) in Bangladesh; with the aim of to determine health status, care seeking patterns and their family behavior with them. Relevant information was collected by face to face interviews using a pre-tested structured questionnaire during home visits. Descriptive and inferential (Chi-square) analysis was done to find the association between dependent and independent variables using statistical software package (SPSS) version 20.

### Ethical considerations

Ethical consideration was maintained according to Helsinki Declaration (Morris, 2013) and considered: autonomy, confidentiality, beneficence and non-maleficance. All participants were informed regarding the purpose of the study and only those who willingly participated in the study were interviewed. Oral and written consent were taken from the participants prior to data collection.

### Results and Discussion

This study was conducted among the 400 elderly people; aged 60 years and above (male-235, female-165). Average age of the respondents was 72.6; SD ± 9.2 years for male and 70.1; SD ± 8.8 years for female. Forty six percent male and 70.9 % of female were illiterate. The findings of this study are congruent with the finding of a previous study; there found 80% of the respondents had low education level (Moe *et al.*, 2012). Higher percentages of male were found educated in all levels of education i.e., male education 54% compared to 29.1% of female education and none of the female found who crossed the Higher Secondary level of education. Regarding the past occupation of the respondent 66% of male was farmers, and 84.2 % of female was housewives. Most of the male (85.7%) as well as female (83.9%) respondents were lived with their families (Table 1). This finding is similar with a previous study finding; there found 85% of the elderly were living with their family or relatives (Tajvar *et al.*, 2008). Greater percentage (82.1%) of male respondents had their wives still alive; whereas only 40.6 % of females had their husbands still alive (Fig 1).

Table 1  
Socio-demographic characteristics of the respondents (N=male-235, female-165).

Parameters	Male (%)	Female (%)	Mean
<b>Age of the respondents</b>			
60-70years	55.3	69.1	M=72.63
71-80 years	26.4	17.6	± 9.23
>80 years	18.3	13.3	F=70.10
			± 8.89
<b>Educational Status</b>			
Illiterate	46	70.9	
Primary	23.8	19.4	
Secondary	23.4	9.7	
HSC and above	6.8	0.0	
<b>Family members</b>			
≤5 numbers	31.1	30.3	

6-9numbers	50.2	53.3	
≥10 numbers	18.7	16.4	
<b>Monthly family income</b>			
≤1000 BDT	90.6	94.4	M6098.42±7654.27
>10000 BDT	9.4	5.6	F4704.63±4431.42
<b>Occupation (previous)</b>			
Service	17	2.4	
Business	11.5	1.2	
Agriculture	66.0	2.4	
House wife	0.0	84.2	
Others	5.6	9.7	
<b>Occupation (Present)</b>			
Service	7.3	2.9	
Business	12.8	2.9	
Agriculture	68.8	0.0	
House wife	0.0	80.0	
Others	11.1	14.3	
<b>Living with their families</b>			
Yes	85.7	83.9	
No	7.1	9.9	
No answer	7.2	6.2	

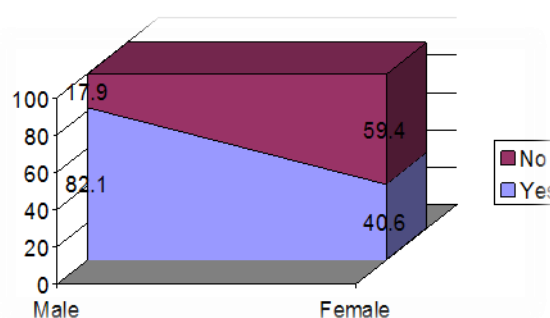


Fig. 1  
Distribution of the respondents by alive with husband/wife.

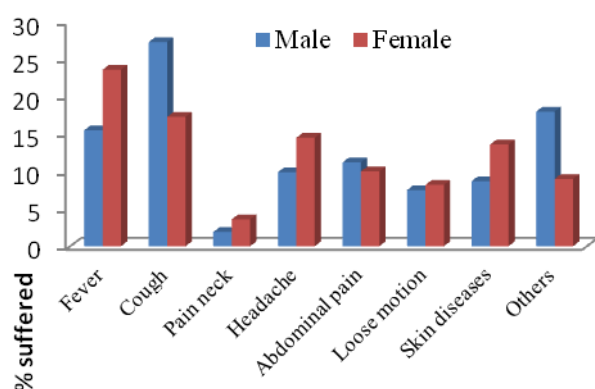
Table 2  
Body mass index (BMI), age related disabilities, sorts of acute and chronic illness, pattern of illness at the time of interview of the respondents.

Parameters	Male (%)	Female (%)
<b>BMI Nutritional status)</b>		
18.5 (underweight)	32.3	23.0
18.5-24.9 (Normal)	56.2	66.1
25.0-29.9 (Overweight)	9.4	6.7
>30.0 (Obese)	2.1	4.2
<b>Disability</b>		
Yes	71.1	69.7
No	28.9	30.3
<b>Any sorts of illness</b>		
Yes	68.5	66.7
No	31.5	33.3
<b>Pattern of illness</b>		
Regularly	33.6	44.8
Occasionally	43.3	38.8
Rare	23.1	16.4
<b>Suffered from chronic diseases</b>		
Yes	68.9	69.7
No	31.1	30.3
<b>Taking treatment during illness</b>		
Yes	95.7%	94.5%
No	4.3	5.5

**Table 3**  
Type of disabilities of the respondents as observed during interview.

Type disability	Male		Female	
	No.	%	No.	%
Difficult in walking	19	11.4	11	9.6
Blurring of vision	37	21.7	16	13.9
Loss of hearing	13	7.8	11	9.6
Physical weakness	35	21.5	18	15.7
Palpitation	12	7.2	7	6.1
Join pain	20	12.9	25	21.7
Abdominal pain	6	3.6	2	1.7
Eating disability	4	2.4	6	5.2
Uncontrolled urine/defecation	8	4.8	10	8.7
Multiple answer	13	7.8	9	7.9
<b>Total</b>	<b>167</b>	<b>100.0</b>	<b>115</b>	<b>100.0</b>

Respondents' nutritional status measured by the body mass index (BMI). Majority (56.2% males and 66.1% females) of the respondents' BMI were normal (Table 2). At the time of interview, males 71.1% and females 69.7% suffered from age related disabilities; like walking difficulty, visual disturbance, physical weakness, join pain etc in both sexes (Table 3). Almost same percents (68.5% males and 66.7% females) suffered from some sorts of illness (Table-2) like cough, fever, headache, skin diseases and others (Fig 2). And also same percentage of males (68.9%) and females (69.7%) suffered from some chronic diseases (Table 2) like gastritis, diabetes, hypertension and others (Table 4). Diabetics was found more common male than female (males 37.7% and females 25.2%), but percentage of Hypertension was more among the female (males 6.8% and females 12.2%) (Table 4). A previous study shown that the proportion of illness of the elderly lower rate (43.8% of Males, 41.4% of Females) compared to this study findings (Tajvar *et al.*, 2008). Greater percent of males suffered from cough and females suffered fever. Almost all (Male 95.7% and Female 94.5%) of the respondents took the treatment for their illness (Table 2). Analogous findings (97.39%) were seen in a previous study (Bhat & Kumar, 2017).



**Fig. 2**  
Sorts of acute diseases the respondents suffered from during interview.

**Table 4**  
Type of chronic diseases of the respondents suffered during interview.

Type chronic disease	Male		Female	
	No.	%	No.	%
Gastric ulcer/gastritis	41	25.3	34	29.6
Hypertension	11	6.8	14	12.2
Diabetes	61	37.7	29	25.2
Cough	19	11.7	15	13.0
Headache/Migraine	2	1.2	2	1.7
TB	9	5.6	11	9.7
Hypertension & Diabetes	8	4.9	5	4.3
Others	11	6.8	5	4.3
<b>Total</b>	<b>162</b>	<b>100.0</b>	<b>115</b>	<b>100.0</b>

**Table 5**  
Care seeking behavior of the respondents.

Parameters	Male (%)	Female (%)
Place of treatment attended by the respondents		
Govt. Hospital	25.5	32.1
Private Clinic	14.9	11.5
Pharmacy	11.5	7.3
Private chamber	2.1	2.4
Kobiraj/Hekim	.8	1.2
Homeopath	8.1	4.8
No treatment	2.1	2.4
Govt. Hospital, Private Clinic	34.8	38.2
Persons accompanied the respondents during treatment		
None	26.4	18.8
Wife/Husband	23.0	29.7
Son	45.9	39.4
Brother/Sister/daughters	4.7	12.1
Financial support provided for treatment		
Self-support	39.1	12.7
Wife/husband	3.4	26.7
Son	45.1	48.5
Others	12.4	12.1
<b>Total</b>	<b>100.0</b>	<b>100.0</b>

**Table 6**  
Behavior of the family members and importance of elderly in the family about decision making matters.

Parameters	Male (%)	Female (%)
Behavior of the family members		
Good behaviors	88.9	66.7
Not good behaviors	8.9	27.2
No answer	2.1	6.1
Giving importance to the elderly of the family in decision making matter		
Decision accept	81.7	45.5
Not accept	11.5	34.5
No answer	6.8	20.0

Majority of the respondents went to Government hospital and private clinics for the treatment. In the hospitals 45.9 % of males and 39.6 % of females accompanied by their son, and a considerable percentages i.e., 26.4 % of males and 18.9 % of females went alone for the treatment. Around fifty percent of the respondents (45.1 % males, 48.5 % females) were financially supported by their son for their treatment cost (Table 5).

Table 7  
Nursing care and satisfaction of the elderly.

Parameters	Male (%)	Female (%)
Persons providing nursing care		
Wife/husband	61.3	18.2
Daughter	2.1	17.6
Daughter-in-law	11.1	26.1
Others (Multiple persons)	25.5	38.1
Satisfied with family members' nursing care		
Yes	90.2	70.9

No	3.0	12.1
No answer	6.8	17.0
Satisfied with family members' nursing care and their education		
Illiterate		
Yes	86.6	65.8
No	13.4	34.2
Literate		
Yes	93.5	83.3
No	6.5	16.7

Table 8  
Suffering from sorts acute illness of the respondents in relation to Monthly family income.

Monthly income Male and Female	Suffering from any diseases								Total		
	Yes				No						
	No		%		No		%		Male	Female	
	Male	Female	Male	Female	Male	Female	Male	Female			
≥ 5000 BD Taka	81	37	62.3	72.5	49	14	37.7	27.5	130	51	χ <sup>2</sup> = 5.189
< 5000 BD Taka	80	58	76.2	50.9	25	56	23.8	49.1	105	114	P<0.02 χ <sup>2</sup> = 7.149 P<0.001

\* Note: (Approximately 80 BD taka equal 1\$)

During their illness 88.9 % of males and 66.7 % of females received good behavior from their family members as stated. In case of family decision making; 81.7 % of males and 45.5 % of females stated that their decision was honored during family decision making. Majority of the respondents i.e., 81.7% male and 45.5 % female stated they were satisfied by living with their families (Table-6). Among the respondents 90.2 % of males and 70.9 % of females were satisfied with their family members' nursing care. Percentage of satisfaction was less among the female and again 17.0 % of female remained silent to make any comment regarding the satisfaction with their members' nursing care. Significant differences were noted between the literate and illiterate group. In literate group, 93.5% of literate males and 83.3% of literate females were satisfied with the family members' nursing care. Whereas among the illiterate group, 86.6 % of illiterate males and 65.8 % of illiterate females were satisfied with their family members' nursing care (Table 7). Additional significant statistical association was found in relation to respondents' monthly family income and sorts of illness. Furthermore, the study shows that the elderly experience of respectful family members' behaviors toward the female elderly was lower than the male (Table 6 and Table 7). Another study found similar findings in similar setting; demonstrating elderly women worse situations (Barikdar *et al.*, 2016). Disruption of personal ties, loneliness and conflictual interactions are major sources of stress, while supportive social connections and intimate relations are vital sources of emotional strength (Wilson *et al.*, 1999). In Japan, for example, older people who reported a lack of social contact were 1.5 times more likely to

die in the next three years than those with higher social support (Gironda & Lubben, 2003). The elderly is a universal truth and reality in our life. So it is the responsibility of all citizens to come forward for the wellbeing of our elderly (Barikdar *et al.*, 2016).

## Conclusion

Positive supportive family behaviors with the elderly and their care patterns could be improved. This was especially true for the female elderly. This vulnerable group in society experienced greater dissatisfaction with care, less decision making and poorer behaviors from their family support. This was compounded by death of a spouse, lower education level and illiteracy. Formulations of equitable proper health policies and programming by the governments, involving international organizations and civil society is very much needed to meet their needs, provision of care and peaceful life circumstances of this group.

## Implication

This data may provide guidance to policy makers and program planners to make need based policies and plan provision of care for the elderly peoples' social well-beings and health status.

## Limitations

This study limitation is study design and disproportionate numbers of males (n = 235) and females (n= 165) respondents. And also these study findings do not depict the whole elderly peoples' scenario of health and wellbeing in

Bangladesh. Subsequent studies would need to be done to draw a more comprehensive summary of family behavior with elderly people and their care seeking pattern in rural Bangladesh.

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